HOSPITAL GUIDE & FAQ

For newly empaneled hospitals
And
The hospitals in the process of empanelment with PHS

- Hospitals are requested to encourage cashless hospitalization over cash paying patients as getting enlisted under insurance increases patient preference for hospitalization and subsequently more IPD admissions.

- Partnering with Paramount TPA will increase the reach of your hospital to maximum patients and healthcare seekers thus increasing your profile growth.

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SECTION I: PERMANENT ONBOARDING

Hospital Network request through traditional on-boarding process (without preauthorization request)

A. Checklist for Permanent Onboarding

Following is the list of mandatory documents and information required for empanelment as a network hospital with PHS and/or with any Insurer:

1. Hospital Registration Certificate
2. Other certification such as NABH accreditation or other such standardization certification
3. Hospital ROHINI ID
4. Hospital KYC
5. Owner Details and KYC
6. List of treatment specialties
7. Hospital Infrastructure (No of beds/ ICU/ OT/ Pharmacy/ Lab/ OPD clinics/ Fire and safety standards/ MRD
8. List of faculty members/ Board of Directors
9. Staff details
10. IT related information for Billing and medical record documentation
11. A copy of Hospital letter head / Standard discharge summary and Final Bill with breakup/
12. A copy of OPD receipt
13. Declaration of other healthcare facilities provided by the hospital such as medical camps, health checkups, ante-natal and post-natal care programs, diabetes and cardiac management programs, psychiatric counseling, tele-consultation, webinars,etc.
14. Tax exemption certificate if any
15. Hospital Contact person - Mobile no. and email ID

B. Hospital Rate-List

1. Hospitals should provide a rate list detailing basic services such as room rent, nursing charges, RMO charges, visit charges, surgical and medical treatment packages, investigation charges, and other associated service costs.

2. These charges should be customary and reasonable to ensure acceptability by Paramount TPA.

3. Additionally, a mandatory discount, commonly referred to as an MOU discount, should be applied to the gross bill amount following rate negotiation.

4. Hospitals may also consider offering an Early Payment Discount (EPD), ranging from 2-3% of the total authorized amount. EPD incentivizes timely payments and enables hospitals to participate in promotional events organized by the TPA, thereby gaining visibility as a Preferred Provider Network for Policy Holders serviced by Paramount TPA.

SECTION II: PROVISIONAL ONBOARDING

Hospital Network request through 'CASHLESS EVERYWHERE' initiative by GIC
(Cashless Intimation received from NON-NETWORK HOSPITALS WITH PRE-AUTHORIZATION REQUEST FORM)

A. Checklist for Provisional Onboarding

Below is the list of mandatory documents and information required for empanelment as a network hospital with PHS and/or with any Insurer:

1. Hospital Registration Certificate
2. Hospital ROHINI ID
3. Hospital KYC
4. Owner Details and KYC
5. Basic Hospital Information
6. Hospital Administration or TPA coordinator details—mail ID and mobile no

B. Hospital Rate-List

1. If the hospital is already on the panel of any other TPA or insurer, it can provide Paramount TPA with the agreed rates from the other TPA or insurer. Paramount TPA will scrutinize the rate list, and if found to be customary and reasonable according to prevailing charges in that specific geographic area or hospital location with the same level of care, Paramount TPA will accept these charges.
2. If the hospital is not part of any TPA or insurer network, both Paramount TPA and the hospital will need to collaborate on mutually agreed rates for various treatments offered by the hospital.
3. The hospital must agree to a mandatory discount on the negotiated rate list.

C. Process for Provisional Onboarding

1. Hospital will be immediately on-boarded by paramount TPA by creating a provisional Hospital ID.
2. Once the provisional ID is generated, Hospital will be required to sign a Provisional MOU with the TPA.
3. Upon receipt of the Provisional MOU, the cashless benefit shall be processed for that particular cashless intimation.

D. Process for Permanent Onboarding

1. Once the Provisional ID is generated and the Temporary/Provisional MOU is signed, Paramount TPA shall initiate the due diligence process for permanent onboarding within 15-30 days.
2. An on-site hospital audit will be conducted, and the hospital infrastructure will be duly verified.
3. Further verification will be carried out as outlined in Section I (A).

SECTION III: DEFINITIONS (Applicable to both Provisional as well as Permanent Network)

Standard Definitions of terminology used in Health Insurance Policies:

Hospital:
A hospital means any institution established for *in-patient care* and *day care treatment* of illness and/or injuries and which has been registered as a hospital with the local authorities under Clinical Establishments (Registration and Regulation) Act 2010 or under enactments specified under the Schedule of Section 56(1) of the said act Or complies with all minimum criteria as under:
i) has qualified nursing staff under its employment round the clock;
ii) has at least 10 in-patient beds in towns having a population of less than 10,00,000 and at least 15 in-patient beds in all other places;
iii) has qualified medical practitioner(s) in charge round the clock;
iv) has a fully equipped operation theatre of its own where surgical procedures are carried out;
v) maintains daily records of patients and makes these accessible to the insurance company's authorized personnel.

ICU Charges:
ICU (Intensive Care Unit) Charges means the amount charged by a Hospital towards ICU expenses which shall include the expenses for ICU bed, general medical support services provided to any ICU patient including monitoring devices, critical care nursing and intensivist charges.

Room Rent:
Room Rent means the amount charged by a Hospital towards Room and Boarding expenses and shall include the associated medical expenses.

Day Care Centre:
A day care centre means any institution established for day care treatment of illness and/or injuries or a medical setup with a hospital and which has been registered with the local authorities, wherever applicable, and is under supervision of a registered and qualified medical practitioner AND must comply with all minimum criterion as under –
i) has qualified nursing staff under its employment;
ii) has qualified medical practitioner/s in charge;
iii) has fully equipped operation theatre of its own where surgical procedures are carried out;
iv) maintains daily records of patients and will make these accessible to the insurance company's authorized personnel.

Day Care Treatment:
Day care treatment means medical treatment, and/or *surgical procedure* which is:
i. undertaken under General or Local Anaesthesia in a *hospital/day care centre* in less than 24 hrs because of technological advancement, and
ii. which would have otherwise required hospitalization of more than 24 hours.
Treatment normally taken on an out-patient basis is not included in the scope of this definition. (Insurers may, in addition, restrict coverage to a specified list).

Hospitalization:
Hospitalization means admission in a hospital for a minimum period of 24 consecutive *'In-patient Care'* hours except for specified procedures/ treatments, where such admission could be for a period of less than 24 consecutive hours

Illness:
Illness means a sickness or a disease or pathological condition leading to the impairment of normal physiological function and requires medical treatment.
(a) Acute condition - Acute condition is a disease, illness or injury that is likely to respond quickly to treatment which aims to return the person to his or her state of health immediately before suffering the disease/ illness/ injury which leads to full recovery
(b) Chronic condition - A chronic condition is defined as a disease, illness, or injury that has one or more of the following characteristics:
1. it needs ongoing or long-term monitoring through consultations, examinations, check-ups, and /or tests
2. it needs ongoing or long-term control or relief of symptoms
3. it requires rehabilitation for the patient or for the patient to be specially trained to cope with it
4. it continues indefinitely
5. it recurs or is likely to recur

Medical Practitioner:
Medical Practitioner means a person who holds a valid registration from the Medical Council of any State or Medical Council of India or Council for Indian Medicine or for Homeopathy set up by the Government of India or a State Government and is thereby entitled to practice medicine within its jurisdiction; and is acting within its scope and jurisdiction of license.

Medical Expenses:
Medical Expenses means those expenses that an Insured Person has necessarily and actually incurred for medical treatment on account of Illness or Accident on the advice of a Medical Practitioner, as long as these are no more than would have been payable if the Insured Person had not been insured and no more than other hospitals or doctors in the same locality would have charged for the same medical treatment.

Medically Necessary Treatment:
Medically necessary treatment means any treatment, tests, medication, or stay in *hospital* or part of a stay in *hospital* which:
i) is required for the medical management of the illness or injury suffered by the insured;
ii) must not exceed the level of care necessary to provide safe, adequate and appropriate medical care in scope, duration, or intensity;
iii) must have been prescribed by a *medical practitioner*;
iv) must conform to the professional standards widely accepted in international medical practice or by the medical community in India.

Reasonable and Customary Charges:
Reasonable and Customary charges mean the charges for services or supplies, which are the standard charges for the specific provider and consistent with the prevailing charges in the geographical area for identical or similar services, taking into account the nature of the illness / injury involved.

Qualified Nurse:
Qualified nurse means a person who holds a valid registration from the Nursing Council of India or the Nursing Council of any state in India.

OPD treatment:
OPD treatment means the one in which the Insured visits a clinic / hospital or associated facility like a consultation room for diagnosis and treatment based on the advice of a Medical Practitioner. The Insured is not admitted as a day care or in-patient.

Network Provider:
Network Provider means hospitals or health care providers enlisted by an insurer, TPA or jointly by an Insurer and TPA to provide medical services to an insured by a cashless facility.

GIPSA Network:
GIPSA stands for **General Insurance Public Sector Association**.It is a group of four General insurance companies. Those 4 companies are New India Assurance Company Ltd, National Insurance Company Ltd, United India Insurance Company Ltd and Oriental Insurance Company.
Any hospital enrolled through such committee is known as GIPSA Network and they have to comply with GIPSA proposed rate-list in-order to become GIPSA PPN (preferred provider network).

Copay:
Co-payment is the percentage of the claim that the insured agrees to pay from his/her pocket irrespective of the claim amount. It is an inbuilt policy clause in some policies and the authorization letter will clearly mention the amount to be collected from the patient under co-pay deduction.

Incremental or proportionate deduction:
If there is a policy sub-limit on rooms and the policyholder occupies a room with a tariff that's more than what he is eligible for, the proportionate deduction on 'associated medical expenses' are the incremental charges which the insured has to pay.

ROHINI ID:
ROHINI (Registry of Hospitals in Network of Insurance) is **a registry of unique hospitals in the Health Insurers and Third Party Administrators (TPAs) network, in India**. The registry has been developed by the Insurance Information Bureau of India (IIB) (promoted by Insurance Regulatory Development Authority of India).

IRDA:
The Insurance Regulatory and Development Authority of India is a statutory body under the jurisdiction of Ministry of Finance, Government of India and is tasked with regulating and licensing the insurance and re-insurance industries in India.

Sanitization and Hygiene and Fire safety standard:
All network hospitals are required to maintain proper hygiene within the hospital premises. There should be adequate fire prevention protocol in place and as well as patient safety measures and evacuation plan in event of any mishap duly charted out in the hospital management protocol.

On-spot verification:
Network hospitals are subjected to regular visits from our verification team who will perform their due diligence to assess the claim records and conduct detailed enquiry of any claim or claims from any particular time duration. Hospitals are under obligation to co-operate with the TPA/ insurer field verification officers for compliance. Any non-cooperation or gross misrepresentations in the audited claims may lead to immediate hospital delisting by the TPA and/or Insurer.

SECTION IV: FREQUENTLY ASKED QUESTIONS (FAQ)

1) What is Cashless Hospitalization?

Cashless health insurance is a type of insurance plan where policyholders can avail medical treatment without having to pay the hospital or medical facility directly. Instead, the insurance company settles the bill directly.

2) What is a TPA Tripartite Agreement?

A TPA Tripartite Agreement is a legal document commonly used in the insurance industry. Concerning provider networking, it is an agreement between three parties – the hospital (entering into this agreement), the insurer (the insurance company providing coverage), and the third-party administrator (TPA) (the company that administers the insurance policy on behalf of the insurer). Cashless services cannot be extended or availed without a tripartite agreement.

3) Why Does the TPA Tripartite Agreement Matter?

- The purpose of a Tripartite Agreement is to clearly outline the rules, regulations, and responsibilities of each party, emphasizing the integrity and compliance of the empanelled hospital (provider network).
- The TPA Tripartite Agreement is an important legal document ensuring effective administration of insurance policies. It helps prevent disputes, establishes clear lines of communication, and provides a framework for handling claims. Each party is responsible for its breach of the contract or agreement.

4) What are MOU Rates and Discounts?

MOU rates refer to pre-negotiated tariff rates and discounts on the gross bill amount or other billed components agreed upon between the network hospital and the TPA and/or insurer. The provider network hospital is required to bill the admitted policyholder as per the agreed rate list and provide the agreed discount, regardless of whether the insured/policyholder opts for cashless facility or pays cash.

5) What is a PPN Declaration Form?

- The PPN Declaration Form is a PSU-mandated form required to be filled and attached with the preauthorization request form (RAL) for all claims arising from PSU-related policies.
- It contains a policy declaration from the patient as well as an undertaking statement about excess billing (more than the agreed rate list with the insurer) to be paid by the policyholder if extra charges are incurred due to the patient opting for a higher room category or treatment modality.

6) How to apply for ROHINI ID?

- Log-in to : https://rohini.iib.gov.in/
- Click on : Register your hospital
- Follow step by step guide.

7) Why is the ROHINI ID important?

- ROHINI (Registry of Hospitals in Network of Insurance) is a registry of unique hospitals in the Health Insurers and Third Party Administrators (TPAs) network in India. Developed by the Insurance Information Bureau of India (IIB), promoted by the Insurance Regulatory and Development Authority of India, ROHINI aims to become a one-stop source of all information related to Health Insurance and Hospitals for insurers, medical service providers, customers, and regulators.
- The ROHINI ID is a mandatory requirement for qualifying for network empanelment with any insurer or TPA.

8) What is the Preauthorization Request Form or RAL (Request for Authorization)?

- The Preauthorization request form is a defined format in which every cashless request must be forwarded to the insurer or the TPA. It contains important basic information such as patient contact details, policy number, insurer/TPA ID, hospitalization details, tentative cost of treatment, diagnosis, treatment details, and medical information.
- Generally, TPAs cannot process any cashless claim without the Preauthorization request form.

9) What is KYC, and why is it required for requesting a claim?

- KYC is one of the most important documents required alongside the preauthorization form. It consists of any government-approved Photo ID and Address proof of the Primary Policy Holder/Employee/Proposer. Additionally, Photo ID proof of the patient is also required along with the KYC of the main policyholder.
- KYC is required as per the provisions set under the AML guideline and as per the IRDA advisory.

10) How do I submit a request for preauthorization to Paramount TPA?

There are 2 modes of cashless request (preauthorization request) submission:

- Through mail: Hospitals can attach all the required preauthorization documents and mail them to our dedicated email ID: al.request@paramounttpa.com.

Note: Paramount TPA will not respond to any other service requests, inquiries, or escalations sent to this dedicated email ID except for requests placed for cashless approvals and active cashless claims.

- Through e-CCN (online platform available in the provider module on our website): This is the recommended mode of cashless request submission and subsequent coordination with Paramount TPA. e-CCN directly places your cashless request with the claim processing team and does not have to wait for Claim No. generation and email queue clearance at the first instance level. Paramount TPA's response time is reduced for requests placed through e-CCN. It is utilized by almost all our network providers and is very convenient for tracking claim status and communications from the TPA for that claim.

11) What is the checklist for preauthorization request submission?

- Preauthorization request form (available on our website)
- Patient ID proof
- Primary Policy Holder/Employee/Proposer KYC, i.e., Government-approved Photo ID and address proof as well as PAN card copy
- Admission notes with ICPs and treatment sheets (if admitted)
- Investigation and radiology reports based on which the diagnosis is made
- Breakup of the estimated expenses
- PPN declaration form for all admissions related to PSU policy

12) What is an Authorization Letter (AL)?

- An AL is the guarantee letter of payment up to the amount (as stated in the letter) released by the TPA after duly verifying the medical records and policy terms and conditions for that particular cashless claim. If the hospital bill exceeds the AL amount, the hospital should send the updated bill with a breakup along with a request note mentioning the claim number for which the additional enhancement is requested. The TPA will scrutinize the updated bill and, upon satisfactory scrutiny, may revise and enhance the AL amount.
- The Authorization Letter is a conditional guarantee based on the facts presented at the time of authorization. The authorization amount can be cancelled or revised based on changes in the medical presentation of the case**.**

13) What is a Denial Letter?

Post receipt of the cashless request and entire medical documents, the TPA will scrutinize the details along with the policy terms and conditions. If any clause in the policy restricts the particular ailment or its etiology or the treatment modality, the claim shall be denied, and a Denial Letter will be issued to the hospital stating the reason for denial.

14) What is a Query Letter/Additional Information Letter/Deficiency Letter?

As the term suggests, this is additional information required by the TPA after receipt of the cashless request from the hospital. The hospital should ensure that the requirements mentioned in the deficiency letter are replied to point-wise as soon as possible. A quick and complete reply will help the TPA arrive at the claim's admissibility more efficiently.

15) How do I avail payment from the insurer post cashless approval?

- Once the hospital receives the final approval from the TPA, it must compile the entire claim documents (hospitalization documents, i.e., discharge summary, final bill, breakup of final bill, ICPs, various invoices, pharmacy receipts, etc.).
- After complete documentation, the hospital shall send the entire folder to the servicing TPA for that claim to the TPA address (preferably Paramount TPA Head office address) as mentioned on our website or on the AL letter.
- The hospital can submit these documents physically at the local Paramount TPA office or courier them to the TPA head office address.
- Paramount TPA will acknowledge the submission of such claim documents. Such proof of delivery (POD) or manual acknowledgment received from the TPA inward desk should be preserved for the record.
- Post the claim submission, Paramount TPA will scrutinize the entire claim again, and if there is no discrepancy in the details and bills provided at the time of preauthorization and in the physical claim file, then the claim will be sent for payment request to the insurer.

- In case Paramount TPA finds a gross discrepancy in the medical details or bill provided at the time of preauthorization as well as the physical file submission, then the TPA will raise clarification for such discrepancy to the hospital. Upon a satisfactory reply, the claim shall be processed further.
- The hospital must ensure that there is no deficiency of any document in the claim file and should submit the claim as per the checklist provided in the subsequent FAQ.

16) What is the Turnaround Time (TAT) for cashless file submission to the TPA?

Hospitals should submit the entire claim documents as per the provided checklist within 15 days of patient discharge.

17) What is the average turnaround time for payment to the hospital?

- Wherever the claim documents are complete in all respects and there is no discrepancy found in the submitted claim, it takes approximately 15 to 30 days for settlement of the claim.
- The claim amount shall be credited by the insurer directly into the hospital's account details provided at the time of hospital empanelment.

18) How will the payment happen for the cashless approved claims?

Claims are paid directly to the hospital by the insurer. The amount is credited by the insurer to the hospital bank account provided at the time of hospital empanelment. UTR no. and the settled amount will be shared with the hospital.

19) Will the hospital get the entire cashless approved amount post complete claim file processing?

As per the governing laws, the claim amount shall be paid after TDS deduction to the hospital. In case the hospital has a tax exemption certificate, it has to be submitted to the TPA at the time of on-boarding.

20) Is GST mandatory for everyone?

The government has mandated those businesses with an annual turnover exceeding Rs. 20 lakhs must obtain a GSTIN. If you are registered under GST, it is essential to file GST returns and pay any GST liability that arises. Moreover, if the GST paid exceeds the GST liability, you are eligible to claim a refund through your GSTIN.

21) Will the hospital get a record of settled claims?

- Post every claim settlement, TPA sends a settlement voucher in which complete payment and deductions details are mentioned.
- Alternatively, the hospital can also log in to the Provider Module and get the records of pending and settled claims and can also download the settlement voucher for any claim.

22) What is the 'Provider Module' mentioned in this FAQ?

- The Provider Module is a tool given to every panel network hospital to track the claim records of the cashless files submitted with Paramount TPA. The Module is accessible only through login credentials specifically generated for that hospital. The hospital can access the real-time status of active cashless (preauthorization claims) in which it can download the AL letter, Query letter, Denial Letter.

- Post claim submission, the hospital can check the outstanding claims with Paramount TPA and generate a record of settled claims. The Provider Module has other interesting features such as e-CCN and other options.

23) What is National health claim exchange NHCX?

- National Health Authority (NHA) and the Insurance Regulatory and Development Authority of India (IRDAI) have joined hands to operationalize the National Health Claim Exchange (NHCX). About National Health Claim Exchange (NHCX).
- It is a digital health claims platform developed by the National Health Authority.
- It will serve as a gateway for exchanging claims-related information among various stakeholders in the healthcare and health insurance ecosystem.
- It is designed to be interoperable, machine-readable, auditable and verifiable, as well as help ensure the information exchanged is accurate and trustworthy.

24) What is Ayushman Bharat Digital Mission ABDM?

- The Ministry of Health and Family Welfare (MoHFW) has prioritized the utilization of digital health to ensure effective service delivery and citizen empowerment to bring significant improvements in public health delivery.
- The Ayushman Bharat Digital Mission (ABDM) has been launched by the Government of India for promoting digitization of healthcare and creating an open interoperable digital health ecosystem for the country. It aims to do so by prescribing common health data standards, developing core modules such as registry of health facilities, healthcare professionals etc required for interoperability; so that various digital health systems can interact with each other by enabling seamless sharing of data across various healthcare providers who may be using different digital health systems.

25) Are the hospitals required to register themselves under NHCX program?

- Government of India is aiming to create a common repository of all healthcare delivery institutions and service providers under a common platform.
- With this aim all the hospitals, daycare canters, diagnostic facilities and even pharmacies and clinical establishments will have to get themselves registered under the NHCX programme which is a subset of Ayushman Bharat digital Mission ABDM.
- Upon registration of such institution, a unique ID is generated which is referred to as HFR or NHC ID.
- It is solicited that going forward such registration will be mandatory for all healthcare facilities keen on providing its services under insurance scheme.

26) How can hospitals / daycare clinic/ OPD canters / diagnostic facilities register themselves under NHCX or ABDM program?

- The healthcare facilities will have to log-in into the national health authority website:
- https://facility.ndhm.gov.in
- Upon visiting the website there is “registration Button” and also you will find full demo video on health facility registry as step-by-step guide.

27) What is e-CCN?

- e-CCN is an online preauthorization request submission platform available to all our network hospitals through the Provider Module. Hospitals can log in with their credentials in the "Provider Module" and select the e-CCN option for submission of cashless requests.
- All our panel hospitals have found e-CCN very convenient for placing cashless requests. It helps the hospital track the real-time claim status of its submitted request and also features all communication details between the hospital and Paramount TPA for that particular claim.
- A short PPT to understand this online platform is available under Hospital Corner on our website.

28) Checklist for Claim File Submission:

1. Preauthorization request form (submitted at the time of cashless approval)
2. Final Authorization Letter (issued by Paramount TPA at the time of discharge)
3. Original Discharge Card / discharge summary
4. Original Final Bill
5. Detailed itemised breakup of the final bill.
6. GST no on the final bill (if applicable)
7. Copy of patient paid receipt amount.
8. Copy of OT notes (for surgical cases)
9. Original Invoice of Implants (if utilised)
10. Original invoice of high value consumables
11. Sticker of implant.

SECTION V: PHS CONTACT DETAILS

Email ID:
Paramount has network support cell and all enquiries to be sent on hospital.support@paramounttpa.com.

PHS call centre : 02266620808 / 1800226655