



Guidance Document for Processing PM-JAY Packages

REPLACEMENT SURGERY FOR CORROSIVE INJURY STOMACH

Package Covered: 01
Speciality: General Surgery

AB PM-JAY Package Name	AB PM-JAY Procedure Name	Procedure Code HBP 1.0.	Procedure Code HBP 2.0	Procedure Code HBP 2022	Package Price
Replacement Surgery for Corrosive Injury Stomach	Replacement Surgery for Corrosive Injury Stomach	New Package	New Package	SG117A	NRP: Rs. 50,000/- Tier 3: Rs. 50,000/- Tier 2: Rs. 58,500/- Tier 1: Rs. 62,500/-

Average Length of Stay (ALOS): 7-10 Days

Minimum Qualification of the treating/operating doctor:

Essential: MS/DNB/Equivalent (General Surgery) (or) MCh/DNB/Equivalent (GI Surgery)

Special Empanelment Criteria / Linkages to Empanelment Module: Care at Tertiary Hospital

Disclaimer:

NHA shall follow these guidelines to monitor and administer the claim management process of **Replacement Surgery for Corrosive Injury Stomach**. This document has been prepared for the guidance of the PROCESSING TEAM and TRANSACTION MANAGEMENT SYSTEM of AB PM-JAY for the claims of the procedures mentioned above. However, this document doesn't provide any guidance on a patient's clinical and therapeutic management.

PART I: Guidelines for Clinicians and Healthcare Providers

1.1 Objective:

The objective of this section is to act as a guidance and a clinical decision support tool for the clinicians in deciding the line of treatment, planning clinical management of patients and decide referral of cases to the appropriate level of care (as required) for treatment of patients under PM-JAY and selection of the 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 PM-JAY.

1.2 Clinical Key Pointers:

Potentially catastrophic presentation and lifelong complications resulting from caustic ingestion make it one of the most challenging clinical situations in gastroenterology. Ingestion of caustic materials is accidental in children and usually suicidal in teenagers and adults. Alkaline caustics and acids are the most common chemicals implicated in caustic burns. Stricture formation with an inability to swallow food after the injury is inevitable in some cases. Burns from such agents may include the oral cavity, pharynx, larynx, oesophagus, and stomach. Destruction of the tissues of these organs may lead to complications, of which respiratory compromise, oesophageal and gastric perforation, septicemia, or even death.

Acids commonly affect the stomach more than alkalis, cause mucosal damage by coagulation necrosis, and require a longer duration of contact. Acids are cleared rapidly from the oesophagus

to the stomach, pooling in the prepyloric area due to corrosive induced pylorospasm. Strictures can also occur in the antrum, body, or the pyloroduodenal area. On the other hand, alkalis cause liquefaction necrosis, are more viscous, and tend to adhere to the oesophageal mucosa with only a relatively small amount reaching the stomach. The extent of oesophageal damage is greater with alkalis than with acids.

Inability to swallow following a corrosive stricture of the oesophagus is one of the most distressing symptoms patients experience. The treatment options include dilations (blind, retrograde endless string, and endoscopic) or creating a new passage (replacement). A variety of options can be considered in choosing a conduit for replacement. Commonly used organs used for replacement are as follows:

- Gastric Conduit
- Colonic Conduit
- Jejunal Conduit

Although the stomach is one of the most preferred conduits for replacement in corrosive injury, colonic conduits also provide excellent results. Gastric conduits are based on the right gastric and gastroepiploic arteries. Its advantage is that it only involves only one anastomosis. These are bypass procedures are usually preferred since the resection procedures have significantly increased morbidity as they are associated with the risk of injury to great vessels, trachea, thoracic duct, or vagus nerve.

The replacement surgery is usually done through the substernal route using either a colonic or gastric conduit. Bypass surgeries may also be accompanied by a resection procedure in case of the involvement of short segments of the stomach. The gastric pull-up is technically easier and requires only one anastomosis. Colon graft, on the other hand, requires three anastomoses and requires extensive dissection.

1.3 Mandatory Documents – For Healthcare Providers:

Following documents should be uploaded by the concerned hospital staff during pre-authorisation and claims submission.

I. For Pre-Authorisation:

- a. Clinical Notes with history and examination and planned line of treatment
- b. Upper GI Endoscopy Report
- c. Barium Study
- d. CT Abdomen/Colonoscopy/Barium Enema

II. For Claims Submission:

- a. Detailed Indoor Case Papers (ICPs)
- b. Detailed Operative/Procedure Notes
- c. Intra Operative Clinical Photograph (Optional)
- d. Detailed Discharge Summary

PART II: Guidelines for Processing Team

PART III: Guidelines for IT

3.1 Objective:

To enable the setting up of cross-check mechanisms/rule engines within the IT platform (TMS) to ensure compliance with STGs and 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 in case of Replacement Surgery for Corrosive Injury Stomach:

a. At Pre-Authorisation (PPD):

- i. Were the patient's clinical history/investigations indicative of the Procedure? Yes.
- ii. Whether the investigation reports confirm the diagnosis? Yes.

b. At Claim Submission (CPD):

- i. Whether detailed Operative/Procedure notes submitted? Yes.
- ii. Whether detailed Discharge Summary Submitted? Yes.

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

References:

1. Kalipatnapu S, Reddipogu JS, George SV, Abraham V, Samarasam I. Corrosive injuries of the upper gastrointestinal tract: A review of management practices. Curr Med Issues [serial online] 2018 [cited 2022 May 27]; 16:92-5.
2. Ananthakrishnan N, Parthasarathy G, Kate V. Acute corrosive injuries of the stomach: a single unit experience of thirty years. ISRN Gastroenterol. 2011;2011:914013. doi:10.5402/2011/914013.
3. Kamat R, Gupta P, Reddy YR, Kochhar S, Nagi B, Kochhar R. Corrosive injuries of the upper gastrointestinal tract: A pictorial review of the imaging features. Indian J Radiol Imaging. 2019;29(1):6-13. doi:10.4103/ijri.IJRI_349_18.