REJECTION OF CLAIMS BY DISTRICT HEALTH INSURANCE SCHEMES: THE CASE STUDY OF SUNYANI MUNICIPAL HEALTH INSURANCE SCHEME

BY

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CERTIFICATION

I hereby declare that this Dissertation is my own work towards the award of CEMBA and that to the best of my knowledge, it contains no material previously published by another person or does not contain any material which has been accepted for the award of any other degree of the University, except where due acknowledgement has been made in the text.

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ABSTRACT

Health Insurance in Ghana is still young after five years of implementation, albeit bedevilled with claims problems. The aim of the study was to determine the factors that contribute to the rejection of health insurances claims submitted from health facilities to the health insurance schemes. This is an evaluative study conducted between January to March, 2009 involving a review of 300 health insurance claims submitted to the health insurances schemes in the Sunyani, Municipality, Ghana. In addition, 50 staff from health facilities and 5 health insurance scheme managers were also interviewed for the study. An observation guide was used for assessing the filled health insurance claim forms and an interview guide for the health workers and health insurance scheme managers. The results showed that 54% of the health insurance claims submitted to the health insurance scheme were rejected. The portions of the claims form not incompletely filled were type of service (5.3%), diagnosis (5.0%), outcome of management (5.3%) and drug list (5.3%). The portion of the forms that were not filled were the price of drugs (8.3%), drugs (0.3%) and investigations (3.7%). The signature of health care provider was not on 10.7% of the forms. The main reasons for rejection of the claims included: poor documentation (31.2%), excess charge (50.9%) and tariff amount not stated (4.3%). Over 50.0% of the health workers had not had refresher training on claims

processing. The health insurance scheme managers were able to resolve 60% of rejected claims. It is concluded that most of the health insurances claims forms are rejected due to poor documentation by physicians and persons working at the health insurance offices in the hospitals. It is recommended that the Regional Health Directorate through the Hospital Management Teams in the Sunyani municipality should ensure close supervision and review of persons responsible for processing insurance claims to improve on the poor documentation practices.

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DEDICATION

This dissertation is dedicated to my parents:

Alhaj Sanni Issah Awudu and Hajia Fati Alhassan. My wife Mrs Hanatu Hussein (Hannah); and my Children, (Hussein Mohammed Sadat, Saeed Hussein and Shamsu-Deen Hussein)

Whose support, encouragement and affection motivated me to complete this dissertation.

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CHAPTER ONE

1.0 BACKGROUND

1.1 Introduction

Increasing access to health care is one of the challenges facing the global community, particularly African populations. Health sector reforms from the eighties and nineties led to the endorsement and introduction of cost recovery mechanisms, in particular out-of-pockets payments at the time of illness. This form of financing had unintended effects of decreasing access to health care by the poor. Since the mid 1990s, increasing morbidity patterns in low income countries have contributed to widening the gap between the need for, and the utilisation of health services among poor people (Arhin-Tenkorang, 2001)

Sub-Saharan African countries tried different modes of health care financing since independence. Due to low and unstable tax revenues as well as cutbacks in public budgets, the initial goal to provide "free health care for all" was never achieved. In the eighties, government resources dried up in many countries, including Ghana, resulting in a deterioration of the quality of existing services. User fee financing mechanism adopted by most Sub-Saharan African countries turned out to be contributing insignificantly to governments' expenditure on health services (Wiesmann and Jütting, 2000).

It is estimated that on the average national user fee systems generated only 5% of recurrent health system expenditure (Gilson, 1998). In Ghana, several reasons including health financing as a major one, account for the slow pace of improvement in the health sector. In particular reductions of public spending on health care and the introduction of user fees have created problems of inaccessibility and inequity in the health care (Asenso-Okyere et. al., 1998). The financing response by creation of insurance schemes suitable for poor people and other disadvantaged groups remains the way forward despite implementation difficulties.

Ghana has prioritized universal coverage of health care and has therefore put in place policies and programmes to meet this goal. Even though success has been achieved in different aspects of the health sector, health care delivery remains inadequate especially for poor people and other disadvantaged groups. The task confronting the health sector remains difficult; life expectancy remains low (60yrs), morbidity of preventable diseases remain high, malaria, diarrhoea and other preventable diseases account for 40% of child mortality, and maternal mortality is still high (240/100,000 live births),Ghana Statistical Service (GSS, 2003).

1.2 Problem Statement

The enactment and subsequent nationwide implementation of the National Health Insurance Act (Act 650) have resulted in the registration of over 11 million people into the National Health Insurance Scheme. The result has been increased access to health services by all especially, the underprivileged and the poor. The consequential effects include increased workload resulting from increasing attendance and a lot of documentation by health care providers for the purpose of accessing payment from the mutual health insurance schemes. The excessive documentation affects reimbursement rates to the health training institution and therefore affects efforts at improving the quality of health services by health providers.

In the Sunyani Metropolis, there has been increase in hospital attendance over the few years of the implementation of the National Health Insurance Scheme (NHIS). In the year 2006 there was a total of 233,670 hospital attendance increasing to 245, 158 in 2007. In the later year 66.2% of the health facility users in the municipality were insured, Regional Health Directorate (RHD, 2007). The increase is observed from the fact that all the health facilities in the catchment areas both private and government have been accredited. However, the 15 accredited health facilities have expressed concern about the eminent effects of the issue on

non-payment of submitted claims by the health insurance schemes. They find this to be detrimental to the sustenance of the NHIS. Yet, several meetings and formal discussions of the matter between the health facilities and the health insurance companies have not yielded much result.

There has not been any scientific assessment of the claims reimbursed and an estimation of the nature of claims reimbursement and related causes of non-payment of health insurance claims and more importantly, modes of resolution for better sustenance of the scheme in the Sunyani metropolis. This study therefore is intended to establish the procedural and managerial factors related to claims management.

1.3 Research Questions

1. What proportion of claims is submitted that are not paid by the health insurance scheme and what are its possible effects on the relationship between the two stakeholders?
2. What capacity exists in the health facilities to ensure effective adherence to accurately and completely filling claims forms to the health insurance company?
3. What level of thoroughness is exhibited by the insurance companies in determining the rejection or acceptance of claims?

1.4 Objectives

General

The main objective of this study is to establish the managerial and procedural factors that account for the rejection of client claims made from the health facilities accredited to render health services, to the health insurance schemes in the Sunyani municipality.

Specific Objectives

1. To estimate the proportion of claims that are rejected by the schemes and amount involved and further examine the consequences on either the health facilities, the health insurance schemes or both in the metropolis
2. To determine the extent to which capacities at the health facilities are built in minimising claims errors

3. To assess the scope with which the insurance company examines claims for its acceptance or rejections
4. To make recommendation to stakeholders for improving the management of claims in the metropolis.

1.5 Significance of the Study

Funds are pivotal in ensuring the sustenance of the NHIS in Ghana. The non-adherence to due process by health facilities and insurance schemes could result in cutting down claims and therefore affect resources available to health care providers to offer quality health care to the vulnerable groups including women and children. Minimising rejected claims therefore is pivotal in ensuring that health facilities are able to continuously replenish their resources, so as to ensure acceptability of the scheme.

Also accepting and paying for wrong claims will deplete the scheme's fully in no time making it unsustainable

Efficient claims management by the Insurance Scheme will also keep the scheme running and ensure continuous operation.

The findings of this study therefore would improve on the general implementation guidelines of the scheme which is aimed among others at providing an acceptable and quality health service through sustainable health financing – via insurance- to improve the health of the ordinary Ghanaian. The Sunyani Health Insurance schemes, the Regional Health

Directorate, the private and public health facilities and most importantly the beneficiaries of the insurance scheme would be well informed based on systematic assessment of the state of reimbursement issues of the scheme. In this regard, the causes that account for such a mishap could be inculcated in stakeholders action plans and hence improve on the total health delivery services in the municipality.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Introduction

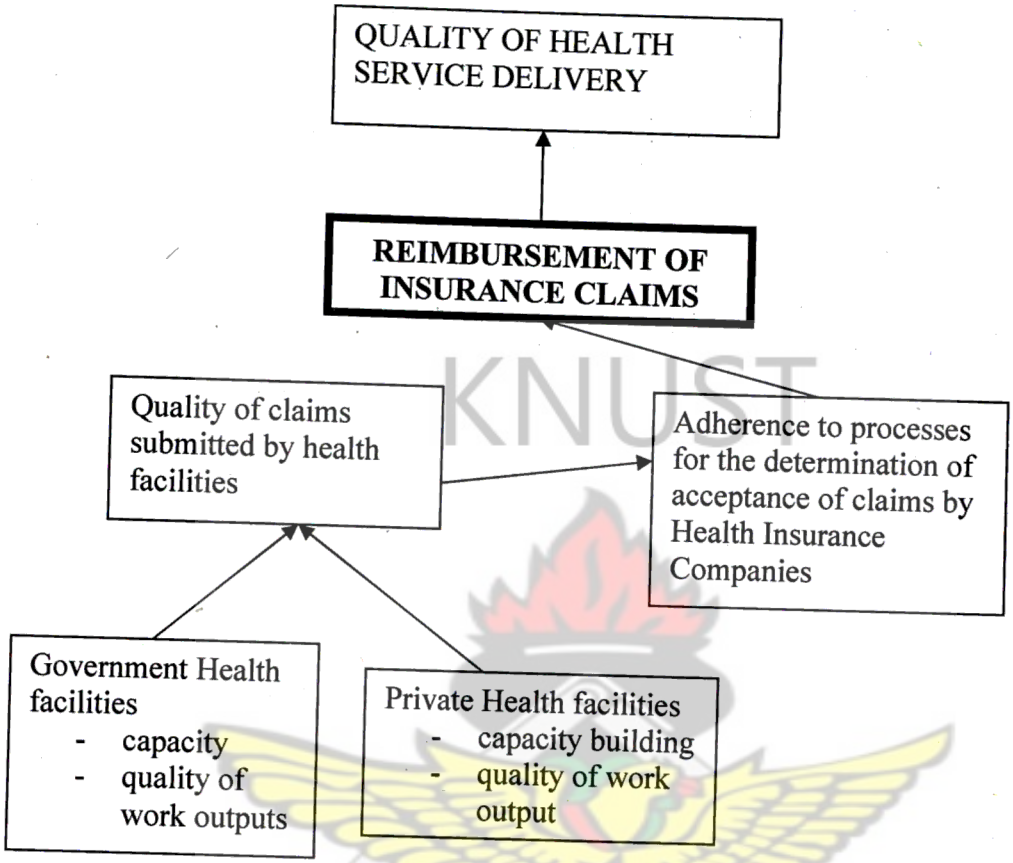
The chapter has been presented in sections of: definition health insurance; types of health insurance; principles of health insurance; and brief history of health insurance in Ghana. It also covers the experiences of stakeholders mainly managers, health care providers and beneficiaries (members of insurance scheme). The evidence of the latter is based on issues relating to the specific objectives raised in the previous chapter. This review examines the experiences of health insurance management issues around the globe with special emphasis on evaluated works conducted in Ghana.

2.2 Conceptual Framework

The quality of health services in the context of the implementation of the NHIS is based on the extent to which the scheme reimburses claims made to its agencies. A low claim reimbursement rate would lead to poor quality of health care and the opposite is true for the vice-versa. However for the purposes of better management of the finances of the health insurance scheme, claims submitted for payment should meet

standards required for payment. In this regard the quality of the claims submitted determines whether approvals could be made for payment or not. Health facilities, government and private, have the responsibility of ensuring that claims forms are well filled so as to facilitate the process of payments and thereby ensure that they continue to be in business. The capacity of health workers in the health facilities in fulfilling this responsibility cannot be underestimated. Low capacity building of staff in meeting the standards of the health insurance companies could lead to high rejection of claims. Obviously, the low capacity could result in poor work output in terms of incomplete and or inappropriately filled claim forms as well as non adherence to due process for assessing costing of services among others. On the other hand, an effectively built staff capacity could have positive results in terms of non-rejection of claims and total reimbursement to the benefit of the health facility and its survival.

Figure 1.1 A conceptual framework showing the factors that affects re-imbursement of insurance claims



Source: Author's construct, 2008

2.3. Health Insurance: Brief History

Health financing worldwide has developed from the era of free care to out-of-pockets payments into health insurance schemes. In most developing countries, particularly Sub-Saharan Africa, health care in most public health facilities used to be free. In West Africa, financing health care solely from tax revenue was considered unsustainable hence the Bamako Initiative (BI) in 1988 (Uzochukwu *et al* 2004). The BI became necessary owing to the situation in the 1980s where there was severe problem in financing health services in sub-Saharan Africa including Mali. Poor health financing policies had led to the virtual collapse of most facilities. Governments in this region subsidized cost of health services yet were unable to support the health facilities financially. Bamako Initiative program (BI) sought to accelerate and strengthen the implementation of primary health care (PHC), with the goal of achieving universal access to these services. It was an initiative that African Ministers of Health introduced in 1987 to reorganize and strengthen Primary Health Care (PHC) with emphasis on Maternal and Child Health. Prior to the revision of these fees Ghana's health service was characterized by structural decay, poor maintenance and frequent break down of facilities without replacement and shortage of essential drug

traces. This resulted in low staff moral and low level of public confidence in health professionals (Donkoh, 2001).

Different actors finance the health care system in Ghana; government of Ghana through direct budget allocation and local government common fund, households, non-governmental organisations (NGOs) that assist religious hospitals and clinics, and the donor community. Others include employment-based arrangements in the form of direct payment of medical bills by employers or re-imbursement after employees have paid their bills.

In Ghana, historically, the independence of 1957 brought among others, free health care for all citizens who accessed public health facilities. This implied, there was not an out- of- pocket payments at the point of consumption of health care in public health facilities. Financing public health facilities was done through tax revenues which were also poorly designed and managed (Ghana Health Service 2004). As times elapsed, the decline of the economy coupled with increasing competing demands for free services on the same scanty resources created a financial depression in the health sector. For instance in 1983, health spending dropped to less than 20% of the 1975 levels. (Arhin-Tenkorang, D (2001).

In 1969 an intention for the introduction of user fees was expressed by the passage of the Hospital Fees Decree (NLCD, 360). This was amended in 1970 (Act 325) and as the hospital Fees Act, 1971, (Act 387). These laws required a legislative instrument to bring it to full implementation. It was in 1985 that legislative instrument (LI) 1313 mandated a nationwide fee-for-services system (Government of Ghana 1971). The fees covered consultation, laboratory and other diagnostic services, medical, surgical, and dental services, medical examination, and hospital accommodation costs were highly subsidised. Drugs were charged to patients at full cost.

The introduction of the user fees resulted in a massive decline in the utilisation of health services resulting in increasing in all forms of morbidity and mortality. Despite these catastrophic outcomes, full cost recovery for drugs was implemented in order to address the shortage of drugs. The system, popularly referred to as *cash and carry (paying out of pocket at the point of service)* created financial barrier to health services. The poor in society could not afford the cost of health services.

The situation was so devastating that some form on insurance scheme was found to be necessary to enable people access health care. The Nkoranza model of community health insurance scheme that was initiated by the Catholic Church in Brong Ahafo Region of Ghana was worthy to

study. Several others followed in the Eastern Region. After several years of studies there was no political will to implement a national health insurance scheme due to fear of operational and financial challenges.

It was after 2001 that a political commitment was made and implementation of a nationwide insurance scheme commenced. This commitment was expressed in the enactment of Act, 650 in the year 2003(Government of Ghana 2003) that established the National Health Insurance Council it is agencies and modus operanda. So far over 12 million Ghanaians have enrolled in the scheme. This indeed has increased access to health facilities till date.

Health Insurance has advantages that include: its ability to provide universal access to health care; reduced administrative cost; and allowing clients to choose their physicians (McConnell, 1999). The realization of the full advantages of the Health Insurance scheme in Ghana is yet to be manifested however; those listed above could be applicable to some extend considering the quality of care in the country in addition to the health worker- patient ratio. Dr. Timothy Evans, Assistant Director-General for WHO in answering questions on what the most important policy to improve health systems substantially had this to say, '*much more should be done to address the woefully inadequate health financing*

in many countries. At present it is primarily the consumer who is paying out-of-pocket for care, and ill health has become the major drivers of poverty'. On the other hand, Health insurance has some weakness these include: adverse selection, moral hazards and fraud.

2.4. Definition and Nature of Health Insurance

Health insurance can be defined as a policy that pays specified sum for medical expenses or treatment (The Entrepreneur, 2003). According to Ghana Health Service GHS, (2003), health insurance can also be defined as a risk pooling arrangement by which the cost of health care to any single individual in the society, whether rich or poor, becomes a collective responsibility of all the people in the society. This is an arrangement which best suits the current socio-economic circumstances in our country (GHS, 2003). Health insurance therefore is a mechanism of financing and managing health care, which depends on resources based on formalised and compulsory contributions (MOH, 2004). This suggests that for every health insurances scheme, there is a recognised and registered structure of its management and persons enrolled make specific contributions to ensure the survival of the health insurance scheme.

The concept of health insurance is based on risk sharing (Arhin-Tenkorang, 2003). Risk sharing means that there relative state of health

of individual with its associated cost. Therefore, persons who are relatively healthy, and participate in a health insurance scheme would be supporting those in need who fall sick regularly.

2.5 Types of Health Insurance

Theoretically, there are two forms of health insurance – private insurance and social insurance. However the nature and form by which a health insurance scheme organised and managed determines whether it is only private or only commercial or bears both characteristics.

2.5.1 Private Health Insurance Scheme

Private health insurance scheme is voluntary scheme therefore; participation is usually small and focused on a specific group of people in a small setting. It is financed through payment of premiums in addition to co-payments and revenue from investments. It is fully managed by a private company and its benefits packages are tightly defined, curative in orientation and exclusive in terms of coverage of diseases. Private health insurance schemes can be organised basically as private mutual or private commercial.

In the case of the private mutual health insurance schemes, it could also be community-based or occupational-based or some form of private group and does not receive subsidy from the government. The private

commercial health insurance schemes operate for profit based on market principles. Premiums are based on the calculated risks of particular groups or individuals who subscribe to it. Thus, those with higher risks pay more (MOH, 2004). Mutual health insurance is a health insurance system that is driven by such principles as democratic governance, autonomy and freedom, personal development, not-for-profit approach, solidarity and responsible management (Ndiaye, 2006). By sharing health-related risks, the system improves access to health care for beneficiaries who contribute to it. Members pay a contribution (monthly or annual), which entitles them to a package of services at partner health facilities (Ndiaye, 2006). There are several types of mutual health insurance schemes, depending on whether they are initiated by the population, health care providers, micro finance institutions or other social groups, and depending on the level of involvement of the state and development assistance agencies (Ndiaye, 2006).

Private commercial health insurance scheme has an authoritative management that is focused on managing health insurance scheme for profit purposes. It is therefore selective in terms of risk sharing. That is, it more centered less risky and less costly disease conditions yet its premiums are very high.

2.5.2 Social Health Insurance Scheme

The social health insurance scheme covers formerly employed persons and their dependants and funded through employer and employee contributions and co-payments. Its funds are managed by an autonomous public body and its benefits packages are tightly defined but cover mostly primary and secondary care but not tertiary care and also often exclude preventive care. The social insurance is scheme underpins the insurance scheme being implemented in Ghana. These are in the form of district wide health insurance scheme and mutual health insurance schemes.

2.5.3 District Wide Insurance Schemes

The district-wide health insurance scheme (DWHIS) in particular receives subsidies from the government in the form of risk equalization and reinsurance for catastrophic events, e.g. disease epidemics. This form of insurance emerged from the Ghana experiences of establishing health insurance scheme. DWHIS basically encompasses all district health insurance schemes, whether community based or organisational based- to be managed under one wide umbrella. This was intended to make health insurance scheme and the community and district level socially responsive and better structured in terms of management, processing of claims and obtaining support from the central government.

2.5.4 National Health Insurance Scheme

It is worthy to mention that National Health Insurance Scheme being implemented in Ghana is the first of its kind globally. It merges the features of a social health insurances scheme and a mutual health insurance scheme into a National Health Insurance System (NHIS). This concept has never been tried anywhere in the world. Hence its organizational structure is not fully determined and to some extent it is still emerging.

2.6. Principles of Health Insurance Schemes

The principles of equity, risk-equalization, cross-subsidization, quality of care and solidarity are central to the establishment and sustenance of health insurance schemes. Others include community ownership, efficiency in disbursement of claims, reinsurance and sustainability among others.

2.6.1 Equity implies access to minimum benefit package irrespective of the background of the member. In other words, the basic health needs of majority of the population would be catered. This mostly reflects in the capturing of all the out patient diseases that is recorded in most part of Ghana (MOH, 2004).

2.6.2 Cross Subsidisation refers to a situation where a sick member even though may be poor and vulnerable, benefits from the payments made by the healthy and wealthy. This implies that there will be adequate funds in the pool of contributions made by registrants of the health insurance scheme. This would ensure that persons who regularly get sick and are poor can always access and afford health services. This is because, contributions form the healthy registrants can be used to settle the cost of services hence ensure quality care (GHS, 2003; MOH, 2004).

2.6.3 Risk-equalisation examines the distribution of diseases burden within the catchments area and taking that into the general framework of the operations of the scheme. To ensure that the scheme is sustained there should be quality of care and up to standard (MOH, 2004).

2.6.4 Community Ownership is vital to ensure community participation. In the past community, participation eluded healthcare planning and delivery. Efforts have been made as part of the primary health care strategy to encourage and sustain community participation without much success. Community ownership of the scheme is expected to promote community participation and thereby bring to bear the client perspective of quality of care on the delivery process (GHS, 2003).

2.6.5 Reinsurance as a principle is at the centre of the operations of any type of insurance. This especially so in health insurance where schemes may run into risk of under funding due to unforeseen catastrophic events such as epidemics and natural disasters. Should such event occur central fund would need to be set aside to recapitalise (MOH, 2004).

2.6.6 Sustainability is essentially about how well the schemes are managed especially in the area of risk management and fraud control (MOH, 2004). Thus, human resource capacity and systems in terms of accountability and validations require strengthening to ensure that health insurance schemes are sustainable (Assenso-Okyere 1998, Arhin-Tenkorang, 2004).

2.7 Current Structure of National Health Insurance Scheme in Ghana

The NHIS is governed by National Health Insurance Council as enshrined in ACT 650 (GoG, 2003). The council appoints a management team headed by a Chief Exective Officer. At the Regional level, Regional Health Insurance Committee that monitors the management of the District Health Insurance Schemes. Each District Health Insurance Scheme has a Council that overlook the decision of the managers of the district insurance scheme.

All district health insurance schemes accredit health facilities that are beneficiaries can access for health services. The registered health facility can be private or public. When health insurance holder attends a hospital, claims that are defined in the National Health Insurance policy, are submitted by filling of specific claim forms to the appropriate District Health Insurance Scheme for payment (DHIS).

On receipt of health insurance claims from eligible health facilities, the DHIS vet the claims. The vetting process takes the form of assessing if the information provided on the health insurance claims form merit the policy defined for the client and in accordance with the national guidelines approval of claims (GoG, 2003). After vetting, some claims are accepted and forwarded to the DHIS claims managers for onward payment to the health facilities. Rejected claims are also returned to the health provider, containing statements showing specific reasons for rejection. This is either resolved or lost to the health facility (GoG, 2003).

2.8 Rejected Claims

Health providers are key stakeholders in the management of health insurance. The role defined in the context of provision of quality health services to beneficiaries of health insurance schemes is pivotal to survival of the schemes. The important responsibilities of health providers also comes with issues about sustaining the quality of services rendered. Hence the need to make claims for services rendered to beneficiaries of health insurance companies.

Claims management is critical in all insurance forms especially when it is mutual based and national in character such as could be seen with health insurance schemes in Ghana. Its importance lies in ensuring not only the

sustainability of the insurance system and the services provided, but more importantly to curtail abuse of the scheme in the form of making undue payments, over payments or promoting fraud. Despite this key role of claims management, it also has its consequences when proportions of claims genuinely made are mistakengly rejected by health insurance schemes. In fact, not much research has been conducted to determine the effects of rejected claims on the survival of health services providers who work with insurance companies. In a case report, Vogin (2009) demonstrated that rejection of claims could lead to the suffering of cases over a long period of times. In his review of a case of an 80 year old woman, he noted consistent rejection of her claims over a two year period. The reason being that she did not apply for such benefit.

There are several reasons that could account for the rejection of claims. It could be as minor as a data entry problem (Vogin, 2009) to others relating to filling of complex forms. In the United Stated of Veterans Affairs that it is important that processing of claims adhered to in terms of procedure and content requirement. The continual assessment of such claim is therefore relevant in monitoring abuse (CHAMPVA, 2009). As detected by CHAMPVA, (2009), Veterans could make erroneous claims with varied intents and motives such as could be made by any beneficiary of an insurance product. In that assessment several attributes were given to

the rejected claims. These included: Duplicate claims, duplicate of a previously processed claims, and late submission of claims, beneficiary not eligible on date of service claimed, services not covered, and diagnostic code missing.

Vogin (2009), in his case report, asserted that records handling and management contributed significantly to the rejection of insurance claims. He identifies six common reasons why insurance claims are rejected. These are: Doctor Error, pre-existing condition, and bad processing. The rest are not medically necessary, noncovered benefit and out of network. Doctors make mistakes. Frequently, they write in the wrong insurance code or make another error on the insurance form.

Pre-existing conditions form one of the most common reasons that insurers deny coverage. Sometimes claims on this basis aren't really denials but the insurer needs or request for more information from the health facility. Other times, the claim is denied because it doesn't conform to the policy's actual language. For instance, a policy may specifically require that the condition be diagnosed and treated for the "pre-existing" clause to apply or whether simply having the symptoms is enough.

Sometimes Medicare errs in processing claims. Errors easily occur because Medicare claims are administered separately in each state, and

each claim is filed in the state where the healthcare was provided. However, claims sometimes are re-routed because a number of seniors divide their time between separate residences in different states.

Frequently, insurers rule that a service or procedure was "not medically necessary," even though usually the person who reviews medical claims usually works for the insurance company, has never seen the patient and probably is not a healthcare practitioner.

Another typical explanation is that the care you received was a "noncovered benefit." Insurance policies always include a list of services that are and are covered and those not covered. Often the definitions of benefits are so vague that it is difficult to compare your situation with the policy's medical terms.

An insurance company may deny claims by contending that the doctor used was "out-of-network" doctor or hospital. Sometimes a medical emergency may prevent a client from getting treatment from a healthcare provider who is part of a registered insurance plan. Or a client may need a specialist for a certain condition, but there is none in the area.

A report in 2007 on medical claims reimbursement from the office of the Medicare programme, presented by the Associate Administrator, to the

US House and Senate Health Committees list a number of reasons that accounts for the rejection of claims to beneficiaries of the Medicare Programme in the United States of America. The enlisted reasons were: incorrect patient's subscriber number; missing physician's signature; incorrect dates; and services not corresponding with diagnosis. In addition, missing diagnosis; not listing reasons for multiple visits; unitemised charges; lack of information on prescribed drugs; blank fee column; and difficulty in reading claims (Medicare, 2007).

2.9 Building Capacities to Minimise Errors on Claims

There has been training on all health professionals and other stakeholders involved in the management of health insurance issues, especially claims. During the operationalisation of the insurance schemes, several facility based courses were organised for health professionals, including administrators, nurses, accountants and doctors on their role in implementing the health insurance schemes. As far as claims management is concerned, accounts clerks, and health administrators were deeply involved. In addition to these, according to the National Health Insurance Authority, regular updates are made on the management of the NHIS which subsequently has resulted in training of many health professionals involved in the scheme.

CHAPTER THREE

3.0 METHODOLOGY

3.1 Introduction

This section of the study provides details about procedures used for the collection of data for the study. It describes the type of study, the study population, study area, sample size and sampling procedures, data handling and analysis and ethical issues. It also addresses the assumptions made before the commencement of data collections.

3.2 Type of Study:

This was a descriptive study with a evaluative design examining the extent of adherence to quality claims management at the health facility and health insurance schemes and how this influences the flow of reimbursement to the health facilities.

3.3 Study Population

This study involved a population of patient claims prepared by health professionals for submission to the health insurance claims over the last three months. In addition, a population of claims submitted at the health insurance companies were also examined from the past three months. Moreover, health professionals and managers responsible for

filling of claims and also staff of health insurance schemes were interviewed for the purpose of this study.

3.4 .0 Sampling and Sampling Techniques

3.4.1 Sample Size

Using EPI STAT Calc software version 4.0.1, the sample size of 300 claims was determined based on presumed population variance of 0.5, and reliability coefficient of 1.96 and at 95% confidence interval. In the selected health facilities and insurance schemes, 150 each of claims processed and claims rejected respectively would be assessed. In addition, managers of insurance claims at the health facilities and health insurance officers would be interviewed. An estimated 50 staff from health facilities and 5 managers from health insurance management teams would be engaged in the study.

3.4.2 Sampling Procedure

The claims prepared by the health facilities for onward submission were randomly selected and assessed based on defined criteria of accurate completion of claims. The selection criteria would be based on:

a. the claims form had been prepared within the past three months
b. the claim had been duly ready for submission to a health insurance scheme
c. Payment on bills of such claims have not been effected or paid.

The health managers and officers at the health facilities were purposively selected based on their responsibility relating to the filling, compilation and or approval of filled claims for submission. The scheme manager and other line officers were also purposively selected for the study to respond to specific issues relating to determination of acceptance or rejection of claims received from the health facilities.

3.4.3 Variables and Outcome Measures

The proportion of approved claims submitted was determined based on previous records and further ascertained based on the standardised assessment of reviewed claims prepared by the health facilities and those rejected by the health insurance company. This was measured in terms of percentages.

The extent of adherence to protocols relating to filling and submission of claims was operationally defined based on the observations made from the errors in filling of the forms by the health professionals and further by responses made by them from the interview schedules.

3.4.4 Data Collection Tools

The data collection tools used was on studied checklist and an interview guide.

The mode of administration of the study guide was by observing the claims filled and identifying errors made which accounted for its rejection or acceptance. The selected mangers from the health facilities and health insurance office were interviewed by the researcher.

3.4.5 Data Analysis

Data was coded and analysed using the Statistical Package for Social Scientist (SPSS) version 15.0. There was a separate template designed for observations made and interviews conducted.

Data collectors and entry clerks were trained for collection and processing of data respectively before analysis was made. The analysed data was presented in tables, graphs and charts and appropriate descriptive and inferential statistics were done.

3.4.6 Ethics

Permission was sought from the management teams of the health facilities and the insurance schemes before access to claims was made. They were assured of the restricted use of the study for the purpose of this

study alone, and the fact that it would not affect their relationship with their employers now and in the future.

A consent form was designed for respondents to the interview guide. They were assured of confidentiality and privacy of their response and also the null effect it would have on their present and future relations with their institution.

3.4.7 Assumption

It is assumed that:

1. all respondent provided accurate results
2. all observations made were accurate account of the nature of the claims assessed.

CHAPTER FOUR

4.0 DISCUSSION OF RESULTS

4.1 Introduction

This section of the study details the findings made from observation of health insurance claim forms in the hospital and those submitted to the health insurance schemes in the Sunyani Metropolis. It is presented in tables and graphs in accordance with the objectives of the study.

Table 4.1 Background Characteristics of Health Staff Interviewed

Variable	Frequency (N = 50)	Percentage (%)
Years of service		
< 5 years	3	6.0
5 – 10 years	38	76.0
10 years and above	9	18.0
Profession		
Accountants	21	42.0
Administrators	5	10.0
Health workers	20	40.0
Insurance Coordinators	4	8.0

Seventy six percent of the respondents had worked in the health sector between 5 – 10 years and six percent had worked for less than five years. Accountant (42%), Health workers, (40%), and administrators (10%) were among the workers interviewed in the selected health facilities in the Sunyani Municipality as detailed in table 1 above.

The five insurance managers had all worked in the services for five years.

4.2 Proportion of Claims Rejected

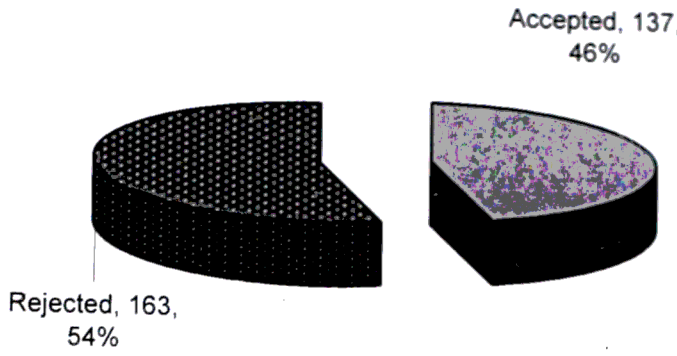


Figure 4.1: The proportion of claims rejected (N = 300)

Figure 4.1 depicts a graphical picture of the proportion of claims rejected. Out of the 300 claims sampled, 54% had indications of rejection by the health insurance schemes.

Table 4.2a Clients Information

Item (N = 300)	% filled	% Incomplete	% Not filled
Date of claim	100.0	0.0	0.0
Name of client	100.0	0.0	0.0
Age of client	100.0	0.0	0.0
NHIS number	100.0	0.0	0.0

Table 4.2a above shows the extent to which the client's information section of the claims form had been documented. The date of claim, name of client, age of client and NHIS number had all been documented in all the 300 claims forms examined.

In table 4.2b, below is depicted the extent of documentation of service items on the claims form. It was evident documentation on the type of services was made on 94.7% on the forms the rest, 5.3% were incomplete. On the study it was noted that for the details of services provided, 96.3% were filled, 0.3% were incomplete and 3.4% were not filled. A similar trend was observed on documentation of the duration spent in the hospital by the patient as 96.3% of the duration spent in the hospital were filled and 3.7% of them incomplete. The outcome of the service provided was indicated on 94.7% but incompletely documented on 5.3% of the claims forms. All (100%) of the forms had indications of the type of attendance the client made. The procedure the client under went was also indicated on 99.7% of the forms but there was no documentation on 0.3% of the forms. Diagnosis of clients were indicated on 91.7% of the claim forms examined whilst on 3.3% of the forms there was no evidence of the diagnosis given to the clients. Laboratory investigations were also recorded on 96.3% of the claim forms; however, 3.3% had no records of laboratory investigations. Price of laboratory investigations was indicated on all (100%) of the claim forms. The types of drugs used were written on 96.3% of the claim forms assessed and the price of the drugs used was also recorded on 91.7% of the claim forms used.

Table 4.2b Services provided

Item	% filled	% Incomplete	% Not filled
Type of service	94.7	5.3	0.0
Details of services provided	96.3	0.3	3.4
Duration spent	96.3	3.7	0.0
Outcome	94.7	5.3	0.0
Type attendance	100.0	0.0	0.0
Procedure	99.7	0.0	0.3
Diagnosis	91.7	5.0	3.3
Investigations	96.3	0.0	3.7
Price of investigations	100.0	0.0	0.0
Drugs list	94.3	5.3	0.3
Prices of drugs	91.7	0.0	8.3

On the summary section of the claim form, it was observed that 90.7% of the claim forms had evidence of summaries whilst 0.3% were not filled. The tariff amount was not recorded on 5.7% of the claims forms but on 94.0% of the forms, it was recorded. The signature of the health care provider was not on 10.7% of the claims forms however, 82.3% of the claim forms had signatures of the service provider.

Table 4.2c. Summary (N = 300)

Item	% Filled	% Incomplete	% Not filled
Summary of claims	90.7	9.0	0.3
Tariff amount	94.0	0.3	5.7
Signature	82.3	7.0	10.7

4.3 Reasons for the Rejection of Claims

Several reasons were recorded on the forms as reasons for the rejection of the claims from the health providers. Among the reasons were that drugs were not stated (7.4%), excess drugs had been recorded (3.7%), drug not properly written, price of drug not stated, wrong drug issued, and tariff on drugs not stated. Thus out of the 163 reasons given 51 representing 31.2% were related to documentation of details on drug.

The other reasons were excess charges (50.9%), tariff amount not stated (4.3%) and type of investigation not stated (6.3%) as detailed in table 4.2 below.

Table 4.2 Reasons for the Rejection of Claims

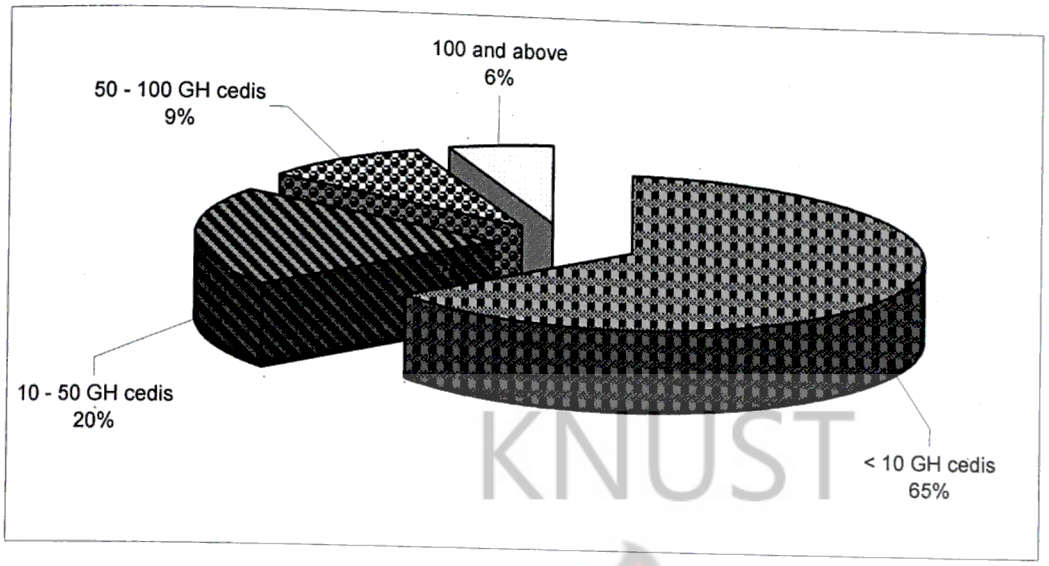
Variables	Frequency (n = 163)	Percentage (%)
Drugs not stated	12	7.4
Excess charge	83	50.9
Excess drugs	6	3.7
Wrong drug	13	8.0
Price of medicine not stated	10	6.1
Drug not properly written	10	6.1
No diagnosis	10	6.1
OPD ticked but procedure was IPD	1	0.6
Tariff amount not stated	7	4.3
Type of investigation not stated	11	6.5

OPD = Out Patient Department

IPD = In patient Department

Total Amount of Claims Rejected

Fig 4.2



Sixty five percent of cost of services rejected was less than 10 GH cedis, and six percent was 100 GH cedis and above as graphically presented in figure 4.2 above.

4.4 Health Workers Perspectives about Effects of Rejected Health Insurance Claims on Hospital

All the workers interviewed were involved in the processing and filling of claims. The extent of involvement was: very involved (68%) involved (20%) and somehow involved (12%). The forms of involvment were documentation (94%), processing file (4%) and storing of files (2.0%). Over ninety percent (94%) of the respondents said that they had heard about claims being rejected. The source of information about claims rejection were from accountant (6.3%), administrators (36.2%), and

during meetings (57.5%). Errors on claim forms had been noted by 58% of the respondents whilst the rest, 42% had not noticed any error while working with the claims. Among those who had studied errors, 10.4% indicated that the errors were very frequent, 31.0% frequent and 58.6%, rarely frequent as detailed in table 4.3 below.

Table 4.3 Health Workers Perspectives about Effects of Rejected Claims on Hospital

Variable	Frequency (N = 50)	Percentage (%)
Filling of claims		
Very involved	34	68.0
Involved	10	20.0
Somehow involved	6	12.0
Form of involvement		
Documentation	47	94.0
Processing file	2	4.0
Storing of files	1	2.0
Heard of claim rejection		
Yes	47	94.0
No	3	2.0
Source	(n = 47)	
Accountant	3	6.3
Administrator	17	36.2
A meeting	27	57.5
Noted errors on claims form		
Yes	29	58.0
No	21	42.0
Frequency of error	**(n = 29)**	
Very often (5 in 10 claims)	3	10.4
Often (2 – 4 in 10 claims)	9	31.0
Rare (1 in 10 claims)	17	58.6
Rejected claims affect hospital		
Yes	50	100.0

The health workers, 78.0%, agreed that rejection of claims affect logistics supply, 82.0% drugs supply, 62.0% finance, 24.0%, motivation and 90.0% quality of care. As shown in table 4.4 below, 72.0 % disagreed that it affected motivation of staff, 22.0% disagreed that it affects the finances of the hospital, and 18.0% thought same for drugs supply.

Table 4.4

Extent of Effect of Rejected Claims on Hospital (N = 50)

	Agree	Undecided	Disagree
% Logistics supply	78.0	6.0	16.0
% Drugs supply	82.0	0.0	18.0
% Finance	62.0	16.0	22.0
% Motivation of staff	24.0	4.0	72.0
% Quality of care	90.0	0.0	10.0

4.5 Capacity Building on Health Insurance Claims at Health Facilities

Training on claims processing had been done for 98% of the health workers interviewed. Out of the 49 who had had training on claims processing, 14.3%, 18.3% and 67.4% had the training less than six months, 6 – 12 months and 12 months and more ago respectively. Refresher training had been done for eight staff representing 16.3%. Twenty two percent (22.0%) of the staff indicated that they had difficulty in processing claims. Among their difficulties were no diagnosis indicated (52.3%), drugs not on drug list 28.7% and poor hand writing, 14.2% as detailed in table 4.5 below. Over twenty percent (22.0%) of the respondents indicated that they had ever made errors in processing the claims. Out of the 11 respondent who had ever made errors in processing the claims, eight representing 72.7% corrected the errors but the rest, 27.3% could not.

Table 4.5 Capacity building of staff for claims management

Variables	Frequency (N = 50)	Percentage (%)
Ever trained on claims forms		
Yes	49	98.0
No	1	2.0
Last time trained	(n = 49)	
< 6months ago	7	14.3
6 – 12 months	9	18.3
12 months and more	33	67.4

Refresher training	(n = 49)	
Yes	8	16.3
No	41	83.7
Difficulty in processing claims		
Yes	11	22.0
No	39	58.0
Type of difficulty	(n = 21)	
No diagnosis	11	52.3
Poor hand writing	3	14.2
Drugs not in drug list	6	28.7
Work load	1	4.8
Made errors in filling claims		
Yes	11	22.0
No	39	78.0
If yes, errors corrected	(n = 11)	
Yes	8	72.7
No	3	27.3

4.6 Examination of Health Insurance Claims for its Acceptance or Rejection by Health Insurance Schemes.

The five health insurance administrators and managers were assessed on the claim forms that inform them to reject or accept health insurance claims. The extent of agreement on reasons for rejection of claims forms were: completeness of the form (100.0%), date of submission of forms (20%), amount indicated on the form (100%) and drugs listed on the form (100%). They (80%) also disagreed that diagnosis made could be a cause to the rejection of claims made. The detail is as shown in table 4.6 below.

Table 4.6
Extent of Agreement to Reasons for Rejection of Claims made by Health Providers

	Agree	Undecided	Disagree
% Incomplete form	100.0	0.0	0.0
%Date of submission	20.0	40.0	40.0
% Amount not indicated form	100.0	0.0	0.0
% Drugs listed	100.0	0.0	0.0
% Pricing of drugs	40.0	20.0	40.0
% Diagnosis made	20.0	0.0	80.0
% Summary of cost	80.0	0.0	20.0

As graphically presented in figure 4.2 below, 60% of the health insurance managers and administrators indicated that queried claims are resolved whilst 40% rejected claims are not resolved.

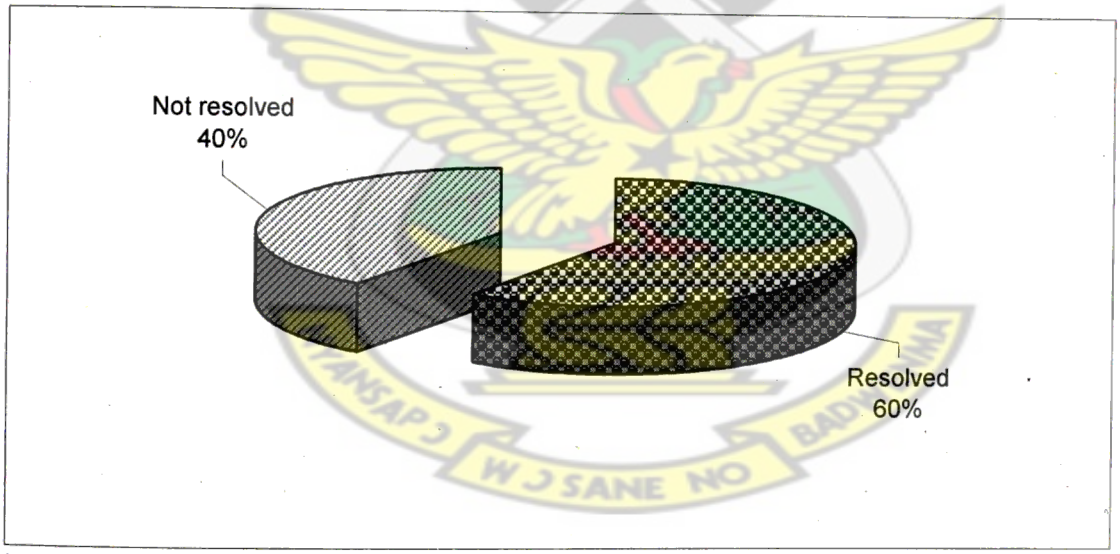
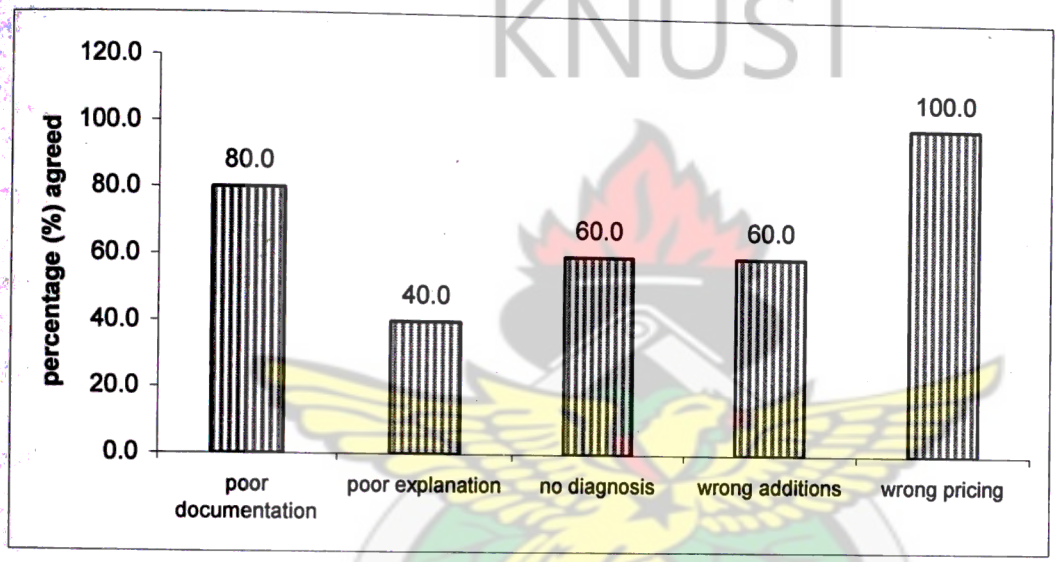


Figure 4.2: Rate of resolution of queried claims

It was agreed by all (100%) the health insurance managers and administrators that wrong pricing accounts for reasons why claims are not

resolved. In addition, 80%, 60%, and 60% agreed that poor documentation, no indication of diagnosis, and wrong addition respectively were reasons why rejected claims are not resolved as shown in figure 4.3 below.

Figure 4.3 Level of agreement on the reasons for inability to resolve queried claim



4.7 Proportion of Claims Rejected

The proportion of rejected claims is extremely high. The study of 300 claims showed evidence of 54% of it being rejected by the health insurance schemes. On the face value it could be said that over half of the amount requested to be paid by the health insurance schemes to the health providers was rejected. The rejection of such huge amount could definitely affect the services provided by the health insurance scheme. The detail examination of the specific sections of the claim forms that were not properly filled and which accounted for such a huge proportion of health insurance claims being rejected are further explained. The sections of the claims form examined were the clients' information, services provision and summary sections.

The clients' information section of the claims form serves to provide basic information of eligibility of the client to benefit from the health insurance scheme. It contains the date of claim, the name of client, age of client and NHIS number. All the claim forms examined had well filled client identification data. This is in line in providing valuable information for the health insurance companies to assess eligibility or otherwise of the beneficiary. The date of claim, in particular is important in checking if the claims falls within section 37 (7) of the National Health Insurance

Regulation (2004) LI 1809. This provides the time period of submitting the claims after treatment. It gives a four weeks grace period within which service provider could submit claims for consideration.

The health care providers also completed the NHIS number in the client identification section of the health insurance claims form. The completion of this section would enable the health insurance managers to ascertain the status of their client and therefore the status as far as benefiting from the scheme is concerned. Certainly, the date of expiration of the client's health insurance package was checked at the health facility before the insurance claim forms were filled.

Recording of the services provided by the client is critical in assessing health insurance claims from health care providers from being rejected or accepted. In this regard, there are standard protocols and procedures for which services rendered to a client would have to be recorded on the forms for easy evaluation by the health insurance schemes. The items captured under services provided section of the claim forms include: type of service, details of services provided, duration spent in the health facility, and outcome of care among others. Other essential ones are, diagnosis made, price of investigations, drug list and price of drugs listed.

Even though majority of these fields on the health insurance claim forms were filled, others were either incompletely filled or not filled at all. The types of service were not recorded for 5.3% of the health insurance claims forms examined. This provides enough bases for the health insurance schemes to reject the claim as enshrined in LI 1809, section 39 that elaborates on the power of the scheme to refuse claims.

Providing details of the services provided give the health insurance scheme information regarding exactly what was done to the patient. Over three percent of such vital information was not recorded, and in 0.3% of the total number claim forms studied such information was incomplete. Missing of vital information could influence health insurance scheme officers to hold on the processing of such claims for payment, assuming all other information on the claim form is accurate. Another concern of poor documentation is the incompletely filled claim forms about the duration spent by the client in the hospital. The duration spent provides claims managers of the health insurance scheme, whether the services provided, for instance, accommodation and feeding, meet the requisite amount allocated.

The outcome of the service rendered to the client need to be documented. The documentation of the whether the client served by the health care

provider has recovered, need to come for review, or dead. Even though the documentation of the outcome of care may not necessarily justify rejection, it provides information to the health insurance scheme whether the selected health care provider is providing quality care. Thus if majority of insurance claims from a particular health provider suggest that most of the clients are dead after being seen, it would suggested that probably the health insurance scheme would have to consider other health services providers. This is because the quality of care to the client may have been compromised resulting in the death of many of them. Such decision would have to be taken since all health insurance companies, are competing for more clients to ensure their sustainability. Thus, if the insurance company stick with a health care provider who is incapable of providing quality health care, it could result in loss of clients and subsequently low registration of new entrants to the health insurance scheme.

In-patient and Outpatient attendance are the types of attendance required to be indicated on the health insurance claim forms before submission to the health insurance schemes. These types of attendance are essential in monitoring the performance of the health facilities as indicated under methods of monitoring performance in LI 1809. The fact that all the insurance claims observed had type of attendance filled is quite

commendable. However, it is worthy of note that, it is more commendable when the indicated type of attendance reflects the type of care provided the patient. For instance, if the type of service is indicated as outpatient, but the other details for example, duration spent is more than 24 hours; it becomes difficult to accept the claim.

A critical determinant of the cost of service provided by every health provider is the type of disease the client is suffering from. The diagnosis made determines the type of drugs and investigations required to use for the treatment of the disease and therefore ensure that the client recovers from the ailment. Health care providers are expected to provide diagnosis of clients seen and indicate as such on all claims made to the health insurance schemes. It is evident from this study that a commensurate proportion of diagnosis is not made on the health insurance claim forms. Doctors did not indicate exactly what the client is suffering from and hence, the insurance staff at the health facilities could not fill that portion of the health insurance claim forms. Apart from those that did not have diagnosis, some also had their diagnosis incompletely filled. It could be explained that some visits to the health facility do not necessarily require practitioners to diagnose. A follow-up visit for a previously reported case, is a standard practice which allows physicians to evaluate the progress of recovery or otherwise of clients. Thus, in case of a follow-up visit, the

physician would not make any new diagnosis but only indicate review of the patient. Obviously, a service has been provided since the practitioner renders consultative and evaluative services during follow-up visit. Therefore claims to that effect need to be paid by the health insurance scheme.

Diagnostic investigations including haematology, parasitology and radiology tests have to be made by practitioners to ascertain the right diagnosis of illness reported by the client and consequently make the appropriate treatment. When any diagnosis is required for the purpose of management of an illness, such records need to be made available and also transferred to the health insurance claim form for onward payment by the health insurance scheme. It is therefore not in all cases that requires diagnostic tests and therefore not all claims forms would contain data on diagnostics. The 3.7% of claim forms that had no indication of diagnostic test may have fallen into the above category of conditions that did not merit further diagnostic investigations. The worrying party would be where a diagnostic test has not been indicated but a price relating to it is found on the health insurance claim form. This may cause a rejection as it puts doubt as to whether the claim is accurate or not or even not forged. Indeed, the later could be the case in this study since all the claims forms contained charges for investigations.

Drug prescribed for the patient should be contained in the health insurance claim forms. Such drugs are supposed to be on the health insurance drug list, popularly referred to as essential drug list. This list contains all forms of drugs, that are suppose to be prescribed by physicians and health workers generally on the management of specifics cases as contained in the Standard Guidelines for Treatment of Diseases.

The section of summary on the claims form indicate summary about the client, the total tariff and signature. This summarises the entire services rendered to the client at the health facility. It also gives a further check of errors since summaries made should corroborate with details provided in the client identification and services provision sections of the heath insurance claim forms. For instance it is of outmost importance that the total tariff indicated on the form sums up equally with the details about cost of services, drugs and investigations provided on the same health insurance claims form. It is worrying that 5.7% of the health insurance claims forms did not have records of the sum of the services or tariff. Clearly, in such circumstances any insurance organisation would not process the claims and hence reject it. But this worrisome situation poses several questions as whether due diligence is taking in completing the forms and also whether supervision of the entire process is done as

required. It is expected that heads of units responsible for submission of claims personally take responsibility to ensure that the forms are completely and accurately filled. In some of the heath facilities the administrator or accountant or both are responsible. It could only be said to be unfortunate, that an important portion such as tariffs amount cannot be ensured to be filled.

Another unfortunate observation was lack of signatures on 10.7% of the health insurance claims. Indeed, this observation buttresses the point of poor supervision of the processing and filling of claims submitted to the health insurance companies. Consequently the laxity results in rejection of most claims submitted to the insurance schemes. This is because, the insurance schemes would need evidence of authentication and originality of the submitted claims from a health care facility that is in contract with. Short of this, there cannot be a way out of approving such claims.

4.8 Reasons for the Rejection of Claims

It is provided on the health insurance claim form, that the health insurance scheme should indicate the reason for the rejection of the claims. As earlier indicted, out of the 300 claims assessed, 163 were rejected and all these had reasons for rejection. The reasons for the rejection of the health insurance claims made by the health care providers included, drug not stated, excess charges, excess drugs, wrong drugs, price of medicine not stated, not diagnosis and tariff amount not stated among others.

Of concern, first of all, is the fact that 50.9% of the reasons for rejection of the claims were due to excess charge made by the health care providers on the health insurance claims forms. This could have easily been corrected if officers recruited to complete the health insurance claims conduct their work more diligently. This is because it requires checking of the cost of services provided with the approved price list for services, investigations and drugs. It also involves making basic additions. It is quiete amazing how such errors could have been made resulting to the rejection of huge numbers of the claims. The situation seems unpardonable, that a question about act of this manner aimed at defrauding the health insurance scheme could be said not to be out of place. Again, the responsibility of insurance coordinators at the health

facilities needs to be questioned. Is it the case, such very important exercise of filling of claims form that would ensure sustaining the quality of care at the health facility is left unsupervised?

Secondly, 8.0% of the health insurance claims forms were rejected because of wrong drugs, drugs not on the health insurance drug list, were prescribed to insured clients. The prescribers and staff responsible for recording of drugs are presumably in the known as to the types of drugs covered by the health insurance scheme. Even when they seem to be uncertain, it is required that reference is made from the health insurance drug list to ensure that such mistakes are avoided. This unfortunate error constitutes a great loss in terms of money and man hours to the health care providers. It may also contribute to the delays in the approval of claims and consequently the release of money.

The third grandious but avoidable error was the none documentation of the price of drugs listed on the claims forms. The cost of drugs constitutes a significant proportion of the total cost of services provided to clients. It is amazing how such important data for filling the claims was forgotten. Indeed, it is just unbelievable that staff, who filled the claim forms, wrote the drugs for the client but did not document the price for the drugs. This could be said to be gross negligence and lackadaisical attitude to

work. Of course as far as management of such situations is concerned, this situation warrants a stringent and discipline action if supervision were to be effective. The question once again is, are the administrators and accountants of the various hospitals in the municipality doing justice to their core responsibility regarding the management of health insurance scheme?

The final error, very unpardonable, is the non-documentation of the total tariff on the claims forms. This was not done, but submitted to the health insurance schemes for approval. How the health providers could anticipated approval when they have not indicated exactly how much, in terms of amount of money, was being requested to be approved and released by the health insurance scheme? Obviously, this error could have resulted from the shabby nature by which the filling of claims is done.

There are other errors which could be explained and could have been rectified before a decision is made to reject the claim forms. This includes drugs not stated, no diagnosis, and drugs not properly written. Drugs are not prescribed all the time for health services rendered. Indeed, in instances when the client re-visits the hospital for a review, it may not require drugs but just counselling and education. The LI 1809 provides a framework for review of such instances by a peer medical review report

at the instance of both the health insurance scheme and the health services providers. On the other hand, the rejection of such claims could be justified, especially so when a specific diagnosis has been indicated on the forms. In such case, it is ideal for the health insurance companies to expect a corresponding drug listed to manage the diagnosis. On the issue of diagnosis not recorded on the claim forms, admissibly this is likely since upon examination of the health insurance claim forms a significant portion did not contain diagnosis. The other explanation could also be the issue of review of clients who report after undergoing treatment. However, a disapproval of the claim could also have been adduced if the health insurance claims forms which had no indication of a specific diagnosis also contained drugs prescribed intended to treat a disease condition. It such case it creates doubts as to the accuracy and authenticity of the services provided and hence cause disapproval.

4.9 Health Workers Perspective on Rejected Claims

Health insurance claims management involves teamwork of all health professionals. This reflects in the various roles played by the different workers in the health facilities. Whilst the physician is expected to examine the client and document findings and plans, the nurses, pharmacists, accountants and other staff do same by documenting requisite procedures used on the client. With this background, it was not surprising that none of the health staff had a dissented view as to being involved in the handling or management of health insurance claims. The health staffs are involved in the documentation, processing and filing of the health insurance claims forms. The documentation of portions of the claims is done directly and indirectly by specific groups of health workers. Directly, the claim forms are filled by the accountant and other administrative staff however, the other health professional indirectly contribute to this exercise, by providing information in patient folders and cards. Since the staffs were all involved in the process of filling the health insurance claim form, they were also aware of the outcome of their involvement.

Majority of the respondents were very much aware of the problem of rejected claim forms submitted from the health facilities to the health insurance schemes. Most of them got their information about the rejected

health insurance claims from organised meetings. This suggests that the management of health facilities admit and recognises the rejected health insurance claims as a major problem. Obviously, these may be due to its effects on the finances and administrative issues of the health facilities. It is presumed that when such meetings are called, adequate attention is spent on educating staff on errors that lead to the health insurance schemes rejecting such huge numbers of claims.

Even though the health staff concedes that the success of managing the health insurance claims requires cooperation and involvement of all, they do not agree that they have contributed in making errors on the claims form. Only half of them conceded that they had made some errors whilst filling the forms relating to the insurance scheme. Obviously in matters like errors being made on health insurance claim forms, naturally some staff would deny just to avoid blame or being embarrassed. However, the important issue is how staff is concientised to minimise such errors. It is overwhelming how such meeting has been ignored. It could be said that health staff are less committed in ensuring that the health insurance claim forms are accurately compiled. This is because, the kind of errors noted above, including lack of documentation on amount of tariff and price of drugs are indicative enough. In addition, the extent of the problem does not suggest that there is much seriousness attached to admonishing of health workers to improve on documentations related to health insurance

claim forms. It could also be that there is a perception about the claims management that might have demotivated others involved to contribute adequately to the exercise.

The staff agrees that rejection of health insurance claims by health insurance schemes affects the hospital administration. However, the extent of appreciation by the health workers on the effects of the problem on the health facilities varies. Health finance is a great challenge to health managers globally. Funds are required to ensure that resources needed for the effective management and sustenance of health facilities and its services are made available. The resources needed in this regard could be in the form of logistics, drugs, and resources to motivate staff. Logistics in the form of hospital beds, linen, scissors, forms, and many others are needed to render quality services. In the context of this study, the concern is with sense of appreciation of how resources made from health insurance claims affects service provision. About twenty percent (18.0%) of the health workers did not agree that rejection of health insurance claims affect the provision of logistics. Similarly, 18.0% also did not agree that the rejection of claims affected drugs supply. As far as the effects of rejection of claims on finance are concerned, 22% disagreed. The link between resource mobilisation and the provision of the above resources is so fundamental that it is amazing that it's not noticed by

many health workers. In fact, the worry effect of such misunderstanding is that, irrespective of the explanation or education provided to minimise errors on claims, such persons would not comply. For instance if the person documenting patient details perceive that, that activity does not affect the replacement of the very resources being used on the patient, then he or she may choose to ignore the seriousness and essence of diligently completing that task.

It is inferred that the health workers are displeased with the manner in which the health insurance claims and its returns, money, are used. Majority of staff disagreed that they could be motivated by approval of health insurance claims. The concern that working to ensure that insurance claims does not add anything to encouraging staff to work harder and well enough to improve services, needs attention. Even though this study did not delve into the management of funds made from health insurance claims, the perspective of the health professional smells of dissatisfaction about claims management. The situation in the health facilities suggest that the staffs are reluctant to do the right things to ensure that the observed errors are avoided.

4.1.0 Capacity Building on Claims Management

Capacity building is essential in building individual skills knowledge and experiences in an organisation so as to achieve optimum results from the groups' action. That is as much as most people in the organisation had been trained on specific issues, the exchange and sharing of ideas, knowledge, skills and experiences brings out the best for the organisation. Health insurance scheme and it related issues including claims management are relatively new in Ghana. The implementation of the health insurance scheme five years ago required that all staff were trained on the scheme. There was therefore an extensive sensitisation and training on health insurance scheme. This extensive training corroborates with the fact that almost all the health professionals have been trained on health insurance specifically health insurance claims management.

Training of the staff on claims management have been done but took place in a relatively long time- over a year and there has not been any refresher training on claims management despite the glaring problems of lot of claims being rejected. Regular training coupled with close monitoring and supervision on management of health insurance claims could reduce errors. The difficulties in processing the claims such as no diagnosis, poor handwriting, and enlisted drugs not on approved rug list and workload are all staff centred. It revolves around the character and

the work culture developed in the health facilities that do not help in getting accurate submission of health insurance scheme. The staff indicated that they still have difficulties in performing their roles related to health insurance claim forms. For this reason, the staff continues to make errors even though these are corrected after sometime of notice.

4.1.1 Examination of Health Insurance Claims for its Acceptance or Rejection by Health Insurance Schemes.

There are prescribed procedures that evolve from the LI 1809 that guides health insurance schemes to accept or reject insurance claims. The LI 1809 also stipulates conditions that warrant a rejection of a health insurance claim made by the health providers. It also provides a framework under which rejected claims can be re-assessed and approved or refused.

It was evident from this study that the health insurance schemes adhere to the regulations guiding the acceptance or refusal of health insurance claims. There were some errors that are considered discretionally whiles for others, it nothing can be done either than rejecting the health insurance claim. Issues about non-submission within four weeks as required by the LI 1809 and pricing of drugs may be considered lightly since some agreements have been made with the health services provider

on them. However, if the summary cost is incomplete, coupled with the non-documentation of amounts on the health insurance claim form, there is outright rejection of the claim.

Resolving rejected claims is very important activity that requires collaboration and cooperation of stakeholders, the health insurance schemes and the health facilities. Indeed, the health insurance schemes asserted that rejected claims are resolved but others are not. The re-assessment of the rejected claims and subsequent approval could go a long way to provides funds for the proper management of the health facilities and thereby improve on service provision to the clients.

The errors associated with claim forms from health facilities in the municipality are human and avoidable in a large extent. The high rate of rejection cannot be entertained if management of health facilities have plans to ensuring that they are viable and can compete with others.

CHAPTER FIVE

5.0 CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

5.1.1 Proportion of Claims Rejected

Majority of insurance claims filled from health facilities within the Sunyani Municipality are rejected by health insurance schemes.

The filling of the claims is short of completeness in respect of most of the details required for assessment by the health insurance schemes. These include type of service rendered, prices of drugs, drug absent from drug list, tariff amount, signature and outcome of treatment.

The reasons why the claims were rejected were excess tariff charges, non-documentation of drugs, drugs not in the health insurance drug list and cost of laboratory investigation.

Most of the claims rejected had a cost lower than one hundred Ghana cedis.

5.1.2 Health Workers Perspectives about Effects of Rejected Health Insurance Claims on Hospital

Health workers involved in the processing of claims are very much aware of the prevalence of errors in filling the claims forms; however, most of them perceive that the occurrences of the errors are rare (1 in 10 claims).

All the health workers admit that rejected claims affect the administration of the health facilities.

The effects mostly are on drugs supply, logistics supply, funds and quality of care of the health facilities.

5.1.3 Capacity Building on Health Insurance Claims at Health Facilities

Even though almost all the health workers had been trained on processing of health insurances claims, majority of them had not had refresher training over a year.

Some of the health workers involved in processing the claims have difficulties about claims processing. These include no indication of diagnosis, poor hand writing by doctors and drugs prescribed which are not on drug list.

Some of the staff admitted making errors whilst processing the health insurance claims but could not correct them.

5.1.4 Examination of Health Insurance Claims for its Acceptance or Rejection by Health Insurance Schemes.

The health insurance managers reject claims due to incompleteness, wrong cost of services indicated on the form and late of submission of claims forms.

There is greater chance for the health facilities and health insurance scheme managers to resolve claims discrepancies or errors.

The health insurance scheme managers would find it difficult to resolve health insurance claims that were rejected due to poor documentation and wrong pricing.

5.2.0 Recommendations

5.2.1 Regional Health Directorate

The Regional Health Directorate should admonish the management of the various health facilities to reduce the incidence of errors made on health insurance claims forms drastically. This can be done through memos and circulars.

5.2.2 Hospital Management Teams

The Hospital Management Team should set a claims review committee that reviews health insurance claims periodically in order to reduce errors made in the processing of health insurance claims.

The Hospital Management Team, should charge managers and persons responsible for processing health insurance claims to do their work properly as the job description dictates.

The Hospital Management Team should inform physicians to prescribe drugs from the health insurance drug list and indicate diagnosis of patients and also write clearly in the patients' notes.

The Hospital Management Team should periodically provide refresher training for physicians, nurses, pharmacists, and health insurance workers in the hospital. These could be guided

by findings of the health insurance scheme claims review committee.

5.2.3 Health Insurance Scheme Managers

The health insurance scheme managers should collaborate with the hospitals to improve on quality of insurance claims submitted to them. This can be done through meetings and training of persons at the health facilities responsible for managing health insurance claims.

REFERENCES

Arhin-Tenkorang, D. (2001). Health Insurance for the Informal Sector in Africa: Design Features. Risk Protection and Resource Mobilization Centre for international Development at Harvard University, Cambridge, USA

Asenso-Okyere, W. Anum, A. Osei-Akoto, I. Adukonu, A. (1998). Cost Recovering in Ghana Are here any Changes in Health Care Seeking Behaviour? *Health Policy Planning 4* (6) pp 35 – 41.

CHAMPVA, (2009). United States of Veterans Affairs: Rejected Claims.

GHS. (2004). Guidelines for Design and Implementation of Mutual Health Insurance Schemes in Ghana. DANIDA, Ghana.

Ghana Statistical Service (GSS), Noguchi Memorial Institute for Medical Research, Legon and ORC Macro Calverton, Maryland, USA(2004). Ghana Demographic and Health Survey 2003. Ghana.

Gilson, L. (1998). The Lessons of User Fee Experience in Africa. In Beattie, A. (eds) Sustainable Health Care Financing in Southern Africa: Papers from an EDI Health Policy Seminar held in Johannesburg, South Africa, June 1996. EDI Learning Resources Series, Washington, DC.

McConnell, B. (1999) Economics Principles, Problems and Policies 14th edition Gary Bunce McGraw- Hill Companies Inc. USA

Medicare (2007). Reimbursement Manual for Medical Office: Briefing of House of Senate on reasons for rejected claims. pp 550 – 553 (unpublished)

MOH (2004) National Health Insurance Policy Framework for Ghana.Revised Version. Ministry of Health, Ghana.

Ndiaye, P. (2006). Development of Mutual Health Insurance Schemes in Africa: A comparative analysis. *Reserch Matters 22- 23.*

The Entrepreneur (2009). Health Insurance. http://www.entrepreneur.com/encyclopedia/term/82174.html (accessed 04/05/09)

Wiesmann, F. and Jütting, H. (2000). The emerging Movement Of Community Based Health Insurance in Sub-Saharan Africa. Experiences and Lessons Learned

Vogin, G. (2009). Dealing with Rejection: Rejection and Medical Woes. WebMed. http://www.medicinenet.com/script/main/art.asp?articlekey=51313 (accessed: 11/06/09)

APPENDICE 1

CHECKLIST
FOR
REJECTED INSURANCE CLAIMS

NAME OF FACILITY.....

NAME OF INSURANCE COMPANY.....

Section A: Clients Information	**Tick appropriately as observed on the patients' claims form**			**Comments** ***(add any comment relevant to the observation made)***
	Filled	Incom-plete	Not filled	
1. HI code				
2. Name of insurance scheme				
3. Claim number				
4. Date of claim				
5. Name of client				
6. Age				
7. NHIS No.				
8. Hospital Record No.				
Section B: Service provided				
9. Type of service				
10. Details of service provision				
11. Duration of spell (days)				
12. Outcome				
13. Type of attendance				
14. Procedure				
15. Diagnosis *(indicate)*.....				
16. investigation				
17. price of investigations				
18. medicines				
19. price of medicine				
Section C: Summary				
20. Summary of claims				
21. tarrif amount				
22. signature				
23. name				

24. Reason for rejecting claim as state on the claims form?	

APPENDIX 2

CONSENT FORM

I am Saeed Hussein Yakubu a student of Kwame Nkrumah University of Science and Technology, Kumasi (KNUST). I am conducting a study into **"Rejection of Claim by District Health Insurance Schemes: The case Study of Sunyani Municipal Health Insurance Scheme".** This is part of my masters' degree programme. I assure you this is purely academic work and answers you provide will be treated confidential. If you agree to participate in this study, kindly sign below.

Sign..... Date 23/09/09

Gyamfi Samuel