ROOT CAUSE ANALYSIS OF REJECTION RATE OF MEDICAL CLAIMS IN INSURANCE DEPARTMENT OF A MULTI SUPER SPECIALTY HOSPITAL

Internship Training
at
GMC Hospital and Research Centre, Ajman, UAE

By
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Under the guidance of
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MBA Hospital & Health Management
2013–15

Institute of Health Management Research
Jaipur
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Dissertation Report

At

GMC Hospital & Research Centre, Ajman, UAE

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

IIHMR UNIVERSITY

TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Ankita Kohli (PT) a student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at Gulf Medical Centre Hospital and Research Centre, Thumbay Group of Hospitals Ajman from 1st March to 15th May.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her success in all her future endeavors.

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مستشفى جي إم سي
GMC HOSPITAL
"Healing through knowledge and wisdom"

ثومبي
THUMBAY

May 14, 2015

To Whom It May Concern

This is to certify that **Dr. Ankita Kohli Dinesh** holder of Indian Passport Number K1374258 was working in our institution as Management Trainee from 1st March 2015 till 14th May 2015, as a part of dissertation of her P.G.D.H.M program .She has completed the assigned project.

We wish her all the best.

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

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **Root Cause Analysis of Rejection Rate of Medical Claims in Multi Speciality Hospital** and submitted by **Dr. Ankita Kohli** Enrollment No_**2013-15/1414** under the supervision of **Dr Monika Chaudary** for award of MBA Hospital and Health Management of the university carried out during the period from **2013 to 2015** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other Institute or other similar institution of higher learning.

Kohli

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- HMIS : Hospital Management Information System

DISSERTATION REPORT

CHAPTER- 1

BACKGROUND OF THE STUDY

1.1 INTRODUCTION

Healthcare is among the priority sectors identified by the UAE government and, as a result, the UAE healthcare industry has displayed extraordinary growth and significant progress in the past few years. The government's focus on healthcare in aimed not only to diversify the oil-reliant economy but also to develop unprecedented healthcare infrastructure to ensure that adequate services are provided in the Emirates. Healthcare is regulated at both the Federal and Emirate level. Federal level legislation dates back to the 1970s and 1980s and there are pending legislative reform initiatives in order to facilitate the development of the healthcare industry. There are also two healthcare free zones in Dubai, Dubai Healthcare City and Dubai Biotechnology and Research Park, which have their own regulatory bodies.

PRINCIPLE REGULATORY AUTHORITIES

Public healthcare services are administered by different regulatory authorities in the United Arab Emirates. The Ministry of Health (Ministry), the Health Authority-Abu Dhabi (HAAD), the Dubai Health Authority (DHA), and the recently formed Emirates Health Authority (EHA) are the main authorities.

Ministry of Health (the Ministry) and Emirates Health Authority (EHA)

The UAE Ministry of Health (the Ministry) was established pursuant to Federal Law No. of 1972 to, among other things, license companies and individuals providing healthcare services, build and manage health facilities and regulate various areas of healthcare, including the practice of medicine, dentistry, nursing, pharmaceuticals and laboratories. According to Cabinet Resolution No. 10 of 2008, the Ministry is to provide UAE citizens with healthcare, prepare health, preventive and training programs, organize the practicing of healthcare professions and establish, manage and supervise health facilities.

Health Authority Abu Dhabi (HAAD)

In 2001, the Abu Dhabi government established GAHS, the General Authority of Health Services, with a mandate to oversee all public healthcare institutions in the Emirate of Abu Dhabi. In 2007, GAHS was split into two organizations, HAAD (Health Authority of Abu Dhabi), the regulatory body of healthcare in Abu Dhabi, and SEHA (Abu Dhabi Health Services Company), the operator of public healthcare assets.

HAAD was established as a public authority with financial and administrative independence pursuant to Abu Dhabi Law No. 1 of 2007. According to Law No. 1, HAAD's mandate is to provide the highest levels of medical and health insurance services and to develop the health sector and related policies in Abu Dhabi. HAAD is also responsible for, among other things, monitoring and regulating the healthcare industry in Abu Dhabi, and overseeing the process to upgrade the hospitals and clinics in the Emirate of Abu Dhabi in accordance with accredited international standards.,

Abu Dhabi Health Services Company (SEHA)

Abu Dhabi Amiri Decree No. 10 of 2007 established SEHA as an Abu Dhabi public joint stock company owned by the Abu Dhabi government. According to Decree No. 10, SEHA owns and manages, either directly or indirectly, public health facilities and is expected to implement the policies, projects and strategies approved by HAAD to develop the healthcare industry in the Emirate of Abu Dhabi. SEHA's website states that it owns and operates 12 hospital facilities, 2,644 licensed beds, and more than 40 Ambulatory and Primary Healthcare Clinics. According to its website, SEHA is currently collaborating with a number of healthcare groups, including the following:

Dubai Health Authority (DHA)

DHA was created in June 2007, pursuant to Law No. 13 issued by His Highness Sheikh Mohammed bin Rashid Al Maktoum, the Ruler of Dubai. As the strategic health authority for the Emirate of Dubai, DHA's principle objectives include healthcare planning and promotion of healthcare investment in Dubai, improving healthcare quality through information

systems and standards, regulating healthcare services in Dubai, developing a comprehensive healthcare insurance and funding policy, public health promotion, developing medical education and research, and owning and operating Dubai government healthcare facilities.

DHA is authorized to regulate all healthcare services in Dubai, including those in free zones. Healthcare facilities and professionals in Dubai must be licensed by DHA. The principle facilities license categories are hospital and day surgical centers, ambulatory care facilities, diagnostic centers, complementary and alternative medicine centers, pharmaceutical facilities and other facilities. DHA owns and operates a network of medical facilities including hospitals (Al Wasl, Dubai and Rashid), and primary health care and specialtity centres (e.g. the Dubai Diabetes Center) spread throughout the Emirate of Dubai.

1.2 HEALTH INSURANCE LAW – MANDATORY INSURANCE TO ALL

The Dubai Health Authority (DHA) enacted a health insurance law (No. 11, 2013) in November 2013 that mandates coverage for all residents and visitors in Dubai, the largest Emirati state, with a population of around three million. This move has been under consideration since 2009. Dubai is following the lead of other nations in the Middle East; workers in Abu Dhabi and Saudi Arabia have long been required to have health insurance, and in June 2013, Qatar enacted a health insurance law that mandates coverage for all Qatari nationals and visitors.

KEY DETAILS

Implementation of the law will be phased in gradually, starting in 2014, and is expected to be completed by June 2016 as follows:

- Employers with over 1,000 workers must comply by the end of October 2014.
- Employers with between 100 and 999 workers must comply by the end of July 2015.
- Employers with less than 100 workers must comply by the end of June 2016.
- All workers' spouses and dependents must be covered by the end of June 2016.

Starting January 1, 2014, insurers, brokers, third-party administrators and health care providers are required to register with and obtain a permit from the DHA. Insurers will not be allowed to deny individuals coverage due to preexisting health conditions.

The new law applies to all residents (including offshore zones) and visitors. Compliance with the health insurance requirements will be a prerequisite to applying for residency or a visitor's visa. Noncompliance could lead to stiff penalties for the employer.

EMPLOYER IMPLICATIONS

Health insurance for employees must be provided and paid for by employers. At a minimum, a prescribed basic health plan must be provided, although it will be permissible to offer richer plans. The basic health plan includes coverage for dental, hearing and vision, and includes deductibles and coinsurance; visits to a specialist are subject to a referral system. Coverage for spouses and dependents is the responsibility of the employee, although we expect that some employers may elect to provide it.

The UAE government spends almost $10 billion on health care annually. According to the World Health Organization, this is 75% of the total spend on domestic health care — 25% is covered by the private sector. The new rules are intended to shift more of this burden from the government to the employer.

1.4 AIM

To develop an understanding of the process flow of insurance department, the claim management and analysis and reduction of rejection rate.

1.5 OBJECTIVES

- To understand thoroughly the process flow of a health insurance claim in GMC, Ajman.
- To examine the issues and challenges faced by the insurance department of hospital.
- To develop an understanding of the preapprovals, claim processing, verification and reconciliation.
- To identify the policy level ambiguities leading to high mediclaim rejection
- To suggest measures to reduce rejection rate of mediclaims in GMC Hospital

CHAPTER- 2

REVIEW OF LITERATURE

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.

CHAPTER- 3

METHODOLOGY

3.1 STUDY DESIGN

A Qualitative Retrospective design was planned to analyse the rejection rate of medical claims of insurance department.

3.4 TIME PERIOD March 1 to May 15

3.5 LOCATION OF STUDY – GMC Hospital, Ajman

3.6 STUDY SUBJECTS All rejected medi claims from may to october 2014

3.7 **SAMPLE SIZE:** 38000 rejected medical claims

3.8 SOURCE OF DATA HMIS and process tracking Secondary data of medical claim processed and medical claims rejected was collected from accounts department HMIS and process tracking

3.9 ETHICAL CONSIDERATIONS

The confidentiality of records was maintained and not shared elsewhere. It was taken only for study purpose and no information of hospital will be revealed elsewhere other than the academic purposes.

CHAPTER 4

ANALYSIS AND RESULTS

4.1 Drafting of Process Map

- After the in depth understanding and observational tracking of the system a process map was drafted to clearly visualize the process flow and services.

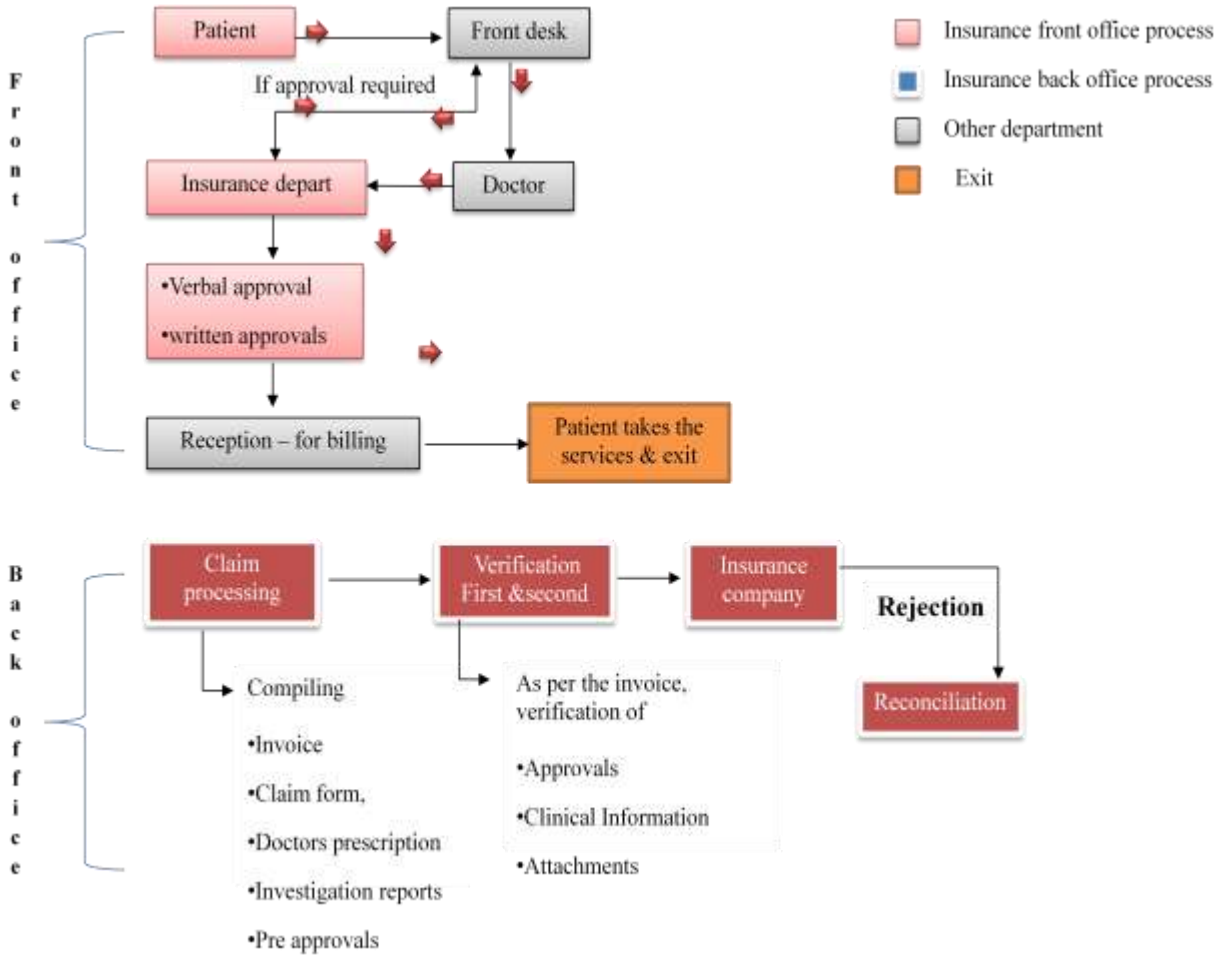
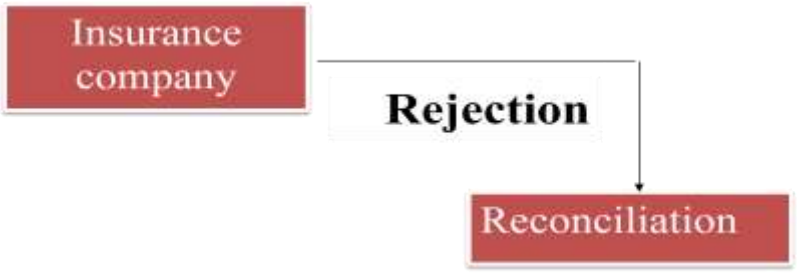


Figure 1Process flow of insurance depart

4.5 REJECTION RATE



After the process of approval request and claim processing, the invoice/bill that are generated are submitted to respective insurance companies. By verifying policy terms and conditions, insurance companies send the request back by rejecting the amount not justified and the reason of rejected amount. The reconciliation team verifies the reasons and replies back with the proper justification to reconsider the rejected amount.

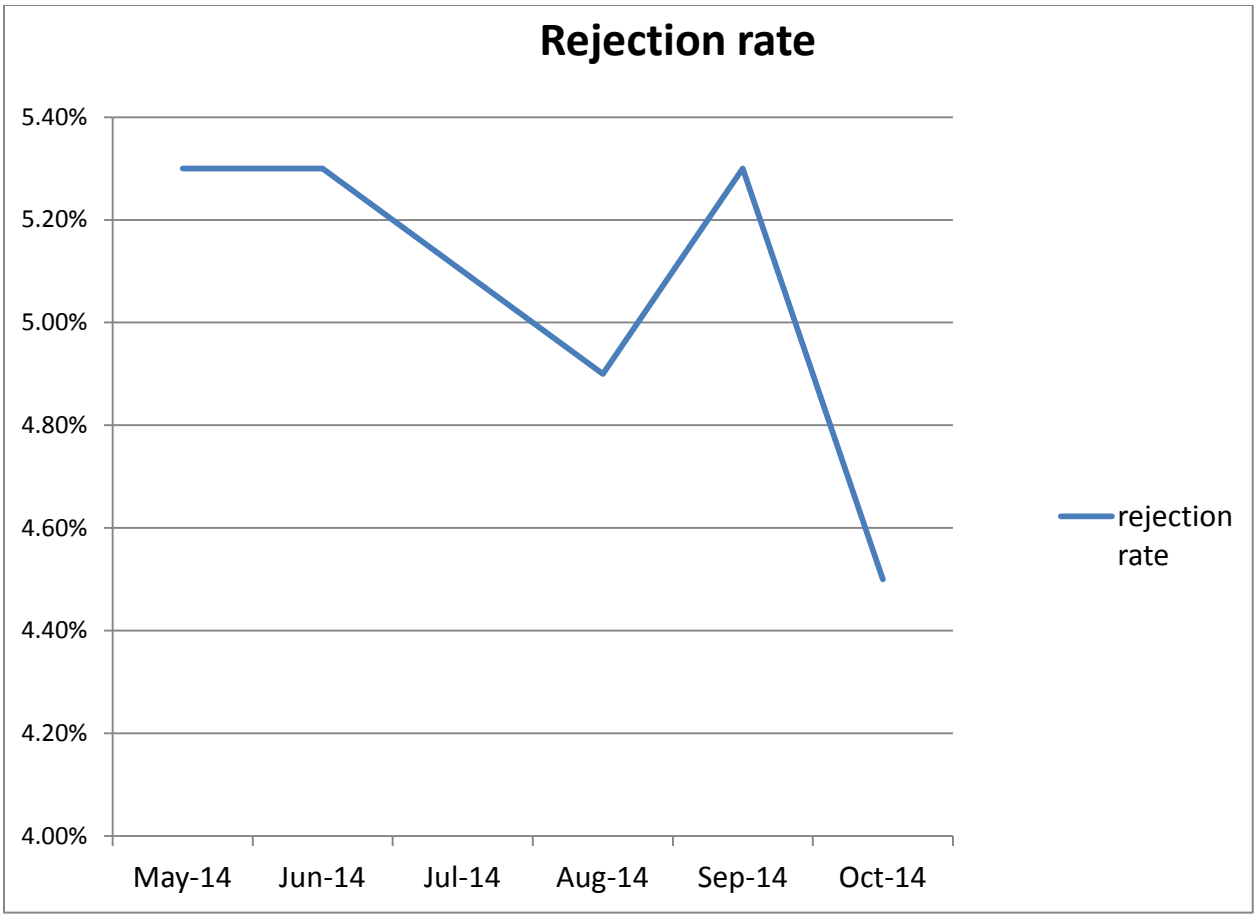
The average rejection rate before reconciliation is 5.1%, and the rejection rate after the process of reconciliation is below 2%

On an average 140 new requests are processed every day, consecutively the processed case are claimed for the bill settlement through Finance team, the amount claimed in the month of may and april are 7,990,301.29 AED and 8,042,480.46 AED out of which the rejected amount was 427,461.51 AED and 368,989.25 AED respectively.

For the comparative rejection rate data of last 6months were collected, following table shows the rejection rate between may 2014 to oct 2014. Average cumulative rejection rate of 5.1% before reconciliation

Sl No	Month	rejection rate
1	May-14	5.30%
2	Jun-14	5.30%
3	Jul-14	5.10%
4	Aug-14	4.90%
5	Sep-14	5.30%
6	Oct-14	4.50%
Total		

Table1.1 shows the rejection rate between may 2014 to oct 2014



Graph 1 represents the rejection rate between between may to October 2014

4.6 Reasons for Rejection

The reasons for above rejection rate were collected from the reconciliation platform of the HMIS and they were categorized in to 3 major headings as follows

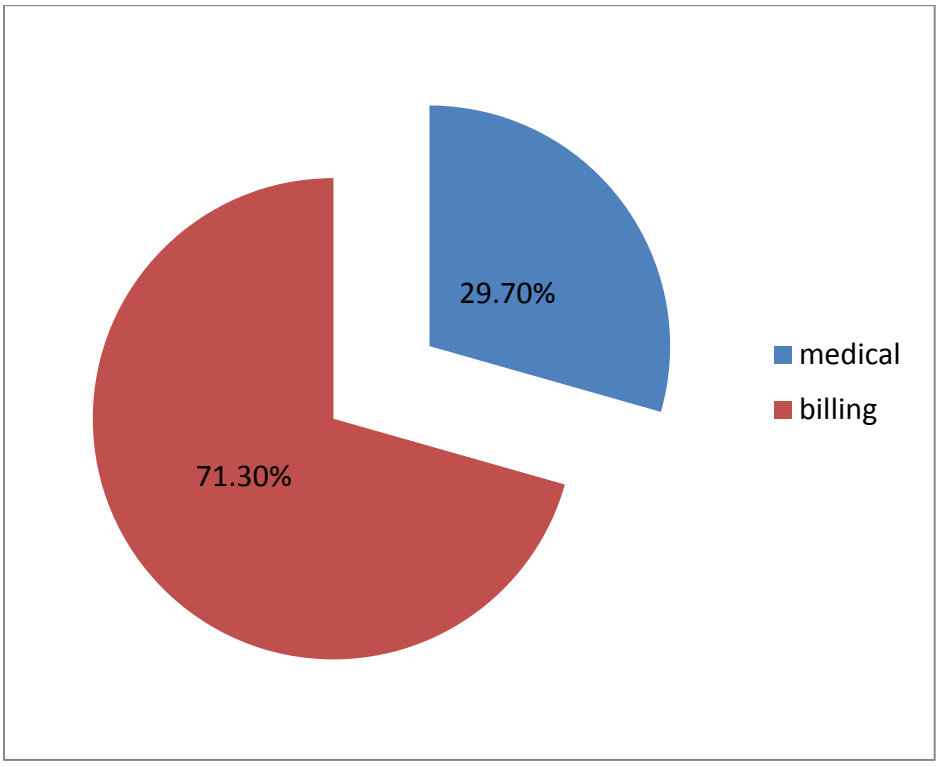
- Medical
- billing

Medical Reasons

- No medical justification
- Incomplete claim form
- Unclear diagnosis
- Service performed after last date of coverage

Billing Reasons

- Co insurance not taken
- Co pay not applied properly
- Calculation discrepancies
- No prior approval taken
- Pre authorization necessary



Graph 2 represents proportion of rejection reasons

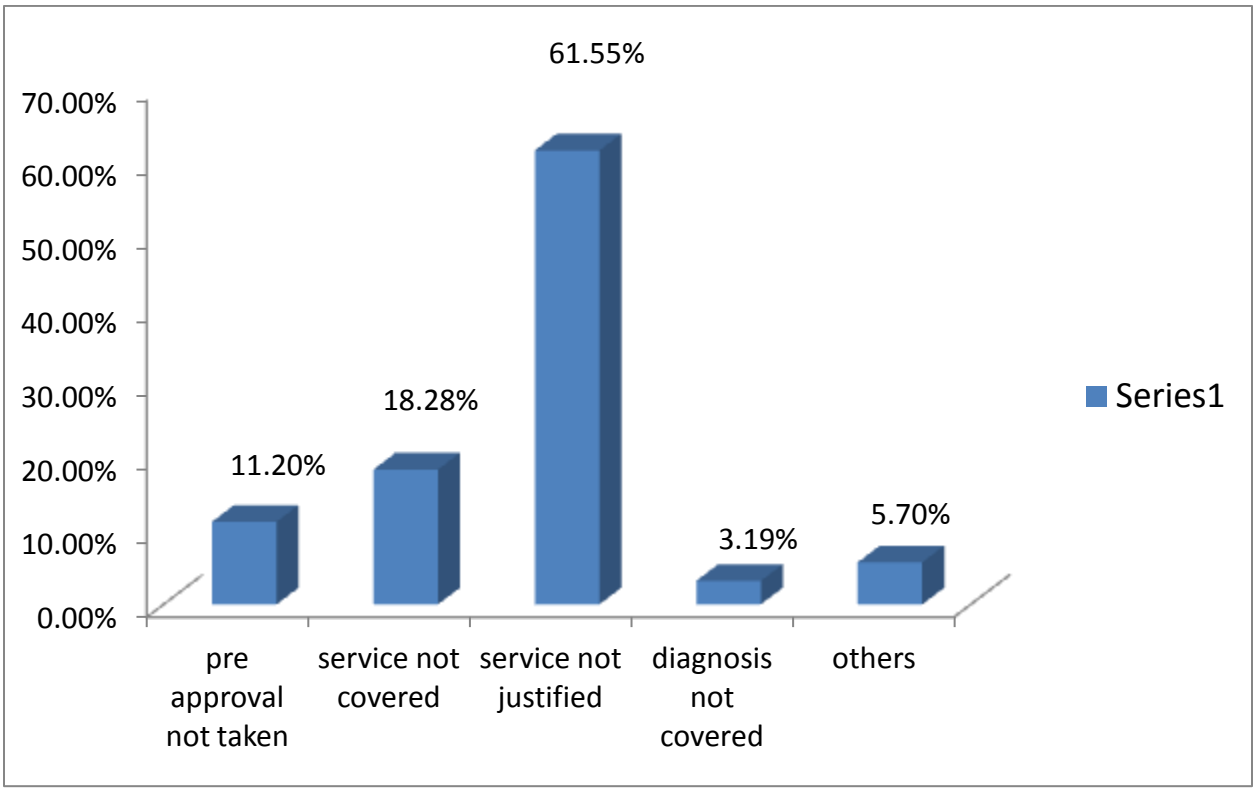
Data interpretation

Out of medical reasons services not justified was found the major reasons

Emphasis is to be given on medical records, supportive documents (radiology, lab reports etc)

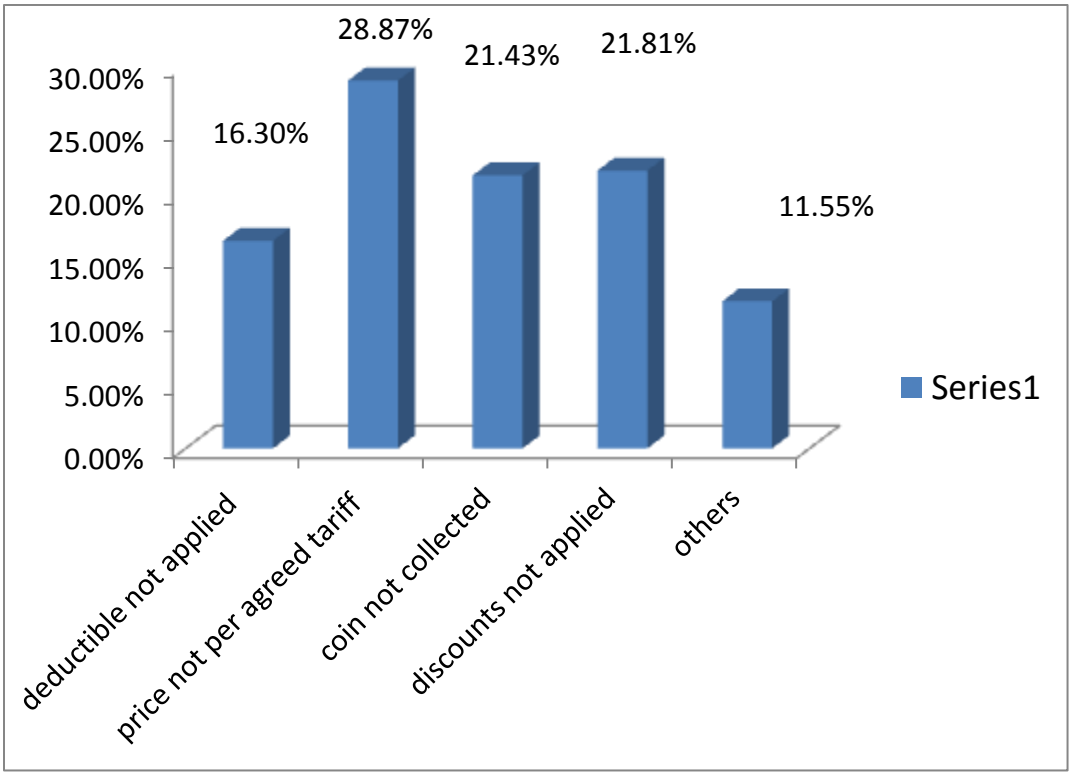
Out of billing reasons- **pricing not as per agreed** tariff is the major reasons

which implies emphasis is to be given on orientation and updation of revised tariffs



Graph 2.1 shows graphical representation of rejections due to medical reasons

Billing Reasons



Graph 2.2 shows graphical representation of rejections due to billing medical reasons

Root Cause Analysis

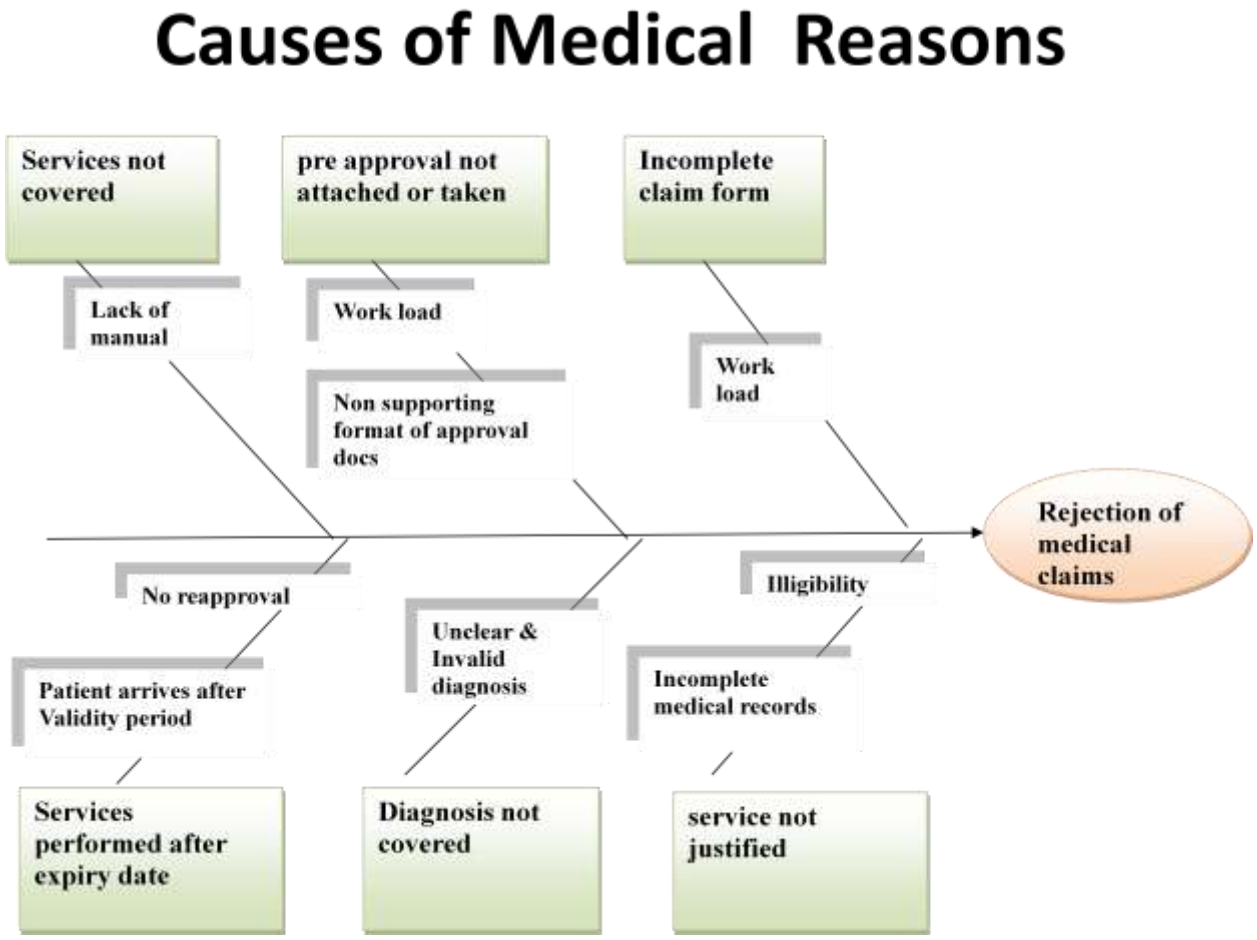


Figure 2.1 fish bone analysis of rejections due to medical reasons

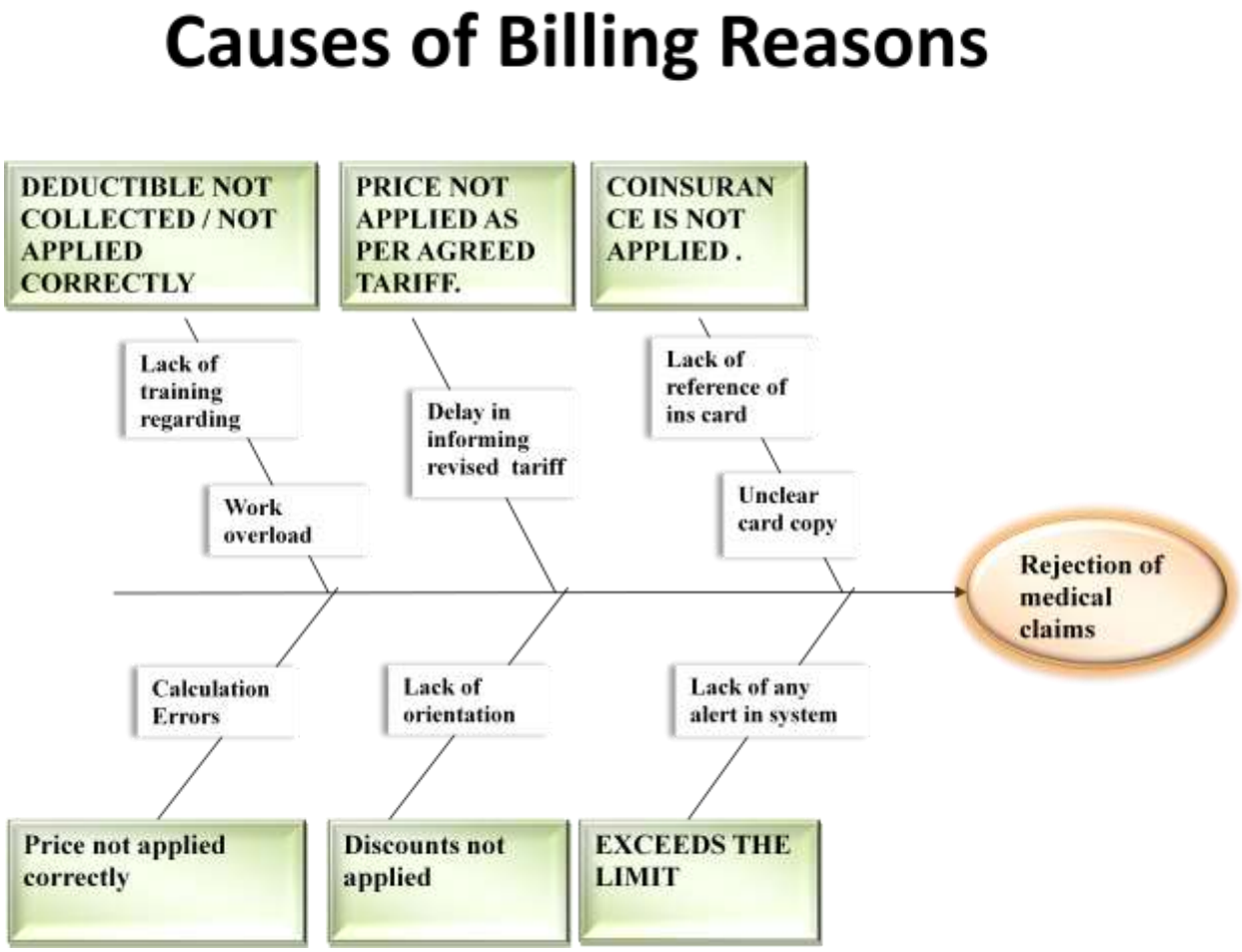


Figure 2.2 shows fish bone analysis of rejections due to medical reasons.

4.6 Gap analysis of Process

- To assess the areas of improvement of insurance department gap analysis of the process was also done.
- The following points were considered as gaps for high rejection rate
- workload on the manpower
- Incomplete clinical information on claim form.
- Incomplete information in medical records
- There is no waiting area and queue system for the patient

- If the limit is crossed for a patient it doesn't show on the system
- The validity expiry for any request is only 7 days and cannot be updated from insurance department

CHAPTER 5

SUGGESTIONS & CONCULSION

Various suggestions and recommendation were suggested for reducing the rejection rate of medical claim in insurance department

5.1 DOCUMENTATION OF Insurance info Manual

Basic information related to

- **contact details**
- **types of card**
- **Services requiring Preapproval**
- **Insurance company limit**
- **Policy coverable and non coverable**
- **Validity period**

HMIS

- **During Registration & Invoice making -**

There should be a mandatory entry option in the HMIS of Billing section for **coins & deductible**

- **During Approval update –**

There should be option in HMIS of Insurance Approval team for **coinsurance/ deductible/ Nil**

- **In Reminder Message to patients –**

Addition of validity period of approved services has to be sent along with approval info.

- **Supportive format of preapprovals –**

HMIS should also support HTML to attach the approval copies during updation

Orientation & Training

- Orientation of involved staff about revised insurance policies once in three months.
- Orientation of medical staff about services and diagnosis that are not covered.

Token system

- Mandatory **token system** and **queuing** of patients is necessary to reduce the **workload** on staff and **waiting period** of patients

Medical Records

- Clear and Detailed information of patient condition in medical records.there should be a format of explaining medical condition to reduce the errors of services not justified.

CONCLUSION

Rejection rate is one of the important measures for insurance department in a hospital as they have the direct impact on efficiency ant the revenue generation of hospital.As per IRDA any hospital having rejection rate less than 2% is considered to have good practice of claim process management.

Hence process improvement to reduce rejection rate should be implented.

Through this study, process improvement is targeted through

- Documentation of Manual
- Upgrading HMIS
- Orientation & training of staff
- Detailed medical records
- Token system

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