TAMANG SAGOT

PhilHealth Circular No. 031-2014

"Health Care Provider Performance Assessment System (HCP PAS)"

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1. What is PhilHealth Circular No. 031-2014

PhilHealth Circular No. 031- 2014 is titled "Health Care Provider Performance Assessment System (HCP PAS)". It is a policy on how to monitor the performance of all PhilHealth accredited Health Care Providers (HCP) in terms of access to PhilHealth benefits, provision of quality health care and ensuring financial risk protection to all PhilHealth members.

2. How will PhilHealth monitor the performance of health care providers?

PhilHealth will monitor the performance of all accredited health care providers through conduct of (but not limited to) different monitoring activities such as:

a. Claims/Services Profiling – a process of reviewing filed claims retrieved from claims database, to establish the trends and to generate profile of claims per HCP based on identified parameters such as volume per illness, length of hospital stay, and referrals, among others.

b. Medical Audit – a mechanism to review the paid claims vis-à-vis the established standards of practice and the applicable provisions in the performance commitment.

c. PhilHealth Patient Exit Survey – A daily survey conducted by the assigned PhilHealth Customer Relations and Empowerment Staff (PCARES) to selected patients for discharge and with a generated billing statement.

d. PCB/Tsekap Client Satisfaction Survey – A semi-annual survey to be conducted by AQAS/LHIOs to selected Primary Care Benefit (PCB) and Tsekap clients who availed of PCB/Tsekap services.

e. Management of member complaints – evaluation of the performance of health care providers based on any reports received from members stating their experience during health care delivery from an accredited HCI.

f. Regular/Routine Facility Visits – is a regular announced or unannounced monitoring activity to assess the compliance of Health Care Institutions (HCI) to their Performance Commitment and established standards of care.

g. Chart Review – process of examining a medical record to determine the patient's information related but not limited to diagnosis, medical management, ICD-10 codes, etc.

h. Field Validation – is the process of verifying the monitoring findings through facility and/or domiciliary visits whenever necessary.

3. How will PhilHealth deliberate all the findings of the different monitoring activities?

A PhilHealth Regional Monitoring Committee (PRMC) shall be created by the regional offices. The PRMC shall deliberate all findings that resulted from different monitoring activities. The PRMC recommends the issuance of a Notice of Warning with the approval of the Regional Vice President.

4. How many warnings shall be given to the erring HCP before they are penalized?

For non-fraudulent validated findings, the HCI shall be subjected to two (2) warnings. A third warning shall be regarded as one (1) offense. For fraudulent findings, one (1) validated finding shall already be regarded as one (1) offense.

The health care provider shall be sanctioned and/or penalized accordingly as prescribed in the IRR of RA 10606 or the National Health Insurance Act of 2013. Due process shall be observed at all times.

5. What are the violations?

Violations may be classified as non-fraud and fraud based on the table below::

NON-FRAUD	FRAUD
Post audit findings as follows: 1. Unjustified use of drugs other than those recognized in the latest Philippine National formulary (PNF) and those for which exemptions were granted by the Board 2. Unjustified use of ARSP drugs (for non-ARSP accredited HCIs) 3. Over and under utilization of services 4. Unnecessary diagnostic and therapeutic procedures and intervention 5. Irrational medication and prescriptions 6. Gross, unjustified deviations from currently accepted standards of practice and/or treatment protocols 7. Inappropriate referral practices 8. Non-serving of meals 9. Utilization of unsafe and inappropriate instruments in the performance/practice of procedures 10. Unethical/mismanagement/questionable practice patterns 11. Unjustified admission beyond accredited bed capacity 12. Absence of physician and/or registered nurse during inspection or monitoring 13. Filing of multiple claims 14. Unauthorized operations beyond service capability 15. Non-compliance to provisions prescribed in the Performance Commitment which are not under fraudulent violations	Fraudulent findings but not limited to the following: 1. Use of fake, adulterated or misbranded pharmaceuticals, or unregistered drugs 2. Padding of claims 3. Claims for non-admitted or non-treated patients 4. Extending period of confinement 5. Post-dating of claims 6. Misrepresentation by false or incorrect information 7. Misrepresentation by furnishing false or incorrect information 8. Fabrication or possession of fabricated forms 9. Other fraudulent acts as described in Title IX Rule I Section 159of the revised IRR of RA 7875 amended by RA 10606 10. Non-compliance to the NBB policy 11. Non-compliance to administrative orders, circulars and such other policies, rules and regulations issued by the Department of Health and all other agencies and instrumentalities governing the operations of HCPs in participating in the National Health Insurance Program (NHIP)

6. Is there a feedback mechanism?

Yes, the feedback mechanism is as follows:

a. For fraud finding, with the approval of the Regional Vice President and with a fact finding investigation report, the PRMC shall endorse the case to the Fact Finding Investigation and Enforcement Department (FFIED) for further evaluation and legal process, when necessary.

b. For non-fraud findings, the PRMC shall request explanation from the concerned health care provider.

   b.1. The concerned health care provider is given **15 calendar days** from date of receipt of the feedback letter to justify their performance. For non-compliance, the PRMC shall issue a notice of warning.

   b.2. If justification is accepted, the PRMC shall feedback to the health care provider.

   b.3. If justification is not accepted, the PRMC shall issue a notice of warning.

   b.4. For cases which the PRMC is unable to decide, they may refer to the Quality Assurance Committee (QAC) for quality issue.

   b.5. The QAC shall deliberate the referred case based on experts' opinion. The QAC shall issue resolution for all referred cases and forwards it to PRMC.

   b.6. The PRMC shall act based on the QAC recommendations and, whenever needed, endorses resolution to Legal Office for appropriate action and to AQAS for tagging in the Accreditation Database.

7. Is there a maximum number of penalties/sanctions? If yes, what will happen to the erring HCP?

Recidivists are health care providers who have been found guilty of the maximum number of offenses, i.e. four (4) for non-fraudulent offenses or three (3) for fraudulent offenses. They shall be meted the penalty of revocation of accreditation in accordance with the Scale of Administrative Penalties as prescribed in Section 170 of the revised IRR of RA 7875 amended by RA 10606, and may no longer be accredited by the Corporation.

8. When is the effectively of this policy?

This circular shall take effect fifteen (15) days after publication in any newspaper of general circulation and deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.

9. When was this circular published and what newspaper?

This circular was published on December 23, 2014 in Manila Bulletin.