PhilHealth
Your Partner in Health

BAGONG PILIPINAS

Republic of the Philippines
PHILIPPINE HEALTH INSURANCE CORPORATION
Citystate Centre, 709 Shaw Boulevard, Pasig City
(02) 8662-2588 www.philhealth.gov.ph
PhilHealthOfficial teamphilhealth

PHILHEALTH CIRCULAR
No. 2025-0010

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

SUBJECT : **Quality Standards on the Diagnosis and Management of Uncomplicated Cataract Among Adults As Reference of the Corporation**

I. RATIONALE

The Universal Health Care Act (R.A. No. 11223) identifies quality of care as one of the major goals to be achieved by the Philippine health system. Quality is also stipulated in the revised Implementing Rules and Regulations (IRR) of the National Health Insurance Act of 2013 (Republic Act No. 10606) wherein quality assurance standards shall be used as reference in ensuring quality of health care services. Due to this mandate, PhilHealth provides quality policies pertaining to standards of care for specific conditions that are in accordance with evidence-based information and opinion from recognized clinical experts in the field.

Cataract extraction, when performed appropriately, usually improves quality of life, reduces injury, and attenuates functional declines. It has been proven to be generally safe and highly successful. However, it is important to ensure that surgery is performed for the appropriate indications since vision-threatening complications can occur.

These quality standards on the diagnosis and management of cataract aim to ensure the appropriate performance of PhilHealth-accredited providers so that members receive quality of care. These standards were based on recognized cataract clinical practice guidelines and consultation with the Philippine Academy of Ophthalmology (PAO) as recognized expert in eye care, to ensure their applicability to the local setting. Further, the perspective of patients was considered through consultation with the Philippine Alliance of Patient Organizations (PAPO). Furthermore, the policy recommendations were reviewed by the PhilHealth Quality Assurance Committee as reference in ensuring quality of care.

II. OBJECTIVES

This PhilHealth Circular aims to define the standard of care in the diagnosis and management of cataract among adults in line with the Quality Assurance Program of the Corporation.

III. SCOPE

This PhilHealth Circular shall cover the following:

A. Patient Involvement in the Management of Cataract;
B. Patient Assessment;
C. Cataract Management (Surgical and Non-Surgical Management);
D. Authorized Health Facilities;
E. Clinical Applications of Intraocular Lens;
F. Postoperative Care; and
G. Documentation of Cataract Surgery.

IV. DEFINITION OF TERMS

A. Cataract – any opacity of the natural crystalline lens of the eye that may or may not be associated with visual problems. Depending on the type and severity, cataracts can manifest in different ways, such as an obstruction of the red orange reflex on fundoscopy or an opacity in the center of the pupil.

B. Quality of Care – the degree to which health services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge[1].

C. Standard of Care – defined as (1) the degree of ability or skill possessed by other physicians in the same community, neighborhood or locality; (2) the degree of care, attention, diligence or vigilance ordinarily exercised by those physicians in the application of their skill; and (3) the special or extraordinary skill of the specialist, if the physician involved has represented himself as possessing it[2].

[1]Medicare: A Strategy for Quality Assurance: Volume 1, Institute of Medicine, Lohr 1990
[2]Medical Jurisprudence: The practice of medicine and the law, Solis 1988

V. POLICY STATEMENTS

A. Patient Involvement in the Management of Cataract

1. Ophthalmologists have a responsibility to educate patients on how decreased vision due to cataract can limit the ability to perform daily tasks, affect personal safety, and decrease quality of life.

2. The management of cataract requires an understanding of the patient's vision-related quality of life and visual function, as well as the patient's needs, desires, and priorities. Appropriate decision-making for non-surgical or surgical management is a collaborative effort between the ophthalmologist and the patient with involvement of other family members and caregivers if necessary. The ophthalmologist must help the patient understand the potential benefits and risks of non-surgical and surgical management.

B. Patient Assessment

1. A patient suspected of having cataract should undergo a comprehensive eye examination as follows[3]:

   a. Measurement of visual acuity with current correction at distance, and at near;
   b. Measurement of best-corrected visual acuity (with refraction when indicated);
   c. External examination including ocular alignment and motility;
   d. Intraocular pressure measurement;
   e. Slit-lamp examination including dilated examination of the lens; and
   f. Dilated fundoscopy.

2. Among patients with suspected cataracts, the following causes of visual impairment should be ruled out[4]:

   a. Error of refraction;
   b. Corneal opacities;
   c. Glaucoma;
   d. Diabetic retinopathy;
   e. Age-related macular degeneration;
   f. Optic neuropathy; and
   g. Uveitis.

[3]PhilHealth Circular No. 018-2015 Guidelines on the Diagnosis and Management of Uncomplicated Cataract in Adults, Item III. A
[4]PhilHealth Circular No. 018-2015 Guidelines on the Diagnosis and Management of Uncomplicated Cataract in Adults, Item III. C

3. In relation to potential cataract surgery, there are three objectives in the evaluation of cataract:

    a. Ensure the patient's symptoms are consistent with cataract;
    b. Preoperatively identify and avoid sources of intraoperative complications; and
    c. Clarify surgeon and patient expectations regarding the course and outcome of surgery.

4. Documentation of the specific visual disturbance and impact on the patient is crucial.

C. Cataract Management (Surgical and Non-Surgical Management)

1. Non-surgical management is recommended in the following conditions:

    a. Patient's refusal of surgery
    b. No visual disability or visual disability does not bother the patient
    c. Best correction results in satisfactory visual function
    d. Surgery is unlikely to improve visual function
    e. Patient cannot undergo surgery due to co-existing medical conditions
    f. No appropriate postoperative care can be arranged

2. The non-surgical options for cataract patients include refraction and spectacle correction, handheld magnifying lenses, and other low vision aids. To date, no commercially available eye drop or oral medicine has been proven to delay or reverse cataract formation in humans.

3. Among patients with cataract, any of the following are indications for surgery:

    a. Visual impairment/disability that bothers the patient and that can not be corrected by nonsurgical methods

    b. Cataract with concomitant ocular problems requiring cataract surgery

4. Acceptable surgical techniques or methods of removing the cataract include extracapsular cataract extraction (ECCE) with manual removal of the entire lens nucleus, manual small incision cataract surgery (MSICS), and phacoemulsification.

5. Type of Anesthesia

    a. All patients scheduled for cataract surgery should undergo history taking and physical examination relevant to the risk factors for undergoing the planned anesthesia.

    b. While local anesthesia is recommended in majority of patients undergoing cataract surgery, sedation or general anesthesia may also be used when indicated.

6. Among healthy adult patients scheduled for cataract surgery under local anesthesia, routine preoperative medical clearance is not necessary.

7. Prior to contemplated cataract surgery, the following procedures must be performed to determine the appropriate type and power of intraocular lens (IOL) to be implanted:
    a. Keratometry;
    b. Axial length measured by ultrasound (A-scan) biometry or optical biometry; and
    c. IOL power calculation.

8. The type of biometry to measure the axial length of an eye would depend on the planned IOL implant. For simple (non-toric) monofocal IOL, axial length can be measured using ultrasound biometry or optical biometry. For monofocal toric, multifocal, or multifocal toric IOL, axial length and keratometry should be measured using optical biometry.

9. Prior to cataract surgery, the patient must be informed about the benefits, possible side effects, complications, and costs of the procedure as well as the available alternative surgical and anesthesia procedures, including the option of declining the recommended cataract surgery and the consequences of such a decision.

D. Authorized Health Facilities

1. Cataract surgery should be performed in any of the following DOH-licensed and PhilHealth-accredited facilities:

    a. Hospital
    b. Ambulatory Surgical Clinic (ASC)

2. Cataract surgery on an outpatient basis is recommended unless systemic or eye conditions necessitate admission.

3. Cataract surgery must be performed in the operating room to ensure clean and safe surgery.

4. Ideally, a health facility where cataract surgery with a monofocal toric, multifocal or multifocal toric IOL implant will be performed must be equipped with an optical biometer. However, if not available, the patient should obtain optical biometry result from another facility prior to surgery.

E. Clinical Applications of Intraocular Lens

1. Among patients who will undergo cataract surgery, implantation of an IOL is recommended unless otherwise contraindicated.

2. Currently, the following are the types of IOLs covered under the PhilHealth benefit package with brief description and clinical applications:

Types of IOL	Description of Lens	Clinical Applications
Monofocal	The type of lens where light is focused on one single point.	To provide good uncorrected vision at one specific distance.
Monofocal Toric	The type of lens where light is focused on one single point with cylinder power added.	To provide good uncorrected vision at one specific distance, with corneal astigmatic correction.
Multifocal	The type of lens having different zones set at different powers. The light is focused on more than one distinct focal point.	To provide good uncorrected vision at more than one distance.
Multifocal Toric	The type of lens having different zones set at different powers with cylinder power correction. The light is focused on more than one distinct focal point.	To provide good uncorrected vision at more than one distance, with corneal astigmatic correction.

Table 1: Types of IOLs, Lens Descriptions, and Clinical Applications

3. Contraindications to the use of multifocal and multifocal toric IOLs include, but are not limited to, the following:

   a. The patient requires good night-time vision because of specific occupational or non-occupational activities (e.g., motor vehicle driving, piloting airplanes)

b. Retinal diseases (e.g., macular degeneration, epiretinal membrane, diabetic retinopathy)

c. Corneal problems (e.g., corneal dystrophy, corneal scars that affect vision)

d. Advanced glaucoma

4. The technology of the IOLs is advancing; patients have more expectations about their vision and frequent desire for spectacle independence after cataract surgery. The expert opinion pertaining to the classification of the following specific IOLs reflects current knowledge and may be revised as new information becomes available:

   a. Extended Depth of Focus (EDOF) IOL provides clear focus at distance and a continuous range of clear vision from distance to intermediate distance. For the purposes of the PhilHealth Circular, EDOF IOLs are classified under multifocal IOL.

   b. Extended monofocal/enhanced monofocal/monofocal plus IOLs have an elongated focal point to give the eye more depth of field. For the purposes of the PhilHealth Circular, these are classified under monofocal IOL.

F. Postoperative Care

1. The eye surgeon who operated on the patient is responsible for the care of the patient during the postoperative interval, the time in which most complications occur, and within which stable visual function is achieved. The eye surgeon also has an ethical obligation to the patient that continues until postoperative rehabilitation is complete.

2. The frequency of postoperative examinations is based on the goal of optimizing the outcome of surgery and swiftly recognizing and managing complications. In consideration of patient safety and quality of care, the attending eye surgeon and patient should be able to discuss the expected number of follow-up visit(s) to take place following surgery.

3. If the attending surgeon cannot follow-up the patient within the recommended period after surgery, then the patient should be referred to another ophthalmologist who can do the follow-up, with the knowledge and consent of the patient. The attending surgeon should be informed of the result of the said follow-up and should be properly documented for purpose of monitoring.

4. During follow-up visit, the eye surgeon must be able to document the uncorrected and best-corrected distance visual acuity using standard charts in the patient record as part of outcome assessment within two (2) weeks from the day of surgery. If a multifocal or multifocal toric IOL is used, uncorrected intermediate and/or near vision shall also be checked to determine the effectiveness of the IOL used. This specific provision shall apply to all admissions (when admitted) or date of surgery (when outpatient) beginning January 30, 2025.

G. Documentation of Cataract Surgery

Clear and accurate documentation of care is a professional and legal requirement of medical practice, and improves patient safety and management of outcomes. The preoperative, intraoperative, and postoperative details of the surgery including the preoperative assessment, biometry results, IOL power calculation, operative procedures, postoperative medicines and other instructions, and findings on the postoperative visits, should be properly documented.

H. Monitoring and Evaluation

Standards of care issued by authorized agencies/organizations shall be regularly reviewed. As deemed necessary, a revision of the policy statements shall be made.

VI. PENALTY CLAUSE

Any violation of this PhilHealth Circular shall be dealt with and penalized in accordance with pertinent provisions of R.A. No. 11223 and R.A. No. 10606, and their respective Implementing Rules and Regulations.

VII. SEPARABILITY CLAUSE

Should parts of the policy be deemed invalid, or unenforceable, the rest of the policy unaffected by the provision is still in full force and effect.

VIII. REPEALING CLAUSE

All PhilHealth Circulars, issuances, rules, and regulations or parts thereof that are contrary to and inconsistent with this PhilHealth Circular are hereby repealed, amended, or modified accordingly.

IX. DATE OF EFFECTIVITY

This PhilHealth Circular shall take effect fifteen (15) days after its publication in the Official Gazette or in any newspaper of general circulation. Three (3) copies shall be deposited to the Office of the National Administrative Register (ONAR) at the University of the Philippines Law Center.

EDWIN M. MERCADO, MD, MHA, MMSc
Acting President and Chief Executive Officer

Date signed: 06/09/2025

MASTER COPY
DC: Date: 6/10/25