ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

Standardizing the Assessment of Return-to-Hospital PhilHealth Claims Towards Effectiveness and Efficiency at Urban Setting

Lailanie C. Revano
Graduate School, Cebu Technological University – Main Campus, Cebu City, Philippines
revanolailanie@gmail.com

Date Submitted:
September 23, 2026

Date Accepted:
October 19, 2026

Date Published:
November 13, 2026

DOI:
10.5281/zenodo.24201029

ABSTRACT

This study assessed the factors affecting Return-to-Hospital (RTH) PhilHealth claims at Chong Hua Hospital, Cebu City, as a basis for developing a standardized claims assessment process to improve the efficiency and effectiveness of claims processing. A descriptive design using a structured survey questionnaire was employed with all 59 administrative, technical, and management personnel directly involved in claims verification, coding, processing, review, and supervision, selected through total enumeration, namely claims processors, billing personnel, PhilHealth review personnel, and department supervisors and managers. Data were analyzed using frequency, percentage, weighted mean, standard deviation, and ranking. Patient documentation (M = 4.30) and coding and claims accuracy (M = 4.28) were perceived to contribute to RTH claims to a very high extent, with incomplete medical documentation (M = 4.41) and errors in patient or claim information (M = 4.54) as the most prominent indicators. Claims processing practices were rated highly effective (M = 4.12), although the use of standardized checklists (M = 3.88) and pre-submission quality checking (M = 3.95) received the lowest ratings, while organizational factors were rated very highly effective (M = 4.37), led by coordination with physicians (M = 4.54). Increased follow-up activities, additional administrative workload, and additional coordination among hospital departments were the leading concerns arising from RTH claims. The findings indicate that RTH claims stem from interconnected documentation, coding, processing, and organizational factors and that a more standardized approach to claims assessment is needed. The study proposes a Standardized PhilHealth RTH Claims Assessment Process that strengthens documentation procedures, internal quality checks, interdepartmental coordination, claims monitoring, and personnel competency development to promote consistent, efficient, and effective PhilHealth claims processing.

Keywords: *PhilHealth, return-to-hospital claims, claims processing, revenue cycle management, hospital administration, standardized assessment process*

INTRODUCTION

The financial stability and operational sustainability of healthcare institutions in the Philippines rely heavily on the efficient processing and reimbursement of claims by the Philippine Health Insurance Corporation (PhilHealth). PhilHealth aims to provide all Filipinos with affordable and quality health care without causing financial hardship, and since 2002 it has applied a three-level accreditation system for hospitals (Ulep et al., 2021). Reimbursements from PhilHealth constitute a primary revenue stream for accredited healthcare institutions, and challenges in PhilHealth claims and financial processes can affect the efficiency of hospital operations and

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

reimbursement (Banogon et al., 2025). For private tertiary hospitals such as Chong Hua Hospital, a 660-bed hospital in Cebu City, a smooth, fast, and clear reimbursement process is essential for sustaining patient care operations, acquiring medical technology, meeting operational overheads, and preventing unexpected out-of-pocket strain on patients caused by delayed benefits.

Delays in PhilHealth reimbursement can affect the cash flow and daily operations of healthcare facilities, and the complexity of the reimbursement process may contribute to administrative delays such as Return-to-Hospital (RTH) claims (Capeding et al., 2025). An RTH claim is a deficient submission that, following initial adjudication and technical validation, is returned to the healthcare institution because of missing or incomplete requirements. Hospitals are given 60 days to correct and resubmit returned claims; claims not corrected within this period may be denied, resulting in financial losses and additional work for the hospital (Cabalfin, 2016; Philippine Health Insurance Corporation, 2019).

At Chong Hua Hospital, returned claims create considerable operational friction because each RTH claim requires manual intervention, multi-departmental re-audits, and administrative re-filing. Uy et al. (2021) observed that private hospitals "showed decent profitability margins, but they may easily fall into financial distress if their cash flows are disrupted such as from inability to collect on receivables from health insurance payments." Insurers are the primary source of hospital receivables, and delayed payments can strain a hospital's available cash and its ability to keep operating (Graham, 2001; McCue & Thompson, 2011; Ullman, 2015). Although reimbursement delays and claims-related challenges have been documented at the health-system level, limited evidence describes how personnel in private tertiary hospitals perceive the documentation, coding, processing, and organizational factors behind RTH claims, or how these perceptions can inform a standardized assessment process.

This study therefore analyzed RTH PhilHealth claims at Chong Hua Hospital, Cebu City, during Calendar Year 2026 to develop a standardized assessment process toward effectiveness and efficiency. Specifically, it sought to determine (1) the profile of the respondents in terms of age, gender, position, years of experience in PhilHealth claims processing, and relevant training attended; (2) the extent to which patient documentation, coding and claims accuracy, claims processing, and organizational factors affect RTH claims, as perceived by the respondents; (3) the issues and concerns encountered by personnel involved in PhilHealth RTH claims processing and compliance; and (4) the standardized assessment process that may be proposed based on the findings. The results are intended to provide hospital management with baseline evidence for policy refinement, resource allocation, and revenue cycle optimization; to guide the PhilHealth processing unit and billing personnel in developing pre-submission audit checklists and standardized workflows; to reduce discharge billing delays for patients and PhilHealth beneficiaries; to inform policy dialogue between private tertiary hospitals and PhilHealth; and to serve as a reference for future research on hospital revenue cycle management and healthcare quality improvement.

Literature Review

PhilHealth as Strategic Purchaser and Hospital Financial Sustainability

The National Health Insurance Act of 1995 (Republic Act No. 7875, as amended by RA 9241 and RA 10606) established PhilHealth as the government corporation administering the National Health Insurance Program, and the Universal Health Care Act of 2019 (Republic Act No. 11223) further positioned PhilHealth as the national strategic purchaser of health services (Republic of the Philippines, 2019). The Philippine health system review describes PhilHealth as a central financing institution whose payments shape provider behavior and hospital finances (World Health Organization & Department of Health Philippines, 2018). Earlier analyses noted that the country's health insurance reforms combined ambitious policy goals with considerable socio-economic and administrative constraints (Hindle et al., 2001).

The financial health of hospitals is closely tied to PhilHealth payments. Uy et al. (2021) found that private hospitals were profitable but vulnerable to financial distress when receivables from health insurance were not collected, and Ulep et al. (2021) documented wide variation in the service capability and readiness of Philippine

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

hospitals to provide high-quality care. Programmatic studies have likewise reported persistent challenges in PhilHealth's social health insurance program in the era of Universal Health Coverage (Querri et al., 2018) and in health financing for the poor (Cabalfin, 2016).

More recent studies highlight claims and payment processes as critical constraints. Banogon et al. (2025), in a qualitative study of public hospitals, found that gaps between PhilHealth policy and hospital practice affected claims and financial processes, while Capeding et al. (2025) identified slow procurement, supplier shortages, and late or problematic PhilHealth reimbursements as purchasing-related barriers to the optimal implementation of the Universal Health Care Act. These findings suggest that hospital-level claims management is an important link between national financing policy and service delivery.

Return-to-Hospital Claims and Claims Compliance

PhilHealth Circular No. 2019-0001 sets the guidelines for the proper recording of RTH and denied benefit claims and for the reconciliation of the corresponding accounting records (Philippine Health Insurance Corporation, 2019). Under these rules, a claim returned because of deficiencies remains a receivable until it is corrected and resubmitted within the prescribed period, after which it may be denied. RTH claims therefore represent both a compliance concern and a financial concern, because each returned claim delays revenue and requires additional verification, documentation, and encoding work (Cabalfin, 2016).

Accreditation and quality standards also shape claims compliance. Mendoza et al. (2020) noted that PhilHealth accreditation standards and the Universal Health Care Act's provisions for third-party accreditation are intended to strengthen continuing quality improvement among health facilities. Because accreditation, documentation standards, and claims requirements are interrelated, deficiencies in medical records, supporting documents, or claim information can translate into returned claims and reduced reimbursement efficiency (Banogon et al., 2025; Ulep et al., 2021).

Revenue Cycle Management, Accounts Receivable, and Cash Flow

Revenue cycle management encompasses the processes through which hospitals capture charges, document and code services, submit claims, follow up on payer responses, and collect payment. Graham (2001) argued that hospitals can increase revenue through accounts receivable recovery and revenue-cycle redesign, while McCue and Thompson (2011) showed that cash flow is a critical indicator of the financial condition of academic medical centers. Ullman (2015) described days in accounts receivable as a key metric for healthcare finance professionals because prolonged collection periods tie up working capital.

Implementing effective revenue cycle management, however, requires organizational readiness. In interviews with financial leaders of seven Saudi governmental hospitals, Alradhi and Alanazi (2023) found that although leaders understood and valued revenue cycle management, none had fully implemented it because of unclear vision, weak accountability, staff resistance, siloed information systems, and inadequate project management and training. These barriers indicate that claims performance depends not only on individual accuracy but also on governance, interdepartmental integration, and staff capacity.

Reimbursement Delays and Administrative Burden in Social Health Insurance

Studies of social health insurance schemes in other low- and middle-income countries describe similar challenges. Sakyi et al. (2012), interviewing managers of 12 accredited district hospitals under Ghana's National Health Insurance Scheme, found that delayed payments from the insurance authority created difficulties in procuring drugs and supplies and constrained administrative initiative, and they recommended streamlining payments and adopting computerized claims systems. Laar et al. (2021) similarly reported that delayed claims reimbursement pushed health facilities toward out-of-pocket charges and prompted managers to seek alternative domestic financing.

In the Philippine context, delayed or problematic PhilHealth reimbursement has been identified as a purchasing barrier that affects service delivery (Capeding et al., 2025), and challenges in claims and financial

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

processes have been linked to reduced hospital efficiency (Banogon et al., 2025). Together with revenue cycle literature (Alradhi & Alanazi, 2023; Graham, 2001), these studies suggest that returned or delayed claims generate follow-up work, accounts receivable buildup, and coordination demands that compound the administrative burden on hospital claims personnel.

Theoretical Framework

The study was anchored on three interrelated theories. Donabedian's Quality Assessment Model (Donabedian, 1966) evaluates performance across structure, process, and outcome. In this study, structure referred to billing systems, health record infrastructure, and coder competency; process to clinical documentation, coding accuracy, and timely filing; and outcome to clean claim submission and reduced RTH occurrences. Systems Theory (Von Bertalanffy, 1968) conceptualizes the hospital as an integrated system in which patient and administrative data serve as inputs, departmental reviews and claim scrubbing as throughputs, submitted claims as outputs, and PhilHealth adjudication notices as feedback used to refine operations.

Total Quality Management (Deming, 1986) provides a framework for continuous process improvement, root-cause analysis, and proactive defect prevention rather than reactive correction. These theories were anchored on legal mandates, including the Universal Health Care Act (Republic of the Philippines, 2019), which demands administrative efficiency in health financing; the National Health Insurance Act, which establishes PhilHealth's statutory authority and compliance standards; and PhilHealth Circular No. 2019-0001 (Philippine Health Insurance Corporation, 2019), which governs the identification, processing, and reconciliation of RTH claim deficiencies. Together, they explain how organizational practices and claims assessment procedures relate to RTH outcomes and support the development of a standardized assessment process.

Conceptual Framework

The study was organized according to the Input-Process-Output (IPO) model shown in Figure 1. The input consisted of the respondents' demographic and professional profiles; the factors associated with RTH claims assessment, namely patient documentation, coding and claims accuracy, claims processing, and organizational factors; and the issues and concerns encountered in RTH claims processing. The process involved securing approval, distributing and retrieving the survey questionnaires, applying statistical treatment, and analyzing and interpreting the data to determine the factors affecting RTH claims and the areas requiring standardization.

The output was the proposed Standardized PhilHealth RTH Claims Assessment Process, which aims to establish a consistent and systematic approach to assessing RTH claims. The proposed process is intended to strengthen documentation compliance, coding and claims accuracy, processing procedures, and organizational coordination, thereby promoting greater effectiveness and efficiency in PhilHealth claims processing.

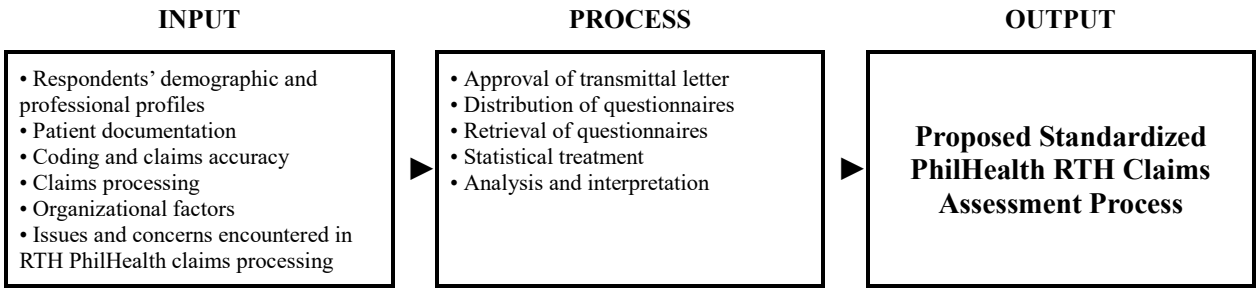


Figure 1. *Conceptual Framework of the Study (Input-Process-Output Model)*

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

METHODS

Research Design

The study employed a mixed-methods descriptive design to assess the factors affecting RTH PhilHealth claims and to develop a standardized assessment process. The quantitative component used a descriptive survey approach to examine the respondents' demographic and professional profiles and their perceptions of the factors affecting RTH claims and of the issues and concerns arising from them. The qualitative component consisted of open-ended questions in the same questionnaire on the common reasons for RTH claims, problems encountered in resolving them, contributing departmental or process factors, and suggested measures, which were analyzed thematically to complement the survey results. The integrated findings served as the basis for the proposed Standardized PhilHealth RTH Claims Assessment Process.

Research Locale

The study was conducted at Chong Hua Hospital, Cebu City, a non-stock, non-profit Level 3 tertiary healthcare institution along J. Llorente Street, Fuente Osmeña, Cebu City, during Calendar Year 2026. The hospital processes a high daily volume of inpatient and outpatient PhilHealth benefit claims. The study focused on the administrative units directly involved in claims generation and reimbursement: the PhilHealth Processing Unit and Billing Department, which oversee eligibility verification, document assembly, eClaims submission, and the refiling of returned claims; and the PhilHealth Claims Review Department, which is responsible for clinical documentation, medical chart completion, ICD-10 diagnostic coding, and RVS procedural coding.

Participants and Sampling Technique

The respondents were administrative, technical, and management personnel directly involved in the verification, coding, processing, review, and supervision of PhilHealth claims. Total enumeration sampling was used, so the entire identified population of 59 qualified personnel was included: 50 personnel (84.75%) from the Billing and PhilHealth Processing Unit, 5 (8.47%) from the PhilHealth Claims Review Unit, and 4 (6.78%) department supervisors and managers.

Research Instrument

A structured survey questionnaire adapted from PhilHealth policies and manuals on claims-processing requirements and deficiency classifications, and from literature on healthcare claims management, documentation quality, coding accuracy, administrative process efficiency, staff competency, and interdepartmental coordination, was used. Part I gathered the respondents' age, gender, position, years of experience in PhilHealth claims processing, and relevant training attended. Part II contained 23 items on the factors affecting RTH claims: patient documentation (6 items), coding and claims accuracy (6 items), claims processing (5 items), and organizational factors (6 items). Part III contained 10 items on the effects of RTH claims, that is, the issues and concerns encountered by personnel, and Part IV contained five open-ended questions. Parts II and III were rated on a five-point scale.

Data Gathering Procedure

Data were gathered in three stages. In the preliminary stage, approval to conduct the study was secured from the Cebu Technological University Graduate School Research Ethics Committee, and a transmittal letter endorsed by the research adviser was submitted to the hospital administration and the heads of the Billing and PhilHealth Processing Unit and the PhilHealth Claims Review Unit to obtain permission to administer the questionnaire. In the data gathering stage, digital versions of the questionnaire were distributed to all 59 qualified personnel after informed consent was obtained, and respondents were given sufficient time to complete the survey, which required approximately 15 to 20 minutes. In the post-data gathering stage, responses were reviewed for completeness, consistency, and accuracy, then encoded, organized, and tabulated for statistical treatment.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

Data Analysis

Frequency and percentage were used to describe the respondents' profiles. Weighted mean and standard deviation were used to determine the perceived extent of the factors affecting RTH claims and the issues and concerns encountered by personnel, and ranking was used to arrange the issues and concerns from the highest to the lowest mean. For patient documentation and coding and claims accuracy, means were interpreted as 1.00–1.80, very low extent; 1.81–2.60, low extent; 2.61–3.40, moderate extent; 3.41–4.20, high extent; and 4.21–5.00, very high extent. For claims processing and organizational factors, means were interpreted as 1.00–1.80, not effective; 1.81–2.60, slightly effective; 2.61–3.40, moderately effective; 3.41–4.20, highly effective; and 4.21–5.00, very highly effective. For the issues and concerns, the same ranges were interpreted as very low, low, moderate, high, and very high, with higher means indicating greater concern.

Ethical Considerations

The study was approved by the Cebu Technological University Graduate School Research Ethics Committee and by the management of Chong Hua Hospital. The purpose of the study, its procedures, potential risks and benefits, and the respondents' rights were explained in an informed consent form before the questionnaire was administered. Participation was voluntary, respondents could skip any question or withdraw at any time without penalty or effect on their employment, and no foreseeable physical risks were involved. Respondents' names did not appear on the questionnaire; responses were assigned identification codes and reported only as group summaries. Digital records were stored in password-protected drives with access limited to authorized research purposes, in compliance with the Data Privacy Act of 2012 (Republic Act No. 10173).

RESULTS AND DISCUSSION

Profile of the Respondents

Table 1. *Profile of the Respondents (N = 59)*

Profile Variable and Category	Frequency	Percentage
Age		
23–25 years	6	10.17
26–30 years	15	25.42
31–35 years	8	13.56
36–40 years	14	23.73
41–45 years	11	18.64
46–50 years	5	8.47
Mean = 34.81; SD = 7.45		
Gender		
Male	6	10.2
Female	53	89.8
Position		
Claims processor	30	50.8
Billing personnel	20	33.9
PhilHealth review personnel	5	8.5
Supervisor/manager	4	6.8
Years of experience in PhilHealth claims processing		
1–3 years	18	30.5
4–6 years	10	16.9
7–10 years	20	33.9
More than 10 years	11	18.6

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

Profile Variable and Category	Frequency	Percentage
Mean = 6.65; SD = 3.75		
Relevant training attended		
0–20 hours	31	52.5
21–50 hours	21	35.6
51–100 hours	7	11.9
101–200 hours	0	0.0
More than 200 hours	0	0.0

Note. Highlighted percentages were recomputed from the reported frequencies; the source reported 28.8, 15.3, and 32.2, which sum with 18.6 to 94.9%.

As shown in Table 1, the respondents had a mean age of 34.81 years (SD = 7.45), with the largest groups aged 26 to 30 years (25.42%) and 36 to 40 years (23.73%). Most were female (89.8%). Claims processors formed the majority (50.8%), followed by billing personnel (33.9%), PhilHealth review personnel (8.5%), and supervisors or managers (6.8%). Respondents had a mean of 6.65 years (SD = 3.75) of experience in PhilHealth claims processing, with the largest group having 7 to 10 years. More than half (52.5%) had attended no more than 20 hours of relevant seminars and training, such as ICD-10 coding seminars and PhilHealth orientations, and none had attended more than 100 hours.

The profile indicates a workforce concentrated in frontline claims-handling roles, suggesting that the assessment of RTH claims should give particular attention to the workflows, procedures, and decision points involved in claims processing, as these are likely to drive both throughput and potential bottlenecks. The predominance of limited training hours points to a need for structured capacity building in coding, documentation, and PhilHealth policies, consistent with observations that staff capacity and training are prerequisites for effective revenue cycle management (Alradhi & Alanazi, 2023) and that PhilHealth's social health insurance program faces persistent implementation challenges (Querri et al., 2018).

Patient Documentation

Table 2. *Perceived Extent to Which Patient Documentation Affects RTH Claims (N = 59)*

Indicator	Mean	SD	Interpretation
Incomplete supporting documents contribute to RTH claims.	4.32	0.71	Very high extent
Missing signatures contribute to the return of claims.	4.31	0.84	Very high extent
Incomplete medical documentation contributes to RTH claims.	4.41	0.62	Very high extent
Inconsistencies between medical records and claim information contribute to RTH claims.	4.37	0.79	Very high extent
Failure to attach required supporting documents contributes to RTH claims.	4.27	0.87	Very high extent
Delays in completion of medical records affect timely claim submission.	4.14	0.94	High extent
Overall	4.30	0.79	Very high extent

Note. 1.00–1.80, very low extent; 1.81–2.60, low extent; 2.61–3.40, moderate extent; 3.41–4.20, high extent; 4.21–5.00, very high extent. The overall SD is the average of the item SDs, as reported in the source.

Table 2 shows that patient documentation was perceived to contribute to RTH claims to a very high extent (M = 4.30). Incomplete medical documentation obtained the highest mean (M = 4.41), followed by inconsistencies between medical records and claim information (M = 4.37), incomplete supporting documents (M = 4.32), missing signatures (M = 4.31), and failure to attach required supporting documents (M = 4.27). Delays in the completion of medical records were rated to a high extent (M = 4.14).

These results indicate that deficiencies in the completeness and consistency of medical records and supporting requirements are central drivers of returned claims. Within Donabedian's (1966) model, documentation

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

represents a process dimension that directly determines the outcome of clean claim submission. The findings are consistent with PhilHealth's classification of RTH claims as submissions returned for missing or incomplete requirements (Philippine Health Insurance Corporation, 2019) and with evidence that gaps between PhilHealth policy and hospital practice affect claims processes (Banogon et al., 2025), underscoring the importance of verifying documentation before submission.

Coding and Claims Accuracy

Table 3. *Perceived Extent to Which Coding and Claims Accuracy Affects RTH Claims (N = 59)*

Indicator	Mean	SD	Interpretation
Incorrect coding contributes to RTH claims.	4.19	0.78	High extent
Inconsistencies between diagnosis and procedure codes contribute to claim returns.	4.10	0.82	High extent
Errors in patient or claim information contribute to RTH claims.	4.54	0.54	Very high extent
Incorrect or incomplete encoding contributes to claim deficiencies.	4.29	0.62	Very high extent
Changes in PhilHealth policies or benefit rules can contribute to claims errors.	4.36	0.58	Very high extent
Lack of adequate claim validation increases the likelihood of RTH.	4.19	0.68	High extent
Overall	4.28	0.67	Very high extent

Note. Interpretation ranges as in Table 2. The highlighted indicator follows item 8 of the questionnaire; the source table listed this row as a duplicate of the policy-change item. The overall SD is the average of the item SDs, as reported in the source.

As presented in Table 3, coding and claims accuracy was perceived to contribute to RTH claims to a very high extent (M = 4.28). Errors in patient or claim information obtained the highest mean (M = 4.54), followed by changes in PhilHealth policies or benefit rules (M = 4.36) and incorrect or incomplete encoding (M = 4.29). Incorrect coding and lack of adequate claim validation (both M = 4.19) and inconsistencies between diagnosis and procedure codes (M = 4.10) were rated to a high extent.

The prominence of errors in patient and claim information and the effect of changing benefit rules indicate that accuracy depends both on careful data handling and on personnel keeping pace with policy updates. These findings align with the emphasis of revenue cycle literature on accurate coding and data capture as prerequisites for timely reimbursement (Graham, 2001) and with Total Quality Management's focus on preventing defects at the source rather than correcting them after return (Deming, 1986). They also reflect the administrative complexity of PhilHealth's payment processes noted by Capeding et al. (2025).

Claims Processing

Table 4. *Perceived Effectiveness of Claims Processing (N = 59)*

Indicator	Mean	SD	Interpretation
The hospital has clearly defined procedures for PhilHealth claims processing.	4.46	0.62	Very highly effective
A standardized checklist is used before claims are submitted.	3.88	0.83	Highly effective
Claims undergo adequate quality checking before submission.	3.95	1.11	Highly effective
Potential deficiencies are identified before claims are submitted to PhilHealth.	4.19	0.78	Highly effective
RTH claims are systematically monitored until resolution.	4.10	0.80	Highly effective
Overall	4.12	0.83	Highly effective

Note. 1.00–1.80, not effective; 1.81–2.60, slightly effective; 2.61–3.40, moderately effective; 3.41–4.20, highly effective; 4.21–5.00, very highly effective. The overall SD is the average of the item SDs, as reported in the source.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

Table 4 shows that claims processing practices were rated highly effective overall (M = 4.12). The existence of clearly defined procedures for PhilHealth claims processing was rated very highly effective (M = 4.46), while the identification of potential deficiencies before submission (M = 4.19) and the systematic monitoring of RTH claims until resolution (M = 4.10) were rated highly effective. The lowest ratings were for adequate quality checking before submission (M = 3.95), which also showed the greatest variability among respondents (SD = 1.11), and the use of a standardized checklist before submission (M = 3.88).

Although established procedures are in place, these results suggest that their implementation is not yet consistent, particularly at the pre-submission stage. In Systems Theory terms (Von Bertalanffy, 1968), the throughput stage of review and claim scrubbing is where deficiencies should be intercepted before they become outputs returned as feedback. Strengthening standardized checklists and internal validation is consistent with recommendations to streamline claims systems and adopt structured processes to reduce payment delays (Sakyi et al., 2012) and with revenue-cycle redesign approaches that reduce rework and accounts receivable (Graham, 2001).

Organizational Factors

Table 5. *Perceived Effectiveness of Organizational Factors (N = 59)*

Indicator	Mean	SD	Interpretation
Effective coordination among departments reduces RTH claims.	4.44	0.53	Very highly effective
Delayed responses from other departments contribute to claim deficiencies.	4.36	0.52	Very highly effective
Coordination with physicians is important in completing claim requirements.	4.54	0.54	Very highly effective
Communication gaps among claims-related units contribute to RTH claims.	4.14	0.71	Highly effective
Clear assignment of responsibility among departments helps prevent RTH claims.	4.25	0.68	Very highly effective
Prompt resolution of documentation deficiencies improves claims processing.	4.49	0.57	Very highly effective
Overall	4.37	0.59	Very highly effective

Note. Interpretation ranges as in Table 4. The overall SD is the average of the item SDs, as reported in the source.

As shown in Table 5, organizational factors were rated very highly effective (M = 4.37), the highest among the four domains. Coordination with physicians in completing claim requirements obtained the highest mean (M = 4.54), followed by prompt resolution of documentation deficiencies (M = 4.49), effective coordination among departments (M = 4.44), delayed responses from other departments contributing to claim deficiencies (M = 4.36), and clear assignment of responsibility among departments (M = 4.25). Communication gaps among claims-related units were rated highly effective (M = 4.14).

These results show that respondents regard interdepartmental collaboration, particularly with physicians, as essential for completing claim requirements. Because claims depend on inputs from billing, medical records, physicians, and other units, fragmented accountability and siloed systems can delay the resolution of deficiencies, consistent with the organizational barriers to revenue cycle management identified by Alradhi and Alanazi (2023). From a systems perspective, the hospital functions as an interdependent whole in which delays in one unit propagate to claims outcomes (Von Bertalanffy, 1968).

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

Issues and Concerns Encountered in RTH Claims Processing

Table 6. *Issues and Concerns Encountered in RTH PhilHealth Claims Processing (N = 59)*

Issue or concern	Mean	SD	Rank	Interpretation
Increase in follow-up activities	4.34	0.54	1	Very high
Increase in administrative workload	4.27	0.64	2	Very high
Additional coordination among hospital departments	4.17	0.65	3	High
Delay in PhilHealth reimbursement	4.12	0.74	4	High
Additional documentation and encoding work	4.08	0.77	5	High
Increase in accounts receivable	4.05	0.68	6	High
Delay in revenue recognition/recovery	4.05	0.71	6	High
Increased pressure on claims personnel	4.03	0.83	7	High
Risk of claim denial	3.92	0.93	8	High
Reduced claims-processing efficiency	3.90	0.69	9	High

Note. 1.00–1.80, very low; 1.81–2.60, low; 2.61–3.40, moderate; 3.41–4.20, high; 4.21–5.00, very high. Tied means share a rank, as reported in the source.

Table 6 presents the issues and concerns arising from RTH claims. Increased follow-up activities ranked first (M = 4.34), followed by increased administrative workload (M = 4.27), both rated very high, and additional coordination among hospital departments (M = 4.17). Delays in PhilHealth reimbursement (M = 4.12), additional documentation and encoding work (M = 4.08), increased accounts receivable and delayed revenue recognition or recovery (both M = 4.05), increased pressure on claims personnel (M = 4.03), risk of claim denial (M = 3.92), and reduced claims-processing efficiency (M = 3.90) were all rated high.

These findings show that RTH claims impose a compounding operational burden: personnel must request missing documents, correct deficiencies, coordinate with other departments, monitor returned claims, and prepare them for resubmission. The concerns about reimbursement delays and accounts receivable reflect the vulnerability of hospital cash flow to uncollected insurance receivables (McCue & Thompson, 2011; Uy et al., 2021) and the importance of days in accounts receivable as a financial indicator (Ullman, 2015). Similar consequences of delayed reimbursement, including constrained procurement and pressure on facility finances, have been reported under social health insurance schemes in Ghana (Laar et al., 2021; Sakyi et al., 2012) and in the Philippines (Capeding et al., 2025), while the administrative workload reflects the governance and integration challenges of revenue cycle management (Alradhi & Alanazi, 2023).

Proposed Standardized PhilHealth RTH Claims Assessment Process

Based on the findings, the study proposes a Standardized PhilHealth RTH Claims Assessment Process for Chong Hua Hospital to be implemented in Calendar Year 2026 (Table 7). The process addresses incomplete medical documentation, inconsistencies between medical records and claim information, errors in patient and claims data, and gaps in pre-submission validation, while strengthening interdepartmental communication, physician involvement, and the timely resolution of deficiencies. It comprises seven areas: patient documentation and medical records; coding and claims accuracy; pre-submission quality checking and validation; interdepartmental coordination and communication; workload and deficiency monitoring; staff capacity building and development; and governance, monitoring, and evaluation.

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

Table 7. *Proposed Standardized PhilHealth RTH Claims Assessment Process (CY 2026)*

Area of Concern	Key Strategies	Persons Involved	Time Frame	Expected Output
Patient documentation and medical records	Implement a standardized pre-submission documentation checklist; conduct regular completeness reviews of medical records and billing attachments; strengthen compliance with physician signature and documentation requirements.	Medical records staff, attending physicians, claims processors, nursing units	Q1	Increased completeness of records; fewer returns from missing signatures and attachments
Coding and claims accuracy	Double-verify patient demographic and clinical information; update personnel on PhilHealth circulars, benefit policies, and ICD-10 guidelines; coordinate with IT and Billing on system-based encoding validation.	Claims processors, medical coders, IT and Billing, PhilHealth review personnel	Q1–Q2	Improved data accuracy; fewer coding and encoding deficiencies
Pre-submission quality checking and validation	Establish a standardized pre-submission review and validation procedure; assign personnel for final claim verification; document and correct deficiencies before transmission.	PhilHealth claims supervisor, PhilHealth review personnel	Q1	Established internal validation; improved initial claim completeness
Interdepartmental coordination and communication	Define responsibilities and response timelines; establish a referral process for urgent deficiencies; hold regular coordination meetings.	Department heads (Claims, Billing, Medical Records), attending physicians	Q1	Defined responsibilities; reduced delays in obtaining missing documents
Workload and deficiency monitoring	Establish a centralized RTH tracking system recording return reasons, outstanding requirements, responsible units, follow-up actions, and resolution dates; set up notification of pending items.	Claims processors, IT Department, billing personnel	Q2	Monitored resubmission turnaround; reduced repetitive follow-up
Staff capacity building and development	Conduct training on PhilHealth policies, documentation, coding, and claims procedures; provide refresher sessions when policies change; assess competencies.	Human Resource Department, PhilHealth resource speakers, claims and billing personnel	Q2–Q3	Improved personnel knowledge and competency
Governance, monitoring, and evaluation	Secure management approval; review monitoring results and implement corrective actions.	Hospital management, PhilHealth department head, quality management committee	Q1–Q4	Approved process; periodic evaluation reports; sustained improvement

Note. Condensed from the implementation action plan of the study. Budget sources are hospital operational, administrative, IT, quality improvement, and training funds. The process is proposed and has not been implemented or evaluated.

The proposed process applies Total Quality Management's emphasis on prevention and continuous improvement (Deming, 1986) and Donabedian's (1966) linkage of structure, process, and outcome. Its monitoring and evaluation mechanism uses key performance indicators such as compliance with pre-submission checklists,

ISSN: 3116-3475
International Journal
of Education, Research, and Innovation Perspectives
Volume 2 Issue 11 (November 2026)

completeness and accuracy of supporting documents, frequency and reasons for returned claims, time to resolve documentation deficiencies, timeliness of resubmission, and personnel participation in training. Regular performance reviews, feedback from personnel, and analysis of recurring deficiencies are intended to guide updates to checklists, verification procedures, communication channels, and training priorities. The process has not yet been implemented, and its effectiveness should be established through these indicators.

CONCLUSION

The occurrence and handling of RTH PhilHealth claims at Chong Hua Hospital, Cebu City, are influenced by interconnected documentation, coding, claims-processing, and organizational factors. Incomplete medical records, inconsistencies between clinical documentation and claim information, errors in patient and claim details, and incorrect encoding contribute substantially to claim deficiencies, while effective interdepartmental communication, active physician involvement, and timely resolution of documentation deficiencies are essential to complete and accurate claims. Although established claims-processing procedures are in place, standardized checklists, consistent pre-submission quality checking, and systematic monitoring of returned claims remain areas requiring strengthening. Increased follow-up activities, additional administrative workload, and interdepartmental coordination demand illustrate the operational burden that RTH claims place on personnel.

A more standardized approach to RTH claims assessment is therefore necessary to promote consistency, accuracy, and efficiency. The proposed Standardized PhilHealth RTH Claims Assessment Process offers a structured guide for assessing claim requirements consistently, addressing deficiencies promptly, and improving the effectiveness and efficiency of PhilHealth claims processing. Because the findings are based on the perceptions of personnel in a single private tertiary hospital, they should be interpreted within this institutional context.

Recommendations

Based on the findings and conclusions, the following recommendations are offered:

1. Hospital management may implement a standardized pre-submission checklist covering medical records, supporting documents, physician signatures, patient information, and claim accuracy, and the PhilHealth Claims Department may strengthen internal validation so that deficiencies are identified and corrected before submission.
2. Hospital management may improve coordination among the PhilHealth Claims Department, Billing, Medical Records, physicians, and other concerned units by establishing clear responsibilities, communication procedures, and timelines for resolving deficiencies.
3. The PhilHealth Claims Department, in coordination with the IT Department, may establish a systematic tracking process to monitor returned claims, outstanding requirements, follow-up activities, and resubmission status.
4. The Human Resource Department may provide continuing training on documentation, coding, claims validation, and updated PhilHealth policies, with refresher sessions whenever relevant policies change and periodic competency assessments.
5. Hospital management may implement and regularly evaluate the proposed Standardized PhilHealth RTH Claims Assessment Process using measurable indicators, including RTH claim frequency, recurring deficiencies, submission completeness, resolution time, and claim denial outcomes.
6. Future researchers may evaluate the proposed process after implementation, analyze institutional RTH claims records alongside personnel perceptions, and extend the study to other private and public hospitals to compare claims assessment practices.

References

Alradhi, Z., & Alanazi, A. (2023). The road ahead and challenges of revenue cycle management in Saudi governmental hospitals. *Healthcare, 11*(20), Article 2716. https://doi.org/10.3390/healthcare11202716

Banogon, M. R., Llanes, G. E. D. C., Nañagas, J. M. P. R., & Tan, J. Z. G. (2025). Bridging policy and practice: A qualitative study on PhilHealth claims and financial processes in public hospitals. *Philippine Journal of Health Research and Development, 29*(3), 79–90. https://doi.org/10.4103/pjhrd.pjhrd_6_25

Cabalfin, M. R. (2016). *Health financing for the poor in the Philippines: Final report* (PIDS Discussion Paper Series No. 2016-37). Philippine Institute for Development Studies. https://www.pids.gov.ph/publication/discussion-papers/health-financing-for-the-poor-in-the-philippines-final-report

Capeding, T. P. J., Pepito, V. C., Lim, L. T., Legaspi, R. S., Ong, M. M., Loreche, A. M., & Dayrit, M. M. (2025). Financing and resource constraints hindering the optimal implementation of the Universal Health Care Act in the Philippines. *Health Systems & Reform, 11*(1), Article 2596404. https://doi.org/10.1080/23288604.2025.2596404

Deming, W. E. (1986). *Out of the crisis*. Massachusetts Institute of Technology, Center for Advanced Engineering Study.

Donabedian, A. (1966). Evaluating the quality of medical care. *The Milbank Memorial Fund Quarterly, 44*(3), 166–206. https://doi.org/10.2307/3348969

Graham, T. (2001). Increasing revenue through A/R recovery, revenue-cycle redesign. *Healthcare Financial Management, 55*(11), 60–64.

Hindle, D., Acuin, L., & Valera, M. (2001). Health insurance in the Philippines: Bold policies and socio-economic realities. *Australian Health Review, 24*(2), 96–111. https://doi.org/10.1071/AH010096

Laar, A. S., Asare, M., & Dalinjong, P. A. (2021). What alternative and innovative domestic methods of healthcare financing can be explored to fix the current claims reimbursement challenges by the National Health Insurance Scheme of Ghana? Perspectives of health managers. *Cost Effectiveness and Resource Allocation, 19*, Article 69. https://doi.org/10.1186/s12962-021-00323-2

McCue, M. J., & Thompson, J. M. (2011). Analysis of cash flow in academic medical centers in the United States. *Academic Medicine, 86*(9), 1100–1107. https://doi.org/10.1097/ACM.0b013e318226a1ef

Mendoza, M. A. F., Zarsuelo, M. A. M., Borlongan, G. R., Silva, M. E. C., Lam, H. Y., & Padilla, C. D. (2020). Development on third party accreditation of healthcare facilities in light of the Universal Health Care Act: Policy analysis. *Acta Medica Philippina, 54*(6). https://doi.org/10.47895/amp.v54i6.2617

Philippine Health Insurance Corporation. (2019). *PhilHealth Circular No. 2019-0001: Proper recording of Return to Hospital (RTH) and denied benefit claims for reconciliation of accounting records*. https://www.philhealth.gov.ph/circulars/2019/TS_circ2019-0001.pdf

Querri, A., Ohkado, A., Kawatsu, L., Remonte, M. A., Medina, A., & Garfin, A. M. C. (2018). The challenges of the Philippines' social health insurance programme in the era of Universal Health Coverage. *Public Health Action, 8*(4), 175–180. https://doi.org/10.5588/pha.18.0046

Republic of the Philippines. (2019). *Republic Act No. 11223: An act instituting Universal Health Care for all Filipinos, prescribing reforms in the health care system, and appropriating funds therefor*. Official Gazette of the Republic of the Philippines.

Sakyi, E. K., Atinga, R. A., & Adzei, F. A. (2012). Managerial problems of hospitals under Ghana's National Health Insurance Scheme. *Clinical Governance: An International Journal, 17*(3), 178–190. https://doi.org/10.1108/14777271211251291

Ulep, V. G., Uy, J., Casas, L., & Nuevo, C. E. L. (2021). *Assessment of the service capability and readiness of Philippine hospitals to provide high-quality health care* (PIDS Discussion Paper Series No. 2021-32). Philippine Institute for Development Studies. https://pidswebs.pids.gov.ph/CDN/PUBLICATIONS/pidsdps2132.pdf

Ullman, K. (2015). Why days in accounts receivable is a key metric for healthcare finance pros. *Healthcare Finance News*. https://www.healthcarefinancenews.com/news/why-days-accounts-receivable-key-metric-healthcare-finance-pros

Uy, J., Nuevo, C. E. L., Casas, L., & Ulep, V. G. (2021). *The financial health of select Philippine hospitals and the role of the Philippine Health Insurance Corporation as the national strategic purchaser of health services* (PIDS Discussion Paper Series No. 2021-36). Philippine Institute for Development Studies. https://pidswebs.pids.gov.ph/CDN/PUBLICATIONS/pidsdps2136.pdf

Von Bertalanffy, L. (1968). *General system theory: Foundations, development, applications*. George Braziller.

World Health Organization & Department of Health Philippines. (2018). *The Philippines health system review* (Health Systems in Transition, Vol. 8, No. 2). World Health Organization Regional Office for the Western Pacific.