

CHAPTER - 03

EVALUATION OF TURNAROUND TIME OF REIMBURSEMENT CLAIM PROCESSING

¹Garvit Gupta

¹Student, IIHMR University

²Dr. Vinod Kumar SV

²Professor, IIHMR University

Ch.Id:- IIHMR/NSP/EB/TSLHSTIOE/2025/Ch-03

DOI: <https://doi.org/10.52458/9789349381452.nsp.2025.eb.ch-3>

INTRODUCTION

Claims processing is a standard procedure involving various components aimed at delivering prompt and efficient customer service. The primary goal is to address issues raised by the client or a third party in accordance with the terms and conditions of the agreement at minimal cost. In cases of complex situations, immediate action from the consumer is crucial. While health insurance may appear as just another paperwork, it has proven to be a lifesaver during medical emergencies, shielding subscribers from potential financial ruin due to exorbitant medical expenses. However, possessing basic knowledge about insurance does not automatically translate into purchasing a plan. It is essential to educate the general public about newer, more cost-effective government-led programs tailored to their financial needs [2].

A study highlights the challenges faced by insurance companies due to systemic errors and provides recommendations

for addressing these issues to reduce claims turnaround time. An informative article outlines the processes involved in insurance claims, covering both cashless and reimbursement, out-of-house, and in-house claims. According to a breakdown of reimbursements, more than one-third of reimbursements are allocated for medical expenses, with diagnostic costs comprising approximately one-fourth of the total. The success of insurance businesses, regardless of their size, hinges on effective claims management. Developing strategies to minimize expenses and fraud while maintaining customer satisfaction is crucial in the claims processing arena. Leveraging technology and claims management solutions can greatly benefit small businesses in streamlining their operations [1,3].

RESEARCH OBJECTIVES

1. To document the process of reimbursement claims within health insurance.
2. To examine the turnaround time for settling reimbursement claims.
3. To pinpoint the challenges and discrepancies present in the reimbursement claims process.

RESEARCH METHODOLOGY

This investigation was conducted at Aditya Birla Health Insurance Private Limited. The study also involved collecting secondary data, followed by an analysis of the Turnaround Time (TAT) and the implementation of improvements to standard operating procedures. The secondary data was obtained over a three-month period. Following the protocols and reviewing the TAT, considering the perspectives of stakeholders for process improvement, their commitment to efficient processing, and

analysis of the gathered information was completed. A simple quantitative random sampling technique was employed to ensure unbiased results from the study. For the reimbursement process, 3444 claims were randomly selected, out of which 2484 were approved, 363 were denied, and 597 were under query.

RESULTS & DISCUSSION

Based on the survey conducted during the data collection period from April 15, 2022, to May 31, 2020, with a sample size of 3444 cases, it was found that 2484 cases were approved, 363 cases were denied, and 597 cases were revoked, in accordance with IRDA policies. The main objective of the refined procedures was to streamline the process flow to achieve optimal efficiency, effectiveness, and customer satisfaction. The aim was to scrutinize the process, identify loopholes/gaps, and areas for process enhancement by eliminating unnecessary manual effort and reducing the turnaround time (TAT).

Recommendations/suggestions for the same were proposed and incorporated into the claims process at Aditya Birla Health Insurance. During the reimbursement process, 72% of cases were approved. Out of the 3444 records reviewed, 2484 cases were approved, indicating the completion of the final processing of the claims. Additionally, during the audit, 17% of cases were queried. A total of 597 cases out of 3444 were queried due to non-disclosure or suspicion of fraud and were referred to the FWA (Fraud, Waste, and Abuse) team for investigation. Furthermore, within the 30-minute timeframe, 11% of cases were denied. A total of 363 instances were denied out of 3444 cases due to the discovery of non-disclosure or fraud.

CONCLUSION

Settlement of protection claims is just one aspect of the claims management process. The duration of processing a claim is divided into various stages, starting with an individual filing a claim. Subsequent stages determine the validity of a claim and the amount the insurance company will reimburse. Customers expect insurance companies to resolve disputes quickly and fairly. As high levels of customer satisfaction can provide a competitive advantage to a company, reducing the time required to settle insurance claims is one approach to decrease the number of customer complaints and enhance services. One specific approach is the utilization of claims management system software, which expedites the process and reduces costs. Streamlining the claims process through automation helps insurance firms conserve resources.

REFERENCES

1. Ekman, B., Liem, N. T., Duc, H. A., & Axelson, H. (2008). *Health insurance reform in Vietnam: a review of recent developments and future challenges*. *Health policy and planning*, 23(4), 252-263.
2. Shukla, K., & Upadhyay, S. (2018). *Predictive modelling for turnaround time (TAT) of discharge process for insured patients in a corporate hospital of Pune city*. *Journal of Health Management*, 20(1), 56-63.
3. Bhat, R., & Reuben, E. B. (2002). *Management of claims and reimbursements: The case of mediclaim insurance policy*. *Vikalpa*, 27(4), 15-28.