



Republic of the Philippines  
**PHILIPPINE HEALTH INSURANCE CORPORATION**  
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**PHILHEALTH CIRCULAR**

No. 2024-0005

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

**SUBJECT :** Quality Policy on the Diagnosis and Management of Pediatric Community Acquired Pneumonia (PCAP) as Reference by the Corporation

**I. RATIONALE**

Republic Act (RA) No. 11223 or the “Universal Health Care (UHC) Act” provides that the Corporation shall support the implementation of standards for clinical care set forth by the Department of Health (DOH) based on approved clinical practice guidelines. Further, the revised Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA No. 7875 as amended by RA Nos. 9241 and 10606) under Title V (Quality Assurance and Accreditation) Rule 1 (Quality Assurance) Section 51 provides the implementation of quality assurance standards as reference for ensuring quality of care services.

Pneumonia is the leading infectious cause of death among children worldwide. The disease is a consequential burden among household everywhere. In PhilHealth claims, pneumonia moderate and high risk (adult and pediatric) remains as one of the top ten medical cases reimbursed for more than 10 years (PhilHealth Stats and Charts CY 2009-2023). Thus, the development of a quality policy on the diagnosis and management of pneumonia in children is vital in providing evidence-based information that is in accordance with current available scientific evidence and/or expert opinion. It shall be used as a reference guide for all accredited health care providers in ensuring quality of care relative to claims and related activities of the Corporation.

The policy statements in this document was largely based on the 2021 Clinical Practice Guidelines in the Evaluation and Management of Pediatric CAP by the Philippine Academy of Pediatric Pulmonologist (PAPP) and Pediatric Infectious Disease Society of the Philippines (PIDSP). The same groups were also consulted as well as the Philippine Pediatric Society (PPS). Further, this evidence-based quality policy was approved by the PhilHealth Quality Assurance Committee (QAC) as

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reference in ensuring quality of care, educational resource, performance monitoring, among others.

## II. OBJECTIVES

This PhilHealth Circular aims to establish standard of care in the diagnosis and management of pneumonia in children in line with the Quality Assurance Program of the Corporation.

## III. SCOPE

- A. This PhilHealth Circular shall serve as reference for all accredited health care providers (HCPs) and PhilHealth Regional Offices (PROs) pertaining to the diagnosis and management of Pediatric Community Acquired Pneumonia in ensuring quality of care relative to claims.
- B. This policy shall be applicable for pediatric patients who are hospitalized due to pneumonia.

## IV. DEFINITION OF TERMS

- A. **Pediatric Community Acquired Pneumonia**<sup>1</sup> – lower tract respiratory infection that affects in children who has not resided in health care facility or hospital.
- B. **Pneumonia**<sup>2</sup> - an acute lung infection involving the lung alveoli (air sacs) and can be caused by infectious agents, such as bacteria, viruses, or fungi.<sup>1</sup>

## V. POLICY STATEMENTS

### A. Clinical Diagnosis

1. A child who presents initially with the following signs and symptoms may be evaluated for possible presence of pneumonia:
  - a. Cough
  - b. Fever
2. The following clinical signs may also be sought:
  - a. Tachypnea (Rapid Respiration)

1 <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2795279/>

2 <https://www.who.int/news-room/fact-sheets/detail/pneumonia>

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Age	Breath per minute (bpm)
3 to 12 months old	≥50 breaths per minute
>1 to 5 years old	≥40 breaths per minute
>5 to 12 years old	≥30 breaths per minute
>12 years old	≥20 breaths per minute

Table 1: Age-specific criteria of tachypnea

b. Other respiratory signs such as:

- b.1. Cyanosis/Hypoxemia
- b.2. Head bobbing
- b.3. Chest indrawing/Retractions
- b.4. Apnea
- b.5. Grunting

3. Auscultatory of the lungs:

- a. Decreased breath sounds
- b. Crackles or Rales
- c. Wheezes
- d. Rhonchi

B. Diagnostics

The following diagnostic aids may be requested for a patient being managed in a hospital setting:

1. Chest x-ray is highly recommended as first-line aid for patient with pediatric community acquired pneumonia (PCAP). A repeat chest x-ray on the 3<sup>rd</sup> hospital day is recommended with an initial normal chest radiographic findings.
2. Point of care chest ultrasonography (POCUS) if available, may be recommended for patient with severe pediatric community acquired pneumonia (PCAP). Due to its advantages in terms of point of care, less cost than chest radiograph, free from ionizing radiation and it can be done to sleeping patients.
3. Complete Blood Count (CBC), Arterial Blood Gas (ABG), and serum electrolytes may also be requested based on necessity of clinical assessment.
4. C-Reactive Protein (CRP) and Procalcitonin (PCT) if available, may be recommended in evaluating for suspected severe pediatric community acquired pneumonia (PCAP).

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### C. Hospital Admission

A patient may be classified according to pneumonia risk classification scheme to identify patients who are at risk for mortality from the illness, thus aid in decision-making for hospital admission, to wit:

1. A pediatric patient initially classified as PCAP A or B (non-severe) with low risk for pneumonia-related mortality may be treated in an outpatient basis but if after 48 hours still without improvement or with signs of clinical deterioration:
  - a. Hypoxemia
  - b. Retractions/Chest indrawing
  - c. Grunting
  - d. Pallor
  - e. Altered sensorium or
  - f. Inability to drink/feed/take oral medications OR
  - g. Comorbidities that can worsen the clinical status, patient should be admitted to a hospital for close observation and monitoring.
2. For a patient classified as PCAP C or D (severe) with high risk for pneumonia related mortality, the presence of one (1) clinical or ancillary parameter is enough basis for admission (Annex A: Risk Classification for Pneumonia-related Mortality).

### D. Empiric Treatment for Suspected Bacterial Etiology

Empiric treatment with antimicrobial, based on appropriate dosage, should be administered when bacterial etiology is strongly considered (Annex B: Bacterial Medications).

### E. Treatment for Suspected Viral Etiology

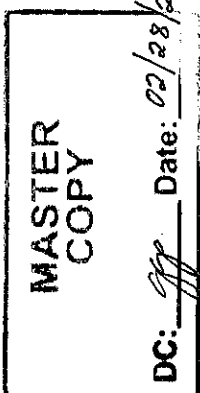
Oseltamivir is highly recommended to start immediately within 36 hours of laboratory confirmed influenza infection (Annex C: Viral Medications).

### F. Hospital Discharge

Patients with sustained stable vital signs for the immediate past 24 hours, who has the ability to maintain oral intake, and does not require oxygen support may be discharge from the hospital. An appropriate follow-up care should be arranged with patient and/or parents/guardian (for young children 18 years old and below).

### G. Monitoring and Evaluation

1. The health care provider shall be bound by the provisions of the Performance Commitment and subject to the rules on monitoring and evaluation of performance as provided in PhilHealth Circular No. 2018-0019 Health Care Provider Performance Assessment System (HCP-PAS) rev.2.
2. Standards of care issued by authorized agencies/organizations shall be regularly monitored. As deemed necessary, a revision of the quality policy



shall be made. Any updates, as a result of the review, shall be disseminated in another PhilHealth Circular.

**VI. PENALTY CLAUSE**

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

**VII. SEPARABILITY CLAUSE**

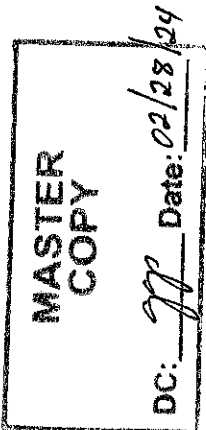
In the event that any part or provision of this PhilHealth Circular is declared unauthorized or rendered invalid by any court of law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

**VIII. DATE OF EFFECTIVITY**

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

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

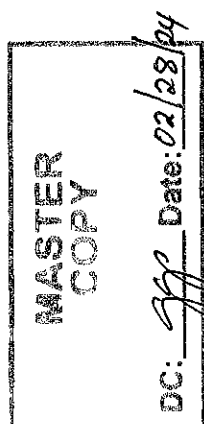
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## Annex A: Risk Classification for Pneumonia-related Mortality

### Risk Classification for Pneumonia-related Mortality

Clinical Parameters	PCAP A or B (non-severe)	PCAP C or D (severe)
<b>1. Respiratory Signs</b>		
a. Cyanosis/Hypoxemia	None	Present
b. Head bobbing	None	Present
c. Chest indrawing/ Retractions	None	Present
d. Apnea	None	Present
e. Grunting	None	Present
<b>2. Central Nervous System Signs</b>		
a. Altered Sensorium	None or Irritable but Consolable	Lethargic/Stuporous/Comatose/GCS < 13
b. Convulsion	None	Present
<b>3. Circulatory Signs</b>		
a. Poor Perfusion	None	Capillary refill >3s or in shock
b. Pallor	None	Present
<b>4. General Considerations</b>		
a. Malnutrition	None or Mild	Moderate to Severe
b. Refusal or Inability to drink/feed/take oral medications	No	Yes
c. Dehydration	None	With some to severe signs
d. Age < 6months	No	Yes
<b>5. Ancillary Parameters</b> (desirable variables but not necessary as determinants for admissions at site of care)		
a. Chest Radiograph or ultrasound findings of consolidation, multi- focal disease, moderate to large effusion, abscess, air leak.	None	Present
b. Sustained oxygen saturation at RA using pulse oximetry for 20 to 30 minutes	≥94%	≤93%



## Annex B: Bacterial Medications

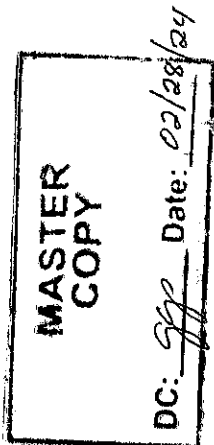
### Bacterial Medications

Antibiotic	Dosage
For PCAP A or B (non-severe) regardless of immunization status against Haemophilus Influenza type b or Streptococcus pneumoniae	
1. Amoxicillin Trihydrate	40-50 mg/kg/day divided into 3 doses for 7 days OR 80-90 mg/kg/day divided in 2 doses for 5 to 7 days.
2. Amoxicillin-Clavulanate	80-90mg/kg/day divided into 2 doses for 5 to 7 days.
3. Cefuroxime	20-30mg/kg/day divided into 2 doses for 7 days.  High level penicillin resistant pneumococci or beta lactamase producing Haemophilus influenzae
For PCAP C or D (severe) regardless of immunization status against Streptococcus pneumoniae	
1. Penicillin G	200,000 units/kg/day in 4 divided doses if with complete vaccination for Haemophilus influenzae type b
2. Ampicillin	200mg/kg/day divided into 4 doses if no or incomplete or unknown vaccination for Haemophilus influenzae type b
3. Cefuroxime	100-150mg/kg/day divided into 3 doses
4. Ceftriaxone	75-100mg/kg/day
5. Ampicillin-Sulbactam	200mg/kg/day divided into 4 doses high-level penicillin-resistant pneumococci or beta-lactamase producing Haemophilus influenzae
6. Clindamycin	20-40mg/kg/day divided into 3 or 4 doses when highly suspected for Staphylococcal pneumonia
7. Vancomycin	40-60mg/kg/day divided into 3 or 4 doses for sepsis and shock

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Antibiotic	Dosage
1. Non type-1 Hypersensitivity	
a. Cefuroxime	20-30mg/kg/day divided into 2 doses or IV 100-150mg/kg/day divided into 4 doses
b. Ceftriaxone	75-100mg/kg/day, once in 24 hours or twice a day
2. Type 1 Hypersensitivity (Immediate or Anaphylactic type)	
a. Azithromycin	10/mg/kg/day PO or IV for 3 days or 10mg/kg/day 1 followed by 5 mg/kg/day for 2-5 days
b. Clarithromycin	15mg/kg/day divided into 2 doses for 7 days
c. Clindamycin	10-40mg/kg/day PO or 20-40mg/kg/day IV divided into 3-4 doses for 7 days
For an Atypical pathogen is highly suspected, macrolide is considered as follows:	
1. Azithromycin	10mg/kg/day PO or IV for 5 days specifically in infants > 6 months and pertussis is suspected  10mg/kg/day for 3-5 days  10mg/kg/day on day 1 followed by 5mg/kg/day for 2-5 days
2. Clarithromycin	15mg/kg/day divided into 2 doses for 7-14 days





## Annex C: Viral Medications

### Viral Medications

Antiviral therapy	Dosage
Oseltamivir	<p>For children &lt; 1-year-old age 3 mg/kg per dose, twice daily x 5 days</p> <p>For children 1-year-old and older may differ by weight</p> <p>15kg or less: 30 mg/kg per dose, twice daily x 5 days</p> <p>&gt;15-23kg: 45 mg/kg per dose, twice daily x 5 days</p> <p>&gt;23-40kg: 60 mg/kg per dose, twice daily x 5 days</p> <p>&gt;40kg: 75 mg/kg per dose, twice daily x 5 days</p>

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