Internship
at
GMC Hospital and Research Centre,
Ajman, UAE

Submitted By
Rajesh Pathania

MBA Hospital & Health Management
2013-2015

Institute of Health Management Research,
Jaipur
2015

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 the Health 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 the premiums.

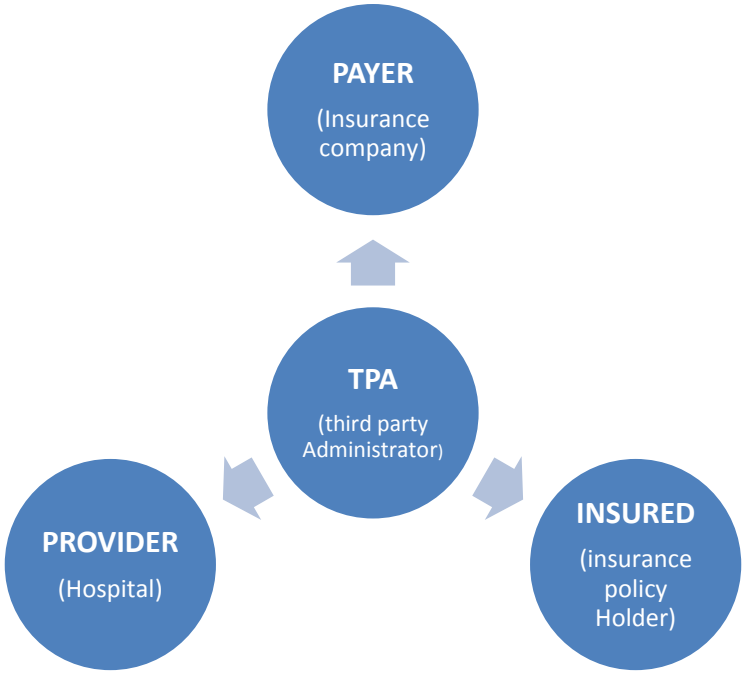
Co-insurance: The percentage of covered expenses paid by the medical plan. The co-insurance amount is per family per calendar year.

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



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

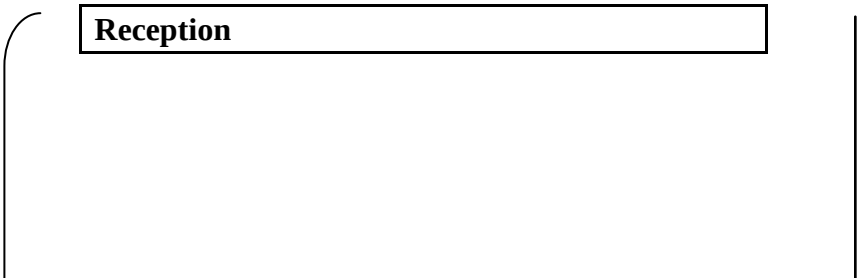
The hospital has a dedicated department to offer quality and affordable specialized superior medical care complemented by a warm and personalized human touch to the members of most of the insurance companies through Insurance department.

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

1 Process flow of insurance department



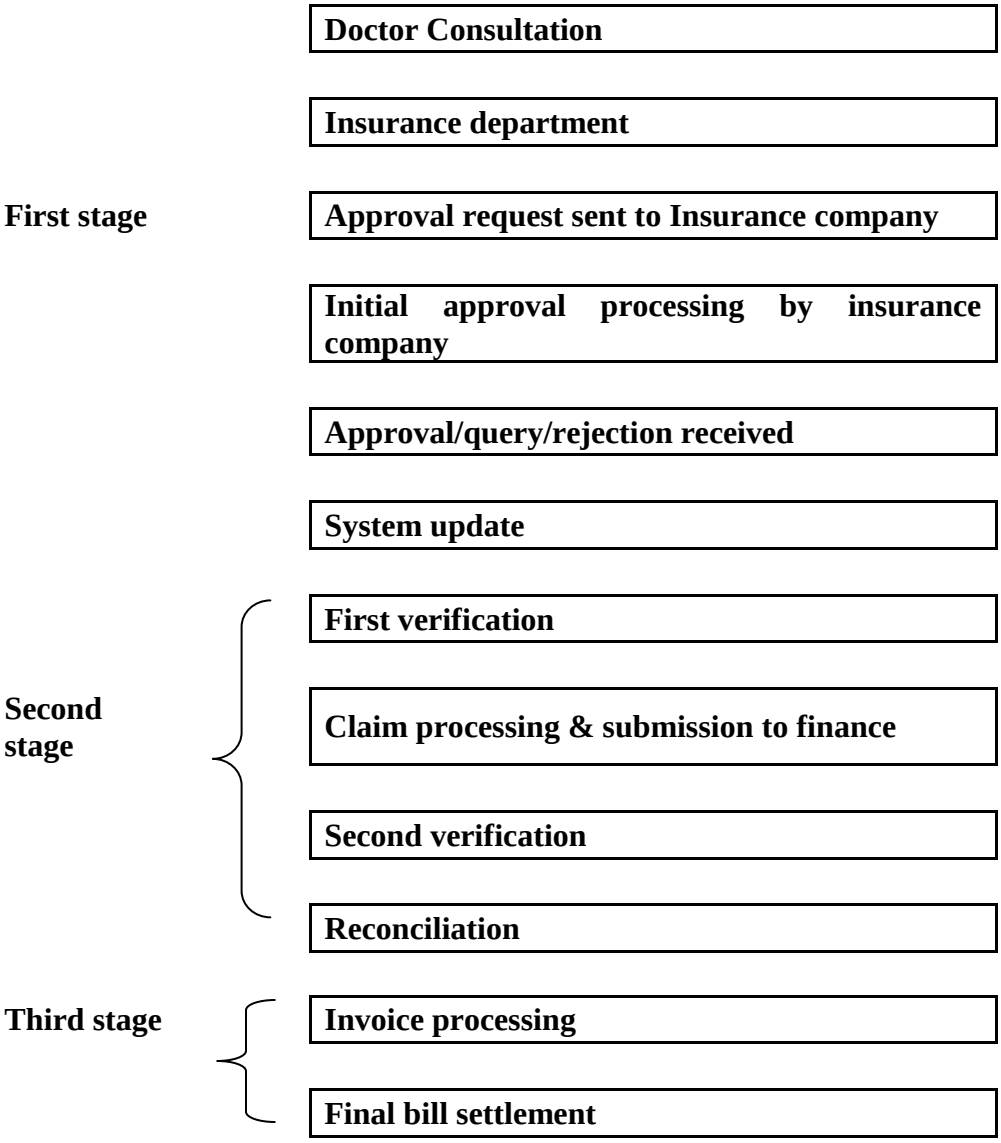


Figure: 2
Insurance department Process flow

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 by insurance 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

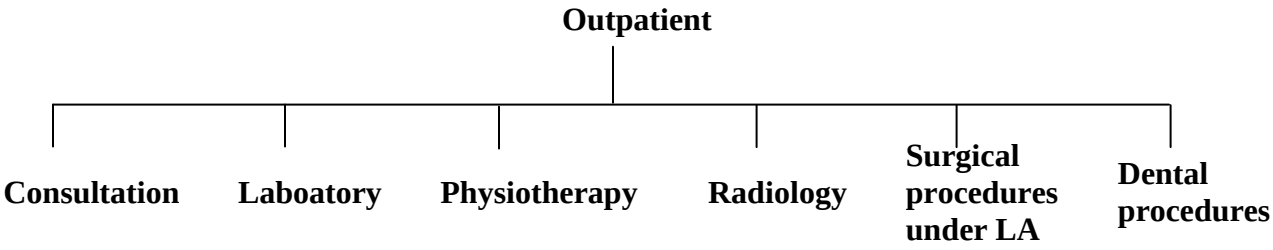


Figure: 3
Outpatient requests

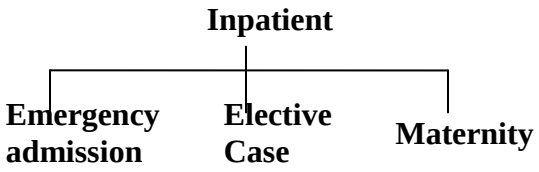


Figure: 4
Inpatient requests

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 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.

2.4 Aim

- To reduce turnaround time
- To decrease rejection rate
- To smoothen the approval process

- To increase efficiency

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 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.

2.4 Aim

- To reduce turnaround time
- To decrease rejection rate

- To smoothen the approval process
- To increase efficiency

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 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.