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Government of Mizoram

MIZORAM UNIVERSAL HEALTHCARE SCHEME (MUHCS)

Mizoram State Health Care Society

Department of Health & Family Welfare

2025

Contents

Abbreviations

MSHCS	Mizoram State Health Care Society
AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
NHA	National Health Authority
MUHCS	Mizoram Universal HealthCare Scheme
PDS	Public Distribution System
ABDM	Ayushman Bharat Digital Mission
CEO	Chief Executive Officer
UPI	Unified Payment Interface
CGHS	Central Government Health Scheme
PE	Provisional Employees
MR	Muster Roll

Mizoram Universal HealthCare Scheme

1. Introduction

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.

1.2 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 included for employees as well as the Civil Pensioners. MUHCS will improve efficiency, cost-effectiveness, quality of health care services, and enhance engagement with private sectors. Keeping in view the situation of the State, the following are the contours of the proposed scheme in the State:

a) MUHCS will initially cover all inpatient conditions (with exclusions as mentioned in Annexure 2) with very few exceptions. MUHCS will have a defined benefit cover per family per year on family floater basis as detailed in para 3.7. 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.

b) 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.

c) 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.

d) 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.

e) Comprehensive IT Platform will 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.

f) 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.

g) Defined vertical programmes integration where benefits are overlapping will also be followed.

h) **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.

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

j) Public hospitals will have the flexibility to keep part of the claims revenue received from claims paid under MUHCS and use it as per the Financial Guidelines.

2. Institutional Mechanism

a) A strong institutional mechanism is required at State level to manage and implement a universal health coverage programme. MSHCS that is currently managing AB PM-JAY will be given the responsibility to manage MUHCS. The agency will be strengthened.

b) For giving policy directions and fostering coordination between different departments, it is proposed to set up a Universal Health Coverage Council (UHCC) comprising of the Chief Secretary, Secretary Health & Family Welfare, Secretary Finance, Secretary Food, Civil Supplies & Consumer Affairs, CEO MSHCS and Chaired by the Minister, H & FW, etc. Other members as necessary may be added. Secretary Health & Family Welfare Department shall be the Member Secretary of UHCC. CEO of MSHCS will be the Convener of UHCC.

3. Details of MUHCS and Implementation Plan

3.1. Scheme Rollout

The scheme shall take effect from 1st April, 2025.

3.2. Eligibility criteria under MUHCS

All bona fide residents of Mizoram will be eligible under the Scheme. Different categories of eligible beneficiaries are as follows:

a) Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) beneficiaries as revised by NHA from time to time.

b) State Government Employees and their dependents as per IFMIS database.

c) Mizoram State Health Care Society (MSHCS) employees and their dependents as per PDS database.

d) Provisional Employees / Muster Roll, under Government of Mizoram and their dependents as per IFMIS database.

e) Civil Pensioners under Government of Mizoram and their dependents within the ambit of PDS database.

f) General population not included in the categories mentioned above as per PDS database and will be considered as Contributory Beneficiaries.

3.3. Registration and Verification of Beneficiary Family Units and Obligations

a) The MSHCS shall register / enroll only those beneficiaries mentioned under Clause 3.2 as above.

b) During the beneficiary registration / enrolment process, the following documents shall be mandatory for identification and verification.

(i) For personal / individual identification

- Aadhaar

(ii) For family/dependent identification or proof of relationship

- Ration Card
- In the absence of Ration Card, Village council / Local Council recommendation letter clearly stating the reasons for the absence and certifying the list of family members residing under the same household/roof.

(iii) The mandatory documents may be added or removed as per notice issued by the Government of Mizoram from time to time.

c) Registration / Enrolment will be done on family basis while the beneficiary identification verification process will have to be undertaken by each members of the family. Once the

beneficiary is successfully verified, the beneficiary will be provided with a unique MUHCS ID which may be used by the beneficiary at the time of availing benefits in the empanelled hospitals.

d) The MSHCS shall ensure that the centres to conduct registration and verification of beneficiaries such as the District Kiosk and the facility Kiosk at CHC/PHC are functional and operational.

e) The MSHCS shall ensure the availability of the IT infrastructure in such centres along-with the functionality of the web portal to facilitate beneficiary registration and verification.

f) The Government Employees and Provisional Employees / Muster Roll do not need to register / enroll. Eligibility under MUHCS can be verified through IFMIS database.

g) Government Offices may reach out to MSHCS for verification and generation of MUHCS ID. MSHCS may organize beneficiary identification drive to verify and generate MUHCS ID for general population in their respective Wards/villages as well as Government Employees in their respective offices. Verification and generation of MUHCS ID can also be done at MHSCS Office, Dinthar, Aizawl during office hours.

h) The beneficiaries under 5 years of age may avail benefits using their parent's card.

i) Civil Pensioners list as available in each treasury will be used for their eligibility while the eligibility of their dependents will be within the ambit of PDS database.

3.4. Online Registration / Enrolment Mechanism

Contributory beneficiaries under 3.2 (f) will be registered / enrolled as per the following:

a) Information about enrolment time, premium amount and benefits will be informed to the population through mass media like TV, newspaper, radio, and social media. In addition, other mechanism like using of church groups and village committees etc. will be used to inform and motivate beneficiaries to join.

b) Beneficiary will be able to register / enroll themselves by providing all the relevant documents online. Payment of premium can be done online through UPI, credit / debit cards and internet banking.

c) Premium once deposited will not be refunded to beneficiaries under any conditions unless otherwise as specified in the guidelines.

3.5. Offline Registration / Enrolment Mechanism

Provisions for Offline Registration / Enrolment will be available where online registration / enrolment is not feasible.

a) Offline registration / enrolment will be done at the sub-centre level where physical registration / enrolment forms will be filled manually.

b) Document referred to in 3.3(b) must be produced at the time of offline registration / enrolment.

c) Duplicate offline registration / enrolment form will be sent to MSHCS from the Sub-Centres and data will be entered in the IT system.

d) The physical registration / enrolment forms and supporting documents must be sent to MSHCS within a stipulated timeframe.

3.6. Premium contribution by the Beneficiaries

Certain set of conditions pertaining to contribution by beneficiaries are laid out for each category of beneficiaries. The amount payable for contribution by beneficiaries under MUHCS may however be revised by the State Government from time to time.

3.6.1. Contribution from AB PM-JAY beneficiary households

No contribution from AB PM-JAY beneficiaries is required.

3.6.2. Premium from Contributory Beneficiaries

There will be three plan options for contributory beneficiaries:

a) **Option 1 (General Plan)** – Premium of **₹2,500/-** per family per year that allows family to get benefit of ₹5,00,000/- per family per year in **General Ward**

b) **Option 2 (Standard Plan)** – Premium of **₹5,000/-** per family per year that allows family to get benefit of ₹5,00,000/- per family per year in **Semi-Private (shared) Ward**.

c) **Option 3 (Private Plan)** - Premium of **₹10,000/-** per family per year that allows family to get benefit of ₹5,00,000/- per family per year in **Private Ward**.

The options are summarized as given in the table below:

Plan Option	Premium amount (for 1 policy year)	Benefit cover	Room entitlement
GENERAL	₹2,500/-	₹5,00,000/- per family per year	General Ward
STANDARD	₹5,000/-	₹5,00,000/- per family per year	Semi Private (Shared) Ward
PRIVATE	₹10,000/-	₹5,00,000/- per family per year	Private Ward

Table 1

3.6.3. Contribution from Government Employees: Each Government Employee will be required to pay a monthly premium as per their Pay Level as given below:

Pay Level	Monthly Contribution	Room / Ward
13 & above	₹1,500/-	Notification for Room entitlement for hospitals will be issued by the Finance Department.
10-12	₹1,000/-	
6-9	₹700/-	
3-5	₹400/-	
1-2	₹300/-	
Provisional Employees (PE) / Muster Roll (MR)	₹200/-	General Ward

Table 2

For employees under MSHCS, the monthly premium contribution as per pay level and benefit coverage for Government Employees will be adopted.

3.6.4. Contribution from Civil Pensioners:

a) Civil Pensioners will be categorized based on the amount of their monthly pension into Category A and Category B as detailed in the table below-

Category	Definition	Monthly Contribution	Benefit	Room / Ward
Category A	Monthly pension >= ₹20,000/-	₹1,000/-	₹12,00,000/- per family per year	Private Ward
Category B	Monthly pension < ₹20,000/-	₹500/-	₹5,00,000/- per family per year	Semi-Private Ward

Table 3

b) Civil pensioners under Category B can opt for benefits under category A by paying a contributory amount of ₹1,000/-. This option should be exercised within one month of implementation of MUHCS. New pensioners will also have to exercise the option within one month of their retirement.

c) Household having two/three pensioners will be eligible for double/triple amount of the Sum Assured respectively, their dependents can be split accordingly as per their convenience. If there is a pensioner and a Government Servant in a family, each will avail its own benefit, dependents can be split accordingly as per Government OM for a Government Employee and those not eligible for Government Employee dependents will be as dependent of the pensioner.

3.7. Benefit Coverage

a) Travel expenditure will be covered upon production of the tickets and boarding passes for portable cases as depicted in Table 4. The permissible upper limit for travel expenditure will be issued by the Finance Department.

b) Upon non availability of entitled room accommodation, it is admissible for such to occupy room accommodation below the entitlement, while expenditure for occupation of room accommodation above the entitlement will not be included in the package rate and will be borne by the beneficiary/patient.

	Contributory Beneficiaries	AB PM-JAY	Govt Employees	PE/MR	Civil Pensioners (Based on amount of contribution)	
					Cat A *Contribution ₹1,000/-*	Cat B *Contribution ₹500/-*
Sum Insured	₹5 Lakhs	₹5 Lakhs	Unlimited	₹5 Lakhs	₹12 Lakhs	₹5 Lakhs
Ward	As per the premium paid (3.6.2)	General	As per entitlement	General	Private	Semi-private
Travel	Patient only	No	Patient +1 attendant	Patient only	Patient only	Patient only
OPD & Day Care Services	Yes	No	Yes	Yes	Yes	Yes

Table 4

3.8. Package Rates

a) Public and private empanelled hospitals will utilise approved package rates to ensure provision of appropriate payment to the hospitals for treatment of beneficiaries.

b) Hospitals will be categorized and incentivised.

c) Package rates will comprise of the essential items, services as enclosed in Annexure 4.

d) Indicative list of Consumables chargeable to beneficiaries as enclosed in Annexure 5.

e) MUHCS Package Master is based on AB PM-JAY Health Benefit Package National Master. However, considering into the local context, package rates has been rationalised.

f) The detailed package rates will be notified separately.

3.9. Unspecified Surgical Package

To ensure that MUHCS beneficiaries are not 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 3.9.1).

3.9.1. Using an unspecified surgical package

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

a) Only for surgical treatments.
b) Within the state, unspecified surgical packages are reserved for public hospitals only.
c) Compulsory pre-authorization is in-built while selecting this code for booking treatments.
d) Cannot be raised under multiple package selection.
e) Cannot be booked for removal of implants, which were inserted under the same policy.
f) 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.
g) None of the treatments that fall under the exclusion list of MUHCS as given in Annexure 2 of this guideline can be availed.
h) In case MSHCS receives multiple requests for the same unspecified package from multiple hospitals or for multiple patients, then the same may be taken up with the Medical Expert Cell for inclusion in the MUHCS Package Master from time to time.
i) 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.

3.9.2. 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.

3.9.2.1. Exceptional circumstances may include:

a) Rare disease conditions or rare surgeries.

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

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

3.9.2.2. Life-saving conditions may include:

a) 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.
b) A Medical Expert Cell constituted under MSHCS will provide inputs on requests received for unspecified surgical packages.
c) 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.
d) 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.

3.10. Availing Benefits under the scheme

MUHCS is a cashless scheme which utilizes an IT platform for seamless and paperless process for processing and approval of claims. All claim processes, such as patient registration, Pre-authorization and approval, Pre-authorization enhancement and approval, claim submission, approval and payment of claims will be an online process. Thus, to avail cashless benefits under the scheme -

a) A beneficiary must have MUHCS ID which is mandatory.
b) A beneficiary, once admitted into the hospital will be registered as a patient in the IT platform by the hospital. A back date of up to a maximum of 5 days will be permissible in the IT Platform. Treatment cost or hospitalization expenses beyond permissible back date provisions in TMS will not be covered under the scheme.
c) A pre-authorization must be raised after registration of patient. The initial pre-authorization will be auto approved or as configured in MUHCS Package Master. Once approved, the pre-authorization will be valid for 24 hours.
d) 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.
e) The granted permission will be valid for up to 5 days as requested and if continuation of hospitalization for that particular patient is required, hospitals must continuously seek approval within 48 hours after the expiry of granted permission.
f) 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.

MUHCS has an exception wherein home dialysis will be on reimbursement basis. The permissible amount for reimbursement will be based on the quantity of usage, the rate of which will be fixed by the Government from time to time.

3.11. Empanelment of Hospitals

a) All public hospitals with inpatient facilities will be empanelled.
b) All private hospitals meeting the empanelment criteria of H&FW Department will be eligible for empanelment. A hospital once empanelled will need to provide services to all beneficiaries

of MUHCS irrespective of their category. They will also agree to be paid within 30 days of the claims being received by MSHCS or other arrangements made by the Government of Mizoram from time to time.

c) All hospitals empanelled under AB PM-JAY will be deemed empanelled under MUHCS.

3.12. Portability (Referral) Cases under MUHCS

3.12.1. Portability feature is available under MUHCS 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:

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

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

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

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

e) Package specific documents, as mandated under the guidelines is 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.

f) 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 the MSHCS to check whether these thresholds are being breached at the time of Pre-authorization.

3.12.2. In addition, MUHCS beneficiaries (excluding PM-JAY beneficiaries) will be allowed to take treatment in Non-Empanelled Hospitals outside Mizoram only, 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.

3.12.3. For Contributory Beneficiaries as well as Civil Pensioners, travel expenses of patient only will be reimbursed by MSHCS with capping. The amount 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.

3.13. Strengthening of Supply Side

To ensure that supply side is strengthened for catering services to the population, Government has decided to undertake defined set of activities including but not limited to the following:

a) Capacity building
b) Signages inside and outside hospital
c) Setting up of help desk inside each empanelled hospital
d) Strengthening each empanelled public hospital.
e) IEC and awareness activities.

3.14. Vertical Program Integration

As defined vertical programmes have been identified for integration in MUHCS (Annexure 1), the IT platform of MUHCS with provisions to track treatment provided under these vertical programmes will support in reporting to Ministry of Health and Family Welfare.

3.15. Standardized Management system through Standard Operating Procedure

For an efficient system, a Standard Operating Procedure needs to be in place and the following modules are developed for the implementation of MUHCS:

a) **Beneficiary Registration and Verification:** Registration, validation, verification and approval of beneficiaries will be available in online and offline. Online payment will also be incorporated for beneficiaries to register within the enrolment window. MUHCS cards with unique ID will be issued to all beneficiaries. 'Beneficiary Registration and Verification Guidelines' will be notified separately.

b) **Claims Management and Adjudication:** The purpose of claims management and adjudication guidelines are to build capacities of adjudication team for accurate and time bound processing/ settlement of claims under MUHCS and to enhance the skills for combining fundamental concepts, system capabilities and human intelligence during claim processing. The necessity of accurate processing is important in multiple aspects, approval of admissible claims, payment of correct amount to Empanelled Health Care Providers, genuine utilisation of beneficiary's wallet etc. 'Claims Management and Adjudication Guidelines' will be notified separately.

c) **Anti Fraud:** The scope of Anti Fraud Guidelines covers prevention, detection and deterrence of different kinds of fraud that could occur at any stages of scheme implementation. The Anti Fraud guidelines sets out the mechanisms for fraud management and lays down the legal framework, institutional arrangements and capacity that will be necessary for implementing effective anti fraud efforts. 'Anti-Fraud Guidelines' will be notified separately.

d) **Grievance Redressal:** For the smooth implementation of the scheme, where beneficiaries could lodge their complaints anywhere around the globe, a grievance management system in line with the Grievance Redressal Guidelines is being developed to ensure that grievances of all stakeholders are redressed within the given timeframe upto the satisfaction of the aggrieved party based on the principles of natural justice while ensuring that cashless access to timely and quality care remains uncompromised. 'Grievance Redressal Guidelines' will be notified separately.

e) **Verification and Categorization of Private Health Care Providers:** As health care providers differs in terms of service quality provided as well as other factors, it is judicious that categorization of private health care providers, based on an exhaustive criterion be made. This can justify the variation in incentives for services while at the same time, it would bring efficient Government fund utilisation for services under Government sponsored schemes. This categorization is also an attempt to bring improvement in quality of services across the network of private health care providers, motivate them to aspire for continuous enhancement of services, thus contributing to overall efficiency. 'Guidelines for Verification and Categorization of Private Health Care Providers' will be notified separately

f) **Service Quality Audits, Monitoring and Control:** Reporting, monitoring and control mechanism are critical audits and related processes necessary for ensuring the seamless implementation of MUHCS constituting a set of continuous procedures of evaluation and review involving the beneficiary and concerned stakeholders. 'Service Quality Audits, Monitoring & Control Guidelines' will be notified separately.

g) **Financial Guidelines:** Financial Guidelines for reporting, utilisation and disbursement of funds under MUHCS will be notified and amended from time to time.

Annexure 1: Details of Vertical Programme Components to be Integrated under MUHCS

1. **Revised National Tuberculosis Control Programme (RNTCP)**: Diagnosis and ATT Drugs will not be admissible
2. **National Mental Health Programme (NMHP)**: Detoxification will be excluded and the duration of stay (IPD) for psychiatric patients may be limited to a maximum period of 30 days.
3. **Reproductive and Child Health (RCH) Programme**: Complicated vaginal delivery such as Breech, Shoulder Dystocia, Big Baby, Caput 3rd Degree, Molding and Caesarean Section only will be admissible. Normal and assisted vaginal delivery will be excluded.
4. **Rashtriya Bal Swasthya Karyakram (RBSK)**: Benefits not covered under RBSK programme will be admissible for coverage with mandatory production of prior verification certification from RBSK for non-coverage.
5. **National Programme for Control of Blindness & Visual Impairment (NCB)**: Claims from empanelled private & public centres under NCB will be admissible and consideration of the amount given to them from the programme will be considered while estimating the MUHCS Package Master.
6. **National Viral Hepatitis Control Programme (NVHCP)**: Admissibility of Hepatitis C & B for treatment will be subject to production of verification certificate from NVHCP for non-availability of services such as drugs and diagnostics under the programme.
7. **Pradhan Mantri National Dialysis Programme (PMNDP)**: Cost of Dialyzer will not be admissible as it is provided under the programme.
8. **National Programme for Palliative Care (NPPC)**: Morphine drug will not be admissible, and the maximum admissible hospitalization period of palliative treatment will be no more than 14 days.

Annexure 2: Exclusions under 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 3)*
   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 3: Selected Day Care/OPD Benefits Inclusions under MUHCS

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 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: 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

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Government of Mizoram

MIZORAM UNIVERSAL HEALTHCARE SCHEME (MUHCS)

Beneficiary Registration and Verification Guidelines

Mizoram State Health Care Society

Department of Health & Family Welfare

2025

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Abbreviations

AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
MSHCS	Mizoram State Health Care Society
MUHCS	Mizoram Universal HealthCare Scheme
ISA	Implementing Support Agency

1. Beneficiary Registration and Verification

Beneficiary registration is a process to enroll eligible beneficiaries under MUHCS while verification is a process to validate whether a person is a registered beneficiary under MUHCS. Beneficiary registration and verification is a mandatory process to avail benefits under the scheme. After verification, an individual MUHCS card is provided to the beneficiary.

1.1. Eligibility criteria under MUHCS

All bona fide residents of Mizoram will be eligible under the Scheme. Different categories of eligible beneficiaries are as follows:

i. Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) beneficiaries as revised by NHA from time to time.

ii. State Government Employees and their dependents as per IFMIS database.

iii. Mizoram State Health Care Society (MSHCS) employees and their dependents as per PDS database.

iv. Provisional Employees / Muster Roll, under Government of Mizoram and their dependents as per IFMIS database.

v. Civil Pensioners under Government of Mizoram and their dependents within the ambit of PDS database.

vi. General population not included in the categories mentioned above as per PDS database and will be considered as Contributory Beneficiaries

1.2. Registration and Verification of Beneficiary Family Units and Obligations

1.2.1 The MSHCS shall register / enroll only those beneficiaries mentioned under Clause 1.1 as above.

1.2.2 During the beneficiary registration / enrolment process, the following documents will be mandatory for identification and verification.

(i) For personal / individual identification

- Aadhaar

(ii) For family / dependent identification or proof of relationship

- Ration Card
- In the absence of Ration Card, Village council / Local Council recommendation letter clearly stating the reasons for the absence and certifying the list of family members residing under the same household / roof.

(iii) The mandatory documents may be added or removed as per notice issued by the Government of Mizoram from time to time.

1.2.3 Registration / Enrolment will be done on family basis while the beneficiary identification and verification process will have to be undertaken by each members of the family. Once the beneficiary is successfully verified, the beneficiary will be provided with a unique MUHCS ID which may be used by the beneficiary at the time of availing benefits in the empanelled hospitals.

1.2.4 The Government Employees and Provisional Employees / Muster Roll do not need to register / enroll. Eligibility under MUHCS can be verified through IFMIS database.

1.2.5 Civil Pensioners list as available in each treasury will be used for their eligibility while the eligibility of their dependents will be within the ambit of PDS database.

1.2.6 The beneficiaries under 5 years of age may avail benefits using their parent's card.

1.3 Online Registration / Enrolment of Beneficiaries

Contributory beneficiaries under 1.1 (vi) will be registered / enrolled as per the following:

i. Beneficiary will be able to register / enroll themselves by providing all the relevant documents online. Payment of premium can be done online through UPI, credit / debit cards and internet banking.
ii. Premium once deposited will not be refunded to beneficiaries under any conditions unless otherwise as specified in the guidelines.

1.4 Offline Registration / Enrolment of Beneficiaries

Provisions for Offline Registration / Enrolment will be available where online registration / enrolment is not feasible. The following must be observed during offline registration / enrolment under MUHCS:

i. Offline registration / enrolment will be done at the sub-centre level where physical registration / enrolment forms will be filled manually.
ii. Document referred to in 1.2.2(ii) must be produced at the time of offline registration / enrolment.
iii. Duplicate offline registration / enrolment form will be sent to MSHCS from the Sub-Centres and data will be entered in the IT system.
iv. The physical registration / enrolment forms and supporting documents must be sent to MSHCS within a stipulated timeframe.

2. Premium Contribution by Beneficiaries

2.1 Contribution from AB PM-JAY beneficiary household.

No contribution from AB PM-JAY beneficiaries is required.

2.2 Premium from Contributory Beneficiaries

There will be three plan options for the contributory beneficiaries:

a) Option 1 (General Plan) – Premium of **₹2,500/-** per family per year that allows family to get benefit of ₹5,00,000/- per family per year in **General Ward**
b) Option 2 (Standard Plan) – Premium of **₹5,000/-** per family per year that allows family to get benefit of ₹5,00,000/- per family per year in **Semi-Private (shared) Ward**.
c) Option 3 (Private Plan) - Premium of **₹10,000/-** per family per year that allows family to get benefit of ₹5,00,000/- per family per year in **Private Ward**.

The options are summarized as given in the table below:

Plan Option	Premium amount (for 1 policy year)	Benefit cover	Room entitlement
GENERAL	₹2,500/-	₹5,00,000/- per family per year	General Ward
STANDARD	₹5,000/-	₹5,00,000/- per family per year	Semi Private (Shared) Ward
PRIVATE	₹10,000/-	₹5,00,000/- per family per year	Private Ward

Table 1

2.3 Contribution from Government Employees:

Each Government employee will be required to pay a monthly premium as per their Pay Level as given below:

Pay Level	Monthly Contribution	Room / Ward
13 & above	₹1,500/-	Notification for Room entitlement for hospitals will be issued by the Finance Department.
10-12	₹1,000/-	
6-9	₹700/-	
3-5	₹400/-	
1-2	₹300/-	
Provisional Employees (PE) / Muster Roll (MR)	₹200/-	General Ward

Table 2

For employees under MSHCS, the monthly premium contribution as per pay level and benefit coverage for Government Employees will be adopted.

2.4 Contribution from Civil Pensioners:

a) Civil pensioners will be categorized based on the amount of their monthly pension into Category A and Category B as detailed in the table below-

Category	Definition	Monthly Contribution	Benefit	Room / Ward
Category A	Monthly pension >= ₹20,000/-	₹1,000/-	₹12,00,000/- per family per year	Private Ward
Category B	Monthly pension < ₹20,000/-	₹500/-	₹5,00,000/- per family per year	Semi-Private Ward

Table 3

b) Civil pensioners under Category B can opt for benefits under category A by paying a contributory amount of ₹1,000/-. This option should be exercised within one month of implementation of MUHCS. New pensioners will also have to exercise the option within one month of their retirement.

c) Household having two / three pensioners will be eligible for double / triple amount of the Sum Assured respectively, their dependents can be split accordingly as per their convenience. If there is a pensioner and a Government Servant in a family, each will avail its own benefit, dependents can be split accordingly as per Government OM for a Government Employee and those not eligible for Government Employee dependents will be as dependent of the pensioner.

2.5. The amount payable for contribution for all categories of beneficiaries under MUHCS may be revised by the State Government from time to time.

3. Approval / Rejection by MSHCS

Request for MUHCS card generation may be approved or recommended for rejection by the State / ISA Approver. All applications recommended for rejection may further be scrutinized by MSHCS for final action.

4. Acceptance of Rejection Request by MSHCS

The MSHCS shall set up a team that reviews all the cases recommended for Rejection. The team shall review the data provided and the reason recommended for rejection. If the MSHCS agrees with the State / ISA Approver, it may reject the application, while if MSHCS disagrees, it may approve the application.

5. Printing of MUHCS Card

After verification and approval of application by the State / ISA / MSHCS Approver, MUHCS card will be generated with unique MUHCS ID. The MUHCS card may be printed and issued to the beneficiaries.

6. Updation of Beneficiary Details in MUHCS Card

A beneficiary may update his / her details viz., name, gender, date of birth, address, etc., in MUHCS card by redoing e-KYC with updated Aadhaar. A new card may be re-generated and printed after approval of updated details.

7. Addition of Family Members

Addition of new family members to an existing family under MUHCS can only occur under the following circumstances:

i. A new family member is added to Ration Card.
ii. A new family member list authorized by the Village Council / Local Council is produced for families without Ration Card.

8. Disabling MUHCS Card

MSHCS may disable a MUHCS card under the following circumstances:

i. Beneficiary opt out
ii. Impersonation
iii. Eligible under other schemes
iv. Deceased (Aadhaar locked)
v. Wrong approval by State / ISA / MSHCS Approver
vi. Confirmed fraud

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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 reformed 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 included for employees as well as the Civil Pensioners. MUHCS will improve efficiency, cost-effectiveness, quality of health care services, and enhance engagement with private sectors. Keeping in view the situation of the State, the following are the contours of the proposed scheme in the State.

1.1.3 MUHCS will initially cover all inpatient conditions with very few exceptions. MUHCS will have 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 will 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 Defined vertical programmes integration where benefits are overlapping will also be followed.

1.1.10 **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.

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

1.1.12 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. Public and private empanelled hospitals will utilise approved package rates to ensure provision of appropriate payment to the hospitals for treatment of beneficiaries.

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 is important in multiple aspects, approval of admissible claims, payment of correct amount to EHCP, genuine utilization of beneficiary's wallet, etc.

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. In MUHCS, 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 under MUHCS 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 under 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 under 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 shall 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 go. 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, wherever CPD is not able to take any decision 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:

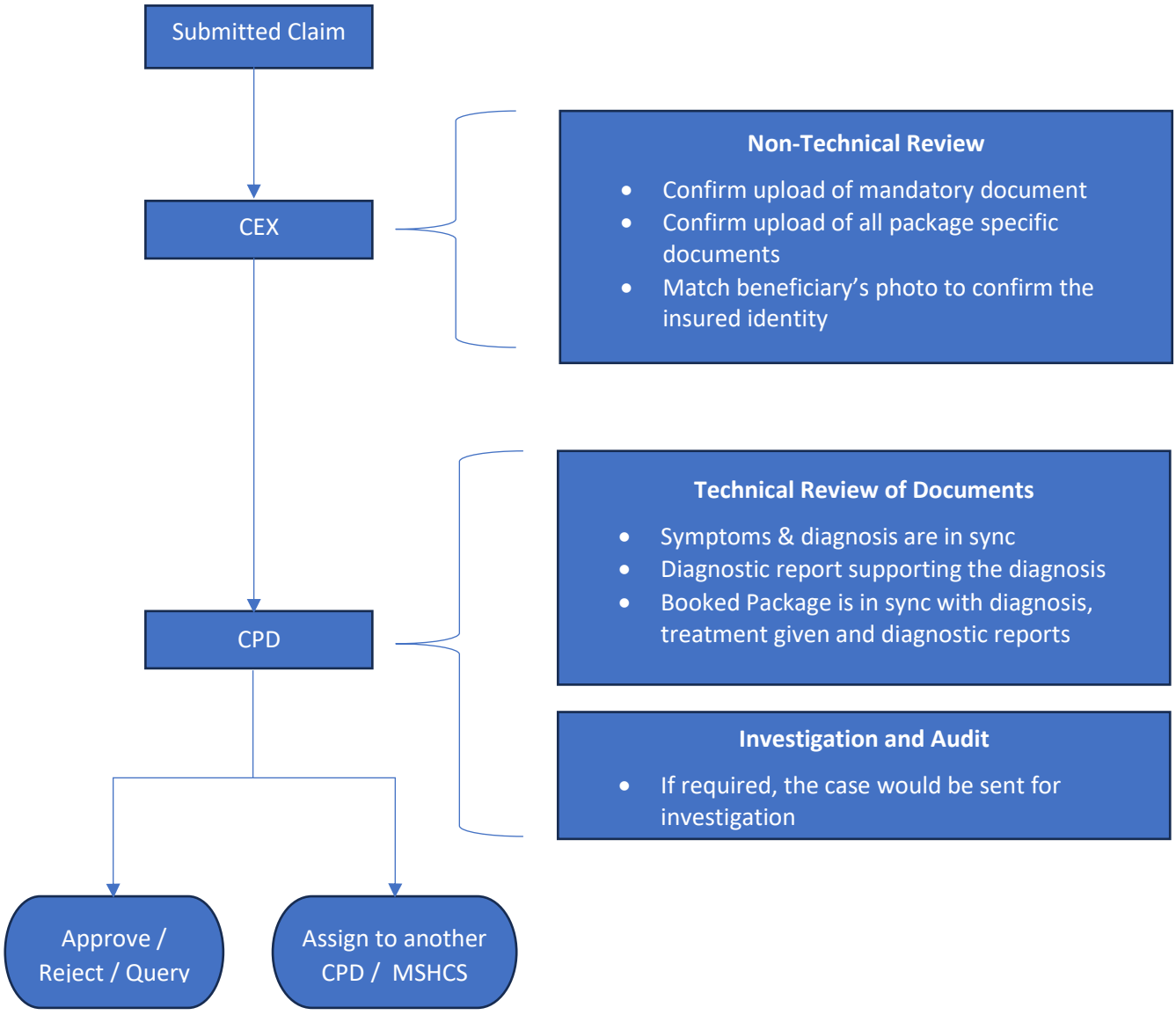

Figure 1: CEX and CPD actions

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 revoking, 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. Above 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 claims are found to be rejected incorrectly, the case will be revoked and send 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 that are 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

Once a beneficiary is admitted in an empanelled hospital, in normal course the beneficiary is discharged from the hospital after completion of treatment and when the beneficiary is in stable condition. 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 all cases irrespective of the fact whether pre-operative investigations have been done 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

As per MUHCS policy, treatment package includes complications arising out of surgery. However, in exceptional cases referral can be made from one empanelled hospital to another empanelled hospital and therein qualify for partial payment. The following scenarios shall be applicable for partial payment:

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 MUHCS beneficiaries are not 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 treatments.

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 under MUHCS 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. Package specific documents, as mandated under the guidelines is 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 the 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 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.

Sl.	Activities	TAT	Action
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.
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

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.

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Government of Mizoram

MIZORAM UNIVERSAL HEALTHCARE SCHEME (MUHCS)

Anti-Fraud Guidelines

Mizoram State Health Care Society

Department of Health & Family Welfare

2025

Contents

Abbreviations

CEO	Chief Executive Officer
CRC	Claims Review Committee
DVO	District Vigilance Officer
FIR	First Information Report
ICU	Intensive Care Unit
ISA	Implementing Support Agency
IT	Information Technology
LOS	Length of Stay
MMRC	Mortality and Morbidity Review Committee
OPD	Out Patient Department
MUHCS	Mizoram Universal HealthCare Scheme
MSHCS	Mizoram State Health Care Society
TPA	Third Party Administrator

Tables

1. Purpose and Scope

1.1 **Anti-Fraud Guidelines** for Mizoram Universal HealthCare Scheme (MUHCS) aimed at assisting the Government of Mizoram in designing and managing a robust anti-fraud system.

1.2 The scope of Anti-Fraud Guidelines covers prevention, detection and deterrence of different kinds of fraud that could occur at different stages of its implementation as can be elicited below:

Fraud Management Approaches	Stages of Implementation
Prevention	• Beneficiary identification and verification • Provider empanelment • Pre-authorisation
Detection	• Claims management • Monitoring • Audits
Deterrence	• Contract management • Enforcement of contractual provisions

Table 1: Scope of anti-fraud guidelines

1.3 The Anti-Fraud Guidelines sets out the mechanisms for fraud management and lays down the legal framework, institutional arrangements and capacity that will be necessary for implementing effective anti-fraud efforts.

1.4 Mizoram State Health Care Society (MSHCS) is the nodal agency for executing anti-fraud guidelines under MUHCS in the state of Mizoram.

2. Health Insurance Fraud under MUHCS

2.1 Principles

2.1.1 Any form of fraud under MUHCS is a violation of patients' right to health and misuse of publicresources.

2.1.2 MUHCS is governed based on a zero-tolerance approach to any kind of fraud and aims at detection, prevention and deterrence of fraudulent practices in all aspects of the scheme's governance. The approach to anti-fraud efforts shall be based on five founding principles: *Transparency*, *Accountability*, *Responsibility*, *Independence,* and *Reasonability*.

Understanding the terms:

i. ***Transparency*** shall mean public disclosure in decision making and in disclosinginformation as necessary in relation to fraud under MUHCS.

ii. ***Accountability*** shall mean clear functions, structures, systems and accountability forservices for effective management.

iii. ***Responsibility*** shall mean management conformity or compliance with soundorganizational principles for anti-fraud efforts under MUHCS.

iv. ***Independence*** shall mean a condition where MUHCS is managed professionally without conflict of interest and under no compulsion or pressure from any party.

v. ***Reasonability*** shall mean fair and equal treatment to fulfil stakeholders' rights arisingfrom agreements in anti-fraud efforts under MUHCS.

2.2 Definition of fraud under MUHCS

2.2.1 Fraud under MUHCS shall mean and include *any intentional deception, manipulation of facts and / or documents or misrepresentation made by a person*

or organization with the knowledge that the deception could result in unauthorized financial or other benefit to himself / herself or some other person or Organisation. It includes any act that may constitute fraud under any applicable law in India.

2.2.2 In addition to the above, any act (indicative list below) that is recognised by different provisions as *fraud* shall be deemed to be *fraud* under MUHCS:

a. Impersonation
b. Counterfeiting
c. Misappropriation
d. Criminal breach of trust
e. Cheating
f. Forgery
g. Falsification
h. Concealment

2.2.3 Human errors and waste are not included in the definition of fraud[1].

Indian Contract Act 1972, Section 17:

"Fraud" means and includes any of the following acts committed by a party to a contract, or with his connivance, or by his agent, with intent to deceive another party thereto of his agent, or to induce him to enter into the contract:

1. the suggestion, as a fact, of that which is not true, by one who does not believe it to be true.
2. the active concealment of a fact by one having knowledge or belief of the fact.
3. a promise made without any intention of performing it.
4. any other act fitted to deceive.
5. any such act or omission as the law specially declares to be fraudulent.

[1] '**Errors**' are un-intentional mistakes during the process of healthcare delivery (like prescribing wrong medications to a patient). '**Waste**' refers to unintentional inadvertent use of resources (prescribing high-cost medicines when generic versions are available). '**Abuse**' refers to those provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the MUHCS, or in reimbursement for services that are not medically necessary or that fail to meet professionally recognized standards for health care. It also includes beneficiary practices that result in unnecessary cost to the MUHCS. Whereas **fraud** is willful anddeliberate, involves financial gain, is done under false pretense and is illegal, **abuse** generally fails to meet oneor more of these criteria. The main purpose of both fraud and abuse is financial and non-financial gain. Few examples of common health insurance abuse would be - excessive diagnostic tests, extended length of stay and conversion of daycare procedure to overnight admission.

2.3 Types of fraud under MUHCS and who may conduct fraud

Fraud under MUHCS may be conducted by either a beneficiary, a provider or a payer. Each type offraud is described in the table below and illustrative examples for each type of fraud are listed in Annexure 1.

Fraud Type	Description
Beneficiary Fraud	Fraud conducted by an eligible beneficiary of MUHCS or an individual impersonating as a beneficiary.
Provider Fraud	Fraud conducted by any private or public health care provider empaneled for providing services under MUHCS.
Payer Fraud	Fraud conducted by an employee of MSHCS, or personnel employed by any of the agencies contracted by the MSHCS directly or indirectly involved with MUHCS. This could include but is not limited to Insurance Companies, Third Party Administrators, Implementing Support Agencies, IT solutions provider, and agencies responsible for management, monitoring or audit.

Table 2: Types of Fraud

3 Institutional Arrangements for Anti-Fraud Efforts

3.1 Dedicated Anti-Fraud Cell

3.1.1 **Mandate and functions**: The MSHCS shall constitute a dedicated Anti-Fraud cell at the state level. The mandate of the Anti-Fraud Cell shall be to:

a. Provide stewardship to the state level anti-fraud efforts under MUHCS.
b. Review and update the state anti-fraud framework and guidelines based on emerging trends for service utilisation and monitoring data.
c. Capacity building on anti-fraud measures under MUHCS including field verification and investigations.
d. Liaise with the IT team / agency to ensure that the IT platform is periodically updated withfraud triggers based on review of trends.
e. Liaise with the monitoring unit of the MSHCS for triangulating fraud related data analytics with the overall service utilisation trends emerging under MUHCS.
f. Provide evidence-based insights to the MSHCS on trends emerging from state-specific fraud data analytics.
g. Handle all fraud related complaints that MSHCS may receive and liaise with other units of MSHCS, especially the monitoring and audit units.
h. Take *Suo moto* action based on *prima facie* evidence as deemed appropriate.
i. Undertake fraud investigations as required, prepare investigation reports that can standlegal scrutiny if needed, file First Information Report (FIR) with the police as needed, navigate the legal system, pursue recovery and all other tasks related fraud investigation and follow up actions, including notice to treating doctors (if required), etc.
j. Incentivise internal team/outsourced agency involved in fraud management based onperformance (if applicable).
k. Publish data on utilization, claim rejection, suspension, de-empanelment, etc.

3.1.2 **Location and structure of the anti-fraud cell**: The state Anti-Fraud Cell should:

a. Be an independent unit in the MSHCS reporting directly to CEO, MSHCS.
b. Be headed by an Officer who reports directly to CEO, MSHCS.
c. Recommended staffing pattern for the Anti-Fraud Cell under the Insurance, Assurance, and mixed (both insurance and assurance) modes: (Table 3)

State level Anti-Fraud staff	Insurance Mode	Assurance and Mixed Mode
Head	1	1
Officer(s)	1	1
District & facility level staff		
District Vigilance Officer(s)	1 in each district	1 in each district

Table 3: State Anti-fraud Unit

d. To avoid possibilities of collusion, it is recommended that the District Vigilance Officers be directly recruited by the MSHCS.

Refer to *Annexure 3* for organogram of the Anti-Fraud Cell in the MSHCS and indicative terms of reference for various positions.

3.2 Core competencies in the Anti-Fraud Cells

The Anti-Fraud Cell should have the following minimum core competencies and skills:

a. Legal skills
b. Case investigation skills
c. Claims processing
d. Medical specialist
e. Medical audit

3.3 Leveraging existing health department structures to strengthen anti-fraud efforts

3.3.1 It is important to integrate and institutionalize anti-fraud efforts within the Department of Health & Family Welfare.

3.3.2 MSHCS may sought the feasibility to coordinate with existing governance and monitoring structures such as the District Health Societies, office of the Senior Chief Medical Officers or the District Medical Superintendents or their counterparts, structures at the block level and sub-divisional level such as CHC/PHC/SDH/UPHC.

3.3.3 Other medium of redressal mechanisms in force under the Government can be utilized for reporting unethical / fraudulent practices / behaviour.

3.4 Operations and management of the Anti-Fraud Cell at the State Level

3.4.1 **Nodal responsibility**: The Head of the Anti-Fraud Cell shall be the nodal person responsiblefor all anti-fraud efforts within the state.

3.4.2 **Annual action plan**: The Anti-Fraud Cell may propose an annual anti-fraud action plan which may include but not be limited to:

a. Statement detailing detected fraud cases with like the agency / individual committing fraud, type of fraud, time taken for detecting and proving the fraud, update on action- taken reports filed and pending and relevant other details.
b. Typology of fraud detected in the last financial year and disaggregation of cases by types of fraud.
c. Any new strategies that may need to be adopted based on the analysis of last year's fraud data.
d. Additional capacity need, if any.

3.4.3 **Review of anti-fraud efforts**: Apart from review meetings conducted as and when required, the Anti- Fraud Cell shall ensure at least a quarterly structured anti-fraud meeting with the MSHCS management team. Alternately, anti-fraud efforts review could feature as a part of the ongoing review meetings of the MSHCS. All discussions and decisions thereof should be minuted and the head of the Anti-Fraud Cell shall ensure follow-up actions as per decisions taken.

4 Anti-Fraud Measures under MUHCS

4.1 Fraud prevention

4.1.1 **Referral protocols for benefits that are more prone to fraud and abuse**: Procedure or certain benefits under MUHCS that are more prone to fraud may either be reserved only for empaneled public providers or can be availed only on referral from a public provider. The existing portability procedures under MUHCS is to be followed, i.e., Medical Referral Board approval shall be mandatory for all portability cases.

4.1.2 **Ensure that all contracts signed by MSHCS with any party (Insurer, ISA, TPA, provider, IT agency, etc.) have adequate anti-fraud provisions that are enforceable:** The MSHCS should ensure that all model contracts of MSHCS have a clear definition of abuse and fraud, what constitutes abuse and fraud and what are their consequences. Liabilities of different parties concerned should be clearly mentioned in the terms of the contract. The MSHCS should ensure that the contracts have adequate dis-incentives and penalties for abuse and fraud.

4.1.3 **Beneficiary identification / verification:** The MSHCS and its affiliates shall ensure strict compliance to MUHCS guidelines for beneficiary verification. For beneficiary fraud prevention, the Anti-Fraud Cell may audit records of pending and verified beneficiaries under Beneficiary Identification System.

4.2 Fraud detection

4.2.1 **Claims management**

a. The MSHCS shall ensure strict compliance to MUHCS guidelines for claims management.
b. Claim data analysis for early detection of fraud may be conducted by the Anti-Fraud Cell.
c. Such claim data analysis shall be conducted through the following approaches:
    i. Identifying data anomalies trigger based and rule-based analysis.
    ii. Advanced algorithms for fraud detection, predictive / regression based, and machine learning models and other advanced data analytics reports received by the MSHCS from relevant government agencies.
d. In conducting claim data analysis, the Anti-Fraud Cell may coordinate with the medical audit team, claims processors and adjudicators in the TPA / ISA / MSHCS or the CRC / MMRC and other parties as necessary.

4.2.2 **Fraud detection during routine monitoring and verification:** The key to an effective fraud and abuse detection is to gather information on provider performance. The Anti-Fraud Cell within MSHCS should combine the following techniques to detect fraud:

a. Data analysis comparing providers on such indices as utilization, performance, outcomes, referrals, de-empanelment, followed by focused reviews on areas of aberrancy.
b. Routine reviews on particular problem areas.
c. Routine validation of provider data.
d. Random reviews and beneficiary interviews.
e. Unannounced site visits; and
f. Use of feedback and quality improvement.

4.2.3 **Comparative analysis:** The Anti-Fraud Cell may elect to perform a comparison of empanelled providers within districts or state-wide. Individual patterns of providers may not be significantly unusual but the cumulative pattern within a provider may require further review. It is recommended that the MSHCS data systems be used to identify benefit utilization patterns that may assist in the case development and in the review.

4.2.4 **Routine reviews on problem areas:** As part of fraud and abuse detection strategy, the Anti-Fraud Cell may identify areas of focus that receive special attention during routine monitoring of provider activities. These areas should be identified through systematic risk assessment, and could include, but not be limited to, items such as:

a. ensuring that providers within networks are eligible to participate in MUHCS.
b. ensuring the authenticity of enrolled beneficiaries.
c. ensuring that provider employees understand MUHCS guidelines, can define fraud and know where, how, and when to report a fraud or potential fraud.

4.2.5 **Random reviews and beneficiary interviews:** MSHCS and its affiliates may plan for a minimum level of random reviews, in which a selected universe of beneficiaries is contacted for interviews. Medical records should also be reviewed to identify any possible errors or evidence of abuseand/or fraud. All such reviews shall be as per the guidelines issued by the MSHCS from time to time.

4.2.6 **Unannounced site visits:** Monitoring plans of MSHCS and its affiliates should include unannounced provider visits, particularly to those providers for which some significant concerns exist. During unannounced provider visits, auditor can observe encounters, interview beneficiaries or employees, confirm the accuracy of facility-based information, and/or review records.

4.2.7 **Use of feedback and quality improvement:** The results of reviews (including feedback) and investigations should be used to improve MUHCS implementation systems. The goal is to prevent fraud and abuse from recurring. This use of feedback is integral to MUHCS quality improvement.

4.3 Guidelines for deterrence

4.3.1 Sound contract management, prompt action, speedy adjudication and strict enforcement of penalties and contractual provisions act as strong deterrence for fraud.

4.3.2 To enable the MSHCS to take firm actions against fraud, MSHCS may consider stringent penalties and firm disciplinary actions.

4.3.3 Public disclosure of providers who have engaged in fraudulent activities may act as a deterrent.

4.3.4 The MSHCS may demand the providers to take firm action including issuing warnings and showcause notices to treating doctors found indulging in unethical practices.

4.4 Monitoring effectiveness of anti-fraud measures

4.4.1 Periodic review of anti-fraud measures is required to improve the quality of the measures and to ensure that the anti-fraud efforts remain responsive and robust. A set of illustrative indicators for measuring the effectiveness of anti-fraud measures is provided in Annexure 4. The MSHCS is at liberty to add more indicators as required.

4.4.2 The Anti-Fraud Cell may set up mechanisms of quarterly reporting against these indicators and recommend corrective measures to the CEO, MSHCS.

5 Use of IT in Anti-Fraud Efforts

5.1 Fraud triggers: The IT infrastructure should have a comprehensive automated fraud trigger alerts based on basic outlier analysis and rule-based analysis.A list of illustrative fraud triggers is provided in Annexure 2. It is recommended that the Anti-Fraud Cell should constantly review the list of triggers in coordination with the Monitoring and Evaluation unit and the Audit unit of the MSHCS and the IT platform be constantly updated with new triggers as required.

5.2 Data mining and analytics: The IT infrastructure set up by the MSHCS is expected to have at least the basic fraud data analytics that allows for rule-based and outlier-based analysis. The MSHCS may engage an external agency for advanced analytics that may include predictive modelling regression techniques and use of social network analysis. Data analytics shall include retrospective and prospective analysis approaches. Whereas retrospective analysis will help identify patterns of fraudulent behaviour based on historical information, prospective analysis will analyse current data on a case-by-case basis to determine the legitimacy of claims.

5.3 Automated tools to assist in fraud management: The IT platform shall have automated security layers and tools to prevent fraud. Security within data processing systems, segregation of responsibilities to prevent conflict of interest and ensure internal checks and balances, passwords and confidentiality policy are important to prevent fraud. This also includes development and use of a unique provider identification mechanism through which claims submitted electronically may be traced to their origin.

6 Managing Fraud Complaints

6.1 Fraud under MUHCS may either be detected internally by the Anti-Fraud Cell or may be externally reported. Sources of information and mechanism of reporting are highlighted below:

Internal Detection Sources	External Reporting
• Audit reports • Monitoring reports • Filed visit reports • Routine validation of provider data • Random reviews and beneficiary interviews • Unannounced site visits • Use of feedback • Data analytics dashboard	• From any individual or agency irrespective of their engagement with the beneficiaries. • In writing through email / letter to the MSHCS • On MUHCS helpline / call-centre. • On grievance redressal helplines, if any, set up under the Chief Minister's office. • Direct confrontation / information through other media.

6.2 MSHCS shall ensure that the identity of those filing grievances related to suspected fraud shall be kept confidential until the investigation is completed, and it is ascertained that fraud has been committed. On receipt of any complaint related to suspected fraud, the Anti-Fraud Cell shall promptly initiate action as follows:

a. Designate a nodal person to lead the enquiry and management of the case.

b. Within 48 hours, undertake preliminary examination to make a prima facie assessment. For a prima facie assessment, the Anti-Fraud Cell should analyse available data to create a hypothesis and test it against available facts to arrive at a reasonably certain prima facie conclusion that an act of fraud may have been conducted.

c. If there is prima facie evidence of fraud, the Anti-Fraud Cell shall take all measures required to initiate detailed investigation.

d. For detailed investigation, the Anti-Fraud Cell shall constitute an investigation team that will be headed by the concerned District Vigilance Officer. The head of the investigation team shall report to the Chief Executive Officer (CEO) of MSHCS. Other members of the investigation team may include members of the medical audit team, monitoring and evaluation team, district level staff as deemed appropriate by CEO, MSHCS. The CEO may, at his / her sole discretion, decide on the inclusion of staff from the ISA / TPA in the investigation team.

e. The investigation team shall undertake a thorough assessment which may include but not be limited to on-site enquiry, verification of original records, verbal examination of concerned individuals, and submit a detailed investigation report to the CEO within 7 working days. The investigation report shall at the minimum include all details of the occurrence of fraud found; recommendations to prevent similar future reoccurrence; and recommendations to impose sanctions on fraud actors.

f. If the investigation report confirms fraud, the MSHCS may issue a show-cause notice to the accused entity providing it within 7 working days to respond to the allegations and provide justification.

g. Following the principles of Natural Justice, the Anti-Fraud Cell shall, within 2 weeks of receiving the response from the accused, communicate its final decision in the matter.

7 Recoveries and Penalties Post Confirmation of Fraud

One or more of the following actions may be taken against the EHCP which has been found to commit fraud:

7.1 MSHCS may execute the following actions based on the severity of offence committed.

7.1.1 **Recovery of amount including penalties from EHCP:** Once it is confirmed that the EHCP has been indulging in fraudulent practices, recovery of excess amount paid for fraudulent claims to EHCP may be recovered by MSHCS. As recommended by MSHCS, SAA may levy additional penalties to the EHCP.

7.1.2 **Issuance of 'Show cause' to EHCP:** Based on the audit of the EHCP, if MSHCS believes that there is clear evidence of EHCP indulging in fraudulent practices.

7.1.3 **Suspension of EHCP:** For the EHCPs which have been issued show cause notice or if the MSHCS observes at any stage that it has data/ evidence that suggests that the EHCP is involved in any fraudulent practices, MSHCS may recommend for suspension of EHCP to relevant authority.

7.1.4 **De-empanelment of EHCP:** If the formal investigation conducted confirms that the EHCP is indeed indulging in fraudulent practices, MSHCS may recommend for de-empanelment of EHCP to relevant authority.

7.2 Action under Criminal Law: The criminal case (FIR) may be filed against the concerned under the relevant provisions of the applicable law.

7.3 No appeal or revision against the order of recovery may be entertained by the competent authority unless minimum 50% of the amount ordered to be recovered is deposited by the EHCP.

7.4 Legal and punitive action against the beneficiary using fraudulent means to get treatment (as defined in Annexure 1 – Types of Fraud)

7.4.1 Cancellation of MUHCS Card and blacklisting the beneficiary and the entire family.

7.4.2 Lodging a FIR with the local police authority

7.4.3 Collecting the entire treatment cost in cash

Annexure 1: Types of Fraud – Some examples

Beneficiary Fraud

a. Making a false statement of eligibility to access health services.
b. Knowingly allowing impersonation / identity theft in own name by another person to access health services.
c. Using their rights to access unnecessary services by falsifying their health conditions.
d. Giving gratifications / bribes to service providers for receiving benefits that are excluded/uncovered under MUHCS.
e. Engaging in a conspiracy with service providers to submit false claims.
f. Knowingly receiving prescribed medicines and/or medical devices for resale.

Provider Fraud

a. Getting empanelled through manipulation of records or service/facilities etc.
b. Manipulating / fudging claims for services covered under other state schemes and interventions and paid out of state budget.
c. Staff of public providers receiving some payment/commission/referral fees from private empanelled providers for referral of beneficiaries.
d. Giving beneficiaries an inappropriate referral in order to gain a particular advantage.
e. Delays in scheduling treatment in anticipation of financial gain from beneficiaries or luring beneficiaries of preferential and early treatment in lieu of bribes.
f. Collecting unauthorized fees from beneficiaries.
g. Diagnosis / Package upcoding (change of diagnosis code and/or procedure to a code of higher rate) and procedure code substitution.
h. Cloning of claims from other patients (duplication of claims from other patients' claims).
i. Phantom visit (claim for patients' false visit).
j. Phantom procedures (claim for procedures never performed).
k. Phantom billing (claim for services never provided).
l. Services unbundling or fragmentation (claim for two or more diagnosis and/or procedures that should be in one service package in the same episode or separate claims for a procedure that should be submitted in one service package in order to produce a larger amount of claims in one episode).
m. Duplicate/repeated billing (claim repeated for the same case).
n. Cancelled services (claim for services that are cancelled).
o. Measures of no medical value (claim for measures taken inconsistent with medical needs or indications).
p. Unnecessary treatment and/or medically inappropriate treatment.
q. Provision of counterfeit medicines.
r. Indulge in unethical practices not permissible under guidelines of State Medical Council for medical practitioners or Clinical Establishment Act or under any other law of land or established medical norms, whether leading to patient harm, future health endangerment of member or not.

Payer Fraud

a. Engaging in a conspiracy with health facilities to falsify information with the aim of meeting empanelment criteria/becoming empanelled under MUHCS.
b. Engaging in a conspiracy with beneficiaries and/or service providers to submit false claims.
c. Manipulating beneficiary list/covered members list.
d. Manipulating uncovered benefits into covered benefits.
e. Withholding legitimate claims payments to service providers to take personal advantage.
f. Not acting against complaints of fraud received against provider(s).

Note: Reference to 'any of the agencies contracted by the MSHCS directly or indirectly involved with MUHCS' in this para include but are not limited to Insurance Companies, Third Party Administrators, Implementation Support Agencies, IT solutions provider, management consultants /agencies, and monitoring and audit agencies.

Annexure 2: Fraud Triggers

Claim History Triggers

a. Impersonation.
b. Mismatch of in-house document with submitted documents.
c. Second claim in the same year for an acute medical illness/surgical.
d. Claims from multiple hospitals with same owner.
e. Claims for hospitalization at a hospital already identified on a "watch" list or blacklisted hospital.
f. Claims from members with no claim free years, i.e., regular claim history.
g. Same beneficiary claimed in multiple places at the same time.
h. Excessive utilization by a specific member belonging to the beneficiary Family Unit.
i. Deliberate blocking of higher-priced package rates to claim higher amounts.
j. Claims with incomplete/ poor medical history: complaints/ presenting symptoms not mentioned, only line of treatment given, supporting documentation vague or insufficient.
k. Claims with missing information like post-operative histopathology reports, surgical / anaesthetist notes missing in surgical cases.
l. Multiple claims with repeated hospitalization (under a specific policy at different hospitals or at one hospital of one member of the beneficiary family unit and different hospitals for other members of the beneficiary family unit)
m. Multiple claims towards the end of policy cover period, close proximity of claims.

Admissions Specific Triggers

a. Members of the same beneficiary family getting admitted and discharged together.
b. High number of admissions.
c. Repeated admissions.
d. Repeated admissions of members of the same beneficiary family unit.
e. Admission beyond capacity of hospital.
f. Average admission is beyond bed capacity of the provider in a month.
g. Excessive ICU (Intensive Care Unit) admission.
h. High number of admissions at the end of the Policy Cover Period.
i. Claims for medical management admission for exactly 24 hours to cover OPD treatment, expensive investigations.
j. Claims with Length of Stay (LOS) which is in significant variance with the average LOS for aparticular ailment.

Diagnosis Specific Triggers

a. Diagnosis and treatment contradict each other.
b. Ailment and gender mismatch.
c. Ailment and age mismatch.
d. One-time procedure reported many times.
e. Treatment for which an Empanelled Health Care Provider is not equipped or empanelled for.
f. ICU/ Medical Treatment blocking done for more than 5 days of stay, other than in the case of critical illnesses.

Billing and Tariff based Triggers

a. High value claim from a small hospital/nursing home, not consistent with ailment and/or provider profile.

General

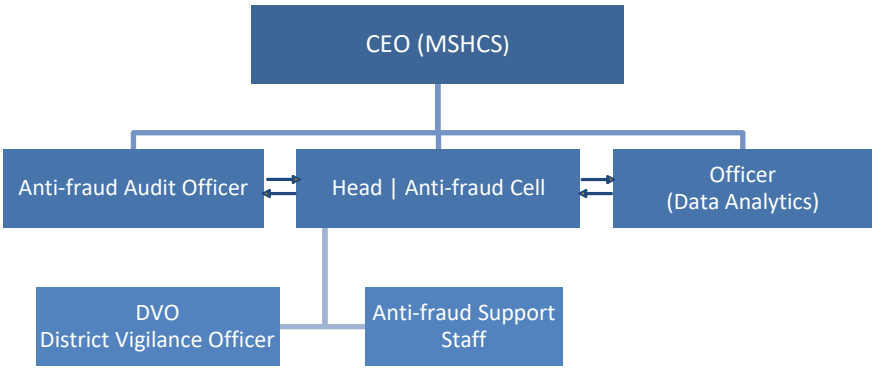
a. Qualification of practitioner doesn't match treatment.
b. Delayed information of claim details to the Insurer.

Annexure 3: Anti-Fraud Cell – Structure and Composition

At the Mizoram State Health Care Society (MSHCS)

For MSHCS, it is proposed to have a combined unit for Anti-fraud, medical audit and vigilance at the state level and to have Vigilance Officers at district level. The structure in MSHCS is proposed to remain same.

ORGANOGRAM OF THE ANTI-FRAUD CELL (MSHCS)



Recommended Positions, skills and key responsibilities:

State Level

Position	Education and skill set	Key responsibilities
Head – Anti fraud, vigilance and legal	- Medical Graduate (MBBS) - 5 years' experience, desirable. - Senior officials engaged in health insurance schemes implementation / hospital / social schemes implementation. - Good communication skills, analytical, investigative and forensics capabilities. - To carry out action – penalty, de-empanelment, prosecution, and other deterrent measures as per anti-fraud guidelines.	- To implement anti-fraud management guidelines laid down by MSHCS and additionally design/implement state specific guidelines, enforce contracts. - To guide, mentor and oversee District Vigilance officers, conduct training programmes. - To work with medical audit and analytics team for ensuring prompt and effective investigation of all suspect cases with collection of documentary evidence. - To develop anti-fraud messaging and public awareness campaigns in local languages along with the communication team, liaise with other state level regulatory bodies for concerted action, local officials, communities for intelligence. - To establish whistle blower mechanism. - To carry out surprise inspection - To carry out action – penalty, de-empanelment, prosecution, and other deterrent measures, etc. as per guidelines against fraudsters

Data Analytics Officer	- Graduate - 5 years, preferably in MIS, reporting in volume business industry / health schemes. - Basic knowledge of Computer application equivalent to Course on Computer Concepts (CCC) of National Institute of Electronics and Information Technology (NIELIT) or Diploma in Computer Application / Certificate in Computer Application from institutions recognised by the Mizoram State Council of Technical Education (MSCTE). - MIS and reporting	- To apply fraud triggers to all transactions on daily basis and share report with Medical audit and Vigilance team. - Update triggers in the system based on new information. - To manage, organize and analyze state level data, compare utilization, average movement, length of stay, outlier cases etc. across providers, districts at micro and macro level. - To publish dashboard pertaining to anti-fraud work.

District Level

Position	Education and skill set	Key responsibilities
District Vigilance Officer	- Graduate. - 3 years, preferably investigation related field jobs. - Good communication skills, sharp and investigative mindset. - Knowledge of hospital billing practices desirable.	- To carry out field investigationof assigned cases within timeline, collecting documentary evidence. - To collect market intelligence reports discretely. - To carry out any other assigned tasks relating to anti-fraud management.
Anti-fraud support staff	- Graduate. - 5 years' experience in health claims processing/audit, desirable. - Knowledge of medical protocols, clinical pathways and standard treatment guidelines. - Operational knowledge of hospital functioning and billing practices.	- To carry out medical audit as per guidelines incorporating state specific practices - To analyze transactions data from medical perspective and highlight outlier/suspect/variant cases for further investigation. - To support investigation team for appropriate probing of suspect cases.

Annexure 4: Measuring Effectiveness of Anti-Fraud Efforts

1. Share of pre-authorization rejected
2. Share of pre-authorization and claims audited
3. Claim repudiation / denial / disallowance ratio
4. Reduction in number of enhancements requested per 100 claims
5. Number of providers de-empanelled
6. Instances of single disease dominating a geographical area are reduced
7. Disease utilization rates correlate more with the community incidence
8. Number of enquiries reports against hospitals
9. Number of enquiries reports against own staff
10. Number of FIRs filed
11. Incidence rate of detected fraud
12. Percent of pre-authorizations audited
13. Percent of post-payment claims audited
14. Fraudulent claims as a share of total claims processed
15. Number of staff removed or replaced due to confirmed fraud
16. Number of actions taken against confirmed fraudulent hospitals in a given time period
17. Amount recovered as a share of total claims paid
18. Share of red flag cases per 100 claims
19. Number of frauds reported on helplines
20. Movement of averages: claim size, length of stay, etc.

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Government of Mizoram

MIZORAM UNIVERSAL HEALTHCARE SCHEME (MUHCS)

Grievance Redressal Guidelines

Mizoram State Health Care Society

Department of Health & Family Welfare

2025

Contents

Abbreviations

ATA	Action Taking Authority
DGNO	District Grievance Nodal Officer
DGRC	District Grievance Redressal Committee
GRC	Grievance Redressal Committee
ISA	Implementing Support Agency
MSHCS	Mizoram State Health Care Society
MUHCS	Mizoram Universal HealthCare Scheme
SAA	State Appellate Authority
SGNO	State Grievance Nodal Officer
SGRC	State Grievance Redressal Committee
SMS	Short Message Service
SNA	State Nodal Agency
TPA	Third Party Administrator

Executive Summary

A Grievance Redressal Mechanism as a multi-tier system at District and State level would be a robust process to redress the grievances received in state of Mizoram under MUHCS. District Grievance Redressal Committee (DGRC) is the nodal authority at the district level and State Grievance Redressal Committee (SGRC) and State Appellate Authority (SAA) at the state level. State Appellate Authority (SAA) will be the final appellate authority for handling and resolution of all grievances received either directly or escalated through the DGRC. At each level, there is a dedicated nodal officer viz. District Grievance Nodal Officer (DGNO) and State Grievance Nodal Officer (SGNO).

The ERP solution for MUHCS has an integrated online Grievance redressal system. The nodal officers are responsible to resolve grievances as per the defined turn-around time. Complainants can track the status of their grievance using the Unique Grievance Number which is generated at the time of registration. The status update will be intimated to the complainant through automated e-mail system and/or SMS notification. For efficient and timely redressal of the grievances, automated intimation is also enabled for the nodal officers through e-mail and/or SMS. The cases which are unresolved by the concerned nodal officer are automatically escalated to the higher authority. If any party is not satisfied with the decision of the concerned nodal officer or committee, the case is escalated to the next higher-level committee for further action.

This document describes the structure of the various committees, modes of grievance registration, mechanism of grievance redressal and reporting system. Additionally, the document also provides a matrix explaining types of grievances, escalation levels, and TAT (Turn Around Time) to ensure effective resolution of the grievances.

1. Introduction

Mizoram Universal HealthCare Scheme (MUHCS) will cover all bona fide residents of Mizoram 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 include existing health scheme for Government employees as well as Civil pensioners with special conditions. MUHCS will be implemented in cashless and paperless manner in all empanelled public and private hospitals.

The state government has established an effective multi-tiered redressal mechanism via Central Grievance Redressal Management System (CGRMS) and Grievance Redressal Guidelines.

2. Objectives of the Grievance Redressal System

To ensure that grievances of all stakeholders are redressed within the given time frame up to the satisfaction of the aggrieved party based on the principles of natural justice while ensuring that cashless access to timely and quality care remains uncompromised.

3. Grievance Types and who can file Grievances

3.1 Grievances can be filed by any stakeholder, for this purpose, a stakeholder includes:

i. Any MUHCS beneficiary
ii. Empanelled or De-empanelled Healthcare Provider
iii. Implementing Support Agency (ISA)
iv. Any other intermediary appointed by the MSHCS (if applicable)
v. MSHCS or its employees or nominated functionaries for implementation of MUHCS
vi. Any other person having an interest and participating in the implementation of MUHCS.

3.2 Any person who may have observations, comments or feedback on any aspect of the scheme, may also file a complaint along with specific details. Vague comments/feedback which are not actionable shall not be entertained/accepted.

3.3 Illustrative and indicative list of grievances is given in the Grievance Redressal Matrix (refer to Annexure 1 in this document)

4. Grievance Redressal Structure and Authorities

MUHCS has a multi-tier grievance redressal structure to ensure timely redressal of grievances. This section of the guidelines lays down these structures, their constitution, and functions.

4.1 District Grievance Redressal Committee

A District Grievance Redressal Committee (DGRC) will be constituted by the MSHCS in each district.

4.1.1 Constitution of the DGRC

i. The Deputy Commissioner will be the Chairman of the DGRC;
ii. The District Senior Chief Medical Officer (Senior CMO) or equivalent rank officer shall be the Convener of DGRC;
iii. The District Grievance Nodal Officer (DGNO) which may be the District Coordinator, MSHCS;
iv. District Coordinator of the ISA who shall be a member of DGRC
v. The DGRC may invite other experts for their inputs for specific cases, if necessity arises.

4.1.2 Functions of the DGRC

The DGRC shall perform all functions related to handling and resolution of grievances within their respective districts. In general, day to day redressal of complaints such as, issues related to the entitlement, or any other MUHCS related issue against the EHCP, its representatives or any functionary, should be done by DGNO. He/ She need not wait for the meeting of the DGRC to take place to initiate an enquiry or action, as expected in the case. He/ She should however keep his / her authorities informed about the inquiry. Regular operational issues should be handled by him / her so that beneficiaries / hospitals / stakeholders do not face any inconvenience or problem. Any serious complaints which warrant action against a person/institution, he / she should submit a report including his observations to DGRC for decision/action.

The specific functions of DGRC shall include:

i. Track and redress all grievances referred to it, following the principles of natural justice

ii. Call for additional information as and when required either directly from an aggrieved party or from the concerned agencies / individuals

iii. Conduct grievance redressal proceedings as required

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

v. Adjudicate and issue final orders on grievances

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

vii. Review grievance records

viii. Monitor the grievances to ensure that all grievances are resolved within 30 days or earlier

ix. DGRC shall be competent to seek report or assistance of any authority in the districtto take suitable action as deemed appropriate

x. Issue directions/take action like recommending de-empanelment of the hospitals, recommending suspension of license of the hospitals, etc. Principles of natural justice should be followed while taking such actions

xi. In case the DGRC is unable to conduct the meeting in foreseeable future, the Chairman or an officer authorized by the Chairman in this regard may take any of the above actions. However, such actions should be placed in front of the Committee during the next meeting for ratification

xii. Ensure compliance to the Grievance Redressal Guidelines of MUHCS

4.2 State Grievance Redressal Committee

The State Grievance Redressal Committee (SGRC) should be constituted by the MSHCS at the state level.

4.2.1 Constitution of the SGRC

i. CEO of SHA / State Nodal Agency (SNA) shall be the Chairman of the SGRC.
ii. Deputy Chief Executive Officer, MSHCS- Member
iii. The State Grievance Nodal Officer (SGNO) of the SHA shall be the Convener of SGRC.
iv. Medical Superintendent of the leading state level Government hospital or the Dean of the leading medical college in the State - Member
v. Director of Finance/State Accounts Officer, MSHCS- Member
vi. Representatives of the State Nodal Agency: Programme Manager, Officer in charge of claims and Officer in charge of service quality– Members
vii. State Coordinator of Insurance Company (if applicable)- Member
viii. Representative from ISA (Implementing Support Agency)/TPA (Third party Administrator)- Member
ix. Other experts for specific cases as determined by the Chairperson or the Convener on behalf of the Chairperson.
x. Representative from Federation of Mizoram Government Employee and Workers (FMGE&W) (as and when applicable)
xi. Aggrieved party (as and when applicable)
xii. Representative from hospital against which grievance is submitted by aggrieved party (as and when applicable).

4.2.2 Functions of the SGRC

The SGRC shall perform all functions related to handling and resolution of all grievances received either directly or escalated through the DGRC. When beneficiary is one of the parties, the decision of the SGRC shall be final. The specific functions shall include:

i. Act as an Appellate Authority for appealing against the orders of the DGRC
ii. Track and redress all grievances referred to it, following the principles of natural justice
iii. Call for additional information as required either directly from an aggrieved party or from the concerned agencies / individuals
iv. Conduct grievance redressal proceedings as required
v. Nominate District Grievance Nodal Officer (DGNO) at each District
vi. Oversee grievance redressal functions of the DGRC including but not limited to monitoring the turnaround time for grievance redressal
vii. Perform all tasks necessary to decide on all such appeals within 30 days of receiving such appeal
viii. Adjudicate and issue final orders on grievances
ix. Ensure compliance to the Grievance Redressal Guidelines of MUHCS

4.2.3. For any appeal escalated to the SGRC, the SGRC at its sole discretion may assign the task of investigation of the grievance to the independent agency or any official as and when necessary.

4.2.4. Complaints/grievances/appeals received against the orders of SGRC shall be filed directly to State Appellate Authority.

4.2.5. Complaints/grievances received against any of the officials of the SNA shall be referred to the State Appellate Authority.

4.3 State Appellate Authority (SAA)

Principal Secretary/Commissioner & Secretary (H&FW) shall function as the State Appellate Authority (SAA) for implementation of MUHCS.

4.3.1 Functions of SAA

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

i. Act as an Appellate Authority for appeal against the orders of the SGRC
ii. Redressal of all grievances referred to it, following the principles of natural justice
iii. Call for additional information as required either directly from an aggrieved party or from the concerned agencies / individuals
iv. Oversee grievance redressal functions of the SGRC including but not limited to monitoring the turnaround time for grievance redressal
v. Perform all tasks necessary to decide on all appeals received within 30 days
vi. Adjudicate and issue final orders on grievances
vii. For any appeal escalated to the SAA, the SAA may at its sole discretion assign the task of investigation of the grievance to the independent agency or any official as and when necessary.
viii. The decision of SAA shall be final and binding wherein SNA and Insurance/ISA are the aggrieved parties.

4.4 Grievance Officer

4.4.1. District Grievance Nodal Officer (DGNO)

DGNO is a person who is nominated by SGRC to resolve the grievances under MUCHS at the district level. The roles and responsibilities of DGNO shall be as listed below:

i. Addressing grievances of stakeholders directly or through DGRC within the defined time frame.
ii. Ratifying the actions taken against the grievances by placing in the DGRC from time to time.
iii. Enter the particulars of the grievance which are received directly, telephonically, through letter, email or social media on the CGRMS portal.
iv. Initiating enquiries whenever felt necessary with the approval of Convener, DGRC or any other official nominated.
v. Referring grievances to convener of DGRC
vi. Forwarding grievances to concerned SGNO/SGRC in case the grievance doesn't fall under his/her jurisdiction
vii. Submitting reports and records

4.4.2. State Grievance Nodal Officer (SGNO)

SGNO is a person who is nominated by the MSHCS to address the grievances at state level under MUHCS. The roles and responsibilities of the SGNO shall be as listed below:

i. Addressing grievances of stakeholders directly or through SGRC within the defined time frame.
ii. Giving priority to the grievances that are of emergent nature

iii. Ratifying the actions taken against the grievances by placing them in the SGRC from time to time
iv. Forwarding the grievances which are received at state level to the concerned DGNO for further action.
v. Referring grievances to Chairman of SGRC
vi. Monitoring and ensuring grievances are resolved within the time frame at State & District Level
vii. Submitting reports and records

5. Meeting Schedule of Committees

The DGRC & SGRC meeting should be conducted Quarterly or as required, on a specific day on regular basis. State can decide a particular date /day based on the convenience and availability of the members of the committee.

SAA meetings shall be convened within one week of receiving the grievances by SAA.

6. Lodging and Registration of Grievances

6.1 Any grievance under MUHCS may be raised through following means:

i. **Online Mode:** Through online grievance redressal portal.

ii. **Offline Mode:** MUHCS Call Centre helpline, letter/ telephone/ e-mail/ helpdesk etc. to the official address of MSHCS, directly with the DGNO of the district where such stakeholder is located or where such grievance has arisen.

6.2 A complainant may lodge a complaint in the following manner:

i. Directly with the DGNO of the district where such stakeholder is located or where such complaint has arisen and if the stakeholder is located outside the Service Area, then with any DGNO located in the Service Area; or
ii. With the State Nodal Agency: If a complaint has been lodged with the State Nodal Agency, they shall forward such complaint to the concerned DGNO.

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

If the DGNO decides that the complaint must be dealt with the grievance Redressal mechanism, the DGNO shall refer such complaint to the convener of the relevant Grievance Redressal Committee depending on the nature of the complaint. (Annexure 1)

6.3 For all grievances received by the call centre, call centre executives shall register the details of the grievance in the CGRMS portal as per defined format. The grievance will appear in the login of concerned Grievance Nodal Officer.

The CGRMS shall automatically generate a Unique Grievance Number (UGN),categorize the nature of the grievance and auto SMS will be sent to the stakeholder.

6.4 Special powers of the authorities: The MSHCS, shall have the authority to initiate Suo moto proceedings and file a grievance on behalf of itself and / or beneficiaries under the scheme. They can also take cognizance of reports in social media and other public forums for further investigation and redressal.

7. Grievance Redressal Mechanism

Upon receipt of a grievance, the DGNO/SGNO shall try to resolve the same directly through his/her own efforts and coordination with concerned parties. However, if he/she is unable to resolve the grievance at his/her level, the same may be put up before the concerned Grievance Redressal Committee.

Each grievance irrespective of the mode of receipt shall be first registered on the CGRMS portal with a unique grievance number for tracking till closure. Following process shall be followed:

7.1 Process for Redressal directly by DGNO/SGNO - While redressing the grievances

i. The DGNO/SGNO should analyze the case and seek explanation from the stakeholder against whom the grievance is being lodged by sending an email or letter.
ii. The stakeholder against whom a grievance has been lodged must send his/ her comments/responses to the aggrieved party with copy to the DGNO/SGNO within 7 days of receiving an email or letter from the DGNO or SGNO. If the grievance is not addressed within such 7 days period, the DGNO/SGNO shall send a reminder for redressal.
iii. The DGNO/SGNO shall try to resolve the grievance by forwarding the same to DGRC/SGRC. If the grievance is not resolved or comments are not received from the stakeholder within 15 days, then the matter may be referred to relevant Grievance Redressal Committee.
iv. If the DGNO/SGNO is satisfied with the comments/ response received from the stakeholders, then the DGNO/SGNO shall communicate this to the aggrieved party by letter/e-mail/SMS/telephone and update the status on the CGRMS portal.
v. If the DGNO/SGNO is not satisfied with the comments/ response received or if no comment/ response is received from the stakeholder despite a reminder, then the DGNO/SGNO shall refer such grievance to the Convener/Chairman of the relevant Grievance Redressal Committee.

7.2 Process of Redressal through the Relevant Grievance Committee

All cases which are appealed against the orders of DGNO/SGNO must be placed before the concerned grievance redressal committee.

i. The Convener of the relevant Grievance Redressal Committee shall place the grievance before the Grievance Redressal Committee for its decision at the next meeting.
ii. Each grievance shall be addressed and arrive at a logical decision by the relevant Grievance Redressal Committee within a period of 30 days of the receipt of the grievance filed inside the state and within 45 days of the receipt of the grievance filed outside the state. Depending on the urgency of the case, the Grievance Redressal Committee may conduct a meeting at the earliest possible for a speedier resolution of the grievance.
iii. All such decisions shall be based on the principles of natural justice (including giving the parties a reasonable opportunity to be heard) and be taken by majority vote of its members present.
iv. If the aggrieved party is not satisfied with the decision of the relevant Grievance Redressal Committee, it may appeal against the decision within 30 days to the higher Grievance Redressal Committee.

v. If an appeal is not filed within 30-days period, the aggrieved party shall lose its right to appeal, and the decision already made by the relevant Grievance Redressal Committee shall be final and binding.

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

8. Compliance with orders of Grievance Redressal Committee

8.1 Parties against whom an order has been issued by any Grievance Redressal Committee, shall ensure that all orders are fully complied and executed within not more than 30 calendar days from the issuance of order or unless such order has been stayed due to appeal.

8.2 If the party against whom such orders have been issued, fails to comply with the order within 30 days period or a time period set forth in the order issued by the Grievance Redressal committee, the defaulting party shall be liable to pay penalty as described under the contract between the parties.

8.3 The defaulting party shall be liable to pay such penalty to MSHCS within 15 days of receiving a written notice from MSHCS. All such payments must be made by the defaulting party in the manner specified by the MSHCS in the notice.

8.4 On failure to pay penalty, the defaulting party shall be liable to pay a penal interest as per the contract between the parties.

8.5 For delays in compliance to the order beyond three months of the date of its issue, the MSHCS shall have the right to seek recourse to available legal remedies all costs of which shall be borne by the defaulting party.

9. Mode of Communication

The decision made by the DGNO/SGNO, or the relevant Grievance Committee must be communicated to all the parties as soon as possible.

9.1. In case of beneficiary - the beneficiary should be informed through any of the following means:

i. Letter
ii. E-mail
iii. SMS- About the status
iv. Outbound call from call centre (Should be recorded and saved)

9.2. In case of Hospitals/ISA

i. Letter
ii. E-mail (in addition to letter if possible)

System generated SMS shall be automatically sent to aggrieved party through CGRMS portal about the status of the grievance.

10. Auto-Escalation of Grievances

The grievances which are not resolved within the prescribed TAT or if no action is taken by the concerned officer, then such cases shall be automatically escalated to the higher authority. E.g., if DGNO has not taken any action within the stipulated time frame, the case will be escalated to the SGNO.

11. Reporting

11.1 CGRMS portal generates various reports like total grievance count, age wise pendency, closure report, SOS Grievances

11.2 Such reports may be utilized by grievance redressal officials in planning and decision making

12. Monitoring

12.1 The MSHCS shall be responsible for monitoring the functioning of the CGRMS portal and MSHCS portal within the state

12.2 Some of the key indicators for tracking the efficiency of Grievance Redressal System shall be as below:

a. Resolution turn-around time ratio

Indicator	Resolution turn-around time ratio
Description	Grievances that are resolved within the prescribed time frame
Numerator (N)	Number of grievances resolved within the prescribed time frame
Denominator (D)	Total number of grievances registered
Calculation	(N /D) *100
Frequency of measurement	Quarterly
Acceptable Threshold (benchmark)	98% or more

Table 1 Turn Around Ratio

b. Escalation ratio

Indicator	Escalation ratio
Description	Grievances that needed escalation
Numerator (N)	Number of GRC orders that were appealed against
Denominator (D)	Total number of GRC orders issued
Calculation	(N /D)*100
Frequency of measurement	Quarterly
Acceptable Threshold (benchmark)	10 % or less

Table 2 Escalation Ratio

12.3 Monitoring of time series grievance data may also provide insights into the overall performance of the MUHCS. Some of these indicators may be:

i. Percentage of grievances resolved through **Direct Channel**
ii. Percentage of grievances related to **out-of-pocket payments**
iii. Percentage of grievances related to **quality of services**
iv. Percentage of grievances related to **denial of services**
v. Percentage of beneficiary grievances related to **delays in receiving services**
vi. Percentage of grievances from empaneled providers related to **delays in receiving claims payment**
vii. Number of grievances related to **portability benefits**
viii. Percentage of provider grievances related to **portability claims**

Annexure 1: Grievance Redressal Matrix

Sl. No	Aggrieved party	Grievance against	Indicative nature of grievances	Approach authority	Turn- around time	Grievance escalated to Committees (if either party is not satisfied)
1	Beneficiary	Empaneled Healthcare providers	**Grievances registered during the course of hospitalization or after discharge of the patient** • Money sought for treatment, despite sum insured under MUHCS cover being available • MUHCS- card retained by Empaneled Health Care Provider • Poor Quality of Treatment • Poor facilities	DGNO	15 days of receipt of grievance	• If not resolved within 15 days by DGNO, case shall be referred to DGRC • If either party is not satisfied with DGRC decision, they can appeal to SGRC within 30 days • SGRC shall have 30 days to resolve the grievance. • SGRC decision shall be final and binding.
3	Beneficiary	Common Service Centre (CSC)	• Demanding money for issuing MUHCS card • Card issued to another family • Card not provided to beneficiary • Poor Quality of Service	DGNO	15 days of receipt of grievance	• If either party is not satisfied with DGNO decision, then they can appeal to DGRC within 30 days • DGRC shall have 30 days to resolve the grievance.
					30 days of receipt of grievance for DGRC	• If either party is not satisfied with DGRC decision, then they can appeal to SGRC within 30 days • SGRC shall have 30 days to resolve the grievance. • SGRC decision shall be final and binding

Sl. No	Aggrieved party	Grievance against	Indicative nature of grievances	Approach authority	Turn- around time	Grievance escalated to Committees (if either party is not satisfied)
4	Beneficiary	District authorities	• Grievance not addressed by the concerned officer	SGNO	15 days of receipt of grievance 30 days of receipt of grievance for SGRC	• If either party is not satisfied with SGNO order, they shall approach the SGRC • Decision of SGRC on such cases shall be final and binding.
5	Health Care Provider	Beneficiary	• Misconduct or harassment by the beneficiary • Any others	DGNO	15 days of receipt of grievance for DGNO 30 days of receipt of grievance for DGRC	• If grievance is not resolved by DGNO within 15 days, case shall be referred to DGRC. • If either party is not satisfied with DGNO's decision, they can appeal to DGRC within 30 days of the DGNO order • DGRC shall have 30 days to resolve the grievance. • If either party is not satisfied with DGRC decision, they can appeal to SGRC within 30 days • SGRC shall have 30 days to resolve the grievance • Decision of the SGRC shall be final and binding.

Sl. No	Aggrieved party	Grievance against	Indicative nature of grievances	Approach authority	Turn- around time	Grievance escalated to Committees (if either party is not satisfied)
6	Health Care Provider	ISA/MSHCS	• Claims rejected by MSHCS in full or partial payment of claims • Demanding money for claim settlement • Misconduct by ISA/TPA/ MSHCS Representatives • Non-cooperation by ISA/TPA/MSHCS	DGNO / SGNO	15 days of receipt of grievance for DGNO / SGNO 30 days of receipt of grievance for DGRC 30 days of receipt of grievance for SGRC	• If either party is not satisfied with DGNO's decision, they can appeal to DGRC within 30 days of the DGNO order • DGRC shall have 30 days to resolve the grievance. • If either party is not satisfied with DGRC decision, they can appeal to SGRC within 30 days • SGRC shall have 30 days to resolve the grievance • If either party is not satisfied with SGRC order, they shall approach the SAA within 30 days of the SGRC order. • The decision of SAA shall be final and binding.
8	Health Care Provider	State Empanelment Committee	• Empanelment/ Suspension/ De-empanelment	SGRC	30 days of receipt of grievance	• SGRC shall have 30days to resolve the grievance • If either party is not satisfied with the SGRC order, they shall approach the SAA within 30 days of the SGRC order. • Decision of the SAA shall be final and binding.

Sl. No	Aggrieved party	Grievance against	Indicative nature of grievances	Approach authority	Turn- around time	Grievance escalated to Committees (if either party is not satisfied)
9	Insurance Company /ISA / TPA	MSHCS/SNA	• Premium not received within time as per service agreement • Fees for Service not paid as per the MOU • MUHCS Beneficiary Database not updated	SGRC	30 days of receipt of grievance	• If either party is not satisfied with SGRC order, they shall approach the SAA within 30 days of the SGRC order. • Decision of the SAA shall be final and binding.
10	Common Service Centre-VLE	TPA/ISA/MSHCS	• Non-Approval of Beneficiary Registration despite all records provided • Not Providing Technical Support • Demanding Money for approval of MUHCS card	SGNO	15 days of receipt of grievance for SGNO 30 days of receipt of grievance for SGRC	• SGRC shall have 30 days to resolvethe grievance • If either party is not satisfied with SGRC order, they shall approach SAA within 30 days of the SGRC order. • Decision of the SAA shall be final and binding.

Annexure 2: Definitions

MUHCS Beneficiary refers to all beneficiaries entitled to receive benefits under MUHCS

Appellate Authority shall mean the State Grievance redressal Committee (SGRC) or State Appellate Authority (SAA) that has the authority to accept, hear and adjudicate on appeals against the relevant Grievance Redressal Committees (GRC) orders

Central Grievance Redressal Management System or the **CGRMS** refers to system for registering, processing, managing, and monitoring redressing all grievances under the MUHCS

Direct Channel refers to the mode of grievance redressal where the concerned District Grievance Nodal Officer (DGNO) or the State Grievance Nodal Officer (SGNO) redresses the grievance by directly getting in touch with the concerned stakeholders and / or the ActionTaking Authority (ATA) without having to route the matter through one of the Grievance Redressal Committees (GRC)

Empaneled Health Care Provider refers to all public or private health care providers that have been empaneled by MSHCS for providing cashless benefits under the MUHCS

Grievance: A Grievance/complaint refers to any communication that expresses dissatisfaction about an action or lack of action, about unfair/wrongful treatment, about the standard of service / deficiency of service that may violate any norms, provisions or guidelines laid down for MUHCS or asks for remedial action.

Grievance Redressal means the mechanism for receiving, registering, and addressing grievances received from any of the aggrieved stakeholder.

Grievance Redressal Committee (**GRC)** refers to committees set up by the MSHCS for redressing all stakeholder grievances under the MUHCS.

Annexure 3: List of Documents required for Quality Grievance Redressal

Sl. No	Aggrieved party	Grievance against	Nature of grievances	Approach authority	Document Attached to resolve the Grievance
2	Beneficiary	Health Care Provider	Denial of treatment	DGNO / DGRC	**If treatment is facilitated** • If treatment is facilitated, document proof/ TMS ID • Action Taken Report **If treatment is not facilitated** • Response/Justification from hospital • Scan copy of warning letter/Show cause notice issued • If the charge has been proved, then action taken/ penalty against hospital. • Any other document from provider as a proof for complete resolution
3	Beneficiary	Health Care Provider	Out of pocket expenditure in Public hospitals	DGNO / DGRC	**If money is reimbursed** • If money is reimbursed to beneficiary, proof of reimbursement (document or audio or video or photo or acknowledgement from beneficiary) • Action Taken Report **If Money is not reimbursed** • Response/Justification from hospital • Scan copy of warning letter/ Show cause notice issued • If the charge has been proved, then action taken/ penalty against hospital. • Any other document from provider as a proof for complete resolution
4	Beneficiary	Health Care Provider	E-card not returned by hospital	DGNO / DGRC	• Proof that E-card is returned to patient (Photo with card/Letter from complainant) • Proof that E-card is not returned to patient (Photo with card/Letter from complainant) • Action taken against hospital
5	Beneficiary	PMAM	Misconduct / Not providing correct information / Demanding Money for treatment	DGNO / DGRC	• Proof of action taken against PMAM, if the grievance is genuine • Proof of reimbursement of money in case money is collected • Copy of explanation provided by PMAM

Sl. No	Aggrieved party	Grievance against	Nature of grievances	Approach authority	Document Attached to resolve the Grievance
6	Beneficiary	CSC	MUHCS-Ayushman card not provided	DGNO / DGRC	**If the Grievance is genuine** • Action taken against CSC **If the Grievance is not genuine** • Proof that E-card provided to beneficiary (Photo with card/Letter from complainant)
7	Beneficiary	CSC	Additional money, beyond the defined cost laid by MSHCS, demanded from beneficiary	DGNO / DGRC	**If the grievance is genuine** • Proof of money reimbursement to beneficiary • copy of Show-cause notice issued to CSC • Explanation provided by CSC **If the grievance is not genuine** • Explanation provided by CSC
8	Health Care Provider	MSHCS / ISA / TPA	Claims rejected by MSHCS, or full Claim amount not paid	DGNO/ SGNO	**If claim is paid (fully or partially)- proof of** • Document to proof the payment made and justification for partial payment by MSHCS/ISA/TPA **If claims not paid** • Response from MSHCS/ISA/TPA as per the grievance if not eligible to pay
9	Health Care Provider	MSHCS	Suspension or de-empanelment of Empanelled Health Care Provider	DGRC/ SGRC	• Detailed investigation report • Decision made/Action taken • Justification provided by IC/ISA • If re-empanelled, proof of re-empanelment • If case is escalated to committee, MoM of committee
10	Insurance Company / ISA / TPA	MSHCS / District Authorities	Premium not received as per service agreement	SGRC	• Proof of premium paid by MSHCS • MoM of the committee

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Government of Mizoram

MIZORAM UNIVERSAL HEALTHCARE SCHEME (MUHCS)

Service Quality Audits, Monitoring & Control Guidelines

Mizoram State Health Care Society

Department of Health & Family Welfare

2025

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1. About MUHCS

Mizoram Universal HealthCare Scheme (MUHCS) aims to reduce the financial burden arising out of catastrophic hospital expenditure and ensure access to quality health services and strives towards the vision of Universal Health Coverage (UHC).

2. Reporting, Monitoring and Control

2.1. What and Why is Reporting, Monitoring and Control Important?

Reporting, Monitoring and Control mechanism are critical audits and related processes necessary for ensuring the seamless implementation of MUHCS constituting a set of continuous procedures of evaluation and review involving the beneficiary and concerned stakeholders.

2.2. Types and Minimum Sample of Audits

The different types of Audits and the accountability of relevant stakeholders are as follows:

Sl.	Type of Audit	Sample for Insurer / TPA	Sample for MSHCS
1.	Medical Audit	5% of total cases hospitalized	2% direct audits + 2% of audits done by the Insurer / TPA /ISA
2.	Pre-Authorisation Audit	10% of total pre- authorizations across disease specialities	2% direct audits + 10% of audits done by the Insurer / TPA / ISA
3.	Mortality audit	100%	100%
4.	Beneficiary audit (during hospitalization)	10% of total cases hospitalized	5% direct audits + 10% of audits done by the Insurer / TPA / ISA
5.	Beneficiary audit (post discharge – through telephone/ Desk Audit)	10% of total cases hospitalized	5% direct audits + 10% of audits done by the Insurer /TPA / ISA
6.	Claims Audit (Approved Claims)	10% of total claims	3% direct audits + 10% of audits done by the Insurer / TPA / ISA
7.	Claims audit (rejected claims)	-	100%
8.	Concurrent Audit	-	MSHCS shall have the right to set up mechanisms for concurrent audit of the implementation of the Scheme and monitoring of Insurer / TPA / ISA performance.

3. Medical Audits

i. MSHCS shall carry out regular inspection of the Empanelled Health Care Providers and shall conduct periodic medical audits, to ensure proper care and counselling for the Beneficiaries at Empanelled Health Care Providers, by coordinating with the authorities of the Empaneled Health Care Providers.

ii. MSHCS shall ensure that the total number of medical audit of claims shall be a minimum of 2% of the total cases hospitalized in each of the Empaneled Health Care Provider in the current quarter.

iii. The medical audit shall include a review of medical notes and a review of the medical appropriateness in the formats specified in Annexure 1. The medical cases to be audited shall be identified randomly or may be specified by MSHCS audit team for specific conditions or cases.

iv. The medical audit shall compulsorily be done by a qualified Medical Practitioner who shall be a part of MSHCS or shall be otherwise duly authorized to undertake such medical audit by MSHCS.

3.1. Process of Conducting a Medical Audit

The process of conducting medical audit is set out below:

i. MSHCS shall extract claims to be audited specific to each EHCP.

ii. The audit shall preferably be conducted in the presence of the hospital physician/treating doctor.

iii. While cross examining the Beneficiaries, the patient's file / indoor case papers shall be made available by the authority of the Empanelled Health Care Provider. The auditor shall review the complete file and note down the anomalies observed in the audit sheet.

iv. If Beneficiary is already discharged, only the patient's file / indoor case papers shall be examined, and the auditor shall note down the anomalies observed in the audit sheet.

v. The auditor shall discuss all anomalies observed with the treating doctor and seek his/ her explanation/opinion on a case-to-case basis.

vi. The report must include any Fraudulent Activity identified during the medical audit, if any.

4. Mortality Audit

i. MSHCS shall ensure that 100% of the Mortality Claims are audited. The Mortality Audits shall be counted as part of the 3% Medical Audit that is required in a quarter.

ii. The Insurer / ISA / TPA shall compile the observations during the Mortality Audit in a format that is shared by MSHCS. The compiled observations shall be submitted to MSHCS on a monthly basis.

iii. MSHCS may issue letters to the concerned EHCP on the discrepancies observed, if any. MSHCS, at its discretion, shall also evaluate the repetitiveness of EHCPs in committing such discrepancies.

iv. MSHCS shall initiate corrective measures/actions on the basis of the compiled reports sent by the ISA. MSHCS shall also undertake actions against EHCPs on the discrepancies reported. Actions/Measures will include but not limited to issuance of letters, issuing show cause notices, imposing penalties, suspension and de-empanelment of EHCP.

5. Beneficiary Audits

i. MSHCS shall conduct Beneficiary Audit by meeting a Beneficiary during hospitalization and/or by communicating with the beneficiary if the beneficiary is already discharged from the EHCP.

ii. MSHCS shall use the format as given in Annexure 2 for the purpose of Beneficiary Audit.

iii. MSHCS shall ensure that at least 20% of the number of Beneficiary Audit should represent the beneficiaries where Medical Audit has been conducted

iv. The auditor shall cross-check the laboratory or diagnostic reports to verify the diagnosis of the beneficiary as well as the booked package.

v. The Insurer / ISA / TPA shall educate the beneficiary on the features of MUHCS, share feedback on any deficiency in the services provided by the EHCP observed during the audit and shall submit a compiled report to MSHCS on a quarterly basis as per the format shared by MSHCS.

6. Monitoring and Evaluation of Health Care Providers

6.1. Quality Assurance

To determine compliance to minimum standards, Empaneled Private Health Care Providers categorized based on Guidelines for Verification and Categorization of Private Health Care Providers (within the state of Mizoram) will undergo a renewal process once every 3 years or till the expiry of validity of MUHCS categorization / NABH certification whichever is earlier.

6.2. Audits

The Empanelled Health Care Provider shall co-operate and provide MSHCS with access to all facilities, records and information for the conduct of audits or any other evaluation of the performances of the Empanelled Health Care Provider.

6.3. Compliance to Guidelines

i. The Empanelled Health Care Provider shall comply with all applicable Laws, statutes, rules and regulations as amended from time to time.

ii. The Empanelled Health Care Provider shall at all times comply with all the guidelines laid under the Mizoram Universal HealthCare Scheme.

iii. The Empanelled Health Care Provider shall comply with the standard treatment guidelines that may be issued by competent government agencies from time to time.

6.4. Regular Monitoring of Health Care Providers

i. If the Insurer / ISA / TPA believes that the performance of the Empanelled Health Care Provider raises any doubts, based on the Claims data analysis and/or the medical audit conducted by MSHCS / Insurer / ISA / TPA, then MSHCS shall put that Empanelled Health Care Provider on the watch list.

ii. The data of such Empanelled Health Care Provider shall be analysed very closely on a daily basis by MSHCS or its representatives for patterns, trends and anomalies.

7. Reports

7.1. Periodic Trend Analysis

The Insurer / ISA / TPA shall prepare periodic analysis of trends and shall promptly provide written reports on such trend analysis to MSHCS highlighting potential frauds.

7.2. Audit Reports

The Insurer / ISA / TPA shall submit a report to MSHCS within 7 working days after the end of each month during the Policy Cover Period regarding the medical and beneficiary audits conducted in the previous month. Report shall comprise of the following:

i. The number of EHCP where Medical Audit has been conducted during the month.
ii. The name of the ECHP along with the number of Medical Audits conducted in that particular EHCP during the month.
iii. District wise report on number of beneficiaries audited along with beneficiary details like name, gender, age and other contact details.

8. MSHCS obligations in relation to Monitoring and Control

MSHCS will have the following obligations in relation to monitoring and control of the implementation of MUHCS and the ISA's performance of its obligations:

i. To organize periodic review meetings with the ISA, review the implementation of MUHCS and periodic review meetings shall be held on a need basis.
ii. The work with the technical team of the Insurer / ISA / TPA to study and analyze the data for improving the implementation of MUHCS.

9. Formation of Committees

9.1. Claims Review Committee (State level)

i. Review 100 percent claims that are rejected by the PPD/CPD/MSHCS and appealed by the provider
ii. Randomly review / audit at least 2 percent of the pre-authorizations and 3 percent of the claims quarterly

9.2. Mortality and Morbidity Review Committee (State level)

i. The scope of MMRC review shall include assessment of line of treatment, review of medical and patient progress records, prescription practices and determine whether the treatment provided is in line with good clinical practices.
ii. Review 100 percent of mortality claims.
iii. Undertake fraud-trigger based review and audit of cases as recommended by the medical audit team or the claims processing team.
iv. Review claims with high value/complex surgical/uncommon procedures.

ANNEXURE 1: Formats Of Medical Audit

Part 1: Medical Audit Format IPD

Sl.	Particulars					
1	Hospital Name					
2	Hospital District					
3	Patient Name					
4	Gender		Age		MUHCS ID	
5	Case No.					
6	Date of Admission	TMS		Hospital Record		
7	Date of Surgery (if Applicable)	TMS		Hospital Record		
8	Date of Discharge	TMS		Hospital Record		
9	Final Diagnosis					
10	Package Booked					
11	Is the booked package relevant to the diagnosis and treatment given	YES			No	
12	Others	LAMA/DAMA/REFERRED/DEATH/NORMAL DISCHARGE				

MEDICAL AUDIT FOR INPATIENT					
1	ON ADMISSION	Y	N	NA	REMARKS
a	DATE OF ADMISSION				
b	TIME OF ADMISSION				
c	CHIEF COMPLAINT				
d	HISTORY OF PRESENT ILLNESS				
e	RELEVANT PAST HISTORY				
f	RELEVANT FAMILY HISTORY				
g	GENERAL EXAMINATION				
h	VITALS				
i	SYSTEMIC EXAMINATION				
j	PROVISIONAL DIAGNOSIS				
k	ADVISED/PLANNED LINE OF TREATMENT				
l	CONSENT FOR ADMISSION /TREATMENT				
2	DOCTORS PROGRESS NOTES FROM ADMISSION TO DISCHARGE	Y	N	NA	REMARKS
a	WRITTEN DAILY				
b	SIGNED DAILY				
c	DATED DAILY				
d	TIMED DAILY				
e	REFLECTIVE TO PATIENT CONDITION				
f	FINAL DISCHARGE NOTE				
3	NURSE NOTE	Y	N	NA	REMARKS
a	WRITTEN DAILY				
b	SIGNED DAILY				

c	DATED DAILY				
d	TIMED DAILY				
e	VITALS CHART MAINTAINED				
f	TREATMENT CHART MAINTAINED				
g	INPUT/OUTPUT CHART				
4	SURGERY	Y	N	NA	REMARKS
a	PRE-ANAESTHETIC CHECK UP				
b	CONSENT FOR SURGERY				
c	DIAGNOSIS				
d	PROCEDURE PERFORMED				
e	PROCEDURE DETAILS				
f	DOCTORS NAME AND SIGNATURE				
g	DATE OF PROCEDURE				
h	TIME OF PROCEDURE (START AND END TIME)				
i	SPECIFIC FINDINGS				
j	IMPLANTS STICKER (WHERE APPLICABLE)				
k	ANAESTHETIST NOTES				
l	POST OP ADVICE				
5	DISCHARGE SUMMARY	Y	N	NA	REMARKS
a	DATE AND TIME OF ADMISSION				
b	DATE AND TIME OF DISCHARGE				
c	FINAL DIAGNOSIS				
d	INVESTIGATIONS DONE WITH REPORT				
e	PROCEDURE PERFORMED (IN CASE OF SURGERY)				
f	TREATMENT GIVEN				
g	PATIENT CONDITION ON DISCHARGE				
h	ADVICE ON DISCHARGE				
6	OTHERS	Y	N	NA	REMARKS
a	MANDATORY INVESTIGATION AS PER PACKAGE				
b	OTHER INVESTIGATIONS (ORDERED/SUPPORTIVE OF DIAGNOSIS)				

ADDITIONAL FINDINGS:

Details of Auditor/Examiner	
Name	
Designation	
Signature	
Date	

Part 2: Medical Audit Format Mortality IPD

Sl.	Particulars					
1	Hospital Name					
2	Hospital District					
3	Patient Name					
4	Gender		Age		MUHCS ID	
5	Case No.					
6	Date of Admission	TMS		Hospital Record		
7	Date of Surgery (if Applicable)	TMS		Hospital Record		
8	Date of Death	TMS		Hospital Record		
9	Final Diagnosis					
10	Package Blocked					
11	Is the booked package relevant to the diagnosis and treatment given	YES			No	

MEDICAL AUDIT FOR MORTALITY IPD

1	ON ADMISSION	Y	N	NA	REMARKS
a	DATE OF ADMISSION				
b	TIME OF ADMISSION				
c	CHIEF COMPLAINT				
d	HISTORY OF PRESENT ILLNESS				
e	RELEVANT PAST HISTORY				
f	RELEVANT FAMILY HISTORY				
g	GENERAL EXAMINATION				
h	VITALS				
i	SYSTEMIC EXAMINATION				
j	FINAL DIAGNOSIS				
k	CONSENT FOR ADMISSION/ TREATMENT				
2	DOCTOR PROGRESS NOTES FROM ADMISSION TO DISCHARGE	Y	N	NA	REMARKS
a	WRITTEN DAILY				
b	SIGNED DAILY				
c	DATED DAILY				
d	TIMED DAILY				
e	REFLECTIVE TO PATIENT CONDITION				
f	FINAL DISCHARGE NOTE/DEATH SUMMARY				

3	NURSE NOTES	Y	N	NA	REMARKS
a	WRITTEN DAILY				
b	SIGNED DAILY				
c	DATED DAILY				
d	TIMED DAILY				
e	VITALS CHART MAINTAINED				
f	TREATMENT CHART MAINTAINED				
g	INPUT/OUTPUT CHART				
4	SURGERY	Y	N	NA	REMARKS
a	PRE-ANAESTHETIC CHECK UP				
b	CONSENT FOR SURGERY				
c	DIAGNOSIS				
d	PROCEDURE PERFORMED				
e	PROCEDURE DETAILS				
f	DOCTORS NAME AND SIGN				
g	DATE OF PROCEDURE				
h	TIME OF PROCEDURE (START AND END TIME)				
i	SPECIFIC FINDINGS				
j	ANAESTHETIC NOTES				
k	POST OP ADVICE				
5	DEATH SUMMARY	Y	N	NA	REMARKS
a	DECLARATION NOTE				
b	DATE OF DEATH				
c	TIME OF DEATH				
d	DEATH CERTIFICATE ISSUED				
6	OTHERS	Y	N	NA	REMARKS
a	MANDATORY INVESTIGATION AS PER PACKAGE				
b	OTHER INVESTIGATIONS (ORDERED/SUPPORTIVE OF DIAGNOSIS)				

ADDITIONAL FINDINGS:

Details of Auditor/Examiner	
Name	
Designation	
Signature	
Date	

ANNEXURE 2: Format Of Beneficiary Audit

Questionnaire for Beneficiary Audit

Sl.	Particulars	
1	Date of audit	
2	Name of village	
3	Name of District	
4	MUHCS Beneficiary ID	
5	Name of Head of the Household	
6	Name of Beneficiary	
7	Age of Beneficiary	
8	Hospital where beneficiary is admitted	
9	What factors helped him/her on deciding which hospital to visit?	
10	What was the mode of transportation and approximate travel time?	
11	What symptoms was the Beneficiary exhibiting when he/she visited the Hospital?	
12	Was he/she operated upon?	
13	If surgery is performed, is there a scar on the body, which could help in verification of the surgery? (for beneficiary audit during hospitalization)	
14	Was the Beneficiary/attendant asked to sign or put their thumb impression on any blank paper/ letterhead? If yes, was the Beneficiary explained why this signature or thumb impression is being taken?	
15	Was the Beneficiary given a discharge summary? Does the Beneficiary still possess that discharge summary?	
16	Was any money asked by the hospital at any point of time? If yes, then for what purpose?	
17	Was Beneficiary or the attendant asked to purchase any of the medicine or carry on any of the diagnostic test at their own cost?	
18	If the Beneficiary has been diagnosed with a chronic ailment, please verify with the Beneficiary if he/she still exhibits the symptoms. Has the Beneficiary been advised to come for any follow up visits?	

Details of Auditor/Examiner	
Name	
Designation	
Signature	
Date	

ANNEXURE 3: Exclusions under 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.
   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 Government Employees 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%.

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Government of Mizoram

MIZORAM UNIVERSAL HEALTHCARE SCHEME (MUHCS)

Guidelines for Verification and Categorization of Private Healthcare Providers

(Within the State of Mizoram)

Mizoram State Health Care Society

Department of Health & Family Welfare

2025

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Abbreviations

MUHCS	- Mizoram Universal HealthCare Scheme
HCP	- Healthcare Provider
ICU	- Intensive Care Unit
IEC	- Information, Education and Communication
NABH	- National Accreditation Board for Hospitals and Healthcare Providers
MSHCS	- Mizoram State Health Care Society

1. Introduction & Scope

This policy / guideline may be called the **"Verification and Categorization Guidelines of Private Healthcare Providers"** within the State.

Due to rising population size, growing income and higher expectations of health care users has resulted in increased demand of health care. This has resulted in inflationary costs of health care services and medical technology coupled with phenomenal growth of private health care sector. Simultaneously, the public sector alone cannot cater to the requirement of the general population, thus the need to onboard more private providers to provide healthcare services is prevalent.

The Govt. of Mizoram does not have a policy/guideline on verification and categorization of private healthcare providers, therefore the department of Health & Family Welfare is framing a policy/guideline for Verification and Categorization of private healthcare providers within the state, where the beneficiaries will get cashless health benefits for treatment within the State.

However, as healthcare providers differs in terms of service quality provided as well as other factors, it is judicious that categorization of private healthcare providers, based on an exhaustive criterion be made. This can justify the variations in incentives for services while at the same time, it would bring efficient government fund utilization for services under government sponsored schemes. This categorization is also an attempt to bring improvement in quality of services across the network of private healthcare providers, motivate them to aspire for continuous enhancement of services, thus contributing to overall efficiency.

For all empaneled private healthcare providers verified and categorised under MUHCS, additional incentives will be provided from the base package rates as per categorisation. The incentive amount may be revised from time-to-time as per the Government's decision. Verification and Categorization of private healthcare providers is a continuous process and interested HCP can apply at any point of time.

While the grading system under National Health Authority has three gradings - Bronze, Silver and Gold where Gold is the NABH accreditation while Silver is the NABH Entry level, it is found that many hospitals in Mizoram currently cannot be graded at Bronze, the lowest strata. Therefore, the need to have category below Bronze is imperative, thus the need for state-based tool, taking into consideration local factors. The tool has been field tested in Aizawl, Lunglei and Serchhip Districts and is found to give an excellent degree of accuracy. The detailed parameters for categorization of private healthcare providers is enclosed (Annexure 1). Any aspiring private HCP will henceforth be verified and categorized according to this policy/guideline only.

2. Verification and Categorization of Private Healthcare Providers- Approach & Criteria

2.1. Approach for Verification and Categorization

2.1.1. All private healthcare providers empaneled under MUHCS will be categorised as follows:

- **Gold** : HCP having NABH Full accreditation
- **Silver** : HCP having NABH Entry Level accreditation
- **Bronze** : HCP verified based on checklist in Annexure 1 with a score of 200 and above.
- **Below Bronze (Upper Crest)** : HCP verified based on checklist in Annexure 1 with the score between 100-199.
- **Below Bronze (Lower Crest)** : HCP verified based on checklist in Annexure 1 with the score below 100.

2.1.2. Private healthcare providers certified under NABH needs no further verification based on the criteria in Annexure 1.

2.1.3. The verified and categorized private healthcare providers will undergo a renewal process, once every 2 years or till the expiry of validity of certification (NABH) whichever is earlier or till such time the HCP submits a request to MSHCS for re-categorization.

2.1.4. MSHCS may revise the verification and categorization criteria as and when necessary.

2.1.5. MSHCS will be responsible for creating awareness among the healthcare service providers about the scheme ensuring maximum private healthcare providers participation. MSHCS may conduct IEC campaigns or sensitisation workshops at various levels to discuss the contours of the scheme, the process and criteria for Verification and Categorization, incentive structure on health benefit packages, process of claims settlement etc. with the private healthcare providers.

2.1.6. ERP system under MUHCS will have the module for verification and categorisation of private healthcare providers.

2.2. Incentive Structure for Verified and Categorised Private Healthcare Providers under MUHCS

Incentives applicable for Private Healthcare Providers under MUHCS.

Categorization	Additional incentives from base package rate
Gold	**40%**
Silver	**30%**
Bronze	**20%**
Below Bronze - Upper Crest	**10%**
Below Bronze - Lower Crest	**N/A**

Annexure 1: Verification and Categorization Checklist under MUHCS

SECTION A: FACILITY INFORMATION		
Facility Name		
Valid Registration No.		
Contact Details		
Address		
District		
Pin Code		
Hospital contact number		
Hospital email id		
Name of Nodal Officer		
Contact number of Nodal officer		
Email id of Nodal Officer		
Facility Type *(tick whichever is applicable)*	Private Hospital	
	Mission Hospital	
	Others	
In-patient bed capacity	Deluxe	
	Private	
	Semi private	
	General	
	ICU	
	ICCU	
	HDU	
	NICU	
Hospital Quality Certification	NABH Full Accreditation	
	NABH Entry Level Accreditation	
	None	

SECTION B: SERVICES OFFERED				
Does the facility offer the following services? (Yes=3, Partial= 1, No=0)				
	YES	**PARTIAL**	**NO**	**Remarks**
1. Out Patient Department				
2. 24x7 Emergency Service (Casualty)				
3. Speciality Offered				
(a) Medicine				
(b) General Surgery				
(c) Pediatrics				
(d) Obstetrics & Gynaecology				
(e) Orthopedics				
(f) Ophthalmology				
(g) Cardiology				
(h) Cardio-thoracic Surgery				
(i) Nephrology				
(j) ENT				
(k) Oncology				
(l) Dentistry				
(m) Dermatology				
(n) Radiology				
(o) Pathology				
(p) Neurology				
(q) Microbiology				
(r) Radiotherapy				
(s) Plastic & Reconstructive Surgery				
(t) Respiratory Medicine				
(u) Hemodialysis				
(v) Haematology				
(w) Anesthesiology				
(x) Gastro-enterology				
(y) Neurosurgery				
(z) Cardiothoracic				
4. 24x7 Pharmacy Service				
5. Physiotherapy/Occupational therapy				

SECTION C: MEDICAL INFRASTRUCTURE				
Does the facility have the following infrastructure? (Yes=3, Partial= 1, No=0)				
	YES	**PARTIAL**	**NO**	**REMARKS**
1. Labour Room				
2. New Born Unit				
3. Functional intensive care unit (Monitors & Ventilators)				
4. Functional intensive care unit (without Monitors & ventilators)				
5. High Dependence Unit				
6. Intensive Critical Care Unit				
7. Neonatal Intensive Care Unit (NICU)				
8. Paediatrics ICU				
9. Surgery ICU				
10. Medicine ICU				
11. General X-Ray machine				
12. Ultrasonography (USG) Machine				
13. CT Scan Machine				
14. MRI machine				
15. Mammography Machine				
16. Dental X-Ray Machine				
17. Defibrillator Machine				
18. Electrocardiogram (ECG) Machine				
19. Electroencephalogram (EEG) Machine				
20. Angiography				
21. Operation Theatre				
22. Minor Operation Theatre				
23. Immunization Room				
24. Family Planning Centre				
25. Functional Hemodialysis				
26. Mortuary/Cold Room				
27. 24 hrs. BLSA Service				
28. Endoscopy Machine				
29. Colonoscopy Machine				
30. Laparoscopy Machine				
31. Incubator				

SECTION D: GENERAL INFRASTRUCTURE				
Does the facility have the following have the following? (Yes-3, Partial= 1, No=0)				
	YES	**PARTIAL**	**NO**	**REMARKS**
1. Supply of clean piped running water & water reservoir				
2. Safe drinking water (Reverse Osmosis)				
3. Laundry Room				
4. Kitchen				
5. Visitors Washroom				
6. ICTC Centre				
7. Fire-fighting equipment				
8. Display of floor plan exit route				
9. Stand by generator (s) and UPS back ups				
10. Incinerator				
11. Composite pit				
12. Support vehicle				
13. Fence & Gate				
14. Ramp/Disability friendly walkways				
15. Elevators/Lift facility				
16. Medical Waste Segregation Bins				
17. Adequate Lighting & Ventilation				
18. Hand Washing Technique Display				
19. Bio-Medical waste color bin display				
20. Documented policies for disinfection & sterilization of instruments				
21. Documented policies for disposal of Bio-Medical Waste				
22. CCTV System				
23. Segregated ward for Medicine				
24. Segregated ward for General Surgery				
25. Segregated ward for Male & Female				
26. Segregated ward for Orthopaedics				
27. Segregated ward for ENT				
28. Segregated ward for Paediatrics				
29. Segregated ward for Ophthalmology				
30. Segregated ward for Obstetrics & Gynaecology				
31. Facility for general ward				
32. Facility for Deluxe/Private/Semi Private Rooms				
33. Burn Management Ward				
34. Health Facility Registration (HFR) under ABDM				
35. Display of Patient's Rights & Responsibilities (citizens charter)				
36. Display of PEP guidelines				
37. Parking facility of at least 5 LMV & 5 Motorcycle within the facility				
38. RCC Type of Hospital Building				
39. Marble/ Glaze Flooring of hospital indoor (ICU/OT/Ward)				
40. Availability of Waiting Hall/Lounge				
41. Rehabilitation therapy				
42. Outdoor space/garden for relaxation				
43. Cafeteria inside hospital				

SECTION E: PERSONNEL				
Does the facility have the following personnel? (Yes=3, Partial= 1, No=0)				
	YES	**PARTIAL**	**NO**	**REMARKS**
1. Health Records Information Manager				
2. Medical Engineering Technician				
3. Medical Laboratory Technician				
4. Radiology Technician				
5. Security Personnel				
6. Pharmacist				
7. Optometrist				
8. Nutritionist/Dietician				
9. Anesthesiologist				
10. General Surgeon				
11. Orthopaedic Surgeon				
12. ENT surgeon				
13. Obs/Gynae specialist				
14. Nephrologist				
15. Neurologist				
16. Ophthalmologist				
17. Dermatologist				
18. Paediatrician				
19. Pathologist				
20. Psychiatrist				
21. Radiologist				
22. Medicine Specialist				
23. Plastic Surgeon				
24. Cardiologist				

SECTION F: FINDINGS AND RECOMMENDATIONS	
Findings	
Recommendations	
Registered owner/ In- charge of the facility/Administrator	
Name:	Designation:
Date:	Signature:

INSPECTION TEAM				
S.No	**Date of inspection**	**Name**	**Designation**	**Signature**
1				
2				
3				
4				

Scoring System		
Yes	**Partial**	**No**
3	1	0

Maximum Score Obtainable: 384	
Category	**Score Level**
Gold	NABH full accreditation
Silver	NABH entry level
Bronze	Above 200
Below Bronze (upper crest)	100 – 200
Below Bronze (lower crest)	Below 100