national health agency
सत्यमेव जयते

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

FRAUD INVESTIGATION AND MEDICAL AUDIT MANUAL

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

NATIONAL HEALTH AGENCY
DECEMBER 2018

national health agency
सत्यमेव जयते

Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

FRAUD INVESTIGATION AND MEDICAL AUDIT MANUAL

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

NATIONAL HEALTH AGENCY
DECEMBER 2018

FOREWORD

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

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

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

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

Dr. Indu Bhushan
Chief Executive Officer
National Health Agency

TABLE OF CONTENTS

Fraud and Abuse Control under PM-JAY

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

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

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

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

Table 1: Fraud Management approaches at different stages of implementation

Fraud management approaches	Stages of implementation
Prevention	• Beneficiary identification and verification • Provider empanelment • Pre-authorisation
Detection	• Claims management • Data analytics • Field and Medical Audits
Deterrence and Recoveries	• Contract management • Enforcement of contractual provisions • Stringent actions against the offenders

Objective of the Manual

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

Minimum Requirements for Audits and Investigations

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

Table 2: Recommended minimum sample for audits

Audit Type	Sample for Insurer / TPA Audit	Sample for SHA Audit
Medical audit	5% of total cases hospitalised	2% direct audits + 2% of audits done by the Insurer / TPA /ISA
Death audit	100%	100%
Hospital audit	Each empanelled hospital at least twice each year	Each empanelled hospital at least twice a year
Beneficiary audit (during hospitalisation)	10% of total cases hospitalised	5% direct audits + 10% of audits done by the Insurer/TPA /ISA
Beneficiary audit (post discharge – through telephone)	10% of total cases hospitalised	5% direct audits + 10% of audits done by the Insurer/TPA /ISA
Beneficiary audit (post discharge – through home visit)	5% total cases hospitalised	2% direct audits + 2% of audits done by the Insurer /TPA /ISA
Pre-authorisation audit	10% of total pre-authorisations across disease specialties	2% of audits done by the Insurer / TPA /ISA for Insurance mode) 10% of audits done by the TPA /ISA (for Assurance mode)

Claims audit (approved claims)	10% of total claims	3% of audits done by the Insurer /TPA /ISA for Insurance mode) 10% of audits done by the TPA /ISA (for Assurance mode)
Claims audit (rejected claims)	-	100%

In addition, the model tender documents specify minimum requirements for investigation of cases by Insurance company/ISA.

It is possible that SHAs may like to carry out audit and investigation of suspect transactions which would also help fulfil/meet the above requirements or may carry out the same additionally.

The Claims Review Committee and Mortality & Morbidity Review Committees set up at State level shall be forwarded all the serious/repeat fraudulent transactions/reject claims/mortality cases for audit in addition to below mentioned processes.

Process Flow and Standard Formats

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

1. Beneficiary Verification Audits

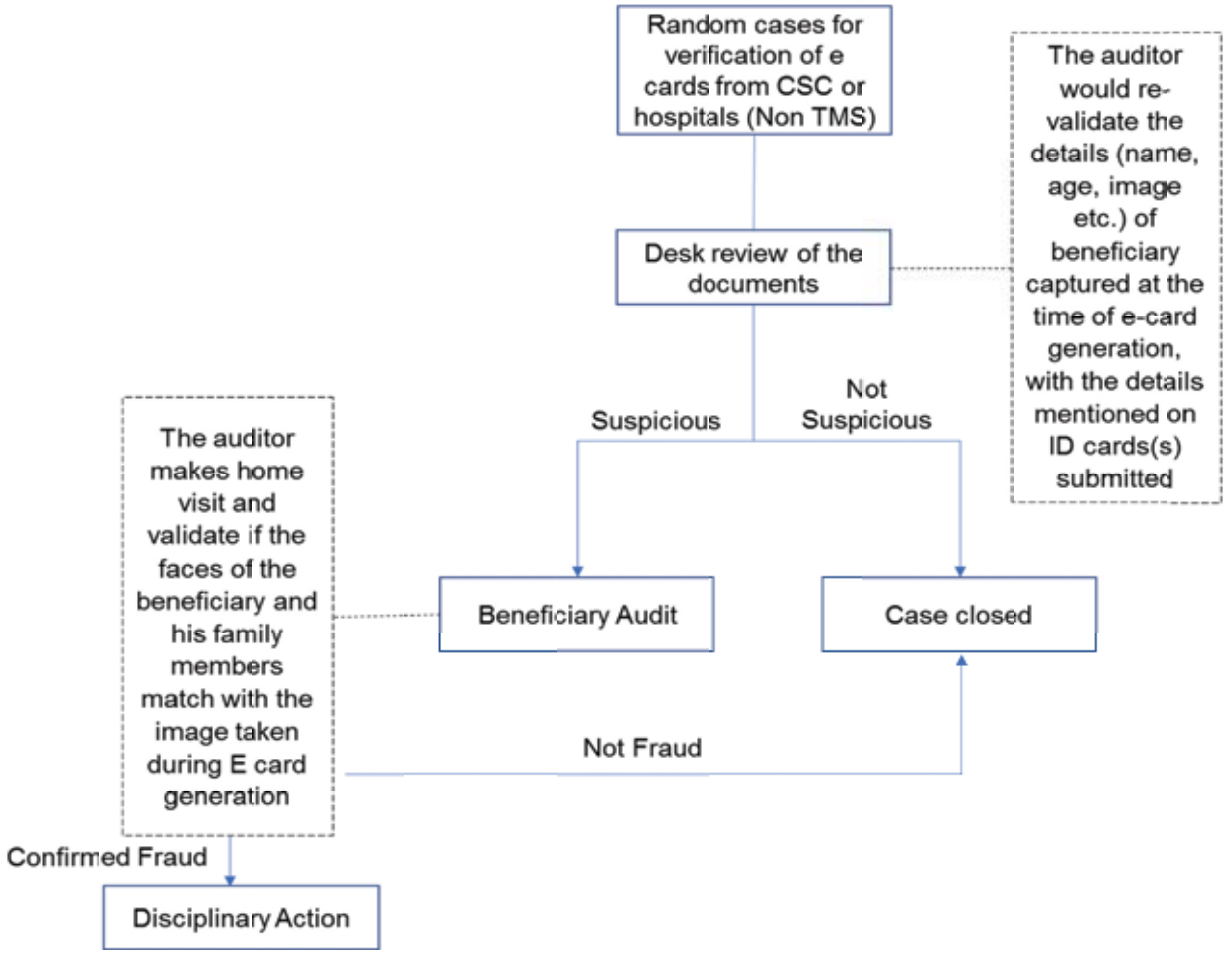
The probable frauds at the level of verification of beneficiary can include:

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

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

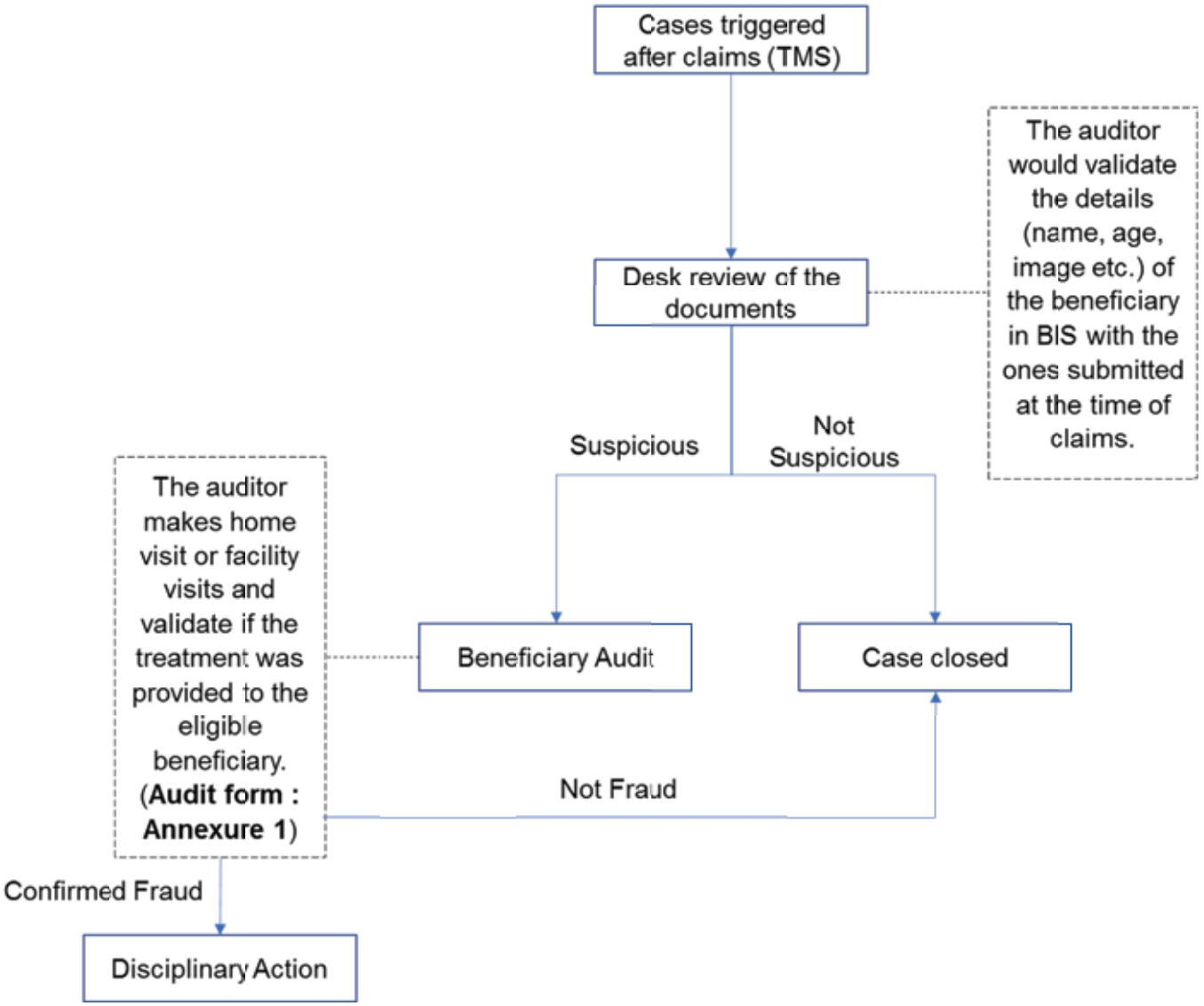
A member of entitled family under PM-JAY can get a golden card (e-card) generated after process of verification either at a CSC or an empanelled hospital

A. Process flow for audit of cases from CSC or Hospitals



Beneficiary audits will also be conducted on random basis or post admission in cases where the anti-fraud triggers flag the claim as suspicious – at pre-auth stage, pre-discharge stage, post discharge or post payment.

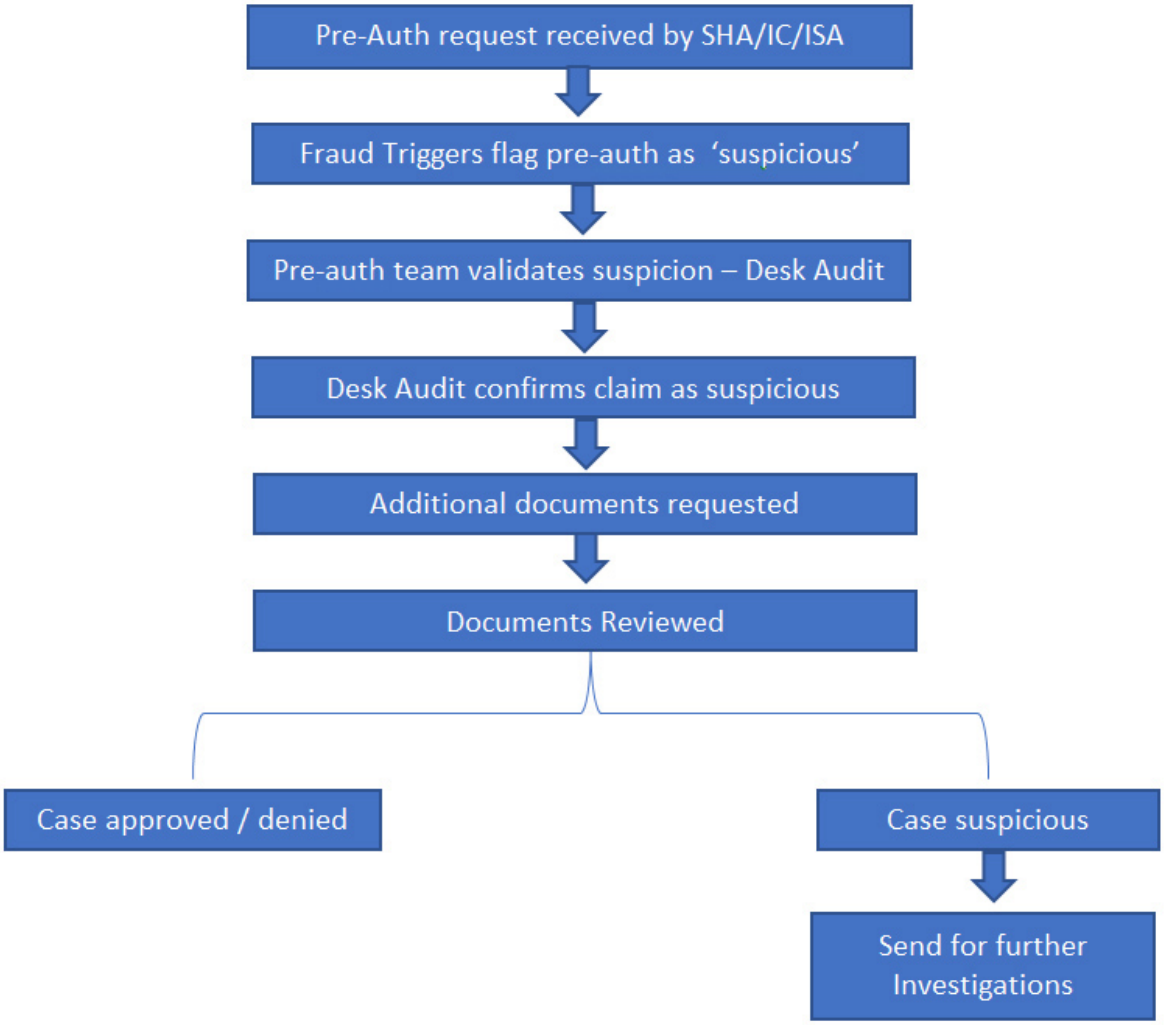
B. Process flow for audit of triggered cases after claims



2. Utilization Audits

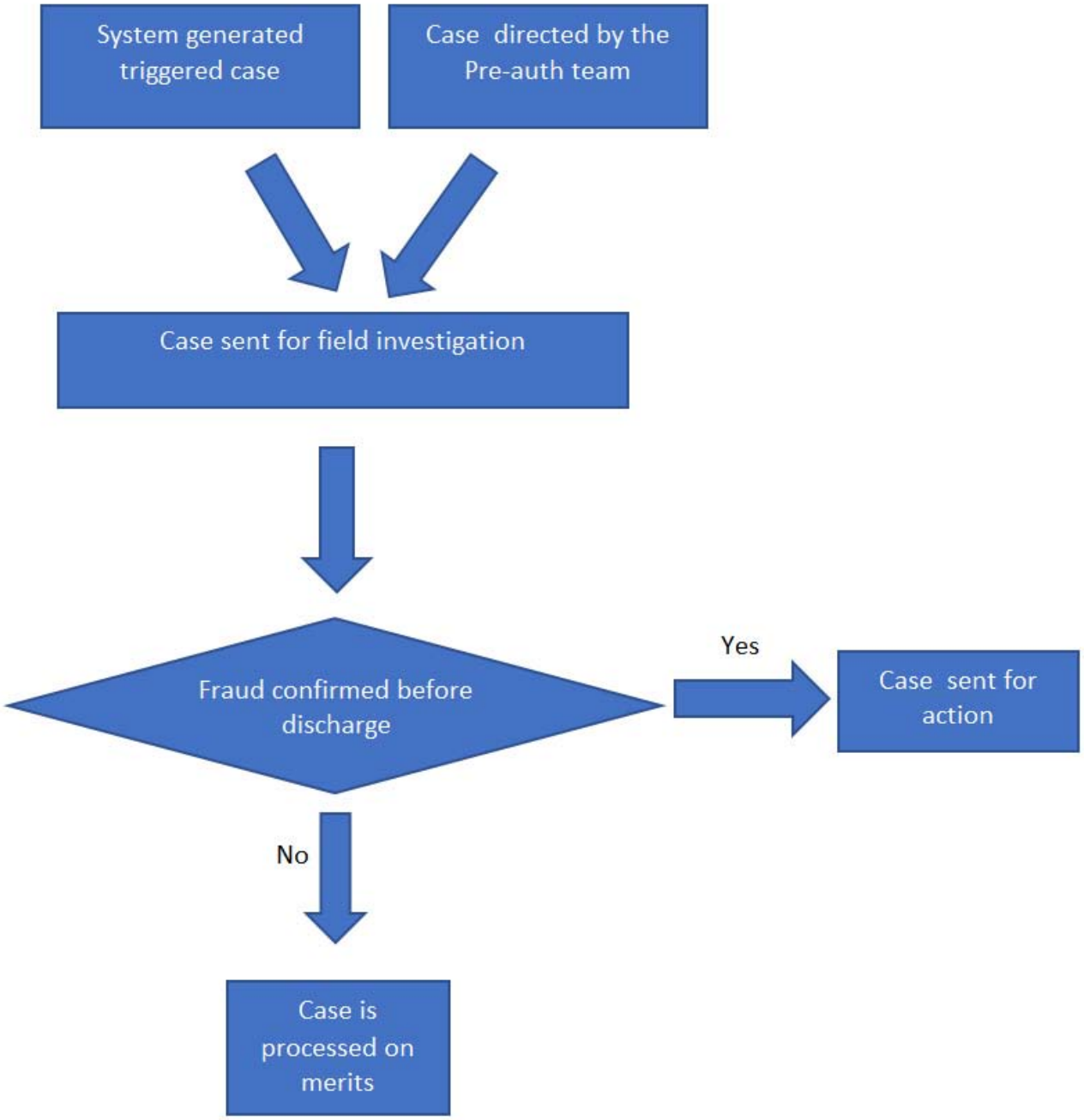
A. Pre-Authorization Stage

At pre - authorization stage, the empaneled health care provider sends pre-authorization request to SHA/ Insurer/ISA. Fraud triggers developed by NHA/SHA would flag the pre-auth request as 'suspicious' if it meets certain pre-defined criteria/triggers. The pre-auth approval team reviews the case and may choose to request additional documents or conduct a medical audit (Annexure 2) as needed, requests for additional documents. After reviewing the document, case may either be approved denied or referred for investigation.



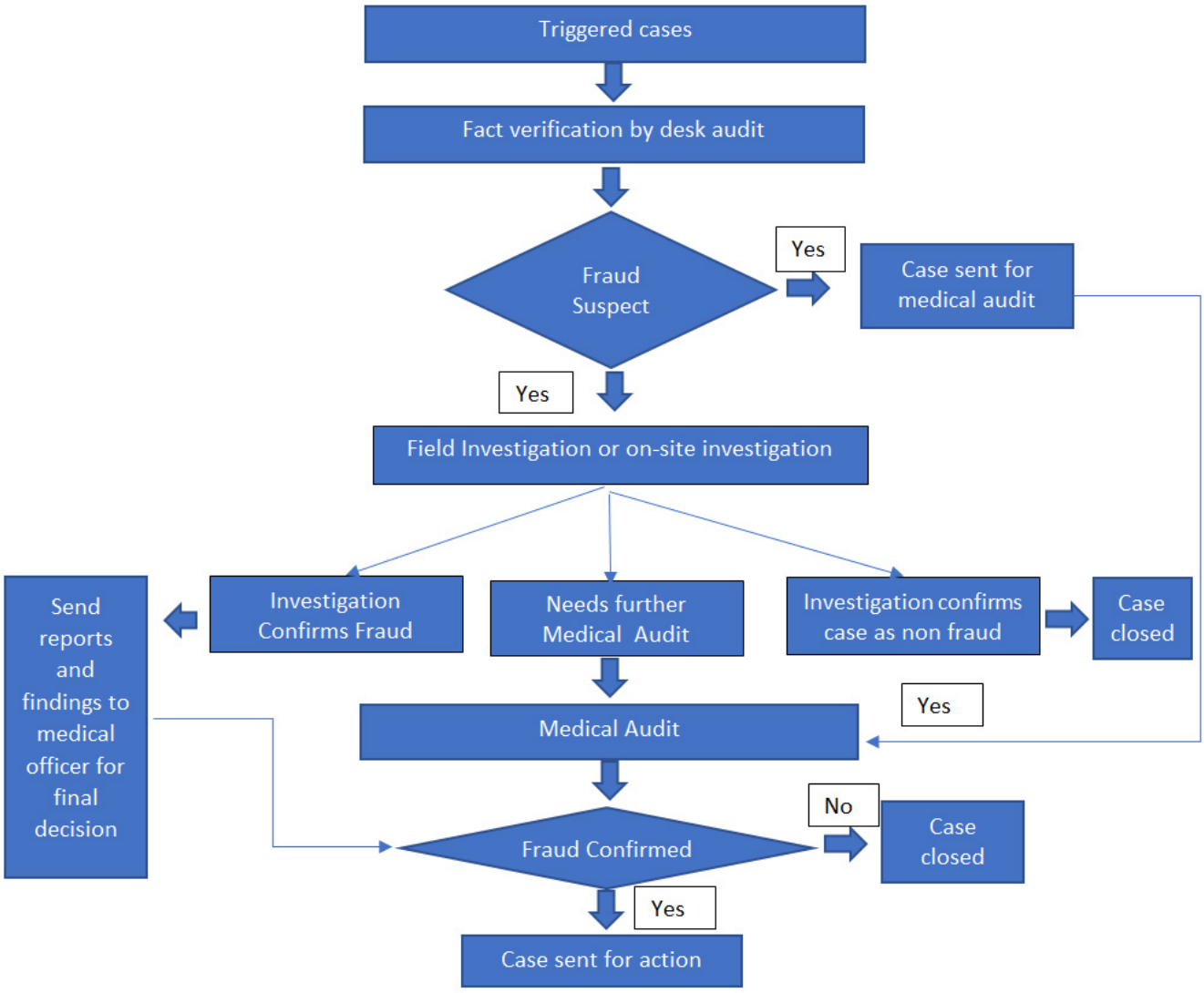
B. During Hospitalization stage (live audits, before discharge)

During hospitalization stage, system triggered cases, or the cases directed by pre-auth team are sent for field investigation (Annexure 3). If fraud is confirmed before the discharge, then case is sent for action/denial of pre-authorization and if confirmed as non-fraud, the case is processed on merits as in normal course.



C. Claims Stage (post-facto audits, after discharge)

In case of post-discharge or at the time of claim adjudication/ payment of the claim, the fraud triggers will highlight certain cases as "suspect" which would need to be investigated/ audited. These cases are first reviewed by the Insurance Company/ ISA for prima-facie/ fact verification to ensure that any apparent false positives are filtered out. If the case remains suspect post first level scrutiny, then the case will be sent for field investigation or medical audit depending on the nature of fraud trigger and the evidence needed for verification (refer annex 3,4). The cases may also be triggered based on review by State Claims Review Committee and Mortality & Morbidity Review Committee in the normal course of their functions. If fraud is confirmed after field investigation, then its report and findings are shared by Medical Officer for the final decision.



As regards cases triggered/marked for medical audit, the Medical Auditor may also conduct a desk audit or field audit depending on the facts to be verified to confirm the suspicion and will communicate his final findings to the Medical officer for his final decision. In some cases, the claim may be sent for field investigation followed by a medical audit team to review additional documentation which may have been collected during the first stage.

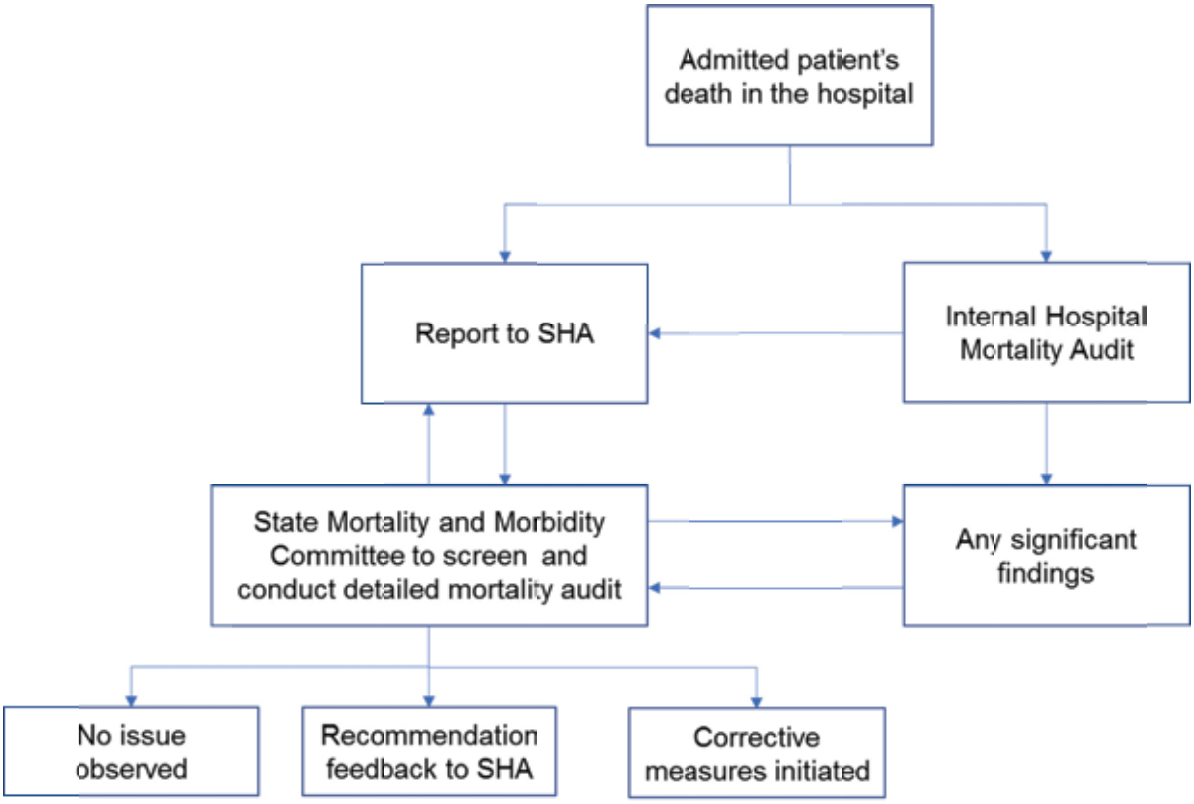
In both cases, the Medical officer will review the observations and findings of the Field Investigator, on-site investigation team and Medical Auditor while taking a final decision on the matter.

3. Mortality Audits

As per Anti-Fraud Guidelines, 100% mortality claims would be referred for audits. The hospitals would be required to provide all the relevant information as specified in Annexure 5 and the same would be reviewed and verified by the audit team to identify the real cause of death and take necessary action in case of death due to negligence. All cases of Mortality must be put up to State Mortality and Morbidity Committee for final review and decision.

Process flow for Mortality Audit

- Every death occurring in the network hospital should be intimated to SHA within 48 hours with a brief death summary
- Each network hospital to constitute a Mortality Audit committee and this committee shall review/examine the cause of death and the report shall be submitted to SHA at the time of claims submission
- State Mortality and Morbidity Committee to screen and conduct detailed mortality audit of all death cases
- Final decision would be taken by State Mortality and Morbidity Committee.



4. Claims Audits

There may be some fraud cases which may initially go undetected and incorrectly approved and paid by the Insurance company/TPA/ ISA/ SHA. To identify such claims, it becomes important that audit of randomly selected cases or triggered cases is done on a periodic basis. The reporting format is mentioned as ***Annexure 6***.

- Claim Review committee shall Review 100 percent claims that are rejected by the Insurer / TPA / ISA / SHA and appealed by the provider;
- Randomly review / audit at least 2 percent of the pre-authorizations and 3 percent of the claims of each provider each quarter.

Process Flow

- Triggered cases or randomly selected approved/paid cases are assigned to the audit team
- Medical doctor of the audit team validates the documents submitted by the hospitals during claims submission and shares report with findings.
- SHA takes a final decision based on the report findings and takes disciplinary action wherever required.

Code of Conduct for Staff handling Field Investigation and Medical Audit

- To maintain highest standards of professional conduct and integrity in all situations
- To carry out investigation/audit work without disrupting or interfering in 'treatment of beneficiary' in any manner whatsoever
- To maintain confidentiality of health data/information collected during the course of investigation and audit and submit the same to competent authority
- To always carry authorization/permission from competent authority to conduct investigation/audit and produce the same to hospital/beneficiary as the case may be
- To always maintain dignity of patient and social norms during beneficiary interviews
- Not to give impression of extraneous authority of any kind while acting on behalf of SHA or any agency working for SHA under PM-JAY

Monthly Reports and MIS to be Submitted to NHA

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

Annexure 1:
Beneficiary Audit Form

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

A. Patient Information

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

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

B. General Information

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

8. For how many days was s/he hospitalized?

9. Was s/he provided free food?

10. What was the treatment given?

11. If any surgery, is there a scar on the body, which could help in verification of the surgery. (If yes, take photograph of the same)

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

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

D. Any other remark or observation:

E. Recommendation of the Auditor:

Name and Signature of the Auditor with Date:

Annexure 2:
Medical Audit Form

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

Modified Medial Audit Qs		Options for answer selection	Remarks
S. No.	**Criteria**		
1	**Pertaining to Clinical Information (Patient history and evidence of physical examination is evident)**		
a.	Is the chief complaint recorded? Pl look for package specific complaints	Yes/ No	
b.	Is History of present illness (HOPI) mentioned? Should have Onset, duration and progress of relevant symptoms/ signs	Yes/ No	
c.	Are relevant personal history of beneficiary noted (positive or negative)? Viz, abuse of tobacco/ alcohol/ intoxicating substances consumption? (the next Q get enabled if answer to this Q is YES)	Yes/ No	
d.	Is the above positive history relevant to having caused the package diagnosis?	Yes/ No	
e.	Does this above history (whether captured or not) makes the package NOT applicable as per exclusion policy?	Yes/ No	
f.	Is a report on relevant physical examination available? Pl look for package specific findings	Yes/ No	
g.	Is general examination and other systems (CVS, CNS, AS, RS) done and findings reported? Pl look for package specific data	Yes/ No	
2	**Progress notes from admission to discharge**		
a.	Are admission notes and detailed findings at admission notes available?	Yes/ No	
b.	Are daily recorded progress reports available? Pl look for package specific sequential information, which should have been captured.	Yes/ No	
c.	Is each progress report signed and dated?	Yes/ No	
d.	Are reports of patient's progress filed chronologically?	Yes/ No	
e.	Are Specific instructions to discharge the patient and line of treatment after discharge captured in ICP's?	Yes/ No	
f.	Is a Discharge summary available?	Yes/ No	
g.	Does the discharge summary capture all details of presenting features, investigations, line of treatment given during stay line of treatment advised at discharge and (Select <No> if investigations and all treatment details, missing as follow up will be not be rational)	Yes/ No	
h.	Are instructions to follow up explicitly given?	Yes/ No	
3	**Pathology/ laboratory/ Radiology reports Scrutiny (only one of the 2 sets a-d or e-f have to be answered)**		
a.	**If it is a Medical / emergency surgery Package, Are pathology/ laboratory reports available**	Yes/ NA	
b.	Are reports relevant to package, the diagnosis and treatment given? Package specific list	Yes/ No	
c.	**If it is a Medical / emergency surgery package, Are radiology reports available?**	**Yes/ NA**	
d.	Are reports relevant to package, the diagnosis and treatment given? Package specific list	Yes/ No	
e.	**If it is a planned surgery package, Are justifying lab/ radiology / Frozen section/ FNAC/ biopsy reports available?**	Yes/ NA	
f.	Are reports relevant to package diagnosis, the diagnosis and treatment given? Package specific list	Yes/ No	
4	**Is an operation report available? (Only for surgical Packages)**	Yes/ No	
	This Surgery Is more likely to be Planned surgery/ emergency surgery/ could be either emergency or planned surgery.		
	Is Pre-op Profile Available (Relevant to Package, Age & Co-morbidities)	Yes/ No	

4A.	**Planned surgery-**	Yes/ NA	
a.	Does the report include Pre and post-operative diagnosis (Both should be same)?	Yes/ No	
b.	Is the correct package blocked?	Yes/ No	
c.	Are the justifications of arriving at the diagnosis rational? Package Specific list	Yes/ No	
d.	Is the date and time of procedure mentioned?	Yes/ No	
e.	Is the surgeon who has operated same as the name given while blocking the package?	Yes/ No	
f.	Is the surgeon's signature available on records?	Yes/ No	
4B.	**Emergency surgery**	Yes/ NA	
g.	Does the report include pre-operative diagnosis?	Yes/ No	
h.	Does the report include post-operative diagnosis?	Yes/ No	
i.	Are the above two similar? (Need not be exactly same)	Yes/ No	
j.	Was the decision to operate rational w.r.t clinical features?	Yes/ No	
k.	Are the justifications of arriving at the diagnosis specified?	Yes/ No	
l.	Is the date and time of procedure mentioned?	Yes/ No	
m.	Is the surgeon who has operated same as the name given while blocking the package?	Yes/ No	
n.	Is the surgeon's signature available on records?	Yes/ No	
5	**Documentation scrutiny**		
a.	Do all entries in medical records contain signatures?	Yes/ No	
b.	Are all entries dated?	Yes/ No	
c.	Are times of treatment noted?	Yes/ No	
d.	Are signed consents for treatment available?	Yes/ No	
e.	Is patient identification recorded on all pages?	Yes/ No	
f.	Are all nursing notes signed and dated?	Yes/ No	
6	Does the claim fall under any clause of Schedule 2 - Exclusions to policy	Yes/ No	

Auditor's Conclusion Red/ Amber/ Green

Space for adding observations basis which this conclusion is arrived at

Annexure 3:
Field Investigation Format

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

Annexure 3 - Field Investigation Format

Reason for field validation	Routine claims review	medical audit request	
A. Patient/Claims Details			
Name of Patient	Gender		Relation
PM-JAY card no. or State Specific scheme No.			
Address			
Name of Hospital -			
Address of Hospital -			
Hospital ID (if available)			
B. Facility inspection: Need to match against the details submitted at the time of empanelment and claim submission			
Hospital Existence	Yes	No	
Response from Hospital	Co-operative	Non Co-operative	Indifferent
Is Hospital Registered DGHS	Yes	No	Reg. No.
No of Beds			
No of OT			
Pathology/ Diagnostics	Inhouse	Out sourced	Not Available
Type of Hopsital	Public	Private	
Name of Treating Doctor			
Speciality			
Dr Registration Number			
Contact Number of Treating Doctor			
Date and time of Hospital Admission as per hospital file			
Date and time of Hospital Discharge as per hospital file			
Type of Treatment	Surgical	Conservative	
If MLC/FIR, not available then specify the reasons			
Diagnosis:			
Any other remark or observation:			
C. Documents Review: Observations noticed for each parameter need to be entered in terms of completeness, errors, overwriting or any discrepancies noticed			
Is IPD Collected		Yes	No
If yes, please upload			
If no specify the reason			
Indoor Register Entry Verified (upload)		Yes	No
Hospital Lab Register Verified (upload)		Yes	No
Treating Doctor Certificate Verified (upload)		Yes	No
All Medical Histroy of patient documented (upload)		Yes	No
Pateint clinical information is documented (upload)		Yes	No
Is there any previous hospitalization of same patient at the same hospital		Yes	No
Past history details documented		Yes	No
Complete Medication list on chart and nursing chart (upload)		Yes	No
Findings and follow ups are documented (upload)		Yes	No
Deatiled progress notes reflecting evaluation of each visit, reason for visit is documented as relevant		Yes	No
Any other remark or observation:			
D. Patient profile			
Patient Photograph collected with ID card (upload)		Yes	No
Patient Id's proof Collected (upload)		Yes	No
Any other remark or observation:			
E. Patient/Attendent interview in the hospital			
What symptoms were the patient exhibiting when he/she visited the hospital?			
When did the patient got admitted?			
Is the patient admitted since then?			
Was the patient informed about the name and value of the package which was blocked by the hospital			
What diagnostic tests (if any) were performed on the patient?			
Was he/she operated upon, if yes, is there a scar on the body, which could help in verification of the surgery. (If yes, take photograph of the same)			
Has any money been charged so far? If yes, how much?			

Any other remark or observation:		
F. Home Visit: Patient/Attendent interview after discharge		
Has s/he availed services under PM-JAY? If yes -proceed further.		
In which hospital did s/he utilize the services?		
What symptoms were the patient exhibiting when he/she visited the hospital?		
When did s/he get admitted?		
When did s/he get discharged?		
For how many days was s/he hospitalized?		
Was s/he provided free food and travel allowance?		
Was the patient informed about the name and value of the package which was blocked by the hospital		
Was the patient given a discharge summary? Does the patient still possess that discharge summary? If yes physically verify the same		
Was post-hospitalization medication provided to the patient?		
Was any money asked by the hospital at any point of time. If yes, then how much and for what purpose?		
Was patient or the attendant asked to purchase any the medicine or carry on any of the diagnostic test at their own cost?		
Does the patient have any receipt for the same? (If yes, take photograph of the same)		
What was the treatment given?		
If any surgery, is there a scar on the body, which could help in verification of the surgery. (If yes, take photograph of the same)		
Any other remark or observation:		

Comment of Investigator

Final Opinion of the Investigator	Genuine	
	Fraud	
	Abuse	

Name of Investigator

Signature of Investigator

Investigation Date & Time

District/State official Siganature

Past History Details (Non Mandatory)		
Name of Disease	Duration prior to getting admitted Only Yes/NO	
High Blood pressure	Yes	No
Diabetes	Yes	No
Asthma	Yes	No
Cancer	Yes	No
IHD/MI	Yes	No
Tobacco	Yes	No
Alcohol	Yes	No
Others		

Annexure 4:
On-Site Investigation Form

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

Annexure 4 – On Site Hospital Investigation

Source: Joint Learning Network Toolkit to develop and strengthen medical audit systems

1. On-site investigation at hospital

A. Information of the Investigation Team	
Name of the spot on-site investigation team leader	
Number of people in the on-site investigation team	
Names of people in the on-site investigation team members	1. 2. 3. 4. 5.
Date of visit to hospital	
Time of field visit	
B. Information of the Hospital	
Name of the hospital	
Location (State, District, Block and Village / Ward)	
Hospital ID	
Number of beds	
Type of hospital (public / private)	

Signatures of Audit team leader and members:

1)
2)
3)
4)
5)

2. Onsite or field investigation Triggers

TRIGGERS FOR ONSITE INVESTIGATION	SOURCE OF DATA	TOOLS FOR INVESTIGATION	PROCESS OF ON-SITE INVESTIGATION
Claims pattern triggers: E.g.; 1. High incidence of day-care procedures (<24hours) 2. Repeated blocking of higher-priced packages (>Rs. 15,000) 3. Length of stay at hospital > 15 days 4. Number of claims disproportionate with bed strength of hospital 5. Inter-district claims more compared to with-in district claims 6. Blocking of cases, that a hospital is not equipped for 7. Showing admission in ICU though not equipped 8. Blocking of multiple packages/procedures	Claims details submitted by Insurance Companies / State Health Agency / NHA server details	*Checklist for -facility inspection at hospital, evaluation of inpatient case records & availability of staff *Questionnaire for interview of beneficiary	Based on the predetermined triggers hospitals with possible deviations from scheme guidelines are identified and listed. On site visit to hospitals by medical audit team members and investigation of availability of facility, infrastructure & staff will be done. Case records of patients will be looked for treatment given. Interview of beneficiaries regarding quality of care and any demand of money for treatment or investigation. Detailed report of the investigation will be submitted for empanelment and disciplinary committee for further action.
Unethical medical practice triggers: 1. ICU admission for more than 7 days 2. Diseases/conditions not related to age/gender of patient 3. Possible Conversion of Outpatient cases to Inpatient cases 4. Hysterectomy performed for patients <40yrs age 5. Cataract related surgeries for <45 yrs. Age 6. Claims pattern of hospital different from that of district	Claims details submitted by Insurance Companies / State Health Agency / NHA server details & complaints or grievances against the hospital.	*Checklist for -facility inspection at hospital, evaluation of inpatient case records, evaluation of operation theatre, evaluation of ICU & availability of staff *Questionnaire for interview of beneficiary *Clinical protocol/pathways	Based on the predetermined triggers and complaints/grievances hospitals with possible deviations from scheme guidelines are identified and listed. On site visit to hospitals by medical audit team members – case records of patients are looked for procedures & surgeries performed using clinical protocol/pathways guidelines. Facility, infrastructure and records of hospital inspection will be done. Detailed report of the investigation will be submitted for empanelment and disciplinary committee for further action.

Fraudulent activities triggers 1. Odd hour transactions 2. Unusual increase in transactions 3. Claims pattern of hospital different from that of district	Claims details submitted by Insurance Companies / State Health Agency / NHA server details & complaints or grievances against the hospital.	Evaluation of complete process of the scheme based on guidelines.	Based on the predetermined triggers and complaints/grievances hospitals with possible deviations from scheme guidelines are identified and listed. On site visit to hospitals by medical audit team members. Complete process of the scheme from registration to discharge (including records of building, accounts etc.) is reviewed and evaluated using checklists, clinical protocol & scheme guidelines to detect any fraudulent activities. Post discharged beneficiaries will be interviewed for detecting quality of service & any fraudulent activities. Detailed report of the investigation will be submitted for empanelment and disciplinary committee at SHA for further legal action.

3. Checklist Template for Onsite/Field Investigations

PM-JAY REGISTRATION/ HELP DESK CHECKLIST			
	QUESTION	**Response**	**REMARKS**
	Is there any signboard outside hospital showing that it is empanelled in scheme?	Yes / No	
	Is there any signage inside the hospital of giving information about the scheme?	Yes / No	
	Is there a scheme help desk at the hospital?	Yes / No	
	Is there a staff/ Arogya Mitra managing the help desk?	Yes / No	
	Is there any scheme patient admitted in the hospital at the time of the visit?	Yes / No	
	If yes, how many scheme patients are admitted	Yes / No	
	Is any Package blocked without patient being admitted?	Yes / No	
	If yes, how many packages are blocked?	Yes / No	

CHECKLIST FOR AVAILABILITY OF STAFF AT THE HOSPITAL			
	QUESTION	**Response**	**REMARKS**
	At least 1 medical officer (RMP) available at all times	Yes / No	
	At least 1 nurse (RNP) available at all times	Yes / No	
	At least 1 information provider is present (staff) at all times.	Yes / No	
	There is a registered nurse appropriately qualified and/or experienced who is responsible for the management of each ward on 24x7 basis	Yes / No	
	There is a system for calling specialists in an emergency	Yes / No	
	Emergency department is manned by an MBBS doctor on 24x7 basis		
	All treating doctors details available at the hospital	Yes / No	

CHECKLIST FOR EVALUATION OF SURGICAL PROCEDURES			
	QUESTION	**Response**	**REMARKS**
	Documented pre-anaesthesia assessment by a qualified anaesthesiologist	Yes / No	
	Informed consent for administration of Anaesthesia is obtained by the Anaesthetist	Yes / No	
	Details of Recorded monitoring of heart rate, cardiac rhythm, respiratory rate, BP, O2 saturation, airway security, and potency and level of anaesthesia	Yes / No	
	OT NOTES- Details of procedure done by respective surgeon of concerned speciality	Yes / No	
	Patient's post anaesthesia status is monitored and documented.	Yes / No	

CHECKLIST FOR OPERATION THEATRE/DEPARTMENT			
	QUESTION	**Response**	**REMARKS**
	OT Sterilization facilities functional.	Yes / No	
	Adequate lights (general level illumination) and Air conditioning is provided in each OT	Yes / No	
	A height adjustable OT Table, shadow less Operating light is available.	Yes / No	
	The operation theatre is equipped for its purpose and includes: - Anaesthetic machine and ventilator - Laryngoscopes (Adult / Paediatric) - Endotracheal tubes/laryngeal masks – Airways - Nasal tubes - Suction apparatus and connectors – Oxygen - Drugs for emergency situations - Monitoring equipment including ECG, ETCO2 (where applicable), pulse oximeter and blood pressure, cardiac monitor, Defibrillator	Yes / No	
	Running tap water supply in OT	Yes / No	
	Hot water supply in OT	Yes / No	
	Procedures are available and up to date for: - Informed patient consent - Pre-operative assessment - Post-operative care	Yes / No	

	Emergency power supply connection is available for all OT equipment's (embedded UPS)	Yes / No	
	Steri labels are used for maintaining the quality of autoclaving (mandatory for ophthalmic specialty)	Yes / No	
	Functional annual maintenance contract for all major equipment's.	Yes / No	
	The OT complex is divided into sterile, clean, protective and disposal zones (maintained physically)	Yes / No	
	Regular documented autoclaving of instruments & linen.	Yes / No	
	Carbonization of the OT, Labour Room after every procedure (documented)	Yes / No	
	Regular validation tests for sterilization (carried out and documented)	Yes / No	

CHECKLIST FOR EVALUATION OF INTENSIVE CARE UNIT (ICU)			
	QUESTION	**Response**	**REMARKS**
	ICU-designated air conditioned space with Standard ICU bed, equipment for the constant monitoring for vitals, emergency crash cart, defibrillator, ventilators, suction pumps, bedside oxygen facility	Yes / No	
	Anaesthesiologist-Intensivist Nursing Staff: B Sc Nursing/Diploma have 2 years of ICU experience What is the Nurse Patient Ratio?	Yes / No	
	Standby Generator/inverter installed in ICU to meet emergency power supply.	Yes / No	
	Policies and procedures for admission, discharge criteria for its intensive and high dependency unit, documented control of infection rate in ICU, re-admission rate, re-intubation rates.	Yes / No	

QUESTIONNAIRRE FOR PATIENTS (BENEFICIARY) ADMITTED IN THE HOSPITAL			
	QUESTION	**Response**	**REMARKS**
	Age	_____ Years	
	Gender		
	Relation with Head of Household		
	Does patient have E-Card with him/ her?	Yes / No	
	E Card number		
	Date of Admission in the hospital		

	Since how many days patient is admitted?		
	Was fingerprint verification done through a fingerprint scanner?	Yes / No	
	Do you know about any provision of transport cost allowance in the scheme?	Yes / No	
	Was the patient provided with food during stay at the hospital?	Yes / No	
	Were all patient related queries answered during your visit to hospital for treatment under the scheme?	Yes / No	
	How would you rate your satisfaction about the treatment provided at the hospital?	Excellent-1 Very good-2 Good-3 Average-4 Poor-5	
	Were you/your family forced to give money for treatment?	Yes / No	
	If yes, total amount medical expenditure paid by patient/family for treatment		
	Will you recommend your relatives/friends to take treatment from the same hospital?	Yes / No	
	If no, why?	Treated badly-1 Poor quality care-2 Not receptive to RSBY patients-3	
	What are the patient's suggestions for improving the scheme?		

Undertaking by Hospital

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

Name/Signature/Date with Seal of the Authorized Person.

Annexure 5:
Mortality Audit Form

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

Annexure 5 – Mortality Audit

Source: www.sast.gov.in

Section 4.1. and 4.2. is to be filled by the hospitals and sent at the time of beneficiaries' death (within 48 hrs)

1. Death Summary (A brief note)

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

2. Progress of the patient during hospitalization

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

Mortality Audit Committee

The committee comprises of individuals constituted from the hospital that represent the key departments - including management, treating doctors and support departments.

Aims and guidelines for conducting mortality audits

The aim is to ascertain the proportion of patients who died because of 'problems in care', defined as patient harm resulting from healthcare processes including acts of omission (inactions), such as failure to diagnose and treat, or from acts of commission (affirmative actions) such as incorrect treatment or management. The focus should be on the systems and processes of care and not on individual performance.

Areas to be identified for each case

Area of CONCERN is where the clinician believes that areas of care SHOULD have been better.

An ADVERSE EVENT is an unintended injury caused by medical management rather than by disease process, which is sufficiently serious to lead to prolonged hospitalization or to temporary or permanent impairment or disability of the patient at the time of discharge, or which contributes to or causes death

The committee would prepare 'DEATH AUDIT REPORT' as mentioned below :

Section A: General Information

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

Section B - Case Summary

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

Section C: Case Assessment

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

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

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

Opinion of the Audit committee regarding overall risk of death

- Minimal/ Mild/ Moderate/ Severe

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

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

Note any areas of concern or Adverse Event

Note if these areas caused any of the following:

Made no difference to outcome _____

May have contributed to death_____

Caused death of patient who would otherwise be expected to survive_____

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

Section D: Record of cause of death

Hospital mortality audit committee review findings:

Primary cause of death: _____

ICD code: _____

Secondary cause of death: _____

ICD Code: _____

Antecedent cause of death: _____

ICD code: _____

FINAL RECOMMENDATIONS (if any) OF THE MORTALITY AUDIT COMMITTEE

1. _____
2._____
3._____

Attestation by the Mortality Audit Committee members:

	Name	Designation	Signature
1			
2			
3			

Date:

First Line Assessment Form on Hospital Mortality Audit Report

Case Note Review

A case note review is a peer assessment of the death of a patient. It should be carried out in a spirit of sympathetic enquiry and provide sufficient detail for a clear view of events. Points should be made in a detached manner and any opinions expressed should be objective and reasonable.

Aim

The aim is to ascertain the proportion of patients who died because of 'problems in care', defined as patient harm resulting from healthcare processes including acts of omission (inactions), such as failure to diagnose and treat, or from acts of commission (affirmative actions) such as incorrect treatment or management.

Criteria for Ranking

An area of CONSIDERATION is where the clinician believes areas of care COULD have been IMPROVED or DIFFERENT, but recognises that it may be an area of debate.

An area of CONCERN is where the clinician believes that areas of care SHOULD have been better.

An ADVERSE EVENT is an unintended injury caused by medical management rather than by disease process, which is sufficiently serious to lead to prolonged hospitalisation or to temporary or permanent impairment or disability of the patient at the time of discharge, or which contributes to or causes death

Section A: General Information

Patient details:

Name:

Age: **Sex:** **Pre-auth No.**

DOA: **DOD:**

Diagnosis:

Reviewing Doctor:

Please provide a summary of the Case in the form of narrative

---

_____

Section B: Case Note Assessment

Were there any areas of CONSIDERATION, of CONCERN or ADVERSE EVENTS in the management of this patient?

Yes

No

1 Describe the most significant event:

Was surgery performed? Yes No

Were there any Areas of Consideration, of Concern, or Adverse Events in any of the following areas if an operation was performed?

Discussion points	Yes	No	N/A
Pre anaesthetic check up/fitness for surgery			
Decision to operate			
Choice of operation			
Timing of operation (too late, too soon, wrong time of day)			
Intra-operative process			
Problems in functioning of OT			
Grade / experience of surgeon deciding			
Grade / experience of surgeon operating			
Post operative period			

If yes above, provide details of

Area of:

Consideration

Concern

Adverse Event

Which:

Made no difference to outcome

May have contributed to death

Caused death of patient who would otherwise be expected to survive

Was it preventable?

Definitely

Probably

Probably not

Definitely not

Don't know

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

---

2 *Describe the second most significant event:*

Area of:

Consideration Concern

Adverse Event

Which:

Made no difference to outcome

May have contributed to death

Caused death of patient who would otherwise be expected to survive

Was it preventable?

Definitely

Probably

Probably not

Definitely not

Don't know

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

_____

_____

3 Describe the third most significant event:

Area of:

Consideration Concern

Adverse Event

Which:

Made no difference to outcome

May have contributed to death

Caused death of patient who would otherwise be expected to survive

Was it preventable?

Definitely

Probably

Probably not

Definitely not

Don't know

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

---

_____

Hospital mortality report review findings:

Record the cause of death (as given)

_____

_____

Conclusion:

Primary cause of death: _____

ICD code: _____

Secondary cause of death:_____

ICD code:_____

Antecedent cause of death: _____

ICD code: _____

Was there enough information to come to a conclusion?

Yes ☐ No ☐

If NO, what information was lacking?

_____

Payment:

Pre-auth approved amount:

Amount Claimed:

Amount Recommended:

Name of the first line assessor:

Designation

Date:

Signature

Annexure 6:
Claim Audit Form

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

A. Claim Specific Information

1. Name of Patient:
2. PM-JAY card no.:
3. Name of Hospital:
4. Package Booked:
5. Package Amount:
6. Status of Claim:

B. Document Validation

		Yes	No
1	Do the photos taken at the time of admission and discharge match with the photo on the card?		
2	Does the information mentioned on the card matches with the information mentioned on the claim documents?		
3	Are the symptoms consistent with the diagnosis?		
4	Are investigation report outcomes consistent with the diagnosis?		
5	Does the diagnosis match the package blocked?		
6	Does the information mentioned on the discharge card consistent with the package blocked?		
7	Was the payment for entire approved amount made?		
8	For rejected cases, was the reason of rejection justified?		

C. Any other remarks

D. Final Conclusion

Date:

Name and Signature of the investigator:

Annexure 7:
Reporting Format

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

Annexure 7: Reporting Format

Name of the state	Gujarat						
Period of performance							
Date of submission							
		Total No of cases triggered for investigation/audit					
A	**B**	**C**	**D**	**E**	**F**	**G**	**H**
State Code (TMS)	**Total Preauths raised**	**Total No of cases trigerred for further review**			**Total amount (value) of cases that were triggerred**	**Total No. of cases investigated / audited**	**% cases investigated/ audited out of triggered (G/ (C+D+E))**
		System generated cases	Cases referred by Processing Team	Cases referred by Claims Review/ Mortality Committee			

Outcomes		Field Investigation				
I	J	K	L	M	N	O
Total amount of cases where fraud was confirmed	% cases confirmed as fraud of total investigated (I/G)	Total Cases sent for Field Investigation		Number of cases where fraud was confirmed after field investigation		Total amount of cases where fraud was confirmed post field investigation
		Hospital	Beneficiary	Hospital	Beneficiary	

Medical Audit			Mortality Audit		
P	Q	R	S	T	U
Total Cases sent for Medical Audit	Number of cases where fraud was confirmed after medical audit	Total amount of cases where fraud was confirmed post medical audit	Total Number of mortalities	Percentage of mortality audits done	Number of cases where death was due to hospital negligence

Action post Confirmation of fraud								
V	W	X	Y	Z	AA	AB	AC	AD
Total Number of hospitals involved in fraud	Number of hospitals against which action was initiated	No of hospitals where showcause was issued	No of hospitals reported to SEC for suspension	No. of hospitals deempanelled	No of hospitals penalised	Amount of penalty recovered	No of hospitals against which FIR is lodged	Amount of punitive Recoveries Made

Beneficiary Audit (ecard /golden record)			
AE	AF	AG	AH
Number of golden records created in CSC	Number of cases selected for audit	Number of cases found fraudulent	Action Taken (List the steps taken after fraud is confirmed)

Annexure 8: Handling Difficult Situations

AYUSHMAN BHARAT – PRADHAN MANTRI JAN AROGYA YOJANA

Handling Difficult Situations during Field Investigation and Audit

A. **Non-cooperation from beneficiary side:** if there is low cooperation from beneficiary during verification or beneficiary is not available to verification, the team will be sending three Queries/Reminder to beneficiary to cooperate in verification. if there is no response, the case will be closed under non-cooperation/ non-submission of required documents.

B. **Non-cooperation from Hospital/provider:** if there is non-cooperation from Hospital/provider, team will be sending three Queries/Reminder to hospital, if there is no response, the claim will be rejected and the amount will be recovered under non-cooperation/ non-submission of required document

C. **Allegation of Bribe/ Misbehave on investigator:** If there is any particular allegation of bride/misbehave on particular investigator, will set up a third party to investigation agency to rule out the actual fact in the case, if allegation found to be correct, action to be taken and dismissal of the agency for future cases

D. **Cases missed out for investigation/Verification**: If any case missed out while assigning the case to investigator for investigation, that need to take it on highest priority to assign to investigator

E. **Not able to assign the case to SHA investigator/NHA team due IT/ technical issue:** in such situation if system is not working or there is any IT issue, where our NHA team or FCM team is not able to assign the triggered case to investigation/FCM team, will do this exercise on manual basis to investigate the case without any fail.

F. **Verification of cases on Holidays:** On any holiday or especially on Saturday and Sunday, FCM team will coordinate with internal team/investigator telephonically and share the investigator/internal inputs on telephone/mobile.

Annexure 9:
Trigger Points

AYUSHMAN BHARAT –
PRADHAN MANTRI JAN AROGYA YOJANA

Triggers Points

1. Claim History Triggers

- Impersonation.
- Mismatch of in-house document with submitted documents.
- Claims without signature of the beneficiary on pre-authorisation form.
- Second claim in the same year for an acute medical illness/surgical.
- Claims from multiple hospitals with same owner.
- Claims from a hospital located far away from beneficiary's residence, pharmacy bills away from hospital/residence.
- Claims for hospitalization at a hospital already identified on a "watch" list or black listed hospital.
- Claims from members with no claim free years, i.e. regular claim history.
- Same beneficiary claimed in multiple places at the same time.
- Excessive utilization by a specific member belonging to the beneficiary Family Unit.
- Deliberate blocking of higher-priced package rates to claim higher amounts.
- Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned,
- only line of treatment given, supporting documentation vague or insufficient.
- Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
- Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the beneficiary family unit and different hospitals for other members of the beneficiary family unit,
- Multiple claims towards the end of policy cover period, close proximity of claims.

2. Admissions Specific Triggers

- Members of the same beneficiary family getting admitted and discharged together.
- High number of admissions.
- Repeated admissions.
- Repeated admissions of members of the same beneficiary family unit.
- High number of admission in odd hours.
- High number of admission in weekends/ holidays.
- Admission beyond capacity of hospital.
- Average admission is beyond bed capacity of the provider in a month.
- Excessive ICU (Intensive Care Unit) admission.
- High number of admission at the end of the Policy Cover Period.

- Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
- Claims with Length of Stay (LOS) which is in significant variance with the average LoS for a particular ailment.

3. Diagnosis Specific Triggers

- Diagnosis and treatment contradict each other.
- Diagnostic and treatment in different geographic locations.
- Claims for acute medical Illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
- Ailment and gender mismatch.
- Ailment and age mismatch.
- Multiple procedures for same beneficiary – blocking of multiple packages even though not required.
- One-time procedure reported many times.
- Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
- Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
- Part of the expenses collected from beneficiary for medicines and screening in addition to amounts received by the Insurer.
- ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of critical illnesses.
- Overall medical management exceeds more than 5 days, other than in the case of critical illness.
- High number of cases treated on an out-of-pocket payment basis at a given provider, post consumption of financial limit.

4. Billing and Tariff based Triggers

- Claims without supporting pre/ post hospitalisation papers/ bills.
- Multiple specialty consultations in a single bill.
- Claims where the cost of treatment is much higher than expected for underlying etiology.
- High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
- Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
- 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.
- 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.

5. General

- Qualification of practitioner doesn't match treatment.
- Specialty not available in hospital.
- Delayed information of claim details to the Insurer.
- Conversion of out-patient to in-patient cases (compare with historical data).
- Non-payment of transportation allowance.
- Not dispensing post-hospitalization medication to beneficiaries.

NOTES

NOTES

NOTES

national health agency

सत्यमेव जयते

Pradhan Mantri Jan Arogya Yojana

Ayushman Bharat

PM-JAY