Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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March 25, 2003

PhilHealth Circular
No. 16 *, s. – 2003*

TO : **ALL CONCERNED**

SUBJECT : **PHILHEALTH MATERNITY CARE PACKAGE FOR NORMAL SPONTANEOUS DELIVERY (NSD) PERFORMED IN NON-HOSPITAL FACILITIES**

Pursuant to PhilHealth Board Resolutions Numbers 486 and 501 series of 2002 and to properly guide all concerned in the implementation of the new PhilHealth Maternity Care Package for normal spontaneous delivery (NSD), PhilHealth hereby issue its implementing guidelines for your reference effective to maternity care services initiated on **May 1, 2003.**

GENERAL RULES:

1) The following non-hospital health facilities shall be accredited by PhilHealth before they can provide the NSD package: Lying-in Clinics, Midwife-managed Clinics, Birthing Homes, or any other analogous health facilities.

2) Currently accredited Rural Health Units (RHU) and Ambulatory Surgical Clinics (ASC) shall also be allowed to provide the NSD package; provided, that they comply with all the requirements enumerated in PhilHealth Circular Nos. ***15, s. -2001*** and ***09, s. - 2003***. No additional accreditation fee shall be imposed on currently accredited RHU and ASC for their accreditation as providers of the NSD package.

3) The new PhilHealth Maternity Care Package for normal spontaneous delivery utilizes a case payment scheme in claims reimbursement. The Relative Value Unit (RVU) assigned for these procedures (Relative Value Scale code number 59409) shall no longer apply.

4) Pursuant to PhilHealth Board Resolution No. 501, this package shall only be limited to the first two (2) normal deliveries.

5) A case rate of 4,500 pesos shall be paid to accredited health care providers

6) For this fee, accredited providers shall provide all the services the member or dependent requires including prenatal care, delivery, newborn care and postnatal services.

7) The payment for the health facility is expected to cover for the necessary room and board, drugs and medicines, diagnostics, operating room, professional fees and all other medically necessary care. Services rendered for maternal complications during delivery is integrated in the package.

8) In order to ensure a holistic quality health care for both mother and child, case rate payment for these facilities shall be divided as follows:

CLAIMS PAYMENTS For **"NON-HOSPITAL HEALTH FACILITIES"**

Covered Services	**Period**	**Benefits**
Prenatal care & Normal delivery	**(1st payment)** After delivery	**P 3,650.00**
Postnatal care & Family planning services	**(2nd payment)** After postnatal consultation	**P 850.00**
TOTAL		**P4, 500.00**

9) The Corporation shall not reimburse claims with incomplete provision of services.

10) Availment of the PhilHealth Maternity Care Package shall be charged one-day to the annual 45-day benefit limit.

ELIGIBILITY RULES:

1) All members and qualified dependents of the National Health Insurance Program (NHIP) who satisfy the criteria of eligibility and are not disqualified by the exclusion criteria may avail of the NSD benefit package.

2) An individually paying member should comply with the rule on sufficient regularity of premium contributions and should have at least nine (9) months or three (3) quarters of premium payments in the immediate twelve (12) months prior to delivery. However, IPP enrolled as a group or through the IPP-OWWA program and for all other types of membership need not satisfy the sufficient regularity rule and are governed by current eligibility requirements.

3) Moreover, the first prenatal visit of the member or qualified dependent must not exceed the four (4) months age of gestation (AOG) of the current pregnancy.

4) The following conditions are considered as **exclusion criteria for the NSD package in non-hospital facilities**, and shall be denied payment when claimed:

   a. Maternal age under 19 years old
   b. Elderly primies with maternal age of 35 years and older
   c. Multiple pregnancy
   d. Ovarian abnormalities (e.g. ovarian cyst)
   e. Uterine abnormalities (e.g. myoma uteri)
   f. Placental abnormalities (e.g. placenta previa)

g. Abnormal fetal presentation (e.g. breech)
h. History of at most three (3) miscarriages or one (1) stillbirth
i. History of previous major obstetric/gynecologic operative intervention (e.g. cesarean section, uterine myomectomy)
j. History of medical conditions (e.g. hypertension, heart disease, pre-eclampsia, eclampsia, diabetes, thyroid disorders, obesity, moderate to severe asthma, epilepsy, renal disease, bleeding disorders)
k. Other risk factors that may arise during the present pregnancy (e.g. premature contractions, vaginal bleeding) that warrants a referral for further management

CLAIMS FILING:

1) Duly accomplished Claims Form 4 shall be required in filing for reimbursement of benefit. Until this new claim form is distributed to providers, they may still use PhilHealth Claim Form No. 2.

2) All claim applications for the Maternity Care Package shall be covered by the rules on ICD-10 requirements by the Corporation.

3) Claims for the prenatal, delivery and newborn care must be filed within sixty (60) calendar days from date of discharge, while the second claim for postnatal and family planning services must be filed within ninety (90) days from date of discharge.

For the information and guidance of all concerned.

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President and CEO