WAITING TIME IN PHYSIOTHERAPY APPROVALS AT GMC HOSPITAL AJMAN, UAE

Dissertation
At
GMC Hospital and Research Centre, Ajman, UAE

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Jaipur
2015

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

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TO WHOMSOEVER MAY CONCERN

This is to certify, Rajesh Pathania student of MBA Hospital and Health Management (2013-2015) from The IIHMR University, Jaipur has undergone internship training at GMC hospital Ajman U.A.E from 4th April 2015 to 13th May 2015. The Candidate has successfully carried out the study designated to him during internship training and his approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.
I wish him all success in all her future endeavors.

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GMC HOSPITAL
"Healing through knowledge and wisdom"

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This is to certify that **Dr. Rajesh Kuldeep Singh** holder of Indian Passport Number Z2675587 was working in our institution as Management Trainee from 4th April 2015 till 13th May 2015, as a part of dissertation of his P.G.D.H.M program. He has completed the assigned project.

We wish him all the best.

For **GMC Hospital and Research Centre, Ajman**

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ABSTRACT

Title: WAITING TIME IN PHYSIOTHERAPY APPROVALat GMC Hospital Ajman, UAE

Name of author: **DrRajesh Pathania**

Introduction: Standards of health care are considered to be generally high in the United Arab Emirates, Compulsory health insurance is emerging in UAE. Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses among targeted group, an insurer can develop a routine finance structure

Health Insurance works based on mainly 2 types of policies

- Group policies
- Individual policies

There are 4 major players in Health Insurance system

- Payer
- Provider
- Insured
- TPA

A health care provider is an individual or an institution that provides preventive, curative, promotional or rehabilitative care services, hospital has a dedicated department to offer quality and affordable specialized superior medical care to the members of most of the insurance companies through Insurance department.

Many times patient have to pay out of pocket in spite of having health insurance coverage due to the rigid process followed by the healthcare provider to take approval from insurer. When the claim process is rigid, many times it ends up with increased turnaround time and high denial rate leading to decreased efficiency of provider. Hence planning the process is very necessary in order to fight the above said challenges.

Aim of the study:

- To reduce turnaround time
- To smoothen the approval process
- To increase efficiency

Objective:

To find out the time taken for approval from :

Service request to service delivery

Service request to submission of service request.

Submission of service request to approval by insurance company.

Approval of service request to informing the insured patient.

Informing the insured patient to service delivery

Methods: For the purpose of study, secondary data was collected through daily.sevice requested from physiotherapy department.

Results and recommmentendations: After analyzing turnaround time for physiotherapy approval, main reasons are identified which causes delays in approvals. There is delay in sending the service request to insurance company. It takes three days to send the request and two days to get the approval from company's side. Office boy takes one day to inform the patient after update. Patients avail the services after one day. It takes time to reply the queries ,arises from insurance company side. If we will reduce this time the total average time automatically reduce from seven days. Frequently queries also increased the waiting time. Training of staff on insurance helps to increase the efficiency of organization .Que/token system helps to manage the high flow of outpatients. Online system should be there to reply the queries.System generated messages should be use to inform the patients.

Conclusion: seven days are taken for approval of physiotherapy service delivery. Mostly time taken in sending the service request to insurance companies and getting the approval from thereside. .Queries are reflecting the waiting time of approval process. Managing the outpatient flow through queue/token system..

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Dr Rajesh Pathania

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1	GMC	Gulf Medical College
2	UAE	United Arab Emirates
3	JCI	Joint Commission International
4	TPA	Third Party Administrator
5	NGO	Non GovernmentOrganization
6	HMIS	Hospital Management Information System
7	AMA	American Medical Association
8	VSM	Value Stream Mapping
9	Min	Minutes
10	Hr	Hour
11	Avg	Average
12	AED	Arab emirate dirham
13	MRD	Medical Records Department
14	LAB	Laboratory
15	HOD	Head Of Department
16	IRDA	Insurance Regulatory and Development Authority

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DISSERTATION REPORT

1. INTRODUCTION

In current times medical costs are sky rocketing, and not having or having inadequate amount of health insurance cover can prove to be a huge financial disaster. If an individual is unable to afford proper health care it could lead to poor health.

1.1 Health insurance

Health insurance is insurance against the risk of incurring medical expenses among individuals. By estimating the overall risk of health care and health system expenses, among a targeted group, an insurer can develop a routine finance structure, such as a monthly premium or payroll tax, to ensure that money is available to pay for the health care benefits specified in the insurance agreement.

According to theHealth Insurance Association of America, health insurance is defined as "coverage that provides for the payments of benefits as a result of sickness or injury. Includes insurance for losses from accident, medical expense, disability, or accidental death and dismemberment"

Standards of health care are considered to be generally high in the United Arab Emirates, resulting from increased government spending during strong economic years. Health care currently is free only for UAE citizens. UAE has seven Emirates.

Compulsory health insurance is emerging in UAE, The aim of the Law is to create an integrated health system for UAE, based on a sustainable financing system that supports the competiveness of Dubai and protects the rights of all participants

The implementation of the health insurance is linked to various socio-economic factors such as ensuring the entire population with minimum coverage at reasonable costs, guaranteeing the healthcare services and infrastructure capacity, safeguarding the system from all abuses and fraudulence, and empowering the financial base with sufficient flow of funds.

1.2 Basics of Health Insurance

Health Insurance works based on mainly 2 types of policies

- Group policies - Insurance that covers a group of people, usually who are the members of societies, employees of a common employer, or professionals in a common group.
- Individual policies – Policies bought by individuals to cover the expenditure of one’s own health

The health care expenditure is covered through these policies by purchasing through premiums; premium is the amount you pay for the coverage. The range of coverage for expenses varies depending on the type of plan. You can purchase the insurance directly from the insurance company through an agent or through an independent broker but most people get their insurance coverage through employer-sponsored programs.

Aside from premiums, there are other costs associated with health insurance coverage.

Deductible: The amount that you pay out of pocket. Generally, the higher the deductible, the lower thepremiums.

Co-insurance: The percentage of covered expenses paid by the medical plan. The co-insurance amount is per family per calendar year.

Co-payment: Sometimes referred to "co-pay", this is a set cap amount that you will pay each time you receive medical services. The co-payment and the coinsurance are not one in the same. If the share of insurer and insured is 80:20 respectively then 80 is coinsurance and 20 is copayment.

1.3 Framework of Health Insurance

There are 4 major players in Health Insurance system

- Payer
- Provider
- Insured
- TPA

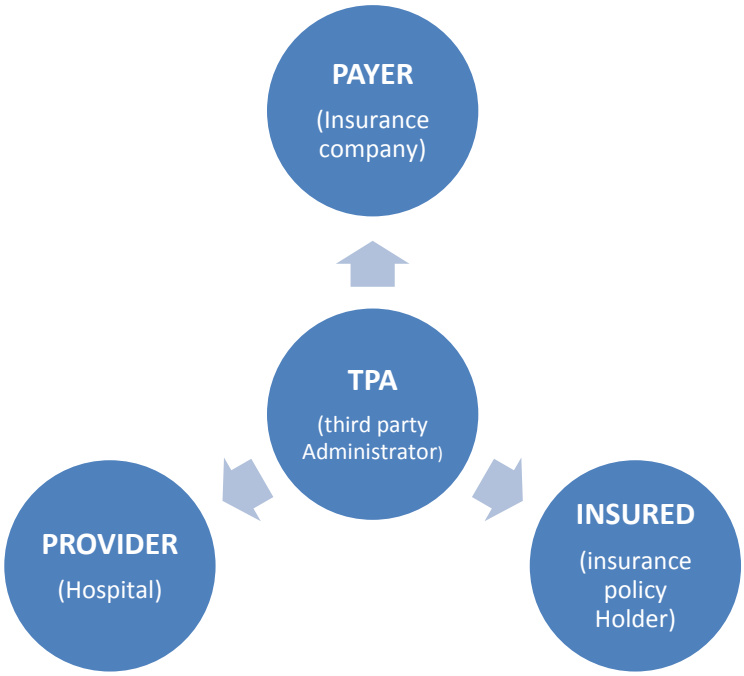


Figure: 1
Framework of Health Insurance

Payer/Organizer/Insurer

The insurer is the entity that manages the fund and takes the risk. The insurer develops the product and manages the risk, so that the insured get their benefits. The main role of payer is to orchestriate the various stakeholders and takes responsibility for the operations. This would include creating awareness, collecting and pooling revenue, purchasing healthcare, reimbursing claims and monitoring the entire program. It plays a dual role of governance and administrator.

TPA (Third Party Administrator)

A Third Party Administrator is an organization that. This can be viewed as "outsourcing" the administration of the claims processing. It could be an entity with government or it could be a Para state body or an NGO. It acts as a broker between provider, payer and Insured.

Insured

A person whose interests are protected by an insurance policy; a person who contracts for an insurance policy that indemnifies him against loss of life or health etc.

Major Health insurance companies in UAE

Provider/Hospital

A health care provider is an individual or an institution that provides preventive, curative, promotional or rehabilitative care services in a systematic way to individuals, families or communities.These may be public or private healthcare providers.

2. HOSPITAL INSURANCE DEPARTMENT

The hospital has a dedicated department to offer quality and affordable specialized superior medical care complemented by a warm and personalized human touch to the members of most of the insurance companies through Insurance department.

This Department is staffed by a team of expert professionals who assist in administering to the needs and queries of patients holding insurance cards.

Roles and Responsibilities

- Communicating and guiding the patients regarding the Insurance process
- Coordinating with insurance companies for initial cashless approvals
- Coordinating with various departments and doctors for handling the queries of insurance companies
- Verification of the documents before submission for claims
- Coordinating with finance department for billing process
- Justifying the rejected claims for reconsideration
- Negotiation with different insurance companies for the tariff and price list of different procedures
- Maintaining all the patient documents with confidentiality
- Maintaining the documents of hospital related to insurance

2.1 Process flow of insurance department

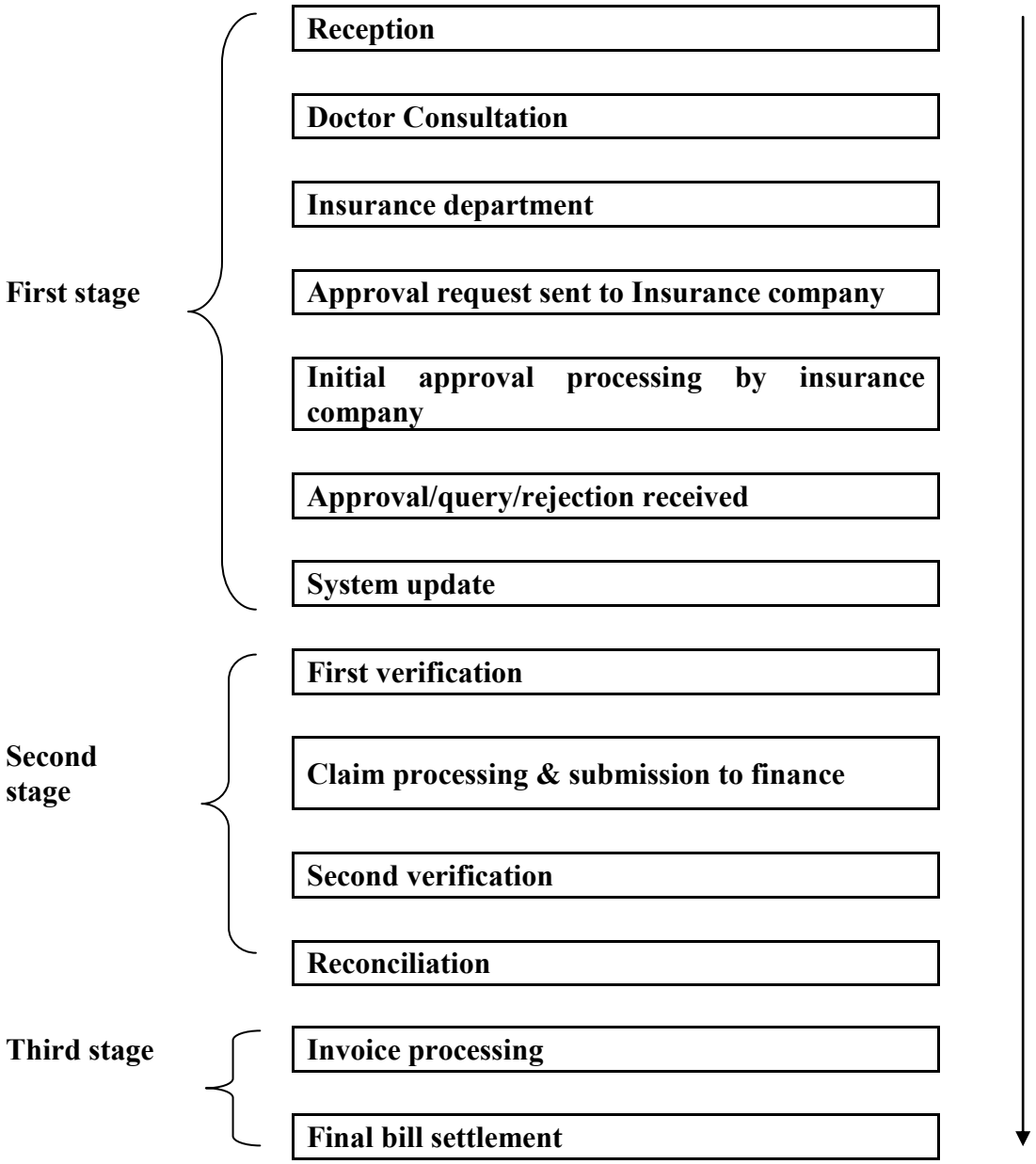


Figure: 2
Insurance department Process flow

2.2 Process of Insurance Claim

The process flow of the Insurance claim can be divided in to 3 major headings

Stage 1: Approval Process

The patient entering the hospital are of 2 types – Out patient/Inpatient, Patients with valid Insurance card are guided to Hospital reception to generate the unique hospital Id, followed byinsurance department in case there is need of approval for consultation or else he is directed to the consultation, depending up on the prescription of doctor the request is generated.

Patient brings the request to insurance department, the request is received and the approval process is initiated. Request is approved based on the terms and conditions of the respective insurance policies, viz some are directly approved as the price of request is less than the limit of approval required.

Requests of outpatients and inpatients are as follows

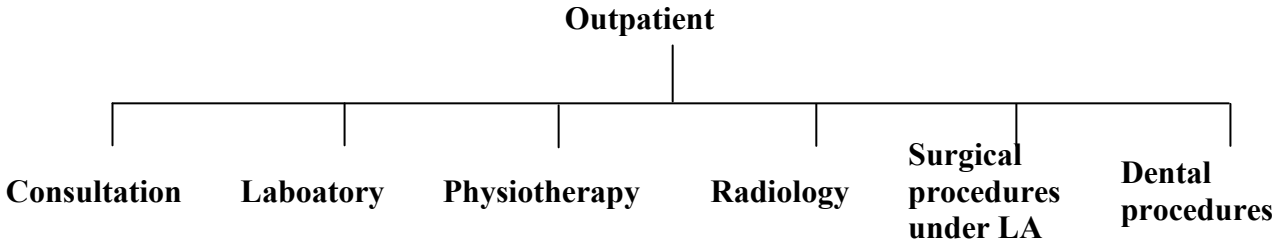


Figure: 3
Outpatient requests

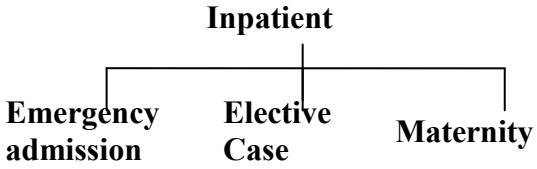


Figure:4
Inpatient requests

Those requests which require approval are processed verbally or through written approval

Verbal approval: Those which need verbal approval are processed by calling insurance company, explaining the case, mentioning the requested prescriptions, mentioning the total amount in turn taking approval/rejection and updating the same in the HMIS

Written approval: Those requiring written approval are kept for processing by taking the phone number of patient for intimating the status, patient is given a time of 2 days and the documents are sent to insurance company through mail/fax/online platforms, insurance company replies back either for query/ rejection/ approval. Queries are replied by referring to medical records or doctors etcwhere as rejections and approvals are updated in the HMIS and patient is given a call for collecting the document and procedure for the procedure the doctor has prescribed.

The time taken for this initial cashless process has huge variation of 30 min to 3days depending on the insurance companies.

Stage 2: Verification & Reconciliation

The process of verification and reconciliation is to decrease the rejections from insurance companies.

The process has 3 basic steps

- First verification
- Claim processing
- Second verification and reconciliation

First verification: The documents processed by initial approval process are verified for the approval code/ written approval copy, in the absence of which the document is sent for approval and approval code/ written approval copy is taken.
Claim processing: In this process all the documents are confirmed before sending to finance department for claiming the bill.
Second verification & Reconciliation: The rejections and the reasons for rejections are verified accurately and replied back to the insurance company with proper justifications to reconsider and approve the rejected amount.

Stage 3: Invoice processing and Final bill settlement

This process is more related to the accounts and finance department, where in all the bills and invoices are gathered, verified and sent for insurance company for final settlement of the claimed amount.

Background of challenges & problems

Challenges faced are of long waiting period for the patients, patients wander between departments for the process, rejections due to improper submission and improper justification of the approval request, untimely intimation of the status of approval request to the patient, time spent in checking the status of the approval request, time spent in referring the records of patient, time spent in collecting the medical report/justification of the request from doctor

The reason for the above said challenges are rigid approval process and improper work distribution which ultimately leads to increased tat or rejection.

2.3 Problem statement

In current times medical costs are sky rocketing, and not having or having inadequate amount of health insurance cover can prove to be a huge financial and health disaster. Many times patient still have to pay out of pocket in spite of having health insurance coverage due to the rigid process followed by the healthcare provider to take approval from insurer.

When the approval process is rigid, many times it ends up with increased turnaround time and long waiting time for insured patient. Patients has to pay high opportunity cost.Hence planning the process is very necessary in order to fight the above said challenges.

2.4 Aim

- To reduce turnaround time
- To smoothen the approval process
- To increase efficiency

2.5 Objective

- To identify the reasons behind high turnaround time and rejection of mediclaim in GMC Hospital
- To identify the policy level ambiguities leading to high mediclaim rejection
- To suggest measures to reduce turnaround time and rejection rate of mediclaims in GMC Hospital

3. Literature review

Comparatively Health insurance coverage is high in developed countries like USA, UAE, Canada, but there are very few reports and work done on the rejection rate and process improvement of Health Insurance claim processing. Few of the literatures worked on rejection rate and process improvement are as follows.

A reporter of Kiser Health news (Galewitz P) through his report has given overview of rejection rates of different insurance companies in America - Kentucky, Columbia.The findings of the report in this context are the denial rates of different insurance companies, comparison between the policies, reasons for the variations in rejection rates, as per the report the reason for variation is difference in claims process adopted between the payers and providers.

A similar study conducted in 2011 (Carmel P.W) gives details about the denial rates, comparative data of before and later stages, and the reason of betterment in America. The key findings of report are health insurers shows that claims denial rates in 2011 are dramatically lower than in previous years.Billions of dollars per year are saved by eliminating administrative waste, by processing the claims timely, accurately and specifically.Health insurers' claims-payment processes are still littered with inaccuracies and inefficiencies. Claim process campaign was introduced; campaign's goal is to spur improvements in the industry's billing process.

Accumed Pm is a TPA; it works on the gap between healthcare providers and service payers. The report made by accumed pm says the gap between health care providers and service payers has been well established and clearly defined in the United States, Canada and Europe, this relationship has yet to mature in the Middle East. The result is lost money and poor business management. As per the report In the UAE it is estimated that up to 15% of claims submitted to insurance companies by private practices are rejected. Another 15% of claims are delayed because of inappropriate processing of claim forms and supporting documents. The average claim payment cycles are between 90 and 120 days.The report works on medical coding, billing, insurance validation, financial and business management through assisting healthcare providers by optimizing healthcare delivery and operational processes.

A report (by Xerox) made aggressive 75 days study with data capture services of over 250000 claims per week. Report gave solution through a smart system to auto-adjudicate claims, processing cycle time was accelerated by 75 percent, from 10 days to 60 hours. Report worked on Implementation of state-of-the-art technology to perform all claims processing services, including full mailroom services, data entry, storage and retrieval, digital imaging, x-ray processing, online updating and Intelligence Queue/Data Cleansing.

4. METHODOLOGY

4.1 Study design and methods

- Type of study – quantitative study
- Location of study – GMC Hospital, Ajman
- Study subjects – All Approval request received between 14 March 2015 to 05 may 2014.
- Sample size -162 service request.
- Data collection method-Review of secondary data through records and HMIS.

Study period – 04 April 2015 to 13 May 15

4.2 STUDY PLAN

Project process flow chart

Figure: 5
study plan

Initial 10 days, with the assistance and guidance of the existing staff the process of insurance was observed and learnt, the gaps were noted down, a process flow chart was made for clear understanding of the process of insurance department, out of which a

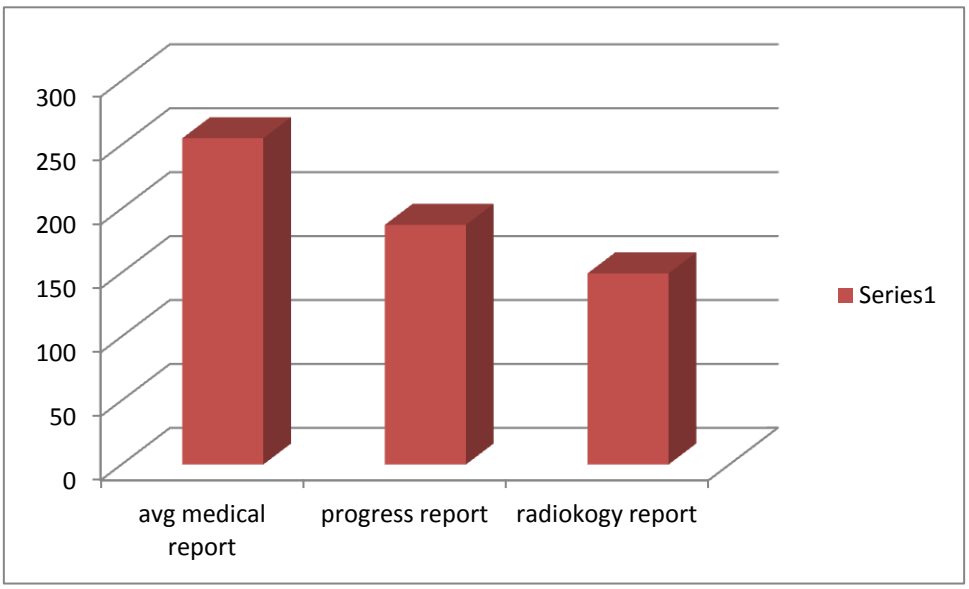
deep study was made through value stream mapping to explore the problems and rigidity of process in each minute steps of the process. Out of the need for the same a tool was made to collect the data of daily receivedapproval request and the cases were tracked for the turnaroundtime and their reasons. Causes were identified in the process, probable solutions were recommended for improving the process, reducing turnaround time.

Insurance companies in UAE which having the agreement with the GMC Ajman hospital .

1	AL BUHAIRA NATIONAL INSURANCE	
2	AL DAFRA INSURANCE	
3	AL KHAZNA INSURANCE	
4	ALMADALLAH INSURANCE	
5	AMITY COMERCIAL BROKER LLC	
6	ARAB ORIENT INS CO ALLIANZ WORLDWIDE CARE	
7	ASCANA INSURANCE	
8	AXA INSURANCE	
9	DAMAN INSURANCE COMPANY	
10	DUBAICARE INSURANCE COMPANY	
11	FMC NETWORK UAE	
12	GLOBALNET TPA LLC	
13	GLOBMED GULF FZ-LLC	
14	INAYAH TPA	
15	INTERGLOBAL LIMITED	
16	MAXCARE LLC	
17	MEDNET INSURANCE	
18	MSH INSURANCE	
19	NEURON INSURANCE	
20	NEXTCAR INSURANCE	
21	NGI INSURANCE	
22	NOW HEALTH INTERNATIONAL	
23	OMAN INSURANCE	
24	PENTACARE INSURANCE	
25	WAP MED INSURANCE	

Table:2

Graph 1:average time taken to respond the queries queries.

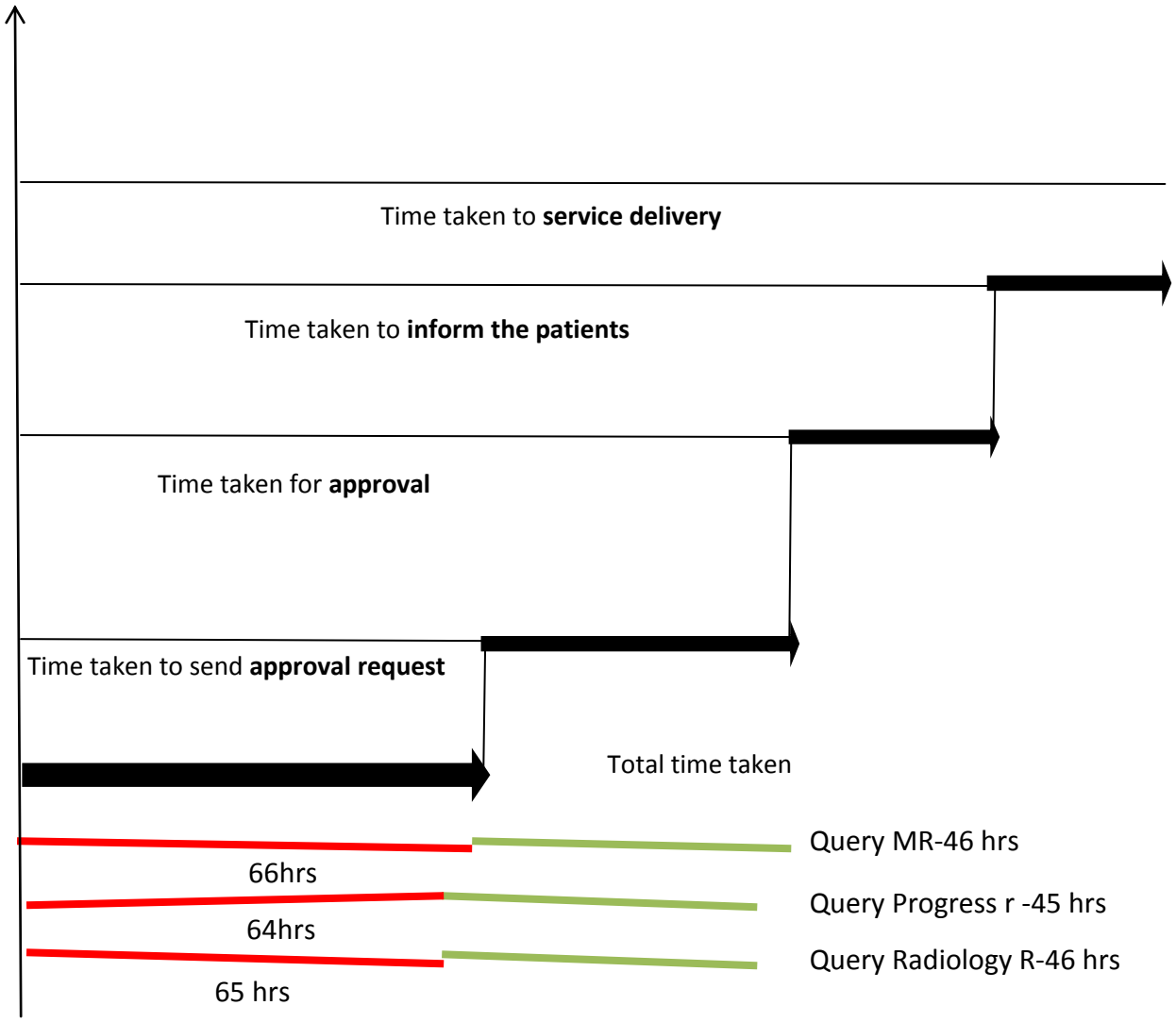


❖ **Average time taken to respond-**

Medical queries -10 days

Progress report -7 days

Graph 2**:** average time of queries reflecting the tat of physiotherapy.



Time taken between service request to insurance company

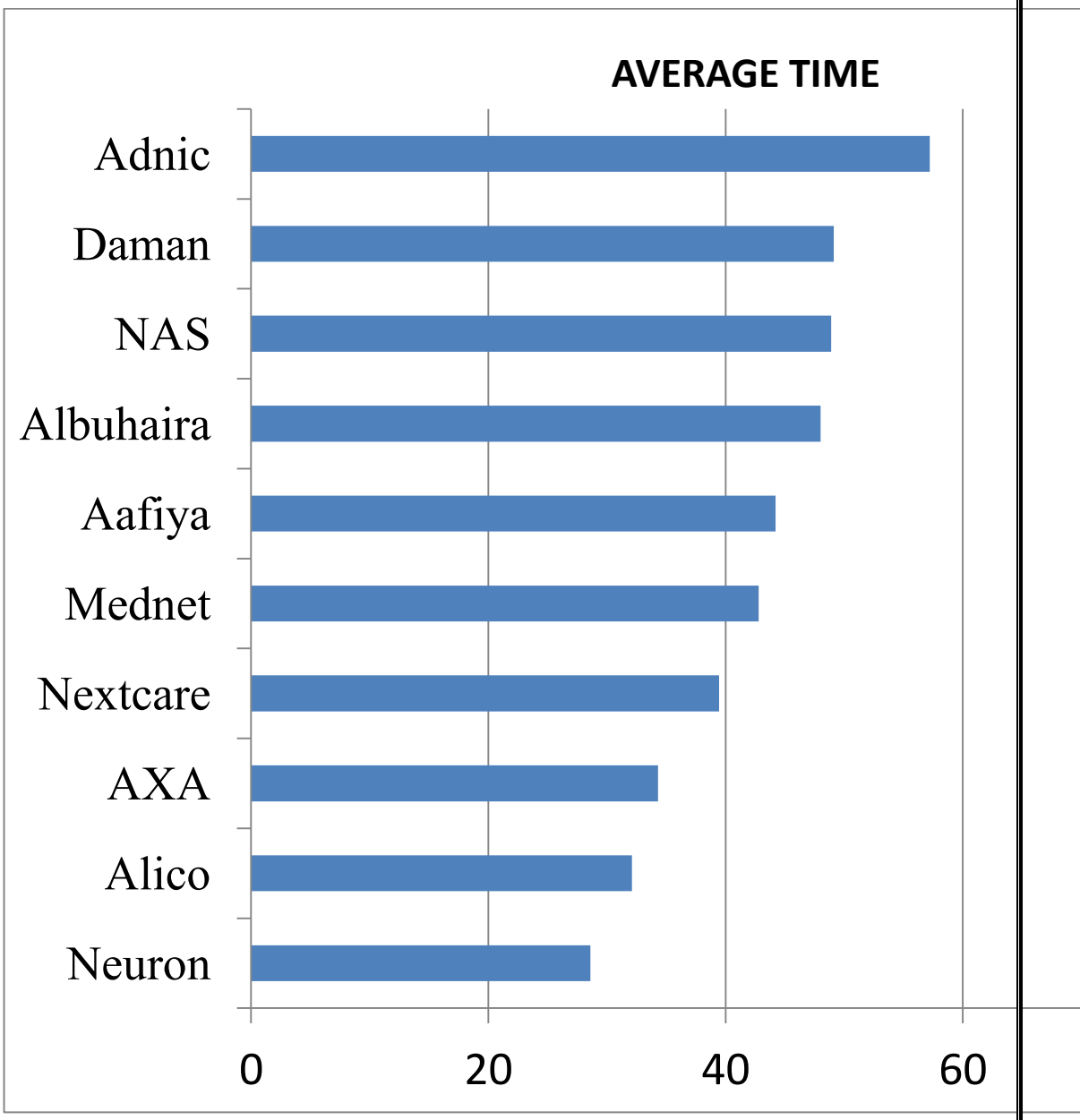
Time taken for the request to get approved

Average time taken between :

- Submission of service request by patient and sending for approval to insurance company is 3 days (65.9 hrs).
- Sending the service request and getting the approval by insurance company is 2 days(47.3 hrs)
- Approvals and inform to the patient 1 day (28.1 hrs)
- Inform to the patient and start the procedure is 1 day (24.4 hrs)

.**Total average time taken between** :

Submission of service request and start the procedure is 7 days(165.7 hours**)**



Insurance companies taking maximum time for approval:

ADNIC - 57.1 hours

DAMAN - 49.1 hours

NAS - 48.9 hours

Insurance companies taking maximum time for approval:

ADNIC - 57.1 hours

DAMAN - 49.1 hours

NAS - 48.9 hours

Insurance companies taking minimum time for approval:

NEURON - 28.6 hours

ALICO - 32.1 hours

AXA - 34.3 hours

Findings:

Average flow of insured out patient is very high:

Mostly patients in U.A.E. are insured by the insurance companies.Patients come with different request from different departments.It leads to heavy out patients flow.Itcauses delay in sending requests and getting the approvals.

Shortage of manpower:

Insurance department has shortage of manpower.it will leads to the delay in whole process of approval.shifting duties of approvals team leads to miscommunication between approval team and with the other staff.

Outpatient approval team have to attend the phone calls of:

Patients: patients calls on hospital extension number to know the approval which are transferred to insurance department. It creates over burden to approval team.

Departments:

Approvals team have to take calls from different departments like LAB.,O.P.D RECEPTION.,RADIOLOGY,DENTAL RECEPTION,PAD,RECEPTION.

Initiate verbal approvals: Approval are also taken verbally for consltation,labtests, emergency cases.

Some companies get the service request through faxes ,for them verbal approvals have to be taken during follow up. It leads to the increase in waiting time in approval process.

Delay in update of :

Medical reports:

Doctors have to give the medical reports .Office boy has to collect the medical reports from doctors. Doctors are on shifting duties,due to this office boy could not collect the medical reports on the time. Frequent queries arises in physiotherapy caes which has to be replied soon.

Progress report:

Progress report has to be issued by physiotherapy department.there is no online system to send the progress report.it takes time to issue the progress reportto insurance departments.It delays the approval process.

Radiology report:

Insurance company frequently asked for X-ray report.mri,ct-scans.But if these reports are not uploaded on HMIS on the same day, leads to increase in waiting time.

- **Delay in follow up of queries.**

  There is shortage of employees, it will leads to the delay in follow up of sending requests**.**

- **Recommendations:**

  - **Queue/token system.:**

    Queue/token system should be in the insurance department.It will be helpful to reduce and manage the heavy outpatientflow.approval team gets the time to send the approvals of physiotherapy on same day. It will helps in reduce the mess-up of patients and smooth functioning of the department.

  - **Training of staff on insurance mainly :**

  - There should be training of all departments on basic insurance. It will be helpful for appropriate information. It will increase the organization efficiency**.**

- **Reception:**

This department deals with patients and inpatients. Training on insurance will increase the efficiency of employees. It will reduce the flow of patients on o.p.d and approval team. It will decrease the time which has been taken to send the service request.

Online phone calls to insurance companies.

There should be option in HMIS to call the different insurance companies. It will help to reduce the time which consumed to call the insurance companies.

Update of medical records, progress report, and radiologyreport on the same day of service delivery through HMIS.

Notification reminder to doctors through online system:

There should be a pop up message for doctors which shows the medical queries to them.Doctors can read the queries and reply to them. It will reduce the extra work.

online system for submission of progress report and medical reports.

Progress reports and medical reports should be uploaded on HMIS.It will helpful to reduce the follow up time.

Separate file should be maintained for physiotherapy service reques

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Insurance Regulatory and Development Authority
Available on
http://en.wikipedia.org/wiki/Insurance_Regulatory_and_Development_Authority

Health insurance
Available on
http://en.wikipedia.org/wiki/Health_insurance

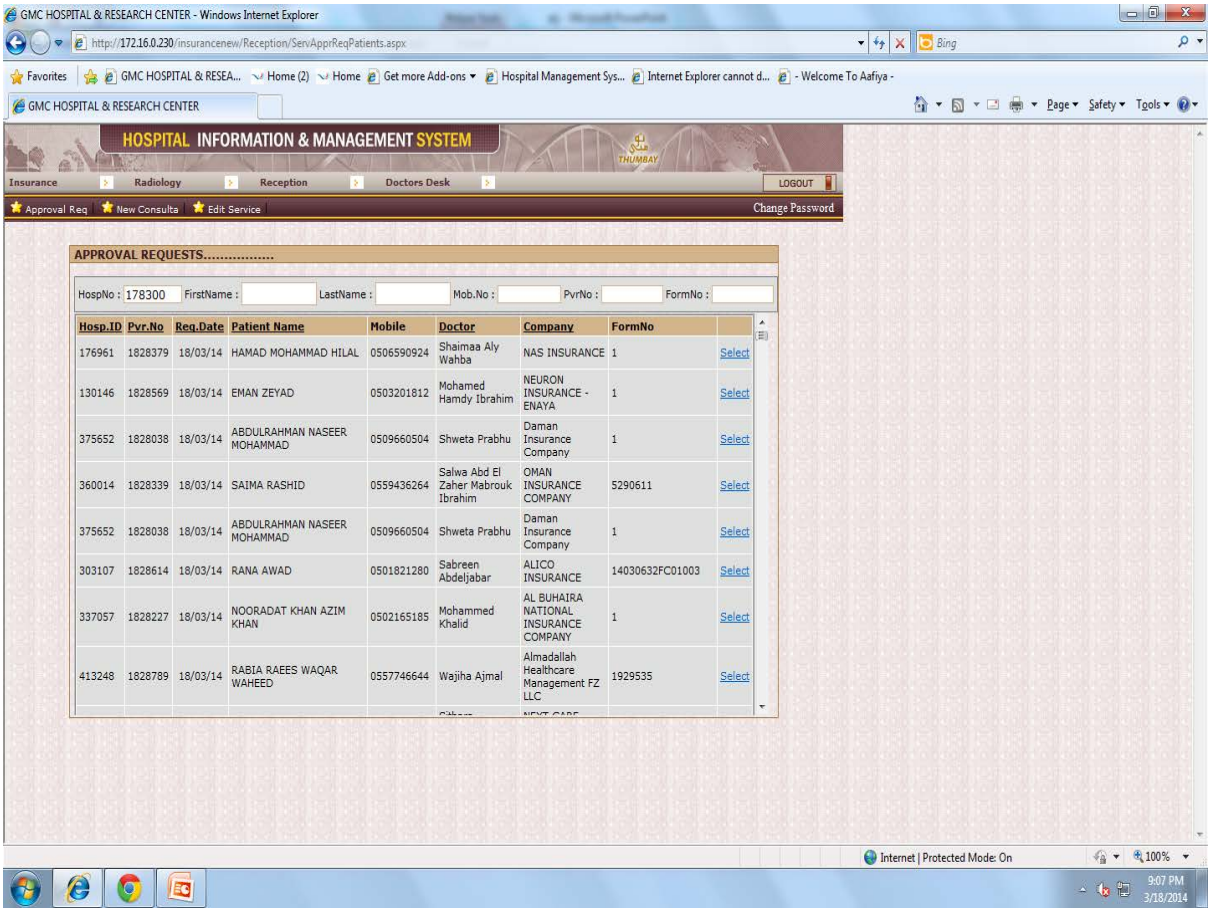
APPENDIX

Annexure (i)

Multiple login modules of HMIS

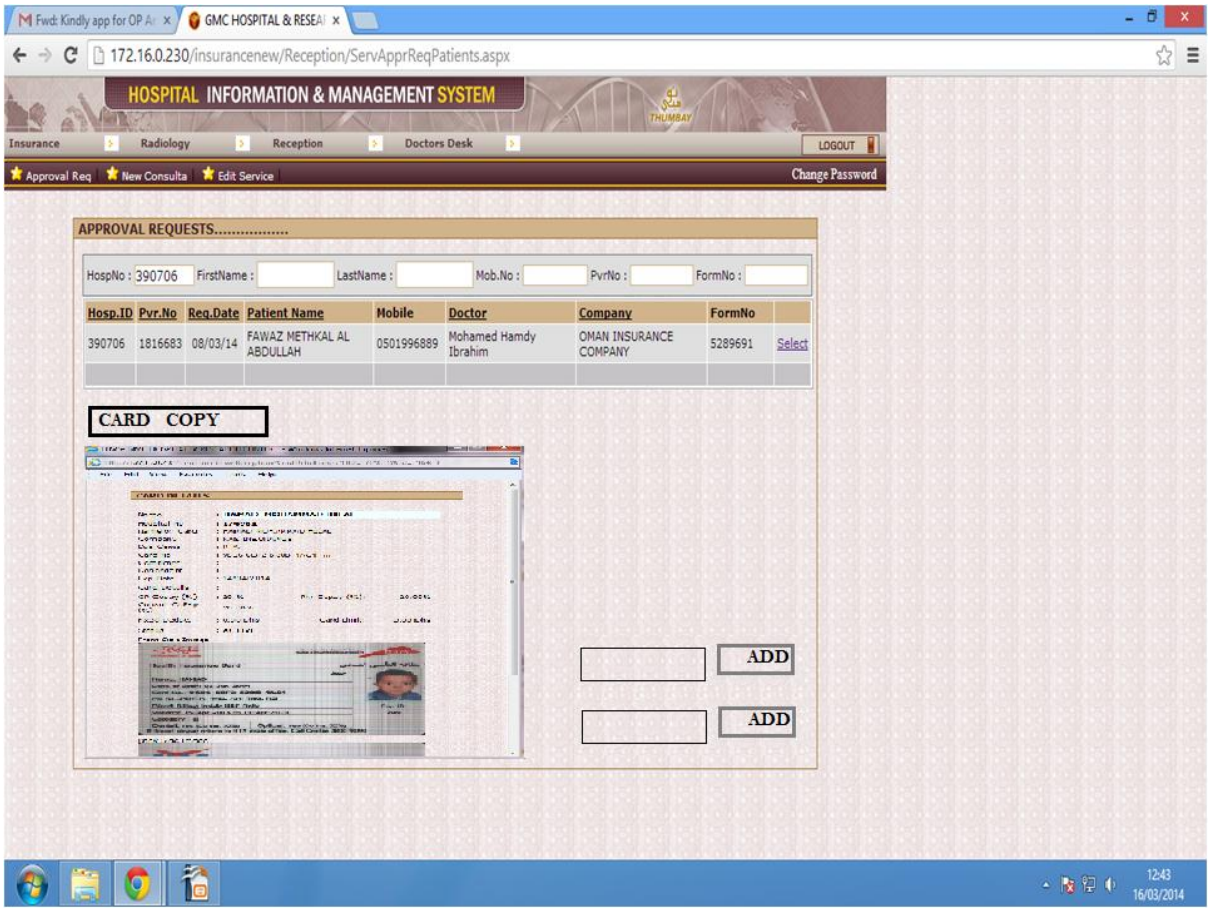
Annexure (ii)

Approval request page

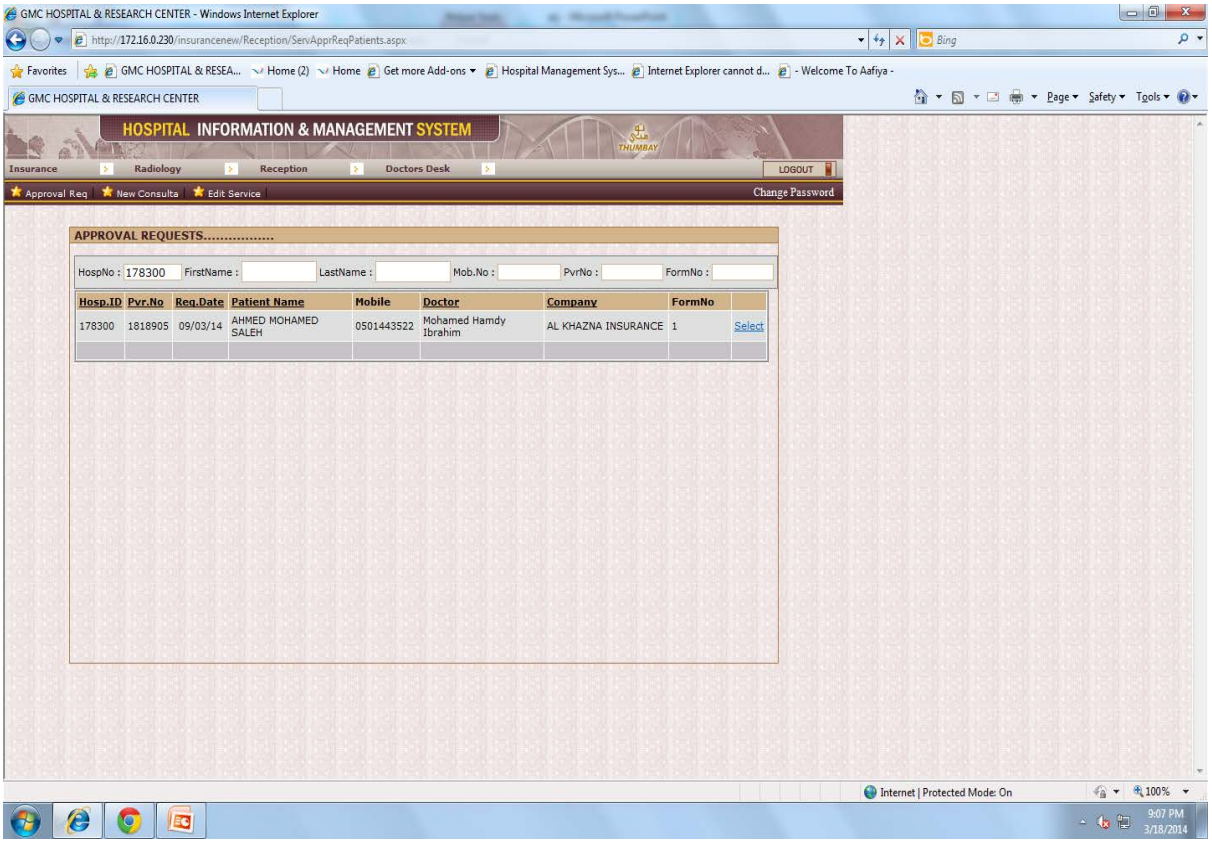


Annexure (iii)
Lab/radio reports page

Annexure (iv)
Card copy page



Annexure (v)
Single platform view page


GMC HOSPITAL & RESEARCH CENTER - Windows Internet Explorer
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Insurance
Radiology
Reception
Doctors Desk
LOGOUT
Approval Req
New Consulta
Edit Service
Change Password
APPROVAL REQUESTS.....
HospNo : 178300
FirstName :
LastName :
Mob.No :
PvrNo :
FormNo :
Hosp.ID
Pvr.No
Req.Date
Patient Name
Mobile
Doctor
Company
FormNo
178300
1818905
09/03/14
AHMED MOHAMED SALEH
0501443522
Mohamed Hamdy Ibrahim
AL KHAZNA INSURANCE
1
Select
Internet | Protected Mode: On
100%
9:07 PM
3/18/2014