





# BIJU SWASTHYA KALYAN YOJANA (BSKY) HEALTHY ODISHA, HAPPY ODISHA

**"EVERY LIFE IS PRECIOUS"** 



CHIEF MINISTER, ODISHA

**CLAIM ADJUDICATION MANUAL** 

**OCTOBER 2023** 

# **CONTRIBUTORS AND ACKNOWLEDGEMENTS**

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# CONTENTS

ABBREVIATIONS	5
1. INTRODUCTION	6
1.1 BSKY	6
1.2 STATE HEALTH ASSURANCE SOCIETY (SHAS)	6
1.3 ENTITLED BENEFICIARIES	6
1.4 BENEFITS	7
1.5 HEALTH BENEFIT PACKAGES	7
2. PURPOSE OF CLAIM ADJUDICATION MANUAL	. 12
3. BASICS OF CLAIM ADJUDICATION	. 12
4. ADJUDICATION WORKFLOW	. 14
4.1. SYSTEM OVERVIEW	. 14
4.2. CLAIMS JOURNEY	. 14
4.3. PRE-AUTHORISATION WORKFLOW	. 14
4.3.1. BLOCK PACKAGE	. 15
4.3.2. PRE-AUTHORISATION ADJUDICATION	. 18
4.4. CLAIMS WORKFLOW	24
4.4.1. PATIENT DISCHARGE	. 25
4.4.2. CLAIM SUBMISSION	. 28
4.4.3. CLAIM ADJUDICATION BY CPD	30
4.4.5. CLAIM REVIEW BY STATE NODAL DOCTORS (SND)	. 37
4.4.6. ROLES AND RESPONSIBILITIES IN CLAIM ADJUDICATION	. 41
4.5. CLAIM PAYMENT PROCESS	. 42
4.6. RECONSIDERATION OF REJECTED CLAIMS	42
4.7. GRIEVANCE REDRESSAL	42
5. PAYMENT IN SPECIAL CASES	. 43
5.1. LAMA / DAMA	. 43
5.2. DEATH DURING HOSPITALISATION	44
5.3. PATIENT REFERRED TO ANOTHER HOSPITAL	44
5.4. UNSPECIFIED PACKAGE	. 45
5.5. UNBUNDLING OF PROCEDURES	
6. CLAIM ADJUDICATION AUDIT	. 47
6.1. PERCENTAGE OF CLAIM ADJUDICATION AUDIT	48
7. GUIDELINES FOR RECOVERIES AND OTHER ACTIONS	48
8. SERVICE PARAMETERS	. 50
8.1. UNIFORM TURN AROUND TIME (TAT)	. 50

8.2. KEY PERFORMANCE INDICATORS (KPI)	50
ANNEXURE - I: EXCLUSIONS TO THE POLICY	51
ANNEXURE – II: LIST OF ACTION REMARKS IN CMS	52
ANNEXURE - III: ACTIONABLE FOR CPD	53
ANNEXURE - IV: DOCUMENT TEMPLATES	54
REFERENCE DOCUMENT LINKS	55

# **ABBREVIATIONS**

BSKY	Biju Swasthya Kalyan Yojana
CEO	Chief Executive Officer
CMS	Claims Management System
CPD	Claim Processing Doctor
DC	District Coordinator
DGNO	District Grievance Nodal Officer
DGRC	District Grievance Redressal Committee
EHCP	Empanelled Healthcare Providers
GST	Goods and Services Tax
НВР	Health Benefit Packages
ICP	Indoor Case Papers (IPD Case Sheets)
ICU	Intensive Care Unit
KPI	Key Performance Indicators
LOS	Length of Stay
MDP	Mandatory Document Protocol
MEDCO	Medical Coordinator
NABH	National Accreditation Board for Hospitals & Healthcare Providers
NFSA	National Food Security Act
ОТ	Operation Theatre
OTP	One Time Password
PFMS	Public Financial Management System
POS	Point of Service
חחח	Pre-Authorisation Processing Doctor
PPD	
PPD Pre-auth	Pre-authorisation
Pre-auth	Pre-authorisation
Pre-auth SAFU	Pre-authorisation State Anti-Fraud Unit
Pre-auth SAFU SEC	Pre-authorisation State Anti-Fraud Unit State Empanelment Committee
Pre-auth SAFU SEC SFSS	Pre-authorisation State Anti-Fraud Unit State Empanelment Committee State Food Security Scheme
Pre-auth SAFU SEC SFSS SHAS	Pre-authorisation State Anti-Fraud Unit State Empanelment Committee State Food Security Scheme State Health Assurance Society
Pre-auth SAFU SEC SFSS SHAS SND	Pre-authorisation State Anti-Fraud Unit State Empanelment Committee State Food Security Scheme State Health Assurance Society State Nodal Doctors
Pre-auth SAFU SEC SFSS SHAS SND TAT	Pre-authorisation State Anti-Fraud Unit State Empanelment Committee State Food Security Scheme State Health Assurance Society State Nodal Doctors Turn Around Time

# **1. INTRODUCTION**

## **1.1 BSKY**

The Hon'ble Chief Minister of Odisha, Shri Naveen Patnaik, has set a guiding principle of valuing every life. He envisions providing quality healthcare to all citizens of Odisha, particularly those who are economically vulnerable. With this objective, Biju Swasthya Kalyan Yojana (BSKY) was launched on August 15, 2018, as a path-breaking program to attain Universal Health Coverage (UHC) while giving special consideration to the healthcare needs of women and vulnerable families.

## **1.2 STATE HEALTH ASSURANCE SOCIETY (SHAS)**

The State Health Assurance Society (SHAS) is the nodal agency responsible for implementing the scheme in the State and is headed by the Chief Executive Officer (CEO). The State Government appoints the CEO of SHAS and is ex-officio member secretary of the Governing Board of SHAS. SHAS is responsible for the day-to-day operations for implementing BSKY in the State, along with data sharing, verification and validation of the beneficiaries, IEC, and monitoring the program.

## **1.3 ENTITLED BENEFICIARIES**

BSKY has two components.

- **Component 1:** All citizens of Odisha are eligible for cashless healthcare services at all State Government Health Care Institutions from the Sub-Centre level to Government Medical College Hospitals. The State Government will bear the cost of treatment incurred by Odisha citizens at public facilities.
- **Component 2:** All BSKY Smart Health Card / National Food Security Act (NFSA) / State Food Security Scheme (SFSS) card holders are eligible to avail cashless health coverage of 5 Lakhs Rupees per annum per family and an additional 5 Lakhs Rupees for the women members of the family, after exhaustion of the initial limit at any empanelled private hospitals, within and outside Odisha.

The coverage unit under the scheme is a family, and each family for this scheme is referred to as a BSKY Beneficiary Family Unit, which comprises all members of that family. Any addition to the family is allowed only as per the provisions approved by the government. The presence of a name in the beneficiary list (amended from time to time due to the addition of family members) serves as proof of eligibility of the Beneficiary Family Unit to avail benefits under the scheme.

No entry or exit age restrictions apply to the members of a Beneficiary Family Unit. No member of a Beneficiary Family Unit is required to undergo a pre-insurance health check-up or medical examination before their eligibility as a beneficiary. All pre-existing illnesses of the beneficiaries are covered.

# **1.4 BENEFITS**

The benefits of Rs. 5 Lakhs per annum are available on a family floater basis and can be utilised by any or all family members. BSKY has been designed so that there is no limit on family size or age of members. With their BSKY / Adhaar / NFSA / SFSS number, members of the Eligible families can avail cashless inpatient and daycare treatments in empanelled hospitals within or outside the state, up to the annual coverage limit. In addition, all pre-existing medical conditions are covered from day one. The coverage under the scheme includes all expenses incurred on the following components of the treatment:

- 1. Medical Expenses, Inpatient Treatment and Consultation
- 2. Daycare Procedures
- 3. Pre-Hospitalisation up to 1 day
- 4. Medicines and Medical Consumables
- 5. Non-intensive and Intensive Care Services
- 6. Diagnostic and Laboratory Services
- 7. Medical Implantation Services (Whenever necessary)
- 8. Food Services
- 9. Complications arising during treatment
- 10. Post-Hospitalisation follow-up care up to 5 days

Apart from the annual coverage of Rs. 5 Lakhs per family, an additional Rs. 5 Lakhs can be availed for treating female members in the beneficiary family unit upon exhaustion of the primary sum insured.

# **1.5 HEALTH BENEFIT PACKAGES**

One of the critical components of BSKY is its comprehensive Health Benefit Packages (HBP). These packages outline the range of medical treatments and services covered under the scheme. The HBPs have been designed to ensure beneficiaries receive high-quality medical care without financial hardships.

BSKY offers various health benefit packages covering a broad spectrum of medical conditions and treatments. The packages encompass primary, secondary, and tertiary healthcare services, including diagnostics, consultations, medications, surgeries and postoperative care. A network of empanelled public and private hospitals across the country provides the services covered under the packages.

**For Hospitalisation expenses**, package rates shall include all the costs associated with the treatment, such as:

- 1. Registration Charges
- 2. Bed Charges
- 3. Nursing and Boarding Charges
- 4. Surgeons, Anaesthetists, Clinicians Consultation Fees
- 5. Anaesthesia, Blood Transfusion, Oxygen, OT Charges, Cost of Surgical Appliances, etc.
- 6. Medicines and Drugs
- 7. Cost of Prosthetic Devices, Implants, Organs etc.

- 8. Pathology and Radiology Test: HBP Package includes essential radiology imaging and diagnostics such as X-ray, Ultrasound, Haematology, Pathology, etc. However, High-End Radiological Diagnostics and High-End Histopathologies and Advanced Serological Investigations can be claimed as Add-on Procedures with Medical or Surgical Packages if required.
- 9. Food for patient
- 10. Pre and Post-Hospitalisation Expenses: Expenses incurred for consultation, diagnostics, and medicines up to 1 day before the patient's admission in the same hospital and cost of diagnostics and drugs up to 5 days after discharge from the hospital for the same ailment/surgery.
- 11. Any other expenses related to the patient's treatment in the hospital.

For Day Care Treatments, expenses shall include:

- 1. Registration Charges
- 2. Surgeons, Anaesthetists, Clinicians Consultation Fees
- 3. Anaesthesia, Blood Transfusion, Oxygen, OT Charges, Cost of Surgical Appliances, etc.
- 4. Medicines and Drugs
- 5. Cost of Prosthetic Devices, Implants, Organs etc.
- 6. Pathology and Radiology Test: HBP Package includes essential radiology imaging and diagnostics such as X-ray, Ultrasound, Haematology, Pathology, etc. However, High-End Radiological Diagnostics and High-End Histopathologies and Advanced Serological Investigations can be claimed as Add-on Procedures with Medical Packages if required.
- 7. Pre and Post-Hospitalisation Expenses: Expenses incurred for consultation, diagnostics, and medicines up to 1 day before the patient's admission in the same hospital and cost of diagnostics and drugs up to 5 days after discharge from the hospital for the same ailment/surgery.
- 8. Any other expenses related to the patient's treatment in the hospital.
- **Note:** Empanelled hospitals can separately claim reimbursement for High-End Diagnostic procedures performed during outpatient care for BSKY beneficiaries, without bundling them with hospitalisation claims.

#### **Other Salient Features**

The SHA shall reimburse claims of Empanelled Healthcare Providers (EHCP) under the BSKY based on Package Rates determined as follows:

- 1. The cost of Medical Treatments, Surgical Procedures or Day Care Treatments fixed in the Health Benefit Package shall apply.
- 2. If the package rate for a surgical procedure requiring Hospitalisation or Day Care Treatment is not listed in the Health Benefit Packages, then the Pre-Authorisation Processing Team may pre-authorise an appropriate amount based on the rates for similar procedures defined in the list or based on other applicable national or state health insurance scheme packages. In the case of medical management, the rate will be calculated on per day basis (24-hour hospitalisation) as specified in the package list except for special packages like High-End Radiological Diagnostics, High-End Histopathology and Advanced Serological Investigation

packages. These procedures can be clubbed with medical or surgical procedures as Add-on procedures.

- 3. BSKY is a cashless scheme, where no beneficiary should be made to pay for availing treatment in any BSKY empanelled hospitals. However, upon exhaustion of the beneficiary wallet, or if the treatment cost exceeds the benefit coverage amount available in the beneficiary wallet, then the liability of such remaining treatment cost as per the rates defined in the HBP list will be borne by the beneficiary. Beneficiaries should be communicated in advance about the additional payment before the start of the treatment.
- 4. If a BSKY beneficiary requires multiple surgical procedures in the same OT (Operation Theater) session, the procedure with the highest rate shall be considered the primary package and reimbursed at 100%. After that, the second surgical procedure shall be reimbursed at 50% of the package rate, and the third and subsequent surgical procedures shall be reimbursed at 25%.
- 5. If multiple procedures are performed in different OT sessions during the same hospitalisation, the treating doctor should justify the reason for separate OT sessions.
- 6. Surgical and Medical procedures will not be allowed to be availed simultaneously (except for Add-on procedures defined in the HBP list and configured in TMS). In exceptional circumstances, hospitals may request such Pre-authorisation, which will be considered for reimbursement by SHA following deliberations with the Technical Committee experts.
- 7. Based on the NABH quality accreditation, additional incentives will be provided to eligible EHCPs over and above the rates defined in the HBP list. Additional incentives are also applicable to empanelled hospitals outside the state. The differential pricing applicable to various EHCPs is detailed below.

Category	Incentive over Base Package Rate
Entry Level NABH Accredited Hospitals – Inside State	20%
Full NABH Accredited Hospitals – Inside State	30%
Hospitals with more than 100 IP Beds – Outside State	10%
Entry Level NABH Accredited Hospital – Outside State	40%
Full NABH Accredited Hospitals – Outside State	45%

Table 1: Hospital Incentives on Quality Accreditation

**Public Reserved Packages:** Approximately 2% of the HBP packages are reserved for public hospitals, and the beneficiaries can only access treatment under these packages from public healthcare facilities. Under no circumstances will SHAS consider private EHCP claims raised under the government-reserved packages for settlement.

**Referral Packages:** Approximately 5% of the HBP packages can only be availed from private EHCPs if the beneficiaries are referred from public healthcare facilities. To receive treatment under referral packages, patients may be referred to private EHCPs in the scenarios outlined below:

- i. The public facilities in the district are not equipped or able to provide the treatment/procedure.
- ii. Prolonged waiting period for the procedure at the public facilities in the district
- iii. Emergency cases requiring immediate referral.
- iv. The following authorities have been designated to issue referrals to the beneficiaries in a specific format.

SI. No.	Institution	Designation
1.	District Headquarter Hospital	CDM / PHO / DMO / Superintendent / Specialists
2.	Sub Divisional Hospital	Superintendent / Specialists
3.	Government Medical College Hospitals	Superintendent / HOD

Table 2: Referral Authorities

Empanelled hospitals are eligible to seek reimbursement for reserved/referral packages in the following situations:

- 1. When a patient is initially admitted for treatment under the regular package(s) and subsequently requires treatment under the reserved/referral packages, as determined during the initial treatment.
- 2. When a patient is admitted in an emergency and requires immediate treatment under the reserved/referral packages.
- 3. In instances where patients are admitted to empanelled hospitals located outside Odisha.

**Note:** For points 1 and 2, the treating doctor's justification for providing treatment under referral/reserved packages at empanelled hospitals must be uploaded, either during the pre-authorisation process for packages requiring pre-authorisation approval or at the time of claim submission for other packages.

The presently implementing BSKY Health Benefit Package (HBP), revised in 2022, has 2066 procedures across 30 specialities, including the Unspecified Package.

SI.	Chaciality	Code	HBP	2022
No.	Speciality	Code	Packages	Procedures
1.	Burns Management	BM	06	22
2.	Cardiology	MC	25	35
3.	Covid-19	CO	02	05
4.	Cardiothoracic Vascular Surgery	SV	41	137
5.	Emergency Room Packages	ER	03	04
6.	ENT	SL	38	84
7.	General Medicine	MG	112	158
8.	General Surgery	SG	122	183
9.	High-End Diagnostics	HD	50	89
10.	High-End Procedures	HP	05	10
11.	Infectious Diseases	ID	01	01
12.	Interventional Radiology	IN	78	108
13.	Medical Oncology	MO	76	288
14.	Mental Disorders	MM	14	22
15.	Neo-natal Care	MN	13	13
16.	Neurosurgery	SN	58	84

	Grand Total		1176	2066
30.	Urology	SU	81	127
29.	Unspecified Package	US	01	01
28.	Surgical Oncology	SC	84	127
27.	Radiation Oncology	MR	21	43
26.	Polytrauma	ST	10	30
25.	Plastic and Reconstructive Surgery	SP	08	15
24.	Paediatric Surgery	SS	42	58
23.	Paediatric Medical Management	MP	39	62
22.	Palliative Medicine	PM	41	43
21.	Orthopaedics	SB	73	143
20.	Organ and Tissue Transplant	OT	03	03
19.	Oral and Maxillofacial Surgery	SM	14	22
18.	Ophthalmology	SE	45	60
17.	Obstetrics and Gynecology	SO	70	89

Table 3: HBP Abstract

*Note:* HBP procedures are updated regularly, and updated HBP will be available on the BSKY website.

If SHAS finds that any treatment is being booked under an unspecified category repeatedly or must be included to address a pressing health problem that has become widely prevalent, then SHAS may add such treatments to the HBP list. Specialised tertiary-level services shall be available and offered only by the EHCPs empanelled by SHAS for those services.

# 2. PURPOSE OF CLAIM ADJUDICATION MANUAL

The purpose of the Claim Adjudication Manual is to:

- Enhance the capacities of the adjudication team to ensure accurate and timely processing and settlement of claims under BSKY.
- Improve the ability to efficiently combine fundamental concepts, system functionalities, and human intelligence during claim adjudication.

Accurate processing is crucial in various aspects, including verifying eligible claims, approving precise amounts to EHCPs and genuine utilisation of the beneficiary wallet. This manual will help Claim Processing Doctors (CPD) and State Nodal Doctors (SND) efficiently and accurately adjudicate pre-authorisations and claims while exercising due diligence. Each defined process has a timeline associated with it.

This manual explains the roles and responsibilities of the personnel involved in the BSKY claim adjudication workflow.

*Note:* Users should refer to the BSKY website for the latest information on any subsequent changes made to the claim adjudication manual guidelines.

# **3. BASICS OF CLAIM ADJUDICATION**

Claim Adjudication refers to the decision on two critical 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 the claims settlement. The decision involves cross-verification of the essential aspects such as the eligible beneficiary, medical condition (symptoms, diagnosis, treatment), policy exclusions, available sum insured, pre-agreed package rate, and empanelled hospitals.

BSKY uses two essential systems: a Transaction Management System (TMS) for beneficiary registration, package selection, and pre-authorisation initiation; and a Claims Management System (CMS) for claims workflow from initiation to adjudication and settlement.

While approving a Pre-Authorisation request or adjudication of a Claim at the settlement stage, the adjudication team should exercise the utmost care and be mindful of the decision because any wrong approval or payment may cause inconvenience to beneficiaries or recoveries from EHCPs at a later stage.

The system under BSKY is designed to enable end-to-end adjudication of the claims by the adjudication team; however, human intelligence needs to be applied while processing and approving both pre-authorisations and claims. Below mentioned points must be kept in mind while adjudicating a Pre-Authorisation or a Claim:

- 1. The patient should be an eligible beneficiary and verified through the state-managed beneficiary database.
- 2. The treatment package claimed should be covered under the scheme and comply with any specific reservations in the HBP list.
- 3. The conditions should not fall under the exclusion criteria defined under the policy. (Annexure I)
- 4. The available sum insured in the beneficiary's family wallet should be enough for payment of the current treatment.
- 5. The adjudication team should ensure that all documents submitted by the EHCPs confirm the necessity of the hospitalisation.
- 6. The adjudication team should validate all the details/information (patient details, diagnosis details, supporting investigations, treatment details) submitted at the time of Pre-Authorisation and Claim and highlight discrepancies, if any.
- 7. The adjudication team should raise a query only in the case of any missing information that is mandatory for the claim adjudication.
- 8. The adjudication team should make an informed and mindful decision regarding the payment to be made to EHCPs.
- 9. The claim-approved amount should not exceed the approved amount during Pre-Authorisation and Wallet Balance.
- 10. EHCPs should submit the mandatory documents as specified in the Mandatory Document Protocols (MDP), both at the time of pre-Authorisation and claim.

# 4. ADJUDICATION WORKFLOW

# 4.1. SYSTEM OVERVIEW

To avail benefits from the scheme, beneficiaries must present their BSKY / Adhaar / NFSA / SFSS number at empanelled hospitals. The Transaction Management System (TMS) oversees beneficiary authentication and package selection at empanelled hospitals. The Hospitals, the Adjudication Team and the SHA, utilise the Claims Management System (CMS) to manage preauthorisation and claims workflow. Here is an overview image of the claims journey in the BSKY system.

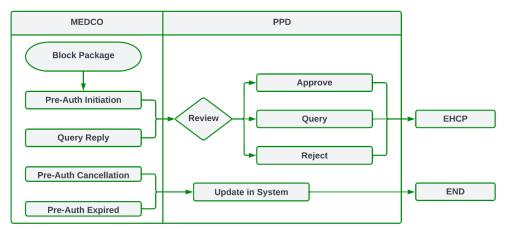
#### BENEFICIARY EHCP MEDCO MEDCO SND Pre-Auth Beneficiary Block Admission Authentication Package Processing Approve / Reject / Query EHCP SHA CPD & SND MEDCO BENEFICIARY Approve / Reject / Query Payment sent Claim Claim Claim Treatment & to Hospital Settlement Adjudication Submission Discharae

# **4.2. CLAIMS JOURNEY**

Flow Chart 1: Claims Journey

# 4.3. PRE-AUTHORISATION WORKFLOW

The Medical Coordinator (MEDCO) or the Data Entry operator at the hospital and the SND at the SHAS are involved in the Pre-Authorisation Processing. The below figure provides an overview of the Pre-Authorisation Workflow.



Flow Chart 2: Pre-Authorisation Workflow

# 4.3.1. BLOCK PACKAGE

When seeking treatment at an empanelled hospital, beneficiary authentication and the package selection for the planned treatment are carried out in the TMS portal by the MEDCO at the hospital. The MEDCO at the empanelled hospital must log in using their provided credentials to the TMS portal (https://bskytms.odisha.gov.in/).



Figure 1: TMS Portal Home Page

The MEDCO then selects the Block Package option on the TMS home page (Figure 1) and enters the beneficiary's URN / NFSA / SFSS number to fetch the household details of the beneficiary family (Figure 2).

/ Block	Package / Add BlockPackag	e Details	_				
6	 Block Package	Package Change	۲ ۲ ۲	hange Ward Type	Unblock	Package 🛛 👔 Di	scharge
Add	View						
NFSA/S	SFSS No.* NFSA/SFS	5 <b>v</b> 7008861737	Search				
atient	Info						
	SS No. : 737	Current Policy : BSKY		Current Policy 01-SEP-22 to 3			
08861				Female Fund (	):	Blocked Amount (₹) : ₹0.00	
	nount (₹) :	Currently Available Amour ₹5,00,000.00	it ( <b>c</b> ) :	₹5,00,000.00		10.00	
im An 00	nount (ਵੈ) : MemberiD		Gender	₹5,00,000.00 Age	Aadhaar Card No.	Ration Card No.	Select Patie
iim An		₹5,00,000.00			Aadhaar Card No. XXXXX XXXX 2180	010100	Select Patie
im An 00	MemberiD	₹5,00,000.00 Name	Gender	Age		Ration Card No.	

Figure 2: Beneficiary Household Details

After selecting the patient from the household list, the MEDCO should choose whether the beneficiary's hospitalisation is regular or emergency and validate the beneficiary. The Aadhaarbased beneficiary authentication must be done by IRIS scan, POS scan or OTP, either by the patient or by any other member of the household (Figure 3). In exceptional circumstances, beneficiary

authentication can be overridden by an Override Code, following approval by the competent authority at the SHAS.

**Note:** In the event that any child members under the age of 18 of a beneficiary family are inadvertently excluded from the NFSA/SFSS database, EHCPs can provide BSKY benefits to such children by raising a claim under the name of the father or mother. To substantiate this claim, the EHCP must furnish documentary evidence provided by the parent that establishes the child's relationship with them.

NFSA/	SFSS No.*	NFSA/SFSS ~ 7008861737		Search							
Patien	t Info										
NFSA/SI	FSS No. : 1737	Current Policy BSKY				urrent Policy Pe 1-SEP-22 to 31-					
Claim A <b>10.00</b>	mount (र) :	Currently Avail ₹5,00,000.00	able Amount	(₹):		emale Fund (₹) 5,00,000.00		Blocked <b>₹0.00</b>	i Amount (रे)		
#SI	MemberID	Name		Gender	Aç	je	Aadhaar Card No.	Ration Ca	rd No.		Select Patient
1	7001	RANJAN DASH		Male	35		XXXX XXXX 2180	70088617	37		Select
2	7002	BHABANI SANKAR MI	OHAPATRA	Male	30		XXXXX XXXXX 3853	70088617	37		Select
Patien	t Details										
Name : RANJAN	DASH	Member ID : 7001	Gender : Male		A 3	ge : 5		Aadhaar Card : XXXX XXXX 2180			
Ом	edical/Surgical/Pre-	Auth O Emergency									
Verifie	d Details										
SI# +	Member Id	Name		Gender	Age	Aadhaar Ca	d No 🕴	Ration Card No	IRIS	POS	OTP
1	7001	RANJAN DASH		Male	35	XXXXX XXXXX :	2180	7008861737	IRIS	POS	OTP
2	7002	BHABANI SANKAR MOHAPATRA		Male	30	XXXXX XXXXX	3853	7008861737	IRIS	POS	OTP

Figure 3: Beneficiary Authentication

Once the patient has been authenticated, the MEDCO blocks the appropriate HBP procedure corresponding to the planned treatment. The MEDCO can review the past claims raised under BSKY for the selected beneficiary household by clicking the 'Click Here For Previous Claims' tab. (Figure 4)

si# 🔶 M	lember Id	Name				Gender	Age	Aadhaa	ar Card No	Ration C	ard No	IRIS	POS	OTP
1 70	001	RANJAN DASH	н			Male	35	XXXX X	XXX 2180	7008861	737	IRIS	POS	Verified
2 70	002	BHABANI SAN	IKAR MOHA	PATRA		Male	30	XXXX X	XXX 3853	7008861	737	IRIS	POS	OTP
		Genera	ite Override	Code										
ackage	Details		н	ospital Type :	1			Ward Ed	itable :	N		Day Care :	Click Here Fo	r Previous Packages 1 A
				ice :		500		Ward Co		97500		Ward Max Unit		
			St	ay Type :	N	4		Max Day	s:	1		Exception Type	: N	
			Pa :	ackage Price Edita	ible N									
ackage he	ader*		Pa	ckage Details*				Sub-Packa	ige*			Ward *		
Cardiolog	IV.		•	ASD Device Closu	e		•	Asd Dev	ice Closure			Routine Ward		
ackage Co	ost *		Wa	ard Cost *				Treatment	Days *			Total Package Cos	t *	
0			5	7500				1				₹97,500.00		
	Add Package													
Package Header	Package Details	Procedure Code	Package Cost	Treatment Days	Ward Name	Ward Cost	Total Cost	Implant Cost	Highend Drugs Cost	Approval Required	Actio	n		
Total Amo	unt to be blocked		₹0.00			₹0.00	₹0.00	₹0.00	₹0.00					

Figure 4: Package Selection

After selecting the package, MEDCO enters additional procedure-specific details like implants and/or high-end drugs, uploads the procedure-specific pre-authorisation mandatory documents

as detailed in the MDP and enters the admission details such as Date of Admission, Treating Doctor's name, the contact details of the treating doctor and the beneficiary. (Figure 5)

0				0			C				0	
Ade	d Package											
Package Header	Package Details	Procedure Code	Package Cost	Treatment Days	Ward Name	Ward Cost	Total Cost	Implant Cost	Highend Drugs Cost	Approval Required	Action	
Cardiology	Asd Device Closure		0.00	1	Routine Ward	97500.00	97500.00	0.00	0.00	YES	1 mplant	
Total Amoun	t to be blocked	i.	₹0.00			₹97,500.00	₹97,500.00	₹0.00	₹0.00			
Total Cost (To	otal Package Co	st +Implant Co	st +Highend	l Drugs Cost)								₹97,500.00
Pre-Auth File*			N	o. Of Days *			Re	ferral Code				
Choose File	1.jpg		×	7			E	nter Referra	al Code		Referral Code	
File to be uploade M8	id in pdf , jpeg , jpg	and size should no	ot exceed 5									
PreAuth Desc	ription *											
ADMITTED F	OR ASD DEVICE	CLOSURE										
Admission	Details											
Actual Date of	f Admission *		D	octor Name*			Do	ctor Phone	No		Patient Phone No *	
15-Jul-23			嚻	DR ARUN KUM	AR		9	898898989			9999888899	
Validate 1	With OTP		0	Validate With	out OTP							
Vital Param	neter											
Decemeter			Malua									

Figure 5: Package-Specific Additional Information and Admission Details

The MEDCO then enters the patient's vital parameters and uploads a clear photo of the patient taken at the hospital during the admission, following which he/she will proceed to block the package. (Figure 6)

RUN KUMAR date Without OTP Add More +	98988985 SL No 1	989 Parameter	999 Value	Action
	SL No	Parameter	Value	Action
Add More +	SL No	Parameter	Value	Action
Add More +	SL No	Parameter	Value	Action
Add More +	1	Parameter	Value	Action
	1			
		Blood Pressure	120/80	٥
	2	Body Temperature	97.6	•
	3	Pulse Rate	72	۰
	4	Respiratory Rate	22	
	5	Sugar	98	
n in Hospital only, this photo will be verified during you	r Pre-Auth and cl	aim Processing. Any other photo like	e Aadhaar card copy, Phot	o where face is not clearly visible or normal passport
ke	ken in Hospital only, this photo will be wrified during you	5	5 Sugar	

Figure 6: Vital Parameters, Patient Photo Upload and Block Package

A case number is assigned after the EHCP has successfully blocked a package (Figure 7). Cases that require pre-authorisation approval are moved to the SND bucket, while others are moved to the EHCP discharge bucket to update claim details.

Actual Date of Admission *		Doctor Name*		Doctor Pho	ne No		Patient Phone	: No *
17-Jul-23	100	DR ARUN KUMAR		98988989	89		9999888899	
Validate With OTP		Validate Without OTP						
/ital Parameter								
Parameter	Value			. Increase	40000000			
Select	~		Add More +	SL No	Parameter	Value		Action
Patient Photo	0	_		1	Blood Pressure	120/80		0
Choose File 2.jpg						97.6		0
Aax file size is 1Mb;Only jpg/jpeg document allow	wed a		6	1		72		
				Č		22		
			Block	Packag	e	98		
Please upload clearly visible patient colored phot photo is not acceptable.	to. The photo sho	ald be taken in Hospital	Save Successfu CASE/9999	Illy, Your Ca	se No is:	e like Aadhaar card co	py, Photo where fa	ce is not clearly visible or normal passpor
Blocking Remark *				ок				
ADMITTED FOR ASD DEVICE CLOSURE				UK				
Block Clear Close								

Figure 7: Block Package Successful

After successfully completing the pre-authorisation request, MEDCO can review submitted preauthorisations under the 'Pre-Auth' tab. Once the Pre-authorisation request has been approved, MEDCO proceeds to block the package in the TMS. Following the successful package blocking, the EHCP can proceed with the patient's treatment. The pre-authorisation approval will expire if the block package is not completed within 7 days of approval. The hospital can cancel the preauthorisation at any point before blocking if required. (Figure 8)

Block Package	P	Package Change	Change Ward Ty	rpe	Jnblock Package		lischarge
Query View							
rom Date :	To Date :	Status :					
01-Jul-23	蘭 17-Jul-23	翩 ALL	<ul> <li>✓ Search</li> </ul>				
Show 10 👻 entries						Search:	
SI No 🕆 URN	Member Details Name   Contact	Case No		ge Details nt   Code   Status	Approved Amount Action Taken By	View Details	Action
SI No 4 URN 0	Name   Contact 7001	Case No CASE/99999/15072023/002		nt   Code   Status 10 7A		View Details	Action Block Cancel
SI No 4 URN		Case No	Request Date Amou Amou	nt   Code   Status		🕴 View Details 🌒	Action

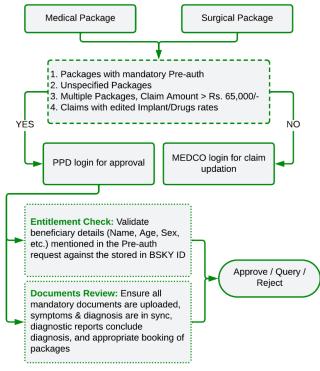
Figure 8: Pre-Auth Tab

# 4.3.2. PRE-AUTHORISATION ADJUDICATION

Pre-authorisation approval from SHAS is mandatory for claims in the following scenarios:

- 1. Packages that require mandatory pre-authorisation approval (Detailed in HBP).
- 2. Unspecified Packages.
- 3. While booking multiple packages, the total claimed amount is more than Rs. 65,000/-.
- 4. Claims with edited implant and/or high-end drug rates.

If an empanelled hospital blocks packages requiring pre-authorisation approval, TMS will raise a Pre-authorisation intimation. The SNDs at the SHAS are responsible for carefully reviewing the preauthorisation requests and taking appropriate action within 24 hours of pre-auth initiation. Preauthorisations are forced approved if SND does not review them within 24 hours. Preauthorisations for unspecified packages are forced approved if not reviewed within 48 hours. A brief outline of Pre-authorisation adjudication is explained below.



Flow Chart 3: PPD Responsibilities and Flow

Once an empanelled hospital submits a pre-authorisation request, it moves to the SND bucket in CMS for review and approval. The SND at the SHAS must log in using their provided credentials to the CMS portal (<u>https://bskyportal.odisha.gov.in/</u>). (Figure 9)

BSKY	三 ) / Preauth / Dashboard						S Welcome TEST SNA
Dashboard	Samesy more					Month-	
	Total Discharged 1					JUCY	
Claim Monitoring U	0		1	0		Year*	
Configuration	Document Upload Pending (Within 7 days of discharge)	Non Uploading (After 7 days of dis	Initial Document	Total Claim Raised		2023	
contraction of the							
Configuration Report	Pending At Hospital	0	Pending At CPD		0 Pending At S	NA	0
Prauth	CPD Query	0	Fresh Claim		0 CPD Approved		0
Ration Card Beneficiary ~	(Within 7 days)	100				ing To Review of CPD Approved	0
Old ClaimMonitoring	SNA Query (Within 7 days)	0	Resettlement		0 CPD Rejected		0
			SNA Reverted		SNA Resettlem	ent	0
	Non Compliance By Hospital	0	Site Structure		Unprocessed C	laim	0
	System Rejected (Non compliance of CPD Query)	0	Pending At DC		0 DC Compliance	0	0
	System Rejected	0	SNA Investigated		Claims On Hold		0
	(Non compliance of SNA Query)		onn mesugateo		System Admin	SNA Rejected	0
		0 Total CPD Approved		SNA Action Taken			0
	0% Action Percentage	0 Approved Of CPD Approved		Total SNA Approved			0
	(Approved & Rejected)	0 Rejected Of CPD Approved		Total SNA Rejected			0
2022 BOKY AS Fights Prograwd	NUTE Presulth details is shown as per						

Figure 9: CMS Portal

SND will then select 'Preauth' to review the pending pre-authorisation requests and select the 'Action' button to review the selected pre-authorisation. The summary of the pre-authorisation requests and past pre-authorisation actions of the concerned SND are shown in the 'Pending' and 'SNA Action Taken List', respectively. (Figure 10)

🕑 BSKI FORM 🛛 🗙	+					_			· - 0	×
← → C	ha.gov.in/#/application/preauth						0,	风迎会	* = 0	0
🌏 BSKY	≡ G) / Preauth / Preauth								S Welcon TEST 8	ns SNA
Desthoord	Presuth SNA Action Taken									
🖸 Claim Monitoring 🔍	Hospital Upload Date From*		To Date*		Status*					
Configuration	01-Jun-2023	8	15-Jul-2023	8	Select Status		*			
MIS Report	State Name		District Name		Hospital Name					
E Configuration Report	Select State	×	Select District	*	Select Hospital Name		*			
E Presuth	Search Reset									
			and a start							
Ration Card Beneficiary	Pending		SNA Action Tak	en List						
Old ClaimMonitoring	1	9%	10				91%		_	
	Presh cases	0 Query Complies	d O Approv	el 🛞	O Reject Cases	0 Query Sent		() 11 or		
	SI No. URN Patient Name		equested Date Package Cor o of Days Package Data		Status	Package Amount	Action	Tak	Action	1
	1 7008861737 RANJAN DAGH	99999 15 Test Hospital		ADMITTED FOR ASD DEVICE CLOSURE	FRESH	₹ 97500	C Details	<i>h</i> e	ion View Details	1
	show 50 v entries;							74.3	revious 🚺 He	1997 (s. 1997) 1997 - 19
8 2023 RDKY A1 Rights Reserved										
and Cloudy			Q Search	= 🐽 🚍 🖷 🧕	9 B					

Figure 10: Pre-authorisation

When a pre-authorisation request is selected, the portal displays hospital Information, Patient Information (including contact and authentication details) and details of the blocked treatment for review by the SND. (Figure 11)

Pre-auth Details			
Case No - CASE/99999/15072023/	/002		
Hospital Information			
Hospital Name Test Hospital	Hospital Code 99999	Hospital Category NABH	
Patient Information			
URN 7008861737	Patient Name RANJAN DASH	Patient Mobile No 9999888899	
Verified Member Name RANJAN DASH	Verified Through OTP	Mobile No Verfied Through OTP NO	
Treatment Information			
Pre-auth Requested On 15-Jul-2023	Procedure Code MC007A	Procedure Name Asd Device Closure	
Package Code MC	Package Name Cardiology	Package Cost ₹ 97,500.00	
Ward Name Routine Ward	Hospitalization Days 1 Days		
Pre-auth Details			
Package Details	Unit	Price/Unit	Total Price

Figure 11: Hospital, Patient and Treatment Information

The SND then reviews the treatment package details, including the details of the implant and/or high-end drugs blocked by the empanelled hospital in the 'Pre-auth Details' section. The documents submitted by the EHCP can be reviewed by clicking the document icon under the 'Latest Document Uploaded' section. (Figure 12)

Package Details	Unit	Price/Unit	Total P
	Implant HighendDrugs		
fotal Package Cost			₹ 97,500
Family Available Fund			₹ 500,000
Female Available Fund			₹ 500,000
nsufficient Amount			₹ 0
atest Document Uploaded			
lospital Upload Date	Hospital Description		Document
7-Jul-2023	ADMITTED FOR ASD DEVICE CLOSURE		
SNA Remark Date	SNA Remark		SNA Description
	-		

Figure 12: Pre-auth Details and Uploaded Documents

The SND can verify the patient's past treatment history under BSKY in the "Treatment History" section. The past claims are thoroughly verified to identify if there are any aberrations in the case. Additionally, details of previous actions taken on the case, ongoing treatments for other household members, and the blocked procedure are visible for scrutiny in the CMS. (Figure 13)

reatme	ent His	story															
Chec	k all dis	scharged	treatment inf	ormation.													
SIØ	Claim No.	URN	Package Code		Hospital Name	Admission Date	Actual Admission Date	Discharge Date	Actual Discharge Date	Hospital C Amount(?)		) Approved punt(१)	SNA App Amount(		Status	CPD Name	Details
Chec	k Old C	laim info	mation.														
SI#	URN	Patient Name	Hospital Name	Date of Admission		ual Date of mission		Actual Date of Discharge		pproved mount(₹)	Approved Date	SNA Appro Amount(₹)		NA Approve ate	ed Ren		SNA Remarks
ation 1	Takan	History															
ction 1	laken I	History	)														
ction 1 SI#		History tion By		Action On		Action Type	A	Action Amount (₹)		Ren	nark	Descriptio	m	Pi	re-auth D	Doc	
SI#	Act	tion By		Action On		Action Type	A	Action Amount (₹)		Ren	nark	Descriptic	n	Pi	re-auth D	Doc	
si# ngoing	Act g Treat	tion By	or URN -														
SI#	Act g Treat	tion By	or URN -	Action On	Proc	Action Type	A Package Code		dmission	Ren		Descriptio Current Sta		Pr Action Date		)oc Arnount I	3locked
Sl# ngoing Case No	Act g Treat o P	tion By transfer for attient Nar	ne Proc	cedure Code		edure Name			dmission								3locked
Sl# ngoing Case No	Act g Treat p P Prmatio	tion By tment for atient Nar	ne Proc		707202	edure Name		e Date of A		Authenticatio		Current St		Action Date	. ,		

Figure 13: Treatment History, Action Taken History, Ongoing Treatment for URN, and Procedure Details

After reviewing all case details and uploaded documents, a pre-authorisation request may be approved, queried, or rejected. The SND must select an appropriate remark from the Standard Remarks Dropdown and enter a description of the action taken. If necessary, the SND can also edit the final approved amount of the pre-authorisation based on the merit of the submitted documents (Figure 14). The list of Standard Remarks is detailed in Annexure - II at the end of this document.

11-6	( <b>A</b>	0.4.05/0000	0/170700	20/201						
l information (	Procedure	Package	Request	Approved	Blocked			Preauth	SNA	
Patient Name	Code	Code	Amount	Amount	Amount	Preauth	Status	Requested Date	Remark	Details
RANJAN DASH	MC	MC007A	97500	0	0	YES	PENDING AT SNA (FRESH)	17-07-2023 11:28:19 AM	NA	0
APPROVED					×₹	97500				
escription										
Provisional Appro	oval is granted b	ased on the n	nerit of the							
Submitted Docum										
				1						
naracters Remaining	: 422									

Figure 14: Pre-authorisation Actions

After carefully reviewing the pre-authorisation request and validating the necessity of the requested treatment, the SND approves the pre-authorisation, and the case will return to the "Pre-Auth" Tab in TMS. (Figure 15)

<ul> <li>⊗ ESIC Portal</li> <li>x +</li> <li>x → C</li> <li>a bskyportal odisha gov</li> </ul>	tion/ormuth		_		_		_	_	•
🋞 BSKY	E A / Preauth /	Preauth	I I ASUR	zuza		Select Status		~	Welcome TEST SNA
	State Name		District N	lame		Hospital Name			
	Select State	~	Select	District	~	Select Hospita	al Name	~	
	Search Reset					_			
	Pending								
	0			$(\checkmark)$				100%	
	0							-	
	0			Success			9	0	<b>a</b> 11
	Fresh cases		Appr	oved Successfully	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	ect ases	(-)	Query Sent	Others
				ок					
							Search		
	SI No. URN Patient Name	Hospital Code Name	Requested Date No of Days	Package Code Package Details	Description Document	Status	Package Amount	Action	Take Action
				N	o data found				
	show 50 v entries								Previous 1 Next *
Anthy cloudy		Q. Sean	h	D 💻 💿 🐂 🔹	9 🧐 🤮 e				1234 17-07-2023

Figure 15: Pre-authorisation Approved Successfully

#### Note:

- The pre-authorisation requests should be reviewed within 24 hours as built-in into CMS.
- If SND takes no action against the raised Pre-authorisation within the defined 24 hours, it will be forced approved. Pre-authorisation for unspecified packages is forced approved if not reviewed within 48 hours.
- In emergencies, the EHCP shall stabilise the patient first and then proceed with beneficiary verification, and in such cases, pre-authorisation approval is not required.

Below mentioned points need to be considered while reviewing the documents:

- Ensure that treatment under the scheme is provided solely to eligible and legitimate beneficiaries. Aadhaar-linked biometric authentication at admission and discharge is mandatory.
- In case of lack of clarity/discrepancy or unavailability of the required information, the SND can raise queries to the EHCP asking for more details.
- Ensure that the EHCP uploads all mandatory documents and that the illness's signs, symptoms and duration are corroborated with the primary diagnosis.
- Ensure that the investigations and diagnostics submitted by the EHCP confirm the final diagnosis.
- Ensure that the treatment package requested by the EHCP is in sync with exhibiting symptoms and the final diagnosis and follows standard treatment modalities.
- Verify the treating doctor's signature, registration number and qualifications.

#### **Pre-authorisation Query:**

If SND cannot make a decision based on the available documents and requires further information, they can raise a query to the hospital. All the deficient documents/information should be asked in one go. The MEDCO at the EHCP should promptly provide SND with the requested information (Query Response) within 7 days.

SND can select the most required deficient document/information from the dropdown options. If multiple documents/information are needed, SND can use the 'Others' option and enter the necessary query details. Sometimes, the query response from a hospital is inadequate, and SNDs may need to raise the same query again. In such cases, SND should explain the reason for rejecting the hospital's response in the 'remarks' box. The SND should raise queries a maximum of 2 times only, and if the necessary information from the EHCP is still not obtained, the pre-authorisation request should be rejected.

#### **Pre-Authorisation Rejection and Reasons:**

Based on the scrutiny of the submitted documents, a pre-authorisation may not be admissible, and SND may decide to reject the Pre-authorisation. The PPD should always mention the reason for the rejection of the Pre-authorisation.

The common reasons for the rejection of Pre-authorisation requests are as follows:

- 1. The clinical findings do not justify the need for hospitalisation.
- 2. Supporting documents and investigation reports necessary to take a decision are not submitted even after multiple queries/reminders.
- 3. Fraud and Misrepresentation.
- 4. The sought treatment falls under the list of exclusions as per the policy terms and conditions.

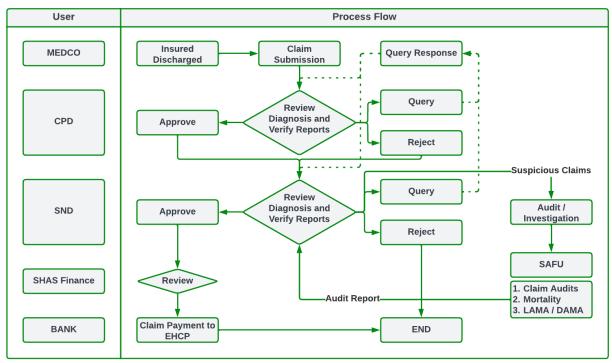
#### Roles and Responsibilities in the Pre-authorisation Process:

SI. No.	Role	Responsibility	Description
1.	Medco / DEO	<ul> <li>Validate and authenticate beneficiaries in TMS.</li> <li>Block appropriate package(s).</li> <li>Raise Pre-authorisation request in TMS.</li> <li>Respond to queries raised by SND.</li> </ul>	<ul> <li>Validate beneficiary household using Adhaar/NFSA/SFSS ID and authenticate the patient.</li> <li>Based on the diagnosis, block the appropriate package(s).</li> <li>Initiate pre-authorisation and provide query response, if necessitated.</li> </ul>
2.	SND	<ul> <li>Verification of medical/clinical information.</li> <li>Decision-making on admissibility and quantum of a claim.</li> </ul>	<ul> <li>Review diagnosis, verify reports, clinical notes, evidence etc.</li> <li>Approve / Reject Pre-authorisation.</li> <li>Raise query / Send back to EHCP for clarification.</li> </ul>

Table 4: Roles and responsibilities in the Pre-authorisation process

## 4.4. CLAIMS WORKFLOW

The MEDCO, CPD, SND, and SHAS Finance Team are involved in the claim's workflow. The below figure provides an overview of the claims process flow.



Flow Chart 4: Claims Process Flow

## **4.4.1. PATIENT DISCHARGE**

After the patient completes the treatment and is discharged from the Hospital, MEDCO will discharge the patient from the TMS in the "Discharge" Tab (Figure 16).

				s delivered to all patients Quarters and Government I rate hospitals for IISKY can				
	Block Package Block Package Blocknog o package spanst patent UIN.	Package Change Change the package through URN.	Change Ward Type Change the ward through URN 2	Unblock Packag Unblock pastar agaret patient URV	e Discharge j	charge patient through URN.	•	
				Show Data	01-Jan-23		17-Jul-23	田
Patient Details	L.	1		=	Procedure		E 8500	

Figure 16: Discharge Tab

On selecting the "Discharge" Tab, the page expands to display the cases available for discharge. To discharge a case, MEDCO clicks the "Discharge" button against the case number (Figure 17).

Action
Discharge
Previous 1 Nex

Figure 17: TMS Cases for Discharge

During discharge from TMS, the patient must undergo an Aadhaar authentication process again. This can be done by the patient or a household member through IRIS scan, POS scan or OTP. In exceptional circumstances, beneficiary authentication can be overridden by an Override Code, following approval by the competent authority at the SHAS. (Figure 18)

Block Package	Package Change	City City	nange Ward Type	Unblock Package		Discharg	2
atient Information   URN - 70	08861737						
atient Name : ANJAN DASH urrent Policy Period : 1-Sep-22 To 31-Aug-23 <b>ferified Details</b>	Current Policy : BSKY Patient Phone No: 9999888699		Blocked Amount: 97500 Cate No: CASE/99999/170720	٥	med Amount:		
Sl# 🗍 Member Id 👋 Name		6 Gender	Age 🕴 Aadhar Card N	lo 🕴 Ration Card No	+ IRIS	POS	OTP
1 7001 RANJA	N DASH	Male	35 XXXX XXXX 21	90 7008861737	1815	POS	019
2 7002 BHAB/	INI SANKAR MOHAPATRA	Male	30 XXXXX XXXX 38	53 7006861737	IRIS	POS	OTP.
	Senerate Override Code						

Figure 18: Patient Authentication during Discharge

After authenticating the patient, MEDCO selects the final blocked packages and enters discharge details. In case of patient death during hospitalisation, MEDCO selects 'Mortality' as 'Yes' and uploads the Death Certificate. (Figure 19)

si# +	Member Id	Name			Gende	r 🕴 Age	Aadhar Card No	+ R	ation Card No	IRIS	POS	OTP	
1	7001	RANJAN DASH			Male	35	XXXX XXXX 2180	7	008861737	IRIS	POS	Verified	
2	7002	BHABANI SANKAR MOHAP	ATRA		Male	30	XXXX XXXX 3853	7	008861737	IRIS	POS	OTP	
		Generate Override C	ode										
	ed Package Detail		Procedur	re Details		Amount Blo	ked						
Sløcke	ed Package Detail	Package Details Code   Name	Procedur Code   Na		÷	Amount Blo Blocked Date	ked Insufficient A	Amount	Package Ar	nount	🔶 Claim An	nount	
		Package Details	Code   Na	ame			ked Insufficient J ₹0	Amount	● Package Ar ₹ 97500	nount		nount	•
SI# ♠ 1	Member Name	Package Details Code   Name	Code   Na	ame		Blocked Date	Insufficient A	Amount		nount			
si#≜ 1 Discha	Member Name RANJAN DASH	Package Details Code   Name	Code   Na	ame		Blocked Date ₹97500 17-Jul-23	Insufficient A	Amount		nount			
SI# 🛉 1 Discha	Member Name RANJAN DASH arge Details Date of Admission *	Package Details Code   Name	Code   Na	ame ice Closure	e of Discha	Blocked Date ₹97500 17-Jul-23	Insufficient A	Amount	₹ 97500	nount			
si#≜ 1 Discha	Member Name RANJAN DASH arge Details Date of Admission *	Package Details Code   Name	Code   Na	ame ice Closure Actual Date	e of Discha	Blocked Date ₹ 97500 17-Jul-23	Insufficient A		₹ 97500 Claimed Amount*	nount			

Figure 19: Selection of Final Blocked Package and Discharge Details

The MEDCO then enters the patient's vital parameters at discharge. If the patient is referred to another empanelled hospital, MEDCO selects the "Yes" option for Refer to Other Hospital and enters the relevant details. (Figure 20)

Vital Parameter						
Parameter Value			Marine and		0.0000	
Select 🗸	Ad	id More +	Si# Para	meter	Value	Action
			1 Bloc	d Pressure	120/80	
			2 Bod	y Temperature	97.6	
			3 Puls	e Rate	72	
			4 Resp	airatory Rate	22	
			5 Sug	er .	98	
			6 Bloc	d Pressure	120/90	
			7 Bod	y Temperature	98.4	
			8 Puls	e Rate	70	
			9 Res	iratory Rate	24	
			10 Sug	ar.	78	•
Refer To Other Hospital	Ves 🔘 No					
Any Empaneled Hospital	Specific Empanele	d Hospital				
State •	Dis	trict *		Hospital Name		
select	¥					
Refer From Other Hospital						
Doctor Name *	Dep	partment *		Date *		
		son for Referring *				
Referral Document	Nea					

Figure 20: Vitals at the time of discharge and Refer to Other Hospital

The MEDCO then uploads all the package-specific mandatory documents at discharge as detailed in HBP. Additionally, MEDCO uploads the Pre, Intra, and Post-Surgery photographs along with the picture of the removed specimen, if applicable. After entering all mandatory details on the discharge page, MEDCO submits the claim by clicking the "Discharge" button. (Figure 21)

				8	Pulse Rate	70	0	
				9	Respiratory Rate	24	8	
				10	Sugar	78	0	
Refer To Other Hospital	Yes O	Νο						
lischarge Summary Document Choose File 3.jpg	×							
le to be uploaded in pdf , jpeg , jpg and size s	hould not exceed 5							
ntra Surgery	PLL .	Post Surgery		Pre Surgery	The second se	Specimen Remo		-
Choose File 4 jpg	COLUMN 1	Choose File S.jpg	1	Choose File 6.jpg	( Internet	Choose File		
tax Re size is 1M8,Only jpg/jpeg document lowed		Max file size is TMB.Only jpgg/peg document slipwed		Max file size is 1148, Only jpg allowed	(peg occument	allowed	nly jpg/jpeg document	
lischarge Remark *								
ASD DEVICE CLOSURE DONE, PATIEN	NT STABLE AND	FIT FOR DISCHARGE						
Discharge Clear Close								

Figure 21: Document Upload and Patient Discharge

Once the patient is successfully discharged, the case will move to the EHCP bucket in CMS. The hospital must submit the claim documents within 7 days to avoid rejection by the IT System. (Figure 22)

			1.050	stood muchanismus	1000	
			8	Pulse Rate	70	
			9	Respiratory Rate	24	0
			10	Sugar	71	
Refer To Other Hospital 👘 Yes	O No					
Refer To Other Hospital 💮 Yes	U NO					
Discharge Summary Document						
Choose File 3.jpg			$\checkmark$			
The to the updatalled in polf , goog , ) pay and time chould not as	covert it MD					
ntra Surgery	Post Surgery	Di	charge	0	Specimen Rem	ioval 🤷
Choose File 4 jpg	Choose File 5/0		scharge		Choose File	7.jpg
Are the size is 1Mb.Celly jpg/gasg document Moned	tates file size is 1MR.Dr. p.	Discharged Successful	days.	im within 7	Marc file size is TMI afforwed	R.Delyjpgjpeg microsert
Dischurge Remark *			OK			
ASD DEVICE CLOSURE DONE, PATIENT STABLE	AND FIT FOR DISCHARG		UK			
Discharge Clear Close						

Figure 22: Patient Discharged in TMS

## 4.4.2. CLAIM SUBMISSION

To submit a claim, MEDCO needs to log in to the CMS portal (Figure 23). The CMS portal can be accessed by clicking the "Login CMS" button at the top right of the TMS Home Page.

⊘ SSCFFortal × ← → Ο		ny/hospital-dashboard			<ul> <li>日 </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日  </li> <li>日   日 <p日< p=""> 日 日 日 <p日< p=""> <p日< p=""> <p日< p=""> 日</p日<></p日<></p日<></p日<></li></ul>
🛞 BSKY		≡			Welcome Test Hospital
Dashboard		Total Dishcarged 2			Month* JULY
Claim Monitoring	~	1	1	0	Year
MIS Report	~	Document Upload Pending (Within 7 days of discharge)	Non Uploading Initial Document (After 7 days of discharge)	Total Claim Raised	2023
Old ClaimMonitoring	~				
		Pending At Hospital	0	Non Compliance By Hospital	0
		CPD Query (within 7 days)	0	System Rejected (Non compliance of CPD Query)	0
		SNA Query (within 7 days)	0	System Rejected (Non compliance of SNA Query)	0
		Notifications	4		
		* IRIS and POS Non-functional Mana	agement 🕹		
		* Admission of beneficiaries under I	BSKY 🕹		
		* Addition of New Package under B	SKY 🕹		
		* UPDATED PACKAGE ON BSKY 🕹			
	rved				
Sinc Meetly cloudy		📑 Q 5e	ech 🕒 🖻 🗎 🤹 🧿	🤹 🧑 🖳 🗸	17-02

Figure 23: Login CMS

Cases for claim submission are available in the "Claim to Raise" tab under "Claim Monitoring". To submit a claim, MEDCO must click the "Claim" button against the corresponding case number. (Figure 24)

SSEP Portal x → → C	+ win/#/applica	ation/claimmise									ė		- 0 1 0 0
🔋 BSKY	= 0	් / Claim M	lonitoring /	Claims to Raise									eloome est Hospita
	Claims	to Raise											
	Actu	al Date of Disch	sarge From*		To*			Case Number					
	01-	-Jun-2023		8	17-Jul-2023		8	Enter Case Nu	mber				
	Pack	kage Category			Package Name			URN					
	Sel	Select Package Category ~ Search Reset			Select Package Name 🗸			Enter URN					
	Se												
MIS Report										Search	here		
Old ClaimMonitoring										± 0			
	SI No.	. URN	Patient Name	Case Number	Invoice Number	Package Code	Admission Date	ActualDate Of Admission	Discharge Date	ActualDate Of Discharge	Claim Raised By	Amount(₹)	Action
			RANJAN DASH	CASE/99999/17072023	/001 30199999170723001	MC007A	17-Jul-2023	17-Jul-2023	17-Jul-2023	17-Jul-2023	24-JUL-2023	97,500.00	Clai
	1	7008861737	phon										
	÷		DNam			•••••			•••••			Desidents	1 Nav
	÷	7008861737	UNIT								3	Previous	1 Mai
	÷		DAGH								3	Previous	1 May
	÷		UNOT								3	Previous	1 May
	÷		UNOT									Previous	1 Hay
	÷		UNOT									Previous	1 Hay
	÷		LAGH								3	Previous	1 Nav

Figure 24: Claim to Raise

The claim details, such as Basic Information, Patient Information, Blocked Treatment Details and the Pre-auth Log, are visible to the MEDCO when selecting a case. (Figure 25)

C 🔒 bskyportal.odisha.gov.	m/#/application/claimrase/Action		0. () 合 条 司 🛛
🛞 BSKY		ils	Welcome Test Hospital
Dashboard	Claim Raise Details		(*) Indicate mandatory
🕙 Claim Monitoring 🔋 🔨	Basic Information	Patient Information	
	URN 9008861737	RANJAN DASH	
→ Claims Queried by SNA     → Claims Queried By CPD     → Non compliance of Query-SNA	Blocking Invoice Number 30199999170723001	<ul> <li>35</li> <li>27 MALE</li> <li>9999888899</li> </ul>	
Non compliance of Query-SNA     Non compliance of Query-CPD     MIS Report	Case Number CASE/99999/17072023/001	CSM TECH, CSM TECH, SHAS, KHODHA, ODISHA	
Old ClaimMonitoring ~	Treatment Details		
	Actual Date of Admission - Actual Date of Discharge 17-Jul-2023-17-Jul-2023	Package Rate (*)	Blocked Amount (*) 97,500.00
	Peckage Code MC Package Name Cardiology	Sub-Package Code MC007 Sub-Package Name Asd Device Closure	Procedure Code MC007A Procedure Name ASD Device Closure
	Authentication Made	Is Patient OTP Verified	Referral Authotatus N/A
Birc Methy deady	Q. Search	🕒 🖉 🖲 🧮 🤹 🎯 🥶 🧶 🖉 🗸	13-49

Figure 25: CMS Claim Raise Details

The MEDCO proceeds to upload all the package-specific mandatory documents in the "Discharge Slip" and "Additional Slip" fields. The mandatory documents to be submitted at the time of claim submission for each package are detailed in HBP. Once all the mandatory documents and the necessary photographs are submitted, MEDCO can proceed with claim submission by clicking the "Submit Claim Request". (Figure 26)

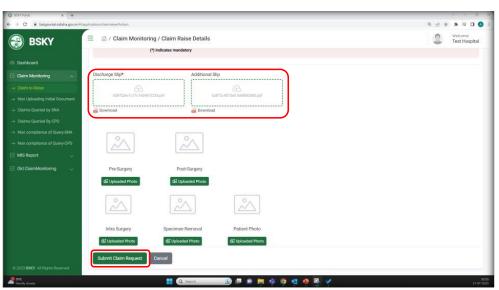


Figure 26: Document Upload and Claim Submission

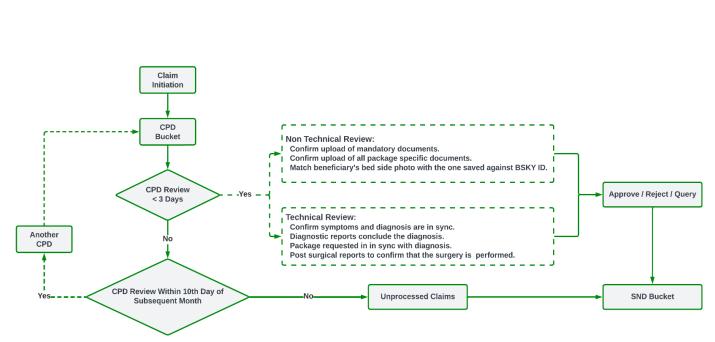
After a claim is submitted successfully, it is assigned a unique claim number and moves to the CPD bucket in CMS for adjudication. (Figure 27)

<ul> <li>⊗ 8507 Fortal</li> <li>× +</li> <li>← → C          <ul> <li>bstyportal od sha gov:n/#</li> </ul> </li> </ul>	application/daimmise			-	-	9	1.0 4	- 0 ×
🌏 BSKY		to Raise					2	Welcome Test Hospital
Dashboard	Claims to Raise							
🔄 Claim Monitoring 🛛 🚿	Actual Date of Discharge From*	To*		Case Number				
-) Claim to Raise	01-Jun-2023	17-Jul-2023	69	Enter Case Numb	xer.			
→ Non Upleading Initial Document	Package Category	Parlane Harris						
	Select Package Category			HURN				
	Search Reset							
	Search March	$\checkmark$						
		0				Search here		
		Success						
		Claim Raised Successfully, (Claim	1 No. : CLF6148489)					
	SI No. URN Patient Case Name Number	ок		Discharge Date	ActualDate Of Discharge	Claim Raised By	Amount(	f) Action
	_			_				
Acouty cloudy		2 Search 🕒 🕒 📄	1 🤨 👰 🤨	B 🗶				22.28 17-07-2023

Figure 27: Claim Submission Successful

## 4.4.3. CLAIM ADJUDICATION BY CPD

After MEDCO submits a claim, a unique claim number is generated for the claim, and it will move to a CPD bucket in the CMS portal. The assigned CPD will have 3 days to complete the claim adjudication. If the CPD does not process the claim within 3 days, it will be randomly assigned to another CPD for adjudication. Claims not processed by the 10th day of the subsequent month will be tagged as Unprocessed Claims and will move to the SND bucket for further review. To better understand this process, refer to the following diagram.



Flow Chart 5: CPD Adjudication Process

The CPD will log in to the CMS using the credentials provided to adjudicate a claim. Next, they will navigate to the 'Claim Monitoring' tab, select 'CPD Approval', and click the 'Action' button corresponding to the claim they want to review. (Figure 28)

	Annews	al by CPD								
B Dashboard										
Claim Monitoring		Date of Discharge From*	田	Actual Date of Discharge To* 02-Aug-2023		Ascendin	д Ву	~	Authentication Mode	
	Searc	ch Reset								
Configuration	Pending	Claims : 3					± 0	Search		
MIS Report	SI#	Claim No	URN	Patient Name		ual Date Admission	Actual Date of Discharge	Allotted Date	Action to be Taken by	Take Action
	1	CL347CD596	22222222	PRIVADARSHAN	01-	Aug-2023	01-Aug-2023	01-Aug-2023	03-Aug-2023	Action
	2	CLA333C483	22222222	AKSHAT GUPTA	01-	Aug-2023	01-Aug-2023	01-Aug-2023	03-Aug-2023	Action 2 days left
	3	CLE9A86B6C	7008861737	RANJAN DASH	01-	Aug-2023	01-Aug-2023	01-Aug-2023	03-Aug-2023	Action 2 days left
	show 1	0 v entries					revious 1 N			
							-			

Figure 28: CMS CPD User and Claim Selection

During claim adjudication, CPD should follow a comprehensive approach consisting of Technical and Non-Technical reviews. These reviews complement each other to provide a thorough evaluation of every claim. This meticulous process ensures that all relevant parameters are scrutinised, leading to reliable and accurate adjudication.

#### **Non-Technical Review:**

To verify the accuracy of the claim, CPD will conduct a non-technical review to confirm the individual's name, age, and gender. Furthermore, the availability of all supporting documents is also to be ensured. The Non-Technical review will examine the following details.

- 1. Confirm if all mandatory documents detailed in the MDP have been submitted and are legible.
- 2. Confirm if the Date of Admission and Date of Discharge updated in the TMS match the submitted documents.
- 3. Confirm if the name, age and gender of the beneficiary detailed in the BSKY database match the submitted documents.
- 4. Confirm if all the documents are duly signed by the treating doctor.

#### **Technical Review:**

For the technical review, the CPD diligently examines the submitted claims and validates all medical details, including patient information, diagnosis, treatment plans, and supporting investigations. This review ascertains the medical necessity of the treatment for the patient's medical condition, as evidenced by the supporting documents and investigation reports, and determines the admissibility and amount of the claim.

On selecting a claim, the CPD can review the patient and treatment details, including the hospitalisation specifics and the package blocked. (Figure 29)

aim						(*) indicate mandatory
RN - 700886173	7				Claim	Submission Date : 01-Aug-2023 09:40:22
35 Years, M 999988889	lale		Case Number CASE/99999/01082023/		0000 Number 9999010823001	Claim Number CLE9A8686C
eatment Details						
Authentication	on Mode (Blocking)	Authentication M	ode (Discharge)	Is Patient OTP Verified	6	Is Emergency Medical/Surgical/Pre-Auth
Date		Actual Date		Package Rate	Amount	
Admission 01-Aug-2023	Discharge 01-Aug-2023	Admission 01-Aug-2023	Discharge 01-Aug-2023	Rote (1)	Biocked (?) 97,500.00	Claired (?) 97,500.00
Mortality	Claim Details				Hospital Incentive Flag	
Hospital NO	Claim Bill Number NA	Referral Code NA	Refertal Aut NA	h Status	During Blocking NABH STATE	Current Status NABH
Package Details Package	Code	Name Cardiology (5				
Sub Package	MC007	Asd Device Closure				
Procedure	MCD07A	ASD Device Closure				

Figure 29: Review of Patient Details and Treatment Details

CPD will then review the pre-authorisation details along with the documents submitted during package blocking and the discharge details along with the documents submitted at the time of claim submission to ascertain the medical necessity and confirm the treatment provided. The CPD then validates the patient and clinical photographs submitted by the EHCP. (Figure 30)

SI#	Pre-Auth Code	Amour (₹)	nt Ap (₹)	proved Amoun	t Pre-Au Date	th Approv Date	ed	Remark								Document		tails
1	74844601	97,500.	00 97,	500.00	01-Aug 2023	- 01-Aug			D ( REMA documer	RK - Provisional Approval is granted based on the merit of the					Do	c1 Doc2	– Clic	
ro.A	uth Log Histo	100																
	Hospital Request Description		Request Amount (₹)		SNA First Query Remarks	SNA First Query Description	First Query Date	First Query Reply By Hospital	First Query Reply Date	Document 2	SNA Second Query Remarks	SNA Second Query Description	Second Query Date	Second Query Reply By Hospital	Second Query Reply Date	Document 3	SNA Final Remarks	SN. Des
_	_	_	_	_	_	_	_		_	ħ	lo data foun	d	_					
Lates	st Documents	Uploaded	d(Verify Al	The Document	s Uploaded)											Ŧ	Download A	
	B.F.	POF	)						[	Pre-Surgery	Po	2		Spec	<u>.</u>	Q. Patient-	1	
	harge A ilip	dditional Doc								×	Sur		Surgery	Rem		Photo		

Figure 30: Review of Pre-authorisation and Discharge Details with Documents

After verifying the treatment details, CPD reviews the High-End Drugs and Implants Details, if any, and confirms the patient's bed category during hospitalisation to determine the payable quantum of the claim. Additionally, CPD verifies the beneficiary's past treatment history to ensure there are no aberrations. (Figure 31)

Q / 0	Claim Monitoring	/ CPD Appro	val									\$	testo
igherid D	muga												
12	Code	Name	Unit Price(R)		UNIE	Total Price(*)	Reconstructed	d Dose	Pre-	Auth Required	Activity Done	0n	
							No Data Found						
plant													
1#	Code	implant N	larrie		Procedure Code		Unit Price(T)		Unit	Total Amount(T)	Acti	ion On	
							No Data Found						
ard													
u.	Ward Name		Ward Am	(T)		Word Block Date		Pre-Auth	Required		crivity Done On		
	Routine Ward		97,500.00			01-Aug-2023 09-28-16		YES		1	1-Aug-2022-09-26-16		
natment	History												
	ge Treatment Inform	vation											
URN URN	Case No		Package Code	Patient Name	Date of Admission	Actual Date of Admission	Date of Discharge	Actual Date of Discharge	Action Amount(#	) CPD Approved Amount(?)	SNA Approved Arrount(T)	Status	Detail
	1861737 CASE/9999		0590MC007A	RANJAN DASH		01-Aug-2023	01-4up-2023	01-Aug-2023	97,500	PACA.	N/A	CLAIM BAISED	
7998	1861737 CASE/9999	9/17072025/001	0500M0007A	BANJAN DASH	17-Jui-2023	17-3d-2023	17-Jul-2023	17-Juil-2023	17,500	NA1.4	N/A	CLAIM BAISED	Cloth
Old Clai	im information												d
* URS	Case No Paties	nt Name Date	of Admission	Actual Date of Add	nission Date o	f Diacharge Actual Date of	Dischurge Claim 5 No data found	Itatus Approved Amount	t(Ŧ) Approved Du	ne SNA Approved Amount	(?) SNA Approved Date	Remarka SN	A Remar
ultiple P	ackage Blocking												

Figure 31: High-End Drugs and Implant Details, Ward Category and Past Treatment History

Once all the details have been reviewed and scrutinised, the CPD can either approve the claim, raise a query, or reject the claim, based on the merit of the uploaded documents, after due diligence. Partial payment can be approved if the claim details or documents do not justify the entire claim. CPD can edit the payable amount in the 'Approved Amount' tab. The CPD needs to select the most relevant remark from the dropdown and enter the description of the action taken. The CPD also needs to confirm the mortality status of the patient in the 'Mortality' dropdown if the patient has expired during the hospitalisation. (Figure 32)

	Admission	Discharge	/	Amount(₹) Date	
		No data found			
Iultiple Package Blockir	ng				
SI# Patient Name	Date of Admission	Date of Discharge	Package Name	Claim Raised	Details
		No data found			
emark * APPROVED	×	pproved Amount * ₹ 97500			
iortality * No	~ ] [	escription * Claim approved based on the m	erit of the submitted		
		documents haracters Remaining: 440		1	
		naracters kemaining, 440			

Figure 32: CPD Action

If CPD needs additional documents/information to decide on the claim, they should ask for all the deficient documents/information in one go. Under no circumstances should CPD raise queries to EHCP more than once. The MEDCO at the EHCP should promptly provide the requested information (Query Response) within 7 days. CPD can select the most required deficient document/information from the dropdown options. If multiple documents/information are needed, CPD can use the 'Others' option and enter the required query details. If the necessary information from the EHCP is still not obtained, the claim should be rejected, and SND will further review the claim. After diligently reviewing all the claim details and determining the payable amount, the CPD can approve the claim. Once approved, the claim will be moved to the SND bucket for review. (Figure 33)

<ul> <li>⊕ DSKYPertal</li> <li>← → C          <ul> <li>■ bskyportal.odi</li> </ul> </li> </ul>	× + isha.gov.in/#//	application/cpdap	proval								• ପ୍ନ	× - ○	x
🛞 BSKY		= @/	Claim Monitorin	g / CPD Appr	oval						4	Welcome testcpd	l
		Approval by	CPD										
	^	01-Jan-2		Ē	Actual Date of Discharge To* 11-Aug-2023	Ħ	Ascending By URN			Authenticati	on Mode	~	
	× ×	Search Pending Cla	Reset		$\checkmark$	)		, 0	Search				
	~	SI#	Claim No	URN	SUCCE	SS		l Date charge	Allotted Date	Action to Taken by		ake Action	
		1	CLA258FA81	2222	Claim Approved S			g-2023	11-Aug-2023	13-Aug-2	023	Action 3 days left	
		2	CL37A7C9C1	2222	ок			g-2023	11-Aug-2023	13-Aug-2	023	Action 3 days left	
		show 10	✓ entries				« Previo	us 🚺					
	erved												
				Q Search	💷 💿 🥠	چ 📮 🧟	E 🤉		2		^ <b>≏</b> <sup>DNS</sup> ⊗	¢× ⊕ 14:28 (	•

Figure 33: Claim Approved by CPD

#### **CPD Re-settlement Claims:**

CPD will raise queries on claims requiring additional documents or information for final action and can review the query responded claims in the 'CPD Re-settlement' bucket under the 'Claim Monitoring' tab. CPD will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 34)

	-	cation/opdreapproval	itoring / CPD Re-S	ottlomont					en Q 🕜 🖈 🖬 🌘
🖁 BSKY			noning / GPD Re-3	ettement					- testcp
Dashboard		Re Settlement by CPD							
Claim Monitoring	~	Actual Date of Discharge		Actual Date of Discharge To*		Select Ascending By		Authentication Mo	ode
	·····*	01-Jun-2023	包	11-Aug-2023	8	URN	*	All	
		Search Reset							
		Search							
Configuration	~	Pending Claims : 0				💷 🔯 Sear	ch		
		rending Claims : U							
HR MIS Report	× 1	∙ending Claims : 0 Sl# Claim No	URN	Patient Name	Actual Date of Admission	Actual Date of Discharge Re-apply on NO DATA FOUND		Action to be Taken by	Take Action
	× 1		URN	Patient Name		of Discharge			Take Action
	× 1		URN (	Patient Name		of Discharge			Take Action

Figure 34: CPD Re-settlement Claims

After diligently reviewing the CPD Re-settlement claims, CPD will select the most relevant remark, enter the description of the action taken, and take appropriate action.

#### **SNA Reverted Claims:**

If the SND finds a shortfall in the quality of CPD adjudication, they will revert such claims to the CPD for re-evaluation. Such claims can be accessed from the 'SNA Reverted' bucket under the 'Claim Monitoring' tab. CPD will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 35)

🕑 BSET FORM	+								
← → C il bikyportal.ods	shagov.in/#	application/cpdrevert						0+	a 🤃 🛪 🛪 🖬 🔕 I
🛞 BSKY		□    □    □    □    □    □    □	g / SNA Reve	rted					Welcome testcpd
Dashboard		Revert by CPD							
Claim Monitoring		Actual Date of Discharge From*		Actual Date of Discharge To		Select Ascending By		Authentication Mode	
		01-Jun-2023	日	11-Aug-2023	0	URN	*	All	Y
		Search Reset							
Configuration						-	Search		
		Pending Claims : 0				± 🛽	Search		
MIS Report		Si# Claim No	URN	Patient Name	Actual Date Actual Of Admission of	tual Date SNA Reverted	On	Action to be Taken by	Take Action
		*				NO DATA FO	UND !!	•••••	
•			Q Search		🤌 🕒 🥶	E 🧿 🖷 🧶 🖳	_	^ <b>6</b>	ENG & C+ 1000 0

Figure 35: SNA Reverted Claims

After diligently reviewing the SNA Reverted claims, CPD will select the most relevant remark, enter the description of the action taken, and take appropriate action within 24 hours of SND revert. If the SNA Reverted claims are not processed within 24 hours, the claims will be pushed back to the SND bucket as unprocessed claims.

#### While making a decision, it is crucial to take into account the following:

- 1. The EHCP is responsible for uploading all mandatory documents as stated in the MDP. Still, failure to submit these documents alone cannot result in claim rejection unless it is crucial to CPD decision-making.
- 2. Ensure that the physician's final diagnosis and the treatment provided are consistent with the symptoms, signs, and duration of the patient's illness.
- 3. Ensure that the investigations and diagnostic reports uploaded by EHCPs support the final diagnosis and validate the post-surgery reports to confirm that the blocked surgery has been performed.
- 4. CPDs should validate the LOS with the discharge summary and carefully verify the ward category and, subsequently, the approval amount.
- 5. Ensure that the packages blocked by EHCPs align with the final diagnosis of the claims.
- 6. CPDs should verify the signature of the treating doctor along with the registration number and qualification.
- 7. In case of death claims, CPD should review the death summary, prognosis notes and other relevant documents.
- 8. The rates claimed for Implants and High-End Drugs should be validated with the GST Purchase Invoice.

#### The Generalised List of Documents for CPD Scrutiny is as follows:

- 1. OT notes and surgery notes as applicable.
- 2. Clinical notes.
- 3. Discharge summary.
- 4. CPD should ensure that the clinical photograph uploaded is relevant and not a "Google" image.
- 5. Investigation reports.
- 6. ICP records as applicable.
- 7. ICU Master Charts/ Nursing Charts are submitted in Mortality / ICU Claims

#### Post CPD scrutiny, the claim actions can be as follows:

- 1. If everything is in order and all the relevant parameters are deemed satisfactory by CPD, the claim will be approved.
- 2. If there are any deficient or incomplete documents, CPDs should raise a query for them.
- 3. If the claim does not meet the criteria for approval and payment, it can be recommended for rejection.
- 4. In cases where the details or documents do not support an entire claim, the CPD can recommend approving partial payments.

#### **Claim Rejection:**

After careful scrutiny, CPD may recommend the rejection of a claim with appropriate justification and remarks. Such cases will then be forwarded to SND for further review. After diligently reviewing such claims, SND may reject the claim if deemed necessary. Such claims can be sent to the Technical Committee for reconsideration. The SHAS reserves the right to revoke a rejected claim, and if the SHAS decides to revoke a claim, it will be sent back to the SND bucket for readjudication. Rejection of claims is recommended under the following scenarios:

- 1. Based on the clinical findings submitted by the EHCP, the need for hospitalisation is not justified.
- 2. Despite multiple queries/reminders, the necessary supporting documents and investigation reports for CPD decision-making have not been provided.
- 3. Fraud and Misrepresentations.
- 4. Insufficient beneficiary household wallet amount.
- 5. The treatment sought falls under the list of exclusions as per the scheme policy.

#### 4.4.5. CLAIM REVIEW BY STATE NODAL DOCTORS (SND)

The State Nodal Doctors (SND) play a pivotal role in the Biju Swasthya Kalyan Yojana (BSKY), encompassing a comprehensive review process. This involves reviewing 10% of CPD approved claims and 100% of rejected, mortality, re-settlement, and unprocessed claims on a monthly basis. This meticulous evaluation is repeated to ensure that all relevant parameters are thoroughly scrutinised, ultimately resulting in reliable and accurate claim adjudication.

#### **CPD Approved Claims Review:**

SND shall randomly review 10% of the total claims approved by the CPDs during a calendar month for review. The review should focus on verifying the accuracy of the information, adherence to BSKY guidelines, and compliance with the HBP package rates. SND shall document the review findings and provide feedback to the CPDs for necessary corrections or improvements. The SND will log in to the CMS portal with their issued credentials. To review the CPD Approved claims, SND will select the 'CPD Approved' bucket under the 'Claim Monitoring' tab. (Figure 36)

BSKY	E 🕼 / Dashboard						C. TEST SNA
Deshboard	Total Discharged 5					Month	
Claim Monitoring 🔷	0		1	4		AUGUST	
CPO Approved	Document Upload Pending	Non Uploading I	initial Decomposi	Total Claim Raised		Year' 2023	
SNA Revettlement.	(Within 7 days of discharge)	(After 7 days of disc		Total Claim Raised		2023	
CPO Reported							
Unprocessed Claim	Pending At Hospital	0	Pending At CPD		3 Pending At S	NA	1
Claims On Hold	CPD Query		-		CPD Approved		1
URN Wale Action	(Within 7 days)	0	Fresh Claim		3	ing To Review of CPD Approved	0
Non Compliance Guery By SRA	SNA Query	0	Resettlement			of the review of Carly Approved	
Non Compliance Query By CPD	(Within 7 days)	U.	Resettement				0
Claim Processed			SNA Reverted		SNA Resettiem	ent	0
Estension Of Non Compilance	Non Compliance By Hospital	0			Unprocessed C	laim	0
DC Compliance	System Rejected (Non compliance of CPD Query)	0	Pending At DC		DC Compliance		0
Post Payment Updation			renaing Actor		Claims On Hold	1	0
Sytem Admin SNA Rejected List Generate Float	Bystem Rejected (Non compliance of SNA Query)	0	SNA Investigated		D System Admin	SNA Rejected	0
Payment Freeze Action							
Configuration ~		1 Total CPD Approved		SNA Action Taken			0
MIS Report	0%	0		Total SNA Approved			0
Configuration Report	Action Percentage (Approved & Rejected)	Approved Of CPD Approved					
Preauth	(detroited a reference)	0 Rejected Of CPD Approved		Total SNA Rejected			0
Bation Card Beneficiary							

Figure 36: Claims Management System – SND User

Within the 'CPD Approved' tab, the CPD approved claims for a specific month are compiled. SND can use the 'Advanced Search' feature to precisely select and extract claims for review under the mandated 10%, ensuring an optimal distribution of claims for the SND review. SND will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 37)

යි / Claim Monitoring / CPD Appr	roved								_	2	Welcom TEST S
Approved											
tual Date of Discharge From*			Actual Date of D	Ascharge To*							
91-Jul-2023		8	09-Aug-2023				8				
Advanced Search											~
State Name		District Name			Hospital N	ame		Authentication	n Mode		
Select State	~	Select District			<ul> <li>✓ Select H</li> </ul>	ospital Name		All			Ŷ
Amount		Description			Mortality			CPD Status			
ALL	*	Enter Descriptio	0		Select M	ortality		CPD Approv	ed		1
Procedure		Package			Ward		Implant			nd Drug	
Select Procedure		Select Package			Select W	bi	Select Implan	6	✓ Sele	ict Highend Drug	~
Search											
Search URN, Claim No, Patient Name, Pho	ne No, Hospital	Details, Invoice No. I	Package ID		9						
earch Repet											•••••
ding Claim : 1 Approved from CPD: 1	Settleme	nt By SNA (Approved	i/Reject): 0	Percent : 0%	Query By SNA: 0						
w 20 💌 Entries						۵					
URN Claim No Patient Name	Phone No	Hospital Details	Hospital Incentive Status	Package ID	Actual Date of Admission	Actual Date of Discharge		CPD Approved Amount (₹)	CPD Mortality	Hospital Mortality	Take Act
7008861737 CLE9A86B6C RANJAN DASH	9999888899	Test Hospital (99999)	NABH	0500MC007A	01-Aug-2023	01-Aug-2023	97,500.00	7,500.00	No	No	Action
v 20 V Entries			•••••			•••••		•••••		++ Previo	-

Figure 37: CPD Approved Claims

Upon selecting a CPD approved claim, the patient details, pre-authorisation and claims information are accessible to the SND for review. SND will ascertain the medical necessity and authenticity of the claim and validate the treatment provided. After diligently reviewing the claim, SND can approve or reject the claim or raise a query to the hospital to obtain more information, if necessary. Partial payment can also be approved if the claim details or documents do not justify the entire claim. SND can edit the payable amount in the 'Approved Amount' tab.

Additionally, SND can take various supplementary actions on a claim. In instances where SND finds a claim suspicious, they can push such claims for 'Investigation', which will then move to the District Coordinator (DC) login for further investigation. In cases where SND finds a shortfall in the quality of CPD adjudication, they can 'Revert' such claims to the CPD for re-evaluation. Furthermore, if necessary, SND can withhold the payment of a claim to the EHCP by selecting the 'Hold' option. On taking action, SND must choose the most appropriate remark from the dropdown options and enter the description of the action taken. (Figure 38)

	ction Time Log					~
SI#	Activity By	Clicked On	Action On	Action Type	Time Difference in Action	
1	testcpd	02-Aug-2023 09:05:35 AM	02-Aug-2023 10:25:41 AM	Approved	01:20:06	
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Figure 38: SND Actions

#### **CPD Rejected Claims Review:**

SND shall review 100% of the claims rejected by CPDs during a calendar month. The review aims to validate the justification for rejection based on the merit of submitted documents by EHCPs. SND shall document the review findings and provide feedback to the CPDs regarding handling rejected claims properly and guidance on decision-making. SND can access the CPD rejected claims in the 'CPD Rejected' bucket under the 'Claim Monitoring' tab. SND will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 39)

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	s	earch Reser	1													
		Claims: 21									(A) 54	sarch here				
	si										Actual Date	Actual Date	Hospital Claim			
	No	URN	Claim No	Patient Name	Phone No	Hospital D	etaila	Invoice I	No	Package ID	of Admission	of Discharge	Amount (₹)	CPD Mortality	Hospital Mortality	Take Action
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nfiguration 🗸	2	15030911050	CLB428DFA9	PADHAN	7854991069	MAA MAN HOSPITAL	IKESWARI (21267001)	3012120	57001020723001	0500S0064A	29-Jun- 2023	02-Jul- 2023	7,350.00	No	No	Action
		02091710975	CL41487510	CHITTABANJAN	8084417381	lumbi bina	pital(21082001)	101210	2001270623016	0500580524	27-Jun-	03-Jul-	15,750.00	No	No	Action
	• 3			DAS				-77210			2023	2023				Canada
	3			minister in							29-Jun-	02-Jul-				
	3 4	15101610246	CL9C7954E0	BASANTILATA GOUD	9040024613	MAA MAN HOSPITAL	(21267001)	3012120	57001020723005	0500SB0768	2023	2023	2,310.00	No	No	Action
	4			GOUD		HOSPITAL			7001020723005			2023 84-Jul-	2,310.00	No	No	Action

Figure 39: CPD Rejected Claims

After selecting the most relevant remark from the dropdown options and entering the description of the action taken, SND will take appropriate action on the CPD rejected claims with due diligence.

#### **Mortality Claims Review:**

SND shall review 100% of the claims related to mortality during a calendar month. The review's objective is to identify and validate any gaps in clinical care and patient safety that impact the morbidity and mortality of BSKY beneficiaries. SND shall document the review findings and provide feedback to the CPDs for necessary corrections or improvements. SND will diligently review such claims and take appropriate action after selecting the most relevant remark from dropdown options and entering the description of the action taken.

#### **SNA Re-settlement Claims:**

SND will raise queries on claims requiring additional documents or information for final action and can review the query-responded claims in the 'SNA Re-settlement' bucket under the 'Claim Monitoring' tab. SND will click the 'Action' button corresponding to the selected claims to review a claim. After diligently reviewing the SNA Re-settlement claims, SND will choose the most relevant remark, enter the description of the action taken, and take appropriate action. (Figure 40)

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Figure 40: SNA Re-settlement Claims

#### **Review of Unprocessed Claims:**

Claims that the CPDs have not adjudicated within the 10<sup>th</sup> day of the subsequent month will be tagged as 'Unprocessed Claims' and will move to the SND bucket for review. SND must review 100% of such claims and can access such claims in the 'Unprocessed Claim' bucket under the 'Claim Monitoring' tab. SND will click the 'Action' button corresponding to the selected claims to review a claim. (Figure 41)

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	Unprocessed Claim												
	Actual Date Of Disc	sharge From*				Actual	Date Of Discharge To*						
	01-Jun-2023				6	13-Ju	12023		63				
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Figure 41: Unprocessed Claims

Upon completion of the review mandate for a given month, SND proceeds to generate a float or a comprehensive report and subsequently forwards it to the finance team of the SHAS. After scrutiny of the financial records and balance sheets, the claims are settled directly to the EHCP bank account through the Public Financial Management System (PFMS) based on the generated float.

1.       CPD       Non-Technical review (non-medical/non-clinical information)       Review of Technical checkli (diagnosis, reports, clinical note evidence etc.)         1.       CPD       Technical review (medical/clinical information)       Approve/Assign/Reject claims         2.       SND       Re-verification of medical/clinical information       Review diagnosis, verify report clinical notes, evidence etc.         2.       SND       Re-verification of medical/clinical information       Review diagnosis, verify report clinical notes, evidence etc.         3.       Technical review       Verify disputed claims       Respond to queries/reconciliatio issues raised by EHCPs concernition	SI. No.	Role	Responsibility	Description
<ul> <li>Re-verification of medical/clinical information</li> <li>SND</li> <li>Experimentation of medical/clinical information</li> <li>Decision-making on admissibility and quantum of a claim</li> <li>Validate financial information of 10% of CPD approved claims</li> <li>Technical Committee</li> <li>Verify disputed claims</li> <li>Committee</li> </ul>	1.	CPD	<ul> <li>medical/non-clinical information)</li> <li>Technical review (medical/clinical information)</li> </ul>	<ul> <li>(availability of documents, dates, beneficiary ID, etc.)</li> <li>Review of Technical checklist (diagnosis, reports, clinical notes, evidence etc.)</li> <li>Approve/Assign/Reject claims</li> <li>Raise query to EHCP for clarification</li> <li>Validate the claimed amount and</li> </ul>
3. Committee • Verify disputed claims issues raised by EHCPs concerning	2.	SND	<ul><li>information</li><li>Decision-making on admissibility and quantum of a claim</li><li>Validate financial information of</li></ul>	<ul> <li>Approve / Reject Claims</li> <li>Raise query / Send back to EHCP for clarification</li> <li>Trigger the cases for</li> </ul>
the final payment.	3.		Verify disputed claims	• Respond to queries/reconciliation issues raised by EHCPs concerning the final payment.

#### 4.4.6. ROLES AND RESPONSIBILITIES IN CLAIM ADJUDICATION

Table 5: Roles and Responsibilities in the Claims Process

#### **4.5. CLAIM PAYMENT PROCESS**

The bank will initiate the claim payment process once SHAS approves the float generated for the claims raised during a particular month. The approved amount will be transferred to the EHCP bank account. SHAS will adhere to the appropriate PFMS guidelines while making payments for BSKY claims.

#### 4.6. RECONSIDERATION OF REJECTED CLAIMS

After careful scrutiny of claims, SND may decide to reject a claim. The SHAS reserves the right to revoke a rejected claim. Upon revoking, the case will return to the SND bucket for re-adjudication. If EHCPs are dissatisfied with the justification provided by the SND / SHAS for the rejection of a claim or have a dispute over the claims, EHCPs can file grievances as per the grievance redressal mechanism.

#### **Right of Appeal and Re-opening of Claims:**

- 1. If the SHA rejects a claim made by an EHCP, the EHCP has the right to appeal the decision. Following the Grievance Redressal guidelines, an appeal can be made by filing a grievance with the DC within 15 days of the rejection.
- 2. If the EHCP provides appropriate and relevant claim documents that support their entitlement to re-open the claims, the SHAS and/or DGNO or the DGRC, as applicable, may reconsider re-opening the claim.

#### **4.7. GRIEVANCE REDRESSAL**

The grievance redressal mechanism under BSKY ensures that the grievances of all stakeholders, including EHCPs, are redressed in the organised mechanism and time frame as detailed in the Grievance Redressal Guidelines, updated from time to time by the SHAS.

**Erroneous Claims (Partial Payment / Excess Payment / Recovery Amount):** Claims that are settled for an incorrect amount, either less or more than what is payable or were not payable, according to the scheme policy, are considered erroneous claims. Erroneous claims can be due to various reasons, as follows:

#### 1. Partial Payment to EHCP:

If a claim is partially paid due to insufficient documents, it is possible to request a reconsideration of payment through CMS in the erroneous claims section. MEDCO can initiate this process by providing the missing documents. SHA will review the submitted documents for reconsideration of payment based on their merit.

#### 2. Excess Payment to EHCP:

In case of excess payment to EHCP in a settled claim, SND can initiate the recovery of the excess payment through CMS.

#### 3. Wrong Claim Payment to EHCP:

If payment is made incorrectly to EHCP, SND has the option to raise a recovery request through CMS.

**Note:** In case of recovery from EHCP (Points 2 and 3), the amount will be adjusted from the subsequent claims of the EHCP. SHA is the final authority for the decisions pertaining to erroneous claims.

# **5. PAYMENT IN SPECIAL CASES**

After a patient is admitted to an empanelled hospital under BSKY, they will be discharged once their treatment is completed. Typically, the hospital will receive payment based on the package booked and the rates defined for that package in most cases. However, this may not happen in some cases for various reasons. For instance, a patient may choose to leave against medical advice, expire while still in the hospital, or require a referral to another medical facility. The EHCPs and the SHAS need clarity regarding payments in these special cases. The following guidelines follow basic principles and outline the payment process in these exceptional cases.

- For the partial payment to be considered, the EHCP must notify the SHAS of any deviations from the normal course within 24 hours.
- Additionally, payment will only be made after a successful audit by the SND in each of these cases.
- The SHAS is responsible for completing the audit process within 15 days of receiving the intimation from the EHCP.
- These deviations are expected to not amount to more than 5% in a particular hospital.

#### 5.1. LAMA / DAMA

Left Against Medical Advice (LAMA) or Discharged Against Medical Advice (DAMA) is an act whereby a patient takes their discharge contrary to the recommendation or will of the attending physician. This can happen due to various reasons related to the beneficiary or the hospital.

After the audit, the payment to the hospital will be made as per the following:

**Surgical Cases:** Patients admitted for a surgical package where a fixed package rate is to be paid.

- LAMA / DAMA before Surgery: The claim amount would be determined based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Payment for 100% of the daily package rate for the total number of days when the patient was admitted will be paid. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. This will be applicable in all cases, regardless of whether pre-operative investigations have been done or not.
- 2. **LAMA / DAMA after Surgery:** Payment for 75% of the package rate will be made to the EHCP by the SHA in such cases. Daily case sheets and OT notes must be submitted by the EHCP for auditing purposes to qualify for payment.

# Medical Cases: Payment for 100% of the daily package rate for each day of the patient admission will be paid based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered.

#### **5.2. DEATH DURING HOSPITALISATION**

If the patient dies in the hospital during the treatment before discharge, after the audit, payment to the hospital will be as follows:

#### **Surgical Cases:**

- Death before Surgery: The claim amount would be determined based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Payment for 100% of the daily package rate for the total number of days when the patient was admitted will be paid. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. This will be applicable in all cases, regardless of whether pre-operative investigations have been done or not.
- 2. Death on Table (During Surgery): If the patient expires during the surgery, then 75% of the blocked package rate will be paid. Daily case sheets and OT notes must be submitted by the EHCP for auditing purposes to qualify for payment.
- 3. Death after Surgery: If the patient expires after the surgery, irrespective of the duration of the postoperative stay, 100% of the package rate will be paid to the hospital after a detailed medical audit.

#### **Medical Cases:**

Payment for 100% of the daily package rate for each day of the patient admission will be paid based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered.

#### **5.3. PATIENT REFERRED TO ANOTHER HOSPITAL**

It is important to note that an EHCP should only refer patients to other EHCPs, except for rare circumstances when referral to a non-empanelled hospital is necessary. The EHCP must provide a compelling justification for referring a patient to a non-empanelled hospital. According to the BSKY policy, the treatment package covers any complications that may arise from surgery. However, in exceptional cases and with prior notification to SHA, an EHCP may refer a patient to another EHCP to manage postoperative complications and be eligible for partial payment. The following guidelines apply:

#### Surgical Cases:

1. **Referral before PAC & Surgery:** In such cases, the claim amount would be determined based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Payment for 100% of the daily package rate for the total number of days when the

patient was admitted will be paid. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. This will be applicable in all cases, regardless of whether pre-operative investigations have been done or not. The receiving EHCP will be eligible for 100% of the package rate of the surgery booked by the hospital.

- 2. **Referral after PAC and before Surgery:** In such cases, the referring EHCP will be paid 15% of the package amount for the surgical package booked by the hospital. The receiving EHCP will be paid 85% of the package rate of the surgery booked. The receiving hospital will need to take pre-authorisation before booking the package.
- **3. Referral after Surgery (Management of Complications):** In such cases, the referring EHCP will be paid 75% of the total package rate. The receiving EHCP would be eligible for 100% of the package rate of the new surgery selected (if required) or in line with the existing medical packages according to the LOS and bed category while admitted (if managed conservatively). The receiving EHCP will need to raise new Pre-authorisation & claim for the treatment provided.

#### **Medical Cases:**

For referring EHCP, payment for 100% of the daily package rate for each day of the patient admission will be paid based on the Length of Stay (LOS) and the bed category of the patient, in line with the existing medical packages. Clinical notes documenting each full day of the patient's admission must be submitted for the payment to be considered. The receiving EHCP would be eligible for 100% of the package rate of the surgery blocked (if required) or in line with the existing medical packages according to the LOS and bed category of the patient (if managed conservatively).

#### Referral to Non-Empanelled Hospital (in Exceptional Cases):

To qualify for partial payment, the referring EHCP must provide a compelling justification for referring a patient to a non-empanelled hospital. Non-empanelled hospitals will not receive any payment from SHAS through BSKY under any circumstances.

#### **5.4. UNSPECIFIED PACKAGE**

To prevent BSKY beneficiaries from being deprived of necessary medical care not featured in the listed interventions, the TMS has a provision for blocking such treatments. However, the following specific criteria must be met before blocking such treatments:

- 1. Compulsory pre-authorisation is in-built while selecting this code for blocking treatments.
- 2. If there are multiple planned procedures and one or more require blocking under the unspecified package, EHCPs should consolidate all procedures into a single unspecified claim. The claim should include a lump sum cost for all intended procedures. If certain procedures have defined rates in the HBP list, those rates must factor into the final amount for the unspecified package.
- 3. Private hospitals cannot avail government reserved packages under this code SHAS may circulate the list of government-reserved packages to all hospitals. Further, SHAS will facilitate the referral of such cases to the public system to avoid denial of care.
- 4. Unspecified Package cannot be blocked for implant removal. However, if no other packages cover a specific implant removal, exceptions can be made with prior approval from the SHA.

- 5. Aesthetic treatments of any nature cannot be availed under this or any other listed codes under BSKY. Only medically necessary surgeries/procedures that address functional indications will be covered. The procedure should result in improving or restoring bodily function, correcting significant deformity resulting from accidental injury/trauma, or addressing congenital anomalies with substantial functional impairment. The procedure should enhance or restore bodily function, correct significant deformities caused by accidental injury or trauma, or address congenital anomalies that significantly impair function.
- 6. Individual drugs or diagnostics cannot be availed under this code.
- 7. None of the treatments that fall under the exclusion criteria of the BSKY can be availed, viz. individual diagnostics for evaluation, outpatient care, cosmetic/aesthetic treatments, vaccination, any dental treatment or surgery which is corrective, cosmetic or aesthetic, filling of cavity, root canal including wear and tear etc., unless arising from disease or injury and requires hospitalisation for treatment.
- 8. If the SHAS receives multiple requests for the same unspecified package from multiple EHCPs or for multiple patients, the SHAS may consider including such treatment in the package master. The decision will be based on the recommendations of the Medical Cell Expert Committee.

To determine the approval amount, PPD may consider the rate of the closest match of the requested surgery listed in other national or state public-funded health insurance packages. It is important to note that the amount approved by PPD is final and will be communicated to the EHCP. The PPD approved cannot be deducted or partially paid by CPD, provided the EHCP submits all the necessary documents.

While it is difficult to define all the situations where an Unspecified Surgical Package may be used or specify the maximum payable rates, booking an Unspecified Surgical Package can be allowed if the Technical Committee of SHAS, encompassing medical experts in the state, approves it.

The following processes are to be adhered to:

- The SHAS will form a Medical Cell Expert Committee to offer insights on Unspecified Package requests in addition to their other responsibilities.
- The SHAS will recommend every case for approval after taking inputs from the standing Medical Cell Expert Committee with the treatment details and pricing duly negotiated with the provider.
- The price should be based on the principle of a case-based lump sum rate that includes expenses associated with all investigations, procedures, consumables and postoperative care, along with the applicable incentives to the hospital. It is preferable to reference ceiling rates from other public health insurance schemes if available.

#### **5.5. UNBUNDLING OF PROCEDURES**

There can be instances where an EHCP blocks one or multiple claims for different procedures for the same patient during the same OT session. Payment for such cases will not be made in full. Instead, the rule of 100% - 50% - 25% (where the most expensive package is reimbursed at 100%, the second most expensive at 50%, and the remaining packages at 25% each) shall be applicable in these cases.

If a combination package for such a case is available in the listed interventions, the EHCP will be paid based on the available package rate or the 100% - 50% - 25% rule, whichever is less.

#### **Example:**

Case ID	EHCP Name	Patient Name	D.O.A	Package Name	Package Rate	Approved Amount
12345	ABC Hospital	Mr. XYZ	01-07-2023	Tonsillectomy	Rs. 15,300/-	Rs. 15,300/-
12346	ABC Hospital	Mr. XYZ	01-07-2023	Myringotomy	Rs. 9,500/-	Rs. 4,750/-

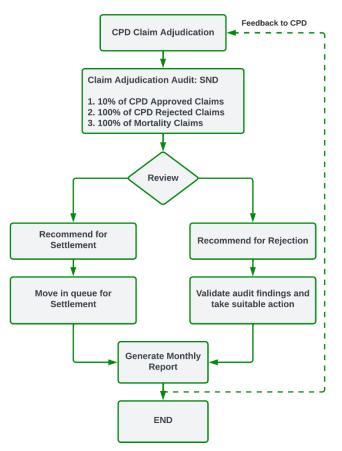
Total amount for these two packages (15,300 + 9,500): Rs. 24,500/-

When both the packages are claimed together for the same patient during the same hospitalisation, 100% - 50% - 25% will apply, and the final approved amount is **Rs. 19,750/-**

# 6. CLAIM ADJUDICATION AUDIT

The objectives of the Claim Adjudication Audit are:

- To improve the overall quality of claim adjudication.
- To ensure that the adjudication team has exercised due diligence during adjudication.
- To ensure compliance of submitted documents with Standard Treatment Guidelines.



Flow Chart 6: Claim Adjudication Audit Workflow

#### **Claim Adjudication Audit Checklist:**

L

Particulars	Yes	No	Remarks
Is the patient's name/age in ICPs, Ecard and investigation reports the same?			
Any aberration noted in the past claim history?			
Are all mandatory documents as per STGs available at claim submission?			
Are presenting symptoms matching with the diagnosis?			
Does the package booked match the final diagnosis?			
Are investigation reports supporting the final diagnosis available?			
Are investigation reports signed by doctor/pathologist with registration no?			
Do the procedure notes detail the steps of surgery? (surgical cases)			
Does the treatment provided match the package claimed?			
Was the length of stay verified with the discharge summary?			
Does the discharge summary capture all details of presenting features, investigations, treatment provided and discharge advice?			
Did PPD / CPD follow the processes mentioned above?			
Were appropriate queries raised?			
Table & Claim Adjudication Audit Chacklist			

Table 6: Claim Adjudication Audit Checklist

Note: Apart from the regular audit, SHA can conduct periodic audits to monitor the quality of claim adjudication.

#### 6.1. PERCENTAGE OF CLAIM ADJUDICATION AUDIT

The minimum required percentage of the claim adjudication audit sample is detailed below:

SI. No.	Audit Type		Sample	nple Objective		
1.	Claim Adju Audit	udication	10% of approved claims	Ensure claims adjudication process is being followed diligently at all levels.	SND	
2.	Rejected Audit	Claims	100%	Verify if the rejection of claims is justified.	SND	
3.	3. Mortality Claims Audit		100%	Identify and verify any gaps in clinical cases and patient safety impacting morbidity and mortality of the beneficiary.	SND	

Table 7: Claim Adjudication Audit – Defined Audit Percentage

# **7. GUIDELINES FOR RECOVERIES AND OTHER ACTIONS**

BSKY has adopted a zero-tolerance approach towards all types of fraud, covering the complete extent of activities for prevention, detection, and deterrence of different kinds of fraud that could occur in BSKY at various stages of its implementation. These guidelines would apply when fraud cases have been confirmed, or other irregularities/misrepresentations of facts have been established on the part of an EHCP under BSKY. One or more of the following actions may be taken

against the EHCP which has been found to have committed any irregularity and/or illegality and/or have violated guidelines and/or terms and conditions of the agreement/MoU/contract:

- 1. **Issuance of 'Show Cause Notice' to Errant EHCP:** Based on the audit of EHCP, if the SHA believes that there is clear evidence of EHCP indulging in malpractices/unethical practices or does not have adequate infrastructure/specialist workforce or has misrepresented facts for empanelment under the scheme, a Show Cause Notice shall be issued to the EHCP.
- 2. **Suspension of EHCP:** For the EHCPs that have been issued Show Cause Notice or if the State Empanelment Committee (SEC) observes at any stage that it has data/evidence that suggests that the EHCP is involved in any unethical practice or is involved in financial fraud related to treatment provided under the scheme, it may immediately suspend that EHCP from providing services under the scheme and a formal investigation shall be initiated.
- 3. **De-empanelment of EHCP:** If the formal investigations confirm that the EHCP indulges in malpractices, the SEC may de-empanel the provider following due process.
- 4. **Recovery of amount including penalties from EHCP:** If it is discovered that the EHCP has engaged in malpractices or misrepresentations, the excess amount paid for fraudulent claims or illegal collection of money from beneficiaries shall be recovered, along with penalties based on the severity of the offence.

SHA may recover the payment made against wrongful claims or penalties imposed or illegal collection of money from beneficiaries for the treatment provided under the scheme from errant EHCP by any of the following means:

- 1. Adjusting against any amount due to EHCP arising from unpaid claims.
- 2. Pursue recourse available under MoU/Contractual provisions.
- 3. Pursue recovery of the outstanding amount and any applicable penalties using the provisions outlined in the Revenue Recovery Act 1890 and other relevant legislation.

#### The various Legal and Punitive Actions that can be taken against the errant EHCP are:

- 1. Suspension of EHCP from the BSKY scheme.
- 2. De-empanelment of EHCP from the BSKY scheme.
- 3. Actions like deregistration and cancellation of the hospital's license under Provisions and Acts of the State Government or any other relevant legislation of the Central Government, such as the Clinical Establishment (Registration & Regulation) Act of 2020.

If a medical and paramedical professional is found to be engaging in malpractices or unethical practices, the relevant Council or Professional Body should be informed with a request for the cancellation or suspension of their corresponding license or registration. Depending on the severity of the offence, a criminal case (FIR) may also be filed against the concerned under the relevant provisions of the applicable law. The Competent Authority will not consider any appeal or revision of the recovery order unless EHCP has deposited at least 50% of the recovery amount.

# **8. SERVICE PARAMETERS**

### 8.1. UNIFORM TURN AROUND TIME (TAT)

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

SI. No.	Activities	ΤΑΤ	Action
1.	Pre-authorisation Adjudication (By PPD)	24 hours	Forced approval after 24 hours for listed packages and after 48 hours for unspecified packages.
2.	Blocking of Approved Pre- authorisation (By EHCP)	7 days	Expiration of Pre-authorisation.
3.	Response to PPD Query (By EHCP)	7 days	Forced rejection after 7 days.
4.	Claim Submission after Discharge (By EHCP)	7 days post Discharge	Forced Rejection after 7 days.
5.	Response to CPD Query (By EHCP)	7 days	Forced rejection after 7 days.
6.	Claim Settlement (By SHAS)	45 days from claim initiation	No action
		Turn Around Tim	

Table 8: Turn Around Times (TAT)

The actual Date of Discharge, as mentioned in the discharge summary, will be considered for TAT calculation.

### 8.2. KEY PERFORMANCE INDICATORS (KPI)

#### **Performance KPI:**

SI. No.	KPI	Timelines	Baseline KPI Measure
1.	Pre-Auth Adjudication	<ul> <li>Action within 24 hours of Pre-authorisation initiation.</li> <li>Forced approvals beyond 24 hours will be considered non-compliant.</li> </ul>	95% Compliance
2.	CPD Adjudication	<ul> <li>Action on claims within 3 days of allocation.</li> <li>Unprocessed claims beyond 3 days will be considered non-compliant.</li> </ul>	95% Compliance
		Table 9: Performance KPIs	

#### Audit KPI:

SI. No.	KPI	Sample	Baseline KPI Measure
1.	Claims Audit	10% of total approved claims across specialities	100% Compliance
2.	Claims Audit	100% of total rejected claims across specialities	100% Compliance
3.	Mortality Audit	100% of all deaths during hospitalisation	100% Compliance
	•	Table 10: Audit KPIs	

During the audit, the team must ensure no more than a 20% overlap in the sample size used across different audits, except for mortality audits.

# **ANNEXURE - I: EXCLUSIONS TO THE POLICY**

The State Health Assurance Society shall not be liable to make any payment under the BSKY policy in respect of any expenses whatsoever incurred by any eligible beneficiary in connection with or related to:

- 1. Conditions that do not require hospitalisation and can be treated under Outpatient Care.
- 2. Any dental treatment or surgery, which is corrective, cosmetic or aesthetic procedure, filling of cavities, root canal including wear and tear of teeth, periodontal diseases, dental implants, etc., are excluded unless arising from illness, injury, neoplasm, or cysts and which requires hospitalisation for treatment.
- 3. Any assisted reproductive techniques or fertility/infertility-related procedures, unless featured in the HBP procedures.
- 4. Any vaccination, immunisation or inoculation.
- 5. Any cosmetic or aesthetic treatment of any description, unless necessitated due to an accident or as a part of any illness.
- 6. Circumcision, unless necessitated for treatment of a disease not excluded hereunder or due to any accident.
- 7. Any treatment of Patients in a Persistent Vegetative State (Completely unresponsive to psychological and physical stimuli, displaying no sign of higher brain function, and being kept alive only by medical intervention).

# **ANNEXURE – II: LIST OF ACTION REMARKS IN CMS**

Approved					
Admission Notes not Submitted					
Anaesthesia Notes not Submitted					
Angiogram Report showing Stent and Post-Stent Flow not Submitted					
Antenatal Records not Submitted					
Barcode of Implants not Submitted					
Barcode of Drugs not Submitted					
CAG Stills showing Blocks with Report not Submitted					
Charts of Chemotherapy/Radiotherapy not Submitted					
Chest X-ray Film with Report not Submitted					
Compliance to Query not Satisfactory					
CT Images with Report not Submitted					
Detailed Clinical Notes not Submitted					
Detailed Discharge Summary not Submitted					
Detailed OT Note not Submitted					
Documents establishing Identity of the Patient not Submitted					
Documents not Signed by the Doctor					
ECG Report not Submitted					
ECHO Stills with Report not Submitted					
Electrophysiology Study Report not Submitted					
FNAC Report not Submitted					
HPE Report not Submitted					
Illegible Documents / Images					
Indications for LSCS not Mentioned					
Intra-OP Stills with Patient ID and Date not Submitted					
Invalid Income Certificate					
Investigation Results do not Confirm the Diagnosis					
Invoice of Implants not Submitted					
IVP / NCCT / CT-IVP not Submitted					
Justification for the Procedure not Mentioned					
Lab Test Reports not Submitted					
Mandatory Documents as per the Package not Provided					
Mismatch in Names in Verification Slip and Supporting Documents					
Mismatch of Dates					
Mismatch of Gender					
Mismatch of Name in Clinical Notes and Eligibility Documents					
MRI Images with Report not Submitted					
Name and Specialisation of Doctor not Mentioned					
Non-Submission of Blocking Transaction Slip					
Not Eligible under BSKY					
Overwriting and Many Corrections made in the Report/Document					
Partogram not Submitted					
Plan of Management Approved by Tumor Board not Submitted					
Post Procedure Imaging Stills with Report not Submitted					
Post Procedure X-ray Film with Report not Submitted					
Post Treatment Clinical Photograph not Submitted					
Pre-Anaesthesia Check-up Report not Submitted					
Query not Complied					
Stickers of Implants not Submitted					

Still image of the Procedure with Patient ID and Date not Submitted				
Transfusion Slips not Submitted				
Treating/Operating Doctor not Satisfying the Minimum Qualification Criteria				
USG Images with Report not Submitted				
Wrong Selection of Procedure				
X-ray Film with Report not Submitted				
Others – Please Specify				
Rejected				

# **ANNEXURE - III: ACTIONABLE FOR CPD**

Actionable	Yes	No
Are all requisite post-treatment evidentiary documents available to confirm the completion of appropriate treatment and follow-up instructions?		
Was the Length of Stay during hospitalisation as per package specification?		
Are admission notes and detailed findings at admission available?		
Is the discharge summsary available?		
Does the discharge summary capture all details of presenting features, investigation, line of treatment, and follow-up advice at discharge?		
Is the age, comorbidities and pre-operative profile relevant to the package blocked?		
Do the submitted reports confirm the final diagnosis?		
Whether the appropriate package is blocked?		
Whether the date and time of the procedure are mentioned in the notes?		
Does the procedure time corresponds to the time ideally taken for the procedure/surgery?		
Whether the operating surgeon and the doctor's information provided while blocking the package match?		
Whether the treating doctor's signature is available across the submitted records?		
Does the Operative Nites detail the steps of the surgery?		
Was the treatment necessary for the patient's clinical condition?		

# **ANNEXURE - IV: DOCUMENT TEMPLATES**

- 1. **OT NOTES:** (Should be on EHCP Stationary and not on plain paper)
  - Date and Time of Commencement and Completion of Procedure
  - Name of Surgeon
  - Name of Anaesthetist
  - Type of Anaesthesia
  - Procedure Details (Site, Side. Steps and Findings)
  - Details of Complications, if any
  - Details of Immediate Post-Op Care

#### 2. CLINICAL NOTES:

- Date and Time of Clinical Notes
- Daily Progress Report with Vitals and Details of Treatment Advised.
- 'Continue Same Treatment' is not acceptable

#### 3. CLINICAL PHOTOGRAPHS:

- The face of the patient and the site of the surgery shall be visible in the same frame.
- It should not be a Google image.

# **REFERENCE DOCUMENT LINKS**

- 1. <u>Timely Uploading of Claim Documents and Changes in Transaction Management System (TMS)</u> of BSKY.
- 2. Order for Additional Coverage in BSKY for Females.
- 3. <u>Guidelines for Payment of Special Cases during hospital admission under BSKY.</u>
- 4. <u>Clarification regarding pre-hospitalisation investigations for procedures under BSKY and zero</u> <u>Out-of-Pocket expenditure for BSKY patients.</u>
- 5. <u>Clarifications regarding pre and post hospitalisation expenses and other guidelines for smooth</u> implementation of BSKY.
- 6. <u>Reserved and Referral Category of Packages under BSKY.</u>
- 7. Declaration of Medical Officers as Authorised Officers for Referral under BSKY.
- 8. <u>Constitution of Technical Committee under SHAS.</u>
- 9. <u>Reserved and Referral Category of Packages under BSKY in the Empanelled Hospitals of Other</u> <u>States.</u>
- 10. Pre-authorisation in case of Unspecified Packages under BSKY.
- 11. Office Order on Extension for BSKY service for Children below 5 years.
- 12. Guidelines for Organ/Tissue Transplantation under BSKY.
- 13. <u>Treatment of Beneficiaries with mismatch of name in eligibility documents and NFSA or SFSS</u> <u>Database under BSKY.</u>
- 14. <u>Benefits of BSKY to Child members of BSKY-covered families in 5 to 18 years of age group</u> whose individual names are not there in NFSA or SFSS Database although Parents names are included in the Database.
- 15. AB PM-JAY Claim Adjudication Manual 2.0