Internship at Reliance General Insurance Ltd., Hyderabad

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About Reliance General Insurance

Reliance General Insurance is an Indian private insurance company. It is a part of Reliance Group. Reliance General Insurance was incorporated on 17 August 2000. It received the license to conduct general insurance business in India from the Insurance Regulatory Development Authority of India (IRDAI) on 23 October 2000. Unlike most insurance companies, who have foreign partners, the firm is promoted solely by Reliance Capital.

Reliance General Insurance offers insurance services across the domains of motor, health, travel and home. The commercial insurance services include commercial vehicle, office and marine.

Motor insurance covers four wheeler, two-wheeler and commercial vehicle. Services such as roadside assistance and cashless facilities through a network of around 2400 garages are provided.

Under Health, there are several plans to choose from. They include Healthgain (can be availed in installments), Wellness, Critical Illness and Personal Accident.

In travel, Reliance General Insurance provides plans for overseas trips such as Schengen, Asia and the US. Travel plans tailored for students and senior citizens are also available. The home insurance portfolio covers house contents against theft and damage. The cover also provides home assistance services.

CHAPTER-1

1.1 INTRODUCTION

A healthinsurance policy is:

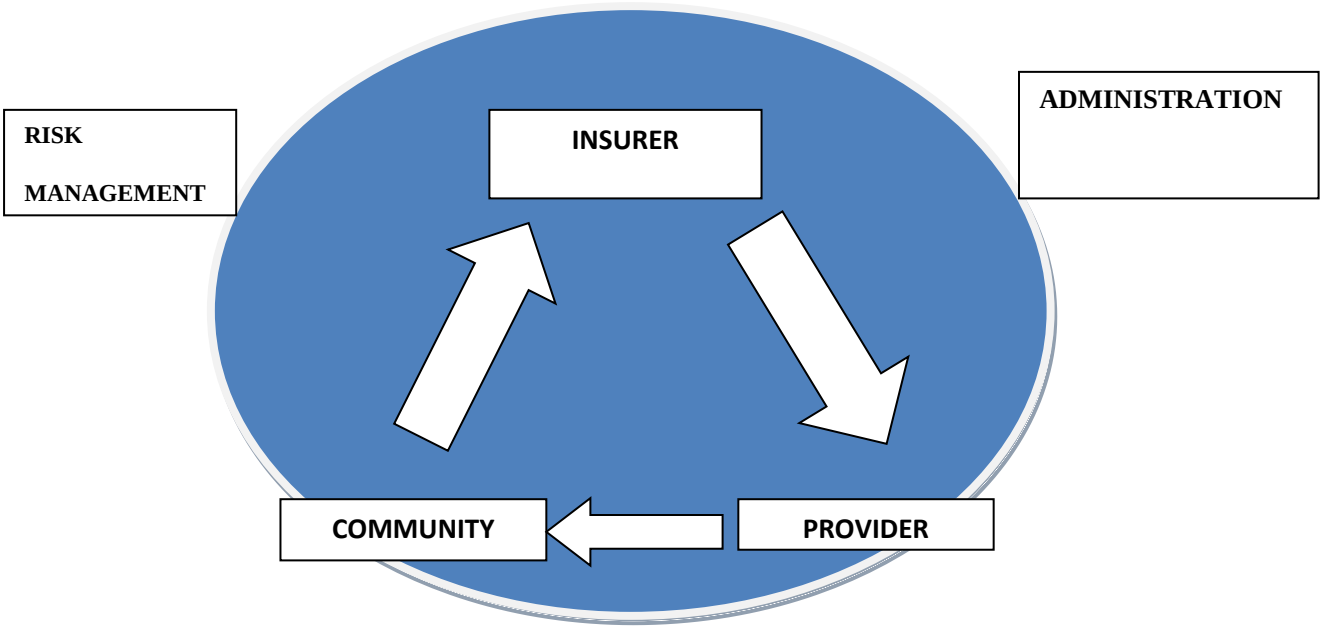
A contract between an insurance provider (e.g. an insurance company or a government) and an individual or his/her sponsor (e.g. an employer or a community organization). The contract can be renewable (e.g. annually, monthly) or lifelong in the case of private insurance, or be mandatory for all citizens in the case of national plans. The type and amount of health care costs that will be covered by the health insurance provider are specified in writing, in a member contract or "Evidence of Coverage" booklet for private insurance, or in a national health policy for public insurance.

Health Insurance programme has two main functions-

1.To increase access to healthcare.

2. To protect households from high medical expenses at time of illness

FIGURE1: Basic elements in health insurance



1.2 CLAIMS PROCEDURE

If the insured person underwent any procedure which may give rise to claim under health insurance policy, the insured can undertake the following-

1.2.1Claim notification

The insured person should give immediate notice to third party administrator named in schedule of policy by calling the toll free number as specified in the schedule of policy and also in writing in the address shown in schedule with particulars as below-

i. Policy number
ii. Name of insured
iii. Nature of disease
iv. Name and address of attending medical practitioner

The information can be provided to company immediately and prior to avilaing treatment and in any case within 7 days of hospitalization/treatment.

1.2.2 Cashless facility for Hospitalisation

The company shall provide cashless facility through TPA.Thae insured person can avail cashless facility for hospitalization up to the limit of sum insured as specified in policy, subject to obtaining pre-authorization form from TPA.

Insured person need to submit complete information of disease , injury to be undertaken in hospital which in within TPA network along with certificate from medical practitioner, considering above TPA issues a pre- auth to the hospital concernedfor cashless hospitalization.

Cashless facility will not be available in non-network hospital. Where cashless facility for hospitalization is pre-authorised the insured need not to pay for hospitalization, and same is paid by company to hospital.There can be instances where company deny cashless facility

for hospitalization due to insufficient sum insured or insufficient information to determine admissibility, in which person may e required to pay for treatment and submit the claim for reimbursement to company.

1.2.3 Re-imbursement

In case of any claim under benefit where cashless facility is not availed, the list of documents mentioned shall be provided ny policy holder immediately but not later than 15 days of discharge from hospital ,to avail the claim.

1.2.4 Claim Documents-

The insured shall submit to company following documents in support of claim-

i. Duly completed and signed cliam form
ii. Medical practitioner referral letter advising hospitalization.
iii. Medical practioner prescription advising drugs/diagnostic tests/consultation.
iv. Original bills,receipts and discharge card from the hospital.
v. Original bills from pharmacy
vi. Original diagnostic tests report
vii. Indoor case papers.
viii. Ambulance receipt and bill.
ix. First information report, if applicable.
x. Post mortem report.
xi. Anyother document required by company to assess the claim.

CHAPTER-2

2.1Claim process in health insurance

Efficient claims management ensures that right claim is paid to right person at the right time.

From the time a claim is made known to the insurer to the time the payment is made as per the policy terms, the health claim passes through a set of well defined steps, each having its own relevance.

The processes detailed below are in specific reference to health insurance (hospitalization) indemnity products which form major bulk to health insurance portfolio.

The claim under an indemnity policy could be a:

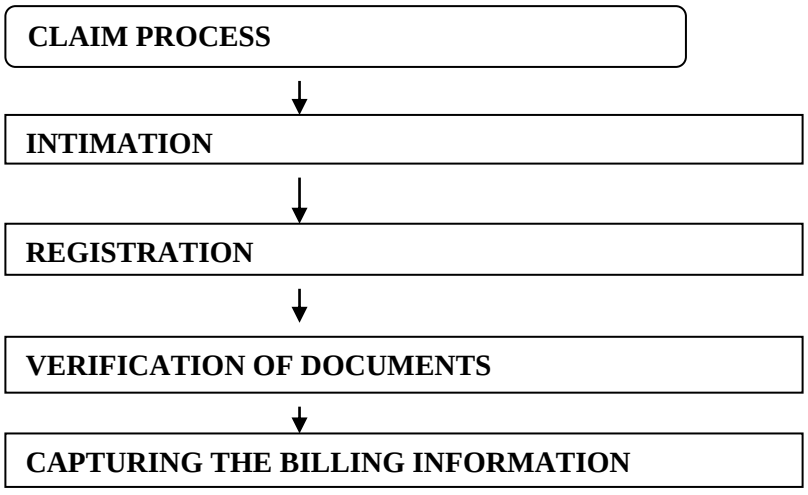
i. Cashless claim

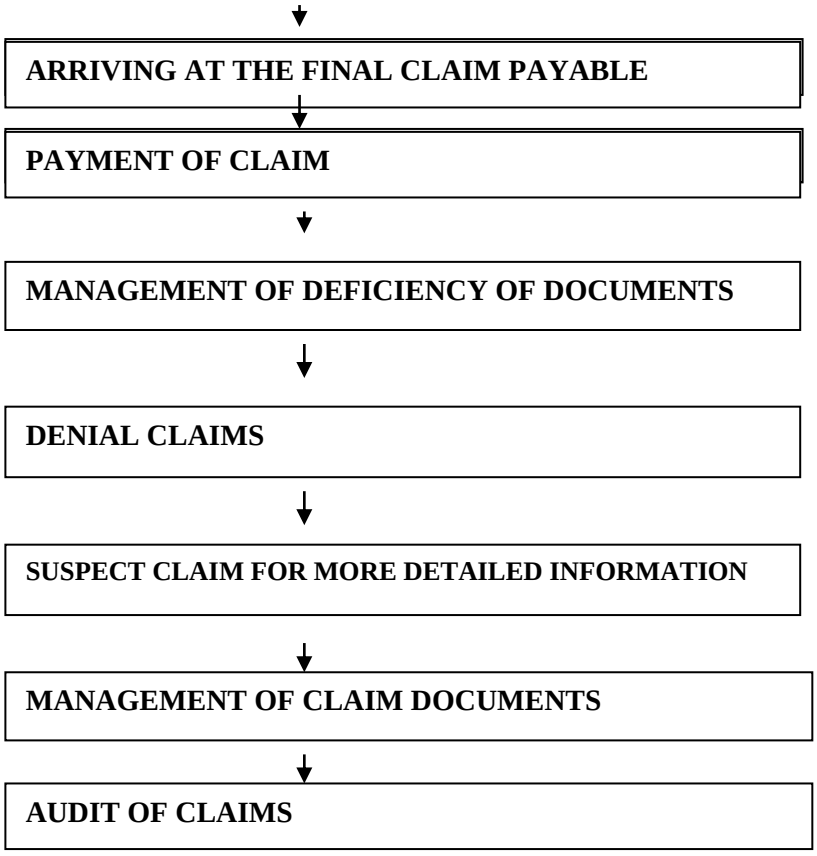
A network hospital provides the services based on a pre- approval from the insurer/TPA and later sublimits the documents for settlement of the claim.

ii. Reimbursement

The customer pays the hospital from his own resources and then files with insurer/TPA for payment of the admissible claim.

In both cases the basic steps remains the same-





2.1 Intimation

Claim intimation is the first instance of contact between the customer and the claims team.the customer could inform the company that he is planning to avail a hospitalization or the intimation would be made after the hospitalization has taken place, especially in case of emergency admission to a hospital.

Till recently the act of intimation of a claim event was a dispensable formality. However, recently insurers have started insisting on the intimation of claim as soon as practicable.this is typically seen as information before hospitaisation in case of planned admission and within say,24 hours of hospitalization in case of an emergency.

The timely availability of information about hospitalization helps in verification that the hospitalization of the customer is genuine – no impersonation or fraud- and the charges can be negotiated.

Intimation traditionally meant a ‘ a letter written, submitted and acknowledged’. With development in communication and technology, intimation is possible through 24 hours call centres run by insurers/TPAs as well as through the internet/e-mail/fax.

2.2 Registration

Registration of a claim is the process of entering the claim in the system and creating a reference number using which the claim can be traced anytime.this number is called claim number, claim reference number or cliam control number.

Registration pattern varies according to the nature of claim. Registration and generation of a reference no. can be done before receipt of documents as well as after receipts of documents.

The claim number could be numeric or alpha-numeric based on the system and processes used by the processing organization

Once claim is registered in the system, a reserve for the same would be created simultaneously.

At the time of intimation/registration, the exact claim amount or estimate may not be known, the reserve amount shall be standard reserve (mostly based on historical average claim size). Once estimate or expected quantum of liability is known, the reserve shall be revised upward/downward to reflect the same. We shall study about reserving in later section.

2.3 Verification of documents

Once a claim is registered, the next step is to check for the receipt of all the required documents for processing. The typical list of documents that are required for processing claims is explained in a separate section.

It must be appreciated that for a claim to be processed following are the most important requirements:

i. The documentary evidence of the illness,

ii. Treatment provided,

iii. In-patient duration,

iv. Investigation Reports

v. Payment made to the hospital,

vi. Further advice for treatment,

vii. Payment proofs for implants etc.

Verification of documents follows a checklist which the claim processor checks out. Most of the companies ensure that such checklists are part of the processing documentation.

The shortfall in documentation is noted at this stage - while some processes involve requesting for the documents not submitted by the customer / hospital at this point, most of the companies first complete the scrutiny of all the documents submitted before requesting for additional information so that the customer is not inconvenienced.

2.4 Capturing the billing information

Billing is an important part of the claim processing cycle. Typical health insurance policies provide for indemnifying expenses incurred in the treatment with specific limits under various heads. The standard practice is to classify the treatment charges into:

iii. Room, Board and Nursing Expenses as charged by the hospital/nursing home including registration and service charges.
iv. Charges for ICU and any intensive care operations.
v. Operation Theatre charges, Anaesthesia, Blood, Oxygen, Operation Theatre Charges, Surgical Appliances, Medicines and Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Cost of Pacemaker, Artificial Limbs and any medical expenses incurred which is integral part of the operation.
vi. Surgeon, Anaesthetist, Medical Practitioner, Consultants, Specialists Fees.
vii. Ambulance charges.
viii. Investigation charges covering Blood test, X-ray, scans, etc.
ix. Medicines and Drugs.

Documents submitted by the customer are scrutinized to capture information under these heads so that the adjudication of claims can be done with accuracy

Though there are efforts being made to standardise the billing pattern of hospitals, it is common for each hospital to use a different method for billing and the challenges faced in this are:

✓ Room charges can include some non-payabtes such as service charges or diet.

✓ Single bill can include different headings or a consolidated bill for all investigations or all medicines.

✓ Non-standard names being used - e.g. nursing charges being called service charges.

✓ Use of words like "similar charges", "etc.", “allied expenses" in the bill.

Where the billing is not clear, the processor seeks the break up or additional information, so that the doubts on the classification and admissibility are resolved.

To address this issue, IRDA Health Insurance Standardization Guidelines include components of standard bill and list of non-payable items, refer Annexure at the end.

2.4.1 Package rates

Many hospitals have agreed package rates for treatment of certain conditions. This is based on the ability of the hospital to standardise the treatment protocol and use of resources. In recent times, PPN created by public sector insurance companies and also in case of RSBY, package cost of many procedures has been pre-fixed.

Package rates typically include:

i. Room charges
ii. OT charges
iii. Investigations based on standard protocol
iv. Medicines during the in-patient period
v. Surgeon and other doctor fees for in-house panel of doctors
vi. Implants (in some cases) such as Intra-ocular lens, screws, artificial knees, etc., in most cases implant cost would be paid on actual basis (may be subject to certain limit)

Additional costs due to complications post surgery are charged separately on actual if incurred over and above these. Packages have the advantages of certainty of the cost involved and standardisation of the procedures and so the claims are easier to handle.

2.4.2Coding of claims

Though the attempt at coding of diseases goes back three centuries, past forty years have seen tremendous development in this effort.

The most important code set used is the World Health Organisation (WHO) developed International Classification of Diseases (ICD) codes.

While ICD is used to capture the disease in a standardised format, procedure codes such as Current Procedure Terminology (CPT) codes capture the procedures performed to treat the illness.

Standardising the information on procedures is vital for studying the correlation between illness and procedures as well as to evaluate the cost of various procedures.

The codes are captured in the system as part of claim processing at this stage. The review of the codes captured is done by a medically trained person later, either during the processing of the claim or as part of an audit. Insurers are relying on the coding increasingly and Insurance Information Bureau (IIB), which is part of Insurance Regulatory and Development Authority (IRDA), has started a repository where such information that can be analysed.

2.4.3 Processing / adjudication of claim

A reading of this health insurance policy shows that whiIe it is a commercial contract, it involves medical terms that define the admissibility of claim and its extent. The heart of claims processing irrespective of which insurance policy, is in answering two key questions:

✓ Is the claim payable under the policy?

✓ If yes, what is the net payable amount?

Each of these questions requires interpretation of a number of issued terms and conditions of the policy ssued to the customer as well as tariff agreed with the hospital in case treatment has taken place at an empanelled hospital.

2.4.4 Admissibility of a claim

For a health claim to be admissible the following conditions must be satisfied

. i.)**T**he member hospitalised must be covered under the insurance policy

While this looks simple, we come across situations where the names (and in more cases, the age) of the person covered and person hospitalised do not match. This could be because of:

✓ Non-inclusion of a newly-wed wife or new-born child under the policy which is issued on a floater basis.

✓ Not updating the age of the person covered.

✓ Change of name of the person which has been done legally but not updated in the policy.

✓ Hospital has issued bills in the house hold name of a person as against the names appearing in the policy contract/ legal document

. ✓ Mistake from the policy issuing office in not including the name.

It is important to ensure that the person covered and the person hospitalised are the same, to prevent impersonation, which is a commonly encountered fraud in health insurance.

ii.)**A**dmission of the patient within the period of insurance

✓ Health insurance policies are issued typically for a year.

✓ The event that triggers a claim is the admission into a hospital, which should happen within the period of insurance.

✓ Date of admission should be within policy period.

✓ The expenses involved relating to the illness such as investigations or medicines just before hospitalisation and for a period after the hospitalisation are also covered in most policies as pre and post hospitalization expenses.

The pre and post hospitalization expenses should pertain to the same ailment for which hospitalization takes place.

iii.)**H**ospital definition

Does the hospital where the person was admitted correspond to the definition of "hospital or nursing home" under the policy.

Definition

A typical policy has the following definition of a hospital:

a) It should be registered with local authorities

b) It should have at least 15 in patient beds (10 in case of class C towns)

c) Fully equipped operation theatre of its own wherever surgical operations are carried out

d) Fully qualified Nursing Staff under its employment round the clock.

e) Fully qualified Doctor(s) should be in-charge round the clock.

The purpose of this definition is to ensure that the treatment carried out was for a proper hospitalisation and not an outpatient treatment. The Health Regulations and Standardization guidelines both have defined the requirements as regards Medical Establishment and Hospital.

iv.)**D**omiciliary hospitalization

Some policies cover domiciliary hospitalisation i.e. treatment taken at home in India for a period exceeding 3 days for an ailment which normally requires treatment at hospital/nursing home.

Domiciliary hospitalisation, if covered in a policy, is payable only if:

✓ The condition of the patient is such that he/she cannot be removed to the Hospital/Nursing Home or

✓ The patient cannot be removed to Hospital/Nursing Home for lack of accommodation therein

v.)**D**uration of hospitalisation

Health insurance policies normally cover hospitalisation exceeding 24 hours as an in-patient. Therefore the dale and time of admission as well as discharge becomes important to note if this is complied with.

2.4.4.1 Day-care treatments

Technological developments in the healthcare industry have led to simplification of many procedures that earlier required extensive/prolonged hospitalization. There are number of procedures carried out on day care basis without need for hospitalisation exceeding 24 hours such as:

✓ Cataract removal,

✓ Dialysis,

✓ Kidney stone removal

Taking note of these developments, insurers allow such procedures as deemed hospitalisation under the policy and the number of such day care procedures is growing by the day.

Additionally, most of the day care procedures are pre agreed package rate basis, resulting in an element of certainty in costs.

vi.)**O**PD

Some policies cover treatment/ consultations taken on an out-patient basis, subject to a specific sum insured which is usually less than the hospitalization sum insured.

The coverage under OPD varies from policy to policy. For such reimbursements, the clause of 24 hours hospitalization is not applicable.

vii.)**T**reatment protocol/line of treatment

Hospitalization is typically associated with Allopathic method of treatment. However, the patient could undergo other modes of treatment such as:

✓ Unani,

✓ Siddha,

✓ Homeopathy,

✓ Ayurveda,

✓ Naturopathy, etc.

Most policies exclude these treatments, some policies cover one or more of these treatments with sub-limits.

vii.)**P**re-existing illnesses

Pre-existing illnesses refer to "Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms and/or was diagnosed and/or received medical advice/treatment within 48 months prior to his/her health policy with the company whether explicitly known to him or not."

The reason for excluding pre-existing illnesses is enshrined in the fundamental principles of insurance that a certainty cannot be covered under insurance.

However, application of this principle is quite difficult and involves a systematic check of the symptoms and treatment to find out whether the person had the condition at the time of insuring. As medical professionals can differ in the opinions of duration of the illness, the opinion of when the disease date of first manifestation is carefully taken before applying this condition to deny any claim.

In the evolution of health insurance, we come across two modifications to this exclusion.

✓ The first is in the case of insurance of homogenous groups where the entire group of people is insured, with no selection against the insurer. Group policies covering say all government employees, all families below poverty line, all families of employees of a

major corporate group, etc. are treated with favour compared to a single family opting to cover for the first time. These policies are provided with an exception to the rule, if negotiated so, with the adequate price built in.

✓ The second exception is allowed for pre-existing illnesses to be covered after the lapse of a certain period of continuous coverage. This follows the principle that even a condition present in a person, if it does not manifest itself for a certain period, can be treated as an uncertainty.

ix.)**I**nitial time-period exclusions/waiting period

A typical health insurance policy covers illnesses (not accident related hospitalisation) only after an initial 3o days. Similarly, there are lists of illnesses such as:

- ✓ Cataract,
- ✓ Benign Prostatic Hypertrophy,
- ✓ Hysterectomy,
- ✓ Fistula
- , ✓ Piles,
- ✓ Hernia
- , ✓Hydrocele,
- ✓ Sinusitis,
- ✓ Knee / Hip Joint replacement,

These are not covered for an initial period that could be one year or two years or more depending on insurance product.

The claim processor identifies if the illness is the one of these and how long the person has been covered to check if it falls within this admissibility criterion.

x.)**E**xcluded illness

The policy lists out a set of excluded illnesses which in general can be classified as:

✓ Benefits such as maternity (though this is covered in some policies)

✓ Diseases caused by alcohol/drug abuse.

✓ Illnesses which are not intended to be covered

✓ Outpatient and Dental treatments. therapy, obesity treatment, fertility treatment, cosmetic surgeries etc

✓ Treatments outside India.

✓ High hazard activities, suicide attempt, radioactive contamination.

✓ Admission for evaluation/investigation purpose only.

The list varies from product to product. The diagnosis carefully studied to check if the illness falls in any of the excluded conditions.

Whilesome are simple to understand, other conditions documentation e.g. such as alcohol certificate in case of accidents or arranging opinion from specialists to verify if illness is covered.

In such a case it is extremely important for the claims handler to specifically explain the circumstances so that the specialist opinion is exactly to the point and will stand the scrutiny in a court of law, if challenged.

xi.)**C**ompliance with conditions with respect to the claims.

The insurance policy also defines certain actions to be taken by the Insured claim. in case of a claim, some of which are important for admissibility of the

In general, these relate to:

✓ Intimation of claim within certain period - we have seen the importance of intimation earlier. The policy could stipulate a time within which such intimation must reach the company.

✓ Submission of claim documents within a certain period.

✓ Not indulging in misrepresentation, mis-descrition and disclosure of material facts.

2.5Arriving at the final claim payable

Once the claim is admissible, the next step is the assessment the amount of claim payable .to compute this we need to understand the factors that decide the claim amount payable.

i. Sum insured available for the member under the policy

There are policies issued with individual sum insured, issued on floater basis the sum insured is available across the family or policies which are on floater basis with a limiter member.

ii. Balance sum insured available under the policy for the member after taking into account any claim made already:

While computing this, any cashless authorization provided to the hospitals Will be fully noted.

iii. Sub-Limits

Most policies specify room rent limitation, either as a percentage of sum Insured or as a limit per day. Similar limitation could be in force for consultant fee, or ambulance charges, etc.

Check for any limits specific to illness

The policy could specify a maternity cover of a certain amount or capping in case of say, cardiac illness.

iv. Check for any other capping in the policy, such as capping related to room rent and nursing charges.

Verify whether the insured is entitled to any no-claim bonus (in case the insured has not claimed from his policy in the previous year/s). No-claim bonus often comes in the form of additional sum insured, which in fact increases the sum insured of the patient/insured.

Other expenses covered with limitation:

v. There could be other limits e.g. if treatment is undertaken under Ayurvedic system of medicine, usually the same entails much lower limit, health check-up costs of a certain limit after four years of the policy, hospital cash payment with a limit per day.

vi. Co-payment

This is normally a flat percentage of the assessed claim before payment. The co-pay could also be applicable only in select circumstances - only for parent claims, only for maternity claims, only from second claim onwards or even only on claims exceeding a certain amount.

Before the payable amount is adjusted to these limits, the claim amount payable is computed net of deductions for non-payable items.

2.5.1 Non-payable items in a health claim

The expenses incurred in treating an illness can be classified into:

✓ Expenses for cure and

✓ Expenses for care.

Expenses for curing an illness comprise of all the medical costs and the normal associated facilities. In addition, there could be costs incurred to make the stay in a hospital more comfortable or even luxurious.

A typical health insurance policy attends to the expenses for curing an illness and unless stated specifically the peripheral expense remain inadmissible.

These expenses can be classified into non-treatment charges such as registration charge, documentation charges, etc to items that can be considered if directly relating to the cure (e.g. protein supplement during the inpatient period specifically prescribed).

Earlier every TPA/insurer had its own list of non-payable items, now the same has been standardized under IRDA Health Insurance Standardization Guidelines. Refer annexure at the end for the standard list.

The order of arriving at the final claim payable is as follows:

Step I List all the bills and receipts under the various heads of room rent, consultant fee, etc.

Step II Deduct the non-payable items from the amount claimed under each head

Step III Apply any limits applicable for each head of expense

Step IV Arrive at the total payable amount and check if it is within sum insured overall

Step V Deduct any co-pay if applicable to arrive at the net claim payable

2.5.2 Payment of claim

Once the claim amount is arrived at, payment is done to the customer or the hospital as the case may be. The approved claim amount is advised to the cheque / Accounts function and the payment may be made either by h cheque or by transferring the claim money to the customer.

When the payment is made to the hospital, necessary tax deduction, if any is made from the payment. Where the payment is handled by the Third Party Administrator, the payment process may vary from insurer to insurer.

Typically these details will be shared through the system with the call centre / customer service team.

Once payment is made, the claim is treated as settled. Reports to management, intermediaries, customers and IRDA are provided on settled claims - typical analysis of settled claims showing the % disposal, amount of non-payables as a proportion, average time taken to settle claims, etc.

Management of deficiency of documents / additional information required Processing of a claim requires the scrutiny of a list of key documents.

These are:

✓ Discharge summary with admission notes,

✓ Supporting investigation reports,

✓ Final consolidated bill with break up into various components,

✓ Prescriptions and pharmacy bills,

✓ Payment receipts,

✓ Claim form and

✓ Customer identification.

Experience shows that one out of four claims submitted has a deficiency in terms of the basic documents. It is therefore required that the customer is advised of the documents not submitted and is given a time within which he can append his claim submission with these documents.

Similarly, it may happen that while a claim is being processed, additional information may be required because,

i. The discharge summary provided is not in the correct format or does not capture some details of the diagnosis or the history of the illness
ii. Treatment given has not been elaborated enough or requires clarification
iii. Line of treatment not consistent with diagnosis as per discharge summary or medicines prescribed are not consistent with the treatment provided

iv. The bills provided do not have the break up.
v. Mismatch of age of the person between two of the documents
vi. . Mismatch in date of admission / date of discharge between discharge summary and the bill.
vii. The claim requires a more detailed scrutiny of the hospitalisation and for this indoor case papers are required.

In both the cases, a communication is sent to the customer detailing the requirement of additional information. In most cases, the customer will be able to provide the information required. However, there are circumstances where the information required is too important to be overlooked and the customer does not respond. In such cases, the customer is sent reminders that the information is needed to process the claim and after three such reminders, a closure notice is sent.

In all correspondence relating to a claim when it is in process, you will see that the words "Without Prejudice" are mentioned on top of the letter. This is a legal requirement to ensure that the right of the insurer to reject a claim after these correspondences remains intact.

Managing shortfalls and additional information required is a key challenge in claims management, while the claim cannot be processed without all the required information, the customer cannot be put to inconvenience by frequent requests for more and more information.

Good practice requires that such request is raised once with a consolidated list of all information that may be needed and no new requirement is raised thereafter.

2.6 Denial claims

The experience in health claims show that 10% to 15% of the claims submitted do not fall in the purview of the policy. This could be because of variety of reasons some of which are:

i. Date of admission is not within the period of insurance.

ii. Member is not covered.

iii. Pre-existing illness (where the policy excludes such condition). I

v. Inordinate delay in submission without valid reason.

v. No active treatment, admission is only for investigation purpose.

vi. Illness treated is excluded under the policy.

vii. The cause of illness is abuse of alcohol or drugs

viii. Hospitalization is less than 24 hours.

Denial or repudiation of a claim (due to whatever reason) has to be informed to the customer in writing. Usually, such denial letter clearly states the reason for denial, narrating the policy term / condition on which the claim was denied.

Most insurers have a process by which a denial is authorised by senior manager than the one authorized to approve the claim. Apart from the representation to the insurer, the customer has the option, to approach the following in case of denial of claim:

✓ Insurance Ombudsman or

✓ The consumer forums or

✓ Even the legal authorities.

In case of each denial the file is checked to assess if the denial the legal scrutiny in the normal course and the documents are nd safe location, should a need to defend the decision arise

2.6 Suspect claims for more detailed investigation

Insurers have been trying to contain the malaise of fraud in all business. In terms of sheer number of claims handled, health insurance presents a substantial challenge to the insurers.

Few examples of frauds committed in health insurance are:

i. Impersonation, the person insured is different from person treated.
ii. Fabrication of documents to make a claim where there is no hospitalisation.
iii. Exaggeration of expenses, either in collusion with hospital or by addition of external bills fraudulently created.
iv. iv.Outpatient treatment converted to in-patient / hospitalisation to cover cost of diagnosis, which could be high in some conditions.

With newer methods of frauds emerging on a daily basis, the insurers have to continuously monitor the situation on the ground, device measures to find and control such frauds

Once a fraud is suspected, it is sent for investigation. Investigation of a claim could be done in-house by an insurer or be entrusted to a professional investigation agency.

The investigator will go through the circumstances, collect documentary proof and give a report on the genuineness of the claim. The claim will be further processed for settlement or rejection based on the report.

2.7Management of claim documents

Once a claim is disposed, the claim file is kept in storage. While the file may have no further need except for post-facto audit internally, the file may be called upon for scrutiny in case of legal suit on the claim settlement. The law of limitation allows a claim settlement to be challenged up to 36 months of settlement.

In addition, the insurer is expected to comply with Rule 39 (8) of the Insurance Rules, 1939, which says,

Every insurer shall retain all the documents relating to claims settled including copies of any survey or loss assessment reports connected therewith:

In respect of every loss or damage on which a claim of less than Rs. 5,000 has been made, for a period of three years;

In respect of every loss or damage on which a claim of Rs. 5,000 or more but less than Rs. 20,000 has been made, for a period of five years;

In respect of every loss or damage on which a claim of Rs. 20,000 or more but less than rupees one lakh has been made, for a period of seven years; and

In respect of every loss or damage on which a claim of rupees one lakh or more has been made, for a period of twelve years.

2.8Audit of claims

Claims department, whether handled by the insurer or outsourced to a TPA, is under the constant pressure to manage the response time and accurate adjudication of all claims. In doing so, it is quite possible that errors creep in - with or without financial impact on the organisation.

Traditionally audit has been an integral function of insurance to verify if the claim has been processed in accordance with the terms of the policy and the processes set out by the company.

It is observed that insurance companies which utilise the services of TPAs for health insurance claims, like the public sector insurance general insurance companies, would not be performing the above mentioned processes/steps involved in claims management on their own and would mostly be focusing on audit of claims managed by the TPA. Usually a special team is formed for the purpose at the regional and corporate level, including system based analysis of claims and team is involved in scrutiny of TPA claim files, verification of cashless pre-authorisation etc.

Typically a quality check format, which is a short checklist, is administered to check the accuracy in financial, process and customer areas of the claim. The auditor or the Quality checker may check all claims or limit to a sample or carry out a combination of the two - check all claims above a certain value while sampling smaller claims.

2.9 DOCUMENTATION IN HEALTH INSURANCE CLAIMS

Health insurance claims requires arrange of documents for processing as explained earlier.each document is expected to assist in answering the two key questions-admissibility and extent of claim.

This section explains the need for and content of each of the documents required to be submitted by the customers:

2.9.1 Discharge summary

Discharge summary can be termed as the most important document that is required to process a health insurance claim. it details the complete information about the conditionof the patient and the lineof treatment.

The discharge summary most contain:

a) Name, age, gender and description of the patient.

b) Date and time of admission and discharge.

c) Description of the patient's condition at the time of admission, temperature, pulse, blond pressure and other parameters and the reason for admission.

d) History of illness, since when the condition presented itself. In maternity cases the details of pregnancy and live children are provided.

e) Investigations done.

f) Consultants treating the condition.

g) Line of treatment - description of surgery, if relevant.

h) Post intervention advice.

i) Medicines used.

j) Investigations to measure progress after surgery.

k) Condition on discharge.

I) Advise on discharge including medicines to be used, procedure / diagnosis to be done and follow up visit.

A well written discharge summary helps the claim processing person immensely to understand the illness / injury and the line of treatment, thereby speeding up the process of settlement. IRDA Standardization Guidelines include suggested contents for Discharge

Summary for efficient processing of claims, refer Annexure at the end. Where the patient unfortunately does not survive, the discharge summary is termed Death Summary in many hospitals.

The discharge summary is always sought in original.

2.9.2 Investigation reports

Investigation reports assist in correlating the diagnosis and treatment, thereby providing the necessary interface to understand the exact condition that prompted the treatment and the progress made during the hospitalisation.

Investigation reports usually consist of:

a) Blood test reports;

b) X-ray reports;

c) Scan reports and

d) Biopsy reports

All investigation reports carry the name, age, gender, date of test etc. and typically presented in original. The insurer may return the x-ray and other films to the customer on specific request.

2.9.3 Consolidated and detailed bills:

This is the document that evidences what needs to be paid under insurance policy. Though there is no standard format for the bill, the usual practice is to present the consolidated treatment charges under the following heads:

a) Room rent including the charges for duty medical officer and basic amenities provided in the room. Nursing charges can be part of this or could be a separate head.

b) Intensive care unit charges if ICU is used for treatment. This includes the charges for the intensivist, a term used for the duty medical officer at the ICU, specialist nursing, pulse monitor, oxygen, etc.

c) Consultant charges which include the fees for all the doctors and specialists treating the patient.

d) Diagnostic tests and investigations.

e) Medicines ordered as part of IP treatment.

f) Procedure charges for any specific procedures such as Dialysis, chemotherapy, etc. done during hospitalisation.

g) Miscellaneous charges such as admission, registration, documentation, service charges and taxes.

While the consolidated .bill presents the overall picture, the detailed bill will provide the break up, with references. Thus while the total bill states room rent and charges, the detailed bill will state the type of room, number of days, rate per day and other charges included in the head. Similarly, for the consultant fee, the detailed bill will provide the break up for each day and each consultant.

The detailed billing also includes pharmacy bills, with prescriptions cross-referred.

Adjudication of non-payable expenses is done using the detailed bill, where the non-admissible expenses are rounded off and used for deduction under the expense head to which it belongs. IRDA Standardization Guidelines provide format for consolidated and detailed bill, refer Annexure at the end. The bills have to be received in original.

2.9.4Receipt for payment

Being a contract of indemnity, the reimbursement of a health insurance claim will also require the formal receipt from the hospital of the amount paid.

While the amount paid must correspond to the total of the bill, many hospitals do provide an element of concession or discount in the payable amount. In such a case, the insurer is called to pay only the amount actually paid on behalf of the patient.

The receipt should be numbered and or stamped and be presented in original.

2.9.5Claim form

Claim form is the formal and legal request for processing the claim and is submitted in original signed by the customer, The claim form consists of:

a) Details of the proposer and the policy number under which the claim is made.

b) Details of the patient.

c) Reason for the claim - for cause of illness, which the hospitalization was done and the

d) Period of hospitalisation.

e) Amount of expenses incurred under various heads.

f) Checklist of documents to be attached.

g) Declaration from the insured.

Besides information on disease, treatment etc., the declaration from the sense. insured person makes the claim form most important document in the legal sense.

It is this declaration which applies the "doctrine of utmost good faith" into the Claim breach of which attracts the misrepresentation clause under the policy.

2.9.6Identity proof

With the increasing use of identity proof across various activities in our life, the general proof of identity serves an important purpose - that of verifying whether the person covered and the person treated are one and the same

. Usually identification document which is sought could be:

a) Voters identity card,

b) Ration card,

c) Driving license,

d) PAN card, etc.

Insistence on identity proof has resulted in a significant reduction of impersonation cases in cashless claims as the identity proof is sought before hospitalisation, making it a duty of the hospital to verify to the insurer or the TPA. and present the same

In reimbursement claims, the identity proof serves a lesser purpose.

2.9.7 Documents contingent to specific claims

There are certain types of claims that require additional documents apart from what has been stated above. These are:

a) Accident claims, where FIR or Medico-legal certificate issued by the hospital to the registered police station, may be required. It states the cause of accident and if the person was under the influence of alcohol, in case of traffic accidents.

b) Case indoor papers in case of complicated or high value claims. Indoor case paper or case sheet is a document which is maintained at the hospital end, detailing all treatment given to patient on day to day basis for entire duration of hospitalization.

c) Dialysis / Chemotherapy / Physiotherapy charts where applicable.

d) Hospital registration certificate, where the compliance with the definition of hospital needs to be checked.

The claims team uses certain internal document formats for processing a claim. These are:

Checklists for document verification

Scrutiny/ settlement sheet,

Quality checks / control format.

Though these formats are not uniform across the insurers, let us study the purpose of the documents with a specimen of the usual contents.

Document verification sheet

It is the simplest of all, a check mark placed on the list of documents received to note that these have been submitted by the customer. Some insurers may provide a copy of this as an acknowledgement to the customer.

Scrutiny/process sheet

It is usually a single sheet where the entire processing notes are captured.

a) Name of the customer and id number

b) Claim number, date of receipt of the claim papers

c) Policy overview, Section 64VB compliance

d) Sum insured and utilisation of sum insured

e) Date of hospitalization and discharge

f) Diagnosis and treatment

g) Claim admissibility / processing comments with reason thereof

h) Computation of claim amount

1) Movement of the claim with dates and names of people who processed Final check or quality control format for checking of

Quality checks / control format

Final check or quality control format for checking of claim by person other than claim handler

Besides check list and claim scrutiny questionnaire, the quality control/audit format shall also include information relating to:

a) Settlement of claim,

b) Rejection of claim or

c) Repudiation of additional information

D. Claims reserving

2.10 Reserving

This refers to the amount of provision made for all claims in the books of the insurer based on the status of the claims. While this looks very simple, the process of reserving requires enormous care - any mistake in reserving affects the insurer's profits and solvency margin calculation.

a) When a claim is reported, the amount claimed is entered into the books of the insurer as the liability. This could be a cashless authorisation provided to the hospital to treat the customer. The amount could move up or down based on the actual cost.

b) When the claim is submitted the actual incurred amount becomes the liability.

c) When the claim is processed and the amount of non-payables is deducted, the liability for the claim moves down.

d) When a claim is settled, the actual amount becomes the reserve, ending the journey through the reserving process.

This process is called reserve movement and the change in amount for the same set of claims is called reserve gain / loss. Processing systems today have built in capability to compute the reserves as at any point of time.