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GUIDELINES ON REFERRAL OF COMPLICATED CLAIMS TO THE PEER REVIEW COMMITTEE

As part of its mandate to implement a quality assurance program to ensure that its accredited health care providers follow accepted norms of medical practice, the Corporation established the Peer Review Committee (PeRC) under the Quality Assurance, Research & Policy Development Group (QARPDG). The PeRC is composed of representatives from Professional Regulation Commission, Philippine Hospital Association, Philippine Medical Association, Philippine College of Physicians, Philippine College of Surgeons, Philippine Society of Anesthesiologists, Philippine Obstetrical and Gynecological Society, Philippine Pediatric Society, Philippine Academy of Opthalmology, Philippine Academy of Family Physicians, and the Corporation. It was established by the PhilHealth Board on 20 June 2002 to resolve issues involving quality of practice and promote quality assurance in the local health care setting.

Consistent with its mandate and in order to ensure that the Corporation pays only for services and resources that are appropriate and necessary in the delivery of quality health care services to its members, the following guidelines on referral of complicated claims to the Peer Review Committee are hereby prescribed:

1. Referring Offices

Offices that may refer claims to the PeRC shall be the PhilHealth Regional Offices, NCR Claims Department, Protests and Appeals Review Department (PARD) and the Claims Review Office (CRO).

2. Claims Covered

Claims that may be referred to the PeRC shall include those involving problems/questions on the following issues/concerns:

2.1 appropriateness of utilization of drugs, supplies and diagnostic procedures;

2.2 interpretation/application of the clinical practice guidelines adopted by PHIC as guides to good practice;

2.3 emergency nature of cases, especially those attended by non-accredited providers, admitted for

less than 24 hours, or served beyond accredited capability, e.g., primary hospital admitting a catastrophic case or performing a procedure with an RVU greater than 30;

2.4 case typing and compensability of certain illnesses and procedures; and

2.5 appropriateness of surgical procedure done.

Claims not involving that above issues but still referred to PeRC shall be returned to the referring office without action.

The Claims Division of the PRO's and Claims Department of NCR shall remain as the proper offices to handle requests for adjustment of payment. However, if there are still unresolved issues included in item #2, such claims may be referred to PeRC together with documentary requirements enumerated in item #3. If the claim was returned to the hospital or member (for directly filed claims), and the same was re-filed without complying with the request for justification/explanation and other documentary requirements, the evaluating office shall decide on the merits of the claim based on the available information. If the hospital or member appeals such a decision, the appeal shall be lodged with the CRO. Only if the CRO could not decide after evaluating the justification/explanation and other pertinent documents shall the claim be referred to PeRC after compliance with documentary requirements.

3. Documentary Requirements

In referring claims, the following documents shall be submitted to QARPDG:

3.1 transmittal letter using the form in Annex A[*]
3.2 photocopy of PhilHealth Forms 2 and 3 (as applicable)
3.3 photocopy of clinical chart
3.4 photocopy of operative, delivery, and/or anesthesia records, as applicable
3.5 justification/explanation of the attending physician on his management or assigned case type or on why the case should be considered emergency.
3.6 other pertinent document(s) as necessary; e.g., explanation from member

The referring office shall be responsible in preparing the above documents and/or securing them from the appropriate parties. Providers and/or members should immediately comply with the request from the referring office to submit such documents in order to facilitate the referral. Upon receipt of the above documents, the referring office shall re-evaluate the claims taking into account the data and information