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# FROM DENIAL TO PREVENTION: CASHLESS PRE-AUTHORISATION REJECTIONS AND A FRONT-END VERIFICATION MODEL IN AN INDIAN TERTIARY-CARE HOSPITAL

**Hospital Administration**

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## ABSTRACT

Hospitals usually treat a rejected cashless pre-authorisation as the insurer's decision. We asked how many such rejections a hospital could itself have prevented. In a tertiary-care multispecialty hospital in India, 2,611 pre-authorisation requests were sent to third-party administrators (TPAs) between June and September 2026. All portal records marked rejected or cancelled were de-duplicated, and each payer remark was graded by reason and preventability. Structured discussions with TPA coordinators helped explain the findings. Of 361 such records, 137 were not true rejections. The 224 genuine rejections gave a rejection rate of 8.6%, and 175 of them (6.7% of all requests) were preventable or partially preventable. Only 49 followed policy terms the hospital could not change. Exhausted cover drove rejections in repeat-cycle oncology and dialysis care, and vague procedure entries marked requests sent before eligibility was checked. Coordinators pointed to missing first-consultation papers, unstated duration of illness and slow clinical replies. We propose VERIFY, a simple front-end model, for hospitals to adopt and test.

## KEYWORDS

Cashless Hospitalisation, Pre-authorisation, Claim Rejection, Third-party Administrator

## INTRODUCTION

In India, an insured patient is admitted on a cashless basis only after the hospital sends a pre-authorisation request to the insurer or its third-party administrator (TPA). If the request is rejected, the family has to pay first and claim later. In our own records, 37 payer remarks said exactly that. Hospitals tend to treat these rejections as something done to them. Some are, because they follow policy terms. Many others begin at our own desk: a lapsed policy, a request sent to the wrong TPA, a diagnosis written only as "pain". Since 2024, insurers are expected to decide cashless requests within one hour (Insurance Regulatory and Development Authority of India [IRDAI], 2024), so what the hospital sends first decides the case.

Studies from the United States describe the cost of insurance paperwork (Tseng et al., 2018) and models that predict denials (Johnson et al., 2023). Indian work covers TPA performance (Shetty et al., 2022) and, under PM-JAY, incomplete documents and late queries (Marathe et al., 2025; Saxena et al., 2022; Trivedi et al., 2022). We found no study that graded private cashless rejections for preventability and checked them against the experience of the staff who prepare the requests.

## OBJECTIVES

The study aimed to measure the true rejection rate, separate preventable from non-preventable rejections, find the case features linked with avoidable rejection and build a front-end model that any hospital can use.

## METHODOLOGY

This mixed-methods study was done in a tertiary-care multispecialty hospital in India. During June to September 2026, 2,611 pre-authorisation requests were sent to TPAs. Insurance desk staff exported every portal record marked "pre-authorisation denied", "discharge denied" or "cancelled". Repeats of the same claim across files were merged, leaving 361 unique records.

Pre-set rules mapped each payer remark to a reason and a grade. A rejection was preventable if a check before submission would have avoided it, partially preventable if hospital action could reasonably have changed it, and not preventable if it followed a policy term. Records with no reason were graded not assessable. The requested amount was treated as exposure, not loss.

The authors also held structured discussions with the hospital's TPA coordinators, using 26 open questions on rejection reasons, documents, queries, training, coordination, turnaround time (TAT) and appeals. Notes were grouped into themes and compared with the records. Proportions are given with Wilson 95% confidence intervals (CI) (Newcombe, 1998); chi-square and Fisher's exact tests were used, with $p<0.05$ taken as significant.

## RESULTS

Of 361 portal records, 137 (38.0%) were not true rejections: 57 cancellations without explanation, 41 without a payer decision, 28 unused or withdrawn authorisations and 11 appeal entries. The 224 genuine rejections gave a rejection rate of 8.6% (95% CI 7.6–9.7) of all 2,611 requests (Figure 1, Table 1).

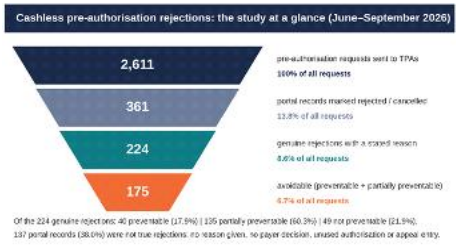


**Figure 1: Study at a glance – from all TPA requests to avoidable rejections**
**Source: Primary data of the study**

**TABLE – 1 REJECTIONS PER 100 TPA REQUESTS (N = 2,611)**

| Category | n | Per 100 requests |
|---|---|---|
| All genuine rejections | 224 | 8.6 |
| Preventable | 40 | 1.5 |
| Partially preventable | 135 | 5.2 |
| Not preventable | 49 | 1.9 |

*Source: Primary data of the study*

Within the 224, 40 (17.9%) were preventable, 135 (60.3%) partially preventable and 49 (21.9%) not preventable. Six reasons made up 62.1% of rejections, and only one of them, waiting period, lay outside the hospital's reach (Figure 2). In one payer group, 10 of 11 requests failed because the policy was serviced by another TPA.

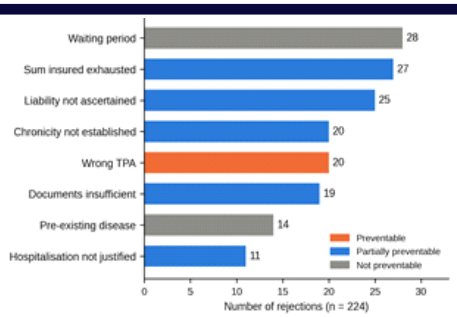


**Figure 2: Leading reasons for rejection**
**Source: Primary data of the study**

Vague procedure entries such as "pain" or "other procedures" appeared in 56.5% of records. They went with eligibility and routing failures (51.6% vs 23.0%, p<0.001), not with medical-necessity rejections. Repeat-cycle care stood out: 50.0% of rejections in such patients were for exhausted sum insured, against 3.3% in others (p<0.001). In oncology, 22 of 24 rejections were avoidable, ten of them for exhausted cover (Figure 3). Avoidable rejections carried Rs. 2.54 crore of requested value; actual loss could not be measured because later collections were not linked.

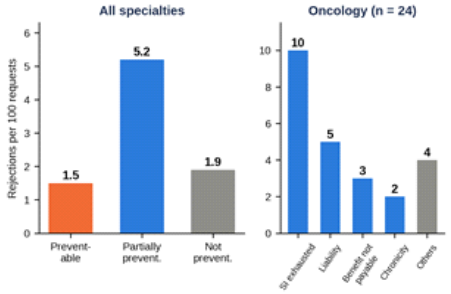


**Figure 3: Rejections per 100 requests and oncology rejection reasons**
**Source: Primary data of the study**

The coordinators confirmed these reasons and explained how they arise. The papers most often missing were the first-consultation note, the cause and duration of symptoms, inpatient case papers and investigation reports. Query replies slowed when doctors were unavailable, at shift change, on Sundays and when papers sat in several departments. Pre-authorisation and discharge were said to take two to four hours, longer than the regulator expects, though the portal keeps no time stamps to confirm this. Training is given through about 10–12 online modules.

## CASE STUDY

This composite case draws on the oncology pattern in the data and the coordinators' accounts; it does not describe a single patient.

A woman with breast cancer received day-care chemotherapy under a group policy. Three cycles were approved without trouble. Each was sent as a fresh request, and no one tracked how much cover remained. For the fourth cycle her oncologist added a subcutaneous targeted injection, and the request was rejected: administration of subcutaneous injections is not payable under day care. The fifth request failed because the sum insured had been restricted. Each time the papers were collected again, and the duration of illness and staging had to be resent. The family paid a deposit and lost confidence in the process (Figure 4).

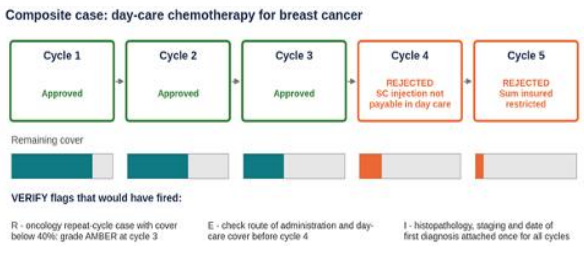


**Figure 4: Illustration of the chemotherapy case and the VERIFY flags that would have prevented it**

*Source: Composite case prepared by the authors*With VERIFY, the case would have been graded amber at the third cycle, the route and day-care cover checked before the fourth, and the histopathology, staging and date of first diagnosis filed once for all cycles.

## DISCUSSION

Three lessons stand out. Nearly four in ten portal "rejections" were not rejections, so counting portal entries misreads the problem. About three in four genuine rejections lay within the hospital's influence. And the warning signs were already in the hospital's records.

PM-JAY studies point mainly to documentation (Marathe et al., 2025; Saxena et al., 2022). Our coordinators explained why: the first-consultation paper and duration of illness are often not collected at admission. In private insurance, though, eligibility and routing failures were larger, because patients bring policies from many insurers and TPAs. Vague entries marked requests assembled in a hurry, which makes them a cheap weekly warning sign. As with safety incidents, these are gaps in process rather than personal failings (Reason, 2000).

These findings shaped VERIFY (Figure 5): validate eligibility, evaluate coverage risk, risk-grade the request, insist on specific clinical content, submit first-time-right and yield learning from every closed case. Emergency treatment is never delayed; checks run alongside care.

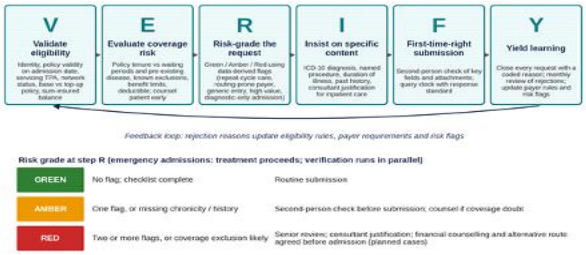


**Figure 5: The VERIFY front-end verification model**
***Source: Developed by the authors***

A few practical steps follow, and none needs new software. Remove closures, duplicates and undecided records before counting rejections. For planned admissions, confirm policy validity, servicing TPA and remaining cover before the request is created, and keep a running balance for chemotherapy and dialysis patients. Collect the first-consultation paper and duration of illness at admission. Give every TPA query a deadline, with a back-up doctor for shifts and Sundays. Record time stamps at submission, query, reply and decision, keep an appeal register, and track monthly rejection rates on run charts (Benneyan et al., 2003).

## LIMITATIONS

Classification relied on payer remarks and one reviewer. The study was short, from one hospital, and staff timings were self-reported. Collections after rejection were not linked to the portal data.

## CONCLUSIONS

In this hospital, 8.6 of every 100 cashless requests were rejected, and 6.7 of these could have been prevented in full or in part. The staff handling them could explain why. VERIFY offers hospitals a simple, testable way to act on this.

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