QUASI-JUDICIAL PROVISIONS OF THE REVISED IMPLEMENTING RULES AND REGULATIONS OF R.A. 10606

TITLE VII
QUASI JUDICIAL POWERS OF THE CORPORATION

RULE I
QUASI-JUDICIAL POWERS

SECTION 75. Quasi-Judicial Powers

The Corporation shall be vested with the following powers:

a. To conduct investigations for the determination of a question, controversy, complaint or unresolved grievances, issue Orders and Resolutions and render Decisions accordingly . It shall proceed to hear and determine cases in the presence of all concerned Parties or even ex parte with due notice to all Parties. It shall conduct Proceedings in public or in executive session, adjourn Hearings to any time and place, refer technical matters or accounts to experts and consider submissions and/or reports as evidence, direct Parties to be joined or excluded from the Proceedings and issue Orders and Directives as may be necessary or expedient in the determination of the dispute pending before it;
b. To summon Parties to a controversy, issue subpoenas requiring the attendance and testimony of witnesses or the production of documents and other materials necessary to a just determination of the case under investigation;
c. To suspend temporarily, deny application and/or renewal, revoke permanently or restore the accreditation of a healthcare provider or the right to benefits of a member and/or impose Fines after due Notice and Hearing. The Decision may immediately be executory even pending Appeal.

The denial of a healthcare provider's accreditation resulting from infractions, violations of R.A. 7875 as amended by R. A. 10606 including its Implementing Rules and Regulations, PhilHealth Circulars and any and/all Rules, Regulations and Policy Issuances by the Corporation shall operate as a disqualification from obtaining another accreditation under the same name, under a different name or through another person whether natural or juridical.

RULE II
THE BOARD AS A QUASI-JUDICIAL BODY

SECTION 76.The Board as Quasi-Judicial Body

The Board as a quasi-judicial body may sit En Banc or in Divisions in all cases brought before it for review.

The Corporation shall be governed by the Board which shall be composed of the following members:

- The Secretary of the Department of Health (DOH);
- The Secretary of the Department of Labor and Employment (DOLE) or a permanent representative;
- The Secretary of the Department of Interior and Local Government (DILG) or a permanent representative;
- The Secretary of the Department of Social Welfare and Development (DSWD) or a permanent representative;
- The Secretary of the Department of Finance (DOF) or a permanent representative;
- The President and Chief Executive Officer (PCEO) of the Corporation;
- The Social Security System (SSS) Administrator (President & Chief Executive Officer) or a permanent representative;
- The General Service Insurance System (GSIS) General Manager (President and General Manager) or a permanent representative;
- The Vice-Chairperson for the basic sector of the National Anti-Poverty Commission (NAP-C) or a permanent representative;
- The Chairperson of the Civil Service Commission (CSC) or a permanent representative;
- A permanent representative of Filipino Migrant Workers;
- A permanent representative of the members in the Informal Economy;
- A permanent representative of the members in the Formal Economy;
- A representative of employers;
- A representative of health care providers to be endorsed by their national associations of health care institutions and medical health professionals;
- A permanent representative of the elected Local Chief Executives to be endorsed by the League of Provinces, League of Cities and League of Municipalities; and,
- An independent Director to be appointed by the Monetary Board.

The Secretary of the Department of Health shall be the ex-officio Chairperson of the Board while the President and CEO shall be the Vice-Chairperson.

SECTION 77. Quorum and Votes Required

When sitting En Banc or in Divisions, the concurrence of the majority of all the participating members shall be required to render a Decision in all cases.

RULE III
INVESTIGATING OFFICERS, PROSECUTORS AND ARBITERS OF THE CORPORATION

SECTION 78. Authority of the Investigating Officers of the Corporation

Investigating Officers shall exercise among others, the powers and functions enumerated under Section 16 (m) of R.A. 7875 as amended and to administer oaths in the performance of official functions and duties.

SECTION 79. Jurisdiction and Qualifications of the Prosecutors and Arbiters of the Corporation

Prosecutors of the Corporation shall have the power and authority to conduct preliminary investigation on Complaints filed by any person or by the Corporation against healthcare providers and/or members and if a prima facie case exists, to file and prosecute the Complaint before the Arbitration Office. The Prosecutor may also administer oaths in the performance of official functions and duties. Prosecutors must be a bona fide member of the Philippine Bar and must have been engaged in the practice of law for at least three years prior to designation as Prosecutor.

The Arbitration Office shall exercise original and exclusive jurisdiction over all Complaints filed with the Corporation in accordance with R.A. 7875 as amended and this Rules. They shall have the power to administer oaths, issue subpoenas and such other powers vested in them by R.A. 7875 and this Rules. An Arbiter must be a bona fide member of the Philippine Bar and must have been engaged in the practice of law for at least three years prior to designation as Arbiter.

TITLE VIII
RULES OF PROCEDURE ON ADMINISTRATIVE CASES AGAINST HEALTHCARE PROVIDERS (HCPs) AND MEMBERS

RULE I
COMPLAINTS GROUNDS, VENUE AND PARTIES

SECTION 80. Who may File

Any person, natural or juridical, may file a Complaint against healthcare providers and/or members. The Corporation shall however, have the authority to motu propio direct the conduct of a fact-finding investigation and the filing of a case against HCPs and/or members.

SECTION 81. Grounds for a Complaint Against a Healthcare Provider

A written Complaint against a healthcare provider may be filed for the commission of any of the offenses enumerated in Rules I and II, Title IX (Definition of Administrative Offenses and Penalties) of this Rules.

SECTION 82. Grounds for a Complaint Against a Member

A written Complaint against a member may be filed for the commission of any of the offenses enumerated in Rule III, Title IX (Definition of Administrative Offenses and Penalties) of this Rules.

SECTION 83. Venue for Filing of Complaints

The formal written Complaint against a healthcare provider and/or member may be filed before any PhilHealth Regional Office (PRO) - Legal Office or with the Fact-Finding Investigation and Enforcement Department (FFIED) – Central Office.

RULE II
CENTRALIZED DOCKETING SYSTEM

SECTION 84. Docketing of Administrative Cases

The Legal Sector shall provide a Centralized Docketing System and assign a specific docket number for each Complaint. Every Complaint with an assigned docket number shall be used from the conduct of the fact-finding investigation, to the preliminary investigation before the Prosecution Department up to the filing of the case against the HCPs and/or members before the Arbitration Office.

Complaints emanating from the PRO Legal Offices shall be forwarded to the Fact-Finding Investigation and Enforcement Department (FFIED) for docketing and monitoring. Upon assignment of the docket number, the docket officer shall endorse the Complaint to the Prosecution Department.

RULE III
PRO- LEGAL OFFICE AND FACT-FINDING INVESTIGATION & ENFORCEMENT DEPARTMENT

SECTION 85. Complaints Filed Before the PRO - Legal Office

Upon receipt of the Complaint filed before the PRO - Legal Office, the following procedure shall be observed:

a. Docket the Complaint;
b. The PRO Legal Office shall conduct the necessary fact-finding investigation;
c. Issue the Fact-Finding Investigation Report (FFIR) with its recommendation on whether the filing of Formal Charges against the HCP or Member or to dismiss the Complaint; and
d. Transmit the FFIR to the FFIED or file the Complaint before the Prosecution within a period of thirty days.

SECTION 86. Complaints Filed Before the Fact-Finding Investigation and Enforcement Department

Upon receipt of the Complaint filed before FFIED, the following procedure shall be observed:

a. Docket the Complaint;
b. Conduct the necessary fact-finding investigation and issue the Fact-Finding Investigation Report (FFIR) within thirty days;
c. File the Affidavit-Complaint with the Prosecution Department within ten days from the issuance of the FFIR upon finding of prima facie evidence.

RULE IV
THE PROSECUTION DEPARTMENT

SECTION 87. Duties and Responsibilities of the Prosecutor

Upon receipt of the Affidavit-Complaint, the Investigating Prosecutor shall immediately conduct the preliminary investigation. The Investigating Prosecutor may, from an examination of the allegations in the Affidavit-Complaint and other supporting evidence, dismiss the same outright on any of the following grounds:

a. Lack of jurisdiction over the subject matter;
b. Failure to state a cause of action; or,
c. statute of limitation
d. Insufficiency of evidence.

The Prosecution Department shall inform the SVP-LS, the FFIED and the concerned PRO Legal Office in writing, of the specific action taken on the Affidavit-Complaint stating the specific ground in cases of dismissal of the Complaint. However, in cases of insufficiency of evidence, the Prosecution shall remand the Affidavit-Complaint to the originating Office/PRO for re-investigation and/or any further appropriate action.

SECTION 88. Directive to File Answer

If no ground for dismissal is found, the Investigating Prosecutor shall issue the corresponding Directive to the Respondent healthcare provider and/or member directing the same to file their verified Answer to the Affidavit-Complaint in triplicate copies within five calendar days from receipt of the Directive.

In case the HCP/Member fails to submit an Answer within the reglementary period despite proper Notice, the Prosecutor shall resolve the Complaint based on the available evidence on record.

SECTION 89. Finding of Prima Facie Case

If upon evaluation of the Affidavit-Complaint, Answer and other supporting evidence, the Investigating Prosecutor finds a prima facie case against the Respondent healthcare provider/member, the Investigating Prosecutor shall submit the Resolution recommending the filing of the appropriate administrative charges against the HCP/Member together with the Formal Charge for the approval of the Senior Vice-President for Legal Sector (SVP-LS) within fifteen days from receipt of the last pleading or from the expiration of the period to file the same.

The Prosecutor shall file the appropriate Formal Charge with the Arbitration Office within fifteen days from express or implied approval of the resolution.

SECTION 90. Evaluation/Recommendation to File Other Administrative and Criminal Charges

The Investigating Prosecutor may, upon evaluation of the Affidavit-Complaint, Answer and other supporting evidence, further recommend to the SVP-Legal Sector the filing of administrative charges and/or criminal charges against the HCP(s)/Member(s) before the appropriate agencies/societies

including but not limited to the Professional Regulatory Commission (PRC), the Ombudsman and/or the Prosecutor's Office as may be appropriate and necessary.

SECTION 91. Approval of the Senior Vice-President for Legal Sector (SVP-LS)

The SVP-LS shall have five days from receipt of the Resolution and the attached Formal Charge to accordingly act on the same. If no action is taken within the given period, the Resolution along with the Formal Charge shall be deemed approved.

Resolutions recommending the filing of the appropriate administrative charges against the HCP/Member denied by the SVP-LS shall be returned to the FFIED for proper information and dissemination to the concerned PRO-Legal Office.

SECTION 92. Finality of Resolutions

The Resolution of the Prosecutor duly approved by the SVP-LS shall be final and unappealable. No Motion for Reconsideration (MR) or any other similar pleadings shall be allowed.

RULE V
CONTENTS OF THE FORMAL CHARGE

SECTION 93. Contents of the Formal Charge

The Formal Charge shall contain the following information:

a. Name and address of the Complainant;
b. Name/s and address/es of the Respondent/s healthcare providers and/or member/s;
c. Pertinent information relative to the Respondent healthcare institution including but not limited to the level and type of accreditation, classification of the HCP whether government or private, location and existence and number of other HCPs within the area/location of the Respondent;
d. Clear and concise Statement of Cause/s of Action; and,
e. Specific Relief/s sought.

RULE VI
ARBITRATION OFFICE

SECTION 94. Formal Charge

A Formal Charge shall be filed by the Prosecution Department with the Arbitration Office in three original copies with attached annexes. Only originals or certified true copies shall be accepted as documentary attachments (Annexes) of the Formal Charge filed by the Prosecution. The receiving officer shall immediately endorse the Formal Charge to the assigned Arbiter for appropriate action.

SECTION 95. THE ARBITRATION OFFICE

The Arbitration Office shall exercise original and exclusive jurisdiction over all Complaints filed with the Corporation in accordance with R.A. 7875 as amended and this Rules. The Arbitration Office shall be under the direct operational and administrative jurisdiction of the Office of the Executive Vice-President & Chief Operating Officer (EVP & COO) of the Corporation.

SECTION 96. POWERS OF THE ARBITER

a. Conduct Proceedings either in public or in executive session;
b. Adjourn Hearings to any time and place;
c. Refer technical matters or accounts to experts and consider submitted reports in evidence;
d. Direct parties to be joined or excluded from the proceedings;
e. Give such directions as may be deemed necessary or expedient in the resolution of disputes;
f. Summon the Parties to a controversy/complaint;
g. Issue subpoenas requiring the attendance and testimony of witnesses or the production of documents and other necessary information;
h. Administer oaths;
i. Certify official acts; and
j. Recommend to the Board the constitution of Ad Hoc Special Arbiters and deputizing the same with temporary authority to hear and adjudicate administrative cases against healthcare providers/professionals and/or members to augment the Arbitration Office or to handle specific cases of particular interest.

SECTION 97. Civil Contempt

Whenever a person, without lawful excuse, fails or refuses to take an oath or to produce documents for examination or to testify, in disobedience to a lawful subpoena issued by the Arbiter, the latter may invoke the aid of the Regional Trial Court within whose territorial jurisdiction the case is being heard to cite such person in contempt, pursuant to Section 14, Chapter 3, Book VII of the Revised Administrative Code.

SECTION 98. Service of Summons

Upon receipt of the docketed Formal Charge, the Arbiter shall issue the Summons to the Respondent/s, directing them to file their verified Answers in three (3) copies within five days from receipt, furnishing the Prosecution Department with a copy, with a Notice that unless the Respondent/s so answers, the Complainant may take judgment by default and demand from the Arbiter the relief/s being sought. A copy of the Formal Charge with the supporting documents shall be attached to the original copy of the Summons. Service of Summons shall be made either personally, by registered mail or any other mode of service as may be sufficient and practicable under the circumstances.

SECTION 99. Verified Answer

Within fifteen calendar days from service of the Summons along with the copy of the Formal Charge and its supporting documents, the Respondent shall file a verified Answer copy furnished the Prosecution Department. Affirmative and negative defenses not pleaded shall be deemed waived except lack of jurisdiction over the subject matter. Failure to specifically deny any of the material allegations in the Formal Charge shall be deemed an admission.

No Motion to Dismiss shall be entertained except on the ground of lack of jurisdiction over the subject matter, failure to state a cause of action, res judicata or statute of limitation.

SECTION 100. Default

Upon acquiring jurisdiction over the Respondent and upon failure to file a verified Answer to the Formal Charge within the prescribed period, the Arbiter may, motu propio or on Motion of the Complainant, render judgment by default as may be warranted by the facts and evidence alleged in the Formal Charge.

SECTION 101. Affidavits and Position Papers

After a verified Answer is filed and the issues are joined, the Arbiter shall issue an Order requiring the Parties to submit their respective Position Papers within fifteen calendar days from receipt of the Order. The Position Paper shall contain a brief statement of the positions of the Parties, setting forth the law and the facts relied upon, including the affidavits of the witnesses and other evidence on the issues.

SECTION 102. Conduct of Hearings/Clarificatory Hearings

The manner and form of the conduct of the administrative proceedings before the Arbitration Office shall be the exclusive jurisdiction and authority of the same. The Arbiter may, at its discretion, require the submission of Pre-Hearing Briefs and conduct clarificatory Hearings. Should the Arbiter find it necessary to conduct clarificatory Hearings, an Order setting the Pre-Hearing Conference shall be issued. Such Order shall further set the date or dates of the Hearings and specify the witnesses who will be called upon to testify.

Conduct of Hearing shall not be bound by the rigidity/stringency of Rules of Court.

SECTION 103. Role of Arbiter in Proceedings

The Arbiter shall:

a. Personally conduct Hearings and determine the order of presentation of evidence by the Parties;
b. Take full control of the Proceedings and as may be necessary, ask clarificatory questions to the Parties and their witnesses with respect to the matters at issue; and,
c. Limit the presentation of evidence to matters relevant to the issue/s.

SECTION 104. Procedure of Trial/Clarificatory Hearings

Whenever the conduct of a Hearing is deemed necessary by the Arbiter, the affidavits submitted by the Parties shall constitute the testimonies of the witnesses. Witnesses who testify may be subjected to clarificatory questions by the Arbiter. No witness shall be allowed to testify unless a corresponding affidavit was previously submitted to the Arbiter.

SECTION 105. Postponement of Hearings

The Parties and their counsel(s) or authorized representative(s) appearing before an Arbiter shall be prepared for continuous Hearings. Postponements or continuances of Hearings shall not be allowed by the Arbiter except upon meritorious grounds and subject to the requirement of expeditious disposition of cases.

SECTION 106. Records of Proceedings

The proceedings before an Arbiter need not be recorded by stenographers except when any or both of the Parties, based on meritorious grounds, request that the proceedings be duly transcribed. The Arbiter shall make a written summary of the proceedings including the substance of the evidence presented. The written summary shall be signed by the Parties and shall form part of the official records.

SECTION 107. Non-Appearance of Parties

When the Complainant or Respondent fails to appear at the trial on two successive occasions despite due Notice, the Arbiter may motu propio or upon motion of the opposing Party, dismiss the case or deem the case submitted for resolution based on the records. The Complainant, upon proper written Motion within ten calendar days after the receipt of the Arbiter's Resolution, may formally move for the re-opening of the case.

SECTION 108. Withdrawal or Desistance of the Complainant

The withdrawal or desistance of the Complainant shall not bar the Arbiter from proceeding with the Hearing of the Complaint against the Respondent. The Arbiter shall act on the Formal Charge based on its merits and evidence on record and impose such appropriate penalties on the erring Respondent as may be deemed appropriate.

SECTION 109. Rendition of Judgment

The Arbiter shall have a period of sixty days from receipt of the last pleading submitted by the Parties and upon submission of the case for resolution within which to render its judgment.

SECTION 110. Contents of Decisions

The Decision of the Arbiter shall be clear and concise and shall include a brief statement of the following:

a. Facts of the case;
b. Issue/s involved;
c. Applicable laws or Rules;
d. Conclusions and the reasons therefor; and,
e. Specific remedy or relief granted.

SECTION 111. Service of Notices, Resolutions, Orders, Decisions and other Official Issuances

Orders, processes and other official issuances from the Arbitration Office shall be delivered by personal service to the Respondent/s and any other Party to the case by the Legal Office staff or its designated authorized personnel of the concerned PhilHealth Regional Office (PRO). The Legal Office staff or its designated authorized personnel shall require the Respondent to sign the record book of mailing transmittal indicating clearly the name, date and signature of the authorized recipient of the official document form the Arbitration Office. The authorized personnel of the PRO-Legal Office shall ensure that the recipient of the official document is authorized to receive the same and shall accordingly indicate in his "Certificate of Service" the complete name and position of the recipient.

In cases where the location of the Respondent(s) or any addressee(s) of the document to be sent would be difficult and/or highly improbable to reach or such service would unnecessarily place the concerned personnel of the Corporation at risk, the Arbitration Office at its discretion, may opt to use other modes of service such as registered mail, private courier services, postal office box, thru agents or any other substituted service that may be sufficient, practical and/or necessary.

SECTION 112. Proof of Completeness of Service

For documents sent through the PhilHealth Regional Office -Legal Offices, the signed Mailing Transmittal List shall be forwarded to the Arbitration Office together with the Certificate of Service duly signed by the authorized personnel of the PRO-Legal Office who delivered the official document which shall be filed on the corresponding case record.

For documents sent through other modes of service, proofs of service such as registry return receipts, airway bills and other proofs of receipt shall be attached to the corresponding case record and shall be considered as completed service.

SECTION 113. Legal Representation

Legal representation may be allowed a Respondent or any Party to the case upon formal entry of appearance filed before the Arbitration Office. Legal representation or appearance by a non-lawyer may also be allowed upon presentation of a verified Certification attested to by the Respondent or a copy of the Resolution of the Board of Directors or Secretary's Certificate of the Respondent's Organization granting such authority.

SECTION 114. Consolidation of Cases

When there are two or more cases arising from similar facts and incidents pending before two Arbiters involving the same healthcare provider and upon motion of either of the Parties, the cases may be consolidated at the discretion of the Executive Arbiter. Notwithstanding the consolidation of cases, each claim shall be counted as one offense and shall be treated accordingly in the imposition of applicable penalties.

SECTION 115. Prohibited Pleadings

The following Pleadings and Motions shall not be allowed:

a. Motion for Reconsideration on the Decision rendered by the Arbitration Office;
b. Subsequent Motions for Extension after the first Motion has been granted;
c. Motion to Dismiss except on the ground of lack of jurisdiction over the subject matter, failure to state a cause of action, if the action is barred by res judicata or statute of limitation;
d. All other interlocutory pleadings that may unnecessarily delay the Proceedings before the Arbitration Office or the Board.

RULE VII
APPEAL TO THE BOARD

SECTION 116. Grounds for Appeal

The Decision of the Arbitration Office may be appealed to the Board on any of the following grounds:

a. The finding of a prima facie evidence resulting from an abuse of discretion by the Arbiter due to a wrong appreciation of facts or misapplication of law or both;
b. The Decision was secured through fraud or coercion, including graft and corruption;
c. The Appeal is grounded on questions of law;
d. Serious errors in the finding of facts which if not corrected, would cause grave or irreparable damage or injury to the Appellant.

SECTION 117. Filing of Appeal (Notice and Memorandum of Appeal)

A Notice of Appeal accompanied by a Memorandum of Appeal in three copies shall be filed before the Arbitration Office.

SECTION 118. Who May File an Appeal

Any Party to the case may appeal from a Decision of the Arbitration Office.

SECTION 119. Appeal Fee and Appeal Bond

Except when the Appellant is the Corporation or a member of the sponsored program, the Appellant shall pay an Appeal Fee in an amount of Ten Percent (10%) of the Fine imposed but not exceeding Ten Thousand Pesos. The Appellant shall post an Appeal Bond in the form of Cash or Surety Bond in the amount equivalent to the Fine imposed in the Decision appealed from. Proof of such payment and posting issued by the Comptrollership Department shall be attached to the Notice of Appeal.

SECTION 120. Period of Appeal

The Decision of the Arbitration Office shall be final and executory unless validly appealed to the Board within fifteen calendar days from receipt of such Decision in accordance with this Rules. If the last day falls on a Saturday, Sunday, holiday, or declared a non- working day due to force majeure, the last day to file and perfect the Appeal shall be the next working day.

SECTION 121. No Extension of Appeal Period

No Motion or request for extension of the period within which to file an Appeal shall be allowed.

SECTION 122. Perfection of Appeal

An Appeal shall be perfected and valid only upon the filing with the Arbitration Office of the following within the prescribed fifteen day period:

a. Notice of Appeal;
b. Memorandum of Appeal;
c. Certified True Copy of the proof of payment of the Appeal fee; and
d. Certified True Copy of the proof of posting of Appeal Bond.

Non-perfection of the Appeal as provided in this Rules shall cause its immediate dismissal by the Arbitration Office and shall render the Decision final and executory.

SECTION 123. Memorandum of Appeal of Appellant

A Memorandum of Appeal shall state the date when the Appellant received the appealed Decision, the grounds relied upon, the supporting arguments and the relief prayed for accompanied by an Affidavit of Service on the other Party of such Memorandum.

SECTION 124. Transmittal of the Records of the Case on Appeal

The Arbitration Office shall transmit the entire records of the case to the Board within five calendar days from receipt of a perfected Appeal.

RULE VIII
REVIEW OF APPEALED ADMINISTRATIVE CASES

SECTION 125. Jurisdiction

The Board shall have exclusive appellate jurisdiction to act, determine, review and decide all perfected Appeals of healthcare providers and members involving Decisions on administrative cases promulgated by the Arbitration Office.

SECTION 126. Delegation of Review

The Board may delegate to a Division of the Board the study and review of the Decisions on administrative cases brought before it on Appeal and the Division shall submit its report and recommendation to the Board. Such Division shall be named as the Committee on Appealed Administrative Cases (CAAC) against Healthcare Providers and Members.

SECTION 127. Composition of CAAC

The CAAC shall be composed of at least five Board Members designated by the Board. The members of the CAAC shall elect among themselves its Chairperson and Vice-Chairperson. In the absence of the Chairperson, the Vice-Chairperson shall preside over all the meetings of the CAAC.

SECTION 128. Authority to Conduct Clarificatory Hearings

The CAAC shall have the authority to conduct clarificatory Hearings and summon the Parties to the case brought before it.

SECTION 129. Review and Recommendation By CAAC

The CAAC shall study and review the Decisions on administrative cases brought before the Board on Appeal. It shall have the power to study and report the Appellant's compliance with all the requirements of Appeal, review the grounds of Appeal and provide reports and recommendations to the Board. The CAAC shall elevate its written report and draft Decision to the Board for consideration and approval.

SECTION 130. Decision of the PhilHealth Board

The Board shall review, evaluate and approve the written reports, recommendations and draft Decisions of the CAAC and to promulgate the Decisions on the appealed administrative cases.

SECTION 131. Inhibition

Any Board member may inhibit from the consideration and resolution of any case/matter before the Board and shall so state in writing the grounds for the inhibition.

SECTION 132. Functions of the Clerk of the Board

The Corporate Secretary shall act as the Clerk of the Board and the CAAC and shall assign any of its personnel within the Office of the Corporate Secretary to perform the following functions:

a. Receive all pleadings, motions, and other papers required to be filed with the Board and the CAAC in connection with any Appeal pending and to legibly stamp the date and hour of filing duly signed by the receiving personnel. If the filing is by registered mail, the Office of the Corporate Secretary shall legibly stamp or indicate on the first page of the pleading, motion or other document the date of receipt, the fact that the same was received by registered mail and the date of posting, duly signed by the receiving personnel. The corresponding envelope or portion showing the date of posting and registry stamp shall be attached to the rollo;
b. Keep such books as may be necessary for recording all the Proceedings of the Board and the CAAC;
c. Send notices to the Appellant as regards the filing of the verified Memorandum of Appeal and the submission of the Appeal Bond;
d. Require the Parties to submit the necessary pleadings, required number of copies of their Pleadings and/or legible copies of the assailed Decision or Order; and
e. Issue Certificate of Finality upon finality of a Decision or Final Resolution.

SECTION 133. Comment/Answer or Reply of Appellee

The Appellee may file its Comment/Answer or Reply to Appellant's Memorandum of Appeal with the Clerk of the Board within a period of fifteen calendar days from receipt of the Memorandum of Appeal. Failure to file such Comment/Answer within the prescribed period shall be construed as a waiver.

SECTION 134. Rejoinder

The Appellant may file its Rejoinder to the Comment/Answer filed by the Appellee within a period of ten calendar days from receipt of such Comment/Answer. Failure to file such rejoinder within the prescribed period shall be construed as a waiver.

RULE X
DECISION PROCESS

SECTION 135. Reply/Deliberation of Appealed Case

The CAAC shall study, deliberate, resolve and cause the preparation of a formal written report on the appealed case within sixty calendar days from the time of the submission of the Appellant's Rejoinder or upon the expiration of the prescribed period to file the same.

SECTION 136. Decision or Resolution on Appeal

The Board shall resolve the Appeal within sixty calendar days from receipt of the entire records of the case.

SECTION 137. Form of Decisions or Resolutions

The Decision or Resolution of the Board shall state clearly and distinctly the findings of facts, issues and conclusions of law on which it is based and the relief/s granted if any.

SECTION 138. Promulgation of Decisions and Resolutions

Promulgation of Decisions or Resolutions shall be the responsibility of the Clerk of the Board.

a. Promulgation is made by filing the Decision or Resolution with the Clerk of the Board who shall annotate the date and time of promulgation and attest to it by signing on the same;
b. The Clerk of the Board shall record in the Promulgation Book the docket number, title of the case, nature of the document and the action taken by the Board. The Promulgation Book shall be under the official custody of the Clerk of the Board or any officially designated custodian within the Office of the Office of Corporate Secretary;
c. Immediately after promulgation of a Decision or Resolution, the Clerk of the Board shall forward the original and two copies to the Prosecution Department for proper action, copy furnished the Respondent and the Arbitration Office;
d. Within seven working days from the promulgation of a Decision or Resolution, the Clerk of the Board shall send notices and copies of the same either personally or by registered mail, in sealed envelopes to the Parties through their respective Counsels.

RULE XII
CERTIFICATE OF FINALITY

SECTION 139. Certificate of Finality of Decisions of the Arbitration Office

If no Appeal is taken on the Decision of the Arbitration Office before the Board within fifteen days from receipt of the copy of the Decision by the Parties, the Arbitration Office shall record in its Book of Judgments. The date when the Judgment or Final Resolution becomes executory shall be deemed as the date of its Certificate of Finality. The record shall contain the dispositive part of the Decision or Final

Resolution and shall be signed by the Executive Arbiter certifying that such Decision or Final Resolution has become final and executory.

SECTION 140. Certificate of Finality of Decisions of the Philhealth Board

If no Appeal or Motion for Reconsideration on the Decision of the Board is filed within the time provided in this Rules, the Decision shall be recorded by the Corporate Secretary, acting as the Clerk of the Board, in the Book of Judgments. The date when the Judgment or Final Resolution becomes executory shall be deemed as the date of its Certificate of Finality. The record shall contain the dispositive part of the Decision or Final Resolution and shall be signed by the Corporate Secretary certifying that such Decision or Final Resolution has become final and executory.

If Appeal on the Decision of the Board is filed before the Court of Appeals or the Supreme Court within the time provided in this Rules, the Decision shall nonetheless be entered by the Corporate Secretary (Clerk of the Board) in the Book of Judgments even pending Appeal. The date when the finality of the Decision of the Board becomes executory shall be deemed as the date of its entry. The record shall contain the dispositive part of the Decision or Final Resolution and shall be signed by the Secretary Corporate (Clerk of the Board) certifying that such Decision or Final Resolution is immediately executory.

SECTION 141. Posting of Decisions in the Philhealth Corporate Website

All Decisions of the Arbitration Office or the PhilHealth Board which have been deemed Final and Executory shall be posted in the PhilHealth Website.

SECTION 142. Execution of a Decision

Any Decision of an Arbiter or of the Board in a Complaint filed against a healthcare provider or member shall be executed after the same shall have become final and executory; provided that, the penalty of fine shall first be satisfied or paid from the forfeiture of the appeal bond, if applicable. The Decision may be enforced and executed in the same manner as Decisions of the Regional Trial Courts.

The Board shall have the power to issue Writs of Execution to the City or Provincial Sheriff or the Sheriff whom it may appoint.

The concerned PRO-Legal Office along with other operating units shall be responsible and authorized to execute the Writ. If necessary, the concerned PRO-Legal Office shall be authorized to coordinate with the City or Provincial Sheriff for the satisfaction of the Writ. Any person who shall fail or refuse to comply with such Decision and Writ after being required to do so shall, upon application by the Board, be punished by the proper Court for contempt. The Decision of the PhilHealth Board shall be executory even pending Appeal when the public interest so requires and as may be provided for in the implementing rules and regulations.

Public interest, to justify the immediate execution of Decisions of the PhilHealth Board even pending Appeal shall refer to either or all of the following circumstances:

a. Act(s) committed by the Respondent healthcare provider/member which endanger public health/safety of members/dependents;

b. Act(s) committed by the Respondent healthcare provider/member which are detrimental to the fund-viability of the Program; and
c. Other analogous circumstances.

RULE XIII
WRIT OF EXECUTION ON HEALTHCARE PROVIDERS (INSTITUTION/PROFESSIONAL)

SECTION 143. Writ of Execution on Healthcare Providers

After the lapse of the fifteen days within which to appeal Decisions of the Arbitration Office and there is a corresponding penalty to be imposed, the Arbitration Office shall motu propio issue the Writ of Execution to the concerned PhilHealth Regional Office.

After the Decision of the Board has become final and executory and there is a corresponding penalty to be imposed, the Arbitration Office shall issue the Writ of Execution to the concerned PhilHealth Regional Office upon the motion of the Prosecution Department.

The Writ shall state the exact date of implementation and effectivity of the suspension or denial of accreditation which in no case shall be earlier than sixty days from the date of issuance of the Writ. No Motion for Reconsideration, Opposition or any other similar pleading shall be allowed by the Arbitration Office except on the ground that the penalties imposed have already been fully satisfied.

SECTION 144. Directive to Execute Writ

The Writ shall contain a Directive to the PRO-Legal Office under whose regional jurisdiction the Respondent healthcare provider is situated to execute and implement the Writ. Copies of the Writ shall be furnished the Office of the Regional Vice-President, the Accreditation Department and Prosecution Department, Central Office.

a. Upon receipt of the Directive to execute, the respective Legal Office shall personally serve the Writ to the Respondent healthcare provider within seven days. The Legal Office shall also coordinate and inform the Accreditation Unit and Benefit Administration Section of the PRO upon its receipt of the Writ. Personal Service of the Writ to the Respondent healthcare Professional shall be made on the last known address or in the Institution where the professional regularly or is otherwise known to practice, as provided by the professional to the Accreditation Department;
b. In the event that the authorized officials or representatives of the Respondent healthcare institution/professional refuse to receive the Writ, the Legal Office shall take note of such refusal and tender the Writ by leaving a copy at the premises of the healthcare institution. Tender of the Writ is tantamount to an effective service of the same;
c. Upon Personal Service of the Writ, the Legal Office shall submit within seven days a formal written report or Certification of Compliance to the Directive to the Arbitration Office and the Manager of the Accreditation Department attaching satisfactory evidence proof of service. The Legal Office shall keep a record of the Writs received and personally served for future reference and verification purposes;

d. Upon receipt of the Certificate of Compliance or the formal written report by the Accreditation Department, it shall effect the appropriate revisions and tagging in the database of the accreditation status of the Respondent healthcare provider. The Accreditation Department shall immediately inform the Legal Office, Accreditation Unit and Benefit Administration Section of the PRO once the revision/tagging has been accordingly effected.

SECTION 145. Notice of Suspension/Denial of Accreditation to a Healthcare Institution

Within ten days prior to the commencement of the suspension or denial of accreditation as stated in the Writ, the Legal Office along with representatives from the Accreditation Unit of the PRO, shall post Notices of Suspension/Denial of Accreditation in three conspicuous areas within the facility preferably near the "PhilHealth Accredited" signage, the main entrance of the Respondent healthcare provider's building/location and near the Billing or Accounting Office of the Respondent healthcare provider where settlement of hospital bills are transacted.

a. The Notice must be made of white tarpaulin in the same size of the required PhilHealth accreditation signage. The Notice must be in bold black letters clearly and visibly stating that: "the PhilHealth Accreditation of (name of hospital) is suspended from (indicate the date of start of suspension period) until (indicate the end of the suspension period). No claims for confinements at this hospital during this period shall be received, processed and paid by PhilHealth" or

   In cases where the Penalty imposed is denial of accreditation, the Notice must state that "the (name of hospital) is no longer a PhilHealth-Accredited healthcare provider effective (indicate the date of removal or end of PhilHealth accreditation). No claims for confinements on such date and onwards shall be paid by PhilHealth".

   The Notices shall also contain a translation in the vernacular language used where the healthcare provider is situated. Upon informing the Respondent healthcare provider and if necessary with the assistance of the Local Barangay Officials or Local Government personnel, the PhilHealth accreditation signage including any other sign or marker pertaining to the accreditation of the Respondent healthcare provider shall be removed.

b. The Legal Office and Accreditation Unit representatives shall continuously and regularly exercise and exhaust all efforts to monitor faithful compliance on the posting of the Notice and to the Writ by the Respondent healthcare institution. In case of violations of the same, such acts shall constitute grounds for possible filing of Formal Charge for further administrative offenses including but not limited to a Breach of Warranties of Accreditation/Performance Commitment;

c. The PRO through its public relations/information office shall also inform PhilHealth members of the Suspension or subsequent Denial of Accreditation of Respondent healthcare institutions/providers within their regional jurisdictions.

SECTION 146. Claims Filed with Suspended Professional

All Claims for reimbursement filed with PhilHealth involving the suspended professional shall be denied payment with respect to the Claim for the professional fees subject to Appeal following the regular procedures for appealed Claims. Healthcare institutions are enjoined to refrain from endorsing or

referring PhilHealth members to suspended professionals who regularly render service or practice in their institution to avoid undue delay in the processing of their Claims.

SECTION 147. Report on the Writ

Upon satisfaction of the Writ and within fifteen days from the expiration of the period of suspension, the Legal Office shall make a written report stating that the Provider has fully complied with the same. The report shall be addressed to the Arbitration Office and the Accreditation Department, Central Office.

SECTION 148. Deduction of Unpaid Fines/Receivables from Current and/or Future Benefit Claims

Where the Respondent healthcare provider refuses or fails to timely satisfy or pay the penalty of Fine despite having been duly served with a Writ of Execution, the Fine shall be deducted from the benefit Claims pending for processing or to be filed by the Respondent healthcare provider with the Corporation or from any other money Claims and/or receivables by the healthcare provider from the Corporation.

RULE XIV
WRIT OF EXECUTION ON MEMBERS

SECTION 149. Writ of Execution on Members

The Writ shall contain a Directive to the PRO-Legal Office under whose regional jurisdiction the Respondent healthcare provider is situated to execute and implement the Writ to its letter. Copies of the Writ shall be furnished to the Office of the Regional Vice-President, the Accreditation Department and Prosecution Department-Central Office.

The writ shall state the exact date of implementation and effectivity of the Suspension which in no case shall be earlier than sixty days from the date of issuance of the Writ. No Motion for Reconsideration, Opposition or any other similar pleading shall be allowed and entertained by the Arbitration Office except on the ground that the Decision is not yet final and executory or that the penalties imposed have already been fully satisfied.

a. Upon receipt of the Directive to execute, the respective Legal Office shall personally serve the Writ to the Respondent member within seven days. The Legal Office shall coordinate and inform the concerned Offices of the PRO upon its receipt of the Writ. Personal Service of the Writ shall be made on the last known address of the member;
b. In the event that the Respondent member refuses to expressly receive the Writ, the Legal Office shall take note of such refusal and tender the Writ by leaving a copy of the same. Tender of the Writ is equivalent to an effective service of the Writ;
c. In the event that Personal Service of the Writ is no longer feasible due to valid and justified reasons, Service by Registered Mail at the last known address of the member shall be used;
d. Upon Service of the Writ using the above-enumerated modes of Service, the Legal Office shall submit within seven days a Formal Written Report or Certification of Compliance to the Directive to the Arbitration Office and the Manager of the Accreditation Department attaching satisfactory evidence Proof of Service. In case the Service shall be made via registered mail, an

explanation on the failure to personally serve the Writ must be stated with the verification of relevant dates to confirm completeness of service under this mode. The Legal Office shall keep a Record of the Writs received and personally served for future reference and verification purposes;

e. Upon receipt of the Certificate of Compliance or the Formal Written Report by the Accreditation Department, it shall effect the appropriate revisions and tagging in the Database of the accreditation status of the Respondent healthcare provider. The Accreditation Department shall immediately inform the Legal Office, Accreditation Unit and Benefit Administration Section of the PRO once the revision/tagging has been accordingly effected.

SECTION 150. Claims Filed by Suspended Member

All benefit Claims for reimbursement filed with PhilHealth involving a suspended member shall be denied payment subject to Appeal following the regular procedures for Appealed Claims.

SECTION 151. Report on the Writ against Members

Upon satisfaction of the Writ and within fifteen days from the expiration of the period of suspension, the Legal Office shall make a written report stating that the Member has fully complied with the same. The report shall be addressed to the Arbitration Office and the Accreditation Department, Central Office.

RULE XV
RESTITUTION

SECTION 152. Restitution of PhilHealth Benefits Erroneously Paid

All medical treatments, services, drugs and medicines obtained and paid for by PhilHealth which were found out to be erroneous and unnecessary shall be immediately restituted by the Respondent upon the issuance of the Certificate of Finality from the Office of the Corporate Secretary. The Arbitration Office shall indicate in its Writ the total amount of specific items/services to be refunded by the Respondent healthcare provider/member.

RULE XVI
APPEAL TO THE COURT OF APPEALS

SECTION 153. Appeal to Court of Appeals of Board Decisions

Final Orders and Decisions of the Board may be reviewed by the Court of Appeals through an Appeal in accordance with the provisions of Revised Administrative Circular No. 1–95 issued by the Supreme Court on May 16, 1995, pursuant to Republic Act No. 7902 duly approved on February 23, 1995 expanding the jurisdiction of the Court of Appeals.

TITLE IX
DEFINITION OF ADMINSTRATIVE OFFENSES AND PENALTIES

RULE I
OFFENSES OF HEALTHCARE INSTITUTIONS

SECTION 154. Padding of Claims

Any healthcare institution who, for the purpose of claiming payment from the Program, files a claim for benefits in excess of the benefits actually provided by adding drugs, medicines, supplies, procedures and services.

SECTION 155. Claims for Non-Admitted or Non-Treated Patients

Any healthcare institution who, for the purpose of claiming payment from the Program, files a Claim for a non-admitted or non-treated Patient in the following manner:

a. Making it appear that the Patient was actually confined or treated in the healthcare institution; or,
b. Using such other machinations that would result in Claims for non-admitted or non-treated Patient.

SECTION 156. Extending Period of Confinement

Any healthcare institution who, for the purpose of claiming payment from the Program, files a Claim with extended period of confinement by:

a. Increasing the period of actual confinement of any Patient;
b. Continuously charting entries in the Doctor's Order, Nurse's Notes and Observation despite actual discharge or absence of the Patient; or,
c. Using such other machinations that would result in the unnecessary extension of confinement.

SECTION 157. Post-Dating of Claims

Any healthcare institution who, for purposes of claiming payment from the Program, files a Claim for payment of services rendered beyond sixty calendar days from the date of discharge of the Patient or such other prescriptive periods as the Corporation may issue but, makes it appear so by amending, erasing, adding to the period of confinement or in any manner altering dates so as to conform with the required prescriptive period.

SECTION 158. Misrepresentation by Furnishing False or Incorrect Information

Any healthcare institution shall be liable for fraudulent practice when, for the purpose of participation in the Program or claiming payment, furnishes false or incorrect information concerning any matter required by R.A. 7875 as amended and this Rules. This Offense includes but is not limited to the following acts involving benefit Claims for case-rate payment:

a. Code substitution – claiming for unrelated illness or procedure with higher benefit payment in lieu of actual illness or procedure or to be able to qualify for reimbursement;
b. Upcoding or upcasing or diagnosis creeping or procedure creeping – claiming for a related illness or procedure of higher severity or complexity to qualify for reimbursement or to gain higher benefit payment; or,
c. Adding a non-existing condition in the diagnosis in order to qualify for reimbursement or receive higher benefit payment.

SECTION 159. Filing of Multiple Claims

Any healthcare institution who files two or more Claims for a Patient for the same confinement or outpatient treatment or illness.

SECTION 160. Unjustified Admission Beyond Accredited Bed Capacity

Any healthcare institution who, for the purpose of claiming payment from the Program, file Claims for Patients confined in excess of its accredited bed capacity.

SECTION 161. Unauthorized Procedures Beyond Service Capability

Any healthcare institution which performs procedures not within its authorized capability except when the procedure is done in an emergency to save life and referral to a facility with suitable capability is physically impossible.

SECTION 162. Fabrication or Possession of Fabricated Forms and Supporting Documents

Any healthcare institution who is found preparing Claims with misrepresentations or false entries or to be in possession of Claim forms without authority and other documents with false entries.

SECTION 163. Patient-Seeking and Other Unethical Recruitment Activities

Any healthcare institution who engages in solicitation of Patients by any means or form or through any medium to obtain undue advantage against other healthcare institutions or to induce business reimbursable under the National Health Insurance Program (NHIP).

Unethical recruitment activity is the conduct of a healthcare provider who knowingly or willfully offers, pays, solicits or receives anything of value for the purposes of obtaining Patients. Such activities shall include but not limited to the following:

a. Medical missions in which a healthcare provider has directly or indirectly entered into a contract or any agreement and/or linked up or tied-up with a non-government organization or an institution in the guise of charity or community service for the sole purpose of soliciting PhilHealth Patients;
b. Medical missions limited to PhilHealth members and its beneficiaries only;
c. Medical missions primarily done for purposes of profit or gain which does not promote the best interest of the Patient or the National Health Insurance Program;
d. The healthcare institution solicit/s Patients through other recruitment schemes for the purposes of enrollment to PhilHealth; and

e. Other analogous activities.

SECTION 164. Breach of the Performance Commitment

Any healthcare institution who commits any breach of its Performance Commitment (PC)

I. Errors and Inefficiencies

a. Administrative oversights such as erroneous/inaccurate information supplied on required forms and documents;
b. Absence or inappropriate credentials/license of healthcare professionals employed in the facility;
c. Unacceptable quality of service rendered to PhilHealth members/dependents;
d. Non-compliance to quality assurance and legal requirements and processes; and
e. Other similar acts.

II. Abuse and Misuse

Any healthcare institution that abuse or misuse the NHIP in order to gain or deprive members of its rightful benefits as enumerated but not limited to the following:

a. Making it appear that the Patient suffered from a compensable illness or underwent a compensable procedure;
b. Charging qualified Patients for medicines and/or services which are legally chargeable to and covered by the Program;
c. Failure/refusal to give benefits due to qualified members/dependents;
d. Failure/refusal to admit/treat members/dependents without cash deposit in an emergency case;
e. Demands or accepts a deposit of any form or makes the deposit a condition for admission or confinement of the patient;
f. Claims or case-rates claimed in full but did not fully utilize or exhaust the benefits thru (1) paid benefits but not rendered; and (2) over-pricing of drugs, medicines, services to make it appear that the full case-rate amount allotted were fully utilized and exhausted;
g. Non-deduction of Professional Fee component in All Case Rates (ACR);
h. Denial of orderly assessment conducted by PhilHealth relative to any findings/reports;
i. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols:
   - Unnecessary diagnostic and therapeutic procedures and intervention
   - Irrational medication and prescriptions
   - Inappropriate referral practices
   - Utilization of unsafe and inappropriate instruments in the performance/practice of procedures
j. Unethical practices/mismanagement;
k. Subjects PHIC to abuse, violation and/or over-utilization of its funds by allowing our institution to be party to any act, scheme, plan or contract that may directly or indirectly be prejudicial or detrimental to the NHIP;
l. The HCI engages directly or indirectly in any form of unethical/improper practices as an accredited healthcare provider;
m. Unjustified use of ARSP drugs (for non-ARSP accredited HCIs);
n. Unjustified use of drugs other than those recognized in the latest Philippine National Formulary (PNF) and those for which were granted exemptions by DOH and/or by the Board;

o. The HCI engages directly or indirectly in any form of unethical/improper practices as an accredited healthcare provider (HCP) the purpose and/or the end consideration of which tends unnecessary financial gain rather than promotion of the NHIP;
p. Detains a Patient for the purpose of claiming payment or for the purpose of ensuring the submission or completion of documentary requirements necessary for PhilHealth Claim;
q. Admits a Patient for the sole purpose of performing on the Patient diagnostic procedures;
r. Claiming for a simulated confinement of a Patient or making it appear that the Patient is suffering from a compensable illness or procedure;
s. Withholds the PhilHealth cards and other documents of a member, by force, intimidation, mistake, fraud, or undue influence, which results to the deprivation of a member of PhilHealth benefits or of opportunity to be confined in other healthcare providers; and
t. Other similar acts

III. Other Violations.

Any healthcare institution can also be held liable for the following violations:

a. Violations of PhilHealth Circulars and other PhilHealth Issuances; and
b. Violations of Related and Applicable Administrative Orders, Circulars and other Issuances of the Department of Health (DOH) and/or other related governing agencies and instrumentalities.

RULE II
OFFENSES OF HEALTHCARE PROFESSIONALS

SECTION 165. Misrepresentation by False or Incorrect Information

Any healthcare professional shall be liable for fraudulent practice when, for purposes of participation in the Program or claiming payment from the Corporation, furnishes false or incorrect information concerning any matter required by R.A. 7875 as amended and this Rules.

This offense covers or includes but is not limited to the following acts involving benefit claims for case-rate payment:

a. Code substitution – claiming for unrelated illness or procedure with higher benefit payment in lieu of actual illness or procedure or to be able to qualify for reimbursement;
b. Upcoding or upcasing or diagnosis creeping or procedure creeping – claiming for a related illness or procedure of higher severity or complexity to qualify for reimbursement or to gain higher benefit payment; or
c. Adding a non-existing condition in the diagnosis in order to qualify for reimbursement or receive higher benefit payment.

SECTION 166. Patient-Seeking and other Unethical Recruitment Activities

Any healthcare professional who engages in solicitation of Patients by any means or form or through any medium to obtain undue advantage against other healthcare professionals or to induce business

reimbursable under the National Health Insurance Program.

Unethical recruitment activity is the conduct of a healthcare provider who knowingly or willfully offers, pays, solicits or receives anything of value for the purposes of obtaining Patients. Such activities shall include but not limited to the following:

a. Direct or in-direct participation in medical missions in which a healthcare provider has healthcare provider has directly or indirectly entered into a contract or any agreement and/or linked up or tied-up with a non-government organization or an institution in the guise of charity or community service for the sole purpose of soliciting PhilHealth Patients;
b. Direct or in-direct participation in medical missions limited to PhilHealth members and its beneficiaries only;
c. Direct or in-direct participation in medical missions done for profit or anything that brings profit but does not promote the best interest of the Patient; and
d. Other analogous activities.

SECTION 167. Breach of the Performance Commitment

Any healthcare professional found to have committed any breach of the Performance Commitment.

I. Errors and Inefficiencies

a. Administrative oversights such as erroneous/inaccurate information supplied on official forms and documents;
b. Absence or inappropriate credentials/necessary licenses to practice;
c. Unacceptable quality of service rendered to PhilHealth members/dependents;
d. Non-compliance to quality assurance and legal requirements and processes; and
e. Other similar acts.

II. Abuse and Misuse

Any healthcare professional committing the following acts of abuse or misuse in order to gain or deprive members of its rightful benefits under the Program:

a. Prescribe qualified Patients for medicines and/or services which are legally chargeable to and covered by the Program (Non-compliance to the NBB policy);
b. Failure/refusal to give benefits due to qualified members/dependents;
c. Non-deduction of Professional Fee component in All Case Rates (ACR);
d. Denial of orderly assessment conducted by PhilHealth relative to any findings/reports;
e. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols:
    - Unnecessary diagnostic and therapeutic procedures and intervention
    - Irrational medication and prescriptions
    - Inappropriate referral practices
    - Utilization of unsafe and inappropriate instruments in the performance/practice of procedures
f. Unethical practices;
g. Charging of additional professional fees in excess of that prescribed by the Corporation pursuant to the case-rate policy and other applicable rules and regulations;

h. Exposes the Corporation to abuse, violation and/or over-utilization of its funds by participating in any act, scheme, plan or contract that may directly or indirectly be prejudicial or detrimental to the Program;
i. Non-compliance to summons, subpoena and other legal or quality assurance processes and requirements;
j. Unjustified prescription of drugs other than those recognized in the latest Philippine National Formulary (PNF) and those for which were granted exemptions by DOH and/or by the Board;
k. Claims for professional fee for a healthcare professional who is other than the one who has rendered the services or undertaken the procedure;
l. Admits a Patient for the sole purpose of performing on the patient diagnostic procedures; and
m. Other similar acts.

III. Other Violations.

Any healthcare professional can also be held liable for the following violations:

a. Violations of PhilHealth Circulars and other issuances of PhilHealth; and
b. Violations of concerned Administrative Orders, Circulars and other issuances of governing agencies and instrumentalities;
c. Any other willful or negligent act or omission of the healthcare professional in violation of RA 7875 as amended and these Rules which tends to undermine or defeat the objectives of the Program shall be dealt with in accordance with Section 44 of R.A. 7875 as amended.

SECTION 168. Criminal Liability and/or other Administrative Violations

In addition to the filing of appropriate Administrative Charges for violations of R.A. 7875 as amended including this Implementing Rules & Regulations, PhilHealth Circulars and other Issuances and Policies, a Criminal Complaint may also be filed against Officials and/or personnel of erring institutional healthcare providers before the appropriate Office of the Prosecutor for violations of this Rules and/or the Revised Penal Code if warranted by attendant facts and evidence.

The filing of additional Administrative Charges for violation of the applicable Code of Professional Code of Ethical Standards & Practices by the erring institutional healthcare providers before the Professional Regulatory Commission (PRC) or before the proper Societies and/or Associations may also be considered if warranted by attendant facts and evidence.

SECTION 169. Filing of Administrative Cases Before the Professional Regulatory Commission (PRC) and/or Criminal Cases Before the Prosecutor's Office

The filing of the appropriate administrative cases by the Corporation before the PRC or the Prosecutor's Office as the case may be, shall be handled by the concerned PRO Legal Office having regional jurisdictional coverage of the erring healthcare professionals or the Legal Sector, Central Office through the Internal Legal Department (ILD) in coordination with the concerned Legal Departments in the Central Office and the PRO Legal Office.

The Prosecution Department, Central Office in coordination with the FFIED and the PRO-Legal Office shall evaluate and determine the possibility and appropriateness of filing administrative cases before the PRC and/or criminal cases before the proper Prosecutor's Office independently and/or simultaneously with the filing of administrative cases with the Arbitration Office.

The PRO-Legal Offices shall have the authority to file administrative cases before the PRC and/or criminal cases before the Prosecutor's Office independently and/or simultaneously with the filing of administrative cases with the Arbitration Office by the Prosecution Department.

RULE III
OFFENSES OF MEMBERS

SECTION 170. Fraudulent Acts

Any member who, for purposes of claiming PhilHealth benefits or entitlement, shall commit any of the offenses provided for in Sections 154 to 164 and Sections 165 and 167, independently or in connivance with the healthcare provider or any other third-party.

TITLE IX
DEFINITION OF ADMINSTRATIVE OFFENSES AND PENALTIES

RULE IV
ADMINISTRATIVE PENALTIES AND ITS APPLICATION

SECTION 171. Administrative Penalties for Erring Healthcare Provider (Institution/Professional)

The following administrative penalties shall be respectively imposed on cases involving administrative offenses committed by healthcare institutions/professionals in addition to the Restitution of payments for all medical treatments, services, drugs and medicines obtained and paid for by PhilHealth as provided under these Rules:

Frequency of Offense	Suspension				Fine (in Peso)		
	Min	Med	Max		Min	Med	Max
First Offense	3 months	4 months	5 months	and/ or	10,000	20,000	30,000
Second Offense	6 months	7 months	8 months	and/ or	40,000	50,000	60,000
Third Offense	10 months	11 months	12 months	and/ or	70,000	90,000	100,000
Fourth Offense	Whole term of accreditation and/or denial of accreditation			and/or	100,000		

SECTION 172. Administrative Penalties for Erring Member

The following administrative penalties shall be respectively imposed on cases against erring members:

Frequency of Offense	Suspension (regardless of the amount of claim)		Fine (in Peso)
First Offense	1 to 2 claims benefit availment	and/or	5,000
Second Offense	3 to 4 claims benefit availment	and/or	7,500
Third Offense	5 to 6 claims benefit availment	and/or	10,000

Suspension of the rights of the member shall not exceed six months or Claims availment equivalent to accumulated one-hundred eighty days confinement.

SECTION 173. Recidivists

Recidivists are healthcare providers who have been found guilty of four or more offenses and meted the penalty of denial of accreditation in accordance with the Administrative Penalties provided in this Rules.

SECTION 174. Application of Multiple Offenses

Multiple offenses are committed by healthcare providers who commit the same offense involving several claims filed within a period of twenty-four hours. The same shall be penalized and treated as one offense with several counts depending on the number of claims involved.

The penalties to be imposed shall be automatically on its maximum in accordance with the Administrative Penalties provided in this Rules.

SECTION 175.Mitigating and Aggravating Circumstances

The following circumstances shall affect the gravity of the violation and the liability of the erring healthcare provider:

a. Mitigating Circumstances – The following circumstances shall mitigate the liability: voluntary admission of guilt, consistent good track record and/or a first offender;
b. Aggravating Circumstances – The following circumstances shall aggravate the liability: Previously finding of liability of an offense as provided for in this Rules, connivance and/or conspiracy to facilitate the commission of the violation and/or gross negligence;
c. Such other similar circumstances that may mitigate or aggravate liability of the healthcare provider as may be determined by the Arbitration Office or the PhilHealth Board.

SECTION 176. Application of Circumstances in the Imposition Of Penalties

a. The presence of a mitigating circumstance without any aggravating circumstance shall limit the imposable penalty to its minimum;

b. When there is neither a mitigating nor an aggravating circumstance, the imposable penalty shall be between the minimum and the maximum of the applicable penalty for the offense committed at the discretion of the Corporation. The same shall apply when both mitigating and aggravating circumstances are present;

c. The presence of any aggravating circumstance without any mitigating circumstance shall increase the penalty for the offense to its maximum.

SECTION 177. Application of Suspension and Denial for Accreditation

If the penalty of suspension imposed upon the healthcare provider exceeds the validity of the current accreditation, the application for renewal or re-accreditation of the healthcare provider shall not be acted upon until the full term of the suspension imposed has lapsed. Suspension shall be carried out by the temporary cessation of the benefits or privileges of the healthcare provider under the Program. Denial for Accreditation shall be carried out by the permanent cessation of the benefits or privileges of the healthcare provider under the Program.

TITLE X
PENAL OFFENSES AND PENALTIES

RULE I
OFFENSES OF OFFICERS AND EMPLOYEES OF THE CORPORATION

SECTION 178. Misappropriation of Public Funds & Infidelity in the Custody of Public Property

This Offense is committed by any Officer or employee of the Corporation who:

a. Receives or keeps funds or property belonging, payable or deliverable to the Corporation, or who shall appropriate the same; or
b. Shall take or misappropriate such fund or property wholly or partially; or
c. Shall consent, or through abandonment or negligence, shall permit any other persons to take such funds or property wholly or partially; or
d. Performs any and all functions and/or commits acts including but not limited to the signing of official documents involving the investment and/or release of funds or property of the Corporation without proper authorization and/or beyond his/her official functions or signing authority.

The Officer or employee found liable for misappropriation of funds or property shall suffer imprisonment of not less than six (6) years but not more than twelve (12) years and a fine of not less than Ten Thousand Pesos (P10,000.00) but not more than Twenty Thousand Pesos (P20,000.00).

Any shortage of funds or loss of the property upon audit shall be deemed prima facie evidence of the Offense.

SECTION 179. Other Violations Involving Funds

All other violations involving funds of the Corporation shall be governed by the applicable provisions of the Revised Penal Code or other laws taking into consideration the provisions under the Rules on collection, remittances and investment of funds.

SECTION 180. Connivance

Any Officer or employee of the Corporation who shall connive with any healthcare provider or any member or third-party, or through gross negligence or imprudence shall facilitate or consent to the commission of the same offenses enumerated in this Rules shall be prosecuted under applicable penal laws, rules and regulations without prejudice to the filing of appropriate administrative actions with the appropriate agency.

RULE II
OFFENSES OF EMPLOYERS

SECTION 181. Failure or Refusal to Register/Deduct Contributions

Any employer or Officer who fails or refuses to register/deduct contributions from the employee's compensation shall be penalized with a fine of not less than Five Thousand Pesos but not more than Ten Thousand Pesos multiplied by the total number affected employees concerned.

SECTION 182. Failure or Refusal to Remit Contributions

Any employer or Officer authorized to collect contributions who, after collecting or deducting the monthly contributions due from the employees, fails or refuses to remits said contributions to the Corporation within thirty days from the date they become due, shall be punished with a fine of not less than Five Thousand Pesos but not more than Ten Thousand Pesos multiplied by the total number of affected employees concerned.

SECTION 183. Unlawful Deductions

Any employer or Officer who shall directly or indirectly deduct from the compensation of the covered employees or otherwise recover from them their own contribution on behalf of such employees shall be punished with a fine of Five Thousand Pesos multiplied by the total number of affected employees.

SECTION 184. Institution as Offender

If any of the acts or omissions provided in the preceding Sections of this Rules be committed by an Association, Partnership, Corporation or any other Institution, its Managing Directors or Partners or President or General Manager and/or any other persons responsible for the commission of the said acts or omissions shall be liable for the penalties provided for in this Rules.

SECTION 185. Reports on Violations by Employers

The PRO shall submit to the Executive Vice-President & Chief Operating Officer (EVP & COO) a Quarterly Report on all violations by employers within their area of jurisdiction for monitoring and proper deduction of their counterpart contributions from their employees' compensation, under remittance and/or non-remittance of their employees' contributions to the Corporation. The Report shall be furnished its Legal Office and Collection Unit of the PRO as well as the SVP-LS for appropriate action if necessary.

SECTION 186. Affidavit-Complaint and Complainant in Actions

The Head or Officer-In-Charge (OIC) of the Collections Unit of the PRO shall, within five days upon receipt from its Legal Office of the final draft of the Affidavit-Complaint on actions against employers, execute or sign the same as the Complainant and nominal witness in behalf of the Corporation against employers within their area of jurisdiction for any of the offenses contained in this Rules. In the absence, failure or inability of the Head or OIC of the Collection Unit of the PRO, the Regional Vice-President or OIC of the PRO shall perform the above-mentioned duties and responsibilities in representation of the Corporation.

SECTION 187. Preparation and Filing of Affidavit-Complaint

The Affidavit-Complaint shall be prepared and filed with the appropriate Office of the Prosecutor/Court or Administrative Body by the Legal Office of the PRO within thirty days from receipt of the Quarterly Report upon approval by the SVP for Legal Services.

TITLE X
PENAL OFFENSES AND PENALTIES

RULE III
FINAL PROVISION

SECTION 188. Application of Rules

Complaints filed with and under deliberation by appropriate bodies/Committees of the Corporation prior to the effectivity of this Rules shall be governed in accordance with the applicable rules.