

Guidance document for processing PM-JAY packages

Thymectomy

Procedures covered: 1

Specialty: General/Pediatric Surgery

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Thymectomy	Thymectomy	S100210	SG072A	28,000

ALOS: 5-7 Days

Minimum qualification of the treating doctor:

Essential: MS/DNB/Equivalent (General Surgery), MCh/DNB/Equivalent (Pediatric surgery), MCh/DNB/Equivalent (Thoracic Surgery)

Special empanelment criteria/linkage to empanelment module: Care at Tertiary Hospital

Disclaimer:

For monitoring and administering the claim management process of **Thymectomy**, 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:

Surgical resection of the thymus gland (ie, thymectomy) is used to treat thymic tumors (thymoma, thymic carcinoma, and thymic neuroendocrine [carcinoid] tumors) and for the management of myasthenia gravis.

Specific indications for thymectomy:

- Thymoma, thymic carcinoma, and thymic neuroendocrine tumors – Thymectomy is indicated for resection of tumors including thymoma, thymic carcinoma, and thymic neuroendocrine tumors. Thymoma is considered malignant and should be resected even though it generally has an indolent growth pattern.

- Myasthenia gravis – Thymectomy is used to manage thymoma associated with myasthenia gravis and is also a validated treatment for those with myasthenia gravis who do not have thymoma (ie, nonthymomatous myasthenia gravis)

Clinical features

Thymic tumors are rare although they are the most common anterior mediastinal tumors in adults. Thymomas account for the majority of thymic neoplasms. Common presenting symptoms include chest discomfort, cough, and muscle weakness involving ocular, facial, oropharyngeal and respiratory, and/or limb muscles due to associated myasthenia gravis.

Diagnosis

All patients being assessed for thymectomy should undergo a thorough history and physical exam. Preoperative studies include cross-sectional imaging, typically in the form of high-resolution computed tomography with and without intravenous contrast, to aid in diagnosis, clinical staging, and determination of resectability; pulmonary function tests to help stratify risk for pulmonary complications and to serve as a baseline for postoperative comparison; routine baseline laboratories (eg, complete blood count, chemistry, and coagulation studies); and electrocardiography or other studies, as indicated. Other laboratory studies, such as thyroid function tests, tumor markers (alpha fetoprotein and beta-hCG), or myasthenia gravis antibodies (eg, anti-AChR, anti-SM, anti-MuSK), can also be obtained if they will help facilitate diagnosis.

Procedure

Surgical management of myasthenia gravis involves resection of the entire thymus gland. For patients with thymoma, thymic carcinoma, or neuroendocrine tumor, thymectomy is the initial treatment for those in whom a complete R0 resection is considered feasible.

Three basic approaches are used that vary in the location/extent of the incisions used to remove the thymus gland.

- Median sternotomy – Median sternotomy is the standard approach for thymectomy (extended transsternal thymectomy, combined transcervical-transsternal thymectomy).
- Transverse neck incision – The "extended-cervical thymectomy" (as compared with simple cervical thymectomy, which removes only parts of the upper thymus) minimizes the impact of postoperative pain on ventilatory reserve
- Thoroscopic surgery port placement incisions – Minimally invasive thymectomy (MIT), such as video-assisted thoracoscopy or robotic-assisted approaches, is performed through small incisions from either the right or left side with the patient in slight decubitus or full decubitus position

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	Thymectomy
i. At the time of Pre-authorization	
Clinical notes	Yes
Clinical Evaluation	Yes
Investigations (Optional – Based on Etiology) 1. CT/MRI/PET 2. Thoracoscopy 3. Biopsy 4. Pulmonary function test 5. Thyroid profile 6. Nerve conduction studies (EMG/ENMG)/Prostigmine/Tensilon test/ 7. Ach receptor antibody testing	Yes
Planned line of treatment	Yes
ii. At the time of claim submission	
Detailed Indoor case papers (ICPs)	Yes
Detailed Procedure / operative notes	Yes
Intra-operative photographs (optional)	Yes
Histopathological examination	Yes
Detailed discharge summary	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 - detailed history, signs & symptoms, planned line of treatment, and indication for procedure?
 - b. Did the investigations confirm the diagnosis?
- 2.2.2 At the time of claim processing- For claims processing doctor (CPD)**
- a. Are the detailed ICPs with daily vitals and treatment details?
 - b. Are the detailed procedure / Operative Notes available?
 - c. Is the Discharge summary with follow-up advise at the time of discharge?
 - d. Was the imaging indicative of surgery?
 - e. Was histopathological report submitted?

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. Was clinical presentation and imaging indicative of surgery? Yes

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

References

1. Bryan M Burt. Thymectomy – UpToDate. last updated: September, 2019.