Vipul Medcorp TPA Private Limited, Gurgaon

By

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ENROLLMENT NO- **PG/14/066**

PGDHHM

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International Institute of Health Management Research

INTERNSHIP TRAINING

At

Vipul Medcorp TPA Private Limited, Gurgaon

A study on the deviations of various aspects in a audit report at Vipul Medcorp TPA Private Limited, Gurgaon

By

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Post Graduate Diploma in Hospital and Health Management

Year 2014-2016

International Institute of Health Management Research

TO WHOMSOEVER IT MAY CONCERN

This is to certify that Dr Ruchi Garg student of Post Graduate Diploma in Hospital and Health Management (PGDHM) from International Institute of Health Management Research, New Delhi has undergone internship training at Vipul Medcorp TPA Private Limited (Gurgaon)
From 07/03/2016 To 30/04/2016.

The Candidate has successfully carried out the study designated to her during internship training and her approach to the study has been sincere, scientific and analytical.

The Internship is in fulfillment of the course requirements.

I wish her all success in all his future endeavors.

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The following dissertation titled **"A study on the deviations of various aspects in an audit report"** at **Vipul Medcorp TPA Private Limited, Gurgaon**" is hereby approved as a certified study in management carried out and presented in a manner satisfactorily to warrant its acceptance as a prerequisite for the award of **Post Graduate Diploma in Health and Hospital Management** for which it has been submitted. It is understood that by this approval the undersigned do not necessarily endorse or approve any statement made, opinion expressed or conclusion drawn therein but approve the dissertation only for the purpose it is submitted.

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Surjeet Thakur	Surjeet
Dr. Anandh. Ramachandra	
Surendra Tyagi	

Certificate from Dissertation Advisory Committee

This is to certify that **Dr Ruchi Garg,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. She is submitting this dissertation titled **"A study on the deviations of various aspects in a audit report" at Vipul Medcorp TPA Private Limited, Gurgaon"** in partial fulfillment of the requirements for the award of the **Post-Graduate Diploma in Health and Hospital Management.**

This dissertation has the requisite standard and to the best of our knowledge no part of it has been reproduced from any other dissertation, monograph, report or book.

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IIHMR DELHI

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This is to certify that the dissertation titled " A **study on the deviations of various aspects in an audit report** and submitted by Dr Ruchi Garg, Enrollment No-PG/14/066 under the supervision of Nishikant Bele, Associate Professor, IIHMR, Delhi for award of Postgraduate Diploma in Hospital and Health Management of the Institute carried out during the period from 07/03/2016 To 30/04/2016 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.

Dr Ruchi Garg

Signature

FEEDBACK FORM

Name of the Student: Dr. Ruchi Garg

Dissertation Organisation: Vipul Medcorp TPA

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Suggestions for Improvement: more analytical approach required.

Signature of the Officer-in-Charge/ Organisation Mentor (Dissertation)

Date: 17/5/2016
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In addition I would also like to thanks my mentor at IIHMR Delhi respected **Nishikant Bele** for his valuable efforts in shaping this study to a meaningful effort.

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Abbreviations

TPA	**THIRD PARTY ADMINISTRATOR**
TAT	**TURN AROUND TIME**
DO/BO	**DISTRICT OFFICE/BLOCK OFFICE**
FDI	**FOREIGN DIRECT INVESTMENT**
MIS	**MANAGEMENT INFORMATION SYSTEM**

A study on the deviations of various aspects in an audit report at Vipul Medcorp TPA Private Limited, Gurgaon

ABSTRACT

Aim of Study: The aim of study was to study deviations of various aspects in an audit report at Vipul Medcorp TPA private limited.

Background: The processing time for claim is considered to be the most significant measure of performance of a TPA. Once the claim is received, it is processed. Based on the processing of the claim, a denial or approval is executed. Many claims could not be settled due to shortfall of documents. If more information is needed to complete processing of claim, then the claim remain in "pended" or “Query” status. For pended claims, the payment process remains suspended until the information is received or verified, and then resulting "clean" claim is returned to the payment processing system. Pending claims or claims in query status required an additional day to process, while more information is being sought.

Method: It was a descriptive, cross sectional study conducted in Vipul Medcorp TPA private limited in corporate claim department with the objective of “To have better understanding of claim process so that we get the better ways of improving it and identify better practices and suggesting best implementable solutions”. Target population for the study was Files of Hospitalization and sample size was 2000 files. Data was collected on observation in a pre made data sheet by Convenience method of sampling.

Findings: Shortfall of documents is major reason for the delay in settlement of claim process. More than 50% claim was pending due to shortfall of documents. Network hospital also shown that around 60% claim was pending due to shortfall of documents.

Conclusion: Shortfall of document increases the processing of claim hence; it is a challenge for the TPA to process the claim quickly and accurately. One of the reasons of high percentage of shortfall of document could be low awareness among policyholder. This need to be improved by taking appropriate action . Establish proper channel to bridge the gap.

INTRODUCTION

The rapid expansion of the health insurance business in India has resulted in significant growth in the third-party administrator (TPA) business. TPAs are the link between the customer and the insurance company, managing claims for the former. They also liaise with hospitals on behalf of the insurer, but are not allowed to market health insurance policies. There are about 30 TPAs operating in the health insurance business in India. They help in a number of situations, like: In case cashless facility needs to be availed in case of planned hospitalization, there is a pre-approved form that needs to be filled and approved by the TPA at least 48 hours before hospitalization. In case cashless facility needs to be availed in case of unplanned hospitalization, TPA counter at the hospitals help out for a speedy pre-approval of the same so that treatment of the patient is not hampered In case of reimbursement, the forms along with the original bills and prescriptions need to be sent to the TPA for filing the claim with the insurer. Moreover, the TPA only helps the customer for the claim to be finally paid out.

During the last few years, a large number of hospitals and nursing homes have been added to the network of providers by the TPAs. As a result, it is anticipated that TPAs, as intermediaries will continue to play a crucial role in the processing of health claims along with other associated activities on insurers behalf, as the sector is witnessing growth. After increasing FDI to 49% there will be more penetration of private companies which advocates for in house TPA but they don't have it in present situation.

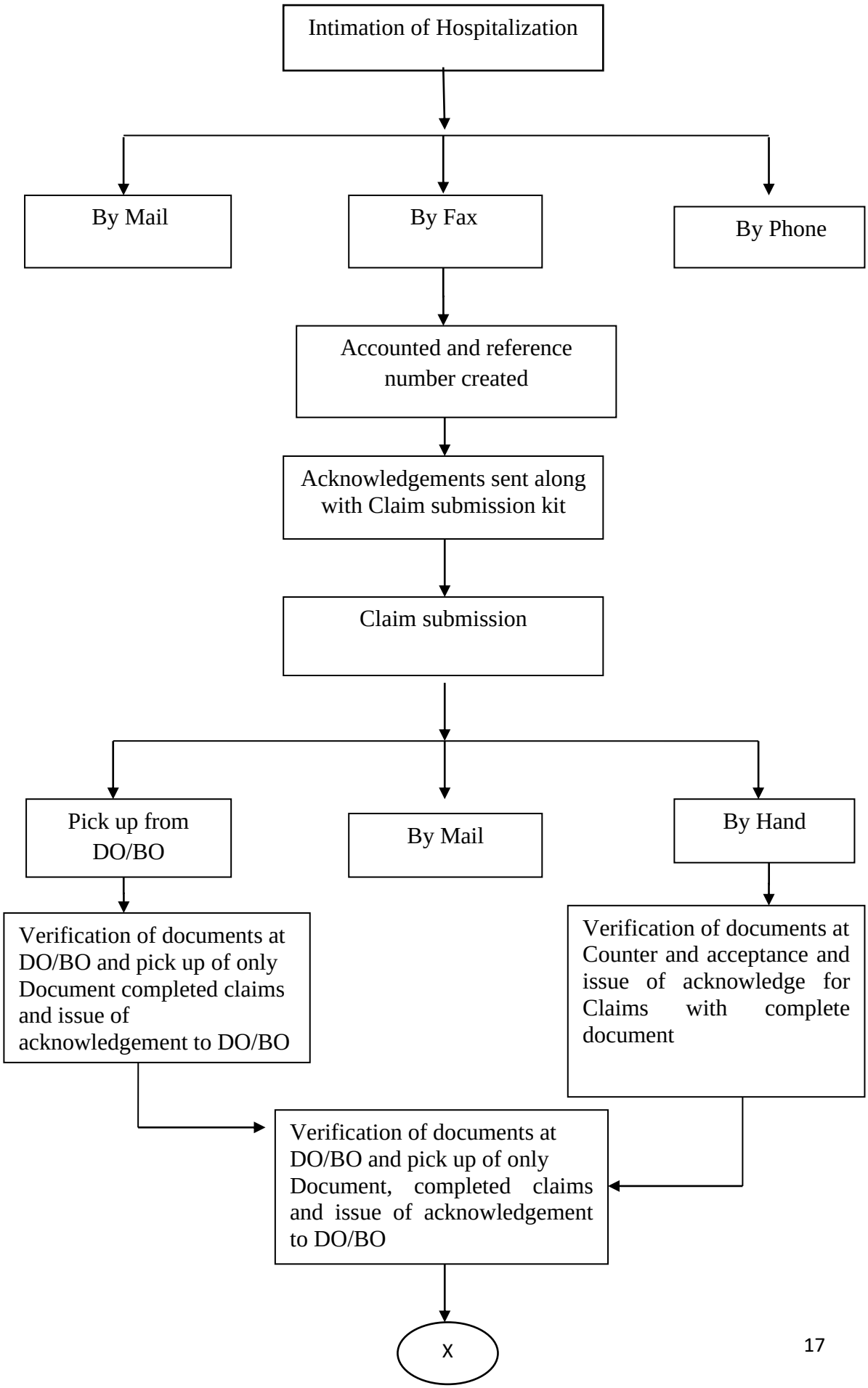
The TPA business is expected to get a further boost with four state-owned non-life insurers – New India Assurance, United India Insurance, Oriental Insurance and National Insurance – planning to set up a joint TPA. Competition among the TPA is set to become more intense and every TPA would compete to provide best services to the insured in terms of processing

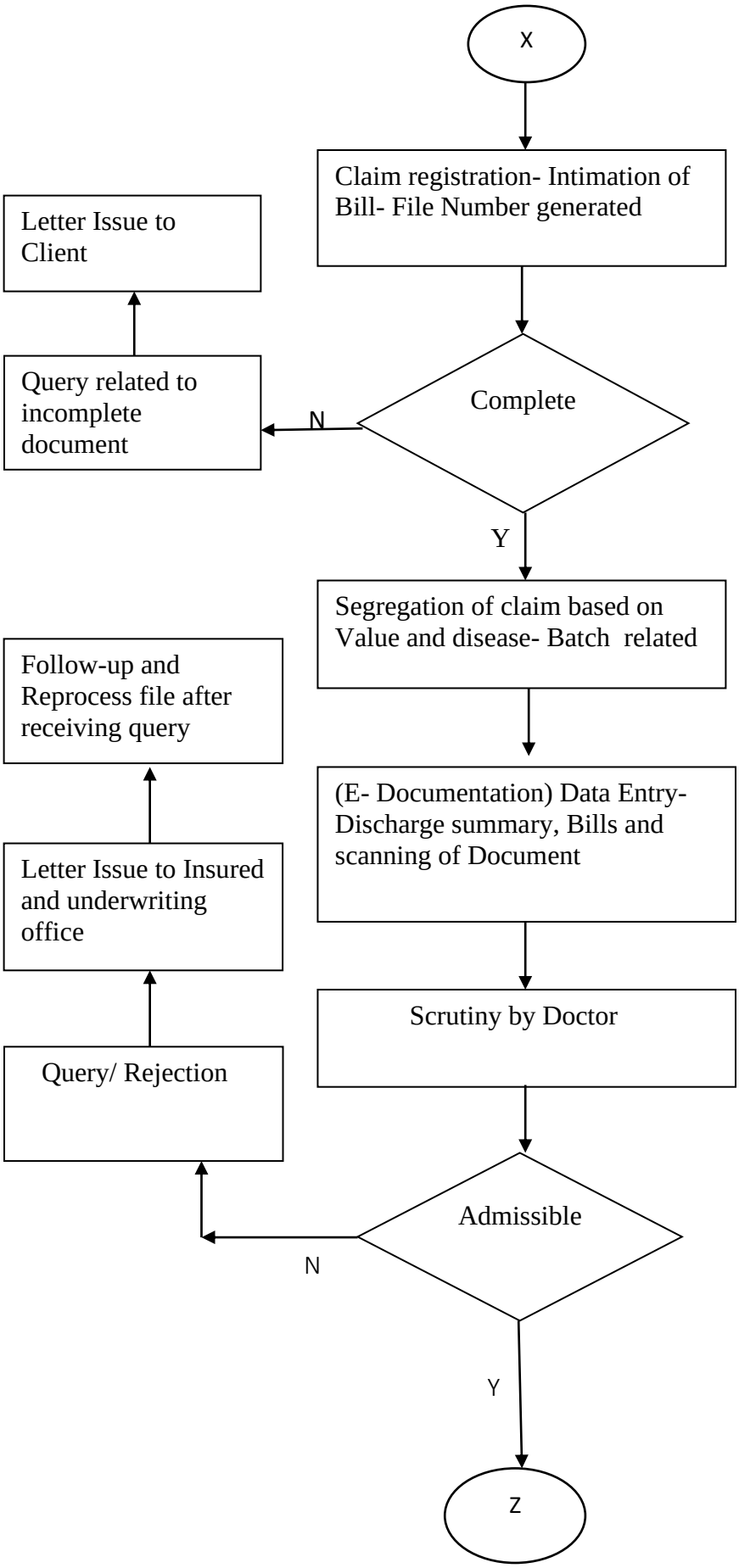
time and accuracy. As the processing time for claim is considered to be the most significant measure of performance of a TPA . However the truth is TPAs today are challenged to process high volumes of claims quickly and accurately. The reality is most TPAs struggle with a system for claims processing which involves various multistep procedures and efficient structure.

Challenge of TPA Company

- Process high volumes of claims quickly and accurately
- As the processing time for claim is considered to be the most significant measure of performance of a TPA.
- Turn Around Time (TAT) for resolving a query is less
- FDI to 49% there will be more penetration of private companies which advocates for in house.
- In-house third party administrator (TPA) of public sector general insurers, named Health Insurance TPA

Claim Process Flow




X
Claim registration- Intimation of Bill- File Number generated
Letter Issue to Client
Query related to incomplete document
N
Complete
Y
Segregation of claim based on Value and disease- Batch related
Follow-up and Reprocess file after receiving query
(E- Documentation) Data Entry- Discharge summary, Bills and scanning of Document
Letter Issue to Insured and underwriting office
Scrutiny by Doctor
Query/ Rejection
Admissible
N
Y
Z

Problem statement

Once the claim is received, it is processed. Based on the processing of the claim, a denial or approval is executed. In case we require additional documents, we send a shortfall letter or Query is raised. In group policy, TPA sets help desk in the corporate for their employees. In corporate claims, there should not be any shortfall of documents as help desk is provided by the TPA. Still many claims could not be settled due to shortfall of documents. If more information is needed to complete processing of a claim, then the claim remain in "pended" or “Query” status. For pended claims, the payment process remains suspended until the information is received or verified, and then resulting "clean" claim is returned to the payment processing system. Pending claims or claims in query status required an additional day to process, while more information is being sought.

- Shortfall of documents
- Excess payment made in various sectors
- Reason why pending claims or claims in query status

General Objectives

To have better understanding of claim process so that we get the better ways of improving it and identify better practices and suggesting best implementable solutions.

Specific objectives

1. To analyze the deviations and documents overlooked in the usual process.

2. To analyze the bottlenecks in the claim process.

3. To analyze the reason for short fall of documents.

4. To analyze lapses in claim settlement due to excess payment.

Review of Literature

1. An updated survey of healthcare claims receipt and processing times, may 2006

America's Health Insurance Plans (AHIP) conducted a survey of its members to examine the issue of claims processing and turnaround times for claim payments. The study was a follow-up to a survey done in 2002. A comparison of findings from the 2002 and 2006 studies shown that claims processing times was improved significantly in the past four years. In the study it was found that If more information was needed to complete processing a claim, a claim may be "pended." For pended claims, the payment process was suspended until the information was received or verified, and then resulting "clean" claim is returned to the payment processing system. Overall, 14 percent of total claims were pended in 2006. On average, pended claims required an additional 9 days to process, while more information was being sought. Nearly half of all claims (48 percent) were pended due to the submission of duplicate claims (35 percent), lack of complete information or other information needed to justify the claim (12 percent), or invalid codes (1 percent). 24% of pended claims were due to coverage issues, including no coverage based on date of service (8 percent), non-covered or non-network benefit or service (7 percent), coordination of benefits (5 percent), or coverage determination (4 percent). Other or miscellaneous reasons were the cause of the remaining 28 percent of pended claims. Pended claims that necessitate manual or other review cost an average of $2.05 per claim.

Awareness and Willingness to Pay for Health Insurance:

An Empirical Study with Reference to Punjab (India)

The study was done to examine the respondents who were aware or not aware about health insurance as well as various sources of awareness; secondly, those who were aware and have subscribed it or not; thirdly, those who had not subscribed, what was the reasons behind the same; and at the last if they were willing to join and pay for it? The study was conducted in Punjab and 600 questionnaires were got filled from randomly selected general public, out of which 563 found to be suitable for analysis. The result shown low level of awareness and willingness to join subscription of health insurance. Result shown significant association existing between the gender; age; education; occupation; income of respondents with their willingness to pay for health insurance

2. **Update: A Survey of Health Care Claims Receipt and Processing Times,2009**

A brief report presented by AHIP's of one of periodic survey of claims receipt and payment timing. The survey shown that nearly three-quarters (74 percent) of 2009 claims in the survey were processed within 7 days, up from 57 percent in 2006 and 46 percent in 2002. Approximately 92 percent of claims were processed within two weeks, up from just over 80 percent in 2006. In general, electronic claims were processed faster than paper claims.

3. **Challenges in Provider Payment under Ghana National Health Insurance Scheme:**

A Case Study was done on Claims Management in two Districts MHIS in the Upper East Region of Ghana: The study evaluated the claim management processes. Retrospective review of secondary claims data (2008) and a prospective observation of claims management

(2009) were undertaken. Qualitative and quantitative approaches were used for primary data collection using interview guides and checklists.

Claims processes in both districts were similar and predominantly manual. There were administrative capacity, technical, human resource and working environment challenges contributing to delays in claims submission by providers and vetting and payment by schemes. Both Schemes rejected less than 1% of all claims submitted. Significant differences were observed between the Total Reimbursement Rates (TRR) and the Total Timely Reimbursement Rates (TTRR) for both schemes. For TRR, 89% and 86% were recorded for Kassena Nankana and Builsa Schemes respectively while for TTRR, 45% and 28% were recorded respectively. Findings of the study was that Ghana's NHIS needs to reform its provider payment and claims submission and processing systems to ensure simpler and faster processes. Computerization and investment to improve the capacity to administer for both purchasers and providers will be key in any reform.

4. Claim patterns of private health insurance for individual and group contracts and the risk selection mechanisms:

A study was done with the aim to study whether insurers with group contracts had higher claims than the individual insures. However the limits in our data make it difficult to give a clear answer. The data was received from one of the Norwegian insurance companies and contained approximately 6300 processed claims from their customer portfolio in the period 2007-2010. Analysis of separate claims and aggregate claims per person for individual and group policyholders was done. Study had controlled for type of the contract (group/individual), gender, age, geographical area, Oslo/other big city, industry sector (for group contracts) and reservations. It was found that the type of the contract does not have any significant effect on the claim, neither considered separately nor aggregate per person. The

finding of the study was that the age of the policyholder had a significant positive impact on the size of the claims independently of the contract type.

Third Party Administrators and health Insurance in India: Perception of Providers and Policyholders

A study was carried out with the objective to ascertain the experiences and challenges perceived by hospitals and policyholders in availing services of TPA in Ahmedabad, Gujrat. The major findings from the study was : (i) low awareness among policyholders; (ii) policyholders have very little knowledge about the empanelled hospitals for cashless hospitalization services; (iii) TPAs insist on standardization of fee structure of medical services / procedures across providers (iv) healthcare providers do experience substantial delays in settling of their claims by the TPAs; (v) hospital administrators perceive significant burden in terms of effort and expenditure after introduction of TPA and (vi) no substantial increase in patient turnover after empanelling with TPAs. Study found an indication that the hospital administrators foresee business potential in their association with TPA in long run. There was a clear indication from the study that the regulatory body needs to focus on developing mechanisms, which would help TPAs to strengthen their human capital and ensure smooth delivery of TPA services in emerging health insurance market.

Methodology

Research Design - Study was done in corporate claim processing department at Vipul Medcorp pvt ltd. Primary data was collected from 15 March 2016 to 15 April 2016.

Target Population: Hospitalization files

Study Type: Descriptive, Cross sectional

Study Area: Claim Department

Sample Size: 2000 files

Sample Method: Convenience sampling . Sample population was selected according to accessibility and availability of the files in given time period.

Data Collection: By observation

Data Collection tool: Pre made data sheet

Duration of study: 15 of March, 2016 to 15of April, 2016

Inclusion Criteria: Fresh Hospitalization files

Exclusion Criteria: Exclusion of following cases

Excess room rent
Deficient documents
Non payable items
No deviation found
Maternity limit excess
Overlook of hospital tariff
Recommended for repudiation
Investigation not relevant with ailment
Supporting prescription / reports not found
Difference in billing vis-à-vis claim amount
Decision pending as further documents/ investigation required

Data Analysis

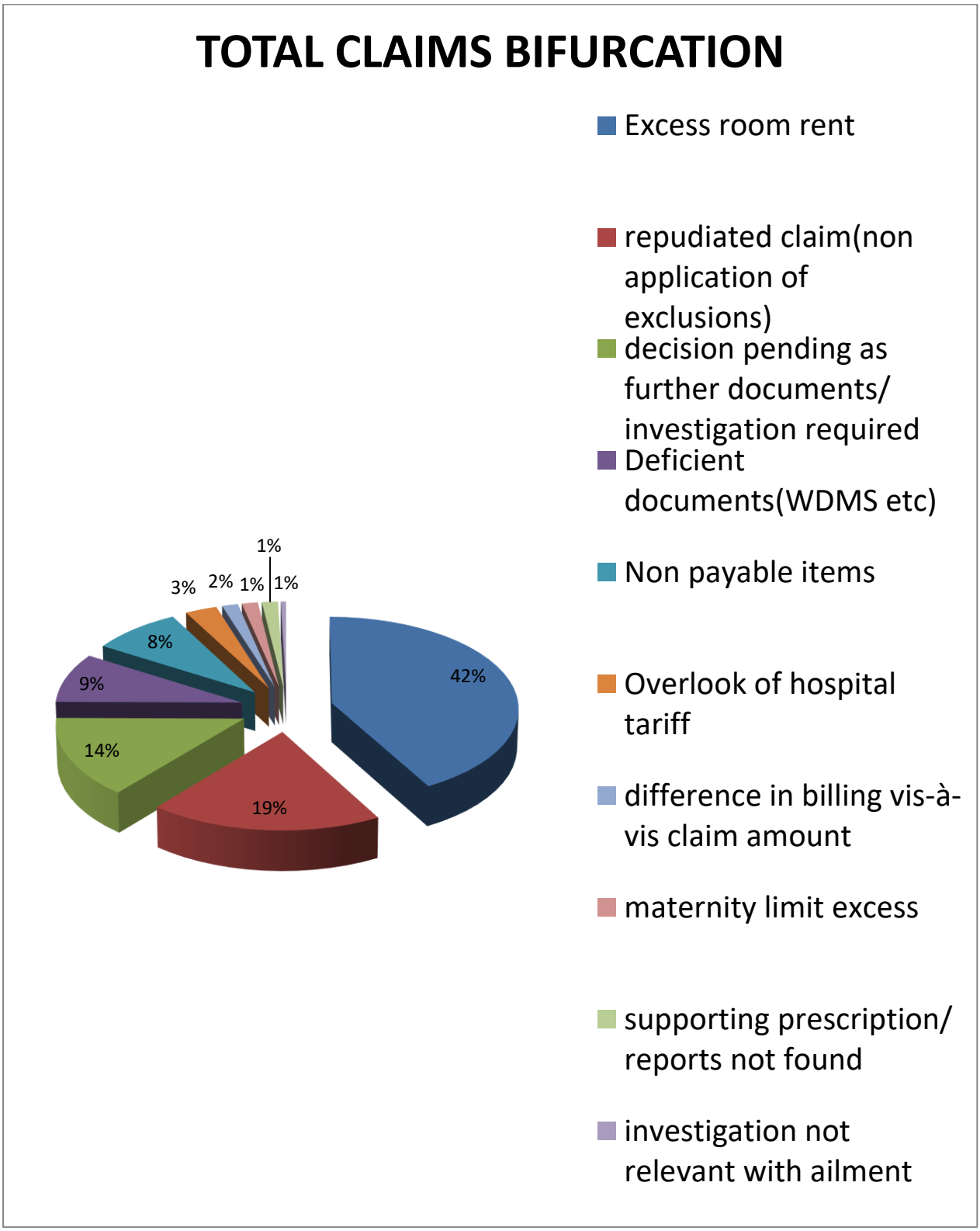
Table 1: Table of total no. of files and status of files

	No. of files
Excess room rent	86
Deficient documents	18
Non payable items	17
Maternity limit excess	3
Overlook of hospital tariff	6
Decision pending as further documents/investigation required	29
Recommended for repudiation	39
Difference in billing vis-à-vis claim amount	3
Supporting prescription / reports not found	3
Investigation not relvant with ailment	1
No deviation found	1795
Total	2000

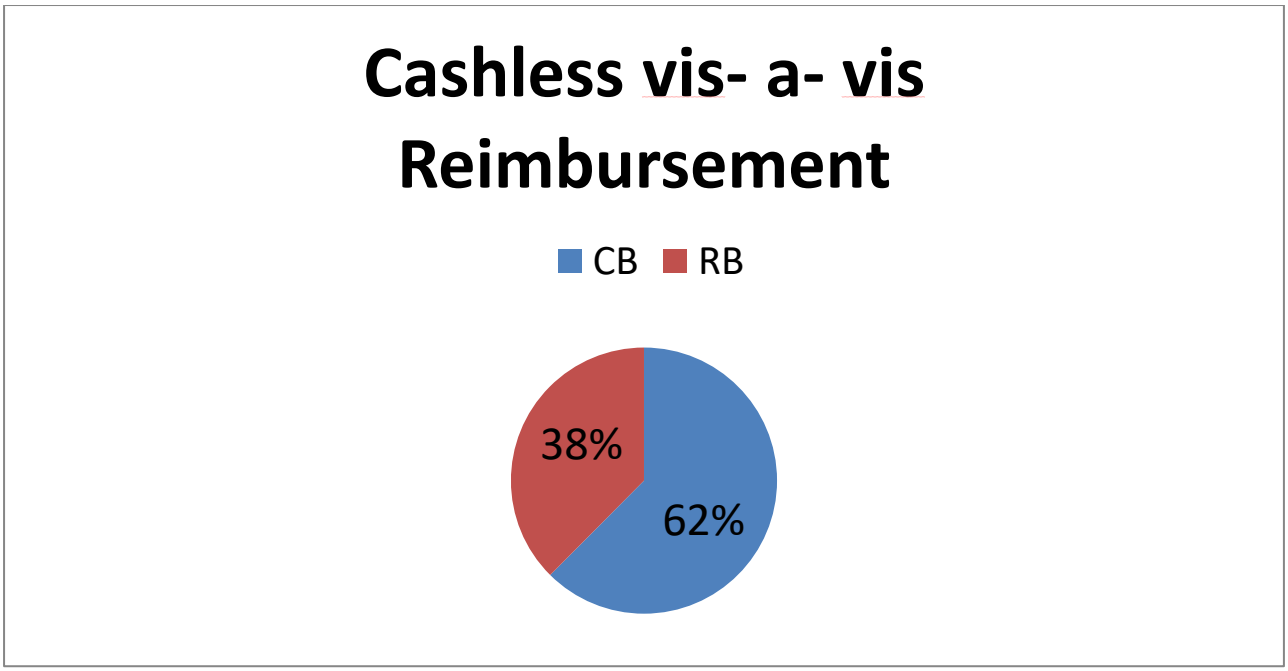
In the study duration, 2000 fresh files were received for the claim processing. Out of 2000 fresh files only 1795 files had all the documents attached, so it could be further processed on time. Out of 2000 files, 205 files could not fulfill the criteria for consideration of getting approval for settlement. Such files were given the status of files “in pending”. Out of 205 files 47 files were in status of “in query” and had some kind of shortfall of documents. If the

documents attached to files looks suspicious for any kind of fraud then also file is withheld till the investigation is completed Some files could not qualify for being considered for further processing due to insurance policy guidelines. Those cases were also given “in query” status and query was raised to the underwriter of the insurance policy to advice for further processing.

Pie chart 1: share of studied files in different status



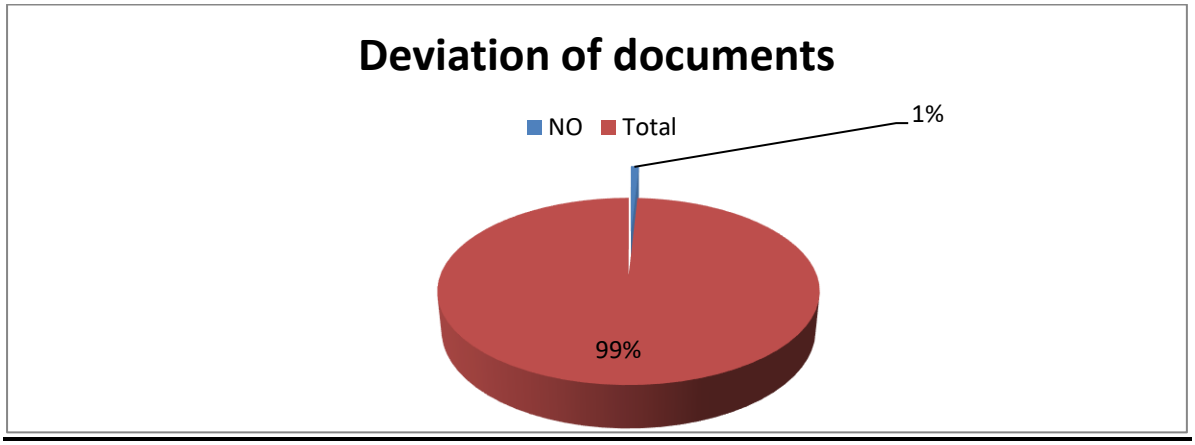
	No of claims	TOTAL SETTLED AMOUNT
CB	1249	83633571
RB	751	39633174
Grand Total	**2000**	**123266745**



Graph 1: Number of Cashless and reimbursement cases.

Objective 1 - Following Deviations were noticed in the usual process

- **The overall percentage of deviation is only 1% .**



- **The detail of all the process deviation is given below:**
- **Duly Signed Claim Form**

  Yes : 1990 NO: 8 % error : 0.4

- **Duly Signed Pre-authorization Request(1249)**

  Yes : 1241 NO: 6 % error : 0.4

- **Duly Signed Discharge Summary**

  Yes : 1966 NO: 32 % error : 1.6

- **Duly Signed Hospital Bill**

  Yes : 1982 NO: 16 % error : 0.8

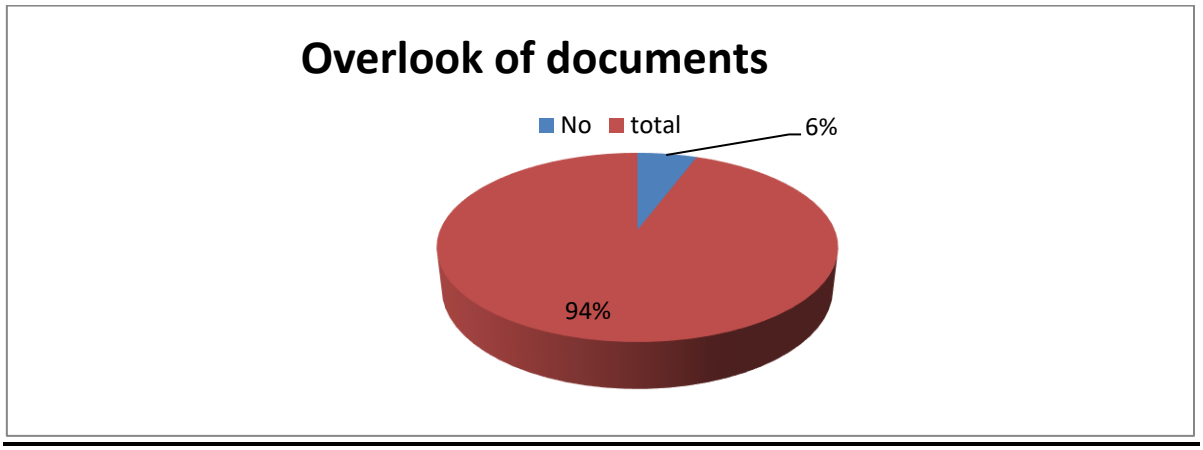
  ****Total 1998 claims taken into account as documents not found in 2 claims.**

  ****Only CB claims taken into account.**

In the study duration, 1998 fresh files were received for the claim processing. Out of 1998 fresh files only 1990 files had the duly signed claim form documents attached, so it could be further processed on time. Out of 1998 files, 8 files could not fulfill the criteria for consideration of getting approval for settlement. In Pre-authorization form, only cashless claims are counted as reimbursement claims donot require pre-authorization form(as out of 2000 files 1249 are cashless and 751 are reimbursement claims) . According to the figures, percentage of error is very less.

Objective – 1.1 Documents overlooked in the usual process

- **The percentage of mandatory documents overlooked while processing the claims is approx 6% .**



- **The detail of all the mandatory documents required , but overlooked are given below:**

Mandatory Documents Checklist

Yes : 1624 NO: 374 % error : 18.7

- **All Investigation Reports**

Yes : 1975 NO: 23 % error : 1.15

- **Photo ID**

Yes : 1954 NO: 44 % error : 2.20

- **Age Proof**

Yes : 1952 NO: 45 % error : 2.25

*** * Total 1998 claims taken into account as documents not found in 2 claims** .

In the study duration, 1998 fresh files were received for the claim processing. Out of 1998 fresh files only 1624 files had complete mandatory checklist of documents attached, so it could be further processed on time. Out of 1998 files, 374 files could not fulfill the criteria for consideration of getting approval for settlement. As the percentage of error is high, so need improvement in this area to have good efficieny and better results.

Objective – 2 Lapses in claim settlement due to Excess payment made due to

- **Overlook in Non Payable items**
  % error : 0.85 Loss amount : Rs 17347/

- **For investigations not relevant with the ailment/ disease**
  % error : 0.05 Loss amount : Rs 2020/

- **Overlook of the hospital tariff**
  % error : 0.3 Loss amount : Rs 1,66,946/

- **Overlook of the room rent as per the product limit**

Total claims	**Excess room rent**	**% Error**
2000	**86**	**4.35**
Total excess paid room rent	**Total settled amount**	**% Loss**
367381	**123266745**	**0.3**

In the study duration, 2000 fresh files were received for the claim processing. Out of 86 fresh files excess room rent is paid means more than agreeded tariff with the hospital. Overall loss from total amount is like 0.3% but it should checked and should telly with the hospital at the time of processing of files. If the hospitals are not charging according to the agreeded room rent tariff than the hospital should be further negotiated for future respect and should be corrected on time to avoid such losses.

- **Overlook of the application of maternity limit**

  % error : 0.15 Loss amount : Rs 65275/-

- **Overlook of sticker/ invoice**

  % error : 8.46

Implant sticker/Invoice required	Implant sticker/Invoice required	
	NO	**YES**
130	**11**	**119**

And in case of implant stickers/invoice , many times the invoive bill or implant sticker is missing or may be mismatched, which delays the processing of claims. As in case of implants / mesh is a factor to have a sticker as well as invoice bill attached with the required documents. Percentage calculated is 8.46% which is quite high and can effect the efficieny. And in case of maternity limit loss amount is 65275 which may be due payment made beyond maternity limit.

- **Overlook of the supporting prescription/ investigation**

  % error : 0.15 Loss amount : Rs 7195/-

- **Overlook of claim amount vis-a –vis billed amount**

  % error : 8.46 Loss amount : Rs 8586/-

Errors in claim adjudication by non application of the exclusions as per the policy terms

- **Recommended for repudiation**

  % error : 1.95 Loss amount : Rs 16,25,294/-

Loss amount is also calculated from various activities such as claim vis-à-vis billed amount means difference in the amount mentioned in the claim bill and in an actual bill(as the percentage is high this point is also important to work on). Loss amount due to

Quantification of Potential amount lost

Excess amount paid	Less discount calculated	Total loss amount
2260044	759030	3019074
Settled amount	-	123266745
% loss	-	2.45

According to the calculations, 3019074 is calculated as the total loss amount which means this much the company had over 2000 files and % loss is 2.45. Discount calculated is the amount which is given by hospital which in return is also loss as the company has not claimed it or got the discount.Excess amount is paid in case of hospital charging more than the agreeded PPN tariff of procedure or excess room rent. Overall percentage of loss is low but it effects company effectiveness and efficiency as it should be 0 or less than 0.99.

Maximum Cases

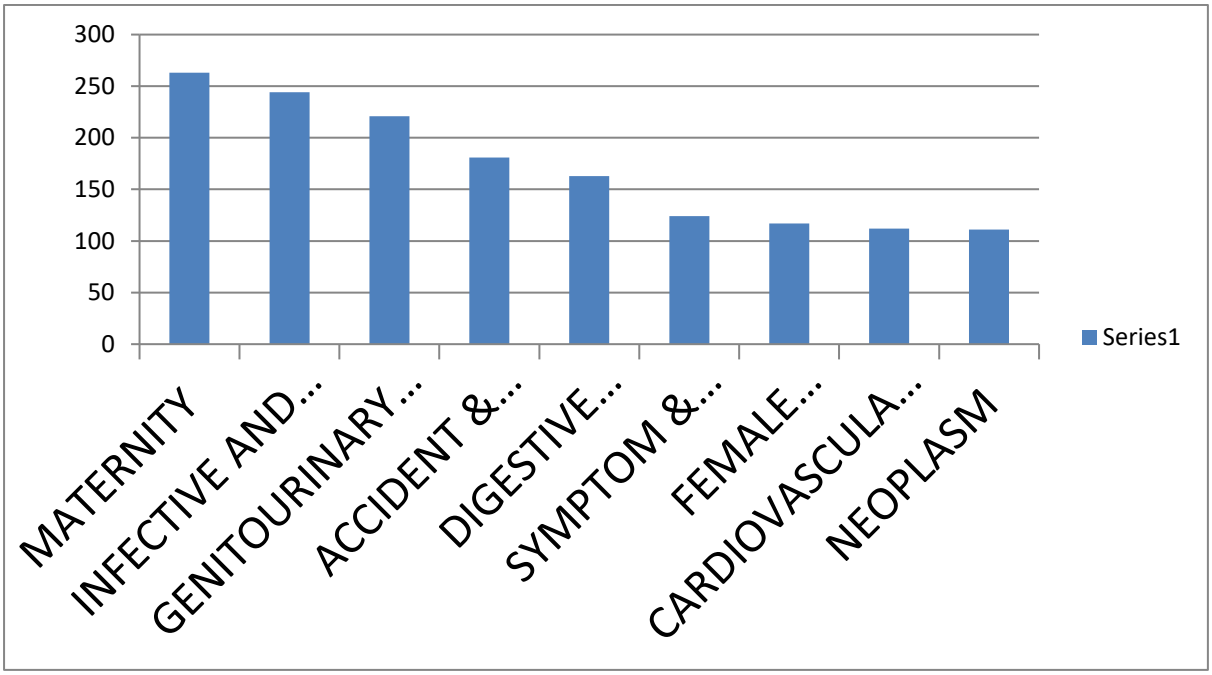


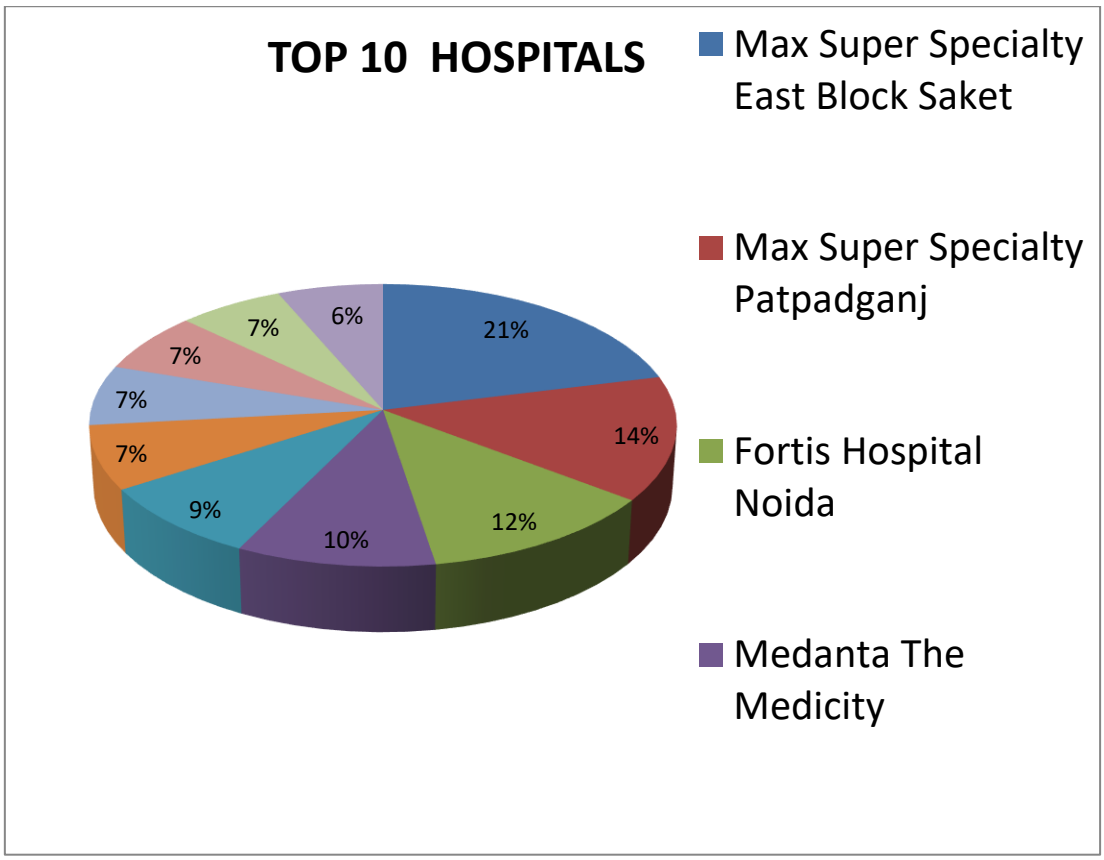
Table 2: Shows recommendations in various sectors.

- Since majority of your claims are from Maternity, even the conception should be included in the waiting period of 2 years because as per the definition of Maternity it implies from conception till delivery. Therefore, most of the claims were paid during first few months after completion of 2 years shall not be payable.
- Any claim for maternity shall be payable after 9 months +/- 7 days after completion of 2 years.
- There should be a specified waiting period for cataract as claims for cataract operation reported below 60 years of age are also on higher side.
- The operative clause of the policy is being ignored, the reasonable and customary charges shall be applicable on the treatments, stents, lens and implants.

The certain diseases which could be congenital / maybe not, therefore, the claim shall be paid after satisfactory query replies supported with the operative notes by the surgeon

- Single window operation : Scan documents should be available in the same system
- Data entry should be item wise so that suitable deduction remarks can be given against each item, wherever applicable.
- Pre post column should be different and system should auto deduct if claims falls beyond the applicable limits.
- Standardization as per IRDA for Procedure code/ Non payable items list
- Co- pay should be system driven
- Tariff should be digitalized, auto deduction of excess room rent etc , wherever possible
- Pop- ups/ trigger to the processors wherever deviation/ any specific condition/ remark
- Both invoice and sticker of the implant/ lens/ stent/ mesh should be obtained
- Justification for open billing should be taken from the hospital for the already packaged procedures

Better negotiation



Pie chart 2: Shows top 10 hospitals for better negotiation.

In the study duration, 2000 fresh files were received for the claim processing. As the study shows hospitals can be better negotiable on room rent and on the packages of frequent surgical claims at least with top hospitals.

Discussion

It was found that approval of corporate fresh files was only 89% of total fresh files and 11% of files was “in pending” status due to shortfall of documents, “under investigation” and “query for rejection”. Out of all fresh file, 5% of files was under query due to shortfall of document. In the Corporate, TPA provide help desk for their employee. TPA also organizes camps to spread awareness about the TPA itself and procedures to be followed by insured during availing cashless claim and reimbursement claim. Still

findings of the study revealed that either the TPA has failed to spread enough awareness about the claim process or that was not enough for the insured.

There were more than 18 files which had 2 or more shortfall of documents. It was found that if more information was needed to complete processing of a claim, if a claim was “in pending” or “in query” status then payment process was also suspended until the information or documents were received or verified. Thus it may slow down the revenue generation of the company.

One of the reasons could be attrition rate and new employee in the corporate. Once old employee leave Corporate and new employee join the Corporate, whole process of spreading awareness has to start again. Indeed the workforce of Corporate is mostly huge that it becomes difficult to communicate with every employee. This could be one of the reasons for the communication gap and low awareness as well.

More over the situation of network hospital is not better in improving the time of processing. Even network hospital has help desk for the patient but still 60% of network hospital files have some kind of shortage of documents. Firstly, reimbursement claim should not be raised by insured if treatment taken from network hospital as cashless facility is available there. Secondly, if insured is unable to avail cashless due to any reason, then in this case also they should be informed about raising claim beforehand.

Suggestion

- Benchmarks the number of files for all the milestones covered in this study and implements the same.
- Re-evaluate the implementation of benchmark after 3 months
- Inform the insured at the time of first communication only (during the time of intimation).

Conclusion

- Shortfall of document increases the processing of claim hence, it is a challenge for the TPA to process the claim quickly and accurately.
- One of the reasons of high percentage of shortfall of document could be low awareness among policyholder. This need to be improved by taking appropriate action.
- TPA need to assess its present situation and need to know exactly, where is discrepancy in the system and to do gap analysis accordingly
- Establish proper channel to bridge the gap
- Proper control of Non Confirming services, timely corrective and preventive actions and some of the tools can be used to achieve continual improvement

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