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. 0019 ,s-2013

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

SUBJECT : **Z Benefits Rate for the Mobility, Orthosis, Rehabilitation, Prosthesis Help (Z MORPH) Package for the Fitting of External Lower Limb Prosthesis Below the Knee**

I. RATIONALE

The Philippine Health Insurance Corporation recognizes the potential towards functional independence and productivity of persons with physical disabilities, particularly those with limb loss or deficiency, once they are provided with the affordable prostheses.

Aligned with the mission of Republic Act 7277 or the Magna Carta for Disabled Persons, PhilHealth seeks to mainstream and reintegrate persons with physical disabilities into the community by rendering prosthetic services available.

Cognizant of the United Nations Convention on the Rights of Persons with Disabilities' vision of full and equal enjoyment of human rights by persons with disabilities, PhilHealth shall ensure protection of their inherent dignity through prosthetic devices that are safe, appropriate, accessible, and of quality.

In fulfillment of the aforementioned, PhilHealth Board Resolution No.1678, s-2012 and PhilHealth Circular No. 29, s-2012, *"Governing Policies on PhilHealth Benefit Package for Case Type Z"*, the following are the services and rates for the ***Mobility, Orthosis, Rehabilitation, Prosthesis Help (Z MORPH)*** package for the fitting of external lower limb prosthesis below the knee.

II. RULES FOR IDENTIFIED Z MORPH

A. The initial fitting of the right and/or left lower limb prosthesis below the knee shall be covered under the benefit package and only those cases that strictly fulfill the selections criteria shall be covered;

B. All qualified members availing of the Z MORPH shall be required a 3-year lock-in membership prior to availment of the benefit. Employed members are required to sign a Z benefit commitment form or submit a certificate of approval/agreement from the employer to the lock-in membership for the next three (3) years. The lock-in membership does not apply to lifetime and sponsored-program members;

C. Pre-authorization from PhilHealth based on the approved selections criteria for Z MORPH for the fitting of the external lower limb prosthesis below the knee shall be required prior to availment of services. All requests for pre-authorization shall be accomplished completely by the contracted hospital and the same is submitted to the Head of the Regional Benefits Administration Section (BAS) for final approval;

D. The fulfillment of the approved selections criteria shall be the basis for approval of the pre-authorization request;

E. The No Balance Billing (NBB) policy shall be applied for eligible sponsored program members and their qualified dependents. Negotiated fixed co-pay shall be applied for eligible non-sponsored members and their qualified dependents. In no instance shall the fixed co-pay exceed the package rate;

F. The professional fees for the Z MORPH for the fitting of external lower limb prosthesis below the knee is 20% of the package rate;

G. Patients enrolled in the Z benefits shall be deducted a maximum of five (5) days from the 45 days annual benefit limit and such deduction shall be made only on the current year during the fitting of the prosthesis. In cases where the remaining annual benefit is less than five (5) days, the member shall remain eligible to avail of the Z benefit, provided that premiums are updated;

H. All rates are inclusive of government taxes;

I. Rules on pooling of professional fees for government facilities shall apply;

J. All mandatory and other services specific to the Z MORPH for the fitting of external lower limb prosthesis below the knee, that ensures the safety and quality of materials used, shall be provided to the patient according to the approved standards set by the reference hospital.

III. CASE TYPE Z BENEFIT FOR THE Z MORPH

Fitting of External Lower Limb Prosthesis Below the Knee

1. The package code for the laterality of the lower limbs is as follows:
   a. **Z010-A** for the right lower limb
   b. **Z010-B** for the left lower limb
   c. **Z010-C** for the right and left lower limbs

   The overall package code for the Z MORPH is **Z010,** which includes the following descriptions and ICD-10 code reflected in the table below:

Description	ICD 10 CODE
Foot or Symes or Ankle (foot)	**Z44.1**
Below Knee or Transtibial (below the knee)	

2. The package rate shall be **15,000 pesos per first right and/or left below the knee lower limb prosthesis and 30,000 pesos if both limbs** for the entire pre- and post-prosthetic management of either the foot, symes, ankle or below knee levels of amputation.

3. Approved Selections Criteria :

   a. Signed Member Empowerment (ME) Form;

   b. No associated disabilities or co-morbidities, such as contractures, deformities, mental or behavioral incapacity, quadriparesis, cardiopulmonary disease;

   c. Community ambulation with or without cane, crutches or walker;

   d. At least three (3) months post-amputation, if acquired; and

   e. At least 15 years and 364 days of age, if congenital.

4. The Z MORPH for the fitting of external lower limb prosthesis below the knee shall reflect the following mandatory and other services as indicated in the table below:

MANDATORY SERVICES	OTHER SERVICES
1. Pre-prosthetic assessment by a board certified physician of the Philippine Board of Rehabilitation Medicine; 2. Prosthetic measurement, fabrication and check-out by International Society of Prosthetics and Orthotics Category 1 (prosthetist) or Category 2 (prosthetic technician) who have undergone training in a prosthetic workshop; 3. Final discharge disposition by a board certified physician of the Philippine Board of Rehabilitation Medicine. **Note**: The reference and contracted hospitals shall have the responsibility to ensure the credentialing of the physicians, prosthetists, prosthetic technicians, physical and occupational therapists.	When warranted, post-prosthetic rehabilitation program* shall be prescribed by a board certified physician of the Philippine Board of Rehabilitation Medicine and implemented by a PRC-licensed physical or occupational therapist. **Post-prosthetic Rehabilitation program – supervised exercises and activities to ensure optimum functionality with prosthesis*

5. The payment for this package shall be **Fifteen Thousand Pesos (Php15,000) per first right and/or left below the knee external lower limb prosthesis and 30,000 pesos if both limbs** for either symes, ankle, foot or below knee, which shall be given in a single tranche payment after the patient has received all mandatory services.

MODE OF PAYMENT	AMOUNT	FILING SCHEDULE
Single tranche	Php 15,000.00 per limb	Within 60 days after the final discharge disposition of the patient by a board certified physician of the Philippine Board of Rehabilitation Medicine

IV. CLAIMS FILING FOR Z MORPH

All claims shall be filed by the contracted hospitals in behalf of the patient according to the ***Implementing Guidelines on the Z Benefit Package*** (PhilHealth Circular 48, series of 2012).

V. EFFECTIVITY

This circular shall take effect for all approved pre-authorization starting August 30, 2013. This shall be published in any newspaper of general circulation and a copy thereof deposited thereafter with the Office of the National Administrative Register, University of the Philippines Law Center.

VI. ANNEXES

1. Pre – authorization checklist and request for Z MORPH for the Fitting of External Lower Limb Prosthesis Below the Knee (ANNEX "A")

2. Documentary Requirements for claims filing

    a. Discharge checklist MORPH (ANNEX "B")
    b. Member Empowerment Form (ME Form) (ANNEX "C")
    c. Z Satisfaction Questionnaire (ANNEX "D")

Please be guided accordingly

ALEXANDER N. PADILLA
President and CEO

Date signed: 8/29/13

PHILHEALTH
MA. TERESA A. QUIAOIT
A.O. IV, Chief, PELMS
Date: 8/29/13
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ANNEX "A"

DATE _____

NAME OF HOSPITAL _____

NAME OF PATIENT _____

PhilHealth ID Number _____

PRE-AUTHORIZATION CHECKLIST FOR Z MORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

Place a check mark (✓) on the appropriate lower limb:

☐Right lower limb ☐Left lower limb ☐Right & left lower limbs

(Place a ✓or NA)

QUALIFICATIONS	Yes	Attested by Rehabilitation Medicine Specialist (Printed name & Signature)
1. Age at least 15 years and 364 days	☐	
2. At least 3 months post-amputation, if acquired	☐	
3. Wheelchair Independent -Community Ambulator With or without prosthesis With or without cane or crutches or walker	 ☐ ☐	
4. No Co-morbidities: a. No congestive heart failure or ischemic heart disease b. No chronic obstructive or restrictive lung disease c. No systemic infection d. No mental or behavioral incapacity	 ☐ ☐ ☐ ☐	
5. Physical Examination: No fresh or non-healing wound No neuroma or painful residual limb No motor strength <4/5 of lower limbs No limitation of motion of lower limbs No incoordination or poor balance	 ☐ ☐ ☐ ☐ ☐	
6. Right lower limb only	☐	
7. Left lower limb only	☐	
8. Right and left lower limbs	☐	

CONFORME BY PATIENT/LEGAL REPRESENTATIVE:

_____

Signature over printed name of patient or legal representative

PHILHEALTH
MA. TERESA A. QUIAOIT
Date: 8/29/13

_____

Date signed by patient/legal representative

ANNEX "A"

PRE-AUTHORIZATION REQUEST FOR Z MORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

DATE OF REQUEST_____

This is to request approval for provision of services under the Z benefit package for

_____ in _____
(NAME OF PATIENT) (NAME OF HOSPITAL)

under the terms and conditions as agreed for availment of the Z Benefit Package.

Requested by:

_____
Printed Name & Signature
Attending Rehabilitation Medicine Specialist

SOCIAL SERVICE ASSESSMENT

The patient belongs to the following category (tick appropriate box):
☐ NBB for sponsored program member ☐ Zero Co-pay for non-sponsored member
☐ FIXED CO-PAY (Indicate Amount) Php _____

ASSESSED BY:

_____
Printed Name & Signature/Designation

CONFIRMED BY:

_____
(Signature over Printed Name)
Medical Director / Chief of Hospital

(For PhilHealth Use Only)
☐ APPROVED ☐Right lower limb ☐Left lower limb ☐Right & left lower limbs
☐ DISAPPROVED
Reason/s for disapproval: _____

_____
(Signature over Printed Name)
Head, Benefits Administration Section

DATE: _____

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MA. TERESA A. QUIAOIT
A.O. Chief, RELMS
Date: 8/09/13
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ANNEX "B"

DATE _____

NAME OF HOSPITAL _____

NAME OF PATIENT _____

PhilHealth ID Number _____

DISCHARGE CHECKLIST FOR Z MORPH FITTING OF EXTERNAL LOWER LIMB PROSTHESIS BELOW THE KNEE

Place a check mark (√) on the appropriate lower limb prosthesis:

☐ Right lower limb ☐ Left Lower Limb ☐ Right and left lower limbs

(Place a ✓or NA)

CRITERIA	Yes	Attested by Rehabilitation Medicine Specialist (Printed Name & Signature)	Date signed
1. External below knee lower limb prosthesis provided is as prescribed with appropriate pressure tolerant & sensitive areas, well-fitting socket, good suspension, aligned shank and stable prosthetic foot while standing & walking			
2. The below knee stump is free of pain, blister, vascular compromise, hypersensitivity after 30 minutes of prosthetic weight bearing while standing &/or walking			
3. Prosthesis user ambulates on even and uneven surfaces within expected gait parameters and steps up & down five (5) steps with or without assistive device			
4. Prosthesis user possesses competent skill and knowledge regarding prosthesis donning , doffing, cleaning, precautions and falling techniques			

Confirmed by: _____
(Signature and Printed Name)
Medical Director/ Chief of Hospital

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CONFORME BY PATIENT/LEGAL REPRESENTATIVE:

_____
Signature over printed name of patient or legal representative

_____
Date signed by patient/legal representative

MEMBER EMPOWERMENT FORM

Inform, support & empower

Instructions:

1. The healthcare provider shall explain and assist the patient in filling-up the ME form.
2. Legibly print all information provided.
3. For items requiring a "yes" or "no" response, tick appropriately with a check mark (√).
4. Use additional blank sheets if necessary, label properly and attach securely to this ME form.
5. The ME form shall be reproduced by the contracted hospital providing specialized care.
6. Duplicate copies of the ME form shall be made available by the contracted hospital—one for the patient and one as file copy of the contracted hospital providing the specialized care.
7. **For patients availing of the Z MORPH for the fitting of external lower limb prosthesis, write N/A for items B2, B3, C4 and D6.**

A. Member/Patient Information

Name of Patient
PhilHealth No.
Current age
Birthday
Sex
Permanent address
Telephone/Mobile No.
Email address

B. Clinical Information

1. Description of condition

2. Applicable Treatment Protocol for Z condition agreed upon with healthcare provider

3. Applicable Alternative Protocol/s for Z condition agreed upon with healthcare provider

C. Treatment Schedule and Follow-up Visit/s

1. Date of initial hospital admission or consult [a] _____
(month/day/year)

[a] **This refers to the external lower limb pre-prostheses rehabilitation consult for the Z MORPH**

2. Date/s of succeeding hospital admission/s or consults [b] _____
(month/day/year)

[b] **This refers to the external lower limb measurement, fitting and adjustments for the Z MORPH**

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3. Date/s of follow-up visit/s [c] _____
(month/day/year)

[c] **This refers to the external lower limb post-prosthesis rehabilitation consult**

4. Emergencies (Write exact date/s with the reason or brief description of the nature of the emergency)

D. Member Education

1. My healthcare provider explained the nature of my condition and the expected outcomes resulting from my condition.
Yes ___ No ___

2. My healthcare provider explained the treatment options[d].
Yes ___ No ___
[d] This refers to the need for pre- and post- external lower limb prosthesis rehabilitation for the Z MORPH

3. The possible side effects/adverse effects of treatment were explained to me.
Yes___ No___

4. My healthcare provider explained the mandatory services and other services required for the treatment of my condition.
Yes___ No___

5. I am satisfied with the explanation given to me by my healthcare provider.
Yes___ No___

6. I have been fully informed that I will be cared for by all the pertinent medical specialties (surgery, medical/ pediatric oncology/ nephrology, radio-oncology, and other pertinent specialties as I may need) present in the PhilHealth contracted hospital of my choice and that preferring another contracted hospital for the said specialized care will not affect my treatment in any way.
Yes___ No ____

7. My healthcare provider explained the importance of adhering to my treatment schedule.
Yes ___ No ___

8. My healthcare provider gave me the schedule/s of my follow-up visit/s.
Yes ___ No ___

9. My healthcare provider gave me information where to go for financial and other means of support, when needed.
Yes ___ No ___

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A.O.V, Chief, RHMS
Date: 8/29/13
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a) Name of government agency (PCSO, PMS, LGU, etc)
   i. _____
   ii. _____
   iii. _____

b) Name of non-governmental organization/s
   i. _____
   ii. _____
   iii. _____

c) Name of Patient Support Group/s
   i. _____
   ii. _____
   iii. _____

d) Name of Corporate Foundation/s
   i. _____
   ii. _____
   iii. _____

e) Others (Media, Religious Group/s, Politician/s, etc)
   i. _____
   ii. _____
   iii. _____

10. I have been furnished by my healthcare provider with a list and contact information of other contracted hospitals for the specialized care of my condition.
    Yes___ No___

11. I have been fully informed by my healthcare provider of the PhilHealth membership policies and benefit availment on the Case Type Z:

    a. I fulfill all selections criteria for my condition. Yes___ No ___

    b. I understand the "no balance billing" (NBB) policy for sponsored members.
       Yes___ No___

    c. I understand the fixed co-pay for non-sponsored members.
       Yes___ No___

    d. Only five (5) days shall be deducted from the 45 days annual benefit limit for the duration of my treatment under the case type Z benefit package.
       Yes___ No___

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e. I shall update my premium contributions in order to avail the Case Type Z package and other PhilHealth benefits.
Yes___ No___

E. Member Roles & Responsibilities

1. I understand that I am responsible for adhering to my treatment schedule.
Yes___ No___

2. I understand that adherence to my treatment schedule is important in terms of treatment outcomes and a pre-requisite to the full entitlement of the case type Z benefit.
Yes___ No___

3. I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the healthcare provider in order to avail of the full case type Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the healthcare provider, I waive the privilege of availing the Z benefit.
Yes___ No___

F. Printed Name, Signature, Thumb Print and Date

Signature or Thumb Print of Patient, if unable to write.
Date (Month/Day/Year)

Name of Attending Doctor
Signature
Date (Month/Day/Year)

Witnesses

1. Name of Hospital staff
Signature
Date (Month/Day/Year)

2. Name of parent/guardian/spouse/next of kin
Signature
Date (Month/Day/Year)

G. Contact PhilHealth

1. PhilHealth CARES

2. Call us at telephone number:

3. Text us:

4. email us:

H. Consent to Access Patient Record/s

I consent to the examination by PhilHealth of my medical records for the sole purpose of verifying the veracity of the Z-claim.

I.	Consent to Enter Medical Data in the Z Benefit Information & Tracking System (ZBITS)	I consent to have my medical data entered electronically in the ZBITS as a requirement for the Case Type Z. I authorize PhilHealth to disclose my personal health information to its contracted partners. I hereby hold PhilHealth or any of its officers, employees and/or representatives free from any and all liabilities relative to the herein-mentioned consent which I have voluntarily and willingly given in connection with the Z claim for reimbursement before PhilHealth.
J.	Name of Patient, Signature/Thumb Print and Date	Name of Patient Signature or Thumb Print, if unable to write Date (Month/Day/Year)
K.	Name of Patient's Representative, Signature and Date	Name of Patient's Representative Signature Date (Month/Day/Year)
	Relationship of the Representative to the Patient	check √ one: ___ Spouse ___ Parent ___ Child ___ Next of Kin/Guardian

Share your opinion with us!

We would like to know how you feel about the services that pertain to the Z Benefit Package in order that we can improve and meet your needs. This survey will only take a few minutes. Please read the items carefully. If you need to clarify items or ask questions, you may approach your friendly healthcare provider or you may contact PhilHealth call center at 4417442. Your responses will be kept confidential and anonymous.

For items 1 to 3, please tick on the appropriate box.

1. Z benefit package availed is for:
   - ☐ Acute Lymphoblastic Leukemia
   - ☐ Breast Cancer
   - ☐ Prostate Cancer
   - ☐ Kidney Transplant
   - ☐ Cervical Cancer
   - ☐ Coronary Bypass
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for Ventricular Septal Defect
   - ☐ Fitting of external lower limb prosthesis

2. Respondent's age is:
   - ☐ 19 years old & below
   - ☐ between 20 to 35
   - ☐ between 36 to 45
   - ☐ between 46 to 55
   - ☐ between 56 to 65
   - ☐ above 65 years old

3. Sex of respondent
   - ☐ male
   - ☐ female

For items 4 to 8, please select the one best response by ticking the appropriate box.

4. How would you rate the services received from the hospital in terms of availability of medicines or supplies needed for the treatment of your condition?
   - ☐ adequate
   - ☐ inadequate
   - ☐ don't know

5. How would you rate the patient's or family's involvement in the care in terms of patient empowerment? (You may refer to your Member Empowerment Form)
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

6. In general, how would you rate the healthcare professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

7. In your opinion, by how much has your hospital expenses been lessened by availing of the Z benefit package?
   - ☐ less than half
   - ☐ by half
   - ☐ more than half
   - ☐ don't know

8. Overall patient satisfaction (PS mark) is:
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

9. If you have other comments, please share them below:

   _____
   _____
   _____
   _____

Thank you. Your feedback is important to us!