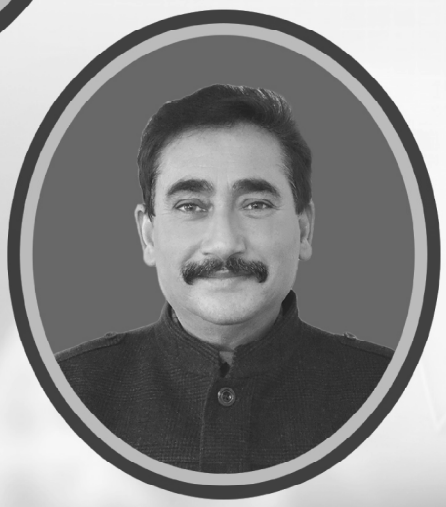

आयुष्मान भारत

प्रधान मंत्री जन आरोग्य योजना

परिचालन दिशानिर्देश
हिमाचल प्रदेश

हिमाचल प्रदेश स्वास्थ्य बीमा योजना सोसाईटी
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आयुष्मान भारत

प्रधान मन्त्री जन आरोग्य योजना

Disclaimer: These guidelines have been prepared by the State Health Agency as per the guidelines received from Govenemnt of India in the month of September, 2018. The guidelines are subject to change as per the instructions of Government of India issued from time to time.

भूमिका

देश के गरीबों को स्वास्थ्य बीमा प्रदान करने के लिए केन्द्र सरकार द्वारा कई प्रयास किए जाते रहे हैं। इस संदर्भ में भारत सरकार ने एक और योजना जोड़ते हुए आयुष्मान भारत–प्रधान मन्त्री जन आरोग्य योजना की शुरूआत की है, जिसके तहत लोगों को स्वास्थ्य बीमा प्रदान किया जाएगा। माननीय प्रधान मन्त्री ने 15 अगस्त, 2018 के भाषण में इस योजना के तहत यह घोषणा की कि आयुष्मान भारत– प्रधान मन्त्री जन आरोग्य योजना के तहत लाभार्थियों को पांच लाख रूपये तक का निःशुल्क स्वास्थ्य बीमा प्रदान किया जाएगा, जो कि कैशलैस एवं पेपरलैस होगा। इस योजना का आरम्भ दिनांक 23 सितम्बर, 2018 को किया जाएगा।

विशेषताएं

1. **सुरक्षा बीमाः** यह योजना चयनित परिवारों के लिए एक राष्ट्रीय स्वास्थ्य संरक्षण योजना है, जिसके तहत माध्यमिक एवं टरशरी अस्पतालों में भर्ती होने पर पांच लाख रूपये तक का निःशुल्क ईलाज प्रदान किया जाएगा जो कि उनकी किसी गंभीर बीमारी का ईलाज कराने के लिए वित्तीय रूप से सहायता करेगा।
2. **लाभार्थियों की कुल संख्याः** इस योजना के अन्तर्गत भारत में लगभग 10 करोड़ परिवारों (लगभग 50 करोड़ लोग) को शामिल किया गया है। हिमाचल प्रदेश में इस योजना के अन्तर्गत लगभग 5 लाख पात्र परिवार (लगभग 22 लाख लोग) शामिल हैं।
3. इसमें आयु एवं परिवार में सदस्यों की संख्या में कोई सीमा नहीं है।

4. **पोर्टेबिलीटी**: लाभार्थी इस योजना का लाभ पूरे देश में किसी भी पंजीकृत अस्पताल में प्राप्त कर सकते हैं। इस योजना में अस्पतालों में निःशुल्क ईलाज प्रदान किया जाएगा।
5. **सूचिबद्ध अस्पताल**: इस योजना के तहत हिमाचल प्रदेश में 175 अस्पताल पंजीकृत हैं जिनमें 151 सरकारी एवं 24 अस्पताल निजी क्षेत्र में है। इसके अतिरिक्त नए अस्पतालों के पंजीकरण की प्रक्रिया आरम्भ कर दी गई है।
6. **वार्षिक रूप से**: इस योजना में प्रति परिवार प्रति वर्ष 5 लाख रूपये तक का स्वास्थ्य बीमा फैमिली फलोटर आधार पर प्रदान किया जाएगा। अर्थात एक सदस्य या परिवार के सभी सदस्य योजना का लाभ ले सकते हैं, परन्तु एक परिवार के लिए एक वर्ष में बीमा की राशि 5 लाख रूपये ही होगी।
7. **अन्य सुविधा**: इस योजना के अन्तर्गत लाभार्थियों की सहायता के लिए अस्पतालों में प्रधान मन्त्री आरोग्य मित्र उपलब्ध होंगे जो कि ईलाज के समय लाभार्थी का पूर्ण मार्गदर्शन करेंगे।

अस्पतालों का पंजीकरण

अस्पतालों के पंजीकरण के लिए जिला स्तर पर जिला पंजीकरण समिति तथा राज्य स्तर पर राज्य पंजीकरण समिति बनाई गई है। योजना के अन्तर्गत अस्पताल को भारत सरकार की वैबसाईट पर पंजीकरण के लिए ऑनलाईन आवेदन करना होगा। जिला समिति अस्पताल के पंजीकरण आवेदन के 15 दिनों के अन्दर अस्पताल में जाकर, सुविधाओं का सत्यापन करके वैबसाईट के माध्यम से आवेदन को स्वीकार या अस्वीकार करेगी। जिला समिति की सिफारिशों के आधार पर राज्य समिति द्वारा अस्पताल के पंजीकरण के लिए अन्तिम मान्यता दी जाएगी।

प्रधान मन्त्री आरोग्य मित्र

योजना के सफलतापूर्वक संचालन के लिए सभी पंजीकृत अस्पतालों को प्रधान मन्त्री आरोग्य मित्र की नियुक्ति करनी होगी। अस्पताल वर्तमान में राष्ट्रीय स्वास्थ्य बीमा योजना के अन्तर्गत कार्य कर रहे ऑपरेटर को भी प्रधान मन्त्री आरोग्य मित्र के रूप में नियुक्त कर सकता है। यह आरोग्य मित्र अस्पताल में आने वाले लाभार्थियों का पंजीकरण करेंगे और उन्हे ईलाज करवाने में सुविधा प्रदान करेंगे। साथ ही यह अस्पताल में क्लेमों से सम्बन्धित दस्तावेज भारत सरकार की वैबसाईट पर डालेंगे ताकि अस्पतालों को क्लेमों का भुगतान समय पर हो सके। यह प्रधान मन्त्री आरोग्य मित्र अस्पतालों में क्लेमों का पूर्ण ब्यौरा भी अपने पास रखेंगे।

योजना के तहत पंजीकरण का ब्यौरा

इस योजना के बारे में सभी लोगों को यह जानना आवश्यक है कि:–

1. आयुष्मान भारत–प्रधान मन्त्री जन आरोग्य योजना के लाभार्थियों को इस योजना के अन्तर्गत लाभ उठाने के लिए किसी भी प्रकार का नामांकन करने की आवश्यकता नहीं है।
2. इसके तहत पंजीकरण फार्म नहीं भरे जाएंगे अपितु सामाजिक, जाति जनगणना, 2011 के अन्तर्गत आने वाले परिवारों को शामिल किया गया है।
3. इसके अतिरिक्त राष्ट्रीय स्वास्थ्य बीमा योजना के लाभार्थियों को भी इस योजना के तहत शामिल किया गया है।

योजना के तहत कॉल सैंटर की सुविधा

लाभार्थियों को इस योजना की जानकारी देने के लिए कॉल सैंटर जिसका नम्बर 14555 है स्थापित किया गया है जिस पर कॉल करके लाभार्थी परिवार योजना की सारी जानकारी प्राप्त कर सकते हैं। इसके अतिरिक्त इस योजना की जानकारी भारत सरकार की वैबसाईट और मोबाईल एप पर भी प्राप्त की जा सकती है। उपरोक्त के अतिरिक्त लाभार्थी प्रधान मन्त्री आरोग्य मित्रों के माध्यम से भी इस योजना की जानकारी प्राप्त कर सकते हैं।

योजना की प्रक्रिया

इस योजना के तहत निम्न प्रक्रिया द्वारा लाभार्थियों की देखभाल की जाएगीः—

1. अस्पताल में भर्ती होने की स्थिति में सबसे पहले लाभार्थी की पहचान एवं पंजीकरण भारत सरकार द्वारा बनाए गए सॉफ्टवेयर द्वारा किया जाएगा जिससे यह पता चलेगा कि लाभार्थी पात्र है या नहीं। इसकी पुष्टि उस व्यक्ति के आधार कार्ड/राशन कार्ड/पंजीकृत मोबाईल नम्बर या राष्ट्रीय स्वास्थ्य बीमा योजना के कार्ड के माध्यम से की जाएगी।
2. इसके बाद अस्पताल द्वारा पैकेज का चयन किया जाएगा और साथ ही कार्ड में बची हुई राशि की जांच की जाएगी और फिर उन्हे ईलाज के लिए जरूरी सहायक दस्तावेज भी जमा करने होंगे।
3. यह प्रक्रिया पूरी जो जाने के बाद उस मरीज का बेहतर ईलाज किया जाएगा। ईलाज पूरा हो जाने के बाद उसे अस्पताल से छुट्टी कर दी जाएगी।

4. छुट्टी के समय लाभार्थी को डिस्चार्ज समरी प्रधान मन्त्री आरोग्य मित्र को दिखानी आवश्यक होगी। आरोग्य मित्र इस समरी को वैबसाईट पर अपलोड करेगा। तदोपरान्त राज्य स्वास्थ्य एजेंसी द्वारा अस्पताल के बैंक में इलैक्ट्रानिक भुगतान किया जाएगा और अंत में मरीजों द्वारा अस्पताल में दी गई सुविधा के बारे में उनसे फीडबैक मांगा जाएगा।

अस्पतालों में लाभार्थियों की पहचान एवं सत्यापन

पंजीकृत अस्पतालों में योजना का लाभ उठाने वाले लाभार्थियों की पहचान करने के लिए सबसे पहले लाभार्थिओं को सहायता डेस्क पर जाना होगा, जहाँ पर उनकी पहचान का सत्यापन किया जायेगा। इसके लिए वह अपने परिवार का राशन कार्ड, आधार कार्ड, पंजीकृत मोबाइल नंबर या राष्ट्रीय स्वास्थ्य बीमा योजना का कार्ड अपने साथ अस्पताल लेके जरूर आएं । इसके बाद उस व्यक्ति का सत्यापन किया जायेगा और वह योग्य है या नही इसकी जांच की जाएगी सत्यापन एवं पहचान की प्रक्रिया पूरी की जाने के बाद लाभार्थी को एक ई कार्ड प्रदान किया जायेगा जिससे वह इलाज प्राप्त कर सकता है।

अस्पतालों को भुगतान

इस योजना के तहत सभी अस्पतालों को इलाज के समय पर भुगतान सुनिश्चित किया जायेगा, जो की निम्न विधि से होगा–

- इस योजना में अस्पतालों को दिए जाने वाले फण्ड का भुगतान राज्य स्वास्थ्य एजेंसी के माध्यम से किया जायेगा।

- भुगतान के लिए राज्य स्वास्थ्य एजेंसी ने एस्क्रौ अकाउंट खोला है, जिसके द्वारा अस्पतालों को भुगतान किया जायेगा।
- अस्पतालों में भुगतान जारी करने के लिए बैंकिंग ट्रिगर मौजूद होगा, और साथ ही अस्पतालों में क्लेम के समय पर सेटलमेंट के लिए मुख्य प्रदर्शन इंडिकेटर भी होगा।

योजना में पैकेज दर

इस योजना में पैकेज की दरों को निम्न अनुसार दर्शाया गया है –

सेवा कवरेज:– योजना में सेवा के लिए लगभग 1800 से अधिक पैकेज दरें शामिल की गई हैं और 24 विशिष्ट्ताओं को इसमें शामिल किया गया है।

पूर्व अधिकार की जांच:– पूर्व अधिकार की जांच के लिए इसमें लगभग 60 प्रतिशत् पैकेज शामिल हैं। इन पैकेज के अन्तर्गत ईलाज से पूर्व अस्पताल को राज्य स्वास्थ्य एजेंसी द्वारा चयनित एजेंसी से अनुमोदन प्राप्त करना होगा।

शिकायतों का निपटारा

योजना के अन्तर्गत राज्य स्तर पर और जिला स्तर पर शिकायतों के निपटारे के लिए समितियां बनाई गई हैं। शिकायतकर्ता अपनी शिकायत पहले जिला स्तर पर दर्ज करवाएगा और जिला स्तर पर समिति शिकायत का निपटारा करेगी। यदि किसी शिकायत का निपटारा जिला स्तर पर नहीं किया जाता तो सम्बन्धित शिकायत का निपटारा राज्य समिति द्वारा किया जाएगा।

Ayushman Bharat

Pradhan Mantri Jan ArogyaYojna

Operation Guidelines

Himachal Pradesh

Table of Contents

Abbreviations

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

Eligible Beneficiaries

A. All AB-NHPM Beneficiary Family Units, as defined under the deprivation criteria of D1, D2, D3, D4, D5 and D7,Automatically Included category (in rural areas) and broadly defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC), 2011 database of the State (as updated from time to time).

B. Existing RSBY Beneficiary Families enrolled in 2014-15 i.e. BPL, MGNREGA workers, Street Vendors, Building & Other Construction Workers, Sanitation Workers, Auto Rickshaw & Taxi Drivers, Contract Employees and >70%disabled.

C. The District wise detail of covered families is as under:-

Districts	RSBY Families	SECC Families
Bilaspur	26705	11360
Chamba	50273	28048
Hamirpur	32054	17906
Kangra	109789	58509
Kinnaur	5354	6011
Kullu	26866	22720
LahulSpiti	2559	2277
Mandi	99878	42338
Shimla	48180	31460
Sirmaur	31343	21598
Solan	25818	17894
Una	24824	18124
Grand Total	483643	278245

Benefits

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

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

b. As on the date of commencement of the Policy Cover Period, the AB-NHPMSumInsured in respect of the Risk Cover for each AB-NHPM Beneficiary Family Unit shall be **Rs. 5,00,000 (Rupees Five Lakh Only)** per family per annum on family floater basis. This shall be called the **Sum Insured**, which shall be fixed irrespective of the size of the AB-NHPM Beneficiary Family Unit.

c. The Sum Insured shall be available to any or all members of such Beneficiary Family Unit for one or more Claims during each Policy Cover Period. New family members may be added after due approval process as defined by the Government.

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

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

f. Package rates of the hospital where benefits are being provided will be applicable while payment will be done to the hospital by the State Health Agency (based on recommendation of ISA working the the State) that is covering the beneficiary under its policy.

g. The SHA shall notify the packages from time to time and the same shall be notified on the website of the SHA i.e. www.hpsbys.in.

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

(i) Hospitalization expense benefits

(ii) Day care treatment benefits (as applicable)

(iii)Follow-up care benefits (as applicable)

(iv)Pre and post hospitalization expense benefits (as applicable)

(v) New born child/ children benefits

i. Pre-existing conditions/diseases are to be covered from the first day of the start of policy, subject to the following exclusions:-

1. **Conditions that do not require hospitalization:** Condition that do not require hospitalization and can be treated under Out Patient Care. Out Patient Diagnostic, unless necessary for treatment of a disease covered under Medical and Surgical procedures or treatments or day care procedures (as applicable), will not be covered.
2. Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.
3. Any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease, illness or injury and which requires hospitalisation for treatment.
4. **Congenital external diseases:** Congenital external diseases or defects or anomalies, Convalescence, general debility, "run down" condition or rest cure.
5. **Fertility related procedures:** Hormone replacement therapy for Sex change or treatment which results from or is in any way related to sex change.
6. **Drugs and Alchohol Induced illness:** Diseases, illness or injury due to or arising from use, misuse or abuse of drugs or alcohol or use of intoxicating substances, or such abuse or addiction
7. **Vaccination:** Vaccination, inoculation or change of life or cosmetic or of aesthetic treatment of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness. Circumcision (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident),
8. **Suicide:** Intentional self-injury/suicide

9. *Persistent Vegetative State*

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

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

l. In case of AB-NHPM Beneficiary is required to undertake multiple surgical treatment within same admission, then the highest package rate shall be taken at 100%, thereupon the 2nd treatment package shall taken as 50% of package rate and 3rd treatment package shall be at 25% of the package rate.

m. Surgical and Medical packages will not be allowed to be availed at the same time.

n. SHA may subsequently introduce differential pricing based on the performance of hospitals or accreditation.

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

(i) Registration charges.

(ii) Bed charges (General Ward).

(iii) Nursing and boarding charges.

(iv) Surgeons, Anaesthetists, Medical Practitioner, Consultants fees etc.

(v) Anaesthesia, Blood Transfusion, Oxygen, O.T. Charges, Cost of Surgical Appliances etc.

(vi) Medicines and drugs.

(vii) Cost of prosthetic devices, implants etc.

(viii) Pathology and radiology tests: radiology to include but not be limited to X-ray, MRI, CT Scan, etc.

(ix) Diagnosis and Tests, etc

(x) Food to patient.

(xi) Pre and Post Hospitalisation expenses: Expenses incurred for consultation, diagnostic tests and medicines before the admission of the patient in the same hospital and cost of diagnostic tests and medicines and up to 15 days of the discharge from the hospital for the same ailment/ surgery.

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

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

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

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

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

Empanelment of Hospitals

A. Empanelment

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

b. Private healthcare providers (both for profit and not for profit) which provide hospitalization and/or day care services (as applicable) would be eligible for empanelment under AB-NHPM, subject to their meeting of certain requirements (empanelment criteria) in the areas of infrastructure, manpower, equipment (IT, help desk etc.) and services (for e.g. liaison officers to facilitate beneficiary management) offered.

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

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

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

B. Agreement with Empanelled Health Care Providers

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

b. This Provider Service Agreement shall be a bipartite agreement.

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

d. Each EHCP will provide the required IT infrastructure (hardware i.e. computer/printer/webcam etc.) as per the AB-NHPM guidelines. For all Public EHCPs ISA shall provide 2D QR Code Reader and Biometric Scanner compliant with UIDAI to and bear its maintenance. However the ownership of all such assets, hardware and software along with its licenses, shall irrevocably vest with the Public EHCP. The Private EHCPS may take ISA's support for procurement of such hardware by the EHCPs at their cost.

C. De-empanelment of Health Care Providers

The SHA shall suspend or de-empanel an EHCP from the AB-NHPM if the EHCP is found to indulge in malpractices as reported by ISA or if otherwise determined by the SHA.

D. Process of Empanelment & De-Empanelment

A. Empanelment requirements

i) All the public hospitals empanelled under RSBY are deemed empanelled under AB-NHPM.

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

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

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

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

Category 1: General Criteria	Category 2: Specialty Criteria
All the hospitals empanelled under AB-NHPM for providing general care have to meet the minimum criteria established under the Mission. No exceptions will be made for any hospital at any cost.	Hospitals would need to be empanelled separately for certain tertiary care packages authorized for one or more specialties (like Cardiology, Oncology, Neurosurgery etc.). This would only be applicable for those hospitals who meet the general criteria for the AB-NHPM.

Online Empanelment

A. A web-based platform has been provided for empanelment of hospitals for AB-NHPM.

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

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

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

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

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

i) Hospital registered but application submission pending
ii) Application submitted but document verification pending
iii) Application submitted with documents verified and under scrutiny by DEC/SEC
iv) Application sent back to hospital for correction

v) Application sent for field inspection

vi) Inspection report submitted by DEC and decision pending at SEC level

vii) Application approved and contract pending

viii) Hospital empanelled

ix) Application rejected

x) Hospital de-empanelled

xi) Hospital blacklisted (2 years)

Following Empanelment Committees have been notified for empanelment of hospitals in the State of Himachal Pradesh:-

State Level

Chief Executive Officer	Chairman
Consultant (AB-PMJAY), HPSBYS	Member
DHS or his representative	Member
DME or his representative	Member
DHS&R or his representative	Member

District Level

Chief Medical Officer	Chairman
Medical Officer of Health (MoH)	Member
Representative of Deputy Commissioner	Member
District Coordinator of SHA	Member

Role of District Empanelment Committee (DEC)

A. Since all the Public Hospitals empanelled under RSBY are deemed empanelled under ABNHPM, hence the DEC will upload a report that "Name of Hospital" is already empanelled under RSBY and approved for empanelment of ABNHPM on web portal and approve these hospital through web portal.

B. After the empanelment request by a hospital is filed, the application should be scrutinized by the DEC and processed completely within 15 days of receipt of application.

C. A login account for DEC has been created by SEC. This login ID will be used to download the application of hospitals and upload the inspection report.

D. In case of Private Hospital and new empanelment, as a first step, the documents uploaded have to be correlated with physical -verification of original documents produced by the hospital. In case any documents are found wanting, the DEC may return the application to the hospital for rectifying any errors in the documents.

E. After the verification of documents, the DEC will physically inspect the premises of the hospital and verify the physical presence of the details entered in the empanelment application, including but not limited to equipment, human resources, service standards and quality and submit a report in a said format through the portal along with supporting pictures/videos/document scans.

F. DEC will ensure the visits are conducted for the physical verification of the hospital.

G. The team will verify the information provided by the hospitals on the web-portal and will also verify that hospitals have applied for empanelment for all specialties as available in the hospital.

H. In case during inspection, it is found that hospital has not applied for one or more specialties but the same facilities are available, then the hospital will be instructed to apply for the missing specialties within a stipulated a timeline (i.e. 7 days from the inspection date).

   i) In this case, the hospital will need to fill the application form again on the web portal. However, all the previously filled information by the hospital will be pre-populated and hospital will be expected to enter the new information.

   ii) If the hospital does not apply for the other specialties in the stipulated time, it will be disqualified from the empanelment process.

I. In case during inspection, it is found that hospital has applied for multiple specialties, but all do not conform to minimum requirements under AB-NHPM then the hospital will only be empanelled for specialties that conform to AB-NHPM norms.

J. The team will recommend whether hospital should be empanelled or not based on their field-based inspection/verification report.

K. DEC team will submit its final inspection report to the state. The district nodal officer has to upload the reports through the portal login assigned to him/her.

L. The DEC will then forward the application along with its recommendation to the SEC.

Role of SEC

A. The SEC will consider, among other things, the reports submitted by the DEC and recommendation approve or deny or return back to the hospital the empanelment request.

B. In case of refusal, the SEC will record in writing the reasons for refusal and either direct the hospital to remedy the deficiencies, or in case of egregious emissions from the empanelment request, either based on documentary or physical verification, direct the hospital to submit a fresh request for empanelment on the online portal.

C. The SEC will also consider recommendations for relaxation of criteria of empanelment received from DEC or from the SHA and approve them to ensure that sufficient number and specialties of empanelled facilities are available in the states.

D. Hospital will be intimated as soon as a decision is taken regarding its empanelment and the same will be updated on the AB-NHPM web portal. The hospital will also be notified through SMS/email of the final decision. If the application is approved, the hospital will be assigned a unique national hospital registration number under AB-NHPM.

E. If the application is rejected, the hospital will be intimated of the reasons on the basis of which the application was not accepted and comments supporting the decision will be provided on the AB-NHPM web portal. Such hospitals shall have the right to file a review against the rejection with the State Health Agency within 15 days of rejection through the portal. In case the request for empanelment is rejected by the SHA in review, the hospitals can approach the Grievance Redressal Mechanism for remedy.

F. In case the hospital chooses to withdraw from AB-NHPM, it will only be permitted to re-enter/ get re-empanelled under AB-NHPM after a period of 6 months.

G. If a hospital is blacklisted for a defined period due to fraud/abuse, after following due process by the State Empanelment Committee, it can be permitted to re-apply after cessation of the blacklisting period or revocation of the blacklisting order, whichever is earlier.

H. There shall be no restriction on the number of hospitals that can be empanelled under AB-NHPM in a district.

I. Final decision on request of a Hospital for empanelment under AB-NHPM, shall be completed within 30 days of receiving such an application.

Detailed Empanelment Criteria

Category 1: Essential criteria:

A Hospital would be empanelled as a network private hospital with the approval of the respective State Health Agency if it adheres with the following minimum criteria:

1. Should have at least 10 inpatient beds with adequate spacing and supporting staff as per norms.
    i. Exemption may be given for single-specialty hospitals like Eye and ENT.
    ii. General ward - @80sq ft per bed, or more in a Room with Basic amenities- bed, mattress, linen, water, electricity, cleanliness, patient friendly common washroom etc. Non-AC but with fan/Cooler and heater in winter.
2. It should have adequate and qualified medical and nursing staff (doctors[1]& nurses[2]), physically in charge round the clock; (necessary certificates to be produced during empanelment).
3. Fully equipped and engaged in providing Medical /Surgical services, commensurate to the scope of service/ available specialities and number of beds.
    i. Round-the-clock availability (or on-call) of a Surgeon and Anaesthetist where surgical services/ day care treatments are offered.
    ii. Round-the-clock availability (or on-call) of an Obstetrician, Paediatrician and Anaesthetist where maternity services are offered.
    iii. Round-the-clock availability of specialists (or on-call) in the concerned specialties having sufficient experience where such services are offered (e.g. Orthopaedics, ENT, Ophthalmology, Dental, general surgery (including endoscopy) etc.)

4. Round-the-clock support systems required for the above services like Pharmacy, Blood Bank, Laboratory, Dialysis unit, Endoscopy investigation support, Post op ICU

[1] Qualified doctor is a MBBS approved as per the Clinical Establishment Act/ State government rules & regulations as applicable from time to time.

[2] Qualified nurse per unit per shift shall be available as per requirement laid down by the Nursing Council/ Clinical Establishment Act/ State government rules & regulations as applicable from time to time. Norms vis a vis bed ratio may be spelt out.

care with ventilator support, X-ray facility (mandatory) etc., either 'In-House' or with 'Outsourcing arrangements', preferably with NABL accredited laboratories, with appropriate agreements and in nearby vicinity.

5. Round-the-clock Ambulance facilities (own or tie-up).
6. 24 hours emergency services managed by technically qualified staff wherever emergency services are offered
    i. Casualty should be equipped with Monitors, Defibrillator, Nebulizer with accessories, Crash Cart, Resuscitation equipment, Oxygen cylinders with flow meter/ tubing/catheter/face mask/nasal prongs, suction apparatus etc. and with attached toilet facility.
7. Mandatory for hospitals wherever surgical procedures are offered:
    i. Fully equipped Operation Theatre of its own with qualified nursing staff under its employment round the clock.
    ii. Post-op ward with ventilator and other required facilities.
8. Wherever intensive care services are offered it is mandatory to be equipped with an Intensive Care Unit (For medical/surgical ICU/HDU/Neonatal ICU) with requisite staff
    i. The unit is to be situated in close proximity of operation theatre, acute care medical, surgical ward units, labour room and maternity room as appropriate.
    ii. Suction, piped oxygen supply and compressed air should be provided for each ICU bed.
    iii. Further ICU- where such packages are mandated should have the following equipment:
        1) Piped gases
        2) Multi-sign Monitoring equipment
        3) Infusion of ionotropic support
        4) Equipment for maintenance of body temperature
        5) Weighing scale
        6) Manpower for 24x7 monitoring
        7) Emergency cash cart
        8) Defibrillator.
        9) Equipment for ventilation.

10) In case there is common Paediatric ICU then Paediatricequipments, e.g.: paediatric ventilator, Paediatric probes, medicines and equipment for resuscitation to be available.

iv. HDU (high dependency unit) should also be equipped with all the equipment and manpower as per HDU norms.

9. Records Maintenance: Maintain complete records as required on day-to-day basis and is able to provide necessary records of hospital / patients to the Society/ISA or his representative as and when required.
   i. Wherever automated systems are used it should comply with MoHFW/ NHA EHR guidelines (as and when they are enforced)
   ii. All AB-NHPM cases must have complete records maintained
   iii. Share data with designated authorities for information as mandated.
10. Legal requirements as applicable by the local/state health agency.
11. Adherence to Standard treatment guidelines/ Clinical Pathways for procedures as mandated by NHA from time to time.
12. Registration with the Income Tax Department.
13. NEFT enabled bank account
14. Telephone/Fax
15. Safe drinking water facilities/Patient care waiting area
16. Uninterrupted (24 hour) supply of electricity and generator facility with required capacity suitable to the bed strength of the hospital.
17. Waste management support services (General and Bio Medical) – in compliance with the bio-medical waste management act.
18. Appropriate fire-safety measures.
19. Provide space for a separate kiosk for AB-NHPM beneficiary management (AB-NHPM non-medical[3] coordinator) at the hospital reception.
20. Ensure a dedicated medical officer to work as a medical[4]co-ordinator towards AB-NHPM beneficiary management (including records for follow-up care as prescribed)

[3] The non-medical coordinator will do a concierge and helpdesk role for the patients visiting the hospital, acting as a facilitator for beneficiaries and are the face of interaction for the beneficiaries. Their role will include helping in preauthorization, claim settlement, follow-up and Kiosk-management (including proper communication of the scheme).

21. Ensure appropriate promotion of AB-NHPM in and around the hospital (display banners, brochures etc.) towards effective publicity of the scheme in co-ordination with the SHA/ district level AB-NHPM team.
22. IT Hardware requirements (desktop/laptop with internet, printer, webcam, scanner/ fax, bio-metric device etc.) as mandated by the NHA.

Category 2: Advanced criteria:

Over and above the essential criteria required to provide basic services under AB-NHPM (as mentioned in Category 1) those facilities undertaking defined speciality packages (as indicated in the benefit package for specialities mandated to qualify for advanced criteria) should have the following:

1. These empanelled hospitals may provide specialized services such as Cardiology, Cardiothoracic surgery, Neurosurgery, Nephrology, Reconstructive surgery, Oncology, Paediatric Surgery, Neonatal intensive care etc.
2. A hospital could be empanelled for one or more specialities subject to it qualifying to the concerned speciality criteria for respective packages
3. Such hospitals should be fully equipped with ICCU/SICU/ NICU/ relevant Intensive Care Unit in addition to and in support of the OT facilities that they have.
4. Such facilities should be of adequate capacity and numbers so that they can handle all the patients operated in emergencies.
    i. The Hospital should have sufficient experienced specialists in the specific identified fields for which the Hospital is empanelled as per the requirements of professional and regulatory bodies/ as specified in the clinical establishment act/ State regulations.
    ii. The Hospital should have sufficient diagnostic equipment and support services in the specific identified fields for which the Hospital is empanelled as per the requirements specified in the clinical establishment act/ State regulations.
5. Indicative domain specific criteria are as under:

[4] The medical coordinator will be an identified doctor in the hospital who will facilitate submission of online pre-authorization and claims requests, follow up for meeting any deficiencies and coordinating necessary and appropriate treatment in the hospital.

A. **Specific criteria for Cardiology/ CTVS**

1. CTVS theatre facility (Open Heart Tray, Gas pipelines Lung Machine with TCM, defibrillator, ABG Machine, ACT Machine, Hypothermia machine, IABP, cautery etc.)
2. Post-op with ventilator support
3. ICU Facility with cardiac monitoring and ventilator support
4. Hospital should facilitate round the clock cardiologist services.
5. Availability of support speciality of General Physician &Paediatrician
6. Fully equipped Catheterization Laboratory Unit with qualified and trained Paramedics.

B. **Specific criteria for Cancer Care**

1. For empanelment of Cancer treatment, the facility should have a Tumour Board which decides a comprehensive plan towards multi-modal treatment of the patient or if not then appropriate linkage mechanisms need to be established to the nearest regional cancer centre (RCC). Tumor Board should consist of a qualified team of Surgical, Radiation and Medical /Paediatric Oncologist in order to ensure the most appropriate treatment for the patient.
2. Relapse/recurrence may sometimes occur during/ after treatment. Retreatment is often possible which may be undertaken after evaluation by a Medical/ Paediatric Oncologist/ Tumor Board with prior approval and pre-authorization of treatment.
3. For extending the treatment of chemotherapy and radiotherapy the hospital should have the requisite Pathology/ Haematology services/ infrastructure for radiotherapy treatment viz. for cobalt therapy, linear accelerator radiation treatment and brachytherapy available in-house. In case such facilities are not available in the empanelled hospital for radiotherapy treatment and even for chemotherapy, the hospital shall not perform the approved surgical procedure alone but refer the patients to other centres for follow-up treatments requiring chemotherapy and radiotherapy treatments. This should be indicated where appropriate in the treatment approval plan.
4. Further hospitals should have following infrastructure for providing certain specialized radiation treatment packages such as stereotactic radiosurgery/ therapy.
    i. Treatment machines which are capable of delivering SRS/SRT
    ii. Associated Treatment planning system

iii. Associated Dosimetry systems

C. **Specific criteria for Neurosurgery**

1. Well Equipped Theatre with qualified paramedical staff, C-Arm, Microscope, neurosurgery compatible OT table with head holding frame (horse shoe, may field / sugita or equivalent frame).
2. ICU facility
3. Post-op with ventilator support
4. Facilitation for round the clock MRI, CT and other support bio-chemical investigations.

D. **Specific criteria for Burns, Plastic & Reconstructive surgery**

1. The Hospital should have full time / on - call services of qualified plastic surgeon and support staff with requisite infrastructure for corrective surgeries for post burn contractures.
2. Isolation ward having monitor, defibrillator, central oxygen line and all OT equipment.
3. Well Equipped Theatre
4. Intensive Care Unit.
5. Post-op with ventilator support
6. Trained Paramedics
7. Post-op rehab/ Physiotherapy support/ Phycology support.

E. **Specific criteria for /Paediatric Surgery**

1. The Hospital should have full time/on call services of paediatric surgeons
2. Well-equipped theatre
3. ICU support
4. Support services of paediatrician
5. Availability of mother rooms and feeding area.
6. Availability of radiological/ fluoroscopy services (including IITV), Laboratory services and Blood bank.

F. Specific criteria for specialized new born care.

1. The hospital should have well developed and equipped neonatal nursey/Neonatal ICU (NICU) appropriate for the packages for which empanelled, as per norms
2. Availability of radiant warmer/ incubator/ pulse oximeter/ photo therapy/ weighing scale/ infusion pump/ ventilators/ CPAP/ monitoring systems/ oxygen supply / suction / infusion pumps/ resuscitation equipment/ breast pumps/ bilimeter/ KMC (Kangaroo Mother Care) chairs and transport incubator - in enough numbers and in functional state; access to hematological, biochemistry tests, imaging and blood gases, using minimal sampling, as required for the service packages
3. For Advanced Care and Critical Care Packages, in addition to 2. above: parenteral nutrition, laminar flow bench, invasive monitoring, in-house USG. Ophthalmologist on call.
4. Trained nurses 24x7 as per norms
5. Trained Paediatrician(s) round the clock
6. Arrangement for 24x7 stay of the Mother – to enable her to provide supervised care, breastfeeding and KMC to the baby in the nursery/NICU and upon transfer therefrom; provision of bedside KMC chairs.
7. Provision for post-discharge follow up visits for counselling for feeding, growth / development assessment and early stimulation, ROP checks, hearing tests etc.

G. **Specific criteria for Polytrauma**

1. Shall have Emergency Room Setup with round the clock dedicated duty doctors.
2. Shall have the full-time service availability of Orthopaedic Surgeon, General Surgeon, and anaesthetist services.
3. The Hospital shall provide round the clock services of Neurosurgeon, Orthopaedic Surgeon, CT Surgeon, General Surgeon, Vascular Surgeon and other support specialists as and when required based on the need.
4. Shall have dedicated round the clock Emergency theatre with C-Arm facility, Surgical ICU, Post-Op Setup with qualified staff.
5. Shall be able to provide necessary diagnostic support round the clock including specialized investigations such as CT, MRI, emergency biochemical investigations.

H. **Specific criteria for Nephrology and Urology Surgery**

1. Dialysis unit

2. Well-equipped operation theatre with C-ARM
3. Endoscopy investigation support
4. Post op ICU care with ventilator support
5. Sew lithotripsy equipment

Process for Disciplinary Proceedings and De-Empanelment

A. **Institutional Mechanism**

i) De-empanelment process will be initiated by ISA/SHA after conducting proper disciplinary proceedings against empanelled hospitals on misrepresentation of claims, fraudulent billing, wrongful beneficiary identification, overcharging, charging money from patients unnecessarily, unnecessary procedures, false/misdiagnosis, referral misuse and other frauds that impact delivery of care to eligible beneficiaries.

ii) Hospital can contest the action of de-empanelment by ISA with SEC. If hospital is aggrieved with actions of SEC, the former can approach the SHA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.

iii) The SEC may also initiate disciplinary proceedings based on field audit reports/survey reports/feedback reports/ complaints filed with them/ complaints.

iv) For disciplinary proceedings, the DEC may consider submissions made by the beneficiaries (through call centre/ mera hospital or any other application/ written submissions/Emails etc.) or directions from SEC or information from other sources to investigate a claim of fraud by a hospital.

v) On taking up such a case for fraud, after following the procedure defined, the DEC will forward its report to the SEC along with its recommendation for action to be taken based on the investigation.

vi) The SEC will consider all such reports from the DECs and pass an order detailing the case and the penalty provisions levied on the hospital.

vii) Any disciplinary proceeding so initiated shall have to be completed within 30 days.

B. **Steps for Disciplinary Proceedings**

Step 1 - Putting the provider on "Watch-list"

Based on the claims, data analysis and/or the provider visits, if there is any doubt on the performance of a Provider, the SEC on the request of the ISA or the SHA or on its own findings or on the findings of the DEC, can put that hospital on the watch list. The data of such hospital shall be analysed very closely on a daily basis by the ISA for patterns, trends and anomalies and flagged events/patterns will be brought to the scrutiny of the DEC and the SEC as the case may be.

The SHA shall notify such service provider that it has been put on the watch-list and the reasons for the same.

Step 2 – Issuing show-cause notice to the hospital

Based on the activities of the hospital if the ISA/ SHA believes that there are clear grounds of hospital indulging in wrong practices, a showcause notice shall be issued to the hospital. Hospital will need to respond to the notice within 7 days of receiving it.

Step 3 - Suspension of the hospital

A Provider can be temporarily suspended in the following cases:

i) For the Providers which are on the "Watch-list" or have been issued showcause notice if the SEC observes continuous patterns or strong evidence of irregularity based on either claims data or field visit of the hospital or in case of unsatisfactory reply of the hospital to the showcause notice, the hospital may be suspended from providing services to beneficiaries under the scheme and a formal investigation shall be instituted.

ii) If a Provider is not in the "Watch-list", but the SEC observes at any stage that it has data/ evidence that suggests that the Provider is involved in any unethical Practice/ is not adhering to the major clauses of the contract / Involved in financial fraud related to patients, it may immediately suspend the Provider from providing services to policyholders/insured patients and a formal investigation shall be instituted.

A formal letter shall be send to the concerned hospital regarding its suspension with mentioning the time frame within which the formal investigation will be completed.

Step 4 - Detailed Investigation

The detailed investigation shall be undertaken for verification of issues raised in disciplinary proceedings and may include field visits to the providers (with qualified allopathic doctor as part of the team), examination of case papers, talking with the beneficiary/ policyholders/insured (if needed), examination of provider records etc. If the investigation reveals that the report/ complaint/ allegation against the provider is not substantiated, the ISA/SHA would immediately revoke the suspension (in case of suspension) on the direction of the SEC. A letter regarding revocation of suspension shall be sent to the provider within 24 hours of that decision.

Step 5 – Presentation of Evidence to the SEC

The detailed investigation report should be presented to the SEC and the detailed investigation should be carried out in stipulated time period of not more than 7 days**.** The SHA will present the findings of the detailed investigation.If the investigation reveals that the complaint/allegation against the provider is correct, then the following procedure shall be followed:

i) The hospital must be issued a "show-cause" notice seeking an explanation for the aberration.

ii) In case the proceedings are under the SEC, after receipt of the explanation and its examination, the charges may be dropped or modified or an action can be taken as per the guidelines depending on the severity of the malafide/error. In cases of de-empanelment, a second show cause shall be issued to the hospital to make a representation against the order and after considering the reply to the second showcause, the SEC can pass a final order on de-empanelment. If the hospital is aggrieved with actions of SEC, the former can approach the SHA to review its decision, following which it can request for redressal through the Grievance Redressal Mechanism as per guidelines.

iii) In case the preliminary proceedings are under the DEC, the DEC will have to forward the report to the SEC along with its findings and recommendations for a final decision. The SEC may ask for any additional material/investigation to be brought on record and to consider all the material at hand before issuing a final order for the same.

The entire process should be completed within 30 days from the date of suspension. The disciplinary proceedings shall also be undertaken through the online portal only.

Step 6 - Actions to be taken after De- empanelment

Once the hospital has been de-empanelled, following steps shall be taken:

i) A letter shall be sent to the hospital regarding this decision.

ii) A decision may be taken by the SEC to ask the SHA to lodge an FIR in case there is suspicion of criminal activity.

iii) This information shall be sent to all the other Insurance Companies as well as other regulatory bodies and the MoHFW/ NHA.

iv) The SHA will notify the same in the local media, informing all policyholders/insured about the de-empanelment ensuring that the beneficiaries are aware that the said hospital will not be providing services under AB-NHPM.

v) A de-empanelled hospital cannot re-apply for empanelment for at least 2 years after de-empanelment. However, if the order for de-empanelment mentions a longer period, such a period shall apply for such a hospital.

C. Gradation of Offences

On the basis of the investigation report/field audits, the following charges may be found to be reasonably proved and a gradation of penalties may be levied by the SEC. However, this tabulation is intended to be as guidelines rather than mandatory rules and the SEC may take a final call on the severity and quantum of punishment on a case to case basis.

Penalties for Offences by the Hospital			
Case Issue	**First Offence**	**Second Offence**	**Third Offence**
Illegal cash payments by beneficiary	Full Refund and compensation 3 times of illegal payment to the beneficiary	In addition to actions as mentioned for first offence, Rejection of claim for the case	De-empanelment/ black-listing

Billing for services not provided	Rejection of claim and penalty of 3 times the amount claimed for services not provided, to ISA /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for services not provided, to ISA /State Health Agency	De-empanelment
Up coding/ Unbundling/ Unnecessary Procedures	Rejection of claim and penalty of 8 times the excess amount claimed due to up coding /unbundling/Unnecessary Procedures, to ISA /State Health Agency. For unnecessary procedure:	Rejection of claim and penalty of 16 times the excess amount claimed due to up coding/unbundling/Unnecessary Procedures, to ISA /State Health Agency	De-empanelment
Wrongful beneficiary Identification	Rejection of claim and penalty of 3 times the amount claimed for wrongful beneficiary identification to ISA /State Health Agency	Rejection of claim and penalty of 8 times the amount claimed for wrongful beneficiary identification to ISA /State Health Agency	De-empanelment
Non-adherence to AB-NHPM quality and service standard	In case of minor gaps, warning period of 2 weeks for rectification, for major gaps, Suspension of services until rectification of gaps and validation by SEC/ DEC	Suspension until rectification of gaps and validation by SEC/ DEC	De-empanelment

All these penalties are recommendatory and the SEC may inflict larger or smaller penalties depending on the severity/regularity/scale/intentionality on a case to case basis with reasons mentioned clearly in a speaking order.

The penalties by the hospital will be paid to the SHA in all the cases.

Packages

The following diseases/specialities are covered under AB-NHPM:-

Speciality Code	Speciality Name
S1	General Surgery
S2	Otorhinolaryngology
S3	Opthalmology
S4	Obstetrics & Gynaecology
S5	Orthopaedics
S6	Polytrauma
S7	Urology
S8	Neurosurgery
S9	Interventional Neuroradiology
S10	Plastic & reconstructive
S11	Burns management
S12	Cardiology
S13	Cardio-thoracic & Vascular surgery
S14	Paediatric surgery
S15	Surgical Oncology
S16	Oral and Maxillofacial Surgery
M1	General Medicine
M2	Paediatric medical management
M3	Neo-natal
M4	Paediatric cancer
M5	Medical Oncology
M6	Radiation Oncology
M7	Emergency Room Packages (Care requiring less than 12 hrs stay)
M8	Mental Disorders Packages

The detailed package rates are uploaded on website www.hpsbys.in/packages

Beneficiary Identification System (BIS)

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

b. The benefits under the AB-NHPM Risk Cover shall only be available to an AB-NHPM Beneficiary through an EHCP after Aadhaar based identification as far as possible. In case Aadhaar is not available then other defined Government recognised ID will be used for this purpose. The beneficiaries will be identified at the point of contact through Beneficiary Identification System (BIS) software. Once successfully identified, the beneficiary will be provided with a print of AB-NHPM e-card which can be used as reference while availing benefits.

c. Beneficiary identification will include the following broad steps:

   i. The operator at the hospital/or any other identified contact point searches through the AB-NHPM list to determine if the person is covered.

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

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

   iv. The system determines a confidence score (threshold score defined by the system but not visible to operator/AyushmanMitra) for the link based on how close the name / location / family members between the AB-NHPM record and documents is provided.

   v. The operator sends the linked record for approval to the ISA. The patient will be advised to wait for approval from the ISA

   vi. The ISA will setup a Beneficiary approval team thatshall perform the verification of the data of identified beneficaiaries. Approvals shall be

provided within 30 minutes back to the hospital operator on 24X7 basis. The AB-NHPM details and the information from the ID is presented to the verifier. The ISA can either approve or recommend a case for rejection with reason.

vii. All cases recommended for rejection will be scrutinised by a SHA. The state team will either accept rejection or approve with reason.

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

- The beneficiary will also be provided with a booklet/ pamphlet with details about AB-NHPM and process for availing services.
- Presentation of this e-card will not be mandatory for availing services. However, the e-card may serve as a tool for reinforcement of entitlement to the beneficiary and faster registration process at the hospital when needed.

Claim Process and Transaction Management

After successful identification of beneficiary through BIS, the following process will be following for providing the treatmet under AB-NHPM at EHCP.

Package Selection

A. The treating doctor will provide the detail in the diagnosis sheet if the patient to be hospitalized.
B. 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.
C. Based on diagnosis sheet provided by doctor, operator should be able to block Surgical or Non-Surgical benefit package(s) using AB-NHPM IT system.
D. Both surgical and non-surgical packages cannot be blocked together, either of the type can only be blocked.
E. As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.
F. The operator can block more than one package for the beneficiary. A logic will be built in for multiple package selection, such that reduced payment is made in case of multiple packages being blocked in the same hospitalization event.
G. If a registered mobile number of beneficiary family is available, an SMS alert will be sent to the beneficiary notifying him of the packages blocked for him.
H. At the same time, a printable registration slip needs to be generated and handed over to the patient or patient's attendant.
I. If for any reason treatment is not availed for any package, the operator can unblock the package before discharge from hospital.

Balance Check, Treatment, Discharge and Claim Request

A. Based on selection of package(s), the operator will check from the Central AB-NHPM Server if sufficient balance is available with the beneficiary to avail services.
B. If balance amount under available covers is not enough for treatment, then remaining amount (treatment cost - available balance), will be paid by beneficiary (OOP expense will also be captured and stored)

C. The hospital will only know if there is sufficient balance to provide the selected treatment in a yes or no response. The exact amount will not be visible to the hospital.

D. SMS will be sent to the beneficiary registered mobile about the transaction and available balance.

E. List of diagnostic reports recommended for the blocked package will be made available and upload of all such reports will be mandatory before discharge of beneficiary.

F. Transaction System would have provision of implementation of Standard Treatment Guidelines for providing the treatment.

G. After the treatment, details will be saved and beneficiary will be discharged with a summary sheet.

H. Treatment cost will be deducted from available amount and will be updated on the Central AB-NHPM Server.

I. The operator fills the online discharge summary form and the patient will be discharged. In case of mortality, a flag will be raised against the deceased member declaring him as dead or inactive.

J. At the same time, a printable receipt needs to be generated and handed over to the patient or patient's attendant.

K. After discharge, beneficiary gets a confirmation and feedback call from the AB-NHPM call centre; response from beneficiary will be stored in the database

L. Data (Transaction details) should be updated to Central Server and accessible to Implementation Support Agencyfor Claim settlement. Claim will be presumed to be raised once the discharge information is available on the Central server and is accessible to the Implementation Support Agency and SHA

M. SMS will be sent to beneficiary registered mobile about the transaction and available balance

N. After every discharge, claims would be deemed to be raised to the Implementation Support Agency. An automated email alert will be sent to the ISA/SHA specifying patient name, AB-NHPM ID, registration number & date and discharge date. Details like Registration ID, AB-NHPM ID, date and amount of claim raised will be accessible to the ISA/SHA on AB-NHPM System. Also details like Registration-ID, AB-NHPM-ID, Date and amount of claim raised, date and amount of claim disbursement, reasons for different in claims raised and claims settled (if any),

reasons for rejection of claims (if any) will be retrieved from the Implementation Support Agencythrough APIs.

O. Once the claim is processed and the hospital gets the payment, the above-mentioned information along with payment transaction ID will be updated on central AB-NHPMsystem by the Implementation Support Agency for each claim separately.

P. Hospital Transaction Management Module would be able to generate a basic MIS report of beneficiary admitted, treated and claim settled and in process and any other report needed by Hospitals on a regular basis

Q. Upon discharge, beneficiary will receive a feedback call from the Call centre where he can share his feedback about his/her hospitalisation experience.

Pre-Authorization

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

b. ISA will not allow any EHCP, under any circumstances whatsoever, to undertake any such earmarked procedure without pre-authorisation unless under emergency. Process for emergency approval will be followed as per guidelines laid down under AB-NHPM

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

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

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

f. The ISA in all cases of pre-authorisation request related decisions shall communicate to the EHCP within 12 hours for all non-emergency cases and within 30 minute for emergencies. If there is no response from the ISA within 12 hours of an EHCP filing

the pre-authorisation request, the request of the EHCP shall be deemed to be automatically authorised.

g. The ISAwill not be liable to honour any claims from the EHCP for procedures, for which the EHCP does not have a pre-authorisation, if prescribed.

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

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

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

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

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

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

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

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

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

q. In case the balance sum available is less than the specified amount for the Package, the EHCP should follow its norms of deposit/running bills etc. However, the EHCP shall only charge the balance amount against the package from the AB-NHPM

beneficiary. The ISA upon receipt of the bills and documents would recommend release of the authorized amount.

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

Payment of Claims

a. The ISA shall be responsible for processing all claims and provide their recommendations regarding acception or rejection to SHA within 10 days of receiving all the required information/ documents so that SHA can make the payment to EHCP**within 15 daysafter receiving all the required information/ documents**.The ISA undertakes that it will exercise due diligence to service any claims under portability from any empanelled hospital under the scheme within India and will settle claims within 30 days of receiving them.

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

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

d. If a Claim is rejected because the Empanelled Health Care Provider making the Claim is not empanelled for providing the health care services in respect of which the Claim

is made, then the ISAwill while rejecting the Claim inform the Beneficiary of an alternate Empanelled Health Care Provider where the benefit can be availed in future.

e. The ISA shall be responsible for ensuring settlement of all claims **within 15 daysafter receiving all the required information/ documents**. The Claim Payment shall be made (based on the Package Rate or the Pre-Authorized Amount) within 15 days, if not rejected, including any investigation into the Claim received from the Empanelled Health Care Provider.

f. In case of all PHCs, CHCs, District Hospitals and other Public Empanelled Health Care Provider full claim payment will be made without deduction of tax. In case of private health care providers, full claim shall be paid without deduction of tax, if **the Empanelled Health Care Provider fails to submit a tax exemption certificate to the SHA, then the Claim Payment recommendation by ISA will be made after deducting tax at the applicable rate.**

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

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

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

   If the ISA fails to process the claim and send to SHA within 10 days of receipt of the complete claim so as to ensure Claim Payment within a Turn-around Time of 15 days then the ISA agrees to be liable to pay a penal interest to the Empanelled Health Care Provider at the rate of 1% of the Claim amount per weekafter 15 days of delay.

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

k. The ISA agrees toensureclaim processing of each Empanelled Health Care Provider against Claims received on a weekly basis and as far as possible through electronic

transfer by the SHA to such Empanelled Health Care Provider's designated bank account.

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

m. The ISA shall submit details of:

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

(ii) every Claim that is pending beyond 10 days to the State Health Agency, along with its reasons for delay in processing such Claim; and

(iii) details of interest paid to the Empanelled Health Care Providers for every Claim that was pending beyond 10 days to the State Health Agency.

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

o. The ISA will however recommend to the SHA on the action to be taken in relation to a Claim. However, the final decision on approval and rejection of Claims shall be made by the SHA.

Right of Appeal and Reopening of Claims

A. The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the ISA, if the Empaneled Health Care Provider feels that the Claim is payable. An appeal may be made within thirty (30) days of the said rejection being intimated to the hospital to the District-level Grievance Committee (DGC).

B. The ISA and/or the DGC can re-open the Claim, if the Empaneled Health Care Provider submits the proper and relevant Claim documents that are required by the ISA.

C. The DGC may suomoto review any claim and direct either or both the ISA and the health care provider to produce any records or make any deposition as it deems fit.

D. The ISA or the health care provider may refer an appeal with the State-level Grievance Committee (SGC) on the decision of the DGC within thirty days (30) failing which the decision shall be final and binding. The decision of the SGC on such appeal is final and binding.

E. The decisions of the DGC and SGC shall be a speaking order stating the reasons for the decision

Grievance Redressal

A robust and strong grievance redressal mechanism has been designed for AB-NHPM. The District authorities shall act as a frontline for the redressal of Beneficiaries' / Providers / other Staekholder's grievances. The District authorities shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Beneficiaries / Providers or any other aggrieved party shall be provided with the number assigned to the grievance. The District authorities shall provide the Beneficiaries / Provider or any other aggrieved party with details of the follow-up action taken as regards the grievance as per the process laid down. The District authorities shall also record the information in pre-agreed format of any complaint / grievance received by oral, written or any other form of communication.

Under the Grievance Redressal Mechanism of AB-NHPM, set of three tier Grievance Redressal Committees have been set up to attend to the grievances of various stakeholders at different levels.

District Grievance Redressal Committee (DGRC)

The District Grievance Redressal Committee (DGRC) has been constituted by the State Health Agency (SHA) in each district as per detail given below:-

- The District Magistrate or an officer of the rank of Addl. District Magistrate, who shall be the Chairperson of the DGRC.
- The CMO shall be the Convenor of the DGRC.
- The Project Officer, District Rural Development Authority.
- The District Coordinator of the ISA.
- The District Grievance Nodal Officer (DGNO) of the ISA
- The DGRC may invite other experts for their inputs for specific cases.

Note: DGNO shall try to resolve the complaint by forwarding the same to Action Taking Authority (ATA). If the complaint is not resolved or comments are not received over the same within 15 days of the complaint, then the matter may be referred to DGRC.

State Grievance Redressal Committee (SGRC)

The State Grievance Redressal Committee (SGRC) has been constituted by the State Health Agency as per detail given below:-

- CEO of State Health Agency / State Nodal Agency shall be the Chairperson of the SGRC.

- Director Health Services.
- State Nodal Officer, SHA
- Consultant, SHA
- The State Cooridnator of ISA
- The SGRC may invite other experts for their inputs on specific cases.

Note: In case of any grievance between SHA and ISA, SGRC will be chaired by the Secretary of Department of Health & Family Welfare of the State. If any party is not agreed with the decision of DGRC, then they may approach the SGRC against the decision of DGRC.

National Grievance Redressal Committee (NGRC)

The NGRC shall be formed by the MoHFW, GoI at the National level. The constitution of the NGRC shall be determined by the MoHFW in accordance with the Scheme Guidelines from time to time. Proposed members for NGRC are:

1. CEO of National Health Agency (NHA) - **Chairperson**
2. JS , Ministry of Health & Family Welfare- Member
3. Additional CEO of National Health Agency (NHA)- Member Convenor
4. Executive Director, IEC, Capacity Building and Grievance Redressal
5. NGRC can also invite other experts/ officers for their inputs in specific cases.

CEO (NHA) may designate Addl. CEO (NHA) to chair the NGRC**.**

Investigation authority for investigation of the grievance may be assigned to Regional Director- CGHS/Director Health Services/ Mission director NHM of the State/UT concerned.

NGRC will consider:

a. Appeal by the stakeholders against the decisions of the State Grievance Redressal Committees (SGRCs)
b. Also, the petition of any stakeholder aggrieved with the action or the decision of the State Health Agency / State Government
c. Review of State-wise performance based monthly report for monitoring, evaluation and make suggestions for improvement in the Scheme as well as evaluation methodology
d. Any other reference on which report of NGRC is specifically sought by the Competent Authority.

The Meetings of the NGRC will be convened as per the cases received with it for consideration or as per the convenience of the Chairman, NGRC.

Grievance Settlement of Stakeholders

If any stakeholder has a grievance against another one during the subsistence of the policy period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of any provision of the scheme, it will be settled in the following way by the Grievance Committee:

A. Grievance of a Beneficiary

i) **Grievance against ISA, hospital, their representatives or any functionary**

If a beneficiary has a grievance on issues relating to entitlement, or any other AB-NHPM related issue against ISA, hospital, their representatives or any functionary, the beneficiary can call the toll free call centre number 14555 (or any other defined number by the State) and register the complaint. Beneficiary can also approach DGRC. The complaint of the beneficiary will be forwarded to the relevant person by the call centre as per defined matrix. The DGRC shall take a decision within 30 days of receiving the complaint.

If either of the parties is not satisfied with the decision, they can appeal to the SGRC within 30 days of the decision of the DGRC. The SGRC shall take a decision on the appeal within 30 days of receiving the appeal. The decision of the SGRC on such issues will be final.

Note: In case of any grievance from beneficiary related to hospitalisation of beneficiary (service related issue of the beneficiary) the timelines for DGRC to take decision is within 24 hours from the receiving of the grievance.

ii) **Grievance against district authorities**

If the beneficiary has a grievance against the District Authorities or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall take a decision on the matter within 30 days of the receipt of the grievance. The decision of SGRC shall be final.

B. Grievance of a Health Care Provider

i) Grievance against beneficiary, ISA, their representatives or any other functionary

If a Health Care Provider has any grievance with respect to beneficiary, ISA, their representatives or any other functionary, the Health Care Provider will approach the DGRC. The DGRC should be able to reach a decision within 30 days of receiving the complaint.

Step I- If either of the parties is not satisfied with the decision, they can go to the SGRC within 30 days of the decision of the DGRC, which shall take a decision within 30 days of receipt of appeal.

Step II- If either of the parties is not satisfied with the decision, they can go to the NGRC within 30 days of the decision of the SGRC, which shall take a decision within 30 days of receipt of appeal. The decision of NGRC shall be final.

C. Grievance of ISA

i) Grievance against district authorities/ health care provider

If ISA has a grievance against District Authority / Health Care Provider or an agency of the State Government, it can approach the SGRC for resolution. The SGRC shall decide the matter within 30 days of the receipt of the grievance.

In case of dissatisfaction with the decision of the SGRC, the affected party can file an appeal before NGRC within 30 days of the decision of the SGRC and NGRC shall take a decision within 30 days of the receipt of appeal after seeking a report from the other party. The decision of NGRC shall be final.

Functions of Grievance Redressal Committees

A. Functions of the DGRC:

The DGRC shall perform all functions related to handling and resolution of grievances within their respective Districts. The specific functions will include:

i) Review grievance records.

ii) Call for additional information as required either directly from the Complainant or from the concerned agencies which could be the ISA or an EHCP or the SHA or any other agency/ individual directly or indirectly associated with the Scheme.

iii) Conduct grievance redressal proceedings as required.

iv) If required, call for hearings and representations from the parties concerned while determining the merits and demerits of a case.

v) Adjudicate and issue final orders on grievances.

vi) In case of grievances that need urgent redressal, develop internal mechanisms for redressing the grievances within the shortest possible time, which could include but not be limited to convening special meetings of the Committee.

vii) Monitor the grievance database to ensure that all grievances are resolved within 30 days.

B. Functions of the SGRC:

The SGRC shall perform all functions related to handling and resolution of all grievances received either directly or escalated through the DGRC. The specific functions will include:

i) Oversee grievance redressal functions of the DGRC including but not limited to monitoring the turnaround time for grievance redressal.

ii) Act as an Appellate Authority for appealing against the orders of the DGRC.

iii) Perform all tasks necessary to decide on all such appeals within 30 days of receiving such appeal.

iv) Adjudicate and issue final orders on grievances.

v) Nominate District Grievance Officer (DGO) at each District.

vi) Direct the concerned ISA to appoint District Nodal Officer of each district.

C. Functions of the NGRC:

The NGRC shall act as the final Appellate Authority at the National level.

i) The NGRC shall only accept appeals against the orders of the SGRC of a State.

ii) The decision of NGRC will be final.

Lodging of Grievances/ Complaints

A. If any stakeholder has a complaint (complainant) against any other stakeholder during the subsistence of the Policy Cover Period or thereafter, in connection with the validity, interpretation, implementation or alleged breach of the Contract between the ISA and the SHA or a Policy or of the terms of their agreement (for example, the Services Agreement between the ISA and an Empanelled Health Care Provider), then such complainant may lodge a complaint by online grievance redressal portal or letter or e-mail.

B. For this purpose, a stakeholder includes: any AB-NHPM Beneficiary; an empanelled

health care provider (EHCP); a De-empanelled Health Care Provider; the ISA or its employees; the SHA or its employees or nominated functionaries for implementation of the Scheme (DNOs, State Nodal Officer, etc.); and any other person having an interest or participating in the implementation of the Scheme or entitled to benefits under the AB-NHPM Cover.

C. A complainant may lodge a complaint in the following manner:
    i) directly with the DGNO of the district where such stakeholder is located or where such complaint has arisen and if the stakeholder is located outside the Service Area, then with any DGNO located in the Service Area; or
    ii) with the SHA: If a complaint has been lodged with the SHA, they shall forward such complaint to the concerned DGNO.

D. Upon a complaint being received by the DGNO, the DGNO shall decide whether the substance of the complaint is a matter that can be addressed by the stakeholder against whom the complaint is lodged or whether such matter requires to be dealt with under the grievance redressal mechanism.

E. If the DGNO decides that the complaint must be dealt with under the grievance redressal mechanism, the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee.

F. If the DGNO decides that the complaint need not be dealt with under the grievance redressal mechanism, then the procedures set out in various process/guidelines shall apply.

Redressal of Complaints

A. The DGNO shall enter the particulars of the complaint on the Web-based Central Complaints and Grievance Management System (CCGMS) established by the MoHFW.

B. The CCGMS will automatically: (i) generate a Unique Complaint Number (UCN); (ii) categorize the nature of the complaint; and (iii) an e-mail or letter to be sent to the appropriate stakeholder to which such category of complaint is to be referred (including updating on phone).

C. Once the UCN is generated, the DGNO shall send or cause to be sent an acknowledgement email/phone call to the complainant and provide the complainant with the UCN. Upon receipt of the UCN, the complainant will have the ability to

track the progress of complaint resolution online through CCGMS and use the same at the time of calling the helpline for allowing easy retrieval of the specific complaint data.

D. The stakeholder against whom a complaint has been lodged must send its comments/ response to the complainant and copy to the DGNO within 15 days. If the complaint is not addressed within such 15-day period, the DGNO shall send a reminder to such stakeholder for redressal within a time period specified by the DGNO.

E. If the DGNO is satisfied that the comments/ response received from the stakeholder will addresses the complaint, then the DGNO shall communicate this to the complainant by e-mail and update the CCGMS.

F. If the DGNO is not satisfied with the comments/ response received or if no comments/ response are received from the stakeholder despite a reminder, then the DGNO shall refer such complaint to the Convener of the relevant Grievance Redressal Committee depending on the nature of the complaint after which the procedures set out shall apply.

Grievance Redressal Mechanism

Upon escalation of a complaint for grievance redressal the following procedures shall apply:

A. The DGNO/SGRC shall update the CCGMS to change the status of the complaint to a grievance, after which the CCGMS shall categorize the grievance and automatically refer it to the Convenor of the relevant Grievance Redressal Committee by way of e-mail.

B. The Convenor of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at its next meeting.

C. Each grievance shall be addressed by the relevant Grievance Redressal Committee within a period of 30 days of receipt of the grievance. For this purpose, each Grievance Redressal Committee shall be convened at least once every 30 days to ensure that all grievances are addressed within this time frame. Depending on the urgency of the case, the Grievance Redressal Committee may decide to meet earlier for a speedier resolution of the grievance.

D. The relevant Grievance Redressal Committee shall arrive at a reasoned decision

within 30 days of receipt of the grievance. The decision of the relevant Grievance Redressal Committee shall be taken by majority vote of its members present. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard.

E. If any party to a grievance is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the relevant Grievance Redressal Committee or other authority having powers of appeal.

F. If an appeal is not filed within such 30-day period, the decision of the original Grievance Redressal Committee shall be final and binding.

G. A Grievance Redressal Committee or other authority having powers of appeal shall dispose of an appeal within 30 days of receipt of the appeal. The decision of the Grievance Redressal Committee or other authority with powers of appeal shall be taken by majority vote of its members. Such decision shall be given after following the principles of natural justice, including giving the parties a reasonable opportunity to be heard. The decision of the Grievance Redressal Committee or other authority having powers of appeal shall be final and binding.

Proceedings Initiated by the State Health Agency, State Grievance Redressal Committee, the National Health Agency

The SHA, SGRC and/ or the National Health Agency (NHA) shall have the standing to initiate *suomoto* proceedings and to file a complaint on behalf of itself and AB-NHPM Beneficiaries under the Scheme.

A. Compliance with the Orders of the Grievance Redressal Committees

i) The ISA shall ensure that all orders of the Grievance Redressal Committees by which it is bound are complied with within 30 days of the issuance of the order, unless such order has been stayed on appeal.

ii) If the ISA fails to comply with the order of any Grievance Redressal Committee within such 30-day period, the ISA shall be liable to pay a penalty of Rs. 25,000 per month for the first month of such non-compliance and Rs. 50,000 per month thereafter until the order of such Grievance Redressal Committee is complied with. The ISA shall be liable to pay such penalty to the SHA within 15 days of receiving a written notice.

iii) On failure to pay such penalty, the ISA shall incur an additional interest at the

rate of one percent of the total outstanding penalty amount for every 15 days for which such penalty amount remains unpaid.

B. Complaints/ Suggestions received through Social Media/Call centre

As Social Media channels will be handled by NHA, hence, the complaints/ suggestions raised through Social Media channels like, Facebook, twitter handles, etc. will be routed to the respective SGNO by NGNO (National Grievance Nodal Officer). SGNO needs to register the same on the Grievance portal and publish a monthly report on the action taken to the NGNO.

Complaint may also be lodged through Call center by beneficiary. Call center need to register the details like complaint details in the defined format and forward the same to State Grievance Nodal Officer of the State concerned. SGNO needs to upload the details of the complaint on the grievance portal and allocate the same to the concerned District. The Complaint / grievance will be redressed as per guidelines.

Note: Matrix for grievance referral under the Scheme is presented in the table below:

Aggrieved Party	**Indicative Nature of Grievance**	**Grievance Against**	**Referred To**
AB-NHPM Beneficiary	• Denied treatment • Money sought for treatment, despite Sum Insured under AB-NHPM Cover being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB-NHPM Cover is insufficient or exhausted • AB-NHPM Card retained by Empanelled Health Care Provider • Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO
Empanelled	• Claims rejected by ISA or full Claim	ISA/ SHA	DGNO

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
Health Care Provider	amount not paid • Suspension or de-empanelment of Empanelled Health Care Provider • Hospital IT Infrastructure not functioning ISA not assisting in solving issue or not accepting manual transaction		
ISA	• No space provided for District Office	DNO	SGNO
	• AB-NHPM Beneficiary Database not updated for renewal Policy Cover Period • Premium not received within time prescribed.	SHA	SGRC
Inter State/UT (Portability issues)			
AB-NHPM Beneficiary	• Denied treatment • Money sought for treatment, despite Sum Insured under AB-NHPM Cover being available • Demanding more than Package Rate/ Pre-Authorized Amount, if Sum Insured under AB-NHPM Cover is insufficient or exhausted • Medicines not provided against OPD Benefits or follow-up care	Hospital	DGNO of the State/UT where Beneficiary is applying/availing benefits of AB-NHPM (other than parent State/UT)
Empanelled Health Care Provider	• Claims rejected by ISA or full Claim amount not paid	ISA/ SHA	SGRC of both parent State/UT and State/UT where the claim is raised

Aggrieved Party	Indicative Nature of Grievance	Grievance Against	Referred To
			State/UT

Monitoring and Fraud Management

Scope of Monitoring

a. Monitoring under AB-NHPM includes supervision and monitoring of all the activities under the AB-NHPM undertaken by the ISA and ensuring that the ISA complies with all the provisions of the Implementation Support Contract signed with the State Health Agency (SHA) for implementation of the Scheme.

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

Monitoring Activities by ISA

Medical Audit

Scope

a. The scope of medical audit under the Scheme shall focus on ensuring comprehensiveness of medical records and shall include but not be limited to:
   (i) Completeness of the medical records file.
   (ii) Evidence of patient history and current illness.
   (iii)Operation report (if surgery is done).
   (iv)Patient progress notes from admission to discharge.
   (v) Pathology and radiology reports.

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

Methodology

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

d. The indicative process of conducting medical audits is set out below and based on this the ISA will submit its detailed audit methodology to the SHA for approval:
   (i) The auditor shall check the data before meeting the EHCP authorities.

(ii) The audit should preferably be conducted in the presence of the EHCP's physician/ treating doctor.

e. The medical audit will include a review of medical records in the format specified in **Annexure-A**.

Personnel

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

Frequency and Sample

The number of medical audits to be conducted by the ISA will be a five percent of the total cases hospitalized in each of the EHCP in the current quarter and each EHCP shall be audited at least once in two months.

Hospital Audit

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

Monitoring Activities to be undertaken by the State Health Agency

Audits by the State Health Agency

a. Audit of the audits undertaken by the ISA: The SHA shall have the right to undertake sampled audits of all audits (Medical Audit and Hospital Audit) undertaken by the ISA.
b. Direct audits: In addition to the audit of the audits undertaken by the ISA, the SHA will undertake direct audits on a regular basis conducted either directly by it or through its authorized representatives/ agencies including appointed third parties. Direct audits shall include:

(i) Claims audit: For the purpose of claims audit, the SHA will constitute a **Claims Review Committee** (CRC) that shall look into

- 100 percent of the claims rejected or recommended for partial settlement by the ISA to assure itself of the legitimacy of the ISA's decisions.
- 2% for Category B States and 5% for Category A States of the accepted claims audit to assure itself of the legitimacy of ISA's decisions
- 100% of the claims settlement decisions of the ISA that are disputed by the concerned EHCP shall be examined in depth by the CRC after such grievance of the EHCP is forwarded by the concerned Grievance Redressal Committee (GRC) to the CRC.

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

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

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

(ii) Beneficiary identification audit: SHA will undertake direct audits to review beneficiay identification decisions/recommendations made by the ISA:

- 100 percent of the beneficiaries rejected by the ISA to assure itself of the legitimacy of the ISA's recommendations.
- 10% of the accepted beneficiary identification to assure itself of the legitimacy of ISA's decisions
- 100% of the beneficiary identification decisions of the ISA that are disputed by the concerned beneficiary shall be examined in depth by the SHA after such grievance of the beneficiary is forwarded by the concerned Grievance Redressal Committee (GRC) to the SHA.

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

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

- Evidence of rigorous review of identification requests.
- Comprehensiveness of beneficiary identification submissions (documentation) by the EHCPs/CSCs or any other contact point.
- Number of type of queries raised by the ISA during review of beneficiary identification – appropriateness of queries.
- Accuracy of beneficiary identification decisions/ recommendations.

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

Spot Checks by the State Health Agency

a. The SHA shall have the right to undertake spot checks of district offices of the ISA and the premises of the EHCP without any prior intimation.
b. The spot checks shall be random and will be at the sole discretion of the SHA.

Performance Review and Monitoring Meetings

a. The SHA shall organize fortnightly meetings for the first three months and monthly review meetings thereafter with the ISA. The SHA shall have the right to call for additional review meetings as required to ensure smooth functioning of the Scheme.
b. Whereas the SHA shall issue the Agenda for the review meeting prior to the meeting while communicating the date of the review meeting, as a general rule the Agenda shall have the following items:
   (i) Review of action taken from the previous review meeting.
   (ii) Review of performance and progress in the last quarter: utilization pattern, claims pattern, etc. This will be done based on the review of reports submitted by the ISA in the quarter under review.

(iii) KPI Results review – with discussions on variance from prescribed threshold limits, if any.

(iv) Contracts management issue(s), if any.

(v) Risk review, fraud alerts, action taken of fraud alerts.

(vi) Inter ISA claim settlement

(vii) Any other item.

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

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

Fraud Management

a. The Scheme shall use an integrated centralized IT platform for detecting outlier behaviour and predictive modelling to identify fraud.

b. The MIS software will be designed to generate automatic reports and present trends including outlier behaviours against the list of trigger alerts.

c. For an indicative (not exhaustive) list of fraud triggers that may be automatically and on a real-time basis be tracked please refer to **Annexure-C**. The ISA shall track the indicative (not exhaustive) triggers and it can add more triggers to the list.

d. Seamless integration of the centralised AB-NHPM IT platform with State level servers shall ensure real time alerts to the SHAs for immediate intimation to the ISA and for detailed investigations.

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

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

g. The SHA shall, on an ongoing basis measure the effectiveness of anti-fraud measures in the Scheme through a set of indicators as per**Annexure-D**.

h. In the event of a fraudulent Claim being made or a false statement or declaration being made or used in support of a fraudulent Claim or any fraudulent means or

device being used by any Empanelled Health Care Provider or other intermediary hired by the ISA or any of the Beneficiaries to obtain any benefits under this Implementation Support Contract (each a Fraudulent Activity), then the ISA's sole remedies as per the approval of SHA shall be to:

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

(ii) recommend to SHA de-empanelment of the Empanelled Health Care Provider, that has made a fraudulent Claim or undertaken or participated in a Fraudulent Activity, with the procedure specified by the SHA;

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

provided that the ISA has: issued a notice to the State Health Agency of its proposed exercise of any of these remedies; and such notice is accompanied by reasonable documentary evidence of such fraudulent activity.

The State Health Agency shall have the right to conduct a random audit of any or all cases in which the ISA has exercised such remedies against an Empanelled Health Care Provider and/or any Beneficiary.

Annexure-A: Template for Medical Audit

AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION ID		Hospital ID	
Patient Name		Hospital Name	
Case No.		Hospital Contact No.	
Date of Admission		Date of Discharge	
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	**Does each medical record file contain:**			
a.	Is discharge summary included?			
b.	Are significant findings recorded?			
c.	Are details of procedures performed recorded?			
d.	Is treatment given mentioned?			
e.	Is patient's condition on discharge mentioned?			
f.	Is final diagnosis recorded with main and other conditions?			
g.	Are instructions for follow up provided?			
2.	**Patient history and evidence of physical examination is evident.**			
a.	Is the chief complaint recorded?			
b.	Are details of present illness mentioned?			
c.	Are relevant medical history of family members present?			
d.	Body system review?			
e.	Is a report on physical examination available?			

f.	Are details of provisional diagnosis mentioned?			
3.	**Is an operation report available? (only if surgical procedure done)**			
a.	Does the report include pre-operative diagnosis?			
b.	Does the report include post-operative diagnosis?			
c.	Are the findings of the diagnosis specified?			
d.	Is the surgeon's signature available on records?			
e.	Is the date of procedure mentioned?			
4.	**Progress notes from admission to discharge**			
a.	Are progress reports recorded daily?			
b.	Are progress reports signed and dated?			
c.	Are progress reports reflective of patient's admission status?			
d.	Are reports of patient's progress filed chronologically?			
e.	Is a final discharge note available?			
5	Are pathology, laboratory, radiology reports available (if ordered)?			
6	Do all entries in medical records contain signatures?			
a.	Are all entries dated?			
b.	Are times of treatment noted?			
c.	Are signed consents for treatment available?			
7	Is patient identification recorded on all pages?			
8	Are all nursing notes signed and dated?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

_____

Signature of the Auditor

Date:

Annexure-B: Template for Hospital Audit

Hospital Name		Hospital ID	
Hospital Address			
Hospital Contact No.			
Date of Audit		Time of Audit	
Name of the Auditor		Contact No. (Auditor)	

Audit Observations

No.	Criteria	Yes	No	Comments
1.	Was there power cut during the audit?			
2.	If yes, what was the time taken for the power back to resume electric supply?			
3.	Was aAYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION kiosk present in the reception area?			
4.	Was any staff present at the kiosk?			
5.	Did you see the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Empanelled Hospital Board displayed near the kiosk in the reception area?			
6.	Was the kiosk prominently visible?			
7.	Was the kiosk operational in local language?			
8.	Were AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION brochures available at the kiosk?			
9.	Were the toilets in the OPD area clean?			
10.	Was drinking water available in the OPD area for patients?			

Overall observations of the Auditor:

Significant findings:

Recommendations:

_____

Signature of the Auditor

Date:

Annexure-C: Indicative Fraud Triggers

Claim History Triggers

1. Impersonation.
2. Mismatch of in house document with submitted documents.
3. Claims without signature of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary on pre-authorisation form.
4. Second claim in the same year for an acute medical illness/surgical.
5. Claims from multiple hospitals with same owner.
6. Claims from a hospital located far away from AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary's residence, pharmacy bills away from hospital/residence.
7. Claims for hospitalization at a hospital already identified on a "watch" list or black listed hospital.
8. Claims from members with no claim free years, i.e. regular claim history.
9. Same AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary claimed in multiple places at the same time.
10. Excessive utilization by a specific member belonging to the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit.
11. Deliberate blocking of higher-priced Package Rates to claim higher amounts.
12. Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
13. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
14. Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit and different hospitals for other members of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit), multiple claims towards the end of Policy Cover Period, close proximity of claims.

Admissions Specific Triggers

15. Members of the same AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit getting admitted and discharged together.
16. High number of admissions.
17. Repeated admissions.
18. Repeated admissions of members of the AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Unit.
19. High number of admission in odd hours.
20. High number of admission in weekends/ holidays.
21. Admission beyond capacity of hospital.
22. Average admission is beyond bed capacity of the EHCP in a month.
23. Excessive ICU admission.
24. High number of admission at the end of the Policy Cover Period.
25. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
26. Claims with Length of Stay (LoS) which is in significant variance with the average LoS for a particular ailment.

Diagnosis Specific Triggers

27. Diagnosis and treatment contradict each other.
28. Diagnostic and treatment in different geographic locations.
29. Claims for acute medical Illness which are uncommon e.g. encephalitis, cerebral malaria, monkey bite, snake bite etc.
30. Ailment and gender mismatch.
31. Ailment and age mismatch.
32. Multiple procedures for same AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary – blocking of multiple packages even though not required.
33. One-time procedure reported many times.
34. Treatment of diseases, illnesses or accidents for which an Empanelled Health Care Provider is not equipped or empanelled for.
35. Substitution of packages, for example, Hernia as Appendicitis, Conservative treatment as Surgical.
36. Part of the expenses collected from AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary for medicines and screening in addition to amounts received by the ISA.
37. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of Critical Illness.
38. Overall medical management exceeds more than 5 days, other than in the case of Critical Illness.
39. High number of cases treated on an OOP basis at a given provider, post consumption of financial limit.

Billing and Tariff based Triggers

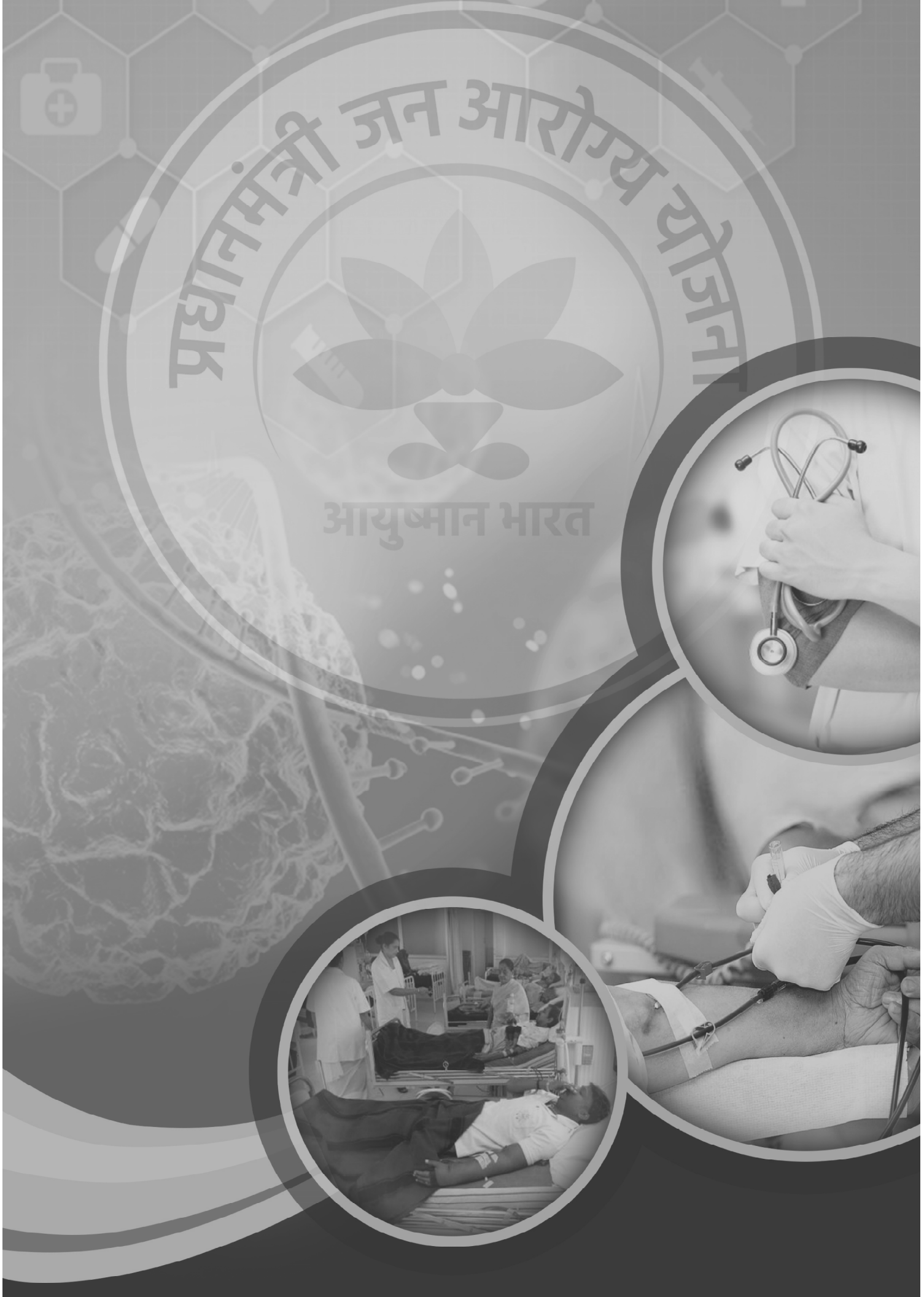
40. Claims without supporting pre/ post hospitalisation papers/ bills.
41. Multiple specialty consultations in a single bill.
42. Claims where the cost of treatment is much higher than expected for underlying etiology.
43. High value claim from a small hospital/nursing home, particularly in class B or C cities not consistent with ailment and/or provider profile.
44. Irregular or inordinately delayed synchronization of transactions to avoid concurrent investigations.
45. Claims submitted that cause suspicion due to format or content that looks "too perfect" in order. Pharmacy bills in chronological/running serial number or claim documents with colour photocopies. Perfect claim file with all criteria fulfilled with no deficiencies.
46. Claims with visible tempering of documents, overwriting in diagnosis/ treatment papers, discharge summary, bills etc. Same handwriting and flow in all documents from first prescription to admission to discharge. X-ray plates without date and side printed. Bills generated on a "Word" document or documents without proper signature, name and stamp.

General

47. Qualification of practitioner doesn't match treatment.
48. Specialty not available in hospital.
49. Delayed information of claim details to the ISA.
50. Conversion of OP to IP cases (compare with historical data).
51. Non-payment of transportation allowance.
52. Not dispensing post-hospitalization medication to AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiaries.

Annexure-D: Indicators to Measure Effectiveness of Anti-Fraud Measures

1. Monitoring the number of grievances per 1,00,000AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiaries.
2. Proportion of Emergency pre-authorisation requests.
3. Percent of conviction of detected fraud.
4. Share of pre-authorisation and claims audited.
5. Claim repudiation/ denial/ disallowance ratio.
6. Number of dis-empanelment/ number of investigations.
7. Share of AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary Family Units physically visited by Scheme functionaries.
8. Share of pre-authorisation rejected.
9. Reduction in utilization of high-end procedures.
10. AYUSHMAN BHARAT - NATIONAL HEALTH PROTECTION MISSION Beneficiary satisfaction.
11. Share of combined/ multiple-procedures investigated.
12. Share of combined/ multiple-procedures per 1,00,000 procedures.
13. Pre-authorisation pendency rate and Claim pendency rate per 100 cases decided OR percent of pre-authorisation decided after additional observation being attended + correlated with frauds detected as a consequence of this effort.
14. Instances of single disease dominating a geographical area/Service area are reduced.
15. Disease utilization rates correlate more with the community incidence.
16. Number of FIRs filed.
17. Number of enquiry reports against hospitals.
18. Number of enquiry reports against ISA or SHA staff.
19. Number of charge sheets filed.
20. Number of judgments received.
21. Number of cases discussed in Empanelment and Disciplinary Committee.
22. Reduction in number of enhancements requested per 100 claims.
23. Impact on utilization.
24. Percent of pre-audit done for pre-authorisation and claims.
25. Percent of post-audit done for pre-authorisation and claims.
26. Number of staff removed or replaced due to confirmed fraud.
27. Number of actions taken against hospitals in a given time period.
28. Number of adverse press reports in a given time period.
29. Frequency of hospital inspection in a given time period in a defined geographical area.
30. Reduction in share of red flag cases per 100 claims.


प्रधानमंत्री जन आरोग्य योजना
आयुष्मान भारत