UCLA Health Ambulatory Practices
Revenue Policy and Procedure

Policy Name: Claim Edits/Rejection Policy		
Policy #: 017	**Developed Date: April 2014**	**Approved Date:**
Approved By:	**Revision Date: 03/2016**	**Revised By:**

I. Purpose

To expedite claims processing by effective and efficient claim rejection management.

II. Policy

Designated claim edits/rejections, assigned to practice staff and managers, will populate daily with claims requiring additional attention before submission to insurance carriers. Claims residing in work queues must not exceed 24 hours or one business day without resolution and resubmission for claim submission.

017 Charge Edits/Rejections Management Policy
Standard Operating Procedure

Procedure

A. Assignment of Ownership

1. Work queues contain claims that are not yet billed. Designated employees must access assigned work queues each morning to:
   - Review each claim rejection for "rejection reason"
   - Correct as directed by "reason for rejection"
   - Send "unresolvable issues" to manager's work queue
   - Clear all claim edits/rejections daily

B. Workqueues Include:

1. *Manager-Assigned/Charge Review Work queues:*
   - Claim rejections for incomplete charge information (i.e. missing diagnosis, incorrectly coded visit, "provider not credentialed", etc.)
   - Claim edits/rejections directed by staff to managers for additional evaluation or escalation
2. *Employee-Assigned/Patient Work queues*:
   - "Missing Registration Items" assigned to the practice for corrections and resubmission (i.e. missing insurance address, patient employment or phone number, missing guarantor information, etc.)
   - "Ready to Schedule" to schedule patients with completed referrals
   - "Incomplete" clear authorization field as needed