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

July 7, 2003

PHILHEALTH CIRCULAR

No. 25 *, s. – 2003*

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:

1. 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**

2. 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**

3. For breech extraction in hospital facilities, code and RVU shall be as follows:

59411	Breech extraction and other abnormal presentation	**80**

4. For Cesarean section (CS) in hospital facilities, the code to be used shall be:

59514	Cesarean delivery	**150**

5. 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**

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)	:Php2,000(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 (1st)	- Package
	G2	-Normal Delivery (2nd)	- Package
	G3	-Normal Delivery (3rd)	- 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 (1st)	- Pay RVU (59411)
	G2	- Normal Delivery (2nd)	- Package
	G3	- Normal Delivery (3rd)	- Not covered
Case #5	G1	- Cesarean Section Delivery (1st)	- Pay RVU (59514)
	G2	- Normal Delivery (VBAC) (2nd)	- Pay RVU (59612)
	G3	- Normal Delivery (3rd)	- Not covered
Case #6	G1	- Stillbirth or Preterm delivery (1st)	- Pay RVU (59409)
	G2	- Normal Delivery (2nd)	- Package
	G3	- Normal Delivery (3rd)	- 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 (1st)	- Package
	G2	-Spontaneous abortion	- Pay RVU of D&C (58120)
	G3	-Normal Delivery (2nd)	- 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 (1st)	- Package
	G2	-Normal Delivery (2nd)	- Package
	G3	-Forceps Delivery (3rd)	- Pay RVU (59409)

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

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

xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

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**

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

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**	(1st payment)
Postnatal care Family planning & Counseling	**Php 850.00**	(2nd 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	1st Q 2003	2nd Q 2003	3rd Q 2003	4th 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.

2. Accreditation Category ☐ Primary ☐ Secondary ☐ Tertiary
☐ Non-Hospital Facilities (Lying-in clinics, Midwife-managed clinics, Birthing Homes, Ambulatory Surgical Clinics)

3. Name of Facility

4. Address of Facility
No., Street | Barangay
Municipality/City | Province | Zip Code

5. Name of Member and Identification
Last Name | First Name
Middle Name | PhilHealth Identification No.

6. Address of Member
No., Street | Barangay
Municipality/City | Province | Zip Code

7. Name of Patient
Last Name
First Name
Middle Name

8. Age

9. Admission Diagnosis

10. Confinement Period
a. Date Admitted m m d d y y y y
b. Date Discharged m m d d y y y y
c. Total No.of Days
d. Date of Death (If Applicable) m m d d y y y y

11. Facility Services	ACTUAL FACILITY CHARGES	PHIC BENEFIT PAYABLE TO FACILITY	PHIC BENEFIT PAYABLE TO PATIENT	REDUCTION CODE
TOTAL				
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

14. ICD-10 Code:

FOR PHILHEALTH USE
RVS Code
Illness Code
Reduction Code

15. Name of Provider | Signature & Date Signed

16. PHIC Accreditation No.

17. BIR/TIN No. - -

18. Services Performed

19. Actual Professional Charges	PHIC BENEFIT PAYABLE TO Provider	PHIC BENEFIT PAYABLE TO Patient
P	P	P

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.

PHILHEALTH

CLAIM FORM 4A

April 2003

MATERNITY CARE PACKAGE

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 ☐ LMP : _____ Menarche: _____
4. Obstetric History ☐ G_____ P_____ (_____, _____, _____, _____)
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 ☐
   - f. History of stillbirth ☐
   - g. History of pre-eclampsia ☐
   - h. History of eclampsia ☐
   - i. Premature contraction ☐
7. Medical/Surgical Risk Factors
   - a. Hypertension ☐
   - b. heart disease ☐
   - c. Diabetes ☐
   - d. Thyroid disorders ☐
   - e. Obesity ☐
   - f. Moderate to severe asthma ☐
   - g. Epilepsy ☐
   - h. Renal disease ☐
   - I. Bleeding disorders ☐
   - j. History of previous cesarean section ☐
   - k. History of uterine myomectomy ☐
8. Determine pertinent abdominal examinations
   - a. Abdomen
     - normoactive bowel sound ☐
     - non-tender ☐
     - active fetal movements ☐
     - fundic ht= _____
     - estimated fetal wt: _____
     - FHT= _____
     - Leopold's Maneuver L1: _____ L3: _____
     - L2: _____ L4: _____
     - presentation: _____
   - b. Speculum Exam
     - parous vagina
     - cervix smooth, closed
   - c. Internal Exam
     - uterus enlarged to AOG
     - adnexal masses
9. Give complete diagnosis: _____

B. Write Delivery Plan indicating:

1. Orientation to LRMC Package/Availment of Benefits
2. Schedule of prenatal examinations Date: ___/___/___ Place: _____
3. Expected date and venue of delivery

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

Visit No.	2nd	3rd	4th	5th	6th	7th	8th	9th	10th	11th	12th
Date of visit											
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			b. Heart/Lungs			c. Skin/Extremities		
anicteric sclerae	(+)	(-)	clear breath sounds	(+)	(-)	full pulses	(+)	(-)
pink palpebral conjunctiva	(+)	(-)	sinus rhythm	(+)	(-)	bipedal edema	(+)	(-)
REMARKS _____			REMARKS _____			REMARKS _____		

4. Determine pertinent abdominal examinations

regular uterine contractions	(+)	(-)	FHT= _____
bloody show	(+)	(-)	fundic ht= _____
active fetal movements	(+)	(-)	estimated fetal wt: _____

5. Perform IE

BOW: _____ Cervical Effacement: _____ Presentation: _____

Cervical dilatation: _____ Station: _____

B. Ascertain that patient is in true active labor	☐	Time of start of labor: _____
C. Admit and obtain informed consent	☐	Time of Admission: _____
D. Monitor course of labor, accomplish partogram	☐	_____
E. Prepare Delivery Room	☐	_____
F. Attend to Delivery of Baby	☐	Time of delivery of newborn: _____
G. Get APGAR score of Newborn	☐	APGAR : _____
H. Routine Newborn Care	☐	_____
I. Perform Delivery of Placenta	☐	Time of delivery of placenta: _____
J. Check if placenta is complete	☐	_____
K. Ensure good uterine contraction	☐	_____
L. Inspect for perineal and vaginal lacerations	☐	_____
M. Explain to patient the procedure of perineal repair	☐	_____
N. Suture perineal laceration under Local Anesthesia	☐	_____
O. Check repair and ensure hemostasis	☐	_____
P. Transfer patient to recovery area	☐	_____
Q. Monitor during Immediate Postpartum Period	☐	BP: ___ HR: ___ RR: ___ T: ___
R. Discharge Clearance (D/C IE)	☐	Vagina: _____ Cervix: _____ Uterus: _____

S. Give Complete Diagnosis

OB Score : G ____ P ____ (____ , ____ , ____ , ____)

Maternal Outcome: _____ , _____ , _____ , _____

Pregnancy Uterine | AOG by LMP | Manner of Delivery | Presentation

Birth Outcome: _____ , _____ , _____ , _____

Live | Sex | Birthweight | APGAR Score

T. Accomplish documents for PHIC Reimbursement _____

U. Schedule Postpartum and Newborn Care follow-up Date: _____

consult - 1 week after delivery ☐

V. Discharge Patient ☐ Date and Time of Discharge: _____

I hereby certify that I received the services indicated above.

_____

Signature of Patient

I hereby certify that I delivered the services indicated above.

_____

Signature of Physician/Midwife

PHILHEALTH

CLAIM FORM 4B
April 2003

MATERNITY CARE PACKAGE

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	☐	_____
B. Check for signs of Maternal Postpartum complications	☐	_____
C. Check for signs of Newborn complications	☐	_____
D. Counselling and Education		
1. Newborn Care	☐	_____
2. Breastfeeding and Nutrition	☐	_____
3. Newborn Immunization	☐	_____
4. Family Planning	☐	_____
E. Provide family planning service to patient if requested	☐	_____
F. Refer to Partner Physician for Voluntary Surgical Sterilization, if requested by patient		_____
G. Schedule postpartum visit 6 weeks postpartum	☐	_____

I hereby certify that I received the services indicated above.

_____
Signature of Patient

I hereby certify that I delivered the services indicated above.

_____
Signature of Physician/Midwife