Analysis of Billing and Claim Processing
Sarvodaya Hospital

A dissertation submitted in partial fulfillment of the requirements for the award of

Post-Graduate Diploma in Health and Hospital Management

by

Dr Sapna Goyat

International Institute of Health Management Research
New Delhi -110075
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FEEDBACK FORM

Name of the Student: Dr Sapna Goyat

Dissertation Organisation: Sarvodaya Hospital
Sector 8, Faridabad

Area of Dissertation: Billing

Attendance: 100%.

Objectives achieved: Indepth Study of Billing Process
Data collection regarding Billing, queries etc
Recommendations for improvement.

Deliverables: Finished project on time
Improved Billing & claim Settlement process

Strengths: Smart working, Dedicated, Commitment

Suggestions for Improvement: Analytical skills, Time management

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

Date: 2/5/13
Place: Faridabad

Certificate of Internship Completion

Date: 02-May-2013

TO WHOM IT MAY CONCERN

This is to certify that Mr./Ms./Dr. Sapna has successfully completed his 3 months internship in our organization from January 10, 2013 to April 10, 2013. During this intern he has worked on .....Billing.....(task performed) under the guidance of me and my team at .....Sarvodaya Hosp...(organsiation). .....(any positive/negative comment)

We wish him/her good luck for his/her future assignments

(Signature)

Dr. Naveen (Name)

Head Medical Billing Designation

Certificate of Approval

The following dissertation titled "**Analysis of Billing and Claim Processing in Sarvodaya Hospital, Faridabad** " 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. BRIJENDER SINGH DHILLON _____ 4/5/13

Certificate from Dissertation Advisory Committee

This is to certify that **Dr Sapna Goyat** , a graduate student of the **Post- Graduate Diploma in Health and Hospital Management**, has worked under our guidance and supervision. He/She is submitting this dissertation titled **"Analysis of Biling and claim Processing"** 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.

Faculty Mentor 4.5.13

Designation Dr A.K. KHOKHAR

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New Delhi

Date 4/5/13

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Date 3/5/13

ABSTRACT

In today's scenario the health care industry is seeing the highest growth and reason of that could be success of health insurance. In India to afford an expensive medical treatment is not in the hand of a common man. For him to cope up with 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, Haryana Government, 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 at 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 in turn effect the revenue of the hospital and as a result the hospital goes into loss.

The basic objective of this 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 .Different types of patients are admitted in the hospital like Cash, TPA, ECHS, CGHS etc. These all have different types of billing

,documentation, payment etc. So utmost care need to be taken while processing these claims. Different types of documents ,paperwork is needed, different types of queries are raised by these agencies which require careful handling of all the claims. This study aims to define the billing types, types of queries received by the billing department, approval process for procedures etc.

The methodology adopted was prospective study that has been conducted by investigating the process, situation, and 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.

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.

ACKNOWLEDGEMENT

I have taken tremendous interest and effort in the project. However, it would not have been possible without the kind support and extended hand of help of many individuals. I would like to express my sincere thanks to all of them. I would like to thank all the professionals at **Sarvodaya Hospital and Research Centre** for sharing generously their knowledge and precious time which inspired me to achieve the best during the dissertation.

My sincere thanks to **Dr. Rajesh Bhalla** (Dean Academic and Student Affairs, IIHMR) and my mentor **Dr A K Khokhar** (Professor, IIHMR) who took all the necessary to make sure that we are in the right hands.

I owe a great debt to **Dr Rakesh Gupta** (Chairman &Medical Director), **Mr Karan Vijani** (Head Marketing) for showing their interest and sharing their valuable views in spite of their busy schedule.

I am highly indebted to **Dr. Naveen Arora** (Head-Medical Billing),**Dr Nitin Prasher** (A M - Billing) for their consistent guidance and marked supervision as well as for providing necessary information regarding the project that enabled me reach the completion of the same successfully.

My sincere thanks and appreciation also go to hospital staff who spared me their valuable time and helped me with all their abilities.

Dr Sapna Goyat

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LIST OF ABBREVIATIONS

CAG - Coronary Angiography

CFA - Competent Financial Authority

CGHS - Central Government Health Scheme

ECHS- Ex-Servicemen Contributory Health Scheme

FDA - Food & Drug Administration

HIS - Hospital Information System

HOD - Head of Department

ICD - International Classification of Diseases

MRD - Medical Records department

MoU - Memorandum of Understanding

OIC - Officer In Charge

PTCA - Percutaneous Transluminal coronary Angioplasty

SEMO - Senior Executive Medical Officer

TPA - Third Party Administrator

1.0 ORGANIZATION PROFILE

Sarvodaya Hospital is a NABH accreditated state of the art Multispecialty hospital, situated in Faridabad Sec-8.The hospital is a 220 bedded facility 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.

The Mission

"Good health to all at an affordable cost, building a healthcare facility with medical excellence and a committed, dedicated and contended workforce."

The Vision

To position the group as a healthcare leader, providing all levels of quality based medical services with a focus on affordability and medical excellence.

Objectives

To provide most efficacious diagnostic and therapeutic services facilitated by periodically updated equipments and patronage of reputed healthcare organizations.
To serve as a platform for medical experts to disseminate information for therapeutic and diagnostic value through conferences and seminars.

Quality statement

Sarvodaya Hospital is committed to serve the humanity by providing its specialized medical services at reasonable cost to all its ailing patients, to enhance their health and satisfying them by meeting their needs & expectations with adherence to statutory regulation through continuous improvement in its with involvement of all levels of its employees.

Values

Sarvodaya Hospital is bound by values that form the foundation of our success. Our core values are respect, social justice, compassion, care of the poor and undeserved, and excellence in whatever we do. We value and trust our people whom we recruit through secular

approach. With a participative, creative style of operation at Sarvodaya Hospital, we appreciate and reward integrity. Our performance is based on customer satisfaction through high quality of care and services based on:

Caring:

- For our patients
- For our community
- For each other

Learning:

- From others, and sharing our knowledge
- To be a part of a committed team

Leading:

- To be flexible and adaptive

By motivating others

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.

Sarvodaya 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.

SPECIALITIES AVAILABLE:

Cardiology

Physiotherapy and Rehabilitation

Pulmonology

Radio Imaging

Transfusion Medicine

Urology

Physiotherapy

Critical Care

CTVS

Dentistry

Dermatology

Emergency and Trauma Centre

ENT

Gastroenterology & GI Surgery

General & Laparoscopic Surgery

Medicine

Nephrology

Neurology

Neurosurgery

Obstetrics & Gynaecology

Oncology & Comprehensive Cancer Care

Ophthalmology

Orthopaedics & Joint Replacements

Pediatrics & Neonatology

2.0 ROLES AND RESPONSIBILITIES DURING INTERNSHIP

I was working as Coordinator Cardiology and CTVS department. This designation entailed the following responsibilities:

1. Financial counseling of cardiac patients undergoing Angioplasty, CABG etc.
2. Scheduling of procedures done at Cath-lab
3. Taking rounds of Cardiac patients, taking their feedback and answering their queries.
4. Co coordinating between various departments for the transfer of cardiac patients to and from Cath lab.
5. Follow up of TPA patients (Papers submitted, queries received, approval)
6. Overall co ordination of Cardiac patients (admission, financial approval, discharge etc.)

Routine/ general management

Handling of the operations in the areas assigned to me and was responsible for the smooth functioning of operations in the department.

In-depth study of the following fields:

- Operations
- Claim processing

Learning during dissertation:

a) Various aspects of billing (Cash, ECHS,TPA)
b) To understand working of whole hospital and seek opportunity that provides me real experience.
c) Coordination within various departments of the hospital.
d) Enhance my managerial skills.
e) To groom myself as a professional.

Project

Analysis of Billing and Claim Processing in Sarvodaya Hospital

3.0 INTRODUCTION

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 chooses an inappropriate method of administering the services or the health provider chose the right solution but executes 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.

4.0 RATIONALE OF THE STUDY

Despite sincere efforts done by the Billing and Processing team, still a number of queries were received from the payer's side which delayed the process of claim settlement. Sometimes the claims were denied because of incomplete paperwork which reduces revenue generation of the hospital.

5.0 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.

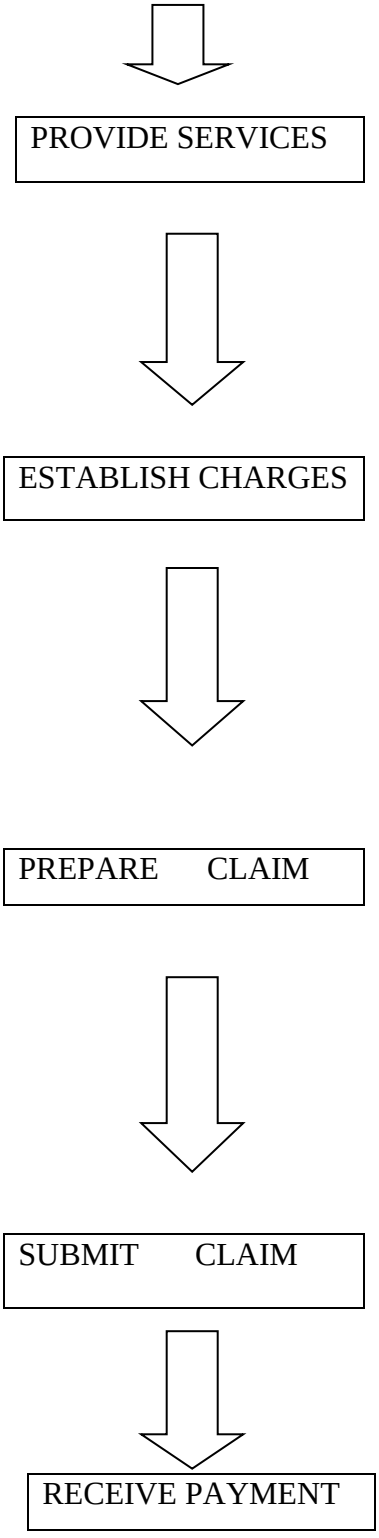
Return to Provider: Problems must be corrected and claim resubmitted.

Suspension: Claim requires further information before it can be processed.

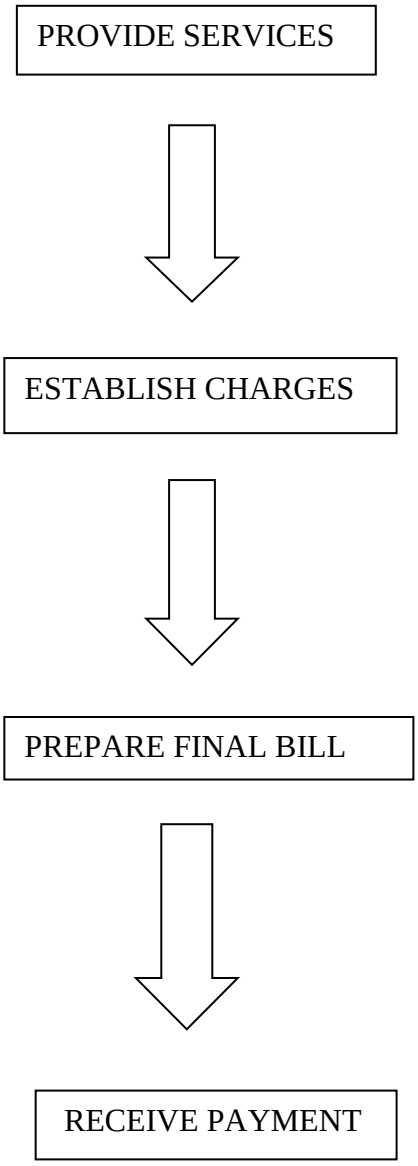
5.1 REVENUE FLOW:

For Panel patients:

INSURANCE VERIFICATION


PROVIDE SERVICES
ESTABLISH CHARGES
PREPARE CLAIM
SUBMIT CLAIM
RECEIVE PAYMENT

For Cash patients:



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 accomplished 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.

5.2 REVENUE CYCLE

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. 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.

5.3 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 Centers. These referrals can only be made by authorized staff of the Polyclinics.

3. Empanelment of Hospitals/Nursing homes and Diagnostic Centers 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.

5.4 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 with his stamp.**

5. **Use of Referral Form**. The referrals to empanelled facilities will be made by the authorized 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. **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.

8. 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 maybe 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.

5.5 PERIOD OF HOSPITALISATION

9. 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) Specialized procedures - 12 days.

(b) Other procedures - 8 days.

(c) Laparoscopic surgery - 3 days.

(d) Day care/ minor procedures 1 day.

10. 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, doctor’s visits (not more than 2 times a day).

5.6 CONDITIONS REQUIRING PRIOR APPROVAL

11. Prior approval of Central Organization ECHS is required to be obtained by the Empanelled Hospitals/ Nursing Home/ Diagnostic Centers, 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.

12. **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
1	Less than 1 lakh	SEMO/ SMO/ PMO
2	1 lakh to 2 lakhs	Senior Adviser in the Specialty at Service Hospital
3	2 lakhs to 4 lakhs	Consultant in the Specialty
4	Above 4 lakhs	Senior Consultant Medicine / Surgery in the Office of DGAFMS.

TABLE NO 1

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

14. 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 Specialty
	(c) 2 lakhs to 4 lakhs	Consultant in Medicine/ Surgery./ Allied specialties (as applicable)
	Condition requiring Approval	**Approving Authority**
	(d) Above 4 lakhs	Senior Consultant Medicine/Surgery in the Office of DGAFMS
	Procedures listed in CGHS for which approval is required	
	Angioplasty with Coronary Stents	
	(i) Upto 2 Coronary stents	No approval required. Cardiologist of empanelled hosp authorized to certify/recommend
	(ii) More than 2 Coronary stents	SEMO

TABLE NO 2

15. **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.

5.7 SUBMISSION OF BILLS

16. 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.

17. 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.

18. **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)

(b) Major Procedure

(c) Minor Procedure (*if applicable*)

19. **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.

20. 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.

21. **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.

5.8 PROCESSING OF BILLS

22. **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.

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

1. Nature of treatment given. That the treatment / investigation were as per ECHS Polyclinic referral and were appropriate.
2. That Standard clinical practice guideline were followed by the Hospital/ Dental / Diagnostic center.
3. That medicines/drugs and consumables were provided as per requirement and necessity.
4. Ratify the rate verification done by the OIC Polyclinic.

24. The SEMO will **submit the recommendations for sanction of the Station Commander**. If the bill amount is beyond the financial powers authorized 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:-

S 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/-

TABLE NO 3

5.9 OTHER TERMS AND CONDITIONS

25. 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.
26. 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.

27. 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.
28. 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.

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

5.10 Health Insurance policy guidelines:

In the event of any claim(s) becoming admissible under the scheme, the company will pay through TPA to the Hospital / Nursing Home or the insured person the amount of such expenses as would fall under different heads mentioned below, and as are reasonably and necessarily incurred thereof by or on behalf of such Insured Person, but not exceeding the Sum Insured in aggregate mentioned in the schedule hereto.

A. Room, Boarding and Nursing Expenses as provided by the Hospital/Nursing Home upto 1% of Sum Insured per day. This also includes Nursing Care, RMO charges, IV Fluids/Blood Transfusion/Injection administration charges and the like.
B. If admitted in IC Unit, the Company will pay upto 2% of Sum Insured per day.
C. Surgeon, Anesthetist, Medical Practitioner, Consultants, Specialists Fees
D. Anesthetist, Blood, Oxygen, Operation Theatre Charges, surgical appliances, Medicines & Drugs, Diagnostic Materials and X-ray, Dialysis, Chemotherapy, Radiotherapy, Artificial Limbs, cost of prosthetic devices implanted during surgical procedure like Pacemaker, relevant laboratory diagnostic tests, etc & similar expenses.
E. All Hospitalization Expenses (excluding cost of organ, if any) incurred for donor in respect of Organ transplant.

Expenses in respect of the following specified illnesses will be restricted as detailed below:	LIMITS FOR EACH HOSPITALISATION
Hospitalization Benefits	
a. Cataract	a. 10% of SI subject to maximum of Rs.25,000/-
b. Hernia	b. 15% of the SI subject to maximum of Rs.30,000/-
c. Hysterectomy	c. 20% of the SI subject to maximum of Rs.50,000/-
d. Following Specified major surgeries -	
i. Cardiac Surgeries	d. 70% of the SI subject to maximum of Rs.4 Lac
ii. Cancer Surgeries	
iii. Brain Tumour Surgeries	
iv. Pacemaker implantation For sick, sinus syndrome	
v. Hip replacement	
vi. Knee joint replacement	

4. EXCLUSIONS:-

The company shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any

Insured Person in connection with or in respect of:

4.1 Any pre-existing condition(s) as defined in the policy, until 48 months of continuous coverage of such insured person have elapsed, since inception of his/her first Policy with the Company.

Pre-Existing Condition/Disease definition – Any condition, ailment or injury or related condition(s) for which insured person had signs or symptoms, and/or were diagnosed, and/or received medical advice/treatment, within 48 months prior to his/her first policy with the Company.

4.2 Any disease other than those stated in clause 4.3, contracted by the Insured person during the first 30 days from the commencement date of the policy. This condition 4.2 shall not however, apply in case of the Insured person having been covered under **any Health Insurance Policy** or Group Insurance Scheme with the Company for a continuous period of preceding 12 months without any break.

4.3 During the first two years of the operation of the policy, the expenses on treatment of diseases such as Cataract, Benign Prostatic Hypertrophy, Hysterectomy for Menorrhagia or Fibromyoma, Hernia, Hydrocele, Congenital internal disease, Fistula in anus, piles, Sinusitis and related disorders, Gall Bladder Stone removal, Gout & Rheumatism, Calculus Diseases, Joint Replacement due to Degenerative Condition and age-related Osteoarthritis & Osteoporosis are not payable.

4.4 External and or durable Medical / Non-medical equipment of any kind used for diagnosis and/or treatment and/or monitoring and/or maintenance and/or support including CPAP, CAPD, Infusion pump, Oxygen concentrator etc., Ambulatory devices i.e., walker, crutches, Belts, Collars, Caps, Splints, Slings, Braces, Stockings, etc., of any kind, Diabetic foot wear, Glucometer/Thermometer and similar related items and also any medical equipment, which are subsequently used at home.

5.11 LIST OF TPA's EMPANELLED WITH THE HOSPITAL

1. Apollo Dkv
2. Alankit
3. Cholamandalam
4. Dedicated Health Care Services Pvt. Ltd.(DHS)
5. East West Assist
6. Focus Health Care
7. Family Health Plan
8. Geninis India Ltd.
9. ICICI Prudential General Insurance
10. I Care Health
11. M D India Health Care
12. Medicare TPA Services
13. Medsave Health Care
14. Medi Assist Healthcare
15. Max Bupa Healthcare
16. Paramount Health Services
17. Park Mediclaim
18. Raksha TPA
19. Rothshield Health Care
20. Safeway Mediclaim
21. Ttk Health Care
22. United Health Care
23. Vipul Med Corp
24. Iffco Tokyo

5.12 FLOW OF TPA PATIENT

During pre-plan admission

Patient with OPD registration

↓

Consultant of concerned OPD advices admission

↓

Consultant asks patient if covered under insurance or not

↓

If yes, consultant gives diagnosis & sends patient to financial counsellor

↓

Counseling given to the patient about estimated costs of treatment and procedures

↓

Patient sent to TPA desk after the counseling

↓

TPA Desk executive confirms the following:

- Validity of insurance policy/card
- Empanelment with SARVODAYA
- Limit of policy
- Room category entitlement

↓

Dr. at the TPA desk fills the Pre Authorization Form

↓

TPA Desk Executive fills other details & estimated cost of stay and treatment

↓

The completed Pre Authorization Form is faxed to TPA Company.

↙ ↘

TPA Approval

↙ ↘

Patient sent to Admission Counter for Admission Formalities

↓

Admission counter confirms consultant with TPA Desk for approval

↓

Admission formalities completed

↓

Patient sent to respective ward

TPA Desk informs of approval to:

- Consultant
- IPD Billing
- Nursing Incharge

TPA Denial

↓

concerned patient informed

↓

Patient advised accordingly & requested to make payments in cash.

Documents to be sent to TPA for approval:-

a) Photocopy's of patient's TPA card
b) Photocopy of patient's photo ID proof
c) Pre-authorization form
d) Patient's case sheet stating consultant's diagnosis
e) Patient's case history sheet
f) Photocopy of the previous policies
g) Photocopy of the previous treatment records (if any)

6.0 OBJECTIVES

6.1 GENERAL OBJECTIVE

To analyze the process of billing and claim processing and make recommendations to improve the process of claim settlement.

6.1 SPECIFIC OBJECTIVES

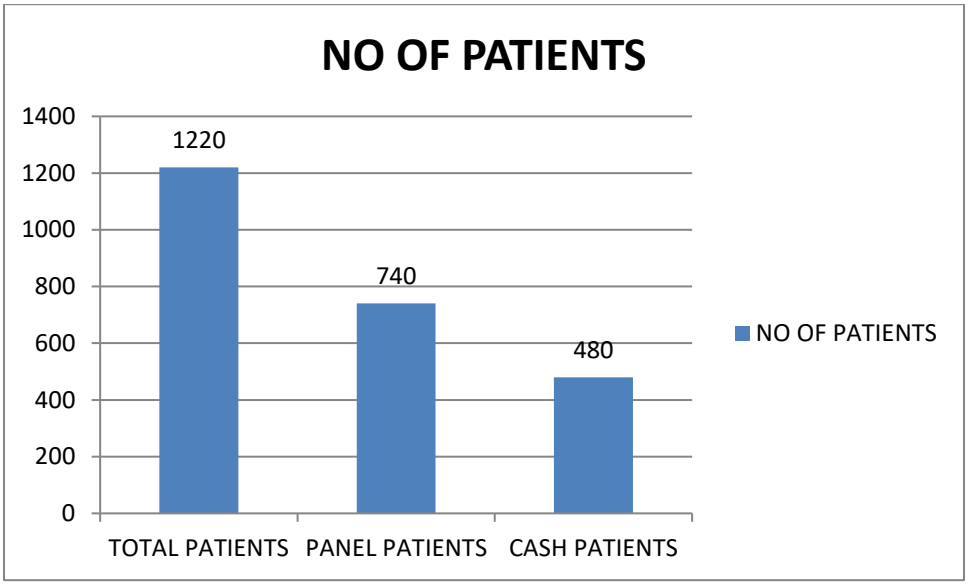
1. Appreciate the role of claims editing in the bill submission process
2. To make recommendations to increase revenue through fast and efficient processing of claims.
3. Make recommendations to improve the process of claim settlement

7.0 RESEARCH METHODOLOGY

Type of study-It is a prospective study conducted over a period of 2 months
Sample Size- 1220 patients
Sampling – Convenience sampling
Data Collection - Data was collected from the billing department by interviewing the relevant staff and reviewing the paperwork. The data used for the present research is primary and secondary in nature and it is used for doing the analytical study.
Duration- 1st February to15th April

8.0 RESULTS AND FINDINGS

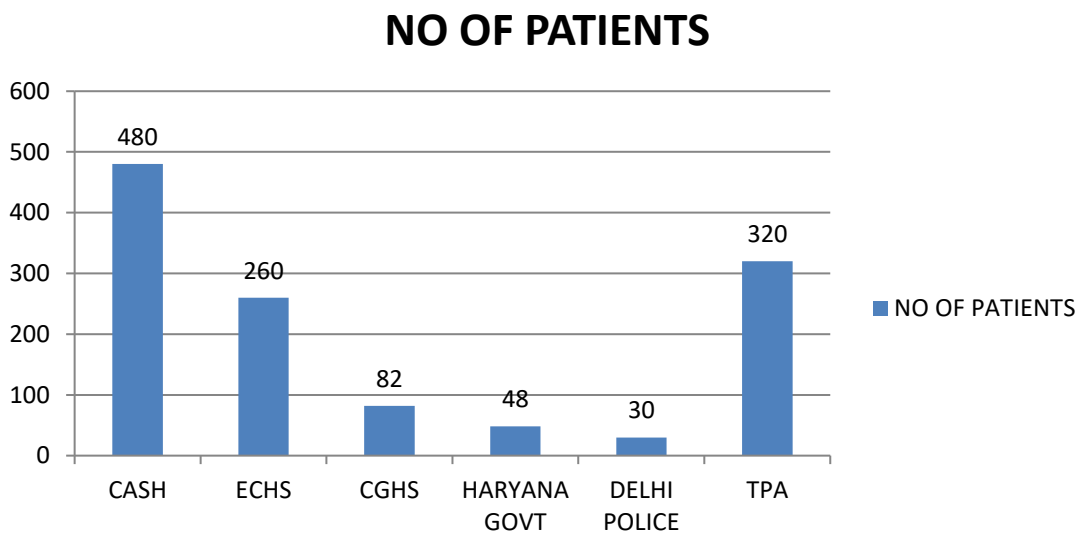
Out of 1220 patients studied 60% of the patients are those patients who have cashless cards either through government panels or from their personal insurance coverage. 40 % of admitted patients paid their bills from out of pocket. The revenue generation of the hospital mainly depends on the cashless treatment.



TOTAL PATIENTS

GRAPH NO 1

Out of total 1220 patients 260 patients admitted from ECHS, 80 from CGHS, 50 from Haryana Government, 30 from Delhi Police, 320 from various TPA's and 480 patients are cash patients. It is evident from the above data analysis that most of the patients are from various panels, ECHS amongst the dominant panel followed by CGHS and rest patients are cash patients who paid their bills out of pocket because of non insurance or rejection of claim by the insurance panel.



CATEGORIZATION OF PATIENTS ACCORDING TO PANELS AND CASH

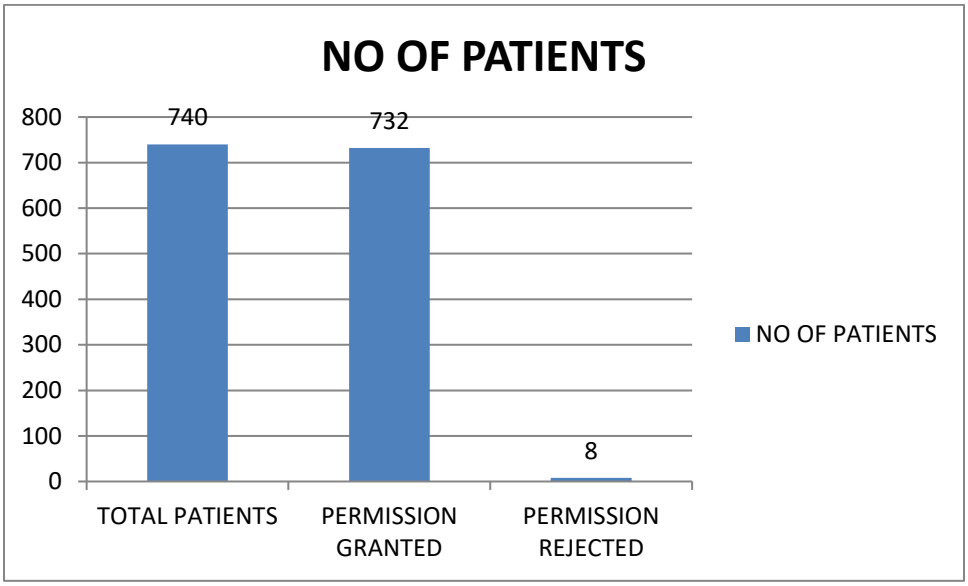
GRAPH NO 2

Out of total 740 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. 60% of the patients admitted in the hospital are through various governmental schemes like ECHS, CGHS and some of the patients were admitted through their personalized insurance. Hospital has to get referral from 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 ECHS if a patient is required more than 12 days of admission then the hospital has to get the further permission 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 get admitted 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.

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.



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

GRAPH NO 3

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).

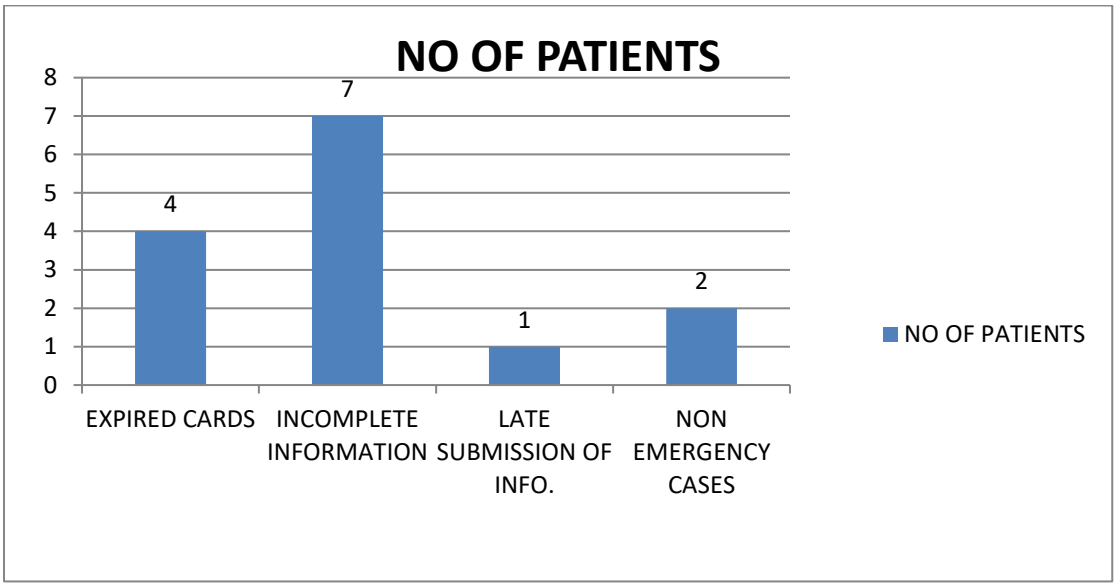
There are various reasons for the denial of the admission of the patient to empanelled hospital. 14 patients have been denied the admission in the hospital on various backgrounds. These are as follows:

1. 4 of the patients have submitted their expired cashless cards to the empanelled hospital.

2. 7 of the 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. 1 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

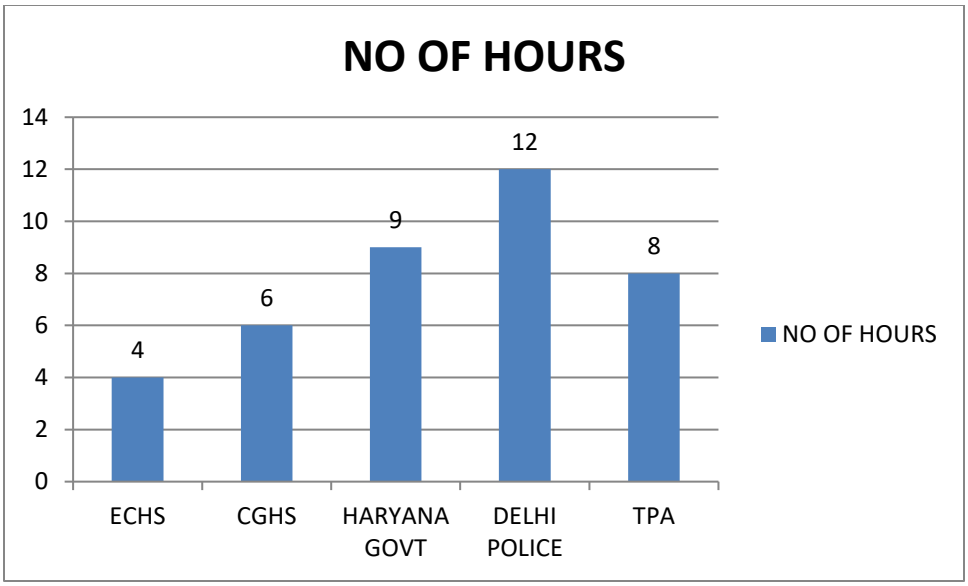
4. 2 of the patients were denied admission because the admission was non emergency case.



REASONS FOR THE DENIAL FOR ADMISSION OF THE PATIENT

GRAPH NO 4

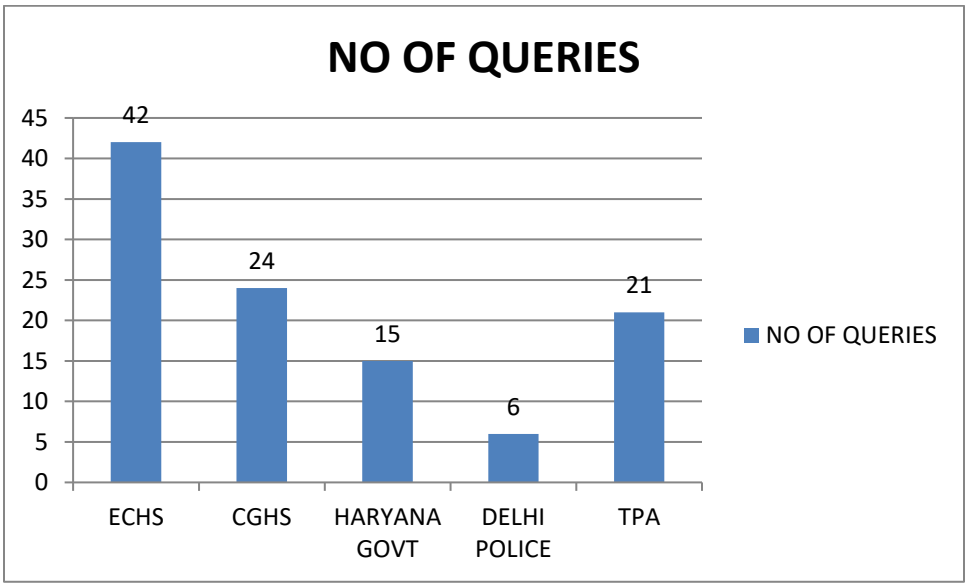
According to the data the time taken by the hospital to get the permission for the admission of the emergency patient is 4 hours for ECHS. This is 6 hours in case of CGHS which is far less than other payers like ECHS and TPA which is due to online intimation the admission of the patient emergency admission 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 6 hours because the intimation and permission process had been done by the empanelled hospital and respective authority manually.



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

GRAPH NO 5

Out of total queries 108 received by the hospital maximum queries 24 has been from CGHS and 42 from ECHS, 21 from various TPA's,15 from Haryana govt.,6 from Delhi police.



NUMBER OF QUERIES RECEIVED BY THE HOSPITAL ACCORDING TO THE PANELS

GRAPH NO 6

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)

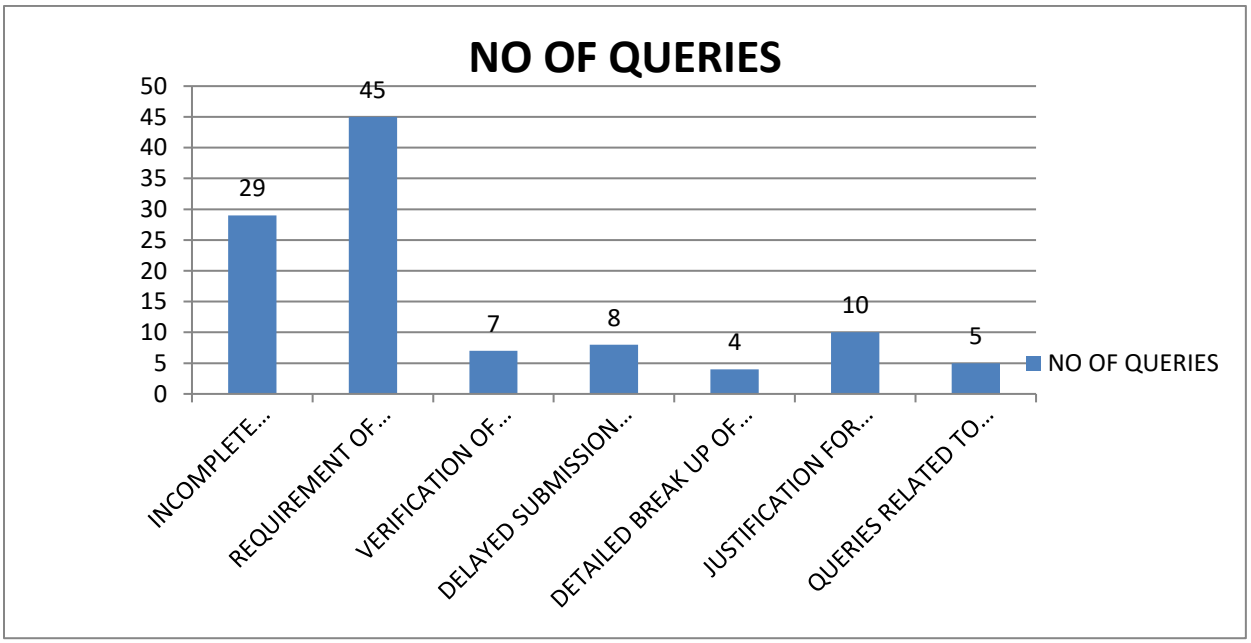
3. Justification for admission in Emergency

4. Verification of insured's dependents

5. Delayed submission of claim

6. Queries related to CGHS Rates billing

7. Detailed break up of final hospital bill



TYPE OF QUERIES RECEIVED FROM PAYERS

GRAPH NO 7

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.

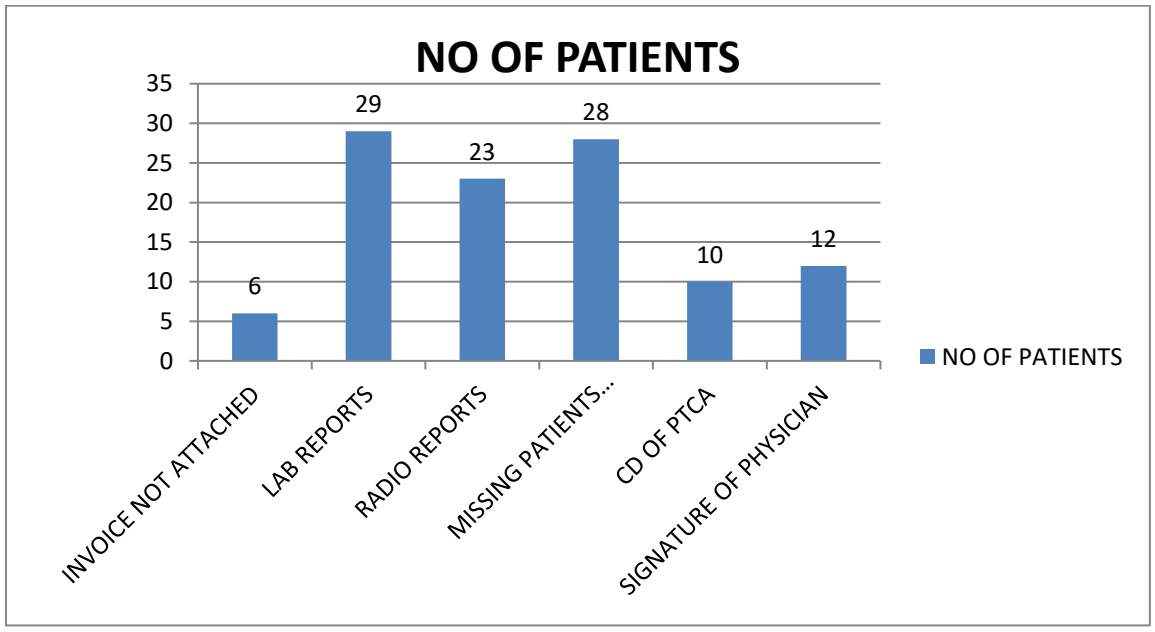
3. Non-availability of radiological examination reports that are significant for the diagnosis of the disease for which patient had receive treatment during hospitalization

4. Missing patient documents

5. CD's which contain recording of the procedure undergone by the patient e.g. CAG,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.



DISTRIBUTION OF QUERIES ACCORDING TO INCOMPLETE DOCUMENTS

GRAPH NO 8

9.0 DISCUSSION

Analysis of the billing and claim processing process shows that most of the queries are avoidable and can easily be rectified if data entry and timely submission of lab and radiology investigations is done. Before sending the claim papers, these should be double checked to reduce chances of error. It should be ensured that discharge summaries, physician's notes, investigation results are attached in the patient's records timely.

Online intimation of claim in all Panels should be done 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 will reduce the claim processing time.

- 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.
- 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 steps for further action should 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.

Proper and quick handling of claims and reimbursement cases can be ensured by proper training of the related staff, setting time limits for all related processes, proper data entry in the system and double checking of all records before being sent to the panel office.

Proper paper work and timely submission of patient records can increase claim settlement and reduce the number of denials from the panels. Proper billing and correct medical records are necessary to ensure quick settlement of claims. Any mistake in the paperwork can lead to denial of claims which will lead to reduction in revenue and loss to the hospital. Manpower training and good HIS can ensure proper record keeping which in turn will reduce the number of unnecessary queries and denials from panels.

10.0 CONCLUSION

This project is a prospective, cross sectional study conducted over a period of 2 months. The aim of the study was to analyze the process of billing and claim process and make suggestions to improve the working of the billing department and increase claim reimbursement of various panels.

An analysis of various types of patients being admitted in the hospital (Cash, TPA, ECHS etc) was done to find out the number and types of patients being admitted in the hospital. Reasons for refusal of admission of the patients was analyzed which may be due to expired cards, incomplete papers etc. Various types of queries received by the billing department from the panels were analyzed and the reasons for the same were recorded.

Time taken for processing of claims by different panels was found out .Reason for queries were ascertained (incomplete records, absence of discharge summaries etc) and steps to reduce these were suggested. Number and types of queries raised by panels were analyzed (absent lab reports, absence of CD of PTCA cases etc).

It was found out that out of these problems maximum were due to human error like non entry of data in the system, late or absent lab reports, incomplete submission of documents by the patients etc. Steps to improve these were suggested like better training of staff, proper counseling of patients at the time of admission ,fixing time limit for various processes like filling of pre –authorization forms of TPA patients, posting of various lab investigations and consumables in the system, proper coding of diseases in patient records, proper billing system with codes for all investigations and procedures.

11. 0 RECOMMENDATIONS

1) Online processing of claims.
2) Understanding the role of coding information in claim generation in healthcare organization. E.g. ICD-9, ICD-10 coding.
3) Proper training of billing and posting staff.
4) Fixing time limit for various processes like filling pre-authorization forms of TPA patients, entry of consumables in the system and delivery of lab and radiology investigation reports etc.

12.0 REFERENCES

http://echs.gov.in/

http://echs.gov.in/images/pdf/med/Med7.pdf

http://echs.gov.in/images/pdf/OBP.pdf

https://www.rakshatpa.com/documents/Raksha_New_Pre-authorization_Form.pdf

echs.gov.in/images/pdf/OBP.pdf

http://uiic.co.in/sites/default/files/uploads/downloadcenter/FAMILYMEDICAREPOLICY.pdf

13.0 APPENDICES

APPENDIX A

(Refers to Para 6 of Central Organization ECHS letter No B/49778/AG/ECHS/PA/Ruling dt 28 Jun 11)

ECHS Membership No ……

APPROVAL FOR UNLISTED PROCEDURE/IMPLANT/TEST AT ECHS EMPANELLED HOSPITAL

PART – I (To be filled by the Empanelled Hospital)

1. Name (Patient)…….2. Relationship with ECHS Member …….

3. No …….. 4. Rank……. 5. Name (Member)……...

6. Hospital……

7. Diagnosis

……

8. Proposed Treatment Procedure/Test/Implants……

9. Estimated Cost (Rs)……. In (words)

10. Case summary including investigation reports attached (Yes/No)…….

11. Remarks ……

12. Date……

13. Signatures & Stamp of Treating Physician/Consultant ……..

PART II – ENDORSEMENT BY OIC POLYCLINIC

14. Received on _____(date) at _____(time) and forwarded to SEMO on _____ at _____.

(OIC Polyclinic)

PART II (To be filled by the SEMO/SMO/PMO/CMO)

15.* APPROVED/NOT APPROVED/FORWARDED FOR APPROVAL TO (competent approving authority)

……

16. Date…….. 17. Place……. 18. Signatures & Stamp of SEMO ……...

(*Strike out whichever is not applicable)

PART III (To be filled by approving authority other than SEMO/SMO/PMO/CMO if applicable)

19.
Remarks……

APPROVED/NOT APPROVED

20. Date …….21. Place ……. 22. Signature with Stamp……

Note:

1. Empanelled Hospitals will forward this form directly to the OIC Polyclinic. Necessary case summary along with investigation reports will be enclosed by the Hospital.

2. SEMO will fwd the case summary & documents directly to the approving authority (if required) with recommendations.

3. In emergencies, the hospital may proceed with the treatment/test/procedure and justify the cause in discharge summary.

APPENDIX B

EX-SERVICEMEN CONTRIBUTORY HEALTH SCHEME

ECHS POLYCLINIC…… (Station)

REFERRAL FORM

Part I

OPD Regn No……Date…… ECHS Card No…….….

Name of patient……..…Age……Relationship with ESM ……. Service No…….…Rank ……..….. Name of ESM……..…….

Brief Clinical Notes

Provisional Diagnosis.....

Vide Referral Serial No …….the above named is referred for

(a) Admission …… (*Specify*)

(b) Investigation …… *(Specify)*

(c) Consultation for……... (Specify)

Referred to …….

(Specify Hospital, Nursing Home, Diagnostic Centre)

Signature of Med

Officer Place:

Dated: (with stamp)

Part 2

SUMMARY OF THE CASE

(To be completed by the empanelled hospital, nursing home, diagnostic centre and consultant)

Clinical Summary/ Investigation Reports (for Diagnostic centers)

Final Diagnosis …….. ICD Code No ……..

Treatment summary

Place: ……. (Signature and Stamp)

Date: ……..

Part 3

Final Disposal

(a) Admission to …… *(Specify Hospital, Nursing*

Home, Diagnostic Centre)

(b) To follow treatment as specified.

Place: Signature of Med Officer

ECHS

Dated: (with stamp)

APPENDIX C

Pre-Authorization form (TPA)

REQUEST FOR CASHLESS HOSPITALISATION FOR MEDICAL INSURANCE POLICY
DETAILS OF THE THIRD PARTY ADMINISTRATOR (To be filled in block letters)

a) Name of TPA / Insurance Company: Raksha TPA Pvt. Ltd./
b) Toll free phone number: 1800 180 1444 , 0129 - 4289999
c) Toll free FAX: 0129 - 4289988
TO BE FILLED BY THE INSURED / PATIENT
a) Name of the Patient:
b) Gender: Male Female c) Age: Years Months d) Contact number:
e) Insured Card ID number: f) Policy Number / Corporate:
g) Employee ID: h) currently do you have any other Mediclaim / Health insurance: Yes No
i. Company Name: ii. Give Details:
ii. Policy No. : iv. Sum Insured:
i) Name of the Family physician: j) Contact number:
TO BE FILLED BY THE TREATING DOCTOR / HOSPITAL
a) Name of the Treating Doctor: b) Contact number:
c) Nature of ILLNESS / Disease with presenting complaints:
_____
d) Relevant Clinical Findings
:_____
_____
e) Duration of the Present ailment: Days I) Date of First Consultation:
II)Past History of Present ailment if any:
_____
_____
f) Provisional diagnosis: _____
I) ICD 10 Code
g) Proposed line of Treatment: Medical Management Surgical Management Intensive care
Investigation Non Allopathic Treatment
h) If Investigation & / or Medical Management Provide
Details:_____
_____
I) Route of drug administration:
_____
_____
i) If Surgical, Name of Surgery :
_____ I) ICD 10 PCS
Code:
j) If Other Treatments provide details:_____ k) How
did injury occur:_____
In case of accident: I) Is it RTA: Yes No II) Date of Injury: III) Reported to Police: Yes No

IV) Injury / Disease caused due to substance abuse / alcohol consumption: Yes No V) Test Conducted to establish this: Yes No (If Yes, attach reports)
l) In case of Maternity: G P L A LMP
Details of patient admitted Mandatory: Past History of any chronic illness
a) Date of admission: b) Time Diabetes
c) Is this an emergency / a planned hospitalization event? Heart Disease
d) Expected no. of days stay in hospital: Days
e) Room Type:
f) Per Day Room Rent + Nursing & Service Charges + Patient's Diet: Rs.
g) Expected cost for Investigation + diagnostics: Rs.
h) ICU Charges: Rs. Cancer, Tumor, Cyst or growth of any kind
i) OT Charges: Rs. Alcohol or drug abuse
j) Professional fees Surgeon +Anesthetist fees+ consultation Charges: Rs.
Any HIV or STD / Related ailments
k) Medicines + Consumables + Cost of Implants (if Applicable please specify)
Epilepsy or Tuberculosis
. Other hospital Expenses if any: Rs.
Any Physical Disability or Disease of Eye
l) All Inclusive package charges if any applicable Rs.
Depression, Mental or psychiatric condition
m) Sum Total expected cost of hospitalization Rs.
Disorder of bones, joints or muscles
Stroke, Anemia, Blood Disorder, Chest Pain
Genito – urinary system, liver disorder, hepatitis
(Including Hepatitis B carrier).
Any Disease or Disorder of Brain & Nervous System, Respiratory system, Digestive system or Circulatory system.
At any Stage During the past 5 years, have you either been prescribed medication (other than for cold or flu) or received medical treatment/advice on a regular basis. Details
_____
_____
Any other ailments –Details:

DECLARATION (PLEASE READ VERY CAREFULLY)
We confirm having read understood and agreed to the Declarations on the reverse of this form
a) Name of treating doctor:
b) Qualification: c) Registration No. With State Code:
Signature of treating doctor Hospital Seal (Must include Hospital ID) Patient / Insured Name &

Signature: