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IN-HOUSE MEDICAL CLAIMS CLEARING HOUSE: CHALLENGES AND BEST PRACTICES IN CONCEPTUALIZATION, IMPLEMENTATION, AND OUTCOMES

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ABSTRACT

The Philippine Universal Health Care Act mandates PhilHealth as a strategic purchaser, yet claims inefficiencies strain public hospitals. This study examined Western Visayas Medical Center's (WVMC) Medical Claims Clearinghouse (MCCH), which internalized traditionally outsourced validation functions. Using thematic analysis of interviews and records, the study found the MCCH successfully mitigated liquidity risks. By reallocating personnel and utilizing free digital tools, the unit achieved 941 consecutive claims with zero returns-to-hospital through pre-discharge reviews. Key outcomes included a 67.54% reduction in coding errors and improved turnaround times. Despite challenges, best practices—including clinical-financial feedback loops and real-time dashboards—demonstrate that adaptive innovation strengthens revenue cycle management, offering a replicable framework for resource-constrained hospitals under Universal Health Care. Thus, strategic institutional shifts can transform administrative hurdles into sustainable financial stability.

Keywords: *Medical Claims Clearinghouse, revenue cycle management, claims processing, Universal Health Care, public hospital, Philippines*

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INTRODUCTION

The Universal Health Care Act positions the Philippine Health Insurance Corporation as the national strategic purchaser of health services. However, operationalizing this mandate has been hampered by structural bottlenecks, including weak purchasing leverage, delayed provider reimbursements, and fragmented financing mechanisms across local government units (Co et al., 2024; Uy, 2024). As the primary payer, PhilHealth's centralized claims processing has created a "single point of failure" within hospital revenue cycles, with state auditors flagging massive backlogs of unpaid claims and data integrity issues (Commission on Audit [COA], 2023). These delays are often worsened by rigid adjudication policies and frequent shifts in payment mechanisms, which have increased denial rates and Return-to-Hospital (RTH) claims (Medina et al., 2024). For government hospitals, these disruptions threaten operational liquidity; as of late 2024, government hospitals reported approximately PHP 14.8 billion in unpaid PhilHealth claims, while RTH claims—returned solely for clerical correction—were estimated at PHP 4.5 billion (The GUIDON, 2025; Philippine Daily Inquirer, 2025). In response, the Western Visayas Medical Center (WVMC) in Iloilo City initiated a strategic shift: the establishment of an In-House Medical Claims Clearinghouse (MCCH). This study examines the challenges encountered and best practices developed in the conceptualization, implementation, and outcomes of this pioneering model, with the goal of providing a replicable framework for other public hospitals.

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MATERIALS AND METHODS

Research Methodology

This study employed a qualitative descriptive design to provide a comprehensive and accurate depiction of the MCCH implementation. This approach was chosen to generate rich, context-specific insights by staying close to the surface of the data without imposing a theoretical lens, focusing on how and why questions (Sandelowski, 2000; Villamin et al., 2024).

Research Method

A single-case study design was utilized, focusing on the MCCH at Western Visayas Medical Center. Primary data were gathered through semi-structured Key Informant Interviews and focus group discussions, while secondary data consisted of operational logs, Standard Operating Procedures, and institutional financial records.

Research Design

The study was guided by the Input-Process-Output (IPO) framework, which organized the investigation into the strategic drivers and resources (inputs), the workflow integration and validation protocols (processes), and the resulting claims outcomes, operational efficiency, financial impact, and staff well-being (outputs) (Creswell & Creswell, 2018; Langabeer & Helton, 2020).

Participants of the Study

Participants were purposively selected as key informants with direct systemic experience. They included technical staff from the Billing, Claims, and MCCH units; operational

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heads such as the Head of MCCH and the Head of Billing and Claims; and strategic leads including the Planning Officer and Budget Officer. This multi-perspective selection ensured a comprehensive understanding of the program's lifecycle.

Sampling Design

Purposive sampling was employed to prioritize the quality of information over statistical representativeness. Participants were selected based on their direct involvement in MCCH operations and their institutional tenure, with the final sample size governed by the principle of data saturation.

Research Instrument

The primary instrument was a researcher-designed, semi-structured Key Informant Interview guide. It contained open-ended questions organized into four thematic areas: Strategic Planning, Resource Readiness, Implementation Dynamics, and Perceived Outcomes. The guide was designed to capture detailed narratives regarding the conceptualization, challenges, and best practices of the MCCH.

Validity of the Research Instrument

Trustworthiness was established through expert validation by a hospital administrator to ensure clarity and relevance. Additional qualitative strategies included triangulation of findings with documentary evidence, member checking, and maintaining an audit trail, which replaced psychometric validation as appropriate for this qualitative inquiry (Creswell & Poth, 2018).

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Data Gathering Procedures

Data collection followed a systematic, multi-phased process. Formal approval was first obtained from the WVMC Medical Center Chief. Primary data were then gathered through focus group discussions and semi-structured Key Informant Interviews, which were audio-recorded and transcribed. A thorough document review was subsequently performed, analyzing operational logs, Standard Operating Procedures, and financial records to triangulate the qualitative narratives with institutional performance data.

Data Analyses

Thematic analysis was used to analyze the data. This involved transcribing the interviews, coding the text to identify recurring patterns, and synthesizing the codes into broader themes. Qualitative findings were triangulated with document review results, including analysis of actual cases processed through the MCCH, to strengthen credibility and confirmability.

RESULTS AND DISCUSSIONS

The findings are organized according to the six research questions that guided the study. Participants' narratives revealed that revenue vulnerability and institutional risk exposure were the primary drivers for establishing the MCCH. The alarming increase in Return-to-Hospital cases and denied claims was identified as having a "dako gid nga financial impact" (very big financial impact) on hospital operations. These findings align with national audit reports documenting PHP 786.6 million in denied claims and PHP 298.7 million in RTH

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claims across DOH-retained hospitals (Inquirer, 2025). Beyond immediate financial concerns, governance and professional safeguards constituted equally important drivers; participants noted that errors in coding posed licensure and reputational risks for physicians, positioning the MCCH as a governance structure to ensure ethical compliance.

Regarding resource allocation, the MCCH was implemented with minimal capital investment through strategic reallocation of existing personnel and reliance on freely available tools such as iHOMIS, Excel, and Google Sheets. The initial staffing comprised six Contract of Service personnel, most reassigned from existing units. This "human-powered rules engine" demonstrated organizational resilience in the absence of automated scrubbing software, consistent with the observation that public hospitals face technological constraints (Dayrit et al., 2021). However, concerns were raised about the sustainability of relying on non-permanent staff, with participants emphasizing the need for plantilla positions to ensure continuity of specialized expertise.

Participants' lived experiences revealed initial cultural resistance from clinical staff and physicians, which gradually transformed into acceptance as the benefits became evident, particularly the reduction of interruptions during clinic hours. This finding supports the theoretical perspective that healthcare organizations, as complex adaptive systems, require sustained engagement to achieve cultural transformation (Borkowski & Meese, 2021). The workflow evolved from CF4-only review to comprehensive chart review, and the most significant innovation was the pre-discharge chart review. In four wards covered by this process, 941 consecutive claims were submitted with zero returns-to-hospital. Formalization

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of the scrubbing protocol resulted in a three-tier validation process: verification of admitting diagnosis, comprehensive chart review, and pre-submission quality checks.

Perceived outcomes included a 67.54% decrease in wrong code claims, a 79.70% decrease in CT scan-related issues, and a 49.68% decrease in operative record deficiencies between 2024 and 2025. Internal turnaround time improved from 38 days in 2023 to 35 days in 2025. These results affirm the clearinghouse literature, which documents that effective claim scrubbing reduces denials and improves reimbursement cycles (Alder, 2024; Experian Health, 2022). Financial stabilization was achieved by preventing "wastage of potential income," directly supporting the hospital's expansion under the UHC Act. Staff well-being also improved, with participants characterizing previous workflows as "toxic" and current workflows as "less toxic" due to the transparency and reduced cognitive load provided by shared monitoring dashboards.

Implementation challenges included regulatory volatility due to frequent PhilHealth policy changes, IT infrastructure and interoperability gaps that prevented reading of RTH notification attachments, documentation and communication barriers such as delayed chart submission, and external system limitations. The frustrations expressed regarding portal glitches and system downtime echo the literature's documentation of policy instability and infrastructure gaps (Cielo et al., 2024; Dayrit et al., 2021). Each challenge, however, triggered adaptive responses, such as the digitization of operative records in response to illegible documentation.

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Best practices that emerged include pre-discharge validation as the most critical intervention; embedded clinical-financial feedback loops through Continuous Quality Improvement (CQI) meetings and dashboard presentations; manual validation matrices that systematize the review process; and real-time monitoring dashboards using Google Sheets to enable transparent tracking and coordination. These practices align with the General Systems Theory perspective that feedback loops and subsystem optimization contribute to overall system resilience (Borkowski & Meese, 2021). Policy recommendations center on institutionalizing the MCCH through permanent plantilla positions, establishing dedicated budget lines, developing standardized clinical documentation guidelines, and integrating MCCH functions into the hospital information system.

CONCLUSION

The in-house Medical Claims Clearinghouse at Western Visayas Medical Center represents a strategic institutional response to systemic claims processing inefficiencies. The study concludes that revenue vulnerability and governance concerns drove the conceptualization of the MCCH, and its implementation succeeded through strategic reallocation of existing resources and adaptive process innovations. The pre-discharge review model, combined with structured validation protocols and transparent monitoring tools, yielded substantial improvements in claims quality, operational efficiency, and staff well-being. While challenges such as regulatory volatility and human capital sustainability persist, the best practices developed at WVMC offer a replicable framework for other resource-constrained

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public hospitals. Ultimately, the MCCH demonstrates that adaptive innovation, grounded in systems thinking and supported by organizational learning, can transform administrative hurdles into sustainable financial stability under Universal Health Care.

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