

Health Benefit Packages 2.0

User Guidelines

National Health Authority

Version: September 2020

Note

State specific modifications in the NHA published guidelines may be expected

Detailed guidelines and manuals for Standard Treatment Guidelines, Hospital Empanelment, Claim Adjudication, Fraud and abuse, Grievance Redressal etc. referred in this document may be accessed at the PM-JAY website

Foreword



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

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) was launched by Hon'ble Prime Minister on 23rd September 2018 from Ranchi, Jharkhand with the aim to offer secondary and tertiary health coverage of ₹ 5,00,000 to the 10.74 crore beneficiary families, accounting for more than 40 percent of India's population at empanelled hospitals.

The scheme was rolled out using the Health Benefit Package (HBP) Master of 1,393 packages out of which 1,083 are surgical, 309 medical and 1 unspecified package (which can be used for booking treatments, not listed). So far, within two years of the scheme, 1.23 crore patients have received treatment amounting to Rs 15.57 crores using these packages across 23,311 empanelled hospitals.

However, since launch, the National Health Authority has been receiving feedback on various aspects of the scheme including the aberrations and anomalies that have crept in the HBP. NHA hopes that with the restructuring and rationalisation of HBP 2.0, every stakeholder's concerns will be addressed, and it will spur PM-JAY towards the objective of empowering the poorest of the poor to access healthcare equitably without having to bother about the expenditure thus taking India one step closer towards its avowed goal of Universal Health Coverage.

I am grateful to all the stakeholders who engaged in the consultation process and provided valuable suggestions in finalizing the benefit packages and empanelment criteria. We intend to continuously refine the design of the scheme based on experience in implementation.

Dr. Indu Bhushan
Chief Executive Officer
National Health Authority

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Section 1. Health Benefit Packages in AB PM-JAY

1.1 Objectives of the Scheme

The objective of Ayushman Bharat Pradhan Mantri Jan Arogya Yojana 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 beneficiary family unit of AB PM-JAY. These eligible AB PM-JAY beneficiary families will be provided coverage for secondary, tertiary and day care procedures (as applicable) for treatment of diseases and medical conditions through a network of Empaneled Health Care Providers (EHCP).

1.2 AB PM-JAY Beneficiaries and Beneficiary Family Unit

All persons that are eligible for the scheme as per SECC 2011 data and RSBY enrolled families (if applicable) in the Service Area are eligible to become Beneficiaries.

All AB PM-JAY 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 unorganised 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 2011 Database which are resident in the Service area (State specific) are considered as eligible for benefits under the Scheme and are automatically covered under the Scheme.

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

Unit of coverage under the Scheme is a family and each family for this Scheme is referred to as an AB PM-JAY Beneficiary Family Unit, which comprises all members in that family. Any addition in the family is allowed only as per the provisions approved by the Government.

The presence of name in the beneficiary list, (amended from time to time, due to addition of family member, as per Guidelines - Schedule 4) serves as the proof of eligibility of the Beneficiary Family Unit for the purpose of availing benefits under this Insurance Contract.

1.3 Health Benefit Package (HBP)

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

- Hospitalization expense
- Day care treatment (as applicable)
- Follow-up care
- Pre and post hospitalization expense
- Newborn child / children

Except for exclusions listed in Annexure 1, treatment / procedures will also be allowed, in addition to the procedures listed in Annexure 2, of up to a limit of ₹ 1,00,000 to any AB PM-JAY Beneficiary (called 'Unspecified Procedure') within the overall limit of ₹ 5,00,000. Surgeries pertaining to Unspecified Procedure are to be governed as per Unspecified Packages Guidelines provided under section 1.7 of the document.

1.4 Package Rates

The Insurer shall reimburse claims of Empaneled Health Care Provider under the AB PM-JAY based on Package Rates determined as follows:

- If the package rate for a medical treatment or surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is fixed in the Health Benefit Package list, then the Package Rate so fixed shall apply for the Policy Cover Period.
- If the package rate for a surgical procedure requiring Hospitalization or Day Care Treatment (as applicable) is not listed in in the Health Benefit Packages, then the Insurer may pre-authorise an appropriate amount based on rates for similar procedures defined in the list, or based on other applicable national or state health insurance schemes such as CGHS. In case of medical care, the rate will be calculated on per day basis as specified in the package list except for special inputs

like High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages or some other special inputs existing in the HBP (or are released by NHA in future) which can be clubbed with medical packages.

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

For the purpose of Hospitalization expenses as package rates shall include all the costs associated with the treatment, amongst other things:

- Registration charges
- Bed charges



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

For the purpose of Day Care Treatment expenses shall include, amongst other things:

- Registration charges
- Surgeons, anaesthetists, Medical Practitioners, consultants' fees, etc.
- Anaesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.
- Medicines and drugs
- Cost of prosthetic devices, implants, organs, etc.
- Pathology and radiology tests: Medical procedures include basic Radiological imaging and diagnostic tests such as X-ray, USG, Haematology, pathology etc. However, High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.

- Pre and Post Hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.
- Any other expenses related to the Day Care Treatment provided to the Beneficiary by an EHCP.

If NHA / SHA finds that a treatment is being booked under unspecified category repeatedly, or some treatment is required to be included within the list to address a pressing health problem which is or have become widely prevalent, then NHA / SHA may add such treatments in the HBP list.

The benefits under the AB PM-JAY Risk Cover shall only be available to an AB PM-JAY Beneficiary through an empaneled healthcare provider (EHCP) after Aadhaar based identification as far as possible as per Guidelines. In case Aadhaar is not available then other defined Government recognized ID will be used for this purpose.

The benefits under the AB PM-JAY cover shall, subject to the available AB PM-JAY sum Insured, be available to the AB PM-JAY beneficiary on a cashless and paperless basis at any EHCP.

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

1.5 Incentives for Hospitals

There is no change in the NHA policy for incentives. However, the percentage of incentive will no longer be applicable to the price of the implant. Incentive will only be calculated on the procedure rate. Indicative incentive mechanisms are as below, (this is a voluntary exercise at the States' discretion, with prior intimation to the NHA).

S. No.	Criteria	Incentive
1	Entry level NABH	10%
2	Full NABH accreditation	15%
3	Situated in Delhi or some other Metro	10%
4	Aspirational district	10%
5	Running PG / DNB course in the empanelled specialty	10%

These percentage incentives are added by compounding rather than in simple way. Thus, for a package costing Rs. 10,000 otherwise, the payment made for a hospital with full NABH accreditation in an aspirational district will be ₹10,000 x 1.15 x 1.10 = ₹12,650. It will not be calculated as ₹10,000 x 1.25 = ₹12,500.

117 Aspirational districts have been identified by NITI Aayog based upon composite indicators from Health & Nutrition, Education, Agriculture & Water Resources, Financial Inclusion and Skill Development and Basic Infrastructure which have an impact on Human Development Index.

The Metros include Delhi (UA) (including Faridabad, Ghaziabad, NOIDA and Gurugram), Greater Mumbai (UA), Kolkata (UA), Chennai (UA), Bangalore / Bengaluru (UA), Ahmedabad (UA), Hyderabad (UA) and Pune (UA). [Cities classified as “X” in Ministry of Finance’s OM No. 2/5/2014-E.II(B) dated 21.07.2015]

1.6 Payment in special cases during hospital admission

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

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

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

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

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

1.6.1 Patient Leave / Discharge Against Medical Advice (LAMA/DAMA)

Leave Against Medical Advice (LAMA), also called discharge against medical advice (DAMA), is an act whereby a patient takes his/her discharge contrary to the recommendation or will of the attending physician. This can happen due to various reasons related to the beneficiary or the hospital.

After the audit, the payment to the hospital will be done as per the following:

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

- b. LAMA/ DAMA after surgery - Payment for 75% of the package rate will be done to the hospital by the SHA/ Insurer in this case. Daily case sheets and OT notes will need to be submitted by the hospital for auditing purposes to qualify for payment.
- B. Medical Cases - Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered.

1.6.2 Patient dies in the hospital

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

A. Surgical Cases

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

1.6.3 Patient referred to another hospital

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

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

A. Referred to an EHCP

- Surgical Cases

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

patient would be eligible for 100% of the package rate of the new surgery selected (if a surgical package is booked), or in line with the existing medical packages according to Length of Stay (LOS) and bed category of the patient (if a medical package is booked), depending on the patient. This surgery in the second hospital will need to be mandatorily pre-authorized.

- Medical Cases – Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid to the referring hospital as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. The hospital that receives the referred patient would be eligible for 100% of the package rate of the surgery selected (if a surgical package is booked), or in line with the existing medical packages according to Length of Stay (LOS) and bed category of the patient (if a medical package is booked), depending on the patient.

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

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

NOTE: In no other cases partial payment will be done to empaneled hospitals

1.7 Unspecified Packages

To ensure that PM-JAY beneficiaries are not denied care, for treatments/procedures that do not feature in the listed interventions, there is an exclusive provision that has been enabled in the TMS (transaction management system) for blocking such treatments, subject to satisfying certain defined criteria (as mentioned)

1.7.1 Using an unspecified package

Criteria for treatments that can be availed under unspecified:

- Only for surgical treatments
- Compulsory pre-authorization is in-built while selecting this code for blocking treatments.

- Cannot be raised under multiple package selection. Not applicable for medical management cases.
- Government reserved packages cannot be availed by private hospitals under this code. PPD / CPD may reject such claims on these grounds. In addition, SHA may circulate Government reserved packages to all hospitals. Further, States need to establish suitable mechanisms to refer such cases to the public system – as a means to avoid denial of care.
- Cannot be booked for removal of implants, which were inserted under the same policy. Exceptions where removal of implants is not covered under any other package, to be approved by State Health Agencies or National Health Authority.
- In the event of portability, the home state approval team may either reject if a Government reserved package of the home state is selected by a private hospital in the treating state or consider on grounds of 'emergency'.
- Aesthetic treatments of any nature cannot be availed under this code or as such under any other listed codes under PM-JAY. Only medically necessary with functional purpose/ indications can be covered. The procedure should result in improving/restoring bodily function or to correct significant deformity resulting from accidental injury, trauma or to address congenital anomalies that have resulted in significant functional impairment.
- Individual drugs or diagnostics cannot be availed under this code. Only LISTED drugs and diagnostics with fixed price schedules, listed under the drop down of respective specialties, are included for blocking treatments.
- None of the treatments that fall under the exclusion list of PM-JAY can be availed viz. individual diagnostics for evaluation, out-patient care, drug rehabilitation, cosmetic / aesthetic treatments, vaccination, hormone replacement therapy for sex change or any treatment related to sex change, any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalization for treatment etc.

- However, for life threatening cases e.g. of suicide attempt or accident due to excess consumption of alcohol, treatment shall be provided by the hospital till the patient's condition stabilizes.
- In case the State/UT is getting multiple requests for the same unspecified package from multiple hospitals or for multiple patients, then the same should be taken up with the Medical Committee for inclusion in the package master for that State/UT within a defined time frame as per the State/UT.
- The same should also be shared with NHA for consideration to include such packages in national package master.

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

1.7.2 Unspecified package above ₹ 1 Lakh

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

The following process to be adhered:

A. For Public Hospitals:

- A standing Medical committee will be constituted by CEO of each state to provide inputs on unspecified packages among their other deliverables.
- CEO, SHA will approve every case after recommendation from the standing medical committee (wherever committee is yet to be constituted, opinion of 2 medical experts will suffice as recommendation in the interim period), with details of treatment and pricing that is duly negotiated with the provider. This approval should have insurance company concurrence, wherever applicable.

- The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, consumables and post-op care included – preferably citing rates as ceiling from any govt. purchasing scheme like CGHS etc., if available.
- A letter or request from the SHA with approval of competent authority may be sent to NHA as an intimation of their approval and requesting technical support for backend change of amount via ticket (including an intimation via mail); TMS will permit to block the unspecified package \geq ₹ 1 lakh.
- Upon request of State Coordinator at NHA, technical team will carry out backend change.

B. For Private Hospitals:

- A standing Medical committee will be constituted by CEO of each state to provide inputs on unspecified packages among their other deliverables.
- CEO, SHA will approve every case after recommendation from the standing medical committee (wherever committee is yet to be constituted, opinion of 2 medical experts will suffice as recommendation in the interim period), with details of treatment and pricing that is duly negotiated with the provider. Justification for the case not being carried out at a public hospital will be required to be highlighted in the approval. This approval should have insurance company concurrence, wherever applicable.
- The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, consumables and post-op care included – preferably citing rates as ceiling from any govt. purchasing scheme like CGHS etc. if available.
- A letter or request from the SHA with approval of competent authority may be sent to NHA for approval along with request for technical support for backend change of amount via ticket (including an intimation via mail); TMS will permit to block the unspecified package \geq Rs. 1 lakh.
- The case upon recommendation of Director (HNW&QA) will be assessed on its merit for approval. Once approved, it will be shared by State Coordinator with technical team for backend change.

1.8 Grievance Redressal

Any issue faced by the hospitals may be escalated through the grievance redressal system under AB PM-JAY. Hospitals can register grievances through portal <http://www.cgrms.pmjay.gov.in>

Once the case is registered, it will automatically reflect in concerned officer login. The District Grievance Nodal Officer (DGNO) / State Grievance Nodal Officer (SGNO) typically has 15 days to act on a case. If no action is taken it will get escalated to next higher authority. If any party (complainant or aggrieved against party) is not satisfied with the decision of officers or committee, they can re-open the case and it will be automatically escalated to next higher committee. Committees at each level have 30 days of time to redress the grievances.

SOS cases (cases which are emergency in nature) or cases against district administrations are directly sent to SGNO. SGNO has 6 working hours to resolve SOS cases and 15 days to resolve normal cases. If no action is taken, the case is escalated to CEO of SHA through an email intimation. A copy of the same is also sent to the concerned NHA officials.

Section 2. Health Benefit Packages 2.0

2.1 Introduction

In April 2019, the Governing Board of NHA, under the Chairmanship of Hon'ble Minister for Health & Family Welfare, directed NHA to undertake an exercise to remove the aberrations and anomalies in the existing HBP. The procedure laid down was very vigorous and scientific, broadly consisting of three steps:

- i. 24 specialty committees were formed consisting of eminent doctors from respective specialties. The members of the committee were drawn from specialists working both in public and private sector hospitals. Examination of the relevant sections of HBP was done by respective specialist committee to make suggestions on nomenclature, inclusion, exclusion, pricing and implants used (if any) in the treatments to be provided under the packages. To these meetings representatives of IMA, FICCI, CII, NatHealth and AHPI were also invited.
- ii. A review committee was constituted under the joint chairmanship of the CEO, NHA and Secretary, DHR (Department of Health Research) to examine the suggestions made by the specialist committees and moderate them if required. The committee had as its members prominent clinicians, representatives of NITI Aayog, Secretary Health, Directorate General of Health Services (DGHS), five states and other functionaries.
- iii. The examination and final approval / modification of the recommendations of review committee was kept in the jurisdiction of the Governing Board.

NHA, along with Department of Health Research (DHR), Indian Council of Medical Research (ICMR) and Tata Memorial Hospital consulted specialist committees, which made recommendations to remove the inconsistencies in the nomenclature and pricing for their respective specialties. These recommendations were examined by the review committee which suggested to take states' feedback also before finalizing the changes. NHA organized the 'First National Workshop on Health Benefit Packages' in August 2019, collated all the feedbacks from various states and UTs which were examined by the review committee and then the recommendations for Governing Board were finalized.

The Governing Board meeting held under the chairmanship of Hon'ble Minister for Health & Family Welfare, Dr. Harsh Vardhan, on September 11, 2019, was also attended by Member – NITI Aayog Dr. Vinod Paul and Secretary, DHR & DG - ICMR Dr. Balram Bhargava as special invitee, apart from the regular members. In the meeting, it was decided to approve some changes in the existing HBP.

NHA hopes that with the restructuring and rationalization of HBP 2.0, every stakeholder's concerns will be addressed, and will spur AB PM-JAY towards the objective of empowering the poorest of the poor to access healthcare equitably without having to bother about the expenditure thus taking India one step closer towards its avowed goal of Universal Health Coverage.

2.2 Salient Features

HBP 2.0 introduces some new concepts that are expected to simplify and improve the utilization of the new packages.

2.2.1 Packages & Procedures

HBP 2.0 introduces packages and procedures as two separate entities. Some of the packages are a group of procedures. A package is split into procedures that help better specify the approach / treatment modality / etiology / complication of the package, among other criteria. Capturing of procedures in place of packages is expected to improve the granularity of the analysis that can be performed on the utilization data of the scheme.

For example, a package of 'Lap/Open Cholecystectomy with / without Exploration of CBD' is split into four independent and specific procedures to be booked for a patient

- i. Lap cholecystectomy with exploration of CBD
- ii. Lap cholecystectomy without exploration of CBD
- iii. Open cholecystectomy with exploration of CBD
- iv. Open cholecystectomy without exploration of CBD

Significance for the user: The list of packages are reference fields for the end user to select a procedure to be performed. The final selection would be at procedure level only. When searching for a procedure to be performed, the TMS would sort through both the list of packages, and procedures to present the user with the best match that should facilitate procedure selection and minimize chances of ambiguity.

2.2.2 Stratification

Stratification has been introduced to further drill down into procedures based on criteria such as type of anesthesia, bed category on admission, surgical technique etc. Stratification enables price differentiation of the procedure to better accommodate the nuances of the procedure performed and improve the associated payment.

For example, the procedure of ‘Incision and Drainage of Abscess’ is split into two stratified packages with a price differential of ₹ 5,000 between them.

- i. Incision and Drainage of Abscess under Local Anaesthesia
- ii. Incision and Drainage of Abscess under General Anaesthesia

Significance for the user: While total price calculation would remain at the back end of the TMS, the end user may be required to feed in certain details of the procedure that would otherwise have been assumed. For example, following selection of the procedure to be performed, the TMS may ask for details such as the type of anesthesia anticipated. There may also be certain criteria that the TMS would pick up automatically from patient details to distinguish between requirement of a pediatric / adult procedure, but these back-end assumptions may be further vetoed by the treating physician based on his clinical judgment. However, such overridden assumptions may trigger a medical audit, and it is recommended that a strong paper trail be maintained to justify such cases.

2.2.3 Stratification in Medical Packages

All Medical packages in HBP 2.0 now feature as stratified packages based on the bed category of patient admission. The bed category for admission and will need to be chosen at the time of selecting a diagnosis. The price of medical packages will continue to be calculated based on the bed category, multiplied by the number of bed days for the patient.

The per day price for bed categories will be as follows:

- i. ₹ 1,800 for Routine Ward
- ii. ₹ 2,700 for High Dependency unit
- iii. ₹ 3,600 for Intensive care not requiring ventilator support
- iv. ₹ 4,500 for Intensive care requiring ventilator support

Significance for the user: There is no significant change at the user end on account of this feature of the HBP 2.0. The TMS will continue to calculate the final price of the medical package at the back end based on patient bed category and number of days' stay.

2.2.4 Cross Specialty Packages

These are packages that fall under more than one specialty and would now feature under all relevant specialties without duplication of the unique package code and maintaining a uniform price for the same procedure across all specialties. This classification of packages as cross specialty packages at the same price is expected to minimize upcoding of the same package by billing it in a different specialty.

For example, the package of 'Temporary pacemaker implantation' is a cross specialty package between Cardiology and CTVS and will feature in both their package lists.

Significance for the user: It is hoped that aberrations such as duplication of packages across specialties, price differential in the same package across specialties, and repetitions or ambiguities in package names have been removed. While number of packages have been reduced in HBP 2.0, the number of treatment areas have been increased. The user would now have to go through a shorter list of packages to seek out the desired procedure. The cross-specialty feature will also permit certain packages to be available across specialties without unnecessarily adding on to the number of packages. For example, the procedure of 'Tracheostomy / Tracheotomy' will now be available to multiple specialties at a fixed rate of ₹ 6,000 irrespective of the specialty under which it is booked. However, it is reiterated here for the benefit of all hospitals and care providers that ability of booking a procedure does not automatically privilege the hospital to perform a procedure that it is not otherwise able, equipped, or authorized to perform.

2.2.5 Add-on Packages

Certain packages / procedures have been defined as add-on procedures riding on another procedure. These add-on procedures may be booked in conjunction with another procedure without losing the sanctity / price of the procedure. These procedures, although booked as enhancements in the TMS, will not be charged at 75% of their original value.

For example, the package of 'NPWT (Negative Pressure Wound Therapy)' in Plastic Surgery is an add-on package for ₹ 2,000. Booking of this package as enhancement of another plastic surgery procedure would

not reduce the cost of the procedure to 75%. Similarly, 'High end histopathology (Biopsies) and advanced serology investigations' is an add-on package for Medical management that can be added to any current medical package.

Significance for the user: There is no significant change at the user end on account of this feature of the HBP 2.0. The TMS will continue to calculate the final price of the package / packages at the back end with additional considerations based on this new criterion.

2.2.6 Standalone packages

Certain procedures have been included in the HBP 2.0 which were consciously left out in the previous version due to their potential of abuse. Similarly, a few procedures were noticed to be abused through the last year of implementation of the scheme. Such procedures have been re-introduced in HBP 2.0 with caution. One of the many steps taken by the NHA in this direction, is introduction of clearly defined Stand-alone packages which may not be claimed as enhancements to other existing / unspecified surgical packages. This has been done primarily to reduce the incidence of abuse of the packages yet keeping them available for use.

For example, the package of 'Laparoscopic adhesiolysis' in OBG is now a standalone package and may not be booked in combination with other packages.

Significance for the user: Packages that have been earmarked as stand-alone packages will not be available to the user as enhancements to an existing / unspecified package. Such packages would be clearly marked in the TMS as 'stand-alone package'.

2.2.7 Splitting of cost of Implants / High End Consumables

The cost of implants and high-end consumables has been independently considered for calculation of the package rate at the back end. This enables the system to vary the price of the procedure based on the quality / number / type of implant required in the performance of the procedure.

For example, package price of a 'Balloon Pulmonary Valvotomy' in Cardiology would vary depending on the use of a pediatric / adult cardiac balloon. Price of plates / screws in orthopedics would also be calculated at the back end based on the number of implants used.

Significance for the user: There is no significant change at the user end on account of this feature of the HBP 2.0. However, there are significant advantages of such a splitting in the long run. Variance in the cost of implant will now be easily incorporated in the final calculation of the package price. Pricing will also become variable based on the number of screws / plates used in the surgery. It also adds flexibility for addition of different types of implants as the scheme matures. However, all the above would not feature in the TMS yet. The TMS will continue to calculate the final price of the package / packages at the back end with additional considerations based on this new criterion.

2.2.8 Step payment of staged procedures

Packages that require multiple stages for complete administration of therapy, with long gaps in between have been split into stages with independent payment of each stage. This is expected to facilitate payment to a treating hospital, if the patient decides to continue / follow up on his / her treatment at a different facility. For example, 'Hypospadias repair - Two or more stages' in Urology will now be paid on each, or either of the following stages:

- i. First stage
- ii. Intermediate stage
- iii. Final stage

Significance for the user: For all staged procedures, the TMS may require the treating physician to specify the stage of surgery he / she is anticipating performing at the time of booking of the package.

2.2.9 Follow up procedures

Packages for follow up have been included in HBP 2.0 for a few select procedures. This enables the hospital / caregiver to maintain a continuum of care to the patient for a period extending beyond the 15 days that he / she is entitled to through the original AB PM-JAY package. This would also enable the patient to seek follow up care for a procedure out of the center that performed the original procedure.

For example, a follow up procedure for 'Stoma Management, follow up of Colostomy' has been introduced in the HBP 2.0 for all patients who need such care.

Significance for the user: A follow up procedure may be booked by the treating hospital / caregiver with clear documentation supporting the need for the package. The documentation would include proof of the

original procedure performed, and activities undertaken as part of the follow up care of the patient. While the NHA remains cautious of the abuse prone nature of such a package, utilization of such a package would be closely monitored to justify keeping it in the subsequent modifications of the HBP.

2.2.10 Abuse Prone Packages

With the experience of implementing AB PM-JAY through the past year, the NHA has been able to identify certain packages that are prone to abuse and require closer monitoring. Such a list of packages has been identified in the TMS and a conscious attempt has been made to keep the price of abuse prone packages at the minimum level to minimize incentives for abuse. Booking of these packages also creates an alert at the National Anti-Fraud Unit (NAFU) at the NHA and may trigger an investigation. The list of these abuse prone packages is held as confidential at the time of publishing of this manual.

Anti-Fraud advisories are issued regularly providing guidance to states on measures to prevent and detect any malpractices in case of fraud and abuse prone packages. Fraud controls in the form of alerts, triggers and machine learning algorithms have been deployed which monitor the utilisation of packages and flag any suspect cases for medical audit and investigation. The detailed process to be followed for medical audit of suspect cases is available in the Field Investigation and Medical Audit Manual.

2.2.11 Standardized nomenclature of procedures

A conscious attempt has been made to standardize the nomenclature and definitions of packages. NHA in collaboration with World Health Organization (WHO), has initiated the process of aligning HBP 2.0 with International Classification of Health Interventions (ICHI) and International Classification of Diseases (ICD) coding of the WHO. When completed, India may become the first country to use ICHI in its HBP list.

The ICHI is being developed to provide a common tool for reporting and analyzing health interventions for statistical purposes. ICHI covers interventions carried out by a broad range of providers across the full scope of health systems and includes interventions on diagnostic, medical, surgical, mental health, primary care, allied health, functioning support, rehabilitation, traditional medicine and public health.

Refer to (<https://mitel.dimi.uniud.it/ichi/>) for the search engine.

2.3 Key differences - HBP 1.0 & HBP 2.0

Criteria	HBP 1.0	HBP 2.0	Significance
Number of packages	1,393	874	Lesser number of packages
Number of procedures	x	1,592	More number of treatments
Duplicate packages	✓	x	Removed aberration
Nomenclature inconsistencies	✓	x	Removed aberration
Lateralization in packages	✓	x	Removed aberration
Rate inconsistencies	✓	x	Removed aberration
Stratifications	x	✓	Price variance for surgical nuances
Cross specialty packages	x	✓	Access to packages across specialties
Add on packages	x	✓	100% reimbursement for procedures
Standalone packages	x	✓	Reduced fraud & abuse potential
Follow up procedures	x	✓	Improved continuity of care
Standardized nomenclature	x	✓	International acceptability

Section 3. Key features by Specialty

The final picture of HBP 2.0 is as follows:

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

3.1 Burns Management

- Total number of packages: 6
- Total number of procedures: 20
- Additional cross specialty procedures: 0
- 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 preauthorization would need to be submitted during claims.
- Admission Criteria to be followed for selecting packages for burn injured patients
 - a. Second and third-degree burns greater than 10% of the total body surface area in patients under 10 or over 60 years of age
 - b. Second and third-degree burns greater than 20% of the total body surface area in other age groups
 - c. Significant burns of face, hands, feet, genitalia, or perineum and those that involve skin overlying major joints
 - d. Third-degree burns greater than 5% of the total body surface area in any age group
 - e. Inhalation injury
 - f. Significant electric injury including lightning injury
 - g. Significant chemical injury
 - h. Burns with significant pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality (e.g. diabetes mellitus, cardiopulmonary disease)
 - i. Burns with significant concomitant trauma
 - j. Burn injury in patients who will require special social and emotional or long-term rehabilitative support, including cases of suspected child abuse and neglect.

3.2 Cardiology

- Total number of packages: 20
- Total number of procedures: 26
- Additional cross specialty procedures: 0
- Number of procedures recommended for auto-approval: 0
- 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.
- 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.
- It is prescribed as standard practice to use medicated stents (approved by FDA/DCGI) where necessary
- The carton / sticker detailing the stent needs to be submitted as part of claims filing by providers
- It is advised to perform cardiac catheterization as part of the treatment package for congenital heart defects

3.3 Cardio-thoracic & Vascular Surgery

- Total number of packages: 34
- Total number of procedures: 118
- Additional cross specialty procedures: 6
- Number of procedures recommended for auto-approval: 4
- 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.

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

3.4 Emergency Room Packages

- Total number of packages: 3
- Total number of procedures: 4
- Additional cross specialty procedures: 2
- Number of procedures recommended for auto-approval: 4
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil
- Emergency care packages are designed for conditions of care requiring less than 12 hours stay which include evaluation, stabilization, resuscitation, life support and arranged referral (if required)
- In case hospitalization of more than 12 hours is required, the patient will be admitted and treated accordingly in the related specialty
- Paper trail is to be maintained by the hospital treating the patient to be submitted during closure of claim
- For the package Animal bites (Excluding Snake Bite) (ER003A), payment to be made after the completion of 5th dose

3.5 General Medicine

- Total number of packages: 76
- Total number of procedures: 98
- Additional cross specialty procedures: 33
- Number of procedures recommended for auto-approval: 72

- 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)
- 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. 5,000 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. 5,000 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
- 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
- For repetitive procedures like Dialysis, a provision is available that a single pre-auth be taken for multiple sittings of the same procedure. All subsequent procedures after the initial pre-auth would be auto approved by the TMS
- Surgical and Medical packages will not be allowed to be availed at the same time (Except for certain Add-on procedures as defined in the HBP list and configured in NTMS). In exceptional circumstances, hospital may raise a request for such pre-auth which will be decided by SHA with the help of concerned medical specialist.
- Serious conditions that may require admission in High Dependency Unit (HDU) - Patients sick with unstable vitals, faced with life threatening conditions, but not requiring ventilator support
- Critical conditions that might require admission in Intensive Care Unit (ICU) - Patients sick with unstable vitals, faced with life threatening conditions, requiring ventilator support
- In case of step-up in patient bed category (Ward to HDU / HDU to ICU), suitable rates would need to be applied and pre-authorization sought

3.6 General Surgery

- Total number of packages: 98
- Total number of procedures: 152
- Additional cross specialty procedures: 41
- Number of procedures recommended for auto-approval: 123
(Mesh implant for SG051 & SG052 needs pre-auth to initiate treatment, for the rest documentation could be retrospectively sent)
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil
- Spinal or other regional anaesthesia are included under General Anaesthesia and need to be claimed accordingly
- Surgical and Medical packages will not be allowed to be availed at the same time (Except for certain Add-on procedures as defined in the HBP list and configured in NTMS). In exceptional circumstances, hospital may raise a request for such pre-auth which will be decided by SHA with the help of concerned medical specialist.
- Management of all medical comorbidities (such as diabetes, hypertension etc.) associated with the patient at the time of a surgical admission are included in the listed package price of the surgery

3.7 Infectious Diseases

- Total number of packages: 2
- Total number of procedures: 3
- A new specialty of Infectious diseases has been introduced in HBP 2.0 to support cases suspected or suffering from infections such as COVID-19. This specialty will be available for designated COVID Care Centers (CCCs), Dedicated COVID Health Centre (DCHC) and Dedicated COVID Hospitals (DCH).
- It is recommended that labs registered with ICMR be used for testing of COVID-19. However, flexibility is available to the States to use the package to their highest advantage in their preparation and management of COVID-19 in lines with the latest guidelines issued by ICMR & the Ministry of Health and Family Welfare

- Management of COVID-19 is to be done in line with guidelines regularly issued by the Ministry of Health & Family Welfare, ICMR and the State governments.

3.8 Interventional Neuroradiology

- Total number of packages: 10
- Total number of procedures: 15
- Additional cross specialty procedures: 4
- 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.

3.9 Medical Oncology

- Total number of packages: 71
- Total number of procedures: 263
- Additional cross specialty procedures: 2
- Number of procedures recommended for auto-approval: 0
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all treatments / malignancies
- Packages for Medical Oncology in HBP 2.0 have been drafted in accordance with the guidelines issued by the National Cancer Grid in discussion with the Tata Memorial Hospital, Mumbai.
- The regimens are available for primary therapy, recurrence, concurrent & sequential (with RT), hormonal therapies etc.
- Packages for medical oncology are inclusive of chemotherapeutic agents, recurring investigations, day care / inpatient charges, supportive care and professional charges. Supportive care per cycle, such as use of antiemetics, pre-medication, post chemo prophylaxis etc. are all included in the package cost.
- Chemo regimens are paid on a per cycle basis, inclusive of IV / Oral dispensation of medication

- Concurrent administration of Chemotherapy and Radiotherapy is allowed on a 100%-100% payout protocol
- Chemotherapy cycles are capped based on number of permissible cycles, use with Radiotherapy and permissible frequency of administration.
- 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.
- 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 center (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 could prove to be very vital, such as implications on the financial cover and to avoid unnecessary treatments.
- Packages of pediatric cancer have been merged with Medical Oncology under HBP 2.0
- Chemotherapy is given per weight (body surface area). Clinical treatment approval/ preauthorization and communication is necessary to ensure each child receives the recommended dose of medicines. Under or overdosing is dangerous. So, dosing will differ in young children and older children.

3.10 Mental Disorders Package

- Total number of packages: 10
- Total number of procedures: 10
- Additional cross specialty procedures: 0

- Number of procedures recommended for auto-approval: 0
- 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

3.11 Neonatal Care Package

- Total number of packages: 10
- Total number of procedures: 10
- Additional cross specialty procedures: 0
- Number of procedures recommended for auto-approval: 0
- Pre-authorization: Mandatory for all packages 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.
- Packages would include neonates up to age of 28 days after birth.
- 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 procedures MN002A, MN003A, MN004A and MN005A, mother's stay and food in the hospital [postnatal ward / special ward for such mothers] for breastfeeding, family centered care and KMC (Kangaroo Mother Care) is mandatory.
- For procedures MN002A, MN003A, MN004A and MN005A 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.
- MN001A (Basic neonatal care package) is inclusive of Monitoring, Breastfeeding Support, Spoon Feeds, Phototherapy and other management as per clinical condition of the neonate.
- MN002A (Special neonatal care package) is inclusive of Monitoring, Breastfeeding Support, Spoon Feeds, Gavage Feeds, Intensive Phototherapy, Oxygen, Intravenous Fluids, Antibiotics, blood products and other management as per clinical condition of the neonate.
- MN003A (Intensive Neonatal Care Package) is inclusive of Monitoring, Breastfeeding Support, Spoon Feeds, Gavage Feeds, Phototherapy, Oxygen, Intravenous Fluids, Antibiotics, Blood Products, Mechanical Ventilation, CPAP, NIMV, HHFNC, Surfactant Exchange Transfusion, Inotropes, Anti-congestive, Anti-convulsant and other management as per clinical condition of the neonate.
- MN004A (Advanced Neonatal Care Package) is inclusive of Monitoring, Breastfeeding Support, Spoon Feeds, Gavage Feeds, Phototherapy, Oxygen, Intravenous Fluids, Antibiotics, Blood Products, Mechanical Ventilation, CPAP, NIMV, HHFNC, Surfactant Exchange Transfusion, Inotropes, Anti-congestive, Anti-convulsant, Therapeutic hypothermia, Peritoneal dialysis, Glove drain, TPN and other management as per clinical condition of the neonate.
- MN005A (Critical Care Neonatal Package) is inclusive of Monitoring, Breastfeeding Support, Spoon Feeds, Gavage Feeds, Phototherapy, Oxygen, Intravenous Fluids, Antibiotics, Blood Products, Mechanical Ventilation, CPAP, NIMV, HHFNC, Surfactant Exchange Transfusion, Inotropes, Anti-congestive, Anti-convulsant, Therapeutic hypothermia, Peritoneal dialysis, Glove

drain, TPN, PGE1, Inhaled Nitric Oxide, HFO and other management as per clinical condition of the neonate.

3.12 Neurosurgery

- Total number of packages: 54
- Total number of procedures: 82
- Additional cross specialty procedures: 23
- Number of procedures recommended for auto-approval: 54
- Pre-authorization: Mandatory for all 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.

3.13 Obstetrics & Gynecology

- Total number of packages: 59
- Total number of procedures: 77
- Additional cross specialty procedures: 25
- Number of procedures recommended for auto-approval: 41
- Pre-authorization: Mandatory for all 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 as Hypertension, Diabetes etc. are to be treated as per medical packages
- High risk deliveries included in obstetrics refer to 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) and other maternal and fetal conditions as per guidelines e.g. previous caesarean section, diabetes, severe growth retardation etc. that qualify for high risk delivery.

3.14 Ophthalmology

- Total number of packages: 40
- Total number of procedures: 53
- Additional cross specialty procedures: 0
- Number of procedures recommended for auto-approval: 0
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil
- 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.
- GA / EUA (Examination under Anaesthesia) is available as a separate add on package for pediatric patients, to be used if clinically indicated

3.15 Oral & Maxillofacial Surgery

- Total number of packages: 7
- Total number of procedures: 9
- Additional cross specialty procedures: 6
- Number of procedures recommended for auto-approval: 0
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil
- Considering the secondary and tertiary care focus of the scheme, outpatient / cosmetic procedures are not included within the purview of the packages in Oral and Maxillofacial Surgery.

3.16 Orthopedics

- Total number of packages: 71
- Total number of procedures: 132

- Additional cross specialty procedures: 30
- Number of procedures recommended for auto-approval: 81
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all replacement surgeries and others as indicated

3.17 Otorhinolaryngology (ENT)

- Total number of packages: 35
- Total number of procedures: 78
- Additional cross specialty procedures: 12
- Number of procedures recommended for auto-approval: 42
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil
- GA / EUA (Examination under Anaesthesia) is available as a separate add on package for pediatric patients, to be used if clinically indicated

3.18 Pediatric Medical Management

- Total number of packages: 46
- Total number of procedures: 65
- Additional cross specialty procedures: 89
- Number of procedures recommended for auto-approval: 61
- 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

- 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. 5,000 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 preauthorization with a cap of Rs. 5,000 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-authorization can be sought as “Unspecified Medical”

3.19 Pediatric Surgery

- Total number of packages: 19
- Total number of procedures: 35
- Additional cross specialty procedures: 179
- Number of procedures recommended for auto-approval: 34
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil

3.20 Plastic & Reconstructive Surgery

- Total number of packages: 8
- Total number of procedures: 12
- Additional cross specialty procedures: 17
- Number of procedures recommended for auto-approval: 0
- 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 / lifesaving / limb saving operative procedures, preauthorization may not be required. However, formal intimation should be done within 24 hours of admission.
- Surgeries related to ageing face & body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc. form part of the exclusion criteria within AB PM-JAY and may not be booked under the scheme

3.21 Polytrauma

- Total number of packages: 10
- Total number of procedures: 21
- Additional cross specialty procedures: 0
- Number of procedures recommended for auto-approval: 21
- 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 clinico-radiological vitals is desired.

3.22 Radiation Oncology

- Total number of packages: 14
- Total number of procedures: 46
- Additional cross specialty procedures: 0
- Number of procedures recommended for auto-approval: 0
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all treatments / malignancies
- Packages for Radiation Oncology in HBP 2.0 have been drafted in accordance with the guidelines issued by the National Cancer Grid in discussion with the Tata Memorial Hospital, Mumbai.



- Regimens are available for conventional and advanced techniques of radiotherapy with the flexibility to add 'per fraction / session over and above the base package
- Packages for radiotherapy are inclusive of treatment planning, immobilizer, investigations, fractions / sessions.
- Radiotherapy regimens are paid after all sessions are complete for one course of radiotherapy
- Concurrent administration of Chemotherapy and Radiotherapy is allowed on a 100%-100% payout protocol
- 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
- 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 center (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 could prove to be very vital, such as implications on the financial cover and to avoid unnecessary treatments
- Booking of Unspecified Surgical Package for Radiation Oncology is not permissible in HBP 2.0

3.23 Surgical Oncology

- Total number of packages: 76
- Total number of procedures: 120
- Additional cross specialty procedures: 109
- Number of procedures recommended for auto-approval: 19

- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all treatments / malignancies
- Packages for Surgical Oncology in HBP 2.0 have been drafted in accordance with the guidelines issued by the National Cancer Grid in discussion with the Tata Memorial Hospital, Mumbai.
- Cross specialty surgical codes from other specialties may be used to augment the packages listed under surgical oncology
- Staging package are inclusive of basic pre-operative diagnostics. Advanced investigations may be booked as separate codes available within the specialty following preauthorization
- In case an AB PM-JAY Beneficiary is required to undertake multiple surgical procedures in one OT session, then the procedure with highest rate shall be considered as the primary package and reimbursed at 100%, thereupon the 2nd surgical procedure shall be reimbursed at 50% of package rate, 3rd and subsequent surgical procedures shall be reimbursed at 25% of the package rate.
- 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
- 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 center (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 could prove to be very vital, such as implications on the financial cover and to avoid unnecessary treatments

3.24 Urology

- Total number of packages: 94
- Total number of procedures: 142
- Additional cross specialty procedures: 16
- Number of procedures recommended for auto-approval: 114
- Pre-authorization: Mandatory for all 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
- It is 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.

Note: NHA does not define a minimum or a maximum length of stay for any medical or surgical package under AB PM-JAY.

Section 4. Using the HBP 2.0

4.1 Package selection

- i. 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.
- ii. Based on diagnosis provided by doctor, operator should be able to block Surgical or Non-Surgical benefit package(s) using the Transaction Management IT system (TMS)
- iii. Both surgical and non-surgical packages cannot be blocked together, only either of the type can be blocked.
- iv. As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.
- v. In case of multiple surgeries in the same admission, the operator can block more than one package for the beneficiary. In case the AB PM-JAY Beneficiary is required to undertake multiple surgical treatment, then the highest package rate shall be taken at 100%, thereupon the second treatment package shall be taken as 50% of package rate and the third treatment package shall be at 25% of the package rate. (Unless otherwise defined)
- vi. Certain packages 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.
- vii. Packages as indicated may have differential pricing for NABH and Non-NABH, for Hospitals running PG / DNB Course, for rural and urban EHCPs and for EHCPs in aspirational districts as identified by NITI Aayog.
- viii. 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.
- ix. At the same time, a printable registration slip needs to be generated and handed over to the patient or patient's attendant.
- x. If for any reason treatment is not availed for any package, the operator can unblock the package before discharge from hospital.

4.2 Raising a Pre-Auth

Guidelines

- i. Packages are defined which require pre-authorization from the insurance company / trust before they can be administered. In case any inpatient treatment is not available in the packages defined, then hospital will be able to provide that treatment to the beneficiary only after the same gets approved by the Insurance company/ trust and will be reflected as unspecified package. Under both scenarios, the operator would be able to initiate a request to the insurance company/trust for pre-authorization using the web application.
- ii. The hospital operator will send all documents required for pre-authorization to the insurance company/trust using the Centralized TMS / States transaction management application.
- iii. The documents needed may vary from package to package and hence a master list of all documents required for all packages is available on the server.
- iv. The request as well as approval of the form will be done using the AB PMJAY TMS system or using API exposed by AB PM-JAY (Only one option can be adopted by the insurance Co.) or using State's own IT system (if adopted by the State).
- v. In case of no or limited connectivity, the filled form can also be sent to the insurance company/ trust either through fax / email. However, once internet connectivity is established, the form should also be submitted using online system as described above.
- vi. The insurance company/ trust will have to approve or reject the request latest by 6 hours. If the insurance company/ trust fails to do so, the request will be considered deemed to be approved after 6 hours by default.
- vii. 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/ Trust or the call centre setup by Insurance Company/ Trust. The documents required for the processing, may be sent using the transaction system within stipulated time.
- viii. In case of emergency, insurance company/ trust will provide the pre-authorization code generated through the algorithm/ utility provided by MoHFW/NHA-NIC.

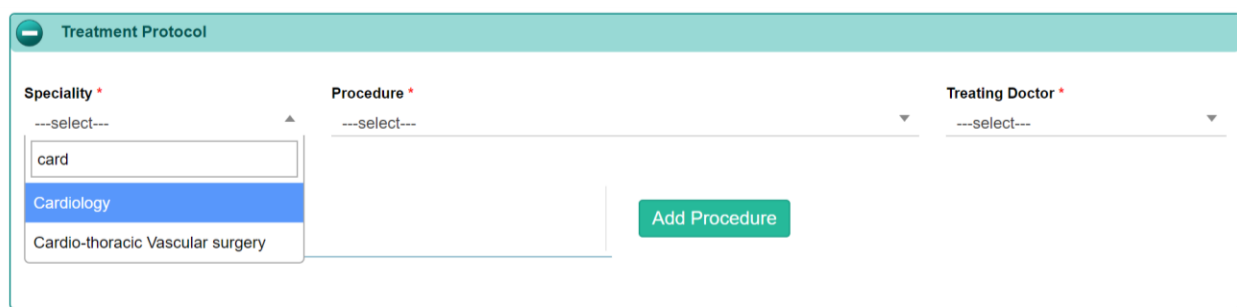
- ix. Pre-authorization code provided by the Insurer/ Trust will be entered by the operator and will be verified by the system.
- x. If pre-authorization request is rejected, Insurance Company / Trust will provide the reasons for rejection. Rejection details will be captured and stored in the transaction database.
- xi. If the beneficiary or the hospital are not satisfied by the rejection reason, they can appeal through grievance system.

4.3 Process for raising a Pre-Auth

The following steps need to be followed for selecting a package / procedure in the TMS

Step 1 - Select a specialty

A specialty may be selected from the dropdown menu available. All procedures are mapped to their respective specialties, so in case the user is not sure of the specialty to be chosen, she / he may proceed to procedure selection and the specialty would be chosen automatically. However, in case a procedure is mapped to more than one specialty, the specialty will need to be selected from the options shortlisted in the dropdown menu based on the procedure selected.



The screenshot shows a web form titled "Treatment Protocol". It contains three dropdown menus: "Specialty", "Procedure", and "Treating Doctor". The "Specialty" dropdown is open, showing a search box with the text "card" and a list of options: "Cardiology" (highlighted in blue) and "Cardio-thoracic Vascular surgery". There is an "Add Procedure" button to the right of the dropdowns.

Fig: Selecting a specialty

Step 2 - Select a procedure

A package / procedure may be selected from the dropdown menu available. The selection dropdown narrows the choices available as the user begins typing in his / her choice. Procedures may be selected through any of the following three options

- i. By typing in the procedure name

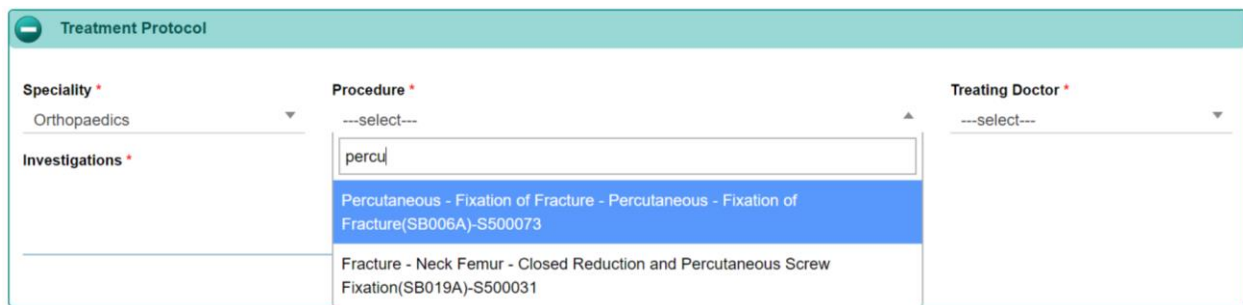
- ii. By typing in the HBP 2.0 procedure code
- iii. By typing in the HBP 1.0 procedure code

Upon selection of a procedure, check the column on procedure price alongside the procedure selected. That column would prompt the user on the next step. If the column displays a procedure price, the process of selecting that procedure is complete. On the other hand, the section may prompt the user to proceed to selection of a stratification or and implant.

The system also requires the user to mandatorily fill in details of the primary clinician associated with the patient. The clinician's name, registration number, qualifications and phone number would auto populate from the Hospital Empanelment Module, if available there. Else, they would need to be filled in here.

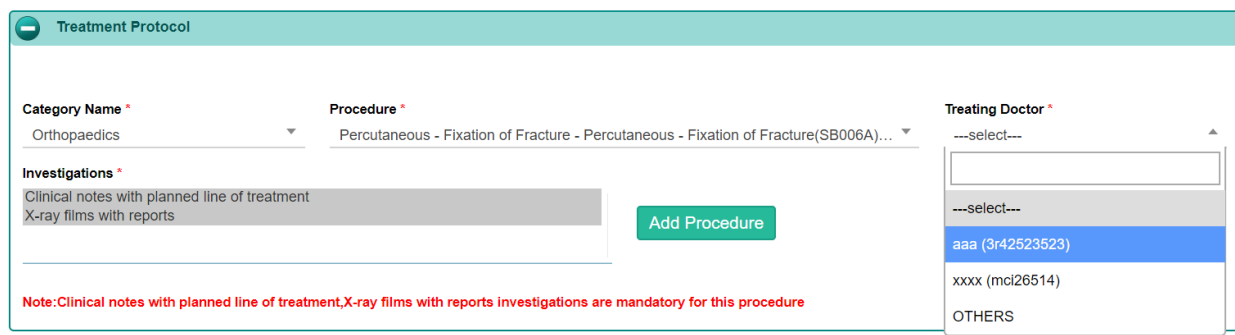
The system also highlights the mandatory documents associated with the procedure that the user would need to upload before raising a pre-auth. The user would be required to select the list of mandatory documents as an acknowledgment to the same and proceed to add procedure.

Please note – the following steps of selection of stratification, and selection of implant are procedure dependent and one, or both may not be required for all procedures to be selected.



The screenshot shows a web form titled "Treatment Protocol". It has three main sections: "Speciality", "Procedure", and "Treating Doctor". The "Speciality" dropdown is set to "Orthopaedics". The "Procedure" dropdown is open, showing a search input with "percu" and two results: "Percutaneous - Fixation of Fracture - Percutaneous - Fixation of Fracture(SB006A)-S500073" (highlighted) and "Fracture - Neck Femur - Closed Reduction and Percutaneous Screw Fixation(SB019A)-S500031". The "Treating Doctor" dropdown is set to "---select---".

Fig: Selecting a procedure



The screenshot shows a web form titled "Treatment Protocol". It contains several fields and a button:

- Category Name ***: A dropdown menu with "Orthopaedics" selected.
- Procedure ***: A dropdown menu with "Percutaneous - Fixation of Fracture - Percutaneous - Fixation of Fracture(SB006A)..." selected.
- Investigations ***: A text area containing "Clinical notes with planned line of treatment" and "X-ray films with reports".
- Adding Procedure**: A green button labeled "Add Procedure".
- Treating Doctor ***: A dropdown menu with "aaa (3r42523523)" selected. Other options include "xxxx (mcl26514)" and "OTHERS".

A red note at the bottom of the form states: "Note: Clinical notes with planned line of treatment, X-ray films with reports investigations are mandatory for this procedure".

Fig: Mandatory details of the treating clinician

Step 3 - Select a stratification

The stratification icon alongside the selected procedure gets enabled whenever there is an associated stratification with the selected procedure. Upon selection of the stratification icon, the user would be prompted to select the stratification detail to be used. Options would be available based on the levels of stratifications available for the selected procedure.

Upon selection of a stratification detail, the user would then need to select a stratification option from the choices available in the dropdown for that stratification. Most procedures have a single level of stratification and the stratification detail would be auto selected. In case multiple stratifications are available for the chosen procedure, the user would need to select each one individually and fill in details for each.

Upon successfully selecting a stratification, the system would return the user to the original procedure selection screen. Upon returning to the screen, the user is advised to check the column on procedure price alongside the procedure selected. That column would prompt the user on the next step. If the column displays a procedure price, the process of selecting that procedure is complete. On the other hand, the section may prompt the user to proceed to selection of an implant.




Treatment Protocol						
Speciality	Procedure	Quantity	Amount(₹)	Stratification	Implants	Action
Orthopaedics(SB)	Percutaneous - Fixation of Fracture(SB006A)	1	Please select Implant/ Stratification as applicable for populating Amount	-	-	  

Fig: Prompts for selecting an implant / stratification

Treatment Protocol						
Speciality	Procedure	Quantity	Amount(₹)	Stratification	Implants	Action
Orthopaedics(SB)	Percutaneous - Fixation of Fracture(SB006A)	1	Please select Implant/ Stratification as applicable for populating Amount	-	-	  

Fig: Add stratification

Stratification ✕

Procedure Name	Stratification Details	Stratification Options	Action
Percutaneous - Fixation of Fracture	Anesthesia	<div style="border: 1px solid #ccc; padding: 2px;"> <div style="background-color: #f0f0f0; padding: 2px;">---select---</div> <div style="border: 1px solid #ccc; height: 20px; margin: 2px;"></div> <div style="background-color: #f0f0f0; padding: 2px;">---select---</div> <div style="padding: 2px;">Local Anesthesia</div> <div style="padding: 2px; background-color: #007bff; color: white;">General Anesthesia</div> </div>	<div style="background-color: #28a745; color: white; padding: 5px 10px; border: none; cursor: pointer;">Add</div>

Close

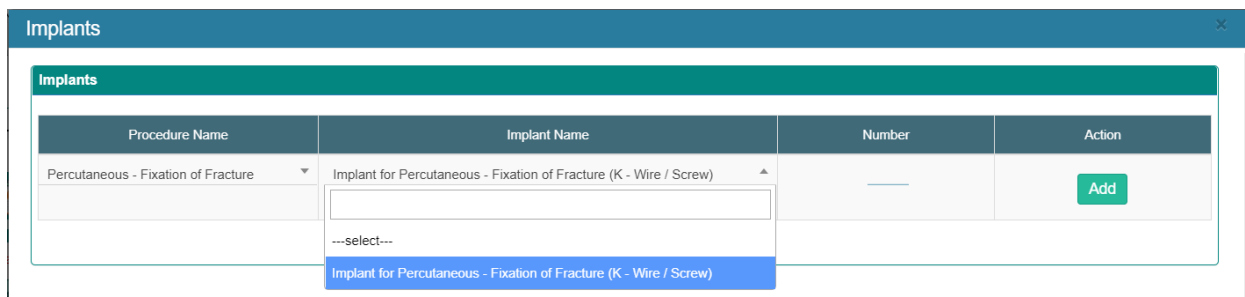
Fig: Select stratification option

Step 4 - Select an implant

The select implant icon alongside the selected procedure gets enabled whenever there is an associated implant with the selected procedure. The user would need to select the implant name from the dropdown available. Upon selecting the implant, the user would also need to specify the number of implants that the user required a pre-auth approval on.

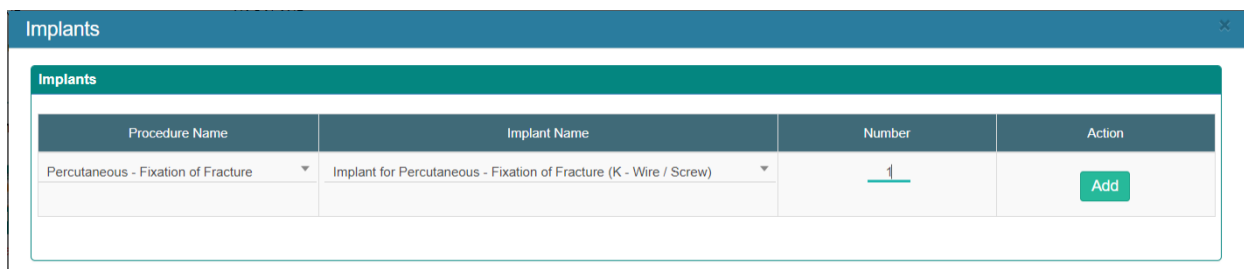
In case of multiple types of anticipated implants, the user may select each implant individually and add the numbers against each. The option of multiple implants is available in select procedures and there may be conditions where the system would not accept the selection of multiple implants for the given procedure. Please note that this is by design and multiple implant types are not permitted in this case.

Upon successfully selecting the implant / implants, the system would return the user to the original procedure selection screen. Upon returning to the screen, the user is advised to check the column on procedure price alongside the procedure selected. That column would prompt the user on the next step. If the column displays a procedure price, the process of selecting that procedure is complete.



Procedure Name	Implant Name	Number	Action
Percutaneous - Fixation of Fracture	Implant for Percutaneous - Fixation of Fracture (K - Wire / Screw)		Add

Fig: Select implant



Procedure Name	Implant Name	Number	Action
Percutaneous - Fixation of Fracture	Implant for Percutaneous - Fixation of Fracture (K - Wire / Screw)	1	Add

Fig: Select Quantity



Treatment Protocol						
Speciality	Procedure	Quantity	Amount(₹)	Stratification	Implants	Action
Orthopaedics(SB)	Percutaneous - Fixation of Fracture(SB006A)	1	11680	Anesthesia - General Anesthesia	Implant for Percutaneous - Fixation of Fracture (K - Wire / Screw) - (1)	  

Fig: Procedure added successfully

Step 5 – Upload mandatory documents

Every procedure requires a set of mandatory documents to be uploaded at the time of submission of a pre-auth request.

Step 6 – Submit pre-auth request

Every procedure requires a set of mandatory documents to be uploaded at the time of submission of a pre-auth request.

Illustrative



4.4 Approving a pre-auth

In addition to the activities listed in Claim Adjudication Manual (February 2019) (<https://www.pmjay.gov.in/documents>), on account of the HBP 2.0, the Pre-Auth Processing Doctor (PPD) at the TPA / ISA would additionally need to check the following before approving a pre-auth.

- i. Confirmation of the selected procedure to the patient condition - Since the HBP 2.0 is significantly more granular than the previous version, the detail of the procedure selected will need to be validated by the patient condition. Packages such as fevers, animal bites, congenital heart diseases etc. have been split into multiple procedures that fall within the same package, but have significant differences in terms of management, skill and therefore, cost. This needs to be looked into and considered closely before approving a pre-auth for the procedure.
- ii. Selected implant / high end consumable in conformity with the age / gender / condition of the patient - Certain implants in the HBP 2.0 are distinguished based on the age of the patient. Paediatric implants / devices are recommended for patients less than or equal to 14 years of age, while adult devices are to be used beyond that age. Once more, keeping the cost implication in mind, it will need to be verified whether the implant / device is in conformation with the age of the patient. Similarly, some implants are gender specific, and some consumables are required only in select patients. Number of screws, plates and other implants are also variable in HBP 2.0 and their anticipated numbers for a surgery will need to be verified before approving a patient pre-auth.
- iii. Selected stratification in lines with the age / gender / condition of the patient - Every stratification of the procedure selected is backed up with a cost implication that needs to be closely considered at the time of approving a pre-authorization. Performing a procedure under LA / GA, Unilateral / Bilateral performance of a procedure, approach to be used are some examples of stratifications that will need to be closely looked into, and justified, owing to the price differential involved.
- iv. Non-Surgical procedures - Medical care packages have been introduced in certain specialties to allow for continuity of care for the patient. Monitoring of the justification of booking such procedures will now add as an additional responsibility of the PPD.



- v. Follow up procedures - In HBP 2.0, follow up procedures can be blocked for certain packages but will need to be supported by documentary evidence that the parent procedure has been performed, even if done outside of the hospitals empanelled under AB PM-JAY.
- vi. Diagnostic procedures - Certain diagnostic procedures have been included under AB PM-JAY based on user demand, and on the judgment of the expert committees. Such procedures have been highlighted in HBP 2.0 as abuse prone procedures and will be closely monitored by the National & State Fraud monitoring teams. The PPD is advised to maintain a close vigil on blocking of these packages.

Section 5. HBP customization for states

Packages and procedures in HBP 2.0 are drafted in concurrence with specialist committees and have been approved by Review committee and the Governing Board of NHA. It is expected that, most conditions that contribute to the morbidity and mortality of the population have been addressed. However, States may have specific requirements based on their specific epidemiology, demographics, infrastructure and challenges for which, some customization of the NHA HBP 2.0 package master have been permitted. While the sanctity of the HBP 2.0 package master is expected to remain unchanged, the following modifications in the package master may be requested by the state.

5.1 Modification in prices

The states may request for a reconsideration in prices for packages and / or implant / high-end consumable available in the NHA list within the following considerations:

- i. All proposed package rates to be in line with costing / procurement data from the State Public Hospitals
- ii. There is no limit on rate reduction of the calibrated package rates
- iii. Package prices may be increased by the states by as much as 10% from the NHA configured package rates

In case states wish to raise the package price beyond 10% of the NHA configured rates, the difference in price liability would need to be borne exclusively by the state with no additional contribution from NHA.

Such states that are migrating from HBP 1 to HBP 2.0, or states that are in the process of merging their state schemes to AB PM-JAY may choose to retain legacy rates that were already available as part of their state specific rates in HBP 1, or that were previously active in their respective state schemes. This allowance is permitted only for three months of state migration / adoption of HBP 2.0 rates to facilitate a smooth migration to the new system. Following the transition period, the states would be expected to adopt the NHA recommended package rates within the considerations listed above.

Note: The additional financial burden for packages priced beyond 110% of the NHA recommended price would be borne exclusively by the state with no additional contribution from NHA.

5.2 Modification in public reservation

Considering the significant variance in public infrastructure among states, a provision is available to the states to recommend, or modify the package selection that has been recommended by the NHA for public reservation within the following considerations:

- i. All mental health procedures are recommended to be reserved for public hospitals considering the potential of fraud and abuse
- ii. All packages related to obstetrics and deliveries should be considered to be kept public reserved considering the nature of the procedure
- iii. Hysterectomy and related procedures feature as one of the most abused procedures within PM-JAY and are advised to be public reserved
- iv. Any other procedures suggested through NAFU advisories, or as deemed fit by the states may be requested to be public reserved within the state specific TMS

In case the state requires any of the above to be de-reserved, a request (with due justification to the satisfaction of the NHA) may be made to the NHA through the respective SHAs for consideration. It is strongly advised that opening of the same for private hospitals be done only through referral from public facilities and in case of emergencies only under strict checks and guidelines.

5.3 Modification in packages marked for mandatory pre-authorization

States may request modification in the list of packages for which pre-auth is to be mandatorily requested with due justification and considerations as released in the NAFU advisories from time to time.

5.4 Inclusion of State specific packages

The States, depending upon the incidence and prevalence of disease in the state may want to include some packages / procedures not otherwise included in HBP 2.0. The state specific packages will be expected to pass the following tests

- a. It should not fall within the purview of the exclusion criteria of AB PM-JAY

- b. It should not be a duplicate of an existing package
- c. The rates should be aligned with the existing similar packages in the National Transaction Master (NTM)

States will be required to send in their proposal with a reasonable justification for inclusion of their packages to the satisfaction of the NHA Hospital Network & Quality Assurance (HN&QA) division.

A. Process to be followed at the State

- i. The State Health Agency would propose any packages / procedures to be added to the state specific packages based on the specific needs of the state.
- ii. The State Health Agency would propose a price for the procedure in line with the cost of the procedure and procurement price of any implant / consumable involved.
- iii. The list would be forwarded to the HN&QA division of the National Health Authority through the respective NHA nominated state coordinator of the state.

B. Process to be followed at NHA

- i. NHA would examine the proposal and consider each procedure and price on a case by case basis for feasibility of addition in the state / national master
- ii. In case of any difference of opinion between the NHA & SHA, the revision shall be shared with the state for modification, or further clarity / justification.
- iii. If NHA agrees with the SHA proposal, the same would be approved by the CEO, NHA. In the event of difference of opinion, the file will be moved for perusal of CEO, along with HN&QA division's and State's observations. The decision of CEO, NHA on the matter shall be final.

Note: The additional financial burden for state specific packages would be borne exclusively by the state with no additional contribution from NHA.

Section 6. Standard Treatment Guidelines

6.1 Introduction

Standard Treatment Guidelines covering all AB PM-JAY procedures, have been developed and integrated in the NHA Transaction Management System (TMS). The integration includes rationalization of the mandatory documents for the respective packages and addition of few questions for the Medco (at the hospital level) and the pre-authorization and claims processing team (at the PPD and CPD level).

The objective of STGs is to aid the Pre-auth Panel Doctor (PPD) and Claims Panel Doctor (CPD) of third party administrators (TPAs), insurance companies, SHAs while processing a pre-authorization / claim by specifying the mandatory documentation required and specific information to look for in these documents for the prescribed procedure; to help prevent and control fraud and abuse; to provide quality care by avoiding unnecessary care to the beneficiaries and assist in bringing uniformity in documentation across EHCPs and to serve as a guidance tool for treating doctors, medical coordinators (MEDCO) and medical auditors.

These guidance documents are based on the standard treatment workflows / standard treatment guidelines developed by DHR-ICMR, National Cancer Grid lead by Tata memorial hospital, MoHFW, current practices from published literature, State guidelines, and other globally accepted standard treatment protocols. Oncology packages mapped with available National Cancer Grid Guidelines have been adapted and customized for HBPs under AB PM-JAY following a rigorous process of review at NHA and by eminent clinical experts in the field.

The anticipated benefits of PMJAY STGs include:

- They will help standardize the documents being submitted by EHCPs
- Lead to reduction in number of queries and repeat transactions
- Decrease unnecessary delay in processing of pre-auth and claims and aid timely payment to hospitals
- Bring in more accountability at all levels – MEDCO, PPD, CPD
- Improve quality of care by avoiding unnecessary treatment with focus on appropriateness of care

- Promote choosing relevant package as per the patient's healthcare requirement
- Prevent fraud and abuse

NHA has initiated orientation and capacity building workshops regarding adoption of standard treatment guidelines for all states / UTs. On 15th August the Standard Treatment Guidelines of PMJAY were launched nationally with the release of first batch of 10 STGs followed by more STGs being released in batches. The states using their own IT system have been requested to integrate the STGs and support for the same is being provided

The Standard Treatment Guidelines, STG - IT user manual & Frequently Asked Questions (FAQs) have also been developed for ease of understanding of the States / UTs and EHCPs and are available at AB PM-JAY official website.

Section 7. Health Benefit Packages version 2.1

7.1 Introduction

The Health Benefit Packages list continues to be a dynamic list, evolving based on feedback and data received on utilization patterns across the states. The following updates may be expected in the next version of the Health Benefit Packages to be rolled out in early 2021 (subject to approval from the competent authorities)

1. Consolidation of state specific packages in the national package master: NHA has identified unique state specific packages which are currently active in various states / UTs under AB PM-JAY HBP 2.0. Based on their utilization in the states, and feedback from the respective specialist committees, the packages would be proposed to be included in the National package master.
2. Inclusion of Packages commonly booked under 'Unspecified Surgical' Packages: Treatments booked under Unspecified Surgical Package under HBP 2.0 are being analyzed to shortlist the packages that may be taken to the respective specialist committees for their consideration for inclusion in the Health Benefit Packages.
3. Removal of unutilized packages: NHA has collated state / UT wise data for non-utilized packages of the National Master and is in the process of identifying packages which have had zero utilization across the country thus far. The same would be presented to the specialist committees for their consideration to be removed from the Health Benefit Packages.
4. Inclusion of independent packages for High-end drugs, diagnostics, and interventions: NHA has initiated the exercise to further stratify the health benefit packages of MG075 (High end radiological diagnostic) and MG076 (High end histopathology (Biopsies) and advanced serology investigation) with the aim to create a package list for commonly used high end drugs, diagnostics and interventions to be included in HBP 2.1.
5. Inclusion of transplant packages is also under consideration at the NHA.

Section 8. Frequently Asked Questions

1. What was the need of HBP 2.0?

- A. Packages were rationalized against the following aberrations found in the original HBP
- Package rates offered for many packages were inadequate to cover the cost of procedures
 - Duplication of packages was observed both within a single specialty and across specialties
 - The terminology used for the nomenclature of packages was inconsistent
 - Few of the procedures were overlapping with the ongoing National Health Programs
 - Some of the high-end procedures / investigations / drugs are not covered in HBP 1.0
 - Due to the non-availability of certain treatments, a lot of procedures were being booked under Unspecified packages

2. What is the total package count of HBP 2.0?

- A. HBP 2.0 has 874 packages split into 1592 procedures. By the new nomenclature, many packages are a group of procedures split primarily based on surgical approach or different types of treatment modalities available for a similar type of treatment. Through the first year of implementation of AB PM-JAY, it was felt that frequency of utilization of individual procedures is required for analysis. Hence, there was a need to capture the different procedures covered under single package separately and thus the concept was introduced.

3. How many specialties are covered in HBP 2.0?

- A. HBP 2.0 covers 23 specialties (including 'Unspecified'). All specialties from HBP 1.0 have been retained except for Paediatric Cancer that has been discontinued. All procedures of paediatric cancer have been split into medical / surgical oncology.

4. The specialty of pediatric cancer has been discontinued. How will these patients be treated?

- A. All the procedures of Paediatric cancer have been included under the other three specialties of oncology viz. Surgical, Medical & Radiation Oncology. Hence Paediatric cancer specialty may not be visible under specialty list, but all the paediatric cancers are adequately covered.

5. Have prices been reduced for some procedures in HBP 2.0?

- A. Prices have been reduced for 57 procedures in HBP 2.0 as compared to HBP 1.0.

6. Have prices been increased for some procedures in HBP 2.0?

- A. Prices have been increased for 270 procedures in HBP 2.0 as compared to HBP 1.0.

7. What was the rationale for discontinuing packages from HBP 1.0?

- A. 554 existing packages were discontinued in HBP 2.0. Four primary principles were followed for discontinuation of packages between HBP 1.0 to HBP 2.0
- Removal of duplicate packages
 - Exclusion of procedures which were covered under other packages
 - Obsolete procedures
 - Packages that were redefined / included elsewhere

The National Health Authority, through revision of packages ensured that no therapeutic area, initially covered under AB PM-JAY is left uncovered in HBP 2.0

8. With 554 discontinued packages, has the treatment coverage reduced in AB PM-JAY?

- A. No. The National Health Authority, through revision of packages made a conscious effort to ensure that no therapeutic area, initially covered within AB PM-JAY is not left uncovered in HBP 2.0. The discontinued packages have been redistributed into other multiple procedures that are included in PM-JAY.

9. Will the unspecified package still be available in HBP 2.0?

- A. Yes. While it has been the aim of package revision to include most commonly used treatment modalities within HBP 2.0, some state specific, or uncommon conditions may still have been

overlooked. So, while it is expected that booking of procedures under the unspecified category would be reduced, the category has still been maintained in new revised package list.

10. Is Cataract still available under AB PM-JAY

A. Yes, it is available

11. What was the rationale for adopting new packages in HBP 2.0?

- A. 237 new packages have been introduced in HBP 2.0. The following packages were introduced as new packages
- Packages that were booked frequently as unspecified packages
 - Therapeutic areas that were earlier not covered
 - Follow up packages
 - Packages recommended by the expert groups

12. What is the new concept of Packages and Procedures?

- A. By the new nomenclature, many packages are a group of procedures split primarily based on surgical approach or different types of treatment modalities available for a similar type of treatment. Through the first year of implementation of AB PM-JAY, it was felt that frequency of utilization of individual procedures is required for analysis. Hence, there was a need to capture the different procedures covered under single package separately and thus the concept was introduced.

13. Can the same package be booked under multiple specialties?

- A. There are many procedures which fall under the purview of more than one specialty. In HBP 1.0, the practice was to repeat the same package under every concerned specialty with individual package codes and independent terminology, resulting in unnecessary repetition / duplication. Now such procedures have been consolidated under a single specialty and marked as 'Cross specialty procedures', so that they can be used by other relevant specialties as well.

14. What is stratification of procedures?

A. In HBP 2.0, certain procedures have been identified that involve different treatment modalities for same or similar procedures e.g. type of anaesthesia, surgical approach, unilateral / bilateral, aetiology etc. Although the difference appears minor between the multiple stratifications of a procedure, there is a clear financial impact of the same. Such procedures have been classified as stratified procedures wherein an additional layer of stratification has been added to account for additional effort / cost.

15. Are implants / High end consumables included in surgical packages?

A. Yes, the price of both these entities, wherever used, are included in the final procedure price. In many packages, the final total cost (including procedure and implant / consumable) is given. In other packages, costs of procedure and implant / consumable is given separately. In such cases, these two costs are entered in the system already and reflected in the form of a final cost in the Transaction Management System (TMS). Thus, it is possible that for the same package, different rates may be seen for certain procedures based on the type of implant / consumable selected in such cases. (Also refer to answers for Q. 16 to 19)

16. Can more than one implant be booked for a procedure?

A. HBP 2.0 provisions for use of multiple implants within a procedure and independently accounts for the price of each implant used. However, for most procedures, there is a cap on the maximum number of implants that will be reimbursed in a procedure.

17. Will the hospitals be getting reimbursed separately for the implants?

A. No. Price of implant will be included in the price of the selected procedure. The price of the implant will be added to the procedure price at the backend by the TMS and will be reflected in the final reimbursement. Some procedures may require details of the number / type of implant used from a selection dropdown to calculate the total price of implants used.

18. What is Static & Dynamic pricing of procedures?

A. A concept of static and dynamic pricing has been introduced in HBP 2.0 to account for variations in prices that are now possible in HBP 2.0 based on number / types of implants used. Procedures with no implants, or pre-defined included implants will follow a static price with no variations. On the other hand, in case of procedures where multiple implants are permitted, or in case there is an available choice in type of implant, the TMS would prompt for details of the number / type of implant used from a selection dropdown to calculate the total price of implants used.

19. How is the final procedure rate calculated in the TMS?

A. For final calculation of procedure rate, Final Procedure Price = Procedure price + Stratification rate (if any) + Incentive (if applicable) + Implant(s) rate (if any).

20. Is there any change in the incentives offered on the package rates under AB PM-JAY?

A. There is no change in the NHA policy for incentives. However, the percentage of incentive will no longer be applicable to the price of the implant. Incentive will only be calculated on the procedure rate. Indicative incentive mechanisms are as below, (this is a voluntary exercise at the States' discretion, with prior intimation to the NHA).

S. No.	Criteria	Incentive
1	Entry level NABH	10%
2	Full NABH accreditation	15%
3	Situated in Delhi or some other Metro	10%
4	Aspirational district	10%
5	Running PG / DNB course in the empanelled specialty	10%

These percentage incentives are added by compounding rather than in simple way. Thus, for a package costing Rs. 10,000 otherwise, the payment made for a hospital with full NABH accreditation

in an aspirational district will be ₹10,000 x 1.15 x 1.10 = ₹12,650. It will not be calculated as ₹10,000 x 1.25 = ₹12,500

21. What are the Aspirational districts?

- A. 117 Aspirational districts have been identified by NITI Aayog based upon composite indicators from Health & Nutrition, Education, Agriculture & Water Resources, Financial Inclusion and Skill Development and Basic Infrastructure which have an impact on Human Development Index.

22. What are the Metros?

- A. The Metros include Delhi (UA) (including Faridabad, Ghaziabad, NOIDA and Gurugram), Greater Mumbai (UA), Kolkata (UA), Chennai (UA), Bangalore / Bengaluru (UA), Ahmedabad (UA), Hyderabad (UA) and Pune (UA).

[Cities classified as “X” in Ministry of Finance’s OM No. 2/5/2014-E.II(B) dated 21.07.2015]

23. What is an Add-on Procedure?

- A. Certain packages which can be booked with a primary package at a 100% reimbursement contrary to the existing principle of 50% reimbursement of the second package. These packages are defined as Add-on Packages.

24. What are Stand-Alone Procedures?

- A. For Fraud prevention and control, some packages have been identified that cannot be booked in combination with any other package / procedure. These are termed as stand-alone packages in the HBP 2.0

25. What are Sequential Procedures?

- A. Some procedures in HBP 2.0 have been identified to follow a logical sequence in patient management. Any break in the sequence would trigger an investigation at the NHA who may seek justification for the same.

26. Is there a provision for Follow-Up procedures?

A. Procedures have been identified that require prolonged follow ups beyond the limit of 15 days as included in the coverage of the scheme. These follow ups may need medical intervention with utilization of consumables and consultations with the treating doctor. These have been sorted as follow up packages and are aligned to their specific primary packages. In addition, these packages can only be booked only upon submission of satisfactory documentary proof that the primary procedure was conducted on the patient, whether within or outside of the purview of AB PM-JAY.

27. Are there defined Day Care procedures in HBP 2.0?

A. All standard HBP guidelines are applicable across all packages in HBP 2.0. There is no relaxation in protocols for any procedures that are booked on Day Care or Inpatient basis / in Public or Private Hospitals / in Elective or Emergency conditions.

28. Have any Fraud control measures been built into the procedures of HBP 2.0?

A. Many Anti-Fraud measures have been built into the procedures of HBP 2.0. A few of them are as under

- a. Procedures within HBP 2.0 have been identified to be fraud prone and would be under scrutiny by the National Anti-Fraud unit (NAFU) at the NHA. Utilization of these packages may trigger show-cause response from the NHA.
- b. Prices of some procedures have been consciously kept at a bare minimum to avoid temptation of hospitals to abuse the same.
- c. In cases where the patient undergoes multiple rounds of treatment, the minimum interval between two consecutive treatment interventions has been configured in the IT system, wherever applicable e.g. Appendicectomy, Hysterectomy, Cataract etc.
- d. The maximum number of times a procedure can be booked for an individual patient has been integrated in the IT system, wherever applicable
- e. Implants / High End Consumables usage has been defined at the procedure level where both the type of Implants / High End Consumables and their maximum permissible limit of usage has been detailed out

29. Is there any relationship between the packages of HBP 1.0 & the procedures of HBP 2.0?

- A. The procedures of HBP 2.0 have been mapped back with the packages of HBP 1.0. The list of mapped packages and procedures is available on the website of AB PM-JAY.

30. How are the new package codes different from HBP 1.0?

- A. A unique alpha - numeric code comprising of five characters is assigned to each package. The first two alphabets of the package code denote the primary specialty and the three numbers denote the serial number of packages under the primary specialty. The sequence of packages is aligned according to their organ systems or the type of treatment modality involved.

31. Is there a standardized nomenclature of procedures in HBP 2.0?

- A. In collaboration with World Health Organization (WHO), the NHA has initiated the process of aligning HBP 2.0 with International Classification of Health Interventions (ICHI) and International Classification of Diseases (ICD) coding of the WHO.

32. Are there any guidelines with respect to reservation of packages for Public Hospitals?

- A. It is the discretion of the States to reserve packages for public hospitals based on their local conditions and infrastructure availability. However, as with HBP 1.0, certain procedures such as Hysterectomy, High Risk Delivery and Mental health packages have been recommended by the National Health Authority to be reserved for Public Hospitals. The same will continue to be reserved for Public Hospitals for HBP 2.0

33. Can states still add state specific packages to supplement HBP 2.0?

- A. Yes. States are still at liberty to add state specific packages. However, prior approval from the NHA is mandatory that would ensure that the requested packages do not fall in the exclusion criteria of the scheme, or that the packages do not prior exist in the national master.

34. What is the process for States to add their own state specific packages to supplement HBP 2.0?

- A. In collaboration with World Health Organization (WHO), the NHA has initiated the process of aligning HBP 2.0 with International Classification of Health Interventions (ICHI) and International Classification of Diseases (ICD) coding of the WHO. The same mapping will need to be adopted by the states before submitting their proposed list to the NHA for approval. The NHA would scan the list to cull out any duplicate procedures with the National list, as well as procedures that fall within the exception criteria of the scheme. States will also be required to send in their proposal with a reasonable justification for inclusion of their packages to the satisfaction of the NHA medical panel.

35. Do States have the flexibility to alter package rates?

- A. Package / Procedure rates recommended by the NHA in HBP 2.0 have been arrived to through a scientific and rigorous process of costing exercises and committee recommendations. However, it is also accepted that costs and prices of services may vary between states. To account for the same, the states have the flexibility of increase the recommended rates anywhere within 10% for their specific state / UT. However, the states have the liberty to reduce the rates to any limits owing to conditions specific to their state.

36. What is the Minimum Document Protocol for HBP 2.0?

- A. A set of mandatory documents have been defined for each package / procedure within the HBP 2.0. These documents would need to be mandatorily uploaded at the time of raising a pre-auth, or for raising a claim. These documents comprise the MDP / 'Minimum document Protocol' for HBP 2.0. These are available in the Transaction management System

37. Is there a defined Average Length of Stay (ALOS) for procedures booked under HBP 2.0?

- A. No. There is no minimum / maximum length of stay defined for any procedure under HBP 2.0. Any defined ALOS published for patient care under HBP 2.0 is purely indicative and is not expected to be restrictive to patient care in any way.

38. What is the effective date of implementation of HBP 2.0?

- A. The effective date of implementation, of HBP 2.0 will be state specific i.e. each state is expected to adopt the same as soon as possible subject to administrative feasibility.

39. How do States prepare for HBP 2.0? Are there any IT related expectations?

- A. For all states using the NHA TMS, the transition to HBP 2.0 would be automated from the backend and would require no preparations at the State level. For states using their own Transaction Management Systems, there would be preparations required that would be facilitated by the IT teams at NHA. Beyond IT, the States would be expected to facilitate and ensure trainings of all stakeholders involved as the system transitions to the newer version.

Abbreviations Used

AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
HBP	Health Benefit Packages
NHA	National Health Authority
SHA	State Health Agency
ISA	Implementation Support Agency
TMS	Transaction Management System
OBG	Obstetrics & Gynecology
ENT	Ear, Nose & Throat Specialty (Otorhinolaryngology)
CTVS	Cardio Thoracic & Vascular Surgery
WHO	World Health Organization
ICHI	International Classification of Health Interventions
ICD	International Classification of Diseases
PPD	Pre-Auth Processing Doctor
CPD	Claim Processing Doctor
DHR	Department of Health Research
ICMR	Indian Council of Medical Research
Lap	Laparoscopic
CBD	Common Bile Duct
LAMA	Leave Against Medical Advice
DAMA	Discharge Against Medical Advice

Annexure 1 – Exclusions to the Policy

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

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

Annexure 2 – Health Benefit Packages 2.0

Available on the AB PM-JAY Website under <https://pmjay.gov.in/resources/documents>