Queries received via email/letters before 17:00 hrs. on 13th July 2023

The queries raised and the clarifications sought by the representatives of the Bidders and the corresponding responses are set out below:		
MHIS 6-PMJAY Queries Received from Email July 2023		
Sl No.	**Questions**	**Response**
1	The Transaction Management System allows blocking of Packages with a maximum back-date of 5 days. In a scenario where the beneficiary is already admitted in an EHCP during the time of registration of such beneficiary, then the commencement of risk cover shall be effective to a maximum of 5 days prior to the day the beneficiary is registered. A) Please clarify the expected scenario/s wherein five days of backdate package blocking is allowed. B) We understand that the pre-authorization must be initiated before the patient's discharge from the hospital, irrespective of the admission date; please clarify.	A) The patient has not yet received the card, BIS technical issues, TMS Technical issues, or any other issue that may have caused the patient to not receive the PMJAY & MHIS Card. B) Pre-authorization will also be allowed to initiate after the patient is discharged, with prior intimation to the SNA. The reason for the delay could be technical issues or the approval of the card by Insurer or TPA is pending, or there are unavoidable circumstances.
2	Are there any changes in the limits of General Ward, HDU, ICU (with and without ventilator) between MHIS-5 and MHIS-6 with respect to separate limits for public and private hospitals.	The clause 5 B b) of the Tender Document Volume 2 has been amended as given in the addedum/corrigendum issued on 18.07.2023. The same is reflected in the Tender Document Volume 2 issued on 18.07.2023.
3	Kindly estimate the impact of addition of the following new clause in the current tender "If a Surgical Treatment Package is not listed in Schedule 3, the EHCP can block the treatment under unspecified surgical package as specified in Schedule 3 and subject to the terms as mentioned in Schedule 5 of the Insurance Contract."	There will be no impact as unspecified surgical package already existed in MHIS 5 but only in Schedule 3. In the current Tender Document Volumne 2, a clause has been added.
4	The reduction in package rate for CHCs, PHCs by 30% and for rest all hospitals the routine ward, HDU, ICU rate to be reduced by 10% - Is that our understanding is correct? Is this applied on private hospital also?	The clause 5 B b) of the Tender Document Volume 2 has been amended as given in the Addedum/corrigendum issued on 18.07.2023. The same is reflected in the Tender Document Volume 2 issued on 18.07.2023.

5	The insurance cover shall also allow utilisation of multiple medical and surgical packages in a single instance of hospitalisation. In such a situation, the medical or surgical package with the highest rate shall be considered as the primary package and shall be payable at 100%, there upon the second package shall be payable at 50% of the applicable rate and the third and subsequent packages shall be payable at 25% of the applicable rate. Please clarify if, in any circumstances, the EHCP is entitled to initiate a pre-authorization request for a medical and another surgical package/s for the same period of hospitalization.	The EHCP will be entitled to initiate a pre-authorization request for a medical and surgical package subjected to the approval of the SNA.
6	If a Surgical Treatment Package is not listed in Schedule 3, the EHCP can block the treatment under an unspecified surgical package as specified in Schedule 3 and subjected to the terms as mentioned in Schedule 5 of the Insurance Contract. Kindly clarify whether these treatments will be treated under non package rates or as per the schedule 5 or define it clearly for our understanding	The treatments shall be treated under unspecified surgical packages (one upto ₹1,00,000 and the other upto ₹ 5,00,000) as specified in Schedule 3 of the Tender Document Volumne 2. The process of such approval is given in Schedule 5 of of the Tender Document Volumne 2.
7	In case of Unspecified Medical Management Package there is no specific mention of Average Length of Stay	The bidders may refer to clause 5 B a)ii, also subjected 4 A a) of the Tender Document Volume 2.
8	Clause-17 (h): As on 31st march -4,58,909 families are covered in this. What is the universe of family and how many new family got enrolled in current policy period	As on 30.06. 2023, 4,88,525 families have been registered. The total number of families registered during the MHIS 5 policy until 30.06.2023 is 19693 families.
9	Mid-term addition & deletion process	The addition or deletion of any Beneficiary Family Unit shall be the responsibility of the SNA.
10	Administrative cost involved for IT integration	No Administrative Cost applicable for IT integration such as procurement of softwares for Beneficiary Identification, the Transaction Management System and any other applicable software for MHIS-PMJAY implementation.
11	After adjusting a defined percent for expenses of management (including all costs excluding only service tax and any cess, if applicable) and after settling all claims, if there is surplus: 100 percent of leftover surplus should be refunded by the Insurer to the SNA within 30 days. The surplus amount to be refunded shall be calculated after a defined administrative cost is adjusted which is given as follows: i. Administrative cost allowed at 10% if claim ratio less than 65%. ii. Administrative cost allowed at 12% if claim ratio between 66% - 75%. iii. Administrative cost allowed at 15% if claim ratio between 76% - 85%.	1. Request for increase in the Percentage of Administrative Cost shall not be considered. 2. The percentage of administrative cost shall hold no relevance when the claim ratio is above 85%.

12	Clause-26: Do we have option to take over the existing call centre or new setup to be done?	The insurer has to adhere to the guidelines as specified in Clause 26 of the Tender Document Volumne 2. The SNA may recommend the human capacity for the call centre and the help-desk.
13	Clause 26-V: The helpdesk setup is requested. Is this the separate or same of call centre	Sujected to operational feasibility the insurer may utilise the same infrastructure set-up as that of the Call centre.
14	The end date of the risk cover for each Beneficiary Family Unit in respect of each Cover provided to it shall be the earlier to occur of: (i) the date on which the available Sum Insured in respect of that Cover becomes zero; and (ii) the date of expiration of the first Policy Cover Period.until 2359 hours on the date of expiration on (insert date) We understand that the same criteria while considering the date of the actual hospitalization, would be applicable during the adjudication of the claims.	Query Cannot be Comprehended
15	Last 3 years per family rate chart required	Query Cannot be Comprehended
16	Kindly highlight the changes in the proposed scheme MHIS-6 vis-à-vis the currently running scheme MHIS-5 with regards to the coverages and other terms of the tender including OPD cover details – overall Sum Insured limit for OPD cover and further limits for maternity benefit, child care benefit, cardiac and diabetes preventive OPD care benefit, OPD Diagnostic benefit and Follow-up care benefit.	Refer to Annexure A and Annexure B of the Pre-Bid Queries from Email
17	Please confirm all terms and condition are as per last year tender condition or any change in the same? If any change please provide details	Refer to Annexure A and Annexure B of the Pre-Bid Queries from Email
18	Any changes in tender compared to last tender	Refer to Annexure A and Annexure B of the Pre-Bid Queries from Email
19	Kindly provide the claim count and amount (with breakup into pre-auth approved, paid, outstanding and rejected), month-wise for MHIS-5, with clear mention of the date up till which the data is provided. Kindly also provide the claims data dump for the currently running scheme MHIS-5, clearly mentioning the date up till which the data is provided.	
20	Kindly provide Claims count and amount of top 30 procedures along with the changes (if any) in the corresponding package rates for the existing (MHIS-5) and proposed scheme (MHIS-6).	

21	Kindly provide the month wise claim count and amount pertaining to OPD Benefits separately for Maternity benefit, Child Care benefit (separately for different age groups of child), Cardiac and Diabetic Preventive OPD Care benefit, OPD Diagnostic benefit, Follow-up care benefit and New born benefit for MHIS-5, with clear mention of the date up till which the data is provided.	Refer to Annexure D of the Pre-Bid Queries from Email.
22	Kindly provide the district wise and hospital type wise (public and private) claim count and amount for the currently running scheme (MHIS-5) , with clear mention of the date up till which the data is provided.	
23	Last 3 years complete claim data with OPD bifurcation in excel file.	
24	We require claim data for the past 3 years.	
25	As we have to quote separately for OPD we should have OPD claims data for 1. maternity 2. follow-up care 3. OPD diagnostics .	
26	Kindly provide Claims dump for existing policy to arrive at appropriate quote	
27	Month on month No. and amount of claims reported, paid, rejected and outstanding in current policy and previous policy.	
28	Hospital wise bifurcation of claims- Private, Public, CHC, PHC etc.	
29	OPD claims details (claimed count/amount, paid, pending, rejected)– month wise, hospital/clinic wise, district wise	
30	Package wise hospital wise utilization in current policy and previous policy	
31	Treatment category / OPD benefit wise OPD claims data (Including the followup care benefit)	
32	Package wise claims data summary	
33	Please provide the following claim related details of last 3 years: 1. Detailed Claim Dump - With OPD and Hospitalization details 2.Claim data as per type of hospital	
34	Screening and follow up care as separate day care packages. This is separate from Pre and post hospitalization coverage mentioned above. Screening and follow-up day-care packages can overlap with the pre-post-hospitalization period. Confirm if any particular gap needs to be maintained in determining claims admissibility.	
35	In case of offline transaction management, what will be the process flow and how the document requirement to be raised to the EHCP	Refer to Clause 10 A c) of the Tender Document Volume 2. The process will be subjedted to claims adjudication manual issued by NHA or terms that may be adopted by the SNA.

36	As per the tender " The Insurer shall require the EHCPs to initiate and submit their Claims electronically after discharge". Please provide clarity on the same.	Claims to be submitted as per the terms under Clause 10 of Tender Document Volume 2 through the Transaction Management Software of the NHA.
37	The Empanelled Health Care Provider shall have a right of appeal against a rejection of a genuine Claim by the Insurer, if the Empanelled Health Care Provider feels that the Claim is payable. Such decision of the Insurer may be appealed by filing a complaint with the DGNO in accordance with Clause 30 of the Insurance Contract. Please clarify the allowed timeline to file an appeal against the rejection of any claim by IC. Also clarify the criteria for Partially approved cases as per the merit of the case.	There is no timeline for the Empaneled health care to appeal the rejeceted claim, empanelled Healthcare providers can appeal the rejected claims at any time.
38	If the Insurer rejects a Claim, the Insurer shall issue a written letter/Email of rejection to the Empanelled Health Care Provider stating: details of the Claim; reasons for rejection; and details of the District Grievance Nodal Officer. The letter of rejection shall be issued to the State Nodal Agency and the Empanelled Health Care Provider within 10 days of receipt of the electronic Claim (unless the EHCP submit the documents beyond the TAT). The Insurer should inform the Empanelled Health Care Provider of its right to seek Redressal for any Claim related grievance before the District Grievance Redressal Committee in its letter of rejection. A)Please clarify if IC shall issue a written letter/Email of rejection to the Empanelled Health Care Provider through any other system or manually, since TMS does not have such a facility, as per our understanding. B) On page 41, it is mentioned, "...Claims Rejection or investigation of the Claim shall be completed such that the Turnaround Time shall be no longer than 15 days". Hence, please clarify the turnaround time for rejecting cases, if any.	A) Subjected to operational feasibility the insurer may give the information to the EHCP through modes including letters or emails. B) Refer to Clause 10 A i) of the Tender Document Volume 2.

39	PRE-AUTHORISATION AND CLAIM PROCEDURES :There are packages available under Schedule 3 that requires to undergo the process of pre-authorization and Claim procedures that are set out in the Medical Treatments, Surgical Procedures, Day Care Treatments, Follow-up Care and OPD Benefits is set out below:Ante- Natal and Post Natal Care,Child Care,Preventive Care (Diabetes and Cardiac),All OPD Diagnostics,Day Care Treatments- Insurer TAT 30 Minutes For the following categories like Ante- Natal and Post Natal Care, Child Care, Preventive Care (Diabetes and Cardiac), All OPD Diagnostics and Day Care Treatments, the tender document mentions - the adjudication turn-around-time as mentioned to be 30 mins. Please explain the following: i. If packages under these categories would follow a separate queue in the TMS to handle the flow and prioritise the case. ii. If these approvals would have any official working hours or to due for action on a 24x7 basis. iii. The turn-around time would be computed only if a satisfactory set of medical documents and other relevant details are uploaded during the Pre-Authorisation initiation. - Please clarify. iv. These cases would follow a FIFO logic and would not appear in the pre-auth approver's queue, along with the cases to be approved within 6 hours of pre-auth initiation.	i) NHA is developing a separate system for all OPD Procedures ii) 24x7 Basis iii) The EHCP is required to upload all the minimum sets of documentation in the TMS and submit to Claims Team, the turn-around time would be auto computed in the TMS after submission. iv) The logic is FIFO Order
40	All EHCPs are required to submit their Claims electronically within 30 days after the patient is discharged. In the event that the EHCP fails to submit the claims within a 30-day period, it is necessary for the EHCP to obtain written permission from the SNA in order to proceed with initiating the claim(s) beyond the initial 30-day deadline. Please specify the actionable of an IC on a claim that has been submitted after the defined claim submission TAT.	If the EHCP has not obtained the written permission, the claim may be rejected
41	Pre authorization process TAT Please specify Preauthorization process and TAT	Bidder to refer to Schedule 5 of the Insurance Contract Vol II. Additionally the process shall be subjected to clams adjudication terms that will be prescribed by the SNA according to MHIS & PMJAY guidleines.

42	Any state specific alteration in process / guidelines	There are operational process/guidelines which are state specific and different from PMJAY. The insurer is recommended to refer only to the Tender Documents Volumne 1 and 2 that is issued on 18.07.2023
43	Will there be any changes in number of empanelled hospitals and package rates during the 3-year period of the contract (if renewal happens).	The number of hospitals may vary based on new empanelment or de-empanelment, but the package rates will remain unchanged unless the government and the insurance company agree on modifications
44	NABH accredited hospital and entry level accredited hospital- We would be needing the hospital list	Refer to Annexure E of the Pre-Bid Queries from Email
45	Provided however that the OPD diagnostic benefit shall only be available to a Beneficiary through an empanelled hospital or a Diagnostics Lab that is empanelled for providing such OPD diagnostic care Kindly clarify any empanelment criteria, eligibility, or infrastructure framework that needs to be considered as a benchmark for the empanelment of a diagnostic laboratory.	Refer to Schedule 7 of the Tender Document Volume 2
46	Minimum Empanelment Criteria for Providing OPD Diagnostic Services.:The State Nodal Agency ..... Until such time, only Specialty Hospitals shall be permitted to provide OPD diagnostic services. We understand that OPD Diagnostic Services are restricted to Specialty Hospitals only until receipt of further guidelines from the office of SHA.	As given in point 5 of Schedule 7 of the tender Document Volume 2.
47	Kindly provide us the numbers of Total Beneficiaries Verified and Total Families Verified till date.	Refer to Annexure C of the Pre-Bid Queries from Email.
48	Total family count enrolled last 3 year and approximate lives for the same.	
49	We require enrollment data for the past 3 years.	
50	No. of families covered in existing policy and the new tender	
51	Member enrolment criteria &Process	Refer to Clause 21 of the Tender Document Volumne 2
52	Health card issuance process	

53	It is observed that the Beneficiary Family units enrolled as on 15/05/2023 for East Jaintia Hills and South West Garo Hills Districts are higher than the beneficiary Family units proposed to be covered under MHIS 6. Kindly Clarify	The excess registered households data over the target households data in East Jaintia Hills and South West Garo Hills is acknowledged. This is caused by the data source consideration of the 2017 post-enrolment database of RSBY and the SECC database of 2011 for Government of India's share on premium payment however both the data source are a subset of each other in practicality. The premium is however paid on 692978 Beneficiary Family Units. Should a scenario arise where the overall registered data is in excess of the target data, terms as mentioned in Clause 21 a) a. of the Tender Document Volumne 2 shall apply.
54	Number of government reserved procedures (if any).	Speciality of Mental disorders and some diagnostics are reserved for public hospitals and some diagnostic reserved for private hospital.
55	Details of additional packages for both OPD and IPD.	OPD Follow up - Cirrhosis with portal hypertension, follow up - chronic kidney disease not requiring dialysis, Follow-up - Acute exacerbation of Inflammatory bowel disease, Follow-up - Peripheral neuropathy. Medical /Surgical Management: Paclitaxel 160mg + Cisplatin 50mg (CT for CA cervix), Medical management (Glaucoma) , Closed Globe injury-Medical/Surgical management, Open Globe injury- Exploration and Repair, Paracentesis + AC Wash, Dacryocystectomy (DCT), Acute intestinal obstruction, Meningomyelocele, Threatened Abortion (Bleeding PV), Paralysis, Acute tonsilitis, Orchitis, , MDR Tuberculosis, Pulmonary Tuberculosis, Extrapulmonary Tuberculosis, Bronchiolitis, Cellulitis- conservative High end drugs : Rabies Immunoglobulin
56	Premium received for last 3 year @ inception and as on day	Refer to Annexure G of the Pre-Bid Queries from Email.
57	As per Ministry of Health and Family Welfare (National Health Authority) Office Memorandum dated 15/07/2022 the package of Caesarean- section delivery package is being reserved for utilization in public facilities only.	C-Sec delivery package is open for both private and public hospitals

58	Clause-18: SHA expect the support of Ins co in IEC. Is there any defined guideline and activity around it?	No Defined Guideline available, however, the insurer has to assist the SNA in its IEC activities in terms of the existing human resource capacity as given in clause 15 c) of the Tender Document Volumne 2.
59	It shall be assumed that 10% of the total Beneficiary Family Units in the Beneficiary Database qualify as families with one or more government employees for which premium shall not be calculated Clarify the logic behind such assumptions and provide data/details available against the same. Kindly provide final count for eligible/entitled families.	Since the commencement of MHIS, an assumption of 10% has been made through recommendations made by an external consultant and approved by the Government of Meghalaya. No Databse is available at present. The count of the eligible/entitle families is 692978.
60	Exclusion of i. Drug & Alcohol abuse ii. Infertility & related treatments	Refer to Schedule 1 of the Tender Document Volume 2
61	Voluntary medical termination of pregnancy is not covered, except in the case of a lawful termination or induced by accident or other medical emergency to save the life of mother. A) We understand that any Voluntary medical termination of pregnancy is not covered. B) Kindly explain the definition of "lawful termination" of pregnancy and the respective act to comply with.	Lawful termination refers to any term that may be applicable under the Medical Termination of Pregnancy Act or abortion laws any other applicable statute/laws/acts of the state or central government.
62	Intentional self-injury/suicide exclusion We understand that deliberately engaging in violence, combat, or aggression & resulting in trauma or assault is also excluded from the policy scope.	Only Intentional self-injury/suicide is not covered.
63	Coverage for meeting expenses of hospitalization for medical/surgical procedures including maternity and new-born benefits, selected outpatient procedures, surgical day care procedures, outpatient diagnostic services or any other treatment classified as Health Benefit Package given under Scheduled 3 for up to ₹ 5,30,000 per family per policy year subject to limits in any of the empanelled health care providers across India. The benefit to the family will be available on a floater basis i.e., benefits can be availed individually or collectively by members of the family per policy year. Please clarify if there is any sub-limit applicable for Secondary and Tertiary Cover hospitalization for a single hospitalization.	No limits defined for single hospitalisation

64	Claims Triggered by NAFU----- Who will be going to Investigate the cases—SHA or IC	The insurer shall conduct all audits triggered by NAFU. The SNA also conducts a portion of the audits the verify the audit conducted by the insurer.
65	100% mortality cases has been advised to be investigated as per Tender guidelines –who will investigate Insurer and SNA both ?	Insurer to conduct mortality audit also subjected to additional evaluations by the SNA.
66	Under MHIS-5, the Cardiac & Diabetes Preventive OPD Care covered expenses of Screening for **cardiac and diabetic profile tests** such as follows: AOE, DOE etc. However, as per the tender terms for MHIS-6, the Cardiac & Diabetes Preventive OPD Care shall now be covering expenses of Screening for cardiac & diabetic, **cardiac profile tests** as follows: AOE, DOE etc. Therefore, kindly clarify whether the coverage of expenses for diabetic treatment which were covered in MHIS-5 are not covered in MHIS-6 and thus there is reduction in cover in MHIS-6 viz-a-viz MHIS-5, or else since the specific list of profile tests covered for diabetic treatment are removed so all profile tests pertaining to diabetic treatment (open cover) shall be covered in MHIS-6 and thus there is increase in cover in MHIS-6 viz-a-viz MHIS-5.	No changes made in the clause from MHIS 5 to MHIS 6
67	Cardiac & Diabetes Preventive OPD Care:This benefit is limited to three OPD consultations per beneficiary in each Policy Cover Period Please confirm if these packages are restricted to any sub-limit per family during a policy span.	Limited upto 3 visits only as per the rate specified in Schedule 3 of the Tender Document Volume 2. Cardiac & Diabetes Preventive OPD Care are subjected to Clause 4 A a) of the Tender Document Volume 2.
68	Cardiac and Diabetic Preventive Care:-- Package rate is not clear and Pathology test rate not clear.	The bidders may refer to clause 3 B (v) of the Tender Document Volume 2. All the necessary tests mentioned in this clause are inclusive as part of Cardiac and Diabetes Preventive care package.
69	OPD Diagnostic Benefit:The OPD diagnostic benefit does not extend to any diagnostic care provided by an Empanelled Health Care Provider that would otherwise be covered by any of the other benefits under the Insurance Cover Please clarify if the OPD diagnostic benefits can be claimed as an add-on along with i) a medical or surgical package during the hospitalization period ii) within the period falling under the scope of covered pre- and post-hospitalization periods for secondary & tertiary care procedures.	i) The bidders may refer to ANNEX 1 of Schedule 3 of the Tender Document Volume 2. ii) The bidders may refer to Clause 3 A d) of the Tender Document Volume 2

70	Patient from any category admitted in Private ward shall only pay out of pocket for the room rent expenditure and any other facilities which is not part of the standard treatment or recovery process of the patient which also includes the list as given in Schedule 4 of the Insurance Contract. A) Please confirm if hospitals must share with IC and patient the exact amount collected towards the rate difference amount of the General Ward tariff and the Private room tariff only and as per the list mentioned under Schedule 4 of the tender document. And we understand that collection of expenses under any other heads would be considered unauthorized and liable for necessary action per the SHA & NHA guidelines- please clarify. B) In surgical packages, all the costs are assumed to be covered in the package rates. Hence, we understand the items under Schedule 4 are not allowed to be charged from beneficiaries in Surgical and Day care packages- please clarify.	A) The insurer may seek information on any unauthorised amount collected by the empanelled health care provider, the same of which should be reported to the SNA. B) Schedule 4 of Tender Document Volume 2 indicates the list of non-medical consumables and non-payable items
71	As part of the regular review process, the Parties shall review information on incidence of common Medical Treatments or Surgical Procedures that are not listed in Schedule 3 and that require Hospitalization or Day Care Treatments. Either Party may suggest the inclusion of additional Package Rates, based on the incidence of diseases or medical conditions and other relevant data. The Parties shall then mutually agree on the Package Rates for such Medical Treatments or Surgical Procedures, as the case may be. Please provide the details of packages, if any, additionally got included on an interim basis during the ongoing policy period.	No Addition of Packages
72	Kindly provide us the complete list of package rates and hospitals (part of tender document -currently in pdf) and all other relevant data files in excel.	Refer to Annexure F of the Pre-Bid Queries from Email.
73	Rate for Diagnostic Test not mentioned in the rate list, thus how it will be standardized or uniform and how it will implemented in remote district.	Bidders may refer to Schedule 3 of the Tender Document Volume 2 under heading of "Implants, Diagnostic/Diagnostic-Laboratory/Diagnostic-Radiological and High End Drugs"
74	On which package rate currently scheme is running. Any change in the new tender package rate?	Currently MHIS-PMJAY is utilising the MHIS 5 and HBP 2022 package rates
75	What are the changes in package rates. Please share the package master in excel format.	Refer to Annexure B of the Pre-Bid Queries from Email. Package Master given in Annexure F of the Pre-Bid Queries from Email.

76	OPD DIAGNOSTIC BENEFIT A) We understand the OPD diagnostic benefits are to be provided to beneficiaries with significant medical history/presenting complaints or prior supporting preliminary level of medical investigation reports to validate the need to undergo further medical diagnostic services and must be prescribed by a registered medical practitioner highlighting the background of the case to prescribe such investigation- please confirm. B) Please confirm that the packages under OPD Diagnostics can not be clubbed with any other IPD Packages.	A) Yes. The SNA shall endeavour to educate all medical practitioners to ensure that proper evidence/doumentation is presented to highlight the need of such OPD Diagnostic services. B) There are diagnostic packages that can be clubbed with IPD packages. Please refer to Annex 1 of Schedule 3 of the Tender Document Volume 2.
77	ALoS: In this column, the expected/average length of stay is mentioned. For packages which have LoS mentioned in Schedule 3, the ALoS shall be indicative. Since the average length of stay (ALoS) is indicative, we understand that there would not be any EHCPs' claim for any additional amount or medical packages for an extended length of hospitalization beyond the mentioned ALoS.	Yes. However, there can be some circumstances or depending on the medical condition of the patient, claim for addtional number of days will be permitted subjected to the approval of the SNA.
78	Implants, Diagnostic/Diagnostic-Laboratory/Diagnostic-Radiological and High End Drugs Certain Laboratory/Diagnostic packages, under generic package code: MG888ML, are mentioned for OPD or IPD and allowed for both public and private EHCPs- like Package "External Loop/event recording". Need clarity on the adjudication guidelines of the same. i) If the patient is already admitted to an IPD with a standard management package, should the IC consider these diagnostic packages an additional claim or not? ii) And should it follow the logic of 100%-50% etc?	i)Bidders may refer to the Annex 1 of Schedule 3 of the Tender Document Volume 2

79	Implants, Diagnostic/Diagnostic-Laboratory/Diagnostic-Radiological and High End Drugs Please clarify if the Specialty mentioned as DIAGNOSTIC - LABORATORY means that these packages can be claimed independently from any DIAGNOSTIC - LABORATORY without any involvement of any EHCP. Also, confirm if any registered medical practitioners' prescription is required while mentioning the presenting complaints and supporting clinical findings of the patient to validate the prescribed investigation.	Yes, for any MHIS empanelled diagnostics center. Yes, Prescription should be from a registered medical practitioner.
80	Implants, Diagnostic/Diagnostic-Laboratory/Diagnostic-Radiological and High End Drugs IMP0084 Coil for embolization of aneurysms - Please specify the number of coils included under this package. We understand the maximum amount capped under this package is INR. 26400/- only- please clarify.	IMP0084 Coil for embolization of aneurysms - INR. 26400/ is for 1 coil only.
81	Codes for Implants and Procedures -The following table represents the list of Procedure Codes (where Implants are applicable for certain procedures given in the Table under Procedure Head) and the corresponding Implant Codes (given in the Table under Implants, Diagnostic/Diagnostic-Laboratory/Diagnostic-Radiological and High End Drugs head) Please clarify the adjudication guidelines in case an EHCP uses additional or other variants of implants not mentioned under the stratification list. For example- IMP0216 "ERCP stent - Plastic" if the hospital uses another variant.	If the hospital use another variant of implants, claims will be paid to the hospital only on the rate of ERCP stent plastic

82	"ADDITIONAL CONDITIONS ON UTILISATION OF CERTAIN PACKAGES-1. Conditions on Packages Listed Under Specialities IPD Diagnostic, High-End Drugs and Implants:Packages under specialities of Diagnostic/Diagnostic-Laboratory/Diagnostic-Radiological (type IPD/IPD&OPD), ...in Schedule 3 of the Insurance Contract." Kindly clarify the adjudication guidelines where the IPD package itself is deemed to include an add-on package. For example:- MG112MLA Typhoid fever and MG888ML Widal Test. In this case, the diagnosis of Typhoid fever can not be made without a Widal test. Hence, the Widal test must be considered inclusive of a Typhoid Fever Claim.	Utilisation of Medical Packages, Surgical Packages, packages under Diagnostic, Diagnostic-laboratory, Diagnostic-Radiological (type IPD/IPD and OPD, high-end drugs and implants are clearly defined in clasues 3 B, 5 B, Schedule 3 and Annex 1 of Schedule 3 of the Tender Document Volumne 2.
83	NON-MEDICAL CONSUMABLES AND NON-PAYABLE ITEMS :List of indicative non-medical consumables and non-payable items for which is not cover under MHIS 6. A) Please illustrate claim admissibility wherein these non-medical consumables are non-inclusive of the claimed package and thereby authorise an EHCP to collect these amounts additionally from the beneficiary. B) Also, confirm if the EHCPs can collect all these expenses from all MHIS-PMJAY beneficiaries or if any exemptions exist for any particular type/class of beneficiaries. C) Please confirm if the EHCP must to share the record of the amount collected from patient towards non-medical consumables to the insurer for claim adjudication in compliance with fixed package amount.	A) The bidders may refer to Schedule 4. B) There is no exemption for any category of beneficiaries. C) The IC may seek information related to the treatment of the patient availing/availed MHIS PMJAY services at the EHCP including information on cost imposition towards non-medical consumables (if any).
84	Unspecified Medical Management Package We understand the liability towards all the unspecified medical management would be limited to Routine Ward/ HDU/ ICU - Without Ventilator/ ICU - With Ventilator with the Per-day rate of 2100/ 3300/ 8500/ 9000 respectively. And this amount is inclusive of the entire treatment cost as per HOSPITALISATION EXPENSES BENEFIT, and no separate clubbing of packages is allowed.	There can be some circumstances or depending on the medical condition of the patient, claim for addtional packages of days will be permitted subjected to the approval of the SNA.

85	If a Surgical Treatment Package is not listed in Schedule 3, the EHCP can block the treatment under unspecified surgical package as specified in Schedule 3 and subjected to the terms as mentioned in Schedule 5 of the Insurance Contract. We understand that unspecified packages apply only to surgical procedures that are not mentioned or completely dissimilar than the procedures mentioned in Schedule 3.	Yes
86	Expenses incurred at an Empanelled Health Care Provider primarily for Screening, i.e., evaluation or diagnostic purposes only during the Hospitalization and expenses on vitamins and tonics etc., other than such expenses that are required as a part of the expenses for: (i) Hospitalization expenses for a Medical Treatment or Surgical Procedure, as certified by the attending physician; (ii) Follow-up Care; or (iii) the OPD consultations and Screening covered under the OPD/OPD Diagnostics Benefits. We understand that the hospitalization, primarily for evaluation and investigation purposes, is not covered and can not be claimed with (ii) Follow-up Care; or (iii) the OPD consultations and Screening covered under the OPD/OPD Diagnostics Benefits.	Yes
87	Same procedures with difference in amount observed wherein stratification option is not applicable Eg 1: Spine - Intradural Haematoma-without fixation SN040A and Spine - Intradural Haematoma-with fixation SN040B (55000) . Eg 2 :Fixation of Fracture of Jaw Closed reduction of 1 jaw under LA SM004A and Fixation of Fracture of Jaw Open reduction of 1 jaw and fixing of plates / wire under GA SM004B (18500) Please confirm the rationale of these similar packages with differences in procedure with equal package amounts and the adjudication guidelines of the same.	These are AB-PMJAY packages of HBP 2022, as prescribed by NHA and no changes has been made.
88	Some procedure are classified as Major and Minor with same package amount Eg :Peripheral Nerve Surgery Minor SN049A and Peripheral Nerve Surgery Major SN049B Please confirm the rationale of this similar packages with difference in procedure with similar package amount	These are AB-PMJAY packages of HBP 2022, as prescribed by NHA and no changes has been made.
89	Some procedures are found with similar package amount for LAP and Open procedures Eg :Anterior Resection of rectum -open SG029A and Anterior Resection of rectum-Lap SG029B (55000)	These are AB-PMJAY packages of HBP 2022, as prescribed by NHA and no changes has been made.

97	The total sum insured per beneficiary unit is Rs. 5,30,000/-, which would be an insurance cover of ₹ 5,00,000 and an additional cover of ₹ 30,000 for Maternity benefit, Child Care benefit, Cardiac and Diabetic Preventive Care benefit, OPD Diagnostic and Follow-up care benefit. It is requested to incorporate the bifurcation of the total sum insured into Rs. 5,00,000/- and Rs. 30,000/- in TMS and the number of OPD benefits utilized are also be recorded in TMS from the inception of the policy, so that EHCPs, beneficiaries and Insurer are all aware of the balance sum insured and number of OPD utilized under the normal cover and OPD cover.	The SNA has endeavoured to make such changes in the Transaction Management Software through necessary requests made to the National Health Authority. Such changes are subjected to NHA's approval

Member Secretary, Tender Committee,
Chief Executive Officer, Megha Health Insurance Scheme &
Secretary, health and Family Welfare,
Government of Meghalaya.