national health authority

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Pradhan Mantri Jan Arogya Yojana
Ayushman Bharat
PM-JAY

Claims Adjudication FAQs

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

NATIONAL HEALTH AUTHORITY
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Acronyms

AB- PMJAY:	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
BIS:	Beneficiary Identification System
CEX:	Claim Executive
CPD:	Claim Panel Doctor
DAMA:	Discharge Against Medical Advice
FIFO:	First in First Out
IC:	Insurance Company
ICU:	Intensive Care Unit
ISA:	Implementation Support Agency
LAMA:	Leave Against Medical Advice
MEDCO:	Medical Coordinator
NHA:	National Health Authority
OT:	Operation Theatre
PMAM:	Pradhan Mantri Arogya Mitra
PPD:	Pre-Authorization Panel Doctor
SHA:	State Health Agency
TAT:	Turn Around Time
TMS:	Transaction Management System
TPA:	Third Party Administrator

Claim Adjudication FAQs

Admission & Discharge

Q 1. What if patient produces PMJAY card late and wants to get treatment under PMJAY at the time of discharge? e.g. patient party has produced card after 4 days post admission.

The hospital must develop a mechanism to identify PMJAY beneficiaries at the time of registration itself. However, a provision is made in the TMS to register the patient, back dated, up to 5 days maximum. Hence, treatment can be facilitated to patients who have produced the card before discharge and hospital should ensure no extra money is collected from the beneficiary.

Q 2. What is the process to be followed if the hospital books a wrong package?

The hospital can cancel the package booked with wrong package code applied earlier and raise a new pre-auth/claim with right package code before discharge.

Q 3. Who is MEDCO? What is the role of MEDCO?

MEDCO is the medical coordinator at the hospital, designated to look after clinical activities related to PMJAY beneficiary. His/her role is mainly to facilitate in ascertaining Diagnosis and blocking right package, Pre-auth initiation, Discharge & Claim Initiation etc. All these activities are done by MEDCO in coordination with treating doctor and PMAM.

Q 4. PMAM is not medically oriented, how they should block the right package in the TMS?

The treating doctor must write appropriate package code as per the treatment decided and intimate to MEDCO. Also, MEDCO in the hospital should help PMAM in blocking the right package. Incase there is no MEDCO is available PMAM can take help from treating doctor.

Q 5. If the patient is admitted for medical case and requires a surgery, how should the case be tackled?

Medical and Surgical packages cannot be booked together. All surgical packages include expenditure related to pre and post-operative care. Hence, the hospital shall cancel the pre-auth and generate a new pre-auth request for required surgery. Surgical package under the scheme covers 3 days pre and 15 days post hospitalization expenses.

Q 6. What is the minimum duration of hospitalization that qualifies to be blocked under medical packages?

Minimum of **24 hours** stay is required and the rationale for hospitalization should be provided by the hospital through clinical documents. The diagnosis needs to match the listed packages under PMJAY.

Pre-Authorization

Q 7. Who is PPD and what is his/her role?

Pre-auth Panel Doctor is part of pre-auth processing team (ISA/IC/TPA/SHA), his/her role is Approval/Rejection/Raising Queries of pre-auth request.

Q 8. What is pre-auth auto approval?

a. Package Level Auto approval: Many packages which do not need approval of Pre-auth Panel Doctor (PPD) will be automatically approved in the TMS without going to PPD bucket instantly.

b. Forced Auto approval: Incase no action is taken by PPD within 6 working hours (from 11 AM to 6 PM) of pre-auth initiation for the packages where pre-auth is mandatory, the case will be auto approved in the TMS.

Q 9. What is the pre-auth auto approval TAT?

For packages which need to be approved by PPD, the Turn Around Time (TAT) is 6 working hours. Incase if the case is not approved within the defined time, pre-auth will get auto approved. The working hours in TMS is defined as 11:00 AM to 6 PM for Auto-Approval of the Pre-Auths

- TMS system calculates time by running schedulers on the data and schedulers shall be running between 11:00 AM and 6:00 PM with a frequency of 2 minutes.
- For example, if a Pre-Auth is raised at 5:00 PM in the evening and no action is taken on the same till 11:00 AM, the Pre-Auth will be auto-approved at 11:00 AM.

  Scheduler start time is 11:00 AM because pre-auth approval team is given 2 hours' time in the morning (assuming working hours start at 9:00 AM) for processing all previous day cases.

Q 10. What shall be done in case of a Medical package is auto-approved and the diagnosis changes, later?

The hospital should cancel the case and block the right package with appropriate rationale, otherwise the claim may be rejected by the CPD.

Q 11. What shall be done if pre auth is approved but audit findings reveal that pre-auth approval was not justified?

The decision and outcome of the investigation may be taken into consideration at the time of claim adjudication and if the claim is found to be fraudulent it shall be rejected, and disciplinary action should be initiated. However, if pre-auth was approved by TPA/IC erroneously same should be considered and paid to the hospital.

Q 12. What is meant by pre-auth enhancement in medical cases?

For medical cases the first day would be on auto approved mode. In case extension of stay is required, the PMAM/MEDCO need to seek enhancement through the TMS. Enhancement request may be approved maximum up to 5 days at a time and the same process may be repeated, if required.

Q 13. What should be done if hospital treat patient before getting pre-auth approval?

The hospital must develop a mechanism to identify PMJAY beneficiaries at the time of registration itself.

1. For Packages requiring pre-auth, mandatory pre-Authorization need to be sought before initiating treatment.
2. In case of emergency, telephonic pre-Authorization can be sought, and treatment can be initiated. However, all the required documentation needs to be uploaded within 24 hours.

Q 14. When pre-auth is already initiated and later found that an additional surgery to be done. What should be done in this case?

The pre-auth raised earlier needs to be cancelled and same should be intimated to PPD. After intimation new package can be blocked.

Q 15. Is uploading of mandatory document compulsory while raising pre-auth?

While initiating the Pre-Auth, uploading of all mandatory documents for the selected package is compulsory. If the patient is registered without Bio-metric Authorization, patient's photograph is also required.

Benefit Package

Q 16. What is the definition of pre-hospitalization expenses under PMJAY?

This is the expenditure incurred by the beneficiary of the scheme up to 3 days before getting admitted in the hospital (Applicable only to the expenses made in same hospital where treatment under PMJAY is initiated). The expenditure may be related to diagnostics, consultation and medications etc. and inclusive in the package.

Q 17. How to implement 3-day pre-hospitalization cashless benefit?

The hospital can register the beneficiary in the TMS when he visits hospital for the treatment. If the beneficiary needs admission, pre-auth can be raised and expenses incurred by the beneficiary till then (up to 3 days) shall be considered inclusive in the package.

Incase if he does not need hospitalization or daycare procedure as under PMJAY scheme, then pre-hospitalization expenses will be borne by the patient.

Q 18. What is the definition of post-hospitalization expenses under PMJAY?

It is the expenses incurred by the patient from the date of discharge up to 15 days for consultation, medicines & diagnostics and post-operative care. It is covered under the package and patient should not be charged additionally.

Also in case of surgery, any post-operative complication and re-admission, linked to the treatment, is to be covered under the earlier package cost.

Q 19. How to implement 15 days post-hospitalization cashless benefit?

Hospital must procure required medications and provide to the beneficiary. In case if diagnostic evaluation and follow-up visits are needed within 15 days post discharge, it should be done free of cost by the hospital.

Q 20. Which brand of implants or chemotherapy drugs to be used?

It is up to the hospital to choose the brand meeting the specifications laid down by concerned authorities and patient should be ensured free and good quality treatment. The patient should not be charged any additional money for drugs or implants on the pretext of better quality.

Q 21. What shall be done if the hospital doesn't have diagnostic facility? Or the investigations are being done outside the hospital?

As per NHA guidelines the hospital cannot be empaneled without in-house diagnostic facility or without a tie up with nearest diagnostic facility for the PMJAY beneficiaries. The hospital should ensure cashless treatment to the beneficiaries of PMJAY.

Even if the investigations are done outside the hospital in a facility with which hospital has signed an MoU, the patient shall not be asked to pay for any services for the diagnostics if it is linked with the hospitalization in the hospital under PM-JAY.

Q 22. Is booking of multiple medical packages allowed?

Booking of multiple medical packages is not allowed under PMJAY.

Q 23. Is booking of multiple surgical packages allowed?

Yes, booking of multiple surgical packages is allowed. However, PPD and CPDs shall perform the due diligence while approving and processing such claims.

Q 24. For multiple surgical packages how much amount will hospital get?

For multiple packages, rule of 100%-50%-25% (i.e. Costliest 100%, 2nd costliest – 50% then 25% each) shall be applied.

Q 25. Is the rule of 100%-50%-25% applicable for all claims with multiple packages blocked by the hospital?

This payout ratio is applicable only for multiple surgical package selection. However, for add-on implant related packages like additional stent, additional coil etc. 100% payouts will be applicable.

Q 26. What is maximum number of surgical packages which can be booked together?

It will depend upon the condition of the patient. In case of planned surgeries this number normally does not go beyond 2 or 3. However, in certain conditions e.g. poly trauma, more number of packages may need to be booked. There is no upper limit prescribed from the policy side.

Q 27. How will rule of 100-50-25 apply if more than 3 surgical packages are booked together?

It is envisaged that it will be a rare occurrence that more than 3 surgical packages have to be booked simultaneously. However, in case more than 3 packages are booked then all the packages beyond second package will be reimbursed at 25% level.

Q 28. Can hospitals book medical package & surgical package together?

No, hospitals are not allowed to book medical and surgical packages together.

Q 29. What shall be done in case of surgical package where ICU care is required?

ICU care, if required, is a part of surgical packages.

Q 30. Can hospital book unspecified and specified package together?

No. It is not allowed to book unspecified and specified package together.

Q 31. What kind of treatments cannot be booked under unspecified surgical code?

Any medical treatment, standalone diagnostics, medications, government reserved packages, treatments under exclusion policy of PMJAY and any specified package that has a listed price under PMJAY cannot be booked under unspecified package code. Unspecified packages should not be used to bypass the laid down guidelines for different packages. Refer to the guidelines on use of unspecified package.

Claim Adjudication- TMS

Q 32. Is any alert system exist in the TMS-hospital login to remind on pending query?

In the left side menu of the TMS, there is a tab which shows number of queries pending. Same can be referred by the PMAM/MEDCO to find out pending queries.

Q 33. How to flag a case in the TMS?

Flagging concept enable user to raise a flag against cases which are suspicious. Flagging can be done by Trust/Insurance users. Once the case is flagged, it will be removed from work list and will be visible in Flagging Committee login for further investigation.
Step 1: Log-in as any Trust/Insurance user. Open a case and click on the Flag tab.
Step 2: Select the nature of Flag and click on "flag" button.
Step 3: Once the user clicks on Flag button, System will throw a confirmation message and select yes. Case will appear in flagging committee log.

Q 34. How to de-flag a case in TMS?

Step 1: In the flagging committee login, user must select the file which has to be removed from the list and use 'de-flag' button
Step 2: A prompt dialogue box will appear to confirm de-flagging
Step 3: After confirmation, the case will be de-flagged.

Q 35. Is Family claim History available to PPD & CPD?

Yes, it is available in PPD and CPD tab(past history), if filled by MEDCO/PMAM.

Q 36. Are reasons for rejection against rejected claims available to Hospitals?

Yes, it is available in 'Case Details Report'

Q 37. Is package master available to states and hospital?

Yes, it is available in MIS tab of PMAM and SHA logins

Q 38. Can TMS work offline?

For the places/Hospitals where there is no internet connectivity, the system will have a single user named as OFFLINE-MEDCO at SHA through offline TMS login. The user would be able to drive the entire process on behalf of hospital(for more details refer to TMS user manual). The hospitals should submit the required documents, case wise, to MEDCO who was mapped with particular hospital for uploading on TMS. MEDCO can register the case on back date basis up to 30 days.

Q 39. What is meant by Query in TMS?

Whenever PPD/CPD/SHA wants to seek extra information/document for making any decision on a specific case, they will raise a query and the same will be visible to the hospital for its compliance on information/documents. Once, the relevant information/documents are attached

by the hospital, the case comes back to the query initiator. There is separate button in the TMS where PPD/CPD can raise query.

Q 40. When a case is assigned to PPD/CPD, where the case will appear?

Pre-Auth Updation/Claim Updation tab of the TMS.

Q 41. What is the TAT for query updation (pre-authorization and claim) for hospitals?

As per Claims Adjudication manual, the suggestive TAT for responding to pre-Authorization and claim query by the hospital is 24 hours.

Q 42. What is idle time out in TMS?

The idle time out in TMS is 15 mins

Fraud & Abuse Control

Q 43. What shall be done if money is collected from the patient by the hospital over and above package rates?

Charging of extra money over and above package amount by hospital from the beneficiary is strictly prohibited and full refund and penalty up to 5 times the amount charged, is to be paid to the SHA by the hospital within 7 days of the receipt of Notice. SHA shall there after transfer money to the beneficiary, charged in actual, within 7 days and retain the balance punitive penalty.

Q 44. What action shall be taken if fraud is confirmed for a paid claim?

In such cases, the claim amount must be recovered by SHA from the hospital and the SHA must initiate disciplinary action as per the guidelines.

Claim Processing

Q 45. What is the minimum qualification required to process the claims?

IC/ISA/TPA/SHA should hire the trained & qualified staff. State specific MOU with IC/ISA may be referred for exact qualification and number.

Q 46. What % of claim amount will be given in case of LAMA/DAMA?

Leave Against Medical Advice or Discharge Against Medical Advice the % of claim amount is as below:

Surgical Cases:

a) LAMA/DAMA before surgery: No payment will be done to the hospital by the SHA /Insurer in such cases. This will be applicable in both cases whether pre-operative

investigations have been done or pre-operative investigations have not been done.

b) LAMA/DAMA After Surgery: Payment for 75% of the package rate will be done to the hospital by SHA/Insurer in such cases. Daily case sheets and surgical notes along with indemnity consent note will need to be submitted by the hospital for auditing purposes to quality for payment.

Medical Cases:

Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid after other details satisfactorily checked. Required documentation (clinical notes) for each full day along with indemnity consent will need to be submitted for payment to be considered.

Q 47. What shall be done if the hospital refuses or fails to provide any of the listed mandatory documents?

The claim can be justifiably repudiated and specific guidelines issued by the state authorities may be followed.

Q 48. Can flexibility or relaxation be given to public hospitals with regards to uploading mandatory documents?

As per NHA guidelines Public & Private hospitals should be treated at par, however, SHA may take a considered view on case to case basis.

Q 49. Is there any minimum stipulated time for Claim processing team to raise query on claim submitted by the hospital?

As per NHA guidelines the claim should be settled within 15 days of submission of claim by hospital, so it is expected that queries, if any, should be raised at the earliest.

Q 50. How should a claim be processed for which investigation results suggest adverse findings?

a. The CPD shall reject the case and intimate the reason of rejection to the hospital.
b. SHA would initiate action as per the applicability of gradation of offences.

Q 51. Who is CPD and what is the role?

Claim Panel Doctor is a part of claim processing team. CPD role is adjudication of claims i.e. Approval/Rejection/Raising Queries.

Q 52. Who is CEX and what is the role?

Claim Executive is a part of claim processing team and his/her roles are verification of Non-technical information like Documents, reports, dates etc. and to forward the case to Claim doctor with Inputs.

Q 53. What is the TAT for claim settlement?

As per NHA guidelines, claim needs to be adjudicated and paid within 15 days of claim submission by hospitals. For portability cases it should be paid within 30 days.

Q 54. How the claim settlement TAT will be calculated if any query is raised?

The TAT for claim adjudication and payment is 15 days and incase of portability cases it is 30 days, inclusive of claim queries, if any.

Q 55. Is there any provision in the TMS to reopen a rejected pre-auth & claim if as per the hospital rejection is not justified?

The system will allow the SHA to revoke cases where preauthorization or claim request has been previously rejected or approved. For more details please refer to TMS user manual for approvers.

Q 56. If two surgeries for same treatment is being carried out with 2 different packages, how should we go ahead with it? (e.g. In some cases where herniorrhaphy & hernioplasty both booked together for treatment of hernia)

The CPDs shall review the claim on merit and hospital shall be paid only for the surgery performed.

Q 57. Is there any specific report/readings to be verified by the processing team while approving a claim?

Every package has defined set of documents which the hospital needs to upload while submitting the claim. These reports shall be verified by the CPD while processing claim and for taking informed decision.

Q 58. How to decide the amount for a procedure booked under 'unspecified surgical package'?

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 and the CPD would not be able to deduct any amount or approve partial payment for that claim.

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. For detailed process please refer guidelines on unspecified packages.

Q 59. In case of death of patient before surgery what percentage of claim amount shall be approved?

If surgery has not been done, then no payment will be made to the hospital. This will be applicable in both cases whether pre-operative investigations have been done or not.

Q 60. In case of death of patient on OT table what percentage of claim amount shall be approved?

If death happens during the surgery, then 75 % of the total package rate will be paid. Daily case sheets and surgical notes will need to be submitted by the hospital for auditing purposes to qualify for payment.

Q 61. In case of death of patient after surgery what percentage of claim amount shall be approved?

If death happens after the surgery/ post-operative stay has been performed, then 100% of package rate will be paid to the hospital after detailed medical audit. If it is observed that the death was due to negligence or mortality audit has significant findings suitable action shall be taken against the hospitals and claim amount shall be withheld till explanation received and reviewed by experts

Q 62. Why mandatory documents are required to be uploaded for all cases?

Mandatory documents are required to be uploaded by the hospitals for all claims to enable the PPD and CPD to make right and informed decision on pre-auth request/claim.

Q 63. Can the cases be assigned to a specific PPD or CPD for process in TMS?

a. The PPD & CPD will be auto-assigned the case on First in First Out basis.
b. However, after FIFO, the case can be assigned to particular PPD/CPD based on the requirement of the case.

Portability related

Q 64. Patient from State A is taking treatment in State B, which state treatment package rate is applicable in this case?

Package list and package rates as applicable in the State where the treatment takes place will be applicable i.e. State B in this case. However, if there are any packages reserved for government hospitals in the beneficiary home state, those packages cannot be treated outside state private hospital.

Q 65. Treatment package in State A is reserved to Government Hospitals, can patient take treatment from empaneled private hospital of State B?

No. If the package is reserved for government hospitals in State A, the treatment can't be taken in State B private hospitals.

Q 66. Who will settle the claims of other state beneficiaries? e.g. If beneficiary from State A takes treatment in State B, who will pay the claims to hospital.

The payment of claims to the hospital will be made by Trust/Insurance Company implementing PMJAY in the home State where the beneficiary belongs to i.e State A in this example.

Q 67. What is the TAT for settlement of portability claims?

TAT for portability cases is 30 days.

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