[PHILHEALTH CIRCULAR NO. 2018-0007, May 23, 2018]

DOCUMENTARY REQUIREMENTS FOR CLAIMS REIMBURSEMENT AND MEDICAL PREPAYMENT REVIEW OF CLAIMS

Adopted: 20 March 2018
Date Filed: 23 May 2018

I. RATIONALE

PhilHealth, as the administrator of the National Health Insurance Program, is mandated to ensure that quality health services are provided, to its beneficiaries, The Corporation may set standards, rules and regulation that will ensure quality of care, appropriate utilization of services, fund viability, member satisfaction and overall accomplishment of Program objectives, In order to sufficiently measure and assess the quality of care, PhilHealth developed and implemented policy statements that defined the standards of care to ensure better health outcomes, These are based on clinical practice guidelines and acceptable/established standards of care. To complement efforts to improve quality, PhilHealth has employed medical pre-payment review in order to assess the quality of care.

II. OBJECTIVES

To establish the guidelines on requiring the CF4 to facilitate systematic data collection and evaluation of claims for payment. The clinical and administrative data contained in the Claim Form 4 (CF4) together with the results of diagnostic tests will be vital to assess the quality of care delivered by health care providers (HCPs).

III. SCOPE

This policy shall cover All Case Rate (ACR) claims of eligible PhilHealth beneficiaries in PhilHealth accredited health care institutions, with exceptions indicated under General Guidelines of this issuance.

IV. DEFINITION OF TERMS

A. **Medical Prepayment Review** - The process of reviewing and evaluating clinical data before claims payment to determine compliance to Corporate policies and widely accepted medical practice.

B. **Claim Form 4 (CF4)** - Summary of pertinent clinical information of a patient/member during their hospitalization/episode of care that shall be utilized by PhilHealth to conduct evaluation and review of claims.

V. GENERAL GUIDELINES

A. All claims for reimbursement should be accompanied by the CF4 following the prescribed format (Annex "A") and photocopies of the corresponding laboratory and imaging results. The Statement of Account shall still be submitted along with the said documents;

B. The CF4 shall replace the requirement for CTC of the complete clinical charts for four (4) conditions (pneumonia, urinary tract infection, acute gastroenteritis and sepsis) which was previously required under PhilHealth Circular No. 2017-0028;

C. eClaims compliant HCIs shall scan the above required documents and attach them during claim application transmission;

D. This policy shall not cover claims directly filed with PhilHealth and those involving confinements abroad. Likewise, this Circular shall not apply to the following packages/benefits as their current required documentary requirements shall still apply:

1. Z-Benefit packages;
2. Outpatient HIV/AIDS Treatment (RVS 99246);
3. Outpatient Malaria Package (RVS 87207)
4. Animal Bite Treatment (RVS 90375);
5. TB-DOTS (RVS 89221 and 89222);
6. Antenatal Care Package (ANC01);
7. Normal Spontaneous Delivery (NSD01);
8. Maternity Care Package (MCP01);
9. Newborn Care Package (RVS 99432);
10. Subdermal Contraceptive Implant Package (FP01);
11. Intrauterine Device Insertion Package (RVS 58300);
12. No-scalpel Vasectomy (RVS 55250)
13. Resuscitation Package (P00000); and
14. Referral Package (P00001)

E. Improperly accomplished or illegible CF4 and/or incomplete attachments shall be returned to the HCP. To process the claim, the properly accomplished CF4 and its relevant supporting documents shall be re-filed to PhilHealth within 60 days from receipt of HCI. (Refer to Annex B);

F. The Corporation reserves the right to subject any and/or all claims application to medical prepayment review;

G. The Corporation shall deny claims attended by any, but not limited to the following circumstances:

1. Over-utilization or under-utilization of services;
2. Unnecessary diagnostic and therapeutic procedures and intervention;
3. Irrational medication and prescriptions;
4. Fraudulent, false or incorrect information as determined by the appropriate office;
5. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols;