A PRACTICAL INSIGHT INTO INSURANCE CLAIM PROCESSING AND HOSPITAL BILLING WORKFLOW IN TERTIARY CARE SETTINGS (APOLLO HOSPITAL ,BANNERGHATTA)

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MISSION
Our mission is to bring healthcare of International standards within the reach of every individual. We are committed to the achievement and maintenance of excellence in education, research and healthcare for the benefit of humanity.

- **VISION**
Touch a Billion Lives

ABOUT APOLLO HOSPITAL

- Apollo Hospital, Bannerghatta Road, Bengaluru, is a premier multi-specialty tertiary care hospital known for its world-class infrastructure, cutting-edge technology, and expert medical professionals. As part of the renowned Apollo Hospitals Group, it offers comprehensive healthcare services across various specialties including Cardiology, Oncology, Neurology, Orthopedics, and more. With a strong focus on patient-centric care, innovation, and clinical excellence, Apollo Bannerghatta has earned a reputation as one of the leading healthcare institutions in South India

CHALLENGES FACED

- Delay in receiving discharge summaries from departments.
- Incomplete or incorrect documentation from wards and patients.
- Difficulty in resolving FTC (Failed to Claim) errors within time limits.
- Coordination gaps between billing, medical, and TPA teams.
- Handling multiple software systems with varying data inputs

LEARNING OUTCOMES

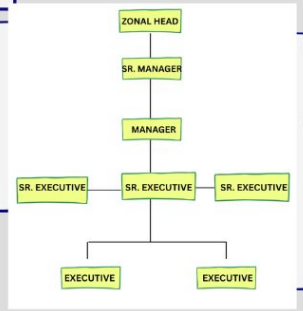
- Gained hands-on experience in insurance claim processing.
- Understood the end-to-end hospital billing and discharge workflow.
- Improved skills in using hospital software for real-time data tracking.

LINKING THEORY TO PRACTICAL

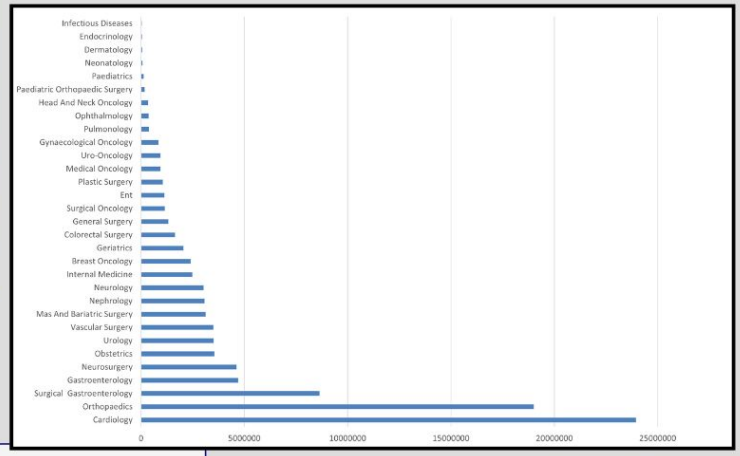
- Utilized knowledge of Hospital Operations Management during discharge planning and workflow optimization.
- Practical exposure to Healthcare IT Systems by working with software for real-time discharge tracking and claim submission.
- Understood importance of Quality Standards (NABH) in maintaining documentation accuracy and audit readiness.

SWOT ANALYSIS

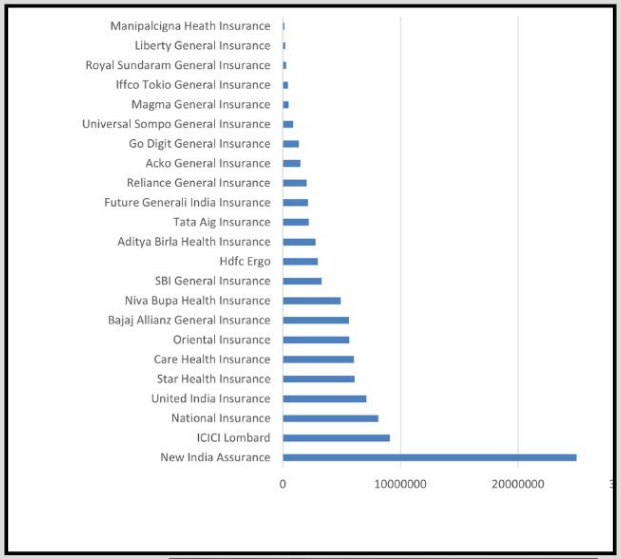
ORGANIZATIONAL CHARTS



DEPARTMENT-WISE CLAIM ANALYSIS(1 MONTH)



INSURANCE COMPANIES CLAIM ANALYSIS(1 MONTH)



INTRODUCTION OF PROJECT

- This project focuses exclusively on IP Patients, analyzing insurance claim data to identify which insurance companies contribute the highest claim amounts, frequencies, and averages. It also highlights the top revenue-generating departments within the hospital and examines which insurers are most significant in those departments. The findings aim to support data-driven decisions for optimizing revenue cycles and strengthening hospital-insurer coordination.

OBJECTIVES

- To study the insurance claim processing cycle, including documentation, pre-authorization, claim submission, and settlement mechanisms in a tertiary care hospital.
- To identify common challenges and delays in hospital billing and insurance claim processing from an operational perspective.

RESULTS

- New India Assurance had the highest total claim value and claim count among all TPAs.
- Star Health recorded the highest average claim amount per case.
- The top three revenue-generating departments were Cardiology, Oncology, and Orthopedics.
- Within these departments, New India Assurance and Medi Assist emerged as the top-paying insurers.
- Significant variation was observed in claim contributions across insurers and departments, highlighting potential for optimization in TPA coordination

RECOMMENDATION

- Improve coordination with top-performing TPAs.
- Train staff in key departments on proper documentation.
- Use analytics dashboards for real-time claim tracking.
- Prioritize high-value TPAs in empanelment decisions.

SUGGESTION

- Streamline discharge summary submission.
- Integrate claim-related software systems.
- Use dashboards to track claim status daily.
- Provide regular training on documentation.