



## Guidance document for processing PM-JAY packages

### Cervical disc disease

Procedures covered: 4

Specialty: Neurosurgery

| Package name   | Procedure name   | HBP 1.0 code | HBP 2.0 code | Package price (INR) |
|--|--|--------------|--------------|---------------------|
| Posterior Cervical Discectomy without implant                  | Posterior Cervical Discectomy without implant                  | S800066      | SN028A       | 30,000              |
| Posterior Cervical Fusion with implant (Lateral mass fixation) | Posterior Cervical Fusion with implant (Lateral mass fixation) | S800067      | SN029A       | 50,000              |
| Cervical Disc Multiple level without Fusion                    | Cervical Disc Multiple level without Fusion                    | S800068      | SN030A       | 40,000              |
| Micro discectomy   | Cervical   | S800022      | SN036A       | 40,000              |

**ALOS:** 5 Days

**Minimum qualification of the treating doctor:**

**Essential:** MCh/DNB/Equivalent in (Neurosurgery)

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

#### Disclaimer:

For monitoring and administering the claim management process of **Posterior Cervical Discectomy without implant/Posterior Cervical Fusion with implant (Lateral mass fixation)/Cervical Disc Multiple level without Fusion/Cervical Microdiscectomy**, 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:

Cervical disc disorders encountered in practice include herniated nucleus pulposus (HNP), degenerative disc disease (DDD), and internal disc disruption (IDD).

### Causes

- HNP results from repetitive cervical stress or, rarely, from a single traumatic incident. Increased risk may accrue because of vibrational stress, heavy lifting, prolonged sedentary position, whiplash accidents, and frequent acceleration/deceleration.
- DDD is part of natural aging, but it is also a consequence of poor nutrition, smoking, atherosclerosis, job-related activities, and genetics.
- IDD can result from cervical trauma, including whiplash, cervical flexion/rotation injury, and repetitive use.
- Cervical radiculopathy results from nerve root compression secondary to herniated disc material, stenosis, or proteoglycan-mediated chemical inflammation released from discs. Smoking and certain occupational activities also predispose patients to cervical radiculopathy.

### Symptoms of cervical disc disease

- Patients usually present with severe cervical radiating pain, giddiness, numbness & weakness of upper limbs
- Discogenic pain without nerve root involvement is typically vague, diffuse and distributed axially.
- Depending on whether primarily motor or sensory involvement is present, radicular pain is deep, dull, and achy or sharp, burning, and electric. Such radicular pain follows a dermatomal or myotomal pattern into the upper limb.
- Cervical radicular pain most commonly radiates to the interscapular region, although pain can be referred to the occiput, shoulder, or arm as well. Neck pain does not necessarily accompany radiculopathy and frequently is absent.

### Management (Surgical)

#### 1. Cervical laminectomy (Cervical Disc Multiple level without Fusion – for decompression)

The indications for a cervical laminectomy are either congenital or degenerative cervical canal stenosis with weakness that has been shown by physical examination and explained by radiography (MRI imaging) to be due to spinal cord compression and that has not responded to conservative treatment.

If there is bowel or bladder disfunction, difficulty walking, severe muscle weakness, or severe pain that is not controlled by strong pain-relieving medications, surgery is absolutely indicated without non-operative trial.

Cervical laminectomy can be performed using a variety of techniques including but not limited to:

- Open Laminectomy
- Microscope assisted Laminectomy
- Less invasive tube assisted Laminectomy

### **Indications:**

Cervical canal stenosis with myelo-radiculopathy

- a. Pattern of myelo-radiculopathy explained by imaging
- b. 12 weeks of non-operative treatment
- c. The following can mitigate the need for initial non-operative trial
  - Severity of symptoms cause forced bed rest
  - Severity of symptoms prevent the patient from working
  - Spinal cord compression resulting in functionally limiting motor weakness (e.g: Paraparesis, spasticity).
  - Spinal cord compression resulting in sphincter disturbances (bladder disfunction)

## **2. Posterior Cervical Discectomy without implant**

- Patient present with severe cervical radiating pain, giddiness, numbness & weakness of hand
- Indication – Disc bulge (C3-C7)/Prolapsed intervertebral disc

## **3. Posterior Cervical Fusion with implant (Lateral mass fixation)**

- Indication – Atlantoaxial Instability (C1-2), Cervical myelopathy (C3-C7)

### **Situations where a posterior approach would generally be the initial approach:**

1. Congenital cervical stenosis where removing osteophytes will still not provide at least  $\approx 12$  mm of AP canal diameter

2. Disease over  $\geq 3$  levels (although up to 4 may occasionally be dealt with anteriorly)
3. Primary posterior pathology (e.g. infolding of ligamentum flavum)
4. Some cases of OPLL (anterior approach has higher risk of dural tear)

### 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  | Posterior Cervical Discectomy without implant / Cervical Disc Multiple level without Fusion / Microdiscectomy (Cervical) | Posterior Cervical Fusion with implant (Lateral mass fixation) |
|---|--|--|
| <b>i. At the time of Pre-authorization</b>  |  |  |
| Clinical notes with evaluation findings, indication of procedure, and planned line of treatment | Yes  | Yes  |
| Clinical photograph   | Yes  | Yes  |
| X-ray / MRI Cervical spine  | Yes  | Yes  |
| Indication of implant requirement   | --   | Yes  |
| <b>ii. At the time of claim submission</b>  |  |  |
| Detailed Indoor case papers (ICPs)  | Yes  | Yes  |
| Detailed Procedure / operative notes  | Yes  | Yes  |
| Intra-operative photographs (optional)  | Yes  | Yes  |
| Implant details (invoice/barcode)   | --   | Yes  |
| Detailed discharge summary  | Yes  | 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, indication for procedure, and planned line of treatment?
- b. Did clinical photograph and imaging 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. Was the CT/MRI Brain/Spine report submitted?
- d. Implant invoice/barcode available (if applicable)?
- e. Is the Discharge summary with follow-up advise at the time of discharge?

**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. Was clinical presentation and imaging indicative of surgery? Yes
- II. Was there a Weakness of upper limb/wrist drop if posterior discectomy is planned? No

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/NEUROSURGERY.pdf>
2. Standard Treatment Guidelines. Neuro-Surgery. Department of Health and Family Welfare. Government of Karnataka. Suvarna Arogya Suraksha Trust.
3. <https://emedicine.medscape.com/article/305720-treatment#showall>