DCM Infotech

CASE STUDY · HEALTHCARE CLAIMS ADJUDICATION

AI-powered claims adjudication at enterprise scale

Scaling corporate health insurance claims operations without proportional workforce growth.

Company overview

- Division of a healthcare company providing claims adjudication services
- Healthcare services and health insurance claims operations
- Supports a medical insurer serving large corporate groups across India
- More than 200 employees before the automation-led scale-up

Operating environment

- Group policies covering inpatient (IPD) and outpatient (OPD) expenses
- Cashless network treatment and reimbursement claims
- Claims arriving through physical mail, email and portals
- Entitlements varying by employee category, benefit type, limits and exclusions

01 · OVERVIEW

Scaling claims without scaling headcount

A healthcare services provider supporting claims adjudication for a medical insurer faced a fundamental scaling challenge. As the insurer expanded its portfolio of large corporate group health policies across India, claims volumes and policy complexity increased. Manual document review, eligibility verification, discrepancy resolution, and data entry required continuous hiring, while employee attrition increased training costs and delayed processing put service-level agreements (SLAs) and commercial performance under pressure.

20×

Corporate account growth, from 2 to 40 customers, with no additional manpower

~1,000

Claims handled by AI agents per day

>40%

First-pass claim closure by AI agents

02 · CHALLENGES

Volume outgrew manual processing

Labor-intensive operations

Additional claims processors were required whenever new corporate accounts were onboarded.

Attrition and training costs

Attrition compounded recruitment, onboarding and training expenses, driving up the cost per claim and eroding profitability.

SLA and compliance exposure

Processing delays made insurer SLAs difficult to meet, exposing the insurer and its service provider to regulatory and contractual financial consequences.

Complex entitlements

Entitlements varied within the same corporate group policy by employee category, benefit type, limits, and exclusions, making manual verification complex.

Inconsistent intake

Claims arrived through physical mail, email, and portals, with inconsistent document formats and scan quality.

Turnaround pressure

The insurer needed faster claim turnaround both to meet compliance obligations and to strengthen its value proposition to corporate customers.

03 · SOLUTION

Three AI agents, one existing workflow

Building on prior AI engagements with other companies in the client's group, DCM Infotech designed a plug-in to automate repeatable claims-processing activities within the existing adjudication workflow. AI agents interpret multiple documents together, compare extracted information with employee-specific policy entitlements, identify exceptions, support decisions, coordinate follow-ups, and prepare validated information for the insurer's claims application.

Document reading

Agent 1 · AI document agent

Multi-channel document intake and AI-assisted reading of claim forms, bills, prescriptions, test reports, and supporting records, with cross-document consistency checks and exception identification for missing, conflicting, or unclear information.

Policy verification

Agent 2 · AI verification agent

Employee identity and KYC checks, including exception handling when legacy bank identifiers conflict with updated bank details, and policy-aware verification of billed services against the claimant's corporate group, coverage tier, limits, and permitted benefits.

Follow-ups and handoff

Agent 3 · AI coordination agent

AI-managed claimant follow-ups to obtain missing documents or resolve discrepancies, plus structured claim data preparation and integration with the existing claims adjudication application, with exception handling where needed.

04 · BUSINESS IMPACT

20× growth, no additional manpower

20× corporate accounts

Claims processing now supports 40 corporate customers, up from 2, without additional manpower.

~1,000 claims a day

AI agents handle approximately 1,000 claims per day, plus claimant follow-ups.

>40% first-pass closure

AI agents close more than 40% of claims on the first pass.

Existing application extended

Workflow integration extends the provider's core claims adjudication application.

05 · WHY DCM INFOTECH

Beyond automating data entry

How DCM Infotech set out to solve an operating-model challenge

DCM Infotech developed an AI-powered plug-in for the provider's core claims adjudication application, using a multi-document reading, analysis, and decision-support framework. Our approach combined multi-document AI that reads and interprets claim documents together, policy-aware decision support against employee-specific entitlements, workflow integration that extends the existing claims adjudication application, and commercial architecture optimization to preserve project economics.

> **How could the provider support a growing portfolio of corporate group policies without continuous hiring?**

06 · SOLUTION IMPLEMENTATION

Implementation challenges, solved

01 ——

Scan quality

Poor-quality scans of physical documents were the most significant obstacle to reliable extraction and required careful handling of low-confidence inputs.

02 ——

Implicit rules

Human adjudicators relied on implicit assumptions that were not always documented in policy rules. During onboarding of new corporate accounts, initial AI approval rates could fall until these exceptions and interpretations were incorporated into the workflow.

03 ——

Bank IFSC changes

Bank mergers and changes in IFSC codes could trigger false KYC exceptions despite valid employee accounts, requiring additional validation logic.

04 ——

LLM pricing

An increase in Google LLM pricing during implementation threatened project economics. DCM Infotech rearchitected the solution around an earlier model version, accepting additional technical complexity to preserve commercial viability.

07 · IMPACT & BUSINESS BENEFITS

A more scalable, predictable claims operation

Decoupled account growth

Decoupled corporate account growth from proportional increases in claims-processing headcount.

Scalable operating model

Reduced dependence on repetitive manual review and claimant coordination, creating a more scalable operating model.

Consistent processing

Improved the capacity to process claims consistently despite variations in corporate benefit structures.

Faster, predictable operations

Supported faster, more predictable claims operations, addressing an important driver of SLA and compliance exposure.

Turnaround as a service differentiator

Created a stronger foundation for the insurer to position claims turnaround as a service differentiator.

08 · NEXT STEP

Ready to scale complex claims operations? The engagement demonstrates how an AI layer can extend an existing enterprise application and enable volume growth without equivalent workforce expansion.



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