Respiratory Coding and Tariff Update 2019/20

British Thoracic Society

1. Introduction

1.1 This year has seen a variety of changes leading to delays in the publication of the formal tariff (3rd week of March ready for "go live" in April 2019).

1.2 There are major changes in the way the tariff will be delivered that affect emergency medicine especially, together with changes to the market forces factor- the MFF (in reality a weighting for payment). Despite some interesting areas in the early stages of developing the tariff, e.g. for full pulmonary function tests, these have "disappeared": All other issues have all now been addressed and overall the envelope for the respiratory chapter (DZ) is stable at approximately £2 billion.

1.3 The document starts with a brief background to coding to remind colleagues of the process, followed by a discussion around the tariff issues for respiratory medicine, concluding with a section on large scale changes introduced this year.

2. Background to coding activity

2.1 Activities in hospital are generally paid for by the National Tariff. Exclusions to this are activity for specialised commissioning, (though it is often difficult to tease this out for respiratory, especially in out-patients), and where providers have entered into block contracts with CCGs. The latter may limit providers in relation to how much it is possible to go back and discuss in year developments.

2.2 Activity in respiratory medicine falls under a treatment function code (TFC) of 340. One can consider this as a specialty code. Unfortunately, some hospital activity is recorded under general medicine, TFC 300. This means that activity performed by respiratory medicine cannot be differentiated from activity performed by other non-respiratory colleagues.

services/getting more resources more difficult, as it is not always possible to identify an income/work stream. **It is therefore important that lead clinicians are clear with management about ensuring respiratory activity comes under the treatment function code 340 to allow clear budget setting around income and spend.**

2.3 Although there are additional treatment function codes for pulmonary rehabilitation (342) and cystic fibrosis, (343) these have little utility, as CF is being paid under the year of care model and the need for vertical integration around PR services.

2.4 There is a treatment function code for respiratory physiology- TFC 341 - that can be used to capture physiology activity if HRGs (highlighted below in section 3) are not used. Lead clinicians should discuss this issue with their senior physiologists to identify the best route for funding physiological services, depending upon the CCG agreements.

2.5 "Activity" is generally defined as outpatients, day cases or inpatients, both elective and acute (non-elective). Some tariffs will only attract an outpatient activity whilst others may attract day case and inpatients. Generally, inpatient elective activity is similar to day case activity in payment – reflecting a drive to reduce elective admissions.

2.6 Whilst many colleagues appreciate that Health Resource Groups (HRGs) are the normal payment mechanism for most elective, non-elective and day case activity it is worth highlighting that these originate from more basic codes. These are disease or symptom based from WHO International Classification of Disease edition 10 (ICD10) and/or procedure codes derived from Office of Population Census Statistics (OPCS). These codes are aggregated to determine the HRG.

Several HRGs may be listed for one disease area to account for additional complications or interventions to ensure the payment reflects the cost of delivering care.

3. Respiratory coding and tariff: 2019/20

3.1 Outpatient HRGs: focus on physiology

Outpatients tend to have a fixed tariff for that specialty i.e. for respiratory outpatients the TFC 340 ensures that the tariff will be paid as a new or follow up, irrespective of how long is spent with the patient. However, there are some outpatient procedures, predominantly in physiology, that have their own HRG and often attract a specific payment. The number of these and the payment, which has been negotiated over many years, is the largest among all the specialties. Common examples are listed below:

- ***Cardiopulmonary exercise tests;*** if captured by coders (need to make sure to describe what test was performed) maps to the HRG of DZ31Z and will attract a payment of £262.

- ***Field exercise tests map*** DZ32Z, and attract an income of £96

- ***Full pulmonary function tests*** (spirometry lung volumes and gas transfer combined), map to DZ52Z and attract an income of £222. This year it has been possible to negotiate a reduction in the somewhat inappropriate income from gas transfer, as this now attracts an income of £101, mapping to DZ56Z.

- ***Outpatient respiratory sleep studies*** have a procedure code of U33.1 and map to the HRG DZ50Z. The income for this is £348 which reflects the patient collecting the piece of equipment and returning it the following day (i.e. only one outpatient attendance), the analysis and of course, depreciation of the equipment. We should not record the same patient taking the equipment and returning it the following day as two separate episodes. This ensures that the patient themselves do not have to return the kit.

- While of limited use in excluding sleep apnoea, some colleagues perform ***overnight oximetry*** as part of their diagnostic work up for sleep related problems. While there is limited guidance on this it is expected, like sleep studies above, that if a patient collects an oximeter as an outpatient and returns it the following day this should be considered as only one out-patient attendance. This activity maps to the out-patient HRG of DZ37A and attracts a tariff of £170. However, given this activity distorts the HRG it is likely to be phased out in forthcoming tariff iterations.

- Unfortunately some physiological tests that we perform such as exhaled nitric oxide have no code (a request has been submitted for one) whilst other activities such as challenge testing has a code but no tariff – an area of continued lobbying.

3.2 ***Skin prick testing*** also has no formal code and one has been requested. In the interim coders should be reminded that this activity has the procedure code of U28.8, that maps to the HRG JC43A. This attracts a tariff of £122 for adults and £166 for under 19 year old individuals.

Capturing this activity as a new or follow up patient under the Treatment Function Code 341, will allow this activity to be paid, even when the patient sees a doctor first under TFC 340 and then has subsequent tests.

It is important that managers work closely with medical and physiological leads in providers to ensure the activity is captured and coded to attract income that can be attributed to physiology departments.

3.3 Reference costs

Reference costs are the returns from providers about how much it actually costs to undertake the activity / manage the patient. If the return from the provider is too low across the whole of the country then the tariff will subsequently

fall. The tariff this year for sleep studies was really very low and was based upon reference cost submissions from 2016/17. It is therefore important to always check that the reference costs returns by finance, and "signed off" by the Medical Director makes sense for the services that we provide. It is currently not yet clear whether these will be collected this year or be substituted by patient level costings that are occurring in our hospitals (PLICS).

3.4 Day case activity

To fulfil day case activity set criteria are required that include a period of recovery.

- For respiratory the most common procedure is DZ69A which is ***fibre-optic bronchoscopy in individuals aged over 19 years*** which attracts a tariff of £569. In contrast, if a bronchoscopy is performed below this age it will map to HRG DZ69B and will attract a tariff of £1029.

- ***EBUS*** maps to DZ70 and attracts a tariff of £1412.

- We do not have a specific procedure code for emerging technologies such as ***radial EBUS*** but this has been reviewed by the classification service and has the codes E49.5

- ***Diagnostic fibreoptic endoscopic*** examination of lower respiratory tract with biopsy, lavage and brush cytology of lesion of lower respiratory tract: Y76.4

- ***Endoscopic ultrasonic*** approach to other body cavity: Y53.4

- ***Approach*** to organ under ***fluoroscopic control***: Z24.6

- ***Lung which maps to DZ69Z*** and attracts a tariff of £569, the same as bronchoscopy. It is clear that the tariff associated with this HRG is not sufficient to cover the cost of this procedure. Therefore it may be appropriate to use tariff flexibility around innovation to discuss appropriate reimbursement with commissioners. Please contact Dr Martin Allen via bts@brit-thoracic.org.uk if you wish to discuss further.

- While looking at ***bronchoscopic procedures*** the codes for endobronchial valve placement have been modified so the following codes should be used- ***Reduction of lung volume:*** - E54.6. ***Endoscopic approach*** to other body cavity: Y76.3

- ***Insertion of prosthesis*** into organ NOC Y02.2

- ***Insertion of endobronchial nitinol coils*** : E54.6

- ***Reduction of lung volume***: Y76.3

- **Endoscopic approach** to other body cavity: Y36.2

- **Introduction of therapeutic implant** into organ NOC: Y53.4

- ***Approach to organ under fluoroscopic control***. These sequence of codes (that you cannot put into discharge letters but need to discuss the terms with coding departments) map to the HRG DZ66Z that attracts a tariff of £7,634 (either day case or elective).

3.5 Non-elective

The DZ chapter contains a variety of conditions e.g. asthma, pneumonia, cancer etc. and commenting on all of these HRG's would produce an article of great length and of little use. The particular HRG and the payments it attracts are available on the NHSI website.

4. Focus on Tuberculosis

The annual focus in 2019 this year is on TB care.

4.1 ***TB nurse activity*** i.e. undertaking activities like contact tracing and BCG administration, is often captured as a nurse led outpatient activity. However this is not correct, as it does not reflect the resources to deliver TB services. There exists

a specific TB nurse tariff mapping to its own HRG. Each patient who is seen by the TB nurse should be counted under the out-patient HRG of DZ42Z, which attracts a tariff of £161 per patient.

4.2 It is clearly important ***that TB nurse led*** clinics are counted under the HRG activity rather than as a straight outpatient which will attract a lower tariff (even when run under a consultants name for follow up activity). Discussing this with the hospital contacting team to highlight the opportunity for charging the HRG rate rather than the clinic attendance tariff may ***allow the opportunities for TB nurse expansion***, an area where investment needs to be maintained, despite falling numbers of cases.

4.3 Those patients with tuberculosis who require a lengthy admission (over 28 days) usually due to social problems, homeless or have difficult to treat TB, including MDR, attract an enhanced tariff. Such patients should be coded under the respiratory HRG of ***DZ51Z as the tariff is £17,847***. This is in contrast to TB coded diagnoses with a shorter length of stay that mapped to DZ14F to J, depending upon interventions and complications.

5. Best Practice Tariffs (BPTs)

5.1 This has been an area of lengthy discussion with a variety of individuals and non-respiratory colleagues. Both the pleural and the COPD best practice tariffs remain this year. The ***best practice tariff for pleural activity is £898.00.*** The ***BPT for COPD*** will depend upon the HRG (ie. severity of exacerbation, complications, interventions and comorbidities), ***ranging from approx. £60.00 to £900.00*** additional payment if the bundle is used. Information on the processing of activity is available on the NHSI website, but it is important to have discussions with coding departments to ensure this activity is captured.

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6. New changes to the tariff process 2019/20

6.1 While the respiratory EWG met with NSHI, NHSE and the Casemix office in February 2018 to discuss the tariff there were huge delays in delivering this. A draft tariff to allow hospitals to consider 2019/20 activity was released prior to Christmas holidays. The formal document for consultation came out more recently and closed within a short timeframe with subsequent release of the formal tariff in the 3rd week of March for implementation in April 2019.

6.2 This delay was due to a series of "high level" changes in the tariff process which can be considered under 4 sections.

- Blended payments
- Changes to Market Forces Factor MFF
- Non Face to Face payments
- Maternity (this will not be expanded upon)

6.3 Blended payments

6.3.1 A more detailed discussion on this topic is needed because of the future impacts, which are mainly in emergency medicine / acute medicine / ambulatory care but are likely to have specialty consequences around acute admissions. Further information is available on the NHSI website.

6.3.2 Rather than CCG's paying for individuals attending emergency departments, the blended payments system is a new method of paying for emergency activity. This sets a discussion leading to an agreement between CCGs and providers, overseen by STPs. If no agreement is reached then the usual arbitration process will occur. It is theoretically the best of both Payment By Results (activity in reality) and a block contract.

6.3.3 The blended payment is a fixed amount agreed in advance for the coming year so trusts will have a good idea of their budget in advance. This is determined by the activity for the coming year (ideally based on previous outturn and even better at specialty level) and multiplying it by the tariff. For example if a trust admits 100 cases of pneumonia that attract a tariff of £2000 if this

agreed the fixed income will be 100 x £2000 i.e. £200,000.

6.3.4 There are clear risk sharing plans with the blended payments. If the overall agreement in 10,000 admissions then the next one i.e. 10,001 will only be paid at 20% of that activity. It has been determined that this is the "variable cost" of care and that the fixed cost i.e. medical staff buildings are already taken account of in the major block of 10,000. However if the activity is 9,999 the provider will get paid 80% of that activity for that 1 less patient they admitted.

6.3.5 If this all fails then there is a "break glass" agreement term that providers and CCGs get back around the table to discuss additional funding. This threshold for the "break glass" will vary across provider / CCG organisations.

6.3.6 Whether this "negotiation" will be at specialty level is yet to be seen. It may be that the income is determined from an average outturn of the emergency department (A&E attendances, acute medical and specialty admissions) and an average cost. NHSI have no real knowledge about the depth of the specialty coding used nor of the amount of clinical involvement in these discussions. This may be unfortunate for respiratory medicine where the growth of emergency admissions is often three times that of other admissions. Proportionately, the blended payment should be inflated to consider some of these aspects for respiratory medicine. An audit of the process and agreements is being undertaken by NHSI to determine the clinical engagement and "granularity" of the process. However, it is likely to be an individual provider discussion about how money from the "blended block" is attributed to specialty wards and the "front door" so it is important respiratory leads have discussions to ensure money flows appropriately.

6.3.7 Because of these changes additional money has been found, with £1bn from the Provider Sustainability Fund (the provider bailout fund) and a reduction in CQUIN funds, which will fall from 2.5% to 1.25% of the budget. In an attempt to simplify matters the previous 70% marginal rate for activity over and above the 2008/9 agreement and the non- reimbursement of 30-day readmissions will be discontinued.

6.3.8 This is a major change in how emergency care will be delivered and there is little modelling work to inform its impact. It is likely that this will lead to greater income for acute providers, something that they have raised with NHSE / NHSI on many occasions that acute care does not pay the same as elective planned care.

6.3.9 As a consequence of this major upheaval the tariff has only been released for 1 year. If the blended payment approach is successful then it is likely it will be rolled out further into planned care. There is a key role for the STPs in the process and this should encourage CCG's and acute providers to try to find alternative ways of managing attendances at A&E. This change in payment mechanisms can be considered as an enabler for some of the structural changes outlined in the LTP to develop and jointly deliver care at health economy / population level.

6.4 Market Forces Factor (MFF)

6.4.1 This apparent small print term is of huge importance and might be considered a local "fudge factor". It is used as a multiplier of the national tariff for the local population. For example if the tariff for an activity is £1000 and the provider MFF is 1.006 then the provider will receive 1000 x 1.006, i.e. £1006 for the activity. In contrast, if the MFF is in an area where the multiplier is 1.1 the provider will be paid £1100.

6.4.2 The MFF has been in place for many years and has not been reviewed until recently. It has been noted that some providers that have had a high MFF for several years will have this lowered which will reduce the provider income. As the drop in funds is substantial for some providers it could destabilise the provider/health economy. Consequently, it has been decided to phase in the changes to the MFF over some 4-5 years. It appears the largest reductions will be in large southern conurbations with the funds being redressed in the north. Each provider's MFF is

available on the NHSI website.

6.5 Outpatient prices and Non Face to Face activity

6.5.1 The current model of paying for outpatient activity is somewhat out of date as recognised by a recent excellent review by the Royal College of Physicians of London. Attempts have been made to alter the weighting of the tariff by NHSE / NHSI for some specialities promoting new rather than follow up patients at a greater tariff in an attempt to drive down follow up activity. Unfortunately this has had unintended consequences, especially in some sub-specialties where patients on prolonged waiting lists for follow ups have been disadvantaged.

6.5.2 As there is no specific coding for outpatients, the only information required is whether the patient is either new or follow up, whether the patient attended and (leads please check) the specialty code, TFC 340.

6.5.3 In an attempt to reflect more of what happens in clinical practice and to drive down a reduction in hospital attendances a new non-mandatory, the non Face to Face tariff which has been developed is set at 68% of the tariff to initiate discussions with commissioners. For consultants this is coded as WF01C under TFC 340 and attracts an income of £85.00 for respiratory consultants. A similar code under TFC 341 attracts £52.00 – therefore if physiologists are informing patients of their results and making management plans that are discussed with patients on the phone for example, they too can charge for this activity.

6.5.4 Whilst CCGs and providers will need to discuss the process in detail, it is important that systems are in place to capture the non Face to Face activity that is undertaken. Respiratory medicine has been doing this for many years e.g. a patient discharged from hospital with a pneumonia will be given an x-ray card in to have the x-ray performed and this will be reviewed by a consultant who then does a letter / call to both the patient and the GP, outlining a management plan.

6.5.5 Such activity has become part of normal practice but providers are often not paid for this perhaps for a variety of reasons. For example, there is no way of capturing such activity on the hospital system; it is too time consuming to enter the data, he commissioners have not been informed; work has been done in the provider units, and the provider commissioners may not discuss it with CCGs. Whatever the reason, (and we need to find out) systems and process need to be in place to both capture the activity and ensure this income returns to the appropriate department, encouraging recognition in job plans. Given some of the proposed changes in the NHSE Long Term Plan which will involve more delivery of care in the community, it is important that we are engaged with commissioners (both those in hospital and within CCGs / STPs) to ensure respiratory medicine is represented.

	First single attendance	Multi-professional	Follow-up single	Follow-up multi-professional
340	£15	£296	£96	£124
341	£155	£238	£77	£77

6.5.6 In respiratory medicine the consultant outpatient attendance codes are tabulated below. The respiratory treatment function code 340, and the respiratory physiology treatment function code of 341 should be used whether this involves seeing one consultant alone or as part of a multi-professional team. There are clear definitions of what constitutes a multi-professional attendance and often commissioners will take a view on whether they wish to purchase the activity. The advice and guidance remains for the electronic referrals but this has gone beyond the £23 that existed to £30 if there is a response in 2 days and £20 if a response in 3-7 days, with no payment beyond that time line.

7. Conclusion

7.1 The envelope for respiratory medicine is generally the same. Best Practice Tariffs have been maintained and there are a few minor changes to the outpatient, day case and non-elective activities, with the EWG successfully ensuring there were little other changes.

7.2 There remains confusion over CPAP and non-invasive ventilation and as requested by many parties including NCPOD we have submitted requests for new OPC's codes for CPAP, ventilation, FeNO and skin prick testing.

7.3 The non Face to Face changes are a real opportunity for respiratory medicine to gain income for activity we are probably already doing. It is important we discuss with managers to explore the processes around this.

7.4 The changes to Market Forces Factor over a 4-5 year period has the opportunity to destabilise some providers though with the gradual changes I think this is unlikely however some hospitals with the combination of the both the blended payments and MFF are likely to find their income is more stable.

7.5 The major change of blended payments has the potential to destabilise the health economy given the relatively little modelling work. However, NHSE / NHSI have taken note of the issues that providers have raised about delivering acute care. An important aspect of this blended payment will be a greater role of STP's into encouraging providers and CCG's to work closer together to deliver optimal care in the right setting as outlined in the long term plan.

As always the author is happy to try and answer questions on codes and tariff and this is best done by emailing him via BTS head office (bts@brit-thoracic.org.uk or martin.allen@uhnm.nhs.uk)

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