5.5 Appendix 6: Operational Guidelines

5.5.1 SHAS-Guidelines for Preauthorization Approval & Claims Settlement

5.5.1.1 Identification, Registration and Admission

5.5.1.1.1 Ration card: At empanelled hospital level

1. All eligible beneficiary groups with valid Yellow or Orange ration cards or Antyodaya or Annapurna card coupled with any valid Photo ID (as finalized by Society) of beneficiary would act as a tool for beneficiary identification only.
2. In case of the possible exceptional situations, the actions would be undertaken by Network hospitals as mentioned in clause 1.4.3

5.5.1.1.2 Pre Authorisation

1. The process of Pre-Authorization commences post inpatient REGISTRATION of the beneficiary.
2. The Network Hospital based on the diagnosis shall admit the patients and send e-preauthorization to the Insurer of the MPJAY.
3. Only in cases, where the patient is admitted in the hospital the preauthorization be processed.
4. The decision on list of cross specialties to be permitted for particular procedure will be taken by Society.

5.5.1.1.3 Verification of Pre-Authorization Details

During the Pre Authorization Process, the following details will be verified & processed accordingly:

1. Beneficiary Details as per the valid ration card / UIN Card or any other as defined by Government of Maharashtra / State Health Assurance Society (SHAS)
2. Identity of beneficiary (ration card along with valid photo ID proof)
3. Proposed date of surgery
4. Diagnosis
5. Estimated Duration of stay

6. Clinical Notes/ Clinical history
7. All mandatory investigation reports & other relevant investigations if any --
8. Package selected by hospital along with clinical data form wherever applicable as per clinical protocols devised by the Society
9. Name & Qualification of treating doctor
10. At the time of preauthorization updation following documents are essential: (a) on bed Photograph (b) confirmation of date of procedure as approved at the time of initial preauthorization (c) Date of admission
11. For day care procedures like Dialysis, Haemophilia, Thalessemia, Growth Hormone treatment for Endocrinology, Chemotherapy, Radiotherapy, Prostheses etc as attached in Appendix 5.1(A). Indoor admission will not be mandatory for preauthorization. Patient will be admitted and discharged on same day.
12. The list of mandatory investigations for various procedures prepared by technical experts will be circulated and published on website. There will be turnaround Time (TAT) of 12 hours for sanction of preauthorization by TPA/Insurer.
13. The list of pre and post-operative procedures and mandatory investigations required for any procedure is enclosed in Appendix 5.1(A)**.** Based on expert advice received by Government/Society, Society reserves the right to modify this list of procedures and investigations in the interest of patient in consultation with insurer.
14. The list of mandatory investigation for various procedures prepared by technical experts of SHAS will be circulated & published on website of scheme. In case these mandatory investigations are not complied with or partially complied with, the preauthorization request will be closed in the system after 10 business days.

5.5.1.1.4 Process of Raising Queries to Hospital

1. If any of information in the above section is missing then query has to be raised to the hospital to enable further processing of the Pre-Authorization.Arogyamitra has to follow up for compliance.
2. In the meantime, while waiting for a query reply, if there is another Pre-Authorization request received for any other member of the family and approval given, then prior Pre-Authorization will be limited to the BSI (Balance Sum Insured).

5.5.1.1.5 Sum Insured

1. The Scheme shall provide coverage for meeting all expenses relating to hospitalization of beneficiary members for per family per year in any of the Empanelled Hospital/Nursing Home/Day Care Unit.
2. For beneficiairies covered under PMJAY, Risk cover of Rs. 5,00,000/- per annum per Family Unit would be provided (Out of this Rs. 1,50,000/- < extendable upto Rs.2,50,000/- in case of renal transplant > through insurance mode and balance Rs. 3,50,000/- would be borne through Trust mode).
3. For beneficiairies covered under MPJAY only, Risk Cover would be upto Rs.1,50,000/- per annum per Family Unit, extendable upto Rs.2,50,000/- in case of renal transplant would be provided under insurance.
4. The benefit shall be available to each and every member of the family on floater basis i.e. the total amount of INR 1,50,000/- (Rupees one lakh fifty thousands only) can be availed either by one individual, or collectively by all members of the family. The First Preauthorization request in, should be First Out. (FIFO)
5. Sum Insured includes the treatment of follow up packages.
6. For Renal Transplant Patient Sum Insured will be INR 2,50,000/- per year.
7. Response: The break up for renal Transplant:
    - Renal Transplant Surgery with AV fistula: INR 1,50,000/.
    - Immunosuppressive therapy at the rate of INR 50,000/- for first six months and INR 50,000/- for the next consecutive six months.

5.5.1.1.6 Non Utilization of Authorization Limits Amount

The validity of an Authorization is 30 days for All Empanelled private Network hospitals and 60 days for Govt and Municipal Hospitals from the date of preauthorization Sanction.

5.5.1.1.7 Partial Pre Auth Approvals

If Balance sum insured (BSI) is less than package amount then such Preauthorization should be approved up to available BSI only. If the next procedure is required with more than BSI amount, then the NWH has to take the Declaration Letter from beneficiary for balance payment before new pre-authorization raised.

5.5.1.1.8 Medical Scrutiny

1. Medical scrutiny will be done on the basis of Admission Notes/Diagnosis & Clinical Evidence/Clinical Protocols. After proper scrutiny of the available details, specialists will approve / Reject the Pre-Authorization with proper reasoning.
2. The quantum for a Pre-Authorization will be the Package rate or Balance Sum Insured (BSI) whichever is less.

5.5.1.1.9 Process of Emergency Preauthorisation Approvals

1. In case of emergencies, the medical / surgical preauthorization approval has to be taken by MCO over telephone – Emergency Telephonic Intimation (ETI) which has a voice recording facility.
2. Nonproduction of required nonclinical documents should not be the reason for raising ETI.
3. Provisional approval is given by collecting minimal essential data : Diagnosis, Mandatory investigation reports, reason for Emergency
4. Call conferencing between the treating Doctor/MCO, Preauthorization executive will be conducted.
5. An intimation number will get created.
6. Ensure commencement of treatment within 24 hours
7. MCO/Arogyamitra will follow up for the relevant documents to ensure eligibility in the next 3 Business days (This means excluding Public Holidays).
8. Preauthorization will be approved only if:
   I. Person is eligible beneficiary of MPJAY/PMJAY.
   II. Procedure is covered in MPJAY/PMJAY.
   III. Procedure is clinically justified.
   IV. Mandatory investigations are complied
9. Procedure selected is same as approval sought in ETI. Deviation from approved pre-authorization procedure needs to be informed by ETI within 6 hours
10. In case the patient fails to provide documents within 72 hours (3 business days), the Preuthorization will stand cancelled and patient will have to bear the expenses of the treatment and the Hospital has to take a suitable declaration from the Patient in this regard.

5.5.1.1.10 Video of the Procedures

1. Video clippings of the procedure/s with date and name of the patient (wherever prescribed by the Society) is required from all Network Hospital/s for
   i. Angiography procedures
   ii. Laparoscopic procedures
   iii. Endoscopic Procedures
2. In Government Hospital, endoscopic / Laparoscopic procedures if there is no provision of display of date and name of patient on video clip in machine, MCO should certify that video clip belongs to same patient.
3. If Government hospital is not having video camera attached to endoscope, photographs certified by treating specialist can be accepted.
4. For angiography / laparoscopic procedures if due to connectivity / uploading problems video clippings are not uploaded then network hospital will have the option of submitting the certified video CDs for the same case. Non submission / non-compliance of any of the above mentioned requirements will result in rejection of the Preauthorization.

5.5.1.1.11 Denial of Pre-Authorization Requests

Under following scenarios the approvals for Preauthorization requests will be denied:

1. Clinical findings not relevant to the package selected.
2. Supportive Documents not submitted
3. Name of the Patient and Date of Report not Printed on ECG, and other Investigation Reports. In case of Government Hospital, ECG machine not having this facility ECG reports certified by treating physician will be accepted.
4. If ABG report is not machine generated. If ABG machine has not got facility of printing name of patient then machine generated print out should be certified by treating doctor that the report belongs to same patient.
5. IPD number, Patient name and Date not lead imprinted on the X-Ray or digital X-Ray films not submitted.
6. Mandatory investigation reports not submitted.

5.5.1.1.12 Dialysis Cases

1. Mandatory required investigation reports which should be shared during preauthorization:
   i. Serum Creatinine: Pre-dialysis per preauthorization
   ii. CBC, S. Electrolyte: Desirable per preauthorization
2. The frequency of dialysis should be minimum 12 cycles per month or as advised by treating Nephrologists/s affiliated to the Dialysis unit. After one month new preauthorization should be raised.
3. Investigation which could be shared once in 3 months would be the viral markers
   i. HBsAg
   ii. HCV
   iii. HIV
   iv. Erythropoietin is to be administered every month as per advice of nephrologists.
   v. Each cycle should last for at least 4 hours
   vi. Cost of AV Fistula which is INR 10,000/- will be sanctioned besides cost of Dialysis.
4. Claims scrutiny should require
   i. "Photograph of MPJAY patient undergoing maintenance dialysis for each cycle with date displaying on each photo on bed withArogyamitra standing besides the patient", For Dialysis of Acute Renal failure patient photograph is not mandatory.
   ii. clinical notes/ Dialysis chart
   iii. Serum Creatinine

5.5.1.1.13 Medical Oncology

1. Palliative and supportive therapy should be given under advice of Oncologist.
2. Submission of Oncology Regimen is mandatory and any deviation from the regimen should be signed by the treating oncologist

5.5.1.1.13.1 Documents to be submitted at the time of Claim

Mandatory investigation reports to be submitted by hospital at the time of claim as per Appendix 5.1.4

5.5.1.1.14 Acute Myocardial Infarction (AMI)

Submission of ECG with printed Date and Name of the Patient, CPKMB, TROP-T (TROP-T kit to be provided)

5.5.1.1.15 Overall Package Treatment for All Procedures

1. The package covers the entire cost of treatment from admission till discharge & 10 days consultation/ medicines/ Investigations after discharge from the Hospital.
2. Same package or any other package arising out of any other complications of the previous illness cannot be taken within 10 days of discharge from the previous package.
3. Complete Package amount for the procedure applicable for that hospital will be auto carried at Preauthorization Level.
4. In Cases of insertion of implants, the Network hospital must submit its barcode sticker/s. This is mandatory. In cases, of non-submission of barcode claim will not be paid.
5. In case of packages where Ventilator care is mandatory, the on bed photo of patient on ventilator must be furnished.
6. Complication will be part of the same package.

5.5.2 Claims

5.5.2.1.1 Check list for claim scrutiny

1. Date of Admission
2. Diagnosis
3. Duration of stay
4. Clinical Notes / OT Notes / Discharge Summary
5. All mandatory & other relevant Investigation Report/s
6. Package selected by hospital & its approval
7. Name & Qualification of treating doctor
8. Compliance of mandatory requirements, including barcode sticker/s, on bed photo etc.

9. On bed photo not required for radiation oncology, Haematology procedures (Haemophilia, Thalessemia), Procedures for Endocrinology (Growth Hormone) and chemotherapy; but photo of patient accepting medicines will be mandatory.

5.5.2.1.2 Scrutiny of the Mandatory documents

Following are the mandatory document checklist & that has to be checked in each claim.

1. Document check List
   i. Mandatory Investigation reports as defined in checklist / clinical protocols
   ii. Preauthorization Request form
   iii. For angiography / endoscopic / laparoscopic procedures if due to connectivity / uploading problems video clippings are not uploaded then network hospital will have the option of submitting the certified video CDs for the same case.
   iv. Final case sheet of the patient submitted at the time of discharge
   v. Operative notes for surgical procedures
   vi. Post procedure photograph
   vii. Post-operative investigation report supporting the procedure done (wherever applicable)
   viii. Discharge Notes, Discharge photo and transport allowance evidence
   ix. Death Certificate in hospital death cases
   x. Patient satisfaction letter
2. A Declaration by NWH that documents uploaded is genuine and relevant to the claim lodged. The NWH must preserve hardcopies of these documents for physical inspection by MPJAY Team.
3. The Insurer or its representative may inspect the hardcopies of the documents uploaded from time to time.
4. The list of mandatory investigations for various procedures will be circulated to all NWH & also published on the MPJAY website

5.5.2.1.3 Evidences for pre- authorization and claim settlement

In order to streamline pre-authorization and claim settlement evidences, the following evidences are prescribed.

Sr. No.	Evidence	Requirement	Reason
1.	On bed photo	Mandatory	To ensure the patient is admitted
2.	Video recording of procedure	Mandatory in all endoscopic procedure/Angioplasty/ Laparoscopy procedures. If the hospital is not having video camera attached to endoscope, photographs certified by treating specialist can be accepted. For angioplasty / laparoscopic procedures if due to connectivity / uploading problems video clippings are not uploaded then network hospital will have the option of submitting the certified video CDs for the same case. For Government Hospitals sketch/diagram depicting the entire procedure/ abnormality may be allowed in exceptional cases.	To ensure procedure is performed as per the claim
3.	Intra-op photo 1) One photograph of the patient with face while on the operation table. 2) Photographs showing the	Mandatory Surgeries under CVTS surgery, Oncosurgery, Neuro-surgery are exempt from during the procedure photos at 2 & 3 However, Government hospital may be exempted from all photos	To ensure procedure is performed as per the claim.

	critical steps of the procedure. 3) One photograph of the suture line at the end of the procedure.	Procedures involving private parts are exempt from photos. 3.1 should be exempted from pediatric CVTS surgeries	
4.	Scar/ suture photo	Mandatory	To ensure procedure is performed.
5.	Discharge photo & Transport cost	Mandatory (photo with MCO/Duty doctor &ARM in front of Kiosk/Banner/Poster in the ward)	To ensure complete recovery of the patient
6.	Clinical photo	Mandatory	Part of intra-op photos
7.	Case sheet, Operative notes for surgical procedures	Mandatory	Required for proper evaluation & audit
8.	Investigations- Pre & post Therapy/Surgery	Mandatory	Required as they are vital for proof of standard diagnosis and treatment.
9.	Webex software for video uploading.	Mandatory (For Government Hospitals CD depicting the entire procedure may be allowed.)	Required in all cases of investigations and Endoscopy procedures.
10.	Death certificate issued by hospital in prescribed format. Death Certificate(final D.C from corporation or	Mandatory. No photo of dead body.	To confirm outcome

	D.C book copy of Hospital)		

5.5.3 Specific Guidelines

5.5.3.1 Blood

The Following guidelines to be followed for the treatment of beneficiary under the scheme while procuring and giving compatible blood under the package.

1. Procure and provide compatible blood even from outside recognized blood banks in case of blood transfusion per se is the treatment for disease under the package.
2. Cost of Blood Transfusion (Blood to be provided as per policy of State Government)
3. Provide compatible blood from own blood bank or outside blood bank for life saving and emergency cases from the own blood bank
4. Provide compatible blood subject to availability for supportive therapy cases from the own blood bank.

5.5.3.2 Medico Legal Cases (MLC)

The SHAS/Insurer reserves the right to call for MLC whenever they deem it necessary. Applicable for Poly-trauma, OP Poisoning or any other poisoning cases. To be uploaded at the time of claim or before discharge.

5.5.3.3 Multiple Packages

1. In the event of more than one surgery is being undertaken in single sitting of surgery or the total approved amount will be calculated based on the package amount: Ist Procedure: 100% + IInd Procedure: 50% of respective package+ IIIrd Procedure: 50% of respective package. The package with higher value will be reimbursed at rate of 100% and lower at 50%.
2. If procedure “Coronary Balloon Angioplasty” under Category Cardiology (code: M7F1.1) is selected as primary procedure and “PTCA Additional Stent” under Category Cardiology (Code: M7F1.2) as secondary procedure, then both should be given as 100% (Same shall be applicable for DJ stent procedure)

3. While going for additional stent the hospital should only select PTCA additional stent.
4. If patient is initially admitted for medical care and subsequently necessitates surgery. The Surgical Procedure will be paid at 100% & Medical at 50%
5. If patient is admitted with more than one medical conditions, I Procedure =100% + II Procedure=50%. **The package which costs more will be reimbursed at rate of 100% and lower at 50%.**

5.5.3.4 Instances of Multiple Packages and Response

1. Fracture of two adjacent long bones requiring Open Reduction Internal Fixation (ORIF) (RESPONSE: 100%+ 50%) For eg Radius-Ulna or Tibia Fibula only.
2. Fracture of two different long bones requiring Open Reduction Internal Fixation (ORIF) Response 100% +90%.
3. Fracture of long bone at two different sites (RESPONSE: 100% + 75%)
4. Fracture of long bone with abdominal injury (Rupture spleen/ liver/intestine etc.) (RESPONSE:100%+85% in single sittings with 2 different operating surgeons of relevant specialty)
5. Fracture of long bone with Chest injury (Haemothorax/ pneumothorax etc.) (RESPONSE:100% + 85% in single sitting with 2 different operating surgeons of relevant speciality)
6. Fracture of long bone with fractured skull or SDH, EDH (RESPONSE:100%+85% in single sittings with 2different operating surgeons of relevant speciality
7. Intestinal obstruction with resection anastomosis (RESPONSE: 100% + 50%)
8. Open Reduction Internal Fixation (ORIF) + Bone grafting (RESPONSE: 100%+ 50%) (Higher package should be given 100%)
9. The two combined procedures to be approved in following conditions.
    a. All long bone fractures with significant communition
    b. Non union of long bone fractures- after 6 weeks
    c. Reconstruction in spine surgery in cases of polytrauma only.
10. Note – If two procedures are done, in same admission, on two different dates then they shall be paid 100% + 100%.

11. Also, in all cases of Spinal fusion/implants, post op Xray plate with name of patient, for evidence of using implant is a must for claim to be paid.

5.5.4 Transfer Cases: (alerts /warnings)

In case patient is transferred from primary treating Hospital to another Hospital for further management; in cases of complications following would be the process of operational guidelines in the various scenarios given below:

5.5.4.1 Post-surgery for management of complications:

As per MoU with the hospital, package includes complications arising out of surgery. However in exceptional cases warranting shifting the patient from one hospital to another empanelled Hospital for better medical treatment, the Insurer will make the following payment on merit of each case (If procedures are covered under 1209 PMJAY and 996 MJPJAY procedures).

1. Referring hospital will be paid 75% of approved package cost
2. Referral hospital will be paid 100% if complication is part of the procedures or due to procedure performed subject to availability of balance sum insured

5.5.4.2 Transfer of Patient before the surgical procedure is performed

1. Referring hospital will be paid 0% of approved package cost
2. Referral hospital will be paid 100%, if the complication is part of the procedures or due to procedure performed

5.5.4.3 In case of Medical cases

1. Referring hospital will be paid @ INR 500/- per day in General Ward, @ INR 1000/-- per day for ICU without ventilator, for non-invasive ventilator Rs 2000 per day @ INR 4000 if on invasive ventilator.
2. Referral hospital will be paid 100% if the complication is part of the procedures or due to procedure performed.

5.5.5 Disallowance based on Length of Stay (LOS)

5.5.5.1 Surgical Cases

1. There is no indicated stay for surgical case. However hospitals are advised to keep patient admitted till 3rd post op day in case of laparoscopic surgery and 7th post-op day in case of open surgery.
2. However patient need to be kept in Hospital till he/she recovers and fit for discharge without any postoperative complications irrespective of LOS. A claim will not be decided based on the length of stay. No disallowances will be made on the basis of LOS.

5.5.5.1.1 Medical Cases

1. Hospital shall treat the patient till he / she is fit for discharge irrespective of length of stay.
2. They can discharge the patient early if they are recovered.
3. In order to facilitate timely discharge of patient who recovered before indicative stay, the following claim guidelines will be followed.
4. Indicative stays are given in the manual for each therapy.
5. Claim settlement (Medical Cases) will be based on per day cost where length of stay is not defined as mentioned below
    i. General ward: 500/- per day.
    ii. ICU without ventilator: INR1000/- per day.
    iii. ICU with Non-invasive ventilator INR 2000/-per day
    iv. ICU with invasive ventilator: INR4000/- per day.
    v. Burns conservative cases INR 2000/- per day not exceeding package cost
6. If length of stay is defined then the payments will be as follows:

Length of stay(LOS)	% of Package
Upto 25%	Per day calculation
>25% to 50%	50% of package
>50% to 75%	75% of package
Above 75%	100% of package

5.5.5.1.2 Claim Settlement in Death Cases

In case of Death of the patient before surgery the hospital will be approved for 10% of the package + INR 3500 for carriage of dead body from NWH to residence subject to proof of using Hearse/mode of carriage of deceased.

5.5.5.1.3 Death on Table (DoT) or during postoperative stay:

1. 75% of package to be approved, INR3500/- for carriage of dead body from NWH to residence subject to death certificate with receipt of Hearse van.
2. In case of death within 24 hours of surgery (1st post-op day), 75% of package amount will be paid. INR 3500 for carriage of dead body from NWH to residence subject to death certificate with receipt of Hearse van along with signature of next kin of patient provided cost should not exceed original package cost.
3. In case of death after 1st post-op day, 100% claim will be paid.

5.5.5.1.4 Death during conservative treatment procedures:

If death occurs in less than 24 hours, Hospital will be paid 15% of the package amount. For every subsequent day, the hospital will be paid @ INR 2000/- per day for ICU, @ Rs 2000 /-if on non-invasive ventilator, @ INR 4000/- if on invasive ventilator & @ INR 500/- per day in General Ward patient stay in days + lump sum INR 3500 /- for carriage of dead body subject to proof of using Hearse/mode of carriage of deceased.

5.5.5.1.5 Death in Burns Cases:

For Burn cases, as they are surgical cases indicative length of stay is not defined so while settling the claims per day cost of INR 2000/- should be sanctioned at the time of settling claims. Hearse Van cost for shifting the dead body i.e. INR 3500/- (Not exceeding package cost).

5.5.5.1.6 Left against Medical Advice (LAMA):

Before surgery: 0% of package

LAMA after surgery: 75% of package

5.5.5.1.7 LAMA for conservative:

If **LAMA** occurs in less than 24 hours, Hospital will be paid 10% of the package amount. For every subsequent day, the referring hospital will be paid @ INR 1000/- per day for ICU without ventilator @ INR 4000 if on invasive ventilator, Non invasive ventilator Rs 2000 & @ INR 500/- per day in General Ward. **The overall capping cannot exceed the 75 % of the package amount.**

5.5.5.2 Failed case: Disallowances on account of failed Procedure/ Incomplete treatment

5.5.5.2.1 Surgical Cases

The claims for failed surgeries/ procedures such as partial removal of the tumour, non-operable tumours found after laparotomy, incomplete clearance of renal stones after ESWL, inability to place the stent in Angioplasty will be cleared in the following manner.

5.5.5.2.1.1 General surgery and surgical oncology

Sr. No.	Failed Procedure	Claim to be paid
1	Incomplete removal of the tumour	50% of the claim
2	Inoperable tumour/only laparotomy done	Rs. 10,000/- or 25% of the package whichever is higher

5.5.5.2.1.2 CVTS Surgery /Cardiology

1. In case of failed Angioplasty, 50% of the package amount less cost of stent at the rate of Rs 20000/-
2. In case of failed Angioplasty with stent, 75% of package amount will be reimbursed.
3. In case of use of implants/devices like stents, valves, permanent pacemaker and IABP, stickers should be mandatorily affixed on procedure/surgery notes.
4. Stickers, with patient name on it, should be affixed on PTCA report/surgery notes only and not on any other document/report

Note – The same shall be applicable for Interventional Radiology (wherever stent is used)

5.5.5.2.2 Urology

1. In case of incomplete clearance of single stone in PCNL as ascertained by the residual stone of more than 6 mm in x-ray, INR 7000/- in the claim will be deducted.
2. A minimum of 80% reduction in size of stone shall be obtained to be eligible for the claim.

5.5.5.3 Special Note on various Specialties

5.5.5.3.1 Orthopedic Procedures

1. Surgical Correction of Long bone fracture (ORIF)

The package under ORIF is for coverage of surgical correction using Nails, Plates, and Screws etc., of standard make. However if any of the surgical correction is done using K-Wire or Screws, nails also in case of un-displaced fracture, the package amount shall be reduced to Rs. 5000 /-except in case of following conditions as all these procedures are technically demanding and require C-arm assistance.

i. Cannulated Cancellous Screws (CCS) for Intra Capsular Fracture neck of Femur
ii. Femoral Condylar Fracture
iii. Tibial Condylar Fracture
iv. Proximal Humerus Fracture
v. Distal Humerus Fracture
vi. Distal Radius Fracture
vii. Medial Malleolus Fracture correction with screw fixation/ Tension band wiring.
viii. Isolated Lateral Malleolus Fracture with subluxation/ dislocation of ankle
ix. Fracture Olecranon correction with Screw fixation/ Tension Band wiring In all the above cases the pre-authorization will be given for full package amount of Rs. 15000/- However, the claim will be settled based on the procedure done and the type of implant used.

2. The following procedures to be approved under ORIF with a package amount of Rs. /-

i. Girdle stone excision Arthoplasty
ii. Radial head excision

3. Combined procedures (Multiple Procedures)

i. Combined Internal and External fixation (Hybrid fixation) to be approved for
    a. Grossly comminuted long bone fractures.
    b. Minimum gap of 3 weeks shall be observed between both the procedures.

ii. Open reduction of dislocations with fractures: In all these cases the approval will be for two procedures of open reduction of dislocation along with associated fracture (100% + 75% of package cost respectively).

5.5.5.3.2 Radiation Packages –

With regards to radiation packages, the following points will be observed**.**

1. The treating doctor will calculate the dosage as per the standard norms. He will submit details of the total dosage and number of fractions to be administered in the treatment plan. This will be submitted along with pre-authorization

S.No	Category Name	Sub Category Name	Name of the procedure	Proposed Rate	Fractionwise Payment Disbursement for current Rate
1	Radiation Oncology	Specialized Radiation Therapy - 3dcrt(3-D Conformational Radiotherapy)	3DCRT complete Radical/adjuvant treatment on accelerator or telecobalt	75000	15% - planning phase, remaining amount divided by per fraction (upper limit- 30 fractions)
2	Radiation Oncology	Specialized Radiation Therapy - Imrt With Igrt	Image guided IMRT (IG-IMRT)complete treatment	150000	15% - planning phase, remaining amount divided by per fraction (upper limit- 40 fractions)
3	Radiation Oncology	Specialized Radiation Therapy - Imrt (Intensity Modulated Radiotherapy)	IMRT radical/adjuvvant complete treatment	100000	15% - planning phase, remaining amount divided by per fraction (upper limit- 40 fraction)
4	Radiation Oncology	Brachytherapy Interstitial	Interstitial LDR Per Application	15000	Full amount to be paid
5	Radiation Oncology	Brachytherapy Interstitial	Interstitial/surface mould HDR per application	25000	Full amount to be paid
6	Radiation Oncology	Brachytherapy Intracavity	Intracavitary LDR Per Application	4500	Full amount to be paid

7	Radiation Oncology	Brachytherapy Intracavity	Intracavitary/intraluminal HDR per application	15000	Full amount to be paid
8	Radiation Oncology	External Beam Radiotherapy (On Linear Acclerator)	Palliative /prophylactic Treatment on accelerator	25000	25% - planning phase, 1- 5 fractions - Rs 12500/-, > 5 fractions - Rs 18750/-
9	Radiation Oncology	Cobalt 60 External Beam Radiotherapy	Palliative Treatment/prophylactic on telecobalt	15000	25% - planning phase, 1- 5 fractions - Rs 7500/-, more than 5 fractions - Rs 11250/-
10	Radiation Oncology	External Beam Radiotherapy (On Linear Acclerator)	Radical /adjuvant Conventional Treatment With Photons on Accelerator	50000	15% - planning phase, remaining amount divided by per fraction (upper limit- 25 fractions
11	Radiation Oncology	Cobalt 60 External Beam Radiotherapy	Radical Treatment/Adjuvant Treatment on telecobalt	30000	15% -planning phase, remaining amount divided by per fraction (upper limit- 25 fractions)
12	Radiation Oncology	Specialized Radiation Therapy - Srs/Srt	Specialized radiation therapy-SRS(1-2 treatments)/SRT(Complete treatment)	150000	SRS- full amount should be paid; SRT- 15% - planning phase, remaining amount divided by per fraction (upper limit- 25 fractions)
13	Radiation Oncology	Specialized Radiation Therapy Rapid Ax Therapy	Volumetric IMRT(VMAT/Rapid Arc/or any other volumetric IMRT)complete treatment	150000	15% - planning phase, remaining amount divided by per fraction (upper limit- 40 fraction)
14	Radiation Oncology	Radiation Oncology	Craniospinal Irradiation (CSI) with posterior fossa boost for medulloblastoma/neuroblastoma /germ cell tumour	150000	15% - planning phase, remaining amount divided by per fraction (upper limit- 35 fraction)

5.5.5.3.3 Cardiology

1. Generally the stent is advocated for > 70% occlusion of vessel and those below that would preferably be given medical trial unless and until some other co-morbidity warrants use of stent. Only FDA (Government of Maharashtra) approved Stents are permitted

2. Selection of procedure in case of Triple Vessel Disease (TVD) (whether) CABG or Angioplasty). In relation to the Co-morbid conditions and age of patient the decision of performing Angioplasty should be taken by two Cardiologists. The opinion of second cardiologists may be taken by E-mail.
3. Additional objective assessment required in case of moderate stenosis (<70%) In cases of moderate stenosis (<70%) where the role of angioplasty is doubtful as perceived by the pre-authorization specialist, the hospital shall submit the following additional objective assessment of Ischemia.
    a. Treadmill Test (for all chronic stable angina patients only).
    b. In such cases opinion of second cardiologist may be taken.

5.5.5.3.4 Acute Myocardial Infarction (AMI)

Submission of ECG with printed Date and Name of the Patient – CPKMB, TROP-T (TROP-T kit to be provided). Treating physician may certify for government hospitals in case where facility to print date and name is not available.

5.5.5.3.5 Guidelines regarding angioplasties to be carried out at standalone Cathlab or cathlab with attached CVTS Facility

Community hospitals without surgical backup have begun performing diagnostic catheterization on higher-risk patients as well as elective interventional procedures. These hospitals should have a written and monitored program in place in a facility before invasive cardiovascular procedures are done at a facility without onsite cardiovascular surgical backup.These are detailed below:-

1. A working relationship should exist between the interventional cardiologist and the cardiothoracic surgeon at the receiving hospital.
2. Surgical backup must be available for urgent cases at all hours and for elective cases at mutually agreed times.
3. Before performing elective procedure, the cardiothoracic surgeon must be available
4. Hospital administration must endorse a written transfer agreement between the two hospitals
5. A transport provider must be available to transfer the patient within 20 minutes
6. The cardiologist must review the patient with the surgeon before transfer

7. The transferring patient should obtain an informal consent for surgery prior to transfer
8. The initial consent form (should be in the language which patient understands) should inform the patient that the procedure is being done without onsite surgical backup.

5.5.5.3.6 Procedures which may not be done without an onsite surgical Back-up

5.5.5.3.6.1 Diagnostic procedures

1. Age>75 years
2. Stress test indicating left main or triple vessel disease.
3. Severe LV dysfunction (LVEF< 30%, patient in Kilip Class 3/4 unless IABP available)
4. Patient at risk for vascular complication.

5.5.5.3.6.2 Therapeutic Procedures

1. Diagnostic/therapeutic pericardiocentesis if operator is competent
2. All congenital heart disease procedures in adult and congenital
3. All acquired valvular heart disease procedures

5.5.5.3.6.3 High Risk PCI

1. LVEF<30%
2. Greater then moderate lesion calcification
3. Extremely angulated, proximal vessel tortuosity and other vessel characteristics which would impede stent deployment.
4. Chronic total occlusion
5. Inability to protect side-branches
6. Chronic kidney disease (Se creatinine>2mg/dl
7. Decompensated congestive heart failure
8. Known clotting disorder
9. Recent CVA

5.5.5.3.7 Operators at PCI sites without surgical back-up

1. The PCI operator at the cardiac cathlab without surgical back-up should have performed at least 100 PCIs as primary operator for at least 2 years before starting work at a facility without onsite surgical back-up.
2. The PCI operator at a site with surgical back-up should have performed 75 cases per year/2 years as primary operator and of the hospital 100 for 2 years before being included in the MPJAY
3. Stand-alone cath labs should have provision of IABP/ covered stents for emergency situations.

5.5.5.3.8 Patient Preparation

1. Informed consent in the language a patient understands , should be signed by the patient
2. Routine lab data should include hemoglobin, platelet count, electrolytes, creatinine within 2-4 weeks of the procedure (repeat if change in clinical status/contrast exposure/change in medications).
3. Patient should be NPO not more than 6 hours pre- procedure

5.5.5.3.9 Operator volume

Minimum operator volume should be 50 per year and of the hospital 100 per year

5.5.5.3.10 Neurosurgery Procedures:

5.5.5.3.11 Laminectomy & Discectomy

1. Laminectomy shall be done only in cases of clear evidence of canal stenosis in MRI with neurological claudication.
2. Discectomy being a procedure done for either an acute or sub acute condition, clear cut clinical evidence should be submitted.
3. Hospitals shall prefer telephonic approval in case of acute indication.
4. All the cases of Laminectomy and Discectomy shall submit evidence of well informed counseling session through video recording. Video recording of pre-operative counseling of the patient with treating doctor, MCO and patients relative is mandatory for giving pre-authorization. The attachment shall be made in the

counseling documents slot in the online workflow at the time of sending the case for pre-authorization. The consent form shall be in local language (patient's mother tongue).

5. Implants shall be of titanium make and shall submit invoice with implant details during claim submission.
6. Second opinion may be obtained before pre-authorizations for above procedures being done for subjective reasons in cases of less than 25 years of age from any hospital.
7. Declaration by the treating doctor to be submitted in the form of a letter stating that other causes of low backache have been ruled out in cases of subjective symptom of pain being the reason for surgery.

5.5.5.3.12 Spinal Fusion Procedures

The Spinal fusion Procedure to be carried out wherever the evidence of spinal instability is established. The hospital shall submit evidence of spinal instability in the form of dynamic views of x-ray viz, Lateral view in flexion and extension and oblique view and/or 3D CT in cases of doubtful indications.

5.5.5.3.13 Day care procedures

Claims of thalassemia and hemolytic anemia may be sanctioned when patient gets discharged on same day as they are day care centers No bed photo for thalassemia, hemophilia, dialysis be asked.

5.5.5.3.14 ENT Surgery

Guidelines for Analogue Hearing Aid:
1) Hearing Aid Trial & Hearing Aid dispensing to be carried out by the RCI registered Audiologist at the empanelled network hospital.
2) At the time of claim settlement following documents to be submitted by the MPJAY registered hospital:

- Registration paper (letter) with recommendation of Hearing Aid Trial by ENT specialist
- Recent Pure Tone Audiometry (within 6 mths) signed by RCI registered Audiologist
- Hearing Aid bill (if available)