Republic of the Philippines
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PhilHealth Circular
No. 2013-215

TO : ALL ACCREDITED HEALTH CARE PROVIDERS,
PHILHEALTH MEMBERS, PHILHEALTH REGIONAL
OFFICES AND ALL OTHER CONCERNED

SUBJECT : Policy statements on the Diagnosis, Empiric Management, and
Prevention of Community-acquired Pneumonia (CAP) in
Immunocompetent Adults as reference by the Corporation in
ensuring quality of care

I. RATIONALE

The revised Implementing Rules and Regulations of the National Health Insurance Act of 2013
(RA 7875 as amended by RA 9241 and RA 10606) under Title V (Quality Assurance and
Accreditation) Rule 1 (Quality Assurance) Section 51 provides the implementation of quality
assurance standards as reference for ensuring quality of care services.

Compliance to clinical practice guidelines (CPGs) shall be one of the strategies in the
implementation of quality assurance standards. The CPG recommendations based on best
available evidence shall be translated into policy statements and shall be used primarily to
provide guidance to doctors, hospitals and patients as to what tests, medicines; and procedures
are strongly recommended if benefits clearly outweigh the harms. It shall be used by the
Corporation as one of its references in assessing the quality of care rendered by PhilHealth-
accredited health care providers to members through performance monitoring and other
activities when necessary. Moreover, this Circular shall focus on moderate-risk and high-risk
CAP which are being reimbursed by the Corporation.

Community acquired pneumonia (CAP) is considered as one of the top illnesses in claims
reimbursement. Moderate-risk and high-risk CAP require inpatient care because of the need for
intravenous treatment and close observation due to risk of developing complications. The
recommendations in this document incorporate updated information from the CAP Policy
Statements published by the Corporation in The HTA Forum 2006. Furthermore, these
evidence-based policy recommendations were approved by the PhilHealth Quality Assurance
Committee (QAC) as reference for ensuring quality of care.
A. DEFINITION
CAP is commonly defined as an acute infection of the pulmonary parenchyma with symptoms of acute illness accompanied by abnormal chest findings. Patients who acquire the infection in hospitals or long-term facilities are typically not part of the definition.

B. DIAGNOSIS
Clinical judgment is needed to make a diagnosis of community-acquired pneumonia (CAP). Patients usually present with:

1. A history of cough within the past 24 hours or less than 2 weeks;
2. Abnormal vital signs of tachypnea (respiratory rate >20 breaths per minute), tachycardia (cardiac rate >100 per minute) and fever (temperature >37.8 C); and
3. With at least 1 abnormal chest finding of diminished breath sounds, rhonchi, crackles, or wheeze.

C. INITIAL CHEST RADIOGRAPHY
1. Chest x-ray (standing posteroanterior and lateral views) should be done for all patients suspected of pneumonia.
2. Chest CT scan should not be done routinely in the evaluation of pneumonia.

D. HOSPITAL ADMISSION
1. Only moderate-risk and high-risk CAP should be admitted [Grade A recommendation]. Refer to Annex A for the clinical features of patients with moderate risk and high risk CAP.
2. Chest x-ray may be repeated for hospitalized patients suspected of pneumonia but have initial “normal” chest radiographic findings.

E. MICROBIOLOGIC STUDIES
For moderate-risk and high-risk CAP, blood cultures AND gram stain and culture with antibiotic sensitivity tests of respiratory specimens should be done prior to starting any antibiotic treatment. [Grade A recommendation]

F. TREATMENT
1. Among patients with moderate-risk and high-risk CAP, initial empiric antibiotic therapy based on initial risk stratification is recommended (refer to Annex B). [Grade B]
2. Routine use of mucolytics is NOT recommended in treatment of troublesome cough associated with pneumonia.

G. MONITORING RESPONSE TO INITIAL THERAPY
1. Patients with CAP should be monitored within 72 hours after initial therapy for clinical response based on improvement of temperature, respiratory rate, blood pressure, sensorium, oxygen saturation, and inspired oxygen concentration.
2. If there is no improvement after 72 hours of treatment, patient should be reassessed for possible resistance to the antibiotics or “for presence of other pathogens such as M. tuberculosis, viruses, parasites or fungi.” [Grade B recommendation]
3. Measurement of arterial oxygenation is important in the initial evaluation of patients with CAP. The use of pulse oximetry may complement rather than replaces clinical severity scoring tools.
4. A follow-up chest x-ray is recommended only for patients who are not clinically improving. [Grade B recommendation]
5. Follow-up cultures of blood and sputum are not indicated for patients who are responding to treatment. [Grade A recommendation]
H. STREAMLINING EMPIRIC ANTIBIOTIC THERAPY

Patients started on parenteral antibiotics can be switched to oral therapy (refer to Annex C) once the patient is clinically improving, is hemodynamically stable and has a functioning gastrointestinal tract. [Grade B recommendation]

I. HOSPITAL DISCHARGE

Patients diagnosed with moderate-risk and high-risk CAP can be discharged based on the following criteria:
1. Absence of unstable co-existing illness or other life-threatening complication;
2. Stable vital signs; and
3. Ability to maintain oral intake
[Grade A recommendation]

J. LENGTH OF STAY

1. Patients with moderate-risk and high-risk CAP should be confined for a minimum of 4 days to provide sufficient time for proper evaluation of patient's response to therapy. Moreover, IV antibiotics should be administered for at least 3 days.
2. Hospital stay can be extended for longer period in high-risk CAP patients due to clinical instability of the condition.

K. PREVENTION

The following are recommended for the prevention of CAP:
1. Pneumococcal and influenza vaccinations
2. Smoking cessation
[Grade A recommendation]

II. Monitoring and Evaluation

The health care provider shall be bound by the provisions of the performance commitment and subject to the rules on monitoring and evaluation of performance as provided for in PhilHealth Circular No. 54 s. 2012 re: Provider Engagement through Accreditation and Contracting for Health Services (PEACHeS) and PhilHealth Circular No. 031-2014 re: Health Care Provider Performance Assessment System (HC-PAS).

III. Repealing Clause

All provisions of previous issuances, circulars and directives that are inconsistent with any of the provisions of this Circular for this particular circumstance wherein the same is exclusively applicable, are hereby amended, modified and repealed accordingly.
IV. Separability Clause

In the event that a part or provision of this Circular is declared unauthorized or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

V. Effectivity

This Circular shall take effect for all admissions starting September 15, 2015. It shall be published in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

Signature:

ALEXANDER A. PADILLA
President and CEO
Date Signed: 8/25/15

Title:
PhilHealth Circular on Policy Statements on the Diagnosis, Empiric Management, and Prevention of Community-Acquired Pneumonia (CAP) in Immunocompetent Adults as Reference by the Corporation in Ensuring Quality of Care
Annex A. Clinical Features of patients with CAP according to risk categories (adapted from CAP Guidelines 2010)

<table>
<thead>
<tr>
<th>Moderate-risk CAP</th>
<th>High-risk CAP</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any of the following:</td>
<td>Any of the criteria under moderate risk CAP category</td>
</tr>
<tr>
<td>Unstable vital signs</td>
<td>Plus</td>
</tr>
<tr>
<td>• RR ≥30 breaths/min</td>
<td>Severe sepsis and septic shock</td>
</tr>
<tr>
<td>• PR ≥125 beats/min</td>
<td>Need for mechanical ventilation</td>
</tr>
<tr>
<td>• Temp ≥40°C or ≤36°C</td>
<td></td>
</tr>
<tr>
<td>• SBP &lt;90 mmHg</td>
<td></td>
</tr>
<tr>
<td>• DBP ≤60 mmHg</td>
<td></td>
</tr>
<tr>
<td>Altered mental state of acute onset</td>
<td></td>
</tr>
<tr>
<td>Suspected aspiration</td>
<td></td>
</tr>
<tr>
<td>Decompensated co-morbid condition</td>
<td></td>
</tr>
<tr>
<td>Chest X-ray:</td>
<td></td>
</tr>
<tr>
<td>- multilobar infiltrates</td>
<td></td>
</tr>
<tr>
<td>- pleural effusion or abscess</td>
<td></td>
</tr>
<tr>
<td>These patients need to be hospitalized for</td>
<td>These patients warrant admission in the intensive care unit. [Grade A]</td>
</tr>
<tr>
<td>closer monitoring and/or parenteral</td>
<td></td>
</tr>
<tr>
<td>therapy. [Grade A]</td>
<td></td>
</tr>
</tbody>
</table>
## Annex B. Usual Recommended Dosages of Formulary Antibiotics in 50-60 kg adults with normal liver and renal functions

<table>
<thead>
<tr>
<th>Risk Category</th>
<th>Empiric Therapy</th>
<th>Antibiotic/Dosage</th>
</tr>
</thead>
</table>
| Moderate Risk CAP | IV non-antipseudomonal B-lactam | Amoxicillin + Clavulanic acid 1.2 gm q8h  
Cefotaxime 1-2 gm q8h  
Ceftriaxone 1-2 gm q24h  
Ertapenem 1 gm q24h |
| PLUS | Azithromycin dehydrate PO/IV 500 mg q24h  
Clarithromycin PO/IV 500 mg q12h  
Erythromycin PO/IV 0.5 - 1 gm q6h |
| OR | Levofloxacin PO/IV 500-750 mg q24h  
Moxifloxacin PO/IV 400 mg q24h |
| High Risk CAP (all antibiotics are given intravenously) | No risk for Pseudomonas aeruginosa: | Amoxicillin + Clavulanic acid 1.2 gm q6-8h  
Cefotaxime 1-2 gm q8h  
Ceftriaxone 1-2 gm q24h  
Ertapenem 1 gm q24h |
| PLUS | Azithromycin dihydrate PO/IV 500 mg q24h  
Clarithromycin PO/IV 500 mg q12h  
Erythromycin PO/IV 0.5 - 1 gm q6h |
| OR | Levofloxacin PO/IV 500-750 mg q24h |
| With risk for Pseudomonas aeruginosa: | IV antipseudomonal B-lactam | Cefepime 2 gm q8-12h |
| PLUS | Azithromycin dihydrate 500 mg q24h  
Clarithromycin 500 mg q12h |
| PLUS | Gentamicin 3 mg/kg q24h  
Netilmicin 7 mg/kg q24h  
Amikacin 15 mg/kg q24h |
| OR | Ciprofloxacin 400 mg q12h  
Levofloxacin 750 mg q24h |
| IV anti-pseudomonal fluoroquinolones (high dose) | | |
| Others | Oxacillin (Staphylococcus) 1-2 gm q4-6h  
Clindamycin (Staphylococcus and anerobes) 600 mg q6-8h  
Metronidazole (anaerobes) 50 mg q6-8h  
Vancomycin (MRSA) 1 gm q12h |
 Annex C. Antibiotics dosage agents for streamlining or switch therapy*

<table>
<thead>
<tr>
<th>Antibiotic</th>
<th>Dosage</th>
<th>Antibiotic</th>
<th>Dosage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amoxicillin + clavulanic</td>
<td>625 mg TID or 1 gm BID</td>
<td>Cefuroxime axetil</td>
<td>500 mg BID</td>
</tr>
<tr>
<td>acid</td>
<td>500 mg OD</td>
<td>Cefdinir</td>
<td>300 mg BID</td>
</tr>
<tr>
<td>Azithromycin dihydrate</td>
<td>500 mg BID</td>
<td>Cefixime</td>
<td>200 mg BID</td>
</tr>
<tr>
<td>Clarithromycin</td>
<td></td>
<td>Levofloxacin</td>
<td>200 mg BID</td>
</tr>
</tbody>
</table>

*for adults weighing 50 to 60 kg with normal liver and renal function