Guide to Common Claim Rejections

Overview

This guide has been developed to provide some of the most common claim rejections received within Kareo. Each entry is broken up into three parts:

Rejection Message

- This section lists the actual rejection message received in the clearinghouse report or claim transaction line in Kareo. Since each payer/clearinghouse words the rejection message differently, there may be multiple messages listed for one entry.

Rejection Details

- This section contains a description of the likely cause(s) for the rejection. Depending on the rejection, there may be several.
- Submitter Action (if applicable): Any steps that may need to be completed outside of Kareo to correct the rejection.
- Details regarding the ANSI loop and segment from the claim's EDI file causing the rejection.
- Tip (if applicable): Suggested best practices that can help avoid the rejection in the future.

Resolution

- Step-by-step instructions for correcting the rejection within Kareo Practice Management.

  Note: The corrective steps may vary depending on the cause, therefore, multiple resolution instructions may be listed. Please ensure you are following the appropriate steps.

  Tip: If you are unsure which cause lead to your rejection, try following the resolution steps (without saving any changes) for all potential causes until you isolate the appropriate one. Then, make the necessary changes to correct that cause and save.

DISCLAIMER: This guide contains suggested best practices and instructions for correcting claim rejections based on information provided by our clearinghouse partners and their payer EDI analaysts. However, clearinghouse and payer edits change often and Kareo cannot guarantee that following the steps provided will result in the claim being processed or paid on by the payer.

Common Claim Rejections and Solutions

Rejection Message	Rejection Details	Resolution
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2310C ELEMENT NM109 IS USED. It is not expected to be used when it has the same value as element NM109 in loop 2010AA	This rejection indicates that the facility and billing NPI sent out on the claim are identical. Per ANSI 5010 requirements, the facility NPI should not be sent on the claim if it is the same as the billing NPI.	Follow the instructions below to remove the facility NPI: 1. Click **Settings > Service Locations**. 2. Double-click on the location to open the Edit Service Location screen. 3. Delete the NPI number. 4. Click **Save**. Then, rebill and resubmit all affected claims.
2400 LOOP 2420E (ORDERING PROVIDER NAME) IS USED	This rejection indicates that the ordering (or referring provider) listed on the claim is the same as the rendering provider. Per this payer's requirements, the ordering provider information should only be sent in the 2420E Loop (of the EDI file) if the service or supply was ordered by a provider who is different than the rendering provider sent in the 2310B Loop.	Follow the instructions below to remove the ordering provider: 1. Click **Encounters** > **Find Encounters**. 2. Click on the All tab. 3. Look for and double-click on the encounter that needs correcting. 4. Click the "X" next to the Referring Provider name. 5. Click **Save and Rebill**. Then, resubmit all affected claims.

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Accident Date is required when the diagnosis code is between 800-999, or the diagnosis code is V015 or 53511 OR First Symptom Date REQUIRED OR CLAIMS SUBMITTED WITH AN ACCIDENT DIAGNOSIS MUST INDICATE IF THE ACCIDENT WAS DUE TO A WORK INJURY, AN AUTO ACCIDENT OR OTHER ACCIDENT	This rejection indicates that the payer requires an accident date (Qualifier 439) and related cause for at least one of the diagnosis codes included on the claim. **Submitter Action:** Check the diagnosis codes on the claim: If there is a code of 800.00 – 999.99, V01.5, or 535.11 an injury or accident date are required by this payer. **Note**: Certain payers are actually looking for an Accident Date even if the rejection message says “First Symptom Date.”	Follow the instructions below to add an accident date: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Click on the Condition tab. 5. Check the appropriate condition box in the “Condition related to” section: a. Valid Related Cause codes for Qualifier 439: • Auto Accident? = AA • Other? = OA 6. To add the accident date: a. In the Date Type drop-down menu, select the “Accident Date.” b. In the Start Date field, enter or select the date in the drop-down menu. c. In the End Date field, enter or select the date in the drop-down menu (if applicable). d. Click on the **Add** button to populate the date to the field below.

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		7. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Acknowledgement/Rejected for Invalid Information Entity's health industry ID number	This rejection indicates that the 3-digit alpha prefix for this patient's insurance policy number is no longer valid.	Follow the instructions below to remove the 3-digit alpha prefix: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the Insurance Policy. 5. Remove the 3 digit alpha prefix from the Policy # field. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
ACKNOWLEDGEMENT/ REJECTED FOR INVALID INFORMATION PROCEDURE CODE-	This rejection indicates that there is an issue with the procedure code/ modifier combination billed out on the claim. **Submitter Action**:	Follow the instructions below to edit a procedure code or modifier: 1. Click **Encounters** > **Track Claim Status**.

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XXXXX MODIFIER(S)-XX SVC Line Response-Procedure Code Modifier(s) for Service(s) Rendered PROCEDURE CODE- XXXXX MODIFIER(S)- XX SVC	The submitter should contact the payer to review the billing rules: Specifically, find out from the payer if the procedure code/modifier combinations listed on the claims are allowed. **Tip:** Most Kareo PM subscription levels include access to a free code scrubbing tool on the Encounter. Utilizing this feature for all encounters can help prevent code rejections. **Note**: Kareo Support cannot provide coding assistance. Please contact your biller/coder with any CPT or ICD coding questions.	2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click into the Procedure cell and replace the CPT code as needed. 5. Click into the Mod cell and replace the modifier as needed. a. To delete a modifier, select the modifier and click “Delete” on your keyboard. 6. Click **Save and Rebill**. Then, resubmit all affected claims. Follow the instructions below if the procedure code needs to be removed from the claim: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Click **Action** > **Void** > **Apply**. a. Or, if there is a payment from another insurance company, then

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		click **Action** > **Settle** > **Apply** rather than voiding the claim**.** 4. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
ACKNOWLEDGEMENT/ REJECTED FOR MISSING INFORMATION Entity's tax id. Rendering Provider **Note**: This rejection message is specific to United Health Care.	This rejection indicates the practice's Tax ID is not in United Health Care's system. **Submitter Action:** There are three possible solutions the submitter may follow to correct: 1.) The submitter may drop the claim to paper Once the claim is received the UHC Claims Department will send the claim to the UHC Demographics team. The provider information will then be loaded into the UHC provider database and future claims for this line of business will be processed correctly.	Follow the instructions below for solution 1 to print paper claims: 1. Rebill all affected claims. 2. Click **Encounters** > **Print Paper Claims**. 3. Narrow the filters for the Start Date, Insurance Company and Patient as needed. 4. Choose the claim type for the insurance company. 5. Click **Print Claims**. 6. Once printed, select Yes to indicate that the claims have been printed. If solution 2 or 3 were taken: rebill and resubmit the affected claims once United Health Care has the practice's tax ID in their system. No further steps for resolving within Kareo.

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	2.) The provider can call the UHC demographics team at 877-842-3210. In the IVR (automated phone) system: 1. Enter the billing Tax ID number. 2. Say “Other Healthcare Professional Services.” 3. Say “Demographics Team.” The provider will then be advised on what steps to take to be loaded into the UHC provider database for the member’s line of business. 3.) The provider may work with their UHC network account manager to have their information loaded into the UHC provider database for the member’s line of business. To determine your UHC network account manager, the provider can go to: www.unitedhealthcareonline.com.	

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Adjudication or Payment Date is required when sending Line Adjudication Information. 2430.DTP*573 OR Claim/Line Check or Remittance Date is required on adjudicated claims. 2320/2430.DTP*573	This rejection indicates that the adjudication date is missing on the payment from the primary payer.	Follow the instructions below to add an adjudication date to the primary payment: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the claim that needs correcting. 3. Double-click on the primary payment in the Transactions section on the right to open the **Edit Payment** window. 4. Enter the Adjudication Date for the payment. 5. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
BCBSNE RULE: 837P - ACCIDENT RELATED INJURY INDICATOR 837P - ACCIDENT RELATED INJURY INDICATOR (I00) OR	This rejection indicates that a Related Causes (Accident) code was not included with the claim and is required by this payer for the service billed. The 2300 Loop, CLM11 is reserved for Related Causes Codes. This was not sent on the claim, and it is required.	Follow the instructions below to add a condition related to the accident date: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Click on the Condition tab.

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RELATED CAUSE INFORMATION IS MISSING OR INVALID (Error Code: 2300~CLM~11)		5. Check one of the Condition related to boxes. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
BILLING PROVIDER NPI/API TO TPI COMBINATION OR NPI/API INFORMATION IS INVALID	This rejection indicates that the provider's TPI (Texas Provider Identifier) was not included on the claim and is required. **Submitter Action**: Verify your NPI/API/Tax ID combo by calling the payer and requesting the provider identifier (TPI) number information.	Follow the instructions below to add the TPI to the provider override: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the appropriate insurance company. 7. Change the NPI dropdown to the appropriate billing option (Group or Individual). 8. (If necessary) Check "Override NPI" if a different Group NPI or Individual NPI needs to be entered. 9. Change the Tax ID dropdown to the correct option (EIN or SSN).

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		10. (If necessary) Check “Override EIN” if a different tax ID needs to be entered. 11. Check the “Show advanced settings” box. 12. Enter the TPI in the Advanced Electronic Claim Settings section: a. If billing with an Individual NPI, use the upper most box. b. If billing with a Group NPI, use the lowermost box. 13. In the Type field, choose 1D – Medicaid Provider Number. 14. In the Value field, enter the TPI number. 15. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
BILLING PROVIDER TAX ID/EIN SUBMITTED DOES NOT MATCH BCBSF FILES	This rejection indicates that the Tax ID submitted on the claim does not match what BCBS has on file for this provider. **Submitter Action**: The provider will need to contact Provider Services at the payer to verify if they are	Once the practice’s tax id has been updated in the BCBS system, rebill and resubmit all affected claims. If necessary, follow the instructions below to update the Tax ID in your practice settings: 1. Click **Settings** > **Practice Information**.

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	billing under the correct NPI and Tax ID and (if necessary) ensure the NPI and Tax ID on file in the payer's system are updated and accurate.	2. Enter the correct Tax ID in the EIN field. 3. Click **Save**. Or set up a claim settings override for the provider: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the appropriate insurance company. 7. Change the Tax ID dropdown to the correct option (EIN or SSN). 8. (If necessary) Check "Override EIN" if a different tax ID/SSN needs to be entered. 9. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
BWC PAY TO PROVIDER NUMBER INVALID	This rejection indicates that the payer requires the "Pay To" address to be included on the claim.	Follow the instructions below to enter the "Pay To" address for all insurance companies the provider bills:

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	The provider needs to submit the “Pay To” address information on the claim. This address needs to be populated in the NM1*87 segment of 2010AB loop information of the EDI file.	1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Check the “Enable Pay-to Address For Professional Claims” box 5. Enter in the practice name in the Name field. 6. Enter in the “Pay To” address in the Address field. 7. Click **Save** all the way out (multiple saves may be required). Follow the instructions below to enter the “Pay To” address for a specific insurance company the provider bills: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the appropriate insurance company. 7. Check the “Show Advanced Settings” box.

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		8. Check the “Override Practice Address” box. 9. Enter the “Pay To” address in the Address field. 10. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Claim failed Pre-Membership Validation OR PATIENT/SUBSCRIBER IS NOT ELIGIBLE PLEASE VERIFY MEMBER ID/INSURANCE/COVERAGE OR ENTITY'S ID NUMBER. – SUBSCRIBER	This rejection has two potential causes: 1. The patient’s insurance policy included on the claim was not eligible for the date of service billed. **Submitter Action**: 1. (If available) run an eligibility check for the patient within Kareo to check for active coverage. 2. Then verify all of the following: • Verify the patient's name, gender, and DOB were submitted correctly on the claim and match the information shown on the patient’s	Follow the instructions below to edit the patient’s demographics if needed: 1. Click **Patient** > **Find Patient**. 2. Look for and open the patient record that needs correcting. 3. Update the patient Full Name, Date of Birth, and/or Gender as needed. 4. Click **Save**. Then, rebill and resubmit all affected claims. Or follow the instructions below to edit the patient’s policy number: 1. Click **Encounters** > **Track Claim Status**.

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OR Entity not eligible for benefits for submitted dates of service OR ENTITY NOT FOUND ENTITY: PATIENT OR Patient Not Covered OR Patient Not Found OR Subscriber and Subscriber ID not found OR	insurance and identification cards. • Verify the Policy # populated on the patient's insurance policy matches the member ID on the patient's insurance card • Verify that the claim was submitted to the correct payer ID ○ Cross reference the insurance name, plan name, and payer ID listed on the patient's insurance card on Kareo's Enrollment Center here to verify the appropriate payer ID is used (based on your clearinghouse). • Verify the patient's eligibility with the payer for the date of service being billed. 2. The patient is a newborn or recently added to the guarantor's insurance policy.	2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the appropriate Insurance Policy. 5. Correct the Policy # and Group # as needed. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims. Or follow the instructions below to verify (or edit) the payer ID associated with the claim: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the appropriate Insurance Policy. 5. Double-click on the Insurance name to open the **Edit Insurance Plan** page.

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SUBSCRIBER GROUP OR POLICY NUMBER-REQUIRED; MUST BE ENTERED FOR PAYER OR SUBSCRIBER PRIMARY IDENTIFIER-INVALID; MUST BE IN A VALID FORMAT FOR PAYER OR UNABLE TO IDENTIFY AS MEMBER OR Contract number not found	**Submitter Action:** Verify the patient is active under the insured's policy. **Tip:** Most Kareo PM subscription levels include access to a free eligibility check feature which can be used with many payers to verify a patient has active coverage. Utilizing this feature prior to submitting claims for a patient can help prevent this type of rejection.	6. Double-click on the Insurance Company name to open the **Edit Insurance Company** page. 7. Click the Electronic Claims tab. The current payer ID is listed in the Clearinghouse Payer ID field. If the payer ID the claim is being billed to is incorrect it can be updated in two ways: 1. By changing the payer ID associated with this insurance company: ***Note:** Changes made within the **Edit Insurance Plan** or **Edit Insurance Company** pages will apply to ALL insurance policies and claims tied to that Insurance Plan or Company within the practice.*** a. Click the Electronic Payer Connection button. b. Search for and select the correct payer ID for the claim. c. Click **Save** all the way out (multiple saves may be required).

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		2. By associating the insurance policy with another insurance company (with the correct payer ID): a. Exit back to the Insurance Policy page b. Click the Insurance button c. Look for an Insurance Plan with the correct payer ID (listed under the “EDI Payer Number” column) i. If there are no insurance plans associated with the correct payer ID a new insurance plan and insurance company will need to be created. d. Double click on the appropriate insurance plan to associate it with the patient’s insurance policy e. Verify all other information listed on the policy is correct f. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.

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		Note: Please verify enrollment is completed (or not needed) before submitting e-claims to a new Payer ID http://helpresources.kareo.com/help/practice-management/enrollment
Claim Frequency Code Acknowledgement/Rejected for Invalid Information	This rejection indicates that an incorrect submission reason was included on the claim per the payer's requirements. The "Invalid Claim Frequency Code" refers to the Submit Reason selected on the encounter. The appropriate submission code depends on the payer's requirements. For example, most Medicare payers will not accept any claim submission reason other than "1 – Original." **Submitter Action**: The provider/biller should contact the payer to verify the appropriate submission reason code.	Follow the instructions below to enter the submit reason on the encounter: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click the dropdown arrows next to Miscellaneous (CMS-1500) to expand. 5. Select the correct "Submit Reason" code. a. If the submit reason is "7" enter the Payer Doc Ctrl #. 6. Click **Save and Rebill.** Then, resubmit all affected claims.

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		Note: The submit reason code depends on the payer's requirements.
CLAIM LEVEL DATE IS MISSING OR INVALID. DATE MUST BE IN THE CCYYMMDD FORMAT **Note**: Several rejections will include this wording. If the rejection message also includes "RELATED CAUSE INFORMATION IS MISSING OR INVALID" the cause and resolution steps will be different than those outlined in this entry. Please see the corresponding entry for that rejection for further information.	This rejection occurs for both professional and institutional claims and indicates that the Admission Date/Hour was sent out on the claim but should not have been. Segment DTP (Admission Date/Hour) has been populated onto the encounter. It may be used only on inpatient claims (and some outpatient claims) as defined by the NUBC (National Uniform Billing Committee). Segment DTP is defined in the guideline at position 1350 of the ANSI 837I (institutional) and loop 2300 DTP*435 of the ANSI 837P (professional) EDI file.	**For professional (837P/CMS-1500) claims:** Follow the instructions below to remove the hospitalization start date on the encounter: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click the arrows next to Hospitalization Dates to expand. 5. Highlight the “Start Date” and click “delete” on your keyboard. 6. Highlight the “End Date” and click “delete” on your keyboard if applicable. 7. Click **Save and Rebill.** Then, resubmit all affected claims. OR

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		Follow the instructions below to remove the hospitalization date from the patient case: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Click on the Condition tab. 5. Right-click on the “Hospitalization Related to Condition” and select **Remove**. **Note:** Any other dates populated to this section must also be removed in order to correct this rejection** 6. Uncheck any Condition related to box. 7. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims. **For institutional (837I/UB-04) claims:** Follow the instructions below to remove the Admission Date on the encounter:

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		1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Select the "Date" field under the Admission section and click "Delete" on your keyboard. 5. Ensure that the "Admission" field now displays None. 6. Click **Save and Rebill**. Then, resubmit all affected claims.
Crosswalk did not give 1 to 1 match for NPI XXXXXXXXXX. Number of rows returned was 0	This rejection indicates the payer does not recognize the provider matched to the NPI/tax ID combination in their system. **Submitter Action**: • Verify the information (Group or Individual NPI, Tax ID or Social Security Number) that the provider is credentialed to bill under with the	If the payer has updated their system to match the billing NPI and Tax ID already set up in Kareo, then rebill and resubmit all affected claims. Or follow the instructions below to update the billing information for a specific provider and specific insurance company: 1. Click **Settings** > **Providers**.

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	payer (You may need to contact the payer to retrieve this information). ○ Request the payer update the information on file if incorrect	2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the insurance company. 7. Change the NPI dropdown to the appropriate option (depending on how you bill). 8. (If necessary) Check “Override NPI” if a different Group NPI or Individual NPI needs to be entered. 9. Change the Tax ID dropdown to the correct option (depending on how you bill). 10. (If necessary) Check “Override EIN” if a different tax ID needs to be entered. 11. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Date of Service From and To dates are invalid. Your claims cannot be submitted because the Date of Service From	**Kareo Internal Validation Error** Claims cannot be submitted if the "From" and "To" Date of Service on the encounter are not valid. The “From” date	Follow the instructions below to verify the “From” and “To” dates on the encounter: 1. Click **Encounters** > **Track Claim Status**.

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date is after the Date of Service To date. This would result in a rejection at the clearinghouse. Please open Encounters > Track Claim Status, then find and open the claim ID above, Double-click on the Encounter number, correct the Date of Service From and To dates, then resubmit the claim	cannot be a date that is after the “To” date.	2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Under the Dates section, check the “From Date” and “Through Date”. Verify that the date range for the month, day and year are correct. 5. Under the Procedures section, check the “From Date” and “To Date” columns for each service line. Verify that the date range for the month, day and year are correct. 6. Click **Save and Rebill.** Then, resubmit all affected claims.
Detailed description of service Acknowledgement / Rejected for relational field in error	This rejection indicates that the claim contains an NOC ("Not Otherwise Classified") procedure (CPT/HCPCS) code without a description. The payer requires that any NOC procedure codes billed to them include a detailed text description in the SV1 01-7 segment of the service line for a	Follow the instructions below to enter an NOC description: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number.

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	professional claim (or the SV2 02-7 of a UB claim) on the ANSI EDI file.	4. Under the Procedure section, right-click the header bar and select **Customize.** 5. Add the following columns to the **Procedure** section (click and hold an item, then drag it to the preferred location in the header bar): a. Ref. Code b. Line Note 6. Select “ADD” under Ref. Code for the service line that needs correction. 7. In the Line Note column, enter the NOC information for the service line that needs correction. a. Enter “NOC” in all caps followed by a space. b. After the space, enter NOC information (cannot exceed 76 characters). 8. Click **Save and Rebill**. Then, resubmit all affected claims.
DIAGNOSIS/PROCEDURE/CONDITION/OCCURRENCE/TREATMENT/	**Institutional Rejection** This rejection indicates that an Admitting Diagnosis was included on the claim.	Follow the instructions below to remove the admitting diagnosis from the encounter:

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VALUE INFO IS MISSING OR INVALID	Per the payer's requirements, Admitting Diagnoses should be used only when the claim involves inpatient admission.	1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Select the "Admitting Diagnosis" field under the Diagnosis section and click "Delete" on your keyboard. 5. Ensure that the "Admitting Diagnosis" field now displays None. 6. Click **Save and Rebill**. Then, resubmit all affected claims.
Drug Unit Count Code Qualifier is required and must be valid	This rejection is caused by having a missing or invalid "Drug Unit Count Code Qualifier" for procedure (CPT/HCPCS) codes with an NDC (National Drug Code) Number. Valid Drug Unit Code Qualifiers: * F2 - International Unit * GR - Gram * ME - Milligram * ML - Milliliter * UN - Unit	Follow the instructions below to add the unit count to the NDC procedure code: 1. Click **Settings** > **Codes** > **Find Procedures**. 2. Look for and open the Procedure (CPT). 3. Ensure the NDC Number is populated (and in the correct 11-digit NDC format) and add the unit qualifier in the following format: a. XXXXXXXXXXX, ML 4. Click **Save**.

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		Visit Converting NDCs From 10 Digits to 11 Digits for help with NDC conversions. Then, rebill and resubmit all affected claims.
DUPLICATE CLAIM; SUBMITTED PREVIOUSLY OR Same day duplicate	This rejection indicates that the claim was resubmitted within 24 hours of the original submission. Until the clearinghouse has fully processed and forwarded the initial submission for the claim, all subsequent submissions will be rejected and not forwarded to the payer.	To prevent this kind of rejection, we recommend waiting 36 to 48 business hours before resubmitting claim(s).
DUPLICATE OF A PREVIOUSLY PROCESSED CLAIM/LINE	**Payer Rejection** This rejection message indicates that the payer has received the exact claim or service before. **Submitter Action**: Contact the payer to verify the status of the previous claim submission and	There are two potential resolutions: Update the encounter (if necessary) so that it is not being resubmitted with the exact same information as the previous submission. OR If the claim needs to be resubmitted as a corrected claim (per payer request), follow the instructions below to enter the submit reason

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	determine if the claim needs to be corrected and (if so) how to properly resubmit.	on the encounter: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click the arrows next to Miscellaneous to expand. 5. Select the correct “Submit Reason” code. • If the submit reason is “7” enter the Payer Doc Ctrl #. 6. Click **Save**. Then, rebill and resubmit all affected claims. **Note:** The submit reason code depends on the payer's requirements. For example, Medicare will not accept any Claim Submission Reason Code other than “1 – Original.” Do not change the Submit Reason unless you are certain the payer needs it changed.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
Entity's Postal/Zip Code	This rejection indicates that an invalid zip code is being sent on the claim. **Submitter Action:** Please verify that the 9-digit zip codes submitted on the claim are valid for all of the following addresses: 1. Payer (Insurance Plan) 2. Provider 3. Practice 4. Patient/Insured **Note:** Most payers require the full 9-digit zip code for addresses on electronic claims. This rejection typically indicates that the claim includes a zip code without the 4-digit extension.	All addresses will need to be verified using the USPS Zip Code Look Up. Follow the instructions below to verify the payer's address: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the appropriate Insurance Policy. 5. Double-click on the Insurance Name to open the **Edit Insurance Plan** page. 6. Enter the address on file into the USPS Zip Code Look Up tool. 7. If the 9-digit zip-code is not correct, enter the correct information into the Address field. 8. Click **Save** until you get to the **Edit Case** screen. 9. If there are multiple policies in the case, follow steps 4-7 for each policy.

Rejection Message	Rejection Details	Resolution
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		10. Click **Save** all the way out (multiple saves may be required). Follow the instructions below to verify the provider's address: 1. Click **Settings** > **Provider**. 2. Look for and open the provider record that needs correcting. 3. Enter the address on file into the USPS Zip Code Look Up tool. 4. If the 9-digit zip-code on file is not correct, enter the correct information into the Address field. 5. Click **Save**. Follow the instructions below to verify the address included on the provider's insurance override (if applicable) is correct: 1. Click **Settings** > **Provider**. 2. Look for and open the provider record that needs correcting. 3. Click on the Claims Settings tab. 4. Double-click on the insurance company name.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		5. Enter the address from the “Override Practice Address” field into the USPS Zip Code Look Up tool. 6. If the 9-digit zip-code is not correct, enter the correct information into the Address field. 7. Click **Save**. 8. If the encounter is billing multiple insurance companies with an address override, follow step 4-7 for each insurance company. 9. Click **Save** all the way out (multiple saves may be required). Follow the instructions below to verify the practice’s address: 1. Click **Settings** > **Practice Information**. 2. Enter the address on file under the Contact Information into the USPS Zip Code Look Up tool. 3. If the 9-digit zip-code is not correct, enter the correct information into the “Address” field under the Contact Information. 4. Click **Save**.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		Follow the instructions below to verify the patient's address: 1. Click **Patient** > **Find Patient**. 2. Look for and open the patient record that needs correcting. 3. Enter the address on file into the USPS Zip Code Look Up tool. 4. If the 9-digit zip-code is not correct, enter the correct information into the Address field. 5. Click **Save**. If the patient's insurance policy is through another individual, follow the instructions below to verify the Insured's address: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the appropriate Insurance Policy. 5. Navigate to the "Insured" section and enter the address on file into the USPS Zip Code Look Up tool.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		6. If the 9-digit zip-code is not correct, enter the correct information into the Address field. 7. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
HCPCS Procedure Code is invalid in Professional Service	This rejection indicates that one of the Procedure (CPT/HCPCS) codes billed on the claim is not valid for the date of service listed. **Submitter Action**: 1. Check the date of service 2. Check an up to date CPT or HCPCS Code Book (or online code resource) to make sure ALL codes submitted on the claim are valid for the date of service listed **Tip:** Most Kareo PM subscription levels include access to a free code scrubbing tool on the Encounter. Utilizing this feature for all encounters can help prevent code rejections.	Once the invalid code has been identified it can be updated or removed from the encounter: Follow the instructions below to change the procedure code listed on a claim: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click into the Procedure cell and replace the CPT with a valid code. 5. Click **Save and Rebill**. Then, resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	NOTE: Kareo Support cannot provide coding assistance. Please contact your biller/coder with any CPT or ICD code questions.	Follow the instructions below if the procedure code needs to be removed from the claim: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Click **Action** > **Void** > **Apply**. a. Or, if there is a payment from another payer already applied to this service line click **Action** > **Settle** > **Apply** rather than voiding the claim**.** 4. Click **Save** all the way out. Then, rebill and resubmit all affected claims.
Insurance Type Code is required for non-Primary Medicare payer. Element SBR05 is missing. It is required when SBR01 is not 'P' and payer is Medicare OR	This rejection occurs when Medicare is used as a secondary insurance and the Insurance Type field has been left blank. The Insurance Type indicates why the insured has Medicare as a secondary payer and is required when submitting secondary claims to Medicare.	Follow the instructions below to enter the insurance type code: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case.

Rejection Message	Rejection Details	Resolution
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Insurance Type Code Missing OR Other Subscriber Identification Code Qualifier is required and must be II or MI. 2330A.NM1*08 OR Other Payer Insurance Type is required when Payer is Medicare (Not Primary)		4. Double-click on the Medicare policy listed as secondary. 5. Select the correct Insurance Type from the drop-down menu. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Internal review/audit Pending/Requested Information	**Payer Rejection** This indicates the payer sent a letter to the provider requesting more information.	There are no resolution steps within Kareo. Please reach out to the payer directly to resolve.

Rejection Message	Rejection Details	Resolution
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	The clearinghouse cannot provide further clarification as the payer will only work directly with the provider to correct. **Submitter Action**: Please reach out to the payer for further assistance.	
INVALID OTH	This rejection indicates that a tertiary insurance was included on the case. Claims cannot be submitted electronically to a tertiary insurance and will need to be sent on paper. If billing to a secondary insurance, the tertiary insurance will need to be made inactive on the case before submitting claims electronically.	Follow the instructions below to deactivate the tertiary insurance: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the tertiary Insurance Policy. 5. Uncheck the “Active” box on the lower right. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
Missing N401 city in address for (Subscriber)	**Kareo Validation Error** This rejection indicates that the patient's insurance policy is through another individual but an address has not been populated for the Insured. Claims cannot be billed without an address for the Insured, therefore Kareo has blocked submission until the error has been corrected.	Follow the instructions below to enter an address for the Insured: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the appropriate Insurance Policy. 5. Enter an address for the Insured in the Address field. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
MISSING NO VENDOR MATCH FOR NPI	This rejection means that the NPI/TIN combination does not exist in the payer's system. This particular payer requires providers to submit a paper claim first in order to be added to their system for electronic claims.	Follow these instructions to print paper claims: 1. Rebill all affected claims. 2. Click **Encounters** > **Print Paper Claims**. 3. Narrow the filters for the start date, insurance company and patient (as needed). 4. Choose the claim type for the insurance company.

Rejection Message	Rejection Details	Resolution
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		5. Click **Print Claims**. 6. Once printed, select Yes to indicate that the claims have been printed. Once a paper claim has been submitted and processed the provider can begin submitting claims electronically to this payer.
Must have hospitalization start date if place of service code is 21 (Inpatient Hospital). Add hospitalization start date to the encounter or to the case OR RECEIVER REJECT REASON COD	This rejection indicates that the claim was submitted without a Hospitalization Start Date. This payer requires that a Hospitalization Start Date be included when billing claims with a place of service of 21 (Inpatient Hospital).	Follow the instructions below to enter the hospitalization date on the encounter: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click the dropdown arrow next to Hospitalization Dates to expand. 5. Enter the “Start Date”. 6. Enter the “End Date” (if applicable). 7. Click **Save and Rebill** Then resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
NDC code [] is invalid. Procedure code <CPT> NDC code [] must be 11 digits. Edit the procedure code under Settings > Codes > Find Procedure. Find procedure code 'CPT' and edit the NDC and make sure it has 11 digits. Dashes (-) are ignored OR REJECTED FOR INVALID INFORMATION NDC NUMBER. NDC NUMBER. NDC NUMBER	This rejection indicates that the claim includes a procedure (CPT/HCPCS) code with an invalid National Drug Code (NDC). **Note**: Although many NDCs are displayed on drug packing in a 10-digit format, electronic billing requires an 11-digit NDC number in a 5-4-2 format. **Submitter Action:** Visit Converting NDCs From 10 Digits to 11 Digits for help with NDC conversions.	Follow the instructions below to correct the NDC code: 1. Click **Settings** > **Codes** > **Find Procedures**. 2. Look for and open the Procedure (CPT) with an NDC number. 3. Change the NDC Number to the correct 11-digit format. 4. Click **Save**. Then, rebill and resubmit all affected claims.
No Trading Partner Associated with this Claim	This rejection indicates that the claim was submitted to a payer ID that does not support the claim form being billed.	Follow the instructions below to select the correct payer ID:

Rejection Message	Rejection Details	Resolution
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	Either Professional (837P/CMS-1500) claims are being sent to an Institutional (837I/UB-04) Payer ID or vice versa.	1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the Insurance Policy that the encounter is billing. 5. Double-click on the Insurance Name to open the **Edit Insurance Plan** page. 6. Double-click on the Insurance Company name to open the **Edit Insurance Company** page. *****Note**: Any changes made on the **Edit Insurance Company** settings will apply to ALL insurance policies and plans within the practice tied to this insurance company.*** 7. Select the Electronic Claims tab. 8. Click the **Electronic Payer Connection** button. 9. Search for and select the correct payer ID for the claim. 10. Click **Save** all the way out (multiple saves may be required).

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		Then, rebill and resubmit all affected claims. **Note**: Make sure to only select a UB Payer ID for Institutional (UB-04) claims submission. Do not select a UB Payer ID for Professional (CMS-1500) claims.
Other insurance coverage information (health, liability, auto, etc.)	This rejection indicates that Medicaid has a different primary insurance on file for this patient. The patient needs to contact Medicaid to update their patient file.	There are no resolution steps within Kareo. Please have the patient contact Medicaid to update their patient file to reflect Medicaid as the primary payer. Then, rebill and resubmit all affected claims.
Other Insured Claim Filing Indicator Code must be valid. 2320.SBR*09	This rejection indicates that the claim was submitted with an Insurance Program code of “09 - Self-Pay.” Certain payers will not accept claims without the appropriate insurance code tied to the insurance company being billed. The patient should not have a Self-Pay policy on a case with an insurance policy.	Follow the instructions below to change the insurance program code: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the Insurance Policy that needs to be corrected. 5. Double-click on the Insurance Name to open the **Edit Insurance Plan** page.

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	Self-Pay policies should be added to a separate case within Kareo.	6. Double-click on the Insurance Company name to open the **Edit Insurance Company** page. 7. Click the Insurance Program dropdown to update the insurance program code. 8. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims. Follow the instructions below if there is a Self-Pay policy attached to the Case with the insurance policy: 1. Click **Encounter** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the self-pay policy. 5. Uncheck the "Active" box on the right. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
OTHER PAYER CLAIM FILING INDICATOR CODE IS INVALID. CANNOT = MEDICARE	This rejection indicates that the Insurance Program Type for both insurances billed on the claim was “Medicare.” When Medicare is listed as one of the payers on a claim, the other payer(s) listed cannot also have an Insurance Program of "MB-Medicare Part B."	Follow these instructions to change the insurance program: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the Insurance Policy that is not Medicare. 5. Double-click on the Insurance Name to open the **Edit Insurance Plan** page. 6. Double-click on the Insurance Company name to open the **Edit Insurance Company** page. ****Note:** Any changes made on the **Edit Insurance Company** settings will apply to ALL insurance policies and plans within the practice tied to that insurance company.** 7. Change the Insurance Program to a program type other than “MB – Medicare.” 8. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
Pay To Affiliation Error| No Pay To Provider Found	This rejection indicates that the payer does not recognize the billing information (NPI and Tax ID) being sent on the claim. **Submitter Action**: 1. Please make sure that this provider is set up in the payer's system and that the NPI and Tax ID submitted match what is on file with the payer. 2. Please verify you are sending valid group and rendering NPI numbers on the claims. 3. Please verify the Tax ID number submitted is valid.	If the payer has updated their system to match your billing NPI and Tax ID, then rebill and resubmit all affected claims. Or follow the instructions below to update the billing information for a specific provider and specific insurance company: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the insurance company. 7. Change the NPI dropdown to the appropriate option (depending on how you bill). 8. (If necessary) Check “Override NPI” if a different Group NPI or Individual NPI needs to be entered. 9. Change the Tax ID dropdown to the correct option (depending on how you bill). 10. (If necessary) Check “Override EIN” if a different tax ID needs to be entered.

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		11. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
PAY TO PROVIDER NUMBER IS AUTHORIZED FOR RENDERING ONLY	The clearinghouse cannot clarify the rejection or provide instructions for correcting. **Submitter Action**: Please contact the payer's Provider Services department for assistance.	No steps for resolving within Kareo. Please contact the payer's Provider Relations department for further assistance.
PER CCI GUIDELINES PROCEDURE CODE XXXXX HAS AN UNBUNDLE RELATIONSHIP WITH PROCEDURE CODE XXXXX BILLED FOR THE SAME DATE OF SERVICE. REVIEW DOCUMENTATION TO DETERMINE IF A	This rejection indicates that the claim has not passed "Smart Edits" put in place by the payer. Smart Edits are based off of Correct Coding Initiative (CCI) rules and are designed to identify claims considered "Certain to Deny" due to billing issues. **Submitter Action**:	Update the claim/encounter information (if necessary) then rebill and resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
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MODIFIER OVERRIDE IS APPROPRIATE	Please review the claim to verify it is being billed appropriately. If your biller disagrees with the edit, you can simply rebill and resubmit the claim (without making any changes), and it will pass Smart Edits. However, it may still deny upon adjudication. **Tip:** Most Kareo PM subscription levels include access to a free code scrubbing tool on the Encounter. Utilizing this feature for all encounters can help prevent code rejections. **NOTE**: Kareo Support cannot provide coding assistance. Please contact your biller/coder with any CPT or ICD code questions.	
PERFORMING PROVIDER NUMBER NOT IDENTIFIED AS PART OF THE GROUP BILLING NUMBER	This rejection indicates that the rendering provider NPI is not linked to the group NPI in the payer's system. **Submitter Action**:	Once the rendering provider has been linked to the group NPI in the payer's system, rebill and resubmit all affected claims. (If necessary) Follow the instructions below to set up a claim override for the provider in order to bill to the payer as individual:

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	Please contact the payer to link the rendering provider to the group NPI or determine if the provider should be billing as an individual.	1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the insurance company. 7. Change the NPI dropdown to “Bill with Individual NPI Only.” 8. (If necessary) Check “Override NPI” if a different Individual NPI needs to be entered. 9. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Prefix for entity's contract/member number	This rejection indicates that the prefix submitted for the patient’s insurance policy number is invalid or missing. **Submitter Action**: Please verify the patient’s policy number matches the member ID listed on their insurance card.	Follow the instructions below to correct the member ID prefix: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the Insurance Policy.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		5. Enter the correct member ID in the Policy # field. 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Procedure Code Modifier(s) for Service(s) Rendered Acknowledgement/Rejected for Invalid Information	**Payer Rejection** This rejection indicates that (per the payer) one of the procedure (CPT/HCPCS) modifiers submitted on the claim was invalid for the date of service being billed. **Submitter Action**: Please verify that the procedure modifiers included on the claim are valid for the service date per payer billing guidelines. **Tip:** Most Kareo PM subscription levels include access to a free code scrubbing tool on the Encounter. Utilizing this feature for all encounters can help prevent code rejections.	Follow the instructions below to edit the modifiers included on an encounter: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click into the Mod cell and replace the modifier as needed. a. To delete a modifier, select the modifier and click “Delete” on your keyboard. 5. Click **Save and Rebill**. Then, resubmit all affected claims.

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Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	NOTE: Kareo Support cannot provide coding assistance. Please contact your biller/coder with any CPT or ICD code questions.	
REFERENCE NUMBER IS MISSING, CONTAINS INVALID CHARACTERS, OR GREATER THAN 30 BYTES	This rejection indicates the CLIA number tied to the service location on the claim is invalid (i.e. incorrect format, incorrect letter case, or invalid characters not supported by the ANSI file).	Follow the instructions below to correct a CLIA number: 1. Click **Settings** > **Service Locations**. 2. Look for and open the service location the claim is billed under. 3. Enter the correct information in the CLIA Number field. ****Note:** The CLIA number must be uppercase and in the following 10-digit format: 11A1111111.** 4. Click **Save**. Then, rebill and resubmit all affected claims.
Referring physician provider number missing	This rejection indicates the provider number is missing from the referring physician's record and is required on this claim.	Follow the instructions below to add the referring provider NPI: 1. Click **Settings** > **Other Lists** > **Find Referring Physicians**.

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		2. Look for and double-click on the referring provider that needs correcting. 3. Enter the Individual NPI number. 4. Click **Save**. Then, rebill and resubmit all affected claims.
REJECTED AT CLEARINGHOUSE 2 ALPHA/5 NUMERIC NORIDIAN ISSUED SUBMITTER ID IS REQURED. THE SUBMITTER ID WAS SUBMITTED OR BRIDGED INCORRECTLY. PLEASE CONTACT CAPARIO EDI SERVICES FOR ASSISTANCE	This rejection indicates the provider's Tax ID/NPI is not set up in the clearinghouse's system. In order to send e-claims, EDI enrollment needs to be completed.	Please contact the Kareo Enrollment Team or visit our Enrollment Center for further assistance enrolling with this payer. Once electronic claims enrollment has been approved please rebill and resubmit all affected claims.
REJECTED AT CLEARINGHOUSE BILLING / PAY-TO PROVIDER	This rejection indicates that the Billing Taxonomy code is required and was not sent out properly on the electronic claim (Loop 2000A, PRV segment).	Follow the instructions below to add the group taxonomy code to the claim: 1. Click **Settings** > **Providers.** 2. Look for and open the provider record.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
TAXONOMY CODE - PROVIDER TYPE QUALIFIER IS MISSING OR INVALID		3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the insurance company. 7. Check “Show Advanced Settings” 8. Click **Group Specialty**. 9. Look for and select the correct taxonomy code. 10. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
REJECTED AT CLEARINGHOUSE BILLLING AND RENDERING PROVIDER NPI CANNOT BE THE SAME VALUE	This rejection indicates that the Billing NPI number and Rendering Provider NPI number included on the claim are the same. This rejection is a Payer Specific Edit – this payer will not accept claims in which the Billing and Rendering Provider NPI are the same value.	Follow the instructions below to update the billing information for a specific provider and specific insurance company: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the insurance company.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		7. Change the NPI dropdown to the appropriate option (depending on how you bill). 8. (If necessary) Check “Override NPI” if a different Group NPI or Individual NPI needs to be entered. 9. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
REJECTED AT CLEARINGHOUSE CLAIM LEVEL DATE IS MISSING OR INVALID	This rejection indicates one of the following: • The claim is missing an accident date and one must be added in order to bill this payer for the services included on the claim. • The accident date included on the claim was invalid	Follow the instructions below to add or edit an accident date: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Click on the Condition tab. 5. Under the Dates section, verify the “Type” and “Dates” entered. 6. Check the “Other” box. 7. To remove an incorrect date: a. Click once on the date. b. Right-click and select **Remove**. 8. To add the correct date:

Rejection Message	Rejection Details	Resolution
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		a. In the Date Type drop-down menu, select “Accident Date”. b. In the Start Date field, enter or select the date in the drop-down menu. c. (If applicable) In the End Date field, enter or select the date in the drop-down menu. d. Click the **Add** button to populate the date below. 9. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
REJECTED AT CLEARINGHOUSE CLAIM SECONDARY IDENTIFIER DESCRIPTION IS NOT TO BE USED	This rejection indicates an invalid authorization number or invalid character included on the authorization number is associated with the Encounter. **Note**: Kareo uses the following delimiters for sending claims electronically in ANSI format: * ; and ~ • Using these characters within Kareo will cause the information in	Follow the instructions below to edit the authorization number: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Click on the Authorizations tab. 5. Double-click the Authorization Number used on the encounter.

Rejection Message	Rejection Details	Resolution
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	the electronic claims file to move a position, resulting in a rejection • Please ensure that the above delimiters are not used in any fields in the Kareo PM	6. Verify that the authorization number is valid and formatted correctly a. Remove any special characters that are not numbers or letters. 7. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Relationship to Insured must be 18 - Self for Medicare. 2000B.SBR*02	This rejection indicates that the Medicare insurance policy attached to the claim was submitted with an insured patient relationship other than “Self.” This Medicare payer will not accept claims with an insured relationship that is not “Self.”	Follow the instructions below to change the “Relationship to Insured” to self: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the Medicare policy. 5. Change the Patient Relationship to Insured dropdown to “Self.” 6. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
RENDERING PHYSICIAN IS REQUIRED	**Payer Rejection** This rejection indicates that the provider is credentialed under a Group NPI with the payer but are billing the claim under the Individual NPI (which removes the Rendering NPI loop from the ANSI file when submitting electronically). **Submitter Action**: Please contact the payer to verify how the provider is credentialed to bill this payer and update settings within Kareo appropriately.	Follow the instructions below to update the billing information for a specific provider and specific insurance company: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the insurance company. 7. Change the NPI dropdown to “Bill with Group and Individual NPI.” 8. (If necessary) Check “Override NPI” if a different Group NPI or Individual NPI needs to be entered. 9. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Requests for re-adjudication must reference the newly assigned payer claim control number	This rejection indicates that an incorrect Payer Claim Control number was submitted on the claim. **Submitter Action**:	Follow the instructions below to enter the correct payer claim control number on the encounter:

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	Please use the original claim control number for the first submission. If necessary, the submitter can call the payer to obtain this information.	1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the encounter number. 4. Click the arrows next to Miscellaneous to expand. 5. The “Submit Reason” should be 7. 6. Enter the correct Payer Claim Control Number in the Payer Doc Ctrl # field. 7. Click **Save and Rebill.** Then, resubmit all affected claim.
Segment has data element errors Loop:2300 Segment:HI Invalid Character In Data Element	This rejection indicates the claim was submitted with an invalid diagnosis (ICD) code. **Submitter Action**: 1. Check the date of service 2. Check an up to date ICD Code Book (or online code resource) to make sure ALL diagnosis codes	Follow the instructions below to edit a diagnosis code: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. On the **Edit Claim** window, double-click on the Encounter number. 4. Click into the appropriate Diag cell and replace the diagnosis with a valid code.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	submitted on the claim are valid for the date of service being billed **Tip:** Most Kareo PM subscription levels include access to a free code scrubbing tool on the Encounter. Utilizing this feature for all encounters can help prevent code rejections. **NOTE**: Kareo Support cannot provide coding assistance. Please contact your biller/coder with any CPT or ICD code questions.	a. To delete a diagnosis, select the diagnosis and click “Delete” on your keyboard. 5. Click **Save and Rebill**. Then, resubmit all affected claims.
SERVICE FACILITITY NPI MUST NOT MATCH BILLING PROVIDER NPI OR SERVICE FACILITY PRIMARY ID# IS MISSING OR INVALID	This rejection indicates that this payer will not accept claims in which the service location NPI matches the billing NPI. The value submitted in loop 2310C NM109 (service location NPI) of the ANSI file cannot equal the value submitted in 2010AA NM109 (billing NPI).	Follow the instructions below to edit the service location NPI: 1. Click **Settings** > **Service Location**. 2. Look for and open the service location that needs correcting. 3. Either remove the NPI or (if appropriate) enter a new NPI that does not match the billing NPI. 4. Click **Save**. Then, rebill and resubmit all affected claims.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
SUBMITTER ID IS REQUIRED	This rejection indicates the claim was submitted without the provider's Submitter ID. This payer requires the provider to submit their Submitter ID in the 2010AA Loop, REF*FH segment of the ANSI file for electronic claims. **Submitter Action:** This payer assigns each provider a unique Submitter ID number. If you do not know the provider's Submitter ID please contact the payer directly.	Follow the instructions below to populate the Submitter ID: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the appropriate Medicare insurance company. 7. Check the "Show advanced settings" box. 8. Enter the Submitter ID in the Submitter Number field. 9. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims.
Submitter not approved for electronic claim submissions on behalf of this entity OR	There are four possible reasons why the claim is rejecting for this reason: 1.) The practice is not credentialed with this payer. 2.) The enrollment paperwork for this payer has not been completed.	The resolution instructions below correspond with the numbered "reasons" to the left: 1.) If the practice is not credentialed with the payer, please contact the payer for further assistance.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
Site is not allowed to send claims to the specified payer OR Provider ID not on file	3.) Claims are being sent out with the incorrect billing information. 4.) Claims are being submitted to the wrong payer ID. **Submitter Action**: Please contact the payer's EDI department for the following information: 1. Verify the payer has approved enrollment for electronic claim submission: a. Are we approved for electronic claims submission through TriZetto or Capario/Emedon? (Specify your clearinghouse) b. What is the effective date of approval? 2. Verify the Provider IDs that the payer has on file (to determine what information the claimed should be billed under).	2.) If the enrollment paperwork has not been completed, contact the Kareo Enrollments Team for further assistance. If the claims were being submitted before the enrollment approval date with the correct billing information. Please rebill and resubmit all affected claims. 3.) If the payer confirmed enrollments for the practice and the approval date, but the billing information was sent incorrectly, please follow the instructions below to update the billing information for a specific provider and specific insurance company: 1. Click **Settings** > **Providers**. 2. Look for and open the provider record. 3. Click on the Claim Settings tab. 4. Click **Add**. 5. Click **Insurance Company**. 6. Look for and select the insurance company. 7. Change the NPI dropdown to the appropriate option (depending on how you bill).

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	a. Is the Provider enrolled with their Group NPI or Individual NPI? b. Is the Provider enrolled with their Tax ID or SSN? 3. Verify if there are any additional payer-assigned Provider IDs that also need to be submitted on the claims.	8. (If necessary) Check “Override NPI” if a different Group NPI or Individual NPI needs to be entered. 9. Change the Tax ID dropdown to the correct option (depending on how you bill). 10. (If necessary) Check “Override EIN” if a different tax ID needs to be entered. 11. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims. 4.) If the claims are being submitted to the wrong payer ID: Follow the instructions below to edit the payer ID associated with the claim: 1. Click **Encounters** > **Track Claim Status**. 2. Look for and double-click on the encounter that needs correcting. 3. Double-click on the Case. 4. Double-click on the appropriate Insurance Policy.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		5. Double-click on the Insurance name to open the **Edit Insurance Plan** page. 6. Double-click on the Insurance Company name to open the **Edit Insurance Company** page. 7. Click the Electronic Claims tab. The current payer ID is listed in the Clearinghouse Payer ID field. If the payer ID the claim is being billed to is incorrect it can be updated in two ways: 1. By changing the payer ID associated with this insurance company: ***Note: Changes made within the **Edit Insurance Plan** or **Edit Insurance Company** pages will apply to ALL insurance policies and claims tied to that Insurance Plan or Company within the practice.*** a. Click the Electronic Payer Connection button. b. Search for and select the correct payer ID for the claim.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		c. Click **Save** all the way out (multiple saves may be required). OR 2. By associating the insurance policy with another insurance company (with the correct payer ID): a. Exit back to the Insurance Policy page b. Click the Insurance button c. Look for an Insurance Plan with the correct payer ID (listed under the "EDI Payer Number" column) i. If there are no insurance plans associated with the correct payer ID a new insurance plan and insurance company will need to be created. d. Double click on the appropriate insurance plan to associate it with the patient's insurance policy e. Verify all other information listed on the policy is correct

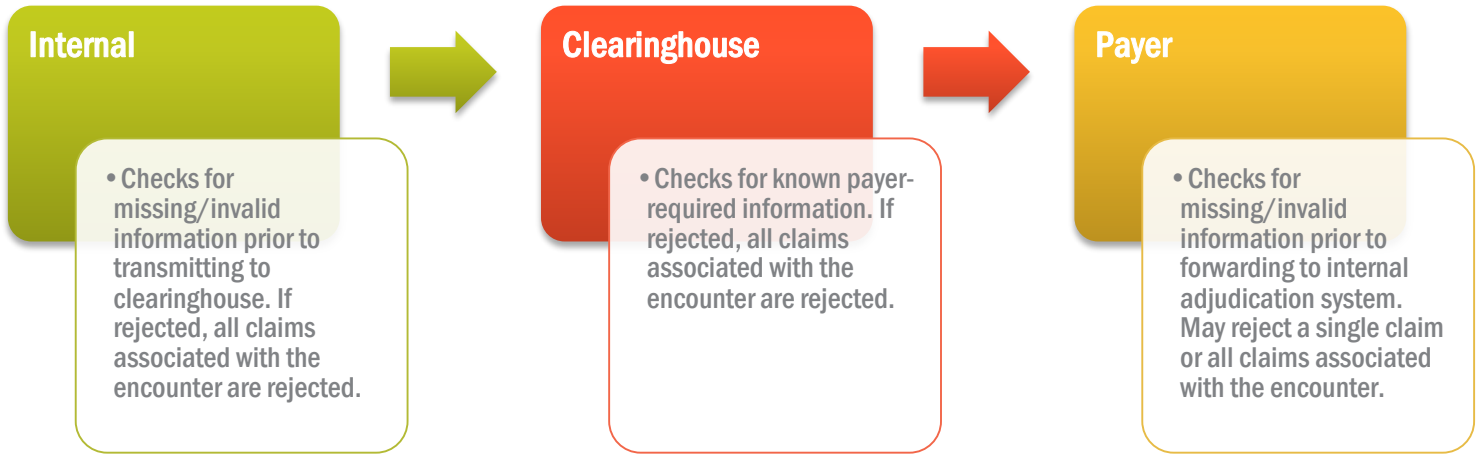
Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
		f. Click **Save** all the way out (multiple saves may be required). Then, rebill and resubmit all affected claims. **Note:** Please verify enrollment is completed (or not needed) before submitting e-claims to a new Payer ID http://helpresources.kareo.com/help/practice-management/enrollment
The Claim/Encounter has been rejected and has not been entered into the adjudication system Status- Other Entity's Adjudication or Payment/Remittance Date Entity- Payer	This rejection indicates the claim was submitted to the secondary payer less than 30 days after the primary payer adjudication date. BCBS and Medicare implemented this edit to eliminate duplicate payments. Medicare should be crossing the claim over directly to BCBS so they ask submitters to wait 30 days before sending a COB to BCBS. **Submitter Action**:	No steps to correct within Kareo. Please wait for 30 days after Medicare's adjudication date before submitting the claim to BCBS as a secondary.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	Please wait 30 days after the Medicare adjudication date before submitting a secondary claim to BCBS for payment.	
Warning: Invalid diagnosis version indicator per payer requirements	This is not a claim rejection but rather a warning message. This warning indicates that the payer has asked the clearinghouse to resend the file for processing. However, since some of the claims in the initial batched submission were successful in going through, the payer wanted to make sure there was a different message associated with the claims so they would not be flagged as duplicates. Therefore this warning message was assigned to the claims in the batch. **Submitter Action**: Please ignore the rejection as it is simply a warning for the clearinghouse and has not stopped the claim from being forwarded to the payer for processing. However, if the payer has not adjudicated	Please ignore the rejection. Depending on the workflow of the practice you can either leave the claim in Rejected status until adjudication or change the status back to Pending Insurance. If the payer has not adjudicated within 30 days of the initial submission, please contact the payer for more information. Then, rebill and resubmit all affected claims if necessary.

Rejection Message	Rejection Details	Resolution
Can't find the rejection you're looking for? Try searching **key words** from the rejection message using **CTRL +F.**		
	within 30 days of the initial submission, please contact the payer for more information.	

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.

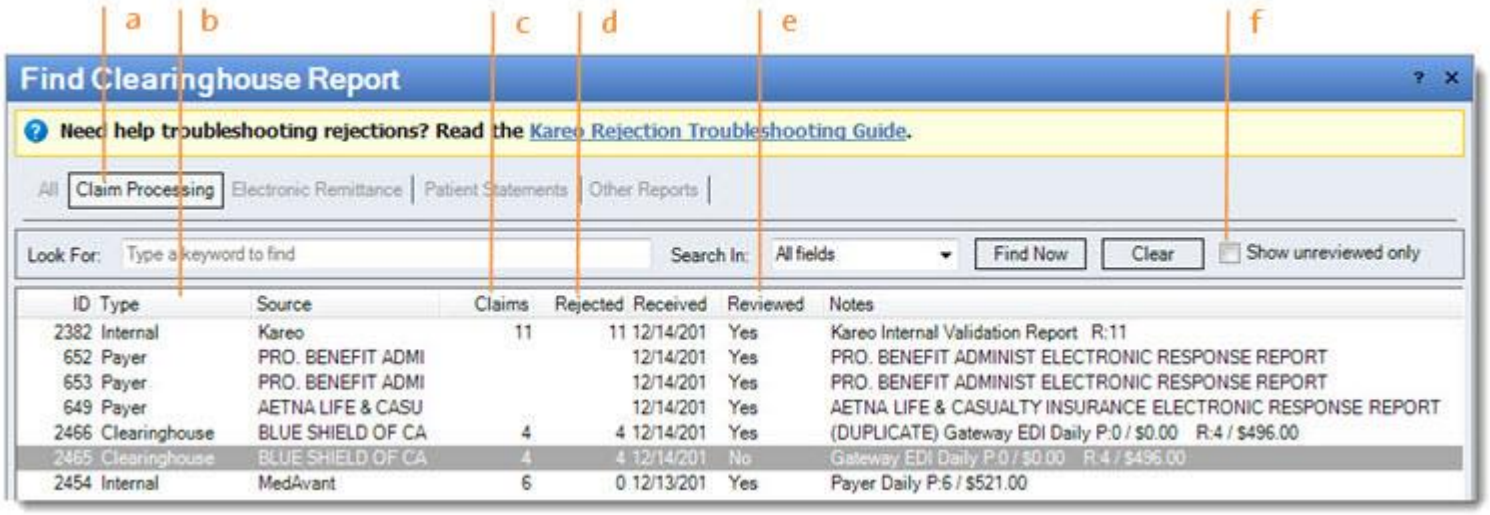
Correcting Claim Rejections

This section is an overview of how to make corrections to rejected claims. 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.

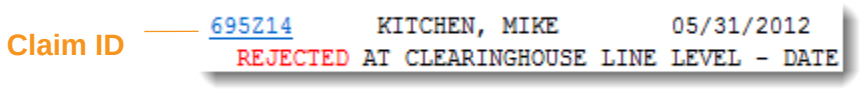
3. View the rejection description. (If applicable) Reference the Common Claim Rejections section to check for specific



correction steps.

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.

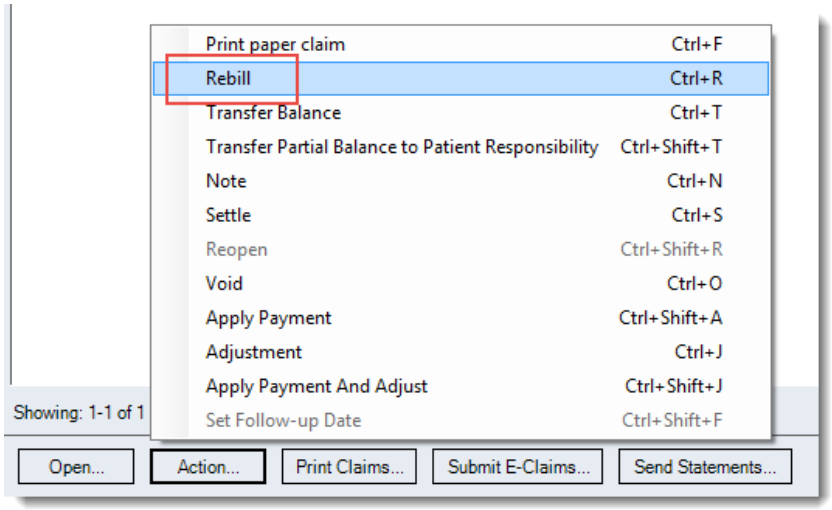
4. Click the Claim ID number to access the encounter record and make corrections. Some corrections are done directly in the encounter record, while other corrections are made to your Kareo settings; please see Tips below. Always save your corrections.



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 = Kareo ID (your individual Kareo 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 are ready to resubmit them. Click **Submit E-Claims**.



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.
- Remember to mark rejection reports as “Reviewed” and rebill affected claims immediately after making corrections so that other users know the claims have been corrected. This will help to avoid confusion and duplicated work.

Kareo Internal Validation Report

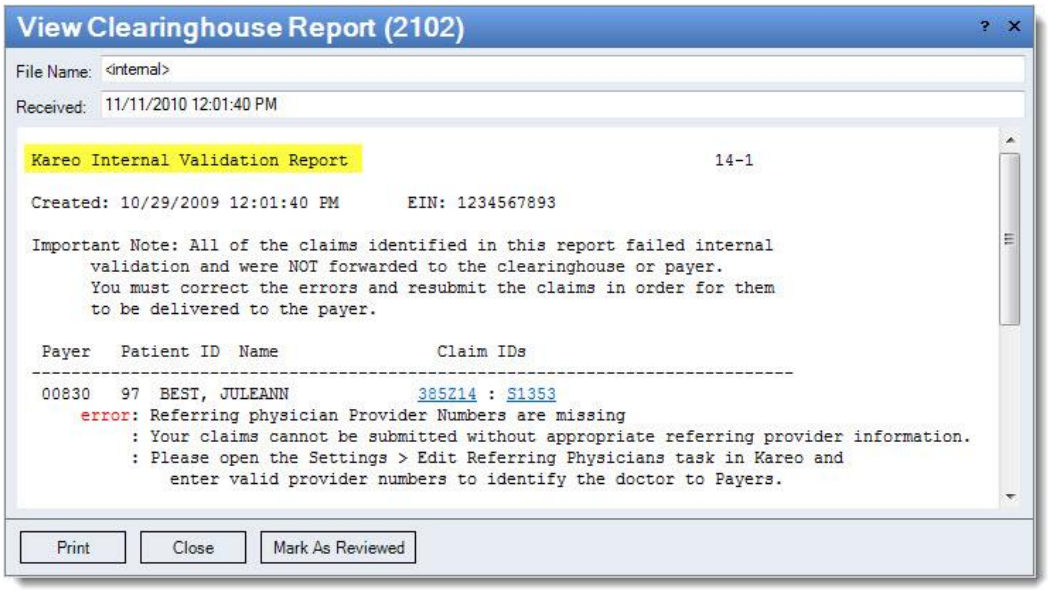
Prior to submitting claims to the clearinghouse, the Kareo system does an internal check for missing information or discrepancies. When detected, the claim will be rejected so that you can make the necessary corrections. Because Kareo's report is generated within a few hours after claim submission, corrections can be made in a timely manner.

Since claims rejected within Kareo are not forwarded to the clearinghouse you will be unable to generate timely filing for that submission. Therefore it is important to review your Claim Processing reports regularly in order to identify any rejections, correct and resubmit.

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

Examples of Kareo Validation Checks:

- Patient's full name, date of birth, gender, address and phone number
- (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 billing secondary payers, charge amount does not equal sum of paid amount and adjustments from primary payer
- Claim Filing Indicator (insurance program type) code is missing or invalid



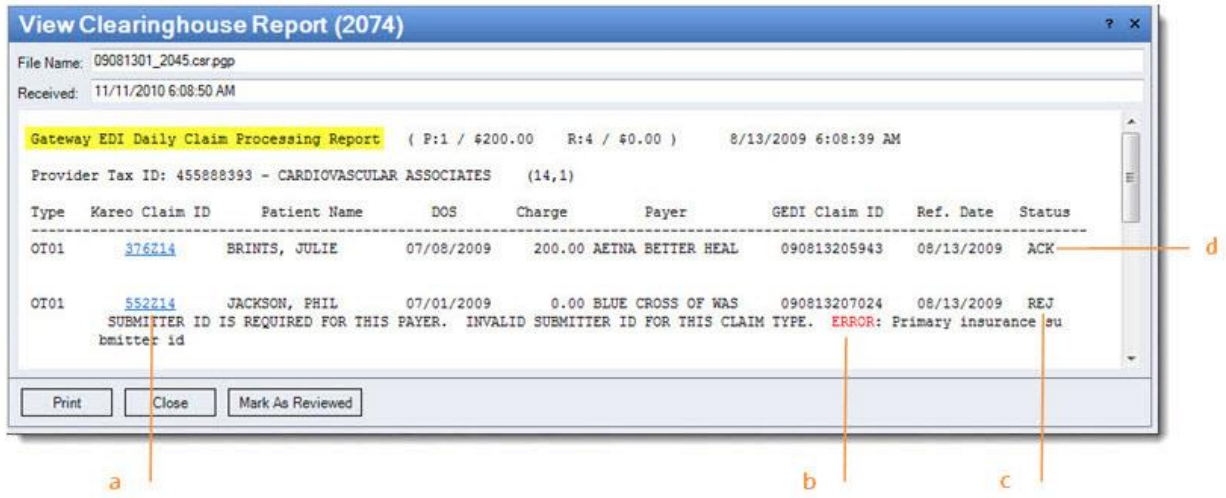
Clearinghouse Reports

Prior to transmitting claims to the payer, the clearinghouse runs a series of checks (or edits) 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 **Common Clearinghouse Rejections** section above.

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

Examples of Clearinghouse Edits:

- Missing or invalid ID qualifiers
- Submitter not approved for electronic claim submission
- Missing submitter ID 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)



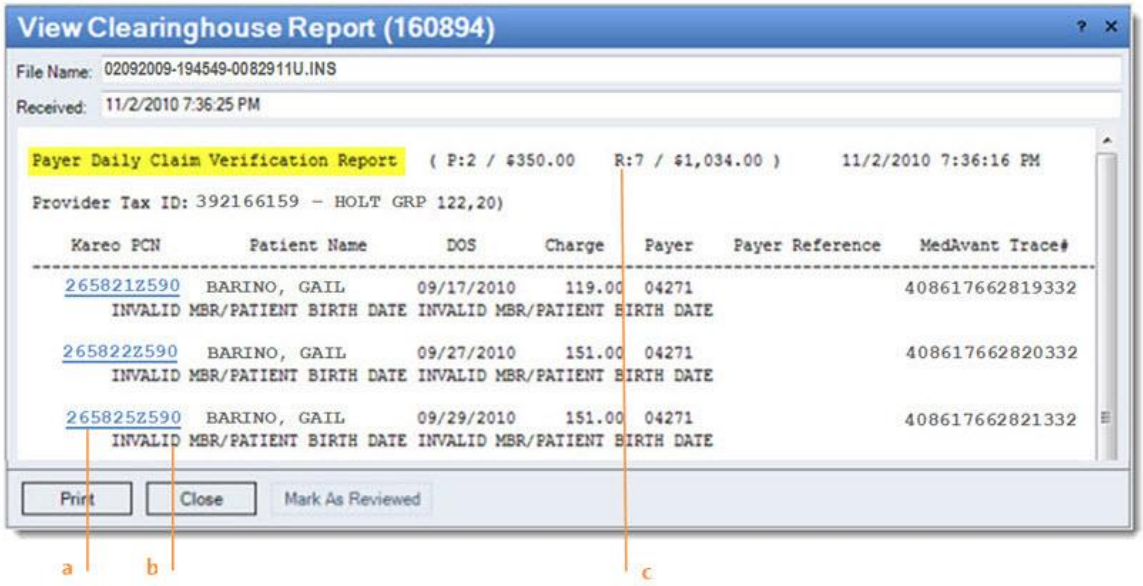
a. Click to access the encounter record
b. Reason for rejection
c. REJ = claim rejected, make corrections and rebill.
d. ACK = acknowledged; claim forwarded to payer. No action necessary.

Note: The Clearinghouse Report layout and column titles will vary slightly depending on your clearinghouse.

Payer Reports

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

Additional Rejection Troubleshooting

Not finding the solution to your rejection listed above?

Search our Help Center here.

Tip: When searching rejections, use just a few key words from the rejection message for best results (e.g. "Submitter not approved" rather than the full rejection message).

Still not finding your rejection?

The Kareo Support team is here to help! Submit a Claim Rejection support ticket here**.**

Complete the ticket info and click Submit. Our team will do the rest!

- Our claim rejection specialists will research the rejection and reply back with further information within 48 business hours. If no solution can be found, they will work with our clearinghouse partners (and their payer EDI analysts to determine the appropriate action.
- Once the resolution is identified, the specialist will respond with detailed steps for correcting within Kareo.

DISCLAIMER:

- Kareo Support can assist in researching payer rejections but not denials. Please contact the payer for explanation of the denial reason and what to correct. Our Support Team can then help identify how to make the corrections in Kareo.
- Kareo Customer Support Representatives can provide instructions for utilizing the Kareo software but cannot provide instructions on how to bill. If you have questions about what codes to use or what information to include on the claim, please contact a certified biller/coder or the payer. If you'd like help with your billing, click here for more information on Kareo Medical Billing.