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ASSESSMENT OF CASE MANAGEMENT PROCESS OF MAXBUPA HEALTH INSURANCE COMPANY, BANGALORE

Dr. Nabila Khan

Hospital Stream

INTRODUCTION

Health insurance companies are always subjected to challenges of increase in the medical loss ratio, resulting from rising claim cost. It is estimated that crores of rupees are lost annually due to healthcare fraud and abuse. National Health Care Anti-Fraud Association (USA) has defined healthcare fraud as "The deliberate submittal of false claims to private health insurance plans and/or tax-funded public health insurance programs." Abuse on the other hand can be defined as "Practices that are inconsistent with business ethics or medical practices and result in an unnecessary cost to claims." Absence of standard treatment protocols and regulatory mechanism by the insurance company, allows the provider/ hospital to add unnecessary cost to claims, in order to get monetary benefit out of it that is completely unjustifiable.

Common healthcare abuse practices that lead to increased claim expenditure include inappropriate billing for the medicines and services that are not provided, substantial tariff variations between actual bill & tariff (up-coding), addition of unwarranted procedures, consultations, expensive medications, excessive diagnostic tests, extended length of stay etc.

Clinical Quality & Governance (CQG) team of Health Risk Management (HRM) Department of MaxBupa has been working on few processes in order to control fraud and minimise abuse by the provider, and thereby reducing the medical loss ratio. One of such process is Case Management, through which MaxBupa is able to investigate such fraud and abuse, before it costs millions to them. Case management for high cost illness is designed to control the health care expenditures for a small proportion of population that accounts for a large share of health expenditures. Main focus of the process is on triggers. i.e. live preauthorisation requests, that helps in early detection of suspicious cases. Preauthorisation request is generated by the hospital at the time of admission of the patient. Preauthorisation form is shared with the company by the provider or hospital at the time of the request, which contains general information of the patient, clinical condition with which the patient is suffering, treatment required by the patient, expected length of stay, estimated amount of

the treatment required and the breakup of the estimated amount. These triggers are either managed through online system or by case manager by personally visiting the hospital, from where the request has been generated. The ultimate purpose of case management is to achieve cost effective quality care.

The present study was conducted to understand the importance and process of case management and to analyse its effectiveness in cost containment.

AIM AND OBJECTIVE

The aim of this study is to understand and analyse the effectiveness of case management by measuring outcomes in terms of savings.

Specific Objectives:

- To calculate savings by comparing the requested amount with the final bill amount.
- To identify the factors that are adding unnecessary cost to claim.

METHODOLOGY:

A cross-sectional study was carried out for a period of 1 month from 15-April 2019 to 20-May-2019 in Maxbupa Health Insurance Corporation, Bangalore. This study was a time and motion study; the total sample size of 50 patients was collected.

Convenient sampling technique was used and planned to involve all the patients whose triggers were generated. Total number of eligible patients were 50.

Data was recorded in a tracker sheet, formulated and entered in an excel spreadsheet and then analysed to measure the outcomes.

Study Criteria:

Inclusion Criteria:

Study population included all the patients with cashless scheme.

Exclusion Criteria:

Patients whose preauthorisation requests were rejected or cancelled

Data Collection, Tools and Techniques:

Source of data collection was primary and data was extracted from-

1. One to one discussion with the TPA person and doctor

2. Case sheet of the patient

Tools and Techniques

Collected data was entered in excel spreadsheet under the following headings:

1. Preauthorisation Number - This is the unique identification number allotted to patient at the time of admission request.
2. Patient Name
3. Age and Sex
4. Estimated Amount - This is the requested amount shared by the Hospital with the insurance company for the treatment of the patient.
5. Estimated Length of Stay by the Hospital
6. Final Bill
7. Final LOS
8. CM Status - It is divided into 2 categories- WIP (Work in Progress) and Closed.
9. Work in Progress means patient is still admitted and requires rigorous follow up and in Closed Status means patient is discharged from the hospital
10. CM Outcome- It is divided into three categories-

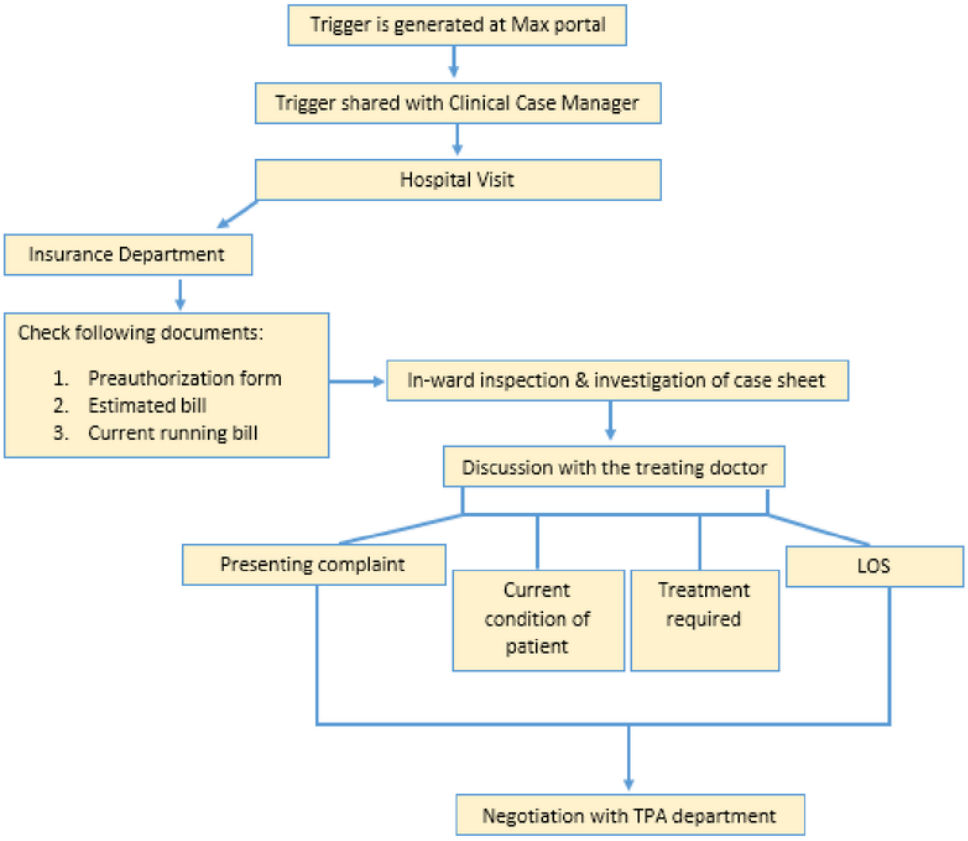
- Deduct and pay/Successful - This means that case management was successful and saving was achieved
- Failed - This means that case management process failed to save any cost
- Screened and abandoned

11. Pointer of Negotiation- It includes two factors, that help us achieve savings-

- Excess LOS
- Over-billing

12. Savings
13. Short Summary

PROCESS FLOW



RESULT AND DISCUSSIONS

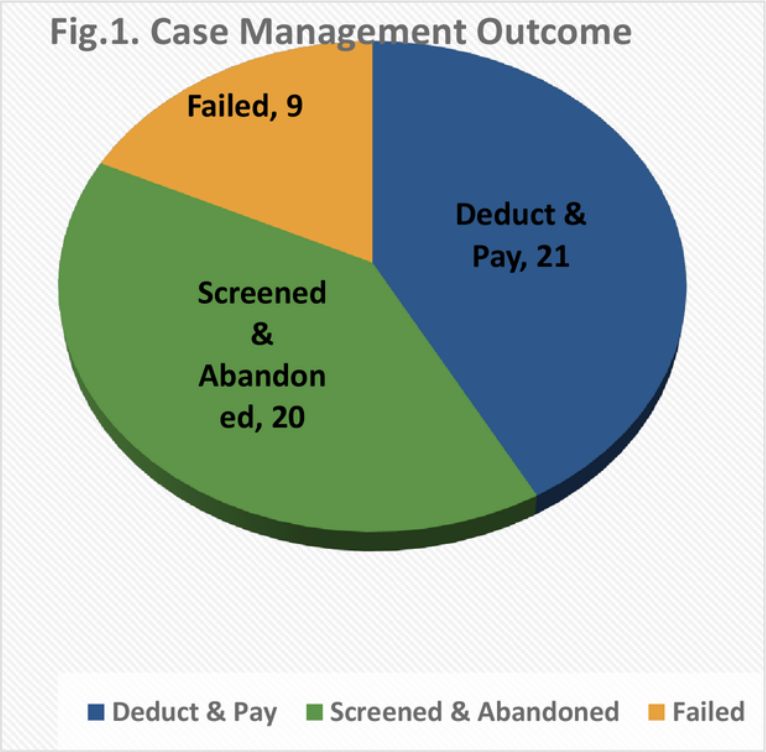


Fig.1 depicts Case Management Outcome. Savings were achieved only in 42% of cases, as case management was successful, where as in 18% cases case management failed to contain cost as the final bill crossed the estimated amount requested by the hospital and this happened in cases where there was lack of rigorous follow up, discrepancy in taking approval for certain specific implants at the time of surgery and in cases wherein final bill shared by hospital was medically appropriate. Rest 40% cases were screened and abandoned, as there was no scope of savings, it included patients with package pricing, patients who were in OT, patients who were on discharge, and patients whose estimated amount given by the hospital was medically justifiable.

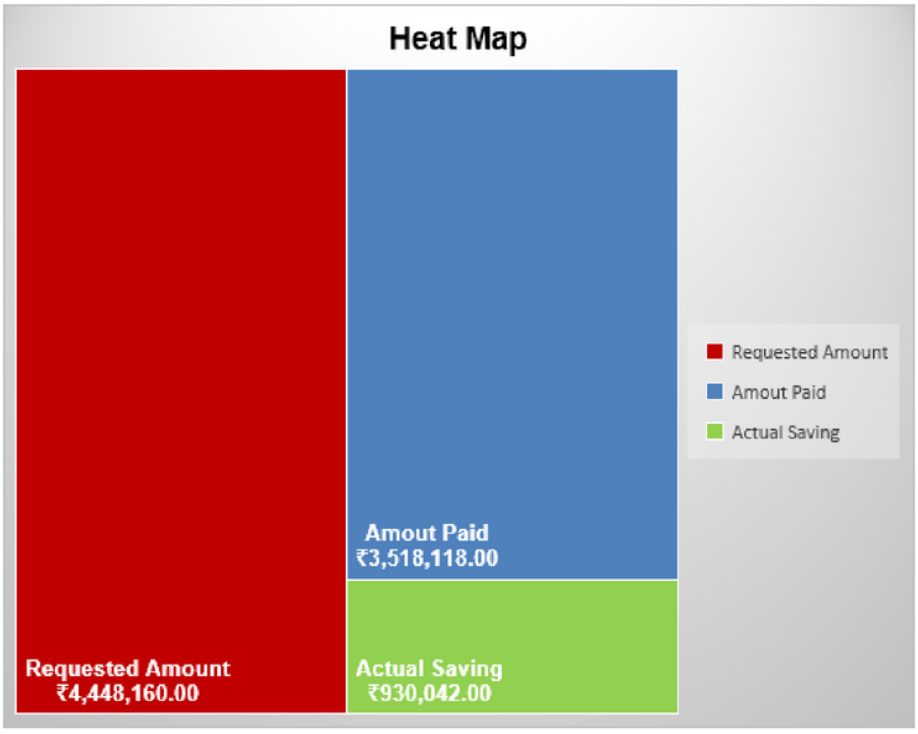


Fig.2. This heat map is a two-dimensional representation of data in which values are represented by colours. It provides immediate visual summary of requested amount by hospital, amount paid by insurance company i.e. the final bill and actual savings achieved through case management process. The one with the highest value is giving a hot color, where as the one with lower value is relatively giving a cold color and hence forth it is easy to visualise the change and analyze the data quickly. The estimated amount shared by the providers was Rs. 4,448,160, and after case management estimated amount was reduced and final bill paid by insurance company was Rs. 3,518,118 and henceforth the actual savings achieved by the company through the process of case management was Rs. 930,042.

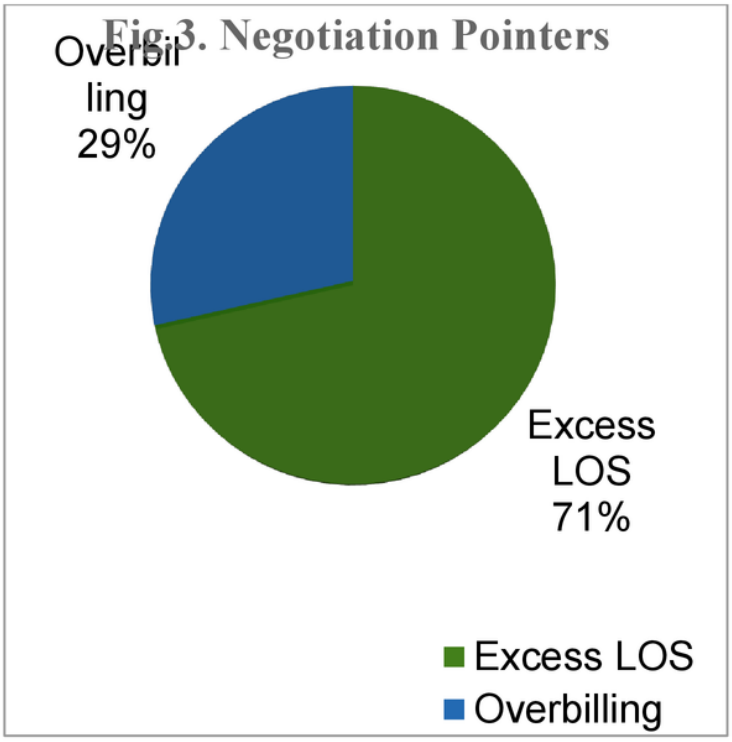


Fig.3. depicts Negotiation pointers. These are the factors that add unnecessary cost to claim. Outcome was successful in cases wherein there was over billing or the estimated LOS shared by hospital was high, since only in these two pointers hospital tries to make maximum profit.

It was observed that in 29% of the cases the estimated amount shared at the time of preauthorisation i.e. admission was very high and after inspection done by case manager the cost reduced drastically. The focus for reduction in cost is made specifically on certain bifurcations that are shared in the preauthorisation form and that are: room charges, nursing charges, consultation fees, pharmacy (medication & consumables) and investigations.

However, in 71% of cases the estimated LOS shared by the hospital was more than actual requirement of the patient. The aim in such cases is to first understand the patient's medical condition and second, to discuss the same with concerned consultant and if it is found to be stable, efforts were made to reduce unjustified length of stay.

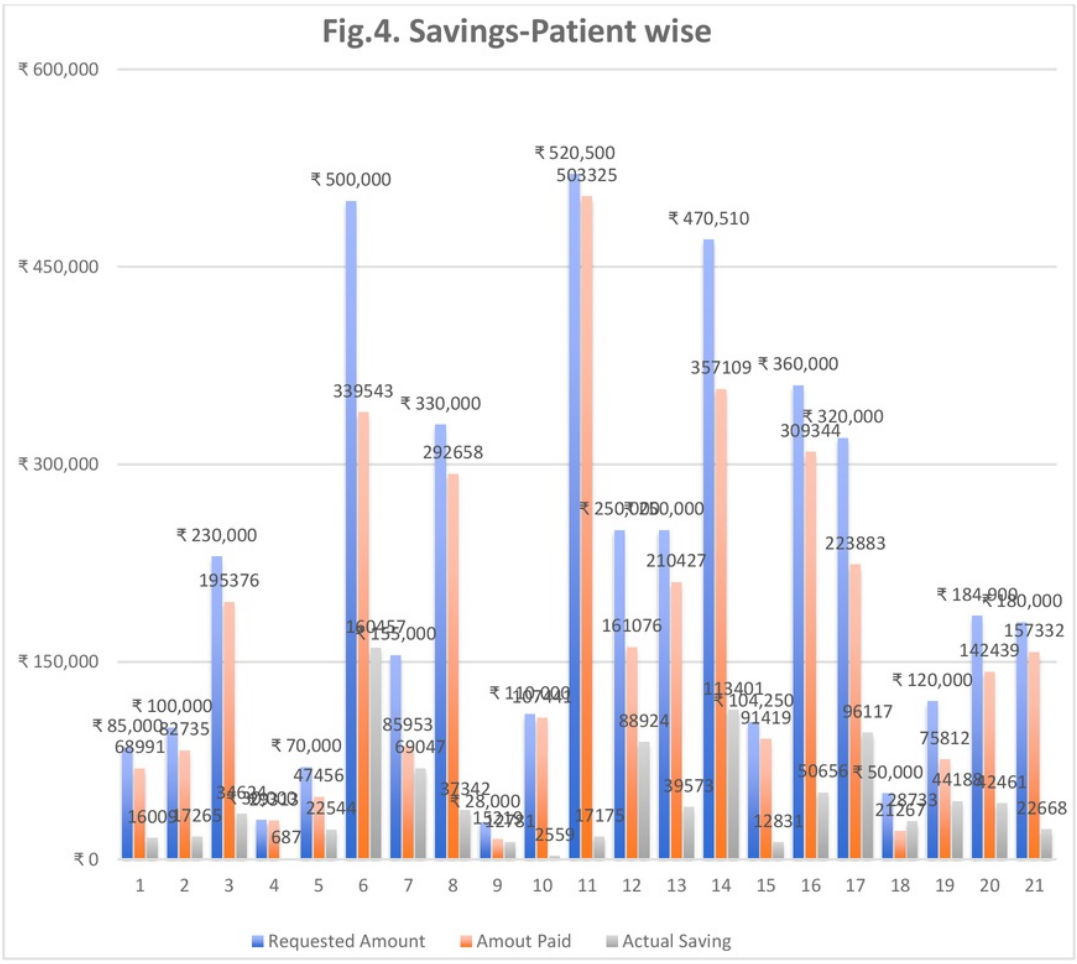


Fig.4. depicts patient wise requested amount, amount paid and actual saving. This bar chart shows the data of patients, where case management was successful, in this blue colour represents the requested amount by the hospital, orange colour represents the final bill and grey colour represents savings that we achieved after comparing requested amount with the amount paid i.e. final bill.

CONCLUSION

It is clearly evident that Case Management plays a vital role in saving cost without compromising on quality of care. Effective case management not only saved cost, but also significantly reduced hospital days i.e. Length of Stay (LOS). Such kind of initiative should be adopted by other health insurance company, in order to control fraud, minimise abuse by the provider, reduce claim expenditure and ultimately save cost.

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