TAMANG SAGOT

PhilHealth Circular 025-2015

Social Health Insurance Coverage and Benefits for Women About To Give Birth (Revision 2)

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1. What is new in this PC 25 - 2015?

This circular contains the following revisions:

a. Payment of conditions that occurred during pregnancy and post partum
b. No balance billing policy in maternity clinics/birthing homes
c. Reiteration on the mechanism to provide social health insurance coverage
d. Clarification of benefit for IUD insertion and No-scalpel vasectomy

2. What is the new in the No Balance Billing policy?

The No Balance Billing Policy shall apply to all member sectors and their dependents in accredited public and private maternity clinics/birthing homes. This shall cover all compensable services allowed in accredited public and private maternity clinics/birthing homes.

3. What will happen if the pregnant women did not qualify for the Point of Care (POC) enrolment?

They shall be required to enrol or shift under the Informal Economy Program and must pay the prescribed premium/s for **one year or the missed and unpaid quarter/s of the applicable year** as provided under Sec. 39b of the Revised IRR of RA 10606. If the date of discharge falls on a weekend or on a holiday, registration under the Informal Economy Program and payment of prescribed premium contributions shall be allowed on the next working day.

4. What will happen if the Health Care Institution (HCI) portal is not available or denied claims availment?

The member may present the PhilHealth Official Receipt (POR) or Certificate of Premium Payment (CPP) to the accredited health care facility as proof of payment and entitlement to PhilHealth benefits.

5. What is the new rule in claiming for IUD insertion benefit packages?

The package is worth 2,000 pesos which covers payment for counseling, professional fee, IUD device, and use of the facility and all other related services patients may require. Post-partum IUD may be claimed as a second case rate at a rate of P2,000.

Also, PhilHealth shall consider the following certificates in addition to Family Planning Competency Based Level 2: Comprehensive Family Planning (FP) Training Course; and PPIUD Training Course. These trainings must be from DOH Recognized trainers.

6. **How does DOH recognize trainers for family planning methods?**

   Recognition of trainers for family planning is based on DOH Administrative Order 2014-0041 (Guidelines on the Recognition of Family Planning Training Providers of the DOH).

7. **How will we know if the training on family planning (e.g. FPCBT Level 2) is given by DOH recognized trainers?**

   These trainings were conducted in coordination with the DOH Regional Office. The training certificates is signed by the DOH Regional Director or his/her representative.

   If the training certificates do not have this signature, providers are advised to go to the concerned DOH Regional Office of the region where the training was conducted and ask for confirmation/letter that the training is indeed provided by DOH recognized trainers. This must be submitted together with a copy of training certificates to PhilHealth.

   This applies for trainings in IUD insertion and No-scalpel vasectomy.

8. **Are the doctors not required to submit training certificates on IUD insertion?**

   At this time, doctors are not required to submit training certificates on IUD insertion. This is to increase access to services for IUD Insertion.

9. **How about for No Scalpel Vasectomy (NSV)?**

   If the doctors are working in PCB1 or Tsekap providers and intend to provide (and be compesated for) NSV services, they are required to submit training on NSV from DOH recognized trainer.

10. **PhilHealth will compensate IUD insertion as second case rate. Will midwives trained in FBCPT Level 2 or Comprehensive Family Planning Training Course be able to claim for this?**

    IUD as second case rate means that normal delivery then IUD insertion right after delivery [post-partum IUD insertion(PPIUD)] could be claimed at the same time. As PPIUD requires further training, only those trained on PPIUD can claim for IUD as second case rate.

    Since they are also trained on basic IUD insertion, they are also qualified to perform interval IUD and claim for the procedure.

11. **What is the new rule in claiming for No-scalpel vasectomy (NSV) benefit package?**

NSV shall also be paid if performed by an accredited physician in PCB1 and Tsekap providers aside from accredited hospitals, infirmaries, ambulatory surgical clinics (ASC). Accredited physician who are certified NSV provider shall be paid for the NSV services performed in non-hospital facility (e.g., RHUs). The RVS Code 55250 (Vasectomy, unilateral or bilateral) shall be used for such procedure.

The subsequent information below is the updated Tamang Sagot of the PhilHealth Circular on Women About to Give Birth. The original reference is Circular 22-2014. The *italicized letters* are the updates based Circular 25-2015.

1. **Why did PhilHealth issue this policy for Women About to Give Birth?**

   The government underscores the need for women to have access to facility based deliveries. This is with the premise that these facilities have adequate equipment and competent health staff who can take care of the mothers and their newborns.

   PhilHealth supports this endeavour by enrolling women about to give birth to social health insurance and enabling them to have financial access to health care facilities where they can give birth.

2. **The Law provides that women about to give birth shall be enrolled to PhilHealth, but why include the guidelines on benefit delivery as well?**

   The intent of the law for enrolling women about to give birth to social health insurance is for these women to have access to health services during their delivery. Enrolling them to PhilHealth will be meaningless if they still could not access services for deliveries and maternity care.

   Hence, guidelines for enrollment and benefits are issued together in one circular

3. **Who are the Women About to Give Birth?**

   They are those who are confirmed pregnant during their first visit to a health care provider and anytime thereafter.

4. **Describe Maternity Care Package and Normal Spontaneous Delivery Package. How are they different from the previous descriptions?**

   Previous definitions of the Maternity Care Package (MCP) and Normal Spontaneous Delivery (NSD) Package are based whether the services were provided in hospitals (NSD Package) or non-hospitals (MCP). As we focus on the health services that must be given to pregnant mothers during her pregnancy, the definitions of these benefit packages are changed based on the health services provided rather than the type of facility where they are provided.

5. **But why are there different rates of MCP and NSD Package in hospitals and non-hospitals?**

The non-hospital facilities have higher rates for MCP and NSD Package to encourage normal low risk deliveries in birthing homes/maternity clinics. This is to allow mothers to experience normal natural birth in a safe environment of a birthing facility and also to decrease the case loads of the normal deliveries in the hospitals for them to focus on management of more complicated cases.

6. **What should pregnant women do to receive the full benefits for women about to give birth?**

   Pregnant women should consult PhilHealth accredited health care provider (institution and professional) upon first signs and symptoms of pregnancy. Through early consultation, the necessary health services will be given to them and the status of their PhilHealth membership will be verified and updated the earliest time possible.

   Pregnant women should regularly consult their health care provider and have a record of these consults by keeping a mother's book.

   They should update their PhilHealth membership status and pay the premium contributions (if necessary) and prepare the documents needed for claims filing.

   They should work closely with the health care provider in ensuring their good health and that of their baby.

   They should give birth to an accredited health care institution.

   They should have post-partum follow-up with their health professional.

7. **What is the advantage for women about to give birth to have prenatal care and be covered with Social Health Insurance the earliest time possible (rather that during the delivery)?**

   By having early and regular pre-natal care early, women about to give birth can be screened for high risk conditions. Appropriate management and action can be done early which can save their lives and their babies.

   If they are enrolled and covered by PhilHealth during the antenatal period, services for the pre-natal care will be covered as well as hospitalisations if they are admitted for pregnancy related conditions.

8. **What should a health care provider do to be able to receive reimbursement for the services they provided for women about to give birth?**

   In order to be qualified to receive reimbursement from PhilHealth, health care providers should apply for PhilHealth accreditation and comply with its requirements.

   They shall install HCI Portal in their facility to ease the process of verification of membership and claims filing.

Health care providers should give health services to pregnant women for antenatal, or intrapartum/ postpartum period or both according to the existing standards of care.

They shall give pregnant women a mother's book and keep an updated health record in their facilities.

They shall assist the pregnant women in checking and updating PhilHealth membership.

If the pregnant women are qualified for Point of Care (POC), they shall refer poor pregnant women to social worker/medical social worker for enrollment to PhilHealth through POC.

They shall provide medical certificate for pregnant women who will be enrolled to PhilHealth through 39b provision of the IRR.

9. How shall the health care provider know if the pregnant woman is an active PhilHealth member?

The health care provider shall check for PhilHealth membership status and coverage through the PhilHealth Enhanced Health Care Institution Portal. Pregnant women who are registered and covered (active PhilHealth members) shall be entitled to the benefit.

10. What shall be done if the pregnant woman is not an active PhilHealth member?

Pregnant women with inactive membership shall be referred to a social worker to assess and enroll them through Point of Care or they can automatically be covered through the provision in 39b of the IRR for NHIA of 2013. For the latter case, pregnant women shall be given a medical certificate or alternative document and be referred to the PhilHealth LHIO/PRO for enrollment and payment of premium. These must be done prior to discharge of the mother from the facility.

11. Can the 39b provision of the IRR be used in the next pregnancy and delivery?

Provisions under 39b may only be availed once in *her lifetime* without penalties. If the women have missed premium payments during her next pregnancy, she may be asked to pay aside from the current premium, the corresponding penalties for missing the payment. This is to discourage the practice of paying the contributions to PhilHealth only when they are about to avail of the benefits. Such practice defeats the principle of social solidarity which PhilHealth applies. PhilHealth will issue separate guidelines on penalties which is applicable to all.

12. Can the provision of automatic availment in 39b of the IRR be used by other members of the family and for other conditions of the mother (not related to pregnancy)?

Only women about to give birth are qualified to enrol using the 39b provision of the IRR. However, upon enrollment of these pregnant women, their qualified dependents shall be entitled to avail of the benefits accorded to the members of the Informal Economy.

13. There are some instances when the women about to give birth are still dependents of their parents. Are they still eligible to claim benefits for delivery?

Being a qualified dependent of their parents, they are still eligible to receive PhilHealth benefits, however their newborns are not.

Hence to ensure that their babies will also have social health insurance coverage, women about to give birth who are still dependents of their parents shall be enrolled as principal member.

14. Is pre-natal checkup required to avail of the Maternity Care Package?

Yes. Maternity Care Package covers the complete essential health care services for women about to give birth throughout their pregnancy and normal delivery (during antenatal, intrapartum and immediate postpartum periods) regardless of the type of health care institution where the services are rendered. Hence, for this benefit to be paid, there should be at least 4 pre-natal check-ups from the same facility.

Only facilities who provided the complete services from antenatal to intrapartum and post partum period may claim for MCP.

15. What if facility provided normal delivery but less than four pre-natal check-ups?

The facility cannot claim for Maternity Care Package. But it can claim for Normal Spontaneous Delivery Package.

16. Is pre-natal checkup required to avail of the Normal Spontaneous Delivery Package?

No. Normal Spontaneous Delivery Package covers health services during intrapartum, and immediate post-partum period for normal delivery regardless of the type of health care institution.

17. What if the Women About to Give birth have prenatal care from other facility and then gave birth to another facility?

In cases when the pregnant women receive pre-natal care from another facility, the facility where pre-natal care is rendered may claim for Antenatal Care Package while the facility that will assist in normal delivery may claim for NSD Package.

18. What is Antenatal Care Package?

Antenatal Care Package covers antenatal or pre-natal care services of expectant mothers. Previously, the benefit is bundled with the benefits for normal deliveries (i.e. NSD Package: Php 1,500 for pre-natal care and Php 5,000 for delivery) however the pre-natal care component is not fully utilized because of gaps in the health care delivery network. To promote access of pregnant women to quality antenatal care services that will ensure good outcome of their pregnancy, this benefit is made distinct from the benefits for delivery.

19. What are the requirements for Antenatal Care Package?

The health care provider (institution and professional) must be accredited. The institution must be accredited as a hospital, birthing home, infirmary/dispensary or PCB1 provider.

The pregnant women must be an active member of PhilHealth. Hence it is important that they consult a health care provider and update their PhilHealth membership during the early part of their pregnancy.

There should be at least four pre-natal visits with 1 visit during the last trimester of pregnancy.

For delivery and post-partum care, the pregnant women are referred to an accredited health care institution.

20. What if the women had less than 4 pre-natal visits?

The facility cannot claim for Antenatal Care Package *unless the pregnancy is terminated earlier e.g. pre-term delivery.*

21. What if the women had pre-natal visits in several facilities? Can *all these facilities* claim for Antenatal Care Package?

No. Only one claim may be filed for Antenatal Care Package. Hence the facility who provided at least 4 prenatal check-ups with one during the last trimester of pregnancy should file the claim.

Also, having several health care providers for pre-natal consultations is not encouraged for it disrupts continuity of care.

22. Can Antenatal Care Package and Maternity Care Package be claimed for the same person at the same period of pregnancy?

No. They cannot be claimed at the same time (whether by the same or different facilities). Antenatal Care Package covers pre-natal care while Maternity Care Package covers pre-natal care and delivery. The facility claiming for Maternity Care Package should have provided the pre-natal care and there should be no separate pre-natal care from another facility.

23. What will happen if there are claims for Antenatal Care Package and Maternity Care Package? If there are two claims for Antenatal Care Package?

Antenatal Care Package and Maternity Care Package claims for the same woman will be referred for investigation. Two claims for Antenatal Care Package will also be investigated.

24. If the mother with Antenatal Care Package from a non-hospital facility was referred to hospital for normal delivery eventually had caesarean section what should these facilities claim for?

The facility that provided pre-natal care will claim for Antenatal Care Package and the hospital that performed caesarean section will claim for caesarean section.

25. How much are the benefits worth and who gets paid?

Case rates for the benefits are the following:

Package	Facilities	Amount Php	Facility Fee Php	Professional Fee Php
Maternity Care Package (MCP01)	Birthing homes/maternity clinics Infirmaries/dispensaries	8,000	4,800	3,200
	hospitals	6,500	3,900	2,600
Normal Spontaneous Delivery Package (NSD01)	Birthing homes/maternity clinics Infirmaries/dispensaries	6,500	3,900	2,600
	Hospitals	5,000	3,000	2,000
Antenatal Care Package (ANC01)	Birthing homes/maternity clinics Infirmaries/dispensaries Hospitals	1,500	900	600
Antenatal Care Package with Intrapartum Monitoring (ANC02)	Birthing homes/maternity clinics Infirmaries/dispensaries	2,150	1,290	860
Intrapartum Monitoring (59403)	Birthing homes/maternity clinics Infirmaries/dispensaries	650	390	260
Cesarean Section (59513 or 59514)	hospitals	19,000	11,400	7,600
Complicated Vaginal delivery (59409)	hospitals	9,700	5,500	4,200
Breech Extraction (59411)	hospitals	12,120	6,720	5,400
Vaginal Delivery after Cesarean Section (59612)	hospitals	12,120	6,720	5,400

26. Before this Circular, mothers who had out-of pocket expenses during the prenatal period were reimbursed by PhilHealth if they attached their official receipts to the claim MCP pr NSD Claim. Can they still do this?

PhilHealth shall NO longer split the payment of Maternity Care Package between the facility (for the delivery) and the mother (for the pre-natal care expenses). Instead, the entire amount will be paid to the facility. PhilHealth maintains that the facility must exhaust first the PhilHealth benefit before asking the women to pay for additional expenses. However, in cases when some laboratory tests are not available in the facility (e.g. ultrasound) and they are done outside with the mothers spending for the tests, then the facility can reimburse the mothers with a maximum amount of Php 1,500.

27. What if the mothers had to buy medicines and supplies or were made to pay for some services during delivery?

PhilHealth upholds that facilities should provide all the necessary health services to the member and these services should include drugs and medicines, supplies such as sutures and laboratory tests. The facility must exhaust first the amount in the benefit the before asking the mothers to pay the additional expenses. In cases when the services are not available and the member has to purchase them outside the facility, the members have an option to pay for all the services and file the claim directly. PhilHealth shall monitor these practices in relation to the provider performance.

28. Why are the services for Essential Newborn Care and Newborn Screening Test mandatory for payment of Newborn Care Package?

Evidence showed that performing the essential newborn care protocol can save the lives of the newborns. Also, the law mandates (RA) that all newborns must have newborn screening test to screen for certain congenital metabolic diseases. Every newborn must have these services. In line with these, PhilHealth requires that these services must be given before claiming for Newborn Care Package.

29. How about Newborn Hearing Screening Test?

Although the law mandates that all newborns must have access to newborn hearing screening tests, there is still a limited number of facilities that conducts newborn hearing screening test. Hence, at this time, this service is not yet "bundled" with the Newborn Care Package.

Also, behavioral tests such as Tuning Fork and Penlight method and other indigenous methods are not compensable since the Universal Newborn Hearing Screening and Intervention Act (RA 9709) provides that no screening fee shall be charged to patient for these tests.

30. What are the reasons for denial of claim?

Common reasons for denial of claim include incomplete documents, failure to submit documents within the prescribed time period and validity of documents submitted. The health care provider shall inquire from LHIO/PRO the reason for denial of claim to facilitate resolution.

31. What is a partograph? How is it done?

The partograph is a printed graph representing the stages of labor. Once the pregnant woman is in active labor, the skilled health provider regularly plots the descent of the baby as well as the dilatation of the women's cervix to keep track of whether the woman's labor is progressing normally and identify when interventions may be needed. In addition, the provider also records details about the condition of both mother and fetus, including fetal heart rate, color of amniotic fluid, presence of molding, contraction pattern, and medications given.

Plotted on each printed graph are an alert line and action line. The alert line is plotted to correspond with the onset of active phase of labor, wherein the provider should expect dilatation to continue at about the rate of 1 cm per hour. The action line, plotted 4 hours after the alert line, shall signal the provider to take necessary actions such as use of oxytocin to augment labor, vacuum-assisted birth or cesarean section. A sample of the WHO partograph form is available below.

ANNEX 2: **Partograph**

Name Gravida Para. Hospital no.

Date of admission Time of admission Ruptured membranes hours

Fetal heart rate: 180, 170, 160, 150, 140, 130, 120, 110, 100

Liquor
Moulding

Cervix (cm) [plot X]
Descent of head [plot 0]

10, 9, 8, 7, 6, 5, 4, 3, 2, 1, 0

Active Phase
Alert
Action
Latent Phase

Hours 0 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23 24

Time

Contractions per 10 mins: 5, 4, 3, 2, 1

Oxytocin U/L
drops/min

Drugs given and IV fluids

Pulse ● and BP: 180, 170, 160, 150, 140, 130, 120, 110, 100, 90, 80, 70, 60

Temp °C

Urine { protein, acetone, volume

Source: WHO, used by permission