



## Guidance document for processing PM-JAY packages

### High risk Newborn post discharge care package

Procedures covered: 1

Specialty: Neo-natal Care

Package name	Procedures name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
High Risk Newborn Post Discharge Care Package (Protocol Driven)*	High Risk Newborn Post Discharge Care Package (Protocol Driven)	M300007	MN007A	2,400

**\*Add on package for follow up upto 1 year from discharge for the below mentioned packages:**

1. Intensive Neonatal Care Package (MN003A)
2. Advanced Neonatal Care Package (MN004A)
3. Critical Care Neonatal Package (MN005A)

#### Minimum qualification of the treating doctor:

**Essential: Multidisciplinary team** - Neonatologist, Developmental Pediatrician, Physiotherapists, Speech and Language therapists, Psychologists, Dieticians, Social workers, Ophthalmologist, ENT, Orthopedician, and Neurologist.

**Special empanelment criteria/linkage to empanelment module:** Follow-up at District/Tertiary Hospital (SNCU/NICU), District Early Intervention Centre (DEIC)

#### Disclaimer:

For monitoring and administering the claim management process of **High-risk Newborn post discharge 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 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:

- All health facilities caring for sick neonates must have a follow up program. It requires establishment of a multidisciplinary team
- The level of follow up can be based on anticipated severity of risk to neurodevelopment. The frequency of follow up and the type of tests depend on “intensity or level of follow up” assigned. The schedule for follow up must be planned before discharge from birth admission
- Prior to discharge, a detailed medical and neurological assessment, neurosonogram, ROP screen and hearing screen should be initiated. A psychosocial assessment of the family should also be done
- The follow up protocol should include assessment of growth, nutrition, development, vision, hearing and neurological status
- Formal developmental assessment must be performed at least once in the first year and repeated yearly thereafter till six years of life. In Indian context, DASII is the best formal test for developmental assessment (till 2 year 6 months)
- Ideally, the follow up should continue till late adolescence, at least till school as many cognitive problems, learning problems and behavioral problems that are more common in at-risk neonates are apparent only on longer follow up
- Early intervention programme (early stimulation) must be started in the SNCU/NICU once the neonate is medically stable
- Timely specific intervention must be ensured after detection of deviation of neurodevelopment from normal

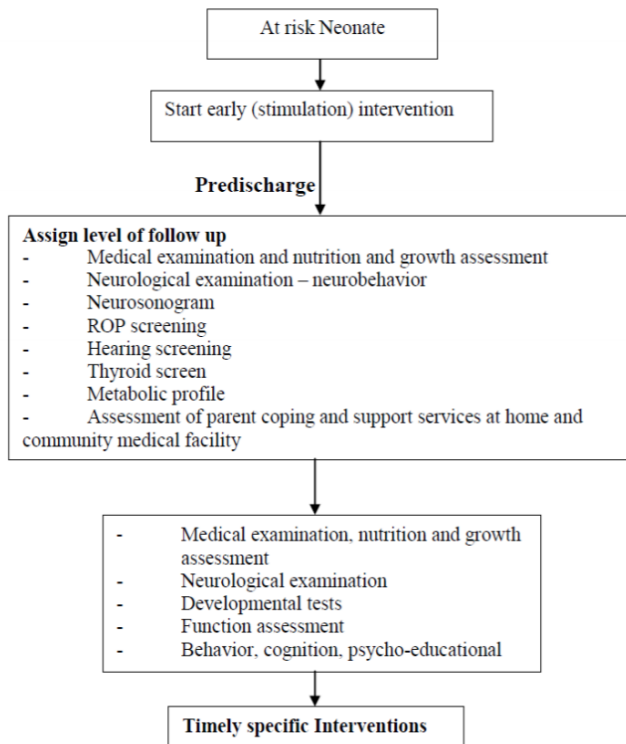
The mission of a neonatal follow up program is to provide a continuum of specialized care to sick babies discharged from NICUs. The neonate “at-risk” of neurodevelopmental disability must be identified before discharge from birth admission. A discharge summary must be provided to primary care provider and parents, the discharge summary should describe the prenatal and perinatal risk factors, neonate’s hospital course and therapies that can increase the risk of neurodevelopmental disability

Mild Risk	Moderate Risk	High Risk
Preterm	Preterm<33 weeks	<28 weeks
Weight 1500-2500g	Weight 1000-1500g	Weight <1000g, SGA, LGA
HIE grade I	HIE moderate	Apgar's<3 at 5 min and or HIE
Transient hypoglycemia	Hypoglycemia(BSL<25 mg/dl)	Persistent prolonged hypoglycemia
Suspect sepsis	Sepsis	Meningitis, shock needing Inotropes/vasopressor support
Neonatal jaundice needing phototherapy	Neonatal jaundice S.bilirubin >20 or needing exchange	Neonatal Bilirubin encephalopathy
Grade I IVH	IVH grade 2	Major morbidities IVH, PVL
		Abnormal neurology on discharge, Seizures
	Twins or triplets	Twin to twin transfusion
		Ventilation more than 24 hours, CLD
	Suboptimal home environment	Surgical conditions, major malformations
		Hypocalcemia
		Inborn errors of metabolism and or genetic disorders
		Infant of HIV+ve mother

### Where should the baby be followed up and who should do the follow-up?

	Low-risk	Moderate risk	High risk
Place of follow up	Well baby clinic	Level II/III SNCU/NICU care	
By whom	Follow up with pediatrician / primary care provider with objective to screen for deviation in growth and development	Follow up with neonatologist and developmental pediatrician: screen for developmental delay, manage intercurrent illnesses <ul style="list-style-type: none"> <li>• Developmental pediatrician</li> <li>• Developmental therapist</li> <li>• Radiologist</li> <li>• Ophthalmologist</li> <li>• Audiologist</li> <li>• Physiotherapist</li> <li>• Social worker</li> <li>• Dietician</li> </ul>	High risk newborn of Neurodevelopmental delay: Neonatologist: supervise and screen for developmental delay Team as for Moderate risk and <ul style="list-style-type: none"> <li>• Pediatric neurologist</li> <li>• Geneticist</li> <li>• Occupational therapist</li> <li>• Speech therapist</li> <li>• Endocrinologist</li> <li>• Pediatric surgeon</li> <li>• Orthopedician</li> </ul>

### Algorithm for follow up of at-risk neonates



### Early stimulation

- As soon as baby is medically stable in the NICU
- In the NICU by –
  - Optimizing lighting
  - Reduce noise, gentle music
  - Club painful procedures, allow suck sucrose/breast milk, hold hand
  - Tactile stimulation – touch, gentle massage
  - Kangaroo mother care
  - Non-nutritive sucking
  - Passive exercises

### Specific interventions

- Motor impairment / Hypertonia – medications and physiotherapy
- Physiotherapy and occupational therapy
- Speech therapy
- Seizures
- DDH and other Orthopedic
- Squint correction
- Behavior therapy and pharmacotherapy for behavioral disorders
- Therapy for learning disabilities



**Recommendations:** Timely specific interventions and compliance must be ensured after detection of deviation from normal.

### **Follow-up protocol for high risk infants**

Very preterm infants (gestation age or weight - based on the unit's protocol)

- After 3-7 days of discharge to check if the baby has adjusted well in the home environment
- Every 2 weeks until a body weight of 3 kg (6, 10, 14 week immunization visits to be covered during these visits)
- At 3, 6, 9, 12, 15 and 18 months of corrected age and then every 6 months until 8 (based on unit's protocol) years of age
- More visits if required

Infants with other conditions

- Two weeks after discharge
- At 6, 10, 14 weeks of age
- At 6, 9, 12, 15 and 18 months of corrected/postnatal age, as applicable and then every 6 months until 8 (based on unit's protocol) years of age
- More visits if required

COMPONENTS +	1 ½ m	2 ½ m	3 ½ m	6 m	9 m	12 m	18 m	24 m
Parental concerns	At every visit							
Medical problems	At every visit							
Vaccination	As per IAP Schedule (2012)							
Anthropometry@	At every visit (Wt~, HC*,TL)							
Nutrition								
• Diet	Exclusive breast feeding			Weaning		Home diet		
• MV drops	For preterm only, Vitamin D for all.							
• Iron	For preterm only			For term	For preterm		-	Yearly
• Cal/PO4	For preterm only			For term	-	-	-	Yearly
• Formula: Shift to term formula at 2 kg weight								
Neurologic exam #	At every visit							
Development test ^	Screening at each visit		Formal testing	Screening at each visit		Behavioral assessment	-	Formal testing
Eye evaluation	ROP Screening at 1 month age				For vision, squint, optic atrophy	-	-	For vision, squint, optic atrophy
Hearing	OAE at discharge. BERA for testing or confirmation at 3 m. Screen at each visit							
CT or MRI Brain USG brain (!)	As clinically indicated (!) At 36-40 weeks corrected age							
Language	-	-	-	-	LEST	-	LEST	-
Counselling	At every visit							
Biochemical screen	-	-	-	-	Hb, Urine		Hb	Hb, Urine,BP

+ Correction for gestational immaturity at birth should be done till 24 months age for all preterms. Use corrected age for weaning and milestone screening. Use postnatal age for vaccination.

Note: Follow up every 2 weeks until a weight of 3 kg. Then follow as per above schedule.

@ Danger signs: Weight gain < 20 g/day, Length growth < 0.5 cm/wk, Head circumference < 0.5 cm/wk

~ Use Wrights/Fenton's chart till 40 weeks gestation for preterm. Thereafter use WHO Growth chart (2006) as for term infants

\*Interpret head circumference with total length till 12 months of age.(HC=TL/2 + 9.5 + 2.5 cm)

# Amiel Tison till 12 months of age.

^ Screening tests = History + TDSC (Trivandrum development screening chart) OR DOC (Development observation card). Formal testing – DASII (Developmental assessment scale for Indian infants).

LEST= Language evaluation scale Trivandrum, Behavioral assessment = CBCL (Achenbach child behavior checklist), Pediatric Symptom Checklist. Formal cognitive development, IQ is tested by 3 years of age

### 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	High risk Newborn Follow-up
<b>i. At the time of Pre-authorization</b>	
Discharge summary of the last admission	Yes
Clinical examination of the current visit	Yes
Any requirement of the investigation for the current visit (optional)	Yes

<b>ii. At the time of claim submission</b>	
Progress notes at the time of visit	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:**

<b>Mandatory document</b>	<b>High risk Newborn Follow-up</b>
<b>2.2.1 At the time of Pre-authorization (PPD)</b>	
<b>Discharge summary of the last admission such as along with follow-up protocol:</b> A) Medical examination B) Neurobehavior and Neurological examination C) Neuroimaging D) ROP screening E) Hearing screening (OAE/BERA) F) Screening for congenital hypothyroidism G) Screening for metabolic disorders H) Assessment of parent coping and developmental environment	Yes
<b>Complete examination of the child such as:</b> I) Medical examination - nutrition and growth, Immunization J) Neurological examination K) Development assessment L) Ophthalmologic assessment – squint and refraction M) Hearing (BERA should be done prior 3 months age) and Language and speech N) Function O) Behavioral, cognitive and intelligence status	Yes
Treatment details	Yes
<b>2.2.2 At the time of claim submission (CPD)</b>	

Progress notes of the infant by the treating doctor including key findings and advice for follow-up including investigations and screening	Yes
--	-----

### **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. Whether the neonate was categorized as High-risk newborn based on the protocol and discharge summary mention the follow-up plan? Yes
- II. Do the progress notes contain clinical examination/screening/investigations? Yes

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

### **References**

1. Evidence based Clinical practice guidelines. National Neonatology Forum, India. 2011  
<https://www.ontop-in.org/ontop-pen/Week-12-13/Follow%20up%20High%20Risk%20NB%20.pdf>
2. [https://www.newbornwhocc.org/pdf/HRCfile-final\\_2013.pdf](https://www.newbornwhocc.org/pdf/HRCfile-final_2013.pdf)
3. [https://nhm.gov.in/images/pdf/programmes/RBSK/Operational\\_Guidelines/Operational%20Guidelines\\_RBSK.pdf](https://nhm.gov.in/images/pdf/programmes/RBSK/Operational_Guidelines/Operational%20Guidelines_RBSK.pdf)
4. Rhishikesh Thakre, Srinivas Murki. Protocols in Neonatology: Indian Academy of Pediatrics Neonatology Chapter. 2nd Edition, 2019.