[PHILHEALTH CIRCULAR NO. 2018-0014, August 29, 2018]

DOCUMENTARY REQUIREMENTS FOR CLAIMS REIMBURSEMENTS AND MEDICAL PREPAYMENT REVIEW OF CLAIMS (REVISION 1)

Adopted: 13 August 2018
Date Filed: 29 August 2018

I. RATIONALE

The National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and 10606) under Article VIII (Health Care Providers) Section 37 (Quality Assurance), provides that "the performance of medical procedures and the administration of drugs are appropriate, necessary and unquestionably consistent with accepted standards of medical practice and ethics. Drugs for which payments will be made shall be those included in the Philippine National Drug Formulary, unless explicit exception is granted by the Corporation."

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. Furthermore, it is also incumbent upon the Corporation to protect the Program and set safeguards to ensure that reimbursement of services are correct, appropriate, and ethical.

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 shall employ medical pre-payment review using Claim Form (CF4) 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 (P0000); and,
14. Referral Package (P0001)

E. Claims related to deliveries such as normal deliveries (NSD01, MCP01); Cesarean section (59620, 59513, 59514); other methods of deliveries (59409, 59411, 59612); and intrapartum monitoring (59403, ANC02) shall use Claim Form 3.

F. Improperly accomplished or illegible CF4 and/ or incomplete attachments shall be returned to the HCP. To process the claim, a