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The Level of Effectiveness of PhilHealth Claims Processing in Sorsogon Medical Mission Group Hospital and Health Services Cooperative

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***Abstract*—** Many healthcare providers in the Philippines are complaining about the delays in payment of PhilHealth of their arrears. In line with this, the researcher would like to determine if the delay starts from the provider itself. Moreover, it can be observed nowadays that healthcare services are availed by many. This suggests more transactions related to health insurance. Therefore, healthcare facilities need proper monitoring to know if claims are processed and paid for by insurance companies. This study was made to know the level of effectiveness of PhilHealth claims processing of one of the private hospitals in Sorsogon City, which is Sorsogon Medical Mission Group Hospital and Health Services Cooperative (SMMGHHSC). It is by determining the status of these claims in terms of the average number of days to collect documents, transmit the claims to the said insurance company, convert receivables into cash, reprocess the returned claims, and the status of current systems being utilized. Further, the level of effectiveness of processing these claims along with document requirements and timeliness, as well as the gaps and issues encountered in the process, were also determined. This could help other institutions to evaluate and improve their internal process. All employees of the Claims Unit of SMMGHHSC, comprising eight (8) staff from the hospital and three (3) staff from its satellites, serve as respondents. This study used a questionnaire, and interview and involved the process of observation in obtaining relevant data in attaining the desired result. The researcher also culled out actual patients' records to support the aforementioned data-gathering procedures. Further, the triangulation method was used on patients' records covering the year 2021 confinement, to develop a comprehensive understanding of the data.

***Keywords*—** PhilHealth Claims, Level of Effectiveness, Claims Processing

I. INTRODUCTION

The COVID-19 pandemic has made the entire world realize that medical exigencies are unpredictable and can cause a financial upheaval that is tough to handle. With a high infection rate, people have started to understand the importance of having a good health insurance plan. Besides, with the rising cost of medical expenses, access to good medical facilities and hospitalization costs can be financially strenuous. Therefore, getting a health insurance cover for yourself and your family can provide the added protection one needs in times like these. Apart from the obvious benefit of having the financial confidence to take care of ones loved ones, a health insurance plan is extremely useful when it comes to beating medical treatment inflation. A health insurance policy is an essential requirement in today's fast-paced lifestyle.[1]

As more people avail healthcare services, more transactions related to health insurance arise. It means that hospitals or healthcare facilities need proper monitoring to know if claims are processed and paid. In the Philippines, it is PhilHealth that administers the National Health Insurance Program, which was established to provide health insurance coverage and ensure affordable and accessible health care services for all Filipinos. Its members are categorized into formal economy, informal economy, sponsored members, indigent members, lifetime program and senior citizens. It provides various types of medical benefits. These include inpatient benefits, outpatient benefits, primary care benefits, Z benefits, MDG benefits and other special benefit packages. These benefits are paid to the healthcare institutions (HCIs) through All Case Rates. These rates are fixed amount for each illnesses/case, hence, it depends on the final diagnosis. The case rate amount shall be deducted by the HCIs from the member's total bill. It is inclusive of hospital charges and professional fees of attending physicians. These deductions are claims that will be reimbursed by PhilHealth if the institution complied with the requirements. Because of PhilHealth's wide scope of coverage, there are more claims created. Thus, proper monitoring of these claims must be in place to ensure payment.

Asokre and Nwankwo[2] defined claim as a demand made by the insured person to the insurer for the payment of benefits under a policy. IBM[3] cited that the speed, accuracy, and effectiveness of claims processing is also paramount for controlling costs, managing risks, and meeting portfolio underwriting expectations.

An article from the masterclass.com[4] defined universal health care as a broad term that encompasses any action that a government takes to provide health care to as many people as possible. Some governments do this by setting minimum standards and regulations and some by implementing programs that cover the entire population. However, the ultimate goal is health coverage for all citizens. The most obvious advantage of universal health care is that everyone has health insurance and access to medical services and that no one goes bankrupt from medical fees.

According to World Health Organization (WHO),[5] the universal health coverage means that all people have access to the health services they need, when and where they need them, without financial hardship. It includes the full range of essential health services, from health promotion to prevention, treatment, rehabilitation, and palliative care.

A universal care system would reduce administrative costs by expanding economies of scale, streamlining processes, and cutting insurance companies' marketing costs and profits from our national health care bill. At the same time, costs for drugs and procedures would be kept in check by increased transparency, as well as increased governmental bargaining power and rate-setting authority.[6]

Universal health coverage (UHC)[7] is about ensuring that people have access to the health care they need without suffering financial hardship. It is key to achieving the World Bank Group's (WBG) twin goals of ending extreme poverty and increasing equity and shared prosperity, and as such it is the driving force behind all of the WBG's health and nutrition investments. UHC allows countries to make the most of their strongest asset: human capital. Supporting health represents a foundational investment in human capital and economic growth—without good health, children are unable to go to school and adults are unable to go to work. It is one of the global economy's largest sectors and provides 50 million jobs, with the majority held by women.

The United States is the only industrialized country in the world that does not have Universal Health Coverage for all citizens. Some countries – Canada and Taiwan – have developed single-payer models to care for their citizens. Other countries such as Germany, Switzerland, and Singapore have shown that it is possible to have universal coverage through a combination of public funding, employer participation, and personal responsibility while maintaining a robust competitive market of insurance payers and medical providers.[8]

The 1987 Philippine Constitution declares that it is the policy of the State to protect and promote the right to health of the people and instill health consciousness among them. In February 2019, the President of the Philippines signed the Universal Health Care Bill into law, ushering in massive reforms in the Philippine health sector. Among the salient factors of the UHC Law is the expansion of population, service, and financial coverage through an array of health system amendments. Along with this is a planned paradigm shift to primary care, which is the core and center of all health reforms under the UHC.[9]

Republic Act No. 11223,[10] otherwise known as the Universal Health Care Act, states that the State shall adopt (a) An integrated and comprehensive approach to ensure that all Filipinos are health literate, provided with healthy living conditions, and protected from hazards and risks that could affect their health; (b) A health care model that provides all Filipinos access to a comprehensive set of quality and cost-effective, promotive, preventive, curative, rehabilitative and palliative health services without causing financial hardship, and prioritizes the needs of the population who cannot afford such services; (c) A framework that fosters a whole-of-system, whole-of-government, and whole-of-society approach in the development, implementation, monitoring, and evaluation of health policies, programs and plans; and (d) A people-oriented approach for the delivery of health services that is centered on people's needs and well-being, and cognizant of the differences in culture, values, and beliefs.

According to the Department of Health (DOH),[11] with UHC, all Filipinos are guaranteed equitable access to quality and affordable healthcare goods and services and protected against financial risk. The UHC helps ensure every Filipino is healthy, protected from health hazards and risks, and has access to affordable, quality, and readily available health service that is suitable to their needs.

Under the said law, there will be more members who will avail of PhilHealth benefits because of its population coverage. Philippine Health Insurance

Corporation or PhilHealth was established to provide health insurance coverage for all Filipinos and ensure affordable, acceptable, available, and accessible health care services for all citizens of the Philippines. The benefits of a PhilHealth member are inpatient, outpatient, primary care, Z, MDG benefits, and other Special Benefit Packages.[12]

Official Gazette of the Republic of the Philippines[13] stated that as of June 30, 2015, a total of 89,417,720 beneficiaries, equivalent to 88% of the Filipino population, are already covered by PhilHealth. But with the signing of the UHC Act, all Filipinos are already automatically included under National Health Insurance Program (NHIP) – making PhilHealth's coverage rate at 100%.

However, the 2020 Stats and Charts of PhilHealth[14] revealed that the total beneficiaries (members and beneficiaries) who are registered in their database are 59,134,723 and 36,865,033 for direct and indirect contributors, respectively, for a total of 95,999,756 Filipinos. In addition, there are 9,731 PhilHealth-accredited health care institutions and 47,693 health care professionals all over the Philippines as of December 2020.

Since it expands its financial protection and access to health services, these will create voluminous transactions with the said company. But with the innovation and technologies, most of the processes nowadays have improved. The insurance sector is not an exception to these developments. Health insurance claims are now filed electronically which requires little effort from patients and the HCI itself.

The article from moneymax.ph[15] published on October 9, 2020 states that as of 2014, the hospitalized members need not directly file their claims. As direct filing is no longer needed, submission of the documents to the hospital before the end of your stay means automatic deduction of your benefits from ones total hospital bill.

There are several advantages that electronic claims submission has to offer over traditional methods. Convenience is the first thing that comes to mind—along with the increased speed that comes from not having to wait for paperwork to move through the mail system.[16]

Apaservices.org[17] stated that the filing of claims electronically can offer many benefits. It helps to minimize disruptions to cash flow, track claim status, increase accuracy and cut down on claim rejections, cut down on paperwork, decrease overhead costs and staff time. Moreover, there are many electronic claim providers exist in the marketplace, and practitioners should choose a provider carefully based on their administrative needs and budget.

In line with the pandemic, the Philippine Health Insurance Corporation assured the public that it is committed to paying benefits due to all Covid-19 patients. It clarified that it has the responsibility to the Filipino people to make sure that their fund is always ready to continue paying for Covid-19 patients as well as the rest of the needy members in the country. However, there are issues of unpaid claims which arise again during this pandemic from different accredited providers.[18]

The economic losses brought about by the pandemic have taken their toll on the overall business climate in the country. It also affects hospitals that reel from the sharp decrease in inpatient admissions due to the COVID scare. Hospitals rely on their collections from patients and from the health insurance companies, to continue their operations. Generally, PhilHealth receivables are the biggest among all receivables of almost HCIs.

The PhilHealth's List of Accredited Health Facilities[19] updated as of May 31, 2021, includes three (3) Level 3 accredited hospitals, 19 Level 2 hospitals, and 32 Level 1 hospital in Region V. Aside from hospitals, other health care facilities are also accredited in PhilHealth such as Ambulatory Surgical Clinics, Freestanding Dialysis Clinics, Maternity Care Package Providers, Animal Bite Package Providers, Accredited Primary Care Facilities (Infirmary/ Dispensary), Family Planning Providers, TB-DOTS Centers, Drug Abuse Treatment and Rehab Centers, and DOH-Designated HIV Treatment Hubs.

In Sorsogon City, there are three (3) accredited Level 2 hospitals. These are Metro Health Specialists Hospital, Inc., Sorsogon Medical Mission Group Hospital and Health Services Cooperative (SMMGHHSC), and Sorsogon Provincial Hospital. Moreover, there are five (5) Level 1 hospitals. These are Castilla District Hospital, Chacon General Hospital, Inc., Donsol District Hospital, Gubat District Hospital, and Irosin District Hospital.

The researcher was encouraged to study the level of effectiveness of transmittal of PhilHealth claims in SMMGHHSC to explore the records and procedures and to find tools on how to improve the collection of receivables from the said insurance company.

II. OBJECTIVES

This study determined the status of PhilHealth claims in SMMGHHSC in terms of (a) the average number of days in processing PhilHealth documents before transmittal; (b) the average number of days to transmit the PhilHealth claims; (c) the number of days to convert receivables into cash; (d) the average number of days to reprocess the returned claims; and (e) current system utilized.

Further, it measured the level of effectiveness of PhilHealth processing claim along documents requirements and timeliness. It also identified the gaps and issues encountered with the processing PhilHealth claims.

III. METHODOLOGY

This study utilized the Mixed Method of Research, both quantitative and qualitative methods of research. For quantitative, it considered the Descriptive Method. This method is a fact-finding study with adequate and accurate information. It constitutes gathering, summarizing, and interpreting data. Moreover, it involves the elements of interpretations of the meaning or significance of what is described. This study also employed a qualitative method that encompassed interviews and observation to gain in-depth knowledge about the subject.

Such methods were used to determine the status of PhilHealth claims, the current system being utilized by SMMGHHSC, its level of effectiveness, the gaps and issues encountered, and the new system that can be proposed to improve the processing of these claims.

IV. RESULTS AND DISCUSSION

The following results were gathered, analyzed and interpreted by the researcher based from the objectives of the study. Tabular presentation and textual analysis and interpretation were also used.

1. Status of PhilHealth Claims in SMMGHHSC

Sorsogon Medical Mission Group Hospital and Health Services Cooperative (SMMGHHSC) is a 100-bed capacity hospital located at Maharlika Highway, Pangpang, Sorsogon City. It was duly registered with Cooperative Development Authority (CDA) under registration number 9520-05010541 on March 18, 1994, through its twenty-two (22) original cooperators. It runs various services such as general outpatient services, inpatient services, laboratory, diagnostic imaging (X-Ray, CT-scan, and Ultrasound), Heart Station (2D Echo, ECG, and Stress Test), Pharmacy with home delivery services, nutrition and dietetics, physical therapy rehabilitation, hemodialysis, dental services with panoramic X-Ray capability, bronchoscopy, endoscopy, operating room, and delivery room services, respiratory, high-risk pregnancy unit, PPMD/PMDT Treatment, Animal Bite Center, ambulance and patient transport services, domiciliary care, mobile diagnostics, molecular laboratory, and electroencephalogram (EEG).

SMMGHHSC is one of the PhilHealth-accredited Health Care Institutions (HCIs) in Sorsogon City. This means that patients can avail of PhilHealth benefits when confined in the said institution. Benefits are in a form of a deduction from the total charges on their bill, which the amount depends on the final diagnosis of the attending physician. This is how a claim from PhilHealth is created.

In recent years, the entitlement of PhilHealth members was based on their corresponding premium payments. But under Universal Health Care (UHC) Law, all Filipinos are now automatically included in the National Health Insurance Program. This makes PhilHealth's coverage to be at 100%. Hence, all Filipinos are entitled to PhilHealth benefits, subject to existing policies. Due to larger population coverage, the number of claims to be processed by hospital staff is expected to increase.

Number of days in processing PhilHealth documents before transmittal

Generally, PhilHealth forms are given once a patient is admitted to the hospital. These include Claim Signature Form (CSF), Claim Form (CF) 1, CF2, CF3, CF4, and PhilHealth Member Registration Form (PMRF). The said forms must be properly accomplished. Guidelines are given on how to complete these forms. All necessary information must be provided so that claim will be processed for payment. Further, all accredited Health Care Institutions shall utilize the updated forms. These are some of the basic requirements for all types of patients. Other basic requirements for patients classified under Pediatrics and Internal Medicine (IM) are laboratory and X-Ray results, and a Statement of Account (SOA). Under Surgery and Gyne, the Certificate of Eligibility Form of Members and Beneficiaries, Operation Record, and SOA are required. Further, under OB, other requirements are Operation Record, SOA, Birth Certificate, PMRF, Marriage Certificate, and Newborn Filter Card.

Upon discharge, these will be collected from the patient's watcher. Signatures of physicians and authorized representatives of the hospital are secured.

Other patient records are being collected from the Medical Records Unit of the hospital. This process indicates that there are many individuals involved to complete the required documents before transmittal. Hence, multiple offices are involved and not specific to Claims Unit alone. The process also indicates that documentation is critical. That is, information must be provided completely from patient registration through the delivery of services. There are three (3) types of information needed in the process. These are clinical, non-clinical, and financial information. Clinical information deals with the medical data of the patient. It includes signs and symptoms, drugs and medicines administered, OR techniques, RN Notes, MD orders, etc. Moreover, non-clinical information deals with the personal data of the patient during confinement. It includes the patient's demographics, member details, employer details, birth certificate, Member's Data Record (MDR), and signatures. In addition, financial information deals with the financial facts of the patient during the time of confinement. Examples are charges captured in the ward or station, professional fees of physicians, Statements of Account (SOA), and out-of-pocket expenses. If this information is not properly documented, there is a great possibility that a claim will be returned, denied, referred to PhilHealth legal, payment will be delayed, or in the worst cases, there will be no payment at all.

The aforementioned forms and other supporting documents should be filed within the prescribed period set by PhilHealth. As part of the response to the pandemic, PhilHealth extended the submission of claims from 60 days to 120 days. It means that the staff of every HCIs should file the claims within 120 days from the patient's discharge date.

Table 1.1 *Average Number of Days in Processing Philhealth Documents Before Transmittal*

Average Number of Days	Frequency	Percentage
45 to 55 days	6	55
36 to 45 days	0	0
26 to 35 days	2	18
15 to 25 days	0	0
7 to 14 days	3	27
TOTAL	11	100

Table 1.1 shows the status of PhilHealth claims in SMMGHHSC in terms of the average number of days in processing PhilHealth documents before transmittal. The table above summarizes the answers of 11 respondents who are all SMMGHHSC staff. Eight (8) of them are from the main hospital, and three (3) are assigned to satellites. The table shows that there are six (6) or 55% of the respondents perceived that the average days to complete the needed documents is 45 to 55 days. Further, the time frames 26 to 35 days and 7 to 14 days were experienced by two (2) or 18% and three (3) or 27% of the respondents, respectively. This reveals that most of the respondents agreed that documents are being processed in approximately not more than two (2) months.

It is gleaned from the table that documents are processed within the 120-day statutory period. But if the target of the institution is to collect payment as soon as possible, being able to meet the prescribed period is not enough. Collecting the documents within two (2) months was caused by late compliance of other units. Based on the interviews, CF4 is the common form that is being complied late by the attending physicians or its representative.

If this 2-month time is continuous, it is expected that payment from the insurance company will always be far more beyond than that. Hence, if this time frame is shortened, it is possible that payment will be earlier, and therefore, the institution will be able to use the money on its operation timely. For instance, payment to suppliers will be made before due dates.

Completion of documents should be made earlier. Turn-around-time for this step in the process must be established. By then, documents will be transmitted to PhilHealth at a lesser time, and therefore, corresponding payment of the claims will be earlier as well.

Number of days to transmit PhilHealth claims

After the collection of the required documents, these will be scanned and submitted online to PhilHealth through a service provider portal. At this point, all forms and other required documents should be completed before sending the claim.

Table 1.2 *Average Number of Days to Transmit Philhealth Claims*

Average Number of Days	Frequency	Percentage
76 to 85 days	2	18
66 to 75 days	0	0
56 to 65 days	1	9

45 to 55 days	3	27
36 to 45 days	0	0
26 to 35 days	0	0
15 to 25 days	1	9
7 to 14 days	4	37
TOTAL	11	100

Table 1.2 shows the status of PhilHealth claims in terms of the average number of days to transmit PhilHealth claims. The result shows that four (4) or 37% of the respondents answered 7 to 14 days, which is still within the prescribed period, even if the number of days of preparation is added. This suggests that most of the respondents agreed that claims are easily transmitted once all necessary documents are complete. However, the researcher considered the answers of six (6) respondents, which is an average of 45-85 days, as a deviation from the group. It is because, as observed, these six (6) respondents are not directly involved in the actual transmittal of claims. Instead, they are assigned only to the collection and preparation of documents before transmittal.

To support the results of the questionnaires answered by eleven (11) respondents who are mainly staff of SMMGHHSC, the researcher obtained daily reports from the Claims Unit. These reports include records of patients' names, discharge, transmittal, and payment dates of claims. The reports also indicate if a claim is refiled or denied. Data gathered are from patients who were confined in the hospital from January to December 2021.

Table 1.2.1 *Average number of days to transmit claims based on the 2021 confinement records*

Respondent	AVERAGE NUMBER OF DAYS TO TRANSMIT CLAIMS FROM DISCHARGE DATE OF PATIENTS
Institution A	55 days
Institution B	46 days
Institution C	53 days
Institution D	53 days

Table 1.2.1 shows that the average number of days to collect documents and transmit claims to PhilHealth is within 45 to 55 days. This confirms the answers of eleven (11) respondents as shown in the previous tables, and therefore claims are submitted within the prescribed period.

The experiences of these respondents are congruent with the records obtained from these four (4) institutions. These findings have been supported by the actual records that the researcher culled out from the in charge of these records. In Institution A, the researcher obtained 327 patients' data which resulted in an average of 55 days to transmit claims from discharge date to submission to PhilHealth. In Institution B, these 46 days have been associated with 21 patients. In Institution C, 20 patients got an average of 53 days to process claims. Likewise, Institution D had an average of 53 days for 17 patients.

As previously discussed, it took an average of two (2) months to collect and submit documents to Philhealth due to several reasons, but commonly it is because of the delay in submission of CF4 from the attending physician. This period contributes to the delay of receiving payment from the insurance company. Thus, it is recommended that this period should be shortened.

Number of days to convert receivables into cash

If a patient is eligible to avail of PhilHealth benefits, a case rate amount will be deducted from his statement of account. This portion will now become a receivable of the hospital from the said insurance company. Recognition of these receivables will commence from the discharge date of the patient, until receipt of payment from PhilHealth.

To verify the results of the questionnaires answered by the 11 staff of SMMGHHSC, the researcher obtained records of discharge dates and PhilHealth payment dates. These were based on confinement for the year 2021.

Table 1.3 *Average Number of Days to Convert Receivables into Cash*

LOCATION	AVERAGE NUMBER OF DAYS TO CONVERT RECEIVABLES INTO CASH
Institution A	82
Institution B	84

Institution C	79
Institution D	71

In Institution A, the actual records of 327 patients show an average of 82 days to convert receivables into cash. Institution B resulted in an average of 84 days from 21 patients' data. In Institution C, 20 patients get an average of 79 days. Lastly, in Institution D, 71 days is the average number of days to convert the receivables of 17 patients. The results show that the institution obtained money in return of its services or goods rendered to members of PhilHealth for an average of not more than three (3) months. Given that the processing of documents within the hospital is not more than two (2) months as previously discussed, it can be concluded from the data above that PhilHealth pays the institution in not more than a month after they receive the documents.

The institution itself has no control to the time frame when will the insurance company pay for their services. This being the case, it can only adjust the time of preparation and submission of claims to PhilHealth. Thus, the healthcare providers must shorten this step.

Number of days to reprocess the returned claims

There are claims submitted to PhilHealth which are redirected back to the HCIs due to some identified deficiencies. There are instructions attached to the reports on how to comply with them. These claims are called Return to Hospital (RTH) claims. Based on the records, the top reason for RTH claims is due to errors encountered in Claim Form 4 or CF4. Some other reasons are failure to submit documents such as itemized billing statements, RT-PCR, laboratory and x-ray results, birth certificates with registry numbers, and other medical documents. Refiled claims will be treated as new claims and should be processed within 120 days from the date of receipt.

Table 1.4 *Average Number of Days to Reprocess the Returned Claims*

Average Number of Days	Frequency	Percentage
56 to 65 days	5	46
45 to 55 days	4	36
36 to 45 days	2	18
26 to 35 days	0	0
TOTAL	11	100

The table above shows that 46% of the respondents assessed an average of 56 to 65 days to reprocess returned claims with appropriate corrections. Moreover, 36% and 18% of the respondents experienced 45 to 55 days, and 36 to 45 days to refile claims. These conclude that RTH claims are still filed within the 120-day statutory period.

To verify the results of the questionnaires answered by the 11 employees of SMMGHHSC, the researcher analyzed the records of patients' discharge dates and PhilHealth payment dates.

Table 1.4.1 *Average Number of Days to Reprocess the Returned Claims Based on 2021 Confinement Records*

Respondents	AVERAGE NUMBER OF DAYS TO REPROCESS THE RETURNED CLAIMS
Institution A	40
Institution B	57
Institution C	56
Institution D	107

Data from 12 patients who were confined during 2021, in each institution were used as samples. It can be observed in the table above that RTH claims in Institution A were reprocessed on an average of 40 days after receipt from PhilHeath. In Institution B and Institution C, claims are reprocessed on an average of almost two months. While on Institution D, claims are reprocessed on the longest period among four institutions, which took an average of 107 days.

It can be concluded that staff still complied with the PhilHealth requirements for re-filing within the statutory period. However, these data imply that claims stay longer as receivable for an additional number of days as RTH claims, and therefore affect the liquidity of the hospital. Usually, these claims are minimal in quantity and equivalent case rates.

Based on the interview, the main focus of the staff were the new claims that need to be transmitted, and RTH claims are still being complied on time. Although, the amount of these claims were not so significant compared to other new claims, these should be refiled earlier than the present practice, so that these will eventually converted into funds.

Current system utilized

As mentioned, processing of PhilHealth claims involves various individuals. From the start of admission of patient to the hospital, a document is created in Emergency Room (ER) wherein vital signs, chief complaints, medicines taken by the patient are noted. The ER staff forwards a document to Admitting Section for them to enter the patient's data in the hospital system. Once the patient is moved to his room, the medical staff assigned in each nurse station provides all the clinical data which all appear in his medical chart. Medical Chart is vital in claims processing. It contains documentation regarding a patient's medical conditions, test results, medicines administered and other treatments made, and more. Its purpose is to provide clinicians with all necessary information to accurately diagnose, and treat the illnesses of the patient. This chart is forwarded to Billing Section for the finalization of the Statement of Account (SOA). This is where a PhilHealth claim is created in a form of a case rate that was deducted on the patient's bill. Further, upon discharge of the patient, the chart stayed in Medical Records Section, and being borrowed by the attending Physician or his representative to create PhilHealth Claims Form 4 (CF4). This form is an additional requirement to process claims. In line with this process flow, each staff uses a different system, depending on their designation.

Table 1.5 *Current System Utilized*

Current System Utilized	Frequency	Rank
Manual	3	3
PhilHealth Portal	6	2
Service Provider Portal	9	1
Computer Applications	2	4

Table 1.5 summarizes the current system being utilized by eleven (11) respondents. Service Provider Portal ranked first among the four (4) systems. This is being used by nine (9) out of the eleven (11) respondents. Second is PhilHealth portal which is being used by six (6) staff. Manual system and computer applications ranked third and fourth, respectively.

As observed, almost all of the staff are using the provider's portal. It must be accredited also by PhilHealth. This is where almost all the needed data can be derived. Now that electronic filing is being used, this portal is used to transmit the scanned documents to PhilHealth. Further, this is where the status of the claim can be seen, especially if it has available check for issuance to the hospital. Moreover, PhilHealth portal is used by six (6) out of eleven (11) respondents, most especially by those who are directly communicating with the patient/relative. Because in this portal, the status of the member/patient, as well as contributions, is viewed to determine if its active or needs updating. Only three (3) of the respondents are still using manual systems. They are the ones who are in charge on verification of the completeness of documents being submitted by the patient's relative. As experienced by the respondents, only few of them are using computer applications in line with processing claims.

In today's modern world, information technology is always part of our daily work. Based on these data and interview, the respondents agreed that service provider portal is vital in the process. Therefore, the hospital must invest in a better portal with less downtime as possible.

II. LEVEL OF EFFECTIVENESS OF PHILHEALTH CLAIMS PROCESSING

Benefits provided and offered by PhilHealth to its members and clients are effectively and efficiently delivered once the processing of claims is carefully facilitated by the certain in-charge unit or entity. The in-charge unit or entity has to thoroughly scrutinize the documentary requirements as to completeness so that the release of claims will be mitigated.

Table 2.1 *Level of Effectiveness of Philhealth Claims Processing Along with Document Requirements*

Indicators	Weighted Mean	Description
Completeness of documents.	3.54	Moderately Effective
Having minimal errors on documents.	3.64	Satisfactorily Effective
Readability of documents.	4.09	Satisfactorily Effective
Validity and authenticity of documents.	4.54	Satisfactorily Effective
Consistency of documents.	4.09	Satisfactorily Effective

Table 2.1 presents the assessment of 11 SMMGHHSC employees on the level of effectiveness of PhilHealth claims to process along documentary requirements. As to the completeness of documents, a weighted mean of 3.54 was achieved and described as moderately effective. This reveals a fair level of compliance among

the concerned in terms of the preparation and submission of documents required for a certain claim. Further implied by the finding, some documents are still lacking, either submitted by the patient or other concerned units or departments.

Based on the results of the interview, the common documents failed to submit include laboratory results, x-ray results, operation technique, clinical chart, RT-PCR result, birth certificate with registry number of member, and itemized billing statement. Most of the time, these documents are not available at the time of transmittal, and the period may lapse if the staff will wait for these. As per the interview, there are cases in which they will transmit the claim being aware that there are lacking documents, and reprocess once it is returned by PhilHealth.

Moreover, employees assessed the last four indicators as satisfactory. Having minimal errors got a weighted mean of 3.64, described as satisfactorily effective. This means that the employees have seen very minimal discrepancies in the documents. As to readability of the documents, it was described also as satisfactorily effective with a weighted mean of 4.09. Based on the interviews, most of the time, the documents submitted to them are readable. Thus, the writings or data filled out on the forms were understood easily by the staff. The validity and authenticity of the documents got a weighted mean of 4.54, described as satisfactorily effective. The staff assessed almost all the documents presented to them as valid and authentic, most especially the birth certificate. As to other documents obtained within the hospital, these can easily be validated due to familiarity with its features. Lastly, consistency of documents got a weighted mean of 4.09 which is described as satisfactorily effective as well. It is very important that documents are consistent with each other for the claim to be paid by the insurance company. For instance, if the final diagnosis is Urinary Tract Infection (UTI), it must be supported by a urinalysis showing the result, and medications administered must be related to the diagnosed illness.

The table above shows that as to documentary requirements, only the completeness of the required documents needs more attention. Some forms are not available during transmittal, and prescribed period might lapse if the staff would wait for it to be complete. If these scenarios would mount up, it is possible that RTH claims will increase. To ensure the completeness of documents is vital in the process to support the claims. That is why, staff should guarantee that forms are completed prior to deadlines.

Table 2.2 *Level of Effectiveness of Philhealth Claims Processing Along with Timeliness*

Indicators	Weighted Mean	Description
Timely submission of the documents.	3.73	Satisfactorily Effective
Appropriateness and currency of documents.	2.54	Less Effective
Timely provision of signatures by the concerned individuals.	2.55	Less Effective
Timely release of documents by the concerned unit.	2.40	Less Effective
Having latest and factual information in the documents	2.18	Less Effective

Table 2.2 presents the assessment of eleven (11) employees on the level of effectiveness of PhilHealth claims to process along timeliness. Looking at the table, the first indicator gets a weighted mean of 3.73 and is described as satisfactorily effective. This means that, generally, claims are submitted on time to PhilHealth.

The last four indicators are described as less effective. As to appropriateness and currency of the documents, it gets a weighted mean of 2.54 which is described as less effective. According to claims staff, they experienced late submission from the patients or its relatives because some of them have lack of knowledge of the requirements and the process, and therefore they mistakenly provided information or document itself. Therefore, it contributes to the delay in the process.

As to timeliness of signatures by the concerned individuals, it is also described as less effective with a weighted mean of 2.55. Based on observation, there were cases wherein the patient or its authorized representative forgot to sign in Statement of Account or other required forms. Sometimes, these are identified when the patient was discharged already. Then, the claim staff will exert an effort to contact these people. Hence, it consumes time, and delays the process. There

were also instances wherein the doctors forgot to sign in claim forms.

As to release of the documents by the concerned units, it got a weighted mean of 2.40 and is described as less effective. According to claims staff, the final source of documents is the Medical Records Section of the hospital. This is where a medical chart is forwarded once the patient is discharged. However, there are delays on their part because of lacking forms, usually CF4, thus, they cannot release the documents to Claims Unit, and therefore affects the timeline of claims processing.

Having latest and factual information in the documents got a weighted mean of 2.18, and is described as less effective. There are experiences by the staff wherein personal information of the patient were mistakenly given by the relative. For example, maiden name was provided instead of its married name. Misspelled names were also encountered more often.

The table above shows that there are still for improvement in the process because of identified factors that affect the timeliness of submission of claims direct to PhilHealth. If the mentioned instances continue to be observed in the process, the time to submit these claims will always be extended. Therefore, these factors that contribute to the delay in the process must be lessen if not totally eliminated.

III. Gaps and Issues Encountered with the Processing of PhilHealth Claims

Table 3 *Gaps and Issues Encountered*

Gaps and Issues	Sum of Ranks	Final Rank
Clinical information is incomplete, incorrect, or inconsistent.	52	1
CF4 not properly accomplished	67	2
Absence/incomplete/incorrect/inconsistent/changes in final diagnosis, hence, affect the Statement of Account (SOA)	70	4.5
Not updated PHIC status of members	70	4.5
Poor internet connection	73	5
Claims are not included in compensable cases of PhilHealth	74	6.5
Lack of other documents required, i.e. laboratory, x-ray results, birth certificate, etc.	74	6.5
Service provider connectivity problem	76	8
CSF not properly accomplished	88	9
Understaff	90	10
CF2 not properly accomplished	104	11
CF3 not properly accomplished	105	12
Medical Doctors have poor awareness of PhilHealth rules and concepts	106	13
Filing beyond the statutory period	114	14
Late refiling of claims	136	15

Table 3.0 presents the gaps and issues in processing PhilHealth claims. These are identified by the researcher based on the records and observations. In the 15 mentioned gaps encountered by 11 respondents, the top two serious problems are incomplete, incorrect, or inconsistent clinical information, and CF4 not being properly accomplished. PhilHealth is very particular about this clinical information such as the vital statistics of a patient during admission, for them to know if the claim is valid and compensable. CF4 is one of the PhilHealth forms needed to be submitted. It is from the attending physician of a patient where additional clinical information can also be obtained. More often, these are the main reasons why a claim is returned by the insurance company.

Absence or incomplete or incorrect or inconsistent and/or changes in final diagnosis, and not having an updated PhilHealth status of members ranked 4.5 among the identified gaps. Any changes in the final diagnosis, affect the case rate covered by the insurance. Hence, it affects the bill or SOA of the patient. Having changes means additional tasks to the staff, and therefore affects the time allotted for the process. Further, the staff encountered several members who have not yet updated their status to PhilHealth. For instance, the member has

changed its employer, or from informal economy to indigent members.

Poor internet connection ranked fifth among the identified gaps and issues. Since the chosen hospital is filing claims electronically, internet connection contributes a great factor in the process. If the internet is unstable more often, filing of claims is expected to be delayed than the target date. Therefore, the institution must invest in a better internet service provider. Further, there are instances wherein claims are not included in compensable cases of PhilHealth. These happens usually when a patient insists to be admitted to monitor his health status, but the diagnosis does not belong to the compensable cases specified by the insurance company. This gap ranked 6.5 among the identified gaps, together with claims that lacks supporting documents. According to claims staff, there are instances wherein the patient or other units omitted or unintentionally overlooked a document.

The aforementioned gaps and issues are experienced mostly by the respondents frequently. These contribute to the delay in the process, and therefore frequent occurrence will have a significant impact to the whole operation of the institution. Thus, these must be addressed by the management to prevent adverse effects.

The least serious problems encountered are filing beyond the statutory period and late refiling of claims. As observed by the researcher, these only happened in very rare cases. This means that most of the time, claims are processed within the statutory period.

IV. PROPOSED MEASURES FOR AN EFFECTIVE PROCESSING OF PHILHEALTH CLAIMS

Table 4. Proposed Measures for an Effective Processing of Philhealth Claims

Proposed Measures	Sum of Ranks	Final Rank
Hire a Claims Medical Evaluator	32	1
Train the clinical staff on proper documentation	49	2.5
Invest in a better E-Claims service provider	49	2.5
Invest in a better internet service provider	53	4
Train non-clinical staff on proper documentation	58	5
Set a Turnaround time (TAT) from patient's discharge to PhilHealth submission of documents	62	6
Train the doctors on how to make a good CF4	63	7
Consistent monitoring of claims processing	72	8
Non-admissible cases should be paid on a cash basis	80	9
Hire additional regular staff	82	10

Table 4.0 presents the proposed measures for the effective processing of PhilHealth claims. In ten (10) measures identified, the top answer by the respondents is to hire a Claims Medical Evaluator. This evaluator is a physician, not necessarily a regular employee, who will evaluate the final diagnosis and other attachments submitted by the patient prior discharge and will evaluate all documents before the actual transmittal to PhilHealth. This will shorten the days to process claims, and therefore will make the collection faster. Professional fee of the said evaluator may cost at around P90,000 per month. The next top measure identified by the respondents is to train the clinical staff on proper documentation. One of the top serious problems, as discussed in table 3.0, is having incomplete, incorrect, or inconsistent clinical information. This clinical information mostly comes from the clinical staff. By training them, they will become more aware of the rules and guidelines of PhilHealth.

This training can be done in less than one year only and can be re-echoed to other newly hired staff in the future or repeated in a lesser time period. This measure may probably cost at a range of P300,000-P400,000, depending on the number of participants including the non-clinical staff. Further, the respondents assessed that there is a need to invest in a better E-Claims service provider. This service provider is vital in the process because, through this, scanned documents are transmitted to the insurance company. Usually, payment to service providers has a standard rate for each good claim. Hence, there might be no significant increase to the company's expenses in line with this proposed measure.

Moreover, investing in a better internet service provider was ranked fourth among the ten (10) identified measures. Similar to E-claims service provider, it is needed to have a stable connectivity to process claims efficiently. These two go hand in hand because they are both required in electronic filing. Also, training of non-clinical staff is considered by the respondents as one of the top measures, as it ranked fifth. Non-clinical staff are the personnel not directly involved in the treatment of the patients. They consist staff from Billing Section, Medical Records Unit, and Claims Unit. Since claims processing is more on documentation, these people must be trained to obtain the needed data and documents. The cost of this training is already included in the estimate mentioned above for the training of clinical staff. Setting a turn-around-time (TAT) from patient's discharge date to submission of claims to PhilHealth was ranked sixth by the respondents. According to the staff, this will compel all the concerned individuals or units to comply with the target.

The identified measures will significantly improve the process as it will make all the staff coordinate with each other to attain the target of the institution as a whole. By implementing these, it will expedite claims processing, and collection thereafter.

Table 4.0 also shows that the Claims Unit does not need to hire additional regular staff, as the respondents considered this as a last solution to the identified gaps. This additional staff will supposedly help them on their daily tasks of collecting documents, scanning, and submitting claims. This means that employees are enough in their units and they can process the claims on time. Only that, they would like to shorten the process by making other units comply with the needed documents at a lesser time.

V. CONCLUSIONS AND RECOMMENDATIONS

Based on the preceding findings, the researcher concludes that the status of PhilHealth claims in SMMGHHSC can be determined by obtaining the average number of days to process the claims and identifying the system being utilized by the staff. Further, the average number of days to convert these claims into cash was about three (3) months from the discharge date of the patient. Further, the Claims Unit staff's level of effectiveness along documentary requirements varies.

The gaps and issues identified by the respondents as to top priority to be addressed are the following: incomplete, incorrect, or inconsistent clinical information, CF4 not properly accomplished, absence or incomplete or incorrect or inconsistent and/or changes in final diagnosis, not having an updated PhilHealth status of members, poor internet connection having claims which are not included in compensable cases and claims which lack supporting documents. The least serious problems encountered are filing beyond the statutory period and late refiling of claims.

Moreover, the effective measures identified by the respondents as to the best solutions are the following: hire a Claims Medical Evaluator, train the clinical staff on proper documentation, invest in a better E-claims service provider, invest in a better internet service provider, train non-clinical staff, and set turn-around-time (TAT).

From the findings and conclusions, the recommendations are forwarded as follows: (1) an action plan be made, implemented, monitored, and evaluated to enhance collection from PhilHealth and minimize and/or prevent returned and denied claims.; (2) clinical and non-clinical staff be trained on proper documentation to ensure synchrony in movement; (3) a medical evaluator be hired to expedite the process; and (4) replicate this study on a wider scope, i.e., increase the number of patients' data and include other concerned units and physicians as respondents, and, after the implementation of the above-mentioned recommendations.

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