# STUDY ON TURNAROUND TIME (TAT) OF POST AUTHORIZATION PROCESS FOR DISCHARGE OF INSURANCE PATIENTS IN A TERTIARY CARE HOSPITAL

Dissertation Submitted to


**The IIHMR University, Jaipur**

for the partial fulfillment forthe award of the

degree ofMaster of Business

Administration(MBA)

in

Hospital and Health Management

by

Avinash Paul Yangcho Kuchipudi

Under the Supervision and Guidance of

Dr. Susmit Jain

2023

**STUDY ON TURNAROUND TIME (TAT) OF POST AUTHORIZATION PROCESS FOR DISCHARGE OF INSURANCE PATIENTS IN A TERTIARY CARE HOSPITAL**

Dissertation Submitted to


**The IIHMR University, Jaipur**

for the partial fulfillment forthe award of the

degree ofMaster of Business Administration

(MBA)

in

Hospital and Health Management

by

Avinash Paul Yangcho Kuchipudi

Under the Supervision and Guidance of

Dr. Susmit Jain

2023

## DECLARATION BY STUDENT

I hereby declare that this dissertation titled "Study on turnaround time (TAT) of post authorization process for discharge of insurance patients in a tertiary care hospital "is the bonafide record of my original researchwork. 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 Information derived from the published or unpublished workof others has been duly acknowledged in the text.

(Signature)
Avinash Paul Yangcho Kuchipudi
Date

**Dt: 26-05-2023**

## TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Mr. Kuchipudi Avinash Paul Yang Cho, ID No: 90402945** has undergone the **Internship** in the department of **Corporate Projects** at **Krishna Institute of Medical Sciences** from **27-02-2023** to **26-05-2023.** During the course of her work, found to be good.

We wish her all the best for his future endeavors.

KIMS is 750 bedded, Multi-Specialty hospital. This is accredited with NABH, NABL & ISO 9001:2015 certified.

**For Krishna Institute of Medical Sciences Ltd.**

CH Koteswara Rao

**Koteswara Rao CH**
**Sr. Manager - HR**
**KIMS Groups of Hospitals**

KRISHNA INSTITUTE OF MEDICAL SCIENCES LTD. Secunderabad

Krishna Institute of Medical Sciences Limited
Minister Road, Secunderabad - 500 003, Telangana, India
Phone: +91 40 4488 5000/4488 5184 | Fax: +91-40-27840980 | kimshospitals.com
CIN: L55101TG1973PLC040558

# CERTIFICATE

This is to certify that dissertation titled "Study on turnaround time (TAT) of post authorization process for discharge of insurance patients in a tertiary care hospital "is a record of the research work undertaken by (Name of Student) in partial fulfillment of the requirements for the award of the degree of MBA (Hospital and Health Management)/MBA (Pharmaceutical Management)/MBA (Development Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Dr. Susmit Jain
Faculty Guide
IIHMR University
Date

Dr. (Col) MahenderKumar
School Dean
IIHMR University
Date

Date

## ABSTRACT

**Submitted by: Avinash Paul** **Submitted to: Dr.Susmit Jain**
**Roll No: 1267**

**Title:** Study on Turnaround Time (TAT) of Post Authorization Process for discharge of Insurance Patients in a Tertiary Care Hospital

### Background

Post authorization department in hospital is for converting the insurance bills and submitting to the insurance companies within the TAT of 45 minutes. Being a major step in the discharge process of patients, this task is very important as it directly affects the satisfaction level of the patient of overall hospital services. The broad aim of this study was to determine the causes of delays in the post-authorization process for the bill submission of insurance patients and to study the compliance percentage of standard TAT to submit the bill.

### Methodology:

Study was done for 70 days from 16th March to 25th May 2023. The study covered post auth insurance team bill submission time for all the insurance companies and TPA's. Primary and secondary data was collected from the conversion process time, audit time and bill closure time, submission time on Remedinet( It is a portal to submit the insurance bills for approval at the time of admission and discharge) respectively to analyze the TAT compliance and observed the process flow in the department. Study was conducted in KIMS Hospital, Secunderabad. Sample size was 638 Discharges and sampling technique was convenient sampling method. Inclusion criteria followed was discharges initiated in the time between working hours (9:30 am to 5 pm) and consideration of only private/ GIPSA (General Insurance Public Sector Association) insurance patient discharges. The exclusion criteria was discharges initiated in the time after working hours (5 pm to 9:30 am) and not cash/ Credit insurance patient discharges. The study was divided into two phases- before implementation of EHR (Electronic health records) and after implementation of EHR.

**Results**

Compliance rate of post auth submission was increased after the implementation of EHR in the second phase from 36% to 62%. L.C (LAN bill closure) issues and prioritizing the duties among the employees shown promising results and the number of delays were decreased constantly. The number of summary corrections decreased due to EHR from 17.7% to 12%, L.C issue at floor biller was sorted which resulted in positive outcome. The management directed and advised the floor billers, floor managers, security team and other personnel who are directing the patients to the post auth team and ordered them to not follow this practice because patient visits used to be more frequent for the post auth department and because of their queries the post auth team gets disturbed and TAT gets delayed for other bills. Patient visits dropped by 80% after this step, and the post-auth staff is now able to submit the bills on time. Regarding the approval time, companies' star health, Niva Bupa and TPA's like Mediassist was taking longer time to approve the claims, so negotiations on tariff structure may happen and the approval time can be decreased in future.

**Conclusion**

Implementation of changes like role revision, EHR, L.C (LAN bill closure) issue at floor biller in the post-authorization bill submission process has resulted in a significant increase in the compliance rate. The revised procedures have successfully addressed the previous challenges and bottlenecks, leading to improved efficiency, accuracy, and timeliness in bill submissions.

**Keywords:** EHR, Insurance, TPA, Discharge, Post authorization department, Conversion, Audit etc.

## ACKNOWLEDGEMENT

I would like to express my sincere gratitude to the Dr. P.R.Sodani, President, IIHMR University, Jaipur for providing me a platform to gain enough knowledge and skills in different aspects of hospital management. I am grateful towards the Dr. (Col) Mahender Kumar School Dean, IIHMR University, Jaipur and the organization who have played a significant role in the completion of this dissertation report conducted at The KIMS Hospital, Secunderabad.

I express my deepest appreciation to Renuka Radhakrishnan (GM operations, Corporate projects Department), Mr.Prabhu kumar (Business analyst, Corporate projects department) and Dr.Ayushi Devi (Business analyst, Corporate projects department) at the KIMS Hospital, Secunderabad for the unwavering support, invaluable guidance and advice. Their expertise and dedication have been instrumental in shaping the direction and quality of this dissertation. Also I would like to express my gratitude to the doctors, nurses and staffs whose cooperation was invaluable during the data collection phase.

My sincere thanks to my Faculty Guide, Dr. Susmit Jain, Associate Professor, IIHMR University, Jaipur, for his support throughout the project. I will strive to use the gained skills and knowledge on the best possible way throughout the journey.

Lastly I would appreciate all the researchers, scholars & authors whose work I have referred and cited in this report.

Sincerely,

**Avinash Paul Yangcho Kuchipudi**

(MBA-HM, 1267)

## TABLE OF CONTENTS

## LIST OF FIGURES

## LIST OF TABLES

## ABBREVIATIONS

SOPs: Standard Operating procedures.

TAT: Turnaround time.

TPA: Third Party assistant

WHO: World Health Organization

GDA: General Duty assistant

HER: Electronic health record

EMR: Electronic medical record

MRI: Magnetic resonant Imaging

ECG: Electrocardiogram

PTCA: Percutaneous trans coronary angioplasty

ID proof: Identity Proof

MLC: Medico legal cases

OPD: Outpatient department

IPD: In patient department

ALOS: Average length of stay

IRDA: Insurance Regulatory Development Authority

NME: Non Medical Expenses

GIPSA: General Insurance Public Sector Association

## CHAPTER 1: INTRODUCTION

**1.1**The hospital's cashless Inpatients must go through a very drawn-out insurance claim in **process**.The hospital's discharge process for these cashless patients takes far longer than it d oes for patients who have paid for their care.Therefore, keeping an appropriate degree of disc harge time for cashless patients gives the organization a competitive edge. The hospital must finish **all** the procedures to ensure a successful discharge while the patients and their family are eager to go home.**By definition, discharge means officially ending a patient's treatme nt and releasing him or her from a hospital or other healthcare facility.**A patient is only released after fully or satisfactorily recovering, in the opinion of the treating physician.It is e ssential to release patients on time.In addition to having a negative financial impact on the h ospital, a **delayed discharge affects the patient's physical, mental, emotional, and psycho logical wellbeing**.**A patient who stays past the allotted period is using the hospital's reso urces needlessly and is wasting their time**.**When a patient is announced physically fit fo r discharge but is unable to leave the hospital as a result of slow process and following of unstandardized procedures and other human, IT (Information technology) issues then the scenario is referred to as a delayed discharge**.In addition to receiving thorough medical care and counsel, a patient visiting a hospital expects total care from the time of adm ission to the time of discharge.Even though the majority of these expectations are realised, th e patient nevertheless wants to leave the hospital as soon as possible.Concerns about the leng th of the discharge process's completion time still exist.It takes significantly longer for cashle ss patients because the insurance company's or TPA's clearance is required.Therefore, the ho spital had to help the patient submit their claim and get discharged as soon as possible.Long and ineffective processes may make patients unhappy and give the institution a bad reputatio n.Delays in the ThirdParty Administrator (TPA) process during the release of insurance patie nts from hospitals can put a heavy burden on both patients and hospitals in the healthcare sys tem.TPAs handle claims, insurance eligibility, and approvals as middlemen between healthc are providers and insurance providers.These delays may result in extended hospital stays, hig her medical expenses, and lower patient satisfaction.It is crucial to pinpoint the issues contri bute to TPA delays and create efficient plans for accelerating the TPA procedure as healthcar e grows increasingly complicated andtechnologydependent.This examination of the literature will give a general overview of the causes of TPA delays that occur while insurance patients

are being discharged from hospitals as well as possible solutions. In house insurance department has two different teams here-preauthorization team and post authorization team. Both these teams handle the insurance patient's admission and discharge process. Post auth team consists of backend executives, auditors who handles the conversion of cash bill to insurance bill at the time of discharge and submits the bills to the TPA/Insurance companies on Remedinet. It is a third party portal used by the hospitals, TPA/insurance companies to collect the bills and send the bills for the authorization process. By using this portal the delays in processing of the preauth and post auth claims are minimized and effective communication takes place between Hopsitals and insurance companies in a timely manner that avoids the delays and clarifies the differences.

**1.2 Health Insurance in India**

The Indian health insurance market was worth 120.1 billion dollars in 2022.From 2023 to 2028, the market is expected to increase at a compound annual growth rate (CAGR) of 10.64% .Rising medical costs, an increase in the incidence of different chronic ailments, and an increase in the number of government health insurance plans are some of the major factors affecting the industry in India.The health insurance market is expected to be 10% using density calculations.India has one of the lowest rates of health insurance penetration, with only 18% of people in urban areas and 14% in rural areas being covered by any kind of health insurance plan.

In exchange for a premium, the insurer agrees to pay the insured's medical and surgical costs under the terms of a health insurance policy.It includes a variety of plans, including top-up, family, senior citizen, group, and individual. In India's drive to achieve Universal Health Coverage (UHC), expanding the availability of health insurance and assurance coverage is an essential step and a gateway

The capacity and quality of healthcare services provided by the public sector have been restri cted by low government spending on health.The bulk of people in India are roughly two thirds who are diverted to seek care in expensive private sector which is not affordable in nature . Low financial protection, however, results in significant out-of-pocket expenses (OOPE).

The populace of India is susceptible to catastrophic spending and poverty brought on by exor bitant visits to hospitals and other medical services.The devastating impact of healthcare spe nding affects all facets of the population, not just the poor. Pre-payment via health insurance

is proving to be a crucial strategy for risk-pooling and protecting against catastrophic (and frequently ruinous) medical shock costs.

Last but not least, pre-paid pooled funds can improve the efficiency of healthcare delivery. At least 40 crore individuals, or 40% of the population, do not have any type of health insurance. In this study, this group is known as the "missing middle". Due to the Ayushman Bharat - Pradhan Mantri Jan Arogya Yojana (AB-PMJAY), which was launched in September 2018, and State Government expansion plans, around 70 crore people in the bottom 50% of the population have access to comprehensive hospitalisation coverage. 20% of the population, or about 25 crore individuals, have access to social and voluntary private health insurance. The remaining thirty percent of the population lacks health insurance; however, due to overlaps and coverage gaps in PMJAY, the actual number of people without insurance is likely greater. The missing middle is a concept used to describe this untapped group. The missing middle is not a single group that spans all quintiles of spending; rather, it is a collection of groupings. The missing middle is distributed throughout all quintiles of expenditure in both urban and rural areas, albeit it is concentrated in the top two rural quintiles and top three urban quintiles. The agricultural and non-farming informal self-employed sector and the diverse variety of vocations (informal, semi-formal, and formal) in cities, respectively, fill the missing middle in rural areas. Low government health spending, high out-of-pocket expenses (OOPE) and scant financial protection against poor health outcomes define the Indian health sector.

At 1.5% of GDP, India's government spending on health is among the lowest in the world. The quantity and caliber of healthcare services provided by the public sector have been limited by persistently low government investment on health. People are frequently redirected from overworked public hospitals to seek care in the more expensive private sector. According to the NSSO's 75th Round study on social consumption of health, 2017–18, the private sector provides 70% of outpatient care and over 60% of all hospitalisations. The private sector has low financial protection due to its high OOPE. India's high out-of-pocket spending (OOPE) is mostly caused by the country's relatively low health insurance coverage and the more expensive private sector delivery of healthcare services. India's OOPE as a percentage of current health spending is 63%, much higher than the norm for lower-middle income nations and among the highest in the world notwithstanding the recent reduction. Individuals face financial danger due to high OOPE. They are susceptible to

becoming impoverished as a result of costly visits to the hospital and other medical facilities. Over 7% of India's population is driven into poverty every year, according to Brookings India analysis based on NSSO surveys. Both rural and urban areas experience a similar level of poverty as a result of health spending. Furthermore, the frequency of catastrophic health spending, which is defined as health spending that exceeds a predetermined percentage of consumer expenditures, has increased. In 2014, 24% of households had catastrophic health expenditures, an increase from 21% in 2004 at the 10% threshold level. Over half of households who accessed any type of healthcare in 2014 incurred catastrophic cost, according to analysis from the National Institute of Public Finance and Policy, which shows that the incidence of catastrophic health expenditure at the 10% level is 58%. The frequency of catastrophic expenditure is similar across expenditure quintiles in both the general population and those utilising healthcare, demonstrating the necessity for financial security at all income levels.

**1.3 Broad Classification into two categories:**

**1)Hospitalization:** Hospitalization plans are indemnity contracts that will pay for the insured's hospital and medical costs up to the amount insured. The amount covered can be applied for members of individual health insurance policies, however it can only be applied on a floater basis for family floater policies. In the instance of floater plans, any member who is covered by the plan may use the sum insured. These insurance typically offer no financial advantages. In addition to hospitalization coverage, certain insurance plans may also offer maternity and newborn coverage, day care services for particular procedures, pre- and post-hospitalization care, domiciliary benefits for patients who can't be transported to a hospital, daily cash, and convalescence benefits .A top up policy is one more variety of hospitalizationinsurance.Topup policies often specify a level of existing coverage with a hig h deductible.The target audience for this coverage is anyone who receives some form of insu rance from their work.If the coverage supplied by the employer is insufficient, individuals ca n add a topup policy to their existing coverage.However, the ultimate amount payable is subj ect to deduction for each claim reported for each member.A defined benefit policy called dai ly cash benefits provides a certain amount of money for each day of hospitalisation.

**2) Critical illness plans:**

If the insured person is found to have one of the ailments listed in the policy, these insurance pay out a lump payment. Some policies demanded an additional payment at the time the

policy was purchased.

**Options for payment**:

1) Payment or Cashless Facility: In this type, the insurer pays the hospital directly, so the pat ient is exempt from making a payment to the facility.The policyholder and everyone else incl uded in the policy are eligible to receive treatment from hospitals that have been approved b y the insurer under the cashless system.

2) Reimbursement at the end of the hospital stay: The patient may submit a claim to the insurer for payment of any covered services after the course of treatment has been completed.

### 1.4 Pre auth and Post auth department

Pre authorization department handles the admission process of an insurance patient

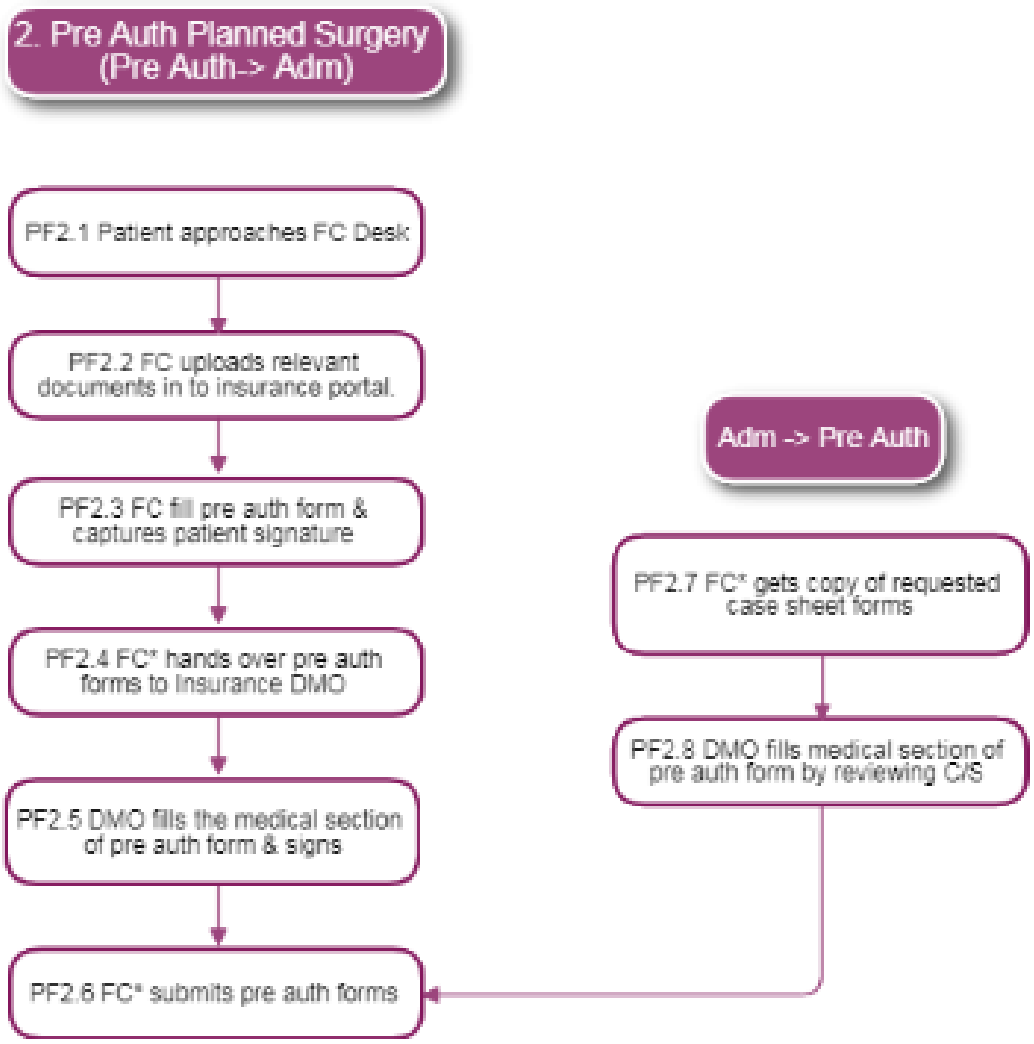


**Figure 1:** Initial process flow of pre auth, Source: Insurance manual, KIMS Hospital

After pre auth submission, the following process will take place

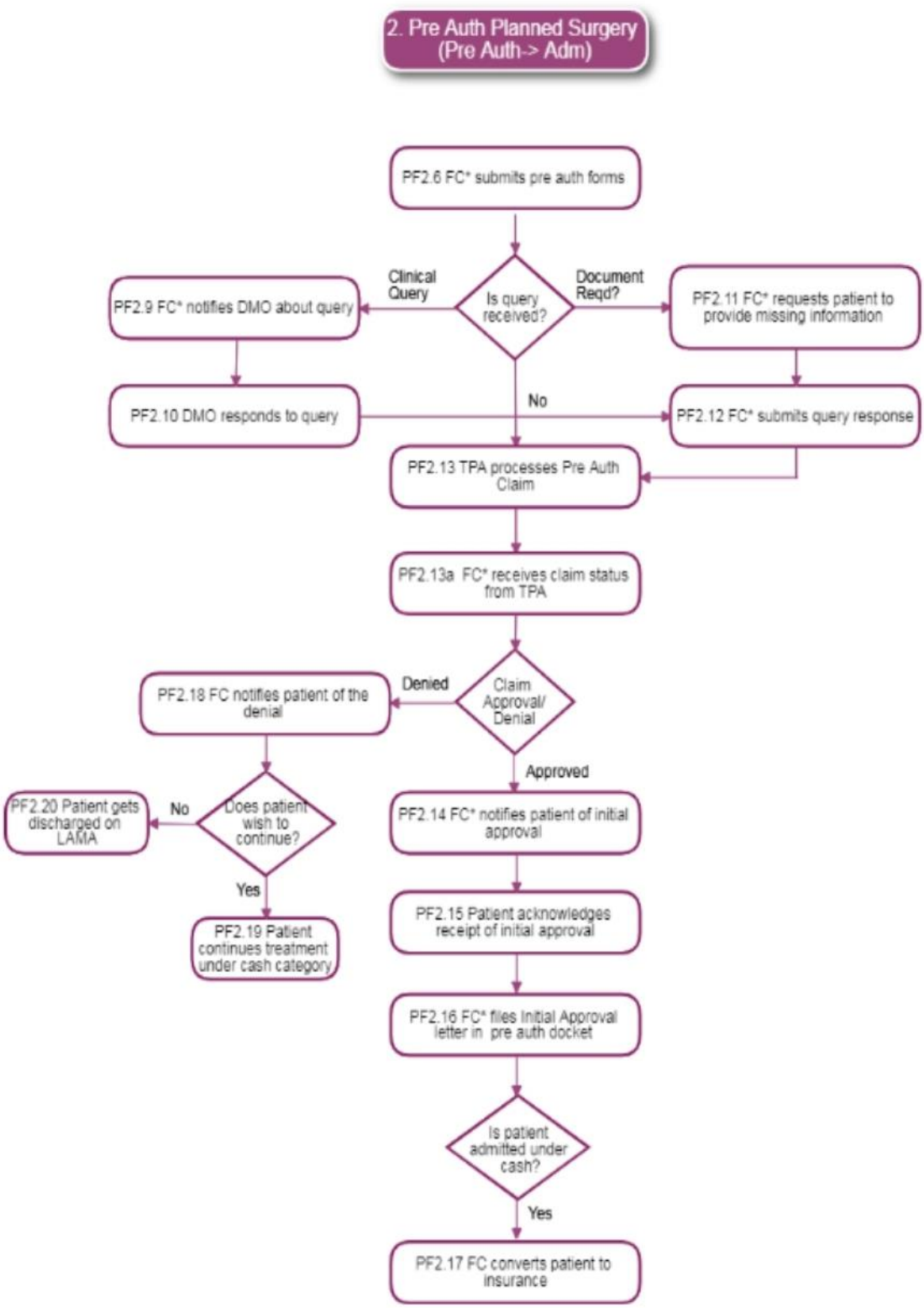


**Figure 2:** Later process flow of pre auth for insurance patients, Source: Insurance manual, KIMS Hospital

After pre auth and once the initial approval is received and patient got admitted under insurance, flowing process will takes place


**Figure 3:** post authorization flow chart at the time of discharge, Source: Insurance manual,

KIMS Hospital

After getting approval from the insurance company, the following process will takes place at the time of discharge

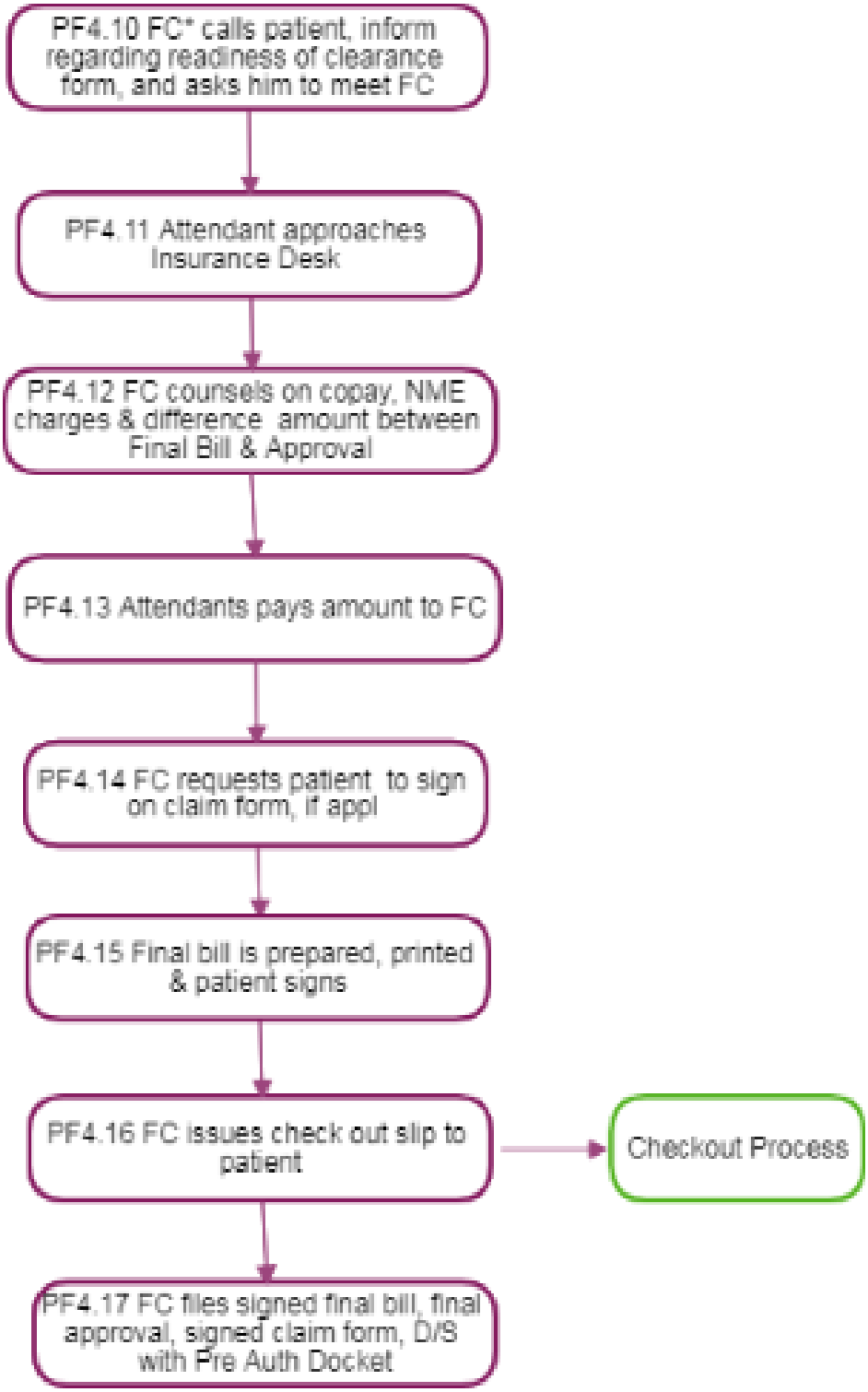


**Figure 4:** Checkout process after final approval, Source: Insurance manual, KIMS Hospital

If the insurance is denied from the company side after submitting the claim at the time of discharge, the following process occurs

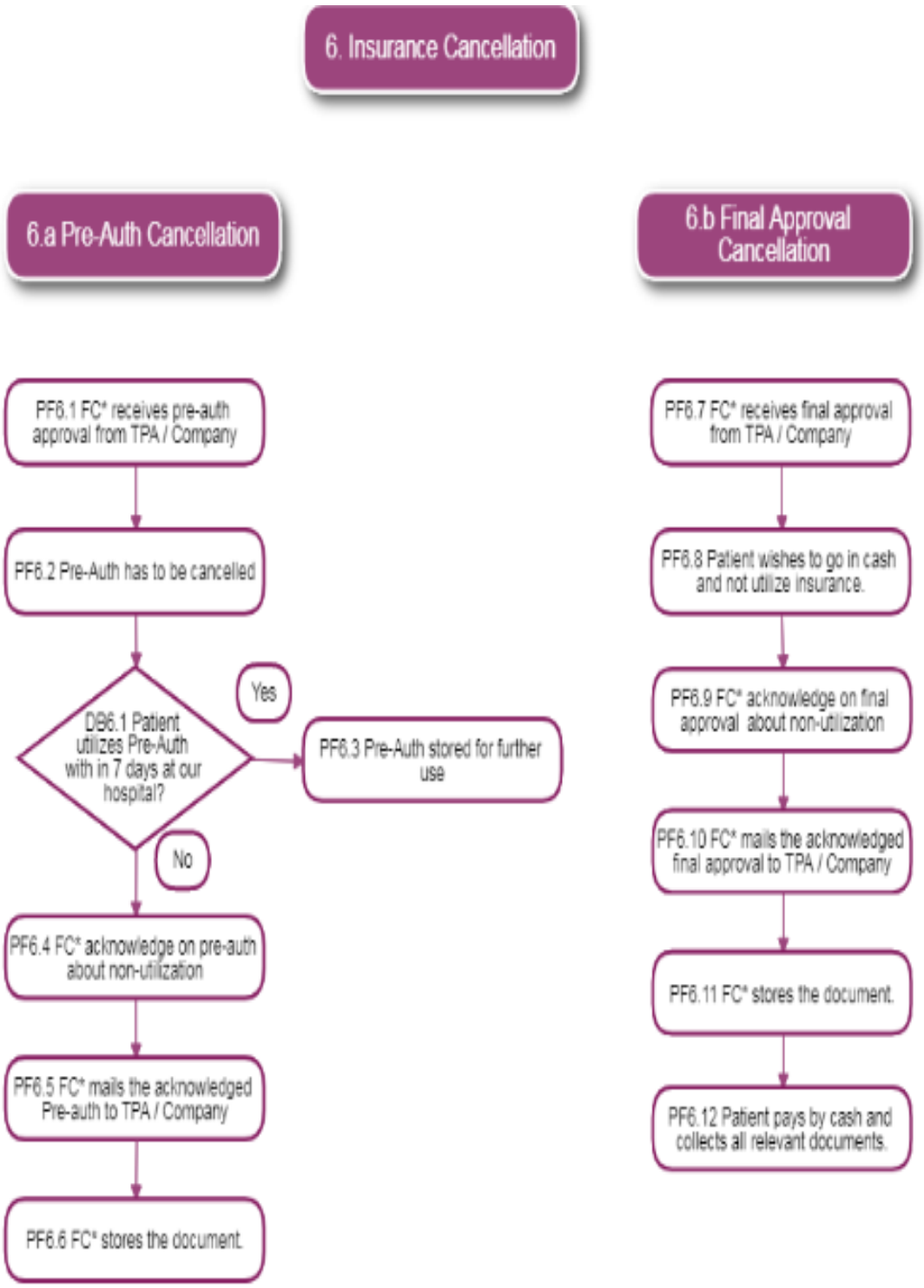


**Figure 5**: Steps after insurance cancellation in both pre auth and post auth, Source: Insurance manual, KIMS Hospital

## AIMS AND OBJECTIVES

**Aim:**

To determine what causes delays in the post-authorization process for the discharging the patients and study the compliance percentage of standard TAT to submit the bill.

**Objectives**:

1. Identify best practises, such as the use of technology, the standardisation of procedures, an d multidisciplinary strategies, for accelerating the procedure in the insurance department.

2. Through a comparison of pre- and post intervention data, assess the efficacy of these measures in minimizing TPA delays and increasing patient outcomes, hospital expenses, and patient satisfaction.

3. Make suggestions for hospitals and decision-makers to improve patient outcomes, the TPA procedure in the insurance division, and the general standard of care.

## CHAPTER 2: REVIEW OF LITERATURE

| Authors (Year) | Study location, Sample size, Sampling technique | Salient features |
|---|---|---|
| Johnson, S., & Brown, K. (2022) | Government county hospital, 500 discharges, cross sectional study | A variety of personal factors, including age, medical considerations, such as the existence of various illnesses, and organisational issues, such as the lack of facilities for alternative forms of treatment, put patients at risk for delayed discharge. |
| Okuzu O, Malaga R, Okereafor K, Amos U et al (2022) | Nigeria state hospital, Cross sectional study,600 samples | According to initial studies, digital insurance administration systems may contribute to an increase in insurance enrollment, particularly among low-income households. A good policy climate, public-private partnerships, ongoing stakeholder involvement, and training were three situational facilitators for the adoption of digital insurance plans.<br>Important factors for scaling up digital health insurance<br>Schemes in Nigeria and comparable contexts include: (i) simplicity of use; (ii) existing digital infrastructure to support electronic insurance systems; and (iii) trust expressed through data. |

| | | |
|---|---|---|
| | | Encryption, keeping records of all data audits, and built-in fraud prevention procedures |
| Ananya C V, A. Bhooma Devi and S. Nithya Priya (2020) | Tertiary care hospital in tamil nadu. 384 respondents, Questionnaire study | This was supported by the present research, which found that of the respondents, fifty four percentages of insured were approached by an insurance agent to enrol in a health insurance policy, while 40% of insured approached their insurance agent to enrol in a health insurance policy.<br>In the current study, out of 352 insured respondents, 28% had insurance owing to employer contributions, 25% had insurance to receive high-quality medical care, and 22% had insurance for risk coverage against future disease, old age, etc. 11% of the insured have subscribed because of an existing disease, 9% have done so as a tax planning strategy, and 3% have done so because they are travelling abroad. |
| Sahoo MC, Dora S, Talwar Y (2019) | AIIMS, Bhubaneswar, 250-samples of inpatients, questionnaire type study | The average time for the discharge process was 195 minutes (plus or minus 32). The longest discharge process involved patients who spent an average of more than 10 days in the hospital. This can also |

| | | |
|---|---|---|
| | | apply to requests for discharge modifications made by the patient's next of kin based on their preferences and travel schedules. More than 90% of discharge summaries, as shown in the graph below, were either completed by the previous evening or within 30 minutes of the recommendation for discharge. |
| Ankit Singh, Priya Ravi (2018). | 250 bedded super specialty hospital in west Bengal. 174, cross sectional and prospective | Time it takes for the internal TPA department to get the discharge summary. First of all, there are less medical transcriptionists in the hospital, and there have been about 20 discharges every day, of which 8-10 discharges are those of insured patients, or about 40%, meaning that this has taken the longest. As a result, the typing of discharge reports is delayed. Second, it takes a long time for the doctors to examine and sign the discharge report because they spend the majority of the time following morning rounds in their OPD rooms seeing patients. |
| Krishnekumaar ST, Nadu T, Meenakshisundaram KS.(2016) | Multispecialty private hospital Simple random sampling, 1000 samples | TPA delays in the discharge process were associated with longer hospital stays and higher costs for patients. They also found that TPA delays were more |

| | | |
|---|---|---|
| | | common among patients with certain types of insurance plans. There are still uncertainties on how long it will take to complete the discharge process.Due to the need for the insurance company's or TPA's clearance, cashless patients must wait a lot longer.As a result, the hospital was required to assist the patient in filing their claim and obtaining a quick discharge.Patients may become dissatisfied with lengthy, ineffective procedures, which could harm the institution's reputation.The healthcare system may be heavily burdened by delays in the ThirdParty Administrator (TPA) procedure during the release of insurance patients from hospitals.TPAs act as intermediaries between healthcare providers and insurance providers, handling claims, insurance eligibility, and approvals. |
| Shukla K.(2018) | cross-sectional study, corporate hospital in Pune city | Hospitals may face financial penalties for TPA delays in the discharge process. Delays in the ThirdParty Administrator (TPA) process during the release of insurance patients from hospitals |

| | | |
|---|---|---|
| | | can put a heavy burden on both patients and hospitals in the healthcare system. |
| Shahnawaz Hamid , Farooq A Jan , Haroon Rashid, Susan Jalali (2018) | SKIMS Hospital. 710 samples, observational type | The outcomes clearly show that the average discharge time in SKIMS is longer than required by NABH guidelines for all discharge types. According to observations, SKIMS complies with many of the requirements of standards, although the discharge procedure and time frame still need to be specified and recorded. The hospital should develop a strategy for a hospital's discharge procedure that specifies the processes to be done, the time involved, and how best to comply with NABH requirements. |
| Bawa D. S. K., & Verma R. (2011). | Analytical Hierarchy Process | TPA delays in the discharge process were associated with increased patient dissatisfaction. The authors suggest that hospitals can improve patient satisfaction by providing better information and communication about TPA delays. Technology can help reduce TPA delays. |
| A. Abiramalakshmi , DR. SN. Soundara Rajan Oct (2017). | Corporate hospital in Ahmedabad, 600 samples | Use of technology, such as electronic health records and online portals, can help reduce |

| | | |
|---|---|---|
| | | TPA delays in the discharge process. The study's goal was to pinpoint the important variables that have an impact on hospital release times. We discovered that there are many other factors which influence the delay in the inpatient discharge process, including clearance times by various departments, planned versus unexpected discharge, patients' insurance status and final bill settlement. |
| Harmanjot kaur, Roopjot Kochar June (2017). | TPA department, rajputana hospital, Chennai, Cross section study | TPA delays in the discharge process can be caused by a different no of factors, like incomplete documentation, lack of coordination between hospitals and TPAs, and delayed approvals from TPAs. As a result, the typing of discharge reports is delayed. Second, it takes a long time for the doctors to examine and sign the discharge report because they spend the majority of the time following morning rounds in their OPD rooms seeing patients. |
| Thompson, R., & Davis, M. (2021) | Private multispecialty hospital, Bangalore, Convenient sampling | TPA delays were more common for patients with certain insurance types, such as Medicaid or Medicare. The study analyzed 4,567 patient records and found |

| | | |
|---|---|---|
| | | that patients with Medicaid or Medicare were more likely to experience TPA delays than those with private insurance. The study's goal was to pinpoint the important variables that have an impact on hospital release times. |
| Davis, L., & Wilson, P. (2021) | | Devising discharge procedure is a standard component of health systems in all the countries. The goal is to close the gap between the hospital and the location of discharge by reducing hospital length of stay, unexpected readmission to the hospital. Since the insurance company's or TPA's approval is needed, cashless patients must wait a lot longer.The hospital had to assist the patient in filing their claim and obtaining a quick discharge as a result.Patient dissatisfaction and a negative reputation for the institution may result from lengthy and unsatisfactory procedures.Patients and hospitals in the healthcare system may experience significant burdens as a result of delays in the ThirdParty Administrator (TPA) procedure during the transfer of insurance patients from hospitals.Between healthcare |

| | | |
|---|---|---|
| | | providers and insurance providers, TPAs handle claims, insurance eligibility, and approvals. |
| Janmejaya Samal, Ranjit Kumar Dehury (2015) | Assessment study. 31 TPA's | The review revealed a contradictory picture, with the TPAs occasionally able to deliver the necessary services as intended by IRDA and occasionally unable to do so as indicated by numerous studies undertaken periodically. |
| Mehta S, Nair J, Rao S, Shukla K (2015) | large multispecialty hospital, 105 discharges cross-sectional study was conducted | When compared to the uninsured patients, whose avg discharge time was 88 mins, the insured patients' avg discharge time was 572 mins, which was substantially longer<br>The discharge time of 524 mins was significantly longer for unplanned ones than for planned ones where the mean discharge time was 85 mins<br>Because more time is spent both before and after the clearing, the total discharge time is very longer than the clearance time. Prior to clearance, time is spent on creating the discharge summary and notifying the departments; however, once clearance has been acquired, time is spent on the patient's final bill. |

| | | |
|---|---|---|
| Sandip Sane,Niharika Singh (2012) | Five Teritary hospitals in pune, 1200 samples, Review and cross sectional study | Customers can contact directly with TPAs when filing a claim, and the TPA will assist with all claim settlement procedures. A TPA offers a range of services, including connecting with hospitals, handling claims, verifying documents, setting up hospitalisation, processing claims, and settlement. Because there are now so many TPAs on the health market, it is quite challenging for insurance firms to decide which one to use to offload their claim-related tasks. This study gives us a thorough understanding of the factors that influence consumer preference for any TPA. The study would also assist TPAs and Insurance Companies in allocating their resources so that they may proactively boost the services that are seen as being most crucial. |
| Kumar Rohit, Rangarajan K., Ranganathan Nagarajan (2011). | Safdarjung hospital, 400 samples, assessment study among consumers | Physical evidences and professionalism are two discernible criteria that together accounted for fifty percent of the overall differences. These two observable elements have had a large and favourable impact on insured patients' hospital loyalty. The hospital should develop a |

| | | |
|---|---|---|
| | | strategy for a hospital's discharge procedure that specifies the processes to be done, the time involved, and how best to comply with NABH requirements. It might be difficult for insurance companies to choose which TPA to utilise to outsource their claim-related work because there are now so many of them competing for the health industry. We now have a good understanding of the variables influencing consumer choice for any TPA because to this study. The survey would also help TPAs and insurance firms allocate their resources so they could proactively improve the services that are perceived as being most important. |
| Anchan PS, Jathanna R, Marla A (2011) | Tertiary Care Hospital, Mangalore cross-sectional study with convenient sampling, | The query validation process takes the longest, followed by preauthorization, preparation and submission. Health insurance was not fully understood by propers and policyholders, just fifty percent of policyholders were familiar with the terms like Third Party Administrator (TPA), and consumers were not entirely satisfied with their health insurance during claims process. |

| | | |
|---|---|---|
| | | The claim process was largely painless. Customers bought health insurance policies due to familiarity and ease of access. As a result, standards must be established with specified times for each procedure. It is necessary to implement some methods that will aid in educating consumers about the many nuances of insurance policies. To adapt their services, healthcare providers must make an effort to understand the needs of their patients. The market reputation of the insurers is directly impacted by their supply channels. |
| Jain K, Sinha SK, Jain D, Kumar R (2016) | Teritary care hospital in north india, cross sectional prospective study | A 76% reply rate was seen. 40% of research participants were admitted through the emergency department, whereas fifty percent were planned admissions. According to the report,sixty percent of the major policyholders were between the ages of forty to fifty. It was discovered that 80% of people were aware of the terms and conditions of the health insurance policy and the servicing TPA. However, it became clear from speaking with patients that, despite being advised by their |

| | | |
|---|---|---|
| | | insurance agent, they encountered difficulties while utilising health insurance benefits and were unaware of the method involved.<br><br>The study's goals were to ascertain the degree of insurance policy and procedure knowledge among those who were insured and to pinpoint any issues these individuals had when seeking out cashless medical care.<br><br>To enhance coverage, strategies to optimise claims by achieving uniformity in the hospital charges for various operations are required. |

## CHAPTER 3: METHODOLOGY

Study design: Descriptive observational study

Study setting: KIMS Hospital, Secunderabad.

Study population:

1. Inclusion criteria: Discharges initiated in the time between working hours (9:30 am to 5 pm), Consideration of only private/ GIPSA insurance patient discharges.

2. Exclusion criteria: Discharges initiated in the time after working hours (5 pm to 9:30 am), not considered cash/ Credit insurance patient discharges.

3. Study tools: Tracking sheet, MS Excel

Duration of the study: 16$^{th}$ March to 25$^{th}$ May 2023

Sample size: 638 Discharges

Sampling technique: Non probability convenient sampling method

Data collection procedure: Softwares like Remedinet, Electronic health records (EHR), HIMS are being used to check the system time of the discharge process. Tracking sheet consists of Date, Patient name, IP number, Discharge initiated time, Discharge summary approved time, Preparation time of LAN bill, Insurance conversion time, Audit time, Time taken from Conversion to post auth submission on remedinet, Total time taken from post auth submission to approval of the claim amount by the insurance company, Ideal-TAT, compliance or non compliance, non-Compliance %, Compliance %.

### 3.1 OPERATIONAL DEFINITIONS:

**Post authorization department:** A post authorization department is responsible for conversion, submission, query handling, issuing clearances for the insurance patients at the time of discharge.

**Pre authorization department:** A Pre authorization department is responsible for handling pre auth process like collecting insurance documents from patient, checking validity of documents at the time of admission.

**Backend executives:** These are the staff that has expertise in converting the cash bill to insurance bill and submitting to the insurance company.

**Auditing:** After conversion of the insurance bill from cash bill, auditor will audit the bill and suggests changes if he/she finds any discrepancies with the agreed hospital tariff of the insurance company

**Discharge Summary:** A discharge summary is a document that explains to any other healthcare professional in any other hospital why the patient was admitted, what has happened to them in earlier hospital, and all the information that they need to pick up to continue the treatment.

**Ideal/Standard TAT (Turn- around time):** Standard time interval from the time of submission of a process to the time of the completion of the process.

**Query management:** After submitting the bill to the insurance company, they may ask any query related to either clinical or non clinical. To the raised query, backend executives will respond as needed.

**TPA (Third Party administrator):** It is a business, agency, or organisation with a licence from the Insurance Regulatory Development Authority (IRDA) to handle claims for corporate and retail policies as well as offer cashless services on behalf of a health insurance provider.

**Insurance approval:** Authorization of the insurance claim by the insurance company to the hospital for a particular patient, so that the patient can be discharged by using cashless facility.

**Non Medical Expenses:** Expenses which are not clinically related to the treatment and to be borne by the care receiver at the time of discharge.

**Copay:** The percentage of amount to be paid by the patient to the hospital while settling the claim as mentioned in the insurance policy of that particular patient.

**In-network provider:** A doctor, hospital, or pharmacy that is a part of the preferred provider network of a health plan. Because in-network providers have agreed to a reduced rate for their services in exchange for the insurance company delivering those more patients, you will often pay less for the services you receive from them.

**Individual health insurance:** Health insurance policies that people buy for their families and themselves. Unlike group plans, which businesses provide for the benefit of all of their employees.The study sought to pinpoint the important variables that have an impact on hospital release times. We discovered that there are a number of factors that might cause a discharge procedure to be delayed, including clearance times from various departments, scheduled or unplanned discharge, patients' insurance status and final bill settlement.

**Cumulative Bonus:** Cumulative bonus and NCB (No Claim Bonus) are comparable. The amount insured rises by a specified percentage in accordance with the policy for each year without a claim, but it cannot exceed 50% of the Main Sum Insured and is only admissible if the policy was constantly renewed.

**Deductible:** The lower the premium, the higher the deductible amount. A health insurance policy's deductible is a requirement for cost-sharing and can be either a set amount or a percentage of the claim's total cost. The insurance company will not be responsible for covering that fixed or percentage of the covered expenses under the terms of this clause. The policyholder is responsible for paying the hospital the agreed-upon.

**Exclusions:** Situations or conditions for which the policy won't provide coverage.

**Grace Period:** The designated window of time, usually 15 days, following the end of the due date for premium payments. During this time, payments for renewing or continuing an insurance may be made without jeopardising continuity benefits like waiting periods and coverage for pre-existing conditions. For the postponed period following the due date, coverage, however, will not be offered. Therefore, it's crucial to renew your health insurance whenever your premium is due. Depending on the condition, the waiting periods for health insurance policies range from 12 to 48 months.

**Sum Insured:** The sum insured is the payout amount that the insurance company owes the insured in the event of an unforeseen circumstance. It operates under the indemnity principle. For instance, if hospitalisation costs are Rs. 2 Lakh and the health insurance policy's sum insured is Rs. 3 Lakh, the company is responsible for paying Rs. 2 Lakh towards the claim.

**Waiting period:** When a new health insurance policy is purchased, there is a waiting period during which the insured will not be eligible for some policy benefits. This is typically a set amount of time from the insurance's start date, after which certain specified advantages of

the policy start to apply.

### 3.2 ETHICAL CONSIDERATIONS:

Before participants decide whether to join or not, informed permission is sought, and they are informed of the study's goals, objectives, risks, and funding. Although I am aware of whom the participants are, confidentiality is maintained and I keep this information a secret from the other participants. I anonymized it to stop other people from tying personally identifiable information to other data. Physical, social, psychological, and other types of harm's potential are kept to an absolute minimum. Communication of the results is ensured. I verified that my work is entirely original; free of research misconduct and plagiarism, and that you have accurately presented your findings.

## CHAPTER 4: RESULTS

As the study was conducted from 16th march to 25th may in the post auth insurance department, it is majorly divided into 2 phases. One is from 16th march to 30th april and other is from 1st may to 25th may. This is because the implementation of the EHR software and the process change that happened by following my suggestions. Compliance is increased after the EHR implementation and the management divided the TAT calculation into two types:

a) Summary approved within 40 minutes from the LAN bill closure time

b) Summary approved above 40 minutes from the LAN bill closure time

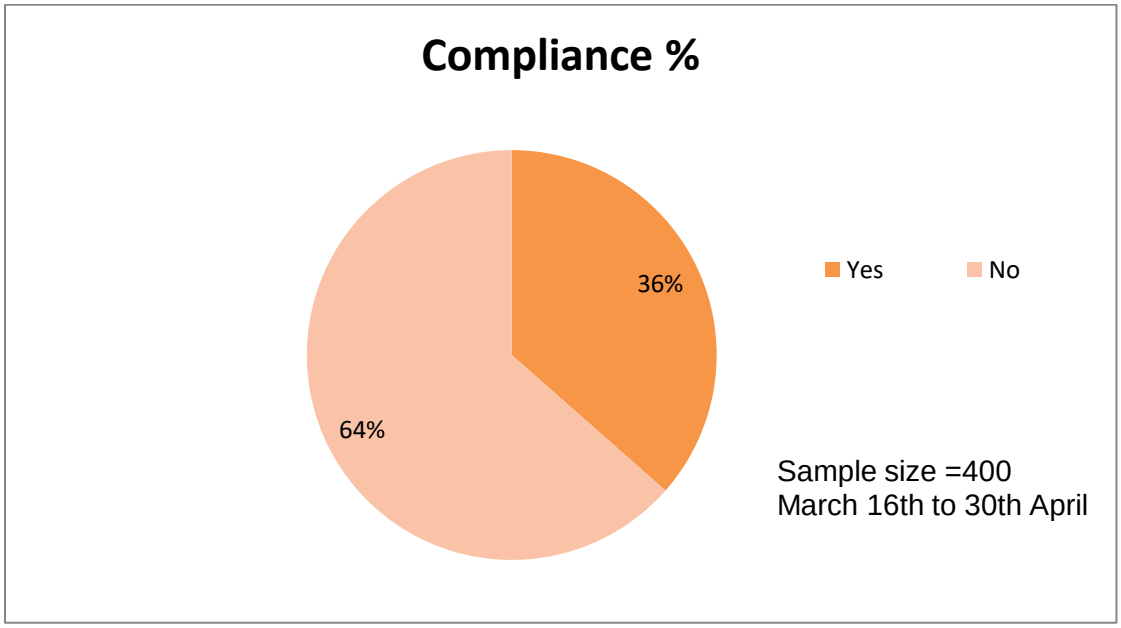


Figure 6**:** Pie chart showing TAT compliance % (16th March to 30th April)

As we can see out of 400 samples that are collected from march 16th to april 30th, only 146 (36%) complied to the TAT of 45 minutes and 254 (64%) is not complied. The reasons can be as follows

| Major delay reasons | Number | % |
|---|---|---|
| **Summary Correction** | 45 | 17.7 |
| **Staff leave(Converter)** | 15 | 5.9 |
| **Staff leave(Auditor)** | 24 | 9.4 |
| **I.T issues** | 11 | 4.3 |
| **L.C issue at floorbiller** | 27 | 10.6 |
| **Surgeon fee response and clearances** | 13 | 5.1 |
| **summary pending** | 50 | 39.4 |
| **Patient visits** | 50 | 39.4 |

Table 1: Major delay reasons and their number and percentage (16th March to 30th April)

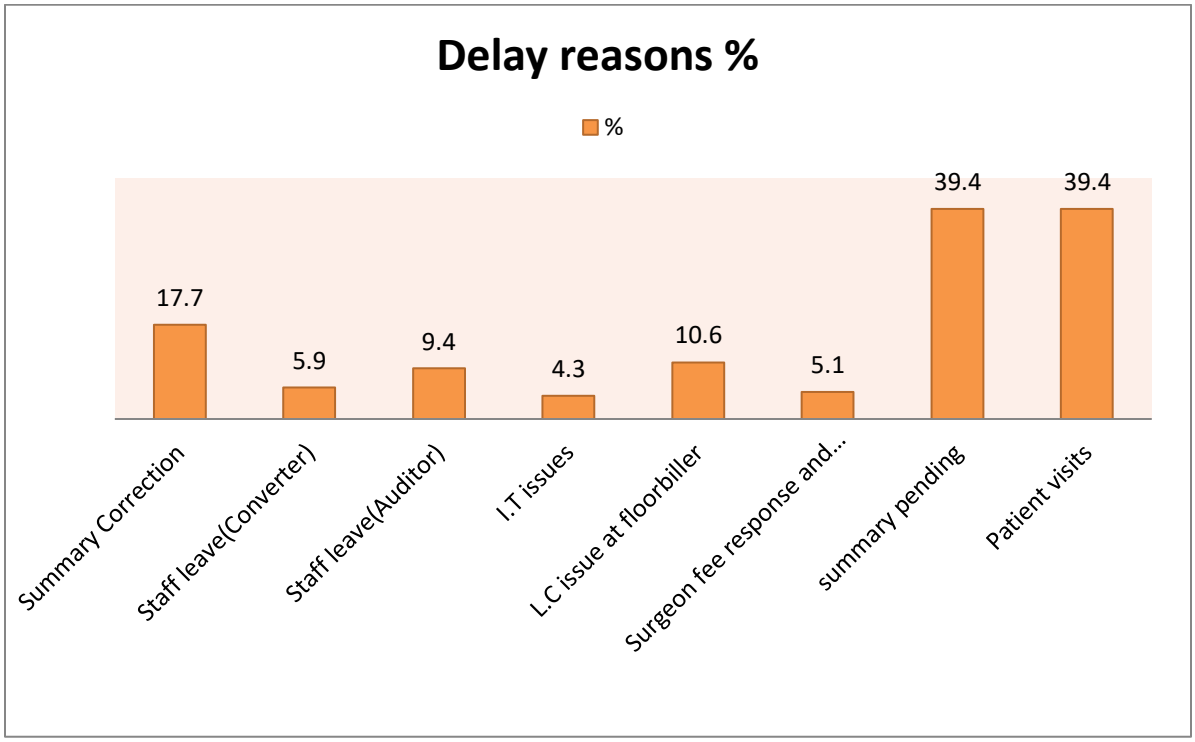


Figure 7: Column graph showing the % of delay reasons (16th March to 30th April)

The main reasons for the delay are summary pending and patient visits which are soaring with a 39.4% out of 254 samples which are not complied. Other reasons are summary corrections, staff leaves, I.T issues and L.C issue at the floorbiller.

The above data shows high non compliance due to the mentioned reasons. So the management took action on some issues by

a) Implementing the EHR software,

b) Strict directions to the floor managers and the security to not to direct the patients to the post auth department for handling the queries

c) L.C issue at floorbiller.

Due to this, the compliance rate in the month of may is increased and shown promising results in almost all the aspects barring IT.issues

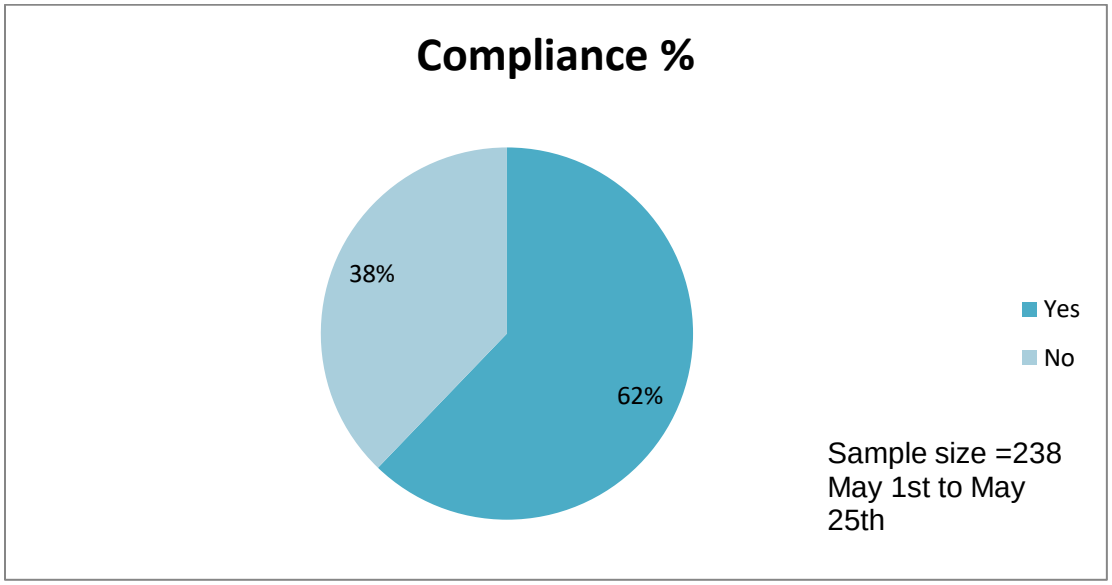


Figure 8: Pie chart showing TAT compliance % (1st May to 25th May)

As we can see, out of 238 samples that are collected from march 1st May to 25th May, only 148 (62%) complied to the TAT of 45 minutes and 90 (38%) is not complied. There is good increase in the compliance rate due to the new system that taken place. The reasons can be as follows

| Major delay reasons | Number | % |
|---|---|---|
| **Summary Correction** | 11 | 12.2 |
| **Staff leave(Converter)** | 4 | 4.4 |
| **Staff leave(Auditor)** | 5 | 5.6 |
| **I.T issues** | 14 | 15.6 |
| **L.C issue at floorbiller** | 0 | |
| **Surgeon fee response and clearances** | 4 | 4.4 |
| **summary pending** | 43 | 47.8 |
| **Patient visits** | 9 | 10 |

Table 2: Major delay reasons and their number and percentage (1st May to 25th May)

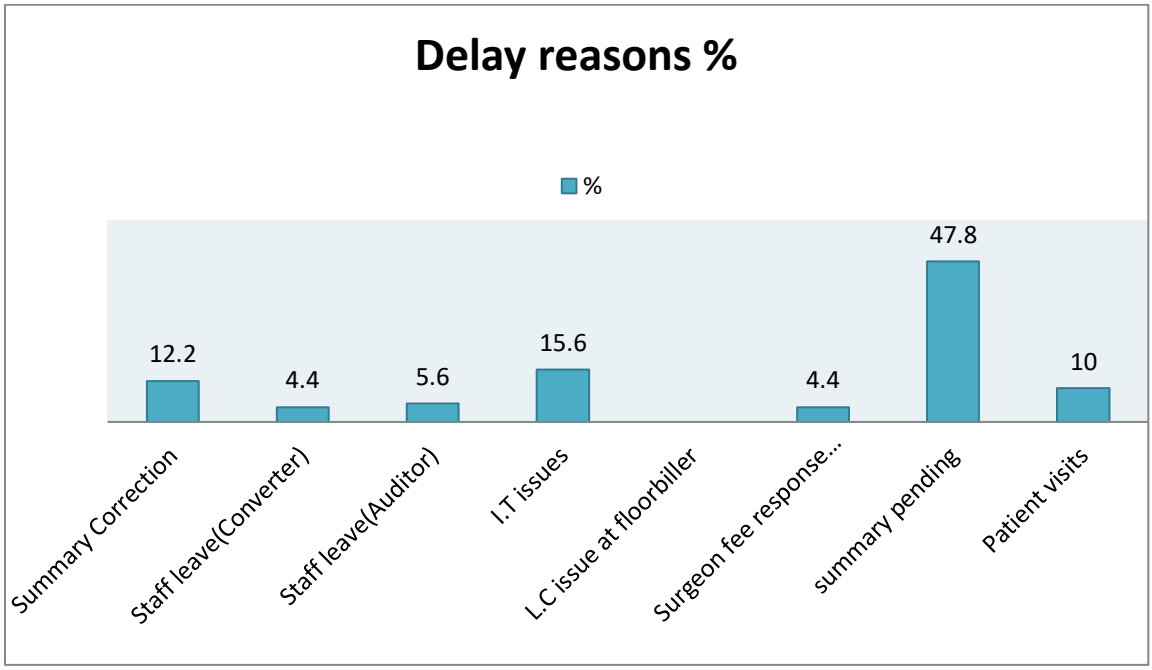


Figure 9: Column graph showing the % of delay reasons (1st May to 25th May)

Even the summary pending is the major reason in the both the phases, much action didn't take place to correct this measure, But management focused on the summary corrections part and the below data shows the summary of it.

| Dept | Total no of discharges | Total no of correction | % |
|---|---|---|---|
| **Cardiology** | 44 | 15 | 34.1 |
| **ENT** | 11 | 2 | 18.2 |
| **General surgery** | 6 | 2 | 33.3 |
| **Gynaecology** | 4 | 1 | 25.0 |
| **Internal medicine** | 56 | 2 | 3.6 |
| **Medical oncology** | 17 | 1 | 5.9 |
| **Nephrology** | 25 | 1 | 4.0 |
| **Neurosurgery** | 27 | 3 | 11.1 |
| **Obstetrics** | 5 | 3 | 60.0 |
| **Plastic Surgery** | 6 | 1 | 16.7 |
| **Pulmonology** | 11 | 1 | 9.1 |
| **Surgical Gastro** | 43 | 4 | 9.3 |
| **Urology** | 29 | 9 | 31.0 |

Table 3: Department wise summary corrections

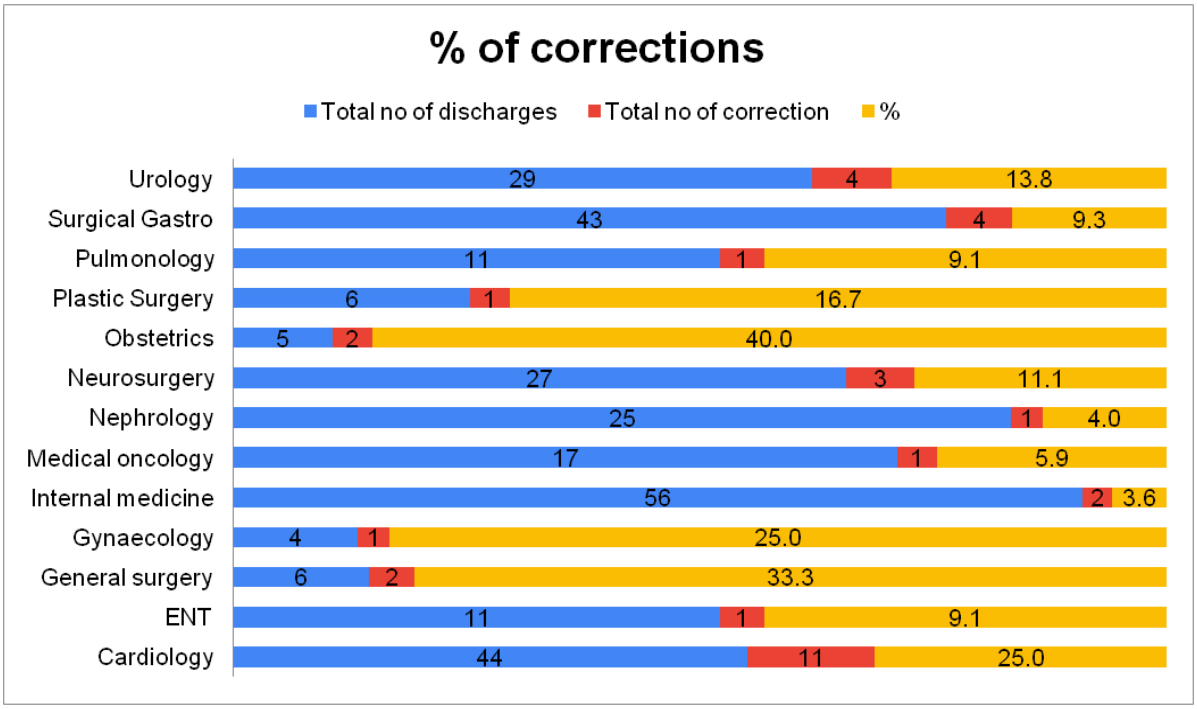


Figure 10: Bar graph showing the % of summary corrections to the total no of discharges by that dept.

In the above graph we can see the no of summary corrections as per the department. Obstetrics department shows higher number of corrections

| Dept | Total no of discharges | Total no of summaries pending | % |
|---|---|---|---|
| **Cardiology** | 44 | 23 | 52.3 |
| **ENT** | 11 | 1 | 9.1 |
| **General surgery** | 6 | 3 | 50.0 |
| **Gynaecology** | 4 | 1 | 25.0 |
| **Internal medicine** | 56 | 15 | 26.8 |
| **Medical oncology** | 17 | 4 | 23.5 |
| **Nephrology** | 25 | 4 | 16.0 |
| **Neurosurgery** | 27 | 8 | 29.6 |
| **Pulmonology** | 11 | 4 | 36.4 |
| **Surgical Gastro** | 43 | 9 | 20.9 |
| **Urology** | 29 | 8 | 27.6 |
| **neurology** | 27 | 9 | 33.3 |
| **Vascular surgery** | 23 | 5 | 21.7 |

Table 4: Department wise summary pendings

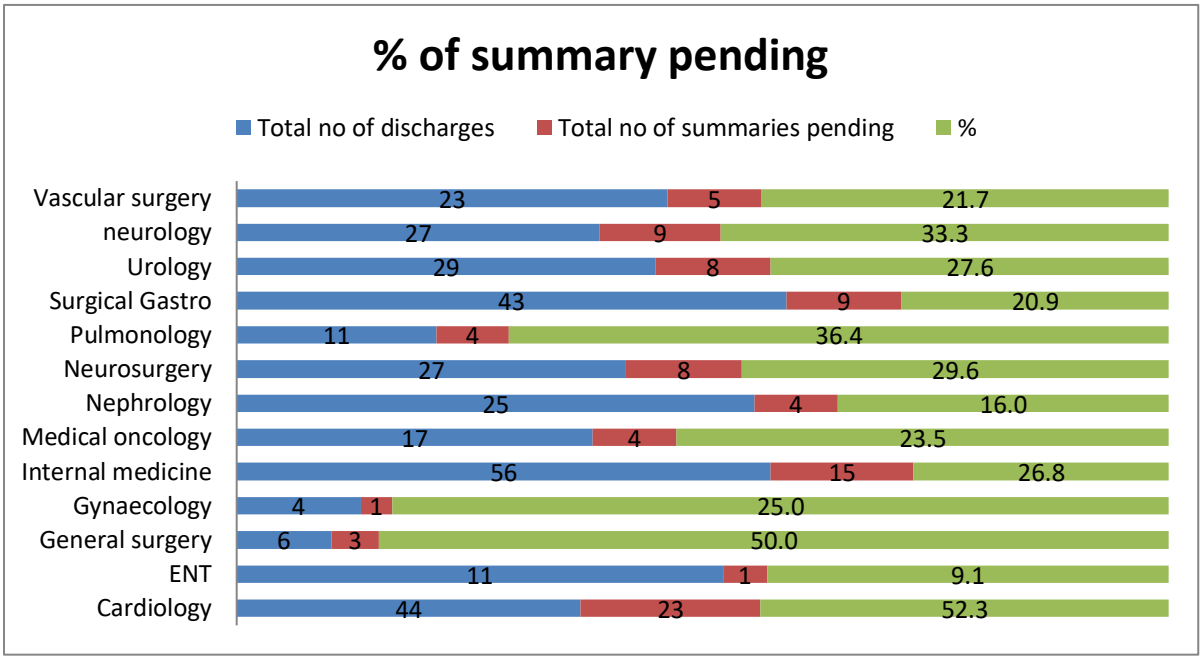


Figure 11: Bar graph showing the % of summary corrections to the total no of discharges by that dept.

In the above graph we can see the no of summary pending as per the department. Cardiology department shows higher number of pendings after initiating the discharge and after that general surgery shows higher number of pendings which impacts the TAT ENT department shown low number of pendings which is a good sign.

It took some time for the discharge summary to go to the internal post auth department. This has taken the longest since, first of all, it needs to be prepared by the medical transcriptionists at the hospital and there are typically 100+ discharges per day, of which 35 to 40 are from insured patients, for whom the summaries needs to be carefully transcripted due to the rejection chances of the claims when the bill is submitted to the insurance company. After preaparing the doctor or consultant needs to check and has to give approval, sometimes he may opt for corrections also then it needs to get modified and has to go for the approval again which takes a lot of time.

Apart from the TAT compliance in the post auth submission, I also checked and compared the approval time of different TPA.s and private insurance companies in my sample. The time taken by them is divided into less than one hour, less than two hours, less than three hours, greater than 3 hours.

| Insurance | Total | < 1hr | < 2 hr | < 3 hr | >3 hr |
|---|---|---|---|---|---|
| **Star** | 68 | 3 | 27 | 13 | 25 |
| **Mediassist** | 68 | 25 | 25 | 14 | 4 |
| **Care** | 22 | 4 | 10 | 5 | 3 |
| **FHPL** | 24 | 0 | 6 | 10 | 8 |
| **Good Health** | 9 | 1 | 2 | 2 | 4 |
| **HDFC ERGO** | 19 | 4 | 7 | 5 | 3 |
| **ICICI Lombard** | 19 | 12 | 2 | 4 | 1 |
| **National India** | 14 | 0 | 5 | 4 | 5 |
| **New India** | 27 | 7 | 7 | 6 | 7 |
| **Niva bupa** | 17 | 0 | 6 | 6 | 5 |
| **Vidal** | 9 | 3 | 2 | 1 | 3 |
| **United India** | 18 | 1 | 7 | 5 | 5 |
| **Oriental** | 14 | 2 | 5 | 4 | 3 |

Table 5: Insurance companies and their respected approval time

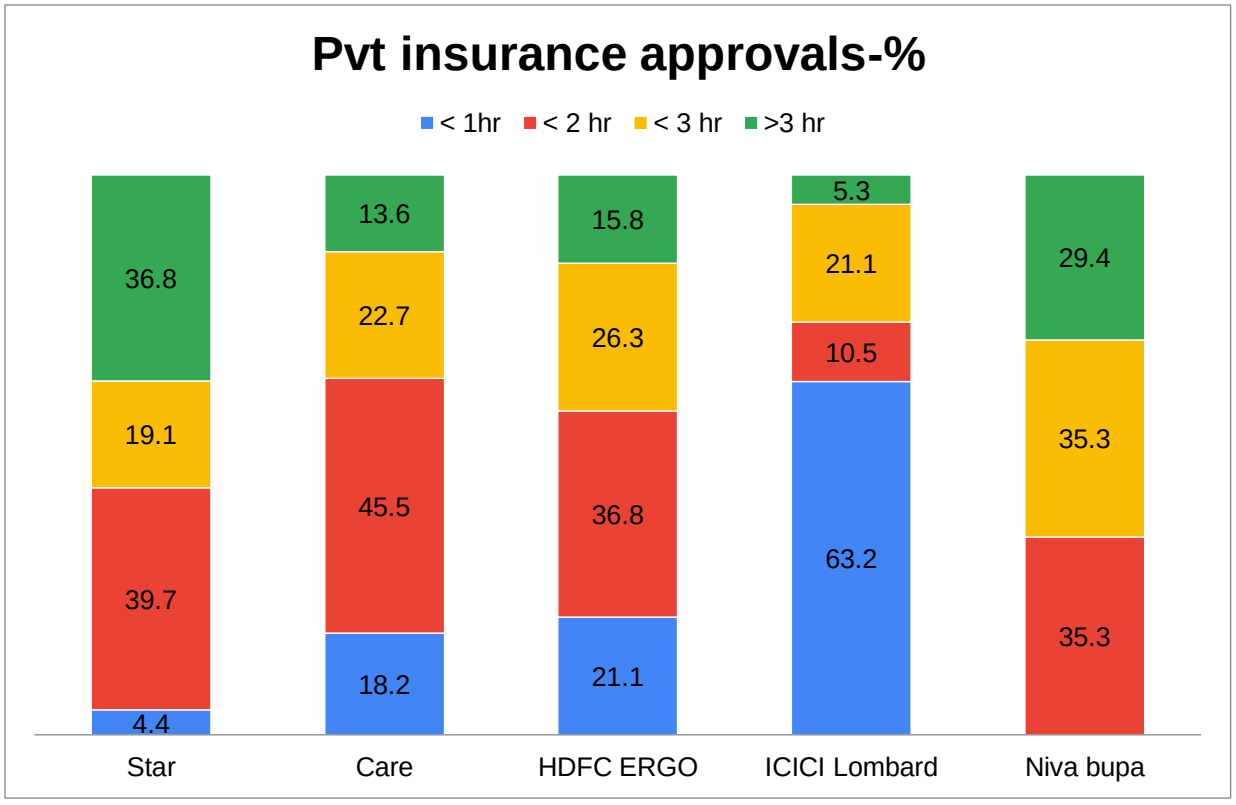


Figure 12: Column graph showing the % of claims settled by different pvt insurance companies in different time intervals

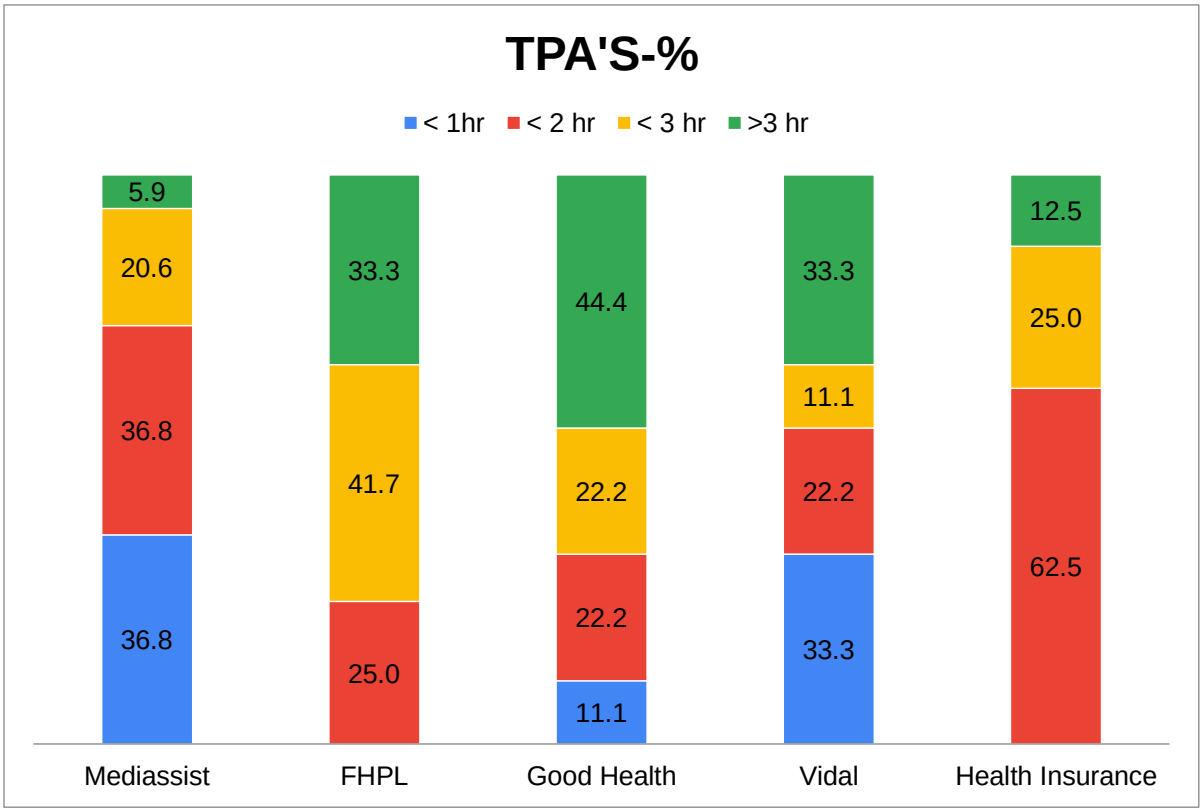


Figure 13: Column graph showing the % of claims settled by different TPA's in different time intervals

In the above graphs it is clearly visible that TPA's like good heath and Vidal are taking more time to issue the clearance and authorize the claim from their side, other TPA's like health insurance and mediassist is taking lesser time when compared to other companies. Compared to the private insurance companies TPA's are taking more time to authorize the claim. This is due to the transferring process involved between multiple companies and communication that needs to occur and pass on between the organizations. Delays in the ThirdParty Administrator (TPA) procedure during the transfer of insurance patients from hospitals. Between healthcare providers and insurance providers, TPAs handle claims, insurance eligibility, and approvals. This time will vary with the query management system. If the queries come then the time taken by the companies to authorize the claim will take more and the patient dissatisfaction with that company and the hospital rises, because he/she is not completely aware of who does what and how the process flow takes place.

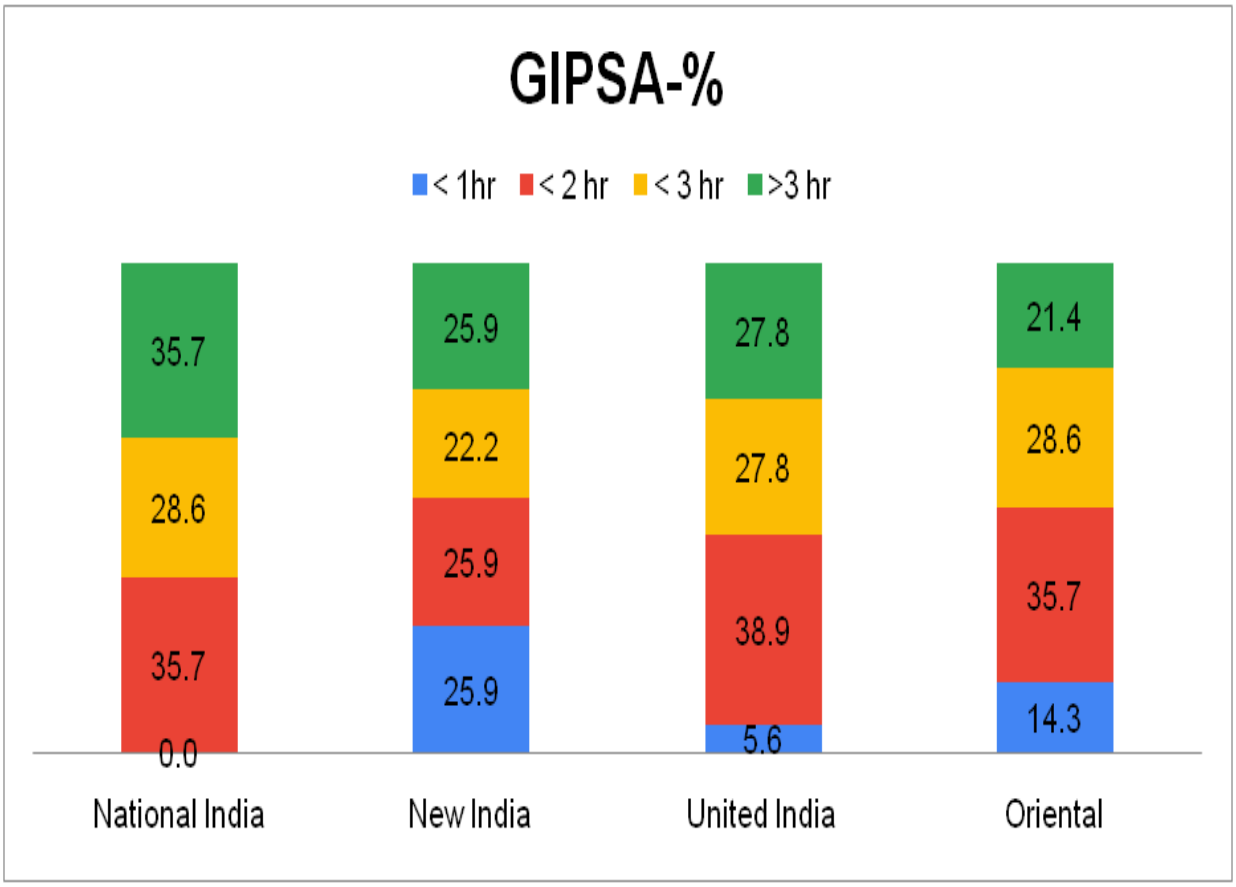


Figure 14: Column graph showing the % of claims settled by different GIPSA companies in different time intervals

Along with the post auth bill submission, 50 samples of query management is also there, by this we can know how much time the queries are responded by the hospital to the TPA or insurance company.

| Compliance % | Total |
|---|---|
| **Yes** | 22 |
| **No** | 28 |

Table 6: Compliance % of queries response within TAT(45 mins)

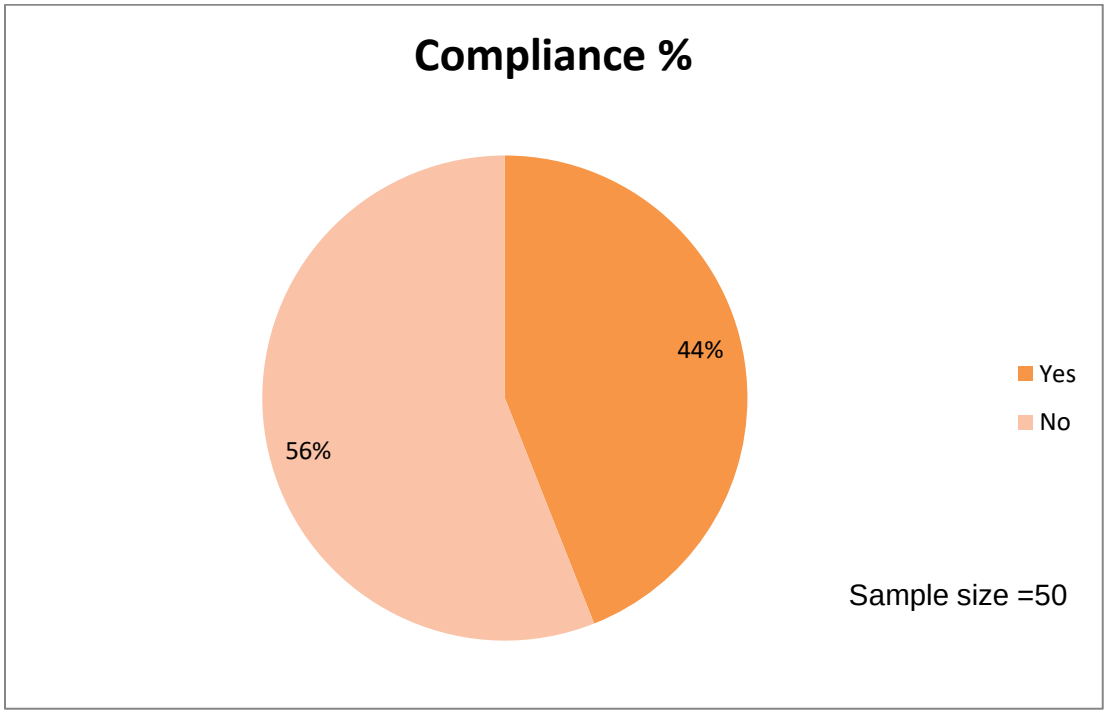


Figure 15: Pie chart showing compliance % of query response

As we can see there is only 44% compliance out of 50 samples an din the below data we can see the no of queries as per the category:

a) Non clinical- means which can be handled by the backend team

b) Clinical- means which needs the doctor involvement

c) Both- Clinical and non clinical- Needs both the backend team and the doctor/consultant to respond the query

| Type of Query | Number |
|---|---|
| **Non clinical** | 39 |
| **Clinical** | 6 |
| **Both** | 5 |

Table 7: No of queries as per their category

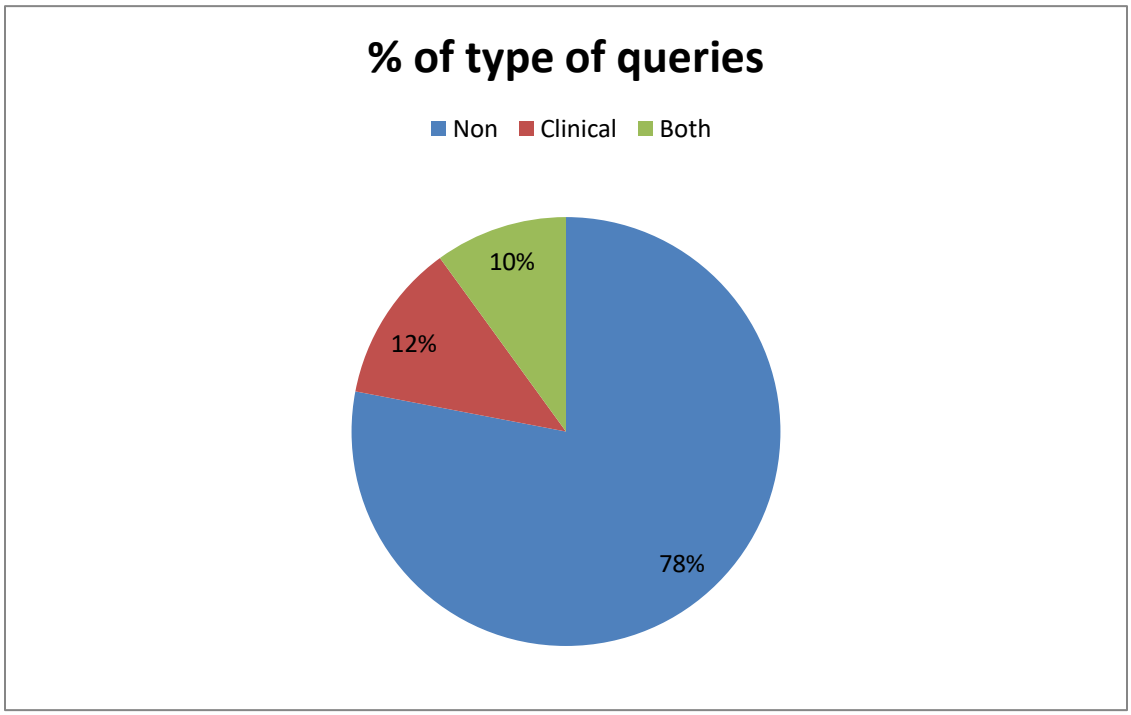


Figure 16: Pie chart showing the % of type of queries

Among the non clinical queries which are highest in number, major of those queries are falls under two categories:

| Major non clinical queries | Number |
|---|---|
| **Revise the bill** | 18 |
| **ID documents** | 13 |

Table 8: No of major non clinical queries

Other queries are about bill on higher side, Price breakup charges, Invoices, CKYC documents etc.

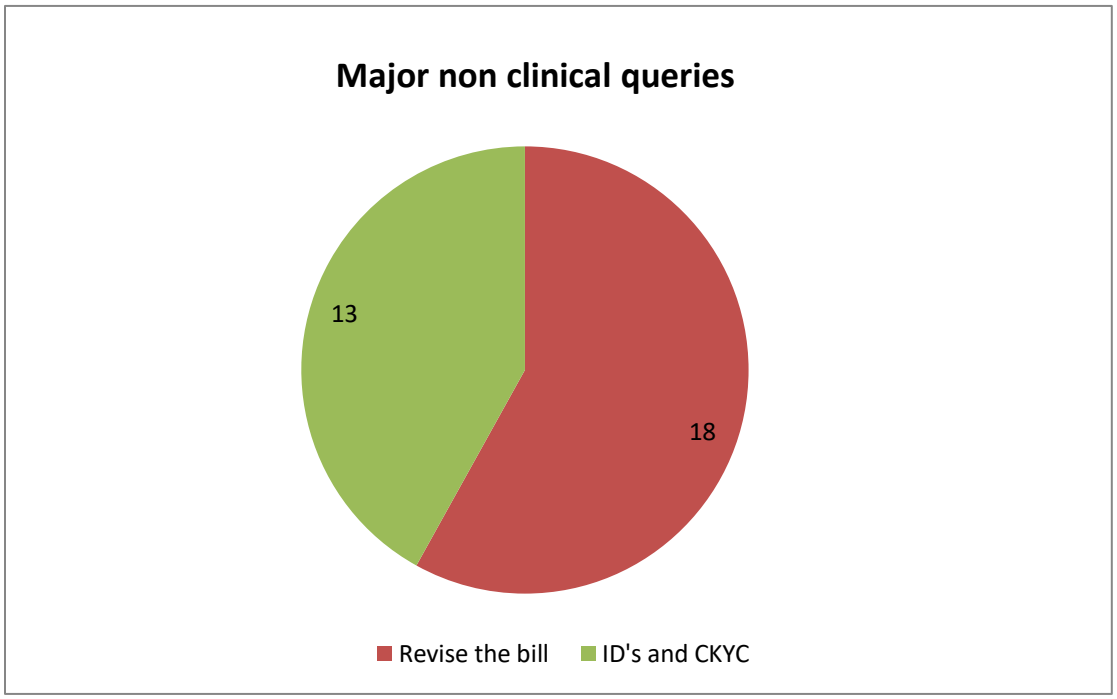


Figure 17: Pie chart showing the no of major non clinical queries

The average time taken for responding to the queries is one hour 19 minutes for all the 50 samples. If we compare which company is raising more queries then it is star health. 80% of the revise the bill category non clinical queries are from star health. As the number of claims from star health are high, so the % of queries rose in the both clinical and non clinical category are from the same company.

## CHAPTER 5: DISCUSSION

The entire data is divided into two phases: 16th march to 30th April and 1st may to 25th may. As you can see the compliance rate is increased in the second phase from 36% to 62%. This is because of the implementation of the EHR software and the process change and the role revision that had been taken place. The number of summary corrections decreased due to the EHR. Summary corrections are two types: a) Date change/Date addition, b) Past history removal. Due to the EHR the date addition and date change is automatic, so that there is no summary correction related to this, but the past history removal is the major concern as it is mandatory to report to the insurance companies while taking the policy, but the patients are not aware of this rule and even if they are aware some patients and the policyholders intentionally don't report. While taking the treatment they will report to the doctor and doctor team mentions it in the D.S, so the post auth team needs to contact the patient for the clarification that if they reported their pre existing diseases to the insurance company or not. Due to this the post auth submission of the bill becomes delayed and increases the rate of non compliance in the overall TAT. Other reason which created delay in first phase is L.C issue at floor biller. Floor biller needs to close the LAN bill within one hour of discharge initiation. So to get comply with this they will close before the audit and wait for the auditor and if the reports later in the whatsapp group. So this malpractice has been identified and directed the floor billers to change the practice. After this issues are completely erased out and EHR implementation also helped. Whatsapp group is closed and now the post auth team will check the EHR for checking the bill, so no delays were there.

Patient visits used to be more frequent for the post auth department and because of their queries the post auth team gets disturbed and TAT gets delayed for other bills, so the management took strict action against the floor billers, floor managers, security team and other personnel who are directing the patients to the post auth team and ordered them to not to follow this practice. After this step, patient visits decreased 80% and the post auth team is able to submit the bills on time. In query management the average time taken is one hour nineteen minutes and only 44% is complied with the TAT of 45 minutes. As most of the clinical queries requires doctor/consultant involvement, it gets delayed in responding due to their involvement in other multiple activities like OPD, Surgery process, cross consultations etc.

**OBSERVATIONS**

- No-entry boards are not there, so multiple patient visits
- Common mail system for pre and post auth teams which can create confusion
- Revenue recovery team who contacts insurance companies for the payment collection
- Total 3 portals are being used- Remedinet, HIMS, IHX(Mediassist), EHR, EMR
- Frequent leaves by auditors and converters
- Pre authorization dockets are being submitted regularly to the post auth department.
- Delay in transferring the documents from Remedinet to the insurance company
- Floor billers regularly ask insurance backend team about the surgeon's fee
- No notification board is maintained in the department related to the contact numbers and names of the respective floor billers and RM's
- Bills are placed seperately in 3 categories after submitting it to the insurance company- 1) Denied bills, 2) Submitted a day before- Waiting for approval, 3) Submiited today and waiting for approval
- Service call-off is initiated by the auditor who audits the cash bill and even the power to revoke is in his hands only.
- Sometimes there is a delay in transferring the documents from remedinet to the mediassist portal which delays the approval time from the company.
- Not all staff who converts the bill are good in billing packages, they need proper training.
- If approval is late from the insurance company, patient may pay the bill in cash and can get the refund after approval from the company
- There will be audit again for the bills that needs to be refunded.
- Insurance DMO’s are not present all the times in the department, so the delay occurs while responding to the clinical query
- Communication between financial counsellors and insurance teams is missing , so it needs to be strengthened,

## CHAPTER 6: SUGGESTIONS/RECOMMENDATIONS

| Problem | Solution |
|---|---|
| Patient visits- Final bill amount, concession, submission status | T.V scrolling, Message system, Call system |
| Multiple duties:<br>a)Bill conversion<br>b)surgeon fee response<br>c)Closing the bills<br>d)Patient queries<br>e)NMI (need more information) queries after submitting the bill | Duty priority needs to be done for both the converters and auditors |
| Summary corrections- Past history | Following the preauth checklist by the F.C, Insurance GRE, editing rights |
| Clearances and surgeon fee issues | Train insurance GRE for issuing clearance |
| Dialysis,Preauth waiting,opthamology ,CT bills, Reconsider and yesterday bills (NMI)TAT | A separate tag system for these bills so that they won't include in TAT |
| EHR-Sorting , auto update ,Late update of L.C and Time reminder | Picking up Remedinet submission time and time reminder (display) |
| Estimation amount issues | Training the F.C and giving regular updates to the patient |

| | |
|---|---|
| Summary pending | Planned discharges and Deploying A.I will help |
| Revise the role | • **Harish**- Summary check, request for reports, NMI queries handling<br>• **Hari krishna** (Shift to GRE counter after 12pm)- handles patient queries and will issue clearances- decreases patient visits<br>• **Pavan**- Close the bills<br>• **Balakrishna and Raghu**- Conversion, surgeon fee |

Table 5: Problems and suggestions

## CHAPTER 7: CONCLUSION

In conclusion, the compliance rate has significantly increased as a result of the implementation of improvements to the post-authorization bill submission procedure. The difficulties and bottlenecks that the updated methods successfully addressed have enhanced efficiency, accuracy, and timeliness in bill submissions.

The streamlined filing process is one of the main drivers behind the higher compliance rate. By implementing clearly devised standards, a proven communication strategy, and less requirement of documentation, the hospital has been able to proceed with the process more easily and effeciently. It will be made simple for staff executives and patients to understand their roles so that they can fulfil their responsibilitie by reducing complexness and uncertainty .The use and utilization of technology, including software/portal like EHR and other automation technologies, has also significantly increased compliance rates. By removing the need for more paperwork and decreasing the chance of errors or delays, electronic billing systems have lighten up the submission process. Due to technology advancements, stakeholders now have a centralised and efficient location to put out legislation, follow its progress, and receive prompt feedback.

Regular training sessions for the financial counsellors and post-auth team have equipped staff with the knowledge and skills necessary to abide by the laws, which has enhanced compliance.The increase in compliance rates has brought about a number of benefits for all stakeholders. Providers have less financial stress and have better cash flow as a result of receiving payments more rapidly. Payers are able to process claims swiftly and make payments on schedule when they receive accurate and timely bills. Improved satisfaction among stakeholders, collaboration and trust are the end effects of this. While the post-authorization bill submission process improvements have been effective in raising compliance rates, it's critical to understand that ongoing monitoring and review are crucial. To find any possible areas for improvement and guarantee the sustainability of the increased compliance rates over time, regular audits, performance evaluations, and feedback systems should be in place.

In conclusion, it is impossible to dispute the advantages brought about by the modifications to the post-authorization bill filing procedure. A major rise in compliance rates has resulted from streamlining processes, technology developments, improved communication, and training activities. Organizations that have adopted these improvements have increased their

operational efficiency while also fostering a more transparent and collaborative environment within the healthcare ecosystem.

## CHAPTER 8: REFERNCES


1. Krishnekumaar ST, Nadu T, Meenakshisundaram KS. A Study on the role of Third Party Adm. inistrators in Health Insurance in India. 2016;1–12.

2. Shukla K. Predictive Modelling for Turn Around Time ( TAT ) of Discharge Process for Insured Patients in a Corporate Hospital of Pune City. 2018;1–8.

3. Bawa D. S. K., & Verma R. (2011). Third Party Adminstrators (TPAs) in India: An insight into role defined and role played with reference to IRDA. ZENITH International Journal of Multidisciplinary Research, 1(3), 13–25.

4. A. Abiramalakshmi , DR. SN. Soundara Rajan Oct (2017). "A Study On Identification Of Cause Of Delay In Inpatient Discharge And To Increase Patient Satisfaction" published in International Journal of Management Research & Review.ISSN:2249-7196. 4)

5. Harmanjot kaur, Roopjot Kochar June (2017). "A Study on Discharge Process of Discharged Patients of a Multispecialty Hospital Ludhiana" published in International Journal of Engineering and Management Research.ISSN :2250-0758. 5)

6. Senu Thomas, N.Junior Sundresh,S.Kishore Kumar April (2017). "A Comparative Time Motion Study Of Patient Discharge Process At Quaternary Hospital" published in Global Journal Of Research Analysis. ISSN NO:2277-8160

7) Thompson, R., & Davis, M. (2021). The impact of third-party administrators on hospital discharge processes: A case study. Healthcare Management Review, 18(2), 78-92.

8) Johnson, S., & Brown, K. (2022). Exploring the Factors Contributing to Delays in the

Discharge Process: Insights from Third-Party Administrators. In Proceedings of the International Conference on Healthcare Systems and Administration (pp. 45-52).

9) Davis, L., & Wilson, P. (2021). Third-Party Administrators and Discharge Delays: Findings from a Multi-Institution Study. In Proceedings of the Annual Conference on Healthcare Management (pp. 112-125).

10) Janmejaya Samal, Ranjit Kumar Dehury (2015). An Exploration and Assessment on the Current Status and Trend of Third Party Administrators (TPA) In India. International Journal of Health Sciences & Research (www.ijhsr.org) Vol.5; Issue: 8; August 2015

11) Ankit Singh, Priya Ravi (2018). Patient satisfaction factors within house Third Party Administrator (TPA) department of a tertiary care hospital: a cross sectional analysis. Journal (Academy of Hospital Administration (India)) 30(2):42

12) Shahnawaz Hamid, Farooq A Jan, Haroon Rashid, Susan Jalali. Study of hospital discharge process viz a viz prescribed NABH standards. International Journal of Contemporary Medical Research 2018;5(8):H1-H4.

13)Sahoo MC, Dora S, Talwar Y. Determinants of Hospital Discharge Process: Experience from an Apex Tertiary Care Autonomous Institute of National Importance of Eastern India. Int J Res Foundation Hosp Healthc Adm 2019;7(2):55–57.

14) Mehta S, Nair J, Rao S, Shukla K. Role of discharge planning and other determinants in total discharge time at a large tertiary care hospital. CHRISMED J Health Res 2015;2:46-50

15) Sandip Sane , Niharika Singh. A Study on Consumer Perception with Reference to Third Party Administrators (TPAs). Indian journal of marketing, Volume 42, Issue 12, December 2012.

16) Kumar Rohit, Rangarajan K., Ranganathan Nagarajan (2011). 'Health Insurance In India A Study of Provider's Perception in Delhi & the NCR.' Journal of Health Management, Volume 78, Number 10, pp. 1 -7.

17) Anchan PS, Jathanna R, Marla A. Evaluation of Health Insurance and Claim Process at Tertiary Care Hospital, Mangalore: A Case Report. Journal of Health Management. 2011;13(1):97-112. doi:10.1177/097206341001300106

18) Ananya C V, A. Bhooma Devi and S. Nithya Priya. Knowledge, Awareness and Perception of Health Insurance among Insured in a Tertiary Care Hospital, International Journal of Management, 11(12), 2020, pp 3647-3655.

19) Okuzu O, Malaga R, Okereafor K, Amos U, Dosunmu A, Oyeneyin A, Adeoye V, Sambo MN and Ebenso B (2022) Role of digital health insurance management systems in scaling health insurance coverage in low- and Middle Income Countries: A case study from Nigeria. Front. Digit. Health 4:1008458. doi: 10.3389/fdgth.2022.1008458

20) Jain K, Sinha SK, Jain D, Kumar R. Does Health Insurance give Us an Assurance? A Study on the Extent of Coverage of Health Insurance at a Tertiary Care Hospital in North India. Int J Res Foundation Hospc Health Adm 2016;4(1):25-30.