



IN THE HIGH COURT OF JUDICATURE AT MADRAS

DATED: 26.09.2023

CORAM

THE HON'BLE Mr. JUSTICE **C.V.KARTHIKEYAN**

W.P.No.2708 of 2018

S.Santhanakrishnan

.. Petitioner

Vs.

1.Treasury Officer,
District Treasury,
Nagapattinam.

2.The Divisional Manager,
United India Insurance Company,
Divisional Office, 5th Floor,
PLA Rathna Tower,
212, Anna Salai, Chennai – 600 006.

.. Respondents

Prayer: Writ Petition filed under Article 226 of the Constitution of India praying to issue a Writ of Certiorarified Mandamus, to call for the records on the file of the 1st respondent in his proceedings Moo.Mu.No.3047/201/U2 dated 26.09.2016 and direct the respondents to forthwith pay petitioner's eligible claim of Rs.2,00,000/- (Rupees Two Lakhs only) under G.O.Ms.No.171 dated 20.06.2014 with interest at the rate of 9% per annum from the date of claim till the date of payment.



For Petitioner	.. Mr.T.V.Lakshmanan
For R1	.. Mr.U.Bharanidharan, AGP
For R2	.. Mr.P.Sankara Narayanan

ORDER

This writ petition has been filed in the nature of a Certiorarified Mandamus calling for the records of the 1st respondent, in proceedings Moo.Mu.No.3047/201/U2 dated 26.09.2016 and direct the respondents to pay the eligible claim of Rs.2,00,000/- to the petitioner under G.O.Ms.No.171 dated 26.06.2014 together with interest at 9% per annum from the date of claim till the date of payment.

2.In the affidavit filed in support of the writ petition, it had been stated that the petitioner had retired as Village Administrative Officer, from the Government of Tamil Nadu. He was eligible for the New Health Insurance Scheme for pensioners as provided by the Government under G.O.Ms.No.171 dated 26.06.2014. His wife, suffered a fracture in the leg which was diagnosed as 'Intera Capsula Fracture Nect of Femur'. She was admitted in Apollo Hospital at Trichy. The total treatment cost was Rs.3,30,806/-. The petitioner produced the Health Card. The hospital



refused to accept it. He therefore paid the entire amount towards the medical treatment for his wife.

3.The petitioner, therefore sent a communication to the respondent on 21.01.2016 seeking reimbursement of the amount to an extent of Rs.2,00,000/- as per G.O.Ms.No.171. This request was placed before the District Level Empowered Committee and after perusal of the document including the bills and vouchers, they had taken a decision that the wife of the petitioner was eligible for medical assistance under the New Health Insurance Scheme – 2014 and intimated United India Insurance Company, Chennai, to consider the request and pay the compensation. The Committee also took into account the opinion of the Joint Director of Health Services, that the treatment was an emergency owing to an accident. However, the 1st respondent / Treasury Officer, Nagapattinam had informed that the claim is rejected, since the hospital namely, Apollo Hospital at Trichy was not covered under G.O.Ms.No.171. This has given rise to the filing of the present writ petition.



4.A counter affidavit had been filed by the 1st respondent, wherein, it had been stated that only treatment or medial expenses incurred in an approved hospitals could be reimbursed. It had been stated that the Apollo Hospital at Trichy was not an approved hospital, as given in the list in G.O.Ms.N0.171, Finance Pension Department dated 26.06.2014. It had also been stated that the petitioner had not followed the proper procedure. With respect to the District Level Empowered Committee, which had recommended the claim for the petitioner, it had been again stated that the hospital not being approved, the petitioner is not entitled for reimbursement. In the counter affidavit, quite strangely, the Treasury Officer had also given a string of judgments of which he relies on.

5.Heard both sides.

6.So far as this Court is concerned, consistently a view had been taken by Co-ordinate Division Benches that taking treatment in an emergency situation even in an unapproved hospitals would entitle the Government servant to seek reimbursement of the medical expenses incurred. The issue first came up for consideration in *Star Health and*



Allied Insurance Company Chennai Vs. A. Chokkar and Ors reported in

2010 SCC OnLine Mad 2160. After examining the fact of this particular case and after also examining about the New Health Insurance Scheme, which was the pioneering scheme in the entire country, the Division Bench had extracted the facts of the case in paragraph Nos. 21 and 22 which were as follows:

“21. In the present case, on facts, the wife of the respondent had taken treatment in Rajaji Hospital, Madurai and had then gone to Thiruvananthapuram in 2008, nine years later. We see from the scheme that in Madurai alone about 24 hospitals have been shown as network hospitals, of which ten or multi speciality hospitals and in Thiruvananthapuram three hospitals are network hospitals. The judgments relied on by the claimants arose out of claims made before this scheme, where the question was when the Government had implemented the health fund scheme by which an assurance was given to the employees that they would receive assistance as per the scheme, whether they could be denied benefit merely because the treatment was taken in a hospital that was not listed in the schedule. In that situation, the legal position is entirely different and in that context there are several decisions of this Court where the Government's denial to



reimburse the amount was set aside on the ground that it was arbitrary and violative of the rights guaranteed by the Constitution.

22. But, in this case, we are faced with a claim that should be decided against the terms and conditions of the contract. The relationship of the insurance company with the claimant is purely contractual. The Insurance Company is not bound to satisfy any claim that is not covered by the scheme. The insurance company is strictly bound to satisfy the claims if they arise out of the procedures/treatments that are listed and if the beneficiaries are treated in network hospitals and not otherwise.”

7. Thereafter, on examination of the law on this aspect, the Division

Bench held as follows:

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.

25. The Tamil Nadu Medical Attendance Rules (“the Rules” in short) clearly lay down the rules regarding dependents and who is entitled to medical concessions under the Rules. It also defines who is a well to do person. The Rules lay down the manner in which claims can be made. According to the learned Advocate General, these Rules are still in force and therefore when it is a claim not covered by the present Insurance Scheme, the Government Servants have the right to make their claims under the Rules. Therefore, as regards Category-A, where treatment has been taken in a non-network hospital, the insurance company cannot be asked to cover the expenses, since the scheme itself makes the network hospitals as intrinsic. However, the petitioners/claimants were also not no remediless and that is why we will issue directions to the claimants to make an



application under the Rules or go before the Redressal Committee.

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:

(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



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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.



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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 Redressal 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. This opinion of the Division Bench had been subsequently followed by yet another Division Bench of this Court reported in **2019 2 Mad LJ 1 : (2019) 1 CWC 760, State Level Empowered Committee Represented by its Commissioner and others Vs. S. Paramasivam and another**. The Division Bench was again concerned with treatment taken in a non-network hospital. The Division Bench had held as follows:

“3. The rejection of the claim of the Petitioner for the medical reimbursement was impugned by the Petitioner in W.P. (MD) No. 23912 of 2016. The Writ Court by order dated 27.02.2017 in that Writ Petition, after referring to the decisions of the Division Benches of this Court in India Healthcare Services (TPA) Limited v. K. Parameshwari, reported in CDJ 2017 MHC 2213 and N. Raja v. Government of Tamil Nadu [2016 (3) CTC 394], held that in cases where the Insurance Company could not be held liable to reimburse the medical expenses incurred for having taken treatment in a non-network hospital, the Pensioner was entitled to his claim to be settled by the State Government under the Tamil Nadu Medical Attendance Rules. Accordingly, the order impugned in the Writ Petition was set aside and direction was issued to the Government of Tamil Nadu to sanction the medical expenses incurred by the Petitioner as per the eligibility criteria in terms of amount under the Scheme along with interest at the rate of 9% per



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annum without standing on technicalities and release the eligible amount within a period of two months from the date of receipt of copy of this order.

4. We have heard Mr. K.K. Senthil, Learned Counsel for the Petitioner, Mr. D. Muruganantham, Learned Additional Government Pleader for the First to Sixth Respondents and Mr. A. Shajahan, Learned Counsel for the Seventh Respondent in this Appeal and perused the materials placed on record apart from the pleadings of the parties.

5. It is strenuously urged by the Learned Additional Government Pleader appearing on behalf of the First to Sixth Respondents that the Writ Court ought not to have fastened any liability on the State Government when the Insurance Company was not held to be liable under Health Insurance Scheme and the direction to the Government of Tamil Nadu to reimburse the medical expenses incurred by the Petitioner would lead to downfall in the implementation of that Scheme itself.

*6. We are unable to countenance any of the submissions made on behalf of the First to Sixth Respondents, particularly in view of the decision of the Division Bench of this Court in *Star Health and Allied Insurance Company Limited v. A. Chokkar* [(2010) 2 LW 90], which has been followed by other Division Benches of this Court in *India Healthcare Services (TPA) Limited v. K. Parameshwari*, reported in CDJ 2017 MHC 2213 and *Director of Pension v. B. Sarada*, reported in CDJ*



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2017 MHC 7488. In the aforesaid decisions, the earlier Judgments of the Hon'ble Supreme Court of India and this Court on the subject have been extensively referred, and suffice here to refer to para nos. 24 and 25 of the decision in *Star Health and Allied Insurance Company Limited v. A. Chokkar [(2010) 2 LW 90]*, which reads as follows:—

“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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is entitled to medical concessions under the Rules. It also defines who is a well to do person. The Rules lay down the manner in which claims can be made. According to the learned Advocate General, these Rules are still in force and therefore when it is a claim not covered by the present Insurance Scheme, the Government Servants have the right to make their claims under the Rules. Therefore, as regards Category-A, where treatment has been taken in a non-network hospital, the insurance company cannot be asked to cover the expenses, since the scheme itself make the network hospitals as intrinsic. However, the Petitioner/Claimants were also not no remediless and that is why we will issue directions to the claimants to make an application under the Rules or go before the Redressal Committee.”

7. The Hon'ble Supreme Court of India in Shiva Kant Jha v. Union of India [2018 (5) MLJ 317], dealing with unfair treatment meted out to several retired Government servants in their old age for medical reimbursement under similar provisions of the Central Government Health Scheme, held in para nos. 13, 14 and 15 as follows:—

“13. With a view to provide the medical facility to the retired/serving CGHS beneficiaries, the Government has empanelled a large number of hospitals on CGHS panel, however, the rates charged for such facility shall be only at the CGHS rates and, hence, the same are paid as per the



procedure. Though the Respondent-State has pleaded that the CGHS has to deal with large number of such retired beneficiaries and if the Petitioner is compensated beyond the policy, it would have large ramification as none would follow the procedure to approach the empanelled hospitals and would rather choose private hospital as per their own free will. It cannot be ignored that such private hospitals raise exorbitant bills subjecting the patient to various tests, procedures and treatment which may not be necessary at all times.

14. It is a settled legal position that the Government employee during his life time or after his retirement is entitled to get the benefit of the medical facilities and no fetters can be placed on his rights. It is acceptable to common sense, that ultimate decision as to how a patient should be treated vests only with the Doctor, who is well versed and expert both on academic qualification and experience gained. Very little scope is left to the patient or his relative to decide as to the manner in which the ailment should be treated. Speciality Hospitals are established for treatment of specified ailments and services of Doctors specialized in a discipline are availed by patients only to ensure proper, required and safe treatment. Can it be said that taking treatment in Speciality Hospital by itself would deprive a person to claim reimbursement solely on the ground that the said Hospital is not included in the Government Order. The right to medical claim cannot be denied merely because the



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name of the hospital is not included in the Government Order. The real test must be the factum of treatment. Before any medical claim is honoured, the authorities are bound to ensure as to whether the Claimant had actually taken treatment and the factum of treatment is supported by records duly certified by Doctors/Hospitals concerned. Once, it is established, the claim cannot be denied on technical grounds. Clearly, in the present case, by taking a very inhuman approach, the officials of the CGHS have denied the grant of medical reimbursement in full to the Petitioner forcing him to approach this Court.

15. This is hardly a satisfactory state of affairs. The relevant authorities are required to be more responsive and cannot in a mechanical manner deprive an employee of his legitimate reimbursement. The Central Government Health Scheme (CGHS) was propounded with a purpose of providing health facility scheme to the Central Government employees so that they are not left without medical care after retirement. It was in furtherance of the object of a welfare State, which must provide for such medical care that the scheme was brought in force. In the facts of the present case, it cannot be denied that the Writ Petitioner was admitted in the above said hospitals in emergency conditions. Moreover, the law does not require that prior permission has to be taken in such situation where the survival of the person is the prime consideration. The doctors did his operation and had implemented CRT-D device and have



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done so as one essential and timely. Though it is the claim of the Respondent-State that the rates were exorbitant whereas the rates charged for such facility shall be only at the CGHS rates and that too after following a proper procedure given in the Circulars issued on time to time by the concerned Ministry, it also cannot be denied that the Petitioner was taken to hospital under emergency conditions for survival of his life which requirement was above the sanctions and treatment in empanelled hospitals.”

8. In this context, it would also be useful to refer to clause 14(4) of the Guidelines for Implementation of New Health Insurance Scheme, 2018, for Pensioners (including Spouse)/Family Pensioners in the Appendix to G.O. Ms. No. 222, Finance (Pension) Department, dated 30.06.2018 issued by the Government of Tamil Nadu, which is extracted below:—

*“14.(4) In case, a Pensioner/Family Pensioner undergoes emergency treatments/surgeries not covered under this Scheme in either Network Hospital or Non-Network Hospital, **no claim can be filed under the Health Insurance Scheme.** However, they shall be eligible for claim to the extent permissible under the Tamil Nadu Medical Attendance Rules and the G.O. Ms. No. 1023, Health and Family Welfare Department, dated 17.06.1980. It may be noted that the Tamil Nadu Medical Attendance Rules requires that treatment in private hospitals should not be resorted to except in case of emergencies. Clause*



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2(3) of the aforesaid Government Order states that in genuine cases of emergency, the claims will be restricted to the expenditure that would have been incurred had the patient taken treatment in a Government hospital excepting diet charges. For claims under Tamil Nadu Medical Attendance Rules, the Beneficiaries may apply to the authority in the department in which the Government employee last served who is competent to process and forward pension proposal to the Accountant General, Tamil Nadu. The Head of Office shall process the claims and pay the eligible claims under the Tamil Nadu Medical Attendance Rules.”

9. Though that Governmental Order has been issued after the claim has been made in this case, the aforesaid guidelines, which are based upon the instructions provided in the earlier Government orders and the Tamil Nadu Medical Attendance Rules, are obviously clarificatory in nature and would apply to past cases as well.

10. In the light of this incontrovertible legal position coupled with the facts of this case, we confirm the findings of the Writ Court. However, we are of the considered view that it would suffice to award interest at the rate of 7.5% per annum instead of 9% per annum that had been granted for the delay in medical reimbursement to the Petitioner.”



9.The reasonings given are binding. It had been very categorically held that treatment on emergency basis even in non-network hospital would not be disqualified so far as obtaining reimbursement of the amounts incurred for the treatment are concerned.

10.In the present case, the petitioner's requests had been placed before the District Level Empowered Committee and after examining the documents, they havd also recommended that the petitioner was entitled for reimbursement of a sum of Rs.2,00,000/- in accordance with G.O.Ms.No.171 dated 26.06.2014. The 1st respondent had taken an incorrect view and had not taken into consideration the Division Bench judgments of this Court, while filing the counter affidavit. In the view of the delay, the petitioner is also entitled for interest and as opined by the Division Bench, I would hold that the petitioner is entitled for interest at the rate of 7.5% per annum from the date of the claim till the date of payment.

11.In view of the above, since the District Level Empowered Committee had already considered the request of the petitioner, a Direction is given to the 2nd respondent to honour the claim of the petitioner together



with 7.5% interest per annum, from the date of claim till the date of payment. Necessary compliance should be done within a period of eight(8) weeks from the date of receipt of a copy of this order. Accordingly, this writ petition stands allowed. No costs.

26.09.2023

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Index: Yes/No

Internet: Yes/No

Neutral Citation: Yes/No

Speaking order: Yes/No

To

1. Treasury Officer,
District Treasury,
Nagapattinam.
2. The Divisional Manager,
United India Insurance Company,
Divisional Office, 5th Floor,
PLA Rathna Tower,
212, Anna Salai, Chennai – 600 006.



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C.V.KARTHIKEYAN,J.

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