CCSD The Clinical Coding & Schedule Development Group

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Christiane Kent
Inquiry Director
Private Healthcare Market Investigation
Competition Commission
Victoria House
Southampton Row
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Dear Ms Kent

CCSD RESPONSE TO THE COMPETITION COMMISION'S PROVISIONAL DECISION OF REMEDIES ON THE PRIVATE HEALTHCARE MARKET PUBLISHED 21 JANUARY 2014

I am writing to you as Chair of the Clinical Coding and Schedule Development (CCSD) Group on behalf of and with the full agreement of CCSD's members in response to your recently published report outlining provisional decisions on remedies of the Competition Commission's inquiry into private healthcare market. We, the board representatives of the five insurers making up the CCSD Group, would like to express our broad support for the CC's package of remedies. However, we have major concerns about the implications of one element of your remedies, the requirement to transition from CCSD to OPCS coding for billing purposes. As part of its information remedies, the CC has suggested that the industry should adapt their IT and billing systems to use OPCS coding by April 2019. We believe that the CC's proposals are based on a misunderstanding of the nature and purposes of OPCS and CCSD, and the implications of a move. In particular, we note the following concerns:

1. OPCS is not fit for purpose as a coding system used for reimbursement.
2. The significant and prohibitive costs of a transition to a new payment system would ultimately be felt by consumers through higher fees and premiums
3. The proposal does not consider the lack of flexibility inherent in a system that was designed for NHS clinical coding, not payments, nor to cover private sector activity
4. The future obsolescence of OPCS due to the medium-term NHS plan to replace OPCS-4 with SNOMED CT for clinical coding. [1,2,3].

We outline these points in further detail below and would like to suggest an alternative and more effective remedy that aids comparability with the NHS whilst retaining the effectiveness of CCSD on the basis of reimbursement for the private sector.

As you will be aware, the CCSD Group consists of the UK's five major private medical insurers: Aviva, AXA-PPP healthcare, Bupa, PruHealth and Simplyhealth. The CCSD Group's objective is to establish and maintain a common set of procedure and diagnostic test codes and narratives that reflect current medical practice within the independent healthcare sector.

It is important to note that the CCSD group does not have any commercial vested interested in maintaining CCSD codes but has instead engaged in the development of CCSD codes due to the commercial necessity of such codes in the sector. Also, the board and working group do not receive any compensation for CCSD work, and have therefore no personal interest in maintaining CCSD codes. Our interest is simply to ensure payment codes are fit for the purpose of paying for clinical activity in Private Healthcare.

The CCSD Group supports the aims of having industry standard coding which is consistent and comparable across the UK health market, including the NHS. CCSD continually reviews and updates coding to ensure that it reflects current clinical practice and facilitates accurate charging by private healthcare providers. Our review processes monitor and assess the coding undertaken by the NHS to ensure equivalence and mappability where this is possible.

Our understanding of the current proposal by the Competition Commission is for the private healthcare sector to replace CCSD codes with OPCS codes for payments using a single procedure code. While CCSD codes are broadly based on and can, to a limited extent, map to OPCS codes, there are a number of significant differences in the nature and purpose of the two coding systems which would cause major transition difficulties adding to the cost of Private Medical cover for our customers.

CCSD codes and OPCS codes are not like-for-like substitutes. OPCS coding alone does not solely determine payment within the NHS.

The purpose of OPCS codes is clinical coding, not for billing and payments. The simplest evidence is that OPCS codes are not used for payments even in the NHS, which created and maintains OPCS codes.

OPCS contributes to the formation of NHS Healthcare Resource Groups (HRGs). OPCS procedure codes are just one component part. ICD10 coding, recording of relevant co-morbidities, the patient's age, gender and length of stay are all contributory factors to HRGs. Payments to NHS providers are determined based on the HRG and not on the basis of just procedure codes.

Further, UK PMIs created CCSD codes for payment for procedures in 2006 – after reviewing and confirming that **OPCS codes could not be used for reimbursing a procedure with one code**. OPCS often requires two or more codes to describe a procedure as per the example below.

The CCSD code "*T8052 Extra corporeal shock wave therapy of lateral epicondylitis*" defines the activity (and enables contract payment) with one code.
The nearest OPCS equivalent (not an exact match) would code this activity as "*T74.5 Extracorporeal shockwave lithotripsy of calculus of tendon*" combined with "*Y13.5 ultrasonic destruction of lesion of organ NOC (not otherwise classified)*" – and the payment is then defined by adding these and relevant diagnostic tests and impairment codes to the HRG grouper. There is also some activity, such as

outpatient consultations, missing in OPCS – so transition to OPCS would still require use of some CCSD codes to cover all PMI payments.

As such, the proposed requirement to move to OPCS from CCSD raises a number of concerns within the sector as follows:

1. CCSD is a common standard of procedure codes that are regularly updated to reflect current medical practice within the independent healthcare sector. It covers diagnostic tests and is available to all those working in the sector at a minimal, equitable charge that does not limit adoption or usage. It is widely used by insurers, hospitals, consultants, physiotherapists, mental health practitioners, other medical practitioners and coding/billing agencies. It was purpose built to be suitable for remuneration. As set out above **OPCS is not designed for this purpose, is not employed for this purpose in the NHS and is not fit for purpose as a reimbursement coding system in the private sector**.

2. Moving to OPCS for payments will result in substantial sector wide costs that are likely to run into the tens of millions of pounds. All contracts between Insurers and providers will need to be renegotiated, with significant effort spent in comparing costs between the different coding systems and all parties will face significant costs in implementing these changes. Insurers will need to invest in changes to all customer service and IT systems, claims technology and the re-training of thousands of employees. Providers will similarly need to invest in overhauling systems and employing trained clinical coders to provide accurate OPCS coding – a resource which is already highly specialist and scarce within the NHS. Other costs will include renegotiating contracts and continuing to operate a second system of coding to cover those areas of expenditure which OPCS does not cover. For insurers and their customers there is also a significant risk of up-coding on the part of providers leading to higher prices.

The significant additional cost and complexity in moving to OPCS coding, will lead to higher prices for customers. While insurers continuously attempt to mitigate member premium increases, the additional costs, both those borne directly by insurers and those borne by providers which are likely to be passed on to insurers, are expected to be substantial so that premium increases for consumers would be inevitable.

3. **OPCS is designed for the NHS and has very limited scope for private sector involvement in setting its direction and scope including how frequently it is updated.** This is part of the reason why a specialist coding system was developed for the private sector, even though insurers would have preferred not to invest in developing and maintaining a different system. Given the relative scale of the NHS and the fact the governance of OPCS coding sits firmly with the NHS, it is unlikely that OPCS will develop in line with the needs of the private sector.

4. Aligning private sector coding with that of the NHS at the moment would be greatly concerning in light of NHS plans to abandon OPCS and transition to Snomed CT (1). Whilst it is not clear exactly when NHS will do this, , we are concerned that **private healthcare organisations that adopt the Competition Commission's latest coding proposals by April 2019 may find themselves aligned with current NHS processes, only to discover that the NHS has moved on.**

Rather than changing the coding for payments we believe there are at least two options that would deliver all or majority of the benefits without incurring the costs for our customers:

1. Maintain the current requirement for providers to provide clinical coding in the same format as NHS (eg. currently OPCS) in addition to – not instead of - payment codes. This (together with mandated ICD10 codes) delivers full comparability of procedures between NHS and PMI, but without incurring the costs caused by changing the basis of payments. Further, this leaves the freedom for providers and insurers to use any payment codes (CCSD, HRG's, DRG's, etc) if they wish to do so in their contracts, and avoid changing again when NHS has completed transition to Snomed.

2. Developing an improved mapping between CCSD and HRG's / OPCS to improve transparency and comparability with the NHS. This would also enhance the flexibility of amending mapping when NHS transitions to Snomed in the future. CCSD would be willing to develop an industry wide, consistent mapping and make this available across the wider industry. This would be a natural development of its role in providing industry standard coding. This would cost a tiny fraction of the enormous transition costs of moving to OPCS.

Additionally, the CCSD group believes that the CC's remedy should instead focus on standardising the areas of coding in the private sector that do not sit under a common coding structure, such as prostheses and drugs

I hope that this information and our suggestions are helpful in implementing relevant outcomes from your review. CCSD Board would be delighted to provide you with any additional information on this matter.

On behalf of the CCSD Board,

Yours sincerely

Riko Scandelius
Chairman

References to NHS transition to Snomed:

1. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_4127040
2. http://www.connectingforhealth.nhs.uk/systemsandservices/data/uktc/snomed/training/why_migrate_v1.1.pdf
3. http://www.connectingforhealth.nhs.uk/systemsandservices/data/uktc/training/snooverview2.pdf