"Trend Analysis of TAT of Health Insurance TPA Claims for the Period Jan - March 2012 "

A Dissertation Proposal for

Post Graduate Diploma in Health and Hospital Management

by

Medha Guglani

PG/10/019

International Institute of Health Management Research
New Delhi

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Under the guidance of

Dr. Bhramesh Jain

Designation: Director & Co founder

Organization: Health Sprint Networks Pvt Ltd

Dr. Anandhi Ramachandran

Designation: Professor, Dept of HIT

Organization: IIHMR, New Delhi

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Acknowledgement

I owe my deep sense of gratitude to **Dr Brahmesh Jain**, my mentor, for giving me an opportunity to learn various aspects of Healthcare Insurance Information Technology with special emphasis on Turn around Time Of the responses given by TPAs/ Insurance companies so that we can contribute in improving the present system.

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Medha Guglani

HealthSprint

CERTIFICATE OF INTERNSHIP COMPLETION

Date: 30/04/2012

TO WHOM IT MAY CONCERN

This is to certify that **Ms Medha Guglani** has successfully completed her 3 months internship in our organization from January 10, 2012 to April 10, 2012. During this internship she has worked on the project '**Trend Analysis of TAT of Health Insurance TPA Claims for the Period Jan -March 2012** ' under the guidance of me and my team at Health Sprint Networks Pvt Ltd.

We wish her good luck for her future assignments.

Brahmesh Jain

Director and Cofounder

HealthSprint Networks Pvt. Ltd.
#39/2, Second Floor, Sagar Complex, Bannerghatta Road, Bangalore – 560 029, Karnataka, India
Phone : 080 – 41466566, Email : hs@healthsprint.com, Web : http://www.healthsprint.com

CERTIFICATE OF APPROVAL

The following dissertation titled " **Trend Analysis of TAT of Health Insurance TPA Claims for the Period Jan -March 2012.**" is hereby approved as a certified study in management carried out and presented in a manner satisfactory 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.

Dissertation Examination Committee for evaluation of dissertation.

Name	Signature
Dr. S B GOGIA	
Prof. I. Bhattacharyya	
Prof. (Dr.) T. MUTHUKUMAR	11/5/12

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CERTIFICATE FROM DISSERTATION ADVISORY COMMITTEE

This is to certify that **Ms Medha Guglani**, a participant of the Post- Graduate Diploma in Health and Hospital Management has worked under our guidance and supervision. She is submitting this dissertation titled "**Trend Analysis of TAT of Health Insurance TPA Claims for the Period Jan -March 2012** " in partial fulfillment of the requirements for the award of the Post- Graduate Diploma in Health and Hospital Management.

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

Prof. Anandhi Ramachandran
Professor , HIT Dept
IIHMR
New Delhi
Date 11/5/2012

Dr. Brahmesh D Jain
Director & Co founder
Health Sprint Networks Pvt Ltd
Bangalore
Date

Abstract

A Quantitative study on trend analysis of Turn around Time of Third Party Administrators and improving business by analyzing the causes for denials.

BY

Medha Guglani

INTRODUCTION

Health Sprint platform is a Web Based platform being used by various Payers and Providers for the exchange of information related to Cashless Hospitalization of patients.

Health Sprint's platform information exchange has many benefits.

- The information exchange is happening real time
- The exchange of information is secure and easy to use.
- The information is reliable and transparent.
- There is no loss of information as incase of Fax at times.
- There is lesser Turn Around time.
- The information can be easily traced and it is complete in digital format.

So I have been given the opportunity to analyze the Turn around time and check whether the internal standards of TAT (Hypothetically assumed) are being maintained and also the causes for denials of cases by various TPAs.

SCOPE

The Analysis would lead us to check Health Sprints platform's impact on TAT. The TAT for three months for different TPAs was analyzed and compared with the assumed TAT. The reasons for denial of cases by various TPAs were also identified. This would help us improve on the services to the providers and ultimately improve patient satisfaction.

METHODOLOGY

Data was collected from the seven payers. All the samples were taken for analysis because the TAT generated from the real time data is being sent to various payers every month.

Sample Size:

	January	February	March
FHPL	556	517	597
Mediassit	2292	2496	3001
TTK	1811	1762	2078
Emeditek	105	101	110
UHC	363	448	598
DHS	45	46	88
ICICI Lomabard	839	884	1107

Time Range taken for the analysis is mentioned below, and the assumption for the percentage of cases

0-2 hours

2-4 hours

4-8 hours

8-12 hours

>12 hours

SPSS Tool was used for analysis of data for these ranges so that the percentage of cases in the particular range is obtained for different payers for the months of January, February and March.

MS Excel was used to obtain different graphs for these percentages obtained for different time range so that the conclusions can be easily drawn.

Analysis of the total number of denial cases for each payer was done with the help of SPSS Tool. This was done so as to identify the major reasons for denial of cases can be identified.

Graphs were obtained with the help of MS Excel.

Conclusion

Payers where we have integrated platform should be monitored closely so as to know if any technical related issues could be avoided. Customer care department should have more people so that the follow up are done properly and TAT could be brought more into the exact range. More number of persons from each payers should be trained so that in case of emergencies any body/ replacements can handle the platform. Timely review meets should be conducted to keep the payers motivated. TAT reports should be sent weekly if there is any problem felt in between. The customer should be kept engaged so that they respond properly when cooperation is expected from them. They should be told about the customer care departments importance so that they realize they'll be troubled less. Implementation of platform is a very profitable and advantageous practice for both hospitals as well as the the payers Patients Satisfaction increases as the TAT reduces and its found out that the TAT is already being maintained according to the internal standards. The above study helps us to have a clear analysis of the TAT that it is being maintained according to the quality and this is very important and should be kept in mind and maintained always. The results of the study also help us determine all the factors because of which the cases are being denied from the payers end and how could we contribute in improving that.

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Part I - Internship Report

1.1 Organization Profile

- HealthSprint Networks is a Healthcare IT services company, founded in May 2006 by 3 promoters who possess desired & complementary skills from healthcare, technology and marketing domains.
- HealthSprint has formulated clear business programs in healthcare, and implemented one revenue generating use scenario “Web enabled In-Patient Insurance Claims Management Network”. This is one specific instantiation of company’s larger program of “Payer-Provider Network”.
- HealthSprint has a growing customer base of Providers, such as Wockhardt, Manipal, and Payers, such as TTK, MediAssist.
- HealthSprint has employee strength of 70+, who comes from Healthcare, Technical and Business arena.

Location

Health Sprint Networks Pvt. Ltd

39/2, Second floor, Sagar Complex

Bannerghatta Road, Bangalore-560029

1.2 Responsibilities handled

I was a part of implementation and services department, handling the seven payers working online with Health Sprint.

1.3 Area Of Engagement

The area of engagement in the organization during the internship was to handle the payers who were a part of the Health Sprint Networks. There are seven payers working online with Health Sprint platform using Isprint web based platform for exchange of information between the provider and the payers for Cashless Hospitalization.

It's a Health Care IT firm which is providing its platform to the Hospitals as well as to the TPAs/ Insurance companies for the exchange of information.

Throughout my dissertation I was mainly associated with the Payers Department, but for the company's requirement and my personal choice to widen my knowledge about the application, I had put my inputs in understanding the provider business and other related works.

The Internship involved working at both on site (Conducting meetings with Insurance companies/TPA across India) as well as off site (Head office Bangalore).

The internship involved the visits to all the seven payers (Insurance company's /TPAS) spread across India. The visits were primarily for gathering the data for the staff to be trained, New user ids to be created and any difficulties or issues if they had to address. It was about making them aware about our new Customer care department which was set up at Head Office. Also these visits served the purpose of interaction with the end users and the management which has proved to be extensively useful in different stages for improving our internal processes and getting the right feedback.

1.4 Tasks performed during Internship

Some of the tasks that were performed during the course of internship are stated as under:

1. Made the work flow for Customer care department. (Developing current and Future state Workflows)
2. Understanding of the Various payers and the kind of platforms they are using
3. Implementation of Isprint platform in Max Bupa New Delhi.
4. Onsite recruitment and training the executive to use the platform
5. Offsite recruitment of executives for customer care department and training them about the business so that they can follow the right protocol for following up of the delayed cases.
6. Creation of new user id for various payers if required.
7. Coordinating for technical issues from various Payers.
8. Collecting the New requirements from the payers for improvement of the platform.
9. Handling a team of 5 members working in various departments.
10. Coordinating for the initiation of Integration discussion between the Health Sprint Technical Team and the Max Bupa technical Team.
11. Prepared a feedback form for taking the feedback from the payers about the Health Sprint Services.

1.5 Reflective Learning

During the entire period of internship, various phases gave various types of knowledge varying from soft skills, stress handling to technical advancements to handling teams and managerial skills. This variation widened the horizon and gave an in depth knowledge of the payers department and it's key job

responsibilities and also the business process. Apart from that the experience of my mentor has been very useful for knowledge transfer.

Some of the learning during the entire internship program are as under:

1. Health Sprint's role in the market, how it has benefited many and ruled out the problems which were earlier a major issue.
2. Developed a good understanding of Health Sprint's market value and Business Models.
3. Understanding of the different payers working and the kind of services Health Sprint is providing to them.
4. Practical issues which may hurdle the implementation process at various places (Payers and Providers) were observed
5. Learned the art of handling teams sitting at various places.
6. How escalations are done and various issues are resolved.
7. One of the major learning was that in the professional work everything should be documented and verbal communication is not relied on.
8. Various soft skills and analytical sessions which were being conducted so as to develop a good understanding between the company and the client for maintaining good client relationships.
9. The various techniques involved to ensure the end user participation throughout so that to instill a sense of belongingness in the end user regarding the Health Sprint Platform to get a feeling of involvement and commitment from the users.
10. Meeting with the top management and the end user together to get the correct feedback and making them aware about the latest company plans as well as the user's commitment towards the process, by taking both the views on same table.

Part II - Dissertation Report

Trend Analysis of TAT of Health Insurance TPA Claims for the Period Jan - March 2012

2.1 Introduction

Healthcare has traditionally seen lower levels of investments in IT than other service industries which has resulted in a number of problems for healthcare providers and payers (Health Insurance companies), with systems in desperate need of modernization to overcome the challenges that have arisen over the years.

Recent advances in IT are enabling providers to improve the quality of patient care. Today's healthcare IT is much more than traditional isolated computers and unfriendly applications. Increasingly, patient care is exploiting new tool and information that systems can provide, while maintaining a patient centric approach to their use.

Fundamental to the success of investment in modern IT, however, is ensuring a holistic approach to the technology, which means understanding the strategic goals of the organization and understanding how IT, from technological and organizational perspectives, can help to achieve them.

Health Insurance Companies are also a part of the Health Care Ecosystem and contribute in Patient satisfaction and Patient Care indirectly by giving Reponses in time for the cashless hospitalization. This sector also needs IT application to reach to a standardized Level. Generally the conventional methods followed for the exchange of information are through Fax or through mails. But these methods are not so reliable because of the following reasons.

- Incomplete information.
- Fax transmission errors and fax transmission losses.
- High Turnaround time.
- No mapped flow of information.
- Traceability & Accountability is absent.

So to improve on these points and to eliminate these, the concept of using a web based platform for the exchange of information between the payers and the providers was brought in.

Health insurance can be defined in a very narrow sense where individual or group purchases in advance health coverage by paying a fee called "premium". But it can be also defined broadly by including all financing arrangements where consumers can avoid or reduce their expenditures at time of use of services. The health insurance existing in India covers a very wide spectrum of arrangements and hence the latter- broader interpretation of health Insurance is more appropriate.

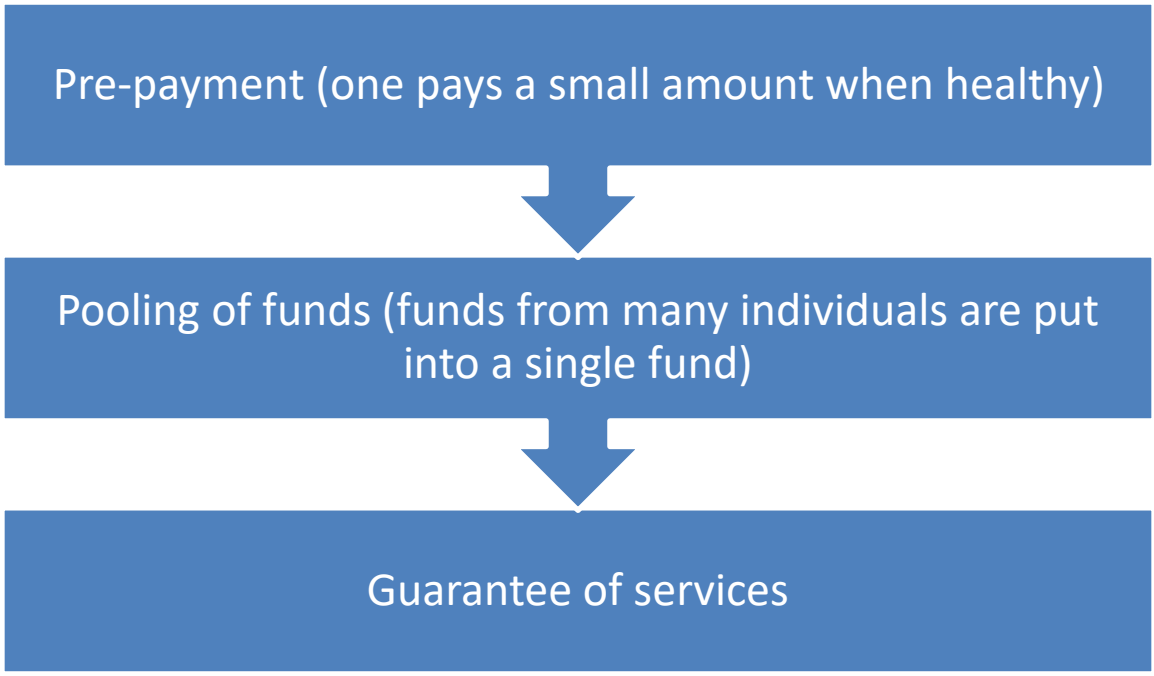
Health insurance is very well established in many countries. But in India it is a new concept except for the organized sector employees. In India only about 2 per cent of total health expenditure is funded by public/social health insurance while 18 per cent is funded by government budget. In many other low and middle income countries contribution of social health insurance is much higher

There are various types of health coverage's in India. Based on ownership the existing health insurance schemes can be broadly divided into categories such as:

- Government or state-based systems
- Market-based systems (private and voluntary)
- Employer provided insurance schemes
- Member organization (NGO or cooperative)-based systems

Government or state-based systems include Central Government Health Scheme (CGHS) and Employees State Insurance Scheme (ESIS).

Health Insurance says:



Once an individual has enrolled in a health insurance scheme, then it is legally binding on the organizers to provide the service promised. Health insurance is a tool to minimize uncertainty –

- The uncertainty of timing of illness
- The uncertainty of the cost of treatment

Under the existing private medical insurance scheme which is indemnity based, policyholders, at the time of needing health care services, first pay for the expenses and are only later reimbursed, depending on the sum insured and the coverage. Besides having cost-escalating characteristics, these schemes are inefficient and have a number of limitations. Insurance companies have to deal with unregulated healthcare providers who work in an environment where there are no standards, quality benchmarks and treatment protocols, and where highly variable billing systems and significant price variations across providers exist (reflected by the adverse claim ratios). It has also been observed that hospitals tend to charge the patients covered by insurance more, but in the absence of monitoring and control mechanisms; it is difficult to handle fraudulent claims.

It is to address such issues that insurance intermediaries such as Third Party Administrators (TPAs) become important and they are bound to play a key role in the growth and development of managed health care system.

TPAs are separate entities who coordinate between insurance companies, customers and healthcare providers; they arrange for cashless hospitalization and closely monitor the use of resources and services. Health insurance companies generally tie up with TPAs for the back office function of managing claims and reimbursements. IRDA has also come up with regulatory guidelines for TPAs and they have to fulfill certain requirements and observe a code of conduct. .

The study will help us understand the functioning of the TPAs in Health Insurance, analysis of the turn around time in the existing TPA system and the reasons for denials of various cases by different TPAs

Features of health insurance

Services covered by insurance: Coverage of services varies with each insurance program. Some cover only curative services whereas others cover primary OPD care too. Coverage varies according to the extent of hospitalization also.

Role of the insurer: The insuring institution can play either an active or a passive role. If it is a mere funding entity and is not directly involved in the provision of healthcare services, controlling of costs becomes difficult. It develops mechanisms of cost sharing to mitigate the negative impacts and beneficiaries are asked to pay an amount each time they use the services as deductibles (the insured pays a specific amount before receiving insurance benefits) or co-payment (a fixed percentage of cost of service is paid by the beneficiary to the insurance company). On the other hand, if the insurance company is a managed care organization (directly involved in organizing and providing healthcare services) it can enforce cost discipline more rigorously.

IT Driven Health Insurance

The driving force behind the revolution in Health Insurance of the healthcare IT is the desire for providers to offer the best possible standard of care to each patient. The Patient is like a GOD to them when He/She comes to Hospitals and if the hospital is not able to help the patient or is not able to sort out patients problems then they are not providing quality care.

In 2006 the first few hospitals signed contracts with Health Sprint Networks, for the implementation of isprint platform. Till date those hospitals are there in Health Sprint Networks with better services and new Business Models.

2.1.2 Vision

To make the information exchange between the payers and the providers fully automated and real time so as to make work **simpler, standardized, error free, and ultimately reducing the Turn around Time.**

2.1.2 Rationale for the Study

The TPA plays the major role in the Health Insurance business. Third party administrators (TPAs) are not technically managed care organizations but play an important role in health insurance markets. Neither insurance companies nor care providers, they are intermediaries who bring all components of healthcare such as physicians, hospitals, clinics, long-term facilities, and pharmacies together.

The services include cashless service at hospitals, call centre support to policyholders, medical cost management, and management of claims and reimbursements. They also provide services to the corporate sector in designing and managing health benefit packages for their employees. Given the demand and supply side complexities in health insurance and healthcare markets, TPAs provide an important link between insurance companies, healthcare providers, and policyholders.

Intermediation by TPAs ensures that policyholders get **hassle-free services; insurance companies pay for efficient and cost-effective services, and healthcare providers/policyholders get their**

reimbursements on time and also get the responses for cashless hospitalization in as low time as possible.

The core product or service of a TPA is ensuring cashless hospitalization to policyholders. TPAs require skills to develop networks, manage finance, and delivery of appropriate healthcare services to its clients.

Functioning of TPA

TPAs organize healthcare providers by establishing networks with hospitals, general practitioners, diagnostic centers, pharmacies, dental clinics, physiotherapy clinics, etc. They sign a memorandum of understanding with insurance companies according to which they inform policyholders about the network of healthcare delivery facilities and various systems and processes for settling claims. Policyholders are enrolled and registered with TPAs to avail these services and in the event of hospitalization, health facilities are expected to inform the TPAs. The medical referee of TPA examines the admissibility of the case and accordingly informs the healthcare facility to proceed with the treatment.

The agreement between TPAs and healthcare facilities provides for monitoring and collection of documents and bills pertaining to the treatment. Documents are audited and after processing sent to the insurance company for reimbursement. TPAs have the responsibility of managing claims and getting reimbursements from the insurance company and paying the healthcare provider. Sometimes they pay the healthcare provider from the corpus amount without getting reimbursement from the insurance company.

With the routing of reimbursements through TPAs the system has undergone a change. Earlier clients were handling everything themselves and there were risks of delay in reimbursements and non-payments of some expenses incurred. But it is providers who now face the risks of not getting reimbursements from TPAs. Besides, once patients are admitted and if treatment costs exceed the sum insured, providers may not get the difference in treatment cost and the sum-insured.

As part of the agreement between healthcare providers and TPAs, some providers insist on getting a part of the expected costs as advance.

TPAs generally have in-house expertise of medical doctors, hospital managers, insurance consultants, legal experts, information technology professionals, and management consultants. The backbone of TPAs has to be information management system.

Analysis of data regarding hospital admissions across the network (this also helps in identifying health need and effective treatment protocols), analysis of treatment, tracking documents pertained to each case, and tracking shortfalls in claims are essentials of claim management. Various functions of TPAs are summarized in Figure below.

Table 1: Range of services offered by TPA

The client groups of TPAs can be divided into two broad groups: corporates and individuals. Often the entire administration of medical facility and benefits for employees are handled and managed by TPAs who design and customize a policy to suit the needs according to the nature of health risks the employees face. Most of the TPAs operating in India focus on corporate.

Revenue generation

The major source of revenue for TPAs is fees charged for providing various services. Insurance companies pay the fee according to the volume and scope of services provided by them and it usually a fixed percentage of the premium collected from the enrollees. However, TPAs may provide many other services to organizations for which the fee is paid by the organization directly. These services include:

1. Benefit management: TPAs help in designing appropriate health plans for the corporate sector and insurance companies.

2. Medical management: This is basically disease management and involves the medical follow-up of the case. TPAs track the line of treatment and ensure genuine treatment.

3. Provider network management: This is the key task. TPAs need to negotiate with service providers regarding quality of care, credit facility, discounts, package pricing, priority appointments and admissions. Periodic review and evaluation of the performance of service providers are also vital.

4. Claims administration: This involves the claim adjudication process. The tasks include documentation, checking eligibility and coverage, claim submission and arranging payment for the service provider.

5. Information and data management: TPAs can generate a lot of reports and database. This can be used as management tools for analysis and controlling cost and besides helping design new products.

Health insurance markets suffer from several shortcomings. The justification for introducing TPAs' services is that they help in minimizing moral hazard. For this purpose, TPAs follow each case in an individualized way. TPAs do comprehensive review of records and keep constant communication with healthcare providers and families. They also evaluate the outcome of treatment and have adequate data to compare it across different service providers. The knowledge base helps them to be more effective in handling future cases.

Value added services provided by TPAs may include arrangement of ambulance services, medicines, and supplies, guide members for specialized consultation, information about health facilities, hospitals, bed availability, organization of lifestyle management and well-being programs, 24 hour help lines, etc.

TPAs are in nascent stages in India. Managed care assumes critical significance in India as the private practice and hospitals are not regulated and face a number of challenges. Considering the current trends most of the government-owned insurance companies offering MediClaim insurance have started hiring TPAs. New entrants in health insurance will also find the services of TPA important.

2.1.4 Need For The Study

Cash Less Hospitalization of the patients being one of the most important parts of hospital for revenue generation and patient care, so the information exchange for the same should be real time, without any errors. The study was conducted to check whether the standardized percentage of cases in different time ranges are being maintained and the cases are being processed within proper time limits. Causes for denial cases from various payers were identified so as to analyze the major reasons of denying cases by various payers. This would help improve the revenue.

2.1.5 Scope Of The Study

To check whether internal Quality is being maintained and ways to improve on the company's Revenue

2.1.6 Problem Statement

There are seven TPAs working online with Health Sprint. List is mentioned in the table. They use the Isprint platform to upload the responses. The Hospital is answerable to the patients who use the cashless facility at their hospitals. Through the services Health Sprint offers, it is made sure that the all things fall in place and the TAT which we maintain for our quality of services and internal standards is maintained.

Analysis of the turn around time being maintained by the different payers in Health Sprint Network has to be analyzed so as to check whether the internal standards are being maintained for quality purposes.

Since the Turn Around Time is the main feature we are trying to showcase through our services, it is important to analyze and maintain the TAT for each case as low as possible.

For the same analysis was done every month for all the payers in the Health Sprint Network and compared with the assumed TAT %

The Health Sprint is offering different Business Models to its Network Hospitals.

- Per Case Model
- Fixed Model
- Percentage Based Model

The cases denied by the TPAs for various reason effect the revenue generated from the Hospitals so the root cause analysis of the cases denied by various TPA's was done to identify the major reasons as to why the TPA deny the cases even after using Health Sprint Services so that we can improve the quality and gradually improve on our revenues.

If the reasons for denial of cases are such which can be improved by Health Sprint services then this would help us improve our services as well as improve our revenue.

2.1.7 General Objective

To analyze the Turn around Time (TAT) so as to identify whether it is being maintained within the assumed standards. To indentify the causes for denials of cases so as to improve our quality of services.

2.1.8 Specific Objectives

1. Collect the data of different payers.
2. Analyze the turn around time for each payer for every month.
3. Analysis of TAT for all the three months by using SPSS Tool
4. Identify all cases of denials by each payer every month.
5. Identifying the payers doing maximum denials by analysis.
6. Analyzing the reasons for denials of cases and identifying the main cause.

2.1.9 Assumptions

1. It is assumed that at the payer's level the various users are adept with the functional knowledge of using the platform.
2. The last response for every case has been noted and taken into consideration for analysis.

The assumed TAT taken for comparison is stated below:

Range time	Percentage of cases to be covered
0-2 hours	**35%**
2-4 hours	**30%**
4-8 hours	**10%**
8-12 hours	**10%**
>12 hours	**15%**

Table 2: Assumed TAT Percentage

2.1.10 Work Plan

Sl No	Task Name	Start Date	End Date	Time Spent
1	Identifying the problem	10/01/2012	24/01/2012	2 weeks
2	Literature Review	25/01/2012	1/02/2012	1 weeks
3	Methodology adopted	2/02/2012	9/02/2012	1 week
4	Data Collection	10/02/2012	10/04/2012	2months
5	Compiled Analysis	27/03/2012	10/04/2012	2 weeks
6	Documentation	10/04/2012	24/04/2012	2 weeks

Table 3: Work Plan

This study and analysis would let us know whether Health Sprint is actually maintaining the standards.

2.1.11 Limitations

As this concept is very new in India that a web based platform is being used for the exchange of information between the payers and the providers for the cashless hospitalization response so there was no previous studies found on this topic which could relate to the present study for the analysis of TAT

2.2 Data and Methodology

The study design adopted for this project is that this is a analytical study done to check whether the TAT is maintained within standards and how the denial of cases can be reduced by identifying the causes of denials.

The data was collected for three months for all the seven TPA. The sample size is:

It was make sure that the age, gender, response status, turn around time and payers remarks were captured for all the patients whose data was collected in the sample.

The method used for analyzing the data is SPSS Tool and MS Excel. The number of cases falling in different ranges of Time frames were obtained and the percentages of cases were obtained in each range category.

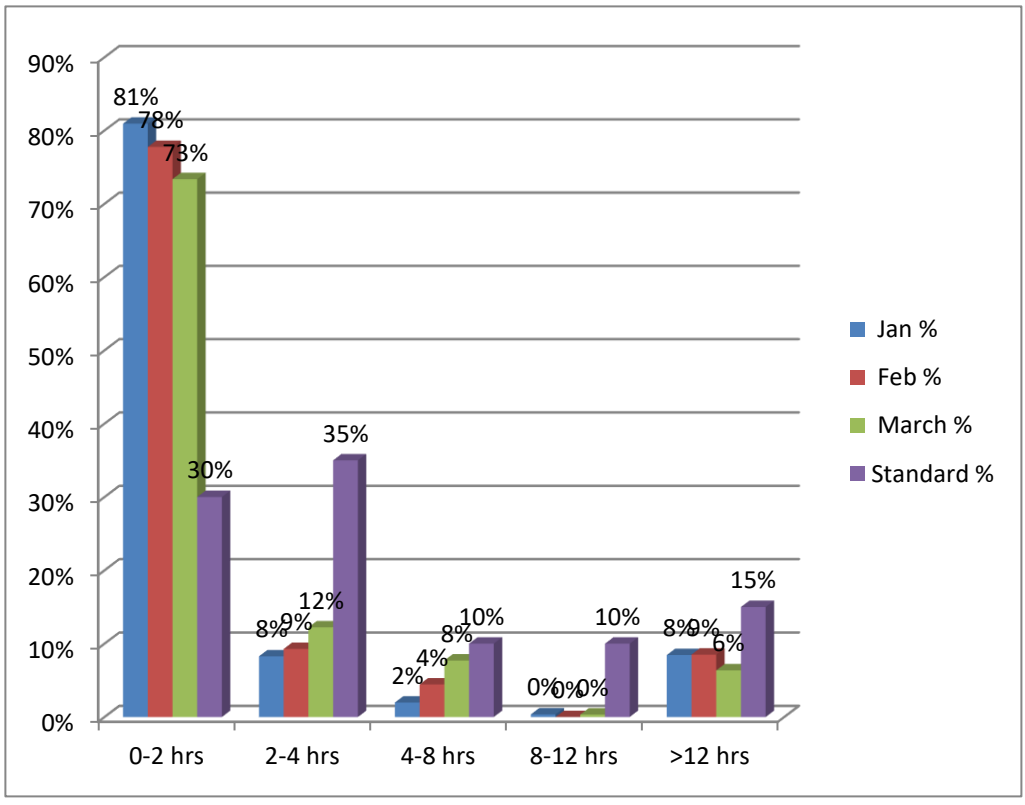
Apart from that, the payer responses which were captured were studied in depth and categorized broadly into 6 categories in which the responses were fed and the most common reason for denials of cases by different payers (insurance company's/ TPA) was identified.

The reason for denial of various cases were shown in percentages. All the findings of above mentioned analysis were shown in different types of graphs.

2.3 RESULTS AND FINDINGS

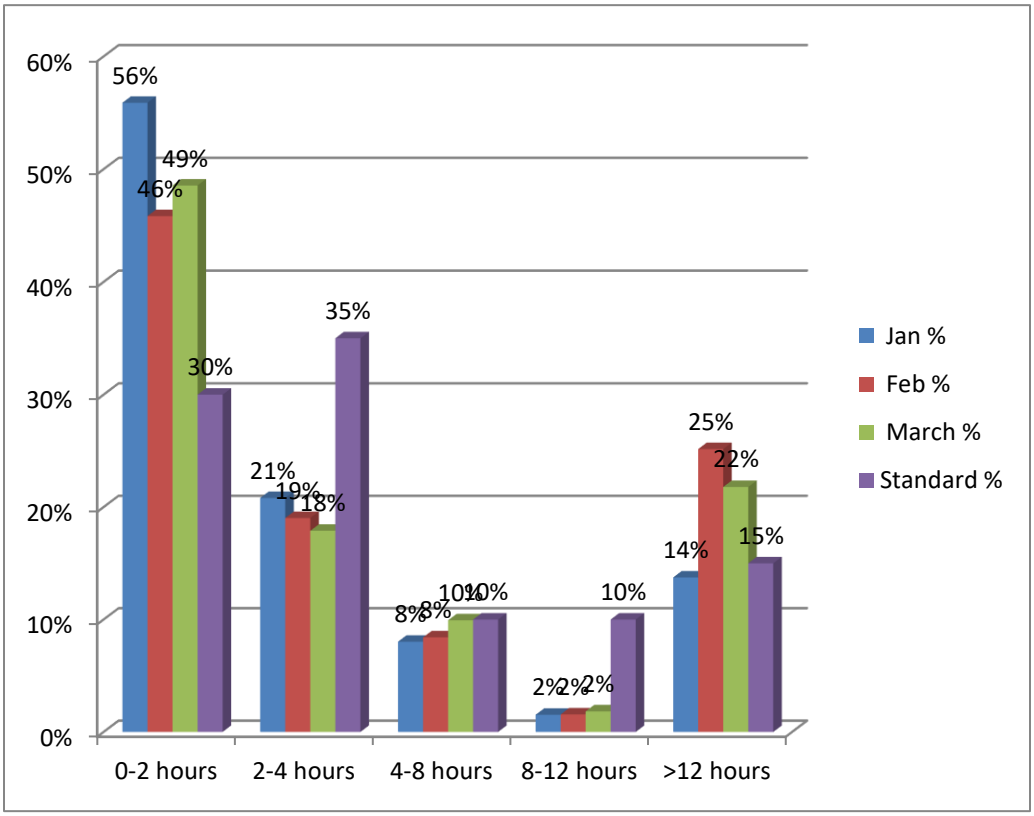
Total TAT of FHPL							
Range	**Jan %**	**Feb %**	**March %**	**Standard %**	**Jan Cases**	**Feb Cases**	**March Cases**
0-2 hrs	81%	78%	73%	30%	450	402	438
2-4 hrs	8%	9%	12%	35%	46	48	73
4-8 hrs	2%	4%	8%	10%	11	23	46
8-12 hrs	0%	0%	0%	10%	2	0	2
>12 hrs	8%	9%	6%	15%	47	44	38
TOTAL	**100%**	**100%**	**100%**	**100%**	**556**	**517**	**597**

Table 4



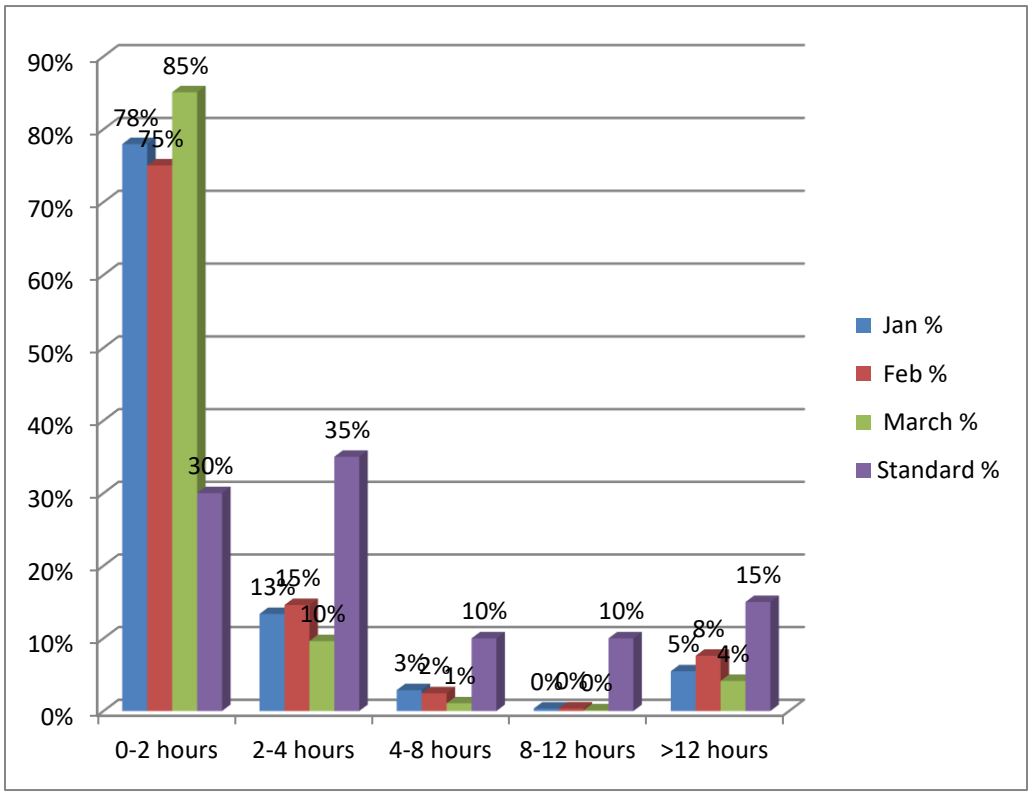
Total TAT of Mediassist							
Range	**Jan %**	**Feb %**	**March %**	**Standard %**	**Jan Cases**	**Feb Cases**	**March Cases**
0-2 hours	56%	46%	49%	30%	1281	1144	1457
2-4 hours	21%	19%	18%	35%	477	475	537
4-8 hours	8%	8%	10%	10%	184	210	298
8-12 hours	2%	2%	2%	10%	35	39	55
>12 hours	14%	25%	22%	15%	315	628	654
TOTAL	**100%**	**100%**	**100%**	**100%**	**2292**	**2496**	**3001**

Table 5

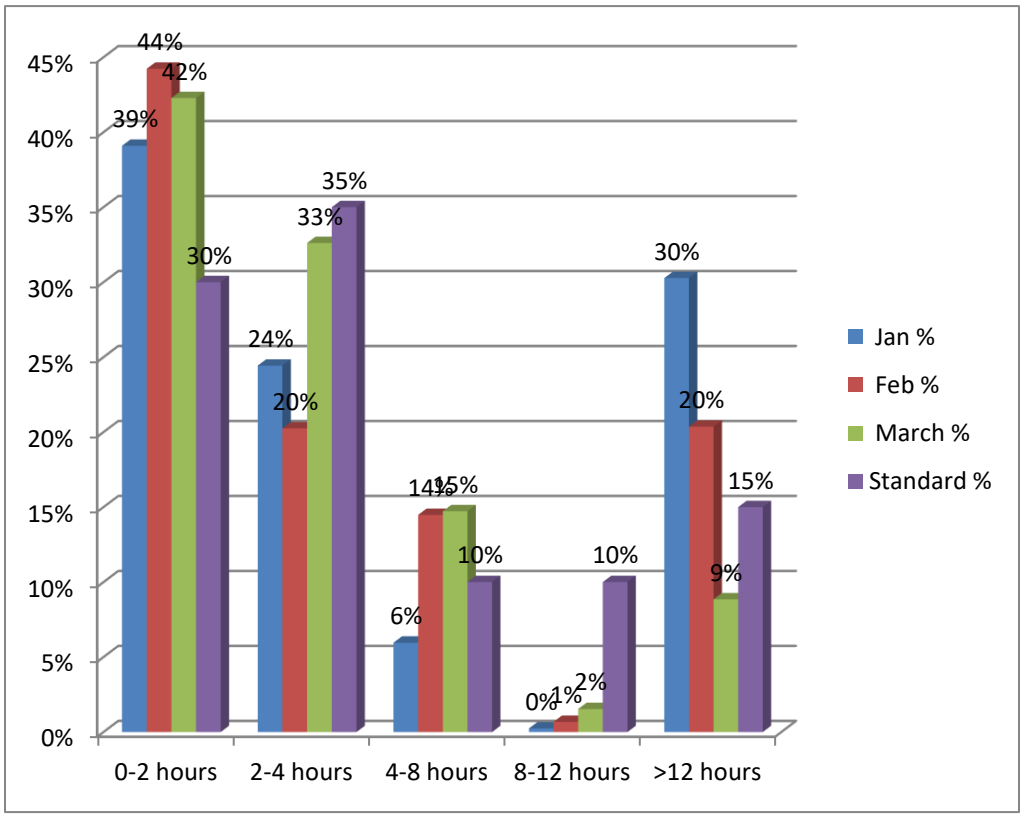


Total TAT of TTK

Range	Jan %	Feb %	March %	Standard %	Jan Cases	Feb Cases	March Cases
0-2 hours	78%	75%	85%	30%	1412	1322	1768
2-4 hours	13%	15%	10%	35%	242	257	200
4-8 hours	3%	2%	1%	10%	52	43	22
8-12 hours	0%	0%	0%	10%	6	6	2
>12 hours	5%	8%	4%	15%	99	134	86
TOTAL	**100%**	**100%**	**100%**	**100%**	**1811**	**1762**	**2078**

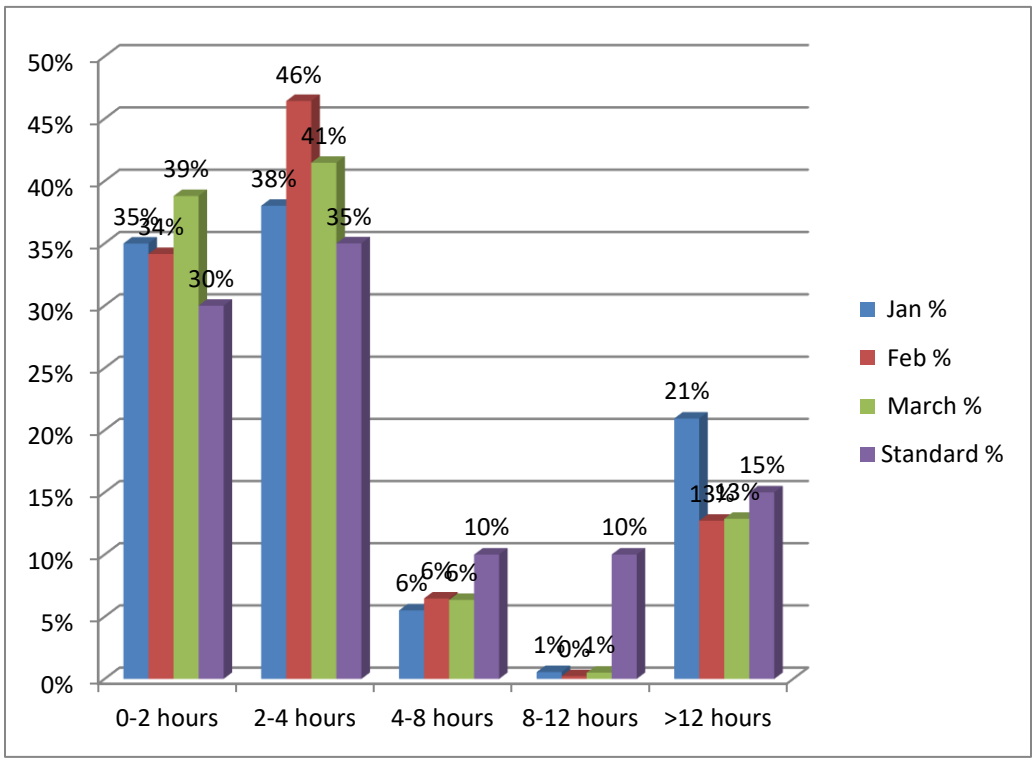


Total TAT of ICICI							
Range	**Jan %**	**Feb %**	**March %**	**Standard %**	**Jan Cases**	**Feb Cases**	**March Cases**
0-2 hours	39%	44%	42%	30%	328	391	468
2-4 hours	24%	20%	33%	35%	205	179	361
4-8 hours	6%	14%	15%	10%	50	128	163
8-12 hours	0%	1%	2%	10%	2	6	17
>12 hours	30%	20%	9%	15%	254	180	98
TOTAL	**100%**	**100%**	**100%**	**100%**	**839**	**884**	**1107**



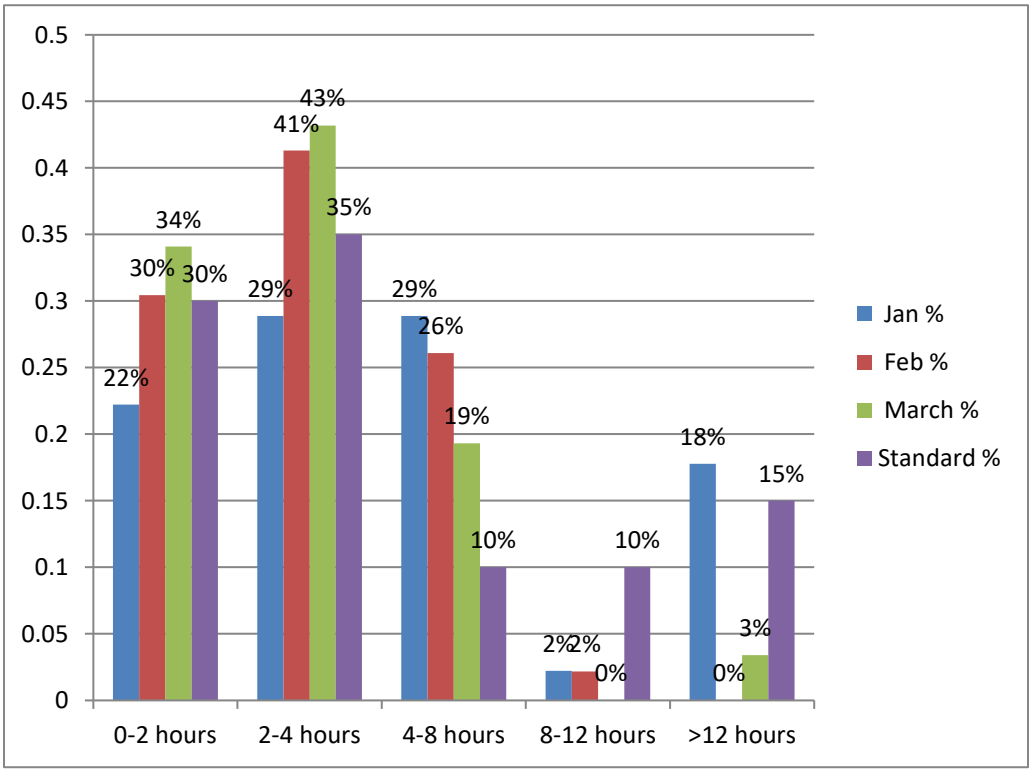
Total TAT of UHC

Range	Jan %	Feb %	March %	Standard %	Jan Cases	Feb Cases	March Cases
0-2 hours	35%	34%	39%	30%	127	153	232
2-4 hours	38%	46%	41%	35%	138	208	248
4-8 hours	6%	6%	6%	10%	20	29	38
8-12 hours	1%	0%	1%	10%	2	1	3
>12 hours	21%	13%	13%	15%	76	57	77
TOTAL	**100%**	**100%**	**100%**	**100%**	**363**	**448**	**598**



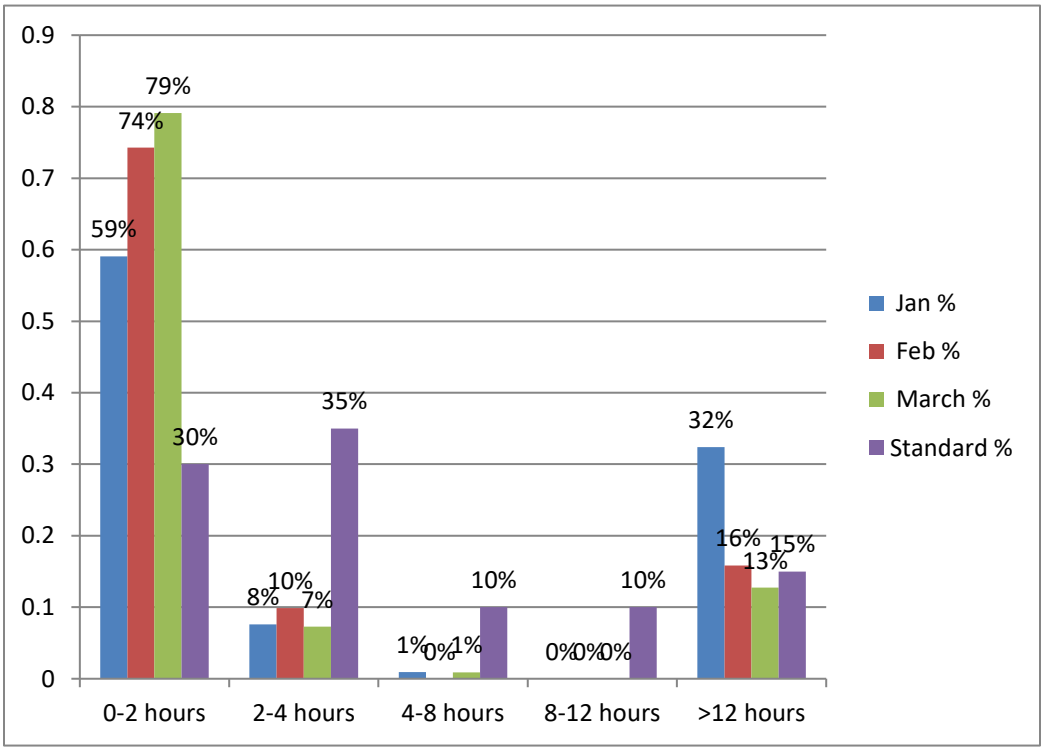
Total TAT of DHC

Range	Jan %	Feb %	March %	Standard %	Jan Cases	Feb Cases	March Cases
0-2 hours	22%	30%	34%	30%	10	14	30
2-4 hours	29%	41%	43%	35%	13	19	38
4-8 hours	29%	26%	19%	10%	13	12	17
8-12 hours	2%	2%	0%	10%	1	1	0
>12 hours	18%	0%	3%	15%	8	0	3
TOTAL	**100%**	**100%**	**100%**	**100%**	**45**	**46**	**88**

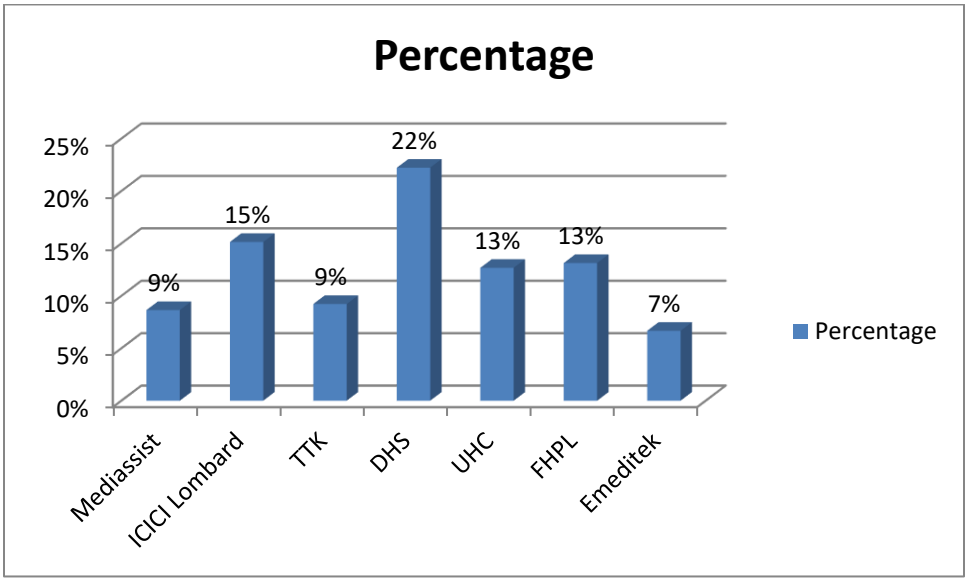


Total TAT of Emeditek

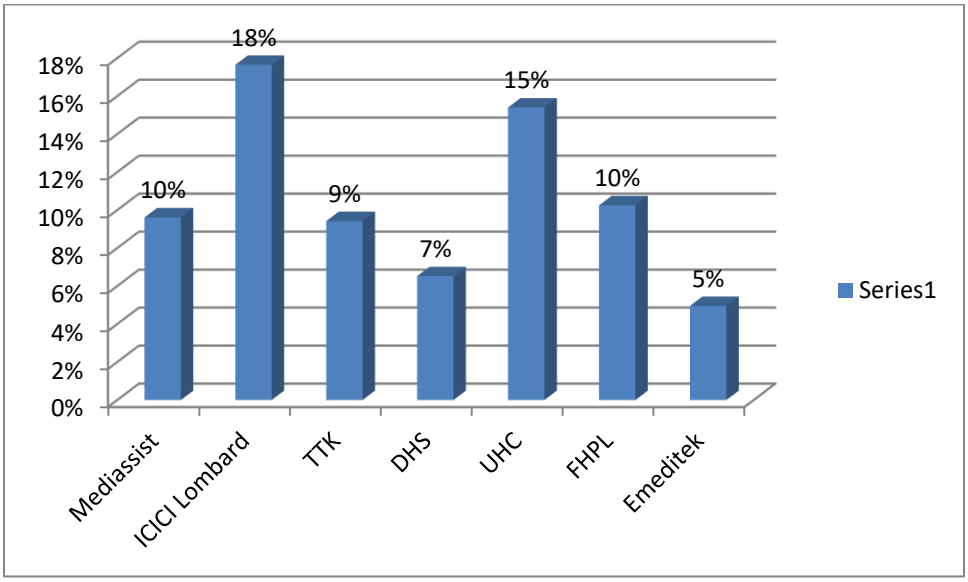
Range	Jan %	Feb %	March %	Standard %	Jan Cases	Feb Cases	March Cases
0-2 hours	59%	74%	79%	30%	62	75	87
2-4 hours	8%	10%	7%	35%	8	10	8
4-8 hours	1%	0%	1%	10%	1	0	1
8-12 hours	0%	0%	0%	10%	0	0	0
>12 hours	32%	16%	13%	15%	34	16	14
TOTAL	**100%**	**100%**	**100%**	**100%**	**105**	**101**	**110**



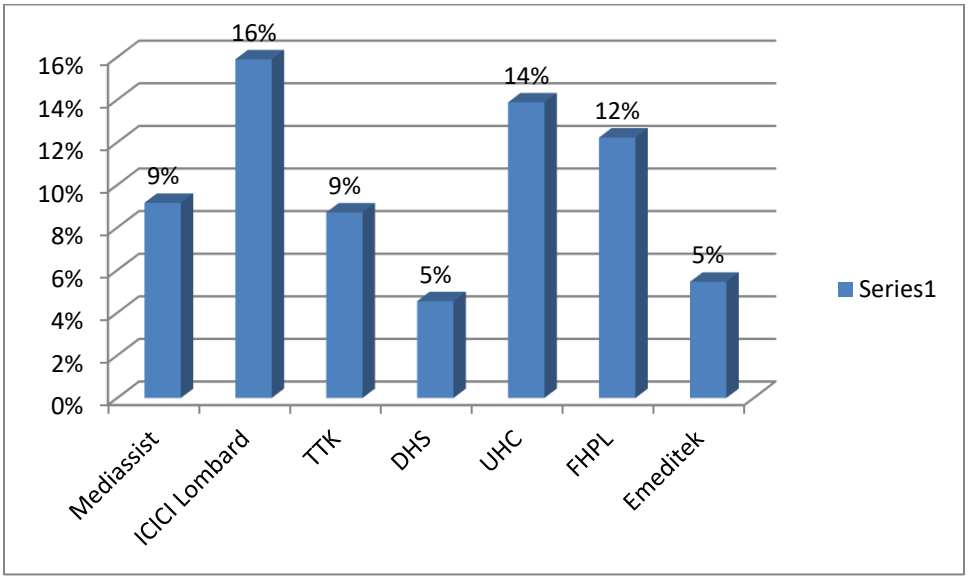
January			
Name of TPA	**Percentage**	**Cases denied**	**Total cases per month**
Mediassist	9%	198	2292
ICICI Lombard	15%	127	839
TTK	9%	167	1811
DHS	22%	10	45
UHC	13%	46	363
FHPL	13%	73	556
Emeditek	7%	7	105



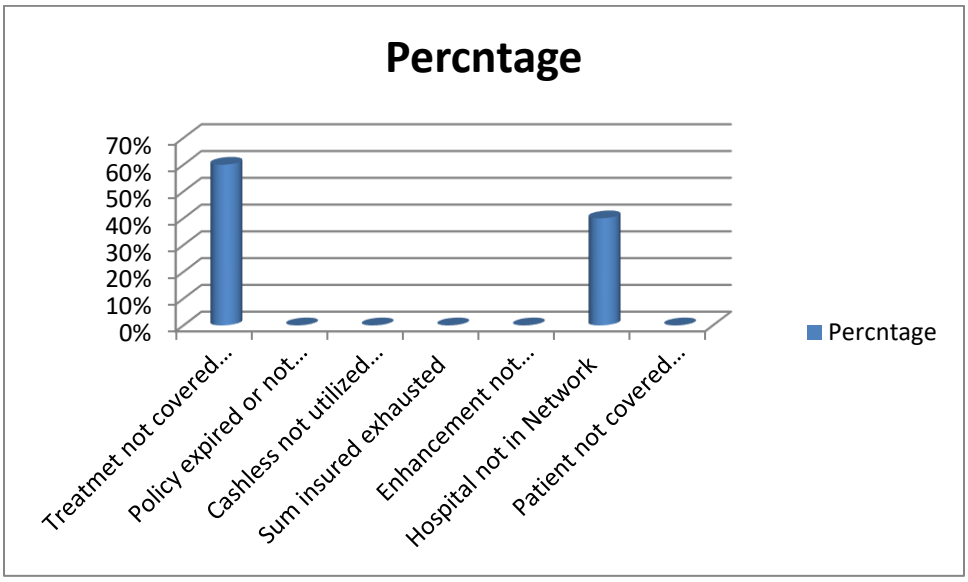
February			
Name of TPA	**Percentage**	**Cases denied**	**Total cases per month**
Mediassist	10%	240	2496
ICICI Lombard	18%	156	884
TTK	9%	166	1762
DHS	7%	3	46
UHC	15%	69	448
FHPL	10%	53	517
Emeditek	5%	5	101



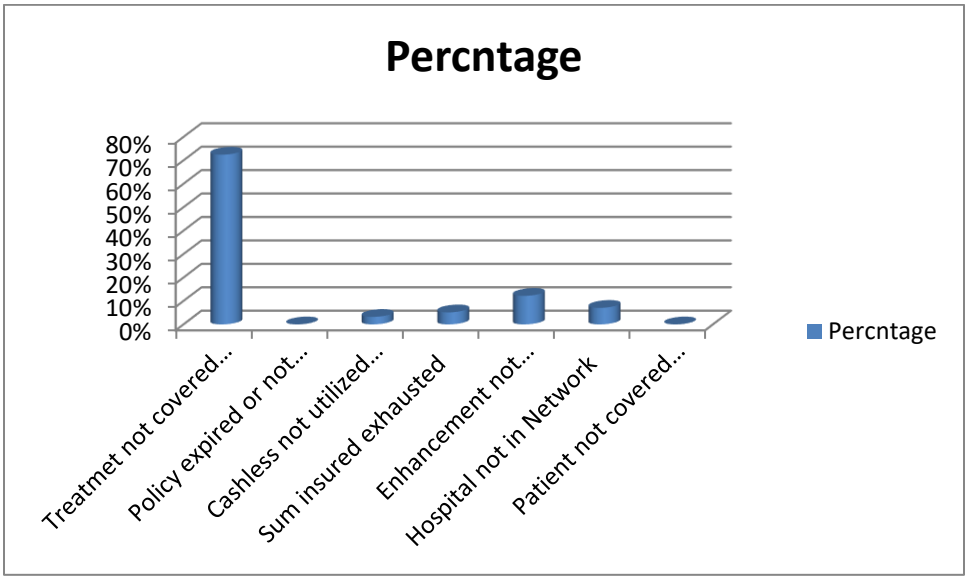
March			
Name of TPA	**Percentage**	**Cases denied**	**Total cases per month**
Mediassist	9%	275	3001
ICICI Lombard	16%	176	1107
TTK	9%	181	2078
DHS	5%	4	88
UHC	14%	83	598
FHPL	12%	73	597
Emeditek	5%	6	110



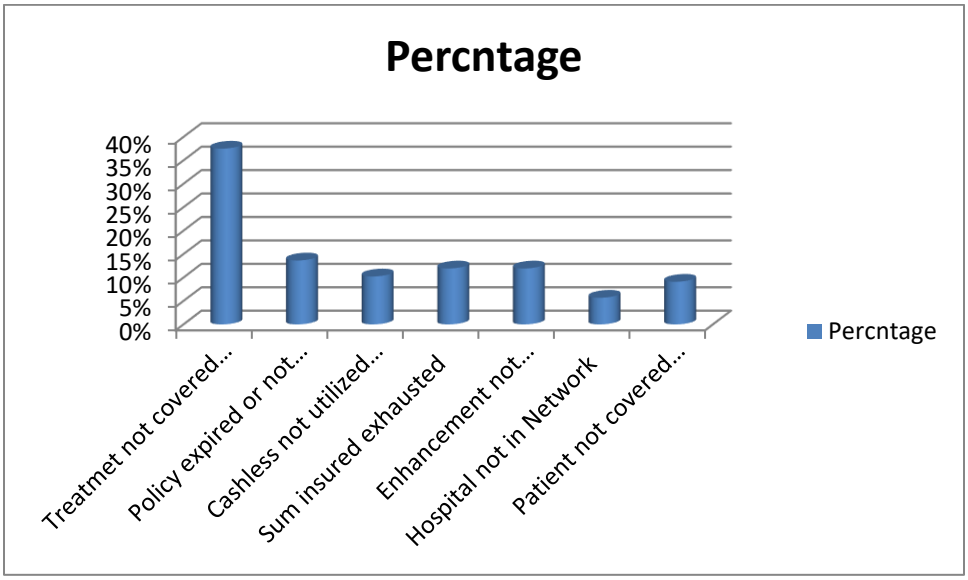
	DHS January DATA		
Sl No	Reasons for denial	Percntage	No of cases
1	Treatment not covered under policy	60%	6
2	Policy expired or not renewed	0%	0
3	Cashless not utilized by the patient	0%	0
4	Sum insured exhausted	0%	0
5	Enhancement not possible	0%	0
6	Hospital not in Network	40%	4
7	Patient not covered under policy	0%	0
	Total	100%	10



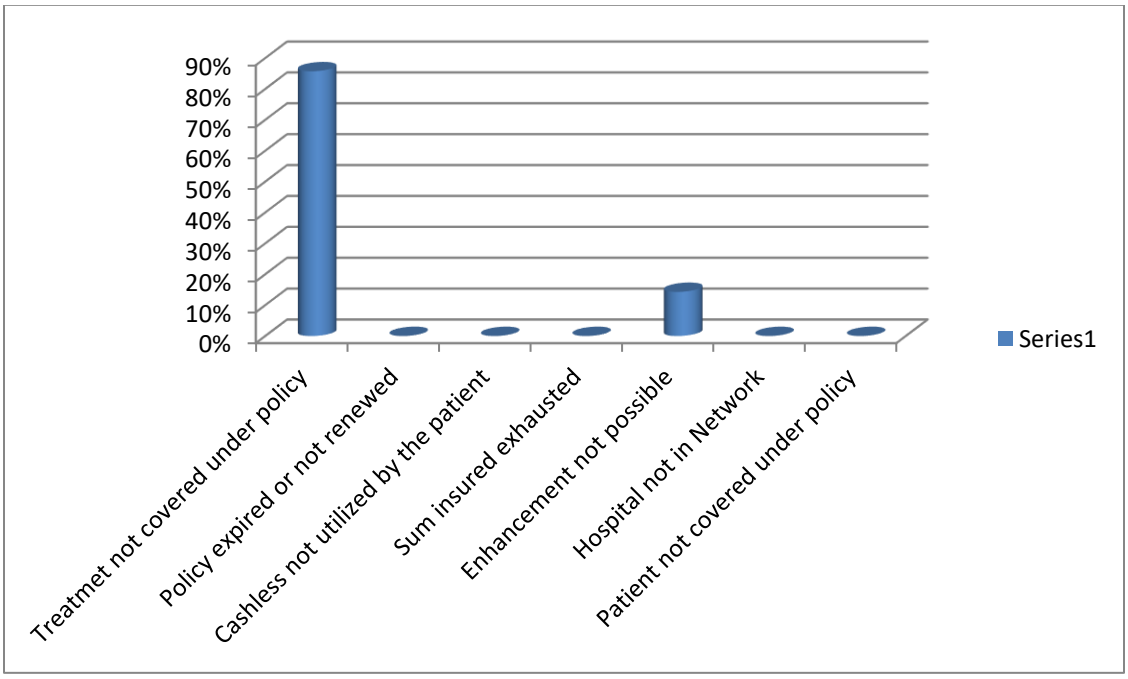
	ICICI Lombard February DATA		
Sl No	Reasons for denial	Percntage	No of cases
1	Treatmet not covered under policy	72%	113
2	Policy expired or not renewed	0%	0
3	Cashless not utilized by the patient	3%	5
4	Sum insured exhausted	5%	8
5	Enhancement not possible	12%	19
6	Hospital not in Network	7%	11
7	Patient not covered under policy	0%	0
	Total	100%	156



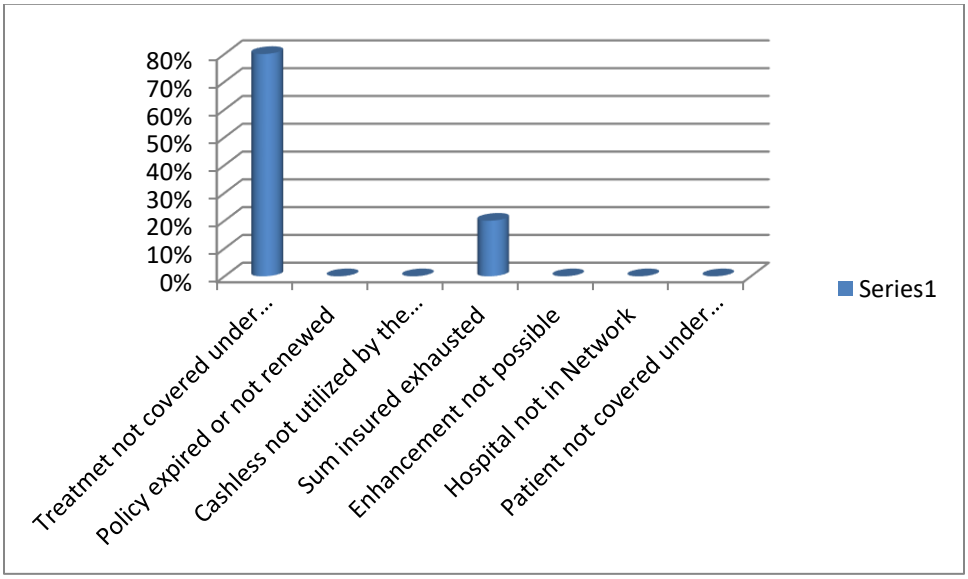
	ICICI Lombard March DATA		
Sl No	Reasons for denial	Percentage	No of cases
1	Treatmet not covered under policy	38%	66
2	Policy expired or not renewed	14%	24
3	Cashless not utilized by the patient	10%	18
4	Sum insured exhausted	12%	21
5	Enhancement not possible	12%	21
6	Hospital not in Network	6%	10
7	Patient not covered under policy	9%	16
	Total	100%	176



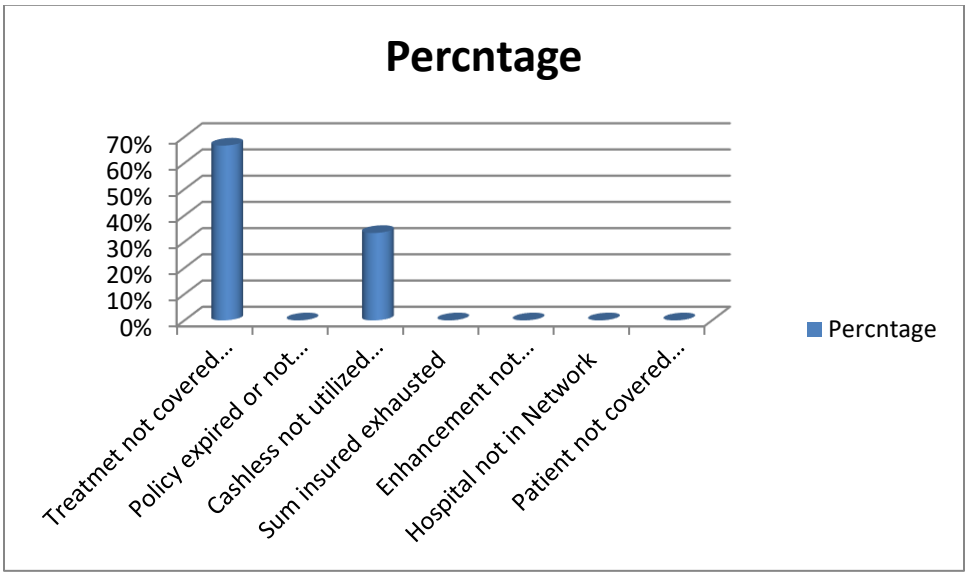
	Emeditek Jan DATA		
Sl No	Reasons for denial	Percntage	No of cases
1	Treatmet not covered under policy	86%	6
2	Policy expired or not renewed	0%	0
3	Cashless not utilized by the patient	0%	0
4	Sum insured exhausted	0%	0
5	Enhancement not possible	14%	1
6	Hospital not in Network	0%	0
7	Patient not covered under policy	0%	0
	Total	100%	7



	Emeditek Feb DATA		
Sl No	Reasons for denial	Percntage	No of cases
1	Treatmet not covered under policy	80%	4
2	Policy expired or not renewed	0%	0
3	Cashless not utilized by the patient	0%	0
4	Sum insured exhausted	20%	1
5	Enhancement not possible	0%	0
6	Hospital not in Network	0%	0
7	Patient not covered under policy	0%	0
	Total	100%	5



	Emeditek March DATA		
Sl No	Reasons for denial	Percntage	No of cases
1	Treatmet not covered under policy	67%	4
2	Policy expired or not renewed	0%	0
3	Cashless not utilized by the patient	33%	2
4	Sum insured exhausted	0%	0
5	Enhancement not possible	0%	0
6	Hospital not in Network	0%	0
7	Patient not covered under policy	0%	0
	Total	100%	6



Findings

FHPL

For FHPL all the cases for all the three months fall in the hypothetical range. There is no Issue with the TAT.

MEDIASSIST

For Mediassist all the categories are falling under the Hypothetical Range except one range. It was observed that lot of cases were processed in the range of more than 12 hours

In Feb 25% of the cases were processed in more than 12 hours.

In March 20% of the cases were processed in more than 12 hours category.

TTK

For TTK all the cases for all the three months fall in the hypothetical range. There is no Issue with the TAT.

ICICI Lombard

For ICICI Lombard all the categories are falling under the Hypothetical Range except one range. It was observed that lot of cases were processed in the range of more than 12 hours

In Jan 30% of the cases were processed in more than 12 hours.

In Feb 20% of the cases were processed in more than 12 hours category.

UHC

For UHC all the categories are falling under the Hypothetical Range except one range. It was observed that lot of cases were processed in the range of more than 12 hours

In Jan 21% of the cases were processed in more than 12 hours.

DHS

For DHS all the cases for all the three months fall in the hypothetical range. There is no Issue with the TAT.

Emeditek

For UHC all the categories are falling under the Hypothetical Range except one range. It was observed that lot of cases were processed in the range of more than 12 hours

In Jan 32% of the cases were processed in more than 12 hours.

Analysis of Denied cases by various TPAs

TPAs denying the maximum cases every month was identified and also the TPA denying the minimum number of cases was identified.

The below mentioned tables and graphs shows the same.

	TPA with Maximum denials	TPA with Minimum denials
January	Dedicated Healthcare	Emeditek
February	ICICI Lombard	Emeditek
March	ICICI Lombard	Emeditek

Reason Identified for the Denial of cases:

- Treatment not covered under policy (Exclusions)
- Policy expired or not renewed
- Cashless not utilized by the patient
- Sum Insured exhausted
- Enhancement not possible
- Hospital not in Network
- Patient not covered under policy

The findings are

In the month of January, DHS denied the maximum number of cases. Out of these cases 60% of the cases were denied because the treatment was not covered under policy.

In the month of February, ICICI Lombard denied the maximum number of cases. Out of these cases 72% of the cases were denied because the treatment was not covered under policy.

In the month of March, ICICI Lombard denied the maximum number of cases. Out of these cases 38% of the cases were denied because the treatment was not covered under policy.

In the month of January, Emeditek denied the minimum number of cases. Out of these cases 86% of the cases were denied because the treatment was not covered under policy.

In the month of February, Emeditek denied the minimum number of cases. Out of these cases 80% of the cases were denied because the treatment was not covered under policy.

In the month of March, Emeditek denied the minimum number of cases. Out of these cases 67% of the cases were denied because the treatment was not covered under policy.

2.4 Discussion

It is found out that almost with all the TPAs the standards of the TAT are being maintained except few exceptions. On going deep into the matter it was found out that

Since mediassist is having an integrated platform so lately lot of issues are happening because of that which is leading to such a large % of cases being processed in more than 12 hours.

In ICICI Lombard they were not updating the cases on the platform which were being uploaded late in the evening. So lot of cases have been pending for long and this is reason for such a large % of cases being processed in more than 12 hours time

In UHC there was some technical issue because of which the cases got delayed and took more than 12 hours for responding.

In Emeditek a person who was using Health Sprint had left suddenly and no other person was aware of using it. So cases were lying pending since the other person was trained and put to use Health Sprint.

The cases getting denied is mostly due to the reason that the treatment is not covered under the policy or they are the exclusions which the patient and his relatives are not aware of and only once the cashless is denied they get to know that the Insurance company would not pay for this treatment.

Monitoring of the Different departments responsible for the same is mandatory to maintain the quality and the internal standards.

For healthcare to be sustainable and be able to meet the patient's requirements, it has to be cost efficient & provide access to quality care. Increasingly the Information Systems are called upon to support these objectives. The benefit of Information Systems adoption in achieving these objectives flows from the following

- To streamline the processes between the the payers and provider.
- Bridging the digital gap between the payers and providers
- Cost effective business models for healthcare insurance processes
- Reliable, Transparent and secure information exchange system
- Real Time communication
- High Turn Around Time
- Traceability and Accountability
- Complete Information Exchange
- Mapped flow of information

2.5 Conclusion

Payers where we have integrated platform should be monitored closely so as to know if any technical related issues could be avoided.

Customer care department should have more people so that the follow up are done properly and TAT could be brought more into the exact range.

More number of persons from each payers should be trained so that in case of emergencies any body/ replacements can handle the platform.

Timely review meets should be conducted to keep the payers motivated. TAT reports should be sent weekly if there is any problem felt in between.

The customer should be kept engaged so that they respond properly when cooperation is expected from them.

They should be told about the customer care departments importance so that they realize they'll be troubled less.

Implementation of platform is a very profitable and advantageous practice for both hospitals as well as the the payers

Patients Satisfaction increases as the TAT reduces and its found out that the TAT is already being maintained according to the internal standards.

The above study helps us to have a clear analysis of the TAT that it is being maintained according to the quality and this is very important and should be kept in mind and maintained always.

The results of the study also help us determine all the factors because of which the cases are being denied from the payers end and how could we contribute in improving that.

2.6 Recommendations

A careful understanding, verification and validation of all the data is mandatory. Not any body without knowledge of this kind of business would be able to handle and maintain the TAT

The payers should provide us with time to time feedback especially for any of the issues related to technicalities in the platform so that the TAT does not get affected.

There should have been a provision that the TAT for all the statuses should have been captured and that should have been taken into consideration.

Training team should be knowledgeable, empathetic and cooperative so that they can share proper lessons about the application without making it appear a difficult application

A strong, dynamic and knowledgeable team should be built for the go-live stage, which can take the entire responsibility of this department, its working and which can act spontaneously if the hospital or the payers face any related problems.

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