



Guidance document for PM JAY packages

Mood (affective) disorders

Packages covered/ package count: 1

Specialty: Mental Disorders

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Mood (affective) disorders	Mood (affective) disorders	M800004, M800011	MM005A	1,500/day

Minimum qualification of the treating doctor:

Essential: MD/ DNB/ PG Diploma/ equivalent (in Psychiatry)

ALOS: 6-8 weeks

Special empanelment criteria/linkage to empanelment module: As per the provisions of the Mental Health Act 2017

Disclaimer:

“ICMR has issued clinical guidelines for **Depression** to be followed in country. For monitoring and administering the claim management process of **Mood (affective) disorders**, 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. 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:

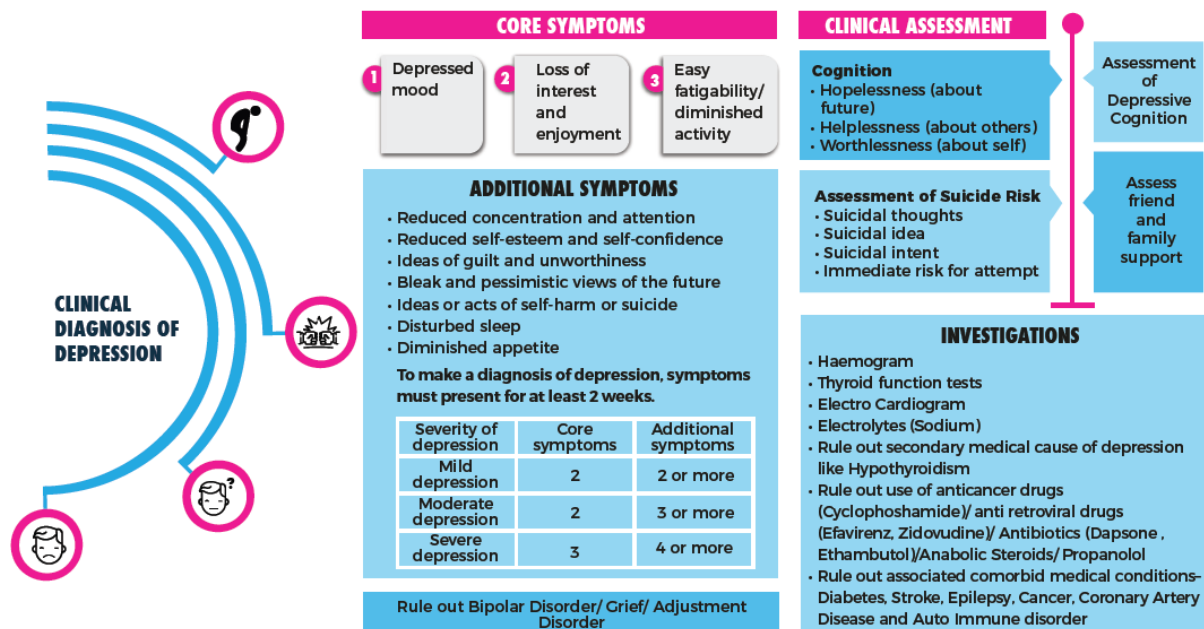
The purpose of this section is to act as a guidance & a clinical decision support tool for the clinicians in deciding the line of treatment, plan clinical management of patient and decide referral of cases to the appropriate level of care (as required) for treatment of patients under PMJAY and selection 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:

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

Standard Treatment Workflow (STW) for the Management of DEPRESSION ICD10-F45



AT PRIMARY CARE		
MILD DEPRESSION <ul style="list-style-type: none"> • Advise Behavioural Activation to patients • Practicing activity monitoring - write down your activities/ rate your depression/ schedule activities that make you feel good/ make a to do list/ set clear and specific goals • Focusing on your value categories - make time for your family/ friends/ set clear goals at work/ contribute to community • Recommend yoga & meditation • Handling daily task - monitor sleep/ diet and practice good personal hygiene • Supportive psychotherapy/ Brief Counselling • Validate the problems and ensure frequent follow-up • If no improvement in 4 to 6 weeks, consider pharmacotherapy 		MODERATE/ SEVERE DEPRESSION <ul style="list-style-type: none"> • Tab. Escitalopram 10 mg-20 mg/day or Cap. Fluoxetine 20mg -40mg/day • Tab. Clonazepam 0.25mg - 0.5mg/day for sleep disturbance/ anxiety symptoms and consider taper and stop after 2 weeks • If patient responds to SSRI in 2 to 4 weeks, then continue treatment for 6 to 9 months and taper and stop
REFERRAL TO SECONDARY CARE	BROAD MANAGEMENT PLANS	AT SECONDARY CARE
<ul style="list-style-type: none"> • Difficulty in making diagnosis • No improvement after 4 to 6 weeks of treatment with first line medications • Depression in special population: Elderly/ Pregnancy/ Lactation/ Children/ Adolescents • Comorbid medical illness/ Substance use • Suicidal risk assessment 	<ul style="list-style-type: none"> • Selective Serotonin Reuptake Inhibitors (SSRI) are usually first choice (watch for GI bleed and drug interaction) • Improvement starts in 2nd week and expect adequate response by 6 weeks • Duration of treatment typically lasts 6-9 months and gradual tapering of medication advised for first episode • Restart SSRI, in case of resurgence and recurrence of depressive symptoms • Observe for switch/ activation with antidepressants • Watch for risk of overdose with TCA (Amitriptyline/ Imipramine) and Mirtazapine 	<ul style="list-style-type: none"> • Confirm diagnosis and suicide risk assessment • Assess for other medical comorbidities • Investigations - Haemoglobin, Thyroid Function Test, Electrocardiogram • Non Responder - Switch over to SNRI (Venlafaxine 75 - 150 mg, Mirtazapine 30 mg) or TCA (Amitriptyline 75- 225mg/ Imipramine 75 -225mg) • Cognitive Behavioral Therapy/ Problem Solving Therapy • Add on Yoga Therapy/ Meditation

REFERRAL TO TERTIARY CARE	SPECIAL POPULATION	AT TERTIARY CARE
<ul style="list-style-type: none"> No improvement in 2nd line treatment Immediate risk for suicidal attempt/ thought Needing intense counselling/ psychotherapy Co Morbid Substance - Cannabis/ Poly substance 	<ul style="list-style-type: none"> Pregnancy/ Lactation period - Pre Conception counselling and preferred drug is Tab. Sertraline 50 mg - use lowest possible dose Elderly - Tab. Escitalopram 10 -20 mg or Tab. Sertraline 100 mg (monitor for hyponatremia) Avoid TCAs like Amitriptyline/ Imipramine in elderly (due to anticholinergic side effects) Adolescents- Cap. Fluoxetine 20 -40 mg/day (observe for switch/ activation/ suicidality) 	<ul style="list-style-type: none"> Reconfirm Diagnosis Assess other psychiatric comorbidities Partial Responder - Optimise the SNRI/ TCA or Augment with Tab. Lithium 300 to 600mg/per day or Tab. Thyroxine 25 - 50 ug per day. Non Responder - Add Tab. Sertraline 100mg or Tab. Bupropion 300mg to existing Venlafaxine 150mg / Tab. Mirtazapine 30mg/ Amitriptyline 225mg/ Imipramine 225mg. Add on Electro Convulsive Therapy for Catatonia/ Suicidality Add on Cognitive Behavioural Therapy/ Inter Personal Therapy/ Problem Solving Therapy Add on low dose antipsychotic treatment (Risperidone 2 -4 mg/ Tab. Olanzapine 5 - 10 mg) for psychotic symptoms
REFERENCES		
<ul style="list-style-type: none"> Gautam S et al, Clinical Practice Guidelines for the management of Depression. Indian J Psychiatry. 2017;59(Suppl 1):S34-S50. Avasthi A, Grover S. Clinical practice guidelines for management of depression In elderly. Indian J Psychiatry 2018;60, Suppl S3:341-62 Sarkar S, Grover S. A systematic review and meta-analysis of trials of antidepressants in India for treatment of depression. Indian J Psychiatry. 2014;56:29-38 National Institute for Clinical Excellence. Depression: management of depression In primary and secondary care. Clinical Guideline 23. London: NICE, 2004. mhGAP Intervention Guide - Version 2.0 for mental, neurological and substance use disorders In non-specialized health settings. World Health Organisation, 2016 		
KEEP A HIGH THRESHOLD FOR INVASIVE PROCEDURES		
<p>This STW has 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 our web portal (stw.icmr.org.in) for more information.</p> <p>© Indian Council of Medical Research and Department of Health Research, Ministry of Health & Family Welfare, Government of India.</p>		

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	Mood (affective) disorders
i. At the time of Pre-authorization	
a. Clinical notes with detailed history and chronicity	Yes
b. Admission document signed by empaneled psychiatrist	Yes
ii. At the time of claim submission	
a. Detailed treatment notes	Yes
b. Are the following investigations done? 1. Complete hemogram 2. Thyroid function test 3. Serum sodium 4. Resting ECG	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 document	Mood (affective) disorders
I. Pre-auth processing Doctor (PPD)	
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
II. Claims processing Doctor (CPD)	
a. Are the detailed treatment notes submitted?	Yes
b. Are the following investigations done? 1. Complete hemogram	Yes

2. Thyroid function test 3. Serum sodium 4. Resting ECG	
c. 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:

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.