PhilHealth
Your Partner in Health

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PHILHEALTH CIRCULAR
No. 2023 - 0027

TO : **ALL ACCREDITED HEALTHCARE FACILITIES AND PROFESSIONALS, PHILHEALTH REGIONAL OFFICES, AND ALL OTHERS CONCERNED**

SUBJECT : **Implementing Guidelines on the Case Rates for Pneumonia High-Risk**

I. RATIONALE

Among the top causes of mortality in the Philippines in 2020, pneumonia was the 5th leading cause of death across all ages[1] and the most common cause of death in children below five years of age.[2] Local data from 2012 shows that the economic burden of community-acquired pneumonia high-risk (CAP-HR) was Php643.76 million.[3] Moreover, PhilHealth has not adjusted its payment rates for pneumonia high-risk since the All Case Rates (ACR) implementation in 2014, leading to discrepancies between the estimated healthcare cost of hospitalization and PhilHealth's inpatient case rates. Limited financial coverage for pneumonia high-risk contributes to uncontrolled out-of-pocket (OOP) expenditures.

As part of PhilHealth's financing reforms under Republic Act (RA) No. 11223, otherwise known as the Universal Health Care Act, alongside the shift to a new provider payment mechanism, i.e., from All Case Rates (ACR) to diagnosis-related groups (DRG), conditions for improving financial coverage and protection against catastrophic healthcare expenditure during illness are now being prioritized. Thus, the PhilHealth Board approved Board Resolution No. 2802, S.2023, which increases the package amount of the case rates for pneumonia high-risk as part of the ACR rationalization.

II. OBJECTIVES

This PhilHealth Circular provides the policies and procedures for implementing the case rates for pneumonia high-risk to ensure quality healthcare delivery by accredited health facilities (HF).

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[1] Philippine Statistics Authority. (2021, March 16). Causes of Deaths in the Philippines (Preliminary): January to December 2020 [Press Release]. psa.gov.ph.
[2] Santos, J. A. (n.d.). A Review of Pneumonia in the Philippines. Pediatric Infectious Disease Society of the Philippines Journal, 22(July-December 2021), 6-11. https://www.pidsphil.org/home/wp-content/uploads/2021/09/003_vol-22-no-2_SANTOS_PNEUMONIA.pdf
[3] Tumanan-Mendoza BA, Mendoza VL, Punzalan FER, Reganit PFM, Bacolcol SAA. Economic Burden of Community-Acquired Pneumonia among Adults in the Philippines: Its Equity and Policy Implications in the Case Rate Payments of the Philippine Health Insurance Corporation. Value Health Reg Issues. 2015 May;6:118-125. doi: 10.1016/j.vhri.2015.03.003. Epub 2015 May 16. PMID: 29698182.

III. SCOPE

This PhilHealth Circular shall apply to all accredited HFs that provide inpatient services for pneumonia high-risk, PhilHealth Regional Offices (PRO), and all others involved in the implementation.

IV. DEFINITION OF TERMS

A. **All Case Rates (ACR)** - refer to PhilHealth's mechanism of paying for inpatient care through a case-based provider payment system.

B. **ACR Rationalization** – refers to PhilHealth's interim strategy to improve financial coverage for selected/priority conditions based on the volume of claims, disease burden, and support value until PhilHealth fully implements DRG as a provider payment mechanism for inpatient services.

C. **Bottom-Up Costing** - refers to a cost calculation method that considers the individual components and activities of delivering a healthcare service and analyzes its various elements separately, such as personnel, medical supplies, equipment, overhead expenses, and administrative costs, to determine the cost incurred for that specific component.

D. **Case-Based Provider Payment Mechanism** – refers to a provider payment system in which a hospital is reimbursed for each discharged patient at pre-determined rates based on the type of case or for groups of cases, with similar clinical profile and resource requirements.

E. **Community-Acquired Pneumonia (CAP)** - refers to acute infection of the lungs acquired outside of hospital settings.

F. **Co-Payment** - refers to a predetermined amount agreed upon by the accredited HF and PhilHealth chargeable to patients to cover the share for amenities, choice of physician, or any additional or upgrade of services during the episode of inpatient care.[4] Co-payment is an example of an out-of-pocket payment or cost-sharing mechanism intended to share the cost of healthcare between the insured and the insurer.

G. **Diagnosis-Related Groups (DRG)**[5] - refer to a patient classification and provider payment system that groups patient cases, including services received, into standardized case groups according to diagnosis and treatment or procedure received. It combines clinical logic with

[4] PhilHealth Circular No. 2021-0022. The Guiding Principles of the Z Benefits (Revision 1)
[5] PhilHealth Circular No. 2020-0016. Governing Policies on the Transitioning the Provider Payment Mechanism (PPM) from All Case Rates (ACR) to Diagnosis-Related Groups (DRG)

economic logic that classifies hospital cases into groups that are clinically similar and are expected to have similar hospital resource use.

H. **Fixed Co-Payment** - refers to a flat-rate co-payment as a cost-sharing arrangement, that is, a predetermined, fixed amount of out-of-pocket that remains the same regardless of the total cost of the service.

I. **Minimum Standards of Care** - refer to essential services that HFs are obliged to provide based on clinical practice guidelines or current best practices in the local setting.

J. **Non-Basic Accommodation** [6] – refers to the provision of the minimum standards of care for patients, and includes fringe and/or additional amenities provided by the facility at the option of the patient.

K. **Out-of-Pocket Payment (OOP)** - refers to the balance of healthcare provider charges that are paid directly by the patients from their own resources or cash reserves or health spending made directly from households to providers.

L. **Pneumonia High-Risk** - refers to a subset of pneumonia cases with a higher likelihood of complications, severe illness, potentially adverse outcomes, or pneumonia-related mortality. Some factors contributing to pneumonia high-risk include underlying health conditions (i.e., diabetes, heart disease, COPD), extremes of age because of weakened immune systems, compromised immune systems due to medications or medical conditions, microbiologic factors, the extent of lung involvement, healthcare setting, etc.

M. **Published Case Rate** – refers to the fixed, predetermined rate or amount that PhilHealth will reimburse for the condition, which shall cover the fees of healthcare professionals and all facility charges, including but not limited to room and board, diagnostic imaging procedures, laboratory/chemistry tests, drugs, medicines, devices, supplies, operating room fees, infection control, healthcare worker salary, and other service fees. The case rate is not a cap but reflects the average cost of treating an episode of care. It may differ from the actual hospitalization charges indicated in the statement of account (SOA). The actual costs of care per patient can be higher or lower than the case rate. Therefore, PhilHealth retains the flexibility to adjust payment rates based on the services covered and the efficiency of healthcare providers in delivering quality care.

N. **Top-Down Costing** - refers to a cost accounting method adopted by PhilHealth that involves estimating the overall budget for the HF or healthcare organization and then breaking it down into various cost centers, such as different departments, clinics, or service lines. The

[6] DOH AO No. 2021-0015. Standards on Basic and Non-basic Accommodation in All Hospitals

allocation of costs to these individual cost centers can be based on revenue, patient volume, or historical cost patterns. This method allows PhilHealth to determine areas of high or low cost or high- or low-intensity use of resources in the HF.

V. POLICY STATEMENTS

A. PhilHealth identified pneumonia high-risk as one of the priority conditions in rationalizing the ACR to improve financial coverage while transitioning its provider payment mechanism to DRG.

B. PhilHealth utilizes a case-based provider payment mechanism to reimburse HFs for the minimum standards in delivering services in a basic or ward accommodation.

C. PhilHealth's case-based reimbursement system for the ACR intends to promote efficiency, cost containment, and quality of care by providing a fixed payment for a specific case or episode of care where HFs deliver services in a more coordinated and streamlined manner to manage resources efficiently and focus on achieving positive patient outcomes rather than simply providing more services. Overall, PhilHealth's case-based provider payment system aims to align financial incentives with the efficient and effective delivery of services.

D. The minimum standards of care recommendations from clinical practice guidelines (CPG) disseminated by the World Health Organization (WHO), Department of Health (DOH), local medical societies, and other guideline sources, which are critically appraised and validated by current best practices in the local setting, are PhilHealth's basis for service coverage and costing analyses.

E. PhilHealth utilizes a combination of top-down and bottom-up costing methodologies to update the case rates using hospital data and information on professional fees submitted by accredited HFs.

F. Any proposal for PhilHealth coverage to include new technologies, such as drugs/medicines and biologicals not listed in the latest Philippine National Formulary (PNF), diagnostic procedures, surgical interventions, and other treatment interventions, shall consider the Health Technology Assessment Council (HTAC) recommendation.

G. PhilHealth highly encourages continuous quality improvement initiatives to promote the quality of healthcare delivery in the Philippines, according to global best practices and collaboration efforts to standardize local practice and improve access to quality services delivered by accredited HFs.

H. PhilHealth shall engage key stakeholders to promote a deeper understanding of the ACR as a case-based provider payment system, which has critical implications for claims processing, quality of care evaluation, and payment audit.

I. Services beyond the minimum standards of care in non-basic accommodation, such as amenities, choice of physician, upgrade of services, or additional services unrelated to the episode of care, shall be subject to co-payment, which shall be thoroughly discussed with the patient as part of full informed consent by the attending physician/s who should properly inform patients of the essential services for the management of pneumonia high-risk as part of informed consent.

As out-of-pocket may also come from purchases outside of the hospital, all accredited HFs should ensure that they maintain the minimum stock levels of essential and/or life-saving medicines and supplies at all times for the timely delivery of quality healthcare services.

J. PhilHealth reiterates Chapter III, Sec. 9, of RA 11223, that PhilHealth members shall not be charged co-payment for standard services rendered in basic or ward accommodation. Claims with copayment or OOP payment incurred by patients in basic or ward accommodations, as indicated in the SOA, shall be denied.

K. As stipulated in the UHC Act, Chapter IV, Sec. 18(b), there will be no differentiation between facility and professional fees. PhilHealth shall credit all payments to the account of the accredited HFs. It is the sole responsibility of the HF to distribute the professional fees (PF) to the attending physicians or the health workers in the case of government HFs based on their internal agreements and processes.

L. PhilHealth shall closely monitor claims for pneumonia high-risk, conduct regular utilization reviews, and strongly urge its accredited HFs to strictly audit their cases of pneumonia high-risk.

M. Accredited HFs should follow and adhere to CPGs and clinical pathways applicable in the local setting in managing cases of pneumonia high-risk and ensure adherence by medical professionals who are appropriately credentialed and privileged to practice in the HFs and all hospital staff in charge of patients with pneumonia high-risk.

N. Accredited HFs that do not have the service capability for managing pneumonia high-risk shall properly coordinate and facilitate the timely referral of patients after providing standard emergency and life-saving measures to higher-level HFs.

O. Benefits for Pneumonia High-Risk

1. As Chapter II, Sec. 5 of RA No. 11223 stipulates, "Every Filipino citizen shall be automatically included in the NHIP," thus, they are eligible to avail of the case rates for pneumonia high-risk. PhilHealth reiterates further that it does not require a printed copy of the member data record (MDR) for claims submission. All accredited HFs should deduct PhilHealth benefits any day of the week upon patient discharge.

2. Accredited HFs shall ensure delivery of the minimum standards of care for managing pneumonia high-risk according to CPG recommendations applicable in the local setting, including the availability of drugs and medicines, functioning radiologic equipment and other types of equipment, timely laboratory chemistry services, and the appropriate human resources.

3. The ICD-10 Codes, Descriptions, and Corresponding Package Rate

ICD-10 Codes	Descriptions	Package Rate (Php)
B20.6	HIV disease resulting in *Pneumocystis carinii* pneumonia	90,100
J12.03	Adenoviral pneumonia, high risk	
J12.13	Respiratory syncytial virus pneumonia, high risk	
J12.23	Parainfluenza virus pneumonia, high risk	
J12.33	Human metapneumovirus pneumonia, high risk	
J12.93	Viral pneumonia, high risk	
J13.3	Pneumonia [bronchopneumonia]due to Streptococcus pneumoniae, high risk	
J14.3	Pneumonia [bronchopneumonia] due to *Haemophilus influenzae*, high risk	
J15.03	Pneumonia due to *Klebsiella pneumoniae*, high risk	
J15.13	Pneumonia due to *Pseudomonas*, high risk	
J15.23	Pneumonia due to staphylococcus, high risk	
J15.33	Pneumonia due to streptococcus, group B, high risk	
J15.43	Pneumonia due to other streptococci, high risk	
J15.53	Pneumonia due to *Escherichia coli*, high risk	

ICD-10 Codes	Descriptions	Package Rate (Php)
J15.63	Pneumonia due to other aerobic gram-negative bacteria; Pneumonia due to *Serratia marcescens*, high risk	
J15.73	Pneumonia due to *Mycoplasma pneumoniae*, high risk	
J15.93	Bacterial pneumonia [bronchopneumonia], high risk	
J16.03	Chlamydial pneumonia, high risk	
J18.03	Bronchopneumonia, high risk	
J18.13	Lobar pneumonia, high risk	
J18.23	Hypostatic pneumonia, high risk	
J18.93	CAP-high risk, as described in the most recent updates from: 1. Philippine Clinical Practice Guidelines on the Diagnosis, Empiric Management, and Prevention of Community-Acquired Pneumonia in Immunocompetent Adults 2. Clinical Practice Guidelines in the Evaluation and Management of Pediatric Community-Acquired Pneumonia, 2021	
J18.99, Y95	Nosocomial pneumonia	

Table 1: ICD-10 Codes, Descriptions, and Package Rate for Pneumonia High-Risk

P. Claims Filing

1. Accredited HFs shall strictly follow current PhilHealth policies on claims submission, including correct ICD coding of the primary diagnosis and/or procedure coding, submission of properly accomplished PhilHealth claims forms (CF), SOA, and other data and documentary requirements as stipulated in existing policies.

2. Accredited HF filing a claim for pneumonia high-risk shall submit the patient's radiographic result as an attachment to the required claim forms during admission, including the repeat radiographic result, as necessary.

3. Accredited HFs shall follow all relevant laws, such as RA No. 9994 or the Expanded Senior Citizens Act of 2010 and RA No. 10754 or the Benefits and Privileges of Persons with Disability, including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on Joint Administrative Order No. 2020-0001, entitled "Operational

Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients," pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act of 2019."

With this, PhilHealth benefits and all mandatory discounts provided by law, such as, but not limited to, senior citizen and PWD discounts, shall be deducted first from the total hospital bill of the patient. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall be applied after PhilHealth deductions and complement the PhilHealth benefits packages.

4. The case rates for pneumonia high-risk shall not be claimed as a "second" case rate.

5. Accredited HFs shall properly indicate the OOP and/or co-payment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption of Benefits," and in the SOA.

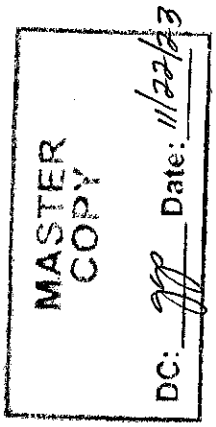
6. Accredited HFs shall file all claims to PhilHealth within the prescribed filing period of sixty (60) calendar days. Direct filing by members/beneficiaries is discouraged.

7. Rules on late filing shall apply, except when the delay in the filing of claims is due to natural calamities or other fortuitous events, where the existing guidelines of PhilHealth on the provision of special privileges to those affected by fortuitous events shall apply.

8. Accredited HFs may file a motion for reconsideration (MR) and appeal for claims denied by PhilHealth following existing policies.

9. PhilHealth shall process and pay claims for confinement abroad based on the remaining balance not covered by any additional insurance or incurred as out-of-pocket expenses but not exceeding the published case rates provided within the policy.

Q. Claims Evaluation and Payment



1. PhilHealth shall reimburse its accredited HFs the published case rates for pneumonia high-risk using a case-based provider payment mechanism based on the minimum standards of care in a basic or ward accommodation. Any amount declared in the SOA that is below or above the published case rates shall not be interpreted as over or underpayment.

2. PhilHealth reserves the right to subject any or all claims to billing audit before and/or after payment or reimbursement of its accredited HFs, following existing guidelines.

3. PhilHealth shall apply the "return to hospital (RTH)" policy for claims documents with incomplete requirements, discrepancies in the supporting documents or attachments, or incompletely filled-out claims forms for compliance within the prescribed period.

4. PhilHealth shall pay accredited HFs that do not have the service capability of managing pneumonia high-risk patients that subsequently refer and transfer patients for further management to higher level HFs at a package rate of four thousand pesos (Php4000) following the guidelines for the Referral Package in PhilHealth Circular (PC) No. 0035, s. 2013 (ACR Policy No.2—Implementing Guidelines on Medical and Procedures Case Rates).

5. PhilHealth shall process claims of accredited Level 1 HFs, including HFs in geographically isolated and disadvantaged areas (GIDA) that managed pneumonia high-risk patients and established the diagnosis solely based on the patient's clinical signs and symptoms in the background of risk factors, following the reimbursement rate of Php32,000, subject to pre-payment audit. Accredited HFs should have the appropriate service capability or level of care to manage patients with a higher likelihood of complications, severe illness, potentially adverse outcomes, or pneumonia-related mortality in delivering the standards of care for pneumonia high-risk. PhilHealth strongly encourages Level 1 HFs to establish their process for timely and coordinated patient referrals to provide quality healthcare services to achieve good outcomes.

6. PhilHealth shall process claims of accredited primary care facilities and infirmaries that provided services for patients with pneumonia moderate to high-risk and that established the diagnosis of pneumonia moderate to high-risk solely based on the patient's clinical signs and symptoms in the background of risk factors shall be reimbursed a package rate of Php15,000, subject to pre-payment audit.

7. Claims for pneumonia high-risk with a length of stay (LOS) of less than 24 hours because of patient death shall be paid by PhilHealth at a package rate of four thousand pesos (Php4,000) using the Package Code P0000.

8. PhilHealth shall pay claims of accredited HFs for pneumonia high-risk with a final disposition of "died" with LOS more than 24 hours up to two (2) days indicated in CF2 following the reimbursement rate of Php32,000.

9. PhilHealth shall not reimburse pneumonia high-risk inpatient confinements of 2 days or less with a patient disposition of "improved" indicated in CF 2 upon hospital discharge. HFs should accurately report the patient discharge disposition and the correct ICD code for the diagnosis.

R. Marketing and Promotion

PhilHealth shall conduct communication and social marketing activities to educate healthcare providers and the public in increasing their awareness of the case rates for pneumonia high-risk following the current Social Marketing and Communication Plan (SMCP).

S. Monitoring

PhilHealth shall enforce current policies and guidelines on monitoring the performance of accredited HFs in implementing the case rates for pneumonia high-risk and establish strict control mechanisms to ensure quality delivery of services and prevent adverse provider behaviors and insurance fraud.

T. Policy Review

PhilHealth shall conduct a policy review of the case rates for pneumonia high-risk in parallel to the development and transition to the DRG provider payment mechanism in collaboration and consultation with key stakeholders.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized following the pertinent provisions of RA 11223 (Universal Health Care Act), other relevant laws, and RA 7875, as amended by RA Nos. 9241 and 10606 (National Health Insurance Act of 2013), and their respective Implementing Rules and Regulations.

VII. TRANSITORY CLAUSE

While PhilHealth is developing the policy on cost-sharing (i.e., co-payment and co-insurance), accredited HFs shall set the co-payments of patients admitted in non-basic accommodation that shall not exceed the published case rates and fully inform patients of this cost-sharing arrangement. In cases of co-payment or OOP payment beyond the published case rates incurred by patients in non-basic accommodations as indicated in the SOA, these claims shall be processed and subjected to a post-payment audit following existing monitoring guidelines.

VIII. SEPARABILITY CLAUSE

In the event that a part or provision of this PhilHealth Circular is declared unconstitutional or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. REPEALING CLAUSE

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

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect after fifteen (15) days following the completion of its publication in a newspaper of general circulation. Three (3) certified copies shall thereafter be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

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

Date signed: 11/28/2023