DISSERTATION

AT

VIPUL MEDCORP TPA PRIVATE LIMITED

IMPROVISING THE TURNAROUND TIME FOR CORPORATE REIMBURSEMENT CLAIMS PROCESS

BY

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This is to certify that **Binita Agarwal,** a graduate student of the **Post- Graduate Diploma in Health and Hospital Management** has worked under our guidance and supervision. He/ She is submitting this dissertation titled "Improvising the Turnaround time for corporate reimbursement claims process" at "**Vipul Medcorp TPA Private Limited, Bangalore**" in partial fulfillment of the requirements for the award of the **Post- Graduate Diploma in Health and Hospital Management.**

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February 2nd to April 30th, 2015

VIPUL MEDCORP TPA PRIVATE LIMITED, BENGALURU

She comes across as a committed, sincere & diligent person who has a strong drive & zeal for learning

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The following dissertation titled **"Improvising turnaround time of corporate claims processing"** at **"Vipul Medcorp TPA Private Limited, Bengaluru** 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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This is to certify that **Binita Agarwal** 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, Bengaluru** from 2nd February 2015 to 30th April 2015.

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The internship is in fulfilment of the course requirements

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Vipul Medcorp TPA Private Limited has asked me to sign the 1 year employment bond in lieu of signing dissertation certificate, feedback forms, using their name, data and symbol of company in dissertation report on 15th May 2015 after completion of dissertation period and signing bond was not part of initial contract of employment.

Because of personal constraints, I am unable to sign the bond hence report does not contain any dissertation certificate, Feedback form and confirm that dissertation report only include the hypothetical data and names.

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Signature

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I acknowledge my gratitude to the Almighty for giving me the power and motivation without whose blessings; this work would not have been possible.

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ABSTRACT

Third Party Administrator (TPA) is a company that manages insurance process usually the service part on behalf of the insurer and in return receives the commission. To make the process hassle free the insurance companies outsource some aspects of insurance business. TPA's perform these functions and act as an intermediary between the insurance companies and the insured. The aim of this study is to review the process and identify the factors affecting the turnaround time of reimbursement claim process and develop an appropriate solution for the major factor which causes backlogs.

An observational study was done to identify the loop holes which increased the turnaround time (TAT) in corporate reimbursement claims processing.

The factors were identified for the increase in TAT. To find out the major cause of increased TAT, pareto analysis principle was applied. The result of pareto analysis showed that out of 300 reimbursements claims the majority of the reasons for increased TAT were falling under incomplete submission of documents (46%) and query reply received late (34%).

This study has tried to find out the issues for increased TAT and has tried to provide a feasible solution for the same. The study confirmed that there has been improvement in the TAT with few changes in the existing system i.e. the development of web portal for the corporate which made process easy and time reducing.

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LIST OF ABBREVIATIONS

TPA	Third Party Administrators
TAT	Turnaround time
EDI	Electronic Data Interchange

INTERNSHIP REPORT

Organization Profile

Vipul Medcorp TPA is promoted by Vipul group of India, a diversified business group having presence in Automobile Dealerships. Real Estate, Information Technologies, Smart Card related services and in Health and wellness domain.

Promoters & Management

Promoters

Vipul medcorp TPA Pvt. Ltd. Has been promoted by Vipul Group. Vipul Group is promoted by Mr. Vinit Beriwala and family, third generation entrepreneurs.

The promoters have a long-term vision of providing Complete Health and Medical Insurance products to the largely untapped Indian population.

Management

The Company has appointed, Mr. Rajan Subramaniam, a Management graduate and a qualified Insurance professional, as its CEO. He has wide experience in the TPA Industry and is assisted by qualified professionals from the field of Insurance and Healthcare.

Vipul medcorp TPA Pvt. Ltd is engaged in the managed healthcare facilitation & has obtained a license from IRDA for TPA activities (Health) and offers its clients a wide array of services and products in the following areas:

- Third party administration (health) services(TPA)
- Claims handling, management & back office operations
- Healthcare assistance services
- Preferred service provider (PSP) networks

Infrastructure

Vipul medcorp TPA- infrastructure

- Headquartered in Gurgaon with branch offices in New Delhi, Noida, Faridabad, Brindavan, Jaipur, Mumbai, Kolkata, Bangalore, Chennai & Cochin.
- Medical network of over 6000 + hospitals/nursing homes.
- Operates a 24/7 assistance centre.
- Tailor-made software developed in-house with full web-based access for claims tracking, on-line access and querying.
- Professional manpower presenting our clients with benefits derived from our knowledge & experience of the medical network, TPA & Insurance fields.

KEY LEARNING

During the entire internship period of three months Vipul Medcorp TPA has allowed a lot of learning from the tasks involved.

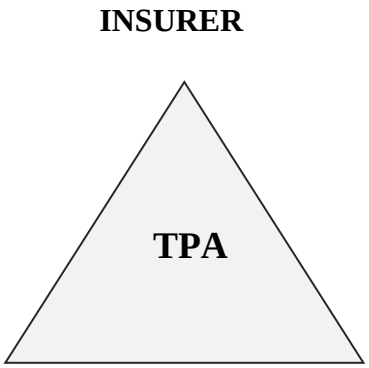
Some of the learning is as follows:

1. Broad perspective of Indian Healthcare from the payer side.
2. Got good understanding on claims processes.
3. Work flow of cashless claims and reimbursement claims.
4. Process of corporate tie ups and was engaged in them.
5. Issues faced by the insured
6. Techniques to handle the issues of the insured
7. Organizing health camps in the corporate offices.

INTRODUCTION

UNDERSATNDING TPA

Third Party Administrator (TPA) is a company that manages insurance process usually the service part on behalf of the insurer and in return receives the commission. To make the process hassle free the insurance companies outsource some aspects of insurance business. TPA's perform these functions and act as an intermediary between the insurance companies and the insured.



TPA's were introduced by IRDA in the year 2001. The core service of a TPA is to ensure better service to the insured. Their basic function is to act as an intermediary and facilitate the cashless services at the time of hospitalization.

A minimum capital requirement of Rs.1 crore is a mandatory requirement for a TPA as spelt by IRDA. License is usually granted for a period of 3 years. Ideally, the TPA functions by collaborating with the hospitals.

ROLE OF TPA IN HEALTH INSURANCE

TPA's first role is to issue an identity card with unique identification number and provide a guidebook on the claims process and list of networked hospitals. The primary function of TPA is to process claims both cashless and reimbursement.

Cashless Claims- The insured need to provide the network hospital with TPA identity card or policy number. The hospital then send preauthorization details with Doctor's certificate, treatment details etc. If TPA finds the claim to be legitimate, they issue letter authorizing hospital to proceed specifying the maximum limit of coverage.

Claim Reimbursement- The insured has to contact the TPA as soon as possible and intimate about the claim. Documents like claim form, hospitalization details, diagnostic tests, discharge summary, bills, policy copy etc should be provided to TPA. If found legitimate, TPA will reimburse the claim.

Reimbursement claims can further be divided into two categories:

- Retail claim
- Corporate claim

For any claim the insurer could be either Private Insurance or a Public Insurance.

Private Insurance companies are many like Bharati Axa, Royal Sundaram, Liberty Videocon General Insurance, ICICI Lombard etc; to name a few.

There are four major Public Sector Insurance Companies for Health Insurance

- New India Assurance Company Limited
- Oriental Insurance Company Limited
- United India Insurance Company Limited

- National Insurance Company Limited

This project will highlight only corporate reimbursement claims of Public sector insurance companies.

The other functions performed by TPA are:

Healthcare Assistance Services- TPA ties up with the hospitals and diagnostic centres to provide comprehensive coverage to the insured. The selection criteria of hospitals depend upon the location, infrastructure, facilities available etc.

Customer Support- TPA provides dedicated call centre to provide quick access to policy holders, respond to their queries and update about the claim status. For online assistance they have the websites.

PROBLEM STATEMENT

The protocol used by Vipul Medcorp TPA states that TAT (turnaround time) for settlement of one corporate reimbursement claim is 7 days from the date of receipt. However, the organization's current system makes inefficient use of time and resources and the settlement of claims are delayed which causes excessive backlogs. If the situation remains the same, they will create an unfavourable brand image in this competitive market. Identifying the major road blocks affecting the TAT of reimbursements claims process and working on the major factor would aid in improvising the TAT.

OBJECTIVE

The specific objectives of this project are to:

- Review the process and identify the factors affecting the TAT of reimbursement claim process
- Develop an appropriate solution for the major factor which causes backlogs

REVIEW OF LITERATURE

1. Improvement of claim processing cycle time through Lean Six Sigma methodology

Author(s): Shri Ashok Sarkar (SQC and OR Division, Indian Statistical Institute, Mumbai, India), Arup Ranjan Mukhopadhyay (SQC and OR Division, Indian Statistical Institute, Kolkata, India), Sadhan Kumar Ghosh (Department of Mechanical Engineering, Jadavpur University, Kolkata, India)

Citation: Shri Ashok Sarkar, Arup Ranjan Mukhopadhyay, Sadhan Kumar Ghosh, (2013) "Improvement of claim processing cycle time through Lean Six Sigma methodology", International Journal of Lean Six Sigma, Vol. 4 Issue: 2, pp.171 - 183

Purpose

In the service sector, reduction of cycle time is one of the key issues. Among various approaches, Lean Six Sigma became very popular as it provides the organisation the desired speed with quality. The purpose of this paper is to present a Lean Six Sigma case study for reducing cycle time in the claim settlement process in insurance or financial services.

Design/methodology/approach

This paper presents an application of Lean Six Sigma methodology for claim settlement cycle time reduction in the insurance sector.

Findings

Lean Six Sigma is found to work very well in the insurance sector for reducing process cycle time by carrying out process changes. Mixing statistical and analytical techniques helps to improve the process speed and is very well demonstrated by Lean Six Sigma approach for service organizations.

Originality/value

This paper utilizes Lean and Six Sigma approaches in process improvement and presents an application. The main idea behind this paper is to demonstrate how combining Lean concepts/techniques with Six-Sigma methodology can speed up problem-solving approaches. Apart from the paper's value for managers, it can also help researchers to extend this for other areas of business processes.

2. Improving Insurance Claim Throughput and Quality with Lean Process Improvement

As companies look for cost-cutting solutions in various service areas (e.g. banks, insurance, retail), current processes have been under great scrutiny. Process improvement efforts such as Lean deployment are being implemented globally. Many of these are carried over from Lean manufacturing and can be of great value to process improvement efforts in the service industry.

The following is an example of the use of Lean process improvement applied to an insurance payer. Insurance is a very tightly-regulated industry where large risk is assumed in incorrectly adjudicating a claim. The focus of the Lean process improvement effort was to improve throughput and quality in the claims handling process.

Looking at the Current State of Insurance Claims Handling

An insurance company’s claims centre is responsible for examining a claim and determining whether a claim is to be paid out or not based on policy guidelines. A claim enters the centre in a digital or manual format, where some claims are automatically processed (using computer systems), while others are sent through to a team, known as adjudicators, who will further evaluate the claims. From there a claim is sent through an auditing process based on

the dollar amount where one or more auditors will check the claim and appropriately adjust the claim if needed. Even with all of these checks in place, a claim may be incorrectly paid out, paid in the wrong amount or denied when it should be approved.

There is a high variance in claim types and complexity, making it difficult to predict the time it takes to complete the work. In addition, claims are currently processed by the first available adjudicator taking on any incoming workload. This high variance makes it very difficult to understand throughput and the variance in quality.

Approach for Impact Using a Lean Process for Insurance Claims

To take an organized approach to understand the core issues, the first thing we must do is break the process improvement problem out. We must understand the current process, workload and performance so that we can identify opportunities to focus on for increased efficiency. Here are some helpful Lean process improvement steps to consider:

Step 1: Create a value stream map. Begin by observing end-to-end process, setting aside time for interviews as needed. This will help us start with a high-level idea of the flow when we sit with both managers and frontline employees to get feedback and understand the process—from receiving a claim to paying out or denying a claim. Though managers have a better idea of external flows and reporting, the details of the day-to-day work is much more accurately captured by the folks doing the regular activities (it may be helpful to have these sessions separately so individuals can speak more candidly). The value stream map that we can create breaks out the work by functions, the flows of different types of work, exceptions, etc.

Step 2: Analyse the workload. During this step we understand all of the different types of incoming work, the complexities posed by each type of claim and pay-out ranges. We also

create a logical categorization of the claim types. This categorization helps us further identify claims with greater complexity that may need specialized groups to handle them and simple claims that may be candidates for automation going forward.

Step 3: Learn from the leaders. Lastly we work with top performers to understand tips and tricks they may have to share with colleagues. We can create a process of continuous improvement by creating incentives to increase regular feedback, which helps us be progressive in our approach to the claims handling process by taking greater input from frontline workers. Many tools can also be developed based on this feedback to decrease wasteful approaches to various activities. Working closely with top performers allows us to understand the plausibility of achieving more aggressive targets and realigning our metrics to create a more productive work environment.

Lean Process Improvement Results

Many of our key findings from this Lean process improvement method lead us to understand our flow better. Changing the method for claim routing allowed the creation of specialized groups to more quickly turn around complex claims and auto-adjudicate claims resulting in 2 percent fewer incorrect pay-outs (based on a cost base in the billions [USD]). Further creation of standard operating procedures through the use of Lean process improvement allowed a uniform approach to claims handling and quick adjustment to best practice tools that we pulled from throughout the organization. In the end-to-end process flows we were able to identify unnecessary redundancy and down-time for the adjudication and auditing process, resulting in an increased throughput of 10 percent and decreased auditing times by about 15 percent.

Understanding an organization from end to end truly allows us to identify areas of particular importance that need to be scrutinized for process improvement. We must understand what

the company is doing, how it is doing it and finally ask why these steps are taken. In breaking out the problem we can clearly identify areas to create solutions using Lean process improvement that help drive value.

3. A New Paradigm in Capturing and Integrating Human Intelligence with Claims Payment Automation

Tom Brekka, Co-Founder and CEO of VestaCare

Forward

With the continued pressures on the health insurance market to control medical costs and improve payment processing turn-around times, conventional automation efforts may seem to provide value. However, upon further examination, these approaches fall short of expectations by their inability to capture human decision-making and business rules into the automated workflow.

While simple automation solutions abound, many offering benefit in isolated areas, the majority require continued human manipulation in the resulting claims workflow. This human manipulation offsets to a large extent the financial benefits of the automation and limits the ability to achieve faster turn-around times.

The new paradigm takes the basic automation steps and combines with it the human decision-making and business rules so critical to achieving a truly automated claim payment process. The results are documented improvements in every step in the claim payment process, in particular a much higher control over medical claim costs, faster turn-around time and lower operating costs.

Article

I recently was told of a story about a major HMO health plan that was trying to set-up web services for its clients. The HMO had contracted with a vendor to install a web-based enrollment and information access portal. However, in order to make this work, the vendor was requiring the HMO to ship back and forth data files comprising hundreds of thousands of records every day. Further, the HMO and the vendor had to set-up a team of technicians that would work to keep these data files synchronized so that changes would be handled properly and so they would not overwrite old data on new data. I thought, "What an astounding effort this HMO is having to undergo, particularly when it is completely unnecessary."

Examining this situation I came to the conclusion that this was not an isolated event. Though, it appears extreme, there are many organizations in the health insurance industry today who are pursuing the objective of automating their business processes, but due to entrenched beliefs or lack of knowledge of the alternatives available, they are spending inordinate sums of money and time on programs. At best, they are providing limited benefit and, at worst creating huge cost burdens that are offsetting all projected savings from their investment in automation.

CEOs and senior management often need help understanding what true automation looks like, to understand what is not only possible, but what are current industry Best Practices and a road map on how to pursue an automation program for their own organizations. As the CEO of a company that specializes in offering World Class Automation for Best Practice Solutions, I have a vested interest in seeing the industry become more knowledgeable. This series of articles is designed to help CEOs and their management teams better process automation.

The Current Paradigm

Before moving to describe what are considered Best Practices in the industry today, it is helpful to review some of the current conventional solutions and recognize what they offer and where they fall short.

The first step in understanding the current automation paradigm in the industry today can be summed up with the phrase: "Requires continued human manipulation." Lets review some examples:

EDI

When an organization sends claim files electronically it is typically called electronic data interchange or EDI. EDI appears to represent in many peoples' minds a significant automation step. For example, a TPA was recently touting its EDI capabilities as representative of its level of automation. In fact, this EDI function as currently deployed by this TPA and most organizations is simply another process that involves handing data files back and forth. What this TPA's management didn't realize is that EDI involves ongoing human manipulation in order for it to work. While EDI offers a semblance of efficiency by enabling the transfer of data in batch files versus paper, people must still be involved in setting up the process of gathering the data into the batch files, setting up the transfer and receipt, and running a process to insert the data back into their claims system.

Data loading and extracting from a claim system is usually done through a custom software program. This program bypasses the human key-entry, and as a result, bypasses the edits and logical decision-making rules that are applied by the examiner as they interact with the claims software. Therefore, significant portions of the claims have to be pended and reworked by the claims examiners.

Has this TPA evaluated their examiners' productivity working through these pended claims?

When human manipulation and intervention remains high, costs savings remain elusive because they are offset by increases in other overhead or processing steps.

Imaging Solutions

Another Payor organization recently spent hundreds of thousands of dollars on a document imaging solution. Every single claim, including attachments were being scanned and indexed. Yet, no consideration was given to how this image data was to be converted into electronic data and entered into the Payor's claims system. The images were being displayed on a terminal for the operators to key the claims into the claims system.

Was there benefit to this investment? Perhaps some, in the form of creating an electronic archive for the paper.

Did it save costs, improve turn-around time and add better control over medical claim costs? It may in the form of having the ability to track the claim more efficiently.

However, is it optimal?

Have the maximum benefits been obtained from the imaging step?

With a fully integrated data conversion, duplicate check and eligibility testing sequence added the initial investment (in both technology and ongoing human labor required to scan the documents) could be much more highly leveraged. Typical costs for data conversion of HCFA claims can be in the $0.20 to $0.35 per page depending upon volume. Typical costs for keying claims from images or paper is $0.50. The added processing for real-time eligibility and duplicate testing is usually included in the fees noted above. So the net effective costs when accounting for the elimination of unnecessary work on claims is very competitive.

Scanning and Eligibility Testing

Taking the above claim scanning example one step further, another company seeking to outsource the data conversion of claims for their company sought to have the outsource vendor process the claim images, and then, return converted claims back to their facility as batch EDI files. This conversion process in principle is a simple workflow. However, when the vendor was asked to perform eligibility testing on the converted files, the only means was for the Payor to ship their complete eligibility files to this scan vendor.

While this exchange is not technically complicated to do, it now requires the Payor to establish a nightly downloading process with this vendor.

The vendor will return two or more files that now require the Payor to establish separate loading and handling processes.

While there are other workflows in which providing a nightly download of an eligibility file may be appropriate, such as for a clearinghouse providing eligibility look-up services to providers, the overhead required to support this function for the scanning/data conversion process is high.

Eligibility testing should be performed in real-time against the claims system directly eliminating the need for downloading files. The result is a more secure, efficient and economic process.

Workflow Management

One other major issue with integrating automation into existing workflow is the limitation created by transferring claims immediately into the claims system. Many claims systems are not well suited to supporting extracting all of the claim data necessary to support routing a claim out to another party for processing (e.g. to a PPO for repricing). Since, frequently not all of the claim data is captured at keying or from the EDI load, (only just the data required to pay toe claim is typically loaded), then it becomes impossible to create a valid HIPAA 4010 compliant claim transaction for outside partners.

Being able to insert workflow automation steps in between the EDI receiving process and the claim load to enable routing of the claims to the next most appropriate step in the processing life cycle is very important to achieving an optimized and fully automated claims payment process.

There are many additional examples of how processes are attempting to be automated but where the adopted approach mandates significant human intervention. While these approaches may give the impression of value and progress, it is incumbent upon the CEOs and senior management of the health insurers to press for more optimal solutions.

The New Paradigm

The automation examples above fall short not only by continuing to require direct labor intervention, but in one other very significant area: capturing and integrating the human intelligence and business rules inherent in the decision-making within a claims processing operation. In order to achieve true automation and significant breakthroughs that have been promised for years as the primary motivation for automation, it is essential that the human intelligence that is currently being applied to the claims payment operation be captured and integrated into the automation workflow.

Consistency of Human Decision-making

The greatest challenge in improving a Payor's control over medical claim costs is getting people to pay attention to the details on a consistent basis. With the average claim requiring over 20 steps, it is difficult for claims examiners to maintain consistency with 100% of those criteria. What is particularly challenging is that many of the criteria are dispersed over multiple processing steps (i.e. eligibility, UR, Provider Identification, PPO repricing, claim loading, final provider selection and verification, and out-of-network fee negotiation). Since

most Payors have separate teams or departments working different stages in the claims payment workflow, instilling and ensuring consistent controls is very challenging.

Mimicking Human Behavior with the Claims System

Imagine being able to capture the human intelligence (meaning the knowledge, experience, policies, procedures and nuances) of experienced claims examiners and then incorporating that intelligence into the automation workflow.

Imagine that this intelligence included the knowledge and experience of how to apply that intelligence to the Payor's claims system.

Included in the process:

Unique methods for navigating through the various screens, states and functions of the claims system

System activation of certain steps in the sequences required.

The ability to "drive" the claims system with the captured intelligence from the Payor's expert claims examiners for more sophisticated claims payment processing.

Expert software applications are available today to efficiently capture this human intelligence, both in the form of the claims examiners' knowledge of the system behavior and control as well as the examiner's knowledge of claims software decision-making logic. After this information is captured it can also be integrated into each processing step in the automated workflow.

Truly Automated Eligibility Testing - PPO Repricing

Eligibility should be examined directly against the claims system in real-time without human intervention or separate data file exchanges. To improve, add the ability to probe into "field criteria" to examine prior eligibility history to enable the automated workflow process to identify a member who has changed their health plans recently. Next, correlate the claim back to the correct plan and PPO based on the claim date of service.

This simple example speaks to how human intelligence can be incorporated into the eligibility test workflow with significant downstream benefits. Now, as the claim is prepared to be submitted for PPO repricing, the correct PPO plan associated with the date of services is selected and receives the claim. The correct discount is applied and maximum control over the medical claim dollar has been achieved.

Truly Automated Claim Load - Provider Matching

One of the most challenging steps in automating claim load is the ability to enter the claim such that all edits, PPO links, Provider matches, revenue code mappings, etc. are performed to achieve the highest proportion of auto-adjudicated claims.

Imagine a solution that mimics the human claim entry process, including ...

- Capture of human decisions regarding how the plan dictates revenue codes are to be consolidated
- Providers are selected and how certain charge items are treated per plan specifications

Most every claims system has 5-10 aliases for each provider. Simple selection schemas are inadequate. Current tools are capable of selecting the correct provider using multiple criteria for determining the correct match. Another important benefit of this approach is that plan payment guidelines, usually performed by human claims examiners, can be applied consistently and reliably through the automation.

Achievements Possible Today

Software tools exist today that capture the human intelligence from the claims examiners and apply this knowledge to fully automate every step in the claims payment. Leading Payors have successfully applied these software tools. These Payors are able to offer their

Employer's the tightest possible control over the medical claim dollar, faster turn-around-time, and lower administrative costs.

TPAs are seeing their examiners process 390 to 450 claims per day up from 150 nominally. New Employer deals are being won at 30% higher PEPM administrative fees, yet, the Employer's are realizing hundreds of thousands in savings in direct medical costs. Claims processing cycles, including scanning, data conversion, eligibility, PPO routing and repricing, claim loading and adjudication are being completed in 4-5 days for in-network claims. Out-of-network claims take 5 days longer but are being screened down to a threshold of $100.00 without any added administrative labor. These results have enabled these Payors to compete at a level previously unimagined.

For FSA health plans the automation being described herein can facilitate processing of claims in seconds, opening up the possibility of effective deployment of FSA debit cards. The ability to ensure that all processing decisions are applied uniformly becomes even more critical when claims payment-processing requirements become real-time.

Typical costs for these expert systems described above vary from $20,000 for single automation workflows to $100,000 for systems that automate every step in the claims workflow lifecycle. Yet, the cost is typically a fraction of the cost for a full claims system and comparable to the cost of implementing one of the functions noted above, such as a claims imaging system. The benefits from the fully automated claims process as noted above far exceed the return on investment as compared with simple automation steps being deployed by many organizations currently.

RESEARCH METHODOLOGY

Type of Research: Observational Study

An observational study was done to identify the loop holes which increased the turnaround time (TAT) in corporate reimbursement claims processing.

This is the appropriate strategy to understand the process and the goals of this study is descriptive understanding of the whole process of corporate reimbursement claims and identify the backlogs.

The work patterns and time taken to process one claim was noted.

An activity model of the workflow was developed to understand the process in detail. This provided to be a useful tool to find out the factors which could have increased the TAT.

Study location: Vipul Medcorp TPA Private Limited, Bengaluru.

Sampling Method: Purposive Sampling

Sample Size: 300

RESULTS

The complete corporate reimbursement claims process was observed and the following as-is workflow was developed.

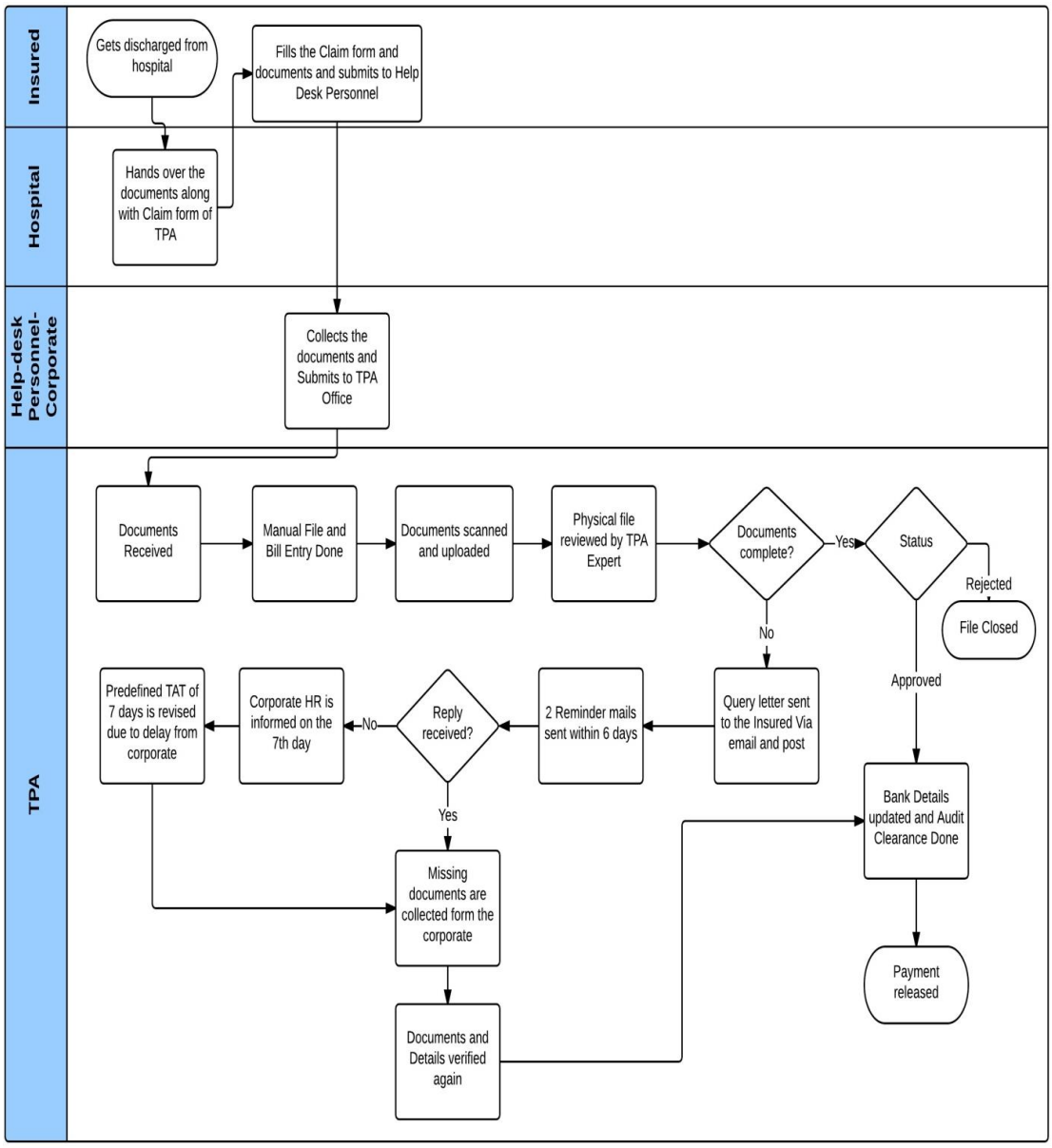


Fig: 1 - Corporate Reimbursement Claim Process-As Is

After studying the as-is process various factors were identified for the increased TAT which are mentioned in table 1.

Reasons for increased TAT	Frequency	Cum. Frequency	Cum. Percentage
Incomplete documents submitted	139	139	46.3
Query reply received late	101	240	80.0
High claims to staff ratio	40	280	93.3
Misplaced documents	20	300	100.0
Total	**300**		

Table 1: Pareto analysis- Reasons for increased TAT in corporate claim reimbursement

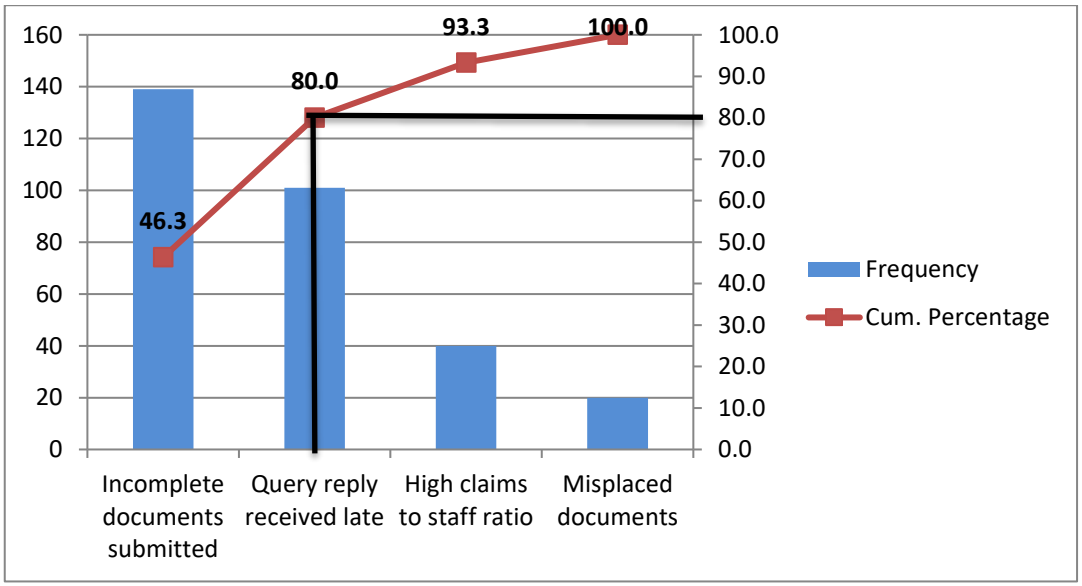


Fig: 1.1: Pareto chart- Reasons for increased TAT in corporate claim reimbursement

The above Pareto Analysis (Table 1 and Figure 1.1) shows that out the 4 major heads (Incomplete documents submitted, Query reply received late, High claims to staff ratio and Misplaced documents), Incomplete documents submitted, Query reply

received late contributes to 80% of the issues for increasing the TAT of corporate reimbursement claims.

Corporate Reimbursement Claim Process-To Be

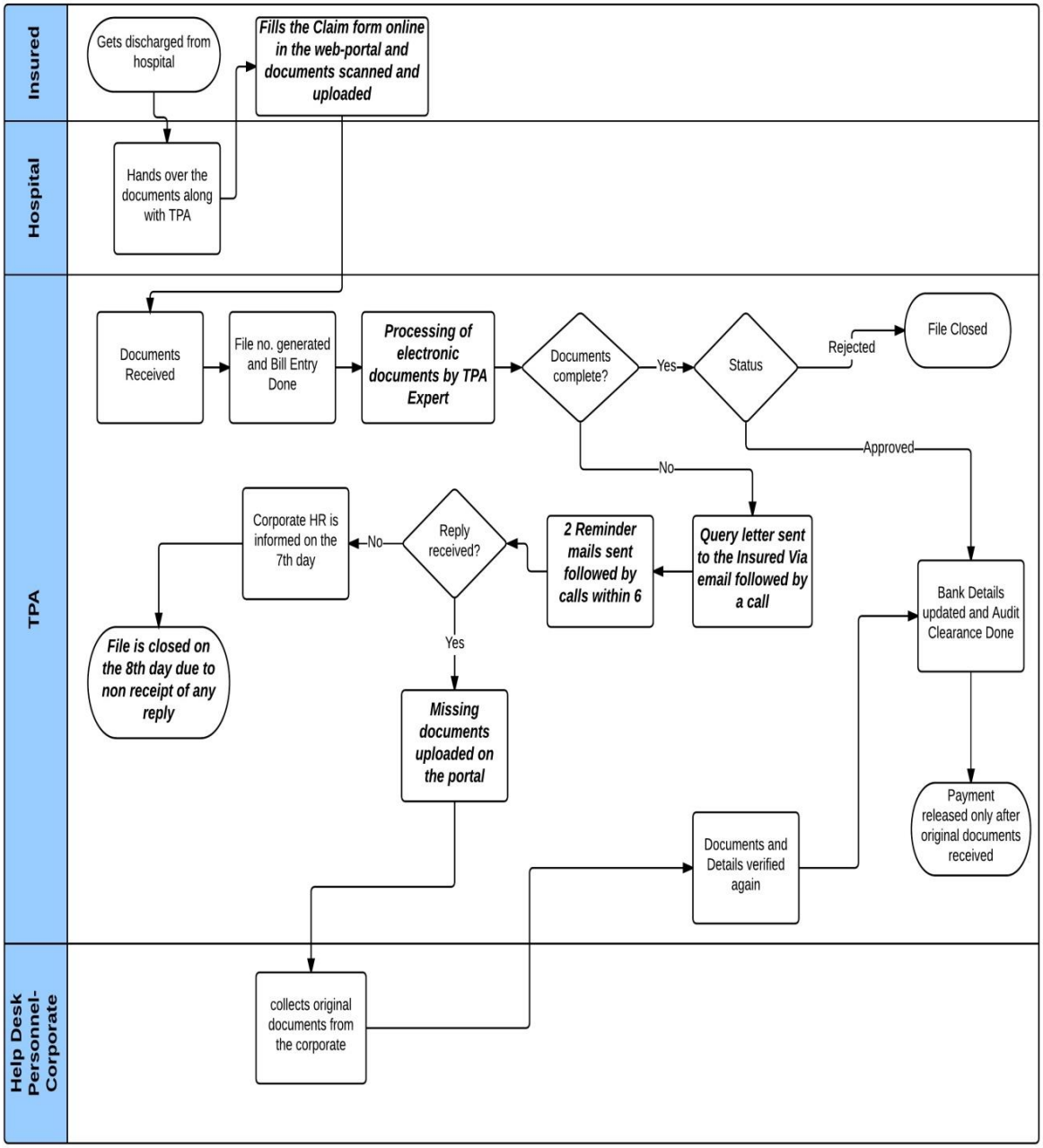


Fig: 2- Corporate Reimbursement Claim Process-To Be

DISCUSSION

Total of 300 corporate reimbursement claims which had increased TAT were chosen. A thorough observational study was done to understand the work flow of how the reimbursement claims are processed. Having studied that for a month, factors were identified for the increase in TAT. To find out the major cause of increased TAT, pareto analysis principle was applied. The result of pareto analysis showed that out of 300 reimbursements claims the majority of the reasons for increased TAT were falling under incomplete submission of documents (46%) and query reply received late (34%).

Further, these two reasons were taken into consideration and measures were taken to refine the existing process.

Incomplete documents submitted

The major reason for submission of incomplete documents included the negligence from the insured. Despite providing them with the claim submission checklist with the claim kit, they failed to submit few mandatory documents. Therefore, a solution was required which could minimize this human error.

Solution: A web portal was developed for the corporate to overcome this issue in which the insured had to upload all the scanned documents along with the online claim form.

Benefits: Possibility of receiving all the documents as the fields in the portal would be mandatory.

It also minimized the visit of the TPA help desk personnel who otherwise had to visit the corporate for collecting the documents every alternate day, which would increase the TAT. This helped the TPA to reduce its resources in a proper way.

Risk of misplacing the documents was reduced, which otherwise was a concern when the physical documents used to come and without being entered into the system used to get misplaced. Easy retrieval of file because of electronic data.

Query reply received late

The reason for this was delayed response from the insured. The active system of communication to the insured was to send the query letter via email and post followed by two reminder mails. But it was observed that this system was not efficient as most of the time the insured missed the emails or it used to go to their junk folders.

Solution: To make the system of communication efficient a 2+2 rule was devised. According to this rule, insured would receive query letters via 2 emails followed by two reminder calls within a period of 6 days. Insured would then upload the query reply in the web portal. If within this period insured doesn't respond to the query then on the 7^{th} day HR of the corporate would be informed. Still no response received, then file would be closed from TPA end.

Benefit: This would help the TPA to maintain its TAT of 7 days for corporate reimbursement claims. It would also minimize the risk of financial penalty due to increased TAT.

CONCLUSION

Through the present study it has been observed that out of 300 claims which had increased TAT, the major issues i.e. submission of incomplete documents and delayed query reply, occurring over the period of time were due to inefficient system and improper use of resources. This study has tried to find out the issues for increased TAT and has tried to provide a feasible solution for the same. The study confirmed that there has been improvement in the TAT with few changes in the existing system i.e. the development of web portal for the corporate which made process easy and time reducing. TPA also realized the benefits of the new system in a very short span of time and would improve the process further.

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