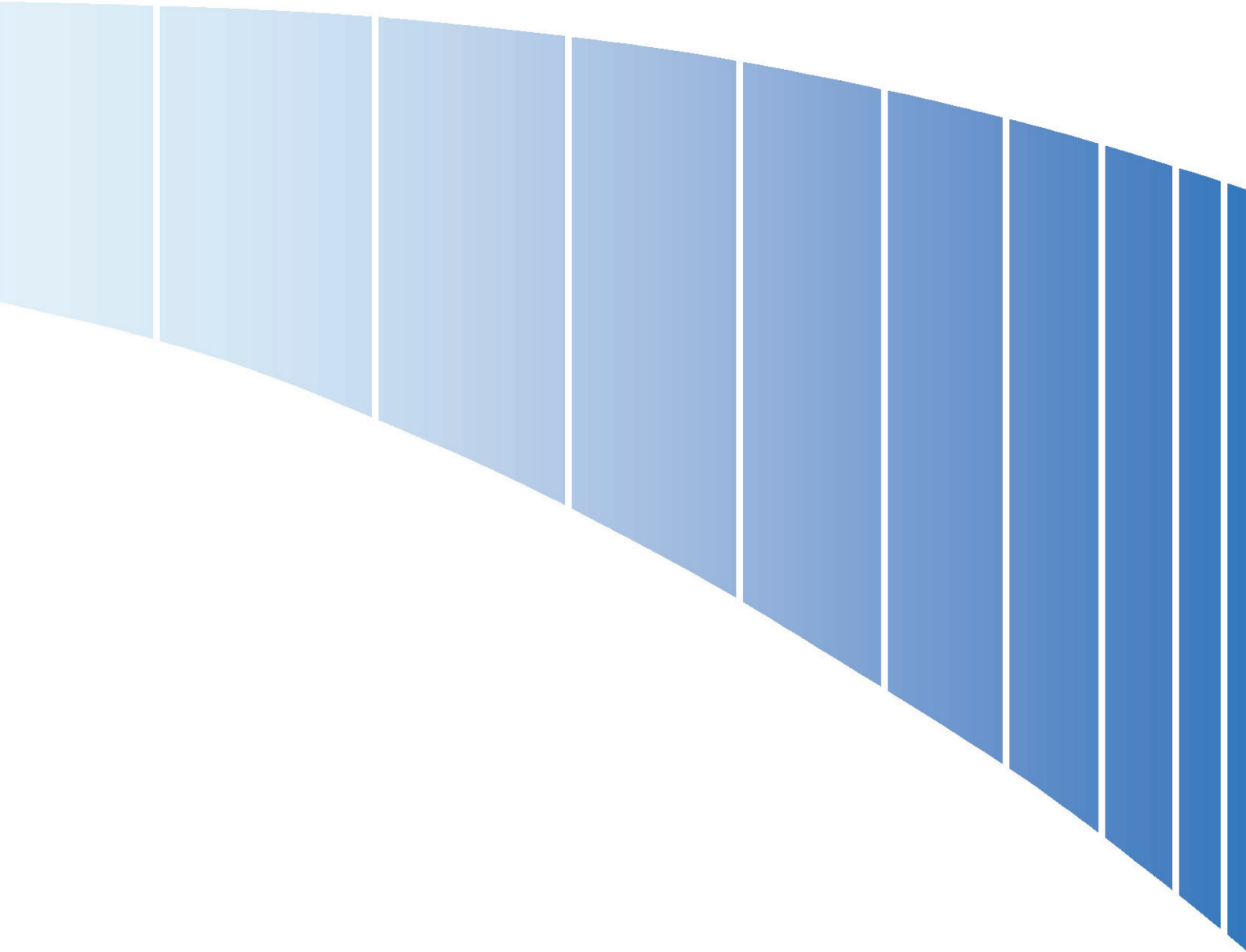


# Payment by Results Q&As for 2012-13



**DH INFORMATION READER BOX**

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<b>For Recipient's Use</b>	

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## Background

The Payment by Results (PbR) guidance for 2012-13 and supporting materials at [www.dh.gov.uk/pbr](http://www.dh.gov.uk/pbr) will enable organisations to operate PbR and the national tariff in 2012-13. We have provided the following Q&As in response to:

- feedback during the road test of the tariff and guidance between 15 December 2011 and 20 January 2012 which we were not able to address in the guidance
- questions sent to our PbRComms mailbox since the publication of the final PbR package on 16 February 2012
- feedback at the Healthcare Financial Management Association (HFMA) PbR event on 6 March 2012.

As we noted in the guidance, it is neither desirable nor possible for PbR guidance to provide advice for every situation that arises locally, and in these circumstances, we ask commissioners and providers to exercise judgement in interpreting the guidance and come to a local agreement. Commissioners will wish to specify in contracts, and within PbR rules, what they will and will not pay for. For their part, providers will wish to ensure that the way they cost and charge for activity is consistent.

With this in mind, further questions about PbR should be directed as follows:

- Commissioners and NHS trusts should contact their SHA PbR leads<sup>1</sup>
- NHS foundation trusts, SHAs and other organisations should contact the PbR team via [PbRComms@dh.gsi.gov.uk](mailto:PbRComms@dh.gsi.gov.uk).

References to paragraph numbers are to paragraphs in the PbR guidance for 2012-13.

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<sup>1</sup>[http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH\\_4000363](http://www.dh.gov.uk/en/Managingyourorganisation/NHSFinancialReforms/DH_4000363)

## Emergency readmissions

Q1: There are no further details/codes as to how transplant patients and renal dialysis patients are excluded from the emergency readmissions policy, so is there any further guidance for these?

A: Both those patients that have been readmitted subsequent to a transplant and those receiving renal dialysis are excluded from the emergency readmissions policy in 2012-13. Commissioners and providers should determine locally which activity should/should not be covered by this exclusion.

Neither of these exclusions will be carried out in SUS PbR and users may need to perform additional processing locally.

Q2: How does the emergency readmissions policy apply when initial treatment was provided at an independent sector provider?

A: The emergency readmissions policy applies to independent sector providers. The clinical review should be undertaken between the provider and its coordinating commissioner, and the findings should be used to inform all contracts between the provider and those commissioners within the group.

Q3: For organisations that have not yet agreed the amount of non-payment for emergency readmissions in 2012-13, how should the threshold from the clinical reviews be operationalised?

A: This should be determined locally but all clinical reviews should be completed by the end of Q1. Organisations could choose to roll over arrangements for last year until the review takes place and make a retrospective adjustment to payments following a reconciliation.

## Marginal rate

Q4: Which baseline does the guidance on the marginal rate for emergency admissions relate to?

A: The baseline referred to relates to non-elective activity. Paragraph 73 of the guidance states that the marginal rate applies to increases in the value of emergency activity and that the point at which the actual value of emergency activity exceeds the baseline will trigger the 30% marginal rate. Paragraphs 81 to 87 cover the setting of the baseline.

Q5: Are there any plans to update the marginal rate emergency tariff baseline from 2008-09?

A: This was discussed in planning for the 2012-13 tariff and it was decided not to change the baseline year. The decision has not yet been made for 2013-14.

## Urgent care

Q6: Should an A&E unit always attract the dead on arrival band 3 tariff regardless of whether or not it is a 24 hour unit, or should a non-24 hour A&E still only receive the band 5 payment?

A: If a patient is dead on arrival at a non-24 hour A&E unit, the band 3 tariff should apply.

## Best practice tariffs

Q7: Can the PbR team suggest ways to operate the pathway tariff for cataracts that minimises administrative burden?

A: It is suggested that organisations make use of the Patient Pathway Identifier (PPI) field. Events coded with the same PPI should be unique to a cataract pathway for a given individual. Outpatient attendances for ophthalmic co-morbidities, for example glaucoma, should not be recorded using the same PPI. Organisations will therefore be able to identify the number of relevant outpatient attendances along a patient's cataract pathway and make the necessary financial adjustments.

Since April 2010, additional functionality has been available in SUS PbR to help organisations to implement this pathway tariff. Commissioners and providers can access an extract that links events along a patient pathway using the Patient Pathway ID field, returning records in chronological order per patient. More information is available in SUS PbR documentation available on the NHS Connecting for Health website<sup>2</sup>.

If providers and commissioners agree, they can implement local solutions for paying for the cataract BPT.

Please note that greater detail on the cataract BPT, including the operational aspects is contained in the 2010-11 PbR Guidance. from paragraph 175:  
[http://www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/@dh/@en/@ps/documents/digitalasset/dh\\_112970.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_112970.pdf)

In an effort to limit the size of the PbR Guidance, we reiterate only minimal guidance in subsequent years.

Q8: What is the relevant tariff for spells where the Local Payment Grouper has generated a BPT flag but for which there is no associated BPT?

A: The Local Payment Grouper generates the flag irrespective of the HRG even though BPTs only apply to certain HRGs. If a spell with a BPT flag is generated in an HRG without a BPT then the conventional tariff (listed in '01 APC &OPROC' tab of the tariff information spreadsheet) applies. SUS PbR automates this process.

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<sup>2</sup> <http://www.ic.nhs.uk/services/secondary-uses-service-sus/updates-and-guidance/payment-by-results-guidance>

Q9: What is the relevant tariff for spells where the Local Payment Grouper has generated multiple BPT flags?

A: A spell is only eligible for one BPT. In the cases where a spell has multiple BPT flags, SUS PbR will apply the relevant tariff to only one of the flags. It does this using a hierarchy of the BPT flags, picking the BPT flag that is highest in the hierarchy from the multiple BPT flags generated for the given spell. Users of the Local Payment Grouper will need to apply the hierarchy, detailed in Annex A, page 168 of the 2012-13 PbR Guidance in order to determine which BPT flag to use.

Q10: For paediatric diabetes, do you pro-rata the year of care if a patient comes in part way through the year?

A: Yes.

Q11: If a diabetes patient is about to become an adult, can they see an adult consultant or does it have to be paediatric?

A: If the patient comes under paediatrics, they should be seen by a paediatric diabetologist. The best practice tariff is paid if, of those patients classified as paediatric who have diabetes, 90% receive care to the best practice standards. If the patient is defined as an adult, they will attract the adult tariff.

If they are defined as paediatric but see the adult diabetologist, they would not be counted as receiving best practice (the trust may still receive the tariff however, as long as they met the standards for 90% of children).

We would encourage trusts to ensure that all those under 19 with diabetes are seen by the paediatric diabetes team.

Q12: Hip and stroke BPTs are quite successful but they are laborious for providers to provide data for; could you ensure that future BPTs are easier to record?

A: It is our intention in selecting and developing BPT areas to minimise any additional administrative burden that is placed on organisations to operate BPTs. All proposals are discussed with expert working groups, PbR governance groups and stakeholders to understand and minimise the additional burden prior to any BPT being implemented.

Each of the BPTs are monitored and reviewed annually to address feedback from the NHS ahead of future tariff cycles.

Q13: What are the OPCS codes for the day case BPTs?

A: The 2012-13 tariff information spreadsheet details the OPCS codes for day case procedures where the BPT applies at the sub-HRG level via the use of a BPT flag (tab 07 'BPT flags'). Where the BPT applies at the HRG level then the OPCS codes can be found in the Code to Group document issued by the Casemix team at the IC, available to download at the link below:

<http://www.ic.nhs.uk/services/the-casemix-service/using-this-service/reference/downloads/payment/hrq4-2012-13-local-payment-grouper-documentation>

Where an HRG covers multiple procedures with different day case rates then it is suggested that users consult the British Association of Day Surgery's Directory of Procedures, which lists the OPCS codes and associated day case rates, available from the BADS website:

<https://www.daysurgeryuk.net/bads/shop/default.asp>

Alternatively, the OPCS codes are listed as part of the documentation to the NHS Better Care, Better Value indicators. The codes are in the appendix of the Definition documentation. Organisations may also find the website of interest as it enables organisations to benchmark performance for each procedure in various ways.

<http://www.productivity.nhs.uk/Indicator/609/For/National/And/25th/Percentile>

Q14: How are future best practice tariff work programmes determined?

- A: The BPT work programme has to date been agreed on an annual basis. Stakeholders are invited to nominate areas which meet the following core criteria:
- high impact (ie high volumes, significant variation in practice or significant impact on outcomes)
  - a strong evidence base on what constitutes best practice (national guidelines, professional body guidelines)
  - clinical consensus on the characteristics of best practice.

The nominations are then assessed internally and presented to the PbR advisory groups<sup>3</sup> for comment ahead of a decision on areas for inclusion in the work programme. The work programme for 2013-14 is currently being finalised and further information will be released in an upcoming PbR Update.

Beyond the 2013-14 tariff, Monitor and the NHS Commissioning Board will have responsibility for the tariff, currency design and price setting.

## Exclusions

Q15: While NICE guidance on drugs is in draft stage, is the cost outside of tariff?

- A: Unless a drug is excluded, or is used within an excluded service, it is still in the scope of tariff even before it has been considered by NICE. Drugs which are introduced without consideration by NICE or in advance of NICE guidance are funded through the general inflation uplift.

Q16: Are drugs on the exclusion list also excluded from non-mandatory prices?

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<sup>3</sup> <http://www.dh.gov.uk/health/about-us/public-bodies/advisory-bodies/pbr-governance-arrangements/>



A: Yes. The general principle is that where a drug is a named exclusion it is excluded from both mandatory tariffs and non-mandatory prices.

Q17: How should we manage the funding of drugs when they are also part of a patient access scheme that proposes a discount, rebate or other variation from the list price of a medicine?

A: Commissioners and providers should agree locally how to apply a discount, rebate or other variation.

Q18: If a drug is not listed as an exclusion from PbR can commissioners and providers still agree extra funding for the drug?

A: Yes. Further details regarding PbR flexibilities can be found in Section 13 of the PbR guidance.

Q19: Have you excluded drugs that are used to treat the side effects of chemotherapy drugs?

A: Yes, we have excluded chemotherapy and chemotherapy covers the treatment costs, ie chemotherapy drugs and other drugs for the side effects of the chemotherapy drugs themselves.

Q20: Are supportive drugs for chemotherapy excluded from PbR?

A: Yes. The drugs are included in the chemotherapy procurement HRGs and are therefore excluded as a part of the chemotherapy service exclusion.

Q21: Are hormonal or hormone antagonist drug treatments for cancer excluded from PbR?

A: It depends on the context in which the drugs are used. Please refer to the following three scenarios:

- drugs used as an intrinsic part of a chemotherapy regimen – included within the chemotherapy procurement HRGs (and so excluded from PbR)
- drugs used as supportive drugs to a regimen – included within the chemotherapy procurement HRGs (and so excluded from PbR)
- drugs used separately (regardless of cancer or non-cancer) - the drugs should be excluded from PbR where they are specifically listed as exclusions or where they are in a BNF section/sub-section wholly excluded from PbR. Where the drugs are not listed as excluded from PbR they are included in PbR.

Q22: We use botulinum toxin for a variety of conditions. You have excluded drugs used to treat torsion dystonias and involuntary movements without listing particular drugs. Do we have to request prior approval for the use of botulinum toxin?

A: Commissioners and providers should agree payments for excluded drugs used for particular indications. Our exclusions list indicates that all drugs in BNF section “4.9.3 > Torsion dystonias and other involuntary movements”, which includes botulinum toxin, are excluded. Therefore, botulinum toxin is excluded for any indication. Whilst we understand that there is often overlap between prior approvals schedules and PbR exclusions, the two should not be confused and should ultimately act

independently of each other i.e. exclusions relate to payment issues and are subsequent to prior approvals schemes which relate to pathway issues.

Q23: Parenteral nutrition is excluded after 14 days or when the patient is receiving parenteral nutrition prior to admission. What does this mean?

A: The exclusion of parenteral nutrition (identified by OPCS code X90.4) covers all forms and applies when it is administered for a period greater than 14 days. The exclusion does not apply for the first 14 days, i.e. only costs from day 15 onwards are excluded from PbR, and if a patient is on parenteral nutrition for 15 days, the costs of days 1 to 14 cannot be reclaimed. The exclusion also applies where the patient has been receiving parenteral nutrition prior to their admission, including at a different organisation or at home. If a patient is receiving parenteral nutrition for a period of time (e.g. 2 months) and stops receiving it during that period for a few days (e.g. 2 days) in the same admission (e.g. owing to a line infection and resiting the line) then the exclusion continues to apply when it is restarted.

Q24: Can you clarify your statement in the guidance that “all blood products are excluded from PbR regardless of whether or not they are listed in the BNF”?

A: BNF section 2.11 does not exhaustively cover blood products. However, as in previous years, blood products are excluded from PbR, regardless of whether or not they are listed in the BNF. The Blood Safety and Quality Regulations 2005 contain some useful definitions which should help define the exclusion:

- “blood” means whole human blood collected from a donor and processed either for transfusion or for further manufacturing
- “blood component” means a therapeutic constituent of human blood (red cells, white cells, platelets and plasma) that can be prepared by various methods
- “blood product” means any therapeutic product derived from human blood or plasma.

Therefore, whilst we would not expect the exclusion to cover blood components like red cells and platelets we would expect it to cover fibrin sealants, thrombin and irradiated blood products. Commissioners and providers should agree locally what the exclusion covers.

Q25: Please can you help us understand section 456 of the guidance relating to complex cardiac ablation procedures as it is unclear what excluded activity can be charged for and under what heading?

A: Only one of the device exclusions can be sought for reimbursement purposes at any one time. Charges should not be made more than once for the same activity, (although it could potentially fall under two separate exclusions).

This is consistent with the exclusions list released as part of the PbR package for 2013/14. Unfortunately the wording within the guidance which reads:

“Radiofrequency, cryotherapy and microwave ablation probes and catheters (when used for treating tumours)”

should read:

“Radiofrequency, cryotherapy and microwave ablation probes and catheters (when used for treating tumours and complex cardiac ablation procedures)”.

## Mental health

Q26: Have there been any developments on the algorithm to assign users to clusters?

A: A national algorithm is being developed that will provide at least 80% accurate assignment. The algorithm will be tested with data from the NHS Information Centre and will be made available as soon as it is signed off by the Mental Health PbR governance groups. It will be useful both within and across organisations, and for commissioners and providers.

Q27: The use of an algorithm could cause problems if the clinician disagrees with the assignment, what should we do?

A: The clinician’s decision is the final one, and the algorithm is only a tool to help support that decision. However, organisations should also put in place internal quality assurance procedures to review clustering decisions and to provide confidence about the use of the clustering tool. The Audit Commission is working on some tools that can help with assurance processes.

Q28: Is there anyone we can speak to for help with the costing process?

A: The HFMA have a buddying system where they will put you in contact with a similar organisation in another part of the country that is further ahead with its costing work. Interested trusts should contact [sarah.crick@hfma.org.uk](mailto:sarah.crick@hfma.org.uk). The Department of Health has a QuickR site that will keep trusts up to date with mental health developments. This can be accessed by contacting [ewa.dziura@dh.gsi.gov.uk](mailto:ewa.dziura@dh.gsi.gov.uk).

Q29: Where should costs incurred before the initial assessment to clusters be coded?

A: When a user is assigned to a cluster, any cost incurred before costing should be coded with the cluster costs. The costs of the initial clustering assessment should be recorded separately against the cluster. If the user cannot be clustered after the initial assessment the costs should be coded to cluster 00. If the costs fall immediately before a year-end, and the initial assessment happens after the year-end work is finished, then the costs should be coded to cluster 99.

## Other operational issues

Q30: How can we map multi-episode spells, that span 2011-12 and 2012-13 and have a deleted ICD10 code in the 2011-12 episode, to valid HRGs using the 2012-13 local payment grouper?

A: For multi-episode spells that end in 2012-13, but contain episodes that finished in 2011-12 (and where the episode from 2011-12 contains one of the deleted ICD10 codes), we would advise commissioners and providers discuss the activity and come to an arrangement locally as to appropriate tariffs.

Q31: How can we group historic data for business planning purposes or calculation of the marginal rate through the 2012-13 local payment grouper?

A: Some historic data may 'error' when run through the 2012-13 local payment grouper owing to the changes to the ICD10 codes that were implemented in the grouper. Where this causes an issue for organisations locally they may wish to use the 2012-13 road test grouper for their planning, however it should be noted that there were a small number of changes made to the groupers between road test and local payment.

Q32: What were the grouper changes between road test and local payment for 2012-13?

A: There were only a few changes to the grouper between road test and local payment for 2012-13:

- Uplift ICD codes to ICD10 4<sup>th</sup> edition (including for SSCs and PBCs)
- Update to BPT flags (as per the road test BPT flag sheet)
- Codes K575, K621 and K622 mapped from EA27Z to EA29Z (from simple to complex ablation)
- Update mapping for IVUS/pressure wires when also having a PCI, in line with updated CFH coding guidance

Q33: Regarding the new ISN "CR1238 and CR1276 (1 April 2012) - ISB 1577 Amd 10/2011 Diagnostic Imaging Data Set and Diagnostic Imaging Data Set Message v 1-0" is it possible from one of the fields to identify whether the diagnostic is direct access or not?

For example if the referring organisation is the same as the registered GP practice could that be assumed to be direct access or is there a specific field that would identify the diagnostic as direct access please?

A: The field PATIENT SOURCE SETTING TYPE FOR DIAGNOSTIC IMAGING (see [http://www.datadictionary.nhs.uk/data\\_dictionary/attributes/p/pati/patient\\_source\\_setting\\_type\\_for\\_diagnostic\\_imaging\\_de.asp?shownav=1](http://www.datadictionary.nhs.uk/data_dictionary/attributes/p/pati/patient_source_setting_type_for_diagnostic_imaging_de.asp?shownav=1)) has value 04 GP Direct Access.

SUS PbR and the Grouper do not identify services which have been accessed directly. We are working with the NHS Information Centre to correct this for the next CDS release.

Q34: Are TFCs 199 and 499 excluded from PbR?

A: Neither TFC 199 or 499 are listed as being excluded from PbR. However, as these TFCs relate to data from non-UK providers they are not within the scope of PbR and data against them should be reviewed by commissioners in relation to the contracts that they have with their non-UK providers, just as if the data were reported against any other TFC