



*Kareo Rejection
Troubleshooting Guide
August 2007*

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Introduction

While using Kareo, you may receive electronic claim rejections from any one of three different sources: 1) Kareo, 2) clearinghouses, or 3) payers. This guide shows how to correct electronic claim rejections and re-bill electronic claims; and it also provides a list of the most common electronic claim rejections along with detailed instructions on how to correct each type of rejection.

Correcting Claim Rejections

As of the August 2007 release, Kareo has simplified the method for correcting and rebilling claims. First, we've added hyperlinks to the **Patient** and **Appointment** records so that you can easily link directly to these records to make needed corrections. Secondly, once corrections have been made to an encounter, you can now click the **Show Claims** button at the bottom of the encounter record to show all claims associated with the encounter. You will then have the option to rebill all claims associated with the encounter record, or rebill only certain claims.

To make corrections and rebill one or more claims associated with the encounter, do the following:

1. You can access the encounter record directly from most of the clearinghouse reports by clicking the hyperlinked encounter number located within the report. If the error is within the encounter record, edit the encounter as necessary.

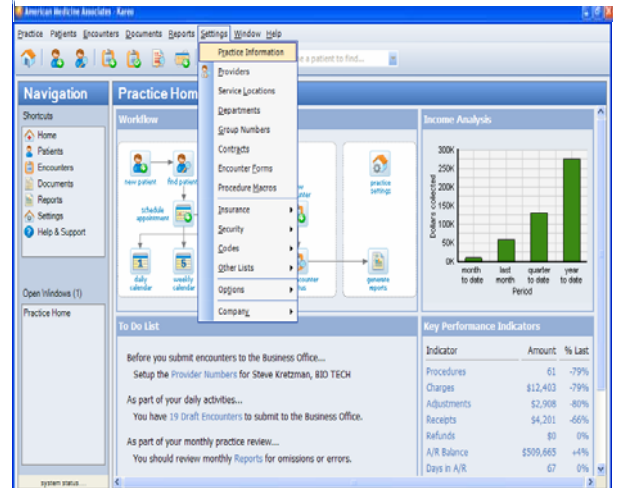
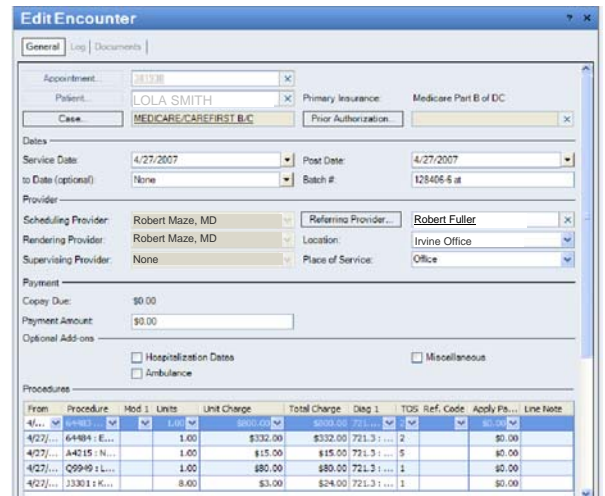
You can also add a referring physician to the encounter record, change the referring physician, or you can double-click the link in the **Referring Physician** field of the encounter to make any changes to the referring physician record.

If any changes need to be made to the patient, case, or appointment record associated with the encounter, double-click on the link within the appropriate field to open the corresponding record. Once you make the corrections to the patient, case, or appointment record and save the record, you will be automatically returned to the encounter record.

Certain rejections will require changes to your settings, particularly provider and group numbers. To make changes to a Practice, Provider, Group, or Service Location record, access the record from the **Settings** menu. Once you locate and select the type of record you wish to change, make the necessary changes and then save the record.

Note: Since many of the electronic claim rejections that Kareo customers receive are related to incorrect configuration of provider and/or group numbers, Kareo has published a special guide for setting up provider and group numbers, which you can download from the "Guides" section of the Kareo Help & Support website. It can also be downloaded by clicking the link at the top of the Provider or Group Number Record. This guide goes into great detail on the user of provider and group numbers, and how to best configure them to avoid claim rejections in the future.

2. Once you have made the necessary corrections to the encounter record, or to any other records related to the encounter or claim, and saved the corrections, you will need to re-set each corrected claim back to the "ready" status so that the claim can be resent. To rebill the claims associated with the encounter, do the following:
 - Click the **Show Claims** button at the bottom of the encounter record. This opens the claims browser displaying all claims associated with the encounter.
 - Right click anywhere within the list area to display the **Action** menu.
 - Select "Rebill" to open the Transaction screen.
 - Click **Apply** on the right of the Transaction screen. Note that a message will appear asking if you would like to rebill all claims associated with the encounter. Clicking **Yes** will reset all claims to Ready status. Clicking **No** will reset only the selected claim.



Kareo Internal Validation Reports

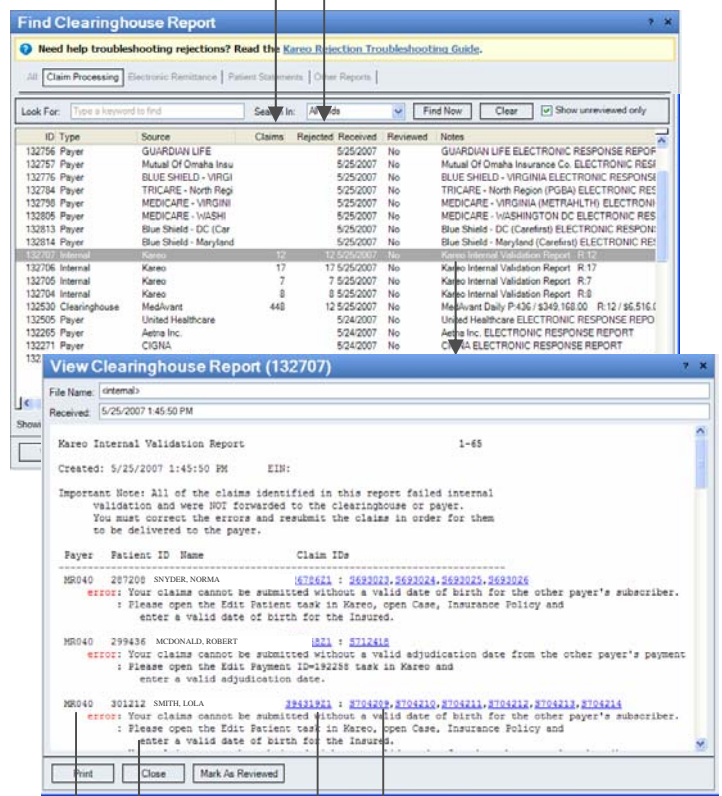
Prior to transmitting claims to the Clearinghouse, Kareo runs an internal validation check to see if all required information is present. If any information is missing or invalid, all claims associated with the encounter are rejected, and reported on an Internal Validation Report. These reports can be found under the “Claim Processing” tab of the Clearinghouse Reports task.

Internal Validation Checks:

- Patient’s full name, date of birth, gender, address, and phone number.
- When Guarantor (other than patient) is checked under the General tab of the patient record, the system checks to see if a guarantor name and address has been entered.
- If Insured is other than patient, the system checks to see if the insured’s full name, address, Insured’s ID, date of birth, and gender have been entered.
- The system checks both the primary and secondary insurance policies to see if the policy number has been entered in the Policy # field.
- The system checks to see if a valid provider number type has been entered under the “Provider Numbers” tab of the rendering provider record, and that the number is the correct provider number type required by the payer being billed.
- When a referring physician has been entered on an encounter record, the system checks to see that a valid provider number type has been entered under the Provider Numbers tab of the referring physician record; and that the number is the correct provider number type required by the payer being billed.
- When billing secondary payors, the system checks to see if an adjudication date has been entered on the payment received from the primary payer.
- When DME-related procedure codes, are used on an encounter record, the system also checks to see if the referring physician’s address has been entered under the “General” tab of the referring physician’s record.

The above list is not all inclusive, but covers the majority of the types of information Kareo checks prior to submitting claims to the clearinghouse. The rejection table on the following page covers the most common types of errors listed in an Internal Validation Report, and provides details on how to resolve the errors.

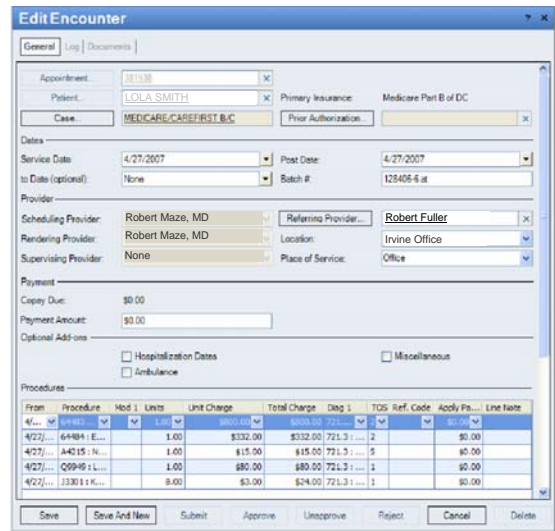
The number under the “Claims” column indicates how many claims are included in the report. The number under the “Rejections” column indicates how many rejections are included in the report.



ID # of Payer billed

Encounter record (Clicking the number with a Z within the number sequence opens the encounter record.

Claim(s) Clicking any of the numbers beginning with the letter S opens the specific claim. Note that when there is more than one claim created from an encounter record, all claims associated with the encounter will be displayed.



Kareo Rejections

(Below is a list of the most common Kareo rejections and how to resolve them.)

	Error: Description	Further Explanation	Resolution
1	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 payor requires a different type of provider number for the referring physician named on a claim.
2	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.
3	UPIN missing for referring provider: (Name)	Your Medicare claims cannot be submitted without appropriate UPIN (1G provider number).	Open the Edit Referring Physician task in Kareo; and under Provider Numbers tab enter a valid UPIN (provider number type 1G). A Valid UPIN format is 6 positions long, either 1st position alpha and positions 2-6 numeric; or positions 1-3 alpha and positions 4-6 numeric. Spaces not allowed in UPINs. Check your UPIN at http://www.upinregistry.com/provider_form.asp
4	Missing 1A or 1B provider number for payer type BL	Your claims cannot be submitted without appropriate provider numbers.	Open the Edit Provider task in Kareo; and under the Provider Numbers tab, add the payer-assigned Blue Shield or Blue Cross provider number.
5	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.
6	Too many (6) Provider Numbers defined	ANSI837 allows up to 5 Provider Numbers	Open the Edit Provider task in Kareo; and under the "Provider Numbers" tab, attach Provider Numbers to specific Insurance Companies, not to ALL; unless, of course a provider number is for all payors who do not require a unique payor assigned provider number.
7	Missing 1C provider number for payer type MB	Your claims cannot be submitted without appropriate provider numbers	Open the Edit Provider task in Kareo; and under the Provider Numbers tab, add the payer-assigned Medicare provider number.
8	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.
9	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).
10	Referring physician Provider Number 1D or G2 is missing	Payer MCO29 requires that you supply Provider Number 1D or G2 to identify the referring physician	Open the Edit Referring Physician record in Kareo; and under the Provider Numbers tab, enter a valid provider number to identify the doctor to the Payer. Typically Medicaid payors require the 1D provider number for referring physicians; unless otherwise specified by the payor.
11	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.
12	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).
13	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.
14	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.
15	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).
16	UPIN not valid [XXXXXXXXXX] for referring provider.	Your Medicare claims cannot be submitted without appropriate UPIN (1G provider number).	Open the Edit Referring Physician task in Kareo; and under Provider Numbers tab enter a valid UPIN (provider number type 1G). A valid UPIN format is 6 positions long, either 1st position alpha and positions 2-6 numeric; or positions 1-3 alpha and positions 4-6 numeric. Spaces not allowed in UPINs. Check your UPIN at http://www.upinregistry.com/provider_form.asp

Clearinghouse Reports

Once claims arrive at the clearinghouse, the clearinghouse also runs a series of checks prior to transmitting the claims to the payor. If any known payor-required information is missing or invalid, all claims associated with the encounter are rejected. These rejections appear along with acknowledgements on the Clearinghouse report. Under the “Notes” column of a clearinghouse report, you can view which claims were acknowledged and forwarded to the payor, and which claims were rejected. (The rejected claims are indicated in red.)

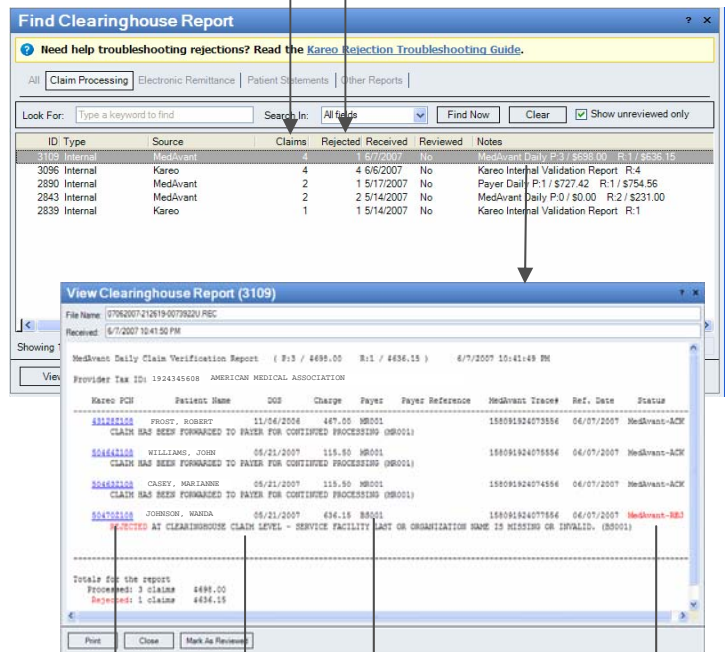
These reports can also be found under the “Claim Processing” tab of the Clearinghouse Reports task.

Clearinghouse Checks:

- Missing or invalid Practice, Provider, Group Number, or Service Location primary and secondary IDs.
- Missing or invalid ID qualifiers.
- Missing submitter IDs when payor requires a unique submitter ID.
- Missing or invalid payor 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.

The above list is not all inclusive, but covers the majority of the types of information the clearinghouse checks prior to transmitting the claims to the payor. It is impossible for the clearinghouse to keep up with every payor’s requirements; and on top of that, payors often change their requirements. However, the clearinghouse tries to catch as many known errors as possible before forwarding the claims to the payor. The rejection table on the following pages covers the most common types of errors listed in Clearinghouse reports, and provides details on how to resolve the errors.

The number under the “Claims” column indicates how many claims are included in the report. The number under the “Rejections” column indicates how many rejections are included in the report.



[Encounter record](#)
(Clicking the encounter link opens the encounter record.)

To view information about this payor (such as the payor name, payor settings, etc.), copy this payor ID number into the search bar of the Insurance Company browser (under Settings > Insurance Companies > Find Insurance Company) and then click **Find Now** to locate the payor.

MedAvant-ACK indicates Clearinghouse acknowledgement

MedAvant-REJ indicates Clearinghouse rejection

For rejected claims, the message below the patient's name indicates the reason for the rejection.

Clearinghouse Rejections

(Below is a list of the most common clearinghouse rejections and how to resolve them.)

	Error: Description	Further Explanation	Resolution
1	<p>REJECTED AT CLEARINGHOUSE BILLING PROVIDER SECONDARY IDENTIFIER IS MISSING OR INVALID (...)</p> <p>or...</p> <p>REJECTED AT CLEARINGHOUSE BILLING PROVIDER NAME / PRIMARY IDENTIFIER IS MISSING OR INVALID (...)</p>	<p>This rejection is caused by one of three reasons:</p> <ol style="list-style-type: none"> 1. No group provider number was included on the claim, if this is the case at the end of the clearinghouse error message you will see the following: () 2. A group provider number was included 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 provider number). 3. A group provider number was included on the claim, but the qualifier used is invalid or included an additional number that is not required. If this is the case at the end of the clearinghouse error message you will see the following: (invalid qualifier). <p>Note: The Billing Provider name is actually referred to as the "Practice" name in Kareo.</p>	<p>If billing the payer as a group, Go to Settings > Group Number s</p> <p>If billing the payer as an individual (no group number) Go to Settings > Provider > Provider Numbers tab</p> <ul style="list-style-type: none"> • Make sure you have a provider number set up and linked to the same insurance plan that is shown on the patient's case. • Make sure the provider number you set up is using the correct qualifier (i.e., 1C = Medicare, 1D= Medicaid, etc.). • Please note that you must set up a provider number for each insurance plan that requires a provider number. For example, if you have 4 different plans for BCBS, you must set up the group and/or provider number 4 times, once for each insurance plan. • If this all appears correct, verify with the payer that you are using the correct group and/or provider number.
2	<p>REJECTED AT CLEARINGHOUSE CLAIM LEVEL - RENDERING PROVIDER SECONDARY IDENTIFIER IS MISSING, INVALID, OR GREATER THAN 30 BYTES (...)</p> <p>or...</p> <p>REJECTED AT CLEARINGHOUSE CLAIM LEVEL - RENDERING PROVIDER NAME / PRIMARY IDENTIFIER IS MISSING OR INVALID (...)</p> <p>or...</p> <p>1 CLAIM LEVEL - RENDERING PROVIDER NAME / PRIMARY IDENTIFIER IS MISSING OR INVALID - [] **** REJECTED **** ----- -----</p>	<p>This rejection is caused by one of four reasons:</p> <ol style="list-style-type: none"> 1. No rendering provider number was included on the claim, if this is the case at the end of the clearinghouse error message you will see the following: () 2. A rendering provider number was included on the claim, but 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 provider number). 3. A rendering provider number was included on the claim, but the qualifier used is invalid or included an additional number that is not required. If this is the case at the end of the clearinghouse error message you will see the following: (invalid qualifier). 4. The group number required by the payer was not on the claim. 	<p>If billing the payer as a group check the following: Go to Settings > Group numbers</p> <p>If billing the payer as an individual (no group number) check the following: Go to Settings > Provider > Provider Numbers tab</p> <ul style="list-style-type: none"> • Make sure you have a provider number set up and linked to the same insurance plan as what is shown on the patient's case. • Make sure the provider number you set up is using the correct qualifier (i.e., 1C = Medicare, 1D= Medicaid, etc.). • Please note you must set up a provider number for each insurance plan that requires a provider number. For example, if you have 4 different plans for BCBS, you must set up the group and/or provider number 4 times, once for each insurance plan. • If this all appears correct, verify with the payer that you are using the correct group and/or provider number.
3	<p>REJECTED AT CLEARINGHOUSE LINE LEVEL - PROCEDURE CODE MODIFIER IS MISSING OR INVALID. (...)</p>	<p>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.</p>	<p>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.</p>
4	<p>ERROR: Primary insurance submitter id</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.</p> <p>Please contact the enrollment department at Kareo if you don't know the submitter number for the payer in question.</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 payor 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 payor 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 > 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 payor in the Group Number field. • Select "Electronic Claims Only" from the drop-down list in the Attach to field.

			<ul style="list-style-type: none"> 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"> Go to Settings > Group Numbers > New Group Number 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> <p>Additional Note: The above settings need to be configured for each insurance plan where the payor requires a unique submitter number; and, again, is ONLY required for claims sent through the MedAvant clearinghouse.</p>
5	<p>1 CLAIM LEVEL ADJUSTMENT - OTHER PAYER CLAIM LEVEL ADJUSTMENT IS MISSING OR INVALID. - [] **** REJECTED **** ----- ----- or...</p> <p>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> <ul style="list-style-type: none"> Click the link that will take you to the patient’s case. 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. 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.
6	<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</p> <p>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>
7	<p>REJECTED AT CLEARINGHOUSE CLAIM LEVEL - SERVICE FACILITY SECONDARY IDENTIFICATION NUMBER QUALIFIER IS MISSING OR INVALID (...)</p>	<p>This rejection is caused by one of three reasons:</p> <ol style="list-style-type: none"> 1. No facility ID number was on the claim, if this is the case at the end of the clearinghouse error message you will see the following: () 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). 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>Typically, you will get this message if the payor requires a facility ID number.</p> <p>Go to Settings > Service Location</p> <ul style="list-style-type: none"> Open Service location record and make sure that you have the Facility ID 2-digit qualifier and description set up correctly (typically “1J – 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.
8	<p>REJECTED AT CLEARINGHOUSE PAYOR ID MISSING/INVALID (...)</p>	<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.</p> <ul style="list-style-type: none"> 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 payor connection appears correct, please contact Kareo support for further assistance.
9	<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>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>

		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.	
10	REJECTED AT CLEARINGHOUSE LINE LEVEL - PROCEDURE CODE IS MISSING OR INVALID. (...)	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 missing.	On the clearinghouse report, click the link that will take you to the original encounter. Make the necessary changes to the procedure code or procedure date. Once you make the correction, save the encounter record.
11	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. (...)	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).	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: <ul style="list-style-type: none"> • 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.
12	REJECTED AT CLEARINGHOUSE CLAIM LEVEL - REFERRING PROVIDER SECONDARY IDENTIFICATION NUMBER QUALIFIER IS MISSING OR INVALID (...)	This rejection is caused by one of three reasons: <ol style="list-style-type: none"> 1. No referring provider number was on the claim, if this is the case at the end of the clearinghouse error message you will see the following: () 2. A referring provider 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 provider number). 3. A referring provider number was included on the claim, but the qualifier used is invalid or an additional number was included but not required. If this is the case at the end of the clearinghouse error message you will see the following: (invalid qualifier). 	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 open the referring physician record; and then do the following: <ul style="list-style-type: none"> • Check to see if you have a provider number set up and linked to the same insurance plan that is shown on the patient's case. • Check to see if the provider number set up is using the correct qualifier <p>Note: The Referring Provider number required would typically be the physician's UPIN number (Type 1G); unless the specific payor being billed requires a different type of provider number. (For example, a Medicaid payor requires the 1D–Medicaid Provider Number, and BC/BS of MI requires the Referring Physician's state license number.</p> <p>If you are not sure what provider type and number to use for a referring physician, contact the payor directly for clarification.</p> <p>Also Note... Many payors will soon require the Referring Physician's NPI number as well. Once you obtain that number from the Referring Physician, enter the NPI number under the "General" tab of the Referring Physician record.</p>
13	REJECTED AT CLEARINGHOUSE SUBSCRIBER PRIMARY IDENTIFICATION NUMBER IS MISSING OR INVALID (...)	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	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, <ul style="list-style-type: none"> • 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.
14	1 CLAIM LEVEL - RENDERING PROVIDER SPECIALTY CODE IS MISSING OR IN VALID. - [ooooooooo] **** REJECTED **** ----- ----- or... REJECTED AT CLEARINGHOUSE CLAIM LEVEL - RENDERING PROVIDER SPECIALTY CODE IS MISSING OR INVALID. (...)	The rejection is cause by the user selecting unknown as the specialty type for the provider or not selecting a specialty at all.	Go to Settings > Providers <ul style="list-style-type: none"> • 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.

Payor Reports

Once the payor receives a batch of claims, they also review the claims for missing or invalid information before adjudicating the claims.

One of the main differences between a clearinghouse report and a payor report is that, with clearinghouse reports, the clearinghouse rejects all claims associated with an encounter record; where a payor may reject a single claim and process the remaining claims created from an encounter, or the payor may reject all claims created from the encounter, depending on the reason for the rejection.

Another difference between the two reports is that under the Status column on the far right of the report screen, it will indicate whether the items listed are Clearinghouse acknowledgements or rejections, or payor acknowledgements or rejections; otherwise the two report screens look almost identical.

The reasons for payor rejections are too numerous to mention since many payors have unique requirements, and those requirements may change over time.

The rejection table on the following pages covers the most common types of rejections listed in payor reports, and provides details on how to resolve the errors.

If you are still not sure how to resolve a problem, contact the payor directly for clarification. Be prepared to provide information about the type of error message you are receiving from the payor.

The number under the "Claims" column indicates how many claims are included in the report. The number under the "Rejections" column indicates how many rejections are included in the report.

[Encounter record](#)
(Clicking the encounter link ,opens the encounter record.

For rejected claims, the message below the patient's name indicates the reason for the rejection.

To view information about this payor (such as the payor name, payor settings, etc.), copy this payor ID number into the search bar of the Insurance Company browser (under Settings > Insurance Companies > Find Insurance Company) and then click **Find Now** to locate the payor.

Payor-ACK indicates payor acknowledgement

Payor-REJ indicates payor rejection

Payor Rejections

(Below is a list of the most common payor rejections and how to resolve them.)

	Error: Description	Further Explanation	Resolution
1	<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 payor in the end when the payor 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 ONLY required when a payor 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 payor 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 payor 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> <p>Additional Note: The above settings need to be configured for each insurance plan where the payor requires a unique submitter number; and, again, is ONLY required for claims sent through the MedAvant clearinghouse.</p>
2	<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.
3	<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 payor Ensure the provider number in question is correct and starts with an alpha character (A-Z)
4	<p>REJ Billing Provider Numbers must begin with an alpha character. (...)</p>	<p>Payer is rejecting the claim due to an invalid group ID number</p>	<p>If billing as a group, Go to Settings > Group Numbers Make sure that the group number in question is correct and starts with an alpha character (A-Z)</p> <p>If billing as an individual (no group number), Go to Settings > Provider > Provider Numbers Make sure that the provider number in question is correct and starts with an alpha character (A-Z)</p>
5	<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>
6	<p>REJ TYPE: Do NO: 01 FIELD: PROV ID DATA IN ERR: 123456789 INV: PROV ID FOR PAYER</p>	<p>Payer is rejecting the claim because the provider number submitted (123456789) is invalid.</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 Make sure that the provider number linked to the payer in question is the number you received approval for electronic submission.</p>
7	<p>REJ 00421 - DETAIL PERFORMING PROVIDER NUMBER NOT ON PROVIDER FILE. NOTE: AS OF 4/7/2002, OLD MEDICAID P NUMBERS ARE NO LONGER ACCEPTED, PLEASE SUBMIT A VALID TPI FOR THIS SERVICE.</p>	<p>Payer is rejecting the claim because the performing provider number submitted is either missing or isn't in the correct format.</p>	<p>Go to Settings > Provider > Provider Numbers Make sure that the provider number linked to the payer in question is the number you received approval for electronic submission.</p>
8	<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 payor-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 payor being billed.</p>
9	<p>REJ Billing Provider Number must be 6 digits.</p>	<p>Payer is rejecting the claim due to an invalid group ID number</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 exactly 6 digits long.</p> <p>If billing as an individual (no group number), Go to Settings > Provider > Provider Numbers tab Make sure that the provider number linked to the payer in question is exactly 6 digits long.</p>
10	<p>REJ ERR CODE: AW1 RENDERING PHYSICIAN EIN/SSN IS REQUIRED</p>	<p>This is a rejection is normally received from TriCare. The payer rejected the claim(s) because they require electronic claims to be sent as a group with a group and individual provider ID number.</p>	<p>Go to Settings > Group Numbers</p> <ul style="list-style-type: none"> • Add a new group number as a 1H type for each TriCare plan. • If Tricare has not assigned you a specific group number use the practice/provider tax ID. <p>Go to Settings > Provider > Provider Numbers tab</p> <ul style="list-style-type: none"> • Add a new provider number as a 1H type for each Tricare plan. • If Tricare has not assigned you a specific provider number use the practice/provider tax ID
11	<p>REJ CLAIM(...) FOR THE ABOVE MEMBER HAD ERRORS: 2010AAREF B P ADTL ID ZZZ32161Z M012 BILLING PROV NOT ON FILE BATCH DELETE 2010AAREF B P ADTL ID ZZZ32161Z M013 SUBMIT BPRV NOT ON FILE BATCH DELETE</p> <p>or...</p> <p>REJ CLAIM(...) FOR THE ABOVE MEMBER HAD ERRORS: 2010AAREF B P ADTL ID 000000 M012 BILLING PROV NOT ON FILE BATCH DELETE 2010AAREF B P ADTL ID 000000 M013 SUBMIT BPRV NOT ON FILE BATCH DELETE</p>	<p>Payer is rejecting the claim due to the provider ID number submitted (000000), not being on file with them and have deleted the batch. 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 tab Make sure that the provider number linked to the payer in question is the number you received approval for electronic submission.</p>
12	<p>REJ Procedure Code must be a valid code. (...)</p>	<p>Payer is rejecting the claim because one of the procedure codes used is invalid per their edits.</p>	<p>On the clearinghouse report, click the link that will take you to the original encounter. 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>

13	<p>REJ PROVIDER-123CBBHP NOT VALID WITH SUBMITTER-GAFo2-999</p> <p>or...</p> <p>REJ ACKNOWLEDGEMENT/RETURNED AS UNPROCESSABLE CLAIM Entity not approved as an electronic submitter. Submitter</p>	<p>The payer is rejecting the claim because they don't have the provider number submitted (123CBBHP) linked to the clearinghouse submitter number(GAFo2-999).</p> <p>or...</p> <p>The rejection is caused by the provider not being fully approval to submit electronic claims to this payer.</p>	<p>Please make sure you don't submit claims electronically until you receive an approval notice from Kareo that your setup is complete for a specific payer.</p> <p>If you did get that approval first and still received this rejection, please contact the enrollment department at Kareo for assistance.</p>
14	REJ ISAo6 INTERCHANGE SENDER ID NOT AUTH (...)	This rejection is typically caused by a communication issue between the clearinghouse and the payer.	Please contact Kareo support for assistance.
15	REJ INVALID PROVIDER GROUP (...)	REJ Billing Provider Numbers must begin with an alpha character. (...)	<p>Go to Settings > Group Numbers</p> <p>Make sure that the group number in question is set up correctly.</p>
16	REJ Billing Provider Number must be 9 to 12 digits.	Payer is rejecting the claim due to an invalid group ID number	<p>If billing as a group,</p> <p>Go to Settings > Group Numbers</p> <p>Make sure that the group number linked to the payer in question is between 9-12 digits long.</p> <p>If billing as an individual (no group number),</p> <p>Go to Settings > Provider > Provider Numbers tab</p> <p>Make sure that the provider number linked to the payer in question is between 9-12 digits long.</p>