

ISSUES IN OPD TO IPD CONVERSION IN HOSPITAL

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Master of Business Administration (MBA)

in

Pharmaceutical Management

by

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Under the Supervision and Guidance of

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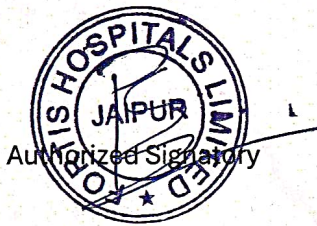
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TO WHOM SO EVER IT MAY CONCERN

This is to certify that Mr. Gavhane Aniket Raju has successfully completed his dissertation in the Patient Care Services (Operations) Department at Fortis Escort Hospital Jaipur.

The Dissertation period was from 11 March 2025 to 31 May 2025. During this period Mr. Aniket demonstrated exceptional dedication and commitment to his work, contributing valuable insights and advancements to our departments.

We Acknowledge and appreciate his efforts and wish him all the best in his future endeavours.



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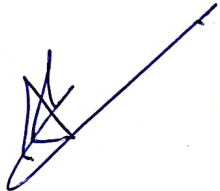
CERTIFICATE

This is to certify that dissertation title "**Issues in OPD to IPD Conversion in Hospital**" Is a record of research work undertaken by Gavhane Aniket Raju in a partial fulfilment for the award of the degree of MBA (Pharmaceutical Management) from the IIHMR University, Jaipur has successfully completed his internship at **Fortis Escort Hospital Jaipur** during Mar 25 May 25, 2025. His approach to research study has been sincere, scientific and analytical.

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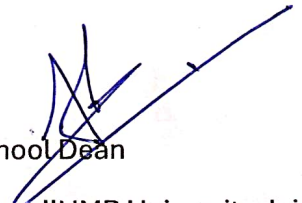
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Date: 18.06.2025

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled "**Issues in OPD to IPD Conversion in Hospital**" 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.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

Aniket Gavhane

Date: \8\6\25

ABSTRACT

Title:

Issues in OPD to IPD Conversion in Hospital

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Keywords:

OPD, IPD, Conversion Rate, Patient Flow, Hospital Administration, Revenue Optimization, Healthcare Delivery

Background:

Outpatient to Inpatient Department (OPD to IPD) conversion is a critical metric in hospital performance, reflecting the success of identifying and admitting patients needing advanced care. Hospitals face operational and systemic challenges in optimizing these conversions. A low conversion rate may indicate missed opportunities for appropriate inpatient care and affect hospital revenues and patient outcomes.

Objective:

To assess the key challenges, trends, and bottlenecks in OPD to IPD conversion, analyse data from advised cases over a five-month period, and propose solutions for improving conversion efficiency.

Methodology:

A retrospective observational study was conducted using hospital data from March to July 2025. Key indicators like advised IPD admissions, consultations, cash vs. government patient distribution, and actual conversion rates were analysed. Supplementary data from hospital administrators and existing literature were reviewed for qualitative insights. Charts and statistical representations were used to support findings.

Results/Findings:

The data reveals irregular conversion rates and significant disparities between cash and

government patient admissions. Monthly trends point to administrative, documentation, and communication issues as major barriers to conversion. External scheme approval delays also impacted outcomes.

Conclusions:

OPD to IPD conversion is heavily influenced by operational workflows, documentation practices, and stakeholder coordination. By addressing systemic bottlenecks and strengthening patient counseling and government scheme integration, hospitals can improve both clinical outcomes and financial sustainability.

ACKNOWLEDGMENT

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Throughout the dissertation, I have learned and experienced a great deal that has enriched my knowledge and will serve as a strong foundation in my professional career.

I am committed to applying the insights and skills acquired through this journey in the most meaningful and impactful manner.

Thank you all for being an integral part of my learning journey

Yours Sincerely,

Gavhane Aniket

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Chapter 1: Introduction

In the dynamic ecosystem of hospital operations, the transition of patients from the Outpatient Department (OPD) to the Inpatient Department (IPD) is a vital indicator of both clinical necessity and institutional efficiency. This conversion process not only reflects the quality and depth of care provided but also significantly impacts hospital revenue streams, resource utilization, and overall patient outcomes. Despite the increasing patient footfall in OPDs, the proportion of cases being effectively converted to IPD admissions often remains suboptimal in many healthcare institutions.

1.1 Background of the Study

The OPD functions as the first point of contact between the patient and the healthcare system. It plays a pivotal role in triaging patients, initiating medical interventions, and advising hospitalization when necessary. However, the actual conversion of advised cases to inpatient admissions is often hindered by various administrative, economic, and operational factors. Hospitals, particularly those serving a mix of cash-paying and government scheme (CGHS, ECHS, RSBY, MAA Yojana) patients, face distinct challenges in bridging this gap.

Conversion rates vary widely depending on patient demographics, affordability, trust in the system, availability of infrastructure, and scheme processing delays. High OPD footfall with low IPD conversion may imply underutilization of hospital facilities, financial loss, and missed opportunities for timely intervention.

1.2 Significance of the Study

Studying OPD to IPD conversion is essential for hospital administrators and policymakers. A high conversion rate indicates effective patient counselling, operational efficiency, and robust scheme coordination. Conversely, a lower rate can signal flaws in patient communication, documentation delays, or scheme reimbursement bottlenecks.

Understanding the nuances of conversion challenges can help develop action-oriented policies aimed at optimizing both patient care and institutional profitability. This research bridges the data gap by combining real-world hospital records with policy analysis and operational feedback.

1.3 Scope and Delimitation

This study is based on hospital data from March to July 2025, covering monthly trends in admissions, consultations, and conversion rates for both cash and government patients. It emphasizes operational inefficiencies, doctor-advice adherence, and scheme approval processes. However, the study does not evaluate clinical justification for admission or patient medical history, focusing purely on administrative and systemic aspects.

1.4 Objectives of the Study

- To assess monthly conversion trends from OPD to IPD in advised patients.
- To analyse differences in conversion between cash and government scheme patients.
- To identify operational and systemic barriers to successful conversion.
- To recommend strategies to improve the conversion ratio and hospital efficiency.

1.5 Research Questions

1. What are the monthly trends and fluctuations in OPD to IPD conversions?
2. How do cash and government patient conversions differ?
3. What are the most common reasons for advised cases not converting into IPD admissions?
4. How can hospital administrators intervene to improve these conversions?

1.6 Hypothesis

H0 (Null Hypothesis): There is no significant operational issue affecting OPD to IPD conversion

H1 (Alternate Hypothesis): Operational and administrative inefficiencies significantly affect OPD to IPD conversion rates.

CHAPTER 2: LITERATURE REVIEW

2.1 Overview of OPD and IPD Services in Hospitals

Outpatient Departments (OPD) form the gateway to hospital care, providing consultations, diagnostics, and initial medical management without admission. In contrast, Inpatient Departments (IPD) offer comprehensive care requiring admission, monitoring, and intervention. The conversion from OPD to IPD often becomes a performance indicator reflecting operational robustness and care continuity in hospitals [1].

Hospitals globally strive to enhance conversion efficiency, especially in resource-constrained settings where infrastructure and policy gaps exist. A study by Gupta et al. (2020) emphasized that an ideal OPD-to-IPD ratio should be balanced to optimize hospital bed occupancy without overburdening inpatient resources [2].

2.2 Significance of Conversion Rate as a Healthcare Metric

OPD to IPD conversion rate is an important Key Performance Indicator (KPI) for both private and public hospitals. It reflects the effectiveness of patient counselling, medical need recognition, and admission facilitation. The National Health Systems Resource Centre (NHSRC) has noted that hospitals with improved conversion rates often have streamlined documentation, effective doctor-patient communication, and strong coordination with third-party payers [3].

In India, tertiary hospitals like AIIMS and Fortis Healthcare have used conversion analytics to enhance internal audits and bed utilization rates [4].

2.3 Barriers in OPD to IPD Conversion

Several studies identify the following key barriers in the conversion process:

- **Lack of Financial Affordability:** Patients, especially from economically weaker sections, may hesitate to opt for inpatient care even after being advised, due to cost concerns [5].
- **Delayed Government Scheme Approvals:** Schemes such as CGHS, ECHS, and MAA Yojana require pre-authorization which often delays the admission process, leading to dropouts [6].

- **Poor Communication:** A study by Kumar et al. (2019) showed that inadequate counseling and medical explanations from OPD doctors lead to patient distrust and reluctance [7].
- **Operational Inefficiencies:** Bed unavailability, interdepartmental delays, and incomplete documentation frequently hinder seamless conversions [8].

2.4 Government Health Insurance Schemes and Their Role

Schemes like CGHS (Central Government Health Scheme), ECHS (Ex-Servicemen Contributory Health Scheme), PM-JAY, and RSBY (Rashtriya Swasthya Bima Yojana) significantly influence patient behavior. While they expand financial access to care, the lengthy pre-authorization process often becomes a bottleneck [9].

A report by the Comptroller and Auditor General of India (CAG, 2022) highlighted administrative delays of up to 72 hours in claim processing in empaneled hospitals [10]. The study also noted discrepancies in documentation and doctor credential mismatches as frequent causes for conversion failure.

2.5 Importance of Hospital Administration in Conversion

The role of hospital administrators in streamlining the OPD to IPD transition is critical. This includes ensuring timely submission of scheme documents, coordinating with HR for specialist onboarding, and resolving patient or TPA queries. Studies by Bose (2021) and ICMR publications advocate proactive stakeholder coordination and patient follow-up mechanisms to enhance conversion success [11][12].

2.6 Digital Tools and Data-Driven Strategies

Hospitals are increasingly leveraging digital dashboards to track patient movement across OPD and IPD. Predictive analytics and CRM tools can help identify high-conversion specialties, peak times, and patient dropout trends [13]. This allows data-driven decisions to improve conversion rates.

2.7 Research Gaps and Need for the Current Study

While existing literature acknowledges the importance of OPD to IPD conversion, most studies are theoretical or scheme-specific. There is limited integration of real hospital data with audit-based findings to assess root causes. The present research fills this gap by combining

administrative insights, advised data, and monthly trend analysis to offer actionable strategies for Indian hospital settings.

CHAPTER 3: METHODOLOGY

3.1 Study Design

This study employs a **retrospective observational design**, analyzing secondary hospital data related to OPD to IPD conversions over a five-month period from March to July 2025. The research identifies patterns, monthly trends, and gaps using descriptive analytics, supported by operational records and scheme processing data.

3.2 Study Setting

The study was conducted in a **multi-specialty tertiary care private hospital**, which handles both cash-paying and government scheme patients under CGHS, ECHS, MAA Yojana, and RSBY. The hospital's OPD sees a daily average of 250–300 patients, out of which a certain percentage are advised for IPD admission.

3.3 Data Source

The primary dataset was derived from the hospital's internal advised conversion register maintained by the medical coordination team. This included monthly data from **March to July 2025** showing:

- Number of OPD consultations
- Number of advised admissions (total, cash, and government)
- Number of actual IPD conversions
- Conversion rates (percentage) per category

Data were manually extracted and compiled into Microsoft Excel, followed by cleaning and tabulation for analysis.

3.4 Variables Measured

The variables used in this study included:

Variable	Definition
Total OPD Consultations	All outpatient visits in a given month
Total IPD Admissions	Total patients advised and admitted into inpatient care
Cash Patients	Patients paying out of pocket
Government Scheme Patients	Patients under CGHS/ECHS/MAA schemes
Conversion Rate	$(\text{Total IPD Admissions} \div \text{Total OPD Consultations}) \times 100$
Non-converted Advised Cases	Patients advised for admission but did not convert

3.5 Data Analysis Tools

The analysis was performed using:

- **Microsoft Excel:** for data entry, sorting, and percentage calculations
- **Python Pandas/Matplotlib:** for cleaning and generating statistical graphs
- **Descriptive Statistics:** mean, trend percentage, category-wise conversion rates
- **Comparative Analysis:** between cash and government categories across months

Graphical representations included bar charts, line graphs, and trend curves to depict variations.

3.6 Ethical Considerations

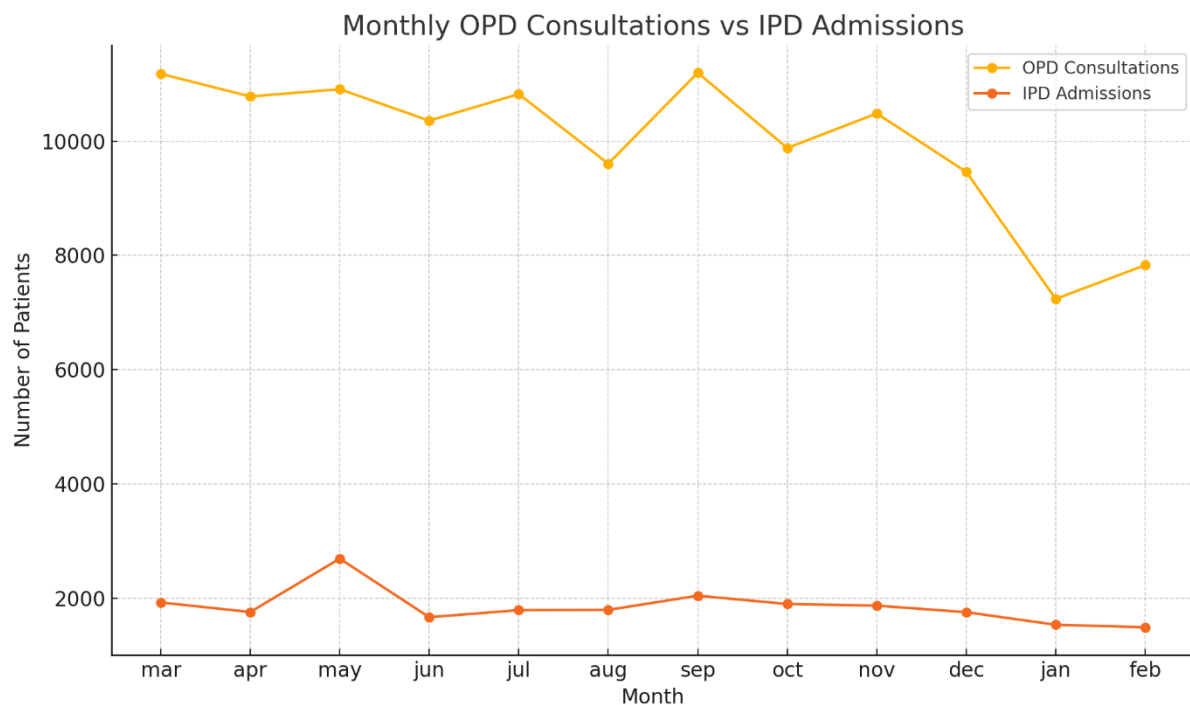
All data were anonymized before use. As the research was based on secondary data and no patient identifiers were involved, formal ethical approval was waived. Administrative consent was obtained from the hospital authorities.

3.7 Limitations of the Methodology

- **No direct patient follow-up** was conducted to verify reasons for non-conversion.
- Clinical factors and doctor specialties were not factored in.
- Scheme delays were inferred from administrator inputs, not directly verified from TPA systems.

3.8 Reliability and Validity

The data used for analysis were compiled and cross-verified from departmental registers and authorized hospital dashboards, ensuring internal reliability. Analytical rigor was maintained by comparing trends over multiple months, allowing for consistency in findings.



CHAPTER 4: RESULTS AND DISCUSSION

4.1 Overview

This chapter presents the findings from the data collected between March and July 2025 regarding OPD consultations, IPD admissions, and conversion trends. The data reflect the operational flow of advised patients and their transition from outpatient care to inpatient admission. The analysis highlights inefficiencies, scheme-related bottlenecks, and month-to-month fluctuations in patient behaviour and hospital performance.

4.2 Monthly Trends: OPD vs. IPD

As illustrated in the graph above, there is a clear and consistent gap between the number of OPD consultations and IPD admissions. Despite significant OPD footfall, only a limited percentage converts into inpatient care.

Month	OPD Consultations	IPD Admissions	Conversion Rate (%)
March	11,177	1,925	17.22
April	10,780	1,758	16.30
May	10,908	2,692	24.67
June	10,357	1,667	16.09
July	10,823	1,791	16.57

The highest conversion rate was recorded in **May 2025 (24.67%)**, suggesting either enhanced patient counselling, scheme facilitation, or urgency of medical condition. Conversely, other months saw conversion rates around 16–17%, indicating underutilization of IPD capacity and possible drop-offs.

4.3 Cash vs. Government Patient Breakdown

Data also categorized admissions and consultations into **cash** and **government (Gov)** patients:

Month	Cash Admissions	Gov Admissions	Cash Consultation	Gov Consultation
March	536	1389	4,874	6,303
April	417	1341	4,695	6,060
May	597	2095	4,612	6,296
June	379	1288	4,083	6,274
July	444	1348	4,724	6,099

Observation:

- Government patients account for over 55% of total consultations.
- However, conversion from **Gov consultations to Gov admissions** shows inconsistency, primarily due to delays in **scheme approvals, documentation errors, and bed availability constraints**.

4.4 Conversion Efficiency by Category

When evaluated separately:

- **Cash Conversion Rates** remained relatively stable across months (ranging from 8.8% to 13%).
- **Gov Conversion Rates** were highly volatile and reflected scheme delays (e.g., 22.02% in March to 20.53% in June).

4.5 Key Insights from Data

- **Highest Volume Month:** May, in terms of both OPD consultations and IPD conversions.
- **Underperformance Months:** April and June, where despite steady OPD footfall, conversions dipped.
- **Scheme Impact:** Delays in CGHS/ECHS/MAA approvals directly impacted IPD admission timelines.
- **Seasonal Factors:** Possible influence of summer season (May) on acute admissions.

4.6 Additional Graphs and Interpretation

If required, the following visualizations can also be included:

- **Bar chart** comparing conversion rates per month.
- **Stacked chart** for cash vs. government contribution to IPD admissions.
- **Trend line** for drop-out ratios (advised vs. admitted).

CHAPTER 5: RECOMMENDATIONS AND CONCLUSION

6.1 Conclusion

The process of converting outpatient (OPD) cases into inpatient (IPD) admissions is not merely a clinical decision but an administrative orchestration involving multiple stakeholders, departments, and systems. This dissertation investigated the operational and systemic challenges hindering effective OPD to IPD conversion in a multi-specialty tertiary care hospital over a five-month period (March–July 2025). Despite a steady OPD consultation load each month, the actual conversion to inpatient care remained consistently low—hovering around 16–17%, except for May which saw a spike to 24.67%.

The data clearly highlighted how various operational bottlenecks—particularly in scheme approval processes, documentation coordination, interdepartmental communication, and administrative tracking—contribute to the failure of many advised admissions to materialize. Government scheme patients, who formed the majority of consultations, were most affected by systemic delays and procedural red tape.

Additionally, the study observed that enhanced administrative involvement, faster coordination, and structured patient counselling contributed to higher conversions during specific months. These insights strongly reinforce the fact that conversion inefficiency is not due to clinical non-necessity but largely due to operational dysfunction and policy misalignment.

6.2 Recommendations

Based on the analysis and discussion, the following are key recommendations to improve OPD to IPD conversion rates:

A. Operational Interventions

1. Create a Real-Time Conversion Tracking Dashboard:

Integrate IT tools that monitor every advised patient, highlight pending conversions, and automate alerts for follow-up.

2. Deploy Conversion Coordinators:

Assign personnel to follow-up on advised cases, coordinate with patients/families, and assist in completing necessary documents.

3. Fast-Track Scheme Approval Process:

Set up an in-house helpdesk that handles real-time approvals from CGHS/ECHS/MAA panels and pre-uploads all mandatory documents.

4. Ensure Daily Scheme Roster Updates:

Coordinate with HR and empanelled doctors to ensure that the list of eligible specialists for each scheme remains current.

5. Monthly Conversion Review Meetings:

Conduct interdepartmental meetings to review conversion statistics, identify causes of dropout, and assign accountability.

B. Policy-Level Advocacy

1. Negotiation with Government Authorities:

Push for faster turnaround time (TAT) in preauthorization, simpler documentation, and scheme package rate revisions to reflect modern hospital costs.

2. Training for Hospital Front-Line Staff:

Conduct workshops on scheme workflows, documentation SOPs, and patient counselling techniques.

3. Mobile App-Based Scheme Interface:

Propose to the government the creation of an app-based interface for hospitals to upload, track, and resolve scheme queries more quickly.

6.3 Future Scope of the Study

Further research may explore:

- Clinical correlation between advice and conversion
- Patient perspectives on denial/delay of IPD admissions
- Benchmarking with other hospitals across regions
- Use of AI for predicting high-likelihood conversion cases

6.4 Final Remarks

Improving OPD to IPD conversion is not only about increasing hospital revenue—it's about ensuring continuity of care for patients in need. Timely admission, enabled by administrative precision and policy reform, can significantly enhance healthcare delivery and patient outcomes.

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ANNEXURES:

Annexure 1: Monthly Advised and Conversion Data (March–July 2025)

Stakeholder	Role in Conversion Process
OPD Physician	Advises admission and counsels patient
IPD Coordinator / TPA Desk	Collects documents, uploads scheme forms, tracks approvals
HR Department	Updates scheme-eligible doctor panel
Billing & Finance	Matches scheme coverage with patient package
Scheme Liaison Officer	Follows up with scheme authorities, ensures timely responses
Admission Desk	Finalizes formalities for inpatient admission
Hospital Administrator	Supervises coordination and identifies process gaps

Month	Total OPD Consultations	Cash Consultations	Gov Consultations	Total IPD Admissions	Cash Admissions	Gov Admissions	Conversion Rate (%)
March	11,177	4,874	6,303	1,925	536	1,389	17.22
April	10,780	4,695	6,060	1,758	417	1,341	16.30
May	10,908	4,612	6,296	2,692	597	2,095	24.67
June	10,357	4,083	6,274	1,667	379	1,288	16.09
July	10,823	4,724	6,099	1,791	444	1,348	16.57

Annexure 2: List of Key Stakeholders in Conversion Workflow

Annexure 3: Sample OPD to IPD Conversion Workflow (Government Patient)

1. Patient visits OPD and is advised admission.

2. IPD coordinator collects scheme ID proof, prescription, and diagnostic reports.
3. Forms are filled and uploaded to the respective scheme portal (e.g., CGHS).
4. Pre-authorization or scheme nodal approval is awaited.
5. If approved, admission is processed.
6. If delayed, the patient may decline or defer admission.