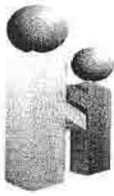


Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre Bldg., 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

PHILHEALTH CIRCULAR
NO. 0014, s 2013

FOR : PARTICIPATING HEALTH CARE PROVIDERS, PHILHEALTH MEMBERS, PHILHEALTH REGIONAL OFFICES, PHILHEALTH CENTRAL OFFICE AND ALL OTHER CONCERNED

RE : Revised PhilHealth Category of Institutional Health Care Providers (IHCP)s and Compensable Benefits in Primary Care Facilities

I. RATIONALE

PhilHealth's mandate is to provide all Filipinos with the mechanisms to obtain financial access to health services. As a vital component in achieving the goals of Universal Health Care, the Corporation continues to rationalize its health benefits simultaneous with the expansion of its membership base. However, accessibility to these benefits by the growing number of PhilHealth members remains an issue.

To address inequities in access, PhilHealth strengthens its primary care and out-patient benefits. However, further scrutiny of the PhilHealth benefits would show that some medical conditions and procedures that are currently compensable in a hospital setting could also be treated in a primary care facility without compromising the quality of care.

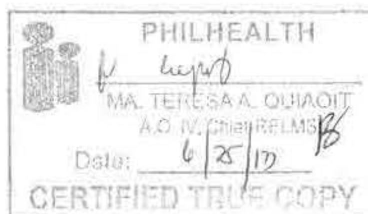
Recently, the Department of Health (DOH) issued the revised "Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines (DOH AO 2012-0012). Essentially, this policy redefines hospitals and other health facilities based on standards set for each type of facility. It now recognized among other facilities the Primary Care Facilities which are subdivided into those with in-patient beds such as infirmaries, dispensaries and birthing homes and those without beds such as Medical Out-patient Clinics.

PhilHealth's new engagement process (PhilHealth Circular 54 s, 2012) adopts this new classification for Institutional Health Care Providers (IHCPs).

In view of these policy changes, which underscore the need to increase accessibility of benefits to appropriate health care providers without compromising the safety and the quality of services to its members, PhilHealth revises its category of institutional health care providers and identifies benefit packages, procedures and medical conditions that are compensable in Primary Care Facilities.

II. OBJECTIVES

This policy aims to increase access to PhilHealth benefits among PhilHealth members and their dependents in different types and levels of facilities.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MA. TERESA A. QUIAOIT
A.O. IV, Chief RELMS
Date: 6/25/17
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The specific objectives are the following:

1. Reclassify PhilHealth category of institutional health care providers with corresponding benefit schedule based on the DOH's New Classification of Hospitals and Other Health Facilities (AO 2012-0012).

2. Identify out-patient packages, procedures and conditions compensable in Primary Care Facilities.

III. COVERAGE

This issuance covers hospitals and other health care facilities including primary care facilities in the DOH's New Classification of Hospitals and Other Health Facilities (AO 2012-0012) that participate as Institutional Health Care Providers of the benefits under the National Health Insurance Program. For the purpose of this circular, medical out-patient clinics shall include health centers, rural health units, stand alone TB DOTS centers, and animal bite treatment centers. Birthing homes shall include maternity clinics.

IV. DEFINITION OF TERMS

1. Primary Care Facility - first-contact healthcare facility that offers basic services including emergency service and provision for normal deliveries. Its sub-classifications are:
    a. With in-patient beds - a short stay facility where patients can be admitted for a short period of 1 to 3 days. Examples include infirmary, dispensary and birthing home.
    b. Without beds – a facility where medical and/or dental examination and treatment and minor surgical procedures are rendered without confining the patient. Example includes Medical Out-patient Clinic.

2. Infirmary – a healthcare facility with in-patient beds, capable diagnosis and treatment of patient but lacks one or several components required of a hospital such as operating room and/or intensive care unit.

3. Dispensary – a healthcare facility where medicine or medical treatment is dispense. Under the new DOH classification (AO 2012 -0012), they are considered primary care facility with in – patient beds.

4. Birthing Home– a facility with in-patient beds that provides maternity services (pre-natal, normal spontaneous delivery, post natal care) and newborn care. Also called maternity clinic.

5. Medical Out-patient Clinic – an institution or facility providing medical out-patient health services such as diagnostic, examination, treatment and health counseling.

6. Specialty Hospital – a hospital that specializes in particular disease or condition or in one type of patient. It was licensed as such with no corresponding level of classification. Example of which includes children's hospital and orthopedic hospital.

7. Ambulatory Surgical Clinics (ASC) – an institution which is primarily organized, constructed, renovated or otherwise established for the purpose of providing elective surgical treatment of out-patients whose recovery under normal and routine circumstances, will not require in-patient care. Under the new DOH classification they are considered a Specialized Out-patient Facility with highly competent and trained staff that performed highly specialized procedures on an out-patient basis.

V. GENERAL GUIDELINES

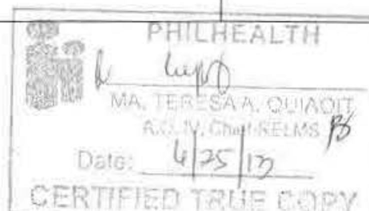
A. Reclassification of PhilHealth Institutional Health Care Providers

1. With the adoption of the DOH's new classification of hospitals and other health facilities, PhilHealth shall revise the hospital category and the corresponding benefit schedule to the following:

DOH New Classification of Hospitals and Other Health Facilities (DOH A.O. No. 2012-0012)	Old Hospital Category (DOH A.O No. 2005 - 0029 & PhilHealth Circular 2, s2006)	New PhilHealth IHCP Category	PhilHealth Benefit Schedule (PhilHealth Circular 9, s2009)
Hospitals			
Level 1	Level 2 (Secondary)	Hospital Level 1	Secondary
Level 2	Level 3 (Tertiary)	Hospital Level 2	Tertiary
Level 3	Level 4 (Tertiary)	Hospital Level 3	
Other Health Facilities			
Primary Care Facilities (With In-patient Beds) – infirmaries/dispensaries	Level 1 (Primary)	Primary Care Facilities (With In-patient Beds) – infirmaries/dispensaries	Primary
Primary Care Facilities (With In-Patient Beds) – birthing homes	-	Primary Care Facilities (With In-Patient Beds) – birthing homes	
Primary Care Facilities (Without Beds) – Medical Out Patient Clinics	-	Medical Out-Patient Clinics	Primary
Specialized Out-patient Facilities – Dialysis Clinics	- *Note: Categorized as Free Standing Dialysis Clinics (Secondary)*	Specialized Out-patient Facilities – Dialysis Clinics	Secondary
Specialized Out-Patient Facilities – Ambulatory Surgical Clinics	- *Note: Categorized as Ambulatory Surgical Clinics (Secondary)*	Specialized Out-Patient Facilities – Ambulatory Surgical Clinics	

2. However hospitals which did not meet the functional capacity corresponding to their level of classification specified in Section V.B.1.c of the DOH AO 2012-0012 but were allowed by DOH to retain their previous classification and have been given a grace period to comply with the requirements for their current level of classification, shall be paid based on their service capability as illustrated below:

Examples	PhilHealth Benefit Schedule to be Applied
Hospital with license to operate (LTO) as Level 1 but lacks operating room and standard equipment for major surgeries	Primary



Examples	PhilHealth Benefit Schedule to be Applied
Hospital with LTO as Level 2 but no provisions for intensive care unit or NICU or no departmentalized clinical services	Secondary
Hospital with LTO as Level 3 but no accredited training program in Surgery	Tertiary

3. Since specialty hospitals do not have any level of classification, those that are already engaged as PhilHealth providers shall retain their current category. However, those that are applying for initial participation shall be evaluated and categorized using the criteria for functional capacity specified in Section V.B.1.c of the DOH AO 2012-0012.

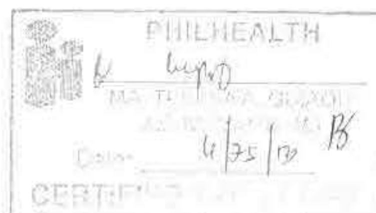
B. Benefits for Primary Care Facilities (PCF)

1. Taking into account the definitions, DOH's licensing requirements and criteria for classification of primary care facilities, PhilHealth shall pay the following selected procedures, health care services and out – patient benefit packages performed or managed in specified type of Primary Care Facilities:

   a. Existing out-patient benefit packages as listed below:

Benefit Package	Package Code/s	Amount and Reference PhilHealth Circular (PC)	Type of Primary Care Facilities
Maternity Care Package	59401	Php 1,500 – pre-natal care fee Php 6,500 – facility fee including professional fee (PC 11, s 2011)	Birthing Homes, Infirmaries/dispensaries
Newborn Care Package	99432	Php 1750 (PC11, s 2011)	Birthing Homes, Infirmaries/dispensaries
TB DOTS Package	89221 (intensive) 89222 (continuation)	Php 4,000 (PC 19, s 2011)	Infirmaries/dispensaries, Medical Out-patient Clinics
Primary Care Benefit 1 (PCB1) Package	-	Php 500 per family payment (PC10, s 2012)	Infirmaries/dispensaries, Medical Out-patient Clinics
PhilHealth Animal Bite Package	90375	Php 3,000 (PC 15, s 2012)	Infirmaries, Medical Out-patient Clinics
Out- Patient Malaria Package	87207	Php 600 (PC 25, s 2008)	Medical Out-patient Clinics

Note: Out-patient clinics of hospitals may also provide TB –DOTS Package, Primary Care Benefit 1 Package and Animal Bite Package subject to the requirements specified in PC 54, s 2012 for each benefit package. PCB1 providers may also provide Out-patient Malaria Package.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b. Selected medical case rates, on PhilHealth Circular (PC) 11-A, s. 2011 shall be compensable if admitted for more than 24 hours. The following rates shall be applied to all admissions starting January 1, 2014:

Medical Case Rates	ICD 10 Code/s	Amount	Type of Primary Care Facilities
Dengue 1	A90, A91.0, A91.1 & A91.9	Php 5,600	Infirmaries/ dispensaries
Pneumonia 1 (Moderate Risk)	J 12.- to J18.-	Php 10,500	
Essential Hypertension	I10, I11.9, I12.9, & I13.9	Php 6,300	
Acute Gastroenteritis(AGE) (with moderate/severe dehydration)	A09, A00.-, A03.0, A06.0, A06.9, A07.1, K52.9 & P78.3 with additional codes of E86.1 or E86.2	Php 4,200	
Asthma	J45.- & J44.-	Php 6,300	
Typhoid fever	A01.-, A02.- & F05.9	Php 9,300	

During the transition period prior to January 1, 2014, the rates of the above cases specified in PhilHealth Circular 11, s 2011 shall apply. The professional fees for the above medical cases shall be 30% of the reflected amount.

c. Selected procedures with Relative Unit Value (RUV) of 30 or less as listed in **Annex A** of this Circular shall be paid as fee for service pending implementation of all case rates. Claims for procedures not on the list shall be denied.

   i. These procedures are compensable if performed in primary care facilities - **infirmaries/dispensaries.** Claims for procedures done in other types of primary care facilities shall be denied.

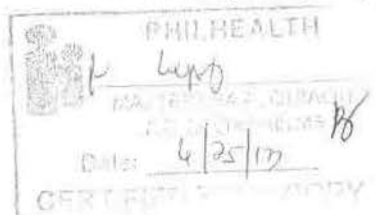
   ii. However, IUD insertion (RVS Code 58300) performed in primary care facilities – **birthing homes** shall be paid.

d. Selected medical conditions as listed in **Annex B** of this Circular shall be paid as fee for service until all case rate policy is implemented. These conditions are compensable only for patients admitted in the **infirmaries/dispensaries** for **more than 24 hours**. Claims for medical conditions not on the list shall be denied.

e. Other procedures and health services that may be determined by PhilHealth.

2. Except for Maternity Care Package, procedures under Surgical Case Rates listed in PhilHealth Circular 11-B, s. 2011 are not compensable in primary care facilities. Claims for these procedures shall be denied.

3. Concerned primary care facilities shall refer cases that are not on the above lists and need further management to hospitals except in emergency cases when immediate management is needed or transfer to another facility is not possible due to unstable condition of the patient. In such cases, the primary care facilities may file the claim for the procedures and conditions that are currently paid as fee for service using the limits specified in PhilHealth Circular 09, s 2009 for primary hospitals.



a. Medical conditions shall be reimbursed up to the limit specified for case type B.
b. Procedures with RUV above 30 shall only be reimbursed if considered emergency.
    i. Payment for hospital charges shall be based on case type A.
    ii. Payment of surgeon's fee shall be ups to 2,000 pesos only.
    iii. Payment of operating room is fixed at 500 pesos.
c. Surgical procedures under case rates listed in PC 11-B, s 2011 shall be denied.
d. Other medical case rates in PC 11-A, s 2011 (aside from those cases listed in V.B.1.b of this circular shall be denied.

4. Primary Care Facilities shall provide all necessary health services for complete management of the medical condition or procedure/s as enumerated below:

PhilHealth Benefit	Services Required from Provider
Maternity Care Package	• Pre-natal care • Management of Labor and Normal Spontaneous Delivery • Post-partum care • Professional Services • Health education including breastfeeding and family planning
Newborn Care Package	• Essential Newborn Care (immediate drying of the newborn, early skin-to-skin contact, cord clamping, non-separation of mother/baby for early breastfeeding initiation, eye prophylaxis, Vitamin K administration, weighing of the newborn) including services of health professional, initial vaccination for BCG and Hepatitis B; • Newborn Screening (NBS) Test and Newborn Hearing Screening Test
Out-patient Malaria Package	• Diagnostic Procedure • Anti-Malarial drugs and medicines • Consultation services; • Patient education and counseling
PhilHealth Animal Bite Package	• Post-exposure Prophylaxis Services for Rabies including vaccines and immunoglobulin • Local wound care • Tetanus Toxoid and anti – Tetanus Serum
TB DOTS Out-patient Package	• Anti TB Drugs • Follow-up sputum smear examinations • Consultation services • Patient education and counseling
Primary Care Benefit 1 (PCB1) Package	• Enlistment and Profiling of Members and Family • Consultation services • Primary Preventive Services • Selected diagnostic examinations, drugs and medicines listed in PhilHealth Circular 10, s 2012 as prescribed by PCB physician
Selected Surgical Procedures	• Room and board • Pre-operative care including pre-operative assessment • Professional fees • Performance of actual procedure including use of operating room, necessary equipment, supplies and drugs and medicines • Post-operative care • Nursing care and health education and counseling

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PhilHealth Benefit	Services Required from Provider
Selected Medical Conditions	• Room and board • Professional services of physician/s • Ancillary and diagnostic services, drugs and medicine and use of equipment and supplies necessary for the management of medical condition/s • Nursing care and health education and counseling

5. Primary Care Facilities shall comply with the existing rules on No Balance Billing Policy of the Corporation.

VI. PROVIDER ENGAGEMENT of PRIMARY CARE FACILITIES

1. The rules on Provider Engagement through Accreditation and Contracting for Health Services (PhilHealth Circular 54, s 2012) shall govern PhilHealth engagement of these facilities.

2. Qualified providers should indicate in their Provider Profile and Performance Commitment the PhilHealth benefit they intend to provide upon their application for participation.

3. Only physicians and midwives with any of the following training may participate as professional providers of IUD insertion:

Professional Providers	Training
Physicians	Residency on Obstetrics and Gynecology; or
	Family Planning Competency Based Training (FPBCT) Level 2
Midwives	FPBCT Level 2

4. Birthing homes and maternity clinics that will provide IUD insertion are required to submit copy/ies of their staff/s' certificate of completion for Level 2 Family Planning Competency Based Training (FBCT) or Obstetrics and Gynecology residency training certificate.

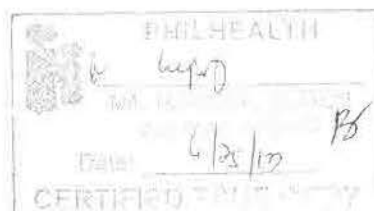
5. PhilHealth shall tag these services in the provider database to link with system for claims processing.

VII. CLAIMS FILING of PRIMARY CARE FACILITIES

1. The current rules and process flow for filing and processing of claims shall apply.

2. Providers shall submit the following requirements for claims processing (except for PCB1 claims):

   i. Properly accomplished Claim Form 1 (CF1)
   ii. Properly accomplished Claim Form 2 (CF2)
   iii. Properly accomplished Claim Form 3 (CF3)
   iv. Other documents required by PhilHealth as proof of eligibility as applicable under PhilHealth Circular (PC) 50, s. 2012 and PC 001, s. 2013 such as PhilHealth Identification Card for members, PhilHealth Number Card or its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alternative and Member Data Record for dependents, proof of contributions such as Official Receipt or Validated Payment Slip and other documents.

v. Copy of Operative Record or O.R. Technique for performed procedures (as applicable)

3. Claims for PCB 1 Package shall be submitted and evaluated according to the procedures and guidelines stated in PC 10 s, 2012.

4. Claims for TB DOTS Package shall have a copy of NTP Treatment Card in lieu of Claim Form 3.

5. For Animal Bite Treatment Package, providers may use Claims Summary Form attached as Annex B of PC 15, s 2012 instead of Claim Form 2. Moreover, submission of Claim Form 3 is not required.

6. Claims for Newborn Care Package shall have a copy of certificate of live birth. A copy from the facility without the registry number is acceptable as long as the records officer/clinic administrator of that facility certifies that it is the same copy which will be submitted for registration to local civil registrar. The Claim Form 2 shall have an attached filter collection card number of the NBS specimen. Also, Claim Form 3 is not required.

7. Claims shall have the correct ICD 10 code/s and RVS or Package Code (if applicable). Claims with no appropriate codes shall be returned to the facility for compliance.

8. As mentioned in PC 11-A, s 2011, claims for AGE should have the following additional ICD 10 codes to indicate level of dehydration:
   ii. E86.1 – moderate dehydration
   iii. E86.2 – severe dehydration

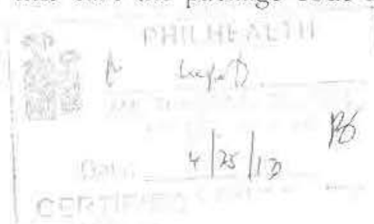
   Acute gastroenteritis with no or some signs of dehydration shall be denied.

9. As reiterated in PC 20, s 2011, only moderate risk community acquired pneumonia is compensable under case rate for Pneumonia I. Hence, for efficient claims processing, ICD 10 Codes for Pneumonia I (J12.- to J18.-) shall have "2" as an additional 4th or 5th character on the last position of the ICD 10 code to specify that the pneumonia case is moderate risk.

   Example

Diagnosis	ICD 10 Code	Case Rate Package
Community Acquired Pneumonia, moderate risk	J18.9<u>2</u>	Pneumonia I
Pneumonia due to Strep. Pneumonia, moderate risk	J13.<u>2</u>	

10. In cases when the patient must be referred or transferred to another facility for further management, the following provisions shall apply to the referring facility:
    i. For Maternity Care Package when patients in labor were initially managed by MCP provider but eventually referred and delivered in the hospital, the referring MCP provider shall be reimbursed 10% of the MCP facility fee (amounting to Php 650.00). In this case the package code shall be **59403**. (PhilHealth Circular 15, s 2011)



ii. If the condition is compensable as case rate, claims filed by referring primary care facility shall be denied. (PhilHealth Circular 11-A, s 2011)

iii. In cases when the condition is compensable under fee for service, claims of the referral hospital shall be paid first while claims of the referring primary care facility may still be paid if the benefit limit for that single period of confinement has not yet been exhausted.

VIII. MONITORING AND EVALUATION

1. Primary Care Facilities shall be included in the enhanced overall monitoring system of PhilHealth stated in Section VII of PhilHealth Circular 54, s 2012. It is reiterated that violations to PhilHealth policies include among others: incomplete provisions of services; non-performance of required laboratory services; and performance of services beyond the service capability.

2. The facility shall keep the patient's medical record and other pertinent documents, which shall be made available during PhilHealth monitoring surveys/visits.

3. Health Finance Policy Sector in coordination with the different stakeholders shall review this policy six (6) months after its implementation. The review shall be the basis for amendments and enhancement including updating of the list of compensable procedures and conditions.

IX. EFFECTIVITY

This Circular shall take effect 15 days from publication in the official gazette or any newspaper of general circulation.

All other existing issuances inconsistent with this Circular are hereby repealed and/or amended accordingly.

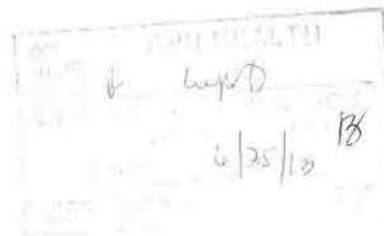
X. ANNEXES

Annex A - List of Compensable Procedures in Primary Care Facilities

Annex B - List Compensable Medical Conditions in Primary Care Facilities – Infirmaries

ENRIQUE T. ONA, MD
Secretary of Health/Chairperson of the Board and
OIC – President and CEO

Date signed: 6/18/13



Annex A - List Compensable Procedures in Primary Care Facilities - Infirmaries

Procedure	RVS Code	RVU
Integumentary System – Skin , Subcutaneous and Accessory Structures		
Incision and drainage of abscess (e.g., carbuncle, suppurative hidradenitis, cutaneous or subcutaneous abscess, cyst, furuncle, or paronychia)	10060	10
Incision and drainage of pilonidal cyst	10080	10
Incision and removal of foreign body, subcutaneous tissues(FB)	10120	10
Incision and drainage of hematoma, seroma, or fluid collection	10140	10
Puncture aspiration of abscess, hematoma, bulla, or cyst	10160	10
Incision and drainage, complex, postoperative wound infection	10180	15
Debridement; skin, partial thickness	11040	10
skin, full thickness	11041	10
skin, and subcutaneous tissue	11042	20
Paring or curettement of benign hyperkeratotic skin lesion w/ or w/o chemical cauterization (such as verrucae or clavi) not extending through the stratum corneum (e.g., callus or wart) w/ or w/o local anesthesia; single lesion	11050	10
two to four lesions	11051	15
more than four lesions	11052	20
Biopsy of skin, subcutaneous tissue and/or mucous membrane (including simple closure), unless otherwise listed ; single or multiple lesion	11100	10
Shaving of epidermal or dermal lesion, single lesion, trunk, arms or legs; lesion diameter 0.5 cm or less	11300	15
lesion diameter 0.6 to 1.0 cm	11301	24
lesion diameter 1.1 to 2.0 cm	11302	30
Shaving of epidermal or dermal lesion, single lesion, scalp, neck, hands, feet, genitalia; lesion diameter 0.5 cm or less	11305	15
lesion diameter 0.6 cm to 1 cm	11306	24
lesion diameter 1.1 cm to 2.o cm	11307	30
Excision, benign lesion, except skin tag (unless listed elsewhere), trunk, arms or legs; lesion diameter 0.5 cm or less	11400	10
lesion diameter 0.6 cm to 1.0 cm	11401	10

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Procedure	RVS Code	RVU
lesion diameter 1.1 cm to 2.0 cm	11402	10
lesion diameter 2.1 cm to 3.0 cm	11403	10
lesion diameter 3.1 cm to 4.0 cm	11404	10
lesion diameter over 4.0 cm	11406	10
Excision, benign lesion, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia lesion diameter 0.5 cm or less	11420	10
lesion diameter 0.6 cm to 1.0 cm	11421	10
lesion diameter 1.1 cm to 2.0 cm	11422	10
lesion diameter 2.1 cm to 3.0 cm	11423	10
lesion diameter 3.1 cm to 4.0 cm	11424	10
lesion diameter over 4.0 cm	11426	10
Excision, other benign lesion (unless listed elsewhere), face, ears, nose, lips, mucous membrane; lesion diameter 0.5 cm or less	11440	12
lesion diameter 0.6 cm to 1.0 cm	11441	12
lesion diameter 1.1 cm to 2.0 cm	11442	12
lesion diameter 2.1 cm to 3.0 cm	11443	12
lesion diameter 3.1 cm to 4.0 cm	11444	12
lesion diameter over 4.0 cm	11446	12
Excision of skin and subcutaneous tissue for hidradenitis, axillary	11450	30
Excision of skin and subcutaneous tissue for hidradenitis, inguinal	11462	30
Excision of skin and subcutaneous tissue for hidradenitis, perianal, perineal or umbilical	11470	30
Debridement of nail(s) by any method(s); one to five	11720	10
six or more	11721	15
Avulsion of nail plate, partial or complete	11730	10
Evacuation of subungual hematoma	11740	10
Excision of nail and nail matrix, partial or complete (e.g., ingrown or deformed nail) for permanent removal	11750	10
w/ amputation of tuft of distal phalanx	11752	25
Biopsy of nail unit, any method (e.g., plate, bed, matrix, hyponychium, proximal and lateral nail folds)	11755	10

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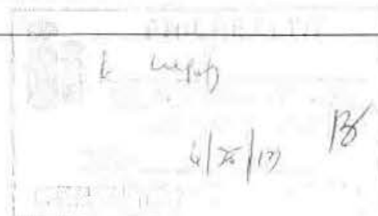
Procedure	RVS Code	RVU
Repair of nail bed	11760	15
Reconstruction of nail bed w/ graft	11762	25
Wedge excision of skin of nail fold (e.g., for ingrown toenail)	11765	10
Excision of pilonidal cyst or sinus	11770	20
Simple repair of superficial wounds of scalp, neck, axillae, external genitalia, trunk and/or extremities (including hands and feet); 2.5 cm or less	12001	10
2.6 cm to 7.5 cm	12002	15
7.6 cm to 12.5 cm	12004	20
12.6 cm to 20.0 cm	12005	20
20.1 cm to 30.0 cm	12006	20
over 30.0 cm	12007	20
Simple repair of superficial wounds of face, ears, nose, lips and/or mucous membranes; 2.5 cm or less	12011	20
2.6 cm to 5.0 cm	12013	25
5.1 cm to 7.5 cm	12014	28
7.6 cm to 12.5 cm	12015	30
12.6 cm to 20.0 cm	12016	30
20.1 cm to 30.0 cm	12017	30
over 30.0 cm	12018	30
Layer closure of wounds of scalp, axillae, trunk, and/or extremities (excluding hands and feet); 2.5 cm or less	12031	10
2.6 cm to 7.5 cm	12032	15
7.6 cm to 12.5 cm	12034	20
12.6 cm to 20.0 cm	12035	20
20.1 cm to 30.0 cm	12036	20
over 30.0 cm	12037	20
Layer closure of wounds of face, ears, nose, lips and/or mucous membranes; 2.5 cm or less	12051	20
2.6 cm to 5.0 cm	12052	20
5.1 cm to 7.5 cm	12053	30



Procedure	RVS Code	RVU
7.6 cm to 12.5 cm	12054	30
Chemical cauterization of granulation tissue (proud flesh, sinus or fistula)	17250	20
Integumentary System – Breast		
Puncture aspiration of cyst of breast;	19000	10
Biopsy of breast; needle core	19100	10
Incisional	19101	15
Excision of cyst, fibroadenoma, or other benign or aberrant breast tissue, duct lesion or nipple lesion (except 19140), male or female, one or more lesions	19120	30
Musculoskeletal System		
Incision and drainage, deep abscess or hematoma, soft tissues of neck or thorax;	21501	20
Biopsy, soft tissue of neck or thorax	21550	20
Excision tumor, soft tissue of neck or thorax; subcutaneous	21555	30
Closed treatment of rib fracture	21800	30
Drainage of finger abscess; Simple	26010	6
Digestive System		
Drainage of abscess, cyst, hematoma, vestibule of mouth	40800	20
Change of gastrostomy tube	43760	15
Introduction of long gastrointestinal tube (e.g., Miller-Abbott)	44500	30
Incision of thrombosed hemorrhoid, external	46083	30
Peritoneocentesis, abdominal paracentesis, or peritoneal lavage (diagnostic or therapeutic)(PIGTAIL)	49080	30
Male Genital System		
Circumcision, using clamp or other device; except newborn *(Note: Compensable only if done with clear indication i.e. phimosis)*	54152	15
Circumcision, surgical excision other than clamp, device or dorsal slit; except newborn *(Note: Compensable only if done with clear indication i.e. phimosis)*	54161	15
Drainage of scrotal wall abscess	55100	6
Vasectomy, unilateral or bilateral *(Note: Non-scalpel vasectomy only for Primary Care Facilities)*	55250	15
Female Genital System		
Incision and drainage of vulva or perineal abscess	56405	15
Incision and drainage of Bartholin's gland abscess	56420	25
Lysis of labial adhesions	56441	25
Destruction of lesion(s), vulva; any method (WART)	56501	25

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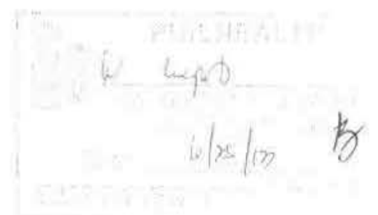
Procedure	RVS Code	RVU
Biopsy of vulva or perineum ; one lesion	56605	25
Colpocentesis	57020	20
Destruction of vaginal lesion(s)	57061	20
Biopsy of vaginal mucosa	57100	20
Colporrhaphy, suture of injury of vagina (nonobsterical)	57200	30
Colposcopy (Vaginoscopy)	57452	30
Cervix Uteri Biopsy, single or multiple, or local excision of lesion, w/ or w/o fulguration	57500	20
Cauterization of cervix; any method	57510	20
Insertion of intrauterine device (IUD)*	58300	10
Endocrine System		
Incision and drainage of thyroglossal cyst, infected	60000	6
Auditory System		
Drainage external ear, abscess or hematoma	69000	8
Drainage external auditory canal, abscess	69020	3

* IUD insertion in Primary Care Facilities – birthing homes is compensable (RVS code58300)

- End of the List-



Annex B - List of Medical Conditions Compensable in Primary Care Facilities - Infirmaries

Description/s (Conditions)	ICD 10 Code/s
Shigellosis	A03.1 to A03.9
Other bacterial intestinal infection	A04.0 to A04.9
Other bacterial food borne intoxications	A05.0 to A05.9 except A05.1
Chronic intestinal amoebiasis	A06.1
Amoebic nondysenteric colitis	A06.2
Other protozoal intestinal diseases	A07.0 to A07.9 except A07.1
Viral and other specified intestinal infections	A08.0 to A08.5
Respiratory tuberculosis, bacteriologically and histologically confirmed	A15.0 to A15.9
Respiratory tuberculosis, not confirmed bacteriologically or histologically	A16.0 to A16.9
Whooping cough	A37.0 to A37.9
Varicella [chickenpox] without complication	B01.9
Measles complicated by Otitis Media	B05.3 + H76.1*
Measles with intestinal complications	B05.4
Measles	B05.9
Measles without complications	B05.9
Rubella with other complications	B06.8
Rubella without complications	B06.9
Viral exanthem	B09
Acute Hepatitis A without hepatic coma	B15.9
Acute hepatitis B (with delta agent)without hepatic coma	B16.1
Acute hepatitis B (without delta agent)without hepatic coma	B16.9
Viral infection of unspecified site	B34.1 to B34.9
Plasmodium falciparum malaria	B50.9
Plasmodium vivax malaria without complications	B51.9
Plasmodium malariae malaria without complications	B52.9
Schistosomiasis [bilharziasis]	B65.1 to B65.9
Ascariasis	B77.9
Intestinal parasitism	B82.0 to B82.9
Non-insulin-dependent diabetes mellitus without complications	E10.9
Insulin dependent diabetes mellitus without complications	E14.9
Drug Induced hypoglycemia *(Note: use additional external cause code for the drug if known)*	E16.0
Hypoglycemia	E16.2
Kwashiorkor	E40
Nutritional Marasmus	E41
severe protein-energy malnutrition	E43
moderate protein-energy malnutrition	E44.1
moderate dehydration	E86.1
severe dehydration	E86.2
Other disorders of fluid, electrolyte and acid-base balance	E87.0 to E87.8
Migraine	G43.0 to G43.9

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Description/s (Conditions)	ICD 10 Code/s
Other headache syndromes	G44.0 to G44.8
Acute suppurative otitis media	H66.9
Disorders of vestibular function	H81.0 to H81.9
Rheumatic fever without mention of heart involvement	I00
Chronic ischaemic heart disease	I25.0 to I25.9
Acute tonsillitis	J03.0 to J03.9
Acute upper respiratory infections of multiple or unspecified sites	J06.0 to J06.9
Influenza, virus not identified	J11.0 to J11.8
Acute bronchitis	J20.0 to J20.9
Unspecified acute lower respiratory infection	J22
Bronchitis, not specified as acute or chronic *(Note: patients under 15 years of age should be coded to J20.-)*	J40
Diseases of pulp and periapical tissues	K04.0 to K04.9
Sialoadenitis	K11.2
Gastro-oesophageal reflux disease	K21.0 to K21.9
Gastric ulcer without hemorrhage or perforation	K25.3
Acute peptic ulcer without hemorrhage and perforation	K27.3
Peptic ulcer, site unspecified (except those with hemorrhage and/or perforation)	K27.3, K27.6, K27.9
Gastritis and duodenitis (except acute hemorrhagic gastritis)	K29.1 to K29.9 (except K29.0)
Dyspepsia	K30
Other diseases of stomach and duodenum	K31.0 to K31.9
Paralytic ileus	K56.0
Constipation	K59.0
Fibrosis and cirrhosis of liver	K74.0 to K74.6
Fibrosis and cirrhosis of liver	K74.0
Cutaneous abscess, furuncle and carbuncle	L02.0 to L02.9
Cellulitis	L03.0 to L03.9
Follicular cysts of skin and subcutaneous tissue	L72.0 to L72.9
Pyogenic arthritis	M00.00 to M00.99
Other rheumatoid arthritis	M06.00 to M06.99
Gout	M10.00 to M10.99
Other arthrosis	M19.00 to M19.99
Calculus of kidney and ureter	N20.0 to N20.9
Cystitis	N30.0 to N30.9
Urinary tract infection	N39.0
Hyperplasia of prostate	N40
Orchitis and epididymitis	N45.0 to N45.9
Phimosis	N47
Inflammatory disorders of breast	N61
Acute pelvic inflammatory disease	N73.0

Description/s (Conditions)	ICD 10 Code/s
Chronic pelvic inflammatory disease	N73.1
Spontaneous abortion, complete without complication	O03.9
Threatened abortion	O20.0
Excessive vomiting in pregnancy	O21.0 to O21.1
Infections of genitourinary tract in pregnancy	O23.0 to O23.9
Preterm labor, not resulting to delivery	O60.0
Single spontaneous delivery* *(Note: ICD-10 Code for Maternity Care Package (mother's chart))*	O80.9
Other maternal diseases classifiable elsewhere but complicating pregnancy (e.g. anemia)	O99.0 to 099.8
Febrile Convulsions	R56.0
Superficial injury of head *(Note: use additional code for external cause if known)*	S00.0 to S00.9
Open wound of head *(Note: use additional code for external cause if known)*	S01.0 to S01.9
Open wound of wrist and hand *(Note: use additional code for external cause if known)*	S61.0 to S61.9
Open wound of lower leg *(Note: use additional code for external cause if known)*	S81.0 to S81.9
Open wound of ankle and foot *(Note: use additional code for external cause if known)*	S91.0 to S91.7
Superficial injuries involving multiple body regions *(Note: use additional code for external cause if known)*	T00.0 to T00.9
Adverse effects, not elsewhere classified *(Note: use additional code for external cause if known)*	T78.0 to T78.9
Post-traumatic wound infection *(Note: use additional code for external cause if known)*	T79.3
adverse effect of drug or medicament *(Note: use additional code for external cause if known)*	T88.7
Singleton, born in facility** *(Note: ICD-10 Code for Newborn Care Package (newborn's chart))*	Z38.0
Post partum care and examination	Z39

* Single spontaneous delivery is compensable in birthing homes and infirmaries as Maternity Care Package

** Singleton, born in facility is compensable in birthing homes and infirmaries as Newborn Care Package

- End of the List