EVALUATION OF TURNAROUND TIME OF REIMBURSEMENT CLAIM PROCESSING IN INTERNATIONAL CLAIMS DEPARTMENT AT CARE HEALTH INSURANCE

Dissertation Submitted to

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For the partial fulfilment for the award of the degree of

Master of Business Administration (MBA)

in

Hospital and Health Management

By

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Under the Supervision and Guidance of

DR. VINOD KUMAR SV

2023

DECLARATION BY STUDENT

I hereby declare that this dissertation titled “Evaluation of Turnaround Time of Reimbursement Claim Processing in International Claims Department at Care Health Insurance” is the bona fide 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text.

DR. NEHA V NAIR

25th June 2023

CARE HEALTH INSURANCE CERTIFICATE

CERTIFICATE

This is to certify that dissertation title **Evaluation of Turnaround Time of Valuation of Reimbursement Claim Processing in International Claims Department at Care Health Insurance** is a record of the research work undertaken by DR NEHA V NAIR in partial fulfillment of the requirements for the award of the degree of MBA Hospital and Health Management from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

DR. VINOD KUMAR S V

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Date

ABSTRACT

The health insurance sector in India is a dynamic and evolving industry that plays a critical role in ensuring access to quality healthcare and protecting individuals and families from the financial burden of medical expenses.

The insurance industry provides a wide variety of coverages to meet various needs and risks. These coverages cover a variety of things, such as life and health insurance as well as motor insurance, liability, and property insurance.

INTRODUCTION –

The turnaround time for processing reimbursement claims refers to how long it takes a health insurance company to examine and pay out a claim for medical services rendered to a patient. Turnaround time is a crucial performance metric that assesses the quickness and effectiveness of the system for processing reimbursement claims. It seeks to determine what causes delays or speeds up the process and offers solutions to increase effectiveness and customer satisfaction.

METHODOLOGY-

The processing of reimbursement claims in the international claims department was carried out at Care Health Insurance Limited from April to May 2023. The results from a sample size of 1,000 cases showed that 38.9% of cases were authorised for reimbursement, 35.8% were refused because they did not comply with the conditions of the policy, and 25.3% were still being processed or were still being questioned. The study shed light on the factors affecting the turnaround time and offered useful insights into the effectiveness of claim processing inside the organisation throughout the designated timeframe.

CONCLUSION:

The study revealed areas for improvement and offered insightful information about how the claim process is currently functioning. The distribution of claims across many categories, including dental charges, inpatient expenses, outpatient expenses, and vision expenses, was disclosed by the study's findings. A significant percentage of claims were found to be rejected or under review, indicating the need for additional analysis and clarity.

The study has drawn attention to the significance of claim processing streamlining, improving transparency and communication, standardizing evaluation criteria, improving documentation guidance, improving customer support services, routine performance monitoring, and continuous process improvement. These suggestions and ideas are meant to fill in the gaps and difficulties in the workflow of processing claims, which will eventually result in a quicker response time, greater efficiency, and higher client satisfaction.

AKNOWLEDGEMENT

I would like to express my deepest gratitude to all those who have contributed to the successful completion of this dissertation.

First and foremost, I extend my heartfelt appreciation to my supervisor, [Supervisor's Name], for their invaluable guidance, unwavering support, and continuous encouragement throughout the research process. Their expertise, knowledge, and insightful feedback have been instrumental in shaping the direction and quality of this study.

I would like to express my heartfelt gratitude to the organization that provided me with the opportunity to conduct this research and complete my dissertation. The support, resources, and guidance extended by the organization have been invaluable throughout my journey.

I am deeply grateful to my mentor at the organization, Dr. Vinod Kumar SV , for their constant guidance, encouragement, and expertise. Their wealth of knowledge and experience have greatly influenced the direction and quality of this research. I am indebted to him for his unwavering support and mentorship.

I also want to express my gratitude to my family and friends for their unwavering support, understanding, and motivation throughout this academic endeavor. Their encouragement, love, and belief in my abilities have been the driving force behind my perseverance.

In conclusion, I acknowledge and appreciate the contributions of all individuals who have played a part, however big or small, in the completion of this dissertation. Their support and encouragement have been instrumental in my academic growth and personal development.

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ABBREVIATION

CHIL- CARE HEALTH INSURANCE LIMITED

IRDAI- INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY OF INDIA

IPD- INPATIENT DEPARTMENT

KPI- KEY PERFORMANCE INDICATOR

MIS- MANAGEMENT INFORMATION SYSTEM

OPD- OUT PATIENT DEPARTMENT

PPN- PREFERRED PROVIDER NETWORK

TAT- TURN AROUND TIME

EVALUATION OF TURNAROUND TIME OF REIMBURSEMENT CLAIM PROCESSING IN INTERNATIONAL CLAIMS DEPARTMENT AT CARE HEALTH INSURANCE

CHAPTER - 1

INTRODUCTION

A health insurance company's turnaround time for processing reimbursement claims is the period of time it takes to examine and resolve a claim for medical services provided to a patient.

It is a critical performance parameter that assesses the efficiency and effectiveness of the reimbursement claim processing system. It aims to pinpoint the reasons behind process acceleration or delays and provide solutions to boost efficiency and customer satisfaction.

This study intends to evaluate the International claims department's turnaround time for processing reimbursement claims and identify areas for development. The study will assess the effectiveness and efficiency of the claim processing processes, identify any delays, and suggest tactics to improve the overall turnaround time. Insights from the research will be used to enhance the effectiveness of the system for processing reimbursement claims, leading to quicker and more efficient claim settlements for claims from abroad.

For a number of stakeholders, the turnaround time for processing reimbursement claims is a significant issue. First of all, for policyholders, a streamlined and quick system for processing claims is essential since it enables them to promptly get payment for their medical bills, relieving financial constraints and raising general satisfaction. Additionally, from an organizational perspective, streamlining the claim processing workflow improves operational effectiveness, lowers the expenses associated with delays, and aids in maintaining a competitive advantage in the insurance market. Additionally, maintaining the legitimacy and reputation of the insurance provider requires assuring compliance with legal standards governing the timetables for claim processing.

For policyholders to receive a seamless and effective service, the International claims department's resource utilisation must be improved, and operational excellence must be achieved. The department can encourage higher customer satisfaction, cultivate trust and loyalty among policyholders, and eventually improve the overall performance and reputation of the insurance organisation by speeding up the processing of reimbursement claims.

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PLANS AND SERVICES

PRODUCT: EXPLORE POLICY

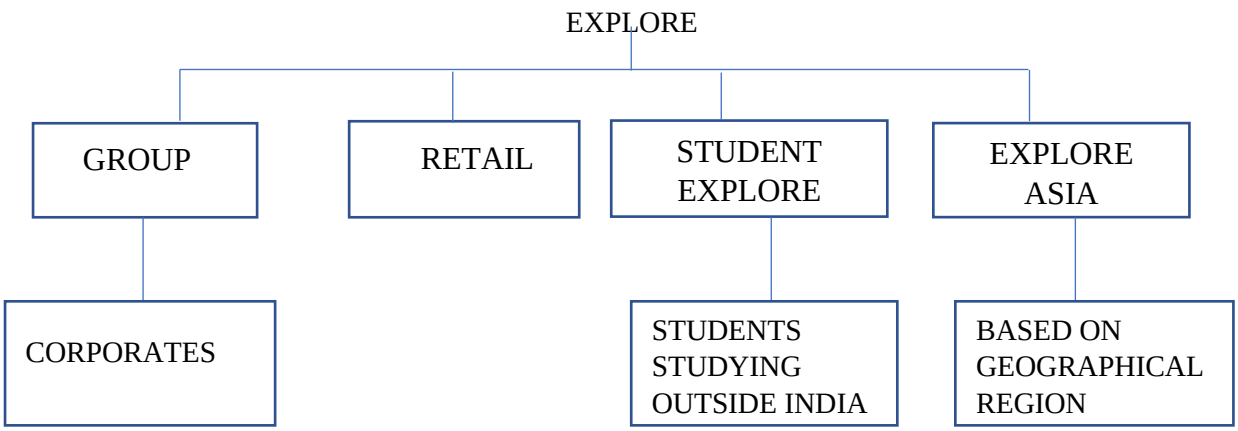

Figure 1- Types of Explore

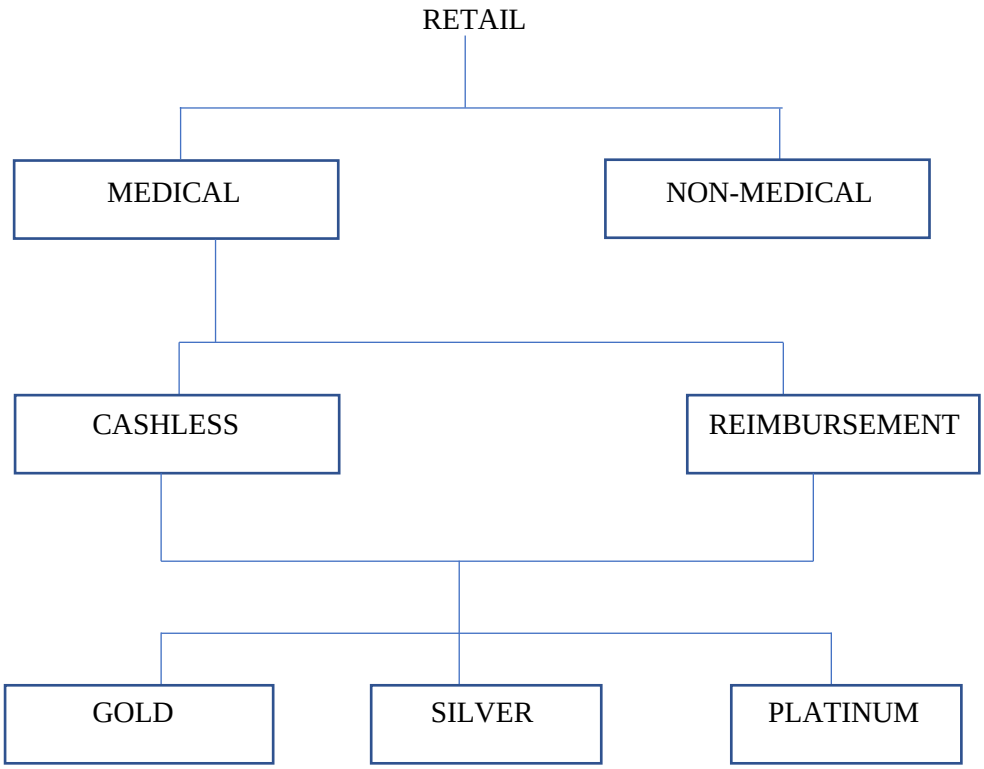

Figure 2- Types of Retail Services

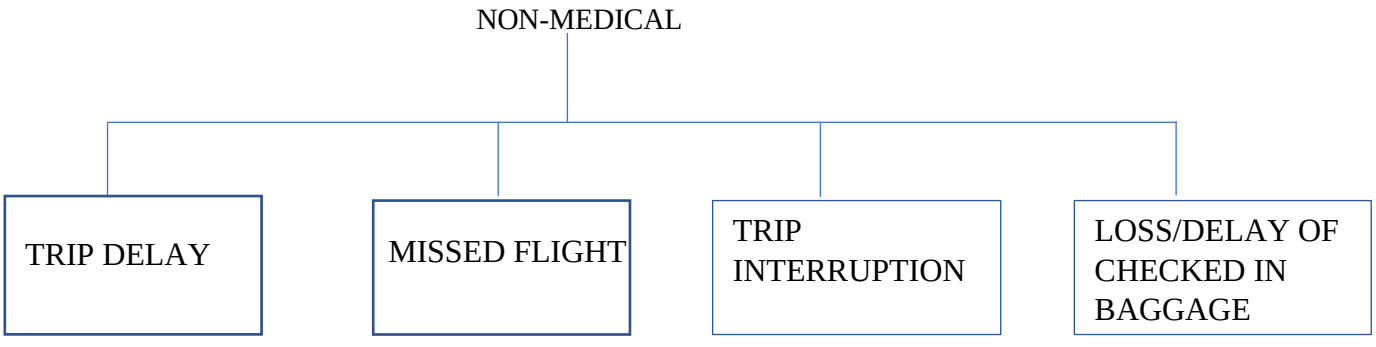

Figure 3- Types of Non-Medical Services

- **CASHLESS FACILITY:**

It means a facility extended by the company to the insured person where the payments, of the costs of treatment undergone by the insured person in accordance with the policy terms and conditions, are directly made to the Network Provider by the company to the extent pre-authorization approved.

- **REIMBURSEMENT –**

  Reimbursement is the act of paying back or making up for previously paid expenses. Reimbursement is frequently used in the context of healthcare to describe the payment of medical costs by an insurance company, either to the patient directly or to the healthcare provider on the patient's behalf.

- **CLAIM PROCESSING-**

  Claim processing describes the steps and actions taken by an insurance company to assess, confirm, and decide the legitimacy of an insurance claim submitted by a policyholder. In this procedure, the claim's specific including the medical care or services rendered are examined in order to determine the appropriate amount of reimbursement that the policyholder is entitled to receive.

- **IPD-**

  IPD, which stands for inpatient department, is the area of a hospital or healthcare facility where patients are admitted for medical care and treatment that necessitates an overnight stay or longer. A minimum of 24 hours must be spent in the hospital.

- **OPD-**

  OPD stands for outpatient department, refers to the area of a hospital or healthcare facility where patients can receive medical care without having to be admitted in the hospital.

- **PATIENT SATISFACTION** –

  Patient satisfaction in terms of reimbursement claim processing refers to a patient's level of satisfaction with the process of submitting and receiving reimbursement for healthcare services, including the ease, speed, accuracy, and communication regarding the status of the claim.

- **MEDICAL CLAIMS-**

  Medical claims refer to requests made by healthcare providers, hospitals or patients to an insurance provider for reimbursement of medical expenses incurred. These claims typically contain detailed information about the medical treatment received, the associated costs, and the insurance policy under which the claim is being made.

- **NON -MEDICAL CLAIMS-**

  Non-medical claims refer to requests made by an individual or entity to an insurance provider for reimbursement of expenses incurred that are not directly related to medical treatment. These claims can include expenses such as property damage, loss of personal property, or liability claims

- **PREFERRED PROVIDER NETWORK (Network Provider) -**

  It means the hospitals or health care providers enlisted by the company or by its assistant service provider and the company together to provide medical services to the insured on payment by a cashless facility.

❖ **MEDICAL BENEFITS OF INTERNATIONAL TRAVEL INSURANCE PLAN**

- Hospitalization Cover
- Dental Expenses
- Accident Death/ Permanent Total Disability
- Medical Evacuation
- Common Carrier Accidental Death
- 2 Way Compassionate Visit
- Pre-existing Disease Cover

❖ **CLAIM PROCEDURE-**

1. **CASHLESS**

PROCESS- IN-PATIENT CLAIMS

a. Claim Intimation
b. Documents Submission
c. Cashless Claim settlement with Hospital

2. **REIMBURSEMENT-**

In this case, the insured will have to self-pay and file the claim directly with the claims department and then the insurance company will pay it to the customer.

Reimbursement refers to the process of compensating individuals or organizations for expenses incurred or services rendered. In the context of insurance, reimbursement commonly relates to the repayment of medical expenses or other covered costs.

STEPS:

1. **Inform the Insurance Company**:
   Member needs to inform the insurance company about expenses incurred during the hospitalization or out-patient visit.

2. **Submit the documents**:
   Member needs to submit the claim documents as per claim advice shared to member by the company.

3. **Claim Processing:**
   Claim documents submitted to insurance company for processing will be reviewed and in case of any further requirement, member will be informed on the pending information and member needs to provide the same.

4. **Claim Decision:**
   Decision on claim will be done on the basis of submitted documents and as per policy terms & conditions, approved claims will be settled in member's account.

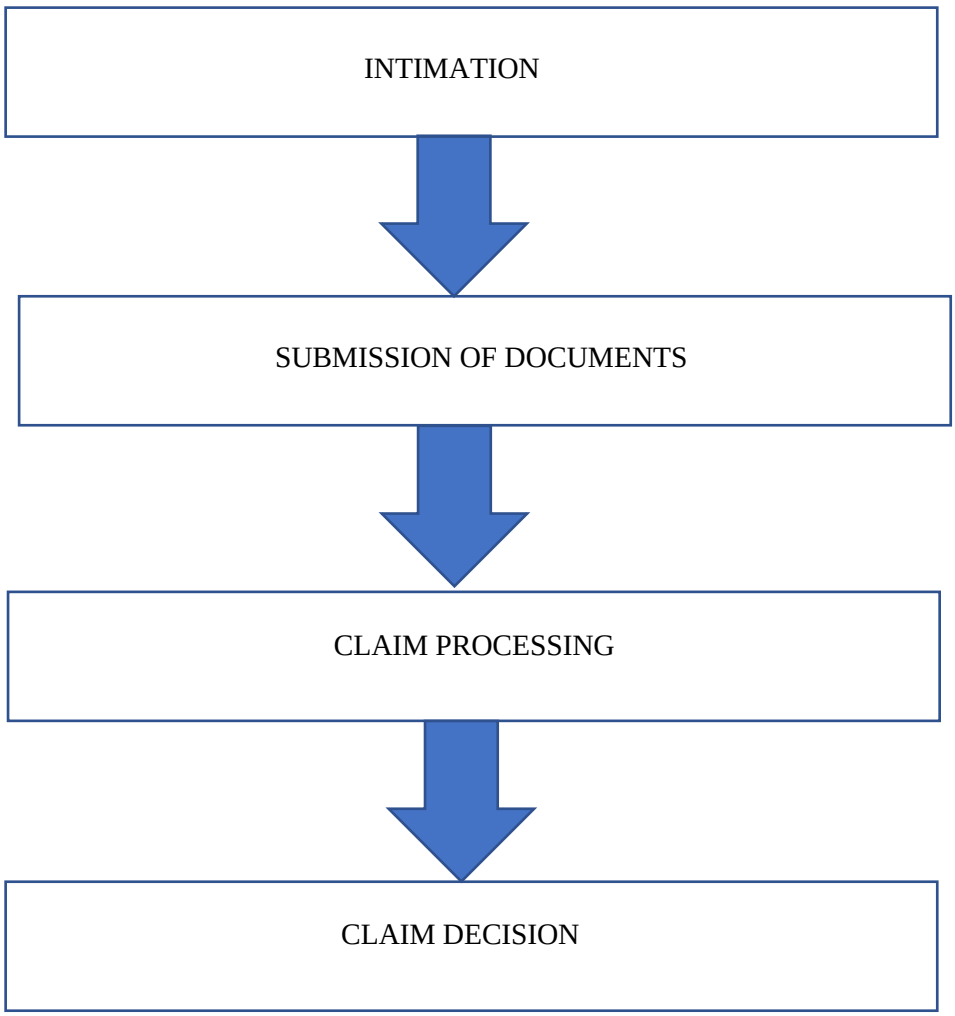

Figure 4- Steps of Claim Process

IRDA

A governmental entity known as the Insurance Regulatory and Development Authority of India (IRDAI) was established by the Insurance Regulatory and Development Authority Act, 1999 (IRDA Act, 1999), for the purpose of overseeing and developing the insurance industry in India.

- It is responsible for licensing, policy formulation, consumer protection, market development, and supervision. IRDA grants licenses to insurance companies to operate in India and regulates their activities to ensure compliance with rules and regulations.

- IRDA's role is to ensure the stability and growth of the insurance industry while safeguarding the interests of policyholders through regulatory oversight and enforcement.
- In the event of alterations to the rules and regulations, the IRDA or IRDAI frequently issues advisories to insurance companies. The regulator directs the insurance sector to encourage efficiency in the way insurance business is conducted while also managing insurance prices and other costs.
- The IRDA's primary objective is to facilitate the orderly growth of the insurance industry for the benefit of the common man. By creating a regulatory framework that encourages transparency, integrity, and accountability, it aims to enhance the overall functioning of the sector and promote a healthy competitive environment.
- Transparency, fairness, and systematic conduct of insurance operations are key priorities for the IRDA
- IRDA safeguards the rights and interests of policyholders by monitoring the financial stability and solvency of insurance companies.

- The authority approves insurance products and ensures that they comply with the necessary guidelines and regulations.
- Grievance Redressal: IRDA plays a crucial role in the resolution of policyholders' complaints and grievances against insurance companies.
- Market Development: IRDA focuses on promoting competition, innovation, and customer-centric practices in the insurance market.
- Financial Regulation: The authority monitors the financial performance of insurance companies, sets investment norms, and establishes solvency requirements.
- Consumer Education: IRDA undertakes initiatives to educate and create awareness among consumers about insurance products and their benefits.

GUIDELINES

- The insurance company is responsible for paying interest on the claim amount at a rate that is 2% higher than the bank rate if the insurer's claim payment is delayed. The claim should be resolved within 30 to 45 days of the date the policyholder received the last necessary document.

- The Company will issue a settlement offer to the Policyholder, and after the Policyholder accepts the offer, the Company will pay the claim within 7 days of receiving the Policyholder's acceptance.

- The standard product's policy period, as defined in the policy schedule, should be the length of the policyholder's trip as a fare-paying passenger and, in the event of an overseas travel insurance, their stay while travelling abroad.

- The entire process takes maximum of 21 days for the reimbursement claim to get settled as the insurance company verify the documents, reports, bills, diagnosed reports etc.

CHAPTER – 2

LITERATURE REVIEW

S.NO	TITLE OF STUDY	KEY TAKEAWAYS	SOURCE
1.	Out-patient coverage: Private sector insurance in India	• Private health insurance sector in India has witnessed a 25% growth in recent years. • Out-patient (OPD) coverage is an emerging trend in private health insurance. • OPD coverage allows policyholders to claim expenses for non-hospitalization medical treatments. • Major insurance companies provide OPD coverage for an additional premium. • Private health insurance sector faces obstacles related to coverage, affordability, and awareness.	National Library of Medicine
2.	Effect of Claim Settlement Practices on the Operating Efficiency and Profitability of Life Insurance Companies of India-A Comparative Study of Public and Select Private Sector	• The study examines claim settlement practices of public and private sector life insurance companies in India. • LIC of India is the industry leader in policy sales and benefit payments. • ICICI Prudential Life Insurance performs well among select private sector companies in benefit payments. • Claim settlement practices significantly impact profitability and operating efficiency. • Maintaining optimal claim settlement practices is crucial for market share and profitability.	Asian Journal of Management

3.	Challenges of Using Medical Insurance Claims Data for Utilization Analysis	• Research using insurance claims data has unique challenges and requires value judgments for data quality improvement. • The study combined medical insurance claims from two large companies to assess complementary and alternative medicine utilization. • Challenges included improving data quality, integrating different coding systems, and describing utilization appropriately. • The paper addresses four methodological challenges: converting claims into unique visits, identifying incomplete data, categorizing providers and service locations, and selecting relevant utilization and expenditure measures.	National Library of Medicine
4.	Health Insurance in India: Issues and Challenges	• The health insurance sector in India faces several challenges, including a high Incurred Claims Ratio and skewed distribution of health business. • Limited consumer awareness and lack of product and pricing innovation are additional challenges in the health insurance sector. • Delays and issues in claims processing and pricing also pose challenges for health insurance providers. • Health insurance policies cover medical expenses and are a contract between insurers and individuals or groups. • Privatization of the insurance sector in India, initiated through the Insurance Regulatory and Development Authority (IRDA) bill, has brought significant changes with implications for the health sector.	International Journal of Current Research

5.	Opportunities for Reducing Expenses through Digital Innovation: The Case of an Insurance Company	• Operational inefficiencies increase overhead expenses and affect the quality of insurance companies' offerings. • Insurance companies with high overhead costs often pass on these expenses to customers through higher premiums. • Digital innovation can help reduce expenses and optimize operational functions in insurance companies. • A single case study of an insurance company demonstrates how operational inefficiencies impact customer costs. • The study emphasizes the importance of adopting digital technologies such as AI, chatbots, RPA, blockchain, and IoT in insurance processes. • Innovation in the digital space may result in reduced operating costs and more inexpensive goods and services for consumers.	The African Journal of Information System

CHAPTER – 3

METHODOLOGY

The study was carried out at Care Health Insurance Limited from April to May 2023. This time range enabled a thorough analysis of the international claims department's reimbursement claim processing. By concentrating on this period, the study attempted to gather a representative sample of claims, evaluate the turnaround time, and identify any factors that affected the process during that time. The study's conclusions and analyses offer important new perspectives on the effectiveness and efficiency of processing claims inside the organization during the course of the study period.

Research Questions:

- What are the key steps and procedures involved in the reimbursement claim processing within the International claims department?
- What is the average turnaround time for the reimbursement claim process, from the time of claim submission to the final settlement?
- What are the factors contributing to delays and inefficiencies in the reimbursement claim processing, such as incomplete documentation, system errors, or communication gaps?

AIM: To evaluate the turnaround time of reimbursement claim processing in the International claims department.

OBJECTIVES

- To record the process of health insurance reimbursement claims.
- To assess the turnaround time for reimbursement claim settlement.
- To identify the factors that contribute to delays and inefficiencies in the process.

Study Design:

This research utilizes a cross-sectional observational study design with an analytical approach. The analytical approach provides the analysis of relationships between variables of interest, whereas the cross-sectional design facilitates the collecting of data at a certain point in time.

Sample Size:

The study includes a sample size of 1000 reimbursement claims from the organization. This sample size offers sufficient statistical power and representation to evaluate the handling of reimbursement claims.

Study Setting:

The study was carried out within the organization's international claims department, which processed requests for payment for medical expenses. The goal of the study was to identify the procedures and other elements that affected this department's claim processing turnaround time.

Hypothesis:

The turnaround time of medical reimbursement claim processing in international claims at an insurance company is significantly different from the industry-standard average processing time.

Data Collection Procedure:

The key sources of secondary data for this study was organization's internal databases and management information systems.This involved extracting relevant information related to reimbursement claims, such as claim submission dates, processing timelines, and any associated delays or issues encountered.

All international claims will be processed through the MIS directly, and all claims will be submitted online using the claims live interface. Before a final disposition is determined, each claim will be evaluated in accordance with the existing policy.In the upcoming study, all parameters will be analysed based on their respective values, and each record will be reviewed to determine the turnaround time and other factors related to claims settlement.

Data Analysis:

The collected data will be subjected to comprehensive analysis using appropriate statistical methods and software tools. Descriptive statistics, such as mean and standard deviation, will be calculated to summarize the turnaround time and identify any patterns or trends. Regression analysis or other relevant statistical techniques may be employed to explore the factors influencing the claim processing time.

Ethical Considerations:

The study will adhere to ethical guidelines and regulations to ensure the confidentiality and privacy of the collected data. Any personal or sensitive information will be anonymized and stored securely. Ethical approvals and permissions will be obtained from the appropriate authorities before commencing the study.

CHAPTER – 3

RESULTS

In the reimbursement process, the application process includes different processes. This process can be divided into three categories. Firstly, there are some cases that are approved, which means the claim has been reviewed, required documents and procedures have been completed and the application is considered valid and payment has been made to the customer. Secondly, there are denials that show the request has been carefully examined and it has been determined that it is not qualified for a Payment. Numerous factors, including a lack of knowledge or a failure to adhere to the insurance company's criteria, may be to blame for this. Last but not least, there are some cases that are still being looked into and evaluated. Before a final acceptance or rejection decision can be made, more review, research, or facts are needed in these instances.

By dividing cases into these three types, the repayment cycle aims to ensure that applications are properly evaluated and processed to ensure that benefits are returned fairly and accurately.

Based on data collected from April 1, 2023 to May 31, 2023, the sample size is 1,000 cases. Of these, 358 were rejected, meaning they did not comply with the policy terms and conditions. In addition, 253 cases are pending or in under process stage, indicating that final decision has not been made. On the other hand, 389 cases were recognized, that is, they were reviewed according to the rules set by the Insurance Regulatory and Development Agency (IRDA) and found eligible for reimbursement. This information gives an idea of the classification of cases in the sample and shows results according to IRDA guidelines.

TAT	DENTAL CLAIMS	APPROVED	REJECTED	UNDER PROCESS	PERCENTAGE
0-5 DAYS	102	30	47	25	56.4%
6-10 DAYS	33	5	15	13	18.2%
10-15 DAYS	30	5	15	10	16.6%
15-20 DAYS	10	4	5	1	5.52%
30-45 DAYS	4	1	3	0	2.20%
50-60 DAYS	2	0	2	0	1.10%
TOTAL	181	45	87	49	

TABLE 7.1 Dental Claims Processing As Per TAT

TAT	IN PATIENT CLAIMS	APPROVED	REJECTED	UNDER PROCESS	PERCENTAGE
0-5 DAYS	104	25	30	49	46.01%
6-10 DAYS	50	22	17	11	22.12%
10-15 DAYS	24	10	12	2	10.61%
15-20 DAYS	20	8	9	3	8.84%
30-45 DAYS	18	9	9	0	7.96%
50-60 DAYS	10	6	4	0	4.42%
TOTAL	226	80	81	65	

TABLE 7.2 Inpatient Claims Processing As Per TAT

TAT	OUT PATIENT CLAIMS	APPROVED	REJECTED	UNDER PROCESS	PERCENTAGE
0-5 DAYS	200	80	50	70	40.81%
6-10 DAYS	100	44	36	20	20.40%
10-15 DAYS	95	42	33	20	19.38%
15-20 DAYS	50	20	18	12	10.20%
30-45 DAYS	35	18	15	2	7.14%
50-60 DAYS	10	4	4	2	2.04%
TOTAL	490	208	156	126	

TABLE 7.3 Outpatient Claims Processing As Per TAT

TAT	VISION CLAIMS	APPROVED	REJECTED	UNDER PROCESS	PERCENTAGE
0-5 DAYS	40	25	8	7	38.83%
6-10 DAYS	25	13	8	4	24.27%
10-15 DAYS	17	8	8	1	16.50%
15-20 DAYS	12	5	6	1	11.65%
30-45 DAYS	5	3	2	0	4.85%
50-60 DAYS	4	2	2	0	3.88%
TOTAL	103	56	34	13	

TABLE 7.4 Vision Claims Processing As Per TAT

STATUS	APPROVED	REJECTED	UNDER PROCESS
0-5 DAYS	160	135	151
6-10 DAYS	84	76	48
10-15 DAYS	65	68	24
15-20 DAYS	37	38	17
30-45 DAYS	31	29	2
50-60 DAYS	12	12	0
TOTAL	389	358	242

TABLE 7.5 Overall Claims Processing As Per TAT

DENTAL CLAIMS

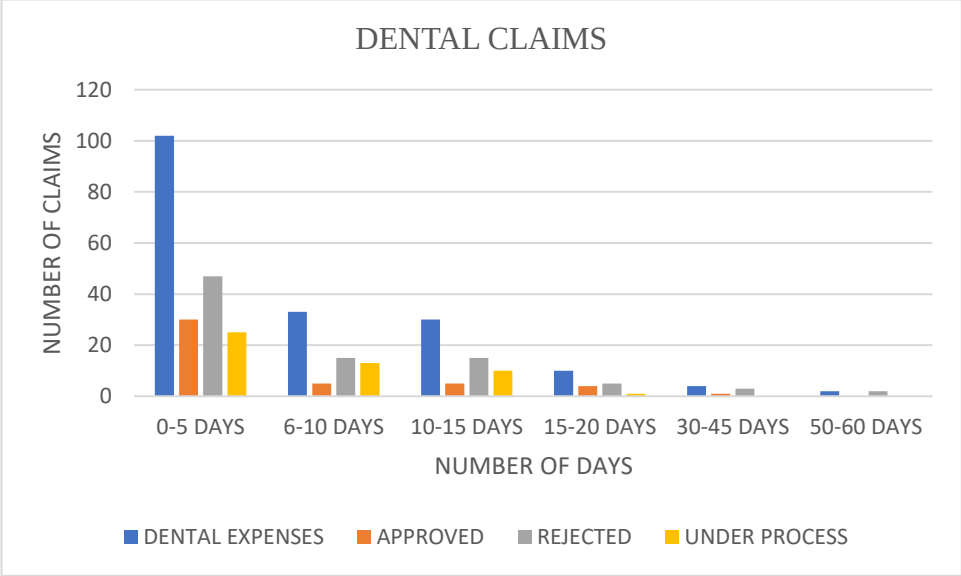

Figure 5- Dental Claims As Per TAT

In this study, a subset of data on dental claims was analysed. Out of a total of 181 dental claims, 48.06% were rejected as they did not meet the criteria for reimbursement. On the other hand, 24.86% applications were approved and deemed eligible for application and reimbursement. Remaining 27.07% applications are pending or suspected, suggesting that further investigation or clarification is required before a final decision can be made.

INPATIENT CLAIMS

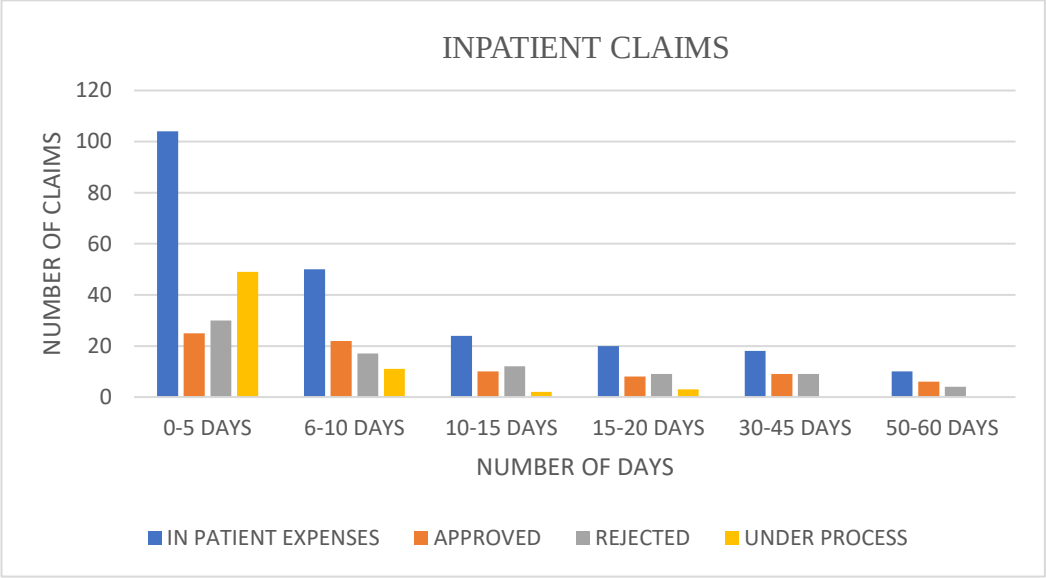

Figure 6- Inpatient Claims As Per TAT

Out of a total of 226 applications reviewed for hospital fees, 35.8% were found ineligible for reimbursement and were therefore rejected. In contrast, 35.3% applications completed the eligibility process and were approved for payment. In addition, 28.7% applications are currently under review or questioned.

OUT PATIENT CLAIMS

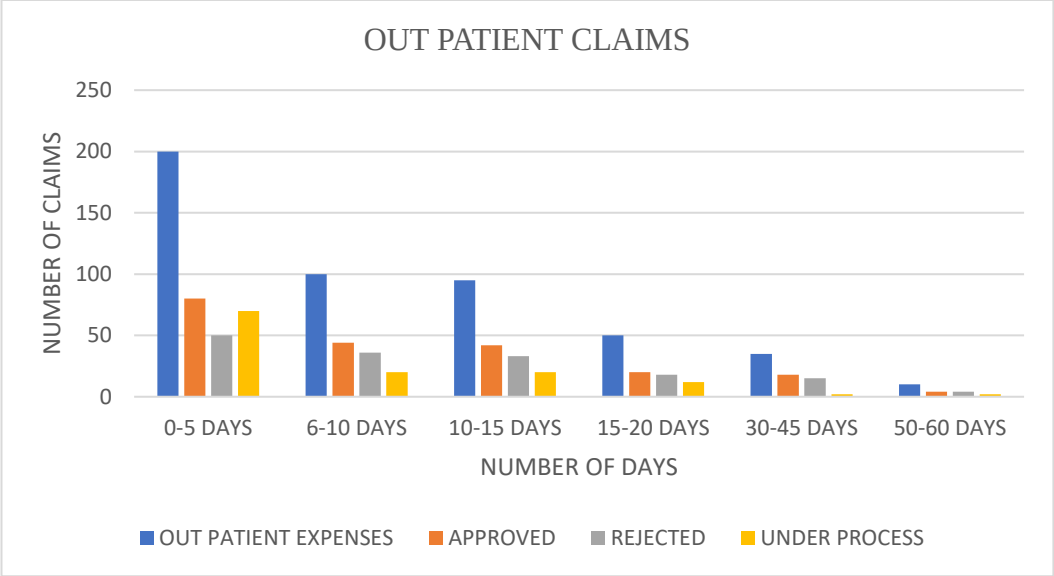

Figure 7- Outpatient Claims As Per TAT

Out of a total of 490 requests reviewed for out-patient or OPD claims, the majority of 31.8% were deemed ineligible for reimbursement and were therefore denied. In contrast, 42.4% applications completed the eligibility process and were approved. In addition, 25.7% applications are currently under review or questioned.

VISION CLAIMS

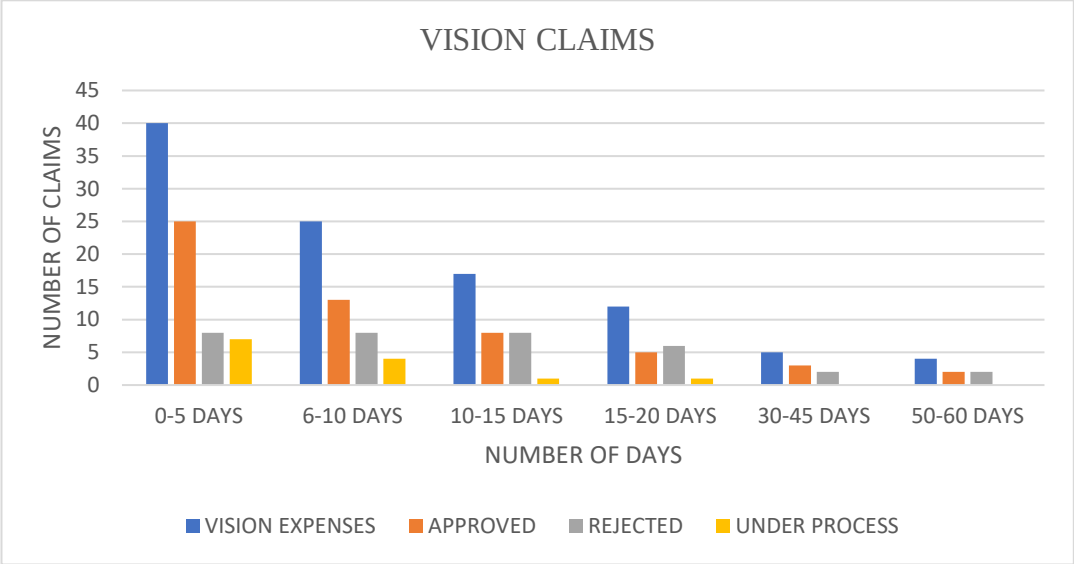

Figure 8- Vision Claims As Per TAT

Out of a total of 103 applications regarding cost of vision, most of the 33% applications were deemed ineligible for reimbursement and subsequently rejected. By comparison, 54.3% applications met the requirements and were approved. In addition, 12.6% applications are still under investigation or raised suspicion, suggesting that further investigation or clarification is needed.

OVERALL CLAIMS

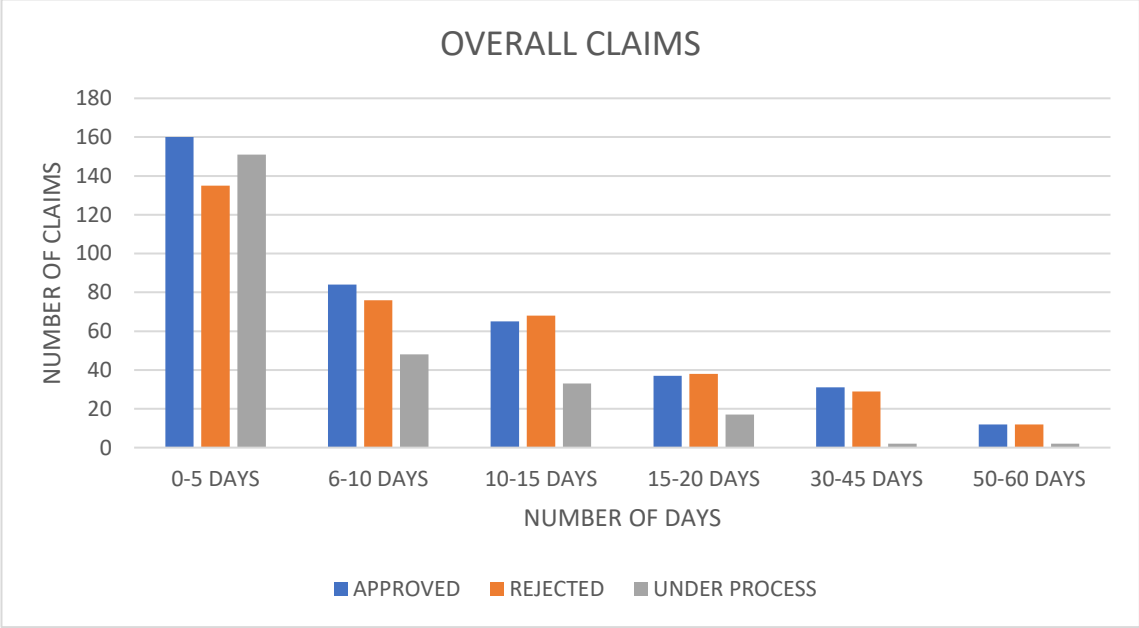

Figure 9- Overall Claims As Per TAT

A total of 1000 applications were examined in this study. A large number of 38.9% of these claims were denied. 35.8% applications were approved by completing the necessary procedures. In addition, 25.3% applications were examined or questioned. The results of the survey provided an overview of the distribution and status of the payment allowing to see the frequency of refusal, approval and current claims tab after review.

- 38.9% of cases were approved. Out of 1000 claims, 389 cases were successfully met the necessary criteria and were approved for reimbursement.

- 35.8% of cases were rejected. Out of 1000 claims, 358 cases were rejected as they didn't meet the criteria as per policy terms and conditions.

- 25.3% of cases were in under process or query raised stage indicating the need for further assessment or clarification.

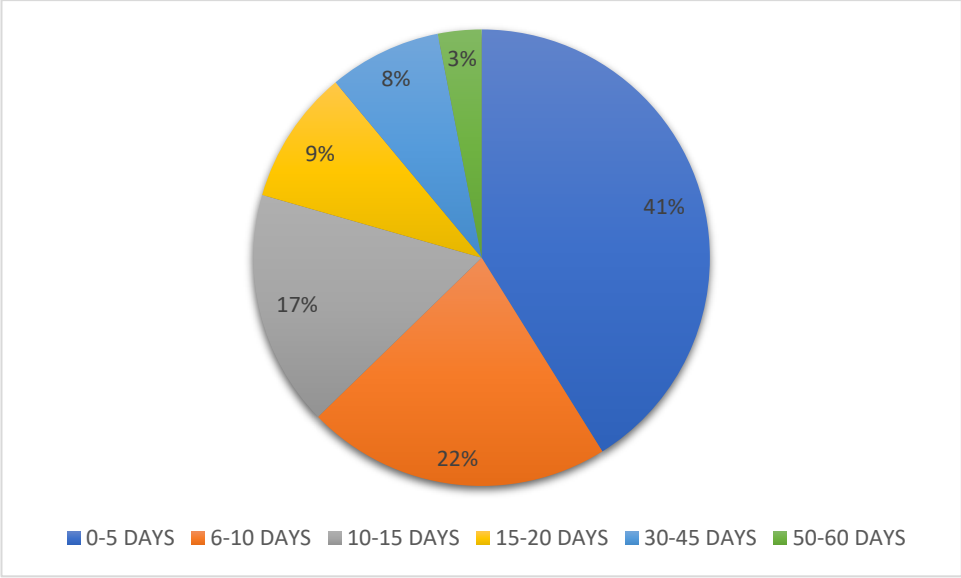

Figure 10- Total Approved Claims As Per TAT

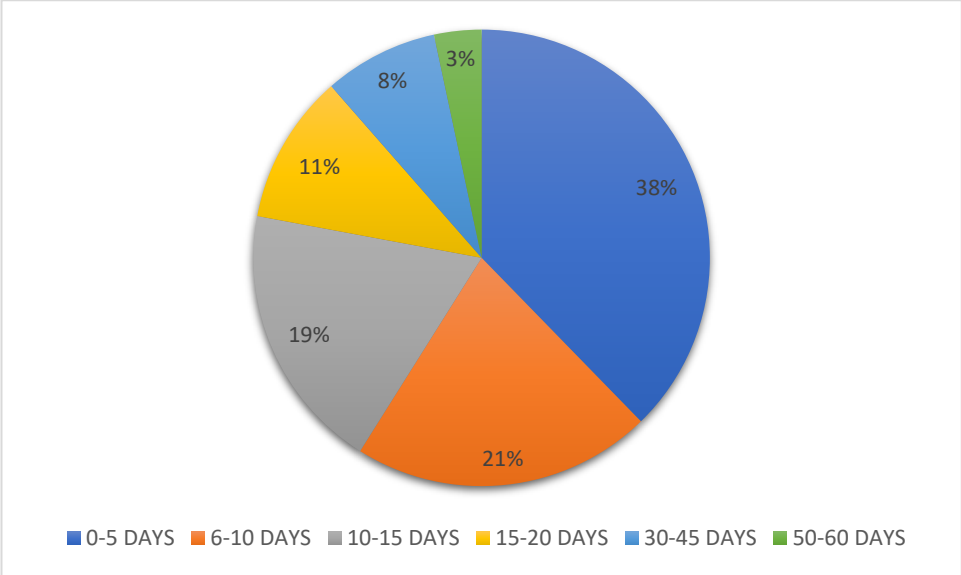

Figure 11- Total Rejected Claims As Per TAT

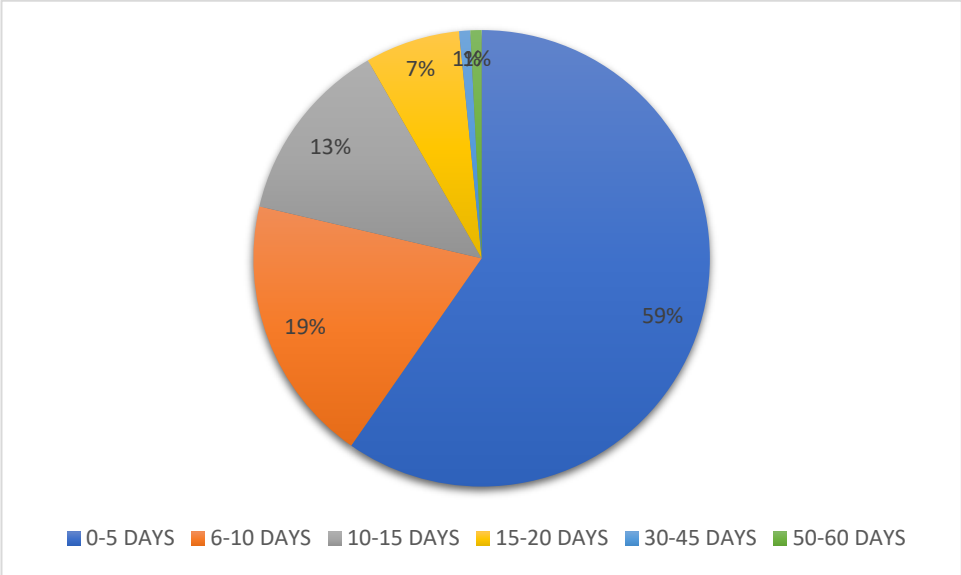

Figure 12- Total Query Raised Claims As Per TAT

CHAPTER - 5

DISCUSSION

FINDINGS OF THIS STUDY:

The findings of the research on the evaluation of turnaround time of reimbursement claim processing in the International claims department are as follows:

- **Dental Claims:** Out of the 181 dental claims analyzed, 87 claims (48%) were rejected, indicating that they did not meet the criteria for reimbursement. On the other hand, 45 claims (25%) were approved and deemed eligible for reimbursement. The remaining 49 claims (27%) are currently under process or have queries raised, suggesting the need for further investigation or clarification.

- **Inpatient Claims:** Among the 226 applications for hospital fees, 81 claims (36%) were found to be ineligible for reimbursement and were therefore rejected. In contrast, 80 claims (35%) successfully completed the eligibility process and were approved for payment. Additionally, 65 claims (29%) are currently under review or have raised queries, indicating the need for further assessment.

- **Out-patient (OPD) Claims:** Out of the 490 reviewed OPD claims, a majority of 156 claims (32%) were deemed ineligible for reimbursement and were consequently denied. On the other hand, 208 claims (42%) successfully completed the eligibility process and were approved. Furthermore, 126 claims (26%) are currently under review or have raised queries, suggesting the need for further investigation or clarification.

- **Vision Claims:** Among the 103 applications related to vision expenses, a significant portion of 34 claims (33%) were deemed ineligible for reimbursement and were therefore rejected. In comparison, 56 claims (54%) met the requirements and were approved. Additionally, 13 claims (13%) are still under investigation or have raised suspicion, indicating the need for further assessment or clarification.

In accordance with Regulation 14 (2) (i) of the IRDAI (Policyholder's Interest) Regulations, 2017, it is mandated that the insurer settles a claim within **30 days** upon receiving all necessary documents, including any requested clarifications. Nevertheless, the insurance company has the flexibility to establish a practice of settling claims even before the specified timeframe.

Status	Number of Claims
Within TAT	663
Outside TAT	337

TABLE 7.6 Number of Claims under TAT

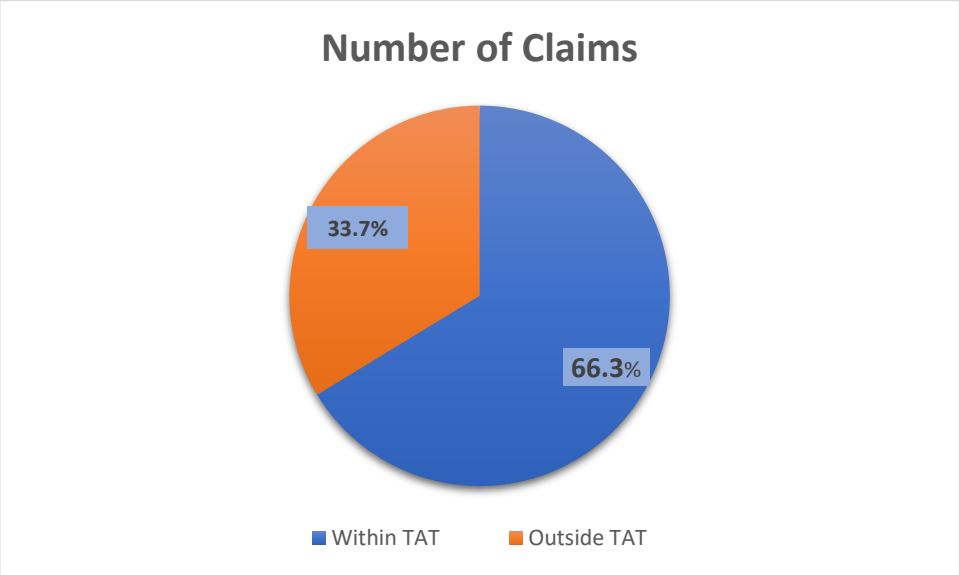

Figure 13- Number of Claims under TAT

The study examined the number of claims processed within the defined turnaround time (TAT) of 30 days, as well as those that exceeded the TAT in the insurance company's International claims department. Out of a total of 1000 claims examined, 663 were resolved within the prescribed TAT and 337 went longer than the benchmark timeframe.

According to this statistics, the department has a high number of claims (66.3%) that are resolved within the anticipated TAT, demonstrating effective claim processing and adherence to the established timeframe. The amount of claims that took longer than the TAT (33.7%), however, emphasizes the need for more analysis and possible modifications in the claim processing workflow to speed up these cases.

In general, the research results reflect the distribution and status of reimbursement claims, including the frequency of claims that have been approved, rejected, or are undergoing review. These results highlight the areas that may need improvement or more research and offer insights into the effectiveness and efficiency of the International claims department's processing of reimbursement claims.

LIMITATIONS

1. Sample size: The study's small sample size may make it harder to extrapolate the results to a wider population.

2. Time constraints: The short duration of the study may place constraints on the scope of the analysis and the capacity to record long-term trends or changes over time.

3. Data availability: The availability and quality of data may vary, which can impact the accuracy and reliability of the study's findings
.
4. External factors: External factors: The study may be influenced by external factors beyond the researchers' control, such as changes in policies, regulations, or market conditions.

5. Selection bias: The study's sample might not accurately reflect the total population, which could result in selection bias and restrict the findings' applicability to a wider population.

6. Data accuracy: The documentation and recording procedures used by the organization, which may contain errors or inconsistencies, determine the accuracy of the data obtained.

7. Resource constraints: The study may face limitations in terms of financial resources, time, and access to information, which could impact the depth and comprehensiveness of the analysis.

8. Lack of qualitative data: The study mainly depends on quantitative information, which may be blind to significant qualitative details and nuances of the processing of reimbursement claims.

9. Human Factors: The study concentrated on the procedural components of processing claims; it did not in-depth examine the influence of human factors, such as employee workload, training, or decision-making procedures. These elements, which could have a substantial impact on claim processing efficiency, call for more research.

10. Scope of Analysis: The study's primary focus was on the turnaround time for processing reimbursement claims; other aspects of the claims management process, such as claim correctness, client satisfaction, or cost-effectiveness, were not thoroughly examined. A more thorough investigation might offer a more complete comprehension of the overall claims management system.

STRENGTHS

1. **Comprehensive methodology:** The cross-sectional observational and analytical design of the study enables a thorough examination of the reimbursement claim procedure in the international claims department.

2. **Inclusion criteria:** The study's emphasis on medical claims helps to focus the investigation and ensures a more specialized examination.

3. **Data collection methods**: The study's use of the management information system (MIS) and direct observation for data collection has improved the validity and reliability of the results.

4. **Research questions:** The study provides insightful information for process improvement by addressing significant research questions on turnaround time, the reimbursement claim procedure, and factors causing delays.

5. **Multidimensional analysis:** The study takes into account different aspects of processing reimbursement claims, like turnaround time and claim status, to give a thorough picture of the procedure.

6. **Practical implications:** The study's conclusions may have applications for the International Claims Department, pointing out potential areas for development and suggesting potential courses of action to boost productivity and speed up turnaround.

7. **Real-world relevance:** The study was carried out in a real organizational context, which increased the findings' applicability to real-world settings.

8. **Scope for further research:** The study can be used as a starting point for future studies in the area that examine additional elements and characteristics that may have an impact on how reimbursement claims are processed.

GAPS

The study on the evaluation of turnaround time of reimbursement claim processing in the International claims department identified several gaps that need to be addressed. These gaps include:

1. Delayed Processing: Prolonged processing times were noted, according to the report, for reimbursement claims. It's possible that this delay will aggravate and upset policyholders who are waiting to get payment for their medical expenses. The overall effectiveness and timeliness of claim processing must be increased by closing this gap.

2. Lack of Transparency: The research findings reveal that there is a lack of transparency in the processing of reimbursement claims. Policyholders may be unaware of the status of their claims or the reasons for claim denials. This chasm can be bridged by improving transparency through regular updates and direct dialogue with policyholders.

3. Inconsistent Evaluation Criteria: Inconsistent Evaluation Criteria: The examination discovered anomalies in the criteria utilised to evaluate reimbursement requests. Different claims may be judged differently, which could lead to policyholder bias or misunderstanding. Fairness and consistency in claim evaluations can be aided by developing standardised and clear evaluation standards.

4. Lack of Documentation: Lack of Documentation: According to the report, good documentation is critical to the effective processing of claims. Claim delays or denials may result from a lack of or insufficient documentation. This gap can be closed by educating policyholders on the necessary documentation and providing direction on how to submit complete, accurate claims.

5. Customer Support and Assistance: The poll results show that better customer support and assistance are required throughout the claim filing procedure. Policyholders may need assistance understanding the claims procedure, supplying the necessary evidence, and responding to any questions or difficulties. This gap can be filled and policyholders' experiences improved by improving customer support services.

Addressing the study's weaknesses will result in a more efficient, transparent, and client-centered approach in the international claims department.

CONCLUSION

- The International Claims Department conducted a research on the turnaround time for reimbursement claims.
- Claims were divided into four categories: dental expenditures, inpatient expenses, outpatient expenses, and vision expenses.
- The study recommends accelerating claim processing, improving transparency, standardizing evaluation criteria, providing documentation guidance, enhancing customer support services, monitoring performance, and continuously improving the process.
- Implementing these suggestions can result in shorter response times, greater efficiency, and higher client satisfaction.
- The study's results and recommendations serve as a platform for future projects and advancements to the claim processing system. • Ongoing research, analysis, assessment, monitoring, and adaptation are required to maintain improvements and satisfy the changing demands of policyholders.

IMPLICATIONS

1. Improvements in reimbursement claim processing can lead to increased patient satisfaction:
   Timely reimbursement of claims is crucial for customer satisfaction. The findings of the study can help organizations identify the causes of delays and put strategies in place to speed up the procedure. Insurers may give their policyholders a better experience by speeding up the turnaround time, which will boost customer loyalty and generate positive word-of-mouth.

2. Improved reimbursement claim processing can lead to better financial outcomes for healthcare organizations and providers:
   Receiving prompt payments can increase cash flow and lessen the administrative effort associated with processing claims, which can be financially advantageous for healthcare organizations and providers.

3. Improved reimbursement claim processing can lead to better overall healthcare outcomes for patient:
   The results of patients' health can be improved by timely payment of medical claims, which can guarantee that patients have access to the appropriate medical services and treatments.

4. Improved reimbursement claim processing can enhance patient trust, loyalty, and engagement:
   Processing reimbursement claims quickly and effectively can increase patient, healthcare provider, and insurance provider trust, which will benefit the healthcare system as a whole.
   Patients may have a higher propensity to stick with healthcare and insurance providers who handle reimbursement claims quickly and effectively, which may boost patient loyalty.

5. Increased efficiency and productivity in reimbursement claim processing can save costs and speed up reimbursements:
   Utilizing techniques to speed up claim processing can cut down on the time and resources needed to process claims, increasing productivity and overall organizational effectiveness.

6. Enhanced compliance with regulations can reduce errors and rejections, leading to more accurate and timely reimbursement:
   Healthcare facilities and insurance companies can lessen the risk of non-compliance and the ensuing fines or other consequences by following the rules and best practices for processing claims.

RECOMMENDATIONS

1. **Streamline Claim Processing**: Take steps to simplify the workflow for processing claims, such as automating repetitive processes, utilising cutting-edge technology, and allocating resources more effectively. This could speed up the processing process and increase productivity.

2. **Enhance Transparency and Communication**: By providing policyholders with clear, intelligible information about how to submit claims, how those claims will be judged, and how things are going, you may improve communication and transparency. Establish effective channels of communication to inform policyholders of the progress of their claims and any additional requirements or actions.

3. **Standardize Evaluation Criteria**: For the review process, standardise evaluation criteria for reimbursement claims to guarantee consistency and fairness. Policyholders and claims evaluators should be provided with clear rules to eliminate ambiguity and promote consistent decision-making.

4. **Enhance Documentation Advice:** Give policyholders detailed documentation advice that identifies the specific documents required for various types of claims. Reduce the likelihood that a claim will be rejected due to a lack of information by providing policyholders with samples and templates to assist them in creating and submitting correct and thorough documentation.

5. **Boost Customer Support Services:** Create a trustworthy system for monitoring and evaluating the effectiveness of processing reimbursement claims. Key performance indicators (KPIs) like customer satisfaction, claim rejection rates, and claim processing timeframes must be watched in order to achieve this. Regularly examine these indicators to identify growth potential and put preventative measures in place to handle any bottlenecks or issues.

6. **Regular Performance Monitoring**: Establish a trustworthy mechanism for tracking and evaluating the effectiveness of processing reimbursement claims. This involves monitoring key performance indicators (KPIs) such customer satisfaction, claim rejection rates, and claim processing times. Analyse these indicators frequently to spot opportunities for development and implement preventative steps to deal with any bottlenecks or problems.

7. **Continuous Process Improvement:** Encourage a culture of ongoing process improvement by actively requesting feedback from policyholders, claims examiners, and other stakeholders. To increase the overall efficiency, accuracy, and satisfaction in claim processing, encourage comments and ideas for process optimisation and put them into practise.

By putting these suggestions into practise, the International Claims Department may work towards a more productive and client-focused approach in the processing of reimbursement claims, thereby enhancing the policyholder experience and assuring prompt and equitable settlement of claims.

REFERENCES

1. Gambhir RS, Malhi R, Khosla S, Singh R, Bhardwaj A, Kumar M. Out-patient coverage: Private sector insurance in India. J Family Med Prim Care [Internet]. 2019 [cited 2023 Jun 1];8(3):788–92. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6482741/

2. Talla NG. Effect of claim settlement practices on the operating efficiency and profitability of life insurance companies of India-A comparative study of public and select private sector. Asian J Manag [Internet]. 2017 [cited 2023 Jun 1];8(4):1207. Available from: https://ajmjournal.com/AbstractView.aspx?PID=2017-8-4-39

3. Tyree PT, Lind BK, Lafferty WE. Challenges of using medical insurance claims data for utilization analysis. Am J Med Qual [Internet]. 2006 [cited 2023 Jun 1];21(4):269–75. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1533763/

4. Itumalla R, Acharyulu GVRK, Kalyan L. Health insurance in India: Issues and challenges health insurance in India: Issues and challenges health insurance in India: Issues and challenges [Internet]. Journalcra.com. [cited 2023 Jun 1]. Available from: https://www.journalcra.com/sites/default/files/issue-pdf/11794.pdf

5. Pillay CP, Kariuki Njenga J, Paper R. Opportunities for reducing expenses through digital innovation: The case of an insurance company [Internet]. Kennesaw.edu. [cited 2023 Jun 1]. Available from: https://digitalcommons.kennesaw.edu/cgi/viewcontent.cgi?article=1822&context=ajis

6. Park Y-T, Yoon J-S, Speedie SM, Yoon H, Lee J. Health insurance claim review using information technologies. Health Inform Res [Internet]. 2012 [cited 2023 Jun 1];18(3):215–24. Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3483480/