[PHIC PHILHEALTH CIRCULAR NO. 09, S. 2009, March 17, 2009]

2009 REVISED INPATIENT BENEFIT SCHEDULE

Consistent with PhilHealth's mandate to provide a responsive, adequate and more equitable benefit package, the revised inpatient benefit schedule pursuant to PhilHealth Board Resolution Number 1212 s-2009 is hereby implemented subject to the following guidelines:

A. GENERAL RULES

1. Primary (Level 1) hospitals shall be reimbursed for:

a. Cases where the primary illness is classified as case types A and B. Medical conditions classified as case types C and D in Level 1 hospitals shall only be reimbursed up to the limit specified in case type B.

b. Procedures with RVU 30 and below:

1) Dialysis, chemotherapy and radiotherapy done in primary hospitals shall not be compensated.

2) Procedures with RVU above 30 may only be reimbursed if considered as emergency.

i. Payment of hospital charges shall be based on case type A only.
ii. Payment of surgeon's fee shall be up to 2,000 pesos only
iii. Payment of operating room fee is fixed at 500 pesos

2. Secondary (Level 2) hospitals shall be reimbursed for clinical conditions classified as case type A, B and C. Conditions classified as case type D in Level 2 hospitals shall only be reimbursed up to the amounts specified in case type C.

3. Only Tertiary (Levels 3 & 4) hospitals shall be reimbursed the maximum amount specified in case type D.

4. All claims with primary conditions classified as case type D shall require submission of PhilHealth Claim Form 3 or Clinical Abstract for proper evaluation regardless of hospital category.

5. Benefits for drugs and medicines, supplies and laboratories shall be subject to the limits covered by the rule on single period of confinement for the same illness. This means that admissions and re-admissions due to the same illness within a 90-day period shall only be compensated within one (1) maximum benefit, to wit:

a. Therefore, availment of benefit for the same illness or condition which is not separated from each other by more than 90 days will not be provided with a new benefit, until after the 90-day period reckoned from the date of admission.

b. Only the remaining benefits from the previous confinement/s may be availed for succeeding confinements due to the same illness.

6. All claims for drugs and medicines, supplies and necessary laboratory procedures supported by official receipts dated 30 days prior to admission may be reimbursed for the following procedures: peritoneal dialysis, hemodialysis, chemotherapy, and other elective surgeries.

7. The new inpatient benefit schedule for Level 1; Level 2; and Levels 3 & 4 hospitals are annexed in this circular. (*See attached Benefit Schedule*[*])

B. ROOM AND BOARD

1. Room and board benefit will depend on hospital category, case type of illness and patient's length of stay.

2. A member is entitled to a maximum of 45 days confinement per calendar year. When the 45-day allowance has been consumed, claims for succeeding confinements shall no longer be covered including payment for drugs and medicines; x-ray, laboratory, and, supplies; operating room fee; and professional fee.

C. DRUGS AND MEDICINES

1. Maximum benefit for drugs and medicines benefit will depend on hospital category and case type of illness.

2. Benefits for drugs and medicines are covered by the rule on single period of confinement.

3. Rules on Phil. National Drug Formulary (PNDF), Antimicrobial Resistance Surveillance Program (ARSP) and rational drug use shall be observed.

D. SUPPLIES, AND RADIOLOGY, LABORATORY & ANCILLARY PROCEDURES

1. Maximum benefit for supplies and radiology, laboratory and ancillary procedures shall depend on hospital category and case type of illness.

2. Benefits for x-ray, laboratory and supplies are also covered by the rule on single period of confinement.

3. As required by the Cheaper Medicines Act, official receipts issued by doctors for devices (e.g., intraocular lens) shall not be reimbursed by PhilHealth.

E. OPERATING ROOM

1. Payment for operating room (OR) will depend on the hospital category and the RVU of the procedure.

a. For primary hospitals, payment of OR is fixed at 500 pesos per use of operating room.

b. For secondary hospitals and ambulatory surgical clinics (ASC), freestanding dialysis centers (FDC), payment for OR shall be as follows:

RVU of the Procedure	Payment for Operating Room
RVU 30 and below	750 pesos per use of operating room
RVU 31 to 80	1,200 pesos per use of operating room
RVU 81 to 600	RVU multiplied by 15 peso conversion factor • Minimum of 2,200 pesos • Maximum of 7,500 pesos

c. For Tertiary hospitals:

RVU of the Procedure	Payment for Operating Room
RVU 30 and below	1,200 pesos per use of operating room
RVU 31 to 80	1,500 pesos per use of operating room
RVU 81 to 600	RVU multiplied by 20 peso conversion factor • Minimum of 3,500 pesos

Example procedures:

Procedure (RVU)	Payment for Operating Room		
	Primary	Secondary	Tertiary
1) Excision breast mass (RVU 25)	500 pesos	750 pesos	1,200 pesos
2) Explor lap (RVU 150)	0	2,250 pesos	(3,000) 3,500 pesos
3) Cholecystectomy (RVU 180)	0	2,700 pesos	3,600 pesos
4) Intracranial surgery (RVU 600)	0	(9,000) 7,500 pesos	12,000 pesos

d. Payment of operating room fee covers the use of operating room complex

- operating room, delivery room, recovery room, minor operating room, endoscopy room, hemodialysis room, or radiotherapy room.

1) Payment for operating room complex also covers payment for machines and equipment used during operation.

2) Drugs (e.g. oxygen, anesthesia) and supplies (e.g., gauze, cotton, suture, etc.) used inside the operating room shall be charged against the benefit allotted for drugs and for supplies, not against the budget for the operating room.

3) Claims for operating room fee for bedside procedures and peritoneal dialysis shall not be reimbursed.

e. For multiple procedures done in separate operative session, payment of OR fee shall be given per use of operating.

F. PROFESSIONAL FEE

Payment for professional fee (PF) depends on service rendered (medical management or surgery) case type of illness, professional and hospital category and patient's length of stay.

1. Daily visits

a. Payment for daily visit will depend on length of stay, case type of illness and doctor category. (*See Attached Benefit Schedule*[*]).

b. Doctors with Claims Code Group Numbers 2, 3, and 4 (*See Annex A*[*] *of PhilHealth Circular No. 11, series of 2005*) shall be classified as specialist in the computation of payment for daily visits.

c. Claims for professional fee for daily visit of doctors with Claims Code Group Numbers 1, 5, and 6 shall be computed using the rate for general practitioners.

d. Payment for multiple doctors is allowed provided that all services claimed are "medically-necessary". Payment shall be based on rate for daily visit but the total payment for all doctors shall not exceed the maximum limit per confinement.

1. Example: Patient admitted for 4 days in a tertiary hospital for pneumonia high risk (classified as case type C) and managed by 2 specialists.

Doctors	Daily rate	PF Payment
Specialist 1 (Group 2)	700 pesos	700 x 4 days = 2,800 pesos
Specialist 2 (Group 2)	700 pesos	700 x 4 days = 2,800 pesos
Total Payment for PF daily visit	**5,600 pesos**	

2. Surgery and Other Services with RVUs