

Insurance Claim Error Cheat Sheet

Introduction	2
Claim Terminologies	2
Types of Claim Rejections:	2
What is EDI 837p?	3
What is a 999 Claim Acknowledgement?	5
What is an EDI 277CA Claim Acknowledgement?	5
Electronic Claims (EDI) Overview	5
What is a Clearinghouse	5
EDI Enrollment	6
Electronic Remittance Advice (ERA)	6
ERA Enrollment	6
Electronic Fund Transfer (EFT)	6
Understanding HCFA (CMS-1500) Form	7
How to Fill the HCFA Form in zHealthEHR	7
About Claim Rejections	7
Claim Submission Tips	9
Most Common Insurance Claim Errors	9
Still not finding your claim error resolution?	16

Introduction

At zHealth, we recognize that timely payments are crucial to your practice's success. One major factor that can delay payment is claim rejections. This guide is designed to help you understand and resolve some of the most common claim errors encountered by practices.

Each entry is divided into three sections:

- **Error Message:** This shows the specific rejection message from the clearinghouse report or claim transaction line in zHealth..
- **Error Meaning:** This section explains the probable cause(s) of the claim error.
- **Resolution (if applicable):** This outlines any actions that may need to be taken inside or outside of zHealth to fix the claim error.



Claim Terminologies

Before we dive into the specifics of claim errors, let's first review the different types of claim rejections, including 277 Claims Acknowledgement, 999 Claims Acknowledgement, and EDI 837p. We'll also cover how to post ERAs or EOBs through zHealthEHR.

Types of Claim Rejections:

There are two types of rejections that may occur during the claim process:

1. **Clearinghouse-Reported Claim Errors or Rejections:**

If the clearinghouse, Office Ally, reports an error in the claim, zHealthEHR receives the EDI-277, processes it, and displays the error. The Office Ally rejection (277 CA) is in EDI format, which we parse to show errors.

For example, the following error is from an OA rejection for secondary claims.

SECONDARY CLAIM INFORMATION MISSING OR INVALID (LOOP 2430) - EACH LINE MUST

BALANCE; LINE CHARGE AMOUNT (SV102 [HCFA]/SV203 [UB]) = LINE SUM OF ADJUSTMENT AMTS (CAS) + LINE PAYER PAID AMT (SVD02)

2. Payer/Insurance Company Rejections:

*Providers must log in to their Office Ally account to view payer errors and make corrections to their claims. Currently, this is not a service we support.

Note for zHealth Billing Software Users: *If there is no error from Office Ally, the claim is sent to the payer. However, if the payer returns an error and does not reflect in zHealthEHR Software, it can only be checked in Office Ally.*

**In such cases, the status will remain as 2S, and you'll need to log in to Office Ally to review the error.*

What is EDI 837p?

EDI 837P (Professional) is a specific version of the EDI 837 format used in the U.S. healthcare industry to submit professional claims for services provided by healthcare professionals, such as doctors, nurses, and therapists. It is used to electronically transmit claim information for individual healthcare encounters between a patient and a healthcare provider to insurance payers, including Medicaid, Medicare, and private insurance companies. The "P" in 837P stands for "Professional," distinguishing it from other types of claims like institutional claims, which are transmitted using the EDI 837I format.

The EDI 837p (Professional) file is divided into several key sections, each containing specific information related to the healthcare claim. These sections help structure the data for electronic submission to payers.

The primary sections of an EDI 837P file are:

1. ISA (Interchange Control Header)

- This is the first segment of the file, containing information about the sender and receiver, control numbers, and transmission dates. It defines the beginning of the transmission.

2. GS (Functional Group Header)

- This segment contains information about the group of related transaction sets (like a group of claims) being transmitted. It identifies the sender, receiver, and the type of transaction being sent.

3. ST (Transaction Set Header)

- This marks the beginning of a single claim and contains a reference number that can be used to identify and track the transaction.

4. BHT (Beginning of Hierarchical Transaction)

- This segment contains general information about the claim, including transaction codes and hierarchical relationships of the data.

5. **NM1 (Name)**
 - This segment contains the names of parties involved in the transaction, such as the provider, patient, or payer.
6. **REF (Reference Identification)**
 - This segment is used to provide additional reference numbers or identification numbers, such as claim numbers or policy numbers.
7. **DTP (Date/Time/Period)**
 - This section includes important dates related to the claim, such as the date of service, admission date, or discharge date.
8. **CLM (Claim Information)**
 - This is the main section containing details of the claim, including the total charge, patient account number, and the diagnosis and procedure codes.
9. **HI (Health Care Diagnosis Code)**
 - This segment provides the diagnosis codes related to the healthcare services provided, such as ICD-10 codes.
10. **SV1 (Professional Service)**
 - This contains specific information about the services provided, including procedure codes (CPT/HCPCS) and associated charges.
11. **LX (Transaction Set Line Number)**
 - This section is used to break down the claim into individual line items (if applicable), such as multiple services or procedures provided during the same encounter.
12. **NM1 (Name) for Other Participants**
 - This segment identifies other participants in the transaction, such as referring providers or attending providers.
13. **SE (Transaction Set Trailer)**
 - This segment marks the end of the transaction set and includes a count of the number of segments in the set.
14. **GE (Functional Group Trailer)**
 - This marks the end of the functional group and includes a count of the transaction sets included in that group.
15. **IEA (Interchange Control Trailer)**
 - This is the final segment, marking the end of the entire transmission, and it provides a summary of the number of groups and transactions in the interchange.

These sections collectively organize all the necessary information to process a healthcare claim, including provider and patient details, services rendered, diagnosis, and charges. Each section ensures that the claim is structured in a way that can be read and processed by the payer's system.

What is a 999 Claim Acknowledgement?

A 999 Claim Acknowledgement is an electronic transaction used in the healthcare industry to acknowledge the receipt of a claim or other electronic healthcare transaction. It provides confirmation that the claim has been received by the clearinghouse or payer and indicates whether the claim was accepted or rejected.

The 999 Acknowledgement gives the following results:

1. Accepted (A)
2. Rejected (R)
3. Accepted with errors (E)

What is an EDI 277CA Claim Acknowledgement?

An EDI 277CA Claim Acknowledgement is an electronic transaction used to provide feedback on the status of a claim submission. It is sent by a clearinghouse or payer to inform the sender (usually the healthcare provider or billing service) whether the claim was accepted or rejected. The 277CA acknowledges receipt of the claim and, if applicable, provides details about any errors or issues that need to be addressed before resubmitting the claim.

Electronic Claims (EDI) Overview

An EDI file is generated after you submit a claim electronically, serving as the outbound communication in the insurance billing process. This 837P file (the technical term for an EDI claim) must be routed through a clearinghouse (Office Ally) to ensure it reaches the correct payer.

EDI is also used for communication between payers, the clearinghouse (Office Ally), and your practice to confirm receipt of a claim or to send a claim rejection notice.



What is a Clearinghouse

A clearinghouse serves as an intermediary between billers (like your practice) and payers (such as the insurance company). To make the process smoother and more efficient, we've partnered with Office Ally. If you already have an Office Ally account, you can update your details in your zHealth account.

EDI Enrollment

EDI enrollment is a necessary process for some insurance companies to start accepting electronic claims from your practice. Your clinic must complete the enrollment and receive approval from the insurance company before you can send claims electronically. Click [here](#) for instructions on how to enroll for an EDI Payer ID.

When you submit an electronic claim, our software generates and sends an 837 EDI file to the clearinghouse (Office Ally). After submission, you or the system no longer have control over the claim. However, the application allows you to track the status of your claim.

Electronic Remittance Advice (ERA)

It is an electronic document sent by insurance companies to healthcare providers, detailing the payment or adjustment made for a claim. The ERA includes information about the amount paid, any deductions, and the reason for any denials or adjustments. It serves as a digital version of the traditional paper Explanation of Benefits (EOB).

ERAs streamline the process of reconciling payments, as they allow providers to automatically match payments with the corresponding claims..



Note: An ERA is a detailed explanation of the payments a payer has made to you. Please note that the actual funds are not processed or handled by our software.

ERA Enrollment

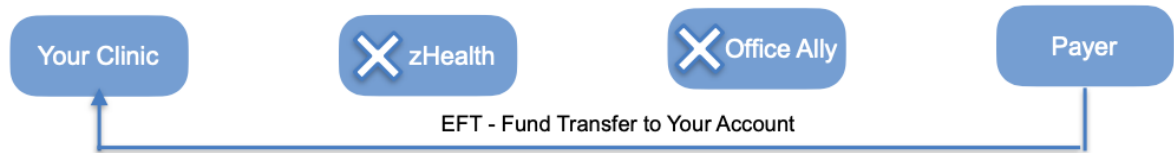
ERA enrollment is the process that some insurance companies require in order to start receiving electronic remittances from a payer to zHealth software. Until your practice completes the enrollment and gets approval from the insurance company, you will continue to receive a paper Explanation of Benefits (EOBs).

For more information, please check: [ERA Enrollment Guide](#).

Electronic Fund Transfer (EFT)

EFT (Electronic Funds Transfer) is the method through which an insurance company sends payments directly from their bank account to yours. Your payment for services does not pass

through a clearinghouse or our software. **If you encounter any issues with delayed, missing, or incorrect payments, you will need to reach out to the payer directly.**



Understanding HCFA (CMS-1500) Form

The HCFA Form, now called the **CMS-1500 form**, is a standard claim form used by healthcare providers to bill insurance companies for services provided to patients. It's primarily used for outpatient medical services, such as physician visits, chiropractic visits, diagnostic tests, and other non-hospital-based care.

The form includes important details like the patient's information, provider details, diagnosis codes, and the procedures performed, which help insurance companies assess and process the claims. It's required for submitting claims for reimbursement from Medicare, Medicaid, and many private & commercial insurance payers.

How to Fill the HCFA Form in zHealthEHR

The HCFA form has 33 boxes that need to be filled out. Refer to this detailed [guide](#) for instructions on how to complete each section and where to find the necessary information for any patient or practice-related details you may need to add or edit.

About Claim Rejections

The claims process typically involves several key steps to ensure that healthcare providers are reimbursed for services rendered.

Here's an overview of the general steps involved:

- 1. Patient Visit and Service Documentation**

The process begins when a patient visits a provider or a clinic for services. The provider documents the services rendered and gathers the necessary information (e.g., diagnosis,

procedures, patient details).

2. **Coding**

The provider or the clinic assigns the appropriate medical codes (ICD codes for diagnoses, CPT/HCPCS codes for procedures) based on the services provided.

3. **Claim Preparation**

The provider or the clinic prepares the claim, which includes all the necessary information such as patient details, codes, dates of service, and insurance information.

4. **Claim Submission**

The prepared claim is submitted to the payer (insurance company or government program like Medicare/Medicaid) either electronically (via EDI) or on paper (e.g., CMS-1500 form).

5. **Claim Adjudication**

Once the claim is received by the payer, it undergoes adjudication. During this process, the payer reviews the claim for accuracy, checks for eligibility, verifies the medical necessity of the services, and applies any applicable policy rules.

6. **Payment or Denial**

After adjudication, the payer either approves and processes the claim for payment or denies it. If the claim is approved, the provider will receive the payment. If the claim is denied, the payer issues a remittance advice or an Explanation of Benefits (EOB) explaining the reason for denial.

7. **Patient Billing**

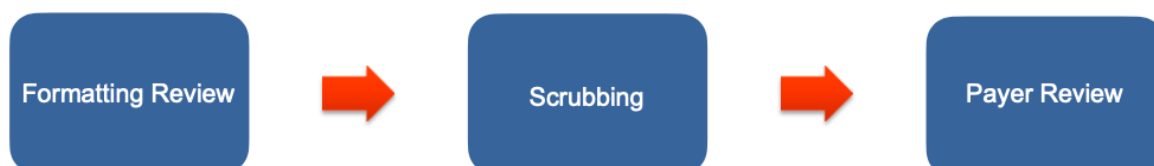
If there is any remaining balance after the insurance payment (e.g., co-pays, deductibles, or coinsurance), the provider will bill the patient for the amount due.

8. **Appeals (if necessary)**

If a claim is denied or underpaid, the provider may choose to appeal the decision. This typically involves reviewing the payer's explanation, correcting any errors, providing additional documentation, and resubmitting the claim for reconsideration.

Note: These steps may vary depending on the payer and type of service provided, but this gives a broad overview of the general claims process.

When a claim is submitted from zHealthEHR, it undergoes three separate checks before it reaches the payer's internal adjudication system.



1. Formatting Review: When you submit a claim from your zHealth account, it is sent to the clearinghouse, Office Ally. The clearinghouse checks the claim for formatting issues. If there's missing or invalid information, it sends an error message back to zHealth. You can view the error in the Billing Center (or the Red Bubble icon). When this happens, review the error report from the clearinghouse and make the necessary corrections before resubmitting the claim.

2. Scrubbing: Next, the clearinghouse reviews the claim for coding and billing accuracy. If any errors are found, an error report is generated and sent to the zHealthEHR system. You can view the error in the Billing Center (or the Red Bubble) for the specific claim and make the necessary corrections before resubmitting it.

3. Payor Review: Once the claim passes the scrubbing process, the clearinghouse forwards it to the payer. The payer then reviews the claim based on factors such as the patient's insurance plan coverage, the contract with the provider, and both patient and provider details, before sending it to the internal adjudication system. Any denials or rejections at this stage are communicated through an ERA (or EOB).

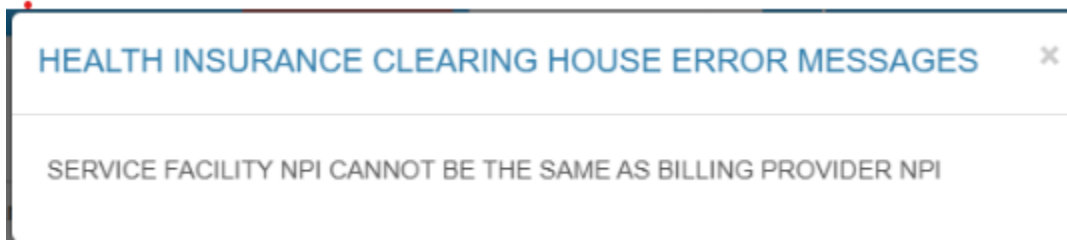
Claim Submission Tips

- zHealth generates clearinghouse reports within a few hours of submitting electronic claims. It's a good practice to check these reports regularly—if you submit claims in the afternoon, for instance, make it a point to review the reports as your first task the next day. zHealth batch out claims, that are in the "RS" status, to the clearinghouse Pacific Time every night.
- Clearinghouses will reject duplicate claims, so it's advisable to wait three (3) business days before resubmitting corrected claims.
- When submitting a claim to Medicare, always enter "1 - Original" in Box #22a, regardless of whether it's an initial submission or a rebilling in case of Medicare.
- Before submitting a claim, review the insurance company's claim settings. To learn how to add or edit claim settings in the insurance master list in your zHealth account, read this [help article](#). For submitting paper claims, click [here](#) to find out how to add or edit claim settings in the insurance master list.

Most Common Insurance Claim Errors

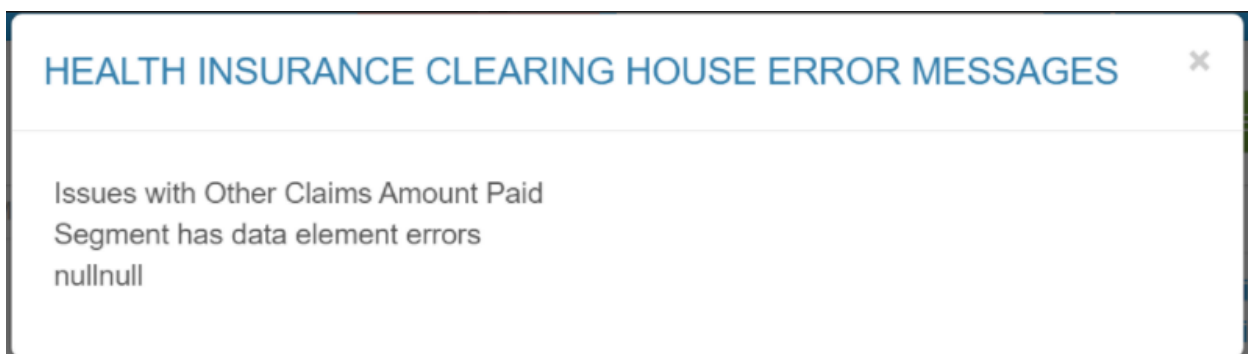
There are several errors a clinic may encounter when a claim is rejected. Below is a list of most common claim errors, along with the likely causes and their resolutions:

1. Error - Health Insurance Clearing House Error Messages (Service Facility NPI cannot be the same as Billing Provider NPI)



What This Means	How to Fix
<p>According to the Office Ally notification dated 01/13/2025, when submitting claims to the following two payers, the "Service Facility Information" on HCFA/UB claims does not require the Service Facility NPI if it is the same as the Billing Provider NPI.</p> <p>Payer IDs:</p> <ul style="list-style-type: none"> ● BCBS Illinois (HCSC): Payer ID 00621 ● Blue Shield of California: Payer ID BS001 	<p>To resolve this issue you may choose either of the following options:</p> <ul style="list-style-type: none"> ● Use Different NPIs: Use two different NPIs in Box 32a and Box 33a ● Leave Box #32a Blank: Leave Box #32a blank and use your billing provider NPI in Box #33a <p>For more information click here.</p>

2. Error - Health Insurance Clearing House Error Messages (Issues with other Claims Amount Paid/Segment has data element errors/nullnull)



What This Means	How to Fix
<ul style="list-style-type: none"> • This error message usually occurs when claims are submitted to the secondary payer without properly posting the Primary ERA/EOB at the CPT level or if it was posted incorrectly. • For BATCH CLAIM SUBMISSION, the system may occasionally generate two claim IDs. In such cases, you might encounter this error message. 	<ul style="list-style-type: none"> • Ensure that the ERA/EOB is posted at the detailed CPT level for each line item, and that the total billed amount equals the sum of the Insurance Paid, Adjusted Amount, and Patient Responsibility. • To resolve this issue in this case, delete the affected claim(s) and resubmit them as new claims.

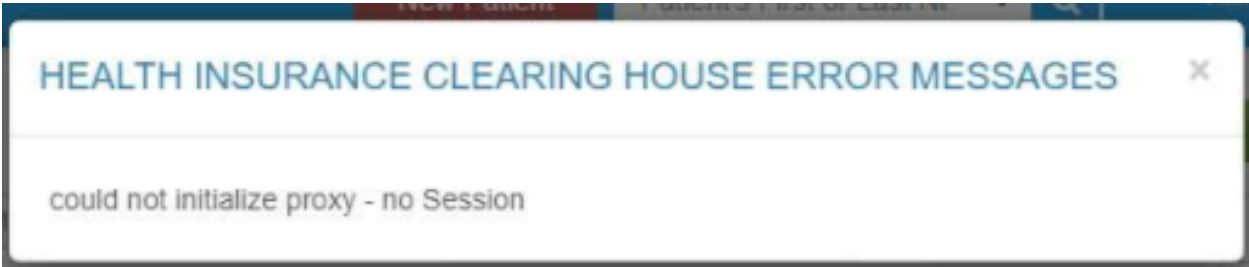
3. Error - Health Insurance Clearing House Error Messages (Value of element REF02 (Care Plan Oversight) is incorrect....)



What This Means	How to Fix
<ul style="list-style-type: none"> • This error indicates that there is an issue with the value provided in the REF02 element for Care Plan Oversight in the claim. The error 	<p>Since the loop number has not been specified, please verify both the rendering provider NPI and the billing provider NPI, as well as the combination of the billing</p>

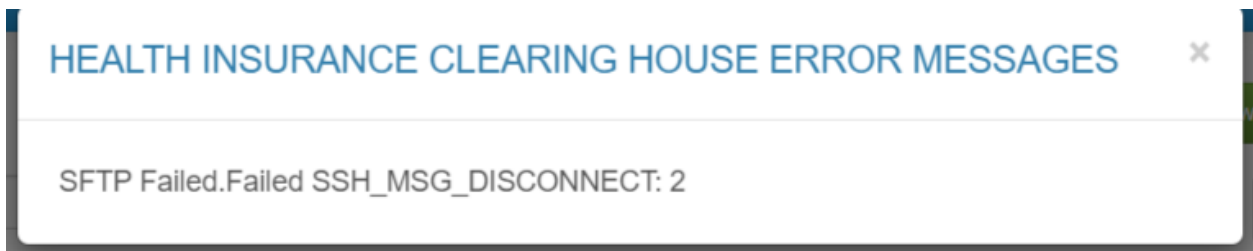
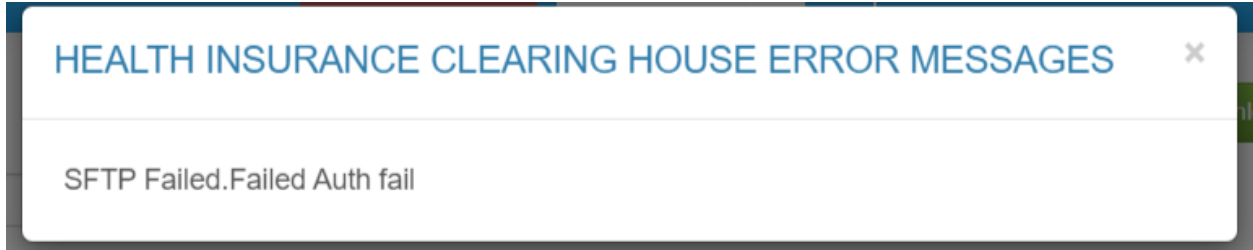
<p>message is specifying that the value entered for this field is incorrect. The expected value for this field should be the National Provider Identifier (NPI), which is a 10-digit number.</p> <ul style="list-style-type: none"> • Or, it has something to do with the combination of NPI/TaxID. The clinic may be using the incorrect group/individual NPI or TaxID than what they were approved with from the payer. 	<p>provider NPI and the TAX ID, to ensure the correct details are sent to the payer.</p>
--	--

4. Error - Health Insurance Clearing House Error Messages (Could not initialize proxy - no session)



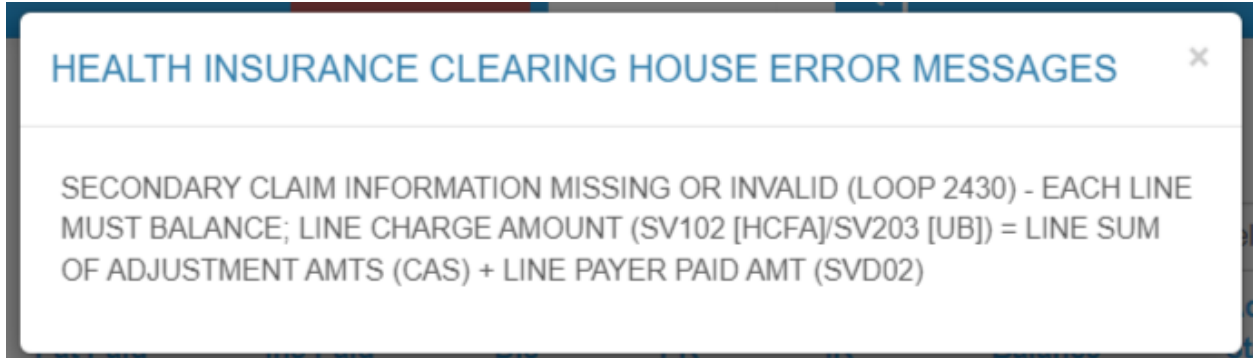
What This Means	How to Fix
<ul style="list-style-type: none"> • It typically occurs in zHealth systems when an attempt is made to access Office Ally FTP server to electronically exchange the EDI files that requires an active session, but no valid session is available. 	<p>Resubmit the claims.</p>

5. Error - Health Insurance Clearing House Error Messages (SFTP Failed. Failed Auth Fail OR SFTP Failed.Failed SSH_MSG_DISCONNECT: 2)



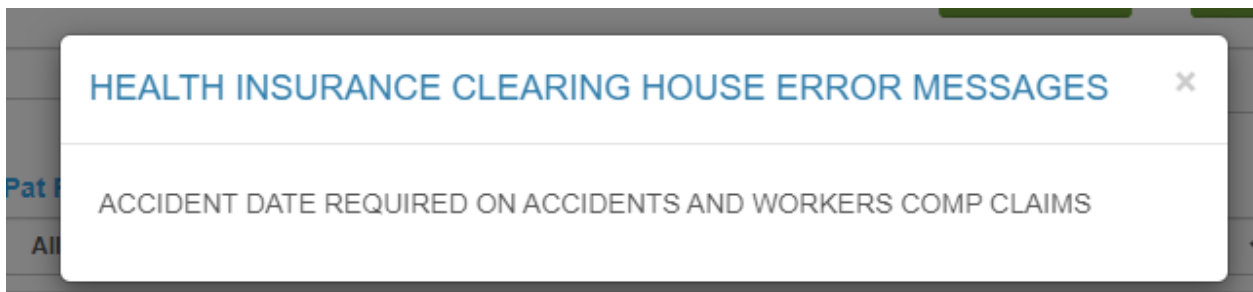
What This Means	How to Fix
<p>We usually receive this error message when zHealth is unable to authenticate or access the OA FTP server needed to exchange EDI files.</p>	<ul style="list-style-type: none"> ● Make sure your OA account SFTP username and password are correctly entered in the zHealth software. ● Ensure all Billing Providers have their SFTP username and password properly configured in the zHealth system. ● Verify that your OA account is active. If there is a balance due and it's not paid, OA may temporarily disable your SFTP account. ● Ensure your SFTP username and password are not configured in any other software, including old software, outside of zHealth. <p>Note: Your SFTP password is separate from your Office Ally account password.</p>

6. Error - Health Insurance Clearing House Error Messages (Secondary Claim Information Missing or Invalid (Loop 2430)...)



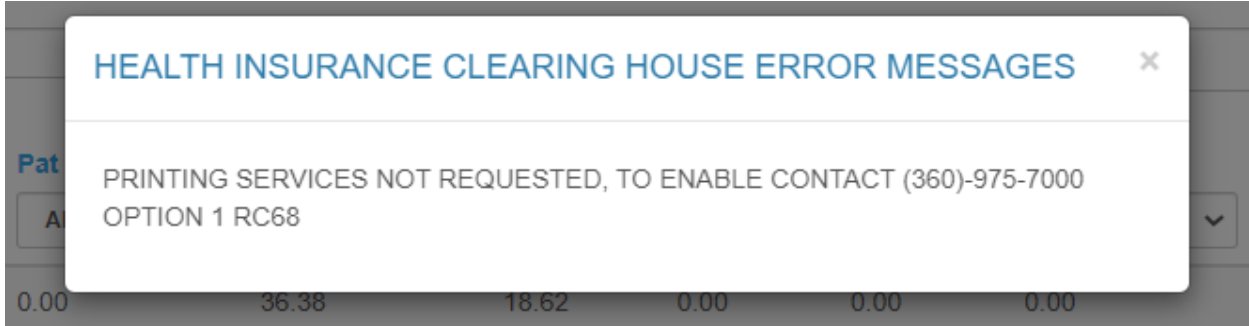
What This Means	How to Fix
<p>This error message indicates that there is an issue with the secondary claim's details in Loop 2430, which relates to the claim line level adjustments and payments. Specifically, the system is checking that the line charge amount (SV102 for HCFA or SV203 for UB) matches the sum of the line adjustment amounts (CAS) and the line payer paid amount (SVD02).</p>	<p>To resolve it, ensure that:</p> <ol style="list-style-type: none">1. The total charge for the service matches the sum of the payer's payment and any adjustments.2. All fields are properly populated with correct values in the secondary claim.

7. Error - Health Insurance Clearing House Error Messages (Accident date required on Accidents and Workers Comp Claims)



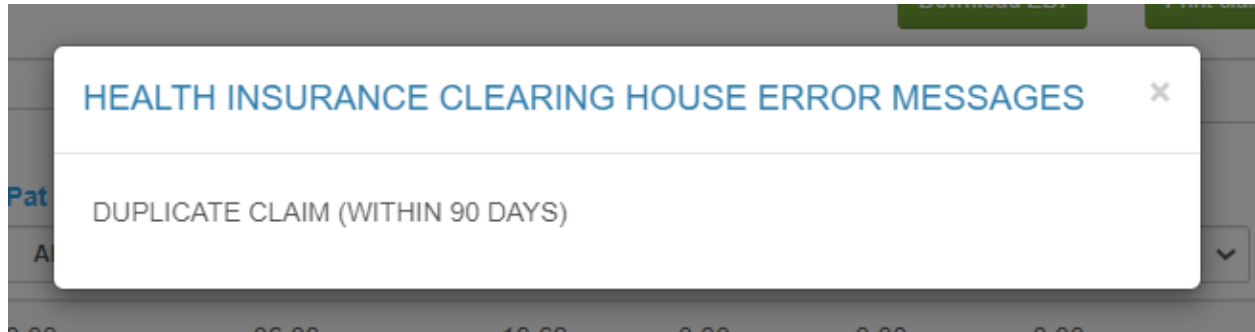
What This Means	How to Fix
<p>This error message means that the accident date is required when submitting claims related to accidents or workers' compensation cases. Insurance companies typically need this information to determine the eligibility and coverage for the claim.</p>	<p>To resolve the error, ensure that the accident date is entered correctly in the claim details (Box #15) for any accidents or workers' comp-related claims before resubmitting the claim.</p>

8. Error - Health Insurance Clearing House Error Messages (Printing Services not requested, to enable Contact (360)-975-7000 Option 1 RC68)



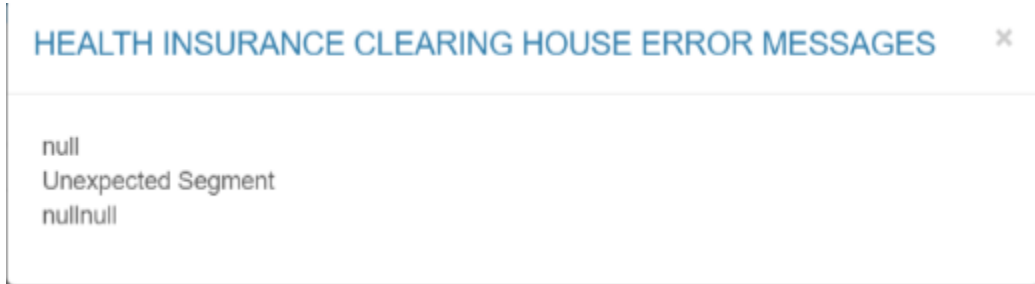
What This Means	How to Fix
<p>This error message originates from Office Ally and may be due to one of the following reasons:</p> <ul style="list-style-type: none"> • The clinic has not recorded pre-enrollment for this payer associated with the NPI in box #33a • The payer does not permit electronic submission of this type of claim. 	<ol style="list-style-type: none"> 1. Verify if the claim was sent to the correct payer. 2. Verify if the claim was sent with the correct Billing Provider NPI number in the Box #33a 3. Confirm if the clinic has received confirmation from the payer that the NPI is set up for electronic submissions.

9. Error - Health Insurance Clearing House Error Messages (Duplicate Claim within 90 Days)



What This Means	How to Fix
<p>We receive this error message usually from the clearinghouse, Office Ally. This indicates that a claim has been submitted to the payer that is a duplicate of a previously submitted claim within the last 90 days.</p>	<p>To resolve this error, you just need to disable a function in Office Ally. The clinic needs to be signed into the 'Service Center' level of Office Ally, not Practice Mate or EHR. To be sure your clinic is logged in correctly:</p> <ol style="list-style-type: none"> 1. Go to www.officeally.com, and login. 2. After logging in, on the left-hand side of the page, there will be a list of blue links. Towards the bottom of the page there will be a category titled 'My Settings'. Under that category will be a link 'Admin Section'. Hold your mouse over that and click 'Duplicate Filter Setting'. 3. On the next page, select how long you would like to turn off the duplicate for, e.g. the next 24 hours, 48 hours, or permanently from the dropdown options. 4. Put your name in the box below so there is a record of who chose to turn off the filter. 5. Click the button that says 'Turn Off DeDuping' and click "Okay". 6. Once this is completed, you can resubmit your claims.

10. Error - Health Insurance Clearing House Error Messages (Null/Unexpected Segment/nullnull)



What This Means	How to Fix
<p>This error message is usually encountered when the HCFA (CMS-1500) Form or the EDI 837p file is missing information.</p>	<ol style="list-style-type: none"> 1. The most common issue is a missing QUALIFIER for the Referring Physician in box 17. When entering a referring provider, always ensure you select the DN (Referring Physician) QUALIFIER from the dropdown menu in box 17. 2. Box #23 is missing the Qualifier for the Prior Authorization Number. Please make sure to include Qualifier G1 along with a valid Prior Authorization Number. 3. If the payer requires the rendering provider taxonomy details in Box #24ij (shaded field) to process the claims electronically, please make sure it is correctly configured in the system so that it pulls accurately on the claim form or EDI 837p. <p>In the EDI file, the rendering provider taxonomy is transmitted in Loop 2310B, Segment PRV03, and the billing provider taxonomy is transmitted in Loop 2000A, Segment PRV03.</p> <p>However, due to a configuration issue</p>

	<p>in our system, the rendering provider taxonomy information is incorrectly passed in Loop 2310B, Segment REF02, which causes the duplicate. As a result of this, the clearinghouse sends the parsing error.</p> <p>**Workaround:</p> <p>Only include the provider taxonomy in box 33b on the HCFA form, and ensure that the rendering provider taxonomy details are entered under the "Update Info > Provider" tab, while the billing provider taxonomy is entered under the "Update Info > Facility" tab.</p> <p>This will ensure that the correct taxonomy information is included in the EDI file, allowing the claim to be successfully submitted to the clearinghouse.</p>
--	--

11. Error - Member Pick Reject

What This Means	How to Fix
<p>The insurance company is unable to find the patient's member ID.</p>	<p>This error message is from the insurance company. This happens when the insurance cannot find the patient's member ID. Make sure the member ID of the patient's insurance plan is entered correctly in the Patient's Profile. To ensure the correct member ID is available:</p> <ul style="list-style-type: none"> • Go to the Patient Profile > Contact Details > Primary Insurance > Member ID • If the member ID is already present, confirm with the patient that the ID is correct.

Not able to find the solution to your rejection listed above?

Click [here](#) to view the full list.

Still not finding your claim error resolution?

The zHealth Customer Support team is here to help! Submit a Claim Error support ticket [here](#). Provide the complete rejection or error issue info and click Submit. Our team will do the rest!

Our claim specialists will research the error and reply with further information within 24 business hours. If no solution can be found, they will work with our clearinghouse partner (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 zHealth.