BIJU SWASTHYA KALYAN YOJANA (BSKY)

HEALTHY ODISHA, HAPPY ODISHA

"EVERY LIFE IS PRECIOUS"

CHIEF MINISTER, ODISHA

CLAIM ADJUDICATION MANUAL

OCTOBER 2023

CONTRIBUTORS AND ACKNOWLEDGEMENTS

This manual has been meticulously prepared under the invaluable guidance of Dr. Sudha Chandrashekhar, Advisor at Health Systems Transformation Platform. Her vital expertise and dedication have resulted in this comprehensive and insightful resource.

We extend our heartfelt gratitude to Sri. Rajeev Sadanandan, CEO of Health Systems Transformation Platform, for his unwavering support and invaluable insights that have greatly enriched the content of this manual.

The development of this manual would not have been possible without the generous contributions of knowledge and input from esteemed colleagues at the State Health Assurance Society, Odisha, especially Sri. Subhanand Mohapatra, Dr. Bishnu Mohapatra, Dr. Ramkrushna Satapathy, and Sri. Ranjan Kumar Dash. Their thoughtful perspectives and dedication have significantly enhanced the quality and scope of this manual.

We would also like to express our sincere appreciation to Smt. Shalini Pandit, Principal Secretary of the Department of Health and Family Welfare, Government of Odisha, and Dr. Brundha D, CEO of State Health Assurance Society, Odisha, for granting us the opportunity to embark on this endeavour and for their continued support throughout its development.

We have adopted the fundamental principles and guidelines outlined in the AB PM-JAY Claim Adjudication Manual 2.0, meticulously tailoring and adapting them to suit the requirements and processes of the BSKY scheme.

The collaborative efforts of all these individuals have culminated in creating this manual, which will serve as a valuable resource for all those engaged in BSKY Claim Adjudication.

Once again, we extend our deepest gratitude to every contributor who has played an integral role in shaping this manual and making it a reality.

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ABBREVIATIONS

BSKY	Biju Swasthya Kalyan Yojana
CEO	Chief Executive Officer
CMS	Claims Management System
CPD	Claim Processing Doctor
DC	District Coordinator
DGNO	District Grievance Nodal Officer
DGRC	District Grievance Redressal Committee
EHCP	Empanelled Healthcare Providers
GST	Goods and Services Tax
HBP	Health Benefit Packages
ICP	Indoor Case Papers (IPD Case Sheets)
ICU	Intensive Care Unit
KPI	Key Performance Indicators
LOS	Length of Stay
MDP	Mandatory Document Protocol
MEDCO	Medical Coordinator
NABH	National Accreditation Board for Hospitals & Healthcare Providers
NFSA	National Food Security Act
OT	Operation Theatre
OTP	One Time Password
PFMS	Public Financial Management System
POS	Point of Service
PPD	Pre-Authorisation Processing Doctor
Pre-auth	Pre-authorisation
SAFU	State Anti-Fraud Unit
SEC	State Empanelment Committee
SFSS	State Food Security Scheme
SHAS	State Health Assurance Society
SND	State Nodal Doctors
TAT	Turn Around Time
TMS	Transaction Management System
UHC	Universal Health Coverage

1. INTRODUCTION

1.1 BSKY

The Hon'ble Chief Minister of Odisha, Shri Naveen Patnaik, has set a guiding principle of valuing every life. He envisions providing quality healthcare to all citizens of Odisha, particularly those who are economically vulnerable. With this objective, Biju Swasthya Kalyan Yojana (BSKY) was launched on August 15, 2018, as a path-breaking program to attain Universal Health Coverage (UHC) while giving special consideration to the healthcare needs of women and vulnerable families.

1.2 STATE HEALTH ASSURANCE SOCIETY (SHAS)

The State Health Assurance Society (SHAS) is the nodal agency responsible for implementing the scheme in the State and is headed by the Chief Executive Officer (CEO). The State Government appoints the CEO of SHAS and is ex-officio member secretary of the Governing Board of SHAS. SHAS is responsible for the day-to-day operations for implementing BSKY in the State, along with data sharing, verification and validation of the beneficiaries, IEC, and monitoring the program.

1.3 ENTITLED BENEFICIARIES

BSKY has two components.

Component 1: All citizens of Odisha are eligible for cashless healthcare services at all State Government Health Care Institutions from the Sub-Centre level to Government Medical College Hospitals. The State Government will bear the cost of treatment incurred by Odisha citizens at public facilities.

Component 2: All BSKY Smart Health Card / National Food Security Act (NFSA) / State Food Security Scheme (SFSS) card holders are eligible to avail cashless health coverage of 5 Lakhs Rupees per annum per family and an additional 5 Lakhs Rupees for the women members of the family, after exhaustion of the initial limit at any empanelled private hospitals, within and outside Odisha.

The coverage unit under the scheme is a family, and each family for this scheme is referred to as a BSKY Beneficiary Family Unit, which comprises all members of that family. Any addition to the family is allowed only as per the provisions approved by the government. The presence of a name in the beneficiary list (amended from time to time due to the addition of family members) serves as proof of eligibility of the Beneficiary Family Unit to avail benefits under the scheme.

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

1.4 BENEFITS

The benefits of Rs. 5 Lakhs per annum are available on a family floater basis and can be utilised by any or all family members. BSKY has been designed so that there is no limit on family size or age of members. With their BSKY / Adhaar / NFSA / SFSS number, members of the Eligible families can avail cashless inpatient and daycare treatments in empanelled hospitals within or outside the state, up to the annual coverage limit. In addition, all pre-existing medical conditions are covered from day one. The coverage under the scheme includes all expenses incurred on the following components of the treatment:

1. Medical Expenses, Inpatient Treatment and Consultation
2. Daycare Procedures
3. Pre-Hospitalisation up to 1 day
4. Medicines and Medical Consumables
5. Non-intensive and Intensive Care Services
6. Diagnostic and Laboratory Services
7. Medical Implantation Services (Whenever necessary)
8. Food Services
9. Complications arising during treatment
10. Post-Hospitalisation follow-up care up to 5 days

Apart from the annual coverage of Rs. 5 Lakhs per family, an additional Rs. 5 Lakhs can be availed for treating female members in the beneficiary family unit upon exhaustion of the primary sum insured.

1.5 HEALTH BENEFIT PACKAGES

One of the critical components of BSKY is its comprehensive Health Benefit Packages (HBP). These packages outline the range of medical treatments and services covered under the scheme. The HBPs have been designed to ensure beneficiaries receive high-quality medical care without financial hardships.

BSKY offers various health benefit packages covering a broad spectrum of medical conditions and treatments. The packages encompass primary, secondary, and tertiary healthcare services, including diagnostics, consultations, medications, surgeries and postoperative care. A network of empanelled public and private hospitals across the country provides the services covered under the packages.

For Hospitalisation expenses, package rates shall include all the costs associated with the treatment, such as:

1. Registration Charges
2. Bed Charges
3. Nursing and Boarding Charges
4. Surgeons, Anaesthetists, Clinicians Consultation Fees
5. Anaesthesia, Blood Transfusion, Oxygen, OT Charges, Cost of Surgical Appliances, etc.
6. Medicines and Drugs
7. Cost of Prosthetic Devices, Implants, Organs etc.

8. Pathology and Radiology Test: HBP Package includes essential radiology imaging and diagnostics such as X-ray, Ultrasound, Haematology, Pathology, etc. However, High-End Radiological Diagnostics and High-End Histopathologies and Advanced Serological Investigations can be claimed as Add-on Procedures with Medical or Surgical Packages if required.
9. Food for patient
10. Pre and Post-Hospitalisation Expenses: Expenses incurred for consultation, diagnostics, and medicines up to 1 day before the patient's admission in the same hospital and cost of diagnostics and drugs up to 5 days after discharge from the hospital for the same ailment/surgery.
11. Any other expenses related to the patient's treatment in the hospital.

For Day Care Treatments, expenses shall include:

1. Registration Charges
2. Surgeons, Anaesthetists, Clinicians Consultation Fees
3. Anaesthesia, Blood Transfusion, Oxygen, OT Charges, Cost of Surgical Appliances, etc.
4. Medicines and Drugs
5. Cost of Prosthetic Devices, Implants, Organs etc.
6. Pathology and Radiology Test: HBP Package includes essential radiology imaging and diagnostics such as X-ray, Ultrasound, Haematology, Pathology, etc. However, High-End Radiological Diagnostics and High-End Histopathologies and Advanced Serological Investigations can be claimed as Add-on Procedures with Medical Packages if required.
7. Pre and Post-Hospitalisation Expenses: Expenses incurred for consultation, diagnostics, and medicines up to 1 day before the patient's admission in the same hospital and cost of diagnostics and drugs up to 5 days after discharge from the hospital for the same ailment/surgery.
8. Any other expenses related to the patient's treatment in the hospital.

Note: *Empanelled hospitals can separately claim reimbursement for High-End Diagnostic procedures performed during outpatient care for BSKY beneficiaries, without bundling them with hospitalisation claims.*

Other Salient Features

The SHA shall reimburse claims of Empanelled Healthcare Providers (EHCP) under the BSKY based on Package Rates determined as follows:

1. The cost of Medical Treatments, Surgical Procedures or Day Care Treatments fixed in the Health Benefit Package shall apply.
2. If the package rate for a surgical procedure requiring Hospitalisation or Day Care Treatment is not listed in the Health Benefit Packages, then the Pre-Authorisation Processing Team may pre-authorise an appropriate amount based on the rates for similar procedures defined in the list or based on other applicable national or state health insurance scheme packages. In the case of medical management, the rate will be calculated on per day basis (24-hour hospitalisation) as specified in the package list except for special packages like High-End Radiological Diagnostics, High-End Histopathology and Advanced Serological Investigation

packages. These procedures can be clubbed with medical or surgical procedures as Add-on procedures.

3. BSKY is a cashless scheme, where no beneficiary should be made to pay for availing treatment in any BSKY empanelled hospitals. However, upon exhaustion of the beneficiary wallet, or if the treatment cost exceeds the benefit coverage amount available in the beneficiary wallet, then the liability of such remaining treatment cost as per the rates defined in the HBP list will be borne by the beneficiary. Beneficiaries should be communicated in advance about the additional payment before the start of the treatment.
4. If a BSKY beneficiary requires multiple surgical procedures in the same OT (Operation Theater) session, the procedure with the highest rate shall be considered the primary package and reimbursed at 100%. After that, the second surgical procedure shall be reimbursed at 50% of the package rate, and the third and subsequent surgical procedures shall be reimbursed at 25%.
5. If multiple procedures are performed in different OT sessions during the same hospitalisation, the treating doctor should justify the reason for separate OT sessions.
6. Surgical and Medical procedures will not be allowed to be availed simultaneously (except for Add-on procedures defined in the HBP list and configured in TMS). In exceptional circumstances, hospitals may request such Pre-authorisation, which will be considered for reimbursement by SHA following deliberations with the Technical Committee experts.
7. Based on the NABH quality accreditation, additional incentives will be provided to eligible EHCPs over and above the rates defined in the HBP list. Additional incentives are also applicable to empanelled hospitals outside the state. The differential pricing applicable to various EHCPs is detailed below.

Category	*Incentive over Base Package Rate*
Entry Level NABH Accredited Hospitals – Inside State	20%
Full NABH Accredited Hospitals – Inside State	30%
Hospitals with more than 100 IP Beds – Outside State	10%
Entry Level NABH Accredited Hospital – Outside State	40%
Full NABH Accredited Hospitals – Outside State	45%

Table 1: Hospital Incentives on Quality Accreditation

Public Reserved Packages: Approximately 2% of the HBP packages are reserved for public hospitals, and the beneficiaries can only access treatment under these packages from public healthcare facilities. Under no circumstances will SHAS consider private EHCP claims raised under the government-reserved packages for settlement.

Referral Packages: Approximately 5% of the HBP packages can only be availed from private EHCPs if the beneficiaries are referred from public healthcare facilities. To receive treatment under referral packages, patients may be referred to private EHCPs in the scenarios outlined below:

i. The public facilities in the district are not equipped or able to provide the treatment/procedure.
ii. Prolonged waiting period for the procedure at the public facilities in the district
iii. Emergency cases requiring immediate referral.
iv. The following authorities have been designated to issue referrals to the beneficiaries in a specific format.

Sl. No.	*Institution*	*Designation*
1.	District Headquarter Hospital	CDM / PHO / DMO / Superintendent / Specialists
2.	Sub Divisional Hospital	Superintendent / Specialists
3.	Government Medical College Hospitals	Superintendent / HOD

Table 2: Referral Authorities

Empanelled hospitals are eligible to seek reimbursement for reserved/referral packages in the following situations:

1. When a patient is initially admitted for treatment under the regular package(s) and subsequently requires treatment under the reserved/referral packages, as determined during the initial treatment.
2. When a patient is admitted in an emergency and requires immediate treatment under the reserved/referral packages.
3. In instances where patients are admitted to empanelled hospitals located outside Odisha.

Note: *For points 1 and 2, the treating doctor's justification for providing treatment under referral/reserved packages at empanelled hospitals must be uploaded, either during the pre-authorisation process for packages requiring pre-authorisation approval or at the time of claim submission for other packages.*

The presently implementing BSKY Health Benefit Package (HBP), revised in 2022, has 2066 procedures across 30 specialities, including the Unspecified Package.

Sl. No.	*Speciality*	*Code*	*HBP 2022*	
			Packages	*Procedures*
1.	Burns Management	BM	06	22
2.	Cardiology	MC	25	35
3.	Covid-19	CO	02	05
4.	Cardiothoracic Vascular Surgery	SV	41	137
5.	Emergency Room Packages	ER	03	04
6.	ENT	SL	38	84
7.	General Medicine	MG	112	158
8.	General Surgery	SG	122	183
9.	High-End Diagnostics	HD	50	89
10.	High-End Procedures	HP	05	10
11.	Infectious Diseases	ID	01	01
12.	Interventional Radiology	IN	78	108
13.	Medical Oncology	MO	76	288
14.	Mental Disorders	MM	14	22
15.	Neo-natal Care	MN	13	13
16.	Neurosurgery	SN	58	84

17.	Obstetrics and Gynecology	SO	70	89
18.	Ophthalmology	SE	45	60
19.	Oral and Maxillofacial Surgery	SM	14	22
20.	Organ and Tissue Transplant	OT	03	03
21.	Orthopaedics	SB	73	143
22.	Palliative Medicine	PM	41	43
23.	Paediatric Medical Management	MP	39	62
24.	Paediatric Surgery	SS	42	58
25.	Plastic and Reconstructive Surgery	SP	08	15
26.	Polytrauma	ST	10	30
27.	Radiation Oncology	MR	21	43
28.	Surgical Oncology	SC	84	127
29.	Unspecified Package	US	01	01
30.	Urology	SU	81	127
	Grand Total		**1176**	**2066**

Table 3: HBP Abstract

Note: *HBP procedures are updated regularly, and updated HBP will be available on the BSKY website.*

If SHAS finds that any treatment is being booked under an unspecified category repeatedly or must be included to address a pressing health problem that has become widely prevalent, then SHAS may add such treatments to the HBP list. Specialised tertiary-level services shall be available and offered only by the EHCPs empanelled by SHAS for those services.

2. PURPOSE OF CLAIM ADJUDICATION MANUAL

The purpose of the Claim Adjudication Manual is to:

- Enhance the capacities of the adjudication team to ensure accurate and timely processing and settlement of claims under BSKY.
- Improve the ability to efficiently combine fundamental concepts, system functionalities, and human intelligence during claim adjudication.

Accurate processing is crucial in various aspects, including verifying eligible claims, approving precise amounts to EHCPs and genuine utilisation of the beneficiary wallet. This manual will help Claim Processing Doctors (CPD) and State Nodal Doctors (SND) efficiently and accurately adjudicate pre-authorisations and claims while exercising due diligence. Each defined process has a timeline associated with it.

This manual explains the roles and responsibilities of the personnel involved in the BSKY claim adjudication workflow.

Note: *Users should refer to the BSKY website for the latest information on any subsequent changes made to the claim adjudication manual guidelines.*

3. BASICS OF CLAIM ADJUDICATION

Claim Adjudication refers to the decision on two critical 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 the claims settlement. The decision involves cross-verification of the essential aspects such as the eligible beneficiary, medical condition (symptoms, diagnosis, treatment), policy exclusions, available sum insured, pre-agreed package rate, and empanelled hospitals.

BSKY uses two essential systems: a Transaction Management System (TMS) for beneficiary registration, package selection, and pre-authorisation initiation; and a Claims Management System (CMS) for claims workflow from initiation to adjudication and settlement.

While approving a Pre-Authorisation request or adjudication of a Claim at the settlement stage, the adjudication team should exercise the utmost care and be mindful of the decision because any wrong approval or payment may cause inconvenience to beneficiaries or recoveries from EHCPs at a later stage.

The system under BSKY is designed to enable end-to-end adjudication of the claims by the adjudication team; however, human intelligence needs to be applied while processing and approving both pre-authorisations and claims. Below mentioned points must be kept in mind while adjudicating a Pre-Authorisation or a Claim:

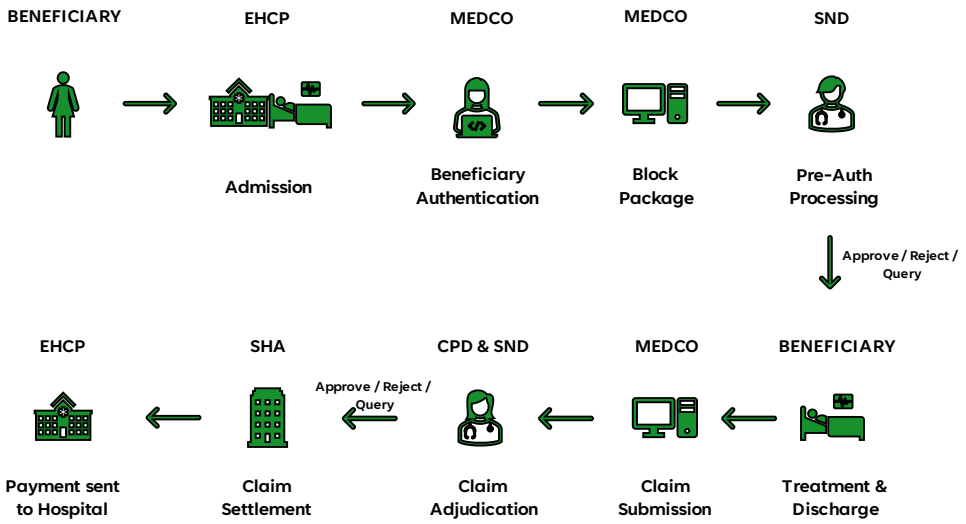
1. The patient should be an eligible beneficiary and verified through the state-managed beneficiary database.
2. The treatment package claimed should be covered under the scheme and comply with any specific reservations in the HBP list.
3. The conditions should not fall under the exclusion criteria defined under the policy. (Annexure - I)
4. The available sum insured in the beneficiary's family wallet should be enough for payment of the current treatment.
5. The adjudication team should ensure that all documents submitted by the EHCPs confirm the necessity of the hospitalisation.
6. The adjudication team should validate all the details/information (patient details, diagnosis details, supporting investigations, treatment details) submitted at the time of Pre-Authorisation and Claim and highlight discrepancies, if any.
7. The adjudication team should raise a query only in the case of any missing information that is mandatory for the claim adjudication.
8. The adjudication team should make an informed and mindful decision regarding the payment to be made to EHCPs.
9. The claim-approved amount should not exceed the approved amount during Pre-Authorisation and Wallet Balance.
10. EHCPs should submit the mandatory documents as specified in the Mandatory Document Protocols (MDP), both at the time of pre-Authorisation and claim.

4. ADJUDICATION WORKFLOW

4.1. SYSTEM OVERVIEW

To avail benefits from the scheme, beneficiaries must present their BSKY / Adhaar / NFSA / SFSS number at empanelled hospitals. The Transaction Management System (TMS) oversees beneficiary authentication and package selection at empanelled hospitals. The Hospitals, the Adjudication Team and the SHA, utilise the Claims Management System (CMS) to manage pre-authorisation and claims workflow. Here is an overview image of the claims journey in the BSKY system.

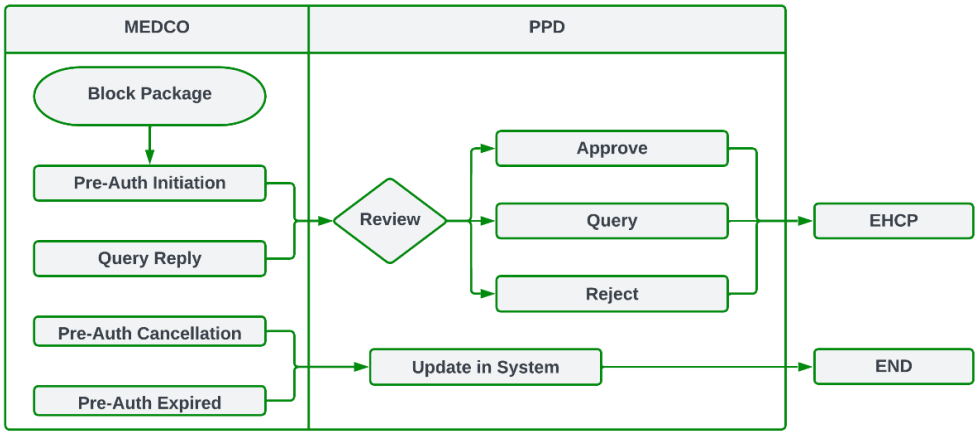
4.2. CLAIMS JOURNEY



Flow Chart 1: Claims Journey

4.3. PRE-AUTHORISATION WORKFLOW

The Medical Coordinator (MEDCO) or the Data Entry operator at the hospital and the SND at the SHAS are involved in the Pre-Authorisation Processing. The below figure provides an overview of the Pre-Authorisation Workflow.



Flow Chart 2: Pre-Authorisation Workflow

4.3.1. BLOCK PACKAGE

When seeking treatment at an empanelled hospital, beneficiary authentication and the package selection for the planned treatment are carried out in the TMS portal by the MEDCO at the hospital. The MEDCO at the empanelled hospital must log in using their provided credentials to the TMS portal (https://bskytms.odisha.gov.in/).

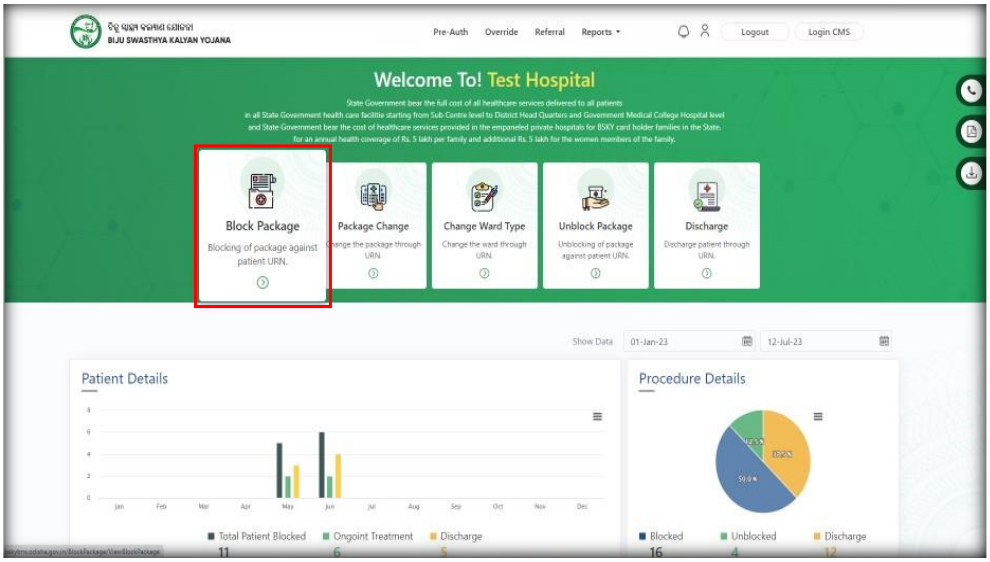


Figure 1: TMS Portal Home Page

The MEDCO then selects the Block Package option on the TMS home page (Figure 1) and enters the beneficiary's URN / NFSA / SFSS number to fetch the household details of the beneficiary family (Figure 2).

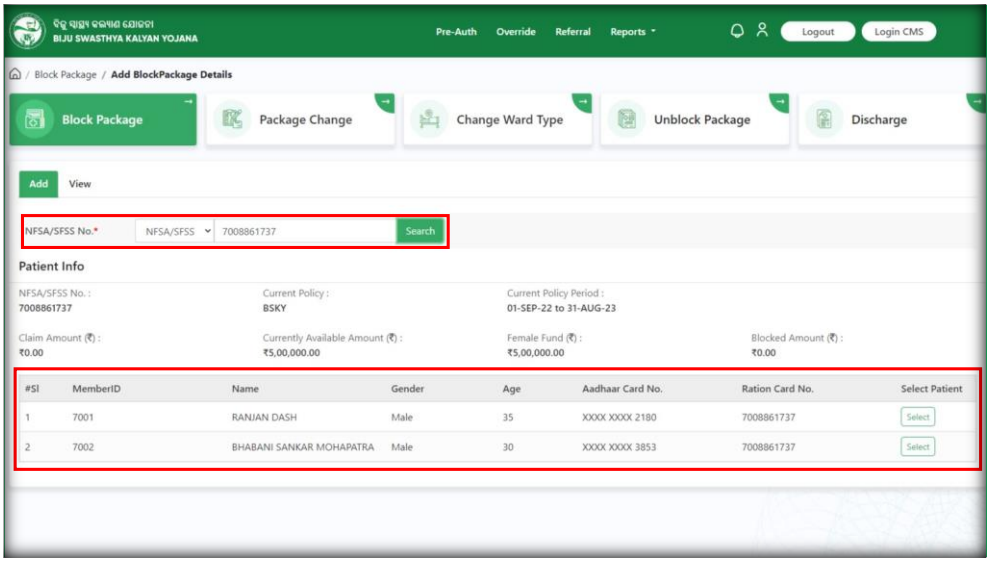


Figure 2: Beneficiary Household Details

After selecting the patient from the household list, the MEDCO should choose whether the beneficiary's hospitalisation is regular or emergency and validate the beneficiary. The Aadhaar-based beneficiary authentication must be done by IRIS scan, POS scan or OTP, either by the patient or by any other member of the household (Figure 3). In exceptional circumstances, beneficiary

authentication can be overridden by an Override Code, following approval by the competent authority at the SHAS.

Note: *In the event that any child members under the age of 18 of a beneficiary family are inadvertently excluded from the NFSA/SFSS database, EHCPs can provide BSKY benefits to such children by raising a claim under the name of the father or mother. To substantiate this claim, the EHCP must furnish documentary evidence provided by the parent that establishes the child's relationship with them.*

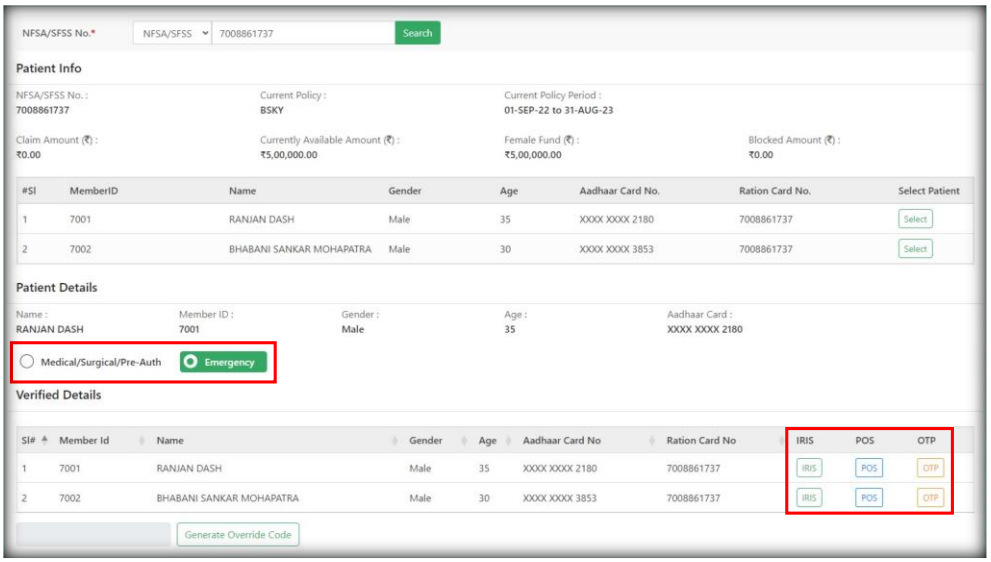


Figure 3: Beneficiary Authentication

Once the patient has been authenticated, the MEDCO blocks the appropriate HBP procedure corresponding to the planned treatment. The MEDCO can review the past claims raised under BSKY for the selected beneficiary household by clicking the 'Click Here For Previous Claims' tab. (Figure 4)

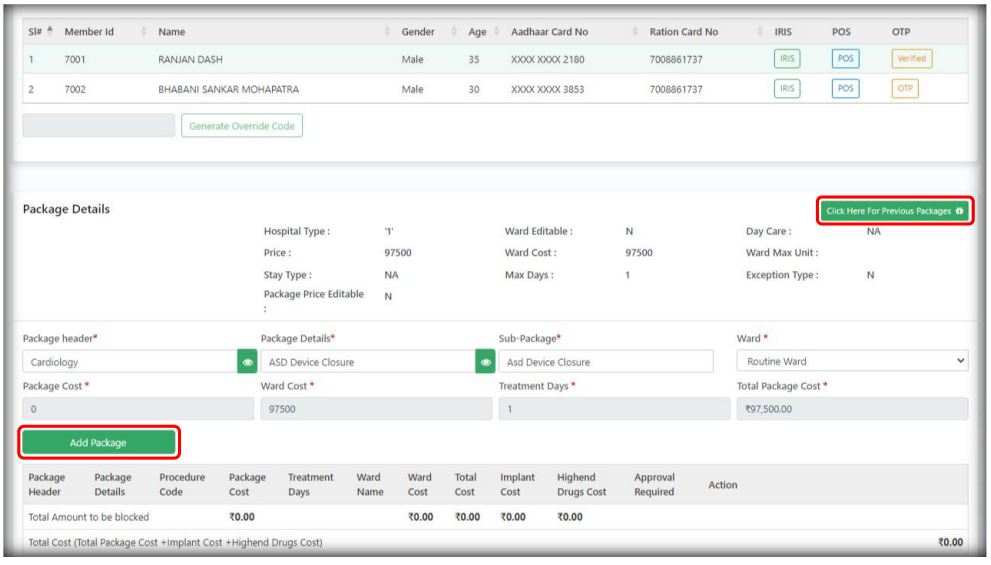


Figure 4: Package Selection

After selecting the package, MEDCO enters additional procedure-specific details like implants and/or high-end drugs, uploads the procedure-specific pre-authorisation mandatory documents

as detailed in the MDP and enters the admission details such as Date of Admission, Treating Doctor's name, the contact details of the treating doctor and the beneficiary. (Figure 5)

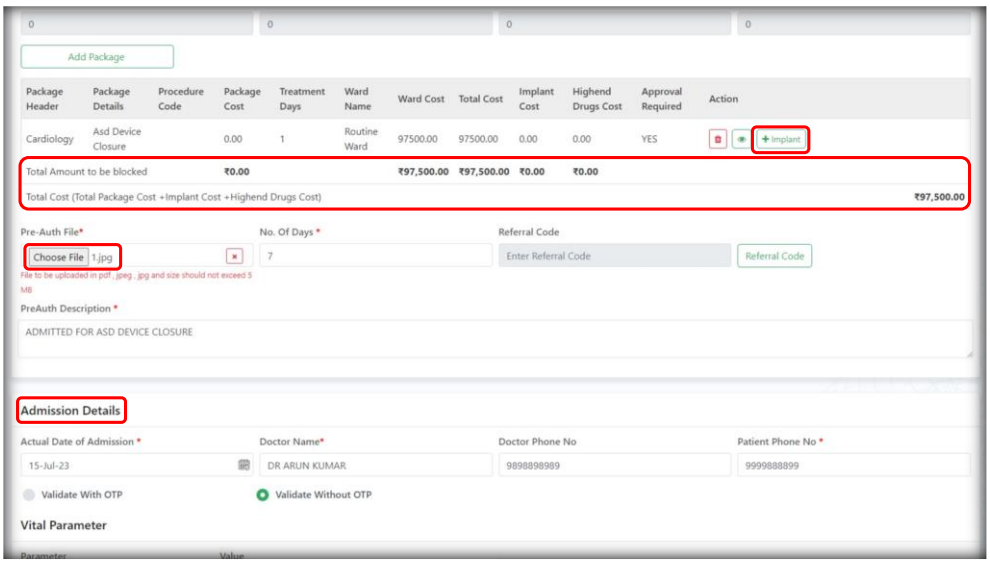


Figure 5: Package-Specific Additional Information and Admission Details

The MEDCO then enters the patient's vital parameters and uploads a clear photo of the patient taken at the hospital during the admission, following which he/she will proceed to block the package. (Figure 6)

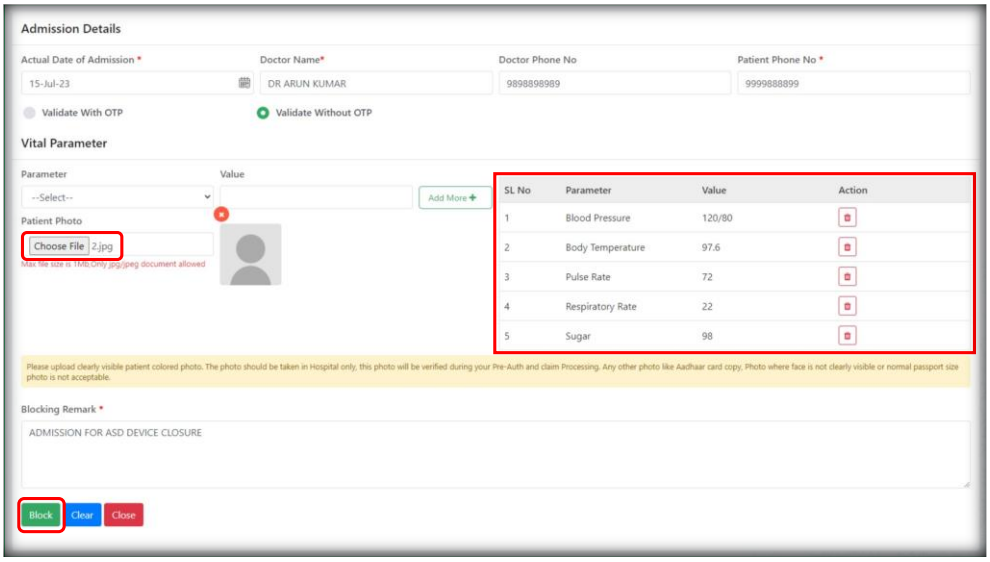


Figure 6: Vital Parameters, Patient Photo Upload and Block Package

A case number is assigned after the EHCP has successfully blocked a package (Figure 7). Cases that require pre-authorisation approval are moved to the SND bucket, while others are moved to the EHCP discharge bucket to update claim details.

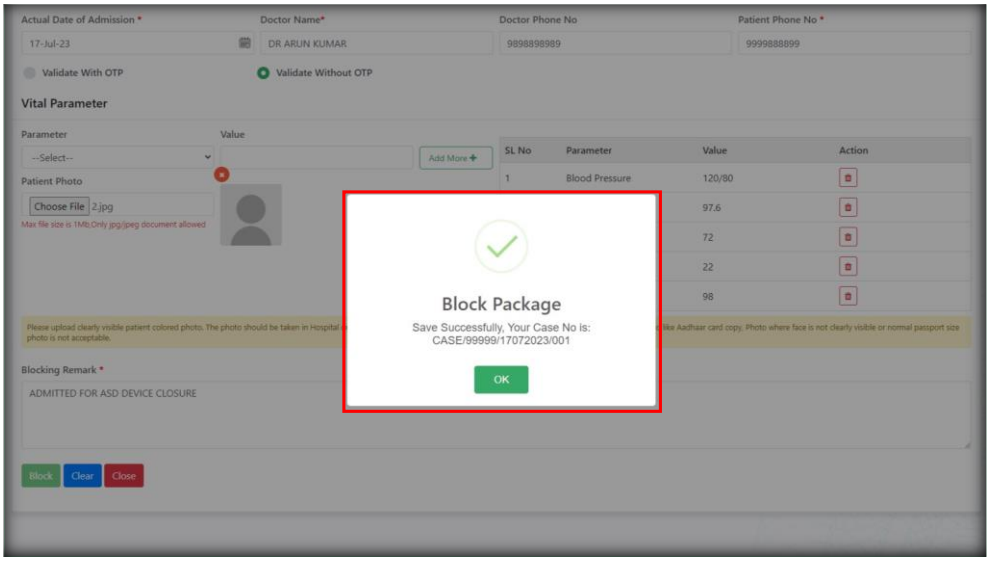


Figure 7: Block Package Successful

After successfully completing the pre-authorisation request, MEDCO can review submitted pre-authorisations under the 'Pre-Auth' tab. Once the Pre-authorisation request has been approved, MEDCO proceeds to block the package in the TMS. Following the successful package blocking, the EHCP can proceed with the patient's treatment. The pre-authorisation approval will expire if the block package is not completed within 7 days of approval. The hospital can cancel the pre-authorisation at any point before blocking if required. (Figure 8)

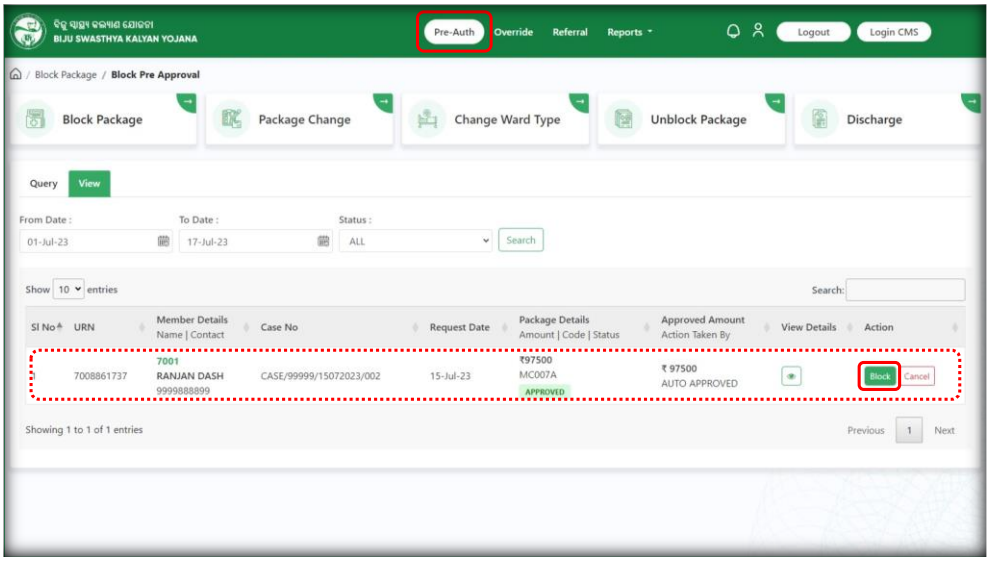


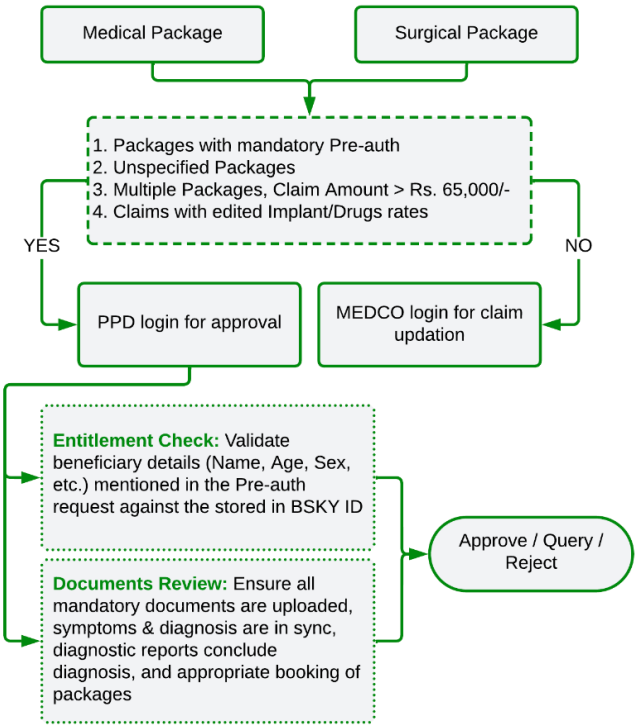
Figure 8: Pre-Auth Tab

4.3.2. PRE-AUTHORISATION ADJUDICATION

Pre-authorisation approval from SHAS is mandatory for claims in the following scenarios:

1. Packages that require mandatory pre-authorisation approval (Detailed in HBP).
2. Unspecified Packages.
3. While booking multiple packages, the total claimed amount is more than Rs. 65,000/-.
4. Claims with edited implant and/or high-end drug rates.

If an empanelled hospital blocks packages requiring pre-authorisation approval, TMS will raise a Pre-authorisation intimation. The SNDs at the SHAS are responsible for carefully reviewing the pre-authorisation requests and taking appropriate action within 24 hours of pre-auth initiation. Pre-authorisations are forced approved if SND does not review them within 24 hours. Pre-authorisations for unspecified packages are forced approved if not reviewed within 48 hours. A brief outline of Pre-authorisation adjudication is explained below.



Flow Chart 3: PPD Responsibilities and Flow

Once an empanelled hospital submits a pre-authorisation request, it moves to the SND bucket in CMS for review and approval. The SND at the SHAS must log in using their provided credentials to the CMS portal (https://bskyportal.odisha.gov.in/). (Figure 9)

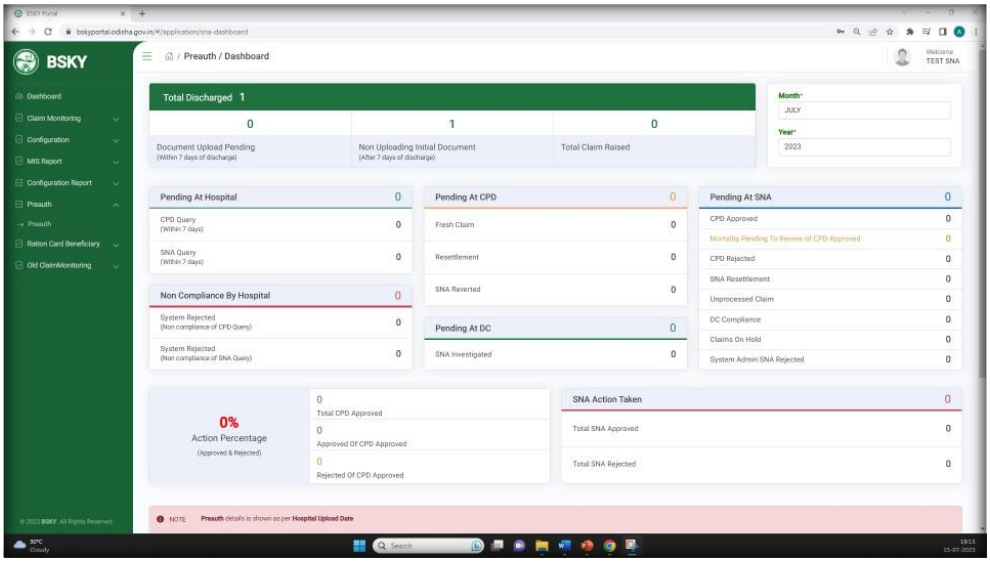


Figure 9: CMS Portal

SND will then select 'Preauth' to review the pending pre-authorisation requests and select the 'Action' button to review the selected pre-authorisation. The summary of the pre-authorisation requests and past pre-authorisation actions of the concerned SND are shown in the 'Pending' and 'SNA Action Taken List', respectively. (Figure 10)

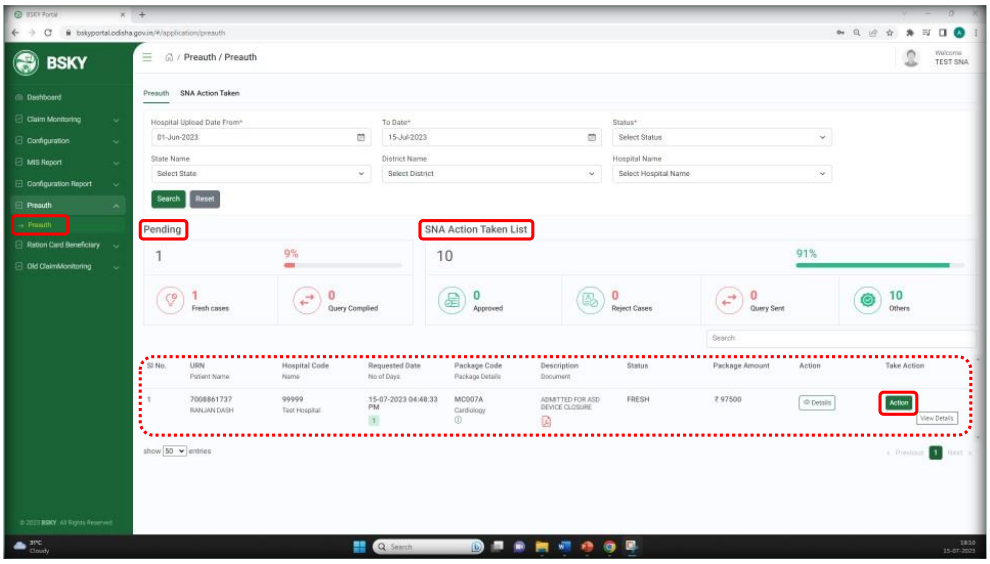


Figure 10: Pre-authorisation

When a pre-authorisation request is selected, the portal displays hospital Information, Patient Information (including contact and authentication details) and details of the blocked treatment for review by the SND. (Figure 11)

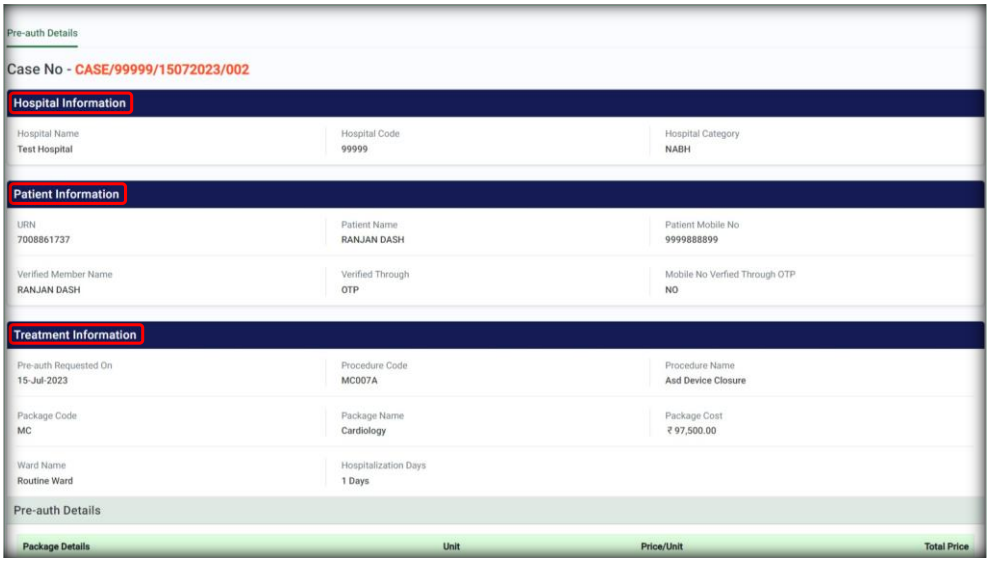


Figure 11: Hospital, Patient and Treatment Information

The SND then reviews the treatment package details, including the details of the implant and/or high-end drugs blocked by the empanelled hospital in the 'Pre-auth Details' section. The documents submitted by the EHCP can be reviewed by clicking the document icon under the 'Latest Document Uploaded' section. (Figure 12)

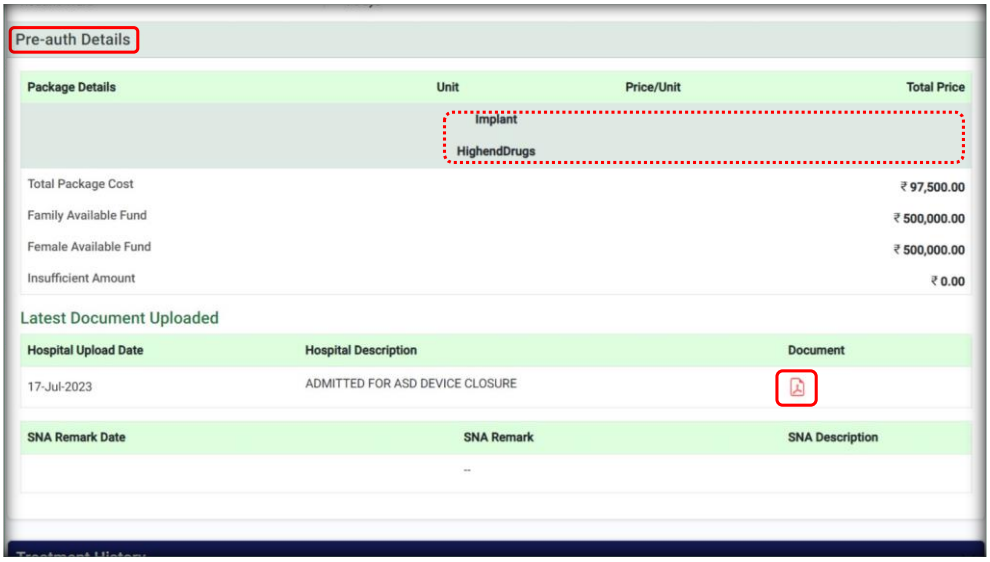


Figure 12: Pre-auth Details and Uploaded Documents

The SND can verify the patient's past treatment history under BSKY in the "Treatment History" section. The past claims are thoroughly verified to identify if there are any aberrations in the case. Additionally, details of previous actions taken on the case, ongoing treatments for other household members, and the blocked procedure are visible for scrutiny in the CMS. (Figure 13)

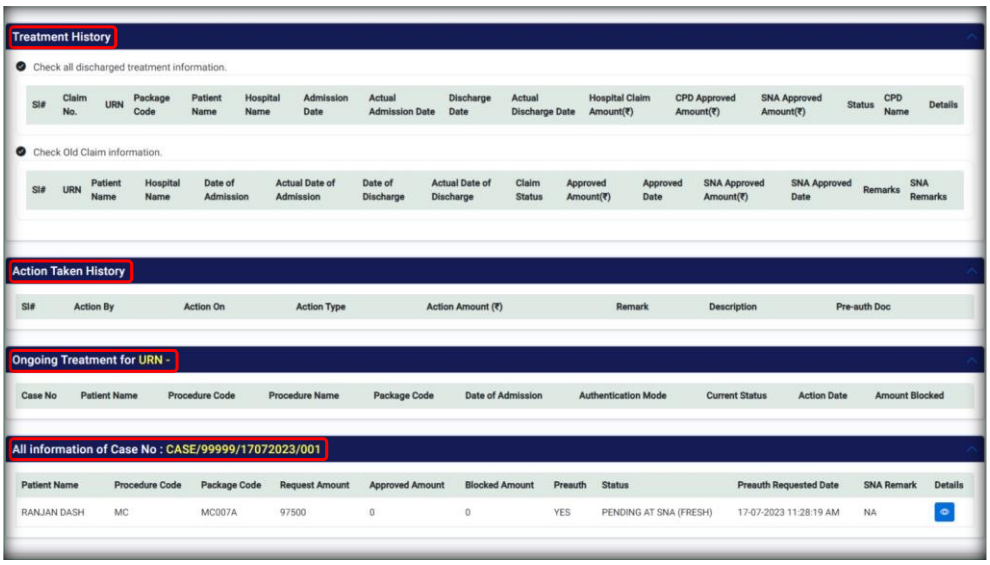


Figure 13: Treatment History, Action Taken History, Ongoing Treatment for URN, and Procedure Details

After reviewing all case details and uploaded documents, a pre-authorisation request may be approved, queried, or rejected. The SND must select an appropriate remark from the Standard Remarks Dropdown and enter a description of the action taken. If necessary, the SND can also edit the final approved amount of the pre-authorisation based on the merit of the submitted documents (Figure 14). The list of Standard Remarks is detailed in Annexure - II at the end of this document.

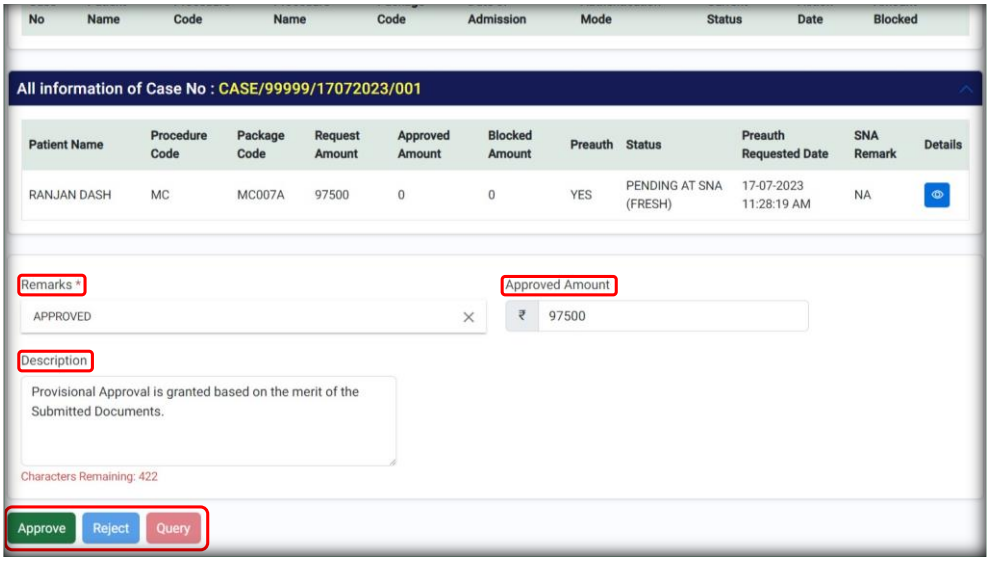


Figure 14: Pre-authorisation Actions

After carefully reviewing the pre-authorisation request and validating the necessity of the requested treatment, the SND approves the pre-authorisation, and the case will return to the "Pre-Auth" Tab in TMS. (Figure 15)

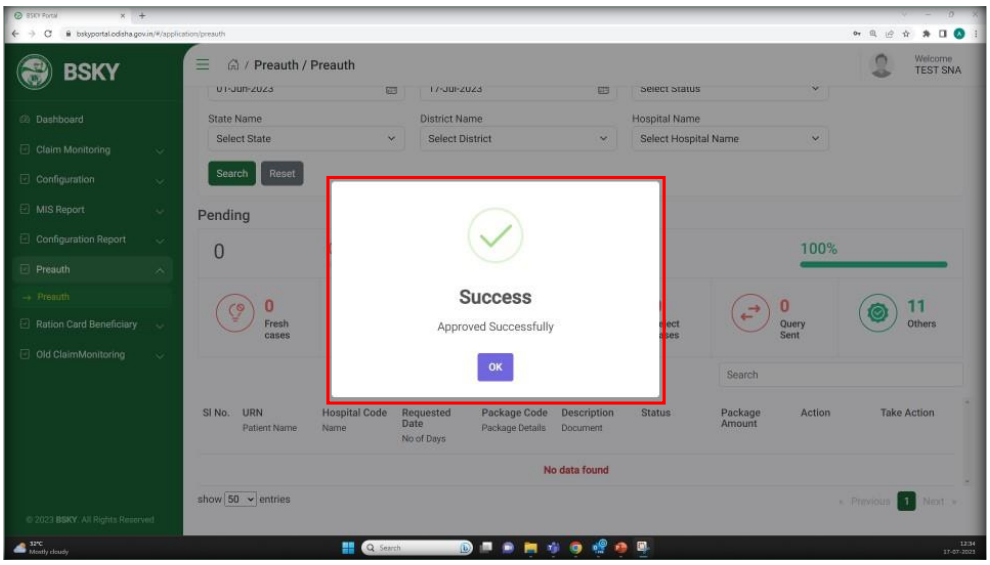


Figure 15: Pre-authorisation Approved Successfully

Note:

- *The pre-authorisation requests should be reviewed within 24 hours as built-in into CMS.*
- *If SND takes no action against the raised Pre-authorisation within the defined 24 hours, it will be forced approved. Pre-authorisation for unspecified packages is forced approved if not reviewed within 48 hours.*
- *In emergencies, the EHCP shall stabilise the patient first and then proceed with beneficiary verification, and in such cases, pre-authorisation approval is not required.*

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

- Ensure that treatment under the scheme is provided solely to eligible and legitimate beneficiaries. Aadhaar-linked biometric authentication at admission and discharge is mandatory.
- In case of lack of clarity/discrepancy or unavailability of the required information, the SND can raise queries to the EHCP asking for more details.
- Ensure that the EHCP uploads all mandatory documents and that the illness's signs, symptoms and duration are corroborated with the primary diagnosis.
- Ensure that the investigations and diagnostics submitted by the EHCP confirm the final diagnosis.
- Ensure that the treatment package requested by the EHCP is in sync with exhibiting symptoms and the final diagnosis and follows standard treatment modalities.
- Verify the treating doctor's signature, registration number and qualifications.

Pre-authorisation Query:

If SND cannot make a decision based on the available documents and requires further information, they can raise a query to the hospital. All the deficient documents/information should be asked in one go. The MEDCO at the EHCP should promptly provide SND with the requested information (Query Response) within 7 days.

SND can select the most required deficient document/information from the dropdown options. If multiple documents/information are needed, SND can use the 'Others' option and enter the necessary query details. Sometimes, the query response from a hospital is inadequate, and SNDs may need to raise the same query again. In such cases, SND should explain the reason for rejecting the hospital's response in the 'remarks' box. The SND should raise queries a maximum of 2 times only, and if the necessary information from the EHCP is still not obtained, the pre-authorisation request should be rejected.

Pre-Authorisation Rejection and Reasons:

Based on the scrutiny of the submitted documents, a pre-authorisation may not be admissible, and SND may decide to reject the Pre-authorisation. The PPD should always mention the reason for the rejection of the Pre-authorisation.

The common reasons for the rejection of Pre-authorisation requests are as follows:

1. The clinical findings do not justify the need for hospitalisation.
2. Supporting documents and investigation reports necessary to take a decision are not submitted even after multiple queries/reminders.
3. Fraud and Misrepresentation.
4. The sought treatment falls under the list of exclusions as per the policy terms and conditions.

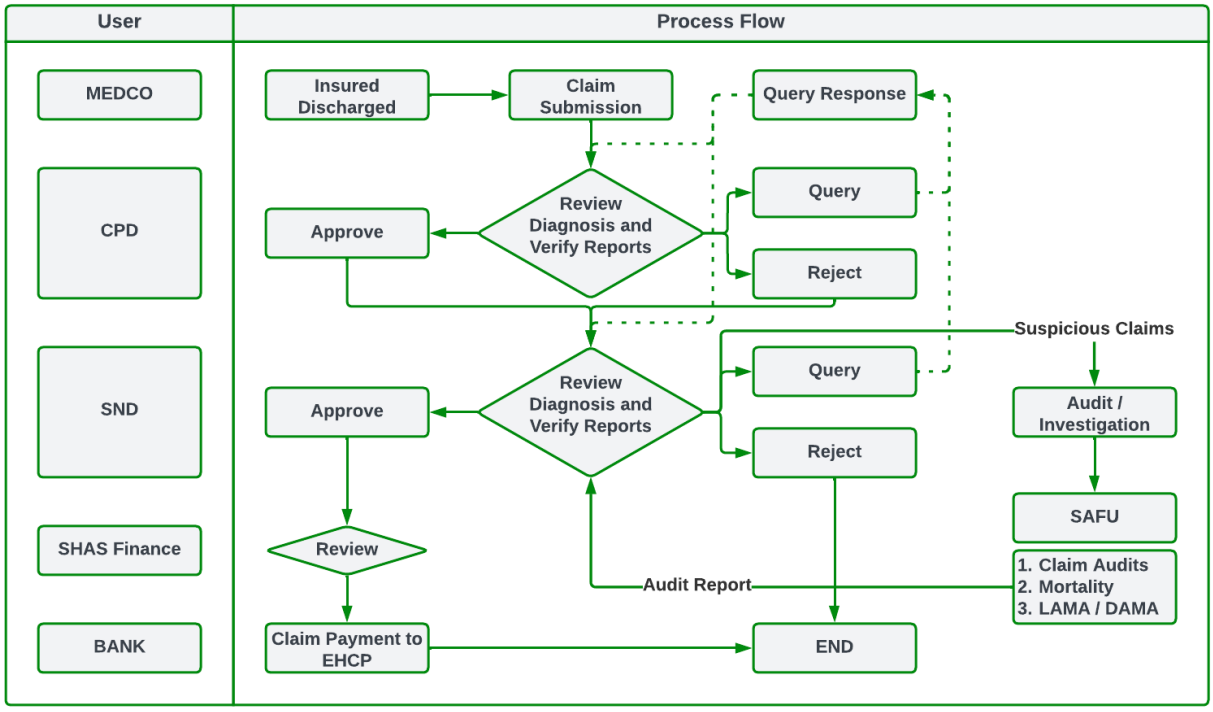
Roles and Responsibilities in the Pre-authorisation Process:

Sl. No.	*Role*	*Responsibility*	*Description*
1.	Medco / DEO	• Validate and authenticate beneficiaries in TMS. • Block appropriate package(s). • Raise Pre-authorisation request in TMS. • Respond to queries raised by SND.	• Validate beneficiary household using Adhaar/NFSA/SFSS ID and authenticate the patient. • Based on the diagnosis, block the appropriate package(s). • Initiate pre-authorisation and provide query response, if necessitated.
2.	SND	• Verification of medical/clinical information. • Decision-making on admissibility and quantum of a claim.	• Review diagnosis, verify reports, clinical notes, evidence etc. • Approve / Reject Pre-authorisation. • Raise query / Send back to EHCP for clarification.

Table 4: Roles and responsibilities in the Pre-authorisation process

4.4. CLAIMS WORKFLOW

The MEDCO, CPD, SND, and SHAS Finance Team are involved in the claim's workflow. The below figure provides an overview of the claims process flow.



Flow Chart 4: Claims Process Flow

4.4.1. PATIENT DISCHARGE

After the patient completes the treatment and is discharged from the Hospital, MEDCO will discharge the patient from the TMS in the "Discharge" Tab (Figure 16).

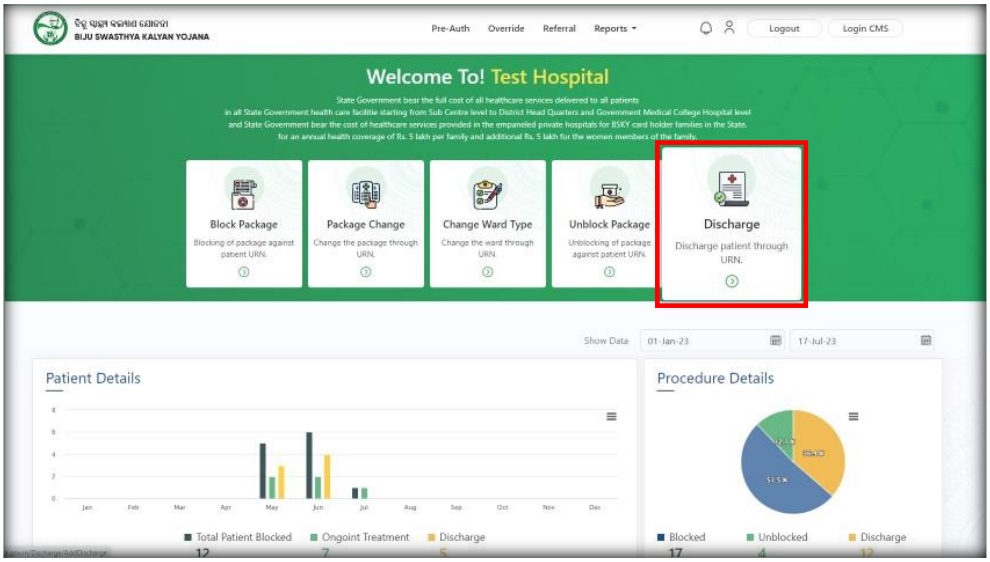


Figure 16: Discharge Tab

On selecting the "Discharge" Tab, the page expands to display the cases available for discharge. To discharge a case, MEDCO clicks the "Discharge" button against the case number (Figure 17).

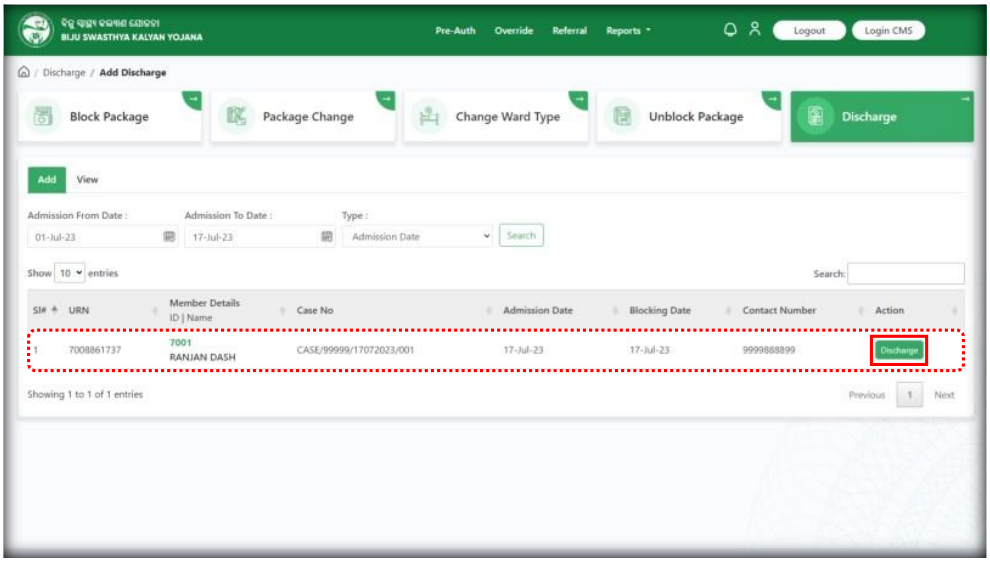


Figure 17: TMS Cases for Discharge

During discharge from TMS, the patient must undergo an Aadhaar authentication process again. This can be done by the patient or a household member through IRIS scan, POS scan or OTP. In exceptional circumstances, beneficiary authentication can be overridden by an Override Code, following approval by the competent authority at the SHAS. (Figure 18)

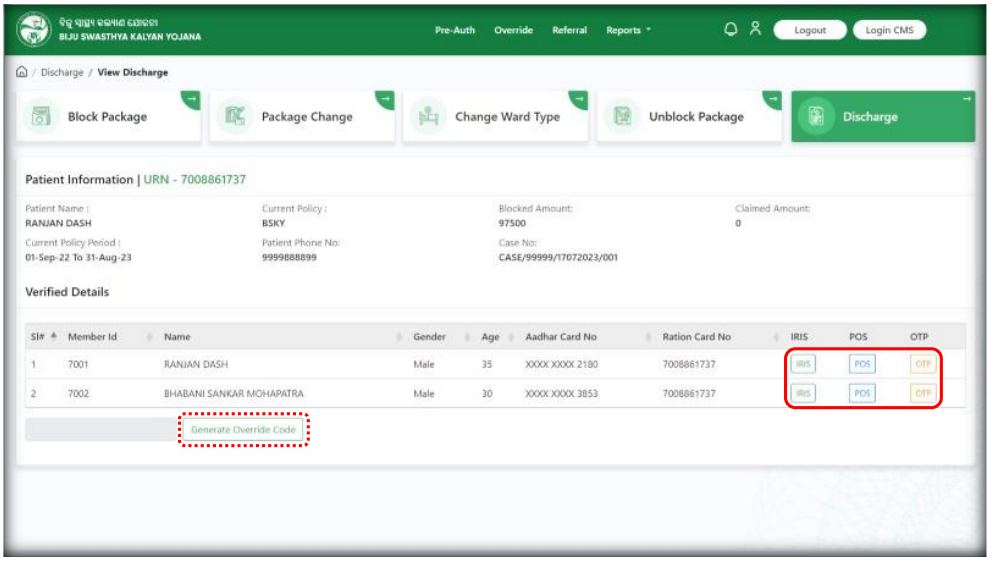


Figure 18: Patient Authentication during Discharge

After authenticating the patient, MEDCO selects the final blocked packages and enters discharge details. In case of patient death during hospitalisation, MEDCO selects 'Mortality' as 'Yes' and uploads the Death Certificate. (Figure 19)

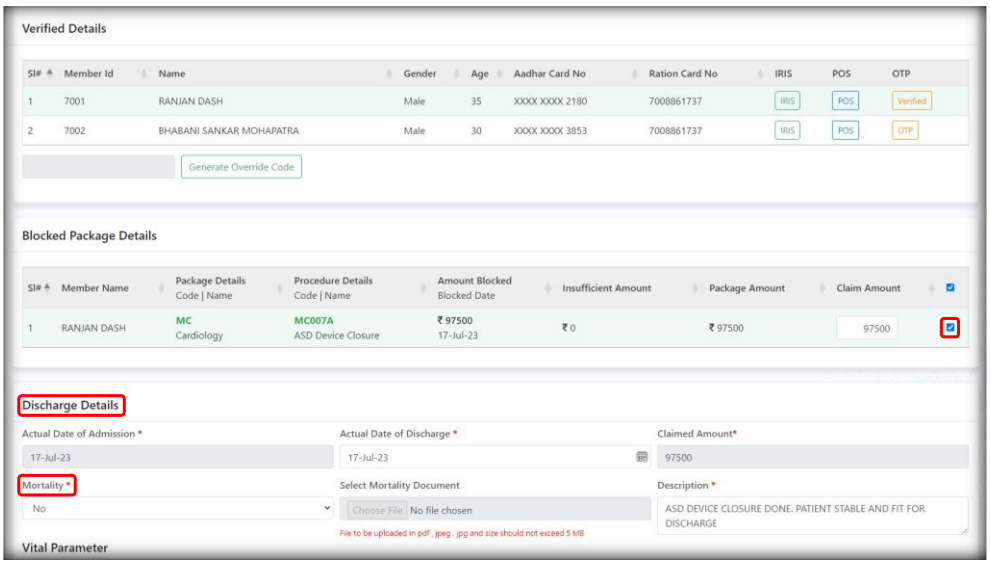


Figure 19: Selection of Final Blocked Package and Discharge Details

The MEDCO then enters the patient's vital parameters at discharge. If the patient is referred to another empanelled hospital, MEDCO selects the "Yes" option for Refer to Other Hospital and enters the relevant details. (Figure 20)

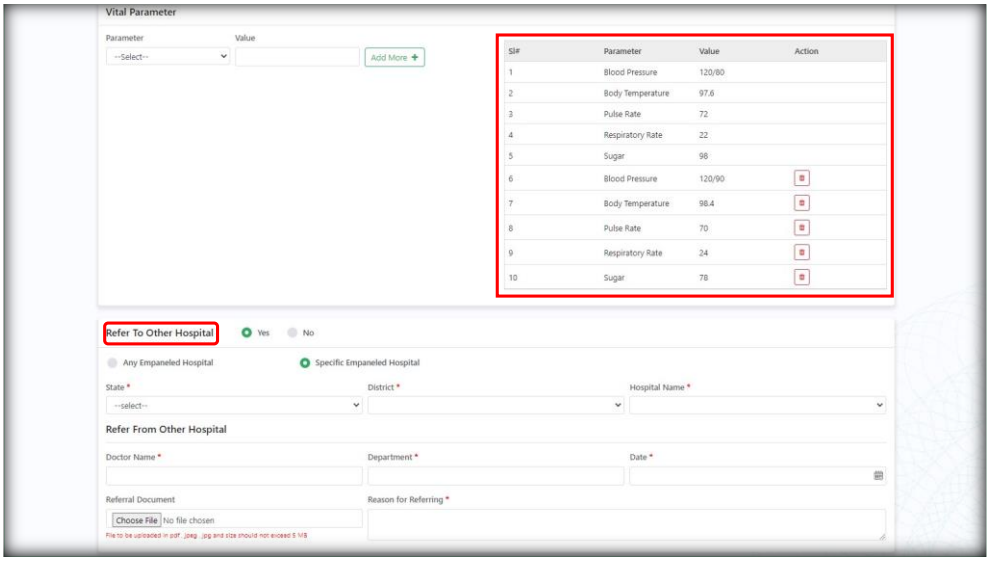


Figure 20: Vitals at the time of discharge and Refer to Other Hospital

The MEDCO then uploads all the package-specific mandatory documents at discharge as detailed in HBP. Additionally, MEDCO uploads the Pre, Intra, and Post-Surgery photographs along with the picture of the removed specimen, if applicable. After entering all mandatory details on the discharge page, MEDCO submits the claim by clicking the "Discharge" button. (Figure 21)

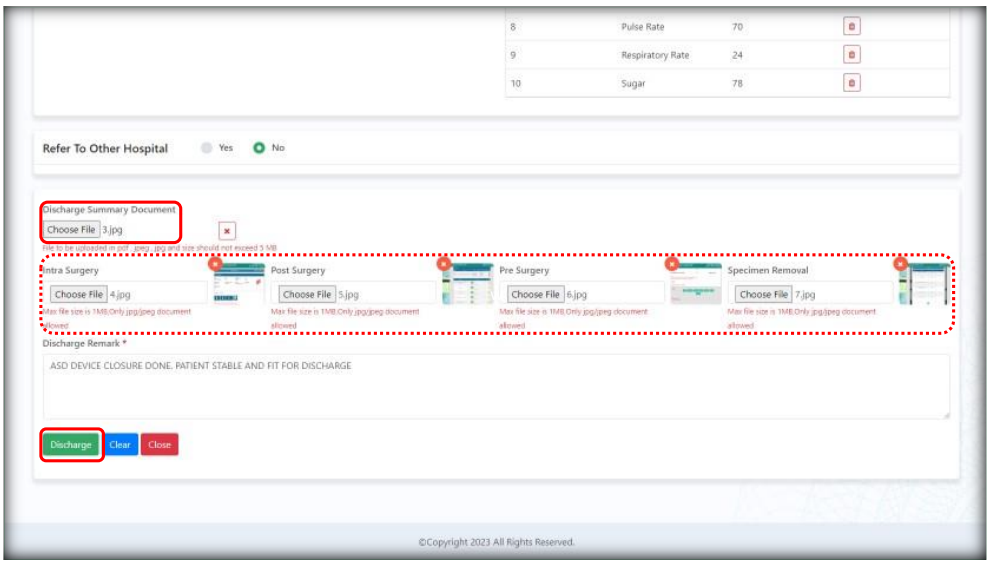


Figure 21: Document Upload and Patient Discharge

Once the patient is successfully discharged, the case will move to the EHCP bucket in CMS. The hospital must submit the claim documents within 7 days to avoid rejection by the IT System. (Figure 22)

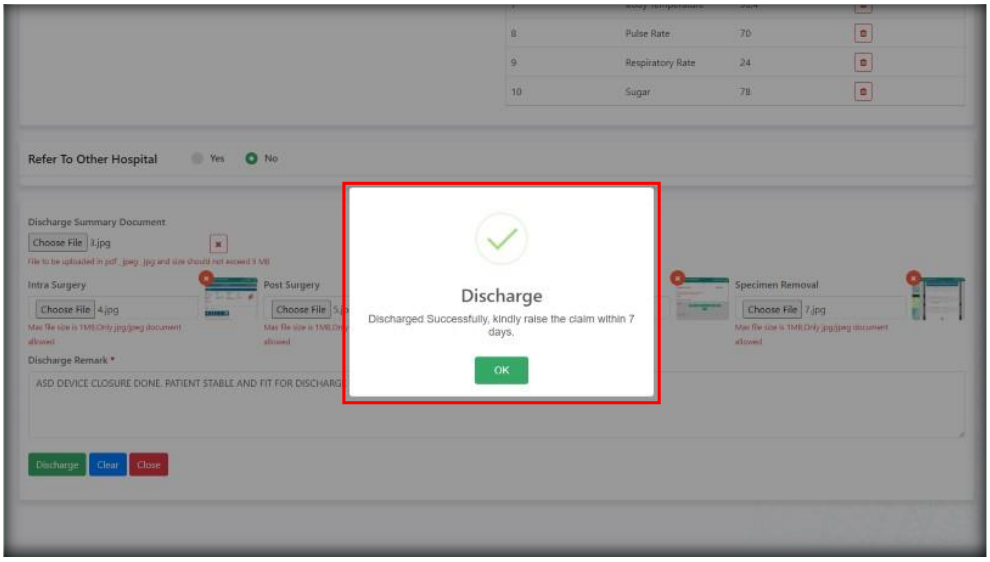


Figure 22: Patient Discharged in TMS

4.4.2. CLAIM SUBMISSION

To submit a claim, MEDCO needs to log in to the CMS portal (Figure 23). The CMS portal can be accessed by clicking the "Login CMS" button at the top right of the TMS Home Page.

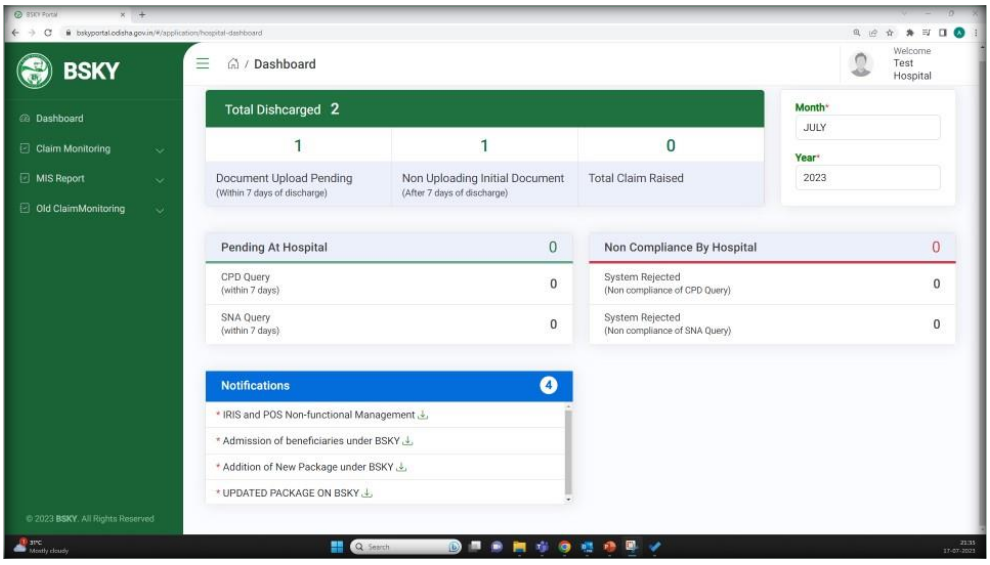


Figure 23: Login CMS

Cases for claim submission are available in the "Claim to Raise" tab under "Claim Monitoring". To submit a claim, MEDCO must click the "Claim" button against the corresponding case number. (Figure 24)

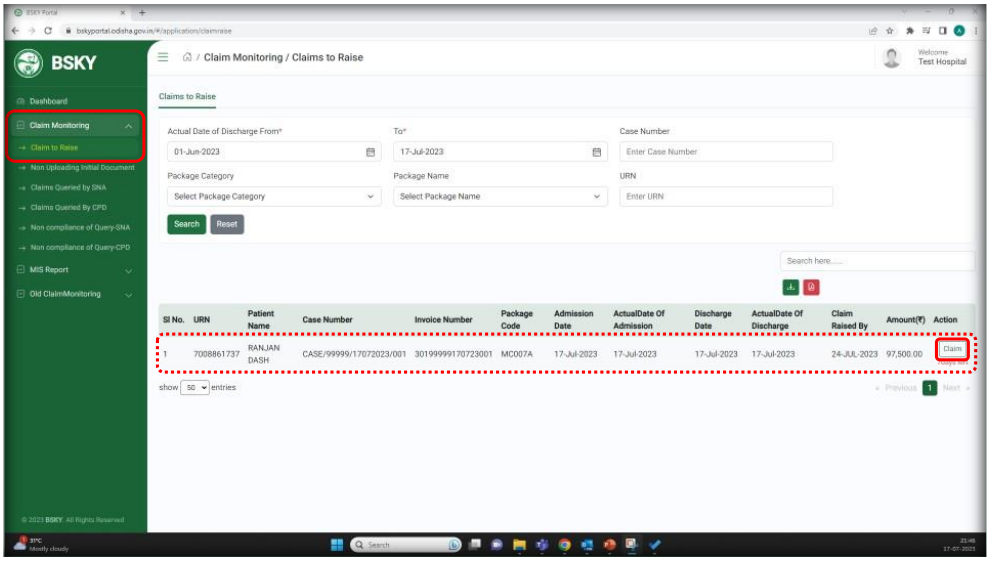


Figure 24: Claim to Raise

The claim details, such as Basic Information, Patient Information, Blocked Treatment Details and the Pre-auth Log, are visible to the MEDCO when selecting a case. (Figure 25)

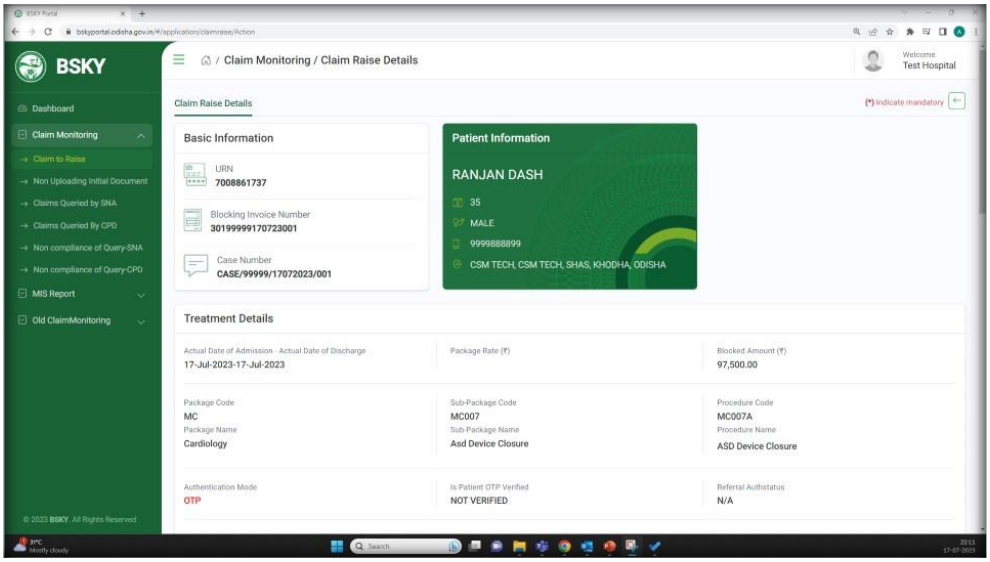


Figure 25: CMS Claim Raise Details

The MEDCO proceeds to upload all the package-specific mandatory documents in the "Discharge Slip" and "Additional Slip" fields. The mandatory documents to be submitted at the time of claim submission for each package are detailed in HBP. Once all the mandatory documents and the necessary photographs are submitted, MEDCO can proceed with claim submission by clicking the "Submit Claim Request". (Figure 26)

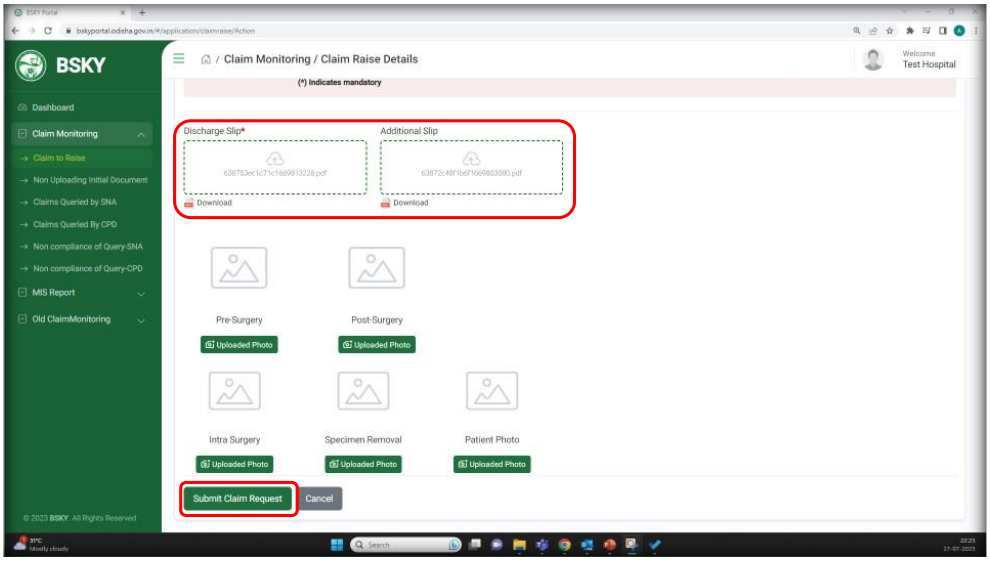


Figure 26: Document Upload and Claim Submission

After a claim is submitted successfully, it is assigned a unique claim number and moves to the CPD bucket in CMS for adjudication. (Figure 27)

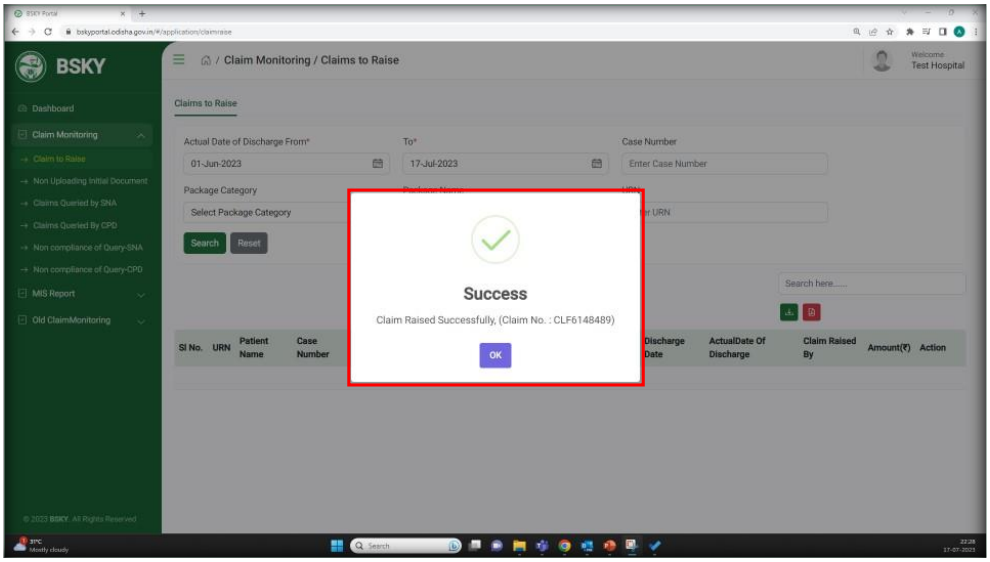
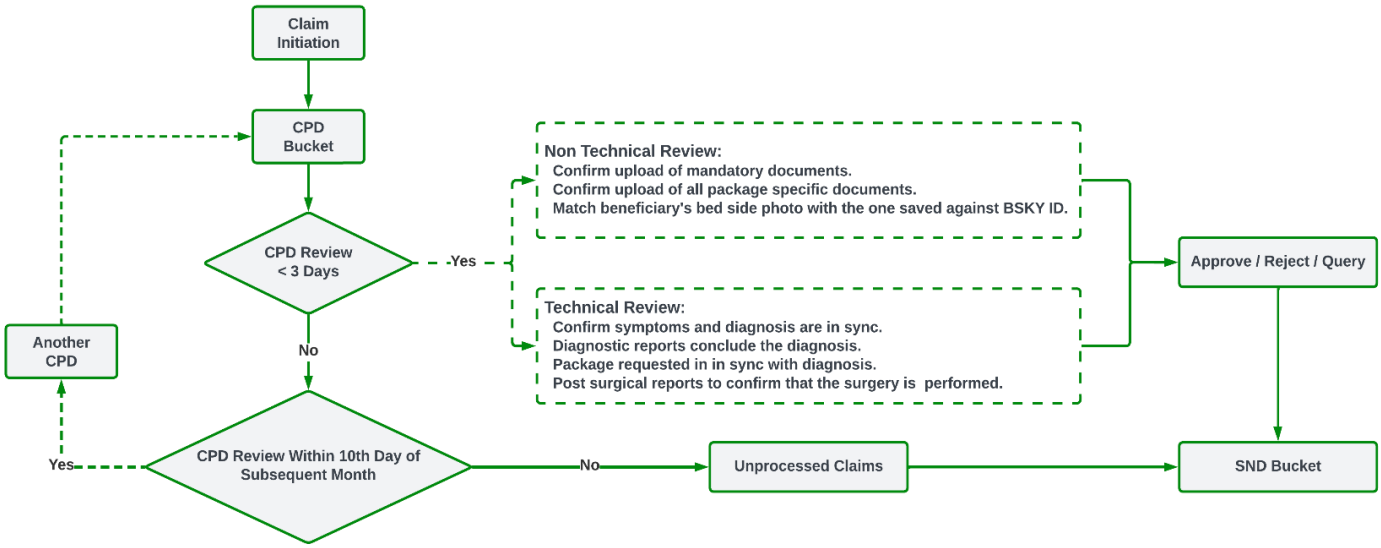


Figure 27: Claim Submission Successful

4.4.3. CLAIM ADJUDICATION BY CPD

After MEDCO submits a claim, a unique claim number is generated for the claim, and it will move to a CPD bucket in the CMS portal. The assigned CPD will have 3 days to complete the claim adjudication. If the CPD does not process the claim within 3 days, it will be randomly assigned to another CPD for adjudication. Claims not processed by the 10th day of the subsequent month will be tagged as Unprocessed Claims and will move to the SND bucket for further review. To better understand this process, refer to the following diagram.



Flow Chart 5: CPD Adjudication Process

The CPD will log in to the CMS using the credentials provided to adjudicate a claim. Next, they will navigate to the 'Claim Monitoring' tab, select 'CPD Approval', and click the 'Action' button corresponding to the claim they want to review. (Figure 28)

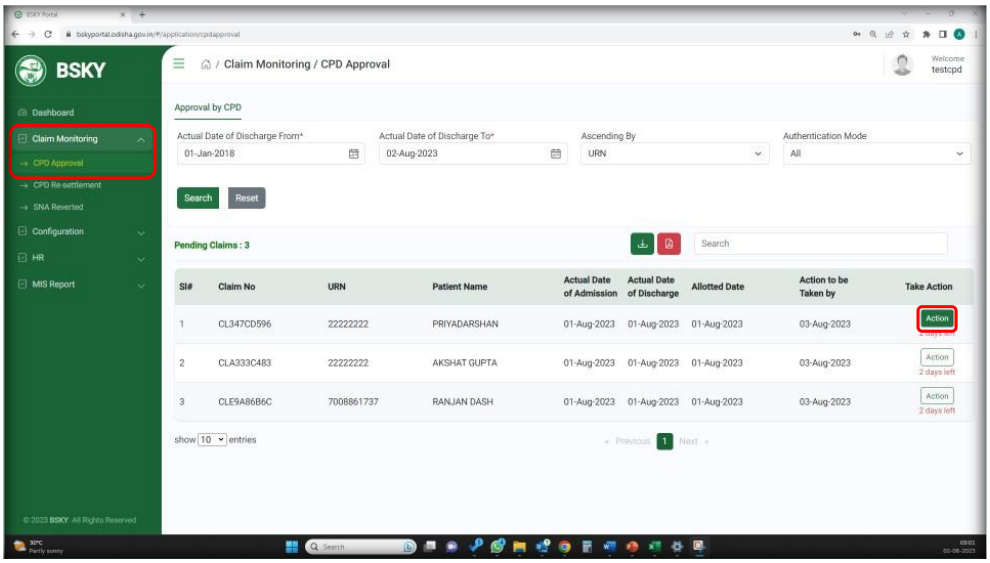


Figure 28: CMS CPD User and Claim Selection

During claim adjudication, CPD should follow a comprehensive approach consisting of Technical and Non-Technical reviews. These reviews complement each other to provide a thorough evaluation of every claim. This meticulous process ensures that all relevant parameters are scrutinised, leading to reliable and accurate adjudication.

Non-Technical Review:

To verify the accuracy of the claim, CPD will conduct a non-technical review to confirm the individual's name, age, and gender. Furthermore, the availability of all supporting documents is also to be ensured. The Non-Technical review will examine the following details.

1. Confirm if all mandatory documents detailed in the MDP have been submitted and are legible.
2. Confirm if the Date of Admission and Date of Discharge updated in the TMS match the submitted documents.
3. Confirm if the name, age and gender of the beneficiary detailed in the BSKY database match the submitted documents.
4. Confirm if all the documents are duly signed by the treating doctor.

Technical Review:

For the technical review, the CPD diligently examines the submitted claims and validates all medical details, including patient information, diagnosis, treatment plans, and supporting investigations. This review ascertains the medical necessity of the treatment for the patient's medical condition, as evidenced by the supporting documents and investigation reports, and determines the admissibility and amount of the claim.

On selecting a claim, the CPD can review the patient and treatment details, including the hospitalisation specifics and the package blocked. (Figure 29)

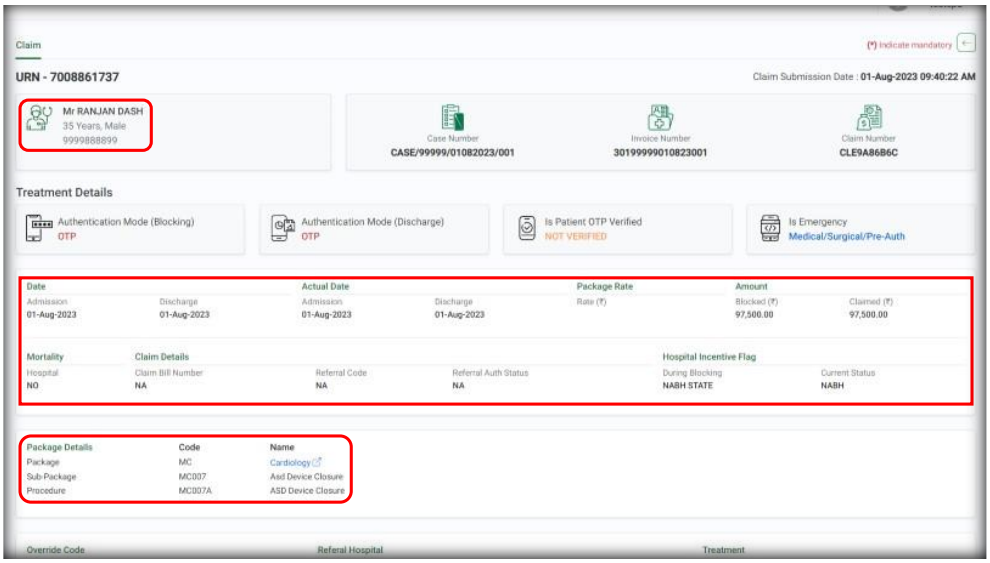


Figure 29: Review of Patient Details and Treatment Details

CPD will then review the pre-authorisation details along with the documents submitted during package blocking and the discharge details along with the documents submitted at the time of claim submission to ascertain the medical necessity and confirm the treatment provided. The CPD then validates the patient and clinical photographs submitted by the EHCP. (Figure 30)

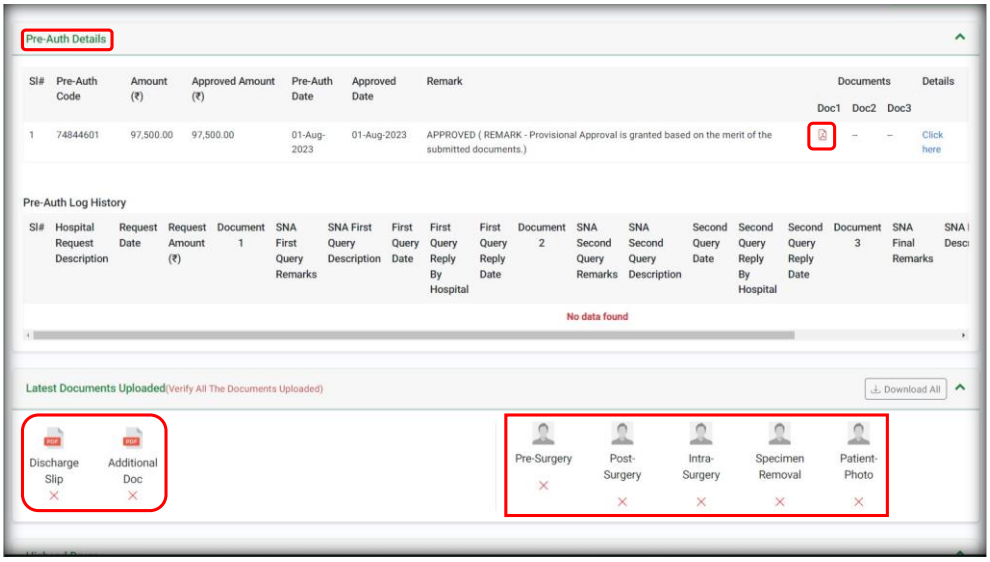


Figure 30: Review of Pre-authorisation and Discharge Details with Documents

After verifying the treatment details, CPD reviews the High-End Drugs and Implants Details, if any, and confirms the patient's bed category during hospitalisation to determine the payable quantum of the claim. Additionally, CPD verifies the beneficiary's past treatment history to ensure there are no aberrations. (Figure 31)

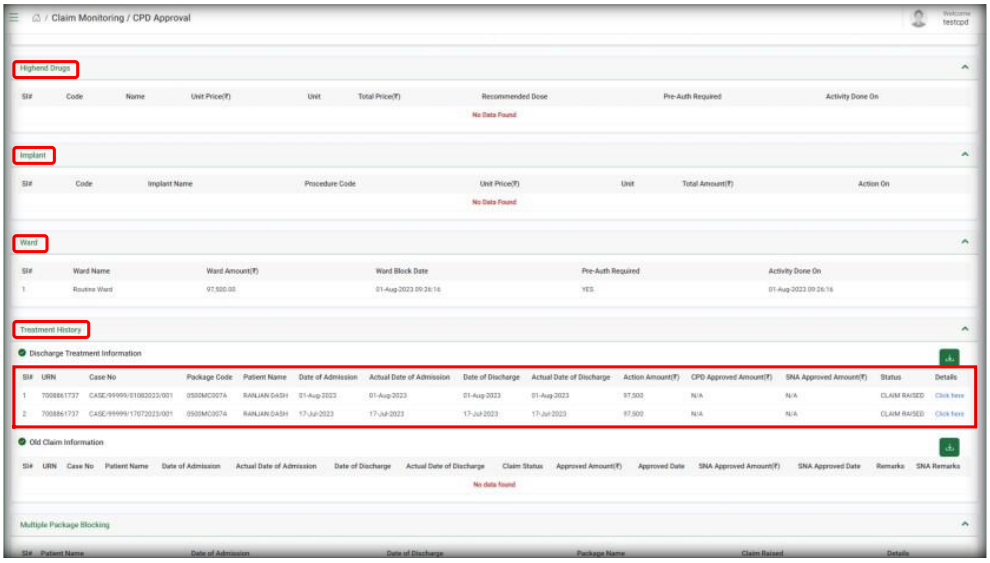


Figure 31: High-End Drugs and Implant Details, Ward Category and Past Treatment History

Once all the details have been reviewed and scrutinised, the CPD can either approve the claim, raise a query, or reject the claim, based on the merit of the uploaded documents, after due diligence. Partial payment can be approved if the claim details or documents do not justify the entire claim. CPD can edit the payable amount in the 'Approved Amount' tab. The CPD needs to select the most relevant remark from the dropdown and enter the description of the action taken. The CPD also needs to confirm the mortality status of the patient in the 'Mortality' dropdown if the patient has expired during the hospitalisation. (Figure 32)

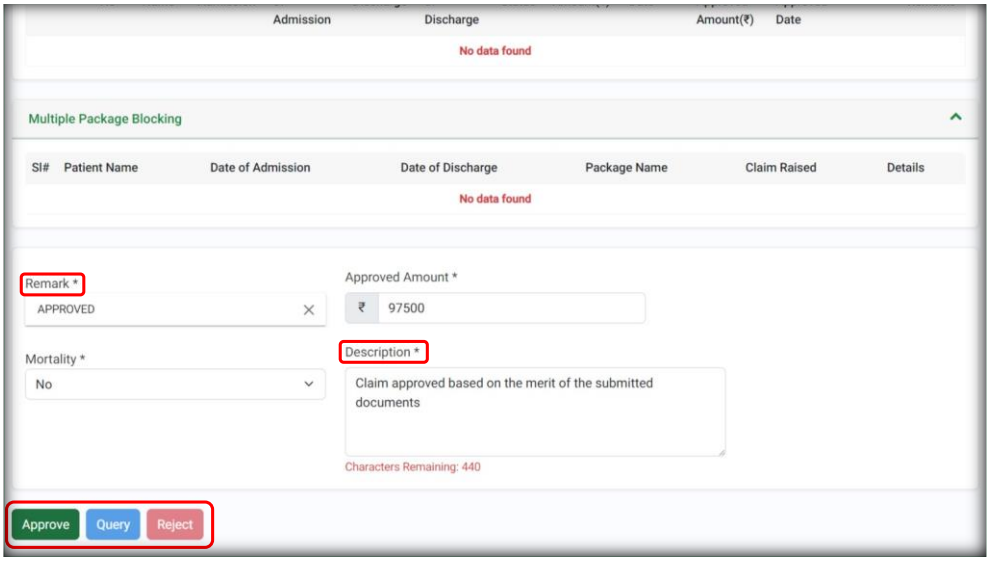


Figure 32: CPD Action

If CPD needs additional documents/information to decide on the claim, they should ask for all the deficient documents/information in one go. Under no circumstances should CPD raise queries to EHCP more than once. The MEDCO at the EHCP should promptly provide the requested information (Query Response) within 7 days. CPD can select the most required deficient document/information from the dropdown options. If multiple documents/information are needed, CPD can use the 'Others' option and enter the required query details. If the necessary information from the EHCP is still not obtained, the claim should be rejected, and SND will further review the claim. After diligently reviewing all the claim details and determining the payable amount, the CPD can approve the claim. Once approved, the claim will be moved to the SND bucket for review. (Figure 33)

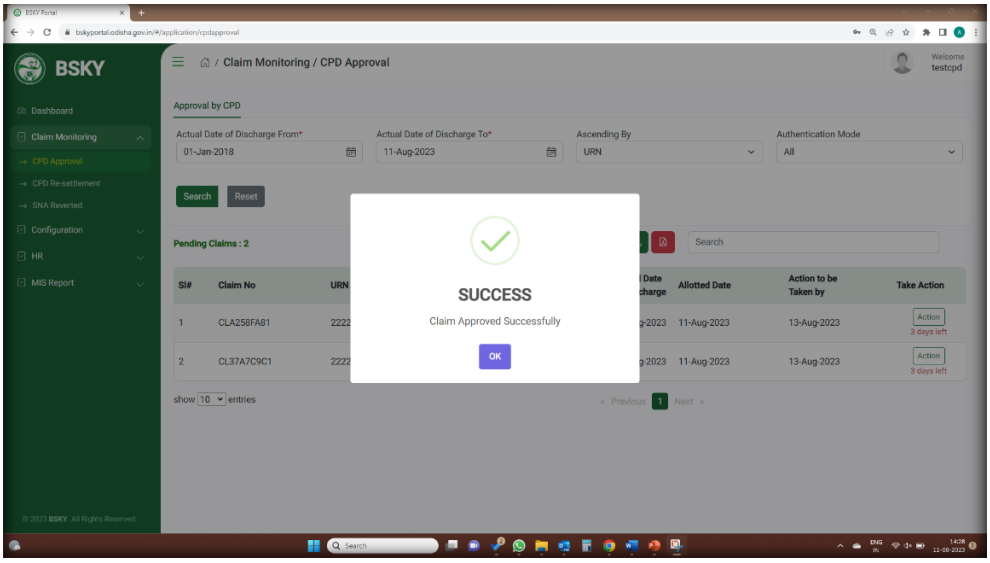


Figure 33: Claim Approved by CPD

CPD Re-settlement Claims:

CPD will raise queries on claims requiring additional documents or information for final action and can review the query responded claims in the 'CPD Re-settlement' bucket under the 'Claim Monitoring' tab. CPD will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 34)

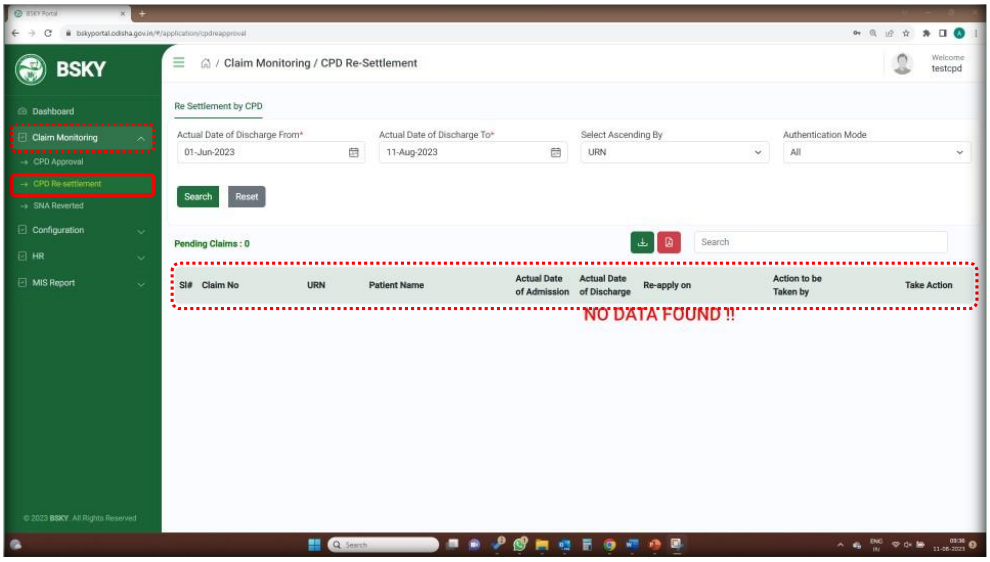


Figure 34: CPD Re-settlement Claims

After diligently reviewing the CPD Re-settlement claims, CPD will select the most relevant remark, enter the description of the action taken, and take appropriate action.

SNA Reverted Claims:

If the SND finds a shortfall in the quality of CPD adjudication, they will revert such claims to the CPD for re-evaluation. Such claims can be accessed from the 'SNA Reverted' bucket under the 'Claim Monitoring' tab. CPD will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 35)

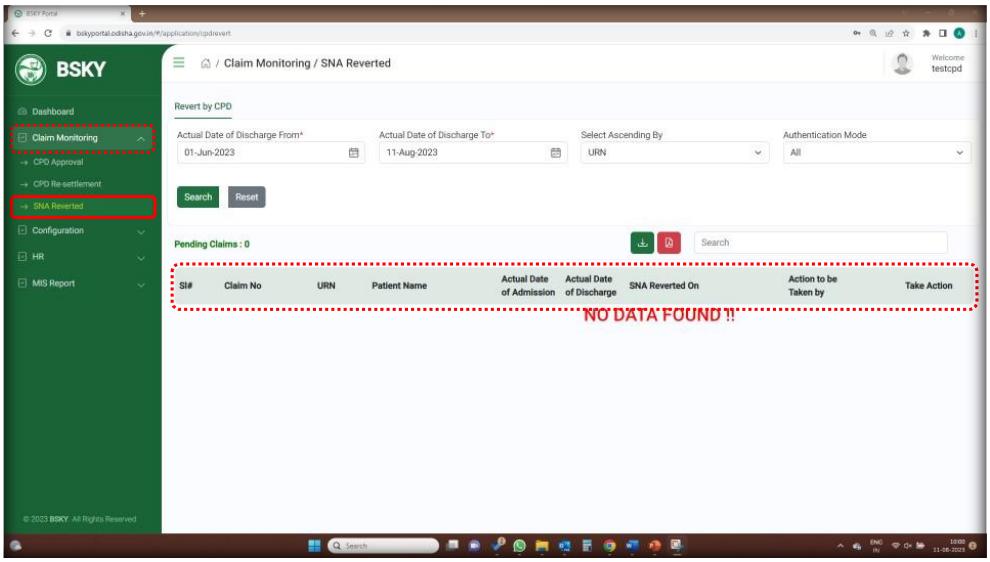


Figure 35: SNA Reverted Claims

After diligently reviewing the SNA Reverted claims, CPD will select the most relevant remark, enter the description of the action taken, and take appropriate action within 24 hours of SND revert. If the SNA Reverted claims are not processed within 24 hours, the claims will be pushed back to the SND bucket as unprocessed claims.

While making a decision, it is crucial to take into account the following:

1. The EHCP is responsible for uploading all mandatory documents as stated in the MDP. Still, failure to submit these documents alone cannot result in claim rejection unless it is crucial to CPD decision-making.
2. Ensure that the physician's final diagnosis and the treatment provided are consistent with the symptoms, signs, and duration of the patient's illness.
3. Ensure that the investigations and diagnostic reports uploaded by EHCPs support the final diagnosis and validate the post-surgery reports to confirm that the blocked surgery has been performed.
4. CPDs should validate the LOS with the discharge summary and carefully verify the ward category and, subsequently, the approval amount.
5. Ensure that the packages blocked by EHCPs align with the final diagnosis of the claims.
6. CPDs should verify the signature of the treating doctor along with the registration number and qualification.
7. In case of death claims, CPD should review the death summary, prognosis notes and other relevant documents.
8. The rates claimed for Implants and High-End Drugs should be validated with the GST Purchase Invoice.

The Generalised List of Documents for CPD Scrutiny is as follows:

1. OT notes and surgery notes as applicable.
2. Clinical notes.
3. Discharge summary.
4. CPD should ensure that the clinical photograph uploaded is relevant and not a "Google" image.
5. Investigation reports.
6. ICP records as applicable.
7. ICU Master Charts/ Nursing Charts are submitted in Mortality / ICU Claims

Post CPD scrutiny, the claim actions can be as follows:

1. If everything is in order and all the relevant parameters are deemed satisfactory by CPD, the claim will be approved.
2. If there are any deficient or incomplete documents, CPDs should raise a query for them.
3. If the claim does not meet the criteria for approval and payment, it can be recommended for rejection.
4. In cases where the details or documents do not support an entire claim, the CPD can recommend approving partial payments.

Claim Rejection:

After careful scrutiny, CPD may recommend the rejection of a claim with appropriate justification and remarks. Such cases will then be forwarded to SND for further review. After diligently reviewing such claims, SND may reject the claim if deemed necessary. Such claims can be sent to the Technical Committee for reconsideration. The SHAS reserves the right to revoke a rejected claim, and if the SHAS decides to revoke a claim, it will be sent back to the SND bucket for re-adjudication. Rejection of claims is recommended under the following scenarios:

1. Based on the clinical findings submitted by the EHCP, the need for hospitalisation is not justified.
2. Despite multiple queries/reminders, the necessary supporting documents and investigation reports for CPD decision-making have not been provided.
3. Fraud and Misrepresentations.
4. Insufficient beneficiary household wallet amount.
5. The treatment sought falls under the list of exclusions as per the scheme policy.

4.4.5. CLAIM REVIEW BY STATE NODAL DOCTORS (SND)

The State Nodal Doctors (SND) play a pivotal role in the Biju Swasthya Kalyan Yojana (BSKY), encompassing a comprehensive review process. This involves reviewing 10% of CPD approved claims and 100% of rejected, mortality, re-settlement, and unprocessed claims on a monthly basis. This meticulous evaluation is repeated to ensure that all relevant parameters are thoroughly scrutinised, ultimately resulting in reliable and accurate claim adjudication.

CPD Approved Claims Review:

SND shall randomly review 10% of the total claims approved by the CPDs during a calendar month for review. The review should focus on verifying the accuracy of the information, adherence to BSKY guidelines, and compliance with the HBP package rates. SND shall document the review findings and provide feedback to the CPDs for necessary corrections or improvements. The SND will log in to the CMS portal with their issued credentials. To review the CPD Approved claims, SND will select the 'CPD Approved' bucket under the 'Claim Monitoring' tab. (Figure 36)

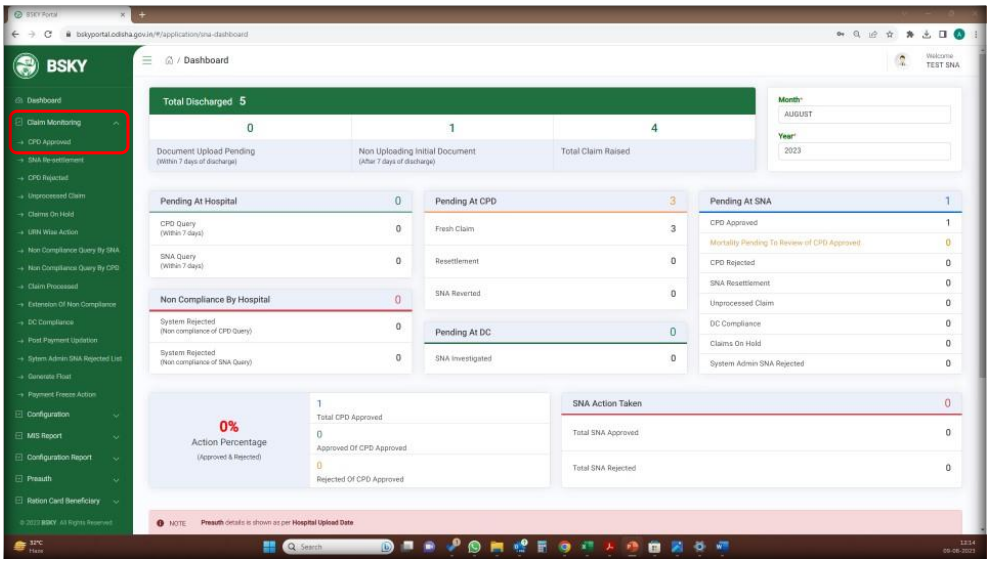


Figure 36: Claims Management System – SND User

Within the 'CPD Approved' tab, the CPD approved claims for a specific month are compiled. SND can use the 'Advanced Search' feature to precisely select and extract claims for review under the mandated 10%, ensuring an optimal distribution of claims for the SND review. SND will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 37)

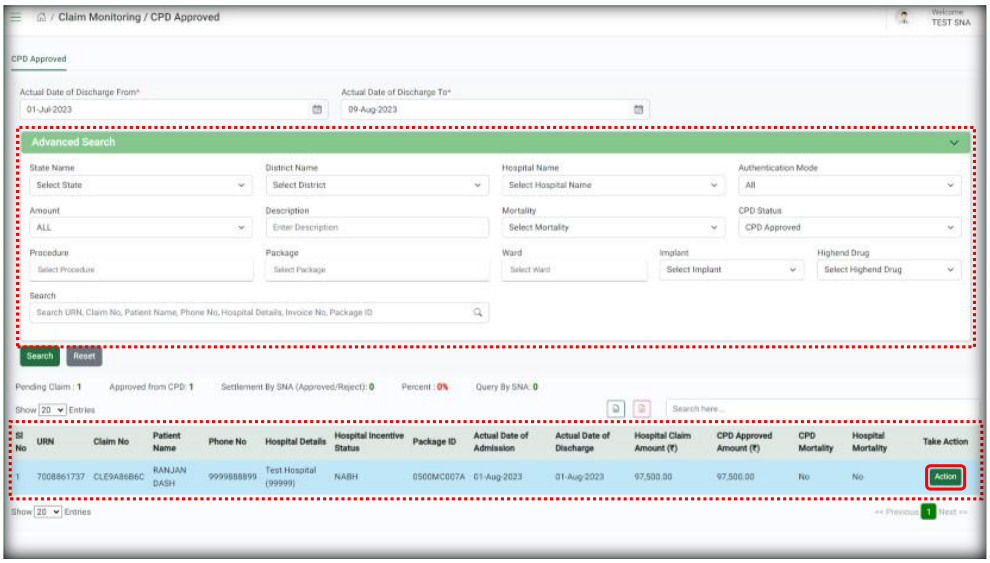


Figure 37: CPD Approved Claims

Upon selecting a CPD approved claim, the patient details, pre-authorisation and claims information are accessible to the SND for review. SND will ascertain the medical necessity and authenticity of the claim and validate the treatment provided. After diligently reviewing the claim, SND can approve or reject the claim or raise a query to the hospital to obtain more information, if necessary. Partial payment can also be approved if the claim details or documents do not justify the entire claim. SND can edit the payable amount in the 'Approved Amount' tab.

Additionally, SND can take various supplementary actions on a claim. In instances where SND finds a claim suspicious, they can push such claims for 'Investigation', which will then move to the District Coordinator (DC) login for further investigation. In cases where SND finds a shortfall in the quality of CPD adjudication, they can 'Revert' such claims to the CPD for re-evaluation. Furthermore, if necessary, SND can withhold the payment of a claim to the EHCP by selecting the 'Hold' option. On taking action, SND must choose the most appropriate remark from the dropdown options and enter the description of the action taken. (Figure 38)

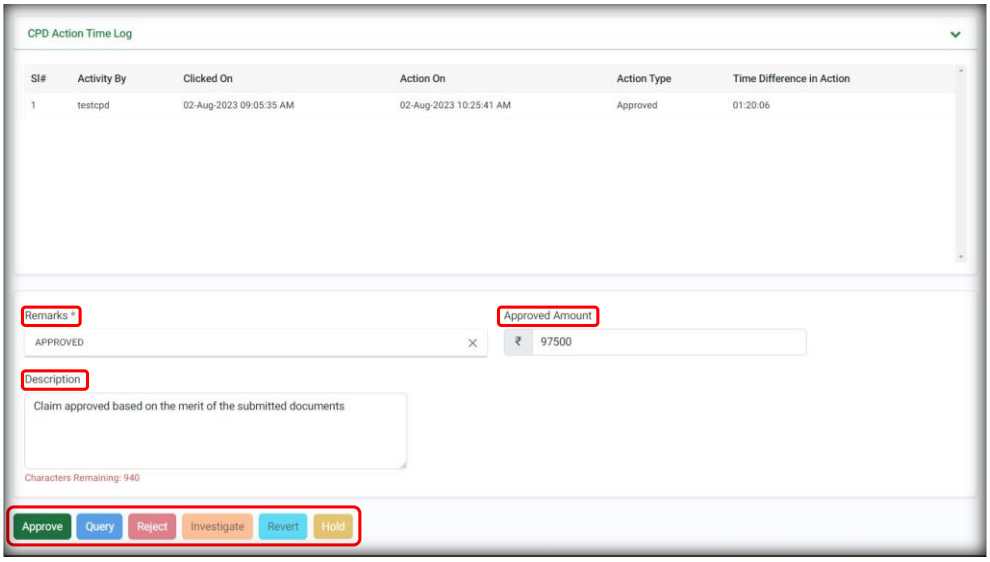


Figure 38: SND Actions

CPD Rejected Claims Review:

SND shall review 100% of the claims rejected by CPDs during a calendar month. The review aims to validate the justification for rejection based on the merit of submitted documents by EHCPs. SND shall document the review findings and provide feedback to the CPDs regarding handling rejected claims properly and guidance on decision-making. SND can access the CPD rejected claims in the 'CPD Rejected' bucket under the 'Claim Monitoring' tab. SND will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 39)

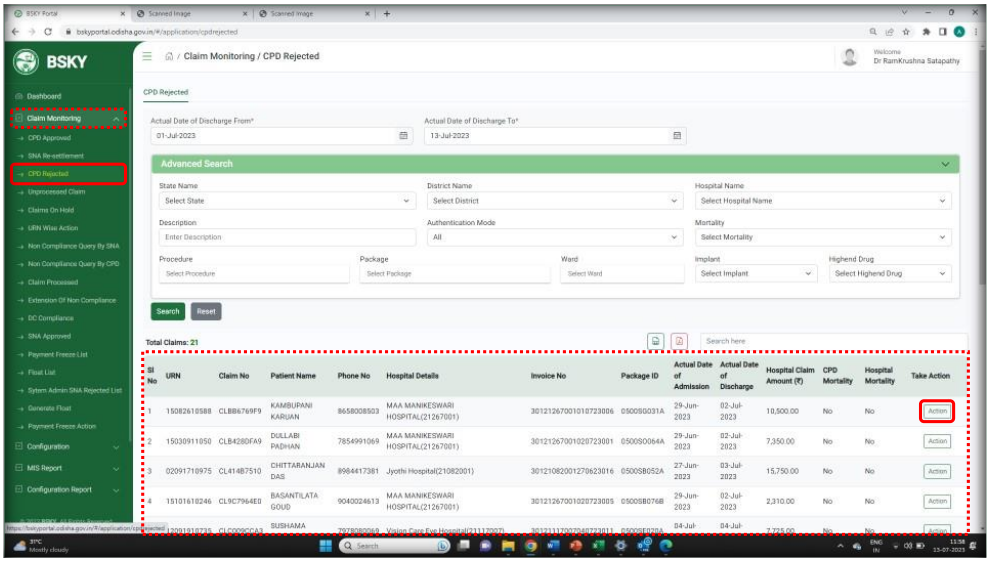


Figure 39: CPD Rejected Claims

After selecting the most relevant remark from the dropdown options and entering the description of the action taken, SND will take appropriate action on the CPD rejected claims with due diligence.

Mortality Claims Review:

SND shall review 100% of the claims related to mortality during a calendar month. The review's objective is to identify and validate any gaps in clinical care and patient safety that impact the morbidity and mortality of BSKY beneficiaries. SND shall document the review findings and provide feedback to the CPDs for necessary corrections or improvements. SND will diligently review such claims and take appropriate action after selecting the most relevant remark from dropdown options and entering the description of the action taken.

SNA Re-settlement Claims:

SND will raise queries on claims requiring additional documents or information for final action and can review the query-responded claims in the 'SNA Re-settlement' bucket under the 'Claim Monitoring' tab. SND will click the 'Action' button corresponding to the selected claims to review a claim. After diligently reviewing the SNA Re-settlement claims, SND will choose the most relevant remark, enter the description of the action taken, and take appropriate action. (Figure 40)

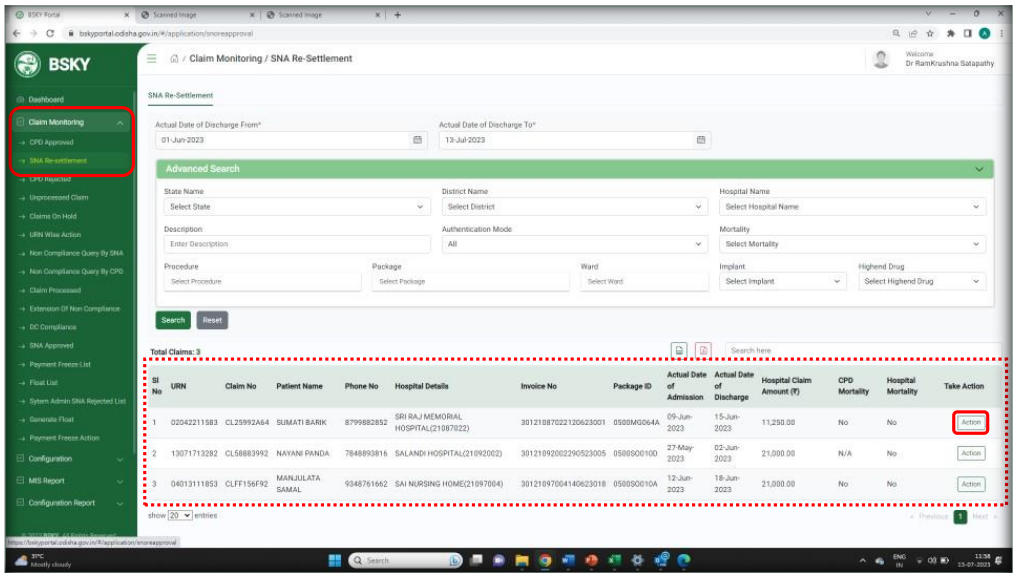


Figure 40: SNA Re-settlement Claims

Review of Unprocessed Claims:

Claims that the CPDs have not adjudicated within the 10th day of the subsequent month will be tagged as 'Unprocessed Claims' and will move to the SND bucket for review. SND must review 100% of such claims and can access such claims in the 'Unprocessed Claim' bucket under the 'Claim Monitoring' tab. SND will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 41)

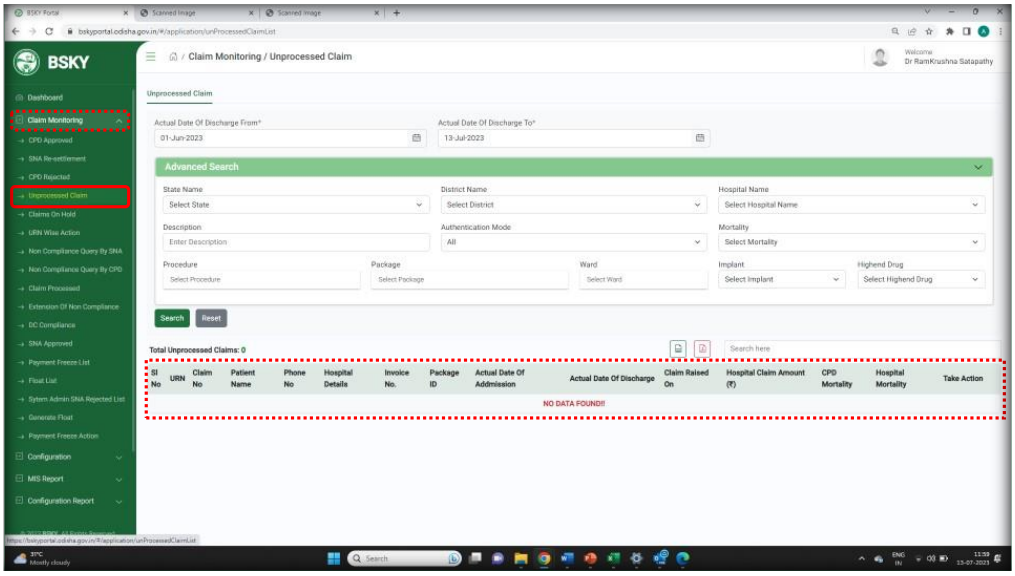


Figure 41: Unprocessed Claims

Upon completion of the review mandate for a given month, SND proceeds to generate a float or a comprehensive report and subsequently forwards it to the finance team of the SHAS. After scrutiny of the financial records and balance sheets, the claims are settled directly to the EHCP bank account through the Public Financial Management System (PFMS) based on the generated float.

4.4.6. ROLES AND RESPONSIBILITIES IN CLAIM ADJUDICATION

Sl. No.	*Role*	*Responsibility*	*Description*
1.	CPD	• Non-Technical review (non-medical/non-clinical information) • Technical review (medical/clinical information) • Decision on the claim	• Review of Non-Technical Checklist (availability of documents, dates, beneficiary ID, etc.) • Review of Technical checklist (diagnosis, reports, clinical notes, evidence etc.) • Approve/Assign/Reject claims • Raise query to EHCP for clarification • Validate the claimed amount and final approval amount
2.	SND	• Re-verification of medical/clinical information • Decision-making on admissibility and quantum of a claim • Validate financial information of 10% of CPD approved claims	• Review diagnosis, verify reports, clinical notes, evidence etc. • Approve / Reject Claims • Raise query / Send back to EHCP for clarification • Trigger the cases for investigation/audit if required
3.	Technical Committee	• Verify disputed claims	• Respond to queries/reconciliation issues raised by EHCPs concerning the final payment.

Table 5: Roles and Responsibilities in the Claims Process

4.5. CLAIM PAYMENT PROCESS

The bank will initiate the claim payment process once SHAS approves the float generated for the claims raised during a particular month. The approved amount will be transferred to the EHCP bank account. SHAS will adhere to the appropriate PFMS guidelines while making payments for BSKY claims.

4.6. RECONSIDERATION OF REJECTED CLAIMS

After careful scrutiny of claims, SND may decide to reject a claim. The SHAS reserves the right to revoke a rejected claim. Upon revoking, the case will return to the SND bucket for re-adjudication. If EHCPs are dissatisfied with the justification provided by the SND / SHAS for the rejection of a claim or have a dispute over the claims, EHCPs can file grievances as per the grievance redressal mechanism.

Right of Appeal and Re-opening of Claims:

1. If the SHA rejects a claim made by an EHCP, the EHCP has the right to appeal the decision. Following the Grievance Redressal guidelines, an appeal can be made by filing a grievance with the DC within 15 days of the rejection.
2. If the EHCP provides appropriate and relevant claim documents that support their entitlement to re-open the claims, the SHAS and/or DGNO or the DGRC, as applicable, may reconsider re-opening the claim.

4.7. GRIEVANCE REDRESSAL

The grievance redressal mechanism under BSKY ensures that the grievances of all stakeholders, including EHCPs, are redressed in the organised mechanism and time frame as detailed in the Grievance Redressal Guidelines, updated from time to time by the SHAS.

Erroneous Claims (Partial Payment / Excess Payment / Recovery Amount): Claims that are settled for an incorrect amount, either less or more than what is payable or were not payable, according to the scheme policy, are considered erroneous claims. Erroneous claims can be due to various reasons, as follows:

1. **Partial Payment to EHCP:**
   If a claim is partially paid due to insufficient documents, it is possible to request a reconsideration of payment through CMS in the erroneous claims section. MEDCO can initiate this process by providing the missing documents. SHA will review the submitted documents for reconsideration of payment based on their merit.

2. **Excess Payment to EHCP:**
   In case of excess payment to EHCP in a settled claim, SND can initiate the recovery of the excess payment through CMS.

3. **Wrong Claim Payment to EHCP:**
   If payment is made incorrectly to EHCP, SND has the option to raise a recovery request through CMS.

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

5. PAYMENT IN SPECIAL CASES

After a patient is admitted to an empanelled hospital under BSKY, they will be discharged once their treatment is completed. Typically, the hospital will receive payment based on the package booked and the rates defined for that package in most cases. However, this may not happen in some cases for various reasons. For instance, a patient may choose to leave against medical advice, expire while still in the hospital, or require a referral to another medical facility. The EHCPs and the SHAS need clarity regarding payments in these special cases. The following guidelines follow basic principles and outline the payment process in these exceptional cases.

- For the partial payment to be considered, the EHCP must notify the SHAS of any deviations from the normal course within 24 hours.
- Additionally, payment will only be made after a successful audit by the SND in each of these cases.
- The SHAS is responsible for completing the audit process within 15 days of receiving the intimation from the EHCP.
- These deviations are expected to not amount to more than 5% in a particular hospital.

5.1. LAMA / DAMA

Left Against Medical Advice (LAMA) or Discharged Against Medical Advice (DAMA) is an act whereby a patient takes their 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 made as per the following:

Surgical Cases: Patients admitted for a surgical package where a fixed package rate is to be paid.

1. **LAMA / DAMA before Surgery:** The claim amount would be determined based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Payment for 100% of the daily package rate for the total number of days when the patient was admitted will be paid. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. This will be applicable in all cases, regardless of whether pre-operative investigations have been done or not.
2. **LAMA / DAMA after Surgery:** Payment for 75% of the package rate will be made to the EHCP by the SHA in such cases. Daily case sheets and OT notes must be submitted by the EHCP for auditing purposes to qualify for payment.

Medical Cases: Payment for 100% of the daily package rate for each day of the patient admission will be paid based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered.

5.2. DEATH DURING HOSPITALISATION

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

Surgical Cases:

1. Death before Surgery: The claim amount would be determined based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Payment for 100% of the daily package rate for the total number of days when the patient was admitted will be paid. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. This will be applicable in all cases, regardless of whether pre-operative investigations have been done or not.
2. Death on Table (During Surgery): If the patient expires during the surgery, then 75% of the blocked package rate will be paid. Daily case sheets and OT notes must be submitted by the EHCP for auditing purposes to qualify for payment.
3. Death after Surgery: If the patient expires after the surgery, irrespective of the duration of the postoperative stay, 100% of the package rate will be paid to the hospital after a detailed medical audit.

Medical Cases:

Payment for 100% of the daily package rate for each day of the patient admission will be paid based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered.

5.3. PATIENT REFERRED TO ANOTHER HOSPITAL

It is important to note that an EHCP should only refer patients to other EHCPs, except for rare circumstances when referral to a non-empanelled hospital is necessary. The EHCP must provide a compelling justification for referring a patient to a non-empanelled hospital. According to the BSKY policy, the treatment package covers any complications that may arise from surgery. However, in exceptional cases and with prior notification to SHA, an EHCP may refer a patient to another EHCP to manage postoperative complications and be eligible for partial payment. The following guidelines apply:

Surgical Cases:

1. **Referral before PAC & Surgery:** In such cases, the claim amount would be determined based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Payment for 100% of the daily package rate for the total number of days when the

patient was admitted will be paid. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. This will be applicable in all cases, regardless of whether pre-operative investigations have been done or not. The receiving EHCP will be eligible for 100% of the package rate of the surgery booked by the hospital.

2. **Referral after PAC and before Surgery:** In such cases, the referring EHCP will be paid 15% of the package amount for the surgical package booked by the hospital. The receiving EHCP will be paid 85% of the package rate of the surgery booked. The receiving hospital will need to take pre-authorisation before booking the package.
3. **Referral after Surgery (Management of Complications):** In such cases, the referring EHCP will be paid 75% of the total package rate. The receiving EHCP would be eligible for 100% of the package rate of the new surgery selected (if required) or in line with the existing medical packages according to the LOS and bed category while admitted (if managed conservatively). The receiving EHCP will need to raise new Pre-authorisation & claim for the treatment provided.

Medical Cases:

For referring EHCP, payment for 100% of the daily package rate for each day of the patient admission will be paid based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. The receiving EHCP would be eligible for 100% of the package rate of the surgery blocked (if required) or in line with the existing medical packages according to the LOS and bed category of the patient (if managed conservatively).

Referral to Non-Empanelled Hospital (in Exceptional Cases):

To qualify for partial payment, the referring EHCP must provide a compelling justification for referring a patient to a non-empanelled hospital. Non-empanelled hospitals will not receive any payment from SHAS through BSKY under any circumstances.

5.4. UNSPECIFIED PACKAGE

To prevent BSKY beneficiaries from being deprived of necessary medical care not featured in the listed interventions, the TMS has a provision for blocking such treatments. However, the following specific criteria must be met before blocking such treatments:

1. Compulsory pre-authorisation is in-built while selecting this code for blocking treatments.
2. If there are multiple planned procedures and one or more require blocking under the unspecified package, EHCPs should consolidate all procedures into a single unspecified claim. The claim should include a lump sum cost for all intended procedures. If certain procedures have defined rates in the HBP list, those rates must factor into the final amount for the unspecified package.
3. Private hospitals cannot avail government reserved packages under this code – SHAS may circulate the list of government-reserved packages to all hospitals. Further, SHAS will facilitate the referral of such cases to the public system to avoid denial of care.
4. Unspecified Package cannot be blocked for implant removal. However, if no other packages cover a specific implant removal, exceptions can be made with prior approval from the SHA.

5. Aesthetic treatments of any nature cannot be availed under this or any other listed codes under BSKY. Only medically necessary surgeries/procedures that address functional indications will be covered. The procedure should result in improving or restoring bodily function, correcting significant deformity resulting from accidental injury/trauma, or addressing congenital anomalies with substantial functional impairment. The procedure should enhance or restore bodily function, correct significant deformities caused by accidental injury or trauma, or address congenital anomalies that significantly impair function.
6. Individual drugs or diagnostics cannot be availed under this code.
7. None of the treatments that fall under the exclusion criteria of the BSKY can be availed, viz. individual diagnostics for evaluation, outpatient care, cosmetic/aesthetic treatments, vaccination, any dental treatment or surgery which is corrective, cosmetic or aesthetic, filling of cavity, root canal including wear and tear etc., unless arising from disease or injury and requires hospitalisation for treatment.
8. If the SHAS receives multiple requests for the same unspecified package from multiple EHCPs or for multiple patients, the SHAS may consider including such treatment in the package master. The decision will be based on the recommendations of the Medical Cell Expert Committee.

To determine the approval amount, PPD may consider the rate of the closest match of the requested surgery listed in other national or state public-funded health insurance packages. It is important to note that the amount approved by PPD is final and will be communicated to the EHCP. The PPD approved cannot be deducted or partially paid by CPD, provided the EHCP submits all the necessary documents.

While it is difficult to define all the situations where an Unspecified Surgical Package may be used or specify the maximum payable rates, booking an Unspecified Surgical Package can be allowed if the Technical Committee of SHAS, encompassing medical experts in the state, approves it.

The following processes are to be adhered to:

- The SHAS will form a Medical Cell Expert Committee to offer insights on Unspecified Package requests in addition to their other responsibilities.
- The SHAS will recommend every case for approval after taking inputs from the standing Medical Cell Expert Committee with the treatment details and pricing duly negotiated with the provider.
- The price should be based on the principle of a case-based lump sum rate that includes expenses associated with all investigations, procedures, consumables and postoperative care, along with the applicable incentives to the hospital. It is preferable to reference ceiling rates from other public health insurance schemes if available.

5.5. UNBUNDLING OF PROCEDURES

There can be instances where an EHCP blocks one or multiple claims for different procedures for the same patient during the same OT session. Payment for such cases will not be made in full. Instead, the rule of 100% - 50% - 25% (where the most expensive package is reimbursed at 100%, the second most expensive at 50%, and the remaining packages at 25% each) shall be applicable in these cases.

If a combination package for such a case is available in the listed interventions, the EHCP will be paid based on the available package rate or the 100% - 50% - 25% rule, whichever is less.

Example:

Case ID	EHCP Name	Patient Name	D.O.A	Package Name	Package Rate	Approved Amount
12345	ABC Hospital	Mr. XYZ	01-07-2023	Tonsillectomy	Rs. 15,300/-	Rs. 15,300/-
12346	ABC Hospital	Mr. XYZ	01-07-2023	Myringotomy	Rs. 9,500/-	Rs. 4,750/-

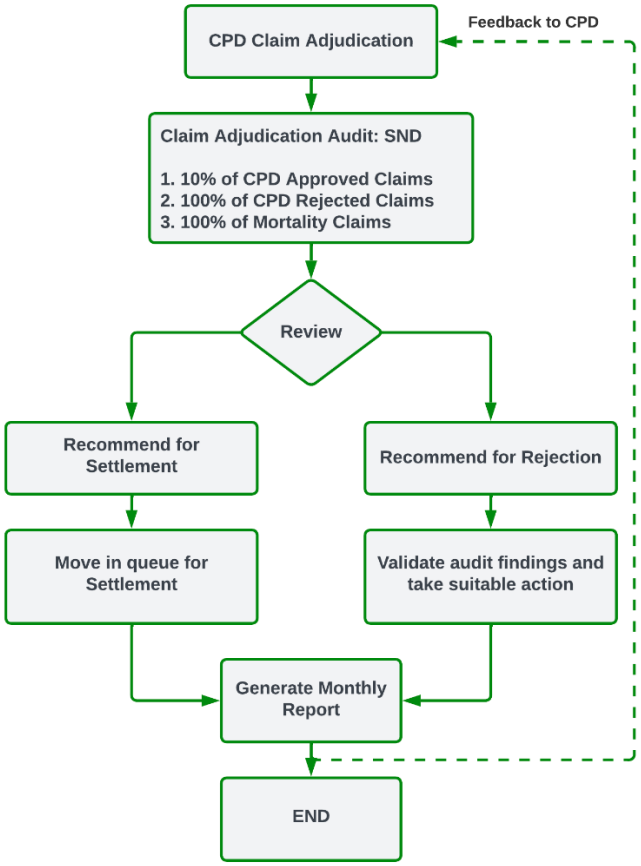
Total amount for these two packages (15,300 + 9,500): **Rs. 24,500/-**

When both the packages are claimed together for the same patient during the same hospitalisation, 100% - 50% - 25% will apply, and the final approved amount is **Rs. 19,750/-**

6. CLAIM ADJUDICATION AUDIT

The objectives of the Claim Adjudication Audit are:

- To improve the overall quality of claim adjudication.
- To ensure that the adjudication team has exercised due diligence during adjudication.
- To ensure compliance of submitted documents with Standard Treatment Guidelines.



Flow Chart 6: Claim Adjudication Audit Workflow

Claim Adjudication Audit Checklist:

Particulars	*Yes*	*No*	*Remarks*
Is the patient's name/age in ICPs, Ecard and investigation reports the same?			
Any aberration noted in the past claim history?			
Are all mandatory documents as per STGs available at claim submission?			
Are presenting symptoms matching with the diagnosis?			
Does the package booked match the final diagnosis?			
Are investigation reports supporting the final diagnosis available?			
Are investigation reports signed by doctor/pathologist with registration no?			
Do the procedure notes detail the steps of surgery? (surgical cases)			
Does the treatment provided match the package claimed?			
Was the length of stay verified with the discharge summary?			
Does the discharge summary capture all details of presenting features, investigations, treatment provided and discharge advice?			
Did PPD / CPD follow the processes mentioned above?			
Were appropriate queries raised?			

Table 6: Claim Adjudication Audit Checklist

Note: Apart from the regular audit, SHA can conduct periodic audits to monitor the quality of claim adjudication.

6.1. PERCENTAGE OF CLAIM ADJUDICATION AUDIT

The minimum required percentage of the claim adjudication audit sample is detailed below:

Sl. No.	*Audit Type*	*Sample*	*Objective*	*Ownership*
1.	Claim Adjudication Audit	10% of approved claims	Ensure claims adjudication process is being followed diligently at all levels.	SND
2.	Rejected Claims Audit	100%	Verify if the rejection of claims is justified.	SND
3.	Mortality Claims Audit	100%	Identify and verify any gaps in clinical cases and patient safety impacting morbidity and mortality of the beneficiary.	SND

Table 7: Claim Adjudication Audit – Defined Audit Percentage

7. GUIDELINES FOR RECOVERIES AND OTHER ACTIONS

BSKY has adopted a zero-tolerance approach towards all types of fraud, covering the complete extent of activities for prevention, detection, and deterrence of different kinds of fraud that could occur in BSKY at various stages of its implementation. These guidelines would apply when fraud cases have been confirmed, or other irregularities/misrepresentations of facts have been established on the part of an EHCP under BSKY. One or more of the following actions may be taken

against the 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:

1. **Issuance of 'Show Cause Notice' to Errant EHCP:** Based on the audit of EHCP, if the SHA believes that there is clear evidence of EHCP indulging in malpractices/unethical practices or does not have adequate infrastructure/specialist workforce 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 that 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 involved in financial fraud related to treatment provided under the scheme, it may immediately suspend that EHCP from providing services under the scheme and a formal investigation shall be initiated.

3. **De-empanelment of EHCP:** If the formal investigations confirm that the EHCP indulges in malpractices, the SEC may de-empanel the provider following due process.

4. **Recovery of amount including penalties from EHCP:** If it is discovered that the EHCP has engaged in malpractices or misrepresentations, the excess amount paid for fraudulent claims or illegal collection of money from beneficiaries shall be recovered, along with penalties based on the severity of the offence.

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

1. Adjusting against any amount due to EHCP arising from unpaid claims.
2. Pursue recourse available under MoU/Contractual provisions.
3. Pursue recovery of the outstanding amount and any applicable penalties using the provisions outlined in the Revenue Recovery Act 1890 and other relevant legislation.

The various Legal and Punitive Actions that can be taken against the errant EHCP are:

1. Suspension of EHCP from the BSKY scheme.
2. De-empanelment of EHCP from the BSKY scheme.
3. Actions like deregistration and cancellation of the hospital's license under Provisions and Acts of the State Government or any other relevant legislation of the Central Government, such as the Clinical Establishment (Registration & Regulation) Act of 2020.

If a medical and paramedical professional is found to be engaging in malpractices or unethical practices, the relevant Council or Professional Body should be informed with a request for the cancellation or suspension of their corresponding license or registration. Depending on the severity of the offence, a criminal case (FIR) may also be filed against the concerned under the relevant provisions of the applicable law. The Competent Authority will not consider any appeal or revision of the recovery order unless EHCP has deposited at least 50% of the recovery amount.

8. SERVICE PARAMETERS

8.1. UNIFORM TURN AROUND TIME (TAT)

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

Sl. No.	*Activities*	*TAT*	*Action*
1.	Pre-authorisation Adjudication (By PPD)	24 hours	Forced approval after 24 hours for listed packages and after 48 hours for unspecified packages.
2.	Blocking of Approved Pre-authorisation (By EHCP)	7 days	Expiration of Pre-authorisation.
3.	Response to PPD Query (By EHCP)	7 days	Forced rejection after 7 days.
4.	Claim Submission after Discharge (By EHCP)	7 days post Discharge	Forced Rejection after 7 days.
5.	Response to CPD Query (By EHCP)	7 days	Forced rejection after 7 days.
6.	Claim Settlement (By SHAS)	45 days from claim initiation	No action

Table 8: Turn Around Times (TAT)

The actual Date of Discharge, as mentioned in the discharge summary, will be considered for TAT calculation.

8.2. KEY PERFORMANCE INDICATORS (KPI)

Performance KPI:

Sl. No.	*KPI*	*Timelines*	*Baseline KPI Measure*
1.	Pre-Auth Adjudication	• Action within 24 hours of Pre-authorisation initiation. • Forced approvals beyond 24 hours will be considered non-compliant.	95% Compliance
2.	CPD Adjudication	• Action on claims within 3 days of allocation. • Unprocessed claims beyond 3 days will be considered non-compliant.	95% Compliance

Table 9: Performance KPIs

Audit KPI:

Sl. No.	*KPI*	*Sample*	*Baseline KPI Measure*
1.	Claims Audit	10% of total approved claims across specialities	100% Compliance
2.	Claims Audit	100% of total rejected claims across specialities	100% Compliance
3.	Mortality Audit	100% of all deaths during hospitalisation	100% Compliance

Table 10: Audit KPIs

During the audit, the team must ensure no more than a 20% overlap in the sample size used across different audits, except for mortality audits.

ANNEXURE - I: EXCLUSIONS TO THE POLICY

The State Health Assurance Society shall not be liable to make any payment under the BSKY policy in respect of any expenses whatsoever incurred by any eligible beneficiary in connection with or related to:

1. Conditions that do not require hospitalisation and can be treated under Outpatient Care.

2. Any dental treatment or surgery, which is corrective, cosmetic or aesthetic procedure, filling of cavities, root canal including wear and tear of teeth, periodontal diseases, dental implants, etc., are excluded unless arising from illness, injury, neoplasm, or cysts and which requires hospitalisation for treatment.

3. Any assisted reproductive techniques or fertility/infertility-related procedures, unless featured in the HBP procedures.

4. Any vaccination, immunisation or inoculation.

5. Any cosmetic or aesthetic treatment of any description, unless necessitated due to an accident or as a part of any illness.

6. Circumcision, unless necessitated for treatment of a disease not excluded hereunder or due to any accident.

7. Any treatment of Patients in a Persistent Vegetative State (Completely unresponsive to psychological and physical stimuli, displaying no sign of higher brain function, and being kept alive only by medical intervention).

ANNEXURE – II: LIST OF ACTION REMARKS IN CMS

Approved
Admission Notes not Submitted
Anaesthesia Notes not Submitted
Angiogram Report showing Stent and Post-Stent Flow not Submitted
Antenatal Records not Submitted
Barcode of Implants not Submitted
Barcode of Drugs not Submitted
CAG Stills showing Blocks with Report not Submitted
Charts of Chemotherapy/Radiotherapy not Submitted
Chest X-ray Film with Report not Submitted
Compliance to Query not Satisfactory
CT Images with Report not Submitted
Detailed Clinical Notes not Submitted
Detailed Discharge Summary not Submitted
Detailed OT Note not Submitted
Documents establishing Identity of the Patient not Submitted
Documents not Signed by the Doctor
ECG Report not Submitted
ECHO Stills with Report not Submitted
Electrophysiology Study Report not Submitted
FNAC Report not Submitted
HPE Report not Submitted
Illegible Documents / Images
Indications for LSCS not Mentioned
Intra-OP Stills with Patient ID and Date not Submitted
Invalid Income Certificate
Investigation Results do not Confirm the Diagnosis
Invoice of Implants not Submitted
IVP / NCCT / CT-IVP not Submitted
Justification for the Procedure not Mentioned
Lab Test Reports not Submitted
Mandatory Documents as per the Package not Provided
Mismatch in Names in Verification Slip and Supporting Documents
Mismatch of Dates
Mismatch of Gender
Mismatch of Name in Clinical Notes and Eligibility Documents
MRI Images with Report not Submitted
Name and Specialisation of Doctor not Mentioned
Non-Submission of Blocking Transaction Slip
Not Eligible under BSKY
Overwriting and Many Corrections made in the Report/Document
Partogram not Submitted
Plan of Management Approved by Tumor Board not Submitted
Post Procedure Imaging Stills with Report not Submitted
Post Procedure X-ray Film with Report not Submitted
Post Treatment Clinical Photograph not Submitted
Pre-Anaesthesia Check-up Report not Submitted
Query not Complied
Stickers of Implants not Submitted

Still image of the Procedure with Patient ID and Date not Submitted
Transfusion Slips not Submitted
Treating/Operating Doctor not Satisfying the Minimum Qualification Criteria
USG Images with Report not Submitted
Wrong Selection of Procedure
X-ray Film with Report not Submitted
Others – Please Specify
Rejected

ANNEXURE - III: ACTIONABLE FOR CPD

Actionable	*Yes*	*No*
Are all requisite post-treatment evidentiary documents available to confirm the completion of appropriate treatment and follow-up instructions?		
Was the Length of Stay during hospitalisation as per package specification?		
Are admission notes and detailed findings at admission available?		
Is the discharge summary available?		
Does the discharge summary capture all details of presenting features, investigation, line of treatment, and follow-up advice at discharge?		
Is the age, comorbidities and pre-operative profile relevant to the package blocked?		
Do the submitted reports confirm the final diagnosis?		
Whether the appropriate package is blocked?		
Whether the date and time of the procedure are mentioned in the notes?		
Does the procedure time correspond to the time ideally taken for the procedure/surgery?		
Whether the operating surgeon and the doctor's information provided while blocking the package match?		
Whether the treating doctor's signature is available across the submitted records?		
Does the Operative Nites detail the steps of the surgery?		
Was the treatment necessary for the patient's clinical condition?		

ANNEXURE - IV: DOCUMENT TEMPLATES

1. **OT NOTES:** (Should be on EHCP Stationary and not on plain paper)

    - Date and Time of Commencement and Completion of Procedure
    - Name of Surgeon
    - Name of Anaesthetist
    - Type of Anaesthesia
    - Procedure Details (Site, Side. Steps and Findings)
    - Details of Complications, if any
    - Details of Immediate Post-Op Care

2. **CLINICAL NOTES:**

    - Date and Time of Clinical Notes
    - Daily Progress Report with Vitals and Details of Treatment Advised.
    - 'Continue Same Treatment' is not acceptable

3. **CLINICAL PHOTOGRAPHS:**

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

REFERENCE DOCUMENT LINKS

1. Timely Uploading of Claim Documents and Changes in Transaction Management System (TMS) of BSKY.

2. Order for Additional Coverage in BSKY for Females.

3. Guidelines for Payment of Special Cases during hospital admission under BSKY.

4. Clarification regarding pre-hospitalisation investigations for procedures under BSKY and zero Out-of-Pocket expenditure for BSKY patients.

5. Clarifications regarding pre and post hospitalisation expenses and other guidelines for smooth implementation of BSKY.

6. Reserved and Referral Category of Packages under BSKY.

7. Declaration of Medical Officers as Authorised Officers for Referral under BSKY.

8. Constitution of Technical Committee under SHAS.

9. Reserved and Referral Category of Packages under BSKY in the Empanelled Hospitals of Other States.

10. Pre-authorisation in case of Unspecified Packages under BSKY.

11. Office Order on Extension for BSKY service for Children below 5 years.

12. Guidelines for Organ/Tissue Transplantation under BSKY.

13. Treatment of Beneficiaries with mismatch of name in eligibility documents and NFSA or SFSS Database under BSKY.

14. Benefits of BSKY to Child members of BSKY-covered families in 5 to 18 years of age group whose individual names are not there in NFSA or SFSS Database although Parents names are included in the Database.

15. AB PM-JAY Claim Adjudication Manual 2.0