STUDY ON INSURANCE PROCESS & TAT THROUGH CMS & OFFLINE PROCESSING RATE FOR CASHLESS INSURANCE PATIENTS AT NARAYANA HEALTH.

Dissertation Submitted to

The IIHMR University, Jaipur

for the partial fulfilment for the award of the degree

Master of Business Administration (MBA)

in

Hospital and Health Management

by

Vansh Lal

Under the Supervision and Guidance of

Dr. Mamta Chauhan

2023

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DECLARATION BY STUDENT

I hereby declare that this dissertation titled “STUDY ON INSURANCE PROCESS & TAT THROUGH CMS & OFFLINE PROCESSING RATE FOR CASHLESS INSURANCE PATIENTS AT NARAYANA HEALTH” is the Bonafede record of my original researchwork. I declare that it has not been submitted to any other university or institution for the award of any degree or diploma. Information derived from the published or unpublished workof others has been duly acknowledged in the text.

(Signature)
Vansh Lal
Date

NH Narayana Multispeciality Hospital
Unit of Narayana Health

NH/JPR/HRD-NOC/2023/1097

13 May 2023

TO WHOM SO EVER IT MAY CONCERN

This is to certify that **Mr. Vansh Lal**, a student of IIHMR, Jaipur, has successfully completed his internship training at **Narayana Multispeciality Hospital Jaipur**, in **TPA Department** from **22 February 2023 to 13 May 2023**.

During the internship his character and conduct was good.

For Narayanaya Multispeciality-Jaipur

Nikhil Mathur
Deputy General Manager – HR

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CERTIFICATE

This is to certify that dissertation titled “STUDY ON INSURANCE PROCESS & TAT THROUGH CMS & OFFLINE PROCESSING RATE FOR CASHLESS INSURANCE PATIENTS AT NARAYANA HEALTH” is a record of the research work undertaken by Vansh Lal in partial fulfilment of the requirements for the awardof the degree of MBA (Hospital and Health Management)/MBA (PharmaceuticalManagement)/MBA (Development Management) from the IIHMR University, Jaipur under my guidance and supervision and his/her approach to the research study has been sincere, scientific, and analytical.

Faculty Guide
IIHMR University, Jaipur

Date

School Dean
IIHMR University, Jaipur

Date

Abstract

Efficient management of the TPA Cashless Insurance process is crucial for hospitals to provide timely and satisfactory healthcare services. This paper presents a novel approach to calculate the Turnaround Time (TAT) for TPA Insurance patients for Pre-Auth, Query and final discharge submission, enabling the identification of delays and suggesting improvements in the process. The study begins by developing a comprehensive framework for TAT calculation in TPA operations. This framework encompasses the various steps involved in the Insurance claim process, including registration, documentation, and bed allocation. By analysing historical data and utilizing statistical techniques, the average TAT for each step is determined, serving as a baseline for performance evaluation.

Additionally, the processing time, which refers to the duration between the Starting of the TPA process and Pre-Auth submission, is taken into consideration. By closely monitoring and recording the processing time for individual patients, are identified. The effectiveness of the proposed approach was evaluated in a real-world hospital setting, where data on TAT and processing time were collected and analysed. The results demonstrate the efficacy of the framework in identifying bottlenecks and delays, enabling targeted interventions to reduce TAT and improve patient satisfaction. The findings also underscore the potential benefits of implementing the suggested improvements, including increased operational efficiency, reduced waiting times, and an overall enhancement in the patient experience.

In conclusion, this research presents a comprehensive methodology for calculating TAT in TPA process of pre-auth submission, Query revert and discharge submission, facilitating the identification of delays and suggesting improvements. The proposed framework provides valuable insights to healthcare providers for optimizing TPA processes, streamlining resource allocation, and improving patient care. The outcomes of this study contribute to the ongoing efforts in achieving efficient and patient-centric healthcare services. By implementing the suggested improvements, hospitals can effectively manage Insurance cashless admissions, minimize delays, and enhance the overall quality of care provided to patients.

KEYWORDS: - Third Party Administrator (TPA), Turnaround Time (TAT), Patient Satisfaction

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Firstly, I would like to extend my sincere thanks to my esteemed faculty mentor,
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Abbreviations

Sr. no	Abbreviations	Meaning
1	TPA	Third-Party Administrator
2	CMS	Claim Management Software
3	TAT	Turn-Around Time
4	SOP	Standard Operating Procedure
5	HIS	Hospital Information System
6	IRDA	Insurance Regulatory and Development Authority

1) Introduction-

A 330-bed multispecialty tertiary care hospital, Narayana Multi-speciality Hospital, Jaipur is located in Pratap Nagar in Jaipur's southern sector. The hospital is defined by its approach to providing patients with comprehensive care. At NH Jaipur, one of the best teams of professionals with training from famous universities abroad and in India provide treatments and operations using their knowledge and experience from other countries.

Narayana is home to one of the biggest dialysis facilities in the region, with a 3000-dialysis session monthly capacity. Furthermore, Narayana, Jaipur, is a certified clinic for doing heart and kidney transplants. The hospital features one of the largest cardiology departments in the region, and it is the largest LIMA RIMA Y CABG (By-pass Surgery) facility in Rajasthan. The hospital has grown to be one of the best in the Narayana Health group and the go-to facility for high-risk, minimally invasive, and re-do surgeries in Western India because to cutting-edge technology equipment and clinical competence.

Modern technology, huge infrastructure, expert treatment, and warm hospitality come together flawlessly at the Narayana Multi-speciality Hospital in Jaipur. The hospital has cutting-edge medical equipment and high-tech infrastructure, such as critical care units, digital x-rays, and modern operating rooms. The Narayana Hospital in Jaipur is dedicated to offering high-quality medical care and first-rate patient service. It is built to exceed both national and international healthcare standards. In order to give patients an accurate diagnostic and medical care, the facility at Narayana Health brings together a knowledgeable group of superspecialist doctors who work cooperatively with a caring nursing staff.

Unexpected medical occurrences are unpredictable, and you never know when you'll encounter one. Taking a proper health insurance policy that enables you to receive cashless coverage for medical issues is the logical course of action in such cases.

Types of claim settlement

1. **Cashless**
2. **Reimbursement**

1.1) How does cashless health insurance works?

When a patient has cashless health insurance it means that he doesn't has to pay cash at the network hospital of the insurer. Under cashless health insurance, the insurer is in direct negotiation with their network hospital to pay for the treatment availed.

1.2) Steps for cashless claims

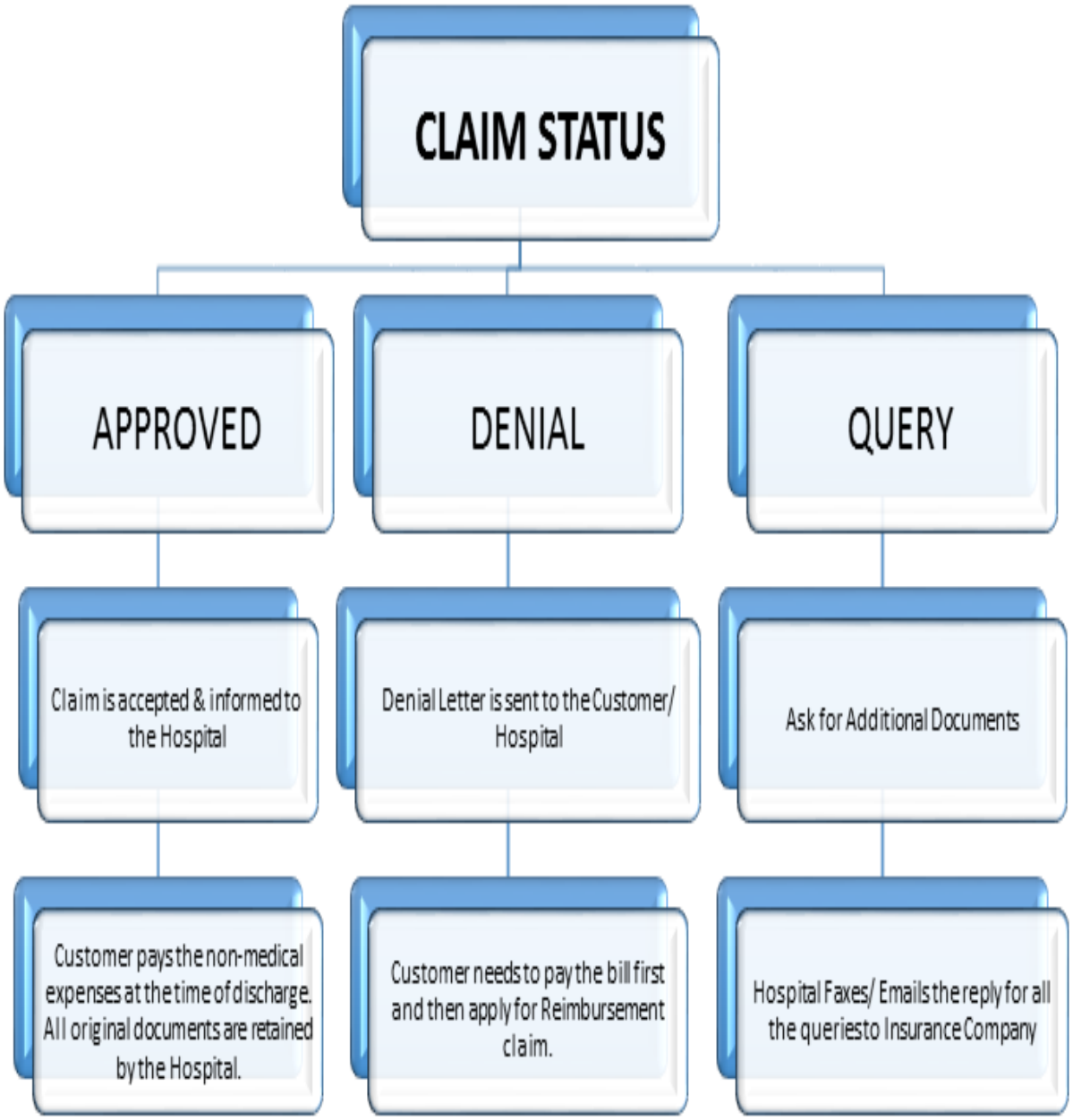
Below are the steps one must take to opt for a cashless claim:

- When receiving medical treatment for a condition, the patient has the option of going cashless. This indicates that the hospitalisation expenses will be covered by the health insurance provider. Only the portions that the health insurance provider does not cover in accordance with insurance requirements will be the responsibility of the policyholder. According to the terms of the policy, the claim is approved. The hospital in question should also be a part of the insurer's provider network.

- At the time of admission, the patient must fill a pre-authorization form which is further processed by the TPA department. Before the TPA submits the form for the insurance company's pre-approval and final approval all required documents are to be submitted by the patient.

- The Third-Party Administration counter will take into submission any pertinent documents. This may include the cashless health care provided by your insurer. Also, for verification purposes, copies of certain KYC documents will be retained.

- By this time, the insurance company gives their cashless approval for hospitalization. They keep an account of all the documents concerning the treatment and final discharge summary and provisional bill is uploaded to the portal for approval from the Insurance company.


CLAIM STATUS
APPROVED
DENIAL
QUERY
Claim is accepted & informed to the Hospital
Denial Letter is sent to the Customer/ Hospital
Ask for Additional Documents
Customer pays the non-medical expenses at the time of discharge. All original documents are retained by the Hospital.
Customer needs to pay the bill first and then apply for Reimbursement claim.
Hospital Faxes/ Emails the reply for all the queries to Insurance Company

1.3) The importance of having a cashless health insurance?

The demand for cashless health insurance is steadily growing. Below are the reasons why cashless health insurance is important to have:

- Cashless health insurance is highly helpful in the times of emergency as the patient might be cash strapped and not have immediate access to cash in emergency situations.
- Cashless health insurance is designed in such a way that financial risk is mitigated at the time any medical requirement and the hospital deals with the insurance company directly.

Just ensure that the hospital chosen is present in the network hospitals of your insurer.

1.4) Steps for reimbursement claims

Below are the steps you must take to opt for a reimbursement claim:

- If a cashless claim is denied, the patient can still recover expenditures incurred at an out-of-network hospital by filing reimbursement claims. Notify the insurance provider of the upcoming claim. Complete and send them the reimbursement claim form. The patient needs to submit the duly signed and sealed hospital-related bills along with the claim form within one month of the hospital's discharge date. These comprise the patient's name, the date of admission, the hospital's registration number, and the physician's prognostic prescription. The final paperwork confirms that the hospitalisation was recommended by a doctor rather than being a self-made decision.
- Collect the Discharge Summary that the hospital provides on the day of discharge. The insurance provider should receive the pre-and post-hospitalization costs are also admissible in settlements of the reimbursement kind. The patient must also provide the insurance provider with the relevant bills in this situation. The statements in their health insurance coverage state that it can be completed in 60 to 120 days.
- In both types of claim settlement, it is required to maintain all your medical and hospitalization data safely.

Documents required for Reimbursement Claims

- Discharge Summary.
- Final Hospital Bill.
- Medicine Bills.
- Investigations & Reports.
- Claim Form.
- A/C Details of the Employee.
- Name of Account Holder (Employee) as per Bank Records

1. Bank Account Number
2. Bank Name and Address
3. IFSC Code
4. Copy of cancelled Cheque with all the above details

1.5) TPA's Vital Role in Health Insurance

A health insurance Third Party Administrator (TPA) handles the hospital bills and other associated costs. TPA oversees the following.

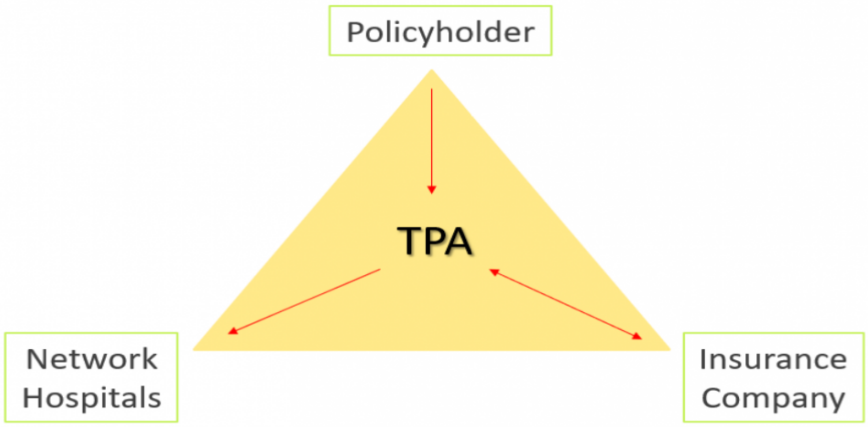
• Handling a high volume of health insurance claims

• Dependable, high-quality services

• Follow the reimbursement TAT and cashless policy.

1.6) The following are a few things you should never forget about TPA:

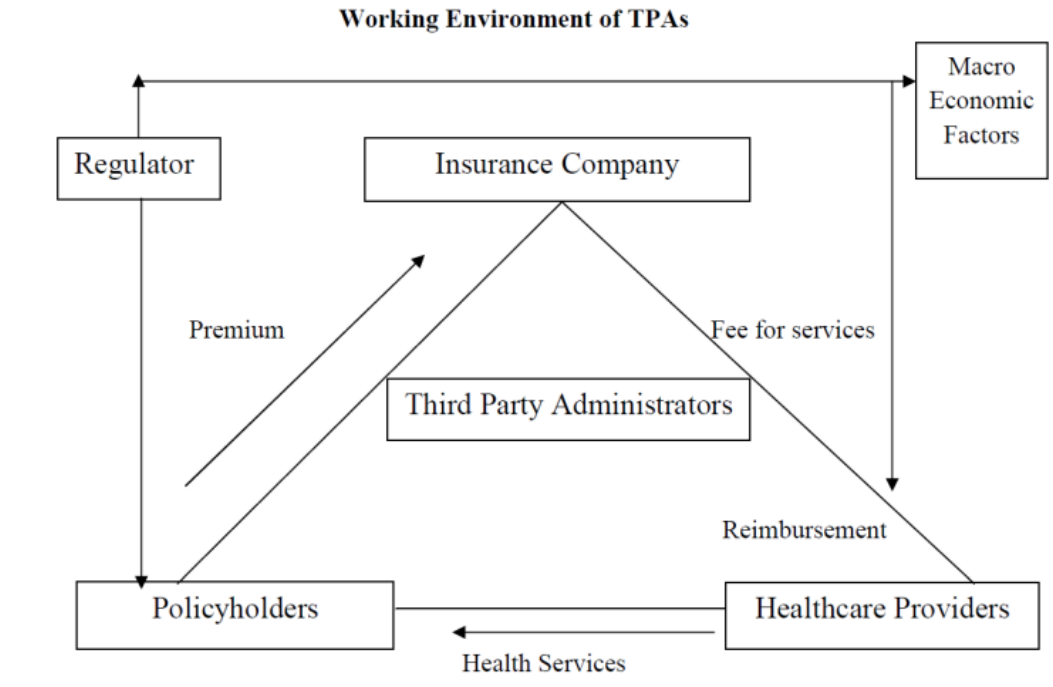
- When a claim is filed, the TPA acts as a mediator between the insurance provider and the policyholder.
- The insurance company chooses the Third-Party Administrator.
- IRDAI, has granted a licence to the Third-Party Administrator.
- The Third-Party Administrator's main goal is to simplify and streamline the claim procedure.
- The Third-Party Administrator is connected to many holders of health insurance.
- The Third-Party Administrator is a crucial component of a seamless settlement procedure for insurance companies.



1.7) Understand the role of TPA in Insurance (Health)

When processing the insurance claims, the TPA plays a vital role. The following list of a TPA's primary responsibilities:

- Provides cashless cards to policyholders, which they must present at network hospitals to avail cashless treatment.
- In direct contact with the policyholders: The insured person must notify the TPA of any health insurance claims. The insured will be directed to a network hospital by the TPA. The insured may receive treatment at any other facility, but in that instance, they will be responsible for paying the hospital fees out of pocket and submitting a subsequent reimbursement request.
- Sends a Pre-authorization letter to the Insurance: After the TPA sends the Insurance a Pre-authorization letter, the hospital keeps track of the case. The hospital administration then sends all the bills through the TPA for final approval.
- Arrange value-added services: A TPA offers additional services in addition to processing claims. These include ambulance services, wellness programmes, etc.
- Strengthens hospital networks: Employing a Third-Party Administrator is a crucial consideration if you want to take use of the benefits of your health insurance policy.



TPAs are anticipated to bring about the following developments, according to industry observers:

- Increased diligence and processes,
- better efficiency, and
- a deeper understanding of healthcare services.
- A new management system.
- Cost-cutting measures.
- Greater uptake of health insurance.
- Possibility of lower health insurance prices
- Create protocols to speed up investigations and prevent any delays.

1.8) Benefits Insurance Companies Receive From TPA's

Smooth health insurance claim settlement is one of the main advantages third party administrators. TPAs also offer the following benefits:

• A dedicated resource for facilitating claim settlement.

• Coordination from the start of treatment through discharge.

• Appropriate handling & examination of claim requests.

• Superior service quality.

1.9) Some Third-Party Administrators in India

- Medi Assist India TPA
- Heritage Health TPA
- E Meditek TPA Services
- Family Health Plan TPA
- Raksha TPA
- United Healthcare Parekh TPA
- Focus Healthservices TPA
- Dedicated Healthcare Services TPA
- Vipul Med Corp
- Rothshield Healthcare TPA
- Focus Health services TPA
- Safeway TPA Services
- Vidal Health TPA Private Limited

The following governmental bodies have recognised Narayana Multi-speciality Hospital (GIPSA) for cashless transactions.

- New India Assurance
- Oriental Insurance
- National Insurance
- United India Insurance

1.10) Cashless / Corporate (SOP) Narayana Multi-Specialty Hospital-

- All credit patients (Corporate, TPA, CGHS, etc.) shall require a pre- authorization letter (in case of planned admission). Patient can admit without prior approval by giving advance deposit, consent / undertaking for payment if approval not given by the TPA / Corporate - Patient Attendant

- Once the approval is received, the same shall be reflected in HIS

- In case, the amount exceeds the approved amount, then grant for next approval shall be sent to the respective TPA/Corporate (Enhancement Process)

- At the time of Discharge, all documents (Discharge Summary, Investigation Reports) are sent to TPA/ Corporate for approval. After the approval of the billing amount patient is discharged from the system

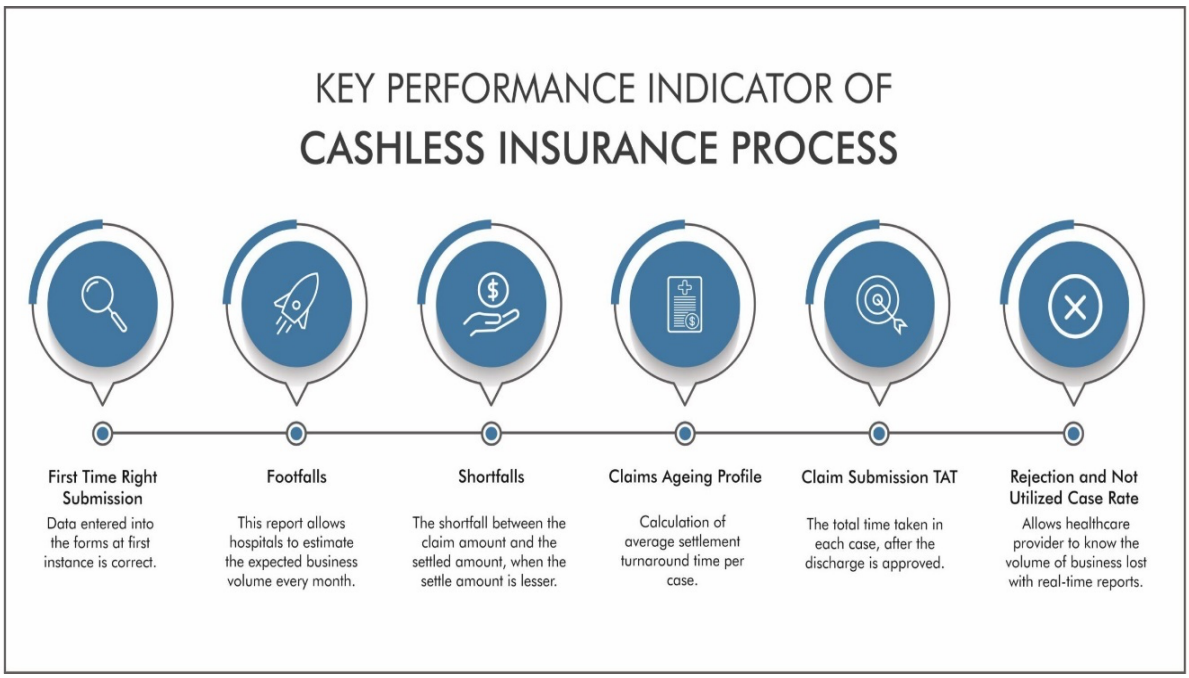
- In case of Planned Admission: The Authorization letter shall be handed over to the staff prior to admission of the patient along with the room category, either a prescription from OPD or History Sheet from Emergency. Executive- Admission Desk / TPA Coordinator

- Advance deposit Policy: If patient is admitting for medical management / observation, then following amount is to be deposited by the patient for initiating Admission:
    - For General Wards: Rs. 10,000/-
    - For HDU: Rs. 30,000/-
    - For MICU & other CCU: Rs 40,000/-
- In case of Surgery / Procedure: Entire advised estimated expense needs to be deposited for OT / Cath Lab clearance and in case patient is not having the counseled amount at the time of admission then a consent is taken from patient after seeking approval of the same from Facility Director / Finance Head / Appropriate Authority. Billing Executive

- In case of Unplanned Admission: The information of the patient shall be given to the TPA Help Desk and the relevant documents (such as approval to treat) shall be collected latest on the same day or on the next day by the TPA Help Desk Department. TPA Help Desk

- The patient shall be explained that the admission is irrelevant to the approval and in case of denial, the patient shall be responsible to make the whole payment.

- The patient shall be explained that in case he/she must undergo a surgery before approval from the TPA Company then the patient must pay the total surgery amount before the surgery is performed.



1.11) About The Study- NARAYANA HEALTH

The hospital and healthcare system rely heavily on the TPA services. Patients desire to choose the cashless option that insurance companies offer because it allows them to transfer their financial risk and concentrate on improving their health. According to the severity of their illness, patients are admitted to the hospital for a specific number of days, and the insurance companies are informed of this through the creation of various packages. The best medical and nursing care facilities are required for the patients being admitted to the hospital.

An average of 130–150 patients with cashless insurance are admitted to Narayana Hospital in Jaipur each month. About 30–35% of a hospital's functional space is used by insurance cashless patients, whose capital expenditure and operational costs are significant. There are various steps to the insurance process, and delays in admittance can occur for a variety of reasons, including a delay in the pre-authorization of insurance, a lack of beds, or incomplete paperwork, among others. Managing long waiting lines presents a significant challenge for managers; the goal of this study is to reduce processing time by attempting to improve the quality of operations. Customer and staff frustration results from overcrowding in the TPA for entry., claim processing time and Queries from the insurance companies create hustle in medical treatment, planned surgery and the discharge process.

- Patient outcomes: The timing of insurance approval can impact the patients' health outcomes.
- Resource utilization: Hospitals have limited resources such as beds, staff, and equipment, and admitting patients at the right time helps optimize their usage. Admitting patients when there is capacity ensures that they receive prompt treatment and reduces wait times in the emergency department.
- Financial implications: Insurance claim approval and processing time impacts the financial health of hospitals. If done so efficiently the process of admission and planned patient care can be carried out in a more optimum manner.
- Efficient use of healthcare infrastructure: Efficient TPA processing and claim management ensures that patients is financially secured which helps to reduce the risk of financial burden and improve overall patient satisfaction.

1.12) Research Question-

- What are the activities which directly or indirectly cause delay in the TPA claim process?

- What is the turnaround time (TAT) of patient claims for pre-auth, Query, and Discharge submission.

1.13) Objectives-

- To understand the Cashless Insurance process.
- To analyse the Pre-Auth submission, Query revert & Final Discharge submission (TAT)
- To find out the major causes for the increase in TAT throughout the insurance process.
- To suggest various ways to streamline the cashless insurance procedure.

2) Review of Literature

Author Name/Year	Title	Methodology	Results
Kasturi Shukla Shri R K Upadhyay (2018)	"Predictive Modelling for Turn Around Time (TAT) of Discharge Process for Insured Patients in a Corporate Hospital of Pune City"	From May to July 2015, a cross-sectional study was conducted on insured in-patients at a corporate hospital in Pune. Using an independent t-test, TAT for each of the six steps in the discharge process as well as the overall TAT were monitored and studied in relation to LOS and discharge type. Using correlation analysis and linear regression, the six TATs were examined to determine how they might affect the overall TAT.	For patients with insurance (n = 443), the average time to discharge was 390 (122.03) minutes. Through statistical analysis, the intervening TATs for submitting the discharge statement to the TPA department and receiving insurance company final bill approval had the strongest predictive effects on the entire TAT. The TAT for discharge did not differ significantly depending on whether it was scheduled or not, but it did rise by an hour for patients with long hospital stays (p-value 0.001).

Author Name/Year	Title	Methodology	Results
Ankit Singh, Priya Ravi and Kursongmit Lepcha (2021)	"Patient satisfaction factors with In house Third Party Administrator (TPA) department of a tertiary care hospital: a cross sectional analysis."	A scale with 25 items is used to measure two domains: patient loyalty to the hospital for using health insurance services, which is measured by three things, and satisfaction with the hospital's in-house TPA services, which is measured by 22 items. After scale purification, 15 elements are used to gauge how satisfied patients are with the hospital's TPA services. Multivariate methods are employed, including Hierarchical Regression Analysis and Principal Component Analysis with Varimax Rotation.	Physical evidence and professionalism are two discernible characteristics that together accounted for 57% of the overall variance. These two observable elements have had a large and favourable impact on insured patients' hospital loyalty.

Author Name/Year	Title	Methodology	Results
A Singh, P Ravi K Lepcha (2019)	"Insured Patients Discharge Delays: Causes & Solutions"	This cross-sectional poll was carried out during a three-month period, between March 2018 and May 2018. The sample consists of 174 patients. The systematic random sample technique is used to determine the important sub processes that significantly affect the overall discharge process time using unadjusted linear regression. The main request types sent by the external TPA department are determined using Pareto analysis.	The two primary subprocesses that account for the greatest variance in the overall discharge process are the time it takes for the discharge summary to reach the internal TPA department and the external TPA's approval after receiving the discharge summary, with adjusted R2 values of.554 and.219, respectively. Out of the 128 categories of queries, 5 categories accounted for 64% of all searches, according to the Pareto analysis.

Author Name/Year	Title	Methodology	Results
Soraia Aparecida da Silva,I Reginaldo Aparecido Valácio,I Flávia Carvalho Botelho,II and Carlos Faria Santos AmaralII (2023)	"Reasons for discharge delays in teaching hospitals"	A total of 395 consecutive patients' medical records from two public teaching hospitals affiliated with the Universidad Federal de Minas Gerais—Hospital Odilon Behrens and Hospital das Clinicals—who were admitted to internal medicine wards were reviewed. In order to decide whether hospitalisation was no longer required and patients might be discharged from care, the Appropriateness Evaluation Protocol was utilised. The time between this predicted time and the actual discharge was defined as the total number of days that the hospital discharge was postponed. The causes of hospital discharge delays were systematically categorised using a tool and frequency analysis.	Delays in discharge occurred in 60.0% of the 207 hospital admissions at the Hospital des Clinicals and 58.0% of the 188 hospital admissions at the Hospital Odilon Behrens. In the first hospital, patients waited an average of 4.5 days; in the second, 4.1 days; these wait times correspond to occupancy rates of 23.0% and 28.0%, respectively. The main reasons for delays at the two hospitals were, respectively, waiting for more testing (30.6% versus 34.7%) or the release of test findings (22.4% versus 11.9%). Delays in discussing the clinical situation, delays in clinical decision-making, and difficulties in giving specialised advice (20.4% versus 9.1%) were all medical-related accountability factors (36.2% versus 26.1%).

Author Name/Year	Title	Methodology	Results
AWANISH VERMA ARSHAD ALI KHAN DEAN. BIJAL ZAVERI (2023)	“A STUDY ON ANALYTICAL STUDY ON TAT IN MEDICLAIM.”	Research is a form of artistic scientific inquiry. The rationale behind taking research methodology into account is that it allows one to be aware of the approach and process used to attain project goals. DURATION OF STUDY: This study will cover the most recent three financial years, which are 2018–19, 2019–20, and 2020–21. Secondary data will be employed in this study's data collection procedure to compare the financial statements from the previous three years. METHODS OF DATA COLLECTION: Ratio analysis has been used to collect data.	The time it takes for the discharge summary to go to the internal TPA department and the external TPA's approval after the discharge summary is submitted, with modified R2 values of.554 and.219, respectively, are the two key subprocesses that account for the largest variance in the total discharge process. The Pareto analysis also revealed that, of the 128 different types of questions, 5 groups accounted for 64% of all searches.

3) METHODOLOGY

Methods:

- **Design: -** A cross-sectional study has been done to understand TPA claim process and to find out the bottleneck related to the process.
- **Setting: -** TPA Insurance Department (Green Channel) at Narayana Multispecialty Hospital, Jaipur.
- **Study population -** 150 Patients

Inclusion criteria: -

Only those patients were included who opted for Insurance cashless facility.

Exclusion criteria: -

i) The OPD patients
ii) The patients who came for only investigation
iii) Those who opted for cash admissions.
iv) Those who were admitted though RGHS & CGHS.

Study tools: -

1. Checklists
2. Data from CMS (Claim management software)

- **Duration of study:** - 3 months

- **Sample size-**

  The average Patient flow at Narayana Hospital Jaipur averages 150 cashless insurance patients a month.
  As the study duration is 3 Months random selection of 50 patients every month has been done with Total sample size – 150.

- **Sampling technique: -**

  Random sampling technique is used.

- **Data collection procedure:**

  The TPA procedure at Green Channel is observed & Primary data was gathered through watching the various steps of the cashless insurance procedure.

Data analysis Plan

- Data analysis from CMS (Claim Management Software)
- MS excel for primary data analysis.

3.1) Ethical Considerations

- **Informed consent:** Patients are fully told about the research's goals, the advantages and dangers of taking part, as well as their right to decline or withdraw at any time. All patients who are being enrolled in the trial should give their informed permission.

- **Confidentiality:** Patient confidentiality must be always maintained. Researchers should ensure that patient data is stored securely and is only accessible to authorized personnel.

- **Privacy:** Patients have a right to privacy, and researchers should take steps to minimize any intrusion into their personal space.

3.2) Implications of Research

- Improved patient outcomes can be achieved by detecting and resolving delays in a hospital's TPA Insurance procedure, according to the report. For instance, speeding up Pre-Auth and final approval of claims can assist patients in receiving timely and appropriate care, which can result in improved outcomes.

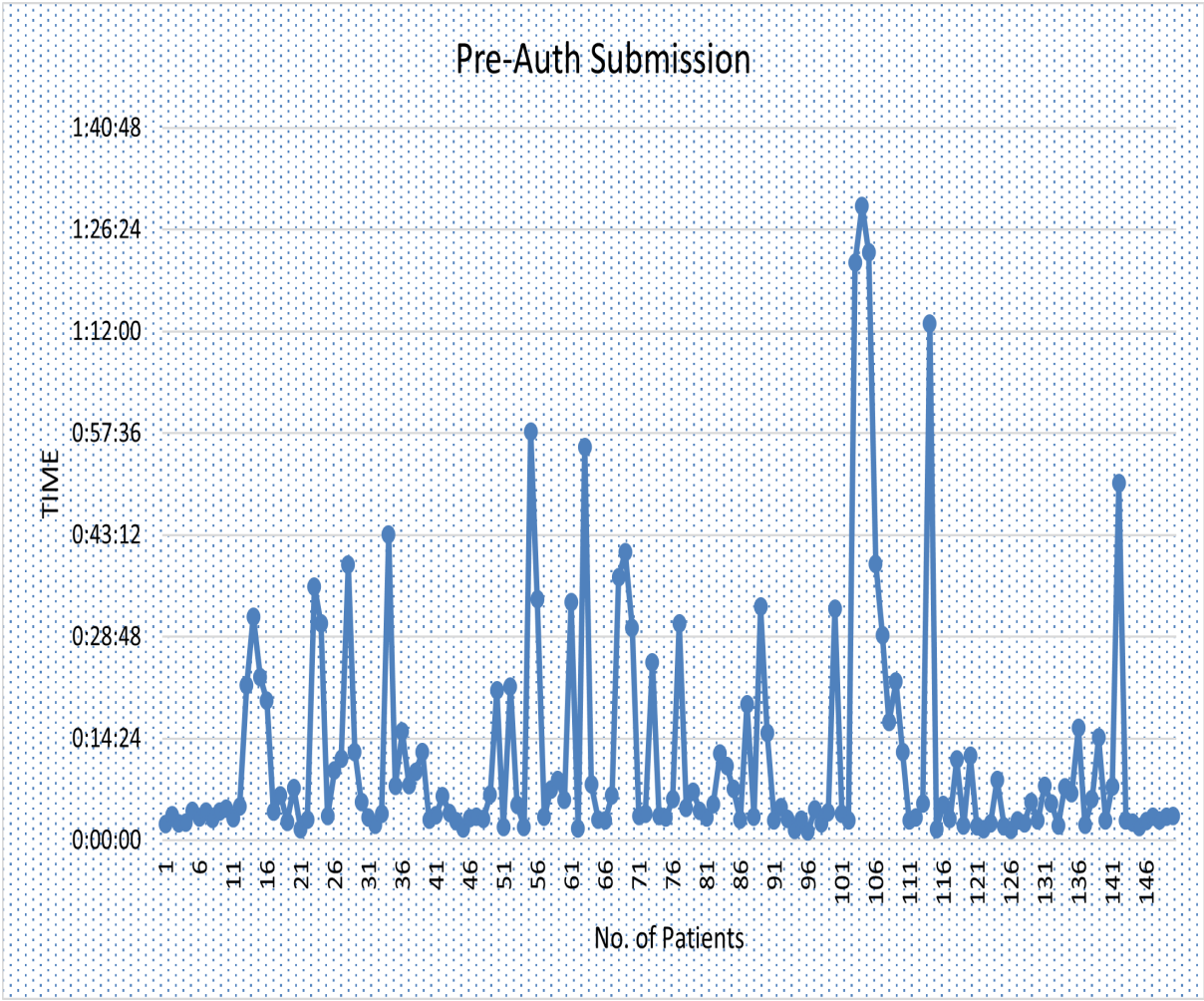
- Efficiency can be improved by monitoring turnaround times and locating bottlenecks in a hospital's TPA insurance department, according to the research. This may result in a shorter wait time for patient release and financial savings for the hospital.

- Increased staff happiness: The research can increase worker satisfaction by decreasing delays and enhancing turnaround times. This may result in more productivity, improved teamwork, and a happier workplace atmosphere.

- Patient satisfaction: By reducing turnaround time and delays, Patient satisfaction will in turn rise If they receive prompt and effective treatment, patients are more likely to be happy with their care.

4) Results

4.1) Pre-Auth TAT-



The above graph represents the statistical data of 150 patients gathered over the course of 3 months. It documents the time taken from the start of the TPA process such as document collection, financial counselling, and processing till the pre-auth is submitted onto the portal. (Claim Book)

The representation depicts the diversity of time taken as the process is a mix of both online and offline processes happening together, thus considering delays from the patient's end Ex. Documentation gathering, and from TPA's end Ex. IT issues, portal connectivity etc.

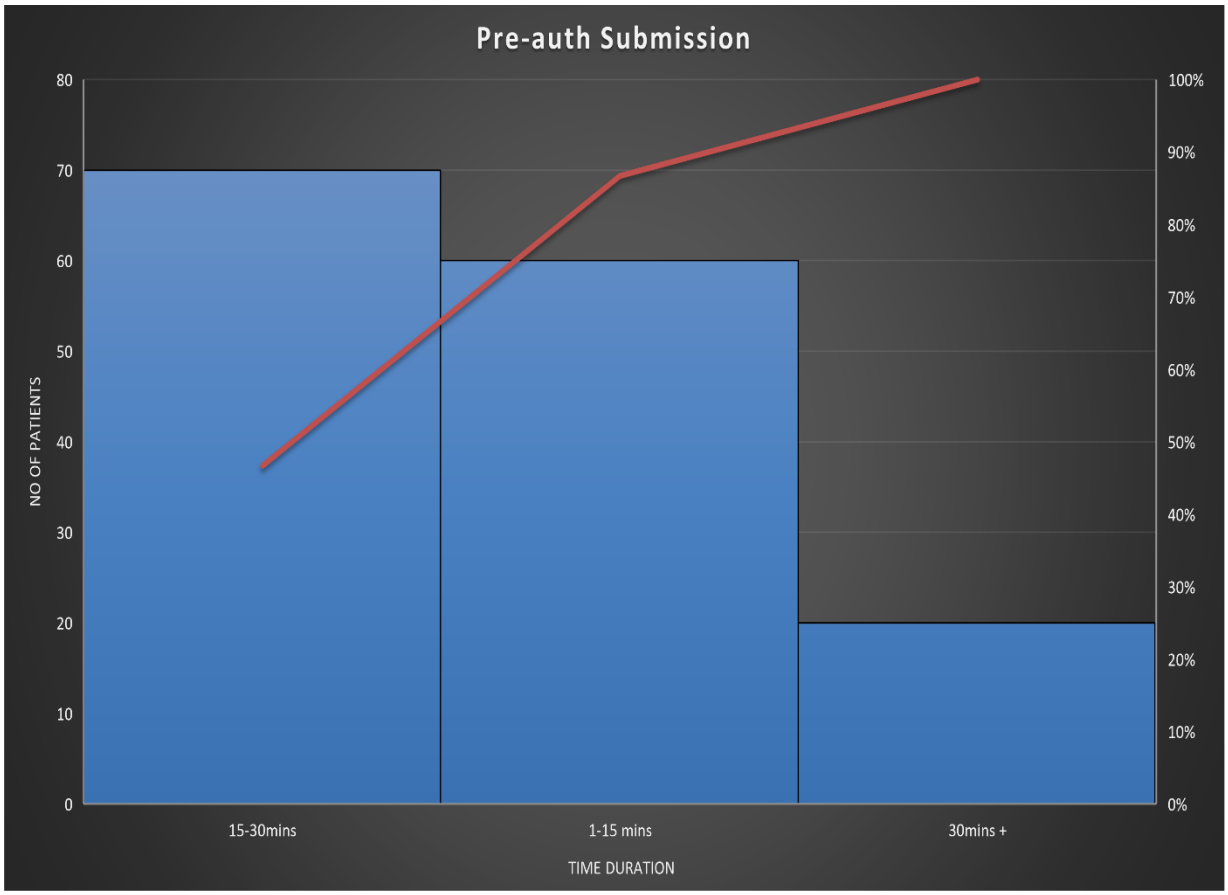
- **The average time taken TAT (Turn Around Time) is 00:16:55 Mins.**

Pre-Authorization is the first step of the Insurance cashless process and must be carried out with utmost clarity as it will be responsible if the claim will be approved and taken forward or not. Sufficient documents should be attached to justify the medical management undertook by the hospital and all previous prescriptions from other doctors to determine the progression on the case.

Once the Pre-auth is submitted it takes 3-4 hours for the approval to come from the Insurance company if not a rejection letter stating as to why the cashless claim was rejected.

The patient is counselled accordingly making it clear if the claim is not approved, they would be required to settle the hospital and treatment charges. Unbiased attention is being provided by the TPA department in works towards getting all the claim cases approved.

4.1.1) Pareto Chart Analysis-

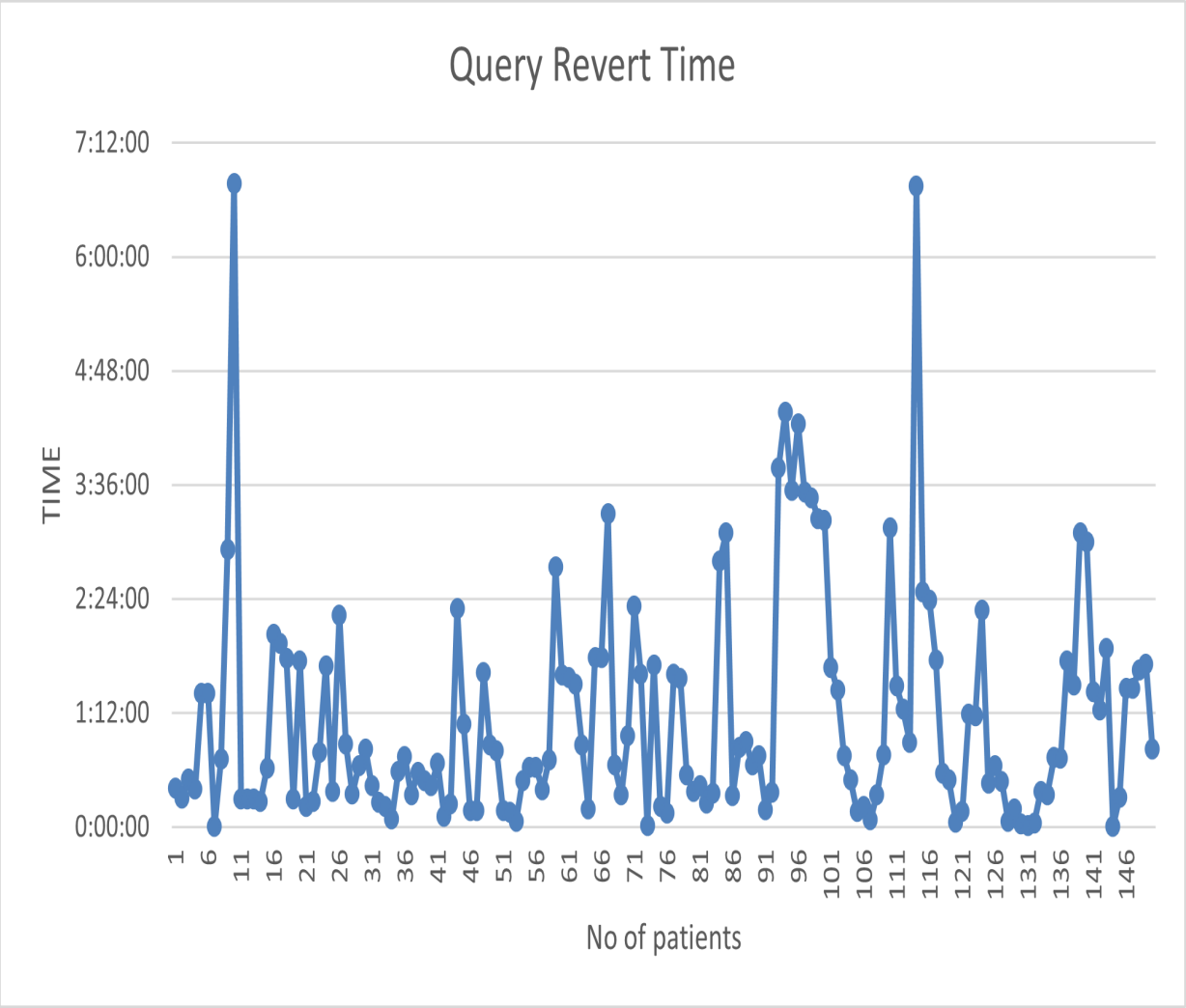


The Pareto chart above depicts that 70 patients out of the of the total no. of patients(150) had their pre-auth submission processed between 15 to 30 mins. Further 60 patients got the pre-auth submission process within 15 mins & 20 patients took more than 30mins due to waiting time for processing.

30 Mins is the optimum time required according to the SOP of Narayana Health.

Further it shows that 80% of the patients complete the process within 15mins and 25% takes more than 30 mins. This shows that further improvement in streaming the process will bring the remaining 25% into the optimum zone.

4.2) Query Revert TAT-



The above graph represents the data of 150 patients gathered over the course of 3 months. It documents the time taken from when a Query is raised by the insurance company to the TPA

department, till the query is revolved by the TPA by sending over required documents to the insurance company.

The process is a mix of both online and offline processes happening together, thus the delays that can take place are -

- From the patient's side (Pending documentation, issue in the Policy terms)
- TPA's side (Documentation gathering like doctors notes, Investigation reports, Justification for procedures, Prescriptions etc.)

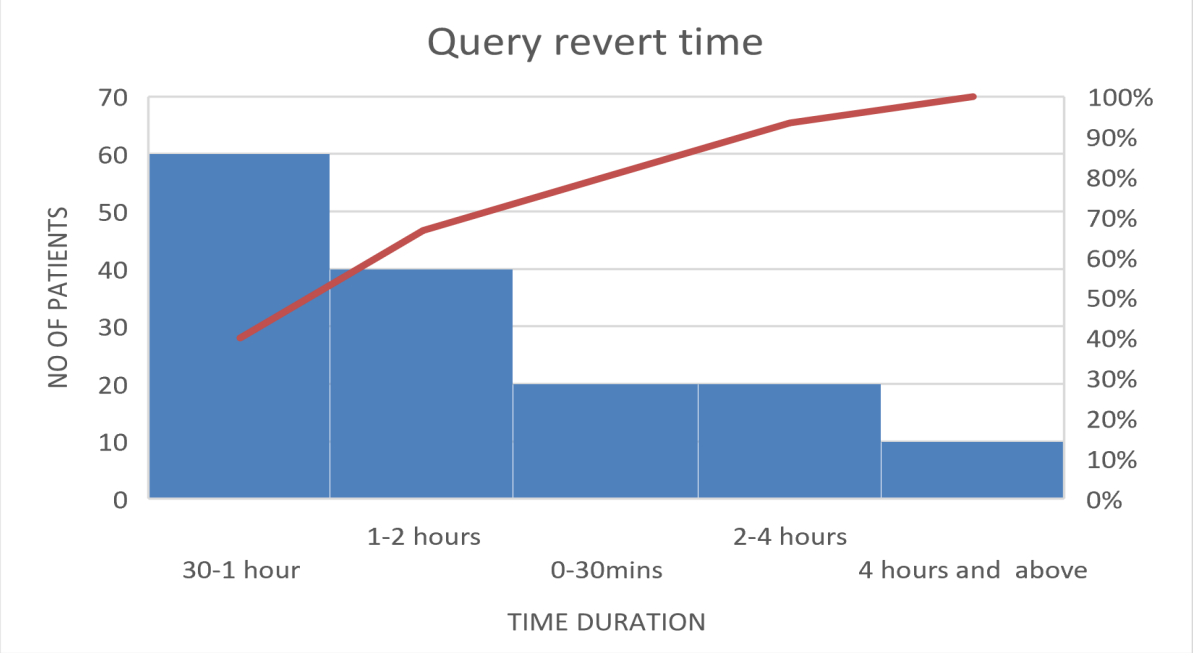
- **The average time taken TAT (Turn Around Time) is 01:09:17Mins.**

A Query can be raised by the insurance company before the approval has been granted if insufficient documents have been presented and would require fulfilling the requirements. Ex: doctors Note, supporting investigations, disease prognosis, documents to determine the onset of disease etc.

Reverting a Query takes time and can be a cause of delay in approval and can be prevented if proper documentation is carried out during the Pre-Auth submission.

If a query is not handled in a proper manner it may lead to the rejection of the claim and further cause financial strain to the patients and their families. TPA plays the role of a mediator to risk management and better patient satisfaction.

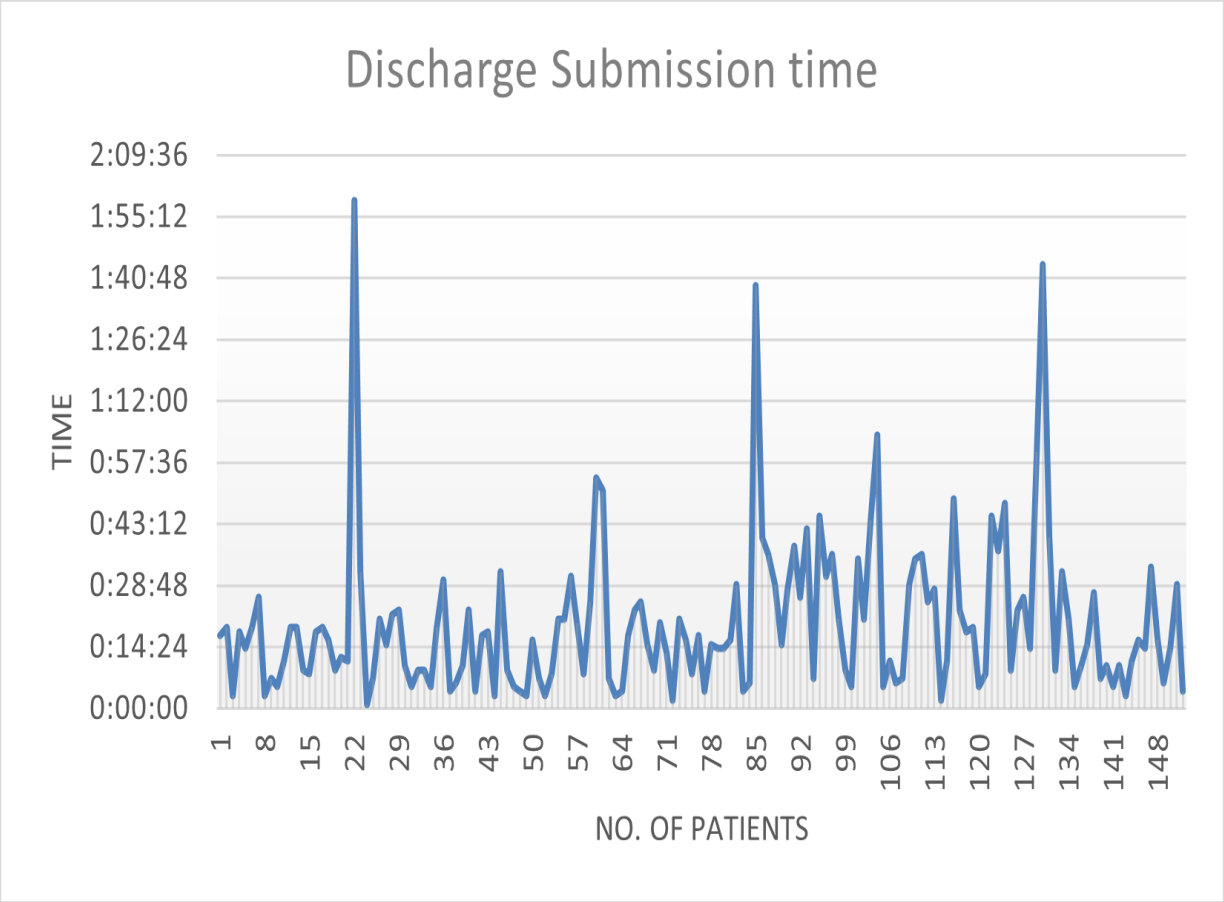
4.2.1) Pareto Chart Analysis-



The Pareto chart above depicts that 60 patients out of the total no. of patients (150) had their Query reverted in between 30 mins to 1 hour while 20 patients completed the process within 30mins. 40 patients query revert took 1-2 hours due to Queries being lined up. 20 patients process took 2-4 hours and 10 patients above 4 hours due to some major issue with the particular cases being peculiar in terms of Insurance approval.

30mins is the optimum time required according to the SOP of Narayana Health.

4.3) Discharge Submission TAT-



The above graph represents the data of 150 patients gathered over the course of 3 months. It documents the time taken from when the Provisional Bill and Discharge summary are received at the TPA department till it is uploaded on the portal for final Approval from the Insurance Company.

The representation depicts the diversity of time taken as the process is a mix of both online and offline processes happening one after other, thus considering the duration for all the physical doc. to reach Green Chanel from different departments like Nursing Station and Billing department. Then after receiving all the documents TPA starts all the internal processing of the documents and sends it to the Insurance Company.

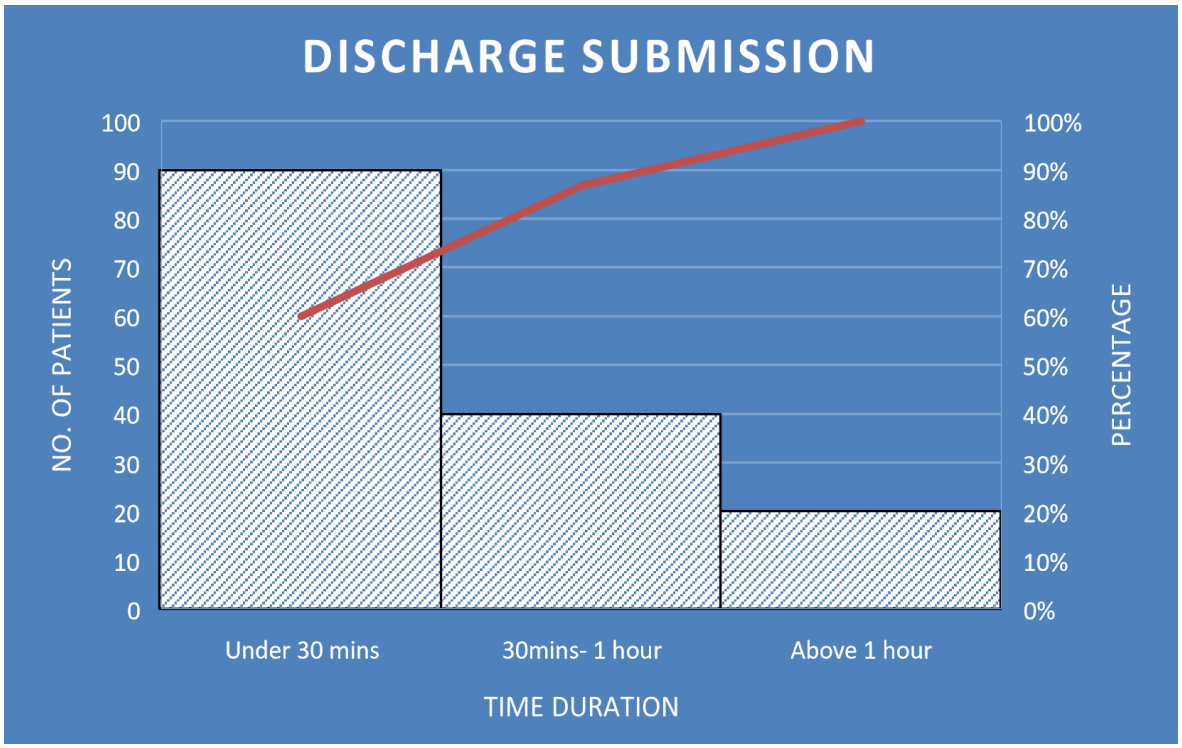
- **The average time taken TAT (Turn Around Time) is 00:19:47 Mins.**

The discharge process being so streamline due to ample no. of human resource being deployed in the TPA department and how they depict seamless coordination among one another is the reason for the process being within the required TAT of Narayana Health.

The discharged process is the final stage of the TPA Cashless claim process in which the documents are sent for final review by the Insurance company which takes about 3-4 hours from their end. Thus, to reduce the waiting time of the patient at the hospitals end it is important to keep the TPA processing time more optimum.

After the approval is received the patient is given a final checklist for discharge and this is where the work of the TPA department ends.

4.3.1) Pareto Chart Analysis-



The Pareto chart above depicts that 90 patients of the total no. of patients(150) had their Discharge submission processed in under 30 mins.

30 Mins being the optimum time required according to the SOP of Narayana Health.

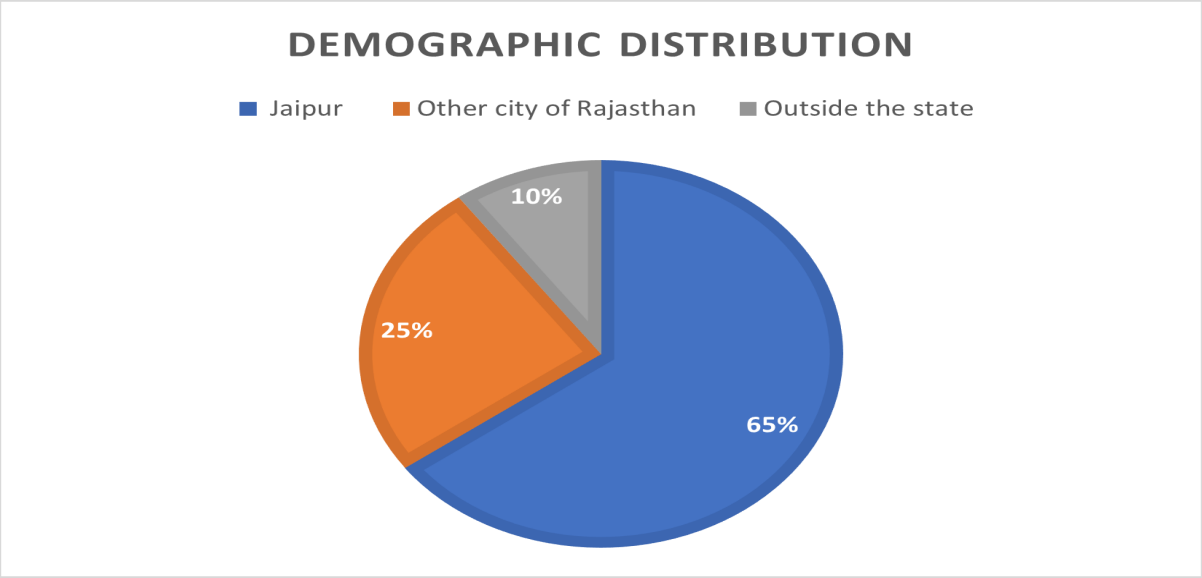
Further it shows that 40 patients complete the process in between 30mins – 1 hour. A slight delay is seen because of multiple factors on the patients end as well as hospitals side (Issue with billing, Bill amount exceeding the insurance sum assured) which can be brought down by proper coordination between internal departments of the hospital as well as communication between the TPA and patients when issues come up & rest 20 patients took more than 1 hour reason being a serious issue in IT infrastructure that is rarely faced and is not a common issue taking place.

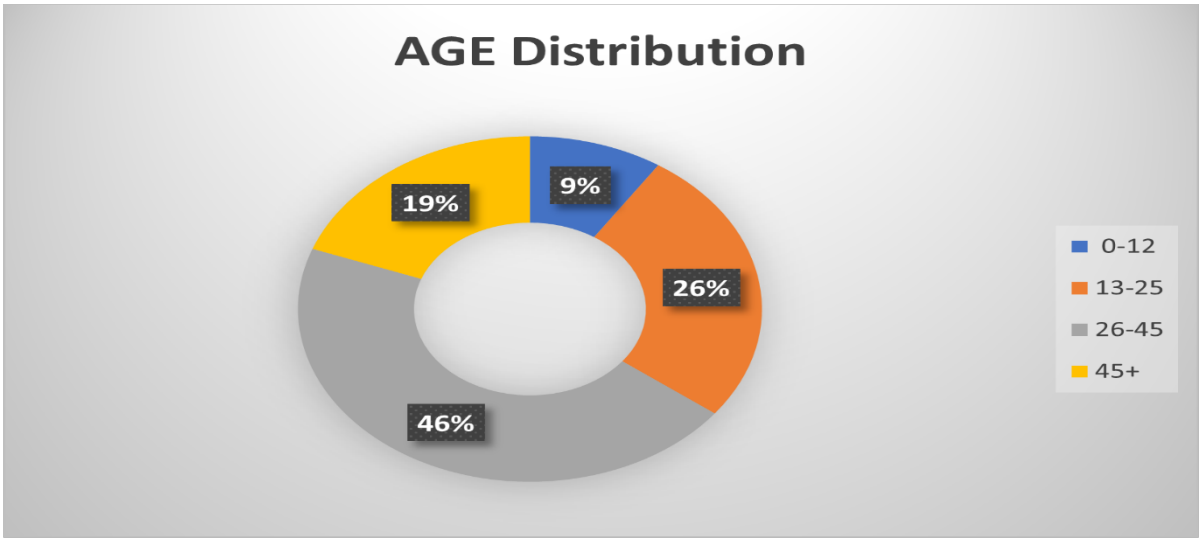
5) Discussion-

Healthcare executives and insured patients generally believe that the Pre-auth & Final Approval TAT for releasing insured patients is between four and six hours. However, there has been very little study done to determine the TAT for insured patients and to discover the elements that can be changed to shorten it. Additionally, the internal Third-Party Administrator department (TPA) is required to respond to and provide numerous documents requested by the external Third-Party Administrator during the course of a patient's stay in the hospital. In everyday language, this type of enquiry is referred to as a "query" or inquiries. To respond to these questions quickly and effectively is one of the most crucial duties of internal TPA department executives. The next process is the final discharge submission that is crucial for the final approval to come from the insurance company to process the discharge of the cashless insurance patient.

All the above-mentioned processes take place according to Naraya Hospitals SOP, that has made the process streamlined. At times delays cause hinderance in the smooth processing of claims, that can be brought down by bring reforms in the offline process of the TPA. Long waiting time to receive the physical file of the patient, coordination with different departments and doctors, dealing with a large traffic of patients with different demographic settings are all causes of delay.

The demography of the cashless insurance patients-





6) Conclusion-

The process of the TPA cashless claim process is a vital part of patient satisfaction and financial addressal thus it possess a utmost need in its reform and proper efficient working for better handling the patients care in term of financial assistance.

The processes of TPA are tedious and are required to be streamlined and efficient. The finding of the study conducted are-

Average Turnaround Time (TAT)

- Pre-auth Submission time- **00:16:55 Mins.**
- Query Revert time **- 01:09:17Mins.**
- Discharge Submission time**- 00:19:47 Mins.**

A large delay can be seen in Query revert as the process being diverse because documents have to be retrieved from different concerned departments as well as a doctors letter is required that can be time consuming. . Most of the delays were caused by procedures that may be enhanced by doctors and care teams' actions. This is required to be shared with the Insurance company to keep them updated with line of treatment being advised by the hospital unit and their doctors. How this process can be streaming line is advised in the recommendations section of the study.

The process of pre-auth submission and Discharge submission time is seen to be quite optimum and could be better improved by digitizing the Patient file to reduce physical movement through different departments.

At times major delays are seen in some exceptional cases either by hospital or patients end. Ex. IT malfunction, system error, portals unresponsive, medical fraud etc. Tho not been recorded in the study are a major cause of delays and dissatisfaction of the patients.

7) Recommendations-

Streamlining the Pre-auth submission process-

To make the pre-auth process more efficient there could be a process to inform the patients of the required documents beforehand so that they could be ready with the formalities from their end to reduce the processing time.

Streamlining the Discharge submission process-

The time it takes for the discharge summary and provisional bill from the billing department to reach the internal TPA and the external TPA's approval following submission of the discharge summary and provisional Bill are the two key subprocesses that describe the discharge process.

As a result, the roadblock and reason for the discharge process's delay is not processing time but rather the actual movement of the documents through various internal departments before they are finally delivered to the TPA department for processing the cashless patient's final approval.

Hospitals must pay attention to how long it takes the discharge report to go to the internal TPA department. They can actually choose technology options like "electronic discharge system," which can make the typing, reviewing, revising, and submitting processes easier to the internal TPA department.

Streamlining the Query Revert process-

Hospitals should gather information about the inquiries sent by the external TPA and use Pareto analysis to identify the key categories that account for the greatest number of queries. By doing this, they can create a tool like a checklist that, when used in its proper form and spirit, will significantly reduce time and effort spent.

Manpower allocation-

Optimum use of human resource, for better efficiency and deliverance towards exceptional patient satisfaction and smooth processing of TPA Insurance cashless claims.

Training-

Better training to employees to refine their communication skills as it is of utmost importance during their financial counselling to make the process more transparent and to reduce the hassle of miscommunication and interpretation.

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