सत्यमेव जयते

Government of Mizoram

MIZORAM UNIVERSAL HEALTHCARE SCHEME (MUHCS)

Claims Management & Adjudication Guidelines

Mizoram State Health Care Society

Department of Health & Family Welfare

2025

Contents

Abbreviations

BIS	Beneficiary Identification System
CEO	Chief Executive Officer
CPD	Claims Processing Doctor
DGNO	District Grievance Nodal Officer
EHCP	Empanelled Health Care Provider
ISA	Implementation Support Agency
LOS	Length of Stay
MSHCS	Mizoram State Health Care Society
MUHCS	Mizoram Universal HealthCare Scheme
NAFU	National Anti-Fraud Unit
OT	Operation Theatre
PPD	Pre-authorization Processing Doctor
SAFU	State Anti-Fraud Unit
SNA	State Nodal Agency
STG	Standard Treatment Guidelines
TAT	Turn Around Time
TMS	Transaction Management System
TPA	Third Party Administrator

1. Mizoram Universal HealthCare Scheme (MUHCS)

Mizoram State Health Care Scheme is a priority health protection scheme of Government of Mizoram since its launch in 2008 to provide health security to the beneficiaries of the State of Mizoram. Mizoram State Health Care Scheme has been revised to MUHCS which aims to reduce the financial burden on poor and vulnerable groups arising out of catastrophic hospital expenditure and ensure their access to quality health services and strives towards the vision of Universal Health Coverage (UHC).

1.1. Introduction

1.1.1 The vision of the Government of Mizoram is to increase the quality of life for its people by attaining the highest level of physical, mental, and spiritual health; and thus, will contribute towards the development of the state. Towards this vision it has fully accepted the principles and vision of globally acclaimed Universal Health Coverage.

1.1.2 Mizoram will cover all population under MUHCS by converging Mizoram State Health Care Scheme with AB PM-JAY and other vertical programs and expanding it to population that is not currently covered. It will also converge existing health scheme for State Government employees with special conditions as well as the Civil Pensioners. MUHCS will improve efficiency, cost-effectiveness, quality of health care services, and enhance engagement with private sectors.

1.1.3 MUHCS will initially cover all inpatient conditions with very few exceptions, with a defined benefit cover per family per year on family floater basis. For accessing care, there will be no waiting period for all covered beneficiaries. The benefits under MUHCS will be aligned with AB PM-JAY in terms of benefit cover, cover for pre-existing conditions and coverage for hospitalization expenses. This amount will be available to be used by the families covered under the scheme to get treatment every year and unutilised amount will not carry forward.

1.1.4 Unit of coverage will be as defined in IFMIS for Govt. Employees and Provisional Employees / Muster Roll while PDS database will define the family size for all other beneficiaries under MUHCS. For contributory beneficiaries, they will need to pay defined premium to be covered in the scheme.

1.1.5 Cashless Benefits will be provided to beneficiaries by empanelled health care providers. All public Hospitals (Primary Health Centre and above) in the State will be deemed empanelled for the Scheme. Private hospitals will be empanelled based on defined criteria. Hospitals will not charge money from patients at the time of treatment, unless otherwise specified by Government for certain conditions.

1.1.6 Portability of benefits of the scheme across the country will be ensured and a beneficiary covered under the scheme will be allowed to take cashless benefits from any empanelled hospitals across the country riding on AB PM-JAY platform.

1.1.7 Comprehensive IT Platform is be prepared which will be robust, modular, scalable, and inter-operable. It will also link with AB PM-JAY IT platform and will be ABDM compliant. Electronic Health Records of beneficiaries will be linked appropriately as the scheme progresses. The IT Platform will also get features over time for premium collection.

1.1.8 A well-defined Complaint and Public Grievance Redressal Mechanism, actively utilising electronic, mobile platform, internet as well as social media, will be in place through which complaints / grievances will be registered, acknowledged, escalated for relevant action, resolved, and monitored.

1.1.9 **Referral mechanism of patient:** Higher public facilities will be the first point of referral of inpatient from an empanelled public or private health facilities, subject to prior confirmation of bed availability and accompanied with a standardized referral note which will be made available to all hospitals**.** This will be applicable for both intra and inter district referrals within the state.

1.1.10 Criteria of empanelled health facility under MUHCS for claim submission, will be subject to availability of the Medical Officer (Allopathy / Homeopathy) within the facility.

1.1.11 Mizoram State Health Care Society (MSHCS) approval must be sought by empanelled hospitals for all cases requiring continuation of hospitalization for more than 30 days. The approval of MSHCS is to be sought by the Empanelled Hospital in written, addressing the Chief Executive Officer (CEO), MSHCS and can be sent via email to ***muhcs.prolongedstay@gmail.com*** for the 31st day of hospitalization onwards. MSHCS may provide approval to continue availing benefits under the scheme for up to a maximum of 5 days per application received. Prior permission must be sought from MSHCS within 48 hours before the expiry of the granted permission.

1.2. State Nodal Agency (SNA)

MSHCS headed by CEO is a State Nodal Agency responsible for implementation of Mizoram Universal HealthCare Scheme (MUHCS). Along with day-to-day operations of scheme implementation, MSHCS is also responsible for data sharing, verification of family members, IEC, monitoring of the scheme etc.

1.3. MUHCS Package Master and Rates

1.3.1. To ensure provision of appropriate payment to the hospitals for treatment of beneficiaries, public and private empanelled hospitals will utilise approved package rates.

1.3.2. Hospitals will be categorized and incentivised.

1.3.3. Package rates will comprise of the essential items, services as under:

i. Bed charges inclusive of water, electricity, files / stationery items

ii. Admission fee

iii. Hospital diet charges for the patient only.

iv. Doctor consultation / bedside visit charge

v. Nursing charge

vi. Investigation cost which are relevant to reason for admission / diagnosis or treatment but excluding high end diagnostics. High end diagnostics such as MRI, PET scan etc. may be booked additionally for selected packages / ailments and will be covered under the cashless scheme.

vii. Medicines and consumables. Consumables which are solely for the purpose of cure will be covered.

viii. Surgery- OT charge, Surgeon charge, Assistant surgeon charge, Anaesthetist charge

ix. Charges for oxygen, syringe pump, monitor, ventilator if required.

x. Therapeutic pleural and ascitic tapping

xi. Bedside Physiotherapy

Note: Inclusiveness of package rate is applicable within the hospitalization period.

2. Purpose of Claims Management and Adjudication Guidelines

The purpose of Claims Management and Adjudication Guidelines are:

i. To build capacities of adjudication team for accurate and timebound processing / settlement of claims under MUHCS.

ii. Enhance the skills for combining fundamental concepts, system capabilities and human intelligence during claims processing.

The necessity of accurate processing such as approval of admissible claims, payment of correct amount to EHCP, genuine utilization of beneficiary's wallet, etc., is important in multiple aspects.

This guideline will help Pre-authorization Processing Doctors (PPD), Claims Executives (CEX), and Claims Processing Doctors (CPD) for efficient and error-free processing of claims and to exercise due diligence at the time of processing the claim. Each defined process has a timeline associated with it.

3. Basics of Claims Adjudication

3.1. Claims adjudication refers to the decision on two key aspects of a claim: whether the claim is admissible under the terms of policy / Scheme and if yes, what is the quantum payable. It applies to the final decision on claims payment. The decision involves cross verification of all-important aspects: covered person, medical conditions like symptoms, diagnosis, treatment, policy exclusions, available sum insured, pre-agreed tariff / package rate, empanelled hospital etc.

3.2. Claim adjudication is done through integrated workflows between two key systems – Beneficiary Identification System (BIS) and Transaction Management System (TMS). The key tasks are performed under Transaction Management System (TMS), partially at the time of Pre-authorization by Pre-authorization Processing Doctor (PPD) and later at the time of claim scrutinization by Claim Processing Doctor (CPD) based on the documents provided by the hospital.

3.3. While approving Pre-authorization request or adjudicating claims at the settlement stage, the processing team must exercise utmost care and be mindful of the decision because any wrong approval / payment may lead to inconvenience to beneficiaries or recoveries from hospital at a later stage.

3.4. The system is designed to help the claims processing team in claim adjudication, however human intelligence needs to be applied while processing / approving both Pre-authorization and claims. Below mentioned points should be kept in mind while processing pre-authorization request or claim:

i. The patient should be an eligible beneficiary and verified through Beneficiary Identification System (BIS) of MUHCS.

ii. The treatment package claimed should be covered under the Scheme.

iii. The conditions should not fall under the exclusion (Annexure 1) criteria as defined under the policy.

iv. The processing team must ensure from the provided documents that unnecessary OP to IP conversion is not made by the EHCP.

v. The processing team should validate all the details / information (patient details, diagnosis details, supporting investigation documents, plan of treatment etc.) submitted at the time of Pre-authorization and highlight discrepancy, if any.

vi. The processing team should raise a query only in case of any missing information which is mandatory for pre-authorization approval or to process a claim or as per the Standard Treatment Guidelines adopted for MUHCS.

vii. The processing team should make an informed and mindful decision on the payment to be made to the EHCP.

viii. The claim approved amount should not be more than the amount approved during pre-authorization and wallet balance.

3.5. At the time of Claim Submission, EHCP must submit, but not limited to the following:

i. Discharge summary or death summary in case of death.

ii. Package specific mandatory documents as per STGs adopted for MUHCS.

3.6. All medical records or documents of the beneficiary must be preserved by EHCP for the purpose of audit, quality assurance etc.

4. Processes

4.1. Pre-Authorization Process

4.1.1. MUHCS Operator / MUHCS Coordinator

Beneficiary approaches MUHCS Operator / MUHCS Coordinator with a valid MUHCS ID for availing benefits under the scheme at EHCP. MUHCS Operator / MUHCS Coordinator would then initiate a pre-authorization request via TMS. For conservative management packages, MUHCS Operator / MUHCS Coordinator may initiate enhancement by providing details like admission unit, number of days and justification remarks in the pre-authorization tab.

4.1.2. Pre-Authorization Processing Doctor (PPD)

PPD would review the documents and take appropriate action as mentioned below:

4.1.2.1. Scrutiny at Pre-authorization stage

For Medical cases

i. Pre-authorization will be auto approved or as configured in MUHCS Package Master. Once approved, the pre-authorization will be valid for the first 24 hours.

ii. If the beneficiary requires further hospitalization, pre-authorization enhancement for up to 5 days may be requested by the hospital. Upon approval of the pre-authorization enhancement, the beneficiary will be able to continue availing benefits under the scheme.

iii. The granted permission will be valid for up to 5 days as requested and if continuation of hospitalization for that particular beneficiary is required, hospitals must continuously seek approval within 48 hours after the expiry of granted permission.

For Surgical cases

i. Pre-authorization will be allocated in PPD's bucket for action.

ii. Based on the documentary evidence as per the defined STGs, decision would be taken by PPD.

Note:

- Add-on packages can be requested by EHCP while raising a Pre-authorization for both medical and surgical specialties such as high-end diagnostics, high end medicines etc.
- For emergency cases, action on pre-authorization request should be taken as a priority and for non- emergency cases within 6 working hours as built in TMS.
- If no action is taken by PPD against the raised Pre-authorization within the defined TAT, then it will be forced approved after 6 working hours.
- In case of emergency procedures, the EHCP shall stabilize the beneficiary and then go ahead with Pre-authorization initiation.

4.1.2.2. Past claim history

It is mandatory for the PPD to check the past claim history of the beneficiary. This would help to identify any aberration.

4.1.2.3. Document Checklist

The MUHCS Coordinator would upload mandatory documents like beneficiary photo and clinical documents mentioned in Standard Treatment Guidelines adopted for MUHCS. Below mentioned points need to be considered while reviewing the documents:

i. It is important to ensure that the entitled and legitimate beneficiary receives the treatment.

ii. The PPD needs to validate beneficiary details (name, age, sex, etc.) mentioned in the Pre- authorization form and other uploaded documents against MUHCS ID stored in BIS. Aadhaar linked biometric authentication at the time of admission and discharge has been made mandatory. In case of lack of clarity / discrepancy or unavailability of required information, the PPD can raise a query to the EHCP asking for required information.

iii. The PPD must ensure that all mandatory documents are uploaded by the EHCP.

iv. The signs, symptoms & duration of illness, presenting complaints of the beneficiary mentioned in the case taking form are aligned with the primary diagnosis / provisional diagnosis.

v. The PPD must ensure that clinical notes and investigation / diagnostic reports uploaded by the EHCP is in sync with the booked package.

vi. PPD would verify treating doctor signature with registration number & qualification.

4.1.2.4. Further, Pre-authorization requests can be either Approved / Queried / Assigned / Rejected based on scrutiny of submitted documents.

4.1.2.5. If PPD is unable to take a decision based on the available documents and feels the need to call for additional documents, PPD can raise a query to the EHCP. The MUHCS Operator / MUHCS Coordinator will provide the necessary information (query response) to PPD as per defined TAT. PPD can select from the standard dropdown available in the TMS. All queries for

incomplete or missing documents will be asked in one go. Multiple queries may be selected from the same dropdown. If the relevant query reason is not listed in the category, “Others” option may be used, and the details of queries needs to be entered manually. There would be a scenario where query response received from hospital does not fulfil the requirement and PPD must raise the same query. In such cases it is mandatory for the PPD to mention the reason for not accepting the query response from the hospital.

4.1.3. Standard Query Reasons for Pre-authorization*

Table 1: Standard query reasons for Pre-authorization

PPD
Investigation reports
Provide X-Ray / MRI / CT / USG / EEG brain Films / ECG graph / ABG chart / CAG diagram (as applicable) with beneficiary name and date
Investigation reports of the beneficiary supporting the diagnosis
Provide Biopsy / HPE / FNAC / PET SCAN / any other diagnostic report confirming malignancy
Hospitalization Records
Provide vitals charts, Treatment plan and progress notes
Provide updated case summary and / or complete ICP records justifying enhancement of package
Provide the clinical photograph of the injury / lesion
Provide Hemodialysis chart and justification for frequent hemodialysis (if applicable)
Clear and legible documents
Provide clear and relevant photo of the beneficiary
Re-Upload legible copy of requested documents
Additional information
Provide justification for selected package
Provide justification for claim amount requested under Unspecified Surgical Package
Provide Doctor's Prescription advising Hospitalization with diagnosis
Provide referral letter from government hospital.
Provide Self-declaration with detailed narration of incident, mentioning date, place and time. MLC / FIR copy.
Others*
There is a free text for entering the details / remarks

**Subject to change from time to time*

4.1.4. Pre-authorization Rejection process and reasons

Based on the scrutiny of documents, pre-authorization may not be admissible. In such a scenario, PPD may decide to reject the pre-authorization request. It is mandatory for the PPD to mention the reasons for rejection of pre-authorization request. Pre-authorization request may be rejected by the PPD due to the following reasons:

i. Need for hospitalization is not justified from the clinical findings.
ii. Supporting documents and investigation reports necessary to take a decision are not submitted even after multiple queries / reminders.
iii. Patient is not covered under MUHCS.
iv. Ailment or disease is not covered under MUHCS
v. Beneficiary family wallet is exhausted.
vi. Fraud & misrepresentations
vii. If the treatment sought falls under the list of exclusion as per Annexure 1

4.1.5. Standard Rejection reasons in Pre-authorization

4.1.5.1. Following are standard rejection reasons for pre-authorization. PPD can select from standard dropdown available in TMS under rejection reasons category.

*Table 2: Standard Rejection reasons for Pre-authorization**

Delayed Pre-authorization Intimation (as per state guidelines)
False / Fraudulent Claim
Outside Scope of cover (Exclusions as per scheme)
Package Selection: Government reserved package
Package Selection: Hospital not empanelled for this speciality
Package Selection: Mismatch of package and disease / diagnosis / treatment / gender / age
Others

** Subject to change from time to time*

4.1.5.2. All rejected pre-authorization requests go to MSHCS for review. MSHCS can choose to revoke a rejected pre-authorization request and send it back to PPD.

4.1.5.3. Assign functionality: Based on the documents, Pre-authorization may be admissible or may not be admissible. In cases where PPD is unable to take any decision, claim can be assigned to MSHCS for their second opinion.

4.1.5.4. Send to Investigation

If the PPD finds the case to be suspicious, it can be referred for field investigation or desk audit. However, lifesaving treatment of patients shall not be delayed and final decision on the pre-authorization request shall be taken based on findings of the investigation and audits.

If the investigation report is not received in stipulated time, the PPD shall go ahead with appropriate decision and the outcomes of the investigation report may be taken into consideration at the time of discharge or during claim adjudication.

4.1.5.5. Flagging of Cases

Pre-authorization can be flagged due to reasons listed in TMS. This flagging is useful for PPD for follow up if cases are referred for either investigation or any other observations which needs to be followed up with concerned authorities.

4.1.5.6. Roles and Responsibilities in Pre-authorization Process

Table 3: Roles and Responsibilities in Pre-authorization Process

Sl.	Role	Responsibility	Description
1	MUHCS Operator	• To register the beneficiary in TMS	As per the beneficiary details- register the beneficiary in TMS with relevant information.
2	MUHCS Coordinator	• To book the relevant package • Raise the Pre-authorization request in TMS • Respond to queries raised by PPD / CPD	• Shall raise the pre-authorization request by booking relevant package as soon as the beneficiary is registered in the TMS. • Shall raise the pre-authorization enhancement request before the expiry of the initial pre-authorization validity.
3	PPD	• Verification of technical (medical / clinical) information • Decision making of the case	• Approve / Assign / Reject Pre-authorization request • Raise Query / Send back to EHCP for clarification • Trigger the cases for investigation / audit if required.

5. Claims Process Flow

MUHCS Coordinator, CEX, CPD, ACO, Medical Officer are involved in claims processing.

5.1. Claim Initiated by MUHCS Operator / MUHCS Coordinator

MUHCS Coordinator would update all the case details of the beneficiary (like date of discharge, all hospitalization records, etc.) and initiate the claim. After claim initiation, the claim lands into Claim Executive (CEX) bucket.

5.2. Claim Verification by Claim Executive

CEX would review and verify the claim documents and forward it to CPD for further action. The CEX will review the non-technical parts like name, age, gender, along with availability of all supporting documents and forward it to CPD for review.

5.2.1. Following details will be checked by CEX while reviewing the claim:

i. Validate all mandatory documents which are non-technical

ii. Verify the photos during the hospitalization and post hospitalization confirming the insured identity

iii. Discharge summary documents

5.3. Claim Scrutiny by Claim Processing Doctor

5.3.1. After receiving the claim for review, CPD will verify the submitted claim based on merits of the claim and take appropriate actions. The CPD can either approve the claim, raise a query, assign the case for second opinion, send the case for investigation, or reject the claim.

5.3.2. In case CPD wants to raise a query, it should be raised in one entirety. Under any circumstances queries should not be raised more than 3 times. There would be scenario where query response received from hospital does not fulfil the requirement and CPD must raise the same query again. In such cases, it is mandatory for the CPD to mention the reason for not accepting the query response from the hospital. Users can select multiple queries in the same dropdown. In case of query raised, hospital must provide required documents / information within the defined TAT.

5.3.3. Below mentioned points need to be considered while reviewing the documents by CPD:

i. The CPD shall ensure that all mandatory documents are uploaded by the EHCP as per STG. However, non submission of mandatory documents may not be a reason for rejection of claim if the hospital provides valid justification for the reason of failure of submission.

ii. The signs, symptoms and duration of illness mentioned by the doctor are aligned with the final diagnosis and treatment given as well as the booked package.

iii. The findings of the investigation / diagnostic reports uploaded by the EHCP supports the diagnosis as well as the booked package.

iv. To ensure that the booked surgical package is matched with the surgery performed as per post operative details provided by EHCP.

v. CPD should also review the ward category and verify according to the medical documents.

vi. Though the LOS is calculated by system, CPD should validate LOS with the discharge summary and subsequent approval amount.

vii. The package booked by EHCP is in sync with the diagnosis and treatment given. CPD would verify Treating doctor Signature with registration number and qualification.

5.3.4. The Claims Processing Doctor would review the technical details (medical / clinical) of a claim. List of documents is as follows:

i. OT notes and Surgery notes as applicable- Refer *Annexure 5*

ii. Clinical notes

iii. Discharge summary in standard format containing complete and relevant information- Refer *Annexure 6*

iv. Death Summary in case of death, containing complete and relevant information.

v. The CPD shall ensure that the clinical photograph uploaded is relevant.

vi. Investigation reports

vii. ICP records as applicable.

5.3.5. CPD can take following actions after reviewing the claim:

i. If the documents provided by EHCP is insufficient, then CPD can raise query.

ii. The CPD can also approve the payment partially if the details / documents do not justify the entire claim. However, reason for deduction / partial payment must be clearly mentioned.

iii. In some instances, where CPD is unable to take any decision, he can assign the claim to MSHCS for second opinion.

5.3.6. The basic workflow of CEX and CPD is represented in the figure below:

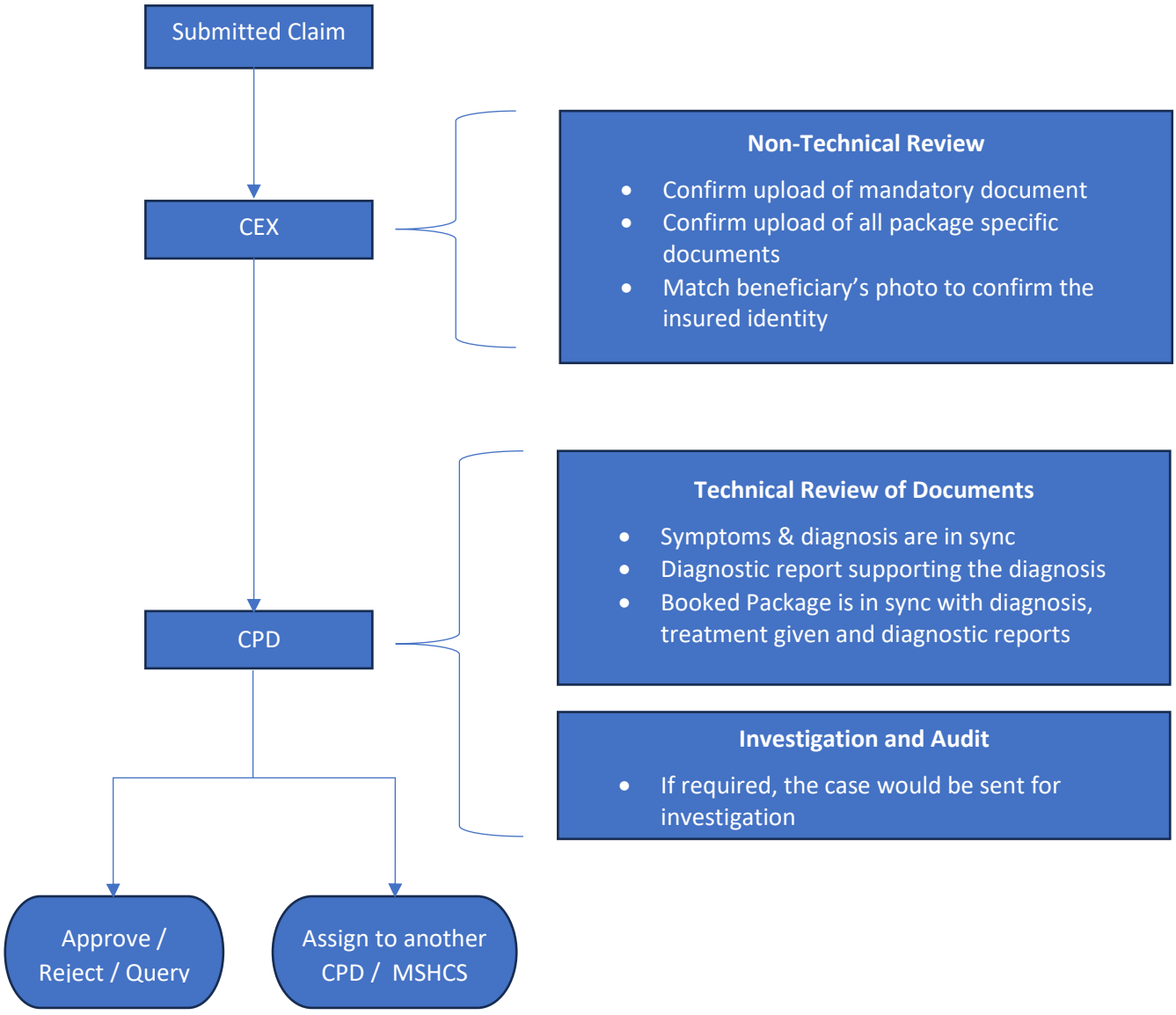

Figure 1: CEX and CPD actions

5.3.7. Standard Query Reasons post claims review

*Table 4: Standard Query Reasons for Claims**

CPD
Hospitalization records
Provide complete Discharge summary / Day care summary (e.g. beneficiary Name, Gender, Age, complaints, treatment done, Diagnosis, DOA & DOD etc.)
Provide death summary / LAMA or DAMA summary.
Provide Surgery / OT / Anesthetic notes
Provide implant / stent sticker / prosthesis / IOL sticker
Clear and legible documents
Provide post-operative scar photo with face of beneficiary in same frame (with consent of beneficiary)
Provide photo of beneficiary in ICU with Ventilator (in ICU-Ventilator cases)
Investigation reports
Provide X-Ray / MRI / CT / USG / EEG brain Films / ECG graph / ABG chart / CAG diagram (as applicable) with beneficiary name and date
Provide Biopsy / HPE / FNAC / PET SCAN / any other diagnostic report confirming malignancy
Others
Blank

**Subject to change from time to time*

5.3.8. Claim Sent for Investigation / Audit

If the CPD finds the claim to be suspicious, it can be referred for field investigation or claims adjudication audit.

5.3.9. Claim Rejection

Based on the scrutiny of the claim, CPD may decide to reject the claim. However, reason for claim rejection must be clearly mentioned. The rejected claim would land into MSHCS bucket for review. The MSHCS reserves the right to revoke a rejected claim, upon which the case would return to CPD bucket for processing.

Under following scenarios, rejection of claim may be recommended:

i. Need for hospitalization is not justified from the clinical findings.
ii. Supporting documents and investigation reports necessary to take a decision are not submitted even after multiple query / reminders
iii. Mismatched package selection
iv. Fraud & misrepresentations
v. If the treatment sought falls under the list of exclusion (as in Annexure 1)

The drop-down contains all the standard rejection reason along with an option as “other” to enter reason manually.

5.3.10. Standard Claim Rejection Reasons

Table 5: Standard Claim Rejection Reasons

Cash bill generated, paid by beneficiary
Documentation: Delayed or no query reply
Documentation: Delayed or non-submission of claim (as per state guidelines)
Documentation: Incomplete submission of documents by hospital after multiple queries
Documentation: Unclear / overwritten documents submitted by hospital
False / Fraudulent Claim
OPD converted into IPD (Justification for admission not found)
Outside Scope of cover (Exclusions as per scheme)
Package Selection: Hospital not empanelled for this speciality
Package Selection: Mismatch of package and disease / diagnosis / treatment / gender / age
Others

5.3.11. Claim Assign Functionality

In case CPD wants to take a second opinion, claim can be assigned to other CPD or MSHCS for review.

5.4. Claim Forward by Accounts Officer (ACO)

Once the Claim Processing Doctor (CPD) approves the Claim, the claim will be moved to the Accounts Officer's bucket for further action. The Accounts Officer will check the claim and if found payable will forward the claim to Medical Officer.

5.5. Claim Review by Medical Officer

The claim after ACO approval will move to Medical Officer. All the claims recommended for rejection will be moved to Medical Officer for final decision. Medical Officer would take the following actions post review of claim documents.

i. Approve
ii. Raise Query
iii. Reject

5.6. Claim Submission and Turn-Around-Time

5.6.1. Post approval of claim by Medical Officer, claim payment would be initiated at the bank. The amount will be transferred to the EHCP account.

5.6.2. The following procedure needs to be complied while processing claims received from the Empanelled Health Care Providers:

i. Public and Private EHCPs must initiate and submit their claims electronically within 15 days after the beneficiary is discharged. Beyond 15 days upto 21 days, if the EHCP provides valid justification, MSHCS may reconsider for submission of claims by special permission of the CEO, MSHCS, or the claim may be rejected. Claims submitted beyond 15 days of discharge of beneficiaries will be admissible only after approval of CEO, MSHCS.

ii. Considering the nature of internet connectivity in the state of Mizoram, there can be instances where empanelled hospitals in remote areas may not have internet access connectivity, the EHCP shall raise claims in offline mode via TMS provided that the hospital is registered in offline mode. EHCP may send a request to MSHCS for offline TMS login. Date of registration of offline claims can be backdated up to 30 days from the current date (actual date of registration) in TMS. Claims must be raised within 15 days from the actual date of registration.

iii. At the end of each Policy period, all EHCPs must close and submit all claims from that Policy period as per the directive of MSHCS.

5.7. Re-Consideration of Rejected Claim

5.7.1. The ISA at PPD and CPD level 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 subjected 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.

5.7.2. All rejected claims will be audited by MSHCS. If any rejected claim is found to be rejected incorrectly, the case will be revoked and sent back to the ISA for processing of such cases.

5.7.3. The ISA shall ensure that rejected claims are not reopened without the knowledge of MSHCS.

5.7.4. For rejected or cancelled cases which are revoked by MSHCS and re-opened, respective EHCP must resubmit the claims containing all the required documents within 15 days from the date of reopening.

5.7.5. Auto-rejected and auto-cancelled cases must be re-submitted by the respective EHCP within 15 days from the date of auto-rejection / cancellation.

5.7.6. Manually rejected cases must be re-submitted with corrections by the EHCP within 15 days from the date of rejection.

5.8. Claim Settlement and Payment

5.8.1. MSHCS shall be responsible for settling all claims within 30 days turnaround time (TAT) from the day the claim is initiated by the EHCP. Unless the claim is rejected, or the claim is under the trigger list of NAFU or SAFU or a query is raised.

5.8.2. For Private Empanelled Health Care Providers, MSHCS shall make tax deduction as per the applicable tax laws on claim payment unless the Private Empanelled Health Care Provider submits tax exemption certificate to MSHCS. Tax deduction is not applicable to Public Empanelled Health Care Providers.

5.8.3. Beneficiary admitted during a policy cover period but discharged after the end of such policy cover period will be applicable for payment of claims subject to availability of sum insured during the policy cover period, irrespective of whether or not the beneficiary has renewed the policy.

5.8.4. In all claims recovery and additional payment, beneficiary wallet should also be updated as required.

5.8.5. For claims where beneficiaries stay is less than the enhanced days, the amount should be adjusted in the final payable amount as per their actual length of stay.

5.8.6. Scrutinization of claims shall be undertaken by qualified and experienced medical practitioners appointed by MSHCS, to ascertain the nature of the disease or illness and to verify the eligibility thereof for availing the benefits under MUHCS Contract and relevant policy. The ISA / TPA staff shall not impart or advise on any medical treatment, surgical procedure or follow-up care or provide any guidance related to cure or other care aspects.

6. Right of Appeal and Reopening of Claims

6.1. The Empanelled Health Care Provider shall have a right of appeal against rejection of a claim by the ISA / TPA / MSHCS, if the Empanelled Health Care Provider feels that the claim is payable. Such a decision may be appealed by filing a complaint with the District Grievance Nodal Officer (DGNO) in accordance with the Grievance Redressal guidelines under MUHCS.

6.2. MSHCS may re-open the claim if the Empanelled Health Care Provider submits the proper and relevant claim documents required for approval of claim.

7. Erroneous Claims

Erroneous Claim – are claims where the claim amount settled is either less or more than the payable amount or the claim was not payable as per terms and condition of contract. Erroneous claim may be raised due to various reasons as follows:

- *Partial payment to EHCP:*

  In case EHCP does not receive the actual receivable amount, MUHCS Coordinator can initiate request for re-consideration of payment recovery through TMS in erroneous claim section within 30 days of claim payment by providing valid documents and MSHCS may consider as per merits of the claim.

- *Excess payment to EHCP:*

  In case of excess payment to EHCP in a settled claim, recovery can be initiated by the Accounts Officer (ACO) through Transaction Management System (TMS) for the excess amount.

- *Wrong claim payment to EHCP:*

  If a claim is paid wrongly to EHCP, ACO can raise this request through TMS.

In case of recovery from EHCP (excess payment and wrongful payment) the amount will be adjusted in the subsequent claims of the EHCP. MSHCS is the final authority for the decisions pertaining to erroneous claim.

8. Roles and Responsibilities – Claims Processing

Table 6:Roles and responsibilities during claims processing

Sl.	Role	Responsibility	Description
1	CEX	• Verification of Non-technical (non- medical / non-clinical) information	• Documents, - dates etc. which are mentioned in TMS • Forward the case to Claim Processing Doctor with Inputs
2	CPD	• Verification of technical (medical / clinical) information • Decision on the claim	• Diagnosis, reports, clinical notes, etc. • Approve / Raise query / Assign / Reject a claim • Validate system calculated claim amount and approve / recommend full / partial amount • Trigger the cases for investigation / audit if required.
3	ACO	• Validate financial information in all the transactions	• Forward the claim to Medical Officer for approval
4	Medical Officer	• Verify the claims submitted through TMS	• Respond to reconciliation issues raised by EHCP • Approve the claim for payment in full or partial amount, reject or raise query if required.

9. Claim Adjudication Audit

9.1. Objectives of Claim adjudication audit:

i. To improve overall quality of Claims Adjudication

ii. To check if due diligence has been applied by the claims processing team

iii. To check if the claims has been processed based on hospitalization documents and as per standard treatment guidelines

9.2. Audit Frequency

Monthly audit must be conducted on 5% of total claims approved during that month.

9.3. Checklist

*Table 7: Adjudication Audit Checklist**

Particulars	Yes	No	Remarks
Is beneficiary name / age in indoor records, E card and investigation reports same?			
Any aberration noted in the past claim history?			
Are all mandatory documents available as per STG at the time of claim submission?			
Are presenting symptoms matching with the diagnosis?			
Is the package booked matching with the diagnosis?			
Are Investigation reports supporting diagnosis available?			
Are investigation reports signed by doctor / pathologist with registration no.			
Are Post op photos showing scar available in surgical cases			
Do the OT notes detail steps of surgery? (Only in surgical cases)			
Is Line of treatment matching with the package booked (specific to general medicine and oncology)			
Are pre and post op x-rays available as per the procedure (case specific in IT system)			
Was length of stay verified with discharge summary? (In medical management cases)			
Does the discharge summary capture all details of presenting features, investigations, line of treatment given during stay, line of treatment advised at discharge?			
Did the PPD / CPD follow the above-mentioned process?			
Were appropriate queries raised? (for cases having queries)			

Subject to change from time to time.

10. Payment in Special Cases

In routine situation, when the patient is in stable condition, he / she is discharged from the hospital after completion of treatment. Hence, in majority of cases, payment to EHCP will be done based on the booked package and rates prescribed for that package.

However, there can be an exception where beneficiary left against medical advice, beneficiary died during the course of treatment or beneficiary is referred to another hospital for further management. In such cases, clarity needs to be provided to both EHCP and the payer (State Nodal Agency / MSHCS) regarding payments to the EHCP.

This guideline provide details of payments to be made in special cases.

10.1. LAMA / DAMA

Leave Against Medical Advice (LAMA) and Discharge Against Medical Advice (DAMA), is an act whereby a beneficiary takes his / her discharge contrary to the recommendation or will of the attending physician.

A. Surgical Cases

i. **LAMA / DAMA before surgery:** The payable amount will be calculated in line with the existing relevant medical packages according to Length of Stay (LOS) and bed category of the beneficiary.100% of the daily package rate for the full number of days for which beneficiary was admitted will be paid. All required documents need to be submitted for payment to be considered. This will be applicable in all cases irrespective of the fact whether pre-operative investigations have been done or not.

ii. **LAMA / DAMA after surgery:** 75% of the booked package rate will be paid. All required documents need to be submitted for payment to be considered.

B. Medical Cases: 100% of the daily package rate for the full number of days for which beneficiary was admitted will be paid as per the bed category. All required documents need to be submitted for payment to be considered.

10.2. Death during Hospitalization

A. Surgical Cases:

i. **Death before surgery -** The payable amount will be calculated in line with the existing relevant medical packages according to Length of Stay (LOS) and bed category of the beneficiary. 100% of the daily package rate for the full number of days for which beneficiary was admitted will be paid. All required documents need to be submitted for payment to be considered. This will be applicable in cases irrespective of whether pre-operative investigations have been executed or not.

ii. **Death on the table during surgery** – If beneficiary dies during surgery, 75% of the booked package rate will be paid. All required documents need to be submitted for payment to be considered.

iii. **Death after surgery** – If the beneficiary dies after surgery, irrespective of the duration of the post-operative stay, 100% of booked package rate will be paid to EHCP.

B. **Medical Cases:** 100% of the daily package rate for the full number of days for which beneficiary was admitted will be paid as per the bed category. All required documents need to be submitted for payment to be considered.

10.3. Payment In Referral Cases

10.3.1. Referred to other EHCP

A. Surgical Cases:

i. **Referral before PAC and surgery** – In case a beneficiary is referred to another EHCP, the amount payable to referring EHCP will be calculated in line with the existing relevant medical packages according to Length of Stay (LOS) and bed category of the beneficiary. 100% of the daily package rate for the full number of days for which beneficiary was admitted will be paid. All required documents need to be submitted for payment to be considered. The receiving EHCP will be eligible for 100% of the booked surgical package rate.

ii. **Referral after PAC but before surgery** - In this case, the referring EHCP will be paid 15% of the booked package amount. 85% of the booked package amount will be paid to the receiving EHCP. Pre-authorization request must be raised by the receiving EHCP for performing surgical procedures.

iii. **Referral after surgery for complication management** - If a beneficiary is referred to another EHCP after surgery for management of post operative complications, the referring EHCP will be paid 75% of the book package amount. The receiving EHCP will be eligible for 100% of the booked package amount. Pre-authorization request must be raised by the receiving EHCP for management of complications.

B. Medical Case: 100% of the daily package rate for the full number of days for which beneficiary was admitted will be paid to the referring EHCP as per the bed category. All required documents need to be submitted for payment to be considered. The receiving EHCP will be eligible for 100% of the booked package amount.

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

MUHCS beneficiaries (excluding AB PM-JAY beneficiaries) will be allowed to take treatment in Non-Empanelled hospitals within the State, provided that such treatment is not available from the empanelled network of hospitals or in an emergency and such treatment will be on reimbursement basis. Expost Facto must be sought by beneficiary from DHME which will be mandatory for claim submission and processing. Reimbursement will be done as per MUHCS package rate. If the treatment given by Non empanelled hospital is not in MUHCS package master, reimbursement will be made to the beneficiary as per the closest match of the MUHCS package amount or CGHS rates (whichever is applicable) within 45 days of receiving the complete set of documents by MSHCS.

11. Unspecified Surgical Package

To ensure that no beneficiary is denied care, provision of exclusive unspecified package is enabled in the TMS (Transaction Management System) for booking such treatments / procedures that are not featured in the listed interventions, subject to satisfying certain defined criteria (as mentioned below in para 11.1).

11.1. Using an unspecified surgical package

Criteria for treatments that can be availed under unspecified surgical package:

i. Only for surgical treatment.

ii. Within the state: unspecified surgical packages are reserved for public hospitals only.

iii. Compulsory pre-authorization is in-built while selecting this code for booking treatments.

iv. Cannot be raised under multiple package selection.

v. Cannot be booked for removal of implants, which were inserted under the same policy.

vi. Aesthetic treatments of any nature cannot be availed under this code or as such under any other listed codes under MUHCS. Only medically necessary, having significant functional impairment for functional purpose / indications can be covered, the procedure of which results in improving / restoring bodily function, to correct significant deformity resulting from accidental injury, trauma or to address congenital anomalies.

vii. None of the treatments that fall under the exclusion list of MUHCS as given in Annexure 1 of this guideline can be availed.

viii. In case MSHCS receives multiple requests for the same unspecified package from multiple hospitals or for multiple beneficiaries, then the same may be taken up with the Medical Expert Cell for inclusion in the MUHCS Package Master from time to time.

ix. Forced approval will not be applicable for unspecified packages.

For deciding on the approval amount of Unspecified surgical package, MSHCS may consider the rate of closest match of the requested surgery in listed MUHCS packages. It should be noted that the amount approved by the Pre-auth Panel Doctor (PPD) would be sacrosanct, to be communicated to the hospital, and the Claim Panel Doctor (CPD) would not be able to deduct any amount or approve partial payment for that claim.

11.2. Unspecified package above ₹ 1 Lakh

Utilization of Unspecified surgical package above ₹1 lakh is to ensure that the same is approved only in Exceptional circumstances and / or for life saving conditions. Exceptional circumstances may include:

i. Rare disease conditions or rare surgeries.

ii. Procedure available under MUHCS Package Master in a different speciality but not available in the treating Empanelled Health Care Provider speciality.

iii. Other conditions / treatments which are not excluded under MUHCS but not listed in MUHCS Package Master.

11.3. Life-saving conditions may include:

i. Emergencies or life-threatening conditions: While it is difficult to define all the situations where unspecified surgical package may be used or the upper limit for booking the package, it can be allowed as long as it is approved by Medical Expert Cell under MSHCS.

ii. A Medical Expert Cell constituted under MSHCS will provide inputs on requests received for unspecified surgical packages.

iii. CEO, MSHCS will recommend every case for approval after taking inputs from the Medical Expert Cell, with details of treatment and pricing that is duly negotiated with the provider.

iv. The price should be based on the principle of case based lump sum rate that includes all investigations, procedure cost, medicines and consumables – preferably citing rates as ceiling from any Govt. purchasing scheme like CGHS etc., if available.

12. Portability Cases

12.1. Portability feature is available where a beneficiary can get treatment in any Empanelled Hospital outside Mizoram in a cashless manner. No Empanelled Hospital can deny services to any eligible beneficiary. Below mentioned points is to be noted for the portability cases:

i. All portable or referral cases will need to get a referral from the Medical Referral Board.

ii. The process of beneficiary identification will have to be completed by the Hospital.

iii. The hospital will be paid as per MUHCS package rates agreed in the MoU / contract.

iv. All portability cases will require a mandatory pre-authorization to be approved by MSHCS.

v. As mandated under the guidelines package specific documents are to be submitted by the treating hospital at the time of raising a pre-authorization request, as well as at the time of claim submission.

vi. MSHCS specific thresholds with respect to utilization of wallets for secondary, tertiary and unspecified packages, if any, will be applicable. It will be the responsibility of MSHCS to check whether these thresholds are being breached at the time of Pre-authorization.

12.2. In addition, MUHCS beneficiaries (excluding PM-JAY beneficiaries) will be allowed to take treatment in Non-Empanelled Hospitals outside Mizoram, provided that such treatment is not available from the empanelled network of Hospitals or in an emergency and such treatment will be on reimbursement basis as per MUHCS package rates with certain terms and conditions. If the treatment given by the Hospital is not in MUHCS Package Master, reimbursement will be made to the beneficiary as per the closest match of the MUHCS package amount or CGHS rates (whichever is applicable) within 45 days of receiving the complete set of documents by MSHCS.

12.3. For Contributory Beneficiaries as well as Civil Pensioners, travel expenses of beneficiary only will be reimbursed by MSHCS with capping, the amount of which will be defined by the Finance Department. These will not be applicable for beneficiaries who failed to obtain referral letter from Medical Referral Board and Final Authorization Letter from Mizoram State Health Care Society prior to seeking treatment outside the state.

13. Unbundling Of Procedures

There can be cases where the EHCP booked more than one surgical procedures for the same beneficiary during the same hospitalization. 100% payment for such cases shall not be made. Rule of 100%-50%-25% (i.e., Costliest 100%, 2nd lowest – 50% then 25% each) shall be applied to such cases.

Example:

Table 7: Payment in Special Cases

Case ID	EHCP name	Patient Name	Date of admission	Package name	Package Rate	Proportion of payment	Approved amount
13345	ABC EHCP	XYZ	30/01/2025	Tonsillectomy (Uni/Bilateral)	7,500	100% payment	7,500
13347	ABC EHCP	XYZ	30/01/2025	Myringotomy – Bilateral	6,000	50% payment	3,000

Total amount = 7500+3000 = 10,500

14. Service Parameters

14.1. Uniform Turnaround Time (TAT)

The TAT of various components for reminders and timely payments are as follows:

Table 8: TAT

Sl.	Activities	TAT	Action
1	Pre-authorization request initiation after beneficiary Registration (by EHCP)	48 Hrs. post registration.	Reminder after 24th hours. Auto Cancel after 48 hrs. Auto rejected after 24hr post Auto Cancel New registration shall be initiated (with valid justification and CEO approval) post rejection due to non-initiation of Pre-authorization within 24hrs of auto cancel.
2	TAT for approval of Pre-authorization Request (by ISA / TPA)	6 Hrs. (as per threshold set in TMS)	Forced approval After 6 hours (working hours) of Pre-authorization initiation
3	Response on PPD Query (by EHCP)	24 Hrs.	1st reminder after 24 hours, 2nd reminder after 48 hours. Auto Cancel after 48 hours post 2nd reminder due to failure of response to PPD Query. Auto rejection after 72 hours due to failure of submission of justification from EHCP post Auto cancel. The Auto rejected claim can be revoked by MSHCS on receiving valid justification from EHCP post 72 hours along with CEO, MSHCS approval.
4	Claim submission after Discharge (by EHCP)	To submit ASAP but not later than 15 days or upto 21 days with CEO, MSHCS approval, beyond 21 days - not admissible. (EHCP shall raise offline claims within 15 days after actual date of registration of beneficiary in TMS)	First auto Reminders would be sent after 1st day & 3rd day and final auto reminder would be sent after 5th day post Discharge. Claim beyond 15 days will move to CEO, MSHCS bucket for approval. Claims submission post 21 days after discharge will **NOT BE ADMISSIBLE.**
5	Response on CPD Query (by EHCP)	To submit ASAP but not later than 7 days	First Auto reminder after 1st day, 3rd day and Auto reject after 7th day due to failure of response to CPD Query. The Auto rejected claim can be revoked by MSHCS on receiving valid justification from EHCP post 7 days along with CEO, MSHCS approval.

Sl.	Activities	TAT	Action
6	TAT for Claim payment (by MSHCS)	30 days from the date of claim submission within the state and 45 days from the date of claim submission for inter- state (portability) This TAT will be applicable for normal claim flow only. In queried claims, the time taken by EHCP to respond to query will not be counted in this TAT In suspected fraud claims, the time taken by SAFU to investigate and settle the claims will not be counted in this TAT	

Example 1: The day EHCP raises claim will be treated as Day 1

If ISA raises query on Day 4, and EHCP complies with query on Day 10, ISA takes action (accepting or rejection of claim) on Day 12, Payment on Day 15,

In this case (4-1=3) days + (15-10=5) days, hence TAT determined is 3+5=8 days

Example 2: The day EHCP raises claim will be treated as Day 1

If ISA raises query on Day 4, and EHCP complies with query on Day 10, ISA raises another query on Day 11, EHCP complies with the second query on Day 14, Payment on Day 17 - In this case (4-1=3) days + (11-10=1) days+ (17-14=3) days, hence TAT determined is 3+1+3=7 days.

15. Performance KPI

Table 9: Key Performance Indicators

Sl.	KPIs	Timeline	Baseline KPI Measure	Penalty
1.	Pre- authorization	Action within 6 hours: of raising pre-authorization request (all forced approvals beyond 6 hours will be considered non-compliance)	95% Compliance	Compliance below 95% up to 90%, then, penalty of 5% of the monthly total delayed pre-authorization amount Compliance below 90% up to 85%, then, penalty of 10% of the monthly total delayed pre-authorization amount Compliance below 85% then penalty of 20% of the monthly total delayed pre-authorization amount with one instance of triggering of SPD (For calculation, monthly delayed pre-authorization amount shall be the amount for delayed pre-authorizations for the admissions in that month) Penalty shall be calculated on this amount and ISA shall pay the penalty as per Penalty Notice per quarter. **Example:** if the ISA handled 100 pre-authorization in the month and failed to meet TAT for 16 cases, 20% pre-authorization amount of only these 16 cases will be charged as penalty. Even if the pre-authorization is rejected, not meeting the TAT will invite the penalty
			100% compliance	In case of wrongful pre-authorization approval, penalty of three times over & above the pre-authorization amount
2.	Scrutiny, Claim processing	Action within 7 days of claim submission for claims within state and 15 days & for claims from outside state (Portability cases)	100% Compliance	If the CPD fails to settle claims (approve / raise query / assign / reject) within Turn Around Time (TAT), then the ISA shall be liable to pay a penal interest to MSHCS at the rate of 0.1% for each claim amount for every day of delay or the part thereof on every delayed claim. If the compliance in the month falls below 85% of total number of claims, it will be treated as one instance of SPD trigger. **Example:** if the ISA processed 100 claims in the month and failed to meet TAT for 16 claims, it will be liable to pay penalty of 0.1% for each claim per day of these 16 claims to MSHCS. It will also be treated as one instance of SPD trigger
			100% Compliance	In case any claim is adjudicated wrongly then penalty of three times over and above the claim amount

16. Penalties

Penalties may be levied against EHCPs for defaults as mentioned below:

Table 10: Penalties

Nature of offence	1st Offence	2nd Offence	3rd Offence
Illegal cash payment / OOPE by beneficiaries	Full refund and penalty upto 2 times of illegal payment / OOPE amount	In addition to actions in 1st Offence, suspension of EHCP	De-empanellment
Upcoding / Unbundling / Unnecessary procedures / Package abuse or misuse	Rejection of claim and penalty upto 3 times the amount claimed	In addition to actions in 1st Offence, suspension of EHCP	De-empanellment
Wrongful beneficiary identification	Rejection of claim and penalty upto 5 times the amount claimed	In addition to actions in 1st Offence, suspension of EHCP	De-empanellment

Annexure 1: Exclusions to the Policy / Scheme (MUHCS)

The MSHCS shall not be liable to make any payment under any of the Covers in respect of any expenses whatsoever incurred by any Beneficiary in connection with or in respect of:

1. **Conditions that do not require Hospitalization**
   a) Expenses incurred at an Empanelled Health Care Provider primarily for Screening, i.e., evaluation or diagnostic purposes only during the Hospitalization, food supplement / nutritional supplement, other than such expenses that are required as a part of the expenses for:
      (i) Hospitalization expenses for a Medical Treatment or Surgical Procedure, as certified by the attending physician;
      (ii) Follow-up Care; or
      (iii) the OPD consultations and Screening covered under selected permissible Day Care / OPD Benefits. *(Annexure 2)*
   b) Any dental treatment or Surgical Procedure which is corrective, cosmetic or of aesthetic nature, filling of cavity, root canal including extraction, wear and tear, dentures, dental implants etc., is excluded.
2. **Congenital Anomalies and Convalescence**
   a) Treatment or procedures for external Congenital Anomalies except club foot, cleft lip, cleft palate and other anomalies that disrupts bodily functions.
   b) Convalescence or treatment for general debility, "run down" condition or rest cure.
   c) Any treatment received in a convalescent home, convalescent hospital, health hydro, nature care clinic or similar establishments.
3. **Fertility**
   a) Sterilization and Re-canalisation
4. **Normal Vaginal Delivery:** Normal and assisted vaginal delivery. (With an exception for Regular Government Employees under the Government of Mizoram). Normal and assisted Vaginal Delivery will not be covered for Provisional Employees / Muster Roll (MR) under the Government of Mizoram.
5. **Vaccinations and Cosmetic Treatments**
   a) Vaccination or inoculation.
   b) Change of life or cosmetic or aesthetic treatments of any description, plastic surgery other than as may be necessitated due to an accident or as a part of any illness.
   c) Circumcision, unless necessary for treatment of a disease or illness not excluded here under or as may be necessitated by any accident.
6. **War, Nuclear invasion:** Disease, illness, or injury directly or indirectly caused by or arising from or attributable to war, invasion, act of foreign enemy, war like operations (whether war be declared or not) or by nuclear weapons / materials.
7. **Intentional self-injury:** With an exception for Regular Government Employees under the Government of Mizoram
8. **Domiciliary Care Expenses:** No benefits shall be available for domiciliary care, except home dialysis.
9. **Detoxification due to alcohol or drug / substance abuse**
10. **Other Exclusions**
    a) Persistent vegetative state
    b) Cost of spectacles and contact lens
    c) Refractive eye surgery less than 5.5 dioptre
    d) Blepheroplasty for beneficiary less than 60 years of age. However, Blepheroplasty will be permissible under MUHCS if the beneficiary is above 60 years of age, with visual field obstruction not less than 20%.

Annexure 2: Selected Day Care / OPD Benefits

1. Hepatitis B
2. Hepatitis C
3. Dialysis
4. Parenteral Chemotherapy for cancer and other chronic disease e.g., Rheumatoid arthritis for rituximab infusion etc.
5. Refractive Eye Surgery for single procedure (not less than 5.5 dioptre)
6. Laser Therapy for Diabetic Retinopathy
7. Hemifacial Spasm/ Blepherospasm/ Cervical Dystonia requiring Therapeutic Botox injection
8. Connective Tissue Diseases e.g., SLE, DLE
9. Lithotripsy
10. Laparoscopic Therapeutic Surgeries
11. Central Line Insertion
12. Chronic Heart Failure
13. Coronary Artery Disease
14. Pulmonary Hypertension
15. Herniotomy under GA
16. Chronic Anal Fissure under GA
17. Circumcision under GA
18. Diagnostic laparoscopic examination
19. Thalassemia and other haematological disorders requiring repeated transfusions / treatment
20. OME for Grommet Insertion under GA
21. Myringoplasty (adults) under LA
22. Surgery for Cataract
23. Surgery for Squint (Adults only)
24. Surgery for Glaucoma
25. Laser procedure for Glaucoma
26. Laser procedure for posterior capsular opacity
27. Continuous Ambulatory Peritoneal Dialysis (CAPD)
28. Arteriovenous (AV) Fistula
29. Sensorineural or mixed hearing loss requiring Hearing Aid (for Government Employees and their dependents)

Annexure 3: Indicative list of 'Consumables and Services' chargeable to Beneficiaries

1. Accommodation beyond entitlement
2. Treatment cost not related solely for the curative component of that particular hospitalization
3. Accommodation for attendants of ICU / NICU / HDU patient.
4. Implant costs beyond the permissible package amount
5. Laundry Services
6. Extra / special attendant services
7. Soap, toothpaste and tooth brush
8. Newspaper and magazines
9. Mineral water
10. Hand sanitizer
11. Diaper
12. Unsterile gloves
13. Blood sugar testing machine and test strips (e.g., accucheck etc.)
14. Disposable sheets (eg. Underpads, Macintosh etc.)
15. Wheelchair
16. Air mattress
17. Crutch
18. Commode chair
19. Mouth wash
20. Moisturising lotion
21. Toilet paper
22. Tissue paper / wipes
23. Hot water bag, heat pouch, heat bag
24. Hand wash
25. Nurse cap / disposable cap
26. Cidex
27. Polythene / Plastic bag / Paper bag
28. Thermometer
29. Measuring cup
30. Urine pot
31. BP apparatus
32. Pulse oximeter
33. Shaving kit (eg. Easy glide etc.)
34. Bed pan
35. Apron
36. Nebulizer
37. Disposable shoe cover
38. Bath towel
39. Baby Bath
40. Steam Bath / Hydrotherapy
41. Disposal gown
42. Plaster / Band aid
43. Cotton roll
44. Mask
45. Spirit
46. Oxygen concentrator
47. Suction machine
48. CPAP, BiPAP, APAP

Annexure 4: Items / Services inclusive in the Package Rate

1. Bed charges inclusive of water, electricity, files / stationery items
2. Admission fee
3. Hospital diet charges for the patient only.
4. Doctor consultation / bedside visit charge
5. Nursing charge
6. Investigation cost which are relevant to reason for admission / diagnosis or treatment but excluding high end diagnostics. High end diagnostics such as MRI, PET scan etc. may be booked additionally for selected packages / ailments and will be covered under the cashless scheme.
7. Medicines and consumables. Consumables which are solely for the purpose of cure will be covered.
8. Surgery- OT charge, Surgeon charge, Assistant surgeon charge, Anaesthetist charge
9. Charges for oxygen, syringe pump, monitor, ventilator if required.
10. Therapeutic pleural and ascitic tapping
11. Bedside Physiotherapy

Note: Inclusiveness of package rate is applicable within the hospitalization period.

Annexure 5: Template – OT Notes, Clinical Notes and Clinical Photo

OT notes (should be on EHCP stationery and not on plain paper)

1. Date and time operation was started and completed
2. Name of Surgeon
3. Name of Anaesthetist
4. Type of Anaesthesia
5. Proposed Surgery
6. Surgery performed
7. Surgery note (site, side and findings)
8. Immediate post-op care
9. Any complications faced.
10. Signature of Surgeon

Clinical notes

1. Date(s) of clinical note
2. Each day progress report should contain, vitals, clinical notes, and treatment given with valid signature of concerned personnel.
3. Just “continue same treatment (CST)” is not acceptable.

Clinical Photographs

1. The face of the person and site of surgery shall be visible in the same frame.
2. It should not be a google image.

Annexure 6: Format of Discharge Summary

Hospital Name	Hospital code
Hospital Address	Hospital District
Patient Name	MUHCS –ID
Patient Address	Age
	Sex
	Patient contact number
IPD number (free text)	
MUHCS Registration Number	
Package booked	
Treating Doctor Name	
Treating Doctor Qualification	
Treating Doctor Speciality	
Date and Time of Admission	
Date and Time of Discharge	
Presenting complaints with duration	
Clinical examination findings	
Significant Past Medical and Surgical History, if any.	
Provisional Diagnosis at the time of Admission	
Final Diagnosis at the time of Discharge	
Investigations done with findings	
Treatment given during hospitalization	
Operative Findings (Only for surgical cases)	
Complications, if any	
Status at the time of discharge	
Next follow-up date (dd/mm/yyyy)	
Advice on discharge	
Signature of treating doctor	

Annexure 7: Actionable for PPD

All mandatory documents uploaded?	Yes / No
Did the patient have a history of trauma / avascular necrosis / severe osteoarthritis?	Yes / No
Are supporting clinical documents and X-Ray / CT available to establish an indication for THR?	Yes / No
Clinical photograph of hip confirms diagnosis?	Yes / No
All mandatory documents uploaded?	Yes / No
Did the patient have a history of trauma / avascular necrosis / severe osteoarthritis?	Yes / No
Are supporting clinical documents and X-Ray / CT available to establish an indication for THR?	Yes / No
Clinical photograph of hip confirms diagnosis?	Yes / No
All mandatory documents uploaded?	Yes / No
Did the patient have a history of trauma / avascular necrosis / severe osteoarthritis?	Yes / No
Are supporting clinical documents and X-Ray / CT available to establish an indication for THR?	Yes / No
Clinical photograph of hip confirms diagnosis?	Yes / No
All mandatory documents uploaded?	Yes / No
Did the patient have a history of trauma / avascular necrosis / severe osteoarthritis?	Yes / No
Are supporting clinical documents and X-Ray / CT available to establish an indication for THR?	Yes / No
Clinical photograph of hip confirms diagnosis?	Yes / No

Annexure 8: Actionable for CEX and CPD

Actionable for CEX

All mandatory documents uploaded?	Yes / No

Actionable for CPD

Are all requisite post-treatment evidentiary documents available to confirm complete appropriate treatment and follow-up instructions	Yes / No
Was Length of Stay as per package specification?	Yes / No
Are admission notes and detailed findings at admission notes available?	Yes / No
Is Discharge summary available?	Yes / No
Does the discharge summary capture all details of presenting features, investigations, line of treatment given during stay, line of treatment advised at discharge and (Select <No> if investigations and all treatment details, missing as follow up will not berational)	Yes / No
Is, Pre-op Profile Relevant to Package, Age & Co-morbidities available?	Yes / No
Does the report include Pre- and post-operative diagnosis and are both the same? If No, is there sufficient evidence to confirm the changed diagnosis?	Yes / No
Is the correct package blocked?	Yes / No
Is the date and time of the procedure mentioned?	Yes / No
Does the OT time correspond to time ideally taken for the procedure / surgery?	Yes / No
Is the surgeon who has operated the same as the name given while blocking the package?	Yes / No
Is the surgeon's signature available on records?	Yes / No
Did the patient have a history of trauma / avascular necrosis / severe osteoarthritis?	Yes / No
Does X-Ray / CT establish an indication for THR?	Yes / No
Do the OT notes detail steps of surgery?	Yes / No
Do the OT notes specify the type of cement used in surgery?	Yes / No
Is there a Post Op X-Ray of Hip confirming the surgery undertaken?	Yes / No
Does it show medications not related to the package for which admitted?	Yes / No
Was the treatment rationale and enough for the patient's clinical condition?	Yes / No

Annexure 9: Claims Adjudication Audit Report

Template for Claims Adjudication Audit:

MUHCS Registration No.	Hospital Name	Package Name	Package Cost	Date of Admission	Date of Discharge	Types of findings	Comments

Claims adjudication audit reporting format:

Name of the Agency		
Month and Year of Audit		
Total number of claims audited		
Total number of errors found during audit	Financial	Non-financial
No of Hospitals found suspected during audit		
Action plan against suspected hospitals		
Major type of errors found during audit		
Executive summary of audit		

Annexure 10: Claims Reporting Timeline

i. CPD Rejected Claims Reporting format: Monthly Basis.

ii. Claims Paid Reporting Format: Monthly Basis.

iii. Summary I – Monthly Hospital Wise Claims Report.

iv. Summary II – Monthly Hospital Type Claims Report.

v. Summary III – Monthly Patient District Wise Claims Report.

Note: All formats for the above will be separately provided by MSHCS.