

## Guidance document for processing PM-JAY packages

### Haemodialysis/ Renal failure/ AV Fistula

**Packages covered/ package count: 3**

**Specialty: General Medicine/ Pediatric medical management/ General surgery**

Sr. No.	Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
1	Haemodialysis / Peritoneal Dialysis	Haemodialysis	M100070, S100214	MG072A	1500/-
2	AKI (Acute Kidney Injury) / Renal Failure <a href="#">(Dialysis, if required, will be add on package)</a>	AKI / Renal failure	M100064, M200067	MG045A	General Ward- 1800/- HDU – 2700/- ICU without ventilator– 3600/- ICU with Ventilator– 4500/-
3	AV Fistula without prosthesis	AV Fistula without prosthesis	S100251	SG094A	6000/-

#### **Average Length of Stay (ALOS):**

- Haemodialysis & AV fistula: Day care (Few complicated cases of AV fistula may need hospitalization >1 day)
- AKI/ Renal failure: 7-14 days

#### **Minimum qualification of the treating doctor:**

**Essential:** MBBS; The patient should be periodically seen by a nephrologist to decide the dialysis prescription and line of treatment

**Desirable:** MD/ DNB (Medicine); DM/ DNB (Nephrology) or equivalent

For AV Fistula: Any trained nephrologist or physician (as above); or MS (Surgery) or equivalent

**Special empanelment criteria/linkage to empanelment module:** Dialysis facilities available, Dialysis machines – for general unit, water treatment plant, separate isolation area for dialyzing patients with hepatitis B, dialysis reprocessing area, Working hours of unit per day

#### **Disclaimer:**

ICMR has issued clinical guidelines for Management of **Acute Kidney Injury and Chronic Kidney Disease** to be followed in country. For monitoring and administering the claim management process of **Management of Haemodialysis, AKI (Acute Kidney Injury) / Renal Failure and AV fistula for dialysis** packages, NHA shall be following these guidelines. This document has been prepared for guidance of PROCESSING TEAM and TRANSACTION

MANAGEMENT SYSTEM of AB PM-JAY for the claims of procedures mentioned above. The ICMR guidelines are also included in the document for better understanding of the SHA teams, Insurance companies and TPAs. The hospitals can also refer to this document so that they have the insight on how the claims will be processed. However, this document doesn't provide any guidance on clinical and therapeutic management of patient. In that respect the hospitals and physicians may refer to the ICMR poster and other relevant material as per the extant professional norms.

## **PART I: Guidelines for Clinicians and Healthcare Providers**

### **1.1 Objective:**

The purpose of this section is to act as a guidance & a clinical decision support tool for the clinicians in deciding the line of treatment, plan clinical management of patient and decide referral of cases to the appropriate level of care (as required) for treatment of patients under PMJAY and selection of corresponding Health Benefit Package.

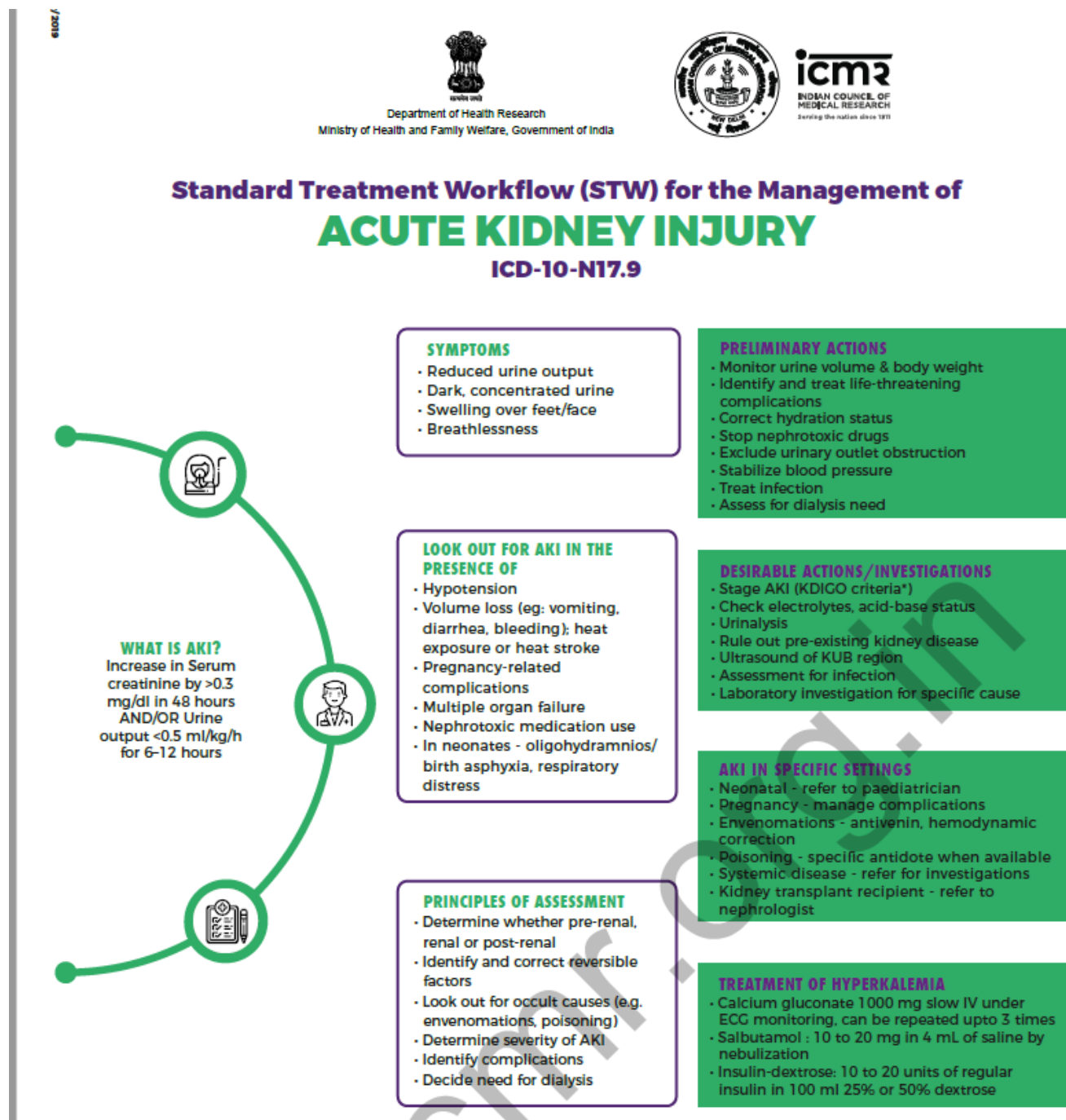
It will also serve as a tool for hospitals to determine and submit the mandatory documents required for claiming reimbursement of health benefit package under PMJAY.

### **1.2 Key clinical pointers:**

- a. Proceed with Haemodialysis only if diagnosis made is backed by clinical signs, symptoms and investigations.
  1. Acute Kidney injury: clinical features (e.g. reduced urine output, dark concentrated urine, swelling of face and limbs and breathlessness), investigations (elevated serum creatinine, electrolyte/acid-base abnormalities, supportive imaging and serological findings) and indications for dialysis
  2. Chronic Kidney Disease: clinical features (e.g. Edema, Hematuria, Proteinuria, renal stone, Family history of kidney diseases, unexplained hypertension and Anemia), elevated serum creatinine, supportive imaging findings
- b. A patient with pre-existing CKD may develop AKI

### 1.3 STANDARD TREATMENT WORKFLOW (DHR-ICMR STW)<sup>i</sup>- For clinicians/ treating doctor

#### a. Acute Kidney Injury



## MANAGEMENT

### PRIMARY CARE

- Detailed history and physical examination
- Identify and correct volume deficit
- Stop nephrotoxic agents
- Identify and correct bladder outlet obstruction
- Give anti-snake venom if indicated
- Identify hyperkalemia and start treatment
- Identify pulmonary edema- start intravenous furosemide and oxygen
- PD if indicated
- Timely referral after stabilisation

### SECONDARY CARE

- Detailed history and physical examination
- Identify and correct volume deficit
- Stop nephrotoxic agents
- Identify and treat hyperkalemia, metabolic acidosis and pulmonary edema
- Identify and correct urinary tract obstruction (USG, CT)
- Detailed investigation for infections
- Manage pregnancy complications - deliver if indicated
- Look for underlying CKD
- Dialysis (PD or HD)

### TERTIARY CARE

- Detailed history and physical examination
- Identify and correct volume deficit
- Stop nephrotoxic agents
- Identify and correct urinary tract obstruction (USG, CT scan)
- Identify and treat hyperkalemia, metabolic acidosis and pulmonary oedema
- Detailed investigation for infections
- Manage pregnancy complications- deliver if indicated
- Look for underlying CKD
- Investigations for specific cause (including imaging, genetic tests)
- Kidney biopsy
- Dialysis (PD or HD)

### RED FLAGS FOR URGENT REFERRAL

- Indications for dialysis
- Unexplained AKI
- Involvement of other organs
- Sepsis
- Systemic disease
- Complicated pregnancy

### INDICATIONS FOR DIALYSIS

- Fluid overload
- Pericarditis
- Hyperkalemia
- Severe metabolic acidosis
- Encephalopathy
- Severe uraemia
- To create space for fluids or blood products

### FOLLOW-UP OF AKI

- UO > 1L, stable or falling creatinine, no symptoms: stop dialysis
- Not resolving for >2 weeks: CECT to exclude cortical necrosis; kidney biopsy as indicated
- Look for systemic diseases (e.g. vasculitis, myeloma, TMA)
- Serum creatinine and urine protein q 6-12 months for life

## ABBREVIATIONS

**AKI:** Acute Kidney Injury

**CECT:** Contrast-enhanced CT scan

**PD:** Peritoneal dialysis

**TMA:** Thrombotic microangiopathy

**CKD:** Chronic Kidney Disease

**HD:** Hemodialysis

**UO:** Urine output

**USG:** Ultrasonography

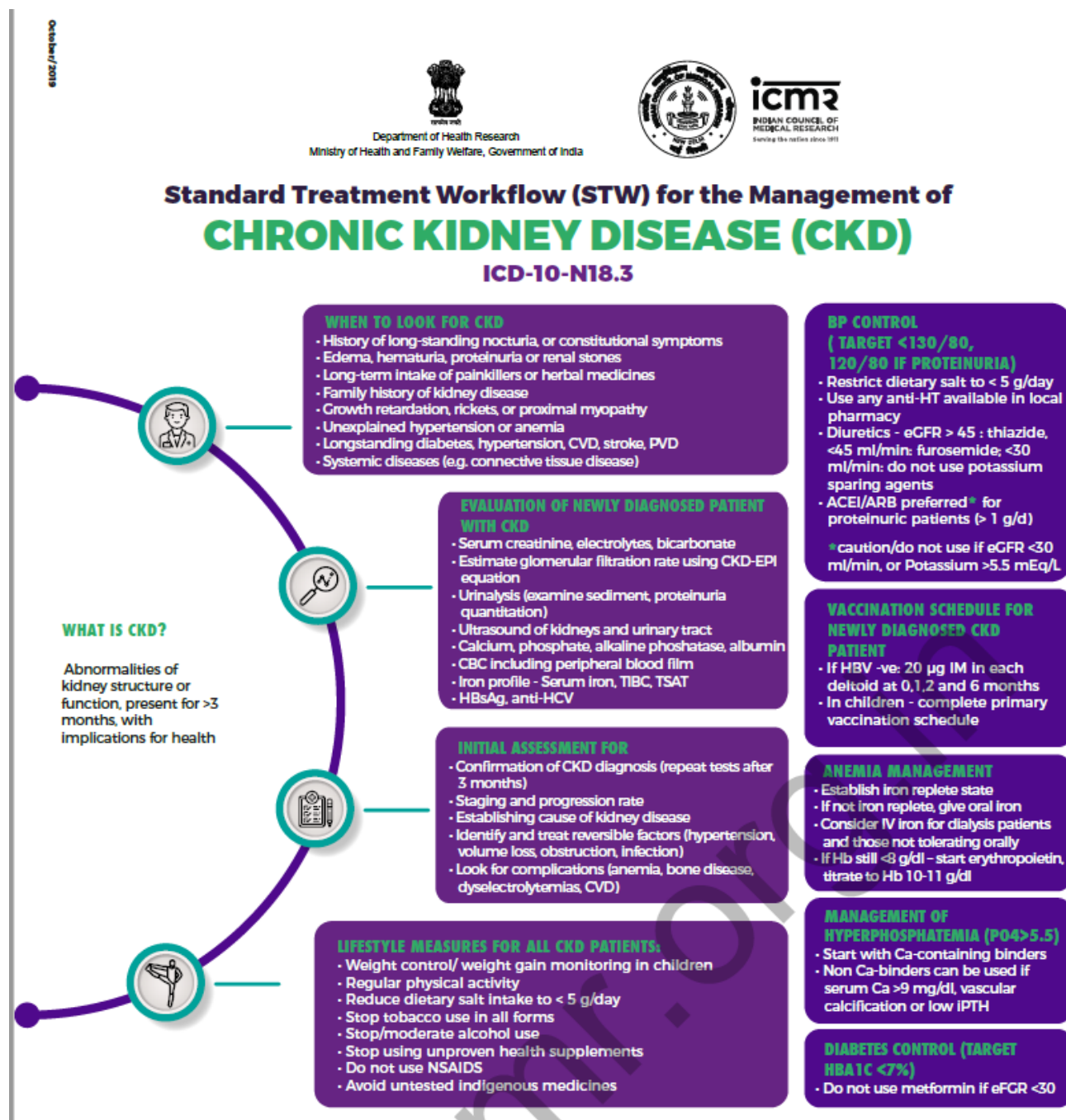
## REFERENCE

**\*KIDNEY DISEASE:** Improving Global Outcomes (KDIGO) Acute Kidney Injury Work Group. KDIGO Clinical Practice Guideline for Acute Kidney Injury. Kidney Int. Suppl. 2012; 2: 1-138

## KEEP A HIGH THRESHOLD FOR INVASIVE PROCEDURES

This STW has been prepared by national experts of India with feasibility considerations for various levels of healthcare system in the country. These broad guidelines are advisory, and are based on expert opinions and available scientific evidence. There may be variations in the management of an individual patient based on his/her specific condition, as decided by the treating physician. There will be no indemnity for direct or indirect consequences. Kindly visit our web portal ([stw.icmr.org.in](http://stw.icmr.org.in)) for more information.  
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## b. Chronic Kidney Diseases



### NUTRITION

- Salt restriction < 5g/d. Protein 0.6-0.8 g/kg/day.
- DO NOT restrict proteins unless documented high protein user (dairy, white meat are good protein sources, mix different types of dal).
- Restrict green leafy vegetables if eGFR <30 ml/min
- Avoid fruit juices, coconut water and carbonated beverages
- For children: ensure adequate protein intake appropriate for age.

### LOW POTASSIUM FRUITS/VEGETABLES:

Apple, pineapple, papaya, pear, tangerine, watermelon, grape, plum, cabbage, carrot, cauliflower, onion, radish, peppers, chillies, brinjal, cucumber, green beans, peas, rice, bread

### VITAMIN D THERAPY

- Supplement 60,000 units cholecalciferol q2W
- Correction of acidosis with oral sodium bicarbonate
- Activated vitamin D if hyperparathyroidism

## MANAGEMENT

### PRIMARY CARE

- Detailed history and physical examination
- Identify and correct reversible factors
- Stop nephrotoxic agents
- Referral after stabilization

### ADMISSION CRITERIA

- Initial evaluation or when patient presents with specific problems – like acute worsening, development of a new complication
- For creation of vascular access
- For PD catheter placement or initiation
- Initiation on HD and for kidney transplant

### TERTIARY CARE

- Detailed history and physical examination
- Investigate to ascertain cause of CKD (imaging/biopsy/genetic studies)
- Tailor treatment to cause
- Identify and manage complications
- Vaccination
- Counseling: nutrition, lifestyle, pregnancy in women of child-bearing age
- Discussion regarding RRT
- Vascular access creation/PD catheter insertion
- Work-up for transplantation
- Send patient back to community with treatment plan

### INDICATIONS FOR REFERRAL

- Initial evaluation of all newly diagnosed cases
- Rapid disease progression
- New complication
- Discussion for Renal Replacement Therapy (RRT)

### DISTRICT HOSPITAL

- Detailed history and physical examination
- Investigate to ascertain cause of CKD
- Tailor treatment to cause
- Identify and manage complications
- Vaccination
- Identify and correct acute factors
- Counseling: nutrition, lifestyle, pregnancy in women of child-bearing age
- Discussion regarding RRT
- Vascular access creation or PD Catheter insertion
- Send patient back to community with treatment plan

### PREPARATION FOR RENAL REPLACEMENT THERAPY

- eGFR < 30 : Preserve veins in the non-dominant arm for AV Fistula
- eGFR < 30 : discuss RRT options.
- eGFR < 15 : May need dialysis soon, counsel for AV fistula, list for transplant
- Dialysis start : depends on symptoms or eGFR <5 ml/min
- Look for contraindications to HD or PD : discuss choice in those suitable for either

### CONSERVATIVE CARE

- If life expectancy limited, multiple comorbidities/personal preference
- Decision-making should be shared with patient/family

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#### 1.4 Mandatory documents- For healthcare providers

Following documents should be uploaded by the concerned hospital staff at the time of pre-authorization and claims submission:

Mandatory document	Haemodialysis - per session	AKI (Acute Kidney Injury) / Renal failure	AV fistula for dialysis
<b>i. At the time of Pre-authorisation (For chronic dialysis patients, dialysis to be done max 3 times/ week. Extra dialysis needs separate pre-auth).</b>			
Clinical notes	Yes	Yes	Yes
Pathological Examination (Complete Blood count, Blood urea, Serum Creatinine, GFR, serum electrolytes). In chronic renal failure/ chronic dialysis patients investigations need to be done and submitted only once. These investigations to be repeated monthly. Quarterly- Serum Iron, ferritin, TIBC, TSAT, SGOT, SGPT, viral markers, calcium, phosphate	Yes	Yes	Yes
Planned line of treatment	Yes	Yes	Yes
<b>ii. At the time of claim submission</b>			
Clinical Notes/ Indoor case papers	Yes	Yes	Yes
Detail discharge Summary & dialysis chart (Only dialysis chart in chronic dialysis pts)	Yes	Yes	Yes (only discharge summary)
All investigation reports	Yes	Yes	No

## **PART II: GUIDELINES FOR PROCESSING TEAM**

**2.1 Objective:** To provide guidance to the pre-authorisation and claims processing team in ascertaining the medical necessity of procedure carried out vis a vis the patient's medical condition as evidenced by supporting documents/investigation reports etc, in deciding the admissibility and quantum of claim and compliance with mandatory documents by the hospital.

**2.2 Following mandatory documents to be diligently reviewed by the pre-auth / claims processing personnel:**



**2.2.1 At the time of pre-authorization processing- For pre-authorization processing doctor (PPD):**

**Haemodialysis (only for ARF) - per session**

- I. Was the patient a confirmed case of ARF?
- II. Did Renal Function Test show Raised Sr. creatinine?
- III. Are detailed vital parameters chart available including Input/output chart?

**Haemodialysis (For chronic renal failure):**

- i. Initial diagnosis has been confirmed as chronic kidney disease and end-stage kidney failure?
- ii. Maximum 3 dialysis sessions being done per week in a single pre-authorisation?

**AV Fistula:**

- i. Clinical notes with indications

**2.2.2 At the time of Claims processing- For Claims processing doctor (CPD):**

- I. Clinical Notes with all the details of the dialysis done?
- II. Any investigation done?
- III. Discharge summary for AV fistula?

### **PART III: GUIDELINES FOR IT**

**3.1 Objective:** To enable setting up of cross check mechanisms/rule engines within the IT platform (TMS) to ensure compliance with STGs and to prevent fraud / abuse of the Health Benefit Package.

**3.2 Below mentioned are the scenarios where a provision would be built in TMS for pop-ups:**

- I. Did the clinical note mention the need for the Dialysis? Yes
- II. Diagnosis of Acute Kidney Injury or Chronic Kidney disease/End-stage kidney disease is mentioned? Yes

Till the time the functionality is being developed, the processing doctors shall check the above manually.

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<sup>[1]</sup> Standard Treatment Workflows of India. 2019 Edition, vol. 1, New Delhi, Indian council of Medical Research, Department of Health Research, Ministry of Health and Family Welfare, Government of India. These STWs have been prepared by national experts of India with feasibility considerations for various levels of healthcare system in the country. These broad guidelines are advisory and are based on expert opinions and available scientific evidence. There may be variations in the management of an individual patient based on his/her specific condition, as decided by the treating physician. There will be no indemnity for direct or indirect consequences. Kindly visit the web portal ([stw.icmr.org.in](http://stw.icmr.org.in)) for more information. © Indian Council of Medical Research and Department of Health Research, Ministry of Health & Family Welfare, Government of India.



