A STUDY TO UNDERSTAND INSURANCE CLAIM DENIALS IN HOSPITAL REVENUE CYCLE MANAGEMENT IN (CORAS HOSPITAL, ASSAM)

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

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Under the Supervision and Guidance of

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TO WHOMSOEVER IT MAY CONCERN

This letter is to certify that **Dr. Ankita Hazarika** has completed her **internship of 3 months in Integra Ventures** in partial fulfillment of the requirements for the award of the degree of MBA (Hospital & Health Management) from the IHMR University, Jaipur. Her internship tenure was from **15th March 2024 to 14th June 2024.**

Sincerely,

Ms. Lipika Sarmah
Chief Academic Coordinator & Healthcare Management Consultant,
Integra Ventures

Internship Completion Certificate

This is to certify that Dr Ankita Hazarika in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur has successfully completed her internship at Integra Ventures during March 15 - June 14, 2024.

Place: Guwahati, Assam

Date: 14/06/2024

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled "Understanding Insurance Claim Denials In Hospital Revenue Cycle Management" is the bonafide record of my original research work. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished work of others has been duly acknowledged in the text.

(Signature) Ankita Mazarika

Name of Student:- ANKITA MAZARIKA

Date :- 27/06/2024

IIHMR UNIVERSITY

CERTIFICATE

This is to certify that dissertation titled "Understanding Insurance Claim Denials In Hospital Revenue Cycle Management" is a record of the research work undertaken by Dr Ankita Hazarika in partial fulfilment of the requirements for the award of the degree of MBA (Hospital and Health Management) from the IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific, and analytical.

Piyusha 27/6/24

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Date :- 27/06/2024

School Dean
Dr. Sanjay Gupta
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Yours Sincerely

Dr Ankita Hazarika

Abstract

This study explores Revenue Cycle Management (RCM) in hospitals, emphasizing the critical issue of insurance claim denials and their impact on hospital finances. RCM encompasses administrative functions from patient registration to the settlement of outstanding amounts. Claim denials, where insurance companies refuse to reimburse healthcare costs, disrupt cash inflows, causing financial strain and operational inefficiencies. Delays in resolving denials further increase costs and reduce operational efficiency. The study underscores the importance of effective financial management and handling of claim denials to maintain hospital stability.

The research identifies high denial rates at crucial points in the RCM process, particularly during pre-authorization and patient discharge. Pre-authorization delays stem from issues like departmental interoperability, missing documentation, and technical problems, while discharge-related delays result from late insurance approvals and technical issues. The study also highlights a gap in employee welfare, noting that many hospital service providers lack health insurance, which could impact service quality.

A mixed-method approach combining descriptive and quantitative analysis was employed. Surveys were administered to patients and service providers to gather data on their experiences and understanding of insurance policies. Findings reveal a significant knowledge gap among patients regarding policy terms and conditions, contributing to claim denials. Data analysis using tools like MS Excel and SPSS identifies common denial reasons and quantifies their prevalence. The study finds a strong correlation between patient awareness and difficulties in the claim application process, indicating that improved understanding of policy details reduces claim-related issues.

The study recommends enhancing patient education to mitigate claim denials, suggesting strategies such as comprehensive education programs and improved communication systems, to streamline the claims process. It also emphasizes the need for service provider training on new insurance policies and claims processes and proposes implementing health insurance for staff to boost morale and productivity.

The findings highlight that reducing denial rates can significantly improve hospital financial stability, enhance patient satisfaction, and ensure a more efficient RCM process. By addressing the root causes of insurance claim denials and implementing the

recommended strategies, hospitals can achieve better financial outcomes and provide higher quality care. The research concludes that effective management of claim denials is crucial for sustaining revenue streams, investing in technological advancements, and improving overall patient care and satisfaction.

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List of Symbols and Abbreviations

RCM	**Revenue Cycle Management**
TPA	**Third Party Administration**
CPT Code	**Current Procedural Terminology**
CMS	**Centres for Medicare and Medicaid Services**
AYUSH	**Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy**
OPD	**Out Patient Department**
IPD	**In Patient Department**
OOP	**Out-Of-Pocket**
T & C	**Terms & Condition**
P-Value	**Probability Value**
OT	**Operation Theatre**
N	**Sample Size**
Sig Value	**Correlation Value**
Pre-Auth	**Pre Authorisation**

Chapter 1:

Introduction

1.1Background:-

RCM can be defined as a system whereby a healthcare provider undertakes the responsibility of identifying a patient encounter starting from registration, through to appointment and service delivery and up to when the patient pays the remaining balance. RCM links the business operations of health care institutions and patient, insurance and revenue management with health care delivery and recordation. Therefore, such a coherent and integrated system continues to enable providers to continue being paid for services offered, and as a result, financial and operational sustainability is sustained.

Fig 1.1:- Flowchart of RCM(Revenue Cycle Management)

Managing the revenue cycles can at times be complex, given its importance to healthcare centres. However, for the reimbursements to be done on time, all the requirements need to be followed to the letter and to the letter; the cash flow will therefore be good. The following steps will be very useful if you are somebody who has recently joined the billing and collections team of an organization.

Step 1:

The patient visits the healthcare organization or clinic, or get an appointment with the health care provider. Som clinics may also have individualized schedules while others may incorporate computerized schedules in their appointment settings.

Step 2:

The confirmation of a patient's qualification for the treatment is initiated as one of the critical steps of revenue cycle management. The provider or the staff has to establish whether the cost of the healthcare that the patient needs, is one that is policy coverage. It is also useful during the final stage of the work to know which auto parts are more popular than others.

Step 3:

The providers only look at the state of the client and conduct all the measures that are essential as a doctor. The patient is discharged and sent home, meanwhile, the provider transmits the patient's information to the billing section for further action.

Step 4:

The billing team then examines the charts of the patient and is given the right code for each procedure performed by a physician known as a CPT code. He or she submits a claim filled based on the need of the policy, the patient has elected and agreed to fund.

Step 5:

Finally, after constantly searching for data in place, the billing team moves the claims to insurance network. Some payers permit the submission of the claims to be made electronically while some teams prefer to make the claims on their own.

Step 6:

Turn to the insurance network and have it analyse the claim that has been provided. This

process therefore takes some time to complete, but it's worth the wait since it delivers the best results. On equal note, the billing team may have to negotiate with the payer's office several times. Based on the number of mistakes made by the submitter, the request is either approved, denied because of specific errors or denied in the course of. Therefore, as a medical biller, you have to take the responsibility of makes sure that the data you send to the corresponding claim is correct and complete.

Step 7:

When insurance payer pays a certain portion of the claim amount, in other words, contributes some amount towards the payment to the healthcare provider, the consumers are expected to fulfil the balance amount. The billing unit then proceeds to present the patient with the final invoice together with the insurance information and the balance that the patient is charged with.

Step 8:

The last step is to ensure that the balance that is supposed to be paid by the patient has been arrived at from the insurance amount paid less the total amount charged by the provider. But the laws always provide leeway like No Surprises Act when some aspects of balance billing the patient are concerned. They should therefore be checked regularly, it is recommended that one should always update themselves with them.(1)

A typical application of RCM in hospitals is highlighted below: A typical application of RCM in hospitals is highlighted below:

Financial Stability: Ideal RCM has a method of sources of steady cash income; it is fundamental in the operation of a hospital, payment of employees' salaries, and negotiating for better technologies and services.

Regulatory Compliance: In other words, RCM assists the hospitals in gaining an assurance that there are no violations of legalities such as the one depicted by the CMS or other such authorities thus saving on penalties and fines.

Operational Efficiency: Expenditure that is saved through the understanding of RCM rationalisation frees up clerical work to allow time for the care of patients and is not simply a monetary savings.

Patient Satisfaction: Effective billing systems should provide avenues for the patients to have endless access in billing processes without exposing themselves to billing complications and causes of disputes that would result in enhanced levels of patients' unsatisfaction.

Improved Scheduling and Pre-registration: In more detail, RCM can be effective in getting rid of several appointments during the course of a practising period by setting the patterns of practising hours and further regulating the same. In addition, improved insurance authorization and accurate estimation of co-payment time also enables a correct pre-registration to be accomplished.

Faster Patient Intake and Discharge: Optimum RCM is the potentiality of handling patients without having to deal with time lost to paperwork since all the necessary paper details have been completed in advance. The also enhance the charges of discharge and transition with regards to the patients.

Reduced Readmissions: From the patients' data analysis, RCM can indicate possibilities of readmission of specific patients, and subsequently, utilizing these probabilities, measures can be initiated to avoid readmissions, enhancing the lives of the patients and preventing instances of avoidable readmissions. It also helps in making space for other new patients more available so that there is an improvement in the patient turnover.

Enhanced Patient Communication: RCM is also useful in appropriate and timely communication to the patients as well as their bills and the insurer. This could help alleviate some of the financial issues and on a broader scope, enhance patient experience.

Impact on Patient flow: RCM in particular enables efficient management of patient's schedule, documentation and fee billing in order to ensure a perfect patient's hospital experience from the moment he enters the hospital till the time when he gets discharged. This means that more patients are treated in their turn and more efficient use of the

existing health facilities as well as, rational use of the scarce hospital beds hence the patient and the hospital respectively.

Common Reasons for Insurance Claim Denials

1) Incorrect information or misrepresentation:- When completing the health insurance application form there are some requirements that need to be followed, all the information provided should be true. It is pertinent that there must not be any form of confusion, whether it is deliberate or accidental in nature due to which the claims may be rejected.

2) Information about pre-existing illnesses and bad habits:- One is bound to have rejected the application of health insurance based on the failure of the applicant to disclose information such as; past illnesses, family history of diseases, lack of exercises, smoking and taking of alcohol amongst others. Some people may keep it under wraps so that they would not be charged a high premium and policy rejection.

3) Making a claim during the waiting period:- Any health insurance plan shall have some waiting period as a safety net to ensure that people do not misuse the system.

a) 30-day waiting period:- There 30 days waiting period put in place when new policy is written meaning no claim can be lodged at this time.

b) Maternity waiting period:- If there is a policy on maternity benefit, the condition is normally one has to wait after joining the company for 24 to 36 months. Furthermore, depending on the coverage provided and the policies of the insurer, the cover may only cover 2 pregnancies.

c) Waiting period for specified diseases/procedures:- Specified diseases/procedures: one can claim treatment for specific disease/procedure after 24months of policy purchase. Some of these are: eye surgery such as cataract, veins treatment among others like varicose veins, pile surgery, sinusitis among others among others. The list and descriptions of these diseases/procedures are well outlined down in the insurance policy document.

d) Waiting period for pre-existing diseases:- The pre-existing diseases treatment is, however, extendable after 24 to 48 months initialization of the plan.

e) Critical illness waiting period:- Any operation or treatment associated with critical illness can be availed by the policy holder after 90 days from the start of the policy.

4) Making a cashless claim at a non-network hospital:- Whenever a cashless claim is being raised at a hospital which is not empanelled with the insurance company, it cannot be entertained. Therefore, if you wish to settle the claim without paying anything OOP, it is wise to clarify with the hospital before admission if it has a contractual agreement with the insurance firm as an authorized network hospital.

5) Claims for services not covered:- However, there are some services which are not provided for in any health care insurance policy. They may also be part of some policies with some restrictions or any other conditions that may be surrounding a given policy. In the event that you make a claim on any of these services that are not eligible to be compensated, then the health insurance company will deny the claim. Some of these services can include: Some of these services can include:

a. Dental treatment

b. AYUSH treatment

c. Out-Patient Department (OPD) While OPD services may be more easily compared to those provided at an emergency care clinic or a health facility, the volume of patients seen and the range of specialisms presented offer a greater insight into the scope of work that Family Doctor and City Clinic deliver to their communities.

d. Maternity claim

6) Exclusions:- You must therefore ensure that the treatments/procedures you want to receive are not standard exclusions across all insurance companies. It means that the majority of plans should not be expected to support them. Some of these may include:

Some of these may include:-

a. Cosmetic or plastic surgery

b. Change of gender treatment

c. Climbing, racing, horseracing, deep-sea diving, gliding, and any other sporting activity which involves risk, adventure or both.

d. Remedial treatment on the grounds of a person's action or plan aiming to commit a criminal violation of the law.

e. Alcohol and substance use and dependency, or any other condition that may not necessarily be classified as psychotic

f. Such costs as sterility/fertility, etc. Thus, one can list the following costs: sterility/fertility, etc.

7) A claim under a lapsed policy:- A health insurance policy is said to be in force and original for the period in which the premium has been paid for, whether it is one year or many years. In case the defined duration is over, then the policy has to be renewed which requires payment of the renewal charges.

8) The claim amount is higher than the sum assured :- Each and every basic health policy provides a sum insured to the policyholder with the policy. In the situation where a claim amount is more than the remaining sum insured for the year or indeed the maximum amount that can be claimed within a single year if there have been previous claims in the year, then would it be possible? The insurance company, therefore, pays the claim to up to the available sum insured and within the existing policy agreement.

9) Not informing the insurance company on time :- Normally it is mandatory to give notice to the insurance company about their hospitalisation and if they fail to do so they were likely to deny their cashless treatment applications. in cases of a scheduled admission to the hospital, one can get the authorisation prior to the conveyance of the individual to the hospital. They are to be reported to the insurance company within 24 hours or within 48 hours in cases of emergency admission as a result of an accident or through other causes in as far as it is allowed under the policy.[(2)]

About the hospital

The Hospital where the study is conducted is situated in Narangi, Guwahati , Assam. Name of the hospital is “CORAS By Pratiksha”. This hospital is facing a problem in Revenue cycle Management , with a low enrolment in TPA(patient applying for cashless claim) and a increasing number of claim denials. So they want a solution from Integra ventures to manage their RCM department and solve the these problems . As I was involved with Integra Ventures RCM project I got involved in the hospital TPA desk and got the opportunity to carry on my study which will help both the hospital and RCM team of Integra ventures by realising the root cause of claim denials and working according to the strategies proposed.

Out of approximately 30 IPD patient daily 14 Patient apply for cashless claim according to the observation done within these 2 months .

There are three types of rate list according to the Insurance company they are :-

OLD, NEW AND UNIQUE RATE LIST

List of TPA ,Individual Insurance and corporates enrolled under the hospital

Max Bupa, Safeway TPA, Medi Assist TPA, HDFC ERGO health, Care health, United Health Care Parekh, FHPL, Bazaz Allianz General Insurance , Raksha TPA,ICICI Lombard, TATA AIG, Aditya Birla Capital, Reliance, OIL India , TATA Motors, NABARD, Airport Authority, NTPC, HUDCO, TCS, NRL, IOCL, NEEPCO etc.

Standard Operating Procedure (TPA)

1. No Day Care procedure
2. The patient should be an IPD patient
3. Patient should stay a minimum of 24 hours
4. Medicines and disposals receipt should have seal and sign of hospital and treating doctor.

Documents Required for applying under Cashless claim

- Valid health and policy card
- Govt ID proof of patient
- Doctors Admission Note (with prescription)
- Relevant Investigation

1.2 Problem Statement

Hospital RCM refers to the set of comprehensive administrative and managerial functions that entails the collection and processing of fees for services offered by hospitals. This process starts from the appointment setting and covers the patient registration, charging, the submission of the claim, collection of the payments, and settlement of the outstanding amount. Ideal RCM helps health facilities sustain their income base or flow especially crucial for hospitals to be able to invest in technological advancement, pay staff, or improve patient care.

Another major concern is the problem of claim denials and it is considered to be one of the most critical within the RCM process. A claim denial scenario is any situation where an insurance company declines to meet the demand for reimbursement of costs incurred in the provision of health services to a patient. Some common causes of claim denials that have negative financial implications for hospitals include the following: Claim denials are a huge blow to hospitals because they tamper with the anticipated cash inflows and demand time and resources to be resolved. Through the denial process, hospitals experience delays and invest much of their energy and resources to decipher the reason for the denial, rectify a mistake if any, and file the claim again. This not only leads to delayed collection of money but also makes the process cumbersome at the same time.

It is, therefore, apparent that sound financial management and efficiency in handling and reducing claim denials are symbiotic in the operations of a hospital. Left unresolved, denials are costly, with potentially adverse effects on a company's revenue stream. For instance, if one hospital receives a denial rate that is high, either from insurance companies or the patients, the cash inflow is affected, which puts pressure on the budget for operations, delays the purchases of equipment and thereby affects the quality of services provided to the patients. In addition, denial rates also peaked high and thus, debt accrued from using external funding or credit was is likely to add more pressure.

This situation creates a host of possibilities for errors in the claim submission process in light of the differences between what patients know and what they should know about their insurance policies. It can be in sum erroneous patient information, inexact coverage details, and missing documents. All these mistakes make it possible for a given claim to be declined if the criteria for refusal were employed. For instance, if the patients name is

spelt wrong, the policy number is wrong or wrong phone number, address etc., the insurer will reject the claim outright.

Moreover, it should also be noted that inadequate information provided to the patient can contribute to the additional workload of the hospital staff. In cases where patients are unfamiliar with certain details of their insurance policy, they may not furnish relevant data or pre-approval, problems which the hospital will then have to address. The administrative staff then need to spend more time and money in search of the required information, rectifying the incorrect information and resubmitting the claims. Such diversions in resources could slow down the absolute performance of the RCM process and also increase operating costs.

These inaccuracies and administrative burdens come with the halt or loss of revenue for healthcare providers in the end. Each time claims are rejected, the hospital is unable to get the amount it was hoping to be paid for the services it provided. Even the denied claims can be appealed and later compensated but the procedure involves a lot of time and resource and there is no certainty that you shall be compensated. Therefore, some of these claims may not be ever settled, which can affect the hospital's revenue intense.

According to one author, the above claim denial has implications that are not limited to financial losses alone, but also have other impacts. Whenever patients refuse treatment, this must be very disadvantageous to the condition of the financial position of the hospital and may greatly affect the strategic planning of the hospital. It could also adversely affect the position of the hospital since patients who fell out of satisfaction with the charges levied might say that were dissatisfied with the kind of service they were offered by the hospital and this may in turn dent the popularity of the hospital among community members.

To get to the heart of the issue directly – the failure of patients to comprehend their policy terms and conditions and their ability to get their claims denied, the following strategies must be implemented: By enhancing the knowledge of patients in insurance policies it's easier for the adopters to cut down large from their claims most of which are likely to be rejected. If the beneficiaries understood more about health policy or coverage, they would be more compliant with the policy, and they adhere to medical policy directives such as getting pre-certification, confined to choose a provider from among those in a specific network and splitting payment processes. This proactive understanding ensures that

founder special services are paid for thereby extending protection to the selvages against unsatisfied claims.

Based on the success achieved from this study, the following recommendations are made to healthcare organisations, especially hospitals with a view to bridging this knowledge divide; Firstly, patient education should be staffed more and needed more extensive service programs. They may use such interventions as; didactic sessions, distribution of knowledge-based handouts, development of agency websites, and one-on-one predisposing-focused counseling sessions to enable patients to understand their insurance plans. What carriers point to as guidelines that could aid in preventing denials include understanding of the process that is unambiguous, as well as circumstances that should not be overlooked since they lead to rejections; this lets patients be active participants in their treatment.

1.3 Purpose of the Study

The main Aim of this study are: To identify the causes of insurance claim denial in hospitals and whether it is possible to find ways to develop a new approach that will improve RCM with low denial rates and To indicate the level of patients' awareness of the policy and terms and conditions as related to the rates of denial and that there is a correlation between T & C levels and problems with the application of a claim. From the above-sustained arguments it could be noted that there is need to properly manage these claim denials so as to have a good financial returns from hospitals. Such a high rate of denial may pose the risks of poor cash flows, more time is spent on clerical work, and even low patient satisfaction.

Objectives of the study

1. To investigate & identify the reason for claim denials affecting hospital revenue cycle management
2. To assess the level of Knowledge and Understanding among patients regarding their insurance policy terms and conditions and its impact on denial rates and find a significant relation between patient knowledge about policy T & C and Difficulty faced by them during application of claim.
3. To propose strategies for improving revenue cycle management by addressing identified factors contributing to denial rates and enhancing patient education on insurance policies.

1.4 Research Questions

What is the average rate of claim denial and reason behind the denials in a hospital ?

How is patient awareness about policy T&C is related to difficulties faced by them during application of claim ?

What strategies are feasible to be adopted for merging of Revenue management cycles with decreased denial rates and proper patient instruction regarding insurance policies ?

1.5 Significance of the Study

The study will help in identifying the major reasons behind claim denials in the Revenue cycle management within the hospital and how it is affecting the hospital in its revenue generation cycle and eventually all the set up in a hospital, because everything is interrelated within a hospital . It will also help the policymaker to make new policies to improve RCM in reducing claim denials rates which will help in higher revenue generation , patient flow and high patient satisfaction. The study will also throw a light on patients awareness towards their policy terms & condition which will help them in reviewing their policy and make sure to know the main benefits and all important terms and conditions required during application of a cashless claim in a hospital.

1.6 Limitations

The study is limited to one hospital and for a limited period of time which may vary in some from other hospitals in some aspects . The study could have a broad insight if it can be conducted across 5-7 hospital in the same city.

1.7 Data Analysis for Denial Reasons

To identify the specific reasons for claim denials within the hospital's RCM, we will analyse denial data over a specified period i.e for over 1 year and a thorough survey will be conducted for over a period of 2 and half months

The analysis will involve:- Collecting data, correlating the patient awareness with the difficulty face by them during claim application and analysing their reasons for denial.

Chapter 2 :- Literature Review

2.1 Summary of each paper

Alradhi and Alanazi, 2023

The purpose of this research is to examine how RCM could be applied in Saudi government hospitals. Gaining insights from the study, hospital leaders were asked questions in a bid to gain their perspectives on the looming challenges and future possibilities. However, that is not the case with other hospitals that already employ the fee-for-service payment method though their systems are not connected. The study established that some of the key issues that may hinder the implementation of LEAN include; The following objectives were set in the study: Clear goals and objectives Introduce change management programmes Resistance to change Lack of accountability Nonetheless, leaders view benefits for RCM in enhancing the financial conditions as of worth. The recipe for making the changes work involves strong leadership, good communication mechanisms, and customer orientation when addressing issues affecting the patients. To enhance the effectiveness of revenue and RCM in Saudi healthcare delivery, new strategies should be employed.[3]

Margaret Schuler, Jane Berkebile, Amanda Vallozzi 2016
Health care revenue cycle management also called as health care RCM is the process of managing the financial interaction of centre patient care from the time of appointment till the time of final payment collection. Healthcare Revolution Healthcare revenue cycle management (RCM) is the process of managing all financial aspects of patient care, from scheduling to payment collection. To be precise, Healthcare RCM refers to the complete cycle of processes through which provider organizations manage claims collection, medical payments and other related aspects. In more detail, Healthcare RCM is the series of process steps that administration entities engage in with regards to claims collection and medical payments amongst other factors It is a long, intricate and multifaceted procedure that has its own issues, but incorporating a blend of technology into it can make the process easier. Here's a summary of the key points:-

- RCM is a preventive, detection, tracking, monitoring and recovering process which is initiated from scheduling to payment.
-One important aspect that needs to be considered is the proper inputting of patient details to minimize cases of claim rejection.-Good RCM enables organizations to employ the best strategies in managing their resources in a way that makes them more profitable.
-Technology can help to perform certain functions, increase efficiency in code entry, and monitor claims.
-The clinic builds new relationships with medical and nursing professionals and patients and can change them under a different legislation and modern concepts of healthcare delivery. (4)

Margaret Schuler, Jane Berkebile, Amanda Vallozzi 2016 Optimizing the often fragmented patient revenue cycle in a hospital can help the organization's business case by increasing its revenue generation and offering the opportunity for equity. (5)

Lockett, 2014
There are many components involved in the delivery of coordinated care and one of them is implementing organized and standard revenue cycle across different health care facilities. Effective revenue management in a complex hospital and physician setting: as new payment models emerge, these organizations can achieve cost savings and revenue growth by integrating and optimizing their revenue cycle operations. These include automated patient access and registration, concurrent surgery coding, automated outpatient scheduling and ancillary services access, and receivables management.(6)

It ranges from 0.02 to 0.05 for a country and depends on a definite type of insurance in a hospital. 68% to 45. Thus, 21%(7) found that the introduction of humanitarian organizations in Middle Eastern countries has led to overwhelming the local society. Having known the three main cause of denial are as follows Documentation issue Resource constraints (8)Clinical assessment (9). Such issues need to be met by better documentation practices, resources as well as clinical decision in an effort to reduce claim rejection incidences which hinder proper patient care.

Bahman, Aisa , Elnaz, 2022

The paper an investigation is based on the following; – The reduction in claims by the Insurance organizations resulted in dissatisfaction among hospitals and therefore led to the reduction of their overall revenues; – The causes of deductions; Of which document

irregularities are among the most common. The paper focuses on how the above-mentioned deductions must be addressed so as to minimize drain of the financial resource and usefulness of hospitals in Iran[7].

Aaron ,Yujun ,Chris ,Dorothea ,Troyen ,Peter ,Joseph 2021

The paper's abstract highlights the assessment of coverage denials involving medical services, which did not pass the necessity requirement for Medicare by providing data on its spending, denial rates, and the ratio of various policies that used in denial during the processing of the Medicare Advantage claims. Similar to the service and provider volume rates, the denial rates for services also vary by types of services or providers.[10]

Adam , Chihwen , Astrid , Robert , Jonathan 2021

In this study, it aims at identifying the rates and details of claims against hospitalists, accompanied by findings showing that hospitalists are notoriously prone to hefty claims and an indemnity value in addition to error laden clinical judgment being the key predictor of payment thus a difficult situation for the hospitalist facing malpractice.[9]

Ninise ,Mrara, Oladimeji 2023

The paper discusses threat of Critical illness as a global issue, Disparities between LMICs and HICs in the availability of crucial care beds, Emerging unmet demand for crucial care at the analysed facility, Recommendations to apply solutions to help clinicians make a reasonable triage decision, and general advice to enhance the care beyond the ICU to support the refused clients.[8]

A .Dunn 2024

It is therefore the aim of this paper to discuss how billing in the health care industry is being burdened and how fees for doctors are on the decline and how the dilemma impacts patients.[11]

Kovach, Jamison V. PhD; Borikar, Shrutika MS 2018

The paper demonstrates the application of Lean Six Sigma methodology to reduce insurance claim denials in a paediatric hospital by improving the registration process, resulting in a 67% reduction in missing/incomplete fields and an enhanced patient experience.[12]

This paper discusses one such concern, that is limitation of access to operating room for paediatric dental treatment, with data analysis of each of the fifty states and the District of Columbia on how often and to what extent the need is fulfilled[13].

Aaron ,Yujun ,Chris ,Dorothea ,Troyen ,Peter ,Joseph 2021

The study aims at identifying the likelihood and prevalence of claims against hospitalists and to provide evidence to support the argument that, hospitalists face a very high probability of claims with high likelihood of indemnity payments and huge payment amounts resulting from unsound clinical reasoning and judgment to support the argument that hospitalists practice in one of the most risky environments for malpractice.[10]

PS, Peng J, Amini H, Litch CS, Hammersmith K 2021

Participants who had transgender status, above the age of 45 years or belonged to the mixed race or bottom economic status said that they were more likely deny healthcare their healthcare requirements or experience negative treatment inclusive of being refused care in general and or trans-specialized healthcare centres.[14]

Magnéli M, Unbeck M, Samuelsson B, Rogmark C, Rolfson O, Gordon M, 2019

In a Swedish study, researchers noted that a small number of patients reported or initiated claims for severe preventable complications that occurred following hip arthroplasty surgery. Furthermore, the proportion of having an insurance company claim was low among the patients with major preventable complications, at only 8%, and the claims were even less frequent among the acute patients, at 0. The majority of the patients with major preventable complications did not file an insurance company claim and for the remaining few who did, the claim proportion was even lower among the acute patients at only 0. 3% compared to 13% This infers that so many patients of health facilities have no clue of their rights or else are reluctant to prosecute for medical negligence claims.[15]

Langford A, Dye L, Moresco J, Riefner DC, 2010

According to the paper, the author forwards recommendations on how to improve business operations on the side of the revenue cycle management by streamlining what is usually referred to as the front-end; processes such as scheduling, eligibility/insurance verification, and financial counselling of the patient.[16]

LaForge RW, Tureaud JS, 2003

The abstract is prepared indicating that it is high time that the hospitals promoted the holistic processes involving cross-functional teams, rewarding of staffs, appropriate training and necessary screening tools in revenue cycle management.[17]

Glaser J, 2011

The paper outlines the steps that healthcare finance executives could take to fashion out effective strategies for dealing with payment reforms through the evaluation of data strengths and weaknesses, engaging stakeholders in data, exploring care delivery gaps and finally developing policies for data.[18]

A number of measures have been suggested that may be used in order to enhance the management of revenue cycle and to decrease the rates of denial. Both Kovach,[12] and Langford,[16] talk of some basic steps that need to be taken such as registration and insurance verification in order to minimize errors and enhance patient satisfaction. A more comprehensive solution is proposed by LaForge [17] emphasizing the essiñŁle of the cross-functional teams to address recurring problems with several forms of medical-necessity screening software also. According to Glaser [18], healthcare finance organizations have to evaluate new data capacities, increase the understanding of reimbursement changes among the stakeholders, and tackle used care workflows. Each of these strategies, when used in conjunction with each other can assist in boosting revenue cycle management and in the process encourage the reduction of denial rates.

2.2 Summary

The conceptual framework was designed to focus on revealing the possibilities of applying the concept of Revenue Cycle Management in the setting of hospitals and the ways in which it can improve the financial environment in this field even in terms of potential drawbacks such as resistance to change and lack of accountability. Managers were asked their views on the above challenges; they and opine that leadership, communication and culture of customer focus should form part of this hospital's key ingredients for its implementation. RCM can be described as the strategic and thorough coordination of the financial management processes of the patient's entire interaction with the facility or organization starting from an appointment right up to payment with reduced reject rates through the best use of technologies. They recommend increased effectiveness of action plans, change management plans, and improved documentation

processes to put more emphasis on the cycles of revenue growth. Other recommendations include, extending the permit of auto generated for the enhancement of revenue, admissions, payment portals, and collection for the delivery of services in all the facilities. This is also followed by how different countries and systems manage the question of the healthcare revenue collection, the repercussions or the impacts that documentation issues have when it comes to claims denial and how this challenge or its effects can be managed or even controlled to enhance the profitability of the hospital as well as the quality of the patients.

Chapter 3 :- Research Methodology

3.1 Research design

This type of research employs the use of descriptive research design. This approach is adopted to plan out the methodology to document the nature and details of patients including insured patients under different insurance policies, the service providers of TPA and Billing department of a hospital with the Revenue Cycle Management at Guwahati, Assam.

Research Methodology:

The research sits well within the positivism paradigm and quantitative research method. The primary rationale for selecting a mixed methodology includes : -

Objective Measurement: The measurement specification in this study is to systematically and effectively assess and in a numerical manner quantify aspects that surround insurance claim denials, patients' comprehension of the policy terms & recommended solutions that could enhance RCM. This is accomplished through the following key elements:

1. Reasons for Denial of Insurance Claims:

Identification and Categorization: The research objectives are; To determine the general reasons that lead to insurance claim denial and To classify the general reasons in an effort to have specific causes of insurance claim denial. This entails gathering of more specific information on each of the denial and grouping them under specific categories inherent in the system (e. g., lack of compliance/documentation, policy, timing issues).

Frequency Analysis: Continuous measurement permits the researchers statistically quantify the prevalence of each reason as a problem, which in turn highlights common concerns and areas for improvement of the existing process.

2. Patient Understanding of Policy Terms:

Assessment of Understanding: The essential component of the study revolves around administering questionnaires to measure the patient's understanding of their insurance policy. The concern is the policy information questions that are aimed at determining their grasp of policy specifics.

Correlation: To further understand the level of understanding, the study will then evaluate how this variable is related to the difficulty encountered by them on the application of a claim. This assists in determining if falls short of expectations by patients, lack of understanding or even lack of knowledge can greatly affect claims denials and in turn assist improve the future Revenue Cycle management of the hospital.

3.2 Data Collection Methods

1. Surveys Administered to Patients and Service Providers:-

Design of Surveys: Two different questionnaires will be designed: self-completed questionnaires for patient participants and postal questionnaires for TPA and Billing department staff participants. They will be properly developed to capture detailed information about different areas that will be of importance to this research.

Content of Patient Surveys: This will involve asking patients about their knowledge of insurance policy jargon, the procedures through which they have been involved in submitting their claims and whether they have ever experienced any specific situations whereby their patients' claims have been denied. This is of essence for one to achieve the intended goal of evaluating the amount of knowledge they possess but also their practical experiences.

Content of Service Provider Surveys: Questions to service providers will be written in the form of closed questions focusing on their opinions regarding common excuses for denial of a claim, the tough experience encountered in handling claims, and the perceptions about patient awareness and sensitization on insurance policies.

Administration Method: These questionnaires will either be typed, or on tablets/on-line appliances/ or other forms, so that the participants can give their response without much difficulty. In this context, to make people more comfortable with the survey and complete the same, necessary help is going to be provided for those who require assistance.

2. Utilization of Relevant Data Available in Hospital Premises:

Access to Hospital Data: As a part of data collection the study will receive data about the TPA and Billing department of this hospital through appropriate permissions. Such data may encompass documented history of insurance claims, reasons for insurance denial explanations, or other pertinent bureaucratic data.

Data Extraction and Compilation: Thus, relevant information will be retrieved, according to a certain pattern, from the hospital's documents. To do this, the following information needs to be gathered: patient characteristics, types of policies, claim amounts, denied claims ration, and the reason for denial.

3.3 Sampling Techniques

The techniques used here involve administering questionnaires to the patients receiving services at TPA and those who attend TPA to seek preauthorization or reimbursement for their medical bills. As for the sample group, this approach does not need to focus on a particular sample of patients since it encompasses any patient who gets in touch with the TPA for these specific purposes; that is, the convenience sample here is rather broad and encompasses a large and, most likely, representative part of the whole patient population interested in authorization or reimbursement services of the TPA.

3.4 Data Analysis Method

Data Entry and Cleaning: Special software will then be used to clean the collected survey responses and raw data extracted from the hospitals' databases in order to prepare the quantitative data for analysis in MS Excel. Preprocessing activity common in data mining will be done to remove or rectify any errors that may have occurred while keying the data.

Preliminary Analysis in MS Excel: Descriptive statistics and data visualization in the

form of tables and figures of distributions (like percentage) and graphs (like pie chart, bar chart) will be done in MS Excel to get elementary features of the data.

Advanced Statistical Analysis in SPSS: In the case of more complex analyses—bivariate analysis, testing for a significance of the obtained results, and calculating the standard deviations—the data will be inputted into the program SPSS (Statistical Package for the Social Sciences). SPSS will be used to perform: SPSS will be used to perform:

Bivariate Analysis: Analysing the link between patient comprehension of policy terms and the level of challenges made to claim an imaginable policy

Significance Testing: Looking at the relationship and differences among the identified variables and evaluating the results' statistical significance.

3.5 Ethical Considerations

In this study, all the participants signed consent to participate in the study and yes I made it clear to them the goal and purpose of the study as well as the risks that can be incurred in the process and that the participants are free to withdraw from the study at any one time informing nobody why they are withdrawing. In addition, permission from the organization was given towards the utilization of the data with regard to issues touching on privacies and confidentiality of some of the collected data Moreover, measures in relation to data security were taken throughout the course of the study that was being conducted. One of such control measures was storage of data belonged to the participants into secure platforms, and another measure of restriction of exposure of a particular data item belonging to the categorization of sensitives was made limited only to a few people. Other measures that were embraced include; Ensuring that the particular data protection regulations in place were complied with structures so that the data that belonged to the participants was protected.

Chapter 4:- Data Analysis & Findings

PATIENTS SURVEY FINDINGS

1. Percentage of Claim Approve /Deny

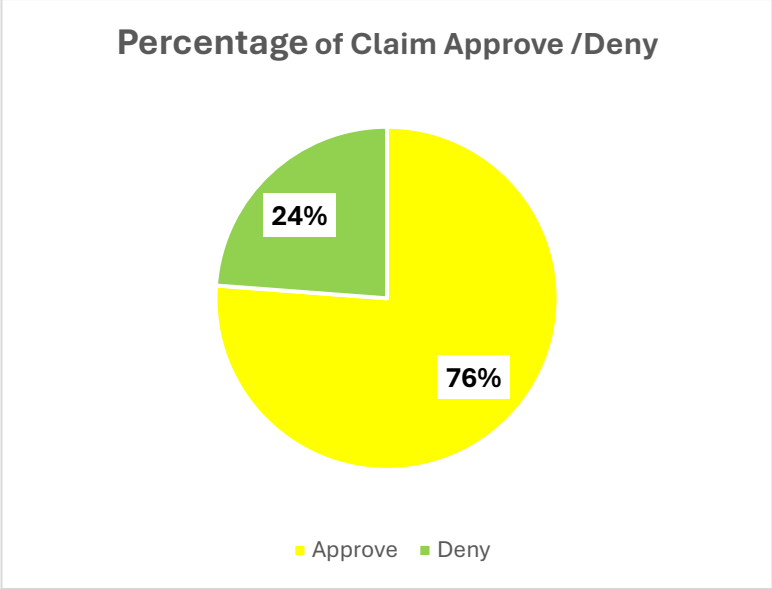

Fig:4.1- Pie chart of claim Approve/query/Deny

Based on a sample of 105 claims, we were able to establish that 76% of the claims were approved while 24% were disapproved. It is crucial to look at denial rates since they could be an indication of the inefficiency in the claims processing system. It is often argued that a denial rate of 15% or higher is high. However, in this case, the denial rate stands at 24% which is higher than this benchmark suggesting that there may be some room for improvement.

2. Percentage of difficulties face during application of a claim

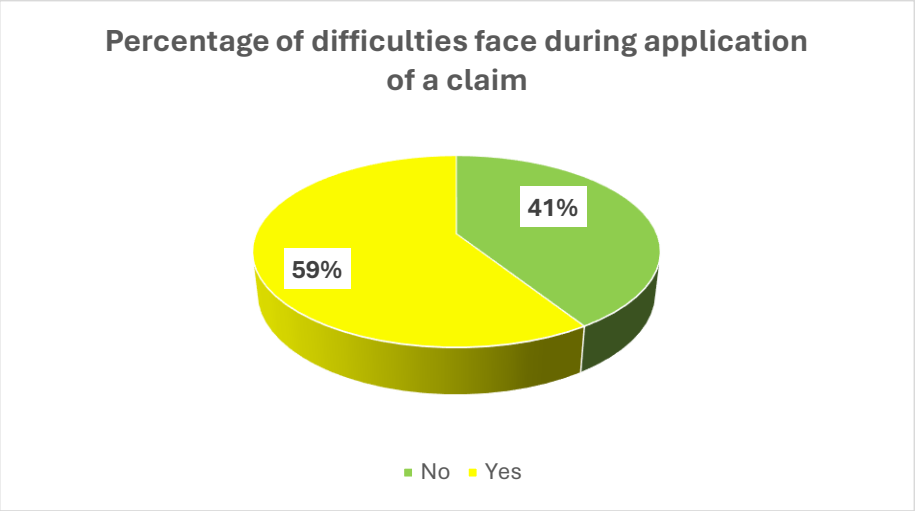

Fig 4.2:-Pie Chart of difficulties Face

In the survey that involved 105 people, 56 percent of the respondents stated that they faced challenges in the application of the claim. This raises the question of why such a large proportion of respondents experienced such problems, which points to a potential need for improvement in the claiming process.

3. Reason for Difficulty faced by patients during cashless claims in the hospital

Reason for Difficulty	
Deny due to fresh policy (Waiting period)	21%
Deny policy due to pre-existing disease	18%
Don't Know	11%
Insufficient Data not given by older Insurance Company to the newer one	19%

Misguided by Agent about the benefits	16%
Repeated Query due to Insufficient document	15%

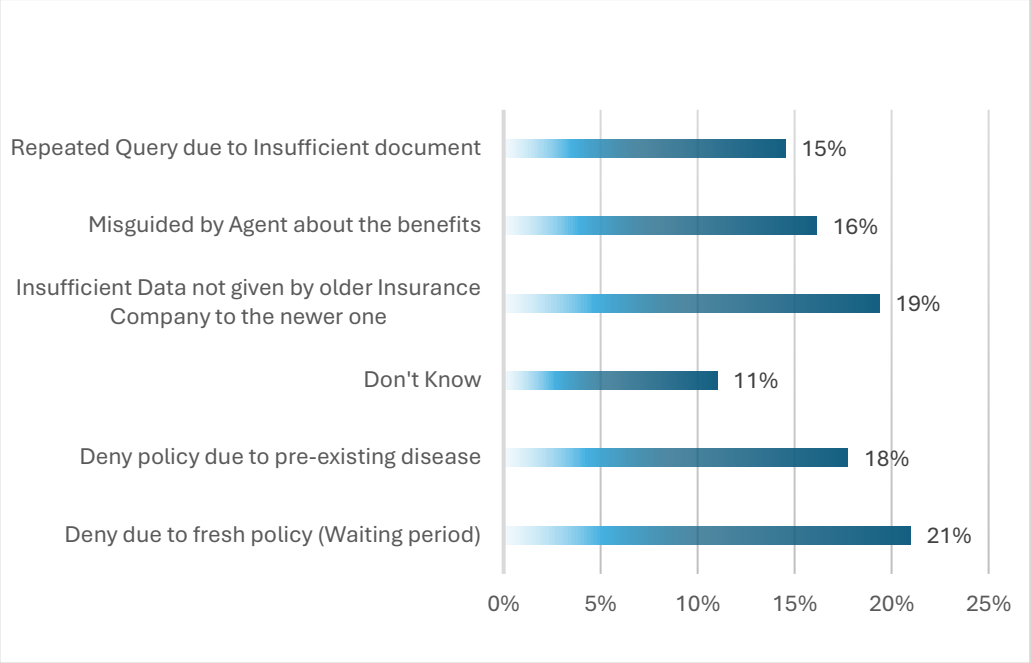

Fig 4.3:- Reasons for Difficulty

Challenges that arose from this included 21% of them being denied by the fresh policy's waiting period meaning that the applicants had to wait in order to be considered for cover. However, 18% of applicants were rejected on the basis of their medical status, this underlines the fact that insurers are not willing to take on people with health issues. 11 percent stated that the reason for denial was unknown and had been tagged as "Don't Know. "19 percent was denied because data transfer from the previous insurance company to the new one was inadequate. The role of agents was further brought into focus due to the fact that 16% of denials were attributed to wrong information from agents regarding policy benefits. Lastly, 15% of queries were made on some applications because of incomplete documentation and this was done more than once suggesting that more attention should be paid to application procedures.

4. Percentage of Knowledge about Coverage of Maternity Benefits

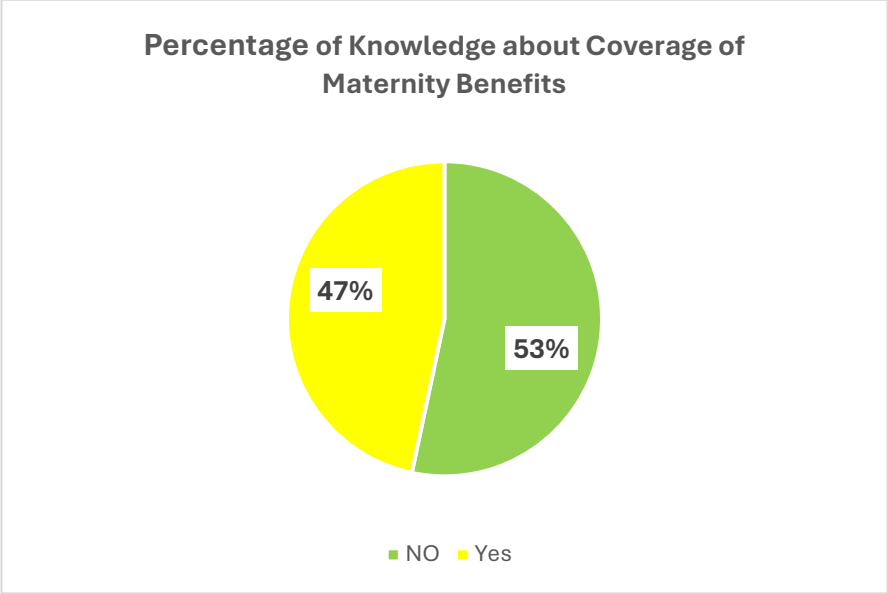

Fig 4.4 :- Pie chart of Knowledge about Coverage of Maternity Benefits

In the assessment of 105 participants on the awareness on coverage of maternity benefits, 53% said they are unaware of the coverage while 47% said they are aware. This translates to a total of 56 people who were not aware of maternity leave and 49 people who were aware of it. Thus, the nearly even distribution of the results indicate that a large segment of the public is likely to lack sufficient information on maternity benefits, a factor that may have significant consequences on cashless claim.

5. Percentage of Knowledge about the waiting period

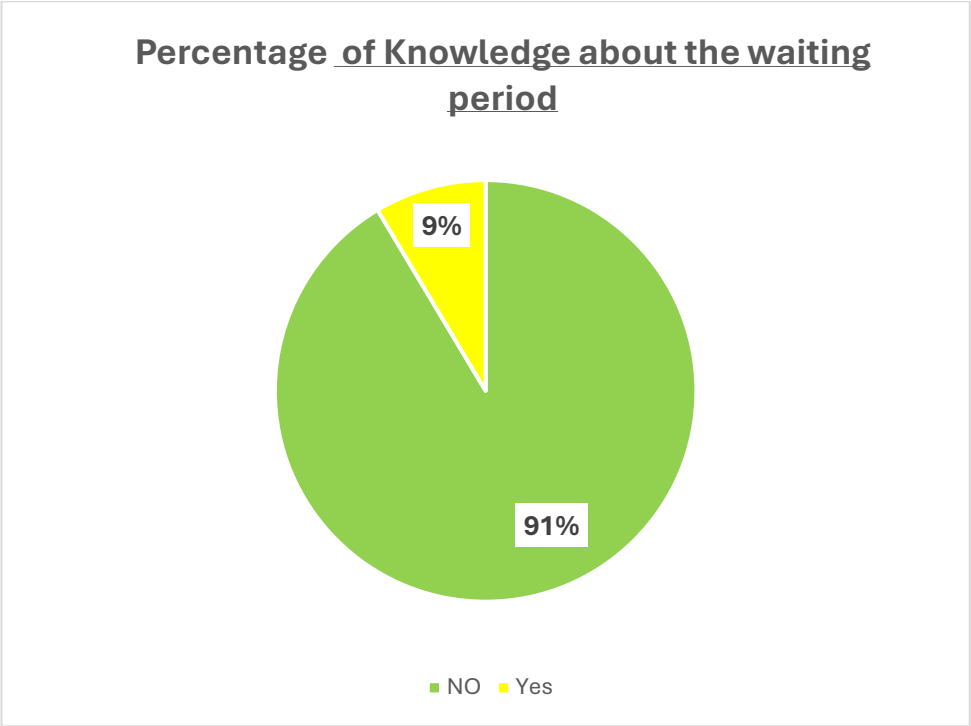

Fig 4.5:- Pie – Chart of Knowledge about the waiting period

With the sample size at 105, the results suggested that 91% of respondents claimed to have no awareness concerning the waiting period and only 9% affirmed their awareness of the issue. This translates to approximately 96 people did not get information relating to the waiting period while just about 9 people were informed. Majority of the respondents, did not know how long they would have to wait, and this finding underlines the fact that there is inadequate community campaigning and public enlightenment on the waiting period necessary in order to ensure that more people are well informed in this regard.

6. Percentage of Knowledge about accidental benefits

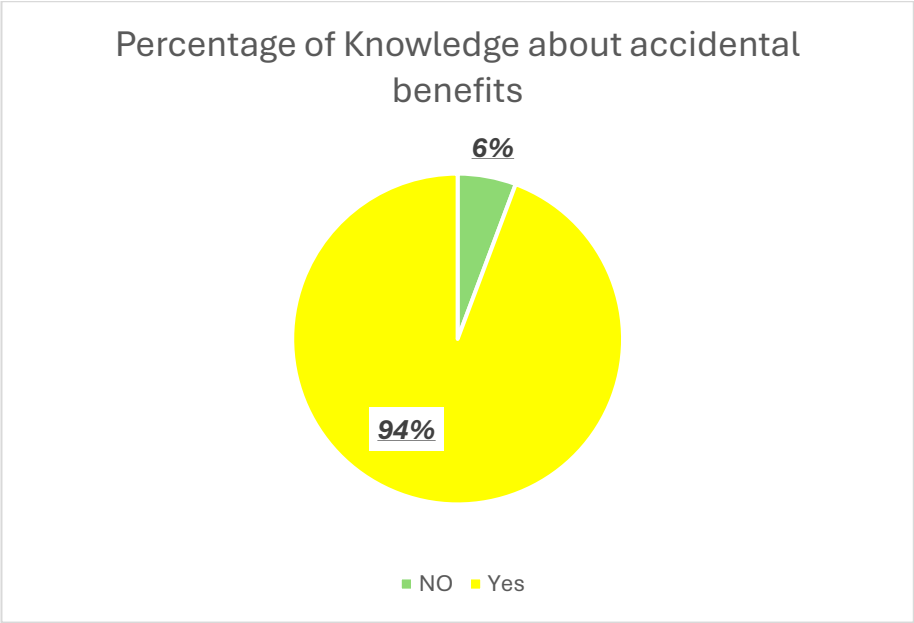

Fig 4.5:- Pie chart of Knowledge about accidental benefits

Responding to knowledge about accidental benefits, 94% of the 105 participants have some form of knowledge of the accidental benefits, while a mere 6% lack any form of knowledge. This means that of the total sample, 99 people are aware of the accidental benefits, while only six people out of the total sample have little or no information concerning them. This high level of awareness could be attributed to increased awareness creation and public enlightenment of the need for accidental benefits, which are usually in form of monetary benefits and services that would be provided to the families of a deceased or an individual who has been involved in an accident.

7. Percentage of aware about existing disease waiting period

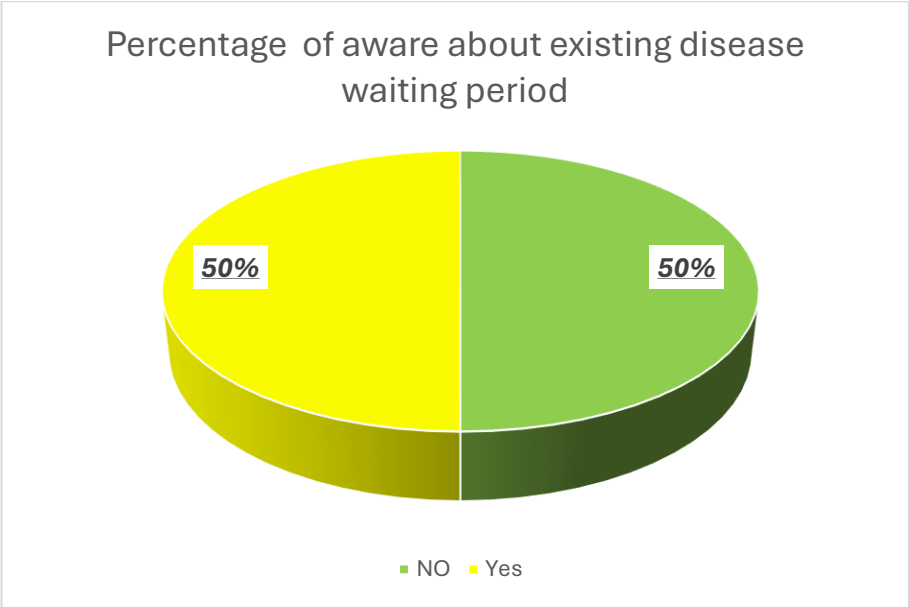

Fig 4.7 :- Pie Chart of aware about existing disease waiting period

In the online survey of 105 random people, it was determined that people have equal knowledge of waiting time for existing diseases. When asked about their knowledge on waiting period for existing diseases 52 or 53 among the respondents said they had some knowledge while the other half of the respondents said they had no knowledge at all about the waiting period for existing diseases. This indicates a fair level of awareness among the surveyed sample, establishing that half of the respondents is aware of the possible delays in the coverage for the pre-existing conditions, while the other half, seemingly does not possess this information and, therefore, may not have clear understanding of how to manage the health insurance policies.

8. Education v/s Detailed explanation about your policy terms and condition

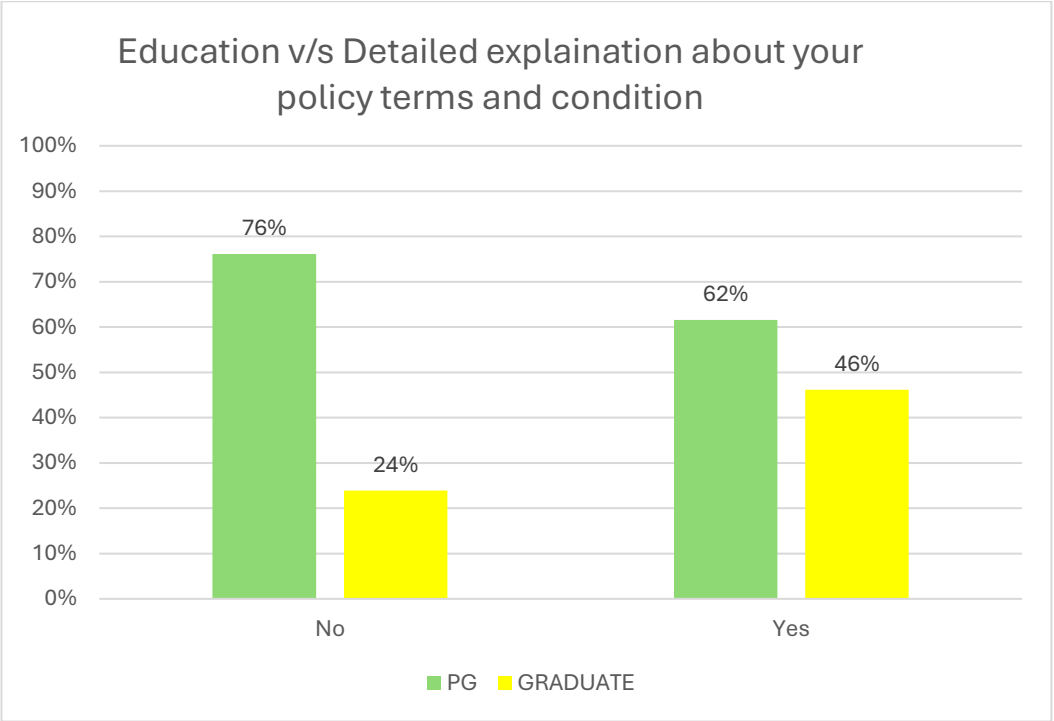

Fig 4.8:- Graph of 'Education' V/s 'Detailed Knowledge about your policy terms and condition

In the Graph it is seen that the percentage of the people who can explain the policy terms and condition in detail is 76% for people who have postgraduate degree whereas the percentage is only 24% for the people those who do not have any degree. Comparing with 76% of people with postgraduate degree who are given detailed explanation about the policy terms and conditions, all the other categories show a very low level of knowledge.

9. Percentage of Age

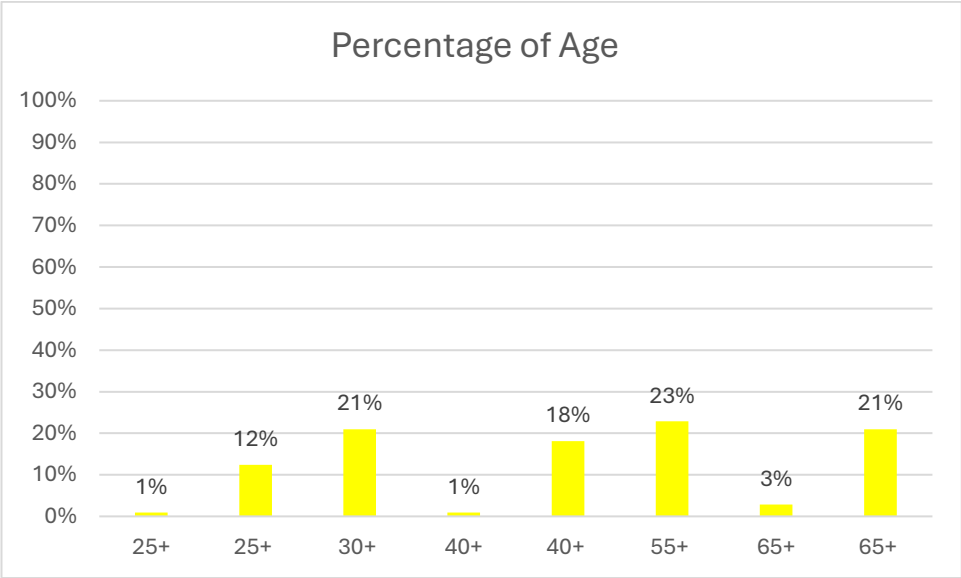

Fig 4.9 :- Graph of Percentage Of Age

The data given below depicts the age analysis of the patients who expired their claims as cashless in a hospital selected for this study and comprised of 105 patients. The age categories are grouped into ranges: Therefore, the outcome will be 25+%, 30+%, 40+%, 55+%, and 65 + % with percentage representing the percentage of patients in each category. From the collected data, it is clear that 13 percent of the patients are 25 and more; 12 percent are in the 25+-to-30 age bracket. Each age group identified above represents 10% of the total population of the city; however 21% of the population is aged 30 years and above. The percentage of the population over 40 is at 19%, while intensively 40-55 years old patients are only 1% of the total value with 18% patients aged between 40+ and 55 years old. Patients who are aged 55 and above were recorded at 23% of the calculated sample size. Finally, patient's age distribution also has 24% of elderly patients in the 65+ category while 3% of the patients are precisely 65+ and 21% are within 65+ and older ages. This information is useful for a demographic analysis of patients making cashless claims, presumably pointing to greater usage among individuals in the later stages of their lives.

10. Correlation Between difficulty faced by patient during cashless claim and their awareness about policy terms and conditions

Correlations			
		YES/NO	Faced/Not Faced
YES/NO	Pearson Correlation	1	-.685**
	Sig. (2-tailed)		.000
	N	105	105
Faced/Not Faced	Pearson Correlation	-.685**	1
	Sig. (2-tailed)	.002	
	N	105	105
**. Correlation is significant at the 0.01 level (2-tailed).			

Descriptive Statistics			
	Mean	Std. Deviation	N
YES/NO	.24	.428	105
Faced/Not Faced	.60	.492	105

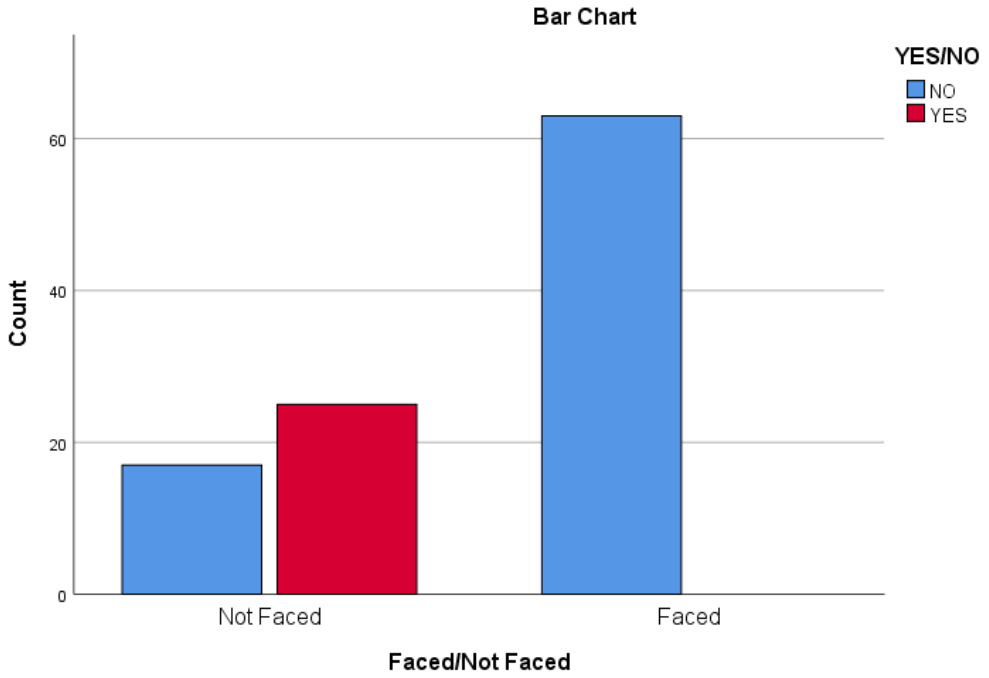

Fig 4.10:-Correlation Graph

- The correlation coefficient is -0.685, which is considered a moderately strong negative correlation.
- The sample size (N) is 105.

The analysis reveals a correlation coefficient of -0.685 between the difficulties faced by patients during the process of applying for a cashless claim and their level of awareness about policy knowledge. This coefficient indicates a moderately strong negative correlation, suggesting that as awareness about policy knowledge increases, the difficulties experienced during the claim application process tend to decrease. The statistical significance of this correlation is supported by a p-value of .002, which is well below the conventional threshold of 0.05. This low p-value implies that the observed correlation is highly unlikely to have occurred by chance, reinforcing the reliability of the results. With a sample size of 105, the study provides robust evidence that better-informed patients encounter fewer challenges when navigating the cashless claim process, highlighting the importance of policy knowledge in facilitating smoother claim experiences.

SERVICE PROVIDERS SURVEY FINDINGS

1. Average Denial rates = 22 out of 100
2. No Service Provider in the hospital is Covered under any health Insurance (neither of Billing executive /TPA Executive or audit team is covered)
3. 5 of them are under the age of 30 and few of them are under 35+ out of which 2 are females others are male out of 8 service providers in that department
4. Out of all 8 service providers 5 of them has whole Knowledge about all the hospital charges and 3 of them has neutral knowledge.

5. **Percentage of Satisfied Service Providers with the communication within and outside the department**

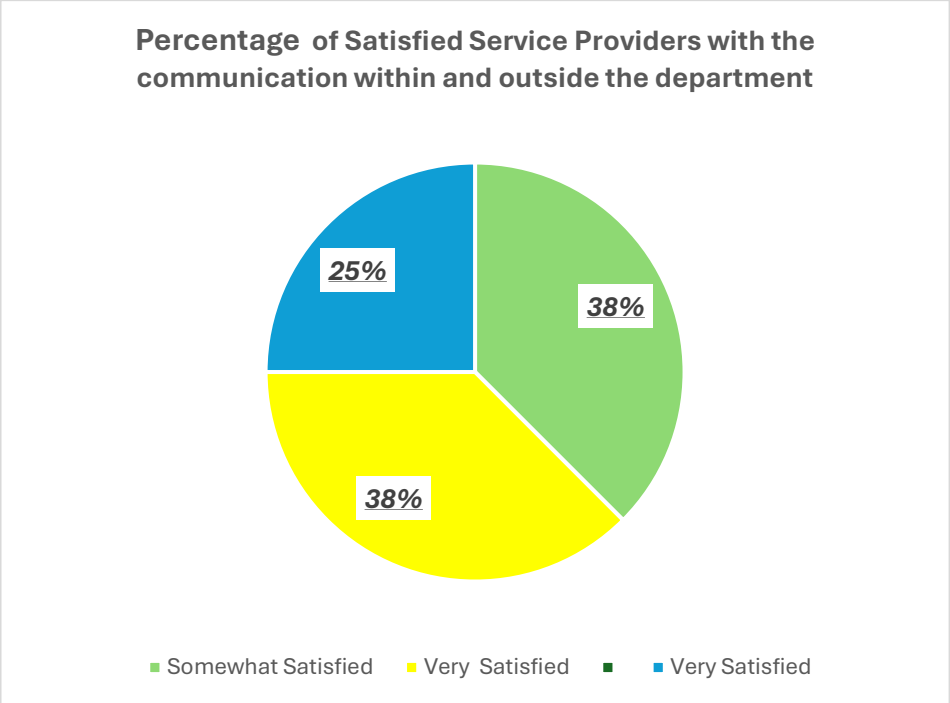

Fig 4.11:- Pie Chart of Satisfied Service Providers with the communication within and outside the department

6. All service providers face Difficulties in Delays in the process of claim approval.
7. Delay Reasons are categorise into Two types on the basis of duration :-
    - Delay during pre-authorization- 1ST Category
    - Delay during patient discharge- 2nd Category

Reasons that comes Under 1st Category are:-

- Interoperability between the department
- Related Investigation Report file in OT (cannot be seen at the time of pre - Auth Admission)
- Patient Doesn't have ID proof and policy card
- Patient engaged in talking
- patient least bothered about the admission in pre-auth (wrong perception of claiming the pre-auth automatically with the admission form) which is due to misguidance by agent
- New Policy
- In case of an Accident Investigators are sent for which approval gets delayed
- Technical Issue in Insurance Company
- Portal down
- Follow-up delay during Discharge in case of higher amount bill
- Demand for revised bill by Insurance Company
- Query by Insurance Company
- Lack of communication
- Interoperability
- Technical Issues
- Query
- TPA delay within the department
- Insurance company approval delay.

Reasons that comes Under 1st Category are:-

- Delay in Approval from Insurance Company
- Consulting doctor is busy in OT or other treatment which is necessary for recommendation of pre-auth admission
- Late query replied on Final and Initial Approval
- Doctors handed the discharge summary late which result in late processing
- Discharge Certificate preparation Late from Typing Department in hospital

- Medicine Bil from pharmacy received Late, Insurance company delay in approval
- Revised Bill Demanding
- Repeated Query
- Late Discharge Approval after 12am which result in stay of one more day in hospital
- Unjustified Bill (i.e higher amount in the final then in the Initial one
- Portal Down
- Technical Issues
- Query
- TPA delay within the department
- Insurance company approval delay.

8. <u>Denial Reasons are categorise into Two types on the basis of duration :-</u>

- Deny during pre-authorization- 1ST Category
- Deny during patient discharge- 2nd Category

(And RCM in hospital is more affected by Denial of claims during or at the time of Discharge or final Approval of claim after pre-authorization)

a) <u>Reasons that comes under the 1st category are:-</u>

- Waiting Period
- Policy Knowledge of patient
- Maternity
- Fresh Policy
- Congenital disease
- Waiting Period
- High price Demand for any single surgery which is more than Normal

b) <u>Reasons that comes under the 2ND category are:-</u>

- Pre- Existing disease
- Congenital disease
- Discharge summary and prescription detail mismatch due to pre-existing Disease
- 24 hours not completed
- Patient Unaware /least Bothered about applying for cashless claim (Insured think everything will be done automatically once they take admission in the hospital)
- Misguided by agents

<u>Flow chart of the pre- auth process</u>

<u>Patient Arrival</u>

Document- ID, policy Card, Investigation reports

Form given for Pre – Auth to fill up by the patient /relatives

Pharmacy Credit Note given to Patient

(To take medicines in credit under the policy)

Documents Sent To Insurance company or to empanelled TPA

Approve/Query

Hospital TPA desk got the mail for approval/query/deny

Approve **Deny** **query**

Proceed the treatment under Cashless claim **Claim cancelled (go for reimbursement)** **documents provided request by insurance company**

Fig 4.12:-Flow chart of pre – auth

Flow chart of the hospital TPA(Detailed Process)

From admission to discharge to sending the documents (Doket) to the insurance company through post i.e The hard copy

Pre – Auth admission (initial bill)

Documents Sent to Respective Insurance company

Approval/Query

If Query **If Approved**

Requested documents Sent **Documents send to Billing department**

At Discharge Bill (final bill) will be prepared with

Discharge Summary and Bill

Send it to Insurance company

If query raised for any documents for investigation,the some is sent to Insurance company

Remaining Payment is taken from patient after approval and the final amount that is settled by the insurance company, Including MOU and deductibles (where the amount is deducted)

Whole File with all the investigation Report is sent (hard copy)to Insurance company for payment to the hospital

The payment is settled within 30 to 45 days

Fig 4.13:-Detailed Process

Chapter 5:-

Strategies for Decreasing Claim Denials & Improving Revenue Cycle Management

1. Enhance Patient Education and Awareness:

Educational Programs:

To introduce proper insurance coverage, create complete educational programs stated for increasing patient awareness of insurance policies and their working, wait periods, coverage subtleties, and document submission. It is advisable to use both brochures, online resources, as well as conduct in-person counselling session.

Clear Communication:

Ensure the patient has adequate knowledge on his/her health insurance policies through an effective communication plan. This may require provisions for posting updates periodically in form of emails, text notifications, and social media platforms on policies and how to file for a claim.

Pre-authorization Guidance: Most of the time, there seems to be a miscommunication regarding what procedures need to be followed to get approvals in a timely manner; therefore, provide the patients with all the relevant information that will make it easier for you to get all approvals before proceeding with the treatment.

2. Improve Documentation and Billing Processes:

Accurate Documentation: It is also important to recall that all interactions with patients, the operations performed, and the actions taken must be documented. This is done through keeping records of the patient's medical and surgical histories, his proposed as well as any contact that the healthcare facility has had with an insurer.

Standardized Billing: The council should ensure that there are standard billing procedures that should be followed ad hoc to the insurance policies. /A The audits should be provided from time to time to monitoring the obligation and non-obligation of the companies based on the Memorandum of Understanding (MOU) and the ratified

rate lists.

Billing Expertise: Utilize professional billing clerks to tackle the documentation or billing systems which might be intricate. Perhaps, it has never been made easier for errors to be detected and corrected when making claims especially since experts in the field will have reviewed it.

3. Regular Evaluation and Quality Improvement:

Continuous Monitoring: It is important to set an evaluation system of the claims on a more regular basis which will help in removing all the flaws in the process and bring more efficiency and effectiveness into play. Track denial percentages, assess what is significant in those denials, and select appropriate tactics for handling the typical causes of denial.

Quality Improvement Initiatives: Incorporate measures to improve claim denial reduction healthy and functional. You need to make sure that claim denial reduction mechanisms are functional and healthy. Some of it involves updating the staff on the latest developments in insurance policies, and improving the internal structure.

4. Automation and Digitalization:

Electronic Health Records (EHR): Implement EHR that would enhance documentation by making sure that all patient details are captured depending on the flowchart developed by the clinician and that this details can be easily retrieved when needed.

Automated Claim Submission: To minimize clerical mistakes and shorten settlement procedures, develop the AL leads automated submission systems.

Data Analytics: One of the most effective approaches to outline and predict potential denial situations is the use of data analytics to analyse the trends and areas that cause increased denial rates and plan the approach to minimising such rates.

5. Denial Analysis and Utilization Management:

Denial Analysis Set-ups: Set up with claim analysis teams specifically for analyzing

claims that have been denied; recommending why was the claim denied; and recommending solutions on how to rectify the situation.

Utilization Management: Establish measures of controlling the use of the institutions resources and adherence to insurance carriers' requirements in this connection the following should be put in place: Some of the examples are pre-authorization checks and ongoing treatment verification that is usually conducted periodically.

6. Insurance Contracting and Case Management:

Negotiation of Insurance Contracts:

It is wise to periodically evaluate insurance policies and clauses so as to have better bargaining power in case insurance costs are incurred or to have well-defined procedures of filing insurance claims.

Case Management:

This way, the eventual goals are to develop case management programs as a means of streamlining patient care and increase the chances of treatments being conveyed with insurance providers to decrease insurance denial rates.

7. Staff and Leadership Engagement:

Incentive Models:

Design and implement staff motivational models to ensure that claims are both accurate and processed efficiently. Reward and identify employees who do their best to prevent and reduce denials of payment by the insurance companies and other programs.

Leadership Involvement:

More to the point, leadership must be actively involved with resource commitment in RCM efforts. Leadership should continue development efforts that focus on staff development, process improvement, and resource infrastructure to strengthen the claims process.

8.Clinically-Driven RCM:

Clinical Involvement: Clinicians must also play their part in the RCM process because treatment must be documented by them in the correct manner and adhering to insurance rules. This may help lower clinical denial rates and boost the overall higher approval chances.

Interdisciplinary Teams: Employ clinician, billing professionals, and case managers to work concomitantly in a single team and identify major cases for discussion while minimizing interdisciplinary hand offs.

As a result of executing these approaches, the chances of getting claim denials will be minimal, and the process of Revenue Cycle Management will be efficient, and this will ensure that the hospitals achieve better financial stability and the patients are satisfied.

Chapter 6:-

Discussions

Analysing the data collected from 105 claims, the study raises the awareness of the need for understanding both the effectiveness of the cashless claim process and obstacles occurring in the hospitals. The analysis revealed that the percentage of approved claim was 76 % and 24% of the claim was rejected which is higher than the industry standards and a benchmark of fifteen percent is not satisfactory for the present claim processing system. That is, 56 percent of respondents can note that they experienced some difficulties or misunderstandings regarding actions directly connected to the application process, thus pointing at the necessity of its improvement. Among all the rejections, 21% were attributed to waiting periods on new policy while 18 % were due to medical conditions The remaining 19 % were attributed to inefficient data transfer from previous insurers, 16 % were attributed to wrong information given by agents and 15% due to incomplete documents. It was also inculpatory to also know the extent of awareness of these specific policies and it was noted that only 47% of the respondent's have knowledge of maternity benefits, and that as for waiting period 91% had no knowledge; proving the fact that there is a severe lack of awareness about these issues. On the other hand, 94% knew of the existence of accidental benefits, an indication that there has been the adequate sensitization on this regard. Greater knowledge regarding waiting periods of existing diseases was evident, with the respondents sharing a mid-level awareness. Knowledge of policy terms: the author estimated that their educational background would prevent them from fully comprehending the policy and found that of the 105 participants, 18 failed to demonstrate detailed understanding, although 92% of them were graduates or post-graduates. The largest group in terms of age distribution among patients seeking cashless claims was in the elderly category with 24% and 20% claiming to be 55+ and 65+ respectively. The correlation coefficient returned as -0. 685 between difficulties encountered during the claim process and policy awareness where the correlation coefficient is moderate and negative. The p-value of . 002 further enhances the stability of this result, meaning that the heightened understanding of policy particulars considerably reduces the problems faced in the claim application process. At the same time, this research emphasises the need to improve the patient's sensitivity to the policy terms with regard to the claim procedures and denial rates. Increased awareness of training programs for service providers, effective means of communication, and sound IT

framework to reduce technical glitches should be viewed as possible activities that can help make a cashless claim process more efficient. Also, adequate insurance policies towards the service providers would help enhance their self-motivation and productivity, which is in the interest of the whole claim processing system. This demographic analysis also helps in identifying the usage patterns; stress on raising awareness towards using social media among the different age brackets. In summary, the study points to big improvements on patient education as well as processes which would translate to improved claim approvals and customer satisfaction.

The critical challenge discussed in this paper is based on a survey conducted among the hospital service providers regarding their experiences and perception towards the cashless claim process of the insurance service providers and identified following important issues as below: The average of the denial rate of cashless claims according to the survey is 22% which reflects that there are challenging factors associated with the approval of insurance claim which can lead to financial burden for the patients and operational inefficiencies for the hospitals One such finding is that neither the billing executives nor the TPA executives nor the audit team members are having any health insurance cover for themselves which is a cause of concern to this writer since the welfare of employees should be paramount for an organization and poor welfare standards are likely to have a cumulative effect on the quality of service delivery. It will also be beneficial to check whether all these employees have adequate health insurance coverage since a healthy workforce tends to be a more productive one. Five of are are below thirty years, while the rest are between thirty-five and forty years of age.The gender breakdown shows that there are two females and six males in the eight total employees. Five service providers presented themselves as knowledgeable regarding hospital charges while three of the service providers posed their level of knowledge as neutral thus recommending more training to ensure all the service providers gained mastery on the charges billing processes. Every service provider established that there was a challenge in terms of the time taken in handling this claim approval has been divided into a couple of areas; the time taken before pre-authorization, and at the time of patient discharge. Common causes for PA delays include policy and procedures interface problems within departments, missing investigation reports, missing patient details, patients' inadequate cooperation, patients' misunderstanding of the process, increased scrutiny of new policies and accident cases, technical issues, and broken downtimes, and TPAs-Insurance Company communication barriers. This leads to delayed discharge as patients wait for approval

from insurance providers, consulting Doctors may not be available, delayed preparation of discharge summaries, delayed receipt of medicine bills, delays in preparing discharge certificates, Insurance providers revising their queries and bills, Technical issues, portals being down or Earth node down and late discharge approvals which may require an extra day in the hospital.

Denials can happen at the pre-authorization stage and at the stage when the patient is discharged and pre-authorization denials arise due to waiting period clauses in policies, policy ignorance by patients, high demand cost for surgeries and where patients do not understand that even with cashless claim, the hospital requires prior authorization from the TPA and may suffer a pre-authorization denial if the patient has other pre-existing illnesses, minimum days stay and many patients fail to Denials that occur within the hospital stay or between discharge and billing have considerable repercussions to the hospitals' RCM since they arise when many hospital resources have been engaged directly impacting the financial status of the hospital and requiring alterations to the system and measures to prevent such situations. To address these issues, several steps can be recommended: better training to the service providers with new latest insurance policies and new claim process, implementing health insurance to the official staffs to boost their morale and productivity, to improve the communication systems and interface between different sections, creating awareness program for the patients to improve their knowledge of cashless claim system and policies, risks, AC & discharge summary, implementation of strong IT solutions which may reduce technical issues and to make the claims process absolutely smooth, efficient ways to manage These measures are particularly beneficial to hospitals since they allow denial rates to be reduced drastically, minimize the time wasted in the entire process of getting reimbursed, and augment the effectiveness of the cashless claim process, hence increasing the satisfaction of patients and providing better stability to the hospital's financial healthier.

Chapter 7:-

Conclusions

The study comprehensively examines the, various aspects of RCM in hospitals are analysed comprehensively, with emphasis placed on the challenge of insurance claim denials. The relationship is illustrated in the research through the exploration of the effect of claim denials on hospital finances, revenue cycle, and patient care management, which becomes a tremendously cumbersome process that results in considerable resource allocation to address the consequences of such denials. With an objective of identifying different causes of claim denial, literature review accumulates specific data on the reasons such as patient misunderstanding, systematic errors, and organizational problems.

Perhaps, the most noteworthy issue that has been identified in the course of the research is the relationship between the level of patients' knowledge of the insurance policy and the rate of claims rejection. Accounts of the patients fail to understand their respective policies and therefore submit incorrect claims and this can lead to high probability of denial. This calls for development of effective patient education programmes to enable the patients to tailor the existing knowledge in this area. The present research also set information gaps to enhance the training of the hospital human resource and the application of an effective IT infrastructure to manage the claims effectively.

The given proposal suggests several possible measures to address the issue of the elevated denial rates and enhance RCM operations. These are; more education to patients by Information promotion agendas that are focused on changing patient's behaviour, promoting awareness of new policies in insurance and communications infrastructure in the hospital. Furthermore, it recommends offering health insurance for hospital staffs so that they may work harder and with more energy.

To sum up, the issue of handling insurance claim denials is crucial to maintain the stability of the hospital's financial state and the fluency of operations. Through the successful application of the outlined strategies, hospitals are likely to record lower denial rates, improved patient satisfaction rates, and better resource management in relation to the services' RCM cycle. This will not only help bring stability in revenues but also will help hospitals put their resources towards adopting better technologies and therefore enhance

the quality of care being offered to patients. To this effect, the study establishes the need for effective management of the RCM activities to cut down on the financial risks and promote sustainability of the health facilities.

Annexures

Questionnaire for Patients

1. Age: _____
2. Occupation: _____
3. Education Qualification? _____
4. Did you get a Detailed explanation about your policy terms and condition?
5. Are you aware about the benefits of policy with all its terms and conditions?
6. Did you have knowledge about Coverage of Maternity Benefits in your Policy?
7. Did you have Knowledge about the waiting period in your policy?
8. Did you have Knowledge about accidental benefits in your policy?
9. Are you aware about existing disease waiting period in your policy?
10. Did you face any difficulties during application for a Mediclaim?
11. If yes why?
12. Claim Approve or Deny?

Questionnaire for service providers

1. Age: _____
2. Gender: _____ (Optional)
3. Do you have health insurance? (Yes/No)
4. If yes, what type of health insurance plan do you have? (e.g., HMO, PPO, Medicare, Medicaid) _____

5. Have you received an explanation of your estimated hospital charges? (Yes/No)
6. How satisfied are you with the clarity of communication regarding hospital billing and insurance? (Very Satisfied, Somewhat Satisfied, Neutral, Somewhat Dissatisfied, Very Dissatisfied)
7. Did you experience any difficulties or delays in getting information about your hospital bill or insurance coverage? (Yes/No)
8. If yes, please describe the difficulties or delays you encountered: _____
9. Average denial rates according to you per month?
10. Reasons For denial……
11. Do you have any suggestions for how we can improve your experience with billing and insurance during your hospital stay? _____

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