



Guidance document for processing PM-JAY packages

Hypoglycemia

Procedures covered: 1

Specialty: General Medicine, Pediatric Medical Management

Package name	Procedure name	HBP 1.0 code	HBP 2.0 code	Package price (INR)
Hypoglycemia	Hypoglycemia	New Package	MG057A	General Ward- 1,800 HDU – 2,700 ICU without ventilator– 3,600 ICU with Ventilator– 4,500

ALOS (days): 1-3 Days

Minimum qualification of the treating doctor:

Essential: MBBS

Desirable: DNB / MD (General Medicine / Pediatric Medicine)

Special empanelment criteria/linkage to empanelment module: None

Disclaimer:

For monitoring and administering the claim management process of **Hypoglycemia**, 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:

Hypoglycemia is often defined by a plasma glucose concentration below 70 mg/dL; however, signs and symptoms may not occur until plasma glucose concentrations drop below 55 mg/dL.



The symptoms of Whipple's triad have been used to describe hypoglycemia since 1938. For Whipple's triad, the practitioner must first recognize symptoms of hypoglycemia, then obtain low blood glucose, and finally, demonstrate immediate relief of symptoms by the correction of the low blood glucose. Most cases of hypoglycemia occur in diabetic patients who are undergoing therapeutic intervention with meglitinides, sulfonylureas, or insulin. Drugs are the most common cause of hypoglycemia. Episode of true hypoglycemia in a non-diabetic patient is likely due to iatrogenic causes such as the surreptitious use of insulin. Other potential causes of hypoglycemia are critical illness, alcohol, cortisol deficiency, insulinoma or malnourishment.

Clinical Features

The clinical manifestations of hypoglycemia can be classified as either neuroglycopenic or neurogenic. Neuroglycopenic signs and symptoms are signs and symptoms that result from direct central nervous system (CNS) deprivation of glucose. These include behavioral changes, confusion, fatigue, seizure, coma, and potential death if not immediately corrected. Neurogenic signs and symptoms can either be adrenergic (tremor, palpitations, anxiety) or cholinergic (hunger, diaphoresis, paresthesias). Neurogenic symptoms and signs arise from sympathoadrenal involvement (either norepinephrine or acetylcholine release) in response to perceived hypoglycemia.

Diagnosis

There is no agreed-upon lab value that defines hypoglycemia. Hypoglycemia is said to be present when the patient has symptoms consistent with hypoglycemia in addition to a low serum glucose measurement (less than 70 mg/dL). As previously mentioned, documentation of Whipple's triad is a potential indicator of hypoglycemia, and any initial laboratory evaluation should confirm hypoglycemia. Other pertinent labs to consider include insulin, proinsulin, and C-peptide levels during any episode of suspected hypoglycemia. If C-peptide levels are low in the presence of high insulin levels, the patient has received exogenous insulin.

Management

Identification of a hypoglycemic patient is critical due to potential adverse effects including coma and/or death. Severe hypoglycemia can be treated with intravenous (IV) dextrose followed by infusion of glucose. For conscious patients able to take oral (PO) medications, readily absorbable carbohydrate sources (such as fruit juice) should be given. For patients unable to take oral agents, a 1-mg intramuscular (IM) injection of glucagon can be administered. Once the patient is more awake, a complex carbohydrate food source should be given to the patient to achieve sustained euglycemia.

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	Hypoglycemia
i. At the time of Pre-authorization	
a. Clinical Notes including evaluation findings, indications for the procedure, and planned line of treatment	Yes
b. Blood glucose level	Yes
ii. At the time of claim submission	
a. Detailed Indoor case papers with treatment details	Yes
b. Post treatment glucose level	Yes
c. Detailed Discharge Summary	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 the patient's blood glucose less than 70 mg/dL? Yes

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

References:

1. Mathew P, Thoppil D. Hypoglycemia. [Updated 2019 Dec 16]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2020 Jan-
2. Marks V, Teale JD. Drug-induced hypoglycemia. *Endocrinol. Metab. Clin. North Am.* 1999 Sep;28(3):555-77.