A Study on Process of Health Insurance Claims

Internship Training
at
E-Meditek Services Limited (EMSL) TPA, Gurgaon.

By

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Post Graduate Diploma in Hospital & Health Management
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TO WHOMSOEVER MAY CONCERN

This is to certify that Dr. Preeti Pareek student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone internship training at E MEDITEK SERVICES LIMITED, GURGAON from 3rd February 2014 to 30th April 2014.

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 all success in all her future endeavors.

Dr.Ashok Kaushik
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INTERNSHIP CERTIFICATE

This is to certify that Ms. Preeti Pareek D/O Sh. G. N. Pareek has successfully completed summer internship from February 2014 to April, 2014 with E – Meditek (TPA) Services Ltd.

We found her sincere, hardworking, and technically sound and result oriented. She worked well as part of a team during her tenure.

We take this opportunity to thank her and wish her all the best for her future.

For E – Meditek (TPA) Services Ltd.

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CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled "A Study on process of health insurance claims" at E-MEDITEK SERVICES LIMITED GURGAON, submitted by DR PREETI PAREEK Enrollment No 1356 under the supervision of DR SHILPI MISHRA SHARMA for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 3rd February 2014 to 30th April 2014 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.

Signature

PREFACE

IIHMR is a pioneering institute of Health and Hospital Management. It empowers students to become efficient and effective managers in their respective fields. The course structure is designed in a manner to give an entire overview of the health sector and its basic fundamentals during the second year. During summer training we are expected to get a better practical knowledge and functioning of health sector, operations and issues. The three months dissertation at the end of second year is an integral part of the PGDHM curriculum. As a trainee we are expected to study on the topic assigned to us by the organization and submit a dissertation report on it.

As a part of this I got the privilege of working for my dissertation training at E-Meditek Services Limited (EMSL) TPA, Gurgaon. It basically aims to provide the services to the insured persons.

There are several challenges for health financing in India including access to health care and suitable financial protection. This report provides an in depth introduction about a relatively new but promising health financing modality- The EMSL ensures cashless as well as the reimbursement transaction for the patients and this also help people to avail the health insurance.

ACKNOWLEDGEMENTS

Work is never a work of an individual. I owe a sense of gratitude to the intelligence and co-operation of those people who had been so helpful towards the completion of this project.

It has been an enriching experience for me to undergo my dissertation at E-Meditek Services Limited (EMSL) TPA, Gurgaon. which would not have been possible without the support and goodwill of the people around. I want to express my gratitude towards **Mr Gopal Verma**, **MD**, EMSL for giving me an opportunity to work in the organization and complete my project. I also extend my warm thanks to **Dr. Dheeraj Singh** , **Assistant Vice President**, for his able guidance and giving us projects from time to time to upgrade our skills. I would like to extend my sincere thanks to **Dr Janradhan and Dr Kanupriya**, mentor here, without their help it was difficult for me to complete my project. I am also thankful to other staff for their support and help. Their inputs have enriched the quality and overall content of the analysis.

At the end I want to acknowledge my sincere thanks to our institute, **Institute of Health Management and Research** for providing me a platform to gain knowledge and skills in different aspects of Health Management. I would like to take this opportunity to thank **Dr S D Gupta**, **Director**, IIHMR, **Dr Ashok Kaushik, Dean** of the institute for arranging an internship at EMSL.

I am also thankful to my Guide **Dr. Shilpi Mishra Sharma** and all faculty members of the institute for proper guidance and assistance extended by them.

I am also thankful to my **parents, family and friends** for their moral support. Finally I extend my heartfelt gratitude to all those people whose insights and experiences have shaped the content of the study directly or indirectly.

However I accept the sole responsibility for any possible error of omission and would be extremely grateful to the readers of this project report if they bring any mistakes to my notice.

ABBREVIATIONS

BSI	Balance sum insured
MOU	Memorandum of Understanding
NH	Network hospital
NICL	National Insurance Company Ltd.
TPA	Third party assistance
SI	Sum Insured

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Introduction

In a country where less than 15 per cent of population has some form of health insurance coverage, the potential for the health insurance segment remains high. It seems that there is an urgent need to ramp up the health insurance coverage in the country as out-of-pocket payments are still among the highest in the world. Furthermore, according to the statistics of the World Health Organization (WHO), in 2011, India has spent only 3.9 per cent of gross domestic product (GDP) on the health sector which is the lowest amongst the BRICS (Brazil, Russia, India, China, South Africa) member countries pack. Moreover, amongst the BRICS nations, in 2011, Russia's out-of-pocket expenses stood highest at 87.9 per cent closely followed by India (86 per cent), China (78.8 per cent), Brazil (57.8 per cent), and South Africa (13.8 per cent). On the other hand, these expenses in developed economies of US and UK were comfortably poised at 20.9 per cent and 53.1 per cent respectively.

Claims can be defined as the formal request to the insurance company asking for the payment based upon the terms of the insurance policy. Insurance claim is reviewed by the TPA doctors for the validity and then paid to requesting party once approved. The process of claims commences only after treatment of patient is complete and patient is discharged from hospital and claim is submitted for approval. If the documents of the treatment are not submitted properly or in a correct manner then the cases are rejected or the claim amount is deducted and paid to the hospital.

Review of literature

Bhat and Babu (2004) provided that introduction of IRDA has paved the way for (TPAs) third party administrators who are playing the role of insurance intermediaries in setting up of managed health care systems. The objective behind setting up of TPAs was to ensure better services to policy holders and to mitigate the negative consequences of private health insurance. However the TPAs face immense challenges in the health sector because of demand and supply side complexities of private health insurance and health care market.

Indrani gupta et al (2004) carried a study to understand the role of TPA's and examines the issues that need to be taken into account while evaluating the usefulness and the functioning. TPA's in spite of their importance in enabling their accessibility to insured health care cannot be seen as a panacea for the problem of health sector. The TPA system should be regulated and checked in order to ensure that consumer interest is not compromised.

Ramesh bhat et al (2004) studied that the TPA play a pivotal role in setting up the self managed healthcare system.TPA have been set to ensure the better services to policyholders and to mitigate some of the negative consequences of private health insurance. The TPA role in controlling costs of health care and ensuring appropriate quality of care is less well defined.

Maheshwari and Saha (2005) ascertained the experiences and challenges faced by hospitals and policyholders in availing the services of TPA in Ahmedabad, Gujarat. The results of the study shown that only a small percentages of respondents have knowledge about existence of TPA, there is substantial delay in settlement of claims between TPAs and health care providers, administrators of hospital perceive burden in terms of efforts and expenditure after the introduction of TPA.

Rationale

The rejection and the reduction of claim cases by the TPA companies is the emerging issue because of this both insurance and TPA companies are facing many problems. The awareness about the scheme is also not up to the mark among the insured clients, which leads to difficulty in availing the services and on the other hand many clients apply with false claim cases, due to this the trust of insured clients come apart from the company as well as the reputation of health insurance companies going towards negative side. This study will be an attempt to find the basis of rejection and reduction of the claim cases and find the ways to minimize the reduction and rejection of genuine cases.

Definitions

Empanelled Hospitals

The hospitals which are registered by EMSL as per parameters defined in the MOU after thorough inspection and audit to provide quality medical care to EMSL beneficiary families.

Health Card

Health photo card for EMSL beneficiary families issued under EMSL having photograph of insured family members with their name on it.

Insured

Means having paid the premium on behalf of their beneficiary families to the insurer.

Insurer

Means insurance company selected by the beneficiary (eg- National, New India, United and Oriental insurance companies).

MOU

Agreement signed between the insurer and the insured and includes all schedules, supplements, appendices and modifications made in accordance with the MOU.

Policy

Health insurance policy of the insurer issued to the insured on behalf of beneficiary families as set out under IRDA.

Premium

An amount agreed by both the parties and charged per family on annual basis as consideration for providing health insurance services under the MOU.

Preauthorization

It can be defined as online procedure for taking consent by the service provider for initiation of surgery/Therapy to be performed on the patient.

Claims

Claims can be defined as the formal request to the insurance company asking for the payment based upon the terms of the insurance policy. Insurance claim is reviewed by the claim doctors and the society doctors for the validity and then paid to requesting party once approved. The process of claims commences only after treatment of patient is complete and patient is discharged from hospital and claim is submitted for approval.

Floter benefit

It means the Sum Insured as specified for a particular Insured and the members of his/her family as covered under the policy and is available for any or all the members of his /her family for one or more claims during the tenure of the policy.

Pre existing disease

It means any sickness/illness, which existed prior to the effective date of this insurance, whether or not the insured person had any knowledge of symptoms related to the sickness/illness. Complications arising from a pre-existing condition will also be considered as a part of that pre-existing condition.

Pre and post hospitalization

Treatment required by the beneficiary is provided at the empanelled hospitals for a period defined under policy T&C from the date of admission to the date of discharge.

The empanelled hospital provides free follow up consultation, diagnostics and medicines if the beneficiary reports for follow up within that period.

Package

The insurer ensures that the Network hospitals follow the packages worked out by Hospitals. The package rates includes bed charges in General ward, Nursing and boarding charges, Surgeons, Anesthetists, Medical Practitioner, Consultants fees, Anesthesia, Blood, Oxygen, O.T. Charges, Cost of Surgical Appliances, Medicines and Drugs, Cost of Prosthetic Devices, implants, X-Ray and Diagnostic Tests, food to inpatient, one time transport cost by State Transport or second class rail fare (from Hospital to residence of patient only) etc.

In other words the package covers the entire cost of treatment of patient from date of reporting to his/her discharge from hospital including complications if any, making the transaction truly cashless to the patient. The planned procedures like hernia, vaginal or abdominal hysterectomy, appendicectomy, cholecystectomy, etc. would preferably be performed in empanelled public hospitals, subject to service availability therein.

Cashless transaction

It is envisaged that for each hospitalization the transaction shall be cashless for covered procedures. Enrolled beneficiary will go to hospital and come out without making payment to the hospital subject to procedure covered under the scheme. When the beneficiary visits the selected network hospital, the services of selected network hospital should be made available (Subject to availability of beds).

In instance of non- availability of beds at network hospital, the facility of cross referral to nearest another Network hospital is to be made available and EMSL will also provide the beneficiary with the list of nearby network hospitals.

Claims

Claims can be defined as the formal request to the insurance company asking for the payment based upon the terms of the insurance policy. Insurance claim is reviewed by the claim doctors and the society doctors for the validity and then paid to requesting party once approved. The process of claims commences only after treatment of patient is complete and patient is discharged from hospital and claim is submitted for approval.

There are various specialized categories are as follows

Sr No	Category
1	Neurosurgery
2	Surgical oncology
3	Medical oncology
4	Radiation oncology
5	Plastic surgery
6	Burns
7	Poly trauma
8	Prosthesis
9	Critical care
10	General medicine
11	Infectious diseases
12	Pediatrics medical management
13	Cardiology
14	Nephrology
15	Neurology
16	Pulmonology
17	Dermatology
18	Rheumatology
19	Endocrinology
20	Gastroenterology
21	General surgery

22	ENT surgery
23	Ophthalmology surgery
24	Gynecology and Obstetrics surgery
25	Orthopedic surgery and procedures
26	Surgical gastroenterology
27	Cardiac and cardiothoracic surgery
28	Pediatric surgery
29	Genitourinary system

The procedures are performed in empanelled public/corporate hospitals subject to availability of facility and procedure planned. The rates for each procedure are indicative and represent upper ceiling. The insurer may negotiate with the empanelled hospitals to bring the rates down amicably.

Research Questions

1. What are the basis of reduction and rejection of claims?
2. Whether the genuine cases also get rejected?

Objectives

1. To understand the claim process in terms of acceptance and rejection and reduction of claimed cases.
2. To identify the reasons behind rejection & reduction of claims.
3. To know the level of knowledge and awareness of claimant about the claimed health insurance scheme/ policy.
4. To suggest the ways to reduce the rejection and reduction of genuine cases, if identified.

Methodology

Study Area: The study is conducted at E- Meditek Services Limited (EMSL) Gurgaon

Study Duration: The duration of study was February 2014 to April 2014 (3 months)

Study Respondents: a) Provider side- EMSL officials and Doctors

b) Beneficiary side- claimant**.**

Sample size: All the cases (reduction as well as the rejection cases) has taken from submitted cases in last three months Feb 2014 to April 2014

Data collection method

Primary data: It is qualitative and quantitative in nature and collected through Participant Observation as well as from Interview Guidelines during three months training with EMSL the total number of processed claim was 1200 during 10th Feb 2014 to 30th April 2014 but the data collected from claimant through interview guidelines is very small (n=28) though it clears the knowledge and awareness among claimant.

Tools and Techniques of data collection:

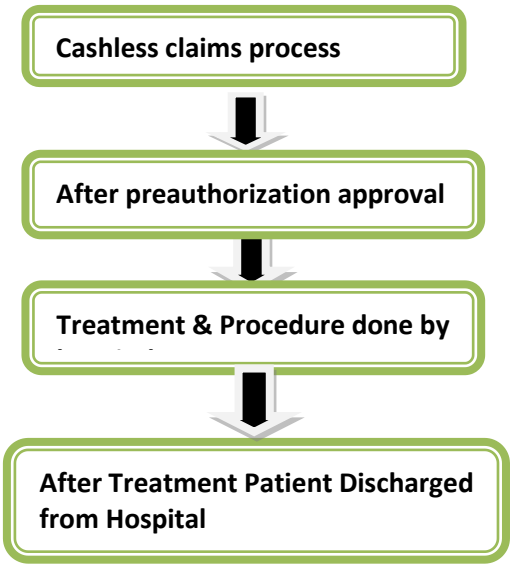
Primary data has been collected with the help of the semi structured interview schedule. Face to face interviews will be conducted with the clients availing/availed or had applied but did not get the claim. The questions also have been asked to doctors who are working under the EMSL and the claim process asked to the EMSL staff.

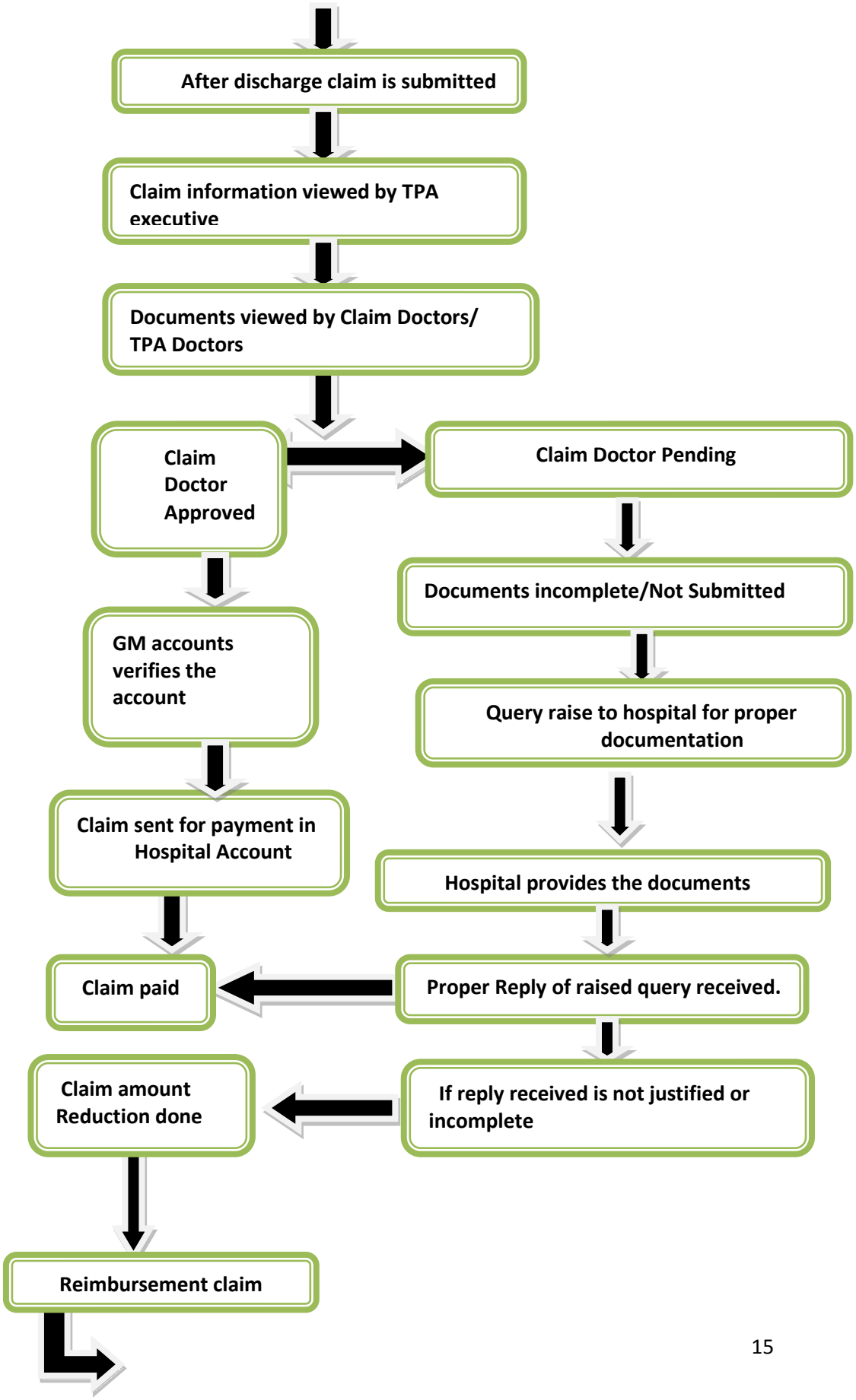
PARTICULARS	RESPONDENTS	NUMBERS	TECHNIQUES	TOOLS
Quantitative	Processed claim cases February to April 2014	1200	-	-
Quantitative	Claimant	28	Face to Face in-depth interview	Semi structured interview schedule
Qualitative	EMSL staff and medical officers	6	Face to Face in-depth interview	Semi structured Interview schedule

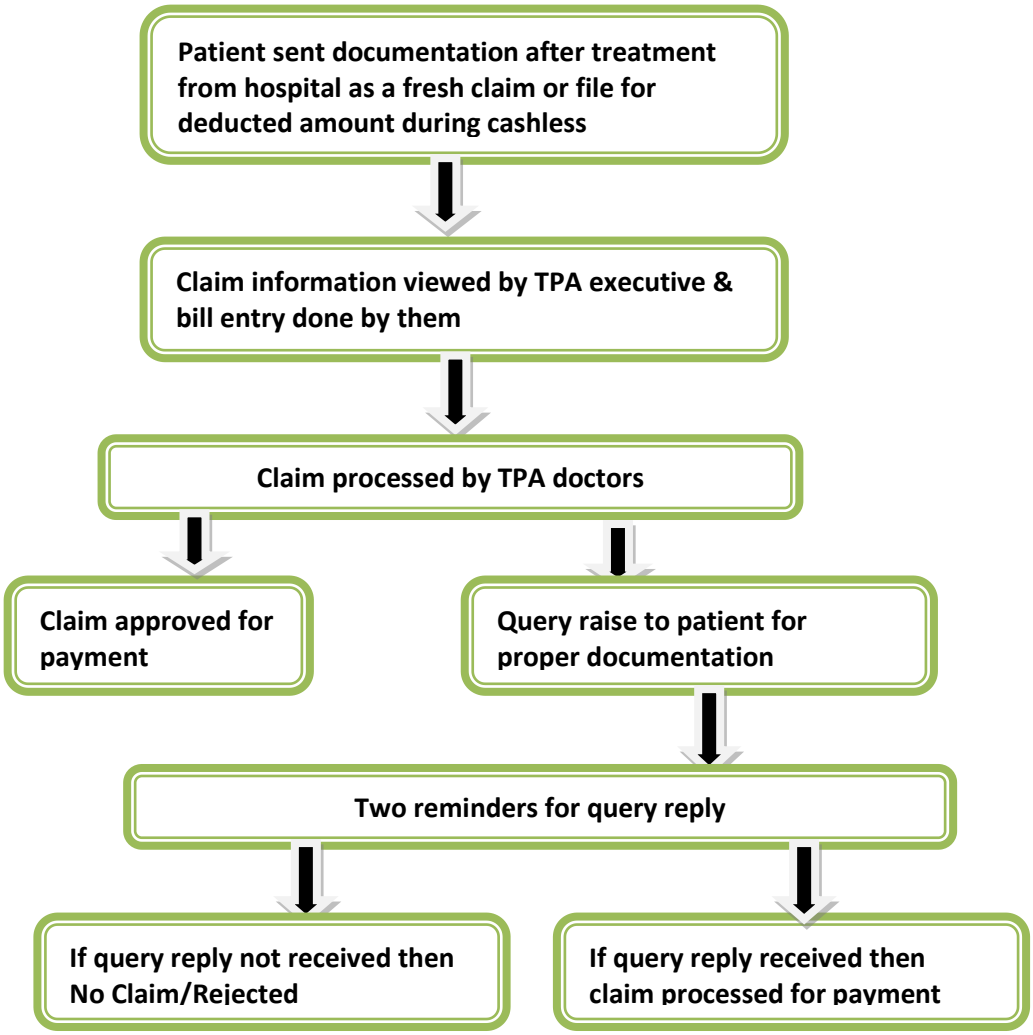
Analysis and Results: The univariate analysis approach is used for the data analysis, the results is shown below in form of the table and graphs as well as the flow chart is used to understand the process of claim.

Process of claim: The below mentioned flow chart is showing the process of claim under both cashless and reimbursement department,

Claim Process




After discharge claim is submitted
Claim information viewed by TPA executive
Documents viewed by Claim Doctors/ TPA Doctors
Claim Doctor Approved
Claim Doctor Pending
Documents incomplete/Not Submitted
GM accounts verifies the account
Query raise to hospital for proper documentation
Claim sent for payment in Hospital Account
Hospital provides the documents
Claim paid
Proper Reply of raised query received.
Claim amount Reduction done
If reply received is not justified or incomplete
Reimbursement claim



(Figure 1)

Step 1 – Preauthorization for cashless

Health insurer approaches from all over India Govt. & Private Hospitals including Network hospitals as well as non network hospitals for treatment. Preauthorization is mandatory for availing the cashless facility, If beneficiary visits Government Health Facility other than the Network Hospital, he/she is given a referral card to the Network Hospital & with preliminary diagnosis by the doctors. The EMSL at the Network Hospital examines the referral card and issued health card, registers the patient and facilitates the beneficiary to undergo specialist consultation, preliminary diagnosis, basic tests and admission process.

The information like admission notes, test done is filled in the database by the Medical Coordinator of the Hospital as per the requirement of the EMSL.The Network Hospital, based on the diagnosis, admits the patient and sends E-preauthorization request to the insurer, same can be reviewed by EMSL. Recognized Medical Specialists of the Insurer and EMSL examine the preauthorization request and approve preauthorization, if all the conditions are satisfied. This is done within 12 working hours. If approved then patient can take treatment as a cashless if denied patient has to pay the money and further file it for reimbursement.

The NH extends cashless treatment and surgery to the beneficiary. The Postoperative notes of the Network Hospitals is updated on the website by the medical coordinator of the Network Hospital. Network Hospital after performing the covered surgery/ therapy/ procedure forwards the Originals bills, Diagnostics reports, Case sheet, Satisfaction letter from patient, Discharge Summary duly signed by the doctor, acknowledgement of payments of transportation cost and other relevant documents to Insurer for settlement of the claim. The Discharge Summary and follow-up details are a part of the EMSL portal.

Insurer scrutinizes the bills and gives approval for the sanction of the bill and makes the payment within agreed period as per agreed package rates. The claim settlement module along with electronic clearance and payment gateway are a part of the workflow in EMSL portal and is operated by the Insurer. The reports are available for scrutiny on the EMSL login.

Step 2: Reimbursement process:

Insurer/patient after taking the treatment from hospital file the claim as reimbursement, in this process patient sends document to the TPA and the TPA executive views the documents and scan the document, file sent for Bill entry after that file processed by Doctor at first level, if approved by senior doctors then sent for the audit clearance and claim paid if not then sent for reprocessing, if documentation is not original or complete then query raise to patient and ask

reply and two reminders generated if reply provided then claim approved if not then file close as no claim.

Details of claims processed: The below mentioned table shows the details of processed claims

Table 1: Number of claims processed by status

Status of claim	**Frequency** (n=1200)	**Percentage**
Approved claims	1188	99%
Rejected claims	12	1%

Table 1 shows the total number of claims processed during Feb 2014 to April 2014 by their status the approved claims were 99 percent where as only 1percent claims got rejected the approved claims doesn't mean the complete reimbursement they approved after some deductions.

Figure 1: Percentage distribution of processed claims

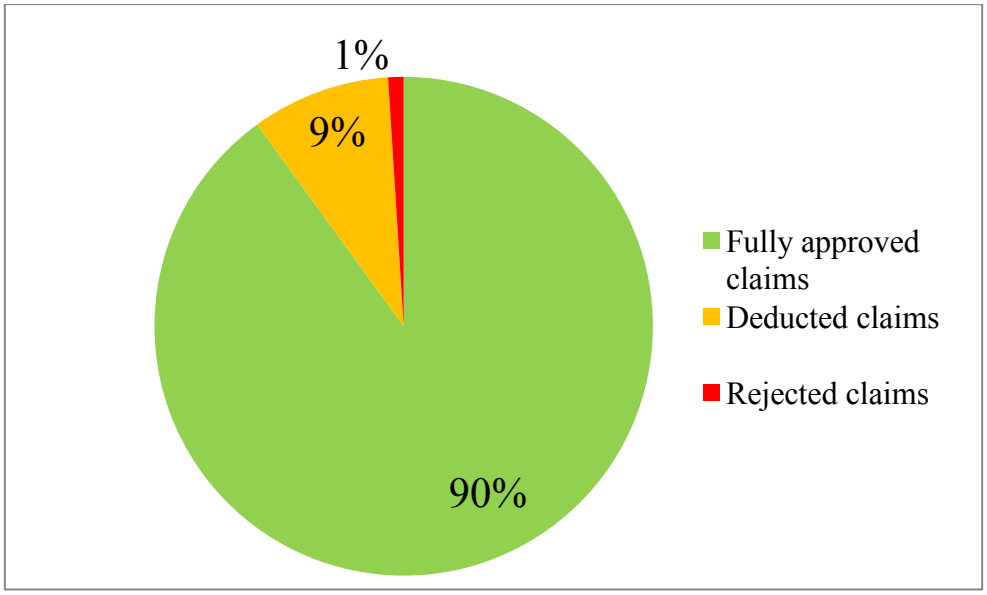


Table 2: Status of claim by mode of approval

Status of claim	**Numbers** (n=1188)	**Percentage**
Fully approved	**1081**	**90**
Partially approved	**107**	**9**

Table 2 shows that the total 1188 claims approved for the payment, the 90 percent claims were fully approved where as 9 percent claims paid after some deductions.

Table 3: Reasons of deduction (N=107)

REASONS OF DEDUCTION	**Numbers**	**Percentage**
S.I exhausted, previous year policy copies not provided	10	9%
Stent not visible, x-ray not clear, sticker not provided, irrelevant medicine is prescribed from the diseased diagnosed	25	23%
Copy of MLC/FIR not provided	15	14%
lack of document confirming diagnosis, two procedure done simultaneously, deviation from preauth approved procedure	12	11%
Non payable deducted as per policy T& C	5	5%
Non payable deducted as per policy T& C, History of Disease with original first consultation paper.	7	7%
S.I exhausted	9	8%
Report not signed by MD pathologist, lack of document confirming diagnosis	10	9%
Above reasonably & customary expenses	14	13%

Table 3 shows that the total 107 claim cases got deducted due to multiple reasons under different category the maximum claim amount deducted were 18.6% under cardiology department then 15% under ophthalmology surgery whereas the minimum deduction were medical oncology 0.9 % respectively the reason of deduction were multiple which is mentioned above in table.

Table 4: Reasons of Rejection

REASONS OF REJECTION	Numbers
Lack of mandatory documents for claim approval (original documents including discharge summary & final bills.)	2
Report not Genuine/ Patient unavailable on bed during DMO visit	1
Deviation from actual procedure which was approved by Preauth. Department	1
Report not signed by MD pathologist/radiologist, Document Discrepancy (Document doesn't contain name of patient/date etc)	1
BSI exhausted (Already consumed the sectioned amount of 150000)	1
Claim falling under pre existing diseases exclusion clause	1
Claim related to Maternity/Pregnancy	2
Claim falling under the first 2 years waiting period exclusion clause	3

A Case

Claim assigned for Investigation

Claim was suspected & the claim documents looked to be fabricated one. A small hospital in Rewari district making a bill of around Rs 60000 in a conservative management case. Claim was put under investigation to verify the hospitalization, indoor case papers & to probe further into this case to rule out any possibility of misrepresentation/fraudulent activity

Table 4 shows the reasons of rejection of claim cases the total number of rejected claims were Twelve which is only one percent of total processed claims and the reasons is mentioned above the above mentioned reasons also confirms that the lack of awareness level among claimant about policy terms and conditions the maximum three cases rejected under two years waiting period exclusion clause.

Table 5: Awareness about policy T& C and times of claimed

	Number of Times of claimed			
Awareness about policy T&C	One time	Two times	Three times	Total
No	62 %	27%	11%	**26**
Yes	50%	50%	0	**2**
Total	**17**	**8**	**3**	**28**

Table 5 shows that the awareness level of policy terms and condition among claimant is only seven percent where as 93 percent people are unaware about the all policy Terms and conditions and among those people 62 percent claimed one time, 27 percent claimed two times and 11 percent claimed three times without knowing policy Terms and conditions.

Figure 2: Number of times claimed

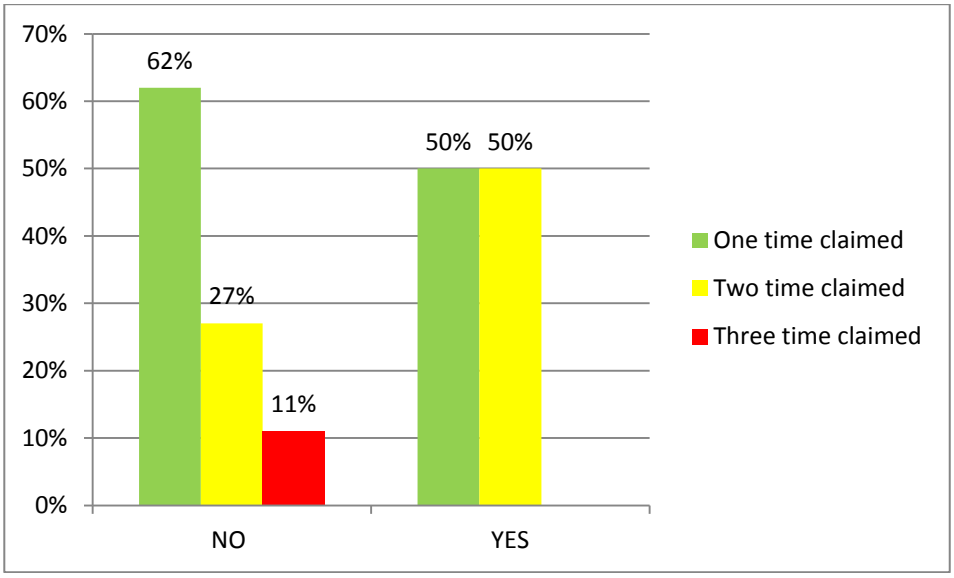


Table 6: Mode of claim and claim outcome

	Claim outcome			
Mode of claim	Full reimbursement	Partial reimbursement/ deducted	Total	P value
Cashless	63%	37%	8	.001
Reimbursement	0	100%	20	
Total	5	23	28	

Figure 3: percent outcome by mode of claim

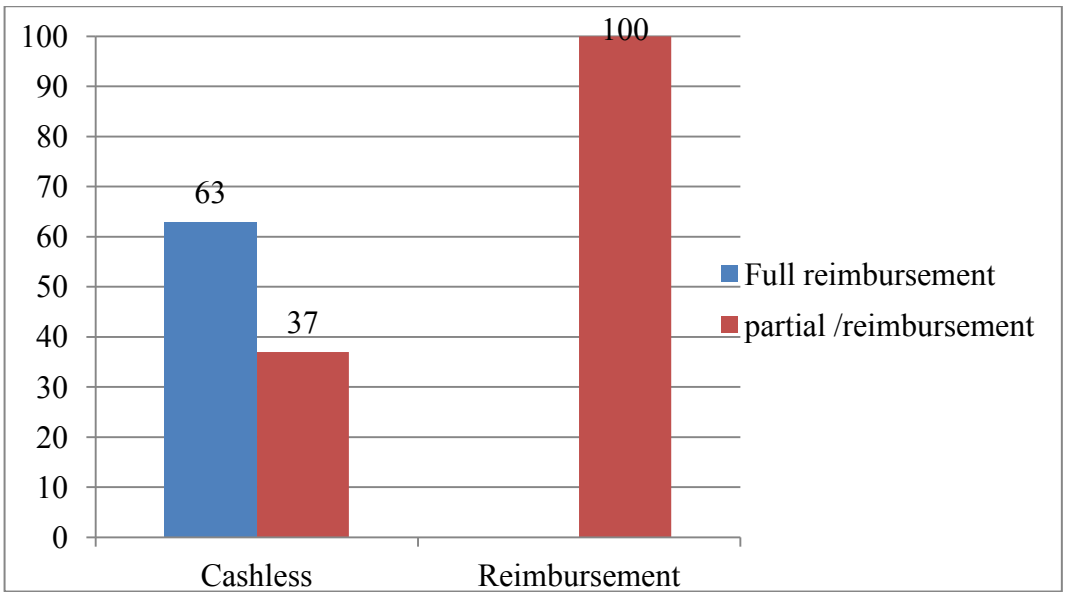


Table 6 shows that the cashless claims (hospital files) get full reimbursement as compare to the reimbursement claims (patient files) in 100 percent reimbursement file deduction done where as in cashless files only 37percent file deduction done.

Statistic used: Chi Square

Statistically significant: P-value is 0.001

There is major problem arises during claim processing because of unawareness of the claimant about all policy Terms and Conditions so the multiple times processing of the same claim also a big challenge in front of TPA and also it enhances the unnecessary work load. Initially there were 1081 approved claims out of 1200 and

the rest 119 claims were deducted and rejected later on after getting reply in multiple times they got approved after deductions were 107 and 12 claims were rejected.

Rejection of genuine cases

The genuine cases do get rejected As per one of the official " *The knowledge about policy T&C is less among claimant due to that their claims get rejected".*The other official said that " *policy ke terms and conditions toh har saal badalte hai claimant ko kya pta....".*

Reasons of Rejection of genuine cases

- Lack of knowledge about policy terms and conditions
- Time of intimation of hospitalization
- No update of changes in terms and conditions of policy among the policy holders.
- Multiple meaning of policy terms and conditions
- Policy terms and conditions changes every year
- Indian legal system is very complex.

Conclusion

The health insurance sector is growing in India but the awareness and knowledge about health insurance is very poor among people, because of that both insurer and insured are suffering , the study of process of insurance claims shows that due to lack of awareness among people they wrongly claimed and the rejections and reduction in claim cases have been done apart from that the process of claim is becoming lengthy which delay the process as well as the create hurdles in availing the health insurance.

Recommendations

At Individual level

- People should get proper knowledge about all policy T & C before taking any policy.
- Ask the agent if any confusion arises if agent is not providing proper information ask him/her to give the written consent whatever he /she assuring, as well as read the basic guidelines of policy before claim.

At Hospital level

- Hospital should inform the claimant about payables and non payables items and also if the disease fall under any exclusion criteria.
- If claimant is going through cashless facility then tell him/her the approved amount.
- In case of reimbursement hospital should provide all the original document.

At TPA & Health Insurance Company Level

- Intradepartmental and interdepartmental coordination should be channelized in TPA.
- All policy terms and conditions should be clear with proper font size of words so the claimant can read without hurdle
- Insurance company should directly send the insurance card
- Misleading Agent involvement should be minimized.
- In case of change in policy T& C inform the insurer

Ethical Consideration

The TPA has been informed before taking the data and consent is taken from them the confidentiality and privacy of the information will be maintained and this data will be solely used for Research purpose.

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Appendix A

Guidelines

Health insurance addresses a major area of public concern. Although it is rapidly growing, access to health insurance still remains limited and add to it complaints especially due to variable interpretations of key policy terms are enormous. In order to address the expectation of public more effectively, the Authority propose to stipulate the following in respect of all health insurance policies issued by life and general insurers in the country.

1. Standard Definition for 46 commonly used terms in health insurance policies:

Standard terms would reduce ambiguity, enable all stakeholders to provide better services and enable customers to interact more effectively with insurers, TPAs and providers. These 46 core terms in all health insurance policies are same.

2. Standard Nomenclature and Procedures for Critical Illnesses (11 critical illness are covered in policy)

In view o f resolving the differences in the definitions of terms on Critical Illnesses adopted by the different insurers which are creating confusion in the minds of consumers and the industry especially at the time when insurers and re-insurers have to arrive at a point where lump sum payment is made, 11 Critical Illness terms have been standardized to be adopted uniformly across industry, if offered under the product. All products offering the 11critical illness coverage shall ensure that definitions of the stated 11 terms are in line with the stipulated definitions.

1. CANCER OF SPECIFIED SEVERITY

A) A malignant tumour characterised by the uncontrolled growth & spread of malignant cells with invasion & destruction of normal tissues. This diagnosis must

be supported by histological evidence of malignancy & confirmed by a pathologist. The term cancer includes leukemia, lymphoma and sarcoma.

B) The following are excluded -

1. Tumours showing the malignant changes of carcinoma in situ & tumours which are histologically described as premalignant or non invasive, including but not limited to:
2. Carcinoma in situ of breasts, Cervical dysplasia CIN-1, CIN -2 & CIN-3.
3. Any skin cancer other than invasive malignant melanoma
4. All tumours of the prostate unless histologically classified as having a Gleason score greater than 6 or having progressed to at least clinical TNM classification T2N0M0
5. Papillary micro - carcinoma of the thyroid less than 1 cm in diameter
6. Chronic lymphocyctic leukaemia less than RAI stage 3
7. Microcarcinoma of the bladder
8. All tumours in the presence of HIV infection.

2. FIRST HEART ATTACK - OF SPECIFIED SEVERITY

A) The first occurrence of myocardial infarction which means the death of a portion of the heart muscle as a result of inadequate blood supply to the relevant area. The diagnosis for this will be evidenced by all of the following criteria:

1. A history of typical clinical symptoms consistent with the diagnosis of Acute Myocardial Infarction (for e.g. typical chest pain)
2. New characteristic electrocardiogram changes
3. Elevation of infarction specific enzymes, Troponins or other specific biochemical markers.

B). The following are excluded:

1. Non-ST-segment elevation myocardial infarction (NSTEMI) with elevation of Troponin I or T
2. Other acute Coronary Syndromes
3. Any type of angina pectoris.

3. OPEN CHEST CABG

The actual undergoing of open chest surgery for the correction of one or more coronary arteries, which is/are narrowed or blocked, by coronary artery bypass graft (CABG). The diagnosis must be supported by a coronary angiography and the realization of surgery has to be confirmed by a specialist medical practitioner.

The following are excluded:

i. Angioplasty and/or any other intra-arterial procedures

ii. any key-hole or laser surgery.

4. OPEN HEART REPLACEMENT OR REPAIR OF HEART VALVES

The actual undergoing of open-heart valve surgery is to replace or repair one or more heart valves, as a consequence of defects in, abnormalities of, or disease-affected cardiac valve(s). The diagnosis of the valve abnormality must be supported by an echocardiography and the realization of surgery has to be confirmed by a specialist medical practitioner. Catheter based techniques including but not limited to, balloon valvotomy/valvuloplasty are excluded.

5. COMA OF SPECIFIED SEVERITY

A) State of unconsciousness with no reaction or response to external stimuli or internal needs. This diagnosis must be supported by evidence of all of the following:

1. No response to external stimuli continuously for at least 96 hours;
2. Life support measures are necessary to sustain life; and
3. Permanent neurological deficit which must be assessed at least 30 days after the onset of the coma.

B) The condition has to be confirmed by a specialist medical practitioner. Coma resulting directly from alcohol or drug abuse is excluded.

6. KIDNEY FAILURE REQUIRING REGULAR DIALYSIS

End stage renal disease presenting as chronic irreversible failure of both kidneys to function, as a result of which either regular renal dialysis (hemodialysis or peritoneal dialysis) is instituted or renal transplantation is carried out. Diagnosis has to be confirmed by a specialist medical practitioner.

7. STROKE RESULTING IN PERMANENT SYMPTOMS

Any cerebrovascular incident producing permanent neurological sequelae. This includes infarction of brain tissue, thrombosis in an intracranial vessel, haemorrhage and embolisation from an extracranial source. Diagnosis has to be confirmed by a specialist medical practitioner and evidenced by typical clinical symptoms as well as typical findings in CT Scan or MRI of the brain. Evidence of permanent neurological deficit lasting for at least 3 months has to be produced.

The following are excluded:

1. Transient ischemic attacks (TIA)
2. Traumatic injury of the brain
3. Vascular disease affecting only the eye or optic nerve or vestibular functions.

8. MAJOR ORGAN /BONE MARROW TRANSPLANT

I. The actual undergoing of a transplant of:

1. One of the following human organs: heart, lung, liver, kidney, pancreas, that resulted from irreversible end-stage failure of the relevant organ, or
2. Human bone marrow using haematopoietic stem cells. The undergoing of a transplant has to be confirmed by a specialist medical practitioner.

II. The following are excluded:

1. Other stem-cell transplants
2. Where only islets of langerhans are transplanted

9. PERMANENT PARALYSIS OF LIMBS

Total and irreversible loss of use of two or more limbs as a result of injury or disease of the brain or spinal cord. A specialist medical practitioner must be of the opinion that the paralysis will be permanent with no hope of recovery and must be present for more than 3 months.

10. MOTOR NEURONE DISEASE WITH PERMANENT SYMPTOMS

Motor neurone disease diagnosed by a specialist medical practitioner as spinal muscular atrophy, progressive bulbar palsy, amyotrophic lateral sclerosis or primary lateral sclerosis. There must be progressive degeneration of cortico spinal tracts and

anterior horn cells or bulbar efferent neurons. There must be current significant and permanent functional neurological impairment with objective evidence of motor dysfunction that has persisted for a continuous period of at least 3 months.

11. MULTIPLE SCLEROSIS WITH PERSISTING SYMPTOMS

The definite occurrence of multiple sclerosis. The diagnosis must be supported by all of the following:

1. Investigations including typical MRI and CSF findings, which unequivocally confirm the diagnosis to be multiple sclerosis;
2. There must be current clinical impairment of motor or sensory function, which must have persisted for a continuous period of at least 6 months, and well documented clinical history of exacerbations and remissions of said symptoms or neurological deficits with at least two clinically documented episodes at least one month apart. Other causes of neurological damage such as SLE and HIV are excluded.

3. Standard Pre-authorization and Claim form:

A common industry wide pre-authorization and claim form will significantly stream line processes at all stages. This will enhance the ability o f providers to obtain a timely prior authorization. By implementing it in an optical character recognition (O C R) format, the ability to transfer data from a handwritten paper based form to IT systems has been enhanced thus reducing the data entry issues for TPA s and insurers. Every company shall attach set of claim forms along with policy term s and conditions to the policyholder.

TOILETRIES/COSMETICS/ PERSONAL COMFORT OR CONVENIENCE ITEMS	
1 HAIR REMOVAL CREAM	Not Payable
2 BABY CHARGES (UNLESS SPECIFIED/INDICATED)	Not Payable
3 BABY FOOD	Not Payable
4 BABY UTILITES CHARGES	Not Payable

5 BABY SET	Not Payable
6 BABY BOTTLES	Not Payable
7 BRUSH	Not Payable
8 COSY TOWEL	Not Payable
9 HAND WASH	Not Payable
10 M01STUR1SER PASTE BRUSH	Not Payable
11 POWDER	Not Payable
12 RAZOR	Payable
13 SHOE COVER	Not Payable
14 BEAUTY SERVICES	Not Payable
15 BELTS/ BRACES	Essential and may be paid specifically for caseswho have undergonesurgery of thoracic or lumbar spine.
16 BUDS	Not Payable
17 BARBER CHARGES	Not Payable
18 CAPS	Not Payable
19 COLD PACK/HOT PACK	Not Payable
20 CARRY BAGS	Not Payable
21 CRADLE CHARGES	Not Payable
22 COMB	Not Payable
23 DISPOSABLES RAZORS CHARGES	(for site preparations) Payable
24 EAU-DE-COLOGNE / ROOM FRESHNERS	Not Payable
25 EYE PAD	Not Payable
26 EYE SHEILD	Not Payable
27 EMAIL / INTERNET CHARGES	Not Payable
28 FOOD CHARGES	(OTHER THAN PATIENT'S DIET PROVIDEDBY HOSPITALNot Payable
29 FOOT COVER	Not Payable
30 GOWN	Not Payable
31 LEGGINGS	Essential in bariatric and varicose vein surgery and should be considered for these conditions where surgery itself is payable.
32 LAUNDRY CHARGES	Not Payable

33 MINERAL WATER	Not Payable
34 OIL CHARGES	Not Payable
35 SANITARY PAD	Not Payable
36 SLIPPERS	Not Payable
37 TELEPHONE CHARGES	Not Payable
38 TISSUE PAPER	Not Payable
39 TOOTH PASTE	Not Payable
40 TOOTH BRUSH	Not Payable
41 GUEST SERVICES	Not Payable
42 BED PAN	Not Payable
43 BED UNDER PAD CHARGES	Not Payable
44 CAMERA COVER	Not Payable
45 CLINIPLAST	Not Payable
46 CREPE BANDAGE	Not Payable/ Payable by the patient
47 CURAPORE	Not Payable
48 DIAPER OF ANY TYPE	Not Payable
49 DVD, CD CHARGES	Not Payable (However if CD is specifically sought by In su re r/T PA then payable)
50 EYELET COLLAR	Not Payable
51 FACE MASK	Not Payable
52 FLEXI MASK	Not Payable
53 GAUSE SOFT	Not Payable
54 GAUZE	Not Payable
55 HAND HOLDER	Not Payable
56 HANSAPLAST/ADHESIVE BANDAGES	Not Payable
57 INFANT FOOD	Not Payable
58 SLINGS	Reasonable costs for one sling in case of upper arm fractures should be considered
ITEMS SPECIFICALLY EXCLUDED IN THE POLICIES	
59 WEIGHT CONTROL PROGRAMS/ SUPPLIES/ SERVICES	Exclusion in policy unless
60 COST OF SPECTACLES/ CONTACT LENSES/ HEARING AIDS ETC	Exclusion in policy unless othe rwise specified
61 DENTAL TREATMENT EXPENSES THAT DO NOT REQUIRE HOSPITALISATION	Exclusion in policy unless othe rwise specified

62 HORMONE REPLACEMENT THERAPY	Exclusion in policy unless othe rwise specified
63 HOME VISIT CHARGES	Exclusion in policy unless othe rwise specified
64 INFERTILITY/ SUBFERTILITY/ ASSISTED CONCEPTION PROCEDURE	.,Exclusion in policy unless othe rwise specified
65 OBESITY (INCLUDING MORBID OBESITY) TREATMENT IF EXCLUDED IN POLICY	Exclusion in policy unless othe rwise specified
66 PSYCHIATRIC & PSYCHOSOMATIC DISORDERS	Exclusion in policy unless othe rwise specified
67 CORRECTIVE SURGERY FOR REFRACTIVE ERROR	Exclusion in policy unless othe rwise specified
68 TREATMENT OF SEXUALLY TRANSMITTED DISEASES	Exclusion in policy unless othe rwise specified
69 DONOR SCREENING CHARGES	Exclusion in policy unless othe rwise specified
70 ADMISSION/REGISTRATION CHARGES	Exclusion in policy unless othe rwise specified
71 HOSPITALISATION FOR EVALUATION/ DIAGNOSTIC PURPOSE	Exclusion in policy unless othe rwise specified
72 EXPENSES FOR INVESTIGATION/ TREATMENT IRRELEVANT TO THE DISEASE FOR WHICH ADMITTED OR DIAGNOSED	Not Payable - Exclusion in policy unless otherwise specified
73 ANY EXPENSES WHEN THE PATIENT IS DIAGNOSED WITH RETRO VIRUS + OR SUFFERING FROM /HIV/ AIDS ETC IS DETECTED/ DIRECTLY OR INDIRECTLY	Not payable as per HIV/AIDS exclusion
74 STEM CELL IMPLANTATION/ SURGERY & STORAGE	Not Payable except Bone Marrow transplantation here covered by policy
ITEMS WHICH FORM PART OF HOSPITAL SERVICES WHERE SEPARATE CONSUMABLES ARE NOT PAYABLE BUT THE SERVICE IS	

75 WARD AND THEATRE BOOKING CHARGES	Payable under OT Charges, not payable separately
76 ARTHROSCOPY & ENDOSCOPY INSTRUMENTS	Rental charged by the hospital payable. Purchase of Instruments not payable
77 MICROSCOPE COVER	Payable under OT Charges, not separately
78 SURGICAL BLADES,HARMONIC SCALPEL,SHAVER	Payable under OT Charges, not separately
79 SURGICAL DRILL	Payable under OT Charges, not separately
80 EYE KIT	Payable under OT Charges, not separately
81 EYE DRAPE	Payable under OT Charges, not separately
82 X-RAY FILM	Payable under Radiology Charges, not asconsumable
83 SPUTUM CUP	Payable under Investigation Charges, not as consumable
84 BOYLES APPARATUS CHARGES	Part of OT Charges, not seperatelv
85 BLOOD GROUPING AND CROSS MATCHING OF DONORS SAMPLES	Part of Cost of Blood, not payable
86 ANTISEPTIC OR DISINFECTANT LOTIONS	Not P ayable -Part of Dressing Charges
87 BAND AIDS, BANDAGES, STERLILE INJECTIONS, NEEDLES,SYRINGES	Not P ayable -Part of Dressing Charges
88 COTTON	Not P ayable -Part of Dressing Charges
89 COTTON BANDAGE	Not P ayable -Part of Dressing Charges
90 MICROPORE/ SURGICAL TAPE	Not Payable-Payable by the patient when prescribed , otherwise included as Dressing Charges
91 BLADE	Not Payable

92 APRON	Not Payable -Part of Hospital Services/ Disposable linen to be part of OT/ICU charges
93TORNIQUET	Not Payable (service is charged by hospitals,consumables can not be separately charged)
94 ORTHOBUNDLE, GYNAEC BUNDLE	Part of Dressing Charges
95 URINE CONTAINER	Not Payable
ELEMENTS OF ROOM CHARGE	
96 LUXURY TAX	Actual tax levied by government is payable .Part of room charge for sublimit
97 HVAC	Part of room charge not payable separately
98 HOUSE KEEPING CHARGES	Part of room charge not payable separately
99 SERVICE CHARGES WHERE NURSING CHARGE ALSO CHARGED	Part of room charge not payable separately
100 TELEVISION & AIR CONDITIONER CHARGES	Payable under room charges not if separately levied
101 SURCHARGES	Not payable separatelyPart of Room Charge
102 ATTENDANT CHARGES	Not payable -part of room charges
103 IM IV INJECTION CHARGES	part of nursing charges - not payable
104 CLEAN SHEET	Part of Laundry/Housekeeping not payable separately
105 EXTRA DIET OF PATIENT(OTHER THAN THAT WHICH FORMS PART OF BED CHARGE)	Patient Diet provided by hospital is payable
106 BLANKET/WARMER BLANKET	Not Payable- part of room charges
ADMINISTRATIVE OR NON-MEDICAL CHARGES	
107 ADMISSION KIT	Not Payable
108 BIRTH CERTIFICATE	Not Payable

109 BLOOD RESERVATION CHARGES AND ANTE NATAL BOOKING CHARGES	Not Payable
110 CERTIFICATE CHARGES	Not Payable
111 COURIER CHARGES	Not Payable
112 CONVENYANCE CHARGES	Not Payable
113 DIABETIC CHART CHARGES	Not Payable
114 DOCUMENTATION CHARGES / ADMINISTRATIVE EXPENSES	Not Payable
115 DISCHARGE PROCEDURE CHARGES	Not Payable
116 DAILY CHART CHARGES	Not Payable
117 ENTRANCE PASS / VISITORS PASS CHARGES	Not Payable
118 EXPENSES RELATED TO PRESCRIPTION ON DISCHARGE	To be claimed by patient under Post Hosp where admissible
119 FILE OPENING CHARGES	Not Payable
120 INCIDENTAL EXPENSES / MISC. CHARGES	(NOT EXPLAINED)Not Payable
121 MEDICAL CERTIFICATE	Not Payable
122 MAINTENANCE CHARGES	Not Payable
123 MEDICAL RECORDS	Not Payable
124 PREPARATION CHARGES	Not Payable
125 PHOTOCOPIES CHARGES	Not Payable
126 PATIENT IDENTIFICATION BAND / NAME TAG	Not Payable
127 WASHING CHARGES	Not Payable
128 MEDICINE BOX	Not Payable
129 MORTUARY CHARGES	Payable upto 24 hrs, shifting cha rges not payable
130 MEDICO LEGAL CASE CHARGES (MLC CHARGES)	Not Payable
EXTERNAL DURABLE DEVICES	
131 WALKING AIDS CHARGES	Not Payable
132 BIPAP MACHINE	Not Payable
133 COMMODE	Not Payable
134 CPAP/ CAPD EQUIPMENTS	Device not payable
135 INFUSION PUMP - COST	Device not payable
136 OXYGEN CYLINDER (FOR USAGE OUTSIDE THE HOSPITAL)	Not Payable
137 PULSEOXYMETER CHARGES	Device not payable
138 SPACER	Not Payable

139 SPIROMETRE	Device not payable
140 SP02 PROBE	Not Payable
141 NEBULIZER KIT	Not Payable
142 STEAM INHALER	Not Payable
143 ARMSLING	Not Payable
144 THERMOMETER	Not Payable
145 CERVICAL COLLAR	Not Payable
146 SPLINT	Not Payable
147 DIABETIC FOOT WEAR	Not Payable
148 KNEE BRACES (LONG/ SHORT/ HINGED)	Not Payable
149 KNEE IMMOBILIZER/SHOULDER IMMOBILIZER	Not Payable
150 LUMBOSACRAL BELT	Essential and should be paid specifically for cases who have undergone surgery of lumbar spine
151 NIMBUS BED OR WATER OR AIR BED CHARGES	Payable for any ICU patient requiring more than 3 days in ICU, all patients with paraplegia /quadriplegia for any reason and at reasonable cost of approximately Rs 200/day
152 AMBULANCE COLLAR	Not Payable
153 AMBULANCE EQUIPMENT	Not Payable
154 MICROSHEILD	Not Payable
155 ABDOMINAL BINDER	Essential and should be paid in post surgery patients of major abdominal surgery including TAH, LSCS, incisional hernia repair, exploratory laparotomy for intestinal obstruction, liver transplant etc.
ITEMS PAYABLE IF SUPPORTED BY A PRESCRIPTION	
156 BETADINE \ HYDROGEN PEROXIDE\SPIRIT\DISINFECTANTS ETC	May be payable when prescribed for patient, not payable for hospital use in OT o r ward or for dressings in hospital

157 PRIVATE NURSES CHARGES- SPECIAL NURSING CHARGES	Post hospitalization nursing charges not Payable
158 NUTRITION PLANNING CHARGES - DIETICIAN CHARGES /DIETCHARGES	Patient Diet provided by hospital is payable
159 SUGAR FREE	Tablets Payable -Sugar free variants of admissible medicines are not excluded
160 CREAMS POWDERS LOTIONS	(Toileteries are not payable,only prescribed medical pharmaceuticals payable) Payable when prescribed
161 DIGESTION GELS	Payable when prescribed
162 ECG ELECTRODES Upto 5 electrodes are required for every case visiting OT or ICU.	For longer stay in ICU, may require a change and at least one set every second day must be payable.
163 GLOVES	Sterilized Gloves payable / unsterilized gloves not payable
164 HIV KIT	Payable - payable Preoperative screening
165 LISTERINE/ ANTISEPTIC MOUTHWASH	Payable when prescribed
166 LOZENGES	Payable when prescribed
167 MOUTH PAINT	Payable when prescribed
168 NEBULISATION KIT	If used d u rin g hospitalization is payable reasonably
169 NOVARAPID	Payable when prescribed
170 VOLINI GEL/ ANALGESIC GEL	Payable when prescribed
171 ZYTEE GEL	Payable when prescribed
172 VACCINATION CHARGES	Routine Vaccination not Payable / Post Bite Vaccination Payable
PART OF HOSPITAL'S OWN COSTS AND NOT PAYA BLE	
173 AHD	Not Payable - Part of Hospital's internal Cost
174 ALCOHOL SWABES	Not Payable - Part of Hospital's internal Cost

175 SCRUB SOLUTION/STERILLIUM	Not Payable - Part of Hospital's internal Cost
OTHERS	
176 VACCINE CHARGES FOR BABY	Not Payable
177 AESTHETIC TREATMENT / SURGERY	Not Payable
178 TPA CHARGES	Not Payable
179 VISCO BELT CHARGES	Not Payable
180 ANY KIT WITH NO DETAILS MENTIONED [DELIVERY KIT, ORTHOKIT, RECOVERY KIT, ETC]	Not Payable
181 EXAMINATION GLOVES	Not Payable
182 KIDNEY TRAY	Not Payable
183 MASK	Not Payable
184 OUNCE GLASS	Not Payable
185 OUTSTATION CONSULTANT'S/ SURGEON'S FEES	Not payable, except for telemedicine consultations where covered by policy
186 OXYGEN MASK	Not Payable
187 PAPER GLOVES Not Payable	Not Payable
188 PELVIC TRACTION BELT	Should be payable in case of PI VI) requiring traction as this is generally not reused
189 REFERAL DOCTOR'S FEES	Not Payable
190 ACCU CHECK (Glucometery/Strips)	Not payable pre hospitalisation or post hospitalisation / Reports and Charts required / Device not payable
191 PAN CAN	Not Payable
192 SOFNET	Not Payable
193 TROLLY COVER	Not Payable
194 UROMETER, URINE JUG	Not Payable
195 AMBULANCE	Payable-Ambulance from home to hospital o r inter hospital shifts is payable/ RTA as specific requirement is payable
196 TEGADERM / VASOFIX SAFETY	Payable - maximum o f 3 in 48 hrs an d then 1 in 24 hrs

197 URINE BAG	Payable where medicaly necessary till a reasonable cost - maximum 1 per 24 hrs
198 SOFTOVAC	Not Payable
199 STOCKINGS	Essential for case like CABG etc. where it should be paid.

4. Standard List o f Excluded Expenses in Hospitalization

Indemnity policies: 199 excluded items

Hospitalization indemnity products are the commonest products in the Indian market and account for most of the health insurance sold in the country. The standard listing of 199 excluded items, an area which has otherwise been fairly variable in its interpretation and implementation, has been finalized. The same is annexed at A nnexure IV. H ow ever, Insurers may include these exclusions, if the product design allow s for, or if the insurer w ants to include these as part o f hospitalization expenses.

Appendix B

A Study on process of Health Insurance Claims

Interview guidelines for the officials

Q1. What is the criteria of claim processing?

Q2. What is the criteria for approval of Pac for different diseases?

Q3. What are the reasons of rejection of cashless claims?

Q4. What are the reasons of rejection of reimbursement claims?

Q5. On what basis the reduction in claim amount have been done? (for cashless/reimbursement claims)

Q6. If any fraudulent case found from the hospital side what action can be taken by TPA?

Q7. If any fraudulent case found from the claimant side what action can be taken by TPA?

Q8. Whether the genuine cases also get rejected? if yes then what are the reasons?

Q9. What would you like to suggest to make the claim policy more understandable and to make claim process simpler and effective?

To know the level of knowledge and awareness of claimant about the claimed health insurance scheme/ policy

Consent Section

I ***..01****...(participants number), understands that i am being asked to participate into interview that forms part of the ..... (Preeti) required coursework in the above noted topic. It is my understanding that the information is taken will be used fully for research purpose and i am free to decline any time to participate.*

Signature

Claimant ID **– 01**

Date ……

Age/Sex …….

Q1. Have you ever availed health insurance policy benefit? (If No then close the interview, yes then continue...)

Q2. Duration of policy which you have?

a) One year old policy
b) Two year old
c) Three year old
d) Four year old
e) More than 4 years

Q3. Do you know how much amount you can avail from insurance company if you get sick?

a) 1) no
b) 2) yes

Q4.Are you aware about the all your policy terms and conditions? (If No than identify the reasons?)

A. no
B. yes
- Provider side negligence
- Receiver side negligence

Q5. What was the exact reason of negligence?

Q6. How many times you have availed health insurance benefit till yet?
a) 1time
b) 2 times
c) 3 times
d) More than 3 times

Q7. Did you avail the actual amount you claimed? if yes close the interview.
a) no
b) yes

Q8. What was the mode of claim?
a) Cashless
b) Reimbursement

Q9. What was the outcome of claim?
a) Full reimbursement
b) Partial reimbursement/reduction
c) Rejected

(If option 2 then go to Q10, If option 3 then go to Q11)

Q10. Why your claim amount get deducted?

Q11. Why your claim get rejected?

Q12.What would you like to suggest to make the claim policy more understandable and to make claim process simpler and effective?