



Guidance document for processing PM-JAY packages

Management of Acute Bronchitis

Packages covered/ package count:1

Specialty: General Medicine

Package name	HBP 1.0 code	HBP 2.0 code	Package price
Acute Bronchitis	M100005	MG028A	General Ward- 1800/- HDU – 2700/- ICU without ventilator– 3600/- ICU with Ventilator– 4500/-

ALOS: 4 days (to be capped, new pre-auth to be raised after 4 days, if required, & should not be auto-approved)

Minimum qualification of the treating doctor:

Essential: MBBS

Desirable: MD / DNB or equivalent (Medicine/ Pulmonology)

Special empanelment criteria/linkage to empanelment module: None

Disclaimer:

ICMR has issued clinical guidelines for **Acute Respiratory Infection in Adults** to be followed in country. For monitoring and administering the claim management process of **Acute Bronchitis** 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.

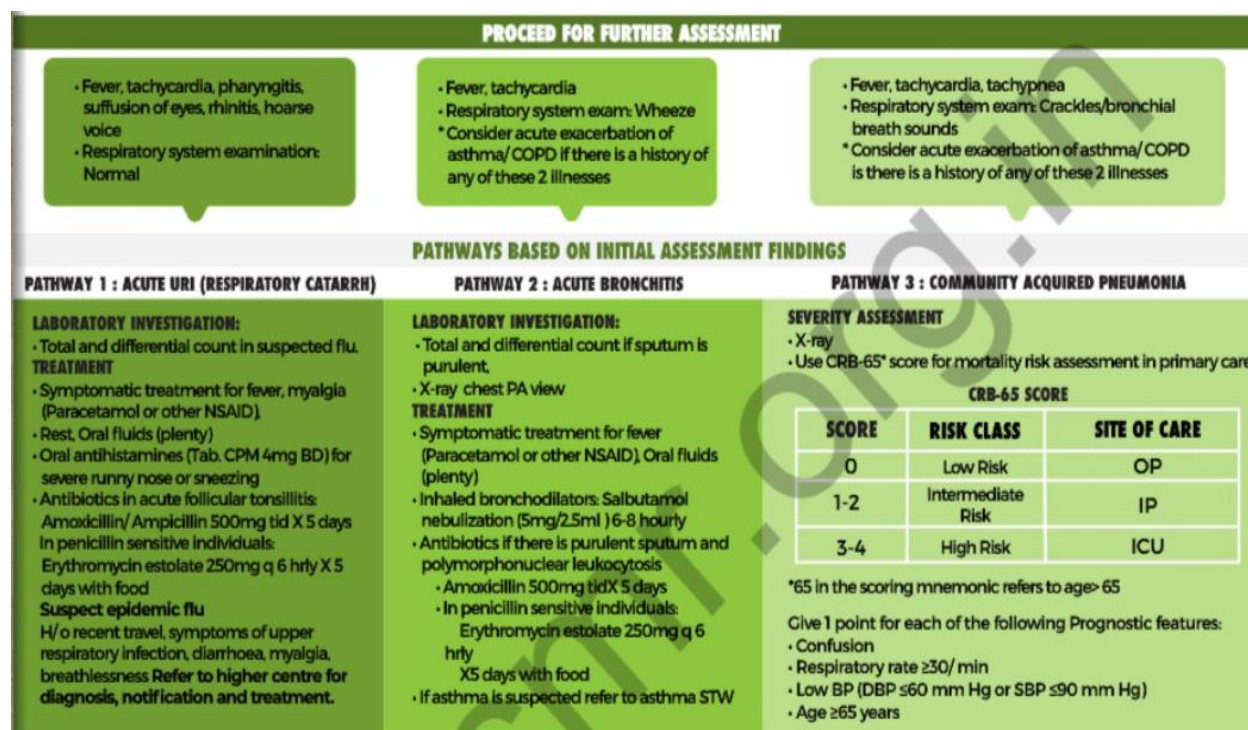
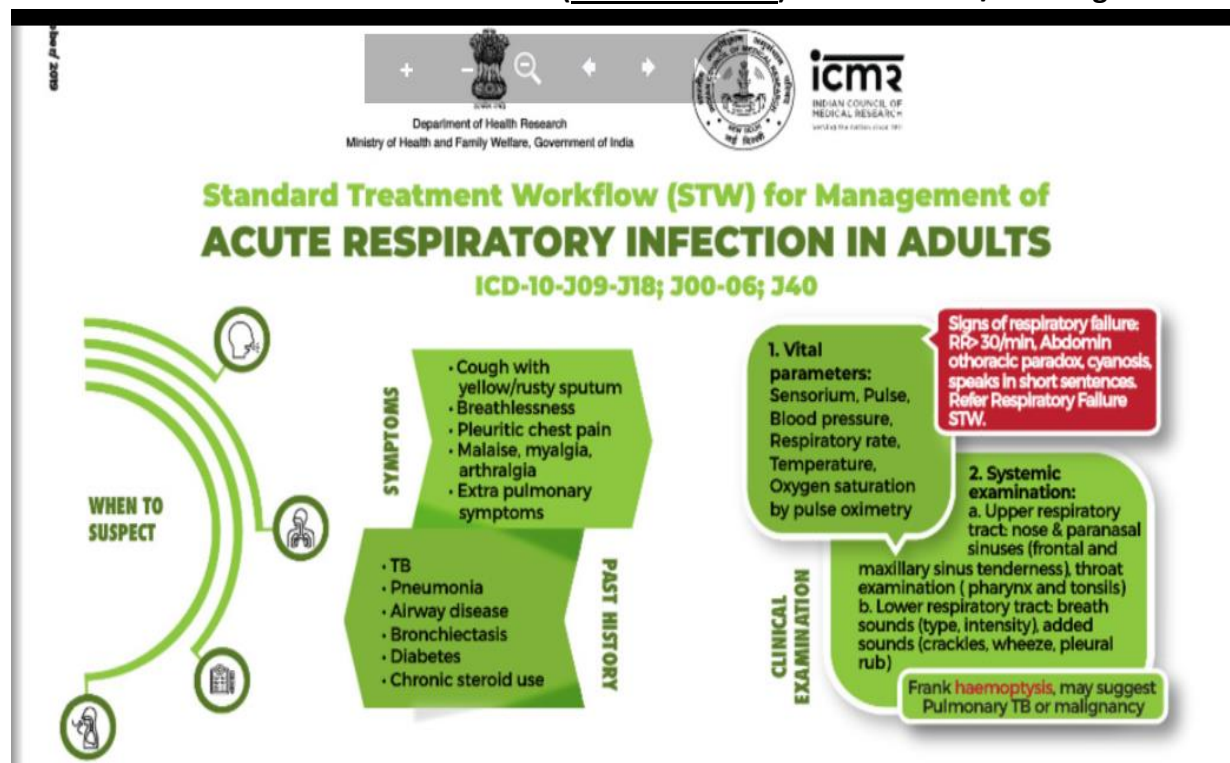


1.2 Clinical key pointers:

Proceed with management of Acute Bronchitis only if diagnosis made is backed by clinical signs, symptoms,

1. Chest congestion
2. Persistent coughing
3. Shortness of Breath
4. Sore throat
5. Fever
6. Body ache

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



OUT-PATIENT BASED CARE OF CAP (CRB-65 SCORE 0-1)

INVESTIGATIONS

Preliminary

Chest radiogram

Repeat if:

i. Patient is not improving/worsening clinically

ii. Suspected underlying malignancy

Desirable

1. Pulse oximetry in outpatients

2. Sputum microbiology. In suspected PTB & non-response after 48 hours of antibiotics

TREATMENT

1. Targeted towards *Streptococcus pneumoniae*
2. Oral antibiotics after checking for comorbidities* (Diabetes, CVDs, CKD, CLD, Hepatic Pathology, Cancer, Alcohol Abuse, H/o antibiotics within last 3 months.)
 - a. Without comorbidities: Cap. Amoxicillin (500 mg TDS)/Tab. Erythromycin 250mg QID/ Tab. Doxycycline 100mg BD
 - b. With comorbidities: Cap. Amoxicillin 500mg TDS + Tab. Azithromycin 500 mg OD
3. Duration: 5 days in (A); extend to a 7-10 days course if there is no response within 3 days of starting treatment and in (B).
4. Do not give:
 - a. Corticosteroids: unless other medical indications present
 - b. Fluoroquinolones: as they have anti-tubercular activity.

INPATIENT MANAGEMENT OF CAP

ANTIBIOTIC THERAPY IN THE HOSPITALIZED NON-ICU SETTING

- a. Single agent IV β -lactam
- b. If suspected atypical pathogens, other end organ disease, diabetes, malignancy, severe CAP, use of antibiotics in past 3 months: Combination of IV β -lactam (Cefotaxime 2 grams TID/ IV Ceftriaxone 1gram BD/ Amoxicillin-Clavulanic acid 1.2 grams TID) + ORAL macrolide (Tab Azithromycin 500 mg PO OD/ Tab Clarithromycin 500 mg PO BD)

ANTIBIOTIC THERAPY IN THE HOSPITALIZED ICU SETTING

- i. Patients without risk factors for *Pseudomonas aeruginosa*: Manage as above
- ii. Suspected *P. aeruginosa* (diabetes, chronic lung disease like bronchiectasis, chronic steroid therapy):
IV Cefepime (1G BD)/ IV Ceftazidime (2G TID)/ Piperacillin-tazobactam (4.5 G QID)/ IV Cefoperazone-sulbactam 1.5G IV TID/ IV Meropenem 1g TID;
Combination therapy: Aminoglycosides (IV Amikacin)/ Antipseudomonal fluoroquinolones (Levofloxacin/Moxifloxacin)

ADJUNCTIVE THERAPIES FOR THE MANAGEMENT OF CAP

- a. Steroids are not recommended for use in non-severe CAP
 - b. Non-invasive ventilation may be used in patients with CAP and acute respiratory failure
- CONTRA INDICATIONS FOR NON-INVASIVE VENTILATION**
- a. Cardiorespiratory arrest
 - b. Presence of severe upper airway inflammation & edema
 - c. Severe haemodynamic instability - hypotension
 - d. Eu-capnic (normal PaCO₂) coma
 - e. Multiple organ dysfunction or severe psychomotor agitation
- DISCHARGE CRITERIA**
Accepting orally, Afebrile and Hemodynamically stable for a period of at least 48 h

REFERRAL TO A HIGHER CENTRE : CLINICAL CRITERIA

1. Frank hemoptysis and /or Signs of respiratory failure (listed under in the history and evaluation sections)
2. CRB-65 score > 1
3. Oxygen saturation by pulse oximetry \leq 92% (patients \leq 50 yrs)
OR $<$ 90% (patients > 50 yrs)
4. Multi-lobe consolidation on chest X-ray
5. Confusion/disorientation
6. Hypothermia (core temperature $<$ 36.0°C)

POINTS TO NOTE WHILE SHIFTING

1. If referring to a higher center, give the first dose of antibiotic (oral and if available, parenteral), secure an IV line and start 0.9% Normal saline and oxygen supplementation through face mask at 4-6 litres per minute during shift
2. If the patient is drowsy, has copious secretions, consider calling for help from the SUB-DISTRICT/DISTRICT hospital for endotracheal intubation and shifting on a transport ventilator

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	Acute Bronchitis
i. At the time of Pre-authorisation	
Clinical notes with indications and planned line of management	Yes
X ray Chest	Yes
ii. At the time of claim submission	
Clinical Notes	Yes
CBC	Yes
X Ray Chest	Yes
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 Pre-auth processing doctors (PPD)

1. Did X ray (Chest) show any abnormality? -Yes
2. Was Wheezing in chest mentioned in the clinical notes? - Yes

2.2.2 Claims processing doctors (CPD)

1. Did X ray (Chest) show any abnormality? - Yes
2. Is presence of wheezing sound mentioned in the clinical notes – Yes
3. Was the patient treated with bronchodilators? - Yes

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:

1. Presence of Wheezing sound– Yes
2. H/O of cough more than 18 days - Yes

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

Acknowledgment:

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.