



## Guidance document for processing PM-JAY packages

### Intussusception

Procedures covered: 2

Specialty: Pediatric Surgery

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price
Intussusception	Non-operative reduction in infants	S1400026	SS007A	20,000
Intussusception	Operative in infants	S1400027, S100087	SS007B	25,000

**ALOS:** 3-5 days

**Minimum qualification of the treating doctor:**

**Essential:** MCh/ equivalent (in Pediatric Surgery)

**Special empanelment criteria/linkage to empanelment module:** None

#### Disclaimer:

For monitoring and administering the claim management process of **Intussusception**, 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 Pediatric surgery guidelines from Mahatma Phule Jeevandayee Arogya Yojana, Gov. of Maharashtra 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 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:

Intussusception refers to the invagination (telescoping) of a part of the intestine into itself. It is one of the most common surgical emergencies in the age group of 6 months to 3 years and almost half of all the cases present between the ages of 6 and 12 months. Most cases are of ileo-colic variety caused by reactive hyperplasia of Peyer's patches in the terminal ileum in response to

upper respiratory or gastrointestinal infections. Small bowel intussusceptions such as jejuno-jejunal or ileo-ileal are usually transient and inconsequential. Secondary intussusception occurs when there is a pre-existing lesion in the gut that may act as a lead point.

Proceed with Intussusception surgery only if diagnosis made is backed by clinical manifestation.

### **Clinical Manifestations:**

Typical presentation:

- Intermittent colicky abdominal pain with drawing up of legs accompanied by inconsolable crying (episodes usually occur at 15-20 min intervals)
- Poor feeding
- Vomiting
- Per rectal passage of blood mixed with mucus (red currant jelly stool)

Atypical presentation:

- Unexplained lethargy or altered consciousness
- Without pain
- Rectal bleeding
- Other symptoms that suggest an intraabdominal process
- Rectal prolapse

Late presentation:

- Abdominal distension
- Bilious vomiting resulting from frank small bowel obstruction
- Dehydration

### **Procedures**

Non-operative reduction:

Nonoperative reduction using hydrostatic or pneumatic pressure by enema is the treatment of choice for an infant or child with ileocolic intussusception who is clinically stable and has no evidence of bowel perforation or shock, when appropriate radiologic facilities are available. Reduction of intussusception is most commonly performed under fluoroscopic guidance, using either hydrostatic (warm saline or barium sulphate solution) or pneumatic (air) enema.

Indications for surgery:

The traditional approach of surgery has been, to do an Operative laparotomy +/- resection & anastomosis.

- Unstable patient – In this case, initiate resuscitation, consult surgeon, and stabilize the patient before proceeding to the operating room
- Peritonitis or intestinal perforation

- Nonoperative reduction is completely unsuccessful. If the reduction attempt was partially successful, it may be repeated

#### 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	Intussusception
<b>i. At the time of Pre-authorization</b>	
Clinical notes	Yes
USG abdomen	Yes
<b>ii. At the time of claim submission</b>	
Indoor case papers (ICPs)	Yes
Detailed Procedure / operative notes	Yes
Detailed discharge summary	Yes
USG Abdomen	Yes
Documentary evidence that conservative management has been tried but failed/ conservative management is not indicated, with reason(s)	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):**

- Clinical notes - detailed history, signs & symptoms, indication for procedure?
- Investigations X Ray abdomen / USG Abdomen / CT abdomen / Barium enema?

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

- Are the detailed ICPs with daily vitals and line of treatment?
- Are the detailed procedure / Operative Notes available?
- Is the Discharge summary with follow-up advise at the time of discharge?

- d. Was the X-ray abdomen/USG abdomen ('target' or 'doughnut/target' sign on USG) report submitted?
- e. Documentary evidence that conservative management has been tried but failed/ conservative management is not indicated, with reason(s)? 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. Is the patient a diagnosed and confirmed case of Intussusception based on USG abdomen? Yes
- II. Did the patient presented with colicky pain in abdomen, vomiting or red currant jelly stool? Yes

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

### **References**

1. Clinical protocol guidelines. Mahatma Jyotiba Phule Jan Arogya yojana. Maharashtra [https://www.jeevandayee.gov.in/MJPJAY/RGJAYDocuments/PEDIATRIC\\_SURGERY.pdf](https://www.jeevandayee.gov.in/MJPJAY/RGJAYDocuments/PEDIATRIC_SURGERY.pdf)
2. Aggarwal SK. Management of Intussusception: Changing Trends. *Indian Pediatr.* 2019;56(1):21-22. <https://www.indianpediatrics.net/jan2019/jan-21-22.htm>
3. [https://www.rch.org.au/clinicalguide/guideline\\_index/Intussusception/](https://www.rch.org.au/clinicalguide/guideline_index/Intussusception/)
4. Nghia "Jack" Vo, Thomas T Sato. Intussusception in children – UpToDate (last updated – May, 2020)