Republic of the Philippines

PHILIPPINE HEALTH INSURANCE CORPORATION

Citystate Centre Building, 709 Shaw Boulevard, Pasig City
Healthline 441-7444 www.philhealth.gov.ph

PhilHealth Circular
No. 059 s.2012

TO : ALL ACCREDITED HEALTH CARE PROVIDERS, PHILHEALTH MEMBERS, PHILHEALTH REGIONAL OFFICES AND ALL OTHERS CONCERNED

SUBJECT : **Requirement of Pre-cataract Surgery Authorization**

To ensure quality and appropriate provision of services and utilization of PhilHealth benefits; as well as to safeguard against possible abuses and unethical practices, all claims/reimbursements involving cataract procedures shall require an approved pre-cataract surgery authorization request from the Corporation.

A. General rules for application of pre-cataract surgery authorization request

1. PhilHealth shall only reimburse claims for cataract surgeries that have been duly pre-approved/pre-authorized (thru a pre-cataract surgery authorization request approved by PhilHealth), except in cases of childhood[1] and secondary cataracts (e.g., traumatic, glaucomatous). Claims for cataract surgeries without approved pre-cataract surgery authorization request shall result to denial of claims.
2. All cataract surgeries must be performed only in PhilHealth-accredited health care facilities (hospitals and ambulatory surgical clinics) where the physician is affiliated, as declared in his/her accreditation profile.
3. All cataract mission activities endorsed by the Philippine Academy of Ophthalmology (PAO) that will be performed in government facilities shall require the prior submission of a pre- cataract surgery authorization request and checklist.
4. PhilHealth-accredited physicians performing cataract surgeries in facilities other than those that they are affiliated with as declared in their accreditation profile will be allowed, provided that the surgical procedures are done in government facilities during mission activities endorsed by the PAO and with approved pre-cataract surgery authorization requests.
5. Existing requirements and rules on eligibility of benefits availment shall apply. An approved pre-cataract surgery authorization request shall not automatically guarantee the approval of the corresponding claim for reimbursement.
6. Direct filing of claims by member/dependent shall not be allowed by the Corporation.

B. Procedure for Securing Pre-cataract Surgery Authorization Request

1. All PhilHealth-accredited physicians who intend to claim for cataract surgery shall notify PhilHealth of the planned surgery before services are actually provided, by submitting a pre-cataract surgery authorization request and checklist (Annexes A & C). The request form must be noted by the medical director or chief of hospital or administrator for ambulatory surgical clinic (ASC).
2. A scanned copy of the pre-cataract surgery authorization request and checklist must be submitted via e-mail to the proper PhilHealth Regional Office – Benefit Administration Section (PRO-BAS). The corresponding e-mail addresses of PRO-BAS to which the requests shall be submitted are listed in Annex B.

[1] WHO definition – 17 years and 364 days (less than 18 years old)

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3. All necessary information in the pre-cataract surgery authorization request and checklist must be sought. The PROs shall not process requests with incomplete information and will return the document for completion.
4. The PRO-BAS shall evaluate the request and notify the concerned health care providers of the decision thereon within five (5) working days from receipt of the complete pre-cataract surgery authorization request and checklist.
5. The requesting physician and institutional health care provider shall be notified of the decision on pre-cataract surgery authorization request by sending a scanned copy of the approved request by e-mail.
6. The pre-cataract surgery authorization is valid for 30 days after the date of approval by the PRO-BAS. If the procedure is not done within that period, another pre-cataract surgery authorization request must be submitted subject to PhilHealth approval.

C. Requirements for submission of claims

PhilHealth shall require a copy of the approved request for pre-cataract surgery authorization (Annex A page 2) as additional documentary requirement for processing of all claims for cataract surgeries.

D. Monitoring and Evaluation

The monitoring and evaluation activities shall be designed to ensure compliance with standards of quality and patient safety. The same shall also monitor compliance with existing policies that safeguard against abuses and unethical practices related to cataract claims conducted through medical missions and other unethical recruitment schemes.

Monitoring activities shall include, among others, inspections, interviews, surveys, document reviews, and analysis of electronic data.

E. Repealing clause

All other issuances inconsistent herein are hereby revised, modified, or repealed accordingly.

F. Effectivity

This circular shall take effect for all admissions starting 1 February 2013.

For information and guidance of all concerned.

DR. EDUARDO P. BANZON
President and CEO

Date signed: 12/5/12

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ANNEX A

Date: _____

Patient: _____ Birthday (mm/dd/yy): _____
(Surname), (First name) (Middle name)
Address of Patient: _____ Phone: _____

Name of PhilHealth Member: _____ PhilHealth ID no.: _____

PhilHealth membership category (pls. check appropriate box)
☐ Employed ☐ Non-paying (retirees/pensioners)
☐ Individual paying ☐ OWP
☐ Sponsored
If sponsored, tick appropriate classification/sponsor
☐ NHTS ☐ LGU ☐ Others (please specify) _____

Pre-cataract Surgery Authorization Checklist (Adult Cataract)

Part I. Clinical Information

1.	Presence of lens opacity	Please check appropriate box. ☐ Right eye ☐ Left eye	
2.	Complete Diagnosis		
3.	Procedure		
4.	Pre-operative Best Corrected Visual Acuity (BCVA)*	Right Eye	Left Eye
5.	Uncorrected Visual Acuity	Right Eye	Left Eye
6.	Refraction	Right Eye	Left Eye
7.	Cardio-pulmonary clearance done.	☐ Yes ☐ No	If No, state reason/s.

** BCVA is the measure of best acuity while wearing corrective lenses*

Part II. Non-Clinical Information

1.	Date of contemplated operation (day/month/year)	
2.	Name and address of hospital/ASC	Accreditation number:
3.	Name of PhilHealth accredited physician	Accreditation number: Contact no/s:
4.	Contact number/s of patient or relative	
5.	Mode of referral/contact (pls. check appropriate box)	☐ Walk-in ☐ Referred by another physician ☐ Referred by another health professional ☐ Referred by family/relatives ☐ Others, please specify: _____
6.	Name of physician who evaluated this patient	
7.	Name of physician who will perform follow-up on this patient	
8.	Patient is to be operated in a mission activity	☐ Yes ☐ No

I hereby certify that the above-mentioned information is true and correct.

Printed name & signature of PhilHealth-accredited physician who will perform the procedure	Printed Name and Signature of Patient	Date accomplished

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PRE-CATARACT SURGERY AUTHORIZATION REQUEST
(Adult Cataract)

Date of request: _____

This is to request approval for my patient _____, _____, who
(name of patient) *(age)*
will undergo cataract operation at _____
(name of hospital/ASC)
and shall claim reimbursement from PhilHealth, under the terms and conditions as agreed for availment of the Cataract Benefit Package.

Requested by:	Noted by:
_____	_____
Name & Signature of Physician	Medical Center Chief/Medical Dir. / ASC Administrator or any authorized personnel

This Portion to be filled-out by PhilHealth	
☐ Approved* *Patient is eligible at the time of approval of pre-cataract surgery authorization. ☐ Disapproved Reason: _____	
Name and Signature of BAS Head	Tracking number
Date signed	

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ANNEX B

EMAIL ADDRESSES FOR PRE-CATARACT SURGERY AUTHORIZATION

No.	Region	E-mail Address
1	PRO I	claims.pro1@philhealth.gov.ph
2	PRO II	dok_neth@yahoo.com
3	PRO IIIA	claims.pro3@philhealth.gov.ph
4	PRO IIIB	benefit.pro3b@philhealth.gov.ph
5	PRO IVA	claims.pro4a@philhealth.gov.ph
6	PRO IVB	claims.pro4b@philhealth.gov.ph
7	PRO V	hcmd.pro5@philhealth.gov.ph
8	PRO VI	pro6.hcdmd@gmail.com
9	PRO VII	claims.pro7@philhealth.gov.ph
10	PRO VIII	claims.pro8@philhealth.gov.ph
11	PRO IX	rossanaparaguya@yahoo.com
12	PRO X	mmalonto@philhealth.gov.ph;bas.pro10@philhealth.gov.ph
13	PRO XI	rubenmd2003@yahoo.com
14	PRO XII	claims.pro12@philhealth.gov.ph
15	PRO CAR	claims.procar@philhealth.gov.ph
16	PRO CARAGA	hcdmd.procaraga@philhealth.gov.ph
17	PRO ARMM	claims.proarmm@philhealth.gov.ph;hcdmd.proarmm@philhealth.gov.ph
18	PRO NCR-North	claims.promla@philhealth.gov.ph
19	PRO NCR-South	claims.prolp@philhealth.gov.ph
20	PRO NCR-Central	claims.progc@philhealth.gov.ph

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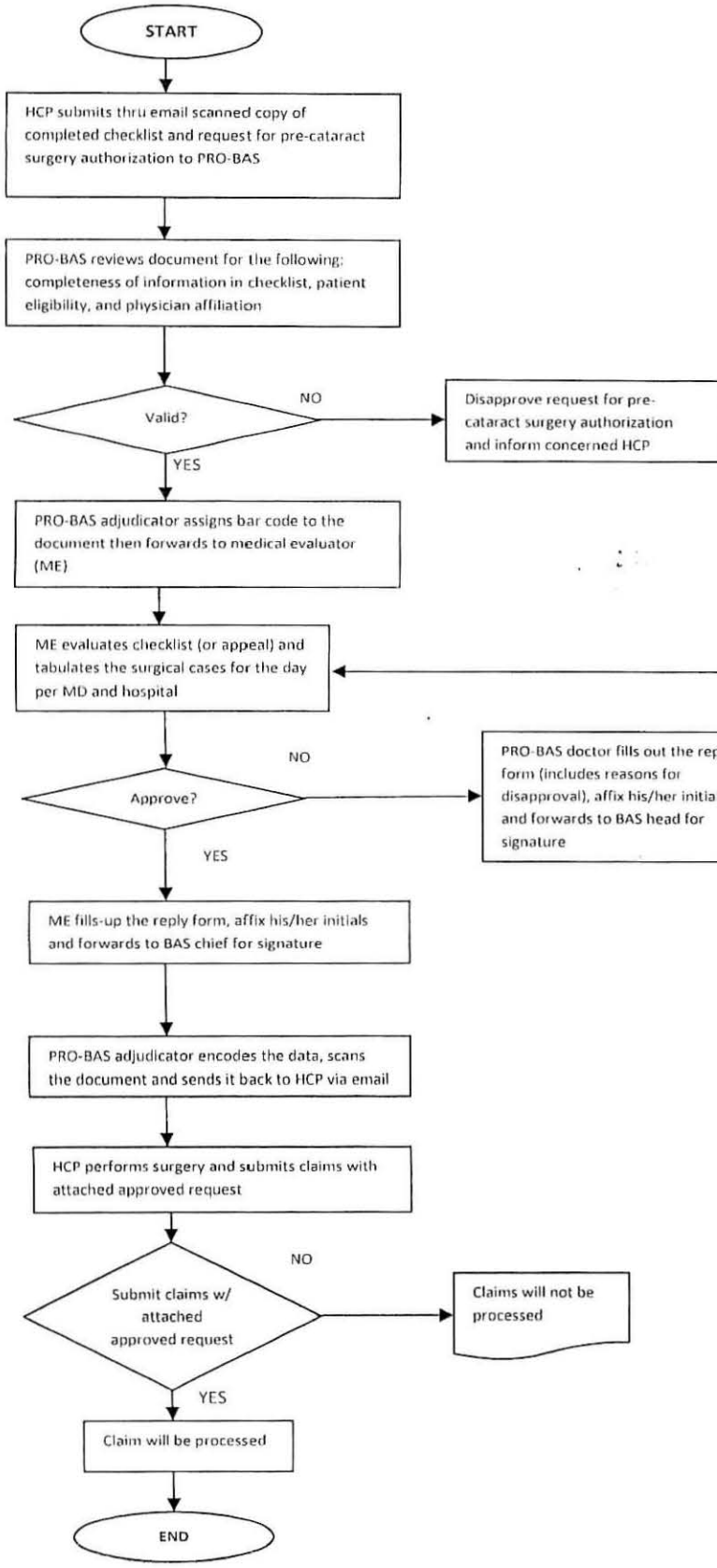
Annex C. Flowchart for pre-cataract surgery authorization request



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Date: 1/25/19
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