



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. 015 - 2015

TO : ALL PHILHEALTH MEMBERS, ACCREDITED HEALTH CARE PROVIDERS (HCPs), PHILHEALTH REGIONAL OFFICES (PROs), AND ALL OTHERS CONCERNED

SUBJECT : CHARGE TO FUTURE CLAIMS (CtFC) POLICY

I. RATIONALE

The Corporation, through the National Health Insurance Act of 2013, utilizes the power to set standards, rules and regulations necessary to efficiently and effectively manage the funds intended for the member's hospitalization benefits. And as part of its quasi-judicial powers, the decisions made by the Corporation shall immediately be executory when the public interest so requires.

The underlying principle of CtFC is primarily a preventive measure to dissuade any potential violation by the service providers on the rights and privileges of PhilHealth members under their care, especially those under the "No Balance Billing (NBB)" policy program.

The Corporation recognizes that for the program to be sustainable, under-deduction of PhilHealth benefits by the health care institution must be avoided whether it was done intentionally or inadvertently. The goal of the Corporation is to persuade the health care providers from avoiding such grievous mistake by appealing to their sense of solidarity with the poor patients they are serving. However, when necessary, the full force of the Corporation's power must be brought to bear upon those institutions that consistently violate the public trust. If left unchecked, even the most miniscule violation can ripple through the program and can potentially threaten its very existence by doing unimaginable harm to the PhilHealth members. Hence, the need for "charge to future claims".

Consistently, as we maneuver efficiency in the utilization of benefit fund and services for members and partners' satisfaction, this Circular is being issued to facilitate the settlement of account/s that would synchronize procedures on applying receivables to current benefit reimbursements for National Health Insurance Program (NHIP) benefit payments of accredited HCIs.

II. SCOPE

This Circular shall cover the following cases (Annex 1: sample cases):

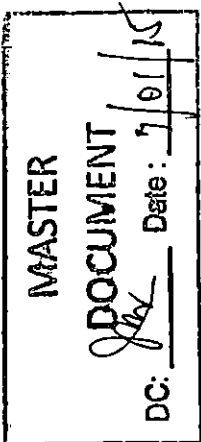
- A. NBB eligible PhilHealth members and their dependents that were made to pay out-of-pocket for treatment-related diagnostic/laboratory examinations, drugs, medicines,

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- supplies and other services to include professional fees during the confinement period of the patient as stipulated in PhilHealth Circular 3, s. 2014 and other related issuances.
- B. Validated claims of PhilHealth members and their dependents found to have underdeduction of PhilHealth benefits based on what was claimed and/or paid for by PhilHealth to health care providers.
 - C. If the delay in the filing of claim is caused by the health care provider and the benefits had already been deducted, the claim will not be paid. If the benefits are not yet deducted, it will be paid to the member chargeable to the future claims of the health care provider. [Section 47 item a.3 Implementing Rules and Regulations of the National Health Insurance Act of 2013 (RA 7875 as amended by RA 9241 and RA 10606)].

III. GUIDELINES

- A. Filing of the request for refund with PhilHealth
 1. The request for refund may be filed by the member, patient, next of kin or authorized representative.
 2. The requesting party may file for refund in any of the following situations:
 - a. prior to discharge of the patient,
 - b. within sixty (60) calendar days from the date of discharge OR
 - c. within sixty (60) calendar days from the receipt of the Benefit Payment Notice (BPN) whichever is later
 3. The requesting party shall completely fill-out the Request for Refund Form (RRF) made available through the following:
 - a. Downloadable from the PhilHealth website: www.philhealth.gov.ph OR
 - b. PCARES assigned in selected accredited HCIs OR
 - c. PhilHealth offices (PROs, Local Health Insurance Offices, Satellite Offices, PhilHealth Express) OR
 - d. Health Care Institutions
 4. The completely filled-out RRF shall be submitted to the following:
 - a. PCARES assigned in selected accredited HCIs OR
 - b. Any of the PhilHealth offices (PROs, Local Health Insurance Offices, Service offices, PhilHealth business centers).
 5. Document/s that shall be submitted along with the RRF:
 - a. For NBB eligible patients with out of pocket
 - i. Official receipt/s (original copies) for the diagnostic examination, laboratory tests, drugs, medicines, supplies, other services to include professional fees etc. OR
 - ii. Document/s (original copies) that will prove the out-of-pocket expenses OR
 - iii. Document/s deemed necessary by PhilHealth.
 - b. For claims with underdeduction of PhilHealth benefits
 - i. Statement of Account (SOA), original copy duly signed by the HCI representative & the member/ representative and
 - ii. Official receipts (original copies) for HCI fees and/or professional fees to support the under deduction.
 - c. For claims with delay in filing caused by the health care provider.
 - i. BPN with notice of denied claim, original receipt/s, SOA and validation report from PRO
 6. Other source documents for the application of CtFC policy maybe any of the following:



- a. PCARES report
- b. Submitted claim forms
- c. Monitoring findings/reports conducted by PhilHealth

B. Processing of the request for refund and application of the CtFC policy

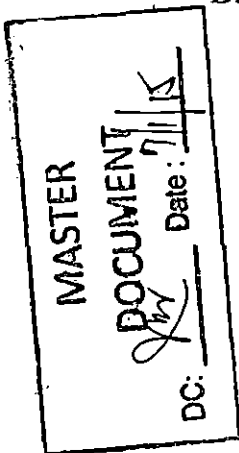
1. The receiving PhilHealth office shall forward the completely filled-out RRF plus the supporting documents to the PhilHealth Regional Monitoring Committee (PRMC) secretariat of the concerned PRO.
2. The PRMC secretariat shall conduct preliminary evaluation of the RRF plus supporting documents and prepare the staff work for inclusion in the agenda of the PRMC meeting for deliberation.
3. The result could either be one of the following:
 - a. Approved – the request for refund of the PhilHealth member or patient is granted. The amount that shall be charged to the future claims shall be indicated.
 - b. Denied – the request for refund of the PhilHealth member/patient is not granted which may be due not exclusively to the following: invalid official receipts/supporting documents and OOP is incurred beyond the confinement period of the patient or the medicines, supplies or diagnostic procedure reflected in the official receipt/s are not indicate for the medical condition of the patient.
 - c. Deferred – the PRMC shall require additional documents or validation to come up with the decision of approval or denial of the request.
4. PRMC Secretariat shall notify, through a letter, the HCI and the member of the PRO decision.

C. Application of the CtFC policy

1. For approved requests for refund, the CtFC policy shall be applied. The future claims of the concerned HCI shall be deducted twice (2x) the approved amount for refund due to the PhilHealth member/patient as determined by the PRO. Only the exact amount determined by the PRO shall be refunded to the member/patient. The rest of the deducted amount from the future claims shall be recorded in the Trust Liability Account under the General Fund of the Corporation and reflected in the Subsidiary Ledger of the concerned HCI account.
2. No payments shall be released to the HCIs until such time that the CtFC amount has been fully settled/deducted from the future claims.

D. Feedback to HCIs on the deductions made from the reimbursements due to CtFC

1. The Accounts Payable Voucher (APV) shall reflect the amount that has been deducted due to CtFC. However, there shall be no generation of check and/or crediting of amount to the HCI bank account for those on Auto Credit Payment System (ACPS) until such time that the CtFC amount has been fully deducted.
2. PhilHealth shall provide the HCIs corresponding Notice of Charges to Future Claims with details as follows: (1) period covered; (2) reasons for charging; (3) amount debited; and (4) remaining amount for charging to the HCP's future claims.
3. The HCI portal may be a means to provide feedback to the HCIs relative to CtFC for efficiency purposes.



IV. FILING OF MOTION FOR RECONSIDERATION (MR)

- A. Both HCI and the member/patient may file for MR on the PRO decision within fifteen (15) calendar days from receipt of the decision of the PRO.
- B. The MR shall be addressed to the regional vice president of the concerned PRO.
- C. The HCI and the member/ patient shall ensure that relevant documents pertaining to their MR shall be submitted at the time of the filing of MR.
- D. The MR shall be deliberated by the PRMC within thirty (30) calendar days from receipt of the MR.
- E. A written communication to the HCI and the member/ patient stating the decision of the PRO shall be sent within fifteen (15) calendar days from approval of the decision.

V. FILING OF APPEAL

- A. Both the HCI and member/patient may file for an appeal for the denied MR within fifteen (15) calendar days from receipt of the notice of the denied MR with the concerned PRO.
- B. The appeal letter shall be addressed to the regional vice president (RVP) of the concerned PRO and shall be forwarded together with the staff work report to the Protest and Appeals Review Department (PARD) of the Central Office for deliberation.
- C. The appeal shall be deliberated and decided upon within sixty (60) calendar days from receipt of the appeal letter by PARD.
- D. A written notice from PARD, indorsed by the PRO, shall be sent to the concerned HCI stating the decision within thirty(30) calendar days from the approval of the decision on the appeal.

VI. MONITORING AND EVALUATION

The health care provider shall be subjected to the rules on monitoring and evaluation of performance as provided for in PhilHealth Circular No. 54, s-2012: Provider Engagement through Accreditation and Contracting for Health Services (PEACHeS) and PhilHealth Circular No. 031-2014 re: Health Care Provider Performance Assessment System (HCP PAS).

Application of CtFC policy is without prejudice to the filing of appropriate charges in the proper courts of law as the Corporation may deem necessary.

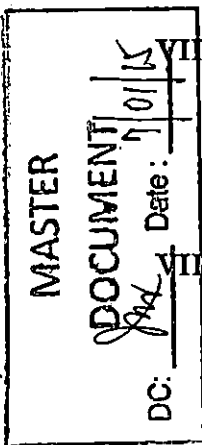
VII. REPEALING CLAUSE

All provisions of previous issuances, circulars, and directives that are inconsistent with any of the provisions of this Circular for this particular circumstance wherein the same is exclusively applicable, are hereby amended, modified or repealed accordingly.

VIII. SEPARABILITY CLAUSE

In the event that a part or provision of this Circular is declared unauthorized or rendered invalid by any Court of Law or competent authority, those provisions not affected by such declaration shall remain valid and effective.

IX. TRANSITORY PROVISIONS

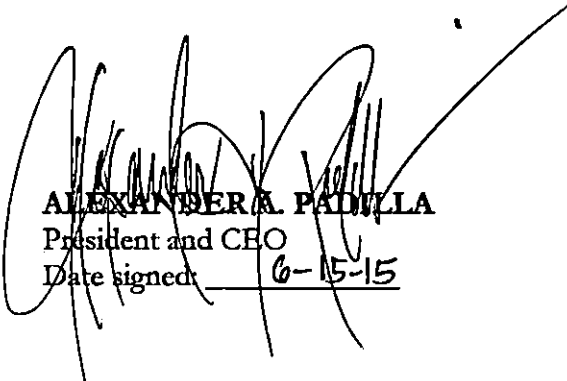


Claims for admission before the effectivity of this Circular shall be deducted/charged only with the exact amount due for refund to the PhilHealth member/patient.

X. EFFECTIVITY

This Circular shall take effect on AUGUST 1, 2015. Claims for admission starting SEPTEMBER 1, 2015 shall be charged twice (2x) the approved refund amount due to the PhilHealth member/patient.

The Circular shall be published in any newspaper of general circulation and shall be deposited thereafter with the National Administrative Register at the University of the Philippines Law Center.


ALEXANDER A. PADILLA
President and CEO
Date signed 6-15-15

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SAMPLE CASES

Example 1:

Mr. X, 75 y/o male, an indigent member of PhilHealth was admitted for 6 days in Hospital A, a government Level 2 hospital due to abdominal pain specifically in the right lower quadrant. Subsequently he underwent appendectomy. The patient was not charged (HCI fee and professional fees) by the hospital. However, he incurred an out – of – pocket (OOP) expense because he was asked to buy the unavailable IV antibiotics and other medicines in the drugstore outside of the hospital amounting to Php 5,000.

Table 1: Computation of the CtFC amount for Example 1

Case Rate	Amount of the IV antibiotics and other medicines bought outside of the hospital	CtFC amount = OOP X 2
Appendectomy (Php 24,000)	Out of Pocket (OOP) is equivalent to Php 5,000	Php 5,000 x 2 = 10,000

Example 2:

Patient Z, 60 y/o female, admitted and managed for pneumonia high risk in a government level 3 hospital. Date of admission is September 1, 2015. Upon discharge, the PhilHealth benefit deducted was only Php 15,000 instead of Php 32,000. The OOP expense of member is Php 17,000. The claimed and reimbursed amount by PhilHealth is Php 32,000.

Table 2: Computation of the CtFC amount for Example 2

Case Rate	Underdeducted amount	CtFC amount = underdeducted amount X 2
Pneumonia high risk Case rate amount =Php 32,000	Php 17,000	Php 17,000 X 2 = 34,000

Example 3:

Ms. Y, 28 y/o female, an LGU sponsored member gave birth via normal spontaneous delivery (NSD) in a private maternity clinic last September 14, 2015. She was charged Php 8,000 for the Maternity Care Package (MCP). Claim was received by PhilHealth Office 60 days after discharge of the member/ patient and the claim was subsequently denied due to late filing.

Table 3: Computation of the CtFC amount for Example 3

Case Rate	OOP for PF	CtFC amount = Underdeducted amount X 2
Maternity Care Package (MCP) <i>With package code MCP01</i> (Php 8,000)	Php 8,000	Php 8,000 X 2 = 16,000

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