



## Guidance document for processing PM-JAY packages

### Ascites

**Procedures covered:** 1

**Specialty:** General Medicine, Pediatric Medical Management

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price
Ascites	Ascites	New Package	MG034A	General Ward- 1,800 HDU – 2,700 ICU without ventilator– 3,600 ICU with Ventilator– 4,500

**ALOS:** 5-7 Days

**Minimum qualification of the treating doctor:**

**Essential:** DNB / MD (General Medicine / Pediatric Medicine); DM/DNB (Gastroenterology)

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

#### Disclaimer:

For monitoring and administering the claim management process of **Ascites**, 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:** Ascites is the pathologic accumulation of fluid within the peritoneal cavity. It is the most common complication of cirrhosis and occurs in about 50% of patient with decompensated cirrhosis in 10 years.

Causes of ascites include:

- Cirrhosis
- Malignancy
- Tuberculosis
- Heart failure
- Chronic alcohol use
- IV drug use
- Obesity
- Hypercholesterolemia
- Type 2 diabetes
- Nephrotic syndrome
- Severe malnutrition
- Pancreatic ascites
- Ovarian lesions
- Rarely Pseudomyxoma peritonei

### **Clinical Features**

Patients typically report progressive abdominal distension that may be painless or associated with abdominal discomfort, weight gain, early satiety, shortness of breath, and dyspnea resulting from fluid accumulation and increased abdominal pressure. Symptoms such as fever, abdominal tenderness, and confusion can be seen in spontaneous bacterial peritonitis.

Patients with ascites typically will have flank dullness on examination, shifting dullness, a fluid wave, evidence of pleural effusions, and findings related to the underlying cause of the ascites, such as stigmata of cirrhosis (cirrhosis includes spider angioma, palmar erythema, and abdominal wall collaterals).

Spider angiomata, jaundice, muscle wasting, gynecomastia, and leukonychia are present in patients with advanced liver disease.

### **Diagnosis**

Ultrasound is the most sensitive test to detect ascites. It will reveal homogenous freely mobile anechoic collection in the peritoneal cavity. The smallest amount of fluid is usually seen in Morison pouch.

Diagnostic abdominal paracentesis with the appropriate ascitic fluid analysis is probably the most rapid and cost-effective method of diagnosing the cause of ascites.

The initial tests that should be performed on the ascitic fluid include a blood cell count, with both a total nucleated cell count and polymorphonuclear neutrophils (PMN) count, and a bacterial culture by bedside inoculation of blood culture bottles.

### **Management**

Appropriate treatment of ascites depends on the cause of fluid retention. The goals of therapy in patients with ascites are to minimize the ascitic fluid volume and decrease peripheral edema, without causing intravascular volume depletion.

Sodium restriction and diuretics form the basis of treatment

In cases of high-albumin-gradient ascites which occurs in cirrhosis, the treatment of ascites in these patients includes abstinence from alcohol, restricting dietary sodium to 88 mEq (2000 mg) per day, and treating with diuretics (spironolactone and furosemide in a ratio of 100:40 mg/day)

Patient with a treatable liver condition, such as autoimmune hepatitis, chronic hepatitis B with reactivation, hemochromatosis, or Wilson disease, should receive specific therapy for these diseases. Occasionally, cirrhosis due to causes other than alcohol or hepatitis B is reversible; however, these diseases are usually less reversible than in alcoholic liver disease, and by the time ascites is present, these patients may be better candidates for liver transplantation than for protracted medical therapy.

Low-albumin-gradient ascites commonly occurs in non-ovarian peritoneal carcinomatosis. These patients often benefit from an outpatient therapeutic paracentesis. Patients with ovarian malignancy may benefit from surgical debulking and chemotherapy.

TB peritonitis is treated with anti-tuberculous medications, while pancreatic ascites and postoperative lymphatic leak from a distal splenorenal shunt or radical lymphadenectomy may resolve spontaneously.

### 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	Ascites
<b>i. At the time of Pre-authorization</b>	
a. Clinical Notes including evaluation findings, indications for the procedure, and planned line of treatment	Yes
b. Liver Function test	Yes
c. Ultrasound abdomen/Upper GI endoscopy	Yes
d. Cancer markers CA-19-9, CEA, CA-125 (females) (as and when applicable)	Yes
<b>ii. At the time of claim submission</b>	
a. Detailed Indoor Case Papers and Treatment given	Yes
b. Serum ascites albumin gradient (SAAG) report	Yes
c. 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:

Mandatory documents	Ascites
<b>i. Pre-auth pro at the time of pre-authorization processing- For pre-authorization processing doctor (PPD)</b>	
a. Was the Clinical Notes including evaluation findings, indications for the procedure, and planned line of treatment submitted?	Yes
b. Was the liver function test report submitted?	Yes
c. Was the Ultrasound abdomen/Upper GI endoscopy report of patient suggestive of ascites?	Yes
d. Was the Cancer markers CA-19-9, CEA, CA-125 (females) (as and when applicable) report submitted?	Yes
<b>ii. At the time of claim processing- For claims processing doctor (CPD)</b>	
a. Was Detailed Indoor case papers and treatment details submitted?	Yes
b. Was the Serum ascites albumin gradient (SAAG) report submitted?	Yes
c. Was the Detailed Discharge Summary submitted with the date of the follow-up mentioned?	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. Was the Clinical notes and USG Abdomen/ Upper GI endoscopy reports Indicative of Ascites? Yes

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

## References

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3. Long B, Koyfman A. The emergency medicine evaluation and management of the patient with cirrhosis. *Am J Emerg Med.* 2018 Apr;36(4):689-698.
4. Burgos AC, Thornburg B. Transjugular Intrahepatic Portosystemic Shunt Placement for Refractory Ascites: Review and Update of the Literature. *Semin Intervent Radiol.* 2018 Aug;35(3):165-168.
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7. Marks V, Teale JD. Drug-induced hypoglycemia. *Endocrinol. Metab. Clin. North Am.* 1999 Sep;28(3):555-77.