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Why cashless claims may be denied even after approval

Pre-authorizations are conditional, and final claims depend on review of the medical records

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Insurance regulator Insurance Regulatory and Development Authority of India (Irdai) mandated in May 2024 that insurers must decide on policyholders' cashless pre-authorization requests within one hour of receiving documents from hospitals. The window extends to three hours for final authorization on discharge day.

While the move has broadly been welcomed, it has also created fresh troubles due to lapses in approvals that are later rejected. What happens when a patient gets approval within an hour, only to face rejection midway through treatment or on the day of discharge?

For many families, the sudden reversal turns into a financial emergency despite having insurance coverage.

Approval shock

Take the case of Jaipur-based Deepika Sharma. She was diagnosed with incompetence of cervix uteri during the fifth month of pregnancy. Her policy did not include maternity coverage. However, the treating doctor clarified that the condition had nothing to do with pregnancy and was merely diagnosed during pregnancy.

Sharma applied for pre-authorization and received approval. But on discharge day, the claim was rejected on the grounds that maternity treatment was not covered.

"They could have rejected pre-auth request itself. They had my policy details. Why initial approval and later rejection? We have reached out to the ombudsman," said Sharma.

In another case, Bengaluru-based Ram Vaithya's premature twins spent nearly two months in hospital after birth. A few months later, his son was hospitalized again with fever.

Vaithya said he had fully disclosed the medical history of both children while adding them to his family floater policy. "I was told the insurer might reject my request to add them, but they eventually accepted it. Later, when my son was hospitalized for fever, the pre-auth request was approved. But on the discharge day, I was suddenly told I had hidden my son's pre-existing disease. I had shared every document. Somehow I managed to get the claim settled, but the insurer later cancelled my policy." Vaithya is considering approaching the ombudsman to challenge this.

Both cases point to lapses in pre-authorization assessment that ideally should have been flagged at the initial stage itself.

Has the 1-hour rule improved the industry?

Veteran insurance expert Dr Bhavani, who has worked with several insurers, said the one-hour rule has significantly improved industry standards despite operational pressure. "Insurance companies now have to share compliance data with GIC and approval deadlines are being met in around 92–93% cases. Earlier, the number was closer to 60–70%," she said.

"The percentage is higher in companies where they have their in-house claims adjudication team versus those relying on third-party administrators (TPAs). Earlier medical adjudication at pre-auth level was not happening. Now all insurers employ doctors, which has improved the quality of pre-auth evaluation," she added.

Amarnath Saxena, chief technology officer-commercial at Bajaj Allianz General Insurance, said the shorter deadline has reduced the depth of evaluation possible for complex clinical reviews, fraud checks and multi-policy validation. "The regulation has improved patient convenience and transparency, while insurers continue to strengthen backend processes to balance speed with accuracy," he said.

Speed dilemma

Avigyan Mitra, founder of health insurance advisory firm Zenoa, said pre-auth responses earlier could take anywhere from four hours to an entire working day, often due to incomplete paperwork. "The intent is right. No one in a hospital bed should be waiting hours to find out whether their insurer will cover the treatment their doctor has recommended, but a flat one-hour deadline for every pre-auth request, regardless of complexity, is where I disagree," he said. Giving an example, Mitra said a knee replacement and a liver resection in a cancer patient cannot be assessed identically.

Experts advise policyholders to preserve records, respond quickly to insurer queries, as approvals are often provisional

"The documentation problem has not disappeared. Only the pressure has shifted. If a hospital sends incomplete papers at 10 pm and the insurer still has to respond by 11 pm, it creates perverse incentives. An insurer that approves without adequate review merely to stay compliant becomes vulnerable to fraud," he said.

Mitra suggested tiered timelines based on complexity. Standard procedures could continue under the one-hour rule, while complex or high-value cases could get longer review windows. He also recommended standardized document checklists for hospitals and mandatory acknowledgement of receipt within 15 minutes to reduce delays caused by repeated queries.

Pre-auth maze

Pre-authorization is the process through which a hospital seeks approval from the insurer or TPA before treatment is carried out under a cashless claim.

Saxena explained that once a patient is admitted to a network hospital, the hospital's insurance desk submits a pre-auth form containing details such as diagnosis, symptoms, clinical findings, proposed treatment or surgery, estimated costs, investigation reports and policy information.

The request is electronically sent to the insurer's claims team or TPA, where a medical reviewer evaluates the case and issues a decision—approval, query, partial approval or rejection.

"Policyholders need to understand that pre-auth approvals are conditional, based on the information available at the time of admission. Final claim adjudication takes place after discharge, once the complete medical records have been reviewed," he said.

Approvals may later be reversed if the final diagnosis changes, discrepancies emerge or material information is found missing, he said.

For instance, a patient admitted with "acute abdomen" under a first-year policy may later be diagnosed with renal stones, which are typically covered only after the waiting period.

"While the initial emergency symptoms may justify admission, the final records may not support coverage under policy terms," he added.

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One-hour cashless approval: relief or risk?

Pre-authorization on cashless claims is getting approved quicker under Irdai's new rules, but many policyholders are facing reversals and rejections during treatment or on discharge day.

Issue: Insurer treated non-maternity condition as pregnancy-related.

"They already had my policy details, so why approve the pre-authorization first and reject the claim later?"

DEEPIKA SHARMA
Jaipur, Banker

Issue: Claim approved initially, later rejected alleging non-disclosure about premature twins.

"I had disclosed everything, so approving the pre-authorization and later alleging non-disclosure made no sense."

RAM VAITHYA
Bengaluru, Assistant VP in a bank

Issue: Rejecting pre-authorization mid-treatment due to non-submission of a document.

"I provided the said document mid-treatment and got cashless claim approved by the discharge day."

GOURAV KUMAR
Delhi, Business owner

Issue: Rejection of pre-authorization on the discharge day due to non-disclosure.

"They rejected my pre-authorization alleging non-disclosure of a surgery that had happened nearly two decades ago."

NATWAR HARI SHARMA
Delhi, Service industry

Why policyholders are worried

- Initial approvals later getting reversed
- Claims rejected mid-treatment or at discharge
- Sudden financial burden despite insurance cover

Why reversals happen

- Final diagnosis differs from initial diagnosis
- Waiting period becomes applicable later
- Missing or incomplete documents
- Alleged non-disclosure of medical history
- Additional medical records emerge during hospitalization

What policyholders must know

- Pre-authorization approval is conditional, not final
- Final claim decision happens after discharge review
- Keep all medical papers safely
- Preserve the first doctor consultation document
- Respond quickly to insurer queries

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