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. 2016-0020

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

SUBJECT : **Z BENEFIT RATES FOR SELECTED ORTHOPEDIC IMPLANTS *(REVISION 1)***

I. RATIONALE

In the latest update of the Philippine National Health Accounts covering 2007 – 2010, more than half of the total expenditure for health care came from out of pocket payments. Only 8.9% is shouldered by the social health insurance.

While PhilHealth reimburses hospitalization expenses for surgeries, the cost of medical devices are usually not completely covered and thus, become out of pocket payments by members.

For orthopedic surgeries, the bulk of expenses are made up by implantable devices. The high cost of the devices pushes patients to stay longer in the hospital. Some even refuse treatment for financial reasons. In the elderly, the delay of surgery may increase mortality rate by *thirty percent (30%)*. This results in productivity losses, lost earnings and lost household production.

Consistent with Republic Act No. 10606, otherwise known as the National Health Insurance Act of 2013, which stipulates granting of benefits for devices, and pursuant to Board Resolution No. 1787 s. 2013, PhilHealth shall cover expenses for specialized medical devices.

II. RULES FOR IDENTIFIED TYPE Z

1. The provision of selected orthopedic implants shall be covered under the benefit package and only those cases that strictly fulfill the selections criteria shall be covered.

2. All patients for admission to the contracted hospitals must first be screened for qualification to the Z benefits. If qualified, these patients shall at all times be permitted to avail of the benefit package.

3. Pre-authorization from PhilHealth based on the approved selections criteria for the provision of selected orthopedic implants shall be required prior to availment of services except for emergency cases of acute hip fracture requiring multiple screw fixation (MSF).

The contracted *health care institution (HCI)* shall submit the accomplished pre-authorization checklist (Annex A-2 of this circular) of patients with acute hip fracture who have undergone emergency implantation requiring MSF within 2 *working* days after surgery.

For implantation of MSF for acute hip fractures performed on a weekend or public holiday (where submission after two days is not possible), the *HCI* shall submit the pre-authorization checklist on the next working day after the weekend or holiday.

It is the responsibility of all members belonging to the Formal Economy, Informal Sector, self-earning individuals, and iGroup with valid Group Policy Contract (GPC) to regularly update their premium contributions to facilitate benefits availment.

All contracted HCIs should remind these patients to update their premium contributions and member profiles prior to enrolment into the Z Benefits.

All requests for pre-authorization shall be accomplished completely *and properly* by the contracted HCIs and submitted to the Head of the Regional Benefits Administration Section (BAS) for approval.

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

5. *The approved Pre-authorization Checklist and Request (Annex "A") shall be valid for 60 calendar days from the date of approval by PhilHealth. All contracted HCIs are responsible for tracking the validity of their approved pre-authorizations. They shall inform PhilHealth immediately if pre-authorization requests lapsed. They can, however, submit a new pre-authorization checklist and request, if needed.*

6. Payment for this package shall be made to the contracted HCIs in full upon filing of claims for the specialized medical devices within 60 days from the date the claim was filed.

7. The No Balance Billing (NBB) Policy shall *be applicable to* indigent, sponsored, household help member, *lifetime and senior citizen* categories.

   Negotiated co-pay shall be applied *to members belonging to the rest of the member categories* and their qualified dependents.

   If the eligible members or their qualified dependents refuse to avail *of* the NBB policy and *agree* to pay the *negotiated* co-pay, they will be allowed to do so provided they *indicate in the Member Empowerment Form* that they are willing to *opt out from the NBB and* pay the *corresponding* negotiated co-pay.

   The negotiated co-pay shall be based on the complexity of the orthopedic procedure. However, it should not exceed the equivalent case rate of the procedure done.

8. The professional fees for the orthopedic surgeries of the Z benefits shall follow the professional fees prescribed in corresponding procedure case rates. Rules on pooling of professional fees for government facilities shall still apply.

9. Patients enrolled in the Z benefits shall be deducted a maximum of five (5) days from the 45 days annual benefit limit. Such deductions shall be made only on the current year during the fixation of the implant. In cases where the remaining annual benefit is *at least one (1) day at the time of application for pre-authorization*, the member shall remain eligible to avail of the Z benefit, provided the premiums are updated; no further deduction will be made for the duration of the hospitalization *of* the patient availing the Z benefit.

10. Those who will avail of this Z benefit for specialized medical devices shall not be eligible for the same procedure in the same site for the next five (5) years; if warranted, re-admission shall be covered by the benefits on all case rates.

11. All applicable policies on all case rates shall be reflected in a separate issuance.

12. All rates are inclusive of government taxes.

13. The medical devices shall be subject to regulation by the Food and Drug Administration (FDA) of the Philippines. For *medical devices that are undergoing the process of FDA approval, the reference hospital shall provide PhilHealth the list of acceptable suppliers. Orthopedic implant companies shall be allowed to supply devices/implants for the Z benefits provided they are able to secure Certificates of Product Registration from FDA within two years from inclusion in the list. The said list should be attested true and correct by the Medical Center Chief of the reference HCI.*

14. Donated medical devices shall not be covered under the benefit package.

15. Contracted hospitals shall transact only with FDA-licensed medical device establishment, manufacturers or traders *or with those identified by the reference HCI* and shall execute a Memorandum of Agreement (MOA) specifically for the Z benefit.

16. The medical devices shall be implanted to patients by a PhilHealth-accredited physician certified by the Philippine Board of Orthopedics and practicing in the contracted hospital.

17. All patients availing of the Z benefit for specialized medical devices shall be monitored for all clinically relevant outcomes (i.e. orthopedic and other adverse events) in the next six (6) months. Reports may be subjected to monitoring and post-audit by PhilHealth.

18. All patients 50 years of age and above, who are under the Z Benefits, are eligible to avail of pneumococcal vaccination as stipulated in PhilHealth Circular 7, series of 2014 ***(Guidelines for the Oks ang Bakuna ko Laban sa Pulmonya).***

III. CASE TYPE Z BENEFIT FOR SELECTED ORTHOPEDIC IMPLANTS

The overall package code for the Z benefit for selected orthopedic implants is **Z011.** The following are the corresponding descriptions, orthopedic implants, RVS codes and rates of the package:

1. Implants for hip arthroplasty

Package Code	IMPLANTS	RVS Codes	Z Package rate (PHP)	Case Rate (PHP)	Rates of implants per side (left or right) (PHP)
Z011-A	Total Hip Prosthesis , cemented	27130	103,400	53,400	50,000
Z011-B	Total Hip Prosthesis , cementless	27130	169,400	53,400	116,000
Z011-C	Partial Hip Prosthesis, bipolar	27125	73,180	37,180	36,000

The use of cemented and cementless total hip prostheses depends on the activity level and pre-morbid conditions of the patient.

The following are the selections criteria for hip arthroplasty:

a. Signed Member Empowerment Form
b. Clinical features
   i. hip fracture
      1. with avascular necrosis of the femoral head; OR
      2. neglected fracture of the hip; OR
      3. hip fracture with pre-existing cox-arthritis; OR
      4. displaced hip fracture
   ii. with avascular necrosis of the femoral head (FICAT Stage III and IV); OR
   iii. hip dysplasia (CROWE I-IV); OR
   iv. severe osteoarthritis; OR
   v. severe inflammatory joint disease (rheumatoid, gout, psoriatic, ankylosing spondylitis)
c. Pre-injury status: ambulatory patients
d. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   ASA I – normal healthy patient
   ASA II - Patient with mild systemic disease; no functional limitation

2. Implants for hip fixation

Package Code	IMPLANTS	RVS Codes	Z Package rate (PHP)	Case Rate (PHP)	Rates of implants per side (left or right) (PHP)
Z011-D	Multiple screw fixation (MSF) 6.5mm cannulated cancellous screws with washer	27235	61,500	46,500	15,000

The following are the selections criteria for hip fixation:

a. Signed Member Empowerment Form
b. Any hip fracture not covered under the total hip package for femoral neck fracture
   i. with no avascular necrosis of the femoral head; OR
   ii. acute fracture of the hip; OR
   iii. displaced hip fracture
c. Pre-injury status: ambulatory patients
d. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   ASA I – normal healthy patient
   ASA II - Patient with mild systemic disease; no functional limitation

3. Implants for pertrochanteric fracture

Package Code	IMPLANTS	RVS Codes	Z Package rate (PHP)	Case Rate (PHP)	Rates of implants per side (left or right) (PHP)
Z011-E	Compression Hip Screw Set (CHS) OR	27244	69,000	46,500	22,500
Z011-F	Proximal Femoral Locked Plate (PFLP) OR	27244	71,000	46,500	24,500
Z011-G	*Proximal Femoral Nail (PFN)*	*27245*	*55,640*	*31,140*	*24,500*

The following are the selections criteria for implants for pertrochanteric fractures:

a. Signed Member Empowerment Form
b. CHS: stable fracture of the intertrochanteric area (AO Classification Type A1 fracture)
c. PFLP OR PFN: unstable/comminuted pertrochanteric fracture (AO Classification Type A2 and A3 fracture)
d. Pre-injury status: ambulatory patients
e. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   ASA I – normal healthy patient
   ASA II - Patient with mild systemic disease; no functional limitation

4. Implants for Femoral *and Tibial* Shaft Fracture

Package Code	IMPLANTS	RVS Codes	Z Package rate (PHP)	Case Rate (PHP)	Rates of implants per side (left or right) (PHP)
Z011-H	Intramedullary Nail with Interlocking Screws- *Femur*	27506	48,740	30,740	18,000
Z011-I	Intramedullary Nail with Interlocking Screws- *Tibia*	*27759*	45,120	27,120	18,000
Z011-J	Locked compression plate – broad, metaphyseal, *proximal* and distal femoral	27507	50,740	30,740	20,000
Z011-K	*Locked compression plate – broad, metaphyseal, proximal and distal tibial*	*27758*	*42,660*	*22,660*	20,000

The following are the selections criteria for implants for femoral shaft fracture:

a. Signed Member Empowerment Form
b. Femoral/*tibial* shaft fracture
   i. without malignant/metastatic pathologic fracture; AND
   ii. with any complete fracture of the femur/tibia
c. Pre-injury status: ambulatory patients
d. With no more than two co-morbid illnesses based on:
   Physical status classification based on ASA (low to moderate risk)
   ASA I – normal healthy patient
   ASA II - Patient with mild systemic disease; no functional limitation

IV. CLAIMS FILING & REIMBURSEMENT

1. The corresponding payment for the packages shall be given in a single tranche.
2. Claims for the Z benefit for specialized medical devices must identify the device and components and must bear a code/serial number by which they and their manufacturer may be explicitly identified.
3. All claims shall be filed by the contracted hospitals in behalf of the patient.
4. *In general, the basis for reimbursement shall be the pre-authorization diagnosis. However in cases when a patient underwent a procedure other than pre-authorized, PhilHealth shall pay the procedure of lower package rate.*

Example:

Pre-authorization diagnosis	*Actual procedure done*	*Reimbursement*
Total hip arthroplasty	*Partial hip arthoplasty*	*Partial hip arthroplasty*

In cases when a procedure with a higher package rate compared to the pre-authorized was done, payment shall be based on the procedure indicated in the operative record.

Example:

Pre-authorization diagnosis	*Actual procedure done*	*Reimbursement*
Partial hip arthroplasty	*Total hip arthroplasty*	*Total hip arthroplasty*

V. *REPEALING CLAUSE*

All provisions of previous issuances that are inconsistent with any provision of this Circular are hereby amended, modified or repealed accordingly.

VI. *TRANSITORY CLAUSE*

Claims filed with approved pre-authorizations prior to the date of effectivity of this circular shall follow the provisions of PhilHealth Circular 012-2014.

VII. EFFECTIVITY

This circular shall take effect fifteen (15) calendar days after its publication in *the Official Gazette or in* a newspaper of general circulation and *shall be* deposited thereafter at the Office of the National Administrative Register, University of the Philippines Law Center.

MASTER DOCUMENT DC: Date: 7/12/16

ALEXANDER A. PADILLA
President and CEO

Date signed: 6/30/2016

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Case No. _____

Annex A1–Ortho Implants

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Fulfilled selections criteria ☐ ***Yes*** *If yes, proceed to pre-authorization application .*
☐ ***No*** *If no, HCI to specify reason/s and encode*
_____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Hip Arthroplasty

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	

CLINICAL FEATURES	**Yes**
Hip fracture: (tick appropriate description): ☐ with avascular necrosis of the femoral head ☐ Neglected fracture of the hip ☐ Hip fracture with pre-existing cox-arthritis ☐ Displaced hip fracture	
With avascular necrosis of the femoral head (FICAT Stage III and IV)	
Hip dysplasia (CROWNE I-IV)	
Severe osteoarthritis	
Severe inflammatory joint disease (rheumatoid, gout, psoriatic, ankylosing, spondylitis)	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. |||||–|||||||–||
	Date signed (mm/dd/yyyy)

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. *However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits.* Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Hip Arthroplasty

DATE OF REQUEST:

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (NAME OF *HCI*) under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

Billing category: (tick appropriate box)	*Type of implant being applied for:*
☐ No Balance Billing (NBB)	☐ *Total hip prosthesis (cemented)*
☐ Co-pay (indicate amount) Php _____	☐ *Total hip prosthesis (cementless)*
	☐ *Partial hip prosthesis (bipolar)*

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ____-____-____ Date signed (mm/dd/yyyy)

Certified correct by:
(Printed name and signature) Executive Director/Chief of Hospital/ *Medical Director/ Medical Center Chief*
PhilHealth Accreditation No. ____-____-____

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION			**COMPLIANCE TO REQUIREMENTS**		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/*BAS*:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to *HCI:*			Received by BAS:		
This pre-authorization is valid for *sixty (60) calendar days* from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

MASTER DOCUMENT Date: 7/12/16 DC:

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Case No. _____

Annex A2 –Ortho Implants

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Fulfilled selections criteria ☐ ***Yes*** *If yes, proceed to pre-authorization application*
☐ ***No*** *If no, HCI to specify reason/s and encode* _____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Hip Fixation

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II))	

CLINICAL FEATURES	**Yes**
Hip fracture: (tick appropriate description) ☐ Without avascular necrosis of the femoral head ☐ Acute fracture of the hip ☐ Displaced hip fracture	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐ Date signed (mm/dd/yyyy)

MASTER DOCUMENT Date: 7/12/16 DC:

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. *However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits.* Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Hip Fixation

DATE OF REQUEST:

This is to request approval for provision of services under the Z benefit package for _____ in _____
(NAME OF PATIENT) (NAME OF *HCI*)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):
☐ No Balance Billing (NBB)
☐ Co-pay (indicate amount) Php _____

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ____-_____-_ Date signed (mm/dd/yyyy)

Certified correct by:
(Printed name and signature) Executive Director/Chief of Hospital/ *Medical Director/ Medical Center Chief*
PhilHealth Accreditation No. ____-_____-_

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION			COMPLIANCE TO REQUIREMENTS		
Activity	**Initial**	**Date**	☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Received by LHIO/*BAS*:					
Endorsed to BAS (if received by LHIO):					
☐ Approved ☐ Disapproved			**Activity**	**Initial**	**Date**
Released to *HCI:*			Received by BAS:		
This pre-authorization is valid for *sixty (60) calendar days* from date of approval of request.			☐ Approved ☐ Disapproved		
			Released to HCI:		

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Case No. _____

Annex A3 –Ortho Implants

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Fulfilled selections criteria ☐ ***Yes*** *If yes, proceed to pre-authorization application*
☐ ***No*** *If no, HCI to specify reason/s and encode*
_____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Pertrochanteric Fractures

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II))	

CLINICAL FEATURES	**Yes**
Stable fracture of the intertrochanteric area, classified as Type A1 fracture	
Unstable/comminuted pertrochanteric fracture classified as Type A2 or A3 fracture	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐ Date signed (mm/dd/yyyy)

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. *However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits.* Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Pertrochanteric Fractures

DATE OF REQUEST:

This is to request approval for provision of services under the Z benefit package for _____ in _____
(NAME OF PATIENT) (NAME OF *HCI*)
under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

Billing category: (tick appropriate box)	*Type of implant being applied for:*
☐ No Balance Billing (NBB)	☐ *Compression hip screw set*
☐ Co-pay (indicate amount) Php _____	☐ *Proximal femoral locked plate*
	☐ *Proximal femoral nail*

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐ Date signed (mm/dd/yyyy)

Certified correct by:
(Printed name and signature) Executive Director/Chief of Hospital/ *Medical Director/ Medical Center Chief*
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐

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☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/*BAS*:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HCI:*		
This pre-authorization is valid for *sixty (60) calendar days* from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		

MASTER DOCUMENT 7/12/16

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Case No. _____

Annex A4 –Ortho Implants

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

Fulfilled selections criteria ☐ ***Yes*** *If yes, proceed to pre-authorization application*
☐ ***No*** *If no, HCI to specify reason/s and encode*
_____

PRE-AUTHORIZATION CHECKLIST
Orthopedic Implants: Femoral *and Tibial* Shaft Fractures

(Place a ✓opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides

ATTESTED BY ATTENDING PHYSICIAN

(Place a ✓if YES, or NA if not applicable)

QUALIFICATIONS	**Yes**
Ambulatory prior to injury	
Normal or with mild systemic disease or no functional limitation (ASA I & II)	

CLINICAL FEATURES	**Yes**
Femoral shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the femur	
Tibial shaft fracture without malignant/metastatic pathologic feature and with any complete fracture of the tibia	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐ Date signed (mm/dd/yyyy)

Note:
Once approved, the contracted HCI shall print the approved pre-authorization form and have this signed by the patient, parent or guardian and health care providers, as applicable. This form shall be submitted to the Local Health Insurance Office (LHIO) or the PhilHealth Regional Office (PRO) when filing the first tranche.

There is no need to attach laboratory results. However, these should be included in the patient's chart and may be checked during the field monitoring of the Z Benefits. Please do not leave any item blank.

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PRE-AUTHORIZATION REQUEST
Orthopedic Implants: Femoral *and Tibial* Shaft Fractures

DATE OF REQUEST:

This is to request approval for provision of services under the Z benefit package for _____ (NAME OF PATIENT) in _____ (NAME OF *HCI*) under the terms and conditions as agreed for availment of the Z Benefit Package.

The patient belongs to the following category (please tick appropriate box):

Billing category: (tick appropriate box)	*Type of implant being applied for:* ☐ *femoral* ☐ *tibial*
☐ No Balance Billing (NBB) ☐ Co-pay (indicate amount) Php _____	☐ *Intramedullary nail with interlocking screws* ☐ *Locked compression plate- broad, metaphyseal, proximal and distal*

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐ Date signed (mm/dd/yyyy)

Certified correct by:
(Printed name and signature) Executive Director/Chief of Hospital/ *Medical Director/ Medical Center Chief*
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐

(For PhilHealth Use Only)

☐ APPROVED
☐ DISAPPROVED (State reason/s) _____

_____
(Printed name and signature)
Head, Benefits Administration Section (BAS)

INITIAL APPLICATION		
Activity	**Initial**	**Date**
Received by LHIO/*BAS*:		
Endorsed to BAS (if received by LHIO):		
☐ Approved ☐ Disapproved		
Released to *HCI:*		
This pre-authorization is valid for *sixty (60) calendar days* from date of approval of request.		

COMPLIANCE TO REQUIREMENTS		
☐ APPROVED ☐ DISAPPROVED (State reason/s)		
Activity	**Initial**	**Date**
Received by BAS:		
☐ Approved ☐ Disapproved		
Released to HCI:		

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Case No. _____

Annex "B – ME Form"

MEMBER EMPOWERMENT FORM
Inform, Support & Empower

Instructions:
1. The health care 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 health care institution (HCI) providing specialized care.
6. Triplicate copies of the ME form shall be made available by the contracted HCI—one for the patient; one as file copy of the contracted HCI providing the specialized care and one for PhilHealth.
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 and for PD First Z Benefits, write N/A for items B2 and B3.**

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI

A. Member/Patient Information		
PATIENT (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)		
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐		
PERMANENT ADDRESS		
Birthday (mm/dd/yyyy)	Age	Sex
Telephone Number	Mobile Number	Email Address

B. Clinical Information	
1. Description of condition	
2. Applicable Treatment Plan agreed upon with healthcare provider	
3. Applicable alternative Treatment Plan agreed upon with health care provider	

C. Treatment Schedule and Follow-up Visit/s	
1. Date of initial admission to HCI or consult[a] (mm/dd/yyyy) [a]For ZMORPH, this refers to the external lower limb pre-prosthesis rehabilitation consult. For PD First, this refers to the date of medical consultation or visit to the PD Provider prior to the start of the first PD exchange.	
2. Date/s of succeeding admission to HCI or consult[b] (mm/dd/yyyy) [b] For ZMORPH, this refers to the external lower limb measurement, fitting and adjustments For the PD First, this refers to the next visit to the PD Provider.	
3. Date/s of follow-up visit/s[c] (mm/dd/yyyy) [c] For ZMORPH, this refers to the external lower limb post-prosthesis rehabilitation consult.	

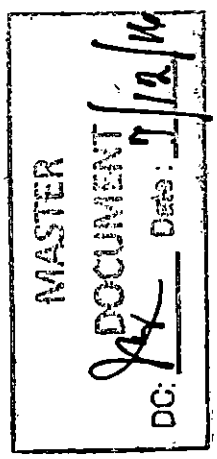
D. Member Education		
Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
1. My health care provider explained the nature of my condition.		
2. My health care provider explained the treatment options[d]. [d] For ZMORPH, this refers to the need for pre- and post-external lower limb prosthesis rehabilitation.		
3. The possible side effects/adverse effects of treatment were explained to me.		
4. My health care provider explained the mandatory services and other services required for the treatment of my condition.		
5. I am satisfied with the explanation given to me by my health care provider.		
6. I have been fully informed that I will be cared for by all the pertinent medical specialties, as needed, present in the PhilHealth contracted HCI of my choice and that preferring another contracted HCI for the said specialized care will not affect my treatment in any way.		
7. My health care provider explained the importance of adhering to my treatment plan. This includes completing the course of treatment in the contracted HCI where my treatment was initiated. Note: Non-adherence of the patient to the agreed treatment plan in the HCI may result to denial of filed claims for the succeeding tranches and which should not be filed as case rates.		

Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
8. My health care provider gave me the schedule/s of my follow-up visit/s.		
9. My health care provider gave me information where to go for financial and other means of support, when needed. a. Government agency (ex. PCSO, PMS, LGU, etc.) b. Civil society or non-government organization c. Patient Support Group d. Corporate Foundation e. Others (ex. Media, Religious Group, Politician, etc.)		
10. I have been furnished by my health care provider with a list of other contracted HCIs for the specialized care of my condition.		
11. I have been fully informed by my health care provider of the PhilHealth membership policies and benefit availment on the Z Benefits: a. I fulfill all selections criteria for my condition.		
b. The "no balance billing" (NBB) was explained to me. Note: NBB policy is applicable to the following members when admitted in ward accommodation: sponsored, indigent, household help, senior citizens and iGroup members with valid Group Policy Contract (GPC) and their qualified dependents.		
c. I understand the NBB policy.		
For sponsored, indigent, household help, senior citizens and iGroup members with valid GPC and their qualified dependents, answer C.1, C.2 and C.3. c.1. I understand that I can opt out from the NBB and may be charged a fixed copay		
c.2. I opt out from the NBB policy of PhilHealth		
The following are applicable to formal and informal economy, lifetime members and their qualified dependents (d.1 and d.2) d. I understand the fixed copay for members belonging to the formal and informal economy, lifetime members and senior citizens.		
d.1. I understand that as a member belonging to the formal and informal economy, lifetime members, the contracted HCI can charge me a fixed copay.		
d.2. I understand that the fixed copay is for other services needed to treat my condition.		
e. Only five (5) days shall be deducted from the 45 days annual benefit limit for the duration of my treatment under the Z Benefits.		
f. I shall update my premium contributions in order to avail the Z Benefits and other PhilHealth benefits.		

E. Member Roles and Responsibilities		
Put a (✓) opposite appropriate answer or NA if not applicable.	YES	NO
1. I understand that I am responsible for adhering to my treatment schedule.		
2. I understand that adherence to my treatment schedule is important in terms of clinical outcomes and a pre-requisite to the full entitlement of the Z benefits.		
3. I understand that it is my responsibility to follow and comply with all the policies and procedures of PhilHealth and the health care provider in order to avail of the full Z benefit package. In the event that I fail to comply with policies and procedures of PhilHealth and the health care provider, I waive the privilege of availing the Z benefits.		

F. Printed Name, Signature, Thumb Print and Date		
Printed name and signature of patient* * For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.	Thumb print (if patient is unable to write)	Date (mm/dd/yyyy)
Printed name and signature of Attending Doctor		Date (mm/dd/yyyy)
Witnesses:		
Printed name and signature of HCI staff member		Date (mm/dd/yyyy)
Printed name and signature of spouse/ parent/ next of kin /authorized guardian or representative		Date (mm/dd/yyyy)

G. PhilHealth Contact Details		
Name of PhilHealth CARES assigned at the HCI		
Telephone number	Mobile number	Email address



H. Sketch of Home Address with Landmark
As part of the continuing efforts of PhilHealth to improve the benefits delivery and services, I am providing the following information for the sole purpose of conducting home visits to patients who availed of the Z Benefits: (Please draw a sketch of your home address below.) Landmark/s: _____ Nearest National Road (as applicable): _____ Nearest Church, School or Establishment (if any): _____ Nearest Barangay Hall: _____ Other information to guide directions to your home: _____

I. Consent to access patient record	J. Consent to enter medical data in the Z benefit information & tracking system (ZBITS)
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 have my medical data entered electronically in the ZBITS as a requirement for the Z Benefits. 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.	

Printed name and signature of patient* * For minors, the parent or guardian affixes their signature or thumb print here on behalf of the patient.	Thumb print (if patient is unable to write)	Date (mm/dd/yyyy)
Printed name and signature of patient's representative		Date (mm/dd/yyyy)
Relationship of representative to patient (tick appropriate box) ☐ spouse ☐ parent ☐ child ☐ next of kin ☐ guardian		

MASTER DOCUMENT Date: 7/12/16

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Annex "C-Ortho Implants"

DISCHARGE CHECKLIST FOR THE Z BENEFIT
Orthopedic Implants

Single Tranche

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐ - ☐
MEMBER *(if patient is a dependent)* (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐ - ☐

(Place a ✓ opposite appropriate answer)

SITE OF INJURY	☐ Left side ☐ Right side ☐ Both sides
IMPLANT PROVIDED	☐ Total hip prosthesis, cemented ☐ Total hip prosthesis, cementless ☐ Partial hip prosthesis, bipolar ☐ Multiple screw fixation, 6.5 mm cannulated cancellous screws with washer ☐ Compression hip screw set ☐ Proximal femoral locked plate ☐ *Proximal femoral nail* ☐ Intramedullary nail with interlocking screws-*Femur* ☐ *Intramedullary nail with interlocking screws-Tibia* ☐ Locked compression plate – broad, metaphyseal, *proximal* and distal femoral ☐ *Locked compression plate – broad, metaphyseal, proximal and distal tibia*

(place a ✓ if DONE)

	MANDATORY SERVICES	Status
1.	Orthopedic implant/s provided is/are as prescribed.	
2.	The individual code/serial or batch/lot number of each of the implants used is indicated in the Operative Technique of the patient.	
3.	The discharge plan is given and explained to the patient.	

Conforme by:	Certified correct by:
(Printed name and signature) Patient/Parent/Guardian	(Printed name and signature) Attending Orthopedic Surgeon
Date signed (mm/dd/yyyy)	PhilHealth Accreditation No. ☐☐☐☐ - ☐☐☐☐☐☐☐☐ - ☐ Date signed (mm/dd/yyyy)

PhilHealth

Benefits

Annex "D"

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 health care provider or you may contact PhilHealth call center at 441-7442. 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 transplantation
   - ☐ Cervical cancer
   - ☐ Coronary artery bypass surgery
   - ☐ Surgery for Tetralogy of Fallot
   - ☐ Surgery for ventricular septal defect
   - ☐ Fitting of external lower limb prosthesis
   - ☐ Orthopedic implants
   - ☐ PD First Z benefits
   - ☐ Colorectal cancer

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 health care institution (HCI) 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 health care professionals that provided the services for the Z benefit package in terms of doctor-patient relationship?
   - ☐ excellent
   - ☐ satisfactory
   - ☐ unsatisfactory
   - ☐ don't know

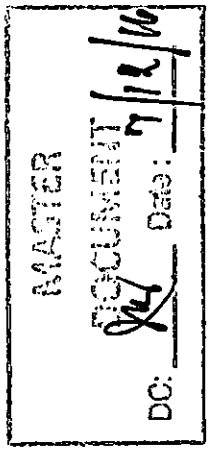
7. In your opinion, by how much has your HCI expenses been lessened by availing of the Z benefit package?
   - ☐ less than half
   - ☐ by half
   - ☐ more than half
   - ☐ don't know

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!



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Case No. _____

Annex "E – Ortho Implants"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐-☐☐☐☐☐☐☐☐-☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐-☐☐☐☐☐☐☐☐-☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Orthopedic Implants

Requirements	Please Check
1. Transmittal Form (Annex H)	
2. Checklist of Requirements for Reimbursement (Annex E-Ortho Implants)	
3. Original copy of approved Pre –Authorization Checklist & Request (Annex A-Ortho Implants)	
4. Photocopy of completely accomplished ME FORM (Annex B)	
5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Discharge Checklist for the Z Benefits (Annex C-Ortho Implants)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Photocopy of Operative Technique	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Orthopedic Surgeon	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)

MASTER
DOCUMENT
DC: _____ Date: 12/16

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Case No. _____

Annex "E – Ortho Implants"

HEALTH CARE INSTITUTION (HCI)
ADDRESS OF HCI
PATIENT (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF PATIENT ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐
MEMBER (if patient is a dependent) (Last name, First name, Middle name, Suffix)
PHILHEALTH ID NUMBER OF MEMBER ☐☐ - ☐☐☐☐☐☐☐☐☐ - ☐

CHECKLIST OF REQUIREMENTS FOR REIMBURSEMENT
Orthopedic Implants

Requirements	Please Check
1. Transmittal Form (Annex H)	
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5. Completed PhilHealth Claim Form (CF) 1 or PhilHealth Benefit Eligibility Form (PBEF) and CF 2	
6. Discharge Checklist for the Z Benefits (Annex C-Ortho Implants)	
7. Photocopy of completed Z Satisfaction Questionnaire (Annex D)	
8. Photocopy of Operative Technique	
DATE COMPLETED : DATE FILED :	

Certified correct by:	Certified correct by:
(Printed name and signature) Attending Orthopedic Surgeon	(Printed name and signature) Executive Director/Chief of Hospital/ Medical Director/ Medical Center Chief
PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐	PhilHealth Accreditation No. ☐☐☐☐☐-☐☐☐☐☐☐☐-☐
Date signed (mm/dd/yyyy)	Date signed (mm/dd/yyyy)

Conforme by:
(Printed name and signature) Patient/Parent/Guardian
Date signed (mm/dd/yyyy)