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# Analysis of Turn Around Time of Claim Settlement Process in Select TPA

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**Abstract: The turnaround time (TAT) in the claim settlement process plays a crucial role in determining the efficiency and effectiveness of Third Party Administrators (TPAs) in healthcare and insurance sectors. This study focuses on the factors impacting TAT in the claim settlement process within TPAs, identifying key challenges, bottlenecks, and potential improvements. The data is collected by administering a questionnaire with a sample size of 150 to the selected TPA staff who are working in pre auth department, CRM, billing department and medical scrutiny department and also through direct observations of claims. The Average TAT for the claim settlement process was calculated for 60 cashless, 60 reimbursement, 20 additional payments, and 10 deduction payments claims. The major findings of the study are, the average TAT for cashless, reimbursement, addition payments, and deduction payments claim settlement is 85.05, 66.2, 47.55, 23.7 days respectively. The study also found the reasons for the delay in the claim settlement process and increase of TAT in claim settlement process. Delay in document recovery, delay in processing and dispatching cheques are found as the major reasons. By examining both internal (process management, documentation, claim verification) and external (policyholder behavior, regulatory requirements) factors, the study highlights the importance of optimizing TAT to enhance customer satisfaction and operational efficiency. Some of the suggestions of the study are to increase staff, decrease time for transferring claims and at issue of cheques and has to speed up the claim settlement process.**

***Keywords:*** *Cashless, Claims, Settlement, TAT, TPA.*

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## I. INTRODUCTION

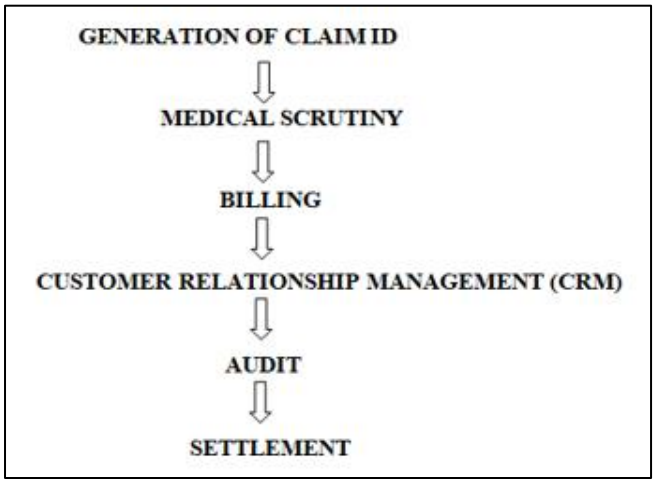
Claim settlement is one of the most important tasks of any insurance company. Proper settlement of claims requires a sound knowledge of law, principles and practices governing insurance contracts, and in particular a thorough knowledge on the terms and conditions of the standard policies and various extensions and modifications there under. The procedure in respect of claims under various classes of insurance follows a common pattern and may be considered under three broad headings:

- Preliminary
- Investigations and
- Settlement

The claim is payable when treatment is given to the insured from a registered hospital or nursing home. However, in the case of non-registered hospital or nursing home the treatment can be covered under the policy subject to hospital/nursing home on confirmation of the few conditions. During claim settlement process, due to some reasons TAT of a claim is increasing which leads to the delay in discharge of a patient.

The following is the claim settlement process generally followed.

➢ *Claims Settlement Process*



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- *Third Party Administrators (TPAs)*

Third Party Administrators (TPA) is an organization that processes insurance claims of the insurer which are traditionally handled by the insurance company. It can be said that they outsource administration of claim services. TPA's liaison between hospitals, insurers and insured. TPA is contacted by the insurer or self- insurers. The risk of loss remains with the employer, and not with the TPA. They have the capability and expertise to administer services like claim administration, enrollment and other administrative services.

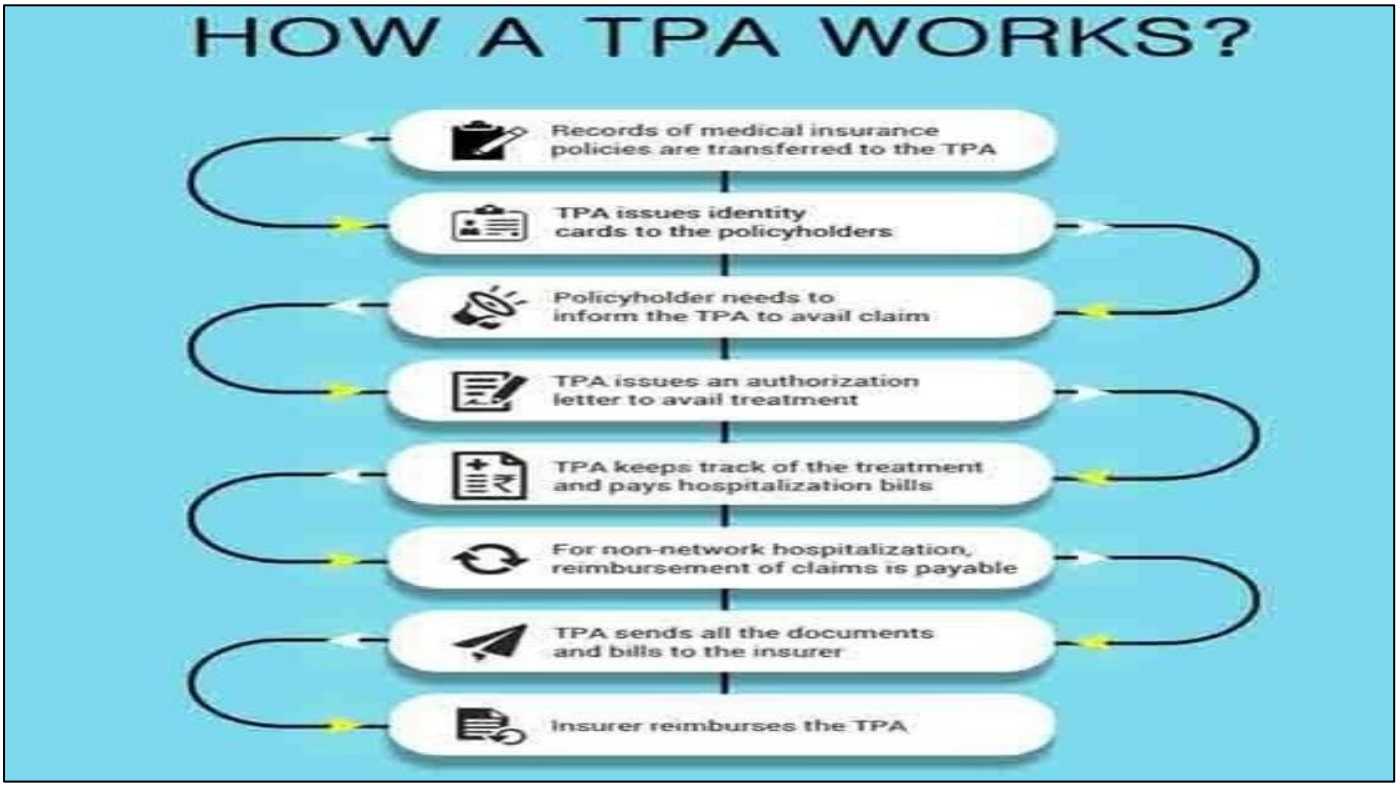


Fig 1 TPA Works

➢ *Turn Around Time (TAT)*

Turnaround Time (TAT) refers to the total time taken from the initiation of a claim to its final resolution, whether it's approved, paid, or denied. This metric is crucial for both policyholders and insurers/TPAs, as it impacts customer satisfaction and operational efficiency. In health insurance, TAT can vary based on the complexity of the claim, the type of claim (cashless or reimbursement), and the efficiency of the TPA's processes.

➢ *Standard TAT for Health Insurance Claims*

- Cashless Claims: Typically processed within a few hours to 48 hours, provided all required information and pre-authorizations are in place.
- Reimbursement Claims: Generally processed within 7 to 30 days, depending on the complexity and completeness of the submitted documents.

➢ *Need for the Study*

Due to various reasons, there is a delay in claim settlement, on account of which TAT of a claim is increasing and intimation to the patient is delayed which affect the discharge of patient. There is a need to study and find out causes which increase the TAT during claim settlement process and identify the performance gaps in the process of claim settlement and provide recommendations to improve the process of claim settlement.

➢ *Objectives*

- To study the present process involved in claim settlement of TPA.
- To do the time study of the existing process involved and calculate TAT.
- To identify and analyze the causes for delay and to suggest measures to reduce it.

➢ *Scope*

The scope of the study is confined only to the claim settlement of the select TPA and the TAT involved for settling the claims. The study is limited to Claim settlement process of different claims for a period of 30 weeks.

## II. METHODOLOGY

➢ *Study Design*

The study approach is by descriptive research design, in order to know the current process of health insurance. The study is done by observing, analyzing different types of claims, their policies, studying reasons and monitoring Turn Around time.

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➢ *Study Population*

The population of the study is the staff working in five different departments of selected TPA.

➢ *Study Instrument*

Closed ended structured questionnaire is administered comprising of 8 questions to the staff working in pre-authorization department, Customer relationship management (CRM), medical scrutiny, medical billing and medical audit departments

➢ *Sample Size*

A sample size for this study is 150 and the samples are collected randomly

➢ *Data Source*

The primary source of data is from questionnaire to the staff those working in pre auth department, CRM, billing department and medical scrutiny and audit department of the TPA and direct observations of claims. The secondary data is collected from websites of TPA and from previous records.

➢ *Tools of Data Collection and Analysis*

The data is collected directly from observation and from software module used in the claim processing into MS excel sheet and from previous records. The analytical tools like Average method, line charts, pie charts are used for analysis and presenting the data.

➢ *Data Analysis*

The various types of claims handled by TPA are:

- Cashless claims
- Reimbursement claims
- Claims for additional payments
- Reconsideration claims
- Health check up claims

➢ *Claims Settlement*

Claims are Mainly of Two Types:

- *Reimbursement Claims-*

Reimbursement claims arise when a member gets treatment done in non-network hospital. Member gets the treatment done in the hospital and files for reimbursement along with all bills and discharge summary and the required documents. These documents together are filed along with identity proof and sent to TPA by courier or post or submit in person: inward stamp is put on the file along with the date of submission. Then, claim ID is generated, all the data is entered and claim sheet is generated. Files are color coded based on which insurer is the member covered under and the type of claim.

- *Cashless Claims-*

Cashless claims come directly from the provider, before hospitalization of the member a pre-authorization form is filled and after the pre- authorization process a PA number is given. After the patient is discharged, the provider sends the bills, investigation reports, pre- authorization letter along with the PA number. This file is received and claim ID is generated and the files are color coded.

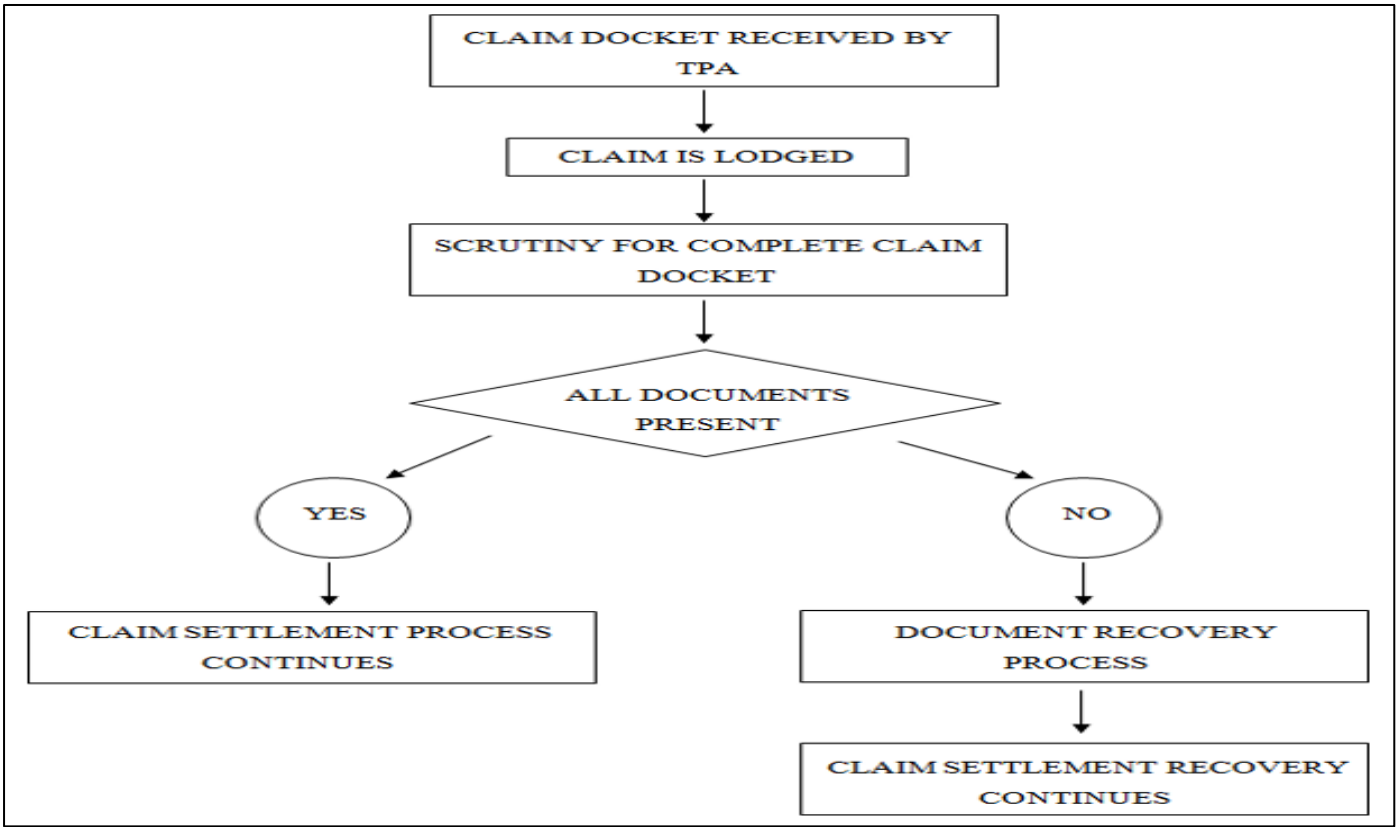


Fig 2 Claim form Process

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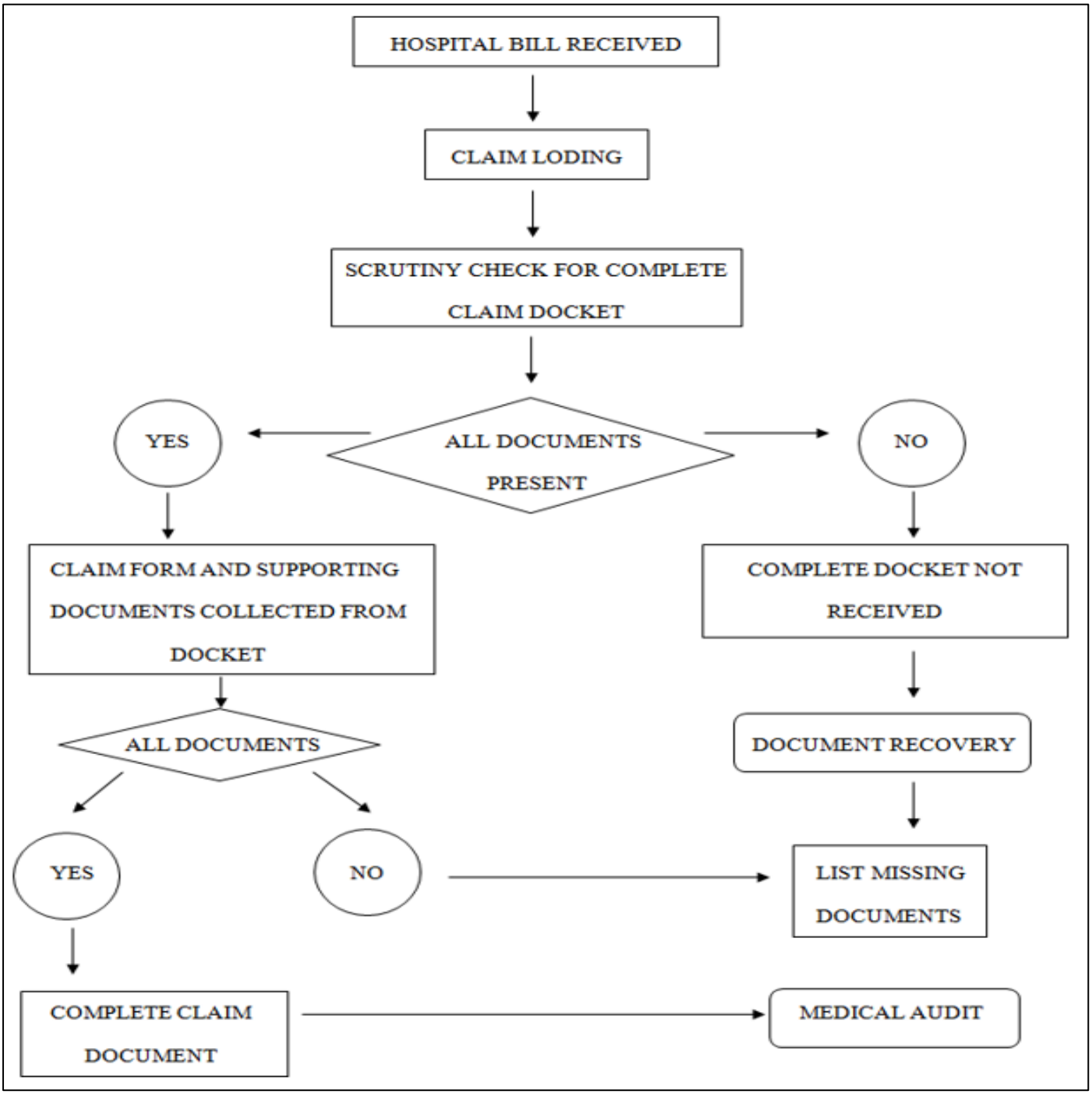


Fig 3 Hospital Bill Settlement Process

If all the necessary documents are not there IR (Information required) is raised and the required documents are recovered for the insured/ Hospital.

➢ *Steps in the Claim Settlement Process*

- Obtaining authorization letter
- Claim Lodging
- Claim Dispatch
- Medical Audit
- Recovery
- Payment Receipt
- Cheque Preparation

➢ *The Steps in the Claim Settlement Process of Cash Less Claims are:*

- Grant of authorization
- Claim receipt
- Claim lodging
- Claim dispatch
- Medical audit
- Document recovery
- Payment receipt
- Cheque preparation

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/25aug978

➢ *The Steps in the Settlement of Reimbursement Claims are:*

- Claim receipt
- Claim lodging
- Claim dispatch
- Medical audit
- Document recovery
- Payment receipt
- Cheque preparation

➢ *The Steps in the Settlement of Additional Payment Claims are:*

- Claim receipt
- Claim lodging
- Claim dispatch
- Medical audit
- Document recovery
- Payment receipt
- Cheque preparation

➢ *The TPA which is Selected for the Study Receives on an Average in a Month:*

- 200 cashless claims
- 200 reimbursement claims
- 100 claims for additional payments
- 75-80 claims for deduction payments

➢ *Of these,*

- 30% of reimbursement claims – 60 claims
- 30% of cashless claims – 60 claims
- 20% of claims for additional payments – 20 claims
- 15% of claims for deduction payments – 10 claims

➢ *Have been Considered for the Purpose of the Study*

In order to analyze the reasons for the claim investigation, in order to grant authorization or to settle the claim, only 10 claims have been considered as investigation is a matter of confidentiality.

In order to analyze the reasons for the repudiation of claims, 50 claims have been considered for the study.

Table 1 The Claim Settlement Time or the Turnaround Time for Cashless Claims (in Days)

| **TIME TAKEN TO RECEIVE CLAIMS** | **25.6** |
|---|---|
| TIME TAKEN TO LODGE | 2.58 |
| TIME TAKEN FOR CLAIM DISPATCH | 4.27 |
| TIME TAKEN FOR MEDICAL AUDIT | 5.6 |
| DOCUMENT RECOVERY TIME | 3.6 |
| TIME TAKEN TO ISSUE PAYMENT | 6.8 |
| TIME TAKEN FOR CHEQUE DISPATCH | 36.6 |
| **TOTAL TURN AROUND TIME** | **85.05** |

The time taken for the receipt of claims from the providers is 25.6 days on an average. If considered, the TAT for cashless claim settlement on an average becomes 85.05 days.

The turnaround time for cashless claim settlement by the TPA is 59.45 days on an average.

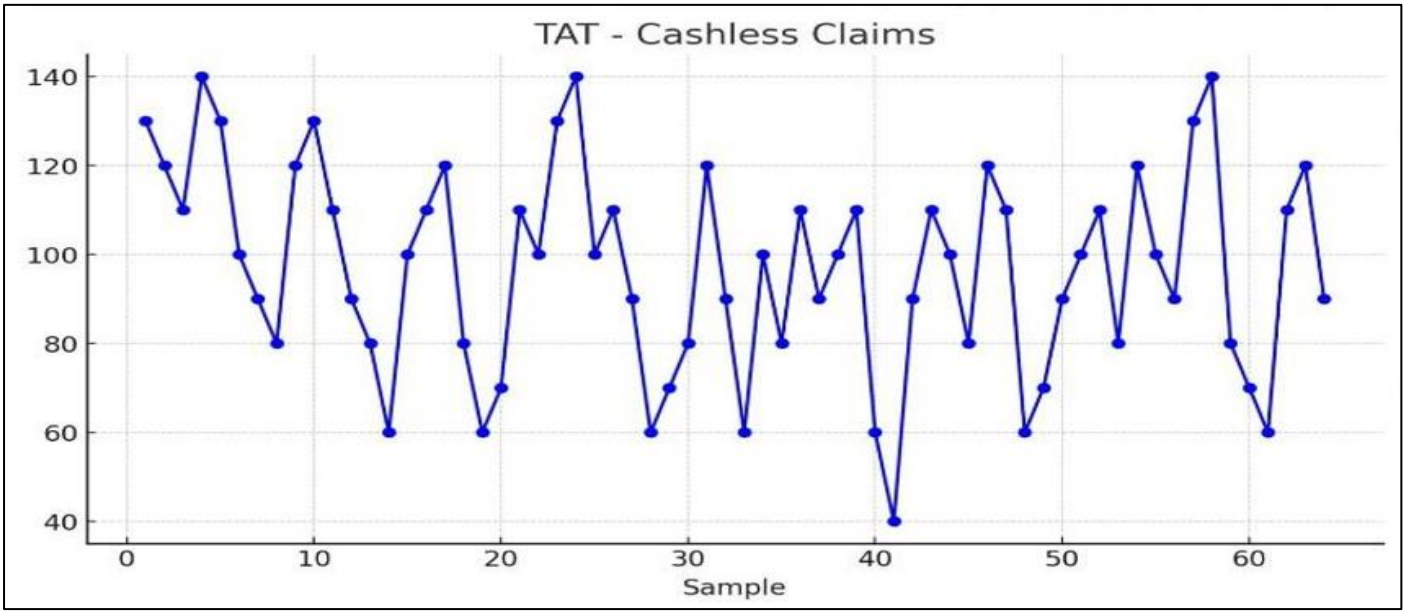


Fig 4 Turn Around Time for Settlement of Cashless Claims

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/25aug978

➢ *Considering the Time taken to Receive the Claims from the Provider*

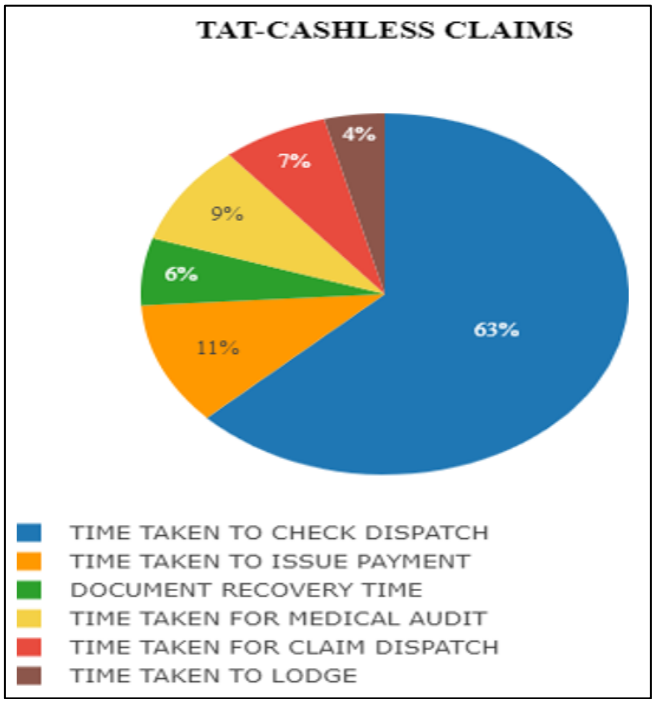


Fig 5 Process-Wise Analysis of the Turnaround Time for Cashless Claims

➢ *Including Document Recovery*

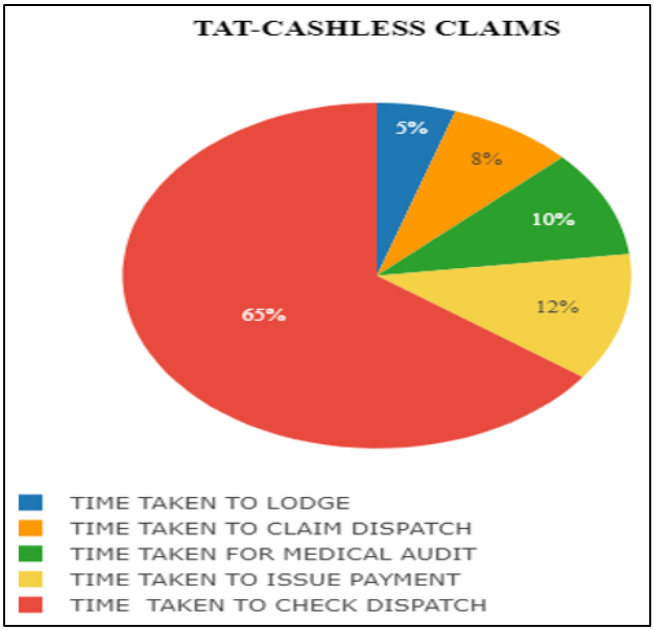


Fig 6 Without Document Recovery

The Maximum delay caused due to non-availability of funds from the TPA and hence the delay is in cheque dispatch.

Table 2 Analysis of Turnaround Time for Reimbursement/ Non- Cashless Claims (in Days)

| **TIME TAKEN TO LODGE** | **2.4** |
|---|---|
| TIME TAKEN FOR CLAIM DISPATCH | 2.9 |
| TIME TAKEN FOR MEDICAL AUDIT | 11.38 |
| DOCUMENT RECOVERY TIME | 34.25 |
| TIME TAKEN TO ISSUE PAYMENT | 6.2 |
| TIME TAKEN FOR CHEQUE DISPATCH | 11.17 |
| **TOTAL TURN AROUND TIME** | **66.22** |

The Total time taken for the settlement of Non cashless claims is 66.22 days on an average. A lot of delay is caused because of incomplete claim submission by the policy holder which accounts for nearly 52% of the total around time.

➢ *Analysis of the Claim Settlement Process for Non – Cashless/Reimbursement Claims*

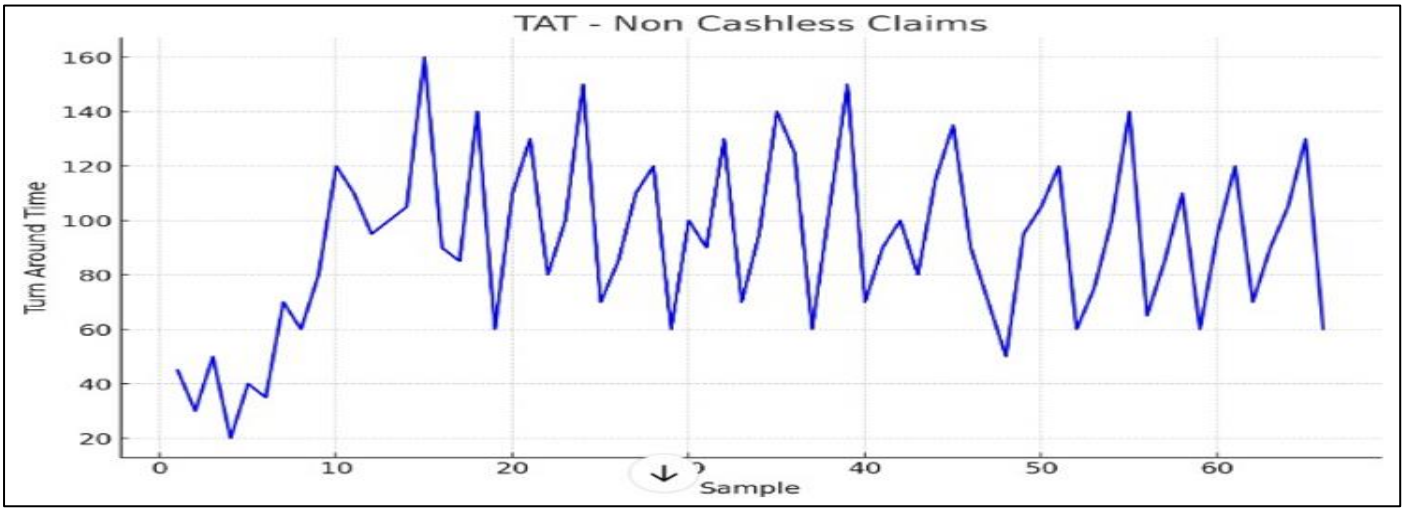


Fig 7 TAT Non-Cashless Claims

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/25aug978

A lot of claims are settled in a range of 60-80 days. Complete claim submission leads to prompt settlement of claim within 15-20 days, whereas non submission of the required documents leads to a higher turnaround time

➢ *Analysis of the Turnaround time for Reimbursement/Non –Cashless Claims*

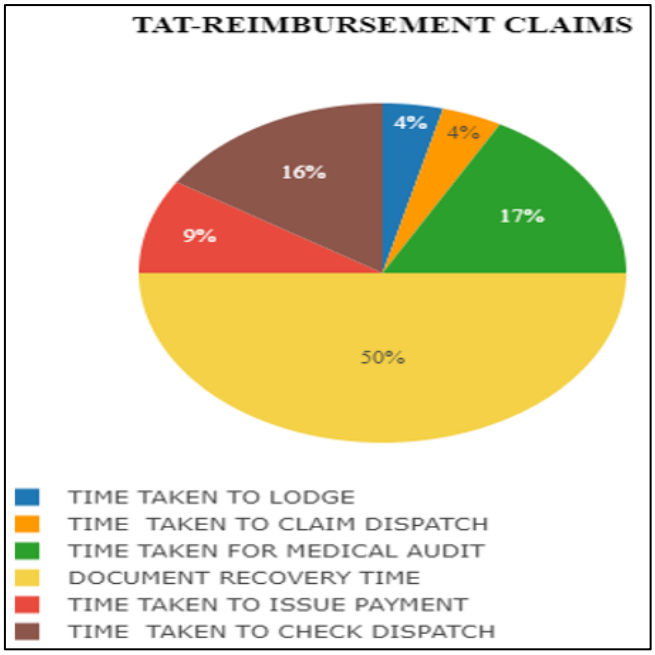


Fig 8 Considering Document Recovery Time

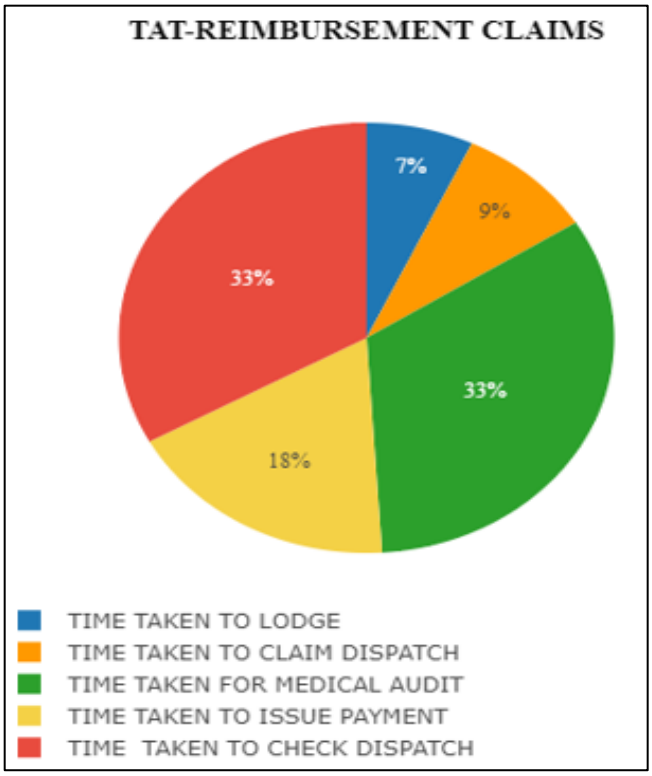


Fig 9 Not Considering Document Recovery Time

It can be clearly seen that the time required in the document recovery causes a lot of time in claim settlement process.

Table 3 Analysis of the Claims Submitted for Additional Payments (in Days)

| | |
|---|---|
| **TIME TAKEN TO LODGE** | **1.65** |
| TIME TAKEN FOR CLAIM DISPATCH | 2.65 |
| TIME TAKEN FOR MEDICAL AUDIT | 9.25 |
| TIME TAKEN TO ISSUE PAYMENT | 15.05 |
| TIME TAKEN FOR CHEQUE DISPATCH | 18.95 |
| **TOTAL TURN AROUND TIME** | **47.55** |

The total time taken for the settlement of claims for additional payments is 47.55 days on an average. Of this, the maximum delay is caused due to issue the payments and to dispatch the cheque which account for 72% of the total turnaround time.

➢ *Analysis of the Turnaround Time for the Settlement of the Claims Received for Additional Payments:*

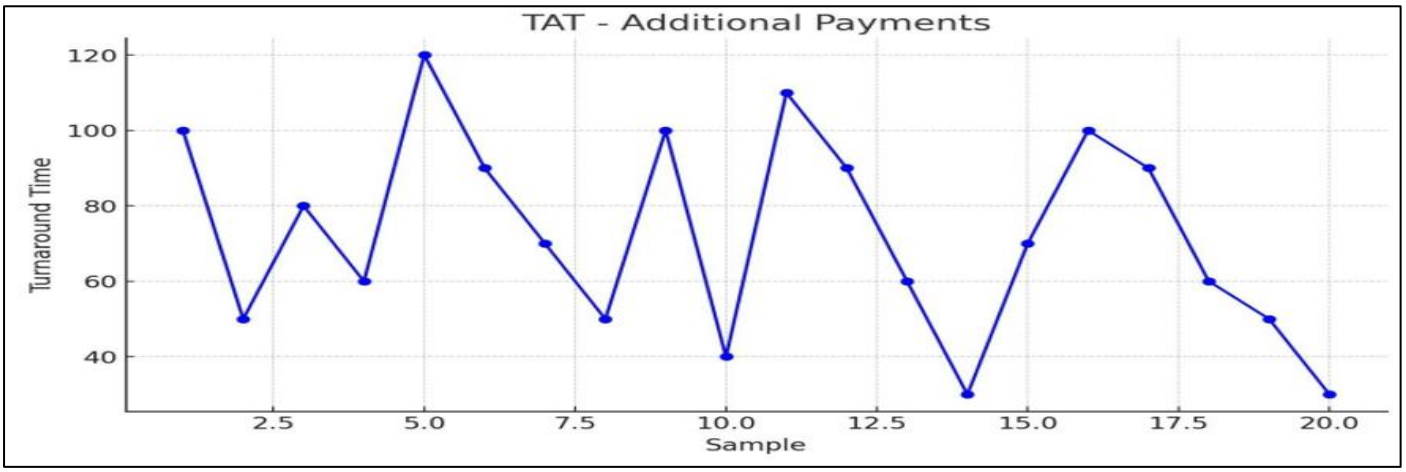


Fig 10 TAT for Additional Payments

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Nearly 45% of the claims fall within the range of 50-70 days. The delay observed is due to the delay by the insurance company in issuance of cheques.

➢ *Analysis of the Claims Submitted for Additional Payments*

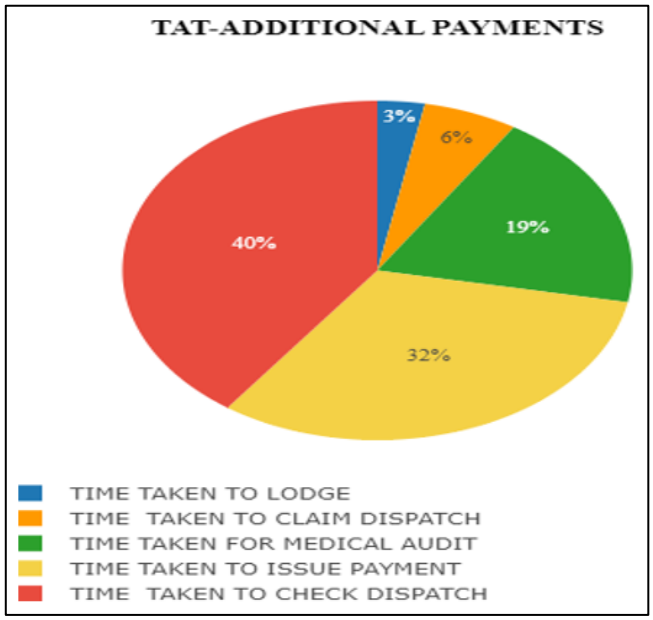


Fig 11 TAT Additional Payments

The process occurring within the scope of the TPA do not cause a huge delay in the turnaround time and fall well within the declared time of 20 days. However, the TAT increases due to delay in the issuance of payments and preparation of cheques.

Table 4 Analysis of the Turnaround Time for Deductions Payments (in Days)

| | |
|---|---|
| **TIME TAKEN TO LODGE** | **1** |
| TIME TAKEN FOR CLAIM DISPATCH | 2 |
| TIME TAKEN FOR MEDICAL AUDIT | 10.7 |
| TIME TAKEN TO ISSUE PAYMENT | 4.1 |
| TIME TAKEN FOR CHEQUE DISPATCH | 5.9 |
| **TOTAL TURN AROUND TIME** | **23.78** |

The total time taken for the settlement of the claims for deduction payments is 23.78 days on an average. Since the claims received for deduction payments are the ones which have been settled first, after cross verification

➢ *Process wise Analysis of the Turnaround Time of Claims for Deduction Payments*

In case of claims submitted for reimbursement by the provider or policy holder, due to the schedule of charge/tariff agreed with the hospital in the MOU or if the policy holder has not submitted certain bills in the first case and submits them later, then the same is settled under the category of deduction payments. This is also considered under the category non-cashless.

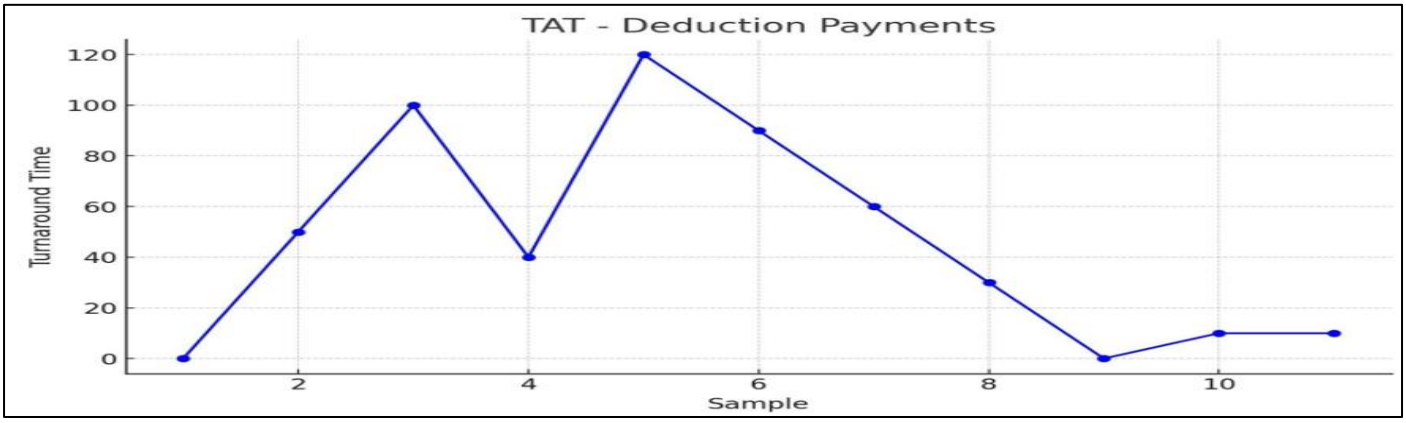


Fig 12 TAT-Deduction Payments

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/25aug978

Most of the claims are settled in the range of 20-30 days which falls within declared time limits of the TPA Analysis of the turnaround time for deduction payments.

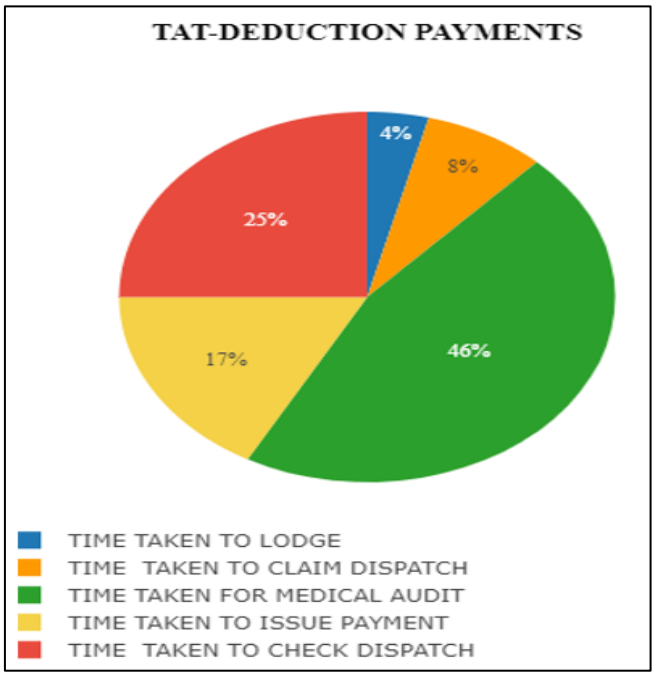

Fig 13 TAT-Deduction Payments

The maximum delay is caused due to detailed medical audit in case of the claims re-submitted for deduction payments

➢ *Analysis of the Turnaround Time in Pre-Authorization Department*

- Claims settled in 1-3 days: 40 claims
- Claims settled in 4-7 days: 30 claims
- Claims settled in 8-14 days: 20 claims
- Claims settled in 15-30 days: 8 claims
- Claims settled in more than 30 days: 2 claims

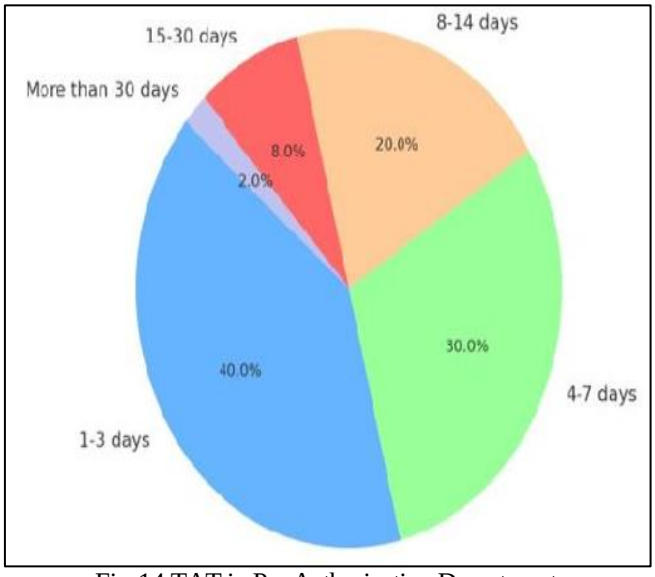

Fig 14 TAT in Pre Authorization Department

The Total Time taken for the Settlement of Claims in Pre-Authorization Department 18.2 Days Reasons for Delays in Completing Claims in Pre-Authorization with a TPA.

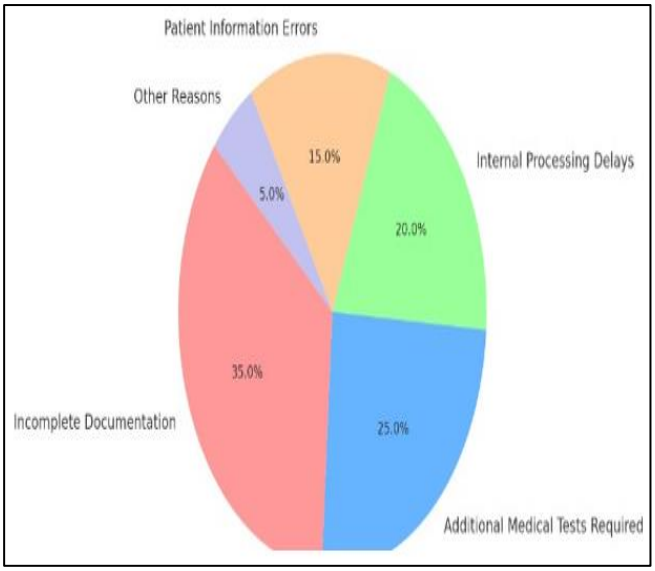

Fig 15 Reasons for Delays

➢ *Analysis of the Turnaround Time in Medical Reviewing Department*

- Claims reviewed in 1-3 days: 45 claims
- Claims reviewed in 4-7 days: 30 claims
- Claims reviewed in 8-14 days: 15 claims
- Claims reviewed in 15-30 days: 8 claims
- Claims reviewed in more than 30 days: 2 claims

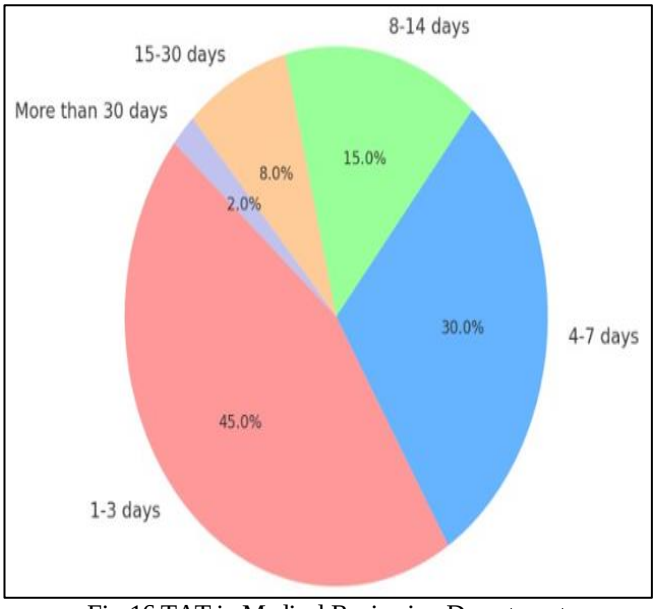

Fig 16 TAT in Medical Reviewing Department

The total time taken for the settlement of claims in Medical Reviewing department is 14.4 days Reasons for Delays in Claim Processing in Medical Reviewing Department with a TPA

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/25aug978

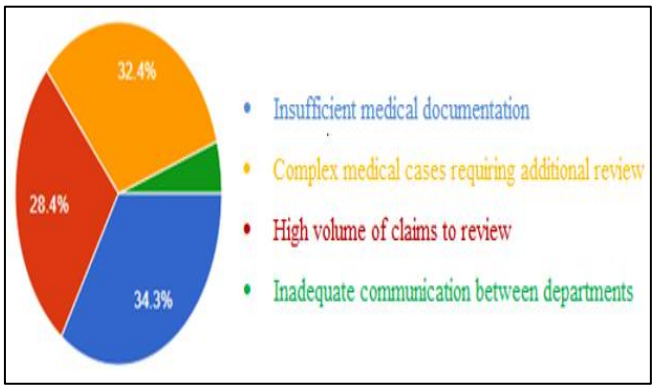

Fig 17 Reasons for Delays

➢ *Analysis of the Turnaround time in Medical Billing Department*

- Claims reviewed in 1-3 days: 30 claims
- Claims reviewed in 4-7 days: 40 claims
- Claims reviewed in 8-14 days: 15 claims
- Claims reviewed in 15-21 days: 10 claims
- Claims reviewed in more than 22+ days: 5 claims

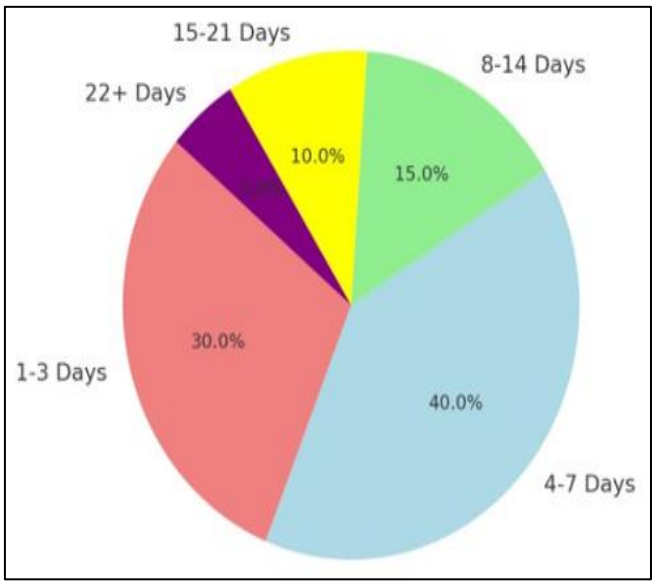

Fig 18 TAT in Medical Billing Department

The total time taken for the settlement of claims in Medical Billing department is 3.8 days

➢ *Analysis of the Turnaround Time in Medical Audit Department*

- Claims reviewed in 1-3 days: 25 claims
- Claims reviewed in 4-7 days: 35 claims
- Claims reviewed in 8-14 days: 20 claims
- Claims reviewed in 15-21 days: 10 claims
- Claims reviewed in more than 22+ days: 10 claims

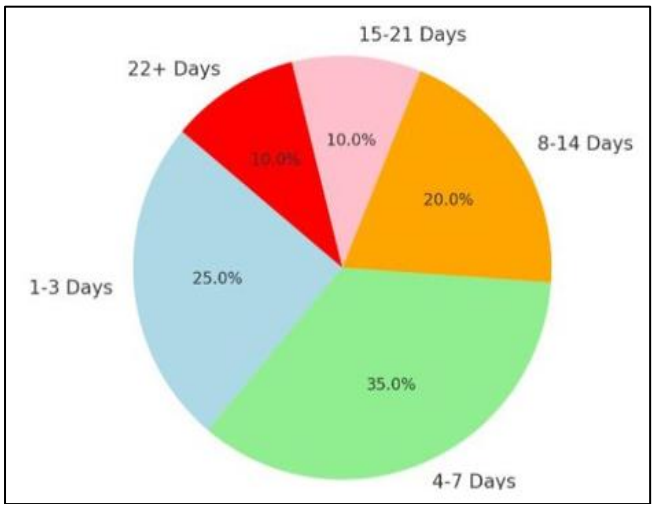

Fig 19 TAT in Medical Audit Department

The total time taken for the settlement of claims in Medical Reviewing department is 16.2 days Reasons for Delays in Claim Processing in Medical Auditing Department with a TPA.

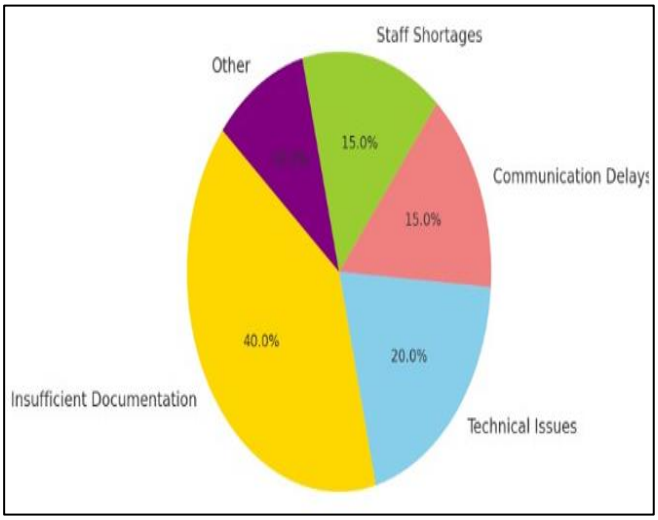

Fig 20 Reasons for Delays

➢ *Reasons for Investigations:*

All the investigations are generally made on the basis of the 4 parameters:

- Fraud
- Over-billing
- Unnecessary hospitalization
- Pre-existing diseases

➢ *Reasons for Deductions:*

The deductions made for the various types of claims are in accordance with:

- Authorization limit granted
- Schedule of charges according to the MOU
- Non-medical expenses
- Charges payable under the revised policy terms and conditions

ISSN No:-2456-2165 https://doi.org/10.38124/ijisrt/25aug978

➢ *Reasons for Repudiation:*

The claims repudiated are generally on the following grounds:

- Pre-existing disease
- Fraud
- Non-compliance with Document request
- Exclusions applicable under the various headings of Clause 4 under the policy

➢ *Root cause Analysis for Delay in TAT of Claim Processing*

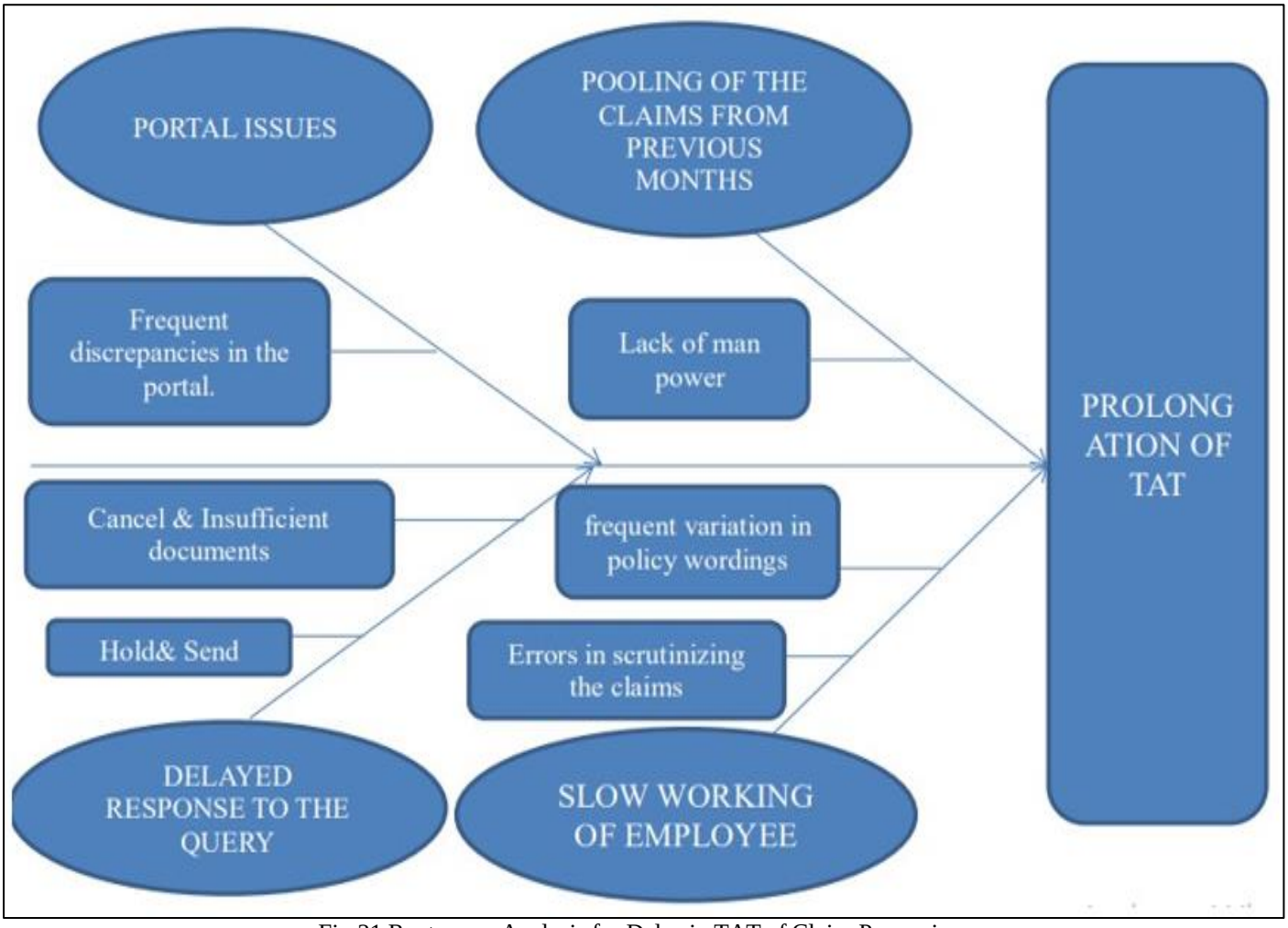


Fig 21 Root cause Analysis for Delay in TAT of Claim Processing

## III. FINDINGS AND DISCUSSION

➢ *Findings in Preauthorization Department*

The Preauthorization Department mainly delays in Claims lodging .The Average time taken for claims lodging for cashless and Reimbursement claims are 2.58 and 2.4 days respectively Findings for the delay in TAT in claim settlement process in Preauthorization Department.

- **Incomplete Documentation**: A significant cause of delay is the submission of incomplete or incorrect documents by hospitals or policyholders. Missing information can lead to multiple rounds of communication, slowing down the approval process.
- **Inadequate Medical Information**: Often, the medical reports or clinical details provided by healthcare providers lack necessary details, requiring additional clarification or supplementary documents, which increase processing time.
- **Manual Processing**: In many TPAs, the preauthorization process involves a significant amount of manual work, including verification of policy coverage and medical necessity. Manual interventions can lead to errors and increase processing time.
- **Communication Gaps**: Poor communication between the TPA, hospitals, and insured parties can result in delays. This includes slow responses to queries, delays in providing required information, or lack of timely follow-ups.
- **High Volume of Claims**: A surge in preauthorization requests due to seasonal factors (like disease outbreaks) or system inefficiencies can overwhelm staff, resulting in longer processing times.
- **Complex or High-Value Claims**: Preauthorization requests involving complex medical procedures or high-cost treatments require more detailed reviews, leading to longer processing times due to extensive scrutiny and decision-making.

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- **Verification of Policy Terms**: Delays often occur when there is confusion or discrepancies in interpreting the policy terms, coverage limits, or exclusions, requiring back-and-forth communication with insurers or policyholders.
- **System and Technical Issues**: Legacy systems or outdated technology can cause delays in data processing, system crashes, or slow access to policy or medical data, impacting the speed of preauthorization decisions.
- **Regulatory and Compliance Requirements**: Stringent regulatory checks or changes in health insurance regulations can introduce additional steps in the preauthorization process, contributing to delays.
- **Lack of Adequate Staff**: Shortage of trained staff or insufficient resources to handle claims in a timely manner, especially during peak times, can increase the time taken for approvals.

➢ *Findings in Billing Department*

The Billing Department mainly delays in Claims dispatching, Medical billing, and coding the for the disease condition. The Average time taken for claims in billing department in cashless and reimbursement claims is 4.27 and 2.9 days respectively Findings for the delay in Tat in claim settlement process in Billing Department

- **Coding Errors**: Incorrect or incomplete medical coding (ICD, CPT, or HCPCS) is one of the primary reasons for claim rejections and delays. Billing errors often require resubmission and additional clarification, which extends processing time.
- **Incorrect or Missing Information**: Inaccurate patient demographics, insurance details, or missing authorization numbers can lead to delays. This requires back-and-forth communication between the billing department, healthcare providers, and policyholders to correct the errors.
- **Claims Scrutiny and Audits**: High-value claims or those with complex billing structures often undergo additional scrutiny or audits, which lengthens the approval process and leads to increased TAT.
- **Delays in Provider Submission**: Delayed submission of bills by healthcare providers or hospitals to the TPA results in longer claim processing times. This may occur due to inefficiencies in hospital billing systems or staff shortages.
- **Inconsistent Documentation**: Missing or inconsistent medical records and invoices can cause delays in verification, requiring additional documentation from healthcare providers.
- **Policy Discrepancies**: Issues related to policy terms and conditions, such as unclear coverage limits, deductibles, or co-payments, can result in delays as the TPA verifies the patient's coverage and benefit eligibility.
- **Manual Review Processes**: Lack of automation in the medical billing department can result in slow, manual processing of claims. This increases the likelihood of human errors and slows down the claim cycle.
- **Coordination of Benefits (COB) Issues**: When a patient has multiple insurance policies, determining the primary and secondary payer can complicate the billing process and cause delays in claim adjudication.
- **Delays in Payment from Insurers**: Slow disbursement from insurers can also cause delays in finalizing claim settlements. Insurers may take time to review and process claims, especially for larger payouts.
- **Disputes and Appeals**: When claims are denied or underpaid, it leads to disputes or appeals, significantly extending the TAT for final settlement. This involves multiple rounds of verification and justification from providers or patients.
- **Regulatory and Compliance Issues**: Changes in healthcare regulations or insurance laws may require additional checks in the billing process, resulting in slower claim settlements due to compliance-related delays.
- **Technical/System Issues**: Outdated billing software or technical glitches in electronic claim submission (ECS) systems can result in claim rejections or delays in transmission, requiring manual intervention to resolve.

➢ *Findings in Medical Scrutinizing and Auditing Department*

The Medical Scrutinizing and Auditing Department will the check the liability of admission of patient in hospital. They check various aspects like discharge summary, PP/MRC, DOA, DOD, additional preauthorization amount, diagnosis, IR status, policy conditions. GMP conditions, P.A number, hospital authorization seal, billing sheet, discounts. TDS in their module.

The Average time taken for claims in Medical Scrutinizing and Auditing in cashless and reimbursement claims is 5.6 and 11.3 days respectively without document recovery and with document recovery it will be 3.6 days and 34.25 days respectively Findings for the delay in TAT in claim settlement process in Medical Scrutinizing and Auditing Department.

- **Incomplete or Inconsistent Medical Documentation**: A lack of complete or consistent medical records, such as unclear treatment details, missing investigation reports, or incomplete discharge summaries, causes delays in the scrutiny and auditing process. This requires back-and-forth communication with healthcare providers to obtain necessary documentation.
- **Complexity of Medical Cases**: Claims involving complicated medical procedures or multiple co morbidities often require detailed reviews by medical experts. This leads to additional time in scrutinizing the validity and necessity of treatments, which increases TAT.
- **Manual Auditing Processes**: In many cases, medical auditing relies on manual review, which is time-consuming. Manually verifying treatments, medical necessity, and policy coverage can introduce human error and delay the entire claim settlement process.
- **Policy and Coverage Clarifications**: Delays occur when there are discrepancies or unclear interpretations of

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policy terms, such as coverage limits, exclusions, and pre- existing condition clauses. Medical auditors need to spend extra time verifying policy details with insurers.

- **Over-treatment or Overbilling**: Claims that appear to involve over-treatment, unnecessary procedures, or inflated billing require deeper investigation. Auditors must examine whether the treatment provided aligns with medical necessity, which can prolong the scrutiny process.
- **Coordination of Benefits (COB)**: When a patient is covered by multiple insurance policies, the auditing team needs to coordinate with other insurers to determine the primary and secondary coverage. This increases the time spent in the auditing process due to the need for verification from various parties.
- **Fraud Detection**: Suspicious claims or potential fraud cases require additional investigation, such as cross-checking medical records, interviewing patients or providers, and consulting medical experts. This rigorous review adds to the overall TAT.
- **Discrepancies in Billing and Treatment**: In some cases, there may be discrepancies between the treatment provided and the charges billed. Auditors need to verify that the billing accurately reflects the treatment, leading to extended claim processing times.
- **System Inefficiencies**: Outdated or inefficient systems in medical auditing departments can slow down the claim review process. Technical issues such as slow data retrieval, lack of automation, or software limitations can delay the auditing process.
- **Regulatory and Compliance Checks**: Compliance with healthcare regulations and insurance guidelines often necessitates thorough audits, especially for high-value claims. This adds additional layers of scrutiny, increasing the time needed for final claim approval.
- **High Volume of Claims**: When there is a large volume of claims submitted for auditing, it strains the department's capacity, leading to delays in claim processing. Peak seasons or surges in claims can overwhelm the auditing team.
- **Dispute Resolution**: In cases where discrepancies or rejections arise, the auditing department may have to engage in lengthy dispute resolution processes with healthcare providers or insured parties. This requires multiple rounds of communication and reevaluation.

➢ *Findings in Customer Relation Management [CRM] Department*

Customer Relation Management [CRM] Department deals in handling inquires, status updates and grievance handling and dispute resolution, Issue Payments, cheque dispatch. The Average time taken for claims in CRM department in cashless and reimbursement 43.8 days and 17.9 days respectively Findings for the delay in Tat in claim settlement process in CRM department.

- **Inefficient Communication Channels**: Delays often occur due to ineffective communication between the CRM department and stakeholders (policyholders, healthcare providers, and insurers). Slow response times, lack of real-time communication tools, or outdated systems (such as emails or phone calls) can lead to longer TAT.
- **Lack of Proper Training for CRM Staff**: Insufficient training of CRM staff in handling complex insurance claims, medical terminologies, and policy nuances can lead to miscommunication or errors in addressing customer inquiries. This can delay the resolution of queries, impacting overall claim processing time.
- **High Volume of Customer Queries**: When the CRM team is inundated with a large number of queries and complaints, particularly during peak times, it results in bottlenecks. Limited resources and long wait times for customer responses further extend TAT.
- **Inconsistent or Incorrect Information Sharing**: CRM agents sometimes provide inconsistent or incomplete information to customers regarding claim status, documentation requirements, or policy terms. This can lead to confusion, miscommunication, and repeated inquiries, slowing down claim settlement.
- **Delays in Follow-ups**: Failure to conduct timely follow-ups with policyholders, healthcare providers, or other departments within the TPA can cause delays in gathering necessary information, resulting in an increase in claim processing time.
- **Inadequate Coordination with Other Departments**: CRM teams often serve as intermediaries between different departments (medical audit, billing, preauthorization) and customers. Poor internal coordination and lack of seamless information flow can cause delays in escalating and resolving claims.
- **System and Technical Issues**: Outdated CRM software or technical glitches can lead to slower resolution of customer issues. Problems like system crashes, data entry errors, or difficulties accessing real-time claim status updates contribute to delays.
- **Frequent Discrepancies in Claim Status Updates**: If CRM agents provide incorrect or outdated claim status updates to policyholders, this results in repeated inquiries and customer dissatisfaction, extending the overall TAT. This often occurs due to poor synchronization between CRM systems and the claims management system.
- **Regulatory and Compliance-Related Queries**: CRM departments may face delays in responding to customer queries related to regulatory compliance or policy changes. These types of inquiries often require coordination with legal or compliance teams, extending response times.
- **Slow Grievance Resolution**: When customers file complaints or grievances regarding claims, resolution often takes a long time due to a lack of structured grievance redressal mechanisms. This creates additional delays in processing the underlying claim while the dispute is addressed.
- **Language and Cultural Barriers**: In cases where CRM teams handle customers from diverse linguistic or cultural backgrounds, communication gaps can arise, leading to misunderstandings and delays in claim processing.

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- **Incomplete or Incorrect Customer Requests**: When customers submit incomplete documentation or incorrect requests (such as missing forms or incorrect policy numbers), the CRM team needs to request the missing information, causing further delays.
- **Manual Processing of Cheques**: In cases where cheque generation and dispatch are handled manually, it leads to a slower process. Manual data entry, printing, signing, and verifying cheques introduce opportunities for errors and delays.
- **Incorrect or Incomplete Beneficiary Information**: Cheque dispatch can be delayed when beneficiary details such as name, address, or bank account information are incorrect or incomplete. This leads to the return of cheques or reissuing them, extending the overall claim settlement time.
- **Approval Delays**: Cheques often require approval from various departments (such as finance or senior management). Delays in obtaining the necessary approvals, especially for high-value claims, can significantly slow down the cheque dispatch process.
- **Batch Processing Delays**: TPAs often process cheques in batches. When batches are delayed due to system issues, insufficient approvals, or errors in other claims within the batch, it impacts the overall timeline for cheque dispatch.
- **Third-Party Vendor Delays**: Many TPAs outsource cheque printing and dispatch to third-party vendors or courier services. Delays on the vendor's side in printing, packaging, or delivering cheques can cause an increase in TAT.
- **Courier or Postal Service Delays**: Once cheques are dispatched, any delays in postal or courier services due to factors such as public holidays, strikes, or logistic inefficiencies can extend the TAT for claim settlement.
- **Cheque Reconciliation Errors**: When there are discrepancies between the payment data and the cheques generated, reconciliation errors occur. Resolving these errors before dispatch can introduce further delays.
- **Bank-Related Issues**: Cheque dispatch can also be delayed due to issues at the bank's end, such as changes in bank details, non-availability of cheque stock, or delays in processing bank account verification.
- **Cheque Return/Reissue Process**: If cheques are returned due to incorrect addresses, expired payees, or other issues, the reissuance of cheques causes significant delays. The process of canceling the old cheque and issuing a new one adds extra time to the claim settlement.
- **Outdated Technology**: If the cheque dispatch department is using outdated systems for generating and tracking cheques, it can slow down the process due to inefficiencies like system errors, slow data processing, or limited automation.
- **High Volume of Cheques**: During peak claim settlement periods or financial year-end, the volume of cheques may overwhelm the cheque dispatch department, leading to processing backlogs and longer dispatch times.
- **Lack of Integration with Other Systems**: If the cheque dispatch system is not integrated with other claim processing systems, there can be delays in the flow of information. This may result in cheques being prepared late or inconsistently with claim settlement timelines.

## IV. CONCLUSION

Claims management is considered to be one of the most valuable possessions of any insurer.The analysis of turnaround time (TAT) in the claim settlement process within Third-Party Administrators (TPA) highlights the critical importance of efficiency and coordination across various departments. Delays in claim settlement can stem from multiple factors, including inefficiencies in preauthorization, medical scrutiny, billing, CRM, and cheque dispatch processes. To reduce TAT, TPAs should adopt automated systems, enhance inter-departmental communication, streamline documentation, and promote digital solutions like electronic payments. By addressing these key areas, TPAs can significantly improve their claim processing speed, reduce bottlenecks, and enhance customer satisfaction.

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