Internship
at
Aafiya TPA Services,
Dubai

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List of tables and figures

ABOUT THE ORGANISATION AAFIYA

Aafiya is a specialized Healthcare Management company which works together with its providers and insurance companies to provide high-quality healthcare for its members. It ensures quick processing of claims, fewer denials and maximum returns for the healthcare provider. TPA closely monitors use of resources and arrange for cashless hospitalisation. It helps insurance company in bringing down the claims ratio and false claims. TPA has license from insurance authority and is member of emirates insurance association. It's an unconditional TPA that is it has license to sell Dubai basic plan.

Aafiya can ease the burden from insurance companies and corporates by managing their member database, online enrolment, full policy automation set-up, and quick turn-around-time of card issuance. It's the job of TPA to do conservative management–don't do it unless it's required.

Organisation profile

Vision

Vision as a third party administrator of international standards that is committed to patient safety and emerges as a trustworthy healthcare facilitator in the region.

Mission

Mission is to facilitate comprehensive health insurance services of high quality standards to all the sectors of the population.

List of Services

1) **Risk Management**-Rising healthcare cost in the region makes it vital for insurance companies and corporates to be able to properly assess & manage the risk while ultimately improve or optimize their loss ratio.To achieve this, Aafiya provides the following services to develop vigorous and innovative healthcare risk management tools-

- Product Design and Pricing
- Underwriting Support
- Sophisticated Reporting Capability – Accurate, detailed, and real time reporting system
- Fraud and Abuse Investigation Tools

2) **Policy Administration** –using highly trained production team, Aafiya can ease the burden from insurance companies and corporates by managing their member database, online enrollment, full policy automation set-up, and quick turn-around-time of card issuance.

3) **Claims Management** –Having extensive clinical experience, Aafiya team is adapted at managing benefit costs while ensuring that insured members receive appropriate, high-quality medical care.Claims processing is empowered with thousands of adjudication rules which will process more than 80% without the need for manual intervention. With this high degree of automation, TPA is not only in the position to diligently settle payments to providers, but tightly manage benefit utilization without compromising on accuracy and consistency.

4) **Provider Network** –With extensive network of providers in the region, members have the freedom to choose from different types of network classifications. Leveraging on wideconnections and experience, Aafiya is in a unique position to negotiate for lower base costs, higher discounts, and more competitive rates.

5)**Online Services**

- Quotation Tool
- Enrolment
- Approval
- Claim Submission
- Tracking Services
- Statistics
- Payment

6)**Personalized Services**

- Training & Orientation
- Provider Induction
- Consultancy & Reviews
- Second Opinion
- VIP Services

7)**Call Centre**

Customer service aims to continuously commit to excellence through dedicated 24x7 call centre which consists of highly trained and qualified medical professionals.

Health system is a network of

- Dubai Health Authority (DHA) who is the guiding and regulating authority responsible.
- Dimension-IT department collecting and managing all the data
- TPA- responsible for managing the care processing.

Insurance companies listed in Aafiya

1. Union insurance co-Capitation of OP by Aafiya and IP by company.
2. Thumbay FZE-Aafiya pays for both.
3. Takaful Emarat insurance PSC –Funded by company itself.
4. United insurance company- All OP and IP cases are funded by Aafiya
5. National life and general insurance company(NLGI)- OP by aafiya and IP by company.

PR/payer- If payer is Aafiya, this means both processing and dispensing of cheque is done by the TPA. That is flow of money from insurance company to provider through TPA. For Takaful, Aafiya is just processing and not paying(Financing in all cases is done by insurance company)

System software

Two systems operate-Toshfa which is made by Aafiya itself for clinics of UAE and PBM/pharmacy benefit management.

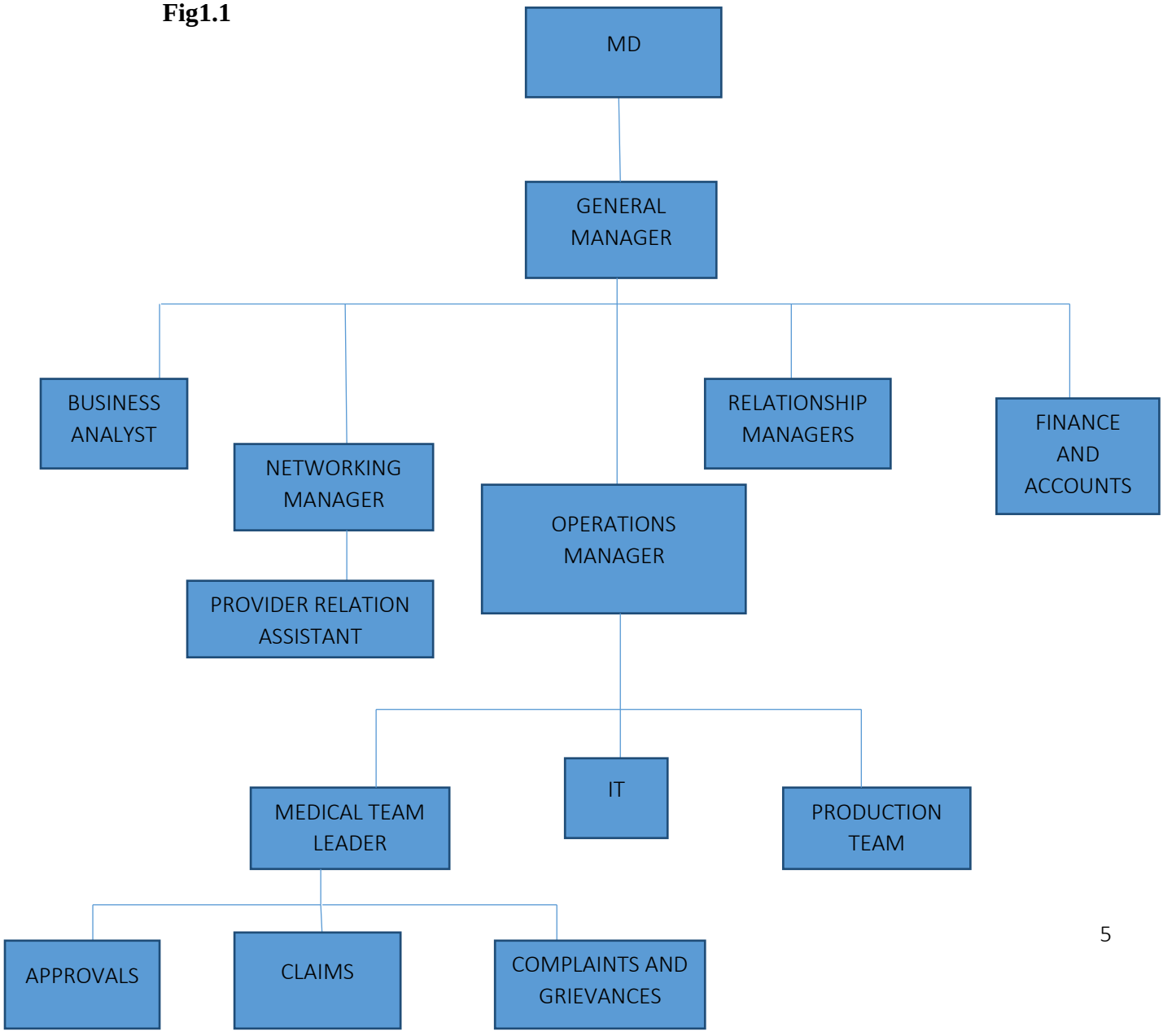
TOSHFA

TOSHFA is a user friendly software designed by Access meditech to simplify member enrolment, premium billing of claims and claims processing. Under this

1) **Provider network**-In this; speciality, service type, room type, doctor list, provider contract, provider group, service price list under provider classification into different network shows cost of services for different network.
2) **Policy administration**-Insurance Company List, Plan Template, Client List, Policy Contract List, Policy Endorsement List, ICD and dental codes
3) **Approvals**-Approval request and status can be checked
4) **Claims**- Entry, batching, review
5) **Customer service**- It provides all the stakeholders to access through online using each individual log-in types (Insurance Company / Provider / Client / Member) which will allow the user to submit online requests, view policy terms and conditions, track approval and claims status requests, verify provider eligibility and provide feedback, customer can lodge their complaints-type of complaint and complaint status can be verified.
6) **Statistical report**-Policy Details (Insurance Company, Plan, Provider Category),Policy Member Details (Insurance Company, Client Group, Policy), Policy Endorsement Details (Insurance Company, Client Group, Policy), Approval Status Report, Claims Status Report, Batch Entry Report.

Organisational structure

Fig1.1



Departments of Aafiya

1. Networking
2. Operations

a. Production
b. Approval
c. Call centre
d. Claims
e. Grievances

3. Accounts
4. Relationship management

DEPARTMENTS OF AAFIYA

Networking

Premium which the patient agrees to pay depending on his salary is the criteria for putting patient under a plan by the TPA. This decides price of a service. There is different pricing for different networks. Procedures, tests cost different in different plans hence the overall cost varies. There is no limit to the cost as such. Cost of administration varies for different hospitals hence the overall cost varies. Different companies (TPAs) build their own network. Base rate /Tariff of a service is decided by the TPA which is a negotiation between the providers and TPA. Patient can receive services from his own network only.

Its job of networking department

- To come up with the base price.
- An addendum is decided as to how much of discount will be provided by the provider and will be effective from which date.
- Including a provider. This process of including a provider in a network is called inclusion.
- It also deals and coordinates with contact person of the provider or insurance company.
- Explains patients which all hospitals are under their network and guide them during customer calls.

Network Classification

Medical Provider Network is an entity or group of health care providers contracted by insurance company or TPA to provide medical services to its insured members. With higher category of networks, premium amount increases and number of hospitals also increases. So patient has wide choice in higher networks. Discount rates decide which provider is in which category of network.Aafiya network means the network of medical providers which have entered into a Medical Service Agreement with Aafiya to secure mutual administrative and financial benefits.

All these networks are not in Abu Dhabi and Alain. If patient of Aafiya goes there during emergency, only reimbursement facility from Aafiya is provided. So, usually patient is in loss.

1. **Aafiya preferred network/APN**-In this emergency cases are treated at hospital that is access to hospitals for IPD and OPD is in clinics. This is focussed on northern emirates (Sharjah, Ajman, Fujairah, Rasal)

2. **APN with GMC**-In this network OPD at clinics or GMC group of hospitals. IP is in hospital. None of the TPA gives OP in hospitals for Dubai mandatory policy. Dental treatment is expensive, it's not covered in Dubai basic plan while in other emirates it's covered. For Dubai basic plans premium is decided by DHA depending on the salary below or above 4000 AED. People with less than 4000 AED salary come under basic DHA plan. Only 7 insurance companies can sell this plan (licensed by DHA). Aafiya in collaboration with Takaful can sell this basic DHA plan under this network.. This is only for people living in Dubai and is mandatory for all. People of Dubai can avail services in any of the hospitals of UAE
3. **APN plus**-OP, IP in any of clinics or hospitals. Group of hospitals (eg. Sunny hospital) agreeing on discounted price called the benchmark price. More are the providers in this than the above two. This plan is not for all the hospitals but only some group of hospitals. Example in Iranian hospital in only one group IPD is covered. Pre-authorization limit for Clinics: Services (including Consultation, diagnostics and radiology) with net amount over and above 150 AED require a pre-approval for APN network. However for APN Plus, pre-approval limit is 200 AED. Prescription with net amount over and above 150 AED requires a pre-approval for APN network and APN Plus.
4. **GMC network only**-Both OP and IP services in only GMC group of hospitals (four).
5. **Gold**-OPD, IPD both in hospitals. Majority of providers lie in gold, diamond and elite.
6. **Diamond**- Both services in hospitals. Cost of treatment, number of hospitals, annual limit is more.
7. **Elite**- Both in hospitals. Cost and network of patients is highest.

Example-For GMC hospital, Ajman
Base charges of consultation
Fig 1.2

	For Uninsured member	**For patient of network APN**	**For patient of network diamond**
GP	75	35	91
SP	210	60	171

Net cost of consultation for SP claimed for patients of different network

Fig1.3

Cost of consultation	**Discount**	**Copay**	**Net amount**
171	51.3	40	79.7
60	0	12	48

Net cost of consultation for GP claimed for patients of different network

Fig1.4

Cost of consultation	**Discount**	**Copay**	**Net amount**
91	27.3	30	33.7
35	0	7	28

Categories of providers under different network

Fig1.5 In every emirate there are different number of providers under different network.

Providers	Elite	Diamond	Gold	APN plus	APN
Clinic					
Diagnostic					
Hospital					
Optical					
Pharmacy					

Concern-Networking department coordinates with providers, include them into list with an agreed tariff and help patients in making decisions regarding which hospital and doctor they can go for services. Updating of list is very important along with a good watch on base rates.

Production

Insurance companies send name, plan number and effective date of client through mail to TPA. TPA designs card and sends it to insurance companies for approval and then after receiving the approval sends that for printing. The beneficiaries will be identified by the provider on the basis of an ID card issued to them bearing the logo of Aafiya Medical Billing Services. Claims sent to Aafiya relating to expired cards will not be paid by Aafiya and will be provider's responsibility. By referring to beneficiary's ID card, physician status who can attend the patient and whether referral required or not, requirement of approvals is checked. Example, verification is done to check if prescribed medicine requires any pre-approval/excluded (According to the exclusion list attached) depending on the policy

As network consists of providers beyond gulf countries, patients can go to India and other ISC countries to avail treatment at lower price. This contributes in cost effectiveness. Under DHA plan, maternity cover is fixed say 6000 which is equivalent to INR or less than that in India. Only elective and emergency cases can be dealt at cheaper price.

Its job of production department to

- Coordinate with insurance company and the client who wants its members to be insured.
- Member enrolment-Add a new member along with his policy details and the network into the system.
- Card designing and issuing it to the member.

Insurance company sends to TPA

1) Pricing details showing the risk shared.
2) Photo of insured client.
3) Confirmation details of each company is sent to TPA which has

- Gross rate (premium) which varies with salary of people.
- DHA ID issued by insurance company.
- Percentage share of premium for TPA, insurance company and broker.
- Reference number of the member.

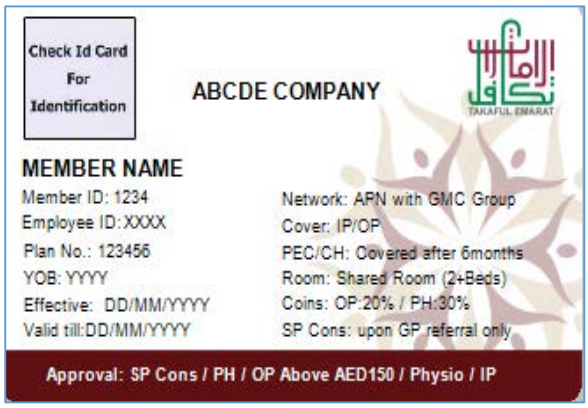
4) Policy contract/ table of benefits (TOB)
5) Client list/ List of individual members insured in the client group.
6) Plan template

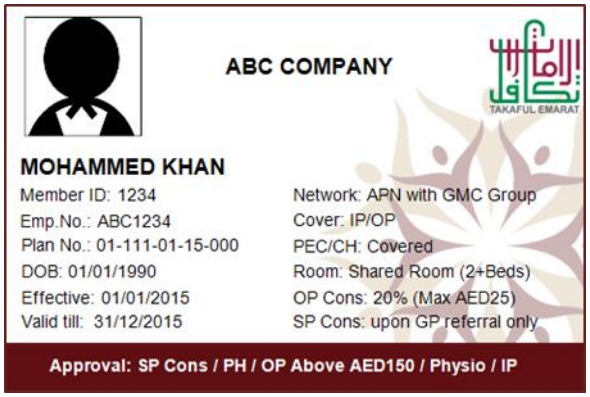
All details are entered in Toshfa under plan template details. Policy number to client is given by TPA in order to refer it in future.

Premium is paid yearly. It increases with enhanced plans. Policy is valid for one year. In all plans the annual aggregate limit for patient is 1,50,000. Services costing more than this will not be covered by insurance company. Plans are not for Abu Dhabi and Al Ain.

Medical insurance card for basic and enhanced plan

Fig. 1.6





Cards of different network are of different colours. Maroon is for APN and APN plus. Elite is green, diamond is blue and gold is yellow.

Concern-Production department coordinates with clients and make insurance cards for their members after going through policy certificates, table of benefits and networks. Delay in production of cards or any wrong details on the card can keep patient unattended at health facility.

Approvals/pre authorizations

Process whereby a medical officer of the insurance company or TPA reviews proposed treatment / diagnostic procedure to assure that the insured's specific medical needs are met in the most cost-effective setting suitable for treatment of the injury or sickness.

TPA receive information regarding patient's history, diagnosis, treatment and drugs prescribed in the form of mails from providers-hospitals and pharmacies or receive calls from patients, and service providers (doctors, insurance coordinator of hospitals, pharmacist) for approvals. Every detail provided in mail is put in the system.

Once approved by TPA then only medicines are dispatched to the patient. Only when a procedure say for example sonography is justifiable clinically by the TPA then only doctor proceeds with it or else will have to do certain test example urine test to justify the procedure. All the decision making power related to clinical procedures lies with TPA. Verbal Pre-authorization Number (VAN) is given which is mentioned on the Medical Claim form while submission. No verbal approvals to be given unless for emergency cases.

For approval, an estimated cost of treatment is sent by the provider and TPA approves of the amount it finds justifiable. This estimated cost can be more than the amount actually claimed of by the provider.
Validity of Pre-authorization isUp to 7 days from the date of Pre-authorization issued. The claims will be denied if the treatment/service is given after this time period.

Requirement of preauthorisation/approval

- Services / Procedures/drugs valuing net amount above AED 1000 for Providers classified as Elite and Diamond network:
- Services / Procedures /drugs valuing net amount above AED 500 for gold.
- Limit is 300 for APN plus
- Limit is 150 for APN, APN plus GMC
- For VIP members, no approvals.

Turn around time
Fig1.7

Description		**Service Level**
Claims Authorization	Elective Cases (with complete and full documentation)	Within maximum 48 hours following the receipt of request and all required documentation
	Emergency Cases	Verbal approval on real time basis followed by a written approval within maximum 24 hours following the receipt of the written request and all required documentation

Concern-Approval department coordinates with insurance coordinators of hospitals and get calls from patients and providers. Delay in approvals can delay treatment at health facility.

Grievance redressal

Complaints can be received from insurance company, brokers on behalf of patients or patients can themselves do that. Complaints are mostly related to delay in approval, long waiting in pharmacy, regarding payment, delay in RA due to wrong details sent in XML files (RA is like informing DHPO that payments is being done by TPA) rejected claims etc. Reasons of rejection can be patient went to SP directly, calculation discrepancy in terms of co-payment and discount etc.
Ex-gratia are those special cases which are considered beyond routine cases. Example in new policies patient is not aware much hence he is given special consideration/exception.
Within three days have to solve the complaint. Not all complaints are registered in the system. DHA watches all complaints and only genuine cases be registered. Depending on the severity of complaint, case is discussed with senior managers and a decision of paying or not is taken.

Complaint category

1. Delay in process
2. Denial of coverage
3. Rejection of claim
4. Accuracy of documentation provide
5. Administration or operational procedure
6. Product dissatisfaction
7. Changes in policy terms

Mode of communication

1. Telephone
2. Fax
3. Mobile
4. E-mail
5. Third party(broker)

Complaint types

1. Policy administration
2. Approval
3. Claims
4. Other services-services related to providers

Complaint status

1. Fully upheld-means patient is satisfied
2. Partially upheld-complaint is resolved by the TPA but patient is not satisfied
3. Denied-non acceptance due to non-agreement between TPA and patient

Resolution score

1. Largely satisfied
2. Completely satisfied
3. Dis satisfied

Complainee department

1. Operations-Related to claims and approval
2. Network-Denial of patient due to non-network hospitals

Concern-Grievance redressal department deals with all sorts of complaints from all the stakeholders. Solving a complaint on time helps in building good relations with clients and patients.

Claims

Types of claims

1. **Paper claims**

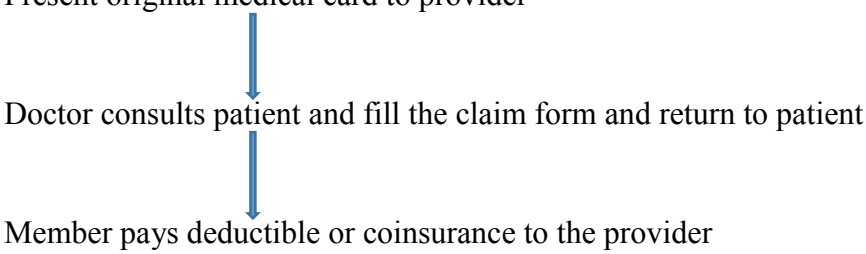
Claim forms with all the details of the services provided to patient, invoice, lab reports are sent by the provider. Encoding of claims is the first step that is claim batch and claim entry is to be done manually by the claim officers.

2. **E-claims**

Provider sends the details to DHPO which sends it to the TPA. There is no batching or entry manually. Details are downloaded to Toshfa and claims are processed same as paper claims. Information is sent to TPA in form of codes like license number of service provider (doctor), code of the provider (hospital or pharmacy) etc. For people of Dubai it's mandatory that they submit e claims. These claims are administered on direct billing basis.

Role of patient

Fig 1.8



3. **Reimbursements**

In case of emergency and even in non-emergency cases, patients can avail services from providers both in network or non- network. When it's in non-network then claims are administered on reimbursement basis. Patients pays to hospital and rather than providers sending the documents, patients sends the original claims forms and invoice, discharge summary for in patient cases,

original reimbursement claim forms, card copy and investigation results. Claims are paid directly to the member. These are not for basic plans.

Role of patient

Fig 1.9

Patient takes the treatment at the hospital

Patient pays to the hospital for the services

Patient submits the documents to TPA

Within 60 days providers have to submit the claims from the date the treatment was given. Within 30 days claims be processed by TPA from the date they receive the claim form and invoice. Claims processing be generally within 60 days but it may be extended under certain conditions, such as the need to obtain additional information. For those claims that require additional information to pay the claim, the organization must contact the claimant promptly to obtain this information. Within 40 -60 days payment be done to the providers depending on the policy and company. Claim forms be checked. It should have total claim amount, name of the company, bill number, card number and other details. Insurance company has the right to completely reject claims that are submitted more than 90 days after the submission date. Resubmission should be made with a maximum period of 45 calendar days from the date of receiving the returned claims/ documents.

From a provider say pharmacy or a hospital the invoice and claim forms of all the patients are sent who received any treatment from that facility in last month.

The documents sent from the providers should have the invoice details with the seal of Aafiya (with the received date)and patient's signature and doctor's seal on the claim form, copy of insurance card of the member, invoice of the drugs, copy of medical reports, investigations, original prescriptions.

Work under claims department

- Claims entry
- Claims adjudication
- Provider Batch Processing
- Provider Batch Verification
- Reimbursement Claims Processing
- Reimbursement Verification
- Payment Processing
- Provider Payment
- Reimbursement Payment

Criteria for Claims Review / Adjudication:

• Member Verification
• Network Coverage
• Network Tariff
• Assessment of medically necessary requested procedure / investigations / medications
• Requested amount
• Policy Exclusions
• Member History

• Member Utilization
• Provider agreed pricing and discount structure
• Co-payments & Deductible

Claims processing

On behalf of and at the cost of the insurer, TPA receive, review, verify, and process payment of claims in accordance with the procedures contained in the relevant network provider agreement and the rules and procedures of the billing and payment structure.

Batching- Creating a batch number for one complete batch of claims. From providers all claims together is received. Depending on payers batching is done. Payer can be any of the insurance company with which TPA is associated or the TPA itself. Claims processing is done by TPA no matter who the payer is. Payer refers to the entity to which claims will be sent after processing. It goes through all the claims and prepare cheque which is to be paid to the provider through TPA.

From the starting of the month till the end, all claim forms are batched. They are given a batch number by the system once details are entered. There are two types of claims, provider claims and reimbursement claims. Provider claims are of two types- paper claims and e-claims. Reimbursements claims are those claims which are not in Aafiya's network. They come from patients themselves and not from the providers. Patient pays out of pocket in the form of cash for the treatment and the money is reimbursed to him. TPA accept it during the time of emergency only (life threatening cases) and it doesn't matter whether the provider was in the list or not. For reimbursements all original documents of prescription, card copy, claim form, invoice are required. IP claims are batched separately

Claim entry-- Creating claim number which is unique of a claim. In this all the information related to service date, doctor's name, patient's complaints, diagnosis, invoice number and the cost of the treatment or drugs which is provided or prescribed by the provider is fed in the system. For claims above approval limits, approval forms be attached while entering.

Claim review- After claim entry, the procedure and the amount which is finally approved of for the payment is got. It's the decision to accept or reject the request of provider based on what is in the system.

Distribution of claimed amount with respect to system

Fig1.10

Invoice	**System review**	**Ineligible**	**Payable**
Unit price			
Discount			
Copay/deductible			
Net amount			

If the claimed amount is less than 150 then compare the claimed amount with the amount provided by the system review. If the amount claimed is lesser then that gets payable. If it's more then only agreed tariff becomes payable and rest gets rejected due to calculation discrepancy.

If the amount claimed is more than 150 then approval form is checked. If there is no approval form then claim gets rejected. If it's present then approved cost of each medicines is compared with the

amount claimed by the provider. The amount for which approval was given, only that amount is payable. For each medicine its checked and approved or else reason for rejection be mentioned.

Status of member and its policy be active when the services was taken by the patient. Doctor's name and diagnosis be mentioned. System review is checked for patient is active member, policy is active, authorization required. All these columns be checked by the system in order to accept the claim. Type of plan is checked whether basic or enhanced. If it's basic then usually 30 percent of coinsurance must be collected from the member and also there should be a gap of more than six months between the policy inception date and claim incurred date for a chronic condition to be covered. Also policy certificate be checked to confirm whether it's covered or not. For enhanced, there is no copay and chronic is also covered from the inception date.

The practioner who has treated the patient be verified. If he is a GP then the claimed amount be the fees of GP only and not of SP. Or else due to variance in the specialty of doctor the claim can get rejected.

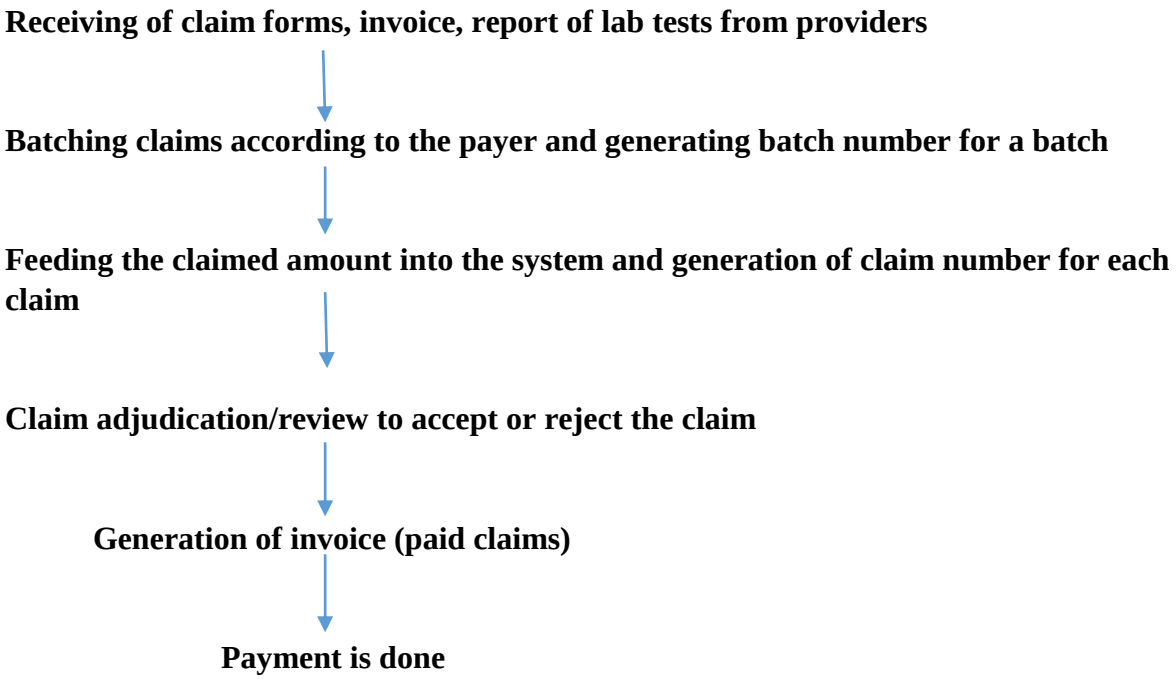
If reason for rejection is CEED review that means service given (example a drug) is not according to the diagnosis mentioned. It's checked automatically by the system based on the ICD code. DHA provided CEED for medical adjudication. Along with CEED, medical officers of claims department review the claims according to their medical knowledge.

Remittance advice (RA) is for e claims. To the DHPO, invoice number (of cheque) from TPA is sent stating that the payment has been done by the TPA to the provider. RA is lodged by provider to the payer. RCA is requested claimed amount which is the cost providers are requesting for.

Three documents to be printed, attached with the claims and sent further to provider through accounts department and insurance company-

- Acknowledgement letter
- Provider claims payment bordearu
- Cheque

PROCESS FLOW
Fig.1.11



For processing of E-claims

Every TPA has an ID in e-claim link. Receiver ID is TPA's license number. In form of XML formats, claims are uploaded in DHPO by DHA to a particular ID of TPA. From here, batches are viewed and downloaded. This is then copied into Toshfa using e- claim upload. System verifies the claims checking doctor's name, and other details. For this system has to be upgraded in order to accept the claim or else because of errors it can reject the claims. In case of no error, batch number is generated by system**.**

Concern-Claims department does the main judgment part as to which services and amount will be accepted. Claims management is controlling cost so that insurance company is not in loss. Unbalance in the premium collected and the claimed amount affects the status of insurance company. Delay in processing delays payment to hospitals.

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Work experience

Internship was of two months starting from 15th March to 14th May 2015. To understand the basic functioning of TPA and health system of Dubai, interactions with staff was done. Claim entries was done which helped me in understanding the various OP cases that comes, investigations done. All claim forms, invoice, lab test reports, card copies, provided was analysed and also learnt the way claims are being reviewed by the team. Reasons for rejection of claims were studied.

The main purpose was to have an overview of all the departments which work together in harmony in order to build good business for the organisation and satisfy the customers through good services.

Key learnings

1. The internship provided me the opportunity to know how a TPA firm works and also gave me a chance to understand all the processes involved.
2. Time given by the staff helped me in better understanding and finding out the reasons for rejection and status of claims.
3. As a trainee, I was given the opportunity to be a part of claims processing and also used to attend the orientation class and go for interaction with doctors.
4. Interacting with members of almost all the departments helped me in understanding the functions of each and their importance well.