

Guidance document for processing PM-JAY packages

Hysterectomy (except Caesarean & Radical Hysterectomy)

Procedures covered/ Procedure count: 6

Specialty: Obstetrics & Gynaecology

Package name		HBP 1.0 code	HBP 2.0 code	Package price
i. Hysterectomy	Abdominal Hysterectomy	New Package	SO010A	20,000
ii. Hysterectomy	Abdominal Hysterectomy + Salpingo-oophorectomy*	S400001	SO010B	20,000
iii. Hysterectomy	Non descent vaginal hysterectomy	S400009	SO010C	20,000
iv. Hysterectomy	Vaginal hysterectomy with anterior and posterior colpoperineorrhaphy*	S400010	SO010D	20,000
v. Hysterectomy	Laparoscopic hysterectomy (TLH)#	S400023	SO010E	20,000
vi. Hysterectomy	Laparoscopically assisted vaginal hysterectomy (LAVH)#	New package	SO010F	20,000

* Additional procedures like Unilateral (U/L) or Bilateral (B/L) Salpingo-oophorectomy / anterior and posterior colpoperineorrhaphy will not change the price of this procedure.

Average Length of Stay (ALOS): 5 days (all except Non descent vaginal hysterectomy- 4days)

Minimum qualification of the treating/operating doctor: MS/ DNB / PG Diploma in Obstetrics & Gynaecology/ equivalent (OBS&GYN)

Special empanelment criteria/linkages to empanelment module- Availability of:

#Laprosopic facilities and trained specialists in laprosopic procedures for performing laprosopic surgeries

Disclaimer:

The Indian Council of Medical Research (ICMR) has issued clinical guidelines for **Hysterectomy** to be followed in country. For monitoring and administering the claim management process of **Hysterectomy (Non descent vaginal hysterectomy, Vaginal hysterectomy with anterior and posterior colpoperineorrhaphy, Laparoscopic hysterectomy (TLH), Laparoscopically assisted vaginal**

hysterectomy (LAVH), Abdominal Hysterectomy, Abdominal Hysterectomy + Salpingo-oophorectomy), the National Health Authority (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 State Health Agency (SHA) teams, Insurance companies and Third Party Assurance (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.

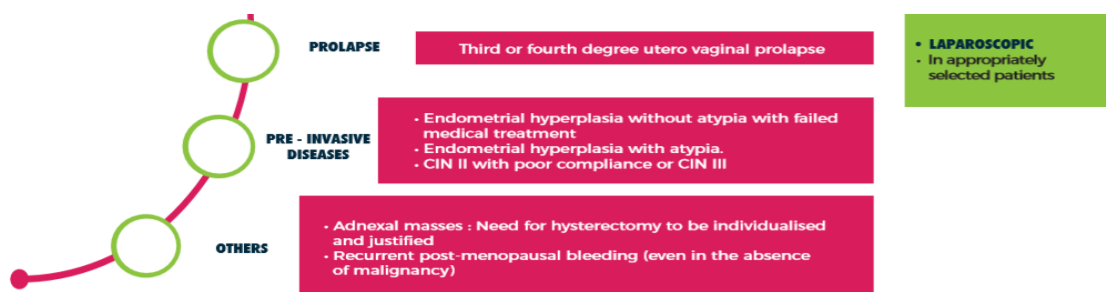
It will also serve as a tool for hospitals to determine and submit the mandatory documents required for claiming reimbursement of health benefit package under PMJAY.

1.2 Clinical key pointers:

- The diagnosis made should be backed by clinical or Ultrasonography (USG) findings and all required reports shall be uploaded
- In women aged less than 40 and/or low parity (≤ 2) it is mandatory to have a second opinion from a qualified gynaecologist. **(However, in case of a public hospital, if only 1 (one) gynaecologist is posted then this condition may be relaxed for that public hospital only)**
- Documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reasons. If failed, documents proving duration of treatment and failure.

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





Simple ovarian cysts less than 5 cm in size and without other significant/ suspicious features should be kept on observation and reviewed after 6 months

HYSTERECTOMY SHOULD NOT BE DONE FOR					
White discharge per vaginum	Cervicitis	Non specific abdominal or pelvic pain	Minor degree of utero vaginal prolapse	Fibroids which are small (less than 5 cm) or Asymptomatic (less than 12 weeks size uterus)	Simple ovarian cyst less than or equal to 5 cm
COMPONENTS OF PRE OPERATIVE COUNSELLING AND INFORMED CONSENT <ul style="list-style-type: none"> • Need for hysterectomy • Alternative treatment options • Risks and benefits • Potential complications of the procedure • Removal/ conservation of ovaries & tubes • Route of hysterectomy • Possible need for post operative Hormone therapy in selected cases 			INVESTIGATIONS <ul style="list-style-type: none"> • Complete Blood Count • Blood grouping & cross matching • Fasting Blood Sugar & Post Prandial Blood Sugar • Renal Function Test • Liver Function Test • Urine Routine & Microscopy • Electrocardiogram • X ray chest • Others as indicated 		
COMPLICATIONS TO BE EXPLAINED <ul style="list-style-type: none"> • Risk of Infection • Bleeding (primary/ reactionary/ secondary) • Injury to bladder/ bowel/ ureter • Pain • Fever • Hernia (rare and late complication) 			FOLLOW UP <ul style="list-style-type: none"> • Discharge summary with operative details • Review for histopathology report • Report if there is fever, bleeding or any other symptoms • Avoid lifting heavy weight for 8 weeks • Abstinence for eight weeks • Adequate Iron and calcium & Vitamin D3 supplements • Evaluate need for hormones in very selected patients 		

- Ovaries should be preserved in most pre-menopausal women unless diseased.
- While doing hysterectomy for benign gynaecological conditions in pre-menopausal women, it is recommended to combine it with bilateral salpingectomy with a view to minimise the risk of subsequent development of ovarian malignancy^{1,2}

1. Pérez-López FR et al, Interventions to reduce the risk of ovarian and fallopian tube cancer: A European Menopause and Andropause Society Position Statement. Maturitas. 2017
2. Darelus A et al, Efficacy of salpingectomy at hysterectomy to reduce the risk of epithelial ovarian cancer: a systematic review. BJOG. 2017.

🏠 COUNSELLING IS AN IMPORTANT ADJUNCT TO MANAGEMENT

🏠 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. Kindly visit the website of DHR for more information: <https://dhr.gov.in/>
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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-authorisation and claims submission:

i. At the time of pre-authorization:

- Clinical notes clearly indicating reason(s) for hysterectomy including medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason thereof
- Lab investigations (Complete Blood count, Blood sugar- fasting and post prandial, Renal function test, liver function test, Urine- routine and microscopy)
- Electrocardiogram
- X-ray chest

- e. Ultrasonography (USG) Abdomen + Pelvis
 - f. Pap smear & Cervical biopsy (Both these investigations are essential only in those hysterectomy cases which are getting operated due to benign conditions of Cervix)
 - g. Documentary evidence of appropriate counselling given to the patient and informed consent form signed by the patient in all cases of hysterectomy **especially** when performing removal of ovaries (oophorectomy- U/L or B/L) also.
- ii. **At the time of claims submission:**
- a. Indoor case papers
 - b. Detailed Operative notes
 - c. Discharge summary with follow up advise
 - d. Intra-operative stills (in cases of laparoscopy)
 - e. Pictures of specimen removed (Gross)
 - f. Histopathology report of the specimen removed

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-authorisation processing doctor (PPD):

- a. Clinical notes clearly indicating reason(s) for hysterectomy including medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason thereof
- b. Lab investigations (Complete Blood count, Blood sugar- fasting and post prandial, Renal function test, liver function test, Urine- routine and microscopy)
- c. Electrocardiogram
- d. X-ray chest
- e. Ultrasonography (USG) Abdomen + Pelvis
- f. Pap smear & Cervical biopsy (Both these investigations are essential only in those hysterectomy cases which are getting operated due to benign conditions of Cervix)
- g. Documentary evidence of appropriate counselling given to the patient and informed consent form signed by the patient in all cases of hysterectomy **especially** when performing removal of ovaries (oophorectomy- U/L or B/L) also.

2.2.2 At the time of claim processing- For claims processing doctor (CPD)

General:

- a. Indoor case papers
- b. Detailed Operative notes
- c. Discharge summary with follow up advise
- d. Picture(s) of specimen removed (Gross)
- e. Histopathology report of the specimen removed

i. Non descent vaginal hysterectomy

- a. Does the patient have indications of vaginal hysterectomy i.e. h/o Dysfunctional uterine bleeding, Fibroid uterus, Adenomyosis, Chronic pelvic pain, Post- menopausal bleeding, Pyometra, Cervical dysplasia, Cervical polyp?
- b. Is there a documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason available? If failed, are the documents proving duration of treatment and failure available?

ii. Vaginal hysterectomy with anterior and posterior colpoperineorrhaphy

- a. Does the patient have indications i.e. Prolapse of uterus- 3rd degree or 4th degree?
- b. Does the patient have evidence of such genital prolapse so as to require both anterior and posterior colpoperineorrhaphy?
- c. Is there a documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason available? If failed, are the documents proving duration of treatment and failure available?

iii. Laparoscopic hysterectomy (TLH)

- a. Does the patient have relevant history of either multiple Uterine Fibroids or Endometriosis or Adenomyosis or severe Dysfunctional Uterine Bleeding or Carcinoma in situ or long standing Pelvic inflammatory disease?
- b. Is there a documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason available? If failed, are the documents proving duration of treatment and failure available?
- c. Are intra-operative stills available confirming the use of laparoscopy?

iv. Laparoscopically assisted vaginal hysterectomy (LAVH)

- a. Does the patient have h/o Recurrent Uterine Fibroids/ Endometriosis/ Adenomyosis/ Heavy periods/ Vaginal prolapse/ Pelvic inflammatory disease?
- b. Is there a documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason available? If failed, are the documents proving duration of treatment and failure available?
- c. Are intra-operative stills available confirming the use of laparoscopy?

v. Abdominal Hysterectomy

- a. Does the patient have h/o Recurrent Uterine Fibroids/ Endometriosis/ Adenomyosis/ Heavy periods/ Vaginal prolapse/ Pelvic inflammatory disease?
- b. Is there a documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason available? If failed, are the documents proving duration of treatment and failure available?

vi. Abdominal Hysterectomy + Salpingo-oophorectomy

- a. Does the patient have h/o Recurrent Uterine Fibroids/ Endometriosis/ Heavy menstrual bleeding/ Malignant conditions?
- b. Is there a documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) should be of hormone therapy and it failed, or it was not indicated, with reason available? If failed, are the documents proving duration of treatment and failure available?
- c. Is the need for additional salpingo-oophorectomy justified in the clinical / operating notes (Ref. Para 1.3 above, i. Ovaries should be preserved in most pre-menopausal women unless diseased. ii. If the hysterectomy is being performed for Benign gynaecological conditions on pre-menopausal women, it is recommended to combine it with bilateral salpingectomy to minimize the risk of subsequent development of ovarian malignancy)?
- g. Is the picture of gross specimen of the Uterus, fallopian tube(s) and Ovary(ies) removed available?
- h. If B/L salpingectomy/ salpingo-oophorectomy is done, no additional costs are charged?

PART III: GUIDELINES FOR IT

3.1 Objective: To enable setting up of cross check mechanisms/rule engines within the IT platform Transaction Management System (TMS) to ensure compliance with these guidelines 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 in cases of hysterectomy:

- a. Sex - Female - Yes
- b. Age >40 years, (If age less than 40 years- reasons for performing hysterectomy?) - Yes
- c. Parity >= 2 - Yes
- d. Youngest child is more than 5 years of age - Yes
- e. Hysterectomy has never been done in the past - Yes
- f. Fibroids > 5 cm - Yes
- g. Non-gravid Uterus size >12 weeks and symptomatic - Yes
- h. Simple ovarian cyst > 5 cm- Yes
- i. Documentary evidence of medical management tried for at least 4-6 months, of which at least 2-3 months (i.e. 2-3 cycles) were of hormone therapy and it failed- Yes
- j. If medical management is not indicated, then reasons thereof available- Yes

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



Acknowledgment:

ⁱ 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) for more information. © Indian Council of Medical Research and Department of Health Research, Ministry of Health & Family Welfare, Government of India.