



Guidance document for processing PM JAY package

Atrial Fibrillation

Procedure covered/ procedure count:1

Specialty: General Medicine

Procedure name	HBP 1.0 code	HBP 2.0 code	Procedure price
Atrial Fibrillation	New Package	MG036A	General Ward- 1800/- HDU – 2700/- ICU without ventilator– 3600/- ICU with Ventilator– 4500/-

ALOS: 5 days

Minimum qualification of the treating doctor: MD (General Medicine)

Desirable: MD/DNB or equivalent (in Cardiology)

Special empanelment criteria/linkage to empanelment module: ECG Machine

Disclaimer:

“ICMR has issued clinical guidelines for **Atrial Fibrillation** to be followed in country. For monitoring and administering the claim management process of **Atrial Fibrillation**, 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 ICMR guidelines are also included in the document for better understanding of the SHA teams, Insurance companies and TPAs. 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 the ICMR poster and 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 Atrial Fibrillation treatment only if diagnosis made is backed by clinical signs, symptoms:

S.no.	Clinical symptoms	
1	Rapid irregular heart beat	Yes
2	General fatigue	Yes
3	Weakness	Yes
4	Exhaustion	Yes
5	Dizziness	Yes
6	Near syncope or Syncope	Yes
7	Shortness of breath	Yes
8	Chest pain	Yes
	Signs	
1	Irregular pulse	Yes
2	Variable heart sound	Yes
3	Systolic blood pressure <90 mm/hg	Yes
4	Heart rate >150 b/m or <50 b/m	Yes
	Risk Factors	
1	Prior valvular heart disease	Yes
2	Chronic heart failure	Yes
3	Myocardial infraction	Yes
4	Prior Transient Ischemic Attack	Yes
5	Stroke	Yes
6	Emboic episode	Yes
7	Hypertension	Yes
8	Diabetes mellitus	Yes
9	COPD	Yes
10	CKD	Yes
11	Obesity	Yes

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

Standard Treatment Workflow (STW) for the Management of
ATRIAL FIBRILLATION
ICD-10-I48.91

WHEN TO SUSPECT ?

SYMPTOMS

- Rapid rate palpitations with or without
- General fatigue or weakness or exhaustion
- Dizziness, near syncope or syncope
- Shortness of breath
- Chest pain
- More marked on exertion

SIGNS

- Irregularly irregular pulse
- Variable heart sound

LOOK FOR RISK FACTORS

- Prior valvular heart disease or CHF or MI
- Prior TIA or stroke or embolic episode
- Hypertension, DM, COPD, CKD, Obesity

LOOK FOR PRECIPITATING FACTORS:

- Post (cardiac) surgery
- Alcoholism or binge drinking
- Myo-pericarditis or ACS
- Pneumonitis or pulmonary embolism
- Sepsis, hyperthyroidism

MANAGEMENT PRINCIPLES:

- Categorize AF
- Look for immediate intervention indicators
- Assess stroke risk & need for anti-coagulation
- Assess bleeding risk
- Need for rate control
- Consideration for rhythm control

CATEGORIZE AF

- Paroxysmal AF: Episodes of AF for less than 7 days
- Persistent AF: AF lasting from 7 days to 1 year
- Long standing persistent AF: AF lasting for > 1 year
- Permanent AF: AF with heart rate control as only option

LOOK FOR IMMEDIATE INTERVENTION INDICATORS:

- Systolic BP 90 mmHg, HR > 150 or <50/min
- Ongoing angina
- CHF or TIA or stroke
- Major bleed on oral anti-coagulants

STROKE RISK SCORE

CHA ₂ DS ₂ -VAS _c	SCORE
• Congestive heart failure/LV dysfunction	1
• Hypertension	1
• Aged ≥ 75 years	2
• Diabetes mellitus	1
• Stroke/TIA/TE	2
• Vascular disease [prior MI, PAD or aortic plaque]	1
• Aged 65-74 years	1
• Sex category [i.e. female gender]	1
Maximum Score	9

OAC if score >1 in men and >2 in women

BLEEDING RISK SCORE

HAS-BLED	SCORE
• Hypertension i.e. uncontrolled BP	1
• Abnormal renal/ liver function	1 or 2
• Stroke	1
• Bleeding tendency or predisposition	1
• Labile INR	1
• Age (e.g. >65)	1
• Drugs (e.g. concomitant aspirin or NSAIDs or alcohol)	1
Maximum Score	9

Bleeding Risk High in score >3

CHOICE OF ANTI-COAGULATION:

- Vitamin K antagonist
- Aim for INR 2-3
- Assess risk of bleeding
- Take measures to reduce/ modify risk of bleeding
- Dietary modification & regular monitoring

MEASURES TO REDUCE HIGH BLEEDING RISK:

- Control SBP to less than 140 mmHg
- Avoid dietary indiscretions
- Avoid concomitant aspirin, anti platelets, NSAIDs
- Avoid alcohol
- Correct anemia

HEART RATE CONTROL

In all patients except haemodynamic instability	Beta blocker or calcium channel blocker or combination	BB ± digoxin in HF	Rate aim to be less than 110/ min
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CONVERSION TO NSR

Haemodynamic instability	Uncontrolled symptoms despite HR control	Unacceptable rate control drug side effects	Patients' preference
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MANAGEMENT

AT PHC/ CHC:

- Detailed clinical evaluation
- Basic investigations
- Careful ECG evaluation
- Start OAC if indicated (based on stroke risk)
- Start Metoprolol if HR >110/ min & no evidence of CHF
- Refer if indicators for early intervention

AT DISTRICT HOSPITAL:

- Admit if indicators of early interventions
- Immediate cardioversion after heparinization, if haemodynamic instability
- Manage precipitating factors if any
- Assess stroke, bleeding risk & coagulation parameters
- Detailed echocardiogram
- Start OAC, maintain INR around 2-3
- Control HR by single drug or combination of BB & Ca Blocker

Refer if HR uncontrolled or CHF or angina

AT TERTIARY CENTRE:

- Re-assess clinical status, adequacy of AC
- Consider need of Noal OAC
- Optimise management of underlying cardiac disease
- Stress life style and AF risk factor modification
- Assess need for rhythm control and discuss pros & cons
- Consider RFA in select patient

INVESTIGATIONS

BASIC INVESTIGATIONS:

- Haemograms
- Blood sugar, Creatinine
- Electrolytes
- 12 lead ECG

DESIRABLE INVESTIGATIONS:

- Plain X-ray chest
- Thyroid evaluation
- Liver function test
- Troponins
- Prothrombin time, INR (Coagulation profile)
- Echocardiography

OPTIONAL INVESTIGATIONS:

- Prolonged ECG monitoring
- Trans-esophageal echocardiography
- Exercise Stress Test
- CT scan
- MRI
- EP study
- Coronary angiography

WHAT TO LOOK FOR IN ECG ?

- Ventricular rate
- Chamber enlargement
- Pre-excitation
- Prior MI
- Bundle branch block
- QT interval

RHYTHM CONTROL

Pharmacological Cardioversion

CHF, CAD, Abnormal LVH → Amiodarone

Normal Heart → Flecainide, Ibutilide, Propafenone

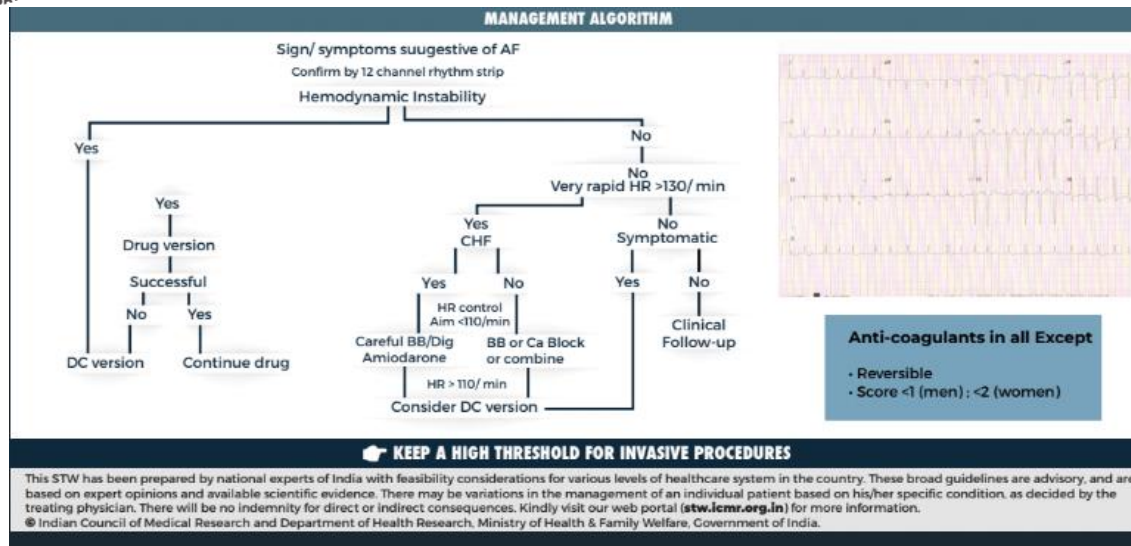
Pill in pocket (Flecainide OR Propafenone)

Long Term Rhythm Control

CHF → Amiodarone

Normal Heart → Flecainide, Propafenone, Sotalol

CAD, LVH → Amiodarone, Sotalol



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	Atrial fibrillation
i. At the time of Pre-authorisation	
a. Clinical notes	Yes
b. Blood test	Yes
i. Coagulation profile (PT, INR)	
ii. Sr. electrolytes	Yes
c. ECG it shows irregular rhythm and abnormal heart rate	Yes
d. X- ray Chest	Yes
ii. At the time of claim submission	
a. Post treatment ECG	Yes
b. Discharge Summary	Yes
c. Detailed Indoor Case Papers (ICPs), Treatment details	Yes
d. All investigations reports	Yes

PART II: GUIDELINES FOR PROCESSING TEAM



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 ECG done at the time of/ before discharge? Yes
2. Did patient's serum electrolytes result reach normal range before discharge? Yes

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

^[1] 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.