2014/15 National Tariff Payment System: A Consultation Notice

Annex 7A: Specified services for acute services for local pricing

3 October 2013

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This annex gives more detail on the nationally specified currencies for acute services with no national price. These currencies should be used in local price-setting for these services, unless an alternative approach is agreed in accordance with Section 7.4.2 of the consultation notice. This annex covers national currencies in the following areas:

- Specialist rehabilitation
- Critical care – adult and neonatal
- HIV adult outpatient services
- Renal transplantation
- Positron emission tomography and computerised tomography (PET/CT)
- Cochlear Implants
- Transcatheter Aortic Valve Implantation (TAVI)
- Complex therapeutic endoscopy
- Dialysis for acute kidney injury

1.1.1 Specialist rehabilitation

In an effort to improve capacity, co-ordinate service provision and improve access to specialist rehabilitation services, a currency model has been developed by the UK Rehabilitation Outcome Collaborative (UKROC) which is based on provider categorisation and patient need.

This currency is designed to incentivise the provision of effective specialist rehabilitation services. As such, it should reduce overall health care costs for this group of patients by supporting patients in moving from an acute bed to a specialist rehabilitation service as soon as this is clinically appropriate. By clearly designating services, the currency model ensures that patients are treated in the correct specialist rehabilitation service appropriate to their needs.

The weighted per diem payment model has been designed to provide a fair and clearer payment approach for high-cost rehabilitation patients.

The currency model

The currency model designates providers into levels of specialist rehabilitation services. These service levels have different service profiles and differing costs. Patient characteristics and needs are defined using the National Definition Set for Specialised Rehabilitation (SSNDS).

The currency model only covers the admitted patient stay for people in adult and designated children services with category A or B needs according to the SSNDS.

The currency model has been designed for patients who will be on a specialist rehabilitation unit for six months or less. Patients for whom rehabilitation is likely to last more than six months will continue to be funded on an individual basis.

During the patient's admitted stay on a specialist rehabilitation unit, clinicians must use the Rehabilitation Complexity Scale (RCS-E) tool to assess the patient's needs. The tool should be reapplied every two weeks for patients in level 1 and 2a services, and on admission and discharge for those in category 2b services. The combination of the type of rehabilitation unit where the patient is treated and the RCS-E score will determine the currency (and locally agreed per diem price).

In 2014/15, all specialist rehabilitation services are required to register with the UK specialist Rehabilitation Outcomes Collaborative (UKROC) database.

Level 1 and 2a units must complete the full UKROC dataset for all case episodes that they wish to have counted as specialist rehabilitation, with fortnightly submissions to the UKROC team.

Level 2b services must submit their dataset quarterly.

Indicative reference prices

The prices for hyper-acute, physical, mixed and 2a are based on the published 2013/14 non-mandatory prices. These prices were developed through a cost collection exercise from providers who were already submitting patient data to UKROC.

The prices for 2b activity are based on the 2013/14 prices but are slightly higher than for 2013/14. The prices for 2b were recalculated after removing some activity that was outside of the scope of the currency model.

The reference prices below have **not** been adjusted for the 2014/15 cost uplifts and efficiency requirement.

Table 7A-1: Specialist rehabilitation reference prices

Provider type / RCS-E complexity score	Level 1 services			Level 2 services	
	Hyper-acute	Physical	Mixed	2a	2b
Very High	655	617	601	578	521
High	509	479	466	454	409
Medium	391	368	358	331	298
Low	318	299	291	231	208
Very Low	245	231	224	206	186

1.1.2 Critical care – adult and neonatal

Critical care is a high cost and low volume service that requires intense management and monitoring of the patient, using advanced nursing, therapy and medical skills. Critical care is a service that can apply across the spectrum of admitted patient care and the majority of its activity is unplanned.

A critically ill patient can be defined as someone who has an immediate requirement for any form of organ support (intubation, ventilation, inotropes), or is likely to suffer acute cardiac, respiratory or neurological deterioration requiring such support.

The introduction of adult and neonatal critical care currencies has made it easier for provider and commissioners to agree activity and price levels.

The currency model

Commissioners and providers must contract for adult and neonatal critical care services using the Healthcare Resource Group (HRG) currencies. These are based on the adult and neonatal critical care minimum datasets.

The HRGs for adult critical care (sub-chapter XC) have been designed using the level of support required by the patient as evidenced by the number of organs supported (0-6).

Table 7A-2: HRG currencies for adult critical care

HRG code	Description
XC01Z	Adult critical care - 6 organs supported
XC02Z	Adult critical care - 5 organs supported
XC03Z	Adult critical care - 4 organs supported
XC04Z	Adult critical care - 3 organs supported
XC05Z	Adult critical care - 2 organs supported
XC06Z	Adult critical care - 1 organs supported
XC07Z	Adult critical care - 0 organs supported

The HRGs for neonatal critical care services (sub-chapter XA) are descriptive rather than linked to a specific number of organs.

Table 7A-3: HRG currencies for neonatal critical care

HRG code	Description
XA01Z	Neonatal critical care intensive care
XA02Z	Neonatal critical care high dependency
XA03Z	Neonatal critical care special care without external carer
XA04Z	Neonatal critical care special care with external carer
XA05Z	Neonatal critical care normal care
XA06Z	Neonatal critical care transportation

Due to the national variation in critical care unit size, commissioners of smaller units may prefer a fixed and variable payment model to ensure capacity and availability of beds, whereas commissioners of larger units may prefer a per-patient payment model to incentivise efficiency or movement of beds to meet other strategies (e.g. major trauma). When adopting alternative payment approaches providers must adhere to the general rules for local pricing and disclosure requirements set out in Section 7.

1.1.3 HIV adult outpatient services pathway currencies

HIV infection is a long-term chronic medical condition requiring lifelong treatment. HIV patients need accessible, consistent and effective specialist care and management of their HIV infection and any associated complications, and prevention of onward transmission.

The objective of the HIV outpatient pathway currency is to ensure the holistic needs of HIV infected individuals are appropriately met. In developing a year of care approach the pathway takes into account ongoing changes in service delivery.

The currency model

The HIV outpatient currencies are a clinically designed pathway for each of three groupings of HIV adult patients (>18 years) that supports an annual year of care payment approach.

The HIV adult outpatient currencies do not include the provision of any antiretroviral (ARV) drugs and the currency rules still apply where patients move from one provider to another.

Table 7A-4: HIV adult outpatient currencies

Category 1: New patients
Category 1 patients are newly diagnosed in England or have newly started on ARV drugs. These patients, in the first year of diagnosis require more intensive clinical input than stable patients. This includes a greater number of more complex diagnostic tests and more frequent clinic visits with a greater input from multi-disciplinary teams. A newly diagnosed patient will be a category 1 patient for one year, after which they will automatically become a category 2 patient. Similarly, a patient starting ARV drugs for the first time will be a category 1 patient for one year when they will automatically become a category 2 patient. These events can immediately follow each other. For example, a patient may be newly diagnosed and then after seven months start ARV drugs. As a result, the patient would be in category 1 for 19 months and then automatically become a category 2 patient. If a patient is category 1, but has one of the category 3 listed complexities then they become a category 3 patient for a year.

Category 2: Stable patients

Category 2 covers patients that do not have one of the listed category 3 complexities and are either not on ARV drugs or started ARV drugs more than one year ago. This category covers the majority of patients and therefore should be used as the default category unless category 1 or 3 criteria can be demonstrated and validated.

If a patient transfers into an HIV service and had started ARV drugs for the first time more than a year ago then they would automatically be classified as category 2 unless they had one of the complexities resulting in them being a category 3 patient.

Category 3: Complex patients

Patients who fall into category 3 have a complexity needing high levels of maintenance, or being highly dependent patients. Complexities are:

• current TB co-infection on anti-tuberculosis treatment;

• on treatment for chronic viral liver disease;

• receiving oncological treatment;

• active AIDS diagnosis requiring active management in addition to ARV drugs (not inpatient care);

• HIV-related advanced end-organ disease;

• persistent viraemia on treatment (more than six months on ARV drugs);

• mental Illness under active consultant psychiatric care; and

• HIV during current pregnancy.

To support the currencies, the HIV and AIDS reporting system (HARS) has been introduced by Public Health England. All organisations providing the HIV outpatient pathways must submit data to HARS. This dataset will support commissioning and epidemiology of HIV adult outpatient activity.

National guidance for the provision of treatment and an appropriate service specification can be found at www.bhiva.org and www.bashh.org.

A full explanation of the HIV Outpatient Clinical Care Pathway (version 11) can be found here.

1.1.4 Renal transplantation

Kidney transplantation is the renal replacement therapy of choice for patients with chronic kidney disease stage 5 who are considered to be medically suitable. The patient's medical suitability is established by assessing the potential benefits of improved quality of life and longer survival relative to the risks of major surgery and chronic immunosuppression.

For suitable patients it is preferable to transplant pre-emptively (within six months of needing dialysis) where possible.

Currencies have been developed by commissioners, NHS providers, the British Transplant Society and NHS Kidney Care to support national data recording consistency and cost convergence. The currencies are linked to all Renal Association, NHS Blood and Transplant/British Transplant Society and European Best Practice Guidelines.

The currency model

An adult renal transplantation currency (>18 years) uses HRGs to collect activity and covers all care directly related to the preparation and provision of a transplant episode. This includes living donation and required post-transplant care delivered in both transplant and specialist renal centres.

This currency does not apply to kidney transplants performed as part of simultaneous pancreas and kidney transplants, and of other multi-organ transplants incorporating a kidney transplant.

The currency covers activity relating to specific HRGs in use, but does not capture the following:

- antibody incompatible transplantation;
- any deceased donor organ donation and costs related to the associated organ retrieval (the responsibility of NHS Blood and Transplant); and
- outpatient attendances where the primary purpose is to formally assess suitability for transplantation.

This care pathway provides the opportunity to include multiple elements within the currency without incentivising multiple outpatient visits, and the ability to include elements, and in particular tissue typing, which do not easily map to an outpatient attendance.

The currency is made up of three components:

- preparation for transplantation outpatient attendances;
- the transplant episode including post discharge drugs; and
- post-transplantation outpatients.

Preparation for transplantation

Pathway starts **after** a patient has been identified as potentially suitable for transplantation and a nephrologist makes a formal outpatient referral to a transplant surgeon. The first outpatient consultation to further assess suitability for transplantation with a transplant surgeon is the start of the pathway under this currency.

All adult pre-transplantation outpatient activity related to both recipient and any potential living donor must be reported against the HRGs, every time each patient is seen within an outpatient clinic. This also includes outpatient activity whilst patients are being maintained on the transplant list.

Table 7A-5 below sets out the activities related to this component of the pathway and the HRGs to be used.

Table 7A-5: Preparation for transplantation

Preparation for transplant	HRGs
• First referral to transplant surgeon to assess suitability • Medical work-up for transplant • Surgical work-up for transplant • Maintenance on transplant list • Living donor suitability and MDT review • Work-up of potential living donor	**LA12A** - Kidney pre-transplantation work-up of recipient 19 years and over **LA10Z** - Live donor screening **LA11Z** – Kidney pre-transplantation work – live-donor

Transplant inpatient episode

The mandatory HRGs cover all activities carried out during the transplant episode.

Table 7A-6 below sets out the activities related to this component of the pathway and the HRGs to be used.

Table 7A-6: The transplant episode

Transplant inpatient episode	HRGs
• Pre operative checks and tests • The kidney transplant procedure (in theatre) • Any required readmission to theatre (whilst the patient is still in hospital) • All Post operative inpatient care • Stent removal. • Elective removal of PD Catheter • Up to 90 days post transplant drugs • Live donor nephrectomy	**LA01A** - Kidney transplant from cadaver non-heart beating donor 19 years and over **LA02A** - Kidney Transplant from Cadaver heart beating donor 19 years and over **LA03A** - Kidney transplant from live donor 19 years and over **LB46Z** – Live donation of kidney

Post-transplant outpatients

All adult post-transplantation outpatient activity, related to both recipient and donor, must be reported against the appropriate HRG every time the patient is seen within an outpatient clinic.

Table 7A-7 below sets out the activities related to this component of the pathway and the HRGs to be used.

Table 7A-7: Post-transplant outpatient HRGs

Post transplant outpatients	HRGs
• All post transplant outpatient activity related to both recipient and donor • Antibody monitoring • Annual review	**LA13A** – Examination for post-transplantation of Kidney – recipient is 19 years and over **LA14Z** – Examination for post-transplantation of kidney of live donor

1.1.5 Positron emission tomography and computerised tomography (PET/CT)

This activity will have a national currency for use in 2014/15 (HRG RA42Z – nuclear medicine category 8).

1.1.6 Cochlear implants

This activity will have national currencies for use in 2014/15 (HRGs CZ25N (without cc) and CZ25Q (with cc)). We do not propose to set a national price but a non-mandatory price is available for use in 2014/15.

1.1.7 Transcatheter Aortic Valve Implantation (TAVI)

This activity will have a national currency for use in 2014/15 (HRG EA53Z).

1.1.8 Complex therapeutic endoscopy

We are introducing a new HRG (FZ89Z) for complex therapeutic endoscopy. Activity for this HRG can be identified using combinations of procedure codes. The majority of the activity that will be covered by the new HRG was previously mapped to HRGs FZ24A/B/C/D (Major Therapeutic Open or Endoscopic Procedures).

1.1.9 Dialysis for acute kidney injury

Dialysis for acute kidney injury is not currently identified by HRGs, and is associated with activity in many different HRGs. In 2014/15, we are changing the design of HRGs to help providers and commissioners better identify and discuss dialysis for acute kidney injury.

The change introduces four new HRGs (LE01A, LE01B, LE02A and LE02B) for dialysis for acute kidney injury. Activity for these HRGs can be identified using combinations of procedure and diagnosis codes. These HRGs are ‘unbundled’ HRGs, that is, they are generated in addition to an HRG for the core activity for the patient. One HRG will be generated for each session of dialysis.