Rajiv Gandhi Jeevandayee Arogya Yojana Society

Adjudication Protocols of Preauthorization and Claims

V 8.0 Dated 19th October 2012

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 Rajiv Gandhi Jeevandayee arogya yojana society.

1. **PRE AUTHORISATION:**

The process of Pre Authorization commences post the REGISTRATION of the patient. Only in cases, where the Registration of the patient has been done, will the Pre Authorization be processed

A. **SUM INSURED:**

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 preauth request inshould 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

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*

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 Authorizations

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 aarogyamitra to ensure compliance of required documents like MMC Registration Certificate of the Treating Doctor. Reminder SMS and Email alerts to MCO and Arogymitra 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

Annexure - Non Availability of Treatm

Exception may be oncology as the surgeon may remove the tumour if found as exploratorylaparotomy which may turn to be malignant after histopathology.

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 Auth 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 amt then such Pre Auth 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.**

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 and 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 Authorisation 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 / VIDEO COUNSELING 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:
Renal Transplant Surgery: Rs. 1,40,000/.
AV Fistula: Rs. 10000/.
Immunosuppressive therapy: 1-6 month: Rs. 50000/.,
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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 autocarried at Pre Auth Level.

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

Q. <u>TRANSFER CASES: (alerts /warnings)</u>

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:

<u>Recommendation</u>:

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

<u>Recommendation</u>:

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:

<u>Recommendation</u>:

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. <u>CLAIM SETTLEMENT IN DEATH CASES</u>

<u>Process to be followed in cases where:</u>

In case of Death of the patient before surgery : **The hospital will be approved for -0 % of the package + Rs. 3500 for carriage of dead body from NH to residence subject to proof of using Hearse/mode of carriage of deceased.**

Death on Table (DoT) or during postoperative stay : **75% of package to be approved + Rs.3500 for carriage of dead body from NH to residence subject to proof of using Hersh/mode of carriage of deceased..**

Death for conservative procedures: The referring hospital will be paid @ INR 1000/- per day for ICU @ INR 4000 if on ventilator & @ INR 500/- per day in General Ward X patient stay in days + cost of diagnostics to establish the falling in to 972 procedure +

lump sum Rs. 3500 for carriage of dead body **subject to proof of using Hearse/mode of carriage of deceased.**

S. DAMA before surgery : 0% **of package**

DAMA after surgery: 7**5% 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;

T. DENIAL OF PRE-AUTH REQUESTS

Under **following scenarios the approvals for Pre-Auth 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 procedure includes implant and 50 % without implant.

V. VALIDITY OF PRE-AUTHORIZATION APPROVAL:

The validity period of the Approval for Pre-Auth will be 3***0 days***

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

निरोगी महाराष्ट्र, प्रगतीशील राष्ट्र...

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.**

2. 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;the List& Quantum of the critical investigations has been decided. 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