#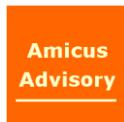 The need for Surveillance, Concurrent & Retrospective Audit of Claims and Process Compliance under Rashtriya Swasthya Bima Yojana (RSBY)

Amicus Advisory

STATEMENT OF THE NEED
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Having successfully rolled out RSBY, it would follow that an insurer would take stock of various aspects of delivery of healthcare benefits to the beneficiaries as also the claims outgo which impacts the financial viability. The rationale underlying any such an initiative is to ensure that

- the desired healthcare is being delivered, both qualitatively and quantitatively
- the costs are actually being incurred
- the system and the processes as provided for in RSBY are being followed
- there are no leakages from the system

Whilst review of data obtained through MIS can help build a macro-level statistical understanding of the performance on the claims front, it would also be advisable that performance of the healthcare providers on the aforementioned parameters is scrutinized to ensure that treatment is dispensed within the scheme framework and the insurance coverage continues to remain financially sustainable.

There are two critical parameters evaluation on which will bring out deviations and shall help course-correct.

- Compliance to all RSBY processes and other mandates
- Measurement of adherence to medical ethics and protocols

A careful scrutiny of the base document as well as the guidelines issued from time to time shall reveal that RSBY is largely a process-driven initiative which premises that a well laid out process architecture shall not only eliminate deviations but shall also create a sustainable, uniform healthcare delivery platform. Adherence to mandated processes by all stakeholders shall surely ensure smooth and economical delivery of healthcare to beneficiaries.

On the other hand there are a number of activities, not forming part of the processes mandated under RSBY, which quantitatively and qualitatively impact services offered by hospitals. These activities need to be audited. Also needs to be audited are practices that the provider may be resorting to and, thereby, rendering the delivery of healthcare and the financials of RSBY sub-optimal.

Health Insurance service delivery includes three major entities responsible for smooth and satisfactory experience for all stakeholders, 1. Insurers 2. Third Party Administrators 3. Hospitals & Nursing Homes.

Whilst first two, at policy and operational level, are regulated by IRDA, a similar checks & balances framework is missing for the healthcare providers involved in the process, thus making it a weak link in the service delivery Chain.
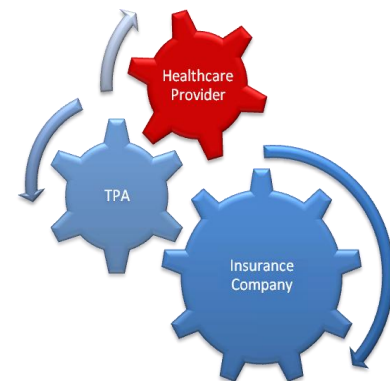
Moreover due to lack of governance and regulation there is surely a lack of implementation of best practices in providers' operations too, further increasing importance of detailed audit mechanism?

Major merit for insurers through the audit will be identifying the pain points in the process, which include undesirable practices by healthcare providers, which if removed through proper course correction shall contribute both at economic as well as qualitative level.

Another impact of the whole exercise on the insured population shall be increase in the satisfaction levels whilst ensuring ethical & economical delivery of service.

Benefits of Process compliance and Review / Audit of claims

A detailed audit of compliance and claims and course corrections based on the findings would lead to a number of benefits for insurers -

- Check on the undesirable practices by healthcare providers
- Better services to the beneficiaries
- Identification of reasons for irregular claims patterns & optimum utilization, post course correction
- Minimization of fictitious / inflated claims leading to better profitability & pricing year-on-year
- Special attention for high claims reporting areas
- Overall better managed RSBY scheme
- Enhancement in quality of service by healthcare providers
- Underwriting inputs for renewals / new business under RSBY

INVENTORY OF THE ACTS OF INDISCRETIONS
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Analysis reveals that some of the most common acts of indiscretion are as under.

1. Fraudulent admissions
2. Conversion of Outpatient cases to Inpatient cases
3. High incidence of day-care procedures
4. Deliberate blocking of higher-priced packages to claim higher amounts
5. Blocking of multiple packages even though not required
6. Connivance with beneficiaries to swipe the cards even without any need for treatment
7. Non-payment of transportation charges
8. Not dispensing post-hospitalization medication
9. Showing medical management cases as non-invasive surgeries
10. Impersonation in connivance with cardholder and hospitals
11. Replacing fingerprints fraudulently at district kiosk
12. Addition of outsiders as family members and inclusion of biometrics
13. Irregular or inordinately delayed synching of transactions to avoid investigations
14. Treatment of diseases which a hospital is not equipped for
15. Showing admission in ICU though treatment is given in general / private wards

TYPES OF AUDIT
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It is necessary to carry out medical surveillance, review of compliance of RSBY processes and concurrent / retrospective audits with a view to optimizing claims outgo, identifying process-

deviations to plug the leakages from the system and ascertaining genuineness of claims.

Audit of Claims Processes & Protocols
RSBY is a process-driven scheme. It is expected that adherence to these processes shall not only standardize claim activities but shall also eliminate undesirable practices. Audit of such processes at hospitals and nursing homes will bring out deviations some of which may be circumstantial in nature but some which will in turn put in place a mechanism for checking fraudulent practices in hospitals, if any.

Audit of Hospital Documentation
RSBY is a paperless scheme and aims at creating a unique convenience for all stakeholders. This requires a greater sense of responsibility at the providers' end. Each claim needs to be audited for compliance to the standard guidelines / practices of keeping the records especially the indoor patients' treatment record. Typically the required documentation maintained by hospitals / nursing homes in substantiation of treatment given to RSBY patients is to be audited.

Audit of Claims Transactions
Transaction is the online conversation between the network hospital and the insurer. The back-end processes involving interface between hospitals need to be regularly monitored by Insurers wherein the idea is to bring out any fraudulent activity.

Audit of Patients Post-Discharge

To ensure the genuineness of a claim, the patients need to be visited to verify the authenticity of the hospitalization & the procedures performed. This can be done through a structured questionnaire for soliciting a claimant's version of hospitalization as we all physical examination for tell-tale marks, if any. The visit will also confirm if the hospital had followed the RSBY guidelines and that no money was charged to the claimant unless BSI was exhausted.

AUDIT POINTS

All four aforementioned activities are to aim at the following –

1. Genuineness of hospitalization
2. Possible conversion of OPD cases into IPD
3. Verification of details of a claimant whilst seeking treatment
4. Blocking of an appropriate disease code
5. Need for blocking multiple disease codes
6. Genuineness of seeking approval for the non package cases
7. Treatment in line with diagnosis
8. Genuineness of invasive / non-invasive surgeries
9. Maintenance of case papers, diagnostic reports, medication etc.
10. Record-keeping carrying expense details by hospitals
11. Frequency and gaps in uploading claims data on server: The uploading pattern can be indicative of fraudulent activities.
12. Review of off-line transactions requiring authorizations from Insurers
13. Level of adherence to pre-agreed charges for all "packaged" treatments.

14. Adherence to processes relating to admissions / discharge. Verification of related documents e.g., receipt, discharge summary etc.
15. Regularity of uploading transactions on servers

AUDIT TRIGGERS

1. Districts having low enrollments but high claim intimations
2. Hospitals reporting inordinately high number of admissions
3. Hospitals having inordinately high number of day care treatment
4. High average claim size
5. Lop-sided Medical Management vs. Surgeries ratio
6. Frequent blocking of non-invasive surgeries
7. Delinquent record of hospital in reporting admissions
8. High Bed vs. Occupancy ratio
9. Hospitals showing trends of delay in synching of PoS machines
10. Treatment of diseases mismatching general health profile of the district / state
11. Frequency and gaps in uploading data on server
12. Frequent blocking of multiple disease codes
13. Frequent blocking of high-end disease codes
14. Hospitals involving frequent incidents of customer grievances or malpractices

METHODOLOGY

Based on the claims data of the insurers relating to the recent past, a brief analysis can be carried out to arrive at the audit-triggers. These triggers are to form basis to all audit activities. TPA's server needs to be accessed on daily basis and claims/ hospitals are identified. For Concurrent audit, such claims can be intimated to the auditors through SMS. For Retrospective audit, recent past data can be scanned and conveyed to auditors at an agreed periodicity.

Concurrent Audit As the name suggests, this means audit of claims as they occur at hospitals. This shall involve obtaining instant information on hospital admissions and auditing all activities / processes obligatory on the part of a hospital, during the period of stay of a claimant in a hospital

Retrospective Audit This will be post-facto audit of all aspects of claims based on pre-determined triggers. The triggers are to be based on historical claims data which will give out trends requiring scrutiny of claims

Patient's Audit Investigators are to visit a claimant to verify the authenticity of hospitalization and the procedures performed.

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SOME AUDIT FINDINGS
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Based on agreed definitions of discrepancies with the Principals, some of the findings of audit of about 2,000 claims are as under.

- Of the total 2,096 claims investigated 1,219(60%) were found to be discrepant in nature.

- Of the 1,219 discrepant claims 693 claims (57%) reported more than one discrepancy.
- On 774 instances we did not find any qualified nursing staff in the hospital. That is 37% of all the claims we investigated.
- On 272 occasions we could not find any Qualified Doctor on rolls in the hospital.
- On 286 occasions either document supporting the diagnosis were absent or reports of diagnostic tests were not available. That is 14% of all investigations.
- Also in 285 instances hospitals could not provide operative notes related to the surgical procedure performed on the patient.
- In 144 cases hospitals did not co-operate with our investigation team. Various excuses were made to avoid the investigation process.
- On 79 occasions RSBY helpdesk was either not available or not active at the time of investigation.
- 63 claims were found where Patient's complaint did not corroborate the package blocked. In most of these cases inflated packages of higher amounts were blocked.
- Additionally 14 cases were reported, where admission was not required as per patient's complaint. Patient could have been treated in OPD in these cases.
- There were 18 cases where patient was not even admitted and package was blocked. In one such case beneficiary had died many years ago and package was blocked in his name.
- In 1% cases we observed poor quality of OT and found that vital equipment needed for surgery cases were missing.

Discrepancy Type	Count	% Occurrence
Qualified nurse not present	774	37
Investigation Report/ Corroborating Diagnosis not available	286	14
OT notes not available	285	14
Qualified Doctor not present	272	13
Didn't co-operate with the Investigation Team	144	7
Indoor case papers incomplete	99	5
Proof of payment of Transportation Charges absent	91	4
RSBY Help Desk not available	79	4
Patient's complaint doesn't corroborate with package blocked	63	3
Treating doctor's details not shared	44	2
Daily monitoring chart not available	28	1
Discharge Card not prepared	19	1
Package blocked without patient being admitted	18	1
Complaints & treatment doesn't justify hospitalization	14	1
Vital equipment missing from OT	12	1
Discrepancy between patient's & Smart Card's details	10	-
Food not provided to patient	6	-