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

May 21, 2003

PhilHealth Circular

No. 19, s. 2003

TO : **ALL HEALTH CARE PROVIDERS, CLAIMS PROCESSING DEPARTMENTS – NATIONAL CAPITAL REGION AND PHILHEALTH REGIONAL OFFICES AND ALL OTHER CONCERNED**

SUBJECT: **PHILHEALTH OUTPATIENT ANTI-TUBERCULOSIS/ DIRECTLY OBSERVED TREATMENT SHORT-COURSE (DOTS) BENEFIT PACKAGE**

Pursuant to PhilHealth Board Resolution Numbers 485 and 490, s-2002 and in order to accomplish its mandate of providing accessible quality health care services to all its members, an **Outpatient Anti-tuberculosis or Directly Observed Treatment Short-course (DOTS) Benefits Package** shall be included in PhilHealth's Benefits Package. The following are the guidelines to avail of this package:

A. BENEFIT

1. A flat rate of 4,000 pesos per case shall be paid to an accredited DOTS facility and this amount shall be given in two separate payments.
2. For this fee, the provider shall cover diagnostic work-up, consultation services and anti-TB drugs the patient requires in an outpatient set-up.
3. The first payment of 2,500 pesos shall be paid after the accredited DOTS center has completed the intensive phase of DOTS treatment. The end of the intensive phase shall be considered as the date of treatment.
4. The final payment of 1,500 pesos shall be paid to the DOTS center after the end of maintenance phase. The end of the maintenance phase shall be considered as the date of treatment.
5. Payment to referral centers, physicians and other health care workers shall be settled by the referring DOTS Center.
6. The Corporation shall not pay for additional services rendered or for an extension of treatment.

7. All claim applications of accredited DOTS Centers shall also be covered by the rules on ICD-10 requirements by the Corporation.

B. ELIGIBILITY:

1. All members and qualified dependents of the National Health Insurance Program (NHIP) who satisfy the criteria of benefit eligibility and are not disqualified by the exclusion criteria may avail of the DOTS Benefit Package.
2. The DOTS Benefits Package is designed for new cases of pulmonary and extrapulmonary tuberculosis for children and adults.

New Case – A patient who has never had treatment for TB or who has taken anti-tuberculosis drugs for less than one month.

3. However, PhilHealth shall not cover the following TB cases:
   a. *Failure case* - A patient who, on previous treatment, is sputum smear positive at five months or later during the course of treatment.
   b. *Relapse case*- A patient previously treated for tuberculosis who has been declared cured or treatment completed, and is diagnosed with bacteriologically positive (smear or culture) tuberculosis.
   c. *Return after default (RAD) case* - A patient who returns to treatment with positive bacteriology (smear or culture), following interruption of treatment for two months or more.
4. A beneficiary shall be entitled to avail of the DOTS package if the following conditions are met:

Type of Membership	Eligibility
Employed Individually Paying Program (IPP)	Three (3) months of contributions must have been paid within immediate six (6) months prior to enrollment at the DOTS Center.
Sponsored (Indigent) Pensioner Overseas Filipino Worker	Enrollment at the DOTS Center shall start within the date of effectivity of membership as stated in the ID Card/Eligibility Certificate.

In addition, all PHIC beneficiaries, regardless of type of membership, should have their monthly premium paid during the duration of DOTS treatment.

C. REIMBURSEMENT PROCESS

1. All accredited DOTS centers shall submit a copy of NTP Treatment Card *(see attached)* of enrolled PhilHealth beneficiaries or register them to the TB Management Information System of the Quality Assurance Research and Policy Development Group (QARPDG) within sixty (60) days of patient's enrolment to the program.
2. A copy of updated NTP Treatment Card, together with the DOTS Claim Form *(see attached),* must be submitted within sixty (60) days upon completion of each treatment phase (intensive and/or maintenance phase) to the Claims Department at the Central Office or the PhilHealth Regional Office.
3. Payment of DOTS centers shall be made within sixty (60) days upon submission of complete requirements.
4. Claims with incomplete requirements shall be returned to the health facility and must be complied within sixty (60) days from date of receipt of notice. Failure to comply shall cause denial of the claim.

D. PROVIDERS

1. The providers of the DOTS benefits package shall be outpatient clinics duly accredited by PhilHealth.
2. To ensure technical capability of health care providers, only facilities duly certified by the Philippine Coalition Against Tuberculosis (PhilCAT) may apply for accreditation.
3. Accreditation of DOTS facilities is prospective. All claims of DOTS facilities wherein the intensive phase were completed prior to the accreditation of the DOTS facilities shall not be compensated.
4. All accredited providers are expected to have computers and access to the Internet to ensure compliance with electronic patient registration requirements of this benefit.

E. EFFECTIVITY

1. This new package shall take effect for all DOTS care provided in PhilHealth-accredited facilities where the date of treatment of the intensive phase is on or after May 21, 2003.

All other issuance not inconsistent with this circular shall remain in full force and effect.

For your information and guidance.

FRANCISCO T. DUQUE, MD, MSc
President and CEO

NTP Treatment Card

TB CASE NUMBER	DATE THE CARD IS OPENED Month day year	REGION & PROVINCE	DHS/RHU/HOSP./OTHERS

NAME OF PATIENT	OCCUPATION	AGE	SEX M / F	WEIGHT kg

ADDRESS	NAME/RELATIONSHIPS/ADDRESS (CONTACT PERSON)	No. of House Hold Contacts:____

PREVIOUS TB TREATMENT:
[ ] No [ ] Yes
Duration: [ ] less than 1 mo. [ ] more than 1 mo. Specify drugs:_____
When:_____ Where:_____

BCG SCAR
[ ] Yes [ ] No
[ ] Doubtful

CLASSIFICATION OF TB:
[ ] PULMONARY
[ ] EXTRA-PULMONARY site:_____

TYPE OF PATIENT:
[ ] NEW [ ] RETURN AFTER DEFAULT (RAD)
[ ] RELAPSE [ ] FAILURE
[ ] TRANS. IN [ ] OTHER

CATEGORY (encircle):
I. 6-SCC (2HRZE/4HR)
New Case
1. Smear(+)
2. Seriously ill
2.1. Smear(-): MA or FA radiographic lesion
2.2. Extra-pulmonary

II. 8-SCC (2HRZES/1HRZE/5HRE)
1. RELAPSE 2. FAILURE
3. RETURN AFTER DEFAULT (RAD)
4. OTHER (smear+)

III. 6-SCC (2HRZ/4HR)
New Case
1. Smear (-): Minimal
2. Extra-pulmonary not seriously ill

SPUTUM EXAMINATION RESULTS

Month	Due Date	Date Examined	Result
0			
2			
3			
4			
5			
6			
>7			

REMARKS:_____

TREATMENT STARTED:
month____ day____ year_____

TREATMENT OUTCOME:

[ ] CURE
Date:__/__/___
[ ] TREATMENT COMPLETED
Date:__/__/___
[ ] DIED
Date:__/__/___
Cause:_____

[ ] TREATMENT FAILURE
Date:__/__/__
[ ] DEFAULTER
Date:__/__/__
Specify:_____
[ ] TRANSFER OUT
Date:__/__/__
Specify:

Name of Treatment Partner:_____ Designation:_____

Drug Intake (Intensive phase)

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Drug Intake (Maintenance phase)

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

REMARKS:_____

PHILHEALTH

March 2003

TB-DOTS PACKAGE CLAIM FORM 5

(DATE RECEIVED)

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

1. PhilHealth Accreditation No.

2. Name of Hospital/DOTS Center

3. Address of Hospital/DOTS Center

No., Street | Barangay

Municipality/City | Province | Zip Code

4. Name of Member

Last Name | PIN

First Name

Middle Name

5. Address of Member

No., Street | Barangay

Municipality/City | Province | Zip Code

6. Name of Patient

Last Name

First Name

Middle Name

7. Age

8. Sex

☐ M
☐ F

9. Date of Registration Enrollment:

Completion of:

☐ intensive phase ☐ date of death _____

☐ maintenance

10. Diagnosis and ICD-10 Code:

11. CLASSIFICATION OF TB:

☐ Pulmonary
☐ Extra-Pulmonary site: _____

TYPE OF PATIENT:

☐ New ☐ Return After Default (RAD)
☐ Relapse ☐ Failure
☐ Trans. In ☐ Other

12. CATEGORY (tick box):

I. 6-SCC (2HRZE/4HR)

☐ New Case
☐ 1. Smear (+)
☐ 2. Seriously ill
☐ 2.1. Smear (-): MA or FA Radiographic lesion
☐ 2.2. Extra-pulmonary

II. 8-CC (2HRZES/5HRE)

☐ 1.Relapse ☐ 2.Failure
☐ 3. Return After Default (RAD) ☐ 4. Other (smear +)

III. 6-SCC (2HRZ/4HR)

☐ New Case
☐ 1. Smear (-): Minimal
☐ 2. Extra-pulmonary not seriously ill

13.CERTIFICATION of HOSPITAL/DOTS CENTER: I certify that the services rendered are duly recorded in the patient's chart and that the information in this form are true and correct.

Signature Over Printed Name of Authorized Representative | Date Signed | Official Capacity