IN THE HIGH COURT OF JUDICATURE AT MADRAS

Dated: 22.04.2019

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The Honourable DR.JUSTICE ANITA SUMANTH

W.P. No.18534 of 2017

Dr.K.Vasudevan ....Petitioner

/Vs/

1.Director of Medical & Rural Service,
Tamil Nadu Government,
Chennai.

2.The District Collector,
Erode District,
Erode.

3.United India Insurance Company Ltd.,
Rep. by Divisional Manager,
5h Floor, Anna Salai,
Chennai.

4.The District Treasury Officer,
Erode,
Erode District. ....Respondents

P R A Y E R: WRIT PETITION under Article 226 of the Constitution of India, in the nature of Certiorarified Mandamus calling for the records of the 3rd Respondent in its proceedings No.Nil dated 24.05.2016 and the consequential order passed by the 1st respondent, this appeal proceedings in its O.Mu.No.60599/KP1/3/2016 dated 08.06.2017 and quash the same and consequently direct the Respondents to reimburse the medical expenses of Rs.1,81,187/- incurred by the petitioner for taking medical treatment at G.Kuppusamy Naidu Memorial Hospital, Coimbatore with interest.

For Petitioner : Mr.J.Ramkumar

For Respondents : Mr.Akhil Akbar Ali (for R1, R2 & R4)
Government Advocate
Mr.P.Sankaranarayanan for R3

O R D E R

The short points arising in this writ petition is whether the petitioner is entitled to reimbursement of amount of Rs.1,81,187/- incurred by him for medical expenditure.

2.The admitted facts are that the petitioner is a retired Government Doctor. He suffered an heart attack on 28.07.2014 and was rushed to G.Kuppusamy Naidu Hospital at Coimbatore where angiogram, angio plasty and surgery for placing of stents was performed on him. He was discharged on 30.07.2014, when he sought reimbursement of the amount of Rs.1,81,187/- spent by him for the aforesaid medical procedures. He was made to run from pillar to post to avail the same.

3.Firstly, the petitioner applied for medical reimbursement to the 4th respondent/ District Treasury Officer on 12.08.2014, with no response. Representation was sent to the District Collector/2nd respondent on 31.03.2015, who passed order dated 14.05.2015 concluding that the petitioner is entitled for a sum of Rs. Rs.1,75,000/- and directed the 3rd respondent Insurance Company to pay the amount within a period of one month upon necessary documents being produced.

4.The order of the District Collector was produced before R3 on 27.05.2015 and the petitioner was asked to await response thereto. Despite several oral representations, there was no action taken for 10 months and finally, the Insurance Company/R3 rejected the claim on 24.05.2016 stating that the treatment has been taken from a non-listed hospital. Hence, the present writ petition.

5. Only the 4th respondent has filed a counter confirming the entitlement of the petitioner to the amount and pointing out that a recommendation has been made to the Insurance Company, which is admittedly, only advisory in nature. Respondents 1 to 3 have not chosen to file counter and only advance oral submissions.

6.The issue before me appears to be covered by two decisions of the Division Bench of this Court, one in the case of Star Health and Allied Insurance Co. Ltd., v. A.Chokkar and others (2010 SCC Online Mad 2198), the other being Government of Tamilnadu and others v. K.Rajendran and others in (W.A.No.2749 of 2018 dated 04.02.2019).

7.In the case of Star Health and Allied Insurance (supra), the Division Bench went into the question of what is the extent to which on Insurance Company will be

bound to indemnify the claims made by the beneficiaries, who are Government employees, whether the insurance company and the beneficiaries were bound strictly by the terms of the contract and whether notwithstanding the terms of the contract, the insurance company is bound to satisfy all claims advanced. The Division Bench also went into the question of who should bear the responsibility in such matters seeing as the claimants are Government employees for the expenditure incurred. At paragraph 24, 26 to 28 the Bench states thus:

> "24.In the present case, what we have to decide is whether the State is bound to reimburse the claim, whether the insurance company is bound to indemnify the beneficiary for the claim made by him. As held in the decisions referred to above, the insurance company is strictly bound to strictly by the terms of contract and cannot be asked to settle a claim which does not fall within the terms of the contract and therefore the claim made by the beneficiaries in respect of treatments that were taken in a non-network hospital or for reimbursement of the claim made the insurance company is not liable. For this reason, the insurance company had made it clear that only if the beneficiary took treatment in a network hospital they would settle the claim and more importantly the facility itself is a cashless facility. The insurance company cannot pay cash and if we issue direction to the insurance company to reimburse the claim, we would be virtually re-writing the contract which we are not entitled to.
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> 25. .....
>
> 26.Before taking up the individual cases, we must record that there are certain situations which may arise and in fact which have arisen, for which the Government must issue clear guidelines. This the Government has to do, since it has made the Scheme obligatory for everyone and there is automatic deduction of premium to an extent of Rs.25/- per month. The directions are as follows:
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> (i) The State shall make it clear that if for some reason, which is satisfactory, the claimant is unable to take treatment in a network hospital but has been advised or had to go to a non-network hospital, then his claim would be considered under the Rules.

(ii) If the claimant has been advised some procedure which is not covered by the Scheme, there again, it must be made clear that he can apply under the Rules.

(iii) To safeguard duplication of payments, the Government can make sure and when they apply under the Rules, that the claimant himself certifies that he has not made claim under the Scheme or vice-versa.

(iv) The State shall inform every network hospital that if it receives complaints from claimants that money was demanded for admission or for treatment, then that hospital will be removed from the network. This warning is necessary, since, at times of crisis, the claimants will not be in a position to argue with the hospital that this is a "cashless" Scheme. We are aware that there is an officer of the Star Health Insurance Company at every network hospital to ensure that hospitals adhere to the terms of the Scheme but, yet, it is better to make this position clear to the hospitals, since one of the questions that has arisen before us is that whether the claimants will be entitled to reimbursement if, by mistake, they pay cash.

27.Now coming to the individual cases, in all the case, whatever may be the category, the petitioners/claimants have paid the amount. The scheme is a 'cashless' one and, therefore, it is only the Government which have to make the payment under the Rules. The Redressal Committee is empowered to decide the following circumstances, namely, any difficulty in availing treatment, non-availability of facilities, bogus availment of treatment for ineligible individuals, etc. It is really not clear what other complaints would be covered under the umbrella "etc.". But, however, since the Paragraph relating to 'Redressal of Grievances' starts with the sentence "The Hospitals shall extend treatment to the beneficiaries under the Scheme on a cashless basis", it is evident that the Committee cannot direct payment of cash.

28.Therefore, if the claimants have made payments whether for a procedure not covered or whether at a non-network hospital or they have paid when they have been treated for a covered

procedure in a network hospital, their only remedy is to approach the Government under the Rules. If, however, before they take treatment they are informed that a particular procedure is not covered, then at that stage, they may approach the Redressal Committee where the medical expert can decide whether that procedure is covered or not. The Redressal Committee may also go into the complaints regarding non-availability of facility at a network hospital, which may be available in favour of the claimant when he applies under the Rules. Otherwise, we do not think that the Redresal Committee can do much in any one of these cases, since all the petitioners/claimants before us would have made payments. But, if there is a petitioner who has not settled the claim and has come before us, then, in the event, that it is for a procedure that is not covered, he may approach the Redressal Committee. In view of the fact that there are the above lacunae in the Scheme, the Government shall not deny any claim validly made under the Rules only because the claimant is a member of the Scheme."

8.In the light of the aforesaid directions, it would suffice to permit the petitioner to appear before the District Treasury Officer along with a fresh representation/claim that will be considered and disposed of by the officer in the light of the observations of the Division Bench of this Court extracted above and as reiterated by a subsequent Division Bench of this Court on 04.02.2019. Necessary orders will be passed by the District Treasury Officer within a period of four(4) weeks from the date of appearance of the petitioner before the officer.

9.The writ petition is disposed of in the above terms. No costs.

Sd/-
Assistant Registrar(CS)

//True Copy//

Sub Assistant Registrar

vs/ska

To

1.Director of Medical & Rural Service,
Tamil Nadu Government,
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2.The District Collector,
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Erode.

3.The Divisional Manager,
United India Insurance Company Ltd.,
5h Floor, Anna Salai,
Chennai.

4.The District Treasury Officer,
Erode,
Erode District.

+1cc to Mr.J.Ramkumar , Advocate SR.No. 38341
+1cc to Mr. P.Sankaranarayanan, Advocate SR.No. 38333

W.P. No.18534 of 2017

A.SK(14/06/2019)