Evaluation of Turnaround Time and Process Enhancement of Reimbursement Claims Processing

By

Sayali Sanjay Sahasrabudhe

Dissertation submitted in partial fulfillment of the requirements of the degree

MBA Hospital and Health Management

Academic year, 2018-2020

The IIHMR University, Jaipur

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TO WHOMSOEVER MAY CONCERN

This is to certify that **Dr. Sayali Sahasrabudhe**, student of MBA Hospital and Health Management from the The IIHMR University, Jaipur internship / dissertation training at Aditya Birla Health Insurance, Mumbai, Maharashtra from 5th February, 2020 to 30th April, 2020.

The student has successfully carried out the study designated to him during the internship /dissertation and his approach to the study has been sincere, scientific and analytical.

The Internship/ Dissertation is in fulfillment of the course requirements.

I wish him all success in all his future endeavors.

Dean Academics and Student Affairs
The IIHMR University, Jaipur

Professor
The IIHMR University, Jaipur

HEALTH INSURANCE
Aditya Birla Health Insurance Co. Limited

ADITYA BIRLA CAPITAL
PROTECTING INVESTING FINANCING ADVISING

June 12, 2020

To Whomsoever It May Concern

This is to certify that **Dr. Sayali Sahasrabudhe** has successfully completed her Internship Program with us from 5th February 2020 to 30th April 2020.

During the internship, she was part of the Service Operations team and has worked on the project "Evaluation of Turnaround Time and Process Enhancement of Reimbursement Claims Processing" at ABHI

We take this opportunity to wish her all the best in her future endeavours.

Thanking you,

Yours sincerely,

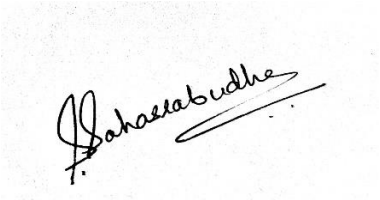
For **Aditya Birla Health Insurance**

Anuradha Puranik
Head – Corporate HR

THE IIHMR UNIVERSITY, JAIPUR

CERTIFICATE BY SCHOLAR

This is to certify that the dissertation titled **"Evaluation of Turnaround Time and Process Enhancement of Reimbursement Claims** and submitted by **Dr. Sayali Sahasrabudhe** Enrollment no: **IIHMR-U/01/2018-20/0822** under the supervision of **Dr. Alok Mathur** for award of MBA Hospital and Health Management of the University carried out during the period from **5th February to 30th April, 2020** embodies my original work and has not formed the basis for the award of any degree, diploma associate ship, fellowship, titles in this or any other institute or other similar institution of higher learning.



Signature

ABSTRACT

Health Insurance is an up-and-coming service sector in India. Due to liberalization of economy and general awareness among the public, there is an upward trend of the Insurance sector. Different health plans have been offered by the private health Insurance companies, so for that the smooth process of the claims processing hold the utmost importance resulting in the efficiency and high customer satisfaction.

'Reimbursement claims is you pay the hospital bill first and then get them compensated from the insurance company at a later stage.' To give the best value to the customers and provide a trouble free experience, and the entire process was observed. The objective of the study is to observe the process flow of reimbursement claims (network and member), access the gaps in the claims processing and evaluation of turnaround time, to provide the recommendation for these gaps and TAT which helps in improving the efficiency and customer satisfaction. The performed study is observational descriptive study. After analyzing the study it was found that the process flow of the claims which was formed initially is totally different form the functional process undergoing now. Gaps are observed reported and the recommendations are done. The study resulted in the time reduction of the claim process, therefore in the improvisation in the efficacy of the employees, adequate use of resources and lowering the Turn-around time.

AKNOWLEDGEMENTS

I owe my massive thankfulness to certain individuals for their full commitment towards this work. This study couldn't have been fruitful without the help of some concerned individuals. I extend my sincere gratitude to my mentor, **Dr. Kamlesh Ghadge**, Chief Manager and Dr. Pankaj Donde, Senior Manager, Claims Dept. of Aditya Birla Health Insurance Company Limited. I am grateful to them for investing their valuable time with me and giving me the bits of knowledge to finish this work. I might likewise want to thank my office partners for continually helping me.

I would also like to thank **Dr. Alok Mathur** IIHMR University my guide for providing me support in completing my project successfully as well as giving insights into the operational issues which came across the project.

I extend my gratitude towards The IIHMR University, Jaipur for giving me the opportunity to embark on this project.

Most importantly, for abundance mercy and providing me good health throughout the study; I thank my Almighty God.

TABLE OF CONTENTS

ABBREVIATIONS

ABC – Aditya Birla Capital

ABHI – Aditya Birla Health Insurance

IRDA – Indian Regulatory and Development Authority

TAT – Turnaround Time

SOP's – Standard Operating Procedure

TPA – Third Party Administrators

PPN – Preferred Provider Network

Section 1: INTRODUCTION

"The term Health Insurance relates to a type of insurance that especially covers your medical expenses. A health insurance policy like other policies is a contract between an insurer and an individual or group in which the insurer agrees to provide specified health insurance cover at a particular "premium" subject to terms & conditions specified in the policy. Health insurance covers the whole or a part of the risk of the person incurring medical expenses, defined as the coverage that provides for the payments for the payments of benefits as a result of sickness or injury includes losses from accident, medical disability and or death due to accidents. It is thus unavoidable for the Insurance company, which makes sure that the process which are related to claims are done accurately thus leading to high customer satisfaction which ultimately reduces the TAT".

The study was conducted at Aditya Birla Health Insurance Private Limited, Mumbai which aims to study(analyze) the gaps in the processing of Reimbursement claims and reducing the TAT in the Claims Department. The standard operating procedures which were formed initially were not functional as they should have been followed, there were gaps and inconsistency in them. Thus the whole focus of the study was to observe the functional process flow of the Reimbursement claims and accordingly make a standard operating procedure for the same. In any claim insurance process the effectiveness can be accessed with the help of the turnaround time of the Reimbursement process which came out to be 15 days. From the point of the Insurance company and the insured the time taken from the processing of the claim is very important as it gives the patient the best services and from the Insurance company point of view, lesser the time, it becomes the selling point of the services of the company which will maintain and increase the productivity.

1.1 AIM

'The aim of the study is to analyze the process of the claims and to evaluate the TAT of the Reimbursement process and updating the process flow'.

1.2 OUTLINE OF THE STUDY PREFERRED

The study was performed using Secondary data, the process flow of ABHI claims was observed with assessment of TAT.

For secondary research, the online reports, ABHI website and previous standard operating procedures were referred to make the changes.

Section 2: RESEARCH QUESTION

- How is the Reimbursement process really operationalized?
- What is the Turnaround Time of Reimbursement process?
- Are there any gaps in the process of Reimbursement which needs to be filled?

Section 3: OBJECTIVES

- To find out the Reimbursement (Network & Member) process flow.
- To assess the turnaround time of the Reimbursement process.

Section 4: METHODOLOGY

This study was a part of my dissertation Programme at Aditya Birla Health Insurance Private Limited and was in Claims Department. This study also included secondary data which was followed by Turnaround time and to make the changes in the standard operating procedures.

MODE OF DATA COLLECTION

The secondary data information was collected for a period of 3 months.

QUANTITATIVE DATA

Watching the procedure and assessing the TAT including the investors point of view about the procedure improvement , their commitment towards the effective processing and analysis on information gathered was finished.

SAMPLING TECHNIQUE

Simple Random Sampling technique was used.

For the Reimbursement process, 1912 cases taken randomly 1274 cases were approved, 208 were denied and 430 cases were under Query.

Section 5: LITERATURE REVIEW

1. Claims is a generally steady procedure including number of characterized steps which are to give efficient and effective customer service. To address the issues of the client or third party as per the terms and states of the arrangement at the most reduced expense. Initial intimation of a case where the customer needs to give the underlying subtleties of the case in empowering the safety net provider, if there should be an occurrence of the mind boggling cases to jump on the site as quickly as possible.

2. Health Insurance organizations have made the hospitalization procedure considerably simpler with the confirmation of cashless case handling in under 30 mins. With their quality in all the main emergency clinics, insurance agencies have become a pioneer in this service. While finding an appropriate hospital which offers cashless cases was an undertaking once, the expanding nearness of different significant hospitals has caused this to vanish too. With a cashless case, you can evade these problems and make the procedure rapider and quicker. It removes the pressure of organizing and taking care of money as well, which turns out to be particularly useful in instances of emergencies.

3. Procedure of Reimbursement of Claims:-

The insured person has to has to submit the necessary documents to TPA (if claim is processed by TPA/ Company) within the prescribed limit.

4.

TYPE OF CLAIM	THE LIMIT FOR SUBMISSION OF DOCUMENTS TO TPA/ COMPANY
Reimbursement of hospitalization, pre hospitalization expenses & ambulance charges	Within 15 days from the date of discharge from hospital
Reimbursement of post hospitalization expenses	Within 15 days from completion of post hospitalization treatment
Reimbursement of domiciliary hospitalization expenses	Within 15 days from issuance of fitness certificate
Reimbursement of anti-rabies vaccination & new born baby vaccination	Within 15 days from date of vaccination
Reimbursement of expenses for infertility treatment	Within 15 days of completion of treatment or 15 days of expiry of policy period, whichever is earlier, once during the policy year

5. Healthcare reimbursement depicts the payment that your hospital, doctor, diagnostic facility, other healthcare providers receive for giving the insured/ policy holder a medical service. Often, the health care coverage organization or an administration payer takes care of the expense of all or part of protected/approach holder might be answerable for a portion of the expense and on the off chance that they don't have social insurance inclusion by any stretch of the imagination, will be mindful to reimburse your healthcare providers for the entire expense of your medicinal services. Payment happens after you get a clinical assistance, which is the reason it is called reimbursement.

6. Settlement & Denial of Claims:

   Insurers or TPA's, as might be appropriate, will attempt to gather records for preparing claims for removal electronically. Claims that are being settled will be done through e-installments by the insurer. Where cases are straightforwardly dealt with by the insurers, the arrangements of Regulations (21) (3) (c) of IRDAI (TPA-Health Services) Regulations, 2016 will be consented in the correspondence to the approach holder w/r/t the settlement of the claims. The insurer will be liable for appropriate and brief support of the policyholders consistently, where a claim is denied or repudiated, the

correspondence about the refusal or repudiation, while fundamental alluding to the relating policy conditions. The insurer will likewise outfit the complaint redressal systems accessible with the Insurance agency and with the Insurance Ombudsman alongside the definite locations of the separate workplaces. More than one TPA might be locked in by an insurance agency. Some of the Issues of Health ClaimsUnregulated Healthcare Sector. \

- Variation in costs for certain techniques across various clinics in various urban communities.
- Variations in costs in same hospitals for same method over various patients.
- Hospitals have separate valuing for Insurance/Non-insurance patients.

Section 6: REIMBURSEMENT PROCESS

"A reimbursement facility is a health insurance policy requires the patient or policyholder to pay the medical bills upfront, the insurer reimburses these costs later after a claim is filed. A reimbursement policy, allows the insured freedom of choice regarding the hospital or healthcare provider".

"The reimbursement claim for the health insurance can be made if the policyholder opts to go to a hospital of his/ her choice, which is a non-empaneled hospital. In this case, the cashless claim facility cannot be used. Therefore, the insured has to pay all his/ her medical bills & other costs involved in hospitalization & treatment & then claim reimbursement. In order to avail reimbursement claim you have to provide the necessary documents including original bills to the insurance provider. The company will then evaluate the claim to see its scope under the policy cover & then make a payment to the insured. In case the treatment is not covered under the policy, the claim will be rejected. The insurance provider generally provides reasons for the rejection".

DOCUMENTATION

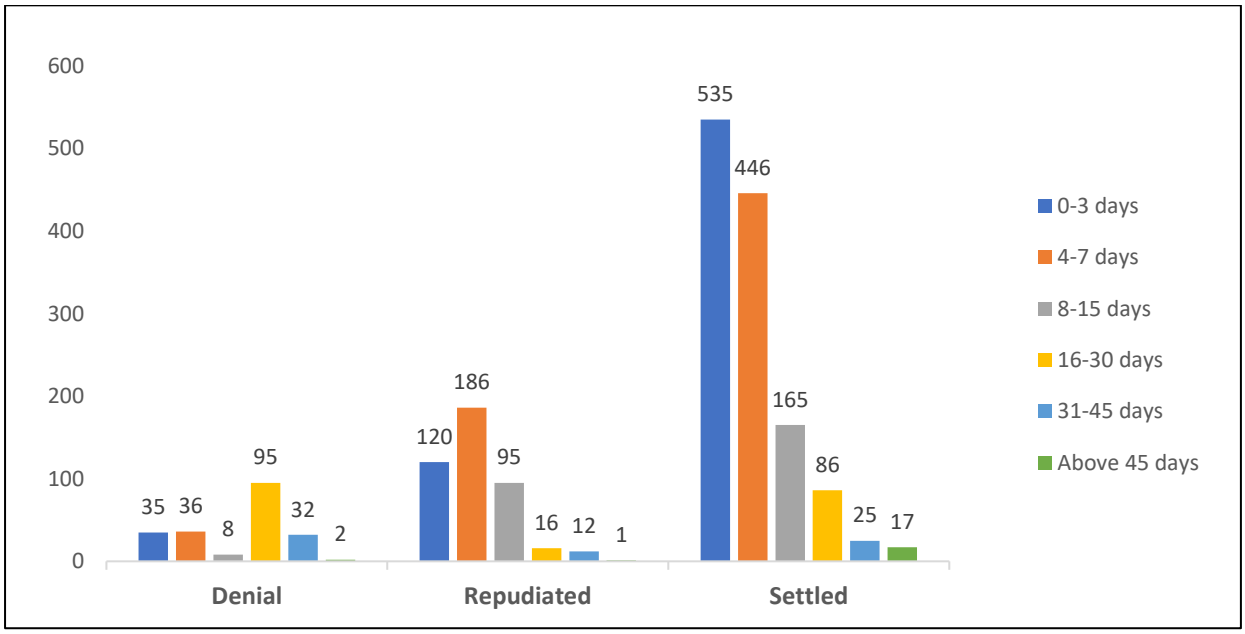
The following documents are required in order to make a health insurance claim:-

- Correctly filled claim form
- Medical Certificate/ Form which is signed by the treating doctor
- Discharge summary or card (original), from the hospital
- All breakup bills& receipts (original)
- Prescription & cash documents from pharmacies/ hospital
- Investigation reports
- If it is an accident case, then FIR or Medico-legal Certificate (MLC) is required.

Depending on the condition and the manner in which an insurer process the reimbursement, for any treatment, safeguarded should meet all the costs and gather each and every doctor's visit expense relating to the treatment. At the point when you are discharged from the hospital, gather the Discharge Certificate or Discharge Summary from the hospital. Present the Discharge card or Discharge Summary alongside the hospital expenses to the insurance agency. The organization would examine the bills and repay you for the claim caused.

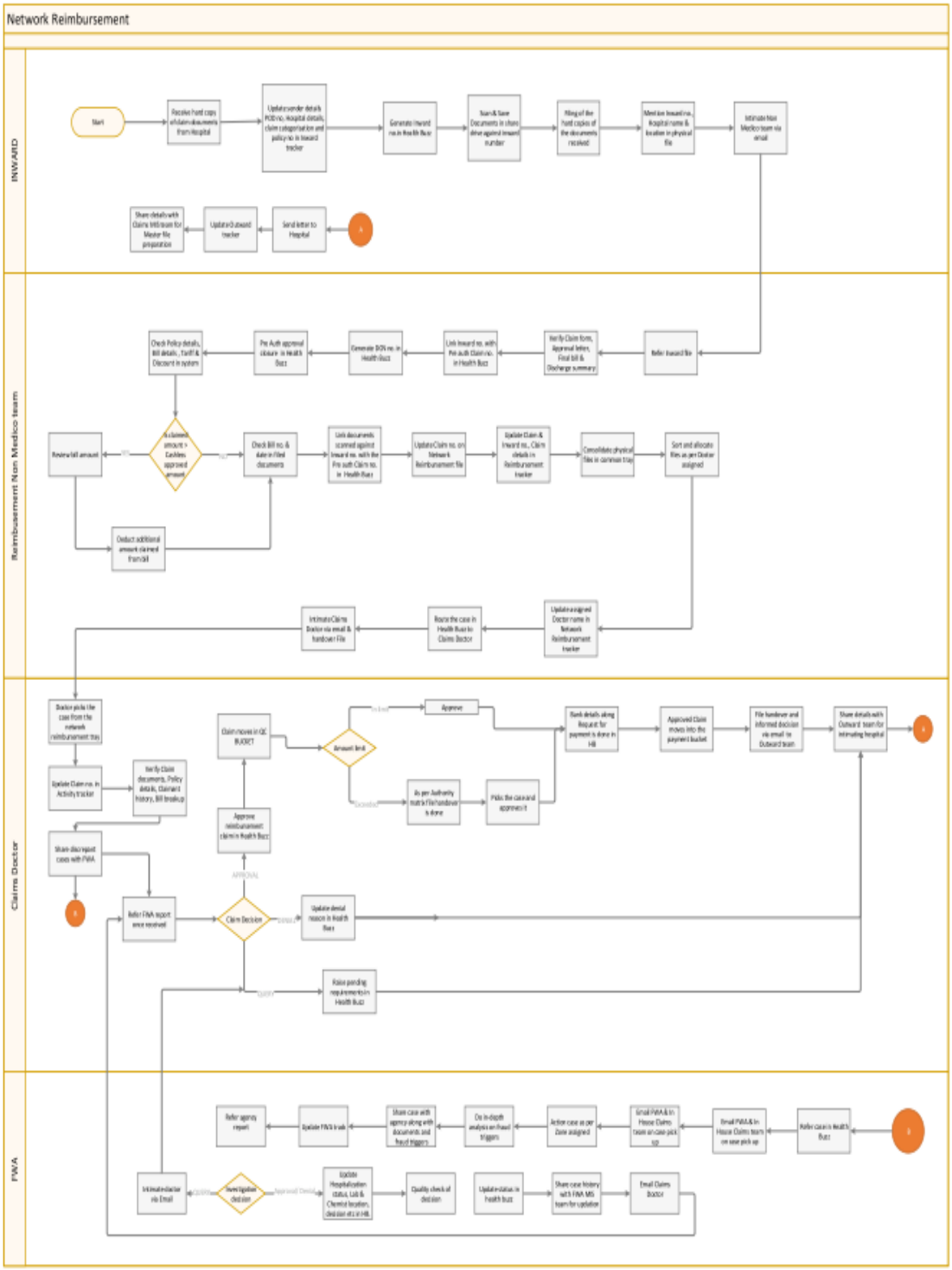
Turnaround Time of Reimbursement Process

STATUS	0-3 days	4-7 days	8-15 days	16-30 days	31-45 days	Above 45 days	Grand Total
Denial	35	36	8	95	32	2	208
Repudiated	120	186	95	16	12	1	430
Settled	535	446	165	86	25	17	1274
TOTAL	690	668	268	197	69	20	1912

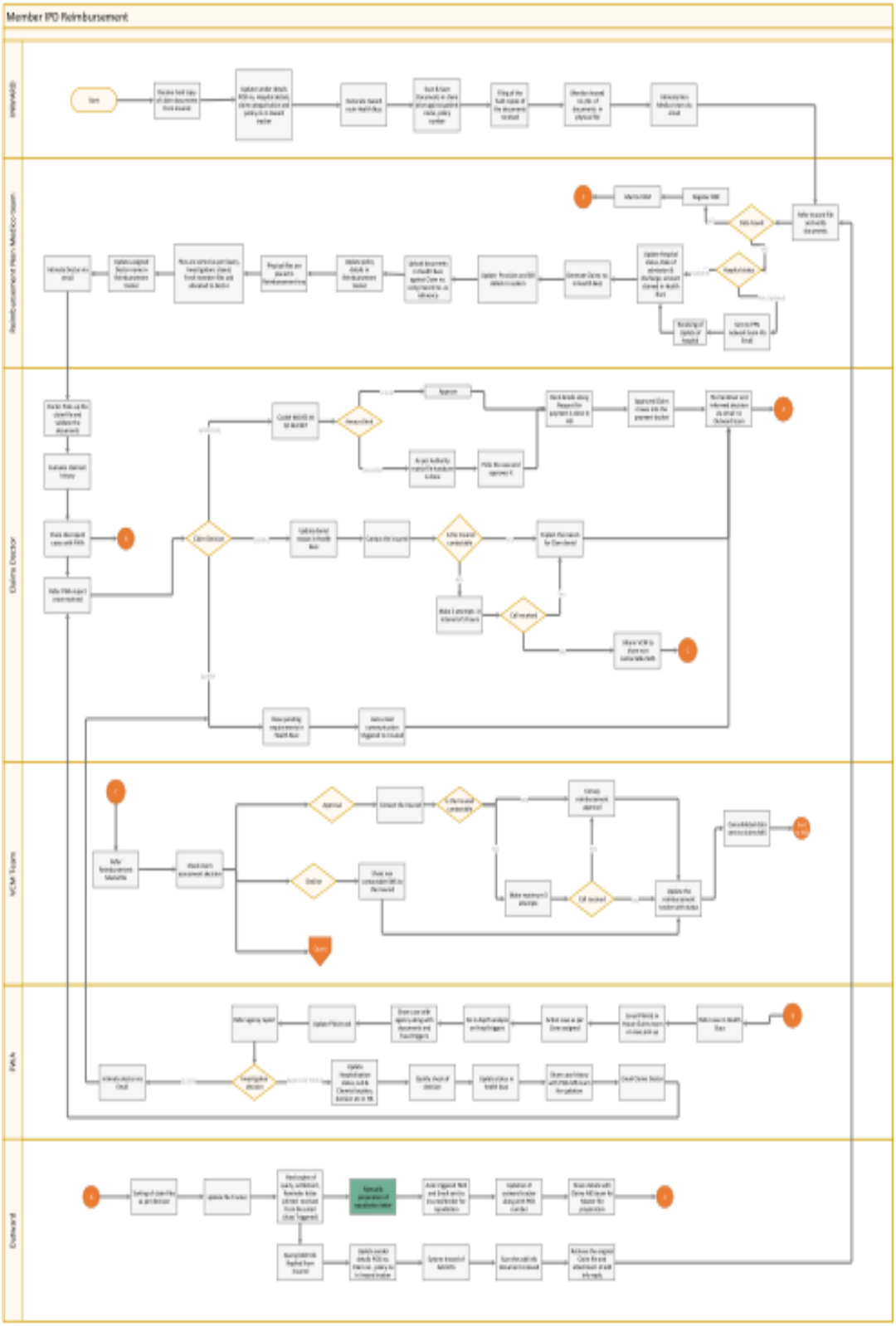


Graph showing Reimbursement process analysis

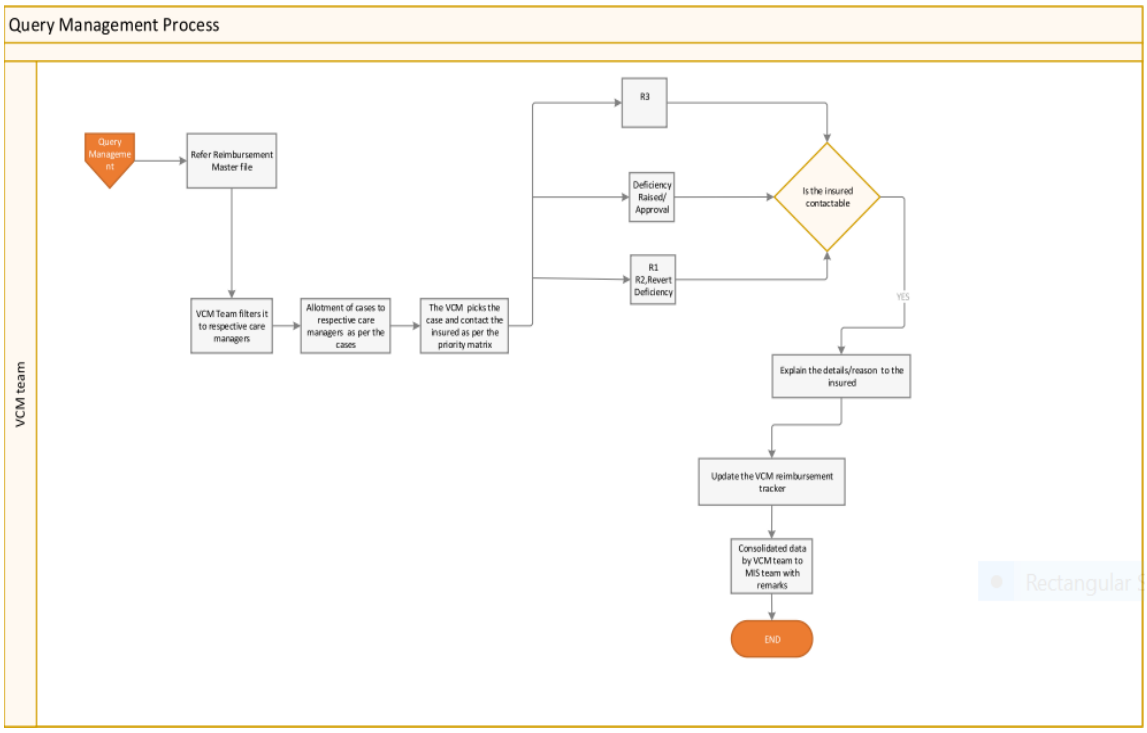
NETWORK REIMBURSEMENT



MEMBER IPD REIMBURSEMENT

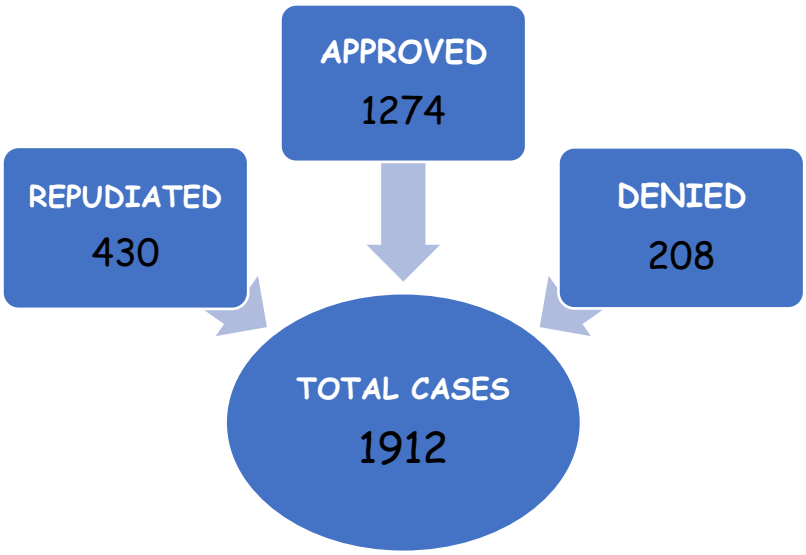


QUERY MANAGEMENT PROCESS

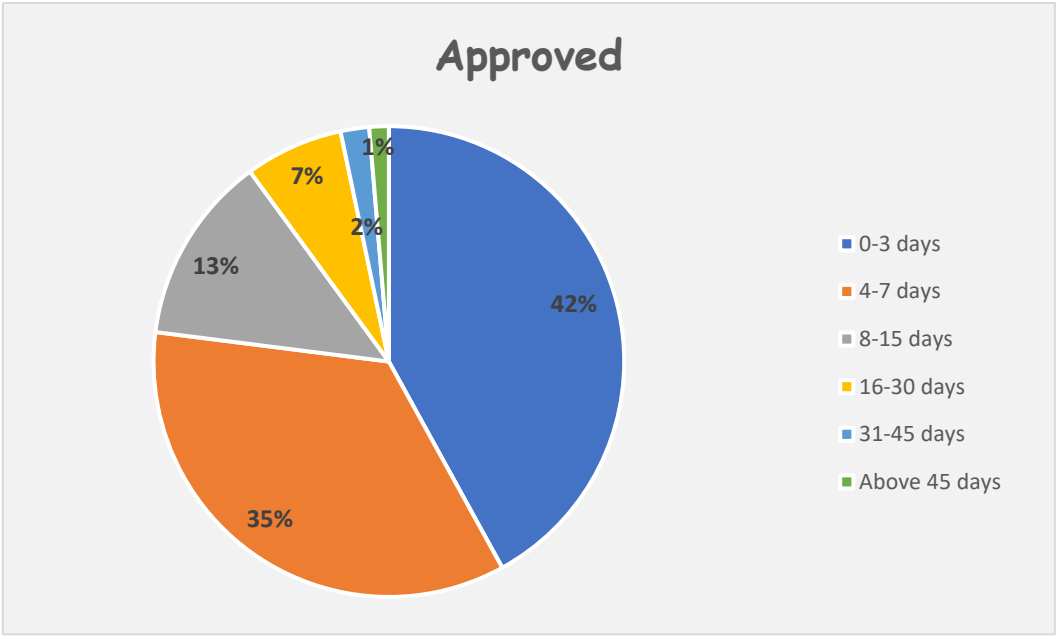


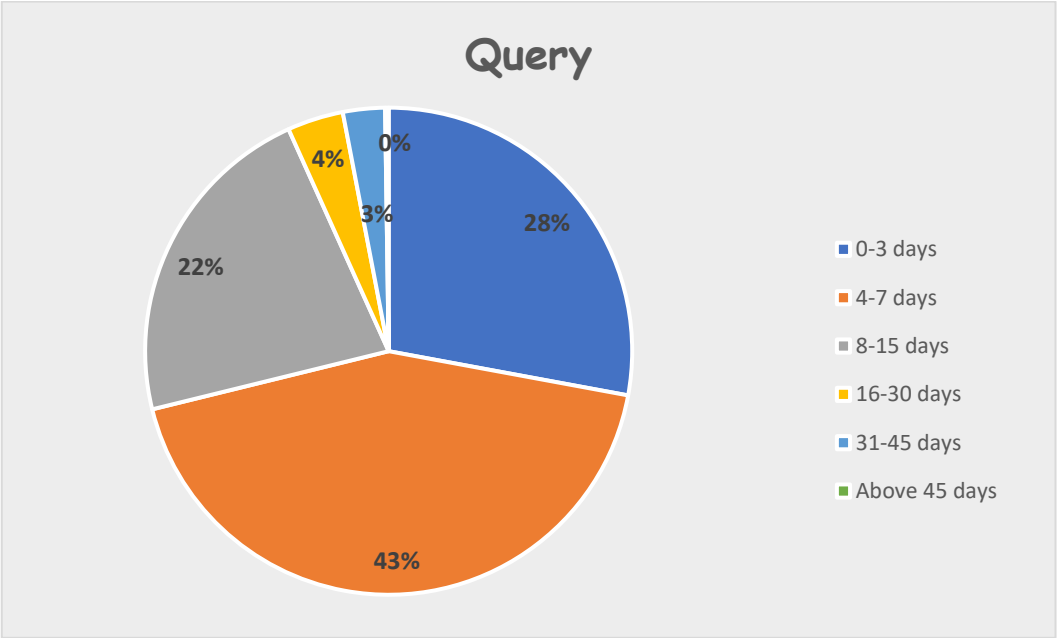
Section 7: RESULTS

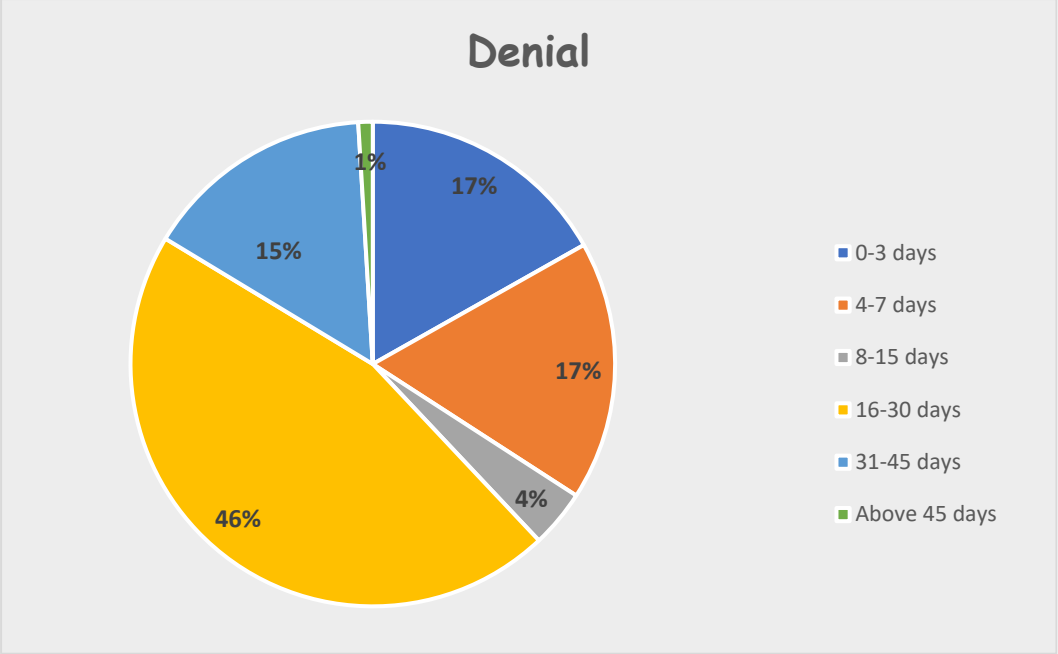
In Reimbursement process, the decisions are similar to the cashless, as either the case can be approved, declined or query will be raised. The Turnaround Time which is being set as per the IRDA regulations and followed by ABHI is around 15 days, As per the analysis for the period of data collection during the period 5th Feb, 2020 to 30th April, 2020 was analyzed, the sample size was 1912 out of 208 cases were denied, 430 were repudiated and 1274 were approved.



As far as the revised processes are concerned the whole focus is to be precise about the process flow to achieve the maximum efficiency, efficacy and customer satisfaction. The objective was to observe the process and observe the loop holes/ gaps and wherever there is scope for improvement in the process through reduction of minimal, manual work and reduction of TAT. Recommendations/ suggestions for the same was done which was implemented in the claims department of Aditya Birla Health Insurance.


Approved
42%
35%
13%
7%
2%
1%
0-3 days
4-7 days
8-15 days
16-30 days
31-45 days
Above 45 days


Query
28%
43%
22%
4%
3%
0%
0-3 days
4-7 days
8-15 days
16-30 days
31-45 days
Above 45 days



- In Reimbursement process, 42% of the claims were approved.
  Out of the 1912 files, 1274 cases were approved, which means that the cases were final processing of these cases were done,

- During the study, for 43% of the claims query was raised.
  Out of 1912 cases, query were raised against 430 cases because of Non-Disclosure or fraud suspect and were referred to the FWA team for investigation.

- In the duration of 30 mins, 46% of the claims were declined.
  Out of 1912 cases, 208 cases were denied because Non Disclosure or fraud wsa found out.

Section 8: GUIDELINESS

"IRDA has presrcibed time frames for policies and claims servicing and has instructed the Insurer & intermediaries to ensure that consumers are kept informed of their rights, in terms of the prescribed time frames for servicing".

- The "Turnaround Time" indicated for different exercises are preparing of proposition and correspondence of choices including prerequisites/issue of strategy/crossing out in 15 days.
- Acquiring duplicate of proposition 30 days post strategy issue administration demands concerning botches/discount of proposition store and likewise Non-claims related help demands 10 days.
- Disaster protection Surrender Value/Annuity/Pension preparing 10 days
- Development guarantee/Survival Benefits/Penal intrigue not paid 15 days
- Raising case prerequisites in the wake of housing the case 15 days demise guarantee settlement without examination necessities 30 days
- Passing case settlement/renouncement with examination necessity a half year
- Recognize a complaint 3 days settle a complaint 15 days.

Section 8: GAPS

- Before the processing of Reimbursement claim, the file comes to the office, here dur to the transport it becomes time consuming.
- Scanning and filling of the file takes a day.
- After bill entry, the file is handed over to the doctor, for final process so for assessment of the file the doctor doesn't get an extra time.
- Then later on after the same the file is either approved, a query raised or it is repudiated.
- If a case a sent for Investigation then, the investigator takes time to find out the necessary scam in the patients file/ genuinity which again increases the TAT.

- Final closure of the cases were not done due to the improper allotment of the file.
- In Reimbursement process, the handover of the physical file by the non-medico team was not sorted and allocated to claim doctor, no communication was auto triggered by the system.
- In Reimbursement process, generation of DCN number after generation of inward claim number for the particular case which increases the TAT of reimbursement process.

Section 9: SUGGESTIONS

- To maintain a tracking sheet in which the files are allocated to the medical team so that in future if any query is raised related to the patient/ documents one can immediately contact the medical person.
- The claims should be processed from scanned documents rather than waiting for original claim documents for saving time.
- Final closure of the case should be done from the system, otherwise it increases the final TAT.
- Updating of the software, HEALTH BUZZ was recommended with the additional features like flagging when case is picked up by a processor. Dashboard having different buckets, Pop up/ Notification on receiving of a claim.
- To make necessary changes and revise the SOP's accordingly.

Section 10: CONCLUSION

"Settling insurance claims is just one aspect of the claims management process. The time it takes to process a claim involves several stages beginning with a person filing a claim. The stages that follow determine if a claim has merit as well as how much the insurance company will pay. Insurance customers expect a company to settle claims quickly & to their satisfaction. As high customer satisfaction levels can give a company a competitive edge, reducing the time it takes to settle insurance claims is

one way to decrease the number of customer complaints & improve service. The use of claims management system software that speeds the process & minimizes costs offers a practical solution. Simplifying the claims process through automation helps reduce expenses for insurance companies".

Section 11: REFERNCES

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- https://www.google.com/search?q=IRDA+time+frames+and+policies&oq=IRDA+time+frames+and+policies+&aqs=chrome..69i57.7466j0j7&sourceid=chrome&ie=UTF-8
- https://www.policygenius.com/health-insurance/learn/health-insurance-basics-and-guide/
- https://www.carecloud.com/continuum/how-healthcare-reimbursement-works/