



Guidance document for processing PM-JAY packages

Hysterectomy as part of Vesicovaginal Fistula (VVF) / Uterovaginal fistula repair

Procedures covered: 1

Specialty: Urology/ Obstetrics & Gynecology

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Hysterectomy as part of Vesicovaginal Fistula (VVF) / Uterovaginal fistula repair	Hysterectomy as part of VVF / Uterovaginal fistula repair	New Package	SU092A	5,000

ALOS: Daycare

Minimum qualification of the treating doctor:

Essential: MS/MD/DNB/ or Equivalent (in Urology, Obstetrics & Gynecology)

Desirable: MCh/Equivalent (in Urology)

Special empanelment criteria/linkage to empanelment module: None

Disclaimer:

For monitoring and administering the claim management process of **Hysterectomy as part of Vesicovaginal Fistula (VVF) / Uterovaginal fistula repair**, 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 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 any 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:

There is increased risk of fistula development, most post-hysterectomy vesicovaginal fistulas occur after an apparently uncomplicated total abdominal hysterectomy for benign disease.

VVF following hysterectomy or other surgical procedures may present on removal of the urethral catheter or may present 1–3 weeks later with urinary drainage per vagina.

Vesicovaginal fistula: Is a free communication **between** the urinary bladder and the vagina. the urine from the bladder freely flows into the vaginal vault, leading to total or continuous incontinence.

Ureterovaginal fistula: is a communication between the distal ureter and the vagina.

Ureterovaginal fistula repair: A fistula may become apparent either immediately or, much more commonly, in a delayed fashion several days to weeks after surgery. Ureterovaginal fistula is the most serious of the urovaginal fistulas because of its potential to cause incontinence, sepsis, and renal loss.

Indications:

- Total abdominal hysterectomy is the most common cause of ureteral injury.
- As a result of Genitourinary endoscopic procedures, Hysterectomy and other Gynaecology & Obstetric Surgeries, Colorectal and vascular surgeries.

Diagnosis- “pad test” for VVF and vaginal “pad test” for Ureterovaginal fistula.

Management: The main factor in correcting vesicovaginal fistula is to separate the fistulous communication between the bladder and the vagina.

- The site of the fistula often guides the surgical approach, Supratrigonal fistulas are corrected transabdominally and infratrigonal fistulas are corrected transvaginally.
- **Through Vaginal incision:** VVF: If the fistula is large, a pad of fat from the side of the vagina can be harvested and sewn as a patch to the fistula. If the fistula is also the result of pelvic radiation, a muscle from the leg can be rotated off the leg and into the vagina to act as a patch.
- **Through Abdominal incision:** Fistulas that are close to the ureter in the bladder often require an abdominal approach, it may need to be resected to the bladder. Fistula is also patched with a fat pad taken from the stomach.
- Fistulas located near the infratrigonal area, and the bladder neck, and fistulas that are occurring after hysterectomy are usually amenable to transvaginal reconstruction. Transvaginal repairs do not require excision of the fistula tract.
- **Laparoscopic surgery:** In corrections of extensive fistulas after radiation therapy, a combined transvaginal and transabdominal approach with fixation of the omentum in the space between the vagina and urinary bladder is often useful.
- The basic rule for fistula repair is that the first operation has the best chance of success, to ensure successful closure of the fistula.
- Endoscopic surgery is an effective technology in the treatment of UVF

1.3 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	Hysterectomy as part of Vesicovaginal Fistula (VVF) / Uterovaginal fistula repair
i. At the time of Pre-authorization	
a. Detailed Clinical notes with history, indications, symptoms, signs, examination findings and advice for admission	Yes
b. Cystoscopy/Vaginoscopy/CT - IVP/IVP +/- cystogram Reports	Yes
ii. At the time of claim submission	
a. Detailed indoor case papers	Yes
b. Histopathology report (In all applicable cases)	Yes
c. Detailed Procedure / Operative notes submitted?	Yes
d. Detailed discharge summary	Yes

PART II: GUIDELINES FOR PROCESSING TEAM

PART III: GUIDELINES FOR TRANSACTION MANAGEMENT SYSTEM (TMS)

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:

- Was the clinical notes and Cystoscopy/Vaginoscopy/CT - IVP/IVP +/- cystogram reports indicative of procedure? Yes

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

References:

- Barber, Matthew D., et al. "Operations and pelvic muscle training in the management of apical support loss (OPTIMAL) trial: design and methods." Contemporary clinical trials 30.2 (2009): 178-189.
- Carmel, Maude E., et al. "Transvaginal neobladder vaginal fistula repair after radical cystectomy with orthotopic urinary diversion in women." Neurourology and urodynamics 35.1 (2016): 90-94.



3. Upadhyay, Amit Mani, et al. "Managing ureterovaginal fistulas following obstetric and gynecological surgeries." Journal of Nepal Health Research Council 16.2 (2018): 233-238.
4. <https://www.columbiaurology.org/vesicovaginal-or-ureterovaginal-fistulas-after-pelvic-surgery>