

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION

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PHILHEALTH CIRCULAR

No. 0035 s. 2013
Long

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

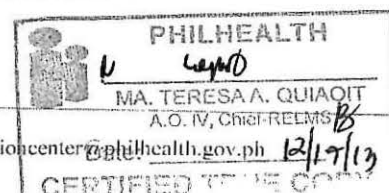
SUBJECT : ACR POLICY NO. 2 --- IMPLEMENTING GUIDELINES ON MEDICAL AND PROCEDURE CASE RATES

I. BACKGROUND

Pursuant to PhilHealth Board Resolution No. 1679, s. 2012, PhilHealth Board Resolution 1758, s. 2013 and PhilHealth Circular (PC) No. 0031 s. 2013 re: "Governing Policies in the Shift of Provider Payment Mechanism from Fee-For-Service to Case-Based Payment", the medical conditions, and procedures with their corresponding case rate grouping and rates are hereby prescribed together with the specific guidelines on its availment and implementation.

II. DEFINITION OF TERMS

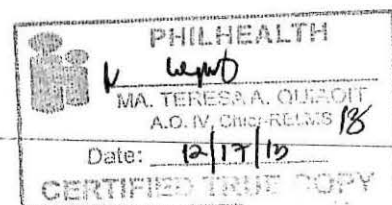
- A. Benefit schedule - The benefit schedule is a complete listing of medical conditions, and procedures with corresponding rates that are reimbursed by PhilHealth.
- B. Case rate (CR) - Fixed rate or amount that PhilHealth will reimburse for a specific illness/case.
 - 1. Medical case rate - Case rate category that covers groups of medical conditions reimbursed by the Corporation. These are based on International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD 10).
 - 2. Procedure case rate - Case rate category that covers procedures or surgical interventions reimbursed by the Corporation, which are based on the Relative Value Scale (RVS).
 - 3. First case rate - Case rate claimed by health care institutions (HCI) for PhilHealth reimbursement which represents/covers the medical condition of the patient with the most resources used, not necessarily the main condition.
 - 4. Second case rate - Case rate claimed by HCIs for PhilHealth reimbursement which represents/covers the medical condition of the patient with the second most resources used.
- C. Case rate code - Code developed by the Corporation assigned to groups of medical conditions, and individual procedures.
- D. Case rate group - One or several medical conditions or procedures of similar nature, hence, with the same case rate.
- E. Health care provider - This refers to both the professional health care providers and health care institutions (also known as facilities).
- F. Immediate cause of death - ICD. 10 defines immediate cause of death as the disease or condition directly leading to death. This does not mean the mode of dying, e.g. heart failure, respiratory failure. It means the disease, injury, or complication that caused death.



- G. Overlapping claims - Overlapping of claims happens when two or more claims of one beneficiary have the same or intersecting confinement periods.
- H. Single period of confinement (SPC) - Single period of confinement rule means that admissions and re-admissions due to the same illness or procedure within a 90-calendar day period shall only be compensated with one (1) case rate benefit. Therefore, availment of benefit for the same illness or procedure that is not separated from each other by more than 90 calendar days will not be provided with a new benefit, until after the 90-calendar day period reckoned from the date of admission.
- I. Total actual charges - This refers to the total expenses during the confinement of the patient for a particular medical condition, or procedure. This includes all fees collected from the patient for the confinement which is not limited to the HCI and professional fees (PF). This shall also include laboratory procedures, medicines, and supplies, among others, that are paid for by the patient but not reimbursed by the HCI.

III. CASE RATE DETERMINATION, CODES AND GROUPING

- A. International Statistical Classification of Diseases and Related Health Problems Tenth Revision (ICD 10) and Relative Value Scale (RVS) shall be used for identifying medical conditions and procedures. The codes of reimbursable medical conditions and procedures shall be given specific rates.
- B. Rates for medical conditions and procedures shall be set by the Corporation through a transparent process that takes into account the following, among others:
 - 1. The evaluated rates as studied per medical condition or procedure within the limits of the resources of the Corporation,
 - 2. Claims data such as average value per claim (AVPC) in hospitals, preferably tertiary hospitals, in the most recent year/s,
 - 3. Consultations with HCIs, professionals, and other stakeholders,
 - 4. Results of review of post-audit monitoring and evaluation,
 - 5. Relevant appraised studies on costing, rates, fair professional fees, and the like
 - 6. Existing reimbursement schedule and its limitations such as the use of specialist's peso conversion factor of 56 pesos for computation of professional fees for procedures with relative value unit (RVU).
- C. Case rate determination for the initial all case rates shall be based on the following:
 - 1. Relevant claims data from Levels 3 and 4 (now classified as Level 2 and 3, respectively) government and private hospitals for the immediate past two (2) years shall be among the significant inputs to the case rates. An additional percentage above the AVPC per medical condition shall be considered subject to actuarial evaluation.
 - 2. The professional fees for procedures with RVUs shall be studied taking into consideration the complexities of the procedures. In order to pay within the reimbursement limits of the fee-for-service scheme, a formula shall be designed based on the RVUs, to cover for PF that takes into account payments to the doctor/s doing the procedure, providing anaesthesia services, and clearing the patient for the specific procedure.
 - 3. The health care institution fees for procedures shall be studied based on AVPC, computed rates, and expert consultations, among others.
 - 4. Medical conditions of similar nature and/or management shall be grouped together whenever feasible.
- D. Case rate codes and/or package codes shall be created for all case rates medical conditions and procedures.



- E. Special rates may be assigned to specific medical conditions and/or procedures in order to promote equity and rationalize the benefit costs given the resource limitations of the Corporation (e.g., dialysis, chemotherapy, cataract, cesarean section, etc).
- F. Medical conditions or procedures not listed in the current ICD 10 and/or RVS codes shall be referred to PhilHealth for proper code assignment and determination of rates.

IV. GENERAL RULES

- A. The case rates shall be the only reimbursement rates for all specified cases. These rates shall be the amount to be paid to the health care institutions and shall include the professional fees. Medical conditions and procedures that are not in the list shall no longer be reimbursed.
- B. Admission due to patient's choice shall not be reimbursed by the Corporation. Only those with indication for admission shall be reimbursed.
- C. Case rate payments shall cover for the PF and all HCI charges including, but not limited to room and board, diagnostics and laboratories, drugs, medicines and supplies, operating room fees, and other fees and charges. Pre-operative diagnostics done prior to confinement are not covered in the case rate payment.
- D. Computation of Reimbursement
 - 1. For medical case rates, the HCI fee and PF shall be 70% and 30% of the case rate amount respectively.
 - 2. For procedure case rates, the following shall be the basis for computation except for specified cases:
 - a. The PF shall be computed as $RVU \times 56 \times 1.5$ except for specified procedure case rates.
 - b. The HCI fee shall be the remaining balance when the PF is subtracted from the case rate amount.
 - 3. A list of the complete benefit schedule for medical and procedure case rates (including the exemptions) is provided in Annexes 1 and 2, and shall be posted in the PhilHealth website.
 - 4. When a patient has multiple conditions that are actively being managed during one confinement, the health care provider may claim for two case rates relevant to the conditions of the patient.
 - a. The first case rate shall be the medical condition or procedure that used the most resources (drugs and medicines, laboratories and diagnostics, professional fees, etc) in managing the patient. The second case rate shall be the medical condition, or procedure with the second most resources used.
 - b. A case rate group shall not be allowed to be used both as first and second case rate in one claim except for procedures with laterality. Rules on procedures with laterality are found on item IV. G. 4 of this circular.
 - c. Initially, not all medical conditions or procedures may be claimed as second case rate. A list of medical conditions, and procedures allowed as second case rate is provided in Annex 3. Medical conditions and procedures not included in Annex 3 shall not be reimbursed as second case rate.
 - 5. For a claim with a combination of case rates i.e., medical condition and medical condition; medical condition and procedure; or procedure and procedure, the provider shall be paid the full case rate amount for the first case rate plus 50% of the second case rate.
 - a. If the second case rate is a medical condition, the 50% shall be divided into 30% professional fee and 20% health care institution fee.



- b. If the second case rate is a procedure, the 50% shall be divided into 40% professional fee and 10% health care institution fee.
- c. A list of medical conditions and procedures allowed as second case rates is provided in Annex 3.

To illustrate (sample cases are in Annex 4):

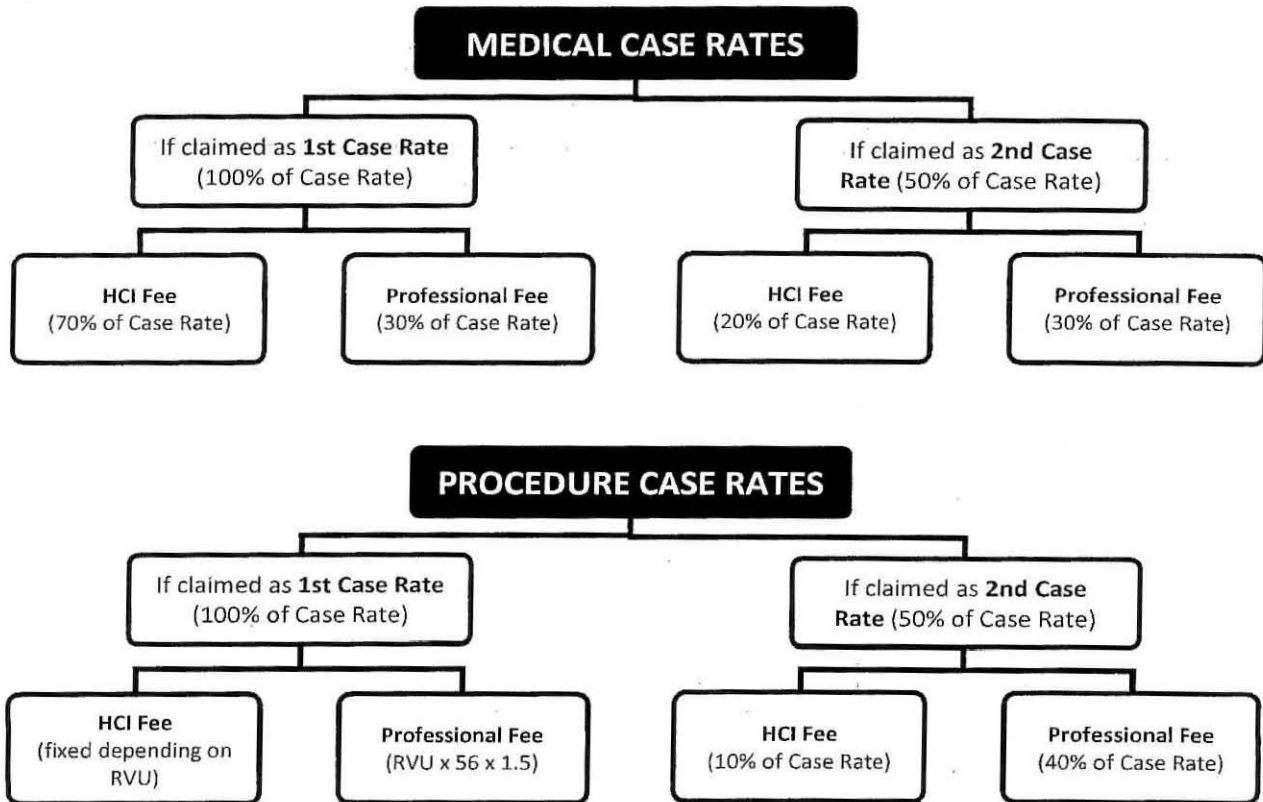
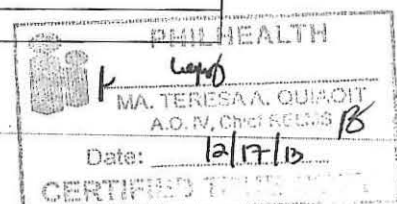


Figure 1. Matrix of Payment for Combination of Case Rates

6. The following are the exemptions to the 50% rule on second case rate and shall be paid the full case rate amount even as second case rate. The HCI fee and PF shall follow the first case rate distribution for the procedure. (See Annex 4, Figures 1.1-1.2 for examples of how this policy is applied.)

Table 1. List of Exemptions to the 50% Rule on Second Case Rate

	Procedure	RVS Code			
1	Bilateral tubal ligation	58600			
2	Blood transfusion	36430			
3	Brachytherapy	77761	77781		
		77776	77789		
4	Chemotherapy	96408			
5	Simple debridement	11000	11012	11042	11720
		11010	11040	11043	11721
		11011	11041	11044	16010
					21627
6	Dialysis other than hemodialysis	90945			
7	Hemodialysis	90935			



	Procedure	RVS Code
8	Paracentesis, abdominal	49080
9	Radiotherapy	77401
10	Vasectomy	55250

7. Aside from being exempted from the 50% rule, claims of multiple sessions of the following procedures under Procedure List A shall be reimbursed even if claimed as second case rate subject to other reimbursement rules. (See Annex 4, Tables 1-3 for examples.)

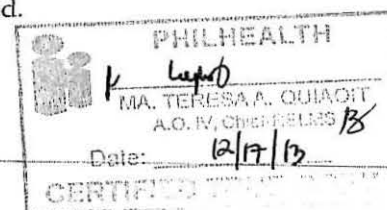
Table 2. Procedure List A

	Procedure	RVS Code		
1	Blood transfusion, outpatient	36430		
2	Brachytherapy	77761 77776	77781 77789	
3	Chemotherapy	96408		
4	Dialysis other than hemodialysis	90945		
5	Hemodialysis	90935		
6	Radiotherapy	77401		
7	Simple Debridement	11000 11010 11011 11012 11040	11041 11042 11043 11044	11720 11721 16010 21627

8. Computation of reimbursements shall be based on the first and second case rates (if applicable) as declared by the HCI in PhilHealth Claim Form 2. The total benefit (sum of the first case rate and 50% of the second case rate) shall be deducted from the total actual charges (HCI fee + PF). The remaining amount shall be charged as out of pocket to the beneficiary except in cases where the No Balance Billing (NBB) policy applies. (See Annex 4, Tables 2 and 3 for examples.)

E. Professional Fees

- The entire case rate amount, including the PF, shall be paid directly to the HCI concerned. The HCI shall act as the withholding tax agent for the PF.
- The PF shall be distributed by the HCI within 30 calendar days from the date of receipt of reimbursement. Policies and procedures on the distribution of PF shall be drafted and enforced by the HCI based on the agreements between the HCI and the professionals. Reports of noncompliance to this provision shall be forwarded to the PRO Health Care Delivery Management Division (HCDMD) and shall be included as a violation of the HCI to the Health Care Provider Performance Commitment.
- The government HCI shall facilitate the payment of the pooled PF share to the health personnel. The payment of the pooled PF shall be subject to existing rules on pooling by the Department of Health (DOH).
- The claims 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.
- The HCIs shall inform the concerned professionals of the status of their claim whether the claim was paid, returned to sender (RTS) or denied.



6. To facilitate distribution of the PF within the prescribed/agreed schedule, each printed voucher for reimbursed HCI claims shall have a corresponding Claims Summary Report. The Claims Summary Report shall contain all information reflected in the voucher with the addition of the name/s of doctor/s who attended to the patient. This shall be sent to the hospital along with the voucher.
- F. Health Care Institutions (HCI)
1. The following medical and procedure case rates shall only be reimbursed when done in the health care institutions listed in Table 3. The complete list of HCI restrictions shall be published at the PhilHealth website (www.philhealth.gov.ph).

Table 3. List of Procedures and Medical Conditions Allowed in Different Types of Health Care Institutions

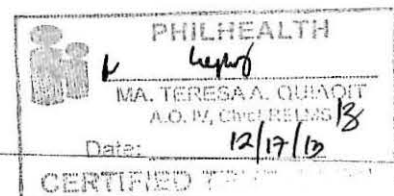
	Procedure/Medical Condition	Level/Type of Health Care Institution
1	Procedures with RVU 200 and below	At least Level 1 Hospital
2	Procedures with RVU 201-500	At least Level 2 Hospital
3	Procedures with RVU 501 and above	At least Level 3 Hospital
4	Day surgeries (procedures with RVU 200 and below that are done on an outpatient basis without need for confinement)	Accredited ambulatory surgical clinics
5	Radiation Therapy (RVS 77401)	Accredited health care institutions
6	Hemodialysis (RVS 90935), Dialysis other than hemodialysis (90945)	
7	Stroke - Hemorrhagic	At least Level 2 Hospital

2. Primary Care Facilities – Infirmaries/Dispensaries
- a. Claims of primary care facilities (PCF) shall be limited to the medical conditions and procedures enumerated in PC 14 s. 2013 (Revised PhilHealth Category of Institutional Health Care Providers [IHCP]s and Compensable Benefits in Primary Care Facilities) and its amendments. The complete list is also found in Annex 5 and 6 of this circular.
- b. Primary care facilities shall be reimbursed at 70% of the case rate except for the following case rates enumerated in PC 14, s 2013, which are hereby assigned new classifications:

	Previous Classification	New Classification
i.	Dengue 1	Dengue Fever
ii.	Pneumonia 1	Pneumonia Moderate Risk
iii.	Essential Hypertension	Hypertensive Emergency/Urgency
iv.	Acute Gastroenteritis	Acute Gastroenteritis
v.	Asthma	Asthma in Acute Exacerbation
vi.	Typhoid Fever	Typhoid Fever

Reimbursement for these medical case rates shall be maintained at 100% of case rates until December 31, 2013 after which, the 70% rate shall be implemented.

- c. The HCI fee shall be 70% of the HCI fee for hospitals. Likewise, the PF shall also be 70% of the PF allotted for hospitals. The complete benefit schedule for primary care facilities is provided in Annex 5 and 6.



To illustrate:

Medical Case Rate	ICD Code	Case Rate Amount	HCI Fee	PF
Hospital	N30.0	7,500	5,250	2,250

70% ↓ 70% ↓ 70% ↓

PCF	N30.0	5,250	3,675	1,575
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Figure 2a. Comparison of Case Rate Amount, HCI Fee and PF between Hospital and PCF for a Medical Case Rate.

Procedure Case Rate	RVS Code	Case Rate Amount	HCI Fee	PF
Hospital	56420	9,300	7,200	2,100

70% ↓ 70% ↓ 70% ↓

PCF	56420	6,510	5,040	1,470
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Figure 2b. Comparison of Case Rate Amount, HCI Fee and PF between Hospital and PCF for a Procedure Case Rate.

- d. The following procedures shall be reimbursed at 100% of case rate when done in accredited PCF:

- i. Hemodialysis (RVS 90935) – Allowed only when PCF is accredited for the service.
- ii. Radiotherapy (RVS 77401) – Allowed only when PCF is accredited for the service.
- iii. Circumcision (RVS 54150, 54152, 54160, 54161)
- iv. Vasectomy (RVS 55250)
- v. IUD insertion (58300)
- vi. Chemotherapy (RVS 96408)
- vii. Thoracentesis (RVS 32000)

3. Claims for medical and procedure case rates that are beyond the service capability of the HCI shall be denied.

G. Single Period of Confinement

1. Case rates are subject to the single period of confinement (SPC) rule. This means that admissions and re-admissions due to the same illness or procedure within a 90-calendar day period shall only be compensated with one (1) case rate benefit. Therefore, availment of benefit for the same illness or procedure that is not separated from each other by more than 90 calendar days shall not be provided with a new benefit, until after the 90-calendar day period reckoned from the date of admission.
2. The first and second case rates shall both be evaluated for compliance with the SPC rule. Please see Annex 4, Table 4 for the examples.
3. The exemptions to the SPC rule are in Table 4. These exempted procedures may be availed of at any time subject to other reimbursement rules.

Table 4. List of Case Rates Exempted from the SPC Rule

	Procedure/Medical condition	RVS/ICD 10 Code
1	Blood transfusion, outpatient	36430

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	Procedure/Medical condition	RVS/ICD 10 Code		
2	Brachytherapy	77761 77776	77781 77789	
3	Cataract surgery* <i>*subject to provisions in PC 17 s. 2013</i>	66983 66984	66987	
4	Chemotherapy	96408		
5	Dialysis other than Hemodialysis	90945		
6	Hemodialysis	90935		
7	Radiotherapy	77401		
8	Simple Debridement	11000 11010 11011 11012 11040	11041 11042 11043 11044	11720 11721 16010 21627
9	Asthma in Acute Exacerbation	J45.00 J45.10	J45.80 J45.90	J46

4. Identified procedures found in Annex 7, when done on the contralateral side, shall also be exempted from the SPC rule. The health care provider shall always indicate the laterality of these procedures in the claim form. When the identified procedures are done on both sides during one confinement, the second procedure shall be considered as the second case rate and shall be reimbursed at 50% of the case rate for the procedure except for cataract package surgeries (RVS 66983, 66984 and 66987), which are subject to the provisions in PC 17 s. 2013: Exemption of Cataract Surgery to the Rule on Single Period of Confinement. These procedures, however, may not be claimed as second case rate together with other medical conditions/procedures. (See Annex 4, Table 5 for examples.)

H. Forty-Five Days Benefit Limit.

1. A member is entitled to a maximum of 45 days confinement per calendar year. All qualified dependents of the member share another 45 days benefit per calendar year. Exceptions to this rule are members with prescribed membership validity (e.g., sponsored beneficiaries, OFW beneficiaries, etc). Members belonging to this category have 45 days benefit per year of membership validity. Dependents of these members share 45 days benefit for the same period.
2. The total number of confinement days shall be deducted from the 45-day benefit limit of the beneficiary except for the following medical/procedure case rates with pre-determined number of days deduction (examples for these rules are in Annex 4, Table 6.1-6.3):
 - a. Dialysis other than hemodialysis e.g., peritoneal dialysis (RVS 90945).
 - i. Six days of dialysis, regardless of the number of exchanges per day, shall be equivalent to one day deduction from the 45 days allowable benefit per year.
 - ii. If the procedure is done during a confinement, whether in the same HCI or not, only the total number of confinement days shall be deducted from the 45 days total allowable benefit for the beneficiary.
 - b. Chemotherapy (RVS 96408).
 - i. One cycle of chemotherapy is equivalent to two (2) days deduction from the 45 days allowable benefit per year regardless of the number of days of confinement per cycle.
 - ii. If the procedure is done during a confinement, whether in the same HCI or not, only the total number of confinement days shall be deducted from the 45 days total allowable benefit for the beneficiary.

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- c. Blood transfusion, outpatient (RVS 36430). One session for each procedure is equivalent to one day deduction from the 45 days allowable benefit per year.
- d. Radiotherapy (RVS 77401) and hemodialysis (RVS 90935).
 - i. One session for each procedure above is equivalent to one day deduction from the 45 days allowable benefit per year.
 - ii. If the procedure is done during a confinement, whether in the same HCI or not, only the total number of confinement days shall be deducted from the 45 days total allowable benefit for the beneficiary.
- 3. For claims with combination of case rates, the single period of confinement rule shall be applied prior to evaluation of deductions from the 45 days benefit limit. In cases when one of the two case rates claimed is denied due to the single period of confinement rule, then the rule for the approved case rate is used to determine the number of days to be deducted from the 45 days benefit limit. Examples for this rule are in Annex 4, Tables 7.1-7.2.

I. Special Reimbursement Rules

- 1. Referral package (P00001)
 - a. Referral is a situation where a patient is transferred from one hospital to another for further management of the same medical condition after formal coordination between the referring and receiving hospital prior to transfer (i.e., referring hospital endorses the case to the referral hospital; referral hospital accepts to manage the case). In such cases, reimbursement of the full case rate package shall be paid to the referral (receiving) hospital. Claims filed by the referring hospital shall be reimbursed a fixed amount of 4,000 pesos. The HCI fee and PI shall be 70% and 30% respectively.
 - b. Claims for referrals shall only be allowed if the transfer is to a higher level hospital except in Level 3 hospitals where transfer to the same level is allowed (e.g., Level 1 to Level 2, Level 1 to Level 3, Level 2 to Level 3 or Level 3 to Level 3).
 - c. Claims for referrals shall be limited to the conditions listed in Annex 8.
 - d. Claims for referrals shall be filed following the same rules as a regular case rate as contained in this circular. Special requirements are as follows:
 - i. The referring and referral hospital shall indicate the complete admission and final diagnoses in their respective claim forms.
 - ii. The referring hospital shall indicate the referral package code in the first case rate field in Claim Form 2. The referral hospital indicates the appropriate case rate codes in the first and second (if applicable) case rate field/s in Claim Form 2.
 - iii. The referring and referral hospitals must tick the appropriate box provided in Claim Form 2 in order for them to get reimbursement.
 - iv. A duly accomplished referral form (Annex 9) is also required for reimbursement.
 - e. The referral package shall not be allowed for referrals to the same level of hospital (except in Level 3 to another Level 3 hospital) or from a higher level to a lower level hospital.
 - f. In cases of series of referrals, only the first and last hospitals to handle the patient shall be reimbursed. Claims of the facilities in between shall be denied.
 - g. Claims for referral from accredited Maternity Care Package (MCP) Providers with P59403 as contained in PC 11 s. 2011 (New PhilHealth Case Rates for Selected Medical Cases and Surgical Procedures and the No Balance Billing Policy) and PC 15 s. 2011 (Clarificatory Guidelines to PhilHealth Circular Nos. 11, 11-A and 11-B series of 2011) shall still be reimbursed based on the rules

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contained in the aforementioned circulars. The referral form shall be accomplished by the MCP provider. Other claims for referral package from the following HCI shall be denied:

- i. Freestanding Dialysis Center
- ii. Ambulatory Surgical Clinic
- iii. Rural Health Units/Health Center
- iv. Primary Care Facilities

2. Confinement abroad

- a. For confinements abroad, the claim shall be reimbursed the full case rate amount based on the final diagnosis/es.
- b. The following are the requirements for filing of claims of patients confined abroad:
 - i. Claim form 1, properly and completely filled out
 - ii. Statement of account with itemized charges (original or photocopy), official receipt/s for itemized charges (original or certified true copy) and/or any proof of payment of hospital bills and professional fees from the HCI where the patient was confined. Certification as true copy of the photocopy shall be done by the person in custody of the original
 - iii. Certification from the attending physician as to the final diagnosis, period of confinement and services rendered
 - iv. English translations from hospital or Embassy for all documents

3. Direct Payment to Member

- a. Claims filed directly by PhilHealth beneficiaries to PhilHealth shall be reimbursed as case rate. Full case rate payment shall be directly paid to the member.
- b. Requirements for directly - filed claims:
 - i. Claim Forms 1 and 2, properly and completely filled-out
 - ii. Claim Form 3 or its equivalent
 - iii. Official receipt/s for itemized charges, original or certified true copy
 - iv. Other documents, depending on membership category, as contained in Section X of this circular
- c. Direct filing of claims shall not be allowed except in the following cases:
 - i. Claims for confinements abroad
 - ii. Emergency in non-accredited health care institutionsThe HCI shall deduct the appropriate PhilHealth benefits from the total actual charges (health care institution and professional fees) of the beneficiary.

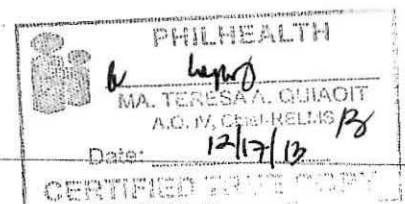
4. Overlapping Claims

Overlapping of claims happens when two or more claims of one beneficiary have the same or intersecting confinement periods.

- a. In cases of overlapping claims, both (or all) claims shall be evaluated and validated.
- b. Only the valid claim/s shall be reimbursed following rules on reimbursement. Invalid claims shall be forwarded to the Legal Services Unit of the PRO for investigation.

5. Others

- a. If the patient dies and a procedure has been done, the HCI shall be reimbursed based on the case rate of the procedure as claimed by the HCI following the rules contained in this circular.
- b. If the patient dies but was confined for more than 24 hours, the HCI shall be reimbursed based on the case rate as claimed by the HCI following the rules contained in this circular.



- c. The immediate cause of death shall be the basis for reimbursement. However, if a procedure has been done, the procedure and/or the immediate cause of death may be claimed as first and/or second case rate. The rules on first and second case rate apply.
- d. In cases of death in a primary care facility, same rules as above shall apply. Immediate cause of death, even if beyond service capability shall be the basis for reimbursement. The rate shall be as reflected in Section IV.F.2 of this circular.

J. Additional Conditions for Entitlement

- 1. Effect of change in accreditation of HCI
 - a. In case the HCI's accreditation status changes, the claim shall still be paid the full amount of the case rate as long as one day of the confinement falls within the validity of the accreditation of the HCI.
 - b. In case the HCI's level of accreditation is upgraded, the claim shall be reimbursed based on the category at the date of discharge. Rules for the HCI category at the time of discharge shall apply.
 - c. In case the HCI's level of accreditation is downgraded, the claim shall be reimbursed based on the category at the date of admission. Rules for the HCI category at the time of admission shall apply.
- 2. Effect of membership and dependency. As long as one day of the confinement falls within the validity of either membership or dependency, the beneficiary is entitled to the full PhilHealth benefit.
- 3. Out-on-pass. Except for day surgeries and Millennium Development Goal (MDG) packages, as long as the beneficiary is admitted for at least 24 hours, the beneficiary is entitled to the full PhilHealth benefit subject to other rules of reimbursement.
- 4. Non-availability of room.
 - a. This refers to cases when admitted patients must stay in the emergency room or within the hospital premises pending the availability of rooms. Day surgeries and MDG packages are exempted from this rule.
 - b. Full payment shall be given if the patient stayed in the hospital for 24 hours or more. However, private HCIs shall submit a letter of justification with the claim. Non-submission of requirements shall result in the denial of the claim.
 - c. If the patient stayed in the HCI for less than 24 hours, the claim shall be denied.

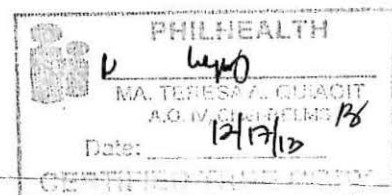
K. Computation of Taxes

PhilHealth adheres to the prescribed computation of taxes issued by the Bureau of Internal Revenue.

L. Quality Standards

- 1. PhilHealth accredited health care providers shall use available current Clinical Practice Guidelines (CPG) adopted by societies, the Department of Health (DOH) or as provided by the World Health Organization (WHO) or if not available, current accepted standards of care, to support their diagnosis and management.
- 2. Claims filed shall be subject to post-audit evaluation to check for the quality of care provided to the patient-beneficiary. Rules on the Philippine National Formulary (PNF) (DOH Administrative Order No. 2012-0023: Revised Implementing Guidelines for the Philippine National Formulary System [PNFS]); Antimicrobial Resistance Surveillance Program (ARSP) and rational drug use shall be observed and monitored (PhilHealth Circular No. 9, s-2009: 2009 Revised Inpatient Benefit Schedule).

- M. Upon evaluation and monitoring, all inconsistencies regarding reimbursement policies shall be charged to future claims of the facilities.



V. MEDICAL CASE RATES

Medical case rates cover groups of medical conditions reimbursed by the Corporation. These are based on ICD 10. The complete list of reimbursable medical case rates, including the specific ICD 10 codes and rates, is found in Annex 1 and may be accessed at www.philhealth.gov.ph.

- A. Only admissible medical conditions shall be reimbursed by PhilHealth.
- B. For medical conditions that are managed primarily using interventional or surgical procedures, health care providers shall use the appropriate procedure case rates.
- C. Specific diagnostic/laboratory examinations per medical case shall no longer be prescribed by PhilHealth.
- D. The following rules enumerate the specific requirements for some medical conditions, otherwise, only the general rules shall apply.
 1. Acute Gastroenteritis (AGE) and Amoebiasis, Nonhepatic. All claims of AGE and all medical conditions under nonhepatic amoebiasis resulting to diarrhea (i.e., A06.0, A06.1, A06.2, A06.3) shall have the following additional codes for level of dehydration, otherwise shall be denied:
 - a. E86.1 – Moderate/ marked dehydration*
 - b. E86.2 – Severe dehydration

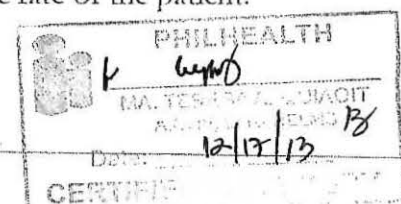
*Note: Taken from the 2013 ICD 10 Philippine Modification released by the Department of Health thru Department Circular No. 2013-0121 (2013 ICD-10 Modifications Partial Updates). This is equivalent to “some dehydration” classification under the World Health Organization Guidelines on the Treatment of Diarrhea 2005.
 2. Asthma in Acute Exacerbation – Claims for asthma in acute exacerbation, except for certain medical conditions, shall be assigned an additional 5th character to be appended to the assigned ICD 10 code. The appropriate and complete ICD 10 codes for each case are found in Annex 1.
 3. Maternal Comorbidities Conditions
 - a. This covers admission of pregnant mothers that do not lead to delivery.
 - b. This shall only be used if the comorbidity has no case rate available from the list.
 4. Pneumonia. Claims for pneumonia, except for certain medical conditions, shall be assigned an additional 4th or 5th character to be appended to the assigned ICD 10 code. The appropriate and complete ICD 10 codes for each case are found in Annex 1.

VI. PROCEDURE CASE RATES

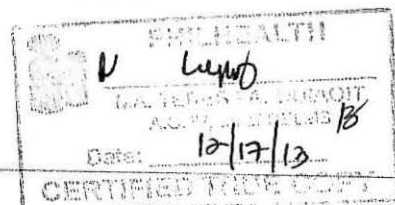
Procedure case rates cover procedures or surgical interventions reimbursed by the Corporation, which are based on the RVS. The complete list of the procedure case rates is found in Annex 2 and may be accessed at www.philhealth.gov.ph

In addition to the general rules above, the following are the specific requirements for some procedures:

1. Adhesiolysis (RVS 44005) shall only be reimbursed if performed independent of any other procedure.
2. Blood transfusion, outpatient (RVS 36430)
 - a. This package covers outpatient blood transfusion only. Inpatient transfusion of blood or blood products shall be covered by the medical case rate of the patient.



- b. One day of transfusion of any blood or blood product, regardless of the number of bags, is equivalent to one session.
 - c. Multiple sessions may be claimed in one claim form. The dates of each session claimed shall be indicated in the blank provided in Claim Form 2.
3. Cataract Package (RVS 66983, 66984 and 66987)
- a. Cataract extraction and vitrectomy. For claims of cataract extraction that are accompanied by vitrectomy secondary to posterior capsular rupture resulting from cataract surgery, only the cataract extraction shall be paid. Moreover, a claim for postoperative vitrectomy performed within 90 days from cataract surgery shall be denied reimbursement whether done during the same or different confinement.
 - b. Vitrectomy performed at the time of cataract extraction shall only be paid if an indication specified in the admitting diagnosis supports the performance of the procedure. In such case, payment of professional fee and hospital charges shall be based on vitrectomy and not on the cataract surgery.
4. Cesarean section (CS) (RVS 59513, 59514, 59620). Cesarean section per patient request shall not be reimbursed by the Corporation.
5. Chemotherapy (RVS 96408)
- a. The case rate amount for chemotherapy is equivalent to one cycle of chemotherapy.
 - b. One cycle of chemotherapy is equivalent to 2 days deduction from the 45 days benefit allowance.
 - c. Chemotherapy may be claimed as inpatient or outpatient.
 - i. If claimed as inpatient and in the same HCI, this package may be claimed as first or second case rate.
 - ii. Multiple cycles may be claimed in one claim form for both inpatient and outpatient chemotherapy. The dates of each cycle claimed shall be indicated in the space provided in Claim Form 2.
6. Circumcision (RVS 54150, 54152, 54160, 54161). Circumcision shall only be reimbursed if done secondary to phimosis (ICD 10: N47).
7. Dialysis other than hemodialysis (e.g., peritoneal dialysis) (RVS 90945)
- a. Any of the modalities of peritoneal dialysis (PD) may be claimed by patients registered at accredited peritoneal dialysis centers and hospitals.
 - b. The case rate amount for Dialysis other than hemodialysis (e.g., peritoneal dialysis) is equivalent to 6 days of PD exchanges.
 - c. All PD exchanges done for six days shall be charged one day against the 45-day benefit allowance. Claims of less than 6 days of exchanges shall also be charged one day against the 45-day benefit allowance.
 - d. Multiple sessions may be claimed in one claim form. The dates of each session claimed shall be indicated in the blank provided in Claim Form 2.
8. Hemodialysis (RVS 90935)
- a. This package covers BOTH inpatient and outpatient hemodialysis procedures including emergency dialysis procedures for acute renal failure.
 - b. Reimbursement shall include payment for use of the dialysis machine and health care institution, drugs and medicines, supplies and others on per session basis.
 - c. Creation of fistula shall be reimbursed using a different case rate but in accredited health care institutions only.
 - d. Multiple sessions may be claimed in one claim form for both inpatient and outpatient hemodialysis. The dates of each session claimed shall be indicated in the space provided in Claim Form 2.

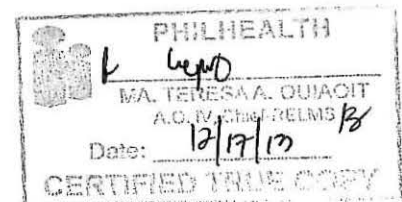


- e. If an admitted patient is sent to another HCI for hemodialysis, a separate claim shall be filed by the HCI that performed the dialysis. This shall be reimbursed the full case rate.
9. Radiation therapy (RVS 77401)
 - a. This includes radiation treatment delivery using cobalt and linear accelerator.
 - b. The HCI shall indicate in Claim Form 2 which between cobalt and linear accelerator was done.
 - c. Multiple sessions may be claimed in one claim form for both inpatient and outpatient radiation therapy. The dates of each session claimed shall be indicated in Claim Form 2.
 - d. If an admitted patient is sent to another HCI for radiation therapy, a separate claim shall be filed by the HCI that did the radiation therapy. This shall be reimbursed the full case rate.
 - e. Radiotherapy performed on the same day as brachytherapy (RVS 77761, 77776, 77781 and 77789) or chemotherapy (RVS 96408) shall be reimbursed the full case rate subject to other reimbursement rules. The equivalent deductions shall be made to the 45 days benefit limit of the beneficiary.
10. Vaginal delivery (RVS 59409). This includes deliveries done vaginally for mothers with medical conditions or other indications that exempt them from the normal spontaneous delivery package. The following are the accepted indications:
 - a. Preterm deliveries O60.1
 - b. Multiple deliveries O84.0
 - c. Maternal distress during delivery (unstable vital signs) O75.0
 - d. Delayed delivery after rupture of membranes O75.6
 - e. Abnormality in uterine contraction O62.4
 - f. Prolonged labor O63.-
 - g. Precipitous delivery O62.3
 - h. Labor complicated by fetal distress O68.-
 - i. Labor complicated by cord complication O69.-

VII. MILLENNIUM DEVELOPMENT GOAL PACKAGES

The following packages shall be paid using case-based payment but will follow the existing rules of reimbursement, payment and claims filing contained in their respective circulars.

1. Maternity Care Package (RVS 59401)
2. Outpatient HIV/AIDS Treatment Package (RVS 99246)
3. Animal Bite Package (RVS 90375)
4. Outpatient Malaria Package (RVS 87207)
5. TB-DOTS (RVS 89221, 89222)
6. Newborn Care Package (RVS 99432)



VIII. EXCLUSIONS

Z benefit packages are excluded from the all case rates policy and shall be governed by existing circulars.

IX. MEMBER AND DEPENDENT ELIGIBILITY

Member and dependent eligibility rules shall follow Section 39 of the Implementing Rules and Regulations of R.A. 7875 as amended by R.A. 10606, otherwise known as the National Health Insurance Act of 2013.

X. RULES ON FILING OF CLAIMS

A. Enhanced PhilHealth Claim Forms

All case rates claims shall use the enhanced PhilHealth Claim Forms in filing for PhilHealth reimbursement.

B. Filling out the Claim Forms


1. The PhilHealth claim forms must be properly and completely filled out, otherwise, it shall be returned to sender (RTS). The health care provider is required to write legibly the correct and complete ICD 10 and RVS codes corresponding to the discharge diagnosis/es and shall be held primarily responsible for any errors that may be found therein on post audit. The codes shall be the basis for claims reimbursement.
2. The PhilHealth accredited healthcare provider shall also write the complete admitting and final diagnoses in the claim form.
3. Claims, except those for confinements abroad, with incorrect/incomplete/without, ICD 10 or RVS codes shall be RTS for completion/correction.
4. Claims with discharge diagnoses written in Claim Form 2 as ill-defined and/or suspected diagnoses i.e., "to consider (T/C)", "versus or vs.", "rule out (R/O)", "probable", or "potential" shall be denied (e.g., T/C Dengue Fever, Probable Typhoid Fever, Potential Sepsis, Suspected Dengue Fever, R/O Community Acquired Pneumonia).
5. All claims that were returned to the sender for correction or completion shall be re-filed within 60 days from receipt of notice; otherwise, it shall be denied. The basis for the receipt of notice shall be the date received by the HCI representative.
6. Re-filed claims with non-compliance to deficiencies stated in RTS shall be denied.
7. The Corporation shall only allow return of claims to the sender (RTS) for correction/revision/completion for claims with admission dates on or before March 31, 2014. RTS shall no longer be allowed for all claims with date of admission starting April 1, 2014. Instead, these claims shall be denied.
8. A properly and completely filled out Claim Form 3 shall be required for Maternity Care Package claims and for all cases managed in Primary Care Facilities.
9. Records of anesthesia and surgical or operative technique are required for all procedure claims except for some procedures. A list of alternative documents for specific procedures is provided in Annex 10.

C. For HCIs that are currently connected and compliant with the IHCP PORTAL, submission of generated Reference Number (RN) as mentioned in PhilHealth Circular No. 002-2012 shall be attached to the claims replacing the PhilHealth Number Card (PNC)/PhilHealth Identification Card (PIC) or Member Data Record (MDR) and other secondary documents like birth certificate, marriage contract and the like. These are applicable to all member segments of the NHIP.

D. In the absence of IHCP Portal, claims of members and their dependents shall submit the following necessary documents:

1. Any valid proof of membership for all member segments of the NHIP
 - a. Member Data Record (MDR) or any alternative document as proof of PhilHealth membership as per PhilHealth Circulars 50 s. 2012 and 1 s. 2013 or
 - b. Properly filled out PhilHealth CARES Form 1 (PCF 1) shall be accepted in lieu of the PNC, PIC, MDR or Form CE - 1 for HCIs with PhilHealth Customer Assistance Relations and Empowerment Staff (PCARES)

Note: Health care providers shall not deny PhilHealth beneficiaries to avail of their benefits on the basis of non-submission of MDR when alternative documents are

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provided. Likewise, PhilHealth shall not return claims of HCLs due to the absence of an MDR when alternative documents are already submitted along with the claim forms.

2. Properly accomplished PhilHealth Claim Form 1 (CF1) for all member segments of the NHIP. For Employed, Claim Form 1 signed by the employer will suffice the eligibility of the said member.
3. Properly accomplished PhilHealth Claim Form 2 (CF2) for all member segments of the NHIP.
4. Properly accomplished PhilHealth Claim Form 3 (CF3) as applicable for all member segments of the NHIP.
5. PhilHealth Member Registration Form (PMRF) duly certified by the member (for availment of dependents of all member segments of the NHIP if not previously declared by the member).
- E. Additional documents required by PhilHealth as proof of qualifying contributions e.g. Official Receipt or Validated Payment Slip and other documents under PhilHealth Circular 50 s. 2012 (Updated Documentary Requirements for Member Registration, Amendment and Benefit Availment) and PC 001 s. 2013 (Amendment to PhilHealth Circular No. 50 s. 2012 on the Updated Documentary Requirements for Benefit Availment) as applicable.
- F. Surgical or Operative technique for all surgical procedures shall be required (original or certified true copy).
- G. E-claims shall be encouraged.
- H. Direct filing of claims by members shall be discouraged.

XI. REITERATION OF THE NO BALANCE BILLING (NBB) POLICY

The No Balance Billing Policy shall be applicable to all case rates subject to existing NBB rules and regulations.

XII. MONITORING AND EVALUATION/POST AUDIT OF CASE RATE CLAIMS

Providers shall be monitored on their compliance to this circular and violations shall be dealt with in accordance with the provisions of PhilHealth Circular No. 54 s. 2012 (Provider Engagement through Accreditation and Contracting for Health Services) and other pertinent issuances. The penalties to these violations shall be charged to future claims of the health care institution or as determined by the Corporation.

XIII. REPEALING CLAUSE

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

XIV. SEPARABILITY CLAUSE

In the event that a part or provision of this Circular is declared unauthorized or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.



XV. EFFECTIVITY

This Circular shall take effect for all admissions fifteen (15) calendar days after publication in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

XVI. ANNEXES

- Annex 1: List of Medical Case Rates
- Annex 2: List of Procedure Case Rates
- Annex 3: List of Medical Conditions and Procedures Allowed as Second Case Rate
- Annex 4: Examples and Scenarios for the All Case Rates Implementing Guidelines
- Annex 5: List of Medical Case Rates for Primary Care Facilities-Infirmaries/Dispensaries
- Annex 6: List of Procedure Case Rates for Primary Care Facilities –
Infirmaries/Dispensaries
- Annex 7: List of Procedures with Laterality
- Annex 8: List of Medical Conditions Allowed for Referral Package
- Annex 9: Referral Form
- Annex 10: List of Alternative Documents for Record of Operative or Surgical Technique
- Annex 11: PhilHealth Claim Forms 1, 2 and 3 and its Guidelines


ALEXANDER A. PADILLA

President and CEO

Date Signed: 11/15/13

