Model Tender Document for Selection of Insurance Company for the implementation of
Ayushman Bharat – National Health Protection Mission (AB-NHPM)

In the State/Union Territory of …………

June 2018

Volume III:

Insurance Contract

To be signed by the Insurance Company

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Abbreviations

AB-NHPM	Ayushman Bharat - National Health Protection Mission
AL	Authorisation Letter (from the Insurer)
BFU	Beneficiary Family Unit
BPL	Below Poverty Line
RC	Risk Cover
CCGMS	Central Complaints Grievance Management System
CHC	Community Health Centre
CRC	Claims Review Committee
DAL	Denial of Authorisation Letter
DGRC	District Grievance Redressal Committee
DGNO	District Grievance Nodal Officer
EHCP	Empanelled Health Care Provider
HPGRC	High Powered Grievance Redressal Committee
GRC	Grievance Redressal Committee
IRDAI	Insurance Regulatory Development Authority of India
MoHFW	Ministry of Health & Family Welfare, Government of India
NGRC	National Grievance Redressal Committee
NHA	National Health Agency
NOA	Notice of Award
PHC	Primary Health Centre
RAL	Request for Authorisation Letter (from the EHCP)
SECC	Socio Economic Caste Census
SGRC	State Grievance Redressal Committee
SGNO	State Grievance Nodal Officer
SHA	State Health Agency
UCN	Unique Complaint Number

Insurance Contract
for the implementation of
Ayushman Bharat – National Health Protection Mission (AB-NHPM)

This Agreement for the implementation of AB-NHPM for providing the AB-NHPM Cover (the **Insurance Contract**) is made at __________ on __________:

BETWEEN

(1) **THE GOVERNMENT OF THE STATE OF _________**, represented by the **______________________________________**, having his principal office at ____________________________________ (hereinafter referred to as the **State Health Agency** which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors and permitted assigns);

AND

(2) The _________________ an insurance company registered with the Insurance Regulatory & Development Authority having registration number ____ and having its registered office at _______________________________ (hereinafter referred to as the **Insurer**, which expression shall, unless repugnant to the context or meaning thereof, be deemed to mean and include its successors and permitted assigns).
The State Health Agency and the Insurer shall collectively be referred to as the **Parties** and individually as the **Party**.

WHEREAS

A. The "Ayushman Bharat - National Health Protection Mission" (the **AB-NHPM**), a Government of India scheme, requires to provide health insurance cover to the extent of ₹ 500,000 per annum on a family floater and cashless basis through an established network of health care providers to the AB-NHPM Beneficiary Family Units (*defined below*).

B. The Government of __________ decided has to implement the AB-NHPM to provide health insurance to defined categories of families that are eligible for the scheme in the State of ____.

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

D. On _______ the State Health Agency commenced a bidding process by issuing tender documents (the **Tender Documents**), inviting insurance companies to submit their bids for the

implementation of the AB-NHPM. Pursuant to the Tender Documents, the bidders submitted their bids on __________ for the implementation of the AB-NHPM.

E. Following a process of evaluation of financial bids submitted by bidders, the State Health Agency accepted the Bid of the Insurer for the implementation of the AB-NHPM. The State Health Agency issued a notification of award dated __________ (the **NOA**) and requested the Insurer to execute this Insurance Contract. The Insurer accepted the NOA on __________.

F. The Insurer represents and warrants that it has the experience, capability and know-how required for carrying on health insurance business and has agreed to provide health insurance services and provision of the Risk Cover (*defined below*) to the Beneficiary Family Units (*defined below*) eligible under the AB-NHPM for the implementation of the AB-NHPM in all the districts in the State of __________.

G. Subject to the terms, conditions and exclusions set out in this Insurance Contract and Policy (*defined below*), the Insurer undertakes that if during a Policy Cover Period (*defined below*) of such Policy any Beneficiary (*defined below*) covered by such Policy:

(i) undergoes a Medical Treatment (*defined below*) or Surgical Procedure (*defined below*) requiring Hospitalization (*defined below*) or a Day Care Treatment (*defined below*) or Follow-up Care (*defined below*) to be provided by an Empanelled Health Care Provider (*defined below*)

then the Insurer shall pay the packages as defined to the Empanelled Health Care Provider in accordance with the terms of this Insurance Contract and such Policy, to the extent of the Sum Insured (*defined below*) under such Policy.

NOW THEREFORE IT IS AGREED AS FOLLOWS:

1. Definitions and Interpretations

1.1 Definitions

Unless the context requires otherwise, the following capitalized terms and expressions shall have the following meanings for the purpose of this Insurance Contract:

AB-NHPM shall refer to Ayushman Bharat - National Health Protection Mission managed and administered by the Ministry of Health and Family Welfare, Government of India with the objective of reducing out of pocket healthcare expenses and improving access of validated Beneficiary Family Units to quality inpatient care and day care surgeries (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers.

AB-NHPM Beneficiary Database refers to all AB-NHPM Beneficiary Family Units, as defined in Category under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (viz as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State / UT along with the existing RSBY Beneficiary Families not figuring in the SECC Database of the Socio-Economic Caste Census (SECC) database which are resident in the Service Area (State for which this Tender Document is issued)

AB-NHPM Guidelines mean the guidelines issued by MoHFW / NHA from time to time for the implementation of the AB-NHPM, to the extent modified by the Tender Documents pursuant to which the Insurance Contract has been entered into; provided that MoHFW/ NHA or the State Healthl Agency may, from time to time, amend or modify the AB-NHPM Guidelines or issue new AB-NHPM Guidelines, which shall then be applicable to the Insurer.

Annexure means an annexure to this Insurance Contract

Appellate Authority shall mean the authority designated by the State Health Agency which has the powers to accept and adjudicate on appeals by the aggrieved party against the decisions of any Grievance Redressal Committee set up pursuant to the Insurance Contract between the State Health Agency and the Insurer.

Sum Insured shall mean the sum of Rs 5,00,000 per AB-NHPM Beneficiary Family Unit per annum against which the AB-NHPM Beneficiary Family Unit may seek benefits as per the benefit package proposed under the AB-NHPM.

Beneficiary means a member of the AB-NHPM Beneficiary Family Units who is eligible to avail benefits under the Ayushman Bharat - National Health Protection Mission.

Beneficiary Family Unit refers to those households (also refered to as families for the purpose of AB-NHPM) including all its members figuring in the Socio-Economic Caste Census (SECC) database under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (viz as Households without shelter, Destitute-living on alms, Manual Scavenger Families, Primitive Tribal Groups and Legally released Bonded Labour) and broadly 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) 2011 database of the State / UT (as updated from time to time) along with the existing RSBY Beneficiary Families not figuring in the SECC Database under the Ayushman Bharat - National Health Protection Mission.

Benefit Package refers to the package of benefits that the insured families would receive under the AB-NHPM.

Bid refers to the qualification and the financial bids submitted by an eligible Insurance Company pursuant to the release of this Tender Document as per the provisions laid down in this Tender Document and all subsequent submissions made by the Bidder as requested by the SHA for the purposes of evaluating the bid.

Bidder shall mean any eligible Insurance Company which has submitted its bid in response to this Tender released by the State/ UT Government.

Cashless Access Service means a facility extended by the Insurer to the Beneficiaries where the payments of the expenses that are covered under the Risk Cover are directly made by the Insurer to the Empanelled Health Care Providers in accordance with the terms and conditions of this Insurance Contract, such that none of the Beneficiaries are required to pay any amounts to the Empanelled Health Care Providers in respect of such expenses, either as deposits at the commencement or at the end of the care provided by the Empanelled Health Care Providers.

CHC means a community health centre located at the block level in the State.

Claim means a claim that is received by the Insurer from an Empanelled Health Care Provider, either online or through alternate mechanism in absence of internet connectivity.

Claim Payment means the payment of eligible Claim received by an Empanelled Health Care Provider from the Insurer in respect of benefits under the Risk Cover made available to a Beneficiary.

Clause means a clause of this Insurance Contract.

Day Care Treatment means any Medical Treatment and/or Surgical Procedure which is undertaken under general anaesthesia or local anaesthesia at an Empanelled Health Care Provider or Day Care Centre in less than 24 hours due to technological advancements, which would otherwise have required Hospitalization.

Days mean and shall be interpreted as calendar days unless otherwise specified.

Empanelled Health Care Provider means a hospital, a nursing home, a district hospital, a CHC, or any other health care provider, whether public or private, satisfying the minimum criteria for empanelment and that is empanelled by the Insurer in accordance with terms of this Contract for the provision of health services to the Beneficiaries.

Hospital IT Infrastructure means the hardware and software to be installed at the premises of each Empanelled Health Care Provider for the provision of Cashless Access Services, the minimum specifications of which have been set out in the Tender Documents.

Hospitalization means any Medical Treatment or Surgical Procedure which requires the Beneficiary to stay at the premises of an Empanelled Health Care Provider for 24 hours or more including day care treatment as defined above.

ICU or **Intensive Care Unit** means an identified section, ward or wing of an Empanelled Health Care Provider which is under the constant supervision of dedicated Medical Practitioners and which is specially equipped for the continuous monitoring and treatment of patients who are in critical condition, require life support facilities and where the level of care and supervision is considerably more sophisticated and intensive than in the general ward.

Insurance Contract shall mean this contract between the State Health Agency and the Insurer for the provision of the benefits under the Risk Cover, to the Beneficiaries and setting out the terms and conditions for the implementation of the AB-NHPM.

Insurer means the successful bidder which has been selected pursuant to this bidding process and has agreed to the terms and conditions of the Tender Document and has signed the Insurance Contract with the State/ UT Government.

IRDA means the Insurance Regulatory and Development Authority established under the Insurance Regulatory and Development Authority Act, 1999.

IRDA Solvency Regulations means the IRDA (Assets, Liabilities and Solvency Margin of Insurers) Regulations, 2000, as amended from time to time.

Law means all statutes, enactments, acts of legislature, laws, ordinances, rules, bye laws, regulations, notifications, guidelines, policies, and orders of any statutory authority or judgments of any court of India.

Material Misrepresentation shall mean an act of intentional hiding or fabrication of a material fact which, if known to the other party, could have terminated, or significantly altered the basis of a contract, deal, or transaction.

Medical Practitioner/Officer means a person who holds a valid registration from the medical council of any state of India and is thereby entitled to practice medicine within its jurisdiction, acting within the scope and jurisdiction of his/her license.

Medical Treatment means any medical treatment of an illness, disease or injury, including diagnosis and treatment of symptoms thereof, relief of suffering and prolongation of life, provided by a Medical Practitioner, but that is not a Surgical Procedure. Medical Treatments include but not limited to: bacterial meningitis, bronchitis-bacterial/viral, chicken pox, dengue fever, diphtheria, dysentery, epilepsy, filariasis, food poisoning, hepatitis, malaria, measles, meningitis, plague, pneumonia, septicaemia, tuberculosis (extra pulmonary, pulmonary etc.), tetanus, typhoid, viral fever, urinary tract infection, lower respiratory tract infection and other such diseases requiring Hospitalization.

MoHFW shall mean the Ministry of Health and Family Welfare, Government of India.

NHA shall mean the National Health Agency set up the Ministry of Health and Family Welfare, Government of India with the primary objective of coordinating the implementation, operation and management of AB-NHPM. It will also foster co-ordination and convergence with other similar schemes being implemented by the Government of India and State Governments.

Package Rate means the fixed maximum charges for a Medical Treatment or Surgical Procedure or for any Follow-up Care that will be paid by the Insurer under Cover, which shall be determined in accordance with the rates provided in this Contract.

Party means either the Insurer or the State Health Agency and **Parties** means both the Insurer and the State Health Agency.

Policy Cover Period shall mean the standard period of 12 calendar months from the date of start of the Policy Cover or lesser period as stipulated by SHA from time to time, unless cancelled earlier in accordance with this Insurance Contract.

Premium means the aggregate sum agreed by the Parties as the annual premium to be paid by the State Healthl Agency to the Insurer for each Beneficiary Family Unit that is eligible for the scheme, as consideration for providing the Cover to such Beneficiary Family Unit under this Insurance Contract.

Risk Cover shall mean an annual risk cover of Rs. 5,00,000 covering inpatient care and day care surgeries (as applicable) for treatment of diseases and medical conditions through a network of Empanelled Health Care Providers (EHCP) for the eligible AB-NHPM Beneficiary Family Units.

Risk Premium means the sum agreed by the Parties as the annual premium to be paid by the State Health Agency to the Insurer for each Beneficiary Family Unit that is covered by the Insurer, as consideration for providing the Risk Cover to such Beneficiary Family Unit under this Insurance Contract and the Policy.

Schedule means a schedule of this Insurance Contract.

Scheme shall mean the Ayushman Bharat - National Health Protection Mission managed and administered by the State Government of ____.

Selected Bidder shall mean the successful bidder which has been selected in the bid exercise and has agreed to the terms and conditions of the Tender Document and has signed the Insurance Contract with the State/ UT Government.

Service Area refers to the entire State/UT) of …………. *(insert the name of the State (s)/ UT)* covered and included under this Contract for the implementation of AB-NHPM.

State Health Agency (SHA) refers to the agency/ body set up by the Department of Health and Family Welfare, Government of ….. *(insert the name of the State/ UT)* for the purpose of coordinating and implementing the Ayushman Bharat - National Health Protection Mission in the State/ UT of ……. *(insert the name of the State/ UT).*

Successful Bidder shall mean the bidder whose bid document is responsive, which has been pre-qualified and whose financial bid is the lowest among all the shortlisted and with whom the State/ UT Government intends to select and sign the Insurance Contract for this Scheme.

Sum Insured in respect of each Beneficiary Family Unit enrolled under a Policy, means at any time, the Insurer's maximum liability for any and all Claims made on behalf of such Beneficiary Family Unit during the Policy Cover Period against the Risk Cover.

State/ UT Government refers to the duly elected Government in the State/ UT in which the tender is issued.

Tender Documents refers to this Tender Document including Volume I "Instruction to Bidders", Volume II "About AB-NHPM" and Volume III " Insurance Contract to be signed by the Insurance Company" including all amendments, modifications issued by the SHA in writing pursuant to the release of the Tender Document.

Treatment (medically necessary) means any Medical Treatment, Surgical Procedure, Day Care Treatment or Follow-up Care, which:

(i) is required for the medical management of the illness, disease or injury suffered by the Beneficiary;
(ii) does not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration or intensity;
(iii) has been prescribed by a Medical Practitioner; and
(iv) conforms to the professional standards widely accepted in international medical practice or by the medical community in India.

Turn-around Time means the time taken by the Insurer in processing a Claim received from an Empanelled Health Care Provider and in making a Claim Payment including investigating such Claim or rejection of the such Claim.

1.2 Interpretation

a. Any grammatical form of a defined term herein shall have the same meaning as that of such term.

b. Any reference to an agreement, contract, instrument or other document (including a reference to this Insurance Contract) herein shall be to such agreement, instrument or other document as amended, varied, supplemented, modified or suspended at the time of such reference.

c. Any reference to an "agreement" includes any undertaking, deed, agreement and legally enforceable arrangement, whether or not in writing, and a reference to a document includes an agreement (so defined) in writing and any certificate, notice, instrument and document of any kind.

d. Any reference to a statutory provision shall include such provision as modified or re-enacted or consolidated from time to time.

e. Terms and expressions denoting the singular shall include the plural and vice versa.

f. Any reference to "persons" denotes natural persons, partnerships, firms, companies, corporations, joint ventures, trusts, associations, organizations or other entities (in

each case, whether or not incorporated and whether or not having a separate legal entity).

g. The term "including" shall always mean "including, without limitation", for the purposes of this Insurance Contract.

h. The terms "herein", "hereof", "hereinafter", "hereto", "hereunder" and words of similar import refer to this Tender as a whole.

i. Headings are used for convenience only and shall not affect the interpretation of this Insurance Contract.

j. The Schedules and Annexures to this Insurance Contract form an integral part of this Insurance Contract and will be in full force and effect as though they were expressly set out in the body of this Insurance Contract.

k. References to Recitals, Clauses, Schedules or Annexures in this Insurance Contract shall, except where the context otherwise requires, be deemed to be references to Recitals, Clauses, Schedules and Annexures of or to this Insurance Contract.

l. References to any date or time of day are to Indian Standard Time.

m. Any reference to day shall mean a reference to a calendar day.

n. Any reference to a month shall mean a reference to a calendar month.

o. Any reference to any period commencing from a specified day or date and till or until a specified day or date shall include both such days or dates.

p. Any agreement, consent, approval, authorization, notice, communication, information or report required under or pursuant to this Insurance Contract from or by any Party shall be valid and effectual only if it is in writing under the hands of a duly authorized representative of such Party.

q. The provisions of the Clauses, the Schedules and the Annexures of this Insurance Contract shall be interpreted in such a manner that will ensure that there is no inconsistency in interpretation between the intent expressed in the Clauses, the Schedules and the Annexures. In the event of any inconsistency between the Clauses, the Schedules and the Annexures, the Clauses shall prevail over the Schedules and the Annexures.

r. The Parties agree that in the event of any ambiguity, discrepancy or contradiction between the terms of this Insurance Contract and the terms of any Policy issued by the Insurer, the terms of this Insurance Contract shall prevail, notwithstanding that such Policy is issued by the Insurer at a later point in time.

s. The rule of construction, if any, that an agreement should be interpreted against the Party responsible for the drafting and preparation thereof shall not apply to this Insurance Contract.

PART I

TERMS AND CONDITIONS OF INSURANCE

2. AB-NHPM Beneficiaries and Beneficiary Family Unit

a. The Parties agree that for the purpose of this Insurance Contract and any Policy issued pursuant to this Insurance Contract, all the persons that are eligible for the scheme as per SECC data and RSBY enrolled families (if applicable) in the Service Area shall be eligible to become Beneficiaries,

b. All AB-NHPM Beneficiary Family Units, as defined under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category (in rural areas) and broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the State/ UT (as updated from time to time) along with the existing RSBY Beneficiary Families not figuring in the SECC Database which are resident in the Service Area (State for which this Tender Document is issued) and fall under one or more of the categories further detailed in **Schedule 1** of this Document shall be considered as eligible for benefits under the Scheme and be automatically covered under the Scheme.

c. The Insurer agrees that: (i) no entry or exit age restrictions will apply to the members of a Beneficiary Family Unit; and (ii) no member of a Beneficiary Family Unit will be required to undergo a pre-insurance health check-up or medical examination before their eligibility as a Beneficiary.

d. Unit of coverage under the Scheme shall be a family and each family for this Scheme shall be called a AB-NHPM Beneficiary Family Unit, which will comprise all members in that family. Any addition in the family will be allowed only as per the provisions approved by the Government.

e. The presence of name in the beneficiary list shall be the proof of eligibility of the Beneficiary Family Unit for the purpose of availing benefits under this Insurance Contract and a Policy issued pursuant to this Insurance Contract.

3. Risk Covers and Sum Insured

3.1 Risk Cover and Sum Insured

The Benefits within the scheme, to be provided on a cashless basis to the beneficiaries up to the limit of their annual coverage, package charges on specific procedures and subject to other terms and conditions outlined herein, are the following

a. **Risk Cover (RC)** will include hospitalization / treatment expenses coverage including treatment for medical conditions and diseases requiring secondary and tertiary level of medical and surgical care treatment and also including defined day care procedures (as applicable) and follow up care along with cost for pre and post-hospitalisation treatment as defined.

b. As on the date of commencement of the Policy Cover Period, the AB-NHPM Sum Insured in respect of the Risk Cover for each AB-NHPM Beneficiary Family Unit shall be **Rs. 5,00,000 (Rupees Five Lakh Only)** per family per annum on family floater basis. This shall be called the **Sum Insured**, which shall be fixed irrespective of the size of the AB-NHPM Beneficiary Family Unit.
c. The Insurer shall ensure that the Scheme's RC shall be provided to each AB-NHPM Beneficiary Family Unit on a family floater basis covering all the members of the AB-NHPM Beneficiary Family Unit including Senior Citizens, i.e., the Sum Insured shall be available to any or all members of such Beneficiary Family Unit for one or more Claims during each Policy Cover Period. New family members may be added after due approval process as defined by the Government.
d. Pre-existing conditions/diseases are to be covered from the first day of the start of policy, subject to the exclusions given in **Schedule 2**.
e. Coverage of health services related to surgical nature for defined procedures shall also be provided on a day care basis. The Insurance Company shall provide coverage for the defined day care treatments, procedures and medical treatments as given in **Schedule 3**.
f. Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

3.2 Benefit Package: AB-NHPM Cover

a. The benefits within this Scheme under the Risk Cover are to be provided on a cashless basis to the AB-NHPM Beneficiaries up to the limit of their annual coverage and includes:

   (i) Hospitalization expense benefits
   (ii) Day care treatment benefits (as applicable)
   (iii) Follow-up care benefits
   (iv) Pre and post hospitalization expense benefits
   (v) New born child/ children benefits

b. The details of benefit package including list of exclusions are furnished in **Schedule 2: 'Exclusions to the Policy' and Schedule 3: 'Packages and Rates'**.

c. For availing select treatment in any empanelled hospitals, preauthorisation is required to be taken for defined cases.

d. Except for exclusions listed in **Schedule 2**, services for any other surgical treatment services will also be allowed, in addition to the procedures listed in **Schedule 3**, of upto a limit of Rs. 1,00,000 to any AB-NHPM Beneficiary, provided the services are within the sum insured available and pre-authorisation has been provided by the insurance company.

e. The Insurer shall reimburse claims of public and private health care providers under the AB-NHPM based on Package Rates determined as follows:
   (i) If the package rate for a medical treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in **Schedule 3**, then the Package Rate so fixed shall apply for the Policy Cover Period.
   (ii) If the package rate for a surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is not listed in **Schedule 3**, then the Insurer may pre-authorise an appropriate amount or the flat daily package rates for medical packages specified in **Schedule 3** shall apply.
   (iii) If the treatment cost is more than the benefit coverage amount available with the beneficiary families then the remaining treatment cost will be borne by the AB-NHPM Beneficiary family as per the package rates defined in this document. Beneficiary will need to be clearly communicated in advance about the additional payment.
   (iv) The follow up care prescription for identified packages are set out in **Schedule 3**.
   (v) In case of AB-NHPM Beneficiary is required to undertake multiple surgical treatment, then the highest package rate shall be taken at 100%, thereupon the 2nd treatment package shall taken as 50% of package rate and 3rd treatment package shall be at 25% of the package rate.
   (vi) Surgical and Medical packages will not be allowed to be availed at the same time.
   (vii) Certain packages as mentioned in **Schedule 3** will only be reserved for Public EHCPs as decided by the SHA. They can be availed in Private EHCPs only after a referral from a Public EHCP is made.
   (viii) Certain packages as indicated in **Schedule 3** have differential pricing. Hospitals having entry level of NABH certification, located in the aspirational distrits as identified by NITI Aayog (Fill names of the aspirational districts________) and running PG/ DNB course will be provided 10% higher package rates in each of the cases. Hospitals with full NABH accreditation shall be provided 15% higher package rates.

f. For the purpose of Hospitalization expenses as package rates shall include all the costs associated with the treatment, amongst other things:
   (i) Registration charges.
   (ii) Bed charges (General Ward).
   (iii) Nursing and boarding charges.
   (iv) Surgeons, Anaesthetists, Medical Practitioner, Consultants fees etc.
   (v) Anaesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.
   (vi) Medicines and drugs.
   (vii) Cost of prosthetic devices, implants etc.
   (viii) Pathology and radiology tests: radiology to include but not be limited to X-ray, MRI, CT Scan, etc.
   (ix) Diagnosis and Tests, etc
   (x) Food to patient.
   (xi) Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same

hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

(xii) Any other expenses related to the treatment of the patient in the hospital.

g. For the purpose of Day Care Treatment expenses shall include, amongst other things:
   (i) Registration charges;
   (ii) Surgeons, anaesthetists, Medical Practitioners, consultants fees, etc.;
   (iii) Anaesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.;
   (iv) Medicines and drugs;
   (v) Cost of prosthetic devices, implants, organs, etc.
   (vi) Screening, including X-Ray and other diagnostic tests, etc.; and
   (vii) Any other expenses related to the Day Care Treatment provided to the Beneficiary by an Empanelled Health Care Provider.

h. Either Party may suggest the inclusion of additional Package for determination of rates following due diligence and procedures and based on the incidence of diseases or reported medical conditions and other relevant data. The Parties shall then agree on the package rates for such medical treatments or surgical procedures, as the case may be; but the decision of the SHA in this regard shall be final and binding on the Insurer. The agreed package rates shall be deemed to have been included in **Schedule 3** with effect from the date on which the Parties have mutually agreed to the new package rates in writing.

i. The SHA and Insurer shall publish the Package Rates on its website in advance of each Policy Cover Period.

j. As part of the regular review process, the Parties (the Insurer and EHCP) shall review information on incidence of common medical treatments or surgical procedures that are not listed in **Schedule 3** and that require hospitalization or day care treatments (as applicable).

k. No claim processing of package rate for a medical treatment or surgical procedure or day care treatment (as applicable) that is determined or revised shall exceed the sum total of Risk Cover for a AB-NHPM Beneficiary Family Unit.

However, in case at the admission package rates for some medical treatment or surgical procedures may exceed the available Sum Insured, it would enable AB-NHPM beneficiaries to avail treatment of such medical conditions or surgical procedures on their own cost / expenses at the package rate rather than on an open-ended or fee for service basis.

3.3 Benefits Available only through Empanelled Health Care Providers

a. The benefits under the AB-NHPM Risk Cover shall only be available to a AB-NHPM Beneficiary through an EHCP after Aadhaar based identification as far as possible. In case Aadhaar is not available then other defined Government recognised ID will be used for this purpose. State Government shall share with the insurance company within 7 days of signing the agreement a list of defined Government IDs.

b. The benefits under the AB-NHPM Cover shall, subject to the available AB-NHPM Sum Insured, be available to the AB-NHPM Beneficiary on a cashless basis at any EHCP.

c. Specialized tertiary level services shall be available and offered only by the EHCP empanelled for that particular service. Not all EHCPs can offer all tertiary level services, unless they are specifically designated by the SHA for offering such tertiary level services.

4. Identification of AB-NHPM Beneficiary Family Units

a. Identification of AB-NHPM Beneficiary Family Units will be based on the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category and 11 broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the State/ UT along with the existing RSBY Beneficiary Families not figuring in the SECC Database.

b. The beneficiaries will be identified using Aadhaar and/or Ration Card and / or any other specified identification document produced by the beneficiary at the point of contact. Once successfully identified, the beneficiary will be provided with a print of AB-NHPM e-card which can be used as reference while availing benefits.

c. States with high coverage under their own health insurance/ assurance scheme with own datasets may be allowed to use their own data with Central share upto numbers derived from SECC data. However, these States will need to map their scheme ID with AB-NHPM ID (AHL TIN) at the point of care. These States will also need to map their own database with SECC data as per MoHFW within a reasonable period of time. States will need to also ensure that no family eligible as per SECC criteria of AB-NHPM is denied services under the scheme and will need to provide undertaking that eligibility under their schemes covers AB-NHPM targeted families as per SECC.

d. Detailed guidelines for beneficiary identification are provided at **Schedule 4**.

5. Empanelment of Health Care Providers

a. All public hospitals with inpatient facilities (Community Health Centre and above) shall deemed to be empanelled.

b. Private healthcare providers (both for profit and not for profit) which provide hospitalization and/or day care services (as applicable) would be eligible for empanelment under AB-NHPM, subject to their meeting of certain requirements

(empanelment criteria) in the areas of infrastructure, manpower, equipment (IT, help desk etc.) and services (for e.g. liaison officers to facilitate beneficiary management) offered, which can be seen at **Schedule 5** of this document.

c. At the time of empanelment, those Hospitals that have the capacity and which fulfil the minimum criteria for offering tertiary treatment services as prescribed by the SHA would be specifically designated for providing such tertiary care packages.

d. The SHA shall be responsible for empanelment and periodic renewal of empanelment of health care providers for offering services under the AB-NHPM. The SHA may undertake this function either directly or through the selected Insurance Company. However, the final decision regarding empanelment of hospital will rest with SHA.

e. Under circumstances of any dispute, final decision related to empanelment of health care providers shall vest exclusively with the SHA.

f. Detailed guidelines regarding empanelment of health care providers are provided at **Schedule 5**.

6. Agreement with Empanelled Health Care Providers

a. Once a health care provider is found to be eligible for empanelment, the SHA and the selected Insurance Company shall enter into a Provider Service Agreement with such health care provider substantially in the form to be provided for the medical treatments, surgical procedures, day care treatments (as applicable), and follow-up care for which such health care provider meets the infrastructure and personnel requirements.

b. This Provider Service Agreement shall be a tripartite agreement where the Insurer shall be the third party. Format for this Agreement is provided at **Schedule 6**.

c. The Agreement of an EHCP shall continue for a **period of at least 3 years** from the date of the execution of the Provider Services Agreement, unless the EHCP is de-empanelled in accordance with the **AB-NHPM guidelines** and its agreement terminated in accordance with its terms.

d. The Insurer agrees that neither it nor its outsourced agency will enter into any understanding with the EHCP that are in contradiction to or that deviates from or breaches the terms of the Insurance Contract between the SHA and the Insurer or tripartite Provider Service Agreement with the EHCP.

e. If the Insurer or its outsource agency or any if its representatives violates the provisions of **Clause 6.d.** above, it shall be deemed as a material breach and the SHA shall have the right to initiate appropriate action against the Insurer or the EHCP or both.

f. As a part of the Agreement, the Insurer shall ensure that each EHCP has within its premises the required IT infrastructure (hardware and software) as per the AB-NHPM guidelines. All Private EHCPs shall be responsible for all costs related to hardware and maintenance of the IT infrastructure. For all Public EHCPs the costs related to hardware and maintenance of the IT infrastructure shall be borne by the Insurance Company. The EHCPS may take Insurance Company's support may be sought for procurement of such hardware by the EHCPs, however the ownership of all such assets, hardware and software along with its licenses, shall irrevocably vest with the EHCP.

7. De-empanelment of Health Care Providers

a. The SHA, either on its own or through Insuance Company, shall suspend or de-empanel an EHCP from the AB-NHPM, as per the guidelines mentioned in **Schedule 5**

b. Notwithstanding a suspension or de-empanelment of an EHCP, the Insurer shall ensure that it shall honour all Claims for any expenses that have been pre-authorised or are legitimately due before the effectiveness of such suspension or de-empanelment as if such de-empanelled EHCP continues to be an EHCP.

8. Issuance of Policies

a. For the purpose of issuance of a policy, all eligible beneficiary family units in the entire State of ……………. shall be covered under one policy. The Insurer shall issue a Policy before the commencement of the Policy Cover Period for such State.

b. The first Policy Cover Period under the Policy for a State/UT shall commence from the date __________.

c. The terms and conditions set out in each Policy issued by the Insurer to the State Health Agency shall at a minimum include:
   i. the Policy number;
   ii. the Policy Cover Period under such Policy; and
   iii. the terms and conditions for providing the Covers, which shall not deviate from or dilute in any manner the terms and conditions of insurance set out in this Insurance Contract.

d. Notwithstanding any delay by the Insurer in issuing or failure by the Insurer to issue a Policy for a State/UT in accordance with **Clause 8(a),** the Insurer agrees that the Policy Cover Period for the State shall commence on the date determined and that it shall provide the eligible Beneficiaries in the State with the Risk Cover from that date onwards.

e. In the event of any discrepancy, ambiguity or contradiction between the terms and conditions set out in the Insurance Contract and a Policy issued for a State/UT by the Insurer, the terms of the Insurance Contract shall prevail for the purpose of

determining the Insurer's obligations and liabilities to the SHA and the AB-NHPM Beneficiaries.

9. Period of Insurance Contract and Policy

9.1 Term of the Insurance Contract with the Insurer

a. This Insurance Contract shall be for a period of maximum 1 year with starting date ________.

9.2 Policy Cover Period

In respect of each policy, the Policy Cover Period shall be for a period of 12 months from the date of commencement of such Policy Cover Period starting at 0000 hours on ______, until 2359 hours on the date of expiration ________. Provided that upon early termination of this Insurance Contract, the Policy Cover Period for the State/UT shall terminate on the date of such termination, wherein the premium shall be paid on pro-rata basis after due adjustment of any recoveries on account of termination.

For the avoidance of doubt, the expiration of the risk cover for any Beneficiary Family Unit in the State during the Policy Cover Period shall not result in the termination of the Policy Cover Period for the State.

9.3 Policy Cover Period for the AB-NHPM Beneficiary Family Unit

a. During the first Policy Cover Period for a State/UT, the policy cover shall commence **from 0000 hours on the date indicated by the SHA**.

b. The end date of the policy cover for each State/UT be 12 months from the date of start of the Policy Cover or the date on which the available Sum Insured in respect of that Cover becomes zero

9.4 Cancellation of Policy Cover

Upon early termination of the Insurance Contract between the SHA and the Insurer, all Policies issued by the Insurer pursuant to the Insurance Contract shall be deemed cancelled with effect from the Termination Date subject to the Insurer fulfilling all its obligations at the time of Termination as per the provisions of the Insurance Contract.

For implications and protocols related to early termination, refer to **Clause 29**.

10. Premium and Premium Payment

10.1 Payment of Premium

a. The payment of the premium to the insurance company by the SHA will be done as per the following schedule:

No.	Central & State Premium Split Ratio	Instalment 1 (On or before the commencement of the Policy Cover Period)	Instalment 2 (After completion of 2nd Quarter of the Policy Cover Period dated ________)	Instalment 3 (After completion of 10 months of the Policy Cover Period dated ________)
i.	For 8 North-East and 3 Himalayan States: Centre: State: 90:10	45% of (State Govt. Share) & 45% of (Central Government Share)	45% of (State Govt. Share) & 45% of (Central Government Share)	10% of (State Govt. Share) & 10% of (Central Government Share)
ii.	For other States Centre: State: 60:40	45% of (State Govt. Share) & 45% of (Central Government Share)	45% of (State Govt. Share) & 45% of (Central Government Share)	10% of (State Govt. Share) & 10% of (Central Government Share)
iii.	For Union Territories with Legislation Centre: State: 60:40	45% of (State Govt. Share) & 45% of (Central Government Share)	45% of (State Govt. Share) & 45% of (Central Government Share)	10% of (State Govt. Share) & 10% of (Central Government Share)
iv.	For Union Territories without Legislation: Centre: 100%	45% of (Central Government Share)	45% of (Central Government Share)	10% of (Central Government Share)

b. The SHA shall make the payment to the respective Insurance Companies through an Escrow Account.

c. Detailed premium payment guidelines are provided at **Schedule 8.**

10.2 Refund of Premium and Payment of Additional Premium at the end of contract period

a. The SHA shall issue a letter to the Insurer stating the Insurer's average Claim Ratio for all 12 months of Policy Cover Period for the State/UT. In the letter, the SHA shall indicate the amount of premium that the Insurer shall be obliged to return. The amount of premium to be refunded shall be calculated based on the provisions of **Clause 10.2.b**.

b. After adjusting a defined percent for expenses of management (including all costs excluding only service tax and any cess, if applicable) and after settling all claims, if there is surplus: 100 percent of leftover surplus should be refunded by the Insurer to the SHA within 30 days. The percentage that will be need to be refunded will be as per the following:

   a. In category A States

i. Administrative cost allowed 12% if claim ratio less than 60%.
ii. Administrative cost allowed 15% if claim ratio between 60-70%.
iii. Administrative cost allowed 20% if claim ratio between 70-80%.

b. In Category B States
   i. Administrative cost allowed 10% if claim ratio less than 60%.
   ii. Administrative cost allowed 12% if claim ratio between 60-70%.
   iii. Administrative cost allowed 15% if claim ratio between 70-85%.

c. All the surplus as determined through formula mentioned above should be refunded by the insurer to the SHA within 30 days.

d. If the Insurer delays payment of or fails to pay the refund amount within 60 days of the date of expiration of the Policy Cover Period, then the Insurer shall be liable to pay interest at the rate of one percent of the refund amount due and payable to the SHA for every 7 days of delay beyond such 60 day period.

e. If the Insurer fails to refund the Premium within such 90-day period and/ or the default interest thereon, the SHA shall be entitled to recover such amount as a debt due from the Insurer through means available within law.

f. The SHA is under no obligation to pay any further premium to the Insurer if claim ratio of the Insurer is upto 120 percent for Category A States and 115 percent for Category B States.

g. If the Insurer's average Claim Ratio for the full 12 months is in excess of 120 percent for Category A States and 115 percent for Category B States, then the SHA will be liable to pay 50% of additional claim cost in excess of the total Premium already paid by it and remaining 50% shall be borne by the insurance company. The total premium, including this additional claim cost, shall be borne by SHA only till the ceiling limit of premium set under AB-NHPM for Central and State Governments' share. After the ceiling is reached claims cost will need to be borne entirely by the Insurer.

10.3 Taxes

The Insurer shall protect, indemnify and hold harmless the State Health Agency, from any and all claims or liability to:

a. pay any service tax assessed or levied by any competent tax authority on the Insurer or on the State Health Agency for or on account of any act or omission on the part of Insurer; or

b. on account of the Insurer's failure to file tax returns as required by applicable Laws or comply with reporting or filing requirements under applicable Laws relating to service tax; or

c. arising directly or indirectly from or incurred by reason of any misrepresentation by or on behalf of the Insurer to any competent tax authority in respect of the service tax.

10.4 Premium All Inclusive

Except as expressly permitted, the Insurer shall have no right to claim any additional amount from the State Health Agency in respect of:

a. the risk cover provided to each eligible Beneficiary Family Unit; or

b. the performance of any of its obligations under this Insurance Contract; or

c. any costs or expenses that it incurs in respect thereof.

10.5 No Separate Fees, Charges or Premium

The Insurer shall not charge any Beneficiary Family Unit or any of the Beneficiaries with any separate fees, charges, commission or premium, by whatever name called, for providing the benefits under this Insurance Contract and a Policy.

10.6 Approval of Premium and Terms and Conditions of Cover by IRDA

a. The Insurer shall, if required by the Health Insurance Regulations, obtain IRDA's approval for the Premium and the terms and conditions of the Covers provided under this Insurance Contract under the File & Use Procedure prescribed in the Health Insurance Regulations, within 75 days of the date of execution of this Insurance Contract.

b. The Insurer undertakes and agrees that it shall not:

   (i) file an application with the IRDA for approval of the revision, modification or amendment of the Premium for or the terms and conditions of or for the withdrawal of any or all of the Covers; or

   (ii) revise, modify, amend or withdraw any or all of the Covers, whether with or without the IRDA's approval under the Health Insurance Regulations, at any time during the Term of this Insurance Contract.

   (iii) The Insurer hereby irrevocably waives its right to seek the IRDA's approval for the revision, modification, amendment or withdrawal of any or all of the Covers under this Insurance Contract by filing an application under the File & Use Procedure.

11. Cashless Access of Services

a. The AB-NHPM beneficiaries shall be provided treatment free of cost for all such ailments covered under the Scheme within the limits/ sub-limits and sum insured, i.e., not specifically excluded under the Scheme.

b. The insurer shall reimburse EHCP as per the package cost specified in this Document agreed for specified packages or as pre-authorised amount in case of unspecified packages.

c. The Insurer shall ensure that each EHCP shall at a minimum possess the Hospital IT Infrastructure required to access the AB-NHPM Beneficiary Database and undertake verification based on the Beneficiary Identification process laid out, using unique AB-NHPM Family ID on the AB-NHPM Card and also ascertain the balance available under the AB-NHPM Cover provided by the Insurer.

d. The Insurer shall provide each EHCP with an operating manual describing in detail the verification, pre-authorisation and claims procedures within 7 days of signing of agreement.

e. The Insurer shall train Ayushman Mitras that will be deputed in each EHCP (at the cost of the EHCP) that will be responsible for the administration of the AB-NHPM on the use of the Hospital IT infrastructure for making Claims electronically and providing Cashless Access Services.

f. The EHCP shall establish the identity of the member of a AB-NHPM Beneficiary Family Unit by Aadhaar Based Identification System (No person shall be denied the benefit in the absence of Aadhaar Card through use of alternate Government ID) and ensure:
   (i) That the patient is admitted for a covered procedure and package for such an intervention is available.
   (ii) AB-NHPM Beneficiary has balance in her/ his AB-NHPM Cover amount.
   (iii) Provisional entry shall be made on the server using the AB-NHPM ID of the patient. It has to be ensured that no procedure is carried out unless provisional entry is completed through blocking of claim amount.
   (iv) At the time of discharge, the final entry shall be made on the patient account after completion of Aadhaar Card Identification Systems verification or any other recognised system of identification adopted by the SHA of AB-NHPM Beneficairy Family Unit to complete the transaction.

12. Pre-authorisation of Procedures

a. All procedures in **Schedule 3** that are earmarked for pre-authorisation shall be subject to mandatory pre-authorisation. In addition, in case of Inter-State portability, all procedures shall be subject to mandatory pre-authorisation irrespective of the pre-authorisation status in **Schedule 3.**

b. Insurer will not allow any EHCP shall, under any circumstances whatsoever, to undertake any such earmarked procedure without pre-authorisation unless under

emergency. Process for emergency approval will be followed as per guidelines laid down under AB-NHPM

c. Request for hospitalization shall be forwarded by the EHCP after obtaining due details from the treating doctor, i.e. "request for authorisation letter" (RAL). The RAL needs to be submitted online through the Scheme portal and in the event of any IT related problem on the portal, then through email or fax. The medical team of Insurer would get in touch with the treating doctor, if necessary.

d. The RAL should reach the authorisation department of the Insurer within 6 hours of admission in case of emergency.

e. In cases of failure to comply with the timelines stated in above **Clause 12.d**, the EHCP shall forward the clarification for delay with the request for authorisation.

f. The Insurer shall ensure that in all cases pre-authorisation request related decisions are communicated to the EHCP within 12 hours for all normal cases and within 1 hours for emergencies. If there is no response from the Insurer within 12 hours of an EHCP filing the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised.

g. The Insurer shall not be liable to honour any claims from the EHCP for procedures featuring in **Schedule 3**, for which the EHCP does not have a pre-authorisation, if prescribed.

h. Reimbursement of all claims for procedures listed under **Schedule 3** shall be as per the limits prescribed for each such procedure unless stated otherwise in the pre-authorisation letter/communication.

i. The RAL form should be dully filled with clearly mentioned Yes or No. There should be no nil, or blanks, which will help in providing the outcome at the earliest.

j. The Insurer guarantees payment only after receipt of RAL and the necessary medical details. And only after the Insurer has ascertained and negotiated the package with the EHCP, shall issue the Authorisation Letter (AL). This shall be completed within 24 hours of receiving the RAL.

k. In case the ailment is not covered or the medical data provided is not sufficient for the medical team of the authorisation department to confirm the eligibility, the Insurer can deny the authorisation or seek further clarification/ information.

l. The Insurer needs to file a report to the SHA explaining reasons for denial of every such pre-authorisation request.

m. Denial of authorisation (DAL)/ guarantee of payment is by no means denial of treatment by the EHCP. The EHCP shall deal with such case as per their normal rules and regulations.

n. Authorisation letter (AL) will mention the authorisation number and the amount authorized as a package rate for such procedure for which package has not been fixed earlier. The EHCP must see that these rules are strictly followed.

o. The authorisation is given only for the necessary treatment cost of the ailment covered and mentioned in the RAL for hospitalization.

p. The entry on the AB-NHPM portal for claim amount blocking as well at discharge would record the authorisation number as well as package amount agreed upon by the EHCP and the Insurer.

q. In case the balance sum available is less than the specified amount for the Package, the EHCP should follow its norms of deposit/running bills etc. However, the EHCP shall only charge the balance amount against the package from the AB-NHPM beneficiary. The Insurer upon receipt of the bills and documents would release the authorized amount.

r. The Insurer will not be liable for payments in case the information provided in the RAL and subsequent documents during the course of authorisation is found to be incorrect or not fully disclosed.

s. In cases where the AB-NHPM beneficiary is admitted in the EHCP during the current Policy Cover Period but is discharged after the end of the Policy Cover Period, the claim has to be paid by the Insurer from the Policy which was operating during the period in which the AB-NHPM beneficiary was admitted.

t. Detailed guidelines for hospitals transactions including pre-authorisation is provided at **Schedule 15.**

13. Portability of Benefits

a. The benefits of AB-NHPM will be portable across the country and a beneficiary covered under the scheme will be able to get benefits under the scheme across the country at any EHCP.

b. Package rates of the hospital where benefits are being provided will be applicable while payment will be done by the insurance company that is covering the beneficiary under its policy.

c. The Insurer is required to honour claims from any empanelled hospital under the scheme within India and will settle claims within 30 days of receiving them.

d. To ensure true portability of AB-NHPM, State Governments shall enter into arrangement with ALL other States that are implementing AB-NHPM for allowing sharing of network hospitals, transfer of claim & transaction data arising in areas beyond the service area.

e. Detailed guidelines of portability are provided at **Schedule 9.**

14. Claims Management

14.1 Claim Payments and Turn-around Time

The Insurer shall comply with the following procedure regarding the processing of Claims received from the Empanelled Health Care Providers:

a. The Insurer shall require the Empanelled Health Care Providers to submit their Claims electronically within 24 hours of discharge in the defined format to be prescribed by the NHA/SHA/Insurer. However, in case of Public EHCPs this time may be relaxed as defined by SHA.

b. The Insurer shall decide on the acceptance or rejection of any Claim received from an Empanelled Health Care Provider. Any rejection notice issued by the Insurer to the Empanelled Health Care Provider shall state clearly that such rejection is subject to the Empanelled Health Care Provider's right to file a complaint with the relevant Grievance Redressal Committee against such decision to reject such Claim.

c. If the Insurer rejects a Claim, the Insurer shall issue a written letter of rejection to the Empanelled Health Care Provider stating: details of the Claim summary; reasons for rejection; and details of the District Grievance Nodal Officer. The letter of rejection shall be issued to the State Health Agency and the Empanelled Health Care Provider within 15 days of receipt of the electronic Claim. The Insurer should inform the Empanelled Health Care Provider of its right to seek redressal for any Claim related grievance before the District Grievance Redressal Committee in its letter of rejection.

   If a Claim is rejected because the Empanelled Health Care Provider making the Claim is not empanelled for providing the health care services in respect of which the Claim is made, then the Insurer shall while rejecting the Claim inform the Beneficiary of an alternate Empanelled Health Care Provider where the benefit can be availed in future.

d. The Insurer shall be responsible for settling all claims **within 15 days after receiving all the required information/ documents**. The Insurer shall make the Claim Payment (based on the Package Rate or the Pre-Authorized Amount) within 15 days, if not rejected, including any investigation into the Claim received from the Empanelled Health Care Provider.

e. The Insurer shall make the full Claim Payment without deduction of tax, for all PHCs, CHCs, District Hospitals and other government sponsored hospitals, for private healthcare providers the Insurer shall make the full Claim Payment without deduction of tax, if the Empanelled Health Care Provider submits a tax exemption certificate to the Insurer within 7 days after signing the agreement with the Insurer making a Claim. If the Empanelled Health Care Provider fails to submit a tax exemption certificate to the Insurer, then the Insurer shall make the Claim Payment after deducting tax at the applicable rate.

f. If the Beneficiary is admitted by an Empanelled Health Care Provider during a Policy Cover Period, but is discharged after the end of such Policy Cover Period and the Policy is not renewed, then the arising Claim shall be paid in full by the Insurer subject to the available Sum Insured.

g. If a Claim is made during a Policy Cover Period and the Policy is not subsequently renewed, then the Insurer shall make the Claim Payment in full subject to the available Sum Insured.

h. The process specified in paragraphs (b) to (d) above in relation to Claim Payment or investigation of the Claim shall be completed such that the Turn-around Time shall be no longer than 15 days.

   Without prejudice to the foregoing, during the subsistence of any delay by the State Health Agency in making payment of the Premium for a Policy Cover Period, the Insurer shall have the right to delay making Claim Payments to the Empanelled Health Care Providers until the Premium is received, provided that the Insurer completes the processing of the Claims in accordance with paragraphs (b) to (d) above within te Turn-Around Time of 15 days.

   If the Insurer fails to make the Claim Payment within a Turn-around Time of 15 days for a reason other than a delay by the State Health Agency in making payment of the Premium that is due and payable, then the Insurer shall be liable to pay a penal interest to the Empanelled Health Care Provider at the rate of 1% of the Claim amount for every 15 days of delay.

i. The counting of days for the purpose of this Clause shall start from the date of receipt of the Claim.

j. The Insurer shall make Claim Payments to each Empanelled Health Care Provider against Claims received on a weekly basis and as far as possible through electronic transfer to such Empanelled Health Care Provider's designated bank account.

k. The Insurer shall ensure that there is an online web portal for processing of all claim payments.

l. All Claims investigations shall be undertaken by qualified and experienced Medical Practitioners appointed by the Insurer or its TPA, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Insurance Contract and relevant Policy. The Insurer's or the TPA's medical staff shall not impart or advise on any Medical Treatment, Surgical Procedure or Follow-up Care or provide any OPD Benefits or provide any guidance related to cure or other care aspects.

m. The Insurer shall submit details of:

(i) all Claims that are under investigation to the district nodal officer of the State Health Agency on a monthly basis for its review;

(ii) every Claim that is pending beyond 15 days to the State Health Agency, along with its reasons for delay in processing such Claim; and

(iii) details of interest paid to the Empanelled Health Care Providers for every Claim that was pending beyond 15 days to the State Health Agency.

n. The Insurer may collect at its own cost, complete Claim papers from the Empanelled Health Care Provider, if required for audit purposes. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

o. The Insurer shall, at all times, comply with and ensure that its TPA is in compliance with the Health Insurance Regulations and any other Law issued or notified by the IRDA in relation to the provision of Cashless Access Services and Claims processing.

p. In case the insurer hires Third Party Administrator (TPA), it shall ensure that the TPA does not approve or reject any Claims on its behalf and that the TPA is only engaged in the processing of Claims. The TPA may however recommend to the Insurer on the action to be taken in relation to a Claim. However, the final decision on approval and rejection of Claims shall be made by the Insurer.

q. Guidelines for submission of claims, claims processing, handling of claim queries, and all other related details are furnished in **Schedule 9**.

14.2 Right of Appeal and Reopening of Claims

a. The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the Insurer, if the Empanelled Health Care Provider feels that the Claim is payable. Such decision of the Insurer may be appealed by filing a complaint with the DGNO in accordance with **Clause 28** of this Insurance Contract.

b. The Insurer and/or the DGNO or the DGRC, as the case maybe, may re-open the Claim, if the Empanelled Health Care Provider submits the proper and relevant Claim documents that are required by the Insurer.

14.3 No Contributions

a. The Insurer agrees that any Beneficiary Family Unit or any of the Beneficiaries or any other third party shall be entitled to obtain additional health insurance or any other insurance cover of any nature whatsoever, including in relation to the benefits provided under this Insurance Contract and a Policy, either individually or on a family floater cover basis.

b. Notwithstanding that such Beneficiary Family Unit or any of the Beneficiaries or any third party acting on their behalf effect additional health insurance or any other insurance cover of any nature whatsoever, the Insurer agrees that:

(i) its liability to make a Claim Payment shall not be waived or discharged in part or in full based on a rateable or any other proportion of the expenses incurred and that are covered by the benefits under the Covers;

(ii) it shall be required to make the full Claim Payment in respect of the benefits provided under this Insurance Contract and the relevant Policy; and

(iii) if the total expenses incurred by the Beneficiary exceeds the available Sum Insured under the Covers, then the Insurer shall make payment to the extent of the available Sum Insured in respect of the benefits provided under this Insurance Contract and the relevant Policy and the other insurers shall pay for any excess expenses not covered.

15. No Duty of Disclosure

a. Notwithstanding the issue of the Tender Documents and any other information provided by the State Health Agency prior to the date of this Insurance Contract, the Insurer hereby acknowledges that it does not rely on and has not been induced to enter into this Insurance Contract or to provide the Covers or to assess the Premium for providing the Covers on the basis of any statements, warranties, representations, covenants, undertakings, indemnities or other statements whatsoever and acknowledges that none of the State Health Agency or any of its agents, officers, employees or advisors or any of the enrolled Beneficiary Family Units have given or will give any such warranties, representations, covenants, undertakings, indemnities or other statements.

b. Prior to commencement of each Policy Cover Period for any State, the State Health Agency or MoHFW undertakes to prepare or cause a third party to prepare the Beneficiary Database as correctly as possible. The Insurer acknowledges that, notwithstanding such efforts being made by the State Health Agency, the information in the Beneficiary Database may not be accurate or correct and that the Beneficiary Database may contain errors or mistakes.

Accordingly, the Insurer acknowledges that the State Health Agency makes no warranties, representations, covenants, undertakings, indemnities or other statements regarding the accuracy or correctness of the Beneficiary Database that will be provided by it to the Insurer.

c. The Insurer represents, warrants and undertakes that it has completed its own due diligence and is relying on its own judgment in assessing the risks and responsibilities that it will be undertaking by entering into this Insurance Contract and in providing the

Covers to the enrolled Beneficiary Family Units and in assessing the adequacy of the Premium for providing the Covers for the Beneficiary Family Units.

d. Based on the acknowledgements of the Insurer in this Clause, the Insurer:

(i) acknowledges and confirms that the State Health Agency has made no and will make no material disclosures to the Insurer;

(ii) acknowledges and confirms that the State Health Agency shall not be liable to the Insurer for any misrepresentation or untrue, misleading, incomplete or inaccurate statements made by the State Health Agency or any of its agents, officers, employees or advisors at any time, whether made wilfully, negligently, fraudulently or in good faith; and

(iii) hereby releases and waives all rights or entitlements that it has or may have to:

– make any claim for damages and/or declare this Insurance Contract or any Policy issued under this Insurance Contract declared null and void; or

as a result of any untrue or incorrect statements, misrepresentation, mis-description or non-disclosure of any material particulars that affect the Insurer's ability to provide the Covers.

16. Fraud Control and Management

a. The insurer is expected to develop a comprehensive fraud control system for the scheme. For an indicative (not exhaustive) list of fraud triggers that may be automatically and on a real-time basis be tracked please refer to **Schedule 13**. The Insurer shall have capactities and track the indicative (not exhaustive) triggers and it can add more triggers to the list.

b. For all trigger alerts related to possible fraud at the level of EHCPs, the Insurer shall take the lead in immediate investigation of the case in close coordination and under constant supervision of the SHA.

c. Investigations pursuant to any such alert shall be concluded within 15 days and all final decision related to outcome of the Investigation and consequent penal action, if the fraud is proven, shall vest solely with the SHA.

d. The SHA shall take all such decision within the provisions of the Insurance Contract and be founded on the Principles of Natural Justice.

e. The SHA shall on an ongoing basis measure the effectiveness of anti-fraud measures in the Scheme through a set of indicators. For a list of such indicative (not exhaustive) indicators, refer to **Schedule 14**.

f. The Insurer shall be responsible for monitoring and controlling the implementation of the AB-NHPM in the State in accordance with **Clause 24**.

g. In the event of a fraudulent Claim being made or a false statement or declaration being made or used in support of a fraudulent Claim or any fraudulent means or device being used by any Empanelled Health Care Provider or the TPA or other intermediary hired by the Insurer or any of the Beneficiaries to obtain any benefits under this Insurance Contract or any Policy issued by the Insurer (each a Fraudulent Activity), then the Insurer's sole remedies as per the approval of SHA shall be to:

(i) refuse to honour a fraudulent Claim or Claim arising out of Fraudulent Activity or reclaim all benefits paid in respect of a fraudulent Claim or any Fraudulent Activity relating to a Claim from the Empanelled Health Care Provider and/or the Beneficiary that has undertaken or participated in a Fraudulent Activity; and/or

(ii) de-empanel the Empanelled Health Care Provider, with approval of SHA, that has made a fraudulent Claim or undertaken or participated in a Fraudulent Activity, with the procedure specified in **Schedule 5**;

(iii) terminate the services agreement with the intermediary appointed by the Insurer; and/or

provided that the Insurer has: issued a notice to the State Health Agency of its proposed exercise of any of these remedies; and such notice is accompanied by reasonable documentary evidence of such fraudulent activity. An indicative list of fraudulent triggers has been set out in **Schedule 13**.

The State Health Agency shall have the right to conduct a random audit of any or all cases in which the Insurer has exercised such remedies against an Empanelled Health Care Provider and/or any Beneficiary. If the State Health Agency finds that the Insurer has wrongfully de-empanelled an Empanelled Health Care Provider, then the Insurer shall be required to reinstate such benefits to such Empanelled Health Care Provider.

h. The Insurer hereby releases and waives all rights or entitlements to:

(i) make any claim for damages and/or have this Insurance Contract or any Policy issued under this Insurance Contract declared null and void; or

as a result of any fraudulent Claim by or any Fraudulent Activity of any Empanelled Health Care Provider.

17. Representations and warranties of the Insurer

17.1 Representations and Warranties

The Insurer represents, warrants and undertakes that:

a. The Insurer has the full power, capacity and authority to execute, deliver and perform this Insurance Contract and it has taken all necessary actions (corporate, statutory or otherwise), to execute, deliver and perform its obligations under this Insurance Contract and that it is fully empowered to enter into and execute this Insurance Contract, as well as perform all its obligations hereunder.

b. Neither the execution of this Insurance Contract nor compliance with its terms will be in conflict with or result in the breach of or constitute a default or require any consent under:

    (i) any provision of any agreement or other instrument to which the Insurer is a party or by which it is bound;

    (ii) any judgment, injunction, order, decree or award which is binding upon the Insurer; and/or

    (iii) the Insurer's Memorandum and Articles of Association or its other constituent documents.

c. The Insurer is duly registered with the IRDA, has duly obtained renewal of its registration from the IRDA and to the best of its knowledge, will not have its registration revoked or suspended for any reason whatsoever during the Term of this Insurance Contract. The Insurer undertakes that it shall continue to keep its registration with the IRDA valid and effective throughout the Term of this Insurance Contract.

d. The Insurer has conducted the general insurance (including health insurance) business in India for at least 3 financial years prior to the submission of its Bid and shall continue to be an insurance company that is permitted under Law to carry on the general insurance (including health insurance) business throughout the Term of this Insurance Contract.

e. In the financial year prior to the submission of its Bid, the Insurer has maintained its solvency ratio in full compliance with the requirements of the IRDA Solvency Regulations and the Insurer undertakes that it shall continue to maintain its solvency ratio in full compliance with the IRDA Solvency Regulations throughout the Term of this Insurance Contract.

f. The Insurer has complied with and shall continue to comply with all Laws, including but not limited to the rules or regulations issued by the IRDA in connection with the conduct of its business and the AB-NHPM Guidelines issued by MoHFW and/or the State Health Agency from time to time.

g. The Insurer has quoted the Premium and accepted the terms and conditions of this Insurance Contract:

(i) after the Insurer and its Appointed Actuary have duly satisfied themselves regarding the financial viability of the Premium; and

(ii) in accordance with the Insurer's underwriting policy approved its Board of Directors.

The Insurer shall not later deny issuance of a Policy or payment of a Claim on the grounds that: (x) the Premium is found financially unviable; or (y) the assumptions taken by the Insurer and/or its Appointed Actuary in the actuarial certificate submitted with its Bid have been breached; or (z) the Insurer's underwriting policy has been breached.

h. Without prejudice to **Clause 17.1 (e)** above, the Insurer is and shall continue to be capable of meeting its liabilities to make Claim Payments, servicing the Covers being provided by it under this Insurance Contract and has and shall continue to have sufficient infrastructure, trained manpower and resources to perform its obligations under this Insurance Contract.

i. The Insurer has at no time, whether prior to or at the time of submission of its Bid and at the time of execution of this Contract, been black-listed or been declared as ineligible from participating in government sponsored schemes (including the AB-NHPM) by the IRDA.

j. After the issuance of each Policy, the Insurer shall not withdraw or modify the Premium or the terms and conditions of the Covers provided to the Beneficiaries during the Term of this Insurance Contract.

k. The Insurer abides and shall continue to abide by the Health Insurance Regulations and the code of conduct prescribed by the IRDA or any other governmental or regulatory body with jurisdiction over it, from time to time.

17.2 Continuity and Repetition of Representations and Warranties

The Insurer agrees that each of the representations and warranties set out in **Clause 17.1** are continuing and shall be deemed to repeat for each day of the Term.

17.3 Information regarding Breach of Representations and Warranties

The Insurer represents, warrants and undertakes that it shall promptly, and in any event within 15 days, inform the State Health Agency in writing of the occurrence of a breach or of obtaining knowledge of a potential breach of any of the representations and warranties made by it in **Clause 17.1** at any time during the continuance of the Term.

PART II

PROJECT OFFICE

18. Project Office and District Offices

18.1 Project Office at the State Level

The Insurer shall establish a Project Office at a convenient place at [*insert name of State/ UT capital*] for coordination with the SHA on a regular basis within 15 days of signing of the contract.

18.2 District Offices

a. The Insurer shall set up an office in each of the districts of the State/UT of [*insert name of State/UT*] at the district headquarters of such district (each a District Office) within 15 days of signing of the contract.

b. Each District Office shall be responsible for coordinating the Insurer's activities at the district level with the SHA's district level administration.

18.3 Organizational Set up and Functions

a. In addition to the support staff for other duties, the Insurer shall recruit or employ experienced and qualified personnel exclusively for the purpose of implementation of the AB-NHPM and for the performance of its obligations and discharge of its liabilities under the Insurance Contract:

   (i) One State Coordinator who shall be responsible for implementation of the Scheme and performance of the Insurance Contract in the State/UT.
   (ii) One full time District Coordinator for each of the districts who shall be responsible for implementation of the Scheme in each of the districts.
   (iii) One full time district medical officer for each of the districts who shall be responsible for medical audits, fraud control etc.
   (iv) One district grievance officer for each of the districts who shall be responsible for grievances in the district.

The State Coordinator shall be located in the Project Office and each District Coordinator shall be located in the relevant District Office.

<u>Role of District Coordinator</u>

- To coordinate and ensure smooth implementation of the Scheme in the district.
- To follow up with the EHCP to ensure that the IT infrastructure installed is fully functional at all times.
- Liaise with the district officials of the SHA to addressing operational issues as and when they arise.

- Liaise with the District Grievance Redressal Cell for resolving all complaints.

b. In addition to the personnel mentioned above, the Insurer shall recruit or employ experienced and qualified personnel for each of the following roles within its organisation exclusively for the purpose of the implementation of the Scheme:

(i) To undertake Information Technology related functions which will include, among other things, collating and sharing claims related data with the SHA and running of the website at the State level and updating data at regular intervals on the website. The website shall have information on AB-NHPM in the local language and English with functionality for claims settlement and account information access for the AB-NHPM Beneficiaries and the EHCP.
(ii) To implement the grievance redressal mechanism and to participate in the grievance redressal proceedings provided that such persons shall not carry out any other functions simultaneously if such functioning will affect their independence as members of the grievance redressal committees at different levels.
(iii) To coordinate the Insurer's State level obligations with the State level administration of the SHA.

c. In addition to the personnel mentioned above, the Insurer shall recruit or employ experienced and qualified personnel for each of the following roles within its organisation at the State/district level, exclusively for the purpose of the implementation of the AB-NHPM:

(i) To undertake the Management Information System (MIS) functions, which include creating the MIS dashboard and collecting, collating and reporting data.
(ii) To generate reports in formats prescribed by the SHA from time to time or as specified in the Scheme Guidelines, at monthly intervals.
(iii) Processing and approval of beneficiary identity verification requests, received from Ayushman Mitras at the hospitals, as per the process defined in the scheme. Scrutiny and approval of beneficiary identity verification requests if all the conditions are fulfilled, within 30 minutes of receiving the requests from Ayushman Mitras at the network hospital.
(iv) To undertake the Pre-authorisation functions under AB-NHPM.
(v) To undertake paperless claims settlement for the Empanelled Health Care Providers with electronic clearing facility, including the provision of necessary Medical Practitioners to undertake investigation of claims made.
(vi) To undertake internal monitoring and control functions.
(vii) To undertake feedback functions which include designing feedback formats, collecting data based on those formats from different stakeholders like AB-NHPM beneficiaries, the EHCPs etc., analysing the feedback data and recommending appropriate actions.
(viii) To coordinate the Insurer's district level obligations with the district level administration of the SHA.

d. The Insurer shall not be required to appoint the concerned personnel if it has outsourced any of the roles and functions listed in the above sections to third parties in accordance with **Clause 25**.

e. Provided, however, that the Insurer shall not outsource any roles or functions that are its core functions as a health insurer or that relate to its assumption of risk under AB-NHPM Cover or that the Insurer is prohibited from outsourcing under the Insurance Laws, including but not limited to: implementation of the grievance redressal mechanism, managing its District Offices, undertaking pre-authorisation (other than in accordance with the Health Insurance Regulations), undertaking Claims Payments (other than in accordance with the Health Insurance Regulations).

f. The Insurer shall provide a list of all such appointments and replacement of such personnel to the SHA within 30 days of all such appointments and replacements. The Insurer shall ensure that its employees coordinate and consult with the SHA's corresponding personnel for the successful implementation of AB-NHPM and the due performance of the Insurer's obligations and discharge of the Insurer's liabilities under the Insurance Contract and the Policies issued hereunder.

g. The Insurer shall complete the recruitment of such employees within 45 days of the signing of the Insurance Contract and in any event, prior to commencement of the Policy Cover Period.

19. Capacity Building Interventions

The insurer shall prepare a training plan and share with SHA within 15 days of signing of the contract. The Insurer shall, at a minimum, conduct the following training and make them part of training plan:

<u>Empanelled Health Care Provider Training</u>

a. The Insurer shall provide training to the Ayushman Mitras for all EHCPs in a State at least once every 6 months, that is, at least twice during each Policy Cover Period for such State. Such training shall minimum include: list of covered procedures and prices, pre-authorisation procedures and requirements, IT training for making online Claims and ensuring proper installation and functioning of the Hospital IT Infrastructure for each Empanelled Health Care Provider.

b. The Insurer shall organize training workshops for each public EHCP (including Community Health Centres- CHCs and Primary Health Centres- PHCs) at the hospital premises at least once every 6 months, that is, at least twice during each Policy Cover Period for a State and at any other time requested by the EHCP, to increase knowledge levels and awareness of the hospital staff.

c. If a particular EHCP frequently submits incomplete documents or incorrect information in Claims or in its request for authorisation as part of the pre-authorisation procedure, then the Insurer shall undertake a follow-up training for such EHCP.

d. The cost of all capacity building interventions associated with the implementation of the Capacity Building Programme shall be borne by the Insurer.

e. The Insurer shall submit to the State Health Agency at the end of every 6 months, a detailed report specifying the capacity building and training conducted by the Insurer and the progress made by the Insurer against the Capacity Building Programme during those 6 months.

20. Other Obligations

20.1 Insurer's Obligations before start of the policy

The Insurer shall mandatorily complete the following activities before the start of policy in each State:

a. Sign contract with the empanelled hospitals

b. Ensure that requisite hardware and software is available in the empanelled hospitals

c. State and district offices as mentioned aboe are set up and functional

d. Print sufficient number of booklets which have to be given to each Beneficiary Family Unit through various mechanisms including hospitals, common service centres, ASHA etc. The responsibility of distributing booklets will lie with the SHA. Such booklets shall contain at least the following details:

   (i) Details about AB-NHPM;
   (ii) Process for utilizing the Covers under AB-NHPM;
   (iii) List of Exclusions;
   (iv) Start and end date of the Policy Cover Period for that State;
   (v) List of the Empanelled Health Care Providers along with addresses and contact details;
   (vi) The names and details of the District Coordinator of the Insurer in that district;
   (vii) Toll-free number of the call centre;
   (viii) Process for filing complaints or grievances;
   (ix) All other details required for smooth usage of the AB-NHPM.

e. Ensuring availability of Policy number for the Policy for State that is issued by the Insurer.

f. Ensuring that contact details of the District Coordinator of the Insurer, and the nodal officer of the other service providers appointed by the Insurer are are provided to SHA before the commencement of each Policy Cover Period.

20.2 State Health Agency's Obligations

The State Health Agency shall mandatorily complete the following activities before the start of the policy in the State:

a. Provide the Beneficiary Database for each district in the format prescribed by the AB-NHPM Guidelines to the insurer prior to the commencement of each Policy Cover Period at least 15 days prior to the scheduled date for start of policy.

b. Appoint the District Nodal Officers (DNOs) and other required staff for each district and work with the DNO appointed by it to create the requisite organization structure at the district level to effectively implement and manage the AB-NHPM within 30 days of the signing of this Insurance Contract.

c. Set up State and District level grievance committees as detailed out in this contract document.

d. Set up Claims review committee as mentioned in 24.3.1 (b) (I)

PART III

OTHER OBLIGATIONS REGARDING IMPLEMENTATION OF THE AB-NHPM

21. Service beyond Service Area

To ensure true portability of the AB-NHPM and to provide the Beneficiaries with seamless access to health care services across the Empanelled Health Care Providers anywhere across India. To ensure true portability of AB-NHPM, State Governments shall enter into arrangement with ALL other States that are implementing AB-NHPM for allowing sharing of network hospitals, transfer of claim & transaction data arising in areas beyond the service area.

22. Plan for Provision of Services in the Absence of Internet Connectivity

The Insurer agrees that if, in the implementation of the Scheme and use of the prescribed technology and systems, there is an issue causing interruption in the provision of Cashless Access Services, the Insurer shall:

a. make all efforts to put in place an alternate mechanism to ensure continued provision of Cashless Access Services to the AB-NHPM Beneficiaries;

b. take all necessary measures to fix the technology or related issues to bring the Cashless Access Services back onto the online platform within the earliest possible time in close coordination with the SHA; and

c. furnish all data/information in relation to the cause of interruptions, the delay or other consequences of interruptions, the mitigating measures taken by the Insurer and any other related issues to the SHA in the format prescribed by the SHA at that point in time.

23. Management Information System

a. All Management Information System (MIS) shall be on a centralised web-based architecture designed by the MoHFW, GoI for the purposes of the Scheme.

b. The Insurer shall maintain a MIS dashboard that will act as a visual interface to provide at-a-glance views on key ratios and measures of data regarding the implementation of the Scheme.

c. The Insurer shall update the information on the MIS dashboard real time and shall provide the SHA and any number of authorized representatives of the SHA or its advisors/ consultants with access to the various modules on the MIS dashboard. The SHA and the MoHFW, GoI shall have the right to download, print or store the data available on the MIS dashboard.

d. In addition, the Insurer shall submit reports to the SHA regarding health-service usage patterns, Claims data and such other information regarding the delivery of benefits as may be required by the SHA on a monthly basis.

e. In addition, the Insurer shall be responsible for submitting such other data and information as may be requested by the SHA and/ or to the MoHFW, GoI and to submit such reports in formats as required by and specified by the SHA from time to time.

f. All data generated by the Insurer in relation to the implementation and management of the Scheme and/or in performing its obligations under the Insurance Contract shall be the property of the SHA and MoHFW, GoI. The Insurer undertakes to handover all such information and dat`a to the SHA within 10 days of the expiration or cancellati`on of the Policy for that State and on the expiration or early termination of the Insurance Contract.

24. Monitoring and Control

24.1 Scope of Monitoring

a. Monitoring under AB-NHPM shall include supervision and monitoring of all the activities under the AB-NHPM undertaken by the Insurer and ensuring that the Insurer complies with all the provisions of the Insurance Contract signed with the State Health Agency (SHA) and all contracts and sub-contracts/ agreements issued by the Insurer pursuant to the Insurance Contract with the SHA for implementation of the Scheme.

b. Monitoring shall include but not be limited to:
   i. Overall performance and conduct of the Insurer.
   ii. Claims management process.
   iii. Grievance redressal process.
   iv. Any other aspect/ activity of the Insurer related to the implementation of the Scheme.

24.2 Monitoring Activities to be undertaken by the Insurer

24.2.1 General Monitoring Obligations

Under the AB-NHPM, the Insurer shall monitor the entire process of implementation of the Scheme on an ongoing basis to ensure that it meets its obligations under its Insurance Contract with the SHA. Towards this obligation the Insurer shall undertake, **but not be limited** to, the following tasks:

a. Ensure compliance to all the terms, conditions and provisions of the Scheme.

b. Ensure monitoring of processes for seamless access to cashless health care services by the AB-NHPM beneficiaries under the provisions of the Scheme.

c. Ensure monitoring of processes for timely processing and management of all claims of the EHCPs.

d. Ensure fulfilment of minimum threshold levels as per the agreed Key Performance Indicators (KPIs).

e. Ensure compliance from all its sub-contractors, vendors and intermediaries hired/ contracted by the Insurer under the Scheme for the fulfilment of its obligations.

24.2.2 Medical Audit

Scope

a. The scope of medical audit under the Scheme shall focus on ensuring comprehensiveness of medical records and shall include but not be limited to:

   (i) Completeness of the medical records file.
   (ii) Evidence of patient history and current illness.
   (iii) Operation report (if surgery is done).
   (iv) Patient progress notes from admission to discharge.
   (v) Pathology and radiology reports.

b. If at any point in time the SHA issues Standard Treatment Guidelines for all or some of the medical/ surgical procedures, assessing compliance to Standard Treatment Guidelines shall be within the scope of the medical audit.

Methodology

c. The Insurer shall conduct the medical audit through on-site visits to the concerned EHCPs for inspection of records, discussions with the nursing and medical staff.

d. The indicative process of conducting medical audits is set out below and based on this the Insurer shall submit its detailed audit methodology to the SHA for approval:
   (i) The auditor shall check the data before meeting the EHCP authorities.
   (ii) The audit should preferably be conducted in the presence of the EHCP's physician/ treating doctor.

e. The medical audit will include a review of medical records in the format specified in **Schedule 10**.

Personnel

f. All medical audits should compulsorily be done by MBBS doctors or Specialists as required who are a part of the Insurer's or the Outsourced agency or is otherwise duly authorized to undertake such medical audit by the Insurer or the outsourced agency. The Insurer shall share the profiles of all such auditors hired/empanelled by it for medical audit purposes under the Scheme.

Frequency and Sample

g. The number of medical audits to be conducted by the Insurer will be a five percent of the total cases hospitalized in each of the EHCP in the current quarter. The sample shall be selected in a manner to ensure that over a period of one year every district and every EHCP is included at least once in the medical audits.

24.2.3 Hospital Audit

a. The Insurer will conduct hospital audit for every single EHCP visited by it as a part of the medical audit as described in **Clause 24.2.2** above.
b. Hospital audit shall be conducted as per the format prescribed in **Schedule 11**.
c. Hospital audit will focus on compliance to EHCP's obligations like operational help desk, appropriate signage of the Scheme prominently displayed, etc. details of which are captured.

24.3 Monitoring Activities to be undertaken by the State Health Agency

24.3.1 Audits by the State Health Agency

a. <u>Audit of the audits undertaken by the Insurer</u>: The SHA shall have the right to undertake sampled audits of all audits (Medical Audit and Hospital Audit) undertaken by the Insurer.

b. <u>Direct audits</u>: In addition to the audit of the audits undertaken by the Insurer referred in **Clause 24.3.1.a**, the SHA shall have the right to undertake direct audits on a regular basis conducted either directly by it or through its authorized representatives/ agencies including appointed third parties. Direct audits shall include:

(i) <u>Claims audit</u>: For the purpose of claims audit, the SHA shall constitute a **Claims Review Committee** (CRC) that shall look into 100 percent of the claims rejected or partially settled by the Insurer to assure itself of the legitimacy of the Insurer's decisions. Claims settlement decisions of the Insurer that are disputed by the concerned EHCP shall be examined in depth by the CRC after such grievance of the EHCP is forwarded by the concerned Grievance Redressal Committee (GRC) to the CRC.

CRC shall examine the merits of the case within 30 working days and recommend its decision to the concerned GRC. The GRC shall then communicate the decision to the aggrieved party (the EHCP) as per the provisions specified in the Clause of Grievance Redressal Mechanism.

During the claims audit the SHA shall look into the following aspects (indicative, not exhaustive):

- Evidence of rigorous review of claims.

- Comprehensiveness of claims submissions (documentation) by the EHCPs.
- Number of type of queries raised by the Insurer during review of claims – appropriateness of queries.
- Accuracy of claims settlement amount.

(ii) Concurrent Audits: The SHA shall have the right to set up mechanisms for concurrent audit of the implementation of the Scheme and monitoring of Insurer's performance under this Insurance Contract.

24.3.2 Spot Checks by the State Health Agency

a. The SHA shall have the right to undertake spot checks of district offices of the Insurer and the premises of the EHCP without any prior intimation.

b. The spot checks shall be random and will be at the sole discretion of the SHA.

24.3.3 Performance Review and Monitoring Meetings

a. The SHA shall organize fortnightly meetings for the first three months and monthly review meetings thereafter with the Insurer. The SHA shall have the right to call for additional review meetings as required to ensure smooth functioning of the Scheme.

b. Whereas the SHA shall issue the Agenda for the review meeting prior to the meeting while communicating the date of the review meeting, as a general rule the Agenda shall have the following items:
(i) Review of action taken from the previous review meeting.
(ii) Review of performance and progress in the last quarter: utilization pattern, claims pattern, etc. This will be done based on the review of reports submitted by the Insurer in the quarter under review.
(iii) KPI Results review – with discussions on variance from prescribed threshold limits, if any.
(iv) Contracts management issue(s), if any.
(v) Risk review, fraud alerts, action taken of fraud alerts.
(vi) Inter insurance company claim settlement
(vii) Any other item.

c. All meetings shall be documented and minutes shared with all concerned parties.

d. Apart from the regularly quarterly review meetings, the SHA shall have the right to call for interim review meetings as and when required on specific issues.

24.4 Key Performance Indicators for the Insurer

a. A set of critical indicators where the performance level below the threshold limit set, shall attract financial penalties and shall be called **Key Performance Indicators** (KPI). For list of KPIs, see **Schedule 12**.

b. At the end of every 12 months, the SHA shall have the right to amend the KPIs, which if amended, shall be applicable prospectively on the Insurer and the Insurer shall be obliged to abide by the same.

24.5 Measuring Performance

a. Performance shall be measured quarterly against the KPIs and the thresholds for each indicator.

b. Indicator performance results shall be reviewed in the quarterly review meetings and reasons for variances, if any, shall be presented by the Insurer.

c. All penalties imposed by the SHA on the Insurer shall have to be paid by the Insurer within 60 days of such demand.

d. Based on the review the SHA shall have the right to issue rectification orders demanding the performance to be brought up to the levels desired as per the AB-NHPM Guidelines.

e. All such rectifications shall be undertaken by the Insurer within 30 days of the date of issue of such Rectification Order unless stated otherwise in such Order(s).

f. At the end of the rectification period, the Insurer shall submit an Action Taken Report with evidences of rectifications done to the SHA.

g. If the SHA is not satisfied with the Action Taken Report, it shall call for a follow up meeting with the Insurer and shall have the right to take appropriate actions within the overall provisions of the Insurance Contract between the SHA and the Insurer.

24.6 Penalties

a. KPI performance related penalties are provided in the KPI table in **Schedule 12**.

b. Apart from the KPI related penalties, the SHA shall impose the following penalties on the Insurer which have been referred to in the other clauses of this Contract and Tender Document:

No.	Additional Defaults	Penalty

(i)	If premium refund is not made by the Insurer to the SHA within 30 days of the communication for refund sent by the SHA to the Insurer	1% penal interest for every week of delay or part thereof and if not received within 30 days, penal interest to be recovered through legal means
(ii)	If the premium is not paid to the Insurer, by the SHA within 6 months of the commencement of the AB-NHPM Cover	Interest @ 1% of the premium amount for every 7 days' delay shall be paid by the SHA to the Insurer
(iii)	If claim payment to the hospital is delayed beyond defined period of 15 days.	An interest of 1% for every seven day of delay after 15 days
(iv)	For claims outside State, if claim payment to the hospital is delayed beyond defined period of 30 days.	An interest of 1% for every seven day of delay after 30 days

25. Outsourcing of Non- core Business by Insurer to an Agency

a. The Insurer shall notify the SHA of the agencies or service providers that it wishes to appoint within three days of NOA.

b. The agency or service providerto be appointed by the insurer shall be as per the latest regulations issued by IRDAI.

c. For the purpose of hiring an outsourced agency or service provider the Insurer shall enter into a Service Level Agreement with the concerned agency or service provider and within 14 days submit a redacted copy to the SHA.

d. The Insurer in all cases shall ensure that the appointment and functioning of agency or service provider shall be in due compliance with latest regulations of IRDAI and any deviation in this manner shall be considered a case of breach of the contract.

e. The appointment of intermediaries or service providers shall not relieve the Insurer from any liability or obligation arising under or in relation to the performance of obligations under this Insurance Contract and the Insurer shall at all times remain solely responsible for any act or omission of its intermediaries or service providers, as if it were the acts or omissions of the Insurer.

f. The Insurer shall be responsible for ensuring that its service agreement(s) with intermediaries and service providers include provisions that vest the Insurer with appropriate recourse and remedies, in the event of non-performance or delay in performance by such intermediary or service provider.

g. The Insurer shall notify the State Health Agency of the intermediaries or service providers that it wishes to appoint on or before the date of execution of this Insurance Contract.

26. Reporting Requirements

a. The Insurer shall submit the following reports as per the scheduled provided in the table below:

No.	Report	Frequency	Deadline
(i)	Medical & Hospital Audit Reports	For each audit	Within 10 days of completing the audit
(ii)	Medical & Hospital Audit Summary Reports	Quarterly	Within 10th day of the month following the end of the quarter
(iii)	Claims/ Utilization Summary Reports	Monthly	Within 5th day of the month following the end of the month
(iv)	Overall Scheme Progress Reports	Monthly	Within 10th day of the month following the end of the quarter

b. All reports shall be uploaded by the Insurer online on the SHA web portal.

c. The Insurer shall receive auto-acknowledgement immediately on submission of the report.

d. The SHA shall review all progress reports and provide feedback, if any, to the Insurer.

e. All Audits reports shall be reviewed by the SHA and based on the audit observations, determine remedial actions, wherever required.

PART IV

COORDINATION AND GRIEVANCE REDRESSAL

27. Coordination Committee

27.1 Constitution and Membership

a. The SHA shall, within 15 days of the date of execution of this Insurance Contract, establish a coordination committee (the **Coordination Committee**) which shall meet quarterly to perform its functions.

b. The Coordination Committee shall be constituted as follows:
   (i) Principal Secretary (Health and Family Welfare) or any other representative designated by her/ him (Chairperson).
   (ii) Mission Director NHM.
   (iii) Director Health Services.
   (iv) The State Nodal Officer and one other member nominated by the SHA.
   (v) The State Coordinator (s) of the Insurance Company (ies) and one other member from the Corporate/ regional office of the Insurer.
   State may add additional members, if required.

27.2 Roles and Responsibilities

The key functions and role of the **Coordination Committee** shall include but not be limited to:

a. Ensuring smooth interaction and process flow between the SHA and the Insurer.

b. Reviewing the implementation and functioning of the Scheme and initiating discussions between the Parties to ensure efficient management and implementation of the Scheme.

c. Reviewing the performance of the Insurer under the Insurance Contract.

d. Any other matter that the Parties may mutually agree upon.

28. Grievance Redressal

A robust and strong grievance redressal mechanism has been designed for AB-NHPM. The District authorities shall act as a frontline for the redressal of Beneficiaries' / Providers / other Staekholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers or any other aggrieved party shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider or any other aggrieved party with details of the follow-up action taken as regards

the grievance as per the process laid down. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication.

Under the Grievance Redressal Mechanism of AB-NHPM, set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels. Details of Grievance Redressal mechanisms and guidelines for this purpose are provided at **Schedule 16**.

PART V

OTHER TERMS AND CONDITIONS

29.Term and Termination

29.1 Term

This Insurance Contract shall become effective on the date of its execution and shall continue to be valid and in full force and effect until:

a. expiration of the Policy Cover Period under each Policy issued under this Insurance Contract;

b. the discharge of all the Insurer's liabilities for all Claims made by the Empanelled Health Care Providers on or before the date of expiration of the Policy Cover Period for each Policy. For the avoidance of doubt, this shall include a discharge of the Insurer's liability for all amounts blocked for the Beneficiaries before the date of expiration of such Policy Cover Period; and

c. the discharge of all the Insurer’s liabilities to the State Health Agency, including for refund of any Premium for any of the previous Policy Cover Periods.

The Insurer undertakes that it shall discharge all its liabilities in respect of all such Claims raised in respect of each Policy and all of its liabilities to the State Health Agency within 45 days of the date of expiration of the Policy Cover Period for that Policy.

The period of validity of this Insurance Contract shall be the **Term**, unless this Insurance Contract is terminated earlier.

29.2 Termination by the State Health Agency

a. The State Health Agency shall have the right to terminate this Insurance Contract upon the occurrence of any of the following events (each an **Insurer Event of Default**), provided that such event is not attributable to a Force Majeure Event:

(i) the Insurer fails to duly obtain a renewal of its registration with the IRDAI or the IRDAI revokes or suspends the Insurer’s registration for the Insurer’s failure to comply with applicable Insurance Laws or the Insurer’s failure to conduct the general or health insurance business in accordance with applicable Insurance Laws or the code of conduct issued by the IRDAI; or

(ii) the Insurer’s average Turn-around Time over a period of 90 days is in excess of 45 days per Claim provided all premium due is paid by the SHA in time to the Insurer; or

(iii) If at any time any payment, assessment, charge, lien, penalty or damage herein specified to be paid by the Insurer to the SHA, or any part thereof, shall be in

arrears and unpaid within 60 days of receipt of a written notice from the SHA requesting payment thereof; or

(iv) the Insurer is otherwise in material breach of this Insurance Contract that remains uncured despite receipt of a 60-day cure notice from the SHA; or

(v) any representation, warranty or undertaking given by the Insurer proves to be incorrect in a material respect or is breached; or

(vi) The Insurer has successively infringed the terms and conditions of the Insurance Contract and/or has failed to rectify the same even after the expiry of the notice period for rectification of such infringement then it would amount to material breach of the terms of the Insurance Contract by the Insurer; or

(vii) The Insurer has failed to perform or discharge any of its obligations in accordance with the provisions of the Insurance Contract with SHA unless such event has occurred because of a Force Majeure Event, or due to reasons solely attributable to the SHA without any contributory factor of the Insurer; or

(viii) The Insurer engaging or knowingly has allowed any of its employees, agents, tenants, contractor or representative to engage in any activity prohibited by law or which constitutes a breach of or an offence under any law, in the course of any activity undertaken pursuant to the Insurance Contract; or

(ix) The Insurer has been adjudged as bankrupt or become insolvent; or

(x) Any petition for winding up of the Insurer has been admitted and liquidator or provisional liquidator has been appointed or the Insurer has been ordered to be wound up by Court of competent jurisdiction, except for the purpose of amalgamation or reconstruction with the prior consent of the SHA, provided that, as part of such or reconstruction and the amalgamated or reconstructed entity has unconditionally assumed all surviving obligations of the Insurer under the Insurance Contract; or

(xi) The Insurer has abandoned the Project Office(s) of the AB-NHPM and is non-contactable; or

(xii) Performance against KPI is below the threshold specified in **Schedule 10** for two consecutive quarters; or

(xiii) Intentional or unintentional act of undisputedly proven fraud committed by the Insurer.

b. Upon the occurrence of an Insurer Event of Default, the State Health Agency may, without prejudice to any other right it may have under this Insurance Contract, in law or at equity, issue a notice of its intention to terminate this Insurance Contract to the Insurer (**Preliminary Termination Notice**).

If the Insurer fails to remedy or rectify the Insurer Event of Default stated in the Preliminary Termination Notice within 30 days of receipt of the Preliminary Termination Notice, the State Health Agency will be entitled to terminate this Insurance Contract by issuing a final termination notice (**Final Termination Notice**).

c. SHA will provide prorata premium for the period for which insurer has provided the policy within 30 days of end of policy. In case excess premium with respect to pro-rata policy has been already received by the insurer then insurer will need to return the

excess premium excluding the premium due for the pro-rata period within 30 days of end of policy.

29.3 State Health Agency Event of Default

a. The Insurer shall be entitled to terminate this Insurance Contract upon the occurrence of a material breach of this Insurance Contract by the State Health Agency that remains uncured despite receipt of a 60 day cure notice from the Insurer (a **State Health Agency Event of Default**), provided that such event is not attributable to a Force Majeure Event.

b. Upon the occurrence of a State Health Agency Event of Default (non-payment of first instalment of premium within 180 days of start of policy), the Insurer may, without prejudice to any other right it may have under this Insurance Contract, in law or at equity, issue a Preliminary Termination Notice to the State Health Agency. If the State Health Agency fails to remedy or rectify the State Health Agency Event of Default stated in the Preliminary Termination Notice issued by the Insurer within 60 days of receipt of the Preliminary Termination Notice, the Insurer will be entitled to terminate this Insurance Contract by issuing a Final Termination Notice.

29.4 Termination Date

The **Termination Date** upon termination of this Insurance Contract for:

a. an Insurer Event of Default, shall be the date of issuance of the Final Termination Notice;

b. a State Health Agency Event of Default, shall be the date falling 120 Business Days from the date of the Final Termination Notice issued by the Insurer; and

c. a Force Majeure Event, shall be the date of expiration of the written notice.

29.5 Consequences of Termination

Upon termination of this Insurance Contract, the Insurer shall:

a. Continue to provide the benefits in respect of the Covers to the Beneficiaries until the Termination Date.

b. Pay to the State Health Agency on the Termination Date (where termination is due to an Insurer Event of Default or a Force Majeure Event), a sum that shall be calculated as follows for the State:

$$TC = P \times N \times \frac{UT}{365}$$

Where:

TC is the sum to be paid by the Insurer to the State Health Agency on the Termination Date in respect of the State;

P is the Premium per Beneficiary Family Unit that has been or has to be paid by the State Health Agency to the Insurer for the Policy Cover Period in which the Termination Date occurs;

N is the total number of Beneficiary Family Units covered in the State, for whom the Premium has been or has to be paid by the State Health Agency to the Insurer for the Policy Cover Period in which the Termination Date occurs; and

UT is the unexpired term of the Policy for that State, calculated as the number of days between the Termination Date and the date of expiration of the Policy Cover Period (had such Policy continued).

Such payment shall be made by the Insurer to the State Health Agency exclusive of all applicable taxes and duties. The Insurer shall bear and pay all applicable taxes and duties in respect of such amount.

c. Continue to be liable for all Claims made by the Empanelled Health Care Providers on or before the Termination Date, including:

   (i) all amounts blocked for treatment of the Beneficiaries before the Termination Date, where the Beneficiaries were discharged after the Termination Date; and

   (ii) all amounts that were pre-authorized for Claim Payment before the Termination Date, where the pre-authorization has occurred prior to the Termination Date but the Beneficiaries were discharged after the Termination Date.

The Insurer undertakes that it shall discharge its liabilities in respect of all such Claims raised within 45 days of the Termination Date.

29.6 Migration of Policies Post Termination

a. At least 120 days prior to the expiration of this Insurance Contract or the Termination Date, the SHA may issue a written request to the Insurer seeking a migration of the Policies for all the districts in the Service Area (**Migration Request**) to another insurance company (**New Insurer**).

b. Once the SHA has issued such a Migration Request:

   (i) The SHA shall have the right to identify the New Insurer to whom the Policies will be migrated up to 30 days prior to the expiration date or the Termination Date.
   (ii) The SHA shall also have the right to withdraw the Migration Request at any time prior to the 30 day period immediately preceding the expiration date or the

Termination Date. If the SHA chooses to withdraw the Migration Request, then the remaining provisions of this **Clause 29.6** shall not apply from the date of such withdrawal and this Insurance Contract shall terminate forthwith upon the withdrawal of the Migration Request.

c. Upon receiving the Migration Request, the Insurer shall commence preparing Claims data, and current status of implementation of training provided to Empanelled Health Care Providers and any other information sought by the SHA in the format prescribed by the SHA at that point in time.

d. Within 7 days of receiving notice of the New Insurer, the Insurer shall promptly make available all of the data prepared by it to the New Insurer.

e. The Insurer shall not be entitled to:
   (i) refuse to honour any Claims made by the EHCPs on or before the date of expiration or the Termination Date until the migration process has been completed and the New Insurer assumes all of the risks under the Policies for the Service Area; or
   (ii) cancel the Policies for the Service Area until the migration process has been completed and the New Insurer assumes all of the risks under the Policies for the Service Area; or
   (iii) charge the SHA, the New Insurer or any third person with any commission, additional charges, loading charges or otherwise for the purpose of migrating the Policies to the New Insurer.

f. The Insurer shall be entitled to retain the proportionate Premium for the period between the date on which a termination notice has been issued and the earlier to occur of: (x) the date on which the New Insurer assumes all the risks under the Policies; and (y) the date of withdrawal of the Migration Request (the **Migration Termination Date**).

29.7 Hand-Over Obligations

Without prejudice to the provisions of **Clause 30.6**, on expiration of the Term or on the Termination Date, the Insurer shall:

a. assign all of its rights, but not any payment or other obligations or liabilities, under its Services Agreements with the Empanelled Health Care Providers and any other agreements with its intermediaries or service providers for the implementation of AB-NHPM in favour of the State Health Agency or to the New Insurer, provided that the Insurer has received a written notice to this effect at least 30 days' prior to the date of expiration of the Term or the Termination Date;

b. hand-over, transfer and assign all rights and title to and all intellectual property rights in all data, information and reports in favour of the State Health Agency or to the New Insurer, whether such data, information or reports have been collected, collated,

created, generated or analysed by the Insurer or its intermediaries or service providers on its behalf and whether such data, information and reports is in electronic or physical form;

30. Force Majeure

30.1 Definition of Force Majeure Event

A **Force Majeure Event** shall mean the occurrence in the State of __________ of any of the following events after the date of execution of this Insurance Contract, which was not reasonably foreseeable at the time of execution of this Insurance Contract and which is beyond the reasonable control and influence of a Party (the **Affected Party**) and which causes a delay and/or inability for that Party to fulfil its obligations under this Insurance Contract:

a. fire, flood, atmospheric disturbance, lightning, storm, typhoon, tornado, earthquake, washout or other Acts of God;

b. war, riot, blockade, insurrection, acts of public enemies, civil disturbances, terrorism, sabotage or threats of such actions; and

c. strikes, lock-out or other disturbances or labour disputes, not involving the employees of such Party or any intermediaries appointed by it,

but regardless of the extent to which the conditions in the first paragraph of this **Clause 30.1** are satisfied, Force Majeure Event shall not include:

a. a mechanical breakdown; or

b. weather conditions which should reasonably have been foreseen by the Affected Party claiming a Force Majeure Event and which were not unusually adverse; or

c. non-availability of or increase in the cost (including as a result of currency exchange rate fluctuations) of suitably qualified and experienced labour, equipment or other resources, other than the non-availability of equipment due to an event that affected an intermediary of the Insurer and that, if it had happened to the Insurer hereunder, would have come within the definition of Force Majeure Event under **Clause 30.1**; or

d. economic hardship or lack of money, credit or markets; or

e. events of physical loss, damage or delay to any items during marine, air or inland transit to the State of __________ unless the loss, damage or delay was directly caused by an event that affected a intermediary of the Insurer and that, if it had happened to the Insurer hereunder, would have come within the definition of Force Majeure Event under **Clause 30.1**; or

f. late performance or other breach or default by the Insurer (including the consequences of any breach or default) caused by the acts, omissions or defaults of any intermediary

appointed by the Insurer unless the event that affected the intermediary and caused the act, omission or default would have come within the definition of Force Majeure Event under **Clause 30.1** if it had affected the Insurer; or

g. a breach or default of this Insurance Contract (including the consequences of any breach or default) unless it is caused by an event that comes within the definition of Force Majeure Event under **Clause 30.1**; or

h. the occurrence of a risk that has been assumed by a Party to this Contract; or

i. any strike or industrial action that is taken by the employees of the Insurer or any intermediary appointed by the Insurer or which is directed at the Insurer; or

j. the negligence or wilful recklessness of the Insurer, the intermediaries appointed by it, their employees or other persons under the control and supervision of the Insurer.

30.2 Limitation on the Definition of Force Majeure Event

Any event that would otherwise constitute a Force Majeure Event pursuant to **Clause 30.1** shall not do so to the extent that the event in question could have been foreseen or avoided by the Affected Party using reasonable *bona fide* efforts, including, in the case of the Insurer, obtaining such substitute goods, works, and/or services which were necessary and reasonable in the circumstances (in terms of expense and otherwise) for performance by the Insurer of its obligations under or in connection with this Insurance Contract.

30.3 Claims for Relief

a. If due to a Force Majeure Event the Affected Party is prevented in whole or in part from carrying out its obligations under this Insurance Contract, the Affected Party shall notify the other Party accordingly (**Force Majeure Notice**).

b. The Affected Party shall not be entitled to any relief for or in respect of a Force Majeure Event unless it has notified the other Party in writing of the occurrence of the Force Majeure Event as soon as reasonably practicable and in any event within 7 days after the Affected Party knew, or ought reasonably to have known, of the occurrence of the Force Majeure Event and it has complied with the requirements of **Clause 30.3** of this Insurance Contract.

c. Each Force Majeure Notice shall:

    (i) fully describe the Force Majeure Event;

    (ii) specify the obligations affected by the Force Majeure Event and the extent to which the Affected Party cannot perform those obligations;

(iii) estimate the time during which the Force Majeure Event will continue; and

(iv) specify the measures proposed to be adopted to mitigate or minimise the effects of the Force Majeure Event.

d. As soon as practicable after receipt of the Force Majeure Notice, the Parties shall consult with each other in good faith and use reasonable endeavours to agree appropriate mitigation measures to be taken to mitigate the effect of the Force Majeure Event and facilitate continued performance of this Insurance Contract.

   If Parties are unable to arrive at a mutual agreement on the occurrence of a Force Majeure Event or the mitigation measures to be taken by the Affected Party within 15 days of receipt of the Force Majeure Notice, then the other Party shall have a right to refer such dispute to grievance redressal in accordance with **Clause 28**.

e. Subject to the Affected Party having complied with its obligations under **Clause 30.3**, the Affected Party shall be excused from the performance of the obligations that is affected by such Force Majeure Event for the duration of such Force Majeure Event and the Affected Party shall not be in breach of this Insurance Contract for such failure to perform for such duration; provided however that no payment obligations (including Claim Payments) shall be excused by the occurrence of a Force Majeure Event.

30.4 Mitigation of Force Majeure Event

Upon receipt of a Force Majeure Notice, each Party shall:

a. mitigate or minimise the effects of the Force Majeure Event to the extent reasonably practicable; and

b. take all actions reasonably practicable to mitigate any loss suffered by the other Party as a result of the Affected Party's failure to carry out its obligations under this Insurance Contract.

30.5 Resumption of Performance

When the Affected Party is able to resume performance of the obligations affected by the Force Majeure Event, it shall give the other Party a written notice to that effect and shall promptly resume performance of its affected obligations under this Insurance Contract.

30.6 Termination upon Subsistence of Force Majeure Event

If a Force Majeure Event continues for a period of 4 weeks or more within a continuous period of 365 days, either Party may terminate this Insurance Contract by giving the other Party 90 days' written notice.

31. ASSIGNMENT

31.1 Assignment by Insurer

Except as approved in advance by the State Health Agency in writing, this Insurance Contract, no Policy and no right, interest or Claim under this Insurance Contract or Policy or any obligations or liabilities of the Insurer arising under this Insurance Contract or Policy or any sum or sums which may become due or owing to the Insurer, may be assigned, transferred, pledged, charged or mortgaged by the Insurer.

31.2 Assignment by State Health Agency

The State Government may assign or transfer all or any part of its rights or obligations under this Insurance Contract or any Policy without the prior consent of the Insurer.

31.3 Effect of Assignment

If this Insurance Contract or any Policy or any rights, obligations or liabilities arising under this Insurance Contract or such Policy are assigned or transferred in accordance with this **Clause 31**, then this Insurance Contract and such Policy shall be fully binding upon, inure to the benefit of and be enforceable by the Parties hereto and their respective successors and permitted assigns.

Any assignment not expressly permitted under this Insurance Contract shall be null and void and of no further force and effect.

31.4 Assignment by Beneficiaries or Empanelled Health Care Providers

a. The Parties agree that each Policy shall specifically state that no Beneficiary shall have the right to assign or transfer any of the benefits or the Covers made available to it under this Insurance Contract or any Policy.

b. The Parties agree that the Empanelled Health Care Providers may assign, transfer, pledge, charge or mortgage any of their rights to receive any sums due or that will become due from the Insurer in favour of any third party.

Without limiting the foregoing, the Parties acknowledge that the public Empanelled Health Care Providers in the Service Area that are under the management of Rogi Kalyan Samitis may assign all or part of their right to receive Claims Payments from the Insurer in favour of the Government of __________ or any other department, organization or public body that is under the ownership and/or control of the Government of __________.

On and from the date of receipt of a written notice from the public Empanelled Health Care Providers in the Service Area or from the Government of __________, the Insurer shall pay all or part of the Claims Payments to the person(s) so notified.

32. Confidentiality of Information and Data Protection

Insurer will treat all non-public, especially health, treatment and payment related information as confidential, and such party shall not disclose or use such information in a manner contrary to the purposes of this Agreement.

All the beneficiary and transaction data generated through the scheme shall be kept securely by the insurer and will not be shared with any other agency than the ones defined in the agreement.

33. Intellectual Property Rights

Each party will be the owners of their intellectual property rights (IPR) involved in this project and will not have any right over the IPR of the other party. Both parties agree that for the purpose of fulfilling the conditions under this contract they may allow the other party to only use their IPR for the contract period only. However, after the end of the contract no parties will have any right over the IPR of other party.

34. Entire Agreement

This Insurance Contract entered into between the Parties represents the entire agreement between the Parties setting out the terms and conditions for the provision of benefits in respect of the AB-NHPM Cover to the Beneficiaries that are covered by the Insurer.

35. Relationship

a. The Parties to this Insurance Contract are independent contractors. Neither Party is an agent, representative or partner of the other Party. Neither Party shall have any right, power or authority to enter into any agreement or memorandum of understanding for or on behalf of, or incur any obligation or liability of, or to otherwise bind, the other Party.

b. This Insurance Contract shall not be interpreted or construed to create an association, agency, joint venture, collaboration or partnership between the Parties or to impose any liability attributable to such relationship upon either Party.

c. The engagement of any intermediaries or service providers by the Insurer shall not in any manner create a relationship between the State Health Agency and such third parties.

36. Variation or Amendment

a. No variation or amendment of this Insurance Contract shall be binding on either Party unless and to the extent that such variation is recorded in a written document executed by both Parties but where any such document exists and is so signed, neither Party shall allege that such document is not binding by virtue of an absence of

consideration.

b. Notwithstanding anything to the contrary in **Clause 34(a)** above, the Insurer agrees that the MoHFW and the State Health Agency shall be free to issue AB-NHPM Guidelines from time to time (including pursuant to the issuance of recommendations of the Working Group constituted by the MoHFW) and the Insurer shall comply with all such AB-NHPM Guidelines issued during the Term, whether or not the provisions or terms of such AB-NHPM Guidelines have the effect of varying or amending the terms of this Insurance Contract.

37. Severability

If any provision of this Insurance Contract is invalid, unenforceable or prohibited by law, this Insurance Contract shall be considered divisible as to such provision and such provision shall be inoperative and the remainder of this Insurance Contract shall be valid, binding and of the like effect as though such provision was not included herein.

38. Notices

Any notice given under or in connection with this Insurance Contract shall be in writing and in the English language. Notices may be given, by being delivered to the address of the addressees as set out below (in which case the notice shall be deemed to be served at the time of delivery) by courier services or by fax (in which case the original shall be sent by courier services).

To: **Insurer**
Attn: Mr. / Ms. ________________________________
E-Mail: ________________________________
Phone: ________________________________
Fax: ________________________________

To: **State Health Agency**
Attn: Mr. / Ms. ________________________________
E-Mail: ________________________________
Phone: ________________________________
Fax: ________________________________

39. No waiver

Except as expressly set forth in this Insurance Contract, no failure to exercise or any delay in exercising any right, power or remedy by a Party shall operate as a waiver. A single or partial exercise of any right, power or remedy does not preclude any other or further exercise of that or any other right, power or remedy. A waiver is not valid or binding on the Party granting that waiver unless made expressly in writing.

40. Governing Law and Jurisdiction

a. This Insurance Contract and the rights and obligations of the Parties under this Insurance Contract shall be governed by and construed in accordance with the Laws of the Republic of India.

b. The courts in [Insert name of State Capital] shall have the exclusive jurisdiction over any disputes arising under, out of or in connection with this Insurance Contract.

IN WITNESS WHEREOF, the Parties have caused this Insurance Contract to be executed by their duly authorized representatives as of the date stated above.

SIGNED, SEALED and DELIVERED	**SIGNED, SEALED and DELIVERED**
For and on behalf of **State of __________**	For and on behalf of **Insurance Company___________**
Represented by ______________________________ ______________________________	Represented by ______________________________ ______________________________
In the presence of:	In the presence of:
(1)	(1)
(2)	(2)

Schedules: Volume III

Schedule 1: AB-NHPM Beneficiaries

To be added by the State

Schedule 2: Exclusions to the Policy

The Insurer shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Beneficiary in connection with or in respect of:

1. ***Conditions that do not require hospitalization:*** *Condition that do not require hospitalization and can be treated under Out Patient Care. Out Patient Diagnostic, unless necessary for treatment of a disease covered under Medical and Surgical procedures or treatments or day care procedures* (as applicable), *will not be covered.*

2. *Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.*

3. *Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease, illness or injury and which requires hospitalisation for treatment.*

4. ***Congenital external diseases:*** *Congenital external diseases or defects or anomalies, Convalescence, general debility, "run down" condition or rest cure.*

5. ***Fertility related procedures:*** *Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.*

6. ***Drugs and Alchohol Induced illness:*** *Diseases, illness or injury due to or arising from use, misuse or abuse of drugs or alcohol or use of intoxicating substances, or such abuse or addiction*

7. ***Vaccination:*** *Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),*

8. ***Suicide:*** *Intentional self-injury/suicide*

9. *Persistent Vegetative State*

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Schedule 3: Packages and Rates - Hospital Packages under AB-NHPM

Index

S.No	Specialty	No. of packages	No. of packages mandated for pre-authorization
1	Cardiology	38	38
2	Cardio-thoracic surgery	71	71
3	Cardio-vascular surgery	21	20
4	Opthalmology	42	42
5	ENT	94	5
6	Orthopaedics	101	26
7	Polytrauma	13	0 (only for extended ICU stay)
8	Urology	161	10
9	Obstetrics & Gynaecology	73	41
10	General Surgery	253	0
11	Neurosurgery	82	29
12	Interventional Neuroradiology	12	12
13	Plastic & reconstructive	9	9
14	Burns management	12	2
15	Oral and Maxillofacial Surgery	9	9
16	Paediatric medical management	100	100 (only for extensions)
17	Neo-natal	10	10
18	Paediatric cancer	12	12
19	Paediatric surgery	34	1
20	Medical packages	70	70 (only for extensions)
21	Oncology	112	112
22	Emergency Room Packages (Care requiring less than 12 hrs stay)	4	0
23	Mental Disorders Packages	17	17 (extensions only)
	Total	1350	636 (47 %)

ALL PACKAGES WILL INCLUDE DRUGS, DIAGNOSTICS, CONSULTATIONS, PROCEDURE, STAY AND FOOD FOR PATIENT

Performance-linked payment:

A performance-linked payment system has been designed to incentivize hospitals to continuously improve quality and patient safety, based on successive milestones. Hospitals qualifying for NABH entry-level accreditation will receive an additional 10%, while those qualifying for full accreditation will receive an additional 15%. To promote equity in access, hospitals providing services in aspirational districts will receive an additional 10%. Also teaching hospitals running PG/ DNB courses would receive an additional 10 % rate.

In addition, States have the flexibility to increase rates up to 10 % or reduce them as much as needed to suit local market conditions. Further States could retain their existing package rates, even if they are higher than the prescribed 10 % flexibility slab.

I. CARDIOLOGY

Total no: of packages: 38
No: of packages mandated for pre-authorization: 38
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Specific Pre and Post-op Investigations such as ECHO, ECG, pre/ post-op X-ray, label/ carton of stents used, pre and post-op blood tests (USG, clotting time, prothrombin time, international normalized ratio, Hb, Serum Creatinine), angioplasty stills showing stents & post stent flow, CAG report showing blocks (pre) and balloon and stills showing flow (post) etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

- It is prescribed as standard practice to use medicated stents (approved by FDA/DCGI) where necessary. Further the carton/ sticker detailing the stent particulars needs to be submitted as part of claims filing by providers.
- It is also advised to perform cardiac catheterization as part of the treatment package for congenital heart defects.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Balloon Atrial Septostomy	18,000	2D ECHO report	2D ECHO report	
2	Balloon Aortic Valvotomy	25,000	2D ECHO report	2D ECHO report	

3	Balloon Mitral Valvotomy	27,500	2D ECHO report	2D ECHO report	
4	Balloon Pulmonary Valvotomy	25,000	2D ECHO report	2D ECHO report	
5	Vertebral Angioplasty with single stent (medicated)	50,000	2D ECHO + Angiogram report	Post op. Angiogram report + carton of the stent used approved by FDA/DCGI only	2
6	Vertebral Angioplasty with double stent(medicated)	65,000	2D ECHO + Angiogram report	Post op. Angiogram report+ cartons of the stents used approved by FDA/DCGI only	2
7	Carotid angioplasty with stent (medicated)	130,000	Angiogram report & film showing the lesion	Post lesion + XRAY + Doppler+ carton of the stent used approved by FDA/DCGI only	2
8	Renal Angioplasty with single stent (medicated)	50,000	ECG, 2D ECHO, CAG stills showing blocks & Reports	Post op. Angiogram report, showing stent & post Stent flow + carton of the stents used approved by FDA/DCGI only	2
9	Renal Angioplasty with double stent (medicated)	65,000	ECG, 2D ECHO, CAG stills showing blocks & Reports	Post op. Angiogram report, showing stents & post Stent flow + cartons of the stents used approved by FDA/DCGI only	2
10	Peripheral Angioplasty with balloon	25,000	2D ECHO, CAG stills showing blocks & Reports	Post procedure Angio stills	2
11	Peripheral Angioplasty with stent (medicated)	50,000	2D ECHO , ANGIOGRAM report & stills	Post procedure Angio stills + carton of the stents used approved by FDA/DCGI only	2
12	Coarctation dilatation	25,000	2D ECHO report	2D ECHO report + stills of ECHO	
13	Medical treatment of Acute MI with Thrombolysis /Stuck Valve Thrombolysis	10,000	2D ECHO, CPK-MB,CAG, ECG with report, TROPONINE-T report	2D ECHO, ECG, Lab Investigation (Troponine - T report)	
14	ASD Device Closure	80,000	2D ECHO report - TRPG	2D ECHO stills showing the device + Report	

15	VSD Device Closure	80,000	2D ECHO report - TRPG	2D ECHO stills showing the device + Report	
16	PDA Device Closure	40,000	2D ECHO report	2D ECHO stills showing the device + Report	
17	PDA multiple Coil insertion	20,000	2D ECHO report	2D ECHO stills showing the coil + Report	
18	PDA Coil (one) insertion	15,000	2D ECHO report	2D ECHO stills showing the coil + Report	
19	PDA stenting	40,000	2D ECHO, Angiogram report & stills	Post procedure Angio stills	
20	Pericardiocentesis	4,000	2D ECHO report	2D ECHO report	
21	Temporary Pacemaker implantation	5,000	ECG + Report by cardiologist	X Ray showing the pacemaker in situ	
22	Permanent pacemaker implantation (only VVI) including Pacemaker value/pulse generator replacement (DOUBLE CHAMBER)	60,000	ECG + Report by cardiologist + Anigiogram report if done	X Ray showing the pacemaker in situ	7 (2-day ICU stay)
23	Permanent pacemaker implantation (only VVI) including Pacemaker value/pulse generator replacement (SINGLE CHAMBER)	50,000	ECG + Report by cardiologist + Anigiogram report if done	X Ray showing the pacemaker in situ	7 (2-day ICU stay)
24	PTCA - single stent (medicated, inclusive of diagnostic angiogram)	65,000	ECG, 2D ECHO, CAG stills showing blocks & Reports	Post op. Angiogram report, showing stent & post Stent flow + carton of the stents used approved by FDA/DCGI only	3
25	PTCA - double stent (medicated, inclusive of diagnostic angiogram)	90,000 (Rs. 27,890 for every additional stent – as per NPPA capping)	ECG, 2D ECHO, CAG stills showing blocks & Reports	Post op. Angiogram report, showing stent & post Stent flow + carton of the stents used approved by FDA/DCGI only	3
26	PTSMA	25,000	ECG, 2D ECHO, CAG	Post op. Angiogram report,	3

			stills showing blocks & reports	showing stent & post Stent flow + carton of the stents used approved by FDA/DCGI only	
27	Pulmonary artery stenting	40,000	2D ECHO, Angiogram report & stills	Post procedure Angio stills	
28	Pulmonary artery stenting (double)	65,000	2D ECHO, Angiogram report & stills	Post procedure Angio stills	
29	Right ventricular outflow tract (RVOT) stenting	40,000	2D ECHO, Angiogram report & stills	Post procedure Angio stills	
30	Rotablation+ Balloon Angioplasty	65,000	CAG Report with stills showing blocks	CAG stills with balloon and stills with post flow	
31	Rotablation+ Balloon Angioplasty + 1 stent (medicated)	100,000	ECG, 2D ECHO, CAG stills showing blocks & Reports	Post op. Angiogram report, showing stent & post Stent flow + carton of the stents used approved by FDA/DCGI only	
32	Rotablation+ Balloon Angioplasty + 2 stent (medicated)	125,000	ECG, 2D ECHO, CAG stills showing blocks & Reports	Post op. Angiogram report, showing stent & post Stent flow + carton of the stents used approved by FDA/DCGI only	
33	Thrombolysis for peripheral ischemia	10,000	Peripheral Angiogram /Doppler Report with Stills	Post procedure Angio stills	
34	Bronchial artery Embolisation (for Haemoptysis)	25,000	Chest x-Ray/CT Scan, Hb, Serum Creatinine	Chest x-Ray/CT Scan, Hb, Serum Creatinine	2
35	Percutaneous Transluminal Tricuspid Commissurotormy (PTTC)	25,000	2D ECHO	2D ECHO	2
36	Coiling - Pseudoaneurysms of Abdomen	55,000	Prothrombin Time (PT), International normalized ratio (INR) Hb, Serum Creatinine	CT, Prothrombin Time (PT), International normalized ratio (INR) Hb, Serum Creatinine	2
37	Embolization - Arteriovenous Malformation (AVM) in the Limbs	40,000	Ultrasound, CT PT, INR, Hb, Serum	Ultrasound, CT PT, INR, Hb, Serum Creatinine	2

			Creatinine		
38	Catheter directed Thrombolysis for: Deep vein thrombosis (DVT), Mesenteric Thrombosis & Peripheral vessels	50,000	CT/MRI, Prothrombin Time (PT), International normalized ratio (INR) Hb, Serum Creatinine	CT/MRI, Prothrombin Time (PT), International normalized ratio (INR) Hb, Serum Creatinine	2

II. CARDIO THORACIC SURGERY

Total no: of packages: 71
No: of packages mandated for pre-authorization: 71
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Specific Pre and Post-op Investigations such as ECHO, ECG, pre/ post-op X-ray, post-op scar photo, CAG/ CT/ MRI reports etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

- It is also advised to perform cardiac catheterization as part of the treatment package for congenital heart defects.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Coronary artery bypass grafting (CABG)	90,000	2D ECHO + CAG report	ECHO,Post op X Ray ,scar photo	5 to 7
2	Coronary artery bypass grafting (CABG) with Intra-aortic balloon pump (IABP)	110,000	2D ECHO + CAG report	ECHO,Post op X Ray ,scar photo	5 to 7
3	Coronary artery bypass grafting (CABG) + one mechanical	150,000	2D ECHO + CAG	ECHO,Post op X Ray ,scar	5 to 7

	Valve Replacement + Intra-aortic balloon pump (IABP)		report	photo	
4	Coronary artery bypass grafting (CABG) with LV Aneurysmal repair	100,000	2D ECHO + CAG report	ECHO,Post op X Ray ,scar photo	5 to 7
5	Coronary artery bypass grafting (CABG) with Mitral Valve repair without ring	100,000	2D ECHO + CAG report	ECHO,Post op X Ray ,scar photo	5 to 7
6	Coronary artery bypass grafting (CABG) with Mitral Valve repair with ring	125,000	2D ECHO + CAG report	ECHO,Post op X Ray ,scar photo	5 to 7
7	Coronary artery bypass grafting (CABG) with post MI Ventricular Septal Defect (Ventricular Septal Defect) repair	100,000	2D ECHO + CAG report	ECHO,Post op X Ray ,scar photo	5 to 7
8	Open Mitral Valvotomy	75,000	2D ECHO	ECHO,Post op X Ray ,scar photo	7
9	Closed Mitral Valvotomy	30,000	2D ECHO	ECHO,Post op X Ray ,scar photo	7
10	Open Pulmonary Valvotomy	75,000	2D ECHO	ECHO,Post op X Ray ,scar photo	7
11	Mitral Valve Repair	80,000	2D ECHO	ECHO,Post op X Ray ,scar photo	7
12	Tricuspid Valve Repair	80,000	2D ECHO	ECHO,Post op X Ray ,scar photo	7
13	Aortic Valve Repair	80,000	2D ECHO	ECHO,Post op X Ray ,scar photo	7
14	Ring for any Valve Repair	30,000	2D ECHO	ECHO,Post op X Ray ,scar photo	7
15	Mitral Valve Replacement (bi-leaflet mechanical (pyrolite carbon) valve)	120,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
16	Mitral Valve Replacement (biological valve)	125,000	2D ECHO	ECHO, Post op X Ray, scar photo	10
17	Aortic Valve Replacement (bi-leaflet mechanical (pyrolite carbon) valve)	120,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
18	Aortic Valve Replacement (biological valve)	125,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10

19	Tricuspid Valve Replacement (bi-leaflet mechanical (pyrolite carbon) valve)	120,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
20	Tricuspid Valve Replacement (biological valve)	125,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
21	Double Valve Replacement (bi-leaflet mechanical (pyrolite carbon) valve)	150,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
22	Double Valve Replacement (biological valve)	155,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
23	Ross Procedure	105,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
24	Atrial Septal Defect (ASD)	75,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
25	Ventricular Septal Defect (VSD)	75,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
26	Atrioventricular septal defect/ Atrioventricular (AV) Canal Defect	100,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
27	Intracardiac repair (ICR) for Tetralogy of Fallot (TOF)	100,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
28	Pulmonary Valvotomy + Right Ventricular Outflow Tract (RVOT) Resection	90,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
29	Aortopulmonary Window (AP Window)	90,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
30	Surgery for Hypertrophic Obstructive Cardiomyopathy (HOCM)	90,000	2D ECHO/TEE + Chest Xray AP view /Cardiac MRI	ECHO,Post op X Ray ,scar photo	10
31	Ebsteins	90,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
32	Fontan	90,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
33	Total Anomalous Pulmonary Venous Connection (TAPVC)	105,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
34	Any RV to PA conduit (Valved)	115,000	2D ECHO	ECHO,Post op X Ray ,scar	10

				photo	
35	Arterial Switch Operation	120,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
36	Double Switch Operation	120,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
37	Sennings	105,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
38	Mustards	105,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
39	Truncus Arteriosus Surgery	115,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
40	Root Replacement (Aortic Aneurysm/ Aortic Dissection) / Bental Procedure	145,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
41	Aortic Arch Replacement	160,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
42	Aortic Aneurysm Repair using Cardiopulmonary bypass (CPB)	150,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
43	Aortic Aneurysm Repair without using Cardiopulmonary bypass (CPB)	75,000	2D ECHO	ECHO,Post op X Ray ,scar photo	10
44	Pulmonary Embolectomy	90,000	2D ECHO + ABG report + CT Chest report	ECHO,Post op X Ray ,scar photo	5
45	Surgery for Cardiac Tumour/ Left Atrial (LA) Myxoma/ Right Atrial (RA) Myxoma	95,000	2D ECHO + CT Chest report	ECHO,Post op X Ray ,scar photo	
46	Patent Ductus Arteriosus (PDA) Closure	30,000	2D ECHO	ECHO,Post op X Ray ,scar photo	
47	Coarctation Repair	30,000	2D ECHO + CAG report	Doppler report with stills	
48	Coarctation Repair with interpostion graft	38,000	2D ECHO + CAG report	Doppler report with stills	
49	Blalock–Thomas–Taussig (BT) Shunt (inclusives of grafts)	30,000	2D ECHO	ECHO,Post op X Ray ,scar photo	

50	Glenn Shunt (without cardiopulmonary bypass)	35,000	2D ECHO	ECHO,Post op X Ray ,scar photo	
51	Central Shunt	50,000	2D ECHO	ECHO,Post op X Ray ,scar photo	
52	Pericardiectomy	30,000	2D ECHO	ECHO,Post op X Ray ,scar photo	
53	Pulmonary AV Fistula surgery	45,000	CT Chest	ECHO,Post op X Ray ,scar photo	
54	Lung Cyst	45,000	CT Chest	ECHO,Post op X Ray ,scar photo	7
55	Space-Occupying Lesion (SOL) mediastinum	45,000	CT Chest	ECHO,Post op X Ray ,scar photo	
56	Surgical Correction of Bronchopleural Fistula	50,000	CT Chest	ECHO,Post op X Ray ,scar photo	10
57	Diaphragmatic Eventeration	40,000	CT Chest	ECHO, Post op X Ray, scar photo	10
58	Oesophageal Diverticula /Achalasia Cardia	35,000	Barium Study + CT Chest	ECHO, Post op X Ray, scar photo	10
59	Diaphragmatic Injuries/Repair	35,000	CT Chest	ECHO, Post op X Ray, scar photo	10
60	Thoracotomy, Thoraco Abdominal Approach	30,000	CT Chest	Post op X Ray, scar photo	10
61	Foreign Body Removal with scope	20,000	CT Chest + Bronchoscopy report	Endoscopy Picture	2
62	Bronchial Repair Surgery for Injuries due to FB	35,000	CT Chest + Bronchoscopy report	Endoscopy Picture	7
63	Lung Injury repair	35,000	CT Chest	Post op X Ray, scar photo	7
64	Thyomectomy	35,000	CT Chest	Post op X Ray, scar photo	
65	Pulmonary Valve Replacement	120,000	2D ECHO	ECHO, Post op X Ray, scar photo	10
66	Intercostal Drainage and Management of ICD, Intercostal Block, Antibiotics & Physiotherapy	10,000	Pre-Op X-ray / CT Scan	Post Op X-ray / CT Scan	7
67	Encysted Empyema/Pleural Effusion - Tubercular	10,000	Pre-Op X-ray / CT	Post Op X-ray / CT Scan	

			Scan		
68	First rib Excision by transaxillary approach, Excision of cervical rib / fibrous band / muscle by cervical approach	30,000	Pre-Op X-ray / CT Scan	Post Op X-ray / CT Scan, scar photo	7
69	Congenital Cystic Lesions	30,000	Pre-Op X-ray / CT Scan	Post Op X-ray / CT Scan, scar photo	7
70	Pulmonary Sequestration Resection	40,000	Pre-Op X-ray / CT Scan	Post Op X-ray / CT Scan, scar photo	7
71	Pulmonary artero venous malformation	40,000	Pre-Op X-ray / CT Scan	Post Op X-ray / CT Scan, scar photo	7

III. CARDIO VASCULAR SURGERY

Total no: of packages: 21
No: of packages mandated for pre-authorization: 20
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Specific Pre and Post-op Investigations such as ECHO, ECG, post-op scar photo, clinical photos of graft/ filter/ balloon & post flow, Angiography/ CT/ MRI/ Doppler/ CT angiogram reports etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Thromboembolectomy (pre-auth not required, usually done as emergency)	20,000	Duplex ultrasound/Angio report	Scar photo + Post op CT angio	3

2	Surgery for Arterial Aneursysm -Upper/Distal Abdominal Aorta	90,000	CT Angio Report	Scar photo + Post op CT angio	10
3	Intrathoracic Aneurysm-Aneurysm not Requiring Bypass Techniques	90,000	CT Angio Report	Scar photo + Post op CT angio	10
4	Intrathoracic Aneurysm-Requiring Bypass Techniques	125,000	CT Angio Report	Scar photo + Post op CT angio	10
5	Surgery for Arterial Aneurysm Renal Artery	40,000	Renal arterial Doppler, Angiogram	Doppler Report + scar photo	
6	Operations for Congenital Arteriovenous Fistula	15,000	Regional Angiogram & Stills	Scar photo	
7	Operations for Stenosis of Renal Arteries	40,000	Renal arterial Doppler, angiogram & Stills	Doppler Report + scar photo	
8	Aorto Bi lliac / Bi femoral /Axillo bi femoral bypass with Synthetic Graft	90,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + scar photo	7
9	Femoro Distal / Femoral - Femoral / Femoral infra popliteal Bypass with Vein Graft	50,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + Duplex ultrasound, scar photo	7
10	Femoro Distal / Femoral - Femoral / Femoral infra popliteal Bypass with Synthetic Graft	70,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + Duplex ultrasound, scar photo	7
11	Axillo Brachial Bypass using with Synthetic Graft	65,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + Duplex ultrasound, scar photo	7
12	Brachio - Radial Bypass with Synthetic Graft	30,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + Duplex ultrasound, scar photo	5
13	Excision of body Tumor with vascular repair	35,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft +	7

				Duplex ultrasound, scar photo	
14	Carotid artery bypass with Synthetic Graft	60,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + Duplex ultrasound, scar photo	7
15	Excision of Arterio Venous malformation - Large	50,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + scar photo	7
16	Excision of Arterio Venous malformation - Small	30,000	Angiogram/spiral CT Angiogram reports	Stills showing the procedure with graft + scar photo	7
17	Deep Vein Thrombosis (DVT) - Inferior Vena Cava (IVC) filter	80,000	Color doppler	X-ray abdomen showing the filter + scar photo	7
18	Carotid endarterectomy	32,000	Angiogram	Stills showing the procedure with graft + scar photo	7
19	Aortic Angioplasty with two stents / Iliac angioplasty with stent Bilateral	90,000	ECG, 2D ECHO, CAG stills showing blocks	Angioplasty stills showing Balloon & post flow + scar photo	7
20	Bilateral thrombo embolectomy	30,000	Duplex ultrasound/Angiogram - pre or intra operative	Duplex ultrasound + scar photo	7
21	Aorto-uni-iliac/uni-femoral bypass with synthetic graft	70,000	Angiogram/ Computed Tomography Angiography (3D-CTA)/Magnetic Resonance Angiography	Duplex ultrasound + scar photo	7

IV. OPHTHALMOLOGY

Total no: of packages: 42
No: of packages mandated for pre-authorization: 42
Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Following might be considered during claims submission & processing:

- Following cataract surgery that implants an IOL, it is prescribed to mention/ attach the barcode no. on the lens used during claims submission by the provider as means to provide information on expiration dates and details from manufacturers for increased quality and safety.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Buckle Removal	5,000			D
2	Canaliculo Dacryocysto Rhinostomy	10,000			1
3	Capsulotomy (YAG)	1,500			D
4	Corneal Grafting	8,500			D
5	Prophylactic Cryoretinopexy- Closed	2,500			1
6	Cyclocryotherapy/Cyclophotocoagulation	3,000			D
7	Pterygium + ConjunctivalAutograft	9,000			D
8	Dacryocystectomy with implants	10,000			D
9	Enucleation	6,000			1
10	Enucleation with Implant	11,000			1
11	Exenteration	15,000			D
12	Glaucoma Surgery (Trabeculectomy only) with or without Mitomycin C, including postoperative medications for 12 weeks (and wherever surgical or laser procedures required for bleb augmentation and anterior chamber maintenance)	10,000			D
13	Intraocular Foreign Body Removal from Anterior Segment	4,000			D

14	Intraocular Foreign Body Removal from Posterior Segment	20,000			D
15	Lensectomy /pediatric lens aspiration	9,000			D
16	LimbalDermoid Removal	4,000			D
17	Surgical Membranectomy	8,000			D
18	Perforating Corneo - Scleral Injury	10,000			2
19	Ptosis Surgery	10,000			D
20	IRIS Prolapse – Repair	4,000			D
21	Retinal Detachment Surgery	15,000			2
22	Small Tumour of Lid – Excision + Lid Reconstruction	10,000			D
23	Socket Reconstruction with amniotic membrane	8,000			1
24	Iridectomy – Laser	2,000			D
25	Iridectomy – Surgical	3,000			D
26	Iris cyst removal	2,500			D
27	Vitrectomy	7,500			1
28	Vitrectomy + Retinal Detachment surgery (pre-auth required)	17,500			1
29	Cataract with foldable hydrophobic acrylic IOL by Phaco emulsification tech	7,500			D
30	Cataract with non-foldable IOL using SICS technique	5,000			D
31	Cataract with foldable hydrophobic acrylic IOL by Phaco emulsification tech + Glaucoma	10,500			
32	Cataract with non-foldable IOL using SICS technique + Glaucoma	6,500			
33	Conjunctival tumour excision + AMG	5,000			D
34	Entropion correction	4,000			D
35	Ectropion correction	5,000			D
36	Evisceration	3,500			D
37	Laser for retinopathy (per sitting)	1,500			D
38	Lid tear	5,000			D
39	Orbitotomy	10,000			D
40	Squint correction (per muscle)	4,000			D
41	Anterior Chamber Reconstruction +Perforating corneo - Scleral Injury + IOL	11,500			2
42	PRP - Retinal Laser including 3 sittings	5,000			D

V. OTORHINOLARYNGOLOGY

Total no: of packages: 94
No: of packages mandated for pre-authorization: 5
Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Not required (select packages)

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
	Ear				
1	Aural polypectomy	4,000			1
2	Labyrinthectomy	20,000			2
3	Mastoidectomy	12,500			2
4	Mastoidectomy corticol modified/ radical	11,500			2
5	Mastoidectomy with tympanoplasty	16,000			2
6	Myringoplasty	7,500			2
7	Myringoplasty with Ossiculoplasty	13,500			2
8	Myringotomy – Bilateral	6,000			2
9	Myringotomy – Unilateral	3,500			2
10	Myringotomy with Grommet - One ear	6,500			2
11	Myrinogotomy with Grommet - Both ear	8,500			2
12	Ossiculoplasty	9,500			2
13	Partial amputation – Pinna	4,000			1
14	Excision of Pinna for Growths (Squamous/Basal) Injuries - Total Amputation & Excision of External Auditory Meatus	8,000			3
15	Excision of Pinna for Growths (Squamous/Basal) Injuries Total Amputation	6,500			3
16	Stapedectomy	10,000			3
17	Tympanoplasty	9,000			3

18	Vidian neurectomy – Micro	9,000			3
19	Ear lobe repair - single (daycare)	1,500			D
20	Excision of Pinna for Growth (Squamous/Basal/ Injuries) Skin and Cartilage	4,000			D
21	Excision of Pinna for Growth (Squamous/Basal/ Injuries) Skin Only	2,500			D
22	Pharyngectomy and reconstruction	15,000			2
23	Skull base surgery (pre-auth required)*	37,000	Yes	Yes	3
24	Total Amputation & Excision of External Auditory Meatus	7,500			3
25	Tympanotomy	4,000			2
26	Removal of foreign body from ear	3,000			D
27	Aural polypectomy +Tympanoplasty	10,000			3
	Nose				
28	Ant. Ethmoidal artery ligation - open/ endoscopic	11,000			3
29	Antrostomy – Bilateral	8,500			3
30	Antrostomy – Unilateral	6,000			3
31	Cryosurgery	3,000			1
32	CSF Rhinorrhoea – Repair	14,000			3
33	Septoplasty + FESS	11,500			2
34	Ethmoidectomy – External	11,500			2
35	Fracture reduction nose with septal correction	8,000			1
36	Fracture - setting maxilla	8,000			2
37	Fracture - setting nasal bone	5,000			1
38	Functional Endoscopic Sinus (FESS)	11,000			1
39	Intra Nasal Ethmoidectomy	5,000			1
40	Rhinotomy – Lateral	7,500			2
41	Nasal polypectomy – Bilateral	9,000			1
42	Nasal polypectomy – Unilateral	6,000			1
43	Turbinectomy Partial – Bilateral	3,000			1
44	Turbinectomy Partial – Unilateral	2,000			1
45	Radical fronto ethmo sphenodectomy	18,000			5
46	Rhinoplasty	15,000			3
47	Septoplasty	5,000			1
48	Youngs operation	3,000			1

49	Angiofibrom Excision	18,000			3
50	Cranio-facial resection	22,500			2
51	Endoscopic DCR	7,000			1
52	Endoscopic Hypophysectomy	21,000			2
53	Intranasal Diathermy	3,000			1
54	Rhinosporidiosis	5,000			2
55	Septo-rhinoplasty	12,500			2
	Throat				
56	Adeno Tonsillectomy	8,000			1
57	Adenoidectomy	5,000			1
58	Arytenoidectomy	10,000			2
59	Choanal atresia	12,500			2
60	Tonsillectomy + Myrinogotomy	10,000			3
61	Pharyngeal diverticulum's – Excision	10,000			2
62	Laryngectomy with block dissection	25,000			3
63	Laryngofissure	5,000			2
64	Laryngophayryngectomy	20,000			2
65	Maxilla – Excision	12,500			2
66	Oro Antral fistula	7,500			2
67	Parapharyngeal – Exploration	12,500			2
68	Parapharyngeal Abscess – Drainage	12,500			2
69	Peritonsillor abscess under LA	2,500			D
70	Pharyngoplasty	10,000			2
71	Retro pharyngeal abscess – Drainage	5,000			D
72	Tonsillectomy + Styloidectomy	10,000			2
73	Thyroglossal Fistula/ cyst – Excision	7,000			2
74	Tonsillectomy – (Uni/ Bilateral)	7,500			1
75	Total Parotidectomy	18,000			2
76	Superficial Parotidectomy	12,000			4
77	Uvulophanyngo Plasty	14,000			2
78	Commondo Operation (glossectomy)	17,500			4
79	Excision of Branchial Cyst	7,000			3

80	Excision of Branchial Sinus	7,000			3
81	Excision of Cystic Hygroma Major/ Extensive	10,000			3
82	Excision of Cystic Hygroma Minor	5,000			2
83	Excision of the Mandible Segmental	7,500			3
84	Hemi-mandibulectomy with graft	15,000			3
85	Hemiglossectomy	6,000			3
86	Palatopharyngoplasty	10,000			2
87	Partial Glossectomy	5,000			3
88	Ranula excision	5,000			3
89	Removal of Submandibular Salivary gland	5,000			3
90	Total Glossectomy	15,000			3
91	Total Laryngectomy + Neck dissection (pre-auth)*	25,000	Yes	Yes	4
92	Laryngopharyngectomy with Gastric pull-up/ jejunal graft (pre-auth)*	30,000	Yes	Yes	4
93	Excision of CA cheek/ oral cavity + radial forearm flap (pre-auth)*	30,000	Yes	Yes	4
94	Excision of growth Jaw + free fibular flap reconstruction (pre-auth)*	30,000	Yes	Yes	4

*Procedures can be done only in specialty centres

VI. ORTHOPAEDICS

Total no: of packages: 101
No: of packages mandated for pre-authorization: 26
Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Selective packages
Pre-authorization remarks: Prior approval must be taken for all replacement surgeries and others as indicated.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	AC joint reconstruction/ Stabilization/ Acromionplasty	25,000	X rays of affected limb,	X rays of affected limb	4

	Nonoperative management is recommended for Rockwood type I and II injuries, whereas surgical reconstruction is recommended for type IV and VI separations. The management for type III and V injuries is more controversial and is determined on a case-by-case basis (pre-auth)		MRI of shoulder		
2	Accessory bone – Excision (limbs) – congenital Accessory digits sometime can be removed (pre-auth)	6,000	X rays of affected limb	X rays of affected limb	3
3	Amputation - Below Elbow	15000			5
4	Amputation - Above Elbow	15000			5
5	Amputation – one or more fingers	6,000			1
6	Amputation – Wrist	15,000			4
7	Amputation - one or more toes/ digits	6,000			1
8	Amputation – Below Knee	15000			5
9	Amputation – Above Knee	18000			5
10	Foot & Hand Amputation (whole/ partial)	15000			5
11	Disarticulation (hind & for quarter)	25,000	Clinical and radiological investigations	Clinical and radiological investigations	10-15 days of hospital stay
12	Anterior Spine Fixation	35,000	Clinical and radiological investigations	Clinical and radiological investigations	6
13	Posterior Spine Fixation	20,000	Clinical and radiological investigations	Clinical and radiological investigations	5
14	Osteochondroma excision/ Excision of Exostosis	10,000	Clinical and radiological investigations	Clinical and radiological investigations	4
15	Excision Arthoplasty	15,000	Clinical and radiological investigations	Clinical and radiological investigations	4
16	Arthorotomy of any joint	15,000			7-10 days hospital

					stay for iv antibiotics
17	Arthrodesis Ankle Triple	15,000	Clinical and radiological investigations	Clinical and radiological investigations	6
18	Excision Arthoplasty of Femur head	22,500			6
19	Bimalleolar Fracture Fixation	15,000			6
20	Bone Tumour Excision + reconstruction using implant (malignant/ benign)	50,000	Clinical and radiological investigations	Clinical and radiological investigations	4
21	Bone Tumour (malignant/ benign) curettage and bone grafting	20,000	Clinical and radiological investigations	Clinical and radiological investigations	
22	Bone Tumour Excision (malignant/ benign) + Joint replacement (depending upon type of joint and implant)	1,50,000	Clinical and radiological investigations	Clinical and radiological investigations	
23	Clavicle fracture management - conservative (daycare)	3,000			D
24	Close Fixation - Hand Bones	4,000			3
25	Close Fixation - Foot Bones	4,000			2
26	Close Reduction - Small Joints	4,000			1
27	Closed Interlock Nailing + Bone Grafting – femur	19,000			5
28	Closed Interlocking Intermedullary	17,500			5
29	Closed Interlocking Tibia + Orif of Fracture Fixation	25,000			5
30	Closed Reduction and Internal Fixation with K wire	6,000			5
31	Closed Reduction and Percutaneous Screw Fixation (neck femur)	15,000			5
32	Closed Reduction and Percutaneous Pinning	15,000			2
33	Closed Reduction and Percutaneous Nailing	20,000			5
34	Closed Reduction of the Hip (including hip Spika)	7,000			2
35	Debridement & Closure of Major injuries - contused lacerated wounds (anti-biotic + dressing) - minimum of 3 sessions	7,000			2
36	Debridement & Closure of Minor injuries	3000			2
37	Closed reduction of dislocation (Knee/ Hip)	6,000			D
38	Closed reduction of dislocation (Shoulder/ Elbow)	5,000			D

39	Duputryen's Contracture release + rehabilitation	10,000			5
40	Exploration and Ulnar nerve Repair	10,000			4
41	External fixation - Long bone	15,000			4
42	External fixation - Small bone	10,000			2
43	External fixation - Pelvis	15,000			5
44	Fasciotomy	7,000			2
45	Fixator with Joint Arthrolysis	20,000			7
46	Fracture - Acetabulum	30,000			7
47	Fracture - Fibula Internal Fixation	10,000			4
48	Fracture - Hip Internal Fixation (Intertrochanteric Fracture with implant) + rehabilitation	17,000			7
49	Fracture - Humerus Internal Fixation	17,000			7
50	Fracture - Olecranon of Ulna	10,000			2
51	Fracture - Radius Internal Fixation	10,000			2
52	Fracture - TIBIA Internal Fixation plating	17,000			4
53	Fracture - Ulna Internal Fixation	10,000			4
54	Head Radius – Excision	8,000			3
55	High Tibial Osteotomy	17,000			5
56	Closed reduction + Hip Spica	7,000			D
57	Internal Fixation Lateral Epicondyle	10,000			4
58	Internal Fixation of other Small Bones (metatarsals)	10,000			3
59	Limb Lengthening	25,000			10
60	Llizarov Fixation	10,000			6
61	Multiple Tendon Repair	20,000	Clinical + electro-diagnostic studies	Clinical Photographs Showing scar	5
62	Nerve Repair Surgery	15,000	Clinical + electro-diagnostic studies	Clinical Photographs Showing scar electro-diagnostic studies	6
63	Nerve Transposition/Release/ Neurolysis	8,000			6
64	Open Reduction Internal Fixation (2 Small Bones)	10,000			3
65	Open Reduction Internal Fixation (Large Bone)	20,000			6
66	Open Reduction of CDH	30,000			7

67	Open Reduction of Small Joint	15,000			1
68	Open Reduction with bone grafting of nonunion	20,000			3
69	Osteotomy -Small Bone	17,000			5
70	Osteotomy -Long Bone	30,000			7
71	Patellectomy	8,000			7
72	Pelvic Osteotomy with fixation with plaster	30,000			10
73	Percutaneous - Fixation of Fracture	7,000			6
74	Excision of Bursa	3,000			2
75	Reconstruction of ACL/PCL with implant and brace	30,000	Clinical and radiological investigations	Clinical and radiological investigations	3
76	Sequestrectomy of Long Bones + anti-biotics + dressing	25,000			7
77	Tendo Achilles Tenotomy	5,000			2
78	Tendon Grafting	15,000			2
79	Tendon Release/ Tenotomy	5,000			2
80	Tenolysis	5,000			2
81	Tension Band Wiring Patella	15,000			3
82	Application of P.O.P. casts for Upper & Lower Limbs	3,000			D
83	Application of P.O.P. Spikas& Jackets	3,500			D
84	Application of Skeletal Tractions with pin	3,000			D
85	Application of Skin Traction	1,000			D
86	Head radius - Excision + Fracture - Ulna Internal Fixation	20,000			3
87	External fixation - both bones of forearms	25,000			5
88	Fracture intercondylarHumerus + olecranon osteotomy	20,000			5
89	Correction of club foot per cast	15,000			D
90	Arthroscopic Meniscus Repair/ Meniscectomy	20,000	Clinical and radiological investigations	Clinical and radiological investigations	3
91	Total Hip Replacement (cemented)	75,000	Clinical and radiological investigations	Clinical and radiological investigations	7
92	Total Hip Replacement (cementless)	90,000	Clinical and radiological	Clinical and radiological	7

			investigations	investigations	
93	Total Hip Replacement (hybrid)	75,000	Clinical and radiological investigations	Clinical and radiological investigations	7
94	Bipolar Hemiarthroplasty (hip & shoulder)	40,000	Clinical and radiological investigations	Clinical and radiological investigations	7
95	Unipolar Hemiarthroplasty	30,000	Clinical and radiological investigations	Clinical and radiological investigations	7
96	Total Knee Replacement	80,000	Clinical and radiological investigations	Clinical and radiological investigations	7
97	Elbow replacement	40,000	Clinical and radiological investigations	Clinical and radiological investigations	7
98	Arthrodesis of shoulder	40,000	Clinical and radiological investigations	Clinical and radiological investigations	7
99	Arthrodesis of Knee (with implant)	40,000	Clinical and radiological investigations	Clinical and radiological investigations	7
100	Arthrodesis of Wrist (with implant)	30,000	Clinical and radiological investigations	Clinical and radiological investigations	7
101	Arthrodesis of Ankle (with implant)	30,000	Clinical and radiological investigations	Clinical and radiological investigations	7

VII. POLYTRAUMA

Total no: of packages: 13
No: of packages mandated for pre-authorization: 0

Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Specific Pre and Post-op Investigations such as pre/ post-op X-ray, CT report, post-op scar photo, electro-diagnostic studies etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

- The minimum length of hospital stay admissible for polytrauma cases would be on a case-by-case depending on the nature, type and vitals (for e.g. coagulation parameters). However weekly submission of clinco-radiological vitals is desired.
- ICU requirement will be Rs.5000 per day (surgical) (beyond 24 hours mandatory pre-authorisation)
- Procedures are available in Specialty Centres.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Nerve Plexus injuries, Tendon injury repair/reconstruction/ Transfer	50,000	Nerve conduction velocity (NCV) + CT	Clinical Photographs with Graft site + Showing scar POST OP ELECTRO DISGNOSTIC STUDY	5-10 Days
2	Plexus injury along with Vascular injury repair/ graft	60,000	Pre-op. Doppler study, Nerve Conduction study, + CT	Post-op. Doppler study, Clinical photo showing scar	5-10 Days
3	Internal fixation with Flap cover Surgery for wound in compound fracture	40,000	PRE OP CLINICAL PICSTURE X-RAY/CT	Post- op. X-ray, Clinical Photograph showing flap cover	5-10 Days
4	Head injury requiring Facio-Maxillary Injury repairs & fixations (including implants)	35,000	X-RAY/CT	Clinical Photograph showing scar + post op. XRAY	5-10 Days

5	Internal fixation of Pelviacetabular fracture	40,000	X-RAY/CT	Clinical Photograph showing scar + post op. XRAY	5-10 Days
6	Craniotomy and evacuation of Haematoma – subdural/Extra dural along with fixation of fracture of single long bone	60,000	Pre-op. X-ray + CT	Post-Op. X-ray/CT + scar photo	5-10 Days
7	Craniotomy and evacuation of Haematoma – subdural/Extra dural along with fixation of fracture of 2 or more long bone.	75,000	Pre-op. X-ray + CT	Post-Op. X-ray/CT + scar photo	5-10 Days
8	Visceral injury requiring surgical intervention along with fixation of fracture of single long bone.	30,000	Pre-op. X-ray, CT scan + Ultra sound/ X-ray	Post-Op. X-ray + scar photo	5-10 Days
10	Visceral injury requiring surgical intervention along with fixation of fracture of 2 or more long bones.	45,000	Pre-op. X-ray, CT scan + Ultra sound/ X-ray	Post-Op. X-ray + scar photo	5-10 Days
11	Chest injury with one fracture of long bone (with implants)	35,000	Pre-op. X-ray of fracture CHEST XRAY	Post-Op. X-ray + scar photo	5-10 Days
12	Chest injury with fracture of 2 or more long bones	45,000	Pre-op. X-ray of fracture	Post-Op. X-ray + scar photo	5-10 Days
13	Emergency tendons repair ± Peripheral Nerve repair/ reconstructive surgery	30,000	Clinical + electro/ diagnostic reports	Clinical Photographs with Graft site + Showing scar MRI	5-10 Days

VIII. UROLOGY

Total no: of packages: 161
No: of packages mandated for pre-authorization: 10
Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Selective packages
Pre-authorization remarks: Prior approval must be taken for surgeries requiring use of Deflux injection, Botox Injection, inflatable penile prosthesis, urinary sphincter and metallic stents.

- Further it is also mandated to get approval for all non-surgical conditions (involving evaluation/ investigation/ therapeutic management / follow-up visits) as indicated.
  - For any procedure whose charges are Rs. 15,000 or higher, extra costs (in the sense other packages) cannot be clubbed/ claimed from the following: cystoscopy, ureteric catheterization, retrograde pyelogram, DJ stenting, nephrostomy – as they would form part of such packages costing Rs. 15,000 or higher as per the need.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Adrenalectomy-unilateral, open	25,000			7
2	Adrenalectomy-unilateral, Laparoscopic	30,000			3
3	Adrenalectomy-bilateral, open	32,000			7
4	Adrenalectomy-biilateral, Laparoscopic	40,000			5
5	Paraganglioma excision with liver mobilization	50,000			
6	Nephrectomy (Benign) Open	25,000			5
7	Nephrectomy (Benign) Laparoscopic	30,000			3
8	Nephrectomy-Radical (Renal tumor) Open	25,000			5
9	Nephrectomy-Radical (Renal tumor) Laparoscopic	30,000			3
10	Nephrectomy-Partial or Hemi, Open	30,000			5
11	Nephrectomy-Partial or Hemi, Laparoscopic	35,000			5
12	Nephro ureterectomy (Benign) Open	25,000			5
13	Nephro ureterectomy (Benign) Laparoscopic	30,000			3
14	Nephro ureterectomy with cuff of bladder Open	30,000			5
15	Nephro ureterectomy with cuff of bladder Laparoscopic	35,000			3
16	Pyeloplasty/pyeloureterostomy/pyelopyelostomy Open	25,000			3
17	Pyeloplasty/pyeloureterostomy/pyelopyelostomy Laparoscopic	30,000			2
18	Endopyelotomy (retrograde with laser/bugbee)	25,000			1
19	Endopyelotomy (antegrade with laser/bugbee)	28,000			2
20	Ureterocalycostomy Open	25,000			5

21	Ureterocalycostomy Laparoscopic	30,000			3
22	Uretero-ureterostomy Open	25,000			3
23	Uretero-ureterostomy Laparoscopic	35,000			3
24	PCNL (Percutaneous Nephrolithotomy) - Bilateral	40,000			3
25	PCNL (Percutaneous Nephrolithotomy) - Unilateral	25,000			3
26	Extracoporeal shock-wave Lithotripsy (SWL) stone, with or without stent (one side)	13,000			D (up to 3 sittings)
27	Extracoporeal shock-wave Lithotripsy (SWL) stone, with or without stent (both sides)	26,000			D (up to 3 sittings)
28	Pyelolithotomy-Open	20,000			3
29	Pyelolithotomy-Laparoscopic	30,000			2
30	Nephrolithotomy-Open	20,000			3
31	Anatrophic nephrolithotomy	30,000			5
32	Perinephric Abscess drainage (percutaneous)	10,000			2
33	Perinephric Abscess drainage (Open)	20,000			3
34	Renal Cyst deroofing or marsupialization-Open	20,000			3
35	Renal Cyst deroofing or marsupialization-Laparoscopic	30,000			3
36	Nephrostomy-percutaneous ultrasound guided	10,000			D
37	Ureterolithotomy-Open	20,000			3
38	Ureterolithotomy-Laparoscopic	30,000			3
39	Ureteroscopy+stone removal with lithotripsy, lower ureter, unilateral	20,000			1
40	Ureteroscopy+stone removal with lithotripsy, upper ureter, unilateral	25,000			1
41	Ureteroscopy+stone removal with lithotripsy, bilateral	30,000			1
42	Ureterotomy (Cutaneous)	20,000			2
43	Endoureterotomy (laser/bugbee)	20,000			1
44	Ureteric reimplantation-unilateral-open	20,000			3
45	Ureteric reimplantation-bilateral-open	25,000			3
46	Ureteric reimplantation-unilateral-Laparoscopic	30,000			3
47	Ureteric reimplantation-bilateral-Laparoscopic	35,000			3
48	Uretero-vaginal/uterine fistula repair open	27,000			3

49	Uretero-vaginal/uterine fistula repair Laparoscopic	37,000			3
50	Ureterolysis-open, for retroperitoneal fibrosis (with or without omental wrapping)	20,000			3
51	Ureterolysis-Laparoscopic, for retroperitoneal fibrosis (with or without omental wrapping)	30,000			3
52	Boari flap for ureteric stricture, open	30,000			3
53	Boari flap for ureteric stricture, Laparoscopic	40,000			3
54	Ileal replacement for ureteric stricture	40,000			5
55	DJ stent unilateral including cystoscopy, ureteric catheterization, retrograde pyelogram	10,000			D
56	DJ stent bilateral including cystoscopy, ureteric catheterization, retrograde pyelogram	10,000			D
57	Ureteric sampling including cystoscopy, ureteric catheterization, retrograde pyelogram	10,000			D
58	Ureterocele incision including cystoscopy, ureteric catheterization, retrograde pyelogram	15,000			1
59	Urachal Cyst excision -open	15,000			2
60	Cystolithotomy-open, including cystoscopy	15,000			2
61	Cystolithotripsy/Urethral Stone endoscopic, including cystoscopy	15,000			1
62	TURBT (Transurethral Resection of the Bladder Tumor)	25,000			2
63	TUR-fulgration (Transurethral fulgration of the Bladder Tumor)	18,000			2
64	Intravesical BCG/Mitomycin 6 induction cycles (weekly for 6 weeks-total cost of 6 cycles)	12,000			D
65	Intravesical BCG/Mitomycin maintenance for 12 doses (total cost of 12 doses)	24,000			D
66	Post TURBT - Check Cystoscopy (Per sitting) with or without cold-cup biopsy	10,000			D
67	Diagnostic Cystoscopy	5,000			D
68	Bladder Neck incision-endoscopic	15,000			1
69	Extrophy Bladder repair including osteotomy if needed + epispadias repair + ureteric reimplant	50,000			5

70	Bladder injury repair (as an independent procedure with or without urethral injury)	20,000			3
71	Bladder injury repair (only to be used if done as a part of ongoing laparotomy/other surgery)	10,000			2
72	Bladder injury repair with colostomy (as an independent procedure with or without urethral injury)	25,000			5
73	Partial Cystectomy-open	20,000			3
74	Partial Cystectomy-Laparoscopic	30,000			3
75	Radical cystectomy with neobladder-open	50,000			7
76	Radical cystectomy with continent diversion-open	50,000			7
77	Radical Cystectomy with Ileal Conduit-open	50,000			7
78	Radical Cystectomy with ureterostomy-open	35,000			7
79	Radical Cystectomy with ureterosigmoidostomy-open	35,000			7
80	Other Cystectomies	30,000			2
81	Suprapubic Cystostomy - Open, as an independent procedure	10,000			D
82	Suprapubic Drainage - Closed/Trocar	5,000			D
83	VVF/Uterovaginal Repair - Transvaginal approach	25,000			5
84	VVF/Uterovaginal Repair - Abdominal,Open	25,000			5
85	VVF/Uterovaginal Repair - Abdominal, Laparoscopic	30,000			5
86	Hysterectomy as part of VVF/uterovaginal fistula repair (top-up)	5,000			
87	Urethrovaginal fistula repair	30,000			3
88	Y V Plasty of Bladder Neck/Bladder Neck Reconstruction	20,000			5
89	Augmentation cystoplasty-open	30,000			5
90	Augmentation cystoplasty-Laparoscopic	40,000			5
91	Open bladder diverticulectomy with/without ureteric re-implantation	25,000			3
92	Open simple prostatetctomy for BPH	25,000			3
93	TURP-Transurethral Resection of the Prostate, BPH, Monopolar/Bipolar/Laser	25,000			2
94	Holmium Laser Prostatectomy	40,000			2
95	TURP/Laser + Circumcision	30,000			2

96	TURP/Laser + Cystolithotripsy	30,000			2
97	TURP/Laser + Cystolithotomy-open	35,000			2
98	TURP/Laser + Orchidectomy	30,000			2
99	TURP/Laser + TURBT	30,000			2
100	TURP/Laser + URS with stone removal	40,000			2
101	TURP/Laser + VIU (visual internal Ureterotomy)	40,000			2
102	TURP/Laser + Hydrocele surgery	40,000			2
103	TURP/Laser + Hernioplasty	40,000			2
104	TURP/Laser + Urethral dilatation-non endoscopic	40,000			2
105	TURP/Laser + Urethral dilatation-endoscopic	40,000			2
106	Radical prostatectomy - open	50,000			5
107	Radical prostatectomy - laparoscopic	70,000			5
108	Transrectal Ultrasound guided prostate biopsy (minimum 12 core)	10,000			
109	Reduction of Paraphimosis	2,000			D
110	Excision of Urethral Caruncle	6,000			1
111	Meatoplasty	3,500			1
112	Meatotomy	3,500			1
113	Post Urethral Valve fulguration	10,000			1
114	Urethroplasty-End to end	20,000			3
115	Urethroplasty-Substitution-single stage	30,000			5
116	Urethroplasty-Substitution-two stage	35,000			5
117	Urethroplasty-Transpubic	30,000			5
118	Urethroplasty-two stage without substitution	30,000			5
119	Perineal Urethrostomy without closure	20,000			2
120	Urethrorectal fistula repair	40,000			6
121	Urethral Dilatation-non endocopic as an independent procedure	2,000			D
122	Urethral Dilatation-endocopic as an independent procedure	5,000			D
123	Internal Ureterotomy including cystoscopy as an independent procedure	10,000			1
124	Hypospadias repair-single stage	20,000			3

125	Hypospadias repair-two or more stage	30,000			3
126	Orchiopexy-without laparoscopy, unilateral	15,000			2
127	Orchiopexy-without laparoscopy, bilateral	15,000			2
128	Orchiopexy-with laparoscopy, unilateral	30,000			2
129	Orchiopexy-with laparoscopy, bilateral	30,000			2
130	Stress incontinence surgery, open	20,000			4
131	Stress incontinence surgery, laparoscopic	30,000			4
132	Stress incontinence surgery with slings	35,000			3
133	Partial Penectomy	15,000			2
134	Total Penectomy + Perineal Urethrostomy	20,000			2
135	Ilio-Inguinal lymphadenectomy-unilateral	15,000			3
136	Ilio-Inguinal lymphadenectomy-bilateral	25,000			3
137	Pelvic lymphadenectomy open, after prior cancer surgery	25,000			3
138	Pelvic lymphadenectomy laparoscopic, after prior cancer surgery	30,000			3
139	Orchiectomy-High inguinal	12,000			1
140	Orchiectomy-simple	10,000			D
141	Bilateral Orchidectomy for hormone ablation	10,000			D
142	Retroperitoneal lymph node dissection-open	25,000			3
143	Retroperitoneal lymph node dissection-Laparoscopic	35,000			3
144	Infertility-Scrotal exploration unilateral	10,000			D
145	Infertility-Scrotal exploration bilateral	12,000			D
146	Infertility-Vasoepididymostomy, microsurgical, unilateral	15,000			D
147	Infertility-Vasoepididymostomy, microsurgical, bilateral	20,000			D
148	Varicocele-unilateral-non microsurgical	10,000			1
149	Varicocele-unilateral-microsurgical	12,000			1
150	Varicocele-bilateral-non microsurgical	15,000			1
151	Varicocele-bilateral-microsurgical	20,000			1
152	Penile prosthesis insertion, Malleable (Indian implant)	30,000			3
153	Priapism-aspiration/shunt	15,000			2

154	Neurogenic bladder-Package for evaluation/investigation (catheter + ultrasound + culture + RGU/ MCU) for 1 month (medicines - antibiotics). Follow up visit once in 3 months	7,500			
155	Chronic prostatitis-Package for evaluation/investigation (ultrasound + culture + prostate massage) for 1 month (medicines). Follow up visit once in 3 months	2,500			
156	Emergency management of Ureteric stone - Package for evaluation/investigation (ultrasound + culture) for 3 weeks (medicines).	3,500			
157	Emergency management of Hematuria	2,000/ DAY			7
158	Emergency management of Acute retention of Urine	2,000/ DAY			3
159	Acute management of upper urinary tract trauma – conservative	2,000/ DAY			
160	Urinary tract trauma – open surgery (exploratory)	20,000			5
161	Urinary tract trauma – Laparoscopy surgery	30,000			5

IX. OBSTETRICS & GYNAECOLOGY

Total no: of packages: 73
No: of packages mandated for pre-authorization: 41
Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Selective packages
Pre-authorization remarks: Prior approval must be taken for all elective Surgeries/Procedures. Although the following packages, namely C-Section, High Risk Delivery, Hysterectomy are primarily for government facilities, they are open to the private hospitals upon referral by government hospitals/Doctors.

- Packages will include drugs, diagnostics, consultations, procedures, stay and food for patient. Medical conditions during pregnancy such at Hypertension, Diabetes etc are to be treated as per medical packages

S. No	Treatment/Procedure/Investigation	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
	A. Abdominal Surgeries				
Benign Conditions					
1	Hysterectomy ± Salpingo-oophorectomy	20,000			5
2	Abdominal Myomectomy	16,000			5
3	Surgeries for Prolapse - Sling Surgeries	16,000			5
4	Surgeries for Stress Incontinence 'Burch'	35,000			5
5	Hysterotomes - 2nd Trimester abortions	5,000			D
6	Incisional Hernia Repair	15,000			3
7	Radical Hysterectomy (Wertheims)	20,000			5
8	Laparotomy and proceed for Ovarian Cancers. Omentomy with Bilateral Salpingo-oophorectomy	20,000			5
	B. Vaginal Surgeries				
9	Non descent vaginal hysterectomy	14,000			4
10	Vaginal hysterectomy with anterior and posterior colpoperineorrhaphy	16,000			5
11	Vaginal surgical repair for vesico-vaginal fistula	10,000			5
12	Sacrocolpopexy	16,000			7
13	Repair for rectovaginal fitulas	10,000			3
14	Vaginoplasty	10,000			3
15	LLETZ	15,000			3
16	Colpotomy	1,200			D
17	Dilation and Evacuation (D&E)	5,000			D
18	Cervical biopsy and Polypectomy	3,000			D
19	Bartholins Cyst Enucleation/ Incision drainage	3,000			D
20	Vulvectomy simple	15,000			3

21	Radical Vulvectomy	15,000			3
	C. Laparoscopic Procedures				
22	Diagnostic laparoscopy	11,000			3
23	Laparoscopic hysterectomy (TLH)	20,000			5
24	Laparoscopic myomectomy	15,000			3
25	Laparoscopic cystectomy	15,000			5
26	Laparoscopic ovarotomy	10,000			3
27	Laparoscopic adhesiolysis	6,000			1
28	Laparoscopic tubal surgeries - salpingectomy, salpingotomy	11,000			3
	D. Hysteroscopic Surgeries				
29	Drag hysteroscopy	6,000			1
30	Hysteroscopic myomectomies	6,000			1
31	Hysteroscopic adhesiolysis	6,000			1
32	Hysteroscopic polypectomy	3,000			2
33	Hysteroscopic IUCD removal	3,000			1
	E. Pregnancy				
34	Caesarian Delivery	9,000			5
35	Caesarian hysterectomy	16,000			5
36	High risk deliveries • Premature delivery • Expected Gestation at delivery less than 35 weeks • Mothers with eclampsia or imminent eclampsia • Obstructed labour, • Major Fetal malformation requiring intervention immediately after birth • Mothers with severe anaemia (<7 g/dL) • Other maternal and fetal conditions as per guidelines-Such as Rh haemolytic disease, uncontrolled diabetes, severe growth	9,000			3

	retardation etc that qualify for high risk delivery etc.				
37	Manual removal of placenta	5,000			2
38	Laparotomy for ruptured ectopic	10,000			5
39	MTP > 12 weeks	6,500			1
40	MTP upto 12 weeks	5,000			1
41	MTP upto 8 weeks	3,500			1
42	McDonald's stitch	4,000			D
43	Shirodkar's stitch	4,000			D
44	Tuboplasty	10,000			5
45	Laparotomy for broad ligament haematoma	16,000			3
46	Trans-vaginal tape/ Trans-obturator tape	5,000			D
	F. Other procedures				
47	Abdominal Perineal neo construction Cx + Uteria + Vagina	20,000			
48	Ablation of Endometriotic Spot + Adhenolysis	10,000			
49	Ablation of Endometriotic Spot +Salpingostomy	10,000			
50	Adhenolysis + Hernia - Ventral - Lipectomy/Incision	16,000			
51	Adhenolysis+ Ovarian Cystectomy	10,000			
52	Adhenolysis+ Salpingostomy	10,000			
53	Broad Ligment Haemotoma drainage	10,000			
54	Brust abdomen repair	14,000			
55	Cone Biopsy Cervix	1,000			
56	Conventional Tubectomy	4,000			
57	Cyst -Vaginal Enucleation	3,000			
58	Cyst-Labial	3,000			
59	Cystocele - Anterior repair	12,000			
60	Cystocele - Anterior Repair + Perineal Tear Repair	13,000			
61	D&C (Dilatation &curretage) + Electro Cauterisation Cryo Surgery	4,000			

62	D&C (Dilatation&curretage)	3,000			
63	Diagnostic laparoscopy & hysteroscopy for infertility	5,000			
64	Electro Cauterisation Cryo Surgery	4,000			
65	Exploration of abdominal haematoma (after laparotomy + LSCS)	14,000			
66	Fractional Curretage	4,000			
67	Gaping Perineal wound secondary suturing/ episiotomy	2,500			
68	HaematoColpo/Excision - Vaginal Septum	5,000			
69	Hymenectomy& Repair of Hymen	7,000			
	G. Procedures for Fetal Medicines (pre-auth)				
70	Amniocentesis	5,000			D
71	Chorionic villus sampling	5,000			D
72	Cordocentesis	5,000			D
73	Intrauterine transfusions	10,000			D

X. GENERAL SURGERY

Total no: of packages: 253
No: of packages mandated for pre-authorization: 0
Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: only for Mesh Rs.5000 for one level

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)

1	Adventious Burse – Excision	10,000			3
2	Anterior Resection for CA	15,000			4
3	Appendicectomy	10,000			2
4	Appendicular Abscess – Drainage	12,000			2
5	Arteriovenous (AV) Malformation of Soft Tissue Tumour - Excision	15,000			3
6	Bakers Cyst – Excision	6,000			3
7	Bilateral Inguinal block dissection	25,000			3
8	Bleeding Ulcer - Gastrectomy & vagotomy	25,000			5
9	Bleeding Ulcer - Partial Gastrectomy	25,000			5
10	Block dissection Cervical Nodes	10,000			3
11	Branchial Fistula	14,000			3
12	Breast Lump - Left – Excision	5,000			2
13	Breast Lump - Right – Excision	6,500			2
14	Branchial Cyst	10,000			2
15	Bursa – Excision	4,000			2
16	Bypass - Inoperable Pancreas	15,000			4
17	Cervial Lymphnodes – Excision	2000			1
18	Colostomy	10,000			4
19	Cyst over Scrotum – Excision	2,000			1
20	Cystic Mass – Excision	2,000			1
21	Dermoid Cyst - Large – Excision	4,000			D
22	Dermoid Cyst - Small – Excision	2,000			D
23	Drainage of Ischio Rectal Abscess	4,000			1
24	Incision and Drainage of large Abscess	4,000			D
25	Drainage of Psoas Abscess	7,500			2
26	Drainage of Subdiaphramatic Abscess	10,000			3
27	Drainage Pericardial Effusion	13,750			5
28	Duodenal Diverticulum	20,000			5
29	Duodenal Jejunostomy	20,000			5
30	Duplication of Intestine	18,000			5
31	Hydrocele + Orchidectomy	8,000			2

32	Epidedectomy	8,000			3
33	Epididymal Swelling –Excision	6,000			2
34	Epidymal Cyst	4,000			D
35	Evacuation of Scrotal Hematoma	5,000			2
36	Excision Benign Tumor -Small intestine	15,000			5
37	Excision Bronchial Sinus	8,000			D
38	Drainage of liver Abscess	8,000			3
39	Excision Filarial Scrotum	5,000			3
40	Excision Mammary Fistula	5,000			2
41	Excision Meckel's Diverticulum	15,000			3
42	Excision Pilonidal Sinus	8,000			2
43	Excision Small Intestinal Fistula	15,000			5
44	Excision of Growth from Tongue only	6,000			1
45	Excision of Growth from Tongue with neck node dissection	15,000			4
46	Excision of Swelling in Right Cervical Region	5,000			1
47	Excision of Large Swelling in Hand	3,000			D
48	Excision of Small Swelling in Hand	1,500			D
49	Excision of Neurofibroma	3,000			2
50	Exicision of Sinus and Curettage	5,000			2
51	Fibroadenoma – Bilateral	8,000			2
52	Fibrodenoma – Unilateral	7,000			2
53	Fissurectomy	8,000			2
54	Fissurectomy and Haemorrhoidectomy	12,000			2
55	Eversion of Hydrocele Sac – Bilateral	10,000			2
56	Eversion of Hydrocele Sac – Unilateral	5,000			2
57	Fissurectomy with Sphincterotomy	15,000			2
58	Foreign Body Removal in Deep Region requiring GA	5,000			2
59	Fundoplication	20,000			3
60	G J Vagotomy/ Vagotomy + Pyloroplasty	15,000			5
61	Ganglion - large – Excision	3,000			1
62	Ganglion - Small – Excision	2,000			D

63	Gastrojejunostomy	15,000			4
64	Gastrostomy	15,000			4
65	Graham's Operation for duodenal perforation	15,000			5
66	Granuloma – Excision	2,000			1
67	Haemangioma – Excision (large)	10,000			3
68	Haemangioma – Excision (small)	5,000			2
69	Haemorrhage of Small Intestine	15,000			3
70	Hepatic Resection (lobectomy)	20,000			7
71	Hernia – Epigastric	11,000			2
72	Hernia – Incisional	15,000			3
73	Hernia - Repair & release of obstruction	15,000			3
74	Hernia – Umbilical	11,000			3
75	Hernia – Femoral	10,000			2
76	Hernioplasty – Inguinal	10,000			3
77	Herniorraphy	9,000			2
78	Hiatus Hernia – abdominal	15,000			5
79	Hydatid Cyst of Liver	12,500			3
80	Hydrocele - Excision – Unilateral	5,000			2
81	Hydrocele - Excision – Bilateral	10,000			2
82	IlieoSigmoidostomy	17,000			5
83	Infected Bunion Foot – Excision	4,000			1
84	Inguinal Node (dissection) - Unilateral	10,000			2
85	Intestinal perforation	12,500			5
86	Intestinal Obstruction	12,500			5
87	Intussusception	15,000			6
88	Jejunostomy	10,000			5
89	Gastric Perforation	15,000			5
90	Intestinal Perforation (Resection Anastomosis)	20,000			5
91	Appendicular Perforation	15,000			5
92	Burst Abdomen Obstruction	15,000			6
93	Closure of Hollow Viscus Perforation	15,000			5
94	Laryngectomy & Pharyngeal Diverticulum	15,000			3

	(Throat)				
95	Ileostomy	10,000			4
96	Lipoma excision	2,500			D
97	Loop Colostomy Sigmoid	12,000			4
98	Mastectomy	12,000			2
99	Mesenteric Cyst – Excision	16,000			3
100	Mesenteric Caval Anastomosis	15,000			5
101	Microlaryngoscopic Surgery	15,000			3
102	Oeshophagoscopy for foreign body removal	7,500			D
103	Oesophagectomy	17,500			5
104	Portal Hypertension shunt surgery t	18,000			5
105	Pelvic Abscess - Open Drainage	10,000			4
106	PancreaticoDuodenectomy	25,000			6
107	Distal Pancreatectomy with PancreaticoJejunostomy t	25,000			7
108	Papilloma Rectum – Excision	4,000			2
109	Haemorroidectomy+ Fistulectomy	10,000			2
110	Growth in the Scalp – Excision	4,000			1
111	Porto Caval Anastomosis	15,000			5
112	Pyeloroplasty	10,000			4
113	Radical Mastectomy	10,000			2
114	Radical Neck Dissection – Excision	15,000			6
115	Hernia – Spigelian	5,000			3
116	Rectal Dilation	2,000			1
117	Prolapse of Rectal Mass – Excision	10,000			2
118	Rectopexy	10,000			3
119	Repair of Common Bile Duct	15,000			3
120	Resection Anastomosis (Large Intestine)	15,000			7
121	Resection Anastomosis (Small Intestine)	15,000			7
122	Retroperitoneal Tumor – Excision	20,000			5
123	Haemorroidectomy	5,000			2
124	Salivary Gland – Excision	10,000			3

125	Segmental Resection of Breast	10,000			3
126	Scrotal Swelling (Multiple) – Excision	5,000			2
127	Sigmoid Diverticulum	15,000			6
128	Simple closure - Peptic perforation	15,000			5
129	Sinus – Excision	5,000			2
130	Soft Tissue Tumor (small) – Excision	5,000			2
131	Soft Tissue Tumor (large) – Excision	10,000			3
132	Splenectomy	25,000			6
133	Submandibular Lymph node – Excision	5,000			2
134	Submandibular Mass Excision + Reconstruction	20,000			5
135	Swelling in foot (small) – Excision	1,500			D
136	Swelling in foot (large) – Excision	3,500			1
137	Coloectomy – Total	20,000			6
138	Pharyngectomy& Reconstruction – Total	20,000			6
139	Tracheal Stenosis (End to end Anastamosis) (Throat)	15,000			6
140	Tracheoplasty (Throat)	15,000			6
141	Umbilical Sinus – Excision	5,000			2
142	Varicose Veins - Excision and Ligation	10,000			3
143	Vasovasostomy	12,000			3
144	Volvlous of Large Bowel	25,000			4
145	Cleft lip operation	12,000			2
146	Cleft palate repair	12,000 (for each stage)			2
147	Cleft lip & palate operation	15,000 (for each stage)			5
148	Aneurysm not Requiring Bypass Techniques t	36,000			
149	Aneurysm Resection & Grafting	36,000			
150	Arterial Embolectomy	10,000			
151	Carotid artery aneurysm repair	20,000			
152	Carotid Body tumour - Excision	20,000			
153	Cholecystectomy & Exploration of CBD	22,000			6
154	Cholecystostomy	10,000			6

155	Congential Arteriovenus Fistula (large)	20,000			
156	Congential Arteriovenus Fistula (small)	10,000			
157	Decortication (Pleurectomy)	20,000			
158	Dissecting Aneurysms	36,000			
159	Distal Abdominal Aorta repair	36,000			
160	Estlander Operation (lip)	7,000			1
161	Excision and Skin Graft of Venous Ulcer	15,000			
162	Excision of Parathyroid Adenoma/Carcinoma	22,000			
163	Flap Reconstructive Surgery	20,000			
164	Split thickness skin grafts – Small (< 4% TBSA)	5,000			D
165	Split thickness skin grafts – Medium (4 - 8% TBSA)	10,000			D
166	Split thickness skin grafts – Large (> 8% TBSA)	15,000			D
167	Free Grafts - Wolfe Grafts	10,000			
168	Hemi thyroidectomy	10,000			
169	Total thyroidectomy	20,000			
170	Laparoscopic Hernia Repair	18,000			3
171	Lap. Assisted left Hemi colectomy t	25,000			5
172	Lap. Assisted Right Hemi colectomy t	25,000			5
173	Lap. Assisted small bowel resection	15,000			3
174	Lap. Assisted Total Colectomy	25,000			5
175	Lap. Cholecystectomy & CBD exploration	20,000			**3**
176	Lap. For intestinal obstruction	15,000			5
177	Lap. Hepatic resection	25,000			5
178	Lap. Hydatid of liver surgery	20,000			5
179	Laparoscopic Adhesinolysis	15,000			5
180	Laparoscopic Appendicectomy	18,000			3
181	Laparoscopic Cholecystectomy	15,000			5
182	Laparoscopic cystogastrostomy	20,000			5
183	Laparoscopic Gastrostomy	12,000			5
184	Laparoscopic Hiatus Hernia Repair	22,000			5
185	Laparoscopic Pyloromyotomy	20,000			5

186	Laparoscopic Rectopexy	15,000			5
187	Laparoscopic Spleenectomy	16,500			5
188	Laparoscopic umbilical hernia repair	15,000			5
189	Laparoscopic ventral hernia repair	20,000			5
190	Laparotomy-peritonitis lavage and drainage	10,000			5
191	Ligation of Ankle Perforators	5,000			3
192	Lymphatics Excision of Subcutaneous Tissues In Lymphoedema	10,000			3
193	Repair of Main Arteries of the Limbs	25,000			5
194	Mediastinal Tumour	20,000			
195	Oesophagectomy for Carcinoma Oesophagus	25,000			7
196	Operation for Bleeding Peptic Ulcer	15,000			5
197	Operation for Carcinoma Lip – Vermilionectomy	10,000			6
198	Operation for Carcinoma Lip - Wedge Excision and Vermilionectomy	12,000			6
199	Operation for Carcinoma Lip - Wedge-Excision	10,000			6
200	Appendicectomy - Appendicular Abscess – Drainage	12,000			5
201	Caecostomy	10,000			
202	Closure of Colostomy	5,000			
203	Coccygeal Teratoma Excision	15,000			
204	Congenital Atresia & Stenosis of Small Intestine	20,000			
205	CystoJejunostomy/or Cystogastrostomy	20,000			
206	Drainage of perivertebral abscess	10,000			
207	Hernia -hiatus-Transthoracic	25,000			5
208	Intercostal drainage	2,000			
209	Operation for carcinoma lip- cheek advancement	12,000			5
210	Thymectomy	20,000			
211	Operation of Choledochal Cyst	15,000			5
212	Operations for Acquired Arteriovenous Fistula	15,000			

213	Operations for Replacement of Oesophagus by Colon	25,000			7
214	Hemodialysis per sitting	2,000			D
215	Parapharyngeal Tumour Excision	20,000			
216	Partial/Subtotal Gastrectomy for Carcinoma	22,000			
217	Patch Graft Angioplasty	20,000			
218	Pericardiostomy	30,000			
219	Pneumonectomy	25,000			
220	Removal of Foreign Body from Trachea or Oesophagus	5,000			
221	Removal Tumours of Chest Wall	20,000			
222	Procedures Requiring Bypass Techniques	35,000			
223	Resection Enucleation of Adenoma (lung)	10,000			
224	Rib Resection & Drainage	10,000			
225	Skin Flaps - Rotation Flaps	6,200			
226	Splenectomy - For Trauma	20,000			
227	Surgery for Arterial Aneurism Spleen Artery	20,000			
228	Surgery for Arterial Aneurism –Vertebral	25,000			
229	Sympathetectomy – Cervical	5,000			
230	Temporal Bone resection	15,000			
231	Thorachostomy	10,000			
232	Thoracocentesis	1,500			
233	Thoracoplasty	20,000			
234	Thoracoscopic Decortication	25,000			
235	Thoracoscopic Hydatid Cyst excision	20,000			
236	Thoracoscopic Lobectomy	25,000			
237	Thoracoscopic Pneumonectomy	30,000			
238	Thoracoscopic Segmental Resection	25,000			
239	Thoracoscopic Sympathectomy	15,000			
240	Thrombendarterectomy	15,000			
241	Thorax (penetrating wounds)	12,500			
242	Total Thyroidectomy and Block Dissection	20,000			
243	Trendelenburg Operation	10,000			

244	Debridement of Ulcer-Leprosy	5,000			
245	Tissue Reconstruction Flap Leprosy	25,000			
246	Tendon Transfer-Leprosy	25,000			
247	Adhenolysis + Appendicectomy	20,000			
248	Hernia - Repair & release of obstruction+ Hernioplasty	20,000			
249	Aspiration of cold Abscess of Lymphnode	3,000			
250	Aspiration of Empyema	2,000			
251	AV Shunt for dialysis	6,000			
252	Peritoneal dialysis per sitting	2,000			
253	Vasectomy	2500			

XI. NEUROSURGERY

Total no: of packages: 82
No: of packages mandated for pre-authorization: 29
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Selective packages
Pre-authorization remarks: Specific Pre and Post-op Investigations such as pre/ post-op X-ray, neuro-diagnostic studies, post-operative clinical photographs showing scars etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

S. No	**Procedure Name**	**Rates (INR)**	**Pre-op Investigations for approval**	**Post-op Investigations/ Evidence for approval of claim**	**Minimum Number of Days Admission (Including Days in**

					intensive care units)
1	Anterior Encephalocele	50,000			8
2	Burr hole	7,000			2
3	Burr hole with chronic Sub Dural Haematoma (including pre and post Op. CT)	20,000			
4	Carpal Tunnel Release including pre and post Op. MRI	10,000			3
5	Cervical Ribs – Bilateral	35,000			7
6	Cervical Ribs – Unilateral	20,000			5
7	CranioPlasty - Endogenous graft	20,000	CT Brain	CT + Clinical photograph showing scar	7
8	CranioPlasty - Exogenous graft	20,000+ cost of implant	CT Brain	CT + Clinical photograph showing scar	7
9	Craniostenosis	28,000			7
10	Duroplasty - Endogenous	12,500			5
11	Duroplasty - Exogenous	12,500+ implant cost			5
12	Haematoma - Brain (head injuries) (including pre and post Op. CT)	55,000			8
13	Haematoma - Brain (hypertensive)	50,000			8
14	Haematoma (Child subdural) inclusive of General anaesthesia, pre and post Op. CT	50,000			10
15	Laminectomy with Fusion and fixation	50,000			
16	Laminectomy with Fusion	40,000			6
17	Local Neurectomy	16,000			5
18	Lumbar Disc including pre and post Op. MRI	30,000			5
19	Meningocele – Anterior	36,000	Brain and spinal cord MRI	X-Ray/ Post.op scar	10 (2 day ICU stay)
20	Meningocele – Lumbar	36000	Brain and spinal cord MRI	X-Ray/ Post.op scar	10 (2 day ICU stay)
21	Meningococcal – Occipital	50,000			10

22	Micro discectomy – Cervical	40,000			10
23	Micro discectomy – Lumbar	40,000			10
24	Brachial Plexus – Repair	27,000			7
25	Shunt (peritoneal, ventriculo-atrial/ peritoneal, theco peritoneal)	30,000			7
26	Skull Traction	8,000			4
27	Spine - Canal Stenosis	40,000			6
28	Spine - Decompression & Fusion	40,000			6
29	Spine - Decompression & Fusion with fixation	50,000			
30	Spine - Extradural Tumour	30,000			7
31	Spine - Extradural Tumour with fixation	40,000			
32	Spine - Extradural Haematoma	30,000			7
33	Spine - Extradural Haematoma with fixation	40,000			
34	Spine - Intradural Tumour	40,000			7
35	Spine - Intradural Tumour with fixation	50,000			
36	Spine - Intradural Haematoma	40,000			7
37	Spine - Intradural Haematoma with fixation	50,000			
38	Spine - Intramedullar Tumour	50,000			7
39	Spine - Intramedullar Tumour - fixation	60,000			
40	Trans Sphenoidal including pre and post Op. MRI	50,000			6
41	Tumours – Supratentorial	50,000	CT	CT + Histopathological report	7
42	Tumours Meninges – Gocussa	50,000	CT	CT + Histopathological report	7
43	Tumours Meninges – Posterior	50,000	CT	CT + Histopathological report	7
44	Ventricular Puncture	15,000			3
45	Brain Biopsy	15,000			3
46	Cranial Nerve Anastomosis	32,000			5
47	Depressed Fracture	40,000			7
48	Nerve Biopsy excluding Hensens	7,000			2
49	Peripheral Neurectomy (Trigeminal)	16,500			5
50	R.F. Lesion for Trigeminal Neuralgia	16,500			3

51	Twist Drill Craniostomy	15,000			2
52	Excision of Brain TumorSupratentorial-Parasagital	50,000	CT	CT + Histopathological report	10
53	Excision of Brain TumorSupratentorial-Basal	50,000	CT	CT + Histopathological report	10
54	Excision of Brain TumorSupratentorial-Brainstem	50,000	CT	CT + Histopathological report	10
55	Excision of Brain TumorSupratentorial-C P Angle	50,000	CT	CT + Histopathological report	10
56	Excision of Brain TumorSupratentorial& others	55,000	CT	CT + Histopathological report	10
57	Abscess Tapping single	20,000			7
58	Abscess Tapping multiple	30,000			7
59	Excision of Brain Abscess	36,000	CT Brain	CT + Clinical photograph showing scar	
60	Aneurysm Clipping including angiogram	65,000 + 15,000 each additional clip	MRA/ DSA report	CT/ X-RAY + clinical photograph showing scar	12
61	External Ventricular Drainage (EVD) including antibiotics	30,000	CT Brain	Post.op CT + Clinical photograph showing scar	
62	Spinal Fusion Procedure with implant	40,000	MRI	Post.op X-RAY	
63	Spina Bifida Surgery	36,000			10
64	Stereotactic Lesioning	60,000	CT/ MRI brain	CT/ MRI brain + Clinical photograph showing scar	
65	Posterior Cervical Discetomy without implant	30,000			
66	Posterior Cervical Fusion with implant (Lateral mass fixation)	50,000	MRI spine	X-RAY cervical spine + clinical photograph showing scar	
67	Cervical Disc Multiple level without Fusion	40,000	MRI spine	X-RAY cervical spine + clinical photograph showing scar	

68	Thoracic/Lumbar Corpectomy with fusion inclusive of implant	60,000	CT/ MRI	Clinical photograph showing scar + X-RAY	
69	Transoral surgery (Anterior) and CV Junction (Posterior Sterlization)	55,000+ cost of implant	MRI spine + X-RAY	Post.op MRI + X-RAY	12 (2 day ICU stay)
70	Trans oral Surgery	40,000			
71	Foramen Magnum Decompression	45,000			
72	Endoscopic CSF Rhinorrhea Repair	30,000+ cost of glue			
73	Muscle Biopsy with report	7,000			
74	Nerve Decompression	16,000			
75	Peripheral Nerve Surgery Major	30,000	Neuro-diagnostic studies (NCV/ EMG)	Clinical photograph showing scar	5
76	Peripheral Nerve Surgery Minor	15,000	Neuro-diagnostic studies (NCV/ EMG)	Clinical photograph showing scar	3
77	Epilepsy Surgery	50,000	CT/ MRI + Neuro-diagnostic studies (EEG)	CT + Clinical photograph showing scar	
78	Arterio venous malformation (AVM) excision (whatever size and location)	50000	MRA/ DSA report	X-RAY + Clinical photograph showing scar	
79	Scalp Arterio venous malformation (AVM)	25,000	CT/ MRI	Histopathological report + Clinical photograph showing scar	
80	Superficial Temporal Artery (STA): middle cerebral artery (MCA) or (other EC - IC) Bypass procedure	60,000	MRA/ DSA report	X-RAY + Clinical photograph showing scar	
81	Excision of Orbital Tumour	40,000	CT/ MRI	CT + Histopathological report + Clinical photograph showing scar	
82	Gamma Knife radiosurgery (GKRS)/ SRS for tumours/ Arteriovenous malformation (AVM)	75,000	CT/ MRI	Clinical photographs	

XII. INTERVENTIONAL NEURORADIOLOGY

Total no: of packages: 12
No: of packages mandated for pre-authorization: 12
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Specific Pre and Post-op Investigations such as pre/ post-op X-ray, CT/ ultrasound report, pre and post-op blood tests, post op clinical photographs with scar etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Coil embolization for aneurysms (includes cost of first 3 coils + balloon and/ or stent if used) 1 to 20 coils may be required as per need.	1,00,000			
		Additional coil – 24,000 per coil			
2	Dural AVMs/AVFs (per sitting) with glue	70,000			
3	Dural AVMs/AVFs (per sitting) with onyx	1,50,000			
4	Carotico-cavernous Fistula (CCF) embolization with coils. [includes 5 coils, guide catheter, micro-catheter, micro-guidewire, general items]	1,50,000			
5	Carotid-cavernous Fistula (CCF) embolization with balloon (includes one balloon, guide catheter, micro-catheter, micro-guidewire, general items)	75,000			
6	Cerebral & Spinal AVM embolization (per sitting). Using Histoacryl	1,00,000			
7	Parent vessel occlusion	Basic – 30,000			

		Additional coil (cost per coil) – 24,000			
		Additional balloon (cost per balloon) – 11,000			
8	Balloon test occlusion	70,000			
9	Intracranial balloon angioplasty with stenting	1,60,000			
10	Intracranial thrombolysis / clot retrieval	1,60,000			
11	Pre-operative tumour embolization (per session)	40,000			
12	Vertebroplasty	40,000			

XIII. PLASTIC & RECONSTRUCTIVE SURGERY

Total no: of packages: 9

No: of packages mandated for pre-authorization: 9

Empanelment classification: Advanced criteria

Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.

Pre-authorization: Mandatory for all packages

Pre-authorization remarks: Specific Pre and Post-op Investigations such as clinical and/or relevant imaging photographs of the patient are essential.

- In case of emergency/life-saving/ limb saving operative procedures, preauthorization may not be required. However, formal intimation should be done within 24 hours of admission.
- Procedures are predominantly available only in Specialty care centres across India

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in

					intensive care units)
1	Ear Pinna Reconstruction with costal cartilage/ Prosthesis (including the cost of prosthesis/implants). *If requiring multiple stages, each stage will cost Rs. 30,000 provided the operating surgeon demonstrates the photographic results of previous stages.	30,000			5
2	Revascularization of limb/digit	25,000			5
3	Hemangioma – Sclerotherapy (under GA)	35,000			3
4	Hemangioma – Debulking/ Excision	35,000			4
5	Tissue Expander for disfigurement following burns/ trauma/ congenital deformity (including cost of expander / implant)	50,000			5
6	Scalp avulsion reconstruction	50,000			5
7	NPWT (Inpatient only)	2,000/day			3
8	Pressure Sore – Surgery	30,000			3
9	Diabetic Foot – Surgery	30,000			3

XIV. BURNS MANAGEMENT

Total no: of packages: 12
No: of packages mandated for pre-authorization: 12 (no. 11 & 12 needs pre-auth to initiate treatment, for the rest documentation could be retrospectively sent)
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Specific Pre and Post-op Investigations such as clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns at the time of admission and follow up clinical photographs on days 5, 10, 15, 20 as per requirements on the basis of pre-authorization would need to be submitted during claims.

- Admission Criteria to be followed for selecting packages for burn injured patients:

1. Second- and third-degree burns greater than 10% of the total body surface area in patients under 10 or over 60 years of age
2. Second- and third-degree burns greater than 20% of the total body surface area in other age groups
3. Significant burns of face, hands, feet, genitalia, or perineum and those that involve skin overlying major joints
4. Third-degree burns greater than 5% of the total body surface area in any age group
5. Inhalation injury
6. Significant electric injury including lightning injury
7. Significant chemical injury
8. Burns with significant pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality (e.g. diabetes mellitus, cardiopulmonary disease)
9. Burns with significant concomitant trauma
10. Burn injury in patients who will require special social and emotional or long-term rehabilitative support, including cases of suspected child abuse and neglect.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	**% Total Body Surface Area Burns (TBSA) (thermal/ scald/ flame burns) - any %** (not requiring admission). Needs at least 5-6 dressing	7,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	D
2	**% Total Body Surface Area Burns (TBSA) (thermal/ scald/ flame burns): Upto 40 %;** Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	40,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
3	**% Total Body Surface Area Burns (TBSA) (thermal/ scald/ flame burns): 40 % - 60 %;** Includes % TBSA skin grafted, flap cover,	50,000	Clinical photograph and diagram with	Clinical photograph	Moderate to severe burns need initial ICU

	follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.		Rule of 9/ L & B Chart for extent of burns		stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
4	**% Total Body Surface Area Burns (TBSA) (thermal/ scald/ flame burns): > 60 %;** Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	80,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
5	**Electrical contact burns: Low voltage- without part of limb/limb loss**; Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	30,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
6	**Electrical contact burns: Low voltage- with part of limb/limb loss**; Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	40,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
7	**Electrical contact burns: High voltage- without part of limb/limb loss**; Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	50,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
8	**Electrical contact burns: High voltage- with part of limb/limb loss**; Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	60,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with

					alternate day dressings
9	**Chemical burns: Without significant facial scarring and/or loss of function**; Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	40,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
10	**Chemical burns: With significant facial scarring and/or loss of function**; Includes % TBSA skin grafted, flap cover, follow-up dressings etc. as deemed necessary; Surgical procedures are required for deep burns that are not amenable to heal with dressings alone.	60,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	Moderate to severe burns need initial ICU stay ranging from 2 – 5 days and then 10 - 14 days of ward stay with alternate day dressings
11	**Post Burn Contracture surgeries for Functional Improvement (Package including splints, pressure garments, silicone-gel sheet and physiotherapy): Excluding Neck contracture**; Contracture release with - Split thickness Skin Graft (STSG) / Full Thickness Skin Graft (FTSG)/ Flap cover is done for each joint with post-operative regular dressings for STSG / FTSG / Flap cover.	50,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	
12	**Post Burn Contracture surgeries for Functional Improvement (Package including splints, pressure garments, silicone-gel sheet and physiotherapy): Neck contracture**; Contracture release with - Split thickness Skin Graft (STSG) / Full Thickness Skin Graft (FTSG)/ Flap cover is done for each joint with post-operative regular dressings for STSG / FTSG / Flap cover.	50,000	Clinical photograph and diagram with Rule of 9/ L & B Chart for extent of burns	Clinical photograph	

XV. ORAL AND MAXILLOFACIAL SURGERY

Total no: of packages: 9

No: of packages mandated for pre-authorization: 9

Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Required

- For Paediatric patients if general anaesthesia is required then Rs.400 extra

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Fixation of fracture of jaw with closed reduction (1 jaw) using wires - under LA	5,000			D
2	Fixation of fracture of jaw with open reduction (1 jaw) and fixing of plates/ wire – under GA	12,000			1
3	Sequestrectomy	1,500			D
4	TM joint ankylosis of both jaws - under GA	15,000			5
5	Release of fibrous bands & grafting -in (OSMF) treatment under GA	3,000			2
6	Extraction of impacted tooth under LA	500			D
7	Cyst & tumour of Maxilla/mandible by enucleation/excision/marsupialization under LA	2,500			D
8	Mandible Tumour Resection and reconstruction/Cancer surgery	6,000			3
9	Cleft lip and palate surgery	15,000 for each stage			3

XVI. PEDIATRICS MEDICAL CARE PACKAGES

Total no: of packages: 100
No: of packages mandated for pre-authorization: 100 (extensions only)

- Separate package for high end radiological diagnostic (CT, MRI, Imaging including nuclear imaging,) relevant to the illness only (no standalone diagnostics allowed) - subject to pre-authorization with a cap of Rs 5000 per family per annum within overall sum insured.

- Separate package for high end histopathology (Biopsies) and advanced serology investigations relevant to the illness only after pre-authorization with a cap of Rs 5000 per family per annum within overall sum insured.
- Blood or Blood components transfusion if required, payable separately subject to pre-authorization. Blood can be procured only through licensed blood banks as per National Blood Transfusion Council Guidelines.
- If a medical condition requiring hospitalization has not been envisaged under this list then a pre-authorisation can be sought as "Unspecified Medical"

Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network. Minimum criteria to elaborate on the specification of beds under various categories of admission (namely Routine ward, HDU and ICU).
Pre-authorization: Mandatory for all packages for progressive extension of treatment/ hospital stay
Pre-authorization remarks: Prior approval must be taken for all medical conditions/ packages under this domain for progressive extension of therapeutic treatments (i.e. for extending stay at 1,5,10 days stay and beyond)

- All clinical test reports, diagnosis, TPR charting, case sheet/ clinical notes and discharge summary need to be submitted for extension of packages and during claims submission.
- Legend of bed day charges:

Admission Type	Per day rate (NABH)	Per day rate (non-NABH)
Routine ward	Rs 2,000/ day	Rs 1,800/ day
HDU	Rs 3,000/ day	Rs 2,700/ day
ICU (no ventilation)	Rs 4,000/ day	Rs 3,600/ day
ICU (ventilation support)	Rs 5,000/ day	Rs 4,500/ day

S.No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
	Common illnesses with or without underlying disease				
1	Diarrhoea				

2	Acute dysentery	Rs 2000 per day (up to a limit of 1 day after which pre-authorization needs to be sought up to a limit of 5 days)			
3	Pneumonia				5
4	Urinary tract infection				
5	Acute Exacerbation of asthma				
6	Acute glomerulonephritis				5
7	Acute urticaria/ Anaphylaxis acute asthma				
8	Poisonings with normal vital signs				
9	Febrile seizures/other seizures				
10	Epileptic encephalopathy				
11	Optic neuritis				5
12	Aseptic meningitis				
13	Trauma		Severity to be checked		
Common illnesses with or without underlying disease					
14	Pyrexia of unexplained origin	Rs 2,000 per day (pre-authorization needs to be sought to continue package beyond 2 and 5 day intervals - up to a limit of 10 days).			
15	Chronic cough				D
16	Wheezing				
17	Unexplained seizures				D
18	Global developmental delay/ Intellectual disability of unknown etiology				D
19	Dysmorphic children				D
20	Rickets				D
21	Unexplained severe anemia				
22	Short stature				D
23	Musculoskeletal problems				D
24	Developmental and behavioral disorders				D
Conditions that might require extended stay					
25	Diabetic ketoacidosis	Rs 2,000 per day (pre-authorization needs to be sought to continue package beyond 5 and 10 day			
26	Nephrotic syndrome with peritonitis				
27	Pyogenic meningitis				
28	Persistent/ Chronic diarrhea				
29	Acute severe malnutrition				

30	Dengue	intervals) Note: If shifted to HDU/ ICU, suitable rates would need to be applied and pre-authorization be sought.			
31	Enteric fever				
32	Chikungunya				
33	Acute hepatitis				
34	Kala azar				
35	Tuberculosis				
36	HIV with complications				
37	Infantile cholestasis				
38	Haemolytic uremic syndrome				
39	ITP				
40	Juvenile myasthenia				
41	Kawasaki Disease				
42	Persistent pneumonia				
43	Empyema				
44	Immune haemolytic anemia				
45	Cyanotic spells				
46	Rheumatic fever				
47	Rheumatoid arthritis				
48	Encephalitis				10-15 DAYS
49	Chronic meningitis				10-15 DAYS
50	Intracranial ring enhancing lesion with complication (neurocysticercosis, tuberculoma)				
51	Refractory seizures				
52	Floppy infant				
53	Acute neuroregression				
54	Neuromuscular disorders				
55	Opsoclonus myoclonus syndrome				
56	Acute ataxia				
57	Steven Johnson syndrome				
58	Metabolic encephalopathy				
59	Ketogenic diet initiation in refractory epilepsy				
60	Inborn errors of metabolism				

61	Wilson's disease				
62	Celiac disease				
63	Unexplained jaundice				
64	Unexplained hepatosplenomegaly				
Serious conditions that might require admission in High Dependency Unit (HDU) - Patients sick with unstable vitals, faced with life threatening conditions, but not requiring ventilator support					
65	Severe pneumonia	Rs 4,000 per day (advised to take pre-authorization beyond 1 day - up to a limit of 5 days) Note: If shifted to routine ward/ ICU, suitable rates would need to be applied and pre-authorization be sought. Extend stay beyond 5 and 10 days as required with pre-authorization			
66	Severe exacerbation of asthma				
67	Acute kidney injury				
68	Poisonings				
69	Serious trauma with unstable vitals				
70	Upper GI hemorrhage				
71	Lower GI hemorrhage				
72	Acute abdomen				
73	Liver abscess				
74	Complicated malaria				
75	Severe dengue with shock				
76	Congestive cardiac failure				
77	Brain abscess				
78	Acute encephalitic syndrome				
79	Acute demyelinating myelopathy,				
80	Immune mediated CNS disorders such as autoimmune encephalitis				
81	Acute transverse myelitis				
82	Guillain Barre Syndrome				
83	Hydrocephalus				
84	Intracranial space occupying lesion				
85	Cerebral malaria				
86	Acute ischemic stroke				
87	Cerebral sino-venous thrombosis				
Critical conditions that might require admission in Intensive Care Unit (ICU) - Patients sick with unstable vitals, faced with life threatening conditions, requiring ventilator support					

88	Respiratory failure due to any causes (pneumonia, asthma, foreign body, poisoning, head injury etc.)	Rs 4,000 per day in the case of no ventilation support and Rs 5,000 per day in the case of ventilation support required (advised to take pre-authorization beyond 1 day - up to a limit of 5 days) Note: If shifted to routine ward/ HDU, suitable rates would need to be applied and pre-authorization be sought. Extend stay beyond 5 and 10 days as required with pre-authorization.			
89	Acute transverse myelitis				
90	Acute encephalitis –infectious/immune-mediated				
91	Convulsive & non convulsive status epilepticus				
92	Cerebral herniation				
93	Intracranial hemorrhage				
94	Hepatic encephalopathy				
95	Complicated bacterial meningitis				
96	Raised intracranial pressure				
97	Hypertensive encephalopathy				
98	CRRT (pre-auth)	8,000 per session			
99	Blood and blood component transfusion (admission for a diagnostic procedure leading to treatment requiring admission, e.g. bone marrow and bone biopsy, endoscopy, liver biopsy, bronchoscopy, CT/MRI under GA, broncho-alveolar lavage, lumbar puncture, muscle biopsy, FNAC, pleural aspiration, ascitic tapping, neostigmine challenge test etc.)	Rs 1,500 per day (up to a limit of 2 days) - needs mandatory pre-authorization			
100	Blood and blood component transfusion for indications like Thalassemia/Hemoglobinopathies-	Rs 1,500 per day (up to a limit of 2 days) -			

		needs mandatory pre-authorization			

XVII. NEO-NATAL PACKAGES

Total no: of packages: 10

No: of packages mandated for pre-authorization: 10

- Packages would include neonates up to age of 28 days after birth. However, for infants born preterm (<37 weeks), the age limit extends to postmenstrual age (period after the first day of last menstrual period) of 44 weeks OR body weight up to 3 kg
- All the packages are inclusive of everything including drugs, diagnostics, consultations, procedures, treatment modalities that the baby would require for its management
- In case a baby in a lower cost package develops a complication requiring higher level of care, the baby should be moved for higher cost package
- For packages 2, 3, 4 and 5, mother's stay and food in the hospital [postnatal ward/special ward for such mothers] for breastfeeding, family centred care and KMC (Kangaroo Mother Care) is mandatory. In packages 2, 3, 4 and 5 mothers should be allotted KMC bed when the newborn is eligible for Kangaroo mother care. The cost of bare bed and food to the mother is included. If the mother requires treatment for her own illnesses, it would be covered under the mother's packages.
- It is MANDATORY to ensure that the neonate receives vaccination as per NATIONAL IMMUNIZATION SCHEDULE before discharge

Empanelment classification: Advanced criteria

Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.

Pre-authorization: Mandatory for Special, Advanced (and needing surfactant therapy) and Critical Neonatal packages and for progressive extension of treatment/ hospital stay/ shifting across packages.

Pre-authorization remarks: Prior approval must be taken for progressive extension of therapeutic treatments (i.e. for extending stay beyond the prescribed limit/ in cases which might need shifting of packages based on clinical vitals and need - then the previously blocked package needs to be unblocked and the total amount of new package needs to be considered to be debited).

- All clinical test reports, diagnosis, TPR charting, case sheet/ clinical notes and discharge summary need to be submitted for extension of packages and during claims submission.

S.No	Procedure Name	Package Criteria	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Basic neonatal care package (Co-bedded with mother) (The mother must be kept in the hospital until the baby is discharged. She is provided a bed and food)	Babies that can be managed by side of mother in postnatal ward without requiring admission in SNCU/NICU: • Any newborn needing feeding support • Babies requiring closer monitoring or short-term care for conditions like: o Birth asphyxia (need for positive pressure ventilation; no HIE) o Moderate jaundice requiring phototherapy o Large for dates (>97 percentile) Babies o Small for gestational age (less than 3rd centile)	Rs.500 per day (maximum Rs.1500)			Less than 5 days
2	Special Neonatal Care Package (Babies that required admission to SNCU or NICU	Babies admitted for short term care for conditions like: • Mild Respiratory Distress/tachypnea • Mild encephalopathy • Severe jaundice requiring intensive phototherapy • Haemorrhagic disease of newborn • Unwell baby requiring monitoring • Some dehydration	Rs. 3000/day (maximum of Rs18,000) (Pre-authorization is needed after 4 days)			Less than 7 days

		• Hypoglycaemia **Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory and included in the package rate**				
3	Intensive Neonatal Care Package	Babies with birthweight 1500-1799 g or Babies of any birthweight and at least one of the following conditions: • Need for mechanical ventilation for less than 24 hours or non-invasive respiratory support (CPAP, HFFNC) • Sepsis / pneumonia without complications • Hyperbilirubinemia requiring exchange transfusion • Seizures • Major congenital malformations (pre-surgical stabilization, not requiring ventilation) • Cholestasis significant enough requiring work up and in-hospital management • Congestive heart failure or shock	Rs. 5,000/day (Maximum of Rs. 50,000) Pre-authorization is needed after 5 days			7 to 14 days

		Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory and included in the package rate				
4	Advanced Neonatal Care Package	Babies with birthweight of 1200-1499 g or Babies of any birthweight with at least one of the following conditions: • Any condition requiring invasive ventilation longer than 24 hours • Hypoxic Ischemic encephalopathy requiring Therapeutic Hypothermia • Cardiac rhythm disorders needing intervention (the cost of cardiac surgery or implant will be covered under cardiac surgery packages) • Sepsis with complications such as meningitis or bone and joint infection, DIC or shock • Renal failure requiring dialysis • Inborn errors of metabolism **Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory and included in the package rate**	Rs. 6,000/day (Maximum of Rs 75,000) Pre-authorization is needed after 7 days			14 to 21 days
5	Critical Care Neonatal Package	Babies with birthweight of <1200 g or Babies of any birthweight with at least one of the following conditions:	Rs. 7,000/day with (Maximum of Rs 1,20,000)			21 to 42 days

		• Severe Respiratory Failure requiring High Frequency Ventilation or inhaled Nitric Oxide (iNO) • Multisystem failure requiring multiple organ support including mechanical ventilation and multiple inotropes • Critical congenital heart disease **Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory and included in the package rate**	Pre-authorization after 10 days			
Add-on Packages **(Preauthorization is required unless there is a genuine emergency such as need for laparotomy for advanced NEC)**						
Medical Packages						
6	Chronic Care Package-	• If the baby requires stay beyond the upper limit of usual stay in Package no 4 or 5 for conditions like severe BPD requiring respiratory support, severe NEC requiring prolonged TPN support	Rs 3000 per day beyond the usual stay (Maximum of Rs 30,000)			
7	High Risk Newborn Post Discharge Care Package (Pre-authorized, Protocol Driven)	• ROP screening • Developmental assessment • Thyroid Screening • Hearing screening • Early intervention • Nutritional counselling Note-Blood transfusion can be given as an	Rs.2400			(for 4 sessions)

		add on package if indicated				
Neonatal Surgical						
8		Laser Therapy for Retinopathy of Prematurity	Rs.1500 per session (Irrespective of no. of eyes affected)			
9		Advanced Surgery for Retinopathy of Prematurity	Rs. 15,000			
10		Ventriculoperitoneal Shunt Surgery (VP) or Omaya Reservoir or External Drainage for Hydrocephalus	Rs.5,000			
	Other Neonatal Surgeries (The surgical packages are add-on to the neonatal packages)		Add on as specified in paediatric surgical packages and Cardiothoracic Packages			

<u>Package Related Management Guidelines</u>

Note: The investigations and treatment guidelines are to be done only if clinical condition warrants them

S.No	**Package Category**	**Package Criteria**	**Investigations**	**Treatment**
1	Basic neonatal care package	Babies that can be managed by side of mother in postnatal ward without requiring admission in SNCU/NICU:	Blood sugar Complete Blood	Monitoring Breastfeeding

	(Co-bedded with mother)	• Any newborn needing feeding support
		• Babies requiring closer monitoring or short-term care for conditions like:
		  ○ Birth asphyxia (need for positive pressure ventilation; no HIE)
		  ○ Moderate jaundice requiring phototherapy
		  ○ Large for dates (>97 percentile) Babies
		  ○ Small for gestational age (less than 3rd centile)
			Counts
			Blood group
			Bilirubin
			Coombs Test
			Others as required
				Support
				Spoon Feeds
				Phototherapy

2	Special Neonatal Care Package (Babies that required admission to SNCU or NICU	Babies admitted for short term care for conditions like: • Mild Respiratory Distress/tachypnea • Mild encephalopathy • Severe jaundice requiring intensive phototherapy • Haemorrhagic disease of newborn • Unwell baby requiring monitoring • Some dehydration • Hypoglycaemia Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory	Blood sugar Complete Blood Picture Blood group Bilirubin Coombs Test Chest X ray CRP Micro ESR Blood Culture Electrolytes Renal function tests Coagulation profile Others as required	Monitoring Breastfeeding Support Spoon Feeds Gavage Feeds Intensive Phototherapy *Oxygen* *Intravenous Fluids* *Antibiotics* *Blood Products*
3	Intensive Neonatal Care Package	Babies with birthweight 1500-1799 g or Babies of any birthweight and at least one of the following conditions: • Need for mechanical ventilation for less than 24 hours	Blood sugar Complete Blood Counts Blood group Bilirubin	Monitoring Breastfeeding Support Spoon Feeds Gavage Feeds

		or non-invasive respiratory support (CPAP, HFFNC) • Sepsis / pneumonia without complications • Hyperbilirubinemia requiring exchange transfusion • Seizures • Major congenital malformations (pre-surgical stabilization, not requiring ventilation) • Cholestasis significant enough requiring work up and in-hospital management • Congestive heart failure or shock Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory	Coombs Test Chest X ray Blood Gas CRP Micro ESR Blood Culture CSF Studies Electrolytes Renal function tests Liver Function tests Serum Calcium Serum Magnesium USG abdomen USG Cranium Echocardiogram EEG MRI Brain Coagulation profile Others as required Screening	Phototherapy Oxygen Intravenous Fluids Antibiotics Blood Products *Mechanical Ventilation* *CPAP* *NIMV* *HHFNC* *Surfactant* *Exchange Transfusion* *Inotropes* *Anti-congestives* *Anti-convulsants*
4	Advanced Neonatal Care Package	Babies with birthweight of 1200-1499 g or Babies of any birthweight with at least one of the following conditions: • Any condition requiring invasive ventilation longer than 24 hours	Blood sugar Complete Blood Counts Blood group Bilirubin Coombs Test	Monitoring Breastfeeding Support Spoon Feeds Gavage feeds Phototherapy

		• Hypoxic Ischemic encephalopathy requiring Therapeutic Hypothermia • Cardiac rhythm disorders needing intervention (the cost of cardiac surgery or implant will be covered under cardiac surgery packages) • Necrotising enterocolitis 2 A and above • Sepsis with complications such as meningitis or bone and joint infection, DIC or shock • Renal failure requiring dialysis • Inborn errors of metabolism Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory	Chest X ray Other X-rays Blood Gas CRP Micro ESR Blood Culture CSF studies Other Body Fluid Cultures Electrolytes Renal function tests Liver Function tests Serum Calcium Serum Magnesium USG abdomen USG Cranium Echocardiogram EEG ECG MRI Brain Coagulation profile Metabolic Screen Others as required Screening	Oxygen Intravenous Fluids Antibiotics Blood Products *Mechanical Ventilation* *CPAP* *NIMV* *HHFNC* *Surfactant* *Exchange Transfusion* *Inotropes* *Anti-Congestives* *Anti-convulsants* *Therapeutic Hypothermia* *Peritoneal Dialysis* *Glove Drain* *TPN*
5	Critical Care Neonatal Package	Babies with birthweight of <1200 g or	Blood sugar Complete Blood	Invasive Monitoring

		Babies of any birthweight with at least one of the following conditions: • Severe Respiratory Failure requiring High Frequency Ventilation or inhaled Nitric Oxide (iNO) • Multisystem failure requiring multiple organ support including mechanical ventilation and multiple inotropes • Critical congenital heart disease Mother's stay and food in the hospital for breastfeeding, family centred care and (Kangaroo Mother Care) KMC is mandatory	Counts Blood group Bilirubin Coombs Test Chest X ray Other X-rays Blood Gas CRP Micro ESR Blood Culture CSF studies Other Body Fluid Cultures Electrolytes Renal function tests Liver Function tests Serum Calcium Serum Magnesium USG abdomen USG Cranium Echocardiogram EEG ECG MRI Brain Coagulation profile Metabolic Screen Others as	Breastfeeding Support Spoon Feeds Gavage Feeds Phototherapy Oxygen Intravenous Fluids Antibiotics Blood Products *Mechanical Ventilation* *CPAP* *NIMV* *HHFNC* *Surfactant* *Exchange Transfusion* *Inotropes* *Anti-congestives* *Anti-convulsants* *Therapeutic Hypothermia* *Peritoneal Dialysis* *Glove Drain* *TPN* *PGE1* *Inhaled Nitric Oxide* *HFO*

			required Screening	
	Add-on Packages (Preauthorization is required unless there is a genuine emergency such as need for laparotomy for advanced NEC)			
	Medical Packages			
6	Chronic Care Package	• If the baby requires stay beyond the upper limit of usual stay in Package no 4 or 5 for conditions like severe BPD requiring respiratory support, severe NEC requiring prolonged TPN support		
7	High Risk Newborn Post Discharge Care Package (Pre-authorized, Protocol Driven)	• ROP screening • Developmental assessment • Thyroid Screening • Hearing screening • Early intervention • Nutritional counselling		
	Neonatal Surgical			
8		Laser Therapy for Retinopathy of Prematurity		
9		Advanced Surgery for Retinopathy of Prematurity		
10		Ventriculoperitoneal Shunt Surgery (VP) or Omaya Reservoir or External Drainage for Hydrocephalus		

XVIII. PEDIATRIC CANCER

Total no: of packages: 12
No: of packages mandated for pre-authorization: 12
Empanelment classification: Advanced criteria

Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.

Pre-authorization: Mandatory for all packages

Pre-authorization remarks: Prior approval must be taken for all treatments/ malignancies.

- The type and duration of treatment is different for all cancers. It is very important to complete the entire treatment which may in some cases last for up to 3 years. For certain cancers like Chronic Myeloid Leukemia (CML) the treatment is lifelong.
- Cancer care treatments are advised to go through a clinical treatment approval process before initiating the best suitable treatment. A clinical treatment approval process is mandated for cancer care, since it involves a multi-modal approach covering surgical, chemotherapy and radiation treatments and appropriate supportive care that could assess to determine the best course of patient management for such conditions.
- There should be pre-authorization at each step for cancer care treatments. It is prescribed that decision regarding appropriate patient care for cancer care treatments should be taken by a multidisciplinary tumor board for tumors requiring multimodal treatment (if available within the treating hospital or if not then it could be sent to the nearest regional cancer centre (RCC) for approval) that should include a highly trained team of Surgical, Radiation and Medical/ Pediatric Oncologist in order to ensure the most appropriate treatment for the patient. A detailed Oncology Treatment Plan Approval form is annexed. This could prove to be very vital for the target group in focus based on factors other than age alone, such as implications on the financial cover and to avoid unnecessary treatments. Further the design of the package and its step-wise approach also reflects the same.
- Relapse/recurrence may sometimes occur during/ after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/ Pediatric Oncologist/ tumor board with prior approval and pre authorization of treatment.
- Chemotherapy is given per weight (body surface area). Clinical treatment approval/ pre authorization and communication is necessary to ensure each child receives the recommended dose of medicines. Under or over dosing is dangerous. So, dosing will differ in young children and older children.
- Only in Specialty care hospitals.

S.No	Name of Cancer	Chemotherapy (including Diagnostics)			Radiation	Surgery	Supportive care/ rehabilitation	Total permissible treatment scenario
		Induction	Consolidation	Maintenance				

								rates (INR)
1	Acute lymphoblastic leukemia	55,000	35,000	15,000	5,000	N/A	20,000	1,30,000
2	Acute Myeloid leukemia	55,000	35,000	N/A	N/A	N/A	30,000	1,20,000
3	Hodgkin Lymphoma (Favorable group)	45,000	N/A	N/A	±10,000	N/A	15,000	70,000
4	Hodgkin Lymphoma (Unfavorable Group)	70,000			15,000	N/A	25,000	1,10,000
5	Non Hodgkin Lymphoma	1,00,000			N/A	N/A	50,000	1,50,000
6	Retinoblastoma (Intraocular)	45,000			± 10,000	10,000	20,000	85,000
7	Retinoblastoma (Extraocular)	65,000			10,000	N/A	35,000	110,000
8	Brain Tumors	40,000			30,000	40,000	25,000	1,35,000
9	Wilms tumor	20,000			± 5000	20,000	N/A	45,000
10	Histiocytosis	45,000			N/A	N/A	5,000	50,000
11	Bone tumors/soft tissue sarcomas	80,000			25,000	80,000 including prosthesis	50,000	2,35 ,000
12	Chronic Myeloid Leukemia	80,000			N/A	N/A	20,000	1,00,000

XIX. PEDIATRIC SURGERY

Total no: of packages: 35
No: of packages mandated for pre-authorization: 1
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.

Pre-authorization: Required for 1 package

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Ankyloglossia Major	15,000			
2	Ankyloglossia Minor	5,000			
3	Hernia & Hydrocele	20,000			
4	Sacrococcygeal Teratoma	20,000			
5	Undescended Testis - Bilateral-Palp + Nonpalp	15,000			
6	Undescended Testis - Bilateral Palpable	15,000			
7	Undescended Testis - Bilateral Non-Palpable	20,000			
8	Undescended Testis - Reexploration/ Second Stage	20,000			
9	Undescended Testis - Unilateral-Palpable	15,000			
10	Ano Rectal Malformation - Abd-Perineal PSARP	20,000			
11	Ano Rectal Malformation – Anoplasty	20,000			
12	Ano Rectal Malformation – Cutback	20,000			
13	Ano Rectal Malformation - PSARP	20,000			
14	Ano Rectal Malformation - Redo Pullthrough	15,000			
15	Ano Rectal Malformation - Transposition	15,000			
16	Anti GERD Surgery	10,000			
17	Duplication Cyst Excision	20,000			
18	Fecal Fistula Closure	25,000			
19	Gastrostomy + Esophagoscopy+ Threading	20,000			
20	GI Tumor Excision	30,000			
21	Hirschsprung’s Disease - Myectomy	25,000			
22	Hirschsprung’s Disease - Pull Through	20,000			

23	Hirschsprung's Disease - Retal Biopsy-Punch	10,000			
24	Hirschsprung's Disease - Retal Biopsy –Open	10,000			
25	Hirschsprung's Disease - Sphinecterotomy	15,000			
26	Intussusception - Non –Operative Reduction in infants	20,000			
27	Intussusception – Operative in infants	25,000			
28	Ladds Procedure	30,000			
29	Rectal Polypectomy - Sigmoiescopic (Ga)	8,000			
30	Retro-Peritoneal Lymphangioma Excision	25,000			
31	Congenital Diaphragmatic Hernia	25,000			
32	Congenital Lobar Emphysema	25,000			
33	Exomphalos/gastroschisis	25,000			
34	Cleft Lip and Palate Surgery	15,000 per stage	Yes	Yes	3

XX. MEDICAL PACKAGES

Total no: of packages: 70

No: of packages mandated for pre-authorization: 70 (extensions only)

- Separate package for high end radiologic diagnostic (CT, MRI, Imaging including nuclear imaging,) relevant to the illness only (no standalone diagnostics allowed) - subject to pre-authorization with a cap of Rs 5000 per family per annum within overall sum insured.
- Separate package for high end histopathology (Biopsies) and advanced serology investigations relevant to the illness only (no standalone diagnostics allowed) - after pre-authorization with a cap of Rs 5000 per family per annum within overall sum insured.
- Blood or Blood components transfusion if required, payable separately subject to pre-authorization. Blood can be procured only through licensed blood banks as per National Blood Transfusion Council Guidelines.
- Endoscopy for therapeutic purpose subject to pre-authorization with a cap of Rs.5000 per family per annum
- If a medical condition requiring hospitalization has not been envisaged under this list then a pre-authorisation can be sought as "Unspecified Medical"

Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network. Minimum criteria to elaborate on the specification of beds under various categories of admission (namely Routine ward, HDU and ICU)
Pre-authorization: Mandatory for all packages for progressive extension of treatment/ hospital stay
Pre-authorization remarks: Prior approval must be taken for all medical conditions/ packages under this domain for progressive extension of therapeutic treatments (i.e. for extending stay at 1,5,10 days stay and beyond)

- All clinical test reports, diagnosis, TPR charting, case sheet/ clinical notes and discharge summary need to be submitted for extension of packages and during claims submission.
- Legend of bed day charges:

Admission Type	Per day rate (NABH)	Per day rate (non-NABH)
Routine ward	Rs 2,000/ day	Rs 1,800/ day
HDU	Rs 3,000/ day	Rs 2,700/ day
ICU (no ventilation)	Rs 4,000/ day	Rs 3,600/ day
ICU (ventilation support)	Rs 5,000/ day	Rs 4,500/ day

S.No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)

Common illnesses with or without underlying disease					
1	Acute gastroenteritis with moderate dehydration	Rs 2000 per day (Admission beyond 1 day requires pre-authorization)			
2	Recurrent vomiting with dehydration				
3	Dysentery				
4	Renal colic				
5	Acute bronchitis				
6	Pneumothroax				
7	Accelerated hypertension				
8	Congestive heart failure				
9	Severe anemia				
10	Diabetic ketoacidosis				
11	Acute febrile illness				
12	Acutre excaberation of COPD				
13	UTI				
14	Malaria				
15	Dengue fever				
16	Chikungunya fever				
17	Leptospirosis				
18	Enteric fever				
19	Pneumonia				
20	Acute excaberation of ILD				
21	Liver abscess				
22	Acute viral hepatitis				
23	Snake bite				
24	Acute organophosphorus poisoning				
25	Other poisoning				
26	Pyrexia of unknown origin				

27	Pericardial/ Pleural tuberculosis				
28	Systematic lupus erythematosus				
29	Vasculitis				
30	Seizures				
31	Bacterial/ fungal endocarditis	Rs 2,000 per day (pre-authorization needs to be sought to continue package beyond 5 and 10 day intervals) Note: If shifted to HDU/ ICU, suitable rates would need to be applied and pre-authorization be sought.			
32	Acute inflammatory demyelinating polyneuropathy				
33	Lung abscess/ Empyema				
34	Acute and chronic meningitis				
35	Viral encephalitis				
36	Persistent/ Chronic diarrohea				
37	Acute and chronic pancreatitis				
38	Visceral leishmaniasis				
39	HIV with complications				
40	Neuromuscular disorders				
41	Metabolic encephalopathy				
42	Sickle cell Anemia				
Serious conditions that might require admission in High Dependency Unit (HDU) - Patients sick with unstable vitals, faced with life threatening conditions, but not requiring ventilator support					
43	Poisonings with unstable vitals	Rs 3,000 per day (advised to take pre-authorization beyond 5 day - up to a limit of 10 days and also beyond to continue package) Note: If shifted to routine ward/ ICU, suitable rates would need to be applied and pre-authorization be sought			
44	Type 1/2 respiratory failure				
45	Acute asthmatic attack				
46	Acutre excaberation of COPD				
47	Severe pneumonia				
48	Acute gastroenteritis with severe dehydration				
49	Hypertensive emergencies				
50	Dengue hemorrhagic fever/Dengue shock syndrome				

51	Complicated malaria	If only in general ward then Rs.2000			
52	Heat stroke				
53	Hyperosmolar Non-Ketotic coma				
54	Cerebrovascular accident				
55	Severe sepsis/Septic shock				
56	Upper GI bleeding (conservative)				
57	Upper GI bleeding (endoscopic)				
58	Lower GI hemorrhage				
59	Immune mediated CNS disorders such as autoimmune encephalitis				
60	Acute transverse myelitis				
61	Guillian Barre Syndrome				
62	Hydrocephalus				
63	Cerebral sino-venous thrombosis				
64	AKI/ renal failure(dialysis payable separately as an add on package for)				
Critical conditions that might require admission in Intensive Care Unit (ICU) - Patients sick with unstable vitals, faced with life threatening conditions, requiring ventilator support					
65	Status epilepticus	Rs 4,000 per day in the case no ventilation support and Rs 5,000 per day in the case of ventilation support required (advised to take pre-authorization beyond 5 days for admission up to a limit of 10 days and mandated to again take pre-authorization beyond 10 days) Note: If shifted to routine ward/ ICU, suitable rates would need to be applied and pre-authorization be			
66	Status asthmaticus				
67	Respiratory failure due to any cause (pneumonia, asthma, COPD, ARDS, foreign body, poisoning, head injury etc.)				

		sought			
68	Blood and blood component transfusion (admission for a diagnostic procedure leading to treatment requiring admission, e.g. bone marrow and bone biopsy, endoscopy, liver biopsy, bronchoscopy, CT/MRI under GA, broncho-alveolar lavage, lumbar puncture, muscle biopsy, pleural aspiration, ascitic tapping etc.)	Rs 2,000 per day (up to a limit of 2 days) - needs mandatory pre-authorization			
69	Plasmapheresis (pre-auth)	2,000 per session			
70	Haemodialysis/Peritoneal Dialysis (only for ARF)	2,000 per session			

XXI. ONCOLOGY

Total no: of packages: 112
No: of packages mandated for pre-authorization: 112
Empanelment classification: Advanced criteria
Procedures under this domain need to have specialized infrastructure and HR criteria. In-order to be eligible to provide services under this domain, the provider needs to qualify for advanced criteria as indicated for the corresponding specialty under the empanelment guidelines provided for AB-NHPM provider network.
Pre-authorization: Mandatory for all packages
Pre-authorization remarks: Prior approval must be taken for all treatments/ malignancies.

- The type and duration of treatment is different for all cancers. It is very important to complete the entire treatment which may in some cases last longer than a year. Relapse/recurrence may sometimes occur.
- Cancer care treatments are advised to go through a clinical treatment approval process before initiating the best suitable treatment. A clinical treatment approval process is mandated for cancer care, since it involves a multi-modal approach covering surgical, chemotherapy and radiation treatments and appropriate supportive care that could assess to determine the best course of patient management for such conditions.

- There should be pre-authorization at each step for cancer care.
- However it is advised that decision regarding appropriate patient care for cancer care treatments would need to be taken by a multidisciplinary tumor board (if available within the treating hospital or if not then it could be sent to the nearest regional cancer centre (RCC) for approval) that should include a highly trained team of Surgical, Radiation and Medical Oncologist in order to ensure the most appropriate treatment for the patient. A detailed Oncology Treatment Plan Approval form is annexed. This could prove to be very vital, such as implications on the financial cover and to avoid unnecessary treatments.
- For Radiotherapy, generic packages have been listed irrespective of primary tumor site. However cost of packages may differ depending upon the technique of radiotherapy used like 3DCRT/IMRT/IGRT etc.
- Packages under surgical oncology might not be exhaustive, since there are significant overlaps with packages under other specialty domains. Such packages may be used as deemed necessary.

Radiotherapy:

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Cobalt 60 External Beam Radiotherapy (Radical/Adjuvant / Neoadjuvant)	20,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
2	Cobalt 60 External Beam Radiotherapy (Palliative)	10,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
3	Linear Accelerator External Beam Radiotherapy (Palliative)	20,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
4	Linear Accelerator, External Beam Radiotherapy 3D CRT/2D Planning (Radical/Adjuvant/ Neoadjuvant)	50,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
5	Linear Accelerator, External Beam Radiotherapy IMRT (Intensity Modulated Radiotherapy) (Radical/Adjuvant/Neoadjuvant)	75,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
6	Linear Accelerator External Beam Radiotherapy IGRT (Image Guided radiotherapy) (Radical/Adjuvant/Neoadjuvent)	120,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
7	SRT(Stereotactic radiotherapy)	70,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	

8	SRS (Streotactic radiosurgery)	70,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
9	Respiratory Gating along with Linear Accelerator planning	70,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
10	Electron beam with Linear accelerator (Radical)	50,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
11	Tomotherapy(Radical/Adjuvant/Neoadjuvant)	75,000	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
12	Brachytherapy High Dose Radiation (Intracavitory)	4,500 per fraction (maximum 4 sessions)	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
13	Brachytherapy High Dose Radiation (Interstitial)	30,000 (one application, multiple dose)	Blood test + CT + Biopsy	Data of RT treatment plan & dose	
14	Brachytherapy High Dose Radiation (Intraluminal)	4,500 per fraction (maximum 4 sessions)	Blood test + CT + Biopsy	Data of RT treatment plan & dose	

Surgical Oncology:

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in intensive care units)
1	Tracheal resection	25,000	CECT, Biopsy	Clinical photograph showing scar, HPE report	
2	Sternotomy with superior mediastinal dissection	40,000	CECT, Biopsy	Clinical photograph showing scar, HPE report	
3	Substernal bypass	30,000	Biopsy	Clinical photograph showing scar, HPE	
4	Resection of nasopharyngeal tumour	40,000	Biopsy, CECT/MRI	Clinical photograph showing scar, HPE report	
5	Myocutaneous flap	20,000	Biopsy	Clinical photograph showing scar	
6	Fasciocutaneous flap	15,000	Biopsy	Clinical photograph showing scar	
7	Palatectomy- Soft palate	20,000	Biopsy, CECT/MRI	Clinical photograph showing scar, HPE report	
8	Palatectomy- Hard palate	20,000	Biopsy, CECT/MRI	Clinical photograph showing scar, HPE report	
9	Microvascular reconstruction	45,000	Biopsy	Clinical photograph showing scar	

10	Composite resection	40,000	Biopsy, CECT/MRI	Clinical photograph showing scar, HPE report	
11	Composite resection with reconstruction(excluding microvascular)	60,000	Biopsy, CECT/MRI	Clinical photograph showing scar, HPE report	
12	Neck dissection-selective	12,000	Biopsy/FNAC	Clinical photograph showing scar, HPE report	
13	Neck dissection-comprehensive	16,000	Biopsy/FNAC	Clinical photograph showing scar, HPE report	
14	Total Maxillectomy	18,000	Biopsy, CECT/MRI	Clinical photograph showing scar, HPE report	
15	Radical Maxillectomy	25,000	Biopsy, CECT/MRI	Clinical photograph showing scar, HPE report	
16	Radical parotidectomy	25,000	FNAC, CECT/MRI	Clinical photograph showing scar, HPE report	
17	Partial laryngectomy (voice preserving)	20,000	Biopsy, CECT	Clinical photograph showing scar, HPE report	
18	Voice prosthesis	30,000	Biopsy, CECT	Invoice of prosthesis, scar photo	
19	Total Thyroidectomy with central compartment LN dissection	20,000	FNAC, CECT	Clinical photograph showing scar, HPE report	
20	Total Thyroidectomy with central compartment LN dissection with Lateral LN dissection	25,000	FNAC, CECT	Clinical photograph showing scar, HPE report	
21	Tracheostomy	5,000		Clinical photograph showing scar, HPE report	
22	Axillary dissection	15,000	FNAC/ BIOPSY, CECT	Clinical photograph showing scar, HPE report	
23	Breast conserving surgery (lumpectomy + axillary surgery)	12,000	FNAC/ BIOPSY, CECT	Clinical photograph showing scar, HPE report	
24	Lung metastectomy- solitary	30,000	FNAC/ BIOPSY, CECT	Clinical photograph showing scar, HPE report, xray chest	
25	Lung metastectomy- multiple (< four)	50,000	FNAC/ BIOPSY, CECT	Clinical photograph showing scar, HPE report, xray chest	
26	Lung metastectomy- multiple (> four)	60,000	FNAC/ BIOPSY, CECT	Clinical photograph showing scar, HPE report, xray chest	
27	Sleeve resection of lung cancer	70,000	FNAC/ BIOPSY, CECT	Clinical photograph showing scar, HPE report, xray chest	
28	Oesophagectomy with two field lymphadenectomy	60,000	UGI endoscopy, Biopsy, CECT	Clinical photograph showing scar, HPE report	
29	Oesophagectomy with three field lymphadenectomy	60,000	UGI endoscopy, Biopsy, CECT	Clinical photograph showing scar, HPE report	
30	Enucleation of pancreatic neoplasm	25,000	CECT	Clinical photograph showing scar, HPE report	
31	Radical Cholecystectomy	25,000	CECT/MRI	Clinical photograph showing scar, HPE report	

32	Abdominal wall tumour resection	25,000	CECT	Clinical photograph showing scar, HPE report	
33	Abdominal wall tumour resection with reconstruction	35,000	CECT	Clinical photograph showing scar, HPE report	
34	Oesophageal stenting including stent cost	40,000	CECT	Stent invoice	
35	Triple bypass GI tract	30,000	Biopsy, CECT, endoscopy	Clinical photograph showing scar, HPE report	
36	Segmentectomy- hepatobiliary system	50,000	CECT/MRI	Clinical photograph showing scar, HPE report	
37	Radical Hysterectomy + Bilateral pelvic lymph node dissection + bilateral salpingo ophorectomy (BSO)/ ovarian transposition	50,000	CECT, biopsy	Clinical photograph showing scar, HPE report	
38	Skin Tumours Wide Excision + Reconstruction	25,000			
39	Skin Tumours Amputation	8,000			
40	Radical Vaginectomy	30,000	CECT, biopsy	HPE report	
41	Radical Vaginectomy + Reconstruction	35,000	CECT, biopsy	HPE report	
42	Bilateral Pelvic Lymph Node Dissection (BPLND)	20,000	CECT, biopsy	Clinical photograph showing scar, HPE report	
43	Radical Trachelectomy	40,000	CECT, biopsy	Clinical photograph showing scar, HPE report	
44	Vulvectomy with bilateral groin dissection	45,000	Biopsy	HPE report	
45	Limb salvage surgery for bone tumor with prosthesis	70,000	Biopsy, CECT/ MRI – local, CT – thorax , bone scan	Clinical photograph, XRAY showing prosthesis, HPE report	
46	Hemipelvectomy	45,000	Biopsy, CECT/ MRI – local	Clinical photograph showing scar, HPE report	
47	Sacral resection	40,000	Biopsy, CECT/ MRI - pelvis	Clinical photograph showing scar, HPE report	
48	Chest wall resection with reconstruction for soft tissue / bone tumors	40,000	Biopsy, CT/ XRAY - thorax	Clinical photograph showing scar, HPE report	

<u>Medical Oncology:</u>

S. No	Site	Procedure Name	Rates (INR)	Pre-op Investigations for approval	Post-op Investigations/ Evidence for approval of claim
1	Lymphoma, Non-Hodgkin's	Cyclophosphamide - Doxorubicin Vincristine - Prednisone (CHOP)- max 8 cycles (Per cycle)	R CHOP Regimen-25000 per cycle x6 CHOP	Biopsy, CT	Chemotherapy drug with batch number and bar code
2	Multiple Myeloma	Vincristine, Adriamycin,Dexamethasone(VAD) - cycle max 6 cycles	Bortezomib+ lenalidomide+ dexamethasone 20,000/ per cycle x6 Bortezomib+ cyclophosphamide+ dexamethasone 10000/per cycle x6 MPT melphalan, thalidomide and prednisolone 6000/per cycle x9 Bortezomib + dexamethasone 6000/per cycle x9	Bone Marrow Aspiration Report	Chemotherapy drug with batch number and bar code

3	Multiple Myeloma	Thalidomide+Dexamethasone(Oral)/ month - max 12 months	3,000	Bone Marrow Aspiration Report	Chemotherapy drug batch number with bar code
4	Colon Rectum	5-Fluorouracil-Oxaliplatin - Leucovorin (FOLFOX) - Max. 6 cycles (Per cycle)	10,000	Biopsy, CT	Chemotherapy drug batch number with bar code
5	Bone Tumors/Osteosarcoma/ Hepatoblastoma - Operable	Cisplatin/carboplatin - Adriamycin- max 6 cycles (Per cycle)	3,000	Biopsy, CT	Chemotherapy drug batch number with bar code

6	Lymphoma, Hodgkin'S	Adriamycin Bleomycin VinblastinDacarbazine (ABVD) - max 8 cycles (Per cycle) (Day 1 & Day 15)	ABVD (day 1 and 15) 5000x2=10,000 per cycle x 6	Biopsy, CT	Chemotherapy drug batch number with bar code
7	Cervix	Cisplatin/Carboplatin (AUC2) along with RT- max 6 cycles (Per cycle)	chemo radiation 5000/per week x 6	Biopsy, CT	Chemotherapy drug batch number with bar code
8	Childhood B-Cell Lymphomas	Remove	Remove	Hematology report + Biopsy	Chemotherapy drug batch number with bar code

9	Neuroblastoma Stage I –III	Variable Regimen – Neuroblastoma - max 1 year (Per cycle)	9,000	Biopsy, CT	Chemotherapy drug batch number with bar code
10	Multiple Myeloma	Melphalan -Prednisone (oral) – per month (max 12 months) - Ovarian CA, Bone CA	1,500	Bone Marrow Aspiration Report	Chemotherapy drug batch number with bar code
11	Wilm'sTumor	SIOP/National Wilms Tumour Study Group (NWTS) regimen(Stages I - V)- max 6 months (Per month) - Wilm's tumour	7,000	Biopsy, CT	Chemotherapy drug
12	Colon Rectum	Monthly 5-FU	4,000	Biopsy, CT	Chemotherapy drug batch number with bar code

13	Breast	Paclitaxel weekly x 12 weeks	4,000	Biopsy, CT	Chemotherapy drug batch number with bar code
14	Breast	Cyclophosphamide/Methotrexate/5Fluorouracil (CMF) (Per cycle)	1,500	Biopsy, CT	Chemotherapy drug batch number with bar code
15	Breast	Tamoxifen tabs - maximum 12 cycles (Per month)	100	Biopsy, CT	Chemotherapy drug batch number with bar code
16	Breast	Adriamycin/Cyclophosphamide (AC) – per cycle (Maximum 4 cycles)	3,000	Biopsy, CT	Chemotherapy drug batch number with bar code
17	Breast	5- Fluorouracil A-C (FAC) – per cycle (Maximum 6 cycles)	3,100	Biopsy, CT	Chemotherapy drug batch number with bar code

18	Breast	AC (AC Then Taxol)	3,000	Biopsy, CT	Chemotherapy drug batch number with bar code
19	Small Cell Lung Cancer	Cisplastin/Etoposide (IIIB) – per cycle (Max. 6 cycles only)	4,000	Biopsy, CT	Chemotherapy drug batch number with bar code
20	Oncology oesophagus	Cisplatin + 5 FU(Neoadjuvant Chemotherapy)/Adjuvant (ADJ)- per cycle (Max. of 6 cycles only)	3,000	Biopsy, CT	Chemotherapy drug batch number with bar code
21	Stomach	Docetaxel +Oxaliplatin+5FU 20,000 per cycle for 4 cycles CapOX- 10,000 per cycle for 8 cycles	4,000	Biopsy, CT	Chemotherapy drug batch number with bar code

22	Breast	Aromatase Inhibitors (Anastazole/Letrozole/Exemestane) - maximum 12 cycles (Per month)	900	Biopsy, CT	Chemotherapy drug batch number with bar code
23	Urinary Bladder	Weekly Cisplatin/Carboplatin- max 6 cycles with RT (Per week)	2,000	Biopsy, CT	Chemotherapy drug batch number with bar code
24	Urinary Bladder	MethotraxateVinblastin Adriamycin Cyclophosphamide (MVAC)	5,000	Biopsy, CT	Chemotherapy drug batch number with bar code
25	Retinoblastoma	Carbo/Etoposide/Vincristine-max 6 cycles (Per cycle)	4,000	Biopsy, CT	Chemotherapy drug batch number with bar code

26	Febrile Neutropenia	IV antibiotics and other supportive therapy (Per episode)	30,000	Haemogram, Blood Culture	Chemotherapy drug batch number with bar code
27	Vaginal/ Vulval Cancer	Cisplastin/5-FU	3,000	Biopsy, CT	Chemotherapy drug batch number with bar code
28	Ovary	Carboplatin/Paclitaxel-max 6 cycles (Per cycle)	Taxol+carboplatin 15000/percyclex6 BEP regimen for germ cell tumor 10000/per cyclex4	Biopsy, CT	Chemotherapy drug batch number with bar code
29	Rectal Cancer Stage 2 And 3	Gemcitabine +capecitabine-15,000 per cycle for 6 cycles	4,000	Biopsy, CT	Chemotherapy drug batch number with bar code
30	Multiple Myeloma	Zoledronic acid - Max 12 cycles (Per month)	2,000	Biopsy, CT	Chemotherapy drug batch number with bar code

31	Gestational Trophoblast Ds. High Risk	Etoposide-Methotrexate-Actinomycin / Cyclophosphamide -Vincristine (EMA-CO)-max 6 cycles (Per cycle)	10,000	Beta - HCG report + CT	Chemotherapy drug batch number with bar code
32	Gestational Trophoblast Ds. Low Risk	Actinomycin- max 10 cycles (Per cycle)	1,000	Beta - HCG report + CT	Chemotherapy drug batch number with bar code
33	Gestational Trophoblast Ds. Low Risk	Weekly Methotrexate (Per week) max. 10 cycles	1,000	Beta - HCG report + CT	Chemotherapy drug batch number with bar code
34	Ovary Germ Cell Tumour	Bleomycin-Etoposide-Cisplatin (BEP) - max cycles 4 (Per cycle)	6,000	Biopsy, CT	Chemotherapy drug batch number with bar code

35	Prostate	Hormonal Therapy - Per month	3,000	Biopsy, CT	Chemotherapy drug batch number with bar code
36	Testis	Bleomycin-Etoposide-Cisplatin (BEP)- max cycles 4 (Per cycle)	BEP regimen for germ cell tumour 10000/per cyclex4	Biopsy, CT	Chemotherapy drug batch number with bar code
37	Acute Myeloid Leukemia	Induction Phase, up to	Daunomycin and cytosine arabinoside (3:7) 100,000	Hematology + Bone Marrow Aspiration Report	Chemotherapy drug batch number with bar code
38	Acute Myeloid Leukemia	Consolidation Phase, up to	High dose cytosine arabinoside 75000 x 3-4 cycles	Hematology + Bone Marrow Aspiration Report	Chemotherapy drug batch number with bar code
39	Histocytosis	Variable Regimen-Histocyosis-max 1 year (Per month)	8,000	Biopsy, CT	Chemotherapy drug batch number with bar code

40	Rhabdomyosarcoma	Vincristine-Actinomycin-Cyclophosphamide (VACTC) based chemo - max 1 year (Per month) - Rhabdomyosarcoma	6,000	Biopsy, CT	Chemotherapy drug batch number with bar code
41	Ewing's Sarcoma	Variable Regimen Inv - Hematology, Biopsy – Payable	6,000	Biopsy, CT	Chemotherapy drug batch number with bar code
42	Unlisted Regimen	Palliative CT- Max 6 cycles (Per cycle)	5,000	Biopsy, CT	Chemotherapy drug batch number with bar code
43	Terminally Ill	Palliative And Supportive Therapy - Per month	3,000		
44	Acute Lymphatic Leukemia	Maintenance Phase - Per month	5000 per month x 24	Hematology + Bone Marrow Aspiration Report	Chemotherapy drug batch number with bar code

45	Acute Lymphatic Leukemia	Induction	50,000	Hematology + Bone Marrow Aspiration Report	Chemotherapy drug batch number with bar code
46	Acute Lymphatic Leukemia	Consolidation	50,000	Hematology + Bone Marrow Aspiration Report	Chemotherapy drug batch number with bar code
47	Head and Neck	Tab Geftinib/Erlotinib-Max 1 Year (Per month)	3,000	Biopsy, CT	Chemotherapy drug batch number with bar code
48	Renal cell carcinoma	Sunitinib/ Pazopanib (per day)	2,500	Biopsy, CT	Chemotherapy drug batch number with bar code
49	chronic myeloid leukemia	Imatinib	6000/per month x 5 years		Chemotherapy drug batch number with bar code
50	Gall Bladder Cancer	Gemcitabine + cisplatin	10,000 per cycle for 6 cycle		Chemotherapy drug batch number with bar code

XXII. Emergency Room Packages (Care requiring less than 12 hrs stay)

Total no: of packages: 4

No: of packages mandated for pre-authorization: 0

Empanelment classification: Essential/ Minimum criteria
In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for AB-NHPM provider network.

Pre-authorization: Nil.

Comments: Patient trail to be maintained by the hospital treating the patient. To be clubbed with the payments made to the referred hospital. In case of hospitalization requiring more than 12 hrs, then patient to be admitted and treated accordingly.

S. No	Procedure Name	Rates (INR)	Pre-op Investigations for approval
1	Emergency with stable cardiopulmonary status	1000	Evaluated, stabilized, arranged referral resuscitated, provided life support
2	Emergency consultation: acute colic, high fever, cut, stitches, soft tissue injury, FB removal		Only in Public sector facilities.
3	Single bone fracture plaster, nebulization for asthmatic attack, moderate dehydration, hypoglycaemia in a diabetic, Dengue without complication, Syncope, Food poisoning etc		Only in Public sector facilities.
4	Animal bites	(500+ 300x4)	Payment after completion of 5th dose.

XXIII. MENTAL DISORDERS PACKAGES

No: of packages mandated for pre-authorization: **17**(extensions only)
Empanelment classification: Essential/ Minimum criteria

In-order to be eligible to provide services under this domain, the provider needs to qualify for the basic essential/ minimum criteria as mentioned under the empanelment guidelines provided for NHPS provider network.

Pre-authorization: Mandatory for all packages for progressive extension of treatment/ hospital stay

Pre-authorization remarks: Prior approval must be taken for all mental health conditions/ packages under this domain for progressive extension of therapeutic treatments.

- Procedures can be done only in public sector hospital with Specialty available
- All clinical test reports, diagnosis, Mental Status Examination (MSE), case sheet/ clinical notes and discharge summary need to be submitted for extension of packages and during claims submission.
- No: 15 included: Cognitive Tests, Complete Haemogram, Liver Function Test, Renal Function Test, Serum Electrolytes, Electro Cardiogram (ECG), CT/MRI Brain, Electroencephalogram, Thyroid Function Test, VDRL, HIV Test, Vitamin B12 levels, Folate levels, Lipid Profile, Homocysteine levels
- Legend of bed day charges:

Routine ward	Rs 1,500/ day
HDU	Rs 2,500/ day

S.No.	Procedure Name	Rates (INR)	Pre-admission / Investigations for approval	During admission Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in High Dependency Units)
1	**F00-F09** Organic, including symptomatic, mental disorders	Rs. 1500 per day (up to a limit of 2 weeks after which pre-authorization needs to be sought up to a limit of 2 weeks)	Clinical assessment and investigations	Clinical assessment& Report	Four weeks
2	**F10-F19** Mental and Behavioural disorders due to psychoactive substance use				
3	**F20-F29** Schizophrenia, schizotypal and				

	delusional disorders				
4	**F30-F39** Mood (affective) disorders				
5	F40-F48 Neurotic, stress-related and somatoform disorders		Clinical assessment and investigations	Clinical assessment & Report	Four weeks
6	**F50-F59** Behavioural syndromes associated with physiological disturbances and physical factors				
7	**F70-F79** Mental retardation				

Serious conditions that might require admission in High Dependency Unit (HDU) - Patients sick with unstable vitals, faced with life threatening conditions, but not requiring ventilator support

S.No	Procedure Name	Rates (INR)	Pre-admission / Investigations for approval	During admission Investigations/ Evidence for approval of claim	Minimum Number of Days Admission (Including Days in High Dependency Units)
8	**F00-F09** Organic, including symptomatic, mental disorders	Rs. 2500 per day (up to a limit of 10 days after which pre-authorization needs to be sought up to a limit of 10 days)	Clinical assessment report / Risk Assessment + Investigation	Clinical assessment & Report	10 Days
9	**F10-F19** Mental and Behavioural disorders due to psychoactive substance use				
10	**F20-F29** Schizophrenia, schizotypal and delusional disorders				

11	**F30-F39** Mood (affective) disorders				
12	**F40-F48** Neurotic, stress-related and somatoform disorders				
13	**F50-F59** Behavioural syndromes associated with physiological disturbances and physical factors				
14	F 70 – 79 Mental Retardation				
15	Pre- Electro Convulsive Therapy (ECT) and Pre- rTranscranial Magnetic Stimulation (TMS)Package *	Rs. 10,000 /-	Clinical assessment	Clinical assessment	
16	Electro Convulsive Therapy (ECT)	Rs. 3000/- per session			
17	Transcranial Magnetic Stimulation (TMS)	Rs. 1000/- per session			

Complete Hemogram, Liver Function Test, Renal Function Test, Serum Electrolytes, Electro Cardiogram (ECG), CT/MRI Brain, Electroencephalogram, Dental Examination, Cognitive Tests

**** Cognitive Tests, Complete Haemogram, Liver Function Test, Renal Function Test, Serum Electrolytes, Electro Cardiogram (ECG), CT/MRI Brain, Electroencephalogram, Thyroid Function Test, VDRL, HIV Test, Vitamin B12 levels, Folate levels, Lipid Profile, Homocysteine levels,**

Schedule 4: Guidelines for Identification of AB-NHPM Beneficiary Family Units

1.1. Brief Process Flow

The core principle for finalising the operational guidelines for proposed AB-NHPM is to construct a broad framework as guiding posts for simplifying the implementation of the Mission under the ambit of the policy and the technology while providing requisite flexibility to the States to optimally chalk out the activities related to implementation in light of the peculiarities of their own State/UT, as ownership of implementation of scheme lies with them.

A. AB-NHPM will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data, both rural and urban. Additionally, all such enrolled families under RSBY that do not feature in the targeted groups as per SECC data will be included as well.

B. States covering a much larger population than the AB-NHPM beneficiary list will need to
   i) Provide a declaration that their eligibility criteria cover AB-NHPM beneficiaries
   ii) Setup a process to ensure any family in AB-NHPM list who may be missed under the State's criteria is covered when they seek care.
   iii) Beneficiaries obtaining treatment should be tagged if they are AB-NHPM beneficiaries. Reports to MoHFW/ NHA will need to be provided for these beneficiaries
   iv) Link all AB-NHPM beneficiaries with the State's Scheme ID and Aadhaar in a defined time period

C. State/UT will be responsible for carrying out Information, Education and Communication (IEC) activities amongst targeted families such that they are aware of their entitlement, benefit cover, empanelled hospitals and process to avail the services under AB-NHPM. This will include leveraging village health and nutrition days, making available beneficiary family list at Panchayat office, visit of ASHA workers to each target family and educating them about the scheme, Mass media, etc among other activities. The following 2 IEC activities are designed to aid in Beneficiary Identification

   i) AB-NHPM Additional Data Collection drive at Gram Sabha's across India will take place on 30th April. MoHFW in collaboration with Ministry of Rural Development (MoRD) will drive collection of Ration Card, Mobile Number for each AB-NHPM household.

ii) Government of India will send a personalised letter via mass mail to each targeted family through postal department in states launching AB-NHPM. This letter will include details about the scheme, toll free helpline number and family details and their ID under AB-NHPM

iii) States which are primarily covering AB-NHPM beneficiaries are encouraged to create multiple service locations where beneficiaries can check if they are covered. These include
   - Contact points or kiosks set up at CSCs, PHCs, Gram Panchayat, etc
   - Empaneled Hospital
   - Self-check via mobile or web
   - Or any other contact point as deemed fit by States

D. Beneficiary identification will include the following broad steps:

i) The operator searches through the AB-NHPM list to determine if the person is covered.

ii) Search can be performed by Name and Location, Ration Card No or Mobile number (collected during data drive) or ID printed on the letter sent to family or RSBY URN

iii) If the beneficiary's name is found in the AB-NHPM list, Aadhaar (or an alternative government ID) and Ration Card (or an alternative family ID) is collected against the Name / Family.

iv) The system determines a confidence score for the link based on how close the name / location / family members between the AB-NHPM record and documents is provided.

v) The operator sends the linked record for approval to the Insurance company

vi) If the confidence score is high (as specified by software), the operator can immediately issue the e-Card and admit the patient for treatment. Otherwise, the patient must be advised to wait for approval from the insurance company

vii) The insurance company will setup a Beneficiary approval team that works on fixed service level agreements on turnaround time. The AB-NHPM details and the information from the ID is presented to the verifier. The insurance company can either approve or recommend a case for rejection with reason.

viii) All cases recommended for rejection will be scrutinised by a State team that works on fixed service level agreements on turnaround time. The state team will either accept rejection or approve with reason.

ix) The e-card will be printed with the unique ID under AB-NHPM and handed over to the beneficiary to serve as a proof for verification for future reference.

   - The beneficiary will also be provided with a booklet/ pamphlet with details

about AB-NHPM and process for availing services.

- Presentation of this e-card will not be mandatory for availing services. However, the e-card may serve as a tool for reinforcement of entitlement to the beneficiary and faster registration process at the hospital when needed.

E. Addition of new family members will be allowed. This requires at least one other family member has been approved by the Insurance Company/Trust. Proof of being part of the same family is required in the form of
   i) Name of the new member is in the family ration card or State defined family card
   ii) A marriage certificate relating to marriage to a family member existing in the family
   A birth certificate relating to a birth to a family member existing in the family is available.

1.2. Detailed Steps for Beneficiary Identification and Issuance of e-card

AB-NHPM will target about 10.74 crore poor, deprived rural families and identified occupational category of urban workers' families as per the latest Socio-Economic Caste Census (SECC) data, both rural and urban. Additionally, all such enrolled families under RSBY that do not feature in the targeted groups as per SECC data will be included as well.
The main steps for the above exercise are as follows:

A. Preparatory Activities for State/ UT's:

Responsibility of – State Government
Timeline – within a period of 15 days, after receiving the approval from MoHFW/NHA, the State/UT may complete the preparatory activities to initiate the implementation and beneficiary identification process.

The State will need to:

i) Ensure the availability of requisite hardware, software and allied infrastructure required for beneficiary identification and AB-NHPM e-card printing. Beneficiary Identification Software/ Application/ platform will be provided free of cost by MoHFW/NHA. Specifications for these will be provided by MoHFW/NHA.

ii) Availability of printed booklets, in abundant quantities at each Contact point, which will be given to beneficiaries along with the AB-NHPM e-cards after verification. The booklet/pamphlet shall provide the following details:

   - Details about the AB-NHPM benefits
   - Process of taking the benefits under AB-NHPM and policy period
   - List of the empanelled network hospitals in the district along with

address and contact details (if available)
- The names and details of the key contact person/persons in the district
- Toll-free number of AB-NHPM call centre (if available)
- Details of DNO for any further contact

iii) State/State Health Agency (SHA) shall identify and set-up team(s) which shall have the capacities to handle hardware and basic software support, troubleshooting etc.

iv) Training of trainers for this purpose will be organised by MoHFW/NHA.

The State shall ensure availability of above, in order to carry out all the activities laid down in this guideline.

B. Preparation of AB-NHPM target data

Responsibility of – MoHFW
Timeline – Preparation of SECC data by 15th March

MoHFW has decided to use latest Socio-Economic Caste Census (SECC) data as a source/base data for validation of beneficiary families under the AB-NHPM. Based on SECC data, number of families in each State, that will be eligible for central subsidy under the AB-NHPM, will be identified. The categories in rural and urban that will be covered under AB-NHPM are given as follows:

For Rural
Total deprived Households targeted for AB-NHPM who belong to one of the six deprivation criteria amongst D1, D2, D3, D4, D5 and D7:

- Only one room with kucha walls and kucha roof (D1)
- No adult member between age 16 to 59 (D2)
- Female headed households with no adult male member between age 16 to 59 (D3)
- Disabled member and no able-bodied adult member (D4)
- SC/ST households (D5)
- Landless households deriving major part of their income from manual casual labour (D7)

Automatically included-
Households without shelter
- Destitute/ living on alms
- Manual scavenger families
- Primitive tribal groups
- Legally released bonded labour

For Urban
Occupational Categories of Workers

- Rag picker
- Beggar
- Domestic worker
- Street vendor/ Cobbler/hawker / Other service provider working on streets
- Construction worker/ Plumber/ Mason/ Labour/ Painter/ Welder/ Security guard/ Coolie and another head-load worker
- Sweeper/ Sanitation worker / Mali
- Home-based worker/ Artisan/ Handicrafts worker / Tailor
- Transport worker/ Driver/ Conductor/ Helper to drivers and conductors/ Cart puller/ Rickshaw puller
- Shop worker/ Assistant/ Peon in small establishment/ Helper/Delivery assistant / Attendant/ Waiter
- Electrician/ Mechanic/ Assembler/ Repair worker
- Washer-man/ Chowkidar

The following activities will be carried out for identifying target families for AB-NHPM:

i) AB-NHPM data in defined format by applying inclusion and exclusion criteria shall be prepared.
ii) Preparation of Rashtriya Swasthya Bima Yojana (RSBY) beneficiary family list (based on existing RSBY enrolled families) for such families where premium has been paid by Government of India and data finalized by MoHFW with inputs of States.
iii) AHL_HH_ID will be considered as Family ID for AB-NHPM targeted families.
iv) Final data will be accessible in a secure manner to only authorised users who will be allowed to access it online and use it for beneficiary verification.

Example:

A. State implementing RSBY –the scenario could be as follows:
   - Number of eligible families in SECC Data = 50 lakhs
   - Number of families currently enrolled in RSBY = 52 lakhs
   - Total Number of eligible families for AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION = 52 lakhs

B. State/ UT not implementing RSBY - the scenario could be as follows:
   - Number of eligible families in SECC data = 50 lakhs
   - Total number of eligible families for AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION = 50 lakhs

C. Informing Beneficiaries on what to bring for Identification

Responsibility of – SHA
Timeline – Ongoing
The process requires that Beneficiaries bring

- Aadhaar
- Any other valid government id(s) decided by the State if they do not have an Aadhaar
- Ration Card or any other family id decided by the State.

All IEC activities as per IEC guidelines must work towards education of the above to ensure it is easy for the beneficiaries to receive care.

D. Beneficiary identification Contact Points – Infrastructure and Locations

Any resident must be able to easily find out if they are covered under the scheme. This is especially critical in States that are launching only on the basis of AB-NHPM list (SECC + RSBY). These states are encouraged to create a large number of resident contact points where they can easily check if they are eligible and obtain a e-card.

The Beneficiary identification contact point will require

- A computer with the latest browser
- A QR code scanner
- A document scanner to scan requisite documents
- A printer to print the e-Card
- A web camera for photos
- Internet connectivity
- Aadhaar registered device for fingerprint and iris biometrics (only at Hospital Contact Points)

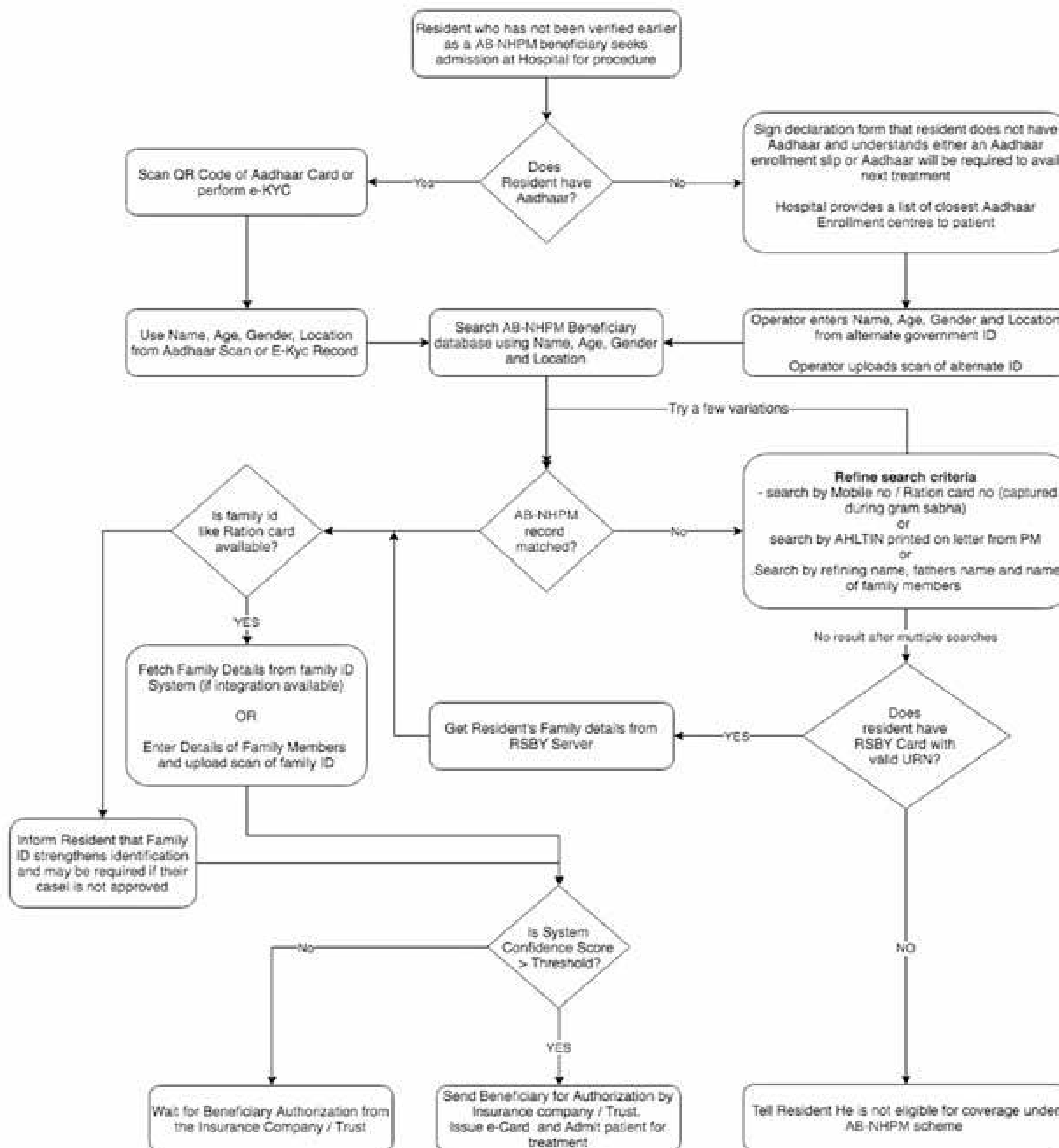
Only Hardware and software as prescribed by MoHFW/NHA shall only be used. Detailed specifications will be provided in a separate document. Beneficiary identification will be available as a web and mobile application. Availability as a mobile app will make it easy to be deployed at larger number of contact points. The DNO shall be responsible for choosing the locations for contact centres within each village/ward area that is easily accessible to a maximum number of beneficiary families including the following:

- CSC
- PHCs
- Gram Panchayat Office
- Empanelled Hospital
- Or any other contact point as deemed fit by States/UTs

Require hardware and software must be setup in these contact points which will be authorized to perform Beneficiary identification and issue e-cards.
SHA/ District Nodal Agency will organize training sessions for the operators so that they are

trained in the Beneficiary identification, Aadhaar seeding and AB-NHPM e-card printing process. Operators are registered entities in the system. All beneficiary verification requests are tagged to the operator that initiated the request. If the insurer (Insurance Company) rejects multiple requests from a single operator – the system will bar the operator till further training / remedial measures can be undertaken.

1.3. Process Flow Chart for Beneficiary Identification



1.4. Identity Document for a Family Member

Aadhaar will be primary identity document for a family member that has to be produced under the AB-NHPM scheme. When the beneficiary comes to a contact point, the QR code on the Aadhaar card is scanned (or an e-KYC is performed) to capture all the details of the Aadhaar. A demographic authentication is performed with UIDAI to ensure the information captured is authentic. A live photograph of the member is taken to be printed on the e-card.

If the AB-NHPM family member does not have an Aadhaar card and the contact point is a location where no treatment is provided, the operator will inform the beneficiary that he is eligible and can get treatment only once without an Aadhaar or an Aadhaar enrolment slip. They may be requested to apply for an Aadhaar as quickly as possible. A list of the closest Aadhaar enrolment centres is provided to the beneficiary
The AB-NHPM family member does not have an Aadhaar card and the contact point is a Hospital or place of treatment then

A. A signed declaration is taken from the Beneficiary that he does not possess an Aadhaar card and understands he will need to produce an Aadhaar or an Aadhaar enrolment slip prior to the next treatment
B. The beneficiary must produce an ID document from the list of approved ids by the State
C. The operator captures the type of ID and the fields as printed on the ID including the Name, Father's Name (if available), Age, Gender and Address fields.
D. A scan of the ID produced is uploaded into the system for verification.
E. A photo of the beneficiary is taken
F. The information from this alternate ID is used instead of Aadhaar for matching against the AB-NHPM record.

1.5. Searching the AB-NHPM Database

The AB-NHPM database will be searched based on the information provided in the Member Identity document. AB-NHPM is based on SECC and it is likely that spellings for Name, Fathers Name and even towns and villages will be different between the AB-NHPM record and the identity document. A beneficiary will be eligible for AB-NHPM if the Name and Location parameters in the beneficiary identity document *can be regarded as similar* to the Name and Location parameters in the AB-NHPM record.
The Search system automatically provides a confidence score between the two.

AADHAAR or OTHER GOVERNMENT ID Beneficiary Identity Document		**AB-NHPM BENEFICARY RECORD**	
Name	Geetha Bandhopadhya	Name	Gita Banarjee
Age	33	Age	40
Gender	F	Gender	F
Father's Name	<Not Available>	Father's Name	Arghya Banarjee
State	West Bengal	State:	West Bengal
District	Malda	District	Malda
Town / Village	Dakshin Chandipur	Town / Village	Dakshen Chandhipur
NAME MATCH CONFIDENCE SCORE: 94%			

The Search system will provide multiple ways to find the AB-NHPM beneficiary record. If there are no results based on Name and Location, the operator should

A. Search by Ration Card and Mobile No (Information captured during the Additional Data Collection Drive)
B. Search using the ID printed on the letter sent by post to Beneficiaries (AHL_HH_ID)
C. Reduce some of the parameters like Age, Gender, Sub district, etc and trial with variation in the spelling of the Name if there are no matching results
D. Try adding the name of the father or family members if there are too many results.

The Search system will show the number of results matched if > 5. The operator is expected to add more information to narrow results. The actual results will be displayed when the number matched is 5 or less. The operator has to select the correct record from the list shown.

1.6. Searching the AB-NHPM Database for Valid RSBY Beneficiaries

The operator is unable to find the person using AB-NHPM search using Name and other methods described above, then he can search from the valid RSBY database. The RSBY URN printed on the beneficiary card is used to perform the search. The system fetches the record from the RSBY database. The operator is presented with the confidence score between the Beneficiary Identity document and the RSBY record.

1.7. Linking Family Identification document with the AB-NHPM Family

One or more Family Identity Cards can be linked with each AB-NHPM Family. While Ration cards will be the primary family document, States can define additional family documents that can be used. SECC survey was conducted on the basis of households and there are possibilities where the household could have multiple ration cards.
Linking a family identification document strengthens the beneficiary identification process as we can create a confidence score based on the names in family identification document and AB-NHPM record.

Ration Card or Other Government FAMILY ID Beneficiary Identity Document		AB-NHPM BENEFICARY RECORD	
Names of family members	RAM, GEETHA, GOVIND, MEENAKUMARI	Names of family members	GEETHA, MEENAKUMARI, RAM
FAMILY MATCH CONFIDENCE SCORE: 92%			

Linking the family identification document will be mandatory ONLY if the same document (Ration Card) is also the ID used by the state to cover a larger base. Operators are encouraged to upload the family document if the name match confidence score is low but they believe the 2 records are the same
Integration with an online family card database is recommended. In this scenario, the operator will enter the Family ID No (Ration Card No) and will be able to fetch the names of the family members from the online database.

If an integration is not possible, the operator will enter the names of the family members as written in the ID card and upload a scan of the ID card for verification.

1.8. Approval by Insurance Company/Trust

The State can appoint either the Insurance company or Trust to perform the verification of the data of identified beneficiaries. The team needs to work with a strong Service Level Agreements (SLA) on turnaround time. Approvals are expected to be provided within 30 minutes back to the operator on a 24x7 basis.
The Approver is presented the Beneficiary Identity Document and the AB-NHPM (or RSBY) record side by side for validation along with the confidence score. The lowest confidence score records are presented first.
If the operator has uploaded the Family Identity document it is also displayed along with the Confidence Score.
The Approver has only 2 choices for each case – *Approve* or *Recommend for Rejection* with Reason
The System maintains a track of which Operator is Approving / Recommending for rejection. The Insurance Company/Trust can analyze the approval or rejection pattern of each of the operators.

1.8.1. Acceptance of Rejection Request by State (applicable only in case of Insurance Company mode of implementation)

The State should setup a team that reviews all the cases recommended for Rejection. The team reviews the data provided and the reason it has been recommended for rejection. If the State agrees with the Insurer it can reject the case.
If the State disagrees with the Insurer it can approve the case. The person in the state making the decision is also tracked in the system. The State review role is also SLA based and a turnaround is expected in 24 hours on working hour basis.

1.8.2. Addition of Family Members

The AB-NHPM scheme allows addition of new family members if they became part of the family either due to marriage or by birth. In order to add a family member, at least one of the existing family members needs to be verified and the identity document used for the verification must be Aadhaar.
To add the additional member the family must produce

- The name of the additional member in a State approved family document like Ration Card OR
- A birth certificate linking the member to the family OR
- A marriage certificate linking the member to the family.

In order to add a family member, at least one of the existing family members needs to be verified and the identity document used for the verification must be Aadhaar.

1.8.3. Monitoring of Beneficiary identification and e-card printing process

Responsibility of – State Government/ SHA
Timeline – Continuous

SG/ SHA will need to have very close monitoring of the process in order to ascertain challenges, if any, being faced and resolution of the same. Monitoring of verification process may be based on following parameters:

- Number of contact points and manpower deployed/ Number and type of manpower
- Time taken for issuance of e-card of each member
- Percentage of families with at least one member having issued e-card out of total eligible families in AB-NHPM
- Percentage of members issued e-cards out of total eligible members in AB-NHPM
- Percentage of families with at least one member verified out of total eligible families in RSBY data (if applicable)
- Percentage of members issued e-card out of total eligible members in RSBY data (if applicable)
- Percentage of total members where Aadhaar was available and captured and percentage of members without Aadhaar number
- Percentage of total members where mobile was available and capture

Schedule 5: Guidelines for Empanelment of Health Care Providers and Other Related Issues

1.9. Basic Principles

For providing the benefits envisaged under the Mission, the State Health Agency (SHA) through State Empanelment Committee (SEC) will empanel or cause to empanel private and public health care service providers and facilities in their respective State/UTs as per these guidelines.
The states are free to decide the mode of verification of empanelment application, conducting the physical verification either through District Empanelment Committee (DEC) or using the selected insurance company (Insurance Model), under the broad mandate of the instructions provided in these guidelines.

1.10. Institutional Set-Up for Empanelment

A. State Empanelment Committee (SEC) will constitute of following members:
- CEO, State Health Agency – Chairperson;
- Medical Officer not less than the level Director, preferably Director In Charge for Implementation of Clinical Establishment Regulation Act – Member;
- Two State government officials nominated by the Department – Members;
- In case of Insurance Model, Insurance company to nominate a representative not below Additional General Manager or equivalent;

The state government may invite other members to SEC as it may deem fit to assist the Committee in its activities. The State Government may also require the Insurance Company to mandatorily provide a medical representative to assist the SEC in its activities.

Alternatively, the State/SHA may continue with any existing institution under the respective state schemes that may be vested with the powers and responsibilities of SEC as per these guidelines.
The SHAs through State Empanelment Committee (SEC) shall ensure:
- Ensuring empanelment within the stipulated timeline for quick implementation of the programme;
- The empanelled provider meets the minimum criteria as defined by the guidelines for general or specialty care facilities;
- Empanelment and de-empanelment process transparency;
- Time-bound processing of all applications; and
- Time-bound escalation of appeals.

It is prescribed that at the district level, a similar committee, District Empanelment Committee (DEC) will be formed which will be responsible for hospital empanelment related

activities at the district level and to assist the SEC in empanelment and disciplinary proceedings with regards to network providers in their districts.

B. District Empanelment Committee (DEC) will constitute of the following members
   - Chief Medical Officer of the district
   - District Program Manager – State Health Agency
   - In case of Insurance Model, Insurance company representative

The State Government may require the Insurance Company to mandatorily provide a medical representative to assist the DEC in its activities.

The structure of SEC and DEC for the two options are recommended as below:

S.No.	Institutional Option	SEC Recommended Composition	DEC Recommended Composition
1.	Approval of the Empanelment application by the State	• Chair: CEO/Officer in Charge of State Health Agency • At least 5 membered Committee	• Chair: CMO or equivalent • At least 3 membered committee • At least one other doctor other than CMO
2.	Verification of the Empanelment application by the Insurance Company and approval by State	• Chair: CEO/Officer in Charge of State Health Agency • SEC may have 1 representative from the insurance company	• DEC may have 1 representative from the insurance company

The DEC will be responsible for:

- Getting the field verification done along with the submission of the verification reports to the SEC through the online empanelment portal.
- The DEC will also be responsible for recommending, if applicable, any relaxation in empanelment criteria that may be required to ensure that sufficient number of empanelled facilities are available in the district.
- Final approval of relaxation will lie with SEC
  - The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return to the hospital the empanelment request.

1.11. Process of Empanelment

A. Empanelment requirements

i) All States/UTs will be permitted to empanel hospitals only in their own State/UT.

ii) In case State/ UT wants to empanel hospitals in another State/UT, they can only do so till the time that State/ UT is not implementing AB-NHPM. For such states where AB-NHPM is not being implemented NHA may directly empanel CGHS empanelled hospitals.

iii) All public facilities with capability of providing inpatient services (Community Health Centre level and above) are deemed empanelled under AB-NHPM. The State Health Department shall ensure that the enabling infrastructure and guidelines are put in place to enable all public health facilities to provide services under AB-NHPM.

iv) Employee State Insurance Corporation (ESIC) hospitals will also be eligible for empanelment in AB-NHPM, based on the approvals.

v) For private providers and not for profit hospitals, a tiered approach to empanelment will be followed. Empanelment criteria are prepared for various types of hospitals / specialties catered by the hospitals and attached in Annex 1.

vi) Private hospitals will be encouraged to provide ROHINI provided by Insurance Information Bureau (IIB). Similarly public hospitals will be encouraged to have NIN provided by MoHFW.

vii) Hospitals will be encouraged to attain quality milestones by making NABH (National Accreditation Board of Health) pre entry level accreditation/ NQAS (National Quality Assurance Standards) mandatory for all the empaneled hospitals to be attained within 1 year with 2 extensions of one year each.

viii) Hospitals with NABH/ NQAS accreditation will be given incentivised payment structures by the states within the flexibility provided by MoHFW/NHA. The hospital with NABH/ NQAS accreditation can be incentivized for higher package rates subject to Procedure and Costing Guidelines.

ix) Hospitals in backwards/rural/naxal areas may be given incentivised payment structures by the states within the flexibility provided by MoHFW/NHA

x) Criteria for empanelment has been divided into two broad categories as given below.

Category 1: General Criteria	Category 2: Specialty Criteria

All the hospitals empanelled under AB-NHPM for providing general care have to meet the minimum criteria established under the Mission detailed in Annex 1. No exceptions will be made for any hospital at any cost.	Hospitals would need to be empanelled separately for certain tertiary care packages authorized for one or more specialties (like Cardiology, Oncology, Neurosurgery etc.). This would only be applicable for those hospitals who meet the general criteria for the AB-NHPM.

Detailed empanelment criteria have been provided as Annex 1.
State Governments will have the flexibility to **revise/relax** the empanelment criteria based, barring minimum requirements of Quality as highlighted in Annex 1, on their local context, availability of providers, and the need to balance quality and access; with prior approval from National Health Agency. The same will have to be incorporated in the web-portal for online empanelment of hospitals.
Hospitals will undergo a renewal process for empanelment once every **3 years or till the expiry of validity of NABH/ NQAS certification whichever is earlier** to determine compliance to minimum standards.
National Health Agency may revise the empanelment criteria at any point during the programme, if required and the states will have to undertake any required re-assessments for the same.

1.12. Awareness Generation and Facilitation

The state government shall ensure that maximum number of eligible hospitals participate in the AB-NHPM, and this need to be achieved through IEC campaigns, collaboration with and district, sub-district and block level workshops.
The state and district administration should strive to encourage all eligible hospitals in their respective jurisdictions to apply for empanelment under AB-NHPM. The SHA shall organise a district workshop to discuss the details of the Mission (including empanelment criteria, packages and processes) with the hospitals and address any query that they may have about the mission.
Representatives of both public and private hospitals (both managerial and operational persons) including officials from Insurance Company will be invited to participate in this workshop.

1.13. Online Empanelment

A. A web-based platform is being provided for empanelment of hospitals for AB-NHPM.

B. The hospitals can apply through this portal only, as a first step for getting empanelled in the programme.

C. This web-based platform will be the interface for application for empanelment of hospitals under AB-NHPM.

D. Following the workshop, the hospitals will be encouraged to initiate the process of empanelment through the web portal. Every hospital willing to get empanelled

will need to visit the web portal, www.abnhpm.gov.in and create an account for themselves.

E. Availability of PAN CARD number (not for public hospitals) and functional mobile number of the hospital will be mandatory for creation of this account / Login ID on the portal for the hospital.

F. Once the login ID is created, hospital shall apply for empanelment through an online application on the web portal - www.abnhpm.gov.in.

G. Each hospital will have to create a primary and a secondary user ID at the time of registration. This will ensure that the application can be accessed from the secondary user ID, in case the primary user is not available for some reason.

H. All the required information and documents will need to be uploaded and submitted by the hospital through the web portal.

I. Hospital will be mandated to apply for all specialties for which requisite infrastructure and facilities are available with it. Hospitals will not be permitted to choose specific specialties it wants to apply for unless it is a single specialty hospital.

J. After registering on the web-portal, the hospital user will be able to check the status of their application. At any point, the application shall fall into one of the following categories:

   i) Hospital registered but application submission pending
   ii) Application submitted but document verification pending
   iii) Application submitted with documents verified and under scrutiny by DEC/SEC
   iv) Application sent back to hospital for correction
   v) Application sent for field inspection
   vi) Inspection report submitted by DEC and decision pending at SEC level
   vii) Application approved and contract pending
   viii) Hospital empanelled
   ix) Application rejected
   x) Hospital de-empanelled
   xi) Hospital blacklisted (2 years)

1.14. Role of DEC

A. After the empanelment request by a hospital is filed, the application should be scrutinized by the DEC and processed completely within 15 days of receipt of application.

B. A login account for a nodal officer from DEC will be created by SEC. This login ID will be used to download the application of hospitals and upload the inspection report.

C. As a first step, the documents uploaded have to be correlated with physical - verification of original documents produced by the hospital. In case any documents are found wanting, the DEC may return the application to the hospital for rectifying any errors in the documents.

D. After the verification of documents, the DEC will physically inspect the premises of the hospital and verify the physical presence of the details entered in the empanelment application, including but not limited to equipment, human resources, service standards and quality and submit a report in a said format through the portal along with supporting pictures/videos/document scans.

E. DEC will ensure the visits are conducted for the physical verification of the hospital. The verification team will have at least one qualified medical doctor (minimum MBBS).

F. The team will verify the information provided by the hospitals on the web-portal and will also verify that hospitals have applied for empanelment for all specialties as available in the hospital.

G. In case during inspection, it is found that hospital has not applied for one or more specialties but the same facilities are available, then the hospital will be instructed to apply for the missing specialties within a stipulated a timeline (i.e. 7 days from the inspection date).

    i) In this case, the hospital will need to fill the application form again on the web portal. However, all the previously filled information by the hospital will be pre-populated and hospital will be expected to enter the new information.

    ii) If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.

H. In case during inspection, it is found that hospital has applied for multiple specialties, but all do not conform to minimum requirements under AB-NHPM then the hospital will only be empanelled for specialties that conform to AB-NHPM norms.

I. The team will recommend whether hospital should be empanelled or not based on their field-based inspection/verification report.

J. DEC team will submit its final inspection report to the state. The district nodal officer has to upload the reports through the portal login assigned to him/her.

K. The DEC will then forward the application along with its recommendation to the SEC.

1.15. Role of SEC

A. The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return back to the hospital the empanelment request.

B. In case of refusal, the SEC will record in writing the reasons for refusal and either direct the hospital to remedy the deficiencies, or in case of egregious emissions from the empanelment request, either based on documentary or physical verification, direct the hospital to submit a fresh request for empanelment on the online portal.

C. The SEC will also consider recommendations for relaxation of criteria of empanelment received from DEC or from the SHA and approve them to ensure that sufficient number and specialties of empanelled facilities are available in the states.

D. Hospital will be intimated as soon as a decision is taken regarding its empanelment and the same will be updated on the AB-NHPM web portal. The hospital will also be notified through SMS/email of the final decision. If the application is approved, the hospital will be assigned a unique national hospital registration number under AB-NHPM.

E. If the application is rejected, the hospital will be intimated of the reasons on the basis of which the application was not accepted and comments supporting the decision will be provided on the AB-NHPM web portal. Such hospitals shall have the right to file a review against the rejection with the State Health Agency within 15 days of rejection through the portal. In case the request for empanelment is rejected by the SHA in review, the hospitals can approach the Grievance Redressal Mechanism for remedy.

F. In case the hospital chooses to withdraw from AB-NHPM, it will only be permitted to re-enter/ get re-empanelled under AB-NHPM after a period of 6 months.

G. If a hospital is blacklisted for a defined period due to fraud/abuse, after following due process by the State Empanelment Committee, it can be permitted to re-apply after cessation of the blacklisting period or revocation of the blacklisting order, whichever is earlier.

H. There shall be no restriction on the number of hospitals that can be empanelled under AB-NHPM in a district.

I. *Final decision on request of a Hospital for empanelment under AB-NHPM, shall be completed within 30 days of receiving such an application*.

1.16. Fast Track Approvals

A. In order to fast track the empanelment process, hospitals which are NABH/ NQAS accredited shall be auto-empaneled provided they have submitted the application on web portal and meet the minimum criteria.

B. In order to fast track the empanelment process, the states may choose to auto-approve the already empanelled hospitals under an active RSBY scheme or any other state scheme; provided that they meet the minimum eligibility criteria prescribed under AB-NHPM.

C. If already empanelled, under this route, should the state allow the auto-approval mode, the hospital should submit their RSBY government empanelment ID or State empanelment ID during the application process on the web portal to facilitate on-boarding of such service providers.

D. The SEC shall ensure that all hospitals provided empanelment under Fast Track Approval shall undergo the physical verification process within 3 months of approval. If a hospital is found to have wrongfully empanelled under AB-NHPM under any category, such an empanelment shall be revoked to the extent necessary and disciplinary action shall be taken against such an errant medical facility.

1.17. Signing of Contract

A. Within 7 days of approval of empanelment request by SEC, the State Government will sign a contract with the empanelled hospitals as per the template defined in the tender document.
B. If insurance company is involved in implementing the scheme in the State, they will also be part of this agreement, i.e. tripartite agreement will be made between the IC, SHA and the hospital.
C. Each empanelled hospital will need to provide a name of a nodal officers who will be the focal point for the AB-NHPM for administrative and medical purposes.
D. Once the hospital is empanelled, a separate admin user for the hospital will be created to carry out transactions for providing treatment to the beneficiaries.

1.18. Process for Disciplinary Proceedings and De-Empanelment

A. Institutional Mechanism

i) De-empanelment process can be initiated by Insurance Company/SHA after conducting proper disciplinary proceedings against empanelled hospitals on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries.

ii) Hospital can contest the action of de-empanelment by Insurance Company with SEC/SHA. If hospital is aggrieved with actions of SEC/SHA, the former can

approach the SHA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.

iii) In case of implementation through the insurance mode, the SEC and DEC will mandatorily include a representative of the Insurance Company when deliberating and deciding on disciplinary proceedings under the scheme.

iv) The SEC may also initiate disciplinary proceedings based on field audit reports/survey reports/feedback reports/ complaints filed with them/ complaints.

v) For disciplinary proceedings, the DEC may consider submissions made by the beneficiaries (through call centre/ mera hospital or any other application/ written submissions/Emails etc.) or directions from SEC or information from other sources to investigate a claim of fraud by a hospital.

vi) On taking up such a case for fraud, after following the procedure defined, the DEC will forward its report to the SEC along with its recommendation for action to be taken based on the investigation.

vii) The SEC will consider all such reports from the DECs and pass an order detailing the case and the penalty provisions levied on the hospital.

viii) Any disciplinary proceeding so initiated shall have to be completed within 30 days.

B. Steps for Disciplinary Proceedings

Step 1 - Putting the provider on “Watch-list”

Based on the claims, data analysis and/or the provider visits, if there is any doubt on the performance of a Provider, the SEC on the request of the IC or the SHA or on its own findings or on the findings of the DEC, can put that hospital on the watch list. The data of such hospital shall be analysed very closely on a daily basis by the SHA/SEC for patterns, trends and anomalies and flagged events/patterns will be brought to the scrutiny of the DEC and the SEC as the case may be.
The IC shall notify such service provider that it has been put on the watch-list and the reasons for the same.

Step 2 – Issuing show-cause notice to the hospital

Based on the activities of the hospital if the insurer/ trust believes that there are clear grounds of hospital indulging in wrong practices, a showcause notice shall be issued to the hospital. Hospital will need to respond to the notice within 7 days of receiving it.

Step 3 - Suspension of the hospital

A Provider can be temporarily suspended in the following cases:

i) For the Providers which are on the “Watch-list” or have been issued showcause notice if the SEC observes continuous patterns or strong evidence

of irregularity based on either claims data or field visit of the hospital or in case of unsatisfactory reply of the hospital to the showcause notice, the hospital may be suspended from providing services to beneficiaries under the scheme and a formal investigation shall be instituted.

ii) If a Provider is not in the "Watch-list", but the SEC observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical Practice/ is not adhering to the major clauses of the contract with the Insurance Company / Involved in financial fraud related to health insurance patients, it may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.

A formal letter shall be send to the concerned hospital regarding its suspension with mentioning the time frame within which the formal investigation will be completed.

Step 4 - Detailed Investigation

The detailed investigation shall be undertaken for verification of issues raised in disciplinary proceedings and may include field visits to the providers (with qualified allopathic doctor as part of the team), examination of case papers, talking with the beneficiary/ policyholders/insured (if needed), examination of provider records etc. If the investigation reveals that the report/ complaint/ allegation against the provider is not substantiated, the Insurance Company/SHA would immediately revoke the suspension (in case of suspension) on the direction of the SEC. A letter regarding revocation of suspension shall be sent to the provider within 24 hours of that decision.

Step 5 – Presentation of Evidence to the SEC

The detailed investigation report should be presented to the SEC and the detailed investigation should be carried out in stipulated time period of not more than 7 days**.** The insurance company (Insurance mode)/SHA (Trust Mode) will present the findings of the detailed investigation. If the investigation reveals that the complaint/allegation against the provider is correct, then the following procedure shall be followed:

i) The hospital must be issued a "show-cause" notice seeking an explanation for the aberration.

ii) In case the proceedings are under the SEC, after receipt of the explanation and its examination, the charges may be dropped or modified or an action can be taken as per the guidelines depending on the severity of the malafide/error. In cases of de-empanelment, a second show cause shall be issued to the hospital to make a representation against the order and after considering the reply to the second showcause, the SEC can pass a final order on de-empanelment. If the hospital is aggrieved with actions of SEC/SHA, the former can approach the SHA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per

guidelines.

iii) In case the preliminary proceedings are under the DEC, the DEC will have to forward the report to the SEC along with its findings and recommendations for a final decision. The SEC may ask for any additional material/investigation to be brought on record and to consider all the material at hand before issuing a final order for the same.

The entire process should be completed within 30 days from the date of suspension. The disciplinary proceedings shall also be undertaken through the online portal only.

Step 6 - Actions to be taken after De- empanelment

Once the hospital has been de-empanelled, following steps shall be taken:

i) A letter shall be sent to the hospital regarding this decision.

ii) A decision may be taken by the SEC to ask the SHA/Insurance Company to lodge an FIR in case there is suspicion of criminal activity.

iii) This information shall be sent to all the other Insurance Companies as well as other regulatory bodies and the MoHFW/ NHA.

iv) The SHA may be advised to notify the same in the local media, informing all policyholders/insured about the de-empanelment ensuring that the beneficiaries are aware that the said hospital will not be providing services under AB-NHPM.

v) A de-empanelled hospital cannot re-apply for empanelment for at least 2 years after de-empanelment. However, if the order for de-empanelment mentions a longer period, such a period shall apply for such a hospital.

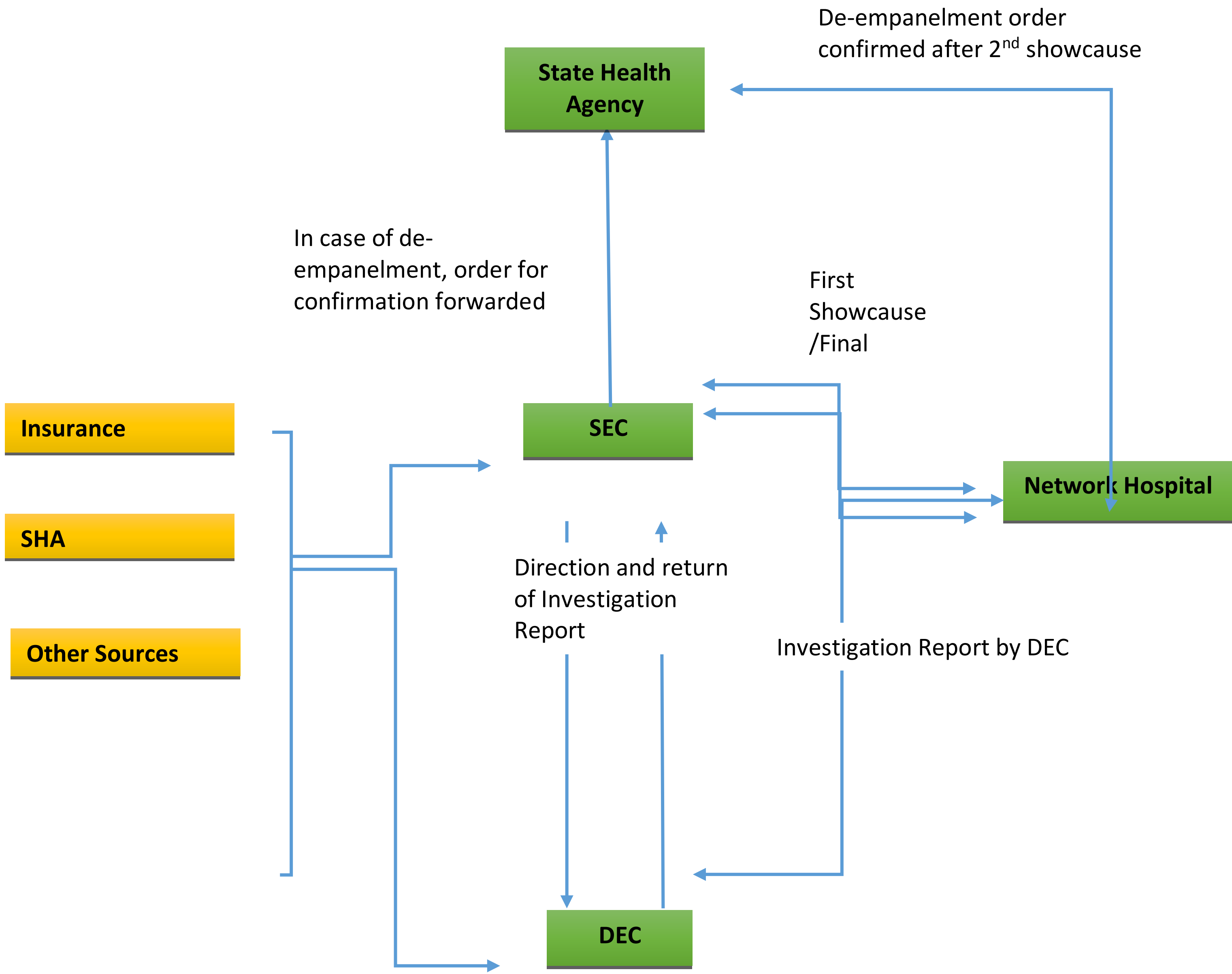
C. Gradation of Offences

On the basis of the investigation report/field audits, the following charges may be found to be reasonably proved and a gradation of penalties may be levied by the SEC. However, this tabulation is intended to be as guidelines rather than mandatory rules and the SEC may take a final call on the severity and quantum of punishment on a case to case basis.

Penalties for Offences by the Hospital			
Case Issue	**First Offence**	**Second Offence**	**Third Offence**
Illegal cash payments by beneficiary	Full Refund and compensation 3 times of illegal payment to the beneficiary	In addition to actions as mentioned for first offence, Rejection of claim for the case	De-empanelment/ black-listing
Billing for services not	Rejection of claim and penalty of 3 times the	Rejection of claim and penalty of 8 times the	De-empanelment

provided	amount claimed for services not provided, to Insurance Company /State Health Agency	amount claimed for services not provided, to Insurance Company /State Health Agency	
Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of 8 times the excess amount claimed due to up coding /unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency. For unnecessary procedure:	Rejection of claim and penalty of 16 times the excess amount claimed due to up coding/unbundling/Unnecessary Procedures, to Insurance Company /State Health Agency	De-empanelment
Wrongful beneficiary Identification	Rejection of claim and penalty of 3 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for wrongful beneficiary identification to Insurance Company /State Health Agency	De-empanelment
Non-adherence to AB-NHPM quality and service standard	In case of minor gaps, warning period of 2 weeks for rectification, for major gaps, Suspension of services until rectification of gaps and validation by SEC/ DEC	Suspension until rectification of gaps and validation by SEC/ DEC	De-empanelment

All these penalties are recommendatory and the SEC may inflict larger or smaller penalties depending on the severity/regularity/scale/intentionality on a case to case basis with reasons mentioned clearly in a speaking order.


De-empanelment order confirmed after 2nd showcause
State Health Agency
In case of de-empanelment, order for confirmation forwarded
First Showcause /Final
Insurance
SHA
Other Sources
SEC
Network Hospital
Direction and return of Investigation Report
Investigation Report by DEC
DEC

Annex 1: Detailed Empanelment Criteria

Category 1: Essential criteria:

A Hospital would be empanelled as a network private hospital with the approval of the respective State Health Authority[1] if it adheres with the following minimum criteria:

1. Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms.
   i. Exemption may be given for single-specialty hospitals like Eye and ENT.
   ii. General ward - @80sq ft per bed, or more in a Room with Basic amenities- bed, mattress, linen, water, electricity, cleanliness, patient friendly common washroom etc. Non-AC but with fan/Cooler and heater in winter.

2. It should have adequate and qualified medical and nursing staff (doctors[2] & nurses[3]), physically in charge round the clock; (necessary certificates to be produced during empanelment).

3. Fully equipped and engaged in providing Medical /Surgical services, commensurate to the scope of service/ available specialities and number of beds.
   i. Round-the-clock availability (or on-call) of a Surgeon and Anaesthetist where surgical services/ day care treatments are offered.
   ii. Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anaesthetist where maternity services are offered.
   iii. Round-the-clock availability of specialists (or on-call) in the concerned specialties having sufficient experience where such services are offered (e.g. Orthopaedics, ENT, Ophthalmology, Dental, general surgery (including endoscopy) etc.)

4. Round-the-clock support systems required for the above services like Pharmacy, Blood Bank, Laboratory, Dialysis unit, Endoscopy investigation support, Post op ICU care with ventilator support, X-ray facility (mandatory) etc., either ‘In-House’ or with ‘Outsourcing arrangements’, preferably with NABL accredited laboratories, with appropriate agreements and in nearby vicinity.

5. Round-the-clock Ambulance facilities (own or tie-up).

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[1] In order to facilitate the effective implementation of AB-NHPM, State Governments shall set up the State Health Authority (SHA) or designate this function under any existing agency/ trust designated for this purpose, such as the state nodal agency or a trust set up for the state insurance program.

[2] Qualified doctor is a MBBS approved as per the Clinical Establishment Act/ State government rules & regulations as applicable from time to time.

[3] Qualified nurse per unit per shift shall be available as per requirement laid down by the Nursing Council/ Clinical Establishment Act/ State government rules & regulations as applicable from time to time. Norms vis a vis bed ratio may be spelt out.

6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
    i. Casualty should be equipped with Monitors, Defibrillator, Nebulizer with accessories, Crash Cart, Resuscitation equipment, Oxygen cylinders with flow meter/ tubing/catheter/face mask/nasal prongs, suction apparatus etc. and with attached toilet facility.
7. Mandatory for hospitals wherever surgical procedures are offered:
    i. Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
    ii. Post-op ward with ventilator and other required facilities.
8. Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU/Neonatal ICU) with requisite staff
    i. The unit is to be situated in close proximity of operation theatre, acute care medical, surgical ward units, labour room and maternity room as appropriate.
    ii. Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
    iii. Further ICU- where such packages are mandated should have the following equipment:
        1) Piped gases
        2) Multi-sign Monitoring equipment
        3) Infusion of ionotropic support
        4) Equipment for maintenance of body temperature
        5) Weighing scale
        6) Manpower for 24x7 monitoring
        7) Emergency cash cart
        8) Defibrillator.
        9) Equipment for ventilation.
        10) In case there is common Paediatric ICU then Paediatric equipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.
    iv. HDU (high dependency unit) should also be equipped with all the equipment and manpower as per HDU norms.

9. Records Maintenance: Maintain complete records as required on day-to-day basis and is able to provide necessary records of hospital / patients to the Society/Insurer or his representative as and when required.
    i. Wherever automated systems are used it should comply with MoHFW/ NHA EHR guidelines (as and when they are enforced)
    ii. All AB-NHPM cases must have complete records maintained
    iii. Share data with designated authorities for information as mandated.
10. Legal requirements as applicable by the local/state health authority.
11. Adherence to Standard treatment guidelines/ Clinical Pathways for procedures as mandated by NHA from time to time.
12. Registration with the Income Tax Department.
13. NEFT enabled bank account
14. Telephone/Fax
15. Safe drinking water facilities/Patient care waiting area

16. Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
17. Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act.
18. Appropriate fire-safety measures.
19. Provide space for a separate kiosk for AB-NHPM beneficiary management (AB-NHPM non-medical[4] coordinator) at the hospital reception.
20. Ensure a dedicated medical officer to work as a medical[5] co-ordinator towards AB-NHPM beneficiary management (including records for follow-up care as prescribed)
21. Ensure appropriate promotion of AB-NHPM in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the SHA/ district level AB-NHPM team.
22. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the NHA.

Category 2: Advanced criteria:

Over and above the essential criteria required to provide basic services under AB-NHPM (as mentioned in Category 1) those facilities undertaking defined speciality packages (as indicated in the benefit package for specialities mandated to qualify for advanced criteria) should have the following:

1. These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Paediatric Surgery, Neonatal intensive care etc.
2. A hospital could be empanelled for one or more specialities subject to it qualifying to the concerned speciality criteria for respective packages
3. Such hospitals should be fully equipped with ICCU/SICU/ NICU/ relevant Intensive Care Unit in addition to and in support of the OT facilities that they have.
4. Such facilities should be of adequate capacity and numbers so that they can handle all the patients operated in emergencies.
    i. The Hospital should have sufficient experienced specialists in the specific identified fields for which the Hospital is empanelled as per the requirements of professional and regulatory bodies/ as specified in the clinical establishment act/ State regulations.
    ii. The Hospital should have sufficient diagnostic equipment and support services in the specific identified fields for which the Hospital is empanelled as per the requirements specified in the clinical establishment act/ State regulations.
5. Indicative domain specific criteria are as under:

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[4] The non-medical coordinator will do a concierge and helpdesk role for the patients visiting the hospital, acting as a facilitator for beneficiaries and are the face of interaction for the beneficiaries. Their role will include helping in preauthorization, claim settlement, follow-up and Kiosk-management (including proper communication of the scheme).

[5] The medical coordinator will be an identified doctor in the hospital who will facilitate submission of online pre-authorization and claims requests, follow up for meeting any deficiencies and coordinating necessary and appropriate treatment in the hospital.

A. **Specific criteria for Cardiology/ CTVS**

1. CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.)
2. Post-op with ventilator support
3. ICU Facility with cardiac monitoring and ventilator support
4. Hospital should facilitate round the clock cardiologist services.
5. Availability of support speciality of General Physician & Paediatrician
6. Fully equipped Catheterization Laboratory Unit with qualified and trained Paramedics.

B. **Specific criteria for Cancer Care**

1. For empanelment of Cancer treatment, the facility should have a Tumour Board which decides a comprehensive plan towards multi-modal treatment of the patient or if not then appropriate linkage mechanisms need to be established to the nearest regional cancer centre (RCC). Tumor Board should consist of a qualified team of Surgical, Radiation and Medical /Paediatric Oncologist in order to ensure the most appropriate treatment for the patient.
2. Relapse/recurrence may sometimes occur during/ after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/ Paediatric Oncologist/ Tumor Board with prior approval and pre-authorization of treatment.
3. For extending the treatment of chemotherapy and radiotherapy the hospital should have the requisite Pathology/ Haematology services/ infrastructure for radiotherapy treatment viz. for cobalt therapy, linear accelerator radiation treatment and brachytherapy available in-house. In case such facilities are not available in the empanelled hospital for radiotherapy treatment and even for chemotherapy, the hospital shall not perform the approved surgical procedure alone but refer the patients to other centres for follow-up treatments requiring chemotherapy and radiotherapy treatments. This should be indicated where appropriate in the treatment approval plan.
4. Further hospitals should have following infrastructure for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/ therapy.
   i. Treatment machines which are capable of delivering SRS/SRT
   ii. Associated Treatment planning system
   iii. Associated Dosimetry systems

C. **Specific criteria for Neurosurgery**

1. Well Equipped Theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with head holding frame (horse shoe, may field / sugita or equivalent frame).
2. ICU facility
3. Post-op with ventilator support
4. Facilitation for round the clock MRI, CT and other support bio-chemical investigations.

D. **Specific criteria for Burns, Plastic & Reconstructive surgery**

1. The Hospital should have full time / on - call services of qualified plastic surgeon and support staff with requisite infrastructure for corrective surgeries for post burn contractures.
2. Isolation ward having monitor, defibrillator, central oxygen line and all OT equipment.

3. Well Equipped Theatre
4. Intensive Care Unit.
5. Post-op with ventilator support
6. Trained Paramedics
7. Post-op rehab/ Physiotherapy support/ Phycology support.

E. **Specific criteria for /Paediatric Surgery**

1. The Hospital should have full time/on call services of paediatric surgeons
2. Well-equipped theatre
3. ICU support
4. Support services of paediatrician
5. Availability of mother rooms and feeding area.
6. Availability of radiological/ fluoroscopy services (including IITV), Laboratory services and Blood bank.

F. Specific criteria for specialized new born care.

1. The hospital should have well developed and equipped neonatal nursey/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms
2. Availability of radiant warmer/ incubator/ pulse oximeter/ photo therapy/ weighing scale/ infusion pump/ ventilators/ CPAP/ monitoring systems/ oxygen supply / suction / infusion pumps/ resuscitation equipment/ breast pumps/ bilimeter/ KMC (Kangaroo Mother Care) chairs and transport incubator - in enough numbers and in functional state; access to hematological, biochemistry tests, imaging and blood gases, using minimal sampling, as required for the service packages
3. For Advanced Care and Critical Care Packages, in addition to 2. above: parenteral nutrition, laminar flow bench, invasive monitoring, in-house USG. Ophthalmologist on call.
4. Trained nurses 24x7 as per norms
5. Trained Paediatrician(s) round the clock
6. Arrangement for 24x7 stay of the Mother – to enable her to provide supervised care, breastfeeding and KMC to the baby in the nursery/NICU and upon transfer therefrom; provision of bedside KMC chairs.
7. Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

G. **Specific criteria for Polytrauma**

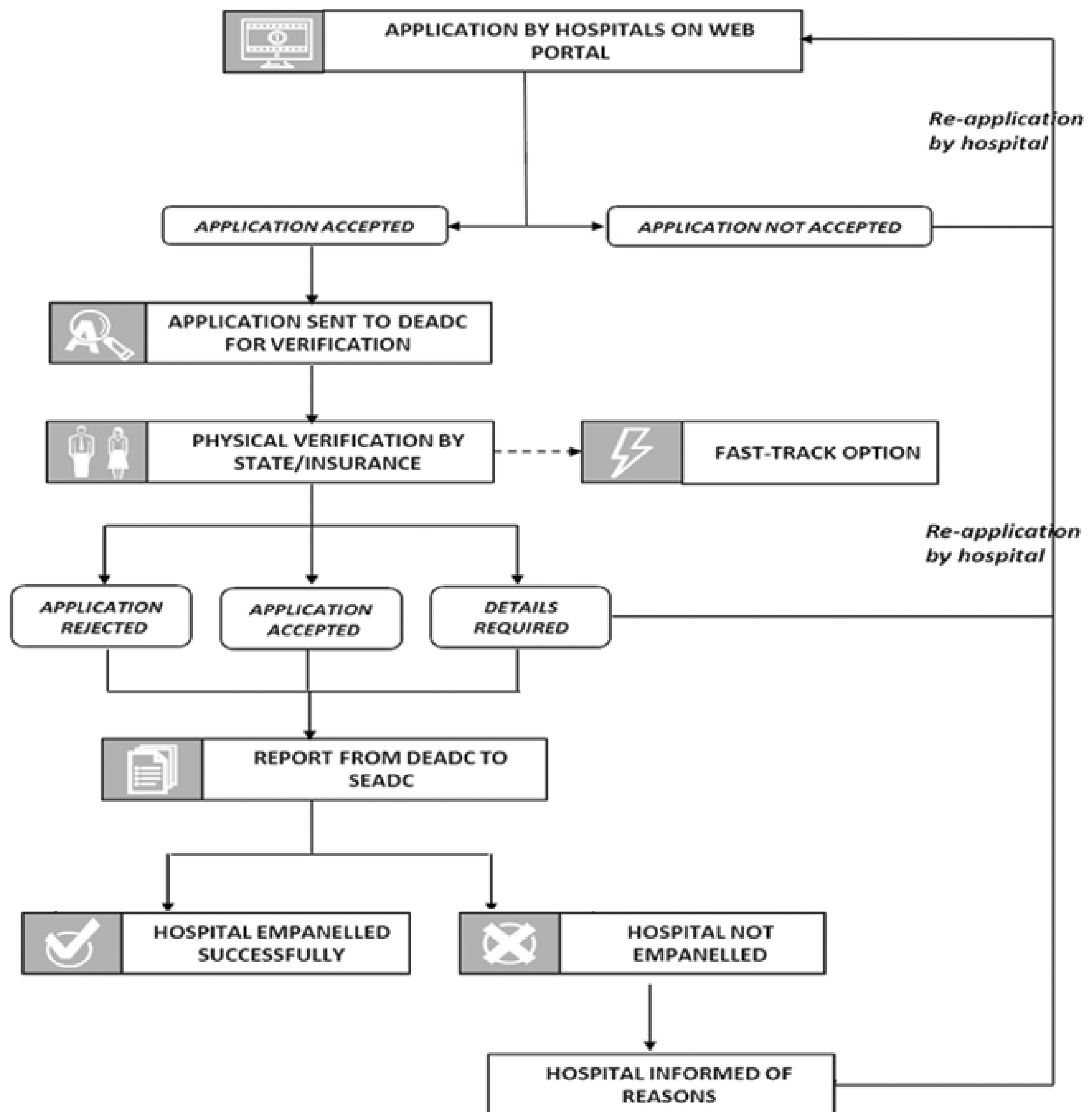
1. Shall have Emergency Room Setup with round the clock dedicated duty doctors.
2. Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and anaesthetist services.
3. The Hospital shall provide round the clock services of Neurosurgeon, Orthopaedic Surgeon, CT Surgeon, General Surgeon, Vascular Surgeon and other support specialists as and when required based on the need.
4. Shall have dedicated round the clock Emergency theatre with C-Arm facility, Surgical ICU, Post-Op Setup with qualified staff.
5. Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

H. **Specific criteria for Nephrology and Urology Surgery**

1. Dialysis unit

2. Well-equipped operation theatre with C-ARM
3. Endoscopy investigation support
4. Post op ICU care with ventilator support
5. Sew lithotripsy equipment

Annex 2: Process Flow for the Empanelment



Schedule 6: Service Agreement with Empaneled Health Care Providers

To be provided

Schedule 7: List of Empanelled Health Care Providers under the Scheme

To be added by the State

Schedule 8: Premium Payment Guidelines

A. Release of Grant-in-Aid/Premium Payment

i) A flat premium per family, irrespective of the number of members under AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION in that family, will be determined through open tendering process.

ii) The State Government/Union Territories shall upfront release the grant-in-aid / premium for the implementation of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION into the designated escrow account, from where it shall be paid by the SHA to the Insurance companies on a per family basis.

iii) The modalities that will be adhered for release of premium for the implementation of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION will that the premium for the targeted beneficiary families as per the eligibility criteria of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION or the number of beneficiary families mapped with the SECC Database (in case a different database, other than SECC Database is used by the States/UTs), as the case may be.

B. Stage of Release of Premium**:**
State Health Agency (SHA) will, on behalf of the Beneficiary Family Units that are targeted/identified by the SHA and covered by the Insurer, pay the Premium for the Cover to the Insurer in accordance with the following schedule:

i) First instalment of Premium for all States and UTs-
The Insurer, upon the issue of policy, shall raise an invoice for the first instalment of the Premium payable for the Beneficiary Family Units that are targeted or identified by the SHA. Thereupon, the State / UT shall upfront release 45% of their respective share viz. (out of 10% / 40%), depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA and the data for whom has been shared with Insurance Company along with their respective administrative expense share into the designated escrow account opened by the States / UTs for the implementation of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION.

However, in case of Union Territories without legislation, where the Central Government shall pay 45% of its respective share of premium (viz. out of 90% / 60% as the case may be] through the designated escrow account into the designated Escrow Account of the State / UT within 21 days from the receipt of duly completed proposal.

Thereafter, within 15 days from the release of their respective share, the State/UT shall raise the proposal for release of proportionate share of Central Government's Share of Premium along with the proposal and requisite documentary evidences and compliance of applicable financial provisions. The Central Government will release 45% of its respective share depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA within 21 days from the receipt of proposal from the State / UT.

Thereafter, upon the receipt of Central Government's Share of Premium, the State /UT shall release the first instalment of premium within 7 days through the designated Escrow Account to the Insurance Company under intimation to the Central Government.

ii) Second instalment for all States and UTs:

The Insurer upon the completion of 2nd quarter shall raise an invoice for the second instalment of the Premium payable for the Beneficiary Family Units that are targeted or identified by the SHA. The State /UT (with Legislature), within 15 days upon the receipt of invoice from the insurance company, shall release their 2nd instalment of premium i.e. 45% of their respective share viz. (out of 10% / 40%) into the designated escrow account. Thereafter, within 15 days from the release of their respective share, the State / UT shall raise the proposal for release of proportionate share of Central Government's Share of Premium along with the proposal and requisite documentary evidences and compliance of applicable financial provisions. The Central Government will release 45% of its respective share depending upon category of State/UT based on the number of eligible families that have been targeted / identified by the SHA within 21 days from the receipt of proposal from the State / UT.

Thereupon, the receipt of Central Government's Share of Premium, the State / UT shall release the second instalment of premium within 7 days through the designated Escrow Account to the Insurance Company under intimation to the Central Government.

iii) Third Instalment for all States and UTs:

Upon completion of 10 Months of Policy, the Insurer shall submit the Claim Settlement Report along with the invoice for the last instalment of the Premium payable for the Beneficiary Family Units that are targeted or identified by the SHA, if applicable. The State / UT (with Legislative) Government shall, upon receipt of the Claim Settlement report from the Insurance Company / Real Time Data available with States / UTs and upon due satisfaction of permissible claim settlement ratio, release the remaining due premium of 10% or the proportionate premium based upon the claim settlement scenario, as the case may be into the escrow account. Thereupon, within 15 days of their release of premium,

shall raise the proposal to the Central Government for the release of 10% of Premium or the proportionate premium based upon the claim settlement scenario, as the case may be into the escrow account as last tranche of premium to the Insurance Company.

Thereafter, upon the receipt of Central Government's Share of Premium, the State / UT shall release the second instalment of premium within 7 days through the designated Escrow Account to the Insurance Company under intimation to the Central Government.

D. Penalty Provision on Delay of Premium

If in case, the State / UT has not deposited its due share of premium into the escrow account, then a penal interest would be levied @ 1% per week for the number of week delay and part thereof on the State / UT.

Similarly, penal interest provision shall also be applicable on the Central Government. The concerned Government viz. State or Central / UT shall have the right to own such penal interest amount for adjusting in their future payable respective share of premium.

E. Interest Earned in Escrow Account

Any interest earned by SHA on Central Government's Share of Premium released into the Escrow account, the Central Government shall have the first right of claim on such interest earned amount and shall have to be transferred back to the Central Government / adjusted in future payment of the Central Government, as the case may be. Similarly, interest provision shall also be applicable for the State Government too.

The State Health Agency shall send the proposal to the Central Government for the release of Central Government's Share of Premium within 15 (Fifteen) days of receipt of the Insurer's invoice along & release of their share of premium, along with requisite documents (viz. Details of Eligible Identified Beneficiary Families, Documentary Proof for release of State Government's Share, etc] and compliance of Applicable Financial Rules.
In case the insurance company is not paid the premium from the escrow account within the stipulated time of 7 (seven) Business Days, then for such unwarranted delay, the States / UTs shall be solely liable to pay a penal interest of 1% per month to the Insurance Company starting from after one month beyond the mutually agreed date as decided between the SHA and Insurance Company.

F. Submission and Approval of Proposal

Before the start of implementation of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION, the States / UTS will have will have to send their proposal to the

Central Government and execute the Memorandum of Understanding with the Central Government indicating their modus operandi for the implementation of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION. Further, for States / UTs, who are implementing through Insurance Mode, shall also upon the completion of the tendering process, send their proposal for the approval of Central Government in order to enable them to execute the insurance contract with the selected insurance company.

G. No Separate Fees, Charges or Premium

The Insurer shall not charge any Beneficiary Family Unit or any of the Beneficiaries any separate fees, charges, commission or premium, by whatever name called, for providing the benefits. However, the aforesaid provision shall not be applicable, if in case, the beneficiary is required to take treatment above the amount of benefit cover of Rs. 5,00,000.

Schedule 9: Claims Management Guidelines including Portability

All Empanelled Health Care Providers (EHCP) will make use of IT system of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION to manage the claims related transactions. IT system of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION has been developed for online transactions and all stakeholders are advised to maintain online transactions preferably to ensure the claim reporting in real time. However, keeping in mind the connectivity constraints faced by some districts an offline arrangement has also been included in the IT system that has to be used only when absolute. The AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION strives to make the entire claim management paperless that is at any stage of claim registration, intimation, payment, investigation by EHCP or by the Insurer the need of submission of a physical paper shall not be required. This mean that this claim data will be sent electronically through IT system to the Central/ State server. The NHA, SHA, Insurer (if applicable), and EHCP shall be able to access this data with respect to their respective transaction data only.

Once a claim has been raised (has hit the Central/State server), the following will need to be adhered to by the Insurance Companies regarding claim settlement:

1. Claim Payments and Turn-around Time

The Insurer shall follow the following process regarding the processing of claims received from the EHCP:

A. The Insurer or the agency (IRDAI compliant only) appointed by it shall decide on the acceptance or rejection of any claim received from an EHCP. Any rejection notice issued by the Insurer or the agency to EHCP shall clearly state that rejection is subject to the EHCP's right to appeal against rejection of the claim.

B. If a claim is not rejected, the Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.

C. The process specified in Clause A and B above (rejection or payment including investigation) in relation to claim shall be carried out in such a manner that it is completed (Turn-around Time, TAT) shall be no longer than 15 calendar days (irrespective of the number of working days).

D. The EHCP is expected to upload all claim related documents within 24 hours of discharge of the beneficiary.

E. The counting of days for TAT shall start from the date on which all the claim documents are accessible by the Insurer or its agency.

F. The Insurer shall make claim payments to each EHCP against payable claims on a weekly basis through electronic transfer to such EHCP's designated bank account. Insurer is then also required to provide the details of such payments against each paid claim on the online portal (IT System of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION).

G. All claims investigations shall be undertaken by a qualified and experienced medical staff/team, with at least one MBBS degree holder, appointed by the Insurer or its representative, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Agreement and relevant Cover Policy. The Insurer's medical staff shall not impart any advice on any treatment or medical procedures or provide any guidance related to cure or other care aspects. However, the Insurance Company can ensure that the treatment was in conformity to the Standard Treatment Guidelines, if implemented.

H. The Insurer will need to update the details on online portal (IT system of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION) of:

   i) All claims that are under investigation on a fortnightly basis for review; and
   ii) Every claim that is pending beyond 15 days, along with its reasons for delay in processing such Claim.
   iii) The Insurer may collect at its own cost, complete Claim papers (including diagnostic reports) from the EHCP, if required for audit purposes for claims under investigation. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

2. Penalty on Delay in Settlement of Claims

There will be a penalty for delay in settlement of claims by the Insurance Companies beyond the turnaround time of 15 days. A penalty of 1% of claimed amount per week for delay beyond 15 days to be paid directly to the hospitals by the Insurance Companies. This penalty will become due after 30 days in case of Inter-State claims or portability of benefits

3. Update of Claim Settlement

The Insurance Company will need to update the claim settlement data on the portal on a daily basis and this data will need to be updated within 24 hours of claims payment. Any claim payment which has not been updated shall be deemed to have been unpaid and the interest, as applicable, shall be charged thereon.

4. Right of Appeal and Reopening of Claims

A. The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the Insurer, if the Empaneled Health Care Provider feels that the Claim is payable. An appeal may be made within thirty (30) days of the said rejection being intimated to the hospital to the District-level Grievance Committee (DGC).

B. The Insurer and/or the DGC can re-open the Claim, if the Empaneled Health Care Provider submits the proper and relevant Claim documents that are required by the Insurer.

C. The DGC may suo moto review any claim and direct either or both the Insurer and the health care provider to produce any records or make any deposition as it deems fit.

D. The Insurer or the health care provider may refer an appeal with the State-level Grievance Committee (SGC) on the decision of the DGC within thirty days (30) failing which the decision shall be final and binding. The decision of the SGC on such appeal is final and binding.

E. The decisions of the DGC and SGC shall be a speaking order stating the reasons for the decision

F. If the DGC (if there is no appeal) or SGC directs the Insurer to pay a claim amount, the Insurer shall pay the amount within 15 days. Any failure to pay the amount shall attract an interest on the delayed payment @ 1% for every week or part thereof. If the Insurer does not pay the amount within 2 months they shall pay a fine of Rs. 25,000/- for each decision of DGC not carried out and Rs. 50,000 for each non-compliance of decision of SGC. This amount shall be remitted to the State Health Agency.

5. Guidelines for Portability

An Empanelled Health Care Provider (EHCP) under AB-NHPM in any state should provide services as per AB-NHPM guidelines to beneficiaries from any other state also participating in AB-NHPM. This means that a beneficiary will be able to get treatment outside the EHCP network of his/her Home State.

Any empanelled hospital under AB-NHPM will not be allowed to deny services to any AB-NHPM beneficiary. All interoperability cases shall be mandatorily under pre-authorisation mode and pre-authorisation guidelines of the treatment delivery state in case of AB-NHPM

implementing States / UTs or indicative pre-authorisation guidelines as issued by NHA, shall be applicable.

Enabling Portability

To enable portability under the scheme, the stakeholders need to be prepared with the following:

A. **States**: Each of the States participating in AB-NHPM will sign MoU with Central Government which will allow all any the hospital empanelled hospitals by that state under AB-NHPM to provide services to eligible beneficiaries of other States from across the country. Moreover, the state shall also be assured that its AB-NHPM beneficiaries will be able to access services at all AB-NHPM empanelled hospitals seamlessly in other states across India.

B. **Empanelled hospitals**: The Empanelled Hospital shall have to sign a tripartite contract with its insurance company and State Health Agency (in case of Insurance Model) or with the Trust which explicitly agrees to provide AB-NHPM services to AB-NHPM beneficiaries from both inside and outside the state and the Insurance Company/Trust agrees to pay to the EHCP through the inter-agency claim settlement process, the claims raised for AB-NHPM beneficiaries that access care outside the state in AB-NHPM empanelled healthcare provider network.

C. **Insurance companies/Trusts**: The Insurance Company (IC) signs a contract with all other IC's and Trusts in the States / UTs under AB-NHPM to settle down the interoperability related claims within 30 days settlement so that the final payment is made for a beneficiary by the Insurance Company or Trust of his/her home state.

D. **IT systems:** The IT System will provide a central clearinghouse module where all inter-insurance, inter trust and trust-insurance claims shall be settled on a monthly/bi-monthly basis. The IT System will also maintain a Balance Check Module that will have data pushed on it in real time from all participating entities. The central database shall also be able to raise alerts/triggers based on suspicious activity with respect to the beneficiary medical claim history based on which the treatment state shall take necessary action without delay.

E. **Grievance Redressal:** The Grievance Redressal Mechanism will operate as in normal cases except for disputes between Beneficiary of Home State and EHCP or IC of Treatment State and between Insurance Companies/Trusts of the Home State and Treatment State. In case of dispute between Beneficiary and EHCP or IC, the matter shall be placed before the SHA of the treatment state. In cases of disputes between IC/Trust of the two states, the matter should be taken up by bilateral discussions between the SHAs and in case of non-resolution, brought to the NHA for mediation. The IC/Trusts of Home State should be able to raise real time flags for suspect activities with the Beneficiary State and the Beneficiary State shall be obligated to conduct a basic set of checks as requested by t-he Home State IC/Trust. These clauses have to be built in into the agreement between the ICs and the Trusts. The NHA shall hold monthly mediation meetings for sorting out intra-agency issues as well as sharing portability related data analytics.

F. **Fraud Detection:** Portability related cases will be scrutinized separately by the NHA for suspicious transactions, fraud and misuse. Data for the same shall be shared with the respective agencies for necessary action. The SHAs, on their part, must have a dedicated team for conducting real time checks and audits on such flagged cases with due diligence. The IC working in the State where benefits are delivered shall also be responsible for fraud prevention and investigation.

Implementation Arrangements of Portability

A. **Packages and Package Rates**: The Package list for portability will be the list of mandatory AB-NHPM packages released by the NHA and package rates as applicable and modified by the Treatment State will be applicable. The Clause for honouring these rates by all ICs and Trusts shall have to be built into the agreement.

   - Clauses for preauthorization requirements and transaction management system shall be as per the treatment state guidelines.

- The beneficiary balance, reservation of procedures for public hospitals as well as segmentation (into secondary/tertiary care or low cost/high cost procedures) shall be as per the home state guidelines.
- Therefore, for a patient from Rajasthan, taking treatment in Tamil Nadu for CTVS in an EHCP – balance check and reservation of procedure check will be as per Rajasthan rules, but TMS and preauthorization requirements shall be as per TN rules. The hospital claim shall be made as per TN rates for CTVS by the TN SHA (through IC or trust) and the same rate shall be settled at the end of every month by the Rajasthan SHA (through IC or trust).

B. **Empanelment of Hospitals:** The SHA of every state in alliance with AB-NHPM shall be responsible for empanelling hospitals in their territories. This responsibility shall include physical verification of facilities, specialty related empanelment, medical audits, post procedure audits etc.

- For empanelment of medical facilities that are in a non AB-NHPM state, any AB-NHPM state can separately empanel such facilities. Such EHCP shall become a member of provider network for all AB-NHPM implementing States. NHA can also empanel a CGHS empanelled provider for AB-NHPM in non AB-NHPM state.
- Each SHA which empanels such a hospital shall be separately and individually responsible for ensuring adherence of all scheme requirements at such a hospital.

C. **Beneficiary Identification:** In case of beneficiaries that have been verified by the home state, the treatment state EHCP shall only conduct an identity verification and admit the patient as per the case.

- In case of beneficiaries that have not been so verified, the treatment EHCP shall conduct the Beneficiary Identification Search Process and the documentation for family verification (ration card/family card of home state) to the Home State Agency for validation.

- The Home State Agency shall validate and send back a response in priority with a service turnaround time of 30 minutes. In case the home agency does not send a final response (IC/Trust check), deemed verification of the beneficiary shall be undertaken and the record shall be included in the registry. The home state software will create a balance for such a family entry.
- The empanelled hospital will determine beneficiary eligibility and send the linked beneficiary records for approval to the Insurance company/trust of Treatment State which in turn will send the records to the Insurance company/trust in the home State of beneficiary. The beneficiary approval team of the Insurance company/trust in the home State of beneficiary will accept/reject the case and convey the same to the Insurance company/trust in the State of hospital which will then inform the same to the hospital. In case the beneficiary has an E-Card (that is, he/she has already undergone identification earlier), after a KYC check, the beneficiary shall be accepted by the EHCP.
- If the NHA and the SHA agree to provide interoperability benefits to the entire Home State Beneficiary List, the identification module shall also include the Home State Beneficiary Database for validation and identification of eligible beneficiaries.

D. Balance Check: After identification and validation of the beneficiary, the balance check for the beneficiary will be done from the home state. The balance in the home state shall be blocked through the necessary API and updated once the claim is processed. The NHA may provide a centralised balance check facility.

E. **Claim Settlement**: A claim raised by the empanelled hospital will first be received by the Trust/Insurer of the Treatment State which shall decide based on its own internal processes. The approval of the claim shall be shared with the Home State Insurance Company/Trust which can raise an objection on any ground within 3 days. In case the Home State raises no objection, the Treatment State IC/Trust shall settle the claim with the hospital. In case the Home State raises an objection, the Treatment State

shall settle the claim as it deems fit. However, the objection of the Home State shall only be recommendatory in nature and the Home State shall have to honour the decision of the Treatment State during the time of interagency settlement.

F. **Fraud Management**: In case the Trust/Insurer of the home State of beneficiary has identified fraudulent practices by the empanelled hospital, the Trust/Insurer should inform the SHA of the Treatment State of EHCP along with the supporting documents/information. The SHA of the Treatment State shall undertake the necessary action on such issues and resolution of such issues shall be mediated by the NHA during the monthly meetings.

G. **Expansion of Beneficiary Set:** In case, there is an alliance between AB-NHPM and any State Scheme or AB-NHPM has been expanded in the Home State, the above process for portability may be followed for all beneficiaries of the Home State.

H. **IT Platform:** The states using their own platform shall have to provide interoperability with the central transaction and beneficiary identification system to operationalize guidelines for portability for AB-NHPM.

I. **Modifications:** The above guidelines may be modified from time to time by the National Health Agency and shall apply on all the states participating in the National Health Protection Mission.

Schedule 10: Template for Medical Audit

Template for Medical Audit

AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION ID		Hospital ID	
Patient Name		Hospital Name	
Case No.		Hospital Contact No.	
Date of Admission		Date of Discharge	
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	**Does each medical record file contain:**			
a.	Is discharge summary included?			
b.	Are significant findings recorded?			
c.	Are details of procedures performed recorded?			
d.	Is treatment given mentioned?			
e.	Is patient's condition on discharge mentioned?			
f.	Is final diagnosis recorded with main and other conditions?			
g.	Are instructions for follow up provided?			
2.	**Patient history and evidence of physical examination is evident.**			
a.	Is the chief complaint recorded?			
b.	Are details of present illness mentioned?			
c.	Are relevant medical history of family members present?			
d.	Body system review?			
e.	Is a report on physical examination available?			
f.	Are details of provisional diagnosis mentioned?			
3.	**Is an operation report available? (only if surgical procedure done)**			
a.	Does the report include pre-operative diagnosis?			
b.	Does the report include post-operative diagnosis?			
c.	Are the findings of the diagnosis specified?			
d.	Is the surgeon's signature available on records?			
e.	Is the date of procedure mentioned?			
4.	**Progress notes from admission to discharge**			
a.	Are progress reports recorded daily?			
b.	Are progress reports signed and dated?			
c.	Are progress reports reflective of patient's admission status?			

d.	Are reports of patient's progress filed chronologically?			
e.	Is a final discharge note available?			
5	Are pathology, laboratory, radiology reports available (if ordered)?			
6	Do all entries in medical records contain signatures?			
a.	Are all entries dated?			
b.	Are times of treatment noted?			
c.	Are signed consents for treatment available?			
7	Is patient identification recorded on all pages?			
8	Are all nursing notes signed and dated?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

____

Signature of the Auditor

Date:

Schedule 11: Template for Hospital Audit

Template for Hospital Audit

Hospital Name		Hospital ID	
Hospital Address			
Hospital Contact No.			
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Was there power cut during the audit?			
2.	If yes, what was the time taken for the power back to resume electric supply?			
3.	Was a AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION kiosk present in the reception area?			
4.	Was any staff present at the kiosk?			
5.	Did you see the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Empanelled Hospital Board displayed near the kiosk in the reception area?			
6.	Was the kiosk prominently visible?			
7.	Was the kiosk operational in local language?			
8.	Were AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION brochures available at the kiosk?			
9.	Were the toilets in the OPD area clean?			
10.	Was drinking water available in the OPD area for patients?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

____
Signature of the Auditor

Date:

Schedule 12: Key Performance Indicators

	KPIs	Time Frame	Penalty
1	Setting up of a State Project Office and Appointment of Project Head and other Staff (to be specified by SHA) for co-ordination and Scheme implementation	15 days after signing of Insurance Contract.	Rs. 25,000 per week and part thereof.
2	Establishment of District Offices	15 days after signing of Insurance Contract.	Rs. 5,000 per week (per district office) and part thereof.
3	Claims-related Activities:		
	a. Pre-authorisation	6 hours for emergency cases and 18 hours for all other cases	Automatic approval post 6 and 18 hours for emergency and non-emergency cases respectively.
	b. Scrutiny and Claim approval from EHCP	Within 15 days of claim submission for the first time excluding the days when the claim is pending with the network hospital.	If the Insurer fails to make the Claim Payment within a Turn-around Time of 15 days for a reason other than a delay by the SHA in making payment of the Premium that is due and payable, then the Insurer shall be liable to pay a penal interest to the EHCP at the rate of 1% of the Claim amount for every 15 days of delay beyond the 30-day period.
4	Delays in compliance to orders of the Grievance Redressal Committee (GRC)	Beyond 30 days.	Rs. 25,000 for the first month of delay in implementing GRC order, Rs. 50,000 per month for every subsequent month thereafter.
5	Completing minimum audit targets - both claims and medical audits (at least 5% of total claims for medical and claims audits)	Specified number of medical and claims audit reports to be submitted in the reporting quarter.	Rs. 10,000 for each audit report not submitted as per plan.
6	Timely submission of a specified minimum audit reports on a quarterly basis – both claims and	Specified number of medical & claims audit	Rs. 10,000 for each audit report not submitted in time.

	medical audits *(To be implemented only when the IT Platform has developed the capability of allowing online filing of these reports)*	reports to be submitted within - 7 days of completing the audit.	

Schedule 13: Indicative Fraud Triggers

Claim History Triggers

1. Impersonation.
2. Mismatch of in house document with submitted documents.
3. Claims without signature of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary on pre-authorisation form.
4. Second claim in the same year for an acute medical illness/surgical.
5. Claims from multiple hospitals with same owner.
6. Claims from a hospital located far away from AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary's residence, pharmacy bills away from hospital/residence.
7. Claims for hospitalization at a hospital already identified on a "watch" list or black listed hospital.
8. Claims from members with no claim free years, i.e. regular claim history.
9. Same AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary claimed in multiple places at the same time.
10. Excessive utilization by a specific member belonging to the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit.
11. Deliberate blocking of higher-priced Package Rates to claim higher amounts.
12. Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
13. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
14. Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit and different hospitals for other members of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit), multiple claims towards the end of Policy Cover Period, close proximity of claims.

Admissions Specific Triggers

15. Members of the same AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit getting admitted and discharged together.
16. High number of admissions.
17. Repeated admissions.
18. Repeated admissions of members of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit.
19. High number of admission in odd hours.
20. High number of admission in weekends/ holidays.
21. Admission beyond capacity of hospital.
22. Average admission is beyond bed capacity of the EHCP in a month.
23. Excessive ICU admission.
24. High number of admission at the end of the Policy Cover Period.

25. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
26. Claims with Length of Stay (LoS) which is in significant variance with the average LoS for a particular ailment.

Diagnosis Specific Triggers

27. Diagnosis and treatment contradict each other.
28. Diagnostic and treatment in different geographic locations.
29. Claims for acute medical Illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
30. Ailment and gender mismatch.
31. Ailment and age mismatch.
32. Multiple procedures for same AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary – blocking of multiple packages even though not required.
33. One-time procedure reported many times.
34. Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
35. Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
36. Part of the expenses collected from AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary for medicines and screening in addition to amounts received by the Insurer.
37. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of Critical Illness.
38. Overall medical management exceeds more than 5 days, other than in the case of Critical Illness.
39. High number of cases treated on an OOP basis at a given provider, post consumption of financial limit.

Billing and Tariff based Triggers

40. Claims without supporting pre/ post hospitalisation papers/ bills.
41. Multiple specialty consultations in a single bill.
42. Claims where the cost of treatment is much higher than expected for underlying etiology.
43. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
44. Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
45. Claims submitted that cause suspicion due to format or content that looks "too perfect" in order. Pharmacy bills in chronological/running serial number or claim documents with colour photocopies. Perfect claim file with all criteria fulfilled with no deficiencies.
46. Claims with visible tempering of documents, overwriting in diagnosis/ treatment papers, discharge summary, bills etc. Same handwriting and flow in all documents from first prescription to admission to discharge. X-ray plates without date and side

printed. Bills generated on a "Word" document or documents without proper signature, name and stamp.

General

47. Qualification of practitioner doesn't match treatment.
48. Specialty not available in hospital.
49. Delayed information of claim details to the Insurer.
50. Conversion of OP to IP cases (compare with historical data).
51. Non-payment of transportation allowance.
52. Not dispensing post-hospitalization medication to AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiaries.

Schedule 14: Indicators to Measure Effectiveness of Anti-Fraud Measures

1. Monitoring the number of grievances per 1,00,000 AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiaries.
2. Proportion of Emergency pre-authorisation requests.
3. Percent of conviction of detected fraud.
4. Share of pre-authorisation and claims audited.
5. Claim repudiation/ denial/ disallowance ratio.
6. Number of dis-empanelment/ number of investigations.
7. Share of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Units physically visited by Scheme functionaries.
8. Share of pre-authorisation rejected.
9. Reduction in utilization of high-end procedures.
10. AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary satisfaction.
11. Share of combined/ multiple-procedures investigated.
12. Share of combined/ multiple-procedures per 1,00,000 procedures.
13. Pre-authorisation pendency rate and Claim pendency rate per 100 cases decided OR percent of pre-authorisation decided after additional observation being attended + correlated with frauds detected as a consequence of this effort.
14. Instances of single disease dominating a geographical area/Service area are reduced.
15. Disease utilization rates correlate more with the community incidence.
16. Number of FIRs filed.
17. Number of enquiry reports against hospitals.
18. Number of enquiry reports against Insurer or SHA staff.
19. Number of charge sheets filed.
20. Number of judgments received.
21. Number of cases discussed in Empanelment and Disciplinary Committee.
22. Reduction in number of enhancements requested per 100 claims.
23. Impact on utilization.
24. Percent of pre-audit done for pre-authorisation and claims.
25. Percent of post-audit done for pre-authorisation and claims.
26. Number of staff removed or replaced due to confirmed fraud.
27. Number of actions taken against hospitals in a given time period.
28. Number of adverse press reports in a given time period.
29. Frequency of hospital inspection in a given time period in a defined geographical area.
30. Reduction in share of red flag cases per 100 claims.

Schedule 15 Guidelines for Hospital Transaction Process including pre-authorisation

AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION would be cashless & paperless at any of the empanelled hospitals. The beneficiaries shall not be required to pay any charge for the hospitalization expenses. The benefit also includes pre- and post-hospitalisation expenses. The scheme is an entitlement based and entitlement of the beneficiary is decided on the basis of family being figured in SECC database.

The core principle for finalising the Balance Check and providing treatment at empanelled hospital guidelines for AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION is to construct a broad framework as guiding posts for simplifying the service delivery under the ambit of the policy and the technology.

1. **Decision on IT platform to be used for AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION:**

Responsibility of – State Government

IT platform for identification of beneficiaries and transactions at the Empanelled Health Care Provider (EHCP) will be provided by MoHFW/NHA.

For ease of convergence and on boarding, States which have their own IT systems under their own health insurance/ assurance scheme may be allowed to continue to use their own IT platform. However, these States will need to map their scheme ID with AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION ID (AHL TIN) at the point of care and will need to share real time defined transaction data through API with the Central server with respect to AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION beneficiaries. States will need to also ensure that no family eligible as per SECC criteria of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION is denied services under the scheme and will need to provide undertaking that eligibility under their schemes covers AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION targeted families as per SECC.

2. **Preparatory Activities for State/ UT's:**

Responsibility of – State Government
Timeline – within a period of 30 days, after approval of empanelment of health care provider

The State will need to:

A. Ensure the availability of requisite hardware, software and allied infrastructure required for beneficiary identification, AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION e-card printing and transactions for delivery of service at the EHCP. Beneficiary Identification and Transaction Software/ Application/ platform will

be provided free of cost by MoHFW/NHA. Specifications for these will be provided by MoHFW/NHA.

B. Ensure that a Medical Officer as Nodal Officer at EHCP for AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION has been nominated.
C. Ensure appointment of Ayushman Mitra for the EHCP
D. Ensure that a dedicated helpdesk for AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION at a prominent place at the EHCP
E. Availability of printed booklets, in abundant quantities at the helpdesk, which will be given to beneficiaries along with the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION e-cards, if beneficiary has not been issued the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION e-card earlier.
F. State/ State Health Agency (SHA) shall identify and set-up team(s) which shall have the capacities to handle hardware and basic software support, troubleshooting etc.
G. Training of EHCP staff and Ayushman Mitras by the SHA/ Insurer.

The State shall ensure availability of above, in order to carry out all the activities laid down in this guideline.

3. Process for Beneficiary identification, issuance of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION e-card and transaction for service delivery

Responsibility of – Ayushman Mitra or another authorised person at EHCP
Timeline – Ongoing

A. Beneficiary Verification & Authentication
   i) Member may bring the following to the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION helpdesk:
      - Letter from MoHFW/NHA
      - RSBY Card
      - Any other defined document as prescribed by the State Government
   ii) Ayushman Mitra/Operator will check if AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION e-Card/ AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION ID/ Aadhaar Number is available with the beneficiary
   iii) In case Internet connectivity is available at hospital
      - Operator/Ayushman Mitra identifies the beneficiary's eligibility and verification status from AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Central Server
      - If beneficiary is eligible and verified under AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION, server will show the details of the members of the family with photo of each verified member
      - If found OK then beneficiary can be registered for getting the cashless treatment.
      - If patient is eligible but not verified then patient will be asked to produce

Aadhaar Card/Number/ Ration Card for verification (in absence of Aadhaar)

- Beneficiary mobile number will be captured.
- If Aadhaar Card/Number is available and authenticated online then patient will be verified under scheme (as per the parameters defined in the software) and will be issued a AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION e-Card for getting the cashless treatment.
- Beneficiary gender and year of birth will be captured with Aadhaar eKYC or Ration Card
- If Aadhaar Card/Number is not available then beneficiary will advised to get the Aadhaar Card/number within stipulated time.

iv) *In case Internet connectivity is not available at hospital*

- AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Registration Desk at Hospital will call Central Helpline and using IVRS enters AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION ID or Aadhaar number of the patient. IVRS will speak out the details of all beneficiaries in the family and hospital will choose the beneficiary who has come for treatment. It will also inform the verification status of the beneficiary
- If eligible and verified then beneficiary will be registered for getting treatment by sending an OTP on the mobile number of the beneficiary
- In case beneficiary is eligible but not verified then she/he can be verified using Aadhaar OTP authentication and can get registered for getting cashless treatment

v) *In* case of emergency or in case person does not show AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION e-Card/ID or Aadhaar Card/Number and claims to be AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION beneficiary and show some photo ID proof issued by Government, then beneficiary may get the treatment after getting TPIN (Telephonic Patient Identification Number) from the call centre and same will be recorded. Government Photo ID proof need not be insisted in case of emergency. In all such cases, relevant AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION beneficiary proof will be supplied within specified time before discharge otherwise beneficiary will pay for the treatment to the Hospital.

vi) If eligibility, verification and authentication are successful, beneficiary should be allowed for treatment

These details captured will be available at SHA/ Insurance Company level for their approval. Once approved, the beneficiary will be considered as successfully identified and verified under AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION.

4. Package Selection

A. The operator will check for the specialty for which the hospital is empanelled. Hospitals will only be allowed to view and apply treatment package for the specialty for which they are empanelled.
B. Based on diagnosis sheet provided by doctor, operator should be able to block Surgical or Non-Surgical benefit package(s) using AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION IT system.
C. Both surgical and non-surgical packages cannot be blocked together, either of the type can only be blocked.
D. As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.
E. Some packages will be reserved for blocking only in public hospitals.
F. The operator can block more than one package for the beneficiary. A logic will be built in for multiple package selection, such that reduced payment is made in case of multiple packages being blocked in the same hospitalization event.
G. If a registered mobile number of beneficiary family is available, an SMS alert will be sent to the beneficiary notifying him of the packages blocked for him.
H. At the same time, a printable registration slip needs to be generated and handed over to the patient or patient's attendant.
I. If for any reason treatment is not availed for any package, the operator can unblock the package before discharge from hospital.

5. Pre-authorisation

A. There would be defined packages which will require pre-authorization from the insurance company. In case any inpatient treatment is not available in the packages defined, then hospital will be able to provide that treatment upto Rs. 50,000 to the beneficiary only after the same gets approved by the Insurance company and will be reflected as unspecified package. Under both scenarios, the operator should be able to initiate a request to the insurance company/trust for pre-authorization using the web application.
B. The hospital operator will send all documents required for pre-authorization to the insurance company/trust using the Centralized AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION/ States transaction management application.
C. The documents exchanged will not be stored on the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION server permanently. Only the information about pre-authorization request and response received will be stored on the central server. It is the responsibility of the insurance company to maintain the documents at their end.
D. The documents needed may vary from package to package and hence a master list of all documents required for all packages will be available on the server.

E. The request as well as approval of the form will be done using the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION IT system or using API exposed by AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION (Only one option can be adopted by the insurance Co.), or using State's own IT system (if adopted by the State).
F. In case of no or limited connectivity, the filled form can also be sent to the insurance company either through fax/ email. However, once internet connectivity is established, the form should also be submitted using online system as described above.
G. The insurance company will have to approve or reject the request latest by 6 hours. If the insurance company fails to do so, the request will be considered deemed to be approved after 6 hours by default.
H. In case of an emergency or delay in getting the response for pre-authorization request due to technical issues, provision will be there to get the pre-authorization code over the phone from Insurance Company or the call centre setup by Insurance Company. The documents required for the processing, may be sent using the transaction system within stipulated time.
I. In case of emergency, insurance company will provide the pre-authorization code generated through the algorithm/ utility provided by MoHFW/NHA-NIC.
J. Pre-authorization code provided by the Insurer will be entered by the operator and will be verified by the system.
K. If pre-authorization request is rejected, Insurance Company will provide the reasons for rejection. Rejection details will be captured and stored in the transaction database.
L. If the beneficiary or the hospital are not satisfied by the rejection reason, they can appeal through grievance system.

6. Balance Check, Treatment, Discharge and Claim Request

A. Based on selection of package(s), the operator will check from the Central AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Server if sufficient balance is available with the beneficiary to avail services.
B. States using their own IT system for hospital transaction will be able to check and update balance from Central AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION server using API
C. If balance amount under available covers is not enough for treatment, then remaining amount (treatment cost - available balance), will be paid by beneficiary (OOP expense will also be captured and stored)
D. The hospital will only know if there is sufficient balance to provide the selected treatment in a yes or no response. The exact amount will not be visible to the

hospital.

E. SMS will be sent to the beneficiary registered mobile about the transaction and available balance
F. List of diagnostic reports recommended for the blocked package will be made available and upload of all such reports will be mandatory before discharge of beneficiary.
G. Transaction System would have provision of implementation of Standard Treatment Guidelines for providing the treatment
H. After the treatment, details will be saved and beneficiary will be discharged with a summary sheet.
I. Treatment cost will be deducted from available amount and will be updated on the Central AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Server.
J. The operator fills the online discharge summary form and the patient will be discharged. In case of mortality, a flag will be raised against the deceased member declaring him as dead or inactive.
K. At the same time, a printable receipt needs to be generated and handed over to the patient or patient's attendant.
L. After discharge, beneficiary gets a confirmation and feedback call from the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION call centre; response from beneficiary will be stored in the database
M. Data (Transaction details) should be updated to Central Server and accessible to Insurance Company for Claim settlement. Claim will be presumed to be raised once the discharge information is available on the Central server and is accessible to the Insurance Company
N. SMS will be sent to beneficiary registered mobile about the transaction and available balance
O. After every discharge, claims would be deemed to be raised to the insurance company. An automated email alert will be sent to the insurance company/trust specifying patient name, AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION ID, registration number & date and discharge date. Details like Registration ID, AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION ID, date and amount of claim raised will be accessible to the insurance company/trust on AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION System/ State IT system. Also details like Registration-ID, AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION-ID, Date and amount of claim raised, date and amount of claim disbursement, reasons for different in claims raised and claims settled (if any), reasons for rejection of claims (if any) will be retrieved from the insurance company/trust through APIs.
P. Once the claim is processed and the hospital gets the payment, the above-mentioned information along with payment transaction ID will be updated on central AYUSHMAN

BHARAT - NATIONAL HEALTH PROTECTION MISSION system by the insurance company/trust for each claim separately.

Q. Hospital Transaction Management Module would be able to generate a basic MIS report of beneficiary admitted, treated and claim settled and in process and any other report needed by Hospitals on a regular basis
R. Upon discharge, beneficiary will receive a feedback call from the Call centre where he can share his feedback about his/her hospitalisation experience.

7. Monitoring of Transaction Process at EHCP

Responsibility of – SHA and Insurance Company
Timeline – Continuous

SHA and Insurance Company will need to have very close monitoring of the process in order to ascertain challenges, if any, being faced and resolution of the same. Some examples of the parameters on which monitoring may be based are as follows:

A. Number of EHCP and Ayushman Mitras
B. Time taken for verification and issuance of e-card of each member
C. Time taken for approval of verification of beneficiaries
D. Percentage of families with at least one member having issued e-card out of total eligible families in SECC
E. Number of admissions per family
F. Grievances received against Ayushman Mitras or EHCP
G. Proportion of Emergency pre-authorisation requests
H. Percent of conviction of detected fraud.
I. Share of pre-authorisation and claims audited
J. Claim repudiation/ denial/ disallowance ratio
K. AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary satisfaction

Schedule 16: Guideline for Greivance Redressal

Grievance Department has to be manned by dedicated resources to address the grievances from time to time as per the instructions of the NHA. The District authorities shall act as a frontline for the redressal of Beneficiaries'/ Providers/ other Stakeholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider with details of the follow-up action taken as regards the grievance as and when the Beneficiaries require it to do so. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication.

Under the Grievance Redressal Mechanism of AB-NHPM, following set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels:

District Grievance Redressal Committee (DGRC)

The District Grievance Redressal Committee (DGRC) will be constituted by the State Health Agency (SHA) in each district within 15 days of signing of MoU with the Insurance Company.

- The District Magistrate or an officer of the rank of Addl. District Magistrate, who shall be the Chairperson of the DGRC.
- The CMO/ CMOH/ DM&HO/ DHO or equivalent rank officer shall be the Convenor of the DGRC.
- Representatives from the district level offices of the Departments of Rural Development.
- The District Coordinator of the Insurer.
- The District Grievance Nodal Officer (DGNO)
- The DGRC may invite other experts for their inputs for specific cases.

Note: DGNO shall try to resolve the complaint by forwarding the same to Action Taking Authority (ATA). If the complaint is not resolved or comments are not received over the same within 15 days of the complaint, then the matter may be referred to DGRC.

State Grievance Redressal Committee (SGRC)

The State Grievance Redressal Committee (SGRC) will be constituted by the State Health Agency within 15 days of signing of MoU with the Central Government.

- CEO of State Health Authority / State Nodal Agency shall be the Chairperson of the SGRC.
- Representatives of the Departments of Rural Development, Women & Child Development, Labour, Tribal Welfare.
- Director Health Services.

- Medical Superintendent of the leading state level government hospital.
- The State Grievance Nodal Officer (SGNO) of the SHA shall be the Convenor of SGRC.
- The SGRC may invite other experts for their inputs on specific cases.

Note: In case of any grievance between SHA and Insurance Company, SGRC will be chaired by the Secretary of Department of Health & Family Welfare of the State. If any party is not agreed with the decision of DGRC, then they may approach the SGRC against the decision of DGRC.

National Grievance Redressal Committee (NGRC)

The NGRC shall be formed by the MoHFW, GoI at the National level. The constitution of the NGRC shall be determined by the MoHFW in accordance with the Scheme Guidelines from time to time. Proposed members for NGRC are:

1. CEO of National Health Agency (NHA) - **Chairperson**
2. JS , Ministry of Health & Family Welfare- Member
3. Additional CEO of National Health Agency (NHA)- Member Convenor
4. Executive Director, IEC, Capacity Building and Grievance Redressal
5. NGRC can also invite other experts/ officers for their inputs in specific cases.

CEO (NHA) may designate Addl. CEO (NHA) to chair the NGRC.
Investigation authority for investigation of the grievance may be assigned to Regional Director- CGHS/Director Health Services/ Mission director NHM of the State/UT concerned.
NGRC will consider:

a. Appeal by the stakeholders against the decisions of the State Grievance Redressal Committees (SGRCs)
b. Also, the petition of any stakeholder aggrieved with the action or the decision of the State Health Agency / State Government
c. Review of State-wise performance based monthly report for monitoring, evaluation and make suggestions for improvement in the Scheme as well as evaluation methodology
d. Any other reference on which report of NGRC is specifically sought by the Competent Authority.

The Meetings of the NGRC will be convened as per the cases received with it for consideration or as per the convenience of the Chairman, NGRC.

1.1. Grievance Settlement of Stakeholders

If any stakeholder has a grievance against another one during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme, it will be settled in the following way by the Grievance Committee:

A. Grievance of a Beneficiary

i) **Grievance against insurance company, hospital, their representatives or any functionary**

If a beneficiary has a grievance on issues relating to entitlement, or any other AB-NHPM related issue against Insurance Company, hospital, their representatives or any functionary, the beneficiary can call the toll free call centre number 14555 (or any other defined number by the State) and register the complaint. Beneficiary can also approach DGRC. The complaint of the beneficiary will be forwarded to the relevant person by the call centre as per defined matrix. The DGRC shall take a decision within 30 days of receiving the complaint.

If either of the parties is not satisfied with the decision, they can appeal to the SGRC within 30 days of the decision of the DGRC. The SGRC shall take a decision on the appeal within 30 days of receiving the appeal. The decision of the SGRC on such issues will be final.

Note: In case of any grievance from beneficiary related to hospitalisation of beneficiary (service related issue of the beneficiary) the timelines for DGRC to take decision is within 24 hours from the receiving of the grievance.

ii) **Grievance against district authorities**

If the beneficiary has a grievance against the District Authorities or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall take a decision on the matter within 30 days of the receipt of the grievance. The decision of SGRC shall be final.

B. Grievance of a Health Care Provider

i) Grievance against beneficiary, insurance company, their representatives or any other functionary

If a Health Care Provider has any grievance with respect to beneficiary, Insurance Company, their representatives or any other functionary, the Health Care Provider will approach the DGRC. The DGRC should be able to reach a decision within 30 days of receiving the complaint.

Step I- If either of the parties is not satisfied with the decision, they can go to the SGRC within 30 days of the decision of the DGRC, which shall take a decision within 30 days of receipt of appeal.

Step II- If either of the parties is not satisfied with the decision, they can go to the NGRC within 30 days of the decision of the SGRC, which shall take a decision within 30 days of receipt of appeal. The decision of NGRC shall be final.

C. Grievance of insurance company

i) Grievance against district authorities/ health care provider

If Insurance Company has a grievance against District Authority / Health Care Provider or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall decide the matter within 30 days of the receipt of the grievance.

In case of dissatisfaction with the decision of the SGRC, the affected party can file an appeal before NGRC within 30 days of the decision of the SGRC and NGRC shall take a decision within 30 days of the receipt of appeal after seeking a report from the other party. The decision of NGRC shall be final.

1.2. Functions of Grievance Redressal Committees

A. Functions of the DGRC:

The DGRC shall perform all functions related to handling and resolution of grievances within their respective Districts. The specific functions will include:

i) Review grievance records.
ii) Call for additional information as required either directly from the Complainant or from the concerned agencies which could be the Insurer or an EHCP or the SHA or any other agency/ individual directly or indirectly associated with the Scheme.
iii) Conduct grievance redressal proceedings as required.
iv) If required, call for hearings and representations from the parties concerned while determining the merits and demerits of a case.
v) Adjudicate and issue final orders on grievances.
vi) In case of grievances that need urgent redressal, develop internal mechanisms for redressing the grievances within the shortest possible time, which could include but not be limited to convening special meetings of the Committee.
vii) Monitor the grievance database to ensure that all grievances are resolved within 30 days.

B. Functions of the SGRC:

The SGRC shall perform all functions related to handling and resolution of all grievances received either directly or escalated through the DGRC. The specific functions will include:

i) Oversee grievance redressal functions of the DGRC including but not limited to monitoring the turnaround time for grievance redressal.
ii) Act as an Appellate Authority for appealing against the orders of the DGRC.
iii) Perform all tasks necessary to decide on all such appeals within 30 days of receiving such appeal.
iv) Adjudicate and issue final orders on grievances.
v) Nominate District Grievance Officer (DGO) at each District.
vi) Direct the concerned Insurance Company to appoint District Nodal Officer of each district.

C. Functions of the NGRC:

The NGRC shall act as the final Appellate Authority at the National level.

i) The NGRC shall only accept appeals against the orders of the SGRC of a State.

ii) The decision of NGRC will be final.

1.3. Lodging of Grievances/ Complaints

A. If any stakeholder has a complaint (complainant) against any other stakeholder during the subsistence of the Policy Cover Period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of the Insurance Contract between the Insurer and the SHA or a Policy or of the terms of their agreement (for example, the Services Agreement between the Insurer and an Empanelled Health Care Provider), then such complainant may lodge a complaint by online grievance redressal portal or letter or e-mail.

B. For this purpose, a stakeholder includes: any AB-NHPM Beneficiary; an empanelled health care provider (EHCP); a De-empanelled Health Care Provider; the Insurer or its employees; the SHA or its employees or nominated functionaries for implementation of the Scheme (DNOs, State Nodal Officer, etc.); and any other person having an interest or participating in the implementation of the Scheme or entitled to benefits under the AB-NHPM Cover.

C. A complainant may lodge a complaint in the following manner:

i) directly with the DGNO of the district where such stakeholder is located or where such complaint has arisen and if the stakeholder is located outside the Service Area, then with any DGNO located in the Service Area; or

ii) with the SHA: If a complaint has been lodged with the SHA, they shall forward such complaint to the concerned DGNO.

D. Upon a complaint being received by the DGNO, the DGNO shall decide whether the substance of the complaint is a matter that can be addressed by the stakeholder against whom the complaint is lodged or whether such matter requires to be dealt with under the grievance redressal mechanism.

E. If the DGNO decides that the complaint must be dealt with under the grievance redressal mechanism, the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee.

F. If the DGNO decides that the complaint need not be dealt with under the grievance redressal mechanism, then the procedures set out in various process/guidelines shall apply.

1.4. Redressal of Complaints

A. The DGNO shall enter the particulars of the complaint on the Web-based Central Complaints and Grievance Management System (CCGMS) established by the MoHFW.

B. The CCGMS will automatically: (i) generate a Unique Complaint Number (UCN); (ii)

categorize the nature of the complaint; and (iii) an e-mail or letter to be sent to the appropriate stakeholder to which such category of complaint is to be referred (including updating on phone).

C. Once the UCN is generated, the DGNO shall send or cause to be sent an acknowledgement email/phone call to the complainant and provide the complainant with the UCN. Upon receipt of the UCN, the complainant will have the ability to track the progress of complaint resolution online through CCGMS and use the same at the time of calling the helpline for allowing easy retrieval of the specific complaint data.
D. The stakeholder against whom a complaint has been lodged must send its comments/ response to the complainant and copy to the DGNO within 15 days. If the complaint is not addressed within such 15-day period, the DGNO shall send a reminder to such stakeholder for redressal within a time period specified by the DGNO.
E. If the DGNO is satisfied that the comments/ response received from the stakeholder will addresses the complaint, then the DGNO shall communicate this to the complainant by e-mail and update the CCGMS.
F. If the DGNO is not satisfied with the comments/ response received or if no comments/ response are received from the stakeholder despite a reminder, then the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee depending on the nature of the complaint after which the procedures set out shall apply.

1.5. Grievance Redressal Mechanism

Upon escalation of a complaint for grievance redressal the following procedures shall apply:

A. The DGNO/SGRC shall update the CCGMS to change the status of the complaint to a grievance, after which the CCGMS shall categorize the grievance and automatically refer it to the Convenor of the relevant Grievance Redressal Committee by way of e-mail.
B. The Convenor of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at its next meeting.
C. Each grievance shall be addressed by the relevant Grievance Redressal Committee within a period of 30 days of receipt of the grievance. For this purpose, each Grievance Redressal Committee shall be convened at least once every 30 days to ensure that all grievances are addressed within this time frame. Depending on the urgency of the case, the Grievance Redressal Committee may decide to meet earlier for a speedier resolution of the grievance.
D. The relevant Grievance Redressal Committee shall arrive at a reasoned decision within 30 days of receipt of the grievance. The decision of the relevant Grievance Redressal

Committee shall be taken by majority vote of its members present. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard.

E. If any party to a grievance is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the relevant Grievance Redressal Committee or other authority having powers of appeal.
F. If an appeal is not filed within such 30-day period, the decision of the original Grievance Redressal Committee shall be final and binding.
G. A Grievance Redressal Committee or other authority having powers of appeal shall dispose of an appeal within 30 days of receipt of the appeal. The decision of the Grievance Redressal Committee or other authority with powers of appeal shall be taken by majority vote of its members. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard. The decision of the Grievance Redressal Committee or other authority having powers of appeal shall be final and binding.

1.6. Proceedings Initiated by the State Health Authority, State Grievance Redressal Committee, the National Health Authority

The SHA, SGRC and/ or the National Health Authority (NHA) shall have the standing to initiate *suo moto* proceedings and to file a complaint on behalf of itself and AB-NHPM Beneficiaries under the Scheme.

A. Compliance with the Orders of the Grievance Redressal Committees

i) The Insurer shall ensure that all orders of the Grievance Redressal Committees by which it is bound are complied with within 30 days of the issuance of the order, unless such order has been stayed on appeal.
ii) If the Insurer fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the Insurer shall be liable to pay a penalty of Rs. 25,000 per month for the first month of such non-compliance and Rs. 50,000 per month thereafter until the order of such Grievance Redressal Committee is complied with. The Insurer shall be liable to pay such penalty to the SHA within 15 days of receiving a written notice.
iii) On failure to pay such penalty, the Insurer shall incur an additional interest at the rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid.

B. Complaints/ Suggestions received through Social Media/Call centre

As Social Media channels will be handled by NHA, hence, the complaints/ suggestions raised through Social Media channels like, Facebook, twitter handles, etc. will be routed to the respective SGNO by NGNO (National Grievance Nodal

Officer). SGNO needs to register the same on the Grievance portal and publish a monthly report on the action taken to the NGNO.

Complaint may also be lodged through Call center by beneficiary. Call center need to register the details like complaint details in the defined format and forward the same to State Grievance Nodal Officer of the State concerned. SGNO needs to upload the details of the complaint on the grievance portal and allocate the same to the concerned District. The Complaint / grievance will be redressed as per guidelines.

Note: Matrix for grievance referral under the Scheme is presented in the table below:

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
AB-NHPM Beneficiary	• Denied treatment • Money sought for treatment, despite Sum Insured under AB-NHPM Cover being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB-NHPM Cover is insufficient or exhausted • AB-NHPM Card retained by Empanelled Health Care Provider • Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO
Empanelled Health Care Provider	• Claims rejected by Insurer or full Claim amount not paid • Suspension or de-empanelment of Empanelled Health Care Provider • Hospital IT Infrastructure not functioning Insurer not assisting in solving issue or not accepting manual transaction	Insurer/ SHA	DGNO
Insurer	• No space provided for District Office	DNO	SGNO
	• AB-NHPM Beneficiary Database not updated for renewal Policy Cover Period • Premium not received within time prescribed.	SHA	SGRC
Inter State/UT (Portability issues)			
AB-NHPM Beneficiary	• Denied treatment • Money sought for treatment, despite Sum Insured under AB-NHPM Cover	Hospital	DGNO of the State/UT where Beneficiary is

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
	being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB-NHPM Cover is insufficient or exhausted • Medicines not provided against OPD Benefits or follow-up care		applying/availing benefits of AB-NHPM (other than parent State/UT)
Empanelled Health Care Provider	• Claims rejected by Insurer or full Claim amount not paid	Insurer/ SHA	SGRC of both parent State/UT and State/UT where the claim is raised State/UT

Schedule 17: Format of Actuarial Certificate for Determining Refund of Premium

[***On the letterhead of the Insurer/Insurer's Appointed Actuary***]

From:

[*Name of Appointed Actuary*]
[*Designation of Appointed Actuary*]
[*Address of Insurer/Appointed Actuary*]

Date: [●]

To:

Mr. [●]
CEO, State Health Agency
Ayushman Bharat - National Health Protection Mission (AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION)
[***Insert Address***]

Dear Sir,

Sub: Actuarial Certificate in respect of Pure Claim Ratio of [*insert name of Insurer*] for Policy Cover Period [●] to [●]

I/We, [*insert name of actuary*], are/am a/an registered actuary under the laws of India and are/is licensed to provide actuarial services.

[*Insert name of Insurer*] (the **Insurer**) is an insurance company engaged in the business of providing general insurance (including health insurance) services in India for the last [●] years. I/We have been appointed by the Insurer as its Appointed Actuary in accordance with the IRDA (Appointed Actuary) Regulations, 2000.

The Insurer has executed a contract dated [●] with the State Health Agency for the implementation of the Ayushman Bharat - National Health Protection Mission (AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION) (the **Insurance Contract**). The Premium payable by the State Health Agency under the Insurance Contract for the Policy Cover Period from [●] to [●] (**Previous Policy Cover Period**) is ₹ [●] (Rupees [*insert sum in words*] only).

In accordance with the Insurance Contract, we are required to certify the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period for all the districts within the Service Area.

I, [*insert name*] designated as [*insert title*] at [*insert location*] of [*insert name of actuary*] do hereby certify that:

(a) We have read the Insurance Contract and the terms and conditions contained therein.

(b) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio for the full 12 months of the Previous Policy Cover Period has been determined by us in accordance with the formula below:

$$\textbf{Pure Claim Ratio} = \frac{C}{P_T} \times 100$$

= [*insert calculation*]

= [*insert result*]%

For the purposes of the formula above:

$\mathbf{P_T}$ is the total Premium collected by the Insurer in the Previous Policy Cover Period for all the Beneficiary Family Units covered by it. It is calculated as the product of the Premium per Beneficiary Family Unit in the Current Policy Cover Period and the total number of Beneficiary Family Units covered by the Insurer in the Current Policy Cover Period, i.e., Rs. [●] (Rupees [*insert sum in words*] only).

C is the total Claims paid by the Insurer to the Empanelled Health Care Providers in the full 12 months of the Previous Policy Cover Period, i.e., Rs. [●] (Rupees [*insert sum in words*] only);

(c) In our fair and reasonable view and based on the information available to us, the Pure Claim Ratio of the Insurer in respect of all the districts within the Service Area in the full 12 months of the Previous Policy Cover Period is [●]% ([*insert sum in words*] percentage).

At [*insert place*]
Date: [*insert date*]

____

On behalf of [*insert name of Appointed Actuary*]
[*Name*]
[*title*]

Name and Counter Signature of Principal Officer of Appointed Actuary, along with Appointed Actuary's name and seal

____

On behalf of [*insert name of Appointed Actuary*]
[*Name*]
[*title*]

[*Note. This counter signature is only required if the Appointed Actuary is an external actuarial firm.*]