

FIELD INVESTIGATION AND MEDICAL AUDIT MANUAL

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

**NATIONAL HEALTH AUTHORITY
April 2020**



FOREWORD

National Health Authority
Ministry of Health and Family Welfare Government of India



Ayushman Bharat – Pradhan Mantri Jan Arogya Yojana (PM-JAY) endeavours to offer secondary and tertiary health coverage of Rs 5,00,000 to more than 10 crore beneficiary families, accounting for more than 40 percent of India’s population at empanelled hospitals. This unprecedented effort of the Government of India is likely to have a significant positive impact on the poor and vulnerable population’s access to high quality healthcare.

Global experience shows that integrity violations in health insurance programs are high. Fraud in such programs not only results in financial losses but have a much greater impact on people’s health. The ultimate responsibility to effectively detect, prevent, and deter fraud lies with the State Health Agencies (SHA). Strong anti-fraud efforts are important not only from the perspective of reducing the adverse impact on scheme finances and for safeguarding beneficiary health but also to mitigate any reputational risk faced by the SHA, state and the scheme resulting from fraud. Hence, SHA’s anti-fraud efforts are key for ensuring effective implementation of PM-JAY and it is critical that a “zero tolerance” approach to fraud be internalized and permeate all aspects of management of the scheme.

With this spirit, the National Health Authority has previously developed Anti-Fraud Guidelines, released by Hon’ble Health Minister on 29th August 2018 laying down the overall vision and roadmap for combating fraud and abuse that could be perpetrated under PM-JAY. To bring uniformity and consistency in antifraud actions and build capacity in SHAs, NHA is proud to share the updated version of the Field Investigation and Medical Audit Manual for PM-JAY. We sincerely hope that state governments participating in PM-JAY will find this updated manual helpful in the management of anti-fraud activities in their respective States.

Dr. Indu Bhushan
Chief Executive Officer
National Health Authority

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A. Fraud and Abuse Control under PM-JAY

The main objective of PM-JAY is to provide the poor and vulnerable population of the country with free quality healthcare services in public and private hospitals. The success of PM-JAY assumes the smooth and effective coordination between different stakeholders to provide quality secondary and tertiary care to the poorest of the poor and vulnerable population (as identified by Socio-Economic Caste Census data 2011) at no cost to them. This also exposes a risk of leakages in the form of fraud and abuse practices at each level.

Fraud under the PM-JAY shall mean and include any intentional deception, manipulation of facts and/or documents or misrepresentation made by a person or organization with the knowledge that the deception could result in unauthorized financial or other benefit to herself/himself or some other person or organization. It includes any act that may constitute fraud under any applicable law in India.

PM-JAY is governed based on a zero-tolerance approach to any kind of fraud and aims at developing an anti-fraud culture that permeates all aspects of the scheme's governance. The approach to anti-fraud efforts shall be based on five founding principles: Transparency, Accountability, Responsibility, Independence, and Reasonability.

The NHA has taken several steps to ensure detection, prevention, deterrence and spreading awareness of fraudulent practices at all levels. These include development of the Anti-Fraud Guidelines, setting up a robust IT system with a proactive and effective fraud control and detection capability and conducting anti-fraud capacity building trainings for State Health Agencies (SHA). The success of these initiatives is dependent on the effectiveness and robustness of the investigation and audit mechanism at the SHA level to investigate fraud, carry out audits and necessary action once the suspect cases are flagged by anti-fraud triggers or by processing teams.

Table 1: Fraud Management approaches at different stages of implementation

Fraud management approaches	Stages of implementation
Prevention	a) Beneficiary identification and verification b) Provider empanelment c) Pre-authorisation
Detection	d) Claims management e) Data analytics f) Field and Medical Audits
Deterrence and Recoveries	g) Contract management h) Enforcement of contractual provisions i) Stringent actions against the offenders

B. Objective of the Manual

This Field Investigation and Medical Audit manual has been developed by NHA to assist SHAs in developing and implementing a robust and consistent fraud investigation and medical audit system to detect, prevent, deter any fraud losses under PM-JAY in different stages – from beneficiary identification to Pre-authorization/Claims submission and payment. All agencies involved in PMJAY implementation must adopt standard practices, formats for data capture and integration with core Transaction Management System to help in meaningful reporting and analysis. The SHAs are also required to submit monthly reports on anti-fraud measures with results achieved thereof.

C. Minimum Requirements for Audit and Investigations

The Anti-Fraud Guidelines developed by NHA specifies the minimum samples for audits to be conducted under AB-PMJAY. The same are outlined in Table 2 below:

SI 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 actually 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
5	Pre-authorisation Adjudication Audit	5% of total pre-authorisations 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
6	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
7	Claims Audit (rejected claims)	-	100%	Verify if the rejection of the preauths/ claims is justified and the reason thereof	SHA Operations

* Note: 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.

This manual deals with Medical Audit, Beneficiary audit, and Mortality Audit which fall under the purview of field investigation and medical audit. Hospital Audit deals with hospital quality audits by the Hospital Network and Quality Assurance team. Tele Audit (Beneficiary feedback), Pre-authorisation Adjudication Audit, Claims Adjudication Audit and Rejected Claims Audit are related to adjudication process audit and are detailed in Adjudication Manual and conducted by Operations team.

D. Process Flow and Standard Formats

The following sections provide an overview of medical audit and field investigation processes along with relevant formats for each. As per provisions of Anti-fraud Guidelines, SHAs are required to recruit trained manpower for investigation and medical audit, or utilize services of specialized external agencies for carrying out investigation and audits. The standard processes and formats apply to all agencies carrying out the task of investigation and audits under PMJAY. SHAs may, however, include additional checks, provisions, data capture and analysis as required for their particular State without diluting the provisions laid down under this manual.

1. Medical Audit

A medical audit is a systematic review of an episode of medical care. This involves a step-by-step analysis of the medical procedure performed by a provider against the explicit criteria of necessity, quality of care and cost. It also includes verification of associated clinical notes, diagnostics, and documentation to validate if:

- Was the procedure actually carried out?
- If carried out, was it medically justified or necessary?
- Could the case have been treated more conservatively?
- Does the hospital have necessary infrastructure, facilities and manpower including specialists for carrying out said procedure?

1.1. Types of medical audit:

a) Desk Medical Audit

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

b) Field Medical Audit

i. 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.

ii. 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. These are the audits referred to in S.No 2 of Table 2. For Medical Audit Format refer to Annexure 2.2

1.2. Medical Audit can be done at the time of

a) Pre-authorization

During this stage, the empanelled health care provider raises a pre-authorization request specifying the patient symptoms, diagnosis and procedure to be done for approval. The PPD reviews the case and may choose to request additional documents or conduct a medical audit (primarily desk medical audit) as needed. Fraud triggers may also flag the pre-auth request as 'suspicious' if it meets certain pre-defined criteria. After reviewing the documents submitted by the hospital, PPD or SAFU may either approve, deny, raise a query or refer the case for field investigation.

b) Before the beneficiary is discharged

During hospitalization stage, fraud triggered cases or the cases flagged by PPD are sent for medical audit. If fraud is confirmed before the discharge, then case is sent for action/denial of pre-authorization and if confirmed as non-fraud, the case is processed on merits as in normal course.

c) After the beneficiary is discharged

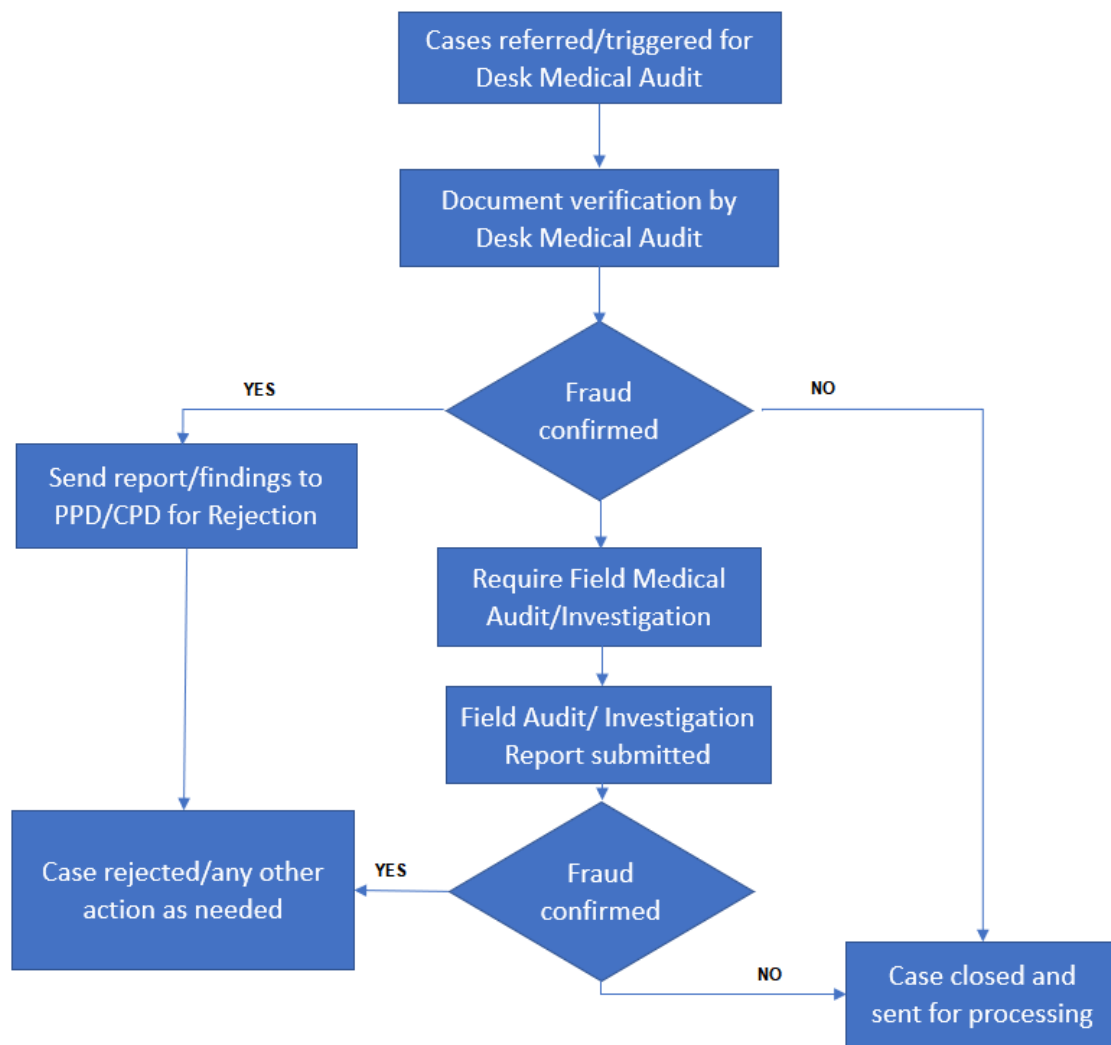
In case of post-discharge or at the time of claim adjudication/ payment of the claim, the fraud triggers highlight certain cases as "suspect" these would need medical audit. Desk medical audit in these cases would be done by SHA/Insurance Company/ ISA for prima-facie/ fact verification to ensure that any apparent false positives are filtered out. If the case remains suspect post first level scrutiny, then the case will be sent for field investigation or field medical audit depending on the nature of fraud trigger and the evidence needed for verification.

Non-Medical individuals may also undertake field investigations in cases which do not require specialised medical knowledge such as cases where one needs to ascertain the identity of the beneficiary or if the treatment actually happened or to collect any additional documentation from the hospital and capture general observations around the hospital and provide the inputs for further confirmation of fraud. A field investigation may be done instead of raising a query to the hospital so that the hospital does not fabricate or manipulate the existing documents. Refer Annexure 3 for field investigation format to be used.

1.3. Process Flow of Desk Medical Audit

The medical auditor verifies case related documents (prescription, clinical notes, investigation reports, discharges summary, etc.) submitted/uploaded by the hospital at the time of pre-auth request or claim submission, with a purpose to ascertain the necessity of treatment and authenticity of claim. Refer Annexure 1.1 Desk Medical Audit Checklist

This audit is primarily based on the scrutiny of medical documents submitted by the hospital. Source of desk medical audit can be any suspicious case basis fraud triggers in the system, inputs received from the field, local intelligence, media, call centre etc. Desk medical auditor may further send the case for field medical audit or field investigations. The cases audited shall be submitted in a format laid out in Annexure 1.2.



1.4. Process Flow of Field Medical Audit

In case any aberration is identified during the desk audit, the case is referred for a Field Medical Audit. The team verifies the detailed case notes related to the triggered claim(s) and the hospital infrastructure and human resource. The details provided by the hospital at the time of empanelment are compared with the actual available functioning facilities. The facts noted at the time of visit are noted in fact sheet (Annexure 2.1) in consensus with the hospital representative. In addition, observations and case specific details are noted in medical audit form (Annexure 2.2).

1.4.1. Pre-Audit Planning & Preparation:

a) Identification of Suspect Cases

The State Anti-Fraud Unit (SAFU) analyses the data to identify out-of-pattern cases and outlier hospitals. The State Anti-Fraud Unit (SAFU) should review the suspect cases and the documents uploaded by the hospitals to determine medical necessity for the procedure and any other Information from any other source.

b) Medical auditor should ensure collection of information from the below mentioned sources

i. Findings from data analytics team / RADAR and other tools

- Utilization trend
- Suspicious cases / entity
- Specialties being used
- ICU/HDU package utilization

ii. Findings from desk audit

iii. Grievance related to selected hospitals from the Grievance redressal team (Money charging /denial of services/other issues)

iv. Findings from operations team (related to frequent forced approvals, high number of rejections, high number of non-submitted claims, high number of cancelled pre-auths or any other trend)

v. Addresses and Phone numbers of suspect beneficiaries

vi. HEM details regarding the facilities declared at the time of empanelment

vii. List of Ayushman Bharat beneficiary shown as admitted in the system

viii. Any other aberration noted.

c) Assemble a multidisciplinary team to conduct the medical audit, being sure to avoid conflict of interest. Define team roles and audit objectives.

d) Set the date and decide whether the field medical audit will be announced or unannounced. The field medical audit should preferably be unannounced to get the true picture on field.

e) The team shall carry printouts of Fact sheet template (Annexure 2.1) and audit forms (Annexure2.2)

1.4.2. Execution of Field Medical Audit

a) Medical Infrastructure

Overall hospital infrastructure is checked for availability of requisite facilities for carrying out the procedure booked by the hospital. It is to be noted that this is not a detailed hospital quality audit which will be conducted by the Hospital Quality Team.

b) Human Resource

Availability of minimum required, and case relevant medical personnel is checked for carrying out the procedure booked by the hospital.

c) Medical Documentation

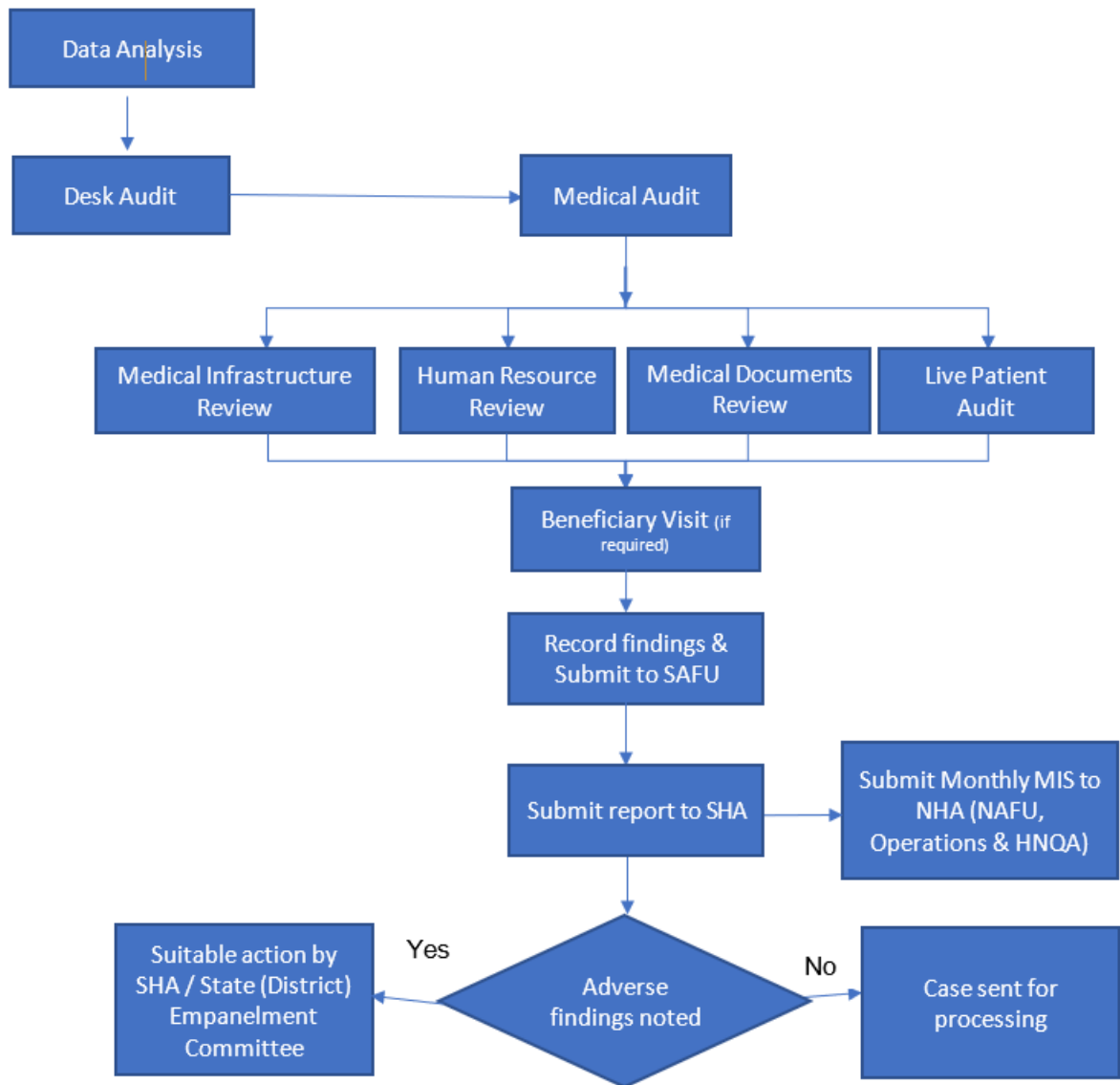
Record keeping and case relevant documents are checked for completeness and consistency. It needs to be checked if the documents are in corroboration with package booked. The auditing doctor either reviews the documents or takes a copy of documents to be reviewed later.

d) Live Medical Audit

Live audit of the patients admitted in the hospital at the time of visit is done. The beneficiary is checked for their presenting and current complaints. The same are compared with the recorded complaints, package booked, and treatment being given. The beneficiary is also asked if any money was charged by the hospital.

e) Beneficiary Audit (Home Visit)

If the patient is already discharged and if required, then the team performs a home visit and interacts with the patient and their attendants to collect relevant details. If needed evidence corroboration with other hospital if partial treatment is taken and also diagnostic centre visit for any discrepancies found regarding investigations are done. This should be recorded as per Annexure 4



1.4.3. Reporting of Medical Audit Findings:

- The findings of medical audit/field investigation are compiled in a logical sequence and shall be submitted to the respective SHAs within 7 days of visit in the format as attached in Annexure 2.3.
- The observation shall be factually correct and shall be submitted with supporting evidences.
- Along with the report, signed acknowledgement from the hospital in-charges shall also be submitted.
- The auditing doctor shall ensure that suitable action is taken on the findings reported.
- The report will also be shared with the operations and Quality team for further action.

2. Mortality Audit

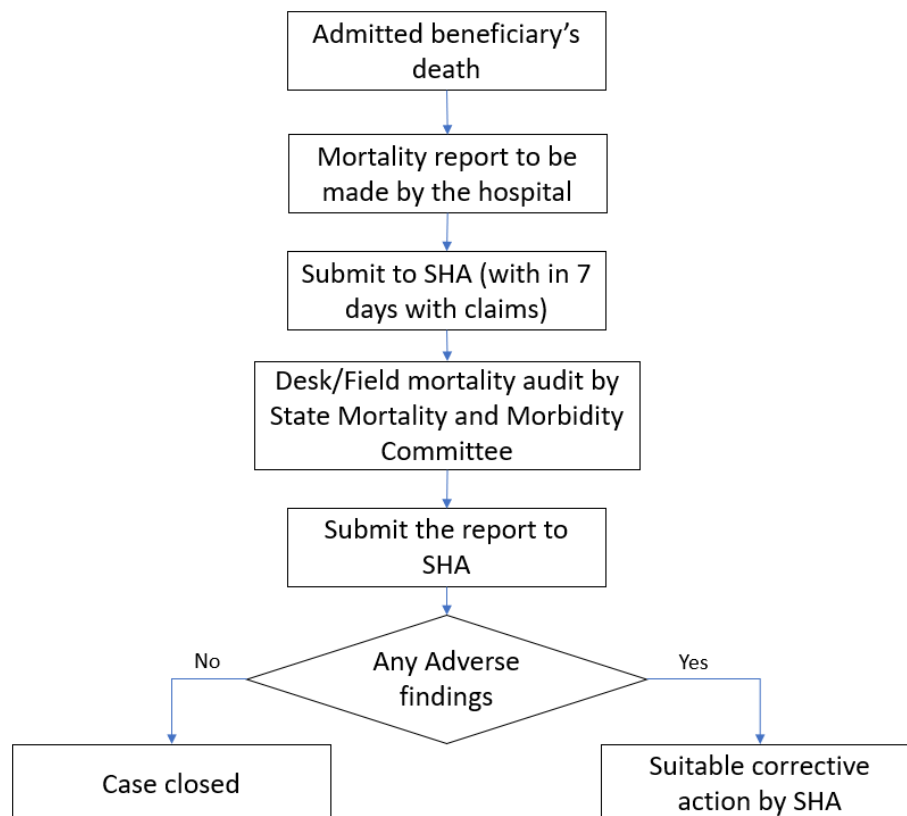
As per Guidelines, 100% of the mortality cases should be audited. The hospitals is required to provide all the relevant information as specified in Annexure 5.1 and the same would be reviewed and verified by State Mortality and Morbidity Committee (setup under SHA) . Based on the review gaps would be identified and necessary actions would be taken to improve patient safety and quality of care. (Annexure 5.2).

Primary objective of mortality audit is to

- Eliminating preventable medical mistakes,
- Guarding against the impact of human error and
- Establishing systems to safeguard beneficiary's health and well-being.

2.1. Process flow for Mortality Audit

Every death occurring in the Empanelled Health Care Provider (EHCP) should have a mortality report prepared by the hospital. Each EHCP should submit a mortality report to SHA at the time of claims submission within 7 days (Refer Annexure 5.1 for Mortality Report). State Mortality and Morbidity Committee to conduct desk/ field mortality audit of all mortality cases (Refer Annexure 5.2 for Mortality Audit Report).



3. Beneficiary audit (BIS Investigation)

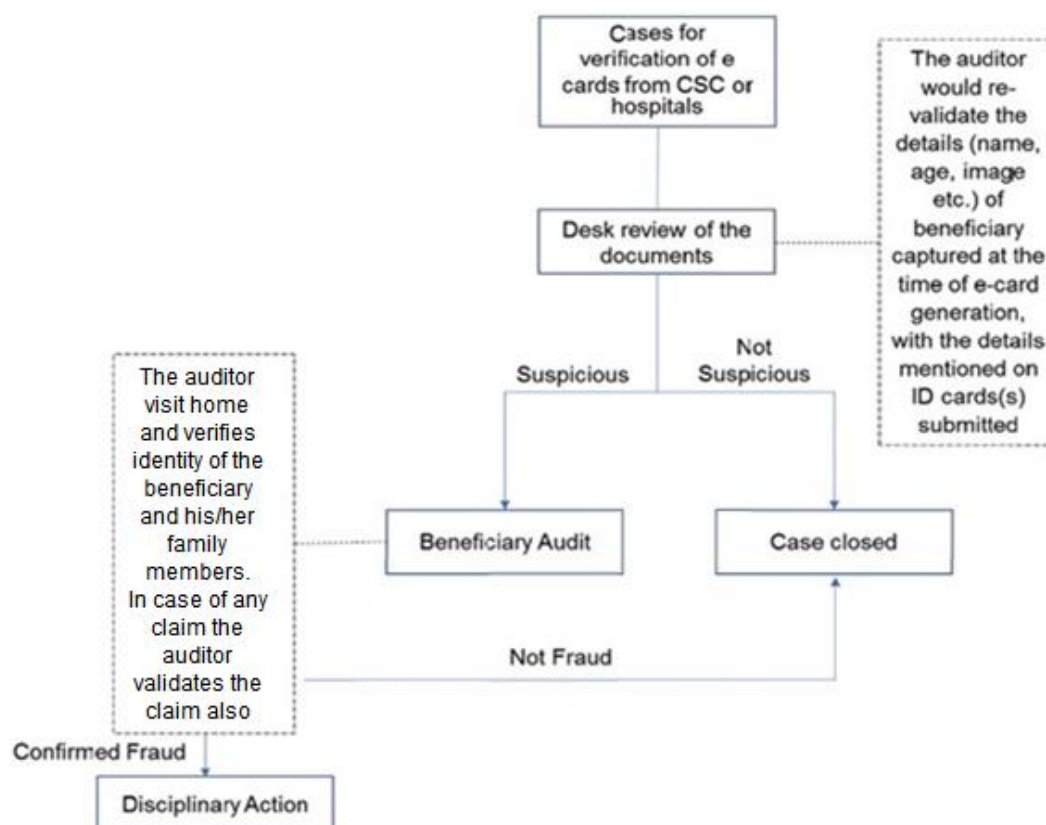
The probable frauds at the level of verification of beneficiary can include:

- Issuance of e-card to a non-eligible person
- Utilization of services under the scheme by someone impersonating to be the beneficiary
- Ghost Utilization – Claim submitted by a provider without actual hospitalization of an entitled beneficiary

Beneficiary audits for issuance of golden card to a non-eligible person

A member of entitled family under PM-JAY can get a golden card (e-card) generated after process of verification either at a CSC or an empanelled hospital. Beneficiary audit is done for random sample or BIS triggered cases, it will also be conducted on post admission in cases where the anti-fraud triggers flag the claim as suspicious – at pre-auth stage, pre-discharge stage, post discharge or post payment. Beneficiary audit conducted to be reported as per annexure 6.

Process flow for beneficiary audit of cases



E. Protocols for Staff handling Medical audit and field investigation team: (Do's and Don't)

- At the time of hospital visit the Medical Auditor/ investigator should introduce her/himself to the hospital and should always carry id cards and authorization/permission from competent authority to conduct investigation/audit and produce the same to hospital/beneficiary, if need be.
- S/he should ensure that the hospital is not alarmed by their visit and should try to make the hospital administration comfortable and administration should be requested for their support and cooperation.
- While talking to the beneficiaries admitted in the hospital, all care should be taken to make the beneficiary feel comfortable and under no circumstances, disruption or interference in 'treatment of beneficiary' shall be done
- Pictures of the beneficiary should be taken only after her/his consent. However, picture of private parts or ones which makes the beneficiary uncomfortable should be avoided.
- While talking to the beneficiary it should be ensured that the s/he is not intimidated by anyone. If need be, the beneficiary may be spoken to in private or without any hospital staff being present in the earshot.
- Photographs of all relevant observations like IEC, registration desk, OT, ICU etc. shall be captured.
- The video of conversation with the beneficiary may be recorded for evidence, but with consent.
- The video should record all relevant and crucial information like name of the patient, date of admission, hospital name, presenting complaints etc.
- Before leaving the hospital premises the medical auditor should record general observations related on the factsheet (Annexure 2.1) and get it acknowledged (signature and stamp) by the hospital (hospital in-charge) The auditing doctor should also put signature and date on the same document.
- All care must be taken by the Auditor/ investigator to ensure her/his safety. To ensure the same s/he should avoid engaging in any unwarranted conversation or arguments with the hospital staff or administration
- If the atmosphere or environment becomes hostile for the Auditor/ investigator, then s/he should leave the hospital immediately.
- In case of any trouble District coordinator of the district shall be reached out to for help.
- During the audit one should also ensure that offerings of any kind is not accepted (e.g. food, beverages, gifts etc.) from the hospital administration/staff
- To avoid getting into any controversial situation s/he should avoid having a conversation with the hospital administration, owner or staff alone or in a closed room

- At all times, Medical Auditor/ investigator shall maintain highest standards of professional conduct and integrity in all situations
- To maintain confidentiality of health data/information collected during the course of investigation and audit and submit the same to competent authority. Also, shall refrain from sharing the audit findings with any outsider, with other hospitals or with the audited hospitals
- The report of observations shall be factually correct and shall be backed by evidences.

F. Monthly MIS to NHA

The SHAs are required to submit monthly report by 7th of every month to NHA listing the measures taken to control fraud, data analysis, cases investigated and audited and the results thereof and punitive action taken against fraudulent parties, notices, issued, recoveries made etc. This would enable NHA to track the progress of the states, draw comparative analysis, provide further support and feedback, to take action as need be. Refer to Annexure 7 for the format of the report. It is suggested to the SHA that monthly report format to be collected at district level for their own reference and detailed analysis.

Annexure 1.1: Desk Audit checklist

	Case number			
	Name of patient			
	Hospital Name & District			
	Package booked			
	Package Amount			
	Admission Date			
	Discharge Date			
		Yes	No	Remarks
1	Are all mandatory documents required at the time of pre-auth uploaded ?			
2	If uploaded, do these documents justifying hospitalization?			
3	Are symptoms and diagnosis in sync?			
4	Do diagnostic reports conclude diagnosis ?			
5	Is the package booked in sync with diagnosis?			
6	Are admission notes and detailed findings at admission notes available?			
7	Are requisite post-treatment evidentiary documents available to confirm complete appropriate treatment?			
8	Do the post-treatment evidentiary documents confirm that treatment was given?			
9	Was Length of Stay as per package specification?			
10	Is a Discharge summary available?			
11	Does the discharge summary capture all details of presenting features, investigations, line of treatment given during stay line of treatment advised at discharge and (Select <No> if investigations and all treatment details, missing as follow up will be not be rational)			

Annexure 2.1: Fact sheet

Name of the hospital		
Location (State, District, Block and Village / Ward)		
Hospital ID		
Type of hospital (public / private)		
Date of investigation		
Number of AB PMJAY beneficiaries admitted in the hospital		
Infrastructure	Y / N	Remarks
Is there any signboard outside hospital showing that it is empanelled in scheme (Y/N)		
Availability PMAM kiosk (Y/N)		
PMAM kiosk located at the entrance (Y/N)		
Availability of AB PMJAY promotional boards (Y/N)		
Availability of registration certificate of the hospital (Y/N)		
Availability of ICU		
Availability of HDU		
No of beds available in:		
General Ward		
ICU		
HDU		
Distance is maintained between two beds		
No of OTs -		
No of OT tables		
Is OT Sterilization facility is functional (Y/N)		
Is Adequate lights and Air conditioning provided in each OT (Y/N)		
Provision of biomedical wastes (Y/N)		
Human Resource		
Resident Medical Officer (RMO)/ duty doctor available at the time of visit (Y/N)		

Availability of qualified nursing staff at the time of visit (Y/N)		
Availability of technicians and pharmacists at the time of visit (Y/N)		
Availability of specialists for which claims are booked at the time of visit (Y/N)		
Medical documentation		
Availability IPD register at the time of visit (Y/N)		
Availability OT register at the time of visit (Y/N)		
Availability pharmacy record at the time of visit (Y/N)		
Availability of laboratory records at the time of visit (Y/N)		
Availability of fumigation register at the time of visit (Y/N)		
Availability of implants and prosthesis register at the time of visit (Y/N)		
Availability of pre-anaesthesia documents at the time of visit (Y/N)		
Availability of requested patient files (Y/N)		

Undertaking by hospital

This is to certify that the information provided by me/us about _____, is true to the best of my/our knowledge and is based on documentation and process followed in this hospital/institution. I/ We had not suppressed any information or fact. Further, I/ We understand that, in case the information provided is found to be incorrect and based on suppression of facts, the hospital stands to forfeit its claims.

Name & Signature of authorized person from hospital and Date with seal of hospital

Name & Signature of Auditing Doctor and date

Annexure 2.2: Medical Audit Form

A. Hospital Details				
1	Date of investigation			
2	Name of Hospital			
3	Address of Hospital			
4	Hospital ID (if available)			
5	Type of hospital (Public / Private)			
6	Number of AB PMJAY beneficiaries admitted in the hospital as per TMS			
7	Number of AB PMJAY beneficiaries admitted in the hospital			
B. Hospital Infrastructure		Yes	No	Remarks
8	Hospital Existence			
9	Response from Hospital (Co-operative/ Non Co-operative/ Indifferent)			
10	Is Hospital Registered DGHS			
11	Availability of PMAM kiosk			
12	Location of PMAM kiosk (Easily Visible/ Far inside)			
13	Promotional boards prominently displayed			
14	Total no of Beds			
15	Number of Beds in general ward			
16	Adequate distance (4 feet) maintained between two beds			
17	Is HDU available?			
18	Number of Beds in HDU			
19	Is ICU available?			
20	Number of Beds in ICU			
21	Is the ICU well equipped			
A	Standard ICU bed			
B	Equipment/monitor for the constant monitoring for vitals			
C	Emergency crash cart			
D	Defibrillator			
E	Ventilators			
F	Suction pumps			
G	Bedside oxygen facility			
H	Air conditioning			
22	Is OT available?			
23	No of OT			
24	No of OT tables			
25	OT sterilization facility functional			
26	Adequate lights (general level illumination) is provided in each OT			
27	Air conditioning is provided in each OT			
28	Is the OT well equipped			
A	Anesthetic machine			
B	Ventilator			
C	Laryngoscopes (Adult / Pediatric)			

D	Endotracheal tubes/laryngeal masks			
E	Airways/ Nasal tubes			
F	Suction apparatus and connectors,			
G	Oxygen			
H	Drugs for emergency situations			
I	Monitoring equipment including ECG, ETCO2 (where applicable)			
J	Pulse oximeter and blood pressure			
K	Cardiac monitor			
L	Defibrillator			
29	Pathology/ Diagnostics (Inhouse/Out sourced/ Not Available)			
30	Availability of Biomedical Waste Management			
31	Over all hygiene maintained in the hospital (Good/Average/ Poor)			
32	Any other remark or observation:			

C. Human Resource		Yes	No	Remarks
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33	Availability of PMAM at the time of visit			
34	Availability of on duty doctors at the time of visit (Whatever applicable)			
A	RMO			
B	Emergency doctor			
C	ICU doctor			
35	Availability of adequate number of nurses at the time of visit			
36	Are the nurses appropriately qualified			
37	Availability of technicians (if applicable)			
38	Availability of pharmacists (if applicable)			
39	Availability of specialists for which claims are booked			
40	Any other remark or observation:			

D. Documentation		Yes	No	Remarks
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41	Availability of IPD register at the time of visit			
42	Completeness of IPD register at the time of visit (should have entry and exit dates of the patient)			
43	Availability of OT register at the time of visit			
44	Completeness of OT register at the time of visit (Should have name of patient, date, procedure name, diagnosis, anesthetist's name, OT technician's name, surgeon's name, operation remarks and signature of surgeon)			
45	Availability of fumigation register at the time of visit			
46	Completeness of fumigation register at the time of visit (Should have date and time of fumigation)			
47	Availability of pharmacy record at the time of visit			

48	Completeness of pharmacy record at hr time of visit (Should have information on patient name and dispensing date)			
49	Availability of laboratory records at the time of visit			
50	Completeness of laboratory records at the time of visit (Should have date, patient name, sample collection date and report received date and findings)			
51	Availability of implants and prosthesis register at the time of visit			
52	Completeness of implants and prosthesis register at the time of visit (if applicable) (Should have dates of dispensing, name of patient, name of consultant, site of insertion, procedure name and bar code stickers)			
53	Any other remark or observation:			

E. Case specific details		Yes	No	Remarks
54	Name of patient			
55	Package booked			
56	Name of Treating Doctor			
57	Specialization of treating doctor			
58	Date and time of Hospital Admission as per hospital file			
59	Date and time of Hospital Discharge as per hospital file			
60	Type of Treatment (Surgical/Medical)			
61	Diagnosis:			
62	Did the patient leave against medical advice			
63	If yes, why?			
64	Entry in Outdoor Register found			
65	Entry in Indoor Register found			
66	Entry in OT Register found (only in case of surgical case)			
67	Entry in Hospital Lab Register found			
68	Availability of IPD papers			
69	Completeness of IPD papers (Should have patient details, presenting complaints, diagnosis, investigations, treatment etc.)			
70	Do the IPD papers align with and justify the treatment given			
71	Availability and completeness of OT notes			
72	Completeness of OT notes (should be on hospital stationery and should have Date & time of beginning and completion of surgery, Name of surgeon, Name of Anaesthetist, Type of anaesthesia, Surgery done (site, side and findings), Immediate Post op care, any complications faced and Signature of surgeon.			
73	Do the OT notes align with and confirm the conduction of booked surgery			
74	Availability of pre-anesthesia documents assessed by a qualified anesthesiologist			
75	Availability of daily nursing notes			
76	Completeness of daily nursing notes (Should have date, status /progress of patient as recorded by nurse)			
77	Availability of daily doctor notes			

78	Completeness of daily doctor notes (Should have date, status /progress of patient and further course of medication/ treatment as recorded by doctor)			
79	Availability of daily progress chart			
80	Completeness of daily progress chart (Should have record of vitals with date and time)			
81	Availability of daily treatment chart			
82	Completeness of daily treatment chart (Should have record of medication with date and time)			
83	Availability of details of recorded monitoring of heart rate, cardiac rhythm, respiratory rate, BP, O2 saturation, airway security, and potency and level of anaesthesia			
84	Availability of Discharge Summary			
85	Completeness of Discharge Summary			
86	Do all the documents align and justify the need of and treatment given? Explain with remarks.			
87	Any other remark or observation:			

F. Patient/Attendent interview in the hospital (Live Audit)		Yes	No	Remarks
88	Name of patient			
89	Package booked			
90	Name of Treating Doctor			
91	Specialization of treating doctor			
92	Date and time of Hospital Admission as per hospital file			
93	Date and time of Hospital Discharge as per hospital file			
94	Type of Treatment (Surgical/Medical)			
95	Patient Photograph collected with ID card			
96	Patient Id's proof Collected			
97	What were the presenting complaints at the time of admission?			
98	Since when was he suffering from the symptoms?			
99	Was he referred from another hospital/ clinic/ doctor?			
100	If yes, please name the hospital/clinic/doctor			
101	When did the patient get admitted?			
102	Is the patient admitted since then?			
103	What diagnostic tests (if any) were performed on the patient?			
104	Was any surgery conducted for the patient?			
105	if yes, is there a scar on the body?			
106	Has any money been charged so far?			
107	If yes, how much?			
108	Do they have receipts of the same?			
109	Is there any previous hospitalization of same patient at the same hospital?			

110	Any other remark or observation:
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Annexure 2.3: Medical Audit Report Format

The medical audit team shall record their findings and submit report in the format as mentioned below. The report should be submitted to the competent authority at the earliest.

<State Name> Field Visit/ Medical Audit

Hospital Name, District

Date of Visit

Trigger:

No of patients found v/s no. of patients shown admitted in the TMS

Infrastructure and Quality of care:

Observation on infrastructure and quality of care (pics if any)

Human Resource

Observation on Human Resource (pics if any)

Documentation

Observation on record keeping and documentation (pics if any)

Specific cases (if any)

Name of beneficiary

PMJAY id

Case no

Date of Admission

Date of Discharge

Package Blocked

Findings-

Name of beneficiary

PMJAY id

Case no

Date of Admission

Date of Discharge

Package Blocked

Findings-

Key Findings and Observations

Conclusion

Annexure 2.4: Field Investigation Format

A. Hospital Details				
1	Date of investigation			
2	Name of Hospital			
3	Address of Hospital			
4	Hospital ID (if available)			
5	Type of hospital (Public / Private)			
6	Number of AB PMJAY beneficiaries admitted in the hospital as per TMS			
7	Number of AB PMJAY beneficiaries admitted in the hospital			
B. Hospital Infrastructure		Yes	No	Remarks
8	Hospital Existence			
9	Response from Hospital (Co-operative/ Non Co-operative/ Indifferent)			
10	Is Hospital Registered DGHS			
11	Availability of PMAM kiosk			
12	Location of PMAM kiosk (Easily Visible/ Far inside)			
13	Promotional boards prominently displayed			
14	Total no of Beds			
15	Number of Beds in general ward			
16	Adequate distance (4 feet) maintained between two beds			
17	Is HDU available?			
18	Number of Beds in HDU			
19	Is ICU available?			
20	Number of Beds in ICU			
22	Is OT available?			
23	No of OT			
24	No of OT tables			
29	Pathology/ Diagnostics (Inhouse/Out sourced/ Not Available)			
31	Over all hygiene maintained in the hospital (Good/Average/ Poor)			
32	Any other remark or observation:			
C. Human Resource		Yes	No	Remarks
33	Availability of PMAM at the time of visit			
34	Availability of on duty doctors at the time of visit (Whatever applicable)			
A	RMO			
B	Emergency doctor			
C	ICU doctor			
35	Availability of adequate number of nurses at the time of visit			
39	Availability of specialists for which claims are booked			

40	Any other remark or observation:
----	----------------------------------

D. Documentation		Yes	No	Remarks
41	Availability of IPD register at the time of visit			
43	Availability of OT register at the time of visit			
47	Availability of pharmacy record at the time of visit			
49	Availability of laboratory records at the time of visit			
51	Availability of implants and prosthesis register at the time of visit			
53	Any other remark or observation:			

E. Case specific details		Yes	No	Remarks
54	Name of patient			
55	Package booked			
56	Name of Treating Doctor			
57	Specialization of treating doctor			
58	Date and time of Hospital Admission as per hospital file			
59	Date and time of Hospital Discharge as per hospital file			
60	Type of Treatment (Surgical/Medical)			
61	Diagnosis:			
62	Did the patient leave against medical advice			
63	If yes, why?			
64	Entry in Outdoor Register found			
65	Entry in Indoor Register found			
66	Entry in OT Register found (only in case of surgical case)			
67	Entry in Hospital Lab Register found			
68	Availability of IPD papers			
71	Availability and completeness of OT notes			
74	Availability of pre-anesthesia documents assessed by a qualified anesthesiologist			
75	Availability of daily nursing notes			
77	Availability of daily doctor notes			
79	Availability of daily progress chart			
81	Availability of daily treatment chart			
84	Availability of Discharge Summary			
87	Any other remark or observation:			

F. Patient/Attendent interview in the hospital (Live Audit)		Yes	No	Remarks
88	Name of patient			
89	Package booked			

90	Name of Treating Doctor			
91	Specialization of treating doctor			
92	Date and time of Hospital Admission as per hospital file			
93	Date and time of Hospital Discharge as per hospital file			
94	Type of Treatment (Surgical/Medical)			
95	Patient Photograph collected with ID card			
96	Patient Id's proof Collected			
97	What were the presenting complaints at the time of admission?			
98	Since when was he suffering from the symptoms?			
99	Was he referred from another hospital/ clinic/ doctor?			
100	If yes, please name the hospital/clinic/doctor			
101	When did the patient get admitted?			
102	Is the patient admitted since then?			
103	What diagnostic tests (if any) were performed on the patient?			
104	Was any surgery conducted for the patient?			
105	if yes, is there a scar on the body?			
106	Has any money been charged so far?			
107	If yes, how much?			
108	Do they have receipts of the same?			
109	Is there any previous hospitalization of same patient at the same hospital?			
110	Any other remark or observation:			

Annexure 4: Home visit format

F. Home Visit: Patient/Attendant interview after discharge		
Has s/he availed services under AB PM-JAY? * If yes, proceed further	Yes	No
In which hospital did s/he utilize the services?*		
What were the presenting complaints at the time of admission?*		
Since when was he suffering from the symptoms?		
Was he referred from another hospital/ clinic/ doctor?	Yes	No
If yes, please name the hospital/clinic/doctor		
When did the patient get admitted?*(calendar)		
When did the patient get discharged?*(calendar)		
Was s/he provided free food and travel allowance?*	Yes	No
Was the patient given a discharge summary?*	Yes	No
Was post-hospitalization medication provided to the patient?*	Yes	No
Was any money asked by the hospital at any point of time?*	Yes	No
If yes, then how much?*		
For what purpose was the money charged? *		
Do they have receipts of the same?*	Yes	No
Did they buy any medicine or did any diagnostic test at their own cost? *	Yes	No
Does the patient have any receipt for the same?*	Yes	No
What was the treatment given? *		
Was any surgery conducted for the patient? *	Yes	No
if yes, is there a scar on the body?*	Yes	No
Any other remark or observation:		

Annexure 5.1: Mortality Report

Source: www.sast.gov.in

Section 5.1. and 5.2. is to be filled by the hospitals and sent at the time of beneficiaries' death (within 48 hrs) and 5.3 to be submitted at claim submission by the hospital

5.1 Death Summary (A brief note)

- Hospital Name
- Hospital ID
- Patient ID (e-card number)
- Patient Characteristics
- Name
- Age
- Sex
- Length of Admission in days
- Clinical Diagnosis (es) on Admission
- Clinical diagnosis(es) on Death
- Emergency or Elective
- Date of Admission:
- Date of Death:

5.2 Progress of the patient during hospitalization

- Abnormal Investigations:
- Hematology, Biochemistry, Radiology, Microbiology Others
- What was the treatment provided?
- Were there any clinical errors, omissions, process problems that hindered the process of giving good quality care?
- Were there identifiable clinical risks/incidents?
- Were there any of the clinical risks/incidents due to delay in Diagnosis, Delay in Treatment, Medical Clinical Errors, Nursing Clinical Errors, Medication Errors, Process Errors
- Please give further details below
- Were all standard protocols followed?
- What according to the treating doctor is the cause of death and contributing factors?
- Any other remarks

5.3 The Hospital would prepare 'MORTALITY REPORT' as mentioned below :

Section A: General Information:

- Patient details:
- Name:
- Age:
- Sex:
- DOA:
- Date of Surgery:
- Diagnosis:
- Treatment given:
- Surgery/Procedure/ Radiotherapy/ Chemotherapy/ Others (specify)
- Hospital name:
- Name of Treating Doctor

Section B - Case summary:

Please provide a summary of the Case in the form of narrative – including complaints at the time of admission, chronology of events up to death of the patient -

Section C: Case Assessment

1. Were there any areas of CONCERN or ADVERSE EVENTS in the management of this patient? -
Yes No
2. Was surgery performed? Yes/ No
3. Were there any areas of Concern, or Adverse Events in any of the following?

Operation/procedure was performed, or treatment provided?	Yes	No	NA
Pre-anesthetic checkup/fitness for surgery/treatment			
.Decision to operate			
.Choice of operation			
Timing of operation (too late, too soon, wrong time of day)			
Intra-operative process			
Problems in functioning of OT			
Grade / experience of surgeon deciding			
Grade / experience of surgeon operating			
Post-operative period			

4. Was this patient treated in a critical care unit (ICU or HDU) during this admission?
 - Yes No
5. If no, should this patient have been provided critical care in ICU/HDU?
 - Yes No

Clinician's Opinion on the overall risk of death

- Minimal/ Mild/ Moderate/ Severe

If there any areas of CONCERN or ADVERSE EVENTS in the management of this patient:

Describe the significant event/s during the course of treatment in the hospital:

Note any areas of concern or Adverse Event

Note if these areas caused any of the following:

Made no difference to outcome _____

May have contributed to death _____

Caused death of patient who would otherwise be expected to survive _____

Was the death preventable? (i) Definitely (ii) Probably (iii) Probably not (iv) Definitely not (v) Don't know

Section D: Record of cause of death

Hospital mortality review findings:

Primary cause of death: _____

ICD code: _____

Secondary cause of death: _____

ICD Code: _____

Antecedent cause of death: _____

ICD code: _____

FINAL RECOMMENDATIONS (if any) OF THE MORTALITY REVIEW

1. _____

2. _____

3. _____

Attestation by:

	Name	Designation	Signature
1			
2			
3			

Date:

Choice of operation
Timing of operation (too late, too soon, wrong time of day)
Intra-operative process
Problems in functioning of OT
Grade / experience of surgeon deciding
Grade / experience of surgeon operating
Post operative period

If yes above, provide details of

Area of:

Consideration

Concern

Adverse Event

Which:

Made no difference to outcome

May have contributed to death

Caused death of patient who would otherwise be expected to survive

Was it preventable?

Definitely

Probably

Probably not

Definitely not

Don't know

Please provide evidence to support your statements given above by referring to specific points relating to any investigation reports or progress

of the patient, treatment provided etc., which substantiate your observations

2 Describe the second most significant event:

Area of:

Consideration Concern

Adverse Event

Which:

Made no difference to outcome

May have contributed to death

Caused death of patient who would otherwise be expected to survive

Was it preventable?

Definitely

Probably

Probably not

Definitely not

Don't know

Please provide evidence to support your statements given above by referring to specific points relating to any investigation reports or progress of the patient, treatment provided etc., which substantiate your observations

3 Describe the third most significant event:

Area of:

Consideration Concern

Adverse Event

Which:

Made no difference to outcome

May have contributed to death

Caused death of patient who would otherwise be expected to survive

Was it preventable?

Definitely

Probably

Probably not

Definitely not

Don't know

Please provide evidence to support your statements given above by referring to specific points relating to any investigation reports or progress of the patient, treatment provided etc., which substantiate your observations

Hospital mortality report review findings:

Record the cause of death (as given)

Conclusion:

Primary cause of death:

ICD code:

Secondary cause of death: _____

ICD Code: _____

Antecedent cause of death:

ICD code:

Was there enough information to come to a conclusion?

Yes No

If NO, what information was lacking?

Payment:

Pre-auth approved amount:

Amount Claimed:

Amount Recommended:

Name of the first line assessor:

Designation

Date:

Signature

Annexure 6: BIS investigation form

A. Patient Information

1. PM-JAY FAMILY ID: _____
2. Name:
3. Father's or Husband's name:
4. Address:
District: _____ State: _____ Pin Code: _____
5. Contact No.
6. Members registered:

S. No.	Name	PM-JAY ID number	Gender	Age	Relationship
1.					
2.					
3.					
4.					
5.					
6.					

B. General Information

1. Where was the E card made?
2. If hospital, was the beneficiary charged any money for the E card? If yes, how much?
3. Has s/he availed services under PM-JAY? If yes -proceed further
4. In which hospital did s/he utilize the services?
5. What symptoms were the patient exhibiting when he/she visited the hospital?
6. When did s/he get admitted?
7. When did s/he get discharged?

8. For how many days was s/he hospitalized?
9. Was s/he provided free food?
10. What was the treatment given?
11. If any surgery, is there a scar on the body, which could help in verification of the surgery. (If yes, take photograph of the same)

(4 -11: match the information provided by the beneficiary with the one recorded in the TMS)

C. Match the photo of the beneficiary being interviewed with the one submitted in TMS

D. Any other remark or observation:

E. Recommendation of the Auditor:

Name and Signature of the Auditor with Date:

Annexure 8: Handling Difficult Situations during Field Investigation and Audit

- A. **Non-cooperation from beneficiary side:** if there is low cooperation from beneficiary during verification or beneficiary is not available to verification, the team will be sending three Queries / Reminder to beneficiary to cooperate in verification. if there is no response, the case will be closed under non-cooperation/ non-submission of required documents.
- B. **Non-cooperation from Hospital/provider:** if there is non-cooperation from Hospital/provider, team will be sending three Queries/Reminder to hospital, if there is no response, the claim will be rejected and the amount will be recovered under non-cooperation/ non-submission of required document
- C. **Allegation of Bribe/ Misbehave on investigator:** If there is any particular allegation of bribe/misbehave on particular investigator, will set up a third party to investigation agency to rule out the actual fact in the case, if allegation found to be correct, action to be taken and dismissal of the agency for future cases
- D. **Cases missed out for investigation/Verification:** If any case missed out while assigning the case to investigator for investigation, that need to take it on highest priority to assign to investigator
- E. **Not able to assign the case to SHA investigator/NHA team due IT/ technical issue:** in such situation if system is not working or there is any IT issue, where our NHA team or FCM team is not able to assign the triggered case to investigation/FCM team, will do this exercise on manual basis to investigate the case without any fail.
- F. **Verification of cases on Holidays:** On any holiday or especially on Saturday and Sunday, FCM team will coordinate with internal team/investigator telephonically and share the investigator/internal inputs on telephone/mobile.



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