Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PHILHEALTH CIRCULAR
No. 09, s-2009

TO : ACCREDITED INSTITUTIONAL AND PROFESSIONAL HEALTH CARE PROVIDERS, MEMBERS OF THE NATIONAL HEALTH INSURANCE PROGRAM, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED

SUBJECT : 2009 Revised Inpatient Benefit Schedule

Consistent with PhilHealth's mandate to provide a responsive, adequate and more equitable benefit package, the revised inpatient benefit schedule pursuant to Philhealth Board Resolution Number 1212 s-2009 is hereby implemented subject to the following guidelines:

A. GENERAL RULES

1. Primary (Level 1) hospitals shall be reimbursed for:
   a. Cases where the primary illness is classified as case types A and B. Medical conditions classified as case types C and D in Level 1 hospitals shall only be reimbursed up to the limit specified in case type B.
   b. Procedures with RVU 30 and below:
      1) Dialysis, chemotherapy and radiotherapy done in primary hospitals shall not be compensated.
      2) Procedures with RVU above 30 may only be reimbursed if considered as emergency.
         i. Payment of hospital charges shall be based on case type A only.
         ii. Payment of surgeon's fee shall be up to 2,000 pesos only
         iii. Payment of operating room fee is fixed at 500 pesos
2. Secondary (Level 2) hospitals shall be reimbursed for clinical conditions classified as case type A, B and C. Conditions classified as case type D in Level 2 hospitals shall only be reimbursed up to the amount specified in case type C.
3. Only Tertiary (Levels 3 & 4) hospitals shall be reimbursed the maximum amount specified in case type D.
4. All claims with primary conditions classified as case type D shall require submission of PhilHealth Claim Form 3 or Clinical Abstract for proper evaluation regardless of hospital category.
5. Benefits for drugs and medicines, supplies and laboratories shall be subject to the limits covered by the rule on single period of confinement for the same illness. This means that admissions and re-admissions due to the same illness within a 90-day period shall only be compensated within one (1) maximum benefit, to wit:
   a. Therefore, availment of benefit for the same illness or condition which is not separated from each other by more than 90 days will not be provided with a new benefit, until after the 90-day period reckoned from the date of admission.
   b. Only the remaining benefits from the previous confinement/s may be availed for succeeding confinements due to the same illness.
6. All claims for drugs and medicines, supplies and necessary laboratory procedures supported by official receipts dated 30 days prior to admission may be reimbursed for the following procedures: peritoneal dialysis, hemodialysis, chemotherapy, and other elective surgeries.

7. The new inpatient benefit schedule for Level 1; Level 2; and Levels 3 & 4 hospitals are annexed in this circular. *(See attached Benefit Schedule)*

B. ROOM AND BOARD

1. Room and board benefit will depend on hospital category, case type of illness and patient's length of stay.
2. A member is entitled to a maximum of 45 days confinement per calendar year. When the 45-day allowance has been consumed, claims for succeeding confinements shall no longer be covered including payment for drugs and medicines; x-ray, laboratory, and, supplies; operating room fee; and professional fee.

C. DRUGS AND MEDICINES

1. Maximum benefit for drugs and medicines benefit will depend on hospital category and case type of illness.
2. Benefits for drugs and medicines are covered by the rule on single period of confinement.
3. Rules on Phil. National Drug Formulary (PNDF), Antimicrobial Resistance Surveillance Program (ARSP) and rational drug use shall be observed.

D. SUPPLIES, AND RADIOLOGY, LABORATORY & ANCILLARY PROCEDURES

1. Maximum benefit for supplies and radiology, laboratory and ancillary procedures shall depend on hospital category and case type of illness.
2. Benefits for x-ray, laboratory and supplies are also covered by the rule on single period of confinement.
3. As required by the Cheaper Medicines Act, official receipts issued by doctors for devices (e.g., intraocular lens) shall not be reimbursed by PhilHealth.

E. OPERATING ROOM

1. Payment for operating room (OR) will depend on the hospital category and the RVU of the procedure.
   a. For primary hospitals, payment of OR is fixed at 500 pesos per use of operating room.
   b. For secondary hospitals and ambulatory surgical clinics (ASC), freestanding dialysis centers (FDC), payment for OR shall be as follows:

RVU of the Procedure	Payment for Operating Room
RVU 30 and below	750 pesos per use of operating room
RVU 31 to 80	1,200 pesos per use of operating room
RVU 81 to 600	RVU multiplied by 15 peso conversion factor • Minimum of 2,200 pesos • Maximum of 7,500 pesos

   c. For tertiary hospitals:

RVU of the Procedure	Payment for Operating Room
RVU 30 and below	1,200 pesos per use of operating room
RVU 31 to 80	1,500 pesos per use of operating room
RVU 81 to 600	RVU multiplied by 20 peso conversion factor • Minimum of 3,500 pesos

Example procedures:

Procedure (RVU)	Payment for Operating Room		
	Primary	Secondary	Tertiary
1) Excision breast mass (RVU 25)	500 pesos	750 pesos	1,200 pesos
2) Explor lap (RVU 150)	0	2,250 pesos	(3,000) 3,500 pesos
3) Cholecystectomy (RVU 180)	0	2,700 pesos	3,600 pesos
4) Intracranial surgery (RVU 600)	0	(9,000) 7,500 pesos	12,000 pesos

d. Payment of operating room fee covers the use of operating room complex - operating room, delivery room, recovery room, minor operating room, endoscopy room, hemodialysis room, or radiotherapy room.
   1) Payment for operating room complex also covers payment for machines and equipment used during operation.
   2) Drugs (e.g., oxygen, anesthesia) and supplies (e.g., gauze, cotton, suture, etc.) used inside the operating room shall be charged against the benefit allotted for drugs and for supplies, not against the budget for the operating room.
   3) Claims for operating room fee for bedside procedures and peritoneal dialysis shall not be reimbursed.

e. For multiple procedures done in separate operative session, payment of OR fee shall be given per use of operating room.

F. PROFESSIONAL FEE

Payment for professional fee (PF) depends on service rendered (medical management or surgery) case type of illness, professional and hospital category and patient's length of stay.

1. Daily visits

a. Payment for daily visit will depend on length of stay, case type of illness and doctor category. *(See Attached Benefit Schedule)*

b. Doctors with Claims Code Group Numbers 2, 3, and 4 *(See Annex A of PhilHealth Circular No. 11 series of 2005)* shall be classified as specialist in the computation of payment for daily visits.

c. Claims for professional fee for daily visit of doctors with Claims Code Group Numbers 1, 5, and 6 shall be computed using the rate for general practitioners.

d. Payment for multiple doctors is allowed provided that all services claimed are "medically-necessary". Payment shall be based on rate for daily visit but the total payment for all doctors shall not exceed the maximum limit per confinement.
   1) Example: Patient admitted for 4 days in a tertiary hospital for pneumonia high risk (classified as case type C) and managed by 2 specialists.

Doctors	Daily rate	PF Payment
Specialist 1 (Group 2)	700 pesos	700 x 4 days = 2,800 pesos
Specialist 2 (Group 2)	700 pesos	700 x 4 days = 2,800 pesos
Total Payment for PF daily visit		**5,600 pesos**

2. Surgery and Other Services with RVUs

Payment for surgeons and anesthesiologist shall be based on the following tables:

Primary (Level 1) Hospitals

Case Type A and B		
Claims Code Group	**Surgeon**	**Anesthesiologist**
Group 1 (GP)	RVU x PCF 40 (baseline)	40% of baseline surgeon's fee
Group 5,6 (With training)	RVU x PCF 48	48% of baseline surgeon's fee
Group 2,3,4 (fellow)	RVU x PCF 56	56% of baseline surgeon's fee
	Maximum of 2,000 per confinement	Maximum fee computed as percentage (40, 48 or 56) of 2,000

Secondary (Level 2) Hospitals

Case Type A, B and C		
Claims Code Group	**Surgeon**	**Anesthesiologist**
Group 1 (GP)	RVU x PCF 40 (baseline) Maximum of 3,200 pesos	40% of baseline surgeon's fee Maximum of 1,280 pesos
Group 5,6 (With training)	RVU x PCF 48	48% of baseline surgeon's fee
Group 2,3,4 (fellow)	RVU x PCF 56	56% of baseline surgeon's fee

Tertiary (Level 3 and 4) Hospitals

Case Type A, B and C		
Claims Code Group	**Surgeon**	**Anesthesiologist**
Group 1 (GP)	RVU x PCF 40 (baseline) Maximum of 3,200 pesos	40% of baseline surgeon's fee Maximum of 1,280 pesos
Group 5,6 (With training)	RVU x PCF 48	48% of baseline surgeon's fee
Group 2,3,4 (fellow)	RVU x PCF 56	56% of baseline surgeon's fee
Case Type D		
Claims Code Group	**Surgeon**	**Anesthesiologist**
Group 1 (GP)	RVU x PCF 40 (baseline) Maximum of 3,200 pesos	40% of baseline surgeon's fee (RVU x PCF 40) Maximum of 1,280 pesos
Group 5,6 (With training)	RVU x PCF 48	48% of baseline surgeon's fee (RVU x PCF 40)
Group 2,3,4 (fellow)	RVU x PCF 56 (for RVU 500 and below)	56% of baseline surgeon's fee (RVU x PCF 40)
Group 2,3,4 (fellow)	RVU x PCF 80 (for RVU 501 and above)	40% of specialist surgeon's fee (RVU x PCF 80)

a. Surgeons Fee

1) Payments of professional fee of surgeons' are based on relative value unit (RVU) multiplied by the peso conversion factor (PCF).
   i. PCF depends on doctor category as stated in tiered payment of PF.
   ii. Doctors classified as general practitioners (Claims Code Group Number 1) shall only be compensated up to RVU 80 (3,200 pesos) per procedure. However this limit shall not be applicable to claims for PF (for pooling) on surgeries performed by salaried physicians as supervised by specialists in government hospitals and private training hospitals and shall therefore be compensated accordingly based on the RVU of the procedure. Likewise, this exemption shall be applicable to general practitioners practicing in PhilHealth identified shortage areas.
2) PCF 80 shall only be applicable to specialists performing procedures with RVU 501 and above in tertiary hospitals. PCF of 40 still apply to Group 1 (general practitioners) and PCF of 48 for Groups 5 and 6 (doctors with training). Example: tertiary hospital

Procedure (RVU)	**Payment of Surgeon** (Δ maximum fee for GP)		
	Group 1	Groups 5,6	Groups 2, 3, 4
Surgery intracranial (RVU 600)	RVU x 40 =(24,000) 3,200 pesos$^{\Delta}$	RVU x 48 =28,800 pesos	RVU x 80 =48,000 pesos

3) For multiple procedures wherein 1 procedure performed has an RVU of 501 and above and the other procedure has an RVU below 500, PCF 80 shall only apply to the procedure with RVU 501 and above. Example:

Procedure (RVU)	**Payment of Surgeon** (Δ maximum fee for GP)		
	Group 1	Groups 5,6	Groups 2, 3, 4
Cutdown (RVU 10)	10 RVU x 40 = 400 pesos	10 RVU x 48 = 480 pesos	10 RVU x **56** = 560 pesos
Resection neoplastic lesion anterior cranial fossa; extradural (RVU 550)	550 RVU x 40-= (22,000) 3,200 pesos$^{\Delta}$	550 RVU x 48 26,400 pesos	550 RVU x **80** 44,000 pesos
Total Payment	**3,600 pesos**	**26,880 pesos**	**44,560 pesos**

4) Additional payment for daily visits shall only be allowed for procedures with RVU of 30 and below.

b. Anesthesiologists Fee

1) Two or more procedures done in one sitting, regardless of site, anesthesiologist shall be compensated using the procedure with the higher/highest value unit. Example: two surgeries for fracture done in 1 session in a single confinement

Procedure (RVU)	Payment	
	Surgeon Doctor Group 3	**Anesthesiologist** Doctor Group 4
1a. Fracture proximal phalanx, right hand, thumb, open (90 RVU)	5,040	2,016
1b. Fracture distal phalanx, left hand, second digit, open (80 RVU)	4,480	~~1,792~~ ⅄
Total	6,400 pesos	**2,016 pesos**
⅄ Pay only the higher procedure in 1 operative session		

2) It is reiterated that professional fee for local anesthesia is not covered.

This Circular shall take effect for all claims with admission dates starting April 5, 2009.

All other issuances inconsistent with this circular are hereby modified or repealed accordingly.

For the information and guidance of all concerned.

DR. REY B. AQUINO
President and CEO
Date signed: 17 March 09

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NEW INPATIENT BENEFIT SCHEDULE

LEVEL 1 HOSPITALS (PRIMARY)		
Benefit Item	**Case Type**	
	A	**B**
Room and Board (maximum of 45 days per year)	300	300
Drugs and Medicine (per single period of confinement)	2,700	9,000
X-ray, Laboratory and Others (per single period of confinement)	1,600	5,000
Operating Room	500	
Professional Fees		
a. Daily visits		
General Practitioner *(Groups 1, 5 and 6)*		
Per Day	300	400
Maximum per confinement	1,200	2,400
Specialist *(Groups 2, 3 and 4)*		
Per Day	500	600
Maximum per confinement	2,000	3,600
b. Surgery (for Case Type A and B)		
	Surgeon	Anesthesiologist
General Practitioner *1st Tier (Group 1)*	RVU x PCF 40 = PF1	40% of surgeon's fee (PF1)
With training *2nd Tier (Group 5 and 6)*	RVU x PCF 48 = PF2	48% of surgeon's fee (PF1)
Diplomate/Fellow *3rd Tier (Group 2,3 and 4)*	RVU x PCF 56 = PF3	56% of surgeon's fee (PF1)
	Maximum of 2,000 per confinement	Maximum fee computed as percentage of 2,000

NEW INPATIENT BENEFIT SCHEDULE

LEVEL 2 HOSPITALS (SECONDARY)			
Benefit Item	**Case Type**		
	A	B	C
Room and Board (maximum of 45 days per year)	400	400	600
Drugs and Medicine (per single period of confinement)	3,360	11,200	22,400
X-ray, Laboratory and Others (per single period of confinement)	2,240	7,350	14,700
Operating Room	For procedures with RVU 30 and below = 750		
	For procedures with RVU 31 to 80 = 1,200		
	For procedures with RVU 81 to 600: RVU x PCF 15 (minimum = 2,200)		
Professional Fees			
a. Daily visits			
General Practitioner *(Groups 1, 5 and 6)*			
Per Day	300	400	500
Maximum per confinement	1,200	2,400	4,000
Specialist *(Groups 2, 3 and 4)*			
Per Day	500	600	700
Maximum per confinement	2,000	3,600	5,600

b. Surgery (for Case Type A, B and C)

	Surgeon	**Anesthesiologist**
General Practitioner *1st Tier (Group 1)*	RVU x PCF 40 = PF1	40% of surgeon's fee (PF1)
With training *2nd Tier (Group 5 and 6)*	RVU x PCF 48 = PF2	48% of surgeon's fee (PF1)
Diplomate/Fellow *3rd Tier (Group 2,3 and 4)*	RVU x PCF 56 = PF3	56% of surgeon's fee (PF1)

NEW INPATIENT BENEFIT SCHEDULE

LEVELS 3 & 4 HOSPITALS (TERTIARY)				
Benefit Item	**Case Type**			
	A	**B**	**C**	**D**
Room and Board (maximum of 45 days per year)	500	500	800	1,100
Drugs and Medicine (per single period of confinement)	4,200	14,000	28,000	40,000
X-ray, Laboratory and Others (per single period of confinement)	3,200	10,500	21,000	30,000
Operating Room	For procedures with RVU 30 and below = 1,200			
	For procedures with RVU 31 to 80 = 1,500			
	For procedures with RVU 81 to 600: RVU x PCF 20 (minimum = 3,500)			
Professional Fees				
a. Daily visits				
General Practitioner *(Groups 1, 5 and 6)*				
Per Day	300	400	500	600
Maximum per confinement	1,200	2,400	4,000	6,000
Specialist *(Groups 2, 3 and 4)*				
Per Day	500	600	700	800
Maximum per confinement	2,000	3,600	5,600	8,000
b. Surgery				
	For RVU 500 and below		**For RVU 501 and above**	
	Surgeon	**Anesthesiologist**	**Surgeon**	**Anesthesiologist**
General Practitioner *1st Tier (Group 1)*	RVU x PCF 40 = PF1	40% of surgeon's fee (PF1)	RVU x PCF 40 = PF1	40% of surgeon's fee (PF1)
With training *2nd Tier (Group 5 and 6)*	RVU x PCF 48 = PF2	48% of surgeon's fee (PF1)	RVU x PCF 48 = PF2	48% of surgeon's fee (PF1)
Diplomate/Fellow *3rd Tier (Group 2, 3 and 4)*	RVU x PCF 56 = PF3	56% of surgeon's fee (PF1)	RVU x PCF 80 = PF4	40% of surgeon's fee (PF4)