



## Guidance document for processing PM-JAY packages

### Autoimmune hemolytic anemia

**Procedures covered:** 1

**Specialty:** Pediatric Medical Management

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Immune hemolytic anemia	Immune hemolytic anemia	M200044	MP041A	Routine Ward - 1800 HDU - 2700 ICU (without Ventilator) - 3600 ICU (with Ventilator) - 4500

**ALOS:** 10 days (Once diagnosis is established the case can be booked in the relevant package, further stay/admission should be decided based on the level of complications of the disease)

**Minimum qualification of the treating doctor:**

**Essential:** MD / DNB / DCH/ equivalent (Pediatric Medicine), DM/DNB/ equivalent (Hematology)

**Special empanelment criteria/linkage to empanelment module:** None

#### 1.2 Disclaimer:

For monitoring and administering the claim management process of **Autoimmune hemolytic anemia**, 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.

### **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:

Autoimmune haemolytic anaemia (AIHA) in childhood is an uncommon condition caused by the presence of auto-antibodies directed against antigens on the surface of red blood cells, leading to premature destruction of the cells.

Proceed with Autoimmune hemolytic anemia only if diagnosis made is backed by clinical manifestation:

Autoimmune hemolytic anemias may occur in either of 2 general clinical patterns.

- The first, an acute transient type lasting 3-6 months and occurring predominantly in children ages 2-12 years, accounts for 70-80% of patients. It is frequently preceded by an infection, usually respiratory.

Onset may be:

- Acute
  - prostration
  - pallor
  - jaundice
  - fever
  - hemoglobinuria
- More gradual
  - Primarily fatigue and pallor
- The other clinical pattern involves a prolonged and chronic course, which is more frequent in infants and in children >12 years old. Hemolysis may continue for many months or years.

Associated factors:

- dark urine
- organomegaly
- weakness
- dizziness
- dyspnea
- Fast heart beat
- headache

## First level tests:

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WBC count, red cell morphology on peripheral smear

Reticulocyte count

Indices of haemolysis (haptoglobin, indirect bilirubin, LDH)

DAT and IAT

Blood group

Liver and kidney function

Urinanalysis

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WBC: white blood cell; LDH: lactate dehydrogenase; DAT: direct antiglobulin test; IAT: indirect antiglobulin test.

Whole blood count, together with reticulocyte count, haptoglobin, lactate dehydrogenase (LDH) and bilirubin are the parameters to define haemolytic anaemia.

## Treatment

- General Management
  - Pre-heated erythrocyte transfusion (37°C)
  - Transfusion at slow rate
  - Steroids
- Warm AIHA
  - Transfusion of packed red blood cells
  - Glucocorticosteroids
- Cold AIHA
  - Transfusion of packed red blood cells
  - Rituximab
  - Treating the underlying infections
- Severe refractory cases
  - Intravenous immunoglobulin (IVIG)
  - Danazol
  - Antimetabolite
  - Miracle mineral supplement (MMS)

### 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	Autoimmune hemolytic anemia
<b>i. At the time of Pre-authorization</b>	
Clinical notes showing vitals, examination findings, planned line of treatment & advice for admission	Yes
Direct Coomb's test (DCT)	Yes
Complete blood count (CBC), peripheral smear, urinalysis, reticulocyte, haptoglobin, total serum bilirubin	Yes
<b>Optional (based on clinical condition and availability)</b>	Yes

Indirect Coomb's test (ICT), Kidney function tests, Bone marrow aspiration, Chest X-ray, lactate dehydrogenase (LDH), viral serology	
<b>ii. At the time of claim submission</b>	
Detailed Indoor case papers (ICPs) with treatment details	Yes
DCT, CBC, peripheral smear	Yes
Detailed discharge summary	Yes

## **PART II: GUIDELINES FOR PROCESSING TEAM**

**2.1 Objective:** To provide guidance to the pre-authorisation 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 documents</b>	<b>Autoimmune hemolytic anemia</b>
<b>Pre-auth processing Doctor (PPD)</b>	
Clinical notes – detailed history, signs & symptoms, detailed treatment line	Yes
Direct Coomb's test (DCT) (antibodies for warm and cold antigen) = positive	Yes
All investigations reports: <ul style="list-style-type: none"> <li>- Complete blood count (CBC) = Severe anemia appropriate to the age, White blood count and platelet normal</li> <li>- Peripheral smear = macrocytosis, polychromasia, anisocytosis, presence of nucleated red cells and microspherocytes</li> <li>- Urinalysis = presence of Hb in urine</li> <li>- Indices of haemolysis - (reticulocyte count (high), haptoglobin (low/absent), indirect bilirubin (increased Sr. Bilirubin),</li> </ul>	Yes
<b>Optional (based on clinical condition and availability)</b> <ul style="list-style-type: none"> <li>- Indirect Coomb's test (ICT) = positive</li> <li>- Kidney function tests (urea, creatinine) (high in hemolysis, acute kidney injury)</li> </ul>	Yes

<ul style="list-style-type: none"> <li>- Bone marrow aspiration – myelofibrosis, malignancy</li> <li>- Chest X-ray - infections</li> <li>- lactate dehydrogenase (LDH – high)</li> <li>- Viral serology</li> </ul>	
<b>Claims Processing Doctor (CPD)</b>	
Detailed ICPs with detailed line of treatment	Yes
DCT – negative CBC, Peripheral smear - normal	Yes
Detailed Discharge summary with follow-up advise at the time of discharge	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:**

- Is Direct Coomb's test positive along with laboratory evidence of hemolysis? Yes

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

### **References**

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5. Robert M. Kliegman, MD. Nelson Textbook of Pediatrics, Twentieth edition. Pg 2357. Chapter 464. Hemolytic Anemias resulting from Extracellular Factors— Immune Hemolytic Anemias
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