Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Healthline 637-9999 *www.philhealth.gov.ph*

PHILHEALTH CIRCULAR
No. 015, s-2011

TO : **ALL PHILHEALTH MEMBERS, ACCREDITED PROVIDERS, PHILHEALTH REGIONAL OFFICES (PhROs), AND ALL OTHERS CONCERNED**

SUBJECT : **Clarificatory Guidelines to PhilHealth Circular Nos. 11, 11-A and 11-B series of 2011**

Pursuant to PhilHealth Circular Nos.11, 11-A and 11-B, series of 2011, the following additional guidelines are being issued for proper implementation.

I. MEDICAL CASES

1) The Newborn Care Package (NCP) shall be composed of the following services and shall be paid a rate of 1,750 pesos.

CODE	DESCRIPTIVE TERMS	AMOUNT
P99432	**A. Provision of essential newborn care** to include all of the following: a. immediate drying of the newborn, b. early skin-to-skin contact, c. cord clamping, d. non-separation of mother/baby for early breastfeeding initiation e. eye prophylaxis, f. Vitamin K administration, g. weighing of the newborn, h. BCG vaccination, i. Hepatitis B immunization (1st dose), and, j. professional fee (including physical examination baby & breastfeeding advice)	1,750 pesos
	B. Newborn Screening Test (NBS)	
	C. Newborn Hearing Screening Test	

a. In cases of incomplete provision of services, the corresponding amounts shall be deducted for the following services:

SERVICES NOT GIVEN	AMOUNT TO BE DEDUCTED FROM CASE RATE (1,750 pesos)
B. Newborn Screening Test (NBS) only	550 pesos
C. Newborn Hearing Screening Test only	200 pesos
BOTH B and C (Newborn Screening Test (NBS)) and (Newborn Hearing Screening Test)	750 pesos

b. Included in the case rate is the allotted 500 pesos for professional fee.

c. The No Balance Billing policy shall still apply as specified.

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Date: 4/4/11
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2) In accredited facilities where the required laboratory or diagnostic tests are not available (e.g., Level 1 hospitals with no X-ray, hospitals with no CT scan) *PhilHealth Claim Form 3* should be properly accomplished to support the diagnosis provided.

   a. This will serve as the document to be evaluated by the Corporation for purposes of monitoring compliance to policies and guidelines.
   b. For facilities which have the necessary equipment to perform the needed laboratory tests, diagnostic and ancillary procedures as provided in Circular 11-A, certified photocopy of the result should be attached to the claim application to support the diagnosis. Submission of *PhilHealth Claim Form 3* is optional.

3) For cases with available current Clinical Practice Guidelines (CPG) adopted by societies or as provided by *the World Health Organization* (WHO), facilities may utilize such guidelines aside from those identified in Circular Nos. 11, 11-A and 11-B and may provide other laboratory test (e.g., TUBEX for typhoid fever as per Circular No. 2 s-2009) and ancillary procedures to support the diagnosis. The same amount of case rate will be paid to facility.

II. SURGICAL CASES

1) Cataract procedures covered under the cataract package are the following: **66983**, **66984** and **66987**.

2) As stated in Item VI. A. 5 of Circular No. 11 s-2011, undelivered cases (baby delivered in referral facility) in non-hospital facilities shall be reimbursed 10% of the MCP Package. In these cases, they shall be coded using **P59403**.

III. GENERAL RULES

1) In the event of death, claims shall be excluded from the package and shall be paid via fee-for-service scheme. As provided in PhilHealth Circular No.18, s-2009, claims shall be considered as:

   a. Case type D in Levels 3 to 4 hospitals,
   b. Case type C in Level 2 hospitals, and;
   c. Case type B in Level 1 hospitals

2) In cases where patients were managed by several doctors (accredited and non accredited), the claim may still be reimbursed in full. The manner of distribution is left with the providers (facility and professional) except in some specified cases. In proper filling of PhilHealth Claim Form 2, there is no need to write the breakdown of amounts in items 11a to 11d.

   a. The total actual hospitalization and PF charges shall **still** be indicated in **11e** Benefit Package (*Actual Charges Column*) and the case rate amount (*PhilHealth Benefit Column*) in the PhilHealth Benefit column.
   b. For item No. 16, there is no need to write the professional charges.

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c. Parts II and III of PhilHealth Claim Form 2 (CF2) should be properly accomplished. The provider however may submit an itemized Statement of Account (SOA) as a replacement for the itemized Parts II and III of CF2.
d. All the other information are still required and forms should be properly accomplished for a more efficient processing and monitoring of claims.

All other issuances which are inconsistent with this circular are hereby amended accordingly.

This Circular shall be effective immediately.

DR. REY B. AQUINO
President and CEO
Date signed: 06 Oct 15

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