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. 020, s-2011

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

SUBJECT : **Clarificatory Guidelines No. 2 to PhilHealth Circular Nos. 11, 11-A and 11-B series of 2011**

Pursuant to PhilHealth Circular Nos.11, 11-A and 11-B, series of 2011, the following additional guidelines are being issued for proper implementation.

I. NO BALANCE BILLING POLICY

A. As regards to Item III-A.1 on No Balance Billing (NBB) Policy of PhilHealth Circular No. 11 s-2011, it is hereby clarified that NBB policy shall only apply to inpatient cases of Sponsored Program members and dependents admitted in **government hospitals**.

Sponsored members and their dependents shall be given utmost priority in service (ward) beds. When all the service beds are occupied, sponsored members/dependents for admission should be placed in an accommodation higher than the service beds; NBB shall still apply and no additional cost shall be charged to the member. Further, government hospitals are reminded not to refuse admissions of Sponsored Members.

B. The NBB Policy shall **not** apply to any of the following conditions:

1. When the sponsored member/dependent requests admission in other types of accommodation other than the service bed.
2. When the sponsored member/dependent requests for a private doctor.
3. When a member initially admitted in service bed then requested transfer to a private bed.
4. When a member initially opted for admission in a private bed and requested transfer to a service bed.
5. Any other analogous case when a Sponsored Member opts for a bed and/or private room different from the ward bed being offered.

C. The NBB policy in claiming for reimbursement for outpatient surgeries (e.g., cataract package), hemodialysis, radiotherapy, TB DOTS, Malaria, HIV-AIDS, Maternity Care Package, and Newborn Care Package in all accredited government hospitals and all non-hospital facilities (government and private) shall still apply as specified in Items III.A.2 to III.A.4 of PhilHealth Circular No. 11 s-2011.

D. All other items stipulated in Section III regarding NBB Policy of PhilHealth Circular No. 11 s-2011 shall remain in effect.

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief, RELMS
Date:
CERTIFIED TRUE COPY

II. GENERAL RULES

A. For those not covered by the NBB policy, the case rate benefit shall be maximized to cover for hospital services and professional fees. If in case the rates will not fully cover the bill, then the excess shall be charged to the PhilHealth member as out of pocket payment.

B. Case rates shall cover provision for all services; hence, all drugs, supplies, laboratories and diagnostic procedures necessary for the management should be provided by the hospitals and not to be bought/done outside by patients. It is reiterated that facilities should purchase necessary item/s in advance in behalf of the member.

C. As provided for by the IRR of RA 7875 as amended by 9241 and the Warranties of Accreditation both for facilities and professional, automatic deduction of PhilHealth benefits shall be provided to PhilHealth patients upon discharge.

1. Direct filing of claims is not encouraged. Only in instances when the necessary (eligibility) documents for availment are not available during discharge that health care providers may not deduct the PhilHealth benefits.

   In cases where there are directly filed claims by the patient, the claim should be supported by official receipts (OR) or waiver coming from the providers to support payment to the claimant. A Statement of Account (SoA) shall also be required which shall include both the hospital and professional charges attested by hospital representative. Itemization of Parts II and III of CF2 is required and shall be evaluated prior to payment of claims. The amount to be paid shall be based on the actual total cost **up to the case rate amount**.

2. If upon evaluation/monitoring and there are violations or non-adherence with issuances, circulars and policies as implemented, necessary steps shall be taken against the accredited providers as stipulated in the aforementioned circular.

D. Additional conditions for entitlement to PhilHealth benefits as specified in PhilHealth Circular No. 31 s-2010 shall apply to all case rate claims. In such cases, the member/patient is entitled to the full case rate amount.

E. Until such time that the Department of Health (DOH) shall issue a policy on how professional fees should be distributed in government facilities for claims designated for pooling, check shall be issued as follows:

1. The 30-40% allotted for professional fee shall be issued payable to the Chief of Hospital or Medical Director. As stated in *PhilHealth Circular No. 14 s-2005* pursuant to *Bureau of Internal Revenue Memorandum Circular No. 21-2005*, all PhilHealth reimbursement for professional fees payable to the "Chief of Hospital" for pooling and distribution among health personnel in a government hospital shall no longer be subject to 10% expanded withholding tax. The accredited government hospital, on the other hand, "upon distribution of their share from PhilHealth to their medical and non-medical personnel shall be responsible for the withholding tax on compensation, the issuance of BIR Form No. 2316 and submission of Annual Information Return".
2. The remaining 60-70% facility fee shall be issued under the name of the facility.

For private patients in government hospitals, the check shall be issued to the facilities following all provisions specified in PhilHealth Circular No. 11 s-2011.

F. To simplify submission of claims for case rate packages, the following rules hereby amend item nos. III-2-a and III-2-c in part III-General Rules of PhilHealth Circular No. 15, s-2011:

1. In PART I – PROVIDER INFORMATION of PhilHealth Claim Form 2 (CF2), facilities only need to write the case rate amount under *11e Benefit Package (PhilHealth Benefit Column).*
2. In PARTS II and III of CF2, facilities only need to write the name/s and quantity of the drugs/medicines in Part II; and supplies, laboratory and ancillary procedures in Part III.

III. MEDICAL CASES

A. For Pneumonia I and II (ICD 10 Codes: J12.- to J18.-), all accredited professionals are required to write the final diagnosis based on the Clinical Practice Guideline classification of Pneumonia for pediatric and adult cases and shall be coded and reimbursed based on the following table:

1. PEDIA PNEUMONIA

DIAGNOSIS (Pedia)	ICD-10 CODE	CASE RATE PACKAGE
PCAP A (Minimal Risk)	J18.90	Denied even in FFS
PCAP B (Low Risk)	J18.91	
PCAP C (**Moderate Risk**)	J18.92	Pneumonia I
PCAP D (**High Risk**)	J18.93	Pneumonia II

2. ADULT PNEUMONIA

DIAGNOSIS (Adult)	ICD-10 CODE	CASE RATE PACKAGE
CAP I (Low Risk)	J18.91	Denied even in FFS
CAP II (**Moderate Risk**)	J18.92	Pneumonia I
CAP III (**High Risk**)	J18.93	Pneumonia II

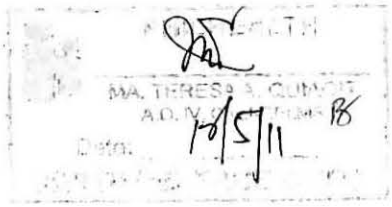
Accredited providers are reminded to write in the final diagnosis the level of risk of pneumonia. The name of the package should not be written in the final diagnosis.

For purposes of efficient claims processing, it is reiterated that all Pneumonia (ICD 10 Codes: J12.- to J18.-) claims shall be assigned an additional 4th or 5th character to be placed in the last position of the assigned ICD 10 code to differentiate the level of risk. Pneumonia (ICD 10 Codes: J12.- to J18.-) claims with *unspecified risk* or *no classification* indicated shall be denied payment.

Example 1:

DIAGNOSIS	ICD-10 CODE	CASE RATE PACKAGE
Pneumonia due to streptococcus pneumoniae (**Moderate Risk**)	J13.2	Pneumonia I
Pneumonia due to pseudomonas (**High Risk**)	J15.13	Pneumonia II

Further, Neonatal and obstetric cases complicated by pneumonia (e.g., neonatal aspiration pneumonia NOS [ICD 10 Code: P24.9]), diarrhea (e.g., other maternal infectious and parasitic diseases complicating pregnancy, childbirth and the puerperium [ICD 10 Code: O.98.8]) and other conditions classified under case rate shall be excluded from the case rate package. It shall be reimbursed via fee-for-



service scheme provided the diagnosis and its applicable ICD 10 code are indicated in PhilHealth Claim Form 2.

B. CVA I Package shall also include cases of Stroke, not specified as haemorrhage or infarction; Cerebro-vascular accident NOS (I64).

C. Acute Gastroenteritis (AGE) Package

1. Unspecified amoebiasis (A06.9) shall now be covered under the AGE Package.
2. All cases covered under AGE Package (ICD 10 codes: A09, A00.-, A03.0, A06.0, A06.9, A07.1, K52.9, P78.3) without mention of level of dehydration shall be denied even under fee-for-service. However, even if the mentioned level of dehydration is mild, it shall still be denied even under fee-for-service scheme.
3. Colitis (even without dehydration) when endoscopy is performed shall be paid via fee-for-service scheme.

D. Requirement for PhilHealth Claim Form 3

1. Claim Form 3 (CF3) is no longer required for reimbursement of Newborn Care Package (NCP) claims.
2. As per PhilHealth Circular No. 15 s-2011 laboratory/ancillary procedure results are required. Submission of CF3 is optional in cases when the required laboratory/ancillary procedure result is positive. However, if the laboratory/ancillary procedure result is negative, submission of CF3 is still required to support the diagnosis.
3. All claims for Pneumonia (I and II) and Dengue (I and II) packages, submission of CF3 is still required.

IV. SURGICAL CASES

A. Level 1 hospitals shall now be reimbursed for hemodialysis procedures provided that hospital is licensed by the Department of Health (DOH) to perform such procedure.

B. For proper payment, health care providers are reminded to indicate applicable RVS codes for all procedures performed in PhilHealth Claim Form 2 (CF2) under Item Nos. 16-c & 16-d. For procedures performed in combination i.e., CS with adhesiolysis, all RVU codes should also be indicated in CF 2.

Example 2:

PROCEDURES	RVS CODE TO BE WRITTEN IN CF2 (Item no. 16-c)
CS with Adhesiolysis	59514, 44005

V. REIMBURSEMENT RULES

A. PhilHealth case rate packages shall still be reimbursed even if managed by several doctors (accredited and non-accredited) provided the said case is attended by at least one (1) PhilHealth accredited doctor.

Example 3:

ATTENDING DOCTORS	PACKAGE	REIMBURSEMENT
Doctor 1: Accredited	CVA II	Paid
Doctor 2: Non-accredited		
Doctor 3: Non-accredited		

Example 4:

ATTENDING DOCTORS	PACKAGE	REIMBURSEMENT
Doctor 1: Non-accredited	CS	Denied
Doctor 2: Non-accredited		
Doctor 3: Non-accredited		

B. To reiterate, policy regarding main condition (PC No.2, s-2002) and provisions in PC No. 011-B-011 (surgical case rates), items no. 7 and 8 shall remain in effect and shall be strictly followed by all concerned.

For efficient processing of claims under medical case rates, all accredited health care providers are reminded that the corresponding ICD-10 code/s for the main condition shall be the first (1st) code to be written in Claim Form 2 to be followed by ICD 10 codes for other existing conditions. The manner of encoding in the system shall be based on how it is written in Claim Form 2 (CF2) and shall be reimbursed accordingly.

Example 5:

Final Diagnosis	ICD-10 Code
Hypertension	I10.9
Pneumonia, moderate risk	**J18.92**
If the patient's main condition is Pneumonia, moderate risk then the coding arrangement in PhilHealth Claim Form 2 should be **J18.92, I10.9.**	
This case shall be paid as **Pneumonia I Package** (Php 15,000.00).	

Example 6:

Final Diagnosis	ICD-10 Code
Hypertension	**I10.9**
Pneumonia, moderate risk	J18.92
If the patient's main condition is Hypertension then the coding arrangement for this case as indicated in PhilHealth Claim Form 2 should be **I10.9, J18.92.**	
This case shall then be paid as **Hypertension Package** (Php 9,000.00).	

All other issuances which are inconsistent with this circular are hereby amended accordingly.

This Circular shall be effective immediately.

DR. EDUARDO P. BANZON
President and CEO
Date signed: 11/21/11

PHILHEALTH
MA. TERESA A. QUMOIT
A.O. IV, CLMS
Date: 12/5/11
CERTIFIED TRUE COPY