RESPIRATORY CODING AND TARIFF UPDATE 2017 / 2018

1. Introduction

1.1 There have been several significant changes affecting respiratory medicine since the last coding / tariff update. This update will outline what the changes are, and will also highlight some challenges for the future.

1.2 Income into acute Trusts comes from specialised services funding and CCGs (Clinical Commissioning Groups) in England. Unfortunately, respiratory medicine attracts little additional funding for specialised commissioning beyond pulmonary hypertension and cystic fibrosis, with a top up available for management of large airway problems, e.g., stenting.

1.3 The bulk of the income from CCGs is via three routes; outpatient activity, day case / elective and acute inpatient care (termed non-elective activity). These will be considered below.

2. THERE HAVE BEEN 5 MAJOR CHANGES THIS YEAR

2.1 **The introduction of Healthcare Resource Groups 4+ (HRG4+)** which is associated with far more 'granularity' by an extended recognition of complications and comorbidities. It is therefore very important to document on discharge summaries for all day case and elective work the relevant comorbidities, complications and procedures that are done as this will significantly increase the likelihood of the activity to a higher resource HRG and therefore resulting in an increase in income.

2.2 **Tariffs have now been agreed for two years**, 2017/2018 and 2018/2019 under the premise that this will allow for better planning.

2.3 **Introduction of a Best Practice Tariff** (BPT) for COPD

2.4 **Enhanced guidance for coding/capturing activity for sleep studies.** This has come about because a few hospitals have not followed the national coding advice and have captured routine simple sleep studies as EEG polysomnography see section 5, below)

2.5 **A greater spread of tariffs for bronchoscopic procedures**, including more appropriate tariffs for thermoplasty and endobronchial valves.

OUT PATIENTS

3. Standard outpatient activity

3.1 For standard outpatient activity, there is no diagnosis code recorded for the activity. Therefore the coding is as basic as either a new patient or a follow up patient attendance which maps to a Treatment Function Code (TFC) which, for respiratory medicine, is 340.

3.2 There is also a split for uni- and multi-disciplinary attendances i.e. when the patient sees both a doctor and another practitioner in the same clinic room. The tariff for the next 2 years has had a 20% increase in the new patient payment for respiratory medicine with a pro-rata reduction in follow up payment in an attempt to drive the practice of discharging patients from clinic.

The funding for 2017/2018 is below:

TFC 340			
	First outpatient attendance	single professional	£208
	First outpatient attendance	multiple professional	£286
	Follow up attendance	single professional	£94
	Follow up attendance	multiple professional	£113

4. Procedures as out patient

4.1 In some specialities, procedures may be undertaken in outpatients which can attract additional funding depending on the specific HRG the activity has been mapped to. It is therefore important that this activity is appropriately captured. Activity is coded using OPCS codes and these are mapped to the appropriate HRGs, which for respiratory begins with a classification 'DZ' with a series of letters and numbers that follow.

4.2 The following procedures, if appropriately captured in the outpatient setting, will attract payment as follows:

DZ30Z	Chest physiotherapy	£202
DZ37A	CPAP initiation (as a group)	£200 (per patient)
DZ37B	CPAP initiation (paediatric patients)	£218 (per patient)
DZ42Z	TB nurse support	£152 (eg BCG, Heaf testing)
DZ50Z	Respiratory sleep study	£408

5. Sleep activity: issues and solution

5.1 There has been an issue with the coding of sleep studies. When generated in the outpatient setting the HRG DZ50Z (Respiratory Sleep Study), is a one off payment for when a patient collects a piece of equipment to undertake multi-channel sleep studies at home and returns it the following day. Only one payment is made for what is effectively 2 attendances, the collection of the equipment and then to return it. The £408 also includes the cost of the analysis. There is no payment for overnight oximetry.

5.2 For colleagues who are undertaking full polysomnography, i.e. recording EEG, this maps to a neurological disorder HRG depending upon the primary diagnosis and any complications/co-morbidities of the patient. This activity will attract an appropriately higher tariff reflecting the increased use of resources.

5.3 It is very important that the reason for the attendance for full polysomnography is appropriately documented. If the primary diagnosis recorded is sleep apnoea, this activity will not map to a neurological disorder HRG but will map to DZ18 Sleep disorders affecting breathing, (D to G, depending on any other interventions), resulting in a tariff as low as £379. This tariff has been set to drive the correct coding practice and to ensure that patients are not admitted to hospital for non EEG polysomnography routinely to attract the neurological tariff. For example, if the respiratory polysomnography code was used in these instances they would generate DZ50Z with a tariff of £408. This manoeuvre is unfortunate, but reflects the fact that several hospitals have failed to follow the clear coding advice, which has ultimately resulted in the dilution of the tariff paid for full polysomnography. If there are uncertainties, Dr Martin Allen, the BTS lead contact for Respiratory Coding would be more than happy to discuss this further.

6. Pulmonary function testing.

6.1 For the procedures listed below, if coded in an outpatient or a day case setting and mapped to these particular HRGs, they will attract the stated tariff.

DZ31Z	Cardiopulmonary exercise testing	£244
DZ32Z	Field Exercise test	£143
DZ52Z	Full pulmonary function tests	£215

6.2 Unfortunately, not all physiological measurements receive payment beyond the standard outpatient attendance tariff. There has been considerable on-going discussion about funding physiology correctly with NHSE/NHSI and the National Casemix Office. Provisional agreements with NHSE/NHSI to pay for other physiological activities have not been forthcoming despite considerable pressure.

6.3 Therefore, to attract appropriate payment for physiological activity, patients should be captured as an outpatient and with a treatment function code (TFC) 341 respiratory physiology. As with medical outpatients, the tariffs associated with this treatment function code are as follows:

TFC 341		
First outpatient attendance	Single professional	£148
First outpatient attendance	Multi professional	£229
Follow up attendance	Single professional	£120
Follow up attendance	Multi professional	£187

6.4 It is important to realise, however, that there is very little multi-professional activity that is likely to be take place as it would be expected that these would be reported under TFC Respiratory Medicine.

6.5 It is hoped that on-going discussions will allow appropriate identification and reimbursement for physiological activity in the future. However, by capturing new and follow-up outpatient attendances for the physiological tests where there is no payment for the actual tests the income into pulmonary physiology departments should remain adequate.

DAY CASE / ELECTIVE ACTIVITY

7.1 It is appropriate for many procedures to be reported in the admitted patient care setting i.e. day case / elective inpatients - those where the patient requires a bed for recovery. These include bronchoscopic procedures which now have more granular HRGs, and therefore will attract more appropriate tariffs.

7.2 As these procedures tend to be short stay and planned, the complications which normally increase the payment for tariff are not applicable. Examples of national tariffs for these procedures for day case or elective inpatients are below:

DZ37A	CPAP or NIV titration (adult)	£741
DZ37B	CPAP or NIV titration (paediatric) (day case only - this requires the patient to be resting in a bed for a period and therefore reflects one to one CPAP initiations)	£959
DZ66Z	Complex therapeutic bronchoscopy (for placement of valves and coils)	£7,293
DZ67Z	Major therapeutic bronchoscopy (eg, stents, thermoplasty)	£2,050
DZ68Z	Therapeutic bronchoscopy (eg, lavarge)	£930
DZ69A	Diagnostic bronchoscopy (adult)	£485
DZ69B	Diagnostic bronchoscopy (child)	£950
DZ70Z	EBUS	£1,276

7.3 For the therapeutic procedures the tariff is set the same for both elective and day case activity, so if an overnight stay follows on from a booked procedure, no additional payment is forthcoming. However, for diagnostic procedures if patient stays overnight a different HRG, which is likely to have a higher tariff, will be generated.

7.4 There are combined day case /elective tariffs set for all other respiratory conditions. However, some are far from ideal and do not reflect current practice, e.g., day case/electivity tariff for bronchiectasis with 0-1 complications is only £872. I did attempt to increase the tariff to reflect the cost of care but was not successful in all areas as the total quantum of costs available for respiratory medicine is a fixed amount – "need to take from Peter to give to Paul" i.e. if tariff was raised in one area – would need to reduce in another to the equivalent value – zero sum game.

NON ELECTIVE ACTIVITY (INPATIENT)

8.1 There are high volumes of non-elective inpatient activity for respiratory medicine. This is therefore the major source of income for respiratory medicine **and it is essential,** now that the HRG design reflects multiple complications and comorbidities, **that the relevant complications, comorbidities and interventions, are clearly recorded in case notes / discharge summaries.**

8.2 This allows coders to identify such complications/comorbidities which may significantly increase the income we receive, appropriately reflecting the increased costs for managing such patients. The tariffs for the HRGs for different diseases are available on the NHSI website although Dr Martin Allen is happy to be contacted about specific issues.

BEST PRACTICE TARIFF (BPT)

9.1 Where care can be enhanced by doing things differently or as a driver to facilitate discharge, Best Practice Tariffs (BPT) have been introduced. We have had a Best Practice Tariff for pleural disease for many years, and a higher tariff is paid when procedures are performed under ultrasound guidance.

9.2 In April 2017/2018 a **new Best Practice Tariff for COPD is available**. The thresholds are triggered when 60% of patients with a primary diagnosis of COPD who are admitted with an exacerbation receives "specialist input" within the first 24 hours and a discharge bundle is used, the activity being captured on the national audit. Depending upon the number of interventions / complications the patient has, this may attract an enhanced tariff of between £50 to just under £600 per admission

FUTURE DEVELOPMENTS

10.1 Tariffs for the above activities are derived from the reference costs reported by all NHS hospitals on an annual basis. There has been recognition for many years that there may be data quality issues with the costs reported by some Providers and that reference costs may not always truly reflect the costs of care in different specialities.

10.2 In the hope of improving the quality of reference cost returns, Medical Directors have recently been mandated to sign off these reference costs returns. However, there are

still some anomalies both within respiratory medicine and across all care areas, which then lead to attempts to "smooth" differences when it comes to using these costs as the basis of the national tariffs.

10.3 The major drive in the coming year will be to collect patient level costings and whilst this year approximately 100 hospitals are undertaking PLICS (Patient Level Information & Costing Systems), this will be mandated next year. By working closely with our costing practitioners, we will hopefully be able to reflect the cost of care more accurately. This is an area that is important for clinical engagement and I would be interested to know of colleagues who are involved with PLICS who would like to be involved in this work.

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