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PHILHEALTH CIRCULAR
No. 2026-0012

TO : **ACCREDITED HEALTH FACILITIES, 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) (Revision 2)**

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 (HF) file individual claims per inpatient episode of care. In this current payment system, HFs are only allowed to file claims for a maximum of two diagnoses and/or procedure codes for reimbursement for the entire episode of care for a patient, thus limiting PhilHealth coverage.

The Universal Health Care Act (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) in accordance with PhilHealth Board Resolution (PBR) No. 2676 s. 2021. 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, among others, which have a significant impact on the resource intensity, and the corresponding cost. As such, PhilHealth published PhilHealth Circular No. 2022-0016 or the "Governing Policies On Transitioning The Provider Payment Mechanism (PPM) From All Case Rates (ACR) To Diagnosis-Related Groups (DRG)."

The implementation of the DRG system requires transition to full IT-based platforms for electronic claims processing to realize seamless transactions between PhilHealth and all its accredited HFs. Part of this transition is to improve the current system to (1) collect information necessary for DRG grouping, (2) have more robust data validations, and (3) allow the integration of a DRG grouper to the systems of PhilHealth and its accredited/contracted HFs.

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

II. OBJECTIVES

This PhilHealth Circular aims to provide rules on the implementation of the Shadow Billing of inpatient claims as a mechanism to live-test the PHL-DRG process, in particular the disease grouping validation and claims processing, excluding payments for accredited/contracted HFs 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 *all* PhilHealth-accredited public and private inpatient HFs. This shall be an interim mechanism which shall be done in preparation for a nationwide roll-out of DRGs.

The interim *Claim Form 5 (CF5)*, as detailed in Section V.C of this policy, will be applicable to all inpatient claims.

IV. DEFINITION OF TERMS

A. All Case Rates (ACR) - a fixed rate or amount that PhilHealth will reimburse for a specific illness *or* 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 HFs.

B. Computed Age - the admission date minus the birth date of a patient in years and days.

C. Dagger-asterisk Codes - diagnosis codes which permit the classification of a disease under two different aspects, i.e. according to its etiology and its manifestation. Dagger codes are primary codes. Frequently, the dagger code is supplemented with the optional asterisk code. Apart from codes marked as dagger codes, each random primary code can be used as an etiology code and combined with an asterisk code. Asterisk codes designate the manifestation of a disease. As additional codes, they are not used on their own but only as part of a dual encoding in the "dagger and asterisk" system.

D. Diagnosis Codes - alphanumeric codes that represent a disease or diagnosis of a patient. These are coded using the 10th edition of the

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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".

E. **Diagnosis-Related Groups (DRG)** - 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. 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.

F. **DRG Manual** - the definitive guide on the logic underlying the DRG classification framework, with the compendiums of all related diagnosis, procedure, and supporting codes. This *is* made available to all HFs and the general public *via the PhilHealth website* as an educational reference.

G. ***Electronic Statement of Account (eSOA)*** - *the digital document of the statement of account in XML (Extensible Markup Language) format.*

H. **Grouper** - 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.

I. **PhilHealth eClaims System** - the IT system which PhilHealth uses to collect and process claims submitted by accredited HFs.

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

K. **PHL-DRG Seeker** - a standalone system to be used as a viewable reference for DRG groupings for inpatient cases.

L. **Procedure Codes** - 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.

M. **Relative Value Scale (RVS)** - a systematic listing and coding of surgical procedures where each procedure is assigned a corresponding Relative Value Unit (RVU). Each procedure or service is identified with a five-digit code. With this coding and recording system, the reporting of procedures performed by physicians are simplified and accurately identified.

N. **Shadow Billing** - a process where HFs start case reporting according to the Case-Based Groups (CBG), or DRG system and the respective payment is calculated. During an agreed transition period, the actual payment still

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follows the previous provider payment method.[1] The detailed process of which shall be described under the policy statements of this PhilHealth Circular.

O. Thai DRG Grouper - 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

A. Grouping of Diagnosis and Procedure Codes

1. PhilHealth, in coordination with medical and surgical specialty societies, shall map current illness (ICD-10) and procedure codes (Relative Value Scale) to corresponding PHL-DRGs derived from the Thai DRG Grouper, following PhilHealth Board Resolution (PBR) No. 2676 s. 2021 entitled, "Resolution Approving the Transitioning of the PhilHealth Provider Payment Mechanism (PPM) from All Case Rates (ACR) to Diagnosis Related Groups (DRG)."

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 Rate;
   b. Relative Weights;
   c. Case Mix Index;
   d. Weighted Activity Units; and
   e. Adjustment Factors

4. An Implementation Manual shall be released to inform and guide accredited HFs on the implementation of PHL-DRGs. This 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 PhilHealth Circular.

B. Shadow Billing

1. Shadow billing refers to a mechanism of converting the diagnosis and procedure codes filed by HFs to the PHL-DRGs, where:

   a. HFs file claims and be reimbursed using the All Case Rates (ACR) system (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

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[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

backend processing mechanisms following the mapping algorithm (Annex A).

c. Process of conversion shall inform the case mix of the health facility in relation to the PHL-DRGs, and consequently, 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.

4. *PhilHealth shall handle all data collected through Shadow Billing in compliance with Republic Act No. 10173, or the Data Privacy Act of 2012.*

C. PHL-DRG Information Technology (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, *disease and procedure code libraries,* adjustment factors, and other components of the DRGs.

d. PhilHealth shall utilize standard security measures to protect the PHL-DRG Grouper *from unauthorized modification and tampering.*

e. The PHL-DRG Grouper shall be used exclusively by PhilHealth.

2. PHL-DRG Seeker

a. PhilHealth shall develop a *standalone* PHL-DRG Seeker which shall act as the front-facing system that HFs 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 HFs, and will not form part of the claims process of the HFs

c. Once the software is available, the utilization of the PHL-DRG Seeker shall be optional for facilities engaged to implement Shadow Billing.

3. Interim Claim Form 5

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a. During the period of the Shadow Billing of DRGs, accredited/contracted HFs shall submit an additional interim claim form which contains supplementary data required for DRG grouping during the period. This interim claim form shall be called "Claim Form 5 (CF5)."

b. The CF5 shall collect DRG data in addition to current data fields being collected for ACR reimbursement.

   b.1. The CF5 shall include additional data entries required for DRG grouping which do not exist in Claim Forms 1 to 4 (Annex B: Claim Form 5)

   b.2. The additional data collected through CF5 shall be utilized for backend DRG grouping. Data entries necessary for DRG grouping which exist in current forms shall be utilized by the Grouper to determine a DRG.

   b.3. The CF5 shall be deployed for health facility usage through the eClaims platform.

   b.4. Facilities shall ensure that data encoded in the *CF5* are true and correct. *Validation of patient confinement information with the respective attending, co-managing, and referral physicians may be done if necessary to ensure quality of data to be encoded in the CF5.*

   b.5. The correctness of the information indicated on the CF5 shall be certified through the Claim Signature Form (CSF). By signing the CSF, it is considered that both the health facility and the patient or legal guardian certify that the information on the CF5 correctly matches the patient's episode of care.

c. All *HFs* shall follow additional coding rules as described in Annex C (Additional Coding Rules for the Shadow Billing of DRGs). These succeeding revisions of these coding rules shall be released as Annex revisions and shall be announced through PhilHealth advisories.

d. *Health facilities shall continue to utilize the required Claim Forms of the All Case Rates system to indicate patient confinement information.*

e. *All inpatient health facilities shall not be allowed to submit an automatically-generated or filled up CF5, pulling data from the CF2 and/or CF4, without manual input, review, and/or revision from pertinent health facility personnel. The CF5 is highly recommended to be fully encoded manually, so health facilities become accustomed to the documentation standards of a DRG system. At the minimum, the CF5 shall be duly validated, and revised as applicable, prior to its submission.*

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4. *Electronic Statement of Account (eSOA)*

    a. *Health facilities shall be required to submit an eSOA for each inpatient claim. The eSOA shall be filled up in accordance with the rules set in PhilHealth Circular No. 2023-0026 and its succeeding revisions.*
    b. *Health facilities shall ensure that data encoded in the eSOA are true and correct.*

    c. *eSOA data shall be analyzed along with the grouping data of each claim in order to build PhilHealth's DRG relative weight library.*

D. Encoding Rules for CF5

1. Diagnosis Codes

    a. One (1) primary diagnosis shall be required in a valid ICD-10 diagnosis code. A list of codes acceptable as primary diagnoses are indicated in the DRG Manual's list of acceptable primary diagnosis codes.

    b. Any dagger-asterisk codes *shall* be split into two codes, and entered in separate fields, with the dagger code as the primary diagnosis, and the asterisk code as a secondary diagnosis to be inputted in the "SDx1" slot.

    c. All secondary 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 secondary diagnosis that cannot be identified with a valid ICD-10 code will not be considered for classification into payment groups.

    d. HFs may encode up to twelve (12) secondary diagnosis codes per inpatient claim. Any succeeding diagnosis codes *beyond the stated limit* shall not be accepted.

2. Procedure Codes

    a. Procedures shall continue to be encoded as RVS codes.

    b. Procedures which are performed multiple times and or multiple sites during the episode of care shall be encoded with an extension code:

        b.1. The extension code shall start with a plus sign (+) succeeding the RVS code.

        b.2. A two-digit code shall succeed the plus sign. The first digit shall signify the multiplicity of the procedure (number of sites). The

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second digit shall signify the ordinal instance of the procedure (*number of times.*) Detailed explanations and examples are listed in Annex D: Example for RVS Code Extensions.

c. All procedures performed in an episode of care shall be entered. HFs may encode up to twenty (20) procedure codes per inpatient claim. Any succeeding procedure codes *beyond the stated limit* shall not be accepted.

d. All the RVS codes and their corresponding ICD-9-CM code *equivalent* 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. Admission weight shall be required for all newborns aged 0-28 days. HFs shall ensure date and time of birth are accurately encoded in the CF2.
b. Admission weight shall be stated in kilograms, down to one decimal *place.*

c. Claims for newborns with a computed age of 1 year or above will yield an error in grouping.

E. Claims Process for Shadow Billing

1. All HFs shall continue to file claims and be paid based on the All Case Rates.

2. All HFs shall submit Claim Form 5 *and eSOA* with all inpatient claims. Specific instructions on this process shall be detailed through a PhilHealth advisory.

3. Data validation mechanisms shall be integrated into the eClaims submission platforms of HFs through their respective service providers or in-house developers. These validation mechanisms can be found in Annex E (Additional Validation Mechanisms for eClaims) of this PhilHealth Circular.

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

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.

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d. A revised eClaims platform integrating a supplementary DRG form shall be developed for the implementation of Shadow Billing.

e. *Inpatient claims which have no attached valid CF5 and eSOA shall not be accepted for submission. PhilHealth shall develop a mechanism to flag incomplete claims in order to inform providers of the corresponding deficiencies.*

F. Health Facility Engagement for Shadow Billing

1. All accredited inpatient HFs which fully utilize PhilHealth's eClaims *3.0, and its later versions,* for its claims submissions shall be *required to participate in the* Shadow Billing for DRGs.

2. All service providers shall be required to enhance their IT systems for the submission of DRG data through the CF5 *and eSOA* as detailed in this PhilHealth Circular.

3. All HFs shall enhance their IT systems capacity and ability to encode claims data required by the DRG system. PhilHealth shall release specific requirements and instructions through a PhilHealth Advisory.

4. *Health facilities may reach out to their respective PhilHealth Regional Office regarding capacity building activities for Shadow Billing and DRGs. The scope of these capacity building activities include an overview of DRGs, core coding rules for the CF5, special coding rules for the CF5, and the importance of encoding good quality data.*

5. HFs 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. *These results shall contain recommendations and guidance from PhilHealth on how to further improve the documentations of patient cases through the CF5.*

6. All HFs may approach the DRG Shadow Billing Help Desk at their respective PhilHealth Regional Office (PRO) for any clarifications regarding Shadow Billing, *specifically on issues on CF5 encoding and IT issues which may be experienced during implementation.*

G. Roles and Responsibilities

1. PhilHealth

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

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b.2. PHL-DRG Seeker
b.3. PHL-DRG Grouper
b.4. Rate Setting Protocols

c. Develop, cascade, and maintain DRG IT systems for the implementation of Shadow Billing;

d. Document all implementation issues and best practices regarding the IT platforms utilized in the implementation;

e. Develop an Implementation Manual for Shadow Billing;

f. Ensure the current diagnosis and procedure coding system is compatible with the DRG system;

g. Develop operational issuances and systems to integrate the submission of the Claim Form 5 in the existing claims process;

h. Assist in the development of the DRG Implementation Manuals;

i. Provide capacity building activities *(through the Head Office or Regional Office)* for HFs in relation to Shadow Billing; and

j. Assist HFs by addressing all concerns related to Shadow Billing.

2. Clinical Coders, *Resident Physicians, Nurses*

   a. Familiarize with coding rules in order to enforce good clinical coding practice across all HFs during the shadow billing period; and

   b. Assist PhilHealth in cascading and promoting DRG clinical coding practices in order to enable accurate data capture.

3. Medical and Surgical Specialty Societies
   a. Assist the Standards and Monitoring Department 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 guided by latest approved standard local clinical and surgical practices; and

   c. Educate other clinical practitioners and HFs regarding the importance of Shadow Billing and the transition to DRGs and its impact to their respective specialty practices.

4. Service Providers *(SP)*

   a. Enhance IT systems to enable submission of the Claim Form 5;

   b. Seek certification from PhilHealth for Claim Form 5 submission;

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c. *Provide sufficient knowledge transfer (e.g. system walkthroughs) to partner health facilities regarding all features of the CF5;*

d. *Provide their respective partner health facilities an accessible change log listing and detailing the different updates to their respective eClaims systems; and*

e. Conduct troubleshooting for HFs experiencing IT issues for Shadow Billing implementation in coordination with PhilHealth.

H. 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 *into the PHL-DRG* corresponding to the All Case Rates;
   b. Case mix of HFs;
   c. Variation of DRG rates in reference to ACR; and
   d. Transmittal of claims from the HFs to PhilHealth.

2. PhilHealth shall conduct a regular review of this policy and introduce enhancements as necessary.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with the pertinent provisions of Republic Act No. 11223 (Universal Health Care Act) and R.A . No. 10606 (National Health Insurance Act of 2013), 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.

VIII. REPEALING CLAUSE

PC No. 2024-0006: Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG) (Revision 1) is hereby repealed. 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 on August 1, 2026, after its publication in the Official Gazette or any newspaper of general circulation. Three (3)

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certified true copies of this PhilHealth Circular shall thereafter be deposited to the Office of the National Administrative Register at the University of the Philippines Law Center.

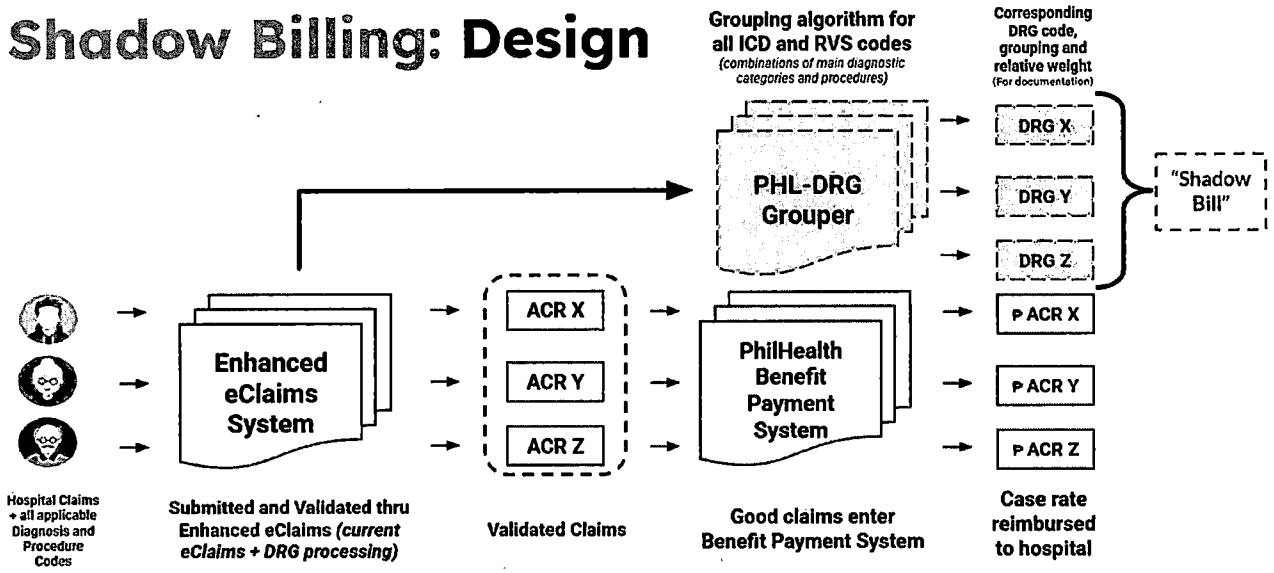
EDWIN M. MERCADO, MD, MHA, MMSc
President and Chief Executive Officer

Date signed: 07/28/2026

Implementation of Shadow Billing for the Transition to Diagnosis-Related Groups (DRG) (Revision 2)

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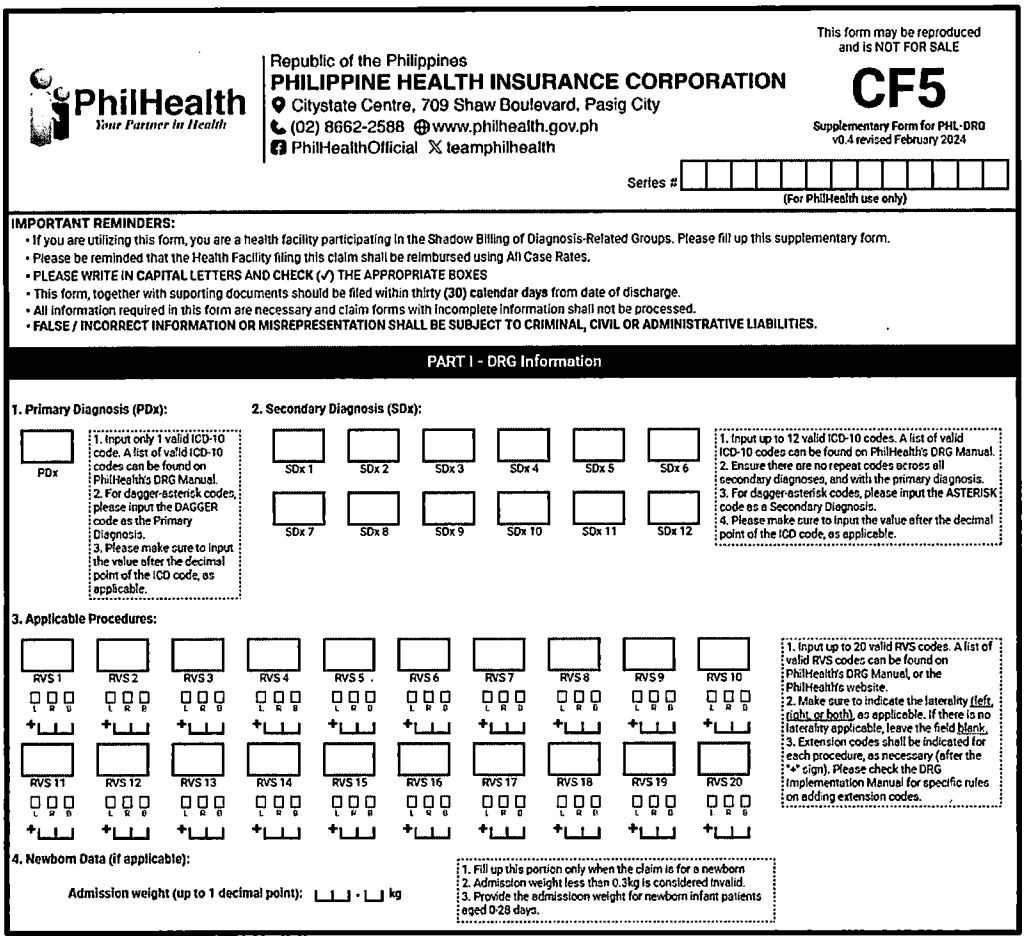
Shadow Billing Design



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Claim Form 5

(The purpose of this form is to illustrate the required data fields. All data shall be collected electronically.)



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CF5

Supplementary Form for PHL-DRG v0.4 revised February 2024

Series # _____ (For PhilHealth use only)

IMPORTANT REMINDERS:
- If you are utilizing this form, you are a health facility participating in the Shadow Billing of Diagnosis-Related Groups. Please fill up this supplementary form.
- Please be reminded that the Health Facility filing this claim shall be reimbursed using All Case Rates.
- PLEASE WRITE IN CAPITAL LETTERS AND CHECK (✓) THE APPROPRIATE BOXES
- This form, together with suporting documents should be filed within thirty (30) calendar days from date of discharge.
- All information required in this form are necessary and claim forms with incomplete information shall not be processed.
- FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - DRG Information

1. Primary Diagnosis (PDx):

PDx

1. Input only 1 valid ICD-10 code. A list of valid ICD-10 codes can be found on PhilHealth's DRG Manual.
2. For dagger-asterisk codes, please input the DAGGER code as the Primary Diagnosis.
3. Please make sure to input the value after the decimal point of the ICD code, as applicable.

2. Secondary Diagnosis (SDx):

SDx 1 | SDx 2 | SDx 3 | SDx 4 | SDx 5 | SDx 6
SDx 7 | SDx 8 | SDx 9 | SDx 10 | SDx 11 | SDx 12

1. Input up to 12 valid ICD-10 codes. A list of valid ICD-10 codes can be found on PhilHealth's DRG Manual.
2. Ensure there are no repeat codes across all secondary diagnoses, and with the primary diagnosis.
3. For dagger-asterisk codes, please input the ASTERISK code as a Secondary Diagnosis.
4. Please make sure to input the value after the decimal point of the ICD code, as applicable.

3. Applicable Procedures:

RVS 1 | RVS 2 | RVS 3 | RVS 4 | RVS 5 | RVS 6 | RVS 7 | RVS 8 | RVS 9 | RVS 10
RVS 11 | RVS 12 | RVS 13 | RVS 14 | RVS 15 | RVS 16 | RVS 17 | RVS 18 | RVS 19 | RVS 20

(L R B) + ___

1. Input up to 20 valid RVS codes. A list of valid RVS codes can be found on PhilHealth's DRG Manual, or the PhilHealth's website.
2. Make sure to indicate the laterality (left, right, or both), as applicable. If there is no laterality applicable, leave the field blank.
3. Extension codes shall be indicated for each procedure, as necessary (after the '+' sign). Please check the DRG Implementation Manual for specific rules on adding extension codes.

4. Newborn Data (if applicable):

Admission weight (up to 1 decimal point): ___ . ___ kg

1. Fill up this portion only when the claim is for a newborn
2. Admission weight less than 0.3kg is considered invalid.
3. Provide the admission weight for newborn infant patients aged 0-28 days.

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Annex C: Additional Coding Rules for the Shadow Billing of DRGs

The following are additional coding rules which health facilities (HFs) must follow in order for the grouper to accurately group patient cases. All of the rules listed below shall be required for accomplishing the **Claim Form 5 (Annex B)**.

1. Tracheostomy and Mechanical Ventilation

   The following is a list of essential procedure codes which the DRG Grouper requires for accurate grouping.

   a. Codes for Continuous Invasive Mechanical Ventilator Usage. Due to the lack of RVS codes for these select procedures, HFs must encode the following procedures as ICD9-CM codes:

Description	ICD9- CM Code
Cont mechanical ventilator - unspecified duration	96.70
Cont mechanical ventilator < 96 hrs	96.71
Cont mechanical ventilator 96+ hrs	96.72

   b. Codes for Tracheostomy Procedures (to be encoded as RVS codes):

Description	RVS Code
Tracheostomy, planned	31600
Tracheostomy, planned under two years	31601
Tracheostomy, emergency; transtracheal	31603
Tracheostomy, emergency; cricothyroid membrane	31605
Tracheostomy, Fenestration procedure with skin flap	31610

2. Parenteral Chemotherapy and Radiotherapy

   a. HFs shall encode **Z51.1** (ICD 10) as part of the Secondary Diagnosis (SDx) for patients who underwent chemotherapy.

   b. HFs shall encode **Z51.0** (ICD 10) as part of the SDx for patients who underwent radiotherapy.

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c. They shall then encode the appropriate RVS code indicating the specific site of parenteral chemotherapy or radiotherapy administration.

3. Obstetric Cases

a. For newborn deliveries, ICD-10 codes **O60 to O84** to be encoded as a Primary Diagnosis (PDx) or Secondary Diagnosis (SDx). If the patient case is a non-delivery, these codes must not be utilized.

b. For newborn deliveries with other non-delivery ICD-10 codes (non-delivery diagnoses), the delivery code should **not** be encoded as PDx.

c. Delivery codes shall not be encoded with a PDx of abortion, false labor, antenatal or postpartum care or post abortion care since these diagnoses will not result to a newborn being delivered

d. Delivery Codes used (as PDx or SDx) **must be consistent** with the procedure codes (RVS).

d.1. The code for Vaginal Delivery (59409, 59411) can only be used with the ICD-10 code for vaginal delivery (O80.0-O80.1, O80.8-O81.5, O83.0-O83.2, O84.0-O84.1)

d.2. The code for Cesarean section (59513, 59514, 59525, 59620) can only be used with the ICD-10 code for Cesarean delivery (O82.0-o82.2, O82.8-O82.9, O84.2)

e. For the Maternity Care Package (MCP01) and Normal Spontaneous Delivery package (NSD01), HFs shall be required to encode the corresponding Primary Diagnosis, Secondary Diagnosis/es, and procedures in Claim Form 5 based on the rules listed above.

4. Wound Debridement

a. HFs shall encode the following RVS codes for wound debridement:

Description	RVS Code
Debridement of extensive eczematous or infected skin	11000
Debridement including removal of foreign material associated w/ open fracture(s) and/or dislocation(s); skin and subcutaneous tissues	11010

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Description	RVS Code
Debridement of extensive eczematous or infected skin	11000
Debridement including removal of foreign material associated w/ open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, and muscle	11011
Debridement including removal of foreign material associated w/ open fracture(s) and/or dislocation(s); skin, subcutaneous tissue, muscle fascia, muscle, and bone	11012
Debridement; skin, partial thickness	11040
Debridement; skin, full thickness	11041
Debridement; skin, and subcutaneous tissue	11042
Debridement; skin, subcutaneous tissue, and muscle	11043
Debridement; skin, subcutaneous tissue, muscle, and bone	11044

5. Blood Transfusion

   a. HFs shall utilize RVS Code **36430** for all inpatient cases with blood transfusion performed during the episode of care.

6. Combination Procedure Codes

   HFs shall apply the following rules in filling up CF5:

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a. Implantable Cardiac Devices

a.1. HFs must create a distinction between total system insertion versus replacement of device or revision of electrodes, or removal of device.

a.2. Similarly, HFs must make sure the coding of the correct device type, whether it's a cardioverter or a pacemaker. If the device is a pacemaker, encoders must distinguish between single or dual chamber devices.

a.3. HFs shall encode the following RVS codes in CF5 to distinguish each device and action:

Description	RVS Code
Cardioverter	
Total system insertion	33241
Replacement of device or revision of electrodes	33245, 33246
Removal of device	33241, 33243, 33244
Pacemaker (Single-chamber)	
Total system insertion	33200, 33201, 33212
Replacement of device or revision of electrodes	33206, 33207
Removal of device	33234
Pacemaker (Dual-chamber)	
Total system insertion	33213
Replacement of device or revision of electrodes	33208
Removal of device	33235

b. Multivessel Percutaneous Transluminal Coronary Angioplasty (PTCA)

b.1. HFs shall use extension codes for PTCA cases **(92982, 92995)** to indicate the number of vessels involved in the procedure through extension codes (please see Annex C of this policy).

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c. Multi-Coronary Valve Procedures

c.1. Hospital encoders shall make sure to distinguish between open and closed valve surgeries. Multi-Coronary Valve Procedures shall only apply to open valve surgeries.

c.2. Hospital encoders shall make sure to properly encode multi-coronary valve procedures. The surgery will count as a Multi-Coronary Valve Procedure if **one surgery is performed on different valves during a single instance of surgery.** Multiple surgeries on the same valve remain as a single coronary valve procedure.

d. Combination Thoracoabdominal Procedure

d.1. During instances where both a Thoracic and Abdominal vessel resection occurs, HFs must encode both their respective RVS codes accordingly. Otherwise, the vessel procedure RVS codes can be encoded on its own.

Thoracic Vessel Procedures	RVS Code
Reconstruction of vena cava, any method	34502
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision	35001
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for ruptured aneurysm, carotid, subclavian artery, by neck incision	35002
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for aneurysm, false aneurysm, and associated occlusive disease, innominate, subclavian artery, by thoracic incision	35021
Direct repair of aneurysm, false aneurysm, or excision (partial or total)	35022

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Thoracic Vessel Procedures	RVS Code
and graft insertion, w/ or w/o patch graft; for ruptured aneurysm, innominate, subclavian artery, by thoracic incision n, hypogastric, external)	
Repair blood vessel w/ vein graft; intrathoracic, w/ bypass	35241
Repair blood vessel w/ vein graft; intrathoracic, w/o bypass	35246

Abdominal Vessel Procedures	RVS Code
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta	35081
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for ruptured aneurysm, abdominal aorta	35082
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	35091
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for ruptured aneurysm, abdominal aorta involving visceral vessels (mesenteric, celiac, renal)	35092

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Abdominal Vessel Procedures	RVS Code
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for aneurysm, false aneurysm, and associated occlusive disease, abdominal aorta involving iliac vessels (common, hypogastric, external)	35102
Direct repair of aneurysm, false aneurysm, or excision (partial or total) and graft insertion, w/ or w/o patch graft; for ruptured aneurysm, abdominal aorta involving iliac vessels (common, hypogastric, external)	35103

e. Phacoemulsification and Lens insertion

e.1. HFs should indicate in the CF5 instances where two separate eye procedures are performed in the same admission in accordance with the rules and guidelines for PhilHealth Cataract pre-surgery authorization. Coding these cases should follow the rules on extension codes as detailed under Annex C.

7. Resuscitation Package

HFs which claim the resuscitation package (P0000) shall be required to encode ICD-10 code **I46.0** as a secondary diagnosis in Claim Form 5.

8. Coding rules for Z Benefit Package Codes

During the implementation of the Shadow Billing of DRGs, HFs shall continue to encode the Z benefit package code in the Claim Form 2.

a. HFs shall encode the corresponding Primary Diagnosis, Secondary Diagnosis/es, and Procedure/s in Claim Form 5.

b. HFs may refer to Annex K of PhilHealth Circular 2021-0022 (The Guiding Principles Of The Z Benefits (Revision 1)), and its succeeding revisions for filling up Claim Form 5.

9. Coding Rules for COVID-19 Packages

a. All HFs shall continue to encode all PhilHealth COVID-19 packages based on the package codes indicated in their corresponding circulars.

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b. HFs filing COVID-19 claims are still highly encouraged to submit the Claim Form 5 indicating applicable diagnoses and procedures. Data gathered from these submissions may be used to develop a PHL-DRG for COVID-19.

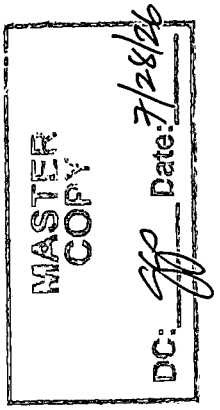
10. Coding Rules for Pneumonia

a. *ACR codes for pneumonia are not recognized by the grouper as valid codes. HFs must continue using the ACR codes in the CF2, but use the appropriate ICD-10 codes in the CF5:*

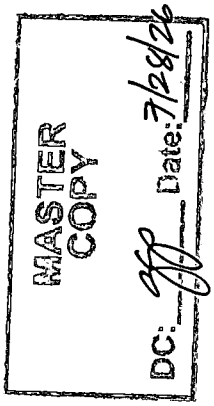
Disease	***Codes to be used in CF 2 - ACR Codes***	***Codes to be used in CF 5 - Updated ICD codes***
Community Acquired Pneumonia, Moderate Risk	*J18.02* *J18.92*	***For primary diagnosis, code any of the ff:*** *J18.0 – Bronchopneumonia, unspecified* *J18.1 – Lobar pneumonia, unspecified* *J18.8 – Other pneumonia, organism unspecified* *J18.9 – Pneumonia, unspecified* *Pathogen-specific pneumonia codes, when a causative agent is identified (e.g., J13 - Pneumonia due to Streptococcus pneumoniae)* ***For secondary diagnoses, code the appropriate decompensated comorbidities**, including but not limited to the ff:* ***1) Uncontrolled Diabetes Mellitus*** *E10.0 – Type 1 diabetes mellitus with coma* *E11.1 – Type 2 diabetes mellitus with ketoacidosis* *E11.7 – Type 2 diabetes mellitus with multiple complications* *2) Active Malignancies* *C34 – Malignant neoplasm of bronchus and lung* *C50 – Malignant neoplasm of breast* *C00-C97 – Malignant neoplasms (any site-specific primary*

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Disease	*Codes to be used in CF 2 - ACR Codes*	*Codes to be used in CF 5 - Updated ICD codes*
		malignancy) ***3) Neurologic Disease in Evolution*** *I60.1 – Subarachnoid haemorrhage from middle cerebral artery* *I61.4 – Intracerebral haemorrhage in cerebellum* *I63.0 – Cerebral infarction due to thrombosis of precerebral arteries* ***4) Congestive Heart Failure Class II-IV*** *I50.0 – Congestive heart failure* *I50.1 – Left ventricular failure* *I11.0 – Hypertensive heart disease with (congestive) heart failure* ***5) Unstable Coronary Artery Disease*** *I20.0 – Unstable angina* *I21.0 – Acute transmural myocardial infarction of anterior wall* ***6) Renal Failure on Dialysis*** *N18.5 – Chronic kidney disease, stage 5* ***7) Decompensated COPD*** *J44.0 – Chronic obstructive pulmonary disease with acute lower respiratory infection* *J44.1 – Chronic obstructive pulmonary disease with acute exacerbation, unspecified* ***8) Decompensated Liver Disease*** *K70.3 – Alcoholic cirrhosis of liver* *K72.0 – Acute and subacute hepatic failure*
Community Acquired Pneumonia, High Risk	*J18.03* *J18.93*	***For primary diagnosis, code any of the ff:*** *J18.0 – Bronchopneumonia, unspecified*



Disease	*Codes to be used in CF 2 - ACR Codes*	*Codes to be used in CF 5 - Updated ICD codes*
		J18.1 – Lobar pneumonia, unspecified *J18.8 – Other pneumonia, organism unspecified* *J18.9 – Pneumonia, unspecified* *Pathogen-specific pneumonia codes, when a causative agent is identified (e.g., J13 - Pneumonia due to Streptococcus pneumoniae)* ***For secondary diagnoses, code the appropriate decompensated comorbidities** (see above list).* ***Code sepsis or septic shock,** as appropriate, including but not limited to the ff:* *A40.3 – Sepsis due to Streptococcus pneumoniae* *A41.4 – Sepsis due to anaerobes* *R57.2 – Septic shock* ***For procedures, code mechanical ventilation* if patient was intubated:*** *96.70 – Cont mechanical ventilator - unspecified duration* *96.71 – Cont mechanical ventilator < 96 hrs* *96.72 – Cont mechanical ventilator 96+ hrs*
Nosocomial Pneumonia	*J18.99+Y95*	***For primary diagnosis, code any of the ff:*** *J18.0 – Bronchopneumonia, unspecified* *J18.1 – Lobar pneumonia, unspecified* *J18.8 – Other pneumonia, organism unspecified* *J18.9 – Pneumonia, unspecified* *Pathogen-specific pneumonia codes, when a causative agent is identified (e.g., J13 - Pneumonia due to Streptococcus pneumoniae)* ***Add the following code as***



Disease	*Codes to be used in CF 2 - ACR Codes*	*Codes to be used in CF 5 - Updated ICD codes*
		secondary diagnosis: *Y95 – Nosocomial Condition*

**Please refer to section 1: Tracheostomies and Mechanical Ventilator of this Annex*

11. *Coding rules for other ACR codes*

HFs should continue using the list of ACR codes in filling out the CF2. However, some of these codes are not applicable for shadow billing, hence, the primary diagnosis, secondary diagnoses, and procedures that are listed in Appendices A1 and A2 from the DRG manual should be encoded in the CF5.*

**the DRG Manual will be released through a separate advisory*

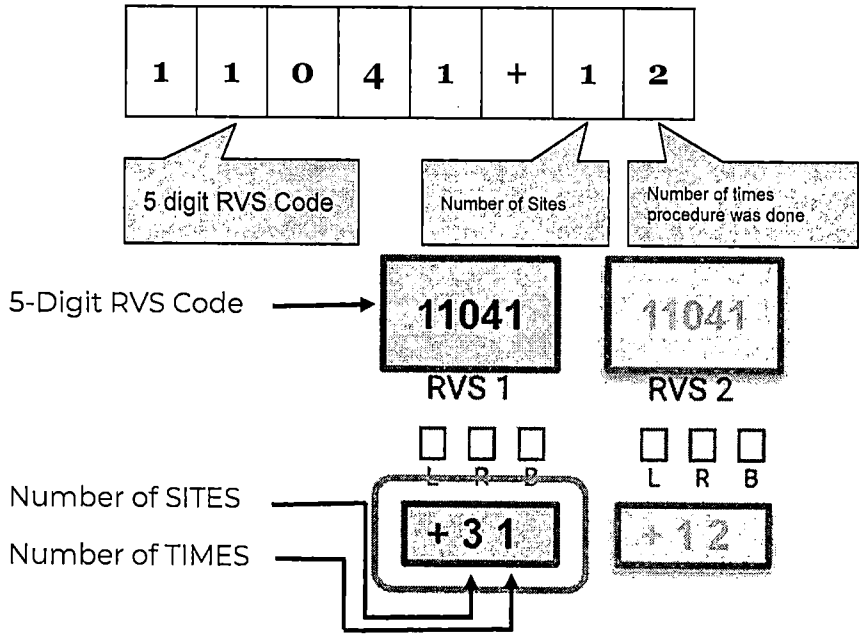
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Annex D: Example for RVS code extensions

1. Model on Philippine RVS procedure with extension codes

The rules on Relative Value Scale (RVS) extension codes were based on the rules developed by Thailand NHSO Manual on Thai DRG Version 5 Volume 1 published in 2011. In the Philippine setting, procedures are encoded as RVS codes in contrast with the Thai DRGs which use ICD-9 CM codes. To provide accurate coverage of procedure codes, continuous efforts to validate and equate the two coding systems are done in close coordination with medical specialty societies in the Philippines. It is for this reason RVS codes are used in the examples illustrated below.

RVS codes that are used in the PhilHealth All Case Rates (ACR) system and will be retained in the DRG system. RVS codes are typically represented by a 5-digit numeric code. Since the ICD9-CM procedure codes used in the Thai DRG Version 5 have an extension code system to indicate the number of sites and multiplicity of procedures done (if applicable), implementing this system of extension codes is necessary for RVS codes as well, as this will have implications in cost weights.



For RVS codes requiring an extension code, the main 5-digit code will be followed by a "+" sign and then two numbers signifying the following:

a. The first digit after the "+" refers to the number of sites a certain procedure was performed on. For example, debridement of different body sites.

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b. The second digit after the "+" refers to the number of times the given procedure was performed in a single episode of care. For example, if a patient had the same procedure performed twice, then the first procedure listed in the record should have the number 1 in the last digit, and the second procedure with the same RVS code should have the code 2. An example of encoding extension codes in a single episode of care is illustrated below.

Excisional debridement and skin graft

Summary	RVS Code	Extension Code
Excisional debridement, both hands and scalp	11041	11041+31
Excisional debridement, right hand	11041	11041+12
Excisional debridement, scalp	11041	11041+13

Summary	RVS Code	Extension Code
Skin graft (full thickness), both hands	15240	15240+21
Skin graft (full thickness), scalp	15220	15220+11
Skin graft (full thickness), right hand	15240	15240+12
Skin graft (full thickness), buttock	15200	15200+11

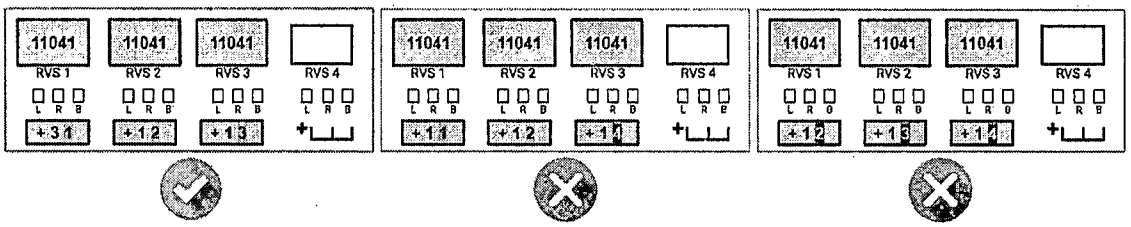
2. Other Definitions

a. The extension code is a method to indicate if there is more than one procedure or more than one location. Writing an RVS code without an extension code implies only one instance of the said procedure. Any inputs involving a RVS code intended to be repeated but without proper adherence to the rules of the extension codes shall be interpreted by the Grouper as only one instance of the procedure.

11041 means 11041+11
11041, 11041 also means 11041+11

b. Number of instances for any code begins with 1 and follows continuously as 1 -> 2 -> 3 ->...
coding 11041+21, 11041+12, 11041+13 will yield correct result
coding 11041+11, 11041+12, 11041+14 -->will yield wrong result
coding 11041+12, 11041+13, 11041+14 --> will yield wrong result

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c. In cases of procedures with more than 9 locations for one procedure, the number "9" is used for the first digit after the +.
d. In cases of more than 9 procedures, the number 9 is used for the second digit after the +.
e. In cases of using an incorrect extension coding, the grouper will be directed to delete the erring extension and default the code to just the 5 digit RVS code.
f. Procedure codes with known extension codes will be prioritized and will require properly coded extension, otherwise it will be omitted by the Grouper from the final DRG determination.
g. Some RVS codes already equate to procedures complete with their laterality or site multiplicities, these codes will no longer be required to use extension codes and will be accepted as is.
h. The objective of the extension code use is to retain the most complete data when there is more than one unit of the same procedure code in the same admission.

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Annex E: Additional Validation Mechanisms for eClaims

Additional Validation Mechanisms for eClaims

Claims that fail to follow even one of the rules may lead to errors (DRGs with a relative weight of zero) or warnings (DRGs with a relative weight that does not accurately reflect the patient's case).

Patient Information

1. Patient "sex" shall have valid entries in the DRG Claim Form.
2. Computed age shall be between 0 days and 124 years.
3. An admission weight below 0.3 kg is considered invalid.

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 and secondary diagnoses, 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 Secondary 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 Primary and Secondary 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. This is in line with the Thai DRG grouping logic.
8. If the patient is a newborn (computed age is below 0 years), admission weight (in kilograms) shall be filled in accordingly and not left blank.
9. Laterality shall be indicated for applicable diagnoses, and procedures, based on rules set by PhilHealth.

