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PHILHEALTH CIRCULAR
No. 2023-0021

TO : **ALL ACCREDITED HEALTH FACILITIES AND HEALTHCARE PROFESSIONALS, PHILHEALTH REGIONAL OFFICES, AND ALL OTHERS CONCERNED**

SUBJECT : **Implementing Guidelines on the Case Rates for Acute Stroke**

I. RATIONALE

Among the Philippines' most burdensome conditions in 2019, stroke ranked second to ischemic heart disease as the most common cause of death and disability. As of 2022, the national stroke incidence rate has ranged from 3.95% to 5.61% with a prevalence rate of 0.49% to 6.00%.[1] In describing the state of stroke care in the country, financing for stroke has been identified as one of the critical gaps in addition to governance, information systems, human resources for health, and medicine. [2] Limited financial coverage for acute stroke contributes to uncontrolled out-of-pocket (OOP) expenditures.

As part of PhilHealth's financing reforms pursuant to Republic Act (RA) No. 11223, otherwise known as the Universal Health Care Act, alongside the shift to a new provider payment mechanism, i.e., from All Case Rates (ACR) to diagnosis-related groups (DRG), conditions for improving financial coverage and protection against catastrophic healthcare expenditure during illness are now being prioritized. Thus, the PhilHealth Board approved Board Resolution No. 2802, S.2023, which increases the reimbursement amount for acute stroke case rates as part of the ACR rationalization.

II. OBJECTIVES

This PhilHealth Circular provides the policies and procedures for implementing the case rates for acute ischemic and hemorrhagic stroke to ensure quality healthcare delivery by accredited health facilities (HF).

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[1] Collantes, M. E. V., Zuñiga, Y. M. H., & Uezono, D. R. (2022, August 15). Incidence and Prevalence of Stroke and its Risk Factors in the Philippines: A Systematic Review. *Acta Medica Philippina, 56*(14), 26. https://doi.org/10.47895/amp.vio.1753

[2] Collantes, M. E. V., Zuñiga, Y. M. H., Granada, C. N., Uezono, D. R., De Castillo, L. C., Enriquez, C. G., Ignacio, K. D., Ignacio, S. D., & Jamora, R. D. (2021, August 17). Current State of Stroke Care in the Philippines. *Frontiers in Neurology, 12*. 10.3389/fneur.2022.1046351

III. SCOPE

This PhilHealth Circular shall apply to all accredited HFs that provide inpatient services for acute stroke, PhilHealth Regional Offices, and all others involved in implementing the case rates for acute stroke.

IV. DEFINITION OF TERMS

A. **Acute stroke** – is also known as cerebrovascular disease or "brain attack" and is classified as ischemic or hemorrhagic, requiring very different management. "Ischemic strokes are due to blood vessel blockage that limits the blood supply to the brain. In contrast, hemorrhagic strokes are due to blood vessel rupture, either intracerebral hemorrhage or subarachnoid hemorrhage."[3]

B. **All Case Rates (ACR)** - refer to PhilHealth's mechanism of paying for inpatient care through a case-based provider payment system.

C. **ACR rationalization** – refers to PhilHealth's interim strategy to improve financial coverage for selected/priority conditions based on the volume of claims, disease burden, and support value until PhilHealth fully implements DRG as a provider payment mechanism for inpatient services.

D. **Bottom-up costing** - refers to a cost calculation method that considers the individual components and activities of delivering a healthcare service and analyzes its various elements separately, such as personnel, medical supplies, equipment, overhead expenses, and administrative costs, to determine the cost incurred for that specific component.

E. **Case-based provider payment mechanism** – refers to a provider payment system in which a hospital is reimbursed for each discharged patient at pre-determined rates based on the type of case or for groups of cases, with similar clinical profile and resource requirements.

F. **Co-payment**- refers to a predetermined amount agreed upon by the accredited health facility (HF) and PhilHealth chargeable to patients to cover the share for amenities, choice of physician, or any additional or upgrade of services during the episode of inpatient care. [4] Co-payment is an example of an out-of-pocket payment or cost-sharing mechanism intended to share the cost of healthcare between the insured and the insurer.

[3] Tadi P, Lui F. Acute Stroke. [Updated 2023 Feb 28]. In: StatPearls [Internet]. Treasure Island (FL): StatPearls Publishing; 2023 Jan-. Available from: https://www.ncbi.nlm.nih.gov/books/NBK535369/
[4] PhilHealth Circular No. 2021-0022, The Guiding Principles of the Z Benefits (Revision 1)

G. **Diagnosis-related groups (DRG)**[5] - refer to a patient classification and provider payment system that groups patient cases, including services received, into standardized case groups according to diagnosis and treatment or procedure received. It combines clinical logic with economic logic that classifies hospital cases into groups that are clinically similar and are expected to have similar hospital resource use.

H. **Fixed co-payment** - refers to a flat-rate co-payment as a cost-sharing arrangement, that is, a predetermined, fixed amount of out-of-pocket that remains the same regardless of the total cost of the service.

I. **Health Technology Assessment (HTA)** - refers to the systematic evaluation of properties, effects, or impact of health-related technologies, devices, medicines, vaccines, procedures and all other health-related systems developed to solve a health problem and improve quality of lives and health outcomes, utilizing a multidisciplinary process to evaluate the social, economic, organizational, and ethical issues of a health intervention or health technology

J. **The Health Technology Assessment Council (HTAC)**[6] - is an independent advisory body created under the Republic Act 11223, otherwise known as the Universal Health Care Act, with the overall role of providing guidance to the Department of Health (DOH) and the Philippine Health Insurance Corporation (PhilHealth) on the coverage of health interventions and technologies to be funded by the government.

K. **Minimum standards of care** - refer to essential services that HFs are obliged to provide based on clinical practice guidelines or current best practices in the local setting.

L. **Non-basic accommodation**[7] - refers to the provision of the minimum standards of care for patients, and includes fringe and/or additional amenities provided by the facility at the option of the patient

M. **Out-of-pocket payment (OOP)** - refers to the balance of healthcare provider charges that are paid directly by the patients from their own resources or cash reserves or health spending made directly from households to providers

N. **Published Case Rate** - refers to the fixed, predetermined rate or amount that PhilHealth will reimburse for the condition, which shall cover the fees of healthcare professionals and all facility charges, including but not limited to room and board, diagnostic imaging procedures, laboratory/chemistry tests, drugs, medicines, devices, supplies, operating room fees, infection control, healthcare worker salary, and other service

[5] PhilHealth Circular No. 2020-0016. Governing Policies on the Transitioning the Provider Payment Mechanism (PPM) from All Case Rates (ACR) to Diagnosis-Related Groups (DRG)
[6] https://hta.doh.gov.ph/health-technology-assessment-council-htac
[7] DOH AO No. 2021-0015. Standards on Basic and Non-basic Accommodation in All Hospitals

fees. The case rate is not a cap but reflects the **average** cost of treating an episode of care. It may differ from the actual hospitalization charges indicated in the statement of account (SOA). The actual cost of care per patient can be higher or lower than the case rate. Therefore, PhilHealth retains the flexibility to adjust payment rates based on the services covered and the efficiency of healthcare providers in delivering quality care.

O. **Top-down costing** - refers to a cost accounting method adopted by PhilHealth that involves estimating the overall budget for the HF or healthcare organization and then breaking it down into various cost centers, such as different departments, clinics, or service lines. The allocation of costs to these individual cost centers can be based on revenue, patient volume, or historical cost patterns. This method allows PhilHealth to determine areas of high or low cost or high- or low-intensity use of resources in the HF.

V. POLICY STATEMENTS

A. PhilHealth identified acute stroke as one of the priority conditions in rationalizing the ACR to improve financial coverage while transitioning its provider payment mechanism to DRG.

B. PhilHealth utilizes a case-based provider payment mechanism to reimburse HFs for the minimum standards in delivering inpatient acute stroke services in a basic or ward accommodation.

C. PhilHealth's case-based reimbursement system for the ACR intends to promote efficiency, cost containment, and quality of care by providing a fixed payment for a specific case or episode of care where HFs deliver services in a more coordinated and streamlined manner to manage resources efficiently and focus on achieving positive patient outcomes rather than simply providing more services. Overall, PhilHealth's case-based provider payment system aims to align financial incentives with the efficient and effective delivery of services.

D. The minimum standards of care recommendations from clinical practice guidelines (CPG) disseminated by the World Health Organization (WHO), Department of Health (DOH), local medical societies, and other guideline sources, which are critically appraised and validated by current best practices in the local setting, are PhilHealth's basis for service coverage and costing analyses.

E. PhilHealth utilizes a combination of top-down and bottom-up costing methodologies to update the case rates for acute stroke using hospital data and information on professional fees submitted by accredited HFs.

F. Any proposal for PhilHealth coverage to include new technologies, such as drugs/medicines and biologicals not listed in the latest Philippine National Formulary (PNF), diagnostic procedures, surgical interventions, and other treatment interventions, shall consider the Health Technology Assessment Council (HTAC) recommendation.

G. PhilHealth highly encourages continuous quality improvement initiatives to promote improving acute stroke care in the Philippines, such as developing a patient registry according to global best practices and collaboration efforts to standardize local practice and improve access to quality services delivered by accredited HFs.

H. PhilHealth shall engage key stakeholders to promote a deeper understanding of the ACR as a case-based provider payment system, which has critical implications for claims processing, medical evaluation, and audit.

I. Services beyond the minimum standards of care in non-basic accommodation, such as amenities, choice of physician, upgrade of services, or additional services unrelated to the episode of care, shall be subject to co-payment, which shall be thoroughly discussed with the patient as part of full informed consent by the attending physician/s who should properly inform patients of the essential services for the management of acute stroke as part of informed consent.

As OOP may also come from purchases outside of the hospital, all accredited HFs should ensure that they maintain the minimum stock levels of essential and/or life-saving medicines and supplies at all times for the timely delivery of quality healthcare services.

J. PhilHealth reiterates Chapter III, Sec. 9, of RA 11223, that PhilHealth members shall not be charged co-payment for services rendered in basic or ward accommodation. As indicated in the SOA, PhilHealth shall deny claims of HFs indicating co-payment or OOP payment incurred by patients in basic or ward accommodations.

K. As stipulated in the UHC Act, Chapter IV, Sec. 18(b), there will be no differentiation between facility and professional fees. PhilHealth shall credit all payments to the account of accredited private and government HFs. It is the sole responsibility of the HF to distribute the professional fees (PF) to the attending physicians or the health workers in the case of government HFs based on their internal agreements and processes.

L. PhilHealth shall closely monitor re-admissions for acute stroke, conduct regular utilization reviews, and strongly urge its accredited HFs to audit their re-admissions.

M. Accredited HFs should follow standard guidelines or clinical pathways to manage acute stroke patients and ensure adherence by medical professionals who are appropriately credentialed and privileged to practice in the HFs and all hospital staff in charge of acute stroke patients.

N. Accredited HFs that do not have the service capability for managing acute stroke shall properly coordinate and facilitate the timely referral of patients after providing standard emergency and life-saving measures to higher-level HFs.

O. Benefits for acute stroke

1. As Chapter II, Sec. 5 of RA No. 11223 stipulates, "Every Filipino citizen shall be automatically included in the NHIP," thus, they are eligible to avail of the case rates for acute stroke. PhilHealth reiterates further that it does not require a printed copy of the member data record (MDR) for claims submission. All accredited HFs should deduct PhilHealth benefits any day of the week upon patient discharge.

2. Accredited HFs shall ensure delivery of the minimum standards of care for managing acute stroke according to CPG recommendations applicable in local practice, including the availability of drugs and medicines (i.e., thrombolytic agents, anticoagulants, antihypertensives, antiplatelets, statins, proton pump inhibitors, etc.), functioning neuroimaging machines and other types of equipment, timely laboratory chemistry services, and the appropriate human resources.

3. The ICD-10 codes, description, and corresponding package rates are indicated in Tables 1 and 2:

ICD-10 Codes	Description	Package Rate (Php)
I63.0	Cerebral infarction due to thrombosis of precerebral arteries	76,000
I63.1	Cerebral infarction due to embolism of precerebral arteries	
I63.2	Cerebral infarction due to unspecified occlusion or stenosis of precerebral arteries	
I63.3	Cerebral infarction due to thrombosis of cerebral arteries	

ICD-10 Codes	Description	Package Rate (Php)
I63.4	Cerebral infarction due to embolism of cerebral arteries	
I63.5	Cerebral infarction due to unspecified occlusion or stenosis of cerebral arteries	
I63.6	Cerebral infarction due to cerebral venous thrombosis, non-pyogenic	
I63.8	Other cerebral infarction	
I63.9	Cerebral infarction, unspecified	
I63.9+G46.7*	Other lacunar syndrome in unspecified cerebral infarction	
I64	Stroke not specified as hemorrhage or infarction	

Table 1. Acute Stroke, Ischemic

ICD-10 Codes	Description	Package Rate (Php)
I60.0	Subarachnoid haemorrhage from carotid siphon and bifurcation	80,000
I60.1	Subarachnoid haemorrhage from middle cerebral artery	
I60.2	Subarachnoid haemorrhage from anterior communicating artery	
I60.3	Subarachnoid haemorrhage from posterior communicating artery	
I60.4	Subarachnoid haemorrhage from basilar artery	
I60.5	Subarachnoid haemorrhage from vertebral artery	
I60.6	Subarachnoid haemorrhage from other intracranial arteries; Multiple involvement of intracranial arteries	
I60.7	Subarachnoid haemorrhage from intracranial artery, unspecified; Congenital ruptured berry aneurysm NOS; Subarachnoid haemorrhage from cerebral artery NOS; Subarachnoid haemorrhage from communicating artery NOS	

ICD-10 Codes	Description	Package Rate (Php)
I60.8	Other subarachnoid haemorrhage; Meningeal haemorrhage; Rupture of cerebral arteriovenous malformation	
I60.9	Subarachnoid haemorrhage, unspecified	
I61.0	Intracerebral haemorrhage in hemisphere, subcortical; Deep intracerebral haemorrhage	
I61.1	Intracerebral haemorrhage in hemisphere, cortical; Cerebral lobe haemorrhage; Superficial intracerebral haemorrhage	
I61.2	Intracerebral haemorrhage in hemisphere, unspecified	
I61.3	Intracerebral haemorrhage in brain stem	
I61.4	Intracerebral haemorrhage in cerebellum	
I61.5	Intracerebral haemorrhage, intraventricular	
I61.6	Intracerebral haemorrhage, multiple localized	
I61.8	Other intracerebral haemorrhage	
I61.9	Intracerebral haemorrhage, unspecified	
I62.0	Acute Subdural haemorrhage; Nontraumatic Subdural haemorrhage	
I62.1	Nontraumatic extradural haemorrhage; Nontraumatic epidural haemorrhage	
I62.9	Intracranial haemorrhage (nontraumatic), unspecified	

Table 2. Acute Stroke, Hemorrhagic

P. Claims Filing

1. Accredited HFs shall strictly follow current PhilHealth policies on claims submission, including correct ICD coding of the primary diagnosis and/or procedure coding, submission of properly accomplished PhilHealth claims forms (CF), SOA, and other data and documentary requirements as stipulated in existing policies.

2. Accredited HFs filing claims for acute stroke shall submit the patients' neuroimaging results as attachments to Claim Form 4 (CF4) during admission, including the repeat neuroimaging result post-thrombolysis for acute ischemic stroke or at least one (1) repeat neuroimaging result for intracerebral hemorrhage. However, PhilHealth will accommodate acute stroke claims of accredited HFs without the service capability for neuroimaging, following the reimbursement rates of Php28,000 for acute ischemic stroke and Php38,000 for acute hemorrhagic stroke.

3. Accredited HFs shall follow all relevant laws, such as RA No. 9994 or the Expanded Senior Citizens Act of 2010 and RA No. 10754 or the Benefits and Privileges of Persons with Disability, including prospective laws providing mandatory discounts, guidelines of the Bureau of Internal Revenue (BIR), and the order of charging based on Joint Administrative Order No. 2020-0001, entitled: Operational Guidelines for the Implementation of the Medical and Financial Assistance to Indigent and Financially-Incapacitated Patients Pursuant to Republic Act No. 11463 also known as "Malasakit Centers Act."

   With this, PhilHealth benefits and all mandatory discounts provided by law, such as, but not limited to, senior citizen and PWD discounts, shall be deducted first from the total hospital bill of the patient. Benefits from private health insurance (PHI), health maintenance organizations (HMO), or employee benefits shall be applied after PhilHealth deductions and complement the PhilHealth benefits packages.

4. The case rates for acute stroke shall not be claimed as a "second" case rate.

5. Accredited HFs shall properly indicate the OOP and/or co-payment of the member/patient and other funding sources in PhilHealth Claim Form 2 (CF2) Part III, "Consumption of Benefits," and in the SOA.

6. Accredited HFs shall file all claims to PhilHealth within the prescribed filing period of sixty (60) calendar days. Direct filing by members/beneficiaries is discouraged and not allowed.

7. Rules on late filing shall apply, except when the delay in the filing of claims is due to natural calamities or other fortuitous events, where the existing guidelines of PhilHealth on the provision of special privileges to those affected by fortuitous events shall apply.

8. Accredited HFs may file a motion for reconsideration (MR) and appeal for claims denied by PhilHealth following existing policies.

9. PhilHealth shall process and pay claims for confinement abroad based on the remaining balance not covered by any additional insurance or incurred as out-of-pocket expenses but not exceeding the published case rates provided within the policy.

Q. Claims Evaluation and Payment

1. PhilHealth shall reimburse its accredited HFs the published case rates for acute stroke using a case-based provider payment mechanism based on the minimum standards of care in a basic or ward accommodation. Any amount declared in the SOA that is below or above the published case rates shall not be interpreted as over or underpayment.

2. PhilHealth reserves the right to subject any or all claims to medical review before and/or after payment or reimbursement of its accredited HFs, following existing guidelines.

3. PhilHealth shall apply the "return to hospital (RTH)" policy for claims documents with incomplete requirements, discrepancies in the supporting documents or attachments, or incompletely filled-out claims forms for compliance within the prescribed period.

4. PhilHealth shall pay accredited HFs that do not have the service capability of managing acute stroke patients that subsequently refer and transfer patients for further management to higher level HFs at a package rate of four thousand pesos (Php4000) following the guidelines for the Referral Package in PhilHealth Circular (PC) No. 0035, s. 2013.

5. Accredited HFs in geographically isolated and disadvantaged areas (GIDA) without the service capability for neuroimaging that established the diagnosis of acute stroke solely based on the patient's clinical signs and symptoms in the background of vascular risk factors, PhilHealth will accommodate acute stroke claims of these accredited HFs, following the reimbursement rates of Php28,000 for acute ischemic stroke and Php38,000 for acute hemorrhagic stroke.

6. Claims for acute stroke with a length of stay (LOS) of less than 24 hours because of patient death shall be paid by PhilHealth at a package rate of four thousand pesos (Php4,000) using the Package code P0000.

7. PhilHealth shall pay claims of accredited HFs for acute stroke with a final disposition of "died" with LOS of more than 24 hours up to two (2) days indicated in CF2 following the reimbursement rates of Php28,000 for acute ischemic stroke and Php38,000 for acute hemorrhagic stroke.

8. PhilHealth shall not reimburse inpatient confinements of two (2) days or less with a patient disposition of "improved" indicated in CF 2 upon hospital discharge. HFs should accurately report the appropriate ICD code for the diagnosis.

R. Monitoring

PhilHealth shall enforce current policies and guidelines on monitoring the performance of accredited HFs in implementing the case rates for acute stroke and establish strict control mechanisms to ensure quality delivery of services and prevent adverse provider behaviors and insurance fraud.

S. Policy Review

PhilHealth shall conduct a policy review of the case rates for acute stroke in parallel to the development and transition to the DRG provider payment mechanism in collaboration and consultation with key stakeholders.

T. Marketing and Promotion

PhilHealth shall conduct communication and social marketing activities to educate HCPs and the public in increasing their awareness of the case rates for acute stroke following the current Social Marketing and Communication Plan (SMCP).

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized following the pertinent provisions of Republic Act (RA) No. 11223 (Universal Health Care Act), other relevant laws, and RA 7875, as amended by RA 9241 and 10606 (National Health Insurance Act of 2013), and their respective Implementing Rules and Regulations.

VII. TRANSITORY CLAUSE

While PhilHealth is developing the policy on cost-sharing, accredited HFs shall set the co-payments of patients admitted in non-basic accommodation that shall not exceed the published case rates and fully inform patients of this cost-sharing arrangement. In cases of co-payment or OOP payment beyond the published case rates incurred by patients in non-basic accommodations as indicated in the SOA, these claims shall be processed and subjected to post-audit following existing monitoring guidelines.

VIII. SEPARABILITY CLAUSE

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

IX. REPEALING CLAUSE

All circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

X. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect after fifteen (15) days following the completion of its publication in a newspaper of general circulation. Three (3) certified copies shall thereafter be filed with the Office of the National Administrative Register (ONAR) of the University of the Philippines Law Center.

EMMANUEL R. LEDESMA, JR.
President and Chief Executive Officer

Date signed: 10/25/2023

MASTER COPY
Date: 10/27/23
DC: