



July 7, 2003

PHILHEALTH CIRCULAR

No. 25, s. - 2003

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TO : ALL ACCREDITED HEALTH CARE PROVIDERS, CLAIMS PROCESSING DEPARTMENTS – NATIONAL CAPITAL REGION AND PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED.

SUBJECT : Supplement to the rules on PhilHealth’s maternity care benefits for hospitals and non-hospital facilities

The following clarifications regarding the rules for NSD package as provided for by PhilHealth Circular Nos. 15 & 16 series of 2003 are hereby issued:

I. HOSPITAL FACILITIES:

A. RVS CODING:

- The RVS Code to be used on all claims for uncomplicated normal spontaneous delivery (NSD) in hospitals shall be:

59400	Routine obstetric care including antepartum care, vaginal delivery and/or postpartum care	Package
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- For vaginal deliveries in hospitals that are associated with medical (hypertension and diabetes) and or other surgical procedures and services, the code to be used shall be:

59409	Vaginal delivery only; with or without forceps	50
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- For breech extraction in hospital facilities, code and RVU shall be as follows:

59411	Breech extraction and other abnormal presentation	80
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- For Cesarean section (CS) in hospital facilities, the code to be used shall be:

59514	Cesarean delivery	150
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- For vaginal birth after Cesarean section (VBAC) in hospital facilities, the code to be used shall be:

59612	Vaginal delivery only, after previous Cesarean section	80
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B. PAYMENT:

1. The case rate amount of Php 4,500 pesos shall be paid for NSD in hospitals regardless of category and length of stay.

Hospital =Php 2,500

Professional =Php 2,000

2. For continued hospital stay due to conditions aside from NSD (e.g. hypertension, diabetes, anemia requiring transfusion of blood products, sepsis) complete accomplishment of PhilHealth Form 2, including Part III and IV, shall be required. Reimbursement for hospital charges shall be based on the case type of the illness and shall follow usual procedures in claims processing. Separate reimbursement for PF shall only be given to an appropriate health professional for co-management of the patient with co-existing disease.

Case #1 - G1P1 - NSD with pre-eclampsia - Pay RVU
Referred to internist for co-management

Code:	59409	
Case type:	Ordinary	
Hospital Category:	Secondary	
Payment:	Room and Board	: Php 300/day
	Drugs & Meds	: Php 1,700
	Lab and Supplies	: Php 850
	O.R. Fee	: Php 1,140
	Surgeon (D3)	: Php 2,000
	Specialist (D2)	: Php 250/day

3. Normal spontaneous deliveries in hospital facilities that are accompanied by additional medically necessary surgical procedures shall be considered as exclusion to the package, provided that, the Relative Value Unit (RVU) of the additional procedure is 31 and above. Complete accomplishment of PhilHealth Form 2 shall be required and reimbursement for hospital charges and professional fees shall be evaluated based on the RVU of the procedure.

Case #2: -G2P2 NSD followed by TAHBSO due to postpartum hemorrhage

Code:	58150, 59409	
Case type:	Intensive	
Hospital Category:	Secondary	
Payment:	Room and Board	: Php 300/day
	Drugs & Meds	: Php 4,000
	Lab and Supplies	: Php 2,000
	O.R. Fee	: Php 3,490
	Surgeon (D3)	: Php 2,000 (NSD)+
		: Php 8,000 (TAHBSO)

C. COVERAGE:

1. The NSD package for all facilities shall only be limited to the normal spontaneous deliveries of the first two (2) births.

Case #3	G1	-Normal Delivery (1 st)	- Package
	G2	-Normal Delivery (2 nd)	- Package
	G3	-Normal Delivery (3 rd)	- Not covered

2. If the first two (2) pregnancies resulted to a Cesarean section, vaginal birth after Cesarean section (VBAC), forceps delivery, breech delivery, preterm delivery or stillbirth, such deliveries shall be counted as part of the limitation of the NSD package to the first two (2) births.

Case #4	G1	- Breech delivery (1 st)	- Pay RVU (59411)
	G2	- Normal Delivery (2 nd)	- Package
	G3	- Normal Delivery (3 rd)	- Not covered

Case #5	G1	- Cesarean Section Delivery (1 st)	- Pay RVU (59514)
	G2	- Normal Delivery (VBAC) (2 nd)	- Pay RVU (59612)
	G3	- Normal Delivery (3 rd)	- Not covered

Case #6	G1	- Stillbirth or Preterm delivery (1 st)	- Pay RVU (59409)
	G2	- Normal Delivery (2 nd)	- Package
	G3	- Normal Delivery (3 rd)	- Not covered

3. However, abortions are not considered as part of the limitation of the NSD package to the first two (2) births.

Case #7	G1	-Normal Delivery (1 st)	- Package
	G2	-Spontaneous abortion	- Pay RVU of D&C (58120)
	G3	-Normal Delivery (2 nd)	- Package

4. The following complicated deliveries are deemed as abnormal hence, compensable in hospital facilities when claimed for reimbursement regardless of the number of previous deliveries:

- a. Cesarean section
- b. Forceps delivery
- c. Delivery associated with abnormal presentation (i.e. breech)
- d. Preterm delivery
- e. Multiple delivery
- f. Stillbirth

Payment shall be based on the case type and RVU of the procedure performed.

Case #8	G1	-Normal Delivery (1 st)	- Package
	G2	-Normal Delivery (2 nd)	- Package
	G3	-Forceps Delivery (3 rd)	- Pay RVU (59409)

5. Only the first vaginal birth after Cesarean section (VBAC) is compensable.

Case #9	G4	- Normal Delivery (1 st)	- Package
	G1	- Cesarean Section Delivery (2 nd)	- Pay RVU (59514)
	G2	- Normal Delivery (VBAC) (3 rd)	- Pay RVU (59612)
	G3	- Normal Delivery (4 th)	- Not covered
	G5	- Cesarean Section Delivery (5 th)	- Pay RVU (59514)
	G6	- Normal Delivery (VBAC) (6 th)	- Not covered

These provisions clarify the terms of coverage issued on PhilHealth Circular Nos. 15 and 16 series of 2003 and shall be applied to all claims with discharge dates starting August 1, 2003.

D. NEWBORN CARE:

1. All medically necessary care of the normal newborn is reimbursable and classified as an ordinary case type. For sick newborns, case type classifications depend on the ICD-10 code of newborn's condition.
2. A separate claim application must be submitted for the newborn child together with the maternal application. An independent benefit limit for drugs, medicines, supplies, laboratory examination, and professional fee is also provided for the newborn. However, charges for room and board, infant formula and diapers shall not be covered.

E. OFFICIAL RECEIPTS:

1. Hospital claims with attached Official Receipts (OR) for drugs/medicines and supplies used during normal delivery shall be reimbursed to the member, provided that, they are included in the list of standard medicines and supplies covered in the NSD package for hospitals (*see Section F*). The total amount shall be deducted from the Php 2,500 hospital reimbursement and only the remaining amount shall be paid to the hospital.

Case #10 OR attached for lidocaine, suture, methergin worth Php 500

Hospital Payment	:	Php 2,500
Less	:	Php 500 (Pay to member)
	:	Php 2,000 (Pay to hospital)

Case #11 Total OR worth Php 2,700

Total OR	:	Php 2,700
Pay Member	:	Php 2,500
Pay Hospital	:	0

2. All official receipts must be submitted together with the claims application.

F. STANDARD MEDICINES AND SUPPLIES COVERED IN HOSPITALS

1. Alcohol 70% isopropyl
2. Butterfly set (G19)
3. D5LR
4. Disposable syringes with needle
5. DR gown/scrub suit
6. IV Tubing (adult)
7. Nasal Cannula
8. Plaster
9. Plastic apron
10. Povidone iodine
11. Soaking/sterilizing solution
12. Sterile absorbable suture with/without needle
13. Sterile cord clips for baby
14. Sterile cotton balls
15. Sterile cotton pledgets
16. Sterile cutting needle
17. Sterile drapes
18. Sterile gauze
19. Sterile gloves
20. Sterile round needle
21. Surgical cap
22. Surgical masks
23. Tape measures
24. Thermometer (oral/rectal)
25. Xylocaine/Lidocaine
26. Methylergonovine maleate ampule

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II. NON-HOSPITAL FACILITIES

A. RVS CODING:

1. The RVS Code to be used on all claims for prenatal, delivery and newborn services (first claim) of non-hospital facilities shall be:

59400	Routine obstetric care including antepartum care, vaginal delivery and/or postpartum care	Package
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2. For postnatal and family planning services (second claim) in non-hospital facilities, the code to be used shall be:

59430	Postpartum care only	Package
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B. PAYMENT:

1. The case rate amount of Php 4,500 pesos shall be paid for NSD in non-hospital facilities and claims payment shall be divided as follows:

Prenatal care Normal delivery Newborn care	Php 3,650.00	(1 st payment)
Postnatal care Family planning & Counseling	Php 850.00	(2 nd payment)
TOTAL	Php 4,500.00	

2. It is reiterated that the exclusion criteria enumerated in Circular No. 16-2003 applies to non-hospital facilities.
3. It is also reiterated that newborn care is incorporated in the maternity care package for non-hospital facilities thus no separate claim shall be filed for the newborn.
4. All accredited non-hospital facilities are obliged to give not less than 40% of the case payments to the health care professionals who provided the services to members and dependents.

III. ELIGIBILITY REQUIREMENTS FOR IPP MEMBERS:

1. Prior to availment of the NSD package, **Individually Paying Program (IPP) members** should have paid three (3) quarterly contributions or nine (9) monthly contributions within the twelve (12) month period prior to the month of availment. The date of effectivity of this rule shall be pursuant to PhilHealth Circular No. 24 series of 2003 or the Omnibus Guidelines on Entitlement to NHIP benefits.

Example: Delivery date is January 2004

Example	1 st Q 2003	2 nd Q 2003	3 rd Q 2003	4 th Q 2003	Eligibility
A	(+)	(+)	(+)	(+)	Eligible
B	(+)	(-)	(+)	(+)	Eligible
C	(+)	(+)	(+)	(-)	Eligible
D	(-)	(-)	(+)	(+)	Not eligible

2. A member of the NHIP who is separated from employment and continued his membership by enrolling to the Individually Paying Program (IPP) may avail of the NSD package, provided that, the member enrolled in the IPP has paid contributions three (3) months after separation.

IV. PHILHEALTH CLAIM FORM # 4

1. To facilitate processing of claims for the NSD package, proper accomplishment of PhilHealth Claim Form #4 is required. *(See attached)*
2. For hospital facilities, properly filled-out claim form #4 shall be submitted.
3. For non-hospital facilities, claim forms #4 and #4A shall be submitted for the first claim (prenatal, delivery and newborn care); and for the second claim (postnatal), claim forms #4 and #4B shall be submitted.
4. All other documents required in claims application still applies.

All other particulars consistent with this Circular shall remain in full force and effect.


FRANCISCO T. DUQUE III, MD, MSc
President and CEO

Date: _____

PHILHEALTH

CLAIM FORM 4

April 2003

MATERNITY CARE PACKAGE

(DATE RECEIVED)

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 1 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

PART I - FACILITY DATA AND CHARGES (Facility to Fill in All Items)

1. PhilHealth Accreditation No. <input type="text"/>	2. Accreditation Category <input type="checkbox"/> Primary <input type="checkbox"/> Secondary <input type="checkbox"/> Tertiary <input type="checkbox"/> Non-Hospital Facilities (Lying-in clinics, Midwife-managed clinics, Birthing Homes, Ambulatory Surgical Clinics)			
3. Name of Facility <input type="text"/>				
4. Address of Facility No., Street <input type="text"/>		Barangay <input type="text"/>		
Municipality/City <input type="text"/>		Province <input type="text"/>	Zip Code <input type="text"/>	
5. Name of Member and Identification Last Name <input type="text"/> First Name <input type="text"/> Middle Name <input type="text"/> PhilHealth Identification No. <input type="text"/>				
6. Address of Member No., Street <input type="text"/>		Barangay <input type="text"/>		
Municipality/City <input type="text"/>		Province <input type="text"/>	Zip Code <input type="text"/>	
7. Name of Patient Last Name <input type="text"/> First Name <input type="text"/> Middle Name <input type="text"/>		8. Age <input type="text"/>	9. Admission Diagnosis <input type="text"/>	
10. Confinement Period a. Date Admitted <input type="text"/> m m d d y y y y b. Date Discharged <input type="text"/> m m d d y y y y c. Total No. of Days <input type="text"/> d. Date of Death (If Applicable) <input type="text"/> m m d d y y y y				
11. Facility Services TOTAL	ACTUAL FACILITY CHARGES	PHIC BENEFIT PAYABLE TO		REDUCTION CODE
		FACILITY	PATIENT	
Medicines & Supplies bought & laboratory performed outside facility during confinement period				
12. CERTIFICATION of FACILITY: I certify that the services rendered are duly recorded in the patient's chart and that the information given in this form are true and correct.				
Signature Over Printed Name of Authorized Representative _____		Date Signed _____		Official Capacity _____

PART II - PROFESSIONAL DATA AND CHARGES (Provider/s to Fill in Respective Portions)

13. Complete Final Diagnosis <input type="text"/>	14. ICD-10 Code: <input type="text"/>	FOR PHILHEALTH USE RVS Code <input type="text"/>
15. Name of Provider <input type="text"/>	Signature & Date Signed _____	
16. PHIC Accreditation No. <input type="text"/>	17. BIR/TIN No. <input type="text"/>	Reduction Code <input type="text"/>
18. Services Performed <input type="text"/>	19. Actual Professional Charges	
	PHIC BENEFIT PAYABLE TO	
	Provider <input type="text"/>	Patient <input type="text"/>

NOTE: ANYONE WHO SUPPLIES FALSE OR INCORRECT INFORMATION REQUESTED BY THIS OR A RELATED FORM OR COMMITS MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE PROSECUTION UNDER THE LAW. ALL DATA REQUIRED ON THIS FORM ARE NECESSARY FOR ADJUDICATION OF THE CLAIM. PHILHEALTH WILL NOT ADJUDICATE ANY CLAIM WHERE FORMS ARE NOT PROPERLY OR COMPLETELY ACCOMPLISHED.

CLAIM FORM 4A

April 2003

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 4 SHOULD BE FILED WITH PHILHEALTH WITHIN 60 CALENDAR DAYS FROM DATE OF DISCHARGE.

Name of Physician/Midwife: _____
 Name of Facility: _____
 Address of Facility: _____
 Name of Patient: _____

PART I - PRENATAL

INITIAL PRENATAL CONSULTATION (date: __/__/__)

A. Clinical History and Physical Examination

1. Vital signs are normal

2. Menstrual History

4. Obstetric History

5. Ascertain 1st Pregnancy was Low-Risk

6. Obstetric risk factors

a. Multiple pregnancy

b. Ovarian cyst

c. Myoma uteri

d. Placenta previa

e. History of 3 miscarriages

7. Medical/Surgical Risk Factors

a. Hypertension

b. heart disease

c. Diabetes

d. Thyroid disorders

e. Obesity

f. Moderate to severe asthma

8. Determine pertinent abdominal examinations

a. Abdomen

normoactive bowel sound

non-tender

active fetal movements

b. Speculum Exam

parous vagina

cervix smooth, closed

LMP: _____ Menarche: _____

G _____ P _____ (_____ , _____ , _____)

f. History of stillbirth

g. History of pre-eclampsia

h. History of eclampsia

i. Premature contraction

g. Epilepsy

h. Renal disease

i. Bleeding disorders

j. History of previous cesarean section

k. History of uterine myomectomy

fundic ht= _____ Leopold's Maneuver L1: _____ L3: _____

estimated fetal wt: _____ L2: _____ L4: _____

FHT= _____ presentation: _____

9. Give complete diagnosis: _____

B. Write Delivery Plan Indicating:

1. Orientation to LRMC Package/Availment of Benefits

3. Expected date and venue of delivery

2. Schedule of prenatal examinations

Date: __/__/__ Place: _____

FOLLOW-UP PRENATAL CONSULTATION (date: __/__/__)

Visit No.

Date of visit

A. Determine AOG in weeks

B. Obtain vital signs

	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
A. Determine AOG in weeks											
B. Obtain vital signs											

a. Wt

b. HR

c. RR

d. BP

e. T

PART II - NORMAL BIRTH (date: __/__/__)

DONE

A. Perform complete Physical Examination (VS)

1. Determine AOG

AOG: _____ LMP: _____

2. Obtain Vital Signs

HR: _____ RR: _____ BP: _____ T: _____

3. Perform pertinent physical examination

a. HEENT

anicteric sclerae (+) (-)

pink palpebral conjunctiva (+) (-)

REMARKS _____

b. Heart/Lungs

clear breath sounds (+) (-)

sinus rhythm (+) (-)

REMARKS _____

c. Skin/Extremities

full pulses (+) (-)

bipedal edema (+) (-)

REMARKS _____

PHILHEALTH

MATERNITY CARE PACKAGE

CLAIM FORM 4B

April 2003

NOTE: THIS FORM TOGETHER WITH CLAIM FORM 4 SHOULD BE FILED WITH PHILHEALTH WITHIN 90 CALENDAR DAYS FROM DATE OF DISCHARGE.

Name of Physician/Midwife: _____
Name of Facility: _____
Address of Facility: _____
Name of Patient: _____

POST-PARTUM CARE (date: ___/___/___)

	DONE	REMARKS
A. Check perineal wound healing	<input type="checkbox"/>	_____
B. Check for signs of Maternal Postpartum complications	<input type="checkbox"/>	_____
C. Check for signs of Newborn complications	<input type="checkbox"/>	_____
D. Counselling and Education		
1. Newborn Care	<input type="checkbox"/>	_____
2. Breastfeeding and Nutrition	<input type="checkbox"/>	_____
3. Newborn Immunization	<input type="checkbox"/>	_____
4. Family Planning	<input type="checkbox"/>	_____
E. Provide family planning service to patient if requested	<input type="checkbox"/>	_____
F. Refer to Partner Physician for Voluntary Surgical Sterilization, if requested by patient		_____
G. Schedule postpartum visit 6 weeks postpartum	<input type="checkbox"/>	_____

I hereby certify that I received the services indicated above.

I hereby certify that I delivered the services indicated above.

Signature of Patient

Signature of Physician/Midwife