CLAIMS ADJUDICATION MANUAL 2.0

AYUSHMAN BHARAT PRADHAN MANTRI JAN AROGYA YOJANA (AB PM-JAY)

NATIONAL HEALTH AUTHORITY

October 2020

TABLE OF CONTENTS

ACRONYMS

AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
BIS	Beneficiary Identification System
CEO	Chief Executive Officer
CEX	Claims Executive
CPD	Claims Processing Doctor
EHCP	Empanelled Hospital Care Provider
HBP	Health Benefit Package
ISA	Implementation Support Agency
IC	Insurance Company
LOS	Length of Stay
MEDCO	Medical Coordinator
NAFU	National Anti-Fraud Unit
NTMS	National Transaction Management System (for portable cases)
NHA	National Health Authority
OT	Operation Theatre
PMAM	Pradhan Mantri Arogya Mitra
PPD	Pre-authorization Processing Doctor
SAFU	State Anti-Fraud Unit
SHA	State Health Agency

STG	Standard Treatment Guidelines
TAT	Turn Around Time
TMS	Transaction Management System
TPA	Third Party Administrator
T & C	Terms and conditions
CGRMS	Central Grievance Redressal Management System
DGNO	District Grievance Nodal Officer
DGRC	District Grievance Redressal Committee
SGRC	State Grievance Redressal Committee
SGNO	State Grievance Nodal Officer
NGRC	National Grievance Redressal Committee
NGNO	National Grievance Nodal Officer

Important Note:

a. **The guidelines provided in this manual are indicative/suggestive, states may modify these guidelines, with information to NHA for approval as need be.**
b. **For more details, the user should refer to the agreement/guidelines laid down by SHA.**
c. **For any changes in documents which are referred in this manual and any changes made to PMJAY claims adjudication subsequent to publication of this manual kindly refer to PMJAY website for latest information.**

1 INTRODUCTION

1.1 AB PM-JAY

Ayushman Bharat is the Pradhan Mantri Jan Arogya Yojana or PM-JAY as it is popularly known was launched by the Hon'ble Prime Minister of India, Shri Narendra Modi on 23rd September 2018 in Ranchi, Jharkhand.

PM-JAY is the largest health assurance scheme in the world which aims at providing a health cover of Rs. 5 lakhs per family per year for secondary and tertiary care hospitalization to over 10.74 crores poor and vulnerable families (approximately 50 crore beneficiaries) that form the bottom 40% of the Indian population. The households included are based on the deprivation and occupational criteria of Socio-Economic Caste Census 2011 (SECC 2011) for rural and urban areas respectively. PM-JAY has subsumed the previous Rashtriya Swasthya Bima Yojana (RSBY) and families covered under RSBY are also entitled for coverage under PM-JAY irrespective of the SECC 2011 database. PM-JAY is fully funded by the Government and cost of implementation is shared between the Central and State Governments.

Journey to 1.2+ cr. treatments

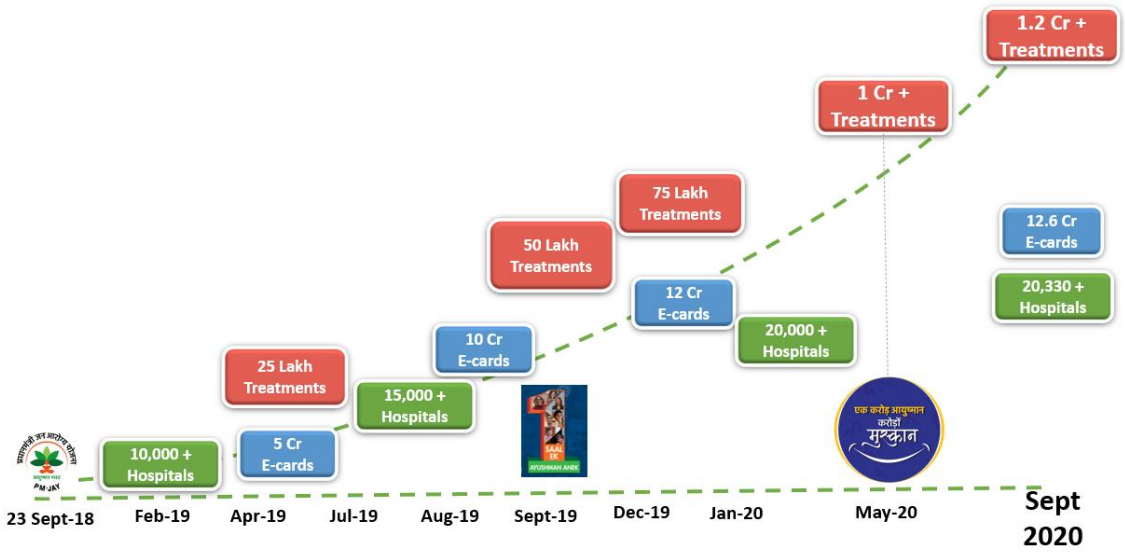

Figure 1Journey to 1.2+ Cr. treatment

1.2 National Health Authority

National Health Authority (NHA) is the apex body responsible for implementing India's flagship public health insurance/assurance scheme AB PM-JAY. National Health Authority was previously functioning as a registered society National Health Agency, which was functioning as a registered society since 23rd May 2018. Pursuant to Cabinet decision for full functional autonomy, National Health Agency was reconstituted as the National Health Authority on 2nd January 2019, under Gazette Notification Registered No. DL –(N) 04/0007/2003-18.

1.3 State Health Agencies

SHA is a nodal agency responsible for implementation of AB PM-JAY in the State/UT is headed by CEO. SHA can hire required additional staff, engage Implementation Support Agency (ISA)/Insurer for implementation of the scheme. CEO, SHA is appointed by the State government and is ex-officio member secretary of the Governing Council of the SHA. Along with day to day operations of implementation of AB PM-JAY in the state, SHA is also responsible for data sharing, verification and validation of family members, IEC, monitoring of the scheme etc.

1.3.1 Entitled Beneficiaries

The objective of AB PM-JAY is to reduce catastrophic health expenditure, improve access to quality health care, reduce unmet needs and reduce out of pocket healthcare expenditures of poor and vulnerable families falling under the deprivation criteria of D1, D2, D3, D4, D5 and D7, automatically included category and broadly 11 defined occupational un-organized workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State/ UT along with the estimated existing RSBY Beneficiary Families not figuring in the SECC Database. These eligible AB PM-JAY beneficiary families are provided coverage for secondary, tertiary and day care procedures (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP) anywhere in India.

Unit of coverage under the Scheme is a family and each family for this Scheme is referred to as an AB PM-JAY Beneficiary Family Unit, which comprises all members in that family. Any addition in the family is allowed only as per the provisions approved by the Government. The presence of name in the beneficiary list, (amended from time to time, due to addition of family member) serves as the proof of eligibility of the Beneficiary Family Unit for the purpose of availing benefits under this scheme.

No entry or exit age restrictions apply to the members of a Beneficiary Family Unit; and no member of a Beneficiary Family Unit are required to undergo a pre-insurance health check-up or medical examination before their eligibility as a beneficiary and all pre-existing illnesses of the beneficiaries are covered.

1.3.2 Benefits

The benefits of INR 5,00,000 per annum are on a family floater basis which means that same can be used by one or all members of the family. AB PM-JAY has been designed in such a way that there is no cap on family size or age of members. In addition, pre-existing diseases are covered from the very first day. The cover under the scheme includes all expenses incurred on the following components of the treatment:

1. Medical examination, Inpatient treatment and consultation
2. Day care procedures
3. Pre-hospitalization up to 3 days
4. Medicine and medical consumables
5. Non-intensive and intensive care services
6. Diagnostic and laboratory investigations
7. Medical implantation services (where necessary)
8. Food services
9. Complications arising during treatment
10. Post-hospitalization follow-up care up to 15 days

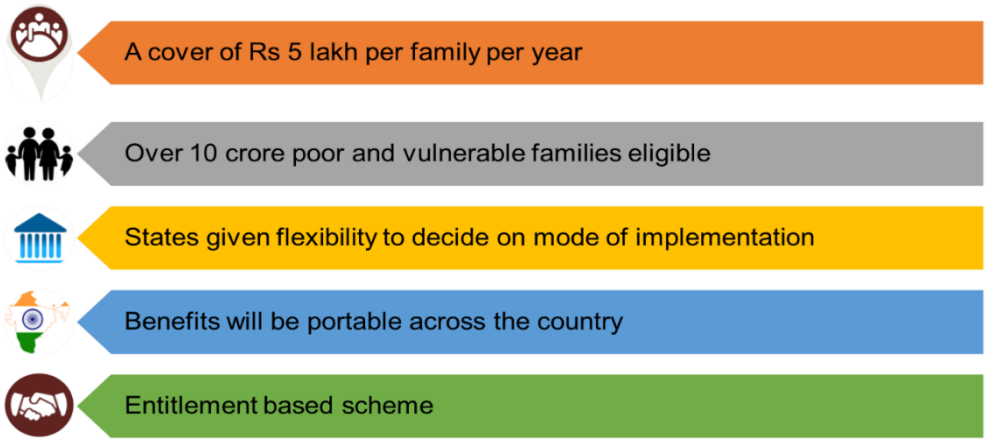

Figure 2 AB PM-JAY Benefits

1.4 Health Benefit Package and Rates

For Hospitalization expenses, package rates shall include all the costs associated with the treatment like:

1. Registration charges
2. Bed charges

3. Nursing and boarding charges
4. Surgeons, Anesthetists, Medical Practitioner, Consultants fees etc.
5. Anesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
6. Medicines and drugs
7. Cost of prosthetic devices, implants etc.
8. Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Hematology, pathology etc. However, High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure, if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.
9. Food to patient
10. Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.
11. Any other expenses related to the treatment of the patient in the hospital.

For Day Care Treatment expenses shall include:

1. Registration charges
2. Surgeons, anesthetists, Medical Practitioners, consultants' fees, etc.
3. Anesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.
4. Medicines and drugs
5. Cost of prosthetic devices, implants, organs, etc.
6. Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Hematology, pathology etc. However, High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.
7. Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.
8. Any other expenses related to the Day Care Treatment provided to the Beneficiary by an EHCP.

Some of the other salient features are mentioned below for easy reference.

The SHA / Insurer / ISA shall reimburse claims of Empanelled Health Care Provider (EHCP) under the AB PM-JAY based on Package Rates determined as follows:

1. Cost of Medical treatment, Surgical procedure or Day care treatment fixed in Health Benefit Package shall apply for the policy period.
2. If the package rate for a surgical procedure requiring hospitalization or day care treatment is not listed in the Health Benefit Packages, then the Pre-auth Processing team may pre-authorize an

appropriate amount based on rates for similar procedures defined in the list or based on other applicable national or state health schemes. In case of medical management, the rate will be calculated on per day basis as specified in the package list except for special packages like high end radiological diagnostic, high-end histopathology (Biopsies) and advanced serology investigations packages. These packages can be clubbed with medical packages as add-on packages.

3. AB PM-JAY is a cashless scheme, where no beneficiary should be made to pay for availing treatment in any AB PM-JAY empanelled hospitals. However, upon exhaustion of the beneficiary AB PM-JAY wallet of Rs. 5.00 Lakhs, or if the treatment cost exceeds the benefit coverage amount available with the beneficiary wallet then the liability for such remaining treatment cost as per the package rates defined in the HBP list will be borne by the beneficiary. Beneficiary should be communicated in advance about the additional payment before the start of treatment.
4. In case an AB PM-JAY beneficiary is required to undertake multiple surgical procedures in one OT session, then the procedure with highest rate shall be considered as the primary package and reimbursed at 100%, thereafter the 2nd surgical procedure shall be reimbursed at 50% of package rate, 3rd and subsequent surgical procedures shall be reimbursed at 25% of the package rate
5. Surgical and Medical packages will not be allowed to be availed at the same time (Except for certain Add – on procedures as defined in the HBP list and configured in TMS). In exceptional circumstances, hospital may raise a request for such pre-auth which will be decided by SHA with the help of concerned medical specialist.
6. Certain packages as mentioned in the HBP master list are reserved for Public EHCPs (as decided by the SHA). The SHA may permit availing of these packages in Private EHCPs only after a referral from a Public EHCP. Some modifications (in not more than 10% of total number of packages) may be done by SHA in this regard.
7. Based on various quality accreditation , additional incentives will be provided to eligible hospitals which will be over and above the rates defined in the HBP master list.

If NHA / SHA finds that a treatment is being booked under unspecified category repeatedly, or some treatment is required to be included within the list to address a pressing health problem which is or have become widely prevalent, then NHA / SHA may add such treatments in the HBP list. Specialized tertiary level services shall be available and offered only by the EHCP for that service. Not all EHCPs can offer all tertiary level services, unless they are specifically designated by the SHA for offering such tertiary level services.

Health benefit package 2.0 (HBP) which is presently implemented as total 1592 procedures across 24 specialties inclusive of unspecified surgical package. [1] [2]

S. No.	Specialty	HBP 2.0		
		Code	Packages	Procedures
1	Burns Management	BM	6	20
2	Cardiology	MC	20	26
3	Cardio-thoracic & Vascular surgery	SV	34	118
4	Emergency Room Packages	ER	3	4
5	General Medicine	MG	76	98
6	General Surgery	SG	98	152
7	Infectious Diseases	ID	2	3
8	Interventional Neuroradiology	IN	10	15
9	Medical Oncology	MO	71	263
10	Mental Disorders Packages	MM	10	10
11	Neo-natal care Packages	MN	10	10
12	Neurosurgery	SN	54	82
13	Obstetrics & Gynecology	SO	59	77
14	Ophthalmology	SE	40	53
15	Oral and Maxillofacial Surgery	SM	7	9
16	Orthopedics	SB	71	132
17	Otorhinolaryngology	SL	35	78
18	Pediatric Medical management	MP	46	65
19	Pediatric surgery	SS	19	35
20	Plastic & reconstructive Surgery	SP	8	12
21	Polytrauma	ST	10	21
22	Radiation Oncology	MR	19	35
23	Surgical Oncology	SC	76	120
24	Urology	SU	93	142
25	Unspecified Surgical Package	US	1	1
	Total		**874**	**1,592**

Table 1 Health Benefit Package 2.0 (HBP) Summary[3]

[1] About AB PM-JAY Coverage, Implementation, Hospital empanelment, Packages and rates - https://pmjay.gov.in/about/pmjay[1]

[2] Journey from HBP 1.0 to HBP 2.0 https://pmjay.gov.in/sites/default/files/2020-01/Journey-from-HBP-1.0-to-HBP-2.0.pdf[2]

[3] Please refer to HBP 2.0 user guidelines September 2020- https://pmjay.gov.in/sites/default/files/2020-10/HBP-2-0-User-Guidelines-vFinal.pdf[13]

Note-

1. Updated HBP packages are developed time to time and are available on the PM-JAY website.
2. For HBP customization for states
   a. Modification in prices/Modification in public reservation/Modification in packages marked for mandatory pre-authorization/Inclusion of State specific packages
3. The additional financial burden for state specific packages would be borne exclusively by the state with no additional contribution from NHA.

1.5 IMPLEMENTATION

Various States are using different models for implementing PM-JAY

They can implement scheme through

1. Assurance/trust model
2. Insurance model
3. Mixed model

In case State Govt chooses to implement through mixed model, it can further choose as to what amount shall be borne by Trust and what amount shall be underwritten by Insurance Company.

About AB PM-JAY Coverage, Implementation, Hospital empanelment, Packages and rates please refer to PM-JAY website.

2 PURPOSE OF CLAIMS ADJUDICATION MANUAL

The purpose of Claims Adjudication Manual is

- To build capacities of adjudication team for accurate and timebound processing / settlement of claims under AB PM-JAY.
- Enhance the skills for combining fundamental concepts, system capabilities and human intelligence during claims processing.

The necessity of accurate processing is important from multiple aspects, approval of admissible claims, payment of the correct amount to EHCP, genuine utilization of beneficiary's wallet, etc.

These guidelines will help Pre-auth Processing Doctors (PPD), Claims Executives (CEX), and Claims Processing Doctors (CPD) for efficient and error-free processing of claims and to exercise due diligence at the time of processing the claim. Each defined process has a timeline associated with it.

This manual elaborates on the roles and responsibilities of the people involved in the entire workflow.

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.

Note –

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b. For more details, the user should refer to the agreement/guidelines laid down by SHA.
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3 BASICS OF CLAIMS 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 the final decision on claims payment. The decision involves cross verification of all-important aspects – covered person, medical condition – symptoms, diagnosis, treatment, policy exclusions, period, available sum insured, pre-agreed tariff/package rate, empaneled hospital etc.

In PMJAY, claim adjudication is done through integrated workflows between three key systems – Beneficiary Identification System (BIS), Transaction Management System (TMS) and Hospital Empanelment Module (HEM). The key tasks are performed under Transaction Management System(TMS), partially at the time of Pre-authorization by Pre-authorization Processing Doctor (PPD) and later at the time of final claim settlement by Claim Processing Doctor (CPD) based on the documents received from hospital.

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

The system under AB PM-JAY is designed to help the claims processing team adjudicate claim end to end, however human intelligence needs to be applied while processing/approving both Pre-authorization and claims. Below mentioned points should be kept in mind while processing a pre-auth or a claim, any of these are auto verified at the system level through inbuilt algorithms and rules:

1. The patient should be an eligible beneficiary and verified through Beneficiary Identification System (BIS) or state managed beneficiary database via NTMS.
2. The treatment package claimed should be covered under the Scheme and should comply with the state-specific reservation in the package masters, if any
3. The conditions should not fall under the exclusion **(Annexure-1)**[4] criteria as defined under the policy
4. The available sum insured in the beneficiary's family wallet should be enough for payment of the current treatment
5. The processing team should ensure that all the documents submitted by the EHCP confirm that admission/ Hospitalization was necessary.
6. The processing team should validate all the details/ information (patient details, diagnosis details, supporting investigation documents, treatment chosen) submitted at the time of Pre-auth and highlight discrepancy if any at the time claim.
7. The processing team should raise a query only in case of any missing information mandatory to process a claim or as per Standard Treatment Guidelines (STG).
8. The processing team should make an informed and mindful decision on the payment to be made to the EHCP.
9. The claim approved amount should not be more than the amount approved during Pre-auth and wallet balance.

At the time of Claim Submission, EHCP must submit:

1. Discharge summary as per the NHA prescribed format **(Annexure- 3)**[5], death summary if applicable.
2. Package specific mandatory documents as per STGs as defined in the TMS.

However, if required for medical audit/checks/quality assurance, all medical records of the beneficiary must be preserved by the EHCP and made available on being asked at the time of audit.

[4] Annexure-1

[5] Annexure- 3

4 PROCESSES & FLOW CHARTS

4.1 SYSTEM OVERVIEW:

Beneficiary must produce the E-card to PM-JAY empaneled EHCP before availing the treatment. Beneficiary verification is done using Beneficiary Identification System (BIS).

TMS is used for end to end claims processing. Following figure 3 describes an overall view of the system and figure 4 provides journey of claim under PM-JAY.

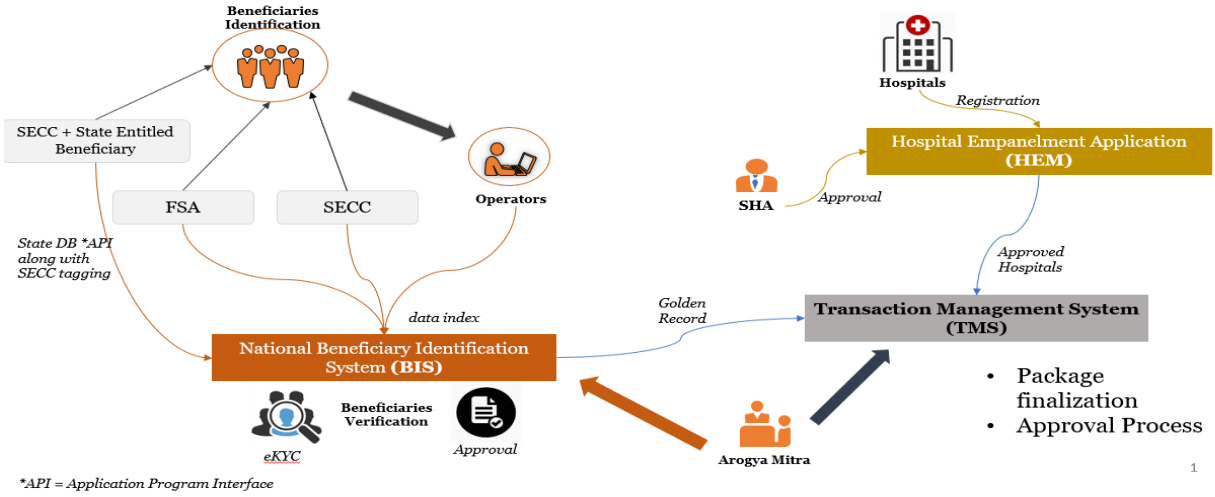
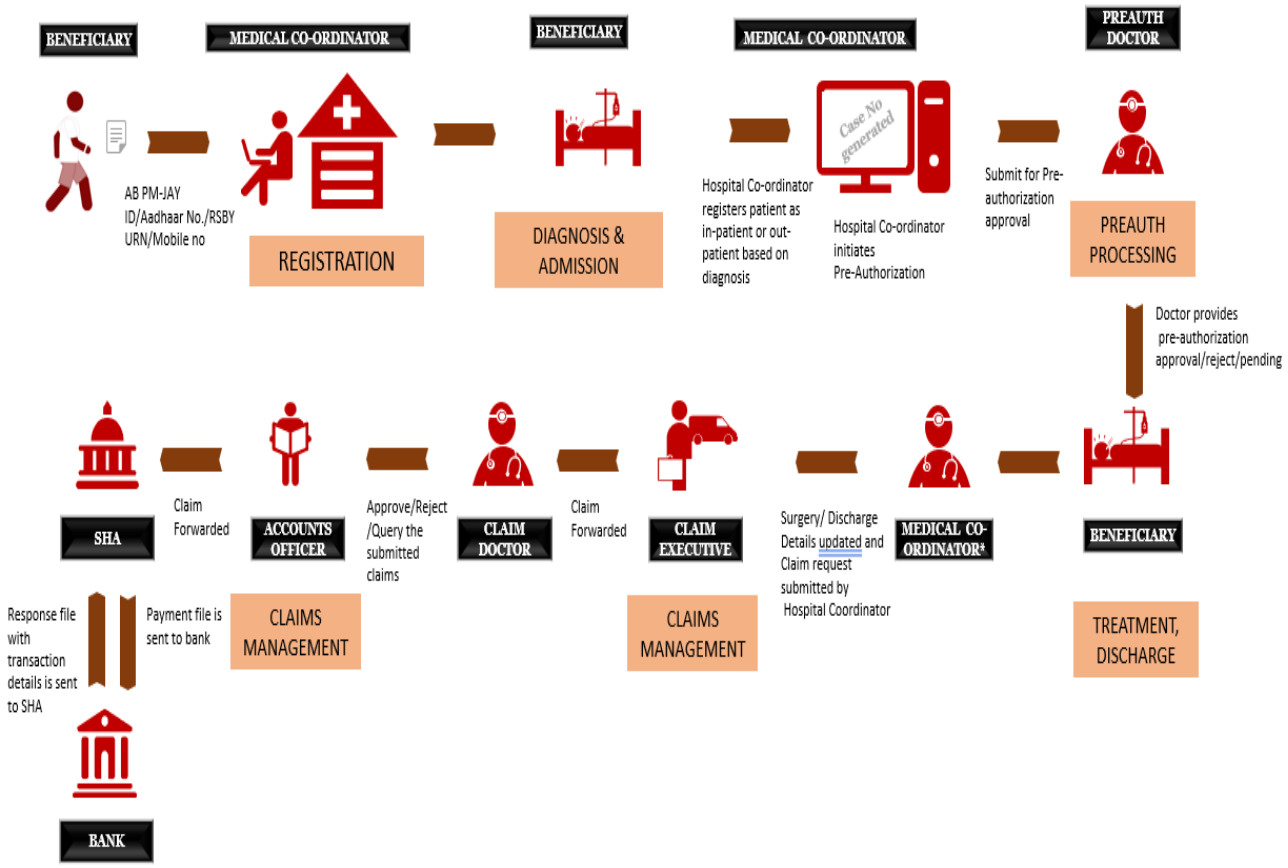


Figure 3 System Overview

4.2 Claims Journey

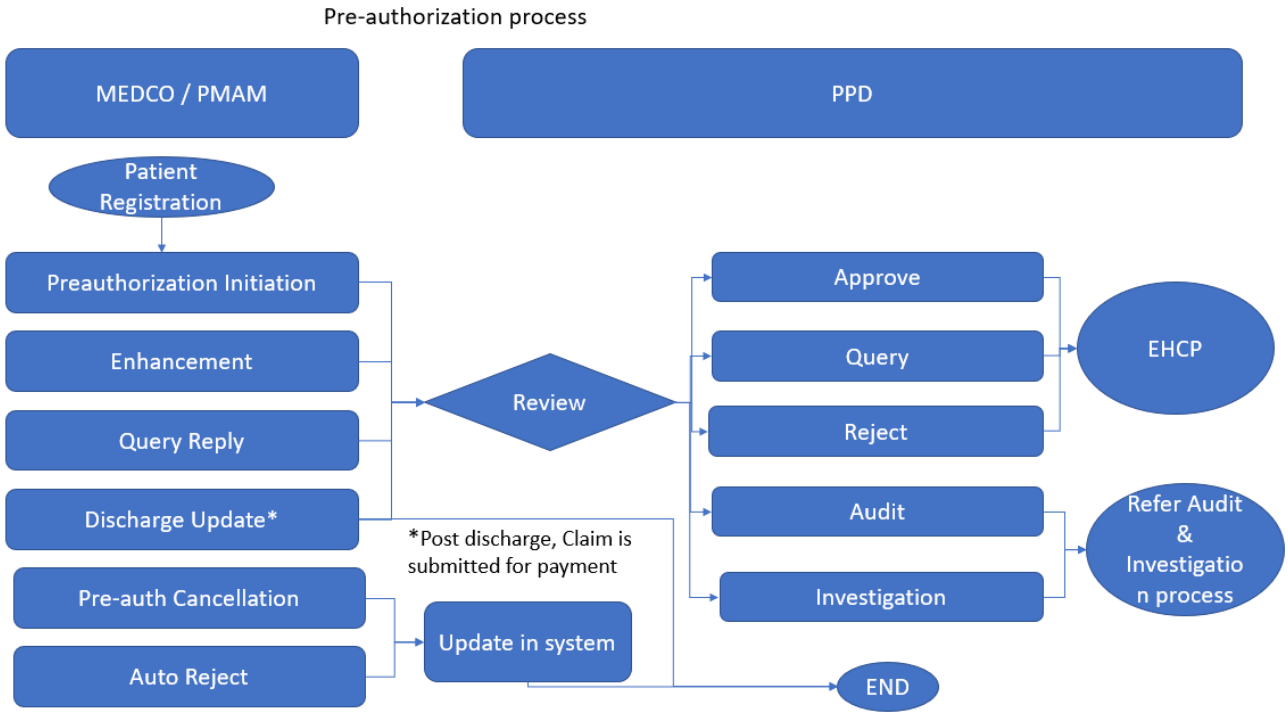


*Medical Coordinator: MEDCO/ Pradhan Mantri Arogya Mitra

Figure 4: Claims Journey

4.3 Pre-authorization Process flow:

PM-AM, MEDCO and PPD are involved in Pre-authorization processing. Below figure provides an overview of the pre-authorization process.



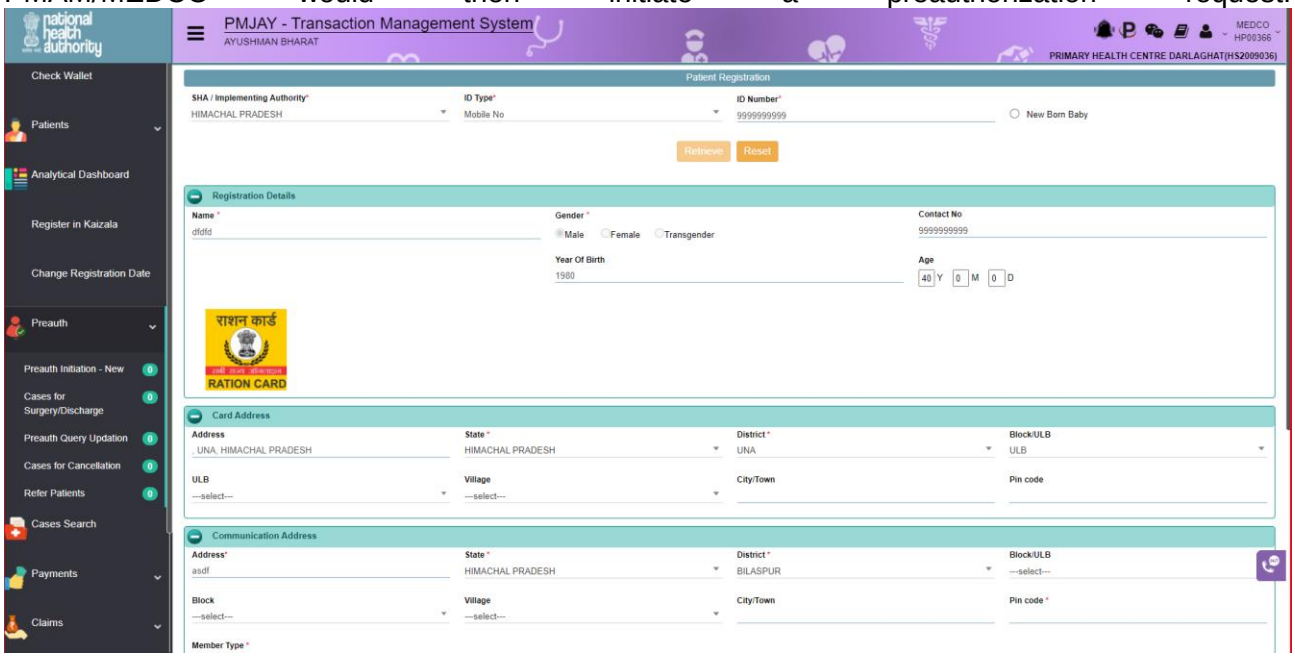
EHCP

- Post approval EHCP receives assurance for payment
- Post query EHCP will need to reply to queries raised by PPD
- Post rejection EHCP will receive a system generated rejection letter/mail stating the reason for rejection. Rejection letter sample template as per Annexure 7

Figure 5 – Pre-authorization process flow

4.4 MEDCO/ PMAM

Beneficiary approaches PMAM/MEDCO with a valid e-card for availing the treatment at EHCP. PMAM/MEDCO would then initiate a preauthorization request.



TMS Image 1- Patient Registration

4.5 Pre-authorization Processing Doctor (PPD)

Pre-auth claim intimation is received from the EHCP via TMS. PPD would review the claim documents and take appropriate action as mentioned below:

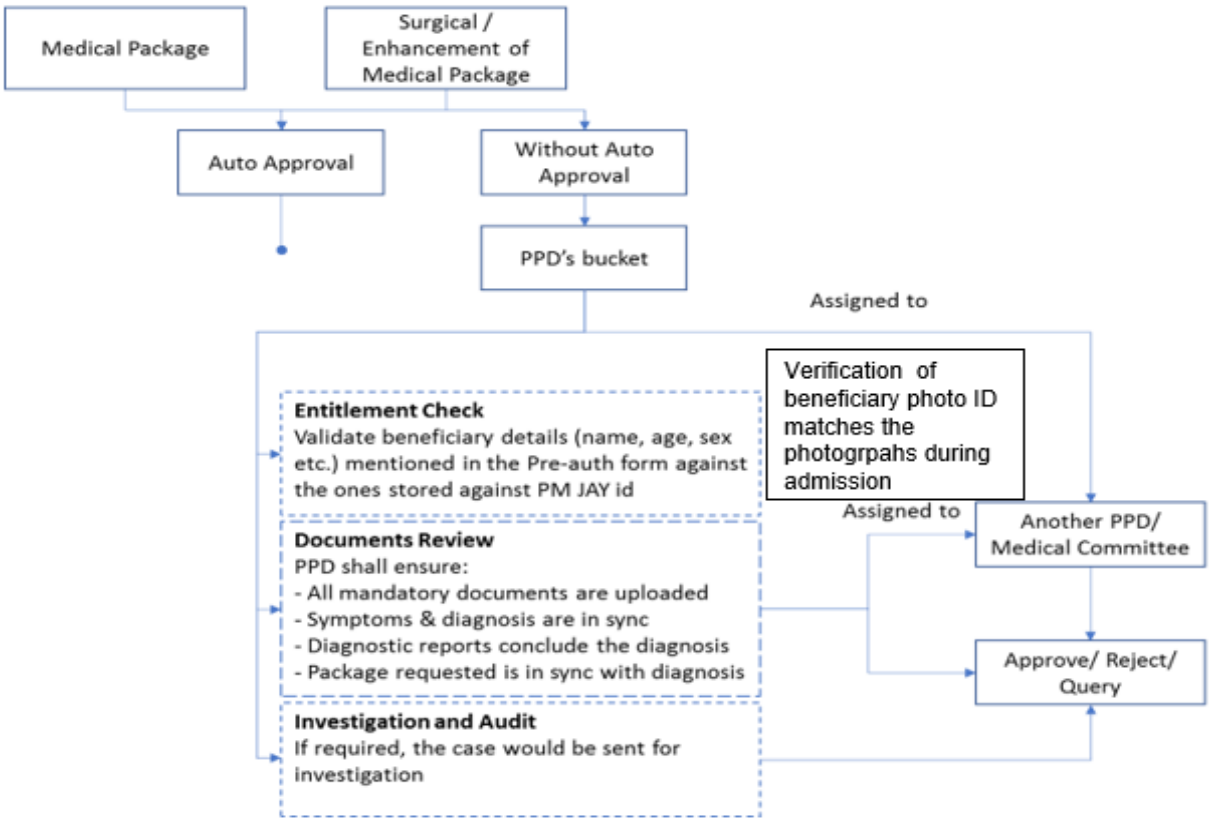


Figure 6- PPD responsibilities and Pre-authorization flow

4.5.1 Scrutiny at Pre-authorization stage

For Medical cases,

1. Preauthorization will be auto approved for the first day of admission
2. The EHCP can take an enhancement of certain number of days at a time; upon providing documentary evidence for the claim. PMAM/MEDCO initiates enhancement by submitting the details like admission unit, number of days and detailing/ justifying remarks in the preauthorization tab.

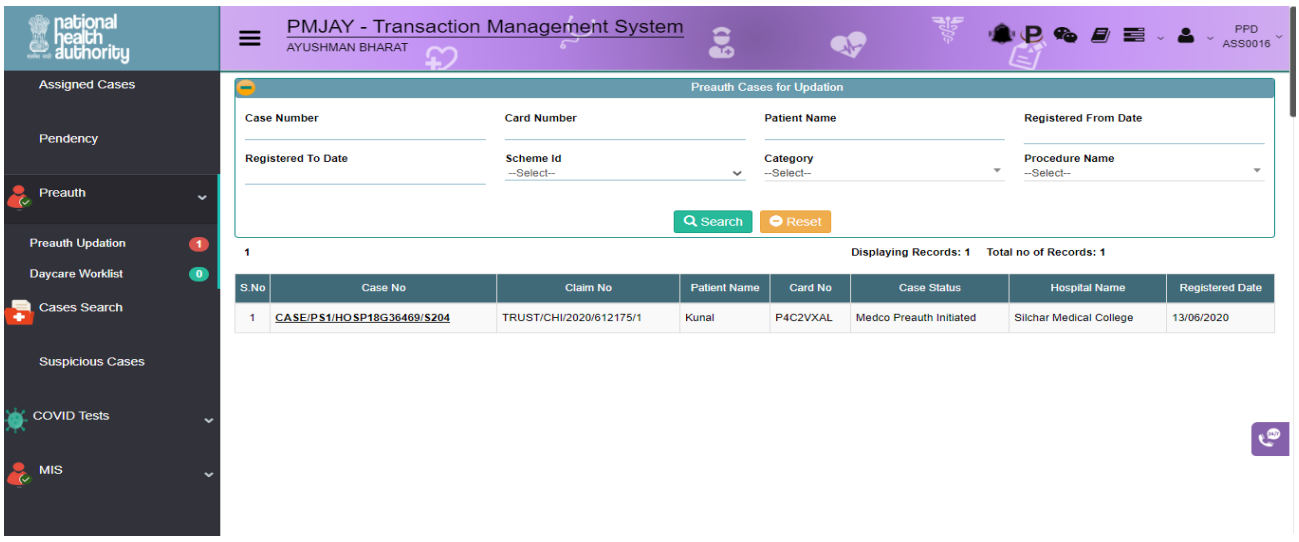
For Surgical cases

1. Preauthorization will be allocated in PPD's bucket for action.
2. Based on the documentary evidences as per the defined STG's decision would be taken by PPD

Note:

- Add on packages can be requested by EHCP while raising a Pre-authorization for both medical and surgical specialties such as high-end radiological diagnostic and high-end histopathology packages etc.
- For emergency cases action on pre-authorization request should be taken on priority and for non- emergency cases within 6 working hours as built in TMS.
- If no action is taken by PPD against the raised Pre-authorization within the defined TAT, then it will be forced approved after 6 working hours.
- In case of emergency procedures, the EHCP shall stabilize the patient and then go ahead with the beneficiary verification and Pre-authorization initiation.

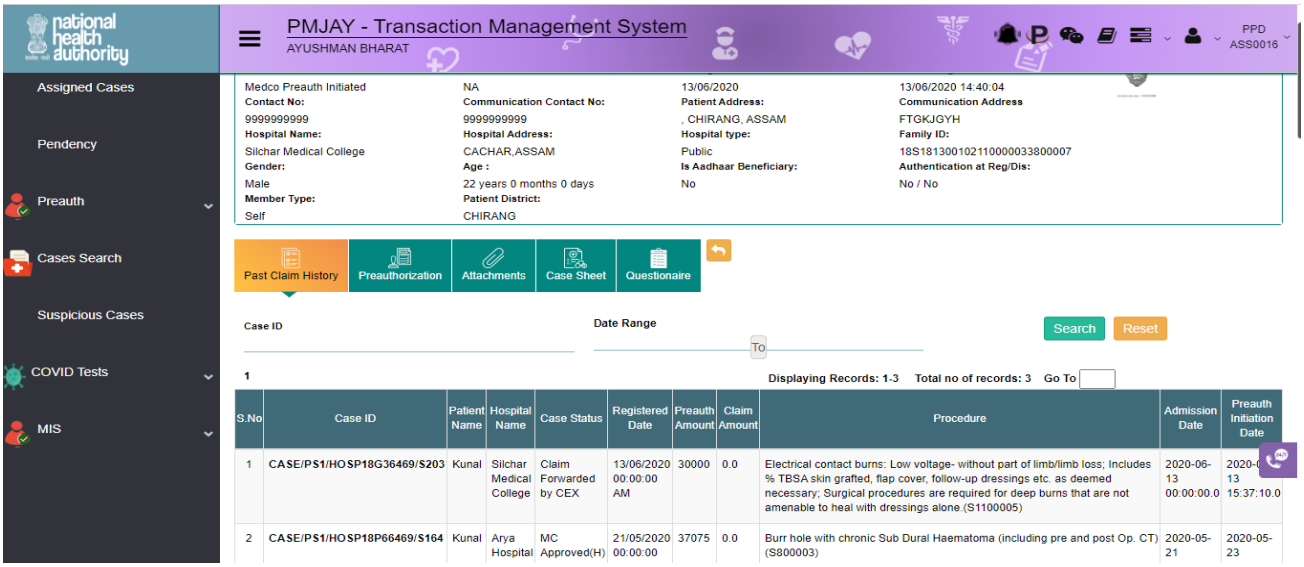
Please refer below TMS image 1 – PPD login can pick up the case for review in the pre-auth updation tab.



TMS Image 2 Preauth Updation Tab

Past Claim history:

It is mandatory for the PPD to check the past claim history of the beneficiary. This would help to identify if there is any aberration.



TMS Image 3- Past claim history of the insured

Document Checklist:

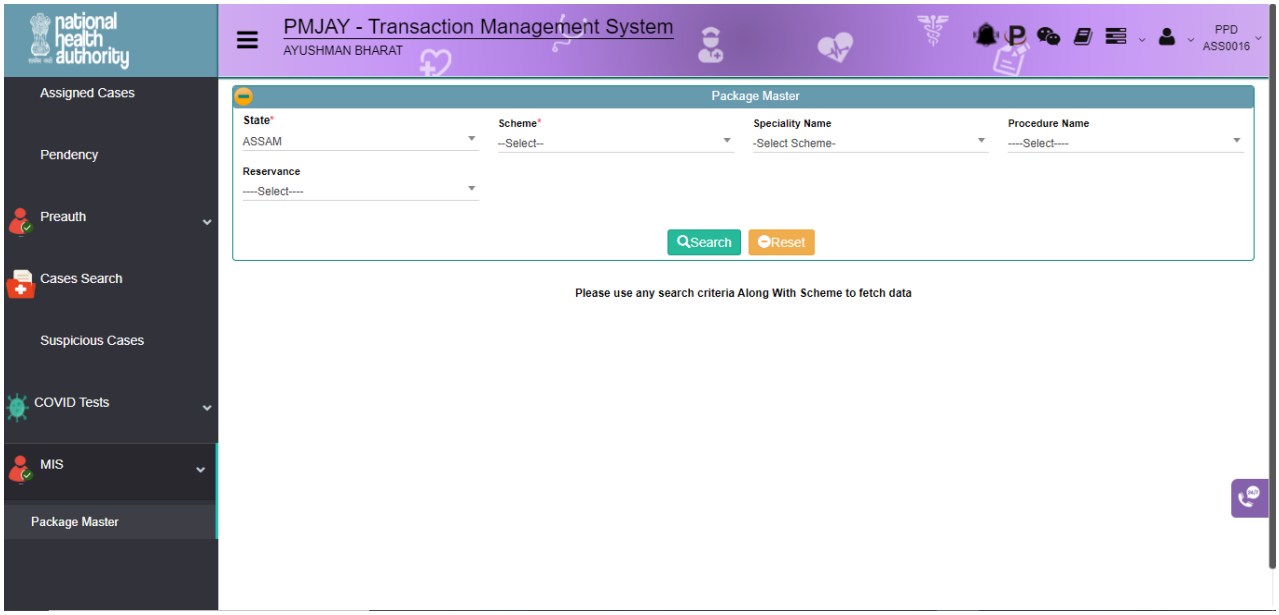
The MEDCO would upload mandatory documents like patient photo and clinical documents mentioned under standard treatment guideline in TMS.[6]

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

- It is important to ensure that the entitled and legitimate beneficiary receives the treatment.
- The PPD needs to validate patient details (name, age, sex, etc.) mentioned in the Pre-authorization form and other uploaded documents against AB PM-JAY ID stored in BIS. In most States/UTs Aadhar linked biometric authentication at the time of admission and discharge has been made mandatory. In case of lack of clarity/discrepancy or unavailability of required information, the PPD can raise a query to the EHCP asking for more information
- The PPD shall ensure that all mandatory documents are uploaded by the EHCP

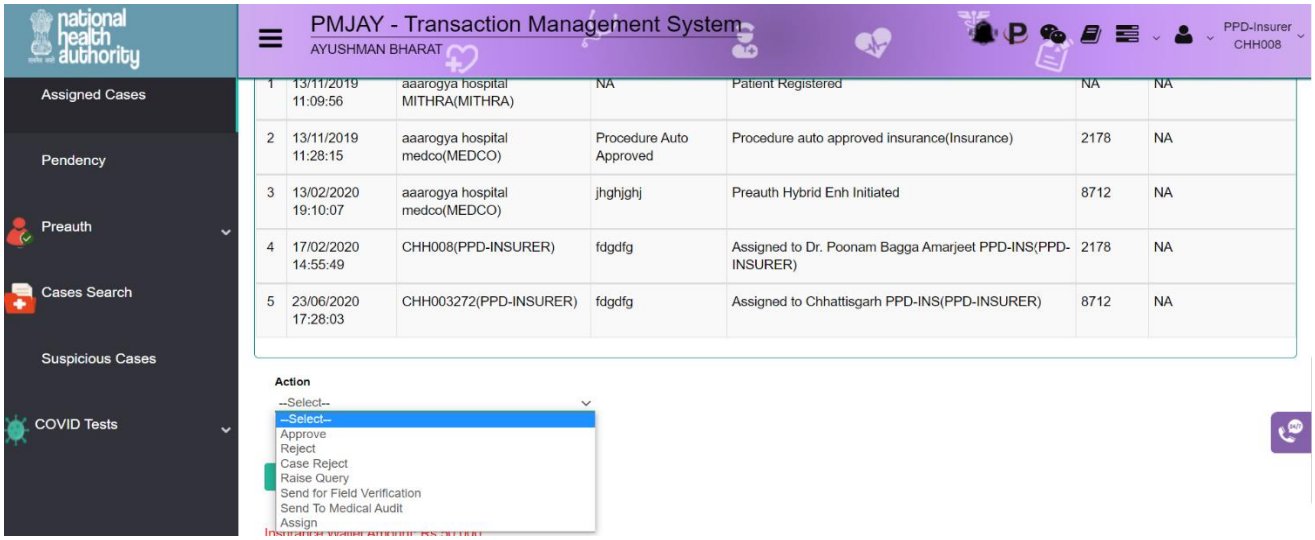
[6] Please refer In Health Benefit Package section - Standard Treatment Guidelines https://pmjay.gov.in/resources/documents [5]

- The Signs, Symptoms & duration of Illness mentioned by the doctor are aligned with the primary diagnosis
- The findings of the investigation/ diagnostic reports uploaded by the EHCP indicate the diagnosis
- The treatment package requested by the EHCP is in sync with exhibiting symptoms and diagnosis made and follows standard treatment modalities.
- PPD would verify Treating doctor Signature with registration number & qualification

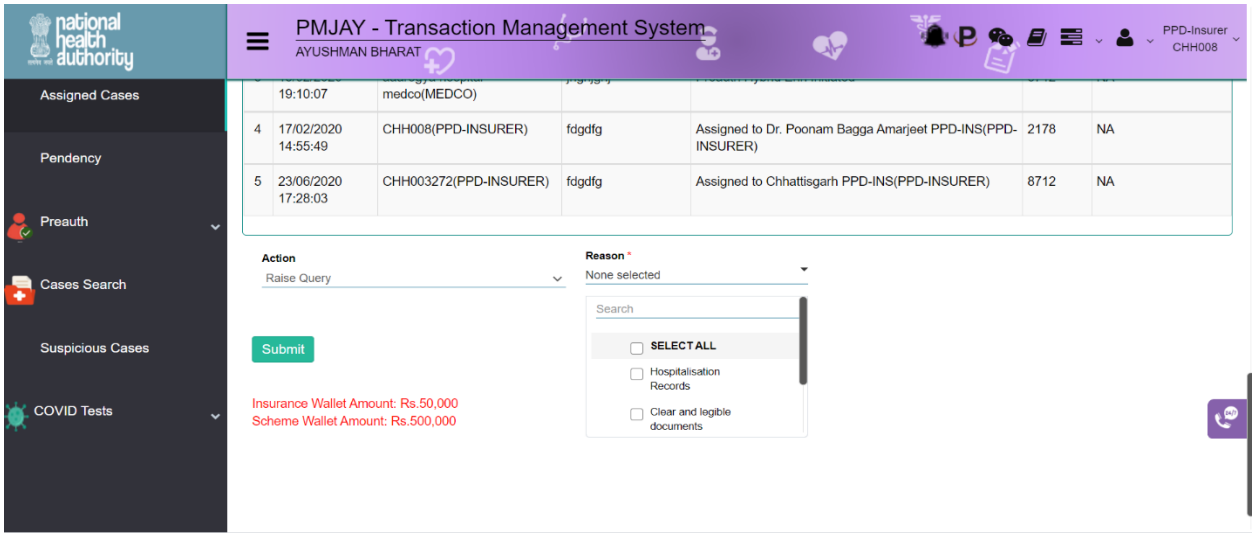


TMS Image 4- Package master can be reviewed for the ailment

Further, Pre-authorization request can be either Approved/ Query raised/ Assigned/ Rejected etc as shown in TMS Image 5 based on scrutiny of submitted documents.



TMS Image 5- Post verification of documents to take the appropriate action as listed.



TMS Image 6- Raise query with the appropriate reasons as listed

If PPD is unable to take a decision based on the available documents and feels the need to call for additional documents, PPD can raise a query to the hospital. The PMAM/MEDCO at EHCP will provide the necessary information (query response) to PPD as per defined TAT. Following are standard queries raised while preauthorization process. PPD can select from standard dropdown available in TMS. All the queries for deficiency documents should be asked in one go. User can select multiple queries from the same dropdown. If Query is not listed in the category, user can use

"others option" and enter the details of query required. There would be scenario where query response received from hospital does not fulfil the requirement and PPD must raise the same query. In such cases it is mandatory for the PPD to mention the reason for not accepting the query response from the hospital in the "free text box".

4.5.2 Standard Query Reasons for Pre-authorization[7]

PPD
Investigation reports
Provide X-Ray / MRI /CT / USG/EEG brain Films/ECG graph/ ABG chart/ CAG diagram (as applicable) with patient name and date
Investigation reports of the patient supporting the diagnosis
Provide Biopsy / HPE / FNAC / PET SCAN / any other diagnostic report confirming malignancy
Hospitalization Records
Provide vitals charts, Treatment plan and progress notes
Provide updated case summary and/or complete ICP records justifying enhancement of package
Provide the clinical photograph of the injury/ lesion
Provide Hemodialysis chart and justification for frequent hemodialysis (if applicable)
Clear and legible documents
Provide clear and relevant photo of the beneficiary

[7] Subject to change from time to time

Re-Upload legible copy of requested documents
Additional information
Provide justification for selected package
Provide justification for claim amount requested under Unspecified Surgical Package
Provide Doctor's Prescription advising Hospitalization with diagnosis
Provide referral letter from government hospital.
Provide Doctor's Prescription advising Hospitalization with diagnosis
Provide Self-declaration with detailed narration of incident, mentioning date, place and time. MLC/FIR copy.
Others*
There is a free text for entering the details/remarks

Table 2 Standard query reasons for Pre-authorization

Pre-authorization Rejection process and reasons[8]:

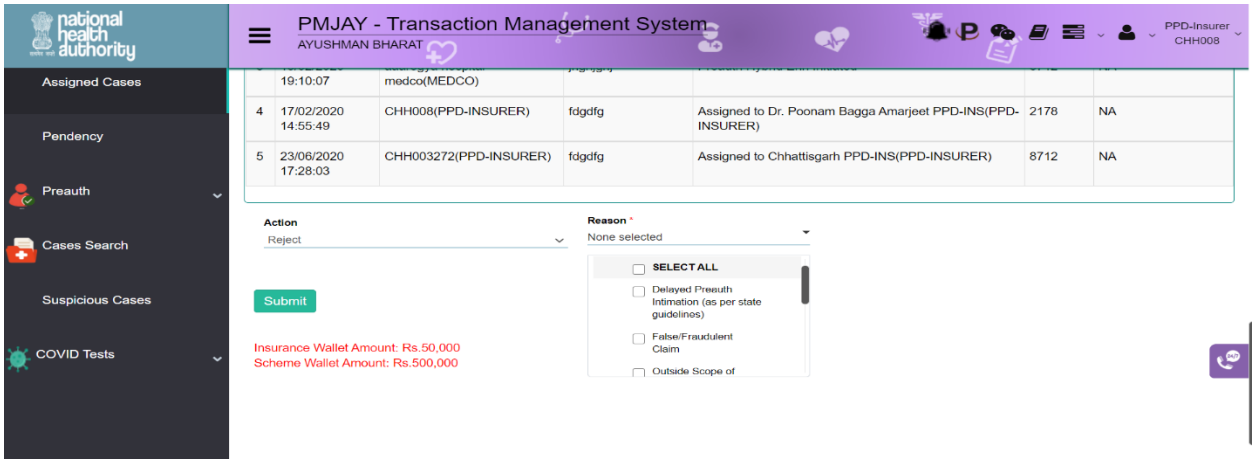
Based on the scrutiny of documents, pre-authorization may not be admissible. In such a scenario, PPD may decide to reject the pre-auth. The PPD shall mention the reason for rejection of the pre-auth.

Reasons for rejection of pre-auth request are as follows:

1. Need for hospitalization is not justified from the clinical findings.
2. Supporting documents and investigation reports necessary to take a decision are not submitted even after multiple query/reminders.
3. Patient is not covered under PM-JAY.

[8] Subject to change from time to time

4. Patient's family wallet does not have sufficient amount.
5. Fraud & misrepresentations.
6. If the treatment sought falls under the list of exclusion as per policy/scheme T & C.



TMS Image 7- Reject the pre-auth claim with appropriate reasons as listed

4.5.3 Standard Rejection reasons in Pre-authorization[9]

Following are standard rejection reasons for preauthorization. PPD can select from standard dropdown available in TMS under Rejection reasons category.

Delayed Pre-auth Intimation (as per state guidelines)
False/Fraudulent Claim
Outside Scope of cover (Exclusions as per scheme)
Package Selection: Government reserved package
Package Selection: Hospital not empaneled for this specialty
Package Selection: Mismatch of package and disease/diagnosis/treatment/gender/age

[9] Subject to change from time to time

Others*

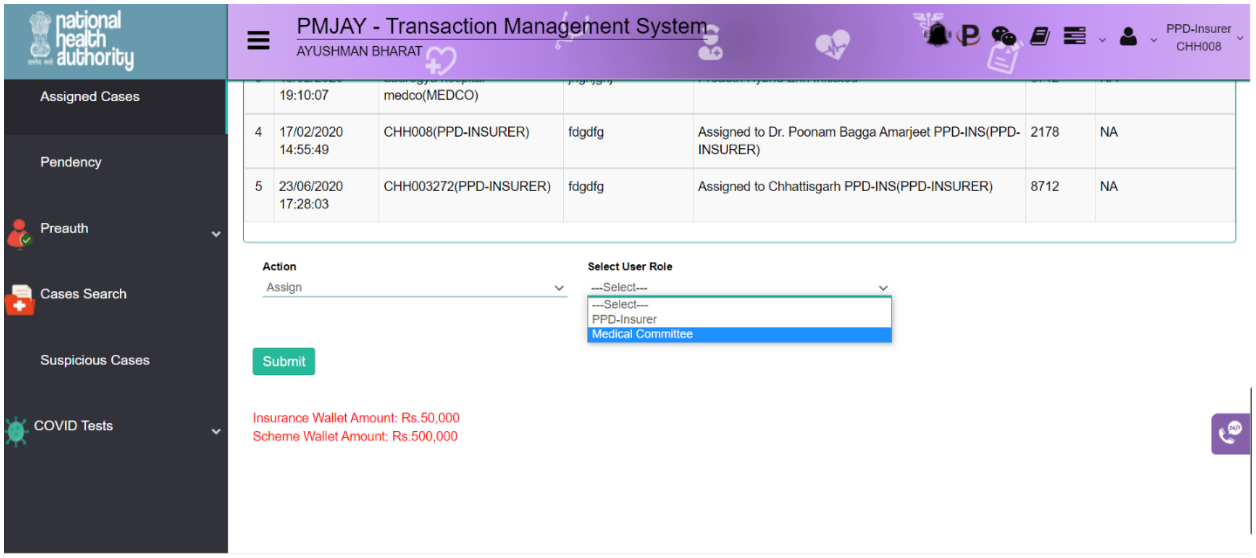
Table 3- Standard Rejection reasons for Pre-authorization

Note- Others* there is a free text for entering the details.

All rejected Pre-auth requests go to the SHA for review. The SHA can choose to revoke a rejected request and send it back to the PPD.

Assign Functionality:

Based on the scrutiny of documents, Pre-authorization may be admissible or may not be admissible. In few cases where PPD is unable to take any decision, claim can be assigned to medical committee for their second opinion. This feature is available in TMS as follows:



TMS Image 8

Assign functionality – To assign a case to other medical expert for his/her action.

4.5.4 Send to Investigation

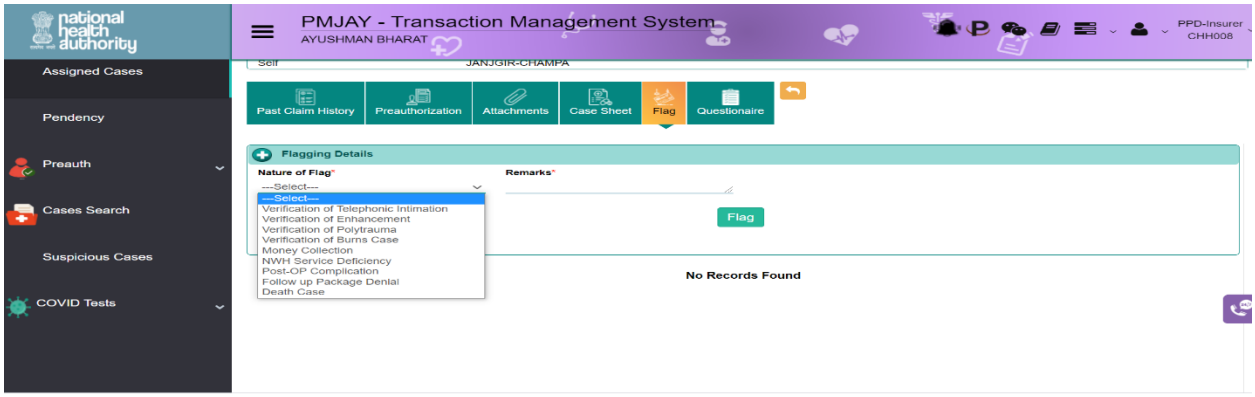
If the PPD finds the case to be suspicious it can be referred for field investigation or desk audit.

However, lifesaving treatment of patients shall not be stopped and final decision on the preauthorization request shall be taken based on findings of the investigation and audits.

If the investigation report is not received in stipulated time, the PPD shall go ahead with appropriate decision and the outcomes of the investigation report may be taken into consideration at the time of discharge or during claim adjudication.

4.5.5 Flagging of Cases

Pre-authorization also can be flagged as reasons listed in TMS. This flagging is useful for PPD for a follow up when cases are refereed for either investigation or any other observations which needs to be followed up with concerned authorities.



TMS Image 9 – User can flag the case for various reasons as listed.

Note- Please refer the Uniform TAT section for Private and Public EHCP Turnaround Time.[10]

[10] 10.1 Uniform TAT section for Private and Public EHCP Turnaround Time

4.5.6 Roles and Responsibilities in Preauthorization Process

S. No.	Role	Responsibility	Description
1	PMAM	• To register the patient in TMS	• As per the beneficiary details – register the patient in TMS with relevant information.
2	MEDCO	• To book the relevant package • Raise the Pre-authorization request in TMS • Respond to queries raised by PPD /CPD	• As per the diagnosis if the patient requires admission to block the relevant package and initiate the Pre-authorization.
3	PPD	• Verification of technical (medical/clinical) information • Decision making of the case	• Diagnosis, reports, clinical notes, evidences, etc. • Approve / Assign/ Reject a claim • Raise Query/Send back to EHCP for clarification • Trigger the cases for investigation/audit if required.

5 CLAIMS PROCESS FLOW

5.1 CLAIM PROCESS FLOWCHART

MEDCO, CEX, CPD, ACO, SHA and Finance are involved in claims processing. Below figure provides an overview of the claims process flow.

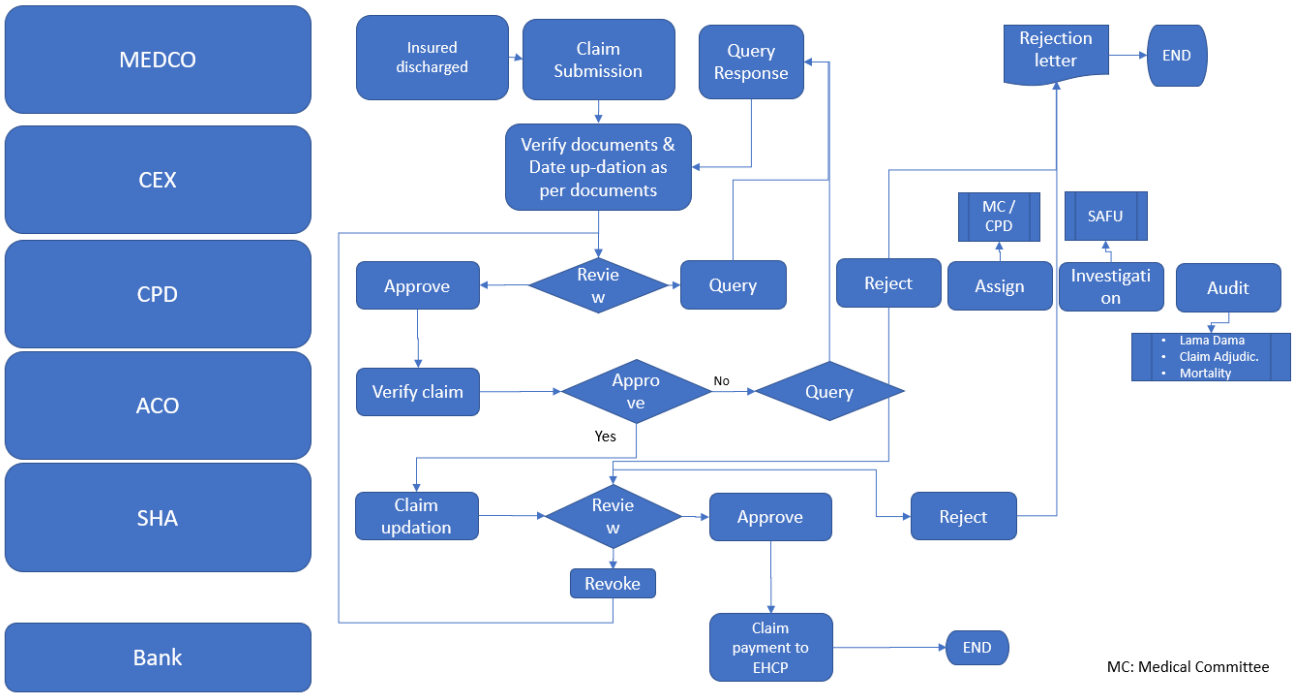


Figure Claims 1 Claims Process Flow

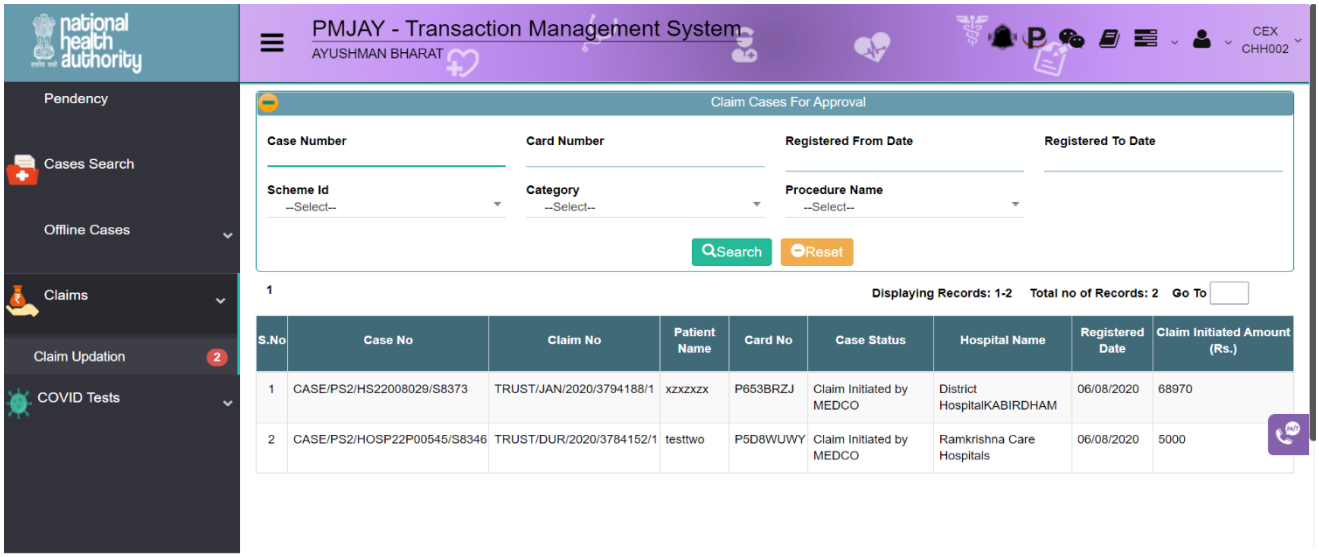
5.1.1 Claim Initiated by MEDCO / PMAM

Once the patient is discharged the Medco would update all the case details of the patient (like Date of discharge, all hospitalization records, etc) and initiate the claim. After claim initiation the claim lands into bucket of Claim Executive.

Claim documents are received from the EHCP via TMS. CEX would review the claim documents as mentioned below and forward it to CPD for review and further actions.

5.1.2 Claim Verification by Claim Executive

CEX would verify the claim initiated by MEDCO in Claim Updation tab as shown in the screen shot.



TMS Claims Image 1 Claim received by CEX in workflow

The basic workflow of CEX can be represented in the figure below.

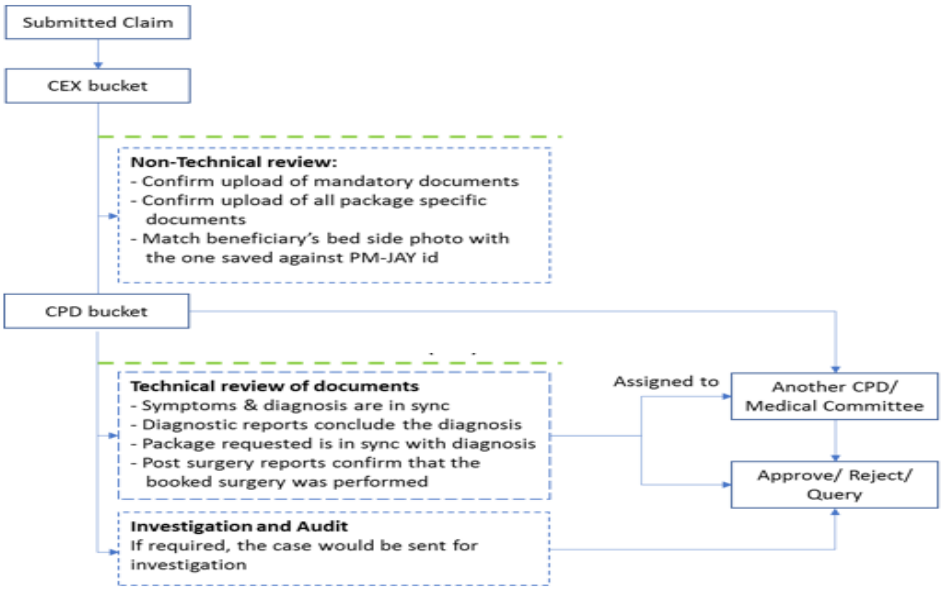


Figure Claims 2 CEX and CPD actions

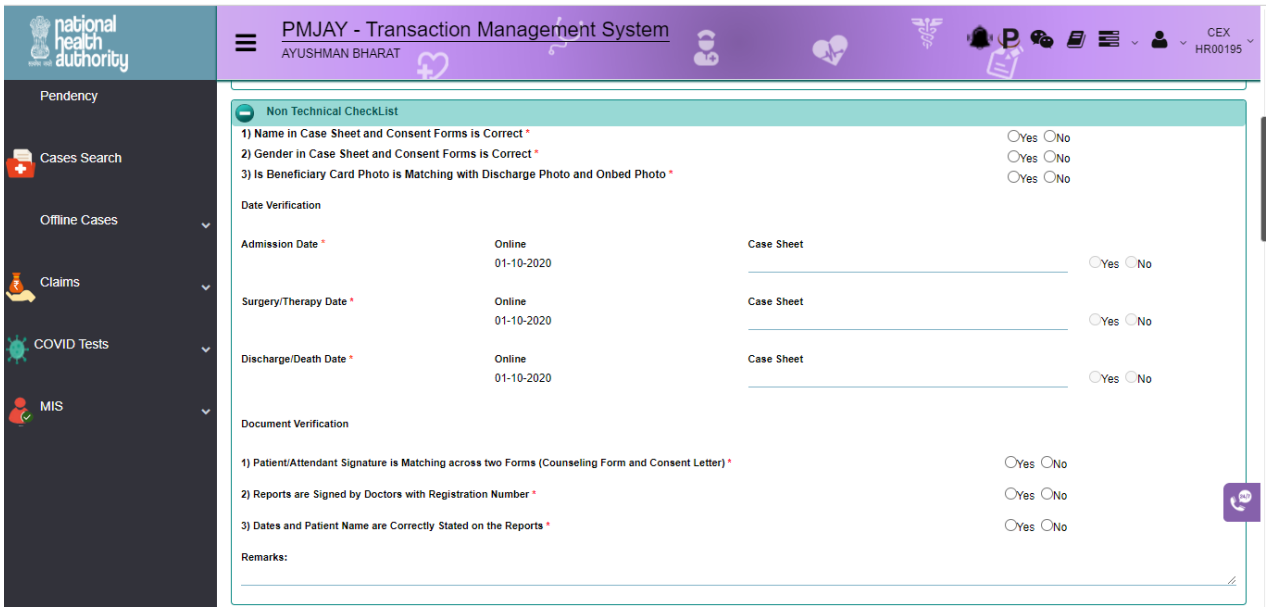
5.1.3 CEX - Non-Technical Documents Review

The CEX will review the non-technical part like name, age, gender, along with availability of all supporting documents and forward it to CPD for review.

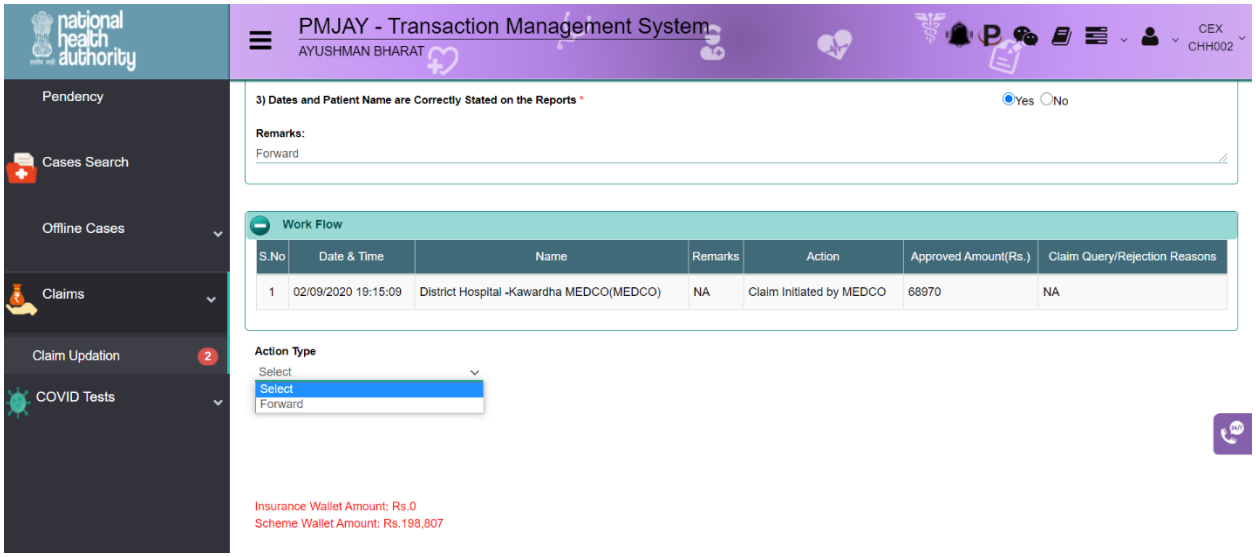
Following details will be checked by CEX while reviewing the claim:

1. Validate all mandatory documents. There is a list of mandatory documents that are uploaded while initiating the claims which needs to be verified as per Standard Treatment Guideline (STG)[11] for packages.
2. Verify the photos during the hospitalization and post hospitalization confirming the insured identity
3. Discharge summary documents

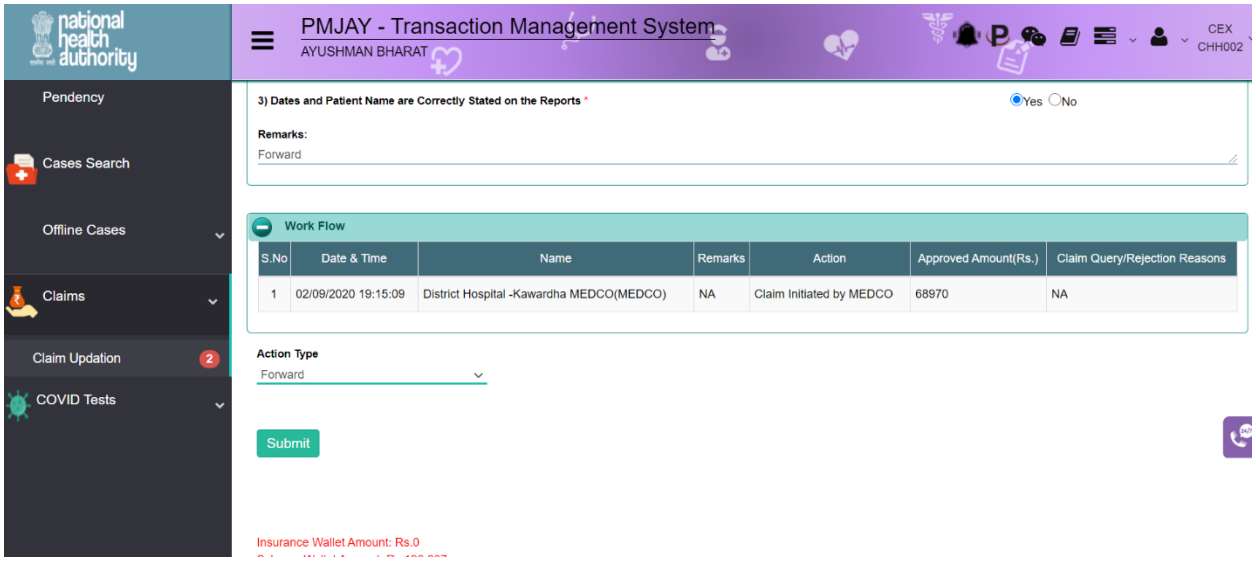
[11] Health Benefit Packages – refer Standard Treatment guidelines https://pmjay.gov.in/resources/documents [5]



TMS Claims Image 2 CEX Checklist



TMS Claims Image 3 CEX post verification of documents forwards claim to CPD

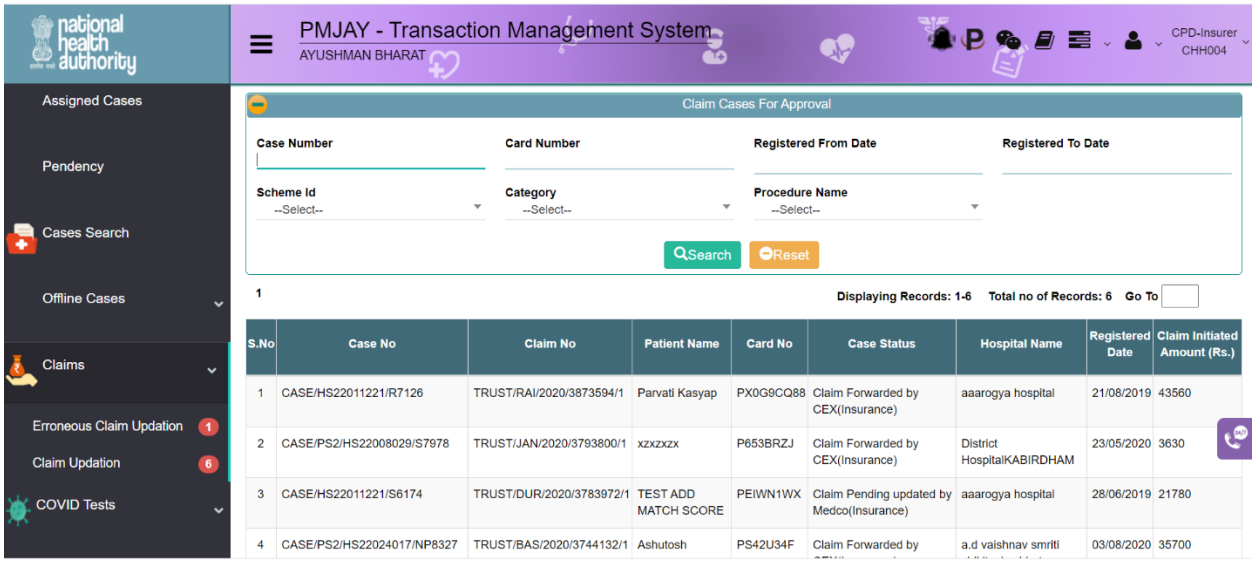


TMS Claims Image 4 CEX to select forward and submit button

5.1.4 Claim Scrutiny by Claim Processing Doctor

After receiving the claim for review, CPD will verify submitted claim based on merits of the claim and take appropriate actions. The CPD can either approve the claim, raise a query, assign the case for second opinion, send the case for investigation, or reject the claim.

In case CPD wants to raise a query, it should be raised in one go. Under any circumstances query should not be raised more than 3 times. There would be scenario where query response received from hospital does not fulfil the requirement and CPD must raise the same query again. In such cases, it is mandatory for the CPD to mention the reason for not accepting the query response from the hospital in the “free text box”. User can select multiple queries in the same dropdown. In case of query raised, hospital must provide pending documents / information within the defined TAT.



TMS Claims Image 5 CPD to select claim for review

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

1. The CPD shall ensure that all mandatory documents are uploaded by the EHCP as per STG. However non submission of mandatory documents should not be a reason for rejection of claim unless it is necessary for CPD decision.
2. The signs, symptoms & duration of Illness mentioned by the doctor are aligned with the final diagnosis and treatment taken.
3. The findings of the investigation/ diagnostic reports uploaded by the EHCP supporting the diagnosis
4. Ensure that post-surgery reports to confirm the booked surgery was performed
5. CPD should also review the ward category and verify according to the medical documents.
6. Though the LOS is calculated by system, CPD should validate LOS with the discharge summary and subsequent approval amount.
7. The treatment package requested by the EHCP is in sync with diagnosis of the claim.
8. CPD would verify Treating doctor Signature with registration number & qualification
9. In case of death, CPD would verify death summary, prognosis notes and all relevant documents including consents and information to relatives by the hospital authority.

The Claims Processing Doctor would review the technical details (medical/clinical) of a claim.

List of documents is as follows:

1. OT notes and Surgery notes as applicable- Refer ***Annexure 2***[12]
2. Clinical notes
3. Discharge summary in standard format containing complete and relevant information- Refer ***Annexure 3***[13]
4. The CPD shall ensure that the clinical photograph uploaded is relevant and is not a 'Google Image'
5. Investigation reports
6. ICP records as applicable

Example: Total Hip Replacement (Cemented)

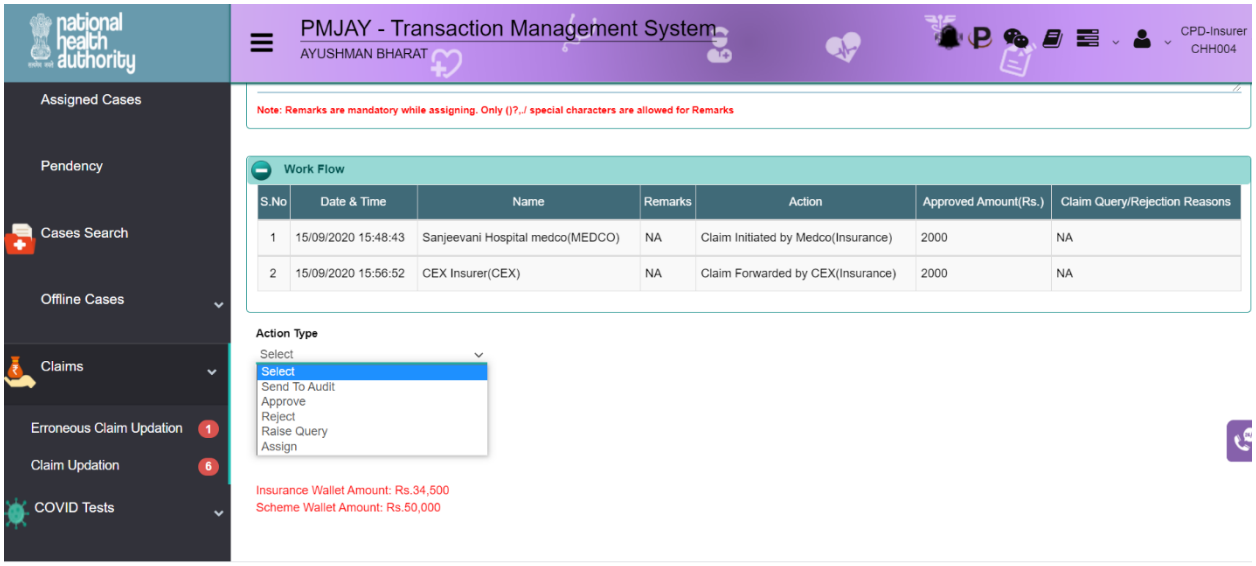
Mandatory Documents as per STG to be uploaded by the EHCP at claim submission level:

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

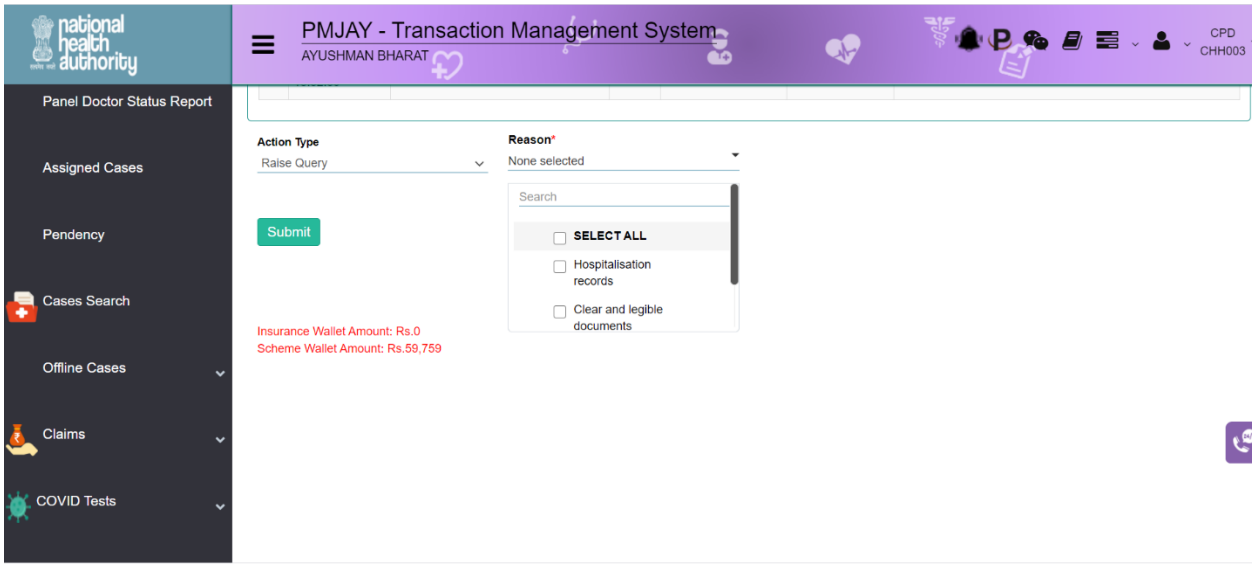
Post CPD review claim actions can be as follows:

1. If there are deficient documents, then CPD can raise query
2. The claim may be approved and paid if the CPD finds everything is in order and is completely satisfied with the relevant parameters.
3. Claim can be rejected; it does not qualify for approval and payment.
4. The CPD can also approve the payment partially if the details/documents do not justify the entire claim.
5. Claim can be referred to field investigation if information provided or submitted documents are doubtful.
6. In some instances, wherever CPD is not able to take any decision can assign the claim to Medical Committee for second opinion.

[12] ***Annexure 2***
[13] ***Annexure 3***



TMS Claims Image 6 Post CPD review claim actions



TMS Claims Image 7 A drop-down list to select document requirements – multiple reasons can be opted at one go if required.

5.1.5 Standard Query Reasons post claims review[14]

CPD
Hospitalization records
Provide complete Discharge summary/ Day care summary (e.g. patient Name, Gender, Age, complaints, treatment done, Diagnosis, DOA & DOD etc.)
Provide death summary/LAMA or DAMA summary.
Provide Surgery / OT/ Anesthetic notes
Provide implant/stent sticker/prosthesis/ IOL sticker
Clear and legible documents
Provide post-operative scar photo with face of patient in same frame (with consent of patient)
Provide photo of patient in ICU with Ventilator (in ICU-Ventilator cases)
Investigation reports
Provide X-Ray / MRI /CT / USG/EEG brain Films/ECG graph/ ABG chart/ CAG diagram (as applicable) with patient name and date
Provide Biopsy / HPE / FNAC / PET SCAN / any other diagnostic report confirming malignancy
Others*
Blank

Table Claims 1 Standard Query Reasons for Claims

Note- Others* has a free text box available for entering details.

Claim Send to Investigation/Audit

If the CPD finds the claim to be suspicious, it can be referred for field investigation or claims adjudication audit.[15]

Claims Rejection

Based on the scrutiny of the claim, CPD may decide to reject the claim. The rejection letter would be sent to EHCP with reason for rejection. This claim would land into in SHA bucket for review. The SHA reserves the right to revoke a rejected claim. Upon revoking , the case would return to CPD bucket for processing.

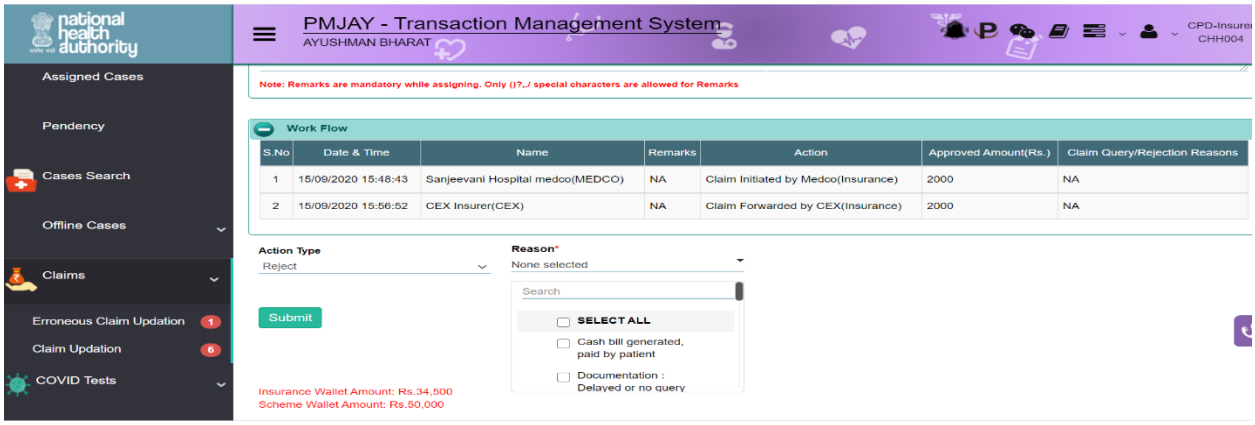
[14] Subject to change from time to time

[15] https://pmjay.gov.in/sites/default/files/2020-04/Field%20Investigation%20and%20Medical%20Audit%20Manual_April-2020.pdf [3]

Under following scenarios rejection of claim may be recommended:

1. Need for hospitalization is not justified from the clinical findings.
2. Supporting documents and investigation reports necessary to take a decision are not submitted even after multiple query/reminders
3. Fraud & misrepresentations
4. Patient's family wallet does not have sufficient amount
5. If the treatment sought falls under the list of exclusion as per policy/scheme T & C

The drop-down contains all the standard rejection reason along with an option as “other” to enter reason manually.



TMS Claims Image 8 Standard Claims Rejections Reasons

5.1.6 Standard Claim Rejection Reasons[16]

Cash bill generated, paid by patient
Documentation: Delayed or no query reply
Documentation: Delayed or non-submission of claim (as per state guidelines)
Documentation: Incomplete submission of documents by hospital after multiple queries
Documentation: Unclear/overwritten documents submitted by hospital
False/Fraudulent Claim

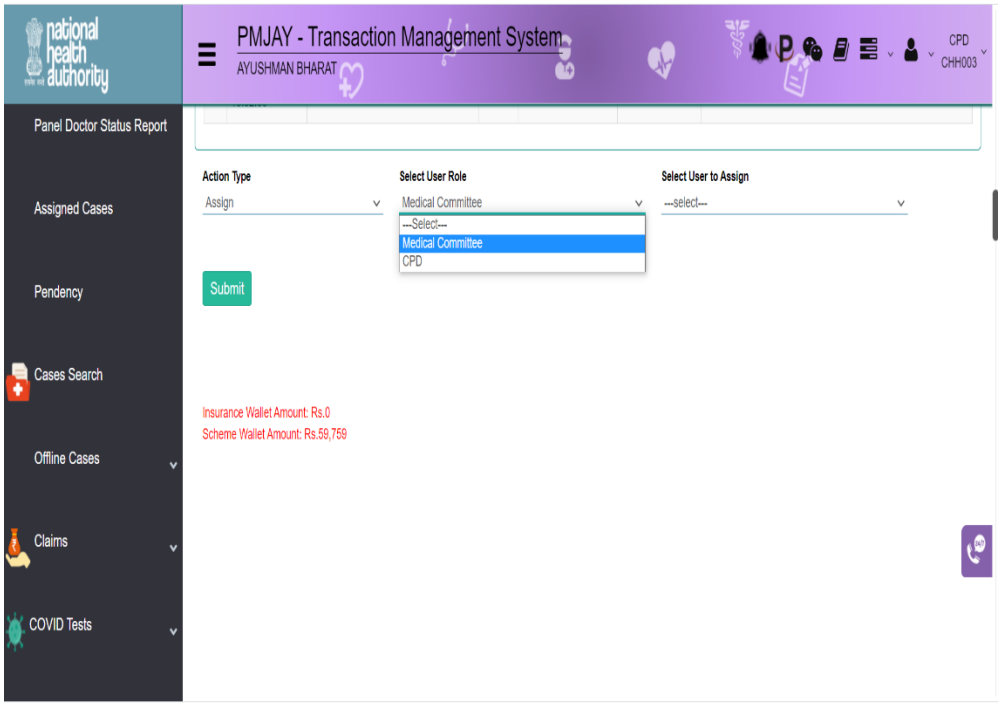
[16] Subject to change from time to time

OPD converted into IPD (Justification for admission not found)
Outside Scope of cover (Exclusions as per scheme)
Package Selection: Hospital not empaneled for this specialty
Package Selection: Mismatch of package and disease/diagnosis/treatment/gender/age
Others*

Table Claims 2 Standard Claim Rejection Reasons

5.1.7 Claim Assign functionality

In case CPD wants to take a second opinion, claim can be assigned to other CPD or Medical Committee for review. This process of assigning case can be seen in the screenshot below

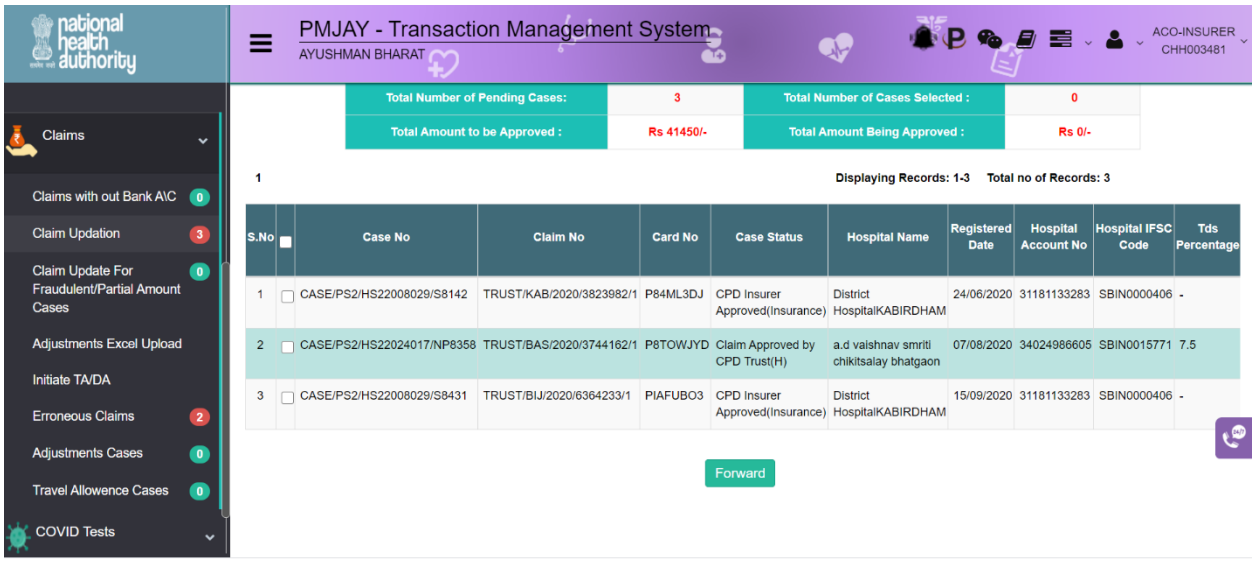


TMS Claims Image 9 Claim Assign Functionality

5.1.8 Claim Forward by Accounts Officer (ACO)

Once the Claim Processing Doctor(CPD) approves the Claim, the claim will move to Accounts officer's bucket for further action.

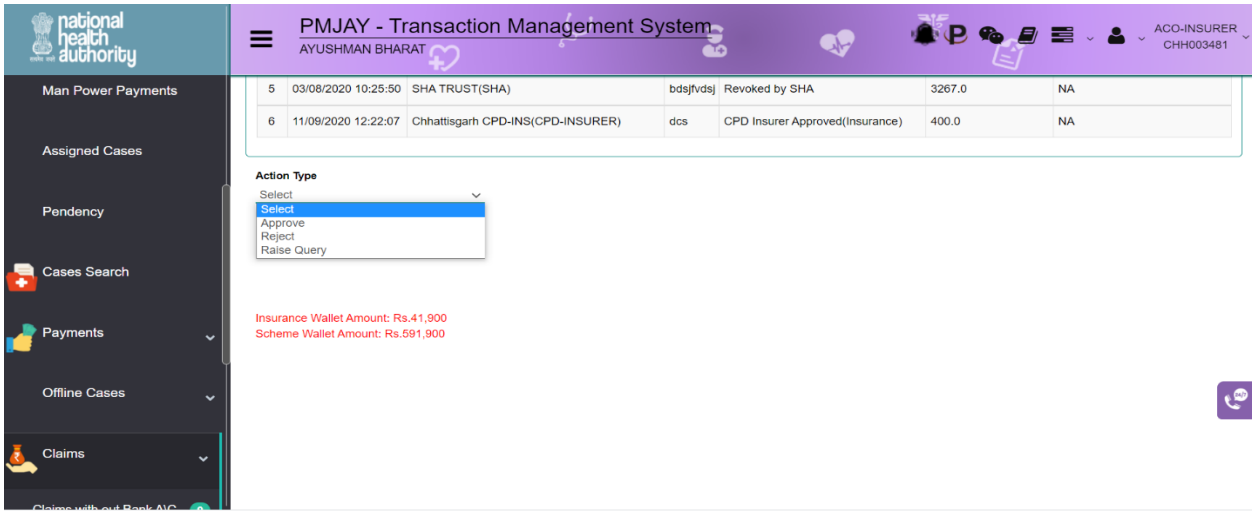
Accounts officer will check the claim and if found payable will forward the claim to SHA as shown in the screen shot.



TMS Claims Image 10 ACO Claims Workflow

ACO can review the claim and take following action:

On the merits of the claim it can be either approved, rejected or query can be raised by ACO.

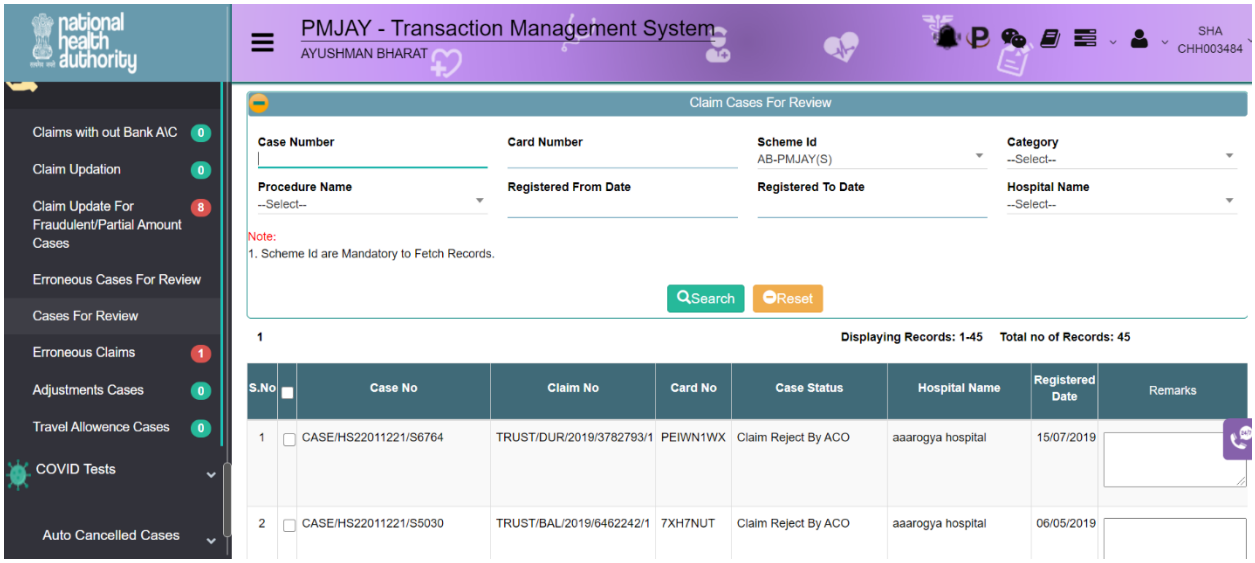


TMS Claims Image 11 ACO's options post claim review

5.1.9 Claim Review by State Health Agency (SHA)

Claim Review by SHA

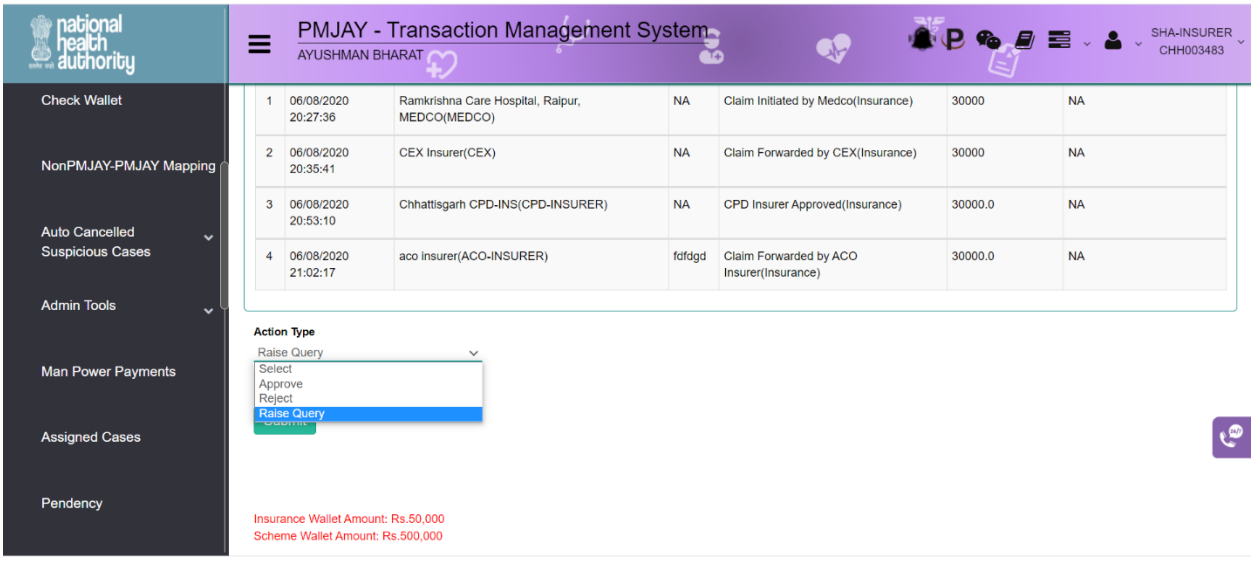
Post CPD and ACO review of claims, ACO will forward the claim to SHA who will verify the claim and take appropriate action. In case of Insurance model of implementation, as liability to pay the claim amount rests with the insurer, claim after ACO approval will move to SHA/Insurer.



TMS Claims Image 12 SHA will be able to view all the cases forwarded by ACO in the workflow .

SHA would take following actions post review of claim documents.

1. Approve
2. Raise Query
3. Reject



TMS Claims Image 13 SHA actions post claims review

5.1.10 Claim payment process

Post approval of claim by SHA (Trust model) or SHA – IC (Insurance model), claim payment would be initiated by the bank. Amount will be transferred to EHCP account. SHA will follow applicable PFMS guidelines for making claims payment.

5.1.11 Re-consideration of Rejected Claim

Based on the scrutiny of the claim, CPD may decide to reject the claim. System generated rejection letter/ mail would be sent to EHCP with reason for rejection. This claim would be sent to SHA bucket in TMS for review. The SHA reserves the right to revoke a rejected claim. Upon revoking, the case would return to CPD bucket for processing. If any hospital is not satisfied with the justification given by the CPD/SHA for claim rejection or in case of any dispute over claims, hospital can raise the issue as per grievance redressal mechanism.

5.1.12 Right of Appeal and Reopening of Claims[17]

a. The Empanelled Health Care Provider has a right of appeal against rejection of a Claim by the Insurer/SHA, Such decision of the Insurer /SHA may be appealed by filing a grievance with the DGNO within 15 days of rejection of claim, in accordance with Grievance redressal guidelines[18].
b. The Insurer and/or the DGNO or the DGRC, as the case may be, may re-open the Claim, if the Empanelled Health Care Provider submits the proper and relevant Claim documents that substantiates their right to re-open such claims.

5.1.13 Grievance redressal :

Grievance redressal mechanism under PMJAY ensures that grievances of all stakeholders including EHCPs are redressed in the prescribed mechanism and within time frame as mentioned in the Grievance Redressal Guidelines[19].

A robust, bi-lingual, user-friendly web-based grievance redressal system enables a person to register grievance on the portal *https://grievance.pmjay.gov.in or https://cgrms.pmjay.gov.in/ or on PM-JAY mobile application.*

5.1.14 Erroneous Claims

(Partial Payment/ Excess Payment/ Recovery amount)

Erroneous Claim – are claims where the claim amount is settled is either less or more than the payable amount or the claim was not payable as per terms and condition of contract. Erroneous claim can be due various reasons as follows -

1. **Partial payment to EHCP**:
   In case the claim is paid partially due to want to certain document and the documents are produced later MEDCO can initiate the reconsideration payment request through TMS in erroneous claim section and SHA may consider as per merits of the claim.
2. **Excess-payment to EHCP**:
   In case of excess payment to the hospital in a settled claim, a recovery can be initiated by ACO through TMS for the excess amount.
3. **Wrong claim payment to EHCP**:

[17] Draft Contract Agreement for Selection of Insurance Company for the implementation of Ayushman Bharat – PM-JAY: Section 14.2
[18] Grievance redressal guidelines - https://pmjay.gov.in/sites/default/files/2020-03/Revised%20Grievance%20Redressal-February%202020.pdf
[19] Grievance redressal guidelines - https://pmjay.gov.in/sites/default/files/2020-03/Revised%20Grievance%20Redressal-February%202020.pdf

If claim is paid wrongly to EHCP, ACO can raise this request through TMS for recovery.

In case of recovery from EHCP (point 2 and 3) the amount will be adjusted in the subsequent claims of the EHCP. SHA is the final authority for the decisions pertaining to erroneous claim.

5.1.15 Roles and Responsibilities – Claims Processing

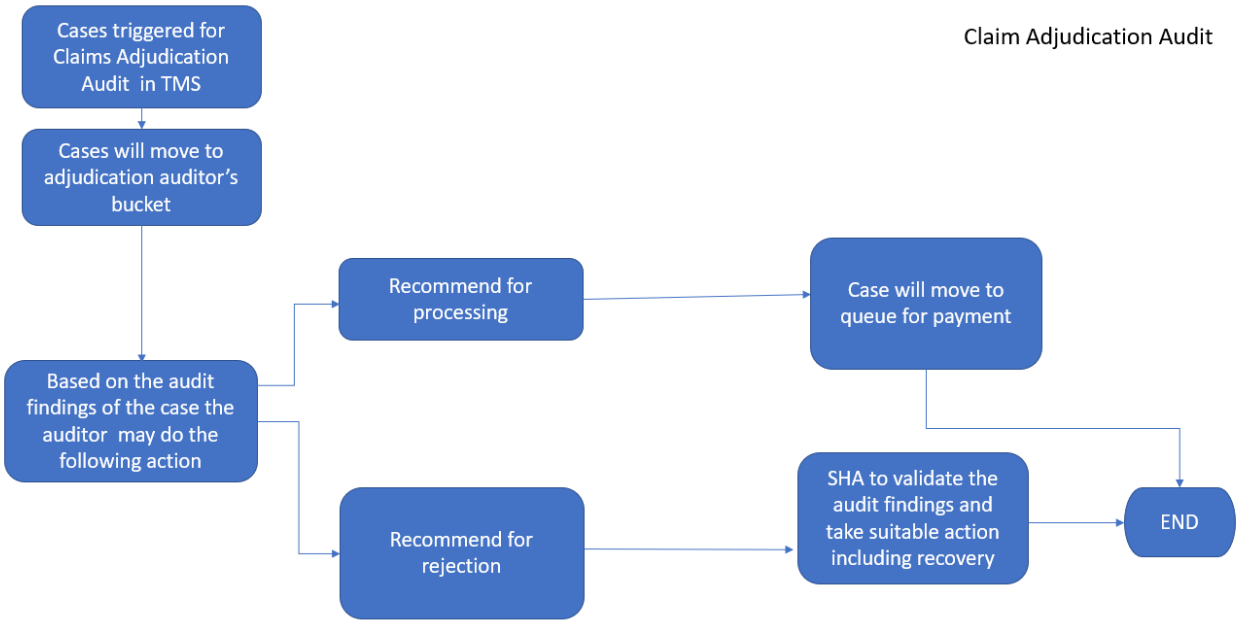
S. No.	Role	Responsibility	Description
1	CEX	• Verification of Non-technical (non-medical/non-clinical) information	• Documents, reports - dates etc. which are mentioned in TMS. • Forward the case to Claim Processing Doctor with Inputs
2	CPD	• Verification of technical (medical/clinical) information • Decision on the claim	• Diagnosis, reports, clinical notes, evidences, etc. • Approve / Assign/ Reject a claim • Validate system calculated claim amount and approve/recommend full/partial amount. • Raise Query/Send back to EHCP for clarification • Trigger the cases for investigation/audit if required.
3	ACO	• Validate financial information in all the transactions	• Forward the claim to SHA/ Insurance Company (IC) for approval
4	SHA/ IC	• Verify the claims submitted through TMS	• Respond to queries/ reconciliation issues raised by EHCP regarding final payment received

Table Claims 3 Roles and responsibilities during claims processing

6 CLAIM ADJUDICATION AUDIT

Objectives of Claim adjudication audit:

- To improve overall quality of Claims Adjudication
- To check if due diligence has been applied by the claims team while processing the claims
- To check if the claims has been processed based on hospitalization documents as per standard treatment guidelines.



Claims Adjudication Audit 1- Claim adjudication audit workflow

Triggers

Based on the triggers, the cases will move to claims adjudication auditors' bucket in TMS.

Frequency

Audits have to be conducted as per the SLA (Service Level Agreement) in the signed MOU.

Please refer Annexure 6 :Claim adjudication audit – Template and Reporting format as per Model Tender[20]

Checklist

Particulars	Yes	No	Remarks
Is Patient's name/age in indoor records, E card and investigation reports same?			
Any aberration noted in the past claim history?			
Are all mandatory documents available as per STG at the time of claim submission?			
Are presenting symptoms matching with the diagnosis?			
Is the package booked matching with the diagnosis?			
Are Investigation reports supporting diagnosis available?			
Are investigation reports signed by doctor/pathologist with registration no.			
Are Post op photos showing scar available in surgical cases			
Do the OT notes detail steps of surgery? (Only in surgical cases)			
Is Line of treatment matching with the package booked (specific to general medicine and oncology)			
Are pre and post op x-rays available as per the procedure (case specific in IT system)			
Was length of stay verified with discharge summary? (In medical management cases)			

[20] Document -ISA- schedules- 0304 as per Schedules 12,16 & 19 https://pmjay.gov.in/sites/default/files/2020-05/3-MTD-ISA-Schedules-0304.pdf

Does the discharge summary capture all details of presenting features, investigations, line of treatment given during stay, line of treatment advised at discharge?			
Did the PPD/CPD follow the above-mentioned process?			
Were appropriate queries raised? (In query cases)			

Adjudication Audit Checklist 1

Note-

1. This checklist has been integrated in the TMS.
2. Apart from regular audit SHA/NHA can conduct periodic audits to monitor the quality of claim processing.

NHA has been conducting regular periodic audits. Some of the major audit findings are mentioned below:

1. Claims paid for higher number of days than actual days of hospitalization
2. Claims paid despite Pre/post hospitalization/post-operative photographs indicating otherwise
3. Stable patients admitted in ICU to inflate package rates
4. Claims paid without query despite all ICP documents in same handwriting
5. Claims paid despite investigation reports not signed or stamped by the doctor
6. Claims paid where prolonged hospitalization was not justified
7. Claims paid without diagnostic/investigation reports
8. Claims paid where patient was discharged directly from ICU
9. Claims paid over and above the maximum capping for that package
10. Claims approved when there were major discrepancies in the indoor case papers.
11. None of the suspicious cases were sent for field investigation
12. Claims approved where the angiography package was booked along with PTCA package

6.1 Percentage of Claims Audit

As per Model Tender Document and Field Investigation and Medical Audit Manual percentage of audit as required is mentioned below:

Sl. No	Audit Type	Sample for Insurer/TPA/ISA/SHA Trust (without TPA) Audit	Sample for SHA Audit (only in case of states with Insurer/TPA)	Objective	Ownership
1.	Pre-authorization Adjudication Audit	5% of total pre-authorizations across disease specialties	2% direct audit +2% of audit done by the Insurer/TPA /ISA	Ensure that the Pre-authorization process is being followed diligently at all levels	SHA Operations
2.	Claims Adjudication Audit	5% of total claims Approved	2% direct audit +2% of audit done by the Insurer/TPA /ISA	Ensure that the claims adjudication process is being followed diligently out at all levels	SHA Operations
3.	Claims Audit (rejected claims)	-	100%	Verify if the rejection of the pre-auth's/ claims are justified and the reason thereof	SHA Operations

Table Claims 4 – Defined Audit % [21]

Note - In case of any conflicts between this document and singed agreement between SHA and ISA/IC (claim adjudication agency) the later will prevail.

[21] Field Investigation and Medical Audit Manual - April 2020 https://pmjay.gov.in/sites/default/files/2020-04/Field%20Investigation%20and%20Medical%20Audit%20Manual_April-2020.pdf[3]

7 CLAIM MEDICAL AUDIT

Some claims might be doubtful/ suspicious like ‘Unspecified procedures’ or cases wherein there is no justification for hospitalization or gross mismatch between symptoms, diagnosis, and procedure etc. All such cases can be referred for a desk review, field investigation or claim adjudication audit based on the facts of the case.

CPD or PPD decides to investigate a claim and selects option of “Send for investigation”, all such claims will be assigned to SAFU for further investigation. Claims are also sent for adjudication audit which is conducted by Claims Adjudication Audit Team.

The decision on the claim shall be taken basis the report submitted by respective functions.

7.1 TYPE OF CLAIM INVESTIGATIONS

Desk Audit

During this process, the medical auditor conducts an audit from her/his desk, without visiting the hospital. Claim related documents like prescription, clinical notes, investigation reports, discharges summary, etc. presented by the hospital at the time of pre-auth request or claim submission are verified. The purpose is to ascertain the necessity of treatment, qualifications of treating doctor and authenticity of claim as evidenced by the documents

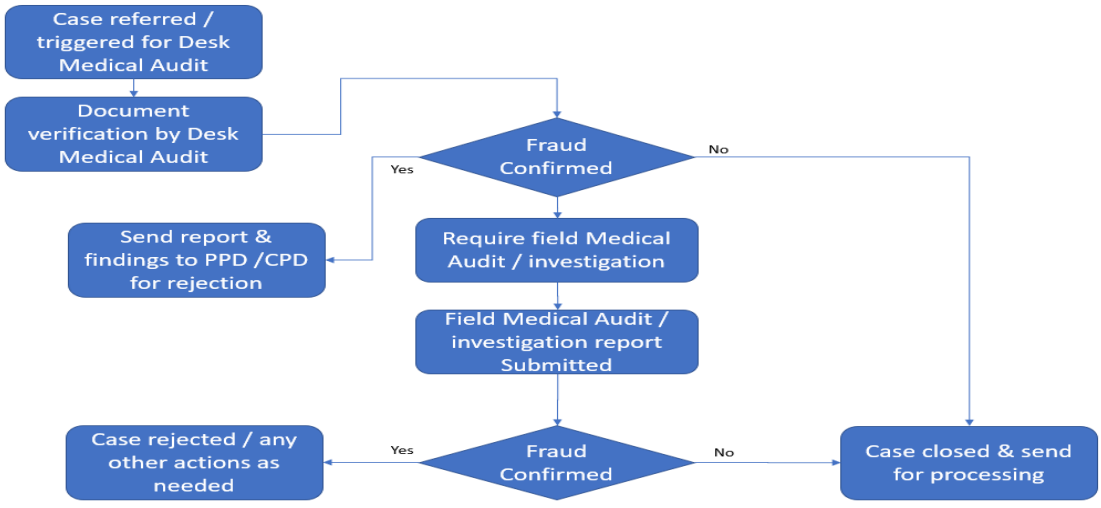


Figure Investigations 1 Desk Audit flow

Field Investigation:

Medical audit at hospital

During this process, the medical auditor visits the hospital premises to conduct live audits on flagged cases, reviews indoor case papers, clinical/operative notes etc. of suspect claims. During the process, the auditor also reviews associated hospital infrastructure and availability of required specialists/ resource, meets the treating doctor to establish if the procedure was performed in the facility ensuring appropriate quality of care. At the time of audit, if AB PM-JAY beneficiaries are admitted in the hospital, then the auditor conducts live audits to establish the correctness of information recorded in the documents, necessity of treatment and obtain any feedback of the patient regarding the quality of service, and whether all benefits of the scheme were made available to her/him.

Beneficiary Medical audit

In case the patient has already been discharged and as need be, the medical auditor may visit beneficiary's home to revalidate/corroborate the information/case papers etc. collected from the hospital and the procedure blocked/claim submitted

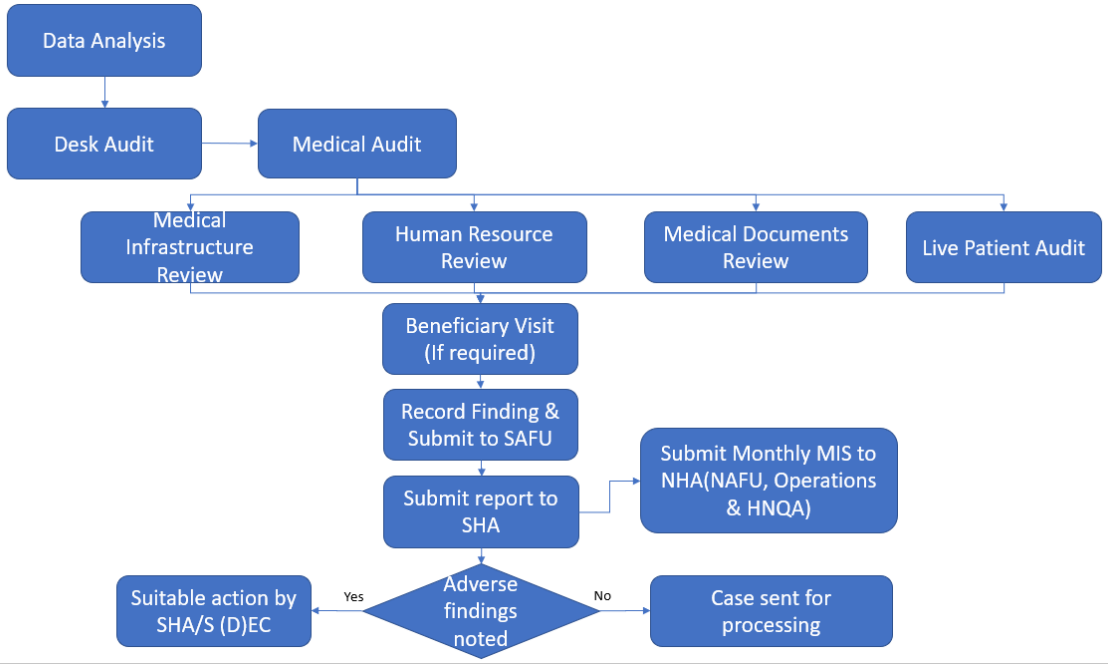


Figure Investigations 2 Field Audit Flow

Sl. No	Audit Type	Sample for Insurer/TPA/ISA/SHA Trust (without TPA) Audit	Sample for SHA Audit (only in case of states with Insurer/TPA)	Objective	Ownership
1	Medical Audit (Desk Audit/ field audit)	5% of total cases hospitalised	2% direct audit +2% of audit done by the Insurer / TPA /ISA	Establish medical necessity and do an objective review of the medical facts related to claim to ascertain the quality of care given.	SAFU
2	Beneficiary Audit (At hospital / At home)	3% of total cases hospitalised	2% direct audit +2% of audit done by the Insurer / TPA /ISA	Establish eligibility, identity of the beneficiary to detect any cases of impersonation, ascertain if claimed procedure was performed and level of satisfaction.	SAFU
3	Mortality Audit	100%	100%	Identify and verify any gaps in clinical care & patient safety impacting morbidity and mortality of the beneficiary.	SAFU
4	Tele Audit (Beneficiary feedback)	5% of total cases hospitalised	2% direct audit +2% of audit done by the Insurer/TPA /ISA	Beneficiary Feedback on free service, Utilization of benefit and overall experience	SHA Operations

Medical Audit percentage 1[22]

[22] Field Investigation and Medical Audit Manual - April 2020 https://pmjay.gov.in/sites/default/files/2020-04/Field%20Investigation%20and%20Medical%20Audit%20Manual_April-2020.pdf [3]

7.2 COMPREHENSIVE AUDIT MODULE

All audits are performed in one single platform referred as Comprehensive Audit Module. SHA / ISA/IC/TPA to conduct & record all audits on this platform. Different types of audits are as follows:

1. Claim Adjudication Audit
2. Medical Audit (Suspicious investigations)
3. Mortality Audit
4. LAMA/DAMA Audit

The audit module is linked with TMS and claims are pushed to audit module based on inbuilt triggers. Claims also can be pushed in audit module as follows:

- Self-Case Selection – using Case Search or Excel Upload
- PPD/CPD can push cases via “Send to Audit”
- Cases sent by NAFU / IMPACT team

Comprehensive audit module has roles for different teams as follows:

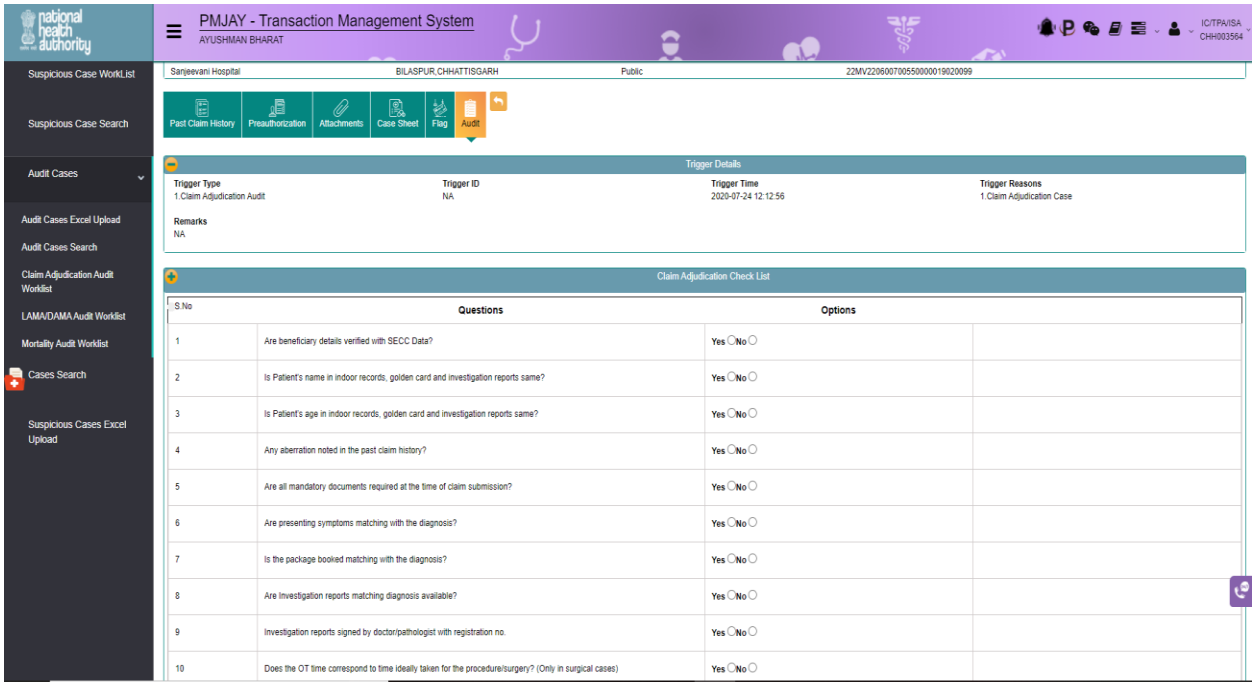
1. NHA Auditor
2. SHA Auditor
3. SAFU Auditor
4. NAFU Auditor
5. IC/TPA/ ISA Auditor

Post completion of case audit, the Auditor would have an option to

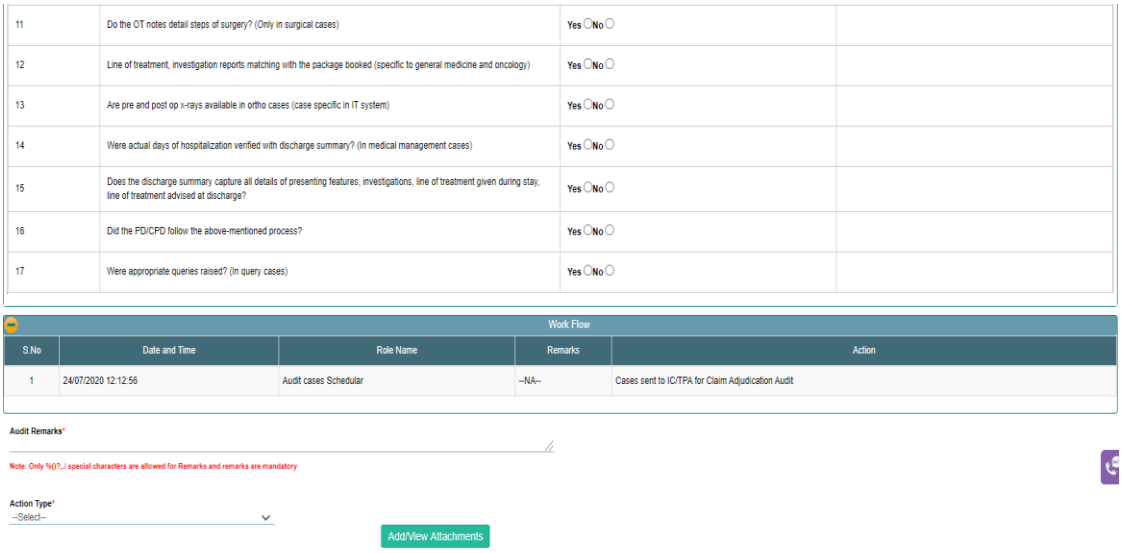
- Take an action based on the findings
- Enter the Detailed remarks
- Upload Attachments (pdf, doc, audio files)
- Recommend Actions for the Approvers (PPD, CPD, ACO, SHA)

Whenever a case is pushed to Audit worklist, then the case will be removed from normal TMS workflow until Auditor completes his investigation.

The below screenshot is the set of questions that are to be filled/marked as it is mandatory in Claim Adjudication checklist. In total there are 17 questions.



Comprehensive Audit Module 1- Claim Adjudication checklist



Comprehensive Audit Module 2 - Claim Adjudication checklist

Note- In the last column there will be a free text box populated based on Yes/No selection. So that comments/remarks can be mentioned in detail for that question.

8 PAYMENT IN SPECIAL CASES

Once a patient is admitted under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) in an empaneled hospital, in normal course the patient will be discharged by the hospital after completing the treatment. Hence in majority of cases, the payment to the hospital will be done based on the package booked and rates prescribed for that package.

However, in some cases, this may not happen due to various reasons e.g. patient may leave against medical advice, patient may die within the hospital or patient may need to be referred to another hospital.

In these special cases clarity needs to be provided to both hospitals and the payers (State Health Agency/ Insurance Company) regarding payments to the hospitals.

These guidelines provide details of payments to be done in these special cases. The basic principles to be followed in implementation of these guidelines are as follows:

- The hospital will be paid partial amount only if the hospital provides information about deviation from normal course to the respective SHA / ISA / Insurer through the IT platform as soon as possible but not later than 24 hours of the deviation. The time limit may be relaxed to 72 hours for public hospitals
- Additionally, in each of these cases payment will be done only after a successful audit by the SHA / Insurer.
- The audit process shall be completed by the SHA/ Insurer within 15 days of receiving the information from the hospital.
- It is expected that these deviations would not amount to more than 5% in a particular hospital

8.1 LAMA / DAMA

Leave Against Medical Advice (LAMA), also called discharge against medical advice (DAMA), is an act whereby a patient takes his/her discharge contrary to 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:

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

a. LAMA/DAMA before surgery - The claim amount would be calculated in line with the existing medical packages according to Length of Stay (LOS) and bed category of the patient. Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. This will be applicable in all cases irrespective of the fact whether pre-operative investigations have been done or not.
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 OT notes will need to be submitted by the hospital for auditing purposes to qualify for payment.

B. Medical Cases - Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered.

8.2 Death During Hospitalization

If the patient dies in the hospital during treatment before discharge, after the audit, the payment to the hospital will be done as follows:

A. Surgical Cases-

a. Death before surgery - The claim amount would be calculated in line with the existing medical packages according to Length of Stay (LOS) and bed category of the patient. Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. This will be applicable in all cases irrespective of the fact whether pre-operative investigations have been done or not.
b. Death on the table during surgery – If the patient dies during the surgery then 75% of the booked package rate will be paid. Daily case sheets and OT notes will need to be submitted by the hospital for auditing purposes to qualify for payment.
c. Death after surgery – If the patient dies after the surgery, irrespective of the duration of the post-operative stay, then 100% of package rate will be paid to the hospital after detailed medical audit.

B. Medical Cases-

Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered.

8.3 PATIENT REFERRED TO ANOTHER HOSPITAL

It is important to note that an empaneled hospital should refer the patients only to another empaneled hospital and only in exceptional circumstances referral to non-empaneled hospital shall be done. Strong justification will need to be provided by the hospital for referring the patient to a non-empaneled hospital.

As per PM-JAY policy, treatment package includes complications arising out of surgery. However, in exceptional cases and on prior intimation to approver (PPD/ CPD), referral can be made from one empaneled hospital to another empaneled hospital and therein qualify for partial payment. The following scenarios shall be applicable for partial payment:

A. Referred to an EHCP

- **Surgical Cases-**
  i. Referral before PAC and surgery – In case a patient is referred to another empanelled healthcare provider, the claim amount would be calculated in line with the existing medical packages according to Length of Stay (LOS) and bed category of the patient to the referring hospital. Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. The hospital (empanelled) that receives the referred patient will be eligible for 100% of the package rate of the surgery booked by the hospital.
  ii. Referral after PAC but before surgery in case surgery is abandoned & patient is transferred - In this case, the hospital that has referred the patient will be paid 15% of the package amount for the surgical package booked by the hospital. The hospital that has received the referred patient will be provided 85% of the package rate of the surgery selected in the hospital. The receiving hospital will need to take pre-authorization before booking the package.
  iii. Referral after the surgery for complication management - If a patient is referred after surgery has been performed, but further complications arise, then the referring hospital would be paid 75% of the total package rate. The hospital that receives the referred patient would be eligible for 100% of the package rate of the new surgery selected (if a surgical package is booked), or in line with the existing medical packages according to Length of Stay (LOS) and bed category of the patient (if a medical package is booked), depending on the patient. This surgery in the second hospital will need to be mandatorily pre-authorized.

- **Medical Cases** –
  Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid to the referring hospital as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. The hospital that receives the referred patient would be eligible for 100% of the

package rate of the surgery selected (if a surgical package is booked), or in line with the existing medical packages according to Length of Stay (LOS) and bed category of the patient (if a medical package is booked), depending on the patient.

B. Referred to non-empanelled hospital (in exceptional cases)

- If any referral is done to a non-empanelled hospital, then no payment will be done to any non-empanelled hospital.

Note: in no other cases partial payment will be done to empaneled hospitals

8.4 Unspecified Surgical Package

To ensure that AB 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).

8.4.1 Using an unspecified surgical package

Criteria for treatments that can be availed under 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. Not applicable for medical management cases.
- 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, SHAs 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. Exceptions where removal of implants is not covered under any other package, to be approved by State Health Agencies or National Health Authority.
- 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 AB 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 AB 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.
- In case the SHA is getting multiple requests for the same unspecified package from multiple hospitals or for multiple patients, then the same should be taken up with the Medical Committee for inclusion in the package master for that SHA within a defined time frame as per the SHA.
- The same should also be shared with NHA for consideration to include such packages in national package master.

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

8.4.2 Unspecified package from ₹ 1 Lakh to ₹ 5 Lakhs

For any State / UT to utilize the unspecified surgical package from ₹1 lakh to ₹ 5 lakhs, it is to be ensured that the same is approved only in (a) exceptional circumstances and / or (b) for life saving conditions.

a. Exceptional circumstances may include:

i. Rare disease conditions or rare surgeries.
ii. Procedure available under HBP in a different specialty but not available in the treating specialty.
iii. Procedure available under HBP in a specialty for which the hospital is not empanelled.
iv. Other conditions / treatments which are not excluded under AB PM-JAY but not listed in HBP.

b. Life-saving conditions may include:

i. Emergencies or life-threatening conditions

While it is difficult to define all the situations where unspecified surgical package may be used or the upper limit for booking the package, but it can be allowed as long as it is approved by medical committee of SHA comprising of experts from public hospitals. Condition for booking such package should also be mentioned as described above.

The following process to be adhered:

- A standing Medical committee will be constituted by CEO of each SHA to provide inputs on requests received for unspecified surgical packages among their other deliverables.
- CEO, SHA will recommend every case for approval after taking inputs from the standing medical committee (wherever committee is yet to be constituted, opinion of 2 medical experts will suffice as recommendation in the interim period), with details of treatment and pricing that is duly negotiated with the provider. This recommendation should have insurance company concurrence, wherever applicable.
- The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, consumables, post-op care and applicable incentive to the hospital

included – preferably citing rates as ceiling from any govt. purchasing scheme like CGHS etc., if available.

- A letter or request from the SHA with approval of competent authority may be sent to CEO – NHA for approval.
- The request letter would be moved on file and the final decision will be taken at the level of the CEO – NHA, as CEO – NHA is the final authority empowered to grant approval.
- Once approved, it will be shared by State Coordinator to the technical team for backend change. The respective state coordinator will request for technical support for backend change of amount via ticket and permission to block the unspecified package ≥ Rs. 1 lakh upto Rs. 5 lakhs.
- The turnaround time for the entire activity shall be 48 hours to ensure that the beneficiary is provided prompt treatment.
- CEO – NHA will place all the approvals in the next Governing Board meeting for information.

Please refer HBP 2.0 user guidelines : Policy document for Unspecified Surgical Package https://pmjay.gov.in/sites/default/files/2020-12/Revised-Policy-US100.pdf[23]

8.5 Portability Cases

A unique feature of portability is available under AB PM-JAY, this means that a beneficiary can get treatment outside his/her home state in any EHCP in a cashless manner. No EHCP can deny services to any eligible beneficiary.

Below mentioned points shall be noted for the portability cases:

1. All empanelled hospitals in the country will use NHA's BIS and TMS applications for catering to portability cases. States may use their own IT system for intrastate transactions.
2. The process of beneficiary identification will have to be completed by the Hospital State. NHA will support integration of State beneficiary database if maintained on a non NHA IT platform.
3. National portability will be permitted on the packages already existing in the National master.
4. The hospital will be paid at the HBP rates agreed to in the MoU/contract entered with the empanel State. In case of hospitals that are directly empanelled with NHA, National master as per HBP 2.0 will be applicable. Subsequent revisions will be intimated to the concerned stakeholders.

[23] Policy document for Unspecified Surgical Package https://pmjay.gov.in/sites/default/files/2020-12/Revised-Policy-US100.pdf

5. All portability cases will require a mandatory pre-auth to be approved by the Home State. The rules related to auto approval due to delay in authorization will be applicable as per the Home State.
6. Package specific documents, as mandated by the Home State shall be required to be submitted by the treating hospital at the time of raising a pre-auth request, as well as at the time of claim submission.
7. Home State specific thresholds with respect to utilization of wallets for secondary, tertiary and unspecified packages, if any, will be applicable. It will be the responsibility of the 'Home State' to check whether these thresholds are being breached at the time of Pre-authorization.

8.5.1 Claims adjudication for portability services

Wallet management of beneficiary will be the responsibility of the 'Home State'

A claim raised by the empaneled hospital through TMS will be received directly by the SHA/Insurer/ISA of the Home State. The Home State IC/Trust shall settle the claim with the hospital within 30 days of receipt of claim along with the required documents.

If a Hospital State has a policy whereby it allocates/deducts certain percentage of approved claim amount payable to their public hospitals and wants it to be applicable for portability cases in their hospitals also, then NHA should be informed to configure the same in the TMS. For this to be implemented, the Hospital state should mandatorily provide a separate bank account for deductions.

Home State shall honor claims raised for the cases wherein the Pre-authorization has been completed either manually or by the system subject to uploading of requisite treatment documents or in case the treatment hospital has been found to be involved in fraudulent practices.

8.5.2 Portability claims payment:

Following scenarios may be applicable in case the scheme implementation is on insurance or mixed mode in the 'Home State'. The scenario 1 is applicable for all the States drafting their Model Tender Document to select an Insurer.

Insurance company will have to carry out due diligence and actuarial analysis based on the existing portability data to account for portability cases and possibility of paying different rates when 'Home State' patients go to other Hospital States to avail services. Quoted premium will account for portability cases and ICs will reimburse the hospitals at the rates applicable in the Hospital State. No separate payment/recovery will be made to or from insurance company on the account of differential rates in other States.

States already implementing the AB PM-JAY scheme in the insurance/mixed mode and currently have no provision in their existing contract with the IC as mentioned in the point f.(i) then, difference in the package rate of the Hospital State with respect to the Home State may be adjusted by the

Insurance company with the SHA of Home State at a mutually agreed interval. However, portability feature should be incorporated as a part of the fresh tender document to select the insurer once the existing arrangement is over and must be accounted for while insurer does the costing exercise as stated in f.(i) above. Such States/UTs may request NHA to make necessary changes in the IT system for calculation of the liability of SHA /Insurance company related to the portability cases.

Example:

Scenario			Maharashtra - Home State			Gujarat - Treatment State		Process
1	MH Patient goes to Gujarat - Home state Package is greater than Treatment State		Maharashtra Package for X Disease.	15000	→	Gujarat Package for X Disease.	12000	IC of MH will pay Guj Hos 12000, IC of MH will pay SHA MH - 3000
2	MH Patient goes to Gujarat - Treatment state Package is greater than home state.		Maharashtra Package for X Disease.	12000	→	Gujarat Package for X Disease.	15000	IC of MH will pay 15000 to Guj Hos, SHA MH will pay - 3000 to IC

Payment in Special Cases 1

Note : New Model Tender Document have also been developed as modular document and once the portability guidelines are revised, they become automatically applicable to Insurer/ISA New Model Tender Document/ Agreements section. [24][25]

8.6 UNBUNDLING OF PROCEDURES

There can be cases where the EHCP registers two different claims for different procedures for the same patient during the 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 a case is available, then the EHCP shall be paid either as per the available combination package or by 100%-50%-25% rule, whichever is lower.

[24] https://pmjay.gov.in/resources/documents [4]

[25] Revised Portability Guideline on June 9th, 2020: https://pmjay.gov.in/sites/default/files/2020-06/AB-ABPM-JAY-Revised-portability-guidelines.pdf [7]

Example:

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

Payment in Special Cases 2

Total amount = 7500+3000 = 10,500

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

8.6.1 Treatment beyond sum insured/ available wallet

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

8.6.2 Payment in case of Mixed 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 payers.[26]

[26] HBP 2.0 user guidelines September 2020 https://pmjay.gov.in/sites/default/files/2020-10/HBP-2-0-User-Guidelines-vFinal.pdf[13]

9 Guidelines for Recoveries and other Actions Post Confirmation of Fraud and other Irregularities[27]

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is being implemented with a zero-tolerance approach towards any kind of fraud, covering entire gamut of activities for prevention, detection, and deterrence of different kinds of fraud that could occur in PM-JAY at different stages of its implementation.

This guideline– "Guidelines for recoveries and other actions post confirmation of fraud and other irregularities" would apply in instances where cases of fraud have been confirmed or other irregularities/misrepresentation of facts has been established on the part of an Empanelled Healthcare Provider (EHCP) under PM-JAY. This guideline should be read in conjunction with provision of other relevant guidelines issued by National Health Authority(NHA) such as Anti-fraud Guidelines, De-empanelment Guidelines, Grievance Redressal Guidelines, Whistle Blower Policy, Claims Adjudication and Claim Settlement Guidelines etc. and other legal recourse/provisions available to State for action against errant entities.

One or more of the following actions may be taken against an errant EHCP which has been found to have committed any irregularity and/or illegality and/or have violated guidelines and/ or terms and conditions of the agreement/MoU/contract:

A. The 'De-empanelment Guidelines' has already been issued by NHA. As per relevant provision of this guideline and the MoU/contract signed between State and empanelled EHCP, process to be followed is outlined, wherein prima facie the EHCP is found to be indulging in malpractices/unethical practices. The key steps are as follows:

[27] Guidelines for Recoveries and other Actions Post Confirmation of Fraud and other Irregularities- https://pmjay.gov.in/sites/default/files/201909/Guidelines%20for%20Actions%20post%20Fraud%20Detecion.pdf

1. **Issuance of 'Show cause' to errant EHCP:** Based on the audit of the EHCP, if the State Health Agency/ Insurance Company believes that there is clear evidence of EHCP indulging in malpractices/unethical practices or does not have adequate infrastructure/specialist manpower or has misrepresented facts for empanelment under the scheme, a show cause-notice shall be issued to the EHCP.

2. **Suspension of EHCP:** For the EHCPs which have been issued show cause notice or if the State Empanelment Committee (SEC) observes at any stage that it has data/ evidence that suggests that the EHCP is involved in any unethical practice or is not adhering to the major clauses of the MoU/contract with the Insurance Company or is involved in financial fraud related to treatment provided under the scheme, it may immediately suspend the EHCP from providing services under the scheme and a formal investigation shall be instituted.

3. **De-empanelment of EHCP:** If the formal investigation conducted confirms that the EHCP is indeed indulging in malpractices, the SEC may de-empanel the provider after following the due process of de-empanelment.

4. **Recovery of amount including penalties from EHCP:** Once it is confirmed that the HCP has been indulging in malpractices/ misrepresentation of facts, recovery of excess amount paid to EHCP for fraudulent claims or illegal collection of money from beneficiaries as well as penalties levied depending on the severity of the offence, as described under De-empanelment Guidelines, shall be made from EHCP.

c. SHA may recover payment made against wrongful claims or penalties imposed or illegal collection of money from beneficiaries for treatment provided under the scheme from errant EHCPs by any of the following means:

1. Adjusting against any amount due to EHCP arising out of unpaid claims

2. Recourse available under MoU/contractual provisions

3. Recovery of the amount due (including penalties) as if it is a sum recoverable as an arrear of land revenue under provisions of the Revenue Recovery Act, 1890 and/or other relevant act(s).

d. Legal and Punitive Action that can be taken against errant EHCP:

1. Suspension of EHCP from PM-JAY scheme
2. De-empanelment of EHCP from PM-JAY scheme
3. Actions like deregistration, cancellation of license of EHCP under provisions and acts of State Govt. or any other relevant act of the Central Govt. such as the Clinical Establishment (Registration and Regulation) Act 2010 etc.

e. Action against Doctors/ Paramedics: The information about errant medical and paramedical professionals found to be indulging in malpractices or unethical practices may be provided to the concerned Council or Professional body requesting for cancellation/suspension of relevant license/ registration.

f. Action under Criminal Law: The criminal case (FIR) may be filed against the concerned under the relevant provisions of the applicable law.

g. No appeal or revision against the order of recovery may be entertained by the competent authority unless minimum 50% of the amount ordered to be recovered is deposited by the EHCP.

These provisions should be included in all the agreements/MoU to be entered into with all EHCPs henceforth. This Guidelines shall also apply to existing MOUs/contracts signed between SHA and empanelled EHCP and may be incorporated by way of an Addendum to the contract w.e.f. date of issuance of the Guidelines.

10 SERVICE PARAMETERS

10.1 UNIFORM TURNAROUND TIME (TAT)

The TAT various components for reminders and timely payments are as follows-

TAT for Private EHCP			
S #	Activities	TAT	Action
1	Pre-Auth initiation after Patient Registration (By EHCP)	48 Hrs. post registration.	Reminder after 24th hours. Auto rejection after 48 hrs. New registration shall be initiated once rejection due to non-initiation Pre-authorizations
2	TAT for Pre-authorization Request	6 Hrs. (as per threshold set in TMS)	Auto approval after 6 hours (working hours)
3	Response on PPD Query (By EHCP)	24 Hrs.	Reminders after 24th hour, 48 hours, Auto reject after 72 hours due to non-submission of PPD Query. The rejected claim can be revoked by SHA on receiving proper justification from EHCP post 72 hours.

4	Claim submission after Discharge (By EHCP)	To submit ASAP but not later than 7 days post discharge, above 7- up to 21 days with SHA's approval above 21 days – up to 45 days with CEO SHA's approval beyond 45 days - not admissible	First auto Reminders would be sent after 1st day & 3rd day and final auto reminder would be sent after 5th day of Discharge. Claim beyond 7 days will move to SHA bucket. For reconsideration up to 21 days, Medco shall raise reconsideration request quoting reasons for delay. Claim beyond 21 days will move to CEO SHA's bucket. For reconsideration up to 45 days, Medco shall raise reconsideration request quoting reasons for delay.
5	Response on CPD Query (By EHCP)	To submit ASAP but not later than 7 days	First Auto reminder after 1st day, 3rd day and Auto reject after 7th day due to non-submission of response to CPD Query. The rejected claim can be revoked by SHA after receiving proper justification from EHCP post 7 days.
6	TAT for Claim payment	15 days within the state and 30 days for inter-state(potability)	No Change. Present practice to continue

TAT 1[28]

Note:

1. Existing contractual liability- In states where existing contractual obligation are not as per Turnaround Times placed above, the SHA may decide the same as per extant contractual clauses.
2. Erroneous Claim -These are the claims where resettlement is requested either by EHCP on partially settled amount or by SHA for excess paid amount / over payment/ wrong payment cases . TAT for erroneous claims will be same as normal claim as above.

[28] O.M. No -s-12017/40/2019-NHA dated 25th May 2020 and revised for Private EHCP and newly developed for Public EHCP dated on 18th September 2020 - https://pmjay.gov.in/sites/default/files/2020-06/OM-Claims-Adjudication-TAT.pdf

TAT for Public EHCP			
S #	**Activities**	**TAT**	**Action**
1	Pre-Auth initiation after Patient Registration (By EHCP)	72 hours post registration.	Reminders after 24 hours and 48 hours. Auto rejection after 72 hours. New registration shall be initiated once rejection due to non-initiation Pre-authorizations
2	TAT for Pre-authorization Request	6 Hrs. (as per threshold set in TMS)	Auto approval after 6 hours (working hours)
3	Response on PPD Query (By EHCP)	To submit ASAP but not later than 5 days	Reminders after 1st day, 3rd day and 4th day. Auto reject after 5 days [29] due to non-submission of PPD Query. The rejected claim can be revoked by SHA on receiving proper justification from EHCP post 5 days.
4	Claim submission after Discharge (By EHCP)	To submit ASAP but not later than 15 days post discharge, above 15th day- up to 30 days with SHA's approval, above 30 days – up to 60 days with CEO SHA's approval Beyond 60 days - not admissible	First auto Reminders would be sent after 5th day and 7th day and final auto reminder would be sent on 12th day of Discharge. Claim beyond 15 days will move to SHA bucket. For reconsideration up to 30 days, Medco shall raise reconsideration request quoting reasons for delay Claim beyond 30 days will move to CEO SHA's bucket. For reconsideration up to 60 days, Medco shall raise reconsideration request quoting reasons for delay.
5	Response on CPD Query (By EHCP)	To submit ASAP but not later than 15 days	First Auto reminder after 5th day, 7th day and 12th day. Auto reject[30] after 15 days due to non-submission of response to CPD Query.

[29] Sample letter – Closure notice Annexure 8
[30] Sample letter – Closure notice Annexure 8

			The rejected claim can be revoked by SHA after receiving proper justification from EHCP post 15 days.
6	TAT for Claim payment	15 days within the state and 30 days for inter-state(potability)	No Change. Present practice to continue.

TAT 2[31]

Note:

1. Existing contractual liability- In states where existing contractual obligation are not as per Turnaround Times placed above, the SHA may decide the same as per extant contractual clauses.
2. Erroneous Claim -These are the claims where resettlement is requested either by EHCP on partially settled amount or by SHA for excess paid amount / over payment/ wrong payment cases . TAT for erroneous claims will be same as normal claim as above.

In case of claims processing, TAT will be determined as days during which claim is with IC/ISA (Excluding the days claim is pending at EHCPs end)

Example 1:

The day EHCP raises claim will be treated as Day 1,
If IC/ISA raises query on Day 4, and EHCP complies with query on Day 10,
IC/ISA takes action (accepting or rejection of claim) on Day 12,
Payment on Day 15,
In this case (4-1=3) days + (15-10=5) days, hence TAT determined is 3+5=8 days

Example 2:

The day EHCP raises claim will be treated as Day 1
If IC/ISA raises query on Day 4, and EHCP complies with query on Day 10,
IC/ISA raises another query on Day 11,
EHCP complies with the second query on Day 14,
EHCP accepts approves the claim on Day 16,
Payment on Day 17
In this case (4-1=3) days + (11-10=1) days+ (17-14=3) days, hence TAT determined is 3+1+3=7 days.
Note- New Model Tender Document/ Agreements section[32]

[31] O.M. No -s-12017/40/2019-NHA dated 25th May 2020 and revised for Private EHCP and newly developed for Public EHCP dated on 18th September 2020

[32] New Model Tender Document/ Agreements section https://pmjay.gov.in/resources/documents [4]

10.2 KEY PERFORMANCE INDICATORS

State may revise/reduce/change/add KPIs. These KPIs have been prepared by NHA and state have flexibility to revise the same

10.2.1 Performance KPI

SN	KPIs	Timeline	Baseline KPI Measure	Penalty
1.	Pre-authorization	Action within 6 * hours: of raising preauthorization request (all auto approvals beyond 6 hours will be considered non-compliance)	95% Compliance	Compliance from compliance below 95% up to 90% then penalty of 5% of the monthly total delayed preauthorization amount Compliance below 90% up to 85% then penalty of 10% of the monthly total delayed preauthorization amount Compliance below 85% then penalty of 20% of the monthly total delayed preauthorization amount with one instance of triggering of SPD** (for calculation, monthly delayed preauthorization amount shall be the amount for delayed Pre-authorizations for the admissions in that month. Penalty shall be calculated on this amount and Insurer shall pay the penalty as per Penalty Notice per quarter, please see Clause 23.5) Example: if the IC/ISA handled 100 preauthorization in the month and failed to meet TAT for 16 cases, 20% preauthorization amount of only these 16 cases will be charged

				as penalty. Even if the preauthorization is rejected, not meeting the TAT will invite the penalty
			100% compliance	In case of wrongful Pre-authorization approval, penalty of three times over & above the preauthorization amount
2.	Scrutiny, Claim processing and payment of the claims	Action within 15 days of claim submission for claims within state and 30 days & for claims from outside state (Portability cases). (This is applicable if the Insurer fails to make the Claims Payment within a Turn-around Time of 15 days/30 days for a reason other than delay on the part of SHA, if any)	100% Compliance	If the Insurer fails to make the Claim Payment within Turn Around Time (TAT)***, then the Insurer shall be liable to pay a penal interest to the EHCP at the rate of 0.1% for each claim amount for every day of delay or the part thereof on every delayed claim. If the compliance in the month falls below 85% of number claims, it will be treated as one instance of SPD trigger Example: if the IC/ISA processed 100 claims in the month and failed to meet TAT for 16 claims, it will be liable to pay penalty of 0.1% for each claim per day of these 16 claims to EHCPs. It will also be treated as one instance of triggering of SPD
			100% Compliance	In case any claim is adjudicated wrongly then penalty of three times over and above the claim amount

Performance KPI 1

10.2.2 Audit related KPI

SN	KPIs	Sample	Baseline KPI Measure	Penalty
1.	Preauthorization Audits	5% of total preauthorization's across disease specialities per quarter	100% compliance	Rs. 50,000 per missing audit report per quarter If IC/ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
2.	Claims Audit (Approved Claims)	5% of total claims of the quarter	100% compliance	Rs. 50,000 per missing audit report per quarter If IC/ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
3.	Medical Audits	5% of total hospitalization cases per quarter	100% compliance	Rs. 50,000 per missing audit report per quarter If IC/ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
4.	Death Audits	100%	100% compliance	Rs. 50,000 Per missing death audit report per quarter If IC/ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers

5	Beneficiary audit (during hospitalization)	2% of total hospitalized beneficiaries in that quarter	100% compliance	Rs. 50,000 per missing beneficiary (on phone) audit report If IC/ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
6.	Beneficiary Audit-On Phone	5% of total hospitalized beneficiaries in that quarter	100% compliance	Rs. 50,000 per missing beneficiary (on phone) audit report If IC/ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
7.	Beneficiary Audit-Home Visit	1% of total hospitalized beneficiaries in that quarter	100% compliance	Per 50,000 per missing beneficiary (on phone) audit report If IC/ISA fails to submit audit report in reporting quarter, then it will be considered as one instances of SPD triggers
While conducting the audit, IC/ISA shall ensure not more than 20% of sample size of overlapping of beneficiaries across audits except SN. 4. Sample size shall be equally distributed across all the districts in the state and ensuring coverage of all suspect entities For the purpose of computing above audit percentages, cases from public hospitals shall be excluded. SHA may give directions regarding inclusion of cases from public hospitals for the audits. If submitted audit report does not mention required sample size or details, it will be treated as non-submission of audit report Audit reports shall contain details as required in Anti-Fraud Guidelines published by NHA Insurer shall ensure audits to be conducted as prescribed by Anti-Fraud Guidelines, however penalty is only applicable on above audit reports				

Audit related KPI 1

Note: - Kindly refer to the signed contract between SHA and ISA/Insurer/TPA. [33]

[33] Kindly refer to the signed contract between SHA and ISA/Insurer/TPA.

10.2.3 Productivity KPIs

Productivity* KPIs for Key Staff by IC				
SN	**Designation**	**Benchmark**	**Location**	**Brief Roles and Responsibilities**
1	**PPD**	100-120 Pre-authorization request per person per day	SPO/Central Office of IC *(Instructions to the state: state shall decide about location of the processor)*	• Approve/assign/reject pre-auth request • Raise query/send for clarification to hosp. • Trigger investigation
2	**CEX**	100-120 claims processing per person per day	SPO/Central Office of IC *(Instructions to the state: state shall decide about location of the processor)*	• Verification on non-technical documents, reports, dates verification • Forward case to CPD for processing with inputs
3	**CPD**	70-100 claims per person per day	SPO/Central Office of IC *(Instructions to the state: state shall decide about location of the processor)*	• Verification of technical information e.g. Diagnosis, clinical treatment, notes, evidences, etc. • Approve/assign/reject a claim • Raise query/as for clarification • Trigger investigation
• * IC shall make the staff available as detailed in Schedule: 16, however productivity KPIs will be applicable on above staff on given parameters. • IC shall ensure that preauthorization and claim approval and rejection shall be approved by an MBBS doctor				

Productivity KPI 1[34][35]

[34] Model Tender Document -ISA- schedules- 0304 as per Schedule-12 and 16 https://pmjay.gov.in/sites/default/files/2020-05/3-MTD-ISA-Schedules-0304.pdf [8]

[35] Impact Portal for dashboards- Query, Rejection and User productivity. https://impact.pmjay.gov.in/Impact/loginnew.htm

10.2.4 Minimum Manpower Requirements

(instructions to the state: please make changes in this schedule as per specific requirement)

The Insurer shall ensure that it shall always during the Tenure of the Contract, maintain at a minimum, the following number of Personnel having, at a minimum, the prescribed qualifications and experience:

SN	Designation	Number	Location	Minimum Qualification and experience (*instructions to the state to specify)*	Brief Roles and Responsibilities
1	**PPD**	100-120 Pre-authorization request per day per person	SPO of IC/Centrally located	•	• Approve/assign/reject pre-auth request • Raise query/send for clarification to hosp. • Trigger investigation
2	**CEX**	100-120 per claims processing per person	SPO of IC/Centrally located	•	• Verification on non-technical documents, reports, dates verification • Forward case to CPD for processing with inputs
3	**CPD**	70-100 claims per person per day	SPO of IC/Centrally located	•	• Verification of technical information e.g. Diagnosis, clinical treatment, notes, evidences, etc. • Approve/assign/reject a claim • Raise query/as for clarification • Trigger investigation
4	**Fulltime medical Auditors**	1 per cluster	1 each district/cluster as per need	•	• Coordinate and conduct required periodical audit • Finalize and submit audit report for the district/cluster to the

					state headquarter for finalization of state wise periodical audit
5	**Empaneled medical auditors**	As per requirement *(Instruction to state: No need to be on payroll but can be ad hoc staff)*	NA	•	• Support conducting medical audits
6	**Empaneled Hospital Auditors**	As per requirement *(Instruction to state: No need to be on payroll but can be ad hoc staff)*	NA	•	• Support conducting hospital audits

Minimum Manpower Requirements [36]

Note- Minimum Qualification and experience (*instructions to the state to specify)-* Qualifications to be decided by state therefore empty.

10.3 Recoveries from ISA & IC

KPI related to claims adjudication are as defined above in 10.23[37]

Process for recoveries[38] related to penalties is as follows:

a. Performance shall be measured as per timeline and threshold provided.
b. Indicator performance results shall be reviewed in the quarterly review meetings and reasons for variances, if any, shall be presented by the Insurer / ISA.

[36] Model Tender Document -ISA- schedules- 0304 as per **Schedule-16** : https://pmjay.gov.in/sites/default/files/2020-05/3-MTD-ISA-Schedules-0304.pdf[8]

[37] 3 MTD-Insurer-Schedules schedule12, Model Tender Document -ISA- schedules- 0304 as per **Schedule-12** : https://pmjay.gov.in/sites/default/files/2020-05/3-MTD-ISA-Schedules-0304.pdf[8]

[38] 2-Insurer-Contract-MTD

c. Insurers /ISA shall pay SHA all penalties imposed by the SHA in line with KPIs mentioned in [39]Schedule 12 of on the Insurer /ISA within 15 days of receipt Penalty Notice from SHA. SHA shall ensure that Penalty Notice contains all the details regarding penalties being imposed
d. Penalty Notice shall be shared with Insurers /ISA in each quarter and calculation of penalties shall be as detailed in Schedule 12.
e. If the Insurer/ ISA wishes to contest the penalty levied by SHA, it may represent to the SHA along with necessary documentary proof within 7 days of receipt of the notice.
f. SHA may examine the evidence and facts and arrive at final penalty amount/decision and shall convey the same to Insurer/ ISA within 7 days.
g. Failure to pay penalty within the timeline will invite penal interest on the penalties as specified in Schedule 12.D.
h. If the Insurer fails to pay Penalty within 90-day period and/ or the default interest thereon, the SHA shall be entitled to recover such amount along with applicable interest, if any, as a debt due from the Insurer. Please refer to Clause 41 for details regarding Dispute Resolution
i. Also, based on the review of Insurer /ISA, the SHA shall have the right to issue rectification orders demanding the performance to be brought up to the levels desired as per the AB-PMJAY Guidelines.
j. In the event of delay due to IT system downtime, KPI penalties shall not be applicable
k. Along with monitoring of KPIs, SHA may issue rectification orders to Insurer / ISA. All such rectifications shall be undertaken by the Insurer /ISA within 30 days of the date of issue of such Rectification Order unless stated otherwise in such Order(s).
l. At the end of the rectification period, the Insurer /ISA shall submit an Action Taken Report with evidences of rectifications done to the SHA.
m. If the SHA is not satisfied with the Action Taken Report, it shall call for a follow up meeting with the Insurer/ISA and shall have the right to take appropriate actions within the overall provisions of the Insurance Contract between the SHA and the Insurer.
n. SHA as policy holder can also approach to IRDAI for necessary action in case the Insurer persistently fails to meet contractual obligations. Such instances of default may related to - as not meeting baseline KPIs, not paying penalties in timely manner or fail to return premium etc.

[39] 3 MTD-Insurer-Schedules-030620

11 ANNEXURE

11.1 ANNEXURE 1 EXCLUSIONS TO THE POLICY/SCHEME[40]

Ayushman Bharat PM-JAY shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

1. Condition that does not require hospitalization and can be treated under Out Patient Care except those expenses covered under pre and post hospitalization 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.
2. Any dental treatment or surgery which is corrective, prosthetic, cosmetic procedure, filling of tooth cavity, root canal including wear and tear of teeth, periodontal diseases, dental implants etc. are excluded. Exception to the above would be treatment needs arising from trauma / injury, neoplasia / tumour / cyst requiring hospitalization for bone treatment.
3. Any assisted reproductive techniques, or infertility related procedures, unless featuring in the National Health Benefit Package list.
4. Vaccination and immunization
5. Surgeries related to ageing face & body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc.
6. Circumcision for children less than 2 years of age shall be excluded (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident)
7. Persistent Vegetative State: a condition in which a medical patient is completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function, being kept alive only by medical intervention.

We request to also refer State specific terms and conditions for exclusions.

[40] Please refer HBP 2.0 user guidelines September 2020 https://pmjay.gov.in/sites/default/files/2020-10/HBP-2-0-User-Guidelines-vFinal.pdf[13]

11.2 Annexure 2 Template – OT notes, Clinical Notes and Clinical Photo

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

- Date/ time of beginning surgery/ procedure and completion of the surgery
- Name of surgeon
- Name of Anesthetist
- Type of Anesthesia
- 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 same treatment (CST)” should not be acceptable.

Clinical Photographs

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

11.3 Annexure 3 - Format of Discharge summary

Hospital Name	Hospital code
Hospital Address	Hospital District
Patient Name	PMJAY ID
Patient Address	Age
	Sex
	Patient contact number
IPD number (free text)	
PMJAY case Id	
Package booked	
Treating Consultant's name	
Treating Consultant's contact number	
Treating Consultant's Qualification	
Registration number	
Treating Consultant's Specialty	
Date of Admission with time	
Date of Discharge with time	
Date of Operation (if surgical package)	
Presenting complaints with duration*	
Initial assessment (Text)	
Significant Past Medical and Surgical History, if any.	
Primary Diagnosis at the time of Admission	
Final Diagnosis at the time of Discharge*	
ICD – 10 code(s) for Final diagnosis	

Key investigations
Investigation findings (Text)
Treatment given during hospitalization*
Operative Findings (Only for surgical cases) *
Complications if any*
Status at the time of discharge*
Next follow-up date (calendar, dd/mm/yyyy)
Advice on discharge* (free text)
Name & Signature of treating Consultant / Authorized Team Doctor*:
Name & Signature of treating PMAM*:
Name & Signature/thumb impression of Patient / Attendant*

11.4 Annexure 4- 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 an indication for THR?	Yes/ No
Clinical photograph of hip confirms diagnosis?	Yes/ No
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 an indication for THR?	Yes/ No
Clinical photograph of hip confirms diagnosis?	Yes/ No
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 an indication for THR?	Yes/ No
Clinical photograph of hip confirms diagnosis?	Yes/ No
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 an indication for THR?	Yes/ No
Clinical photograph of hip confirms diagnosis?	Yes/ No

11.5 Annexure 5 - Actionable for CEX and CPD

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 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 the same? If No is there sufficient evidences to confirm the changed diagnosis?	Yes/No
Is the correct package blocked?	Yes/No
Is the date and time of the 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 the 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 an indication for THR?	Yes/No
Do the OT notes detail steps of surgery?	Yes/No
Do the OT notes specify the 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 the package for which admitted?	Yes/No
Was the treatment rationale and enough for the patient's clinical condition?	Yes/No

11.6 Annexure 6- Claims Adjudication Audit Report[41]

11.6.1 Template for Claims adjudication Audit

Case ID	Hospital Name	Package name	Package Cost	Date of Admission	Date of Discharge	Types of findings	Comments

11.6.2 Claims adjudication audit reporting format

Name of the IC/ISA/TPA	
Month and year of Audit	

[41] Please refer - Model Tender Document -ISA- schedules- 0304 as per Schedules - 19 https://pmjay.gov.in/sites/default/files/2020-05/3-MTD-ISA-Schedules-0304.pdf[8]

Total number of claims audited		
Total number of errors found during audit	Financial	Non-financial
No of Hospitals found suspected during audit		
Action plan against suspected hospitals		
Major type of errors found during audit		
Executive summary of audit		

11.7 Annexure 7 : Sample letter – Rejection Letter

Rejection Letter

To

<Hospital Name,

<Hospital Address>

Subject - <Claim>/<Pre-Auth> rejection for <case id > of <Patient name > with AB PMJAY <Card number – PMJAY ID>

Dear Sir/Madam

Patient Name		Date of Admission	
AB PM-JAY ID		Date of Discharge (If applicable)	
Package(s) blocked		Claim/ Preauth amount	
Date of Rejection			

The above <Claim>/<Pre-Auth> has been scrutinised based on the documents submitted and has been rejected due to:

<Reason 1> < Final level Rejection reason from the rejection reason drop down list > <Text captured in remarks column at PPD and CPD level >

<Reason 2> < Final level Rejection reason from the rejection reason drop down list > <Text captured in remarks column at PPD and CPD level >

<Reason 3> ….

Note-

In case of dispute, the EHCP can raise the issue as per Grievance redressal guideline within 15 days of rejection of claim.

This is a computer-generated letter and does not require signature.

11.8 ANNEXURE 8: SYSTEM GENERATED SAMPLE EMAIL– CLOSURE NOTICE

Closure Notice

To Date___/____/___ (DD/MM/YY)

<Hospital Name,

<Hospital Address>

Subject - <Claim>/<Pre-Auth> closure for <case id > of <Patient name > with AB PMJAY <Card number – PMJAY ID>

Dear Sir/Madam

Patient Name		Date of Admission	
AB PM-JAY ID		Date of Discharge (If applicable)	
Package(s) blocked		<Claim>/< Preauth approved amount>	
Date of closure			

The above <Claim>/<Pre-Auth> has been closed due to non-submission of the following documents:

<Reason 1> < Final level query reason from the drop-down list > and <Text captured in remarks column by PPD and CPD

<Reason 2> < Final level query reason from the drop-down list > and <Text captured in remarks column by PPD and CPD

Note-

In case of dispute, the EHCP can raise the issue as per Grievance redressal guideline within 15 days of closure of claim.

This is a computer-generated letter and does not require signature.

12 Reference Documents links

1) About PM-JAY Coverage, Implementation, Hospital empanelment, Packages and rates - https://pmjay.gov.in/about/pmjay
2) Journey from HBP 1.0 to HBP 2.0 https://pmjay.gov.in/sites/default/files/2020-01/Journey-from-HBP-1.0-to-HBP-2.0.pdf
3) Field Investigation and Medical Audit Manual https://pmjay.gov.in/sites/default/files/2020-04/Field%20Investigation%20and%20Medical%20Audit%20Manual_April-2020.pdf
4) New Model Tender Document/ Agreements section https://pmjay.gov.in/resources/documents
5) In Health Benefit Package section - Standard Treatment Guidelines https://pmjay.gov.in/resources/documents
6) TMS Change release https://support.pmjay.gov.in/file.php?key=oxblz8k7fdjjiucb6xwfi3qkxaipqlgi&expires=1600473600&signature=6e5734954fefe0c947272e86815c7a5f8ff721a3&id=62711
7) Guidelines for Special case https://pmjay.gov.in/sites/default/files/2020-05/NHA-Guidelines-for-Special-Cases-vFinal.pdf
8) Revised Portability Guideline on June 9th, 2020 https://pmjay.gov.in/sites/default/files/2020-06/AB-PM-JAY-Revised-portability-guidelines.pdf
9) Guidelines for Payment for Special Cases During Hospital Admission May 2020 https://pmjay.gov.in/sites/default/files/2020-05/NHA-Guidelines-for-Special-Cases-vFinal.pdf
10) Model Tender Document -ISA- schedules- 0304 as per Schedule 12 https://pmjay.gov.in/sites/default/files/2020-05/3-MTD-ISA-Schedules-0304.pdf
11) Grievance Redressal Guidelines https://pmjay.gov.in/sites/default/files/2020-03/Revised%20Grievance%20Redressal-February%202020.pdf
12) HBP 2.0 FAQ https://pmjay.gov.in/sites/default/files/201912/FAQ%20for%20website.pdf
13) Public EHCP incentives details: https://pmjay.gov.in/sites/default/files/2020-05/Guidelines-for-use-of-claim-amount-earned-by-Public-Hospitals-under-AB-PM-JAY-vFinal.pdf

14) Quality certification process for more details https://www.pmjay.gov.in/sites/default/files/201909/Quality%20Certification%20Process%20Guidebook.pdf
15) Guidelines for Recoveries and other Actions Post Confirmation of Fraud and other Irregularities- https://pmjay.gov.in/sites/default/files/201909/Guidelines%20for%20Actions%20post%20Fraud%20Detecion.pdf
16) Grievance Redressal Strategy – https://pmjay.gov.in/sites/default/files/2020-10/Grievance_Redressal_Strategy.pdf
17) Policy document for Unspecified Surgical Package https://pmjay.gov.in/sites/default/files/2020-12/Revised-Policy-US100.pdf

***Note**- Please refer PM-JAY website for the updated information.*