Republic of the Philippines
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PHILHEALTH CIRCULAR
NO. 025-2014

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

RE : **Revised PhilHealth Category of Health Care Institutions (HCIs) and Compensable Benefits in Primary Care Facilities (PCF) (1st Revision)**

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 enhance the benefits packages simultaneous with the expansion of its membership base. However, accessibility to these benefits by the growing number of PhilHealth members remains an issue.

The Department of Health (DOH) has issued the revised "Rules and Regulations Governing the New Classification of Hospitals and Other Health Facilities in the Philippines (DOH AO 2012-0012). This policy reclassifies hospitals and other health facilities based on standards set for each type of facility. PhilHealth's new engagement process (PhilHealth Circular 54 s, 2012) adopts this new classification for Health Care Institutions (HCIs) . *Furthermore, PhilHealth Circular 14,s 2013 was issued defining the benefit payment guidelines on the reclassified health care institutions.*

PhilHealth recently implemented the All Care Rates Policy as defined in PhilHealth Circular 31, s 2013, which shifts its payment mechanism from fee-for-service to case-based payment. With this major shift in provider payment, some provisions in PhilHealth Circular 14, s 2013 need to be revised particularly those affecting the reclassified primary care facilities.

II. OBJECTIVES

This policy aims to increase access of PhilHealth members and their dependents to PhilHealth benefits in different types and levels of health care institutions.

Specifically, this Circular aims to:

1. Clarify the *compensable benefits of reclassified* health care institutions based on the DOH's New Classification of Hospitals and Other Health Facilities (AO 2012-0012) with their corresponding benefit schedule ;

MASTER DOCUMENT Date: 10/10/14
PhilHealth | Office of the PCEO

2. Identify outpatient packages, procedures and conditions that are compensable in Primary Care Facilities.

III. COVERAGE

This Circular covers hospitals and other health care institutions including Primary Care Facilities in the DOH's New Classification of Hospitals and Other Health Facilities (AO 2012-0012).

IV. DEFINITION OF TERMS

1. Primary Care Facility - a first-contact healthcare facility that offers basic services including emergency service and provision for normal deliveries. *It is subdivided into:*
    a. With in-patient beds - a short stay facility where patients can be admitted for a short period of 1 to 3 days. Examples *are* 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. Examples are Medical Outpatient Clinic, *OFW Clinics, and Dental Clinics.*

2. Infirmary – a healthcare facility with in-patient beds capable of providing diagnosis and treatment of medical conditions and simple surgical procedures, 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 dispensed. 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 Outpatient Clinic – an institution or facility providing medical outpatient 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 includes children's hospital and orthopedic hospital.

7. *Geographically Isolated and Disadvantage Areas (GIDA) – communities with marginalized population that are physically and socio-economically separated from the mainstream society and characterized by:*
    (a) Physical Factors - isolated due to distance, weather conditions and transportation difficulties (island, upland, lowland, landlocked, hard to reach and unserved/ underserved communities);
    (b) Socio-economic Factors (high poverty incidence, presence of vulnerable sector, communities in or recovering from situation of crisis or armed conflict).
    These areas are identified by the Department of Health.

8. *Heath Human Resource Shortage (HHRS) areas – areas with no adequate health human resource which have been determined based on the following criteria: accessibility (terrain, distance, availability of public transportation, socio-economic factors (poverty rate, income, etc.), peace and order (presence of armed conflict in the area) and evaluation reports from the PhilHealth Regional Office and other offices (Department of Health and National Statistics Coordination Board).*

MASTER DOCUMENT Date: 10/10/12
PhilHealth | Office of the PCEO

V. GENERAL GUIDELINES

A. General Provisions

1. *With the implementation of All Case Rates Policy, PhilHealth is revising the compensable health services of various health care facilities as classified by DOH AO 2012 – 12.*

2. *Consistent with the PC 54, s 2012, all licensed health care facilities shall be automatically accredited and be paid for the compensable health service according to the classification indicated in their DOH License to Operate (LTO).*

3. *All accredited PCF (Infirmary / Dispensary) located in Geographically Isolated and Disadvantaged Areas (GIDA) and/or in government facilities in Health Human Resource Shortage (HHRS) areas shall be paid the full case rate payment. The list of accredited PCF (Infirmary, Dispensary) located in GIDA and/or in HHRS areas shall be updated annually in coordination with DOH and PhilHealth Regional Offices (PROs), respectively.*

4. *All accredited HCIs that submitted a Letter of Intent* ***during application for DOH LTO for CY 2013****, referred in this issuance as reclassified HCIs, shall be paid the full payment of case rate.*

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

B. Processing of Claims for the Reclassified Level 1 HCIs

1. *Claims of reclassified for admissions from January 1, 2014 up to November 18, 2014.*

a. *Previously denied claims (for medical / procedure cases with RVU of 200 and below) of reclassified level 1 hospitals may file a Motion for Reconsideration (MR) provided that the applicable case rate amount has been deducted from the total actual charges (both the HCI and professional fees) upon discharge. To illustrate:*

Deducted from total actual charges and Claimed	***PhilHealth Action on the Claim***	***Action to be taken by HCI***
100% of case rate deducted from patient bill	*Denied*	*File MR for full payment of case rate*
Case rate not fully deducted	*Denied*	*Cannot file MR*

Part II.A. of PhilHealth Claim Form 2 - CERTIFICATION OF CONSUMPTION OF BENEFITS must be properly and completely filled out by the HCIs.

b. *Reclassified government HCIs that did not file a claim but applied the No Balance Billing (NBB) policy to eligible PhilHealth member/patient may file a claim until January 17, 2015. It shall be reviewed and paid following the rules contained in this circular and other applicable all case rate rules. To illustrate:*

MASTER DOCUMENT Date: DC:

PhilHealth | Office of the PCEO

Deducted from total actual charges and Claimed	*PhilHealth Action on the Claim*	*Action to be taken by HCI*
Applied NBB but did not claim	*NA*	*File MR for full payment*

c. *HCIs that deducted 100% of the case rate from the total actual charges but were only reimbursed 70% of the case rate shall file for a Motion for Reconsideration for payment of the remaining 30% of the case rate. To illustrate:*

Deducted from total actual charges and Claimed	*PhilHealth Action on the Claim*	*Action to be taken by HCI*
100% deducted and claimed	*Paid 70% of case rate*	*File MR for payment of remaining 30%*

2. *Direct filing of claims by PhilHealth members:*

In the event that PhilHealth benefits were not deducted from the total actual charges, the HCI must not file any claim, otherwise it shall be denied, without prejudice to the filing of appropriate administrative charges for possible violation of R.A. 7875, as amended. If the conditions for direct filing of claims (Annex A), provided in PhilHealth Circular 35 s. 2013 "ACR Policy No. 2 - Implementing Guidelines on Medical and Procedure Case Rates" and PhilHealth Circular 20 s. 2014 "ACR Policy No. 4- Directly filed Claims for All Case Rates and Return to Sender" are met, the member may file the claim as follows:

a. *Members who were admitted between January 1, 2014 up to November 17, 2014 can file their claim directly until January 17, 2015, provided that the HCIs did not deduct any PhilHealth benefit upon discharge.*

b. *Directly filed claims must include the following attachments:*
   i. *Waiver Form for Directly Filed Claims included as Annex 1 of PC 20, s. 2014 (attached here as Annex B)*
   ii. *Claim form 1 and 2, completely and properly filled-out*
   iii. *Claim Form 3 (CF3) completely and properly filled-out*
      1. *in lieu of CF3, other acceptable alternative are the photocopy of chart and clinical abstract, etc.*
      2. *For Animal Bite Package, the treatment card/ animal bite treatment record shall be submitted instead of CF3*
   iv. *Other documents as needed such as but not limited to proof of premium contribution, records of operative or surgical technique and anesthesia.*

c. *The direct filing of claims by members is not applicable to HCIs with approved contract/ MOA for the Interim Reimbursement Mechanism, as provided in PhilHealth Circular No. 4 s. 2014 "Implementation of the Interim Reimbursement Mechanism (IRM) for Health Care Institutions directly Affected by "Super Typhoon Yolanda".*

B. Compensable Benefits Provided in Primary Care Facilities

1. *All existing outpatient benefit packages, such as but not limited to Maternity Care Package (MCP) Newborn Care Package (NCP), TB DOTS Package, TSeKaP (Primary Care Benefit 1*

MASTER DOCUMENT Date: 6/20/15 DC:

Package), Animal Bite Treatment Package, and Outpatient Malaria Package shall be compensable in PCFs provided they are accredited for those benefit packages/ services.

2. *Services for Normal Spontaneous Delivery (as Package Code 59400) provided in PCF-Infirmary/ dispensary by an accredited physician prior to effectivity of PhilHealth Circular 22,s-2014 (Social Health Insurance Coverage and Benefits for Women About to Give Birth)*

3. Selected procedures with Relative Value Unit (RVU) of 30 or less *as listed in Annex 6 of PhilHealth Circular 35, s 2013 and other related issuance.*

4. *Selected medical conditions listed in Annex 1 of PhilHealth Circular 09, s 2014.* These conditions are compensable only for patients admitted in the infirmaries/dispensaries for 24 hours *or more.*

5. *Insertion of Intrauterine Device (IUD) (58300) is also compensable in Birthing Homes, provided that health care providers have the necessary skills as certified by DOH.*

Accredited government Primary Care Facilities shall comply with the existing rules on No Balance Billing Policy of the Corporation. Concerned Primary Care Facilities shall refer cases that are not on the above lists and that 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, *following the provisions in Section IV.I of PhilHealth Circular 35 s. 2013. In such cases, the referral package shall be reimbursed by the PCF.*

VI. BASIC PARTICIPATION 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 *with* these facilities. HCIs shall be responsible in submitting the necessary requirements for continuous participation.

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

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 (*FPCBT*) Level 2
Midwives	FPCBT Level 2

4. Birthing homes and maternity clinics that will provide IUD insertion are required to submit copy/ies of their personnel's certificate of completion for Level 2 Family Planning Competency Based Training (*FPCBT*) or Obstetrics and Gynecology residency training certificate. *The said FPCBT training must be provided by DOH recognized trainers and coordinated with the respective DOH Regional Offices.*

MASTER DOCUMENT Date: DC:

PhilHealth | Office of the PCEO

VII. CLAIMS FILING of PRIMARY CARE FACILITIES

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

2. Except for PCB1 claims, providers shall submit the following requirements for claims processing:

   i. PhilHealth Benefit Eligibility Form (PBEF) or, if not available, properly accomplished Claim Form 1 (CF1)
   ii. Properly accomplished Claim Form 2 (CF2)
   iii. Properly accomplished Claim Form 3 (CF3) *except for Newborn Care Package*
   Other documents required by PhilHealth (*in cases when PBEF response is "No" or not available*) 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 alternative and Member Data Record for dependents, proof of contributions such as Official Receipt or Validated Payment Slip and other documents.
   iv. Copy of Operative Record or O.R. Technique for performed procedures (as applicable)

3. Reports for TSeKaP (PCB 1 Package) shall be submitted and evaluated according to the procedures and guidelines stated in *PhilHealth Circular 15, s 2014.*

4. Claims for TB DOTS Package shall have a certified true 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. Claim Form 3 is not required for this benefit package.

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.

7. Claims shall have *complete entries including* correct ICD 10 code/s and/ or RVS or Package Code (if applicable). Claims with *incomplete or inconsistent entries* shall be returned to the facility for compliance.

8. Consistent with PC 35 s, 2013, 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. *Claims for pneumonia shall have the appropriate 4th or 5th character in its ICD 10 Codes as listed in Annex 1 of PhilHealth Circular 09, s 2014.*

MASTER DOCUMENT Date: 18/04/14 DC:

PhilHealth | Office of the PCEO

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. Violations may include, among others: incomplete provision 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 at least one (1) year 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 for all admissions starting November 18, 2014. It shall be published in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

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

ALEXANDER A. PADILLA
President and CEO

Date signed: 10/28/14

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