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. 19, s-2010

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

SUBJECT : OUTPATIENT HIV/AIDS TREATMENT PACKAGE

In support of the United Nation's Millennium Development Goal Number 6 to halt or reverse the incidence of Human Immuno-deficiency Virus (HIV)/Acquired Immune Deficiency Virus (AIDS) by 2015, PhilHealth through Board Resolution No. 1331, series of 2009 has approved the implementation of an outpatient HIV/AIDS treatment package. This benefit aims to increase the proportion of the population having access to effective HIV/AIDS treatment and patient education measures.

A. General Rules

1. The Outpatient HIV/AIDS Treatment (OHAT) Package will be paid through a case payment scheme. Annual reimbursement is set at 30,000 pesos per year.
2. Only confirmed HIV/AIDS cases requiring treatment shall be covered by the package.
3. Package shall be based on Department of Health (DOH) guidelines on anti-retroviral therapy among adults and adolescents with human immunodeficiency virus infection. All treatment hubs in accredited facilities are required to follow the guidelines set by the DOH.

B. Specific Rules

1. Covered items under this benefit are drugs and medicines, laboratory examinations including Cluster Difference 4 (CD4) level determination test and test for monitoring of anti-retroviral drugs (ARV) toxicity and professional fees of providers
2. The package will be released in four (4) quarterly payments; each sub-package is worth 7,500 pesos payable to the recognized treatment hub of accredited facilities. A maximum of four (4) treatment sub-packages per year may be claimed by the treatment hub.
3. Each quarterly claim is covered by the rule on single period of confinement computed from the date of consultation. Any additional claims filed within this same period for the same reason will be denied.
4. Only the actual quarters wherein services were provided in a year will be reimbursed. For example:

Start or treatment	October 15, 2010
Covered period of benefit entitlement	October 15, 2010 – December 31, 2010
Total amount of benefit	7,500 pesos

5. Each quarterly claim shall be charged one (1) day against the 45-day annual limit or a sum of 4 days per year.
6. In cases of transfer from one treatment hub to another, PhilHealth will still reimburse provided:
   a. The facility that the patient was transferred to is also PhilHealth accredited.
   b. A referral letter from the referring facility to the receiving facility is accomplished.

c. The Corporation will reimburse the facility prior to the transfer.

C. Inclusion Criteria

1. PhilHealth shall only pay for cases confirmed by STD/AIDS Central Cooperative Laboratory (SACCL) or Research Institute for Tropical Medicine (RITM).

D. Exclusion Criteria

1. Excluded in this OHAT Package are the following:
   a. Diagnosis of HIV/AIDS with no laboratory confirmation
   b. HIV/AIDS cases with no indication for anti-retroviral therapy
   c. Management of patients with pulmonary tuberculosis co-infection. A separate package for TB-DOTS may be reimbursed in accredited TB-DOTS facilities. A member may avail of both the OHAT and TB-DOTS packages simultaneously.
   d. Illness (opportunistic infections) secondary to HIV/AIDS that requires hospitalization
2. HIV/AIDS cases requiring confinement are covered under the regular inpatient benefit of PhilHealth.

E. Claims Availment and Processing

1. Claims for the OHAT Package must be submitted to PhilHealth within sixty (60) days from the first day of treatment.
2. Claims with incomplete requirements shall be returned to the facility for completion. The following documents are required for processing of claims:
   a. For all claims
      i. Duly accomplished revised PhilHealth Claim Form 1 by member and employer.
      ii. Duly accomplished revised PhilHealth Claim Form 2 by the health care providers. Fill in all blanks and write "NA" if the information required is not applicable
      a.) Part I: Items 1 to 13 should be properly filled out. The following boxes should be filled out as follows:
         1.) Item No. 4, write Outpatient HIV/AIDS Treatment Package or OHAT on the Category of Facility (see Annex C).
         2.) Item No. 10, write the date that corresponds to the day of consultation as seen in the Health Regimen Card as the date of admission and the date of discharge. Write "NA" in the Time of Admission and Time of Discharge. For the item No. of Days Claimed, write "OPD."
         3.) Item No. 11, write the amount 7, 500 pesos in the column provided for the Total Actual Charges and also in the column corresponding to the Total PhilHealth Benefit
         4.) Item No. 13, write "NA" in the space provided.
      b.) Part II: the physician must accomplish this portion
         1.) Item No. 14, write HIV/AIDS in the space for Admission Diagnosis
         2.) Item No. 15, write Human Immunodeficiency Virus – Acquired Immune Deficiency Syndrome in the space for Complete Final Diagnosis
         3.) Item No. 16, write "NA" in the columns provided for the Total Actual PF Charges and PhilHealth Benefit
         4.) For the portion provided for drugs and medicines, write "OHAT PACKAGE"
      c.) Part III: the physician must accomplish this portion by writing "OHAT PACKAGE" in the spaces provided for x-ray, laboratories, supplies and others.
      d.) Part IV: the institutional health care provider accomplishes this portion by affixing the signature over printed name of the authorized representative and writing his/her official designation and the date the form was signed in the prescribed format.

e.) Part V: the patient or his/her representative accomplishes this portion by signing in, the appropriate space provided together with the date the form was signed; indicate the relationship to the patient, if a representative signs in behalf of the patient; and the reason for signing on behalf of the patient.

iii. Updated Member Data Record (MDR)

iv. Proof of premium payment for individually paying members

v. PhilHealth ID card for sponsored, pensioners and overseas workers program members

b. Other documents to be submitted:

Initial Claims	Succeeding Claims
• Photocopy of the following: 1. HIV screening test result 2. confirmatory test results by SACCL or RITM 3. health regimen booklet • clinical abstract • waiver and consent for release of confidential information (see Annex A)	1. photocopy of the health regimen booklet 2. waiver and consent for release of confidential information (see Annex A) ❖ include referral letter in cases of transfer

3. For previously diagnosed cases but are filing for the first time, the claimant must still submit all the necessary laboratory test results together with the other requirements. This will be considered as the initial claim.
4. To ensure patients' rights to confidentiality, all claims for the OHAT Package shall be enclosed in a sealed envelope, marked **"CONFIDENTIAL"** and submitted to the PhilHealth Regional Office.
5. PhilHealth employees who will be directly involved in the processing of claims for HIV/AIDS shall sign a confidentiality agreement to further ensure patients' right to confidentiality.
6. All claims for the OHAT Package shall undergo regular claims processing (appropriate office order shall be provided for the guidelines).
7. To facilitate processing of this package, the Relative Value Scale (RVS) code shall be used by PhilHealth in claims evaluation:

Code	Description	RVU
99246	OUTPATIENT HIV/AIDS PACKAGE	Package

F. Accredited Providers

1. Only DOH-designated treatment hubs in accredited facilities may file for reimbursement for the OHAT Package. (see Annex B)
2. No separate accreditation for treatment hubs as OHAT Package providers shall be required, as long as the hospital is currently accredited by PhilHealth. In cases where there are gaps between facility accreditation, claims for the sub-package will not be paid.
3. Accredited providers designated as treatment hubs are required to create a trust fund for reimbursement of OHAT Package.
4. The disposition of PhilHealth payment shall be:
   a. 80% as revolving fund for the delivery of the required service e.g., drugs, supplies, laboratory reagents, equipment, site improvement, referral fee.
   b. 20% administrative costs including staff training and incentive that shall be divided among the HIV/AIDS Core Team (HACT) and other staff directly providing the services composed of, but not limited to the following: doctors, dentists, nurses, medical social workers and medical technologists.
5. All fees for the OHAT Package are payable to the provider who filed the initial claim. In cases where there is transfer of patient from one treatment hub to another, PhilHealth

facility, for such claim to be processed. In cases where transfer occurred within the same quarter, PhilHealth shall pay the initial facility.

G. Eligibility Rules for Members and Dependents

1. Sponsored and Overseas Workers Program members are entitled to the package if the period of treatment falls within the validity periods of their membership as stated in the ID card.
2. Retirees and pensioners shall be entitled to avail of the package upon presentation of PhilHealth ID.
3. Employed members including KASAPI and the Individually Paying Program (IPP) members must have at least three (3) months of contribution within the immediate six (6) months prior to the availment of claim.

This Circular shall take effect for all claims starting October 1, 2010.

All other provisions of previous Circulars, Office Orders and all other related issuances that are not inconsistent with any provisions of this Circular remain in full force and effect.

DR. REY B. AQUINO
President and CEO

Date signed: _____

PhilHealth
Your Partner in Health

OP-S10-32395

ANNEX A

WAIVER AND CONSENT FOR RELEASE OF CONFIDENTIAL PATIENT HEALTH INFORMATION

I, _____, with Patient Code No. _____,
(NAME OF PATIENT)
of legal age, and presently undergoing anti-retroviral therapy hereby

authorize:_____
(NAME OF ATTENDING PHYSICIAN)

of _____
(NAME OF ACCREDITED HOSPITAL)
to release the following information from my medical records to PhilHealth:

- ☐ Photocopy of HIV test result
- ☐ Photocopy of confirmatory test result from RITM/SACCL
- ☐ Clinical Abstract
- ☐ Health Regimen Booklet
- ☐ Others: Specify _____

The above enumerated information is to be released strictly to the authorized representative of the Philippine Health Insurance Corporation (PhilHealth) for the purpose of benefits availment.

By signing below, I request that payment of PhilHealth benefits for the Outpatient HIV/AIDS Treatment Package be made on my behalf to the aforementioned hospital for services provided to me by the hospital and its staff.

I undertake to release PhilHealth and its employees from any and all liabilities relative to the release of the above-enumerated information.

_____	_____	_____
Name of Patient or Person Acting on Patient's Behalf	Signature	Date

Reasons for Signing on Patient's Behalf: _____

_____	_____	_____
Name of Attending Physician	Signature	Date

Witnesses:

_____	_____	_____
Print Name	Signature	Date

Revised: December 2009

ANNEX B

LIST OF ACCREDITED TREATMENT HUBS IN THE PHILIPPINES

TREATMENT HUB	ADDRESS
LUZON	
San Lazaro Hospital (SLH)	Quiricada St., Sta Cruz, Manila
Research Institute for Tropical Medicine (RITM)	DOH Compound, Filinvest Corporate City, Alabang, Muntinlupa City
Philippine General Hospital (PGH)	Taft Avenue, Manila
Ilocos Training and Regional Medical Center (ITRMC)	San Fernando City, La Union
Baguio General Hospital and Medical Center (BGHMC)	BGHMC Compound, Baguio City
Bicol Regional Training and Teaching Hospital (BRTTH)	Legaspi City, Bicol
Cagayan Valley Medical Center	Tuguegarao City, Cagayan Valley
Jose B. Lingad Memorial Medical Center	San Fernando City, Pampanga
VISAYAS	
Vicente Sotto Sr. Memorial Medical Center (VSSMMC)	B. Rodriguez St., Cebu City
Western Visayas Medical Center (WVMC)	Mandurriao, Iloilo City
Corazon Locsin Montelibano Memorial Regional Hospital (CLMMRH)	Lacson St., Bacolod City
MINDANAO	
Davao Medical Center	J.P. Laurel Ave., Davao City
Zamboanga City Medical Center	Dr. Evangelista St., Sta Catalina, Zamboanga City

00-049ANNEX C

PhilHealth
Your Partner in Health

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CF2

(Claim Form)
revised February 2010

Series # _____
(For PhilHealth use only)

IMPORTANT REMINDERS:

PLEASE WRITE IN CAPITAL **LETTERS** AND **CHECK** THE APPROPRIATE BOXES.
For **local confinement**, this form together with CF1 and other supporting documents should be filed within **60 DAYS** from date of discharge.
All information required in this form are necessary and claim forms with incomplete information shall not be processed.
FALSE / INCORRECT INFORMATION OR MISREPRESENTATION SHALL BE SUBJECT TO CRIMINAL, CIVIL OR ADMINISTRATIVE LIABILITIES.

PART I - PROVIDER INFORMATION (Institutional Health Care Provider to fill out items 1 to 13)

1. Name of Facility: _____

2. Address: _____

3. PhilHealth Accreditation No. **(PAN)**: _____
(Institutional Health Care Provider)

4. Category of Facility:
☐ T-L4 /L3 ☐ ASC ☐ RHU
☐ S-L2 ☐ FDC ☐ TB DOTS
☐ P-L1 ☐ MCP ☒ "OHAT" (OTHERS)

5. PhilHealth Identification No. **(PIN)**: _____ - _____ - _____
(Member)

6. Name of Patient

Last Name | First Name | Middle Name (example: Dela Cruz, Juan Jr., Sipag)

7. Date of Birth ___ - ___ - ____ (month-day-year) 8. Age ___ Year/s ☐ Month/s ☐ Day/s ☐ 9. Sex ☐ Male ☐ Female

10. Confinement Period

a. Date Admitted: ___ - ___ - ____ (month-day-year)
b. Time Admitted: "NA" AM ___ PM
e. No.of Days Claimed "OPD"
c. Date Discharged: ___ - ___ - ____ (month-day-year)
d. Time Discharged: "NA" AM ___ PM
f. In case of Death, specify date ___ - ___ - ____ (month-day-year)

11. Health Care Provider Services	Actual Charges	PhilHealth Benefit	For PhilHealth Use Only (Adjustments / Remarks)
a. Room and Board Private ☐ Ward ☐			
b. Drugs and Medicines (Part II for details)			
c. X-ray/Lab./Supplies & Others (Part III for details)			
d. Operating Room Fee			
TOTAL	**"7,500.00"**	**"7,500.00"**	
e. Benefit Package			

12. Case Type* ☐A ☐B ☐C ☐D 13. Complete ICD-10 Code/s "NA"
*This is only applicable for claims with fee for service payment mechanism

(Professional Health Care Providers to fill out items 14 to 16)

14. Admission Diagnosis	15. Complete Final Diagnosis
"HIV/AIDS"	**"Human Immuno-defficiency Virus - Acquired Immune Defficiency Syndrome"**

16. Professional Fees / Charges

a. Name of Professional b. PhilHealth Accreditation No.	c. Number of Visits / RVS Code d. Inclusive Dates (mm-dd-yyyy)	e. Total Actual PF Charges	f. PhilHealth Benefit	g. Amount paid by members	h. Signature i. Date Signed	For PhilHealth Use Only
_____ ___ - ___ - ____	_____ _____	"NA"	"NA"			

PART II - DRUGS AND MEDICINES (use additional sheet if necessary)

Generic/Brand name	Preparation (dose/ cap/ syrup/ injectible /tab with ml/mg/gm content)	Qty	Unit Price	Actual Charges	PhilHealth Benefit
"OHAT PACKAGE"					
			TOTAL		

PART III - X-RAY, LABORATORIES, SUPPLIES AND OTHERS (use additional sheet if necessary)

Particulars	Qty	Unit Price	Actual Charges	PhilHealth Benefit
A. X-Ray (Imaging)				
"OHAT PACKAGE"				
B. Laboratories/Diagnostics				
"OHAT PACKAGE"				
C. Supplies and Others				
"OHAT PACKAGE"				
		TOTAL		

☐ Official receipts for drugs and medicines / supplies purchased by member from external sources as well as laboratory procedures done outside the hospital which are necessary for the confinement are attached to this claim.

PART IV - CERTIFICATION OF INSTITUTIONAL HEALTH CARE PROVIDER

I certify that services rendered were recorded in the patient's chart and hospital records and that the herein information given are true and correct.

The foregoing items and charges are in compliance with the applicable laws, rules and regulations.

Signature Over Printed Name of Authorized Representative

Official Capacity / Designation

Date Signed (month-day-year)

PART V - CONSENT TO ACCESS PATIENT RECORD/S

I hereby consent to the examination by PhilHealth of the patient's medical records for the sole purpose of verifying the veracity of this claim.

I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with this claim for reimbursement before PhilHealth.

Signature Over Printed Name of Patient

Date Signed (month-day-year)

Signature Over Printed Name of Patient's Representative

Date Signed (month-day-year)

Relationship of the Representative to the Patient:

☐ Spouse ☐ Child ☐ Parent ☐ Guardian/ Next of Kin

Reason for Signing on Behalf of the Patient: