Process Improvement and Evaluation of Turnaround Time of Cashless and Reimbursement Claim Processing at Aditya Birla Health Insurance, Mumbai, Maharashtra

By

Ria Bhat

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2017-2019

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INSTITUTE OF HEALTH MANAGEMENT RESEARCH
(WHO Collaborating Centre for District Health System Based on Primary Health Care)

IIHMR UNIVERSITY

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr Ria Bhat, student of MBA Hospital and Health Management from The IIHMR University, Jaipur has undergone internship training at Aditya Birla Health Insurance, Mumbai, Maharashtra from 1st February to 30th April 2019.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfilment of the course requirements.

I wish her all success in all her future endeavours

Dr. Ashok Kaushik
Dean, Academics and Student Affairs
The IIHMR University, Jaipur

16 May 19

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May 10, 2019

Internship Completion Certificate
To Whom So Ever It May Concern

This is to certify that **Ms. Ria Bhat** has completed her internship with **Aditya Birla Health Insurance Company Limited (ABHICL)** from **1st February 2019 to 30th April 2019.**

She has successfully completed her project **"Process improvement and evaluation of turnaround time of cashless and reimbursement claim processing."**

Her performance was found to be as per the high standard required by ABHICL.

We wish her all the best in her future endeavours.

Thanking you,

Yours sincerely,

Anuradha Puranik
Head – Corporate HR

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled"Process Improvement and Evaluation of Turnaround time of Cashless and Reimbursement Claim Processing at Aditya Birla Health Insurance" and submitted by **Ria Bhat**, Enrolment no. **IIHMR-U/01/2017-19/0647** under the supervision of Dr. Monika Chaudhary for award of MBA in Hospital and Health/ Pharmaceutical / Rural Management in Health and Hospitals of the University carried out during the period from 1st February to 30th April 2019 embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.

(RIA BHAT)

Signature

Abstract

Health Insurance in India is a growing sector of India's economy.As per the reports, more than 80% of Indians are not covered under private health insurance plan. As Insurance sector is showing an upward trend and with the different health plans that are being offered by the private insurance companies, the smooth functioning of the claims process hold the utmost importance resulting in the efficiency, efficacy and better customer satisfaction.

This observational study was performed at Aditya Birla Health Insurance Pvt. Ltd**,** Mumbai for a period of two months. To provide and deliver superior value to the customers and provide hassle free experience, the entire process was observed including the inter departments associated to the claims and reimbursement process. The objective of the study includes observing the process flow of cashless, network reimbursement and member reimbursement is done, evaluate the gaps in processes, and evaluation of turnaround time, providing the recommendation for those gaps and TAT thus improving the efficiency and customer satisfaction. The study performed is observational descriptivestudy. After the analysis, it was evaluated that the process flow that was formed two years back is totally different from the functional process undergoing now. Gaps are observed, notified and recommendation for the same are done. The study resulted in the reduced time of the process thus improving the efficacy of the employees, efficient use of resources and reduction in Turn-around time.

Acknowledgement

Success of any project is never due to an individualistic effort. It requires the active participation of many members to lead to a satisfying conclusion. My dissertation project is no different. First, I would like to thank my parents for their never-ending support and the confidence that they show in me.

I would like to extend my heartfelt gratitude to The IIHMR University,Jaipur for giving me this opportunity to apply our theoretical knowledge in a practical set up, especially, my guide, **Dr. Monika Chaudhary** for guiding me at every step.

I would also like to extend a note of thanks to the team at Aditya Birla Health Insurance Pvt. Ltd. for allowing me to be a part of their organization and helping me learn the minute details of claim processes. I would like to make a special mention of **Dr.Jimeet Jain**, a truly exceptional talent in the field of Health Insurance. Thank you, Sir, for sharing your valuable knowledge about your field of expertise and for giving ample exposure to me which shall be beneficial for me in my future endeavors.

And above all, I thank God Almighty, without whose blessings nothing can come to pass.

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LIST OF SYMBOLS AND ABBRIVATION:

ABHI – Aditya Birla Health Insurance.

SOP's – Standard Operating Procedures.

TAT- Turnaround Time.

PPN- Preferred Provider Network.

Pre Auth - Pre Authorization

IRDA – Insurance Regulatory and Development Authority

TPA-Third Party Administrators

INTRODUCTION

The term 'Health Insurance' relates to a type of insurance that essentially covers your medical expenses. A health insurance policy like other policies is a contract between an insurer and an individual or group in which the insurer agrees to provide specified health insurance cover at a particular "premium" subject to terms and conditions specified in the policy. Health insurance covers the whole or a part of the risk of the person incurring medical expenses, defined as the coverage that provides for the payments of benefits as a result of sickness or injury includes losses from accident, medical expense and disability or accidental death. It is thus inevitable for the insurance company to make sure that the process related to claims are done efficiently thus retaining the customer's satisfaction and thereby reducing the TAT.

The study was conducted at Aditya Birla Health Insurance Pvt. Ltd. Mumbai and aims at analyzing the gaps in the process of cashless and reimbursement under the claims department. The standard operating procedures which were formed two years back in the company were not found to be fully functional and there were few changes,gaps, discrepancy related to them. Thus the whole focus of this study was to observe the functional process flow of cashless/pre-auth and reimbursement and prepare the standard operating procedure. In any insurance claim process efficiency is being evaluated with the help of turn-around time thus in cashless/pre-authorization and reimbursement process the TAT came out to be two hours and 15 days respectively. From the perspective of the insurer and the insured the time taken for the claim processing holds the utmost importance as the patient will be availing the services without any trouble, for the insurer the time taken or the TAT for the process can be the selling point of the company which will attract more customers and thereby has to maintain the profitability.

1.1 Aim

The aim of this study is to analyze the process of the claims and to evaluate the TAT of cashless and reimbursement process and thus revising and preparing the revised process flow.

1.2 Objectives

The following objectives were kept in mind while conducting the study:-

- To identify the cashless and reimbursement-network and member process flow.

- To evaluate the turnaround time of pre-auth and reimbursement process
- To analyze the gaps in the cashless and reimbursement process.
- To identify the dependency among the inter departments for the process.
- To provide recommendations and prepare the revised functional standard operating procedures.

1.3Outline of the Study Performed

This study was performed using secondary data,the entire functional process of the ABHI claims were observed along with evaluation of TAT.

For secondary research the online reports,ABHI website, previous SOP's was referred to look into the changes.

2. METHODOLOGY

This study was conducted as a part of the dissertation programme at Aditya Birla Health Insurance Pvt. Ltd and the whole process was operational under the claims department.This study included econdary data followed by analysis of Turn around time and preparing the revised standard operating procedures.

DATA COLLECTION –

For the analysis secondary data was collected for the period of two and half months starting from 1st Feb to 16th April 2019

Secondary Data –Observation of process flow and evaluation of turnaround time

- The source was online data base.
- Claims process flow.
- ABHI MIS database.

Research Questions-The following research questions formed the basis of the study:

- How is the cashless and reimbursement (member and network) process is actually operationalized?
- What is the TAT of pre-authorization/cashless and Reimbursement process?
- Does a gap exist in the process of cashless and reimbursement?

- What are the recommendations/suggestions for the entire process?

S. NO	TASKS NAME	TIME IN WEEKS /DAYS	18 Feb - 24 Feb	25 Feb – 3rd March	4th March –	11 March -17 March	18 March- 24 March	25th March	1st April - 7th April	8th April- 14th April	15th April- 21 April	22nd April- 29th April	29th April -2nd May
1	Understanding the project need	One											
2	Observing the cashless process and TAT.	One											
3	Draft of cashless process	Two											
4	Final report of the cashless process	One											
5	Observing the network and member Reimbursement And TAT.	Three											
6	Draft of network and member reimbursement process	One											
7	Final process report of network and member reimbursement	One											
8	Report writing and presentation	Five Days											

Figure 1.1: Gantt chart for the proposed study

Research Design: An Observational Descriptive design was used for this study.

Duration:75 days

- Understanding the project need – One week.
- Observing the cashless process and TAT-One week.
- Draft of cashless process –Two weeks.
- Final report of the cashless process – One week.
- Observing the network & member reimbursement process and TAT-Three weeks.
- Draft of network and member reimbursement process –One week.
- Final process report of network and member reimbursement –One week.

Report writing and presentation -5 days.

QUANTITATIVE DATA :Observing the process and evaluating the TAT involving stakeholders' perspective about the process improvement,their contibution towards the efficient processing and analysis on data collected was done.

SAMPLING TECHNIQUE: Simple Random Sampling was used.

Simple Random Sampling is a method of selecting a subset of population from the universe in which each member has the equal probability of being selected.

In this study, for the cashless/pre-auth process 2437 cases were taken randomly out of which 920 were approved ,232denial ,1285 query were done.

For the reimbursement process 1878 cases were taken randomly 196 denial ,505 Query,1177 cases approved.

3. REVIEW OF LITERATURE

1. Claims is a relatively consistent process involving number of defined steps which are to provide efficient and effective customer service. Meet the needs of the customer or third party claimant in accordance with the terms and conditions of the policy at the lowest cost. Initial intimation of a claim where the client has to provide initial details

of the claim in writing enabling the insurer, in complex claims to get on the site as soon as possible.

2. Health insurance companies have made the hospitalisation process even easier with the assurance of cashless claim processing in less than 30 minutes. With their presence in all leading hospitals, Insurance companies have become a pioneer in this service. While finding a suitable hospital which offers cashless claims was once a task, the increasing inclusion of various major hospitals has made this woe disappear as well. With a cashless claim, you can avoid these hassles and make the process swifter and quicker. It takes away the stress of arranging and handling cash too, which becomes especially helpful in cases of emergencies.

3. Procedure for Cashless Claims

1. Cashless facility for treatment in network hospitals can be availed, if TPA service is opted.2.Treatment may be taken in a network provider/PPN and is subject to pre authorization by the TPA. Booklet containing list of network provider/PPN shall be provided by the TPA. Updated list of network provider/PPN is available on website of the Company and the TPA mentioned in the schedule. 3. Cashless request form available with the network provider/PPN and TPA shall be completed and sent to the TPA for authorization. 4. The TPA upon getting cashless request form and related medical information from the insured person/ network provider/PPN shall issue pre-authorization letter to the hospital after verification. 5. At the time of discharge, the insured person has to verify and sign the discharge papers, pay for non-medical and inadmissible expenses.6.The TPA reserves the right to deny pre-authorization in case the insured person is unable to provide the relevant medical details. 7. In case of denial of cashless access, the insured person may obtain the treatment as per treating doctor’s advice and submit the claim documents to the TPA for processing.

4. Procedure for Reimbursement of Claims

The insured person may submit the necessary documents to TPA (if claim is processed by TPA)/Company (if claim is processed by the Company) within the prescribed time limit.

5.

Type of claim	**Time limit for submission of documents to Company/TPA**
Reimbursement of hospitalization, pre hospitalization expenses and ambulance charges	Within fifteen days from date of discharge from hospital.
Reimbursement of post hospitalization expenses	Within fifteen days from completion of post hospitalization treatment
Reimbursement of domiciliary hospitalization expenses	Within fifteen days from issuance of fitness certificate.
Reimbursement of anti-rabies vaccination and new born baby vaccination	Within fifteen days from date of vaccination.
Reimbursement of expenses for infertility treatment	Within fifteen days of completion of treatment or fifteen days of expiry of policy period, whichever is earlier, once during the policy year

6 Healthcare reimbursement describes the payment that your hospital, doctor, diagnostic facility, or other healthcare providers receive for giving the insured/policy holder a medical service. Often, the health insurance company or a government payer covers the cost of all or part of insured/policy holder's health care. Depending on the health plan, insured/policy holder may be responsible for some of the cost, and if they don't have health care coverage at all, will be responsible to reimburse your health care providers for the whole cost of your health care. Payment occurs after you receive a medical service, which is why it is called reimbursement

7 Settlement and Denial of Claims: Insurers and/or TPAs, as may be applicable, shall endeavor to collect documents for processing claims for disposal electronically. Claims that are being settled shall be done through e-payments by the insurers. Where claims are directly handled by the Insurers, the provisions of Regulation (21) (3) (c) of IRDAI (TPA-Health Services) Regulations, 2016 shall be complied in the correspondence to the policyholder with respect to settlement of the claims. The insurer shall be responsible for proper and prompt service to the policyholders at all times, where a claim is denied or repudiated, the communication about the denial or the repudiation shall be made only by the Insurer by specifically stating the reasons for the denial or repudiation, while necessarily referring to the corresponding policy conditions. The insurer shall also furnish the grievance redressal procedures available with the Insurance Company and with the Insurance Ombudsman along with the detailed addresses of the respective offices. More than one TPA may be engaged by an insurance company.

8 Some of the Issues In Health Claims

i. Unregulated Health Care Sector.
ii. Variation in Prices for Same Procedures across Different Hospitals in Different Cities.
iii. Variations in Prices In Same Hospital for Same Procedure Over Different Patients
iv. Hospitals Have Separate Pricing for Insurance/ Non-insurance Patients.

4. CASHLESS PROCESS

A Cashless facility in a health insurance policy is wherein the insurance company direct settles bill with the hospital. The patient is not required to make any payment a cashless health insurance policy limits you in terms of the hospital you choose. To avail of the cashless benefit, the patient must be admitted in a hospital that comes under the insurer's network. Seek treatment at a network hospital and the insurance company/insurer will settle the bill directly without requiring any payment from the patients end.

Cashless process help the insured get the money to pay for the hospital bills at the time of emergency which is of utmost priority. The cashless process begins with the receiving of pre-

authorization request from the hospital and is acknowledged, processed by the claims department of the insurance company. This kind of policy is great for the insured, low on cash, in case of emergency when the insured is already in an emotional disturbance. As long as the insured is under the network hospitals.

When the pre authorization request is received by the pre-auth team of the claims department, after checking for the empanelment of that particular hospital it is processed further and a claim number is generated where the documents are attached to that particular number. In case the hospital is not panelled then the pre-auth team notifies to the provider network team for the empanelment via call as no auto trigger mail is sent to the PPN which was considered as a gap. After completion of the Pre- Authorization Process the case is send to the Medical Assessor for further processing. On the health buzz the medical assessor will put up the claims number and check the documents, policy details including the start and end date. Then the medical condition of the patient, consultation and investigation, disease history, medical history and the authenticity is checked for that particular claim.If there is any discrepancy it is notified to the insured/hospital/provider. The claims process for treatment at a cashless network hospital varies according to the type of treatment – Planned or Unplanned. Unplanned medical treatment at a cashless network hospital usually happens in case of an emergency.

4.1 Claims Process for Planned Treatment at the Cashless Network:

Usually, the insured has to inform the insurance company of the hospitalization or treatment requirement ahead of time in order to avail cashless treatment. The insurance company should be informed at least 4 days before the treatment date. A cashless claim request form should be submitted at the relevant address of the insurance provider – mostly via post, e-mail, or fax. For more information you can contact the customer care of your health insurance provider. Once these steps are completed, the insurance provider will notify the insured as well as the concerned hospital regarding the policy cover and eligibility. On the day of admission in the hospital, the policyholder has to display his/her health insurance card and the confirmation letter. The medical bills will be paid by the insurance provider, directly to the hospital.

4.2 Claims Process for Emergency Treatment at the Cashless Network:

The policyholder can contact the customer care help desk of an insurance provider in order to get information about the nearest network hospital. By displaying your health insurance card, you can avail cashless hospitalization. The hospital has to fill in the cashless claim request form/Pre-Authorization form and submit it at the relevant address of the insurance provider – mostly via post, e-mail, fax or through customer care/TPA. An Authorization Letter will then be issued by the insurance provider to the hospital, indicating the policy coverage and sum insured. The medical bills will be paid by the insurance provider, directly to the hospital. In case of rejection of the claim, a letter will be sent to the insured, stating the reasons for rejection, In case of query/discrepancy again the hospital/insured is notified through a call by the insurance company.

Turnaround time of cashless process

Row Labels	0-30 Min	31-60 Min	61-120 min	above 2 hr	Grand Total
Approved	38	175	593	114	920
Denial	3	27	152	50	232
Query	46	234	886	119	1285
Grand Total	**87**	**436**	**1631**	**283**	**2437**

Figure 1.2Table showing analysis of Cashless process

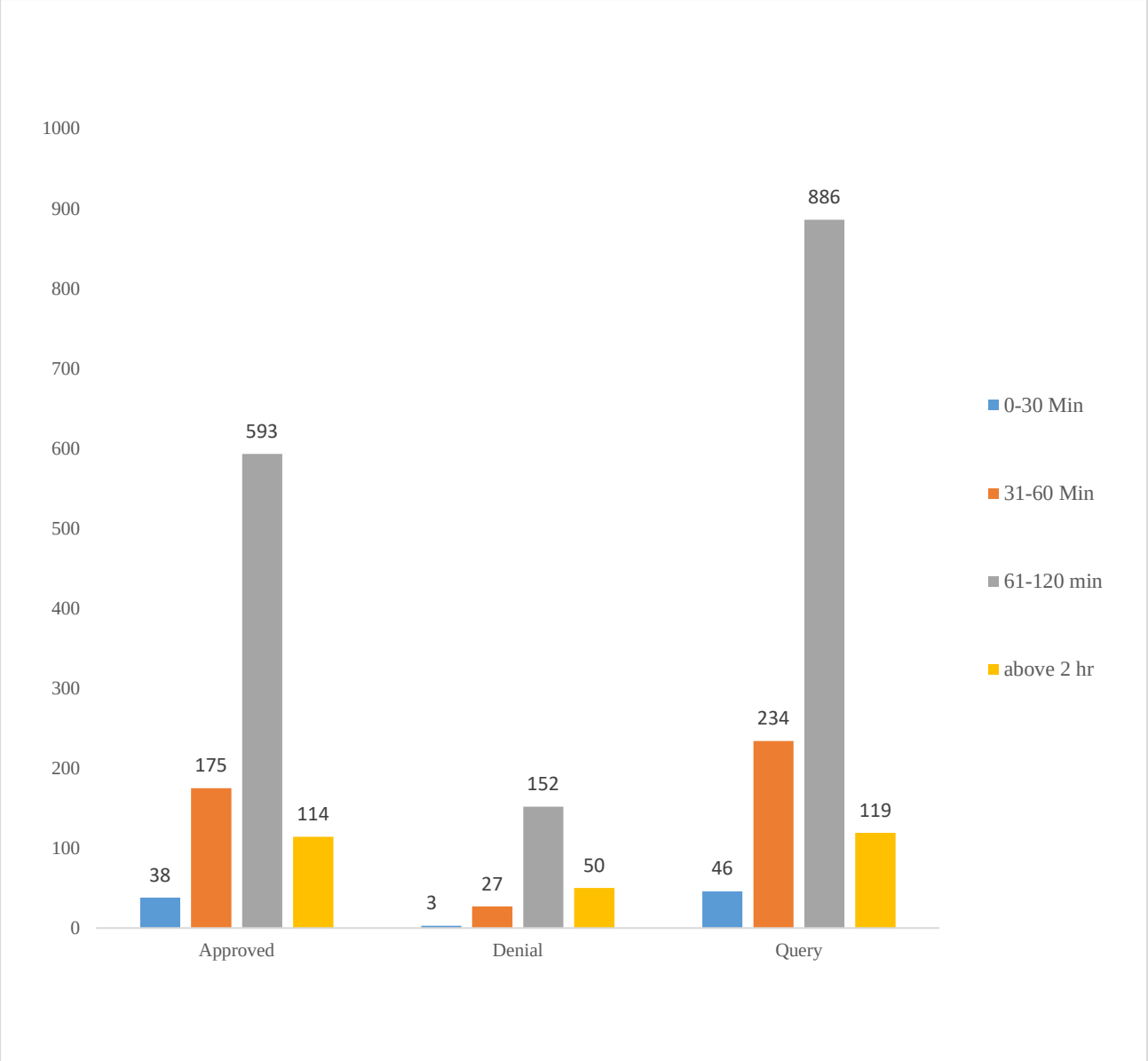


Figure 1.3 Graph showing analysis of cashless process

5. REIMBURSEMENT PROCESS

A reimbursement facility in a health insurance policy requires the patient or policyholder to pay the medical bills upfront, the insurer reimburses these costs later after a claim is filed. A reimbursement policy, allows the insured freedom of choice regarding the hospital or healthcare provider.

The reimbursement claim for health insurance can be made if the policyholder opts to go to a hospital of his/ her choice, which is a non-empanelled hospital. In this case, the cashless claim facility cannot be used. Therefore, the insured has to pay all his/ her medical bills and other costs involved in hospitalization and treatment and then claim reimbursement. In order to avail reimbursement claim you have to provide the necessary documents including original bills to the insurance provider. The company will then evaluate the claim to see its scope under the policy cover and then makes a payment to the insured. In case the treatment is not covered under the policy, the claim will be rejected. The insurance provider generally provides reasons for the rejection.

Documentation: The following documents are required in order to make a health insurance claim:

- Duly filled claim form
- Medical Certificate/ Form which is signed by the treating doctor.
- Discharge summary or card (original), availed from the hospital.
- All bills and receipts (original)
- Prescription and cash memos from pharmacies/ the hospital.
- Investigation report
- If it is an accident case, then the FIR or Medico Legal Certificate (MLC) is required.

Depending upon the condition and the way an insurer process the reimbursement, for any treatment, insured should meet all the expenses and collect each and every medical bill pertaining to the treatment.When you are discharged from the hospital, collect the Discharge Certificate or the Discharge Summary from the hospital.Submit the Discharge Certificate or

Summary along with the medical bills to the insurance company. The company would scrutinize the bills and reimburse you for the claim incurred.

Turnaround time of reimbursement process

Row Labels	0 -3 Days	4 - 7 Days	8 - 15 Days	16 - 30 Days	31 - 45 Days	Above 45 Days	Grand Total
Denial	35	33	5	93	29	1	196
Repudiated	140	204	108	29	23	1	505
Settled	503	414	149	78	19	14	1177
Grand Total	**678**	**651**	**262**	**200**	**71**	**16**	**1878**

Figure 1.4 Table showing analysis of Reimbursement process

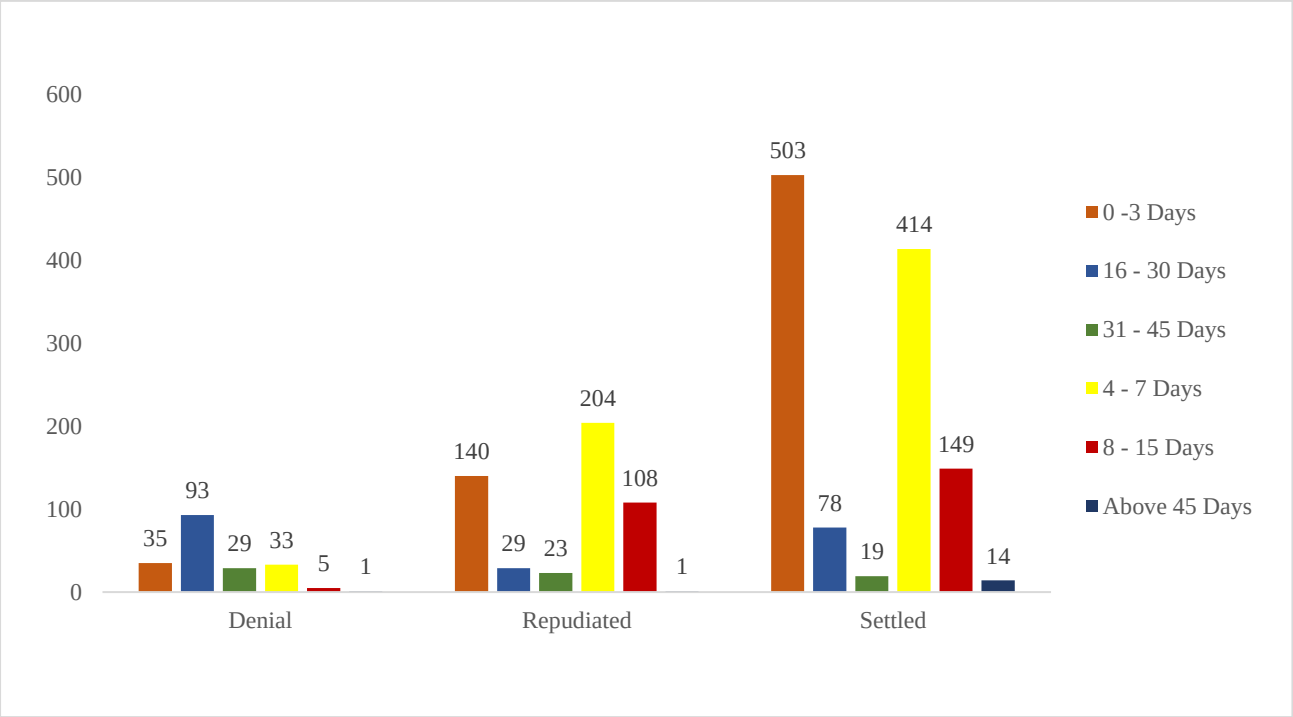


Figure 1.5 Graph showing analysis of Reimbursement process

Figure 1.6 Revised Cashless Process Flow

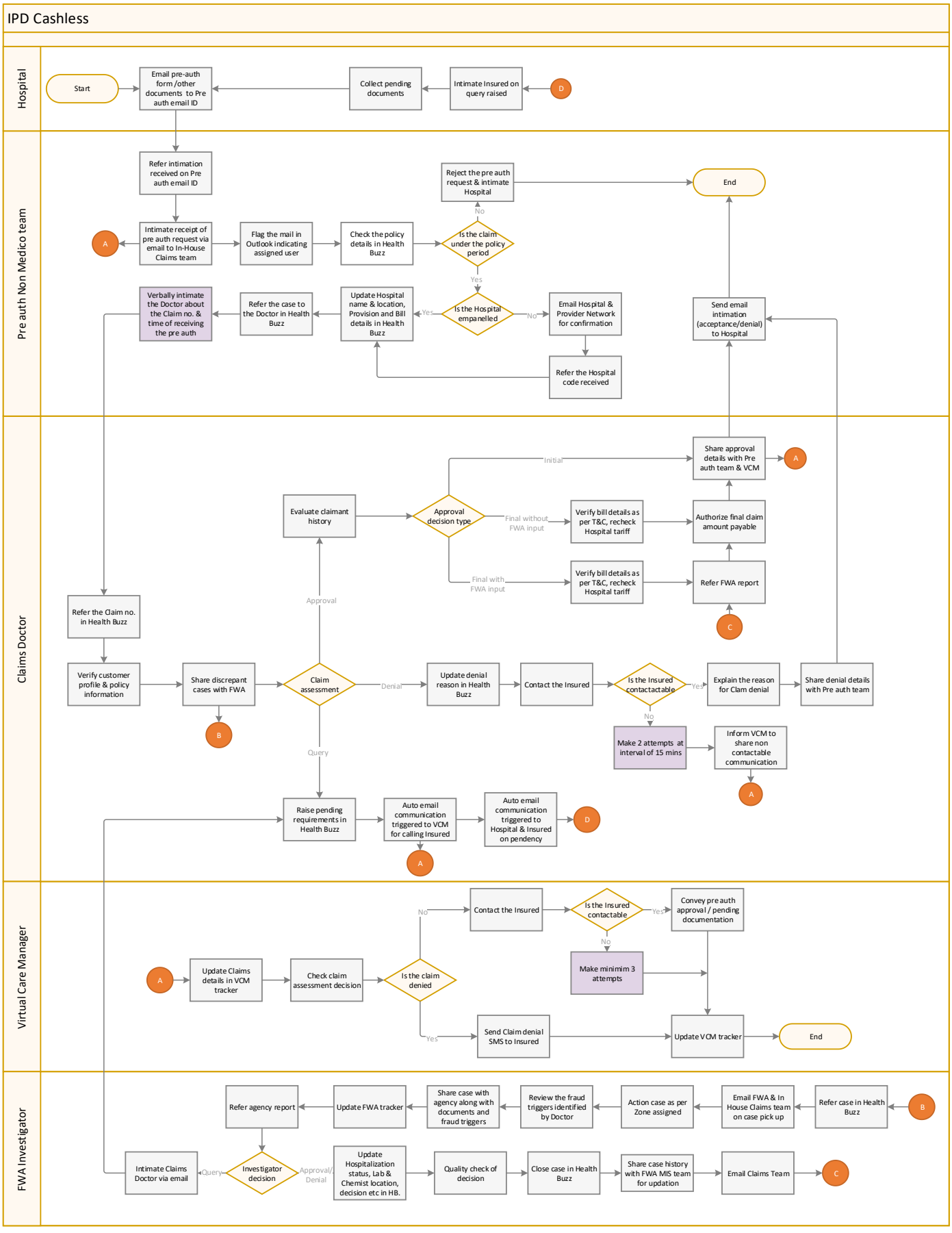


Figure 1.7Revised Network reimbursement Process Flow

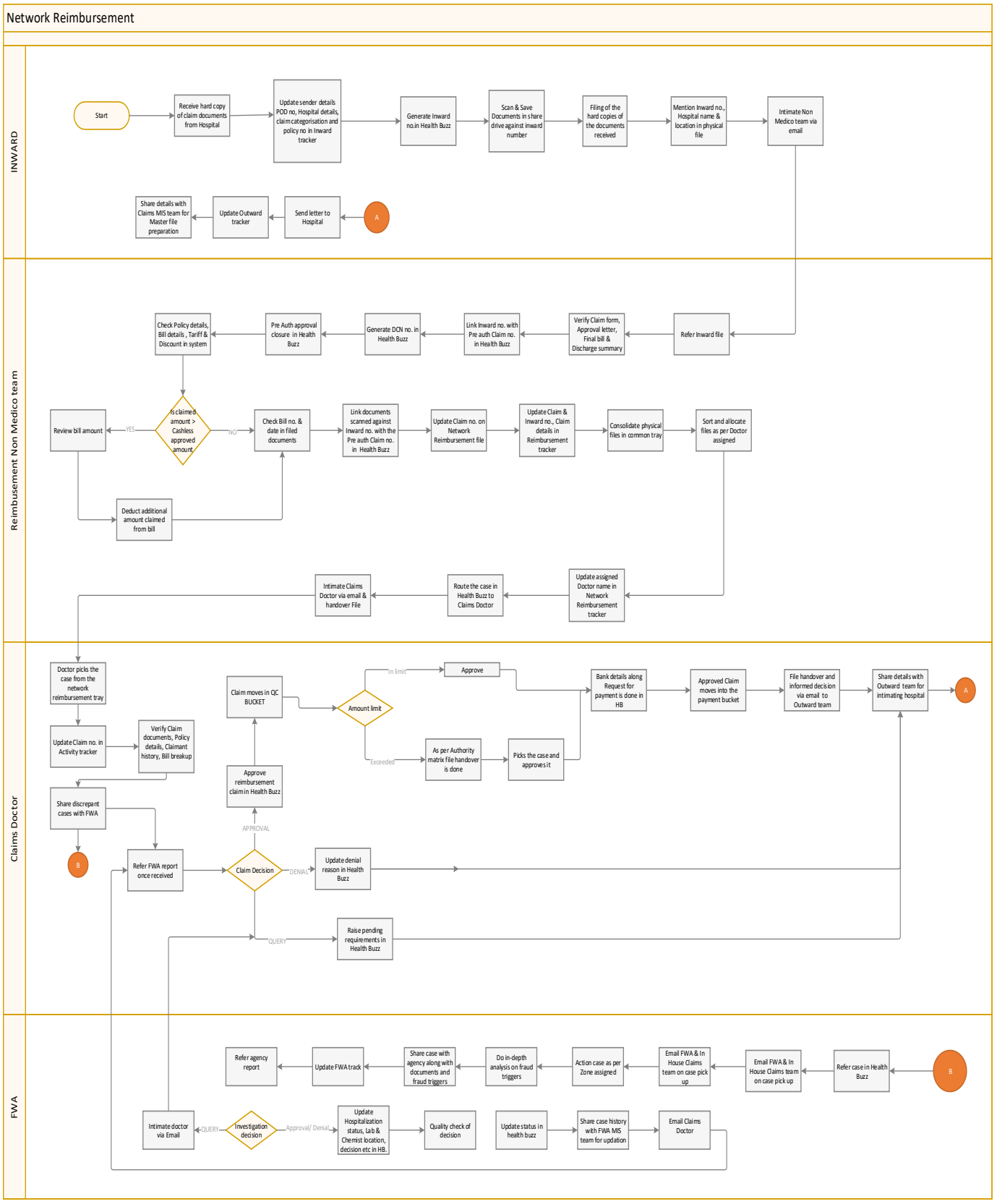


Figure 1.8 Revised Member Reimbursement Process Flow

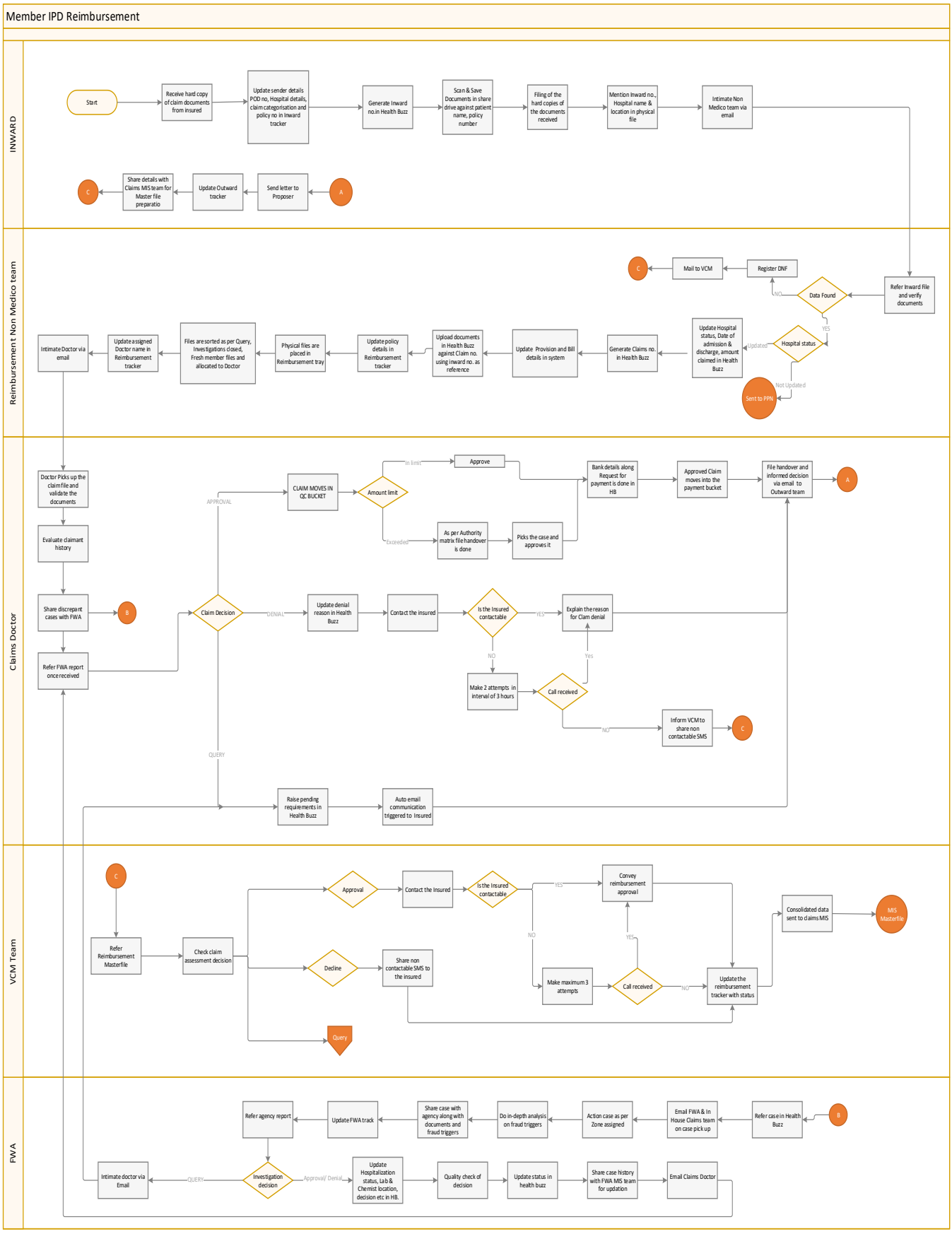
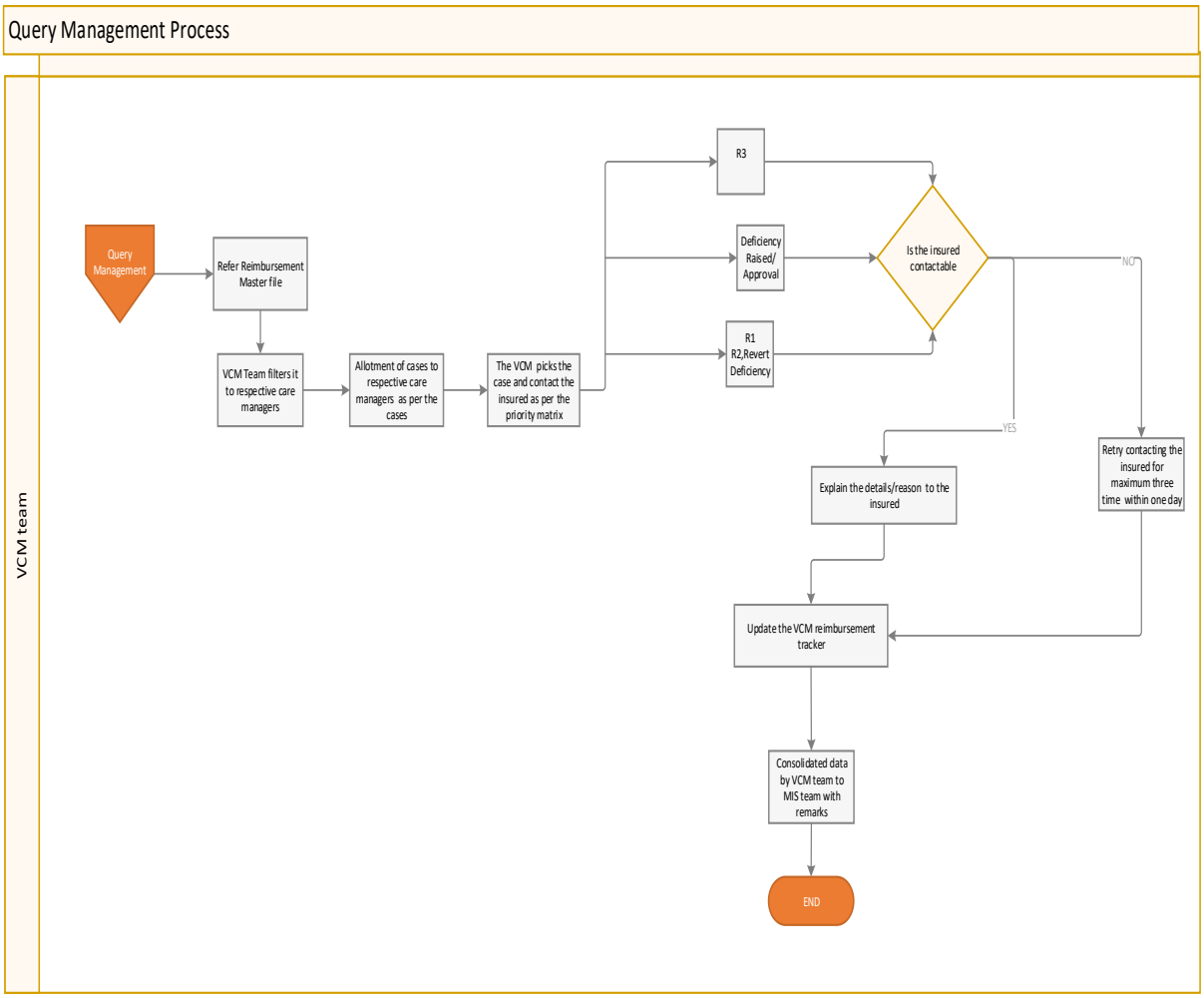
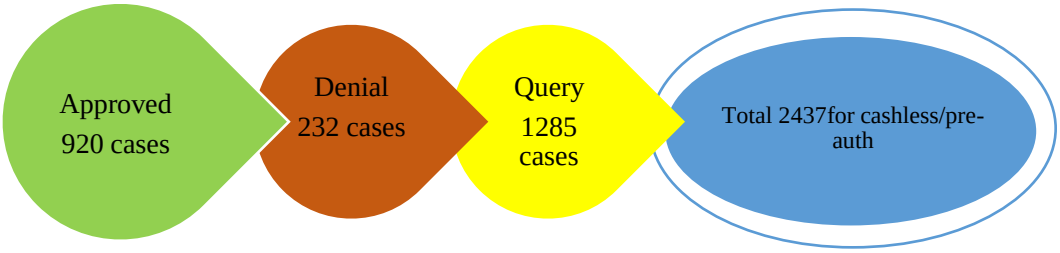


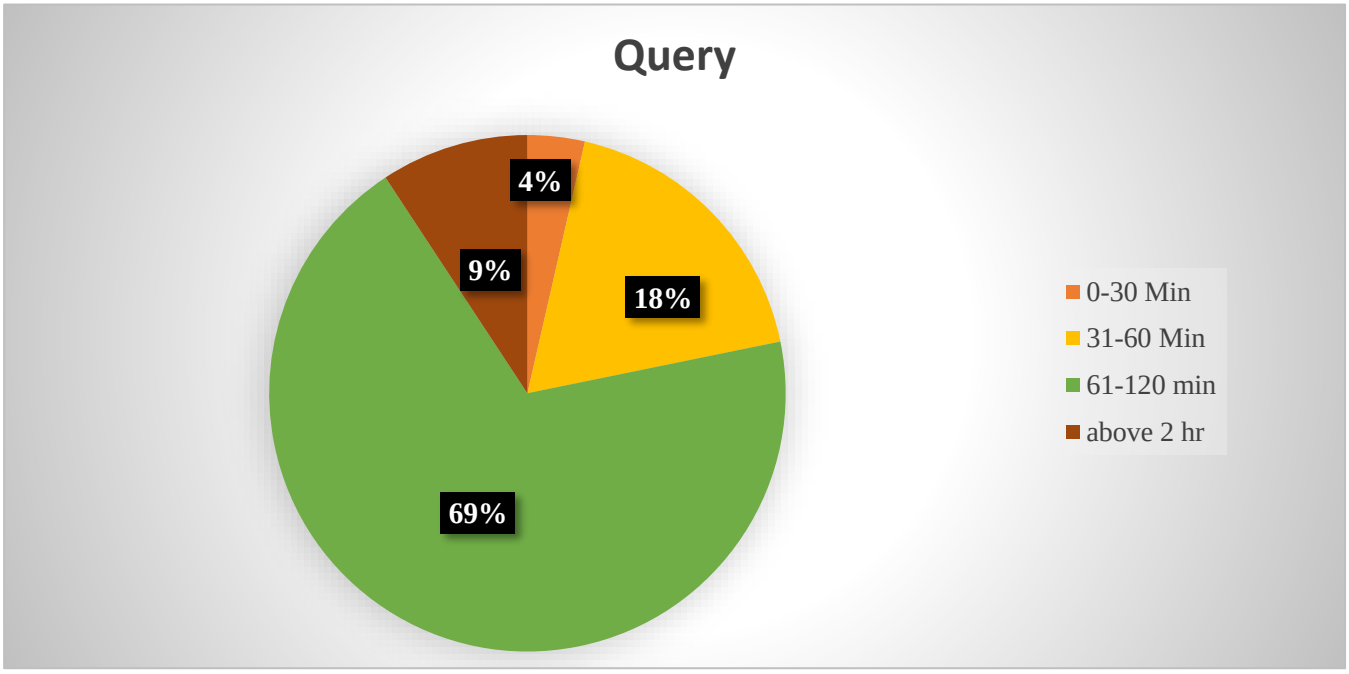
Figure 1.9 Revised Query Management Process Flow

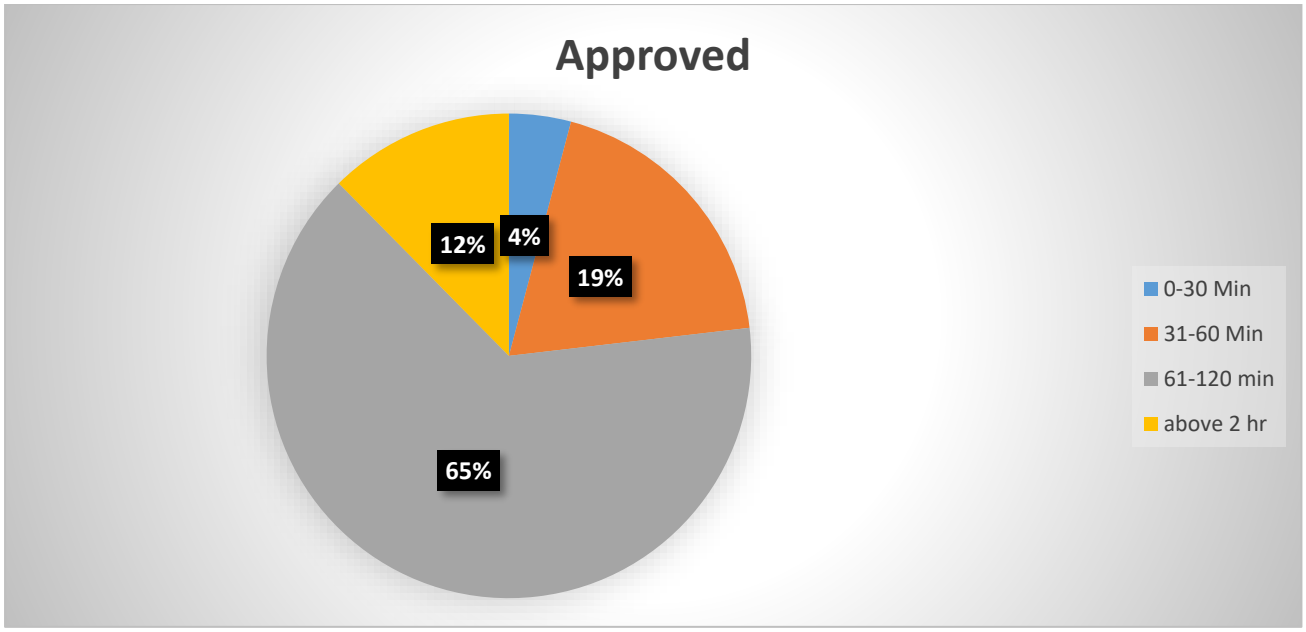


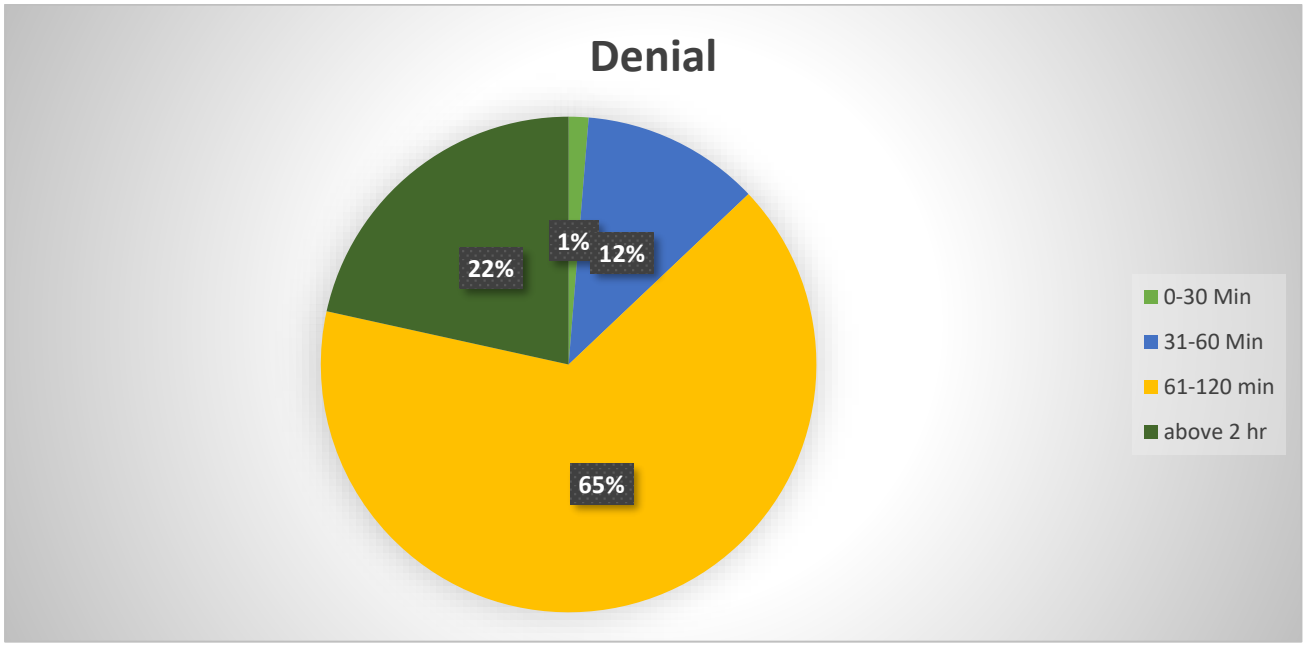
6. RESULTS

In **Pre-auth/cashless process** among the mandatory decision of approval, query, denial majority of the cases are being processed within 120 minutes after the receiving of pre-auth request 88 percent of the cases are being done in that specific TAT, thereby SOP'S have 2 hours. The ABHI has designed a specific TAT for the cashless process and every step holds the specific importance, the manpower is skilled and aware about the process thus realizing the value of time does their work efficiently.The data that was taken from 1st Feb 2019 to 15th April 2019 as secondary data from ABHI MIS system(online database) that was analyzed.





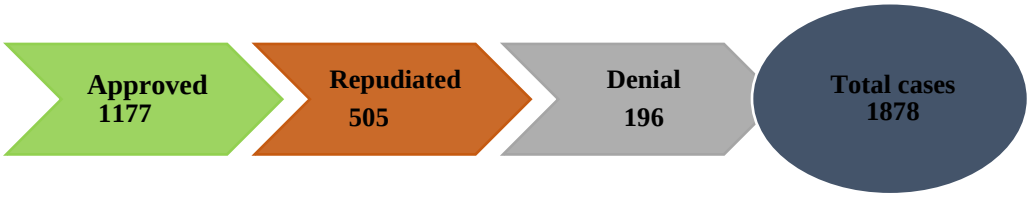




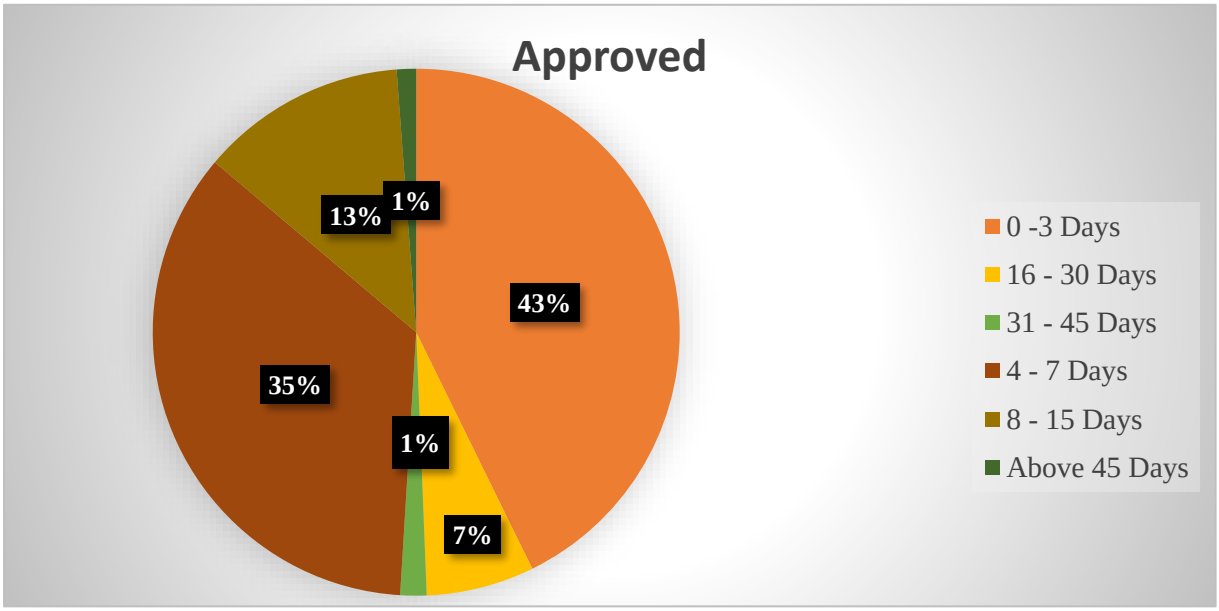
- For the approved cases in Cashless/Pre authorization 65 % of cases for the period of study period were approved with the duration of 0-30 minutes.
- 69 percent of cases were having the outcome of query within 0-30 minutes
- 65 percent of the cases were denied in the 0-30 minutes.

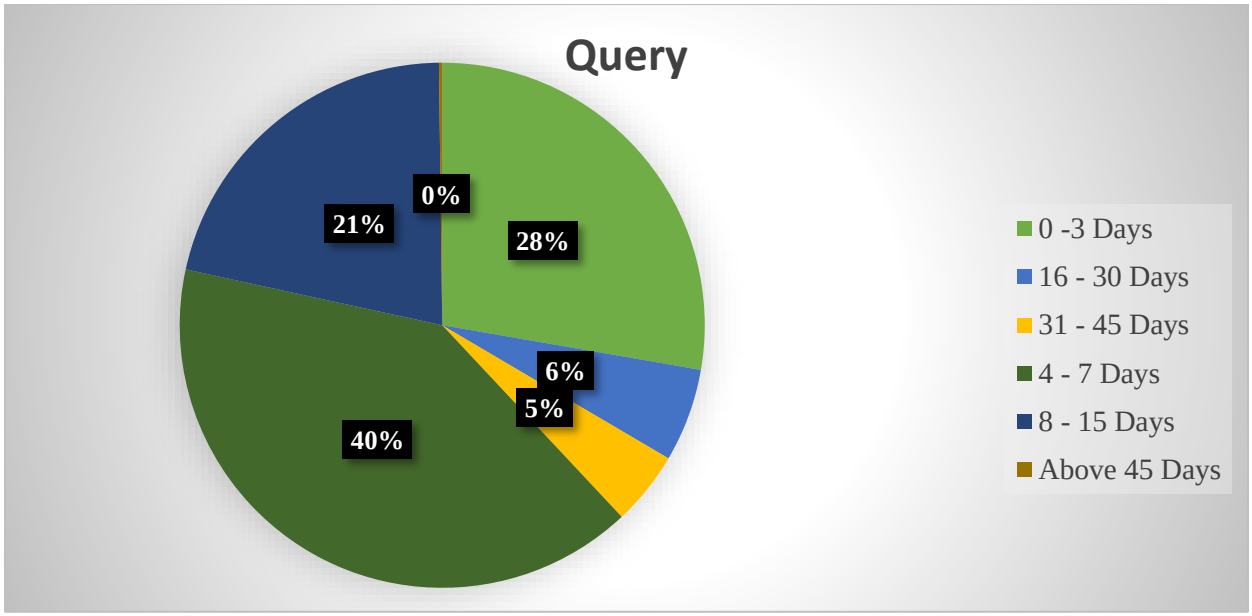
In **Reimbursement process** the decisions are similar to the cashless, as either the case can be approved, declined, or query will be raised. The Turnaround time which is being set as per

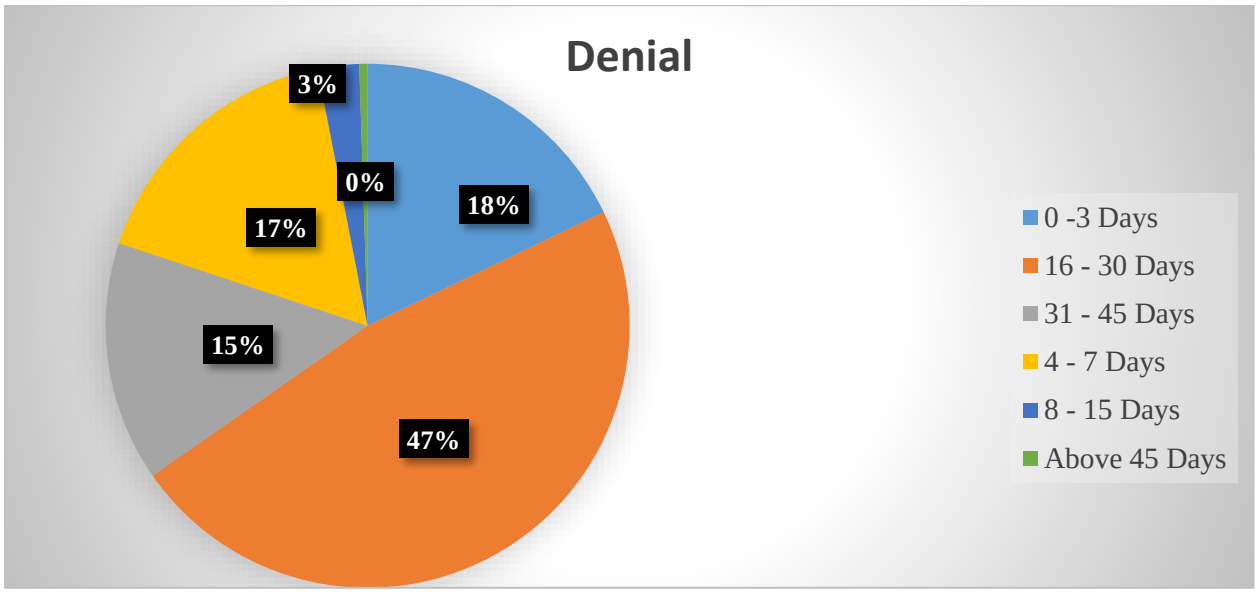
the IRDA regulations and followed by ABHI is around 15 days,As per the analysis for the period of data collection during the period 1st Feb 2019 to 15th April 2019 was analyzed, the sample size was 1878 out of 196 cases were declined,505 were repudiated and 1177 were settled/approved.



As far as the revised processes are concerned the whole focus is to be precise about the process flow to achieve the maximum efficiency, efficacy, and customer satisfaction. The objective was to observe the process and observe the loop holes/ gaps or where ever there is scope for improvement in process through reduction of minimal, manual work and reduction of TAT. Recommendations /suggestions for the same was done which was implemented in the claims department of Aditya Birla Health Insurance.







- For the Reimbursement process 43 percent claim were approved.
- In 40 percent of claims query was raised.
- 47 percent of claim were declined in the duration of 0-30 minutes.

7. MARKET INSIGHTS /COMPETITORS

Stand Alone Health Insurer	Pre-Authorization Benchmark	Source
Apollo Munich	90 % Transactions in 60 min	website
Max Bupa	100 % transactions in 30 min	Website
Religare	100 % transactions in 90 min	Verbal
Cigna Ttk	95 % transactions in 120 min	Verbal
Star Health	100 % transactions in 120 min	Verbal

received (Ref: In line with the latest Guidelines CA/Gen/CS/2011

), IRDA has prescribed time frames for policies and claims servicing, and has instructed the Insurer and intermediaries to ensure that consumers are kept informed of their rights, in terms of the prescribed time-frames for servicing

- The "Turn- Around Time" specified for various activities are Processing of proposal and communication of decisions including requirements/ issue of policy/cancellation is 15 Days
- Obtaining copy of proposal 30 Days Post Policy issue service requests concerning mistakes/refund of proposal deposit and also Non-claims related service requests 10 Days
- Life insurance Surrender Value/Annuity/ Pension processing 10 Days
- Maturity claim/Survival Benefits/Penal interest not paid 15 Days
- Raising claim requirements after lodging the claim 15 Days Death Claim settlement without investigation requirements 30 Days
- Death claim settlement/repudiation with investigation requirement 6 Months
- Acknowledge a grievance 3 Days Resolve a grievance 15 Days

8. GAPS

- In pre-authorization process, verbal communication of the time of received pre-auth request is done.
- Denial call done by VCM team, was only attempted twice in the time of 24 hours and case closure was done.
- Under the reimbursement process, the handover of the physical fileby the non-medico team wasn't sorted and allocated to claim doctor, no communication was auto-triggered by the system.
- In re-imbursement process generation of DCN number after generation of inward number claim number for the particular case which increases the TAT of reimbursement process.

9. SUGESSTION

- The time should be visible along with the other information in the system.
- Suggestion of three denial calls at the interval of 15 minutes in pre-authorization cases
- Suggestion of minimum three denial calls for VCM team before the case closure.
- Sorting and allocation of the file should be done before handover.
- DCN number with Inward/Claim number should be auto linked.
- Updating of the software Health Buzz was recommended with the additional features like flagging when case is picked by a processor, Dashboard having different buckets, Pop up/Notification on receiving of a claim.

10.CONCLUSION

Settling insurance claims is just one aspect of the claims management process. The time it takes to process a claim involves several stages beginning with a person filing a claim. The stages that follow determine if a claim has merit as well as how much the insurance company will pay. Insurance customers expect a company to settle claims quickly and to their satisfaction. Because high customer satisfaction levels can give a company a competitive edge, reducing the time it takes to settle insurance claims is one way to decrease the number of customer complaints and improve service. The use of claims management system software that speeds the process and minimizes costs offers a practical solution. Simplifying the claims process through automation helps reduce expenses for insurance companies

SUPPLEMENTARY

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