Dissertation at

EMEDITEK TPA SERVICES LTD

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DISSERTATION STUDY

A Study Of Issues In Claim Processing In TPA And Scope For Improvement

THE STUDY

- The study is about the monitoring of multiple processes carried out in the organization
- To find out reasons of delay in claim settlement, reasons for claim repudiation and denial of pre authorization forms and how to overcome with these problems.

INTERNSHIP REPORT

- The Internship period - 3 months
- The position – Medical Intern

The main objective of internship

- To understand every practical aspects of the study
- To look into the administrative and Operational functioning of the organization.

About TPA

- **Third Party Administrator (TPA)** is an organization which processes claims and provides cashless facilities as a separate entity
- An insurance company hires TPA to manage its claims processing.
- The services include claims processing, premium collection, enrollment and cashless processing, giving pre-authorization.

ABOUT E-MEDITEK TPA SERVICES

Vision

To be industry leader in TPA industry by building Customer Satisfaction through quality service, fairness, transparency, ethical business practices, high integrity and quick response.

Mission

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.

Services provided by E Meditek TPA

TPA Services (Health)

- Cash less hospitalization.
- Member enrollment, online profile management
- 24*7*365 Helpline and Customer Support
- Claims settlements

Pre-policy Health Checkup

- Empanelment of Diagnostic centers
- Member health-checkup – fixing appointment and communication, picking up reports
- Digitizing reports and uploading for online access

Wellness Program

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

KEY LEARNING

- To know how the TPA firm works
- To understand various processes and monitor to find out the loopholes and problems.
- Learnt the Claim processing work and participated in number of tender/ technical bid meetings which has given me the experience of business world.
- Conducted interviews in the branch office.
- As I was working in a branch office with less number of staff helps me to keep eye on all major and minor processes which helps me to take lead at every point of time.

DISSERTATION REPORT

A Study Of Issues In Claim Processing In TPA And Scope For Improvement

BACKGROUND OF THE STUDY

- TPA industry is a service field where customer satisfaction is the priority
- Services rendered should be quick and of quality.
- Evaluation of multiple processes for betterment of customer services in TPA.
- An attempt to find the root causes for the problems and making the process more efficient to lowering the delay and decrease the rejection of claims and pre authorization forms.

PROBLEM STATEMENT

It is seen by the study that clients/patients are facing challenges due to

- Delay in settlement of claim and getting timely reimbursement due to multiple errors in the process.
- Rejection of claims
- Denial of preauthorization forms

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.
- To find out the reasons for repudiation of claims.
- Recommend & implement suggestions to improve TPA process.

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?

METHODOLOGY

8.1 Primary source of data-

- Observation
- Focused group discussions (FGDs).
- Interviews with medical and administrative staff

8.2 Secondary source of data-

- Literature review- Going through the literature available regarding the organization and Reviewing the status of n number of files.
- Going through the online maintained records through Managed information system and checked the files on daily basis.

STUDY DESIGN AND METHODS

- **Study design-** Descriptive study
- **Type of data –** Quantitative data
- **Sample size-** Random 190 claimed files
- **Data collection tool-** MS_Excel sheet
- **Data analysis - S**imple tables, bar charts and graphs for each data separately.

FINDINGS OF THE STUDY

Delay in claim settlement

Repudiation of claims both reimbursement and cashless

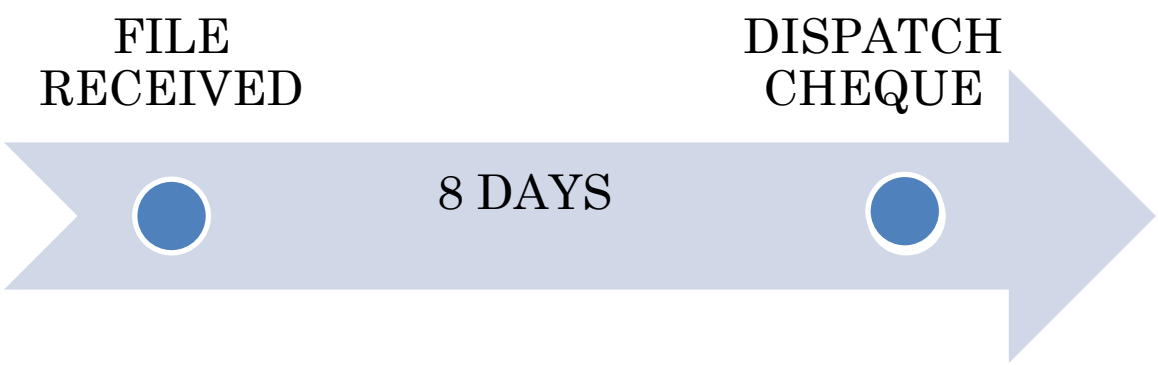
Denial of Pre- authorization for treatment on behalf of TPA.

Other problems

STANDARDS SET BY EMEDITEK TPA

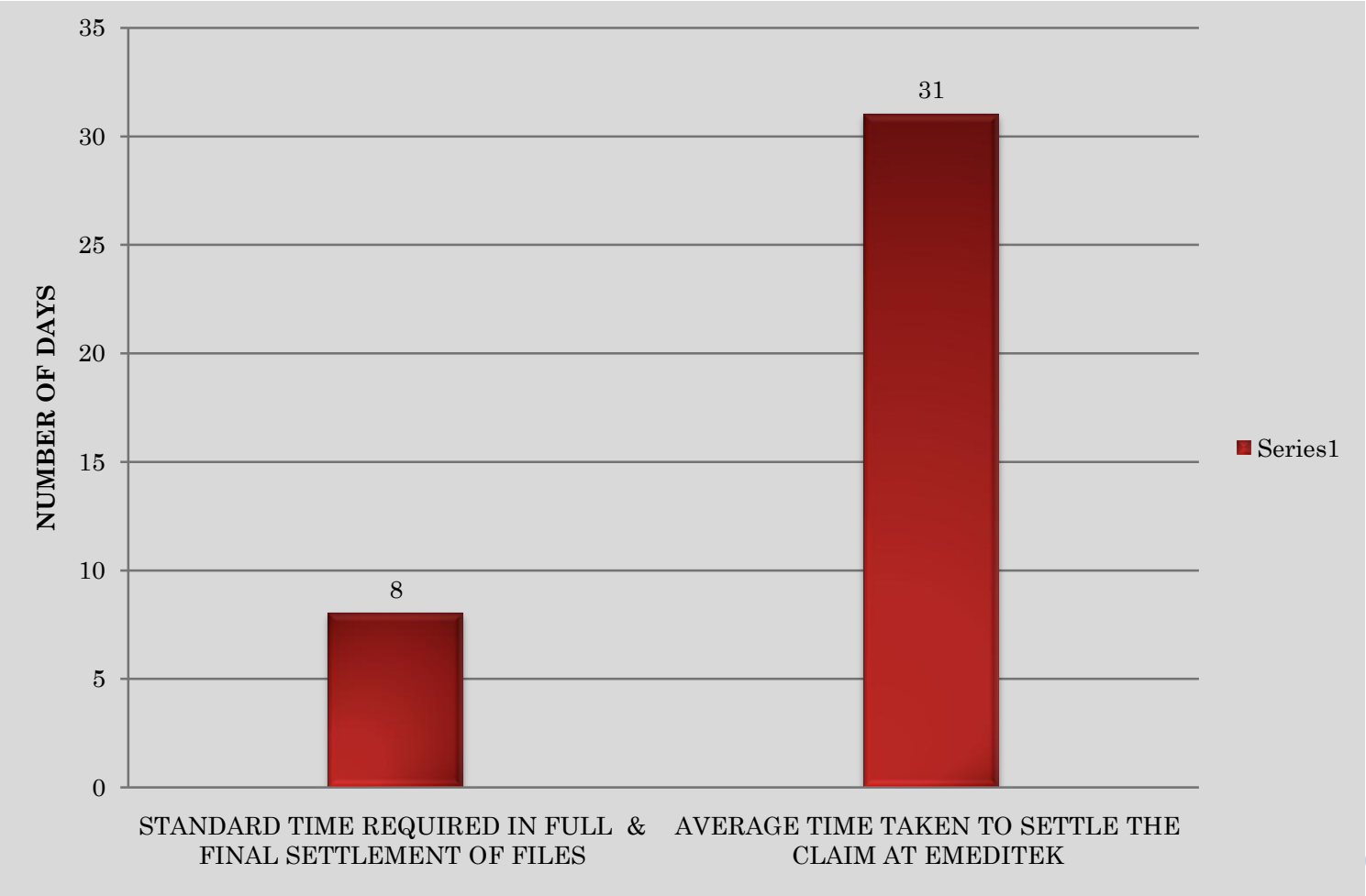
The organization has set a **STANDARD TURNAROUND TIME of 8 days** for all the claims

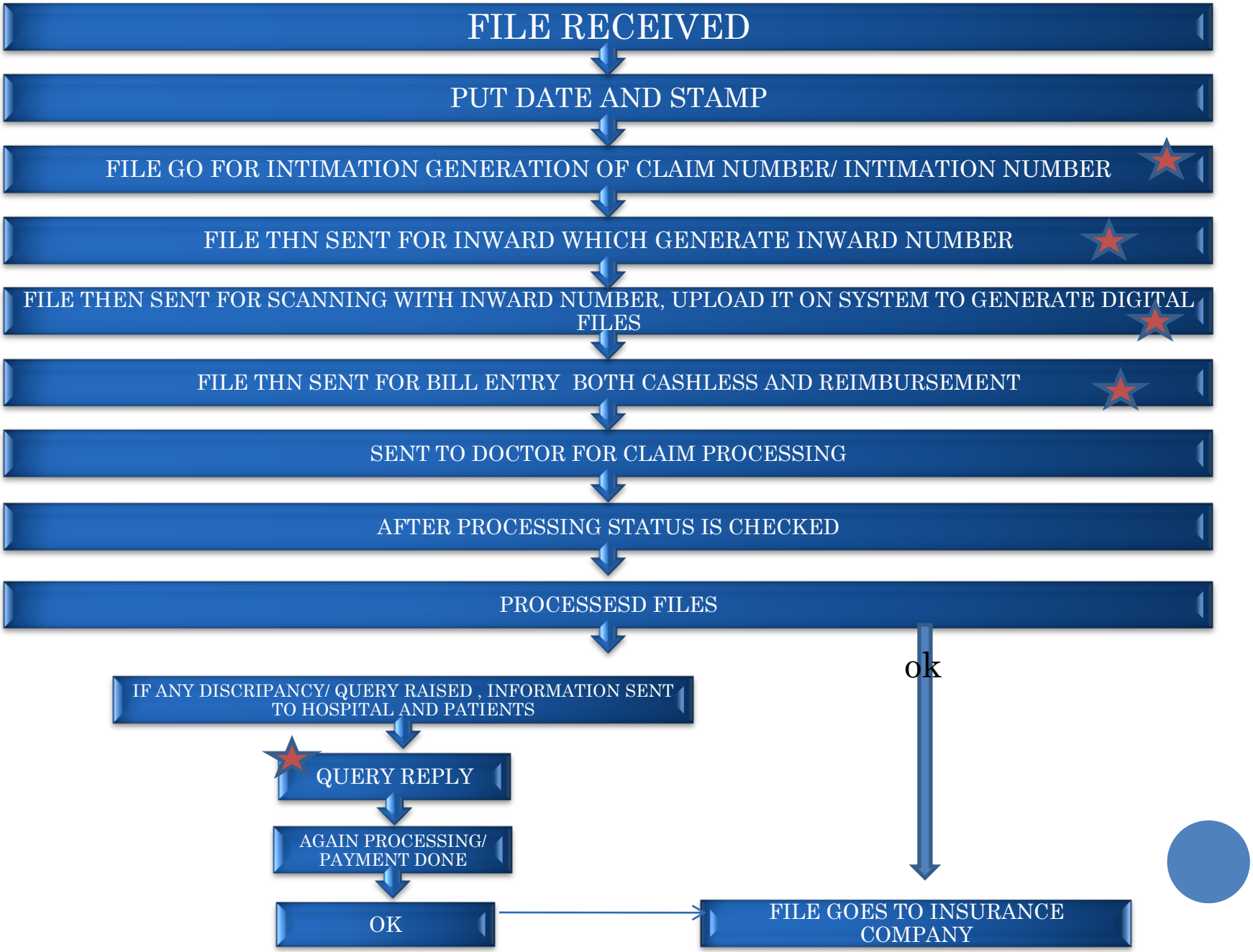
(Turnaround time is a total time required for completing a process)



BUT THE RESULT WAS

GRAPH SHOWING THE DIFFERENCE BETWEEN THE STANDARD AND THE OUT PUT RESULTS




FILE RECEIVED
PUT DATE AND STAMP
FILE GO FOR INTIMATION GENERATION OF CLAIM NUMBER/ INTIMATION NUMBER
FILE THN SENT FOR INWARD WHICH GENERATE INWARD NUMBER
FILE THEN SENT FOR SCANNING WITH INWARD NUMBER, UPLOAD IT ON SYSTEM TO GENERATE DIGITAL FILES
FILE THN SENT FOR BILL ENTRY BOTH CASHLESS AND REIMBURSEMENT
SENT TO DOCTOR FOR CLAIM PROCESSING
AFTER PROCESSING STATUS IS CHECKED
PROCESSESD FILES
ok
IF ANY DISCRIPANCY/ QUERY RAISED , INFORMATION SENT TO HOSPITAL AND PATIENTS
QUERY REPLY
AGAIN PROCESSING/ PAYMENT DONE
OK
FILE GOES TO INSURANCE COMPANY

PROBLEM-1

REASONS FOR DELAY IN FULL AND FINAL SETTLEMENT

a) Delay in the Processes which includes intimation, inward, scanning, bill entry processing etc

b) Documents not scanned on time

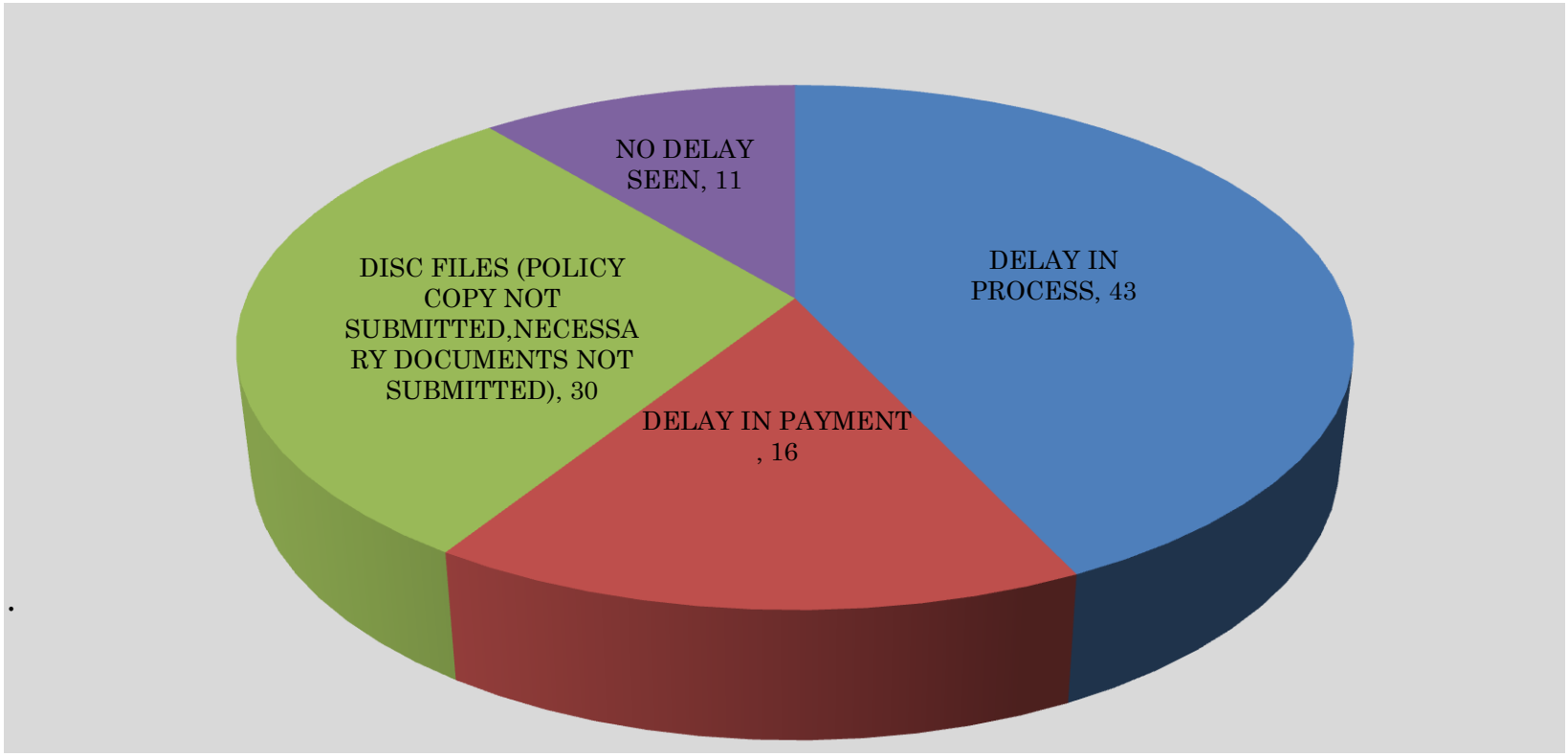
c) Documents pending (policy details missing, condo nation letter not sent, discrepancies)

d) Delay in payment

e) Files were badly managed ,Random movement of files as well as searching for the file takes a lot of time.

REULTS

DELAY IN FULL AND FINAL SETTLEMENT OF THE CLAIM FILES



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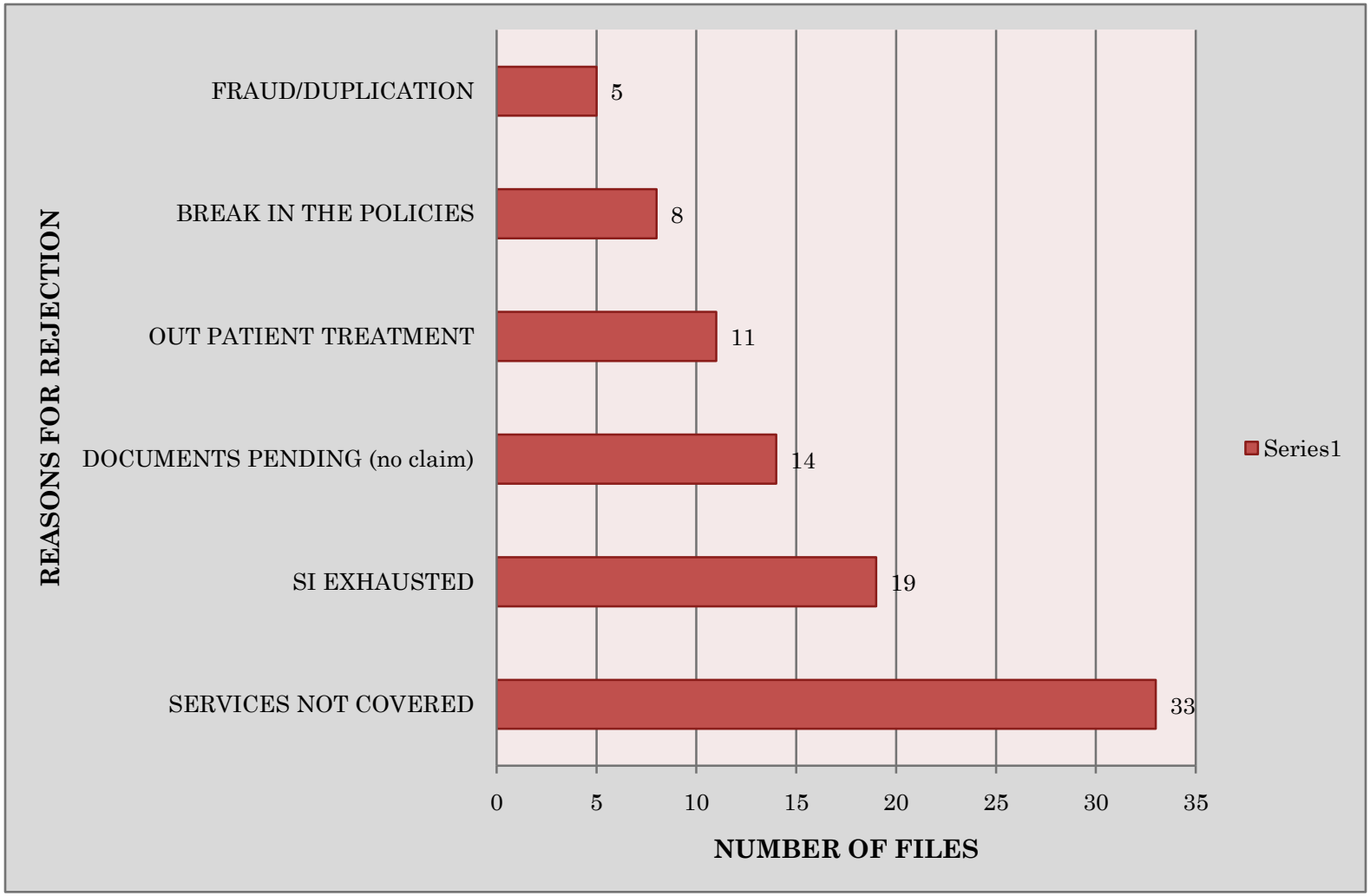
PROBLEM-2

REASONS “WHY” MEDICAL BILLING CLAIMS GET REJECTED

- Documents pending
- Services not covered
- Complication not payable
- Fraud cases
- Exhausted the sum insured
- Provided two services in one day
- Services comes under OPD basis
- Break in the policies

RESULTS
REASONS FOR REJECTION OF CLAIMS



PROBLEM 3

REASONS FOR DENIAL OF PREAUTHORIZATION FORMS

- The disease for which cashless is apply is not under coverage (OPD procedures, congenital diseases.)
- The matter not coinciding with the documents send.
- Irrelevant Entries in the pre auth forms.

OTHER PROBLEMS

- Insufficient manpower 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.

PROBLEM-1

RECOMMENDATIONS

(a) Intimation Inward delay

- Intimated and inward done on the same day
- Daily target to be allotted.
- Triaging of files
- Electronic tracking of files with file id and barcode stickers which will be generated at front office which provide complete status of files.
- Separate team of doctors for separate corporate claims should be maintained

(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
- 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.

(c)Documents pending

Solutions

- Maintain checklist
- Auto policy updation should be entertained

(d) Delay in payment

- **Solution-**
- Maintain the checklist
- Entertain Online banking
- Branch office should have own finance department.

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)	☐

(e) Files management-

Solution-

- The circulation of files should be hassle free there should be proper tracking of the files.
- File and documents segregation.
- All the files should be kept according color code with respect to the insurance companies and should be arranged in chronological order in the shelf And the files which got settled should sent back to insurance rather then piling up them in bulk.

PROBLEM-2

Recommendations

- A front office person who checks claim with the checklist for the standard set of documents before they are processed
- Know the coverage by a single click.
- Customize pamphlet with the common reasons of rejection of claims in layman terms to avoid repudiation
- 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.
- Clients should read the details and limits of coverage, or ask about them.
- Correct information to be given.

PROBLEM-3

RECOMMENDATION

- With electronic submission, computers validate information as you complete the electronic form."
- So the filling of preauthorization form should be done electronically so that if you miss a single field or mistype something, the computer will prompt you 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.

LIMITATIONS AND PROBLEM FACED

- Limitations faced include –
- Poorly arrangement of the claim files
- Missing documents.
- 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.
- Pre authorization process is handled over by the head office so data collection was the limitation.

IMPLEMENTATION

- Front desk person recruited
- Targets allotted
- Checklist maintained
- Files color coding implemented
- Utilization of resources
- Scanning issues solved
- Phone lines connected separately
- Power backup
- On call intimation of pending documents

IMPLEMENTATION

CHECKLIST FOR FRONT DESK

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Action to be taken

- Bar-coding & electronic tracking files
- Customize pamphlets to make process easier.

Conclusion

The important components like settlement of claims and repudiation of claims where implementation of new strategy is very important and good pace needed. We cannot 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. As per the study no processes were error free and smooth .With current status of processes and Turnaround Time 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.

Thank you