SOP Template: Procedures for Addressing Discrepancies or Rejected Claims

This SOP details **procedures for addressing discrepancies or rejected claims**, including the identification of claim errors, documentation requirements, communication protocols with claimants, steps for claim correction or resubmission, and timelines for resolution. The goal is to ensure efficient handling of claim issues to minimize delays and maintain accurate financial records.

1. Purpose

To outline the steps for addressing and resolving discrepancies or rejected claims efficiently and accurately.

2. Scope

This procedure applies to all personnel involved in claims processing, including billing, finance, and customer service departments.

3. Responsibilities

- **Claims Processor:** Identifies and investigates discrepancies, prepares documentation, and communicates with claimants.
- **Supervisor/Manager:** Reviews disputed claims, approves corrections, and monitors resolution timelines.
- **Finance Department:** Ensures accurate recordkeeping and reporting of claim adjustments.

4. Procedure

1. **Identification of Discrepancies or Rejected Claims**
    - Review claim submission reports and denial notifications daily.
    - Flag any claims marked as "discrepant," "denied," or "rejected" by the payer.
2. **Documentation Requirements**
    - Collect all relevant documents including claim forms, correspondence, denial codes, and supporting evidence (e.g., invoices, explanation of benefits).
    - Log the discrepancy or rejection in the claims tracking system with details of the error or rejection reason.
3. **Communication Protocols**
    - Notify the claimant or responsible department of the discrepancy or rejection within 2 business days of identification.
    - Provide clear instructions/request for additional information (if required).
    - Document all communications in the claims management system.
4. **Claim Correction or Resubmission Steps**
    - Analyze the rejection reason to determine if additional information, corrections, or clarifications are required.
    - Make necessary corrections to the claim and attach all supporting documentation.
    - Resubmit the corrected claim to the payer as per their guidelines.
    - If corrective action is not possible, escalate to supervisor for review and alternative action.
5. **Resolution and Timelines**
    - Track the status of resubmitted claims and follow up with the payer or claimant as needed.
    - Resolve claims issues within 15 business days from the date of identification whenever possible.
    - Update all records to reflect final resolution and communicate outcome to relevant stakeholders.

5. Documentation and Record Keeping

- Maintain an updated log of all discrepancies, rejections, corrections made, and final outcomes for audit purposes.
- Retain all correspondence and supporting documentation as per the organization's document retention policy.

6. Review and Continuous Improvement

- Supervisors shall review the effectiveness of these procedures at least annually.
- Identify recurring issues and implement changes to prevent future discrepancies or rejections.

7. References

- Claims Processing Policy
- Document Retention and Management Policy
- External Payer Guidelines