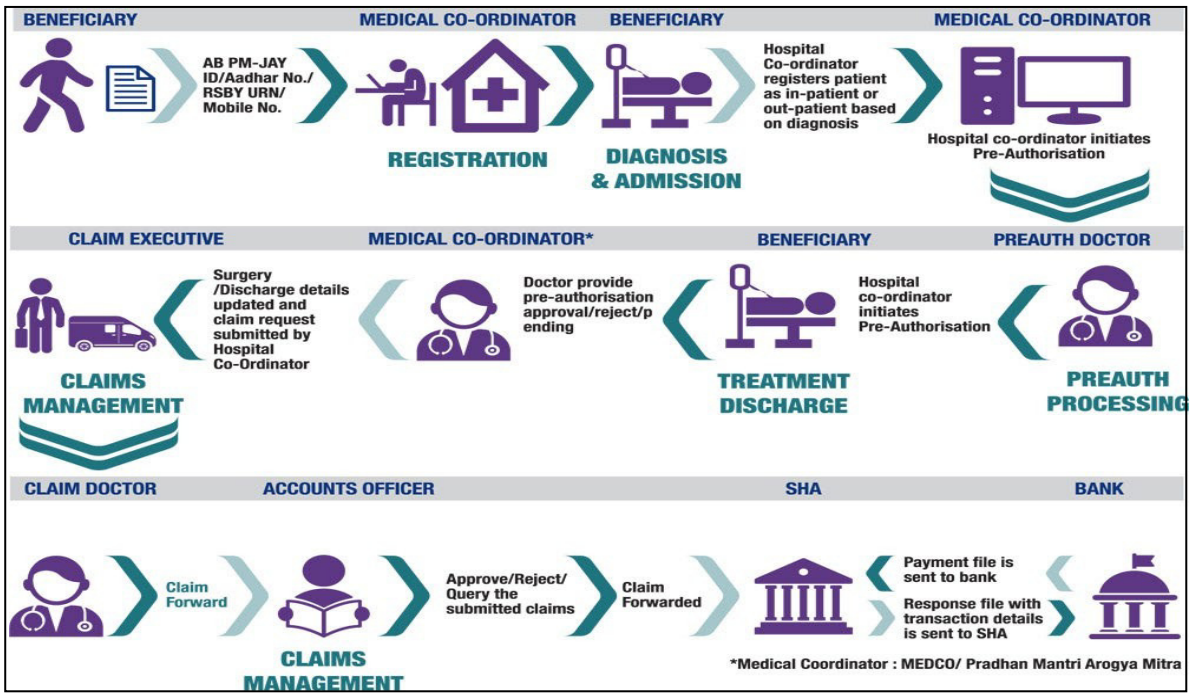
CHAPTER V

Claims Management

5.1 System of settlement of claims of Empanelled Health Care Providers (EHCPs)

PMJAY provides cashless and paperless services for beneficiaries at the point of service. These services include in-patient treatment, medical investigations, etc. After providing treatment/investigations, Empanelled Health Care Providers (EHCPs) upload all the claim related documents in the Transaction Management System (TMS) and submit the claims to State Health Authority/Agency (SHA)/Insurance Company. Thereafter, the SHA/Insurance Company scrutinizes the claims and makes payments to EHCPs. The process of approval of claims is described in **Chart-5.1**.

Chart-5.1: Process flow for Transaction Management System



An efficient and timely system of settlement of claims is the backbone of the Scheme as this is a time bound medical service. A timely and efficient system would ensure the smooth functioning of the scheme.

5.1.1 Claims settled

Transaction Management System (TMS) is an IT application which enables the empanelled hospitals to carry out paperless and cashless transactions by providing services to the beneficiaries of PMJAY starting from registration of beneficiary till payment to the hospital.

Apart from TMS, six States referred as Brownfield States *viz*. **Andhra Pradesh, Arunachal Pradesh, Rajasthan, Karnataka, Maharashtra** and **Tamil Nadu,** which were implementing

their own schemes, use their own IT Platform to process the claims. The data of claims settlement in respect of these States is subsequently fed into TMS through an Application Programming Interface (API).

As per the information given by NHA, 3.57 crore claims amounting to ₹ 42,433.57 crore were settled as of November 2022. Details of claims settled is given in **Annexure-5.1**. Out of these, claims amounting to ₹ 22,619.88 crore (53.30 *per cent*) pertained to the Brownfield States which are sharing the data through API, where the transaction did not capture PMJAY Id of beneficiaries (as detailed in Para 5.8.1). With no segregation of PMJAY beneficiaries in such cases, there is a possibility of overlap of PMJAY with state specific schemes.

5.1.2 Claims under process

As per the Claims-Adjudication-Manual of PMJAY, action has to be taken within 15 days of claim submission for claims within the State and 30 days for claims from outside the State (Portability cases).

As per the information given by NHA, 40.23 lakh claims of EHCPs amounting to ₹ 6,052.47 crore were under process for final decision (approval or rejection) as of November 2022. Details of claims under process for settlement is given in **Annexure-5.1**.

NHA, while accepting the audit observation, stated (August 2022) that the reasons for such delay were lack of human resources, non-performance of ISA/TPA, migration to other mode of implementation (Insurance to trust) etc. NHA further stated that concerted efforts are being made to achieve full bank integration for all the States for timely settlement of claims.

5.1.3 Delay in pre-authorization

In TMS, approvals are required mainly at three stages (i) Pre-authorization, (ii) claim verification, and (iii) claim payment. Claim Adjudication and Payment Manual for the scheme stipulates a Turn-around Time (TAT) of six hours for a pre-authorization approval. However, in cases where a query is raised with the Hospital, another six hours is allotted for the hospital's response.

Data analysis revealed that 39.57 lakh claims (in both API and TMS tables) took more than the specified 12 hours for approval of pre-authorization. Details in **Annexure-5.2**.

NHA replied (August 2022) that a preauthorisation case which is pending with the hospital for query response cannot be processed further until the hospital responds to the query. Thus, six hours TAT is not applicable for the hospitals. The working hours are defined as 11:00 AM to 06:00 PM. The auto approval is triggered if six hours within the working hours are consumed. Therefore, pre-authorization approval time is within six hours as per the approved calculation of period.

Audit is of the opinion that delay in pre-authorisation may lead to denial of health care benefit to eligible beneficiaries in time.

5.2 Excess payment of ₹ 57.53 crore to EHCPs

Audit noted that in four States, **Andhra Pradesh, Madhya Pradesh, Punjab** and **Tamil Nadu** excess payment amounting to ₹ 57.53 crore were made to the EHCPs as discussed below:

In **Andhra Pradesh**, the SHA is providing free health care services through a network of Hospitals and the rates for each package was fixed. On scrutiny of the claims data, it was noticed that the SHA approved 20,354 claims with higher package rates and made excess payment of ₹ 19.12 crore to the Hospitals. Further, PMJAY guidelines do not allow booking of surgical and medical packages at the same time. It was seen that claims amounting to ₹ 4.63 crore were made for medical procedures in addition to surgical procedures and approved by SHA in full, resulting in excess payment of ₹ 4.63 crore.

NHA in its reply stated that many States have added new packages or have altered the cost of package as per the State specific needs.

The reply is to be viewed from the fact that the Claim Adjudication Manual of PMJAY does not allow booking of surgical and medical packages at the same time and SHA cannot pay higher package rate than that fixed by NHA.

In **Madhya Pradesh**, 25 hospitals submitted claims twice in respect of 81 patients (162 claims) for various surgical procedures during the same length of stay (LoS). SHA paid the full amount for both claims as against the prescribed rate of 50 *per cent* payment on second claim[24] which resulted in over-payment of ₹ 29.61 lakh to EHCPs. The SHA also made double payment of ₹ 3.27 lakh to 13 hospitals which submitted claims twice in respect of 35 patients for caesarean delivery during same length of stay.

NHA accepted (August 2022) the audit observation.

In **Punjab,** in 13 cases, an amount of ₹ 21.26 lakh was paid to the empanelled hospitals by SHA against admissible payment of ₹ 13.35 lakh resulting in excess payment of ₹ 7.91 lakh.

In **Tamil Nadu**, (i) Settlements of claims by SHA amounting to ₹ 18.53 crore were made for 5,990 URNs[25] (Unique IDs) which were not available in the beneficiary database, (ii) Hospital claims amounting to ₹ 14.84 crore were settled by the SHA for 3,310 State Government pensioners' families which were not eligible under the PMJAY. This resulted in excess payment of ₹ 14.84 crore to the Hospitals, and (iii) In 15 cases, claim settlement was

[24] In case of multiple surgical procedure in OT session, procedure with highest rate shall be reimbursed at 100 *per cent*, second at 50 *per cent* and subsequent procedures at 25 *per cent* of package rate.

[25] Health card's Unique Request Numbers

made twice for the same treatment by SHA which resulted in duplicate claims settlement amounting to ₹ 0.61 lakh.

NHA, in its reply (August 2022), assured that it would look into the matter and get the fact verified by the insurance coordinator in the empanelled hospitals. NHA further stated that the database had now been cleaned and the cases were from the earlier period.

Thus, lack of adequate internal controls and absence of checks in the application resulted in extra expenditure on the part of SHAs.

5.3 Utilization of claim amount by Public/Government Hospitals

All public hospitals empanelled under PMJAY to provide in-patient services to the eligible beneficiary families are reimbursed by the insurance companies/trusts for the services rendered by them as per package rates under PMJAY as claim amount.

Deemed empanelment under the PMJAY provides Government hospitals an opportunity to mobilise and independently manage revenues earned through claims (hereinafter referred to as "claim revenues") for treatment provided to PMJAY beneficiaries.

Claim revenues earned under PMJAY by Government hospitals are credited directly into the bank accounts of the hospital-level entities such as Rogi Kalyan Samiti (RKS) or Hospital Development Societies/Committees or other specific hospital-level entities tasked with this role.

The Government hospital may use the PMJAY claim revenues as per the indicative categories and allocation shares mentioned in **Table-5.1** below:

Table-5.1: Indicative categories and allocation shares for use of claim revenues

Indicative items where PMJAY claim revenues may be used (Expenditure categories)	Allocation shares in percentage
Staff incentives	15
Human Resources: Salaries for personnel recruited primarily for PM-JAY in the hospital	15
Medicines, consumables, and pathology/radiology tests	40
Hospital upgradation & Quality Improvement	20
Administrative expenses	10

SHAs have the flexibility to determine their expenditure categories and allocation shares as per their requirements. States may opt for anywhere from three to seven expenditure categories, with fewer categories implying greater flexibility but potentially less clarity for hospitals.

Discrepancies in various States relating to utilization of claim amount earned by the Public/Government Hospitals under the scheme are discussed in succeeding paragraphs.

Audit observed that despite earning a claim amount of ₹ 9.12 lakh for treatment of PMJAY patients up to March 2021, no expenditure had been incurred therefrom, till October 2021 in **Andaman & Nicobar Islands**. In case of **Andhra Pradesh**, in test checked hospitals, it was observed that the claim amount received was either used for inadmissible purposes or kept idle.

In **Assam**, it was observed that (i) one hospital (Dr. B. Borooah Cancer Institute, Guwahati) adjusted the entire amount received against the treatment provided to the PMJAY beneficiaries in the budget of the hospital. As such, incentive to the staff, contribution towards Infrastructure, Arogya Nidhi, and Hospital Management Society etc. has not been paid, (ii) six hospitals have not paid any incentive to their staff as of March 2021.

In **Bihar**, information in respect utilization of claim amount by Public Hospitals was provided by Bihar Swasthya Sewa Samiti (BSSS) only in respect of 2019-20. Audit observed that claims amounting to ₹ 63.85 crore were released to 530 public hospitals during the financial year 2019-20 by SHA out of which only 86 hospitals (16 *per cent*) submitted expenditure report for ₹ 3.50 crore to BSSS as of August 2021. Further, scrutiny of information provided in respect of utilization of claim by selected public hospitals under sampled districts for the year 2018-21 disclosed (i) less/more amounts of claim spent on development of infrastructure facilities, and (ii) No expenditure was incurred for incentive to medical and paramedical team.

Nearly no expenditure was incurred on Hospital up-gradation and Quality Improvement as well as no incentive was paid to medical staff in **Chandigarh**, **Jammu and Kashmir**, **Rajasthan**, **Uttar Pradesh** and **Uttarakhand**.

In **Uttarakhand**, NHA directed that claim amount received by Public Hospitals empanelled under AB-PMJAY shall be utilized as incentive to hospital-staff (25 *per cent*) and the remaining amount can be utilized for improving the over-all infrastructure.

Audit observed that till 31 March 2021, SHA retained ₹ 4.65 crore which was not utilised for the purpose specified in the guidelines.

In **Punjab** and **Rajasthan**, committee for utilization of claim on development of Infrastructure of public hospitals and for giving incentive to medical staffs was not formed and nodal officer was not aware of guidelines issued in this regard.

SHA **Gujarat** instructed (November 2018) that a committee may be formed in the public hospitals for deciding the distribution of incentives amongst the hospital staff involved in the procedures. Audit observed that in five[26] out of 10 district hospitals visited, no committee had been formed by the public hospitals for deciding the distribution of the incentives amongst the hospital staff involved in the procedures and, thus, no incentives had been distributed to the staff in these Districts. The percentage of distribution of incentives by the remaining five district hospitals ranged from 1.12 *per cent* (Devbhoomi Dwarka) to 14.60 *per cent* (Bharuch) against the stipulated 25 *per cent* of the claim amount. Audit observed that Government hospital, Bharuch distributed the incentive amount to PMJAY staff (Arogya Mitra/MEDICO and RMO of the hospital) and not to medical/para-medical/non-medical staff who are instrumental for the success of the scheme as they are involved in procedure/treatment of the patients.

In **Ladakh**, as per the guidelines for implementation of PMJAY in public hospitals of **Jammu** & **Kashmir** regarding utilization of claim revenue in the hospitals, the same is to be divided into three heads namely RKS share (75 *per cent*), Incentive share (20 *per cent*) and SHA share (5 *per cent*). The status of utilization of claim revenue (till March 2021), for the three selected hospitals for **Ladakh** is given in **Table-5.2**.

Table-5.2: Status of utilization of claim revenue

EHCP	Claim Settled (in ₹)	RKS Share (in ₹)	Incentive Share (in ₹)	SHA share (in ₹)
SNM Hospital	1331792	486861 (36.56%)	142317 (10.68%)	0
CHC Sankoo	14974	0	0	0
DH Kargil	822340	820817 (99.81%)	0	0

From the above, it is clear that the public hospitals have not been utilizing the claim revenue in line with the guidelines prescribed for the same. Further, Audit noted that no clear guidelines have been framed for utilization of RKS share by EHCPs for infrastructure development and for usage of SHA share by SHA.

In **Madhya Pradesh**, out of the selected 26 public hospitals, 19 hospitals either did not utilize or utilized only one to 25 *per cent* of amount so earned.

In **Maharashtra**, the Public Health Department, Government of Maharashtra issued (January 2019) instructions for utilisation of claim amount received by Government hospitals. As per the instruction, 25 *per cent* of the claim amount received was to be remitted to Government account, 20 *per cent* to be used as incentive to treating doctors and staff,

[26] Banaskantha, Botad, Morbi, Sabarkantha, Surat.

three *per cent* was required to be used for outsourcing the work of claim processing and 52 *per cent* for meeting any emergency expenditure.

Out of total ₹ 80.58 crore received as claim revenue, ₹ 20.14 crore (25 *per cent*) was not remitted to Government account, no incentive was granted to doctors and medical staffs. Further, 12 hospitals incurred an expenditure of ₹ 7.81 crore for meeting emergency expenditure without the approval of the committee.

In **Nagaland**, the hospital made an expenditure of ₹ 7.50 lakh against repayment of capital loan and also hospitals did not submit reports of utilization of funds to the SHA.

In **Manipur**, claim amount was utilized either on payment to pharmacies for supply of medicines or reimbursement to beneficiaries for purchase of medicines.

In **Meghalaya**, as per the guidelines issued by the NHA (May 2020) for 'Use of claim amount earned by public hospitals, 70 *per cent* of the claim amount should be used for infrastructure up-gradation while 30 *per cent* for incentive of staff'.

Out of the ₹ 52.56 crore available, an amount of ₹ 9.57 crore (18 *per cent*) was utilized towards reimbursement to beneficiaries and for payment of pharmacy bills for medicines & diagnostics, which was not to be provided by the public hospitals. ₹ 5.18 crore (10 *per cent*) was utilised towards incentive payment of staff against stipulated 30 *per cent*. An amount of ₹ 0.76 crore (Two *per cent*) was diverted to two hospital accounts. An amount of ₹ 18.02 crore (35 *per cent*) was utilized for medicines/equipment purchase, COVID expenses, repair & maintenance, etc. while, ₹ 19.03 crore (35 *per cent*) remained unutilized as on 31 March 2021.

In Mizoram, hospital share of the claims amount was deposited into the common bank account of Rogi Kalyan Samiti and the hospital did not maintain separate cash book, vouchers etc. for utilization of claims amount under PMJAY. Thus, audit could not verify the expenditure incurred specifically under the claims amount of PMJAY. No incentive was given to the medical staff by public hospitals from the claim amount.

In **Puducherry**, 11 Public/Government Hospitals had received ₹ 2.37 crore of claim revenue earned from the medical services rendered to PMJAY beneficiaries. Out of these, six hospitals did not utilize the claim revenue, while the remaining five hospitals utilized claim revenue ranging from 6 per cent to 52 *per cent* only.

In **Tripura,** during 2018-2021, hospitals received ₹ 778.56 lakh as claim amount from SHA and ₹ 12.48 lakh as interest from bank. An expenditure of ₹ 534.13 lakh was incurred by the selected hospitals during the period covered by audit.

Thus, the Public/Government Hospitals failed to adequately tap the feature of PMJAY that enables them to utilize the reimbursed claims for improving the overall infrastructure, functioning of the hospital, quality of services and delivery of services etc.

NHA, while accepting the audit observation, stated (August 2022) that from time-to-time NHA issues guidelines for effective utilization of such funds by Public Hospital. NHA has been encouraging SHAs to ensure that the funds released to the public hospitals are used for the purpose of improved infrastructure and better amenities for the beneficiaries.

5.4 Private Hospitals performing procedures reserved for Public Hospitals

PMJAY guidelines mandate reservation of a list of procedures to be performed only in Public Hospitals. In HBP 1.0 (Health Benefit Package), 124 packages were reserved for treatment in Government hospitals and in HBP 2.0, 180 packages have been reserved for treatment in Government hospitals. However, audit noticed instances of violation of this in some of the States as outlined in the succeeding paragraphs.

Andhra Pradesh reserved 133 packages (June 2018) exclusively for public hospitals. However, 123 of these 133 packages were allowed in Private Teaching Hospitals. Audit noted that private hospitals performed procedures in 458 cases involving packages reserved for public hospitals and claims amounting to ₹ 1.37 crore were approved and paid by the Trust.

Referral Guidelines issued by SHA, **Punjab** in August 2020 allowed 25 Government reserved packages for treatment in private empanelled hospitals. Analysis of TMS database with HBP 1.0 and HBP 2.0 relating to **Punjab** showed that in 1080 cases, packages reserved for Government empanelled hospitals were booked by the private empanelled hospitals against which payment of ₹ 3.61 crore was also made to private empanelled hospitals in contravention of the provisions.

NHA stated (August 2022) that during COVID period many public hospitals were designated as COVID Care facility hence many States had temporarily opened Public reserved packages for the Private Hospitals.

5.5 Delay in submission of claims

The Claim Adjudication Manual Guidelines (applicable from May 2020 to September 2020) prescribe that claim documents should be uploaded/submitted by private hospitals as soon as possible but not later than seven days post discharge of patient. If claim documents are uploaded after seven to 21 days of discharge, approval of Chief Executive Officer (CEO) of

SHA must be obtained before settlement of claims and, thereafter, claims of hospitals are not admissible.

With effect from October 2020, the guidelines relaxed the time limit and allowed private hospitals to get approval of CEO, SHA if claim documents were uploaded between 21 days to 45 days post discharge of patients and after 45 days, claims of hospitals were not to be admitted. In case of public hospitals, claim documents uploaded after 60 days of discharge of patients are not admissible. Delays in claim submission invites non-standard settlement of the claim with the reduction in claim payable amount by 0.1 *per cent* per day for each day of delay beyond seven days from the date of discharge. The cases of delay in submission of claims by hospitals are discussed in the succeeding paragraphs.

In **Jharkhand**, (i) EHCPs have uploaded the claims after the stipulated time but the Insurance Company paid ₹ 1.66 crore to the EHCPs without obtaining approval from the CEO, SHA, (ii) In 3,460 cases, public hospitals received payment of ₹ 1.45 crore without obtaining approval of SHA though they had submitted/uploaded the claim documents with delay ranging from one day to 108 days beyond the prescribed time limit of 60 days of discharge.

In **Ladakh**, claims in 160 cases were initiated by test checked hospitals 16 to 504 days after the turn-around time (TAT) of 15 days.

In **Rajasthan**, 3,796 claims were not submitted by 288 hospitals within the prescribed time; however, the entire claim amount of ₹ 1.26 crore was paid to them without imposing any penalty.

In **Tamil Nadu**, in 170 cases, the delay in submission of claim was more than 300 days.

In 51 cases in **Tripura**, claims amounting to ₹ 9.39 lakh were submitted by the private hospitals beyond 45 days of discharge and payment made to the hospitals. Further, in 1,628 cases, claims amounting to ₹ 1.12 crore were submitted beyond 60 days of discharge (ranging from 60 to 353 days) of the beneficiaries but, payment was made to the hospitals which was inadmissible.

In **Uttar Pradesh**, 726 claims amounting to ₹ 1.14 crore were rejected by the SHA on grounds of late submission (*range of delay was up to 685 days*) of claims. On the other hand, 2,04,654 claims amounting to ₹ 201.55 crore which were also submitted late (*range of delay was one day to 831 days*) were approved by the SHA which shows inconsistency in adherence to prescribed guidelines in approval of claims.

NHA, while accepting the audit observation, replied (August 2022) that shortage of required human resources to raise and submit the claims within prescribed timelines and deployment of resources in COVID management led to delay in submission of claims.

5.6 Processing of claims in death cases

As per the PMJAY Guidelines, every death occurring in EHCP should have a mortality report prepared by the hospital. Each EHCP should submit a mortality report to SHA at the time of claims submission within seven days. State Mortality and Morbidity Committee conducts desk/ field mortality audit of all mortality cases. If it is observed that the death occurred due to negligence or mortality audit has significant findings, suitable action is required to be taken against the hospitals and claim amount is to be withheld till satisfactory explanation received and reviewed by SHA.

In **Gujarat**, mortality reports of death cases (1,547) were not available on records in SHA and number of mortality audits (death review) done by State Mortality and Morbidity Committee was also not available with SHA. Further, Civil Hospital, Ahmedabad, has not submitted mortality reports for 128 death cases that had occurred in the hospital and thus, claim amount of ₹ 40.03 lakh was yet to be settled.

NHA stated (August 2022) that the State has confirmed that it has already paid the hospital; however. since uploading of UTR was pending, cases are shown as pending for settlement. The reply is not acceptable as NHA has not provided any document or evidence for it.

In **Uttarakhand,** payment of ₹ 15.35 lakh was made without receiving death summary from the hospitals in 120 cases. Death certificate and cause of death was also not mentioned.

NHA stated (August 2022) that all death cases are processed by CPD/ISA as per guidelines and if any case is found with deficiency in documents during post claim audit, then same is rejected by SHA. However, the reply has not addressed the audit observation.

5.7 Inadequate Validation checks

Data validation refers to the process of ensuring the accuracy and quality of data. It is implemented by building several checks into a system to ensure the logical consistency of input and stored data. The inadequate validation checks such as admission before pre-authorization, transaction before inception of the Scheme, surgery after discharge of patient, payment prior to submission of claims, non-availability/invalid dates and other entries etc. noted during the course of audit at SHAs are tabulated in **Table-5.3**.

Table-5.3: Inadequate Validation checks

Sl. No.	State	Error	Amount Involved	Comment
1.	Assam	Transaction before inception of Scheme	3.06 lakh	Date of payment was prior to the inception of Scheme in 59 cases.
		Payment prior to submission of claim.	4.70 lakh	Claim was paid prior to claim submission date in 70 cases.
		Date of approval of claim is nil.	2.68 crore	Date of approval of claim is nil in 1,908 cases.
		Surgery after discharge of patient	7.03 crore	Date of surgery was after the date of discharge in 6,663 cases.
		Claim paid amount less than claim approved amount	6.89 crore	-
		Claim paid prior to claim approval	0.07 crore	-
2.	Haryana	Non-availability of certain crucial dates	-	Non-availability of certain crucial dates was also noted in TMS platform *viz.* admission date, discharge date, pre-authorization date, claim submission date and claim approval date were marked as 'Null' in 56,702 cases in the State.
3.	Jammu & Kashmir	Incorrect household IDs	3.76 lakh	System is unable to detect incorrect household IDs while processing the claims.
		Treatment before disabling of card	3.89 crore	17,458 card holders availed treatment before disabling of cards and claim amount of ₹ 388.98 lakh was approved against 12,633 disabled cards mainly due to non-conducting of periodic review of verified cards in a time bound manner by SHA J&K.
		Treatment on disabled card	5.51 lakh	₹ 5.51 lakh was approved against 241 disabled cards indicates lack of auto rejection of claims in the system against disabled cards.
4.	Jharkhand	Invalid/null entries in patient age column	17 lakh	EHCPs have treated 150 cases in which the patients having invalid or null entries of age. EHCPs have not taken care during admission/registration of patients due to which claim amount of ₹ 17 lakh paid for the above-mentioned irregularities
5.	Ladakh	Non-availability of certain crucial dates	-	Date of discharge of patient from the hospital was not available in 15 cases.
6.	Madhya Pradesh	Non availability of certain crucial dates	-	1,32,836 claims had either date of pre-authorization or date of admission as `NULL` in TMS database. Also, 1,66,193 claims amounting to ₹ 0.11 lakh had either date of initiation of pre-authorization or date of approval

Sl. No.	State	Error	Amount Involved	Comment
				of pre-authorization as `NULL` in TMS database.
		Admission before pre-authorization initiation date	-	Beneficiaries were admitted before approval of pre-authorization in 16,643 claims after that it was rejected
7.	Maharashtra	Data of discharge earlier than date of admission/pre-authorization	-	3,231 records (233 EHCPs) were found where the date of discharge was before either the date of admission to the hospital or the date of surgery/therapy in the EHCP.
8.	Punjab	Follow-up of triggers raised by NHA on TMS	-	NHA raised 995 triggers on account of suspicious activities under TMS database. Final action against 775 triggers had been taken by the SHA, and action on 220 triggers is still under process.
		Patient unique id in TMS database not found in the BIS	6.32 lakh	In 29 cases the card number (PMRSSM_ID) in TMS database did not match with PMRSSM_ID of the beneficiaries in BIS database whereas the Household ID (HHID) of these beneficiaries matched in both the databases. The claim amounting ₹ 6.32 lakh was also paid to the hospitals in these cases.
9.	Rajasthan	System allowing date of payment earlier than date of claim submission and date of pre-authorization at a later date than the date of discharge	-	Results of data analysis (performed on 8 January 2022) revealed that the date of claim submission was later than the date of claim payment for 281 claims, amounting to ₹ 0.21 crore and that 942 claims were submitted before patients' discharge, of which 803 claims (₹ 0.47 crore) were paid. Further, data analysis (performed on 3rd January 2022) revealed that in 15,530 claims (0.85 *per cent*) out of 18,30,487, pre-authorization was done at a later date than the discharge date. Moreover, 12,826 claims (82.59 *per cent*) amounting to ₹ 12.48 crore out of these 15,530 claims were paid.
		Patients aged above 18 years were provided treatment under 'Paediatrics Speciality' packages	18.16 crore	-
		Transaction ID of patient in normal admissions	5.13 crore	Transaction ID of patient in normal admissions was not generated on the date of admission in 15,100 processed claims, out of which, 12,072 claims (79.95 *per cent*) were paid.

Sl. No.	State	Error	Amount Involved	Comment
		Transaction ID (TID) of patient in emergency admissions	₹ 0.09 crore	Transaction ID (TID) of patient in emergency admissions was not generated within 72 hours from the time of admission in 185 processed claims, Out of which, ₹ 0.09 crore for 158 claims (85.41 *per cent*) had been paid
		Cancellation of TID generated in the TMS.	-	11,96,869 TIDs were generated (Patients Enrolled) in normal admission, out of which, 1,05,240 (8.79 *per cent*) TIDs were cancelled due to non-selection of package in the TMS.
10.	Tamil Nadu	Data of discharge earlier than date of admission/pre-authorization	-	In 11,779 records out of 16,73,504 records, date of pre-authorization was after the date of discharge
		Reduction in package cost without valid reasons-loss of insurance claim amount	4.38 lakh	In Coimbatore Medical College, the claim amount settled by insurer was less than the approved package cost for three procedures. Reduction of claim amount for approved package resulted in loss to the Government hospital.
11.	Uttar Pradesh	Data of discharge earlier than date of admission/ pre-authorization	-	In 57,476 cases pre-authorization was done after the date of discharge. Out of which in 49,682 cases (86.44 *per cent*) payment amounting to ₹ 1,543.28 lakh was also made.

NHA accepted (August 2022) the audit observations.

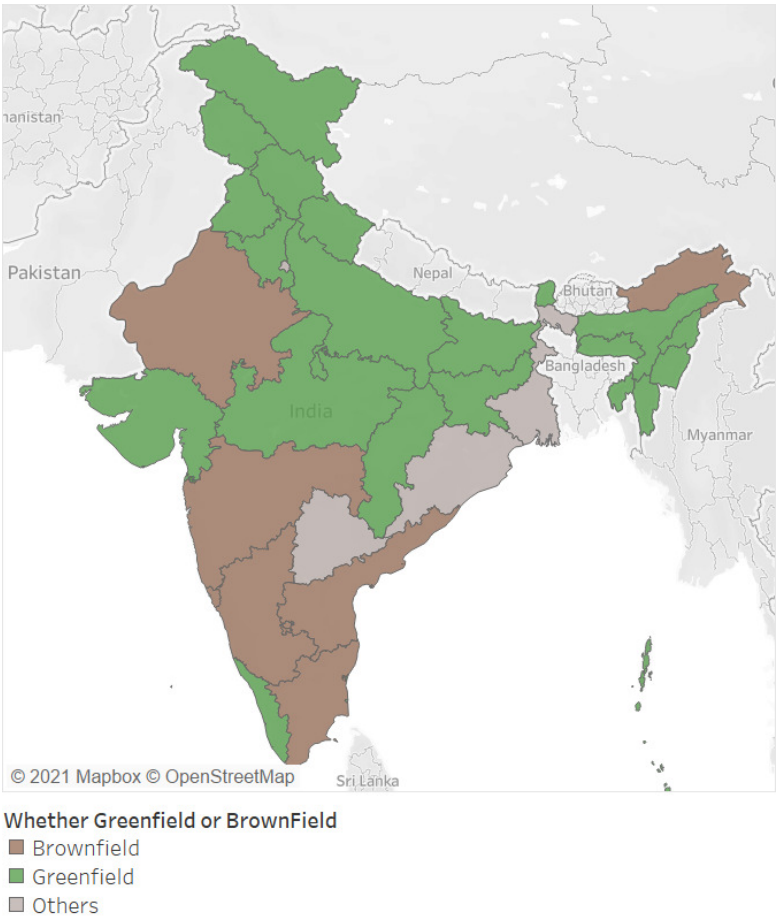
5.8 Deficiencies in claims processing and settlement system

With respect to claims processing and settlement system (TMS as well as API), following irregularities were noted as detailed in succeeding paragraphs. These observations are the result of data analysis done at NHA during the month of July 2022.

5.8.1 Non usage of common format for maintaining the data by State specific IT Platform

As stated, there are a few brownfield States, *i.e.* States where beneficiary data is not kept by NHA and these States share the data with NHA through external systems as shown in the following map.

As per data available with NHA, as of July 2021, six States were sharing data with NHA through external systems (APIs), as listed below:



1. Andhra Pradesh
2 Arunachal Pradesh
3 Rajasthan
4 Karnataka
5 Maharashtra
6 Tamil Nadu

In addition to the above States, **Assam** also used its own IT system till 31 March 2020 and therefore transactions for that period in respect of Assam were available in API table only. None of these transactions captured PMJAY id of beneficiaries claiming the benefit in these brownfield States and instead another system generated (or State specific patient ID) was available. Master data of any of these patient IDs was not being maintained and available in NHA. In the absence of this master data (in Beneficiary Identification System or otherwise), audit could not ascertain how the terms and conditions of the Scheme were being monitored in these States by NHA. It was also not clear as to how States segregated these claims into State-specific schemes and PMJAY for submission of Utilization Certificates. Further, audit could not ascertain how these brownfield States were allowing the benefit of the Scheme to patients belonging to other States (portability cases as admissible under PMJAY). In fact, data analysis revealed that value of portability-flag field was null (not available) in respect of all claims/transactions available in API table.

NHA accepted (August 2022) the audit observation and stated that API integration has been completed with most of the States. However, the issue of intermittent loss of data is being addressed for more reliable data transfer.

5.8.2 Inadequate pre-validation control on data captured through TMS/API (States specific IT Platform)

TMS/API capture records with respect to claims submitted by EHCP for online processing and settlement. The records consist of data such as patient number, case number, card number, patient age, patient gender, patient state-code, admission date, surgery date,

discharge date, claim submission amount, claim approved amount, claim paid amount, etc. along with attachment option for scanned copy of discharge bill/summary.

A robust system should not accept data in any particular field which is logically not possible or which is beyond PMJAY defined criteria. For example; date of surgery should be before date of discharge or date of discharge should be after date of admission, etc. Such invalid/illogical entries would reduce the reliability of data thus resulting in false disclosure of transitions.

However, during analysis of claim settlement data, various discrepancies were observed which are discussed in succeeding paragraphs:

5.8.2.1 Invalid dates of admission/pre-authorization/claim processing

Audit noted that several transactions were available in the API systems where date fields related to crucial information were invalid, *i.e.* either before scheme inception date or after current date. State-wise details are given in **Table-5.4**.

Table-5.4: Invalid dates captured through API

State	Number of invalid dates					
	Admi-ssion date	Discharge date	Pre-authorisation initiation date	Pre-authorisation approval	Claim submission	Claim approval
Arunachal Pradesh	4	4	2	2	-	-
Assam	15	7	-	-	-	-
Karnataka	77	14,888	4	6	4	
Maharashtra	-	6,140	-	-	-	-
Tamil Nadu	334	19,958	526	208	119	489
Total	**430**	**40,997**	**532**	**216**	**123**	**489**

NHA accepted the observation and stated (August 2022) that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.2 Non-availability of certain crucial dates

Similarly, several crucial dates were left blank/not available in the data shared with NHA. In all of these records, it was further ascertained that amount paid on these claims was not null. Details are given in **Table-5.5**.

Table-5.5: Non availability of certain crucial date

State	Dates not available (in number)			
	Pre-authorization initiation date	Pre-authorization approval	Claim submission	Claim approval
Andhra Pradesh	23,973	19,298	26,961	33,656
Assam	4	6	16	72
Karnataka	2,532	6,421	4,260	80,469
Maharashtra	7,951	8,030	7,103	7,525
Tamil Nadu	1,800	2,066	985	1,381
Total	**36,260**	**35,812**	**39,325**	**1,23,103**

In addition to above, NHA had provision of capturing 'date of death', in case where any patient dies during treatment. In such cases, date of discharge is not captured. In API table, date of death was left blank in all the cases, indicating that brownfield States are not capturing this crucial piece of information.

NHA accepted the observation and stated (August 2022) that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.3 Date of surgery after date of discharge of related patient

In 2,25,827 cases, even the simplest of validation rules were not built into the API system, which resulted in claims being paid in cases where date of surgery was later than discharge of that patient from the hospital. State-wise details are given in **Table-5.6**.

Table-5.6: Date of surgery after date of discharge

(Amount in ₹)

State	No. of Claims	Amount paid on these claims
Andhra Pradesh	2	28,602
Arunachal Pradesh	41	4,06,050
Assam	26,425	12,75,48,124
Karnataka	19,223	6,41,95,947
Maharashtra	1,79,584	3,73,08,27,276
Tamil Nadu	552	46,19,030
Total	**2,25,827**	**3,92,76,25,029**

NHA accepted the audit observation and stated (August 2022) that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.4 Invalid and null entries in patient age column

Patient age field in API table was not correctly mentioned in the database. State-wise details are given in **Table-5.7**.

Table-5.7: Invalid patient age

State	Patient Age (in years)			Total
	0 or Null	100 to 139	259	
Andhra Pradesh	37,602	7	0	37,609
Arunachal Pradesh	1	0	0	1
Assam	196	54	2	252
Maharashtra	46,688	6	0	46,694
Total	**84,487**	**67**	**2**	**84,556**

Similar error was also noted in TMS. It is evident from the above that both systems namely API and TMS lack proper validation controls to prevent suspicious entries in the age column in the system.

NHA accepted the observation (August 2022) and assured to incorporate the necessary validation in the system.

5.8.2.5 Admission before pre-authorization initiation date

Audit noted that in several claims date of admission was earlier than pre-authorization initiation date in TMS system. State-wise details are given in the **Table-5.8**.

Table-5.8: Admission before pre-authorization date

State/UT	Number of Claims where date of admission earlier than date of pre-authorization initiation	Number of Claims where date of pre-authorization approval earlier than date of pre-authorization initiation
Andaman & Nicobar Island	182	Not Available
Gujarat	34,409	3
Madhya Pradesh	305	55
Kerala	1959	Not Available

NHA stated (August 2022) that back-date of admission is allowed in system for various operational reasons. Currently pre-authorization can be raised within 3 days of actual date of admission in case of private hospital and in five days for public hospitals.

5.8.2.6 Date of discharge earlier than date of admission

Audit noted that in 45,846 claims in the API system, date of discharge was earlier than date of admission of these patients. State-wise details are given in the following **Table-5.9**.

Table-5.9: Date of discharge earlier than admission date

(Amount in ₹)

State	Count of Claims	Amount paid on these claims
Assam	21	2,74,842
Karnataka	19,223	6,41,95,947
Maharashtra	26,049	15,58,71,719
Tamil Nadu	552	46,19,030
Total	**45,845**	**22,49,61,538**

NHA accepted the audit observation and stated (August 2022) that the data validation in API has been relaxed in order to capture maximum data without rejecting them. It has also assured that data sharing through API is being streamlined and necessary validation will be put in place to avoid such inconsistencies.

5.8.2.7 Admission of same patient in multiple hospitals during same hospitalization period

Scheme provides a cover of ₹ five lakh per family per year for secondary and tertiary care hospitalization across public and private empanelled hospitals in India. Out-patient care/treatment is, however, not covered under PMJAY.

Data analysis during desk audit (July 2020) revealed that the IT system (TMS) did not prevent any patient from getting admission in multiple hospitals during the same period of hospitalizations. NHA, while acknowledging the lapse, stated (July 2020) that primarily these cases arise in scenarios where a baby is born in one hospital and shifted to neo-natal care in another hospital using PMJAY ID of mother.

However, illustrative[27] data analysis revealed that 78,396 claims of 48,387 patients were initiated in TMS where date of discharge of these patients for earlier treatment was later than admission date for another treatment of the same patient. Contrary to the claim of NHA, these patients included 23,670 male patients. These claims pertained to 2,231 distinct hospitals. State-wise details are given in **Annexure-5.3**.

Highest number of cases were noted in the States such as **Chhattisgarh, Gujarat, Kerala, Madhya Pradesh** and **Punjab** and lowest number of cases were noted in **Daman and Diu, Goa, Karnataka, Puducherry** and **Tamil Nadu**.

Successful payment of such claims further indicates lapses on part of SHAs in processing the claims without even verifying the requisite checks therein.

[27] For cases where admission date pertained to period between 1 January 2021 and 31 March 2021.

NHA stated (August 2022) that the observation is primarily due to non-synchronization of date and time of computer, cases of neo-natal babies, recording of pre-authorization after the date of admission.

Audit is of the opinion that the TMS should be able to synchronize the date and time first and only then accept any entry. Regarding the contention about neo-natal cases, it is reiterated that there are cases of male patients also.

5.8.2.8 Treatment of a beneficiary shown as 'died' during earlier claim/treatment

Guidelines[28] for payment of claims submitted by hospitals provide different payment structure for 'mortality' cases. These further stipulate that if death of the patient happens after admission in hospital and before discharge, payment to the hospital is done after audit of such cases. These three dates, as the case may be, are captured in TMS. During desk audit (July 2020) audit had earlier reported to NHA that the IT system (TMS) was allowing pre-authorization request of same patient who was earlier shown as 'died' during her/his earlier treatment availed under the scheme. NHA, while acknowledging the audit comment, stated in July 2020 that necessary check(s) have been put in place on 22 April 2020 to ensure that PMJAY ID of any patient who has been shown as died in TMS is disabled for availing further benefit under the scheme.

However, audit noted that patients earlier shown as 'died' in TMS continued to avail treatment under the Scheme. Data analysis of mortality cases in TMS revealed that 88,760 patients died during treatment specified under the Scheme. A total of 2,14,923 claims shown as paid[29] in the system, related to fresh treatment in respect of these patients.

Audit further noted that in 3,903 of above claims amounting to ₹ 6.97 crore pertaining to 3,446 patients were paid to hospitals. State-wise details are given in **Annexure-5.4**.

Maximum number of such cases were observed in **Chhattisgarh, Haryana, Jharkhand Kerala** and **Madhya Pradesh** and minimum number of cases were observed in **Andaman & Nicobar Islands, Assam, Chandigarh, Manipur** and **Sikkim**.

Similarly, as reported in the desk audit report, audit noted that the TMS was not only allowing initiation of pre-authorization request for beneficiaries already shown as dead in the system but was also allowing all other entries such as admission date, surgery date and discharge dates.

---

[28] Claim Adjudication and Payment Manual

[29] Amount of Claim payment is greater than 0

NHA stated (August 2022) that back-date of admission is allowed in the system for various operational reasons. Currently, pre-authorization can be raised within three days of actual date of admission in case of private hospital and in five days for public hospitals.

The reply is not tenable, as pre-authorization initiation, claim submission and final claim approval by ISA[30]/SHA for beneficiaries already shown as died during treatment earlier, indicate flaws in application and make it susceptible to misuse at user levels. NHA as well as SHA should ensure a comprehensive investigation of all cases to obviate the risk of irregular payment and malfeasance.

5.8.2.9 Number of patients admitted to hospitals exceeded declared bed strength of that hospital

During desk audit we reported that the system (TMS) allowed both pre-authorization requests and admissions of patients simultaneously, at any given point of time by any hospital empanelled in the PMJAY system, counting more than its declared/updated bed strength. To illustrate, audit noted that there were 195 such hospitals (103 private and 92 public hospitals) which allowed beneficiaries more than their declared bed strength during the month of January 2020. NHA, in its reply dated July 2020 had stated that National Anti-Fraud Unit (NAFU) had a trigger which is raised when any hospital exceeds its bed strength. Reasons may include cases of day care procedures such as cataract, hemodialysis, chemotherapy, etc.

Data analysis of claims of patients admitted during January 2021 to March 2021 excluding day care cases[31] revealed multiple cases in 224 hospitals where declared bed strength exceeded on at least one day during the period (Jan-Mar 2021). State-wise list of such hospitals is given in **Annexure-5.5**.

NHA stated (August 2022) that in respect of Public hospitals, the updated data on bed strength was filled from the back-end which may not be correct. In case of private hospitals, the bed strength is filled at the time of empanelment and the same is not updated by the hospital on the HEM portal whenever they upgrade the facilities in their hospital. NHA further stated that the day care packages (dialysis, chemotherapy, radiotherapy) do not occupy the bed for the whole day and in some scenarios, the package is blocked for multiple sittings for administrative convenience.

---

[30] Implementation Support Agency.

[31] Excluding cases where either of these conditions was matched (i) discharge date is missing, (ii) discharge date is equal to admission date; (iii) discharge is next day of admission date, and (iv) bed-strength of hospital is not available in the system.

NHA's reply is not convincing as during data analysis, day care cases had been excluded. Further, NHA admitted that bed strength data is not available on real time basis which implies that NHA does not review the bed strength of the hospitals periodically.

5.8.2.10 Payment of claims over and above the allowable limit of ₹ five lakh per household per year

PMJAY provides free hospitalization coverage of ₹ five lakh per entitled family (household) per year, through a network of public and private empanelled health care providers.

During desk-audit[32] (data analysis on table containing claims data in respect of Greenfield States only) in July 2020, audit noted that in two cases, the claims exceeding ₹ five lakh were paid in one policy year. NHA, while acknowledging the audit comment, in its reply (dated 27 July 2020) stated that the errors will be rectified after due diligence.

However, data analysis (September 2018 to March 2021) revealed that NHA has still not put in place the relevant validations in the TMS database, as we noted five cases (in TMS application only) where the amount released per household per policy year exceeded the threshold of ₹ five lakh, as shown in **Table-5.10**.

Table-5.10: Over and above allowable limit of ₹ five lakh

State	Patient family Id	Total claim amount	Last claim date	No of claims
Chhattisgarh	22CK223751218468	504000	18-03-2021	32
Chhattisgarh	22CK223870477539	500500	02-12-2020	1
Chhattisgarh	22R22240208516001921	500500	20-03-2020	2
Uttarakhand	5S0513002001100000002700003	552600	26-04-2021	10
Uttarakhand	5SGHSG3C01S95502	699410	22-03-2021	3

Besides this, following two fields which may flag any transaction as (i) PMJAY or non-PMJAY and (ii) Mention of policy year in API data (pushed by brownfield States) were also found missing. In the absence of these fields, it is not possible to ascertain to which scheme (*i.e.* PMJAY or State scheme) and to which Policy year any transaction or bunch of transactions for each family, relate. Further, in the absence of these fields, audit could not ascertain how NHA was monitoring validations of threshold limits to be placed in claims management as stipulated in scheme guidelines.

State-wise payment where the amount released per household per policy year exceeded the threshold of ₹ five lakh is shown in **Table-5.11**.

[32] Query on public.tms_t_patient table performed on 11 July 2020.

Table-5.11: Amount released in excess of ₹ five lakh per household per policy year

Sl. No.	State	Cases	Amount (in ₹)
1.	Manipur	3	76,775
2.	Rajasthan	17	13,61,187
3.	Nagaland	2	5,62,000
4.	Tamil Nadu	2	3,88,790

Payment of claim amount exceeding the permissible limit indicates lack of adequate validation controls in TMS system as well as State-specific system which needs to be reviewed/corrected in the system to prevent any further misuse.

The reasons for excess payment beyond the permissible limit were given by NHA (August 2022) as (i) Few States like Chhattisgarh provides a top-up beyond ₹ five lakh to their beneficiaries under the State-scheme, (ii) under insurance mode when the policy period is extended beyond 12 months then the wallet id is fully refreshed to ₹ five lakh, though the premium is paid on pro-rata bases for the incremental period. Such extension is given by insurance company when the tendering process is delayed. Any cover beyond ₹ five lakh is borne by the State Government.

The reply is not acceptable as in no case the wallet amount should exceed the permissible limit of ₹ five lakh.

5.8.2.11 Claims paid without Aadhaar authentication (for a second time)

Scheme guidelines stipulate that if the PMJAY family member does not have an Aadhaar card and the contact point is a location where no treatment is provided, the operator will inform the beneficiary that they are eligible and can get treatment only once without an Aadhaar or an Aadhaar enrolment slip. They may be requested to apply for an Aadhaar as quickly as possible. A signed declaration is taken from the Beneficiary that they do not possess an Aadhaar card and understand that they will need to produce an Aadhaar or an Aadhaar enrolment slip prior to the next treatment.

Data analysis further revealed that out of 118.47 lakh claims processed in TMS application, 47.46 lakh claims (40 *per cent*) pertained to patients who availed the benefit of scheme second time or onwards. Out of these claims, claims amounting to ₹ 39.51 lakh (83 *per cent),* however, were processed and paid in TMS without biometric authentication at the time of registration/admission. Further, 69 *per cent* of these claims pertained to those beneficiaries who were registered in BIS on the basis of Aadhaar authentication. Details of patients and amount paid in respect of these claims is given below in **Table-5.12**. State-wise details is given in **Annexure-5.6**.

Table-5.12: Claims paid without Aadhaar authentication (for a second time)

Total Claims in TMS	Claims Count Patient Count Amount Paid on these claims	1,18,47,059 56,56,498 ₹ 7,321.33 crore
Claims of Second time onwards	Claims Count Patient Count Amount Paid on these claims	47,45,950 10,07,766 ₹ 2,072.03 crore
Out of above, Claims where biometric authentication at the time of patient registration/admission was not done	Claims Count Patient Count Amount Paid on these claims	39,50,818 8,20,182 ₹ 1,678.68 crore
Out of above, Claims where patients were already registered in PMJAY with Aadhaar authentication	Claims Count Patient Count Amount Paid on these claims	27,40,245 5,45,979 ₹ 1,111.98 crore

Acceptance of second and onward pre-authorization request of any patient, in contravention to scheme guidelines indicates lack of effectiveness controls in the PMJAY IT system over such transactions.

Due to inadequate pre-validation checks and in the absence of mandatory filling of essential fields, audit could not derive assurance about accuracy, completeness, and reliability of data in the TMS/API.

NHA accepted the audit observation and stated (August 2022) that during the COVID period Aadhaar authentication via bio-authorization was disabled to avoid the spreading of infection. Now Aadhaar has been made mandatory for availing treatment under PMJAY.

Audit is of the view that SHAs may initiate re-verification of such claims to rule out any possibility of payment in respect of any unentitled beneficiary therein.

5.9 Internal control for fraud detection

5.9.1 Payment of claims on disabled and rejected cards

PMJAY cards, where malpractices or unintentional errors were noticed, were being disabled by NHA after conclusive investigation. As of July 2021, NHA had disabled 14.81 lakh PMJAY cards.

Audit noted that TMS could not restrict disabled cards for pre-authorization, as 1,081 claims were initiated after the cards were disabled in BIS database and payment of ₹ 71.47 lakh was made against these disabled cards. State-wise details are given in **Annexure-5.7**.

TMS system allowed initiation of 590 claims after their rejection date and an amount of ₹ 55.31 lakh was paid on 462 of these claims. State-wise details are given in **Annexure-5.7**.

NHA accepted the audit observation (August 2022).

5.9.2 Suspected card and beneficiary registration

NHA has generated several trigger alerts for identification of suspicious beneficiary registration. As of July 2021, 33.11 lakh trigger alerts were raised on 11.04 lakh beneficiaries. Details are shown in **Table-5.13**.

Table-5.13: Trigger Alerts

Sl. No.	Trigger Reason	Count of Triggers	Count of Distinct Beneficiaries involved
1.	Added Member	10,17,303	3,39,101
2.	Fuzzy Analysis	9,58,725	3,19,443
3.	Mobile number analysis	4,71,525	1,57,175
4.	Null HHID SECC	2,96,976	98,992
5.	BIS Image Analytics	2,12,700	70,900
6.	Ghost Beneficiaries with Multiple Cards	1,46,643	48,881
7.	Single set of document images used to create multiple PMJAY cards in same or multiple families	80,262	26,754
8.	Same document used to create multiple PMJAY cards in same or multiple families	71,517	23,839
9.	Invalid image in beneficiary image and set of documents	36,273	12,091
10.	Multiple cards of a single beneficiary in same family	17,664	5,888
11.	Beneficiary image not identifiable	1,446	482
12.	NULL SECC Name	207	69
	Total	**33,11,241**	**11,03,615**

These cases were forwarded to SHA's anti-fraud teams (SAFU) for further investigation. The State-wise responses captured by NHA are given in **Annexure-5.8**.

A summary of investigation carried out by states and their responses is summarised in **Table-5.14**.

Table-5.14: Summary of Investigation

Response	Cases	Percentage	Distinct Cards	Percentage
Fraud	13,51,299	40.81%	4,36,711	40.86%
Inconclusive	2,32,470	7.02%	77,490	7.25%
Not Fraud	5,81,274	17.56%	1,92,872	18.04%
Pending	10,59,039	31.98%	3,33,037	31.16%
Under Investigation	87,159	2.63%	28,806	2.69%
Grand Total	**33,11,241**	**100.00%**	**10,68,916**	**100.00%**

Out of 10.69 lakhs cards identified, only 7,07,073 cards constituting 66 *per cent* were investigated by SHAs. Investigation in respect of 77,490 cards (out of 7,07,073 cards) could not reach any conclusion. Remaining 3,61,843 cards (3,33,037+28,806) constituting 34 *per cent* of total suspected cards, were awaiting investigation.

Highest number of cases were noted in **Gujarat, Madhya Pradesh, Meghalaya** and **Uttar Pradesh**, while lowest number of cases were noted in **Andaman & Nicobar Islands, Karnataka, Lakshadweep** and **Tamil Nadu**.

Audit noted that any mechanism of submission of field investigation remarks/ report by States was also not made in the system of NHA which could have helped in ensuring that SHAs were following a uniform methodology while investigating such suspected cases.

NHA accepted the audit observation (August 2022).