STUDY ON SETTLEMENT OF REIMBURSEMENT CLAIMS IN TPA

Internship Training
at
E-Meditek TPA Services LTd, New Delhi

By
Manika Singh

Under the guidance of
Dr. Neetu Purohit

MBA Hospital & Health Management
2013–15

Institute of Health Management Research
Jaipur
2015

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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. Manika Singh**, student of MBA Hospital and Health Management from IIHMR University, Jaipur has undergone internship training at E-**Meditek TPA Services Ltd., Gurgaon** from 02 February 2015 to 30 April 2015.

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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— (TPA) SERVICES LIMITED

Ref: EMSL/13621/HR

Date: 07th May, 2015

To whomsoever it may concern

This is to certify that **Dr. Manika Singh** studying MBA (Hospital Management) in **IIHMR University - Jaipur** has successfully completed the project work titled as **"Problems in Reimbursement Claim Settlement and its Solutions"** in our Company with SAIL Department during the period **02nd February, 2015 to 30th April, 2015** under the guidance of **Mr. Jim John (DGM).**

We wish Dr. Manika Singh all the best in his future endeavors.

Yours truly,

for E- Meditek (TPA) Services Limited

Authorized Signatory

7/5/15

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

IIHMR UNIVERSITY

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"Study on Settlement of Reimbursement Claims in TPA"** and submitted by **Dr. Manika Singh** Enrollment No. **1461** under the supervision of **Dr. Neetu Purohit** for award of MBA Hospital and Health Management of the university carried out during the period from **02 February 2015 to 30 April 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.

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Abstract

"A study on Settlement of Reimbursement Claims in TPA"

Dr. Manika Singh, Student (IIHMR University, Jaipur)

"Claim" is the only reason the consumer (insured) buys an insurance product. After filing a claim the insured wants it to be reimbursed as soon as possible and if delay occurs or the claim gets rejected due to some reason the insured becomes dissatisfied. Sometimes insured files case against the insurance company or TPA. The fast administration of Claims is, therefore not only a legal obligation of an insurance firm, but a strong public relations and marketing strategy.

Nowadays insurance companies hire TPAs for the claims settlement but Healthcare providers experience substantial delay in setting of their claim by TPAs. Provider perceive significant burden in terms of effort and expenditure after introduction of TPAs. There is no substantial increase in patient's turnover after empanelling with TPAs.

Studies show that every four out of nine policyholders have faced problems with their health insurance providers and third party administrators (TPA) at the time of getting their claims approved which resulted in lot of delay in claims settlement or rejection of claims. Ultimately they feel dissatisfied with the services offered by the Insurance Company/TPA.

A descriptive study was done in E-Meditek TPA Services Ltd., Gurgaon which is the head office of the company to identify the reasons of delay in claims settlement and reasons of repudiation of claims.

Total 260 claims (130 IPD and 130 OPD) were studied for delay in claims settlement and total 200 claims (100 IPD and 100 OPD) were studied for repudiation of claims. Discussion was also held with the staff members to understand the reasons of delay and rejection of claims.

Results revealed that most of the claims settled after delay (64% and 57% in IPD and OPD respectively) and a considerable percentage of claims are repudiated (8% and 13% in IPD and OPD respectively).

Further reasons were identified for the above issues and recommendations were given accordingly.

KEY WORDS: *Reimbursement, Claim, TPA, Repudiation, Inward*

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First of all I would like to thank IIHMR Jaipur for giving me this opportunity to get placed and go for dissertation at E-Meditek TPA Services Ltd. (Gurgaon).

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I express my gratitude towards senior Medical Officers Dr. Amit Srivastava, Dr. Avinash Jain and Dr. Deepa Binoriya and the entire SAIL team for helping me out and clear my doubts.

I want to give special thanks to my mentor Dr. Neetu Purohit without whom this report could not have been completed.

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- Dr. Manika Singh

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List of abbreviations

BPL	Below Poverty Line
CEO	Chief Executive Officer
CMD	Chief Managing Director
DMS	Data Management System
E-Card	Electronic Card
ED	Executive Director
HOD	Head of the Department
IPD	In-Patient Department
IRDA	Insurance Regulatory and Development Authority
IT	Information Technology
MIS	Management Information System
MS	Microsoft
NEFT	National Electronic Fund Transfer
NIC	National Insurance Company
NSP	Network Service Provider
OPD	Out Patient Department
PSU	Public Sector Undertaking
RSBY	Rashtriya Swasthya Bima Yojana
SAIL	Steel Authority of India Limited
SI	Sum Insured

SMS	Short Message service
TAT	Turn Around Time
TPA	Third Party Administrator
UHIS	Universal Health Insurance Scheme

Dissertation Report

A Study on Settlement of Reimbursement Claims in TPA

1. Introduction

A third party Administrator (TPA) is an organization that processes insurance claims or certain aspects of employee benefit plans for a separate entity. This can be viewed as "outsourcing" the administration of the claims processing, since the TPA is performing a task traditionally handled by the company providing the insurance or the company itself. Often, in the case of insurance claims, a TPA handles the claim processing for an employer that self insures its employees. Thus the employer is acting as an insurance company and under writes the risk. The risk of loss remains with the employees and review, or membership functions. While some third- party administrators may operate as units of insurance companies, they are often independent. Third- party administrators also handle many aspects of other employee benefit plans such as the processing of retirement plans and flexible spending accounts. Many employee benefit plans have highly technical aspects and involves difficult administration that can make using a specialized entity such as a TPA more cost effective than doing the same processing in house.

The Insurance Regulatory & Development Authority of India (IRDA) defines TPA as a Third Party Administrator who, for the time being, is licensed by the Authority, and is engaged for a fee or remuneration, in the agreement with an insurance company, for the permission of health services TPA was introduced by IRDA in 2001.

Claims processing is the major task of TPA and customer satisfaction is directly related to the on time claims processing. So, the study includes finding out the reasons for delay in claim processing and/or claiming repudiation and their causes and solutions.

Due to the delay in medical claims processing, patients get delayed re-imbursement of their claims and in case of repudiation they don't get the claimed amount and ultimately feel dissatisfied with the services offered by the Insurance Company/TPA.

Every four out of nine policyholders have faced problems with their health insurance providers and third party administrators (TPA) at the time of getting their claims approved, a study conducted by consumer rights organisation Consumer Voice has found.

According to a Zenith study "The time agreed for claim settlement with TPA is less than 1 month, whereas actual time taken for claim settlement varies from 2 to 3 months. All this leads delay in settlement of claim and resulting dissatisfaction to the policyholders and hospitals."

As on time claim settlement is the major issue for insured this study is based upon that. In the study the reasons for delay in claims settlement and reasons for repudiation of claims were identified and their possible solutions were given.

IPD and OPD claims were studied separately. Reason for that was IPD claims are more crucial than OPD claims as patients hospitalize in that case, more monetary value incurred in IPD claims. Sometimes people go into BPL category after the out of pocket payment of hospitalization in cases like cancer.

Apart from that reasons of repudiation of claims and magnitude of delayed and repudiated claims are different in IPD and OPD.

2. Literature Review

The most critical moment in the entire tenure of an insurance policy is when a claim is filed. "One of the most common queries we get from people buying a policy is whether the insurance company will honour the claim," says Shankar Nath, founder, Policytiger.com, an online insurance service provider.

According to the annual report of the Insurance Regulatory Development Authority (Irda), the number of claims rejected by life insurance companies for 2009-10 stood at 14,693 (it was 12,781 in 2008-09). The amount involved was Rs 245 crore. The number of claims pending at the end of 2009-10 was 15,892 (it was 16,915 in 2008-09), with a pending value of Rs 286 crore. Of these, 2,180 were pending for more than one year.

Bhat at el (2005) in their paper "Third party administrator and health insurance in India: perception of policyholders and providers" found that Healthcare providers experience substantial delay in setting of their claim by TPAs. Provider Perceive significant burden in terms of effort and expenditure after introduction of TPAs. There is no substantial increase in patient's turnover after empanelling with TPAs.

Claims settlement is like a mirror through which the members of the public see Insurance Company. A Company, which fails to settle claims to the satisfaction of customers, would definitely attract less business, as it is likely to discourage such clients to continue to insure with the company. Such clients might even advise their friends, colleagues and relations not to patronize such a company. Prudent claims administration strategy promotes customer loyalty as it helps to develop a perception of „membership" or belonging within a particular

group of customers, thereby providing the company with opportunities to retain existing customers while attracting new ones and profitable ones (Braers, 2004)

The advent of TPAs is expected to play an important role in health insurance market in ensuring better services to policy holders. Their presence is expected to address the cost and quality issues of the vast private healthcare providers in India. However, the insurance sector still faces challenges of effectively institutionalizing the services of the TPA. Towards these findings of survey study are:- (i) low awareness among policy holders about the existence of TPA; they rely on their insurance agents; (ii) healthcare providers do experience substantial delays in settling of their claims by the TPAs; (iii) hospital administrators perceive significant burden in terms of effort and expenditure after introduction of TPA and (iv) no substantial increase in patient turnover after empanelling with TPAs. So regulatory body needs to focus on developing such mechanism that will help TPAs to strengthen their human capital and ensure smooth delivery of TPA services in health insurance market. (A study on third Party Administrators and Health Insurances in India: Perception of providers and policy- holders by Ramesh Bhat, IIM Ahmadabad)

3. Rationale of the study

By the above studies we can say that delay in claims settlement and repudiation of claims are the major issues related to insurance sector and as nowadays claims settlement is done by TPAs, the onus of this issue is on the shoulders of the TPA.

So, it is necessary to do some work in this direction for betterment in future.

The issue of delayed processing of claims impacts the insurance sector in following ways:

- Customer satisfaction decreases with delay in claims settlement.
- Customer grievances increase.
- Market credibility of TPA goes down.
- Ultimately it affects the revenue generation and policy renewals.

Similarly repudiation of claims affects TPA as well as patients.

- It takes time, labor and money to process the claim and for requisition of claim.
- It adversely affects the patient's psychology.

To overcome the above issues study is done. Benefits by the study are as follows:

- Identification of the gaps in standard and current status of the claims processing.
- Impact and reasons of the gaps.
- Practical solutions, to overcome the problems identified, can be implemented.
- Quality of the processes can be enhanced.
- Increased patient satisfaction.

4. General Objective

- To bring standardization in the processes involved in claim settlement (intimation, inward, processing, payment etc.) and to enhance the efficiency of TPA.

5. Specific Objectives

- To find out the reasons of delay in claims settlement.
- To find out the reasons of repudiation of claims.
- Recommend solutions to prevent the delay and repudiation of claims.

6. Research Questions

- How to prevent the delay in final claims settlement?
- How to prevent repudiation of claim?

7. Methodology

7.1. Area of the study

E- meditek TPA Services Ltd. (Gurgaon) – Head Office

7.2. Study Design

A descriptive study was conducted on the data of claim files to identify the reasons of delay in claims settlement and reasons of repudiation of claims.

7.3. Type of data

Data of claim files collected was quantitative type of data.

7.4. Sample size

Total 260 claims were studied: - 130 IPD and 130 OPD claims for delay in claim settlement. Apart from that total 200 claims (100 IPD & 100 OPD) were studied for repudiation of claims.

7.5. Sampling Technique

Random sampling technique was used to pick the claims- Data of claim files was taken by lists (the claims processed) and some data was taken from DMS. Filtering was done for IPD

and OPD claims. Out of total IPD claims 130 claims were randomly taken and same was done for OPD claims for the study of delay in claim settlement.

Then for repudiation filtering was done and again they were filtered to differentiate between IPD and OPD. Out of them 100 IPD and 100 OPD claims were taken from repudiated IPD and repudiated OPD claims respectively.

7.6. Data Collection Tool

Data of claims were collected and entered in MS Excel sheet and analyzed by calculations, graphs and pie charts.

7.7. Data collection

Two approaches for data collection was used- Data observation and processing of claim files was done and date of processing was noted. Besides that discussion with staff was done for queries related to claims settlement.

Primary Data :

- Direct observation: claim files were observed and processed.
- Discussion with medical and administrative staff for the understanding of process and issues related to claims settlement.

8. Results

Criteria taken for data analysis were:-

- **TAT (Turn around Time):** was calculated by MS Excel. TAT was calculated from the date of documents received to the date of final settlement of the claim. Then it was compared by the standard TAT set by the organization.

Standard TAT which is set by E- Meditek is 15 days for OPD claims and 30 days for IPD claims, if a claim settles beyond that it comes under the delay in TAT of claim settlement.

Total 260 claims were studied: - 130 IPD and 130 OPD claims for delay in claim settlement; total 200 claims (100 IPD & 100 OPD) were studied for repudiation of claims.

- **Percentage distribution of claims according to TAT:** In this no. of claims were identified as processed within normal TAT, processed after delay in TAT, repudiated and under discrepancy. Then they were divided by the total no. of claims and their percentage was taken out separately for both IPD and OPD claims.

- **Average Number of days of claims settlement:** In this aging (No. of days at the time the claim finally settled) of the claims were identified and they were added and divided by the total no. of claims and compared by the standard time of claim settlement. (30 days for IPD and 15 days for OPD)

Figure 8.1 Distribution of claim settlement according to TAT in IPD claims

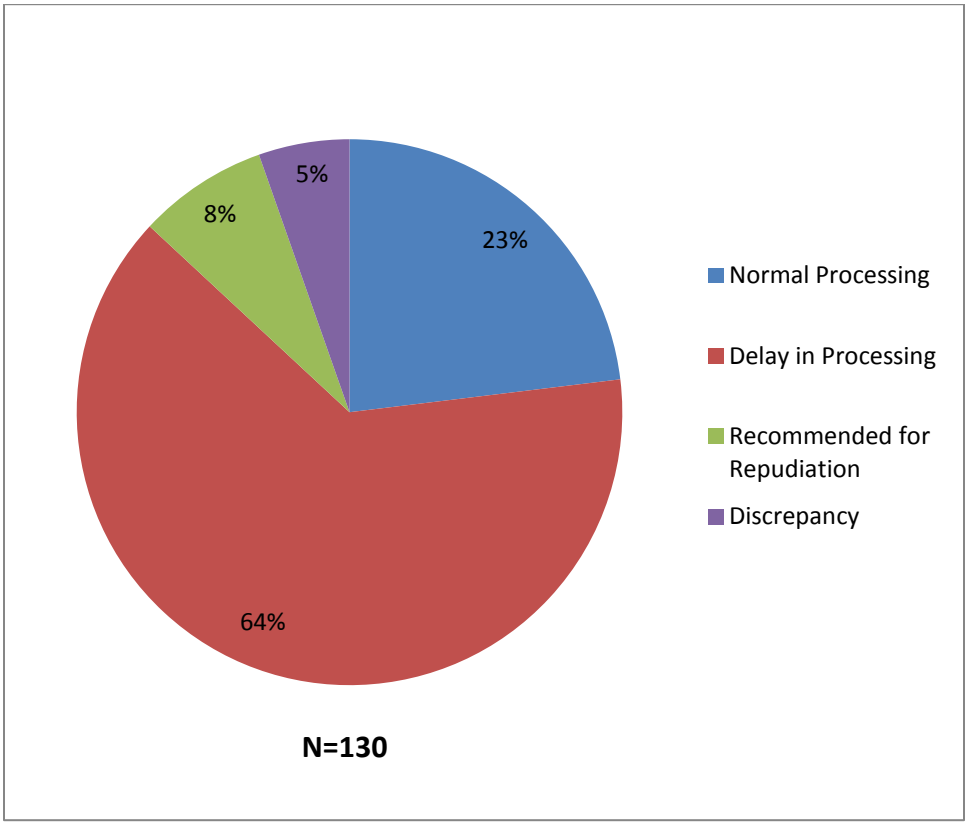

Figure 8.1 shows that out of 130 IPD claims, only 23% claims are settled within TAT, 64% are settled with delay in TAT, 8% are repudiated and 5% are still in discrepancy. They are not processed yet. So, magnitude of problem is high to focus on that. Almost 3 out of nine insured get their IPD claim settled with delay.

Figure 8.2 Number of days of claim settlement in IPD Claims

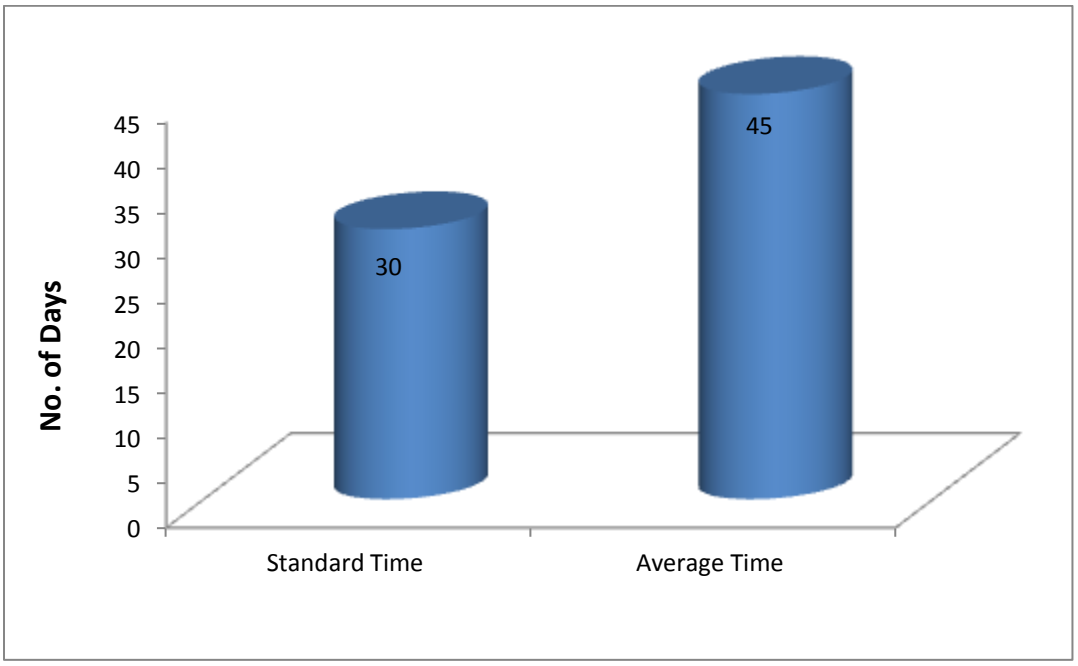

Figure 8.2 shows that in IPD the standard TAT set by E- Meditek is 30 days but on an average claims are settled in 45 days. Majority of claims (approximately 64%) are settled by delay in TAT which should be the focus for the organization as it affects the growth of the organization.

Figure 8.3 Reasons for delay is final settlement of IPD claims.

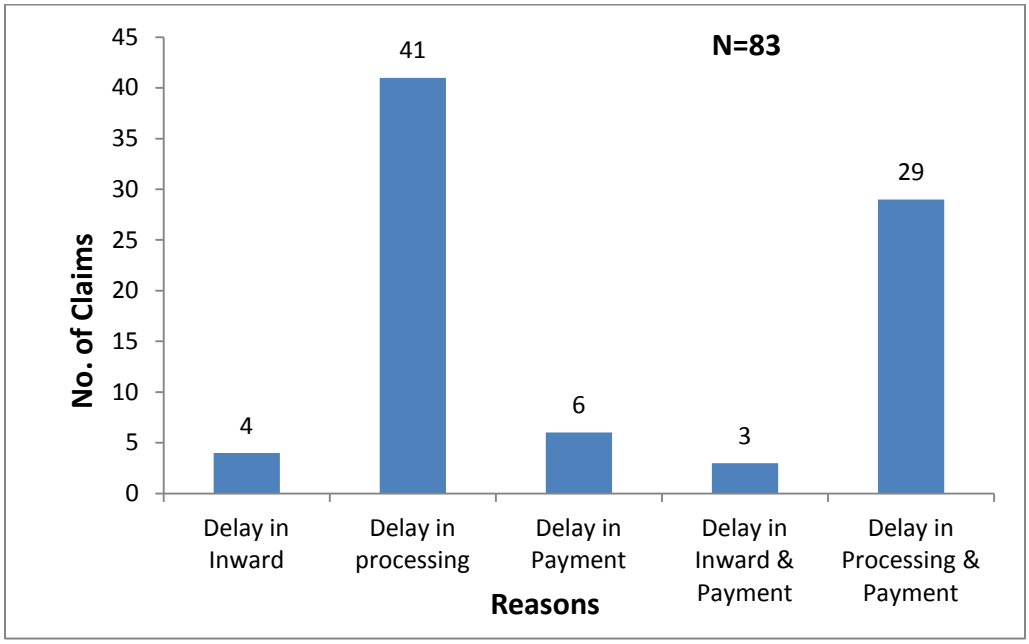

Figure 8.3 shows that out of 83 IPD claims majority of claims are delayed due to delay in processing. The other main reason is delay is processing and payment both followed by other reasons like delay in payment, delay in inward, delay in inward and payment.

So, the organization has to focus more on these steps to overcome this problem.

Figure 8.4 Reasons for repudiation of IPD claims.

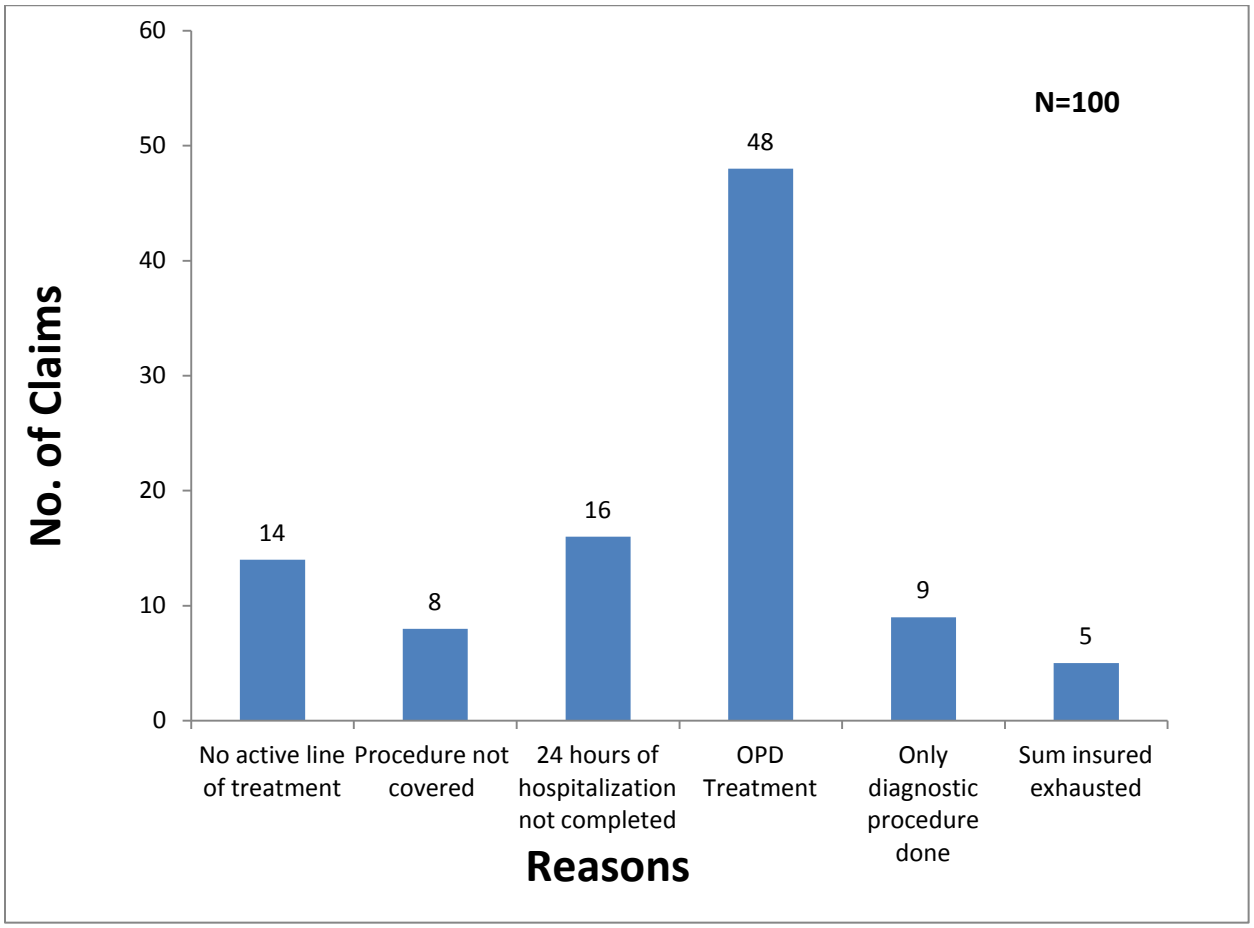

Figure 8.4 shows that out of 100 IPD repudiated claims, majority of claims (approximately 48%) are repudiated due to the reasons that patients are taking OPD treatment during hospitalization. In this sometimes patient claims his OPD claim in IPD for the reason either his/her OPD limit exhausted or he/she is not aware about the differentiation of IPD and OPD claims written in the policy. Rest repudiated for other reasons like 24 hours hospitalization was not there which is a mandatory condition for IPD claim, next is no active line of treatment was there for hospitalization (Patient was taking treatment which he/she could take without hospitalization), then only diagnostic tests or procedures done which can be done without hospitalization, then patient is claiming for the procedure which is not

covered, eg: intravitreal injection, cosmetic surgery etc., and last if patient don't have remained sum-insured amount without which claim can't be re-imbursed.

Figure 8.5 Distribution of claim settlement according to TAT in OPD claims.

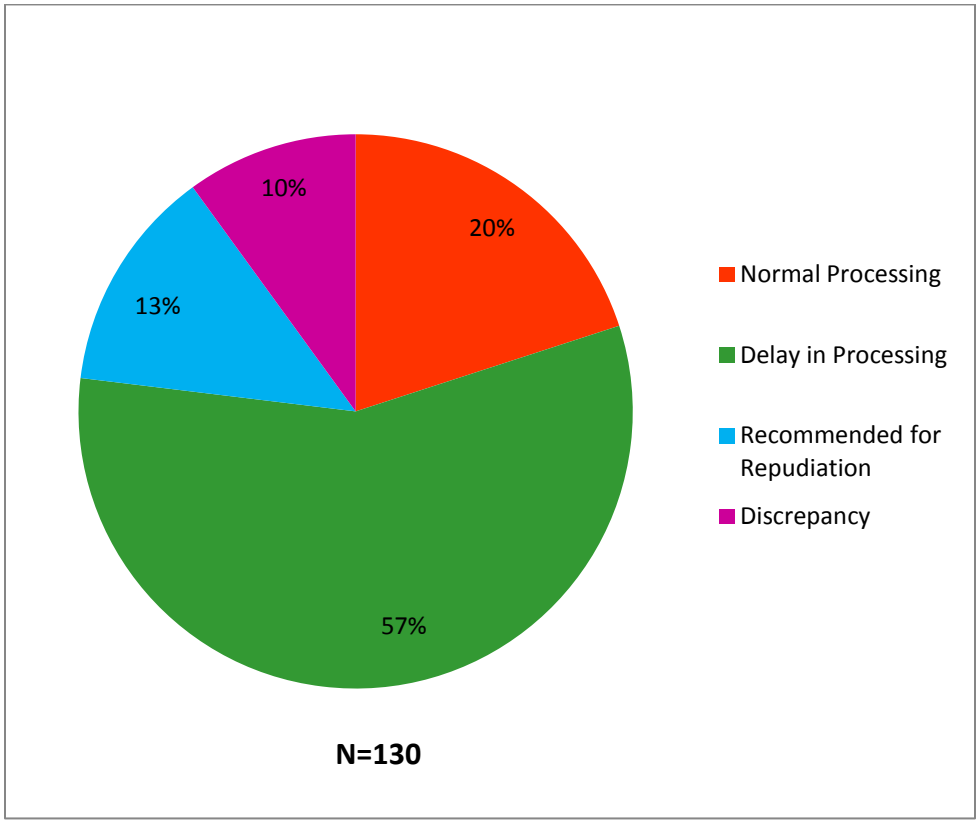

Figure 8.5 shows that out of 130 OPD claims, only 20% claims are settled within TAT, 57% are settled with delay in TAT, 13% are repudiated and 10% are still in discrepancy and not processed yet. So, magnitude of the problem in OPD is also in considerable percentage like IPD. Only we can say that in IPD more loss is incurred in one time. But repudiated claims in OPD are more- 15% instead of 8% in IPD.

Figure 8.6 Number of days of claim settlement in OPD claims.

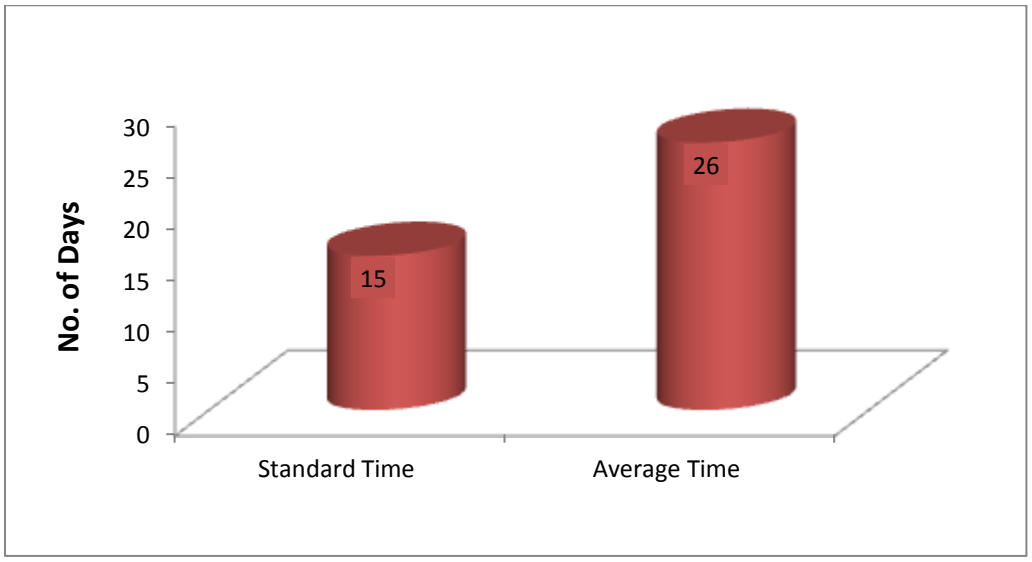

Figure 8.6 shows that in OPD the standard TAT set by E- Meditek is 15 days but on an average claims are settled in 26 days. Majority of claims (approximately 57%) are settled by delay in TAT which should be the focus for the organization as it also affects the growth of the organization.

Figure 8.7 Reasons for delay is final settlement of OPD claims.

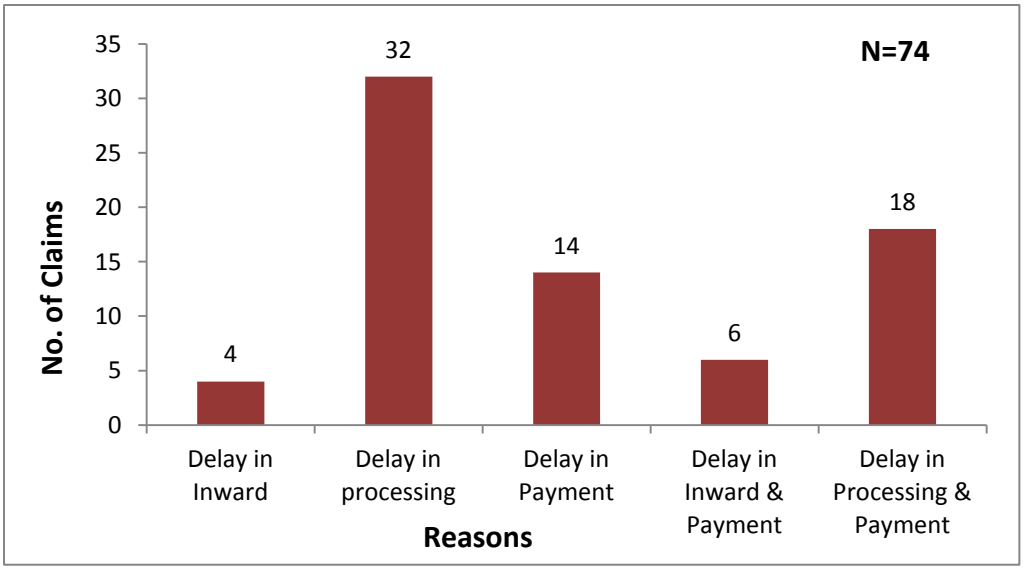

Figure 8.7 shows that like IPD in OPD claims also, majority of claims (32 out of 74) are delayed by delay in processing followed by delay in processing & payment both, delay in payment, delay in inward and payment both and delay in inward.

Figure 8.8 Reasons for repudiation of OPD claims.

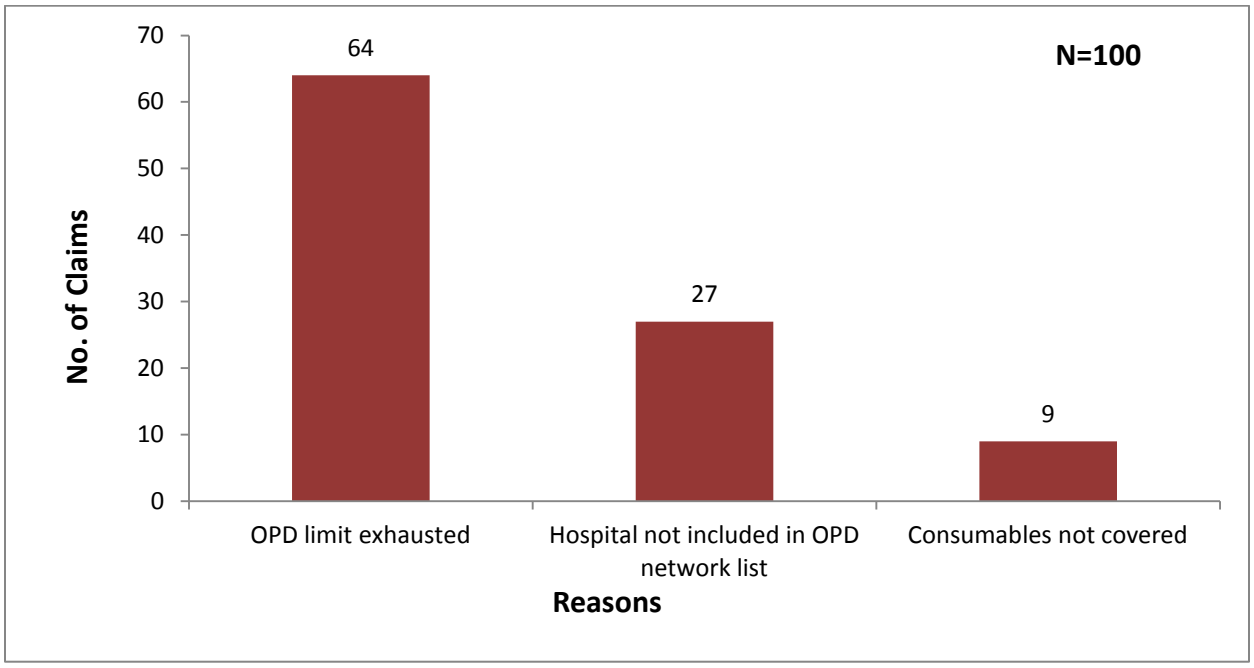

Figure 8.8 shows that in OPD claims, out of 100, majority of claims (approximately 64%) are repudiated due to the reasons that patient's OPD limit exhausted. They don't have OPD limit money left to reimburse their claims further. The rest of the cases were repudiated for other reasons like the hospital from where patient is taking prescription is not included in the OPD network list according to the policy and last reason is that patient is taking claim for the consumables which come under non-payable list like eye glasses, knee brace etc.

Steps of Claim Settlement in E -Meditek

1. Patient's claim File comes in the office.
2. Assistant puts stamp of date and seal of receiving on the file and gives acknowledgement letter to the patient.
3. Then data entry is done according to Claim Form and file is intimated and a unique intimation number id is generated for the patient.
4. Then scanning of all file-documents is done.
5. Then inward is done and inward number is generated. By the end of this point, documents can be seen by anyone in the organization having authorized access to such information.
6. Thereafter, Bill entry is done by the Data-operators as per the bills attached in the documents by patient.
7. Then the file comes to Doctor's end for claim processing.
8. Thereafter file undergoes two tier approval: Internal and External quality check.
9. After the above two quality checks claim is uploaded in the computer application for payment.
10. Finally status of files is checked and if settlement is done then these files are sent to respective Insurance Companies.

By the observation of claim files and discussion with the staff some more findings came out which were not reflected in the above data analysis.

Delay can be occurred at any of the above steps of claim settlement which were discussed in the reasons of delay.

9. Discussion

On the basis of the above analysis and by the discussion with the staff of the company, it can be interpreted that there is a lot of scope for improvement to smoothen the claim settlement procedures in TPA. As it affects the insurance sector in many ways it should be the focus for insurance industry.

For that first of all we have to identify the reasons because of which problems persist. These reasons were summarized according to:

- Claim files data observed and processed by daily provided work list.
- Claim files data collected by the discussion with the staff of the organization.

9.1Reasons

9.1.1 Reasons for delay in claims settlement are as follows:

- Main reasons were delay in processes like inward (when documents uploaded in DMS and they can be seen in any branch of the company), scanning, bill entry, processing by doctors, payments etc.

  Apart from these, some issues were identified by the discussion with the staff and observation.
- Sometimes there is delay from customer side. They don't give pending documents on time and their reply to discrepancy in document is often received late.(Due to this processing by doctor delays)

- Sometimes delay occurs from the branches of the Company. Branches don't forward files to the Head office on time.
- Some claims are critical. So, we have to take permission from the Insurance Companies for further processing but insurance companies don't intimate on time. So, all these offices are interconnected and a coordinated effort is necessary.
- Sometimes files get misplaced due to lack of proper file management.
- Other reasons include errors on the part of Doctor, first of all doctors don't identify that this claim is how old before processing and high aging claims will not processed on priority, other issues are that doctor applies wrong discrepancy or does wrong processing. Then the claim comes back for reprocessing. In other situation if discrepancy reply don't come in time claim then claim goes under "No Claim", but after that if reply comes then we have to re- process the claim. There is no provision of formal training of data entry operators and medical officers. So, sometimes doubts don't clear off.
- Similarly if patient or hospital is doing fraud or it seems that there is some fraud going on then it goes for investigation. Investigation team checks for the hospitalization details and if its genuine than we process the claim but if it is fraud it goes under "No Claim".
- Some other issues include employee retention data entry operators and Doctors are the main and in majority as Human Resource in TPA_S but attrition is very high. Due to which claims are pending for processing. Sometimes they are over- loaded with work and quality of processing gets adversely affected.

9.1.2 Reasons for repudiation of claims

9.1.2.1 Repudiation of IPD claims

- If patient is taking some treatment which can be taken under OPD.
- If there is no active line of treatment during hospitalization.
- If 24 hours of hospitalization is not completed which is a mandatory condition for IPD.
- If patient is admitted for only diagnostic procedure.
- If patient is undergone a procedure which is not covered under the policy.
- If patient SI (Sum- Insured) is exhausted.

9.1.2.2 Repudiation of OPD claims

- Main reason is exhaustion of OPD limit of the insured. In the Insurance Project under consideration SAIL's retired employees and their responses are covered. Normally they have non – communicable diseases like hypertension and diabetes and take medicines regularly but they have less OPD limit (Rs. 2000/- per member) and unlike IPD, clubbing is not allowed in OPD. So after 2 or 3 claims their OPD limit gets exhausted and they have to pay out of their pocket.
- Other reason is that the hospital from where the patient is undergoing OPD treatment is not included in OPD network list of insurance company.
- Also, the claim is repudiated if the treatment which the patient is taking is not covered in OPD procedures allowed under the scheme. E.g.: Intravitreal injection.

9.2 Recommendations

9.2.1 Recommendations to prevent delay in settlement of claims

- For delay in inward, software up-gradation should be undertaken, especially in the branches so that the claims inward should be done as soon as possible after the receipt of documents.
- Scanning of documents should be done properly. Re- scanning wastes a lot of time. Technical up-gradations should be done for this as well. By this if prevention cost is high ultimately failure cost will be low.
- When claims are assigned to the Doctors, there should be some blinking colors incorporated in the software for high aging claims. This shall make the Doctors aware of such claims pending in the system allowing them to process them on priority basis.
- There is a set of TAT for the whole settlement. However, there should be set time limits for each and every step and the Competent Authority should check the progress of processing at each level on regular basis. This will ensure distribution of responsibility among the various channel partner responsible participating at various levels of processing.
- Sometimes, delay occurs when Doctors have to take decision on their own while processing the claim. At times, they do discuss with senior doctors before taking such decision. Nonetheless, if such decision goes wrong then the claim has to be reprocessed again from the beginning. This results in wastage of time. This can be prevented by having a thorough discussion among all stakeholder i.e. the TPA, the

Insurance Company and officials of SAIL so as to devise a framework or put down a standard code for decision making.

- If any discrepancy is raised by any Doctor while processing claim then the same should be intimated to the patient concerned on the same day via phone or email so as to ensure his reply to discrepancy as soon as possible.
- For receiving reply to the discrepancies or some pertinent documents/case files from any Branch, a smooth line of communication should be ensured among the Branches and Head Office. This will ensure saving of time wasted in waiting for such reply among the Branches and Head Office.
- For some critical cases, the case can be discussed with the insurance companies directly via phone or through meetings on priority basis. This may ensure early reply enabling the TPA to process the case more accurately and time efficiently.
- Proper File Management system should be developed to minimize the chances of file missing in transit. This should also include a manual/electronic file placement system according to the status of file under processing.
- Delay in payment to the beneficiary is often due to unavailability of updated NEFT details of the beneficiary's account in death cases. In such cases details like cancelled cheque, NEFT details, details of nominee etc. should be kept on record. This will ensure their prompt verification at the time of documents receipt for claim processing and if any discrepancy is observed then the same can be conveyed to the concerned person via mail or phone before further processing. This will prevent wrong processing and save valuable time.

- A checklist of essential documents should be provided to the patients/customers in advance to file the claim.
- For tackling Fraud claims, Technical training should be given to Doctors. This will enable them to detect fraudulence at their level of processing, thus saving valuable time and money of the organization from getting wasted.
- For preventing wrong entries, Data Operators and Medical Officers should be provided with requisite training on regular basis. Moreover, the new joiners should be supervised closely and should be provided with proper technical training for dealing all aspects of claim processing at their level.

9.2.2 Recommendations to prevent Repudiation of claims

- Patients/customers should be provided with a proper booklet of health insurance policy from the concerned Insurance Company that includes all the relevant information viz. Treatments covered under IPD/OPD, documents required while submitting claims, SI Limit, OPD Limit etc.
- Above information should also be available on the official website of the Insurance Company in easily comprehensible language.
- Also, the TPA Desk members should also educate/inform the patients about the policy and how to go about the claims.
- If the SI/OPD limit of a particular patient is exhausted, the same should be informed immediately by the concerned Doctor in the office which in-turn should communicate the same to the patient via mail, phone or SMS by the TPA as soon as possible.

- Also, if any patient is claiming OPD treatment under IPD then instead of out rightly repudiating the claim the TPA may inform the same to the concerned patient and with his prior approval may process the claim under OPD claims.

10. Conclusion

This study was conducted mainly to understand the loopholes in claims settlement in TPA and to find out the practical solutions for them. By virtue of above findings, we can conclude that there is lot of scope for improvement to prevent delays in settlement and to repudiation of the claims. By preventing this, the TPA can effectively prevent the negative impacts of such delays leading to creating value for the organization in terms of time, money and labor. This will lead to higher customer satisfaction and enhanced growth for the Insurance sector in general and concerned TPA in particular.

11. Annexure

Data of Claims Beyond TAT:

Claim No	Doc Recd Date	Inward Date	Recom Date	TAT	Aging	Reasons of delay
#######	04/03/2015	04/03/2015	05/04/2015	> 30 Days and <= 45 days	41	Delay in processing
#######	09/03/2015	13/03/2015	14/03/2015	> 30 Days and <= 45 days	32	Delay in payment
#######	03/03/2015	13/03/2015	14/03/2015	> 30 Days and <= 45 days	32	Delay in inward,Delay in payment
#######	07/03/2015	09/03/2015	10/04/2015	> 30 Days and <= 45 days	36	Delay in processing
#######	07/03/2015	09/03/2015	10/03/2015	> 30 Days and <= 45 days	36	Delay in payment
#######	09/03/2015	10/03/2015	01/04/2015	> 30 Days and <= 45 days	31	Delay in processing, Delay in payment
#######	27/02/2015	02/03/2015	10/03/2015	> 30 Days and <= 45 days	43	DISC in claim

Data of Claims within Normal TAT:

Claim No	Doc Recd Date	Inward Date	Recom Date	TAT	Reasons of delay
#######	28/03/2015	31/03/2015	01/04/2015	<= 15 days	14
#######	02/04/2015	09/04/2015	13/04/2015	<= 15 days	5
#######	12/03/2015	16/03/2015	00/01/1900	> 15 Days and <= 30 days	29
#######	14/03/2015	20/03/2015	21/03/2015	> 15 Days and <= 30 days	25

Data of Repudiated Claims:

Claim No	Doc Recvd Date	Status	TAT	Aging	Reason
#######	2/26/2015 10:28:45 AM	RFR	> 45 Days and <= 90 days	72	No active line of t/t
#######	2/27/2015 3:28:57 PM	RFR	> 45 Days and <= 90 days	80	Only MRI
#######	2/26/2015 12:49:42 PM	RFR	> 45 Days and <= 90 days	68	Inj Avastin
#######	2/26/2015 12:41:48 PM	RFR	> 45 Days and <= 90 days	53	Inj Accentrix
#######	2/16/2015 5:00:26 PM	RFR	> 45 Days and <= 90 days	73	24 hrs hosp not complete

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