A Project Report on Healthcare Revenue Cycle Management

As a part of AHRB Fellowship Program
For
Certified Compensation & Benefit Manager

Submitted by
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Acknowledgement

I take this opportunity to express my profound gratitude and respect to the Management and Staff of Health Prime Services (I) Pvt. Ltd.

To my family, for their love and support without which the project would not have been completed.

My many friends and colleagues who took extra pain to offer suggestions for the text and language, many of which are incorporated in the project.

To my innumerable friends, colleagues and well wishers who know who they are, for their encouragement and valuable support, because they missed me quite often while I was engaged in the project.

I consider myself extremely fortunate to have been a part of this Fellowship program by Middle Earth Consultants and Carlton Advance Management Institute which has enriched my knowledge of Management in systematic and scientific manner.

Dr.Hemjith Balakrishnan

US Healthcare

Health care in the United States is provided by many separate legal entities. Health care facilities are largely owned and operated by the private sector. Health insurance is primarily provided by the private sector, with the exception of programs such as Medicare, Medicaid, the Children's Health Insurance Program and the Veterans Health Administration.

At least 15% of the population is completely uninsured and a substantial additional portion of the population is "underinsured", or less than fully insured for medical costs they might incur. More money per person is spent on health care in the United States than in any other nation in the world, and a greater percentage of total income in the nation is spent on health care in the U.S. than in any United Nations member state except for East Timor. Despite the fact that not all citizens are covered, the United States has the third highest public healthcare expenditure per capita. A 2001 study in five states found that Medical debt contributed to 62% of all personal bankruptcies. Since then, health costs and the numbers of uninsured and underinsured have increased.

Active debate about health care reform in the United States concerns questions of a right to health care, access, fairness, efficiency, cost, and quality. Many have argued that the system does not deliver equivalent value for the money spent. The US pays twice as much yet lags behind other wealthy nations in such measures as infant mortality and life expectancy, though the relation between these statistics to the system itself is debated.

The healthcare environment today faces challenges that it has never seen before. The industry is under attack from every possible direction such as cost containment, HIPAA (Health Insurance Portability & Accountability Act) compliance, lack of stability, to an uncertain future. After trying various managed care techniques and concepts the onus is to contain costs.

Concepts such as defined contribution mutated into various consumer driven health plans are being touted as the nirvana pill for an aching industry. Medical and disease management is expected to play a key role for payers as they try to manage healthcare delivery.

While executives are trying to grope for answers in an ever changing environment, the light at the end of the tunnel seems far away and a dim one at that. Regardless of the concepts that will or will not be around three years from now, one thing is certain; the degree of COMPLEXITY is increasing by the day.

Healthcare Payers are facing the following points of pain:

- Managing increasing medical costs and balancing customer satisfaction
- Reducing operating costs
- Complying with HIPAA standards and requirements
- Upgrading IT infrastructure and moving to the web to provide real-time connectivity
- Focusing on survival and developing a strategy to differentiate products from other incumbents and new players

Traditional payer organizations with their excess baggage are finding it difficult to be nimble and are feeling threatened. They are also not able to keep up with the pace of technological change and find that their legacy systems are just not up to the challenge.

Given the inherent process intensive nature of the industry, outsourcing is and will become more and more important as plans/payors move towards concentrating their efforts on activities that help them differentiate from competition. These organizations are constantly looking at pursuing KPO opportunities to help them become flexible and impact the bottom line.

"Outsourcing in the best sense allows companies to operate at a higher level of flexibility and at the same time see direct implications in cost reduction & revenue enhancement with a dramatic improvement in profitability."

Chapter I

An Overview of the US Healthcare Industry

Healthcare - the management of the resources of healing - is one of the most complex and difficult enterprises on the planet, and in the mid-1990s it is changing with great speed and turbulence. This turbulence is likely to continue for some time into the future, for a combination of reasons both within healthcare and outside it.

In the mid-1990s; continuing rapid increase in costs have ballooned healthcare into a $1 trillion industry accounting for nearly 15 percent of the world's largest economy - yet U.S. statistics for such benchmarks as infant mortality and longevity consistently fall behind those of many other industrialized nations, and some 40 million U.S. residents lack health insurance.

Other developed nations, though their per-capita costs are far lower, also face tough political struggles over rising costs and constricted resources. At the other end of the scale, the World Health Organization (WHO) estimates that more than half of the world's 5.6 billion people lack access to the most essential drugs - vaccines, antibiotics and painkillers - and more than a third of the world's children are malnourished. Many Third World governments spend less than 1 percent of gross domestic product on healthcare.

A number of outside factors will affect healthcare in the future. The growing scarcity and depletion of natural resources, point to the likelihood of increased chaos and war. For healthcare this means an increase in trauma, in malnutrition (as the chaos disrupts food supplies), of infectious disease and stress-induced illness, as well as a diversion of resources. Other trends point toward continued and locally increased industrial pollution, which affects people's health over wide areas. Continued population growth will stretch all resources thinner. Increasing industrialization and urbanization around the world tend to break up the family, clan, and village support systems that have traditionally supported health. The increasing power and size of global corporations, less stable global finances, the

increasing influence of donor nations, of central finance agencies such as the World Bank and the International Monetary Fund, and of the central government banks and finance ministries of wealthy countries, may mean even more constraint on resources for healthcare in many Third World countries.

National health systems will increasingly transcend into crisis and chaos. The effect will be most marked at the ends of the economic spectrum, in the bloated U.S. healthcare industry and in the highly strained economies of the Third World.
Healthcare is also being driven with various advances being made which hold a promise of delivering better services and care. These advances are bound to take healthcare to the next level. A few of these advances are:

- The Human Genome Project, which may isolate the genetic roots of many human diseases - including many that are not generally considered genetic.
- Nanotechnology, the just-born craft of building molecular-scale machines that holds the promise of completely new types of drugs: tiny machines with the tools and intelligence to perform specific tasks, kill certain viruses, repair certain cells, and manufacture certain needed proteins or enzymes.
- New modes of pharmaceutical research that go far beyond the old blind trial-and-error techniques to actually building the molecules (or evolving the bacteria) that can carry out specific tasks, lock onto specific receptor sites in the body, or defeat specific pathogens.

Even though these advances show a lot of promise of superior healthcare, they also pose questions in accordance with past trends.

Chapter II

US Healthcare- Outsourcing and the need of KPO's

The US healthcare industry is having a high spending for the past three years and hence need to outsource most of the processes to low cost destinations.

The recommendations from HIPAA (Health Insurance Portability and Accountability Act) for automating the entire provider services by the end of current year can clearly initiate a new outsourcing wave.

The US healthcare market is divided into two segments –The Payers and The Providers. The US payers outsource more than the providers and the net spending of the US healthcare industry on outsourcing was U$39.6 billion in 2003-2004.

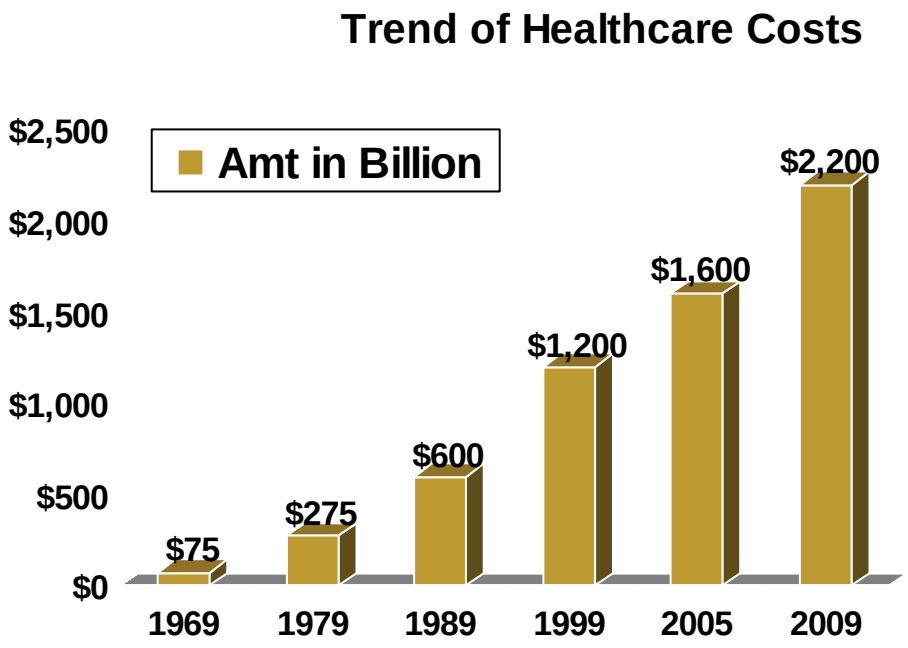
The comparison of the various low cost destinations clearly indicated that India has all the advantages individually provided by various countries. The US payers initiated the outsourcing initiatives to India by late 1990s. Claims processing was the major process outsourced by US payers to India in terms of revenue

The availability of the HIPAA trained talent pool in India is driving the momentum in claims processing. The payer BPO vendors of Indian healthcare market specialize in individual claim formats than going for a horizontal integration. The KPO market in India is growing with more and more vendor presence offering service.

The key process in KPO space for Indian vendors is medical analytics-The Indian BPO vendors if they could provide the data analytics they could integrate their existing service and can command a piece of KPO pie -The US providers followed the trend of outsourcing started by payers and medical transcription was the first process outsourced.

The need for outsourcing arises from the most important factor affecting the US Healthcare industry today – Cost of Healthcare. The US healthcare industry has shown a trend of increase in costs not just for the Providers, but also for the

payers. This directly impacts the cost for the patients, who bear the brunt of this trend. This has caused concern for both – the payers and the providers and has left them with not choice but to control the increase of costs. To maximize profits and to minimize costs without loosing patients, the best option left to them is to outsource their service functions. An illustration of the increase in costs is shown as follows:



Chapter III

HEALTH REVENUE CYCLE MANAGEMENT (HRCM)

The *Healthcare Revenue Cycle Management (HRCM)* relates to all of the processes, sub processes and enabling technologies associated with the initial patient registration through the collection of the amounts due.

Revenue Cycle Management is a comprehensive approach that evaluates, improves, and manages all components in obtaining patient encounter information and applying it to ensure patient safety, while creating a simplified, integrated workflow designed to optimize and expedite reimbursement.

The process of Revenue Cycle Management is as follows:

- Pre registration/registration
- Financial Counseling/Insurance Verification
- Charge/ Visit Processing
- Third party/Billing/Patient Billing qualification
- Account Follow up
- Case Management
- Correspondence
- Data Request compliance
- Payment Processing/Posting
- Allowance Processing
- Bad debt management
- Management Reporting/Usage

About Revenue Cycle Management

A range of services beginning from the admission to post-discharge of a patient including medical coding, billing, medical transcription, claims generation, patient follow-up, etc. are referred to as revenue cycle management. Although more than half of the hospitals in the US are directly or indirectly off-shoring various components of healthcare services, offshore vendors can now expect more end-to-end work. Rising cost pressures, coupled with increasing workload are forcing healthcare institutions to explore the outsourcing / off-shoring option.

Today, hospitals and other medical providers are challenged by ever-increasing operating costs, uncollected revenues and issues retaining staff in key Revenue Cycle departments. These issues are prevalent due to inefficiencies in revenue cycle processes and misalignment of technology, process workflow design and trained personnel in the total solution. Revenue Cycle Management (RCM) performance can significantly be enhanced through objective assessment, innovative improvement, planning and implementation of effective information management systems.

Revenue cycle solutions are the key to improving access management, responding to healthcare consumerism, accelerating cash collection.

A New Challenge

- **Improving Access Management:** The use of financial clearance solutions in healthcare revenue cycle enables you to determine not only insurance eligibility but also the ability and willingness to pay healthcare costs. Including medical necessity checking during registration, scheduling and ordering can help reduce Medicare denials and increase reimbursement by providing medically necessary services. By facilitating improved workflow processes and eliminating the paper chase, it enable physician and hospital staff to accurately authorize services, determine, validate coverage for payment, assess payment risk and schedule resources prior to the patient's arrival.

- **Responding to Healthcare Consumerism:** Consumer self-service is becoming a standard part of day-to-day life. Access to a healthcare kiosk and portal will become an expectation in your patient community. Allowing consumers to research healthcare costs, schedule appointments, receive online statements and make electronic payments are just a few of options available to help respond to consumer demands.

Accelerating Cash Collection after services are delivered in revenue cycle solutions in helping maximize revenue and streamline the billing and collection process with electronic claim processing, direct entry of Medicare claims, automatic secondary billing, remittance posting, document image retrieval, contract and denial management, and financial analysis. Cash flow is the life blood of any healthcare revenue cycle management initiative.

Functional Area Targets

Technology plays a key role across all health entity revenue cycle operations. By functional area, the following are key targets:

Patient Access: This is the front-end of a hospital's or doctor's revenue cycle. It is made up of all the pre-registration, registration, scheduling, pre-admitting and admitting functions.

Enhancing revenue cycles in this area requires the following:

- A call center environment with auto dialing, faxing, and Internet connectivity to quickly ensure and verify all pertinent information that is key to correct and timely payment for services rendered;
- Master Person Index software to eliminate duplicate medical record numbers and assist with achieving of a unique identifier for all patients;
- Registration and admission software that scripts the admission process to assist employees in obtaining required elements and check that insurer-required referrals are documented;
- Denial management definition, including focus on how to obtain all the correct patient information up front while the patient is in-house; and
- Imaging of data up-front.

Health Information Management: This is the middle process of a hospital revenue cycle and is often still referred to as Medical Records.

This area is made up of chart processing, coding, transcription, correspondence, and chart completion. Better control of revenue cycles requires the following recommended technology:

- Chart-tracking software to eliminate manual out guides and decrease the number of lost charts.
- Encoding and grouping software to improve coding accuracy and speed and improve reimbursement.
- Auto printing and faxing capabilities.

- Internet connectivity for release of information and related document management tasks.
- Electronic management of documents.

Patient Financial Services: This is the back-end process of a hospital or medical practitioner's revenue cycle. The operations include all business office functions of billing, collecting, and follow-up post-patient care.

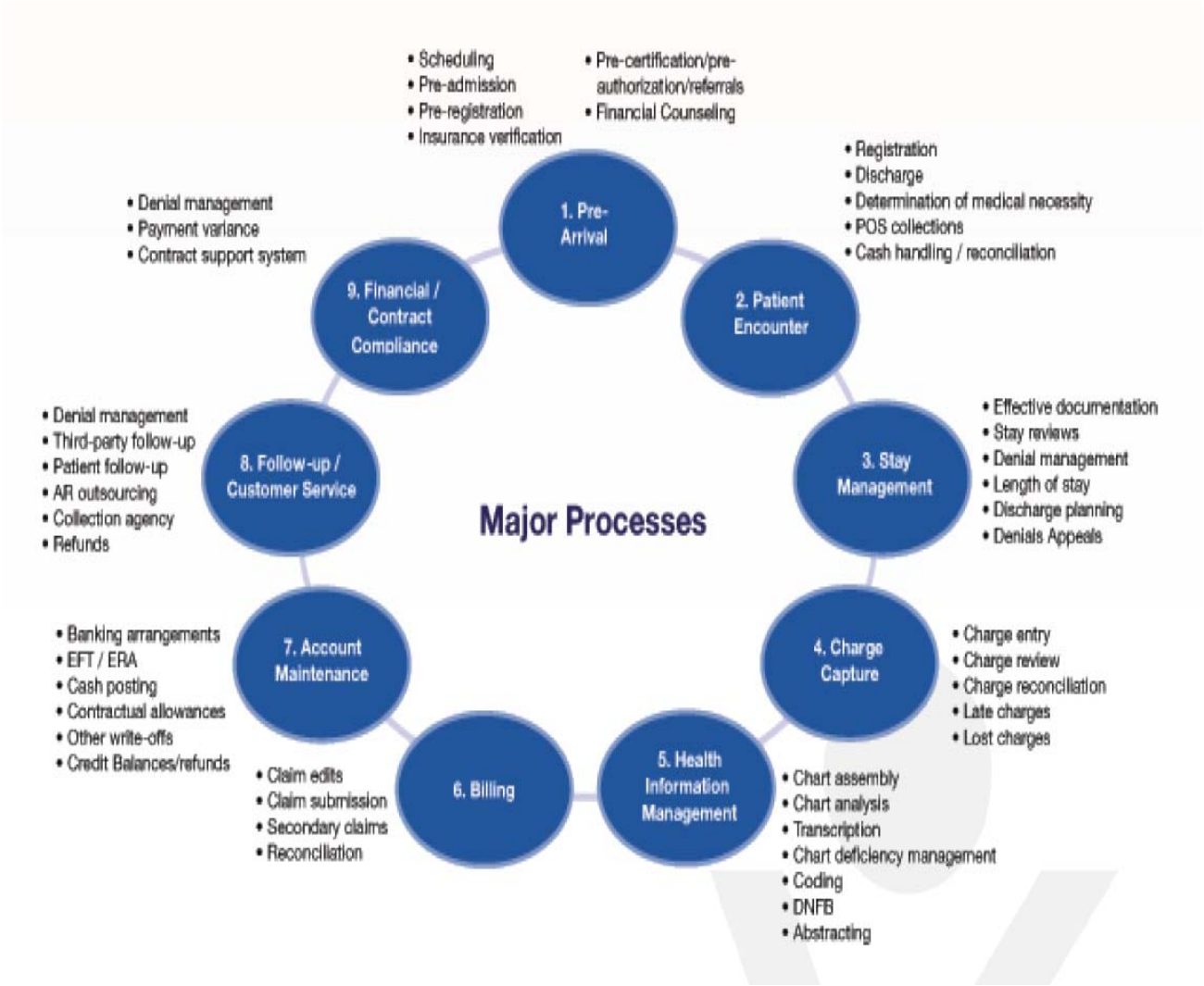
Recommended technology to optimize these functions includes the following:

- Automated biller queues to improve and track the productivity of each biller;
- Claims scrubbing software to ensure that necessary data is included on the claim prior to submission; and
- Electronic claims and reimbursement processing to expedite the payment cycle.

With RCM services clients benefit from streamlined processes resulting in decreased accounts receivable, increased cash flow, lower processing costs and compliance with RCM requirements. Here are some of the benefits clients can realize:

Chapter IV

Revenue Cycle Processes



The following process needs to be adhered to have accurate, efficient, cost-effective and quality controlled revenue cycle management:-

Process:

- Obtain demographics.
- Reconfirm Appointment.
- Explain payment policy.
- At the time of appointment, Verify obtained information.
- Scan insurance information.
- Collect co-pay and previous balance.
- Schedule follow–up appointment.
- Immediately after visit (48 hrs), Submit charges for billing.
- Verify diagnosis & procedure (CPT/ICD).
- Submit error free and accurate claim.
- Ensure accuracy of payment.
- Bill balance to responsible party i.e. Secondary Insurance, employer, guarantor etc.
- Follow up with payers for denials and incomplete payments.
- Monthly report review.
- Monitoring collection ratio.
- Accounts Receivable Aging Analysis.
- Practice performance report.
- Deleted Entry report – audit trail.
- Patient billing cycle.
- Responding to patient inquiries.
- Resolving outstanding balance.
- Reviewing courtesy adjustment.

The phrase "revenue cycle" has come to mean multiple things to different groups within a hospital. Originally, it signified the financial part of the patient's encounter, from registration to coding to submission and payment of a claim.

Medical Coding is assigning codes to diagnoses and procedures which help in financial reimbursement from insurance companies and government agencies, software companies and consulting firms. Medical Coding is also known as insurance coding. This field generates medical coders who specialize in coding after a thorough training program and a certification process. The American Health Information Management Association offers certification in this field.

Medical billing is the process by which the needed data for completion of all the necessary forms (insurance cards, patient info, encounter forms, diagnosis, treatment, etc) is collected and processed for payment. This data is then entered into one of a variety of competing medical billing/patient accounting software programs.

Claim generation or charge entry: Once the account of the patient is created in the billing software, charge can be posted.

Claim Submission: There are 2 ways of **Claim submission** to submit the claims to the insurance companies:

(1) Electronic Media Claims submission (EMC).
(2) Paper claims.

Payments - Amount paid to the physicians against the services rendered by them to the patient.

The services that are provided to the patients are sent out to the insurance companies in the form of claims. These claims get paid by the insurance companies. The payments are received at the provider's mailing addresses and or at the billing companies' addresses. In cases when they are received at the providers' addresses then they are in turn forwarded to the billing company to the payment in their system. Such payments come in the form of batches and may have bank's deposit slip or payment listing with them. Payments that are received directly at the billing companies' address do not have the bank's deposit slip.

Sometimes, in the case of non-participating provider's, payments are received by the insured parties address and they forward the payment to the physician's address.

Claim that do not get paid, come back as Denials from the Insurance carriers. This can be due to posting errors, incorrect procedure / diagnosis codes, lack of information (medical records) while filing the claims, or missing / incomplete patient details.

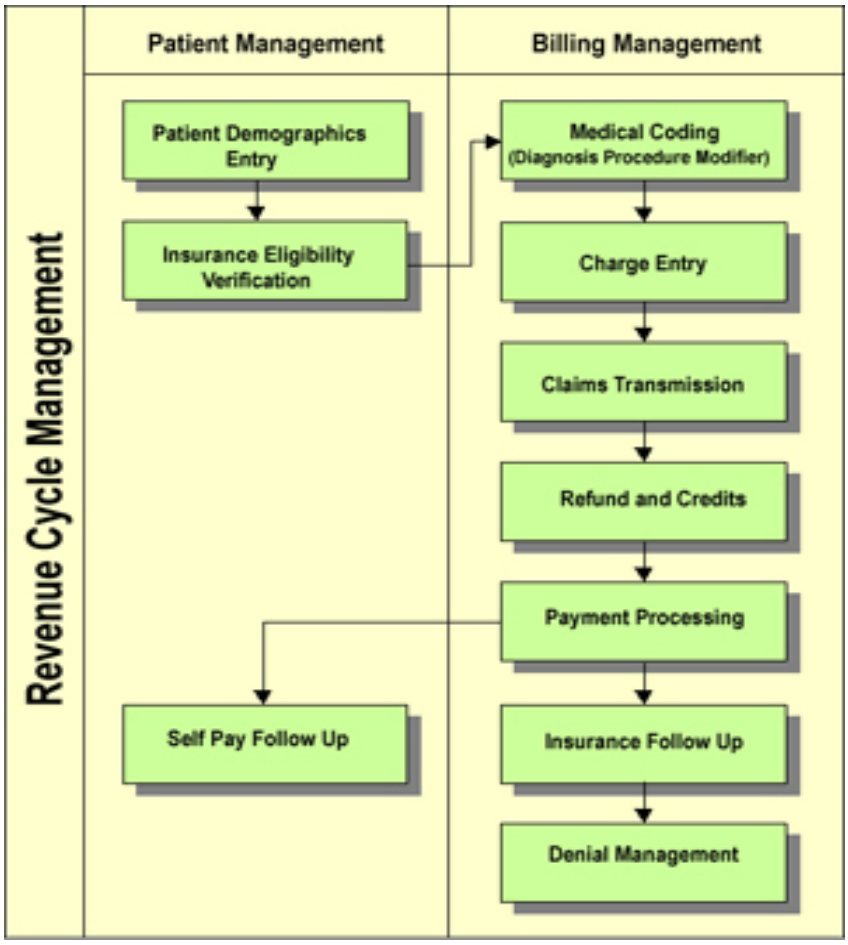
Denials are broken down into two categories:

1. **In-House**
2. **Patient Responsibility.**

1) In-House denials are the ones that require some type of correction from our part and can be resubmitted. We do not bill patient.

2) Patient Responsibilities are those denials that we can't do anything to get the claim paid by the insurance company. All we can do is, transfer the charge to the patient with the correct message code.

The process flow of Patient Financial Service is as follows:-



Pay for performance is an emerging movement in health insurance (initially in Britain and United States). Providers under this arrangement are rewarded for meeting pre-established targets for delivery of healthcare services. This is a fundamental change from fee for service payment.

Also known as "P4P" or "value-based purchasing," this payment model rewards physicians, hospitals, medical groups, and other healthcare providers for meeting certain performance measures for quality and efficiency.

Disincentives, such as eliminating payments for negative consequences of care (medical errors) or increased costs, have also been proposed. In the developed

nations, the rapidly aging population and rising health care costs have recently brought P4P to the forefront of health policy discussions.

What is pay-for-performance (a.k.a. value-based purchasing)?
Pay-for-performance and value-based purchasing are terms used to describe health care payment systems which reward doctors, hospitals, and other health care providers for their efficiency. Efficiency is usually defined as providing higher quality for a lower cost.

Pay-for-performance (P4P) is usually discussed in the context of health care reform. The federal government has begun efforts to implement P4P in its Medicare program, but these efforts are in the very early stages and have not yet yielded enough data to determine whether P4P is effective in reducing or containing healthcare costs.

Why adopt a pay-for-performance system?
Under our current healthcare system, providers are paid for each service performed. This gives healthcare providers a strong financial incentive to perform as many services as possible. This, combined with providers' understandable reluctance to expose themselves to potential lawsuits, may lead to overprescribing and overutilization of healthcare services.

Furthermore, some health policy experts believe that our current payment system is lacking because it neglects the role that preventive care can play in improving health and reducing healthcare costs. Today, providers receive more money for treating a diabetic patient who suffers kidney failure than they would for working with the patient to try to prevent the kidney failure, through better blood glucose control, in the first place. This seems backwards to many health care reformers.

A new payment system which rewards providers for maximizing the impact of preventive care may help to contain rising healthcare costs. Pay-for-performance has been proposed as such a system. It would reward doctors for providing care that has been proven to improve health outcomes and would encourage them to minimize waste whenever possible.

What are some of the challenges of implementing a pay-for-performance system?

The biggest challenge in implementing P4P is getting everyone to agree on quality standards. Quality standards are objective measures used to determine whether providers are offering high quality care. For example, one possible quality standard would be for doctors to test A1C levels in patients with diabetes four times a year. In a P4P system, doctors who meet this standard would be rewarded appropriately.

The problem is that many health care providers believe that the practice of medicine is as much an art as it is a science, and that boiling everything down to checklists and treatment algorithms would do a disservice to patients. Also, providers sometimes disagree on the proper course of treatment in patients with the same diagnosis and similar medical histories. These disagreements will have to be resolved before P4P can be fully implemented.

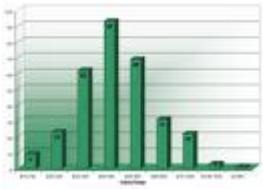
Pay for Performance: A step in right direction

Consumerism is re-defining the healthcare landscape. P4P had the focus of moving from Pay for improved process to pay for improved Outcomes. This has resulted in:

- *Patient awareness:* You can gauge the level of interest has considerably gone up among patients in their care decision from the trends in web traffic volumes for last 3-4 years around healthcare portal sites(Eg: WebMD), clinical outcome scores (e.g., Health Grades) or healthcare blog sites. While some patients may not be educated or qualified to understand the information, perception matters--and may ultimately influence their care decisions.

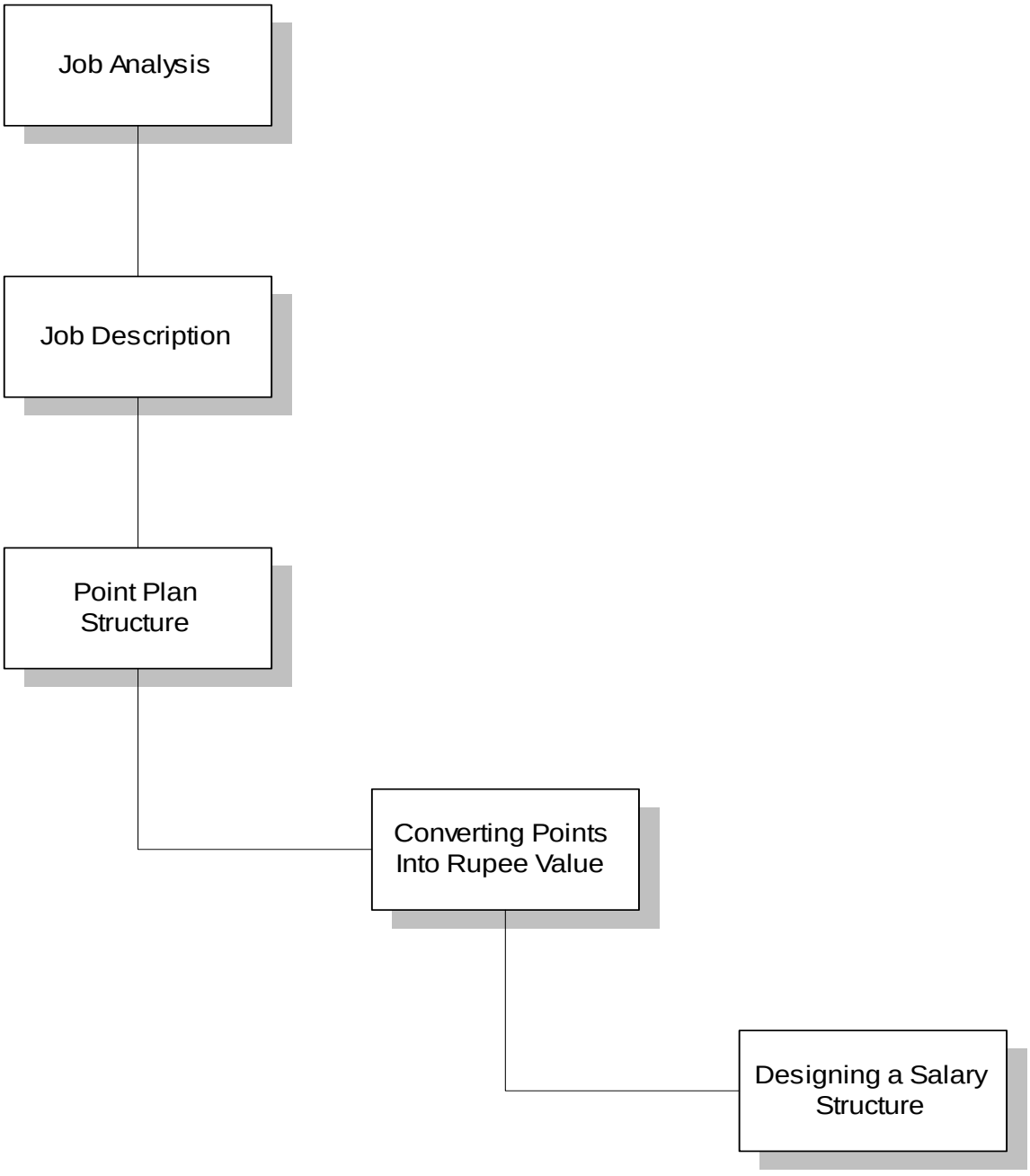
- *Informed decision making:* Pay-for-performance programs allow patients to compare the care offered at various hospitals based upon clearly defined and standardized metrics.
  Payers will provide clinical outcome data to customers and encourage them to use it in order to bring down their reimbursement cost. Such incentives will help increase the importance of the quality information being published. Hospitals that perform well on quality indicators can leverage their scores to differentiate themselves from their competitors, thereby resulting in improved public awareness and increased patient preference to obtain their care there.

- *Physician- Hospital collaborative Incentive:* Positive patient outcomes require a collaborative effort on the part of doctors and hospitals. Physician can provide quality care by working collaboratively with the hospital support staff. The win-win situation achieved through P4P is that a physician will be incentivized for achieving higher compliance score and the hospital in turn can expect better reimbursements on the services delivered. Again the non financial incentive in terms of improved public awareness and increased patient preference. Moreover, the good compliance scores of physicians, nurses and support staff can be a good recruiting tool. Hospitals with superior quality outcomes would be in a position to attract top physicians and top physicians can expect premiums on their services. The hospital would be able to being down the operational cost by using the services of efficient physicians and there by passing on that benefit to the patient.



Chapter V

PROCESS OF DETERMINING A SALARY STRUCTURE USING POINT METHOD



JOB DESCRIPTIONS OF SELECTED POSITIONS

1. **Director/VP**
2. **Manager HR**
3. **Manager IT**
4. **Manager Accounts**
5. **Manager Operation**
6. **System Engineer**
7. **TL**
8. **ATL**
9. **PFS AR Agent**
10. **Insurance AR Agent**
11. **Denial Analyst**
12. **Claims Processor**
13. **Biller**
14. **Coder**
15. **HR Executive**
16. **Assistant Accounts**
17. **Admin Officer**
18. **Receptionist**
19. **Office Boy**

DIRECTOR/VP

Definition:

The key responsibility of this position is to manage the business.

Job Specification

General ♦ Management degree or an MBA degree. ♦ Should have excellent written & verbal communication skills. ♦ Atleast 10 years experience in managing large teams/processes.
Technical Requirements ♦ Oversight of all key deliverables ♦ Handsome experience in managing large teams ♦ Excellent understanding of US Medical Billing & AR Processes
Behavioural Requirements ♦ Team Handling Skill. ♦ Good Interpersonal Skills. ♦ Should be an excellent team player.

Key Responsibility Areas:

- ♦ Planning & managing operations of unit.
- ♦ Analyzing workflow to improve process quality & enhance production levels.
- ♦ Developing team to efficiently execute business operations & cater to projected growth.
- ♦ Training team & developing operating processes & systems.

MANAGER HR

Definition:

The main responsibility of this position is to be a strategic business partner along with creating a balance between people, process and performance.

Job Specification

General ♦ Management degree/MBA or PHD in HR ♦ Atleast 8 years experience
Technical Requirements ♦ Knowledge on various management practices
Behavioural Requirements ♦ Expertise on people handling skills ♦ Excellent interpersonal skills ♦ Oversight of all key deliverables ♦ Proactive and analytical ability

Key Responsibility Areas

- Independently responsible for overall recruitment, including preparing job descriptions, analysing job requirements and finalising candidates. Design and implementation of sourcing strategy.
- Ensuring compliance of SOPs and company policies.
- Designing the organisation structure keeping in view the future expansion plans.
- Ensures optimum utilisation of human resources i.e. manpower planning and deployment.
- Introduces new HR initiatives like linking pay to performance, reward and recognition policy etc.
- Planning additional manpower requirement on all India basis.
- Allocation of budget to all regions.
- Ensure all HR Operation processes meet the benchmarks.
- Direct team members in all the HR-Operations related processes to execute well on time.

MANAGER IT

Definition

The key responsibility of this position is to manage and troubleshoot all the technical aspects of the organization**.**

Job Specification

General ♦ Have technical degree of IT and telecommunication. ♦ CCNA/CCIE Certified ♦ Minimum 8 years of experience in the related field.
Technical Requirements ♦ Training & Lab Maintenance ♦ Asset Management
Behavioural Requirements ♦ Teamwork ♦ Client management ♦ Tech savvy

Key Responsibility Areas:

- ♦ Assists in the planning and implementation of additions, deletions and major modifications to the supporting regional infrastructure.
- ♦ Implements network security at the regional level as established by corporate Security Director.
- ♦ Oversees the administration and maintenance of the company's infrastructure, and directs more junior Innovators when necessary.
- ♦ Implements improvements in all areas of IT responsibility.
- ♦ Serves as main point of contact on all IT-related matters for the office assigned.
- ♦ Responds/acts on upper-management direction

MANAGER ACCOUNTS

Definition:

Responsible for applying accounting principles and procedures to analyze financial information, prepare accurate and timely financial reports and statements and ensure appropriate accounting control procedures.

Job Specification:

General

- Accounting degree or equivalent.
- Usually a minimum of 3 years experience in the management of financial systems and budgets, financial reporting, financial data analysis, auditing, taxation and providing financial advice.

Technical Requirements

- Knowledge of accepted accounting practices and principles.
- Knowledge of economic principles.
- Knowledge of auditing practices and principles.
- Knowledge of applicable laws, codes and regulations.
- Knowledge and experience of related computer applications.

Behavioural Requirements

- Attention to detail and accuracy
- Planning and organizing
- Strong communication skills
- Information and task monitoring
- Problem analysis
- Judgment and problem-solving
- Supervisory skills
- Stress tolerance

Key Responsibility Areas:

- Compile and analyze financial information to prepare financial statements including monthly and annual accounts
- Ensure financial records are maintained in compliance with accepted policies and procedures
- Ensure all financial reporting deadlines are met
- Prepare financial management reports
- Ensure accurate and timely monthly, quarterly and year end close
- Establish and monitor the implementation and maintenance of accounting control procedures
- Resolve accounting discrepancies and irregularities
- Continuous management and support of budget and forecast activities
- Monitor and support taxation issues
- Develop and maintain financial data bases
- Financial audit preparation and coordinate the audit process
- Ensure accurate and appropriate recording and analysis of revenues and expenses
- Analyze and advise on business operations including revenue and expenditure trends, financial commitments and future revenues
- Analyze financial information to recommend or develop efficient use of resources and procedures, provide strategic recommendations and maintain solutions to business and financial problems

MANAGER OPERATION

Definition:

Responsible for all Billing and Collections Activities process - auditing and accomplishment

Job Specification

General ♦ Management degree/MBA in Operations and Quality ♦ Atleast 8 years experience ♦ Exposure to Quality Management Systems
Technical Requirements ♦ Excellent understanding of US Medical Billing & AR Processes
Behavioural Requirements ♦ Team handling skill ♦ Good Interpersonal Skills ♦ Flair for numbers ♦ Analytical abilities ♦ Problem-solving, Decision making

Key Responsibility Areas:

- Instrumental in maintaining a high standard of discipline in the Dept.
- Set standards and objectives for operations in the areas of high process quality /productivity /cost control measures.
- Establishing good communication and relationship with all team members so that they are confident of the planning and implementation of programs to maintain good work culture.
- Designing and conducting of training programs.
- Advice management about latest developments in the field of Medical BPO practices and trends in other industries etc.
- Ensure manpower planning, forecasting acquisition and utilization including selection and recruitment for all levels in the Billing and Collections department.

SYSTEM ENGINEER

Definition:

Installs, configures, and troubleshoots computer networks and associated assemblies by performing the following duties.

Job specification:

General ♦ Bachelors degree in Computer Engineering ♦ CCNA/CCIE Certified.
Technical Requirements ♦ Working Knowledge on various upcoming and upgraded software.
Behavioural Requirements ♦ Good Service orientation ♦ Excellent Interpersonal and listening skills ♦ Analytical ability

Key Responsibility Areas:

- Performs network troubleshooting to isolate and diagnose common network problems. Upgrades network hardware and software components as required. Installs, upgrades, and configures network printing, directory structures, rights, security, and software on file servers.
- Provides users with network technical support.
- Responds to the needs and questions of users concerning their access of resources on the network.
- Establishes network users, user environment, directories, and security for networks being installed.

Team Leader

Definition:

The main responsibility of this position is to act as a 2nd level support to team & ATL.

Job specification:

General ♦ Graduate or post-graduate degree in operations/finance or management. ♦ Minimum 6-8 years of experience.
Technical Requirements ♦ Good knowledge on AR and Billing cycle. ♦ Regular updated knowledge about the Industry and the trends.
Behavioural Requirements ♦ Team Handling Skills ♦ Motivator ♦ Good Interpersonal Skills ♦ Multi tasking ability ♦ Analytical ability

Key Responsibility Areas:

- Conduction/ coordinating for client meetings and internal meetings.
- Identify areas of improvements of supervisors & initiate training plans (if required)
- Monitor (& revise if required) benchmarks to measure quantity and quality of team members
- Work on escalated activities
- Keep track & communicate (with responsible parties) on discrepancies that don't allow us to meet our defined protocols
- Research on websites on finding new ways of effective billing and making reports more user-friendly
- Re-training and cross-training

Assistant Team Leader

Definition:

The main responsibility of this position is to act as a 2nd level support to team members.

Job specification:

General ♦ Graduate or post-graduate degree in operations/finance or management. ♦ Minimum 5-6 years of experience
Technical Requirements ♦ Good knowledge on AR and Billing cycle. ♦ Regular updated knowledge about the Industry and the trends
Behavioural Requirements ♦ Team handling skills ♦ Motivator ♦ Good Interpersonal relationship. ♦ Multi tasking ability

Key Responsibility Areas:

- Allocation & completion of assigned work within specified TAT with optimum level utilization of resources
- Also working on Internal process activities (as per client requirement)
- Conducting internal team meetings
- Identify areas of improvements of team members & initiate training plans
- Random Audit of team member work

Patient Financial Service AR AGENT

Definition:

The key responsibility of this position is to be able to recover the visit charges due from the patient.

Job specification:

General ♦ Graduate / Post Graduate
Technical Requirements ♦ Excellent communication skills ♦ Knowledge about the process
Behavioural Requirements ♦ Grasping power/good comprehending skills ♦ Good analytical skills ♦ Good persuading and probing skills ♦ Problem solving and negotiation

Key Responsibility Areas

- Ensuring daily completion of Pending COB tasks.
- Updating Addresses for return mails
- To send dunning letters and make collection calls based on the Accounts Analyzed.
- Printing and sending commercial letters after analyzing the patient records in the system on a daily basis.
- To receive Inbound Calls and provide Customer Service to the best of ones abilities.
- To work on credit transfer and credit balance report.
- To merge duplicate patients in the system.

INSURANCE ACCOUNTS RECEIVABLE AGENT

Definition:

The key responsibility of this position is to be able to recover the visit charges due from the patient's insurance company.

Job specification:

General ♦ Graduate or any post graduate
Technical Requirements ♦ Excellent communication skills ♦ Knowledge about the process
Behavioural Requirements ♦ Grasping power/good comprehending skills ♦ Good analytical skills ♦ Good persuading and probing skills ♦ Problem solving and negotiation

Key Responsibility Areas

- Work on the corresponding batch
- Follow-up over task assigned by the payment posters
- Analyzing claims are denied but go for further appeals (denial EOB and Justification)
- Work on the A/R Brackets
- Follow-up on Multiple Denials

DENIAL ANALYST

Definition:

The key responsibility of this position is to be able to analyze the trend of denials and finding the solutions.

Job specification:

General ♦ Minimum graduate (in any field).
Technical Requirements ♦ Knowledge about the US Healthcare and insurances
Behavioural Requirements ♦ Administrative effectiveness ♦ Abreast of Insurance details of different Insurance Companies ♦ Eye for details ♦ Patience ♦ Speed Delivery ♦ Focused

Key Responsibility Areas

- Insurance Correspondence
- Collection problem Task (as per the payer)
- Resubmission of Claims or Appeal for denial
- Online ck
- Create task for Front Desk for Medical Records
- Reassigning task to the Night shift if an Insurance calling is required.

CLAIMS PROCESSOR

Definition:

Job of an Electronic Claims (EC) Processor is to generate all the claims. Generate the electronic files and upload it to the clearing house web portals. Once the files are uploaded, the EC processor will have to check for any rejections received from the payers and re-file them again after making necessary corrections on the web portal as well as in system.

Job specification:

General ♦ Minimum graduate in any field.
Technical Requirements ♦ Knowledge about the US Healthcare and insurances
Behavioural Requirements ♦ Multi-tasking ♦ Time Management ♦ Good Microsoft Excel & Word skills ♦ Eye for details ♦ Patience & tact for reconciliation ♦ Analytical skills ♦ Problem solving ability ♦ Written English communication and writing with intention

Key Responsibility Areas

- Generating the NextGen audit reports for all of the charges posted on the previous day and to get the errors corrected before processing the claim if any.
- Bill all of the claims.
- Generating the EDI (Electronic Data Interchange) files by financial class.
- Uploading the EDI files to the clearing house web portals.
- Work on the rejections received from the payers and re-file the claim.
- Share any updated with the team which are received from the clearing house.

BILLER

Definition:

The main responsibility of this position is to manage the Charge Posting effectively so that revenue is generated to the earliest.

Job specification:

General ♦ Minimum graduate in any field ♦ Billing certification
Technical Requirements ♦ Knowledge on medical terminology ♦ Computer skills
Behavioural Requirements ♦ Eye to detail ♦ Multi-tasking ♦ Time Management ♦ Analytical skills ♦ Problem solving ability

Key Responsibilities Areas

Charge Posting

- Check on CPT and Dx entered, date of service and rendering Doctor.
- Check the updates and run a report on validation
- Enter co-pay amount or any previous visit amount due.
- Attachment of Insurance

- Post the batch and report to the TL/ATL
- Run individual reports.
- Achievement of set targets – quality and quantity.

Payment Posting

- Posting the transaction
- Balancing the batch (Batch Reconciling)
- Maintaining of excel and records.
- Run daily reports.
- Follow-up on their reports.

CODER

Definition:

The purpose of this position is to apply the appropriate diagnostic and procedural codes to individual patient health information for data retrieval, analysis, and claims processing.

Job Specification:

General ♦ Minimum of successful completion of a coding certificate program in a program with AHIMA approval status. ♦ RHIA, RHIT, CCS, and CCS-P certification status preferred. ♦ Coding certification preferred from the American Health Information Management Association. ♦ Prefer someone with work experience as a coder or strong training background in coding and reimbursement.
Technical Requirements ♦ Knowledge on medical terminology ♦ Computer skills
Behavioural Requirements ♦ Listening to Comprehend ♦ Enhancing Listening Skills ♦ Effective Listening Simulation ♦ Writing with Intention

Key Responsibilities Areas

- Abstracts pertinent information from patient records. Assigns ICD-9-CM or HCPCS codes, creating APC or DRG group assignments.
- Queries physicians when code assignments are not straightforward or documentation in the record is inadequate, ambiguous, or unclear for coding purposes.
- As a coder or strong training background in coding and reimbursement.
- Checking medical charts for accuracy and completion
- Verifying signatures
- Verifying medical data in computers
- Clarifying information or diagnosis by communicating with healthcare providers
- Utilizing computer software to analyze data.

HR EXECUTIVE

Definition:

The main responsibility of this position is to be a people's person and manage day to day employee related activities.

Job Specification:

General ♦ Educational qualification – Post graduate in HR/ MBA in HR ♦ Atleast 1 year experience
Technical Requirements ♦ Various technical knowledge like how to calculate attrition, rate of investment, etc. ♦ Knowledge about various people management and handling skills
Behavioural Requirements ♦ Good communication skills ♦ Effective Listener ♦ Patient ♦ Empathetic

Key Responsibilities Areas

- Attending to the Employee queries well in time & relevant information.

- Sourcing from Job Portals, Database, References and scheduling them for an interview
- Joining Formalities
- Inductions/Presentations on company's policies & Procedures
- Creation of User ID/Visiting Cards/IT Facilities(Operation team has to forward these request to the concern Dept)
- Formal Introduction within the Department
- Employee Entire database.
- Payroll Section (PF & Tax related Queries)
- Retentions
- Full & Final Settlement and Recoveries (If Any)
- Issue Reliving/Experience/Termination/Transfers Letters

ASSISTANT ACCOUNTS

Definition:

Apply principles of accounting to analyze financial information and prepare financial reports by compiling information, preparing profit and loss statements, and utilizing appropriate accounting control procedures.

Job Specification:

General ♦ Educational qualification – B.Com/ Any Financial Accounting post graduate ♦ Minimum experience of 4-5 years
Technical Requirements ♦ knowledge of accepted accounting practices and principles ♦ knowledge of economic principles ♦ knowledge of auditing practices and principles ♦ knowledge of applicable laws, codes and regulations ♦ knowledge and experience of related computer applications
Behavioural Requirements ♦ Eye to detail ♦ Alert and cautious while dealing with numbers

Key Responsibilities Areas

- Prepare profit and loss statements and monthly closing and cost accounting reports.
- Compile and analyze financial information to prepare entries to accounts, such as general ledger accounts, and document business transactions.
- Maintaining a day to day MIS of income and expenditure.
- Resolve accounting discrepancies
- Interact with internal and external auditors in completing audits
- Monthly reconciliation for AP/AR
- Issue cheque and official receipts

ADMIN OFFICER

Definition:

The primary responsibility of this position is to ensure the effective and efficient utilization of all departments resources (overall financial planning, staff, budget, space, renovations and relocations, purchases, computers, equipment, etc.) to maximize the organisations mission.

Job Specification:

General ♦ Graduates in any field. Post graduation not required. ♦ Age: Between 35 to 55 yrs. ♦ Experience: 10 to 20 yrs preferably in Army, Navy, Air force or Military having strong personality.
Technical Requirements ♦ Knowledge purchase and admin on vendor selection. ♦ Knowledge of utility/equipments.
Behavioural Requirements ♦ Command over situation and people ♦ Liasoning

Key Responsibilities Areas

- Managing Office Supplies (looking after stationary, computer peripherals, stocks and inventories, etc.)
- Maintenance of files; attendance and record keeping.

- Management of facilities like power, water, phones, etc.
- Ensure smooth and efficient running of the various administrative functions like Front Office, Conference Room, Training Room and the Lounge room.
- Instrumental in maintaining a high standard of discipline at the front office.
- Working in close coordination with Management in organizing activities.
- Attempt to maintain conducive atmosphere among the various department and inculcate a culture of participation at all the levels.
- Co-ordination with Management to pre-empt grievances of collective nature such as transport/ canteen/ welfare/ safety, etc.
- Trying to establish discipline that challenges the organization to strive for excellence in all aspects of performance and Organization Culture.
- Office routine work.

RECEPTIONIST

Definition:

The primary responsibility of this position is to manage and co-ordinate the front desk of the organization.

Job Specification:

General ♦ Female candidate. ♦ Minimum 1-1 and half years of experience as a receptionist. ♦ Graduates preferred. Undergraduates with minimum H.S.C. qualification can be exceptions. ♦ Candidate needs to be decent looking, matured, having good dressing sense.
Technical Requirements ♦ Knowledge of computer basics ♦ Knowledge of EPABX
Behavioral Requirements ♦ Patience and customer orientation ♦ Good Interpersonal skills ♦ Excellent communication & Voice quality ♦ Pleasing personality

Key Responsibilities Areas:

- Attend and transfer calls.
- Maintain and update various MIS's on regular basis.
- Attend and maintain records of visitors.
- Record time in and time out of every employee.
- Make arrangements for meetings.
- Be updated with all the upcomings in the Company.
- Provide necessary information to the employees when required by them.
- Work in close coordination with Administration and HR.
- Take up assignments as and when assigned by the Reporting Head.

OFFICE BOY

Definition

The primary responsibility of an office boy is to provide service to all the employees and management in the organization along with maintaining it.

Job specification:

General: ♦ Professional training on etiquettes.
Technical Requirements: ♦ Methods and techniques on cleaning/maintaining the office premises.
Behavioral Requirements ♦ Attention to detail and alert. ♦ Basic etiquettes. ♦ Clear communication and good listening skills.

Key Responsibilities Areas;

- Provision of high quality domestic services to everyone in the organization
- Responsible for maintaining and improving standards of hygiene and cleanliness in the office premises.

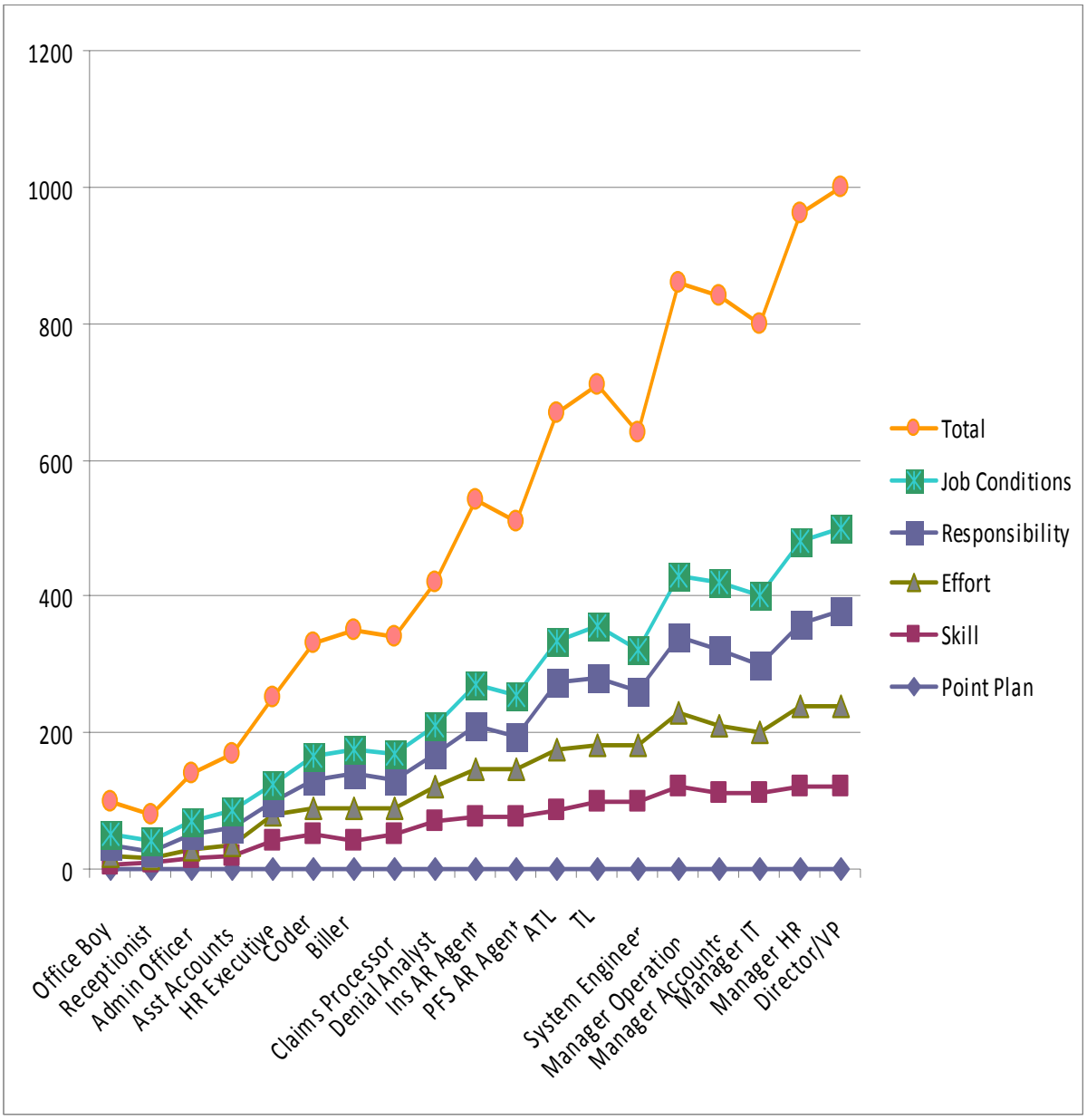
Chapter VII

JOB EVALUUATION PROCEDURE

POINT PLAN

Designation / Point Plan	Skill	Effort	Responsibility	Job Conditions	Total
Office Boy	5	15	15	15	50
Receptionist	10	5	10	15	40
Admin Officer	15	15	20	20	70
Asst Accounts	20	15	25	25	85
HR Executive	40	40	20	25	125
Coder	50	40	40	35	165
Biller	40	50	50	35	175
Claims Processor	50	40	40	40	170
Denial Analyst	70	50	50	40	210
Ins AR Agent	75	70	65	60	270
PFS AR Agent	75	70	50	60	255
ATL	85	90	100	60	335
TL	100	80	100	75	355
System Engineer	100	80	80	60	320
Manager Operation	120	110	110	90	430

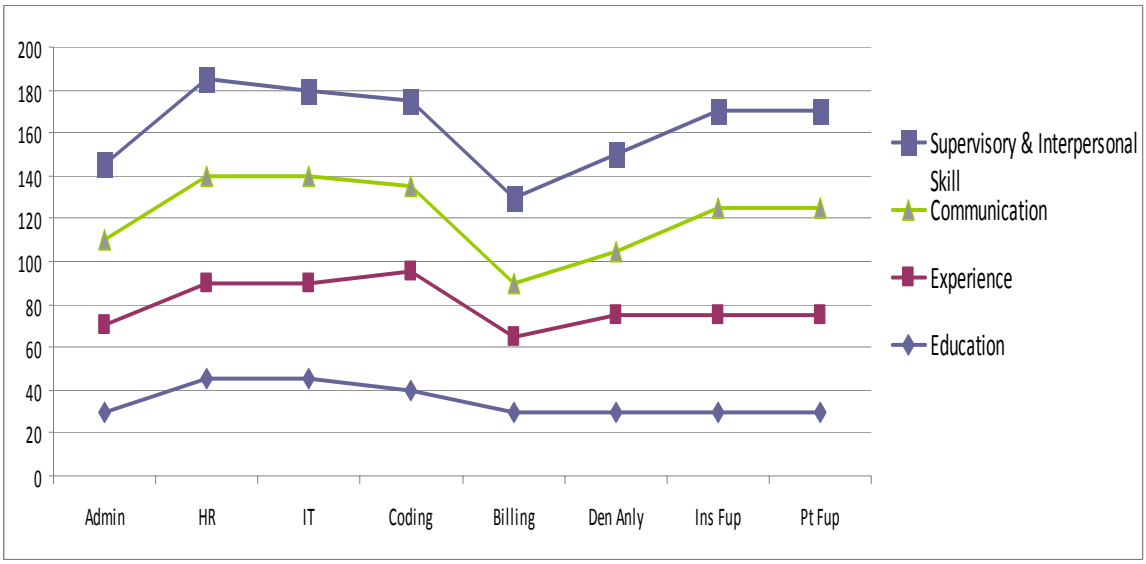
Manager Accounts	110	100	110	100	420
Manager IT	110	90	100	100	400
Manager HR	120	120	120	120	480
Director/VP	120	120	140	120	500



PAIRED COMPARISON RANKING TABLE

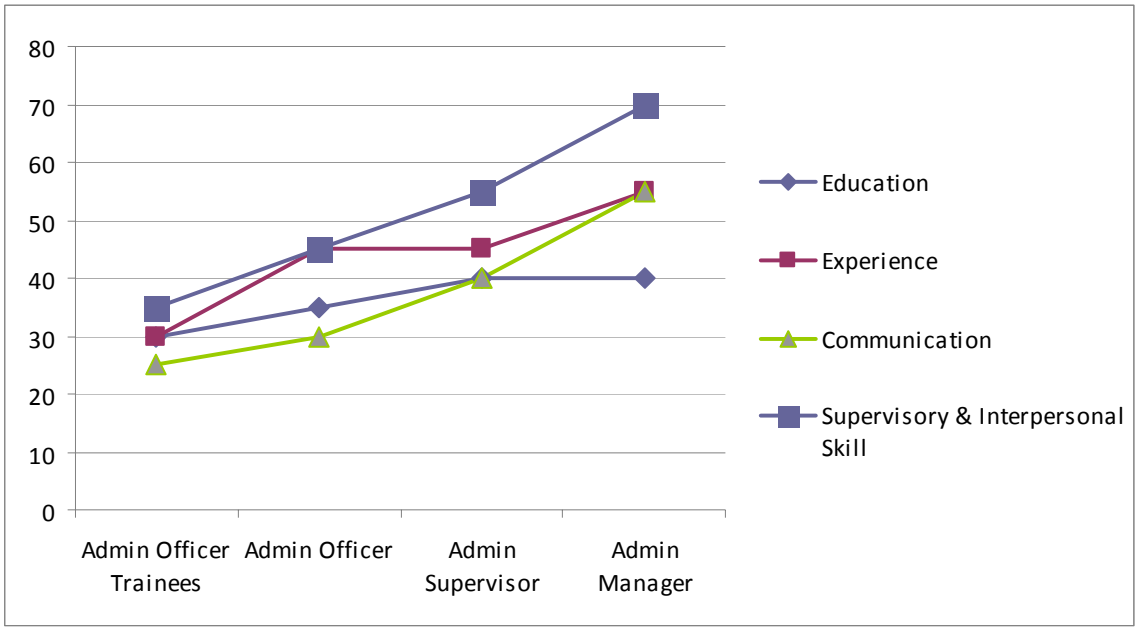
I) All Positions

Factors	Admin	HR	IT	Coding	Billing	Den Anly	Ins Fup	Pt Fup
Education	30	45	45	40	30	30	30	30
Experience	40	45	45	55	35	45	45	45
Communication	40	50	50	40	25	30	50	50
Supervisory & Interpersonal Skill	35	45	40	40	40	45	45	45



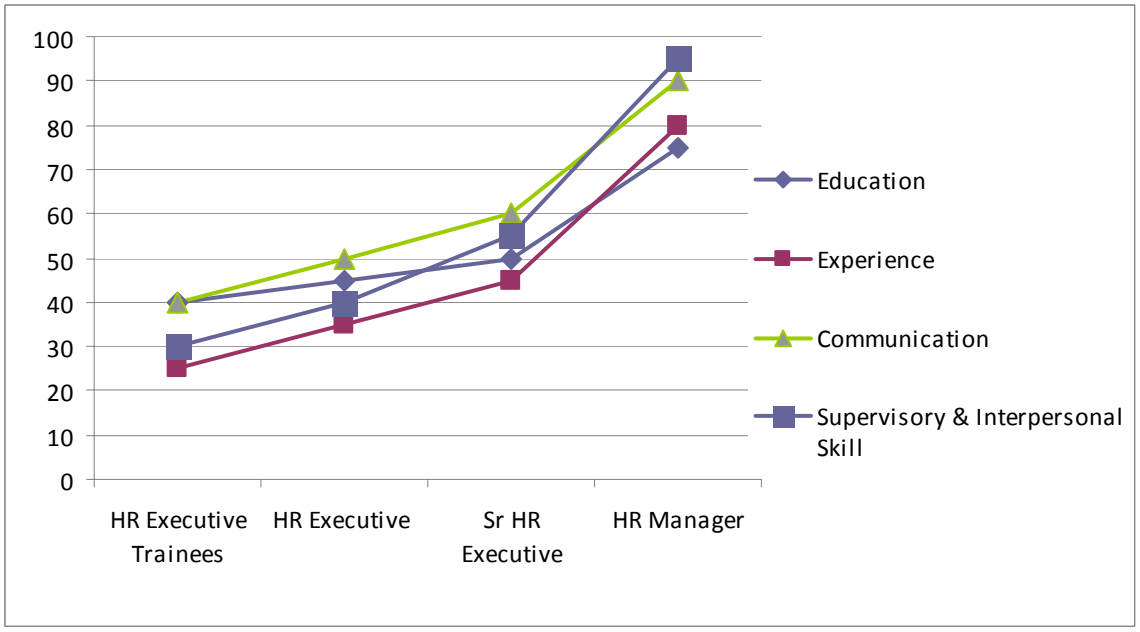
II) FACTORS FOR ADMIN

Factors for Admin	Admin Officer Trainees	Admin Officer	Admin Supervisor	Admin Manager
Education	30 (Grad)	35 (Grad/PG)	40 (PG)	40 (PG with MBA)
Experience	30 (0-1 Yr)	45 (1-3 Yrs)	45 (3+ Yrs)	55 (5+ Yrs)
Communication	25 (Understand)	30 (Understand and Communicate)	40 (Good Communication)	55 (Excellent Communication)
Supervisory & Interpersonal Skill	35 (Supervisory Guidance)	45 (Day to Day Reporting)	55 (Able to Manage Team)	70 (Accountability & Admntrtn)



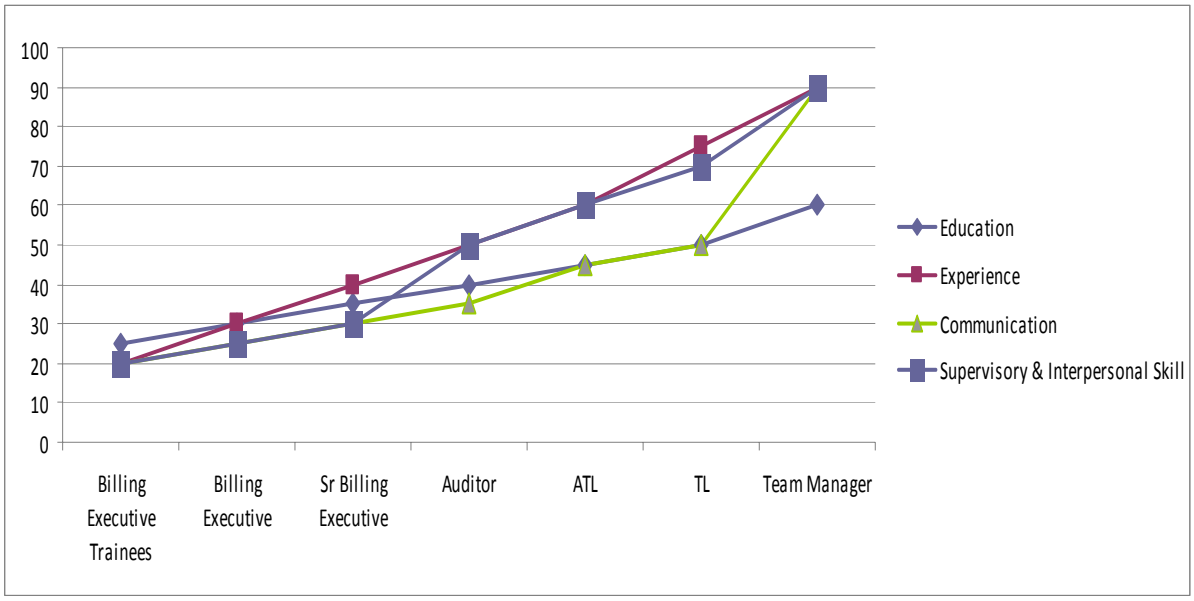
III) Factor for HR

Factors for HR	HR Executive Trainees	HR Executive	Sr HR Executive	HR Manager
Education	40 (MBA in HR)	45 (MBA in HR)	50 (MBA in HR)	75 (MBA in HR & Othr Deg)
Experience	25 (0-1 Yr)	35 (1-3 Yrs)	45 (3-5 Yrs)	80 (5+ Yrs)
Communication	40 (Very Good Com)	50 (Very Good Com)	60 (Excellent Com)	90 (Excellent Command over Eng)
Supervisory & Interpersonal Skill	30 (Const Guid)	40 (Manage HR Actv)	55 (Indept Handles HR Activity)	95 (Manages and achvd Org HR need)



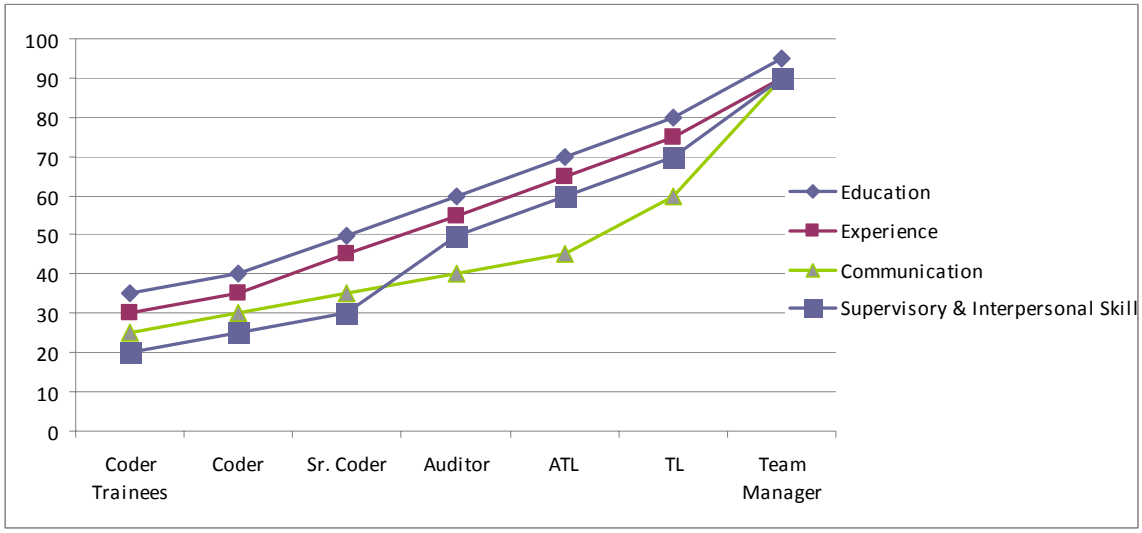
IV) Factor for Billing

Factors for Billing	Billing Executive Trainees	Billing Executive	Sr Billing Executive	Auditor	ATL	TL	Team Manager
Education	25 (Any Grad)	30 (Any Grad)	35 (Any Grad)	40 (Grad or PG)	45 (Grad & PG)	50 (Grad/PG))	60 (PG)
Experience	20 (0-1 Yr)	30 (1-2 Yrs)	40 (2-4 Yrs)	50 (3+ Yrs)	60 (3-5 Yrs)	75 (5+ Yrs)	90 (7+ Yrs)
Communication	20 (Understand)	25 (Understand and Com)	30 (Good Com)	35 (Good Com)	45 (Very Good Com)	50 (Very Good Com)	90 (Excellent Com)
Supervisory & Interpersonal Skill	20 (Const Guid)	25 (Med Sup Guid and Day Report)	30 (Less Guid Req)	50 (take own dec)	60 (Manage Team)	70 (Manage Team with Opt Lvl)	90 (Achieve Bus Obj)



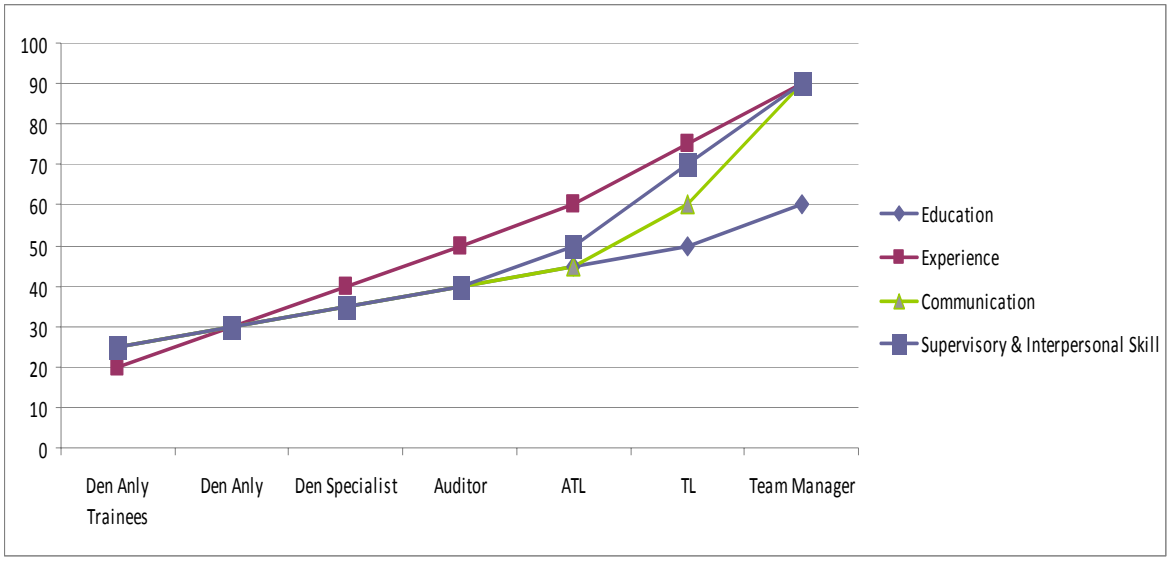
V) Factors for Coding

Factors for Coding	Coder Trainees	Coder	Sr. Coder	Auditor	ATL	TL	Team Manager
Education	35 (Sc Grad)	40 (Sc Grad)	50 (Any Grad with CPC)	60 (Grad or PG with CPC)	70 (Grad & PG with CPC)	80 (Grad/PG with CPC & CPC H))	95 (PG with CPC & CPC-H)
Experience	30 (0-1 Yr)	35 (1-2 Yrs)	45 (2-4 Yrs)	55 (3+ Yrs)	65 (3-5 Yrs)	75 (5+ Yrs)	90 (7+ Yrs)
Communication	25 (Understand)	30 (Understand and Com)	35 (Good Com)	40 (Good Com)	45 (Very Good Com)	60 (Very Good Com)	90 (Excellent Com)
Supervisory & Interpersonal Skill	20 (Const Guid)	25 (Med Sup Guid and Day Report)	30 (Less Guidance Req)	50 (take own dec.)	60 (Manage Team)	70 (Manage Team with Opt Lvl)	90 (Achieve Buss. Obj)



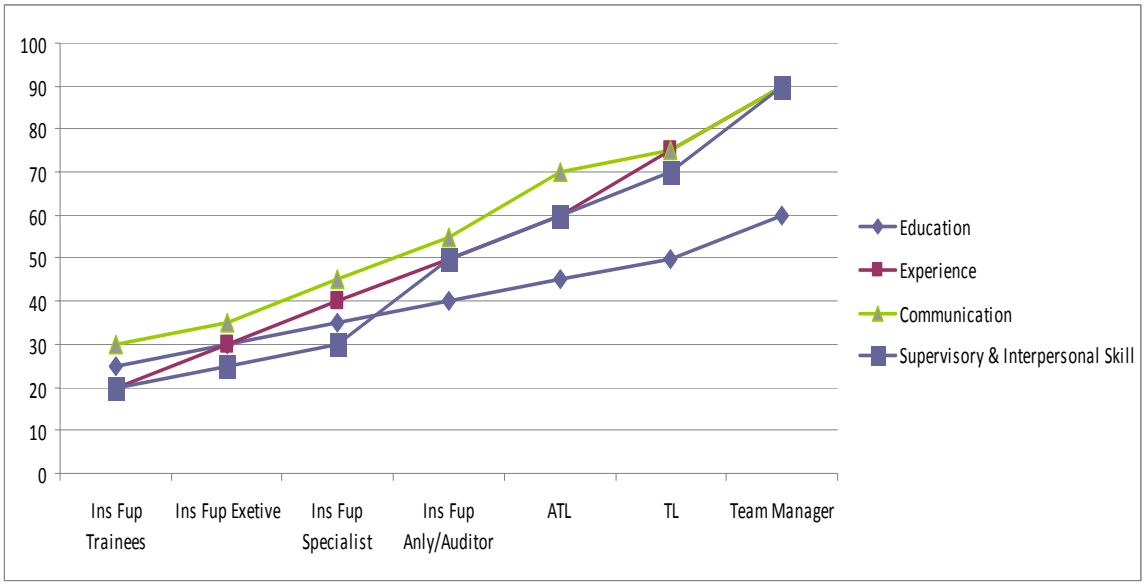
VI) Factors for Denial Analyst

Factors for Den Anly	Den Anly Trainees	Den Anly	Den Specialist	Auditor	ATL	TL	Team Manager
Education	25 (Any Grad)	30 (Any Grad)	35 (Any Grad)	40 (Grad or PG)	45 (Grad & PG)	50 (Grad/PG))	60 (PG)
Experience	20 (0-1 Yr)	30 (1-2 Yrs)	40 (2-4 Yrs)	50 (3+ Yrs)	60 (3-5 Yrs)	75 (5+ Yrs)	90 (7+ Yrs)
Communication	25 (Underst and)	30 (Underst and and Com)	35 (Good Com)	40 (Good Com)	45 (Very Good Com)	60 (Very Good Com)	90 (Excellen t Com)
Supervisory & Interperso nal Skill	25 (Const Guid)	30 (Med Sup Guid and Day Report)	35 (Less Guid Req)	40 (take own dec)	50 (Manage Team)	70 (Manage Team with Opt Lvl)	90 (Achieve Bus Obj)



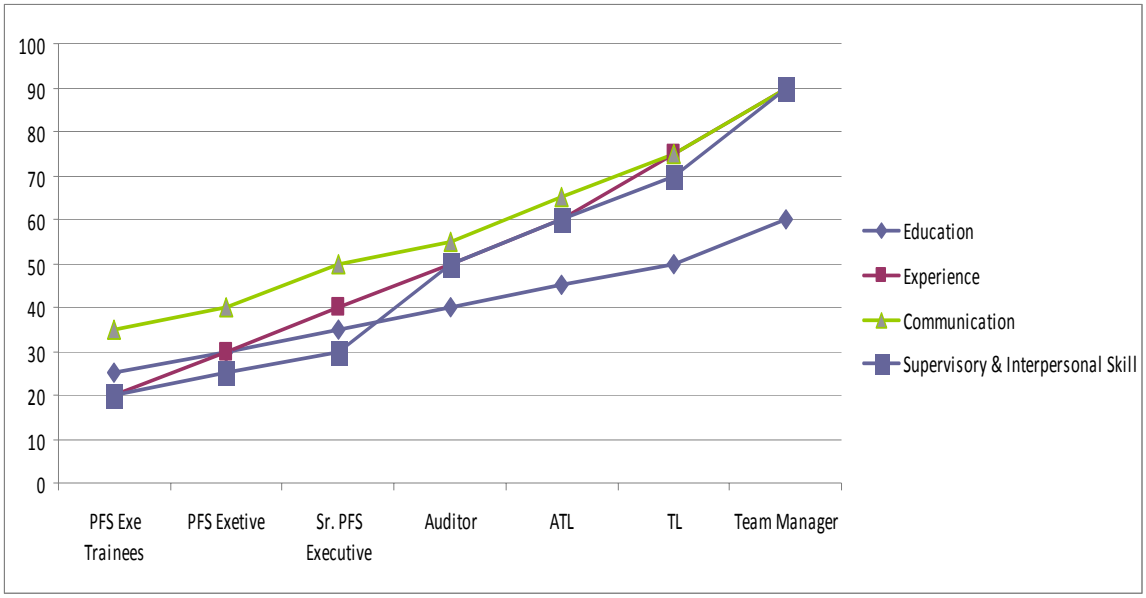
VII) Factors for Insurance Follow-up

Factors for Ins Fup	Ins Fup Trainees	Ins Fup Exetive	Ins Fup Specialist	Ins Fup Anly/Auditor	ATL	TL	Team Manager
Education	25 (Any Grad)	30 (Any Grad)	35 (Any Grad)	40 (Grad or PG)	45 (Grad & PG)	50 (Grad/PG)	60 (PG)
Experience	20 (0-1 Yr)	30 (1-2 Yrs)	40 (2-4 Yrs)	50 (3+ Yrs)	60 (3-5 Yrs)	75 (5+ Yrs)	90 (7+ Yrs)
Communication	30 (Good Com)	35 (Good Com)	45 (Very Good Com)	55 (Very Good Com)	70 (Very Good Com)	75 (Very Good Com)	90 (Excellent Com)
Supervisory & Interpersonal Skill	20 (Const Guid)	25 (Med Sup Guid and Day Report)	30 (Less Guid Req)	50 (take own dec)	60 (Manage Team)	70 (Manage Team with Opt Lvl)	90 (Achieve Bus Obj)



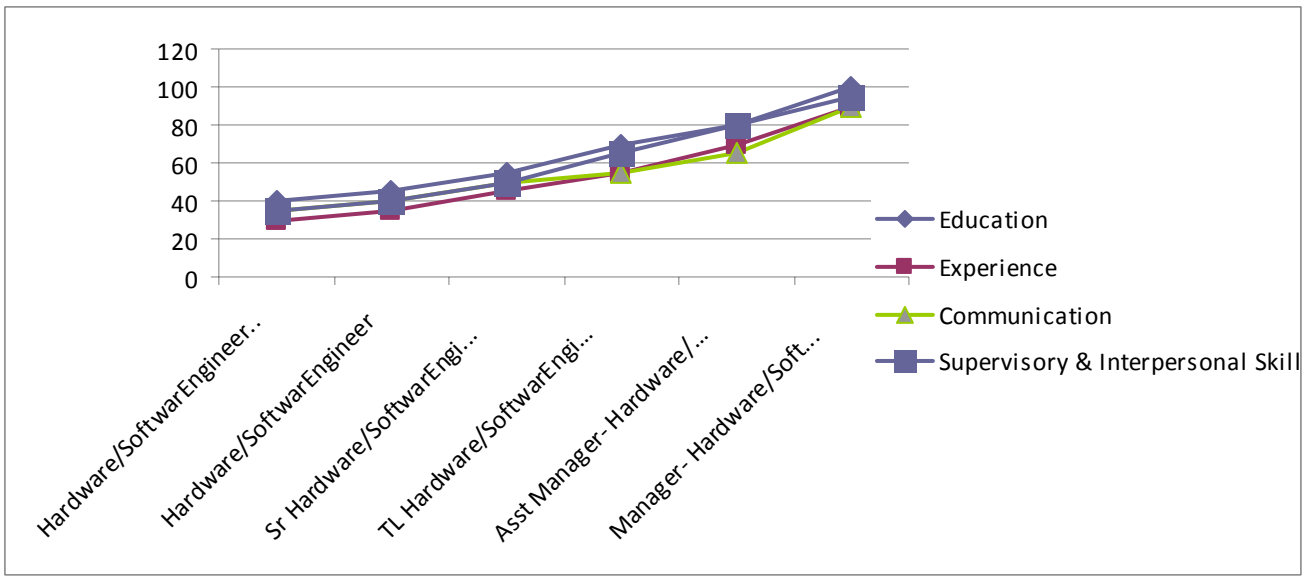
VIII) Factors for Patient Financial Service

Factors for Pat Follow up	PFS Exe Trainees	PFS Exetive	Sr. PFS Executive	Auditor	ATL	TL	Team Manager
Education	25 (Any Grad)	30 (Any Grad)	35 (Any Grad)	40 (Grad or PG)	45 (Grad & PG)	50 (Grad/PG))	60 (PG)
Experience	20 (0-1 Yr)	30 (1-2 Yrs)	40 (2-4 Yrs)	50 (3+ Yrs)	60 (3-5 Yrs)	75 (5+ Yrs)	90 (7+ Yrs)
Communication	35 (Good Com)	40 (Good Com)	50 (Very Good Com)	55 (Very Good Com)	65 (Very Good Com)	75 (Very Good Com)	90 (Excellent Com)
Supervisory & Interpersonal Skill	20 (Const Guid)	25 (Med Sup Guid and Day Report)	30 (Less Guid Req)	50 (take own dec)	60 (Manage Team)	70 (Manage Team with Opt Lvl)	90 (Achieve Bus Obj)



IX) Factors for IT

Factors for IT	Hardware/ Software Engineer - Trainees	Hardware/ Software Engineer	Sr Hardware/ SoftwarEngineer	TL Hardware/ SoftwarEngineer	Asst Manager- Hardware/SoftwarEngineer	Manager- Hardware/Softwar Engineer
Education	40 (BE in IT)	45 (BE in IT)	55 (BE in IT with Cert)	70 (BE in IT with Cert)	80 (BE in IT with Adv Lvl Cert)	100 (BE in IT with Adv Lvl Cert)
Experience	30 (0-1 Yr)	35 (1-3 Yrs)	45 (3+ Yrs)	55 (5+ Yrs)	70 (5+ Yrs)	90 (5+ Yrs)
Communication	35 (Good Com)	40 (Good Com)	50 (Very Good Com)	55 (Very Good Com)	65 (Excellent Com)	90 (Excellent Com)
Supervisory & Interpersonal Skill	35 (Sup Guid)	40 (Day to Day Issues)	50 (Able to Manage Indp)	65 (Accoutability & Admntrd)	80 (Can Manage and Achv Bus Obj)	95 (Can Manage and Achv Bus Obj)



Knowledge Process Outsourcing is a popular word in globalised world. There are two major entities involved in KPO. First entity comprises of organizations in developed countries like United States, Canada, Australia and UK, and second entities are organizations from developing countries like India, China, and Philippines providing various knowledge and information-based complex services.

The prospects of growth and need for KPO services will further improve in future. According to a comprehensive study done by Evalueserve, the global KPO industry is expected to grow at a Cumulative Annual Growth Rate (CAGR) of 46 per cent from $1.2 billion in 2003 to $17 billion in 2010. A majority of growth will be visible in the already booming KPO industry in India and other Asian countries.

Here one thing is universal truth that complex processes being handled by KPO service providers are not temporary. The requirements for solution of several complex business processes will even increase along with the time. So the growth rate of KPO will not decline in coming years.

Rapid growth of research & development, automation, and digitization of Industries led to several new requirements in sectors like Finance, Web & IT Services, Medicine and Pharmaceuticals, Healthcare. These increased requirements will create new scope of opportunities for KPO and it will also require numerous skilled professionals with diverse set of knowledge, IT proficiency and business acumen. It simply means that small, medium or large enterprises in developed countries will always need cost-effective and quality solutions to business processes based on knowledge and information. It will increase career prospects in developing countries for people with high education and professional experience as well as new business and revenues prospects will be opened for KPO service providers.

BPO is likely to grow worldwide by 10 per cent a year from $140 billion in 2005 to over $220 billion by 2010. The industry is rapidly growing and maturing and India has established itself as a major outsourcing hub. India is the world's favorite outsourcing destination. India's share of the global offshore outsourcing market for software and back-office services is **44%.** The Nasscom-McKinsey Perspective 2020 report notes that healthcare will emerge as a very big opportunity for outsourcing services. India with its knowledge base and lower costs will be leading the pack in the race for Knowledge Process Outsourcing (KPO) businesses.

According to a report by Evalueserve, India will capture more than 70% of the Knowledge Process Outsourcing (KPO) territory by 2010. Incase of healthcare BPO sector India is still not mature, which is required to provide multiple customer

care services like a multi-shore model to serve different purposes and applications. These multiple serviceability is required in order to sustain as a healthcare BPO India.

The healthcare segment, internationally acknowledged as an important IT spender, will present many opportunities to Indian IT, BPO and ITES firms. Healthcare BPO India is improving its domain knowledge to tap the huge opportunity offered by the global healthcare industry.

Today India's healthcare outsourcing industry stands transformed with the steady migration of services to the higher-end of the value spectrum. The traditional knowledge-intensive yet non-core health information management activities such as medical transcription, medical coding, and revenue cycle management and claims processing have created a robust foundation for the growth of a wide spectrum of healthcare services offshoring to India.

Many Indian companies are at the moment providing solutions like customer management systems and electronic maintenance of medical record, etc. mainly to healthcare service firms, life sciences and health insurance firms and medical equipment companies, health care claim processing. There are many other areas like clinical research conducting various pathology test for new drugs developed, companies are also getting accreditations to reach international standards. India uses the same techniques, processes and chemicals as those in developed nations this is another reason for being preferred.

There is increasing **global competition** and **pressure on margins** from emerging lower-cost outsourcing destinations. **Risk factors** for outsourcing like terrorism and war, disaster and disease make contingency plans a necessity. Outsourcing **expenditure** will continue to rise. India will show excellence in Services that require advanced English like Research and Analysis Outsourcing, Content and Medicine. **Regional outsourcing hubs will develop** as companies will take **strategic near-shoring initiatives** to minimize risk and leverage cultural and linguistic compatibility. India can collaborate with other countries to leverage local knowledge of the business environment and language skills while providing its domain knowledge and technological expertise for successful outsourcing. However, the challenges for India is ‘rising costs and low efficiency will weaken many organization and bring a drop in their earnings. India’s terrible Infrastructure will continue to be a drag on the potential of India giving other countries the competitive advantage.

Challenges for a HR Professional

1. **Brand equity**: People still consider BPO to be "low brow", thus making it difficult to attract the best talent.

2. **Standard pre-job training**: Again, due to the wide variety of the jobs, lack of

general clarity on skill sets, etc, there is no standard curriculum, which could be designed and followed.

3. **Benchmarks**: There are hardly any benchmarks for compensation and benefits, performance or HR policies. Everyone is charting their own course.

4. **Customer Expectations:**-companies tend to demand better results from outsourcing partners than what they could actually expect from their own departments. "When the job is being done 10,000 miles away, demands on parameters such as quality, turn around timeliness, information security, business continuity and disaster recovery, etc, are far higher than at home. So, how to be more efficient than the original?

5. **Lack of focused training and certifications**. Given this background, the recruiting and compensation challenges of HR departments are only understandable.

Few add-ons that help to retain employees and have more satisfaction are:-

- Provident Fund
- Gratuity
- Group Mediclaim Insurance Scheme
- Personal Accident Insurance Scheme
- Subsidized Food and Transportation
- Company Leased Accommodation
- Recreation, Cafeteria, ATM and Concierge facilities
- Corporate Credit Card
- Cellular Phone / Laptop
- Personal Health Care (Regular medical check-ups
- Educational Benefits and Loans
- Performance based incentives
- Flexi-time / Flexible Salary Benefits
- Regular Get together and other cultural programs
- Wedding Day Gift
- Employee Referral Scheme
- Paid Days Off
- Maternity Leave
- Employee Stock Option Plan

The industry is expected to grow at over 50 per cent CAGR (compounded annual growth rate) over the next five years, with healthcare contributing close to 40 per cent of its revenue. The primary reason for India being favored healthcare BPO India and health care claim processing is the vast talented pool with analytical ability which is required for these healthcare BPO India services. Healthcare BPO India can offer value added services for example diagnostic analysis and that too at a lowered cost.