Private healthcare market investigation

Response to Provisional Decision on Remedies related to reimbursement coding

Bupa Health Funding

February 2014

TABLE OF CONTENTS

1. EXECUTIVE SUMMARY

1.1   Bupa Health Funding ("BHF") welcomes the Competition Commission's ("CC's") Provisional Decision on Remedies ("PDR") aimed to address the Adverse Effects on Competition ("AECs") identified in the Provisional Findings ("PFs"). This response comments on only one element of the proposed package of remedies, namely the proposal to mandate a move from the existing CCSD coding structure[1] to OPCS coding[2] by 1 April 2019[3]. BHF is submitting a comprehensive response to the full package of remedies proposed by the CC in a separate submission.

1.2   BHF strongly believes that the proposed transition from CCSD to OPCS would fundamentally undermine the way in which the private healthcare ("PH") market operates. BHF outlines below the reasons why the CC's proposal is disproportionate and not well targeted at the AECs identified in the PFs. We also propose an alternative remedy that the CC could use to more effectively address the AECs identified in the PFs.

1.3   This response is confidential as it contains commercially sensitive information. BHF will provide a non-confidential version of the submission on request.

BHF has major concerns about the proposed transition from CCSD to OPCS coding

1.4   In its PDR, the CC has proposed that the PH sector should move to OPCS coding by April 2019. In particular, insurers will need to adapt their IT and billing systems to use OPCS for reimbursement purposes (rather than CCSD). The CC's rationale for the proposed change appears to be twofold: (i) improved comparison between private and public healthcare and (ii) reduced processing costs for hospitals (which would now only need to submit invoices based on one coding structure).

1.5   However, BHF has very significant concerns about the process by which the CC has arrived at this proposal and the impact this proposed remedy is likely to have on the PH sector:

   a.   OPCS is unlikely to work as a reimbursement method in PH. The CC risks critically undermining the payment mechanisms in PH to the massive detriment of the consumer.

   b.   The costs the move will impose on the industry, both in transition and in ongoing working costs, will significantly outweigh any potential benefits.

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[1] Clinical Coding & Schedule Development ("CCSD") Group.
[2] Office of Population Censuses and Surveys Classification of Interventions and Procedures, 4th Revision ("OPCS").
[3] PDR, para 2.467: "*[…] While we thought that it would be preferable for a single system of coding to be used across the whole healthcare sector since this would lose processing costs, we recognize that the conversion of IT and billing systems is also a potentially costly and time-consuming process. We thought, therefore, that over the next five years the private hospital operators could provide both an OPCS and a CCSD code on their invoices to Healthcode, with the insurers using the latter and the information organisation using the former. However, given that greater information availability is beneficial to the sector as a whole and that the comparability of the data across both the NHS and the private sector is important to gain a full understanding of quality and performance, in the longer run, we reasoned that the private system would need to come in line with the NHS in terms of its coding protocols. Therefore, by April 2019, we will require the insurers to adapt their IT and billing systems to use OPCS coding, allowing the private hospitals to submit invoices with a single procedure code. We believe that this five-year transition period will allow the insurers to make the appropriate changes without incurring undue costs, as well as minimizing the longer-term costs to the private hospital operators of providing performance information.*"

c. The CC has failed to articulate the benefits to the consumer of its recommendation and has made this recommendation without proper due diligence on whether OPCS is fit-for-purpose as a reimbursement coding system in private healthcare.

1.6 The CC's proposal will in effect change not only the clinical activity coding system used in PH but also the reimbursement system for the entire PH sector. However, in its PDR, the CC has not presented any analysis of the impact of the proposed change on the private sector. In addition, the CC has not properly consulted with parties on whether OPCS is appropriate for recording clinical activity and for reimbursing private providers.

1.7 BHF believes that the CC <u>has not fully considered the inherent challenges</u> of transitioning from CCSD to OPCS:

   i. OPCS coding is not fit for purpose for payments in PH. Unlike CCSD in PH, OPCS is not directly used for reimbursement purposes in the National Health Service ("NHS") or elsewhere. Rather, reimbursement in the NHS is based on both diagnosis (ICD-10) and procedure (OPCS-4) coding, as well as patient characteristics, which together determine Healthcare Resource Groups ("HRGs") - the basis for payment in acute NHS care[4].

   ii. There are likely to be very substantial transition costs for hospitals, consultants and insurers in moving to OPCS as basis for payment – costs that are likely to be borne ultimately by patients. We explain the transition costs for insurers in Section 5. For example, BHF invested over ✂ in building its existing claims management system which is based on CCSD coding. We expect we will need to run two claims management systems in parallel during the transition period (e.g. so that experience-rated policies can be priced accurately during the transition). Therefore, BHF could be exposed to new system costs running into tens of millions of pounds[5]. Other insurers are also likely to face substantial costs. The CC has not considered these costs in the PDR.

   iii. As a coding system, OPCS has been developed to meet the information needs of the NHS for procedural activity only. OPCS does not cover non-procedural activity such as outpatient appointments. It also does not unbundle elements that are coded and paid for separately in PH (e.g. consultant or anaesthetist time).

   iv. The CC assumes that all PH providers already operate on dual systems, recording information on private patients using CCSD and NHS patients using OPCS. While this may be true of the largest hospital operators who serve private, self-pay and NHS patients, many private hospital operators, many small private clinics and most if not all individual practitioners in private practice only use CCSD to record activity. High

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[4] HRGs are the basis of payment for acute care in the NHS. HRGs are used to pay for a spell of care, i.e. from hospital admission to hospital discharge of a patient. The HRG for a spell of care is determined based on the diagnoses of a patient (ICD-10 codes), procedures (OPCS-4.6 codes), and patient information (such as age, sex, length of stay, and comorbidities). This information is grouped together to determine the HRG using the Secondary Users Service ("SUS") or relevant grouper software, published by the Health and Social Care Information Centre ("HSCIC") to avoid developing too many prices in the NHS. Other areas of care (outside the acute service) are reimbursed using a range of other currencies. For a brief introduction on HRGs and PbR, see: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213150/PbR-Simple-Guide-FINAL.pdf .

[5] It could take 6 months to get a complete assessment of system and process changes for such a massive change in IT requirements, so it is not possible to give an exact cost estimate for the transition. A project including contract management, claims routing and adjudication, a complete overhaul of industry standard payment codes and payment rules changes required for updating payment systems and processes would necessitate a large cross-business change programme.

transition costs would fall disproportionately on these players that currently use CCSD only, and these transition costs would likely outweigh any perceived benefit from reduced processing costs for those hospital operators which already use both systems.

v.   The future of OPCS is likely to be dictated by the needs and pace of the NHS rather than those of PH. In contrast, CCSD has been developed specifically for commercial use in the PH market and is used to reimburse hospitals and consultants[6]. CCSD is granular, updated monthly, nuanced and clear. Indeed, while CCSD has its origins in OPCS it has over years substantially evolved, and in some areas diverged, from this root precisely because OPCS was not fulfilling the needs of providers and insurers. Therefore, a return to OPCS is a retrograde step.

vi.   The PH market would lose a degree of autonomy because the NHS governs OPCS. This would mean that there would be less opportunity for PH to shape coding to ensure that it reflects the evolving needs of the PH sector in the same way as it has done to date. In addition, given the rate at which OPCS is updated, the NHS is unlikely to keep pace with the evolution of new treatments in PH – to date it has proved necessary to update CCSD on a monthly basis for this purpose. By contrast, business cases for new codes to be included in the updated version of OPCS to be released in April 2014 had to be submitted by December 2012 – meaning a lag of over a year.

1.8   BHF is also concerned that the transition to OPCS does not address in a targeted way the AEC identified in the PFs. If the intention of the CC's remedy is to increase standardisation, then the CC should take into account that standardisation already exists in PH across surgical procedure codes through CCSD procedure coding. The CC's proposed remedy does not address the areas of PH where coding is not standardised and where coding is most in need of standardisation – ✂ of BHF's claims expenditure is not under a common coding structure in the PH market[7]. The CCSD group has been the driver behind rolling out common coding into these non-standardised areas of spend (areas of spend that are also not covered by OPCS coding). By mandating a transition to OPCS the CC will force providers and insurers to prioritise energy on replacing coding for procedures that is currently standardised across PH, rather than on expanding the level of standardisation across PH.

1.9   BHF, therefore, believes that the CC should rather focus on encouraging the standardisation of coding in the areas of spend that currently lack standardised coding arrangements, e.g. where PH provider use different codes to describe the same activity, making payment integrity and comparison of clinical activity difficult. Further standardisation will deliver far greater gains in transparency and comparability across the PH sector than transitioning in to a new payment currency using a code-set which will create major payment processing challenges.

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[6] Consultant and hospital invoices quote CCSD codes and associated narratives as a basis for charges and payment for procedures.
[7] BHF response to Remedies Notice, Table 6. An additional ✂ of BHF's expenditure is expected to be recorded under a common diagnostic coding structure that was recently launched by the CCSD group. However, even after this schedule is completely implemented, more than ✂ of BHF's expenditure is expected to remain in activity areas that lack standardised coding.

1.10 The CC has failed to recognise that while CCSD is a commercial payment vehicle, OPCS is not used for payment purposes in the NHS and not suited for use as a commercial payment mechanism without an over-arching payments architecture. In the NHS, this architecture is provided by the Payment by Results ("PbR") tariff system, which is designed specifically for the circumstances and requirements of the NHS and would not be appropriate for the private system.

1.11 CCSD on the other hand is designed in a way that allows hospitals, consultants and insurers to negotiate a bespoke fee for each procedure. CCSD codes and their associated narratives are then quoted as the basis for payment in invoices, as well as for reporting activity. This has facilitated transparency and comparability of payments between insurers, hospitals or consultants.

1.12 The structure of OPCS codes, which allows for more detailed coding, is designed for clinical coding and not as suitable for use as a payment vehicle. Basing payment on OPCS codes would require the development of detailed grouping rules that would define the level of payment that different groupings of OPCS codes would incur, as any one OPCS code is usually an incomplete reflection of the activities that have taken place. Indeed, in the NHS, information stored in OPCS codes is combined with data from ICD-10 codes and other patient level information, and used to determine a HRG for a given spell[8] of care. Each HRG carries a tariff, set annually by the Department of Health and by Monitor from FY2013/14 onwards. Any one HRG can cover a range of procedures and complexities and does not immediately reflect the precise procedure used to address a patient's care needs[9]. In this sense, HRGs are also more difficult to audit by an insurer, can facilitate 'upcoding' by providers which can add in costs, and do not carry the same degree of payment integrity that can be achieved under CCSD where one code applies to one procedure only.

CCSD and OPCS have different coverage

1.13 The coverage of OPCS is focussed on surgical procedures with some (but not comprehensive cover of) diagnostic tests[10]. OPCS does not cover other types of care such as outpatient appointments, pathology tests, rehabilitation therapies, patient transport, community care, and high cost drugs. The NHS uses different coding systems for these areas[11]. If the PH sector were to adopt OPCS, it would need to agree which OPCS codes can be charged separately by consultants alone, or in addition to hospitals. The PH sector would also need to combine OPCS with coding for other areas of care which in the NHS are coded and paid for using other coding systems and currencies than OPCS/HRGs, by either (i) implementing other NHS coding structure, (ii) using existing CCSD coding where available, or (iii) developing parallel coding systems for other care covered by Private Medical Insurance ("PMI"). This would add

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[8] In the PbR system, which is used to reimburse admitted patient care ("APC") in the NHS, a spell is defined as the period from admission to discharge that a patient spent in hospital.

[9] For example, HRG AA05C (Major intracranial procedures except trauma with haemorrhagic cerebrovascular disorders, with CC score 4+) applies to a combination of two procedure codes (A013 and Z012) that are recorded with a primary diagnosis of haemorrhagic cerebrovascular disorder (from a list of 21 potential diagnoses).

[10] For example, OPCS includes codes for spirometry, echocardiograms ("ECGs") and some diagnostic imaging, but not pathology, histopathology and other tests in much detail. Tests can be paid for using HRGs (if they are performed as part of an inpatient spell), direct access diagnostic currencies, or through bloc contract.

[11] Codes for chemotherapy and high cost drugs can be mapped into OPCS but have separate governance and updating procedures.

substantial additional costs to the transition and the ongoing working of a new reimbursement system.

1.14 In contrast, the CCSD group has been working to extend CCSD procedure codes with a new list of Diagnostics tests. CCSD procedure codes also include codes for consultations to enable payments to independent practitioners. The CCSD group has ambitions to develop codes for all remaining activities that are covered by PMI but not subject to standardised coding, such as drugs, prostheses, theatre fees, etc.

Insurers, hospitals and practitioners face substantial transition costs and risks

1.15 The transition costs of moving from CCSD coding to OPCS coding will be significant. BHF anticipates that costs would fall on insurers, hospitals operators (hospitals/clinics) and independent practitioners (consultants/therapists, etc) alike and ultimately on customers. Some hospital operators and practitioners will face disproportionate costs compared to those institutions that already use OPCS coding for treating NHS patients.

1.16 Transition will require significant operational, strategic, and financial challenges:

a. **Resetting of insurer fee schedules** – Each insurer publishes a fee schedule that outlines the reimbursement rates for practitioners. These schedules will need to be completely revised if OPCS codes are adopted. This will involve significant difficulties including, for example, unbundling and re-bundling CCSD codes, determining complexity ratings for OPCS codes, establishing which codes are to be used for areas not covered by OPCS, and defining which OPCS codes are solely chargeable by hospitals and which codes independent consultants can charge for separately to avoid duplicate charges by hospitals and consultants for the same activity. In addition, areas of care not covered by OPCS coding would require additional 'bolt-on' coding and payment structures. Such a shift is likely to create uncertainty of financial surety and a lack of transparency for insured and self-pay patients. The wholesale revision of all insurer fee schedules would create a major financial risk for the whole industry.

b. **Negotiating and amending contracts** – All insurers and providers will most likely have to negotiate new contracts since all existing pricing for procedures is set out in CCSD coding. This is complicated by the fact that providers will have different contract cycles. As a result, transitioning will involve operating two payment currencies (one for CCSD and one for OPCS) in parallel while contracts are negotiated at different points in time. This will create additional logistical challenges in how customer policies are set and priced and claims are processed. During this transition, customers are highly likely to face unnecessary shortfalls due to confusion between providers and insurers on billing – or increased costs if insurers cover all costs. Significant internal senior staff time will be required to negotiate and agree new pricing with each hospital operator, as well as compensation agreements with over 40,000 independent medical practitioners.

c. **Updating, revising and recoding information systems** – Insurers will have to invest in new information systems to incorporate OPCS coding structure for

payments. It is likely that insurers will need to run two IT systems (one on OPCS and one on CCSD) during the transition period. New systems built to support OPCS will require their own coders[12] and significant re-training of all staff. BHF's current claims management system, called SWIFT, is based on CCSD and was developed and installed with costs in excess of ✂. Establishing a new system (to run in parallel during transition) would cost tens of millions (BHF would also be forced to impair its SWIFT system investment). It would seem likely that other insurers would have also incurred substantial costs in developing their own payment systems. As a result of the high IT transition costs, there is likely to be a significant negative impact on customer premiums. The CC does not appear to have taken these costs properly into account in its analysis. The extra costs incurred by insurers are likely to outweigh any notional processing efficiencies amongst hospitals.

d. **Managing the impact on customer policies** – BHF and other insurers would need to devote additional resources to manage the actuarial pricing of risk during the transition period as errors in coding could lead to customers receiving prices that do not accurately reflect their claims history or risk profile. BHF would also need to re-write more than 5,000 pages of internal guidance on policy and procedure eligibility used by our staff when engaging with customers and patients. Other insurers are likely to face a task on a similar scale.

1.17 All the above activities are likely to incur significant cost and take several years to implement. Moreover, BHF anticipates that the affected parties (hospitals, insurers, practitioners) would want to launch the new coding system in a single "big bang moment", which will require the introduction and running of a shadow system for several years in advance, to ensure neutrality in costs and revenues. Additional costs would be incurred on an ongoing basis after the transition, relative to the current costs of CCSD maintenance.

1.18 The transition would also likely result in disruption to current payment flows. Hospitals, insurers and consultants would have to take precautionary steps to ensure neutrality of cost and revenue streams during the transition. There is significant risk of "up-coding" within OPCS due to its less tailored code descriptions. This is likely to increase private healthcare expenditure. There will also be greater risk of up-coding during the years immediately following transition as insurers need to observe patterns of coding over a period before payment integrity rules can be written to flag and stop fraudulent claims. Providers would have to adapt to the new system and may take advantage of payment and coding rules at early stages of development. The costs of overpayment to providers will be borne by customers.

An alternative remedy can be used to address the AEC identified in the PFs

1.19 BHF believes that the CC has not established a sufficiently strong benefits case to justify the proposed change and the costs inherent in a transition to OPCS coding. We believe the CC's proposal is unworkable, disproportionate, and counterproductive to the CC's overall aims of the market investigation.

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[12] For example, following transition clinical coding would only be in the remit of trained clinical coders, requiring hospitals to hire new staff and ensure a process by which patient notes and other information held by consultants is transferred onto systems effectively and accurately. BHF is not aware of a legal requirement for clinical coders to reach a certified level of coding ability. However, NHS experience has shown that coding should be completed by trained individuals to ensure accurate and effective coding of information.

1.20   For the reasons outlined above, BHF <u>firmly believes</u> that the CC should retain CCSD coding in PH. Indeed, if the CC is seeking further standardisation of coding information in PH, BHF believes an alternative remedy would be equally effective but avoid the substantial costs involved in the CC's current proposal.

1.21   In particular, the CC should recommend for **the industry to commit to investing in, maintaining and making available as complete a mapping between CCSD and OPCS as possible**. **In addition, the CC should recommend for the industry to maintain CCSD as the standard reimbursement system in PH**. A mapping between CCSD and OPCS will never be perfect, but discrepancies will arise for inevitable reasons where OPCS is inappropriate for PH use. This proposal will allow increased comparison between PH and the NHS to be achieved, but at substantially lower cost to the industry than full transition to OPCS for reimbursement. For example, this remedy would avoid the need to invest in new IT systems, hire specialist clinical coders, and re-negotiate hospital-insurer contracts. The information organisation could implement this remedy, reporting annually to the Competition and Markets Authority ("CMA").

1.22   In addition, the CC should recommend that there is **mandatory industry participation in agreeing and adopting common coding for the areas where currently no common coding between hospitals exists**. At least ✂ of BHF's claims expenditure is not under a common coding structure[13]. Focussing energy on this area will deliver far greater gains to consumers through improved value for money and the ability to compare procedures better across the PH sector than seeking to replace coding in the one area of spend – surgical procedures – where common coding currently applies. The CC should also consider mandating the use of CCSD coding by providers for invoicing purposes to ensure that the sector conforms to the agreed common coding structure.

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[13] See footnote 7

2. INTRODUCTION

2.1   The PDR[14] sets out proposed remedies to address the AECs identified in the PFs. A package of remedial measures is proposed to address the AEC caused by the lack of information published by hospitals and consultants.

2.2   One element of this package is to standardise surgical procedure coding used in PH with that used in the NHS by mandating a move from the existing CCSD coding structure to OPCS coding by 1 April 2019:

> "*While we thought that it would be preferable for a single system of coding to be used across the whole healthcare sector since this would lose processing costs, we recognize that the conversion of IT and billing systems is also a potentially costly and time-consuming process. We thought, therefore, that over the next five years the private hospital operators could provide both an OPCS and a CCSD code on their invoices to Healthcode, with the insurers using the latter and the information organisation using the former. However, given that greater information availability is beneficial to the sector as a whole and that the comparability of the data across both the NHS and the private sector is important to gain a full understanding of quality and performance, in the longer run, we reasoned that the private system would need to come in line with the NHS in terms of its coding protocols. Therefore, by April 2019, we will require the insurers to adapt their IT and billing systems to use OPCS coding, allowing the private hospitals to submit invoices with a single procedure code. We believe that this five-year transition period will allow the insurers to make the appropriate changes without incurring undue costs, as well as minimizing the longer-term costs to the private hospital operators of providing performance information.*"[15]

2.3   While BHF agrees with the principle of increasing standardisation in PH, BHF has <u>very major concerns</u> about the proposal to move to OPCS.

2.4   BHF believes that this element of the remedy is highly disproportionate with the direct costs and unintended consequences significantly outweighing any possible benefits. BHF firmly believes that this element of the remedy should be scrapped.

Structure of this submission

2.5   We set out our evidence in the following sections:

i.   Section 3 explains the OPCS coding system in further detail, including purpose, coverage, relationship to reimbursement, and its suitability for PH.

ii.   Section 4 explains the purpose, coverage and benefits of the CCSD coding and reimbursement system.

iii.   Section 5 explains the likely transition costs that would be incurred from migrating from CCSD to OPCS codes, by insurers, providers, and consultants.

iv.   Annex A briefly discusses the principle differences between a clinical coding system and a reimbursement system.

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[14] Competition Commission. Private healthcare market investigation: provisional decision on remedies. 16 January 2014. Website: http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/140121_private_healthcare_pdr_summary_and_sections_1_to_4__.pdf
[15] PDR, para 2.467

3. UNDERSTANDING OPCS CODING

3.1   Developed in the 1980s and 1990s, OPCS was designed to allow users to keep a highly detailed record of the clinical activities that have been performed. Given that OPCS was developed to meet the requirements of the NHS, insurers recognised that an alternative coding structure was needed for reimbursement in PH. In this section, we provide a brief background on the OPCS coding system and discuss its suitability for PH.

Overview of OPCS

3.2   OPCS is a statistical classification that translates medical operations and surgical procedures into codes[16]. It was originally published by the Office of Population Censuses and Surveys in England. Since its introduction, OPCS has been used in the NHS to record activity and support operational and strategic planning, resource utilisation, performance management, reimbursement, and research.

3.3   OPCS is currently supported, maintained and developed by the NHS Classification Service ("NCS"), and governed by Crown Copyright[17]. The classification is a mandatory NHS data standard, meaning that data returns containing OPCS codes feed into Commissioning Data Sets ("CDS") and SUS; the Hospital Episode Statistics ("HES") in England; Patient Episode Data for Wales ("PEDW"); and Scottish Morbidity Records ("SMR").

3.4   OPCS-4 codes indirectly support hospital reimbursement in the NHS. They form part of the information set that is used to determine HRGs for a spell of inpatient care and for outpatient procedures. Other information that is used to determine the HRG includes ICD-10 diagnostic codes and patient specific data (e.g. age, sex, length of stay and observed comorbidities). Patient level information[18] is grouped into HRGs by a bespoke software package, to limit the number of tariffs that are used for acute care in the NHS[19]. Payment in other care areas of the NHS (primary, community, outpatient, and care for long term conditions) is delivered using currencies other than HRGs. OPCS codes are not used to inform these other currencies and other care areas.

3.5   Hence, the primary purpose of OPCS codes is to record, in a sufficient amount of detail, the nature of all surgical and procedural activity undertaken in the NHS. This information is used to inform payment (among other items) but does not as a standalone form the basis of payment.

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[16] This is enabled via a structure that allows multiple levels of primary and secondary coding. OPCS codes are organised into anatomically based chapters. Each alphanumeric code begins with a letter (referencing a chapter), followed by 3-4 digits. The strict link between chapters and body systems and organs was breached in OPCS-4.3 because of limited capacity in some chapters. For example, a joint replacement may be coded with the type of procedure, the complexity and the laterality. For detail, see: Health and Social Care Information Centre (2014) Website: http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/background.

[17] Health and Social Care Information Centre (2014) Website. http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/

[18] A typical spell will have 3-6 ICD-10 codes, 2-3 OPCS-4 codes and a selection of patient characteristics attached to it. Some of these may be 'side-codes', reflecting issues such as left or right limb, different arteries, etc. Where these codes are missed-out from patient notes the grouping process may results in the allocation of a an HRG with lower payment attached to it or an 'unclassified' HRG.

[19] Currently HRG4 has about 1,500 tariffs. Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213150/PbR-Simple-Guide-FINAL.pdf

3.6   While OPCS was used in PH prior to the development of CCSD, insurers used different individual codes for reimbursement until they agreed to standardise procedures in the formation of CCSD. OPCS was reviewed as an alternative but not deemed suitable for the PH sector due to a variety of reasons. We discuss these shortcomings, which still exist, below.

Coverage and bundling

3.7   OPCS covers a wide range of procedures and has the capability to record information at a very granular level (limited only by system capacity). Detailed coding is possible with multiple levels of primary and secondary procedure coding. For example, hip replacement can be coded with the type of procedure, the complexity, and the laterality of the work.

3.8   However, there are a number of limitations to OPCS in terms of coverage and bundling:

     i.   OPCS is not a stand-alone classification system. The uses and developments in OPCS are reflective of the payment arrangements for different services in the NHS. For example, some services are not covered by HRGs and instead covered by another type of currency. In such instances, OPCS codes are not developed and another form of coding tends to be used, adding additional complexity.

     ii.   Within admitted patient care ("APC"), some services are allocated their own codes that are subsequently mapped to OPCS. These include chemotherapy treatments and high cost drugs, for which the Department of Health maintains separate guidance, code lists and a bespoke code change process[20]. Different sets of codes for chemotherapy and high cost drugs were developed to reimburse NHS providers separately for these line items. These distinct code sets and mapping tools imply additional coding requirements.

     iii.   Non-procedural areas common in PH (e.g. outpatient consultations, community care, ambulatory care and pathology) are not covered and hence OPCS does not have an application beyond admitted patient care.

     iv.   Payment in the NHS is directed to an NHS Trust, rather than to a department or individual consultants. As a result, specific bundling rules apply in the NHS[21] that are not directly applicable, or capable of application, to the PH sector. OPCS bundles together a number of items that for commercial and strategic reasons are reimbursed separately in the PH market such as drugs, prostheses, pathology and diagnostic services, and consultant and anaesthetist time.

3.9   OPCS is suited for the needs of large hospitals that offer a full range of medical services to a diverse patient base. It is not suitable for use in a market with a narrower service offering and large number of small independent practitioners and clinics like PH where a more compact coding system is likely to create efficiencies for users[22].

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[20] See http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/chemoregimens
[21] NHS Trusts maintain internal profit and loss accounts at a department level to understand the relative profitability of departments. These are governed by complex allocation rules and internal prices for different services that vary from Trust to Trust. Consultant profitability may be monitored, but is rarely tied to reward in the same direct way as in PH.
[22] The effective use of OPCS requires a fully functional Patient Administration System (PAS) and preferably a Patient-Level Information and Costing System (PLICS). Coders who transfer information from patient notes onto the systems should have access to tailored training on the effective use of codes and the OPCS coding manual, including any updates. The infrastructure requirements to support an OPCS system alone imply substantial cost for organisations.

3.10   The OPCS-schedule is published by the HSCIC on the Technology Data Update Distribution website. Updates to OPCS are available in summary format for organisations that have already licenced the full document[23].

3.11   OPCS is intended to be reviewed on an annual basis to ensure that it evolves with NHS policy, healthcare provisions, and coding used in electronic health records – revisions are expected to be published on 1 April each year[24]. However, as shown in the table below, the dates of previous releases of OPCS-4 suggest that major revisions are made less frequently.

Table 1: Schedule of release dates for OPCS-4

Release date	Usage	Version
	Until 31 March 2006	OPCS-4.2
1 April 2006	1 April 2006 – 31 March 2007	OPCS-4.3
1 April 2007	1 April 2007 – 31 March 2009	OPCS-4.4
1 April 2009	1 April 2009 – 31 March 2011	OPCS-4.5
1 April 2011	1 April 2011 – 31 March 2014	OPCS-4.6
1 April 2014*	1 April 2014 onwards	OPCS-4.7

*Expected release date[25]. Source: NHS Data dictionary (2014). Website:
http://www.datadictionary.nhs.uk/web_site_content/supporting_information/clinical_coding/opcs_classification_of_interventions_and_procedures.asp?shownav=1.

3.12   In particular, the rate at which OPCS is updated is slow:

> i.   Requests for new codes must be submitted via the OPCS requests portal[26] ahead of each new release and supported by detailed evidence[27]. Requests are reviewed by the NHS Classifications Service. Separate request portals and submission procedures exist for activities excluded from OPCS, such as chemotherapy and high cost drugs[28].

> ii.   However, the time taken from when the requests are logged to when changes are applied is significant. The next version of OPCS, OPCS-4.7[29], is due to be implemented in the NHS on 1 April 2014 <u>but will only incorporate requests received by 1 December 2012</u>.

3.13   The process for requesting updates to OPCS codes is onerous, slow, and not suited to the needs of PH where new treatments can be introduced on a monthly bases. For PMI to remain

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[23] Clinical Classifications Service, Summary of changes OPCS-4.6 – OPCS-4.7 (2013). Website:
http://www.isb.nhs.uk/documents/isb-0084/amd-10-2013/0084102013summ.pdf
[24] Health and Social Care Information Centre (2014) Website:
http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/background
[25] HSCIC. (2014) See also http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/opcs-4.7
[26] The OPCS-4 Requests Portal, maintained by the HSCIC, is available at:
http://termrequest.connectingforhealth.nhs.uk/requests/opcs.
[27] See the Submission Guidelines for enhancements to OPCS-4 (2009) for detail. Website:
http://termrequest.connectingforhealth.nhs.uk/requests/opcs/submission-guidelines
[28] HSCIC (2014). Website: http://systems.hscic.gov.uk/data/clinicalcoding/codingstandards/opcs4/chemoregimens
[29] The revision will include new codes and descriptions, and retire some codes. No major changes to the architecture of OPCS-4 are currently envisaged.

commercially viable, providers, consultants and insurers need a user-friendly and timely code requests system that keeps the procedure schedule current.

Using HRGs for reporting and payment

3.14   OPCS coding is used to determine payment to NHS providers through HRGs. The PH industry has considered and rejected a transition to HRGs in the past, because the classification system is not practical for reimbursement in the PH market:

    i.   OPCS, PbR and HRGs are highly complex to administer and require detailed specialist (clinical coding) training and understanding of coding and payment manuals and rules at a greater level of detail than needed in PH[30].

    ii.   The underlying cost assumptions for HRGs include all consultant input and fees, which are paid to the hospital only but has historically been separated in PH to facilitate separate payments to independent healthcare practitioners.

    iii.   In many cases, HRGs themselves do not convey the procedure or the diagnosis. Further underlying information is necessary to understand what the diagnosis was and what was done in response. HRG codes such as "Reconstructive procedure category 6 with complications and comorbidities" cover a wide range of procedures and diagnoses without being specific about the part of the body where the procedure was performed or what the original diagnosis was. Claims assessors or insurers faced with an HRG code could not in many cases ascertain what procedure or diagnosis a patient had, unless the components determining the HRG are reported in parallel. Further, HRGs can only be created after all relevant activity in a spell has been performed. In contrast, activities in PH can be invoiced immediately following the treatment even before the patient has been discharged. Using HRGs for reimbursement in PH was likely to negatively impact provider cash flows. Checking claims on a routine basis on HRGs will be operationally more difficult and costly and likely to result in delayed payments.

    iv.   Due to their more generic nature, HRGs are likely to be open to abuse and gaming. The NHS has had to continually modify HRGs and rebase the tariff to prevent code creep which, we understand, has nonetheless been significant. This propensity of the OPCS system to 'code creep' creates additional risk for the private sector.

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[30] BHF is not aware of a legal requirement for clinical coders to reach a certified level of coding ability. However, NHS experience has shown that coding should be completed by trained individuals to ensure accurate and effective coding of information.

4. UNDERSTANDING CCSD CODING

4.1   CCSD was developed by the PH market between 1996 and 2004 to address the need to facilitate the standardised and efficient collection of information in the narrower PH market and to facilitate payments from insurers to providers and consultants. It is designed to be a streamlined system for activity recording and payments. In this section, we discuss the development of the CCSD coding system and the key benefits it offers for the PH sector.

Overview of CCSD

4.2   The CCSD coding system evolved from OPCS coding to reflect and meet the needs of PH. Recognising the limitations of OPCS, the CCSD group was formed in 2006 with the aim to establish a common set of procedure codes and narratives within the independent healthcare sector that would reflect current medical practice and that could be used as a basis for payment in PH. The CCSD group has board-level representation from the five major insurers in the UK: Aviva, AXA-PPP Healthcare, Bupa, PruHealth and SimplyHealth.

4.3   The codes that have been developed are published in the publicly available CCSD Schedule[31]. The CCSD Schedule is the *de facto* industry standard for activity coding across PH, covering procedure coding, consultations and increasingly other areas, for example diagnostic coding.

4.4   The CCSD Schedule is also the basis of the payment mechanism in PH, used to reimburse hospitals and practitioners for completed activity. Consultants and hospitals invoice insurers with reference to CCSD codes and narratives where these have been standardised[32]. It is important to distinguish between a clinical coding system that is used primarily for recording clinical activity (e.g. OPCS) and a coding system that is used to record activity and directly pay for care (e.g. CCSD) – Annex A discusses the difference between these two systems in further detail. The CC should note that the two coding systems are not easily interchangeable.

Divergence of CCSD from OPCS coding

4.5   When launched in 2006, the CCSD coding system was modified from OPCS in a number of ways to help make it fit for purpose for the commercial and coding requirements of PH:

    i.   The number of codes was reduced from approximately 6,000 to approximately 2,000, by abandoning codes that are not offered in PH;

    ii.   Single clinical interventions were bundled together to improve efficiency of coding and ease of payment; and

    iii.   Descriptions and payment rules were introduced to minimise issues such as duplicate billing.

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[31] CCSD group, CCSD Schedule. Updated on an ongoing basis. Website: http://www.ccsd.org.uk/CCSDSchedule.
[32] Note that while the CCSD group approves and publishes codes and their corresponding narratives, insurers negotiate the fee for each procedure separately with hospitals and consultants.

4.6   Most CCSD codes are recorded as an alphanumeric string, much like OPCS codes. However, most CCSD and OPCS codes are not directly comparable and may have different descriptions even in the event of one-to-one mappings.

Coverage of CCSD coding

4.7   The CCSD Schedule has wider coverage than OPCS codes, which are strictly procedural. For example, the CCSD Schedule includes codes for investigations, consultations, and intensive care (Chapter 1) and also non-clinical services, such as ambulance transport. These are covered by other coding systems in the NHS.

4.8   The CCSD Schedule is relatively more efficient than the OPCS schedule, given the needs of PH. Codes for procedures undertaken in PH have been removed or bundled into other codes to simplify the CCSD Schedule.

4.9   The CCSD group foresees further work on the CCSD Schedule in the coming years, to expand the coverage of the Schedule and standardise coding for treatments that currently have different codes depending on the provider and/or practitioner. This is a necessary piece of work for the sector, given the amount of spend not covered by standardised codes[33].

Use and maintenance of CCSD

4.10   The simplifications introduced to the CCSD Schedule made it possible for staff in PH to use the coding system without substantial training. Coders do not require the extensive clinical coding training that is a pre-requisite for NHS coders who use the OPCS system.

    i.   As an example from the CCSD Schedule, CCSD code W5200 for a unicompartmental knee replacement, which covers the knee replacement in one code, with one clear price, with a layman's terminology that members, member service advisors ("MSAs"), claims assessors, and medical secretaries understand.

    ii.   The equivalent primary code in OPCS-4.6, W581 (Primary resurfacing arthroplasty of joint), is a clinical way to state the operation. Coding the operation requires the use of further codes to specify which joint the operation was performed on, the laterality, and materials used. Coding the operation using OPCS requires a trained clinical coder and significant redesign of systems to allow the documentation of multiple codes.

4.11   The CCSD Schedule is continuously updated to ensure that it remains relevant and robust as a payment vehicle. New codes are added and deactivated on a monthly basis to reflect evolving medical practice. Requests for new codes are received from practitioners, providers and insurers and processed on a monthly basis.

4.12   For CCSD to remain fit-for-purpose as a payment mechanism in PH:

    i.   Codes must be sufficiently granular and mutually exclusive so that there is no overlap between codes in terms of activity;

    ii.   Activity covered by each code is clear and unambiguous to ensure transparency;

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[33] See footnote 7

iii. The list of codes must be continuously updated to ensure it keeps pace with changing medical practices; and

iv. Collectively exhaustive to cover all PH procedural activity.

Mapping from CCSD to OPCS

4.13 Mapping between CCSD and OPCS codes is possible. However, we note that a full mapping will never be perfect and discrepancies will appear in a number of areas.

4.14 Analysis conducted by BHF[34] suggests that mapping would unlikely be one-to-one – this is expected given that CCSD codes were developed to suit the commercial and clinical needs of PH. Table 2 below illustrates a one-to-one mapping of a CCSD to OPCS code for enema care. In contrast, Table 3 below illustrates the current one-to-many mapping from a CCSD code used for the second, third or further revision of a total hip replacement or proximal femoral replacement (excluding acetabular and linear head changes) to OPCS.

Table 2: One-to-one mapping CCSD to OPCS codes

CCSD Code	CCSD Narrative	Cross Map Type	OPCS Code1	OPCS Narrative1
64101	Small bowel enema	One-to-one	U17.4	Barium enema

Source: BHF, Coding Department.

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[34] In 2012, BHF conducted an exercise to understand how CCSD could be mapped to OPCS, if and where possible. BHF obtained mapping for approximately 680 clinical procedures that represented the top ✂ of claims expenditure for BHF in 2011. This mapping was unidirectional (i.e. CCSD codes were mapped to OPCS only where possible rather than the other way around). Administrative codes such as operating theatre fees were excluded from the mapping exercise.

Table 3: One-to-many mapping CCSD to OPCS codes

CCSD Code	CCSD Narrative	Mapping Type	OPCS Code1	OPCS Narrative1	OPCS Code2	OPCS Narrative2
		One-to-many	W37.3	Revision of total prosthetic replacement of hip joint using cement	Y71.6	Second revisional operation NOC
		One-to-many	W37.3	Revision of total prosthetic replacement of hip joint using cement	Y71.7	Third or greater revisional operation NOC
		One-to-many	W37.4	Revision of one component of total prosthetic replacement of hip joint using cement	Y71.6	Second revisional operation NOC
W3734	Second, third or further revision total hip replacement or proximal femoral replacement (excluding acetabular liner and head changes)	One-to-many	W38.3	Revision of total prosthetic replacement of hip joint not using cement	Y71.6	Second revisional operation NOC
		One-to-many	W38.4	Revision of one component of total prosthetic replacement of hip joint not using cement	Y71.6	Second revisional operation NOC
		One-to-many	W39.3	Revision of total prosthetic replacement of hip joint NEC	Y71.6	Second revisional operation NOC
		One-to-many	W39.5	Revision of one component of total prosthetic replacement of hip joint NEC	Y71.6	Second revisional operation NOC

Source: BHF, Coding Department.

4.15 The outcome of the analysis mentioned in paragraph 4.14 was:

- One-to-one – 19% of CCSD codes;
- One-to-many – 54% of CCSD codes;
- Many-to-many – 13% of CCSD codes; and
- Many-to-one – 3% of CCSD codes.
- In addition, BHF estimates that up to 11% of codes may remain unmapped, due to the inherent differences between CCSD and OPCS, the types of services that are provided in PH compare to the NHS, and the way in which these services are reimbursed.

4.16 This shows that a mapping from CCSD to OPCS would not be perfect, but there would be a significantly greater risk that OPCS would create ambiguity (and potential up-coding). Over 50% of CCSD codes analysed had multiple coding options in OPCS (which would give the

provider room to choose the code that was most favourable to them from a reimbursement perspective).

Transparency and payment integrity

4.17   The CCSD group is engaged in the continuous development of the CCSD Schedule, implementing new codes and refining payment rules as new treatments are introduced or challenges to payment integrity arise. As a result, CCSD has allowed a higher level of payment integrity in the PH market to develop compared to OPCS.

4.18   In addition, PMI and self-funded customers have benefited from greater transparency in pricing of comparable services, based on coding that is easier to understand by the layperson.

5. TRANSITION COSTS AND RISKS

5.1 The CC's proposed transition to OPCS coding will entail significant change across the PH market. Costs will be incurred by insurers, hospital operators (hospitals/clinics) and practitioners (consultants/therapists etc.). This section explains these costs and proposes an alternative remedy. Where possible we have provided estimates of the likely costs for BHF. However, in undertaking its assessment of costs and benefits, the CC must collect other market participants' estimates. It is our view that the total cost of this transition, both direct operational costs and in unintended consequences, are likely to be very substantial. We estimate that BHF may have to incur tens of millions of pounds of cost to support a transition to OPCS.

5.2 As some general points on likely costs, we note:

    i. The CC appears to have considered only the large hospital providers which undertake both private (on CCSD) and NHS (on OPCS) work and already have systems in place for both. However, there are a large number of smaller private hospitals/clinics that only operate CCSD because they do not deliver NHS work. For these facilities, the transition will require investment in new systems and coding staff.

    ii. The CC appears to have paid no consideration to the costs that practitioners (consultants/therapists) will face in moving to OPCS. These practitioners are paid by insurers on the basis of CCSD codes. They will need to engage with insurers in agreeing new fees and complexity ratings for the new codes, together with the costs incurred in updating their own practice management systems.

    iii. The costs of this transition must be considered within the context of the other information requirements the CC is placing on the sector. Transitioning to OPCS will load an additional set of resource needs and costs into a system which will already be facing a challenging reform agenda (e.g. moving to ICD-10). Further, it is very likely that this transition will come at the expense of focusing resources on more beneficial activity such as increasing the coverage of CCSD to areas of spend not currently covered by common coding. There is, therefore, the 'opportunity cost' of this transition that should also be considered.

5.3 Table 4 below summarises key areas of business operations affected by the transition from CCSD to OPCS. We will explain each of these areas of cost in detail.

Table 4: Transition costs incurred by different parties in the process of transferring from CCSD to OPCS coding

	Insurers	Hospitals	Practitioners
A) Resetting of insurer fee schedules	• Develop new Schedule of Procedures and prices, including complexities. • Conduct a complexity review of the schedule with input from independent consultants and medical directors before publishing. • Conduct a consultation with providers on the revised coding and prices. • Manage publicity and reputational impact with providers that results from price changes		• Participation in multiple insurer consultations.
B) Negotiation/amending of contracts	• Conduct analysis for each hospital to support cost-neutral transition in contracts (requires recruitment of new FTE support). • Evaluate impact on package prices. • Update and rewrite hospital, consultant and therapist contracts. • Negotiate final terms with all affected counterparties.	• Conduct additional analysis to support cost-neutral transition in contracts (requires recruitment of new FTE support) • Re-negotiate contracts with insurers • Review contracts and payment terms with privately practicing consultants (who may no longer be paid separately under OPCS-4)	• Negotiate new contractual terms with insurers (regarding ability to practice and payment) • Negotiate new contractual terms with hospitals (re package prices)
C) Information system requirements	• Rewrite thousands of lines of coding behind procedure, eligibility and payment integrity rules (e.g. code relation rules). • Recode (or rebuild) internal coding and payment IT systems. • Run dual systems, one on CCSD and one on OPCS, during period of transition (as CCSD would need to remain live to process claims up until transition). This would require a dedicated team of IT personnel. • Update portals used to interact with hospitals, consultants and patients. • Operational costs incurred in testing and cross-checking between the data produced by the two systems	• Purchase or build invoicing systems based on OPCS-4 (a new cost for smaller hospitals/clinics currently not treating NHS patients) • Update, revise and merge coding systems (for hospitals already treating NHS-patients). • Employ clinical coders and/or train staff in using new systems. • Update invoicing systems.	• Update practice systems for new codes
D) Managing impact on customer policies	• Experience-rated pricing of Corporate policies relies on analysis of historic spend levels. Therefore, a mapping will need to be conducted on historic spend to the new coding architecture before policies can be issued. This will force insurers to run two systems in parallel (recording invoices in both systems) during transition • Update and rewrite customer policies to reflect changes to the internal payment policy procedures • Rewrite internal payment policy procedure pages		
E) Post-transition costs	• OPCS-4 licensing costs • Risk of up-coding for codes in OPCS-4 which has insufficient granularity • Costs of delays between new procedures becoming available and the OPCS coding structure being updated. Costs of business cases to introduce new codes into OPCS-4. • Annual system change costs as NHS updates OPCS-4 codes • Potential costs of moving to HRGs reimbursement structure	• OPCS-4 licensing costs and fees for manuals (if not already using OPCS-4) • Costs of business cases to introduce new codes • Annual system change costs as NHS updates OPCS-4 codes (instead of incremental cost changes)	• Cost of reduced granularity in parts of the coding schedule and resulting payment uncertainty • Costs of business cases to introduce new codes

A) Resetting of insurer fee schedules

5.4   Each insurer publishes a fee schedule that explains the rates of reimbursement for practitioners. In BHF's case this is the Schedule of Procedures, which contains the benefit maxima for surgical procedures. These fee schedules will need to be completely revised if OPCS codes replace the existing CCSD architecture.

5.5   BHF anticipates a number of significant challenges in revising the schedules:

i.   There are many more codes in OPCS (approximately 6,000) than in CCSD (approximately 2,000 as of December 2013). This, in part, reflects the fact that CCSD is more streamlined and often describes a procedure in a single code where in OPCS different elements of that procedure are covered by separate codes. For example, "*T7983 Open subacromial decompression and limited, less than 2cm tear rotator cuff repair*" in CCSD would be an (imperfect) combination of the OPCS codes "*O29.1 Subacromial decompression*" and "*T79.1 Plastic repair of rotator cuff of shoulder NEC*". Each of these OPCS code would need to be priced separately (because some O29.1 subacromial decompressions can be delivered without rotator cuff repair). The challenge will be agreeing with consultants the pricing of each individual element of the procedure such that the total procedure cost is unchanged (i.e. the move from CCSD to OPCS is cost neutral) and the pricing of the individual elements is appropriate too.

ii.   The process of unbundling or re-bundling of CCSD codes will require significant analysis. It will also spark significant discussion, and potential disagreement, with consultants and consultant professional bodies.

iii.   There are codes in CCSD that are currently not in OPCS. This reflects, as noted above, that for many procedures CCSD has a consolidated code. But it also reflects the fact that CCSD more quickly incorporates codes for new procedures than OPCS. CCSD is updated monthly, whereas we understand that the last time OPCS was updated in full was in April 2011. It is unclear how the CCSD-only codes should be handled at point of transition as there will be no equivalent OPCS code. Indeed, going forward as PH advances, it is unclear how new procedures will be billed if OPCS is updated infrequently.

iv.   Each code within the current Schedule of Procedures has an associated complexity rating. This complexity rating determines the reimbursement level for the procedure. With new OPCS codes, a new complexity rating will need to be determined for each code. Determining complexity ratings is a significant undertaking. The CC is aware that BHF conducted a complexity review of approximately ✄   codes within the CCSD structure during 2012. In our letter of 26 July 2012, we set out the rigorous, evidence-based process that is necessary to arrive at these complexity ratings – a process that requires engagement from medical directors, independent experts, and affected consultants. The CC is also aware that there was significant uproar from some consultants who challenged new complexity ratings where these impacted fees. This led to reputational damage for BHF in the media and, in part, contributed to additional customer complaints reported to the FSA during this period. We anticipate that heated discussion will again arise between insurers and consultants when complexity ratings across the new OPCS structure are determined. There will be an even greater number and complexity of codes for discussion. Consultants will see this as an opportunity to re-set previous fee levels or complexity ratings that they consider too low. Moreover, all insurers will be undertaking the exercise in parallel, which is likely to magnify this risk.

5.6 Transforming our Schedule of Procedures from CCSD to OPCS would therefore be a very substantial undertaking, creating costs and uncertainty across the industry.

5.7 BHF's complexity review in 2012 had a much narrower scope than is contemplated in creating a new Schedule of Procedures with OPCS and focused only on surgical codes, excluding any complexity review of anaesthetic codes. Therefore, BHF believes it would not be unrealistic to expect significant one-off costs for BHF in creating a new Schedule of Procedures. Substantial costs would also be incurred by other insurers. Individual consultants and consultant bodies would also bear costs.

B) Negotiation/amending of contracts

5.8 Insurers will need to negotiate new contracts with any provider (hospitals or practitioners) whose existing pricing is set out in CCSD coding.

5.9 In theory, it may be possible to transition contracts to the new coding as they come up for renegotiation in the normal course of a contract's cycle. However, in reality, different suppliers have different contract cycles. This is necessary and desirable because insurers simply do not have the resources to run detailed negotiations with all suppliers in parallel. So, in practice, transitioning contracts as they expire and are renegotiated would result in BHF needing to operate two IT systems in parallel – one for those contracts already transitioned to OPCS and one for those contracts still coming up for renewal. As is discussed below, running two systems in parallel will also create very significant logistical issues in the processing and paying claims, and critically in pricing policies for customers. Therefore, practically, BHF is likely to need a "big bang moment" at which coding and all contracts change at once. This would involve amending all existing contracts at the same time – an incremental legal expense to those incurred in the normal contracting process.

5.10 Further, BHF anticipates that significant analytics will be necessary on each of its major hospital group contracts to ensure that the move to OPCS is 'cost neutral' (i.e. leaves neither hospital nor insurer worse off). This will involve negotiation and rebalancing of fees across procedure and package prices. The analytical costs involved would be experienced also by the other main insurers and the hospital groups.

5.11 Another substantial cost would be the internal senior staff time required to negotiate and agree the new pricing with each hospital operator. Each contract could take several months of negotiation. Further, there would be the risk of the rebalancing of fees triggering disputes if no agreement on fees could be reached.

C) Information system requirements

5.12 BHF anticipates significant system requirements to manage the period of transition to a new OPCS coding structure.

5.13 It is highly likely that BHF will be forced to run two systems, one on OPCS and one on CCSD, in parallel during the period to transition (and likely for a period after transition until all suppliers can adopt the new codes). There are several reasons why the two systems will need to run in parallel for a period:

   i. The OPCS system will need to be built, while the CCSD system is still operating day-to-day in receiving and paying claims (to give customers continuity of service). BHF's current claims management system is called SWIFT. It contains over ✂ lines of code which rely on CCSD coding. ✂. These lines of codes will all need to be substantially

rewritten to accommodate OPCS and new code would need to be written to 'bundle' multiple OPCS codes to match the CCSD code it replaces. The new program code will need to be operational and trialled before it can go live so that bugs can be fixed.

ii. BHF's pricing of policy renewals is based on previous claims experience (e.g. experience-rated pricing for corporate customers). For all affected policy renewals over this period where the market shifts from CCSD to OPCS, BHF will need to translate previous claims experience, recorded in CCSD codes, to the OPCS equivalent so that actuarial pricing of risk, in the new OPCS world, can be done correctly. BHF anticipates that this will require running the two systems in parallel during the period just before transition so that there is confidence in the accuracy and integrity of the OPCS data on which future claims will be priced. In addition, during the period of transition, this could require BHF to translate invoices from CCSD to OPCS on the ✂ claims it receives annually to ensure that future pricing based on the OPCS system is accurate.

5.14 The OPCS system built during the transition period will require additional servers, specialist clinical coders and staff re-training. Personnel will also need to check and test the consistency of the two systems during this period to ensure the OPCS system is fully functional at the moment of 'big bang' transition.

5.15 BHF has not yet had an opportunity to form a bottom up cost estimate on designing, building, testing and running this shadow OPCS system during the period of transition. However, it is likely to be very substantial. As an indication of scale, when BHF installed its current claims management system, SWIFT, the time and resources necessary were approximately ✂.

5.16 The new system would need to replace SWIFT. Were BHF to face even half of the costs incurred in developing SWIFT there would be a significant negative impact on the profitability of the business. Unavoidably, given the narrow margins within the PMI sector, an increase in operating costs of this magnitude would result in an increase in premiums for customers. The new system would also result in an impairment of the SWIFT intangible asset held on the Bupa Group balance sheet[35].

5.17 We expect that other insurers are likely to also face comparable system redesign costs.

D) Managing impact on customer policies

5.18 As noted above, a significant challenge is how to manage the actuarial pricing of risk during the transition. Any errors in the coding could lead to customers receiving pricing that does not accurately reflect their claims history or risk profile. BHF expects that to ensure that customers are held harmless through the transition all insurers will need to invest heavily in building appropriate systems, installing checks and balances, and maintaining seamless claims handling.

5.19 BHF would need to re-write the 5,000 pages of internal information on policy and procedure eligibility used by our staff when engaging with customers (e.g. during pre-authorisation). CCSD coding and descriptions are embedded into this internal database. These codes and descriptions would need to be amended to reflect the OPCS structure, noting that OPCS descriptions are highly technical, clinical in nature and not easily understood by the layperson.

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[35] The cost of implementing SWIFT was capitalised as an asset which has been amortised over the years. This asset is valued at ✂ on the balance sheet as of 31 December 2013.

5.20   Similar costs would likely affect all insurers.

E) Post-transition costs

5.21   In addition to the costs of transition to OPCS, BHF anticipates certain costs will arise on an ongoing basis after OPCS is implemented. These include:

i.   There is significant risk of "up-coding" within OPCS due to its less tailored code descriptions. This will increase private healthcare expenditure. There will also be greater risk of up-coding during the years immediately following transition as insurers need to observe patterns of coding over a period before payment integrity rules can be written to flag and stop these fraudulent claims. Insurers will have lost the payment integrity rules established during years of learning through observing CCSD coding patterns. It is difficult to quantify the scale of this cost.

ii.   There will be costly delays between new procedures becoming available and the OPCS coding structure being updated.

iii.   There will be system change costs as NHS updates OPCS-4 codes annually.

iv.   Insurers will need to pay ongoing licensing fees for OPCS coding and manuals.

v.   Finally, BHF notes that the NHS has approved the SNOMED Clinical Terms ("SNOMED CT"), a coded clinical language, as a fundamental information standard to be used across all NHS organisations when providing patient care. The UK Terminology Centre are working to support the adoption of SNOMED CT throughout the UK[36]. SNOMED CT has much wider coverage and applications than OPCS coding, but may in the future replace OPCS as a coding language. This would imply a second transition for the PH sector from OPCS to SNOMED, which would incur substantial additional costs that are eventually passed on to policyholders.

ALTERNATIVE REMEDIES

5.22   BHF proposes two alternative remedies to help remedy the AEC identified by the CC. With respect to improving comparability with the NHS, the CC should consider mandating the information organisation to invest in a mapping tool between CCSD and OPCS. In addition, BHF is strongly of the view that the CC should mandate the industry to standardise coding outside of CCSD. These remedies are more likely to facilitate better decision making inside the PH sector and improve comparability with the NHS, at a lower cost than the CC's current proposal.

Information organisation to invest in and maintain a mapping tool between CCSD and OPCS

5.23   The CC can commit the information organisation to fund the build, maintenance and making available (free of charge) of a mapping between CCSD and OPCS codes that is *as complete as*

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[36] For details, see: https://www.gov.uk/government/news/common-clinical-language-for-nhs-will-help-improve-patient-care-and-safety

is reasonable and practicable[37]. The remedy could be an ongoing commitment with annual reporting to the Information Organisation Board on the progress and upgrades on the mapping.

5.24 If the CC is seeking greater comparability with the NHS, but at the same time does not wish to prejudice the performance of PH, then this solution would be lower cost and more proportionate:

    i. It would not require investment in changing the payment and reimbursement architecture of PH. CCSD has been developed to suit the commercial needs of the private sector. It facilitates payments and is updated more frequently than OPCS – as a result, innovation in the private sector will continue to be adopted quickly through the CCSD group. Private hospital operators and consultants would continue invoicing self-pay patients and insurers using CCSD codes.

    ii. A mapping tool would still facilitate comparisons with the NHS (but in a less costly manner). Clinical activity and performance can be compared to activity in the NHS. Pricing may be more difficult to compare between the PH sector and the NHS – while it requires the conversion of OPCS and other patient information into HRGs, the reimbursement rates for each HRG include some elements that are unbundled in the PH sector for payment purposes. However, this problem would still exist under the CC's proposed remedy of a full transition to OPCS. A mapping tool would deliver the same benefits of the CC's proposed remedy but at a lower cost.

    iii. The development of a mapping tool will avoid the need for insurers to invest in new IT systems to support the shift to processing claims using OPCS. Insurers would also not need to recruit specialised clinical coders or invest in training of staff during the transition period.

    iv. Resources will not have to be invested in revising each insurer's schedule of fees. Additionally, pricing and other terms of hospital-insurer contracts will not need to be re-negotiated.

    v. The PH sector will avoid the significant risks of up-coding in OPCS. In addition, guidance documents will not need to be re-written.

Standardise coding

5.25 The CC should commit providers and insurers to standardise coding for the areas of expenditure outside of CCSD that are currently not on common codes. This process can be managed and governed by the CCSD group. It would need to be mandatory for all providers and insurers to participate and adopt the new coding.

5.26 Standardisation outside of CCSD would significantly improve comparison and competition between private hospitals within the market, and as such would directly target the AEC identified by the CC. In particular, standardising of coding outside of CCSD will help reduce transactional costs in the sector and facilitate benchmarking – for example, insurers could easily benchmark hospital prices across all services (e.g. drugs) rather than only surgical procedures. Moreover, in the long run, parties in PH would not have to incur significant additional costs and resources in an attempt to process a plethora of different codes from

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[37] As explained in this paper, there are good reasons why CCSD and OPCS will never match perfectly (see Section 4).

different providers. Overall, transparency for the sector would be substantially improved as prices are more easily comparable.

ANNEX A: DISTINGUISHING BETWEEN A CODING SYSTEM AND A PAYMENTS SYSTEM

A.1 To usefully discuss a transition from CCSD to OPCS coding, the CC must distinguish between a clinical coding system used to record clinical activity and a reimbursement system used to pay for care.

A.2 The purpose of a clinical coding system is to facilitate the recording of activity that occurs to patients. Activity in this context refers to clinical events experienced by patients: appointments, medical assessments, diagnostics, tests, procedures, minutes in an operating theatre, days on a ward, hours in an intensive care unit (ICU), rehabilitation courses, etc. Clinical coding systems tend to include a great amount of detail about the activities performed. They may be run in parallel or linked in with systems that collect patient data and characteristics, such as age, gender, comorbidities.

A.3 The purpose of a reimbursement system is to facilitate clear and timely payment from commissioners of care to providers of care. A well-functioning reimbursement system needs to be relatively simple, with single codes for clinical interventions and clear payment rules that prevent misuse of the system (e.g. payment for overlapping codes).

A.4 The basis of reimbursement varies across health care systems. We can usefully distinguish four broad systems:

    i.   Where payment is based on the patient's diagnosis and usually a "fixed fee". Australia and Germany use diagnosis based payment, grouping diagnoses into Diagnosis Related Groups (DRGs). DRGs are the "currencies" on the basis of which providers are then reimbursed.

    ii.   Where payment based on activities much like "time and materials" based payment. Activity based payment is used in parts of the NHS, to reimburse items such as direct access diagnostics, drugs, chemotherapy and radiotherapy [confirm], outpatient appointments, excess bed days and some therapies.

    iii.   Where payment is for a bundle of care in response to an identified diagnosis and personal characteristics of the patient (age, comorbidities, gender). The diagnoses, characteristics and procedures together determine a payment category. In the English NHS, Healthcare Resource Groups (HRGs) that are based on diagnostic, procedural and patient information are used to pay for most acute care delivered in a secondary care setting.

    iv.   Where payment is based on bloc contracts. Bloc contracts are used in the English NHS to pay for groups of activities such as community based services (e.g. district nursing services for a year to a given population).

A.5 CCSD codes are reimbursement codes that pay hospitals based on the activity that they deliver (payment system 2 above). While fairly granular, they have not been developed for the purpose of clinical coding.

A.6 OPCS codes are procedure codes that are used to record the clinical activity on hospital systems. In the English NHS, they are one of the components that determine the HRG that is

used then used to reimburse a hospital. OPCS codes themselves are not a basis of reimbursement.

A.7   It is worth noting that CCSD codes evolved from OPCS codes, meaning that there are similarities between the two systems. However, their purposes are different and the two systems have diverged since the initial introduction of CCSD codes.

A.8   A proposal to transfer from CCSD codes to OPCS codes is not only an operational proposal. It is also a proposal to reconsider the basis of payment in the PH market.