

## Guidance document for PM-JAY package

### Neuro-Developmental Disorders (NDD) Other than Intellectual Disability

Procedures covered/ procedure count: 5

**Specialty:** Mental Disorders

Package name	Procedure Name	HBP 1. Code	HBP 2022 code	Package price (INR)	ALOS
Neuro-Developmental Disorders (NDD) Other than Intellectual Disability	Autism Spectrum Disorder	New Package	MM010A	<b>Routine Ward -</b> NRP: 2100 Tier 1: 2300 Tier 2: 2300 Tier 3: 2100  <b>HDU -</b> NRP: 3300 Tier 1: 3800 Tier 2: 3800 Tier 3: 3300	3-4 weeks
Neuro-Developmental Disorders (NDD) Other than Intellectual Disability	Mixed Developmental Disorder	New Package	MM010B		3-4 weeks
Neuro-Developmental Disorders (NDD) Other than Intellectual Disability	Tourette Syndrome / Chronic Tic Disorder	New Package	MM010C		3-4 weeks
Neuro-Developmental Disorders (NDD) Other than Intellectual Disability	Attention Deficit Hyperactivity Disorder (ADHD)	New Package	MM010D		3-4 weeks
Neuro-Developmental Disorders (NDD) Other than Intellectual Disability	Specific Developmental Disorders	New Package	MM010E		3-4 weeks

#### Minimum qualification of the treating doctor:

**Essential:** MD/DNB/ equivalent (Psychiatry)

**Special empanelment criteria/linkage to empanelment module:** As per the provisions of the Mental Health Act 2017 (<https://egazette.nic.in/WriteReadData/2017/175248.pdf>) be referred for details on Admission & Discharge criteria.

#### Disclaimer:

For monitoring and administering the claim management process of **Neuro-developmental disorders other than intellectual syndromes associated with physiological disturbances and physical factors**, 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 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:**

The provisions under Mental Healthcare Act 2017 be referred for details on Admission & Discharge criteria.

Neurodevelopmental disorders other than intellectual disorders come under ICD 11 and DSM-5 which includes the following conditions:

#### **i. LANGUAGE/SPEECH DISORDERS**

Developmental speech or language disorders arise during the developmental period and are characterized by difficulties in understanding or producing speech and language or in using language in context for the purposes of communication that are outside the limits of normal variation expected for age and level of intellectual functioning. The observed speech and language problems are not attributable to regional, social, or cultural/ethnic language variations and are not fully explained by anatomical or neurological abnormalities. The presumptive aetiology for Developmental speech or language disorders is complex, and in many individual cases, is unknown.

Developmental Speech or Language Disorders are characterized by difficulties in understanding or producing speech and language or in using language in context for the purposes of communication. Developmental Speech or Language Disorders include:

- Developmental Speech Sound Disorder
- Developmental Speech Fluency Disorder

- Developmental Language Disorder
- Other Specified Developmental Speech or Language Disorders

Regional, social, or cultural/ethnic language variations (e.g., dialects) must be considered when an individual is being assessed for language abilities. For example, phonological memory tasks may offer a less biased assessment compared to lexical tasks. A language history documenting all the languages the child has been exposed to since birth can assist in determining whether individual language variations are better explained by exposure to multiple languages rather than a speech or language pathology *per se*.

## **ii. AUTISM SPECTRUM DISORDER**

Autism spectrum disorder is characterized by persistent deficits in the ability to initiate and to sustain reciprocal social interaction and social communication and by a range of restricted, repetitive, and inflexible patterns of behaviour, interests or activities that are clearly atypical or excessive for the individual's age and socio-cultural context. The onset of the disorder occurs during the developmental period, typically in early childhood, but symptoms may not become fully manifest until later, when social demands exceed limited capacities. Deficits are sufficiently severe to cause impairment in personal, family, social, educational, occupational or other important areas of functioning and are usually a pervasive feature of the individual's functioning observable in all settings, although they may vary according to social, educational, or other context. Individuals along the spectrum exhibit a full range of intellectual functioning and language abilities.

## **iii. DEVELOPMENTAL LEARNING DISORDERS**

Developmental learning disorder is characterized by significant and persistent difficulties in learning academic skills, which may include reading, writing, or arithmetic. The individual's performance in the affected academic skill(s) is markedly below what would be expected for chronological age and general level of intellectual functioning, and results in significant impairment in the individual's academic or occupational functioning. Developmental learning disorder first manifests when academic skills are taught during the early school years. Developmental learning disorder is not due to a disorder of intellectual development, sensory impairment (vision or hearing), neurological or motor disorder, lack of availability of education, lack of proficiency in the language of academic instruction, or psychosocial adversity.

## **iv. ATTENTION-DEFICIT/HYPERACTIVITY DISORDER**

Attention deficit hyperactivity disorder is characterized by a persistent pattern (at least 6 months) of inattention and/or hyperactivity-impulsivity that has a direct negative impact on academic, occupational, or social functioning. There is evidence of significant inattention and/or hyperactivity-impulsivity symptoms prior to age 12, typically by early to mid-childhood, though some individuals may first come to clinical attention later. The degree of inattention and hyperactivity-impulsivity is outside the limits of normal variation expected for age and level of intellectual functioning. Inattention refers to significant difficulty in sustaining

attention to tasks that do not provide a high level of stimulation or frequent rewards, distractibility and problems with organization. Hyperactivity refers to excessive motor activity and difficulties with remaining still, most evident in structured situations that require behavioural self-control. Impulsivity is a tendency to act in response to immediate stimuli, without deliberation or consideration of the risks and consequences. The relative balance and the specific manifestations of inattentive and hyperactive-impulsive characteristics varies across individuals and may change over the course of development. In order for a diagnosis to be made, manifestations of inattention and/or hyperactivity-impulsivity must be evident across multiple situations or settings (e.g., home, school, work, with friends or relatives), but are likely to vary according to the structure and demands of the setting. Symptoms are not better accounted for by another mental, behavioral, or neurodevelopmental disorder and are not due to the effect of a substance or medication.

#### **v. PRIMARY TIC/TIC DISORDERS**

Primary tics or tic disorders are characterized by the presence of chronic motor and/or vocal (phonic) tics. Motor and vocal tics are defined as sudden, rapid, non-rhythmic, and recurrent movements or vocalizations, respectively. In order to be diagnosed, tics must have been present for at least one year, although they may not manifest consistently.

##### **a) Tourette syndrome**

Tourette syndrome is a chronic tic disorder characterized by the presence of both chronic motor tics and vocal (phonic) tics, with onset during the developmental period. Motor and vocal tics are defined as sudden, rapid, non-rhythmic, and recurrent movements or vocalizations, respectively. In order to be diagnosed as Tourette syndrome, both motor and vocal tics must have been present for at least one year, although they may not manifest concurrently or consistently throughout the symptomatic course.

##### **b) Chronic Motor Tic Disorders**

Chronic motor tic disorder is characterized by the presence of motor tics over a period of at least one year, although they may not manifest consistently. Motor tics are defined as sudden, rapid, non-rhythmic, and recurrent movements.

##### **c) Chronic Phonic Tic Disorders**

Chronic phonic tic disorder is characterized by the presence of phonic (vocal) tics over a period of at least one year, although they may not manifest consistently. Phonic tics are defined as sudden, rapid, non-rhythmic, and recurrent vocalizations.

##### **d) Transient motor tics**

Tics are sudden, non-rhythmic stereotyped movements such as blinking, sniffing, tapping, etc. They should have been present for less than 1 year.

#### vi. **MOTOR DISORDERS**

Developmental motor coordination disorder is characterized by a significant delay in the acquisition of gross and fine motor skills and impairment in the execution of coordinated motor skills that manifest in clumsiness, slowness, or inaccuracy of motor performance. Coordinated motor skills are markedly below that expected given the individual's chronological age and level of intellectual functioning. Onset of coordinated motor skills difficulties occurs during the developmental period and is typically apparent from early childhood. Coordinated motor skills difficulties cause significant and persistent limitations in functioning (e.g. in activities of daily living, school work, and vocational and leisure activities). Difficulties with coordinated motor skills are not solely attributable to a Disease of the Nervous System, Disease of the Musculoskeletal System or Connective Tissue, sensory impairment, and not better explained by a Disorder of Intellectual Development.

#### vii. **STEREOTYPED MOVEMENT DISORDERS**

Stereotyped movement disorder is characterized by the persistent (e.g., lasting several months) presence of voluntary, repetitive, stereotyped, apparently purposeless (and often rhythmic) movements that arise during the early developmental period, are not caused by the direct physiological effects of a substance or medication (including withdrawal), and markedly interfere with normal activities or result in self-inflicted bodily injury. Stereotyped movements that are non-injurious can include body rocking, head rocking, finger-flicking mannerisms, and hand flapping. Stereotyped self-injurious behaviors can include repetitive head banging, face slapping, eye poking, and biting of the hands, lips, or other body parts.

### 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:

<b>Mandatory document</b>	<b>Behavioral syndromes associated with physiological disturbances and physical factors</b>
<b>i. At the time of Pre-authorization</b>	
a. Clinical notes with detailed history and chronicity	Yes
b. Admission document signed by empanelled psychiatrist	Yes
<b>ii. At the time of claim submission</b>	
a. Detailed treatment notes	Yes
b. 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:**

<b>Mandatory document</b>	<b>Behavioral syndromes associated with physiological disturbances and physical factors</b>
<b>I. Pre-auth processing Doctor (PPD)</b>	
a. Clinical notes - detailed history, mini mental status test, indication for treatment and need of hospitalization	Yes
b. Was the admission document signed by an empanelled psychiatrist?	Yes
<b>II. Claims processing Doctor (CPD)</b>	
a. Are the detailed treatment notes submitted?	Yes
b. Is there a Detailed Discharge Summary mentioning date of follow-up submitted?	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 patient admission document signed by an empanelled psychiatrist? Yes

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

### **References**

1. <http://id.who.int/icd/entity/1516623224>
2. <https://acrobat.adobe.com/link/track?uri=urn:aaid:scds:US:907fa51f-b6cb-494c-95b1-5cac626fc55>