A study into the working of Aafiya TPA services, Dubai

By

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تشفى
TOSHFA

Regulatory bodies of UAE

- MOH for Sharjah, Ajman, Ras al khaimah, Fujairah, Um Al Quwain that is all northern emirates

- Health Authority Abu Dhabi/HAAD which is responsible for regulating the healthcare industry and developing Abu Dhabi’s health policy and Al Ain

- Dubai Health Authority/DHA for Dubai

Health insurance market

- Premiums were increasing
- Government expenditure on health was increasing
- Medical inflation was an issue
- Depending on salary fixed the premiums so that health care cost is justifiable
- The index rate be verified for an insurance company in order to sell a plan
- Requirement of DHA permit to be called participatory insurers
- Entry of private players for both basic and enhanced plans
- Mandatory policy increased premium flow
- Only TPA meeting requirements of DHA and collaborating with licensed insurance companies can stay and sell basic plan

Phase wise enrolment in insurance

- By 2014, all companies with more than 1000 employees be covered under health insurance.
- By 2015, companies with more than 100 and less than 1000 employees be covered.
- By 2016, companies with less than 100 employees and their dependents be covered

All providers of Dubai must be registered on E-Claim Link and submit their healthcare related transactions through the Dubai Health Post Office (DHPO).

Dubai basic plans v/s enhanced plans

- There is coinsurance and co-pay in basic plans for OPD services
- Premium is high for enhanced plans
- Annual limit for drugs is more in enhanced
- Basic plan has a waiting period of six months for chronic cases
- Maternity is covered in both but with coinsurance in basic
- Wider is the network of hospitals in enhanced

E-claim portal

- **E-claims-**Submitting claims on the system rather than submitting paper claim forms.
- **ERX-**From the e-claim portal, drugs and diagnosis is selected by the provider. He prepares prescription and gives numeric code to the patient which is unique.
- **PBM-**Software called pharmacy benefit management. Pharmacist opens PBM and submits this code. He goes through the details of the patient like the network, policy and approval limit of the patient and submit the approval request to TPA through a code unique to the TPA
- **E- referral-** At first patient has to go to GP and only then he will be referred to SP through E-referral.
- **E-authorisation-**For any lab tests, x ray and for all the services approval is given online.

Aafiya, medical billing services LLC

- TPA has license from insurance authority(Fial)
- Member of emirates insurance association
- Its an unconditional TPA that is it has license to administer Dubai basic plan
- Departments of Aafiya

1 .Networking

2. Operations

   a. Production

   b .Approval

   c. Call centre

   d. Claims

   e. Grievances

3. Accounts

4. Relationship management

Objectives

- To assess the functioning of various departments with respect to the standard working processes.
- To understand the status of claims in TPA.

Methodology

- Primary source of data-Interviews and discussions with the staff of TPA to understand the process flow and the complaints they receive from the providers and patients
- Secondary source-From MIS(from 15th October to 31st March) and convenient selection of 500 claims
- Study design-Descriptive to understand the process flow and analytical to study reasons for rejection and types of cases and claims from each network
- Type of data-Quantitative
- Data collection tool-For understanding the process, reasons for rejection and complaints; observing the steps and discussions with staff was done along with the data from MIS.
- Data collected

1. Number of OP and IP cases
2. Number of claims from each network
3. Reasons for rejection of claims
4. Types of diagnosis

- Ethical consideration-Purpose of study was explained to staff and confidentiality of data collected was taken care of

Networking

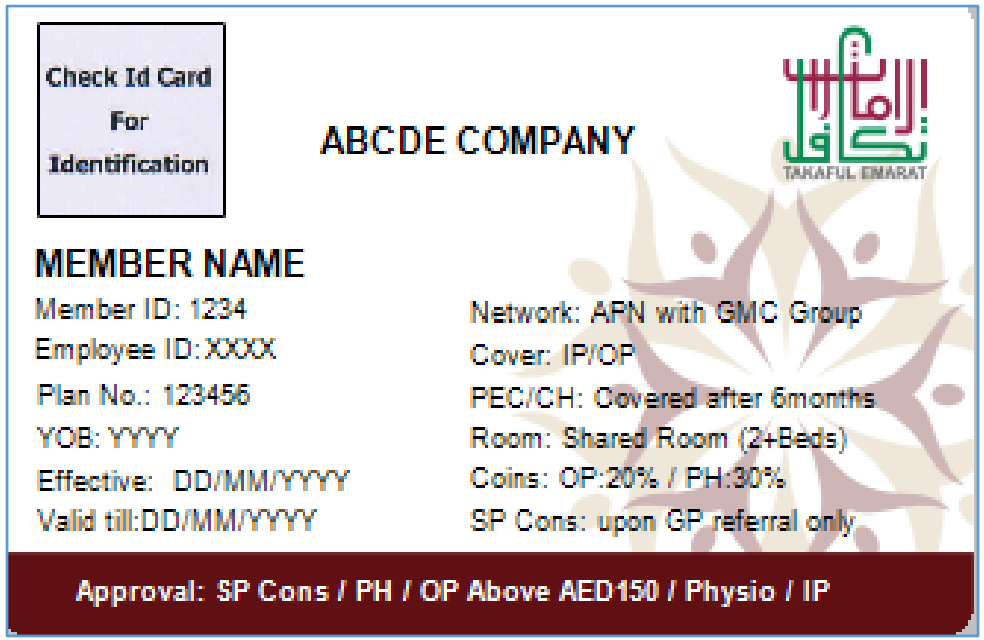
- Different pricing for different network
- Base rate is the agreed tariff between providers and TPA
- Member has choice of enrolling for any network depending on salary
- Rates are lower than cost for non insured
- Inclusion and lives decides performance of a TPA
- With higher category of networks, premium amount increases
- Not includes hospitals of Abu Dhabi and Alain
- Guides patients to health facility depending on their network

Production

- Member enrolment
- Insurance companies coordinates with production department
- Policy name and its client list, pricing details, photos of members, policy certificate and table of benefits/plans
- Issuance of medical card to members
- With enhanced plans,

1. Premium increases
2. No limits and coinsurance for maternity and other services
3. No waiting period for chronic
4. Network varies/geographical scope increases
5. No limits and coinsurance for medicines

Medical insurance card



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-authorisation

- Medical professionals to keep a watch on escalated cost by providers

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

Process flow

From providers' side

- Propose treatment or medicines via mail or calls
- Estimated cost is mentioned

Approvals department

- Goes through policy certificate, if medically justified approves
- Approved amount is sent to provider

Providers

- Proceed with the procedures or dispense the drug
- Receive deductibles/co-payments from patients

Grievance redressal

- From patients, insurance company or brokers
- Via telephone, e-mail
- 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

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.

Types of complaints

- Delay in approval
- Denial of approvals
- Long waiting period in facility
- Delay in payment
- Claims rejection
- Denial of coverage
- Wrong card details
- Related to policy terms
- Administration or operational procedure

Claims

Claims administration

1). Direct billing

Present original medical card to provider

Doctor consults patient and fill the claim form and return to patient

Member pays deductible or coinsurance to the provider

2). Reimbursements(only for enhanced plans)

Patient takes the treatment at the hospital

Patient pays to the hospital for the services

Patient submits the documents to TPA

Claims processing

Batching

- Providers send claim form, lab reports, invoice, card copy, approval form
- Payer wise batch number is assigned with total claimed amount

Entry

- Service date, doctor’s name, patient’s complaints, diagnosis, and the cost of the treatment or drugs is fed in the system
- Claim number is generated which is unique to a claim

Review

- Medical adjudication is done, agreed tariff, status of member, plan type, approval status, coverage and exclusions are checked
- Acknowledgement letter, Provider claims payment bordearu and Cheque is attached

Claim entry and review

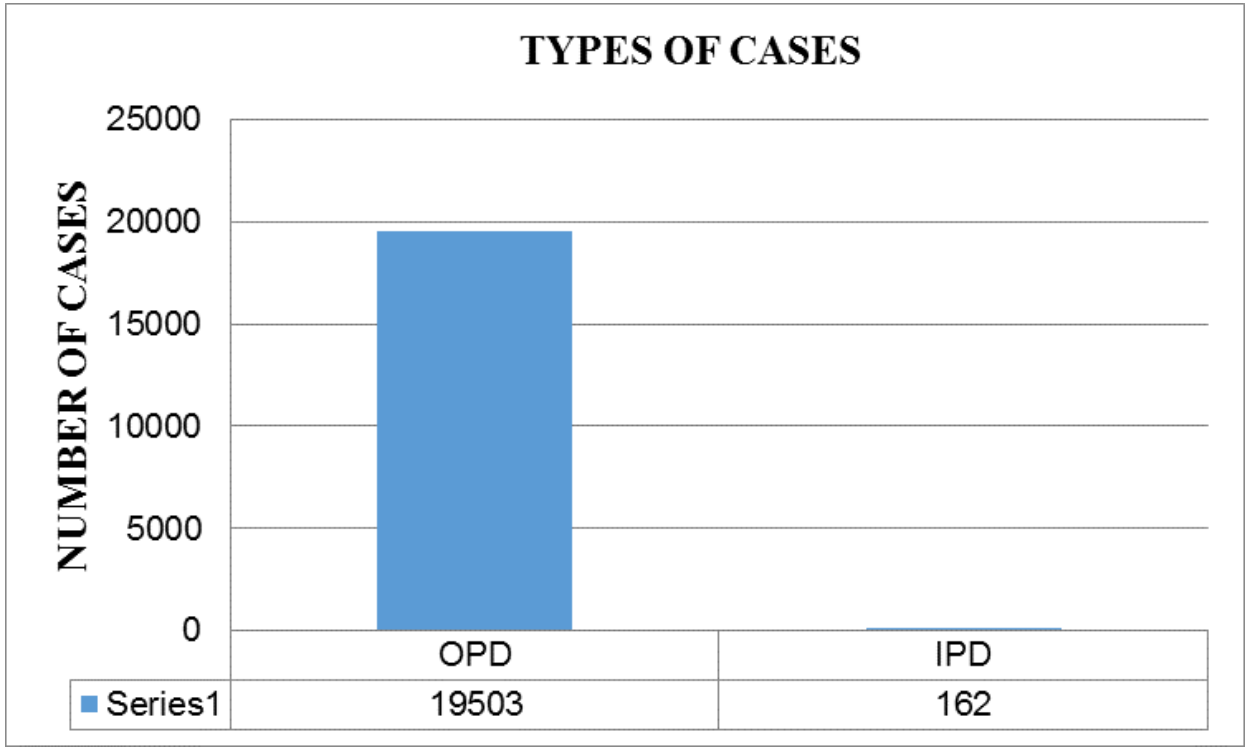
CPT code	Description of services performed(eg incision,repair,glucose test etc)	Service type(consultation,dental,lab,procedure,ECG, radiology)	Discount	Copayment	Net amount

CEED review, total cost claimed, per service distribution of cost is checked

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

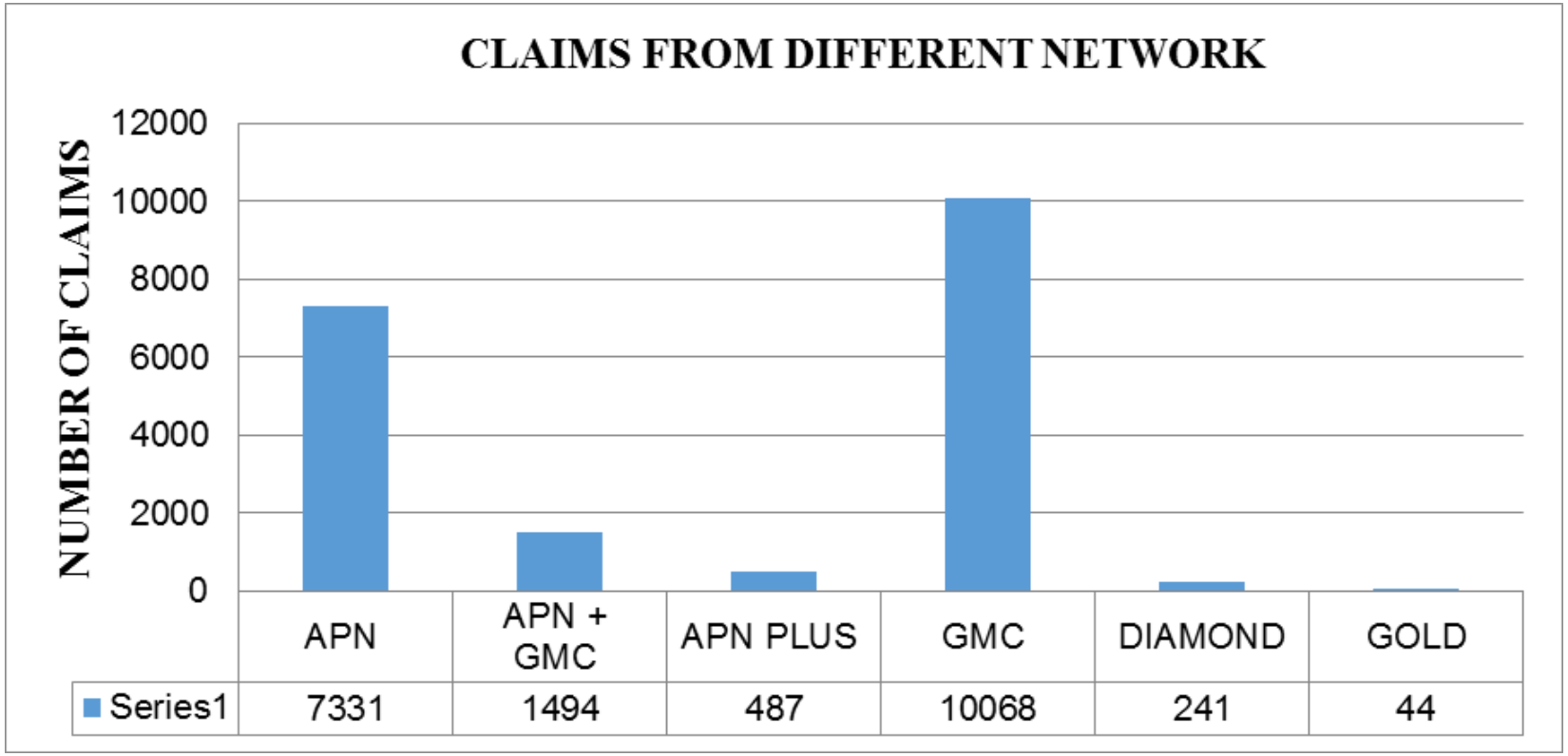
Findings of data on status of claims

Types of cases-Majority of cases are of out-patient departments



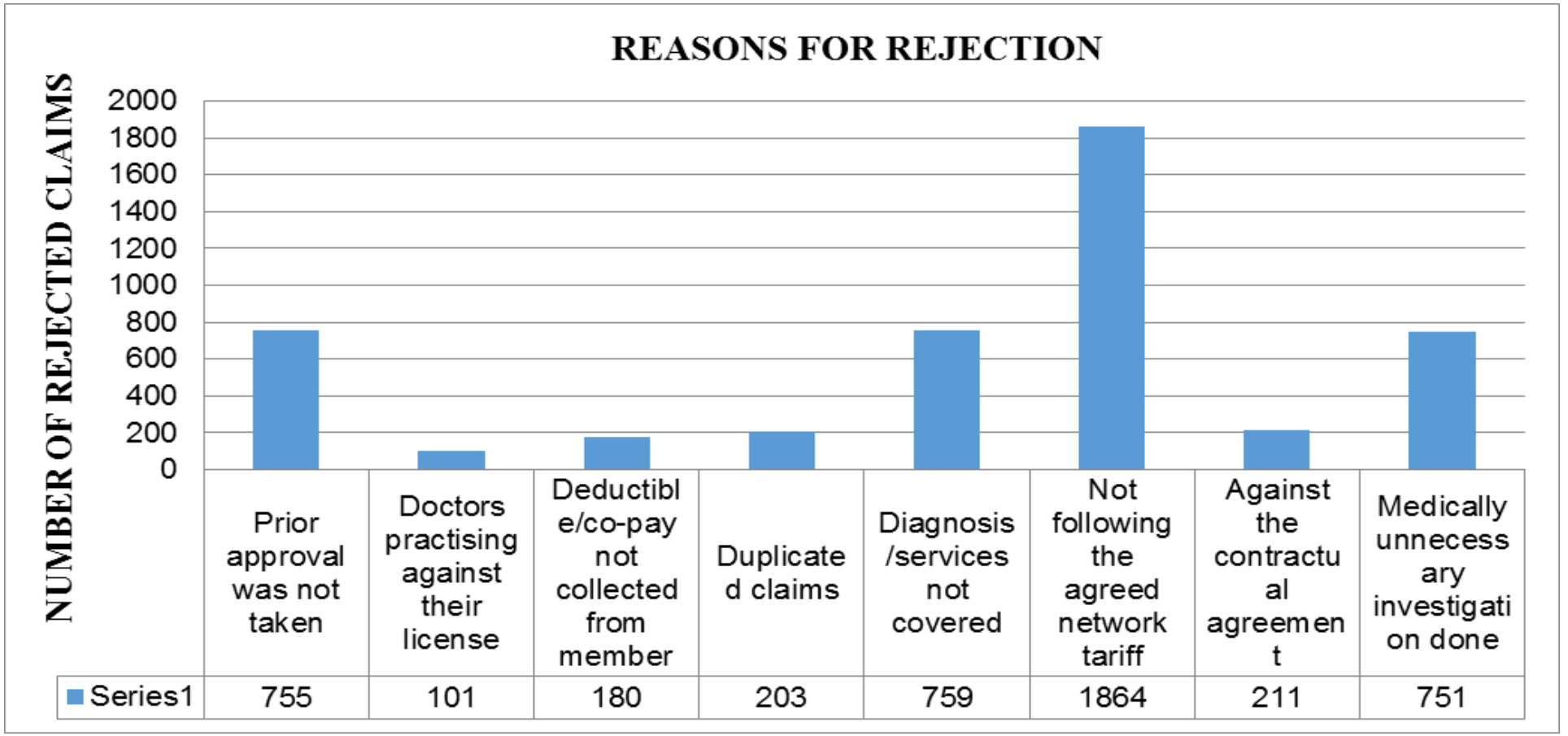
Network category

Majority of claims are from GMC network

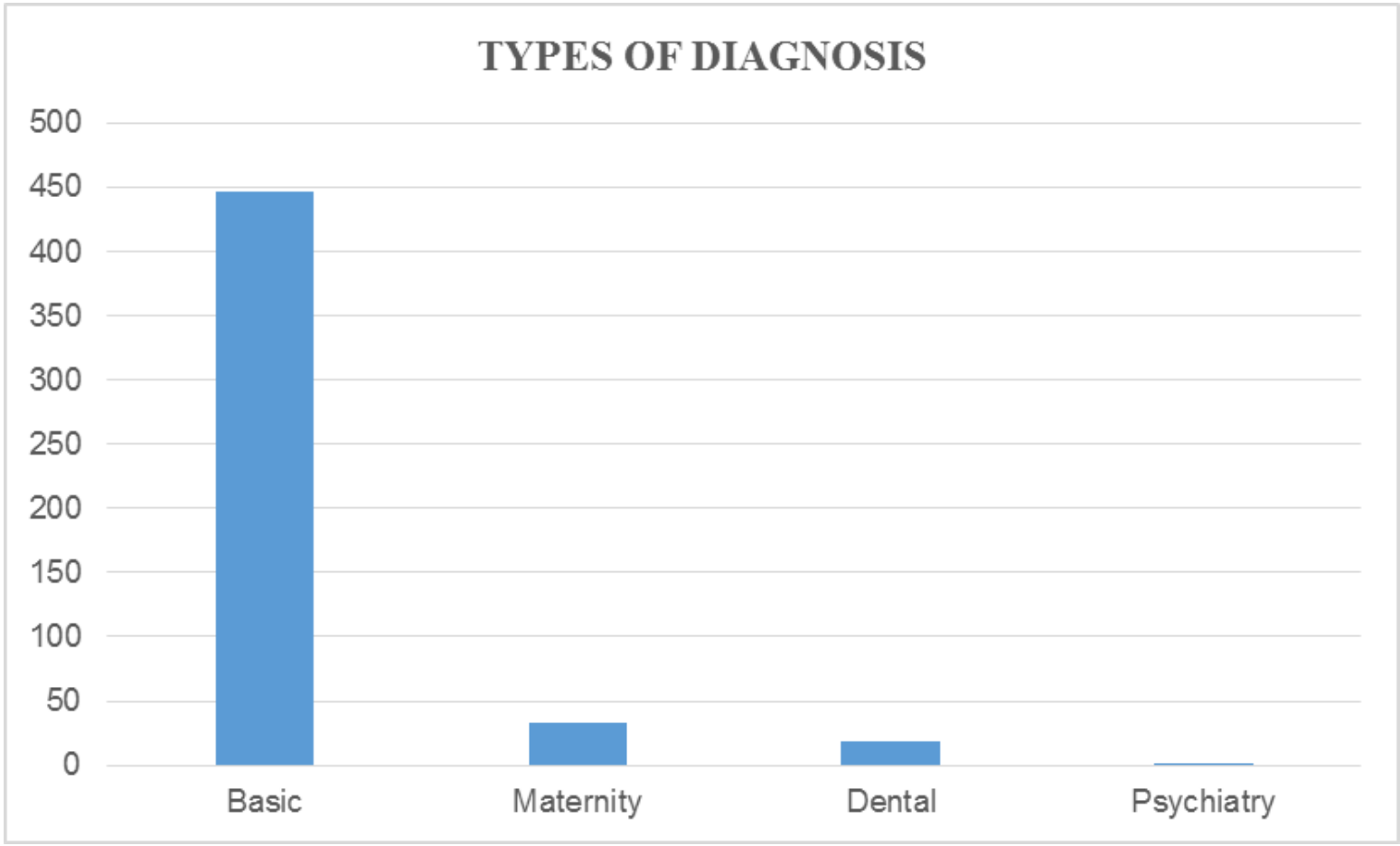


Rejection reasons

Majority of rejections are because of doctors not following the agreed base rates

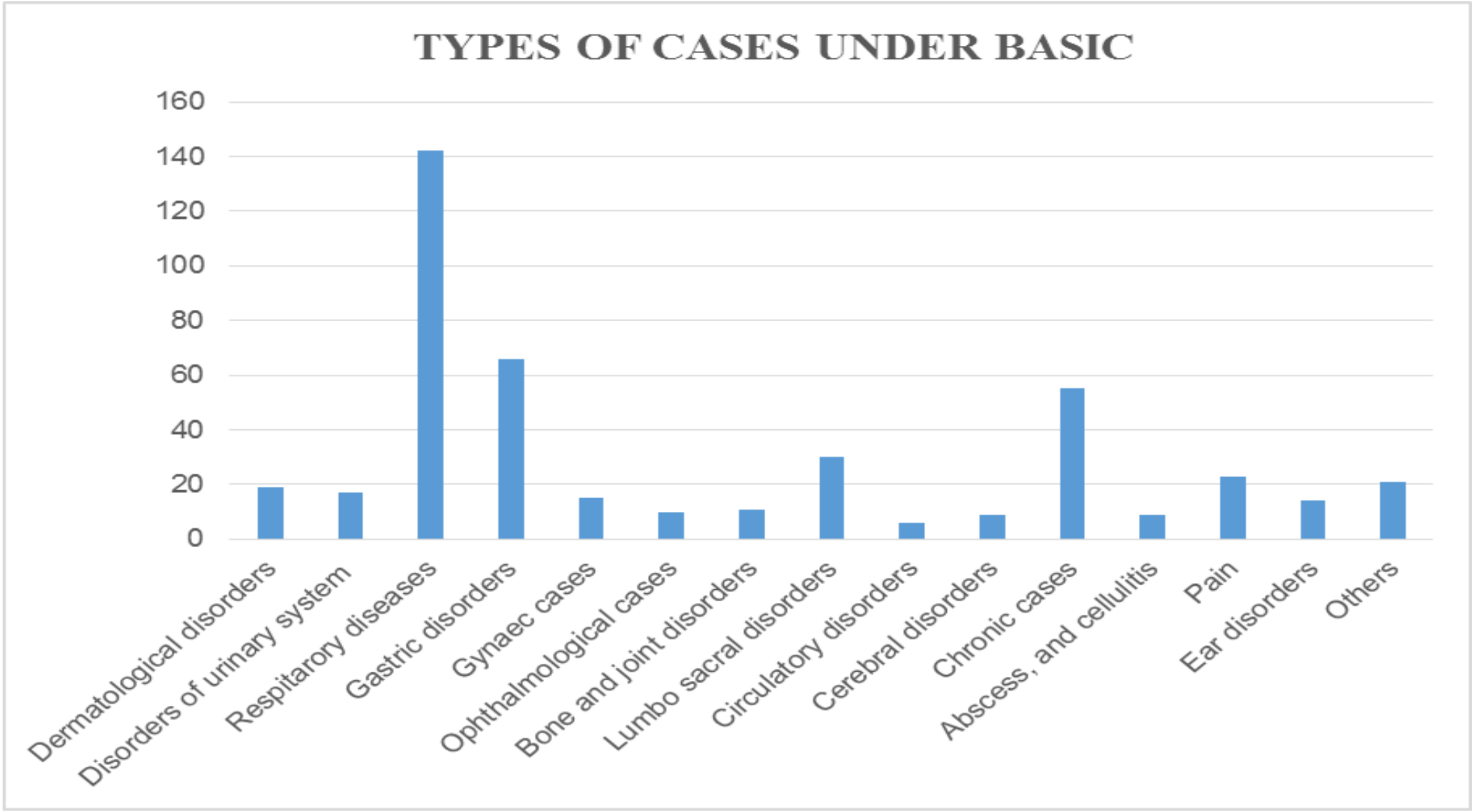


Out of 500 claims which were selected on convenient basis



Majority of cases were of basic category. Next comes maternity and then dental. Psychiatric cases are least.

Different types of basic cases found in out patient



Interpretation

- Shows disease burden in general population
- Majority of cases are related to respiratory problems like pharyngitis, respiratory tract infections, asthma etc.
- Next are digestive disorders like gastritis, colitis, enteritis, haemorrhoids etc.
- Chronic cases like hypertension, diabetes and hyperlipidaemia are still a burden like it is globally
- Understanding disease burden helps in targeting the common causes

Advantageous position and sales strategy

- Providing OP access to hospitals in basic plan
- Keeping agreed tariff lower and providing discounts
- Different cost and co-payments under different networks checks overutilization of services
- Time to time maintaining a record of KPI keeps a track of performance of the organisation
- Training of GPs so as to promote conservative management(generic drugs and symptomatic treatment)
- Audits in health facilities to keep a check on frauds

Conclusion

- E-referral, E-prescription, E-claims, E-approvals(PBM)to fasten the process and keep control
- GP consultation before SP to reduce overcrowding and bypassing
- OP can be covered if governing bodies checks on overutilization by bringing in co-payments per encounter of services basis
- Premium is fixed for basic plans which prevents increase in premium from insurance company
- Base agreed tariff prevents cost escalation from provider’s side
- Different networks for different income strata of people depending on premium, co-payments and annual limits so that cost is justified accordingly