Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
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PHILHEALTH CIRCULAR
NO. 011-A-2011

TO : **ALL ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES (PhROs), PHILHEALTH MEMBERS AND ALL OTHERS CONCERNED**

SUBJECT : **Selected Medical Case Rates - Additional Implementing Guidelines**

In compliance to PhilHealth Board Resolution No. 1441, series of 2010 and as an addendum to PhilHealth Circular No. 011, s-2011 (New PhilHealth Case Rates for Selected Medical Cases and Surgical Procedures), the following guidelines on claims payment are set for the following medical cases:

I. GENERAL RULES

1. The following are the cases with their corresponding rates:

CASES	CASE RATE
Dengue I (Dengue Fever and DHF Grades I and II)	**8,000**
Dengue II (Dengue Hemorrhagic Fever Grades III and IV)	**16,000**
Pneumonia I (Moderate Risk)	**15,000**
Pneumonia II (High Risk)	**32,000**
Essential Hypertension	**9,000**
Cerebral Infarction (CVA I)	**28,000**
Cerebro-vascular Accident with Hemorrhage (CVA II)	**38,000**
Acute Gastroenteritis (AGE)	**6,000**
Typhoid Fever	**14,000**
Asthma	**9,000**

2. The entire case rate amount shall be paid directly to the facility concerned.
3. Included in the abovementioned case rates are the professional fees of all doctors. For these cases, professional fees are compensated at 30% of said case rates.
4. Reimbursement for these packages shall be based on the main condition as stated in PhilHealth Circular No. 04, s-2002. Cases accompanied by presence of co-morbid conditions (e.g., hypertension, diabetes mellitus) and/or other medical conditions that arose during confinement shall have no additional payment.
5. Claims with final diagnoses written only as ill-defined and/or suspected diagnoses (e.g., T/C Dengue Fever, Probable Typhoid Fever, Suspected Dengue Fever, R/O Community Acquired Pneumonia) written in Claim Form 2 shall be **denied**. This shall also apply for all claims under the fee-for-service scheme.
6. For efficient claims processing, all accredited hospitals are required to provide correct ICD 10 codes up to the last character requirement.
7. In cases when a patient must be referred or transferred to a higher level facility for management, payment for these packages shall be paid to the referral facility. Claims filed by the referring facility shall be **denied** except Maternity Care Packages in accredited birthing facilities.
8. All claims for medical case rates shall be required to submit duly accomplished Claim Form 3.

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II. SPECIFIC RULES PER PACKAGE

A. DENGUE I (Dengue Fever and Dengue Hemorrhagic Fever Grades I and II)

1. This benefit includes cases with signs and symptoms of Dengue Fever and Dengue Hemorrhagic Fever Grades I and II and shall be reimbursed in all accredited hospitals.

CLASSIFICATION	CRITERIA
Dengue Fever	Presence of acute febrile illness with two (2) or more manifestations (i.e., headache, retro-orbital pain, myalgia, arthralgia, rash, hemorrhagic manifestations or leucopenia)
Dengue Hemorrhagic Fever (Grade I and II)	Presence of all of the following: history of fever lasting 2-7 days; positive tourniquet test or spontaneous bleeding; thrombocytopenia (platelet count $100+10^9$/L or less; and evidence of plasma leakage shown either as hemoconcentration or by development of pleural effusions or ascites, or both)

2. The following ICD 10 codes are covered by this benefit: A90, A91.0, A91.1 and A91.9.
3. Excluded in this benefit are cases of undifferentiated fever and asymptomatic dengue viral infections. Claims with these diagnoses shall be **denied** payment even on a fee-for-service basis.
4. Results of diagnostic tests (platelet count and hemoglobin/hematocrit results) should be attached to the claims application.

B. DENGUE II (Dengue Hemorrhagic Fever Grades III and IV)

1. This package shall be reimbursed in all accredited hospitals; but cases of Dengue II managed in Level 1 hospitals shall only be reimbursed as Dengue I package.
2. This benefit includes cases of Dengue Hemorrhagic Fever with all the criteria listed above plus presence of shock (Dengue Shock Syndrome).
3. The following ICD 10 codes are covered by this benefit: A91.2 and A91.3
4. Result of diagnostic tests (platelet count and hemoglobin/hematocrit results) should also be attached to the claims application.

C. PNEUMONIA I (Moderate Risk Pneumonia)

1. This package covers adult and pediatric pneumonia with unstable vital signs and with presence of co-morbid conditions and shall be reimbursed in all accredited hospitals.

AGE GROUP	SIGNS AND SYMPTOMS	CO-MORBID CONDITIONS
Adult	• Presence of unstable vital signs: ✓ RR ≥ 30 breaths/min; ✓ PR ≥ 125 beats/min ✓ Temp ≥ 40°C or < 35°C • evidence of: ✓ extra pulmonary sepsis or ✓ suspected aspiration	uncontrolled diabetes mellitus, active malignancies, progressive neurologic disease, congestive heart failure Class II-IV, unstable coronary artery disease, renal failure on dialysis, uncompensated chronic obstructive pulmonary disease, and decompensated liver disease
Pediatrics (up to 18 y/o)	• Presence of moderate dehydration, inability to feed, increased respiratory rate, with signs of respiratory failure and with presence of complications (i.e. effusion, pneumothorax)	

2. This package includes the following ICD 10 codes: J12.- to J18.-
3. For purposes of efficient claims processing, community acquired pneumonia cases shall be assigned an additional 5th character to the ICD 10 code to differentiate Pneumonia I and II claims.

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DIAGNOSIS	ICD-10 CODE	PACKAGE
Community Acquired Pneumonia II	J18.91	Pneumonia I
Community Acquired Pneumonia III	J18.92	
Community Acquired Pneumonia IV	J18.93	Pneumonia II

4. This package excludes low risk pneumonia. Claims for community acquired pneumonia I, with assigned ICD 10 code: **J18.90** is excluded in this benefit and shall be **denied** payment either as case rate or fee-for-service scheme.
5. Result of diagnostic test (chest x-ray result) should be attached to the claims application.

D. PNEUMONIA II (High Risk Pneumonia)

1. This package includes pneumonia cases with any of the clinical features seen in moderate risk pneumonia plus presence of shock or signs of hypoperfusion (i.e., hypotension, altered mental state, urine output < 30mL/hr, hypoxia or acute hypercapnea)
2. This package shall be reimbursed in all accredited hospitals; however, cases of Community Acquired Pneumonia IV (Pneumonia II Package) managed in Level 1 hospitals shall be reimbursed as Pneumonia I Package only.
3. This package includes the following ICD 10 codes: J12.- to J18.- with the following additional codes:
   a. **I95.9** - for hypotension
   b. **R06.4** - for hypercapnea
   c. **I24.8** - for hypoxia
4. Pneumonia II claims without additional codes for signs of shock or hypoperfusion shall be reimbursed as Pneumonia I package.
5. Result of diagnostic test (chest x-ray result) should be attached to the claims application.

E. ESSENTIAL HYPERTENSION

1. This package shall be reimbursed in all accredited hospitals and covers hypertensive emergency cases (e.g., hypertensive urgencies or Stage II hypertension with severe headache, shortness of breath, epistaxis or severe anxiety) requiring admission.
2. The following ICD 10 codes are covered by this benefit: I10.-, I11.9, I12.9 and I13.9
3. Excluded in this package are cases of hypertension involving vessels of the brain (ICD 10 codes I60-I69), vessels of the eye (ICD 10 code H35.0) and cases of secondary hypertension (ICD code I15.-). These cases shall be paid on a *fee-for-service scheme* based on the case type of the illness.

F. CEREBRO-VASCULAR ACCIDENT I AND II

1. This package shall be reimbursed in all accredited hospitals but cases of CVA II managed in Level 1 hospitals shall be reimbursed as CVA I package.
2. The following ICD 10 codes are covered by this benefit:

Package	ICD 10 Codes
CVA I (Cerebral Infarct)	I63.- , I64.-
CVA II (Cerebral Hemorrhage)	I60.-, I61.-, I62.-

3. The following are excluded from these benefit packages and shall be reimbursed on a 'fee-for-service" scheme:
   a. CVA cases requiring neurosurgical intervention
   b. ICD 10 codes: G45.-, I65.- to I69.-
4. For CVA I and II packages, detailed neurologic examination should be attached to the claim application.

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5. Result of computed tomography (CT) scan should be attached for CVA II claims. CVA II claims without attached CT scan result shall be reimbursed as CVA I package.

G. ASTHMA

1. This package shall be reimbursed in all accredited hospitals and covers persistent and severe cases of adult and pediatric asthma requiring admission based on accepted/adopted treatment guidelines.
2. The ICD-10 codes included in this package are the following: J45.- and J44.-
3. Excluded in this package are the following ICD-10 codes: J46, J82 and J60-J70. These cases shall be paid on a fee for service scheme based on the case type of the illness.
4. Cases of asthma that are not in acute exacerbation shall remain non-compensable even on a fee-for-service scheme.

H. TYPHOID FEVER

1. This package shall be reimbursed in all accredited hospitals and includes the following cases:
   a. Typhoid and paratyphoid fever (A01.-)
   b. Other salmonella infection (A02.-)
   c. Typhoid (infective) psychosis (F05.9)
2. Typhoid ileitis requiring surgical intervention (i.e., ileal resection) is excluded in this package and shall be paid through fee-for-service scheme based on RVU of the procedure performed.
3. Result of diagnostic tests (typhidot or Widal test) shall be attached to the claims application.

I. ACUTE GASTROENTERITIS

1. This package shall be reimbursed in all accredited hospitals and includes cases of AGE with moderate or severe dehydration, as well as patients who remain dehydrated despite initial treatment and any child with bloody diarrhea and severe malnutrition.
2. Cases of AGE package with no signs or some signs of dehydration are non-admissible as per World Health Organization (WHO) treatment guidelines and Health Technology Assessment (HTA) hence, shall not be compensable as a package and even on a fee-for-service basis.
3. The ICD-10 codes included in this package are the following: A09, A00.-, A03.0, A06.0, A07.1, K52.9 and P78.3
4. All AGE claims should have the following additional codes for level of dehydration:
   a. E86.1 - Moderate dehydration
   b. E86.2 - Severe dehydration
5. Result of fecalysis and/or culture and sensitivity should be attached to the claims application.

This Circular shall take effect for all claims with admission date September 1, 2011. Further, this circular shall be published in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

All other provisions of previous issuances that are inconsistent with any provisions of this Circular are hereby repealed/modified or amended accordingly.

DR. REY B. AQUINO
President and CEO
Date signed: 05 Aug '11

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