

## Guidance document for processing PM-JAY packages

### Basic Neonatal Care Package

Procedures covered: 1

Specialty: Neo-natal Care

Package name	Procedures name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Basic neonatal care package: Babies that can be managed by side of mother in postnatal ward without requiring admission in SNCU/NICU: • Any newborn needing feeding support • Babies requiring closer monitoring or short-term care for conditions like: o Birth asphyxia (need for positive pressure ventilation; no HIE) o Moderate jaundice requiring phototherapy o Large for dates (>97 percentile) Babies o Small for gestational age (less than 3rd centile)	Basic neonatal care package: Babies that can be managed by side of mother in postnatal ward without requiring admission in SNCU/NICU: • Any newborn needing feeding support • Babies requiring closer monitoring or short-term care for conditions like: o Birth asphyxia (need for positive pressure ventilation; no HIE) o Moderate jaundice requiring phototherapy o Large for dates (>97 percentile) Babies o Small for gestational age (less than 3rd centile)	M300001	MN001A	500

#### Minimum qualification of the treating doctor:

**Essential:** MD/DNB/DCH/Equivalent (in Pediatrics)

**Desirable:** DM/DNB/Equivalent (in Neonatology)

**Special empanelment criteria/linkage to empanelment module:** Care at Postnatal ward

#### Disclaimer:

ICMR has issued clinical guidelines for 'Post-Asphyxial Management of Neonates' and 'Neonatal Jaundice' to be followed in country. For monitoring and administering the claim management process of **Basic Neonatal Care Package** 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 Clinical key pointers:

### • Any newborn needing feeding support

Breast milk is unquestionably the best milk for a newborn baby. WHO recommends infants should be exclusively breastfed for the first 6 months. Breastfeeding should be immediately initiated after birth in hemodynamically stable newborns.

#### **Breastfeeding technique**

For mothers to produce enough milk, the baby must suckle often enough, and must also suckle in the correct manner. Correct positioning ensures effective suckling and prevents breast engorgement as well as sore nipples.

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##### **Proper positioning involves:**

- Baby's body is well supported
  - The head, neck and body of the baby are in the same plane
  - Entire body of the baby faces the mother
  - Baby's abdomen touches mother's abdomen
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##### **Proper attachment involves:**

- Baby's mouth is wide open
  - Lower lip is turned outwards
  - Baby's chin touches mother's breast
  - Majority of areola is inside the baby's mouth
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## **Breast conditions and breastfeeding problems**

1. Inverted/flat nipples – it causes difficulty in attachment to the breast. Treatment – Nipple is manually stretched and rolled out several times a day
2. Sore nipples – it is caused by incorrect attachment of the baby to the breast. Treatment – correct positioning and attachment of the baby to the breast.
3. Breast engorgement – if feeding is delayed or infrequent, milk accumulates in the alveoli and becomes swollen, hard, warm, and painful. Treatment – local warm water packs and analgesics for pain relief. Early and frequent feeding and correct attachment of the baby to the breast can prevent.

4. Breast abscess – if a congested, engorged breast, infected cracked nipple or a blocked duct and mastitis are not treated in the early stages it can form an abscess. Treatment – analgesics and antibiotics. The abscess is to be incised and drained.
5. Reduced milk supply/not enough milk – mothers complain of inadequate milk supply. Reassurance is needed if baby is gaining weight adequately, passing urine 6-8 times/day and sleeps for 2-3 hrs after each feed.

#### • **Moderate jaundice requiring phototherapy**

Icterus or jaundice is yellowish discoloration of skin, sclera and mucus membrane. Jaundice should be observed in broad daylight. Severity of jaundice is assessed based on the onset, intensity of skin discoloration, associated clinical signs of haemolysis, lab reports and clinical features of bilirubin induced brain dysfunction.

#### Classification

- Jaundice after 24 hours is often physiological (use transcutaneous bilirubinometer)
- Alert signs in neonatal jaundice (pathological jaundice)
  - Clinical jaundice in first 24 hrs of life
  - Total serum bilirubin increasing by  $> 5\text{mg/dl/day}$
  - TSB  $> 15\text{ mg/dl}$
  - Conjugated serum bilirubin  $> 2\text{ mg/dl}$
  - Clinical jaundice persisting for  $> 2$  weeks in full term and  $> 3$  weeks in preterm neonates

#### Approach and Management

- Visible assessment of jaundice in all babies in the postnatal ward. Assess the severity of jaundice and risk factors for bilirubin encephalopathy
- Chart on the American academy of Pediatrics (AAP) nomogram (Term and late preterm infants ( $\geq 35$  wk gestation)) to decide on role of phototherapy or exchange transfusion based on gestation, birth weight and postnatal age in hours

Note: If the total serum bilirubin does not decrease or continues to rise referral or admit in NICU. High risk category should be admitted and investigated.

### • **Large for dates (>95 percentile) Babies**

Newborns born >97th centile by customized centile charts are defined as Large for gestation age (LGA). Often infants of mothers with poorly controlled diabetes are macrosomic due to the effect of fetal hyperinsulinism secondary to exposure to high maternal glucose. Occasionally LGA can also be associated with increased concentrations of maternal triglycerides and free fatty acids.

#### **Complications:**

- Shoulder dystocia
- brachial plexus injury
- perinatal asphyxia if traumatic delivery

#### **These babies are at risk of:**

1. Hypoglycemia
2. Respiratory distress
3. Hypothermia
4. Jaundice secondary to polycythemia

#### **Management in postnatal ward**

1. Temperature should be monitored before feeds for 12 hours or until stable
2. Baby should be closely observed for signs of hypoglycaemia or hypothermia (jitteriness, pallor, lethargy)
3. Routine blood glucose measurement as per the unit schedule
4. Feeding should be commenced early; first feed within one hour of delivery
5. The baby should be watched for jaundice and bilirubin levels measured as indicated

### • **Birth asphyxia (need for positive pressure ventilation; no HIE)**

Perinatal asphyxia (PA) is a major cause of neonatal and under-5 mortality. PA is a multi-organ disorder affecting virtually every organ system in the body including brain, heart, lungs, kidneys and intestine.

	Definition
World Health Organization <sup>6</sup>	Failure to initiate and sustain breathing
NNPD Network	<ul style="list-style-type: none"> <li>Moderate PA: Slow/gasping breathing or an Apgar score of 4 to 6 at 1 minute</li> <li>Severe PA: No breathing or an Apgar score of 0-3 at 1 minute of age</li> </ul>
American Academy of Pediatrics and American College of Obstetrics and Gynecology <sup>7</sup>	Presence of all of following criteria: <ul style="list-style-type: none"> <li>Profound metabolic or mixed acidemia (pH &lt; 7.0) in umbilical cord blood</li> <li>Persistence of low Apgar scores less than 3 for more than 5 minutes</li> <li>Signs of neonatal neurologic dysfunction (e.g., seizures, encephalopathy, tone abnormalities)</li> <li>Evidence of multiple organ involvement (such as that of kidneys, lungs, liver, heart and intestine).</li> </ul>

➤ Immediate Transfer to NICU if:

- Apgar score at 1 minute is  $\leq 3$
- Required prolonged bag and mask ventilation (60 seconds or more)
- Required chest compressions

➤ Mild asphyxia

Requiring bag and mask ventilation for less than 60 seconds and no intubation or medications at birth → Assess at 5 minutes after birth (sensorium, tone, movements)

→ If normal tone, sensorium, no abnormal movements and no other complications

→ Shift to mother's side (requirement of minimal respiratory support)

➤ Transfer to postnatal ward

- Even neonates transferred to mother should be monitored frequently in the first 48-72 hours for development of features suggestive of HIE.
- Care of asphyxiated neonates therefore should be oriented towards determining the severity of dysfunction of critical organ-system and providing appropriate support to allow recovery to happen.
- Start breastfeeding/alternative methods of feeding once the neonate is hemodynamically stable, not on vasopressor support, and has normal abdominal examination findings (no distension and normal bowel sounds).
- Monitoring of short time minimum requirement respiratory support - Oxygen/Continuous Positive Airway Pressure (CPAP) (if required), temperature, heart rate, respiration, color, capillary refill time, pulse oximetry, blood sugar
- Management of asphyxiated neonates is mainly supportive and involves maintaining optimum oxygenation, ventilation, perfusion, metabolic milieu and control of seizures.
- There should have a complete neurological assessment and early intervention, if needed, for follow-up

- Admission to NICU if hemodynamically unstable or any features suggestive of HIE.

### • **Small for gestational age (less than 3rd centile)**

Intrauterine growth retardation (IUGR) are defined as small for gestation age (SGA), if their weight is below 3<sup>rd</sup> centile on charts, for that gestational age.

#### **Clinical features**

1. Neonates who have been growing slower than expected during pregnancy, will also present with a head circumference below the 10th centile.
2. Neonates who have lost weight during the last few weeks of pregnancy will be wasted with loose, dry, peeling skin and thin arms and legs.
3. They are often meconium stained, especially if born at term or post-term.

#### **Maternal causes**

- Low maternal weight
- Poverty and manual labour
- Smoking
- Excess alcohol intake
- Hypertension or pre-eclampsia

#### **Fetal Causes**

- Multiple pregnancy
- Chromosomal abnormalities, e.g. Down syndrome
- Severe congenital abnormalities
- Chronic intra-uterine infections, e.g. syphilis
- Post-term delivery

#### **Problems of SGA neonates**

The basic underlying problem amongst them is in-utero under nutrition and hypoxia. They are more prone to:

- Fetal distress, meconium passage in utero and birth asphyxia
- Polycythemia
- Hypothermia
- Hypoglycemia
- Congenital malformations



- If condition at birth is hemodynamically unstable/ abnormal umbilical doppler changes of absent or reversal/birth weight < 1.8 kg admit in NICU

### Monitoring in the postnatal ward

- Immediate breastfeeding/alternative method of feeding
- Monitor for feed intolerance: abdominal girth/bowel sounds
- Vital signs – heart rate, respiration, temperature, capillary refill time, saturation (24 hrs)
- Blood sugar, calcium, PCV as and when indicated
- Visual assessment of jaundice
- Prior to discharge neurological examination, explain about danger signs and method of Kangaroo mother care (if indicated)
- Depending on clinical picture and birth weight these infants may require follow up

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

<https://stw.icmr.org.in/stws>

### 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	Basic Neonatal Care Package
<b>i. At the time of Pre-authorization</b>	
Clinical notes including evaluation findings and planned line of management	Yes
<b><u>Any newborn needing feeding support</u></b> Documentation of feeding difficulties Clinical photograph (in case orofacial deformities)	Yes
<b><u>Birth asphyxia (need for positive pressure ventilation; no HIE)</u></b> <b>Mandatory</b> Neonate resuscitation notes Indication for monitoring in postnatal ward Neonate vital monitoring <b>Optional</b>	Yes

Arterial cord blood analysis Blood sugar Complete blood count	
<b><u>Moderate jaundice requiring phototherapy</u></b> <b>Mandatory</b> Total serum bilirubin Blood group: Mother and baby <b>Optional</b> Hemoglobin, reticulocyte count, peripheral smear for evidence of hemolysis G6PD enzyme activity Direct Coomb's test	Yes
<b><u>Large for dates (&gt;97 percentile) Babies</u></b> Blood glucose Serum calcium Complete blood count Feeding monitoring Vitals monitoring	Yes
<b><u>Small for gestation age (&lt;3 percentile) Babies</u></b> Blood glucose Serum calcium Complete blood count Feeding monitoring Vitals monitoring <b>Optional</b> Karyotyping report - If dysmorphic features present $\pm$ h/o previous miscarriages	Yes
<b>ii. At the time of claim submission</b>	
Indoor case papers (ICPs) / clinical notes	Yes
Investigations reports (if done)	Yes
Detailed Procedure notes and indication (if any)	Yes

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

**2.1 Objective:** To provide guidance to the pre-authorization 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):**

- a. Clinical notes including maternal and neonatal history, signs and symptoms, vitals, examination findings, planned line of treatment and requirement for admission (optional) (refer the clinical criteria mentioned above)?
- b. Was Karyotyping report (optional) submitted For Small for gestation age (<3 percentile) Babies if dysmorphic features are present  $\pm$  h/o previous miscarriages?

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

- a. Are the detailed neonatal notes with daily vitals and line of treatment available?

**Investigations based on the etiology such as:**

- b. Blood sugar/ Serum bilirubin documented/APGAR score/ABG/weight plotted available?

**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:**

**• Any newborn needing feeding support**

- a. Were the feeding or breast issues documented in clinical notes? Yes

**• Birth asphyxia (need for positive pressure ventilation; no HIE)**

- a. Was the APGAR score > 5/positive pressure ventilation documented < 60 sec? Yes

**• Moderate jaundice requiring phototherapy**

- a. Was Serum bilirubin report submitted? Yes

**• Large for dates (>97 percentile) Babies**

- a. Was the baby weight >97 percentile according to the unit's chart? Yes

**• Small for gestational age (less than 3rd centile)**

- a. Was the baby weight <3<sup>rd</sup> centile according to the unit's chart? Yes

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

**References**



1. Facility based Newborn Care (FBNC). Training Module for Doctors and Nurses. Ministry of Health and Family Welfare. Government of India. 2014
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3. Vishnu Bhat, Nishad Plakkal. NICU Protocols of JIPMER. Indian Journal of Pediatrics. 2020.
4. <http://www.adhb.govt.nz/newborn/Guidelines/Admission/SGALGAOnThePostnatalWard.htm>
5. Standard Treatment Guidelines. Department of Public Health & Family Welfare. Madhya Pradesh. 2016.
6. STANDARD TREATMENT GUIDELINES PEDIATRICS & PEDIATRIC SURGERY. Ministry of Health & Family Welfare Govt. of India
7. Standard Treatment Guideline & Essential Medicine List. Janani Shishu Suraksha Karyakram. Health & Family Welfare Department. Government of Odisha.
8. Standard Treatment Guidelines. A Manual for Medical Practitioners. Health & Family Welfare Department. Government of Tamil Nadu. 2010

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**Acknowledgment:**

<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.