STRATEGIC INITIATIVES TO ENHANCE THE OVERALL EFFICIENCY OF CLAIM RESUBMISSION PROCESS AT THUMBAY UNIVERSITY HOSPITAL, AJMAN, UAE

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INTRODUCTION

Thumbay University Hospital has established affiliations with over 34 insurance companies and works in partnership with 15 third-party administrator (TPA) companies. Among the 34 insurance providers, a significant portion has maintained a longstanding cooperative relationship with the hospital. Patients utilizing their insurance company cards receive services and treatment in accordance with the policies and benefits outlined by their respective insurance providers. While many insurance companies facilitate prompt approvals, a noteworthy number frequently issue denials and subsequent rejections. Within the hospital, the insurance company's operational process involves seven key steps: patient registration, verification, submission, collection, reconciliation, resubmission, and sign-off [1,2].

The concept of insurance fundamentally revolves around providing security. Insurance serves as a shield against risks and unforeseen circumstances. In general, Indians tend to be risk-averse and prefer not to take unnecessary chances. Insurance acts as an effective risk management tool that can safeguard individuals and businesses from financial risks arising from various uncertainties. While personal and emotional losses may not be compensated, insurance can mitigate the financial losses associated with such uncertainties. Although life is characterized by inherent uncertainties, insurance undoubtedly helps manage the financial risks associated with unforeseen events [3].

RESEARCH OBJECTIVES

1. To examine claims resubmissions recorded between January 1, 2021, and January 1, 2022.
2. To gain insights into the healthcare insurance framework, particularly from the perspective of claim resubmissions, across Thumbay Group facilities.
3. To analyze the significant reasons behind rejections in the fully/partly rejected category of claim resubmissions at Thumbay Group facilities.

4. To implement strategies to reduce the overall incidence of billing rejections issued by affiliated insurance companies at Thumbay Group facilities.

RESEARCH METHODOLOGY

The study design employed was a non-interventional, descriptive study utilizing a survey approach. The dataset consisted of information from 45,806 patients obtained from the Hospital Information System, focusing on all insured patients. Inclusion criteria encompassed all insured patients, while non-insured patients were excluded as part of the exclusion criteria. Primary data collection involved the completion of questionnaires by all members of the Insurance department at Thumbay University Hospital. The tools utilized for this purpose were Google Form and MS Excel. The Google Form, comprising a set of 12 questions, was distributed to the insurance department members for completion. Additionally, secondary data was sourced from the Business Intelligence Oracle software. For data analysis, descriptive statistical techniques were applied with the assistance of Pivot Tables, Pie charts, Bar charts, and Column charts to comprehensively analyze the collected data.

RESULTS & DISCUSSION

Ensuring proper coding and verification of primary and secondary diagnoses at the initial stage was emphasized. The upgrade of claim management software and enhancement of employees' skill sets were recommended. Simplification of the claim's resubmission step in the entire process was identified as crucial to save overall time, considering it as the most time-consuming step in the process. Suggested changes included a critical analysis of incorrect billing practices, improvement of patient data quality and quantification, and tracking possible denial reasons to minimize claims rejections. The top challenges observed were billing errors, incorrect insurance information, and incorrect patient details, collectively contributing to 50% of daily claims rejections, which were considered controllable. In terms of patient types, inpatient (IP) patients faced the highest volume of fully and partially rejected claims, followed by outpatient (OP) patients, as they are 100% eligible for claims reimbursement or coverage. Out of the total partially

rejected claims (39,406), 50% of rejections were attributed to calculation discrepancies, co-pay not collected, and discounts discrepancies. The remaining 50% had various reasons subject to claims policy norms and regulations.

The top reasons for rejections were identified as calculation discrepancies, co-pay not collected, and patients not covered. It was emphasized that these reasons could be mitigated at the front end through critical observation of each parameter related to the patient and calculations. Among all 12 facilities, Thumbay Clinic, Thumbay Hospital Ajman, and Thumbay University Hospital reported the highest claim rejections, potentially influenced by the highest patient footfalls. These findings were based on responses from 20 participants, considering a total of 45,806 claims about rejections across all 12 facilities.

CONCLUSION

Based on the analysis and survey findings, there is a necessity to enhance the general quality of patient data, aiming to decrease instances of issues such as calculation discrepancies, discount discrepancies, and problems related to deductible/copayment non-collection. In light of the analysis and survey outcomes, dedicated efforts should be directed towards evaluating each parameter of claims rejection, particularly concerning Oman Insurance Company, Nas Insurance Company, Next Care Insurance Company, and FMC Insurance Company. These companies have been identified as the major contributors to the highest volume of claim rejections.

REFERENCES

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