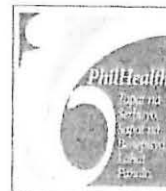




*Republic of the Philippines*  
**PHILIPPINE HEALTH INSURANCE CORPORATION**  
 Citystate Centre, 709 Shaw Boulevard, Pasig City  
 Healthline 441-7444 [www.philhealth.gov.ph](http://www.philhealth.gov.ph)



**PHILHEALTH CIRCULAR**

No. 011-B-2011

**TO :** <sup>day</sup> **ALL ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH REGIONAL OFFICES (PhROS), PHILHEALTH MEMBERS AND ALL OTHERS CONCERNED**

**SUBJECT:** **Selected Surgical 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 surgical procedures:

**I. GENERAL RULES**

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

CASES	CASE RATE
Cesarean Section (CS)	19,000
Dilatation and Curettage (D&C)	11,000
Hysterectomy	30,000
Mastectomy	22,000
Appendectomy	24,000
Cholecystectomy	31,000
Herniorrhaphy	21,000
Thyroidectomy	31,000
Radiotherapy	3,000
Hemodialysis	4,000
Cataract	16,000

2. The entire case rate amount shall be paid directly to the facility concerned.
3. Included in the abovementioned case rates are payment of professional fees of all doctors. Except for hemodialysis payment for professional fees for these case rates are compensated at 40% of said case rates.
4. These new rates shall apply to all claims by eligible PhilHealth members and dependents in all Level 2 to Level 4 accredited hospitals except for radiotherapy which shall be allowed in Levels 3 and 4 hospitals only and for the following cases which may also be allowed in the following hospitals/facilities as specified:

**PHILHEALTH**  
 MA. TERESAA QUIPOIT  
 A.O. III, Chief, RLSMS  
 Date: 8/11/11  
**CERTIFIED TRUE COPY**

CASE	FACILITY
D & C (Completion and Fractional Curettage)	Level 1 hospitals
D & C (Fractional Curettage)	Ambulatory surgical clinics (ASCs)
Herniorrhaphy	
Laparoscopic cholecystectomy	
Cataract	
Hemodialysis	Freestanding dialysis centers (FDCs)

5. Reimbursement for these packages shall be based on the main condition as stated in PhilHealth Circular No. 04, s-2002. Presence of co-morbid conditions (e.g., hypertension, diabetes mellitus) and/or post-operative complications that arose during confinement shall have no additional payment.
6. Case rates (e.g., mastectomy, herniorrhaphy, thyroidectomy) for surgical procedures with laterality shall be reimbursed as a single rate whether done in one or different operative session in a single confinement or different confinement within 90 days.
7. For two or more different surgical case rates performed in one operative session, PhilHealth shall reimburse the higher package.
8. For two or more different surgical case rates performed in separate operative sessions within a single confinement period, PhilHealth shall reimburse all packages.
9. 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.
10. For emergency procedures performed in accredited primary hospitals, payment shall be paid by a fee-for-service scheme based on RVU 30.
  - a. Claims from primary hospitals for the aforesaid procedures which are considered non-emergency shall be **denied**.
  - b. Therefore, all claims from primary hospitals are required to submit PhilHealth Claim Form 3.

## II. SPECIFIC RULES PER PACKAGE

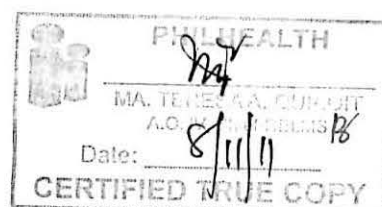
### A. CESAREAN SECTION PACKAGE

1. This package covers only indicated cesarean sections and includes RVS codes 59513, 59514 and 59620.
2. Elective cesarean sections (e.g., CS per patient request) including repeat cesarean sections performed without indication shall not be reimbursed by the Corporation.
3. This package also covers cesarean section with BTL, cesarean deliveries with incidental appendectomy, and cesarean deliveries with adhesiolysis.

**Adhesiolysis** (RVS Code: 44005) shall only be reimbursed if performed independent of any other procedure.

### B. DILATATION AND CURETTAGE PACKAGE

1. This benefit covers all dilatation and curettage procedures and includes RVS codes 58100, 58120, 59812 and 59814.



2. Excluded from this benefit package is the performance of uterine evacuation and curettage for hydatidiform mole (RVS Code: 59870)
3. This package shall be reimbursed in all accredited Levels 1 to 4 hospitals. However, ambulatory surgical clinics shall only be paid for claims with RVS code 58100 and 58120.

### C. HYSTERECTOMY PACKAGE

1. This benefit covers hysterectomy procedures whether following a delivery (e.g., vaginal or cesarean) or for other indications with the following RVS codes 58150, 58152, 58180, 58200, and 59525.
2. Excluded from the package are the following RVS codes: 58210, 58240, 58260, 58262, 58263, 58267, 58270, 58275, 58280, and 58285.

### D. MASTECTOMY

1. This benefit applies to both unilateral and bilateral mastectomy done within a single confinement.
2. This package includes the following RVS codes: 19140, 19160, 19162, 19180, and 19182.
3. Radical mastectomy procedures (RVS Codes: 19200, 19220 and 19240) are excluded from this package and shall be compensated based on the RVU of the procedure.

### E. THYROIDECTOMY

1. All procedures involving removal of thyroid gland are included in this package.
2. This package includes the following RVS codes: 60210, 60212, 60220, 60225, 60240, 60252, 60254, 60260, 60270, and 60271.
3. Excluded from this package are excision of thyroglossal duct cyst or sinus and parathyroidectomy (RVS codes 60280 and 60500). Claims for these procedures shall be paid through fee-for-service scheme.

### F. APPENDECTOMY

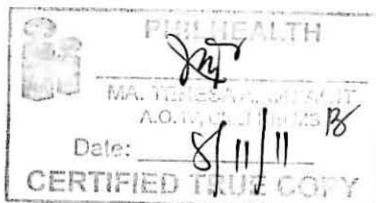
1. This benefit covers all appendectomy procedures, including laparoscopic appendectomy.
2. This package includes RVS codes: 44950, 44960 and 44970.
3. Elective appendectomy is non-compensable. Claims for elective appendectomy shall be denied even on a fee-for-service scheme
4. Excluded in this package are cases of appendectomy following exploratory laparotomies; such claims shall be paid as exploratory laparotomy based on RVS code 49000.

### G. CHOLECYSTECTOMY

1. This benefit covers all cholecystectomy procedures, including laparoscopic cholecystectomy.
2. This package includes the following RVS codes: 47560, 47561-47564, 47570, 47600, 47605, 47610, 47612 and 47620.

### H. HERNIORRHAPHY

1. The package shall apply to both unilateral and bilateral herniorrhaphy done within a single confinement.
2. Repair of abdominal and femoral hernia are included in this benefit.
3. This package covers repair of inguinal, femoral, lumbar, incisional, epigastric, umbilical, and spigelian hernia whether reducible, incarcerated or strangulated (RVS Codes 49495-49590, 49650-49651).



4. Excluded from this package are the following: repair of omphalocele, lung hernia, para-esophageal or diaphragmatic hernia (RVS Codes: 49600, 49605, 49606, 49610, 49611, and 32800). Claims for these procedures shall be paid through fee-for-service scheme.
5. Herniorrhaphy may be performed in ambulatory surgical clinics provided that the hernia is reducible, non-incarcerated and non-strangulated.

**I. HEMODIALYSIS PACKAGE**

1. This benefit covers all outpatient hemodialysis procedures with RVS code 90935. The professional fee is P500 for every session.
2. Reimbursement shall include payment for facility use and dialysis machine, drugs and medicines (0.9% sodium chloride, heparin, bicarbonate or acetate hemodialysis solution, e-cart drugs and **epoetin alfa or beta**), supplies and others (fistula kits, blood tubing set, **dialyzer**, syringe, and gauze) on a per session basis.
3. The following shall be excluded from the package and shall be paid via fee-for-service scheme:
  - a. Hemodialysis performed during hospital confinement
  - b. Other renal replacement therapy (e.g., CAPD, automated peritoneal dialysis).
  - c. Emergency dialysis procedure for Acute Renal Failure (e.g., ARF secondary to leptospirosis)
  - d. Creation of fistula for hemodialysis.

**J. RADIOTHERAPY PACKAGE**

1. This benefit covers outpatient radiotherapy procedures only on a per session basis.
2. This package includes only radiation treatment delivery using cobalt or Linear Accelerator (RVS code: 77401)
3. The following procedures are excluded in this package and shall be paid based on the fee for service scheme:
  - a. Therapeutic radiology treatment planning (simple)
  - b. Intensity Modulated Beam delivery plan
  - c. Stereoscopic X-ray guidance for localization of target volume for the delivery of radiation therapy
  - d. Stereotactic radiation treatment management for cerebral lesions
  - e. Brachytherapy
  - f. Radiotherapy performed on the same day with chemotherapy or brachytherapy. This shall be paid on a fee for service scheme based on RVU of the procedure performed.

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

**DR. REY B. AQUINO**  
President and CEO

Date signed: 05 Aug 11

