



नियोगी महाराष्ट्र, प्रगतीशील राष्ट्र...


Rajiv Gandhi Jeevandayee Arogya Yojana

Adjudication Protocols Pre - Authorization Claims

These protocols are being decided as on today but will be subject to regular review based on experience and inputs from the stakeholders and appropriate corrective measures in the interest of beneficiary and objectives of the scheme will be taken from time to time by RGJAYS.

1. PRE AUTHORISATION:

- A. The process of Pre Authorization commences only after the REGISTRATION of the patient. SUM INSURED:


Dy CEO 11/11/13
RGJAY



The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary members up to **INR 1,50,000/- per family per year** in any of the Empanelled Hospital/Nursing Home/Day Care Unit

The benefit shall be available to each and every member of the **family on floater basis** i.e. the total amount of **Rs.1, 50,000/- (Rupees one & Half lakhs only)** can be availed either by one individual, or collectively by all members of the family. The First precut request in should be First Out. (FIFO)

* **Sum Insured includes the treatment of follow up packages.**

EXCEPTION: For Renal Transplant Sum Insured will be INR 2,50,000 per year.

Response: The break up for renal Transplant:

- **Renal Transplant Surgery: Rs. 1,40,000/.** (this will be allowed even if the beneficiary has utilized money earlier, but total should not cross 2.5 lakhs)
- **AV Fistula: Rs. 10000/.**
- **Immunosuppressive therapy: 1-6 month: Rs. 50000/., 7-12 month: Rs. 50000/.**

In case of differential packages linked to grade of the Network Hospital; the difference of amount for renal transplant and actual BSI (Rs. 1.5 Lakh) can be utilized for any other treatment. However for Immunosuppressive therapy therein, the amount will be utilized from rest of Rs. 1 lakh as mentioned in RFP.

In case of Renal Transplant, automatically sum insured goes up to Rs. 2.5 lakh.

B. HEALTH CARD:

Beneficiaries shall be identified by a "Health Card" issued by the society. This card would be used across all the Network Hospitals of District to access Health Insurance Benefits.

The photograph embedded in the Card will be taken as the proof for determining the eligibility of the beneficiaries.

If the name is on image of B1 verification form /ration card, but photo is not there even then s/he will still be accepted subject to production of valid photo identity.

If the beneficiary instead of health card presents yellow, orange, Antyodaya, Annapurna ration card with any photo id also, he will be accepted.

C. DELETION OF THE FAMILY MEMBER:

In case of death of the patient flag has to be updated against such member & no further claims will be allowed in the system

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CEO
RGJAY 1/1/13

Challenge: In case the death of patient is not during hospitalization and we have no information of same. Aarogymitra is expected to update this database

D. VERIFICATION OF PRE-AUTHORIZATION DETAILS:

During the Pre Authorization Process, the following details will be verified & processed accordingly:

- i. Beneficiary Details
- ii. Identity of beneficiary
- iii. Date of Admission
- iv. Diagnosis
- v. Estimated Duration of stay
- vi. Clinical Notes/Operative Notes/claim history
- vii. All relevant Investigation Reports
- viii. Package selected by hospital
- ix. Name & Qualification of Treating doctor

(In all cases of pt. on ventilator or ICU pt. (invasive or non-invasive) including ARDS, the arogya-mitra of respective hospital will take a photograph of on bed patient i.e. pt. with ventilator or pt. on ICU bed.)

E. PROCESS OF RAISING QUERIES TO HOSPITAL:

If any of above information is missing then query has to be raised to the hospital to enable further processing of the Pre Authorization

Arogyamitra has to follow up for compliance

The following proposal will be considered after the first quarter. : 1st Reminder SMS/Email within 4 hrs. of query to be raised has to be sent to Arogyamitra and MCO After 6 hrs. of reminder, 2nd reminder SMS/Email is generated by the system In case of non-compliance of query,

F. TREATING SPECIALIST:

If the name of treating specialist is not present in Database for the Specialty, however the **Specialty is offered to the hospital**, then the **specialist will be added to the database.**

Hospital in coordination with Aarogymitra to ensure compliance of required documents like MMC Registration Certificate of the Treating Doctor. Reminder SMS and Email alerts to MCO and Aarogymitra will be generated.

However, in case, the specialty has not been offered to the hospital, then the category will not be entertained for that Pre-Auth. Letter depicting Non availability of Treatment facility from the Software has to be generated for the beneficiary as per Annexure



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11/12/2013



Annexure - Non
Availability of Treatm

G. CLAIM HISTORY:

Past claim history with claim status has to be checked in each & every claim, to ensure relevance of treatment, if any.

H. SUM INSURED:

With each Pre Authorization approved by Society Doctor, the Sum Insured will be debited to calculate the Balanced Sum Insured.

All Pre Authorizations approved will be a part of the Amount blocked for utilization & hence Liability Amount.

Amount blocked will be as per the package offered to the hospital & non editable in the system.

I. NON UTILIZATION OF AUTHORIZATION LIMITS AMOUNT:

The validity of an Authorization is 30 days for private hospitals and 60 days for Public hospitals. (Validity relaxed to 90 Days for radiation oncology and Dialysis but not beyond the run off of policy period.)

Reminders in the system to be sent to MCO after 10th day and 25th days of non utilization for private and 45 and 55 days for Public hospitals.

In case, there is no evidence of utilization of the Authorized Amount (with follow up with Arogyamitra), & there is another Pre Auto request for the same family, then reminder SMS and Email alerts may be generated. In spite of this no response is obtained, then "the blocked amount will be released into the BSI. It may be cancelled automatically.

Observations: Auto cancellation will be done after 30/60 days; however the BSI will be credited to Sum Insured.

The network hospital can however put a preauth cancellation request if it is required within the preauthorization validity period (30 / 60 days).

J. PARTIAL PRE AUTH APPROVALS:

If BSI is less than package amount then such Preauth should be approved up to available BSI only.

K. MEDICAL SCRUTINY:

Medical scrutiny will be done on the basis of admission notes/Diagnosis & clinical evidence.

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By CEO
RGJAY
11/1/2013*

After proper scrutiny of the available details, specialist will **Approve/Reject the Pre Authorization** with proper reasoning.

The quantum for a Pre- Authorization will be the Package rate / BSI whichever is less & will not be editable. System driven rather than human discretion. TAT is important.

L. PROCESS OF EMERGENCY PRE AUTHORISATION APPROVALS:

- In case of emergencies medical / surgical approval has to be taken by MCO over telephone – Emergency Telephonic Intimation (ETI)
- Provisional approval is given by collecting minimal essential data :
 - a. **Diagnosis, relevant investigation reports, reason of emergency**
- **Call conferencing between the treating Doctor/MCO, Preauth executive** will be conducted.
- **An intimation number** will get created.
- Arogyamitra will follow up for the **relevant documents to ensure eligibility in the next 72 hours**. Reminder SMS and Email alerts may be generated.
- **Pre Authorization will be approved only if:**
 - a. Person is eligible beneficiary of RGJAY
 - b. Procedure is covered in RGJAY
- **In case the patient fails to provide identification within 72 hours in spite of SMS and Email alerts , the Authorization will stand cancelled and patient will have to bear the expenses of the treatment.**

M. VIDEO OF THE PROCEDURES:

Video of procedures required for:

- laparoscopy procedures
- Angiography
- **Not applicable in Govt. hospitals**
- **If not submitted by Private hospital,**
 - Query SMS and Email alerts has to be given to hospital for submission of the said video recording.
 - If compliance is not received within 30 days, the case has to be denied.

N. MLC CASES:

The RGJAYS may not take note of MLC or no MLC.

O. RENAL TRANSPLANT:

For Renal Transplant Sum Insured will be INR 2,50,000 per year.

Response: The break up for renal Transplant:

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*Dy CEO
RGJAY
11/1/2013*

P. PACKAGE TREATMENT:

The package covers the *entire cost of treatment & 10 days consultation/ medicines/ Investigations after discharge from the Hospital.*

Complete Package amount for that procedure for that hospital will auto carried at Preauth Level.

In instance of implant, the Network Hospital should put its barcode sticker.

Generally the stent is advocated for occlusion > 70 % of vessel and those below that would preferably be given medical trial unless and until some other comorbidity warrants use of stent.

In case of ARDS package, the mandatory on bed photo of patient on ventilator may be sought and its absence may impede the claim release.

Q. TRANSFER CASES: (alerts /warnings)_

In case Patient is transferred from primary treating Hospital to another Hospital for further management; in cases of complications... the process of adjudication in the various scenarios given below:

Post-surgery for management of complications :

Recommendation:

The referring hospital will be paid 75% of approved package

The referral hospital will be paid 100% if the complication is part of the procedures or due to procedure performed.

Patient is transferred before the surgical procedure is performed

Recommendation:

The referring hospital will be paid 0% of approved package

The referral hospital will be paid 100% if the complication is part of the procedures or due to procedure performed

In case of Medical cases:

Recommendation:

The referring hospital will be paid @ INR 1000/- per day for ICU @ INR 4000 if on ventilator & @ INR 500/- per day in General Ward; to a maximum of 3 days.

The referral hospital will be paid 100% if the complication is part of the procedures or due to procedure performed

R. CLAIM SETTLEMENT IN DEATH CASES

I. Process to be followed in surgical procedure cases :

- i. *In case of Death of the patient before surgery : The hospital will be approved for -0 % of the package + Rs. 3500*

Dy CEO
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11/12/2013

for carriage of dead body from NH to residence subject to proof of using Hearse/mode of carriage of deceased.

ii. Death on Table (DoT) or during postoperative stay: 100% of package to be approved.

II. Death during conservative treatment procedures: 100% of package to be approved.

U. DAMA before surgery : 0% of package

DAMA after surgery: 75% of package

DAMA for conservative: The referring hospital will be paid @ INR 1000/- per day for ICU @ INR 4000 if on ventilator & @ INR 500/- per day in General Ward;

V. DENIAL OF PRE-AUTH REQUESTS

Under following scenarios the approvals for Preauth requests will be denied:

Clinical findings not relevant to the package selected.

U. Failed case

In instance of failed surgical procedures 60 % of agreed package amount will be made available if with implant and 50 % if implant not used.

V. VALIDITY OF PRE-AUTHORIZATION APPROVAL:

The validity period of the Approval for Preauth will be 30 days

If patient is not admitted in the validity period the Approval letter will stand cancelled.

(Dialysis and radiation oncology cases may be excluded from validity period)

W. FOLLOW UP PROCEDURES:

Only Package amount shall be blocked for procedures which supports follow up treatment

FOLLOW UP HAS TO BE CONDUCTED BY THE PRIMARY TREATING HOSPITAL & CANNOT BE AVAILED IN ANY OTHER HOSPITAL

The amount for the first follow up will be blocked only when the patient avails the facility

If case any of the family member opts for the pre-authorization for any procedure & BSI gets exhausted, then the remaining follow up package will not be authorized.

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Dy CEO
RGJAY 1/1/2013

2. CLAIMS:

Claims

- i. Beneficiary Details
- ii. Identity of beneficiary
- iii. Date of Admission
- iv. Diagnosis
- v. Duration of stay
- vi. Clinical Notes
- vii. All relevant Investigation Reports
- viii. Package selected by hospital
- ix. Name & Qualification of Treating doctor

Scrutiny of the Mandatory documents:

Following are the mandatory document checklist & that has to be checked in each claim.

Document check List

- Mandatory Investigation reports as defined in the protocols
- Pre Auth Request
- Videos in case of Laparoscopic procedures.....NOT IN Govt hosp
- Daily clinical Notes
- Operative notes for surgical procedures
- Post procedure photograph
- Post-operative Prescriptions
- Discharge Notes, Discharge photo and transport allowance evidence
- Death Certificate in hospital death cases
- Patient satisfaction letter (Not reason for rejection)

INVESTIGATION REPORTS:

All the investigation reports have to be submitted at the time of claim submission by the Hospital. Deficiency of any documents, if any, shall be communicated to the Empanelled Hospital within 7 working days. A reminder for the same will again be forwarded to the Empanelled Hospital once every 3 days of first intimation of the deficient documents are not received or are partially received.

MLC CASES: Same as the Pre auth guidelines

BILL BREAKUP: NOT MANDATORY

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1/1/2013