Guidelines for Referral Health Care in Lebanon

Standard Operating Procedures

Lebanon

Updated June 2018

UNHCR
The UN Refugee Agency

List of Abbreviations

BO	Branch Office
CMR	Clinical Management of Rape
CRP	C-Reactive Protein
CT	Computer Tomography
ECC	Exceptional Care Committee
ER	Emergency Room
ERCP	Endoscopic Retrograde Cholangiopancreatogram
ESWT	Extracorporeal Shockwave Therapy
ICU	Intensive Care Unit
MoPH	Ministry of Public Health
MVA	Motor Vehicle Accident
MRI	Magnetic Resonance Imaging
NGO	Non-Governmental Organization
NICU	Neonatal Intensive Care Unit
PHC	Primary Health Care
PHCC	Primary Health Care Centre
PHU	Public Health Unit
PICU	Paediatric Intensive Care Unit
PoC	Person of Concern
SGBV	Sexual and Gender Based Violence
STI	Sexually Transmitted Infection
SOP	Standard Operating Procedure
TPA	Third Party Administrator
TURP	Transurethral Resection of the Prostate
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestine Refugees

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1. Introduction

Since the onset of the civil war in Syria, people have fled to neighboring countries. By April 2018, there were just under 1 million Syrian refugees and approximately 20,000 refugees of other nationalities registered with UNHCR in Lebanon. Refugees are living predominantly in urban settings.

UNHCR's role is to *facilitate* and *advocate* for access to its persons of concern through existing services and health service providers and to *monitor* access to health care services. While the primary health care strategy is the core of all interventions; referral care is an essential part of access to comprehensive health services (UNHCR Public Health Operational Guidance, 2013).

These standard operating procedures (SOPs) outline the policy and procedures for referral care applicable to all UNHCR recognized refugees and persons of concern in Lebanon.

2. Definition of Referral Care

Referral health care is care that is too advanced for primary health care facilities and therefore provided at health care facilities of secondary or tertiary level (i.e., hospitals). It usually requires admission of the patient.

3. Guiding Principles

The below principles are based on UNHCR's Principles and Guidance for Referral Health Care for Refugees and Other Persons of Concern (2009):

1. ***Equity of care and access between PoCs and host population***
   UNHCR aims to provide refugees with access to and quality of referral care at similar levels as received by Lebanese citizens in government health facilities.

2. ***Prioritizations should be based on prognosis and cost***
   Since funds are limited, prioritization needs to be done in order to deliver the most necessary care to the highest number of people. The two most important factors determining whether to make treatments available are therefore prognosis and cost.

3. ***The decision to provide referral care is medical***
   The medical aspect should always remain central in the decision making about what treatment should be available for whom and the responsibility for final decisions should lie with a medical doctor.

4. ***The decision making procedure should be consistent and transparent***
   Decisions should be made following available SOPs and guidelines and involve qualified experts according to the nature of the different cases.

5. ***Medical confidentiality is ensured throughout the referral care process***
   Please refer to *Annex 1*

4. Persons Eligible for Referral Care Support

Anyone residing in Lebanon who is recognized by UNHCR as a refugee or person of concern (PoC) is eligible for supported referral care. This includes children born in Lebanon whose fathers are PoCs, even though their mothers are not.

The following are not recognized as PoCs by UNHCR for referral care support:

- Lebanese citizens
- Palestinians, including Palestinians originating from Syria (fall under mandate of UNRWA)
- PoCs' spouses who does not fall under UNHCR mandate (e.g. Palestinians or Lebanese)
- Children born to PoC mothers married to a non PoC father
- Migrants

In some cases, the determination of who is a PoC might be difficult. See section 14.1 for special cases.

5. Conditions Eligible for Referral Care Support

Considering available financial resources, UNHCR is required to prioritize care for the following:

- Deliveries
- Urgent potentially life threatening conditions
- Urgent conditions that might lead to severe permanent disability

Non-urgent and chronic conditions are normally not eligible for support, but there are exceptions. See sections 14.5 and 14.11.

6. Provision of Referral Care Support

6.1 The TPA

To facilitate the process of providing access to UNHCR support, UNHCR contracts a Third Party Administrator (TPA). The TPA is the link between the beneficiary and the facility where he/she receives health care. It ensures that the beneficiary is a UNHCR PoC and that his/her condition is eligible for UNHCR support. The TPA manages the financial and medical audit of care provided and the payments to the hospital on behalf of UNHCR.

6.2 The UNHCR hospital network

The TPA contracts a network of public and private hospitals throughout the country where refugees can access care. Inclusion is decided by UNHCR based on proximity to beneficiaries, availability of services and cost effectiveness. The network is subject to continuous review according to needs. As a general rule UNHCR does not support care given in hospitals outside of the network. For a list of hospitals that currently are part of the network see Annex 2.

6.3 Referral care support

UNHCR supports provision of referral care to PoCs through a cost-sharing mechanism. The TPA agrees with the contracted hospital upon standardized fees following Ministry of Public Health (MoPH) fixed rates. UNHCR contributes by paying a proportion of the charges which is 75% of costs

above 100 USD. The first 100 USD of the bill is paid by the beneficiary. If the beneficiary's share reaches 800 USD, UNHCR covers the remainder of the costs to mitigate catastrophic costs. For a few special categories the UNHCR contribution is higher. Please see section 14.4.

A ceiling is set of 10,000 USD as maximum total cost for a single admission. UNHCR will not reimburse the part of the hospital bill exceeding this amount. For certain types of care (i.e. neonatal intensive care and burns intensive care) the ceiling can be extended to 15,000 USD. The maximum total amount that UNHCR will provide for one single household during a year is 30,000 USD.

7. The Referral Process

7.1 Seeking care

Beneficiaries have access to information about how to seek health care through a variety of channels such as leaflets, text message campaigns and social media and community outreach.
Primary Health Care centers are informed on referral care support and contracted hospitals in order to refer persons. The TPA has a call center to provide guidance for persons of concern and is the primary point of contact. UNHCR also has a call center that can direct persons to the TPA.

As a general rule governmental hospitals should be prioritized and if not possible, the most cost-effective alternative. See Annex 2.

Very exceptionally for conditions that cannot be treated in the network, UNHCR may approve care at a hospital outside the network taking cost into consideration.

7.1.1. Urgent cases

These are cases when care needs to be provided urgently. Usually the beneficiary has suffered a trauma or experienced acute onset of severe symptoms.

Most commonly the TPA is contacted when the beneficiary already is in a network hospital that is able to provide care. If this is not the case the TPA's responsibilities towards the beneficiary are the following:

- If the beneficiary has not yet been assessed by a physician, the TPA should provide information about the closest contracted hospitals where an assessment can be obtained.
- If the beneficiary has been assessed and meets the criteria for UNHCR support, the TPA is responsible to guide the beneficiary to a contracted hospital where suitable care can be obtained. This includes ensuring that beds at the receiving facility are available and for time-critical cases assisting in getting access to Lebanese Red Cross/Crescent Ambulance services.

The network hospitals' responsibilities in regards to the beneficiary seeking urgent health care are:

- To assess and provide initial emergency care.
- If the hospital has the capacity to provide the care that the beneficiary requires, to request approval from the TPA as soon as possible.
- If the hospital does not have the capacity to provide the necessary care (not enough beds or the specific service not available) – to ensure that the TPA is aware of the case in order to assist in finding a facility where supported care can be obtained.

7.1.2. Non-urgent cases

These are cases when health care does not need to be provided urgently (see section 14.5). In many cases the beneficiary has already been diagnosed and some investigations have already been performed as an outpatient.

Non-urgent cases are often not eligible for UNHCR support and in order to determine if they are, a detailed medical report is needed accompanied by appropriate copies of medical investigations performed. The TPA's responsibility is to instruct the beneficiary what documentation is needed and where it should be delivered in order for the case's eligibility to be assessed by the TPA and UNHCR.

7.2. Approving initial UNHCR support

In order to approve UNHCR support for care the TPA needs to confirm three things:

1) Whether the beneficiary is a UNHCR PoC
2) Whether the condition warrants UNHCR support and;
3) Whether the requested treatment is warranted

1) The beneficiary should provide the hospital and TPA with documentation showing that indeed he or she is a PoC, usually a UNHCR registration certificate. The TPA has access to the UNHCR database of recognized PoCs and are able to cross-check the validity. If the beneficiary lacks documentation or validation cannot be obtained through cross-checking see section 14.2.

2) The TPA needs a medical report in which the beneficiary's diagnosis is stated, accompanied with copies of investigations done supporting the diagnosis. The TPA should determine whether the diagnosis is supported by the results of the investigations and that it warrants UNHCR support according to the guidelines set out in these SOPs. For further details see section 14.

3) The medical report must state the proposed interventions in terms of investigations and treatment, the relevant MOPH codes for the interventions and the estimated costs. The TPA will decide whether these interventions are warranted according to standard praxis and these SOPs. For further details see 14.

When the above is confirmed the TPA should issue a written approval to the hospital that UNHCR will cover the proposed intervention according to the cost sharing scheme described above.

Certain interventions need UNHCR approval (see section 14 and *Annex 4a*). This includes all interventions that are expected to cost 2900 USD or above.

In certain situations the beneficiary might have a condition that warrants UNHCR support, but the intervention suggested by the hospital is not in agreement with best practice and the SOP's (e.g. hospital suggests surgical intervention while conservative treatment would be appropriate). In these cases, the TPA and the hospital should have a dialogue about the most appropriate treatment rather than the beneficiary being declined coverage completely.

7.2.1 Urgent cases

For urgent cases, approval is done while the beneficiary is in the hospital and it is important that it is issued as soon as possible.

Beneficiaries that are not presenting for delivery care and are not known to UNHCR or whose PoC status has become inactivated should be offered fast track determination of their PoC status (see section 14.2).

As soon as the hospital has produced a medical report supported by appropriate documentation the TPA can start the approval process.

Even though some cases need confirmation from UNHCR or are waiting for fast track determination of PoC status, in the meantime **the TPA can approve any relevant investigation or intervention, as long as it is aimed to confirm or address, a condition that is urgent and believed to be either life threatening or might lead to permanent severe disability.**

If the hospital has not contacted the TPA for approval within 24 hours of the arrival of the beneficiary or decides to proceed with an intervention despite the TPA having rejected it, the hospital will not be reimbursed.

7.2.2 Non-urgent cases

For non-urgent cases, the medical report and confirmation of PoC status is done as an out-patient. UNHCR will in most cases not cover costs for out-patient investigation. Neither will UNHCR offer fast track determination of PoC status for non-urgent cases.

The TPA needs however to guide the beneficiary during the investigation process. There might be misunderstandings about which type of physician he needs to see or which investigations need to be done. Several contacts between the beneficiary and the TPA might be needed. The TPA can also guide the beneficiary towards NGO's that can provide financial support for investigations.

When all the documentation has been delivered by the beneficiary to the TPA it might take some time before a decision has been made whether the intervention is supported or not (these are often cases that needs to be discussed with the ECC – see section 8). It is the TPA's responsibility to inform the patient on how the case is proceeding and about any decisions made. When a decision has been made, the beneficiary should be notified by the TPA as soon as possible. However, all further information (such as date for intervention) has to be provided to the beneficiary by the treating facility.

7.3. Approving continued UNHCR support

If a beneficiary is admitted, the TPA needs to follow up how the admission is progressing. If the hospital requests further investigations or interventions, the TPA needs to approve these as well.

As for the initial process the TPA is authorized to immediately approve **an investigation or intervention aiming to confirm or address an urgent condition believed to be either life threatening or leading to permanent severe disability.**

For long admissions UNHCR needs to be continuously updated about progress of the admission. If not instructed otherwise, the TPA needs to send weekly reports from the beginning of the 3rd week of hospitalization for patients in a normal ward. For intensive care patients the reports need to be sent from beginning of second week.

The update is to include interventions and investigations done as well as prognosis and planned further interventions. Reports on NICU cases need to follow a specific template (see details in

Figure 1: The Referral Process for Urgent Cases (Non Deliveries)

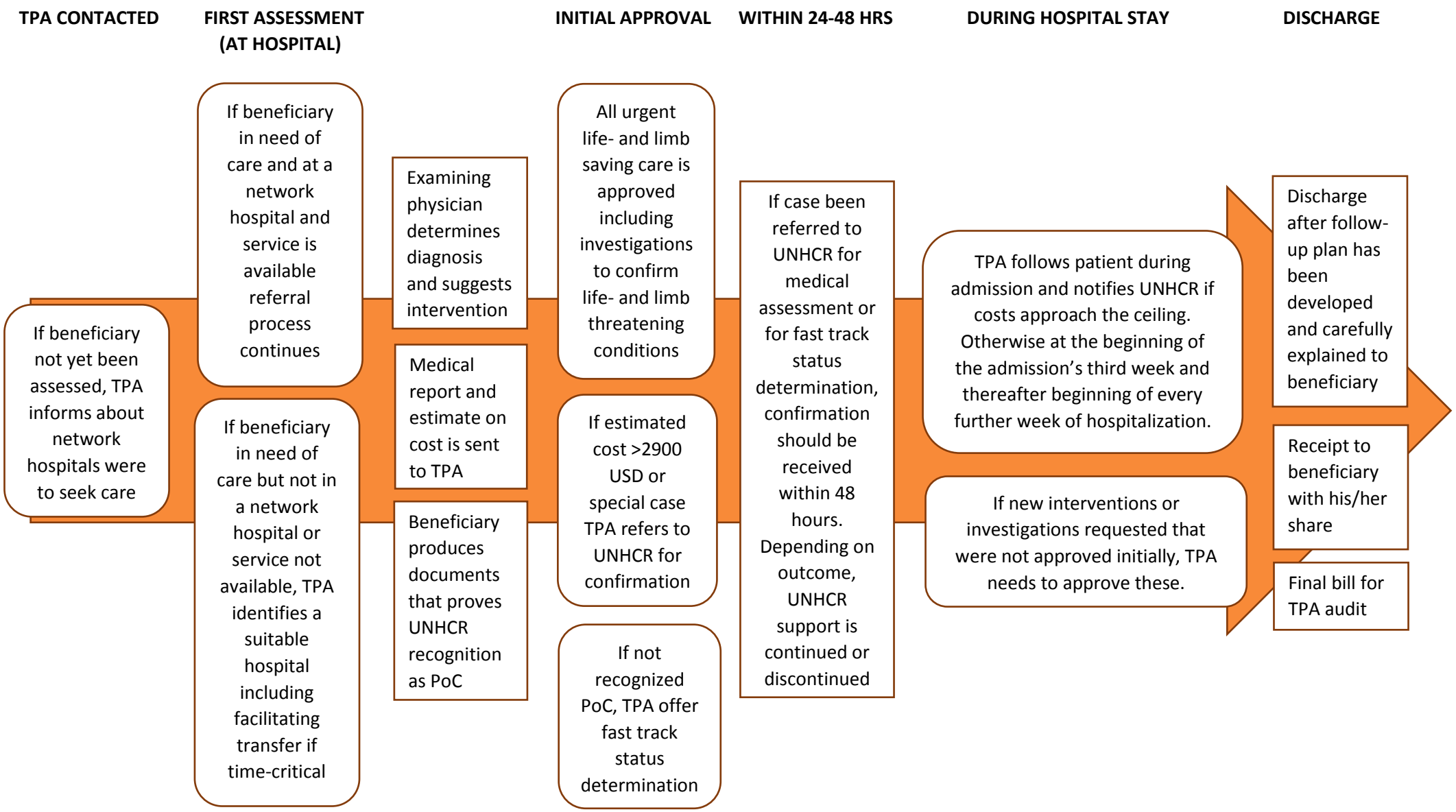


Figure 2: The Referral Process for Deliveries

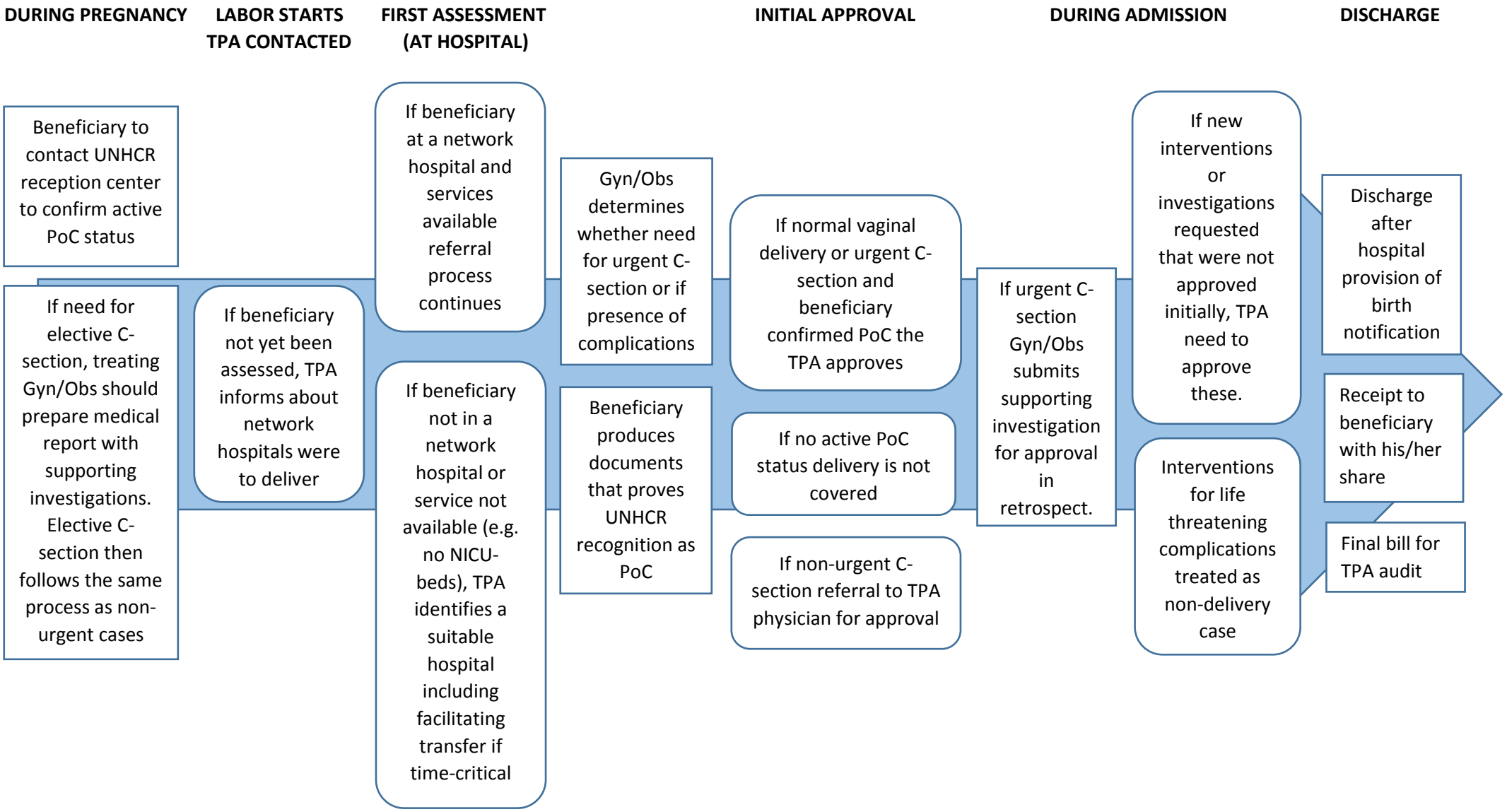
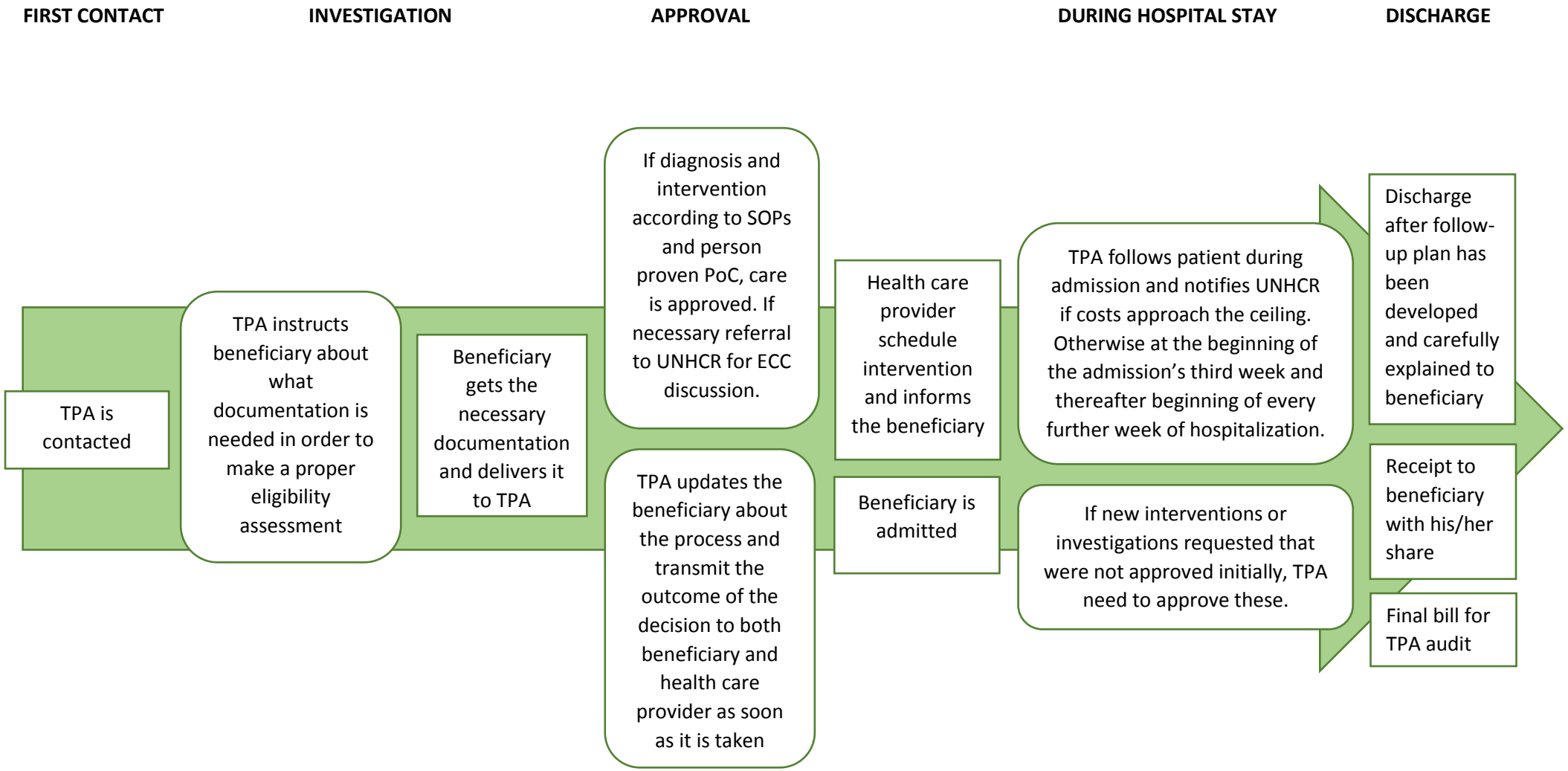


Figure 3: The Referral Process for Non-Urgent Cases



section 14.9.). If costs are likely to exceed the ceiling, the hospital and patient must be informed and given advice by the TPA in good time.

7.4. Discharge and payment

When the treating physician consider it safe, the patient will be discharged. If needed, a follow-up plan should be developed and carefully explained to the beneficiary.

The hospital should provide the beneficiary with a bill for the patient share and a receipt as soon as it is paid. In the case of deaths or births the hospital should also provide birth- and death notifications/certificates or equivalent. The TPA should before discharge ensure that the beneficiary has received the necessary and correct documents.

The UNHCR-share should be sent to the TPA who will conduct an audit to confirm that the care provided is appropriate and has been approved by the TPA. If not, deductions might be made.

The TPA in turn sends the audited bills to UNHCR who conducts a further financial and medical audit prior to financial transfer to the TPA who pays the hospital.

8. The Exceptional Care Committee (ECC)

Refugees may present with serious and complex diseases. Treatments of such diseases may be complicated, protracted and expensive. As a consequence, an Exceptional Care Committee (ECC) has been established by UNHCR to review and decide on possible support for such cases.

The ECC consists of three anonymous expert medical professionals and is independent in its decision-making. The ECC meets with the UNHCR Public Health Unit (PHU) every two weeks to discuss cases.

The PHU will refer to the ECC complicated and costly cases for which prognosis is difficult to foresee. Examples are extensive surgery and removal of malignant tumors. Non-urgent cases will be discussed and decided upon during the ECC meetings. For urgent cases the relevant individual ECC member is contacted by phone or email. The ECC will decide on whether to support treatment for the case as well as the level of support to be provided. The decisions of the ECC are primarily based on:

- Necessity and duration of the suggested treatment
- Concomitant diseases and age
- Feasibility and evidence base of the treatment plan
- Prognosis
- Cost

The ECC meetings are chaired by the UNHCR Senior Public Health Officer and the Assistant Public Health Officer acts as the secretary; responsible for preparation, communication, documentation, minutes and follow-up. UNHCR maintains a confidential record of cases and decisions.

Representatives from the TPA are also requested to attend the ECC meetings.

9. Communication between the TPA and UNHCR

To respect patient confidentiality and for documenting purposes, communication between UNHCR and the TPA needs to follow certain rules:

- Medical case management should be restricted between the TPA and the UNHCR public health unit (PHU) in Beirut Branch Office (BO).
- Communication between the public health teams in the regional offices and the TPA should be restricted to issues not related to the medical management of cases such as access issues and complaints against hospitals.
- Communication should follow hierarchical lines and communication with TPA head office should be conducted exclusively by PHU BO Beirut

Most communication will be by email, even though in emergencies some cases might be discussed and approved by telephone. In these cases, an email containing a summary of the discussion and the decision should still be sent for documenting purposes.

Emails sent by the TPA on patient cases should contain enough data to make a decision i.e. basic bio data of patient and a medical report with relevant results of investigations attached following a basic template. Please see *Annex 5* for details and sample emails.

10. Complaints

Irregularities noted in the provision of referral care should be brought to UNHCR's attention. Typically complaints may be raised by refugees, NGO partners, the TPA and hospitals.

The TPA should, according to the frame agreement between it and UNHCR have a mechanism for receiving complaints and act upon them. Received complaints and actions taken should be shared with UNHCR on a regular basis.

Refugees, NGO's and hospitals may also bring the complaint to the nearest UNHCR regional BO where it will be presented to the public health unit.

Complaints, whatever their nature, must be specific i.e. it has to concern a specific case or beneficiary and it should contain a detailed description of what has occurred with names of the involved individuals if relevant.

Regarding complaints about hospitals, a confidential online form (Hospital Incident Tracking System - HITS) can be completed by the TPA and UNHCR staff. It should always be used for such cases and forwarded to PHU BO Beirut for action. Cases of suspected medical negligence will be reported to the appropriate medical regulatory authorities. Repeated cases of misconduct by a hospital will lead to termination of the contract.

Complaints on TPA performance brought to the regional BO should be forwarded to the PHU BO Beirut for assessment and action with the TPA senior management.

11. Support provided by NGO partners

There are several NGOs who may support either financially or are supporting access to services outside UNHCR support. These NGOs can be contacted for cases outside the scope of UNHCR assistance. Typical examples are:

- Beneficiaries who cannot pay the patient share of hospital bills
- Beneficiaries for whom the cost of treatment exceeds the UNHCR limit of support
- Beneficiaries who suffer from conditions not covered by UNHCR

The referral to an NGO for financial support is normally done by the UNHCR field office, but may also be done by the TPA.

NGO support to beneficiaries in the form of payment of hospital bills is a transaction directly between the hospital and the NGO.

Regarding NGOs providing health services, UNHCR and the TPA can refer suitable beneficiaries to NGO's with good track records with which collaboration is well established. Regarding other NGO's UNHCR and the TPA can provide information, but should avoid direct referrals.

For info about NGO's operating in Lebanon and providing health related services to refugees please see http://data.unhcr.org/lebanon/ under Health Sector Working Group Page/(Lebanon Health Sector 5Ws ; who is doing, what, where, how and until when)

12. Monitoring and Evaluation

Monitoring and evaluation of referral care will be conducted through several mechanisms:

Monitoring by TPA:

- Collection of data on care supported: number of admissions, age and sex of patients, diagnosis, length of stay and outcome. UNHCR has direct real-time access to the TPA's continuously updated database.
- Collection of data regarding call-center activity such as number of calls and average length of calls. Shared with UNHCR.
- Collection of data regarding complaint hot-line. Number of calls received, the complaints and actions taken. Shared with UNHCR.

Monitoring by UNHCR public health teams in regional BOs:

- Regular visits to network hospitals to audit admission documentation of current beneficiary inpatients and discuss ongoing issues with relevant hospital staff. Findings presented in reports.
- Regular exit surveys of beneficiaries who have received referral health care. Questions will include how much was paid, whether receipt was provided and whether beneficiary was happy with provided services.

By UNHCR Project Control:

- Monitoring of how UNHCR Public health unit follows up recommendations made in the monthly management letters provided by the external audit company.

By UNHCR PHU BO Beirut:

- Continuous medical audit by UNHCR of randomly selected sample of hospital bills from each received invoice (at least 1% of bills)
- Regular visits to contracted hospitals for review of quality of care
- Annual detailed referral care report and regular review of referral care data
- Inclusion of questions on referral care in the annual "Health access and utilization survey among Syrian refugees in Lebanon"

- Tracking of complaints and actions taken
- Compiling of data on cases referred to UNHCR and actions taken
- Compiling of data on cases referred to the ECC and actions taken

By Professional External Auditing Company:

- Continuous audit of contractual agreement between the TPA and UNHCR. The audit covers financial transactions as well as health care provision.
- Audit findings are presented to UNHCR on a monthly basis.

Please see *Annex 7* for the monitor and evaluation framework.

13. Legal Issues

UNHCR and the TPA shall not be held responsible for malpractice, physical or mental harm or adverse outcomes of medical interventions provided by the contracted hospitals or any third party hospital that have admitted refugees. All these incidents will have to be dealt with between the treating hospitals and the patient or his/her family. Support may be provided by partners to obtain legal assistance in these matters.

14. Specific Cases

14.1. Uncertain PoC status

PoC-status are in certain cases difficult to determine. One example is children born to a PoC mother with an unknown father or a father who is not a PoC but who refuses to acknowledge his fatherhood. Another example are recognized PoCs about whom information emerges that casts doubt on their PoC status (residents in Lebanon since many decades or known combatants). All cases need to be referred to UNHCR registration centers for determination of status and eligibility for support.

In all cases, the decision made by registration is final and if considered PoCs at the time of receiving care, the person is eligible for health care support.

14.2. Fast-track determination of PoC status

A person may lack a UNHCR ID or there might be a problem verifying PoC status through the UNHCR database.

Some problems can be solved through email contact between the TPA and the regional UNHCR registration office and a correct UNHCR ID number obtained in order for the approval process to continue.

However, there are also persons who have never approached UNHCR or whose registration has become inactivated. If the case is urgent and not a delivery the person can be eligible through a fast-track process while he/she is in the hospital. For this to happen, a household member needs to approach the nearest UNHCR reception center as soon as possible.

While the fast track procedure is ongoing, the TPA can still approve all life and limb-saving care and UNHCR will cover it. However, if no household member has approached the reception center within 48 hours or the person is found not to be a PoC, UNHCR support will discontinue.

Since deliveries are not unexpected events, beneficiaries receiving care included in standard delivery packages (vaginal and C-section) do not have the option of fast tracked determination of PoC status. Pregnant beneficiaries not yet known to UNHCR are instead advised to approach a UNHCR office to confirm their PoC status as soon as they are aware of their pregnancy in order to be eligible for financial support. Such cases will be prioritized by the reception centers in order to have a status confirmation prior to delivery.

Non urgent/cold cases also do not have the option of fast track status determination.

14.3. False identities

UNHCR identity documents are occasionally being used by other persons than the ones they were issued for. If discovered some guidelines are to be followed:

If the person using the documents is not a PoC (e.g. Lebanese or Palestinian) support will immediately be withdrawn for the whole episode of care.

If the person is a PoC but for some reason lacks documents of his/her own, decision has to be made on a case by case basis.

When wrongfully used identities have been used in relation to deliveries they are often discovered in retrospect when the owner of the identity presents for delivery and records show that the identity was used for a delivery just a few months prior. These cases are also to be dealt with on a case by case basis, but as a general rule (if no particular extenuating circumstances are present such as a mix-up between IDs within the same household), the support for the current delivery will have been forfeited.

Cases of false identity should always be reported to the registration department.

14.4. Beneficiaries with additional protection needs

Certain beneficiaries have additional protection needs and receive additional coverage by UNHCR:

- Victims of torture – covered 100% for care of injuries sustained during torture and any follow up needed requiring referral health care
- Survivors of Sexual and Gender Based Violence – covered 100% for care of injuries sustained, clinical management of rape (CMR)[1], forensic investigations and any follow-up needed requiring referral health care (including deliveries)
- Patients suffering from primary Severe Acute Malnutrition (SAM) – covered 100% for care related to the malnutrition
- Psychiatric Patients – covered 90% for acute inpatient psychiatric care

The first two categories must be confirmed by the UNHCR protection department for UNHCR PHU BO Beirut to forward the cases to the TPA for approval.

The TPA is requested to appoint a focal person who will coordinate care for all these cases in close collaboration with the UNHCR PHU. Cases will be directed to chosen contracted hospitals (or in the case of forensic investigations to contracted forensic doctors) that are known to have the capacity to provide the required services.

[1] See UNFPA/IRC guidelines for what care is included in CMR

If the TPA come across suspected cases of abuse they should always alert UNHCR that can initiate an investigation by the protection department.

14.5. Non-urgent (cold) cases and chronic conditions

Cold cases are cases that do not need immediate care. In order for a cold case to get UNHCR support the condition needs to be:

a) potentially life- or limb-threatening and;
b) treatable through a single intervention

Example of cold cases that are eligible for UNHCR support:

- Early stage cancers without spread where a surgical procedure may significantly improve the prognosis
- Myoma leading to severe anemia
- Severe coronary stenosis (without acute coronary symptoms) in need of stent or by-pass

Example of cold cases not eligible for UNHCR support:

- Metastatic cancers
- Hernias (without strangulation)
- Arthrosis

Investigations of cold cases can in most instances be performed as outpatient investigations and are not covered. Exceptions can be made if a beneficiary is considered to be a candidate for resettlement and a specific diagnosis is needed.

The section about specific diagnoses gives further guidance on which cold cases are covered. When there are doubts, the TPA should refer the case to UNHCR for final decision.

Care for chronic conditions are generally not covered. However, if an urgent life-threatening condition arises as a consequence of the chronic condition, UNHCR will cover.

Examples of such situations:

- Liver cirrhosis with acute hemorrhage of esophageal varices
- Diabetes with a gangrenous foot
- Hematological disorders with need for blood-transfusion
- End stage cancer for which simple procedures can alleviate suffering (draining of ascites or pleural effusion)

14.6. Presence of a third party payer

In certain instances a third party is paying for care. Normally it is an insurance company of a person or company who are responsible for an injury that the beneficiary has suffered. UNHCR will normally not support care in such cases. One exception is if third party coverage is much below what UNHCR would have covered. UNHCR can then consider to pay the difference.

In other instances there should be a third party payer although such a payer has not stepped forward. Examples of such cases are work accidents and hit and run traffic accidents. If a third party payer cannot be identified or cannot pay for treatment UNHCR will cover as usual.

When it is the beneficiary's own responsibility to be insured, UNHCR will not contribute with support. UNHCR will consequently not cover care for an injured driver and owner of a vehicle involved in an accident, nor injured passengers who are members of the driver's household.

For accidents, hospitals will often require an Internal Security Forces (ISF) report. Such a report is not necessary in order to approve UNHCR support. The only time support might be withheld waiting for an ISF report is when the patient is suspected of being the driver and the owner of a vehicle involved in an accident (see above).

14.7. ER care

ER care is not to be considered different than care provided as an inpatient. Care given for urgent potentially life or limb threatening conditions should be covered. This includes investigations made to confirm or exclude the condition in question. Whether the beneficiary ends up being admitted or not does not make a difference to whether the care is covered. Proportion of cost covered is calculated in the same way as for in-patient care.

14.8. Obstetric care

UNHCR/TPA has agreed with every hospital in the referral network on a single charge for a package of services included in a normal vaginal delivery and in a delivery by C-section. The charge may vary between hospitals. The patient/UNHCR share of the fee is however calculated in the same way as for all other care.

Care included in the delivery package is only given if the beneficiary is previously known to UNHCR and has an active PoC status.

If there are severe complications to the delivery such as pre-eclampsia/eclampsia, post-delivery hemorrhage or sepsis, interventions for such complications are covered in the same way as other referral care and the beneficiary should be offered fast track PoC status determination if previously unknown to UNHCR or with inactive PoC status. Observe that coverage for this additional care is 75% and does not include the 100 USD threshold.

Elective C-sections must have been approved by the TPA in good time before delivery and a medical report accompanied by relevant investigations must be submitted as basis for approval. Ultrasound reports should be from a radiologist (i.e. not performed by the treating obstetrician). Only internationally valid indications for C-sections are accepted. See *Annex 4c* for list of accepted indications.

Urgent C-sections, especially if fetal indication, can be approved urgently, but a medical report and accompanying documentation (ultrasound and/or CTG) needs to be submitted in retrospect. During non-office hours, an ultrasound made by the obstetrician can be accepted.

UNHCR will not cover for ultrasound investigations in relation to deliveries if they have not been requested by the TPA.

Pregnancy-related emergencies not related to deliveries are to be covered in the same way as other referral care.

Dilatation and curettage is covered in cases of incomplete and missed abortion and in molar pregnancies. For non-urgent cases there is need for confirmed dead fetus on ultrasound made by radiologist. In urgent cases the ultra sound can be made by the Gyn/Obs.

14.9. Neonatal intensive care

UNHCR supports neonatal intensive care unit (NICU) care for neonates born at and above 26 weeks of gestation. Neonates of less than 26 weeks and with a weight less than 1000 g are not covered due to the poor prognosis (i.e. if the neonate is both < 26 weeks and weighs less than 1000g, care is not supported. If gestational age at or above 26 weeks care is supported regardless of weight). The TPA must show the utmost consideration for the parents in these cases and guidance on where to find support and counselling should be given.

When the hospital requests an admission into NICU, the medical report needs to be accompanied by a filled in form specifying gestational age, birth weight, Apgar score, mode of delivery, multiple gestation, diagnosis/reason for admission, prognosis and expected cost. The information needs to be forwarded to UNHCR for approval. As always the TPA can approve lifesaving interventions waiting for UNHCR confirmation.

Care in NICU needs to be re-evaluated every week and updates on weight, feeding, breathing and neurological status as well as current treatment, prognosis, costs so far and estimated further costs have to be provided. It should also be noted whether a TPA physician has seen the child. These medical reports and updates should be referred to UNHCR that at any point may decide to discontinue support if either:

1) the child is considered well enough (stable and > 1750 g)
2) prognosis is very poor

See *Annex 4d* for further details

Newborns with severe congenital conditions should be referred to UNHCR with a suggestion for intervention. The case will thereafter be assessed by the ECC.

The ceiling for NICU care is 15,000 USD rather than 10,000 USD.

14.10. Implants and transplants

Due to the extreme price range on implants UNHCR have developed certain rules regarding implants.

The following are NOT covered:

- Costs of orthopedic implants even though the surgery is covered if indicated by SOPs (i.e. fractures)
- Removal of orthopedic implants with the exception of growing children, acute osteomyelitis and if the implants are pins (procedure usually done in ER)
- Insertion and cost of orthopedic prostheses
- Costs of coronary drug eluting stents (only bare metal stents covered)
- Insertion and cost of defibrillators

The following ARE covered:

- Insertion and cost of pacemakers on a case by case basis
- Insertion and cost of coronary bare metal stents
- Insertion and cost of cardiac valve replacements on a case by case basis
- Insertion and cost of VP shunts (including externally adjustable if <16 years)
- Temporary drains, tubes and catheters including double J-stents

UNHCR does not cover any transplants.

14.11. Specific diagnoses

14.11.1. Congenital Heart Disease

Patients with severe congenital heart disease (CHD) should be referred to UNHCR and considered for coverage by the ECC. Priority will be given to children less than one year of age who are cyanotic on room air. All CHD cases will be evaluated on a case by case basis taking into account any associated co-morbidities that may affect overall prognosis.

14.11.2. Cerebrovascular disease and cardiovascular disease

Care for a Cerebrovascular Accident (CVA) need to be approved by UNHCR and will be assessed on a case-by-case basis. The duration of coverage will be influenced by the prognosis, complications, and evolution of the Glasgow Coma Scale (GCS). For CVAs the ceiling of hospital costs below which UNHCR provide support is 5000 USD. All patients with acute coronary syndrome (ACS) for whom percutaneous transluminal coronary angioplasty (PTCA) or coronary artery bypass graft (CABG) are requested must be referred to UNHCR for approval. If urgent life-threatening situation a PTCA can be approved in retrospect.

14.11.3. Orthopedics/trauma

UNHCR cover acute care for injuries that threaten to render function of a limb severely impaired such as fractures and ruptures of muscles, ligaments, tendons and nerves.

UNHCR also cover orthopedic emergencies that may not be the result of an injury such as acute bacterial arthritis and osteomyelitis, cauda equina syndrome or acute onset of paralysis due to prolapsed discs.

UNHCR does normally not cover care for chronic orthopedic conditions such as arthrosis, lower back pain, scoliosis and sequelae of old injuries or interventions. Neither are orthopedic congenital conditions covered.

However exceptions can be made for certain cold cases if good prognosis after a single intervention is expected.

Simple orthopedic intervention such as closed reduction of fractures and appliance of casts do not need to be referred to UNHCR

Orthopedic surgical interventions on the other hand always need prior approval by UNHCR. All cases referred need to be accompanied by appropriate radiological investigations.

14.11.4. Hematological Conditions

All blood disorders (including thalassemia) will be covered for lifesaving emergency transfusion of Packed Red Blood Cell (PRBC) if Hb $\leq$ 7 g/dl or Fresh Frozen Plasma (FFP) if platelets are < 10,000/µL. Such cases do not need prior approval by UNHCR.

Other treatments including Immunoglobulin G will be covered only in life threatening situations and only after approval by UNHCR.

N.B. During active bleeding Hb should not be guiding the decision to transfuse but rather the intensity of the bleeding in combination with vital parameters such as pulse and blood pressure.

14.11.5. Cancers

Metastasized cancer that requires chemo- and/or radiotherapy is not covered. However, if it is believed that prognosis can be drastically improved through a single surgical intervention it can be considered to cover that intervention. Such cases always need to be approved by UNHCR. Since most of these cases needs to be discussed by the ECC it is necessary that the TPA refers the cases accompanied by enough information to make a decision. This include detailed medical history and prognosis, radiological and laboratory examinations as well as cytology.

14.11.6. Kidney- and gall-stones

Presence of a stone in the urinary tract or gall bladder is in itself not an indication for UNHCR supported intervention.

UNHCR will support surgical intervention to remove gall stones (ERCP or cholecystectomy) only if the beneficiary has:

- An acute cholecystitis requiring hospital care with diagnosis supported by both elevated inflammatory parameters (WBC/CRP) and ultrasound (presence of stones and/or wall thickening of gall bladder)
- Obstructed biliary duct, supported by elevated bilirubin and/or ultrasound findings
- Complications such as pancreatitis supported by laboratory findings (elevated inflammatory parameters and amylase).

Cholecystectomy will not be covered if beneficiary is asymptomatic or only has biliary symptoms that can be managed as an outpatient.

UNHCR will support urgent surgical removal of stones in the urinary tract (alternatively relieving obstruction with methods such as insertion of double j-stent)

- in the presence of hydronephrosis (supported by radiological investigation)
- or pyelonephritis (supported by elevated inflammatory parameters and urinary analysis)

If none of the above is present, elective interventions such as percutaneous lithotripsy or extracorporeal shockwave lithotripsy can be considered for ureter stones that are not passing spontaneously.

UNHCR will not support surgical interventions for asymptomatic stones in the renal pelvis or ureter stones likely to pass spontaneously (<6mm and less than 2 months has passed).

TPA approval of surgical intervention for kidney and gallstones does not require referral to UNHCR for approval if the criteria above are fulfilled.

14.11.7. Ophthalmological disorders

Interventions for acute ophthalmological conditions such as injury or acute glaucoma are supported and does not need to be referred to UNHCR.

Interventions for chronic ophthalmological disorders are only supported on children under 18 and if good prognosis. These cases must be preapproved by UNHCR.

14.11.8. Inguinal/femoral/umbilical hernias

In boys, surgical repair of inguinal and femoral hernias is covered before 1 year of age. In girls, up to 16 years of age.

For all other hernias, UNHCR will only support intervention if acute strangulation. N.B. that diagnosis of strangulation is made clinically and intervention is urgent. TPA does not need confirmation from UNHCR in order to approve such cases.

14.11.9. Orchidopexy

Surgical correction is covered after 6 months of age when there is no hope of spontaneous descent. Does not need preapproval from UNHCR.

14.11.10 Thyroid disorders

Can in most cases be managed in primary care and is then not covered by UNHCR.

Thyroidectomy is supported if:

- Laboratory proven toxic goiter for which medical treatment has failed
- Radiologically proven airway obstruction

If any of the above criteria are fulfilled, referral to UNHCR is not needed.

If malignancy see 14.11.5.

14.11.11 Hemorrhoids, anal fissures and fistulas

Surgery may be considered for severe cases of anal fistula formation but only after ECC approval. Surgery for hemorrhoids and fissures is not supported.

14.11.12 Renal failure

In acute renal failure with good prognosis i.e. the patient has a good chance of recovering renal function, a maximum number of 3 sessions of hemodialysis can be supported. These cases need preapproval from UNHCR.

If renal function is unlikely to return and for chronic renal failure, hemodialysis is not covered. UNHCR does also not cover interventions associated with continuous hemodialysis such as creating arteriovenous fistulas. Patients will be oriented to partners who support these services.

14.11.13 Hydatid Cysts

Surgical removal of hydatid cysts is covered by UNHCR. However they need to be confirmed by radiology and:

- Positive serology
- If serology negative a recommendation from an infectious diseases specialist

If the above is fulfilled there is no need for referral to UNHCR.

14.11.14 Gynecological conditions

UNHCR supports surgical removal of ovarian cysts in case of suspected torsion.

UNHCR supports surgical removal of myomas in uterus if

- Intramural or submucosal and presence of iron deficiency anemia that needs transfusion
- Size of uterus equal size or larger than it would be at 12 weeks pregnancy

If any of the above criteria are fulfilled preapproval is not needed from UNHCR.

Elective hysterectomy is only supported in case of severe conditions and for each case age and medical history needs to be considered. Needs to be preapproved by UNHCR.

UNHCR is not covering interventions for prolapse or incontinence.

Regarding gynecological cancers or suspected cancers, the same rules apply as for all cancers (see 14.11.5.).

14.11.15 Burns

Due to the long and costly treatment of burns, the ceiling under which UNHCR covers hospital costs is 15,000 USD. However, the TPA need to monitor these cases closely and ensure transfer to regular ward as soon as it is possible.

14.11.16 Disorders of the prostate

UNHCR supports prostate surgery (TURP or prostatectomy depending on pathology) if hypertrophy causing urinary retention in need of catheterization.

If above criteria fulfilled there is no need for referral to UNHCR.

If malignancy see 14.11.5.

14.11.17 Pediatric ENT conditions

UNHCR does not support tonsillectomies or adenoidectomies if not exceptional circumstances (proven severe sleep apnea, risk of dental and palatial malformation, failure to thrive etc).

Myringotomy is covered if chronic otitis and loss of hearing seen in an audiogram.

All ENT surgery needs to be pre-approved by UNHCR.

14.11.18 Malnutrition

As mentioned previously, care for primary Severe Acute Malnutrition is covered 100% by UNHCR. This means however that the reason for the malnutrition is lack of food (e.g. financial reasons, negligence or abuse).

If the Severe Acute Malnutrition is secondary to a medical condition (e.g. gastroenteritis or malabsorption) the care should be covered as per the usual rate.

14.11.19 Psychiatric care and substance abuse

UNHCR is covering psychiatric in-patient care 90% in any of the psychiatric in-patient wards within the hospital network. Despite substance abuse considered as a psychiatric condition UNHCR is not able to cover rehabilitative care for substance abuse (detoxication). UNHCR do cover acute and life-threatening withdrawal symptoms like delirium tremens. This however does not require care in a specialized psychiatric ward and is therefore covered as per normal rates in any hospital. Non-psychiatric care for psychiatric patients is covered as per normal rates.

All psychiatric in-patient care needs to be referred to UNHCR.

14.11.20 HIV and TB

These are conditions covered by the Global Fund through IOM.

If a beneficiary has or is suspected to have HIV he/she can be referred to UNHCR who will arrange with further management through IOM.

If a beneficiary has or is suspected of having TB he/she can be referred directly to IOM for further management.

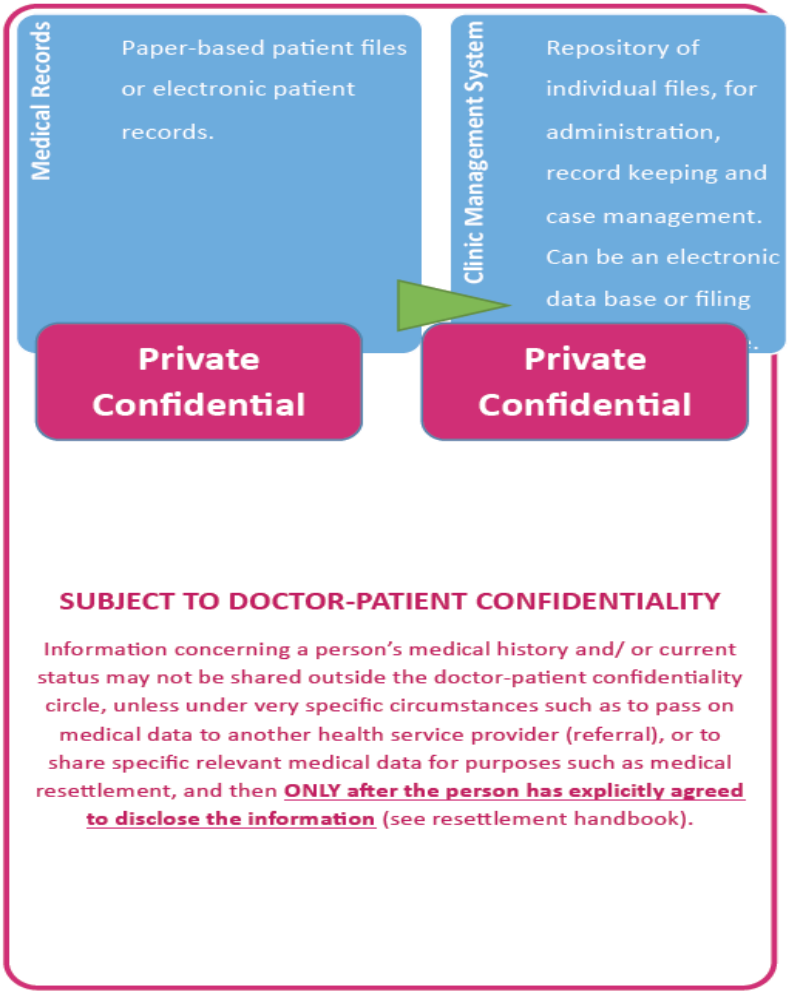
Annex 1) UNHCR medical confidentiality

Medical Data Confidentiality

Any medical data that has an individual identification tag is subject to data confidentiality. This includes medical records, referral forms, medical reports (diagnostic, hospital) and any other forms such as health insurance claims and medical assessment forms (MAF), such as those relevant to UNHCR, i.e. the MAF for medical resettlement.

Personal data in medicine and health is related to the **doctor-patient-confidentiality privileges** that are the basis of medical ethics as well as anchored in national and international laws.

Any sharing of this data outside of the doctor-patient relationship requires the agreed and explicit consent of the individual in writing to a disclosure of information agreement.



Annex 2) List of contracted hospitals and prioritizations when referring

The below list is from May 2018 and is subject to constant review. For the latest updated list please see http://data.unhcr.org/lebanon/ in the health section under "guidance".

Region	District	Name of Hospital	ICU/CCU	NICU	Type	Condition
North	Tripoli	Al-Salam Hospital	YES	YES	Private	Burns and NICU
	Tripoli	Tripoli Hospital (Gov.)	YES	YES	Gov	
	Tripoli	Al-Hanan Hospital	YES	NO	Private	
	Tripoli	Orange-Nassau Hospital (Gov)	NO	YES	Gov	NICU and maternity
	El Koura	Al Koura Hospital	YES	YES	Private	
	El Koura	Lebanon Heart Hospital	NA	NA	Private	Only cardiac
	El Minieh-Dennie	El-Kheir Hospital	YES	NO	Private	
	El Minieh-Dennie	Sir El Donnieh Hospital (Gov.)	NO	NO	Gov	
	Akkar	Notre-Dame de la Paix Hôpital	YES	YES	Private	
Bekaa	Zahle	El-Bekaa Hospital	YES	YES	Private	
	Zahle	Elias El-Hraoui Hospital (Gov.)	YES	YES	Gov	
	Zahle	Taanayel Hospital	YES	YES	Private	
	West Bekaa	Kherbet Kanafar Hospital (Gov)	YES	NO	Gov	
	West Bekaa	Dr. Hamed Farhat Hospital	YES	YES	Private	
	Baalbek	Rayan Hospital	YES	YES	Private	
	Baalbek	Baalback Governmental Hospital (Gov.)	YES	NO	Gov	
	Rachaya	Rashaya El-Wadi Hospital (Gov.)	YES	YES	Gov	
	El Hermel	Hermel Hospital (Gov.)	YES	YES	Gov	
Beirut/Mt-Lebanon	Baabda	Rafik Hariri University Hospital (Gov.)	YES	YES	Gov	
	Baabda	Sahel General Hospital	YES	YES	Private	
	Baabda	Baabda University Hospital (Gov.)	NO	NO	Gov	
	Keserwan	Bouar Hospital Ftouh Kerserwan (Gov.)	NO	NO	Gov	
	Keserwan	Notre-Dame du Liban Hôpital	YES	YES	Private	
	Chouf	Iklim Hospital	YES	YES	Private	
	Chouf	Ain Wazein Hospital	YES	YES	Private	Also Psychiatry
	Chouf	Othman Hospital	YES	YES	Private	
	Beirut	Karantina Governmental Hospital (Gov.)	NO	YES	Gov	Only NICU/PICU
	El Metn	Dahr El-Bashek Hospital (Gov.)	NO	NO	Gov	
	El Metn	Lebanese Canadian Hospital	YES	YES	Private	
	El Metn	Hopital Psychiatrique De La Croix	NO	NO	Private	Only psychiatry
South	Saida	Saida Hospital (Gov.)	YES	YES	Gov	
	Saida	Kassab Hospital	YES	YES	Private	
	Saida	Raee Hospital	YES	YES	Private	
	Saida	Hammoud Hospital University Medical Center	CCU only	NO	Private	Only cardiology
	Marjaayoun	Marjayoun Hospital (Gov.)	YES	YES	Gov	
	Sour	Lebanese Italian Hospital	YES	YES	Private	
	Sour	Hiram Hospital	YES	YES	Private	
	Bent Jbeil	Tebnine Hospital (Gov.)	YES	NO	Gov	
	Bent Jbeil	Shaheed Salah Ghandour Hospital	NO	YES	Private	
	El Nabatieh	Nabih Berri/ Nabatieh Hospital (Gov.)	YES	YES	Gov	

Prioritization:

- If large distance between hospitals – chose the nearest
- If short distance between hospitals – prioritize governmental
- If governmental full – prioritize lowest fees

Annex 3) Summary UNHCR support

Persons eligible for UNHCR support
• Anyone recognized by UNHCR as a Person of Concern (PoC) • Children to a PoC father
Persons NOT eligible for UNHCR support
• Lebanese citizens • Palestinians, including Palestinians originating from Syria (fall under mandate of UNRWA) • PoCs' spouses who does not fall under UNHCR mandate (e.g. Palestinians or Lebanese) • Children born to PoC mothers married to a non PoC father • Migrants

UNHCR cost sharing mechanism:		
The first 100 USD of the cost of care is paid by the beneficiary 75% of costs exceeding 100 USD is covered by UNHCR If the patient share reaches 800 USD, UNHCR covers all exceeding costs		
Examples of beneficiary shares for different costs of care:		
Cost of care	Beneficiary share	UNHCR share
75 USD	75 USD	0 USD
100 USD	100 USD	0 USD
200 USD	125 USD	75 USD
500 USD	200 USD	300 USD
1500 USD	450 USD	1050 USD
2900 USD	800 USD	2100 USD
5000 USD	800 USD	4200 USD
10000 USD	800 USD	9200 USD

Ceilings for UNHCR support
For most admissions the cost sharing mechanism is in effect until the cost of care reaches 10,000. Thereafter UNHCR will no longer cover any costs.
There are three exceptions to the above rule: • Neonatal intensive care with a ceiling of 15,000 USD • Intensive care for burns with a ceiling of 15,000 USD • Care for CVA with a ceiling of 5,000 USD
The maximum amount that UNHCR will pay for care to one household per year is 30,000 USD

Beneficiaries with extra protection needs:	
Certain patient categories are further supported:	
Patient category	UNHCR coverage
SGBV cases	100%
Torture cases	100%
Primary acute severe malnutrition	100%
Psychiatric patients	90%

Annex 4a) Lists of diagnoses and interventions covered and not covered

The below lists are not to be regarded as exhaustive but as guidance.

<table>
<tr><th colspan="2">Covered cases that does not require referral to UNHCR</th></tr>
<tr><td colspan="2">Deliveries and urgent life- or limb threatening conditions (if estimated total cost for care < 2900 USD) including:</td></tr>
<tr><td>Obstetrics/ Gynecology
Ectopic pregnancy
Molar pregnancy
Incomplete abortion
Ovarian cyst with torsion
Severe post-partum hemorrhage
General
Severe infections in need of i.v. antibiotic treatment
Severe anemia requiring blood transfusion
Diabetic ketoacidosis/insulin coma
Gastroenteritis with severe dehydration
Cardiac
Acute coronary symptoms
Cardiogenic shock/cardiac failure
Hypertensive emergencies
Hemodynamically unstable arrhythmias not needing pacemaker
Respiratory
Acute asthma in need of nebulization
Severe pneumonia with respiratory distress
Pulmonary edema with respiratory distress</td><td>Hemodynamically unstable pulmonary embolism
Haemo-/pneumothorax in need of drainage
Massive hemoptysis
Neurological
Meningitis
Status epilepticus
Unconsciousness
Surgical
Acute abdomen
Appendicitis
Severe acute gastrointestinal bleeding
Strangulated hernias
Acute cholecystitis or biliary duct occlusion
Urinary tract calculi with hydronephrosis or pyelonephritis
Other
Severe trauma
Fractures in need of closed reduction
Severe burns (> 10% BSA adults/5% in children)
Poisoning
Acute ophthalmic conditions threatening vision</td></tr>
<tr><td colspan="2">Non-urgent conditions:</td></tr>
<tr><td colspan="2">Undescended testes in children > 6 months old
Renal lithotripsy for stones that do not pass spontaneously
Prostate surgery when hypertrophy and catheter-demanding obstruction despite medical treatment
Inguinal/femoral hernias in girls < 16 years of age and males < 1 year of age
Thyroid surgery when radiologically proven airway obstruction or toxic and medical treatment failed
Myomas if iron deficiency anemia has required transfusion
Hydatid cysts if serology positive or recommended by infectious disease specialist</td></tr>
</table>

Covered cases/interventions that need referral to UNHCR
All cases with estimated cost > 2900 USD
All cases when uncertainty if UNHCR coverage or not
Early stage cancer for which surgery is not complicated and may significantly improve prognosis
Prematurity and other severe neonatal conditions
Congenital conditions in the neonate
Congenital heart disease
Chronic ophthalmological conditions threatening vision in patients < 18 years of age
Cardiac catheterization/stenting
Pacemaker insertion
Open heart surgery
Cerebrovascular accidents
Orthopedic surgery
Hysterectomy
Acute renal failure
Hematological urgencies demanding treatment other than transfusion
ENT surgery
Suspected or confirmed HIV
Psychiatric disorders requiring psychiatric in-patient care
Suspected cases of primary severe acute malnutrition
Suspected cases of abuse (including sexual abuse and torture)

Cases not supported by UNHCR (to be referred to other partners if support available)
General
Long term treatment for chronic conditions
Cosmetic and reconstructive surgery (including cleft lip/palate surgery)
Non-evidence based, unproven or experimental treatment
Dental care
Eye glasses
Hearing aids
Infertility treatment
Obesity surgery
Bone marrow and organ transplantation
Hemodialysis for chronic renal failure
Treatment for late stage cancers (including radiotherapy and chemotherapy)
Surgery for congenital orthopedic conditions
Specific
Chronic ophthalmological conditions in beneficiaries > 18 years of age
Antiviral therapy for hepatitis B and C
Inguinal/femoral hernias in males > 1 year without strangulation
Inguinal/femoral hernias in females > 16 years without strangulations
Umbilical/ventral hernias without strangulation
Undescended testes in boys < 6 months old
Gallbladder stones without radiological and/or laboratory proof of acute cholecystitis/gall-way obstruction or pancreatitis
Urinary tract stones likely to pass spontaneously (<6mm) and not causing hydronephrosis and/or pyelonephritis
Benign ovary cysts without torsion
Myomas not causing iron deficiency anemia and not causing mass-effect
Gynecological surgery for incontinence and prolapse
Non-cancerous thyroid tumors responding to medical treatment (in case they are toxic) and not causing compression on airways
Surgery for uncomplicated hemorrhoids or anal fissures
Surgery for benign prostate hyperplasia without urinary tract obstruction
Traffic accidents in which the injured is the driver and the owner of the vehicle involved or belong to his/her household

Annex 4b) List of orthopaedic cases covered and not covered by UNHCR

The below list is not to be regarded as exhaustive but as guidance.

N.B. that the below cases all need admission and should be referred to UNHCR for preapproval. Simple orthopedic cases (closed fractures that can be reduced in the ER) are also covered but does not need pre-approval.

Orthopedic cases supported by UNHCR
• Open fresh fractures with need for surgical intervention • Closed fractures with significant displacement requiring reduction under anesthesia • Debridement of soft tissue and bone in open wounds and fractures (Gustilo II and III) • Acute upper limb nerve injuries including those of the brachial plexus • Primary tendon repair • Acute osteomyelitis
Orthopedic cases not supported by UNHCR (to be referred to other partners if support available)
• Malalignment with acceptable function • Surgery for herniated lumbar discs (to be referred to ECC only if neurological complications) • Sciatic nerve injuries not part of an acute injury or complete nerve injury with trophic changes • Very stiff hands with intra-articular fibrosis that prevent any further improvement of the function • Cases where the nerve was explored previously and was released or repaired • Complex surgeries for reduction and fixation of old fractures, or malunion (including intra-articular) • Tendon graft or transfer • Bone transplant procedures or free vascularized grafts for bone gaps • Post-burn contracture release • Chronic osteomyelitis requiring extensive antibiotic treatment and multiple surgeries

Annex 4c) Deliveries

UNHCR Approval
Fast track PoC status determination
• In order for UNHCR to cover costs for delivery (normal vaginal delivery and C-section) the beneficiary must have an active PoC status when patient is admitted. Fast track PoC status determination cannot be offered for deliveries. • If severe complications to delivery or pregnancy (preeclampsia/eclampsia, massive post-partum hemorrhage, sepsis) care for these complications is to be covered as other life-saving intervention. I.e. in these cases fast track PoC status determination can be offered. Observe that in these cases UNHCR coverage is 75% and does not include the 100 USD threshold
C-sections
• For elective C-sections to be approved they have to be indicated and a detailed medical report must be provided accompanied by investigation results such as obstetrical ultrasound made in an independent radiology center (not by the Gyn/Obs) • Urgent C-sections can be approved urgently and investigation results can be provided in retrospect. In such cases ultrasound by the Gyn/Obs can be approved. For urgent C-section due to fetal distress a CTG print-out should be included.

Indications for C-section*	
Maternal indications	
Absolute	Relative
• Failed induction of labour • Failure to progress; labour dystocia • Cephalopelvic disproportion • 2 or more previous C-sections	• 1 previous C-Section. Note: if no other indication trial of vaginal delivery is strongly recommended • Maternal disease (cardiac, DM, cancer…) • Severe preeclampsia • Infection (genital herpes, HIV…)
Utero-placental indications	
Absolute	Relative
• large placental abruption	• previous uterine surgery (other than c-section) • placenta praevia (depending on location)
Fetal indications	
Absolute	Relative
• fetal distress, hypoxia • cord prolapse • breech presentation	• macrosomia • fetal anomaly, hydrocephalus • multiple pregnancy • fetal malpresentation

*** This list is not exhaustive and indications not on this list might also warrant UNHR supported C-sections**

Annex 4d) Neonatal care

Admission Criteria for NICU	
• Babies ≤45 days of age and any of the below: • Between 25 completed and 35 completed weeks of gestation • Birth weight less than 1.7 kgs • Birth weight more than 5 kgs • Respiratory distress • In need of resuscitation after birth or Apgar score less than 5 at 5 mins or equal to 5 at 10 mins • Congenital abnormalities likely to threaten immediate survival • Neurological abnormalities	• Suspected cardiac problems • Suspected sepsis in need of i.v. antibiotics • Jaundice in need of phototherapy or exchange transfusion • Low temperature (<36 degrees Celcius) not responding to measures available on postnatal ward • Hypoglycemia if IV therapy required • Major feeding problem and/or vomiting • Any other life threatening condition
Discharge Criteria from NICU	
• Baby weight is > 1750 and • able to maintain a normal and stable temperature in a crib • able to take all feedings by nursing, bottle or a combination • shows a consistent appropriate weight gain • is cardiorespiratory event free (no apnea, bradycardia or desaturation) • NB. If measures are taken for home care, discharge can happen without some of the above criteria fulfilled (nasogastric tube, oxygen through nasal cannula etc)	
Reasons for rejecting or discontinuing support for NICU due to poor prognosis	
• Less than 26 weeks of gestation *and* weight less than 1 kg • Severe brain injury • Serious malformation, dysplasia or genetic condition for which there is no treatment • Intensive care is futile and death is inevitable	

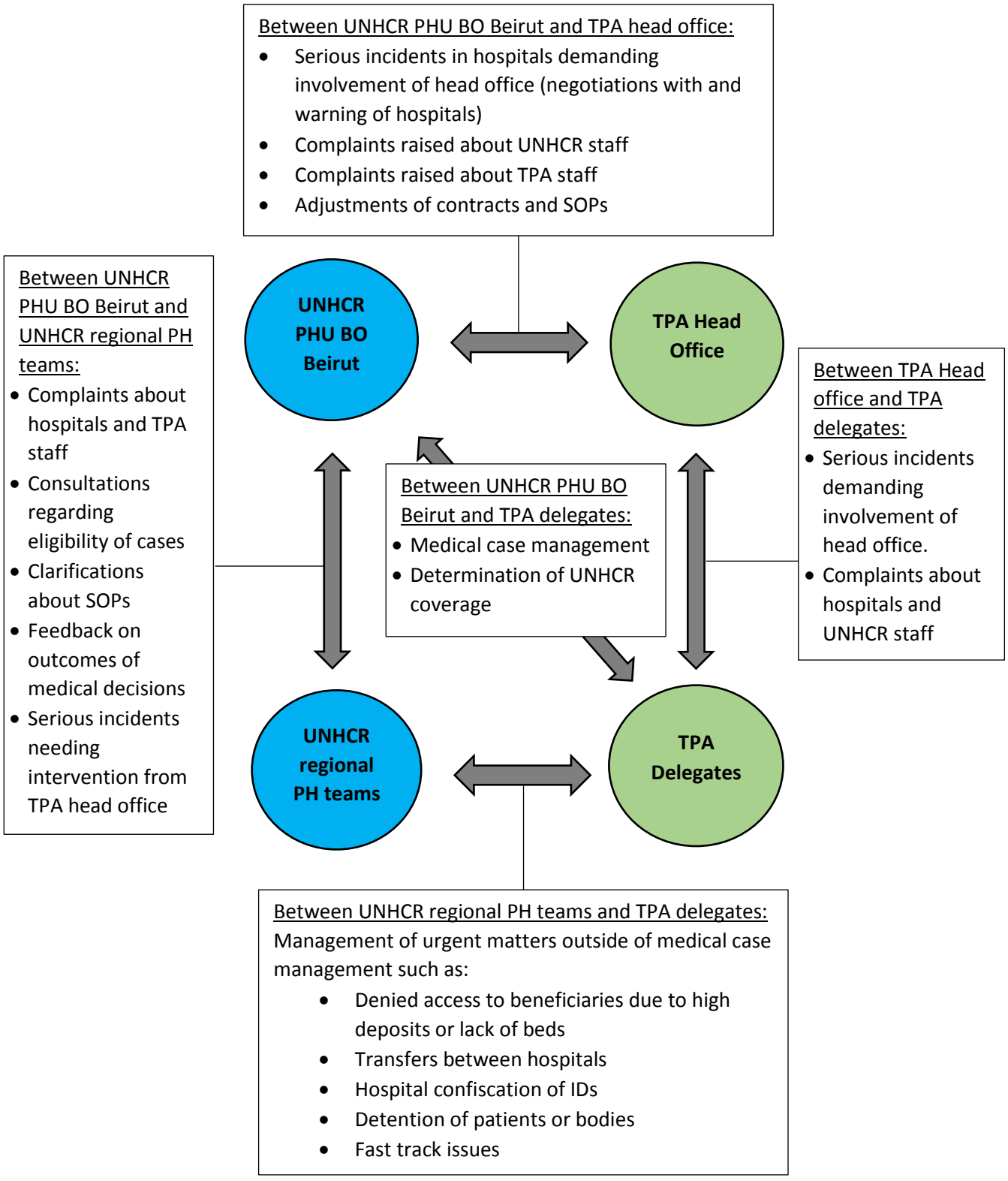
Information to be provided by treating physician for every admission to NICU:

Hospital	Patient Name	UNHCR ID	Gestational Age (weeks)	Birth Weight (g)	Apgar score at 1 min	Apgar score at 5 min	Apgar score at 10 min	NVD or C/S	Multiple pregnancy (indicate #)	Main reason for admission	Other pathology	Prognosis (good / inter-mediate / poor)	Estimated cost	Seen by TPA physician (Y/N)

Information to be provided by treating physician every week

Hospital	Patient Name	UNHCR ID	Number of weeks in NICU	Weight (g)	Stable tempera-ture (Y/N)	Able to feed bottle or breast (Y/N)	Respira-tory stable (Y/N)	Intuba-ted (Y/N)	Circula-tory stable (Y/N)	Normal neu-rology (Y/N)	On what treat-ment?	Prognosis (good / inter-mediate / poor)	Cost so far	Estima-ted total cost	Seen by TPA physician (Y/N)

Annex 5a) Communication between UNHCR and TPA



Annex 5b) Emails about case management

Medical referrals from the TPA to UNHCR can either concern:

- Approval of admission
- Approval of further intervention/investigations
- Approval of continued admission (for long admissions especially for beneficiaries admitted in NICU or the burns unit)

Emails from the TPA to UNHCR can also be about non-medical issues such as hospital detaining beneficiaries or confiscating IDs.

UNHCR is obliged to document and archive the cases in which it is involved. It is therefore important that these emails follow a certain formula.

Medical referrals

All medical referrals should be sent to the lebbeshc@unhcr.org mailbox

The subject label should always start with the region and the beneficiary's ID-number followed by a brief description of content. Examples: "BEX 123-12345678 admission for cholecystectomy" or "SOX 098-09876543 request for prolonged admission".

The email should contain a copy pasted excel row specifying TPA claim number, UNHCR ID, name, D.O.B, region, hospital, date of referral to UNHCR, type of referral[2], intervention/investigation requested, whether the beneficiary is admitted or not, date he/she was admitted and estimated cost of the admission/intervention. The copy pasted excel-row is the same for all admissions apart from NICU care which has a separate one.

Sometimes the same patient is subject for several referrals (e.g. one for request of admission, one for prolongation of admission. The subject label should then be changed so that a different thread about the beneficiary is created for that particular referral.

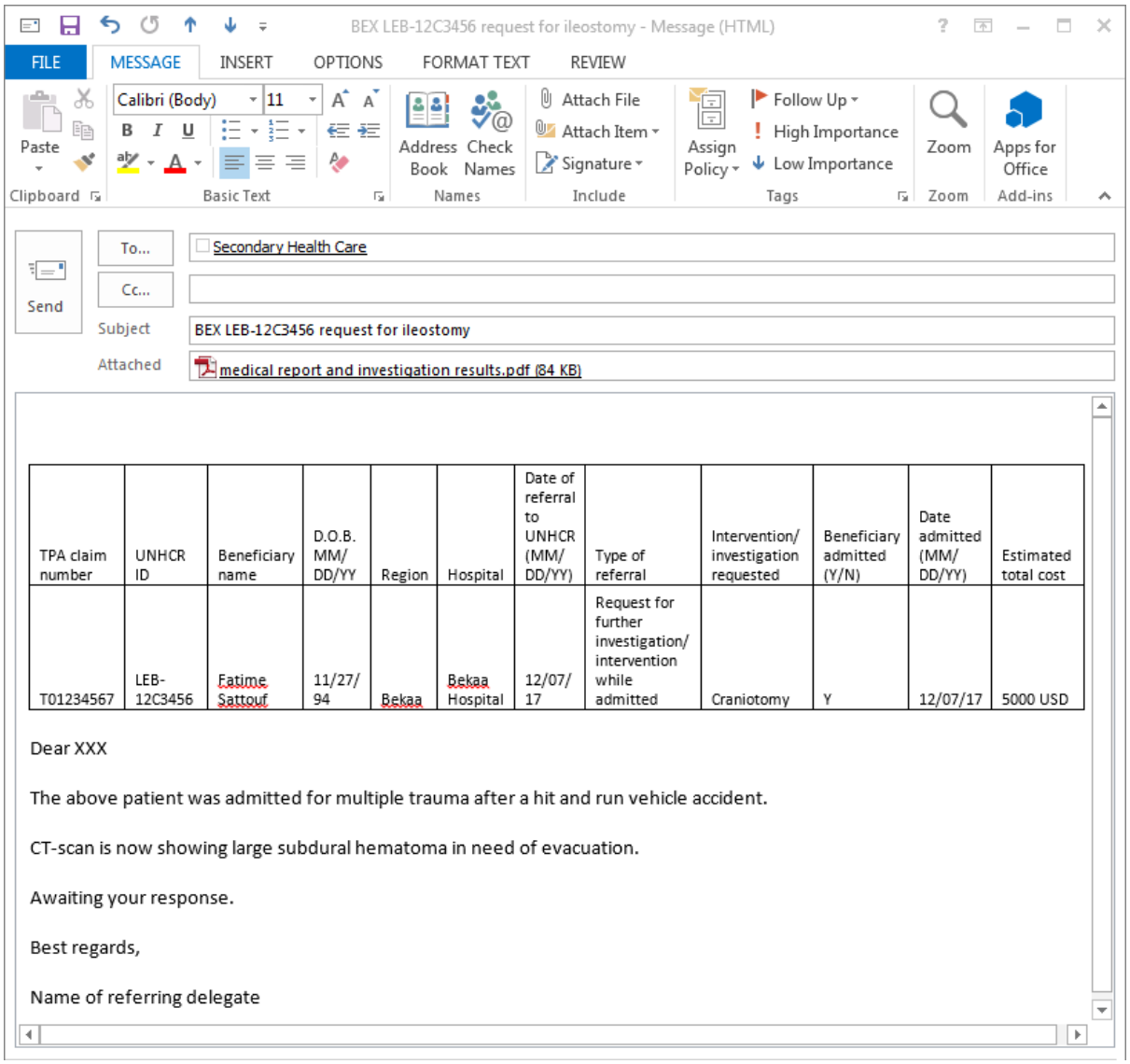
Non-medical referrals

Should not be sent to the lebbeshc@unhcr.org mailbox but to the UNHCR staff concerned. Neither should lebbeshc@unhcr.org be in CC. The subject label should follow the format above, but it is not necessary to copy paste any excel rows in these letters but it is still important that they contain enough information about the case for UNHCR to act upon it i.e. beneficiary ID, name, hospital concerned and description about the issue.

[2] Type of referral could either be:

- request for urgent admission,
- request for elective admission/intervention,
- request for further investigation/intervention while admitted or;
- request for prolongation of admission

Annex 5c) Sample email



TPA claim number	UNHCR ID	Beneficiary name	D.O.B. MM/ DD/YY	Region	Hospital	Date of referral to UNHCR (MM/ DD/YY)	Type of referral	Intervention/ investigation requested	Beneficiary admitted (Y/N)	Date admitted (MM/ DD/YY)	Estimated total cost
T01234567	LEB-12C3456	Fatime Sattouf	11/27/94	Bekaa	Bekaa Hospital	12/07/17	Request for further investigation/ intervention while admitted	Craniotomy	Y	12/07/17	5000 USD

Dear XXX

The above patient was admitted for multiple trauma after a hit and run vehicle accident.

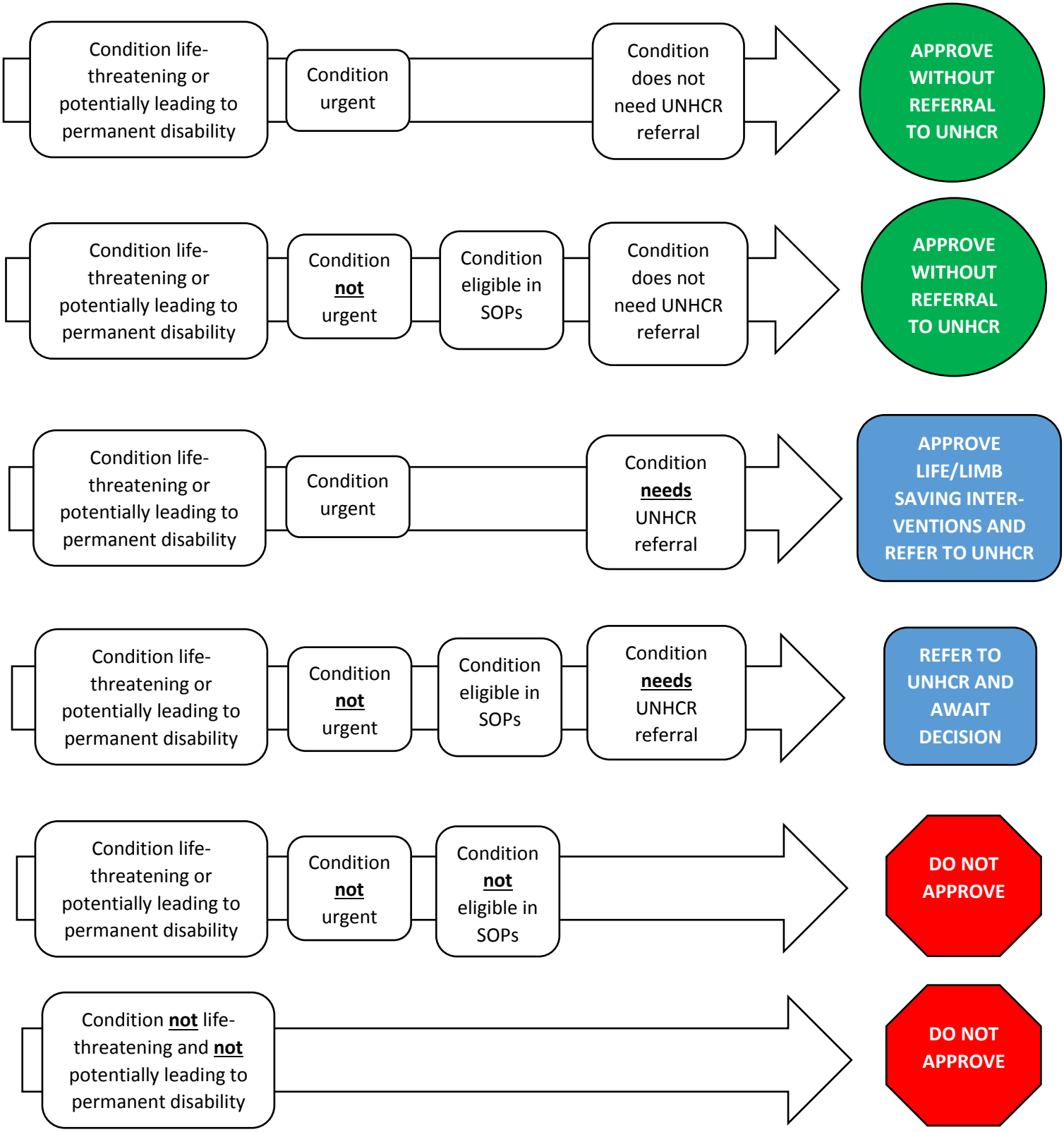
CT-scan is now showing large subdural hematoma in need of evacuation.

Awaiting your response.

Best regards,

Name of referring delegate

Annex 6) Algorithm to follow for referrals other than deliveries



Annex 7) Monitoring and Evaluation framework

There are two broad aspects of the monitoring and evaluation of the programme:

1. Monitoring of the programme through collection, analysis and reporting of data
2. Monitoring of the performance of the TPA through Key Performance Indicators monitored on an ongoing basis.

Data to be collected by TPA for the monitoring of the programme

Variable	Variable description. Options for pull down menus are in curved parenthesis {}
Unique patient id (generated by TPA system - not to be confused with hospital number)	Unique ID provided
UNHCR ID	UNHCR registration number
Full Name	Full name of patient
Gender	Gender {Male, Female}
Date of birth	Date of birth (ensure format is fixed)
Age	Age at time of referral
Nationality	Nationality of refugee {Syrian, Sudanese, Iraqi, Other}
Hospital name	Hospital or other health facility name (please use name in official list)
Region	Region where hospital is located {North, Mt Lebanon, Bekaa, Beirut, South}
Presentation date	Date patient presented to hospital
Presentation time	At what time patient presented to hospital
Delivery?	{Yes-vaginal, Yes-C-section, No}
ER case?	{Yes,No}
Estimated cost at admission	Estimated cost provided by caregiver as basis for approval in USD
Referred to UNHCCR?	{Yes, No}
Need for fast track recording?	{Yes, No}
Approved/Rejected	{Approved, Rejected}
Date of approval	Date TPA gave approval for case
Time of approval	At what time TPA gave approval to case
Reason for rejection	Reason for not approving {Not PoC, Not life or limb-saving, Not urgent, Not in SOPs, Investigation case, Third party coverage, Patient defaults[3], Other}
Main intervention	Intervention Code + Description
Discharge date	Date of discharge
Diagnosis at discharge	ICD-10
Nosocomial complication?	{No, Infection, Surgical complication, Other}
Outcome	{Death, Alive}
Reason for mortality	Description of reason for death
Hospital Bill (UNHCR Share)	USD
Hospital Bill (Patient Share)	USD
Approved Hospital Bill (UNHCR Share) after audit	USD

In order to monitor the programme and TPA performance the TPA should provide UNHCR access to their continuously updated data base that contains:

- Data related to each case managed by them. See list below

[3] Default here defined as patient self-discharges or does not show up with the consequence that a treatment that initially has been approved cannot be provided. If more than 10 days pass the case will be rejected.

- A summary of calls made to the TPA call center detailing number of received calls from beneficiaries and their length

Furthermore, the TPA is obliged to archive the medical reports for each claim that was rejected and the reason for rejection for regular auditing by the UNHCR PHU.

TPA key performance indicators

	Indicator	Target	Source	Reporting (by PHU)
Availability and responsiveness of TPA	% Beneficiaries reporting difficulties reaching or getting sufficient information from TPA	< 10%	Quarterly exit interviews	Quarterly
	% hospitals reporting difficulties reaching TPA	< 10%	Interviewing hospital staff during regular hospital visits of regional PH teams	Quarterly
	% hospitals reporting TPA delegate not in the hospital as much as they should	< 10%	Interviewing hospital staff during regular hospital visits of regional PH teams	Quarterly
Admission Process	% Urgent cases not approved within of reasonable limits.	< 10%	Control patient files during regular hospital visits of regional PH teams	Quarterly
	% TPA approvals outside of SOPs	0%	Control patient files during regular hospital visits of regional PH teams	Quarterly
	% TPA approvals of admissions without referring to UNHCR when needed	< 5%	Control patient files during regular hospital visits of regional PH teams	Quarterly
Hospital Performance	Patients reporting excessive deposits	< 10%	Quarterly exit interviews	Quarterly
	Patients reporting being overcharged	< 10%	Quarterly exit interviews	Quarterly
	Patients reporting not getting a receipt	< 10%	Quarterly exit interviews	Quarterly