

**PMRSSM GUIDELINES
ON
CLAIM SETTLEMENT**

1. Guidelines on Claim Settlement

All Empanelled Health Care Providers (EHCP) will make use of IT system of PMRSSM to manage the claims related transactions. IT system of PMRSSM has been developed for online transactions and all stakeholders are advised to maintain online transactions preferably to ensure the claim reporting in real time. However, keeping in mind the connectivity constraints faced by some districts an offline arrangement has also been included in the IT system that has to be used only when absolute. The PMRSSM strives to make the entire claim management paperless that is at any stage of claim registration, intimation, payment, investigation by EHCP or by the Trust/Insurer the need of submission of a physical paper shall not be required. This mean that this claim data will be sent electronically through IT system to the Central/ State server. The NHA, SHA, Insurer (if applicable), and EHCP shall be able to access this data with respect to their respective transaction data only.

Once a claim has been raised (has hit the Central/State server), the following will need to be adhered to by the Trust/Insurance Companies regarding claim settlement:

1.1. Claim Payments and Turn-around Time

The Trust/Insurer shall follow the following process regarding the processing of claims received from the EHCP:

- A. The Trust/Insurer or the agency (IRDAI compliant only) appointed by it shall decide on the acceptance or rejection of any claim received from an EHCP. Any rejection notice issued by the Trust/Insurer or the agency to EHCP shall clearly state that rejection is subject to the EHCP's right to appeal against rejection of the claim.
- B. If a claim is not rejected, the Trust/Insurer shall either make the payment (based on the applicable package rate) or shall conduct further investigation into the claim received from EHCP.
- C. The process specified in clause a and b above (rejection or payment/investigation) in relation to claim shall be carried out in such a manner that it is completed (Turn-around Time, TAT) shall be no longer than 15 calendar days (irrespective of the number of working days). For claims outside the State, a time of 30 calendar days will be provided.
- D. The EHCP is expected to upload all claim related documents within 24 hours of discharge of the beneficiary.
- E. The counting of days for TAT shall start from the date on which all the claim documents are accessible by the Trust/Insurer or its agency.

- F. The Trust/Insurer shall make claim payments to each EHCP against payable claims on a weekly basis through electronic transfer to such EHCP's designated bank account. Insurer is then also required to provide the details of such payments against each paid claim on the online portal (IT System of PMRSSM).
- G. All claims investigations shall be undertaken by a qualified and experienced medical staff/team, with at least one MBBS degree holder, appointed by the Trust/Insurer or its representative, to ascertain the nature of the disease, illness or accident and to verify the eligibility thereof for availing the benefits under this Agreement and relevant Cover Policy. The Trust/Insurer's medical staff shall not impart any advice on any treatment or medical procedures or provide any guidance related to cure or other care aspects. However, the Trust/Insurance Company can ensure that the treatment was in conformity to the Standard Treatment Guidelines, if implemented.
- H. The Trust/Insurer will need to update the details on online portal (IT system of PMRSSM) of:
- i) All claims that are under investigation on a fortnightly basis for review; and
 - ii) Every claim that is pending beyond 15 days, along with its reasons for delay in processing such Claim.
 - iii) The Trust/Insurer may collect at its own cost, complete Claim papers (including diagnostic reports) from the EHCP, if required for audit purposes for claims under investigation. This shall not have any bearing on the Claim Payments to the Empanelled Health Care Provider.

1.2. Penalty on Delay in Settlement of Claims

There will be a penalty for delay in settlement of claims by the Trust/Insurance Companies beyond the turnaround time of 15 days. A penalty of 1 % of claimed amount per week for delay beyond 15 days to be paid directly to the hospitals by the Trust/Insurance Companies. In case of Inter-State claims with respect to portability of benefits, penalty of 1 % of claimed amount per week for delay beyond 30 days to be paid directly to the hospitals by the Trust/Insurance Companies.

1.3. Update of Claim Settlement

The Trust/Insurance Company will need to update the claim settlement data on the portal on a daily basis and this data will need to be updated within 24 hours of claims payment. Any claim payment which has not been updated shall be deemed to have been unpaid and the interest, as applicable, shall be charged thereon.

1.4. Right of Appeal and Reopening of Claims

- A. The Empanelled Health Care Provider shall have a right of appeal against a rejection of a Claim by the Trust/Insurer, if the Empaneled Health Care Provider feels that the Claim is payable. An appeal may be made within thirty (30) days of the said rejection being intimated to the hospital to the District-level Grievance Committee (DGC).
- B. The Trust/Insurer and/or the DGC can re-open the Claim, if the Empaneled Health Care Provider submits the proper and relevant Claim documents that are required by the Trust/Insurer.
- C. The DGC may suo moto review any claim and direct either or both the Trust/Insurer and the health care provider to produce any records or make any deposition as it deems fit.
- D. The Trust/Insurer or the health care provider may refer an appeal with the State-level Grievance Committee (SGC) on the decision of the DGC within thirty days (30) failing which the decision shall be final and binding. The decision of the SGC on such appeal is final and binding.
- E. The decisions of the DGC and SGC shall be a speaking order stating the reasons for the decision
- F. If the DGC (if there is no appeal) or SGC directs the Trust/Insurer to pay a claim amount, the Trust/Insurer shall pay the amount within 15 days. Any failure to pay the amount shall attract an interest on the delayed payment @ 1% for every week or part thereof. If the Trust/Insurer does not pay the amount within 2 months they shall pay a fine of Rs. 25,000/- for each decision of DGC not carried out and Rs. 50,000 for each non-compliance of decision of SGC. This amount shall be remitted to the State Health Agency.