

# Enhancing Medical Claim Approval Efficiency and Patient Satisfaction: An In-Depth Analysis of Third-Party Administrator (TPA) Rejections at Tertiary Care Hospital

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## Abstract

**Background:** Cashless medical claim denials by Third-Party Administrators (TPAs) can lead to financial burdens and dissatisfaction among patients.

**Objective:** To analyze TPA rejections at a tertiary care hospital, identify factors contributing to cashless denials, and suggest measures to enhance claim approval efficiency and patient satisfaction.

**Methods:** The data for this study was collected through a retrospective approach from a period of March 2023 to December 2023. The dataset included information related to Mediclaim claim rejections, patient details, comments from TPAs, discharge notes, and hospital remarks.

**Results:** The study revealed a 25% cashless denial rate, primarily due to inadequate documentation, 40% followed by TPA response time delays and claim type discrepancies and (35%). Disease categories with highest denial rates were identified.

**Conclusion:** The pivotal role played by Third-Party Administrators (TPAs) in facilitating the smooth disbursement of mediclaims and contributing significantly to the hospital's revenue stream was evident. However, the study revealed that despite the critical role of TPAs, a considerable number of mediclaim rejections were occurring, leading to conflicts between the hospital, patients, and their families.

**Keyword:** Mediclaim; TPA; Claim; Denial; Revenue.

## INTRODUCTION

In the complex landscape of modern healthcare, the relationship between hospitals, Third-Party Administrators (TPAs), and the insurance industry plays a pivotal role in ensuring efficient patient

care, streamlined revenue cycles, and overall satisfaction for patients and healthcare providers. This intricate interplay between these entities has far-reaching implications for both the financial viability of healthcare institutions and the quality of care delivered to patients. Hospitals and TPAs: Hospitals are not just places for medical treatment; they are also intricate financial entities with diverse revenue streams. A substantial portion of a hospital's revenue often hinges on patients who are covered under various insurance schemes. These insured patients, whether under private insurance policies or state-sponsored government schemes, are required to file medical claims with TPAs when seeking healthcare services at hospitals. TPAs, or Third-Party Administrators, act as indispensable intermediaries in this process. Their role extends

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far beyond mere paperwork; they are entrusted with a wide array of responsibilities, including documentation, verification, claim adjudication, and numerous other tasks essential for the seamless management of medical claims. TPAs serve as the liaison between the insurance company, the healthcare provider (the hospital), and the patient, ensuring that the claims process is executed smoothly and efficiently.

**The Role of TPAs:**

- 1. Documentation and Verification:** TPAs are responsible for collecting, reviewing, and verifying the documentation submitted by patients for medical claims. This documentation includes medical records, bills, and other necessary paperwork.
- 2. Claim Adjudication:** TPAs assess the validity of claims based on policy terms, medical necessity, and other criteria. They determine whether a claim should be approved, partially approved, or denied.
- 3. Financial Intermediaries:** TPAs handle financial transactions related to medical claims. They facilitate payments from insurance companies to hospitals and, in some cases, reimburse patients for their medical expenses.
- 4. Communication Hub:** TPAs facilitate communication between the hospital and the insurance company. They ensure that the necessary information is exchanged promptly to expedite the claims process.
- 5. Patient Advocacy:** TPAs also serve as advocates for patients. They assist patients in understanding their insurance policies, coverage limitations, and the claims process, helping them navigate complex healthcare systems.

#### Some prominent TPAs are:

- 1. Medi Assist India TPA Pvt. Ltd.:** Medi Assist is one of India's leading TPAs, specializing in health insurance claims processing and related services.
- 2. Paramount Health Services and Insurance TPA Pvt. Ltd.:** Paramount Health Services is a prominent TPA known for its expertise in claims administration and healthcare management.
- 3. Vidal Health TPA Pvt. Ltd.:** Vidal Health is a trusted TPA in India that offers a range of healthcare management solutions, including claim processing.
- 4. MD India Healthcare Services (TPA) Pvt. Ltd.:** MD India Healthcare Services is a well-established TPA with a strong presence in the health insurance sector.
- 5. FHPL (Family Health Plan Insurance TPA Limited):** FHPL is a leading TPA that provides

a wide range of healthcare services, including claims processing and network management.

- 6. Raksha TPA Pvt. Ltd.:** Raksha TPA is known for its efficient claims processing services and is a recognized name in the industry.
- 7. Vipul MedCorp TPA Pvt. Ltd.:** Vipul MedCorp is a TPA that offers comprehensive healthcare services, including claims management and assistance to policyholders.
- 8. Heritage Health TPA Pvt. Ltd.:** Heritage Health TPA is known for its commitment to quality healthcare services and efficient claims processing.
- 9. Chola MS General Insurance TPA Pvt. Ltd.:** Chola MS is a well-known TPA that provides healthcare solutions, including claims management, for various insurance companies.
- 10. ICICI Lombard Health Care:** ICICI Lombard offers TPA services in addition to its insurance offerings, specializing in claims processing and customer support.
- 11. Reliance General Insurance Company Ltd.:** Reliance General Insurance also provides TPA services, including claims adjudication, as part of its insurance offerings.
- 12. Bajaj Allianz General Insurance Company:** Bajaj Allianz, a prominent insurance company, offers TPA services for efficient claims processing and customer support.

#### Processes Followed by TPAs in Hospitals:

TPAs play a critical role in the claims management process within hospitals. Here are the key processes they follow:

- 1. Documentation Verification:** TPAs collect and verify all the necessary documentation from patients. This includes medical records, bills, prescriptions, and other relevant documents to substantiate the claim.
- 2. Claim Adjudication:** TPAs assess the validity of claims based on the terms and conditions of the insurance policy. They determine whether the treatment is covered, medically necessary, and compliant with the policy guidelines.
- 3. Financial Transactions:** TPAs handle financial transactions related to claims. They coordinate the payment process, ensuring that hospitals are reimbursed for their services and that patients receive their entitled benefits.

4. **Communication:** TPAs facilitate communication between the hospital, the insurance company, and the patient. They ensure that all parties are informed about the progress of the claim and any additional information required.
5. **Claim Settlement:** TPAs assist in settling claims promptly and accurately. They calculate the amount to be paid to the hospital and coordinate the payment from the insurance company.

4. **Late submission of claim documents:** If a patient does not submit the documents within the stipulated period, their claim may be denied.
5. **Fraudulent claims:** If the insurance company finds a patient has made any fraudulent claim, it can deny it.
6. **Lapse of policy:** If a patient's health insurance policy lapses due to non-payment of premium, their claims will not be honored.

**Claim rejection:**

Health insurance claims rejection refers to the situation where an insurance company or Third Party Administrator (TPA) denies or refuses to pay a medical expense that a policyholder or patient has submitted for reimbursement or coverage. Health insurance claims in India can be denied, according to the Insurance Regulatory and Development Authority of India (IRDAI):

1. **Non-disclosure of pre-existing diseases:** If you do not disclose any pre-existing diseases you have when taking the health insurance policy, your claim to treat these diseases can be denied.
2. **Waiting period:** Most health insurance policies have a waiting period for certain diseases. This means you will not be covered for these diseases until the waiting period ends.
3. **Claims made outside the policy terms and conditions:** If a patient makes a claim not covered by their health insurance policy, it will be denied.

**Additional reasons why health insurance claims can be denied in India:**

1. **Treatment received at a non-network hospital:** If a patient is admitted to a hospital not in their health insurance network, their claim may be denied.
2. **Treatment not authorised by the insurance company:** If a patient does not get prior authorisation from the insurance company for a certain treatment, their claim may be denied.
3. **Claims for experimental or cosmetic treatments:** Health insurance policies typically do not cover experimental or cosmetic treatments
4. **Claims for pre-existing diseases after the waiting period is over:** Even after it is over, a patient's health insurance policy may not cover pre-existing diseases if they have worsened.

Insurance Company	Network Hospitals	Claim Settlement Ratio for year 2022-23	Incurred Claim Ratio
Edelweiss General Claim Settlement Ratio (CSR)	Over 2,578	85.57%	113.05%
Star Health and Allied Claim Settlement Ratio (CSR)	Over 9,900	78.62%	65.91%
Kotak Mahindra Claim Settlement Ratio (CSR)	Over 4,000	96.38%	49.22%
HDFC ERGO Claim Settlement Ratio (CSR)	Over 10,000	86.52%	73.69%
IFFCO Tokio Claim Settlement Ratio (CSR)	Over 5,000	96.33%	95.66%
ICICI Lombard Claim Settlement Ratio (CSR)	Over 5,025	99.98%	81.96%
Bajaj Allianz Claim Settlement Ratio (CSR)	Over 6,500	92.24%	89.36%
Care Health Claim Settlement Ratio (CSR)	Over 8,250	92.83%	103.30%
Reliance General Claim Settlement Ratio (CSR)	Over 7,300	96.93%	69.90%

**Payment to TPAs:**

Third-Party Administrators (TPAs) are typically paid by the insurance companies or health plans that contract their services. Insurance companies hire TPAs to handle various administrative tasks, including claims processing, on their behalf. The fees or compensation for TPAs are usually negotiated between the insurance company and the TPA. The payment structure can vary, but it often includes a fee for each claim processed or a fixed annual fee.

In essence, the smooth functioning of both the medi claim process and the TPA department is a prerequisite for the fluid operations of hospitals. The revenue generated from insured patients is vital for sustaining healthcare institutions, making the collaboration between hospitals, TPAs, and the insurance industry an integral part of the healthcare ecosystem. Any disruptions or inefficiencies in this interplay can lead to delayed responses, conflicts, and a less than optimal patient experience. Therefore, understanding, analyzing, and optimizing the roles of TPAs, alongside the broader insurance industry dynamics, is essential for the financial health and patient satisfaction of hospitals.

**OBJECTIVES**

1. **Identify Reasons for Claim Rejections:** The primary objective of this study is to identify the reasons behind the rejection of mediclaim claims processed by various Third-Party Administrators (TPAs) in the hospital.
2. **Categorize Rejection Reasons:** To categorize the identified rejection reasons into broader thematic groups, facilitating a comprehensive understanding of the underlying causes.
3. **Prioritize Rejection Themes:** Prioritize rejection themes by analyzing the frequency of appearance, focusing on the most prevalent reasons that contribute to the majority of claim rejections.
4. **Develop Recommendations:** Formulate practical recommendations for addressing the identified rejection themes, both at the hospital and TPA levels, to minimize claim rejections and improve the mediclaim process's efficiency.

**METHODOLOGY**

The data for this study was collected through a retrospective approach from March 2023 to December 2023. The dataset included information

related to Mediclaim claim rejections, patient details, comments from TPAs, discharge notes, and hospital remarks.

**1. Data Cleaning and Organization:**

- **Data Cleaning:** Clean the dataset by addressing missing values, inconsistencies, and errors. This step is crucial for ensuring the dataset's quality and reliability.
- **Data Organization:** Organize the cleaned dataset into relevant headings and categories to create a structured and easily navigable dataset for analysis.

**2. Thematic Analysis:**

- **Identification of Reasons:** Conduct a thematic analysis of the dataset to identify the reasons for mediclaim claim rejections. This involves reviewing each rejection case and categorizing them based on common themes.
- **Categorization into Broad Themes:** Categorize the identified reasons into broader thematic groups. This step helps in creating a comprehensive understanding of the rejection landscape.

**3. Frequency Analysis:**

- **Counting Reason Frequencies:** Count the frequency of each identified reason for rejection within the dataset. This analysis highlights which rejection themes are more prevalent.

**4. Pareto Analysis:**

- **Prioritization of Themes:** Use Pareto analysis to prioritize rejection themes. Identify the top 20% of themes that contribute to 80% of the claim rejections. This step helps in focusing on the most critical issues.

**5. TPA-Wise Analysis:**

- **Analysis by TPA Companies:** Conduct a detailed analysis of claim rejections specific to each TPA company operating within the hospital's network. Determine which TPAs have the highest number of claim rejections.
- **High Alert Companies:** Identify TPAs with a larger share in claim rejection proportion. Earmark these TPAs as high-alert companies, requiring careful handling from an operational perspective.



## OBSERVATIONS & FINDINGS

**Reasons for Rejection:** Through meticulous data cleaning and analysis, 350 distinct reasons for mediclaim rejection were identified. These reasons ranged from administrative discrepancies to documentation errors.

**Categorization into Broad Themes:** The identified reasons were further categorized into 22 broad themes, providing a structured framework to understand rejection patterns. This categorization aided in simplifying the complex data.

**Priority Themes:** Employing Pareto analysis, it became apparent that a subset of themes accounted for the majority of claim rejections. Identifying these priority themes allows for focused improvement efforts.

**Pareto Analysis Visualization:** A Pareto Chart was generated to visually highlight the priority themes, making it easier to grasp the critical areas that need immediate attention.

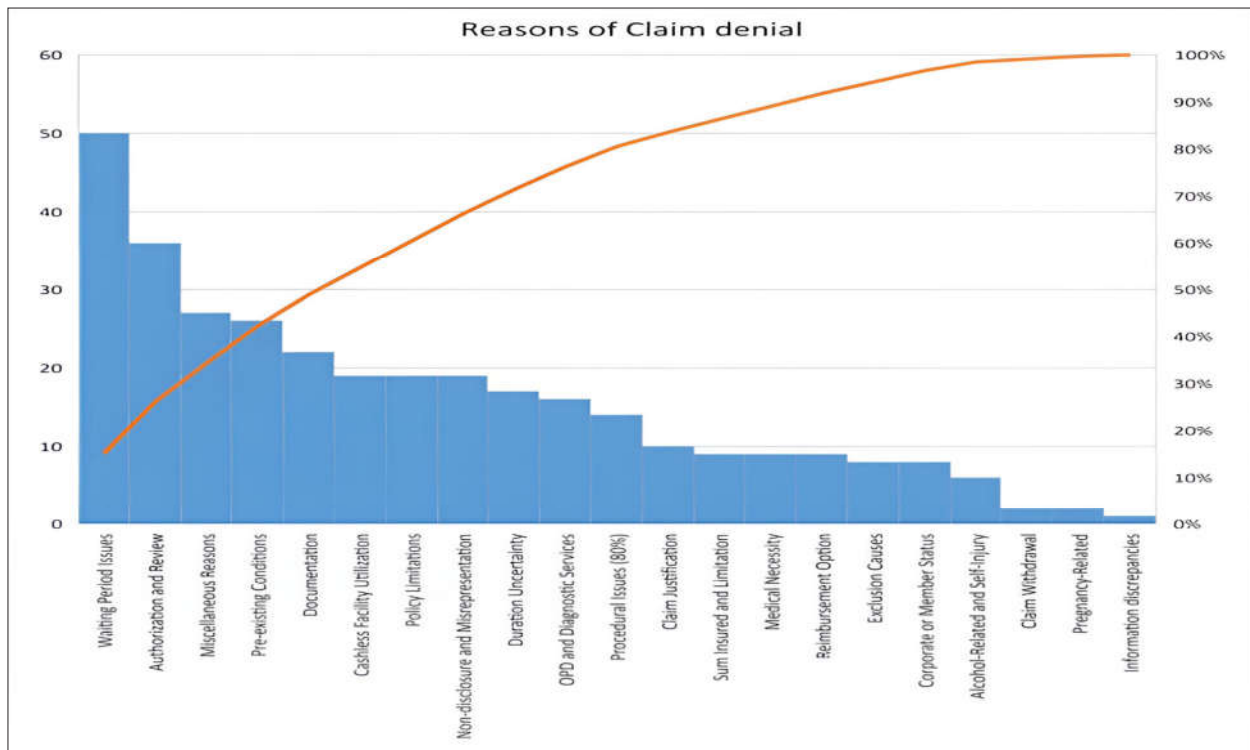
**TPA-specific Analysis:** The analysis at the TPA level revealed variations in claim rejection frequencies among different TPA companies. Some TPAs had notably higher rejection rates, necessitating their categorization as high-alert companies.

**High-Alert TPAs:** Six TPAs were identified as high-alert due to their significant contribution to claim rejections. These TPAs require tailored strategies for claim management and patient satisfaction.

**Sub-Segmentation of Themes:** Sub-segmentation at the TPA level allowed for a deeper understanding of rejection themes within each TPA company. This fine-grained analysis provides practical insights for crafting TPA-specific recommendations.

**Table 1:** Major identified themes with frequency

Themes	Count	Cumulative frequency
Waiting Period Issues	50	50
Authorization and Review	36	86
Miscellaneous Reasons	27	113
Pre-existing Conditions	26	139
Documentation	22	161
Cashless Facility Utilization	19	180
Policy Limitations	19	199
Non-disclosure and Misrepresentation	19	218
Duration Uncertainty	17	235
OPD and Diagnostic Services	16	251
Procedural Issues (80%)	14	265
Claim Justification	10	275



**Fig. 1:** Pareto chart showing themes of rejections

*Explanation of Themes*

- **Waiting Period Issues:** This theme likely relates to claims being rejected due to patients seeking coverage for conditions or treatments that fall within a waiting period stipulated by their insurance policy. Many policies have waiting periods during which certain conditions or treatments are not covered.
- **Authorization and Review:** This theme suggests that some claims may be rejected because they lack proper authorization or have not undergone the necessary review process by the insurance company or TPA.
- **Miscellaneous Reasons:** This category likely encompasses a range of diverse and less common reasons for claim rejections that don't fit neatly into other predefined categories.
- **Pre-existing Conditions:** Claims under this theme may be rejected when patients seek coverage for conditions that were pre-existing, meaning they existed before the insurance policy's effective date.
- **Documentation:** Claims in this category might have been rejected due to insufficient or inaccurate documentation provided by the patient or healthcare provider. Proper documentation is crucial for claim approval.
- **Cashless Facility Utilization:** This theme suggests that claims related to cashless facility utilization may face issues, possibly due to discrepancies in the utilization process.
- **Policy Limitations:** Claims may be rejected if they exceed the policy's coverage limitations or if the treatment or condition is not covered under the policy.
- **Non-disclosure and Misrepresentation:** This category could involve claims that were rejected because the patient failed to disclose relevant information during the policy application or misrepresented facts.
- **Duration Uncertainty:** Claims under this theme might be related to uncertainty or ambiguity regarding the duration of treatment or recovery, which can affect claim approval.
- **OPD and Diagnostic Services:** Claims related to outpatient department (OPD) services and diagnostic tests may face specific challenges or requirements leading to rejections.
- **Procedural Issues:** This theme, with a high

percentage, indicates that a substantial number of claims were rejected due to procedural issues. These could involve errors or omissions in the claim filing process.

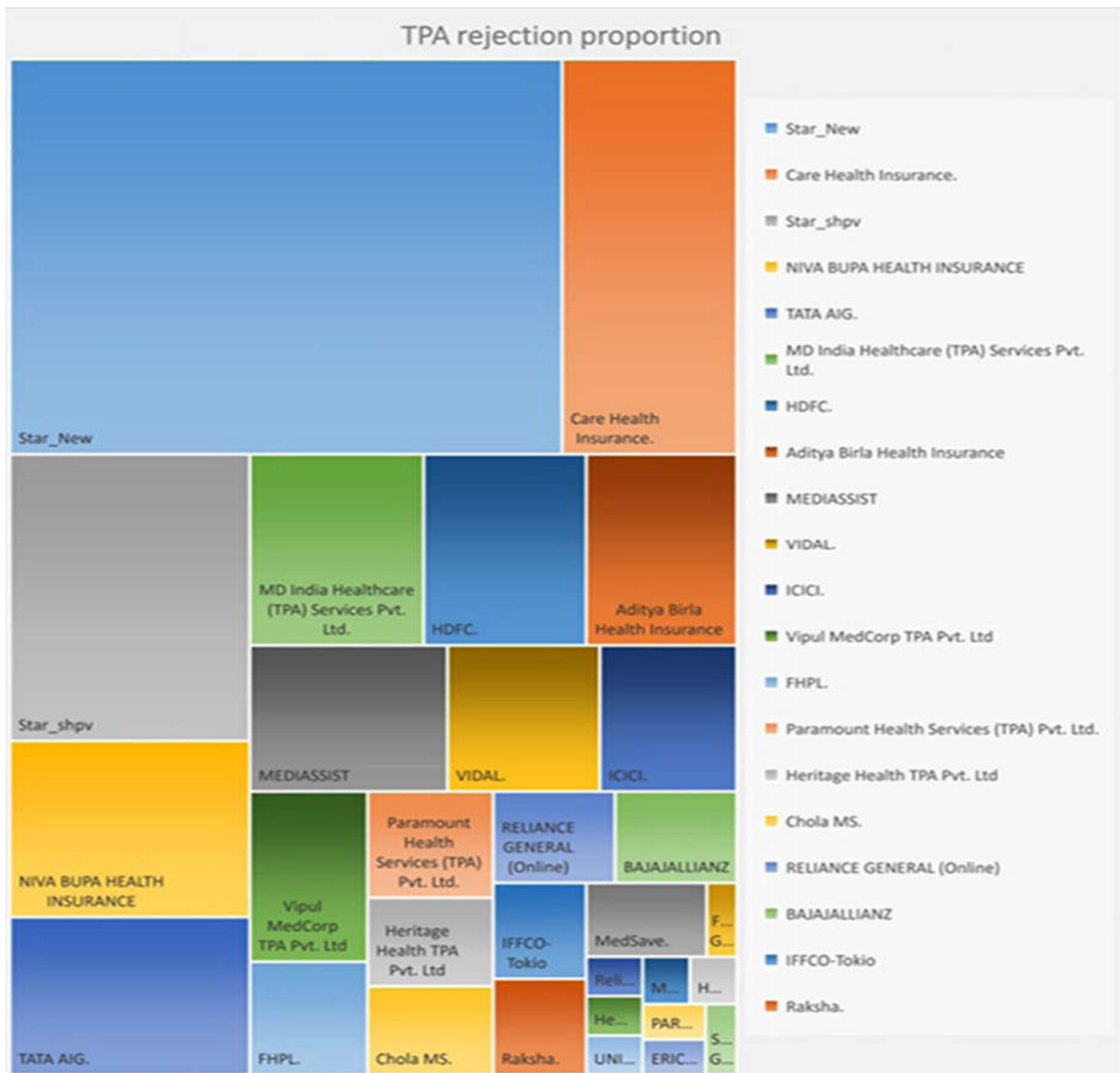
- **Claim Justification:** Some claims may require additional justification or documentation to demonstrate the medical necessity or appropriateness of the treatment.
- **Sum Insured and Limitation:** Rejections under this theme could be tied to claims that exceed the sum insured or coverage limitations defined in the policy.
- **Medical Necessity:** Claims may be rejected if the insurance company or TPA deems the treatment or procedure as not medically necessary or justified.
- **Reimbursement Option:** This theme may involve claims for which patients opted for reimbursement rather than cashless treatment, leading to specific considerations or requirements.
- **Exclusion Causes:** Claims related to conditions or treatments explicitly excluded from coverage in the policy may be rejected.
- **Corporate or Member Status:** Some claims may be tied to the corporate or membership status of the insured individual, leading to specific processing requirements.
- **Alcohol-Related and Self-Injury:** Claims associated with injuries or conditions resulting from alcohol use or self-inflicted injuries may be subject to special scrutiny.
- **Claim Withdrawal:** Patients may withdraw their claims for various reasons, and these instances might be categorized under this theme.
- **Pregnancy-Related:** Claims related to pregnancy and maternity care may have unique considerations and requirements.
- **Information discrepancies:** Claims with discrepancies or inconsistencies in the information provided may be subject to rejection until these issues are resolved.

**Table 2:** TPA Wise Distribution

Payer TPA	TPA account
Star New	98
Care Health Insurance	31
Star SHPV	31

*Table Cont...*

Niva Bupa Health Insurance	19	Bajaj Allianz	5
TATA AIG	17	IFFCO-Tokio	4
MD India Healthcare (TPA) Services Pvt. Ltd.	15	Raksha	4
HDFC	14	MedSave	4
Aditya Birla Health Insurance	13	Future Generali	1
Mediassist	13	Reliance General Insurance Company Ltd.	1
Vidal	10	Health India TPA	1
ICICI	9	Universal Sompo General Insurance Company	1
Vipul MedCorp TPA Pvt. Ltd	9	Medvantage Insurance TPA Private Limited	1
FHPL	6	Health Insurance TPA India Ltd.	1
Paramount Health Services (TPA) Pvt. Ltd.	6	Paramount Health (Online)	1
Heritage Health TPA Pvt. Ltd.	5	Ericson TPA healthcare Pvt. Ltd.	1
Chola MS.	5	SBI General Insurance	1
Reliance General (Online)	5		



## CONCLUSION

In conclusion, this study delved into the complex landscape of mediclaim processing within the context of a prominent hospital, Bombay Hospital. The pivotal role played by Third-Party Administrators (TPAs) in facilitating the smooth disbursement of mediclaims and contributing significantly to the hospital's revenue stream was evident. However, the study revealed that despite the critical role of TPAs, a considerable number of mediclaim rejections were occurring, leading to conflicts between the hospital, patients, and their families.

The primary objective of this study was to identify the reasons behind these rejections and categorize them into thematic areas through a meticulous analysis of retrospective data, comments from TPAs, discharge notes, and hospital remarks. Through this analysis, we successfully identified 22 broad themes encompassing various rejection reasons.

The findings highlighted several key areas that required attention to reduce the rejection ratio effectively. These included issues related to waiting periods, authorization and review processes, documentation, pre-existing conditions, and policy limitations. Additionally, non-disclosure and misrepresentation, duration uncertainty, procedural issues, claim justification, and medical necessity also played significant roles in claim rejections.

The study further scrutinized TPA-wise rejection patterns, pinpointing high-alert TPA companies with a higher share of claim rejections. This knowledge enabled the hospital to focus on addressing issues related to these specific TPAs more diligently, ultimately improving operational efficiency.

To complement the data-driven analysis, the study included questionnaires for hospital staff and TPA desk staff. These questionnaires unveiled practical insights into the delay in discharges, common medical process errors, denial reasons from the TPA end, and queries and documents requested from patients filing mediclaim.

Based on the comprehensive analysis and feedback received from stakeholders, a set of recommendations and actionable measures were

formulated to minimize claim rejections. These recommendations spanned the entire process, from policy verification and documentation to fraud detection and customer service, ensuring a more seamless and patient-centric mediclaim experience.

Furthermore, the study emphasized the importance of patient education and awareness by developing a detailed checklist for insured patients to review their policy criteria before admission, minimizing the risk of rejection. Similarly, guidelines were formulated for hospital staff to ensure adherence to industry recognized clinical pathways and prevent potential fraud suspicions.

In sum, this study offers a valuable roadmap for Bombay Hospital and similar healthcare institutions to enhance their mediclaim processing efficiency, reduce claim rejections, improve patient satisfaction, and bolster revenue cycles. By addressing the identified issues and implementing the recommended measures, the hospital can strive for a future where mediclaim processing becomes a seamless and conflict-free process for all stakeholders involved.

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