Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
Call Center (02) 441-7442 Trunkline (02) 441-7444
www.philhealth.gov.ph

PHILHEALTH CIRCULAR
No. 031-2014

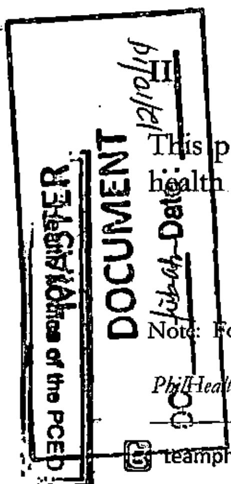
TO : ALL ACCREDITED HEALTH CARE PROVIDERS AND ALL OTHERS CONCERNED

SUBJECT : Health Care Provider Performance Assessment System (HCP PAS)

I. RATIONALE

As PhilHealth responds to the call for Kalusugan Pangkalahatan, the Corporation has institutionalized major reforms in implementing the National Health Insurance Program. Various efforts have been done to expand PhilHealth membership especially to provide insurance coverage for more poor and near-poor families from the list of the National Household Targeting System for Poverty reduction (NHTS-PR) of the Department of Social Welfare and Development (RA 10633 or General Appropriations Act FY 2014). Poor patients who were somehow missed in the identification of the poor are now being covered at the Point of Care (PhilHealth Circular 32, s. 2013). Moreover, the process of accrediting health care providers became faster and simpler: licensed health facilities are automatically accredited by just submitting the documentary requirements (PhilHealth Circular 54, s. 2012); less documentary requirements are required from health care professionals (Implementing Rules and Regulations of RA 10606 or the National health Insurance Act of 2013); and the accreditation of health care providers has become continuous by just submitting the documentary requirements or updating the health care provider information. Lastly, paying for PhilHealth benefits has become clearer and faster with the implementation of the All Case Rates (PhilHealth Circulars 31 and 35, s. 2013).

While PhilHealth has streamlined policies on membership especially of the poorest families, accreditation of health care providers and benefit payment, it is the Corporation's duty and responsibility to ensure that all accredited health care providers (HCPs) render accessible, safe, quality and affordable health care to Filipinos that are covered by the National Health Insurance Program. Consistent with the implementing rules of the 2013 National Health Insurance Act, PhilHealth shall strengthen the mechanisms to monitor the performance of accredited health care providers, assess the outcomes of the services that they render and provide feedback to the health care providers as well as the public. Alongside the assessment of health care providers, PhilHealth shall establish the process to encourage better provision of care, provide incentives for best performing health care providers and penalties and sanctions for those who repeatedly violate PhilHealth rules and other mandatory laws and regulations.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II. OBJECTIVES

This policy aims to establish procedures to monitor access to PhilHealth benefits, provision of quality health care and assurance of financial risk protection to all members.

Note: For Definition of Terms, please refer to Annex D

Specifically, it intends to:

1. Establish the different tools to assess the performance of accredited health care providers;

2. Establish the performance indicators that will guide in the analysis and disposition of the output of the performance assessment;

3. Standardize the process of recording, reporting and analyzing the performance of health care providers;

4. Establish a feedback mechanism that will serve as a basis for evaluation and the recommendation/s on remedial measures or sanctions to accredited health care providers, whichever is applicable; and

5. Create the PhilHealth Regional Monitoring Committee (PRMC) and establish its composition and responsibilities.

III. GENERAL GUIDELINES

1. The performance of health care providers shall be assessed using a set of indicators that will guide in the analysis and disposition of the output of the assessment. Core performance indicators shall be used to compare the performance of health care providers regardless of level or type of institution. The mentioned set of indicators are grouped into the following four (4) domains (**Annex A**):

    a. Performance indicators on Quality of Care
    b. Performance indicators on Patient Satisfaction
    c. Performance indicators on Financial Risk Protection (FRP)
    d. Performance indicators on Fraud Detection

2. PhilHealth through its regional offices shall regularly monitor and assess the performance of accredited health care providers.

3. PhilHealth shall employ various tools in assessing the performance of accredited health care providers such as but not limited to the following:

    a. electronic Medical Post-audit System (eMPAS)
    b. Mandatory Monthly Hospital Report (MMHR)

4. The performance assessment process encourages health care institutions to improve performance. As such, any identified poor performance or offense shall be reported back to the health care provider for validation and corrective measure. Validation may be through facility visit, review of facility reports and chart review. All validated reports shall be counted as PHILHEALTH FINDINGS.

5. Health Care Institutions shall ensure that their affiliated health care professionals perform according to the Performance Commitment that they have signed. Any breach of Performance Commitment committed by the health care professional shall be reported back to the health care institution and may be taken against the facility.

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6. All administrative offenses, classified as non-fraudulent and fraudulent, in Rule IV Sec. 168 and 169 of the new Implementing Rules and Regulations (IRR) of Republic Act (RA) 7875 as amended by RA 10606 shall be covered by this policy. In addition, all questionable/unethical practices as determined by the Quality Assurance Committee after post-audit findings as identified in Title IV Rule II Sec 47-e of abovementioned IRR, and other violations relative to quality healthcare delivery shall also be covered by this policy.

7. All non-fraudulent findings shall be subjected to two (2) warnings. A third warning shall already be regarded as one (1) offense and shall be referred to the Legal Sector of this Corporation for appropriate action in accordance with the provisions prescribed in the new IRR of RA 7875 amended by RA 10606.

8. For verified non-fraud violation, due to lapses in the clinical management, which may be contributory to a patient's death or permanent disability, issuance of warning may not be applicable. This violation shall be elevated to the appropriate regulatory body such as the Professional Regulations Commission (PRC), the Philippine Medical Association (PMA) or the Philippine Hospital Association (PHA) as applicable. The case shall also be forwarded to Legal Sector for appropriate action.

9. The accreditation database shall be used to store records of PhilHealth findings, warnings and offenses committed by health care providers including those justified and confirmed by PhilHealth. This system shall also be used by other offices of this Corporation to verify status of offenses of health care institutions.

10. The provider assessment period shall commence for all case rate claims with admission dates starting **January 1, 2014**, and to be done on a regular basis and whenever deemed necessary.

11. After having been found guilty for a maximum number of offenses as prescribed in Title IX Rule IV Section 171 of the new IRR of RA 7875 amended by RA 10606, the erring HCI shall be considered as **"recidivists".**

IV. SPECIFIC RULES

1. PhilHealth Regional Monitoring Committee (PRMC) shall be created by the regional offices. It shall be composed of the following:

    a. Chief of the Health Care Delivery Management Division (HCDMD) as **chair** (If the chair is not available, the co-chair shall be the one to preside)

    b. Head of the Legal Services Office as **co-chair**

    c. Head of the Benefits Monitoring Unit (BMU), if present

    d. Head of the Accreditation and Quality Assurance Section (AQAS)

    e. Head of the Benefits Administration Section (BAS)

    - For regions NCR and III, members shall be the BAS heads of the branches. Their voting power will only be for resolution of cases under their jurisdiction.

    f. Head of the Field Operations Division (FOD) or its equivalent

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- For regions that do not have FODs, the Regional Vice President/Vice President shall designate a representative

2. The PRMC shall:

   a. Recommend the issuance of a Notice of Warning (**Annex B**) to concerned HCP with the approval of the Regional Vice President/Vice President;

   b. Elevate non-fraudulent findings that need expert clinical opinion to the Quality Assurance Committee (QAC);

   c. Refer fraudulent findings and recommendations for serving of offense to the Fact-Finding Investigation and Enforcement Department (FFIED) for review and appropriate action; and

   d. Submit reports to the Standards and Monitoring Department (SMD) on regular basis. Monthly reports will be submitted for the performance monitoring of HCIs with red-flags (please see definition in Annex D) on or before the 10th day of the succeeding month, and quarterly reports for regular monitoring activities on or before the 10th day of first month of the succeeding quarter;

3. The office of the AQAS shall act as PRMC secretariat and shall be responsible for:
   a. Deliberating/evaluating initial monitoring findings;

   b. Providing feedback to Health Care Institutions on the results of monitoring activities, including the recommendations for corrective actions;

   c. Reviewing/evaluating/analyzing all submitted reports/referrals;

   d. Requesting additional information from health care institutions such as but not limited to clinical chart;

   e. Preparing special orders or the like to authorize conduct of facility visit with the approval of the Regional Vice President or Vice President;

   f. Filing of all reports/referrals and maintaining a database for all findings;

   g. Providing feedback to health care providers and other concerned offices; and

   h. Transmitting consolidated monthly report to the SMD.

4. The PRMC shall convene monthly or more frequently as necessary to deliberate on the findings. If upon deliberation, the finding is fraudulent, the Committee shall refer the case to FFIED for investigation. If non-fraudulent, the Committee shall provide feedback to the concerned health care provider. The health care provider shall then be required to provide explanation regarding the PhilHealth findings.

5. Reports on questionable/unethical practices, post audit reports and other performance monitoring findings shall come from field observations, member and patient complaints, facility visit reports, document review (claims and medical records), and claims database, among others. All reports shall be validated and any validated offense/questionable/unethical practices from field observations or

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member and patient complaints, facility visits, and chart reviews shall automatically be counted as PHILHEALTH FINDINGS, unless refuted by the concerned healthcare provider.

6. Questionable/unethical practices or claims findings observed from medical audit shall not be treated on a "per claim" basis. Counting of offenses shall be based on any single or combination of findings which will be done on a daily basis. Thus, any single or combination of questionable/unethical practices or claims findings noted in one batch of claims reviewed shall be treated as one, and shall be subject to validation. For it to be a PHILHEALTH FINDING, only one from the combination of questionable /unethical practices or medical audit claim findings must be validated through other monitoring tools such as chart review and field validation. Once validated, the feedback mechanism shall ensue.

7. All PHILHEALTH FINDINGS after each monitoring period (stated in Part VI of this circular) shall be submitted to the PhilHealth Regional Monitoring Committee (PRMC) for deliberation. Concerned health care providers shall be given feedback on all validated reports. The feedback mechanism shall require the concerned health care provider to provide explanations for such reports. The concerned health care provider shall be required to submit explanation within 15 calendar days from receipt of the feedback from PhilHealth. For non-submission of justification within the prescribed period, findings shall be considered a violation, thus, PRMC shall issue a Notice of Warning.

V. PROVIDER PERFORMANCE ASSESSMENT PROCESS

(Please see flow chart in Annex C)

1. The appropriate offices shall conduct monitoring using the following **primary monitoring tools** indicated below:

   (Please see details in Part VI of this circular)
   1.1. Claims/Services Profiling and Monthly Reports Review
   1.2. Medical Audit
   1.3. Surveys
   1.4. Complaints
   1.5. Facility visits

2. All reports shall be submitted to the PRMC Secretariat for consolidation and initial review.

3. The PRMC Secretariat shall encode and analyze all reports and feedback to the concerned office for reports/complaints with or without findings. Reports with good and bad findings shall be tagged in the accreditation database for reference.

4. Findings that do not require **secondary monitoring tools** such as Chart Review and Field Validation shall be deliberated by the PRMC. On the other hand, findings that warrant Chart Review shall be facilitated by the PRMC secretariat in coordination with the Local Health Insurance Office (LHIO) for the request of clear photocopies of the complete clinical chart.

5. The PRMC may recommend Field Validation whenever necessary during deliberation of findings.

6. Verified reports from secondary monitoring tools (chart review and field validation) shall be submitted to the PRMC for deliberation.

7. The PRMC shall identify the findings whether fraud or non-fraud based on the list below:

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NON-FRAUD	FRAUD
Non-Fraud violations 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. Unauthorized operations beyond service capability. 14. Filing of multiple claims 15. Non-compliance to provisions prescribed in the Performance Commitment which are not under fraudulent violations	Fraudulent violations 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 159 of 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)

8. For fraud finding, the PRMC with the approval of the Vice President or Regional Vice President and with a fact finding investigation report attached to the endorsement letter shall endorse to FFIED for evaluation.

9. After FFIED evaluation, all verified fraud violations shall undergo legal process. FFIED shall inform SMD for all verified fraud violations. Likewise, FFIED shall send feedback to the PRMC for findings without violation.

10. For non-fraud findings, the PRMC shall request explanation from the concerned health care provider. The concerned health care provider shall reply within 15 calendar days from date of receipt of the feedback letter. The PRMC shall issue a notice of warning for non-compliance. The PRMC shall reconvene and evaluate if the justification provided by the health care provider is acceptable. If acceptable and therefore not a violation, the PRMC shall feedback to the concerned health care provider. If justification is not acceptable, the PRMC shall issue a Notice of Warning. The PRMC Secretariat shall prepare a monthly report for all Notice of Warnings issued to health care providers and submit to SMD.

11. For findings which the PRMC is unable to decide, they may refer to the Quality Assurance Committee (QAC). The QAC is composed of representatives from 10 medical specialty societies.

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12. 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. 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.

13. For all deliberated findings that were confirmed and warned by the PRMC, appropriate penalty shall be imposed by the Legal Sector of this Corporation in accordance with the provisions prescribed in Title IX Rule IV Section 170 of the new IRR of RA 7875 as amended by RA 10606 and shall be tagged in the accreditation database for future reference.

14. For non-fraudulent PhilHealth Findings, erring HCPs shall be given a maximum of two (2) warnings. A third violation shall be forwarded to the Legal Office for possible sanction.

15. Consequently, HCIs that have been found guilty four (4) times for non-fraudulent offenses or three (3) times for fraudulent offenses by the Legal Sector of this Corporation shall be considered as recidivists and their accreditation shall be revoked.

VI. ASSESSMENT PERIOD AND SCHEDULE OF FEEDBACK

MONITORING TOOL	OBJECTIVE/ PURPOSE	RESPONSIBLE OFFICE	DATA COLLECTION	SCHEDULE OF FEEDBACK
1. Claims/ services profiling	To determine the claim characteristics of the health care providers	HCDMD/ BAS	Quarterly	15 days after every round of performance monitoring process
2. Mandatory Monthly HCI Report (MMHR) review	To determine the profile of health care providers in terms of patient load, bed occupancy rate and health service delivery through review of such reports.	HCDMD, AQAS, PRO-IT	Monthly	
3. Medical audit	To determine the compliance of accredited health care providers to standards of care and PhilHealth policies	BAS	Daily	
4. PhilHealth Patient Exit Survey (No Balance Billing and Case rates)	To determine the compliance of accredited health care providers to PhilHealth policies on No Balance Billing (quality of care and co-pay) and all case rates payment mechanism (benefit awareness, benefit utilization and co-pay) and determine which areas need improvement.	PCARES/ AQAS	Daily	

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MONITORING TOOL	OBJECTIVE/ PURPOSE	RESPONSIBLE OFFICE	DATA COLLECTION	SCHEDULE OF FEEDBACK
5. PCB1/Tsekap Client Exit Survey	To obtain feedback from members on the benefit awareness, quality, financial risk protection and satisfaction on services provided by accredited PCB1 and/or Tsekap providers as part of the system of outcomes assessment.	AQAS/LHIO	To be done during routine facility visit annually	15 days after every round of performance monitoring process
6. Member complaints	To evaluate the performance of health care providers based on member/patient complaints and address the concern accordingly.	Corporate Action Center (CAC), PRMC and FFIED (whenever applicable)	As reported	
7. Facility visits	To validate the compliance of accredited health care providers to PhilHealth policies and standards of care, as well as to assess health outcomes using facility reports (eg. DOH reports, Morbidity/Mortality Reports, Infection Control Reports) For NBB compliance, review of financial statement vs. PhilHealth benefit applied	AQAS	Annually or whenever necessary	
8. Chart Review	To validate the compliance of accredited health care providers to standards of care and PhilHealth policies as well as to assess health outcomes.	PRMC/ BAS/AQAS	Whenever necessary	
9. Field Validation	To validate initial monitoring findings as a result of claims profiling, medical audit, facility visits, surveys and member complaints.	BAS/AQAS and PAFT/PRO Legal Office	Whenever necessary	

Note: For Definition of Terms, please refer to Annex D

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VII. ANNEXES

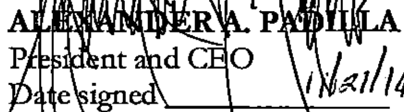
1. Performance indicators (**Annex A**)
2. Notice of Warning (**Annex B**)
3. Provider performance assessment process – flow chart (**Annex C**)
4. Definition of terms (**Annex D**)

VIII. REPEALING CLAUSE

All other issuances inconsistent with this circular are hereby revised, modified or repealed, accordingly.

IX. EFFECTIVITY

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.



ALEXANDER A. PADILLA
President and CEO
Date signed 11/21/14

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ANNEX A

PERFORMANCE INDICATORS ON QUALITY OF CARE
1. Number of admitted patients with primary care sensitive cases
2. Number of patients who were given inappropriate/irrational medicines/drugs
3. Number of patients who were given any of the 6 drugs under Anti-Microbial Resistance Surveillance Program (ARSP) in non-ARSP-accredited facilities
4. Number of patients who were subjected to inappropriate diagnostic services/laboratory procedures
5. Complication rate in the following procedures: • Normal Spontaneous Delivery (NSD) • Cesarean Section (CS) • Dilatation and curettage (D and C) • Appendectomy • Thyroidectomy • Cataract extraction
6. Number of patients who experienced healthcare associated infections (HAIs) such as the following: • Bloodstream infections related to central catheter use • Urinary tract infections related to catheter use • Respiratory infections from mechanical ventilators and artificial airways • Surgical site infections • Drug resistant infections • Emerging infections
7. Annual Net Death Rate
8. Referral rate for caesarian section
9. Occurrence of bed sharing among sponsored members
10. Bed occupancy rate
11. Bed turn-over rate
12. Multiple admissions of members and dependent for different case illnesses within 90 days
13. Number of patients with unjustified use of non-PNF* drug(s)

PERFORMANCE INDICATORS ON PATIENT SATISFACTION
1. Number of validated member or patient complaints on medical and/or administrative management
2. Number of patients satisfied with health care services
3. Number of patients satisfied with childbirth-related care

PERFORMANCE INDICATORS ON FINANCIAL RISK PROTECTION
1. Number of NBB patients with co-pay
2. Number of hospital claims with attached official receipts for drugs and medicines bought by PhilHealth members and/or dependents "out-of-pocket
3. Number of members with directly filed claims from non-accredited facilities due to emergency
4. Number of claims with under-deduction of case rates
5. Compliance to fixed-co pay for Z benefits
6. Compliance to service capability
7. Established trust fund account intended for PhilHealth reimbursements in LGU-owned facilities.

PERFORMANCE INDICATORS ON FRAUD DETECTION
1. 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)
2. Number of referred cases from MCP providers that were refused by a referral facility

*PNF- Philippine National Formulary

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ANNEX B

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PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City

Healthline 441-7444 www.philhealth.gov.ph

NOTICE OF 1st/2nd WARNING

Name of Medical Director/Name of MD
Name of Facility
Address

Dear Dr. ______________,

This is to inform you that upon the recommendation of the PRO Monitoring Committee /Quality Assurance Committee, this serves as your 1st/2nd warning.

As an accredited healthcare provider, we urge you to strictly abide by your Performance Commitment. PhilHealth will continue to conduct its mandate of monitoring performance to ensure that all participating healthcare providers to the National Health Insurance Program are responsible and accountable in all their dealings with the Corporation and its members.

Thank you.

Very truly yours,

____
Regional Vice President

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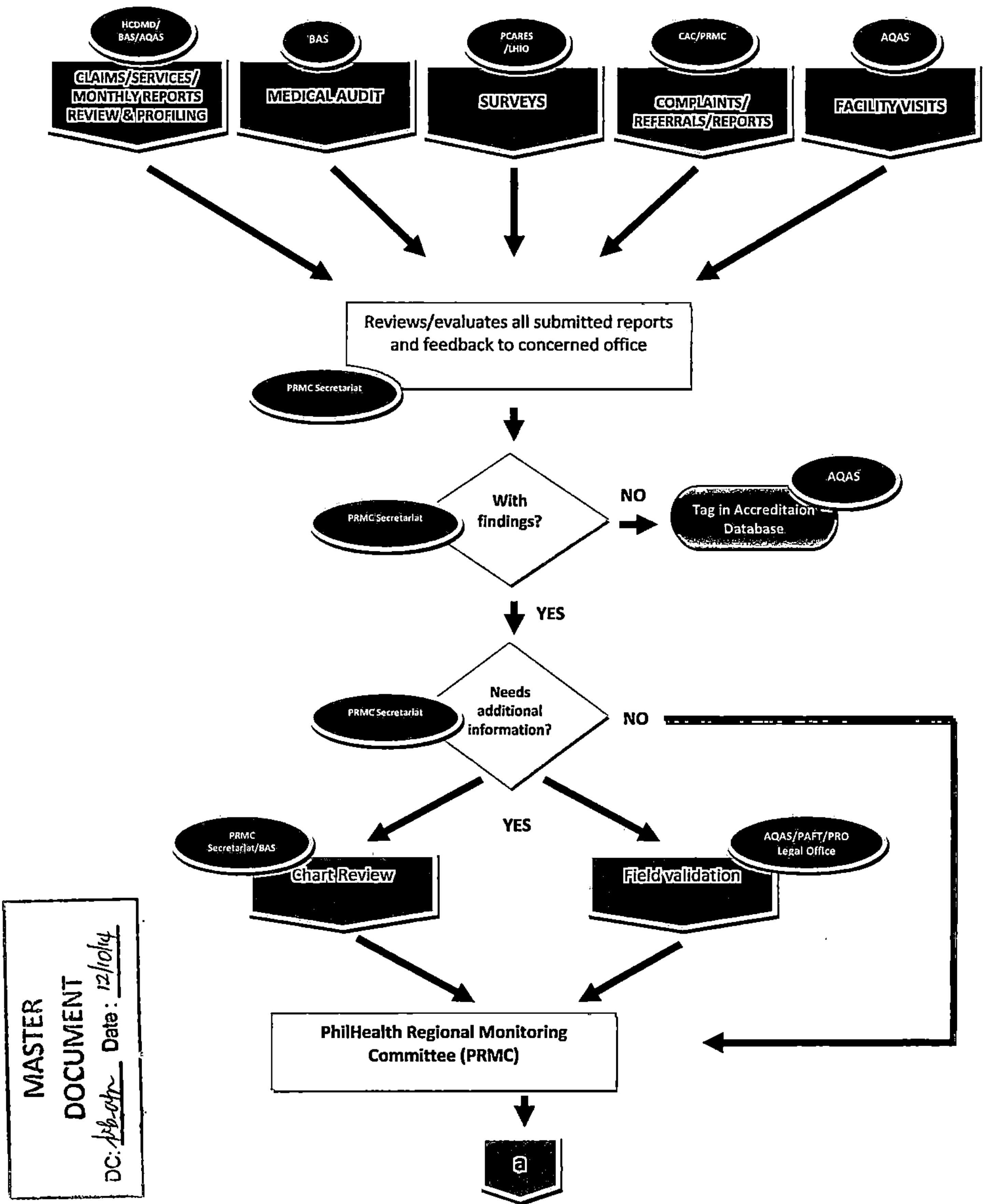
ANNEX C

HCP PERFORMANCE ASSESSMENT PROCESS – FLOW CHART



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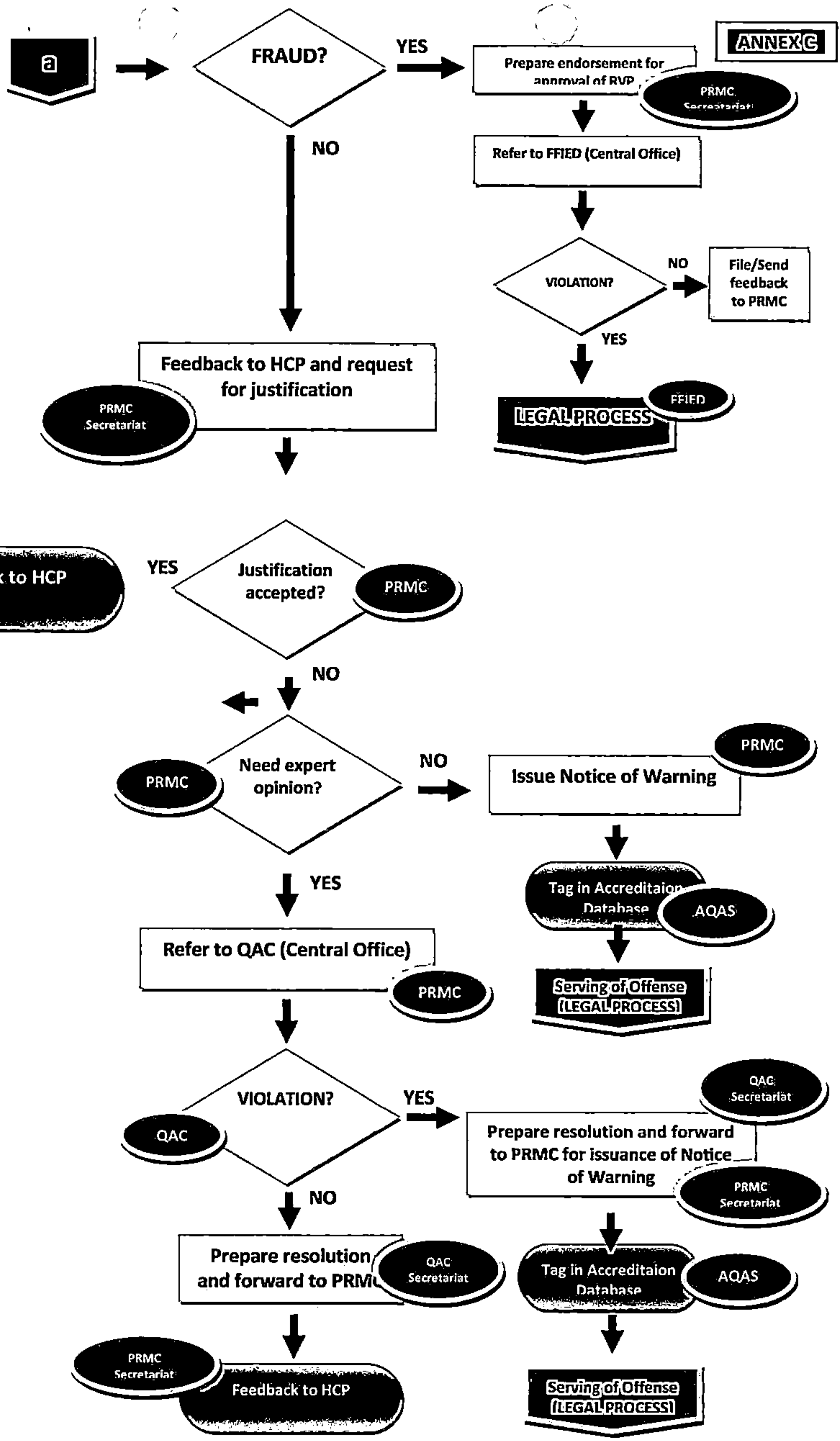

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ANNEX D

DEFINITION OF TERMS

1. **Annual Net Death Rate** - refers to the adjusted death rate (institutional death rate) excluding those that occur within the 48 hour period.

2. **Bed Occupancy Rate (BOR)** - percentage of authorized beds occupied by hospital inpatient over a period of time.

3. **Bed Turn-Over Rate** – the mean number of patients "passing through" each bed during each period. Indicates the use of available beds.

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

5. **Claims for Non-Admitted or Non-Treated Patients** - This is committed by any health care institution who, for the purpose of claiming payment from the Program, files a claim for a non-admitted or non-treated patient by:
   a. Making it appear that the patient was actually confined or treated in the health care institution; or,
   b. Using such other machinations that would result in claims for non-admitted or non-treated patient.

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

7. **Clinical Practice Guidelines (CPG)** – Systematically developed statements based on best evidence, intended to assists practitioners in making decisions about appropriate management of specific conditions or diseases.

8. **Complication** - a disease that appears during episode of care, due to pre-existing condition or arising as a result of the care received by the patient (source: ICD-10 book)

9. **Complication Rate** - Number of claims with complicated cases per condition / Total number of claims per condition (conditions are limited to those indicated in No. 5 of Annex A)

10. **Extending Period of Confinement** - This is committed by any health care 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.

11. **Fabrication or Possession of Fabricated Forms and Supporting Documents** - Any health care institution who is found preparing claims with misrepresentations or false entries, or to be in possession of claim forms and other documents with false entries.

12. **Facility visits** – is a regular announced or unannounced monitoring activity to assess the compliance of health care institutions to their Performance Commitment and established standards of care.

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13. **Family confinement** – hospital admission of the following persons for the same period regardless of the diagnosis:
    a. member and any of 3 qualified dependents
    b. any 4 of qualified dependents

14. **Feedback Mechanism** - the process by which the Corporation informs the health care providers of the results of the performance monitoring and outcomes assessment; part of the process is securing justification or explanation from the HCP for performance monitoring results that are inconsistent with PhilHealth policies including compliance to acceptable standards of quality and questionable/unethical practices.

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

16. **Filing of Multiple Claims** - Any health care institution who files two or more claims for a patient for the same confinement or out-patient treatment or illness.

17. **Financial Risk Protection (FRP)** – protection of the population from high and unexpected cost of illness.

18. **Healthcare Associated Infections (HAIs)** - are infections that are acquired as a result of health care interventions.

19. **Health Care Provider (HCP)** – refers to any of the following:

20. **Health Care Institution (HCI)** – refers to health facilities that are accredited with PhilHealth which include, among others, hospitals, Ambulatory Surgical Clinics (ASC), Tuberculosis Directly Observed Therapy Short course (TB-DOTS), Free-Standing Dialysis Clinics (FDC), Primary Care Benefit (PCB) facilities, and Maternity Care Package (MCP) providers.

21. **Health Care Professional (HCProf)** –doctor of medicine, nurse, midwife, dentist, pharmacist or other health care professional or practitioner duly licensed to practice in the Philippines and accredited by the Corporation

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

23. **Misrepresentation by False or Incorrect Information** - Any health care 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;
    b. **Upcoding** or **upcasing** or **diagnosis creeping** or **procedure creeping** – claiming for a related illness or procedure of higher severity or complexity to gain higher benefit payment;
    c. Adding a non-existing condition in the diagnosis in order to receive higher benefit payment.

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24. **Misrepresentation by Furnishing False or Incorrect Information** - Any health care institution shall be liable for fraudulent practice when, for the purpose of participation in the Program or claiming payment therefrom, it 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;
    b. **Upcoding** or **upcasing** or **diagnosis creeping** or **procedure creeping** – claiming for a related illness or procedure of higher severity or complexity to gain higher benefit payment; or,
    c. Adding a non-existing condition in the diagnosis in order to receive higher benefit payment.

25. **Monitoring Period** – the period of time for which the performance of a given HCI is being assessed. This depends on the monitoring tool that will be used, which includes medical audit, claims/service profiling, Facility visits, surveys and review of member complaints or referrals.

26. **Monitoring Tools** – used to gather information related to the performance of HCPs including but not limited to claims profiling, medical audit, surveys, complaints/referrals/reports and Facility visits.

27. **Notice of Warning** – a document which serves to warn the erring healthcare institution that a violation has been committed; this is served upon the recommendation of the Quality Assurance Committee and confirmed by the President/CEO of the Corporation (e.g. Quality Assurance Committee, Accreditation Committee, Audit Group)

28. **Offense** - any confirmed violation after due process. Due process includes feedback, notice of warning for non-fraudulent violations and deliberation of the deciding body as authorized by the Corporation. The type of offense shall be categorized according to Title IX Rule IV Section 170 of the revised IRR of RA 7875 amended by RA 10606.

29. **Other Fraudulent Acts** - Any health care institution shall also be liable for the following fraudulent acts:
    a. Making it appear that the patient suffered from a compensable illness or underwent a compensable procedure;
    b. Failure or refusal to give benefits due to qualified members/dependents;
    c. Charging qualified patients for medicines and/or services which are legally chargeable to and covered by the Program;
    d. Failure or refusal to refund to the member the payment received from the Program within a period of thirty (30) days from the date of receipt of the refund check from the Corporation when the hospital charges and professional fees are fully paid in advance by the member;
    e. Failure or refusal to accomplish and submit the required forms in connection with letter d.;
    f. Failure or refusal to provide the members with the required forms for direct filing of claims, billing statements, official receipts and other documents required/necessary for filing of claims; or,
    g. Deliberate failure or refusal to comply with the requirements of RA 7875 as amended and this Rules.

30. **Padding of Claims** – any health care institution who, for the purpose of claiming payment from the Program, files a claim for benefits which are in excess of the benefits actually provided by adding drugs, medicines, supplies, procedures and services.

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31. **Performance Commitments** – a document signed by the health care institutions who intend to participate in the program, which stipulate their undertakings to provide complete and quality services to PhilHealth members and their dependents, and their willingness to comply with PhilHealth policies on benefits payment, information technology, data management, and reporting and referral, among others.

32. **Performance Monitoring Process** – a systematic sequence of steps to evaluate accredited health care providers using the outcome indicators described in Annexes 1-3 as guides to identify opportunities for improvement in health care delivery. This process involves the different divisions and units in the regional office, as well as different departments in the central office. The steps and tools that will be used are claims profiling, medical audit, surveys, complaints, Facility visits, chart review and field validation.

33. **PhilHealth Finding** - any confirmed or validated violation identified though monitoring of HCP's performance. Such finding, along with the HCP explanation/justification, shall be presented to and deliberated by a deciding body authorized by the Corporation,.

34. **Post-Dating of Claims** - Any health care institution who, for purposes of claiming payment from the Program, files a claim for payment of services rendered not within sixty (60) 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 changing, erasing, adding to the period of confinement or in any manner altering dates so as to conform with the adopted prescriptive period.

35. **Primary Care Sensitive Cases** – refer to hospital admissions for condition ideally managed in the primary care level facilities as identified under PCB Package such: HPN, DM, asthma, AGE, URTI, and UTI.

36. **Quality Assurance** – a formal set of activities to review and ensure the quality of services provided. It includes quality assessment and corrective actions to remedy any deficiency identified in the quality of patient care, administrative and support services.

37. **Questionable practice** – practice patterns/behaviour of healthcare professionals that are found to be inconsistent with acceptable standards of quality and are not in accordance to the code of ethics set by a recognized healthcare professional body and/or by the Professional Regulations Commission.

38. **Recidivists** – are health care providers who have been found guilty of the maximum number of offenses and meted the penalty of revocation of accreditation in accordance with the Scale of Administrative Penalties as prescribed in Section 170 of the revised IRR, and may no longer be accredited by the Corporation.

39. **Red Flag** – a tag used for health care providers with observed unusual practices that are not supportive of the National Health Insurance Program (NHIP) goals.

40. **Referral** - the process of directing or redirecting (as a medical case or a patient) to an appropriate specialist or agency for definitive treatment (source: Merriam-Webster Medical Dictionary)

41. **Referral Rate** - Number of claims on referral package per Obstetric condition / total number of paid claims per obstetric condition (obstetric conditions limited to MCP, NSD and CS)

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ANNEX D

42. **Surveys** – A detailed study of a market or a geographical area to gather data by polling a section of the population such as but not limited to NBB/case rate exit surveys, patient satisfaction survey.

43. **Tagging** – an automated or manual labelling to identify claims for medical audit.

44. **Unauthorized Operations Beyond Service Capability** - Any primary care facility which performs a surgical operation beyond its authorized capability except when the operation is done in an emergency to save life and referral to a higher category provider is physically impossible.

45. **Unjustified Admission Beyond Accredited Bed Capacity** - Any private health care institution who, for the purpose of claiming payment from the Program, files claims for patients confined in excess of its accredited bed capacity at any given time without justification in the form and manner prescribed by the Corporation.

46. **Violation** – any breach of PhilHealth policies and acceptable standards of quality committed by accredited Health Care Providers.

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