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UNIVERSAL HEALTH CARE
KALUSUGAN AT KALINGA PARA SA LAHAT

PHILHEALTH CIRCULAR
No. 2022 - 0028

TO : **ALL ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH MEMBERS, PHILHEALTH OFFICES (HEAD OFFICE AND REGIONAL OFFICES) AND ALL OTHERS CONCERNED**

SUBJECT : **Quality Policy on the Diagnosis and Management of COVID-19 (In-Patient) in Adult as Reference of the Corporation**

I. RATIONALE

Republic Act no. 11223 otherwise known as the Universal Health Care Act, provides that the Corporation shall support the implementation of standards for clinical care set forth by the Department of Health (DOH) based on approved clinical practice guidelines. Further, Section 51 of the revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA7875 as amended by RA9241 and RA10606) provides the implementation of quality assurance standards as reference for ensuring quality of health care services.

When the WHO declared coronavirus disease 2019 (COVID-19) a global pandemic on March 2020, providing quality and safe care to patients proved to be challenging in many health care systems including the Philippines. The diagnosis and treatment recommendations were based on early scientific evidence that is rapidly evolving. Despite it, there is a need to come-up with recommendations based on best available evidence that need to be carefully balanced with clinical judgement.

The released interim guidelines by the World Health Organization (WHO) and the Philippine Society of Microbiology and Infectious Diseases (PSMID) were used as references in the development of policy statements. Further, consultative activities with the Philippine College of Physicians (PCP) and PSMID were conducted during the development stages. Furthermore, the PhilHealth Quality Assurance Committee (QAC) has approved it as reference in ensuring quality of care, educational resource, performance monitoring, among others.

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II. OBJECTIVES

This PhilHealth Circular aims to:

A. Describe the expected clinical manifestation of a patient suspected to have COVID-19, in relation to the benefit package being claimed.

B. Define the presence of risk and/ or co-morbidities of the patient to indicate hospital admissibility, which is essential in claims for mild pneumonia.

III. SCOPE

A. This PhilHealth Circular shall serve as reference for all accredited health care providers

(HCPs) and PhilHealth Regional Offices (PROs) pertaining to the diagnosis and management of Corona Virus Disease 2019 (COVID-19) in ensuring quality of care relative to claims.

B. This policy shall be applicable for adult patients who are hospitalized for respiratory illness due to SARS CoV-2.

IV. DEFINITION OF TERMS

A. Coronavirus – a large family of viruses causing a range of illness in people from the common colds to more infection that is serious and a variety of disease in farm animals and domesticated pets.

B. Reverse Transcriptase-Polymerase Chain Reaction. (RT-PCR) – is a method that is considered by the World Health Organization (WHO) as the standard method in detection or diagnosis of SARS CoV-2.

C. Pneumonia - an acute infection of the pulmonary parenchyma with symptoms of acute illness accompanied by abnormal chest findings. Pneumonia, based on clinical signs and symptoms may be classified as mild, moderate, or severe.

V. POLICY STATEMENTS

A. Clinical Presentation

1. The common clinical presentation of COVID-19 infection is related to respiratory problems, which may range from a mild condition to severe/critical. A patient with history of exposure either by travel or residence or contact may present with any but not limited to the following conditions:

   a. Flu-like symptoms such as dry cough, rhinorrhea (nasal congestion), sore throat, dyspnea, body malaise, fatigue (muscle soreness), and with/out fever.

   b. Other clinical presentation of COVID-19 infection, based on some studies, includes the following:

      b.1. Anosmia (loss of smell) and/or dysgeusia (loss of taste) precede respiratory symptoms
      b.2. Shortness of breath
      b.3. Headache
      b.4. Rhinorrhea (nasal congestion)
      b.5. Myalgia
      b.6. Diarrhea
      b.7. Nausea and vomiting

2. High-risk adults and/or having underlying health conditions are known to have co-morbidity(-ies) increases the risk for poor outcome, which may include, but are not limited, to the following:

   a. Cardiac (hypertension, coronary artery disease)
   b. Diabetes
   c. Structural lung disease (COPD, bronchiectasis)
   d. Immunocompromised (HIV or AIDS, on chronic steroids, malignancy)
   e. Age 60 years old and above

f. Pregnancy
g. Autoimmune disorder
h. Kidney disease
i. With major surgical conditions

B. Confirmatory Test for COVID-19

1. The currently recommended test to confirm COVID-19 infection (ON-GOING infection) is Real Time–reverse transcription Polymerase Chain Reaction (RT-PCR) assay, which detect the viral RNA.

2. Repeat testing for patients with an initial negative COVID-19 test result should be performed ONLY if there is a high index of suspicion for COVID-19 infection despite an initial negative test result.

3. If two RT-PCR tests yield negative results and patient may have symptoms for at least 15 days that are highly suggestive of COVID-19, an antibody test may be performed as a confirmatory test.

4. For RT-PCR test to be valid should be taken within 2 weeks (14 days) from the onset of known symptoms related to SARS-CoV2 infection.

C. Chest Imaging

The diagnosis of respiratory illness due to COVID-19 can be made on clinical grounds but the following chest imaging modalities may assist in the diagnosis and identification or exclusion of pulmonary complications:

1. Chest x-ray is recommended as first-line imaging modality in patient suspected to have COVID-19 presenting with respiratory symptoms.

2. Chest x-ray may appear normal initially, especially in mild cases. The common finding in chest radiograph is the presence of infiltrates, which is usually bilateral than unilateral. Other descriptive findings include hazy opacities, often rounded in morphology, with peripheral and lower lung distribution, consolidation and pleural effusion.

3. Chest CT scan can detect early pneumonia before symptom onset and show ground glass opacities in the lungs typically bilateral, but may be unilateral. Other findings include peripheral distribution of fine reticular opacities and vascular thickenings.

4. Lung ultrasound is not recommended to be used alone in diagnosing patients with suspected COVID-19 infection.

D. Other Diagnostic Tests

The recommended diagnostic tests are, but not limited to the following when COVID-19 is suspected/probable/confirmed to guide management, depending on the patient's presentation and/or service capability of the health facility: (refer to PSMID Guideline, Summary of Diagnostic Tests for additional/detailed information on guidance of use).

1. Complete blood count (CBC)
2. Blood tests for creatinine
3. Liver Function Tests (LFTs)

4. Serum electrolytes – sodium, potassium, magnesium, calcium
5. Albumin
6. Inflammatory markers such as lactate dehydrogenase (LDH), Ferritin, C-reactive protein (CRP), procalcitonin
7. Prothrombin and D-Dimer
8. Arterial blood gas (ABG) measurement
9. Blood cultures, if concomitant bacterial infection is suspected
10. Respiratory tract specimen for influenza testing
11. Sputum, endotracheal aspirate (ETA) or bronchoalveolar lavage fluid culture and sensitivity
12. Electrocardiogram (ECG)

E. Severity Levels of Respiratory Illness due to SARS CoV-2

1. Mild COVID-19 case

   a. A mild COVID-19 case is characterized with non-specific signs and symptoms:

      a.1 Fever, cough, fatigue, anorexia, myalgias
      a.2 Sore throat, nasal congestion, headache, diarrhea, nausea and vomiting
      a.3. Loss of smell (anosmia) or loss of taste (ageusia) preceding the onset of respiratory symptoms

   b. In a mild case there is NO pneumonia or signs of hypoxia.

2. Moderate COVID-19 case

   a. Without pneumonia

      a.1. with risk factors for progression elderly (60 years old and above)
      a.2. and/ or with comorbidities

   b. With pneumonia characterized by the following:

      b.1. No difficulty of breathing or shortness of breath
      b.2. Respiratory rate less than 30 bpm
      b.3. SpO2 ≥ 94% at room air

3. Severe COVID-19 case

   a. Severe pneumonia is characterized by the following:

      a.1. Respiratory rate ≥30 breaths/minute
      a.2. Signs of respiratory distress
      a.3. SpO2 <94% at room air

   b. Requires supplemental oxygen therapy with regular assessment for need of intubation and mechanical ventilation.

   c. Patients are closely monitored for signs of clinical deterioration, such as rapidly

progressive respiratory failure and sepsis, and supportive care interventions are applied immediately.

4. Critical COVID-19 case

   a. Critical pneumonia is a severe form associated with any of the following conditions:

      a.1. Acute respiratory distress syndrome (ARDS)
      a.2. Sepsis or septic shock
      a.3. Requiring ventilatory support
      a.4. Deteriorating sensorium
      a.5. Multi-organ failure
      a.6. Thrombosis

   b. Severely hypoxemic patients should be monitored closely in an ICU setting/set-up for clinical deterioration and progression to ARDS and need for invasive mechanical ventilation is considered.

   c. For patients who refuse intubation or with advance directives should be properly documented in the patient chart by the attending physician or any authorized physician.

F. Management

1. Supportive therapy and monitoring for COVID-19 patients with pneumonia:

   a. There is currently no medicine approved to specifically treat human coronaviruses. The core management recommendations remain to be supportive care and intensive respiratory management.

   b. Supplemental oxygen therapy immediately given to patients with severe pneumonia and/or respiratory distress, hypoxemia, or shock.

   c. Regular assessment of blood oxygenation to determine the need for intubation and mechanical ventilation.

2. Antibiotics may be given only if there is clinical suspicion of a bacterial co-infection.

3. Routine use of anti-influenza is NOT recommended for suspected or confirmed mild COVID-19 disease.

4. There is moderate quality of evidence to recommend the use of corticosteroid therapy (dexamethasone) as adjunctive treatment for COVID-19 patients requiring oxygen support. Inhaled steroids are NOT recommended for the treatment of COVID-19. Oral, inhaled or IV steroids are NOT recommended for prophylaxis or prevention of COVID-19.

5. There is insufficient evidence to support the use of intravenous immunoglobulin (IV Ig) for the management of COVID-19 among moderate/severe hospitalized patients EXCEPT in the context of a clinical trial.

6. There is insufficient evidence to support the routine use of interferon (IFN) for patients hospitalized with COVID-19 EXCEPT in the context of a clinical trial or for compassionate use.

7. Anticoagulation may be used in the treatment of hospitalized patients with moderate, severe, or critical COVID-19 unless there are any contraindications.

8. The recommendations on the use of investigational drugs are mainly based on research outcomes and safety data. It should be discussed with the patient or a legally authorized representative carefully outlining the potential adverse reactions and the potential clinical benefits of these investigational drugs. A signed informed consent should be obtained by the clinician. For reimbursement, investigational drugs shall be subjected to current applicable benefit policy.

G. Hospital Discharge

1. A repeat negative RT-PCR test is no longer needed for discharge of immunocompetent patients with suspect, probable or confirmed COVID-19 regardless of severity.

2. Patients who have clinically recovered (with resolution of symptoms) may be discharged from the hospital at the discretion of the healthcare team.

H. Monitoring and Evaluation

1. 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. 2018-0019 Health Care Provider Performance Assessment System (HCP-PAS) rev.2.

2. Standards of care issued by authorized agencies/organizations shall be regularly monitored. As deemed necessary, a revision of the policy statements shall be made. Any updates, as a result of the review, shall be disseminated in another PhilHealth Circular.

MASTER COPY DC: mgs Date: 12/14/22

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of R.A. No. 10606, R.A. No. 11223 otherwise known as the Universal Health Care Act and R.A. No. 7875 as amended by R.A. Nos. 9241 and 10606 their respective Implementing Rules and Regulations.

VII. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days after publication in the Official Gazette or in any newspaper of general circulation. A copy shall thereafter be deposited to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
Acting President and Chief Executive Officer

Date signed: 12/14/22