

RESPIRATORY TARIFFS

2009/10

Introduction

This overview of tariffs, which will come in to effect from April 2009, is aimed at all Respiratory health professionals and it is hoped that it will serve as a document that can be referred to when discussing such issues with both Trust finance departments and purchasers.

Following a process of sense checking of the original proposed tariffs and revision of some of the more inappropriate estimated costs, the remaining tariffs were circulated for 'Road Testing' and the observations in this document refer to the final tariffs which will be used for Payment by Results in 2009/10.

It was clear in the initial sense check that some of the reference costs for both diagnosis (ICD10) and procedures (OPCS) were based on too few episodes to provide reliable costs and this was particularly true for the newer codes which had not yet been universally taken up by clinicians and coders. It was felt, therefore, that these tariffs should not be mandated for this year but deferred until 2010/11 in the hope that the newer codes would be much more widely taken up to provide better national data. However, whereas diagnosis driven HRGs are costed by considering the average length of spell in hospital (after applying a trimpoint) and then multiplying this number of days by an average day cost, it is more difficult to see how reference costs for procedure/intervention driven HRGs < 1 day could be reliably costed in such a way. We have therefore suggested that during this coming year we consider patient-level costing of all lung function and sleep medicine HRGs with advice from the specialist committees of ARTP, BSS and the BTS Sleep SAG. A national guidance on patient-level costing is close to publication and will act as a valuable reference in such processes.

We had suggested some normative tariffs for other HRGs which had been excluded for this year such as Oxygen assessments, TB nurse activity, Respiratory Nurse activity, NIV assessment and monitoring and chest physiotherapy but these were not accepted. **It is still essential that such activity is recorded, coded and discussed at local level negotiations otherwise it will appear that no such activity exists and we will be no further forward next year.**

The following sections will highlight the main tariffs that we need to be aware of and wherever appropriate, I have added some explanatory comment. For the full detail of all tariffs please refer to:

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_094089

Emergency admissions

These tariffs are referred to as **non-elective spell tariffs** in the PbR documents. You will find that there are also **elective spell tariffs** for many diagnoses which one would never expect to generate elective activity. The tariff for several of these elective admissions was in fact higher than the emergency tariff. These are likely to be the result of spurious coding and the numbers are relatively small compared with the emergency activity.

An elective admission is defined in the CfH guidance as.

- 11 Waiting list admission. A patient admitted electively from a waiting list having been given no date of admission at a time a decision was made to admit
- 12 Booked admission. A patient admitted having been given a date at the time the decision to admit was made, determined mainly on the grounds of resource availability
- 13 Planned admission. A patient admitted, having been given a date or approximate date at the time that the decision to admit was made. This is usually part of a planned sequence of clinical care determined mainly on social or clinical criteria (eg check cystoscopy)

There were some HRGs where the complexity of the admission (especially in cases where the patient was intubated and ventilated) was not reflected in the tariff. This may be for 2 reasons – either that there were inadequate numbers of coded admissions to derive more reliable reference costs or that an additional tariff will be added to account for the spell in Critical Care depending on the number of organs supported. This Critical Care funding will be non-mandatory for this year and should be part of discussions with Trust finance and commissioners. In some cases, where there appears to be anomalous reflection of complexity, the PbR Team have produced an average combined (normative) tariff (e.g. see COPD with intubation).

In the following list I have not included the elective tariffs but concentrated on the emergency (non-elective) tariffs which comprise the majority of Respiratory in-patient activity.

I have not included, unless it is to make a specific point, the tariffs for those HRGs where there are no complications or comorbidity (CC) recorded. As a general rule you can assume that these HRGs have lower tariffs, as one would expect.

Wherever appropriate I have added commentary to clarify issues relating to anomalous costing or provide further coding guidance.

Diagnosis and HRG No.	Tariff
Pulmonary embolus with major CC (09A)	3339
Pulmonary embolus with CC (09B)	2323
Lung abscess with major CC (10A)	4842
Lung abscess with CC (10B)	3341
Lobar, atypical or viral pneumonia with major CC (11A)	4019
Lobar, atypical or viral pneumonia with CC (11B)	2347
Bronchiectasis with CC (12A)	2584
Bronchiectasis without CC (12B)	1894
There was no indication to split bronchiectasis further in to a major CC HRG on the basis of length of spell stats.	
Pulmonary, pleural or other Tuberculosis with CC (14A)	4423
Pulmonary, pleural or other Tuberculosis without CC (14B)	3067
There is no TB HRG with major CC but there is agreement to put forward a case for complex TB admissions which should go some way towards reflecting the extra resources involved in MDRTB admissions.	
Asthma with major CC with intubation (15A)	2311
Asthma with CC with intubation (15B)	1476
Asthma without CC with intubation (15C)	1025
Asthma with major CC without intubation (15D)	2330
Asthma with CC without intubation (15E)	1476
Asthma without CC without intubation (15F)	1025
It is clear that, in these costs, the intubation element has not been factored in. I understand that additional HRGs can be generated for the Critical Care component, however, reimbursement for this activity will be for local negotiation.	
Pleural effusion with major CC (16A)	4297
Pleural effusion with CC (16B)	2574

Respiratory neoplasm with major CC (17A) 3899

Respiratory neoplasm with CC (17B) 2864

Please note that the respiratory neoplasm HRGs reflect inpatient emergency admissions for care of patients who have this diagnosis as the main reason for admission and may be reflecting terminal care or other palliation but not chemotherapy/radiotherapy which has separate HRGs.

Sleeping disorders affecting breathing (18) 2036

Please note that this tariff represents a non-elective admission which is ultimately coded as obstructive sleep apnoea. Either the patient has been admitted as an emergency and further tests have led to the final diagnosis or the patient is known to have the condition but has had to be admitted as an emergency because of deterioration requiring stabilisation and adjustment of treatment. There is now a separate HRG for Cardio-pulmonary sleep studies (DZ50Z – see below).

Other respiratory diagnoses with major CC (19A) 2071

Other respiratory diagnoses with CC (19B) 1446

Please note that this HRG tends to be populated mostly by symptom-based admissions (e.g. dyspnoea) and it is hoped that clinicians will, wherever possible, avoid using this as the sole primary diagnosis as it corrupts national epidemiology.

Pulmonary oedema (20) 2269

Please note that this HRG relates to non-cardiac pulmonary oedema.

COPD with length of stay < 1 day discharged home (21A) 532

A number of these admissions will be assisted early discharge and the costs will not reflect a period of hospital at home care pathway. There are on-going consultations with regard to the addition of a new discharge code to reflect discharge to such a pathway. In the interim it is important that such local activity is recorded separately as the basis for local discussion with commissioners.

COPD with major CC with intubation (21B) 3363

COPD with CC with intubation (21C) 3363

COPD without CC with intubation (21D) 3363

The above tariffs do not reflect decreasing comorbidity and complexity. Where the PbR team felt that the original reference costs were unreliable or appeared inappropriate

(possibly due to the very small number of FCEs recorded), the tariff was normatively adjusted. Once again, HRGs can be generated for the unbundled Critical Care component but would require local negotiation.

COPD with major CC with NIV (21E)	4450
COPD with CC with NIV (21F)	2871
COPD without CC with NIV (21G)	1772
COPD with major CC without NIV without intubation (21H)	3951
COPD with CC without NIV without intubation (21J)	2415
COPD without CC without NIV without intubation (21K)	1849

It is strongly recommended that the full clinical details are entered on to the coding form (CC/NIV/intubation) to reflect the complexity of COPD admissions. This will inform the reference costs for next year, improve our epidemiology with reference to the proportion of patients discharged within 1 day or requiring NIV or intubation. If a patient has an initial trial of NIV but ends up being ventilated then this should be entered as COPD with intubation as this may attract additional critical care tariffs. It is not certain at this stage as to whether NIV, per se, would qualify for critical care increments. We would speculate that if the procedure was carried out in a designated critical care setting there would be reimbursement as per the critical care minimum dataset guidance.

Unspecified acute lower respiratory tract infection with major CC (22A)	3545
Unspecified acute lower respiratory tract infection with CC (22B)	1949

These HRGs above are likely to represent the clinician diagnosis, ‘chest infection’, and should be avoided wherever possible as it will corrupt national epidemiology.

Bronchopneumonia with major CC (23A)	3879
Bronchopneumonia with CC (23B)	2366
Inhalation lung injury or foreign body with major CC (24A)	4779
Inhalation lung injury or foreign body with CC (24B)	2940

These probably reflect frail elderly admissions who aspirate and the relatively high tariffs may reflect the longer length of spell in hospital.

Fibrosis or pneumoconiosis with CC (25A)	2828
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Pneumothorax with CC (26A)	2239
Pneumothorax without CC (26B)	1332

The differential in tariff for pneumothorax is likely to be due to the presence or absence of COPD as the CC.

Respiratory failure with major CC with intubation (27A)	3681
Respiratory failure with CC with intubation (27B)	2506
Respiratory failure with major CC without intubation (27D)	3740
Respiratory failure with CC without intubation (27E)	2506

It would appear that complexity has been taken in to consideration but intubation once again has not and it is assumed, at this stage, that an additional Critical Care tariff will need to be negotiated.

It might be tempting for some Respiratory specialists to use the respiratory failure HRG to cover COPD admissions with respiratory failure. However, in the majority of cases there would be no financial advantage and it would distort national data on COPD admissions. I would strongly discourage this approach. The Respiratory failure HRG tends to be populated by conditions such as ARDS.

Pleurisy (28)	647
Granulomatous, allergic alveolitis or autoimmune lung disease with CC (29A)	2225

Trimpoint data

If a patient remains in hospital longer than the trimpoint length of stay the Trust is reimbursed on a reduced per diem rate.

Please refer to:

http://www.dh.gov.uk/en/Publicationsandstatistics/Lettersandcirculars/Dearcolleagueletters/DH_094089

for further details.

Planned same day activity (PSD)

Respiratory polysomnography (DZ50Z) has a planned same day tariff of £444 and elective tariff of £517. A limited cardio-pulmonary sleep study, currently labelled as polysomnography (U33.1) will group to DZ50Z to reflect this activity.

The following extract from the Specialty Services National Definition Set explains the problems of definition relating to sleep disorders:

“In the past there has been miscoding of non-specialised sleep study activity.

OPCS v4.3: A84.7 - which is confusingly entitled “sleep studies”, should only be used for the more complex, polysomnography tests. The proposed new title under OPCS v4.5 is: “full polysomnography”.

OPCS v4.4: U33.1 - which is confusingly entitled “polysomnography”, should only be used for the less complex and limited cardiopulmonary sleep studies. The proposed new title under OPCS v4.5 is: “cardio-pulmonary sleep studies”.

Local hospitals study sleep-related breathing disorders, both as an in-patient service and out in the community, and carry out simple cardio-pulmonary sleep studies (OPCS code: U33.1 which groups to HRG DZ50Z).

Specialised centres investigate those sleep disorders which may have both a respiratory and neurological component and carry out full polysomnography (OPCS code: A84.7). Full polysomnography includes EEG, electro-oculography (EOG), and surface electromyography (EMG) and frequently cardiopulmonary sleep study together with multiple sleep latency test (MSLT), the maintenance of wakefulness test (MWT) and Osler’s test. (Note: these last three named tests do not yet have OPCS intervention codes which will be required as they are performed separately from full polysomnography).”

Fibreoptic bronchoscopy (07) has a PSD tariff of £494 and an elective tariff of £671. It is hoped that future HRGs will include a ‘Complex fibreoptic bronchoscopy’ HRG to reflect additional costs relating to laser, EBUS –NA and autofluorescence. Although a new code for EBUS-NA has been approved it will currently group to the fibreoptic bronchoscopy HRG and be reimbursed via the 09/10 local payment grouper. This will of course, not truly reflect the additional costs involved. Without this action there would have been no process of reimbursement until 2013.

HRGs that do not have a mandatory tariff for 2009/10

The following exclusions are either because they are part of national specialty commissioning or because there isn’t currently enough reference cost data to formulate a tariff. It is very important that this activity is recorded during 2009/10 to ensure that we have enough data to

inform the reference costing process for next year. It is hoped that patient-level costing will be considered as an alternative option particularly for the < 1 day activity.

DZ01Z	Lung Transplant
DZ13A	Cystic Fibrosis with CC
DZ13B	Cystic Fibrosis without CC
DZ27C	Respiratory Failure with Intubation without CC
DZ30Z	Chest Physiotherapy
DZ31Z	Complex Lung Function Exercise Testing
DZ32Z	Simple Lung Function Exercise Testing
DZ33Z	Hyperbaric Oxygen Treatment
DZ34Z	Complex Bronchodilator Studies
DZ35Z	Simple Bronchodilator Studies
DZ36Z	Bronchial Reactivity Studies
DZ37Z	Non-Invasive Ventilation Support Assessment
DZ38Z	Oxygen Assessment and Monitoring
DZ39Z	Complex Gas Exchange Studies
DZ40Z	Simple Gas Exchange Studies
DZ41Z	Smoking Cessation Support
DZ42Z	TB Nurse Support
DZ43Z	Complex Airflow Studies
DZ44Z	Simple Airflow Studies
DZ45Z	Lung Volume Studies
DZ46Z	Respiratory Muscle Strength Studies
DZ48Z	Respiratory Drive Studies
DZ49Z	Respiratory Nurse and AHP education/support

The following extract is taken from PbR guidance on non-mandatory unbundled rehabilitation activity and seems to suggest that there is a potential to identify a period of post-acute care for community acquired pneumonia that could be unbundled and considered as a separate episode of rehab care which, for the time being, would be reimbursed on a non-mandatory basis. I am unaware of any consultation, with Respiratory physicians, on this as a valid concept. This idea may have arisen because the average length of stay for ‘pneumonia’ appears too long but it is possible that this has been skewed by a significant proportion of the admissions being in the elderly comorbid category. It would be potentially risky to define a set period of acute care to cover all casemix as this might not be in the best interests of patients.

Code	Description	Elective Acute Phase Tariff (£)	Non-Elective Acute Phase Tariff (£)	% of Full tariff
DZ11A	Lobar, Atypical or Viral Pneumonia with Major CC		1,961	49%
DZ11B	Lobar, Atypical or Viral Pneumonia with CC		1,437	61%
DZ11C	Lobar, Atypical or Viral Pneumonia without CC		1,050	69%

The following non-mandatory tariffs have been set for unbundled outpatient diagnostic imaging and would presumably be the basis for local discussions regarding decisions as to choice of provider.

Final HRG	HRG Label - Including Split	Non-mandatory tariff (£)	Cost of reporting only (£) 2009/10
RA01Z	Magnetic Resonance Imaging Scan, one area, no contrast	173	26
RA02Z	Magnetic Resonance Imaging Scan, one area, post contrast only	234	
RA03Z	Magnetic Resonance Imaging Scan, one area, pre and post contrast	234	
RA04Z	Magnetic Resonance Imaging Scan, two - three areas, no contrast	274	35
RA05Z	Magnetic Resonance Imaging Scan, two - three areas, with contrast	319	
RA06Z	Magnetic Resonance Imaging Scan, more than three areas	287	
RA07Z	Magnetic Resonance Imaging Scan, requiring extensive patient repositioning and/or more than one contrast agent	353	24
RA08Z	Computerised Tomography Scan, one area, no contrast	102	
RA09Z	Computerised Tomography Scan, one area with post contrast only	127	
RA10Z	Computerised Tomography Scan, one area, pre and post contrast	147	33
RA11Z	Computerised Tomography Scan, two areas without contrast	112	
RA12Z	Computerised Tomography Scan, two areas with contrast	137	
RA13Z	Computerised Tomography Scan, three areas with contrast	147	13
RA14Z	Computerised Tomography Scan, more than three areas	153	
RA15Z	Dexa Scan	66	
RA16Z	Contrast Fluoroscopy Procedures less than 20 mins	122	n/a
RA17Z	Contrast fluoroscopy Procedures 20 - 40 minutes	153	
RA18Z	Contrast fluoroscopy Procedures more than 40 minutes	183	
RA23Z	Ultrasound Scan less than 20 minutes	55	n/a
RA24Z	Ultrasound Scan more than 20 minutes	85	
RA35Z	Nuclear Medicine - category 1	141	23
RA36Z	Nuclear Medicine - category 2	181	
RA37Z	Nuclear Medicine - category 3	300	31
RA38Z	Nuclear Medicine - category 4	407	
RA39Z	Nuclear Medicine - category 5	712	65

Outpatient tariffs

The following are outpatient attendance tariffs for 09/10.

Treatment Function	Treatment Function Name	WF01B First Attendance - Single Professional	WF02B First Attendance - Multi Professional	WF01A FollowUp Attendance - Single Professional	WF02A Follow Up Attendance - Multi Professional
340	Respiratory Medicine	242	271	110	137
341	Respiratory Physiology	185	370	109	219
370	Medical Oncology	241	481	99	104
800	Clinical Oncology	178	305	69	69
300	General Medicine	189	194	91	97

Non face-to face activity

The following is taken from the PbR guidance 2009:

In 2009-10 there is a non-mandatory price of £23 for none face to face outpatient appointments. This applies to all Treatment Function Codes (TFCs) that have a mandatory tariff for face to face activity and is applicable to both consultant-led and non consultant-led activity. The funding for this activity is no longer in the outpatient attendance tariff as an overhead.

The definition of a non face to face appointment is an appointment which must directly entail contact with a patient or with a proxy for the patient such as a parent of a young child. A non face to face contact should replace a face to face appointment. The introduction of this non-mandatory price is designed to support the use of convenient communications.

The tariff is designed to apply where there is an opportunity for discussion between patient and healthcare professional. For instance, a telephone call to explain the implications of test results to a patient would warrant the use of this tariff, but a telephone call, text or e-mail to report a result would not.

Drug exclusions

The following is a list of high cost drug exclusions, which could be relevant in Respiratory Medicine, with mapping to their respective BNF categories:

Exclusions for 2009/10 (by category)	2009/10 Exclusions (categorised by BNF where appropriate)
Cytokine Modulators	1.5 >Cytokine Modulators 10.1.3 >Drugs affecting the immune response>Cytokine Inhibitors (includes Certolizumab Pegol, Golimumab and Tocilizumab)
Vasodilator antihypertensive drugs/ Primary Pulmonary Hypertension	2.5.1 >Bosentan 2.5.1 >Iloprost 2.5.1 >Sitaxentan 2.5.1 >Sildenafil * *(Sildenafil excluded only when used for PPH) 2.8.1 >Epoprostenol 7.4.5 >Tadalafil * *(Tadalafil excluded only when used for PPH) Ambrisentan (no BNF category available) Nitric Oxide (no BNF category available)

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Fibrinolytic drugs	2.10.2 >Alteplase** **(Alteplase is dealt with as a top-up under PbR in 2009/10)
Allergen Immunotherapy	3.4.2 >Omalizumab
Pulmonary surfactants	3.5.2 >Beractant 3.5.2 >Poractant alpha
Mucolytics	3.7 >Dornase alfa
Antifungals	5.2 >Drugs used in fungal infections >Amphotericin>lipid formulations 5.2 >Drugs used in fungal infections >Anidulafungin 5.2 >Drugs used in fungal infections >Caspofungin 5.2 >Drugs used in fungal infections >Posaconazole 5.2 >Drugs used in fungal infections >Voriconazole
AIDS/HIV antiretrovirals	5.3.1 (includes Etravirine, Raltegravir and Zalcitabine)
Viral Hepatitis (B&C) & Respiratory Syncytial Virus	5.3.3 5.3.5 8.2.4 >Interferon alfa (includes Motavizumab)
Antineoplastic drugs	8.1.5 >Bevacizumab 8.1.5 >Bortezomib 8.1.5 >Cetuximab
Corticosteroids and other immunosuppressants	8.2.2 >Basiliximab 8.2.2 >Daclizumab
Immunomodulating drugs	8.2.4 >Interferon alfa>interferon alfa 8.2.4 >Interferon beta 8.2.4 >Aldesleukin 8.2.4 >Glatirimer 8.2.4 >Lenalidomide 8.2.4 >Natalizumb 8.2.4 >Thalidomide
Drugs affecting the Immune response	8.2.3 >Alemtuzumab 13.5.3 >Efalizumab
intravenous/subcutaneous human normal immunoglobulins	14.5 >Normal immunoglobulin>for intravenous use 14.5 >Normal immunoglobulin>for subcutaneous use

Conclusions

This year should be considered as an important year of evolution in Respiratory coding and tariffs. There are a number of new code submissions, pending with CfH, for consideration in March 2009 which include:

Programmed pulmonary rehabilitation

CPAP - High flow

Initiation of low flow

Follow up & assessment of low flow

Actigraphy, MSLT/MWT

Autofluorescence bronchoscopy

Respiratory Physiotherapy interventions

Occupational peak flow analysis

There are many other issues not addressed in this document and I would recommend the PbR Guidance document 2009/10 (attached to this) if you wish to know more about the following:

Main changes in 2009-10

Updates to tariff calculation

Tariff uplift

NHS Next Stage Review report

What activity is excluded from PbR?

High cost drug, device and procedure exclusions (services and items to be priced locally)

PET, PETCT and SPECTCT scans

Outpatient treatment function exclusions

Chemotherapy

Inpatient activity

Planned same day tariff

Short stay elective tariff

Short stay emergency tariff

Removal of the differential tariff

Outpatient attendances

Specialised service top-up payments

Diagnostic imaging

Outpatient procedures

Non face to face outpatient appointments

Acute phase of rehabilitation

Adult critical care
Principles for the application of local flexibilities
Unbundling
'Pass through' payments
Emergency readmissions
Fixing local prices for activity outside the scope of PbR
Creative use of flexibilities in the future
Joint incentives and gain sharing
Infectious Disease Isolation Units
SHA flexibilities
Market Forces Factor (MFF) payment process for mandatory tariff activity
Activity commissioned by devolved administrations and non-contract activity
NICE adjustments
De-hosting
Long stay outliers

We will consult further with the PbR Team as to whether they will support patient-level costing of some of our new OPCS codes which predominantly reflect PSD activity.

There are ongoing consultations on the request to have a new discharge code to reflect Hospital at Home pathways of care.

The most important take home message is to make early contact with Trust finance and specialist Respiratory coder (if you have one!) and consider the issues raised in this document. In spite of the fact that a number of Respiratory HRGs are non-mandatory for this year it is essential that the activity is recorded accurately with the support of your coding department. Wherever possible, identify activity that requires local negotiation with commissioners and facilitate dialogue between the Trust finance department and PCT on quality pathways of care that have the potential to be coded and costed.

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25/02/2009

