PhilHealth
Your Partner in Health

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8441-7442 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

**PHILHEALTH CIRCULAR**
No. 2023 - 0014

**TO** : **ACCREDITED HEALTH FACILITIES, MEDICAL SOCIETIES, PHILHEALTH REGIONAL OFFICES, BRANCHES, LOCAL HEALTH INSURANCE OFFICES, AND ALL OTHERS CONCERNED**

**SUBJECT** : **Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG)**

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## I. RATIONALE

PhilHealth currently implements the All Case Rates (ACR) system (PhilHealth Circular No. 31 s. 2013) which is a case-based payment mechanism where accredited health facilities file individual claims per inpatient episode of care. In this current payment system, health facilities are only allowed to file claims for a maximum of two diagnosis and/or procedure codes for reimbursement for the entire episode of care for a patient, thus limiting PhilHealth coverage. Further, ACR implementation has remained unchanged since 2014.

The Universal Health Care (UHC) Act aims to improve its coverage for inpatient services by shifting PhilHealth from the ACR provider payment mechanism to Philippine Diagnosis-Related Groups (PHL-DRGs). A DRG system is also a case-based provider payment mechanism which groups together inpatient cases with similar clinical characteristics and resource use. DRGs take into account important factors in each episode of care - i.e. all relevant diagnoses and procedures, patient age, patient sex, length of stay, patient disposition, etc., which have a significant impact on the resource intensity, and the corresponding cost. As such, PhilHealth published Circular No. 2022-0016 or the "Governing Policies On Transitioning The Provider Payment Mechanism From All Case Rates To Diagnosis-Related Groups."

The implementation of the DRG system requires transition to full information technology (IT)-based platforms for electronic claims processing to realize seamless transactions between PhilHealth and all its accredited health facilities. Part of this transition is to improve the current system to (a) collect information necessary for DRG grouping, (b) have more robust data validations, and (c) allow the integration of a DRG grouper to the systems of PhilHealth and its accredited/contracted health facilities. This enhancement

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process must be accompanied by rigorous testing to ensure that all needed features work as intended before the new claims processing and reimbursement system is rolled out to all accredited health facilities, and avoid unnecessary disruptions in transactions and service delivery.

## II. OBJECTIVES

This PhilHealth Circular aims to provide guidelines on the implementation of the Shadow Billing of inpatient claims as a mechanism to live-test the entire process of the PHL-DRGs for select accredited/contracted health facilities and PhilHealth Offices.

## III. SCOPE

This PhilHealth Circular covers the implementation of live-testing of the PHL-DRGs for inpatient services through Shadow Billing among identified PhilHealth-accredited public and private inpatient health facilities. This shall be an interim mechanism which shall be done in preparation for a nationwide roll-out of DRGs.

## IV. DEFINITION OF TERMS

**A. All Case Rates (ACR)** refer to a fixed rate or amount that PhilHealth will reimburse for a specific illness/case, which shall cover for the fees of health care professionals, and all facility charges including, but not limited to, room and board, diagnostics and laboratories, drugs, medicines, and supplies, operating room fees and procedures, regardless of member category, that are admitted in accredited health care institutions.

**B. Diagnosis Codes** refer to alphanumeric codes that represent a disease or diagnosis of a patient. These are coded using the 10th edition of the International Classification of Diseases (ICD-10), taking into consideration the PhilHealth modifications introduced under DOH Department Circular number 2016-0363 entitled "2016 ICD-10 Updates".

**C. Diagnosis Related Groups (DRG) or Case-based Groups (CBG)** refer to a patient classification system which utilizes an algorithm in assigning a case to a specific group by using a special backend system called a grouper. A DRG system classifies hospital cases into groups that are clinically similar and are expected to use similar amounts of hospital resources. When used for payment, the amount per episode of care is fixed for patients within a single DRG category (based on average cost), regardless of the actual cost of care for that individual episode, but varies across DRG.

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D. **Grouper** refers to the backend system that shall classify inpatient cases into payment groups based on diagnoses, procedures rendered, patient demographics, and patient disposition (i.e recovered, improved, died, referred, home against medical advice). Each payment group will be identified by a DRG code, which shall be used to determine the corresponding payment.

E. **PhilHealth eClaims System** refers to the IT system which PhilHealth uses to collect and process claims submitted by accredited health facilities.

F. **Philippine Diagnosis-Related Groups (PHL-DRGs)** refer to the local iteration of DRGs which use the Thai DRGs as the template for development.

G. **PHL-DRG Seeker** refers to a version of the Grouper that can be made available to all health facilities to be used as a viewable reference for DRG groupings for their inpatient cases.

H. **Procedure Codes** refer to a numeric code which represents interventions done on a patient during the course of admission, whether surgical or medical. These are coded using the current relative value scale (RVS) for both ACR and Shadow Billing.

I. **Shadow Billing** refers to a process where health facilities start case reporting according to the CBG, or DRG system and the respective payment is calculated. During an agreed transition period, the actual payment still follows the previous provider payment method.[1] The detailed process of which shall be described under the policy statements of this PhilHealth Circular.

J. **Thai DRG Grouper** refers to the software Thailand uses to group patient claims data into a Diagnosis-Related Group. This shall be used as the template for the development of Philippine DRGs.

## V. POLICY STATEMENTS

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### A. Grouping of Diagnosis and Procedure Codes

1. PhilHealth, in coordination with medical societies, shall map current illness (ICD-10) and procedure (Relative Value Scale) codes to corresponding PHL-DRGs derived from the Thai DRG Grouper, following PhilHealth Board Resolution (PBR) No. 2676 s. 2021.

[1] Diagnosis-related groups (DRG): A Question & Answer guide on case-based classification and payment systems. / Aurelie Klein, Inke Mathauer, Karin Stenberg and Triin Habicht WHO/UHC/HGF/Guidance/20.10

2. PhilHealth shall adopt the grouping algorithm from the Thai DRG Grouper Version 5, as basis for subsequent development of the PHL-DRGs.
3. PhilHealth shall set a baseline for the following components of the DRG system:
   a. Base weights
   b. Relative weights
   c. Case Mix Index
   d. Weighted Activity Units
   e. Adjustment factors

4. PhilHealth shall release an Implementation Manual which shall indicate specific details on the PHL-DRGs, including the mapped diagnosis and procedure codes, the grouping algorithms, and the other components of the DRG system listed on this Circular. This shall inform and guide accredited health facilities on the implementation of PHL-DRGs.

**B. PHL-DRG IT Systems**

1. Grouper
   a. PhilHealth shall develop a PHL-DRG Grouper which shall act as the backend system that will convert each inpatient claim – complete with patient attributes and diagnosis and procedure codes – to its corresponding DRG code.
   b. The Grouper shall only convert claims that are compliant with minimum data quality requirements as set by PhilHealth.
   c. PhilHealth shall regularly update the PHL-DRG Grouper based on updated algorithms, adjustment factors, and other components of the DRGs.
   d. PhilHealth shall utilize standard security measures to protect the PHL-DRG Grouper.
   e. The PHL-DRG Grouper shall be used exclusively by PhilHealth.

2. PHL-DRG Seeker
   a. PhilHealth shall develop a PHL-DRG Seeker which shall act as the front-end system that health facilities may utilize to check the corresponding DRG for each inpatient claim.
   b. The PHL-DRG Seeker shall act as a reference platform on the PHL-DRGs for HCPs, and will not form part of the claims process of the health facilities.
   c. The utilization of the PHL-DRG Seeker shall be optional for facilities engaged to implement Shadow Billing.

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## C. Shadow Billing

1. Shadow Billing refers to a mechanism of converting the diagnosis and procedure codes filed by health facilities to the PHL-DRGs, where:
   a. Health facilities file claims and be reimbursed using the All Case Rates (ACR) system (See Annex A: Shadow Billing Design).
   b. Submitted diagnosis and procedure codes by the health facility shall be converted to their corresponding codes in the PHL-DRGs, through backend processing mechanisms following the mapping algorithm (See Annex A).
   c. This process of conversion shall inform the case mix of the health facility in relation to the PHL-DRGs, and consequently potential future payouts. It shall also provide practical information on the filing of claims with additional data requirements, and actual grouping of the codes.

2. Shadow billing shall be utilized as an interim mechanism for PhilHealth to determine the system requirements and operationalization considerations of PHL-DRGs for future nationwide implementation.
3. PhilHealth shall strictly document and troubleshoot all bugs and system errors arising from the entirety of the Shadow Billing implementation.

## D. Claims Process for Shadow Billing

1. Health facilities selected for Shadow Billing shall continue to file claims and be paid based on the ACR system as stipulated in pertinent PhilHealth Circular and its succeeding amendments.
2. The following additional rules must be be followed when filing claims:
   a. Submission of additional data requirements for DRG grouping (see Annex B: "Additional Data Requirements for eClaims" for more specific data requirements)
      a.1. All Diagnosis Codes relevant to the episode of inpatient care
      a.2. All Procedure Codes relevant to the episode of inpatient care
      a.3. Newborn Data
      a.4. Administrative Data

   b. Strengthened data validations (see Annex C: "Additional Validation Mechanisms for eClaims" for more specific data validation requirements)

3. Full electronic submission through PhilHealth's eClaims system must be followed.

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a. A data validation mechanism following the additional data points and requirements of the grouping algorithm shall be built into the eClaims system to ensure only good claims are submitted.
b. The eClaims mechanism shall be made compatible with the initial version of PhilHealth's DRG Grouper.
c. The claims submitted through PhilHealth's eClaims system shall feed directly into the DRG grouper.
d. A revised eClaims platform integrating a supplementary DRG form shall be developed for the implementation of Shadow Billing.

## E. Health Facility Engagement for Shadow Billing

1. A representative sample of accredited health facilities which fully utilize PhilHealth's eClaims system for its claims submissions shall be subject to Shadow Billing for DRGs.
2. Participation of health facilities in the Shadow Billing of DRGs shall be voluntary. Health facilities that intend to participate in the Shadow Billing of DRGs shall be subject to the following processes:
   a. Health facilities that wish to participate shall submit a letter of intent which indicates capacity and commitment to comply with implementation requirements, such as additional data requirements and new validation mechanisms set by this PhilHealth Circular. This includes the capacity to upgrade Electronic Medical Records/Health Information Systems to submit DRG data to PhilHealth.
   b. Participating health facilities are expected to attend any consultative meetings, and other meetings which PhilHealth may set before and during the implementation of Shadow Billing.

3. Participating health facilities shall have access to the results of Shadow Billing implementation specific to their facility, including the conversion of diagnosis and procedure codes to PHL-DRGs, IT system recommendations, casemix data, and other relevant analyses.

## F. Roles and Responsibilities

1. PhilHealth UHC Surge Team
   a. Lead the development of all policies relevant to the implementation of Shadow Billing of PHL-DRGs.
   b. Develop and operationalize the front-end and back-end DRG systems including, but not limited to:
      b.1. Enhanced eClaims system
      b.2. PHL-DRG Seeker
      b.3. PHL-DRG Grouper

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b.4. Rate setting protocols

c. Conduct troubleshooting for the DRG IT systems throughout the duration of Shadow Billing implementation
d. Document all implementation issues and best practices regarding the IT platforms utilized in the implementation.
e. Ensure, through the DRG Technical Working Group, that all implementation timelines are met and all outputs are accomplished. This is in accordance with Corporate Personnel Order (CPO) No. 2023-0218 (Creation of a Technical Working Group and Sub-Technical Working Groups for Transitioning All Case Rates (ACR) to Diagnosis-Related Groups Provider Payment Mechanism [Revision 1]) and its succeeding revisions.
f. Ensure PhilHealth Regional Offices are capacitated to perform their respective functions as listed in this PhilHealth Circular.
g. Assist the Standards and Monitoring Department (SMD) in all its functions listed in this PhilHealth Circular.
h. Assist the Information Technology Management Department (ITMD) in all its functions listed in this PhilHealth Circular.

2. Standards and Monitoring Department (SMD)
   a. Validate the mapping for diagnosis and procedure codes.
   b. Assist the PhilHealth UHC Surge Team in the development of the DRG manual, specifically the mapping of medical and procedure codes, and grouping algorithms.
   c. Assist in the documentation of all changes on the mapping of codes and grouping algorithms that were made before, and throughout the implementation of Shadow Billing.
   d. Perform other functions as detailed under CPO No. 2023-0218 and its succeeding revisions.

3. Information Technology Management Department (ITMD)
   a. Provide guidance and technical assistance to the UHC Surge Team in the development and operationalization of DRG systems including, but not limited to:
      a.1. Enhanced eClaims system
      a.2. PHL-DRG Seeker
      a.3. PHL-DRG Grouper

   b. Assist the PhilHealth UHC Surge Team in the troubleshooting for the DRG IT systems throughout the duration of Shadow Billing implementation.
   c. Perform other functions as detailed under CPO No. 2023-0218 and its succeeding revisions.

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d. Conduct quality assurance checks on DRG IT systems
e. Provide necessary IT access to the UHC Surge Team to enable the performance of aforementioned roles and responsibilities.

4. PhilHealth Regional Offices (PROs)
   a. Conduct troubleshooting for any administrative concerns of health facilities on Shadow Billing.
   b. Conduct troubleshooting for any concerns regarding the eClaims system.
   c. Relay concerns regarding Shadow Billing to the Head Office as necessary.

5. Medical Societies
   a. Assist SMD in the mapping of diagnosis and procedure codes.
   b. Assist the Standards and Monitoring Department in the development of the grouping algorithms for the DRGs.
   c. Educate other clinical practitioners and health facilities regarding the importance of Shadow Billing and the transition to DRGs.

### G. Monitoring and Evaluation

1. PhilHealth shall monitor and evaluate the implementation of Shadow Billing based on the following components of DRG implementation:
   a. Grouping of diagnosis and procedure codes corresponding to the All Case Rates
   b. Case mix of health facilities
   c. Variation of DRG rates in reference to ACR
   d. Transmittal of claims from the health facility to PhilHealth

## VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with the pertinent provisions of RA No. 11223 and RA No. 7875, as amended by RA Nos. 9241 and 10606, and their respective Implementing Rules and Regulations.

## VII. SEPARABILITY CLAUSE

Should any provision of this PhilHealth Circular declared invalid, unconstitutional or unenforceable in whole or part by any competent authority, it shall not affect or invalidate the remaining provisions hereof.

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## VIII. REPEALING CLAUSE

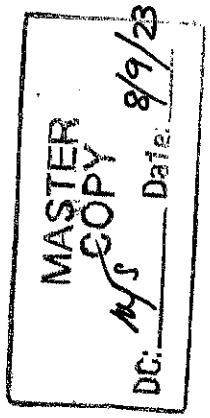
All previous issuances that are inconsistent with any provisions of this PhilHealth Circular are hereby amended, modified, or repealed accordingly.

## IX. DATE OF EFFECTIVITY

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

**EMMANUEL R. LEDESMA JR.**
Acting President and Chief Executive Officer (APCEO)

Date signed: 7/12/23



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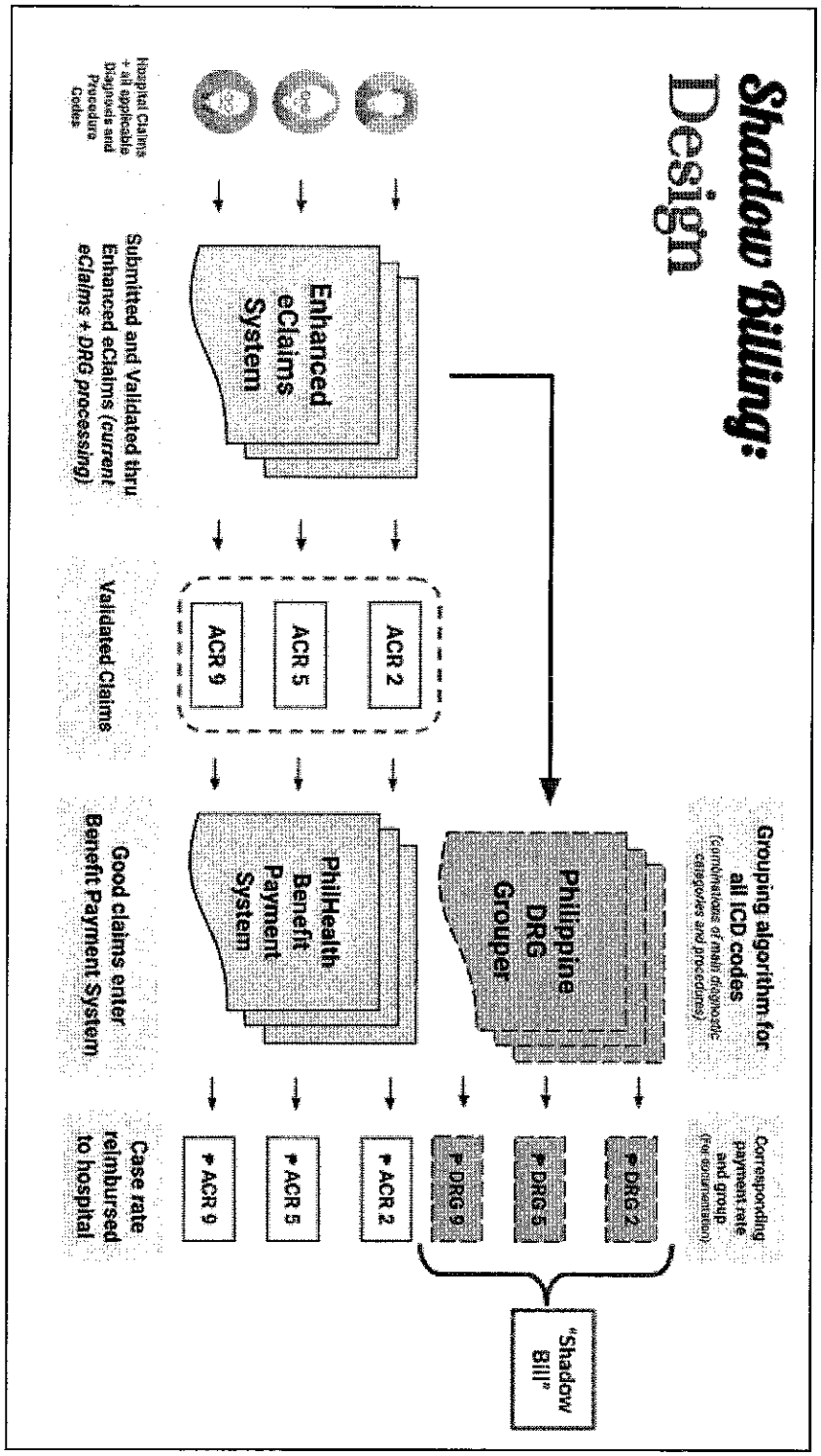
## Annex A: Shadow Billing Design

**Shadow Billing Design**



## Annex B: Additional Data Requirements for eClaims

### Additional Data Requirements for eClaims

1. Diagnosis Codes
    a. Primary diagnosis shall be required in valid ICD-10 diagnosis codes. A list of codes acceptable as primary diagnoses are indicated in the DRG Manual's list of ICD-10 diagnoses.
    b. Apart from the primary diagnosis, health facilities shall indicate all admission diagnoses and discharge diagnoses in separate, required fields.
    c. Any dagger-asterisk codes will have to be split into two codes, and entered in separate fields, where appropriate.
    d. All admission and discharge diagnoses should be listed as a valid ICD-10 code, per the list of valid diagnosis codes listed in the DRG Manual's list of ICD-10 diagnoses. Any admission and discharge diagnoses that cannot be identified with a valid ICD-10 code will not be considered for classification into payment groups.
    e. Health facilities may encode up to twelve (12) procedure codes per inpatient claim.
2. Procedure Codes
    a. Procedures shall continue to be encoded as RVS Codes.
    b. All procedures performed in an episode of care shall be entered. Health facilities may encode up to twenty (20) procedure codes per inpatient claim.
    c. All the RVS codes and their corresponding ICD-9-CM codes that are acceptable as procedure codes shall be included in the DRG Manual, which shall regularly be updated and published in official PhilHealth channels.
3. Newborn Data
    a. Birth weight and date and time of birth shall be required for all newborn patients.
    b. Birth weight shall be stated in kilograms, down to one decimal point.
    c. Date and time of birth shall be stated in "yyyy-mm-dd HH:MM (24-hour)" format.
    d. Claims for newborns with a computed age of 1 or above will not be processed.
4. Administrative Data
    a. The total health care institution fees and total professional fees, as charged by the hospital for the inpatient case, shall be declared through the Electronic Statement of Account (PhilHealth Circular No. 2023-00XX). Claims which leave both of these fields missing or with invalid values will not be processed. Invalid values are comprised of, but not be limited to:

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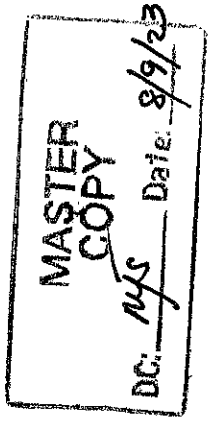
i. Negative values
ii. String values
iii. Percentages

b. A standard, machine-readable format (ie .XML format) shall be required for the Statements of Accounts to be attached to the claim. The particulars of this provision shall be detailed in a separate PhilHealth Circular.



## Annex C. Additional Validation Mechanisms for eClaims

### Additional Validation Mechanisms for eClaims

Claims that fail to follow even one of the rules will be automatically rejected:

*Patient Information*

1. Patient "sex" shall have valid entries in the DRG Claim Form.
2. Time of birth shall be indicated for newborns.
3. Computed age shall be between 0 days and 124 years.

*Confinement Information*

1. "Primary diagnosis" shall not be left blank and shall be an acceptable primary diagnosis in the official list of ICD-10 codes in the DRG Manual.
2. The computed age and "sex" of the patient shall be appropriate to the primary diagnosis, admission and discharge diagnosis, and all listed procedures. The acceptable computed age and "sex" of the patient for each diagnosis and procedure code is also indicated in the DRG Manual's list of diagnoses.
3. All listed admission and discharge diagnoses shall be part of the list of codes in the Philippine ICD-10 Modifications.
4. There shall be no duplicates among the list of admission and discharge diagnoses.
5. All procedure codes listed in the claim form shall be a valid RVS code. All valid codes and corresponding ICD-9 CM counterparts shall be indicated in the DRG Manual.
6. Patient disposition upon discharge shall be filled in accordingly with strictly one entry per patient, and it shall not be left blank.
7. There shall be at least six (6) hours between the patient admission date-time and the discharge date-time for all inpatient cases.
8. If the patient is a newborn (computed age is below 0 years), both birth weight (in kilograms) and date and time of birth shall be filled in accordingly and not left blank.
9. Any and all OR procedures listed shall be related to the Major Diagnostic Category (MDC) of the primary diagnosis. The DRG Manual shall indicate the MDC which corresponds to each diagnosis and each OR procedural code.
10. Laterality shall be indicated for applicable diagnoses, and procedures.