FICCI

Health Insurance Report-2010

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Compiled, Edited and Published By
FICCI's Health Insurance Group

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Health Insurance Report-2010

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Foreword

Chairman-IRDA

जे. हरि नारायण
अध्यक्ष
J. Hari Narayan
Chairman

बीमा विनियामक और विकास प्राधिकरण
INSURANCE REGULATORY AND DEVELOPMENT AUTHORITY

It is gratifying to note that FICCI is publishing a 'Knowledge Book' detailing the accomplishments of health insurance group during the year. The release of this book comes at a very opportune and appropriate time when the Healthcare industry of the country is set to take off.

Providing the people of India with adequate healthcare is an immense enterprise and central and state governments have been addressing this task for all these decades. Several models have been introduced in the past with varying degrees of success and some of the basic premises of the models introduced have been challenged by the market economy, which has been growing more rapidly since 1990. Healthcare expenditure annually is of the order of Rs 3,00,000 crores of which a little over Rs 2,00,000 crores is expended on OP treatment, domiciliary treatment, investigations, medicines etc, and a little less than Rs 1,00,000 crores is spent on hospital related procedures and treatment. The insurance industry makes a very modest contribution to this vast effort and almost entirely in the space related to institutional based healthcare.

Private expenditure is the principal source of meeting the entire cost. Significant measures have been taken up recently by the central and state governments to introduce insurance based schemes to expand the coverage, particularly to the weaker sections of the society. The RSBY programme of the Government of India, the Arogyashree of the State Government of Andhra Pradesh and similar programmes of the State Governments of Karnataka and Tamil Nadu are particularly noteworthy. However, the task has been begun.

It would be entirely correct to state that the task is so huge that it would require the efforts of everyone to establish a satisfactory healthcare system in India covering all sections of the population. It is in this endeavour that the current efforts of FICCI must be recognized. The members of FICCI represent the leaders in healthcare insurance and in the financial industries. They have amongst their midst eminent specialists in various fields of medicine besides experts in finance, management and communication. It is a pleasure and privilege for IRDA to be associated with such a body. Working together it is our common endeavour to enable the emergence of a strong and vibrant health sector in India which is humane in its approach, effective in meeting needs even in the remotest corners of the land and affordable.

The FICCI Health Insurance Conference which has now become an annual event provides all of us an opportunity to consider the distance still to be travelled.

Hyderabad
26.07.2010

(J HARI NARAYAN)
Chairman, IRDA

Acknowledgement

It gives us immense pleasure to bring out the **"FICCI's Health Insurance Report 2010 "** during the Health Insurance Conference on 30th July 2010 on the theme **"De-Bottlenecking the Health Insurance Growth"**

We sincerely appreciate and acknowledge the direction and content provided by **IRDA** in enabling us accomplish this task successfully.

We take this opportunity to convey our sincere appreciation to all the key stakeholders involved in the exercise - leading Insurance Companies, healthcare organizations, TPAs, Consultants, General Insurance Council and Life Insurance Council to make this initiative meaningful and useful for the industry.

Our special thanks to **World Bank, NABH, ICICI Lombard General Insurance Co, Apollo Munich Insurance Co and E-Meditek (TPA) Services** for providing technical assistance to the FICCI's Health Insurance Group in editing and formatting the content of the work.

Our special thanks to **Dr Narrotam Puri**, Advisor-Healthservices, FICCI & Advisor-Medical, Fortis Healthcare Ltd, and **Mr S L Mohan**, Secretary General, General Insurance Council, **Mr S B Mathur**, Secretary General, Life Insurance Council for providing able leadership and visionary direction to the group.

Organisers

Preface

Secretary General, FICCI

Massive urbanization in developing countries can have significant implications on accessibility and quality public health. India is currently facing this challenge. Proper health Infrastructure and appropriate models of health financing hence become need of the hour. Current statistics clearly point out the criticality of the situation. Hitherto, less than 15% of population is covered under some kind of health financing. Out-of-pocket payments therefore form a bulk of healthcare expenditure. Without insurance, the poor resort to borrowings at times at unsustainable rates or selling assets to meet the costs of hospital care.

Health Insurance if done in right manner to some extent can help ease the pain. The recent infrastructural and policy developments have given a positive push to the Health Insurance sector with tremendous business opportunities. However, to sustain the growth the emphasis has to be on consumer awareness & satisfaction, provision of quality health care, improved insurance services and greater collaboration and trust between the key stakeholders of the sector i.e. insurers and health care providers.

"FICCI envisions an ideal universe of health insurance business with satisfied customer at its core, greater penetration of health insurance products and affordable quality healthcare for masses". With this objective in mind, FICCI began its journey three years back in this space and has since been working on developing strategies and procedures that could help being about greater transparency in the system.

In 2009 FICCI Group comprising key representatives from Insurance and Health care Industry, TPAs, IRDA, developed and provided recommendations for 21 Standard Treatment guidelines (STGs) for common reasons for hospitalisation, Standard definitions of 11 Critical Illnesses and a Standardized list of excluded expenses in the hospitals indemnity policy. Aim of this work was to streamline the differences between stakeholders, minimize the ambiguity and reduce any friction on claim settlements. These are being reviewed by the regulator for suitable adoption by the industry.

Continuing its efforts in this area, this year the FICCI's Health Insurance Group focussed on identifying and developing possible framework for providing high quality healthcare through insurance and standardisation of certain processes to facilitate smooth and transparent claim processing. Three working groups were formed under the aegis of the FICCI's Health Insurance Group:

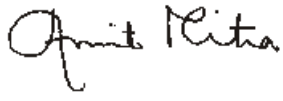
- **"Promoting Quality in Healthcare through Health Insurance"** - The group's objective is to develop possible framework for pay for Quality in India.
- **Standardization of Billing Procedures in Hospitals and contents of Discharge Summary Format**- Standardizing billing formats and enabling mapping of hospital information systems to specific data requirements of the Insurance companies for faster claim processing and enhanced analysis of data.

- **Standardization of TPA/Insurer and TPA/Hospital Contracts** - To develop a basic template for TPA/Insurer contract in order to ensure uniformity across the industry and avoid variation in the clauses of the agreement.

The terms of reference and members of each of the Working Groups were identified in consultation with Insurance Regulatory and Development Authority (IRDA). This document presents the work carried out so far by the respective Working Groups and includes the feedback received from leading Hospitals, Medical institutions, Insurance companies, TPAs, and other key stakeholders etc .

The aim of the conference is to share the findings, disseminate the work done by the FICCI's Health Insurance Group to a larger audience and seek their response.

In this endeavour, we have been supported by many Industry players who have worked tirelessly in putting framework together that has translated in the work being disseminated today. My heartiest thanks to all of them for dedicating their time and effort to this important cause.



Dr Amit Mitra
Secretary General
FICCI

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FICCI's Advisory Board on Health Insurance - Members

Dr Narottam Puri, Advisor-Healthservices, FICCI and Advisor-Medical, Fortis Healthcare Limited (Chairman-Advisory Board)	Mr S B Mathur, Secretary General, Life Insurance Council (Co-Chairman Advisory Board)
Mr S L Mohan, Secretary General, General Insurance Council (Co-Chairman-Advisory Board)	Mr Prabodh Chander, Executive Director, IRDA
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Dr Somil Nagpal, Health Specialist, The World Bank	Dr. Girdhar J Gyani, Secretary General, Quality Council of India
Dr Nandakumar Jairam, Chairman & Group, Medical Director, Columbia Asia Hospital	Dr B K Rana, Deputy Director, Quality Council of India
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Ms Shobha Mishra Ghosh, Director, FICCI	

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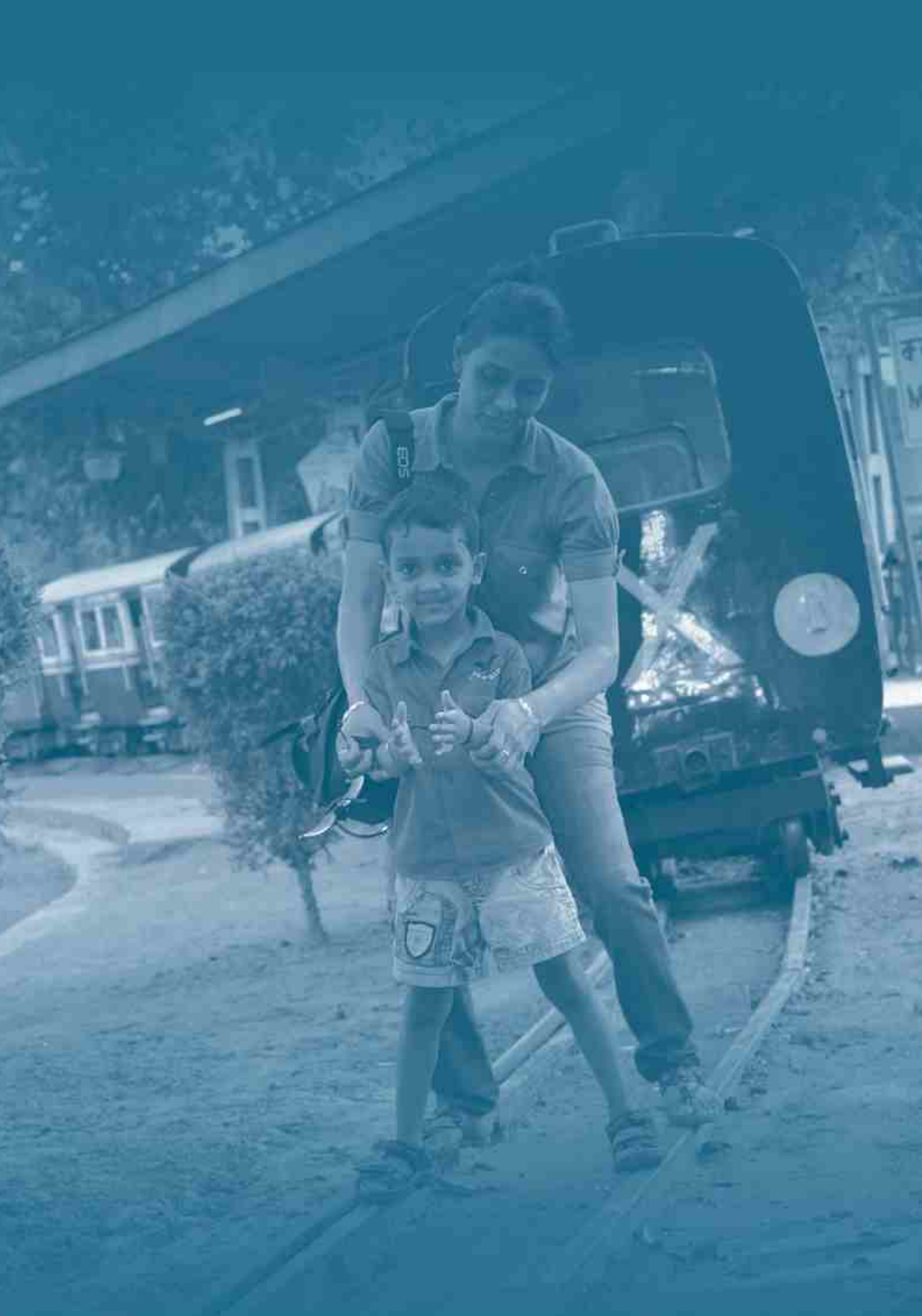
FICCI WORKING GROUP REPORTS



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Promoting Quality Healthcare Through Health Insurance

Chapter 1

Promoting Quality Healthcare Through Health Insurance

DEFINITIONS

Quality in healthcare is defined as the combined and unceasing efforts of everyone—healthcare professionals, patients and their families, researchers, payers, planners and educators—to make the changes that will lead to better patient outcomes (health), better system performance (care) and better professional development (learning).[1] Pay for performance (P4P) incentives are defined more broadly as the transfer of money or material goods conditional on taking a measurable action or achieving a predetermined target. Pay for performance is being vigorously studied and experimented in developed nations like US and UK, which have developed information and administrative systems as compared to developing nations like India. However, pay for quality is emerging as a policy tool that can be used in addressing quality concerns globally. The WHO calls for incentives that are sensitive to performance.[2] Quality-based payment has the potential to fit within a developing country's framework of strategies to ensure and promote quality of care. Pay for quality has already been experimented in Haiti, Costa Rica, Nicaragua, Brazil etc. In some cases, evaluation findings are available and have found the incentives to have a positive impact. Quality based payment has thus been implemented in a variety of approaches and breadth of contexts. Implementation has not been constrained to private sector purchasers, private sector providers, nor to any particular type of underlying payment system. Further, quality based pioneers are using a variety of incentive structures, and are tapping a rich mix of structural, process, and outcome standards to benchmark quality. With more experience and studies on P4P schemes it has become clear that flexibility and adjustment is important to a P4P scheme in order to adapt itself to a dynamic healthcare environment.

QUALITY FRAMEWORKS IN INDIA

The majority of the Indian population is unable to access high quality healthcare as a result of low awareness of Quality issues, non-reporting of Quality indicators, limited regulatory impact on provider quality and often high costs attributed to perceived higher quality. Many are now looking towards insurance companies for providing alternative financing options and somehow being able to influence provider quality, so that they too may seek better quality healthcare. Health insurance penetration is especially important to make equitable, affordable and quality healthcare accessible to the masses especially the poor and vulnerable sections of society. The recently launched schemes like Rashtriya Swasthya Bima Yojana and Aaryogyasri have proved that there is a viable way of reaching out to the large mass living below poverty line by creating products and instituting public private partnerships in various forms. However, the aspect of Quality still remains nebulous, whether in mass schemes like the above, or even in the voluntary private health insurance context.

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[1] *Batalden et. al. 2007, What is 'quality improvement' and how can it transform healthcare ?*
[2] *McNamara , Quality Based Payment : Six Case Examples*

Multifarious agencies already exist with their varying standards and mechanisms for ensuring quality in India:

- NABH has its parameters for accrediting healthcare providers
- The insurance industry has worked on its own empanelment and quality monitoring criteria which varies across the industry.
- Government schemes like RSBY are working on their own set of quality criteria
- Healthcare providers too have adopted quality systems such as ISO standards for non clinical activities and also certain internal protocols and guidelines which vary from provider to provider
- IRDA seeks to promote quality of health services to policy holders.

Such fragmentation in quality framework creates a confusing picture for providers especially when different payers / agencies demand varying standards of quality. This induces providers to ignore the incentives offered by fragmented payers and does not lead them on the road to Quality. It would be critical to avoid multiple quality accreditation and empanelment criteria being used by different agencies. In order to enhance quality of healthcare in India it was suggested that efforts of IRDA, NABH, RSBY, insurance industry, healthcare providers and other key stakeholders be harmonized to achieve uniform national accreditation standards which can be applied to all contexts and all providers.

A multi-stakeholder group has been created by FICCI, supported by IRDA, with representatives from World Bank, NABH, RSBY, insurance companies and healthcare providers to develop a pay for quality framework through consultation and consensus.

OBJECTIVES OF THE GROUP

i. Explore the role of Health Insurance in promoting quality healthcare and recommend the way forward to achieving the same

ii. Enhance quality in healthcare through synergistic efforts of IRDA, NABH, insurance industry, healthcare, providers and FICCI quality group

METHODOLOGY

i. Analyzing the existing structure of the accreditation system in India through NABH.

ii. Reviewing the existing literature and holding consultation workshops on the subject of pay for quality to understand international models for quality in healthcare.

iii. Identifying hospitals that are empanelled with the health insurance system as the target hospitals for implementing the quality framework.

iv. Identifying a common set of minimum quality parameters based on NABH accreditation, Clinical Establishment Act, various state acts, RSBY listing and IPHS requirements for 30 and 100 bedded hospitals.

v. Analyzing and discussing these criteria in detail. Subsequent reviewing of the list by the broader advisory group and incorporating their comments.

vi. In the days to come, this set of indicators will be tested through a pilot study, keeping in mind concerns of adequate acces, geographic variability and ease of facilitation and implementation. This will involve sharing the list of suggested minimum criteria & quality indicators to almost 200 hospitals in remote, rural areas that have recently been empanelled.

vii. Finalizing the minimum quality criteria for empanelment based on a better understanding of the status of hospitals today and what can be a feasible level of Quality within a defined timeframe which they can be expected to move towards. This level will be staged in a manner that it rises to higher expectations periodically, which are made known in advance.

viii. Staging, producing support documents to promote ease of facilitation through consultation and consensus with the group.

ix. In the next phase of this group's working, the group will investigate possible incentives and mechanisms that insurers are willing to provide for higher performers on Quality parameters and considering sources of funding for the same.

DRAFT DOCUMENTS FOR DISSEMINATION PRESENTLY

i. List of Quality Indicators for periodical reporting *(Annexure I)*

ii. Essential criteria for empanelment with definitions thereof *(Annexure II)*

Dissemination of the above documents is with the intent to seek feedback from a larger audience which will also guide future activities of the group.

WORK IN PROGRESS

i. The essential criteria for empanelment will be refined in the coming weeks based on the results of the pilot study.

ii. A multi-stage Quality improvement process, with accreditation being a major milestone, is the plan to cater to all hospital segments and also allow for convergence towards a single Quality system for all the organizations involved in health quality, including organizations involved in health insurance and accreditation of hospitals such as RSBY, IRDA, NABH and healthcare industry representatives.

iii. A certain set of parameters and quality indicators will be identified for each level of the process.

iv. A system of creating incentives for hospitals to move forward towards higher stages of accreditation/Quality will be developed and suggested by the group.

v. For instance, Hospitals will be incentivized to meet the essential criteria for quality by being included in the insurance system, and those already meeting these criteria will be incentivized

through different mechanisms if they move forward with incremental improvement in their Quality parameters including those on infrastructure and processes.

vi. To ensure that this does not adversely impact access, in areas with little or no access to healthcare, the healthcare providers who face significant challenges in achieving minimum criteria may be provided some additional grace time to reach the minimum criteria level.

vii. Another possibility suggested was that of providing a grant/incentive to motivate hospitals in higher stages of Quality, far beyond the minimum empanelment criteria, which can, with some investment, even achieve accreditation level. For example, a financial PPP between government and healthcare organizations, with support from multilateral organizations like the World Bank, private insurers and TPAs, could be in the form of a 'Challenge Fund' to encourage middle level hospitals, and the same is being worked upon in the group. However, the incentive/ lump sum amount will only partially offset the investment in quality and hospitals too need to understand the advantages and be motivated themselves, as also invest resources in their own quality because some financial burden on the hospital will still remain.

viii. In addition to the quality requirements, the group would attempt to understand the logistics of implementing and monitoring this quality framework. The group would consider mechanisms for facilitation and monitoring the Quality system, including self-reporting, using TPA/Insurer systems and those of NABH.

ix. In addition, in order to allow easier self reporting, a do-it-yourself guide, detailed methodology and definitions would be provided to allow providers to accurately measure and report the data themselves.

EXPECTED OUTCOMES

i. Achieve a common approach for promoting and measuring of quality healthcare services in the country

- Suggest a uniform approach and parameters for Quality across the healthcare industry
- Suggest a transparent staging process to inform providers upfront on Quality expectations over the years to come

ii. Develop an incentive and disincentive mechanism which could be used by the insurance industry to promote quality in health services.

- Bring in all categories of healthcare providers i.e. small, medium and large into a uniform quality process encompassing and leading towards accreditation and beyond.
- Recommend the implementation of the essential criteria in a staged manner allowing sufficient time for providers to build their Quality systems and processes, with upfront knowledge of expectations and stages.

(Annexure I)

Quality Indicators

1. **Medication Errors**
2. **Transfusion Reaction**
3. **Catheter Related Urinary Tract Infections**
4. **Readmission**
5. **Re Exploration Rates**
6. **Patient Falls**
7. **Pressure Ulcers**
8. **Average Length of Stay**
9. **Needle Stick Injury**
10. **Net Death Rate**
11. **Neonatal Mortality Rate**
12. **Maternal Mortality Rate**

MEDICATION ERRORS

Definition

Number of medication errors occurring in a health care setting against the number of discharges and deaths during that time.

Rationale

Medication errors refer to errors in processes of dispensing, administering, or monitoring medications.

Medication errors are known to be common but preventable events that occur in both inpatient and outpatient settings. Studies have already found that half of medication errors occur at the stage of drug ordering (Bates, 1995; Kaushal, 2001) although direct observation studies indicate that many errors also occur at the administration stage (Allan and Barker, accessed September 2003).

Operational issues

Incident reporting and consequent analysis are not protected from legal action and discovery, possibly resulting in underreporting to avoid litigation.

Numerator

Total number of medication errors.

Denominator

Total number of bed days.

Inclusions

1. Dispensing errors
2. Administration

- Wrong patient
- Wrong Medicine
- Wrong Time
- Wrong Route
- Wrong dose
- Wrong speed

How to measure

$$\frac{\text{Total Number of medication errors in a month X 100}}{\text{Total number of discharges and deaths in that month}}$$

The feedback received until July 22, 2010 has been incorporated in the document. Those received post July 22 will be taken into account before submission of the final report to Regulator, Councils and concerned authorities.

TRANSFUSION REACTION

Definition

Number of transfusion reactions happening in a hospital in a given month.

Rationale

Significance: The administrations of blood to the wrong person may have serious effects. The risk of adverse outcome from erroneous transfusion rivals or exceeds current estimates of the risk of acquiring infectious disease by transfusion

Operational issues

It sometimes really becomes difficult to prove that it was a real transfusion reaction.

Numerator

Total number of proven transfusion reactions in a month.

Denominator

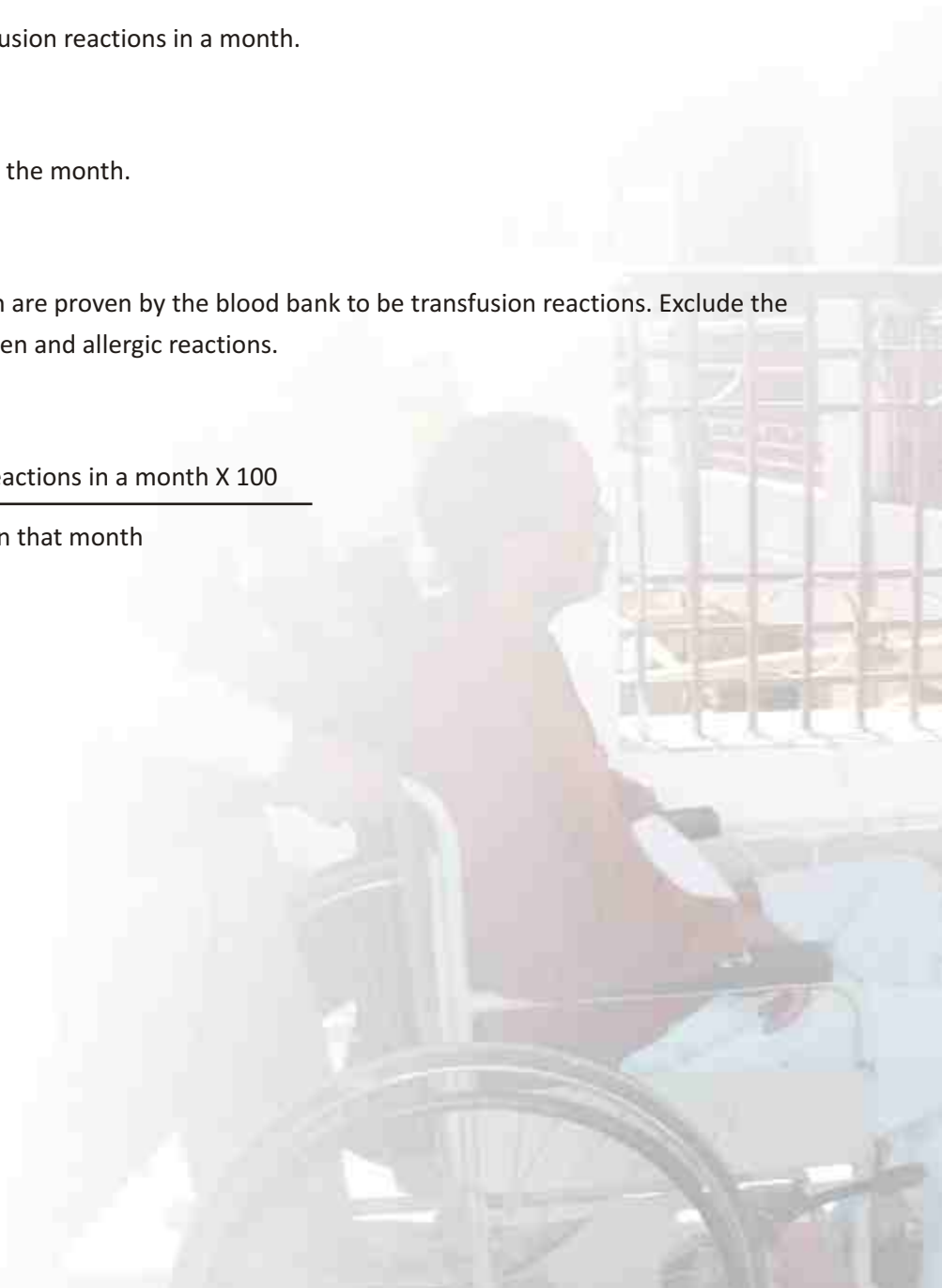
Total number of transfusion in the month.

Inclusions

All transfusion reactions which are proven by the blood bank to be transfusion reactions. Exclude the rigors and chills due to pathogen and allergic reactions.

How to measure

$$\frac{\text{Total number of transfusion reactions in a month X 100}}{\text{Total number of transfusions in that month}}$$



CATHETER RELATED URINARY TRACT INFECTION

Definition

The incidence of Foleys catheter related urinary tract infections per one thousand catheter days.

Rationale

Catheter insertion poses a risk for introduction of infection to urinary tract. The infection rates are acceptable up to a certain limit and if the rates are high then it points towards that the inappropriate method of insertion and maintaining the catheter.

Operational issues

The identification of a UTI in catherized patient sometimes becomes difficult.

Numerator

Total number of proven urinary tract infection in a person who has been catheterized for more than 48 hrs in the hospital. Also it has to be ruled out that the patient did not come with a UTI to the hospital.

Denominator

Patient catheter days.

Inclusions:

All patients who were admitted to the hospital without any UTI were catheterized in the hospital and developed the UTI after 48 hrs of admission. The diagnosis of UTI is made according to the Annexure 3

How to measure

$$\frac{\text{Numbers of UTI in patients on Foleys Catheter (See inclusions) X 1000}}{\text{Total patient catheter days}}$$

The number of catheter days is calculated by noting the number of patients on Foleys catheter on day to day basis and added at the end of the month.

Example

On day one 3 patient were on catheter, Day two one patient on day three six patients and so on for the whole month then add 3+2+6 and so on .By the end of the month you will have the total patient catheter days

Get the total number of Catheter related UTI as per the criteria

Use the formula mentioned above to calculate the CAUTI

READMISSION RATE

Definition

The patients who were readmitted within 30 days of discharge and were readmitted with the same problem or related to the disease they were first admitted in.

Rationale

Readmission either points towards some complication happened related to the procedure/surgery or the patient was not properly evaluated to be declared fit for discharge.

Operational issues

Identification and tracking of the readmissions.

Numerator

Total number of patients who were readmitted to the hospital with the same disease or due to some problem related to the disease/procedure the patient was first admitted with in 30 days of discharge. The number should be calculated for the month.

Denominator

Total number of discharges in that month.

Inclusions

Total number of patients who were readmitted to the hospital with the same disease or due to some problem related to the disease/procedure the patient was first admitted within 30 days of discharge. The number should be calculated for the month.

How to measure

Total number of patients who were readmitted to the hospital with the same disease or due to some problem related to the disease/ procedure the patient was first admitted within 30 days of discharge. The number should be calculated for the month X 100

Total Discharges in the given month

RE EXPLORATION RATE

Definition

The patients who were taken back for surgery in the same admission in an unplanned manner.

Rationale

Unplanned re exploration means that some unexpected complication related to the surgical procedure has been done during the surgery.

Operational Issues

It is a trigger indicator and needs further evaluation before reaching any conclusion

Numerator:

Total number of patients who were taken up for the surgery again in the same admission in an unplanned manner

Denominator

Total number of surgeries / performed in the OT.

Inclusions

Total number of patients who were taken up for the surgery again in the same admission in an unplanned manner. Exclude those patients who were taken to the OT again, but the re surgery was a planned one and documented.

How to measure

$$\frac{\text{Total number of patients who were taken up for the surgery again in the same admission in an unplanned manner X 100}}{\text{Total number of surgeries / procedures}}$$

PATIENT FALLS

Definition

The number of the patients who had a fall from the bed while being admitted they were admitted in the hospital.

Rationale

Patient fall is a serious matter and can result in an sentinel event. The fall is a good indicator of the level of care in a hospital.

Operational issues

Nil

Numerator

Total number of patient' falls who are admitted in a hospital in a given month.

Denominator

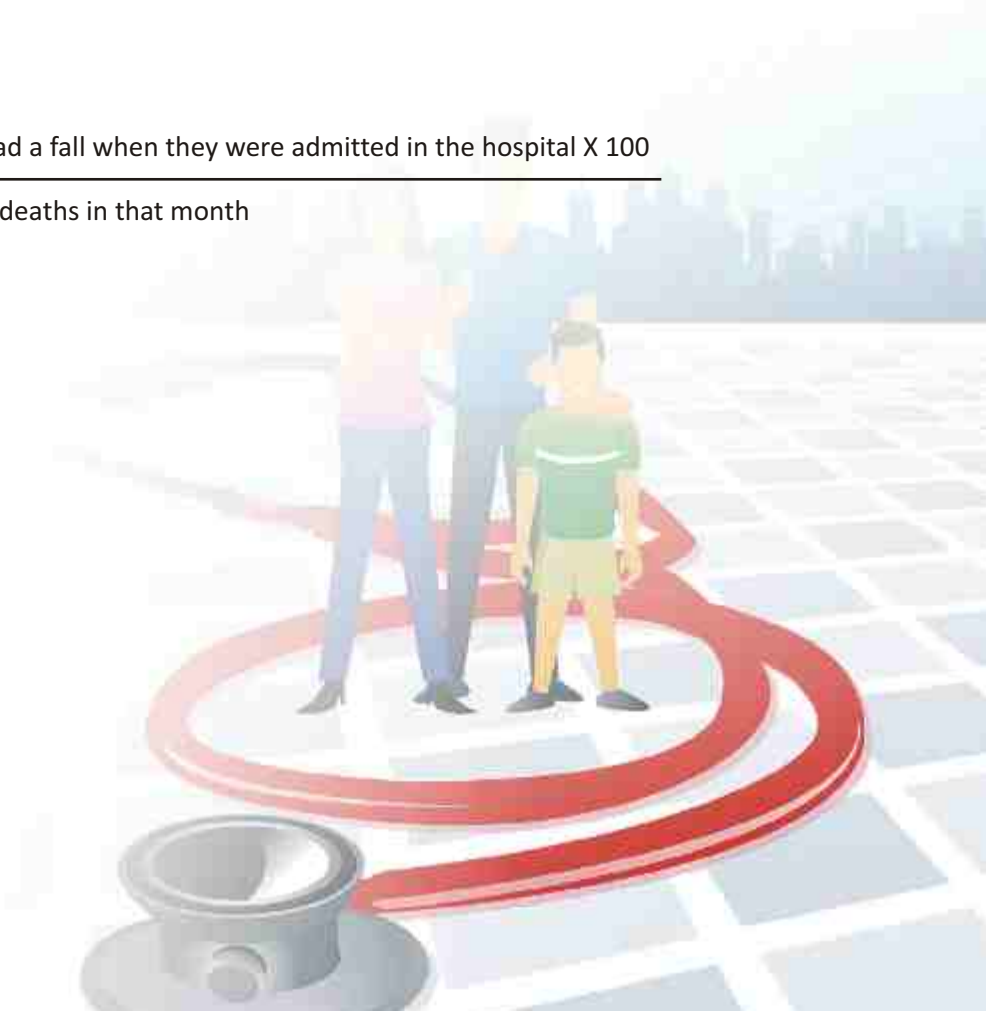
Total number of discharges and death in that month.

Inclusions

Total number of patient' falls who are admitted in a hospital in a given month be it in a ward ICU or step down units.

How to measure

$$\frac{\text{Total number of patients who had a fall when they were admitted in the hospital X 100}}{\text{Total number of discharges and deaths in that month}}$$



PRESSURE ULCERS

Definition

The number of the patients who developed a pressure ulcer after 48 hrs of admission to the hospital.

Rationale

Pressure ulcer development is an direct indicator of the level of care of nursing. A patient should never develop a pressure ulcer once he/she is admitted to the hospital

Operational issues

Sometimes it becomes difficult in chronic patients to differentiate weather the patient developed the pressure ulcer or he came with the one which had started at home/other care setting. Also it is sometimes difficult for nursing to identify the pressure ulcer in the initial stages.

Numerator

Total number of patients who developed pressure ulcers after being admitted in the hospital for 48 hrs in a given month.

Denominator

Total number of discharges and death in that month.

Inclusions

Total number of patients who developed pressure ulcers after being admitted in the hospital for 48 hrs in a given month. Do not include the patients who came with the frank pressure ulcer.

How to measure

$$\frac{\text{Total number of pressure ulcers after 48 hrs of admission in the month X 100}}{\text{Total number of discharges and deaths in that month}}$$

AVERAGE LENGTH OF STAY

Definition

The average number of days a patients stayed in the hospital for the particular month.

Rationale

The length of stay of a patient in a hospital indicates the appropriateness of care. It tries to see whether there was overuse or underuse of the facilities as against the optimal care.

Operational issues

Nil

Numerator

Number of inpatient days in the particular month.

Denominator

Total number of discharges and death in that month.

Inclusions

Number of inpatient days is the sum of daily inpatient census which is calculated at midnight. Do not include rehabilitation beds, emergency beds, Neonatal costs, dialysis and other transitional beds.

How to measure

$$\frac{\text{Number of inpatient days in the particular month X 100}}{\text{Total number of discharges and death in that month.}}$$

NEEDLE STICK INJURY

Definition

Number of needle stick injuries happening in the hospital area in the given month.

Rationale

Needle stick injury measurement points towards the risk of blood borne infections the healthcare worker is exposed to. The measurement points towards the inadequacy either in t he structure (Like availability of sharp disposal containers) or the process which includes the training of the workers on the preventive aspect.

Operational issues

Under reporting

Numerator

Numbers of needle stick injuries happening in the month.

Denominator

Number of inpatient days in the particular month.

Inclusions

Include all the needle stick injuries happening not only in the wards and other areas but also in the campus areas also.

Number of inpatient days is the sum of daily inpatient census which is calculated at midnight. Do not include rehabilitation beds, emergency beds, Neonatal cots, dialysis and other transitional beds.

How to measure

$$\frac{\text{Numbers of needle stick injuries happening in the month X 100}}{\text{Number of inpatient days in the particular month.}}$$

NET DEATH RATE

Definition

Number of deaths happening in a hospital after 48 hrs of admission in a given month.

Rationale

Death is a sentinel event and should be measured in every hospital. Net death rate is a better indicator of care rather than the gross death rate as it excludes all the cases which possibly could not be saved due to their critical condition when they were admitted.

Operational issues

Nil

Numerator

Total number of inpatient deaths minus deaths < 48 hours in a given month

Denominator

Total number of discharges (including deaths) minus deaths < 48 hours from the same period

Inclusions

Inpatient deaths to include the newborn deaths also. Brought in dead should not be included.

How to measure

$$\frac{\text{Total number of inpatient deaths minus deaths < 48 hours in a given month X 100}}{\text{Total number of discharges (including deaths) minus deaths < 48 hours from the same period}}$$

MATERNAL MORTALITY RATE

Definition

The number of maternal deaths in the hospital for the given period of time.

Rationale

Maternal death in a hospital delivery is a sign of deficient facilities or the training of those providing care.

Operational issues

Nil

Numerator

Number of direct maternal deaths for a period

Denominator

Number of obstetrical discharges for the period

Inclusions

Denominator also includes all the obstetrical deaths also.

How to measure

$$\frac{\text{Number of direct maternal deaths for a period} \times 100}{\text{Number of obstetrical discharges (including deaths) for the period}}$$

NEONATAL MORTALITY RATE

Definition

The death of a live born infant within the period of 27 days, 23 hours, and 59 minutes from the moment of birth per 1000 live births.

Rationale

The death of a live born child within 27 days 23 hrs and 59 minutes is related to a condition related to the delivery related problems in most of the cases hence an indicator for the care given.

Operational issues

Time frame should be measured correctly. How to deal with cases who have been delivered in one facility and died in other facility?

Numerator

The death of a live born infant within the period of 27 days, 23 hours, and 59 minutes from the moment of birth in a given month

Denominator

Total number of live births in the given month.

Inclusions

The death of a live born infant within the period of 27 days, 23 hours, and 59 minutes from the moment of birth in a given month. Still born cases not to be included

How to measure

$$\frac{\text{The death of a live born infant within the period of 27 days, 23 hours, and 59 minutes from the moment of birth in a given month X 1000}}{\text{Total number of live births in the given month.}}$$

(Annexure II)

Suggested Essential Criteria for Provider Enrollment

(i)	Is in compliance with all provisions and requirements of the 'clinical establishment act' and is registered with appropriate authorities duly appointed for the purpose (if the same is required)
(ii)	Is not, except incidentally, a clinic, rest home, or convalescent home for the addicted, detoxification centre, sanatorium, home for the aged, mental asylum, remodelling clinic or similar institution
(iii)	Is under the constant supervision of a Medical Practitioner Registered with the state medical council or IMC
(iv)	Has fully qualified nursing staff (that hold a certificate issued by a recognised nursing council) under its employment in constant attendance
(v)	Maintains daily records of each of its patients (admission register and in-patient medical records) and for Pharmacies & implants
(vi)	Has at least 10 Inpatient/Day care beds, and ICU (where applicable)
(vii)	Has a fully equipped operation theatre which is compliant to standard quality norms (where surgeries are conducted)
(viii)	Has atleast one fully equipped 'crash cart'
(ix)	Maintains adequate quantity of life saving drugs at all times
(x)	Has available in-house facility at all the times to conduct basic diagnostics, including but not limited to ECG, Haemoglobin, Sugar (Fasting and Random)
(xi)	Has Assured supply of blood and blood products at time of need
(xii)	Has power back up facility (Inverter/Generator/Solar power) for maintaining all essential services uninterrupted including operation theatre in event of power failure
(xiii)	Has uninterrupted potable water supply
(xiv)	Has functional autoclaving for sterilization
(xv)	Must be in compliance with relevant laws (e.g drugs and cosmetics act, pollution control act of the state etc)
(xvi)	Has agreed to publish regular reports on defined quality parameters in prescribed format and would make all possible attempts to implement the 'standard treatment guidelines' provided.

The feedback received until July 22, 2010 has been incorporated in the document. Those received post July 22 will be taken into account before submission of the final report to Regulator, Councils and concerned authorities.

List of Members - Working Group 1 on " Promoting Quality Healthcare Through Health Insurance"

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FICCI

Suggested Standard Format For Provider Bills

Chapter 2

Suggested Standard Format for Provider Bills

1. BACKGROUND

There is a huge variation in the billing formats and understanding of various items in a provider bill. Each provider provides a format specific to their organization which often has insufficient or redundant information. In many cases the same information may have been interpreted differently by the hospital and provider. This creates inefficiencies in the claim processing resulting in higher costs of healthcare and lower quality for the patients. Standardisation of Billing Procedures in the hospitals promotes transparency and removes the friction between the insured, providers and payers.

FICCI constituted a committee with the purpose of looking at “standardizing the billing procedures in various hospitals" to avoid any ambiguity between the health insurance stakeholders. The Objective of the working group was to look at how billing items and formats could be standardized with integration into the standard suggested claim form. The group would also look at how hospitals can map their existing information system to a particular requirement of the Insurance companies. This exercise was aimed at standardization of formats rather than fixing tariffs and rates.

The ultimate objective of this exercise is to facilitate electronic transmission of provider bills to the payers for processing and payment. The standardized format would be shared with providers for implementation and could be included as part of the standard contract between insurers/TPA's and the providers.

The committee had representatives from all stakeholders including insurers, TPA's, providers and consultancy companies and was headed by Shri. S L Mohan, Secretary General, General Insurance Council.

2. OBJECTIVE

- Standardizing billing formats and enabling mapping of hospital information systems to specific data requirements of the Insurance companies for faster claim processing and enhanced analysis of data

3. COMPONENTS OF STANDARDIZATION

Standardization involves three aspects:

- Bill Format
- Codes for billing items and nomenclature
- Standard guidelines for preparing the bills so that the interpretations of the headings in the bill are uniform.

4. METHODOLOGY

4.1 Collecting various bill formats from multiple hospitals of different sizes and also take into cognizance the existing bill processing systems of the TPA's and Insurance companies as also the HIS of hospitals.

4.2 Defining and listing the above into main components and various sub-components of the bill. Some of these were extracted from Standardized Claims Form which was developed by IRDA last year.

4.3 Discussing each component of the bill in detail with the multi-stakeholder group ensuring that the data in the format is not reported in any other document and is sufficient for claim processing without being too difficult for the hospital to report.

4.4 Testing the evolved Bill Format from both IT and hospital perspective to check its adaptability electronically. Any feedback would be incorporated.

4.5 Providing guidance notes in the format for the reference of Doctor's and patients detailing and defining the components.

4.6 Disseminating this format to the larger audience for review and feedback. Finalizing the format based on the feedback received.

5. FORMAT SUGGESTED

The bill is expected to be in two formats.

- The summary bill and
- The detailed breakup of the bills.

Explanation of headings – Summary Bill

The suggested summary format is annexed in the report (Annexure I)

The Bill is expected to be generated on the letter head of the provider and in A4 size to aid scanning.

Field Name	Remarks
Provider Name	Legal entity name and not the trade name
Provider Registration Number	Registration number of the provider with local authorities. once the clinical establishments (registration and regulation) bill, 2007 is passed, then registration number under this act
Address	Address of the Facility where member is admitted. A provider can have more than one facility.
IP No.	Unique number identifying the particular hospitalization of the member
Patient Name	Full name of the patient
Payer Name	Name of the Insurance company with whom the member is insured. In case of cash patient then the field is to be left blank. If the bill is raised to more than one insurer then the primary insurer who has given cashless is to be mentioned. The name of insurance company needs to be mentioned and not the TPA.
Member address	Full address of the member
Bill Number	Bill number of the provider
Bill Date	Date on which the bill is generated.
PAN Number	PAN Number - Mandatory
Service Tax Regn. No.	Registration number from service tax authorities. Mandatory in case service tax is charged in the bill
Date of admission	Date of admission of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure
Date of discharge	Date of discharge of the member in case of IPD cases. In case of Day care procedures, this is the date of procedure(same as date of admission)
Bed Number	Bed number in which the patient is admitted. In case the member is admitted under more than one bed number, all the numbers have to be mentioned.
SL No 1 of billing Summary	All items under the primary head '100000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.

Field Name	Remarks
SL No 2 of billing Summary	All items under the primary head '200000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 3 of billing Summary	All items under the primary head '300000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 4 of billing Summary	All items under the primary head '400000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 5 of billing Summary	All items under the primary head '500000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 6 of billing Summary	All items under the primary head '600000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 7 of billing Summary	All items under the primary head '700000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 8 of billing Summary	All items under the primary head '800000' in the detailed bill have to be summarized into this. In case the procedure is packages, then only bills amount beyond the package needs to be mentioned here.
SL No 9 of billing Summary	All items under the primary head '900000' in the detailed bill have to be summarized into this. If more than one procedure is done, the total amount of the two procedures needs to be summarized

Field Name	Remarks
Total Bill amount	Sum total of all items 1 to 9 in the bill
Amount paid by the member	Amount of bill paid by the member including co-pay, deductible, non-medical items etc incl discount offered to member, if any.
Amount charged to Payer	Amount payable by Insurance company
Discount Amount	Amount offered as discount to the insurance company
Service tax	Service Tax chargeable to insurance company
Amount Payable	Total amount payable by insurance com[any including service tax
Amount in words	Above mount in words for the sake of clarity
Patients signature	Signature of the patient or the attendant of the patient needs to be mandatorily taken
Authorized signatory	The signature of the authorized signatory at the provider

Explanation of headings – Detailed Breakup of the Bill

The suggested summary format is annexed in the report (Annexure II)

The Bill is expected to be generated on the letter head of the provider and in A4 size to aid scanning.

The first section of the bill is same as the bill summary.

Field Name	Remarks
Date	Date on which service is rendered. For example, this is the date of investigation, date of procedure etc.
Code	Level 2 or 3 code of the billing item as per the codes(annex III)
Particulars	Text explanation of the item charged
Rate	Per unit price (per day room rent, per consultation charge)
Unit	No of units charged(hours, days, number as appropriate)
Amount	Rate*unit(s)

6. STANDARD GUIDELINES

Summary Bill

- The summary bill should not have any additional items (only 9)
- The provide has to mention the service tax number in case they charge service tax to the insurance company/TPA
- The payer mentioned in the bill has to be necessarily the insurance company and not the TPA.
- In case of package charged for any procedure/treatment, the provider is expected to mention the amount in serial no 9. Only items beyond the package are to be mentioned in sl nos 1 to 8.
- The patient/attendant signature is mandatory on the summary bill

Detailed breakup

- The billing has to be done at level 2 or 3
- In case of medicines/consumables, the relevant level code three has to be mentioned (40100, 401002) and the text should indicate the actual medicine used
- Some providers have outsourced the pharmacy to external vendors. In such cases the providers can attach the original bills separately. However, the summary of this has to be mentioned in the summary bill.
- In case of pharmacy returns the same code originally used is to be used with a negative sign in the units
- In case of cancellation of any service the same code originally used is to be used with a negative sign indicating reversal
- The date on which the service is rendered is to be mentioned in the bill. This would be
    - the date of requisition in case of investigations
    - date of consultation for professional fees
    - date of requisition in case of pharmacy/consumables irrespective of when they were used
    - Date of return of pharmacy items for pharmacy returns

Implementation Plan

Post final adoption of this plan by all stakeholders the plan for implementation would, inter alia, need to incorporate the following steps:

- Central body for maintenance, dissemination and addition of billing codes
- Integrating it as a standard format with provider HIS and as part of EDI mechanism for electronic data transfer between insurers and providers
- Publicity plan to create user awareness to promote usage before making it mandatory as part of provider empanelment norms

7. ANNEXURES

Annexure I

SUMMARY BILL FORMAT

Provider Name Provider registration No.	……	Bill Number Bill Date	……
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name	XXXX Insurance Company Ltd	Date of Discharge	
Member Address		Bed Number	

Billing Summary

Sl No	Primary Code	Particulars	Amount
1	100000	Room & Nursing Charges	
2	200000	ICU Charges	
3	300000	OT Charges	
4	400000	Medicine & Consumables	
5	500000	Professional Fees'	
6	600000	Investigation Charges	
7	700000	Ambulance Charges	
8	800000	Miscellaneous Charges	
9	900000	Package Charges	

Total Bill Amount	0
Amount paid by member	……0
Amount charged to Payer	0
Discount Amount	0
Service Tax	0
Amount Payable	0
Amount in Words	Rupees Zero Only

Patients Signature

Authorized Signatory

STANDARD BILL FORMAT

DETAILED BREAKUP FORMAT

Provider Name	.....	Bill Number	.....
Provider registration No.		Bill Date	
Address		PAN Number	
IP No		Service Tax Regn No	
Patient Name		Date of admission	
Payer Name		Date of Discharge	
Member Address		Bed Number	

Billing Details

Sl No	Date	Code	Particulars	Rate	Nos(Unit)	Amount
1		101001	General Ward Charges	500	1	500.00
2		401001	XXX medicine	50	2	100.00
3		401001	XXX Medicine - return	50	-1	-50.00

STANDARD BILL FORMAT

Annexure III

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
100000	Room & Nursing Charges					
100000	Room & Nursing Charges	101000	Room Charges			
100000	Room & Nursing Charges	101000	Room Charges	101001	General Ward charges	
100000	Room & Nursing Charges	101000	Room Charges	101002	Semi-private room charges	
100000	Room & Nursing Charges	101000	Room Charges	101003	Single Room charges	
100000	Room & Nursing Charges	101000	Room Charges	101004	Single Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101005	Deluxe room charges	
100000	Room & Nursing Charges	101000	Room Charges	101006	Suite charges	
100000	Room & Nursing Charges	101000	Room Charges	101007	Electricity charges	
100000	Room & Nursing Charges	101000	Room Charges	101008	Bed sheet charges	
100000	Room & Nursing Charges	101000	Room Charges	101009	Hot water charges	
100000	Room & Nursing Charges	101000	Room Charges	101010	Establishment Charges	
100000	Room & Nursing Charges	101000	Room Charges	101011	Alpha/Water Bed Charges	
100000	Room & Nursing Charges	101000	Room Charges	101012	Attendant Bed Charges	
100000	Room & Nursing Charges	102000	Nursing charges			
100000	Room & Nursing Charges	102000	Nursing charges	102001	Nursing fees	
100000	Room & Nursing Charges	102000	Nursing charges	102002	Dressing	
100000	Room & Nursing Charges	102000	Nursing charges	102003	Nebulization	
100000	Room & Nursing Charges	102000	Nursing charges	102004	Injection charges	
100000	Room & Nursing Charges	102000	Nursing charges	102005	Infusion pump charges	
100000	Room & Nursing Charges	102000	Nursing charges	102006	Aya Charges	
100000	Room & Nursing Charges	102000	Nursing charges	102007	Blood Transfusion Charges	
100000	Room & Nursing Charges	103000	Duty Doctor fee			
100000	Room & Nursing Charges	103000	Duty Doctor fee	103001	Duty Doctor fee	
100000	Room & Nursing Charges	103000	Duty Doctor fee	103002	RMO Fees	
100000	Room & Nursing Charges	104000	Monitor charges			
100000	Room & Nursing Charges	104000	Monitor charges	104001	Pulse Oxymeter charges	If used in normal Room
200000	ICU Charges					
200000	ICU Charges	201000	ICU Charges			
200000	ICU Charges	201000	ICU Charges	201001	Burns Ward	
200000	ICU Charges	201000	ICU Charges	201002	HDU charges	
200000	ICU Charges	201000	ICU Charges	201003	ICCU charges	
200000	ICU Charges	201000	ICU Charges	201004	Isolation ward charges	
200000	ICU Charges	201000	ICU Charges	201005	Neuro ICU charges	
200000	ICU Charges	201000	ICU Charges	201006	Pediatric/neonatal ICU charges	
200000	ICU Charges	201000	ICU Charges	201007	Post Operative ICU	
200000	ICU Charges	201000	ICU Charges	201008	Recovery Room	
200000	ICU Charges	201000	ICU Charges	201009	Surgical ICU	
200000	ICU Charges	202000	ICU Nursing charges			If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202001	Nursing fees	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202002	Dressing	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202003	Nebulization	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202004	Injection charges	If ICU nursing charged seperately
200000	ICU Charges	202000	ICU Nursing charges	202005	Infusion pump charges	
200000	ICU Charges	203000	Monitor charges			

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
200000	ICU Charges	203000	Monitor charges	203001	Monitor charges	
200000	ICU Charges	203000	Monitor charges	203002	Pulse Oxymeter charges	If used in ICU
200000	ICU Charges	203000	Monitor charges	203003	Cardiac Monitor charges	
200000	ICU Charges	204000	Monitor charges	203004	IABP charges	
200000	ICU Charges	204000	Monitor charges	203005	Phototherapy Charges	
200000	ICU Charges	204000	ICU Supplies & equipment			
200000	ICU Charges	204000	ICU Supplies & equipment	204001	Oxygen charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204002	Ventilator charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204003	Suction pump charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204004	Bipap charges	
200000	ICU Charges	204000	ICU Supplies & equipment	204005	Pacing Charges	Temporary Pacemaker
200000	ICU Charges	204000	ICU Supplies & equipment	204006	Defibrillator Charges	
300000	OT Charges					
300000	OT Charges	301000	OT rent			
300000	OT Charges	301000	OT rent	301001	Major OT charge	
300000	OT Charges	301000	OT rent	301002	Minor OT Charge	
300000	OT Charges	301000	OT rent	301003	Cath Lab Charges	
300000	OT Charges	301000	OT rent	301004	Theatre charges	
300000	OT Charges	301000	OT rent	301005	Labour Room Charges	
300000	OT Charges	302000	OT Equipment charges			
300000	OT Charges	302000	OT Equipment charges	302001	C-arm charges	
300000	OT Charges	302000	OT Equipment charges	302002	Endoscopy charges	
300000	OT Charges	302000	OT Equipment charges	302003	Laproscope charges	
300000	OT Charges	302000	OT Equipment charges	302004	Equipment charges	If not specified
300000	OT Charges	302000	OT Equipment charges	302005	Monitor charges	for OT monitoring
300000	OT Charges	302000	OT Equipment charges	302006	Instrument charges	for OT instruments
300000	OT Charges	303000	OT Drugs & Consumables			
300000	OT Charges	303000	OT Drugs & Consumables	303001	OT Drugs	
300000	OT Charges	303000	OT Drugs & Consumables	303002	Implants	
300000	OT Charges	303000	OT Drugs & Consumables	303003	OT Consumables	includes guidewires, catheter etc
300000	OT Charges	303000	OT Drugs & Consumables	303004	OT Materials	
300000	OT Charges	303000	OT Drugs & Consumables	303005	OT Gases	
300000	OT Charges	303000	OT Drugs & Consumables	303006	Anaesthetic drugs	
300000	OT Charges	304000	OT Sterlization			
300000	OT Charges	304000	OT Sterlization	304001	CSSD Charges	
400000	Medicine & Consumables charges					
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges			

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401001	Ward Medicines	OT drugs under OT Charges
400000	Medicine & Consumables Charges	401000	Medicine & Consumables charges	401002	Ward Consumables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401003	Ward disposables	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401004	Ward Materials	
400000	Medicine & Consumables charges	401000	Medicine & Consumables charges	401005	Vaccination drugs	
500000	Professional fees charges					
500000	Professional fees charges	501000	Visit charges			
500000	Professional fees charges	501000	Visit charges	501001	Consultation Charges	
500000	Professional fees charges	501000	Visit charges	501002	Medical Supervision Charges	
500000	Professional fees charges	501000	Visit charges	501003	Professional fees	
500000	Professional fees charges	502000	Surgery Charges			
500000	Professional fees charges	502000	Surgery Charges	502001	Surgeons Charges	
500000	Professional fees charges	502000	Surgery Charges	502002	Assisstant Surgeons Fee	Would also include Standby Surgeon
500000	Professional fees charges	503000	Anaesthetists fee			
500000	Professional fees charges	503000	Anaesthetists fee	503001	Anaesthetists fee	
500000	Professional fees charges	503000	Anaesthetists fee	503002	OT standby charges	Providers charge for standby anaesthetist
500000	Professional fees charges	504000	Intensivist Charges	504000		
500000	Professional fees charges	505000	Technician Charges	505000	OT /Cath Lab Technician	
500000	Professional fees charges	505000	Physiotherapy			
500000	Professional fees charges	504000	Procedure charges			
500000	Professional fees charges	504000	Procedure charges	504001	Bedside procedures	Catheterization, Central IV Line, Tracheostomy, Venesection
500000	Professional fees charges	504000	Procedure charges	504002	Suture charges	
600000	Investigation Charges					
600000	Investigation Charges	601000	Bio Chemistry			Serum Sodium, Ueres etc
600000	Investigation Charges	602000	Cardiology charges			for procedures like echo, ECG etc
600000	Investigation Charges	603000	Haemotology charges			cross matching etc
600000	Investigation Charges	604000	Microbiology charges			blood culture, C&S
600000	Investigation Charges	605000	Neurology			for EMG, EEG etc
600000	Investigation Charges	606000	Nuclear medicine			PET CT, Bone scan etc
600000	Investigation Charges	607000	Pathology charges			
600000	Investigation Charges	608000	Radiology services			X-ra, CT, MRI etc
600000	Investigation Charges	609000	Serology charges			
600000	Investigation Charges	610000	Medical Genetics			Chrosomal Analysis etc
600000	Investigation Charges	611000	Profiles			Profiles instead of individual tests (Lipid profile, LFT etc)
700000	Ambulance Charges					
700000	Ambulance Charges	701000	Ambulance Charges			

Level 1 Code	Level 1	Level 2 Code	Level 2	Level 3 Code	Level 3	Remarks
800000	Miscellaneous charges					
800000	Miscellaneous charges	801000	Admission charges			
800000	Miscellaneous charges	802000	Attendant food charges			
800000	Miscellaneous charges	803000	Patient food charges			
800000	Miscellaneous charges	804000	Registration charges			
800000	Miscellaneous charges	805000	MRD Charges			
800000	Miscellaneous charges	806000	Documentation charges			
800000	Miscellaneous charges	807000	Telephone charges			
800000	Miscellaneous charges	808000	Bio Medical Waste Charges			
800000	Miscellaneous charges	809000	Taxes		Luxury Tax/Surcharge/ Service Charge	Excluding VAT & Service Tax
900000	Package Charges					To be used only in case of packages
900000	Package Charges	901000	Cardiac Surgery	ICD-10-PCS	CABG	To be used only in case of packages
900000	Package Charges	902000	CardiologyPackages	ICD-10-PCS	PTCA	To be used only in case of packages
900000	Package Charges	903000	Cath Lab	ICD-10-PCS	CAG	To be used only in case of packages
900000	Package Charges	904000	Dental Procedures	ICD-10-PCS	Root Canal Treatment	To be used only in case of packages
900000	Package Charges	905000	ENT	ICD-10-PCS	FESS	To be used only in case of packages
900000	Package Charges	906000	Gastroenterology	ICD-10-PCS	Gastrectomy - Partial	To be used only in case of packages
900000	Package Charges	907000	General Surgery	ICD-10-PCS	Inguinal hernia	To be used only in case of packages
900000	Package Charges	908000	Gynaecology	ICD-10-PCS	LSCS	To be used only in case of packages
900000	Package Charges	909000	Nephrology	ICD-10-PCS	Nephrectomy	To be used only in case of packages
900000	Package Charges	910000	Neuro Surgery	ICD-10-PCS	Craniotomy	To be used only in case of packages
900000	Package Charges	911000	Oncology Procedures	ICD-10-PCS	IMRT	To be used only in case of packages
900000	Package Charges	912000	Opthalmology procedures	ICD-10-PCS	Cataract	To be used only in case of packages
900000	Package Charges	913000	Orthopaedic Surgery	ICD-10-PCS	Bilateral TKR	To be used only in case of packages
900000	Package Charges	914000	Plastic Surgery	ICD-10-PCS	Skin Grafting	To be used only in case of packages
900000	Package Charges	915000	Pulmonology Packages	ICD-10-PCS	Pleural Tapping	To be used only in case of packages
900000	Package Charges	916000	Urology	ICD-10-PCS	ERCP	To be used only in case of packages
900000	Package Charges	917000	Vascular Surgery	ICD-10-PCS	Embolectomy	To be used only in case of packages

Suggested Discharge Summary Contents

Chapter 3

Suggested Discharge Summary Contents

BACKGROUND

Discharge summary is a document prepared by an IP provider for benefit of the patient and also his primary physician. The health insurance industry also used the discharge summary as a key document in processing the claim, and has been affected by discharge summaries that are not uniform and also not adequate to meet the needs to the stakeholders. Specific to payers, the lack of adequate information on the discharge summary leads to delay in processing claims as requests have to be sent to providers to provide additional information. Also, due to difference in nature of information sent by the hospital there could be problems in interpretation.

FICCI constituted committee, was entrusted with the task of suggesting standard contents for discharge summary which could be used by various hospitals forming part of provider network for insurance purpose to ensure that the discharge summary issued by them provided the necessary information required to process claims.

The committee had representatives from all stakeholders including insurers, TPA's, providers and consultancy companies and was headed by Shri S L Mohan, Secretary General, General Insurance Council.

OBJECTIVE

- To suggest a standard content for the discharge summary to be used across providers for benefit of all stakeholders and facilitate processing of claims at payer end
- To seek only relevant information which would integrate with standard claim form and provider bills
- To suggest contents in line with acceptable quality standards, like compliance of NABH standards so that it benefits all stakeholders
- The standardized format would be shared with providers for implementation and could be included as part of the standard contract between insurers/TPA's and the providers.

COMPONENTS OF STANDARDIZATION

- Suggested list of contents in discharge summary
- Standard guidelines for preparing a discharge summary so that the interpretation of the terms in the document and the information provided is uniform.

METHODOLOGY

1) Collating various Discharge Summary Formats used across the industry and taking into account requirements of insurance companies. Discussing and editing each components in great detail by the group during the interactive meetings.
2) Attempting to standardise the contents of discharge summary format based on the suggestions of the group. Circulating the suggested contents of discharge summary format among all members for further suggestion

Once the feedback has been incorporated, FICCI will be submitting these draft documents to Insurance Councils and Regulator for Consideration

NABH GUIDELINES

AAC 15, Chapter 1 – Access, assessment and continuity of care (AAC) under Section 1 – Patient care standards in Second Edition of Accreditation Standards for hospitals, contains following provisions as

regards Discharge Summary:

a. Discharge summary is provided to the patients at the time of discharge.
b. Discharge summary contains the reasons for admission, significant findings and diagnosis and the patient's condition at the time of discharge.
c. Discharge summary contains information regarding investigation results, any procedure performed medication and other treatment given.
d. Discharge summary contains follow up advice, medication and other instructions in an understandable manner.
e. Discharge summary incorporates instruction about when and how to obtain urgent care.
f. In case of death the summary of the case also includes the cause of death.

The suggested contents below are in conformity with the NABH guidelines on the previous page.

SUGGESTED CONTENTS

With above perspective sub-group discussed the discharge summary contents and made following recommendations for including essential information required for insurance purposes in the discharge summary.

SUGGESTED CONTENTS OF DISCHARGE SUMMARY FORMAT:

1. Patient's Name:
2. Telephone No / Mobile No:
3. IPD No:
4. Admission No:
5. Treating Consultant/s Name, contact numbers and Department/Specialty :
6. Date of Admission with Time :
7. Date of Discharge with Time :
8. MLC (Medico Legal Case) No / FIR No:
9. Provisional Diagnosis at the time of Admission:
10. Final Diagnosis at the time of Discharge:
11. ICD-10 code(s) for Final diagnosis*:
12. Presenting Complaints with Duration and Reason for Admission:
13. Summary of Presenting Illness:
14. Key findings, if any, on physical examination at the time of admission:
15. History of alcoholism, tobacco or substance abuse, if any:
16. Significant Past Medical and Surgical History, if any:
17. Family History if significant/relevant to diagnosis or treatment :
18. Summary of key investigations during Hospitalization:
19. Complications during the Course in the Hospital if any:
20. Advice on Discharge:
21. Name & Signature of treating Consultant/ Authorized Team Doctor:
22. Name & Signature of Patient / Attendant:

*Desirable, not mandatory

STANDARD GUIDELINES

These are still under preparation and finalization by the working groups and will be shared in due course.

The feedback received until July 22, 2010 has been incorporated in the document. Those received post July 22 will be taken into account before submission of the final report to Regulator, Councils and concerned authorities.

List of Members- Working Group 2 on "Standardisation of Billing Procedures in Hospitals and Suggested Contents of Discharge Summary Format"

Mr S L Mohan, Secretary General, General Insurance Council
(Chairman of Working Group)

Sub-Group 1 on "Standardization of Billing Formats"	**Sub-Group 2 on "Standardisation of Suggested Contents of Discharge Summary Format"**
Mr Sanjay Datta, Head- CS, ICICI Lombard ***(Chairman-Sub Group 1)***	Ms Malti Jaswal, CEO, E-Meditek TPA Services ***(Chairman-Sub-Group 2)***

Dr Somil Nagpal, Health Specialist, The World Bank ***(Knowledge Partner)***
Mr Shardul Admane, Sr. Assistant Director, IRDA ***(Regulator)***

MEMBERS

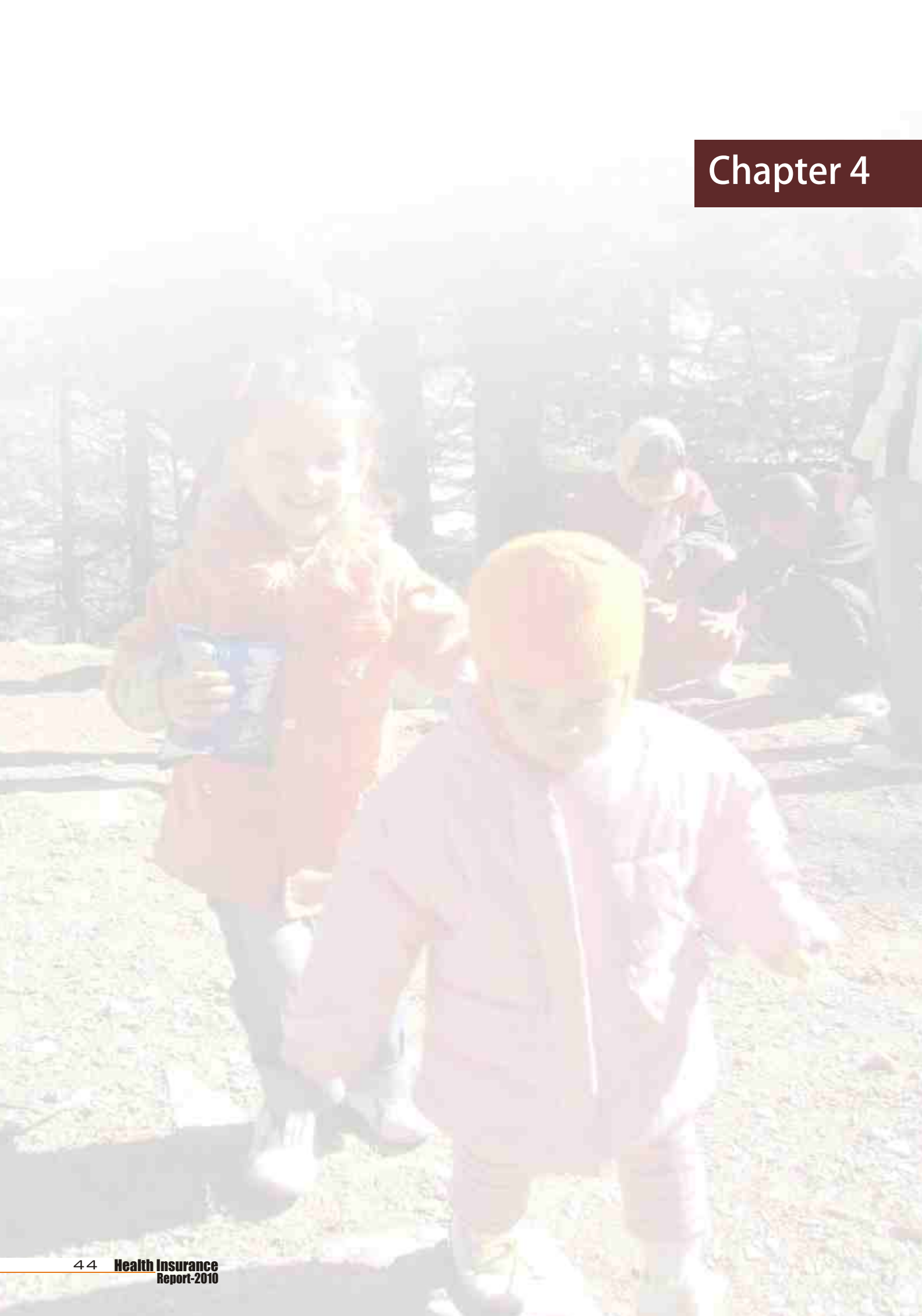
1. Mr Rajagopal Rudraraju, Chief Manager, Apollo Munich Health Insurance
2. Mr Sameer Bahadur, CEO, Healthcare Info-exchange, India
3. Mr Neeraj Basur, Director Finance, Max Bupa Health Insurance Co. Ltd.
4. Dr Rajesh Bhalla, Managing Partner, Nous Consultants (P) Ltd
5. Mr Mahipal Singh Bhanot, Head-Patient & Support Services, Max hospital
6. Dr. A K Dubey, Medical Suprdt, Dr. BL Kapur Memorial Hospital
7. Mr Nitin Jain, COO, Religare Health Insurance Co. Ltd.
8. Dr Jitendra Nagpal, Health Insurance Consultant, Apollo Hospital
9. Mr Retheesh Pillai, Raksha TPA
10. Mr TVS Prasad, COO, Medi Assist India

Dr. Faisal Khan, Branch Manger, Medi Assist India TPA Pvt. Ltd

11. Mr Alam Singh, Assistant Managing Director, Milliman
12. Mr Lalit Baveja, Senior Healthcare Consulatnt, Milliman
13. Mr Bhupesh Bhatia, Sr. Manager Finance, Dr. BL Kapur Memorial Hospital
14. Dr Rajiv Malhotra, Director, Med Edge Consultancy
15. Dr S.C. Marwah, CEO-Panecea Healthcare Ventures
16. Mr Amit Gupta, Religare Health Insurance
17. Mr Kamlesh Manuja, ICICI Prudential Insurance Co. Ltd.
18. Mr Manish Jain, Health Policy Development Manager- India, Johnson & Johnson Medical

Suggested TPA/Insurer Contract and Concept on Standardisation of TPA/ Hospital Contract

Chapter 4



SuggestedTPA/Insurer Contract and Concept on Standardisation of TPA/Hospital Contract

1. BACKGROUND

Presently there are variations in the TPA/Insurer contracts and TPA/Hospital contracts across the industry, without any uniformity in the clauses of the agreement. A skeletal framework for he contract was felt necessary in order to bring uniformity, more clarity about the service standards and minimize the chances of disputes over interpretation. The basic premise of the work was to standardize the terms of contract and time lines for various activities. The document would also be instrumental in streamlining other processes and documents like pre-authorization form, discharge summary form, bill formats, etc. Accordingly, certain sections of the contract that form the foundation, would be standard for all cases, with the mutual terms like scope of services, etc. forming part of the annexures.

2. OBJECTIVE

- To develop a basic template for TPA/Insurer contract in order to ensure uniformity across the industry and avoid variation in the clauses of the agreement.
- To work on a standard common format for TPA-Insurer Contract and TPA/Insurer-Hospital Contract, with sufficient representation from all stakeholders. This standard TPA-Insurer contract and TPA/Insurer - Hospital contract can be used across the industry for benefit of all stakeholders including:
  - TPAs
  - Insurers
  - Provider and
  - Policy holders
- To ensure that the main agreement is short and concise with only the standard clauses while all other details are included in the annexure.
- To facilitate the standardization of Terms of Contract & Timelines and use this agreement to streamline other processes and documents like pre-authorization form, discharge summary form, bill formats, etc

3. COMPONENTS OF STANDARDIZATION

Standardization involves two aspects:

- Suggested terms of TPA/Insurer Contract
- Standard guidelines for preparing a TPA/Hospital contract so that there are uniform clauses and annexure in the agreement.

4. METHODOLOGY

- Collating various TPA/ Insurer contracts across the industry and taking into account requirements of both the TPAs as well as the Insurance companies. Discussing and editing each main clause and sub item in great detail by the group during interactive meetings.
- Attempting to standardize the TPA/Insurer Contract for adoption by the industry based on suggestions and requirements of TPAs and Insurance providers.
- Circulating the revised TPA/Insurer Contract among all members of the Working Group for further suggestions.

Once the feedback has been incorporated, FICCI will be submitting these draft documents to Insurance Councils for consideration and adoption.

5. STANDARD GUIDELINES FOR PREPARING A TPA/HOSPITAL CONTRACT

While the sub-group has worked on the TPA-Insurer contract in detail, the redrafting and standardization of the TPA-Hospital contract would be taken up soon. Some other standardization measures like the standard document formats like pre-authorization form, discharge summary format, billing format, etc. are about to be competed and would form the foundation of the TPA- Hospital contract. Meanwhile, certain relevant issues about various aspects of he TPA-hospital contract which came up during discussions of the meetings of the working group have been proposed as guidelines for revisiting the provider contract format.

- Recommendation to have a clause on access to medical records in the TPA-Insurer/Hospital Contract. Discharge protocol from TPA report can also be included in the agreement.
- The contract to include clauses on recourse for hospitals on denial of franchisees claim settlement, as well as whether the TPA can provide key clauses on cost sharing at the authorization stage.
- The cost, service, TATs, to be taken to annexure. Also, the discount structure to be clearly spelt out in the agreement as committed in cashless reimbursement.
- The contract to also incorporate a paragraph on 'cost and quality' which is to be submitted by the quality group.

Annexure I

DRAFT SERVICE LEVEL AGREEMENT

This agreement made and entered into on this ----- day of ------2010 at, _____, India between:-

"_____" an insurance company having its Registered Office at _____ and its Corporate Office at _____, (hereinafter referred to as the "**Insurer",** which expression shall unless repugnant to the context or meaning thereof be deemed to mean and include its successors and permitted assigns) of the First Part.

AND

"_____" licensed by the Insurance Regulatory and Development Authority under the IRDA(Third Party Administrators-Health Services), Regulation 2001, under License no----------and having its Registered Office at (_____) (hereinafter referred to as the "**TPA**", which expression shall unless repugnant to the context or meaning thereof be deemed to mean and include its successors and permitted assigns) of the Second Part.

("**The Insurer"** and the "**TPA"** are individually referred to as a **"party"** and collectively as **"parties")**

WHEREAS

1 The Insurer has been registered under Section 3 of the Insurance Act 1938 (Act 4 of 1938) and is, inter-alia, engaged in the business of providing general insurance in India.

2 The TPA has obtained a license as a Third Party Administrator under the IRDA (Third Party Administrator - Health Services) Regulation, 2001 (hereinafter referred to as "the Regulation") framed under Sections 14 and 26 of the Insurance Regulatory and Development Authority Act, 1999 (Act 4 of 1999) read with Section 114 A of the Insurance Act, 1938 (Act 4 of 1938) and is engaged in making available health services and services in support of such health services.

3 The parties have agreed that the TPA shall provide the customers of the Insurer, health care and ancillary services for a fee and on terms and conditions more particularly described in this Agreement.

4 Whereas the parties are desirous of recording in this Agreement, the terms and conditions under which the TPA will render the aforesaid services to the customers of the Insurer.

NOW THEREFORE IT IS AGREED as follows: -

1 DEFINITIONS & INTERPRETATION

1.1 The following terms and expressions shall have the following meanings for purposes of this Agreement.

The feedback received until July 22, 2010 has been incorporated in the document. Those received post July 22 will be taken into account before submission of the final report to Regulator, Councils and concerned authorities.

1.1.1 **"Agreement"** shall mean this agreement and all schedules supplements, appendices, appendages, annexure and modifications thereof made in accordance with the terms of this agreement and shall be deemed to be the Agreement as defined in Section 2(a) of the Regulation.

1.1.2 **"Benefit"** shall mean the extent or degree of service the Insured Persons are entitled to receive based on their contract with the Insurer.

1.1.3 **"Billing Service"** shall have the meaning ascribed to it in clause 4 below.

1.1.4 **"Business Day"** shall mean days on which commercial banks are open for business in India.

1.1.5 **"CRCM Service"** shall have the meaning ascribed to it in clause 4 of Annexure A.

1.1.6 **"CPP Service"** shall have the meaning ascribed to it in clause 5 below.

1.1.7 **"Call Centre Service"** shall have the meaning ascribed to it clause 2 of Annexure A below.

1.1.8 **"Cashless Access Service"** shall have the meaning ascribed to it in clause 3 of Annexure A below.

1.1.9 **"Claim Float"** shall mean the money made available to the TPA for settlement of claim of the Insured Person by the Insurer.

1.1.10 **"Claim Float Account"** shall mean the bank account where the claim float is parked and replenished on agreed terms by the Insurer.

1.1.11 **"Coverage"** shall mean the entitlement by the Insured Person to Health Services provided under the Policy, subject to the terms, conditions, limitations and exclusions of the policy.

1.1.12 **"Emergency"** shall mean a serious medical condition or symptom resulting from injury or sickness which arises suddenly and requires immediate care and treatment, generally received within 24 hours of onset to avoid jeopardy to life or serious damage to the health of Insured Person, until stabilization at which time this medical condition or symptom is not considered an Emergency anymore.

1.1.13 **"Force Majeure Event"** shall have the meaning ascribed to it in clause 20 below.

1.1.14 **"Fees"** shall mean the agreed fees payable by the Insurer to the TPA for Services rendered by it as detailed in clause 3 of the Agreement hereto.

1.1.15 **"Government"** shall mean either the Government of India or the Government of any State in India or both.

1.1.16 **"Government Authority"** shall mean Central Government, any State Government, any central, regional, state, local or political subdivision within India and any entity exercising executive legislative, judicial, regulatory or administrative functions of or pertaining to Government of India and having jurisdiction over the Parties including any authority within India but not limited to the Insurance Regulatory and Development Authority.

1.1.17 **"Guidebook"** shall mean the instruction manual issued by the TPA to the Insured Person

containing information regarding the policy as detailed in clause 3.1.2 of Annexure A below. The guidebook shall be formatted after due discussion with the Insurer.

1.1.18 **"Health Services"** shall mean the health care services and supplies covered under the policy issued to the Insured Person, except to the extent that such healthcare services and supplies are limited or excluded and shall not include the business of an insurance company or the soliciting, directly or through an insurance intermediary, including an insurance agent, of insurance business, as defined in terms of Section 2(d) of the Regulation.

1.1.19 **"Hospitalization Services"** shall have the meaning ascribed to it in clause 1 of Annexure A below.

1.1.20 **"IRDA"** shall mean the Insurance Regulatory and Development Authority established under the Insurance Regulatory and Development Authority Act 1999.

1.1.21 **"I.D. Card"** shall mean the identity card provided by the TPA to the Insured Persons as part of its cashless access service and bearing the details listed in clause 3.1.4 of Annexure A below

1.1.22 **"Insured Person(s)"** shall mean customers of the Insurer who are entitled to benefit under a valid health insurance policy of the Insurer in the Service Area.

1.1.23 **"Law"** includes all statutes, enactments, acts of legislature, laws, ordinances, rules, bye-laws, regulations, notifications, guidelines, policies, directions, directives, and orders of any Government, Government Authority, Court, Tribunal, Board or recognized stock exchange of India, as may be applicable to the Scope and Terms of this Agreement.

1.1.24 **"MIS Service"** shall have the meaning ascribed to it in clause 10 below.

1.1.25 **"Network Service Provider"** shall mean the hospital, day-care centre, nursing home or such other medical aid provider, as the case may be, that has agreed with the TPA to participate for providing cashless services in relation to the health insurance business of the Insurer.

1.1.26 **"Person"** shall mean any individual, partnership, corporation, company, unincorporated organization or association, trust or other entity, including a Government or a political subdivision or an agency or instrumentality thereof.

1.1.27 **"Policy"** shall mean the health insurance policies of the Insurer duly filed with IRDA under the File and Use guidelines, provided to the Insured Persons and to be serviced by the TPA.

1.1.28 **"Policy Holder"** shall mean the customer of the Insurance policy issued by the Insurer and to whom the TPA provides services against fees received from Insurer.

1.1.29 **"Schedule of Charges"** shall mean the expenses incurred per ailment for the hospitalization service provided by the TPA.

1.1.30 **"Services"** shall mean all medical health care and ancillary services agreed to be made available by the TPA to the Insurer and/or the Policy Holders and/or the Insured Persons including the following.

(i) Hospitalization Services

(ii) Call Centre Service

(iii) Cashless Access Service

(iv) CRCM Service

(v) Billing Service

(vi) CPP Service and

(vii) MIS Service

(viii) Any other medical and related/ancillary services agreed between the parties.

1.1.31 **"Service Area"** shall mean the area within which the Insurer has authorized the TPA to provide services.

1.1.32 **"Third Party Administrator"** shall mean any TPA who is licensed under the Third Party Administrator Health Services Regulation 2001 by IRDA to practice as a third party administrator.

1.1.33 **"TPA Regional Office"** shall mean the offices of the TPA located at various regional locations throughout India and agreed with the Insurer to be known as TPA Regional Office.

1.1.34 **"Underwriting Offices"** shall mean the offices of the Insurer located at various locations throughout India.

1.2 No provision of this Agreement shall be interpreted in favour of or against any Party by reason of the extent to which such Party or its counsel participated in the drafting hereof or by reason of the extent to which any such provision is inconsistent with any prior draft hereof.

1.3 Any grammatical form of a defined term herein shall have the same meaning as that of such term.

]1.4 Any reference to an Agreement, Memorandum of Understanding, Instrument or other Document (Including a reference to this agreement) herein shall be to such Agreement, Instrument or other Document, as amended, supplemented or notated pursuant to the terms thereof.

1.5 Terms and expressions denoting the singular shall include the plural and vice versa.

1.6 The term "including" shall always mean "including, without limitation," for purposes of this Agreement.

1.7 The terms "herein", "hereinafter", "hereto", "hereunder" and words of similar import refer to this agreement as a whole.

1.8 Headings are used for convenience only and shall not affect the interpretation of this Agreement.

2 THE SERVICES

The TPA hereby agrees to provide the services, by itself, in due compliance of the terms and conditions and in the manner more particularly set out in Annexure A to this Agreement.

3 SERVICE FEES

Subject to the TPA rendering the Services, the Insurer shall pay to the TPA the Fee as detailed below

Rate of Service Charge

4 BILLING SERVICE

The TPA will draw bills on behalf of the Network Service Provider, whose bill shall be settled by the Insurer. This service provided by the TPA along with the responsibilities of the TPA as detailed in Annexure B to this agreement is collectively referred to as the "Billing Service"

5. CLAIMS PROCESSING AND PAYMENT (CPP) SERVICES

The procedure of processing of the claims shall be handled by the TPA Regional Offices. Any intimation of claim and receipt of claim papers by the respective Underwriting office of the Insurer shall be forwarded to the Regional Processing Office of the TPA. This service provided by the TPA along with the responsibilities of the TPA as detailed in Annexure C to this agreement is collectively referred to as the "CPP Service".

6 REPUDIATION OF CLAIMS

The TPA shall not repudiate any claim, only the insurer shall have the right to repudiate a claim. The TPA may convey the repudiation of a claim to the insured, as and when advised by the insurer. Where the TPA sends the intimation about the repudiation to the claimant, it shall be clearly indicated in the repudiation letter that "the claim has been repudiated as advised by the insurer". Further, the repudiation letter shall also clearly mention that the insured may approach the grievance cell of the insurer if he/ she is not satisfied by the settlement. The contact details of grievance cell may be provided in the letter.

7 PAYMENT OF CLAIMS AND CLAIM TURN AROUND TIME

The TPA will settle all eligible claims and pay the sum to the Insured Person within __ days of within such time after receipt of the complete set of claim documents, as may be indicated in the TAT schedule for various activities included in the Annexure _____.

8 CLAIM FLOAT AND CLAIM FLOAT ACCOUNT

The Insurer will provide a Claim Float, as defined in the DEFINITIONS & INTERPRETATION Clause above, to the TPA to pay to the Insured Person making a valid claim. The TPA will give a report of the claims paid to Insurer's Head office. The Head Office of the Insurer, on receipt of any replenishment request from the TPA, shall within --- days of receipt, replenish the claim float in the claim float account to the extent of a valid request.

The TPA will also send monthly claim statement to all underwriting offices containing the information about a) claims intimated b) claims settled and c) claims outstanding pertaining to the concerned underwriting office, with details as specified by the insurer.

9 MANAGEMENT INFORMATION SYSTEMS (MIS) SERVICE

The TPA shall provide management information system reports whereby the Insurer will be provided information regarding the enrolment, pre authorization, claims settlement and reimbursement and such other information regarding the services as required by the Insurer. The reports will be submitted by the TPA to the Insurer on a regular basis as agreed between the Parties. The Management Information system reports provided by the TPA to the Insurer is referred to as the "MIS Service" and are detailed in Annexure D to this agreement.

10 POWER CAPACITY AND AUTHORITY OF TPA

The TPA has declared that it has full power, capacity and authority to execute deliver and perform this Agreement and it has taken all necessary action(s) (corporate, statutory or to otherwise) to execute, deliver, perform and authorize the execution, delivery and performance of this Agreement and that it is fully empowered to enter into and execute this Agreement, as well as perform all its obligations hereunder.

11 TPA REPRESENTATIONS WARRANTIES AND RESPONSIBILITES

The TPA representations, warranties and responsibilities are detailed in Annexure E to this agreement

12 COMPLAINTS BEFORE JUDICIAL AND QUASI-JUDICIAL BODIES

Any complaint filed before any judicial or quasi-judicial body against the TPA due to repudiation of claim would be jointly defended by the Insurer and the TPA (through an advocate in case of judicial bodies). Where an advocate has been engaged for the purpose, the professional fee will be paid by the Insurer.

Where the case is due to deficiency of service by the TPA and is not related to policy terms and conditions, the complaint would be defended by the TPA alone and all costs to defend the complaint would be borne by the TPA.

13 POWER CAPACITY AND AUTHORITY OF THE INSURER

The Insurer has full power, capacity and authority to execute deliver and perform this Agreement and it has taken all necessary action (corporate, statutory or otherwise) to execute delivery, perform and

authorize the execution delivery and performance of this Agreement and that it is fully empowered to enter into and execute this Agreement as well as perform all its obligations hereunder.

14 INSURER REPRESENTATIONS WARRANTIES AND RESPONSIBILITIES

The Insurer representations, warranties and responsibilities are detailed in Annexure F to this agreement.

15 CONFIDENTIALITY

Maintenance and Confidentiality of information

(i) TPA shall abide by its obligations mentioned under IRDA (Third Party Administrators - Health Services) Regulations, 2001 with respect to data maintenance and confidentiality.

(ii) TPA shall, in maintaining the records in terms of Regulation (22) (1), follow strictly the professional confidentiality between the parties as required.

(iii) If the licence granted to the TPA is either revoked or cancelled in terms of these regulations, the data collected by the TPA and all the books, records or documents, etc., relating to the business carried on by it with regard to an insurance company, shall be handed over to that insurer by the TPA forthwith, complete in all respects.

(iv) TPA shall maintain the data under this agreement by taking all reasonable care and precautions including but not limited to:

(a) The Data must be maintained and updated using information technology.

(b) The TPA shall have systems, fireballs and all paraphernalia to avoid jeopardizing the data.

(c) The TPA shall have a Business Continuity Plan ready, in order to face any contingency that may arise.

(d) The TPA shall make adequate arrangements for data backup. Data backup shall be done in electronic data Storage (e.g. Magnetic tape, used for tertiary and off-line storage) and the data backup shall be preserved for three years

(e) Data related to claims/policy will be sole proprietary of Insurer

The expression Confidential Information shall, without limitation, include confidential or proprietary information received by the other party whether directly from the other party or otherwise. Confidential Information includes without limitation inventions, innovations, works or intellectual property and any idea, trade secret, know-how or data of any nature concerning the development, use, formulation, manufacture or performance of either party or its products or prospective products or services, and any research and development activities, process, techniques, inventions, specifications, algorithms, prototypes, designs, drawings or test data thereof, software programs, computer programs or documentation, specifications, source code, object code of such software and computer programs, inventions, processes, engineering products, services, the Insurer's markets or the business of either party or that of their respective clients. Information shall be deemed to be

confidential whether the same comes to the knowledge of the other party orally or is contained in tangible or fungible form and whether contained in a floppy disc, computer system, brochure, booklet or otherwise. Unless otherwise specified, all information received by the either party and pertaining to the other party shall be deemed to be Confidential Information. The terms of this Agreement are confidential and shall only be disclosed on a need to know basis.

The TPA shall keep the Insurer informed of any breach of the confidentiality obligations and shall provide necessary assistance and co-operation to the Insurer as the Insurer may require in this regard.

Notwithstanding anything contained herein, the restriction on use and disclosure set out above shall not apply to any Confidential Information which is required to be disclosed by way of an action, subpoena or order of a court of competent jurisdiction or of any requirement of legal process, law or governmental order, decree, regulation or rule;

16 INDEMNIFICATION

16.1 TPA shall hereby indemnify and keep the Insurer indemnified from and against all and any costs, damages or losses (whether consequential, business or otherwise) arising out of the breach of any representation warrant and or covenant made by it in this Agreement, breach of the Agreement generally or for non-fulfillment of its obligations under law or to any third party/parties.

16.2 TPA shall be solely liable for and will indemnify defend and hold harmless the other party from and against any and all claims, liability damages and/or costs (including but not limited to legal fees) arising from out of or in connection with:

16.2.1 The breach of any warranty, representation, covenant or term of this agreement;

16.2.2 The non-fulfillment of its obligations under law or to any third party / parties;

16.2.3 The gross negligence and / or willful misconduct by it and/or its Officers, Directors, Employees, Agents or Affiliates;

16.2.4 The infringement or violation of any third party's copyright patent, trade, secret, trademark, intellectual property, intellectual property right in relation to the services.

16.3 The TPA hereby indemnifies the Insurer for

16.3.1 Any amounts paid to any Insured Person in excess of the claim amount or in excess of the coverage.

16.3.2 Any amount paid to any Insured Person for risk not included in the coverage.

16.3.3 Any amount paid to a non- Insured Person.

16.3.4 Any amount payable to an Insured Person due to under payment of any amount due under Coverage including any reasonable fees incurred for defending any legal proceedings in furtherance thereof.

16.3.5 Any excess amount charged by the TPA in the Schedule of Charges than the charges agreed by the TPA with the Network Service Provider.

16.3.6 Any amount paid to other Third Party Administrators during the term of this Agreement in the event that the TPA ceases to hold a license as a third party administrator or is unable to carry on the services of third party administrator.

17. TERM & TERMINATION

17.1 This Agreement shall take effect on the date of execution hereof by both Parties, and shall remain in force for an initial period of 1 year subject to quarterly review at the discretion of the Insurer and also subject to a right to the Insurer to terminate the Agreement after review of the performance of the TPA by the Insurer on a monthly basis. The Insurer will review the performance of the TPA based on factors including but not limited to:-

17.1.1 The facilities set up including quality and reliability of software other infrastructure based on the volume of business serviced and arrangement made by the TPA towards servicing the Policy Holders of the TPA.

17.1.2 The extent of presence of Network Service Provider in the Service Area;

17.1.3 The quality of service provided;

17.1.4 The customers satisfaction reports received and

17.1.5 Such other factors as the Insurer deems fit and specifies

17.2 This Agreement may be terminated;

17.2.1 By both Parties by mutual consent; or

17.2.2 By the non- defaulting Party in the event of a change in the management or a change in the controlling interest of the other party without the prior written consent of the non defaulting Party; or

17.2.3 By the non-defaulting Party in the event that the other Party fails a maintain any license certification or accreditation required to conduct or perform the business contemplated by such party under this agreement; or

17.2.4 By the Insurer in the event of breach by the TPA of

(i) This agreement or

(ii) Its representations and warranties in this Agreement; or

(iii) Its covenants, agreements or obligations contained herein;

17.2.5 By the Insurer after a period of three months in pursuance of clause 17.1 above.

17.3 The TPA shall apply in writing for renewal of this agreement at least 15 days before expiry of one year from the date of execution (if not already cancelled in terms of clause 14.1) with relevant data. The Insurer may consider continuance of the services of the TPA and may require them to enter into a fresh agreement. Continuance of services is not mandatory but it is at the discretion of the Insurer and the decision of the Insurer shall be binding final in this regard.

17.4 This Agreement may be terminated forthwith by either Party if the other Party is prevented from performing any of its obligations hereunder due to a Force Majeure Event and such Force Majeure Event continues for a period of 4 weeks without interruption.

17.5 On termination of this agreement for any reason whatsoever.

17.5.1 The Insurer shall be liable to the TPA for all costs and charges for services performed in accordance with the terms of this agreement until the date of termination.

17.5.2 The TPA shall continue to be liable to provide the services either through itself or other third party administrator on a run-off basis for any claims of Insured Persons for whom the TPA has received Fees.

17.5.3 The TPA shall not deny access to Insurer for any records, documents, evidence, books of all transactions or any related information for a period of five years from the date of termination of agreement.

18 COSTS

Except as provided to the contrary in this Agreement, each party shall bear their own costs in relation to complying with the terms and conditions of and performing their respective obligations under this agreement including without limitation legal fees, advisory fees and other expenses required for the preparation and execution of this agreement.

19 FORCE MAJEURE

19.1 Neither Party shall be in breach of any of its obligations under this agreement to the extent that its performance is prevented, physically hindered or delayed by an act, event or circumstance (whether of the kind described herein or otherwise) which is not reasonable within the control of such.

Force Majeure shall include the following:

(a) Fire, flood, atmospheric disturbance, lighting, storm, typhoon, tornado, earthquake, washout, or other acts of God;

(b) War, riot, blockage, insurrection, acts of public enemies, civil disturbances, terrorism and sabotage and threats of such actions;

(c) Strikes lock-outs, or other industrial disturbances or labors disputes;

(d) Changes of any applicable Rule, Regulation or Law.

19.2 In the event that any Force Majeure Event continues for a period of 4 (four) weeks without interruption, the party not affected by such Force Majeure Event shall be entitled to terminate this Agreement by giving notice to the other Party pursuant to and in accordance with the provisions of clause 18.4 of this Agreement.

20 ASSIGNMENT

20.1 Neither Party shall be entitled to assign its rights and/or obligations under this agreement.

20.2 Subject to the foregoing this agreement shall be fully binding to the benefit of and be enforceable by the Parties hereto and there respective successors and permitted assigns.

21 GENERAL

21.1 The Insurer shall have the discretion in entrusting/ allocating the servicing of its policy holders to the TPA.

21.2 The Insurer may allow the TPA to continue to service the existing clients irrespective of the Zone allocated to the TPA.

21.3 The Insurer shall have discretion at all times, in modifying, adding, deleting or canceling the areas and / or offices entrusted with the TPA at its sole discretion.

21.4 The Insurer shall have discretion at all time to induct new TPAs to provide services to the Policyholders at any place or region.

21.5 The Insurer shall have discretion at all times to inspect the TPAs infrastructure and activities.

22 ENTIRE AGREEMENT

This Agreement entered into between the Insurer and the TPA represents the entire agreement between the Parties and shall supersede any previous agreement or understanding between the Parties in relation to matters covered hereby. In the event of a conflict between the provisions of this Agreement and any previous like agreement or understanding the provisions of this Agreement shall prevail.

23 RELATIONSHIP

23.1 The parties to this Agreement are independent contractors. Neither Party is an agent, representative or partner of the other Party. Neither Party shall have any right, power or authority to enter into any agreement or memorandum of understanding for or on behalf of or incur any obligation or liability of or to otherwise bind the other party. This Agreement shall not be interpreted or construed to create an association, agency, joint venture collaboration or partnership between the Parties or to impose any liability

attributable to such relationship upon either Party.

23.2 It is clarified that neither the TPA nor any of its employees, Network Service Providers or associated consultants or sub-contractors shall be deemed to be the employees of the Insurer for any purpose whatsoever.

24 VARIATION

No variation of this Agreement shall be binding on either Party unless, and to the extent that such variation is recorded in written document executed by both Parties. Where any such document is executed by both Parties, neither Party shall allege that such document is not binding by virtue of an absence of consideration.

25 SEVERABILITY

If any provision of this Agreement is invalid, unenforceable or prohibited by Law, this Agreement shall be considered divisible as to such provision and such provision shall be inoperative and the remainder of this Agreement shall be valid, binding and do the like effect as though such provision was not included herein.

26 NOTICES

Any notice given under or in connection with this Agreement shall be in writing and in the English language. Notices may be given by being delivered to the address of the addressee as set out below (in which case the notice shall be deemed to be served at the time of delivery) by courier services or by fax (in which case the original shall be sent by courier services).

Address :. . . . . :

Tel :. . . . . :

Fax :. . . . . :

Email :. . . . . :

Name of the TPA :. . . . . .

Address of the TPA :. . . . . .

Tel :. . . . . :

Fax :. . . . . :

Email : . . . . . .

27 DISPUTE RESOLUTION

27.1 If any dispute arises between the Parties hereto during the subsistence of this agreement or thereafter in connection with the validity, interpretation, implementation or alleged breach of any provision of this agreement, the Parties will refer such dispute to their respective Head Offices for resolution. If the dispute is not resolved within 30 days of such reference, either party may refer the dispute for resolution to a sole arbitrator who shall be jointly appointed by both parties. Where

the parties do not agree upon a sole arbitrator within 30 days from receipt of a request by one party from the other party, parties would appoint one arbitrator each, who shall in turn appoint the presiding arbitrator.

27.2 The law governing the arbitration shall be the Arbitration and Conciliation Act, 1996 as amended or re-enacted from time to time.

27.3 The proceedings of arbitration shall be conducted in English language.

27.4 The arbitration shall be held in Delhi, India.

29 GOVERNING LAW AND JURISDICTIONAL COURTS

This agreement shall be governed and construed by the laws of India without regard to the conflict of laws, principles and any dispute in relation to this AGREEMENT. Disputes not resolved between the parties shall be subject to the exclusive jurisdiction of the courts at Delhi.

IN WITNESS WHEREOF the Parties have caused this agreement to be executed by their duly authorized representative in as of the date first hereinabove written.

SIGNED, SEALED AND DELIVERED
BY The Within Named
By

Authorized signatory
For _____

In the presence of

1.

2.

SIGNED SEALED AND DELIVERED
By the within named
By ……., Director
For (_____).

In the presence of

1.

2.

Annexure A

1. HOSPITALISATION SERVICE

The TPA shall ensure that the Insured Persons are provided with an option of choosing from a list of hospitals, day care centers, nursing homes or such other medical aid providers for the purposes of seeking treatment for their ailments. This service will be made available to all Insured Persons by the TPA and the list of such medical centers shall be expanded from, time to time, by the TPA, in terms of the responsibilities of the TPA as detailed in this clause 1, collectively referred to as the **"Hospitalization Service".**

1.1 Responsibilities of the TPA in providing the Hospitalization Service

1.1.1 Size and Spread of Network Service Providers

The TPA will provide access to the agreed network of hospitals to the Insured Persons. The hospitals networked should be well-maintained and should have all the necessary and up-to-date facilities for treatment of the Insured Persons. The geographic spread of the network needs to be sufficient so as not cause any inconvenience to the Insured Person. The TPA should make special effort to network charitable, Governmental and other low cost hospitals for the service of the Insured People.

1.1.2 Changes in the Network Service Provider

The TPA will intimate from time to time any changes in the number of Network Service Providers to the insurer and the website maintained by TPA, inter-alia, for this purpose, shall be updated on a real time basis. All deletions will be intimated in advance to the insurers before it is de-paneled.

1.1.3 Duties of Medical Team on Medical Advice

The TPA and its Network Service Providers as part of its medical investigation services will have qualified and experienced medical staff responsible for ascertaining the nature of ailment and verifying the eligibility of the Insured Person. The medical staff of the TPA is not expected to impart or advise the course of treatment or medical procedure guidance related to cure and other such medical care aspects.

The Insurer will be in no circumstance liable for any action of the TPA in this regard. The Insurer on this subject will entertain no complaints by the beneficiaries and it shall be the sole liability of the TPA, to redress such grievances. Further, the Insurer reserves the right to take such steps not limited to cancellation of this Agreement and/or forfeiting all or any of the payments due to the TPA and/or also proceeding for damages, against the TPA in case of such a default.

1.1.4 TPA to provide list of Network Service Providers.

The TPA shall make available the list of Network Service Providers affiliated by the TPA to the Insured Person in the Guidebook issued to the Insured People.

1.1.5 Non-Network Service Providers

The TPA shall also settle claims of such Insured who have not opted for Cashless Service and also Claims of Insured who avail treatment from non-Network Service Providers.

1.1.6 No Increase in Schedule of Charges.

The TPA shall ensure that during the term of this Agreement, prior intimation is given to the Insurer, for any increase in the schedule of charges by the Hospital, in form of a written notice, which needs to be submitted, to the Insurer, at least 14 days in advance from the proposed change in the schedule of charges. Any amount forming part of claims payments, due to an increase, not communicated, as aforesaid, to the Insurer shall be borne by the TPA.

1.1.7 Confirm hospitalization at pre-authorization

The TPA shall at the time of pre authorization of the Insured Person also confirm whether hospitalization is required or not for the Insured Person.

1.1.8 Eliminate unnecessary cost

The TPA shall also monitor and co-ordinate the delivery of health care in such a manner that the health care costs are reduced by eliminating irrelevant treatment.

1.1.9 Utilization review

The TPA shall also conduct utilization review about the health services provided either prospectively or retrospectively by methods such as second surgical opinion, prior authorization for hospital admission, ongoing monitoring while the patient is in hospital, discharge planning etc.

2. CALL CENTER SERVICES

The TPA shall provide telephone services for the guidance and benefit of the Insured Persons whereby the Insured Persons shall receive guidance about various issues by dialing a national Toll free number. This service provided by the TPA along with the responsibilities of the TPA, in this stead, and is further in turn, subject to responsibilities of the TPA and subject to responsibilities of the Insurer, as detailed in this clause 2.2, is collectively referred to as the Call Centre Service.

2.1.1 Call Centre Information

The TPA shall operate a call center for the benefit of all Insured Persons. The call center shall function for 24 hours a day 7 days a week around the year. As part of the call Centre Service the TPA shall provide the following:-

1) Provide instant accessibility to the clients for all information required for medical services.

2) Provide comprehensive coverage of network hospitals at all locations of client operations.

3) Provide Fax confirmation (received, and sending).

4) Provide Claim status (Cashless, Reimbursement, and Payments).

5) Detailed information for Policy holder.

6) Provide information related to E-Card.

7) Provide all assistance related to Cashless Claims.

2.1.2 Language

The TPA undertakes to provide the call centre service to the Insured Persons in the following languages viz. English & Hindi

2.1.3 Toll Free Number

The TPA will operate a toll free number, for general queries on cashless, claims and card statuses, auto mailers, and auto generated SMS facilities for updating claims statuses and automated email facilities. The cost of operating of the entire call centre service not limited to provision of toll free voice and fax number shall be borne solely by the TPA.

2.1.4 Call Centre Analysis

The TPA will provide general call centre statistic in a format i.e. MIS sheet for call analysis, as may be mutually agreed to by the Parties, on a monthly basis including aspects of grievance redressed and pending redressal. Any specific format, if required will have to be intimated by the Insurer in advance to the TPA.

2.1.5 Information at Local Offices

The TPA branch offices located across the country will assist the Insured Person in obtaining the necessary information during working hours of the TPA. All information required after working hours will be available from the central call center or processing house only.

2.2 Responsibilities of the Insurer in respect of the Call Centre Service

2.2.1 Insurer to inform Insured Person

The Insurer will intimate the toll free number to all Insured Persons along with addresses and other telephone numbers of the TPA's main office and regional offices.

3. CASHLESS ACCESS SERVICE

The TPA has to ensure that all the Insured Persons are provided with adequate facilities so that the Policy Holders do not have to pay any deposits except in few corporate hospitals to cover the expenses which are not covered under medi-claim policy, at the commencement of the treatment or bills after the end of treatment to the extent as the Services are covered under the policy. This service provided by the TPA along with the responsibilities of the TPA and subject to responsibilities of the Insurer as detailed in this clause 3 is collectively referred to as the "Cashless Access Service".

Responsibilities of the TPA in providing the Cashless Access Service

Data Collection/Data Format

The TPA will have to ensure that agreed details or data from proposal forms, policies, schedules and endorsements, which are available in electronic format, which are adequately computerized will be collected from the head office of the Insurer. Under no circumstances will the TPA be allowed to accept the data from the Insured Person and process it without the knowledge and acceptance of the head office of the Insurer.

Guidebook and other details

The TPA shall forward a user guidebook/brochure prepared by them to the Insurer for its approval, upon such approval; the guidebook/brochure shall be filed along with the agreement.

The TPA shall dispatch the approved Guidebook and related information to the Insured Person within 5 days of receipt of information regarding the issuance of policy to the Insured Person from the Insurer along with the identity card. The Guidebook will inter-alia contains information regarding the following:

1) SMS service Details
2) Cashless request form
3) Specimen Certificate
4) NSP list
5) Cashless Hospitalization Process
6) Reimbursement Process
7) List of _____ branch offices and their contact numbers

Deficiencies in the Required Data

In case the data given to the TPA does not comply with the requirements of the proposal forms and is not sufficient for the purpose of preparing the I.D. Card the TPA will intimate to the Head office of the Insurer on daily basis. The TPA shall be responsible for dispatch and delivery of the I.D. Cards to the Insured Person only after the requisite information regarding the Insured Person is submitted by the Insurer to the TPA.

I.D. Card production

The issue I.D. Cards will bear a logo of the Insurer as well as that of the TPA in a size and format mutually agreed by the Insurer and the TPA.

The I.D. Card will have :

(i) A unique specific Alpha-numerical Identification Character Set, which will be generated uniquely for each Insured Person

(ii) Name of the Insured Person and relationship with the Policy Holder

(iii) Age of the Insured Person

(iv) The photograph of the Insured Person

(v) Emergency contact number of the TPA Insurer and

(vi) Name of the Insurer

The cost of manufacturing the I.D. Card shall be borne solely by the TPA. The Validity period of the cards can be defined by the Insurer, depending upon, whether long term cards are to be given to the Insured Person.

Dispatch of I.D. Card and other material

The I.D. card along with the Guidebook and Network Service Provider directory of the respective city/area etc will be sent directly to the Insured Person/underwriting Office as per instruction of the Insurer.

Turn Around Time for enrolment processing and I.D. Card issuance.

The TPA will complete the processing of data and issuance of the I.D. Card to the Insured Person within __ days of receipt of complete information either from the system or the head office of the Insurer.

Deficient I.D. Cards

In case of error in data/printing mistakes etc. the Insured Person will be requested to return the I.D. Card to the TPA. TPA will rectify the mistake and redeliver the I.D. Card within __ days of its receipt at its office to the Insured Person.

3.1.7.A. TPA will intimate on a regular basis, the errors, which the TPA would have come across in the issuance of Policy/I.D. card etc. to the Insurer.

3.1.7.B. Cost of re-issuance of the new cards arising from TPA error will be borne by TPA. Cost of re-issuance of new cards arising from error in data will be borne by the insured at the rate of Rs ___ per card.

Renewals Termination of the Policy I.D. Card retrieval

Upon termination or expiry of the policy period, the I.D. Cards will have to be made invalid.

The cards will then have to be revalidated by the TPA on confirmation of renewal of the Policy by the Office of the Insurer.

Reporting to Insurer Office on the Status of I.D. Card retrieval

TPA shall send a weekly report to each underwriting office via E-mail on the status of enrolment and I.D. Cards related to the particular underwriting office

3.1.10. Pre-Authorization for Cashless Access

The TPA shall upon getting the related medical information from the Policy Holders/ Network Service Provider, verify that the person is eligible under the policy and after satisfying itself, will issue authorization letter/guarantee of payment letter to the Network Service Provider mentioning the guarantee of the sum, duration of stay and the ailment for which the person is seeking to be admitted as a patient within ____ hrs of receipt of preauthorization request. All authorization requests received by the TPA shall have a detailed break up of the estimated costs. The TPA shall grant Cashless Access to an Insured Person, after properly satisfying itself, that the amount being authorized is justified.

3.1.11 Denial of Preauthorization

In case the Policy Holder fails to provide relevant medical details as required by the TPA, the TPA may deny the guarantee of payment to the Network Service Provider and may not authorize the Insured Person for cashless access. Unless the TPA is in receipt of data conclusively showing that the Policy holder is eligible for insurance coverage within the terms and conditions of the Policy, the TPA shall not issue the preauthorization letter /guarantee of payment letter to the Policy holder.

The TPA is expected by the Insurer to communicate to the Policyholder that denial of Cashless Access is in no way construed to be treated as denial of treatment. The Policyholder is expected to obtain the treatment as per his/her treating doctor's advice. The denial of preauthorization letter shall not be construed to mean that the Policyholder cannot claim under the terms and conditions of the Policy from the TPA, as and when, the Policyholder provides all the relevant medical details, the said amounts can be claimed.

The Insurer will not be liable for payment of claims arising of False medical information given by the Hospital, in which case the claim will be denied and the authorization will be canceled

3.1.12 EMERGENCY CASES

In cases of emergency if the TPA is not satisfied with the medical details, it may deny preauthorization. However the TPA shall verify from the Network Service Provider about the nature of ailment and on such verification if the Policyholder is found to be eligible under the terms of the Policy, the TPA will send a guarantee of payment letter to the Network Service Provider provided the patient is still admitted in the hospital.

3.2 Responsibilities of the Insurer in providing the Cashless Access Service

3.2.1 Insurer to provide data to the TPA

The Insurer shall co-ordinate with the TPA by providing the TPA with the necessary data regarding the Policyholder so as to enable the TPA to process the applications for allotment of I.D. cards received from the Policy holders.

3.2.2 TPA not to issue I.D. Cards without sanction of Insurer

The Insurer shall ensure that the TPA issues the I.D. cards as per the terms and condition of the Policies of the Insured Persons. Any I.D. card issued without the sanction of the Insurer shall be invalid and the TPA hereby indemnifies the Insurer for any payment made under such I.D. Card not validated by the Insurer.

3.2.3 Responsibility of Collection of Data

The responsibility of making available the data to the TPA Regional office lies with the underwriting office of the Insurer the responsibility of collecting data lies with the TPA.

4. CUSTOMER RELATIONS AND CONTACT MANAGEMENT (CRCM) SERVICE

The TPA shall provide adequate services to the Policyholders and ensure that customer grievances are resolved to their satisfaction. This service provided by the TPA along with the responsibilities of the TPA and subject to responsibilities of the Insurer as detailed in this clause 4.2.1 is collectively referred to as the "CRCM" Service.

4.1 Responsibilities of the TPA in providing the CRCM Service

4.1.1 CRCM Cell

The TPA shall have a dedicated CRCM cell for receiving documents and handling individuals and groups services. The TPA shall also ensure that the CRCM cell have enough representatives and personnel in all cities/towns where Insurer has zonal offices.

4.1.2 Customer Grievance

The TPA shall act as a frontline for the redressal of Insured Person's grievances. The TPA shall also attempt to solve the grievance at their end. The grievances so recorded shall be numbered consecutively and the Insured Person who records the grievance shall be provided with the number assigned to the grievance. The TPA shall provide the Insured Person with details of the follow-up action taken as regards the grievance as and when the Insured Person requires it to do so. The TPA shall provide to the Insurer Information in pre agreed format of any complaint / grievance received by oral, written or any other form of communication.

4.1.3 Action Taken Report for Customer Grievance

The TPA shall record in details the action taken to solve the grievance of the Policyholder in the form of an action taken report [ATR] within ___ days of the recording of the grievance. The TPA shall provide the Insurer with the comprehensive action taken report ATR on the grievances reported in pre agreed format. Any grievance not solved within __ days will be intimated to the respective underwriting office.

4.1.4 Customer Satisfaction Survey

The TPA shall on annual basis carry out customer satisfaction survey from a random sample of the Insured Persons who have obtained and availed the services provided by the TPA. The TPA shall use the rating card provided in the Guidebook for the purpose of conducting the survey. The TPA is expected to provide a synopsis of the findings of the survey along with the Plan of Action to address the deficiencies, shortcomings in the service provided by the TPA, if any, or suggestions for improvement at the end of the Insurer, in a format, that may be mutually arrived at by the Parties. The Insurer reserves the sole right to carry out a survey of the Insured Persons, on its own accord, to gather customer feedback and may share the findings of the same with the TPA, who will be obliged to treat the same at par, with the findings of the survey carried out by the TPA. Further, the Insurer or agencies appointed by it or its personnel shall also have access to copies of completed survey cards, collated by the TPA, for the purposes of the survey for its audit purposes.

4.2 Responsibilities of the Insurer in providing the CRCM Service

4.2.1 Insurer to co-ordinate with TPA

The Insurer shall co-ordinate with the TPA in order to solve the grievance as and when required by the nature and circumstances of the grievance.

Annexure B

Responsibilities of the TPA in providing the Billing Service

1 STANDARDIZED BILLING PATTERN

The TPA will provide a standardized billing pattern in an electronic format to all their Network Service Providers and the billing and settlement on behalf of the Insurer shall be done by the TPA on the basis of these standardized billing patterns. Any Network Service Provider not adhering to providing billing information in the said formats, within such time, as may be prescribed by the Insurer, shall be replaced by the TPA, after due consultation with the Insurer.

2 BILLING FOR NECESSARY TREATMENT CHARGE

The TPA shall co-ordinate with the Network Service Providers and ensure that only the necessary charges for the treatment of the Insured Person are billed and paid for. The TPA shall ensure that the Network Service Provider charges only for the ailment for which the Insured Person has been admitted. Unrelated treatments/investigations carried on the patient's insistence are not payable by the Insurer. TPA would keep the Insurer indemnified for the costs of any unrelated treatment availed of by the Policyholder.

3 DIAGNOSIS AND PROCEDURE CODES

The TPA shall ensure that Diagnosis Codes and Procedures Codes are maintained by them for all Claims and shall strive to introduce it along with the Billing Service in a phased manner, as may be mutually agreed, between Insurer and the TPA.

Annexure C

Responsibilities of the TPA in providing the CPP Service:-

1 CLAIM INTIMATION

The TPA shall receive claim intimation from the Insured Person. The TPA shall submit a daily report by e-mail to respective underwriting office and the Head Office of the Insurer of any claim intimations received by them, under each Regional Office.

2 COLLECTION OF CLAIM DOCUMENTS

The TPA shall offer a single window service at the respective TPA Regional Office to the Insured Persons for receiving the claim documents. In case of pre-authorization for the Cashless Access Service, the Network Service Provider will send the claim documents along with the invoice and discharge voucher, duly signed by the Insured Person directly to the TPA. In the event that the Insured Person collects the claim documents, the Insured Person will have to submit the same to the Regional/closest office of the TPA within seven days of discharge from the medical facility. In the event that the Insured Person does not opt for a Network Service Provider the Insured Person may collect the Claim Form from either the Underwriting Office or the office of the TPA or download the form from the website of the TPA. The documents for claim will have to be submitted to TPA by the Insured Person. The TPA office will also submit the pre & post hospitalization claim documents. TPA shall give due acknowledgement of collected documents.

3 SCRUTINY OF CLAIM DOCUMENTS

The TPA shall scrutinize the claim documents at the initial stage regarding the medical and eligibility aspect. Deficiency of documents, if any, shall be intimated to the Insured Person and respective underwriting Office within --- days. A reminder to send the same will again be forwarded to the insured Person after -------- days of first intimation of the deficient documents are not received or are partially received. A closure letter will be sent after another seven days giving the time of ___ days for document submission, after which the file will be closed.

4 CLAIM CONTROL NUMBER

The TPA shall issue a claim control number to all claims reported for future reference purposes.

5 PRE AND POST HOSPITALIZATION CLAIMS

The TPA shall receive pre and post hospitalization claim documents either along with the indoor hospitalization papers or separately and process the same based on merit of the claim derived on the basis of documents received. TPA reserves its right of recovery of any amount due to it from the Insured Person for billed services, which are not covered by the Policy.

6 CLAIM CONTROL MEASURES

(i) Close monitoring of hospitals reporting frequent claims.

(ii) Close study of pattern/ trends: similarities in diagnosis, treatment, length of stay at hospital.

(iii) Fixing package rates for standard surgical procedures prior to empanelment city wise.

(iv) Detection cases admitted primarily for investigative purposes which could have been treated on OPD basis also.

(v) Detection cases of overstay and communicating to the concerned NSP that further cashless extension will not be extended.

(vi) All cases doubtful in nature are subjected to go through investigation, including reimbursement claims.

7 CLAIMS CO- ORDINATION COMMITTEE

The Insurer and the TPA shall form a committee at every TPA Regional office level to facilitate smooth running and function of the activities.

8 STORAGE OF CLAIM DOCUMENTS

The TPA shall store the claim documents for a period of one year from the date of origin, and thereafter on a monthly basis, be handed over to the Insurer's Head Office to dispatch them to respective underwriting Office.

However, the Insurer has the right to seek the claim files in soft form from the TPA, within the period of one year, for audit and other such regulatory purposes.

9 BANK RECONCILIATION

The TPA will submit Bank reconciliation Statement to the insurer on monthly basis.

Annexure D

1 RESPONSIBILITIES OF THE TPA IN PROVIDING THE MIS SERVICE:

1.1 The TPA shall ensure that it shall provide a standardized billing pattern as detail in Annexure B above.

1.2 The TPA shall also provide to the Insurer data required for actuarial pricing and product development. The data so provided will, inter-alia, include.

(i) Number of persons covered for TPA services, age, group wise.

(ii) Number of claims made

(iii) Average amount per claim

(iv) Average stay in no. of days at hospital

(v) Average cost per day

(vi) Disease wise analysis

(vii) Age wise analysis

2 MIS REPORTS WILL BE MADE AVAILABLE TO IRDA AS AND WHEN REQUIRED WITHOUT ANY PRE-CONDITION BY THE TPA.

3 EXPORT/IMPORT OF DATA THROUGH ELECTRONIC MEDIA

The TPA shall arrange for export/import of data as per data formats and specifications given by the Insurer form time to time.

Annexure E

1 The TPA represents and warrants to the TPA that:

1.1 COMPLIANCE WITH MEMORANDUM AND ARTICLES

Neither the making of this Agreement nor any due compliance with its terms will be in conflict with or result in the breach of or constitute a default or require any consent under:-

(a) Any provision of any Agreement or other Instrument to which the TPA is a party or by which it is bound

(b) Any judgment, injection, order, decree or award which is binding upon the TPA and/or

(c) The TPA's the memorandum and/or articles of association.

1.2 COMPLIANCE WITH LAWS

The TPA should comply with all applicable Laws including but not limited to the Insurance Regulatory and Development Authority (Third Party Administrator - Health Services) Regulations 2001.

1.3 THIRD PARTY ADMINISTRATOR LICENSE

Throughout the term of this Agreement the TPA shall continue to be licensed with the IRDA as a third party administrator or such other law in force as required to carry on the activities contemplated herein.

1.4 CAPABILITY OF SERVICE

The TPA should ensure that it is capable of servicing all the products and policies offered by the Insurer and also has sufficient infrastructure, trained manpower and resources to carry out the activities for servicing these products and policies.

1.5 AUDIT OF CLAIMS SETTLED BY TPA

The TPA agrees that the Insurer shall have the right to audit all claims of the Insurer settled by the TPA. The TPA further agrees to provide access to the Insurer to their books of accounts and records for the purpose. The frequency and model of audit will be decided mutually between the TPA and the Insurer.

1.6 DISCLOSE TPA - NETWORK SERVICE PROVIDER AGREEMENT

The TPA agrees that it shall, if requested by the Insurer, disclose all Agreements entered into by the TPA with any Network Service Provider.

2 On execution of this Agreement and during the time it is in force the TPA agrees that it shall be responsible to and shall :

2.1 FILE AGREEMENT

File a copy of this Agreement and every modification there to within 15 days of its execution to or modification, as the case may be with the IRDA

2.2 NO OTHER BUSINESS

Not carry on or conduct any business other than giving third party administrator services as envisaged in the provision of the Insurance Regulatory and Development Authority (Third Party Administrator- Health Services) Regulations 2001.

2.3 CONTROL AND MANAGEMENT AND MATERIAL CHANGE

Disclose to the Insurer the shareholding, control and management of the TPA and also intimate any material change in the shareholding, control or management of the TPA to the Insurer. Further, the TPA shall also disclose its shareholding and/or interest in control and management in any associate company/sister concern engaged in the health care services.

2.4 INTIMATION OF CHANGE

Intimate change in the office of Chief Executive Officer (CEO) / Chief Administrative Officer (CAO) or any functional director as well as Change of Address of the Registered Office / Operation office / Regional Offices and contact details to IRDA and the Insurer within one week from the date of its occurrence.

2.5 CODE OF CONDUCT

Abide by the code of conduct prescribed by the IRDA or any other Government Body or the General Insurance Council or the Council for Fair Business Practices, from time to time.

2.6 IRDA REGULATION

Abide by the Regulations of IRDA as amended from time to time and any circular, notification or rule framed by the IRDA, from time to time.

2.7 ANNUAL REPORT

Furnish to the Insurer and the IRDA an annual report and any other return as may be required by the IRDA on its activities.

2.8 VERIFICATION BY THE DIRECTOR/CAO/CEO

Submit the annual report referred to in clause 2.7 above duly verified by a Director of the TPA and the CAO or CEO within a period of sixty days of the end of its financial year or within such extended time as IRDA may grant.

2.9 NO SEPARATE FEES

Not charge any separate fees from the Insured Persons, which it serves under the terms of this Agreement in respect of any policies that is being serviced by the TPA on behalf of the Insurer.

2.10 DISCOUNTS AND REBATES

Disclose to the Insurer the benefit of any discount or rebates provided by the Network Service Provider(s) to the TPA.

2.11 BUSINESS CONTINUITY PLAN

Ensure that they have adequate data back up in case of any unforeseen accident for the purpose of business continuity requirement.

Annexure F

1 The Insurer represents and warrants to the TPA that:

1.1 COMPLIANCE WITH MEMORANDUM AND ARTICLES

Neither the making of this Agreement nor compliance with its terms will be in conflict with or result in the breach of or constitute a default or require any consent under:-

(i) Any provision of any agreement or other instrument to which the Insurer is a party or by which it is bound;

(ii) Any judgment injection, order, decree or award which is binding upon the Insurer; and/or

(iii) The Insurers Memorandum and / or Articles of Association.

1.2 COMPLIANCES WITH LAWS

It has complied with all applicable Laws including but not limited to the Insurance Regulatory and Development Authority (Third Party Administrator - Health Services) Regulations 2001.

1.3 INSURANCE LICENSE

Throughout the term of this agreement the Insurer shall continue to be an insurance company under Law to carry on the activities contemplated herein.

2 On execution of this Agreement and during the time it is in force the Insurer agrees that it shall be responsible to the TPA for the following :

2.1 INFORM TPA ON INSURED'S DATA

Pass on the data to the TPA Regional Office on weekly/fortnightly basis as the case may be.

2.2 INSURED PERSON TO RETURN I.D. CARD

Instruct the Insured Person to return the cards upon expiry or termination of the policy.

2.3 INSTRUCT UNDERWRITING OFFICES

Instruct all their Underwriting Offices to commence TPA operations from the date hereof.

2.4 CLAIMS MANAGEMENT

Forward all intimation claim documents if received by the Underwriting Offices to the respective TPA Regional Office.

The process standards as laid down in the above clauses are summarized as below:

Process	TAT
Identity card dispatch to insured	
Report on deficient member data	
Report on data not found cases	
Response to grievance of insured	
MIS reports	
Claim intimation report	
Cashless report for settled/outstanding authorization	
Claim settlement / outstanding report	

List of Members - Working Group 2 on "Standardisation of TPA-Insurer and TPA/Insurer-Hospital Contracts"

1. Mr S.L. Mohan, Secretary General, General Insurance Council (Chairman of Working Group)
2. Dr Somil Nagpal, Health Specialist, The World Bank(Knowledge Partner)
3. Mr Shardul Admane, Sr. Assistant Director, IRDA (Regulator)

Members

4. Mr Sanjay Datta, Head- CS, ICICI Lombard
5. Ms Malti Jaswal, CEO, E-Meditek TPA Services
6. Mr Rajagopal Rudraraju, Chief Manager, Apollo Munich Health Insurance
7. Mr Sameer Bahadur, CEO, Healthcare Info-exchange, India
8. Mr Neeraj Basur, Director Finance, Max Bupa Health Insurance Co. Ltd.
9. Dr Rajesh Bhalla, Managing Partner, Nous Consultants (P) Ltd
10. Mr Mahipal Singh Bhanot, Head-Patient & Support Services, Max Hospital
11. Dr A K Dubey, Medical Suprdt, Dr. BL Kapur Memorial Hospital
12. Mr Nitin Jain, COO, Religare Health Insurance Co. Ltd.
13. Dr Jitendra Nagpal, Health Insurance Consultant, Apollo Hospital
14. Mr Retheesh Pillai, Raksha TPA
15. Mr TVS Prasad, COO, Medi Assist India Dr. Faisal Khan, Branch Manger, Medi Assist India TPA Pvt. Ltd
16. Mr Alam Singh, Assistant Managing Director, Milliman
17. Mr Lalit Baveja, Senior Healthcare Consulatnt, Milliman
18. Mr Bhupesh Bhatia, Sr. Manager Finance, Dr. BL Kapur Memorial Hospital
19. Dr Rajiv Malhotra, Director, Med Edge Consultancy
20. Dr S C Marwah, CEO-Panecea Healthcare Ventures
21. Mr Amit Gupta, Religare Health Insurance
22. Mr Kamlesh Manuja, ICICI Prudential Insurance Co. Ltd.
23. Mr Manish Jain, Health Policy Development Manager- India, Johnson & Johnson Medical

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