Zurich Kotak General Insurance Company (INDIA) Ltd

Guidelines for Standards and Benchmark for the Hospitals in the provider network

ENTERPRISE LEVEL

Background:

A. IRDAI has issued a circular on "*Standards and Benchmarks for the Hospitals in the Provider Network"* on 20 July 2022 (**"Circular"**), in furtherance of its earlier circular with the same title of 23 July 2021, with an objective of "*enhance[ing] the scope for offering cashless facility across [India]*". The Circular modifies the guidance issued under Chapter I of the IRDAI's "*Master Circular on Standardization of Health Insurance Products*" of 22 July 2020 (**"Master Circular"**).

The insurance company (**"Insurer"**) to have a board approved criterion to empanel network providers. Insurer has to necessarily consider the minimum "*manpower and healthcare infrastructure facilities"* to be specified for such network providers.

Insurer to have focus on "*delivery of quality healthcare services*" of Hospitals in the Provider Network for cashless facility.

B. IRDAI has issued a circular (IRDAI/HLT/CIR/GDL/31/01/2024) dated 31st January 2024 directing insurer to have board approved quality parameters as well as procedure for enrolling AYUSH Hospitals/Day Care Centers as network providers for the purpose of providing cashless facility.

1. CRITERIA FOR HOSPITAL EMPANELMENT

1.1. Criteria to qualify for hospitals directly in the provider network.

a. Entry level certification issued by National Accreditation Board for Hospitals & Healthcare Providers
b. Hospitals in panel of Central Government Health Scheme (CGHS)

1.2. Common qualifying criteria applicable to all categories of the Network Hospitals other than above.

a. Hospital should be registered with local body (respective municipality)

b. Should have the facility of 24 hrs. Nursing Staff/Medical Staff consisting of fully qualified Doctor (s), round the clock and 24hrs admission facility.

c. Should have at least two permanent resident doctors on its roll.

d. Should have facility of In-House pharmacy and pathological lab or tie-ups for pathological tests/pharmacies to ensure completely cashless treatment of the Beneficiaries.

e. Should have at least 15-bed indoor treatment capacity along with full-fledged operation Theatre and Intensive Care Unit. 10 beds for smaller towns and villages and or single specialty hospitals (any locations)

f. Should have a Help desk at In-patient (IPD) reception, for the beneficiaries.

g. Should have necessary IT infrastructure such as computer, fax machine, software, hardware, Internet at its own cost etc. for implementing E- Preauthorization and facilitating online transmission of documents

h. Enter into agreement with Insurance Company which shall be valid till either of the party executes termination clause.

i. Should always adhere to the schedules of rates which form an integral part of agreement entered

j. The necessary formalities are completed by the Provider Network for electronic mode of payment:
   - ❖ Duly Filled Contact details sheet.
   - ❖ Duly Filled NEFT/EFT Mandate Form.
   - ❖ Duly Filled Payee Name Confirmation Format or sample Cheque (Cancelled Cheque)

k. Adherence of Turnaround time (TAT) and cashless procedure as laid down in the agreement or amendment.

1.3.PROCEDURE FOR EMPANELEMNT OF AYUSH HOSPITAL

An AYUSH Hospital is a healthcare facility wherein medical/surgical/para-surgical treatment procedures and interventions are carried out by AYUSH *Medical Practitioner*(s)

Criteria to qualify for hospitals in the provider network

a. Central or State Government AYUSH Hospital and/ or accredited by National Accreditation Board for Hospitals & Healthcare Providers (NABH) or equivalent accreditation bodies.
b. Teaching hospital attached to AYUSH College recognized by the Central Government/Central Council of Indian Medicine/Central Council for Homeopathy or
c. Standalone private AYUSH Hospital including Day care centre with in-patient facility of any recognized system of medicine and is registered with the local authorities and is under the supervision of a qualified registered AYUSH *Medical Practitioner*

Common qualifying criteria applicable to all categories of the AYUSH Network Hospitals other than above:

i. In-patient facility
ii. Qualified AYUSH *Medical Practitioner* in charge round the clock
iii. Dedicated AYUSH therapy sections as required and/or has equipped operation theatre where surgical procedures are to be carried out
iv. Help desk at for the beneficiaries
v. IT infrastructure at its own cost for implementing E- Preauthorization and facilitating online transmission of documents
vi. Enter into agreement with Insurance Company which shall be valid till either of the party executes termination clause.

vii. Should always adhere to the schedules of rates which form an integral part of agreement entered

viii. The necessary formalities are completed by the Provider Network for electronic mode of payment:

- ❖ Duly Filled Contact details sheet.
- ❖ Duly Filled NEFT/EFT Mandate Form.
- ❖ Duly Filled Payee Name Confirmation Format or sample Cheque (Cancelled Cheque)

ix. Adherence of Turnaround time (TAT) and cashless procedure as laid down in the agreement or amendment.

2. CRITERIA FOR NOT SELECETING OR DELISTING HOSPITAL FROM NETWORK

2.1. Hospital blacklisted by other insurer for alleged involvement in fraud & malpractice
2.2. Hospitals which has inadequate facility and safety measures
2.3. Hospitals which are not registered with local authority and do not meet the minimum requirement as per the definition of hospital in the policy wordings
2.4. Hospital involved in fraud & malpractice after onboarding in network
2.5. Billing Errors/Change in medical history**:** Repeated errors which are not resolved. A high number could indicate a problem with the facility's employee and their integrity.
2.6. Hospitals which repeatedly violates agreements terms and condition
2.7. Hospitals breaching law and order prevalent / enforced in their respective locality or any breach of law as per other central/state govt viz. Income tax/sales tax/GST council etc
2.8. Safety measure, patient satisfaction is not consistently above acceptable level as listed in section 3.

3. Parameters for *delivery of quality healthcare* for hospitals:

3.1. Safety and quality

a. **Complication Rate**: The hospital is expected to minimize the complications arising during provision of care to the patient. It takes adequate care in this regard during patient admission. Our management will monitor such cases periodically for feedback to the hospitals and take decision on the continuation of empanelment with the insurance company.

b. **Leaving Against Medical Advice (LAMA)**: The hospital is expected to take utmost care and minimize the LAMA cases. Our management will monitor such cases periodically for feedback to the hospitals and take decision on the continuation of empanelment with the insurance company. (This excludes LAMA due to financial issues of policy holder)

c. **Post-Procedure Death Rate:** The number of deaths that occur during hospitalization as against total admission cases in the hospital of the insurer in a financial year. Death 1% + may be an indicator of low quality of care**.** However, this would be looked in conjunction to other

parameters, as certain death counts are expected in certain critical situation / procedure beyond control of the treating doctors.

d. **Readmission Rate:** The hospital is expected to take utmost care and minimize the readmission rates of our policy holders. Our management will monitor such cases periodically for feedback to the hospitals and take decision on the continuation of empanelment with the insurance company.

e. **Hospital Acquired Conditions (HACs):** The hospital is expected to take utmost care and minimize the Hospital Acquired Conditions to our policy holders. Our management will monitor such cases periodically for feedback to the hospitals and take decision on the continuation of empanelment with the insurance company.

f. **Average Length of Stay:** The total time it takes for patients to be admitted, treated, and discharged. If ALOS is more than national average and has ineffectiveness in any other above parameters, would be an indicator of low-quality care. The management will monitor the length of stay periodically for feedback to the hospitals and take decision on the continuation of empanelment with the insurance company.

g. All above criteria will be noted and tagged during claim adjudication for the feedback to the management on periodical basis.

3.2. Patient's feedback

h. **Number of Patient Complaints:** The amount of complaints submitted by patients regarding the care they received. These complaints could be submitted in the midst of care or post-treatment. Percentage of 0.50%+ of complaints against a hospital over total admission of insurer's covered person in a financial year may be an indicator of low quality and ineffective treatment.

a. Patient Survey Questionnaire: Rating of network hospital given by all the patients admitted there in a financial year. If the aggregate rating i.e. total of the average ratings divided by total number of patients is less than 2, basis response of minimum 20 patient's in a year can signal a problem with hospital operations or care quality.

Hospital which breaches minimum acceptable level in at least 3 or more areas in points listed in. 3.1 and/or any one of the parameters as listed in 3.2. will be served show cause notice.

If there is no response within 30 days from date of notice or inadequate response, hospital may be served de-panelment notice with immediate effect and removed from the network list. However, this would not restrict cashless facility for patient already admitted in the hospitals or for patient who took part of the treatment earlier in this hospital.

4. **Geographical spread of network hospitals and grading Criteria of the Hospital:**

Adequate network of hospitals across length and breadth of the country would facilitate customer to take cashless treatment. Basis the following grading criteria, Insurer would strive to have network hospitals in all states and union territories of the country.

4.1. Grading Criteria for Super-Specialty (Tertiary care) / Multi-Specialty Hospitals (Secondary care hospitals)

Parameter	Grade A	Grade B	Grade C
No of Beds	50+	26-50	15-25
No of ICU	2	1	1
Day care facility	Yes	Yes	Yes
No of Ventilators	2	1	0
No of Operation Theatre	1	1	1
No of trained Nurses registered with Nursing Council of India	12	6	3
No of Permanent MBBS	3	2	2
Inhouse Pathology / Pharmacy	Yes	Yes	Yes
No of MD doctors	1	1	1
No of DM/MCH Doctors	1	1	1

4.2. Grading Criteria for Primary care hospitals

Parameter	Grade A	Grade B	Grade C #
No of Beds	15+	10-15	>10
No of ICU	0-2	0	0
No of Ventilators	1	0	0
No of Operation Theatre	1	0	0
No of trained Nurses registered with Nursing Council of India	3	3	2
No of Resident medical officer	2	2	1
Permanent MBBS/MD	1	1	1
On call specialist	Yes	Yes	Yes or no

applicable in very smaller towns/ villages

4.3. Grading Criteria for Single Specialty Hospital other than Eye/ ENT/Maternity

Parameter	Grade A	Grade B	Grade C
No of Beds	20+	15-20	10-14
No of ICU	1	1	1
No of Ventilators	1	1	0
No of Operation Theatre	1	1	1
No of trained Nurses registered with Nursing Council of India	6	3	2
Specialist on roll / on call	2	2	2
Inhouse Pathology / Pharmacy	Yes	Yes	Yes or No
No of MD doctors	1	1	1

4.4. Grading Criteria for Single Specialty Hospital (Eye /ENT/Maternity)

Parameter	Grade A	Grade B	Grade C
No of Beds	10+	5-9	1-5
No of ICU	1	1	1
No of Operation Theatre	1	1	1
No of trained Nurses registered with Nursing Council of India	3	2	1
Specialist on roll / on call	1	1	1
Inhouse Pathology / Pharmacy	Yes	Yes or No	Yes or No
No of MD doctors	1	1	1

Note: The guidelines stated will be reviewed and changed time to time whenever there is a change in directions from the regulatory authority or any change in government policies