A Study of Issues in Claim Processing in TPA and Scope for Improvement

Internship Training
at
E-Meditek TPA Services LTD

By
Nidhi Gupta

Under the guidance of
Dr. Barun Kanjilal

Post Graduate Diploma in Hospital & Health Management
2012–14

Institute of Health Management Research
Jaipur
2014

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Nidhi Gupta** student of Postgraduate Diploma in Hospital and Health Management (PGDHM) from Institute of Health Management Research, Jaipur has undergone internship training at **E Meditek TPA Service3s LTD** from March 3rd, 2014 to May 19th, 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
Dean, Academics and Student Affairs
IIHMR, Jaipur

Mr. Barun Kanjilal
Professor
IIHMR, Jaipur

EMSL **E-MEDITEK**
— (TPA) SERVICES LIMITED

The Certificate Awarded To
Dr. Nidhi Gupta

In recognition of having successfully completed her dissertation in the department of TPA (Third party administrator)
Project Title
"A Study of issues in claim processing in TPA and Scope for improvement"

In

E-MEDITEK TPA SERVICES LTD
(3-3-14 to 19-5-14)

He/she comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning
We wish him/her all the best for future endeavors

Assistant Branch Manager
EMEDITEK TPA SEVICES LTD

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Acknowledgement

I am grateful to my Guide Prof. Barun Kanjilal and my Mentor Dr. S.D Gupta who helped and guided me throughout these two years of my course. They have guided me through every difficulty.

My deepest gratitude goes to Mr. C.Narayana Prasad Branch Manager and Mr.Sumesh Ramakrishna Assistant Branch Manager E-Meditek TPA Services LTD. who helped me in every step of my study. Also I would like to appreciate the support provided by all the E-Meditek TPA Services LTD staff.

I am grateful to Dr. B.Balakrishna Sr. Medical officers who've been so co-operative in responding the queries, without their co-operation and involvement this study would not have been possible.

Dr. Nidhi Gupta

LIST OF TABLES / FIGURES

LIST OF ABBREVIATION

A.PLAN	Annuity Plan
AA	Active Agent
ADV. SEL	Adverse Selection
AL	Acceptance Letter
ANNIV	Anniversary
CC	Claim Concession
CI	Claim Intimated
CL	Check List
COND L	Condolence Letter
DB	Disability Benefit
DC	Death Certificate
DF	Discharge Form
DO	Divisional Office
DS	Discharge Summary
DOB	Date Of Birth
DOC	Date Of Commencement
DOM	Date Of Maturity
DISC	Discrepancy
FC	Free Cover
FUP	First Unpaid Premium
P HLY	Premium Half Yearly
P MLY	Premium Monthly
SA	Sum Assured
SI	Sum Insured
SOC	Settlement Of Claim
TAT	Turn Around Time
RC	Repudiate Claim
RBD	Recommended By Doctor
QR	Query Reply

Definitions

Definitions	
Third party administration(TPA)	An organization that administrates group insurance policies for an employer. They works with the employer as well as the insurer to communicate information between the two, as well as processing claims and determining eligibility.
Turnaround time (TAT)	Turnaround time is a total time required for completing a process
Focus group discussions(FGD)	A form of structured group discussion involving people with knowledge and interest in a particular topic and a facilitator.
Insurance Regulatory and Development Authority (IRDA)	Insurance Regulatory and Development Authority, an agency of Government of India for insurance sector supervision and development
National Electronic Funds Transfer (NEFT)	National Electronic Funds Transfer (NEFT) is a nation-wide payment system facilitating one-to-one funds transfer. Under this Scheme, individuals, firms and corporate can electronically transfer funds from any bank branch to any individual, firm or corporate having an account with any other bank branch in the country participating in the Scheme.

CONTENTS OF REPORT

The report consist of two parts

Part-1 Internship report

Internship report includes the brief description of the organization E-Meditek TPA Services Ltd, it consist of the overall internship experience and the key learning.

Part-2 Dissertation report

Dissertation report includes the study which was done as a curriculum of a course, as it was conducted in the organization E-Meditek TPA Services ltd. The topic of the study was "A Study of Issues in Claim Processing in TPA and Scope for Improvement "The report consist of the processes involved in the organization, also involves multiple findings of the study along with the results, recommendations.

PART 1

INTERNSHIP REPORT

1.1. INTRODUCTION

A **Third Party Administrator (TPA)** is an organization which processes claims and provides cashless facilities as a separate entity. Seen as an outsourcing of claim processing, TPA processes claims for both retail and corporate policies. The risk of loss incurred remains with the insurance company. An insurance company hires TPA to manage its claims processing, provider network and utilization review. While some TPA operates as units of insurance companies, most are often independent.

TPA is also involved in handling healthcare claims using a specialized set of manpower and technology, therefore hiring a TPA for the same is a more cost effective method.

The Insurance Regulatory and 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 provision of health services. TPA was introduced by the IRDA in 2001.

Being one of the prominent players in the managed care industry, it has the expertise and capability to administer all or a portion of the claims process. The services include claims processing, premium collection, enrollment and cashless processing. Insurance companies setting up its own health plan and outsource responsibilities to a TPA.

The TPA acts like a claims adjuster for the insurance company. In some cases the insurance company sets up an entire department within their own company to act as TPA as opposed to hiring a commercial TPA company.

1.2. OBJECTIVE

The primary objective of the internship is to evaluate the processes carried out at E-Meditek TPA Services LTD. It was an Initiative in Improving the Turnaround Time of processing claim files within the standard set time in the organization. The criteria for evaluation is to monitor the effectiveness of work, As an intern the key responsibilities had been to do data collection and its analysis, data management, report generation and making appropriate recommendations. Certain period was also spent in the head office of E-Meditek and hospitals to find out the problematic area and come up with suitable recommendations.

1.3. ORGANIZATION PROFILE

About E-Meditek TPA Services

The Vision of the organization is to be industry leader in TPA industry by building Customer Satisfaction through quality service, fairness, transparency, ethical business practices, high integrity and quick response.

The Mission is as a responsible customer focused health benefit TPA, the company will strive to understand the needs of insurers in its endeavor to provide quality service that can win the trust of policy holders and translates into portfolio growth for the insurer.

E-Meditek TPA Services is India's leading Third Party Administrator (TPA), they have been blending the art of health benefit administration with technology, innovations and best practices in constant endeavor to deliver the very best to over 7 million registered members. They have strong relationship with 24 insurers, 10000+ health providers and host of other partners and international alliances make it possible for to attain excellence in every activity that we undertake as a TPA. In addition, the extensive interface with Mass schemes, Pre-insurance Health Screening and International Travel insurance management signify their commitment to provide end to end solutions to valued principals and customers.

The core competence of E-Meditek lies in reducing claims cost while ensuring quality care for valued customers, checking fraud & abuse, promoting preventive care & wellness programs, advanced analytics and predictive modeling. The robust technology platform helps support wide spectrum of services to growing volumes of customers with ever growing demands and wide range of health insurance products.

E-Meditek was the first TPA to introduce E Card, SMS Alerts, and Auto mailers in the TPA industry and are constantly upgrading their service delivery for ease and convenience of all stake holders, including system integration with insurers and providers. The skilled and trained manpower is the biggest asset and their internal processes like concurrent audit, fraud alerts, Gatekeeper negotiations/case management, verification & investigation of suspect cases, tariff arrangements and discounts with hospitals etc. are unmatched in the industry, resulting in one of the lowest claims cost.

Services Provided by E-Meditek

E-Meditek as leading TPA in the country offers Health Benefit Administrations under various health insurance policies issued by 15 insurers as its mainline activity. E-Meditek is the only TPA to offer host of other services such as Pre-Policy Health Check Ups, RSBY Implementation and claims administration and Hospital Bill Re-pricing for Overseas travel claims. They have also initiated number of wellness programs in recent years as proactive approach to challenge the cost of healthcare as preventive measures.

TPA Services (Health)

Cashless and hassle free hospitalization benefits at network hospitals/ nursing homes

- Member enrollment, benefit confirmation, on line profile management
- Empanelment of service providers, negotiation of tariffs and discounts
- 24*7*365 Helpline and Customer Support
- Claims adjudication and payment
- Analytics/Under Writing Support

Travel Insurance

EMSL has tied up with international firms for servicing overseas travel claims of Indian travelers. Our Services include support for:

- Emergency Medical Treatment
- Accidental Death
- Loss of Baggage
- Baggage Delay
- Loss of Passport
- Sickness Dental Relief
- Others as per customized requirement

Pre-policy Health Checkup

- Finalization of rates, tariffs and document templates for different insurance companies
- Member health-check up, fixing appointment, picking up reports
- Digitizing reports and uploading for on line access

Mass / Rural Schemes

- Implementation of RSBY – beneficiary mobilization and field enrollment, empanelment of rural providers, providing IT support – machines and manpower, processing of claims and payment, liaison with nodal agencies/Ministry, uploading of data on World Bank server etc.
- Implementation of UHIS and similar schemes in different states.
- Self funded schemes of state governments.

Wellness Program

Programs designed to encourage preventive care, to reduce the incidence and impact of life style diseases prevalent among affluent section, among older insured population. The services include as shown in (Figure1.1)

- Health camps (on site / off site)
- Health talks and mailers
- Health Risk Profiling, screening, prevention and maintenance
- Electronic Health records

FIGURE 1.1.WELLNESS TREE

(Figure shows Group of services provided by E-Meditek wellness center)

1.4. ORGANIZATIONAL STRUCTURE E-MEDITEK TPA SERVICES LTD

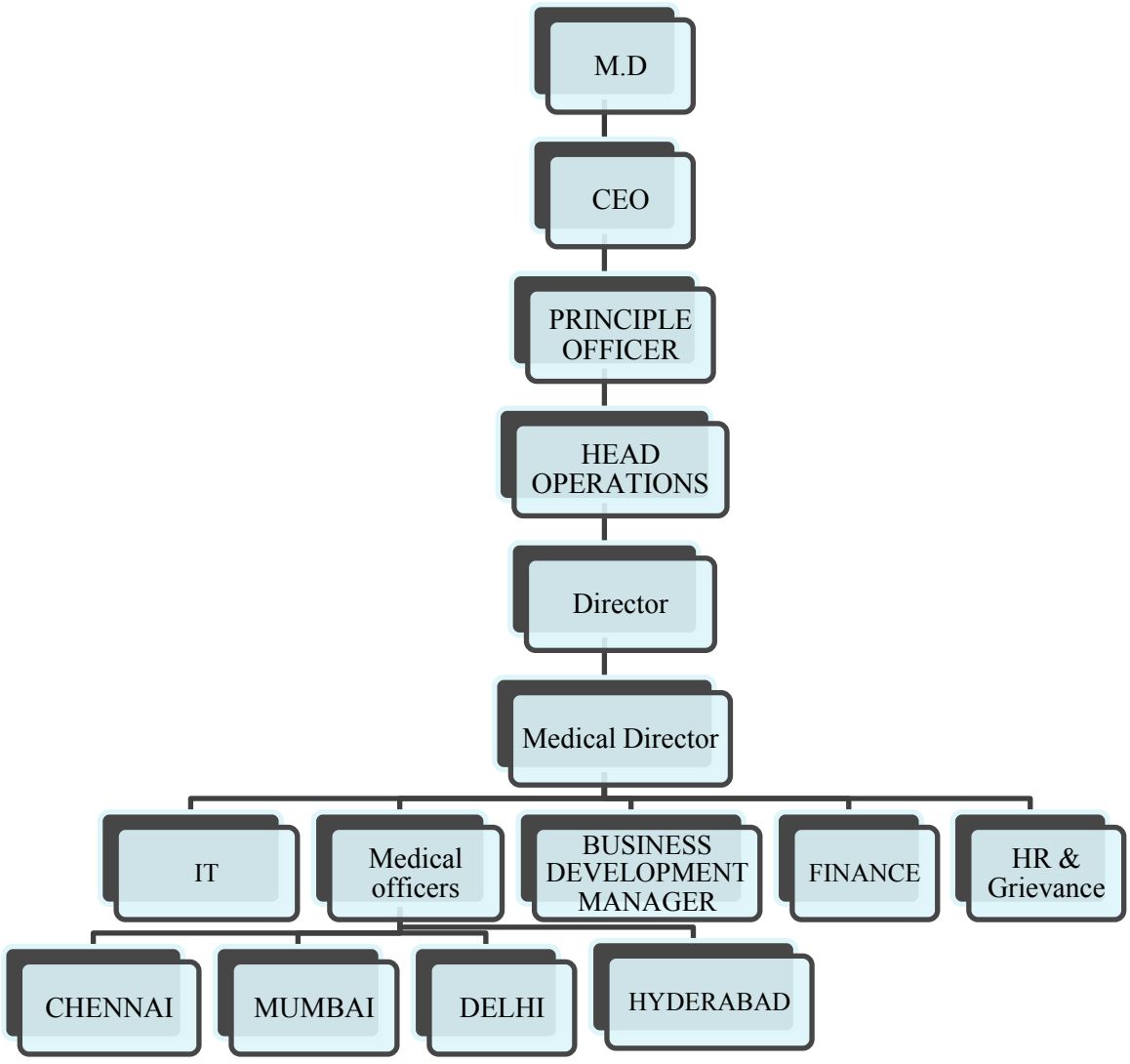


FIGURE1.2. ORGANIZATION STRUCTURE OF E-MEDITEK TPA SERVICES LTD.

1.5. INTERNSHIP EXPERIENCE

The Internship was for a period of 3 months starting from March 2014 to May 2014 where in the position held was that of a medical intern in the project A Study of Issues in claim processing in TPA and scope for Improvement. It is about the monitoring of multiple processes carried out in day to day basis from the time of file received in the TPA office till the settlement of payment done, to find out the key reasons of claim repudiation and denial of pre authorization forms and how to overcome with the problems of repudiation and denials.

The main purpose was to acquire a basic understanding of every practical aspects of the project, during the internship visits were also made to hospital's TPA Desk, and many insurance and corporate firms, at the end of internship a visit was also made to E-Meditek head office, Gurgaon to look into the administrative and Operational functioning of the organization.

1.6. **KEY LEARNING**

- This internship provided me the opportunity to know how the TPA firm works and also given exposure to understand various processes and allow me to monitor them and find out the loopholes.
- The time spent with the medical and administrative team of TPA had helped me in data collections. A random study of 200 files in a period of 2-3 months was carried out successfully with primary as well as secondary data.
- As a medical intern I have also learnt the Claim processing work and participated in number of tender/ technical bid meetings which has given me the experience of the business world.
- The organization has given me opportunity to represent E-Meditek TPA to get in to the new business as well.
- I also got an opportunity to conduct interviews in the branch office.
- The data analysis for the purpose of the report was also done which was then compared with the standards set by the organizations.
- As I was working in a branch office with less number of staff which helped me to keep eye on all major and minor processes.

PART-2

DISSERTATION REPORT

A Study of issues in claim processing in TPA and scope for improvement

2.1. INTRODUCTION

A Third Party Administrator 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, TPA handles the claims processing for an employer that self-insures its employees. Thus, the employer is acting as an insurance company and underwrites the risk. The risk of loss remains with the employer, and not with the TPA.

An insurance company may also use a TPA to manage its claims processing, provider networks, utilization review, or membership functions. While some third-party administrators may operate as units of insurance companies, they are often independent. TPA also handle many aspects of other employee benefit plans such as the processing of retirement plans and flexible spending accounts.

2.2 BACKGROUND OF THE STUDY

Third party administration (TPA) industry is a service field where customer satisfaction is the priority and keeping it as a priority the services rendered should be quick and of quality. IIHMR has given the responsibility of carrying out the evaluation of multiple processes for betterment of customer services in TPA. The study outlines the various findings and steps taken for the evaluation and monitoring of processes. The present evaluation exercise is regarding the timely settlement of claims, to decreases the repudiation of claims and thus providing the services in a better way.

This project is an attempt to find the root causes for the delay in claim settlement and making the process more efficient to decrease the rejection of claims. The present study will provide the reasons of delay seen in full and final settlements of the claims and reasons for repudiation of claims. The findings of the present study will help in leading ahead to deliver quality services under the E-Meditek TPA Services Ltd.

2.3 PROBLEM STATEMENT

It is seen by the study that clients/patients are facing challenges in getting treatment on time because of the rejection of preauthorization forms, delay in settlement of claim and getting timely reimbursement from the insurance firm. This is a result of multiple errors in the processes carried out in hospitals as well as in the TPA organization itself which are responsible for deteriorating the quality of services provided to the insured

2.4. AIM

To bring higher efficiency, standardization of processes and improving penetration of TPA in the country.

2.5. SPECIFIC OBJECTIVES

- To bring down the delays by incorporating the control methods in the organization.
- To find out the key reasons of denials of pre authorization forms on behalf of TPA
- To find out the reasons for repudiation of claims both reimbursement and cashless while claim processing.
- Recommend & implement suggestions to improve TPA process which are responsible for causing delay.

2.6. RESEARCH QUESTIONS

- How to reduce time taken in whole claim settlement process and what is the scope for improvement?
- How to overcome with the repudiation of claims in TPA while claim processing?
- How to reduce denial of pre-authorization forms?

2.7. SHORT LITERATURE REVIEW

The study was carried out with the objectives to study and understand the current claim process of existing health insurance schemes, to identify the barriers in the claim process at the hospital level and to study the consumer awareness and satisfaction in health insurance. Overall there is a delay in query justification followed by preauthorization, preparation and faxing. Policyholders were not fully aware about health insurance, 50 per cent of policyholders knew what Third Party Administrator (TPA) means and consumers were not fully satisfied with health insurance. Overall claim process was partially smooth. Acquainted person and convenience in availing made consumers purchase health insurance policy. As conclusion, standards have to be set with standard timings for each process. (Roopalekha Jathanna etall; Study of functioning in the TPAs)

2.8. METHODOLOGY

2.8.1. Primary source of data

- Observation- This method involved observation of the movement of file from the time it is received till the time settlement is done. The observational data collection was also carried out from the hospital TPA desk; administration related processes are also observed during the study.
- Focused group discussions (FGDs) – 2 FGDs were conducted at the branch office to know the opinions, and attitudes towards the service which are being delivered by the organization.
- Interviews with medical and administrative staff to understand the processes in the organization and also know the challenges which they are facing while their working hours.

2.8.2. Secondary source of data

Going through the literature available regarding the organization, reviewing the status of files and also through the online maintained records through Managed information system and checked the files on daily basis.

2.9. STUDY DESIGN AND METHODS

2.9.1. Study design

Descriptive study was done by going through the previous maintained records to measure the average length of claim settlement (TAT) and to compare it with standard length of claim settlement which is 8 days as per the organization norms.

2.9.2. Type of data

The data collected was Quantitative data

2.9.3. Sample size

Random 190 claimed files which are received in the TPA office were analyzed for the study and required data was collected from those file.

2.9.4. Data collection tool

Data of each claimed files are collected and data than entered in MS-Excel sheet and actual time taken in whole process is calculated and analyze with the help of charts and graphs. According to the analysis, recommendations are given for the same.

2.9.5. Data analysis

Separate excel sheet is prepared with required fields to measure Turnaround Time. The difference between the date of file receipt and the day of final settlement, Turnaround time is calculated using Microsoft excel software. Quantitative data is collected and analyzed and presented in form of simple tables, bar charts and graphs for each data separately.

The evaluation method to address the research questions was based on a comparison between the baseline/standards provided by the organization norms and the output result. The baseline status was available in the Standard operating procedures (SOPs) of the organization.

2.9.6. Location of study

E-Meditek TPA Services Ltd
Hyderabad Branch

2.9.7. Data (information) collected

- Reasons for delay in claim settlement.
- Reasons for repudiation of claims both reimbursement and cashless
- Reasons for denial of Pre- authorization for treatment on behalf of TPA

2.10. ETHICAL CONSIDERATIONS

- Informed consent was taken from the organization to look each and every file.
- Purpose of the study was explained to all the staff.
- Confidentiality of data collected was taken care.

3. PURPOSE OF STUDY

Study was done with the aim of assessing the effects and implementing the recommendations to give quality services to customers and gain their confidence.
The findings in this report focus on the monitoring the delays in claim settlement. The report presents the findings in three sections
a) Reasons for delay in full and final settlement of the claims
b) To find out the key reasons for repudiation of claims, as it is disappointing factor for the patients as well as for the customers
c) To find out the reasons for denial of pre authorization forms in having cashless stay in hospitals and implementation of the recommendation will be the factors that will affect a change and will bring quality in service.

4. ROLE IN THE PROJECT

The project was carried out in the period that is March 2014 to May 14 and hence most of the activities carried out involved data analysis and report writing.

As an intern, activities like claim processing, attending tender meetings, data analysis, status checking of claim files, business meetings and interviews were carried out along with the Managing Director (M.D), Chief Executive Officer (CEO), and Branch head of the organization.

5. JUSTIFICATION AND ARGUMENTS

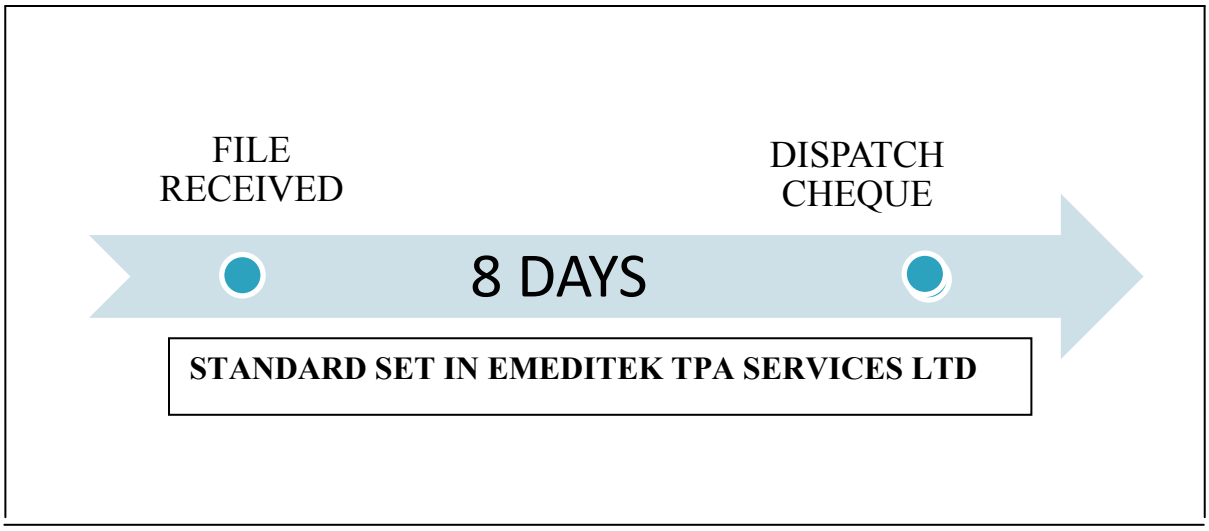
According to the standards maintained by E-Meditek standard TAT for settling the claims is 8 days (**as shown in figure 2.1**). Normally the TAT is taken from the day of file received till the day the cheque is dispatched to the receiver from the TPA. Due to number of reasons the TAT keeps on increasing and delay in payments results in poor and low performance of the services. Therefore to monitor the efficiency, the organization should implement the technologies and resources to provide better quality services. And hence, I have targeted the processes which results in delay the most and those processes are the major attention seeking area.

The details for data collection for the denials of pre authorization form are not mapped as per expectation because the cashless is mostly handled at the head office.

The study was primarily focused on reducing the TAT of settlement of claimed files and also overcome with the repudiation of claims

As per the standards set by E-Meditek TPA, the Turnaround time (TAT) start from the day of receiving file in the TPA office till the payment done online or cheque dispatched for the settlement. **As shown in Figure 2.1,** The whole process should be completed within 8 working days which is the standard TAT set by the insurance industry norms which should be followed by E-Meditek TPA Services LTD.

Figure 2.1 Standard Set In E-Meditek TPA Services LTD



6. PROCESS

The standard processes that are followed by the TPA for cashless hospitalization whether it is emergency or planned and in network or non network hospital are as follows

Planned hospitalization in network hospital

In a planned hospitalization, patient generally have a recommendation for hospitalization by the doctor and have time to decide which hospital to go to for hospitalization patient have to complete the formalities at least 3-4 days before the hospitalization.

- Step-1 Patient select the network hospital provided to him/her while buying the policy or patient can also call the customer care and select the network hospital nearest and most convenient.

- Step-2 After this patient shows his/her health insurance card and fill up the first part that is to be filled by the patient and other part is to be filled by the physician of the 'pre-authorization' form that the patient can get in the insurance desk of the network hospital or it can be downloaded from the website of E-Meditek.

- Step-3 Patient than provide the filled form on the insurance desk of the hospital, the person at the insurance desk will verify its completeness and then fax it to the TPA

- Step-4 the TPA than look after the form and either approve or reject the request.

- Step-5 If form is approved, the TPA send the authorization letter with an approved amount for the treatment.

Planned hospital in Non-network

In the case if patient select for non network hospital which is not empanelled with the TPA than in that case

- Step-1 Patient Informs TPA first about his/her planned hospitalization in xyz hospital.

- Step-2 Avail the health care facility according to the requirement or disease for which the patient is admitted.

- Step-3 At the time of discharge, patient settles all the bills in full and collect the bills, documents and reports from the hospital and lodge the complain with the registered TPA and claim for reimbursement.

Emergency hospitalization

In an emergency hospitalization, the important thing is to get the patient treatment at the earliest and to bring the patient in a stable condition. But the patient needs to start the procedure for cashless facility within the 24 hours of hospitalization. The process which carries out in emergency hospitalization is as follows

- Step-1 Patient needs to show his/her health insurance card provided by the E-Meditek TPA and fill in the pre-authorization form.

- Step-2 The TPA insurance desk in the hospital will fast track the process for the cashless process but in case if patient cannot wait for the approval, than the patient need to pay the

deposit if demanded by the hospital and start the treatment and reimburse the complete expense later on.

- Step-3 Generally the time taken to process an emergency case is 6 hours and patient need to follow up with the TPA to know the status of the request.

- In case of rejection of authorization from TPA At the time of discharge/leaving the network provider premises, patient settles the bills in full and collect all the bills documents and reports after that patient claims with TPA for processing and reimbursement.

Process inside the E-Meditek

All the organization has a set of processes which needs to be of for proper functioning. The processes followed in the E-Meditek are as follow**, (as shown in Figure 2.2)**

- Step-1 Firstly the file comes in the office either by courier or brought by the patient/ relative.

- Step-2 After receiving the file, the assistant put the stamp of date and the seal of receiving on the file and gives the acknowledgement letter to the patient or if file comes by a courier the acknowledgement letter sent to their respective address.

- Step-3 File go for intimation, all the data entry is to be made according to the claim form and than a unique claim number generates which is also known as intimation number.

- Step-4 File than sent for inward which generate inward number, inward is about entering the query reply of the documents, entering the bank details of the claims

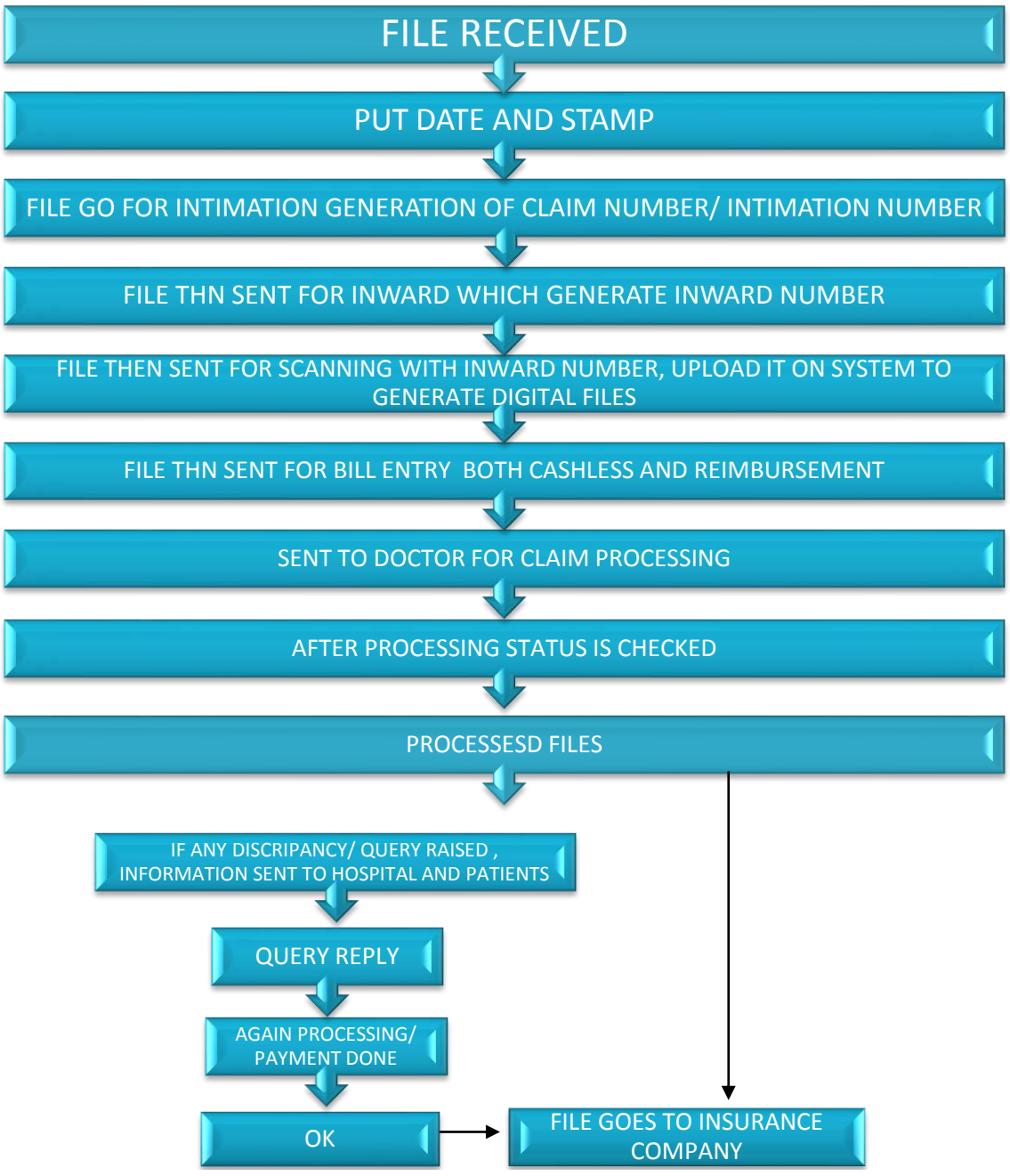
- Step-5 File then sent for scanning with inward number; upload it on system which results in generation of digital files.

- Step-6 File then sent for bill entry both cashless and reimbursement as per the bill details and breakup sent by the hospital

- Step-7 File than sent to doctor for claim processing

- Step-8 After processing status of the files are checked if the settlement is done than those files are sent to the insurance companies

Figure2.2: Process in E-Meditek TPA Services LTD



7. FINDINGS AND DISCUSSIONS.

The problem faced was the incapacity to maintain TAT of claim processing below the standard TAT set by the organization due to number of reasons.
In the branch office the claim processing was restricted to Doctor Level only.

There was no finance department and all the files after settlement were relocated to Head Office for final Approval as well as final financial settlement and once it is done cheque dispatched and couriered at the address of insured. The increased TAT is a very critical issue as it has direct effect on the business strategy and the image of the organization in the market.

Some of the issues due to high TAT could be:

- Cost of non maintenance of TAT, as long as the file remains within the organization it bears the cost of maintenance.
- Customer satisfaction decreases with delay in settlement.
- Financial benefits assessment. Lower the customer satisfaction, continuous lowering down of customer turnover rate and lowered down revenue generation.

7.1. REASONS FOR DELAY IN FULL AND FINAL SETTLEMENT

Delay is seen basically due to delay in the Processes (as shown in figure 8.2) which includes intimation, inward, scanning, bill entry, processing etc and also because of random movement of the files.
Documents pending (delay in payment ,National electronic fund transfer (NEFT) details which is a wide payment system facilitating one-to-one funds transfer is not uploaded in the claim forms, condo nation letter not sent, discrepancy/query reply)
All the files relocated to Head Office (HO) for final approval as well as final financial settlement which results in increase in the TAT of settlement
D/t reprocess, No claim
No policy updation- it takes doctors time as well to ask for policy updation to the enrollment desk. Sometimes policies are not available with the TPA. So it takes time to intimate the client and receive the policy

7.2. REASONS "WHY" MEDICAL CLAIMS GET REJECTED

Rejection of claims is another problem in TPA; there are lots of reasons for the claims get rejected, **(as shown in Figure .2.5)**. One of the commonest problems is when the disease for which customer or patients claimed comes under non-coverage in the policy terms and conditions.

- When there is Delay in submission of the claim without any valid reasons and without the letter attached to it showing the reason for delay or documents not submitted
- Many times claims got rejected, when patient claims for Complication of disease which is not payable as per terms and condition of the policies.
- Fraud cases for example- same hospital is claiming 3-4 claims with change in person names and some time hospital is not available for which the person claims, as well duplicates cases directly get rejected.
- If patients/ policy holder's sum insured gets exhausted and the policy holder is unaware of the information.
- Services not covered in the policies, If the ailment for which patient is hospitalized is not covered in the policy results in rejection of the claim
- When patient for which claim is raised comes under Outpatient department (OPD) which is mostly likely to get rejected as OPD services is very rarely covered in the policies.
- Pre existing disease not covered according to the policy.
- Patient is unaware that there is break in the policy and claim for insurance in that case claims got rejected.
- The provider isn't paneled and does not fall under the eligible criteria of policies.

7.3. DENIAL OF PREAUTHORIZATION FORMS

The information contained in pre-authorization form is insufficient and not eligible to approve the request, though most of the time the TPA will request the hospital if additional information is needed. Pre auth also get rejected due to irrelevant data it also takes time for approval, as the pre authorization is handled over the head office not from the Hyderabad branch.
Various reasons for denial of pre authorization form are

- The disease for which cashless is apply is not covered under the terms and condition of the policy.
- The matter not coinciding or matching with the documents send along with the pre authorization form to the TPA results in the denial.
- Missing as well as Irrelevant Entries made in the pre authorization form, many times there are multiple mistakes in the form like incorrect name, sex, policy number etc.

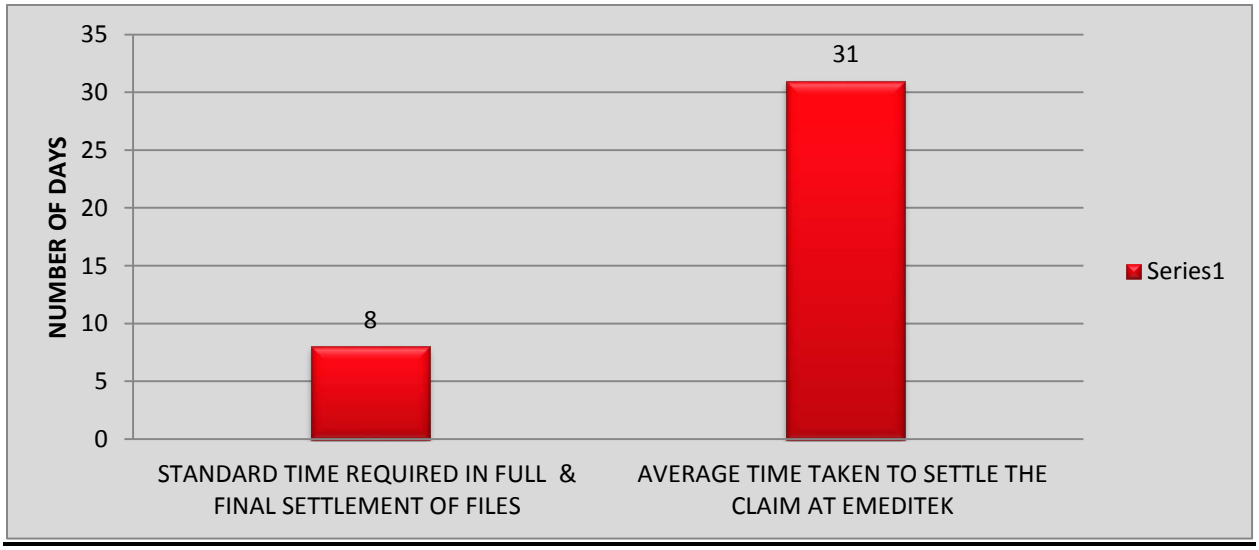
7.4. OTHER PROBLEMS COME ACROSS WHILE STUDY

- There was no proper file handling system, no record maintenance of the files.
- The office is running with insufficient resources which are making employees overloaded with work which results in dissatisfaction and resignations.
- No power backup for systems in the branch, and during power cut phones also get disconnected which creates trouble to the clients and hospitals.
- The resources which are available are unutilized.
- Auto saving of documents is lacking

8. RESULTS

Any files which comes in the TPA office for the claim settlement should be settled within 8 working days as per the insurance company's laws as well as E-Meditek follow the same norms.8 working days is the standard time. But after viewing 100 claimed files the results were very poor the average time of claim settlement among those files are 31 days which should be 8 days as per the standards. **(As shown in Figure 2.3)**

Figure2.3: Standard and the average days of claim settlement



Interpretation: The vertical axis of the graph is showing the number of days requiring for the full and final settlement of claims and vertical axis shows the standard days which is to be follow and the average days of settlement of claims .100 random files were studied out of them 31 days were the average day of settling the full and final claims which should be 8 days ideally.

Claims settlement is the most important aspect of the functioning of an insurance as well as TPA companies. The customer has many expectations with the TPA. Timely settlement of the claim should be the priority but at E-Meditek maximum number of claim files that is 80-90% settles with delays **(as shown in Figure 2.4)** due to multiple errors in the processes and there is no monitoring for those errors, documents remains pending and payment by the cheque delivering method further delay the settlement of the medical claim files which hampers the client or patient's satisfaction.

Figure 2.4: Reasons for delay in full and final settlement of the claim files

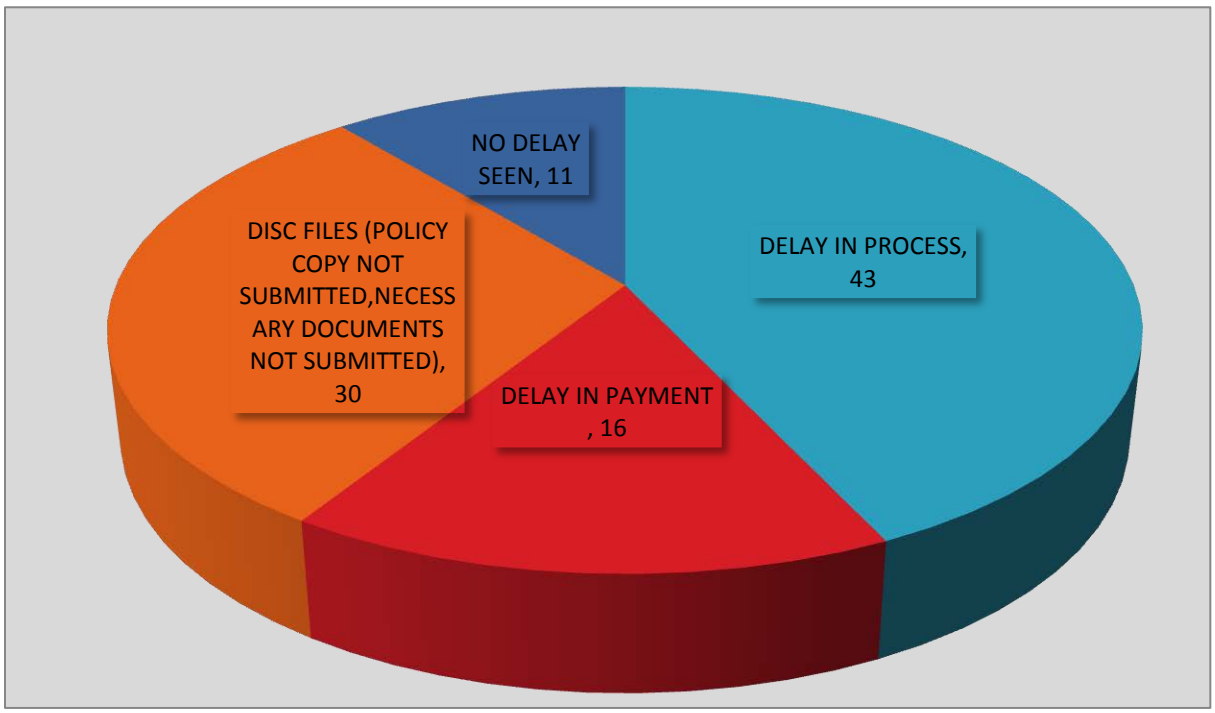
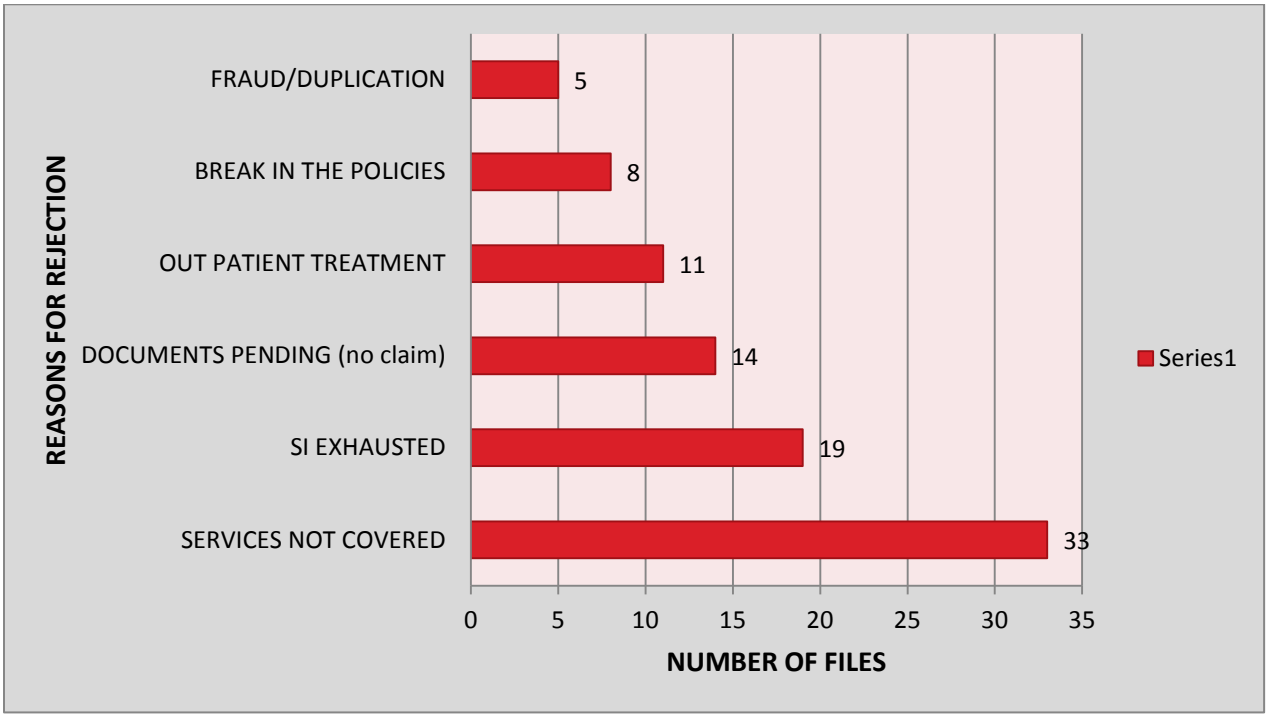


Chart Interpretation: Pie chart 2.4 above shows the status of the claim files showing the causes of delay with respect to number of files. 100 files were studies out of which 11 were processed without any delay as per 8 days standard, the major delay in full and final settlement of claims is due to delay in processes which are carried out in the office which is the major area which needs management attention, and in 30 files it is seen that delay is due to missing necessary documents in the files, and 18 files accounted for delay due to delay in payments from the TPA itself.

Claims submitted by the hospitals, corporate or by the patients may get rejected for a variety of error conditions. (**As shown in the figure 2.5**) Each medical file submission is processed by the doctors at E-Meditek, scrutiny is done for each and every claims. The problem is with the person claiming for the claim do not bring the complete claim relevant documents, many times the policy holder who is claiming is unaware of the basic terms and conditions of his/her policy results in rejection of the claims.

Figure 2.5: Reasons for rejection of claims



Interpretation: The Figure 2.5 above shows the reasons why the medical claims get rejected, this data was collected after viewing 90 medical claim files. The vertical axis shows the key reasons for the rejection of the claim files and the horizontal axis displays the number of files going for repudiation due to particular reasons. After studying the files the major repudiation was found due to services not covered and minor reasons (5 files out of 90) for repudiation was fraud /duplication.

9. RECOMMENDATIONS

9.1. FOR DELAY IN FULL AND FINAL SETTLEMENT OF THE CLAIMS

Recommendations

(A) Intimation Inward delay

The files should be intimated and inward on the same day of receiving which will help in fastening the process. The daily target should be allotted to every employee according to the files received.

Electronic tracking of files with file id and barcode stickers which will be generated at front office and assigning priority to various clients, triaging of files can be done (CORPORATE, LIC whose TAT is comparatively LOW should be handles first). This will facilitate the timely settlement of claim as well as tracking of incoming claim files in a single click. The files can be track on daily basis with date and time of receiving, status of the files (at what step the file is) all this can be seen in a single window by the senior management and all other staff.

Separate team of doctors for separate corporate claims should be maintained. For example one panel of doctor process xyz company's claims, another doctor processes other corporate claims that will reduce the delay as doctor handing particular company will be thorough with all the terms and conditions of that particular organization.(Bar coding benefits-1.Availing the information of pending claim files their status with a single click).Replacing the in hand writing of claim numbers to Bar-coding system which will help in detecting the correct files with its full details and saves the time.

(B) Scanning issue

Re-scanning of the files takes the maximum time because of the software problems.
Hardware and software upgrades. Software integration issues should be resolved immediately.

(C) Documents pending

Delay in receiving query from the hospital or the patient-
At the time of processing if any document is missing or not submitted then those files should be kept separately with a description of pending documents and one person should assign a responsibility to intimate hospital or patient for the same and after intimation sticker should be put on those files saying "customer intimated" (it is better to inform via call because many times patient, insured or hospital does not even look to the mails or messages due to many reasons which results in delay in receiving the query

(D) Delay in payment due to

NEFT details not uploaded or Documents are pending with the claim files, many times cancelled cheque is not there with the files so they should maintain a proper check list so that no documents remain pending.

Branch office should have own finance department in order to do decrease delays in payments. And if done from HO instead of sending courier the online payment should be entertained.

(E) **Policy updation**

The policy should be updated at the time of Enrollment and Renewable. Because it takes doctors time as well to ask for policy updation to the enrollment desk.

Sometimes policies are not available with the TPA. So it takes time to intimate the client and receive the policy.

Solution- Auto renewable of policy should be entertain

The front desk personnel should ask for the policy copy at the time of submission of the claim in the front desk only.

(F) **Files management**

The circulation of files should be hassle free there should be proper tracking and segregation of the files (documents pending, investigation, settled files and rejected files with labeled stickers).

All the files should be kept in color coded files with respect to the insurance companies and should be arranged in chronological order in the shelf which will facilitate in searching the files. And the files which got settled should sent back to insurance rather than piling up them in bulk

9.2.REPUDIATION OF CLAIMS

Recommendations

- There should be a front office person who checks claim with the checklist for the standard set of documents before they are processed, they warns if there is any missing or incorrect data which helps in doing additional claims and increases the productivity, the claim processing administrator also required less time in reworking potentially shortening the processing time and avoiding the consequences of delays. Rejected claims cost money, time and efforts so lesser rejections more the productivity.

- Know the coverage. Employees often submit claims for things they don't have coverage for, either because they don't understand their plan or because they hope for the best. TPA Desk should remind them to check their coverage before submitting and to not submit for a specific

treatment when they are not covered for it. Encourage TPA employees to call the insurance provider when they are in doubt to verify what's covered and not.

- Customize pamphlet with the common reasons of rejection of claims in layman terms to avoid repudiation

- Ensure that hospital or the client insurance booklets are the most up-to-date versions because sometimes clients have outdated booklets. A good practice is to direct members to read the online version of the insurance booklet, or call a customer-service representative for the guidance.

- Just a single click - There should be option in the website for looking out the coverage, inclusions and exclusions of the policy just by entering the policy number or the claim number and this is to be entertained.

.

- When submitting a claim. Correct information given to client or hospitals will help decrease errors.

- Double-check of each and every document, especially the provider information, which is the most common type of error.

9.3. REASONS FOR DENIAL OF PREAUTHORIZATION FORMS

Recommendation

- "With electronic submission, computers validate information as the patient completes the electronic form."
- The filling of preauthorization form should be done electronically so that if patient misses a single field or mistype something, the computer will prompt to complete the form properly. With paper claims, members tend to rush and skip parts of the claim form if they don't have the information at hand or don't understand what's being asked.
- Forms should be filled under the guidance of TPA desk.
- As number of claims processed by Hyderabad branch is high so the branch can be provided with staff handling pre authorization process.

10. LIMITATIONS AND PROBLEM FACED

The limitation of the study was with the poor arrangement of the claim files and missing documents due to improper arrangements. The results are different from that of the standard data. Initially the problem is with data collection because of the busy staff due to financial ending year. All the factors that might play a role in affecting the outcomes that were measured could not be captured.

11. CONCLUSION

The aim of the study was to check the various processes handled in the organization and helping them in implementation of the various strategies. After analysis it was found that current processes and the settlement of claims are not working smoothly. Some of the important components like settlement of claims and repudiation of claims where implementation of new strategy is very important and good pace needed. We can-not think of good implementation without good and complete knowledge. So we need to train the workers as well as implement technologies in order to deliver good results. Also with the help of this study we came to know about the reasons of delay and repudiation in claim settlement, None of the processes was error free and smooth .With current status of processes and TAT of claim files it can be concluded that a lot of improvement is required in terms of training and technology about this newly introduced strategy.

12. ANNEXURE

	A	B	C	D	E	F	G	H	I	J
1	CLAIM NUMBER	INSURANCE	Patient discharge d	DATE OF RECEIVIN	CLAIM APPROVAL DATE	DATE OF SETTLEME	AVERAGE TI	REMARK-	REASON FOR DELAY	
2	107021400104	UNITED	12-Feb-14	15-Feb-14	21-Feb-14	25-Feb-14	10	GOOD	NO DELAY SEEN	
3	107121300107	UNITED	26-Nov-13	11-Dec-13	6-Jan-14	9-Jan-14	29		DELAY IN INTIMATION, INWARD AND SCAN	
4	107121300027	UNITED	10-Dec-13	15-Jan-14	27-Jan-14	30-Jan-14	15		DELAY IN INTIMATION, INWARD AND SCAN	
5	107121300112	UNITED	23-Dec-13	2-Jan-14	7-Jan-13	9-Jan-14	7	GOOD	NO DELAY SEEN	
6	1070114001498	UNITED	21-Jan-14	31-Jan-14	25-Mar-14	26-Mar-14	54		DELAY IN INTIMATION, INWARD AND SCAN	
7	108031400056	NATIONAL	7-Mar-14	18-Mar-14	23-Mar-14	8-May-14	51		NEFT DETAILS NOT UPLOADED	
8	1070114001498	UNITED	21-Jan-14	31-Jan-14	25-Mar-14	26-Mar-14	54		DELAY IN INTIMATION, INWARD AND SCAN	
9	107031400130	UNITED	11-Feb-14	11-Mar-14	26-Mar-14	N.D	0		NEFT DETAILS NOT UPLOADED	
10	107051300277	UNITED	28-Apr-14	13-Mar-14	N.D	N.D	0		DISC (NO CLAIM- DOC PENDING (not having phone	
11	107101300274	ORIENTAL	5-Oct-13	29-Oct-13	22-Mar-14	26-Mar-14	148		DISC (DELAY- CONDONATION LETTER NOT SENT	
12	107031400060	ORIENTAL	13-Feb-14	24-Feb-14	23-Mar-14	26-Mar-14	30		DISC	
13	107021400124	UNITED	7-Feb-14	11-Feb-14	13-Mar-14	18-Mar-14	35		DISC (ORIGINAL DOC NOT SUBMITTED)	
14	107011400076	ORIENTAL	9-Jan-14	14-Mar-14	N.D	N.D	0		DISC (PENDING DOCS)	
15	107011300290	UNITED	27-Jan-13	1-Mar-14	12-Mar-14	15-Mar-14	14		DISC (PENDING DOCUMENTS (MULTIPLE QUERY REPLY)	
16	107031400029	UNITED	5-Mar-14	8-Mar-14	21-Mar-14	26-Mar-14	18		DISC (DELAY IN RECEIVING DOCUMENTS	
17	122021404375	UNITED	6-Mar-14	8-Mar-14	22-Mar-14	26-Mar-14	18		DISC (DELAY IN RECEIVING DOCUMENTS	
18	101031400332	ORIENTAL	8-Mar-14	10-Mar-14	23-Mar-14	26-Mar-14	16		DELAY IN INTIMATION, INWARD AND SCAN	
19	107031400124	UNITED	13-Mar-14	15-Mar-14	23-Mar-14	3/26/2014	11		DELAY IN INTIMATION, INWARD AND SCAN	
20	107021300240	UNITED	8-Jan-14	27-Feb-14	12-Mar-14	22-Mar-14	23		PENDING DOCUMENTS	
21	107021400238	UNITED	17-Feb-14	24-Feb-14	13-Mar-14	18-Mar-14	22		DISC (DISREPANCY IN DISC. SUMMARY	
22	107031400029	UNITED	5-Mar-14	8-Mar-14	21-Mar-14	26-Mar-14	18		DELAY IN INTIMATION, INWARD AND SCAN	
23	107011400029	UNITED	5-Jan-14	23-Jan-14	7-Mar-14	21-Apr-14	88		NEFT DETAILS NOT PROVIDED BY PATIENT - NO CLAIM	
25	107011400219	UNITED	17-Jan-14	24-Jan-14	19-Feb-14	25-Feb-14	32		DISC (DELAY IN QUERY REPLY(29-1-14 QUERY RAISE, 16-2 RECEIV	
26	107031400079	ORIENTAL	7-Mar-14	8-Mar-14	21-Mar-14	26-Mar-14	18		DELAY IN INTIMATION, INWARD AND SCAN	

DELAY IN SETTLEMENT | REPUDIATION 1 | REPUDIATION | GRAPHS

CHECK LIST FOR SUBMISSION OF CLAIM

Please attach the checklist with the claim file.

Employee Name _____Employee No_____ Claim No. _____

Name of the company: _____

Contact Number _____Mobile no. _____E- Mail ID: _____

Check list for Documents: Please put a "tick" mark against the box

1. **Original Claim Form duly signed** ☐
2. **Original Main Hospital bill with Bill Number & break up**, ☐
3. **Original Discharge summary** ☐
4. **Original Death summary** ☐
5. **Original Hospital Payment Receipt with receipt number** ☐
6. **Original Payment Receipt with receipt number** ☐
7. **Hospital registration number** ☐
8. **Doctor's registration number** ☐
9. **Original Pharmacy and Investigation bills** ☐
10. **Original prescriptions** ☐
11. **Updated policy copy** ☐
12. **Investigation reports in original/attested from hospital** ☐
13. **Police FIR / Medico Legal Certificate (MLC)** ☐

Points to remember

Please retain copies of all the documents submitted to us for future reference.

For any assistance with any of the above formats, please contact us at customercare@emeditek.com

Or call at **0124-4466666**

Please retain a POD copy of the courier for tracking your consignment in case of any delay etc.

The above list of documents is indicative. In case of any other document requirement as specified by the Insurance company our Document recovery Team will contact you on receipt of your claim documents by Us.

For Implants used in Cataract, Heart Valve surgeries, CABG, Abdominal Surgeries, Knee replacement Surgeries, please submit the bill from the vendor for the prosthetic device used along with Sticker.

Please enter your Bank Account details online for Electronic Fund Transfer of your medical claim Directly into your bank account. Please ensure that you mention the correct account number for the Fund transfer since the claim credit will be processed solely based on the account number provided by insured.

CHECKLIST FOR FRONT DESK

Check list for Documents: Please put a "tick" mark against the box

1. **Original Claim Form duly signed** ☐
2. **Original Main Hospital bill with Bill Number & break up**, ☐
3. **Original Discharge summary** ☐
4. **Original Death summary** ☐
5. **Original Hospital Payment Receipt with receipt number** ☐
6. **Original Payment Receipt with receipt number** ☐
7. **Hospital registration number** ☐
8. **Doctor's registration number** ☐
9. **Original Pharmacy and Investigation bills** ☐
10. **Original prescriptions** ☐
11. **Updated policy copy** ☐
12. **Investigation reports in original/attested from hospital** ☐
13. **Police FIR / Medico Legal Certificate (MLC)** ☐

EMSL **E-MEDITEK**
— (TPA) SERVICES LIMITED

To whom it may concern

This official letter is written to inform you that Dr. Nidhi Gupta, who is a Medical Intern in Emeditek TPA Services Ltd, is doing "A study of issues in claim processing in the TPA and scope for improvement" has given a permission to view the medical claim files and all the other maintained records and permitted to process the medical claim files.

Thank you, kindly for your understanding.

Assistant Branch Manager

Mr. Sumesh Ramakrishnan.

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