



## Guidance document for PM JAY packages

### Neurotic, stress-related and somatoform disorders

Procedures covered/ procedure count: 1

Specialty: Mental Disorders

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Neurotic, stress-related and somatoform disorders	Neurotic, stress-related and somatoform disorders	M800005, M800012	MM004A	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 **Anxiety disorder, Somatoform disorders** to be followed in country. For monitoring and administering the claim management process of **Neurotic, stress-related and somatoform 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.

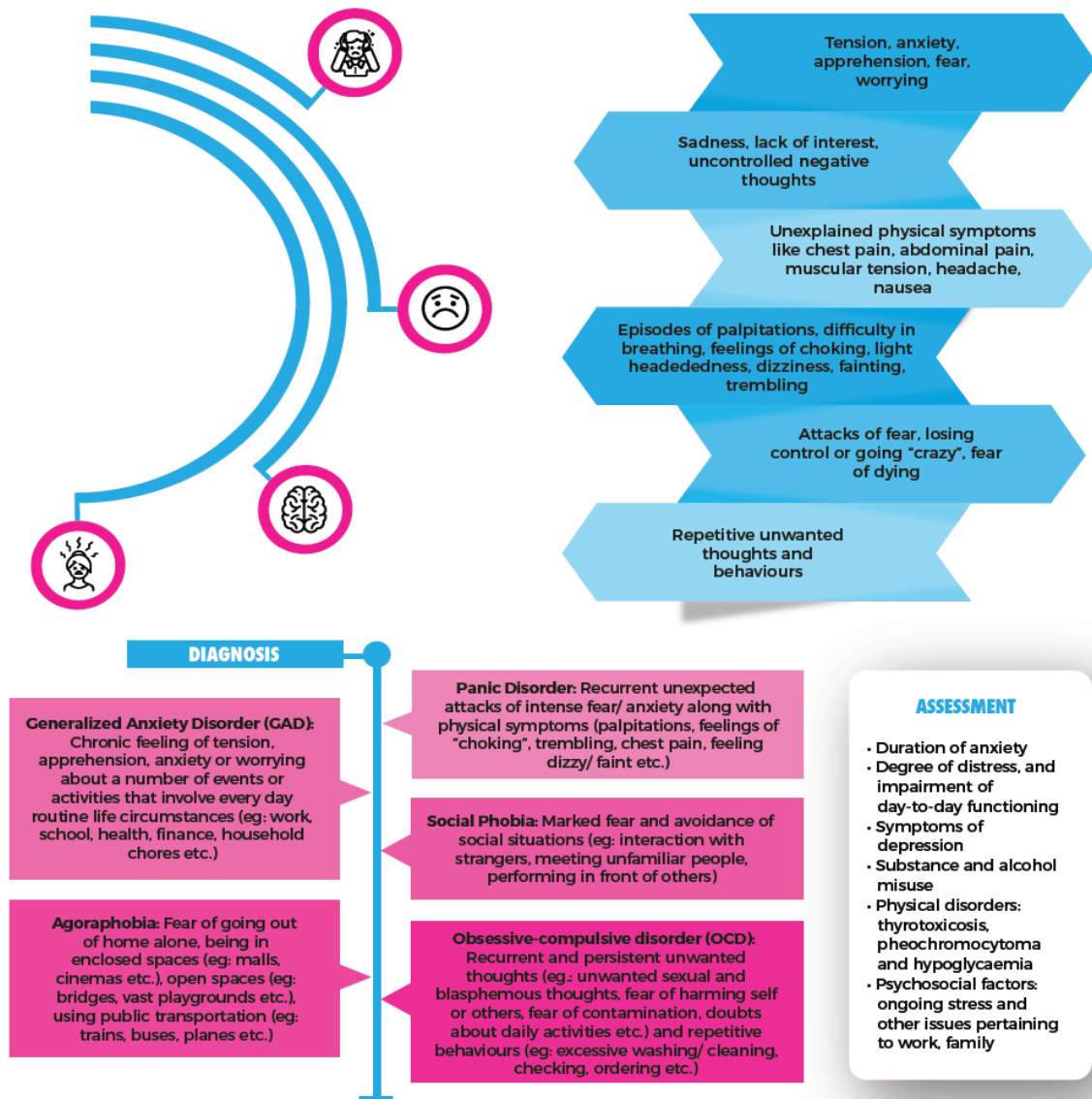
It will also serve as a tool for hospitals to determine and submit the mandatory documents required for claiming reimbursement of health benefit package under PMJAY.

## 1.2 Clinical key pointers:

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

October/2019

## Standard Treatment Workflow (STW) for the Management of ANXIETY DISORDERS ICD-10-F40-F42



## MANAGEMENT

### PRIMARY CARE LEVEL

#### Psychoeducation

- Reassurance
- Explain symptoms are of anxiety/ fear and mimic symptoms of physical illnesses (eg: heart attack)
- Do not investigate excessively. Few investigations like ECG, ECHO maybe necessary in some patients
- Discourage doctor shopping
- Do not avoid triggers of panic attacks (eg: physical exertion, agoraphobic situations) and fear (eg: travelling by public transport)
- Emphasize avoidance maintains fears and phobias
- OCD: Educate that the unwanted thoughts are a part of illness, and not a reflection of character or hidden intentions

#### Pharmacological treatment

- Mild illness: Spending time, reassurance, and psychoeducation. May not need any medications.
- No improvement (few weeks): Escitalopram 5mg/d at night, with increase to 10 mg/d in a week. No satisfactory improvement in 4-6 weeks, may increase to 20 mg/d. If there is no significant improvement in another 4-6 weeks, refer to a specialist.
- Severe and unbearable anxiety: Diazepam (5-10 mg) may be given at night. Do not continue for > 1 month. Taper and stop over 2 weeks. Long-term treatment with benzodiazepines to be avoided
- Escitalopram to be continued for at least 1-2 years after remission
- Side-effects (sexual dysfunction, sedation, weight gain): monitor and address periodically

### SECONDARY CARE LEVEL (DISTRICT HOSPITAL)

- Review diagnosis and treatment history if there is no improvement with a trial of Escitalopram
- Check whether the patient has taken medication at prescribed dose and on a regular basis
- Second SSRI (either of them for about 2-3 months):
  - Sertraline upto 200 mg/d,
  - Fluoxetine upto 60 mg/d,
  - Paroxetine upto 50 mg/d,
  - Fluvoxamine upto 300 mg/d
- No response to second SSRI: cognitive behaviour therapy (CBT) if trained therapists available
- Refer to tertiary centre if unsatisfactory response after second SSRI and/ or addition of CBT
- If referral to tertiary centre is not feasible, psychiatrists may try other strategies (other than Deep Brain Stimulation and surgery for OCD) mentioned under the "tertiary care" at the secondary level itself

### TERTIARY CENTRE (MEDICAL COLLEGE, REGIONAL MEDICAL CENTRE, PSYCHIATRIC HOSPITAL)

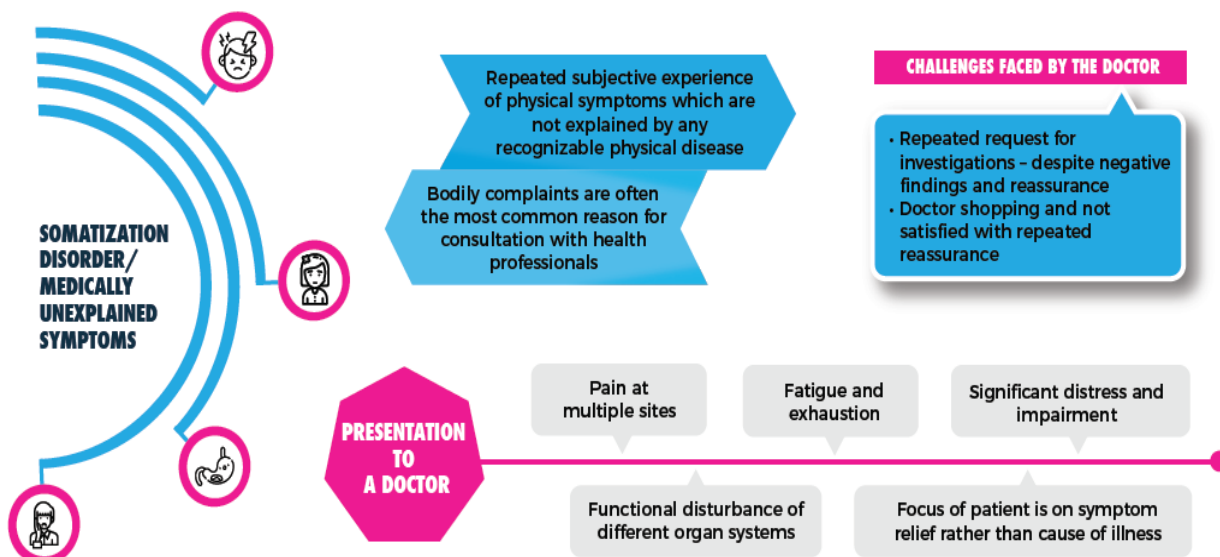
- Evaluate reasons for treatment resistance like
  - Wrong diagnosis
  - Inadequate drug treatment,
  - Poor adherence to treatment
  - Inadequate CBT
  - Presence of comorbid conditions such as personality disorders and organicity
- Panic disorder: evaluate any medical conditions that mimic panic disorder (hyperthyroidism, hyperparathyroidism, pheochromocytoma, vestibular diseases, seizures, arrhythmias, etc.)
- OCD: Trial of third SSRI or clomipramine
- Treatment resistant OCD: inpatient treatment for intensive therapist-assisted daily CBT and for rationalization of medication regimen
- Other anxiety disorders: Trial of non-SSRIs (eg: venlafaxine, duloxetine, pregabalin etc.) and tricyclic antidepressants
- If response to medications is poor or unsatisfactory:
  - CBT is the preferred mode of treatment alone or in combination with medications
  - Treat comorbid psychiatric disorders (eg: personality disorders)
  - Pharmacological augmenting strategies if antidepressants and CBT do not provide relief

## KEEP A HIGH THRESHOLD FOR INVASIVE PROCEDURES

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.lcmr.org.in](http://stw.lcmr.org.in)) for more information.

© Indian Council of Medical Research and Department of Health Research, Ministry of Health & Family Welfare, Government of India.

## Standard Treatment Workflow (STW) for the Management of SOMATOFORM DISORDERS (SD) ICD10-F45



DIAGNOSTIC CRITERIA	
INITIAL ASSESSMENT	PSYCHOSOCIAL ASSESSMENT
<ul style="list-style-type: none"> <li>Detailed clinical examination - to rule out any medical illnesses which might explain the symptoms</li> <li>Complete history of the onset of all symptoms, exacerbating and relieving factors</li> <li>Assessment for any other psychiatric illness such as depression or anxiety disorders</li> </ul>	<ul style="list-style-type: none"> <li>Encourage to talk about psychosocial stressors if any</li> <li>Individual factors - poor coping skills, anxiety, life events, health anxiety, medical illnesses</li> <li>Family related factors - Substance use in family, interpersonal relationship with family, financial status</li> <li>Environmental factors - support system, peer relationship, work environment</li> </ul>
DIAGNOSTIC CRITERIA	
<p>A. One or more somatic symptoms that are distressing or result in significant disruption of daily life.</p> <p>B. Excessive thoughts, feelings, or behaviours related to the somatic symptoms or associated health concerns as manifested by at least one of the following:</p> <ol style="list-style-type: none"> <li>Disproportionate and persistent thoughts about the seriousness of one's symptoms</li> <li>Persistently high level of anxiety about health or symptoms</li> <li>Excessive time and energy devoted to these symptoms or health concerns</li> </ol> <p>C. Although only one somatic symptom may not be continuously present, the state of being symptomatic is persistent (typically more than 6 months)</p> <p>A persistent course is characterized by severe symptoms, marked impairment, and long duration (more than 6 months)</p> <p>Severity:</p> <p>Mild - only one of the symptoms specified in criterion B is fulfilled</p> <p>Moderate - Two or more of the symptoms specified in criterion B is fulfilled</p> <p>Severe - Two or more of the symptoms specified in criterion B are fulfilled, plus there are multiple somatic symptoms (or one very severe somatic symptom)</p>	<p>Following list include the commonest symptoms</p> <ol style="list-style-type: none"> <li>Pain symptoms at multiple sites (such as abdominal, back, chest, dysmenorrhea, dysuria, extremity, head, joint, rectal) is often present</li> <li>Gastrointestinal sensations (pain, belching, regurgitation, vomiting, nausea)</li> <li>Abnormal skin sensations (itching, burning, tingling, numbness, soreness) and blotchiness</li> <li>Sexual and menstrual complaints (ejaculatory or erectile dysfunction, hyperemesis of pregnancy, irregular menses, menorrhagia, sexual indifference) are also common</li> </ol>

## MANAGEMENT

### PRIMARY CARE

- Detailed physical examination
- Management of anaemia and nutritional deficiencies
- Avoid irrational use of pain medications
- Low dose of antidepressant medications - Amitriptyline 12.5 mg to 50 mg (max) night dose
- Explain that onset of medication effect will take 2-3 weeks
- Validate the somatic symptoms
- Advise to engage in routine activities, physical exercise and relaxation techniques like deep breathing
- Discuss with family members that the symptom, distress and disability are genuine
- Strengthen supports
- Regular follow up

### REFER TO SECONDARY CARE IF

1. Difficulty in making diagnosis
2. No improvement after 4 weeks of treatment with first line medications
3. Comorbid medical illness
4. Suicidal risk
5. Comorbid psychiatric illness

### SECONDARY CARE

- Investigations - to rule out any medical illnesses that might explain the symptoms
- Complete history with behavioural observation
- Use 2nd line medications - SSRIs (Escitalopram 10-20 mg, Sertraline 50-100 mg, Fluoxetine 20 mg) and SNRIs (Venlafaxine 75 - 150 mg, Duloxetine 30- 60 mg)
- Combination of two psychotropic medications (might be required if poor response to single medication)
- Brief counselling
- Psycho education - focusing on relationship between stress and physical symptoms
- Relaxation training, regular exercise, yoga and meditation

### TERTIARY CARE

- Inpatient care if needed
- Combination of two psychotropic medications (when required)
- Add on second and third line medications - Duloxetine, Mirtazapine, anticonvulsants ( Lamotrigine, Pregabalin). Use of Gabapentin, Carbamazepine if chronic pain symptom predominates
- Structured Cognitive Behavioural Therapy, Cognitive restructuring, Mindfulness and acceptance based approach
- Use of alternative medicine approach - Yoga
- Collaborative approach - involve Physician, Neurology team and Pain Clinic referral (where indicated)
- Vocational rehabilitation if needed
- Physical therapies - guided exercise and physiotherapy

1. No improvement in 2nd line treatment
2. High suicidal risk
3. Needing intense counselling/ psychotherapy
4. Difficult patients

### REFER TO TERTIARY CARE IF

## REFERENCES

- Desai G & Chaturvedi SK. Medically Unexplained Somatic Symptoms & Chronic Pain - assessment & management. A primer for Healthcare professionals. 1st Edition 2017. Paras medical publisher, Hyderabad, India.
- World Health Organization. (2017). mhCAP training manuals for the mhCAP intervention guide for mental, neurological and substance use disorders in non-specialized health settings - version 2.0 for field testing. World Health Organization. <http://www.who.int/iris/handle/10665/259161>.
- Agarwal V, Srivastava C & Sitholey P. Clinical Practice Guidelines for the Management of Paediatric Somatoform disorders. Indian Psychiatric Society - Practice guidelines 2018.
- Guidance for health professionals on medically unexplained symptoms (MUS) - [https://www.rcpsych.ac.uk/pdf/CHECKED%20MUS%20Guidance\\_A4\\_4pp\\_6.pdf](https://www.rcpsych.ac.uk/pdf/CHECKED%20MUS%20Guidance_A4_4pp_6.pdf)
- Jacob KS. A simple protocol to manage patients with unexplained somatic symptoms in medical practice. Natl. Med. J. India. 2004; 17: 326-8

## KEEP A HIGH THRESHOLD FOR INVASIVE PROCEDURES

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.lcmr.org.in](http://stw.lcmr.org.in)) for more information.

© Indian Council of Medical Research and Department of Health Research, Ministry of Health & Family Welfare, Government of India.



### 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	Neurotic, stress-related and somatoform disorders
<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:**

Mandatory document	Neurotic, stress-related and somatoform disorders
<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 empaneled 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](http://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.