Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Healthline 637-9999 *www.philhealth.gov.ph*

PHILHEALTH CIRCULAR
No. 011-2011

To	:	**All PhilHealth Stakeholders and All Concerned**
Subject	:	**New PhilHealth Case Rates for Selected Medical Cases and Surgical Procedures and the No Balance Billing Policy**

I. RATIONALE

In consonance with the Government's thrust to attain **Universal Health Coverage (UHC) in 3 years (by the end of CY2013)**, PhilHealth has embarked on continuous improvement of member benefits to be consistently responsive to ever-changing demands. This also serves to keep members within the PhilHealth system as well as entice prospective members to join the social health insurance fund.

Under Section 16, Article IV of Republic Act (RA) 7875 as amended by RA 9241, PhilHealth has the power and function to formulate and promulgate policies for the sound administration of the National Health Insurance Program. Further, under the same Section, Philhealth can formulate and implement guidelines on contributions and benefits; portability of benefits, cost containment and quality assurance; and health care provider arrangements, payment methods, and referral systems. Meanwhile, Section 46, Rule VIII of the Implementing Rules and Regulations of RA7875 as amended, provides that, payment of a healthcare provider shall be made through such other mechanisms as may hereafter be determined by the Corporation.

Accordingly, case rates payment is an internationally accepted payment mechanism that serves to package payment for health interventions. It is beneficial for members, providers, and the Corporation as it is much simpler to administer, and it potentially is more transparent in terms of prices for interventions. Through this mechanism, members will be able to predict how much PhilHealth would be paying for each of the services provided. Moreover, Case Rates improve turn-around time for claims processing and payment to providers in order to achieve better cost-efficiency for PhilHealth and faster reimbursements for accredited providers and members, when necessary.

The computation for fair rates were determined through a process where tariff rates, contracting rates for public and private hospitals, and average value per claims for preceding years were considered and percentage weights were given to each. The highest computed rates were identified and used. The top conditions and procedures that make up 49% of total claims from preceding years were prioritized to be packaged into case rates.

Corollary to case rate payments, and since it is the aspiration of UHC to provide optimal financial risk protection for all its members, especially to the most vulnerable groups including the poorest of the poor, the Corporation, through PhilHealth Board Resolution No. 1441, series of 2010, adopted a **"No Balance Billing Policy" (NBB)** for the most common medical and surgical conditions experienced in the country. The "No Balance Billing" policy and its conditions are defined under Section III of this Circular.

Of special note are the Maternity Care and Newborn Care packages. Consistent still with the objectives of UHC and in support of the United Nation's Millennium Development Goals (UN-MDGs) of reducing maternal and infant mortality rates through affordable interventions, PhilHealth increased the existing Maternity Care package (MCP) and Newborn Care Package (NCP) for non-hospital facilities. This is to promote facility-based deliveries and ensure completeness of provision of quality newborn care. Guidelines of the latter are included in this Circular.

II. CASE RATES AND PROFESSIONAL FEES

The new case rates shall be the new reimbursement rates for all cases specified. These rates shall be the amounts to be paid to the facilities and shall include the Professional fees.

Listed below are the approved cases and their corresponding rates:

	A. Medical Cases	Case Rates (Php)		Medical Cases	Case Rates (Php)
1	Dengue I (Dengue Fever and DHF Grades I & II)	**8,000**	6	Cerebral Infarction (CVA I)	**28,000**
			7	Cerebro-vascular Accident (hemorrhage) (CVA II)	**38,000**
2	Dengue II (DHF Grades III & IV)	**16,000**	8	Acute Gastroenteritis (AGE)	**6,000**
			9	Asthma	**9,000**
3	Pneumonia I (Moderate Risk)	**15,000**	10	Typhoid Fever	**14,000**
4	Pneumonia II (High Risk)	**32,000**	11	Newborn Care Package in Hospitals and Lying in Clinics	**1,750**
5	Essential Hypertension	**9,000**			

	B. Surgical Cases	Case Rates (Php)		Surgical Cases	Case Rates (Php)
1	Radiotherapy	**3,000**	6	Cholecystectomy	**31,000**
2	Hemodialysis	**4,000**	7	Dilatation and Curettage	**11,000**
3	Maternity Care Package (MCP)	**8,000**	8	Thyroidectomy	**31,000**
	NSD Package in Level 1 Hospitals	**8,000**	9	Herniorrhaphy	**21,000**
	NSD Package in Levels 2 to 4 Hospitals	**6,500**	10	Mastectomy	**22,000**
4	Caesarean Section	**19,000**	11	Hysterectomy	**30,000**
5	Appendectomy	**24,000**	12	Cataract Surgery	**16,000**

The Professional Fees for the above medical cases shall be 30% of the reflected amounts while that for surgical cases shall be 40%.

III. No Balance Billing (NBB) Policy

A. The **No Balance Billing (NBB)** Policy shall be applied to all PhilHealth Sponsored Program members and/or their dependents for the above specified cases and under any of the following instances:

1. When admitted in government facilities/hospitals.
2. When claiming reimbursement for outpatient surgeries, hemodialysis and radiotherapy performed in accredited government hospitals and all non-hospital facilities (ex. freestanding dialysis centers and ambulatory surgical clinics (ASCs).
3. When availing of existing outpatient packages for TB-DOTS (Php 4,000), Malaria (Php 600), and HIV-AIDS (Php 7,500 per quarter or Php 30,000 per year). All other existing policies/guidelines covering these packages shall remain in effect.
4. In support of the country commitment to reduce maternal and infant mortality rates and improve maternal and newborn care enunciated in the Millennium Development Goals (MDG), the NBB policy, in addition to covering Sponsored members and their dependents, shall also apply to any other member type in all accredited MCP (non-hospital) providers. This shall cover claims for MCP and Newborn Care Package (NCP) in these facilities.

B. For these purposes, the "No Balance Billing" Policy shall mean that no other fees or expenses shall be charged or paid for by the patient-member above and beyond the packaged rates.

C. For drugs and medicines, supplies, or diagnostic procedures not available in the hospital, said facility shall purchase necessary items/services in advance on behalf of the member.

D. In instances when out-of-pocket spending is incurred for health facility costs (Ex. when PhilHealth members/dependents are made to purchase necessary items and services during confinement, whether from the health facility itself and/or providers outside the health facility), the health facility is required to attach the official receipt/s (OR/s) detailing the purchases in the claim application for the said confinement. The member shall be reimbursed allowable expenses detailed in the attached OR/s with the said payment to the member deducted from the case payment that would be paid to the health facility.

E. In instances when out-of-pocket spending is incurred for professional fees (such as when PhilHealth members/dependents are made to pay professional fees (PF) over and above the case payment), the health facility is required to attach the official receipt/s (OR/s) detailing the PF payment in the claim application for the said confinement. The member shall be reimbursed allowable PF payment expenses detailed in the attached OR/s with the said payment to the member deducted from the case payment paid to the health facility. The health facility shall then make the necessary adjustments and application of sanctions to the health professional/s.

F. In instances wherein the case rate was already paid in full to the facility but the official receipts for necessary items and services bought during confinement or payment for professional fees were not attached to the claim application, the member may request for re-adjustment within six (6) months from the date of discharge. This shall be evaluated and paid accordingly to the member once request has been made and the necessary

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MA. TERESA V. QUIAOIT
A.O. IV
Date: 8/11/11

evidences of payment have been submitted to PhilHealth. This shall be charged to future claims of the health facility with corresponding sanctions or penalties the Corporation may charge.

IV. General Rules

A. Reimbursement for the abovementioned case rates shall be made directly to the facility. Hospitals shall act as the withholding tax agent for Professional Fees.

B. Abovementioned case rates are inclusive of payment to all accredited doctors who attended or managed a specific case. Cases attended by non accredited professionals shall be denied. Government hospitals shall facilitate the payment of the PF share to health personnel with the payment of PF subject to the existing rules on pooling as stated in Section 35 of RA7875 as amended and its Implementing Rules and Regulations and PhilHealth Circular No. 27, s-2009.

C. For Claims of PhilHealth members not covered by Section III (NBB Policy) of this circular, the benefit shall be deducted from the total actual charges, with the remaining amount to be charged to the member as out-of-pocket payment. *For example*: Acute Gastroenteritis = Php 6,000

Total Actual Charges	PhilHealth Benefit	Co-payment of member
Php 9,000	Php 6,000	Php 3,000

D. For purposes of efficient processing of claims, all accredited facilities are required to provide correct RVS and/or ICD-10 codes in Claim Form 2.

E. Reimbursement for these packages shall be based on the main condition as stated in PhilHealth Circular No. 04, s-2002.

F. The total number of confinement days shall be deducted from the 45-day limit per calendar year as stated in PhilHealth Circular 14 s. 2010 re: Order of Discharge. For hemodialysis and radiotherapy, one (1) day shall be deducted from the 45-day allowance per year for each availment. For the outpatient packages for Malaria and HIV-AIDS, existing rules on the 45-day limit will apply. TB DOTS is excluded from the 45 day limit.

G. The case rates shall follow the rule on single period of confinement except for hemodialysis and radiotherapy packages, where availment is on a per session basis.

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

V. Rules on Filing Claims

A. All claims shall be filed within sixty (60) days from the date of discharge.

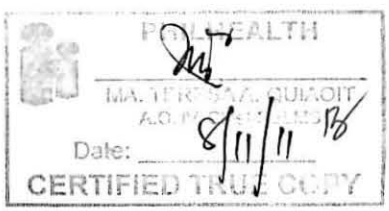
B. All existing documents and information shall still be required. Please be reminded on the proper accomplishment of the claim form 2 and to indicate correct RVS/ICD10 code appropriate for the package being claimed.

C. For NCP claims, under the column of drugs and medicines specify Hepatitis B and BCG vaccination if given. Essential Newborn Care, NBS and Newborn Hearing Screening Test should be written under laboratories, supplies and others.

D. Claims with incomplete documentary requirements shall be returned to the facility for completion and shall be re-filed within 60 days from receipt of notice; otherwise it shall be denied.

E. The hospitals shall segregate the claims with separate transmittal as follows:

1. Case Payment claims
2. Fee for service claims



VI. Specific Rules Per Package

A. Maternity Care Package (MCP)

1. The payment for this enhanced package shall be Eight Thousand Pesos (Php 8,000) in **accredited non-hospital facilities** (e.g., lying-in clinics, maternity clinics, birthing homes and RHUs) and divided as follows:

SERVICES COVERED	AMOUNT (Php)
a. Facility fee (Including professional fee)	6,500
b. Member's prenatal care fee	1,500
TOTAL	**8,000**

2. The NBB Policy shall only be applied to all claims as described in Section III above.
3. Reimbursement shall be made to the facility except for components directly payable to the member (prenatal care fee).
4. For normal deliveries completed in accredited MCP providers requiring emergency obstetric services and subsequent referral to a higher facility, the MCP provider shall be reimbursed fully and the referral facility shall also be reimbursed depending on the services rendered.
5. For instances where no deliveries were completed in the MCP facility due to complications, the MCP facility shall also be reimbursed the total amount equivalent to ten percent (10%) of the facility fee (amounting to Php 650) for the services provided.

B. Normal Spontaneous Delivery (NSD) Package

1. The payment for normal spontaneous delivery (NSD) package in accredited government and private hospitals shall be as follows:

Level of Facility	NSD	
	Prenatal Care	**Facility including PF**
Level 1 Hospitals	**Php 8,000**	
	1,500	6,500
Levels 2 to 4 Hospitals	**Php 6,500**	
	1,500	5,000

2. The NBB Policy shall be applied to claims as described in Section III.
3. Reimbursement shall be made directly to the facility including payment of professional fees for medically necessary services except for components directly payable to the member.

C. Newborn Care Package (NCP)

1. The package shall be increased to One Thousand Seven Hundred and Fifty Pesos (Php 1,750) which shall include the following services, immediate drying of the newborn, early skin-to-skin contact, cord clamping, non-separation of mother/baby for early breastfeeding initiation, eye prophylaxis, Vitamin K administration, weighing of the newborn, BCG vaccination, Hepatitis B immunization (1st dose), Newborn

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MA. TERESA V. [illegible]
A.O. IV
Date: 8/11/17
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Screening Test (NBS), Newborn Hearing Screening Test, and Professional fee (that includes breastfeeding advice and physical examination of the baby, among others).

2. In instances when the enumerated services for NCP above were not provided completely or patient-members were asked to purchase/access services outside the facility and an Official receipt is attached to the claim, the member shall be reimbursed all eligible expenses detailed in the attached OR/s with the said payment to the member deducted from the case payment that would be paid to the health facility.
3. In instances where, upon post-audit, services were not rendered or were not complete as shown above, then these shall be charged to future claims of the health facility with corresponding sanctions or penalties the Corporation may charge
4. All NCP claims are covered by the NBB Policy as described in Section III.

VII. Compliance Monitoring

Compliance to the above shall be monitored and evaluated periodically in accordance with implementing guidelines to be issued.

VIII. Penalties And Sanctions

Accredited providers that violate any provision of this Circular shall be meted the appropriate sanctions and penalties available to the Corporation. Furthermore, these shall be included in the Provider Assessment Monitoring System (PAMS) and shall be subjected to warranties of accreditation and other such instruments that the Corporation may utilize. Finally, these may be reported to the Department of Health (DOH) and/or Professional Regulation Commission for appropriate action, when necessary.

IX. Periodic Review, Evaluation, And Adjustments

This Circular, including the case rates, processes, and the no balance billing policy, shall be subject to regular evaluation and adjustments as necessary. Such review and evaluation shall be done 6 months after effectivity of this Circular and yearly thereafter unless revoked, modified, amended or repealed.

X. Repealing Clause

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

XI. Effectivity

This Circular shall take effect for all claims with admission date of September 1, 2011. Further, this Circular 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.

DR. REY B. AQUINO
President and CEO
Date signed:

PHILHEALTH
MA. TERESA A. ...
A.O. IV - ...
Date: 8/11/11
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