



Guidance document for processing PM-JAY packages

Hospitalization for Antenatal Complications

Procedures covered: 1

Specialty: Obstetrics & Gynecology

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Hospitalization for Antenatal Complications	Hospitalization for Antenatal Complications	New Package	SO046A	Routine Ward - 1800 HDU - 2700 ICU (without Ventilator) - 3600 ICU (with Ventilator) - 4500

ALOS: 1 day (Once diagnosis is established the case can be booked in the relevant package or further stay/admission should be decided based on the level of complications of the disease)

Minimum qualification of the treating doctor:

Desirable: MBBS with specialized training

Essential: MS/MD/DNB/DGO/Equivalent (in Obstetrics & Gynecology)

Special empanelment criteria/linkage to empanelment module: Facilities with well-equipped operation theatre and indoor care areas including blood transfusion arrangements

Disclaimer:

ICMR has issued clinical guidelines for '**Ante-natal Management of Normal Pregnancy**' to be followed in country. For monitoring and administering the claim management process of **Hospitalization for Antenatal Complications**, 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 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:

KINDLY CONSIDER BOOKING THE RELEVANT PACKAGE FOR RELEVANT GUIDELINES (the list of indications inclusive are but not exhaustive)

Obstetric complications:

- Hyperemesis Gravidarum
- Miscarriage and recurrent pregnancy loss
- Ectopic pregnancy
- Intrauterine fetal death
- Multifetal pregnancy
- Fetal growth disorders: Growth restriction and Macrosomia
- Disorders of Amniotic fluid
- Preterm Labor and Birth
- Prelabor Rupture of the Membranes
- Postterm Pregnancy
- Red cell Alloimmunization
- Antepartum hemorrhage

Maternal diseases complicating pregnancy

- Hypertensive disorders
 - Gestational Hypertension
 - Chronic Hypertension
 - Chronic Hypertension with superimposed preeclampsia
 - Preeclampsia and Eclampsia
- Diabetes in pregnancy
 - Pregestational Diabetes Mellitus (DM) – Type 1 & 2
 - Gestational Diabetes (GDM)
 - Diabetic Ketoacidosis (DKA)
- Hematological disorders
 - Anemia in pregnancy
 - Sickle cell disease in pregnancy
 - Thalassemia's in pregnancy
 - Thrombocytopenia in pregnancy
- Cardiac diseases in pregnancy
- Hepatobiliary and gastrointestinal disorders

- Intrahepatic cholestasis of pregnancy
- Acute fatty liver of pregnancy
- Hepatic diseases that occur in pregnancy
- Preexisting chronic disease in pregnancy
- Gallstones in pregnancy
- Constipation and Diarrhea
- Gastroesophageal reflux disease (GERD)
- Appendicitis
- Endocrine disorders and obesity
 - Thyroid disorders in pregnancy (hypothyroidism, hyperthyroidism, thyroid storm)
 - Adrenal disorders and pregnancy
 - Obesity in pregnancy
- Respiratory, dermatological, and connective tissue disorders
 - Asthma
 - Systemic Lupus Erythematosus (SLE) in pregnancy
- Thromboembolic disorders
 - Thrombophilia
 - Deep vein thrombosis
 - Pulmonary embolism
- Urinary tract and renal disorders
 - Urinary tract infections
 - Acute renal failure in pregnancy
 - Chronic renal diseases in pregnancy
- Infections
- Benign and Malignant Tumors of the Reproductive tract

Common clinical presentation

- Fatigue or weakness
- Anorexia and indigestion
- Palpitation
- Bleeding per vaginum with pregnancy
- Pain abdomen
- History of trauma / lifting heavy weight
- Breathing problems
- Unexplained headaches
- Excessive weight gain

- Swelling in any part of the body
- Increased thirst
- Frequent urination
- Extreme hunger
- Unexplained weight loss
- Irritability
- Blurred vision
- Incidental findings during routine antenatal examination

Management

Treatment will either be conservative or involve active intervention, depending on the diagnosis, gestation age and physical condition of the mother and fetus.

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

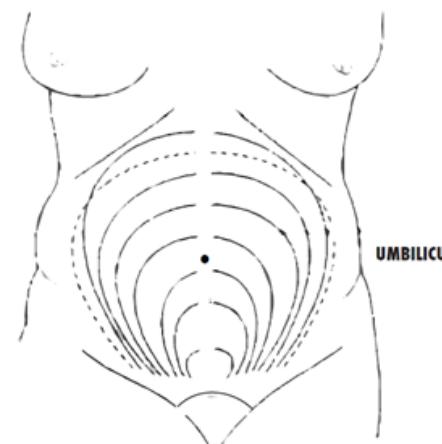
Standard Treatment Workflow (STW) for ANTE-NATAL MANAGEMENT OF NORMAL PREGNANCY			
FIRST VISIT (PREFERABLY IN FIRST TRIMESTER)			
ASK	EXAMINE	INVESTIGATIONS	DO
<ul style="list-style-type: none"> • Age • LMP • Parity & obstetric history • Any complaints especially excessive nausea & vomiting/ bleeding PV • H/o medical illness : diabetes, hypertension, cardiac problem, epilepsy or any other chronic illness • Consanguinity, multiple pregnancy • H/o blood transfusion and H/o prior surgical intervention • Personal history : tobacco/ alcohol intake • Family history : diabetes, hypertension, genetic disorders/ congenital problems, multiple pregnancy, infections including tuberculosis 	<ul style="list-style-type: none"> • Height, weight • Calculate BMI • Pallor, Jaundice, Pedal edema • Pulse, BP, RR, temperature • Thyroid • Breast • Respiratory and CVS examination • P/A examination, P/S and P/V examination # If woman presents with bleeding per vaginum do P/A & P/S to confirm amount of bleeding & rule out local causes. All such cases to be referred to CHC or higher centre 	<p>ESSENTIAL TESTS</p> <ul style="list-style-type: none"> • Haemoglobin • Urine R & M • ABO & Rh grouping <p>DESIRABLE TESTS</p> <ul style="list-style-type: none"> • VDRL/ RPR • HIV • HBsAg • WHO OGTT/ DIPSI test for diagnosis of CDM • TSH in high risk cases (BOH, goiter, obesity or residing in iodine deficiency prone areas) <p>OPTIONAL TESTS*</p> <ul style="list-style-type: none"> Aneuploidy screen* by USG & double marker 	<ul style="list-style-type: none"> • UPT if in doubt • Fill up MCH protection card or ANC card, make entry on RCH portal & generate RCH number (in public sector) • Give filled MCH protection card & safe motherhood booklet to woman • Give Tab Folic Acid daily • Give first dose of tetanus toxoid

SECOND VISIT (SECOND TRIMESTER)			
ASK	EXAMINE	INVESTIGATIONS	DO
<ul style="list-style-type: none"> Any complaints since last visit Quickening and/or fetal movements Adherence to medications 	<ul style="list-style-type: none"> Weight Pallor Pedal edema Pulse, BP in sitting position P/A examination for fundal height 	ESSENTIAL TESTS <ul style="list-style-type: none"> Haemoglobin Urine albumin DESIRABLE TESTS <ul style="list-style-type: none"> USG (Level II between 18-20 weeks for gross congenital malformations) WHO OGTT/ DIPSI test if >24 weeks & at least 4 weeks have elapsed after 1st test OPTIONAL TESTS* <ul style="list-style-type: none"> Quadruple test as per availability <p><small>*Should be performed only if adequate counselling facilities are available</small></p>	<ul style="list-style-type: none"> IFA tablet one (if Hb >11g%) or twice (if Hb <11g%) daily with water or lemon juice Calcium carbonate 500 mg with vitamin D 250 mcg tablet twice daily with meals. Calcium Carbonate and IFA not to be given together Single dose of Albendazole 400mg Ensure compliance for investigations and treatment Discuss birth preparedness Give second dose Tetanus Toxoid at least four weeks after first dose

THIRD (28 – 34 WEEKS) AND FOURTH VISIT (36 - 40 WEEKS)			
ASK	EXAMINE	INVESTIGATIONS	DO
Same as above	<ul style="list-style-type: none"> Same as above Auscultate FHS Measurement of abdominal girth and Symphysiofundal Height 	<ul style="list-style-type: none"> Haemoglobin Urine albumin Optional USG for fetal growth and liquor 	<ul style="list-style-type: none"> Continue IFA and calcium tablets and ensure compliance If non compliant or Hb < 9g% give parenteral iron sucrose therapy (not > 200mg at one time & not > 3 times a week) and refer patient with Hb < 7g% to higher centre Refer to higher centre if any discrepancy between fundal height and period of gestation

DANGER SIGNALS FOR PATIENT TO REPORT TO HEALTH FACILITY	HIGH RISK PREGNANCY
<ul style="list-style-type: none"> Fever Persistent vomiting Abnormal vaginal discharge Palpitations, easy fatigability and breathlessness at rest and/ or on mild exertion. Generalized swelling of the body/ puffiness of the face Vaginal bleeding Decreased or absent fetal movements at > 28 weeks gestation Leaking of watery fluid per vagina (P/V) Severe headache/ blurring of vision/ convulsion Passing lesser amounts of urine and/ or burning sensation during micturition Itching all over the body 	<ul style="list-style-type: none"> Any H/o medical illness, previous caesarean section, past obstetric mishap or congenital malformation Past H/o PPH Age > 35 years or < 19 years or parity > 4 Malnourished (BMI < 18.5 kg/m² or > 30 kg/m²) Hemoglobin < 7g% BP > 140/90mm Hg on 2 occasions 6 hours apart APH Discrepancy between fundal height and period of gestation > 4 weeks GDM/ overt DM Multiple pregnancy Malpresentation at term Previous uterine surgery <p><small>* High risk pregnancy to be delivered at district hospital/medical college</small> <small>* Preferably to have antenatal care also at these centres</small></p>

COUNSELLING AT ALL LEVELS FOR :	BIRTH PREPAREDNESS MUST INCLUDE IDENTIFICATION OF THE FOLLOWING :
<ul style="list-style-type: none"> Timing and place of next ANC visit based on presence or absence of risk factor Rest, nutrition, balanced diet and exercise Counselling for HIV testing Danger signs Institutional delivery Birth preparedness Early & exclusive breastfeeding for six months Post partum contraception 	<ul style="list-style-type: none"> Facility for delivery Support persons Birth companion Means of transport in emergency Blood donors (if required in emergency)

ASSESSMENT OF FUNDAL HEIGHT & ITS CORRELATION WITH GESTATIONAL AGE	
<p>At 12th week : Just palpable above the symphysis pubis</p> <p>At 16th week : At lower one-third of the distance between the symphysis pubis and umbilicus</p> <p>At 20th week : At two-thirds of the distance between symphysis pubis and umbilicus</p> <p>At 24th week : At the level of umbilicus</p> <p>At 28th week : At lower one-third of the distance between the umbilicus and xiphisternum</p> <p>At 32nd week : At two-thirds of the distance between the umbilicus and xiphisternum</p> <p>At 36th week : At the level of xiphisternum</p> <p>At 40th week : Sinks back to the level of the 32nd week, but the flanks are full, unlike that in the 32nd week</p>	

COUNSELLING IS AN IMPORTANT ADJUNCT TO MANAGEMENT
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.icmr.org.in) for more information.
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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	Hospitalization for Antenatal Complications
i. At the time of Pre-authorization	
Detailed clinical notes with history, symptoms, signs, examination findings, planned line for management, and advice for admission	Yes
Blood pressure documentation	Yes
Complete Blood Count	Yes
Urine routine and microscopic examination	Yes
Blood glucose	Yes
USG Abdomen/pelvis	Yes
Oral Glucose Tolerance Test (OGTT)	Yes
Optional <ul style="list-style-type: none"> Peripheral Blood Film USG for placental localization Blood culture Bleeding Time / Clotting Time / Coagulation profile Doppler for fetal well being Liver Function Test Kidney Function Test Hemoglobin A1c test (HbA1c) Fasting blood sugar (FBS) Post Prandial blood sugar (PLBS) ABO Rh blood group Chest X-ray 2D ECHO Arterial blood gas (ABG) analysis Ammonia level Thyroid profile Pulmonary function test Spirometry Duplex ultrasound TORCH profile 	Yes
ii. At the time of claim submission	
Detailed Indoor Case Papers (ICPs)	Yes
Investigation reports (if done)	Yes
Detailed operative/procedure notes, if applicable	Yes
Blood transfusion notes, if given	Yes

Detailed Discharge Summary	Yes
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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):

- Detailed Clinical notes* – all vitals, detailed history especially current obstetric history, symptoms, signs, physical examination including local examination, and planned line of treatment, advice for admission?
- Did clinical condition, evaluation findings, and/or imaging confirm the diagnosis?

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

- Are the detailed Indoor Case Papers with daily vitals and line of treatment?
- Are the detailed procedure / Operative Notes available (if applicable)?
- Was the history, clinical findings, and investigations/imaging indicative of admission?
- Is the Discharge summary with follow-up advise at the time of discharge?

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:

- Did investigations and/or imaging confirm pregnancy? Yes
- Did the diagnosis or patient's condition or imminent symptoms documented requiring admission for further management? Yes

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

References:



1. Dutta, D. (2015). Medical and Surgical Illness Complicating Pregnancy. Text Book of Obstetrics including Perinatology & Contraception, (304 – 314).
2. Dutta, D. (2015). Text Book of Obstetrics including Perinatology & Contraception.
3. Bhide, A., Arulkumaran, S., Damania, K., Daftary, S. (2015). Aria's Practical Guide to High Risk Pregnancy & Delivery
4. Lakshmi Seshadri, Gita Arjun. Essentials of Obstetrics. First Edition. 2015. Wolters Kluwer.

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.