

PHILIPPINE HEALTH INSURANCE CORPORATION, PETITIONER, VS. CHINESE GENERAL HOSPITAL AND MEDICAL CENTER, RESPONDENT.

G.R. NO. 163123. April 15, 2005

Ponente: CORONA, J.

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CORONA, J.:

Before us is a petition for review on certiorari under Rule 45 of the Rules of Court assailing the March 29, 2004 decision[1] of the Court of Appeals, the dispositive portion of which read:

FOR THE FOREGOING DISQUISITIONS, the petition is GRANTED, the Philippine Health Insurance Corporation[2] is hereby ordered to give due course to petitioner's, Chinese General Hospital and Medical Center, claims for the period from 1989 to 1992, amounting to FOURTEEN MILLION TWO HUNDRED NINETY ONE THOUSAND FIVE HUNDRED SIXTY EIGHT PESOS and 71/100 PESOS (P14,291,568.71).[3]

The facts, as culled by the Court of Appeals, follow.

On February 14, 1995, Republic Act No. 7875, otherwise known as "An Act Instituting a National Health Insurance Program for all Filipinos and Establishing the Philippine Health Insurance Corporation For the Purpose," was approved and signed into law. As its guiding principle, it is provided in Section 2 thereof, thus: "Section 2. Declaration of Principles and Policies. – Section 11, Article XIII of the Constitution of the Republic of the Philippines declares that the state shall adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all the people at affordable cost. Priority for the needs of the underprivileged, sick, elderly, disabled, women, and children should be recognized. Likewise, it shall be the policy of the State to provide free medical care to paupers.

Prior to the enactment of R.A. 7875, CGH[4] had been an accredited health care provider under the Philippine Medical Care Commission (PMCC), more popularly known as Medicare. As defined by R.A. 7875, a health care provider refers to a health care institution, which is duly licensed and accredited devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment and care of individuals suffering from illness, disease, injury, disability or deformity, or in need of obstetrical or other medical and nursing care.[5]

As such, petitioner[6] filed its Medicare claims with the Social Security System (SSS), which, together with the Government Service Insurance System (GSIS), administered the Health Insurance Fund of the PMMC. Thus, petitioner filed its claim from 1989 to 1992 with the SSS, amounting to EIGHT MILLION ONE HUNDRED TWO THOUSAND SEVEN HUNDRED EIGHTY-TWO and 10/100 (P8,102,782.10). Its application for the payment of its claim with the SSS was overtaken by the passage of R.A. 7875, which in Section 51 and 52, provides:

SECTION 51. Merger. – Within sixty (60) days from the promulgation of the implementing rules and regulations, all functions and assets of the Philippine Medical Care Commission shall be merged with those of the Corporation (PHILHEALTH) without need of conveyance, transfer or assignment. The PMCC shall thereafter cease to exist.

The liabilities of the PMCC shall be treated in accordance with existing laws and pertinent rules and regulations. xxx

SECTION 52. Transfer of Health Insurance Funds of the SSS and GSIS. – The Health Insurance Funds being administered by the SSS and GSIS shall be transferred to the Corporation within sixty (60) days from the promulgation of the implementing rules and regulations. The SSS and GSIS shall, however, continue to perform Medicare functions under contract with the Corporation until such time that such functions are assumed by the Corporation xxx.

Being the successor of the PMCC, PHILHEALTH, in compliance with the mandate of R.A. 7875,[7] promulgated the rules and regulations implementing said act, Section 52 of which provides:

SECTION 52. Fee for Service Guidelines on Claims Payment. – xxx b. All claims for payment of services rendered shall be filed within sixty (60) calendar days from the date of discharge of the patient. Otherwise, the claim shall be barred from payment except if the delay in the filing of the claim is due to natural calamities and other fortuitous events. If the claim is sent through mail, the date of the mailing as stamped by the post office of origin shall be considered as the date of the filing.

If the delay in the filing is due to natural calamities or other fortuitous events, the health care provider shall be accorded an extension period of sixty (60) calendar days.

If the delay in the filing of the claim is caused by the health care provider, and the Medicare benefits had already been deducted, the claim will not be paid. If the claim is not yet deducted, it will be paid to the member chargeable to the future claims of the health care provider.

Instead of giving due course to petitioner's claims totaling to EIGHT MILLION ONE HUNDRED TWO THOUSAND SEVEN HUNDRED EIGHTY-TWO and 10/100 (P8,102,782.10), only ONE MILLION THREE HUNDRED SIXTY-FIVE THOUSAND FIVE HUNDRED FIFTY-SIX and 32/100 Pesos (1,365,556.32) was paid to petitioner, representing its claims from 1989 to 1992 (sic).

Petitioner again filed its claims representing services rendered to its patients from 1998 to 1999, amounting to SEVEN MILLION FIVE HUNDRED FIFTY FOUR THOUSAND THREE HUNDRED FORTY TWO and 93/100 Pesos (P7,554,342.93). For being allegedly filed beyond the sixty (60) day period allowed by the implementing rules and regulations, Section 52 thereof, petitioner's claims were denied by the Claims Review Unit of Philhealth in its letter dated January 14, 200, thus:

“xxx

This pertains to your three hundred seventy three Philhealth medicare claims (373) which were primarily denied by Claims Processing Department for late filing and for which you made an appeal to this office. We regret to inform you that after thorough evaluation of your claims, [your] 361 medicare claims were DENIED, due to the fact that the claims were filed 5 to 16 ½ months after discharge. However, the remaining medicare claims have been forwarded to Claims Processing Department (CPD) for payment.

SECTION 52 (B) Rule 52 (B) Rule VIII of the Implementing Rules and Regulations of 7875 provides that all claims for payment of services rendered shall be filed within sixty (60) days from the day of discharge of the patient. However, Philhealth Circular No, 31-A, series of 1998, state that all claims pending with Philhealth as of September 15, 1998 and claims with discharge dates from September to December 31, 1998 are given one

hundred twenty (120) days from the date of discharge to file their claim. In as much as we would like to grant your request for reconsideration, the Corporation could no longer extend the period of filing xxx.

Petitioner's claim was denied with finality by PHILHEALTH in its assailed decision dated June 6, 2000.

In a petition for review under Rule 43 of the Rules of Court, the Court of Appeals ordered herein petitioner Philippine Health Insurance Corporation (Philhealth) to pay the claims in the amount of Fourteen Million Two Hundred Ninety-one Thousand Five Hundred Sixty-eight Pesos and 71/100 (P14,291,568.71), principally on the ground of liberal application of the 60-day rule under Section 52 of RA 7875's Implementing Rules and Regulations. According to the Court of Appeals:

The avowed policy in the creation of a national health program is, as provided in Section 11, Article XIII of the 1987 Constitution, to adopt an integrated and comprehensive approach to health development which shall endeavor to make essential goods, health and other social services available to all people at affordable cost. To assist the state in pursuing this policy, hospitals and medical institutions such as herein petitioner are accredited to provide health care. It is true, as aptly stated by the OGCC, that petitioner was not required by the government to take part in its program, it did so voluntarily. But the fact that the government did not "twist" petitioner's arm, so to speak, to participate does not make petitioner's participation in the program less commendable, considering that at rate PHILHEALTH is denying claims of health care givers, it is more risky rather than providential for health care givers to take part in the government's health program.

It is Our firmly held view that the policy of the state in creating a national health insurance program would be better served by granting the instant petition. Thus, it is noteworthy to mention that health care givers are threatening to "boycott" PHILHEALTH, reasoning that the claims approved by PHILHEALTH are not commensurate to the services rendered by them to its members. Thus, how can these accredited health care givers be encouraged to serve an increasing number of members when they end up on the losing end of this venture. We must admit that the costs of operating these medical institutions cannot be taken lightly. They must also earn a modicum amount of profit in order to operate properly.

Again, it is trite to emphasize that essentially, the purpose of the national health insurance program is to provide members immediate medical care with the least amount of cash expended. Thus, with PHILHEALTH, members/patients need only to present their card to prove their membership and the accredited health care giver is mandated by law to provide the necessary medical assistance, said health care giver shouldering the PHILHEALTH part of the bill. However, it is the members/patients who bear the brunt. Thus, they are made to shoulder the PHILHEALTH part of the bill, and the refund thereof is subject to whether or not the claims of the health care providers are approved by PHILHEALTH. This is blatantly contrary to the very purpose for which the National Health Insurance Program was created.[8]x x x x x x x x

We agree.

The state policy in creating a national health insurance program is to grant discounted medical coverage to all citizens, with priority to the needs of the underprivileged, sick, elderly, disabled, women and children, and free medical care to paupers[9].

The very same policy was adopted in RA 7875[10] which sought to:

- a) provide all citizens of the Philippines with the mechanism to gain financial access to health services;
- b) create the National Health Insurance Program to serve as the means to help the people pay for the health services;
- c) prioritize and accelerate the provision of health services to all Filipinos, especially that segment of the population who cannot afford such services; and

d) establish the Philippine Health Insurance Corporation that will administer the program at central and local levels.[11]

To assist the state in pursuing the aforementioned policy, health institutions were granted the privilege of applying for accreditation as health care providers.[12] Respondent Chinese General Hospital and Medical Center (CGH) was one of those which received such accreditation.

Under the rules promulgated by the Philhealth Board pursuant to RA 7875, any claim for payment of services rendered (to a patient) shall be filed within sixty (60) calendar days from the date of discharge of the patient. Otherwise, the claim is barred.[13]

But before a claim is filed with petitioner Philhealth for services already rendered, an accredited health care provider like respondent CGH is required to:

- accomplish a Philhealth claim form;
- accomplish an itemized list of the medicines administered to and medical supplies used by the patient concerned, indicating therein the quality, unit, price and total price corresponding thereto;
- require the patient concerned and his/her employer to accomplish and submit a Philhealth member/employer certification;
- in case the patient gave birth, require her to submit a certified true copy of the child's birth certificate;
- in case the patient died, require the immediate relatives to submit a certified true copy of the deceased's death certificate; and
- in case a member's dependent is hospitalized for which the member seeks coverage, require the member to submit proof of relationship to the patient and to execute an affidavit of support.[14]

Apart from the foregoing requirements which often necessitate securing documents from other government offices, and the fact that most patients are unable to immediately accomplish and submit the required documents, an accredited health care provider like CGH has to contend with an average of about a thousand members and/or dependents seeking medical treatment for various illnesses per month.

Under these circumstances, it is unreasonable to expect respondent CGH to comply 100% of the time with the prescribed 60-day rule of Philhealth. Despite the prescribed standard procedures, respondent has no assurance of the members' prompt submission of the required documents. This factor is completely beyond its control. There will always be delay not attributable to respondent.

The unreasonably strict implementation of the 60-day rule, without regard to the causes of delay beyond respondent's control, will be counter-productive to the long-term effectiveness of the NHIP. Instead of placing a premium on participation in the Program, Philhealth punishes an accredited health provider like CGH by refusing to pay its claims for services already rendered. Under these circumstances, no accredited provider will gamble on honoring claims with delayed supporting papers no matter how meritorious knowing that reimbursement from Philhealth will not be forthcoming.

This Court will not hesitate, whenever necessary, to allow a liberal implementation of the rules and regulations of an administrative agency in cases where their unjustifiably rigid enforcement will result in a deprivation of legal rights. In this case, respondent had already rendered the services for which it was filing its claims. Technicalities should not be allowed to defeat respondent's right to be reimbursed, specially since petitioner's charter itself guarantees such reimbursement.

A careful reading of RA 7875 shows that the law itself does not provide for any specific period within which to file claims. We can safely presume therefore that the period for filing was not per se the principal concern of the legislature. More important than mere technicalities is the realization of the state policy to provide Philhealth members with the requisite medical care at the least possible cost. Truly, nothing can be more disheartening than to see the Act's noble objective frustrated by the overly stringent application of technical rules.

The fact is that it was not RA 7875 itself but Section 52 of its Implementing Rules and Regulations which established the 60-day cut-off for the filing of claims.

While it is doctrinal in administrative law that the rules and regulations of administrative bodies interpreting the law they are entrusted to enforce have the force of law^[15], these issuances are by no means iron-clad norms. Administrative bodies themselves can and have in fact "bent the rules" for reasons of public interest. On September 15, 1998, for instance, petitioner issued Philhealth Circular No. 31-A:^[16]

IN ORDER to allow members of the National Health Insurance Program (NHIP) sufficient time to complete all documents to support their medical care claims, Philhealth is temporarily suspending the sixty (60)-day reglementary period for filing claims.

While Section 52 (b), Rule VIII of the Implementing Rules and Regulations of R.A. 7875 provides that all claims for payment of services shall be filed within 60 calendar days from the day of discharge of a patient, there is a need to extend this period to minimize the incidence of late filing due to members' personal difficulties and circumstances beyond their control. (emphasis ours)

And then again, on April 20, 1999, Philhealth Circular No. 50 was issued:

TO MINIMIZE the incidence of late filing of claims due to members' personal difficulties in preparing the needed documents, Philhealth is extending the period for filing of claims xxx (emphasis ours)

The above circulars indubitably recognized the necessity of extending the 60-day period because of the difficulties encountered by members in completing the required documents, often due to circumstances beyond their control. Petitioner appeared to be well aware of the problems encountered by its members in complying with the 60-day rule. Furthermore, implicit in the wording of the circulars was the cognition of the fact that the fault was not always attributable to the health care providers like CGH but to the members themselves.

Delay on the part of members is an ordinary occurrence. There is no need to make a mountain out of a molehill as far as this particular point is concerned. To this day, members continue to encounter delay in submitting their documents. There was therefore no compelling reason for the exacting and meticulous enforcement of the rule when, in at least two instances, petitioner itself implemented it liberally and on the same ground that it was using against respondent.

Petitioner likewise contends that respondent failed to exhaust administrative remedies before resorting to judicial intervention. We disagree.

Under the doctrine of exhaustion of administrative remedies, an administrative decision must first be appealed to the administrative superiors at the highest level before it may be elevated to a court of justice for review.

This doctrine, however, is a relative one and its flexibility is conditioned on the peculiar circumstances of a case.^[17] There are a number of instances when the doctrine has been held to be inapplicable. Among the established exceptions are:

- 1) when the question raised is purely legal;
- 2) when the administrative body is in estoppel;

- 3) when the act complained of is patently illegal;
- 4) when there is urgent need for judicial intervention;
- 5) when the claim involved is small;
- 6) when irreparable damage will be suffered;
- 7) when there is no other plain, speedy and adequate remedy;
- 8) when strong public interest is involved;
- 9) when the subject of the controversy is private land;
- 10) in quo warranto proceedings.[18]

As explained by the appellate court:

It is Our view that the instant case falls as one of the exceptions, concerning as it does public interest. As mentioned earlier, although they were not made parties to the instant case, the rights of millions of Filipinos who are members of PHILHEALTH and who obviously rely on it for their health care, are considered, nonetheless, parties to the present case. This Court is mandated herein to take conscious and detailed consideration of the interplay of the interests of the state, the health care giver and the members. With these in mind, We hold that the greater interest of the greater number of people, mostly members of PHILHEALTH, is paramount.

Furthermore, when the representatives of herein petitioner met with Dr. Enrique Zalamea, PHILHEALTH's President and Chief Executive Officer, he informed them that, in lieu of protest to be filed directly with him, the representatives could make representations with the Office of the President, which petitioner did to no avail, considering that the formal protest filed was referred back by the Office of the President to Dr. Zalamea. Being then the head of PHILHEALTH, and expected to have an intimate knowledge of the law and the rules creating the National Health Insurance Program, under which PHILHEALTH was created, he instructed herein petitioner to pursue a remedy not sanctioned by the rules and not in accord with the rule of exhaustion of administrative remedies. In so doing, PHILHEALTH is deemed estopped from assailing the instant petition for failure to exhaust administrative remedies when PHILHEALTH itself, through its president, does not subscribe to it.[19]

There is no need to belabor the fact that the baseless denial of respondent's claims will be gravely disturbing to the health care industry, specially the providers whose claims will be unpaid. The unfortunate reality is that there are today some health care providers who admit numbers for treatment and/or confinement yet require them to pay the portion which ought to be shouldered by Philhealth. A refund is made only if their claim is first paid, due to the apprehension of not being reimbursed. Simply stated, a member cannot avail of his benefits under the NHIP at the time he needs it most.

We cannot turn a deaf ear to respondent's plea for fairness which essentially demands that its claims for services already rendered be honored as the National Health Insurance Program law intended.

WHEREFORE, the assailed decision of the Court of Appeals is hereby **AFFIRMED**. Petitioner is hereby ordered to pay respondent's claims representing services rendered to its members from 1989 to 1992.

No costs.

SO ORDERED.

Panganiban, (Chairman), Sandoval-Gutierrez, and Carpio-Morales, JJ., concur.

Garcia, J., no part.

[1] Penned by Associate Justice Danilo B. Pine, and concurred in by then Presiding Justice Cancio C. Garcia (now Justice of the Supreme Court) and Associate Justice Renato C. Dacudao.

[2] Herein petitioner Philippine Health Insurance Corporation.

[3] Rollo, p. 21.

[4] Chinese General Hospital and Medical Center.

[5] Section 4 (o) (1), Republic Act No. 7875.

[6] Herein respondent Chinese General Hospital and Medical Center.

[7] Section 49. Implementing Rules and Regulations. – Within thirty (30) days from the completion of such appointments, the Board shall convene to formulate the rules and regulations necessary for the implementation of this Act.

[8] CA Decision, Rollo, pp. 18-19.

[9] Section 11, Article XIII of the 1987 Constitution.

[10] An Act Instituting a National Health Insurance Program for all Filipinos and Establishing the Philippine Health Insurance Corporation for the Purpose.

[11] Section 3, RA 7875.

[12] Defined as a health institution duly licensed and accredited devoted primarily to the maintenance and operation of facilities for health promotion, prevention, diagnosis, treatment and care of individuals suffering from illness, disease, injury, disability or deformity, or in need of obstetrical or other medical and nursing care.

[13] Section 52, Implementing Rules and Regulations of RA 7875.

[14] CA Decision, Rollo, p.17.

[15] Philippine Administrative Law by Cruz, 1991 Edition, pp. 17-18.

[16] Rollo, p. 104.

[17] Leonardo Paat v. Court of Appeals, 334 Phil. 146 (1997).

[18] Nachura, Outline/Reviewer in Political Law (2002), pp. 346-349; Corsiga v. Defensor, G.R. No. 139302, 28 October 2002, 391 SCRA 267; Aurillo, Jr. v. Rabi, G.R. 120014, 26 November 2002, 392 SCRA 595.

[19] CA Decision, Rollo, p. 20.

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