Analysis of Billing and Claim Processing In Park Hospital

A Dissertation proposal for

Post-Graduate Diploma in Health and Hospital Management

By

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PG/10/025

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May, 2012

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ACKNOWLEDGEMENTS

First and foremost I thank **GOD** for the successful completion of this project.

It is my pleasure to acknowledge the debt I owe to **Dr. Ajit Gupta**, Chairman and **Dr. Ankit Gupta**, Medical Director of Park group of Hospitals who have given me the opportunity to complete my internship in their prestigious organization.

With immense pleasure I express my heartfelt gratitude to **Dr. N.P. Singh**, Director, Institute of Health Management Research, Delhi and **Dr. Rajesh Bhalla**, Dean (Academic and Students Affairs), Institute of Health Management Research, Delhi for having given me this opportunity to undergo an internship.

It is with immense sense of gratitude that I thank my mentor Prof. (**Dr.) T. Muthu Kumar** , Professor, Institute of Health Management Research, Delhi for his helpful attitude and valuable suggestions, which helped in shaping and completion of this project. I owe a great debt to him for showing his interest and sharing his valuable views in spite of his busy schedule.

I am extremely indebted to **Dr. Vikas Gupta**, Billing Head, Park Hospital, for his valuable guidance and encouragement. It has been my privilege to work under his dynamic supervision in the hospital.

I thank **all the professionals** at Park group of Hospitals, for generously sharing their knowledge and precious time which inspired me to do the best during the internship.

Last but not the least; with all my gratitude and love for **my parents and family**, I would like to express my humble love for them since I could not have expected to take even a single step further without their presence around me.
I also extend my special thanks to **all my friends** for their support and valuable suggestions.

Dr. Naveen Kumar

ABSTRACT

In today's scenario where the health care industry is seeing the highest growth and reason of that could be success of health insurance, as in India where to afford an expensive medical treatment is not in the hand of a common man. For him to cope up such expensive treatment had been made possible by insurance industry be it the private insurance companies or various government health schemes and panels like CGHS< ECHS, ESI, NDMC, Delhi Police etc. The reason of increasing cost of health care could be advanced technology, more qualified doctor, better quality treatment. But all these have been made easier to achieve by just giving small premium (based on health status of the person) or working in a government organization which caters to the health related needs of the employee and his dependents. It not only benefitted the common man but the corporate hospital also. It has also increased the market share of the hospital by giving more patients.

But in the same time it involves a lot of managerial work, for a patient it is just a cashless process where he do not need to pay a penny, but for a hospital actual calculation starts when the patient leaves the campus just on the basis of approved letter, later it is scrutinized and corrected by doctor sitting in the insurance company or a government body, It involves a number of steps before issuing or getting the final payment.

It worsen the process if the doctor or the patient fails to understand the clauses which is been written by the insurance bodies and panels for the concerned patient. For the patient it is important to understand that if permission from the concerned payer doesn't come at the time of admission, the patient himself has to pay for his expenses. The hospital can just act as a mediator. These things have to be explained to the patient at the time of admission itself to avoid any disputes in future. Such cases intern effect the revenue of the hospital and results the hospital goes into a loss making called deduction.

The basic objective of my study was to ensure increase in revenue through fast and efficient processing of claims, define major bill types used in the hospital and appreciate the role of claims editing in the bill submission process and the methodology adopted were a combination of retrospective and prospective study that has been conducted by investigating the process, situation, problem or issue that effect the smooth processing of claims. The study has been done

on the basis of data available for that period. The data used for the present research is primary in nature and it is used for doing the analytical study with sample size of 1220 patients.

Various queries are raised from time to time during the time of claim processing, If the billing and processing is not done accurately, it would mean a lot of revenue loss for the hospital which is not good for any organization. Reasons behind the raising of queries are many such as submission of incomplete documents, delayed submission of claim etc.

And the suggestion and recommendation given to the higher management includes, proper training of billing and processing staff, unrelated treatment intimation should be given prior to the procedure done(so that staff can take the approval of that procedure before hand),proper counseling of the patient should be done at the time of admission, online processing of claims for timely approval of hospital claims.

LIST OF ABBREVIATIONS

1. ECHS- Ex-servicemen Contributory Health Scheme
2. CGHS- Central Government Health Scheme
3. ESI- Employee State Insurance
4. DP- Delhi Police
5. NDMC- National Delhi Municipal Corporation
6. TPA- Third Party Administrator
7. DRG- Diagnosis Related Group
8. CDM- Charge Drug Master
9. MOA- Memorandum of Agreement
10. OIC- Officer In charge
11. SEMO- Senior Executive Medical Officer
12. CFA- Competent Financial Authority
13. ICP- Indoor Case Papers
14. ICD- International coding of Disease

PART – I

INTERNSHIP REPORT

1.1 ORGANIZATION PROFILE

Park Hospital Gurgaon is an ambitious initiative from the house of Park. Fully-equipped with all state-of-the-art medical facilities, this 250 bed super-specialty hospital is the beginning of a new era in taking healthcare services in Gurgaon to a new level. Park Hospital Gurgaon envisions of providing a comprehensive spectrum of advanced medical & surgical interventions with a perfect mix of inpatient and outpatient services to people of all social and economic backgrounds. It is the onset of a new experience where patients not only get medical services as per international standards but also receive an empathetic and humane treatment by the professionals attending to them. It is about pursuing a dream called 'wellness for all'

A branch of Park Group of Hospitals having branches in South Delhi, West Delhi, Faridabad and other upcoming hospitals in Panipat and Cancer Hospital in West Delhi

Fully equipped 70 bedded ICU/ CCU complex with ultramodern intensive care facilities manned by intensivists, physicians and residents round the clock

Department of Interventional Cardiology and Cardiothoracic Surgery equipped with latest GE Innova, IQ Cath Lab and Ultramodern Cardiothoracic Operation Theatres.

Park Mother's Nest- High end premium boutique birthing center with Labor Delivery Recovery (LDR) suite.

The Park Mission

"To deliver state-of-the-art personalized healthcare services to people of all social and economic background and achieve highest level of patient satisfaction."

The Park Vision

"To be a leading name in the healthcare sector by providing holistic healthcare at affordable cost."

About Logo

P E R S O N A L I S E D

A L L S P E C I A L I T I E S

R E S O N A B L E C O S T

Q U A L I T Y S E R V I C E S

The two hands stand for care & help.Blue color signifies excelence and orange indicates the zeal for care.The logo also assure people that they are in safe and caring hands

Commitment Towards Quality

At Park Hospital, we believe in our people, our systems and our commitment to quality and continuous improvement. It is our aim to deliver safe, cost-effective care to the community and the patients we serve. At Our Hospital we believe that the patient experience is comprised of outstanding quality and excellent customer service.

We are committed to provide our patients with the: Highest-quality, safest and most-satisfying care possible.

We continuously strive to improve the quality of our health care services by

- Adopting latest technology and equipments to strengthen our Medical processes and procedures to achieve the set objectives.
- Induction of regular training programs for staff.

- To meet the National and International Standards.
- Park Super Speciality Hospital, Gurgaon is in the process of applying for NABH Accreditation at the earliest.

There are many factors that patients and their families consider when choosing a hospital, but, the most important ones are the quality of patient care and the satisfaction experienced by both the patients and their families. That's why we follow strict quality and safety practices throughout our entire hospital, monitor our staff's compliance with these practices and continuously seek ways to improve.

Park Hospital is committed to meet or exceed customer expectation in quality, delivery and cost. As the level of their expectation increases every year, continuous quality improvement is critical to our success in the competitive marketplace.

The key elements of a successful strategy can be organized into the following categories:

- Developing the right culture for quality to flourish
- Attracting and retaining the right people to promote quality
- Devising and updating the right in-house processes for quality improvement
- Giving staff the right tools to do the job.

Salient features of Park Hospital

- More than 25 departments, 100 doctors, 500 paramedical support staff available round the clock
- A branch of Park Group of Hospitals having branches in South Delhi, West Delhi, Faridabad and other upcoming hospitals in Panipat and Cancer Hospital in West Delhi
- Fully equipped 70 bedded ICU/ CCU complex with ultramodern intensive care facilities manned by intensivists, physicians and residents round the clock
- Department of Interventional Cardiology and Cardiothoracic Surgery equipped with latest GE Innova, IQ Cath Lab and Ultramodern Cardiothoracic Operation Theatres

- Park Mother's Nest- High end premium boutique birthing center with Labor Delivery Recovery (LDR) suite.
- Department of Neonatology comprising of all the ultramodern facilities with monitoring units, open and close Incubator, Ventilators, Analyzers, with dedicated team of Neonatologists and Paramedical staff.
- Park Trauma Center- Comprehensive integrated approach by team of Orthopaedicians, Neurosurgeons, General Surgeons and other paramedical staff to handle all kind of trauma cases.
- Fully functional Gastroenterology department with all ultramodern equipments manned by Gastroenterologist and Gastro Intestinal surgeon to deal with all kind of routine and emergency procedures.
- 24 x 7 Blood Bank services.
- Department of Radio Diagnosis equipped with advanced CT, MRI, Ultrasound, Color Doppler, and Digital X- Ray system 24 x 7

Various departments and services

- Anesthesia /Pain Management
- Blood Bank
- Cardiology and Cardio Thoracic Vascular Surgery
- Critical care
- Cancer and Oncology
- Dentistry
- Dermatology and Cosmetic Surgery (Plastic and Reconstructive Surgery)
- Emergency Medicine and Ambulance Services

- Endocrinology
- ENT (Ear , Nose and Throat)
- General and LaparoscopicSurgery (Minimal Invasive and Bariatric Surgery)
- Gastroenterology
- Gynecology and Obstetrics
- Internal Medicine
- Nephrology
- Neurology and Neurosurgery
- Ophthalmology
- Orthopedics
- Pediatrics
- Pulmonology and respiratory Medicine
- Urology
- 24 hour emergency and pharmacy
- Radiology Services and diagnostics

Location of services & Distribution

Basement:

1) Radiology- X-Ray, Ultrasound, CT Scan, MRI
2) Pathology and Microbiology
3) Neurology Lab- EEG, EMG

4) OPD Chambers- ENT, Psychiatry and Psychology, Respiratory Medicine, Urology and Nephrology,
5) Ophthalmology
6) Dermatology
7) Blood bank
8) Physiotherapy
9) Dental
10) Accounts
11) IPD Billing
12) Medical Record Department and Store
13) Admin Offices
14) Conference Room and Auditorium
15) Gas Manifold
16) Restaurant

Ground floor:

1) RECEPTION (Front Desk)
2) TPA and International Patients Desk
3) Casualty
4) Admin Offices
5) OPD Chambers- Medicine, Surgery, Orthopaedics, Gastroenterology, Paediatrics, Neurology and Neurosurgery, Cardiology and Cardiothoracic Surgery, Obs & Gynae etc.

6) Mother's Nest- Obs & Gynae Wards, Labour Room, LDR (Birthing) Suites, NICU and Nursery.

7) Surgical ICU

8) Gastro Lab

9) OT Complex- 3 Major and 1 Minor Operation Theatre

First Floor:

1) Inpatients Wards – Single Rooms and Twin Sharing Rooms, Suite Rooms

2) Medical ICU- I

Second Floor:

1) Inpatient Wards- General Wards, Single Rooms and twin sharing rooms.

2) Dialysis Unit

3) Heart Centre - Cardiac OT, Cath Lab, Heart Command, CCU and Medical ICU-II.

PARK GROUP - OTHER HOSPITALS

1) Park Sunil Hospital (South Delhi) – 50 bedded

2) Park Hospital (West Delhi, Keshopur) – 304 bedded and NABH Accredited.

OTHER UPCOMING PROJECTS:

3) Park Hospital (Faridabad)

4) Park Hospital (Panipat)

5) Park Cancer Hospital (West Delhi)

OBJECTIVES OF THE INTERNSHIP

Internship is an integral part of our Postgraduate Programme in Hospital Management. As part of the curriculum, each student of final year is required to undergo three months internship with reputed organization to: -

- Learn through assessing the manager in daily operational management.
- Study and address some identified issues, associated with some specific operational areas.
- Enhance our sills in regards to giving practical and effective solutions to day to day Problems.
- To acquire new skills from our day to day activities to become more effective and efficient in our delivery of results.

Roles and Responsibilities during Internship

Working in Park Group Of Hospitals, West Delhi Branch as Processing Head in the Billing Department..

General role:

Handling the daily routine operations of the billing and processing department of the hospital.

Specific Roles and Responsibilities:

- Responsible for handling all the queries that occur between the hospital and various insurance panels.
- Checking of bill in accordance with the treatment given during hospitalization stay.
- Checking of investigation reports including lab and radiological reports in accordance with Bill, services given and discounts.
- Visits to base hospitals.
- Responding to the queries that are raised by the concerned panels and insurance bodies.

Learning During Dissertation

- Role of Health care IT in smooth processing of the hospital affairs.
- Attention to details
- Quicker and effective decision making.
- Enhance my managerial skills.
- To understand working of whole hospital and seek opportunity that provides me real experience.
- To groom myself as a professional.
- Coordination within various departments of the hospital.
- Role of good communication skills in interacting with patient or health care professionals.

PART – II

DISSERTATION REPORT

ON

INFECTION CONTROL

IN

INTENSIVE CARE UNIT

AT

PARK HOSPITAL

CHAPTER ONE- INTRODUCTION

1.1 BACKGROUND

Healthcare organizations are for the most part business oriented organizations. The ultimate financial survival of healthcare organizations depends on a consistent and recurring flow of funds from the services they provide to patients. Without an adequate stream of revenue these organizations would be forced to cease operations. In this regard, healthcare organizations are similar to most business entities that sell products or services in our economy. The critical stages in the revenue cycle for healthcare organizations are the provision and documentation of services to the patient, the generation of charges for those services, the preparation of a bill or a claim, the submission of a bill or claim to the respective payer and the collection of payment. No other industry in our Indian economy faces the same level of billing complexity that most healthcare organizations face. Part of this complexity is related to the nature and importance of the services provided. Regulation is also a factor that further complicates documentation and billing of healthcare services. Finally, the existence of different payment methods and rates for multiple payers further complicates the revenue cycle for most healthcare organizations.

Although the primary purpose of the data accumulated in the medical record may be related to clinical record decision making, a substantial proportion of the information may also be linked to billing. For example, the assignment of diagnosis and procedure codes within the medical record by the physicians plays a key role in diagnosis- related group (DRG) assignment. Many healthcare payers provide payment for inpatient care based on DRG assignment. Data in the medical record are also the primary source for documenting the provision of services. For example, if a patient's bill listed a series of drugs used by the patient but the medical record didn't show those drugs as being used, the claim would not be supported. The primary linkage between the claim and the medical record is related to the documentation of specific services provided.

Accurate billing and coding are essential to a healthcare organization's financial survival. This is a very complex area and requires the input of billing and coding professionals. Failure to capture all charges associated with a patient encounter can result in significant revenue loss. Some estimate of loss charges run as high as 5% of total charges. Given the relatively low margins for

most healthcare organizations, this could be a catastrophic loss. Healthcare organizations are unique in many respects, but coding is an area of special importance. In most other business settings, a bill simply lists the items purchased or services rendered. In healthcare organizations the charge code describing the products or services must be related to standard procedure codes and supplemented with diagnosis codes to document the legitimacy of services. These codes can and do have a major role in not only the amount of payment received, but also the timeliness of that payment.

There is an urgent need of proactive and collaborative approach to improve billing and claim processing in current health care scenario.

As a general acceptance, an error occurs when a health-care provider chose an inappropriate method of administering the services or the health provider chose the right solution but executed it incorrectly. Most of the errors in the billing and claim processing are often due to human errors.

However, the practice of billing and processing in the hospital setting is very complicated, and so many steps occur from "pen to patient" that there is a lot to analyze. Implementing efficient practices requires developing efficient systems. Many errors occur as a result of poor oral or written communications. Enhanced communication skills and better interactions among members of the health care team and the patient are essential. Faulty systems must be redesigned, and seamless, computerized integrated healthcare delivery must be instituted by health care professionals adequately trained to use such technological advances.

1.2 OBJECTIVES OF THE STUDY-

1. To ensure increase in revenue through fast and efficient processing of claims.
2. Define major bill types used in the hospital.
3. Appreciate the role of claims editing in the bill submission process

1.3 LITERATURE REVIEW

The process often begins with the collection of information about the patient before the delivery of services in the patient registration functions. Information about the patient, including address, DOB and insurance details is collected to facilitate bill preparation after services are provided. Once services have been provided, data from that encounters flow into 2 areas-

1. Medical documentation
2. Charge capture

There are four claim-level dispositions:

- Rejection: Claim must be corrected and resubmitted.
- Denial: claim cannot be resubmitted but can be appealed.
- Return to Provider: Problems must be corrected and claim resubmitted.
- Suspension: Claim requires further information before it can be processed.

Data from the provision of services also flow directly to billing through the capture of charges. The posting of charges to a patient's account is usually accomplishment through the issuance and collection of charge slips in a manual mode or through direct order entry or barcode readers in an automated system. The critical link here is the hospital's price list from which information flows into the actual claim. The final step before actual claim submission is claims editing which is critical step for most of the hospital. In this editing process various key areas are reviewed. First, does the claim have enough information to trigger payment by the patient's payer? For example, perhaps the claim is missing the patient's healthcare plan identification number. Second, does the claim meet logical standards and is it complete? For example, a claim may have a charge for laboratory panel but no charge for a blood draw to collect the sample. Editing is critical to accurate and timely payment by third party payers.

Registration

In most cases a patient or their representative provides a basic set of information regarding the patient before the actual delivery of services. In a physician's office, this may be done just before

medical service performance. For an elective hospital inpatient admission, it may be done a week or more before admission. A number of clinical and admission sets of information are collected at this point. From the financial perspective, 3 activities are especially important in the billing and the collection process.

Perhaps the most important activity is insurance verification. If the patient has indicated they have third party insurance coverage, it is important to have this coverage verified from the payer. The patient may also have secondary coverage from another health plan. Verification of that coverage is also critical to accurate and timely billing. The critical piece of information to collect from the patient in this regard is their health plan identification number, which may sometimes be their social security number. Queries to the health plan before service can validate the type of coverage provided by the health plan and the eligibility of the patient for the scheduled service. In today's current environment insurance verification is often done online. Sometimes prior approval of elective services is required by the health plan before a claim can be submitted. For example, in case of ESI (Employee State Insurance) claim if angioplasty is to be done after angiography, permission for the same is taken before the procedure is done. This prior verification is often referred to as precertification. It is important, however, to verify the existence of the current coverage.

The second activity in Registration is often related to the computation of copayment of deductible provisions that may be applicable for the patient. This activity is carried out in case of TPA claims but not in the ECHS and CGHS Schemes. Once the insurance coverage has been determined, it is usually possible to calculate the required amount that may still be due from the patient.

The third activity in this registration process relates to financial counseling. Staff at the healthcare firm can advise the patient regarding eligibility and help them to complete the necessary documents required for coverage.

Charge entry and charge master

Performing actual medical services is the lifeblood of a healthcare organization's revenue cycle. Without the provision of services there is no revenue, but it is imperative that charges for those

services are captured. A service that is performed but not billed does not produce revenue. The three greatest concerns in billing are:

- Capture of charges for services performed
- Incorrect billing
- Billing late charges

Charge capture is usually accomplished in one of two ways. For a number of providers actual paper documents or charge slips are used to identify services performed. These charge slips are then posted to a patient's account in a batch-processing mode by data processing. Alternatively, an order entry system could be used that may involve direct entry of charges to the patient's account through a computer terminal.

The key link between the charge capture and the billing process is the charge code that is reflected in the order entry system or the charge slips and also represented on the organization's charge master (also known as CDM). There is a unique charge code for each service procedure, supply item or drug in the CDM. Every charge master has the following common elements:

- Charge code
- Item description
- Charge
- Revenue code

Claims Editing

Healthcare providers are interested in two major objectives. First, they want to ensure they receive the maximum payment for the medical services delivered to their patients. Second, providers want to shorten the amount of time from claim submission to actual payment. Payers have a similar set of incentives except they are reversed. Payers do not want to make payment in an amount that is greater than the amount of their obligation. Payers also would like to delay payment as long as possible without violating payment laws or contract discount terms.

ECHS GUIDELINES FOR EMPANELLED HOSPITALS

1. The aim of the Ex-Servicemen Contributory Health Scheme (ECHS) is to provide comprehensive and quality medical care to Ex-Servicemen for all known diseases. The following categories are eligible for availing the facilities on membership:-

(a) Ex-servicemen drawing pension/ disability pension.
(b) Widows drawing family pension.
(c) Spouse of pensioner.
(d) Unemployed sons below 25 years
(e) Unemployed and/or unmarried daughters.
(f) Dependent parents whose income is less than Rs. 1500/- per month.
(g) Mentally/ Physically challenged children for life

2. **Facilities.** Medical facilities are to be provided through a network of 227 Polyclinics spread across the country, to be established over 4 years. Basic outdoor services will be provided at the Polyclinics. In case further management is required, referral will be made from ECHS Polyclinics to Armed Forces Medical Services Hospitals, Empanelled Private Hospitals/ Dental and Diagnostic Centres. These referrals can only be made by authorized staff of the Polyclinics.

3. Empanelment of Hospitals/Nursing homes and Diagnostic Centres is carried out after signing a Memoranda of Agreement (MOA). Expenditure incurred on services provided by an Empanelled Hospital /Dental / Diagnostic Centre will be paid directly to them by ECHS as per approved rates.

Referral to empanelled facility

4. Referrals to Empanelled facilities can be made by Medical Officers, Specialists and Dental Officers of ECHS Polyclinics. Referrals will only be made **once all available facilities of the Polyclinic are fully utilized**. In case the referral to Empanelled facility is recommended by Service Specialist/ Dentist, a referral form will be generated by the ECHS Polyclinic under the signature of a Polyclinic Medical/ Dental Officer. **All referrals from ECHS Polyclinics will be authenticated by Officer In Charge (OIC) Polyclinic under his stamp.**

5. **Use of Referral Form**. The referrals to empanelled facilities will be made by the authorised Medical Officers/Specialists in the Polyclinics on ECHS Referral form only. A format of the Referral form is enclosed at Appendix 'C'. **The referrals will be duly stamped by the seal of the Polyclinic** and will clearly outline a brief history of the case, the diagnosis, the hospital/ diagnostic centre to which the ECHS beneficiaries have been referred, and **the specific treatment procedure/investigation** for which the referral has been done.

6. In emergencies and life threatening conditions, when patients may not be able to follow the normal referral procedure, they are permitted to be admitted to any / nearest hospital. In case of admission to an empanelled facility, the member would be required to produce his/ her ECHS card as proof of ECHS membership. In such circumstances **the empanelled hospital is required to inform the Polyclinic of that station,** or the nearest Service Hospital/ Station Headquarters (Stn HQ) in case the Polyclinic cannot be contacted, **within a period of 48 hours**, regarding the particulars and the nature of admission. The OIC Polyclinic may make arrangements for verification of the facts and issue of a formal referral.

7. By and large the conditions of emergency are listed as under : -

(a) Acute Cardiac Conditions/ Syndromes including Myocardial Infarction, Unstable Angina, Ventricular Arrhythmias, Paroxysmal Supraventricular Tachycardia, Cardiac Tamponade, Acute Left Ventricular Failure/ Severe Congestive Cardiac Failure, Accelerated hypertension, Complete dissection.

(b) Vascular Catastrophies including Acute limb ischaemia, Rupture of aneurysms, medical and surgical shock and peripheral circulatory failure.

(c) Cerebro-Vascular Accidents including Strokes, Neurological Emergencies including coma, cerebro meningeal infections, convulsions, acute paralysis, acute visual loss.

(d) Acute Respiratory Emergencies including Respiratory failure and decompensated lung disease.

(e) Acute abdomen including acute obstetrical and gynaecological emergencies.

(f) Life threatening Injuries including Road traffic accidents, Head Injuries, Multiple Injuries, Crush Injuries. and thermal injuries.

(g) Acute poisonings and snake bite.

(h) Acute endocrine emergencies including Diabetic Ketoacidosis.

(j) Heat stroke and cold injuries of life threatening nature.

(k) Acute Renal Failure.

(l) Severe infections leading to life threatening sequelae including Septicaemia, disseminated/ miliary tuberculosis.

(m) Any other condition in which delay could result in loss of life or limb. In all cases of emergency the onus of proof lies with the ECHS member.

8. Payment of bills for Emergency treatment will be made by ECHS as per approved rates and the member is not required to pay.

9. **Follow-up Treatment/ Reviews.** In cases where regular follow-up/review are required, such follow-up treatment, (OPD/ Indoors) will be provided for a maximum **period of 1 month at a time**. Referral form in such cases should mention the same; for e.g., "Referred for follow-up treatment for a period of one month." Fresh referral has to be initiated on termination of the 1 month period.

10. The same provisions will apply for cases where treatment procedures are to be repeated at regular intervals as an ongoing process, e.g., cases requiring dialysis or regular long term physiotherapy. An example of what the referral should read is illustrated below :

"Referred for Haemodialysis, 3 sessions per week for a period of one month."

11. The Original referral form will be attached along with the first lot of bills in all such cases. A photocopy of the referral form will be attached with subsequent bills for the same referral, with an endorsement by the hospital linking the case to the original referrals.

12. When another test/procedure is to be carried out on account of new illness/ complication (other than the one for which referred), treatment of which cannot be deferred, the same may be undertaken in the hospital and fresh referral is not required. However, as in the CGHS**,** the 'other' procedure will be charged at 50% of package rate. For non-package investigations /

treatment, actuals as per authorized rates are admissible. Need for additional procedure undertaken is to be elaborated in clinical summary submitted with the bills.

PERIOD OF HOSPITALISATION

13. Where a patient is admitted for specific treatment, he will be hospitalized for such period as is necessary for completion of the treatment. For treatments, specialized procedures or diagnostic tests for which Package rates are specified, the periods of hospitalization should not exceed the following limits, under ordinary circumstances :-

(a) Specialised procedures - 12 days.
(b) Other procedures - 8 days.
(c) Laparoscopic surgery - 3 days.
(d) Day care/ minor procedures 1 day.

14. In case the beneficiary has to stay in the hospital for his/ her recovery for more than the period covered under Package rates, the additional payment will be limited to room rent as per entitlement, cost of the prescribed medicines and investigations, doctors visits (not more than 2 times a day).

CONDITIONS REQUIRING PRIOR APPROVAL

15. Prior approval of Central Organisation ECHS is required to be obtained by the Empanelled Hospitals/ Nursing Home/ Diagnostic Centres, when the anticipated expenditure for medical treatment/ investigation of an ECHS member for a single hospitalization period is beyond Rs 5 lakhs. The request must be routed through the Polyclinic. In case of an Emergency, the sanction will be obtained through Fax/ Signal/ Telegram/Verbally and will be supported by the following details:-

(a) ECHS Membership Number.
(b) Particulars and age of the patient.
(c) Preliminary Diagnosis of the Hospital.
(d) Summary of the case including brief past history.
(e) Tests/ Procedure/ Treatment recommended.

16. **Adaptation to Modern Treatment System.** Medical care is a dynamic science with new technologies being introduced each day and on a regular basis. Before clinical implementation, these new methodologies of treatment have to undergo a process of rigorous cost effective trials. Many of these methodologies are not listed in the CGHS/ AIIMS procedures. Where implants/ methodologies of treatment, not listed under the CGHS/ AIIMS, are recommended for an ECHS member, prior approval will be obtained in writing as per table below. The request will be forwarded to the Polyclinic, for obtaining approval through the Senior Executive Medical Officer (SEMO):-

S No	Cost of Implant/ Procedure	Approval
(a)	Less than 1 lakh	SEMO/ SMO/ PMO
(b)	1 lakh to 2 lakhs	Senior Adviser in the Speciality at Service Hospital
(c)	2 lakhs to 4 lakhs	Consultant in the Speciality.
(d)	Above 4 lakhs	Senior Consultant Medicine / Surgery in the Office of DGAFMS.

17. **Cardiology.** Prior approval is also required for use of more than two Coronary Stents, or for the use of Medicated Stents.

18. The above conditions which require prior approval are listed in the Table below. Approving authority is also mentioned against each condition.

S.No	Condition requiring Approval	Approving Authority
1.	Treatment procedure above 5 Lakhs	Central Org ECHS
2.	Implants/Procedures not listed in CGHS	
	(a) Less than 1 lakh	SEMO/ SMO/ PMO/ CMO
	(b) 1 lakh to 2 lakh	Senior Adviser in Speciality
	(c) 2 lakhs to 4 lakhs	Consultant in Medicine/ Surgery./ Allied specialities (as applicable)
S.No	**Condition requiring Approval**	**Approving Authority**
	(d) Above 4 lakhs	Senior Consultant Medicine/Surgery in the Office of DGAFMS
3.	Procedures listed in CGHS for which approval is required	
	(a) Angioplasty with Coronary Stents	
	(i) Upto 2 Coronary stents	No approval required. Cardiologist of empanelled hosp authorised to certify/recommend
	(ii) More than 2 Coronary stents	SEMO

	(b) Angioplasty with Medicated stents	
	(i) Cypher /Taxus stents upto 2 stents.	Classified Specialist (Cardiology) or Senior Adviser (Medicine) or Cardiology
	(ii) More than 2 Cypher/Taxus stents.	Senior Advisor Cardiology or Consultant or Senior Consultant (Medicine)

19. **Procedure for approval** - Requests for approval are to be submitted by the Empanelled Hospital or Dental/ Diagnostic Centre to the Polyclinic by Fax/Courier. Polyclinic will fwd the request, as per proforma (Appendix A), to SEMO for obtaining the necessary approval and communicating the same to the concerned Empanelled facility.

Submission of Bills

20. ECHS Empanelled facilities will submit bills to the OIC Polyclinic with the following enclosures:-

(a) Original Referral slip from Polyclinic/ Service Hospital.

(b) Photocopy of ECHS Card/ Membership Application Registration Slip.

(c) Copy of admission and discharge slip.

(d) Summary of the case, including outcome of treatment.

(e) Bills in duplicate, ink signed and duly marked as 'ORIGINAL' and 'DUPLICATE', with signature of ECHS member/ representative endorsed.

21. Bills submitted by the Empanelled Hospitals/ Dental or Diagnostic Centres should provide following details**:-**

(a) Particulars of the Patient.

(b) ECHS Registration No.

(c) Polyclinic Referral No and date.

(d) Diagnosis.

(e) Treatment/Procedure/Investigation.

(f) Date & Time of admission.

(g) Date and time of Discharge.

(h) Signature of ECHS member/ representative should be obtained prior to discharge of patient / on completion of treatment/ investigation.

22. **Package Deals negotiated with Empanelled Facilities as per MOU.** Zonal jurisdiction of Package deal rates of CGHS, as detailed in Appendix B, will be applicable. For diseases and treatment procedures not covered in the list of package deals, the payment would be at the rates of AIIMS, New Delhi. Where the AIIMS rates are not available, the cost of drugs, room rent, laboratory investigations etc., will be paid as per authorized rates/ actuals whichever is less. Billing in these cases will be for a lump-sum package. In case of two procedures, as mentioned in Para 12 above, the bill should mention them separately :-

Package Deal Rates (as per Zonal rates concluded in MOU)

(a) Major Procedure

(b) Minor Procedure (*if applicable*)

23. **Action in Cases where Package Deal Rates Not Available.** When the Package deal charges are not specified for a particular procedure, either in the CGHS or AIIMS list, the bills from the Hospitals/Diagnostic Center should reflect the following details :-

(a) Hospital Charges.

(*Where Package deal rates are not applicable*)

(i) Accommodation (*List type of Ward- private/semi-private/general)*

(iii) Surgical Operation or Medical treatment charges.

(iv) Pathological Tests (*Specify tests and Number*)

(v) Radiological tests (*Specify investigations and number*)

(vi) Specialised investigations (*Specify investigations and number*)

(vii) Medicine *(Specify drugs and costs)*

(viii) Ordinary Nursing

(ix) Special Nursing

(x) Ambulance Charges

(xii) Consultation charges *(Number and date)*

(xi) Other miscellaneous charges (to be clearly specified).

24. **Cancer Treatment**. In the case of treatment undertaken for Oncology, billing will be as for a **Non-Package disease**. The following can be billed item wise:

(a) Drugs as per actuals

(b) Administration charges as per CGHS.

(c) Investigations, Accommodation etc as per CGHS.

(d) Consultation as per CGHS.

(e) Radiotherapy as per CGHS rates.

25. The summary of the case and the bills should specify the following:-

(a) Protocol for management of the case.

(b) Radiotherapy – Type of course and charges for complete course.

(c) Chemotherapy - Number of cycles of chemotherapy.

- Procedural/ Administration charges per cycle.

- Drugs to be specified, along with cost.

26. **Outsourcing of Investigations.** Outsourcing of Investigations is often resorted to by empanelled hospitals. In all these cases, the payment to the outsourced facility is to be made by the hospital referring the case. **ECHS will not be dealing with any third party**. Bills may be submitted by the empanelled facility and will be cleared by ECHS as per CGHS rates. Excess cost, if any, may be recovered from the patient directly, with his/ her prior consent.

27. **Dialysis**. Package charge will include procedure + cost of consumables for dialysis. Investigations and other essential drugs (eg Inj Erythropoetin), if required, may be billed to ECHS as separate items, along with an essentiality certificate.

28. **Emergency Case Bills from Empanelled Facilities.** Bill for emergency treatment will be forwarded to concerned Polyclinic for payment as per normal procedure laid down above. However such bills will include an **emergency certificate** issued by the hospital and will be

superscribed with 'EMERGENCY BILL- EMPANELLED FACILITY' written in block capitals in Red.

Processing of Bills

29. **Action at Polyclinics.** The bills will be examined by the OIC Polyclinic for authentication and verification of rates charged. On receipt of bills at the Polyclinic, the OIC Polyclinic will verify the particulars of the patient and cross check against the original referral records /emergency treatment records of the Polyclinic. It will be verified if the tests/procedures conducted by the empanelled facility were the same for which the referral was made and that no major deviation took place without prior approval of the Medical Officer of the Polyclinic. The rates charged will be compared with approved rates and amount approved for payment will be endorsed by the OIC. For purposes of vetting of bills, OIC Polyclinic may seek advice/assistance of Medical / Dental Officers of the Polyclinic. The OIC Polyclinic will thereafter prepare a cover note with all relevant details. The cover note together with bills/documents, will be forwarded by the OIC to the Senior Executive Medical Officer (SEMO) for technical examination.

30. The SEMO will consider the following issues while examining the Bills for correctness :-

(a) Nature of treatment given. That the treatment / investigation were as per ECHS Polyclinic referral and were appropriate.

(b) That Standard clinical practice guidelines were followed by the Hospital/ Dental / Diagnostic center.

(c) That medicines/drugs and consumables were provided as per requirement and necessity.

(d) Ratify the rate verification done by the OIC Polyclinic.

31. The SEMO will submit the recommendations for sanction of the Station Commander. If the bill amount is beyond the financial powers authorised to the Station Commander, sanction of Competent Financial Authority (CFA**)** will be obtained prior to payment, and case will be projected up the static chain of command to the appropriate CFA. However, in order not to delay payments to empanelled facilities, the CFA will forward approvals directly to Station Headquarters. Payments will be made by cheque to the empanelled facilities after receipt of sanctions and will be attached to the bills and subject to post-audit. Financial limits of CFA are as under:-

Ser No	**Rank**	**Financial limit per transaction**
(a)	Station Commander	
	(i) Lt Col/Col	Rs 20,000/-
	(ii) Brig	Rs 50,000/-
(b)	Sub Area Commander	Rs 1,00,000/-
(c)	Area Commander	Rs 2,00,000/-
(d)	Army Commander	Rs 4,00,000/-
(e)	Vice Chief Of Army Staff	Rs 5,00,000/-
(f)	Ministry of Defence	> Rs 5,00,000/-

OTHER TERMS AND CONDITIONS

32. The Hospital/ Dental/ Diagnostic Centre shall provide the agreed upon services to cases referred from ECHS Polyclinics on a Referral slip duly authenticated and stamped as mentioned in Para 4 above. The Hospital/ Dental or Diagnostic centre would not refuse admission/treatment or investigations to referred cases on flimsy grounds.

33. The Hospital/ Dental or Diagnostic centre shall raise bills in the prescribed format to the ECHS Polyclinic in respect of the ECHS members treated on completion of treatment/ discharge of the patient. The rates for tests and treatment would be charged as per mutually agreed rate list and approved by ECHS. **Under no conditions will rates exceed the rates laid down by the CGHS** for the particular zone. ECHS will make payments only as per approved/ CGHS rates. Expenditure in excess of approved / package deal rates would be borne by the beneficiaries.

34. The Hospital will not be at liberty to revise the rates suo moto.

35. The Hospital/Nursing Home or Diagnostic centre would not refer the ECHS cases further to other institute, and if it does so, it will be at their own arrangements, and ECHS would not be responsible to the other institute for any liability. **Payment in such cases would also be restricted to approved rates only**. Excess charges incurred over and above the approved rates may be recovered from the patient with his/ her prior consent.

36. The Hospital/Nursing Home or Diagnostic centre shall provide access to the financial and medical records for assessment and review by medical and financial auditors of the ECHS, as and when required and the decision of ECHS on necessity or requirement shall be final.

37. Any liability arising out of or due to any default or negligence in provision or performance of the medical services shall be borne exclusively by the Hospital/Nursing Home or Diagnostic centre, who shall alone be responsible for the defect in rendering such services.

38. During In-patient treatment of the ECHS beneficiaries, the Hospital shall not ask the members to purchase separately the medicines from outside but bear the cost on its own, as the **package deal rate fixed for the ECHS includes the cost of drugs**, surgical instruments and other medicines etc.

39. On approval of the facility for empanelment a Memoranda of Agreement will be signed between the Hospital/Nursing Homes or Diagnostic centre and ECHS. The MOA shall remain in force for a period of one year from the date of its execution, extendable on mutual agreement.

The MOA may be terminated by either party serving one calendar month's notice in writing.

40. The ECHS shall be at liberty at any time to terminate this agreement on giving 24 hours notice in writing to the Hospital for breach of any of the terms and conditions of this Agreement and the decision of the ECHS in this regard shall be final.

41. Any dispute or difference arising between the Hospital/Nursing Home or Diagnostic centre and ECHS shall be referred to an arbitrator to be appointed by mutual consent of both parties herein.

42. All other conditions listed in the MOA will be complied with by both parties, that is, the Empanelled facility and ECHS.

CHAPTER TWO

RESEARCH METHODOLOGY

2.1 Research problem

Despite sincere efforts done by the Billing and Processing team, still a number of queries were received from the payer's side.

2.2 Study design

A combination of retrospective and prospective study has been conducted by investigating the process, situation, problem or issue that effect the smooth processing of claims. The study has been done on the basis of data available for that period.

2.3 Data Collection

The task of data collection begins after a research problem has been defined. The data used for the present research is primary in nature and it is used for doing the analytical study.

2.4 Sample Size- 1220 patients

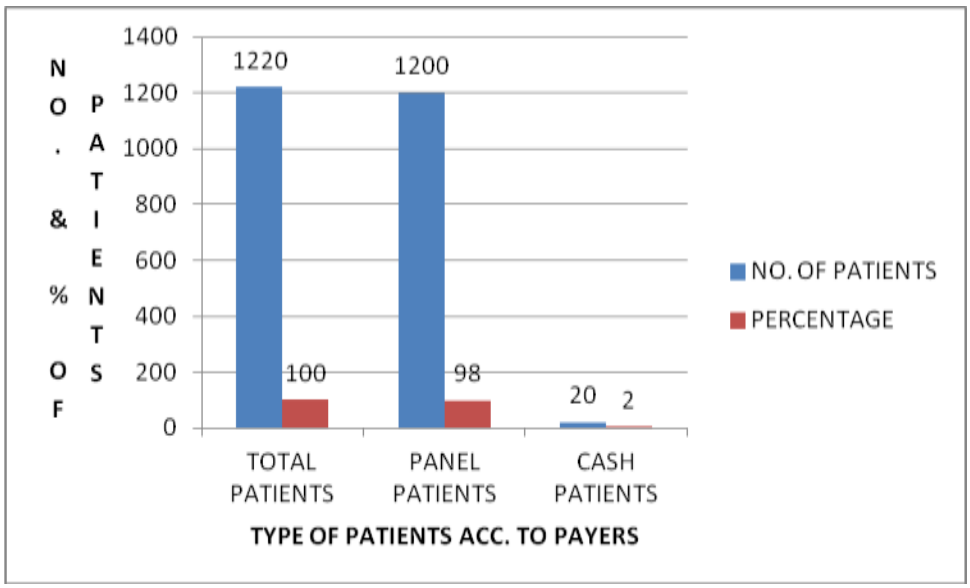
2.5 Data Collection period

15th January to 31st March

CHAPTER THREE

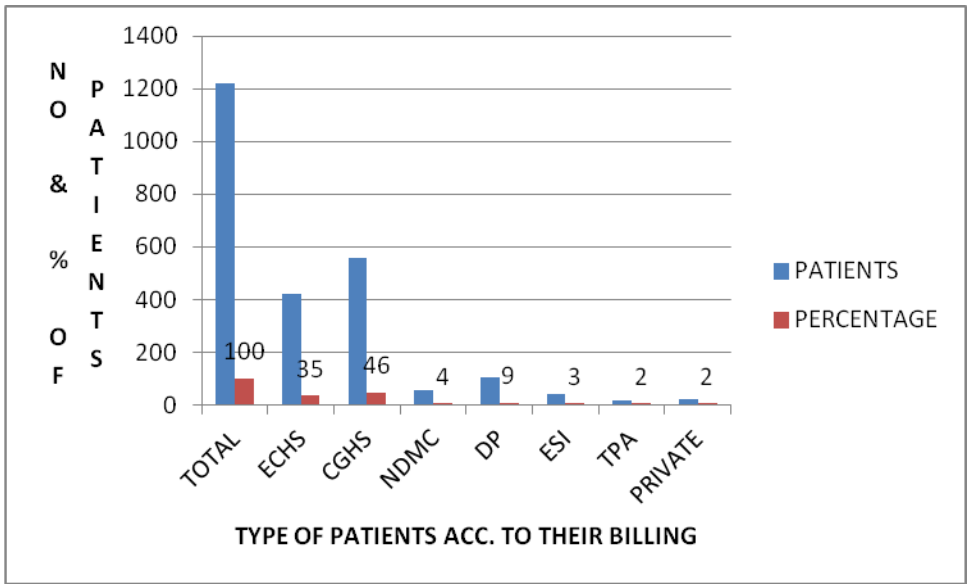
OBSERVATIONS & RESULTS

3.1 TOTAL PATIENTS



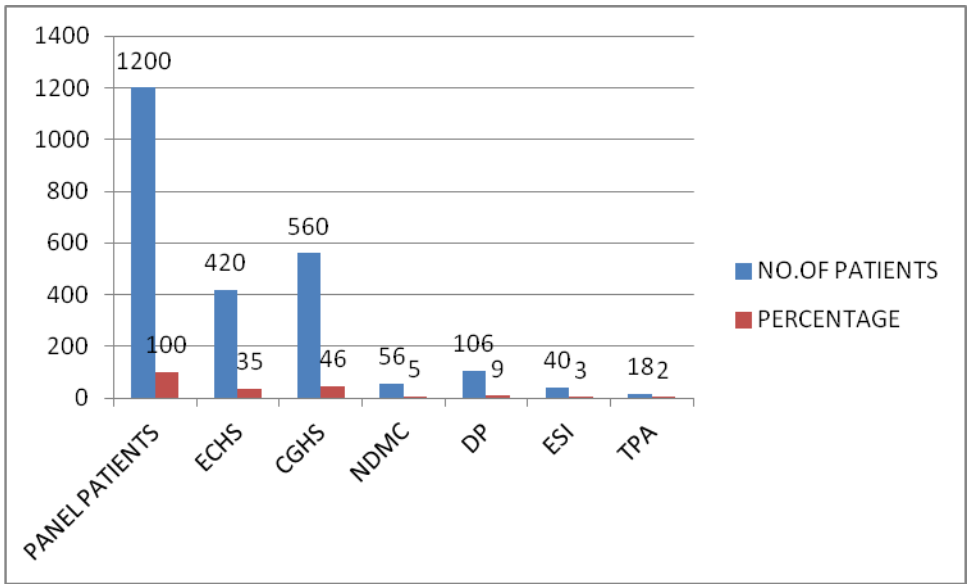
Out of 1220 patients studied 98% of the patients are those patients who have cashless cards either through government panels or from their personal insurance coverage. Only 2 % of admitted patients paid their bills from out of pocket. The revenue generation of the hospital totally depends on the cashless treatment.

3.2 CATEGORIZATION OF PATIENTS ACCORDING TO PANELS & CASH



Out of total 1220 patients 35 % patients admitted from ECHS, 46 % from CGHS, 4% from NDMC, 9% from Delhi Police, 3% patients from Employee state insurance scheme, 2 % from various TPA's and 2 % patients are cash patients. It is evident from the above data analysis that most of the patients are from various panels, CGHS amongst the dominant panel followed by ECHS and very few patients are cash patients who paid their bills out of pocket because of non insurance or rejection of claim by the insurance panel.

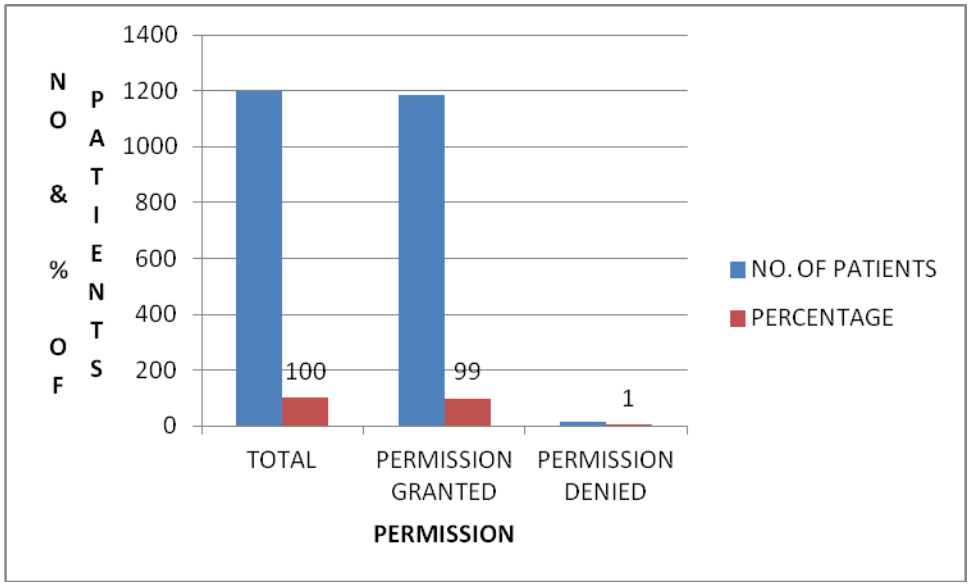
3.3 DISTRIBUTION OF PATIENTS ACCORDING TO THEIR PANELS.



Out total 1200 panel patients either who have the cashless cards from their government schemes or those who get insurance from their employers or those who get their personal insurance by themselves. 98% of the patients admitted in the hospital are through various governmental schemes either though ECHS, CGHS and only 2 % of the patients were admitted through their personalized insurance. Hospital has to get referral from every their respective panels before their admission but not in the case of emergency admission. But still after admitting the patient in the emergency, the hospital has to send the documents which certified their emergency admission to the respective panel of the patient and get the permission of the patient. In case of ESI if a patient is admitted with one diagnosis and second diagnosis is made in the hospital then the hospital has to get further permission for the treatment of second diagnosis. e.g. if ESI gave the permission for coronary angiography and patient angiography reveals blockage in any of the coronary arteries then the hospital has to get second permission from the ESI for angioplasty otherwise the bill will not be paid by the ESI. In case of ECHS if a patient is required more than 12 days of admission then the hospital has to get the further permission in the form of appendix for the extended stay in the hospital because the first permission given by ECHS authorities permits the patient for the maximum 12 days for staying in the hospital and that referral will be

valid for 30 days only, means after the issue of permission patient has to admit in any of the empanelled hospital within 30 days, otherwise patient has to get the fresh permission from the ECHS authorities. In case of CGHS intimation of the patient has been to UTI-TSL through online method which is a third party between the empanelled hospital and CGHS authorities. The hospital has to submit their bills also to UTI-TSL for the approval.

3.4 DISTRIBUTION OF PATIENTS ACCORDING TO THE PERMISSION RECEIVED OR DENIED BY RESPECTIVE AUTHORITIES

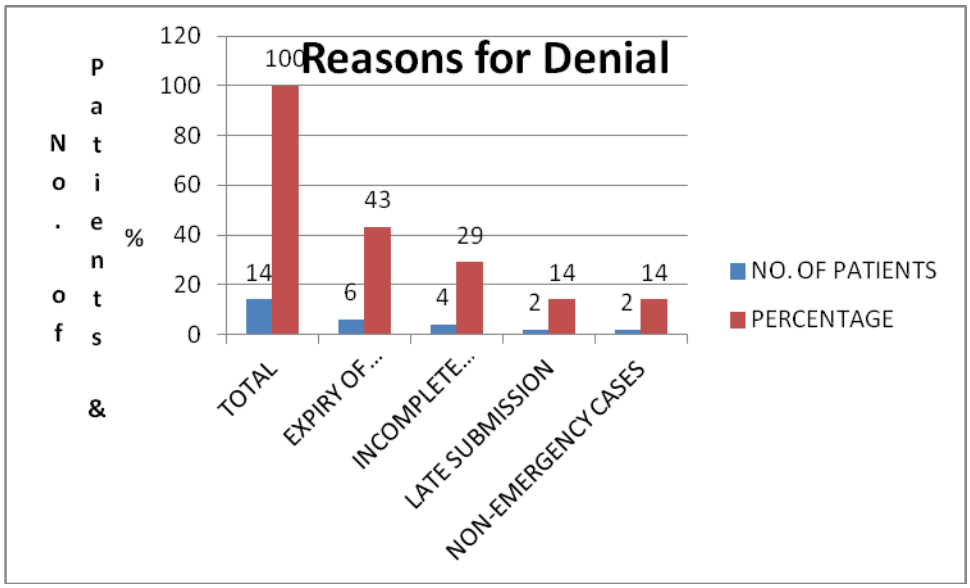


Out of the total patients admitted, the respective authorities have given the permission for 99% of the patients and 1% of the patients denied the permission for various reasons.

1. Non availability of cashless cards issued by respective authorities.
2. Non emergency cases which are denied.

In case of various specified emergency reasons, empanelled hospital has the authority to admit the patients directly without the referral letter of respective authorities; otherwise in case of non emergency cases patient has to obtain the permission from their various polyclinics. In referral letter, authorities have to specify the empanelled hospital where the patient can be admitted or not. It is the patient's choice which hospital he wants to admit but the payment of bills are according to the specific rates which had been defined in the rate list at the time of signing of memorandum of understanding(MOU).

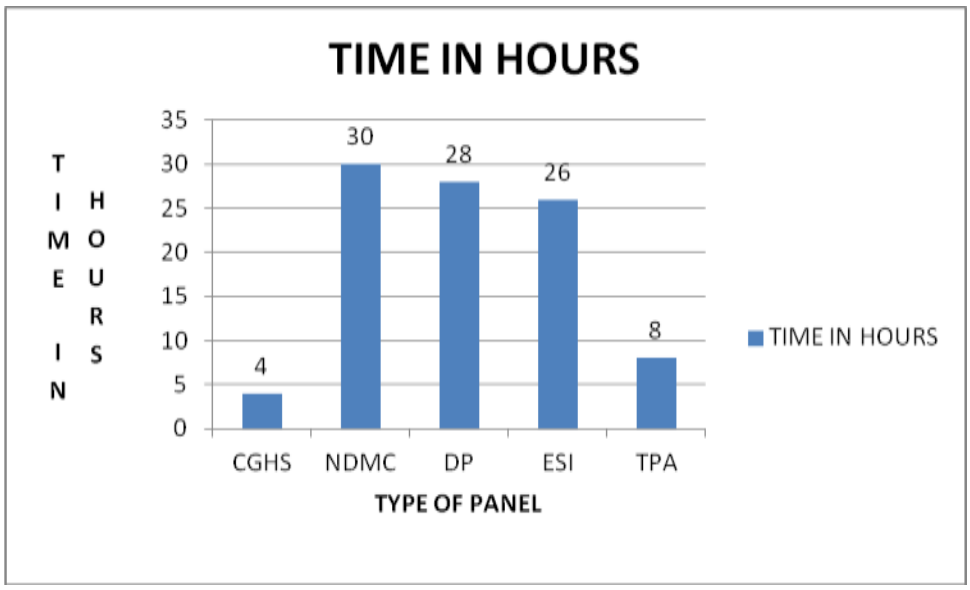
3.5 REASONS FOR THE DENIAL FOR ADMISSION OF THE PATIENT



There are various reasons for the denial of the admission of the patient to empanelled hospital. 14 patients have been denied the admission in the hospital on various backgrounds. These are as follows.

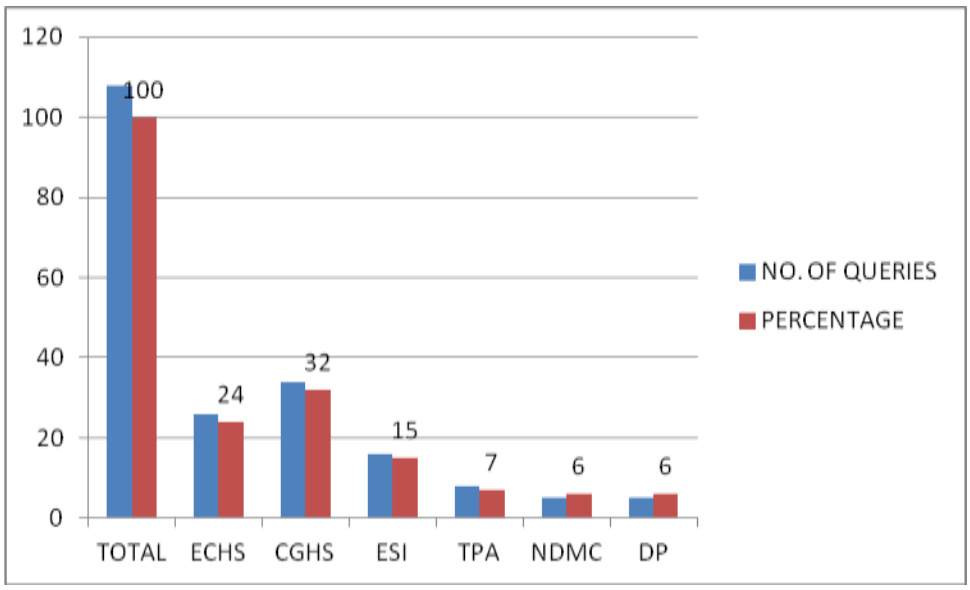
1. 43% of patients have submitted their expired cashless cards to the empanelled hospital.
2. 29% of patients denied admission on the basis of incomplete information provided to the respective authorities either by hospital to payer authorities or by patient to the hospital.
3. 14 % of the patients denied admission because of late submission of the patient's information to their respective authorities. Because the hospital has to intimate respective authorities within 24 hours of emergency admission.

3.6 MAXIMUM TIME TO GET THE PERMISSION FOR THE ADMITTED PATIENT ACCORDING TO THE PANELS.



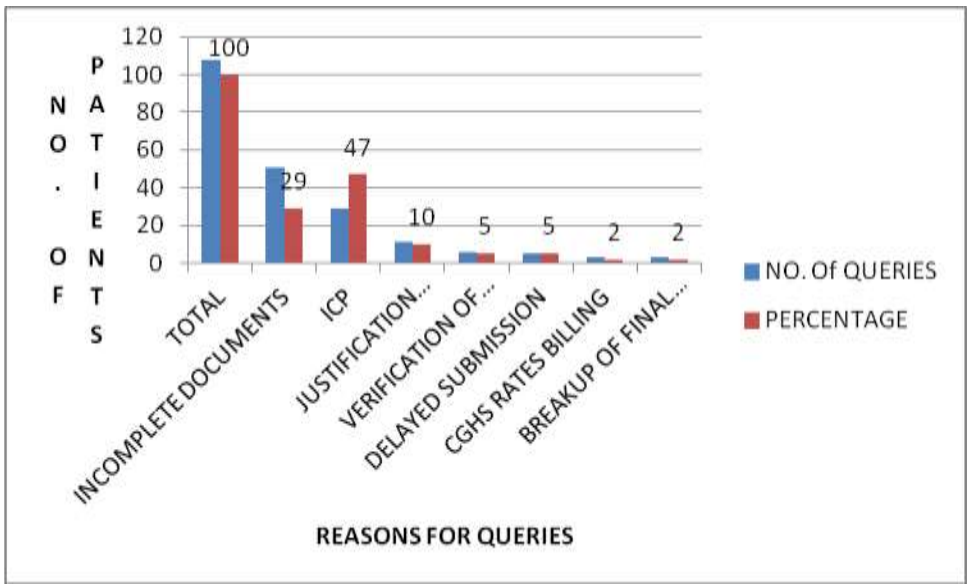
According to the data the time taken by the hospital to get the permission for the admission of the emergency patient. This is 4 hours in case of CGHS which is far less than other payers like ECHS, ESI and TPA which is due to online intimation the admission of the patient emergency admission and retrieval of the approval by UTI-TSL which is a third party between the empanelled hospital and CGHS. Time taken is also less in TPA which is 8 hours because of the permission and denial of the patient admission has been approved by emails but not though online processing. But in case of other payers time taken is more than 24 hours because the intimation and permission process had been done by the empanelled hospital and respective authority manually.

3.7 NUMBER OF QUERIES RECEIVED BY THE HOSPITAL ACCORDING TO THE PANELS.



Out of total queries 108 received by the hospital maximum queries 32% has been from CGHS which were through UTI-TSL and 24% from ECHS, 15% from ESI and 7% from various TPA's. This is due to the processing of claims by the third party by UTI-TSL in case of CGHS, even out of total 34 queries, 06 queries were from CGHS itself even approved by the UTI-TSL.

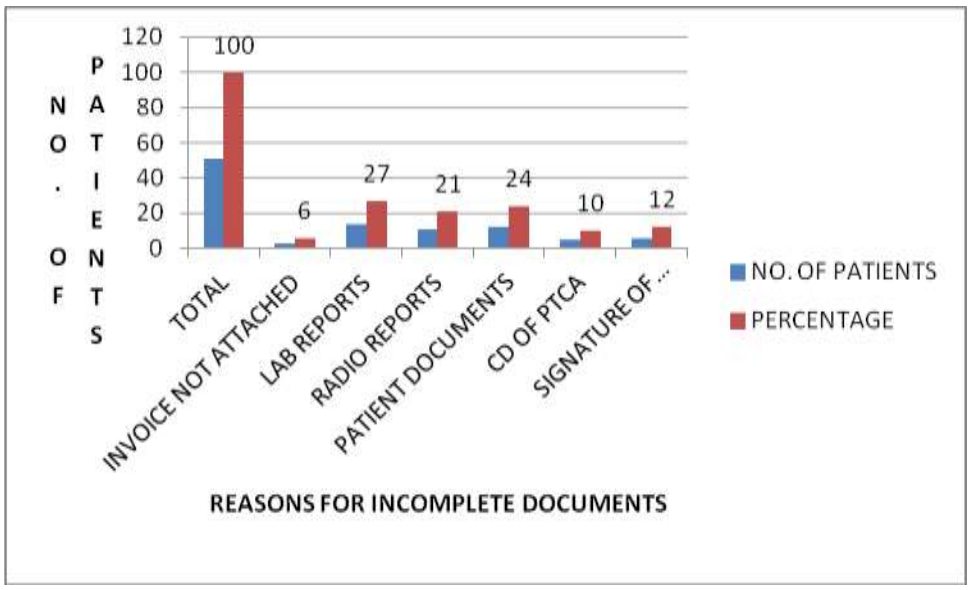
3.8 TYPE OF QUERIES RECEIVED FROM THE PAYERS.



A total of 108 queries were received by the hospital during the study. Hospital has to respond to these queries for getting the claim approved. If these queries are not responded well, then claim is either denied or rejected. Various reasons for these queries are as follows:

1. Incomplete documents
2. Requirement of Indoor Case Papers(ICP)
3. Justification for admission in Emergency
4. Verification of insured's dependents
5. Delayed submission of claim
6. Queries related to CGHS Rates billing
7. Detailed break up o final hospital bill

3.9 DISTRIBUTION OF QUERIES ACCORDING TO INCOMPLETE DOCUMENTS



Queries due to submission of incomplete documents includes following:

1. Invoice not attached
2. Incomplete or non availability of lab reports especially culture and sensitivity reports, histopathology reports.
3. Non-availability of radiological examination reports that are significant for the diagnosis of the disease for which patient had receive treatment during hospitalization
4. Missing patient documents
5. CD's which contain recording of the procedure undergone by the patient e.g. PTCA
6. Signature of the concerned authority not available.
7. Unsigned discharge summary or hospital bill by the patient or the attendant at the time of discharge.

CHAPTER 4 – DISCUSSION

- The results of medical claims recovery can be tracked by keeping a denial rate report and by recording the turnaround time from claim filing to payment.
- Online intimation of claim in all Panels to ensure that no time is wasted in the appeal process.
- Developing standard appeal letters that can be easily customized with information about the particular patient and situation involved in every denial.
- If an insurer routinely down-codes claims, then the appeal can be made for the code that was submitted originally and include supporting documentation.
- If an insurer consistently refuses payment for a certain code, the physicians can be requested to discuss the situation and bring along supporting documentation instead of sending more appeals.
- Before signing any contract with a payer, the steps to be taken after a denial and consider steps for further action can be explained clearly.
- Steps for further action include finding out whether mediation is allowed, whether grievance hearings are held, can the group request a physician peer review if a claim is denied for medical necessity etc.

LIMITATIONS OF THE STUDY

- Majority of the panels except ECHS and CGHS are offline.
- Delayed response to clarification by payers side.
- Lack of Health standards like ICD coding of the disease.
- Lack of common protocols by different centers of same payers.

CHAPTER FIVE

CONCLUSIONS AND RECOMMENDATIONS

- Online processing of claims
- Understanding the role of coding information in claim generation in healthcare organization. E.g. ICD-9, ICD-10 coding
- Adoption of health care standards

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