

PHILHEALTH CIRCULAR

No. 2024-0030

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

SUBJECT : Quality Standards on the Diagnosis and Management of Acute Stroke as Reference of the Corporation

I. RATIONALE

The Universal Health Care Act (Republic Act No. 11223) ensures that quality of services and financial protection are provided to all Filipinos. The use of evidence – based clinical practice guidelines (CPG) in ensuring safety and quality of care supports the implementation of clinical standards set by the Department of Health (DOH) in cooperation with professional societies and the academe. For PhilHealth, compliance to CPGs shall be one of the strategies in the implementation of quality assurance to all PhilHealth-accredited health care providers.

Stroke infarction (hemorrhagic/non-hemorrhagic) is considered as one of the top illnesses in claims reimbursement.¹

This PhilHealth Circular incorporates the updated 2024 recommendations in the clinical practice guidelines entitled “Clinical Practice Guidelines on the Management of Acute Ischemic Stroke and Intracerebral Hemorrhage in the Philippines 2024” by the Stroke Society of the Philippines (SSP). Further, value judgment/expert opinion through consultative meetings with the Philippine Neurology Association (PNA) and SSP were incorporated in this policy. Furthermore, patient perspective through the assistance of the Philippine Alliance of Patient Organization (PAPO) was considered.

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¹ http://www.philhealth.gov.ph/about_us/statncharts/SNC_2023_202403306.pdf

II. OBJECTIVES

This PhilHealth Circular establishes the standards of care in the diagnosis and management of acute stroke in line with the quality assurance program of the Corporation.

III. SCOPE

This PhilHealth Circular covers the adult patients with established clinical diagnosis and management of acute stroke (ischemic or hemorrhagic).

IV. DEFINITION OF TERMS

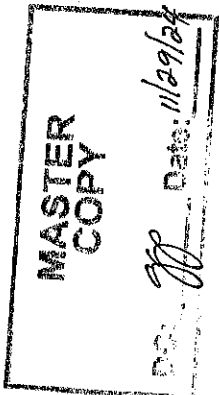
A. Acute Stroke - also known as cerebrovascular disease or “brain attack” and is classified as ischemic or hemorrhagic, requiring very different management. Ischemic strokes are due to blood vessel blockage that limits the blood supply to the brain. In contrast, hemorrhagic strokes are due to blood vessel rupture, either intracerebral hemorrhage or subarachnoid hemorrhage. Based on the time acute stroke initially labeled within 6-72 hours.²

B. Thrombolysis - a fibrinolytic therapy, which dissolves blood, clots to prevent ischemic damage by improving blood flow.³

V. POLICY STATEMENTS

A. Clinical Diagnosis

1. The clinical diagnosis of acute stroke is based on clinical history, physical examination (PE), and neurologic assessment.
2. The patient’s history should include the following essential information:
 - a. Time of witnessed symptom onset or last known well time if the event was unwitnessed.
 - b. Activity of the patient at the time signs and symptom/s the event occurred.
 - c. Part(s) of the body that was/were initially affected.
 - d. Description on the rate of progression of neurologic deficit (i.e. rapid or slow).
 - e. Co-morbidities such as hypertension, heart disease, and diabetes.
 - f. Current and recently taken medications.
 - g. Management and interventions done, if any.
3. Any accompanying signs and symptoms should be reported that include but not limited to numbness or weakness of the face, arm, or leg, confusion,



² PhilHealth Circular No. 2023-0021 “Implementing Guidelines on the Case Rates for Acute Stroke”

³ ncbi.nlm.nih.gov/books/NBK557411/

slurred speech, blurred vision, dizziness, loss of balance/coordination, severe headache of unknown cause, etc.

B. Diagnostic Tests

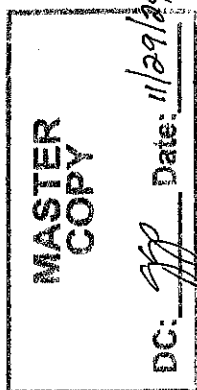
1. The following are the minimum recommended emergent diagnostics for patients with a suspected stroke.
 - a. Complete Blood Count (CBC)
 - b. Glucose Level (Capillary Blood Glucose or Random Blood Sugar)
 - c. Coagulation Studies: (Prothrombin Time or PT, Activated Partial Thromboplastin Time or aPTT)
 - d. Electrocardiogram (ECG)
 - e. Serum Electrolytes
 - f. Creatinine
 - g. Neuroimaging: Computed Tomography Scan of the Head (CT-scan) or Magnetic Resonance Imaging of the Brain (MRI)
2. Other emergent tests may include drug screening for high-risk individuals, pregnancy tests for women of reproductive age (i.e. all women aged 15-49 years, WHO Reproductive Health Indicators) with recent amenorrhea, and troponin levels for patients with concurrent signs of myocardial ischemia.
3. Other tests to evaluate stroke risk factors and determine stroke etiology can be done in the acute or subacute phases of stroke as determined by the health care team.

C. Role of Neuroimaging

1. The diagnosis of acute stroke remains clinical although neuroimaging helps determine whether stroke is ischemic or hemorrhagic. It is important to note that signs of cerebral infarction may not be present in imaging, especially in hyperacute ischemic stroke, and those with lacunar or brainstem infarction.
2. Patients suspected with acute stroke should undergo urgent brain imaging. Neuroimaging is essential to rule out stroke mimickers and determine eligibility for thrombolysis.
3. Repeat neuroimaging may be done based on the decision of the attending physician or neurologist to assess disease progression, complications, or treatment effectiveness. This shall apply to all admissions beginning November 24, 2023.

D. Management

1. Early stroke treatment varies depending on the type of stroke making neuroimaging crucial.



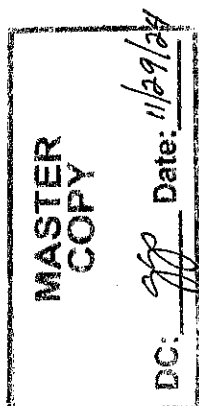
2. After initial acute management, further evaluation may be needed to determine the underlying stroke mechanism and etiology, guiding subsequent management.
3. Reperfusion therapy with thrombolytic agents is the gold standard for hyperacute ischemic stroke, provided the patient is eligible. This treatment should be delivered by an experienced multidisciplinary stroke team. Only experts in the thrombolysis procedures should administer thrombolytic agents, carefully considering the indications, drug administration, contraindications, and possible complications.
4. Adherence to post-thrombolysis protocol including close monitoring of patients is crucial following thrombolysis (Annex A: Treatment for Acute Stroke).⁴

E. Hospital Discharge and Follow-Up Care

1. The attending physician and other healthcare team members should engage in comprehensive discussions with the patient and his/her family, offering clear instructions on post-stroke care to ensure a smooth transition from hospital care. This includes medication schedules, necessary lifestyle adjustments as well as how to recognize stroke warning signs and symptoms, and guidance on how to respond to new stroke symptoms.
2. Impairment and disabilities from stroke such as but not limited to motor or sensory impairment, mood changes, pain, incontinence, language, or cognitive deficits, should be promptly assessed for intervention and monitoring. The attending physician should actively facilitate referrals to specialists such as neurologists, physiatrists, psychiatrists, and pain management specialists to ensure comprehensive and appropriate treatment for patients throughout the acute, subacute, and chronic phases of stroke care.

F. 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) Revision 2].
2. Standards of care issued by authorized agencies or organizations shall be regularly monitored. As deemed necessary, a revision of the policy shall be made as a result of policy review.



⁴ SSP HandBook of Strokes Guidelines for Prevention, Treatment and Rehabilitation, 6th Edition, 2014

VI. REPEALING CLAUSE

This PhilHealth Circular specifically repeals item no. V. Policy Statements (claims filing no. 2) of PC No. 2023-0021 (Implementing Guidelines on the Case Rates for Acute Stroke).

All PhilHealth Circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

VII. PENALTY CLAUSE

Any violation shall be dealt with and penalized in accordance with pertinent provisions of Republic Act No. 10606 (National Health Insurance Act of 2013) and its respective Implementing Rules and Regulations.

VIII. DATE OF EFFECTIVITY

This PhilHealth Circular shall be published in the Official Gazette or in any newspaper of general circulation and shall take effect fifteen (15) days after its publication. Three (3) copies 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.
President and Chief Executive Officer

Date signed: 11 | 25 | 2024

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Quality Standards on the Diagnosis and Management of Acute Stroke as Reference of the Corporation

I. Management of Minor Stroke

A. Early Specific Treatment (Requires Neuroimaging Confirmation)

Cardioembolism Not Suspected	Cardioembolism Suspected
<ul style="list-style-type: none"> Aspirin (ASA) 325 mg/day for 14 days Maintenance: Aspirin 80mg + Clopidogrel 75mg for 21 days Ensure neuroprotection 	<ul style="list-style-type: none"> Aspirin (ASA) 325 mg/day Give antibiotics for infective endocarditis, do not coagulate Ensure neuroprotection

II. Management of Moderate and Severe Stroke

A. Early Specific Treatment (Requires Neuroimaging Confirmation)

Cardioembolism Not Suspected	Cardioembolism Suspected
<ul style="list-style-type: none"> Refer to neurologist for evaluation and decision Intravenous (IV) thrombolysis with recombinant tissue Plasminogen Activator (rt-PA) for patient present within 3 hours of stroke onset Give aspirin 325 mg/day 24 hours after IV rt-PA treatment and continue for 14 days Ensure neuroprotection Early rehabilitation once stable within 72 hours Early consult to neurosurgeon for cerebellar infarct 	<ul style="list-style-type: none"> Refer to neurologist for evaluation and decision IV thrombolysis with (rt-PA) for patient present within 4.5 hours of stroke onset Give antibiotics for infective endocarditis, do not coagulate Ensure neuroprotection Early rehabilitation once stable within 72 hours

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III. Post rt-PA Care: First 24 hours

- Admit the patient to an intensive care or stroke unit for monitoring.
- If the patient develops severe headache, acute hypertension, nausea, or vomiting or has a worsening neurological examination, discontinue the infusion (if IV alteplase is being administered) and obtain emergency head Cranial CT scan.
- Measure blood pressure and perform neurological assessments every 15 minutes during and after IV alteplase infusion for 2 hours, then every 30 minutes for 6 hours, then hourly until 24 hours after IV alteplase treatment.

4. Increase the frequency of blood pressure measurements if systolic blood pressure is >180 mmHg or if diastolic blood pressure is >105 mmHg. Administer antihypertensive medications to maintain blood pressure at or below these levels.
5. Delay placement of nasogastric tubes, indwelling bladder catheters, or intraarterial pressure catheters if the patient can be safely managed without them.
6. Obtain a follow-up CT or MRI scan at 24 hours after IV thrombolysis before starting anticoagulants or antiplatelet agents.

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