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

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Introduction

Health Insurance is defined as coverage that provides for the payments of benefits as a result of sickness or injury. It includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment. In Year 2000, Government of India liberalized insurance and allowed private players into the insurance sector. The advent of private insurers in India saw the introduction of many innovative products like family floater plans, top-up plans, critical illness plans, hospital cash and top up policies.

The study was conducted at Aditya Birla Health Insurance Pvt. Ltd. Mumbai and aims at analysing the gaps in the process of cashless and reimbursement under the claims department. The process flow which was formed two years back in the company were not found to be operational because of the advancement in the technology it was observed that 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 work flow thus revising the standard operating procedures for the cashless ,reimbursement, and query management process.

Types Of facilities in health insurance policy

1) **Cashless Facility/Direct payment** - Under this facility, the person does not need to pay the hospital as the insurer pays directly to the hospital, the policyholder and all those who are mentioned in the policy can undertake treatment from those hospitals approved by the insurer.

2) Reimbursement Facility: After staying for the duration of the treatment, the patient can take a reimbursement from the insurer for the treatment that is covered under the policy undertaken.

Aim

The aim of the study is to identify the gaps and evaluate the turn around time of cashless and reimbursement claim process and forming of revised SOP’s.

Objectives

- To identify the cashless and reimbursement-network and member process flow.
- To evaluate the turnaround time of pre-auth and reimbursement process
- To analyse 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

Methodology

- **Study design –** The observational Descriptive Study.

- **Sample size –**In this study, for the cashless/pre-auth process out of 2437 cases were processed , out of which 920 were approved ,232were denied ,1285 query was raised. For the reimbursement process 1878 cases were processed in which 196 were denied ,505 query ,1177 cases were approved.

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

- **Sampling technique –**Non probability convenient sampling.

Cashless Process

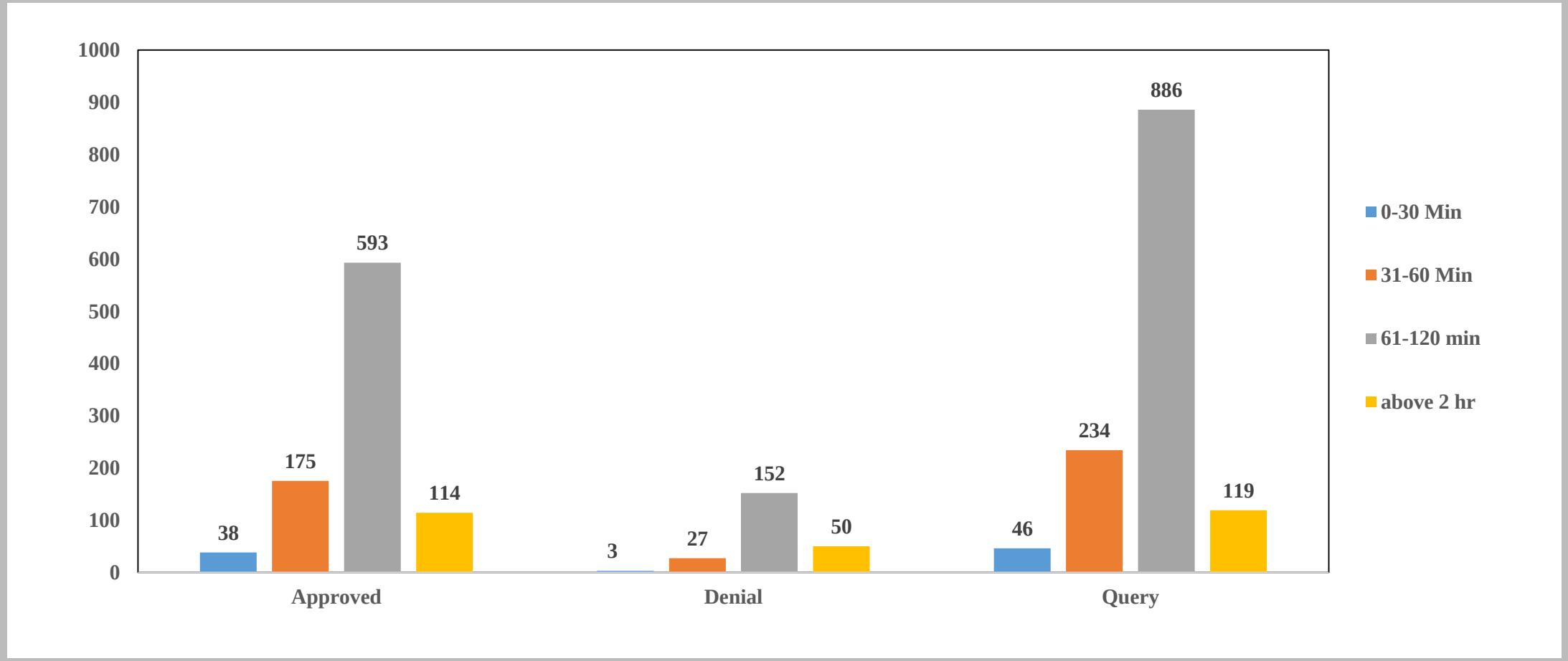
Cashless is a facility under the health insurance where the policy holder does not have to pay cash for treatment and the settlement of the bills is taken care of directly between the hospital and the insurance company. The cashless health insurance provider has to be notified two days in advance in case of planned hospitalization and within 24 hours in case of emergency hospitalization.

The settlement of bills is taken care of under the TPA/In house and the mediclaim card has to be submitted at the hospital. One thing to keep in mind in case of cashless health insurance is that the treatment has to take place in a one of the network hospitals of the mediclaim service provider, or else the amount is disbursed later when all the bills are submitted to the insurance provider

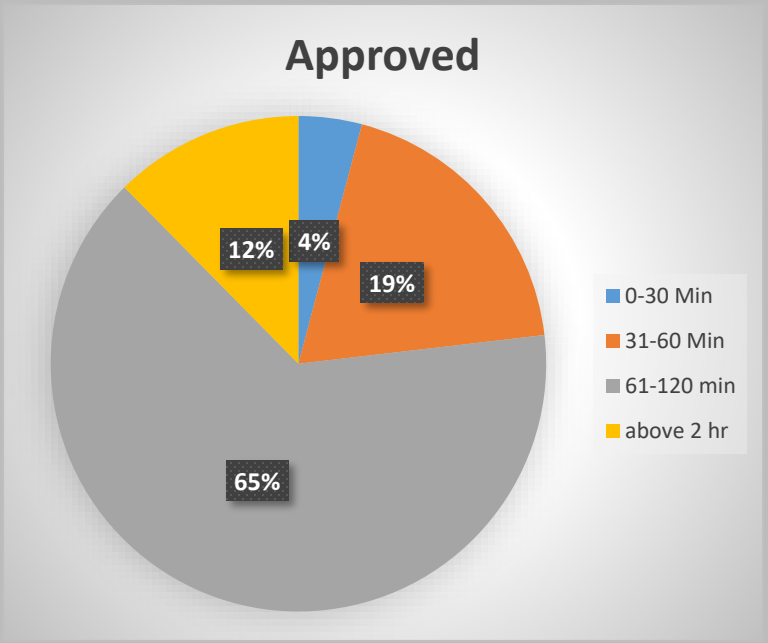
No. of cases for cashless process

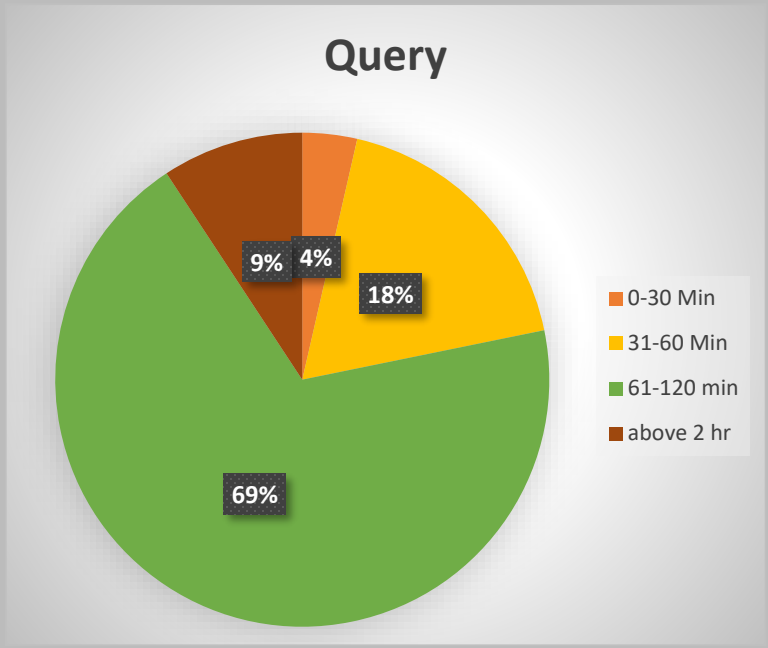
Row Labels	0-30 Min	31-60 Min	61-120 min	above 2 hr	Grand Total
Approved	38	175	593	114	920
Denial	3	27	152	50	232
Query	46	234	886	119	1285
Grand Total	**87**	**436**	**1631**	**283**	**2437**

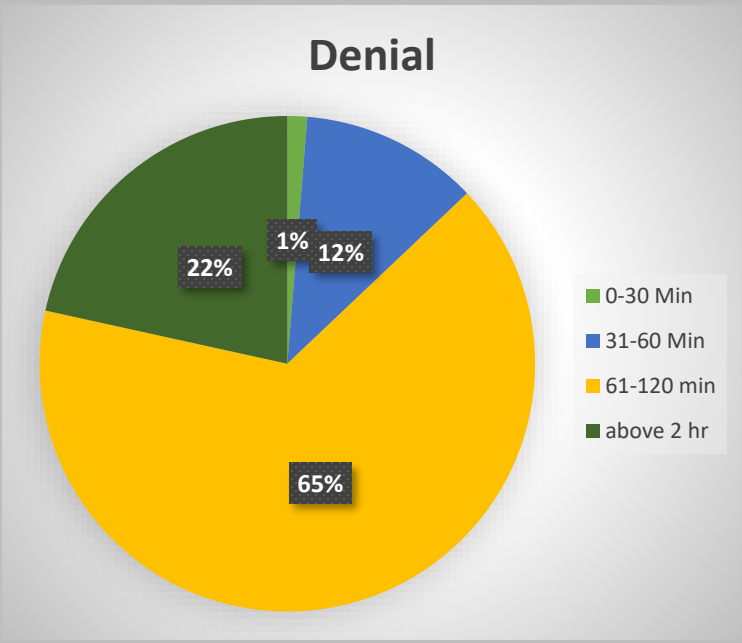
Turnaround time of cashless process



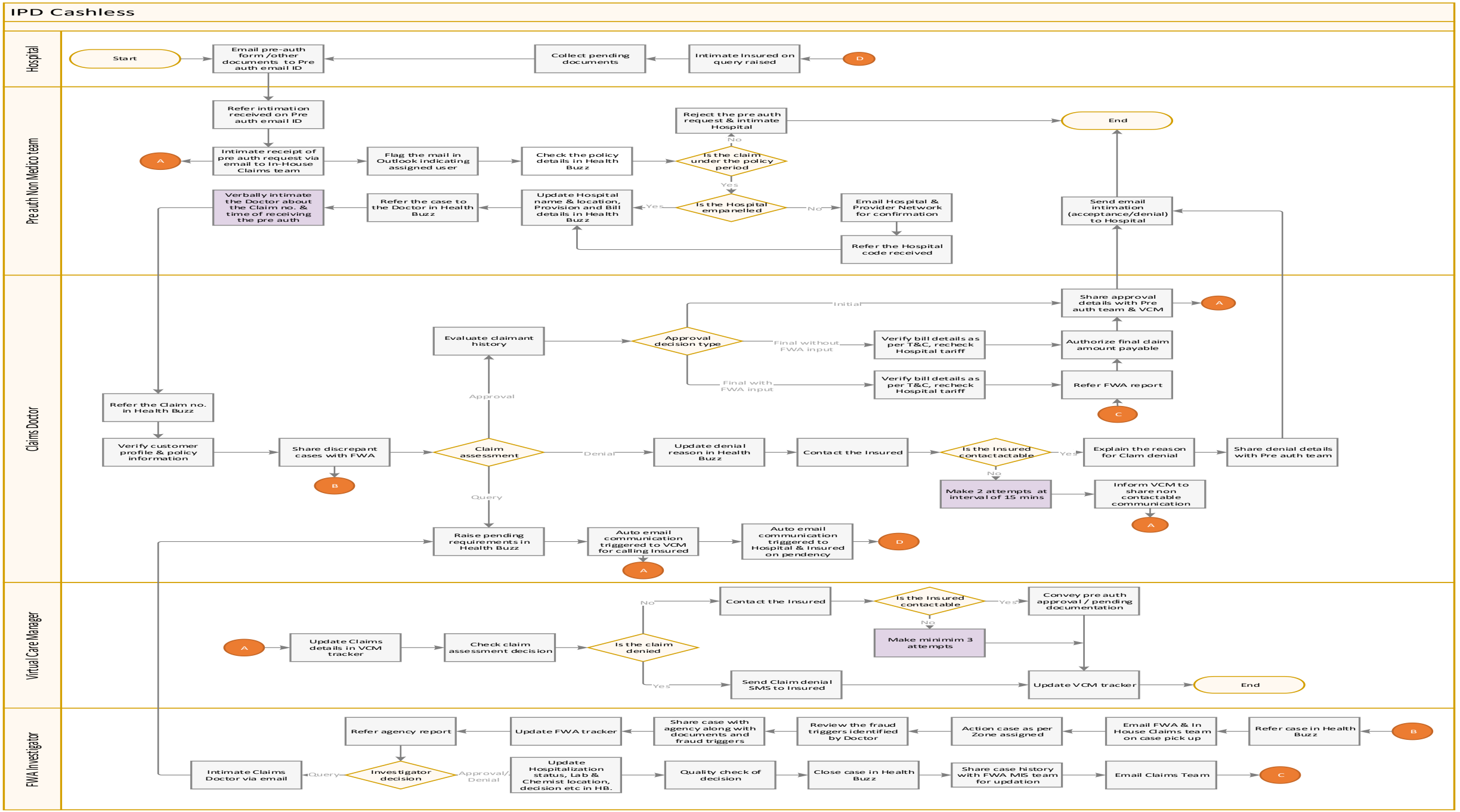
Percentage showing Cashless claim outcome in TAT







- 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.


IPD Cashless
Hospital
Pre auth Non Medico team
Claims Doctor
Virtual Care Manager
FWA Investigator
Start
Email pre-auth form /other documents to Pre auth email ID
Collect pending documents
Intimate Insured on query raised
D
Refer intimation received on Pre auth email ID
A
Intimate receipt of pre auth request via email to In-House Claims team
Flag the mail in Outlook indicating assigned user
Check the policy details in Health Buzz
Is the claim under the policy period
No
Reject the pre auth request & intimate Hospital
End
Yes
Is the Hospital empanelled
No
Email Hospital & Provider Network for confirmation
Refer the Hospital code received
Yes
Update Hospital name & location, Provision and Bill details in Health Buzz
Refer the case to the Doctor in Health Buzz
Verbally intimate the Doctor about the Claim no. & time of receiving the pre auth
Send email intimation (acceptance/denial) to Hospital
Refer the Claim no. in Health Buzz
Verify customer profile & policy information
Share discrepant cases with FWA
B
Claim assessment
Approval
Evaluate claimant history
Approval decision type
Initial
Share approval details with Pre auth team & VCM
A
Final without FWA input
Verify bill details as per T&C, recheck Hospital tariff
Authorize final claim amount payable
Final with FWA input
Verify bill details as per T&C, recheck Hospital tariff
Refer FWA report
C
Denial
Update denial reason in Health Buzz
Contact the Insured
Is the Insured contactable
Yes
Explain the reason for Clam denial
Share denial details with Pre auth team
No
Make 2 attempts at interval of 15 mins
Inform VCM to share non contactable communication
A
Query
Raise pending requirements in Health Buzz
Auto email communication triggered to VCM for calling Insured
A
Auto email communication triggered to Hospital & Insured on pendency
D
A
Update Claims details in VCM tracker
Check claim assessment decision
Is the claim denied
No
Contact the Insured
Is the Insured contactable
Yes
Convey pre auth approval / pending documentation
No
Make minimim 3 attempts
Yes
Send Claim denial SMS to Insured
Update VCM tracker
End
Refer agency report
Update FWA tracker
Share case with agency along with documents and fraud triggers
Review the fraud triggers identified by Doctor
Action case as per Zone assigned
Email FWA & In House Claims team on case pick up
Refer case in Health Buzz
B
Intimate Claims Doctor via email
Query
Investigator decision
Approval/ Denial
Update Hospitalization status, Lab & Chemist location, decision etc in HB.
Quality check of decision
Close case in Health Buzz
Share case history with FWA MIS team for updation
Email Claims Team
C

Reimbursement Process

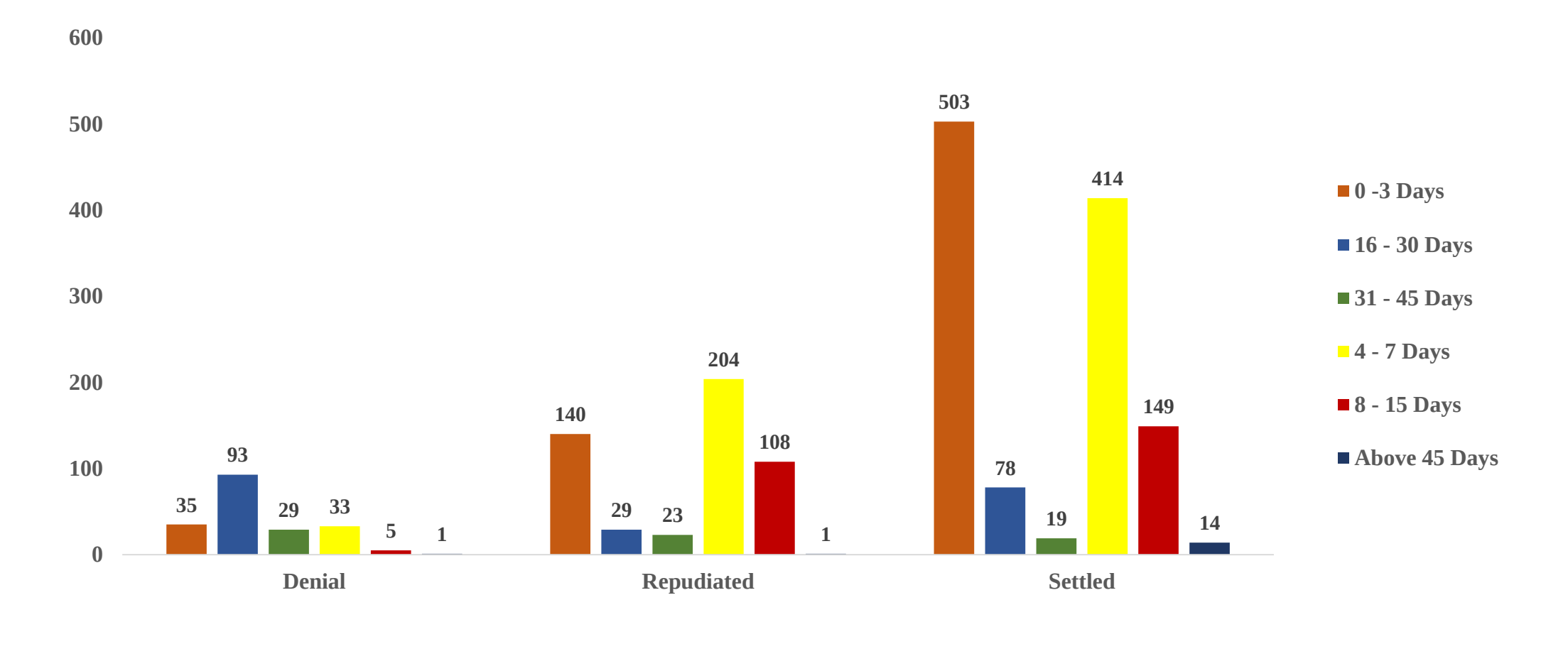
The reimbursement claim for health insurance can be made if the policyholder opts to go to a hospital of his/ her choice, which is a non-empanelled hospital. In this case, the cashless claim facility cannot be used. Therefore, the insured has to pay all his/ her medical bills and other costs involved 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.

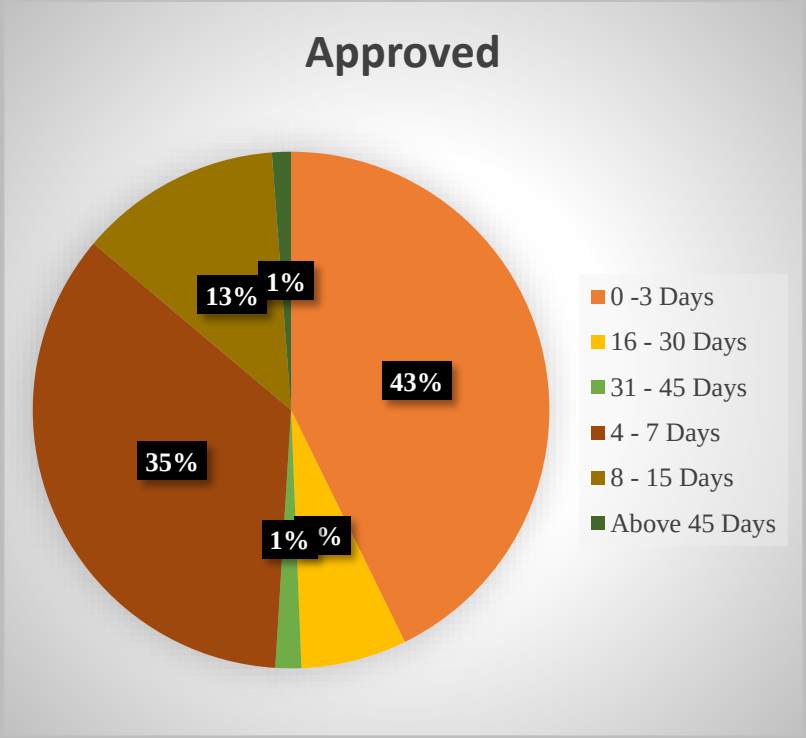
No. of cases for reimbursement process

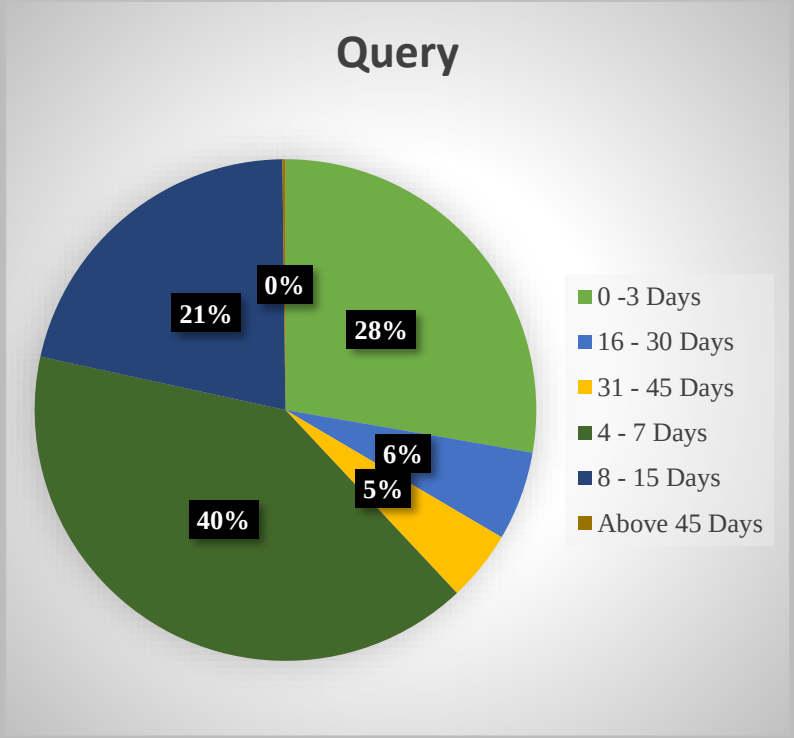
Row Labels	0 -3 Days	16 - 30 Days	31 - 45 Days	4 - 7 Days	8 - 15 Days	Above 45 Days	Grand Total
Denial	35	93	29	33	5	1	196
Repudiated	140	29	23	204	108	1	505
Settled	503	78	19	414	149	14	1177
Grand Total	**678**	**200**	**71**	**651**	**262**	**16**	**1878**

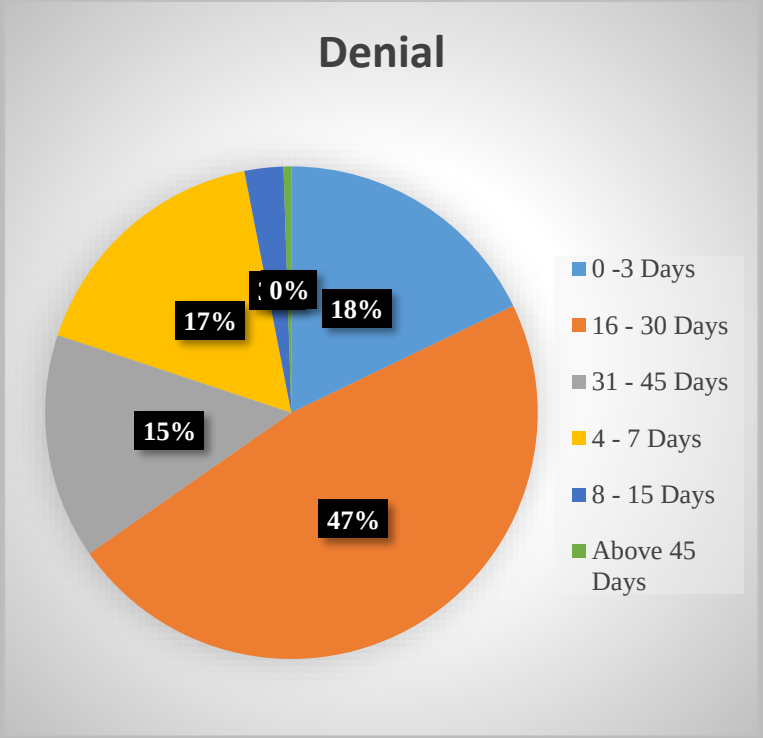
Turnaround time of reimbursement process



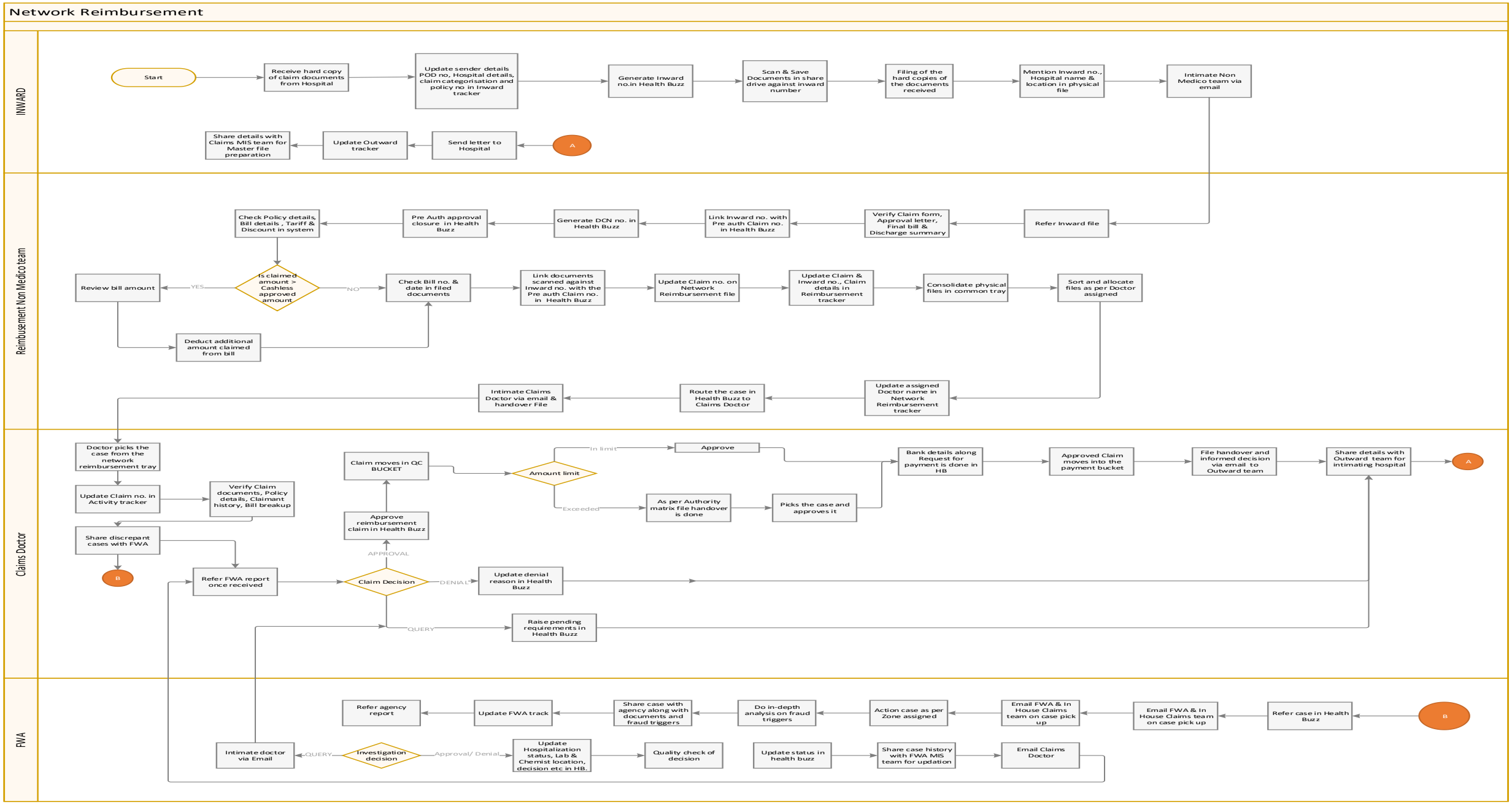
Percentage showing Reimbursement claim outcome in TAT



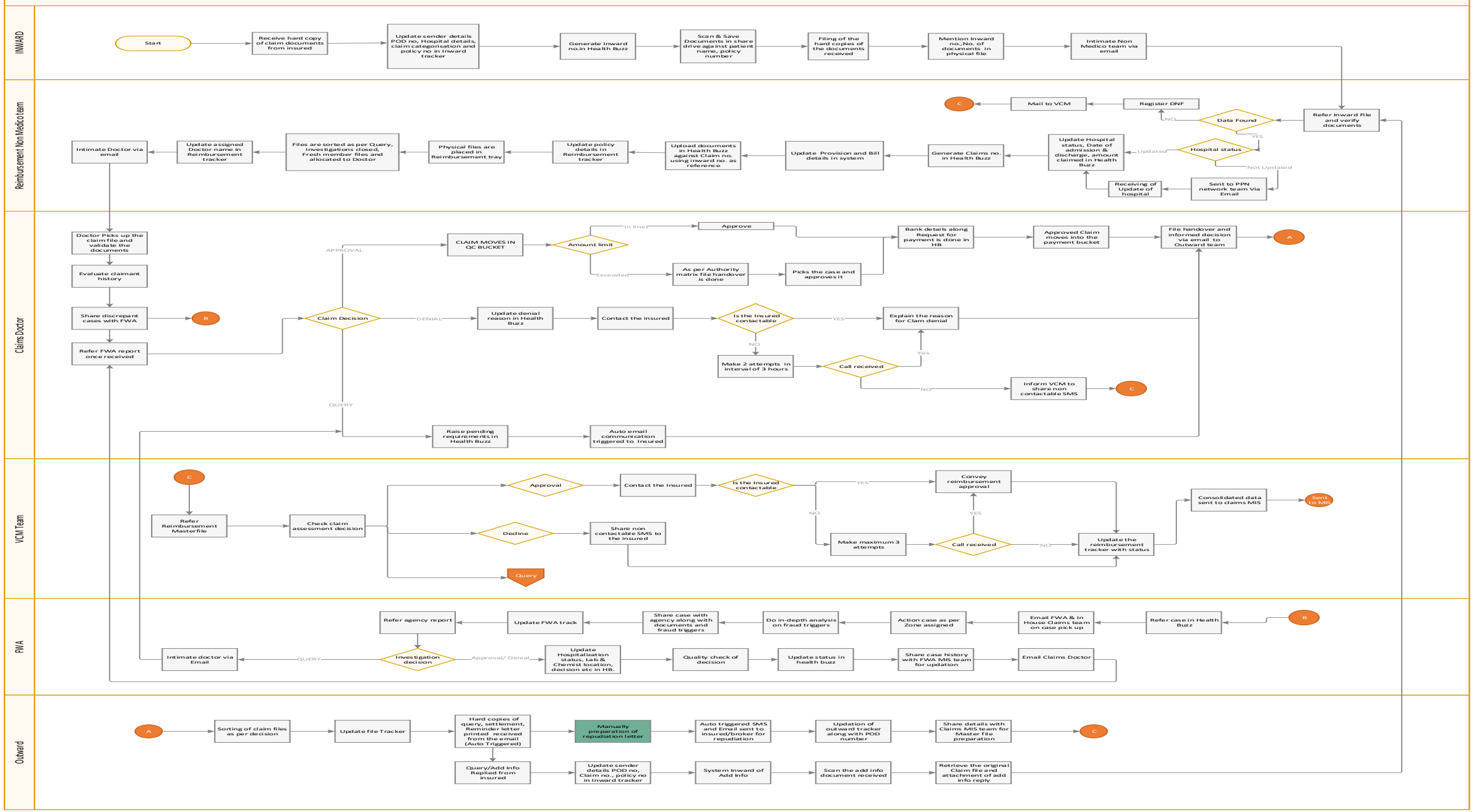




- For the Reimbursement process 43 percent claim were approved.
- In 40 percent of claims query was raised .
- 47 percent of claim were declined in the duration of 0-30 minutes

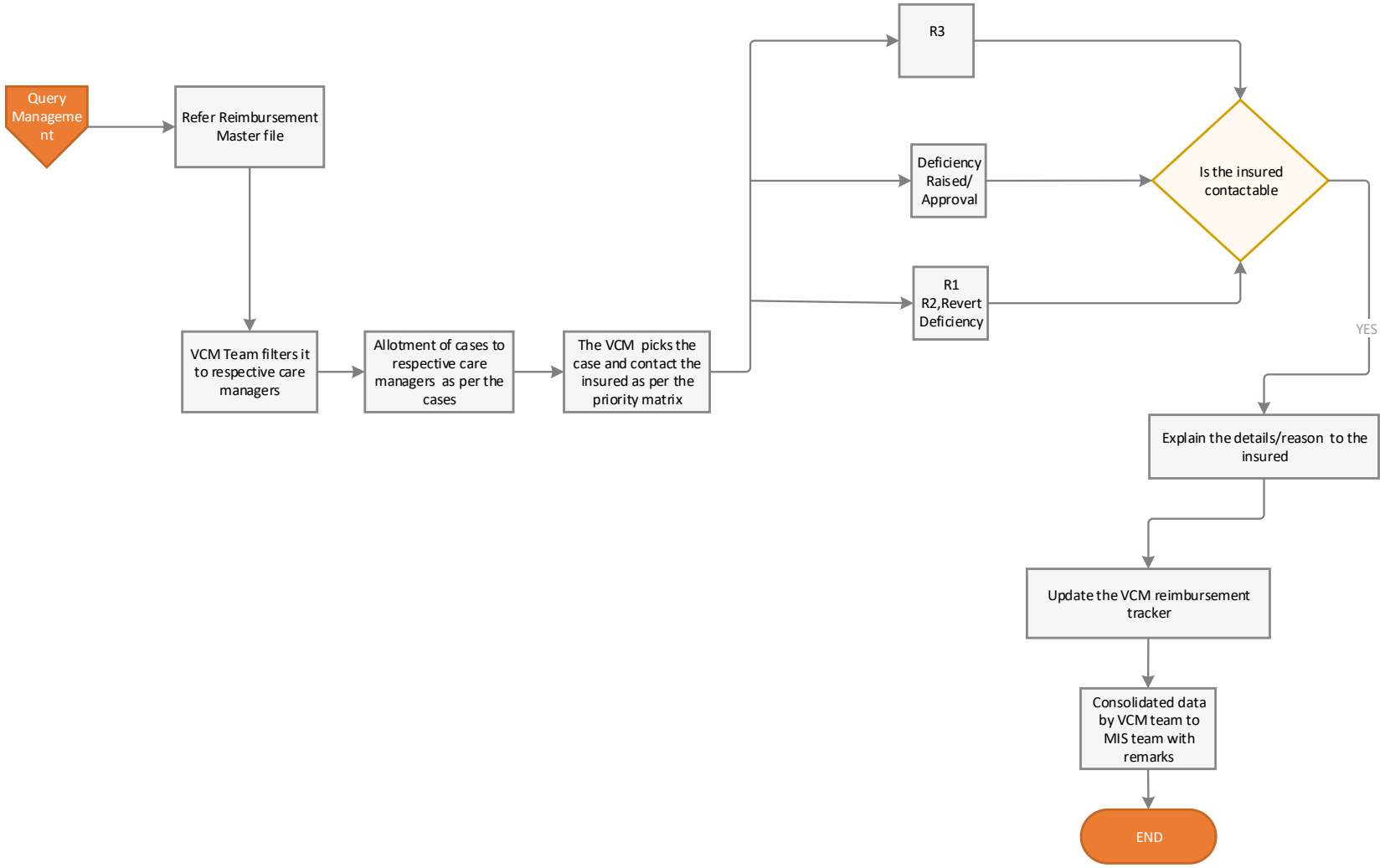

Network Reimbursement
INWARD
Start
Receive hard copy of claim documents from Hospital
Update sender details POD no, Hospital details, claim categorisation and policy no in Inward tracker
Generate Inward no.in Health Buzz
Scan & Save Documents in share drive against inward number
Filing of the hard copies of the documents received
Mention Inward no., Hospital name & location in physical file
Intimate Non Medico team via email
Share details with Claims MIS team for Master file preparation
Update Outward tracker
Send letter to Hospital
A
Reimbusement Non Medico team
Refer Inward file
Verify Claim form, Approval letter, Final bill & Discharge summary
Link Inward no. with Pre auth Claim no. in Health Buzz
Generate DCN no. in Health Buzz
Pre Auth approval closure in Health Buzz
Check Policy details, Bill details , Tariff & Discount in system
Is claimed amount > Cashless approved amount
YES
NO
Review bill amount
Deduct additional amount claimed from bill
Check Bill no. & date in filed documents
Link documents scanned against Inward no. with the Pre auth Claim no. in Health Buzz
Update Claim no. on Network Reimbursement file
Update Claim & Inward no., Claim details in Reimbursement tracker
Consolidate physical files in common tray
Sort and allocate files as per Doctor assigned
Update assigned Doctor name in Network Reimbursement tracker
Route the case in Health Buzz to Claims Doctor
Intimate Claims Doctor via email & handover File
Claims Doctor
Doctor picks the case from the network reimbursement tray
Update Claim no. in Activity tracker
Verify Claim documents, Policy details, Claimant history, Bill breakup
Share discrepant cases with FWA
B
Refer FWA report once received
Claim Decision
APPROVAL
DENIAL
QUERY
Approve reimbursement claim in Health Buzz
Claim moves in QC BUCKET
Amount limit
In limit
Exceeded
Approve
As per Authority matrix file handover is done
Picks the case and approves it
Update denial reason in Health Buzz
Raise pending requirements in Health Buzz
Bank details along Request for payment is done in HB
Approved Claim moves into the payment bucket
File handover and informed decision via email to Outward team
Share details with Outward team for intimating hospital
A
FWA
Refer case in Health Buzz
B
Email FWA & In House Claims team on case pick up
Email FWA & In House Claims team on case pick up
Action case as per Zone assigned
Do in-depth analysis on fraud triggers
Share case with agency along with documents and fraud triggers
Update FWA track
Refer agency report
Email Claims Doctor
Share case history with FWA MIS team for updation
Update status in health buzz
Quality check of decision
Update Hospitalization status, Lab & Chemist location, decision etc in HB.
Approval/ Denial
Investigation decision
QUERY
Intimate doctor via Email

Member IPD Reimbursement



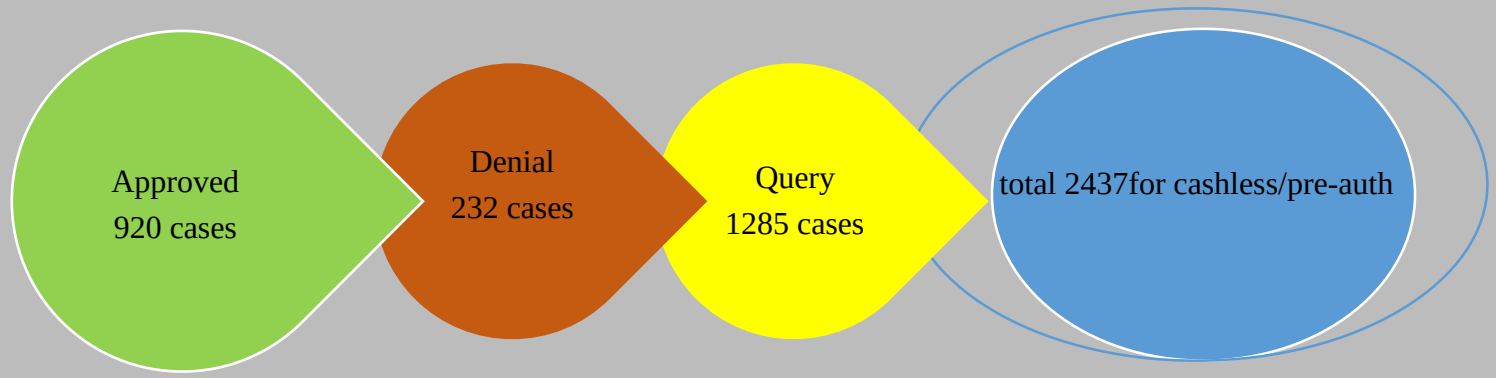
Query Management Process

VCM team



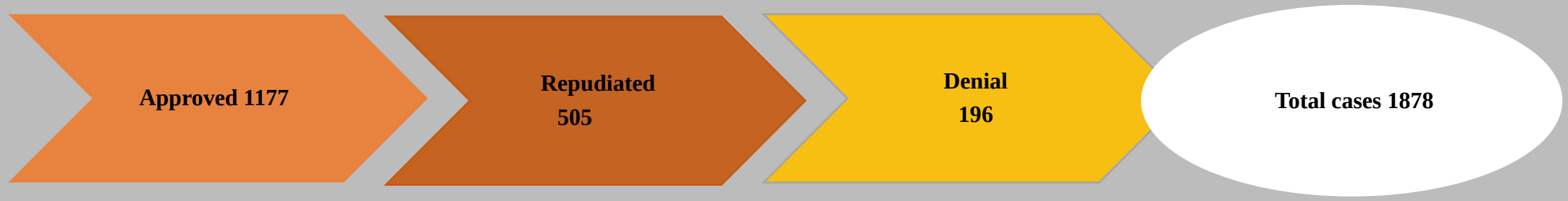
Result

Majority of the cashless 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 FOR 100 percent cases SOP’S have 2 hours.



Result

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 analysed, the sample size was 1878 out of 196 cases were declined, 505 were repudiated and 1177 were approved



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 file by 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.

Suggestions

- 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.

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 thus the project ensured and focus on the minimal time taken for the decision related to claims.

The project helped the claims department to optimize the use of claims management system software that speeds the process and minimizes costs , errors and offered a practical solution along with simplification of the claims process.

THANKYOU