Guidance document for processing PM-JAY packages

Pancreatic pseudocyst

Procedures covered: 4 **Specialty: General/Pediatric Surgery**

Package name	Procedure	HBP 1.0 code	HBP 2.0 code	Package price (INR)
CystoJejunostomy / Cystogastrostomy	CystoJejunostomy - Open	S100205	SG011A	20,000
	CystoJejunostomy - Lap.		SG011B	20,000
	Cystogastrostomy - Open		SG011C	20,000
CystoJejunostomy / Cystogastrostomy	Cystogastrostomy - Lap.	S100182	SG011D	20,000

ALOS: 5-7 Days

Minimum qualification of the treating doctor:
Essential: MS/DNB/Equivalent (General Surgery), MCh/DNB/Equivalent (Pediatric Surgery, Surgical Gastroenterology)

Special empanelment criteria/linkage to empanelment module: None

Disclaimer:
For monitoring and administering the claim management process of **CystoJejunostomy / Cystogastrostomy**, 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:

A pancreatic pseudocyst is a collection of amylase-rich fluid around the pancreas as a result of acute or chronic pancreatitis bound to the pancreas by inflammatory tissue. Fluid collection in the first 4 weeks is an acute fluid collection. After 4 weeks, it becomes an pseudocyst. Fluid is enclosed by a wall of fibrous granulation tissue and is called a pseudocyst. Pancreatic pseudocysts are the most common cystic lesions of the pancreas; accounting for 75-80% of such masses.

Etiology

1. Following an attack of acute pancreatitis, it usually appears after 4 weeks, as upper abdominal swelling
2. Blunt injury of abdomen causing a ductal disruption wherein the pancreatic duct in the region of body is crushed against vertebral body results in a pseudocyst
3. Some cases of chronic pancreatitis may be associated with pseudocyst

Common locations of pseudocyst

1. Between stomach and transverse colon
2. Between stomach and liver
3. Behind or below the transverse colon

D'EGIDIO classification of pseudocyst

- Type I: Acute postnecrotic pseudocyst that occurs after an episode of acute pancreatitis and is associated with normal duct anatomy and rarely communicate with pancreatic duct
- Type II: Post necrotic pseudocyst that occur after an episodic of acute on chronic pancreatitis and have a diseased but not strictured pancreatic duct and there is after---communication between the duct and pseudocyst
- Type III (also called retention cyst): occur in chronic pancreatitis, uniformly associated with a duct stricture and a communication between duct and pseudocyst

Presenting symptoms

- The most common presenting symptom is epigastric pain.
- Other symptoms include mass, nausea, vomiting, feeling of bloating or a deep ache in the abdomen
- Additional symptoms include jaundice, chest pain, anorexia, weight loss, ascites and rarely gastrointestinal hemorrhage.

Management

I. Conservative line of treatment

- Majority of the pseudocysts following acute pancreatitis resolve spontaneously within 3-4 weeks.
- Symptomatic management

II. Intervention

➢ **Drainage**

- Indications for drainage include enlargement of the cyst to more than 6 cm, setting in of complications, symptoms and concerns about possible malignancy
- The methods of intervention include percutaneous drainage (only in infected pseudocysts), endoscopic drainage and surgical drainage
- Transmural drainage may be cystogastrostomy or cystoduodenostomy

➢ **Surgery**

- Increase in size of cyst, severe pain, no response to conservative line of treatment are indications for surgery
- If a pseudocyst is persistent over 6 weeks or causing symptoms, then surgical treatment of the cyst is required
- Pancreatic pseudocysts with associated major ductal disruption or a transected pancreas require operative therapy with cyst enterostomy
- The type of surgical procedure depends on the location of the cyst. For cysts that occur in the body and tail of the pancreas either a cysto-jejunostomy or cystogastrostomy is performed depending on the location of the cyst in the abdomen

1. **Cystogastrostomy**

- Indications: Pseudocyst in relation to head and body of pancreas.
- Timing: Surgery is done after 6 weeks because that is the time required for the wall to become fibrous.
- Size of the cyst should be at least 6 cm.
- Procedure: Anterior gastrotomy is done and an incision in the posterior wall of stomach opens into the cyst cavity. The contents are drained, opening is enlarged and cut end of stomach in posterior wall is sutured to cut edge of cyst wall. After one week, the cyst collapses. For reasons not known, the food does not enter the cyst cavity. Size of cystogastrostomy stoma is about 6 cm.

2. **Distal pancreatectomy:** Cyst confined to the tail of the pancreas is treated with removal of the tail and the cyst.
3. **Cystojejunostomy:** By using Roux-en-Y loop can be done, for large cysts by suturing jejunal limb to the cyst in the most dependent area

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	**CystoJejunostomy / Cystogastrostomy**
i.At the time of Pre-authorization	
Clinical notes including evaluation findings, indication for procedure, and planned line of management	Yes
White blood cell count, serum amylase reports	Yes
USG/CECT/MRI Abdomen	Yes
Optional Endoscopic Retrograde Cholangiopancreatography (ERCP)	Yes
ii. At the time of claim submission	
Detailed Indoor case papers (ICPs) with treatment details	Yes
Detailed Procedure / operative notes	Yes
Post-operative photographs (optional)	Yes
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:**

2.2.1 **At the time of pre-authorization processing- For pre-authorization processing doctor (PPD)**:

a. Clinical notes - detailed history, signs & symptoms, planned line of treatment indication for procedure?

b. Did USG/CECT/MRI Abdomen confirm the diagnosis?

2.2.2 At the time of claim processing- For claims processing doctor (CPD):

a. Are the detailed ICPs with daily vitals and treatment details?

b. Are the detailed procedure / Operative Notes available?

c. Post-operative photographs submitted (optional)?

d. Was imaging indicative of surgery?

e. Is the Discharge summary with follow-up advice at the time of discharge?

PART III: GUIDELINES FOR IT

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 (PPD)**:

I. Was the radiographic imaging indicative of surgery? Yes

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

References:

1. Devendra K Gupta (Editor). Pediatric Surgery-Diagnosis and Management, First Edition 2008. Chapter 31: Esophageal Strictures; Pg:369
2. K Rajgopal Shenoy, Anitha Shenoy (Nileshwar). Manipal Manual of Surgery. Fourth Edition.
3. Gurusamy K, Pallari E, Hawkins N, Pereira SP, Davidson BR. Management strategies for pancreatic pseudocysts. Cochrane Database of Systematic Reviews 2016, Issue 4. Art. No.: CD011392. DOI: 10.1002/14651858.CD011392.pub2
4. Pan G, Wan MH, Xie KL, et al. Classification and Management of Pancreatic Pseudocysts. *Medicine (Baltimore)*. 2015;94(24):e960. doi:10.1097/MD.0000000000000960