



Guidance document for processing PM-JAY package

Respiratory failure due to any cause (Pneumonia, asthma, COPD, ARDS, foreign body, poisoning, head injury etc.)

Procedure covered/ procedure count: 1

Specialty: General Medicine

Procedure name	HBP 1.0 code	HBP 2.0 code	Procedure price
Respiratory failure due to any cause (Pneumonia, asthma, Chronic Obstructive Pulmonary Disease (COPD), Acute Respiratory Distress Syndrome (ARDS), foreign body, poisoning, head injury, etc.)	M100044	MG040C	1,800 (General ward)/ 2,700 (HDU)/ 3,600 (ICU without ventilator)/ 4,500 (ICU with ventilator)

ALOS: 4 -7 days (2-3 days ICU)

Minimum qualification of the treating doctor:

Essential: MBBS; **Desirable:** MD/ DNB/ equivalent (Medicine or Pulmonology)/ Diploma in Tuberculosis and Chest Disease (DTCD)

Special empanelment criteria/linkage to empanelment module: None

Disclaimer:

ICMR has issued clinical guidelines for **Management of Respiratory failure** to be followed in country. For monitoring and administering the claim management process of **Respiratory failure due to any cause (pneumonia, asthma, COPD, ARDS, foreign body, poisoning, head injury etc.)**, 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 document 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:

- Proceed for admission for management of respiratory failure only if indicated
- The diagnosis made should be backed by clinical signs, symptoms, physical examination, investigations.
- Look for underlying causes in hypercapnia, headache, bounding pulse, tremor/ flap, papilloedema, coma.
- Refer** to a higher center if there is no relief from treatment/ mechanical ventilation is needed/ life threatening features

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

June/ 2019

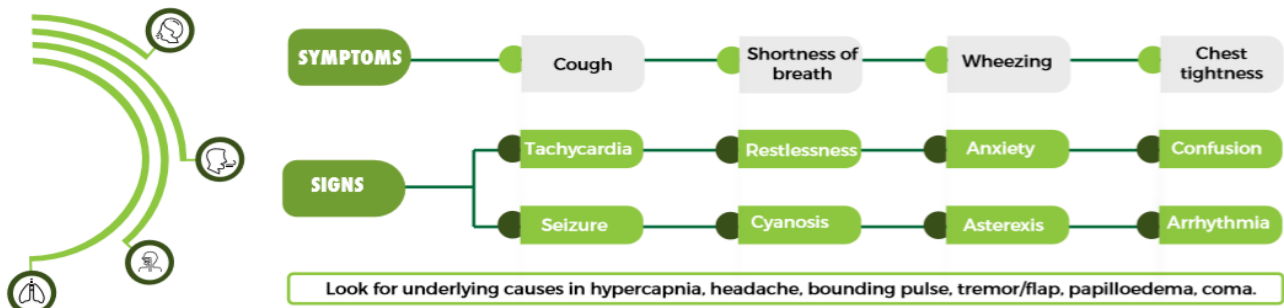


Department of Health Research
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Standard Treatment Workflow (STW) for the Management of RESPIRATORY FAILURE ICD 10 : J96.0



HYPOXIA (SpO2 <90%)					
HEART FAILURE		PNEUMONIA/ LRTI		PULMONARY EMBOLISM	
SYMPTOMS	SIGNS	SYMPTOMS	SIGNS	SYMPTOMS	SIGNS
<ul style="list-style-type: none"> Dyspnea or exertion or rest Chest Pain Wheezing Fatigue 	<ul style="list-style-type: none"> Tachycardia Pulsus Alterans Weak Rapid Thready Pulse Pink Frothy Sputum Cyanosis Pallor Distended Neck Veins 	<ul style="list-style-type: none"> Cough with or without Sputum Chest Pain Fever with Chills, Fatigue, Malaise 	<ul style="list-style-type: none"> Tachypnea Tachycardia Crackles and Rhonchi Hypoxemia Pleuritic Chest Pain 	<ul style="list-style-type: none"> Sudden Shortness of Breath Chest Pain Calf Pain & or Swelling Hemoptysis 	<ul style="list-style-type: none"> Syncope Arrhythmia Tachycardia
AIRWAY DISEASE					
ACUTE ASTHMA		AE OF COPD		BRONCHIOLITIS	
SYMPTOMS	SIGNS	SYMPTOMS	SIGNS	SYMPTOMS	SIGNS
<ul style="list-style-type: none"> Wheeze Shortness of Breath Chest Tightness Cough 	<ul style="list-style-type: none"> Tachypnea Tachycardia Fall in SPO2 Use of Accessory Muscle 	<ul style="list-style-type: none"> Worsening of Dyspnea Increase in Sputum Production Increased Cough 	<ul style="list-style-type: none"> Tachypnea Hypoxemia Hypercarbia Confusion Drowsy Peripheral Edema 	<ul style="list-style-type: none"> Cough Shortness of Breath Wheezing 	<ul style="list-style-type: none"> Cyanosis Nasal Flares Tachypnea Paradoxical Breathing (children) Crackles and or Rattling sounds in Lung

INVESTIGATIONS						
ABG, CRP, FBC, U&E	Chest Xray	Sputum culture, Blood culture (if febrile)		Spirometry(COPD, Neuromuscular disease)		
TREATMENT						
DIAGNOSIS	Heart failure	Acute Severe Asthma	AE COPD	ARI	Pneumonia LRTI	Pulmonary embolism
OXYGEN	Start oxygen therapy at SpO2 < 90% Monitor SpO2 during oxygen therapy to titrate flow rate: target SpO2 < 96% Oxygen delivery usign Nasal cannulae/ Simple face mask/ Venturi mask/ Non re-breathing mask (Note: for patients with AECOPD, keep lower target SpO2 = 88-92%)					
BRONCHODILATORS	SOS	SABA ± SAMA (Salbutamol ± Ipratropium neb q20 min X 1 hr then prn)	SABA + SAMA (Salbutamol neb hourly + Ipratropi-um neb 4 hourly)	SABA + SAMA	SOS	SOS
DIURETICS	Yes (IV Furosemide 40 mg or Torsemide 20 mg)	SOS	SOS	SOS	SOS	SOS
ANTIBIOTICS	---	---	No risk factor Pseudomonas: Ceftriaxone or levofloxacin or moxifloxacin Pseudomonas risk factor: levofloxacin or piperacillin tazobactam or ceftazidime or cefepime Influenza suspect: Oseltamivir	---	Mild/Mod cases: Amoxycillin PO/IV or Ceftriaxone IV Severe Cases: Amoxycillin IV or Ceftriaxone IV Atypical pneumonia: Azithromycin IV/PO or Doxycycline IV/PO	---
STEROIDS	---	Yes (Methylprednisolone IV 40 to 60 mg or Prednisolone PO 60mg)	Yes (Methylprednisolone IV 60 to 125 mg IV q6-12 hourly)	Yes	Severe CAP (fiO2 > 0.5 AND pH <7.3 OR lactate >4 mmolL-1 OR CRP > 150 mgL-1): Methylprednisolone IV 0.5 mg/kg q12h	---
LMWH	Prophylactic, if indicated	Prophylactic, if indicated	Prophylactic, if indicated	Prophylactic, if indicated	Prophylactic, if indicated	If high suspicion with low risk of bleeding: UFH (if thrombolysis anticipated), OR LMWH
REFERRAL	No relief OR Need for mechanical ventilation OR life threatening features: Stabilize CAB, transfer to higher center					
ABBREVIATIONS						
• LRTI : Lower Respiratory Tract Infection • LMWH: Low Molecular Weight Heparin		• SABA : Short Acting Beta Agonist • SAMA: Short Acting Muscarinic Antagonist		• CAP: Community Acquired Pneumonia • UFH : Unfractionated Heparin		
🏠 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.lcmr.org.in) for more information. © Indian Council of Medical Research and Department of Health Research, Ministry of Health & Family Welfare, Government of India.						

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:

Mandatory document	Congestive cardiac failure	Pneumonia	Bronchiolitis	Asthma	COPD	ARDS	Foreign body	Poisoning	Head injury
i. At the time of Pre-authorisation									
a. Clinical notes with APACHE score	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b. Investigations									
1. CBC	No	Yes	Yes	Yes	Yes	No	No	No	No
2. Chest X-ray	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. ABG (if available)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. ECG	Yes	No	No	No	No	No	No	Yes	No
5. NCCT Head	No	No	No	No	No	No	No	No	Yes
6. Fundus examination	No	No	No	No	No	No	No	Yes	Yes
c. Clinical photograph of the patient on bed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ii. At the time of claim submission									
a. Still photograph of the patient undergoing the treatment (+/- ventilatory support)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b. Detailed Indoor case papers having treatment and management	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

c. Relevant investigations including serial ABGs (refer para 1.5 i. b.) (ABG if Available)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
d. Detailed discharge summary	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

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):

Mandatory documents	Congestive cardiac failure	Pneumonia/ lower respiratory tract infection	Bronchiolitis	Asthma	COPD	ARDS	Foreign body	Poisoning	Head injury
a. Clinical notes with APACHE score	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
b. Investigations									
1. CBC	No	Yes	Yes	Yes	Yes	No	No	No	No
2. Chest X-ray	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
3. ABG (if Available)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
4. ECG	Yes	No	No	No	No	No	No	Yes	No
5. NCCT Head	No	No	No	No	No	No	No	No	Yes
6. Fundus examination	No	No	No	No	No	No	No	Yes	Yes

c. Clinical photograph of the patient on bed	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
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2.2.2 At the time of claim processing- For claims processing doctor (CPD)

- a. Do the documents (clinical notes, physical examination & investigation reports) available justify the need for admission? An indicative chart of symptoms, signs and investigation as per the cause of respiratory failure is given below for reference:

i. Symptoms	Congestive cardiac failure	Pneumonia/ lower respiratory tract infection	Bronchiolitis	Asthma	COPD	ARDS	Foreign body	Poisoning	Head injury
Dyspnea/ Shortness of breath	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Worsening of Dyspnoea	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chest Pain/ Tightness of chest	Yes	Yes	No	Yes	No	No	No	No	No
Wheezing	Yes	No	Yes	Yes	No	No	No	No	No
Fever with Chills	No	Yes	Yes	No	No	No	No	No	No
ii. Signs									
Tachycardia/ Bradycardia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Pink frothy sputum	Yes	No	No	No	No	Yes	No	No	No
Cyanosis	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Tachypnea/ Hypoapnea	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Added chest sounds	Yes	Yes	Yes	Yes	Yes	Yes	No	No	No
Hypoxemia	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Confusion/ Drowsiness	No	No	No	No	Yes	No	No	Yes	Yes
Peripheral edema	Yes	No	No	No	Yes	No	No	No	No
iii. Investigations									
CBC	No	Yes	Yes	Yes	Yes	No	No	No	No
Chest X-ray	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

ABG (if Available)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
ECG	Yes	No	No	No	No	No	No	Yes	No
NCCT Head	No	No	No	No	No	No	No	No	Yes
Fundus examination	No	No	No	No	No	No	No	Yes	Yes

- b. Was there documentary evidence of record & monitoring of vitals- Respiratory rate, SpO₂, Heart rate, chest examination, abnormal breath sounds?
- c. Is medication/ treatment chart available? An indicative chart of treatment and management as per the cause of respiratory failure is given below for reference:

Treatment	Congestive cardiac failure	Pneumonia/ lower respiratory tract infection	Bronchiolitis	Asthma	COPD	ARDS	Foreign body	Poisoning	Head injury
Oxygen (with SpO ₂ monitoring)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Bronchodilators	SOS	SOS	SOS	Yes	Yes	SOS	SOS	SOS	SOS
Diuretics	Yes	SOS	SOS	SOS	SOS	Yes	SOS	SOS	Yes
Antibiotics	SOS	Yes	Yes	SOS	Yes	SOS	SOS	SOS	SOS
Steroids	No	Yes (In severe conditions)	No	Yes	Yes	Yes	No	SOS	Yes
Low molecular weight heparin	Prophylactic; if indicated	Prophylactic; if indicated	Prophylactic; if indicated	Prophylactic; if indicated	Prophylactic; if indicated	Prophylactic; if indicated	Prophylactic; if indicated	Prophylactic; if indicated	Prophylactic; if indicated except in Intracranial bleeds

- d. Do the discharge documents show the discharge / referral criteria (if applicable); counselling on control of risk factors; post discharge treatment advise including follow-up after discharge?
- e. If the patient is in HDU/ ICU +/- BIPAP/ ventilator following additional questions may be referred:
- Do the documents show a need for admission to HDU/ ICU (+/- BIPAP/ ventilator)
 - Is there a documentary evidence to show monitoring in HDU/ ICU/ BIPAP/ ventilator

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:

- a. Abnormal HR/ Rhythm (>90-100/ <45-50/ min)- Yes
- b. Respiratory rate (>20/ <12/ min)- Yes
- c. SpO2 < 90%- Yes
- d. ABG (if available) suggestive of Acute respiratory failure- Yes
- e. Chest X-ray with abnormal findings- Yes
- f. Fundus examination suggestive of Papilloedema (where applicable)- Yes
- g. Is PFT available (where applicable)- Yes, then, FEV 1 < 80%
- h. Is there a history of trauma (In case of head injury) – Yes
- i. Is there a history of poisoning (In cases of poisoning)- Yes

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

Acknowledgment:

¹ 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.