Republic of the Philippines
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PhilHealth Circular
No. 2016 - 002

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

SUBJECT : **Policy statements on the Diagnosis and Management of Urinary Tract Infection in 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.

Urinary Tract Infection (UTI) is considered as one of the top illnesses in claims reimbursement. Certain cases of UTI are admissible when patient is unable to accept oral medication; condition requires need for intravenous treatment and close observation due to risk of developing complications. This document provides updates of the UTI in Adults 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.

II. SPECIFIC POLICY RECOMMENDATIONS

The Corporation shall adopt as standards the following statements in managing urinary tract infection in adults which shall serve as guide to health care practitioners. However, specific

provisions may be explicitly stated to affect reimbursement i.e., denial of claims for less than 4 days confinement.

A. DEFINITION

Urinary tract infection (UTI) is an infection that affects any part of the urinary tract. If the infection affects the lower urinary tract it is known as simple cystitis (a bladder infection) while if it affects the upper urinary tract it is known as pyelonephritis (kidney infection).

B. CLINICAL DIAGNOSIS

To make a clinical diagnosis of urinary tract infection (UTI), one or more of the following should be sought in the patient's history:

- acute onset of dysuria
- frequency
- urgency
- hematuria
- lower abdominal pain
- flank pain
- nocturia
- fever with/without chills
- flank pain
- costovertebral angle tenderness
- absence of vaginal discharge and/or irritation in the presence of the above clinical signs and symptoms

C. DIAGNOSTIC TESTS

1. Routine urinalysis is not needed to confirm the diagnosis of UTI presenting with one or more of the above symptoms of UTI in the absence of vaginal discharge.

2. Urinalysis or urine gram stain may be requested for the following conditions: acute uncomplicated pyelonephritis, acute pyelonephritis in pregnancy, acute uncomplicated cystitis in women with gynaecological (vaginal) signs and symptoms, and uncomplicated cystitis in men.

3. Urine culture and sensitivity may be requested for patients with worsening signs and symptoms, for screening asymptomatic bacteriuria among pregnant women, for acute uncomplicated pyelonephritis, acute pyelonephritis in pregnancy and suspected complicated UTI.

4. Following up urine culture is not necessary for patients clinically responding to therapy.

5. Renal ultrasound and plain abdominal X-ray should be done only in the presence of gross hematuria during UTI episode, obstructive symptoms, clinical impression of persistent infection, infection with urea-splitting bacteria, history of pyelonephritis, history of or symptoms suggestive of urolithiasis, history of childhood UTI and elevated serum creatinine.

6. Blood cultures are NOT routinely recommended except in patient with signs of sepsis.

D. HOSPITAL ADMISSION AND LENGTH OF STAY

1. The following are the indications for admission:

- In acute uncomplicated pyelonephritis in women who are unable to accept oral hydration or take oral medications
- In acute pyelenephritis in pregnant women;
- In complicated UTI;
- In urinary candidiasis patients who are under critical care, neutropenic, post-renal transplant, or about to undergo neurological procedures;
- Severe illness with high fever, severe pain, marked debility, and signs of sepsis

2. The recommended length of stay (LOS) for uncomplicated UTI should be minimum of 96 hours (72 hours of IV antibiotics and 24 hours switch to oral) to provide sufficient time for proper evaluation of patient's response to therapy. Otherwise, the claim shall be denied.

E. TREATMENT

1. The aminopenicillins (ampicillin or amoxicillin) and first generation cephalosporins are NOT recommended because of the high prevalence of resistance and increased recurrence rates in patients given these beta-lactams.

2. The TMP-SMX is NOT recommended for empiric treatment but it can be used when the organism is found to be susceptible on urine culture and sensitivity.

3. For patients with acute uncomplicated pyelonephritis requiring hospitalization, ceftriaxone, fluoroquinolones, or aminoglycosides are recommended as empiric first-line treatment (see annex A).

4. Intravenous antibiotics can be shifted to any of the listed oral antibiotics once the patient is afebrile and can tolerate oral drugs. The choice of continued antibiotic therapy should be guided by the urine culture and sensitivity results once available.

5. Carbapenems and piperacillin-tazobactam should be reserved for acute pyelonephritis caused by multi-drug resistant organisms that are susceptible to either drug.

6. Nitrofurantoin macrocrystal (100 mg BID for five days) is recommended as the first line treatment for acute uncomplicated cystitis due to its high efficacy, minimal resistance and minimal adverse effects (see annex B).

F. RECURRENT UTI

1. Recurrent UTI is defined as 2 or more episodes of uncomplicated UTI in 6 months or more traditionally, as three or more 3 positive cultures within the preceding 12 months.

2. Urinalysis and midstream urine culture and sensitivity should be performed with the first presentation of symptoms in order to establish a correct diagnosis of recurrent UTI.

3. Prophylaxis for recurrent UTI should NOT be undertaken until a negative culture of 1 to 2 weeks after treatment has confirmed eradication of the urinary tract infection.

4. Start antibiotic therapy with a 3-day treatment dose antibiotic at the onset of symptoms for the treatment of recurrent uncomplicated UTI.

III. MONITORING AND EVALUATION

The diagnostic tests and therapeutic interventions mentioned in this document shall be expected to be performed in health care facilities with service capability as reflected in their licensed by the Bureau of Health Facilities and Services (BHFS) of the Department of Health (DOH). While HCIs without such service capability, they shall not be required to be performed. However, health outcomes of patients shall be monitored by the Corporation using the following monitoring tools but not limited to: facility visits, domiciliary investigations, chart review, and others as appropriate.

Furthermore, 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 in PhilHealth Circular No. 31 s-2014 (HC P-PAS).

This Circular shall be reviewed periodically and as necessary.

IV. 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 particularly applicable, are hereby amended, modified or repealed accordingly.

V. EFFECTIVITY

This Circular shall take effect fifteen days after publication in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

ALEXANDER A. PADILLA
President and CEO
Date signed: 11 - 01/12/16

MASTER DOCUMENT
DC: Date:

Annex A. Empiric Treatment Regimens for Uncomplicated Acute Pyelonephritis (Adapted from PSMID 2013 Update)

ANTIBIOTICS		DOSE, FREQUENCY, DURATION
Oral		
Primary	Ciprofloxacin	500 mg BID for 7-10 days
	Ciprofloxacin extended release	1000 mg OD for 7 days
	Levofloxacin	250 mg OD for 7-10 days
		750 mg OD for 5 days
	Ofloxacin	400 mg BID for 14 days
Alternative	Cefixime	400 mg OD for 14 days
	Cefuroxime	500 mg BID for 14 days
	Co-amoxiclav (when GS shows gram+ organisms)	625 mg TID for 14 days
Parenteral		
Primary	Ceftriaxone	1-2 gm q24h
	Ciprofloxacin	200-400 mg q12h
	Levofloxacin	250-750 mg q24h
	Ofloxacin	200-400 mg q12h
	Amikacin	15 mg/kg BW q24h
Alternative	Ampicillin-sulbactam (when GS shows gram+ organisms)	1.5 grams q6h
Reserved for MDROs	Ertapenem (if ESBL prevalence >10%)	1 gram q24h
	Piperacillin-Tazobactam	2.25-4.5 grams q6-8h

Annex B. Antibiotics that can be used for Acute Uncomplicated Cystitis (Adapted with modification from PSMID 2013 Update)

ANTIBIOTICS		DOSE, FREQUENCY, DURATION
Oral		
Primary	Nitrofurantoin macrocrystals	100 mg QID for 5 days PO
Alternative	Ofloxacin	200 mg BID for 3 days PO
	Cirofloxacin	250 mg BID for 3 days PO
	Cirofloxacin extended release	500 mg OD for 3 days PO
	Levofloxacin	250 mg OD for 3 days PO
	Norfloxacin	400 mg BID for 3 days PO
	Co-amoxiclav	625 mg BID for 7 days PO
	Cefuroxime	250 mg BID for 7 days PO
	Cefixime	200 mg BID for 7 days PO
Only if with proven susceptibility	Trimethoprim-sulfamethoxazole (TMP-SMX)	160/800 mg BID for 3 days PO