496 Phil. 349

THIRD DIVISION

[G.R. NO. 163123, April 15, 2005]

PHILIPPINE HEALTH INSURANCE CORPORATION, PETITIONER, VS. CHINESE GENERAL HOSPITAL AND MEDICAL CENTER, RESPONDENT.

D E C I S I O N

CORONA, J.:

Before us is a petition for review on *certiorari* under Rule 45 of the Rules of Court assailing the March 29, 2004 decision[1] of the Court of Appeals, the dispositive portion of which read:

> **FOR THE FOREGOING DISQUISITIONS**, the petition is **GRANTED**, the Philippine Health Insurance Corporation[2] is hereby ordered to give due course to petitioner's, Chinese General Hospital and Medical Center, claims for the period from 1989 to 1992, amounting to FOURTEEN MILLION TWO HUNDRED NINETY ONE THOUSAND FIVE HUNDRED SIXTY EIGHT PESOS and 71/100 PESOS (P14,291,568.71).[3]

The facts, as culled by the Court of Appeals, follow.

> On February 14, 1995, Republic Act No. 7875, otherwise known as "An Act Instituting a National Health Insurance Program for all Filipinos and Establishing the Philippine Health Insurance Corporation For the Purpose," was approved and signed into law. As its guiding principle, it is provided in Section 2 thereof, thus:
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> > "Section 2. Declaration of Principles and Policies. – Section 11, Article XIII of the Constitution of the Republic of the Philippines declares that the state shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women, and children should be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.
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> Prior to the enactment of R.A. 7875. CGH[4] had been an accredited health care provider under the Philippine Medical Care Commission (PMCC), more popularly known as Medicare. As defined by R.A. 7875, a health care provider refers to a health care institution, which is duly licensed and accredited devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment and care of individuals suffering from illness, disease, injury,

disability or deformity, or in need of obstetrical or other medical and nursing care.[5]

As such, petitioner[6] filed its Medicare claims with the Social Security System (SSS), which, together with the Government Service Insurance System (GSIS), administered the Health Insurance Fund of the PMMC. Thus, petitioner filed its claim from 1989 to 1992 with the SSS, amounting to EIGHT MILLION ONE HUNDRED TWO THOUSAND SEVEN HUNDRED EIGHTY-TWO and 10/100 (P8,102,782.10). Its application for the payment of its claim with the SSS was overtaken by the passage of R.A. 7875, which in Section 51 and 52, provides:

> SECTION 51. Merger. – Within sixty (60) days from the promulgation of the implementing rules and regulations, all functions and assets of the Philippine Medical Care Commission shall be merged with those of the Corporation (PHILHEALTH) without need of conveyance, transfer or assignment. The PMCC shall thereafter cease to exist.
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> The liabilities of the PMCC shall be treated in accordance with existing laws and pertinent rules and regulations. xxx
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> SECTION 52. Transfer of Health Insurance Funds of the SSS and GSIS. – The Health Insurance Funds being administered by the SSS and GSIS shall be transferred to the Corporation within sixty (60) days from the promulgation of the implementing rules and regulations. The SSS and GSIS shall, however, continue to perform Medicare functions under contract with the Corporation until such time that such functions are assumed by the Corporation xxx.

Being the successor of the PMCC, PHILHEALTH, in compliance with the mandate of R.A. 7875,[7] promulgated the rules and regulations implementing said act, Section 52 of which provides:

> SECTION 52. Fee for Service Guidelines on Claims Payment. – xxx b. All claims for payment of services rendered shall be filed within sixty (60) calendar days from the date of discharge of the patient. Otherwise, the claim shall be barred from payment except if the delay in the filing of thee claim is due to natural calamities and other fortuitous events. If the claim is sent through mail, the date of the mailing as stamped by the post office of origin shall be considered as the date of the filing.
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> If the delay in the filing is due to natural calamities or other fortuitous events, the health care provider shall be accorded an extension period of sixty (60) calendar days.
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> If the delay in the filing of the claim is caused by the health care provider, and the Medicare benefits had already been deducted, the claim will not be paid. If the claim is not yet

deducted, it will be paid to the member chargeable to the future claims of the health care provider.

Instead of giving due course to petitioner's claims totaling to EIGHT MILLION ONE HUNDRED TWO THOUSAND SEVEN HUNDRED EIGHTY-TWO and 10/100 (P8,102,782.10), only ONE MILLION THREE HUNDRED SIXTY-FIVE THOUSAND FIVE HUNDRED FIFTY-SIX and 32/100 Pesos (1,365,556.32) was paid to petitioner, representing its claims from 1989 to 1992 (sic).

Petitioner again filed its claims representing services rendered to its patients from 1998 to 1999, amounting to SEVEN MILLION FIVE HUNDRED FIFTY FOUR THOUSAND THREE HUNDRED FORTY TWO and 93/100 Pesos (P7,554,342.93). For being allegedly filed beyond the sixty (60) day period allowed by the implementing rules and regulations, Section 52 thereof, petitioner's claims were denied by the Claims Review Unit of Philhealth in its letter dated January 14, 200, thus:

"xxx

This pertains to your three hundred seventy three Philhealth medicare claims (373) which were primarily denied by Claims Processing Department for late filing and for which you made an appeal to this office. We regret to inform you that after thorough evaluation of your claims, [your] 361 *medicare claims* were *DENIED*, due to the fact that the claims *were filed 5 to 16 ½ months after discharge*. However, the remaining medicare claims have been forwarded to Claims Processing Department (CPD) for payment.

SECTION 52 (B) Rule 52 (B) Rule VIII of the Implementing Rules and Regulations of 7875 provides that *all claims for payment of services rendered shall be filed within sixty (60) days from the day of discharge of the patient*. However, Philhealth Circular No, 31-A, series of 1998, state that *all claims pending with Philhealth as of September 15, 1998 and claims with discharge dates from September to December 31, 1998 are given one hundred twenty (120) days from the date of discharge to file their claim*. In as much as we would like to grant your request for reconsideration, the Corporation could no longer extend the period of filing xxx.

Petitioner's claim was denied with finality by PHILHEALTH in its assailed decision dated June 6, 2000.

In a petition for review under Rule 43 of the Rules of Court, the Court of Appeals ordered herein petitioner Philippine Health Insurance Corporation (Philhealth) to pay the claims in the amount of Fourteen Million Two Hundred Ninety-one Thousand Five Hundred Sixty-eight Pesos and 71/100 (P14,291,568.71), principally on the ground of liberal application of the 60-day rule under Section 52 of RA 7875's Implementing Rules and Regulations. According to the Court of Appeals:

> The avowed policy in the creation of a national health program is, as provided in Section 11, Article XIII of the 1987 Constitution, to adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services **available to all people at affordable cost**. To assist the state in pursuing this policy, hospitals and medical institutions such as herein petitioner are accredited to provide health care. It is true, as aptly stated by the OGCC, that petitioner was not required by the government to take part in its program, it did so voluntarily. But the fact that the government did not "twist" petitioner's arm, so to speak, to participate does not make petitioner's participation in the program less commendable, considering that at rate PHILHEALTH is denying claims of health care givers, it is more risky rather than providential for health care givers to take part in the government's health program.
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> It is Our firmly held view that the policy of the state in creating a national health insurance program would be better served by granting the instant petition. Thus, it is noteworthy to mention that health care givers are threatening to "boycott" PHILHEALTH, reasoning that the claims approved by PHILHEALTH are not commensurate to the services rendered by them to its members. Thus, how can these accredited health care givers be encouraged to serve an increasing number of members when they end up on the losing end of this venture. We must admit that the costs of operating these medical institutions cannot be taken lightly. They must also earn a modicum amount of profit in order to operate properly.
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> Again, it is trite to emphasize that essentially, the purpose of the national health insurance program is to provide members immediate medical care with the least amount of cash expended. Thus, with PHILHEALTH, members/patients need only to present their card to prove their membership and the accredited health care giver is mandated by law to provide the necessary medical assistance, said health care giver shouldering the PHILHEALTH part of the bill. However, it is the members/patients who bear the brunt. Thus, they are made to shoulder the PHILHEALTH part of the bill, and the refund thereof is subject to whether or not the claims of the health care providers are approved by PHILHEALTH. This is blatantly contrary to the very purpose for which the National Health Insurance Program was created.[8]
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We agree.

The state policy in creating a national health insurance program is to grant discounted medical coverage to all citizens, with priority to the needs of the underprivileged, sick, elderly, disabled, women and children, and free medical care to paupers[9].

The very same policy was adopted in RA 7875[10] which sought to:

> a) provide all citizens of the Philippines with the mechanism to gain financial access to health services;

b) create the National Health Insurance Program to serve as the means to help the people pay for the health services;

c) prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford such services; and

d) establish the Philippine Health Insurance Corporation that will administer the program at central and local levels.[11]

To assist the state in pursuing the aforementioned policy, health institutions were granted the privilege of applying for accreditation as health care providers.[12] Respondent Chinese General Hospital and Medical Center (CGH) was one of those which received such accreditation.

Under the rules promulgated by the Philhealth Board pursuant to RA 7875, any claim for payment of services rendered (to a patient) shall be filed within sixty (60) calendar days from the date of discharge of the patient. Otherwise, the claim is barred.[13]

But before a claim is filed with petitioner Philhealth for services already rendered, an accredited health care provider like respondent CGH is required to:

a. accomplish a Philhealth claim form;

b. accomplish an itemized list of the medicines administered to and medical supplies used by the patient concerned, indicating therein the quality, unit, price and total price corresponding thereto;

c. require the patient concerned and his/her employer to accomplish and submit a Philhealth member/employer certification;

d. in case the patient gave birth, require her to submit a certified true copy of the child's birth certificate;

e. in case the patient died, require the immediate relatives to submit a certified true copy of the deceased's death certificate; and

f. in case a member's dependent is hospitalized for which the member seeks coverage, require the member to submit proof of relationship to the patient and to execute an affidavit of support. [14]

Apart from the foregoing requirements which often necessitate securing documents from other government offices, and the fact that most patients are unable to immediately accomplish and submit the required documents, an accredited health care provider like CGH has to contend with an average of about a thousand members and/or dependents seeking medical treatment for various illnesses per month.

Under these circumstances, it is unreasonable to expect respondent CGH to comply