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Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

CLAIMS ADJUDICATION MANUAL

Ayushman Bharat
Pradhan Mantri Jan Arogya Yojana (PM-JAY)

NATIONAL HEALTH AUTHORITY
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TABLE OF CONTENTS

Acronyms

AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
BIS	Beneficiary Identification System
CEX	Claims Executive
CPD	Claims Panel Doctor
IC	Insurance Company
MEDCO	Medical Coordinator
NHA	National Health Authority
OT	Operation Theatre
PMAM	Pradhan Mantri Arogya Mitra
PM-JAY	Pradhan Mantri Jan Arogya Yojana
PPD	Pre-authorization Panel Doctor
SHA	State Health Agency
TAT	Turn Around Time
TMS	Transaction Management System
NTMS	National Transaction Management System (for portable cases)

1. About AB PM-JAY

The Government of India is committed to ensuring that its population has universal access to good quality health care services without anyone having to face financial hardship therefore. Under the ambit of Ayushman Bharat, Pradhan Mantri Jan Arogya Yojana (PM-JAY) was launched to reduce the financial burden on poor and vulnerable groups arising out of catastrophic hospital episodes and ensure their access to quality health services.

Entitled Beneficiaries: Pradhan Mantri Jan Arogya Yojana (PM-JAY) provides financial protection to 10.74 crore poor, deprived rural families and identified occupational categories of urban workers' families as per 2011 Socio-Economic Caste Census (SECC) data (approx. 50 crore beneficiaries).

Benefits: It offers a benefit cover of Rs. 500,000 per family per year (on a family floater basis), there is no cap on family size and age. The scheme is cashless & paperless at public hospitals and empanelled private hospitals. The beneficiaries are not required to pay any charges as hospitalization expenses. However, there would be some packages reserved for public hospitals only. This would vary from state to state.

Implementation Mode: The Scheme allows State Governments to choose mode for implementation as it suits their specific requirements and seek implementation partner accordingly. Three modes of implantation of Scheme are Insurance, Trust, or Hybrid. In case State Govt chooses to implement through hybrid, it can further choose as to what amount shall be borne by Trust and what amount shall be underwritten by Insurance Company. At present all 3 modes of implementation are operating in different States.

Covered Procedures: PM-JAY covers medical and hospitalization expenses for almost all secondary care and most of tertiary care procedures, bundled as 1,393 treatment packages covering surgery, medical and day care treatments. However, number of packages may differ from state to state.

A treatment package covers Medical examination, treatment, and consultation:

- Pre-hospitalization (3 days): consultation involving diagnostic tests and medicines before admission within the same hospital
- During hospitalization: Medicine and medical consumables, non-intensive and intensive care services, diagnostic and laboratory investigations, procedure costs including medical implant services (where necessary), accommodation benefits and food services for the patient, complications/co-morbid conditions arising during treatment
- Post-hospitalization up-to a limit of 15 days, that includes discharge medicines

2. Purpose of Manual

The purpose of Claims Adjudication Manual is to build capacities of processing team for accurate processing/settlement of claims under PM-JAY and to enhance their skills combining fundamental concepts and human intelligence during claims processing. The necessity of accurate processing is important from multiple aspects – approval of admissible claims, payment of correct amount to hospital and genuine utilization of beneficiary's wallet etc. to name a few. These guidelines will help Pre-authorization Panel Doctors (PPD), Claims Executives (CEX) and Claims Panel Doctors (CPD) in efficient and error free processing of claims and to exercise due-diligence at the time of pre-authorization approval.

This manual describes the process and factors to be considered while processing a claim and as well as a Pre-authorization under PM-JAY. Each process has a time line associated to it, few of the timelines are inbuilt in the system, few are suggestive/contractual for maintaining process efficiency. The manual elaborates on the roles and responsibility of the people involved in the entire workflow. Few sample cases and complicated cases have been explained to help the processing team to adjudicate such cases without difficulty.

The process flows, titles of people performing different roles, IT configuration may vary in different States, especially those States which do not use NHA provisioned TMS, however basic concepts of adjudication would remain the same and shall apply.

3. Basics of Adjudication

Claims adjudication refers to the decision on two key aspects of a claim: whether the claim is admissible under the terms of policy/Scheme and if yes, what is the quantum payable. It applies to final decision on claims payment. In the context of cashless provisions of PM-JAY, the concept is also applicable for Pre-authorization to a certain extent because once a Pre-authorization is approved, it is an admissible liability/claim unless it can be proved at later stage that pre-authorization approval was obtained by hospital through submission of falsified documents/ mis-representation of facts.

While approving a Pre-authorization request or adjudicating a claim at settlement stage, the processing team should exercise utmost care and be mindful of the decision because any wrong approval/ payment may lead to recoveries at later stage.

Below mentioned points should be kept in mind while processing a pre-authorization or a claim:

- The patient should be an eligible beneficiary and verified through Beneficiary Identification System (BIS) or through state managed beneficiary database via NTMS
- The treatment package claimed should be covered under the Scheme and should comply with the state specific reservation in the package masters
- The disease should not fall under the exclusion (refer Annexure 1) criteria as defined under the policy

- The available sum insured in beneficiary's family wallet should be enough for payment of the current treatment
- The processor should ensure that all the documents submitted by the hospital confirm that admission/ hospitalization was absolutely necessary
- Claim processor should validate all the details/information (patient details, diagnosis details, treatment chosen) submitted at the time of Pre-authorization and highlight discrepancy if any
- Claim processor should raise a query in case of any missing information rather than rejecting the claim
- Processor should make an informed and mindful decision on the payment to be made to the hospital
- The claim approved amount should not be more than the amount approved during Pre-authorization and wallet balance

To ensure claims adjudication in a uniform manner, National Health Authority (NHA) has listed packages which are covered under AB PM-JAY and has assigned a rate (price) to each. Further, package wise mandatory documents – as decided by the state (to be submitted by the hospital at the time of Pre-authorization initiation and claim submission) have also been identified and have been inbuilt in the system. The processing team should familiarize itself with the system and utilize it to the best of its capability.

The system under PM-JAY is designed to help the claims processing team, however, human intelligence needs to be applied while processing both Pre-authorization and claims.

Query: The processor may come across common errors/ typographical mistakes and missing information. In such cases, rather than rejecting the case right away the PPD/CPD should ask for clarification or missing information. Also, If the PPD/CPD cannot reach to any conclusion and feels the need to examine more details, in that case the hospital might be asked for providing case specific additional documents like IPD papers, OT register, Lab registers etc. It is necessary that all the queries are raised in a one go and not more than 3 times in any circumstances

Investigation/Audit: Some claims might seem doubtful/ suspicious, those cases can be sent for a desk review, field investigation or medical audit. Such a scenario is likely to arise as in case of 'Unspecified procedures' or cases wherein apparently there is no justification for hospitalization or gross mismatch between symptoms, diagnosis and procedure etc.

Outcomes/ Actions: There would be three possible outcomes of claims adjudication.

1. The claim may be paid if the CPD finds everything is in order and is completely satisfied on the relevant parameters.
2. Claim can be rejected, if the CPD after reviewing all the details feels that it does not qualify approval and payment.
3. The CPD can also approve the payment partially, if the details/documents do not justify entire claim.

4. Target Turn- Around-Time

Pre-authorization approval	6 hours
Pre-authorization enhancement approval	6 hours
Response to Pre-authorization/ claim query by the hospital	24 hours
Claim Submission by hospital	15 days
Claim Adjudication and payment after claim submission (Approval/ Rejection/ Query)	15 days
Claim Adjudication and payment for portability cases	30 days
Field Investigation/Onsite Medical Audit after trigger of case	7 days
Request reconsideration of Rejected Claim by hospital after notification	7 days
Claim reconsideration after request for reconsideration	7 days

A few of the timeframes are already incorporated in the Transaction Management System (TMS) and remaining are suggestive. These timelines cannot be the sole basis of rejecting cases; however, providers and approvers are advised to comply with the above to make the processes more efficient.

5. Roles & Responsibilities

Pre-authorization Panel Doctor (PPD)

- Approve/Assign/Reject a Pre-authorization request
- Raise Query/Send back to hospital with request for clarification and/ or additional inputs
- Trigger investigation, if need be

Claims Executive (CEX)

- Verification of Non-technical (non-medical/clinical) information like Documents, reports, dates etc.
- Forward the case to Claim doctor with Inputs

Claims Panel Doctor (CPD)

- Verification of technical (medical/clinical) information like diagnosis, reports, clinical notes, evidences etc.
- Approve/Assign/Reject a claim
- Raise Query/Send back to hospital for clarification
- Trigger field investigation, if need be

Accounts Officer

- Validate financial information in all the transactions
- Forward the claim to SHA/ Insurance Company (IC) for approval

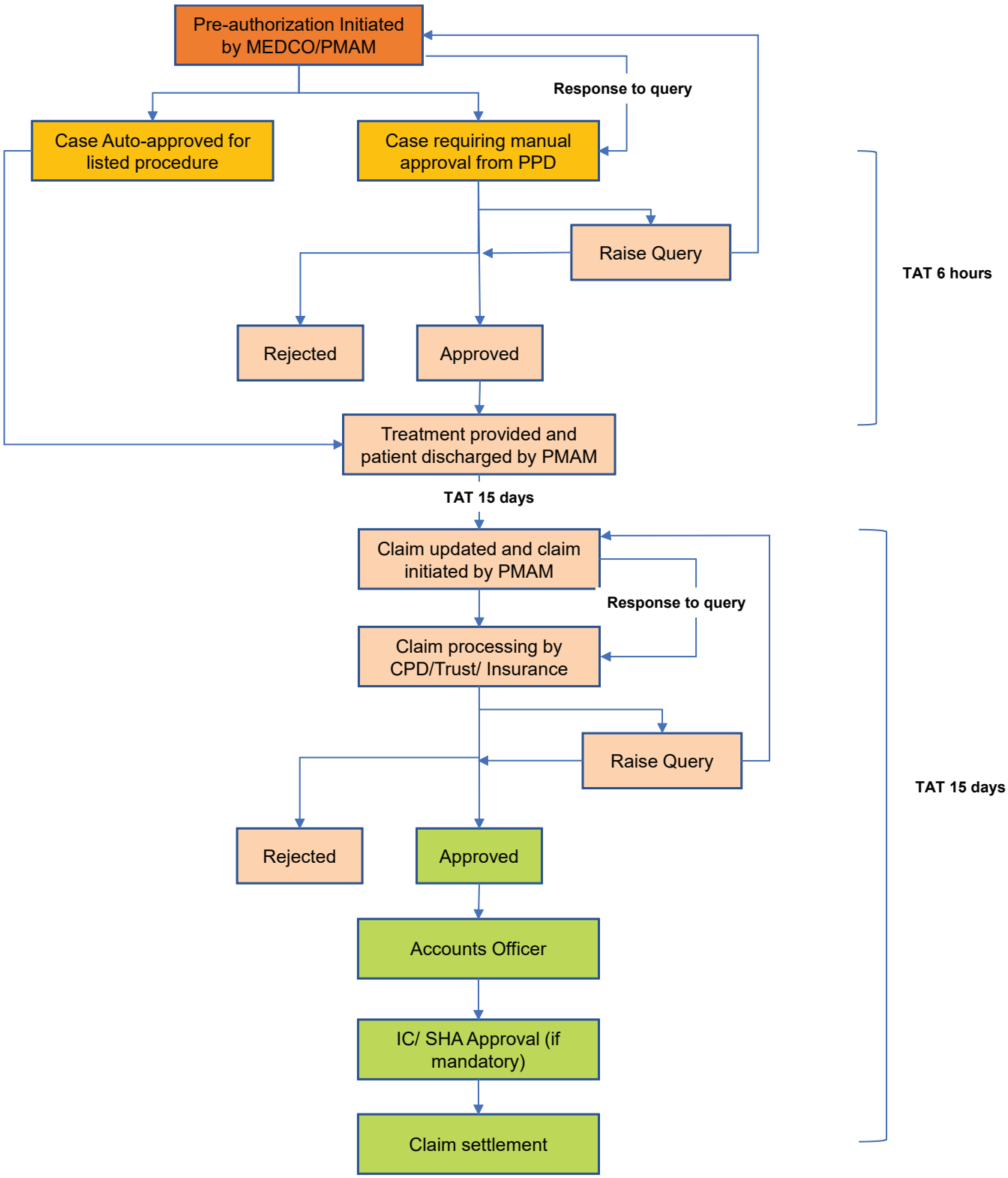
SHA/IC/NHA IT System (As applicable)

- Verify and approve/ revoke the submitted claims
- Respond to queries/ reconciliation issues raised by hospitals regarding final payment received
- Quality audits of processing done by ISA/ IC / TPA of approved claims (100% for mortality or rejected claims and 10% of approved claims to be audited), higher percentage of claims can be audited as per Contractual or local requirements

Bank

- Process payment for all the transactions
- Share response file with SHA / Insurance Company

6. End to End Workflow



7. Process Flows

7.1. Pre-authorization Process

Before initiating the treatment of beneficiary under the Scheme, hospital needs to seek approval from designated authority – ISA/Insurance Company/SHA. Pre-Authorization needs to be approved by Pre-authorization Panel Doctor (PPD) for proposed In-patient registered beneficiary. This process is known as Pre-Authorization.

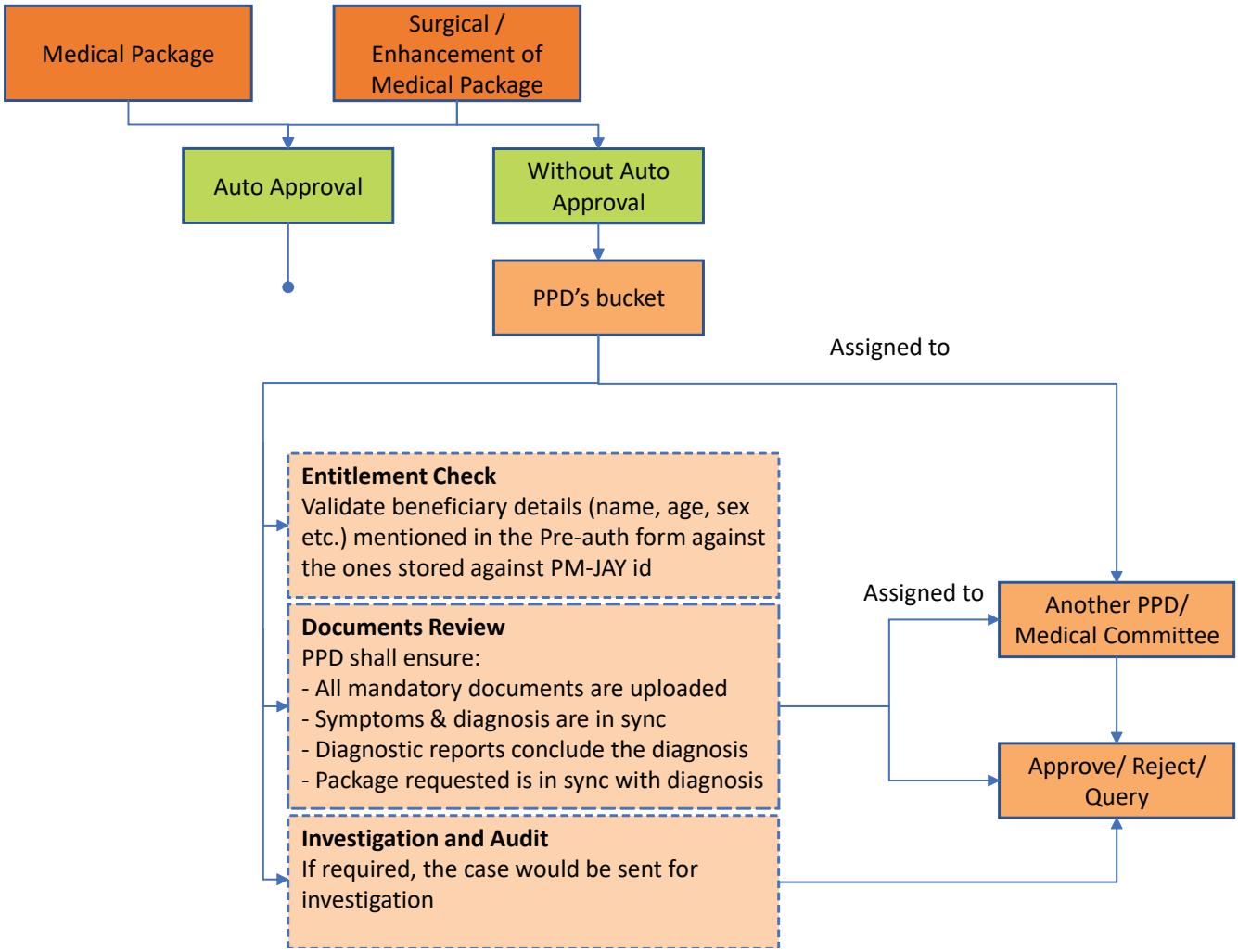
a) **Pre-authorization Process Initiated by MEDCO/ PMAM:**
MEDCO (Network Hospital doctor) initiates the Pre-authorization process by submitting all mandatory information as per the specific packages like illness details, proposed surgery details etc. After this action, the case status changes to 'Pre-authorization MEDCO Initiated' in TMS.

b) **Pre-authorization Approval by Pre-authorization Panel Doctor (PPD):**

- For most of the medical cases (number may differ in states), pre-authorization will be auto approved for the first day of admission. However, the hospital can take an enhancement of only up to 5 days at a time. upon providing documentation evidence as listed.
- For surgical cases, based on selected procedures pre-authorization request may be auto approved. This would also vary from state to state. Further, Pre-authorization Panel Doctor (PPD) can Approve/ Mark Pending (Query) / Assign/ Reject a Pre-authorization request.
- If PPD marks Pre-authorization request as pending, it goes to the hospitals for more information (query). The PMAM/MEDCO is to provide required information to PPD within 24 hours.
- If any additional surgery is to be conducted the PMAM/MEDCO need to submit surgery details in Pre-authorization tab
- For enhancement of medical package, PMAM/MEDCO initiates enhancement by submitting the details like admission unit, number of days and detailing/ justifying remarks in the pre-authorization tab
- PPD will then take appropriate action

Please refer to Approver's Manual for detailed information on the above:
https://www.pmjay.gov.in/sites/default/files/2018-12/Approvals%20_User_Manual_v2.0.pdf

Actions to be taken by PPD on a Pre-authorization request (TAT: 6 Hours)



Once the Pre-authorization request is received by the PPD, s/he can assign it to another PPD or medical review committee. Below mentioned steps would have to be followed while taking appropriate decision on the pre-authorization request.

TAT: The TAT for this process is 6 hours. However, in cases where a query is raised to the hospital, the PPD would be allotted another 6 hours after receipt of hospital's response.

7.1.1. Entitlement check

It is very important to ensure that the entitled and legitimate beneficiary receives the treatment under this Scheme. The PPD needs to validate patient details (name, age, sex etc.) mentioned in the Pre-authorization form and other uploaded documents against the ones stored against PM-JAY id. In case of lack of clarity/discrepancy or unavailability of required information the PPD can raise a query to the hospital asking for more information.

7.1.2. Documents review

The MEDCO would upload below mentioned mandatory document –

- Pre-authorization form
- Patient Photo

Besides above, there are many packages for which "**minimum required documents**" have been defined/ listed. For these packages along with mandatory documents the hospital would also upload the package specific mandatory documents.

Below mentioned points need to be considered while reviewing the documents-

- The PPD shall ensure that all mandatory documents are uploaded by the hospital
- The symptoms mentioned in the doctor prescription shall align with the primary diagnosis
- The findings of the investigation/ diagnostic reports uploaded by the hospital indicate the diagnosis
- The treatment package requested by the hospital is in sync with exhibiting symptoms and diagnosis made and follows standard treatment modalities.

In case of rejection of request for a Pre-auth, the PPD shall provide the details for rejection clearly in the comments section. The case would go back to the hospital for notification. At the same time the case would also go to SHA. The SHA has authority to revoke the Pre-authorization. Once revoked the case would again come to PPD's bucket.

In case of emergency procedures similar process must be followed. However, the hospital shall stabilize the patient and then go ahead with the identification and Pre-authorization initiation.

For Auto-approved packages:

- It shall be ensured that the hospital submits the documents required at the time of Pre-authorization along with the Pre-authorization form or at the time of claims submission
- CEX and CPD shall follow the above-mentioned process during claims adjudication

Example: Total Hip Replacement (Cemented)

Mandatory documents to be uploaded by the hospital at Pre-authorization level:

1. Clinical and radiological investigations confirming the diagnosis
2. Clinical photograph of affected part

Actionable for PPD

All mandatory documents uploaded?	Yes/No
Did the patient have a history of trauma/avascular necrosis/severe osteoarthritis?	Yes/No
Are supporting clinical documents and X-Ray/CT available to establish indication for THR?	Yes/No
Clinical photograph of hip confirms diagnosis?	Yes/No

Investigation and Audit

If the case looks risky to authorise or suspicious to the PPD, s/he can refer it for field investigation or desk audits. However, lifesaving treatment of patient shall not be stopped and final decision on the pre-authorization request shall be taken basis the findings of the investigation and audits.

If the investigation report is received after the stipulated time, the PPD shall go ahead with appropriate decision and the outcomes of investigation report may be taken into consideration at the time of discharge or during claim adjudication.

7.1.3. Pre-authorization Approval/Rejection

Based on the scrutiny of the above, PPD may decide the approval or rejection of the Pre-auth. All rejected Pre-authorization requests would go to the SHA for review. The SHA can choose to revoke a rejected request and send it back to the PPD. The PPD shall mention reason of rejection of the pre-authorization, if applicable.

Under following scenarios **rejection** of Pre-authorization request can be done:

- Patient is not covered under PM-JAY
- If the requested treatment falls under exclusion criteria of PM-JAY
- Patient's family wallet does not have sufficient amount
- Clinical findings not relevant to the package selected
- Complete supportive Documents and Mandatory investigation reports not submitted even after query/ reminders.
- Fraud/misrepresentation is established.

7.2. Claims Processing

MEDCO/ PMAM raises the claim after entering the date of discharge of the patient by submitting all the relevant documents. Claim Executive (CEX) will verify and forward the claim to Claim Panel Doctor (CPD). CPD to scrutinize the documents submitted by the hospital and process the claim. Once the claim is processed, it will be reviewed by accounts officer and SHA/IC after which the claim amount will be credited into the hospital account.

a) **Claim Initiated by MEDCO/ PMAM:**
MEDCO (Network Hospital Doctor)/ PMAM raises the claim by selecting the discharge updated cases. He puts remarks and initiates the claim. The claim will come to the Claim Executive (CEX)

b) **Claim Verification by Claim Executive (CEX):**
The CEX will verify check list and provide his/her remarks and update the claims. Once the claim is verified, he will forward to CPD.

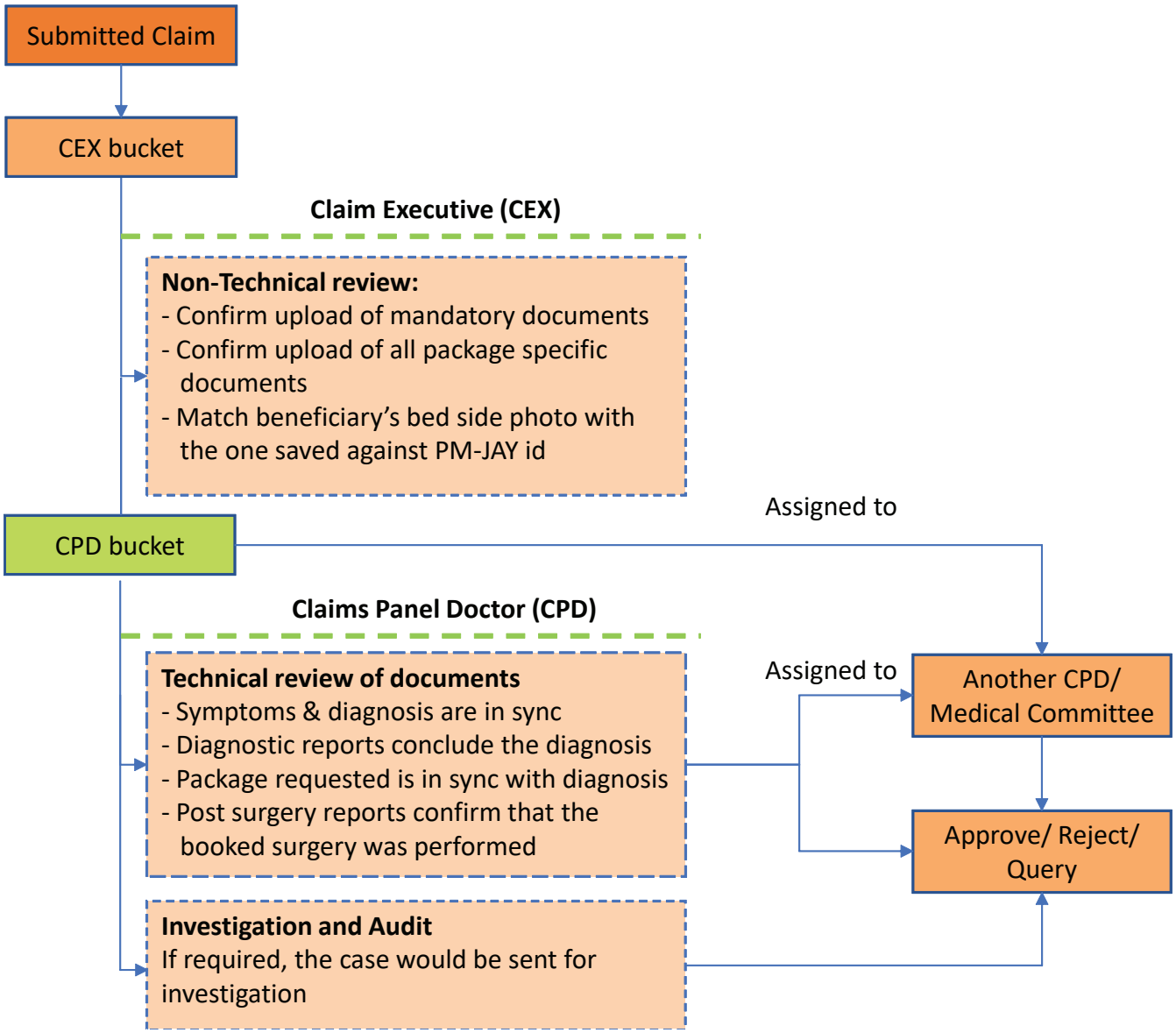
c) **Claim Processed by Claims Panel Doctor (CPD)**:
After Verification, claim will come to Panel Doctor where s/he will verify check list and provide his/her remarks and update the claims. S/he can Approve/ Assign/ keep it Pending (query)/ Reject the claims. If s/he can mark the claim pending (raise query), then the hospital shall provide additional information. Once the claim is approved, it goes to the accounts officer. For Rejected case, the case would be forwarded to the SHA for review and also, be notified to the hospital for the purpose of intimation.

d) **Claim Forward by Accounts Officer**:
Accounts Officer will receive the claim case after claim accepted by CPD. Accounts Officer will view the claim case and will forward the case to the SHA/ IC.

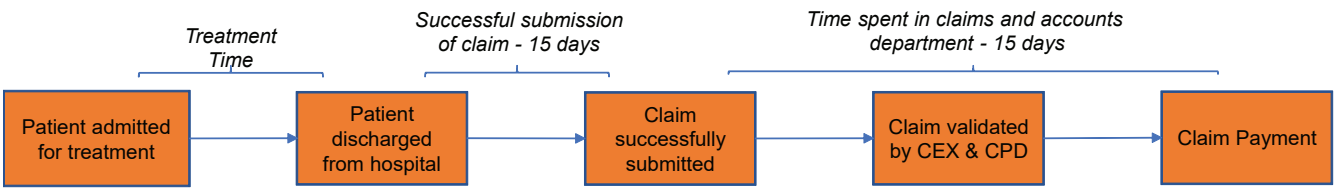
e) **Claim Approval & Payment by SHA/ IC:**
SHA/ IC will verify the claim case forwarded by Accounts Officer and will approve the claim and is the final approval. After approval, claim amount will be directly credited into the hospital account.

Please refer to Approver's Manual for detailed information on the above:
https://www.pmjay.gov.in/sites/default/files/2018-12/Approvals%20_User_Manual_v2.0.pdf

Actions to be taken on a claim by CEX & CPD:



Claims Processing Timeline



7.2.1. Non-Technical Documents Review

The CEX will review the non-technical part (name, age, sex, availability of all documents etc.) of the claim documents and forwards it to the CPD with his comments and feedback. He will check the below mentioned:

- Confirm upload of all mandatory documents. There is a list of mandatory documents which is uploaded while submitting the claims. These are as mentioned below –
  - After Discharge Photo
  - After surgery/ therapy photo (relevant imaging report)/current on bed photo of patient (after initiation of treatment)
  - Discharge summary documents

- Confirm upload of all package specific documents. This would be different for all the packages and may vary from state to state in some cases.
- Match beneficiary's bed side photo with the one saved against PM-JAY id.

7.2.2. Technical Documents Review

The Claims Panel Doctor would review the technical details (medical/clinical) of a claim and would take appropriate decision on the same. The CPD would review the claims on the below mentioned parameters

- The CPD shall ensure that the OT notes, clinical notes and discharge summary contain complete and relevant information. Refer Annexure 2 for the template for the same
- The CPD shall ensure that the clinical photograph uploaded is relevant and is not a 'Google Image'
- The CPD shall ensure that symptoms and signs are aligned to the diagnosis
- It should be ensured that findings of diagnostic reports (should contain observation/ descriptive diagnosis, date and signature) are in sync with the diagnosis
- Package requested by the hospitals shall be related to the diagnosis
- Ensure that post-surgery reports confirm that the booked surgery was performed

Based on the conclusion arrived at after following all above mentioned steps, CPD may decide to approve/ raise query/ reject the case or send it for investigation. If the CPD is unable to take a decision, s/he may assign to another CPD or medical review committee.

Example: Total Hip Replacement (Cemented)

Mandatory documents to be uploaded by the hospital at claim submission level:

1. Post procedure imaging study
2. Post procedure clinical photograph
3. Detailed operative notes

Actionable for CEX

All mandatory documents uploaded?	Yes/No

Actionable for CPD

Are all requisite post-treatment evidentiary documents available to confirm complete appropriate treatment and follow-up instructions	Yes/No
Was Length of Stay as per package specification?	Yes/No
Are admission notes and detailed findings at admission notes available?	Yes/No
Is a Discharge summary available?	Yes/No
Does the discharge summary capture all details of presenting features, investigations, line of treatment given during stay, line of treatment advised at discharge and (Select <No> if investigations and all treatment details, missing as follow up will be not be rational)	Yes/No
Is, Pre-op Profile Relevant to Package, Age & Co-morbidities available?	Yes/No
Does the report include Pre and post-operative diagnosis and are both same? If No are there sufficient evidences to confirm the changed diagnosis?	Yes/No
Is the correct package blocked?	Yes/No
Is the date and time of procedure mentioned?	Yes/No
Does the OT time correspond to time ideally taken for the procedure/ surgery?	Yes/No
Is the surgeon who has operated same as the name given while blocking the package?	Yes/No
Is the surgeon's signature available on records?	Yes/No
Did the patient have a history of trauma/ avascular necrosis/ severe osteoarthritis?	Yes/No
Does X-Ray / CT establish indication for THR?	Yes/No
Do the OT notes detail steps of surgery?	Yes/No
Do the OT notes specify type of cement used in surgery?	Yes/No
Is there a Post Op X-Ray of Hip confirming the surgery undertaken?	Yes/No
Does it show medications not related to package for which admitted?	Yes/No
Was the treatment rational and enough for patient's clinical condition?	Yes/No

7.2.3. Investigations and audits

If the case looks suspicious to the CPD, s/he can refer it for field investigation/desk audits/Medical audit. The decision on the claim shall be taken basis the findings of the same.
https://www.pmjay.gov.in/sites/default/files/2018-12/Fraud_Investigation_and_Medical_Audit_Manual.pdf

7.2.4. Claim Approval/ Rejection

Based on the scrutiny of the above, CPD may decide the approval or rejection of the claim. All approved cases would go to SHA/ IC for final approval. They can revoke the approval if need be and send it back to the CPD. The rejected cases would go to the hospitals for intimation, with reason of rejection and to SHA for review. The SHA has the authority to revoke a rejected claim which would again go the CPD.

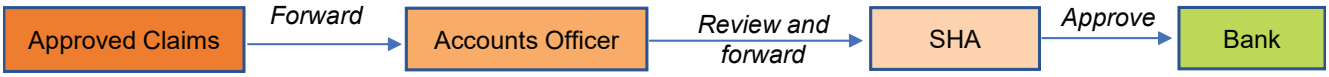
Under following scenarios rejection of claim may be recommended/done:

- Clinical findings do not justify the need for package selected
- Supporting documents and mandatory investigation reports are not submitted even after query/ reminders.
- Fraud & misrepresentations are found

7.3. Review by Accounts Officer and Payment by SHA/IC

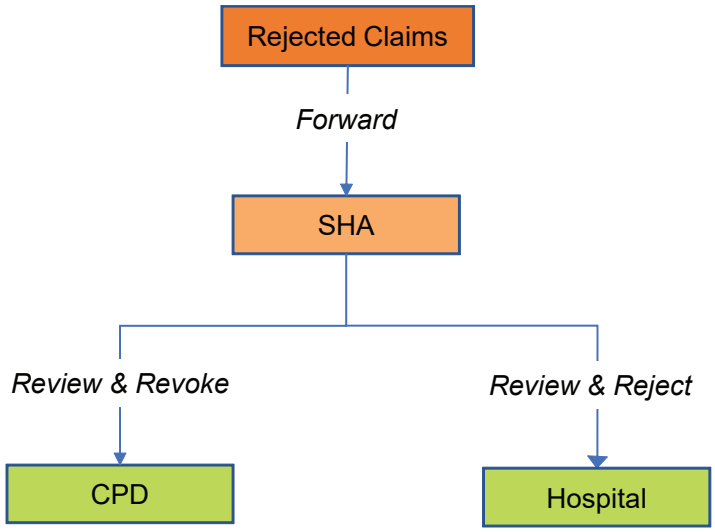
Approved claims:

Once the claim is approved, it is forwarded to the Accounts officer for her/his review and approval on the same. The Account officer after reviewing the claim, forwards it to the SHA/IC.



Rejected claim:

All rejected claims are referred to the SHA for review and final decision. The SHA after verifying and validating the details can either reject or revoke the claim. Once revoked the claim again goes to the CPD for her/his reconsideration.



7.4. Reconsideration of Rejected Claim

There would be very few claim rejections as a check would already be done at the Pre-authorization level. If any hospital is not satisfied with the justification given by the CPD for claim rejection or in case of any dispute over claims, it can raise the issue though grievance portal within 7 days of rejection notification.

7.5. Claims Audit for Quality Check

For mechanism of internal audit, SHA/IC shall audit 10% of the approved cases and 100% mortality case, rejected cases and cancelled cases every month to check the quality of claims adjudication and process improvement. The audit shall also be done as per the provision of contract and due diligence.

8. Complicated Cases

PPD/CPD may encounter cases which are more complex from routine cases e.g. patient may leave against medical advice, patient may die within the hospital or hospital may ask for enhancement. In such cases clarity needs to be provided to both hospitals and the payors (State Health Agency/ Insurance Company) regarding payments to the hospitals. Below mentioned are a few such cases:

8.1. Leave Against Medical Advice (LAMA)/Discharge Against Medical Advice (DAMA)

Leave Against Medical Advice (LAMA), also called Discharge Against Medical Advice (DAMA), is an act whereby a patient leaves against the recommendation or will of the attending physician. This can happen due to various reasons related to the beneficiary or the hospital. After the audit, the payment to the hospital will be done as per the following:

Surgical Cases – Patient has been admitted for a surgical package where a fixed package rate is to be paid.

(a) **LAMA/DAMA before surgery** – No payment will be done to the hospital by the SHA/ Insurer in this case. This will be applicable in both cases whether Pre-operative investigations have been done or Pre-operative investigations have not been done.

(b) **LAMA/DAMA after surgery** – Payment for 75% of the package rate will be done to the hospital by the SHA/ Insurer in this case. Daily case sheets and surgical notes will need to be submitted by the hospital for auditing purposes to qualify for payment.

Medical Cases – Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid after other details satisfactorily checked. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered.

The CPD shall consider the above mentioned and shall approve justifiable amount for payment to the hospital.

8.2. Mortality Case

Patient Death in the hospital – If the death of the patient happens after admission in the hospital and before discharge, payment to the hospital shall be done after audit as per the following description:

Surgical Cases

(a) **Death before surgery** – If surgery has not been done then No payment will be made to the hospital. This will be applicable in both cases whether Pre-operative investigations have been done or Pre-operative investigations have not been done.

(b) **Death on the table during surgery** – If death happens during the surgery then 75 % of the total package rate will be paid. Daily case sheets and surgical notes will need to be submitted by the hospital for auditing purposes to qualify for payment.

(c) **Death after surgery** – If death happens after the surgery/ post-operative stay has been performed then 100% of package rate will be paid to the hospital after detailed medical audit. If it is observed that the death was due to negligence or mortality audit has significant findings suitable action shall be taken against the hospitals and claim amount shall be withheld till satisfactory explanation received and reviewed by experts/SHA.

Medical Cases – Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid after detailed medical audit. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. If it is observed that the death was due to negligence or mortality audit has significant findings suitable action shall be taken against the hospitals and claim amount shall be withheld till explanation received and reviewed by experts

The CPD shall consider the above mentioned and shall approve justifiable amount for payment to the hospital.

8.3. Unspecified Surgical Cases

To ensure that PM-JAY beneficiaries are not denied care, for treatments/procedures that do not feature in the listed interventions, there is an exclusive provision that has been enabled in the TMS (transaction management system) for blocking such treatments, subject to satisfying certain defined criteria (as mentioned)

It is suggested that below mentioned criteria shall be considered before booking Unspecified Surgical Package:

- Only for surgical treatments.
- Compulsory Pre-authorization is in-built while selecting this code for blocking treatments.
- Cannot be raised under multiple package selection.
- Government reserved packages cannot be availed by private hospitals under this code. PPD/ CPD may reject such claims on these grounds. In addition, SHA may circulate Government reserved packages to all hospitals. Further, States need to establish suitable mechanisms to refer such cases to the public system – as a means to avoid denial of care.
- Cannot be booked for removal of implants, which were inserted under the same policy
- In the event of portability, the home state approval team may either reject if a Government reserved package of the home state is selected by a private hospital in the treating state or consider on grounds of ‘emergency’.

- Aesthetic treatments of any nature cannot be availed under this code or as such under any other listed codes under PM-JAY. Only medically necessary with functional purpose/ indications can be covered. The procedure should result in improving/restoring bodily function or to correct significant deformity resulting from accidental injury, trauma or to address congenital anomalies that have resulted in significant functional impairment.
- Individual drugs or diagnostics cannot be availed under this code. Only LISTED drugs and diagnostics with fixed price schedules, listed under the drop down of respective specialties, are included for blocking treatments.
- None of the treatments that fall under the exclusion list of PM-JAY can be availed viz. individual diagnostics for evaluation, out-patient care, drug rehabilitation, cosmetic/ aesthetic treatments, vaccination, hormone replacement therapy for sex change or any treatment related to sex change, any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalization for treatment etc. However, for life threatening cases e.g. of suicide attempt or accident due to excess consumption of alcohol, treatment shall be provided by the hospital till the patient's condition stabilizes.

For deciding on the approval amount, the PPD may consider the rate of closest match of the requested surgery, in listed PM-JAY packages. It should be noted that the amount approved by the PPD would be sacrosanct and the CPD would not be able to deduct any amount or approve partial payment for that claim.

8.4. Portability Cases

A feature of portability is available under AB PM-JAY, this means that a beneficiary can get treatment outside his/her home state in any empaneled hospital in cashless manner. No empaneled hospital is allowed to deny services to any eligible beneficiary. Below mentioned points shall be noted for the portability cases:

- Only packages from the National Package Masters will be available.
- Package rates of the treating state will be applicable under National Portability system.
- Regarding reservation of packages for public facilities, the rules of reservation of home states will apply.
- All approvals regarding the beneficiary treatment including pre-authorization, claims settlement would have to be obtained from the beneficiary's home ISA (and further from SHA in case ISA isn't able to do so) for the treatment through NTMS.
- The investigations/audits (if need be) will be done by treating EHCP's state.
- Upon completion of treatment, treating EHCP will raise the claim using NTMS with same case ID.
- Treating EHCP will get the payment from beneficiary's home SHA/ISA as per the guidelines.
- Pre-authorisation will be mandatory for all portability cases
- Pre-authorization and claims pertaining to portability shall be processed as per regular guidelines.

8.5. Enhancements and Partial Payments

The below mentioned process is suggested for Enhancements and Partial Payments:

Medical case: In case the length of stay of a patient needs to be extended (medical cases), the hospital would raise a Pre-authorization request for claim enhancement. The hospital can take an enhancement of only up to 5 days at a time. While processing such claim, the CPD shall compare the days for which Pre-authorization was approved and number of days the patient was admitted in the hospital. In case of mismatch the CPD shall approve the amount according to the number of days of admission. Functionality of editing the claims amount is available with the CPD.

In a scenario when Pre-authorization is taken for 5 days in a general ward, and patient is shifted to HDU or ICU after 2 days, the hospital would raise a new enhancement request for ICU/HDU. The CPD would approve partial payment for the former claim i.e. only for 2 days out of 5 days for general ward and approve full payment for latter claim provided s/he is stratified with evidence provided by the hospital.

Surgical case*:* In case a hospital has booked a combination package for a patient but the CPD notices that only a part of the surgery was carried out or if the hospital informs of the same, in such cases only partial payment shall be made to the hospital (the rule of 100%-50%-25%, i.e. Costliest 100%, 2nd lowest – 50% than 25% each will apply). For e.g.

i. Two packages selected and only one package performed: 100% rate of package performed.
ii. Three packages selected and only one package performed: 100% rate of package performed.
iii. Three packages selected and only two packages performed: 100% rate on highest package amount and 50 % rate on second highest package amount.
iv. Four packages selected and only three packages performed: 100 % rate on highest package amount and 50 % rate on second highest package amount and 25 % rate on the third package shall be taken.

8.6. Unbundling of Procedures

There can be cases where the hospital registers two different claims for different procedures for the same patient during same admissions. 100% payment for such cases shall not be done. Rule of 100%-50%-25% (i.e. Costliest 100%, 2nd lowest – 50% than 25% each) shall be applied to such cases.

If a combination package for such case is available, then the hospital shall be paid either as per the available combination package or by 100%-50%-25% rule, whichever is lower.

Example:

Case id	Hospital name	Patient Name	Date of admission	Package name	Package Rate	Proportion of payment	Approved amount
13345	ABC Hospital	XYZ	30/01/2019	Tonsillectomy – (Uni/ Bilateral)	7,500	100% payment	7,500
13347	ABC Hospital	XYZ	30/01/2019	Myringotomy – Bilateral	6,000	50% payment	3,000

Total amount = 7500+3000 = 10,500

However, rate of Tonsillectomy + Myrinogotomy is 10,000, hence a payment of 10000 would be approved.

8.7. Treatment Beyond Sum Insured/Available Wallet

There may be cases which are very complicated in nature and are resource intensive. The treatment cost of such cases might exceed beyond sum insured or dedicated package rate. Such cases shall be referred to SHA for appropriate action.

8.8. Payment in Case of Hybrid Model

In cases where a part of the claim payment is to be done by IC and the other part is to be done by the SHA/Trust, the CPD/ IC and the SHA/Trust are required to approve their respective amounts. In case of rejection of the same claim it needs to be rejected by both the payors.

Annexure 1: Exclusions to the Policy/Scheme – Also Refer to State Specific Terms and Conditions

The payor (insurance company/SHA) shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any covered beneficiary in connection with or in respect of:

1. Conditions that do not require hospitalization**:** Condition that do not require hospitalization and can be treated under Out Patient Care, Out-patient Diagnostic, Medical and Surgical procedures or treatments unless necessary for treatment of a disease covered under day care procedures (as applicable) will not be covered.
2. Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation/diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc. unless forming part of treatment for injury or disease as certified by the attending physician.
3. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalisation for treatment.
4. Congenital external diseases: Congenital external diseases or defects or anomalies, Convalescence, general debility, “run down” condition or rest cure.
5. Fertility related procedures: Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.
6. Vaccination: Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),
7. Suicide: Intentional self-injury/suicide
8. Persistent Vegetative State

Annexure 2: Template – OT Notes, Clinical Notes, Discharge Card and Clinical Photo

OT notes (should be on hospital stationary and not on plain paper)

- Date/ time of beginning surgery/ procedure and completion of the surgery
- Name of surgeon
- Name of Anaesthetist
- Type of anaesthesia
- Surgery done (site, side and findings)
- Immediate Post op care
- Any complications faced
- Signature of surgeon

Clinical notes

- Date(s) of clinical note
- Each day progress report should contain, vitals, clinical notes and treatment given
- Just “continue all” should not be acceptable

Discharge card

- Date of Admission
- Date of Discharge
- Date of Operation (if surgery package)
- Presenting symptoms / vitals at admission
- Investigations done with Key finding of investigation
- Treatment given
- Follow-up advice

Clinical photographs

- Face of the person and site of surgery shall be visible in same frame
- It should not be a google image

national health authority

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Pradhan Mantri Jan Arogya Yojana

Ayushman Bharat

PM-JAY