

National Health Benefit Package 2.2

User Guidelines

National Health Authority

Version: November 2021

Note: State specific modifications in the NHA published guidelines may be expected

Foreword



सत्यमेव जयते

**national
health
authority**



Dr. R.S. Sharma
Chief Executive Officer



भारत सरकार
Government of India
राष्ट्रीय स्वास्थ्य प्राधिकरण
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Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) is the flagship scheme of the Government of India and the world's largest health assurance scheme that provides a cover of up to ₹5 lakh per family per year, for secondary and tertiary care hospitalization to over 10.74 crore vulnerable entitled families (approximately 50 crore beneficiaries). PM-JAY provides cashless and paperless access to over 1,670 health benefit packages across a network of over 25,000 empanelled hospitals and health care providers in the country.

The National Health Authority (NHA) has developed this manual for guidance of Empanelled Hospital Care Providers (EHCPs), National Hospital Care Providers (NHCPs), State Health Agencies (SHAs), and teams doing pre-authorization and claim processing for treatment of beneficiaries of AB PM-JAY. It will also serve as a guidance tool for EHCPs to book the right package as per the medical necessity of the beneficiaries, and for state medical audit committees for policies on payment as per inclusion / exclusion criteria of Health Benefit Packages (HBP).

I am grateful to the medical cell experts of the NHA, the SHAs, members of the technical medical committee, members of the Health Policy & Quality Assurance (HP&QA) division, and all the stakeholders who were engaged in the consultation process and provided valuable suggestions in defining the Health Benefit Packages (HBP 2.2) under the AB PM-JAY scheme. We intend to continuously innovate and enhance the design of the scheme based on our experiences in its implementation.

Dr. Ram Sewak Sharma
Chief Executive Officer,
National Health Authority,
Ministry of Health & Family Welfare

3rd, 7th & 9th Floor, Tower-I, Jaewan Bharati Building, Connaught Place, New Delhi-110001
Tel.: 011-2346 8908, 011-2346 8915 E-mail : rssharma3@gmail.com Website: www.pmjay.gov.in

Disclaimer: The key objective of this user guideline document of National Health Authority (NHA) is to give an overview of the national health benefit package available under AB PM-JAY. This manual has been prepared for guidance of EHCPs, NHCPs, State Health Agencies (SHAs), pre-authorization and claims processing teams for processing treatment of beneficiaries. It will also serve as a guidance tool for EHCPs and state medical audit committees for policies on payment as per inclusion/exclusion criteria of HBP. In that respect, EHCPs and physicians may refer to other relevant material as per the extant professional norms. The content of the document may be reproduced/cited with due acknowledgment of the original publication, AB PM-JAY and NHA.

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Section 1. Health Benefit Package under AB PM-JAY

1.1 Objectives of the Scheme

AB-PMJAY aims to reduce catastrophic health expenditure, improve access to quality health care, reduce unmet needs and reduce out of pocket healthcare expenditures of poor and vulnerable families falling under the deprivation criteria of D1, D2, D3, D4, D5 and D7, Automatically Included category and broadly 11 defined occupational un-organised workers (in Urban Sector) of the Socio-Economic Caste Census (SECC) database of the State/ UT along with the estimated existing RSBY Beneficiary Families not figuring in the SECC Database. These eligible AB-PMJAY beneficiary families will be provided coverage for secondary, tertiary and day care procedures (as applicable) for treatment of diseases and medical conditions through a network of Empaneled Health Care Providers (EHCP).

1.2 Health Benefit Package (HBP)

The benefits within this Scheme under the basic risk cover are to be provided on a cashless basis to the AB PM-JAY Beneficiaries up to the limit of their annual coverage and includes:

- Hospitalization expense
- Day care treatment (as applicable)
- Follow-up care
- Pre and post hospitalization expense
- Newborn child / children

The details of benefit packages are furnished in Annexure 2: 'Packages and Rates' and exclusions are furnished in Annexure 1.

For availing select treatment in any empaneled hospitals, pre-authorization is required to be taken for defined cases. Except for exclusions listed in Annexure 2, treatment / procedures will also be allowed, in addition to the procedures listed in Schedule 3, of up to a limit of ₹ 1,00,000 to any AB-PMJAY Beneficiary (called 'Unspecified Procedure') within the overall limit of ₹ 5,00,000. Operations pertaining to Unspecified Procedure are to be governed as per Unspecified Packages Guidelines provided under section 1.7 of the document.

1.3 Package Rates

Insurer shall reimburse claims of EHCPs based on package rates determined as follows:

- If package rate for a medical treatment or surgical procedure requiring hospitalization or Daycare treatment (as applicable) is fixed in the HBP, then the package rate so fixed shall apply for the policy cover period.
- If package rate for a surgical procedure requiring hospitalization or Daycare treatment (as applicable) is not listed in the HBP, then the Insurer may pre-authorise an appropriate amount based on rates for similar procedures defined in the list, or based on other applicable national or state health insurance schemes such as CGHS. In case of medical care, the rate will be calculated on per day basis as specified in the package list except for special inputs like High end radiological diagnostic and High-end histopathology (Biopsies) and advanced serology investigations packages or some other special inputs existing in the HBP (or are released by NHA in future) which can be clubbed with medical packages.
- AB PM-JAY is a cashless scheme, where no beneficiary should be made to pay for availing treatment in any EHCP. However, upon exhaustion of the wallet, or if the treatment cost exceeds the benefit coverage amount available with the beneficiary families then the liability for such remaining treatment cost as per the package rates defined in the HBP list will not be of the insurer. Beneficiary and SHA (through ISA/TPA) will need to be clearly communicated in advance about the additional payment at the start of such treatment.
- In case a beneficiary is required to undertake multiple surgical procedures in one OT session, the procedure with highest rate shall be considered as the primary package and reimbursed at 100%, thereupon the 2nd surgical procedure shall be reimbursed at 50% of package rate, 3rd and subsequent surgical procedures shall be reimbursed at 25% of the package rate.
- Surgical and medical packages will not be allowed to be availed at the same time (Except for Add-on procedures as defined in the HBP and configured in NTMS). In exceptional circumstances, hospital may raise a request for such pre-authorization which will be decided by SHA with the help of concerned medical specialist.
- Certain packages as mentioned in the HBP master will only be reserved for Public EHCPs as decided by NHA. SHAs may permit availing these packages in private EHCPs only after a referral from a public EHCP is made. Some modifications (in not more than 10% of total number of packages) may be done by SHA in this regard.
- Incentivization will be provided to certain hospitals which will be over and above the rates defined in the HBP.

For the purpose of hospitalization expenses as package rates shall include all the costs associated with the treatment, amongst other things:

- Registration charges
- Bed charges
- Nursing and boarding charges
- Surgeons, anesthetists, medical practitioner, consultant's fees etc.
- Anesthesia, blood transfusion, oxygen, O.T. charges, cost of surgical appliances etc.
- Medicines and drugs
- Cost of prosthetic devices, implants etc.
- Pathology and radiology tests: Medical procedures include basic radiological imaging and diagnostic tests such as X-ray, USG, hematology, pathology etc. However, high end radiological diagnostic and high-end histopathology (biopsies) and advanced serology investigations packages can be booked as a separate 'Add-on procedure', if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.
- Food to patient
- Pre and post hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.
- Any other expenses related to the treatment of the patient in the hospital.

For the purpose of Daycare treatment expenses shall include, amongst other things:

- Registration charges
- Surgeons, anesthetists, medical practitioners, consultants' fees, etc.
- Anesthesia, blood transfusion, oxygen, operation theatre charges, cost of surgical appliances, etc.
- Medicines and drugs
- Cost of prosthetic devices, implants, organs, etc.
- Pathology and radiology tests: Medical procedures include basic radiological imaging and diagnostic tests such as X-ray, USG, hematology, pathology etc. However, high end radiological diagnostic and high-end histopathology (Biopsies) and advanced serology investigations packages can be booked as a separate add-on procedure if required. Surgical packages are all inclusive and do not permit addition of other diagnostic packages.

- Pre and post hospitalization expenses: Expenses incurred for consultation, diagnostic tests and medicines prior to admission of the patient in the same hospital and cost of diagnostic tests and medicines up to 15 days after discharge from the hospital for the same ailment / surgery.
- Any other expenses related to Daycare treatment provided to the beneficiary by an EHCP.

If NHA finds a treatment being booked under unspecified surgical procedure repeatedly, or some treatment is required to be included within the national HBP, to address a pressing health problem which is or have become widely prevalent, then NHA may add such treatment(s) under national HBP.

The benefits under the ABPM-JAY cover shall, subject to the available ABPM-JAY sum Insured, be available to the beneficiary on a cashless and paperless basis at any EHCP.

1.4 Payment in special cases during hospital admission

Once a patient is admitted under Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (PM-JAY) in an EHCP, in normal course the patient will be discharged by the hospital after completing the treatment. Hence in majority of cases, the payment to the hospital will be done based on the package booked and rates prescribed for that package.

However, in some cases, this may not happen due to various reasons e.g. patient may leave against medical advice, patient may die within the hospital or patient may need to be referred to another hospital. In these special cases clarity needs to be provided to both hospitals and the payers (State Health Agency/ Insurance Company) regarding payments to the hospitals. These guidelines provide details of payments to be done in these special cases.

The basic principles to be followed in implementation of these guidelines are as follows

- The hospital will be paid partial amount only if the hospital provides information about deviation from normal course to the respective SHA / ISA / Insurer through the IT platform as soon as possible but not later than 24 hours of the deviation. The time limit may be relaxed to 72 hours for public hospitals
- Additionally, in each of these cases payment will be done only after a successful audit by the SHA / Insurer.
- The audit process shall be completed by the SHA/ Insurer within 15 days of receiving the information from the hospital.
- It is expected that these deviations would not amount to more than 5% in a particular hospital

1.4.1 Patient Leave / Discharge Against Medical Advice (LAMA/DAMA)

Leave Against Medical Advice (LAMA), also called Discharge Against Medical Advice (DAMA), is an act whereby a patient takes his/her 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 done as per the following:

- A. Surgical Cases – Patient has been admitted for a surgical package where a fixed package rate is to be paid.
 - LAMA/DAMA before surgery –The claim amount would be calculated in line with the existing medical packages according to Length of Stay (LoS) and bed category of the patient. Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. This will be applicable in all cases irrespective of the fact whether pre-operative investigations have been done or not.
 - LAMA/ DAMA after surgery –Payment for 75% of the package rate will be done to the hospital by the SHA/ Insurer in this case. Daily case sheets and OT notes will need to be submitted by the hospital for auditing purposes to qualify for payment.
- B. Medical Cases –Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered.

1.4.2 Patient dies in the EHCP

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

- A. Surgical Cases:
 - Death before surgery – The claim amount would be calculated in line with the existing medical packages according to Length of Stay (LoS) and bed category of the patient. Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. This will be applicable in all cases irrespective of the fact whether pre-operative investigations have been done or not.

- Death on the table during surgery – If the patient dies during the surgery then 75% of the booked package rate will be paid. Daily case sheets and OT notes will need to be submitted by the hospital for auditing purposes to qualify for payment.
- Death after surgery – If the patient dies after the surgery, irrespective of the duration of the post-operative stay, then 100% of package rate will be paid to the hospital after detailed medical audit.
- B. Medical Cases – Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered.

1.4.3 Patient referred to another EHCP

It is important to note that an EHCP should refer the patients only to another EHCP and only in exceptional circumstances referral to non-empanelled hospital shall be done. Strong justification will need to be provided by the hospital for referring the patient to a non-empanelled hospital.

As per PM-JAY policy, treatment package includes complications arising out of surgery. However, in exceptional cases and on prior intimation to approver (PPD/ CPD), referral can be made from one EHCP to another and therein qualify for partial payment. The following scenarios shall be applicable for partial payment:

- Referred to an empanelled hospital
 - Surgical Cases
 - i. Referral before PAC and surgery – In case a patient is referred to another empanelled healthcare provider, the claim amount would be calculated in line with the existing medical packages according to Length of Stay (LoS) and bed category of the patient to the referring hospital. Payment for 100% of the daily package rate for the full number of days when patient was admitted will be paid. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. The hospital (empanelled) that receives the referred patient will be eligible for 100% of the package rate of the surgery booked by the hospital.
 - ii. Referral after PAC but before surgery in case surgery is abandoned & patient is transferred – In this case, the hospital that has referred the patient will be paid 15% of the package amount for the surgical package booked by the hospital. The hospital that has received the referred patient will be provided 85% of the package rate of the

surgery selected in the hospital. The receiving hospital will need to take pre-authorization before booking the package.

- iii. Referral after the surgery for complication management – If a patient is referred after surgery has been performed, but further complications arise, then the referring hospital would be paid 75% of the total package rate. The hospital that receives the referred patient would be eligible for 100% of the package rate of the new surgery selected (if a surgical package is booked), or in line with the existing medical packages according to Length of Stay (LoS) and bed category of the patient (if a medical package is booked), depending on the patient. This surgery in the second hospital will need to be mandatorily pre-authorised.

- Medical Cases – Payment for 100% of the daily package rate for the full number of days for which the patient was admitted will be paid to the referring hospital as per the category of ward. Required documentation (clinical notes) for each full day will need to be submitted for payment to be considered. The hospital that receives the referred patient would be eligible for 100% of the package rate of the surgery selected (if a surgical package is booked), or in line with the existing medical packages according to Length of Stay (LoS) and bed category of the patient (if a medical package is booked), depending on the patient.
- Referred to non-empanelled hospital (in exceptional cases)
- If any referral is done to a non-empanelled hospital, then no payment will be done to any non-empanelled hospital.

Note: In no other cases partial payment will be done to empanelled hospitals.

Clause	Previous NHA Policy	Revised Policy
LAMA before surgery	No payment	Payment as per length of stay and ward category
LAMA after investigations	No current policy	Payment as per length of stay and ward category
LAMA after surgery	75% of total package amount	75% of total package amount
Death before Surgery	No payment	Payment as per length of stay and

		ward category
Death on table	75% of total package amount	As per LOS prior to incision 75% of package price post incision
Death after surgery	100% of package amount	No change to existing clause
Referral before surgery	No payment	Payment as per length of stay and ward category
Referral after PAC	No fixed percentage for referring Referred hospital may raise a new pre-auth	15% of package price to referring EHCP 85% to referred EHCP
Referral after surgery	75% of total package amount to referring hospital Referred hospital may raise a new pre-auth	75% of total package amount to referring hospital Referred hospital may raise a new pre-auth
Postponed / cancelled surgery cases	No payment	Payment as per length of stay and ward category

In case of unforeseen events or pandemic situations, if scheduled surgeries may be postponed and the patient may be discharged without surgery, in those scenarios, claims may be processed as per partial payment policy i.e. payment as per length of stay and ward category.

*This is primarily applicable for NHCPs and public hospitals and for private hospitals, concurrence may be sought from NAFU.

1.5 Unspecified surgical packages

To ensure that PM-JAY beneficiaries are not denied care, for treatments/procedures that do not feature in the listed interventions, there is an exclusive provision that has been enabled in the TMS (transaction management system) for blocking such treatments, subject to satisfying certain defined criteria (as mentioned)

1.5.1 Using an unspecified package

Criteria for treatments that can be availed under unspecified

- Only for surgical treatments

- Compulsory pre-authorization is in-built while selecting this code for blocking treatments.
- Cannot be raised under multiple package selection. Not applicable for medical management cases.
- Government reserved packages cannot be availed by private hospitals under this code. PPD/ CPD may reject such claims on these grounds. In addition, SHA may circulate Government reserved packages to all hospitals. Further, States need to establish suitable mechanisms to refer such cases to the public system – as a means to avoid denial of care.
- Cannot be booked for removal of implants, which were inserted under the same policy. Exceptions where removal of implants is not covered under any other package, to be approved by State Health Agencies or National Health Authority.
- In the event of portability, the home state approval team may either reject if a Government reserved package of the home state is selected by a private hospital in the treating state or consider on grounds of 'emergency'.
- Aesthetic treatments of any nature cannot be availed under this code or as such under any other listed codes under PM-JAY. Only medically necessary with functional purpose/ indications can be covered. The procedure should result in improving/restoring bodily function or to correct significant deformity resulting from accidental injury, trauma or to address congenital anomalies that have resulted in significant functional impairment.
- Individual drugs or diagnostics cannot be availed under this code. Only LISTED drugs and diagnostics with fixed price schedules, listed under the drop down of respective specialties, are included for blocking treatments.
- None of the treatments that fall under the exclusion list of PM-JAY can be availed viz. individual diagnostics for evaluation, out-patient care, drug rehabilitation, cosmetic/ aesthetic treatments, vaccination, hormone replacement therapy for sex change or any treatment related to sex change, any dental treatment or surgery which is corrective, cosmetic or of aesthetic procedure, filling of cavity, root canal including wear and tear etc. unless arising from disease or injury and which requires hospitalization for treatment etc.
- However, for life threatening cases e.g. of suicide attempt or accident due to excess consumption of alcohol, treatment shall be provided by the hospital till the patient's condition stabilizes.
- In case the State/UT is getting multiple requests for the same unspecified package from multiple hospitals or for multiple patients, then the same should be taken up with the Medical Committee for inclusion in the package master for that State/UT within a defined time frame as per the State/UT.

- The same should also be shared with NHA for consideration to include such packages in national package master

For deciding on the approval amount, the PPD may consider the rate of closest match of the requested surgery, in listed PM-JAY packages. It should be noted that the amount approved by the PPD would be sacrosanct, to be communicated to the hospital, and the CPD would not be able to deduct any amount or approve partial payment for that claim.

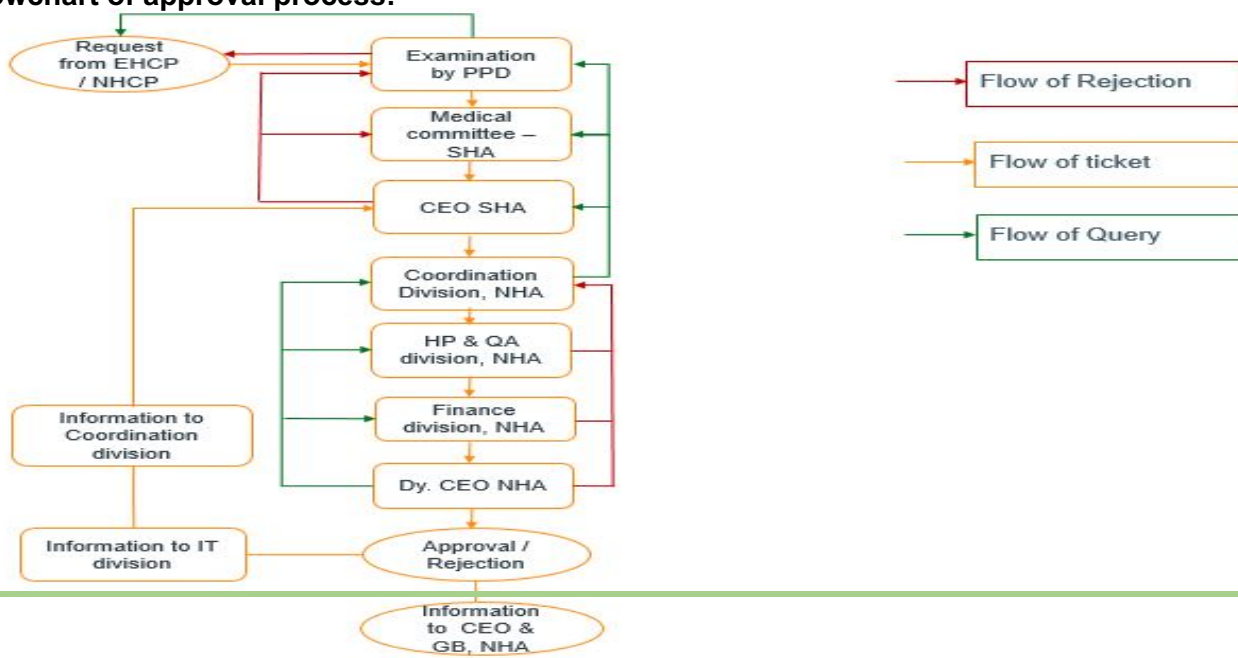
1.5.2 Unspecified package above ₹ 1 Lakh

For any SHA to utilize the unspecified package above ₹1 lakh, it is to be ensured that the same is approved only in (a) exceptional circumstances and / or (b) for life saving conditions. Process to be followed:

- EHCPs / NHCPs may move the request for approval of unspecified surgical packages beyond Rs. 1,00,000/- on the ticketing system.
- The request will be reviewed on the same platform by the respective SHA, record their inputs / recommendations and forward it to HP & QA division of NHA for consideration.
- HP & QA division may provide its feedback on the request and forward the ticket to Finance division.
- Based on inputs from HP & QA and Finance division, a decision for approval / rejection may be taken at the level of Dy. CEO, NHA
- Once approved / rejected, the ticket is shared with IT team for backend change in TMS.

Ticketing system is already approved for Unspecified surgical packages. Through this process, EHCPs / NHCPs will get approval within 48 hours.

Flowchart of approval process:



Section 2. National Health Benefit Package

2.1 Introduction

Review and rationalization of national HBP is an ongoing process. In continuation to this process, following activities are undertaken regularly:

- Analysis of unspecified surgical packages booked across the country
- Gather feedback from medical experts
- Request from multiple stakeholders for inclusion of various treatments / packages

2.2 Salient Features

The latest update in the national HBP is termed 'HBP 2.2', it introduces some new procedures which are expected to improve access to care:

- Organ & Tissue Transplant consisting of procedures for renal transplant & corneal transplant
- Inclusion of procedures like ERCP, PTBD
- Inclusion of conservative management procedures for neurosurgery and spine.

2.2.1 Packages & Procedures

Concept of introducing packages and procedures as two separate entities, was introduced in HBP 2.0. Some of the packages are actually a group of procedures. A package is split into procedures that help better specify the approach / treatment modality / etiology / complication of the package, among other criteria. Capturing of procedures in place of packages is expected to improve the granularity of the analyses that can be performed on the utilization data of the scheme.

For example, a package of 'Lap/Open Cholecystectomy with / without Exploration of CBD' is split into four independent and specific procedures to be booked for a patient

- i. Lap cholecystectomy with exploration of CBD
- ii. Lap cholecystectomy without exploration of CBD
- iii. Open cholecystectomy with exploration of CBD
- iv. Open cholecystectomy without exploration of CBD

Significance for the user: The list of packages are reference fields for the end user to select a procedure to be performed. The final selection would be at procedure level only. When searching for a procedure to be performed, the TMS would sort through both the list of packages, and procedures to present the user with the best match that should facilitate procedure selection and minimize chances of ambiguity.

2.2.2 Stratification

Stratification has been introduced to further drill down into procedures based on criteria such as type of anesthesia, bed category on admission, surgical technique etc. Stratification enables price differentiation of the procedure to better accommodate the nuances of the procedure performed and improve the associated payment.

For example, the procedure of 'Incision and Drainage of Abscess' is split into two stratified packages with a price differential of ₹ 5,000 between them.

- i. Incision and Drainage of Abscess under Local Anaesthesia
- ii. Incision and Drainage of Abscess under General Anaesthesia

Significance for the user: While total price calculation would remain at the back end of the TMS, the end user may be required to feed in certain details of the procedure that would otherwise have been assumed. For example, following selection of the procedure to be performed, the TMS may ask for details such as the type of anesthesia anticipated. There may also be certain criteria that the TMS would pick up automatically from patient details to distinguish between requirement of a pediatric / adult procedure, but these back-end assumptions may be further vetoed by the treating physician based on his clinical judgment. However, such overridden assumptions may trigger a medical audit, and it is recommended that a strong paper trail be maintained to justify such cases.

2.2.3 Stratification in Medical Packages

All Medical packages in HBP 2.1 are featured as stratified packages based on the bed category of patient admission. The bed category for admission and will need to be chosen at the time of selecting a diagnosis.

The price of medical packages will continue to be calculated on the basis of the bed category, multiplied by the number of bed days for the patient. The per day price for bed categories will be as follows:

- i. ₹ 1,800 for Routine Ward
- ii. ₹ 2,700 for High Dependency unit
- iii. ₹ 3,600 for Intensive care not requiring ventilator support
- iv. ₹ 4,500 for Intensive care requiring ventilator support

Significance for the user: There is no significant change at the user end on account of this feature of the HBP 2.0, HBP 2.1 & HBP 2.2. The TMS will continue to calculate the final price of the medical package at the back end based on patient bed category and number of days' stay.

2.2.4 Cross Specialty Packages

These are packages that fall under more than one specialty and would now feature under all relevant specialties without duplication of the unique package code and maintaining a uniform price for the same procedure across all specialties. This classification of packages as cross specialty packages at the same price is expected to minimize upcoding of the same package by billing it in a different specialty.

For example, the package of 'Temporary pacemaker implantation' is a cross specialty package between Cardiology and CTVS and will feature in both their package lists.

Significance for the user: It is hoped that aberrations such as duplication of packages across specialties, price differential in the same package across specialties, and repetitions or ambiguities in package names have been removed. While number of packages have been reduced in HBP 2.0, the number of treatment areas have been increased. The user would now have to go through a shorter list of packages to seek out the desired procedure. The cross-specialty feature will also permit certain packages to be available across specialties without unnecessarily adding on to the number of packages. For example, the procedure of 'Tracheostomy / Tracheotomy' will now be available to all specialties at a fixed rate of ₹ 6,000 irrespective of the specialty for which the hospital has been empaneled, and independent of the specialist performing the procedure. However, it is reiterated here for the benefit of all hospitals and care providers that ability of booking a procedure does not automatically privilege the hospital to perform a procedure that it is not otherwise able, equipped, or authorized to perform.

2.2.5 Add-on Packages

Certain packages / procedures have been defined as add-on procedures riding on another procedure. These add-on procedures may be booked in conjunction with another procedure without losing the sanctity / price of the procedure. These procedures, although booked as enhancements in the TMS, will not be charged at 75% of their original value.

For example, the package of 'NPWT (Negative Pressure Wound Therapy)' in Plastic Surgery is an add-on package for ₹ 2,000. Booking of this package as enhancement of another plastic surgery procedure would not reduce the cost of the procedure to 75%. Similarly, 'High end histopathology (Biopsies) and advanced serology investigations' is an add-on package for Medical management that can be added to any current medical package.

Significance for the user: There is no significant change at the user end on account of this feature of the HBP 2.0. The TMS will continue to calculate the final price of the package / packages at the back end with additional considerations based on this new criterion.

2.2.6 Stand Alone packages

Certain procedures have been included in the HBP 2.0 which were consciously left out in the previous version due to their potential of abuse. Similarly, a few procedures were noticed to be abused through the last year of implementation of the scheme. Such procedures were re-introduced in HBP 2.0 with caution. One of the many steps taken by the NHA in this direction, is introduction of clearly defined Stand-alone packages which may not be claimed as enhancements to other existing / unspecified surgical packages. This has been done primarily to reduce the incidence of abuse of the packages yet keeping them available for use.

For example, the package of 'Laparoscopic adhesiolysis' in OBG is now a standalone package and may not be booked in combination with other packages.

Significance for the user: Packages that have been earmarked as stand-alone packages will not be available to the user as enhancements to an existing / unspecified package. Such packages would be clearly marked in the TMS as 'stand-alone package'.

2.2.7 Splitting of cost of Implants / High End Consumables

The cost of implants and high-end consumables has been independently considered for calculation of the package rate at the back end. This enables the system to vary the price of the procedure based on the quality / number / type of implant required in the performance of the procedure.

For example, package price of a 'Balloon Pulmonary Valvotomy' in Cardiology would vary depending on the use of a pediatric / adult cardiac balloon. Price of plates / screws in orthopedics would also be calculated at the back end based on the number of implants used.

Significance for the user: There is no significant change at the user end on account of this feature of the HBP 2.1. However, there are significant advantages of such a splitting in the long run. Variance in the cost of implant will now be easily incorporated in the final calculation of the package price. Pricing will also become variable based on the number of screws / plates used in the surgery. It also adds flexibility for addition of different types of implants as the scheme matures. However, all the above would not feature in the TMS yet. The TMS will continue to calculate the final price of the package / packages at the back end with additional considerations based on this new criterion.

2.2.8 Step payment of staged procedures

Packages that require multiple stages for complete administration of therapy, with long gaps in between have been split into stages with independent payment of each stage. This is expected to

facilitate payment to a treating hospital, if the patient decides to continue / follow up on his / her treatment at a different facility.

For example, 'Hypospadias repair - Two or more stages' in Urology will now be paid on each, or either of the following stages:

- i. First stage
- ii. Intermediate stage
- iii. Final stage

Significance for the user: For all staged procedures, the TMS may require the treating physician to specify the stage of surgery he / she is anticipating performing at the time of booking of the package.

2.2.9 Follow up procedures

Packages for follow up have been included in HBP 2.0 for a few select procedures. This enables the hospital / caregiver to maintain a continuum of care to the patient for a period extending beyond the 15 days that he / she is entitled to through the original AB PM-JAY package. This would also enable the patient to seek follow up care for a procedure out of the center that performed the original procedure.

For example, a follow up procedure for 'Stoma Management, follow up of Colostomy' has been introduced in the HBP 2.0 for all patients who need such care.

Significance for the user: A follow up procedure may be booked by the treating hospital / caregiver with clear documentation supporting the need for the package. The documentation would include proof of the original procedure performed, and activities undertaken as part of the follow up care of the patient. While the NHA remains cautious of the abuse prone nature of such a package, utilization of such a package would be closely monitored to justify keeping it in the subsequent modifications of the HBP

2.2.10 Abuse Prone Packages

With the experience of implementing AB PM-JAY through the past year, the NHA has been able to identify certain packages that are prone to abuse and require closer monitoring. Such a list of packages has been identified in the TMS and a conscious attempt has been made to keep the price of abuse prone packages at the minimum level to minimize incentives for abuse. Booking of these packages also creates an alert at the National Anti-Fraud Unit (NAFU) at the NHA and may trigger an investigation. The list of these abuse prone packages is held as confidential at the time of publishing of this manual.

2.2.11 Standardized nomenclature of procedures

A conscious attempt has been made to standardize the nomenclature and definitions of packages. NHA in collaboration with World Health Organization (WHO), has initiated the process of aligning HBP 2.0 with

International Classification of Health Interventions (ICHI) and International Classification of Diseases (ICD) coding of the WHO. When completed, India may become the first country to use ICHI in its HBP list.

The ICHI is being developed to provide a common tool for reporting and analyzing health interventions for statistical purposes. ICHI covers interventions carried out by a broad range of providers across the full scope of health systems and includes interventions on: diagnostic, medical, surgical, mental health, primary care, allied health, functioning support, rehabilitation, traditional medicine and public health.

Refer to (<https://mitel.dimi.uniud.it/ichi/>) for the search engine.

2.3 Key highlights – HBP 2.0, HBP 2.1 & HBP 2.2

Criteria	HBP 2.0	HBP 2.1	HBP 2.2
Number of packages	874	920	920
Number of procedures	1,592	1,669	1,670
Specialty	25	26	26
Additional procedures	NA	77	76

Section 3. Key features by Specialty

The final picture of HBP 2.2 is as follows:

S. No.	Specialty	HBP 2.2		
		Code	Packages	Procedures
1	Burns Management	BM	6	20
2	Cardiology	MC	21	27
3	Cardio-thoracic & Vascular surgery	SV	35	129
4	Emergency Room Packages	ER	3	4
5	General Medicine	MG	81	106
6	General Surgery	SG	105	159
7	Infectious Diseases	ID	3	4
8	Interventional Neuroradiology	IN	10	15
9	Medical Oncology	MO	72	264
10	Mental Disorders Packages	MM	10	10
11	Neo-natal care Packages	MN	10	10
12	Neurosurgery	SN	63	96
13	Obstetrics & Gynecology	SO	60	79
14	Ophthalmology	SE	41	55
15	Oral and Maxillofacial Surgery	SM	14	19
16	Orthopedics	SB	73	134
17	Organ & Tissue Transplant	OT	1	6
18	Otorhinolaryngology	SL	35	79
19	Pediatric Medical management	MP	48	67
20	Pediatric surgery	SS	19	35
21	Plastic & reconstructive Surgery	SP	8	12
22	Polytrauma	ST	10	23
23	Radiation Oncology	MR	14	46
24	Surgical Oncology	SC	81	125
25	Urology	SU	97	148
26	Unspecified Surgical	US	1	1
Total			919	1670

3.1 Burns Management

- Total number of packages: 6
- Total number of procedures: 20
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Specific Pre and Post-op Investigations such as clinical photograph and diagram with Rule of 9 / L & B Chart for extent of burns at the time of admission and follow up clinical photographs on days 5, 10, 15, 20 as per requirements on the basis of preauthorization would need to be submitted during claims.
- Admission Criteria to be followed for selecting packages for burn injured patients

- a. Second and third-degree burns greater than 10% of the total body surface area in patients under 10 or over 60 years of age
- b. Second and third-degree burns greater than 20% of the total body surface area in other age groups
- c. Significant burns of face, hands, feet, genitalia, or perineum and those that involve skin overlying major joints
- d. Third-degree burns greater than 5% of the total body surface area in any age group
- e. Inhalation injury
- f. Significant electric injury including lightning injury
- g. Significant chemical injury
- h. Burns with significant pre-existing medical disorders that could complicate management, prolong recovery, or affect mortality (e.g. diabetes mellitus, cardiopulmonary disease)
- i. Burns with significant concomitant trauma
- j. Burn injury in patients who will require special social and emotional or long-term rehabilitative support, including cases of suspected child abuse and neglect.

3.2 Cardiology

- Total number of packages: 21
- Total number of procedures: 27
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Specific Pre and Post-op Investigations such as ECHO, ECG, pre / post-op X-ray, label / carton of stents used, pre and post-op blood tests (USG, clotting time, prothrombin time, international normalized ratio, Hb, Serum Creatinine), angioplasty stills showing stents & post stent flow, CAG report showing blocks (pre) and balloon and stills showing flow (post) etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.
- It is prescribed as standard practice to use medicated stents (approved by FDA/DCGI) where necessary
- The carton / sticker detailing the stent particulars needs to be submitted as part of claims filing by providers

- It is advised to perform cardiac catheterization as part of the treatment package for congenital heart defects

3.3 Cardio-thoracic & Vascular Surgery

- Total number of packages: 35
- Total number of procedures: 129
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Specific Pre and Post-op Investigations such as ECHO, ECG, post-op scar photo, clinical photos of graft / filter / balloon & post flow, Angiography / CT / MRI / Doppler / CT angiogram reports etc. will need to be submitted / uploaded for pre-authorization / claims settlement purposes
- It is advised to perform cardiac catheterization as part of the treatment package for congenital heart defects

3.4 Emergency Room Packages

- Total number of packages: 3
- Total number of procedures: 4
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil
- Paper trail is to be maintained by the hospital treating the patient to be submitted during closure of claim
- In case hospitalization of more than 12 hours is required, the patient will be admitted and treated accordingly in the related specialty
- For the package Animal bites (Excluding Snake Bite) (ER003A), payment to be made after the completion of 5th dose

3.5 General Medicine

- Total number of packages: 81
- Total number of procedures: 106
- Pre-authorization: Mandatory for all packages for progressive extension of treatment/ hospital stay

- Pre-authorization remarks: Prior approval must be taken for all medical conditions/ packages under this domain for progressive extension of therapeutic treatments (i.e. for extending stay at 1,5,10 days stay and beyond)
- Separate package for high end radiologic diagnostic (CT, MRI, Imaging including nuclear imaging,) relevant to the illness only (no standalone diagnostics allowed) - subject to pre-authorization with a cap of Rs 5000 per family per annum within overall sum insured
- Separate package for high end histopathology (Biopsies) and advanced serology investigations relevant to the illness only (no standalone diagnostics allowed) - after pre-authorization with a cap of Rs 5000 per family per annum within overall sum insured
- Blood or Blood components transfusion if required, payable separately subject to pre-authorization. Blood can be procured only through licensed blood banks as per National Blood Transfusion Council Guidelines
- All clinical test reports, diagnosis, TPR charting, case sheet / clinical notes and discharge summary need to be submitted for extension of packages and during claims submission

3.6 General Surgery

- Total number of packages: 105
- Total number of procedures: 159
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil
- Spinal / other regional anesthesia are included under General Anesthesia and need to be claimed accordingly

3.7 Infectious Diseases

- Total number of packages: 3
- Total number of procedures: 4

Treatment and testing to be conducted as per the latest protocol from ICMR or State government & Recently added MIS-C packages under HBP 2.2

3.8 Interventional Neuroradiology

- Total number of packages: 10

- Total number of procedures: 15
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Specific Pre and Post-op Investigations such as pre/ post-op X-ray, CT/ ultrasound report, pre and post-op blood tests, post op clinical photographs with scar etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

3.9 Medical Oncology

- Total number of packages: 72
- Total number of procedures: 264
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all treatments/ malignancies
- The type and duration of treatment is different for all cancers. It is very important to complete the entire treatment which may in some cases last longer than a year. Relapse/recurrence may sometimes occur
- Cancer care treatments are advised to go through a clinical treatment approval process before initiating the best suitable treatment. A clinical treatment approval process is mandated for cancer care, since it involves a multi-modal approach covering surgical, chemotherapy and radiation treatments and appropriate supportive care that could assess to determine the best course of patient management for such conditions
- There should be pre-authorization at each step for cancer care
- It is advised that decision regarding appropriate patient care for cancer care treatments would need to be taken by a multidisciplinary tumor board (if available within the treating hospital or if not then it could be sent to the nearest regional cancer center (RCC) for approval) that should include a highly trained team of Surgical, Radiation and Medical Oncologist in order to ensure the most appropriate treatment for the patient. A detailed Oncology Treatment Plan could prove to be very vital, such as implications on the financial cover and to avoid unnecessary treatments

3.10 Mental Disorders Package

- Total number of packages: 10
- Total number of procedures: 10

- Pre-authorization: Mandatory for all packages for progressive extension of treatment/ hospital stay
- Pre-authorization remarks: Prior approval must be taken for all mental health conditions/ packages under this domain for progressive extension of therapeutic treatments
- Procedures can be done only in public sector hospital with specialty available
- All clinical test reports, diagnosis, Mental Status Examination (MSE), case sheet / clinical notes and discharge summary need to be submitted for extension of packages and during claims submission

3.11 Neonatal Care Package

- Total number of packages: 10
- Total number of procedures: 10
- Pre-authorization: Mandatory for all packages for progressive extension of treatment/ hospital stay / shifting across packages
- Pre-authorization remarks: Prior approval must be taken for progressive extension of therapeutic treatments (i.e. for extending stay beyond the prescribed limit/ in cases which might need shifting of packages based on clinical vitals and need - then the previously blocked package needs to be unblocked and the total amount of new package needs to be considered to be debited).
- All clinical test reports, diagnosis, TPR charting, case sheet / clinical notes and discharge summary need to be submitted for extension of packages and during claims submission.
- Packages would include neonates up to age of 28 days after birth
- All the packages are inclusive of everything including drugs, diagnostics, consultations, procedures, treatment modalities that the baby would require for its management
- In case a baby in a lower cost package develops a complication requiring higher level of care, the baby should be moved for higher cost package
- For procedures MN002A, MN003A, MN004A and MN005A, mother's stay and food in the hospital [postnatal ward / special ward for such mothers] for breastfeeding, family centered care and KMC (Kangaroo Mother Care) is mandatory
- For procedures MN002A, MN003A, MN004A and MN005A mothers should be allotted KMC bed when the newborn is eligible for Kangaroo mother care. The cost of bare bed and food to the

mother is included. If the mother requires treatment for her own illnesses, it would be covered under the mother's packages

- It is mandatory to ensure that the neonate receives vaccination as per National Immunization Schedule before discharge

3.12 Neurosurgery

- Total number of packages: 63
- Total number of procedures: 96
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Specific Pre-op and Post-op Investigations such as pre/ post-op X-ray, neuro-diagnostic studies, post-operative clinical photographs showing scars etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.

3.13 Obstetrics & Gynecology

- Total number of packages: 60
- Total number of procedures: 79
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all elective Surgeries/Procedures. Although the following packages, namely C-Section, High Risk Delivery, Hysterectomy are primarily for government facilities, they are open to the private hospitals upon referral by government hospitals/Doctors.
- Packages will include drugs, diagnostics, consultations, procedures, stay and food for patient. Medical conditions during pregnancy such as Hypertension, Diabetes etc. are to be treated as per medical packages

3.14 Ophthalmology

- Total number of packages: 41
- Total number of procedures: 55
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil

- Following cataract surgery that implants an IOL, it is prescribed to mention/ attach the barcode no. on the lens used during claims submission by the provider as means to provide information on expiration dates and details from manufacturers for increased quality and safety

3.15 Oral & Maxillofacial Surgery

- Total number of packages: 14
- Total number of procedures: 19
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil

3.16 Organ and Tissue Transplant

- Total number of packages: 01
- Total number of procedures: 06
- Pre-authorization: Mandatory for all packages

Pre-authorization remarks: NOTTO ID of the recipient and / donor, donor work-up summary sheet, recipient work-up summary sheet, cross-match report with donor and recipient photo-ID proof, admission notes, undertaking signed by donor (in living donor transplant), hospital authorization letter on recipient

3.17 Orthopedics

- Total number of packages: 73
- Total number of procedures: 134
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all replacement surgeries and others as indicated

3.18 Otorhinolaryngology (ENT)

- Total number of packages: 35
- Total number of procedures: 79
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil

3.19 Pediatric Medical Management

- Total number of packages: 48
- Total number of procedures: 67
- Pre-authorization: Mandatory for all packages for progressive extension of treatment/ hospital stay
- Pre-authorization remarks: Prior approval must be taken for all medical conditions/ packages under this domain for progressive extension of therapeutic treatments (i.e. for extending stay at 1,5,10 days stay and beyond)
- All clinical test reports, diagnosis, TPR charting, case sheet/ clinical notes and discharge summary need to be submitted for extension of packages and during claims submission
- Separate package for high end radiological diagnostic (CT, MRI, Imaging including nuclear imaging,) relevant to the illness only (no standalone diagnostics allowed) - subject to pre-authorization with a cap of Rs 5000 per family per annum within overall sum insured.
- Separate package for high end histopathology (Biopsies) and advanced serology investigations relevant to the illness only after preauthorization with a cap of Rs 5000 per family per annum within overall sum insured.
- Blood or Blood components transfusion if required, payable separately subject to pre-authorization. Blood can be procured only through licensed blood banks as per National Blood Transfusion Council Guidelines.
- If a medical condition requiring hospitalization has not been envisaged under this list, then a pre-authorization can be sought as "Unspecified Medical"

3.20 Pediatric Surgery

- Total number of packages: 19
- Total number of procedures: 35
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Nil

3.21 Plastic & Reconstructive Surgery

- Total number of packages: 8
- Total number of procedures: 12

- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Specific Pre-op and Post-op Investigations such as clinical and/or relevant imaging photographs of the patient are essential.
- In case of emergency/lifesaving/ limb saving operative procedures, preauthorization may not be required. However, formal intimation should be done within 24 hours of admission.

3.22 Polytrauma

- Total number of packages: 10
- Total number of procedures: 21
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Specific Pre-op and Post-op Investigations such as pre/ post-op X-ray, CT report, post-op scar photo, electro-diagnostic studies etc. will need to be submitted/ uploaded for pre-authorization/ claims settlement purposes. The costs for such investigations will form part of the approved package cost.
- The minimum length of hospital stay admissible for polytrauma cases would be on a case-by-case depending on the nature, type, and vitals (for e.g. coagulation parameters). However weekly submission of clinico-radiological vitals is desired.

3.23 Radiation Oncology (19)

- Total number of packages: 14
- Total number of procedures: 46
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all treatments/ malignancies
- The type and duration of treatment is different for all cancers. It is very important to complete the entire treatment which may in some cases last longer than a year. Relapse/recurrence may sometimes occur
- Cancer care treatments are advised to go through a clinical treatment approval process before initiating the best suitable treatment. A clinical treatment approval process is mandated for cancer care, since it involves a multi-modal approach covering surgical, chemotherapy and radiation treatments and appropriate supportive care that could assess to determine the best course of patient management for such conditions
- There should be pre-authorization at each step for cancer care

- It is advised that decision regarding appropriate patient care for cancer care treatments would need to be taken by a multidisciplinary tumor board (if available within the treating hospital or if not then it could be sent to the nearest regional cancer center (RCC) for approval) that should include a highly trained team of Surgical, Radiation and Medical Oncologist in order to ensure the most appropriate treatment for the patient. A detailed Oncology Treatment Plan could prove to be very vital, such as implications on the financial cover and to avoid unnecessary treatments

3.24 Surgical Oncology

- Total number of packages: 81
- Total number of procedures: 125
- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for all treatments/ malignancies
- The type and duration of treatment is different for all cancers. It is very important to complete the entire treatment which may in some cases last longer than a year. Relapse/recurrence may sometimes occur
- Cancer care treatments are advised to go through a clinical treatment approval process before initiating the best suitable treatment. A clinical treatment approval process is mandated for cancer care, since it involves a multi-modal approach covering surgical, chemotherapy and radiation treatments and appropriate supportive care that could assess to determine the best course of patient management for such conditions
- There should be pre-authorization at each step for cancer care
- It is advised that decision regarding appropriate patient care for cancer care treatments would need to be taken by a multidisciplinary tumor board (if available within the treating hospital or if not then it could be sent to the nearest regional cancer center (RCC) for approval) that should include a highly trained team of Surgical, Radiation and Medical Oncologist in order to ensure the most appropriate treatment for the patient. A detailed Oncology Treatment Plan could prove to be very vital, such as implications on the financial cover and to avoid unnecessary treatments

3.25 Urology

- Total number of packages: 97
- Total number of procedures: 148

- Pre-authorization: Mandatory for all packages
- Pre-authorization remarks: Prior approval must be taken for surgeries requiring use of Deflux injection, Botox Injection, inflatable penile prosthesis, urinary sphincter, and metallic stents
- It is mandated to get approval for all non-surgical conditions (involving evaluation/ investigation/ therapeutic management / follow-up visits) as indicated
- For any procedure whose charges are Rs. 15,000 or higher, extra costs (in the sense other packages) cannot be clubbed / claimed from the following: cystoscopy, ureteric catheterization, retrograde pyelogram, DJ stenting, nephrostomy – as they would form part of such packages costing Rs. 15,000 or higher as per the need and donor with details of the surgery.

Section 4. Using the HBP 2.2

4.1 Package selection

- i. The operator will check for the specialty for which the hospital is empanelled. Hospitals will only be allowed to view and apply treatment package for the specialty for which they are empanelled.
- ii. Based on diagnosis provided by doctor, operator should be able to block Surgical or Non-Surgical benefit package(s) using the Transaction Management IT system (TMS)
- iii. Both surgical and non-surgical packages cannot be blocked together, only either of the type can be blocked.
- iv. As per the package list, the mandatory diagnostics/documents will need to be uploaded along with blocking of packages.
- v. In case of multiple surgeries in the same admission, the operator can block more than one package for the beneficiary. In case the AB PM-JAY Beneficiary is required to undertake multiple surgical treatment, then the highest package rate shall be taken at 100%, thereupon the second treatment package shall be taken as 50% of package rate and the third treatment package shall be at 25% of the package rate. (Unless otherwise defined)
- vi. Certain packages will only be reserved for Public EHCPs as decided by the SHA. They can be availed in Private EHCPs only after a referral from a Public EHCP is made.
- vii. Packages as indicated may have differential pricing for NABH and Non-NABH, for Hospitals running PG/ DNB Course, for rural and urban EHCPs and for EHCPs in aspirational districts as identified by NITI Aayog.
- viii. If a registered mobile number of beneficiary family is available, an SMS alert will be sent to the beneficiary notifying him of the packages blocked for him.
- ix. At the same time, a printable registration slip needs to be generated and handed over to the patient or patient's attendant.
- x. If for any reason treatment is not availed for any package, the operator can unblock the package before discharge from hospital.

4.2 Raising a Pre-Auth

Guidelines

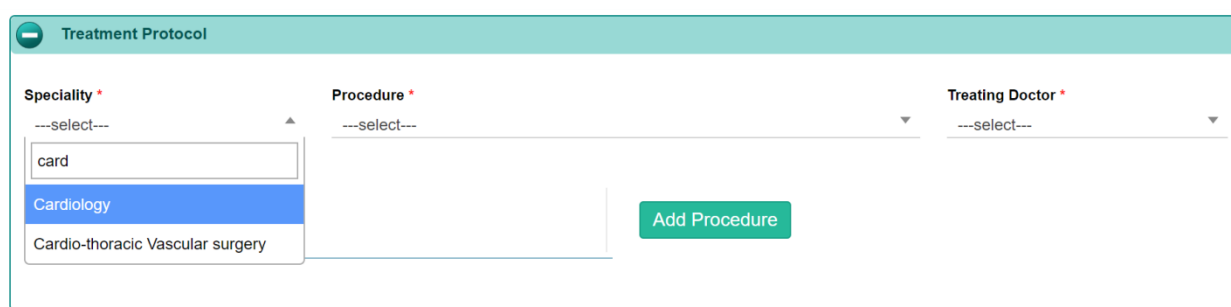
- i. Packages are defined which require pre-authorization from the insurance company / trust before they can be administered. In case any inpatient treatment is not available in the packages defined, then hospital will be able to provide that treatment to the beneficiary only after the same gets approved by the Insurance company/ trust and will be reflected as unspecified package. Under both scenarios, the operator would be able to initiate a request to the insurance company/trust for pre-authorization using the web application.
- ii. The hospital operator will send all documents required for pre-authorization to the insurance company/trust using the Centralized TMS / States transaction management application.
- iii. The documents needed may vary from package to package and hence a master list of all documents required for all packages is available on the server.
- iv. The request as well as approval of the form will be done using the AB PMJAY TMS system or using API exposed by AB PM-JAY (Only one option can be adopted by the insurance Co.) or using State's own IT system (if adopted by the State).
- v. In case of no or limited connectivity, the filled form can also be sent to the insurance company/ trust either through fax/ email. However, once internet connectivity is established, the form should also be submitted using online system as described above.
- vi. The insurance company/ trust will have to approve or reject the request latest by 6 hours. If the insurance company/ trust fails to do so, the request will be considered deemed to be approved after 6 hours by default.
- vii. In case of an emergency or delay in getting the response for pre-authorization request due to technical issues, provision will be there to get the pre-authorization code over the phone from Insurance Company/ Trust or the call centre setup by Insurance Company/ Trust. The documents required for the processing, may be sent using the transaction system within stipulated time.
- viii. In case of emergency, insurance company/ trust will provide the pre-authorization code generated through the algorithm/ utility provided by MoHFW/NHA-NIC.
- ix. Pre-authorization code provided by the Insurer/ Trust will be entered by the operator and will be verified by the system.
- x. If pre-authorization request is rejected, Insurance Company / Trust will provide the reasons for rejection. Rejection details will be captured and stored in the transaction database.
- xi. If the beneficiary or the hospital are not satisfied by the rejection reason, they can appeal through grievance system.

4.3 Process for raising a Pre-Auth

The following steps need to be followed for selecting a package / procedure in the TMS

Step 1 - Select a specialty

A specialty may be selected from the dropdown menu available. All procedures are mapped to their respective specialties, so in case the user is not sure of the specialty to be chosen, she / he may proceed to procedure selection and the specialty would be chosen automatically. However, in case a procedure is mapped to more than one specialty, the specialty will need to be selected from the options shortlisted in the dropdown menu based on the procedure selected.



The screenshot shows a web form titled "Treatment Protocol". It contains three dropdown menus: "Specialty *", "Procedure *", and "Treating Doctor *". The "Specialty *" dropdown is open, showing a search bar with the text "card" and a list of suggestions: "Cardiology" (highlighted) and "Cardio-thoracic Vascular surgery". There is an "Add Procedure" button to the right of the dropdowns.

Fig: Selecting a specialty

Step 2 - Select a procedure

A package / procedure may be selected from the dropdown menu available. The selection dropdown narrows the choices available as the user begins typing in his / her choice. Procedures may be selected through any of the following three options

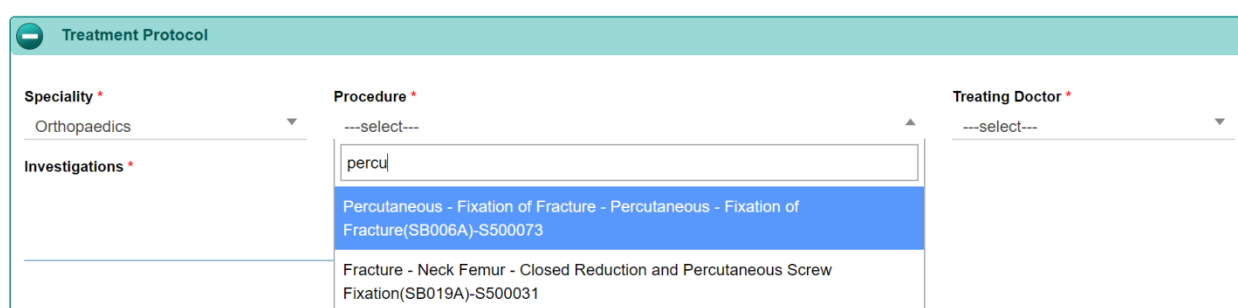
- By typing in the procedure name
- By typing in the HBP 2.0 procedure code
- By typing in the HBP 2.2 procedure code

Upon selection of a procedure, check the column on procedure price alongside the procedure selected. That column would prompt the user on the next step. If the column displays a procedure price, the process of selecting that procedure is complete. On the other hand, the section may prompt the user to proceed to selection of a stratification or and implant.

The system also requires the user to mandatorily fill in details of the primary clinician associated with the patient. The clinician's name, registration number, qualifications and phone number would auto populate from the Hospital Empanelment Module, if available there. Else, they would need to be filled in here.

The system also highlights the mandatory documents associated with the procedure that the user would need to upload before raising a pre-auth. The user would be required to select the list of mandatory documents as an acknowledgment to the same and proceed to add procedure.

Please note – the following steps of selection of stratification, and selection of implant are procedure dependent and one, or both may not be required for all procedures to be selected.



Treatment Protocol

Speciality *
Orthopaedics

Procedure *
---select---

Treating Doctor *
---select---

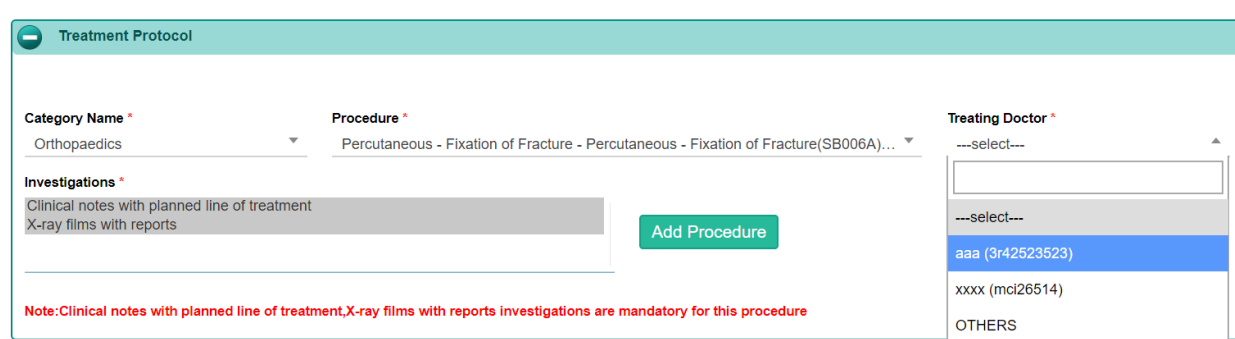
Investigations *

percu

Percutaneous - Fixation of Fracture - Percutaneous - Fixation of Fracture(SB006A)-S500073

Fracture - Neck Femur - Closed Reduction and Percutaneous Screw Fixation(SB019A)-S500031

Fig: Selecting a procedure



Treatment Protocol

Category Name *
Orthopaedics

Procedure *
Percutaneous - Fixation of Fracture - Percutaneous - Fixation of Fracture(SB006A)...

Treating Doctor *
---select---

Investigations *

Clinical notes with planned line of treatment
X-ray films with reports

Add Procedure

Note: Clinical notes with planned line of treatment, X-ray films with reports investigations are mandatory for this procedure

aaa (3r42523523)

xxxx (mcl26514)

OTHERS

Fig: Mandatory details of the treating clinician

Step 3 - Select a stratification

The stratification icon alongside the selected procedure gets enabled whenever there is an associated stratification with the selected procedure. Upon selection of the stratification icon, the user would be

prompted to select the stratification detail to be used. Options would be available based on the levels of stratifications available for the selected procedure.

Upon selection of a stratification detail, the user would then need to select a stratification option from the choices available in the dropdown for that stratification. Most procedures have a single level of stratification and the stratification detail would be auto selected. In case multiple stratifications are available for the chosen procedure, the user would need to select each one individually and fill in details for each.

Upon successfully selecting a stratification, the system would return the user to the original procedure selection screen. Upon returning to the screen, the user is advised to check the column on procedure price alongside the procedure selected. That column would prompt the user on the next step. If the column displays a procedure price, the process of selecting that procedure is complete. On the other hand, the section may prompt the user to proceed to selection of an implant.




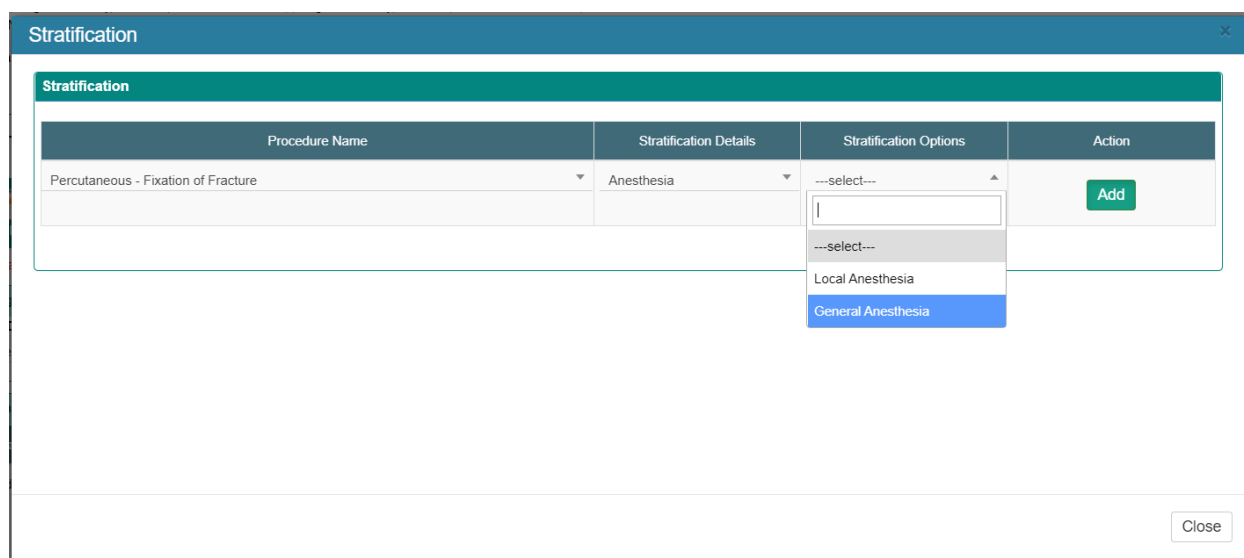
Treatment Protocol						
Speciality	Procedure	Quantity	Amount(₹)	Stratification	Implants	Action
Orthopaedics(SB)	Percutaneous - Fixation of Fracture(SB006A)	1	Please select Implant/ Stratification as applicable for populating Amount	-	-	  

Fig: Prompts for selecting an implant / stratification

Treatment Protocol						
Speciality	Procedure	Quantity	Amount(₹)	Stratification	Implants	Action
Orthopaedics(SB)	Percutaneous - Fixation of Fracture(SB006A)	1	Please select Implant/ Stratification as applicable for populating Amount	-	-	  

Fig: Add stratification



Procedure Name	Stratification Details	Stratification Options	Action
Percutaneous - Fixation of Fracture	Anesthesia	<div> <div>---select---</div> <div> <div>Local Anesthesia</div> <div>General Anesthesia</div> </div> </div>	<div>Add</div>

Fig: Select stratification option

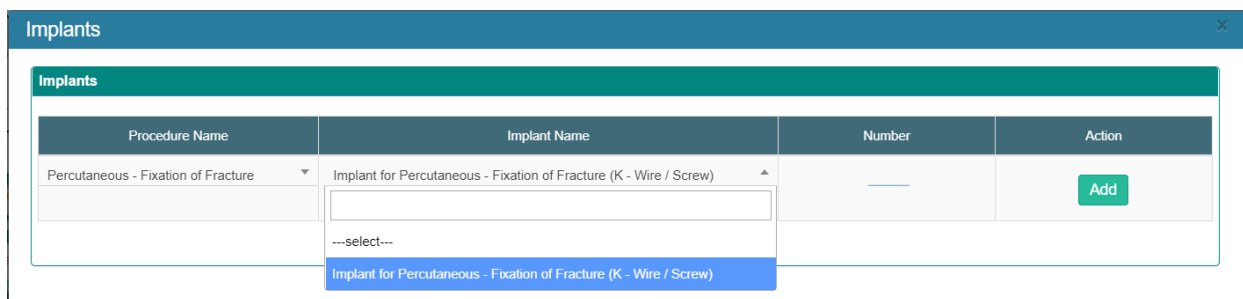
Step 4 - Select an implant

The select implant icon alongside the selected procedure gets enabled whenever there is an associated implant with the selected procedure. The user would need to select the implant name from the dropdown available. Upon selecting the implant, the user would also need to specify the number of implants that the user required a pre-auth approval on.

In case of multiple types of anticipated implants, the user may select each implant individually and add the numbers against each. The option of multiple implants is available in select procedures and there may be conditions where the system would not accept the selection of multiple implants for the given procedure. Please note that this is by design and multiple implant types are not permitted in this case.

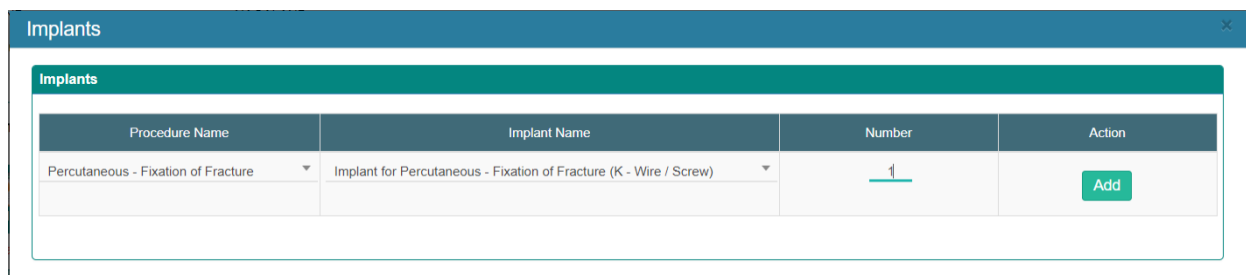
Upon successfully selecting the implant / implants, the system would return the user to the original procedure selection screen. Upon returning to the screen, the user is advised to check the column on

procedure price alongside the procedure selected. That column would prompt the user on the next step. If the column displays a procedure price, the process of selecting that procedure is complete.



Procedure Name	Implant Name	Number	Action
Percutaneous - Fixation of Fracture	Implant for Percutaneous - Fixation of Fracture (K - Wire / Screw)		Add

Fig: Select implant



Procedure Name	Implant Name	Number	Action
Percutaneous - Fixation of Fracture	Implant for Percutaneous - Fixation of Fracture (K - Wire / Screw)	1	Add

Fig: Select Quantity

Treatment Protocol						
Speciality	Procedure	Quantity	Amount(₹)	Stratification	Implants	Action
Orthopaedics(SB)	Percutaneous - Fixation of Fracture(SB006A)	1	11680	Anesthesia - General Anesthesia	Implant for Percutaneous - Fixation of Fracture (K - Wire / Screw) - (1)	  

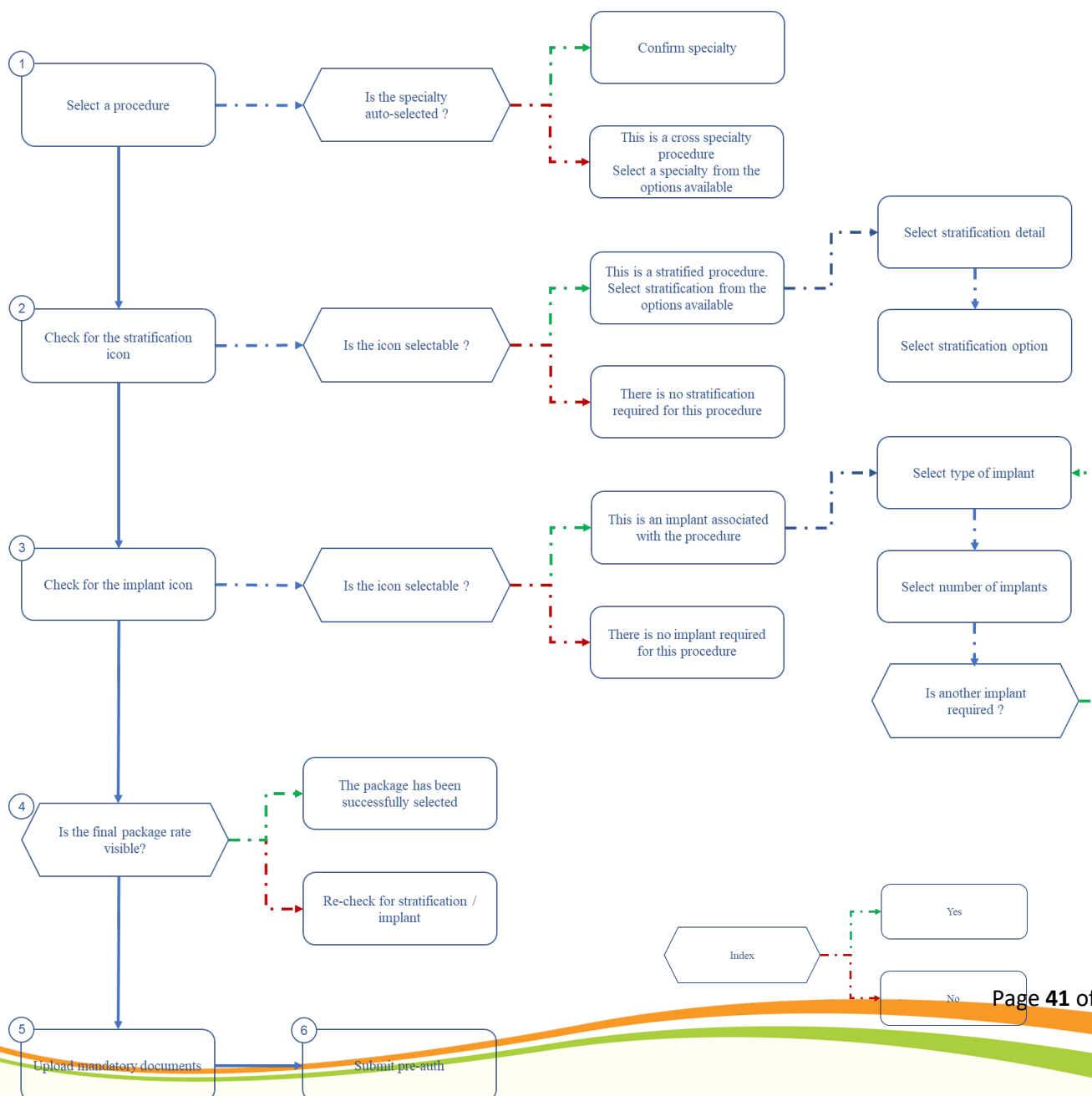
Fig: Procedure added successfully

Step 5 – Upload mandatory documents

Step 6 – Submit pre-auth request

Every procedure requires a set of mandatory documents to be uploaded at the time of submission of a pre-auth request.

Illustrative



4.4 Approving a pre-auth

In addition to the activities listed in Claim Adjudication Manual (February 2019) (<https://www.pmjay.gov.in/documents>), on account of the HBP 2.0 / 2.1, the Pre-Auth Processing Doctor (PPD) at the TPA / ISA would additionally need to check the following before approving a pre-auth.

- i. Conformation of the selected procedure to the patient condition - Since the HBP 2.0 was significantly more granular than the previous version, the detail of the procedure selected will need to be validated by the patient condition. Packages such as fevers, animal bites, congenital heart diseases etc. have been split into multiple procedures that fall within the same package, but have significant differences in terms of management, skill and therefore, cost. This needs to be looked into and considered closely before approving a pre-auth for the procedure.
- ii. Selected implant / high end consumable in conformity with the age / gender / condition of the patient - Certain implants in the HBP 2.0 were distinguished based on the age of the patient. Paediatric implants / devices are recommended for patients less than or equal to 14 years of age, while adult devices are to be used beyond that age. Once more, keeping the cost implication in mind, it will need to be verified whether the implant / device is in conformation with the age of the patient. Similarly, some implants are gender specific, and some consumables are required only in select patients. Number of screws, plates and other implants are also variable in HBP 2.0 and their anticipated numbers for a surgery will need to be verified before approving a patient pre-auth.
- iii. Selected stratification in lines with the age / gender / condition of the patient - Every stratification of the procedure selected is backed up with a cost implication that needs to be closely considered at the time of approving a pre-authorization. Performing a procedure under LA / GA, Unilateral / Bilateral performance of a procedure, approach to be used are some examples of stratifications that will need to be closely looked into, and justified, owing to the price differential involved.
- iv. Non-Surgical procedures - Medical care packages have been introduced in certain specialties to allow for continuity of care for the patient. Monitoring of the justification of booking such procedures will now add as an additional responsibility of the PPD.
- v. Follow up procedures - In HBP 2.0, HBP 2.1 & HBP 2.2 follow up procedures can be blocked for certain packages but will need to be supported by documentary evidence that the parent procedure has been performed, even if done outside of the hospitals empanelled under AB PM-JAY.

- vi. Diagnostic procedures -Certain diagnostic procedures have been included under AB PM-JAY based on user demand, and on the judgment of the expert committees. Such procedures have been highlighted in HBP 2.0, HBP 2.1 & HBP 2.2 as abuse prone procedures and will be closely monitored by the National & State Fraudmonitoring teams. The PPD is advised to maintain a close vigil on blocking of these packages.

Section 5. Frequently Asked Questions

1. What is the rationale of HBP 2.1?

- a. Non availability of certain procedures, lead to repeated booking under Unspecified Surgical Package
- b. Packages listed exclusively under multiple SHAs as state specific packages
- c. New packages requested by SHAs, medical experts & other stakeholders

2. What is the total package count of HBP 2.1?

- A. HBP 2.1 has 918 packages split into 1669 procedures. Difference from HBP 2.0 is inclusion of Organ & Tissue transplant (OT) as new specialty with additional 6 procedures.

3. How many specialties are covered in HBP 2.1?

- A. HBP 2.1 covers 25 specialties (including 'Organ & Tissue transplant'). All specialties from HBP 2.0 have been retained.

4. Have prices been reduced for some procedures in HBP 2.1?

- A. Prices are same as in HBP 2.0.

5. Will the unspecified package still be available in HBP 2.1?

- A. Yes. While it has been the aim of package revision to include most used treatment modalities within HBP 2.1, some state specific, or uncommon conditions may still have been overlooked. So, while it is expected that booking of procedures under the unspecified category would be reduced, the category has still been maintained in new revised package list.

6. In case of patients diagnosed with Osteosarcoma, treatment booked under Procedure: CT for Osteogenic Sarcoma (code:MO010C), the maximum number of chemotherapy cycles allowed are 4 on TMS. Are the number of cycles exceeded in HBP 2.1?

- A. No, the cycles not exceeded in HBP 2.1. As per the NCG, standard regimen is 4 cycles.

7. What should be the minimum duration between the chemotherapy cycles?

- A. Cycle interval is counted considering the first day of first cycle as Day-1. The minimum duration between cycles is based on the regimen.

For e.g. If patient has received R-CHOP- (Rituximab 375mg/m²+Cyclophosphamide 750 mg/m²+Vincristine 1.4 mg/m², on Day1+Etoposide 65mg/m² Day 1 to 3+Prednisolone 100 mg Day 1-5), Total 6 cycles, repeat 21 days (Procedure name: CT for B - Cell NHL - High Grade(Except Burkitt's & PCNSL), Procedure code:MO029A)

- If the 1st cycle is given on 31.12.2020, then 2nd cycle should have been given on 21.01.2021.
- Reducing gap is not advisable as these are based on the prior data on these regimens. However, if this is the technical issue due to which hospitals are not able to get the package approval, you can reduce it by one day as acceptable period. (so instead of 21.01.2021 in the above scenario- approval can be given on 20.01.2021)

8. Whether organ transplant provided to beneficiaries under AB PM JAY?

A. Yes, Organ and Tissue transplant is added as new package under HBP 2.1 which includes renal transplant and corneal transplant packages.

9. What was the need of HBP 2.0?

- A. Packages were rationalized against the following aberrations found in the original HBP
- a. Package rates offered for many packages were inadequate to cover the cost of procedures
 - b. Duplication of packages was observed both within a single specialty and across specialties
 - c. The terminology used for the nomenclature of packages was inconsistent
 - d. Few of the procedures were overlapping with the ongoing National Health Programs
 - e. Some of the high-end procedures / investigations / drugs are not covered in HBP 1.0
 - f. Due to the non-availability of certain treatments, a lot of procedures were being booked under Unspecified packages

10. What is the total package count of HBP 2.0?

- B. HBP 2.0 has 874 packages split into 1592 procedures. By the new nomenclature, many packages are a group of procedures split primarily based on surgical approach or different types of treatment modalities available for a similar type of treatment. Through the first year of implementation of AB PM-JAY, it was felt that frequency of utilization of individual procedures is required for analysis. Hence, there was a need to capture the different procedures covered under single package separately and thus the concept was introduced.

11. How many specialties are covered in HBP 2.0?

- A. HBP 2.0 covers 25 specialties (including 'Unspecified'). All specialties from HBP 1.0 have been retained except for Paediatric Cancer that has been discontinued. All procedures of paediatric cancers have been split into medical / surgical oncology.

12. The specialty of pediatric cancer has been discontinued. How will these patients be treated?

- A. All the procedures of Paediatric cancer have been included under the other three specialties of oncology viz. Surgical, Medical & Radiation Oncology. Hence Paediatric cancer specialty may not be visible under specialty list, but all the paediatric cancers are adequately covered.

13. Have prices been reduced / increased for some procedures in HBP 2.0?

- A. Prices have been reduced for 57 and increased for 270 procedures in HBP 2.0 as compared to HBP 1.0.

14. With 554 discontinued packages, has the treatment coverage reduced in AB PM-JAY?

- A. No. The National Health Authority, through revision of packages made a conscious effort to ensure that no therapeutic area, initially covered within AB PM-JAY is not left uncovered in HBP 2.0. The discontinued packages have been redistributed into other multiple procedures that are included in PM-JAY.

15. Will the unspecified package still be available in HBP 2.1?

- A. Yes. While it has been the aim of package revision to include most commonly used treatment modalities within HBP 2.1, some state specific, or uncommon conditions may still have been overlooked. So, while it is expected that booking of procedures under the unspecified category would be reduced, the category has still been maintained in new revised package list.

16. Is Cataract still available under AB PM-JAY

- A. Yes, it is available

17. What was the rationale for adopting new packages in HBP 2.0?

- A. 237 new packages have been introduced in HBP 2.0. The following packages were introduced as new packages

- a. Packages that were booked frequently as unspecified packages
- b. Therapeutic areas that were earlier not covered
- c. Follow up packages
- d. Packages recommended by the expert groups

18. What is the new concept of Packages and Procedures?

- A. By the new nomenclature, many packages are a group of procedures split primarily based on surgical approach or different types of treatment modalities available for a similar type of treatment. Through the first year of implementation of AB PM-JAY, it was felt that frequency of utilization of individual procedures is required for analysis. Hence, there was a need to capture the different procedures covered under single package separately and thus the concept was introduced.

19. Can the same package be booked under multiple specialties?

- A. There are many procedures which fall under the purview of more than one specialty. In HBP 1.0, the practice was to repeat the same package under every concerned specialty with individual package codes and independent terminology, resulting in unnecessary repetition / duplication. Now such procedures have been consolidated under a single specialty and marked as 'Cross specialty procedures', so that they can be used by other relevant specialties as well.

20. What is stratification of procedures?

- A. In HBP 2.0, certain procedures have been identified that involve different treatment modalities for same or similar procedures e.g. type of anaesthesia, surgical approach, unilateral / bilateral, aetiology etc. Although the difference appears minor between the multiple stratifications of a procedure, there is a clear financial impact of the same. Such procedures have been classified as stratified procedures wherein an additional layer of stratification has been added to account for additional effort / cost.

21. Are implants / High end consumables included in surgical packages?

- A. Yes, the price of both these entities, wherever used, are included in the final procedure price. In many packages, the final total cost (including procedure and implant / consumable) is given. In other packages, costs of procedure and implant / consumable is given separately. In such cases, these two costs are entered in the system already and reflected in the form of a final cost in the

Transaction Management System (TMS). Thus, it is possible that for the same package, different rates may be seen for certain procedures based on the type of implant / consumable selected in such cases. (Also refer to answers for Q. 22 to 25)

22. Can more than one implant be booked for a procedure?

- A. HBP 2.0 provisions for use of multiple implants within a procedure and independently accounts for the price of each implant used. However, for most procedures, there is a cap on the maximum number of implants that will be reimbursed in a procedure.

23. Will the hospitals be getting reimbursed separately for the implants?

- A. No. Price of implant will be included in the price of the selected procedure. The price of the implant will be added to the procedure price at the back end by the TMS and will be reflected in the final reimbursement. Some procedures may require details of the number / type of implant used from a selection dropdown to calculate the total price of implants used.

24. What is Static & Dynamic pricing of procedures?

- A. A concept of static and dynamic pricing has been introduced in HBP 2.0 to account for variations in prices that are now possible in HBP 2.0 based on number / types of implants used. Procedures with no implants, or pre-defined included implants will follow a static price with no variations. On the other hand, in case of procedures where multiple implants are permitted, or in case there is an available choice in type of implant, the TMS would prompt for details of the number / type of implant used from a selection dropdown to calculate the total price of implants used.

25. How is the final procedure rate calculated in the TMS?

- A. For final calculation of procedure rate, Final Procedure Price = Procedure price + Stratification rate (if any) + Incentive (if applicable) + Implant(s) rate (if any).

26. Is there any change in the incentives offered on the package rates under AB PM-JAY?

- A. There is no change in the NHA policy for incentives. However, the percentage of incentive will no longer be applicable to the price of the implant. Incentive will only be calculated on the procedure rate. Indicative incentive mechanisms are as below, (this is a voluntary exercise at the States' discretion, with prior intimation to the NHA).

S. No.	Criteria	Incentive (Over and above base procedure rate)
1	Entry level NABH	10%
2	Full NABH accreditation	15%
3	Situated in Delhi or some other Metro	10%
4	Aspirational district	10%
5	Running PG / DNB course in the empanelled specialty	10%

These percentage incentives are added by compounding rather than in simple way. Thus, for a package costing Rs. 10,000 otherwise, the payment made for a hospital with full NABH accreditation in an aspirational district will be ₹10,000 x 1.15 x 1.10 = ₹12,650. It will not be calculated as ₹10,000 x 1.25 = ₹12,500

27. What are the Aspirational districts?

- A. 117 Aspirational districts have been identified by NITI Aayog based upon composite indicators from Health & Nutrition, Education, Agriculture & Water Resources, Financial Inclusion and Skill Development and Basic Infrastructure which have an impact on Human Development Index.

28. What are the Metros?

- A. The Metros include Delhi (UA) (including Faridabad, Ghaziabad, NOIDA and Gurugram), Greater Mumbai (UA), Kolkata (UA), Chennai (UA), Bangalore / Bengaluru (UA), Ahmedabad (UA), Hyderabad (UA) and Pune (UA).

[Cities classified as “X” in Ministry of Finance’s OM No. 2/5/2014-E.II(B) dated 21.07.2015]

29. What is an Add-on Procedure?

- A. Certain packages which can be booked with a primary package at a 100% reimbursement contrary to the existing principle of 50% reimbursement of the second package. These packages are defined as Add-on Packages.

30. What are Stand-Alone Procedures?

- A. For Fraud prevention and control, some packages have been identified that cannot be booked in combination with any other package / procedure. These are termed as stand-alone packages in the HBP 2.0

31. What are Sequential Procedures?

- A. Some procedures in HBP 2.0 have been identified to follow a logical sequence in patient management. Any break in the sequence would trigger an investigation at the NHA who may seek justification for the same.

32. Is there a provision for Follow-Up procedures?

- A. Procedures have been identified that require prolonged follow ups beyond the limit of 15 days as included in the coverage of the scheme. These follow ups may need medical intervention with utilization of consumables and consultations with the treating doctor. These have been sorted as follow up packages and are aligned to their specific primary packages. In addition, these packages can only be booked only upon submission of satisfactory documentary proof that the primary procedure was conducted on the patient, whether within or outside of the purview of AB PM-JAY.

33. Are there defined Day Care procedures in HBP 2.0 and HBP 2.1?

- A. All standard HBP guidelines are applicable across all packages in HBP 2.0 and HBP 2.1. There is no relaxation in protocols for any procedures that are booked on Day Care or Inpatient basis / in Public or Private Hospitals / in Elective or Emergency conditions.

34. Have any Fraud control measures been built into the procedures of HBP 2.0 and HBP 2.1?

- A. Many Anti-Fraud measures have been built into the procedures of HBP 2.0. A few of them are as under
- Procedures within HBP 2.0 have been identified to be fraud prone and would be under scrutiny by the National Anti-Fraud unit (NAFU) at the NHA. Utilization of these packages may trigger show-cause response from the NHA.
 - Prices of some procedures have been consciously kept at a bare minimum to avoid temptation of hospitals to abuse the same.
 - In cases where the patient undergoes multiple rounds of treatment, the minimum interval between two consecutive treatment interventions has been configured in the IT system, wherever applicable e.g. Appendicectomy, Hysterectomy, Cataract etc.
 - The maximum number of times a procedure can be booked for an individual patient has been integrated in the IT system, wherever applicable

- e. Implants / High End Consumables usage has been defined at the procedure level where both the type of Implants / High End Consumables and their maximum permissible limit of usage has been detailed out

35. Is there a standardized nomenclature of procedures in HBP 2.0?

- A. In collaboration with World Health Organization (WHO), the NHA has initiated the process of aligning HBP 2.0 with International Classification of Health Interventions (ICHI) and International Classification of Diseases (ICD) coding of the WHO.

36. Are there any guidelines with respect to reservation of packages for Public Hospitals?

- A. It is the discretion of the States to reserve packages for public hospitals based on their local conditions and infrastructure availability. However, as with HBP 1.0, certain procedures such as Hysterectomy, High Risk Delivery and Mental health packages have been recommended by the National Health Authority to be reserved for Public Hospitals. The same will continue to be reserved for Public Hospitals for HBP 2.0 and HBP 2.1

37. Can states still add state specific packages to supplement HBP 2.1?

- A. Yes. States are still at liberty to add state specific packages. However, prior approval from the NHA is mandatory that would ensure that the requested packages do not fall in the exclusion criteria of the scheme, or that the packages do not prior exist in the national master. Although, as per the rationale of HBP 2.1 many state specific packages are already included in national master

38. What is the process for States to add their own state specific packages to supplement HBP 2.0 and HBP 2.1?

- A. In collaboration with World Health Organization (WHO), the NHA has initiated the process of aligning HBP 2.0 and HBP 2.1 with International Classification of Health Interventions (ICHI) and International Classification of Diseases (ICD) coding of the WHO. The same mapping will need to be adopted by the states before submitting their proposed list to the NHA for approval. The NHA would scan the list to cull out any duplicate procedures with the National list, as well as procedures that fall

within the exception criteria of the scheme. States will also be required to send in their proposal with a reasonable justification for inclusion of their packages to the satisfaction of the NHA medical panel.

39. Do States have the flexibility to alter package rates?

- A. Package / Procedure rates recommended by the NHA in HBP 2.0/HBP 2.1 have been arrived to through a scientific and rigorous process of costing exercises and committee recommendations. However, it is also accepted that costs and prices of services may vary between states. To account for the same, the states have the flexibility of increase the recommended rates anywhere within 10% for their specific state / UT. However, the states have the liberty to reduce the rates to any limits owing to conditions specific to their state.

40. What is the Minimum Document Protocol for HBP 2.0/HBP 2.1?

- A. A set of mandatory documents have been defined for each package / procedure within the HBP 2.0/HBP 2.1. These documents would need to be mandatorily uploaded at the time of raising a pre-auth, or for raising a claim. These documents comprise the MDP / 'Minimum document Protocol' for HBP 2.0/HBP 2.1. These are available in the Transaction management System

41. Is there a defined Average Length of Stay (ALOS) for procedures booked under HBP 2.0/HBP 2.1?

- A. No. There is no minimum / maximum length of stay defined for any procedure under HBP 2.0/HBP 2.1. Any defined ALOS published for patient care under HBP 2.0/HBP 2.1 is purely indicative and is not expected to be restrictive to patient care in any way.

42. How do States prepare for HBP 2.1? Are there any IT related expectations?

- A. For all states using the NHA TMS, the transition to HBP 2.1 would be automated from the back end and would require no preparations at the State level. For states using their own Transaction Management Systems, there would be preparations required that would be facilitated by the IT teams at NHA. Beyond IT, the States would be expected to facilitate and ensure trainings of all stakeholders involved as the system transitions to the newer version.

Abbreviations Used

AB PM-JAY	Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
HBP	Health Benefit Packages
NHA	National Health Authority
SHA	State Health Agency
ISA	Implementation Support Agency
TMS	Transaction Management System
OBG	Obstetrics & Gynecology
ENT	Ear, Nose & Throat Specialty (Otorhinolaryngology)
CTVS	Cardio Thoracic & Vascular Surgery
WHO	World Health Organization
ICHI	International Classification of Health Interventions
ICD	International Classification of Diseases
PPD	Pre-Auth Processing Doctor
CPD	Claim Processing Doctor
DHR	Department of Health Research
ICMR	Indian Council of Medical Research
Lap	Laparoscopic
CBD	Common Bile Duct
LAMA	Leave Against Medical Advice
DAMA	Discharge Against Medical Advice

Annexure 1 – Exclusions to the Policy

Ayushman Bharat PM-JAY shall not be liable to make any payment under this policy in respect of any expenses whatsoever incurred by any Insured Person in connection with or in respect of:

- Condition that does not require hospitalization and can be treated under Outpatient Care
- Except those expenses covered under pre and post hospitalisation expenses, further expenses incurred at Hospital or Nursing Home primarily for evaluation / diagnostic purposes only during the hospitalized period and expenses on vitamins and tonics etc unless forming part of treatment for injury or disease as certified by the attending physician.
- Any dental treatment or surgery which is corrective, prosthetic, cosmetic procedure, filling of tooth cavity, root canal including wear and tear of teeth, periodontal diseases, dental implants etc. are excluded. Exception to the above would be treatment needs arising from trauma / injury, neoplasia / tumour / cyst requiring hospitalisation for bone treatment.
- Any assisted reproductive techniques, or infertility related procedures, unless featuring in the National Health Benefit Package list.
- Vaccination and immunization
- Surgeries related to ageing face & body, laser procedures for tattoo removals, augmentation surgeries and other purely cosmetic procedures such as fat grafting, neck lift, aesthetic rhinoplasty etc.
- Circumcision for children less than 2 years of age shall be excluded (unless necessary for treatment of a disease not excluded hereunder or as may be necessitated due to any accident)
- Persistent Vegetative State: a condition in which a medical patient is completely unresponsive to psychological and physical stimuli and displays no sign of higher brain function, being kept alive only by medical intervention.

ANNEXURE – I



सत्यमेव जयते

**national
health
authority**



2027462/2021/HNQA-NHA

No. S-12015/08/2019-NHA(HN&QA)

Government of India
National Health Authority

OFFICE MEMORANDUM

Subject: Roll – out of the feature of multiple booking of a single procedure in TMS.

Certain procedures, owing to their nature of treatment, are required to be booked more than once for a patient in a single pre – authorization. HN & QA has shortlisted such procedures which should be allowed to be booked more than once in a single pre – authorization. A list of total 138 procedures so identified is placed at Annexure – 1.

The suggestive payment mechanism for such procedures shall follow the existing methodology of booking more than one surgical procedure:

- 100% for the first procedure (100% Implant cost, if used)
- 50% for the second procedure (100% Implant cost, if used)
- 25% for the third procedure and thereafter (100% Implant cost, if used)

The feature of multiple booking of procedures has been tested and is ready for roll-out. SHAs may communicate a suitable date to make it live in their production environment.

Kindly coordinate & communicate the same to EHCPs.

Dated: 06.01.2020

(Dr. Ajai Aggarwal)
Director, HN&QA

ANNEXURE – II

1756341/2020/HNQA-NHA

No. S-12015/20/2020-NHA(HN&QA)
Government of India
National Health Authority

OFFICE MEMORANDUM

Sub: Testing and treatment for COVID-19 under Ayushman Bharat Pradhan Mantri Jan Aarogya Yojna.

With reference to the OM of even number dated 4th April 2020, it is further clarified that.

1. For testing, payment shall be made in the following circumstances:
 - a. Public hospitals having tie up with private labs.
 - b. Private hospitals doing testing

Note: No payment shall be made to public hospitals utilising their own or other public testing facility

2. For treatment, payment shall be made to both public and private hospitals at the rate decided by the respective state government.

It may also be noted that the payment for PM-JAY beneficiaries shall be made by the National Health Authority as per the current mechanism of sharing the financial burden.

Dated: April 8, 2020


(Dr Arun Gupta) 8.4.2020
Executive Director
HN&QA

ANNEXURE – III

64

2021109/2021/HNQA-NHA

No. S-12015/31/2020-NHA(HN&QA)
Government of India
National Health Authority

OFFICE MEMORANDUM

Subject: Roll out of Health Benefit Package 2.1


After the implementation of HBP 2.0 in 19 States / UTs, NHA undertook the activity to further rationalize national health benefit package master to address the existing gaps. The rationalization was primarily based on feedback received from states in the form of state specific packages, experts from the medical cell of NHA and a few other sources. A deep dive analysis was also undertaken of the procedures booked under Unspecified surgical package across all states / UTs implementing HBP 2.0. The recommendations made by the medical cell were put up to the Governing Board of NHA for consideration and were approved to be rolled out as HBP 2.1.

HBP 2.1 comprises of a total of 63 packages containing 94 procedures (including cross – specialty procedures) which will be added to the existing HBP for each state implementing HBP 2.0 and will be rolled out as HBP 2.1 with effect from 1st January 2021. The details of package(s) / procedures(s) with the costing is provided as Annex – 1. List of procedures where rates are mentioned as zero in attached draft OM will be given as per day bed rates criteria.

Before the roll – out of HBP 2.1, feedback from SHAs is sought latest by 8th January 2021 for any state specific modifications in terms of package price, auto – approval or public reservation after which the roll – out shall be made as per the package configuration made by the medical cell of NHA.

Kindly coordinate & communicate the same to EHCPs.

Dated: 1.1.2021


(Dr. Ajai Agarwal)
Director, HN&QA

ANNEXURE – IV

S-12015/78/2020-NHA(HN&QA)

Government of India
National Health Authority

Office Memorandum

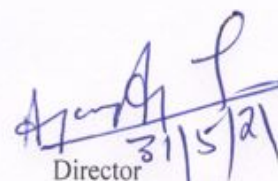
Reference: OM of even no. dated 12th April 2021 regarding release of 22nd set of 27 Standard Treatment Guidelines for PMJAY packages.

The 23rd set of 11 Oncology STGs is scheduled for release in the NHA IT platform within the Transaction Management System (TMS) on 4th June 2021. A list of these 11 STGs is enclosed. The STG documents, IT user manual and orientation presentation are available for reference at https://pmjay.gov.in/standard_treatment_guidelines. Any queries related to PMJAY STGs may be sent to stg.hnqa@nha.gov.in.

The States are requested to kindly inform their teams, SHAs, EHCPs, ISAs/ TPAs for a wider circulation of the STGs/ Guidance documents and its implementation.

Encl.: As above.

Dated: 31.05.2021



Director

डॉ. अजय अग्रवाल / Dr. AJAI AGARWAL
निदेशक / Director
आयुष्मान भारत-प्रधानमंत्री जन आरोग्य योजना
Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana
राष्ट्रीय स्वास्थ्य प्राधिकरण / National Health Authority
भारत सरकार / Government of India
नई दिल्ली / New Delhi

To

1. CEOs (All SHAs)
2. NHCPs

Copy

1. Addl. CEO, NHA
2. Dy. CEO, NHA
3. NHA (HN&QA, State co-ordination, NAFU, Operations, IT, Capacity building)

ANNEXURE –V

No. S-12015/16/2020-NHA(HNQA)
Government of India
National Health Authority

9th Floor, Tower-1, Jeevan Bharti Building
Connaught place, New Delhi

OFFICE MEMORANDUM

Subject: Relaxation in mandatory document protocol for public hospitals providing care under AB PM-JAY


OM Ref No. S-12015/16/2020-NHA (HNQA) dated 09.06.2020 was issued by NHA regarding relaxation of few mandatory documents for Public EHCPs as per Standard treatment guidelines.

2. National Health Authority while analysing STG dashboard and during discussion with SHAs has observed non – compliance in relaxation of mandatory document protocol for public hospitals by adjudicating agencies, this leads to inadvertent delays in submission of pre-authorization, claim submission and processing.
3. SHAs may kindly issue necessary instructions / guidelines to respective ICs / ISAs regarding relaxation in mandatory document protocol for public hospitals, which includes:

- I. Pre-authorization request
 - a. Admission / clinical notes
- II. Claim submission:
 - a. Operative / procedure notes
 - b. Post-operative investigations if any
 - c. Discharge Summary

An action taken report may kindly be shared with National Health authority by 30th June 2021.

Date: 14.06.2021


Director
Dr. AJAI AGARWAL
HP&CD
आयुष्मान भारत-प्रधान मंत्री जन आरोग्य योजना
Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana
राष्ट्रीय स्वास्थ्य प्राधिकरण/National Health Authority
भारत सरकार/Government of India
नई दिल्ली/New Delhi

ANNEXURE –VI

S-12015/122/2021/NHA(HPQA)
Government of India
Ministry of Health and Family Welfare
National Health Authority

3rd, 7th & 9th Floors, Jeevan Bharti Building, Tower 1
Connaught Place, New Delhi – 110001

OFFICE MEMORANDUM

Subject: Inclusion of 5% Incentive on Base Package Rates for AB PMJAY Bronze Certified empaneled hospitals

NHA has released AB PMJAY quality certification along with Quality Council of India in 2018. NHA has already issued guidelines on quality-based incentive of 10% for attaining NABH entry level accreditation and 15% incentive for attaining NABH full accreditation to empaneled healthCare providers (EHCPs).

The Governing Board of National Health Authority has now approved the grant of an incentive of 5% to be granted to EHCPs for attaining AB PM-JAY Bronze Quality Certification. This will ensure that non-accredited hospitals (NABH) empaneled under AB-PMJAY will get quality certification for better service provision to beneficiaries.

This is issued with the approval of Competent Authority.

All SHAs are to implement the same in their respective States/UTs.

Dated: 14/06/2021


डॉ. अजेय अग्रवाल / Dr. AJA AGARWAL
निदेशक / Director
आयुष्मान भारत प्रधानमंत्री जन आरोग्य योजना
Ayushman Bharat Pradhan Mantri Jan Arogya Yojana
संस्थान / National Health Authority
भारत सरकार / Government of India
नई दिल्ली / New Delhi

To,

1. CEO, SHA all States/ UTs

Copy to:

1. Principal Secretary (Health) of all State/UT
2. Secretary General, Quality Council of India

ANNEXURE –VII

2286347/2021/HNQA-NHA

No. S-12015/62/2020-NHA(HN&QA)

Government of India
National Health Authority

OFFICE MEMORANDUM

Subject: Revisions in the national health benefit package master.

As per approval of the Governing Board of National Health Authority, the rates of all medical management packages are being revised for an initial period of 06 months from 16th August 2021 to 16th February 2022 as per Annexure – 1.

In addition to medical management packages, rates for surgical packages currently available under National Health Benefit Package Master that may be utilized for management of mucormycosis have also been revised and are placed in Annexure – 2.

SHAs who have defined their COVID-19 treatment package rates with per day premium rate over and above existing bed charges may continue with existing rates, if the revised package rates are below the total amount with existing premium to ensure long term viability of packages and to take care of regional variations in pricing.

A package for medical management of post COVID-19 complications will be added under 'Infectious Diseases' specialty by the name of "Treatment of systemic fungal infections". This package will follow the same pricing structure as the revised medical management packages.

Inclusion of an 'Add-on' package for high end drugs for management of COVID-19 and its complications has also been approved by the Governing Board of National Health Authority. High end drugs may now be booked over and above the package as per the price notified by the concerned state governments from time to time.

SHAs will continue to be given flexibility in adoption of the proposed revisions for the SHAs where NHA shares the cost of treatment with the SHAs. The implementation of revised packages in such State/ UTs shall be done only after receiving concurrence from the concerned State / UT.

It may be noted that NHA's share in all the above cases will be capped as a percentage on the pro rata cost of Rs. 1,052/- per beneficiary family as per the arrangement with concerned State/ UT. Any expenditure over and above this shall have to be borne by concerned State/ UT.

Following this, all of the above revisions in the National Health Benefit Package Master will be rolled out across all SHAs. Any state-specific modifications required may be communicated by SHAs to NHA before 13th August 2021 positively.

This issues with the approval of the competent authority.

Dated: 09.08.2021


डॉ. अजेय अग्रवाल / Dr. AJAL AGRAWAL
निदेशक / Director
आयुष्मान भारत-प्रधानमंत्री जन आरोग्य योजना
Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana
संस्थान प्रमुख / National Health Authority
भारत सरकार / Government of India
नई दिल्ली / New Delhi
HP&QA

ANNEXURE –VIII

S-12015/133/2021/NHA(HPQA)
Government of India
National Health Authority

OFFICE MEMORANDUM

Subject: Implementation of modified national health benefit package master.

National Health Authority (NHA) has made three revisions to its national health benefit package master till date. The highlights of release of health benefit package masters is as below:

S. No.	HBP version	Release date	New packages/ procedures	Change in rates of existing packages/ procedures
1.	HBP 1.0	September 2018	1,393	0
2.	HBP 2.0	November 2019	671	450
3.	HBP 2.1	November 2020	76	0
4.	HBP 2.2	November 2021 (scheduled)	1	409

National Health Authority is constantly working on the feedback received from stakeholders for rationalization of health benefit package master. Over the past three years, new packages have been added to cover more disease conditions and changes have been made in the package rates (Annexure – 1). These changes are necessitated to ensure effective implementation of the scheme and will be made in Transaction Management System (TMS) to ensure that there are no challenges in portability.

State Health Agencies (SHAs) currently implementing any of the previous versions of HBP shall now have the option to accept and implement only the latest version of Health Benefit Packages (HBP 2.2). SHAs implementing the scheme in trust mode may adopt this change latest by 31st October 2021. NHA's IT system will migrate totally to revised HBPs on 31st October 2021. However, SHAs implementing the scheme in insurance mode may adopt the changes as soon as possible, and in any case before 30th November 2021. In case SHAs are unable to make changes due to the contract with insurance company, SHAs may make the payment to EHCPs by filling in for the positive or negative difference in payment. SHAs implementing in hybrid/ mixed mode may consider suitable mix of the two approaches mentioned above.

Handwritten signature
28/9

Date: 20.09.2021

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Director 28/9

डॉ. अजय अग्रवाल / Dr. Ajay Agrawal
निदेशक / Director
HP&QA
आयुष्मान भारत-प्रधानमंत्री जन आरोग्य योजना
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