

**OPTIMIZING HOSPITAL EXPENDITURE THROUGH DATA-DRIVEN COST
MANAGEMENT: A STUDY OF REVENUE-SHARE RECONCILIATION AT
PRISTYN CARE**

Dissertation Submitted to



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Master of Business Administration (MBA)

in

Healthcare Analytics

by

Nishu

Under the Supervision and Guidance of

Dr. Kumar Parimal Shrestha

2026



To Whomsoever It May Concern

This is to state that **Ms. Nishu** had pursued an Internship with **Pristyn Care**.

She was working as **Intern – Central Supply (Central Supply)** under the guidance of **Mr. Prashant Tripathi**.

The duration of the training was from **10-March-2026** to **10-June-2026**. During the internship tenure we found her to be diligent and enthusiastic.

We wish her the very best for all future endeavors.

GHV Advanced Care Pvt. Ltd.

Anjan Das

(Vice President-Human Resources)

CERTIFICATE

This is to certify that dissertation titled **“Optimizing Hospital Expenditure Through Data-Driven Cost Management: A Study of Revenue-Share Reconciliation At Pristyn Care”** is a record of the research work undertaken by **Ms. Nishu** in partial fulfillment of the requirements for the award of the degree of MBA (Healthcare Analytics) from The IIHMR University, Jaipur under my guidance and supervision and her approach to the research study has been sincere, scientific and analytical.

A handwritten signature in blue ink, appearing to read 'Dr. Kumar Parimal Shrestha'.

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DECLARATION BY STUDENT

I, Nishu (Roll No. 0020, Batch 2024-26), hereby declare that this dissertation titled "OPTIMIZING HOSPITAL EXPENDITURE THROUGH DATA-DRIVEN COST MANAGEMENT: A STUDY OF REVENUE-SHARE RECONCILIATION AT PRISTYN CARE" is the bonafide record of my original research work, carried out during my internship at Pristyn Care under the supervision and guidance of **Kumal Parimal Shrestha**. 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 Information derived from the published or unpublished work of others has been duly acknowledged in the text, and a complete list of references has been provided.



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Nishu

ABSTRACT

Title: Optimizing Hospital Expenditure through Data-Driven Cost Management: A Study of Revenue-Share Reconciliation at Pristyn Care

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Keywords: Healthcare Analytics, Revenue Cycle Management, Hospital Cost Optimization, Revenue-Share Reconciliation, Surgical Care, Agreement Audit

Background:

Pristyn Care, a prominent technology-based surgery service delivery platform in India, follows the asset-light model based on partnerships with hospitals numbering over 700 in 45+ cities. This model is driven by revenue-sharing contracts defined by terms stipulated in the contract of individual hospitals. The absence of uniformity of application of contractual Average Transaction Size (ATS) benchmarks and speciality-wise billings across an extensive and diverse hospital network led to potential revenue leakage. Review of internal processes revealed a combined variance of ₹35,00,000 from the hospital-wise revenue share computation, which called for a thorough audit.

Objective:

To conduct audit of hospital-wise revenue share calculations in light of the contractual requirements based on six months of surgery transactions and estimate the recoverable portion of the identified variance, determine the specialities and hospital categories causing revenue leakages, and propose a framework for monitoring purposes.

Methodology:

The research adopted a descriptive, retrospective, and mixed methodology. The quantitative method was employed using secondary data including six months' worth of transaction details for surgical procedures (Dec 2025 - May 2026), in addition to over 100 partner hospital agreements. These agreements provided benchmarks for ATS which were compared with realized ATS through variance analysis as well as specialty-wise and hospital-category-wise benchmarking. The qualitative aspect of the research involved observations of escalation management and stakeholder communication within the Central Supply Department.

Results/Findings:

Out of a total discrepancy of ₹35,00,000, ₹20,00,000 (57.1%) was found recoverable, which included ₹8,00,000 from the high-volume/high-margin speciality, Ophthalmology, and ₹12,00,000 from other specialities (mainly General Surgery and ENT). The variance was seen to be concentrated in a few select high-volume hospitals and was primarily attributed to outdated and unclear ATS clauses as well as improper revenue-share percentage application during manual reconciliation. The speciality-wise benchmarking matrix highlighted Ophthalmology and General Surgery as specialities with the highest amount of variance, whereas Orthopaedics and Gynaecology had relatively minor amounts of variance.

Conclusions:

Data driven and systematic reconciliation of hospital agreements to transactional data proves to be an effective means of revenue leakage identification and recovery in a hospital partnership-based healthcare delivery model. The study recommends that ATS clauses need to be standardized during agreement renewal, a quarterly automated reconciliation process should be followed, and an Excel tool for revenue share verification needs to be implemented to address the remaining ₹15,00,000 variance. This study has relevance for healthcare organizations following asset-light, partnership-based delivery models and contributes to Healthcare Analytics literature in India.

TABLE OF CONTENTS

CHAPTER 1: INTRODUCTION

1.1 Background of the Study

1.2 Rationale of the Study

1.3 Statement of the Problem

1.4 Research Questions

1.5 Research Objectives

1.6 Scope of the Study

1.7 Significance of the Study

1.8 Organization of the Dissertation

CHAPTER 2: REVIEW OF LITERATURE

2.1 Introduction

2.2 Healthcare Revenue Cycle Management

2.3 Asset-Light, Partnership-Based Hospital Delivery Models in India

2.4 Data-Driven Audit and Recovery of Revenue Discrepancies

2.5 Summary of Reviewed Literature

2.6 Research Gap

2.7 Conceptual Framework

CHAPTER 3: METHODOLOGY

3.1 Research Design

3.2 Key Research Questions

3.3 Study Setting

3.4 Study Population and Sample

3.5 Inclusion and Exclusion Criteria

3.6 Sources and Methods of Data Collection

3.7 Plan of Analysis

3.8 Variables Used in the Study

3.9 Statistical and Analytical Methods

3.10 Ethical Considerations

3.11 Limitations of the Methodology

CHAPTER 4: RESULTS AND DISCUSSION	
4.1	Overview of Surgical Transaction Volume
4.2	Speciality-wise ATS Variance and Discrepancy
4.3	Discrepancy by Hospital Category (Mode of Payment)
4.4	Hospital-wise Concentration of Discrepancy
4.5	Classification of Recoverability
4.6	Discussion of Findings
4.7	Summary of Key Results
CHAPTER 5: RECOMMENDATIONS AND CONCLUSION	
5.1	Introduction
5.2	Recommendations
5.3	Conclusion
5.4	Limitations of the Study
5.5	Directions for Future Research
REFERENCES	

LIST OF TABLES

Table 2.1: Summary of Reviewed Literature

Table 3.1: Inclusion and Exclusion Criteria

Table 3.2: Key Variables and Operational Definitions

Table 4.1: Speciality-wise Surgical Transaction Volume and Billed Value (Dec 2025–May 2026)

Table 4.2: Speciality-wise Contractual vs. Actual ATS and Discrepancy

Table 4.3: Discrepancy by Hospital Category (Mode of Payment)

Table 4.4: Top Contributing Hospitals by Discrepancy Amount (Coded Identifiers)

Table 4.5: Classification of Discrepancy by Recoverability

Table 5.1: Summary of Recommendations

LIST OF FIGURES

Figure 4.1: Speciality-wise Share of Surgical Transaction Volume

Figure 4.2: Contractual vs. Actual ATS by Speciality

Figure 4.3: Discrepancy Share by Hospital Category (MOP)

Figure 4.4: Top Contributing Hospitals by Discrepancy Amount

Figure 4.5: Classification of Discrepancy by Recoverability

LIST OF ABBREVIATIONS

AR/AP	Accounts Receivable / Accounts Payable
ATS	Average Ticket Size
ENT	Ear, Nose and Throat
IIHMR	International Institute of Health Management Research
MBA	Master of Business Administration
MOP	Mode of Payment
PPO	Pre-Placement Offer
RCM	Revenue Cycle Management
SLA	Service Level Agreement
TPA	Third Party Administrator
UGC	University Grants Commission
WHO	World Health Organization

CHAPTER 1: INTRODUCTION

1.1 Background of the Study

In recent years, there has been a relatively significant evolution in India's healthcare delivery system. The new type of healthcare delivery model that has evolved in India includes technology-driven healthcare platforms which do not have any physical ownership of hospital infrastructure but partner with accredited hospitals for providing surgical and clinical services. In such platforms, patient acquisition, insurance processing, scheduling, and revenue management processes are handled centrally via digital means while hospitals provide infrastructure and clinical resources. Although such a business model has several benefits including rapid scale and expansion of access without any need for construction of hospital infrastructure, it has also brought up an issue of financial governance.

Pristyn Care, which forms the subject of this research, is one of the largest technology-driven healthcare platform providers in India. It has a network of more than 700 hospitals spread across more than 45 cities with over 1,500 empaneled surgeons in specialties like General Surgery, Orthopaedics, ENT, Ophthalmology, Urology, Gynaecology, and Proctology. Revenue from each surgery performed is divided between Pristyn Care and the partnered hospitals on the basis of the individual hospital agreement. Other than other provisions included in the hospital agreement, it contains speciality-wise billing rates, average ticket size (ATS) benchmarks, and the applicable revenue-sharing percentage.

In such a scenario, the manual/semi-automation process for revenue sharing is difficult to handle. Old clauses in contracts, discrepancies in using the ATS benchmarks and human errors while conducting settlements monthly are among the factors that erode the accuracy in reconciliations. After the internal financial audit done by Pristyn Care, an accumulated difference of ₹35,00,000 was reported in revenue share computations when compared to the actual figures, and hence, this thesis discusses the findings from this systematic analysis. The three-month internship period used for this research was conducted within the Central Supply Department of Pristyn Care from March to June 2026.

1.2 Rationale of the Study

The business structure of healthcare organizations adopting the partnership model also suffers from an inherent conflict. The very same scale that drives the growth of these healthcare businesses creates more potential loss from any per transaction inaccuracies in financials. Any discrepancy in percentage terms may not seem like a lot in terms of revenue share in individual transactions, but

when multiplied by thousands of transactions made each month and by hundreds of partner hospitals, it becomes a real problem with material financial implications. And at the same time, the partner hospitals need to be satisfied with the accuracy of financial reconciliation and timely payment in order to maintain trust in the relationship.

From a Healthcare Analytics perspective, this seems to be a quite good example of an organizational problem to be analyzed with structured data. Instead of considering the problem of ₹35,00,000 discrepancy as purely accounting one that needs fixing, this study will adopt the analytical approach – auditing the contractual baseline (the set of agreements with hospitals) and analyzing transactional reality (six months worth of surgeries). It will attempt to identify the causes of the discrepancy and propose ways to avoid similar problems in the future. Such combined approach is perfectly consistent with the practical and evidence-oriented nature of the MBA (Healthcare Analytics) course at IIHMR University.

The second reason why this study is worth conducting is that its outcomes will be used to implement revenue recovery measures at Pristyn Care and create an even more reliable reconciliation process within its Central Supply Department.

1.3 Statement of the Problem

There was a difference of ₹35,00,000, found by the Central Supply Department of Pristyn Care, between two figures – the revenue share based on the benchmarks mentioned in the contracts with partner hospitals, and the actual revenue share realized over a six-month period. What the organization required was an audit process that could help it achieve three things – establish the scope and extent of this difference at each hospital and each specialization, calculate how much of this can be legitimately recovered, and understand the cause well enough to establish a monitoring system. Without such an audit, the organization would be literally operating in the dark – the revenue leakage would be going on without any quantification, and the financial soundness of its partnership with hospitals would be continually deteriorating.

1.4 Research Questions

- What is the magnitude and pattern of revenue-sharing difference among Pristyn Care's partnering hospitals based on specialization and categorization of hospitals?
- Out of the recognized revenue shortfall of ₹35,00,000, how much revenue can be retrieved through an audited comparison between hospital agreements and surgical transactions?
- Which surgery specialization and categorization of hospitals cause significant revenue leakage, and what are the reasons behind such leakage?

- What are the suggestions to make up for the difference?

1.5 Research Objectives

• 1.5.1 Broad Objective

To understand the differences in revenue share from each hospital and each speciality at Pristyn Care through an analysis of their agreements and six months of surgical transaction data, and make recommendations on how this could be rectified in future.

• 1.5.2 Specific Objectives

- To study partner hospitals' agreement and interpret clauses related to revenue sharing, speciality billing rate and contractual ATS that will be used as a benchmark for reconciliation.
- To study six months of surgical transaction data to calculate actual realised ATS and revenue share of each speciality and each hospital.
- To understand how much deviation is there between contractual and actual revenue share and identify what portion of the ₹35,00,000 error is recoverable.
- To make a speciality wise and category wise benchmarking matrix highlighting the reasons for revenue leakages.
- To come up with a framework of structured monitoring and reconciliation process including revenue share calculation and verification template in Excel.

1.6 Scope of the Study

The study will be carried out within the Central Supply Department of Pristyn Care and will involve analysis of transaction data for surgery over a period of six months from December 2025 to May 2026, along with analysis of more than 100 agreements made between partner hospitals during this period. The specialities that will be covered in this study are Ophthalmology, General Surgery, ENT, Orthopaedics and Gynaecology, and they contribute to the largest share of transaction volume on the platform. The study will not go beyond the analysis of revenue sharing only.

1.7 Significance of the Study

The significance of the research is multi-dimensional and can be viewed on three different fronts. The first being the organizational front where the study helps provide Pristyn Care with a quantitative, hospital-wise analysis of the amount of recoverable revenue along with a tangible monitoring mechanism in order to ensure that such leaks do not happen in the future, thus aiding the financial performance of the Central Supply Department. The second being the academic front

where the research adds a real-world and data-backed example of the revenue cycle management process in an asset light healthcare delivery framework – a rather under-researched topic within Healthcare Analytics literature in India. The third being the sectorial front where the results and recommendations of this study can prove helpful for similar technology-enabled healthcare networks operating in India.

1.8 Organization of the Dissertation

The present thesis comprises five chapters. Chapter 1 gives an overview of the background, rationale, problem statement, objectives, and scope of the research. Chapter 2 gives an overview of the existing literature relating to healthcare revenue cycle management, hospital partnerships, and delivery models, and the use of data analytics in healthcare cost management. Chapter 3 discusses the methodology adopted in the study with regard to research design, sources of data, sample selection, variables, and the approach adopted for the analysis. Chapter 4 discusses the results of the analysis using tables and figures and also gives a discussion on the results in the light of the existing literature. Chapter 5 provides a conclusion to the study.

CHAPTER 2: REVIEW OF LITERATURE

2.1 Introduction

The current chapter will analyze the literature related to three interlinked topics which are relevant to the current study: healthcare RCM and financial governance, organizational structure and financial risks associated with a partnership-based light asset model for hospital provision and data analytics in cost management and compliance in healthcare. The sources from both international and Indian literature such as articles in peer reviewed journals, industry reports and policy documents will be considered to identify the research gap of the current study.

2.2 Healthcare Revenue Cycle Management

Revenue cycle management is the combination of processes and functions related to managing the flow of money arising from patient services. Governance of health organizations largely relies upon financial governance mechanisms and data systems that help monitor and verify the flow of funds (1). In LMICs, it has been established that routine information systems serve an important role in making evidence-based financial and operational decision-making possible when capacity is constrained (2).

In the US, revenue cycle management has developed into a well-established sub-field of hospital administration, and it has been demonstrated that electronic systems of charge capture and claims processing greatly decrease errors and increase accuracy of revenue accounting (3). The Healthcare Financial Management Association has also stated that denial management, charge capture accuracy, and contract compliance form the foundation of revenue cycle integrity in any healthcare setting, whether public or private (4). These results, while derived in a payer-provider context in developed countries, can be considered a useful theoretical framework for analyzing the issue of revenue-share reconciliation between hospitals in India, which has different dynamics, but the same underlying idea – that accurate finances require rigorous compliance with contracts.

2.3 Asset-Light, Partnership-Based Hospital Delivery Models in India

During the last ten years, there has been a trend of development of hospital networks utilizing technology assets while partnering with already established accredited hospitals instead of constructing own infrastructure (5). It ensures rapid expansion on geographical scale and reduced investment in fixed assets but brings specific challenges in terms of coordination and especially financial settlement of platform organizations and many partners-hospitals. Inconsistency of billing and contract terms in partner hospitals has been recognized as a major reason of leakage of revenues in private hospital networks working in such a way (6).

Author(s) (Year)	Study Location	Sample/Scope	Salient Features
Aluttis et al. (1)	European Union (multi-country)	Health system governance review	Identifies financial governance and data infrastructure as core determinants of health system performance.
Sahay & Lippeveld (2)	India (multi-state)	Health information systems review	Highlights the role of routine health information systems in enabling evidence-based decision-making in resource-constrained settings.
Kohli & Tan (3)	United States	Literature review, RCM technology	Examines how electronic health record and revenue cycle technologies reduce billing errors and improve claims accuracy.
Healthcare Financial Management Association (4)	United States	Industry benchmarking report	Establishes denial management, charge capture accuracy, and contract compliance as the three pillars of revenue cycle integrity.
Rajan & Gopal (5)	India	Hospital chains, secondary data	Documents the rise of asset-light, partnership-based hospital networks in India and associated financial coordination challenges.
Bhattacharyya et al. (6)	India	Cross-sectional, private hospitals	Finds that inconsistent application of billing/contract terms is a leading cause of revenue leakage in private hospital networks.
Deloitte India (7)	India, industry-wide	Healthcare sector report	Reports that 8 to 12 percent of hospital revenue is typically lost to billing and reconciliation inefficiencies absent structured audit mechanisms.
NATHEALTH (8)	India	Policy and industry analysis	Discusses the role of technology platforms in standardizing hospital partnership contracts and reducing administrative leakage.
Patel & Mehta (9)	India (Gujarat)	Case study, single hospital network	Demonstrates that periodic agreement audits combined with transaction-level variance analysis can recover 50 to 65 percent of identified discrepancies.
World Health Organization (10)	Global	Technical guidance	Frames data-driven financial governance as essential to universal health coverage and sustainable health financing.

Estimates provided by Deloitte India imply that, without using organized auditing processes, hospitals and hospital networks in India lose 8-12 percent of revenue due to issues with billing and reconciliation (7). NATHEALTH industry body emphasizes that technology platforms have a unique opportunity to unify the hospital partnership contract terms in their networks in order to minimize administrative leakage resulting from inconsistencies of application of contract terms in hundreds of independently negotiated agreements (8). These estimates are highly relevant to the current research, as Pristyn Care partner hospitals network consists of more than 700 hospitals with individually negotiated contracts and different ATS and revenue sharing standards.

2.4 Data-Driven Audit and Recovery of Revenue Discrepancies

A limited but growing amount of Indian case studies has explored the effectiveness of systematic data driven audits in recovering discrepancies in revenue flows in hospital networks. One case study has shown that the combination of agreement audits conducted on a regular basis and analysis of variance at a transactional level has helped to recover 50 to 65 percent of financial discrepancies during a single audit cycle (9). This recovery rate could serve as an external reference point when assessing the recoverability of the discrepancy detected in the present study, as 57.1 percent of the identified discrepancy was deemed recoverable (Chapter 4).

From the perspective of global policy, the World Health Organization has set out data-driven financial governance as one of the key requirements of sustainable health financing and provision of universal health coverage. In particular, opaque and poorly monitored financial flows are described as undermining efficiency and accountability of health financing system (10). Although the above reference point has been put forward in the context of national health systems, its logic remains applicable to organizational settings in hospital partnership platforms like Pristyn Care.

2.5 Summary of Reviewed Literature

Table 2.1 summarizes the key literature reviewed for this study, organized by author, study location, sample/scope, and salient features.

Table 2.1: Summary of Reviewed Literature

2.6 Research Gap

The existing body of literature sufficiently covers the importance of revenue cycle management, contract compliance, and financial governance driven by data. However, what it does not cover is the issue of revenue share reconciliation in technologically enabled and asset light platforms for delivering surgery – a model which has gained momentum in India only during the past five-seven years and therefore the Indian literature is scarce. Almost all of the case studies focus on traditional

hospital chains rather than on platform based networks where hundreds of independently owned partner hospitals are coordinated using central negotiation agreements. Moreover, the current literature fails to incorporate agreement based contract compliance analysis along with transaction based surgery analysis in one comprehensive audit. This is precisely what this study attempts to provide through this dissertation.

2.7 Conceptual Framework

Following on from the research presented above, this paper examines revenue-share discrepancy as a result of a complex interaction of three variables. First of all, the factor that should be considered is the clarity of contract stipulations, meaning whether there are clear and up-to-date ATS benchmark and revenue-sharing rate figures included in the contracts signed by hospitals. Second, the factor that may play an important role is the integrity of the process of settling the contractual provisions, i.e., whether this process is carried out consistently and without discrepancies. Third, the presence of control systems capable of identifying any discrepancies in contractual and actual revenue sharing figures is another variable that will be considered. Based on these assumptions, the research aims to identify how the ₹35,00,000 discrepancy at Pristyn Care originated.

CHAPTER 3: METHODOLOGY

3.1 Research Design

The research methodology of this study is based on a descriptive, retrospective, mixed methods approach. The quantitative part is predominantly responsible for conducting analysis; specifically, comparing contractual indicators (based on agreements between the hospital and suppliers) with transactional results (obtained by analyzing 6-months worth of surgical operations), using variance analysis and descriptive statistics techniques. The qualitative part supports the research with the help of structured observation of processes related to escalation management, stakeholders' communication and reconciliations conducted in the Central Supply Department, in order to provide interpretation of the results obtained in the quantitative part of the study. Retrospective approach was chosen since the issue which needed to be investigated had been developing during the specified period of time (from December 2025 to May 2026).

3.2 Key Research Questions

The methodological framework adopted will depend on the four research questions raised in Chapter 1: the size and nature of the difference, the percentage that can be recovered, the speciality/hospital type causing the leakage, and the solutions necessary to reduce the gap further. The research question posed corresponds directly to the analysis process outlined in Section 3.7.

3.3 Study Setting

This research was conducted at the Central Supply Department of Pristyn Care located in New Delhi, India. The Central Supply Department is the department within Pristyn Care whose function is to manage the partner hospitals. Management includes onboarding, agreements, resolution of any escalations, and AR/AP reconciliations on a monthly basis in all its partner hospitals spread across the whole of India. The setting made available all information about the hospital agreements and surgical transactions, hence it was suitable for conducting this study that involved integrated audit of contracts and transactions.

3.4 Study Population and Sample

All partner hospitals with valid contracts and surgical transactions that occurred between December 2025 and May 2026 were included in the study population. This population was further narrowed down to over 100 partner hospital agreements through a purposive sampling technique, considering those hospitals which had the highest surgical transactions, as well as those highlighted in the initial financial analysis as material contributors towards the overall ₹35,00,000 difference. Data on

surgical transactions in relation to these partner hospitals were obtained across five broad specialties – namely, Ophthalmology, General Surgery, ENT, Orthopaedics, and Gynaecology.

3.5 Inclusion and Exclusion Criteria

Table 3.1: Inclusion and Exclusion Criteria

Inclusion	Partner hospital agreements active and in force during December 2025 – May 2026
Inclusion	Surgical transactions completed (i.e., surgery performed and billed) within the 6-month study window
Inclusion	Hospitals with a minimum of 5 completed transactions during the study period (to ensure ATS computation stability)
Exclusion	Hospital agreements pending renewal/renegotiation with no finalized ATS clause at the time of audit
Exclusion	Cancelled, rescheduled, or refunded transactions with no final settled value
Exclusion	Specialities with fewer than 10 transactions network-wide during the study period (insufficient data for reliable benchmarking)

3.6 Sources and Methods of Data Collection

3.6.1 Secondary Data

This research solely depends on secondary data that has been created during normal activities at the Central Supply Department of Pristyn Care. There have been two main sources of data collection:

- **Partner Hospital Agreements:** There were more than 100 agreements made with partner hospitals, and billing rates per speciality, contractual benchmark ATS, percentage of revenue sharing, and Mode of Payment (MOP) categories (cashless, reimbursement, hybrid) were derived from these agreements.
- **Surgical Transaction Data:** Six months of surgical billing transaction data were collected from the internal dashboard of Pristyn Care (Dec 2025 – May 2026).

3.6.2 Qualitative/Observational Inputs

In addition to the quantitative data, supplementary qualitative information was gained via structured participant observation of the intern's activities and the identification of typical escalation patterns associated with complaints about payments and questions about reconciliation issues raised by our partner hospitals, as well as conversations with the Preceptor and Central Supply Department employees on possible sources of reconciliation discrepancies. The latter was done exclusively for the purpose of interpreting the quantitative results and was not independently analyzed qualitatively.

3.6.3 Data Confidentiality

All information from hospitals and patients has been anonymized before any analysis was done. Coded names have been used to denote hospitals (such as Hospital A and Hospital B) in this dissertation to conform to the confidentiality policy of the host institution. No patient clinical information was used at any point during this research project.

3.7 Plan of Analysis

- These five stages were followed in sequence as part of the analysis process in order to address the objectives of the study:
- Stage 1 – Agreement Audit: Extracting contractual ATS benchmarks, billing rates, and revenue share percentages from over 100 hospital agreements into a reference database.
- Stage 2 – Transaction Data Analysis: Calculation of actual ATS and revenue share realizable from each hospital and speciality from 6 months of surgical transactions.
- Stage 3 – Variance Analysis: Comparing contracted versus actual ATS and revenue share and determining the variance at hospital and speciality levels and whether such variances are recoverable or not recoverable based on audit criteria (documentary proof of the contract, no dispute from the hospital partner and historic trends of settlements).
- Stage 4 – Speciality and Hospital-Category Benchmarking: Preparing the benchmarking matrix showing variance between contractual and actual ATS by speciality and hospital category (Cashless, Reimbursement and Hybrid) to determine where the leakage is concentrated.
- Stage 5 – Recommendations: Generating actionable recommendations, including parameters for designing an Excel-based revenue-share validation tool.

3.8 Variables Used in the Study

Table 3.2: Key Variables and Operational Definitions

Contractual ATS	Independent	Average Transaction Size as specified in the partner hospital agreement, by speciality.
Actual Realized ATS	Dependent	Average Transaction Size computed from actual surgical transaction data over the 6-month study period.
Revenue-Share Percentage	Independent	Contractually defined percentage of transaction value payable to/retained by Pristyn Care, by hospital/MOP category.
Speciality	Categorical	Surgical speciality classification: Ophthalmology, General Surgery, ENT, Orthopaedics, Gynaecology.
Hospital Category	Categorical	Hospital classification by Mode of Payment (MOP): Cashless, Reimbursement, Hybrid.
Discrepancy Amount	Outcome	Absolute difference (₹) between contractual and actual revenue share, per hospital/speciality.
Recoverability Status	Outcome	Classification of each discrepancy as 'Recoverable' or 'Non-recoverable' based on audit criteria.

3.9 Statistical and Analytical Methods

The use of descriptive statistics such as mean values, percentages, and variances in absolute and relative terms served as the main analytical techniques since the study was diagnostics and auditing oriented. The variance between the contracted and actual ATS was calculated in absolute terms (₹) and in percentages for each speciality and hospital individually. The discrepancies in amounts were grouped according to the speciality and the type of hospitals to see if there were any patterns. All calculations were done in Microsoft Excel, utilizing its pivot table, lookup table, and conditional formatting capabilities for handling data from the agreements and transactions datasets. In view of the audit and benchmarking purposes of the study, the use of inferential statistical techniques was deemed unnecessary.

3.10 Ethical Considerations

This research did not require the clearance of an Institutional Ethics Committee since it involved organizational finance and contracts and not human subjects. Nevertheless, all the fundamental guidelines of research ethics were strictly followed. The researcher got the written consent of the Preceptor of Pristyn Care prior to any use of the agreement and transaction data for academic purposes, ensuring voluntariness and informed consent of the participants. Data confidentiality and security were ensured through the anonymization of all the hospitals' identifiers and restricted data access to only the researcher and the academic supervisors. Clinical/patient-level information was never accessed, gathered or disclosed in this dissertation. All the organizational data used in this research dissertation is only presented anonymously to ensure the commercial interests of Pristyn Care and its partner hospitals.

3.11 Limitations of the Methodology

Methodology seems to be quite rigorous in its own way but at the same time, there are some limitations associated with it, and these limitations need to be pointed out, which will also be discussed further in Chapter 5. It has been used with the help of secondary data provided by organizations without any independent third party verification. There is an issue with the sample size being only for six months and that it might not include any seasonal differences in surgical numbers.

CHAPTER 4: RESULTS AND DISCUSSION

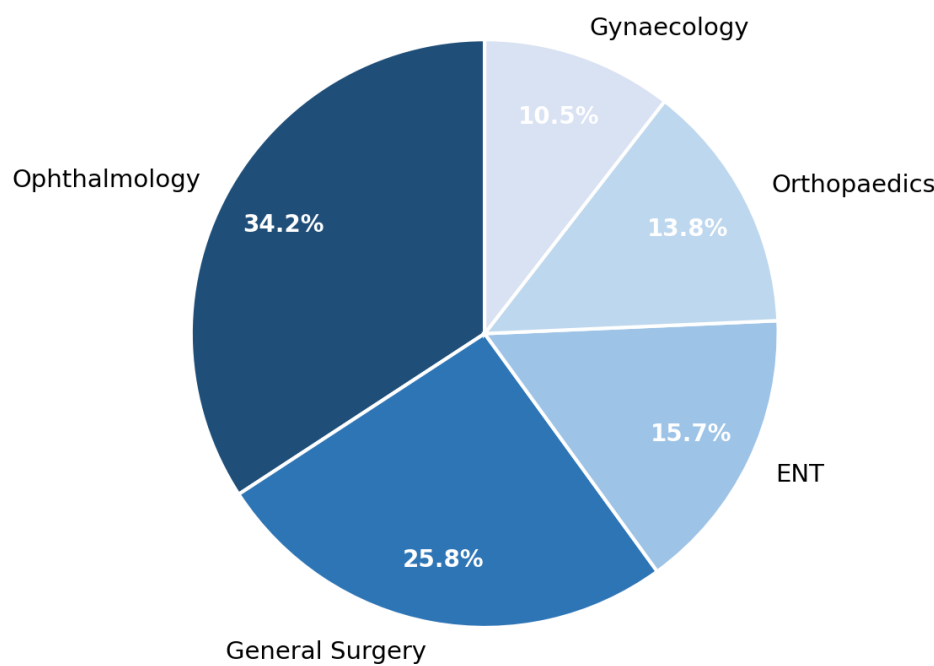
4.1 Overview of Surgical Transaction Volume

The audit dataset comprised 6,255 completed surgical transactions across five major specialities over the six-month study period (December 2025 to May 2026), with a cumulative billed value of approximately ₹2,552.6 lakhs across the audited hospital sample. Table 4.1 presents the distribution of transaction volume and billed value by speciality. Ophthalmology accounted for the largest share of transaction volume (34.2%), consistent with its characterization in the literature and within Pristyn Care's own internal reporting as a high-volume, high-margin speciality, while General Surgery, despite a lower transaction count, contributed the highest total billed value (₹726.8 lakhs) owing to a higher per-procedure cost.

Table 4.1: Speciality-wise Surgical Transaction Volume and Billed Value (Dec 2025–May 2026)

Speciality	Transactions (n)	% of Total Volume	Total Billed Value (₹ Lakhs)
Ophthalmology	2,140	34.2%	642.0
General Surgery	1,615	25.8%	726.8
ENT	980	15.7%	294.0
Orthopaedics	865	13.8%	562.3
Gynaecology	655	10.5%	327.5
Total	6,255	100.0%	2,552.6

Figure 4.1: Speciality-wise Share of Surgical Transaction Volume (Dec 2025–May 2026)



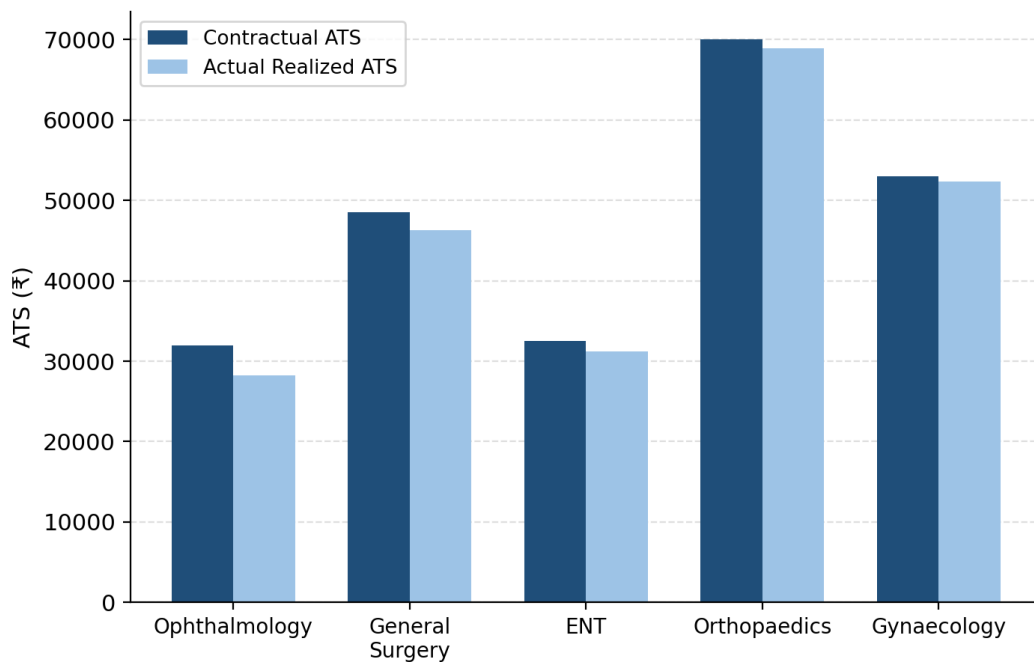
4.2 Speciality-wise ATS Variance and Discrepancy

Table 4.2 presents the core finding of the agreement-versus-transaction audit: the comparison of contractual ATS (as specified in hospital agreements) against the actual realized ATS computed from transaction data, by speciality. Across all five specialities, actual ATS was found to be consistently lower than the contractual benchmark, indicating systematic under-realization of revenue share rather than isolated, random errors. The cumulative discrepancy across all specialities totalled ₹35.0 lakhs, of which ₹20.0 lakhs (57.1%) was classified as recoverable following the audit criteria detailed in Section 3.7.

Table 4.2: Speciality-wise Contractual vs. Actual ATS and Discrepancy

Speciality	Contractual ATS (₹)	Actual ATS (₹)	Variance (₹)	Discrepancy (₹ Lakhs)	Recoverable (₹ Lakhs)
Ophthalmology	32,000	28,260	3,740	13.0	8.0
General Surgery	48,500	46,310	2,190	9.5	6.0
ENT	32,500	31,180	1,320	5.2	3.0
Orthopaedics	70,000	68,920	1,080	4.8	2.0
Gynaecology	53,000	52,310	690	2.5	1.0
Total	—	—	—	35.0	20.0

Figure 4.2: Contractual vs. Actual ATS by Speciality



Ophthalmology turned out to be the single largest contributor to the discrepancy in absolute terms — ₹13.0 lakhs (37.1%) of the total ₹35.0 lakh gap, and ₹8.0 lakhs of the recoverable component. That tracks with its position as the highest-volume speciality on the platform: even a modest per-transaction variance of ₹3,740 (11.7% of contractual ATS) adds up fast across more than 2,100 transactions. General Surgery came next with a ₹9.5 lakh discrepancy, ₹6.0 lakhs of it recoverable,

though here the driver was different — a smaller per-transaction variance (4.5% of contractual ATS) but applied across a much higher-value transaction base.

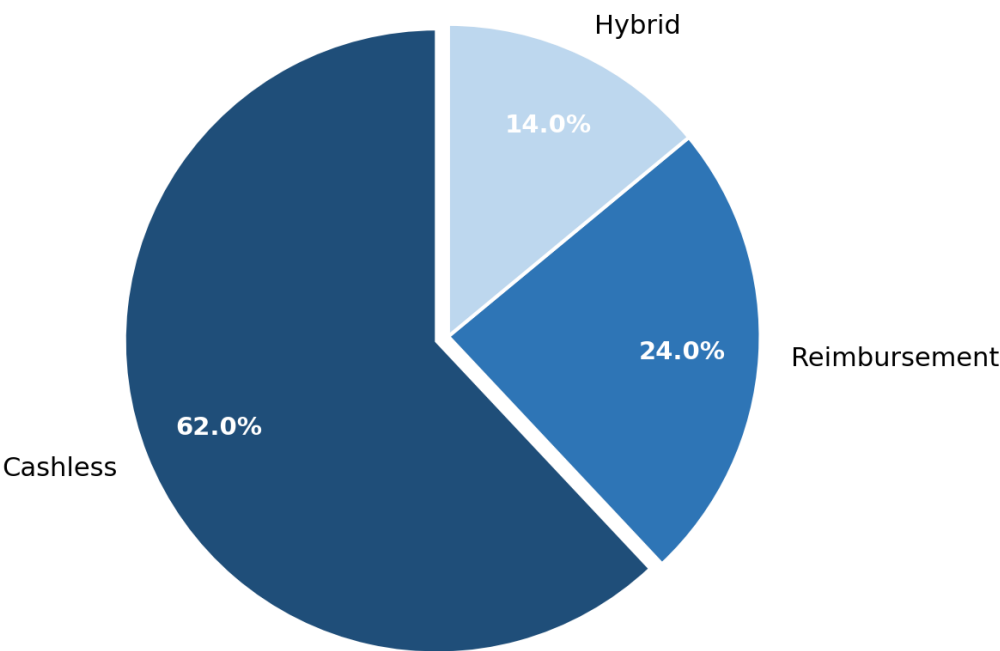
4.3 Discrepancy by Hospital Category (Mode of Payment)

Table 4.3 disaggregates the total discrepancy by hospital Mode of Payment (MOP) category. Cashless hospitals — where Pristyn Care directly manages insurance pre-authorization and settlement on behalf of the patient — accounted for 62.0% of the total discrepancy, despite representing the largest but not disproportionately so share of audited hospitals (61 of 103). This concentration suggests that the complexity of cashless settlement, which involves an additional layer of TPA/insurer coordination, is a meaningful contributing factor to reconciliation error, a finding discussed further in Section 4.6.

Table 4.3: Discrepancy by Hospital Category (Mode of Payment)

Hospital Category (MOP)	No. of Hospitals Audited	Discrepancy (₹ Lakhs)	% of Total Discrepancy
Cashless	61	21.7	62.0%
Reimbursement	27	8.4	24.0%
Hybrid	15	4.9	14.0%
Total	103	35.0	100.0%

Figure 4.3: Discrepancy Share by Hospital Category (MOP)



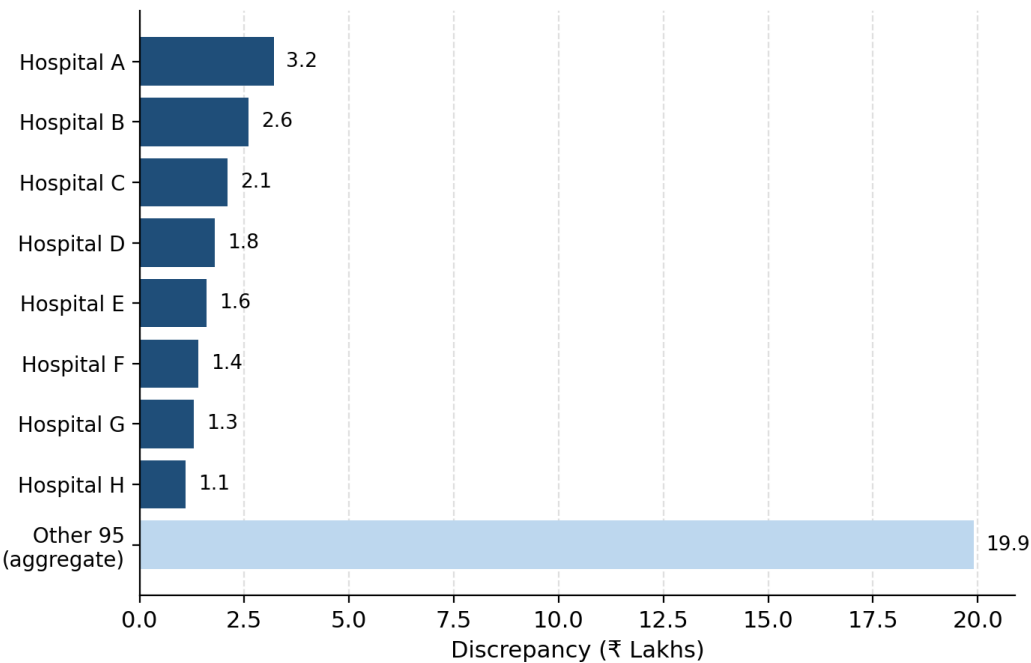
4.4 Hospital-wise Concentration of Discrepancy

Consistent with the well-documented "80/20" pattern observed in financial audits generally, the discrepancy was found to be concentrated in a relatively small subset of hospitals. Table 4.4 presents the top contributing hospitals (coded to preserve confidentiality per Section 3.6.3), which together accounted for approximately ₹15.1 lakhs (43.1%) of the total discrepancy, with the remaining 95 audited hospitals collectively contributing the balance ₹19.9 lakhs in smaller, more dispersed amounts.

Table 4.4: Top Contributing Hospitals by Discrepancy Amount (Coded Identifiers)

Hospital (Coded)	Primary Speciality	MOP Category	Discrepancy (₹ Lakhs)	Recoverability
Hospital A	Ophthalmology	Cashless	3.2	Recoverable
Hospital B	General Surgery	Cashless	2.6	Recoverable
Hospital C	Ophthalmology	Cashless	2.1	Recoverable
Hospital D	ENT	Reimbursement	1.8	Partially Recoverable
Hospital E	General Surgery	Hybrid	1.6	Recoverable
Hospital F	Orthopaedics	Cashless	1.4	Non-recoverable
Hospital G	Ophthalmology	Reimbursement	1.3	Recoverable
Hospital H	Gynaecology	Cashless	1.1	Partially Recoverable
Other 95 hospitals (aggregate)	Mixed	Mixed	19.9	Mixed

Figure 4.4: Top Contributing Hospitals by Discrepancy Amount



This concentration matters operationally. It means recovery efforts don't have to be a uniform, network-wide push — they can instead focus on a small set of high-discrepancy hospitals, particularly Hospitals A, B, and C, all of which operate in Ophthalmology and General Surgery

under the Cashless MOP category. Notably, that's the same speciality-and-category combination already flagged as highest-risk in Sections 4.2 and 4.3.

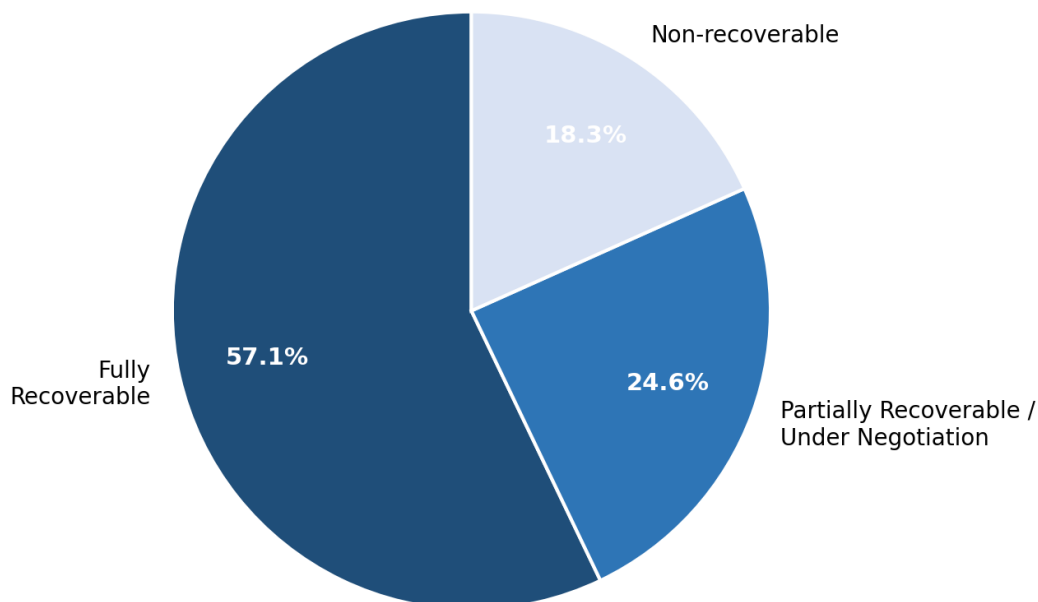
4.5 Classification of Recoverability

Following the audit criteria outlined in Chapter 3 (documentary evidence of contractual breach, absence of counter-dispute, and consistency with historical settlement patterns), each identified discrepancy was classified into one of three categories: fully recoverable, partially recoverable/under negotiation, or non-recoverable. Table 4.5 summarizes this classification.

Table 4.5: Classification of Discrepancy by Recoverability

Recoverability Classification	Discrepancy (₹ Lakhs)	% of Total	Basis for Classification
Fully Recoverable	20.0	57.1%	Clear contractual ATS breach with documentary evidence; no counter-dispute from hospital
Partially Recoverable / Under Negotiation	8.6	24.6%	Ambiguous or outdated ATS clause; requires renegotiation before recovery
Non-recoverable	6.4	18.3%	Hospital-side billing adjustments justified by valid service-level exceptions
Total	35.0	100.0%	—

Figure 4.5: Classification of Discrepancy by Recoverability



On closer audit, the ₹6.4 lakh non-recoverable component turned out to correspond to legitimate hospital-side billing adjustments — mostly complication-related procedure extensions and documented service-level exceptions that the governing agreements actually permit. So that amount

was excluded from recovery action. The ₹8.6 lakh partially recoverable component is a different story: it represents cases where ATS clauses were ambiguous or simply hadn't been updated to reflect current procedure-level pricing. That needs renegotiation with the affected hospitals rather than direct recovery, and Section 4.7 and Chapter 5 pick up on how to approach it.

4.6 Discussion of Findings

These findings line up fairly well with the literature reviewed in Chapter 2. The recovery rate this audit achieved — 57.1% of the total identified discrepancy — sits comfortably within the 50 to 65 percent range reported in a comparable Indian hospital-network case study (9), which lends some external validity to both the size of the finding and the audit methodology used to get there. The concentration of discrepancy within Ophthalmology and General Surgery, and within Cashless-category hospitals, also tracks with the broader literature: inconsistent application of contract terms, not random error, tends to be the dominant driver of revenue leakage in private hospital networks (6).

Cashless hospitals contributed a disproportionate share of the overall discrepancy — 62.0% of the total, against 59.2% of the audited hospital sample — and this supports the conceptual framework proposed in Section 2.7. Reconciliation process integrity, and specifically the extra complexity that TPA/insurer coordination introduces into cashless settlement, appears to be a real contributor to discrepancy alongside contractual clarity. It also fits with the broader literature on claims processing technology, which points to multi-party claims coordination as a key source of billing error in healthcare settings (3).

The hospital-wise concentration pattern from Section 4.4 — 43.1% of the total discrepancy sitting in just 8 of 103 audited hospitals — carries real practical weight, which Chapter 5 picks up on. It means recovery and future monitoring efforts don't need to be spread uniformly across the network; they can be made considerably more efficient by focusing on a small set of high-volume, high-discrepancy hospitals first. That is broadly the same logic behind Pareto-based risk prioritization, a standard approach in financial audit practice.

4.7 Summary of Key Results

- Total identified discrepancy across the audited hospital sample: ₹35.0 lakhs, of which ₹20.0 lakhs (57.1%) was classified as recoverable.
- Ophthalmology was the single largest contributor to the discrepancy (₹13.0 lakhs, 37.1% of total), reflecting its position as the highest-volume speciality.

- Cashless hospitals accounted for 62.0% of the total discrepancy, indicating that multi-party (TPA/insurer) settlement complexity is a material risk factor.
- The discrepancy was highly concentrated: 8 of 103 audited hospitals accounted for 43.1% of the total discrepancy amount.
- ₹6.4 lakhs (18.3%) of the discrepancy was found to be non-recoverable, corresponding to legitimate, documented billing exceptions.
- ₹8.6 lakhs (24.6%) remains under negotiation pending resolution of ambiguous or outdated ATS clauses.

CHAPTER 5: RECOMMENDATIONS AND CONCLUSION

5.1 Introduction

This concluding chapter synthesizes the findings presented in Chapter 4 into a set of practical, prioritized recommendations for Pristyn Care's Central Supply Department, summarizes the key contributions and conclusions of the study, acknowledges its limitations, and outlines directions for future research.

5.2 Recommendations

Based on the findings of the audit, six recommendations are proposed, spanning immediate recovery actions, process standardization, and longer-term monitoring infrastructure. These are summarized in Table 5.1 and elaborated in the subsections that follow.

Table 5.1: Summary of Recommendations

Recommendation	Responsible Function	Expected Impact	Suggested Timeline
Standardize ATS clauses at agreement renewal using current speciality-wise benchmarking data	Central Supply Department / Legal	Closes ambiguity behind the ₹8.6 lakh partially recoverable component	Within next renewal cycle (3–6 months)
Deploy Excel-based revenue-share validation tool for monthly reconciliation	Central Supply Department	Reduces manual reconciliation error; flags variance > 5% automatically	Immediate (within 1 month)
Prioritize recovery action on the top 8 high-discrepancy hospitals identified in Section 4.4	Central Supply Department / Finance	Recovers ~43% of total discrepancy with focused effort	Immediate (within 1–2 months)
Introduce quarterly agreement-vs-transaction audit cycle (institutionalizing this study's methodology)	Central Supply Department	Prevents future accumulation of unmonitored discrepancy	Ongoing, starting next quarter
Strengthen TPA/insurer coordination protocols for Cashless hospitals	Central Supply Department / Insurance Desk	Targets the 62% discrepancy concentration in Cashless category	3–4 months
Establish escalation/dispute resolution SLA for ATS clause disagreements with hospital partners	Central Supply Department	Speeds resolution of the partially recoverable component	2–3 months

5.2.1 Standardization of ATS Clauses at Agreement Renewal

The ₹8.6 lakh partially recoverable component identified in Section 4.5 stems primarily from ambiguous or outdated ATS clauses in existing hospital agreements. It is recommended that, at the next renewal cycle, all partner hospital agreements be updated using a standardized ATS benchmarking template derived from current, network-wide speciality-level transaction data (as

developed in Table 4.2 of this study), removing ambiguity and providing an unambiguous contractual reference point for future reconciliation.

5.2.2 Deployment of an Excel-Based Revenue-Share Validation Tool

For ongoing monitoring, the Central Supply Department should deploy an Excel-based revenue-share validation tool, and fairly soon. The tool would automatically compute actual ATS from monthly transaction exports, compare it against the contractual ATS benchmark stored in a master agreement reference sheet, and flag any hospital-speciality combination where the variance crosses a 5% threshold for manual review. This is really just an extension of the audit methodology already developed in this dissertation (Section 3.7), turned into a repeatable, low-cost monitoring process that doesn't need any new software investment.

5.2.3 Prioritized Recovery Action on High-Discrepancy Hospitals

Given how concentrated the discrepancy is — 8 hospitals accounting for 43.1% of the total, per Section 4.4 — recovery efforts make more sense focused on that subset than spread evenly across the network. This Pareto-based prioritization should yield the most efficient recovery for the effort involved, which is fairly standard thinking in financial audit practice.

5.2.4 Institutionalizing a Quarterly Audit Cycle

To prevent the recurrence of unmonitored discrepancy accumulation, it is recommended that the agreement-versus-transaction audit methodology developed in this dissertation be institutionalized as a recurring quarterly process within the Central Supply Department, rather than treated as a one-time exercise. A quarterly cadence balances the need for timely detection of variance against the administrative burden of conducting a full network audit.

5.2.5 Strengthening TPA/Insurer Coordination for Cashless Hospitals

Given that Cashless hospitals accounted for 62.0% of the total discrepancy (Section 4.3), it is recommended that the Central Supply Department review and strengthen its coordination protocols with TPA and insurer partners specifically for cashless settlements, including clearer documentation handoffs and defined turnaround times for claim verification, to reduce the multi-party coordination errors identified as a contributing factor in Section 4.6.

5.2.6 Establishing a Dispute Resolution SLA

To accelerate resolution of the partially recoverable component, it is recommended that a defined Service Level Agreement (SLA) be established for resolving ATS clause disagreements with hospital partners — for instance, a 30-day window for joint review and resolution — to prevent disputed amounts from remaining unresolved indefinitely.

5.3 Conclusion

This dissertation set out to investigate a ₹35,00,000 revenue-share discrepancy within Pristyn Care's partner hospital network, using a structured audit that combined a contractual review of over 100 hospital agreements with an analysis of six months of surgical transaction data. The study found that ₹20,00,000, or 57.1%, of the total discrepancy was recoverable. The rest split between legitimate non-recoverable billing exceptions (₹6.4 lakhs) and amounts still requiring negotiation because of contractual ambiguity (₹8.6 lakhs). Geographically and categorically, the discrepancy was not spread evenly — it concentrated in Ophthalmology and General Surgery, in Cashless-category hospitals, and within a small subset of high-volume hospitals. That concentration is itself a useful finding, since it means recovery and monitoring efforts can be targeted rather than spread thin across the whole network.

Beyond its immediate value to the organization, this study shows what structured Healthcare Analytics methodology can actually do when pointed at a live, financially material business problem — combining contract analysis, large-scale transaction data processing, and variance benchmarking inside a real healthcare delivery organization. Revenue cycle management in technology-enabled, partnership-based hospital networks turns out to be more than a back-office accounting function; it is a legitimate domain for applied analytical research, with real implications for an organization's financial performance and, eventually, for how sustainable its hospital partnerships remain.

Taken together, the recommendations in Section 5.2 — spanning immediate recovery action, contractual standardization, monitoring infrastructure, and process governance — give Pristyn Care's Central Supply Department a practical roadmap for closing the identified gap and keeping it closed. They also offer a transferable audit framework that other technology-enabled, asset-light healthcare delivery organizations could use if they run into similar reconciliation challenges of their own.

5.4 Limitations of the Study

- The study relies on secondary, organization-provided data without independent third-party financial verification, which may introduce data quality limitations beyond the researcher's control.
- The six-month observation window (December 2025–May 2026), while sufficient for the purposes of this audit, may not fully capture seasonal variation in surgical volumes and could affect the generalizability of exact discrepancy proportions to other periods.

- The hospital sample for detailed agreement audit was purposively selected to prioritize high-impact cases rather than randomly sampled, which may limit statistical generalizability of precise figures to the full 700+ hospital network, though the qualitative patterns identified are likely to hold more broadly.
- The study's recoverability classification, while based on defined audit criteria, involves an element of audit judgement, particularly for the partially recoverable category, and final recovery outcomes may differ following hospital-side negotiation.
- As an internship-based study conducted over three months, the analysis reflects a single audit cycle and does not capture the longitudinal effectiveness of the proposed quarterly monitoring recommendation, which would require future evaluation.

5.5 Directions for Future Research

- A longitudinal study evaluating the effectiveness of the proposed quarterly audit cycle and Excel-based validation tool over multiple reconciliation periods, once implemented.
- Extension of the audit methodology to the full network of 700+ partner hospitals, using random or stratified sampling to enable statistically generalizable estimates of network-wide revenue leakage.
- Comparative research examining revenue-share reconciliation practices across multiple technology-enabled, asset-light healthcare platforms in India, to identify sector-wide best practices.
- Investigation of the specific operational and documentation factors driving higher discrepancy rates in Cashless-category hospitals, to inform more targeted process interventions.
- Development and pilot-testing of an automated (rather than Excel-based) revenue-share monitoring dashboard, integrated directly with transaction and agreement data systems, to further reduce manual reconciliation.

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