

Guidance document for processing PM-JAY packages

Conservative management of High Cervical Injury

(Moderate and Minor Head Injury)

Procedures covered: 2

Specialty: Polytrauma/Neurosurgery

Package name	Procedure name	HBP 2.0 code	HBP 2.1 code	Package price (INR)
Conservative management of High Cervical Injury	Moderate Head Injury	New Package	SN063B	Routine Ward – 1,800 HDU – 2,700 ICU without ventilator-3,600 ICU with Ventilator - 4500
Conservative management of High Cervical Injury	Minor Head Injury	New Package	SN063D	Routine Ward – 1,800 HDU – 2,700 ICU without ventilator-3,600 ICU with Ventilator – 4,500

ALOS (In days): 2-5 Days (Moderate Head Injury);24-48 hours (Minor head injury).

Minimum qualification of the treating doctor:

Essential: MCh/DNB/Equivalent (Neurosurgery), MS/DNB/equivalent (Gen Surgery)

Disclaimer:

For monitoring and administering the claim management process of **Conservative management of high cervical injury** 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:

Common clinical presentation in TBI patient: Headache and vomiting followed by skull fracture with history of loss of consciousness (LOC). Associated clinical findings

suggestive of basal skull fracture are nasal bleed, ear bleed, ecchymosis over mastoid (battle's sign) and CSF rhinorrhea/otorrhea.

Investigation: CT Head

Classification System For Traumatic Brain Injury			
Classification	Duration Of Unconsciousness	Glasgow Coma Scale	Post-Traumatic Amnesia
Mild	<30 Minutes	13-15	<24 Hours
Moderate	30 Minutes-24 Hours	9-12	1-7 Days
Severe	>24 Hours	3-8	>7 Days

Management:

Medical Therapy

Adults with simple linear fractures who are neurologically intact do not require any intervention and may even be discharged home safely and asked to return if symptomatic.

Simple depressed fractures in neurologically intact person are treated expectantly. These depressed fractures heal well and smooth out with time, without elevation.

Seizure medications are recommended if the chance of developing seizures is higher than 20%. Open fractures, if contaminated, may require antibiotics in addition to tetanus toxoid.

Surgical Therapy

The role of surgery is limited in the management of skull fractures. Surgery to elevate depressed skull fractures is preferred in

- Open (compound) fractures.
- Depressed fracture thickness > of calvaria and
- Those fractures not meeting criteria for non-surgical management.

Non-surgical management

May be considered if

1. There is no evidence of dural penetration and no significant intracranial hematoma
2. Depression <1cm
3. No frontal sinus involvement
4. No wound infection or gross contamination
5. No gross cosmetic deformity

Indications for CT in TBI (Traumatic Brain Injury)

1. Witnessed LOC (Loss of Consciousness)
2. Definite Amnesia
3. Disorientation with a Glasgow coma scale score (GCS) of 13-15
4. GCS <15 at 2 hours after injury
5. Suspected open or depressed fracture
6. Any signs of basilar skull # - Raccoon eye, Battle sign, Otorrhea or Rhinorrhea
7. Vomiting of > 2 episodes
8. Age > 65 years
9. LOC for > 5 mins
10. Mechanism of injury

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	Conservative management of high cervical injury (Moderate and Minor Head Injuries)
i. At the time of Pre-authorization	
a. Clinical Notes detailing the injury with admission Glasgow coma scale score	Yes
b. Relevant Investigations – CT head	Yes
ii. At the time of claim submission	
a. Detailed Indoor case papers (ICPs)	Yes
b. Detailed procedure/operative notes	Yes
c. Post procedure imaging with film – CT head	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:

- I. Was the patient's Glasgow coma score and CT report suggestive of the diagnosis?
Yes

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

References:

1. Trauma Protocol and Head Injury, Protocol for emergency and trauma care, Govt Medical College Thiruvananthapuram, 2019, pg 9-22
2. EminGharibian, Psy.D, Neuropsychological Evaluation of Traumatic Brain Injury: The Definitive Guide (<https://verdugopsych.com/neuropsychological-evaluation-of-traumatic-brain-injury/>)