BUSINESS RULES FOR MATERNITY PATHWAY PAYMENTS

What is included in maternity pathway payments?

Community-based maternity care	1.	Includes all community-based antenatal and postnatal maternity care.
Inpatient maternity care	2.	Includes all maternity and obstetrics care coding to NZ HRGs.
Outpatient care	3.	Includes all maternity and obstetrics care coding to outpatient TFCs 501 or 560.
Scans, screens and tests	4.	Includes the undertaking of all maternity ultrasound scans, maternity and newborn screening, and tests.
Birth	5.	Includes the birth, irrespective of type and setting.
Post-birth care for well/healthy babies	6.	Includes the costs of caring for well/healthy babies, both during the birth spell and pathway checks/screening during the postnatal phase.
CNST	7.	All CNST costs are included.

What is excluded from maternity pathway payments?

Specialist diagnostic analysis for maternity screening	8.	Excludes the analysis elements of the screening process undertaken by specialist diagnostic laboratories under a separate commissioner contract.
Pre-pregnancy care	9.	Excludes pre-pregnancy/pre-conception care and reproductive services, payable through PbR or other contracts
Neonatal care	10.	Excludes neonatal pathways for unwell/unhealthy babies. Babies requiring inpatient treatment are admitted for care on their own admission record.
Critical care	11.	Excludes critical care. Critical care is payable separately on local contracts using the mandated critical care currencies and their published definitions.

Specialist services	12.	Excludes activity covered by any Specialist Service National Dataset Specification.
Non-maternity care	13.	Excludes all hospital activity that codes to non-NZ HRGs or non-obstetric/non-midwife TFCs for pregnant women.
	14.	Excludes activity that is the named responsibility of other professionals or providers who receive payment to deliver that care for the population (eg, drug and alcohol services, mental health services, stopping smoking services, weight management services etc).
	15.	The pathway covers the maternity care required to take into account these factors, to deliver the best-practice maternity care given those circumstances, advise on risks and best practice management in the context of the pregnancy, and referral to other relevant professionals where necessary for resolution if possible.
Ambulance transfers	16.	Excludes all Ambulance Trust transfer costs.
Accident and Emergency	17.	Excludes care provided to pregnant women as part of an unscheduled A&E attendance. A&E activity is paid through the A&E tariff.
Primary care	18.	Excludes all primary care activity applicable to payment under the GP Contract.
	19.	This does not exclude general practice from being part of a local maternity network for delivery of the pathway under Any Qualified Provider status. In these circumstances, a woman may choose some of her maternity pathway to be delivered by that provider, or for that provider to be the lead pathway provider.

PAYMENT AND BUSINESS RULES - ANTENATAL CARE

Commissioners only pay once per pregnancy	20.	A commissioner will make one payment per pregnancy for all antenatal care included in the scope.
	21.	Payment is based on the commissioner receiving information about the woman's health and social care assessment recorded from the booking appointment, assigning each woman to standard resource, intermediate resource or intensive resource payment pathway.
	22.	The information for the commissioner must include the woman's NHS number, GP Practice, date of the booking appointment and choice of maternity lead provider. If a woman does not have an NHS number, further information will need to be provided to the commissioner.
The tariff paid is dependent on the woman's health and social care complexities identified at the booking appointment.	23.	The level of payment is dependent on the pathway assigned – standard resource, intermediate resource, or intensive resource - based on the woman's health and social care complexities identified at the booking appointment.
	24.	The **Standard** casemix price has been developed taking into account that a) a proportion of women will develop complications during the pregnancy that will require higher levels of care, and b) some characteristics may develop or be disclosed later in the pregnancy.
Market forces factor is payable	25.	Commissioners pay the pathway price plus the market forces factor.
What if a woman receives some of her care from a different provider?	26.	Where a woman chooses to use a different provider for part of her care (e.g. a scan, an investigation or appointment etc), or where the woman is referred to a different provider for any reason, it is the responsibility of the pathway provider to pay the other organisation.
	27.	Prices will continue to be published for maternity activity. Published prices (see Q&A 2 - PbR HRGs including trim points and excess bed day charges, outpatient attendances, and prices for other pathway activities) should be used, plus MFF. Prices for activities that are

not covered by a published price should be agreed between the two organisations for any maternity care.

28. This payment mechanism will also be applicable if care is required while the woman is on holiday or unable to access her pathway provider and needs to access care from another NHS provider.

29. Providers should not attempt to claim NZ HRG payments or elements of maternity care costs from local commissioners. Invoices and contracts should be agreed between the relevant providers.

What if a woman permanently changes her lead pathway provider and/or commissioner?

30. A pathway change should lead to a transfer of funding between organisations – see Q&A 1.

31. The second provider may choose to reassess the woman's pathway at the time of transfer. If the current information suggests a higher resource pathway would be applicable, the pro-rata payment should be based on the value of the higher resource pathway.

What if a woman's pregnancy ends early?

32. The antenatal pathway payment is payable for all pregnancies where a booking appointment is undertaken.

33. Contracts should contain local outcome and quality measures to incentivise reducing the number of avoidable pregnancy losses.

34. Funding for terminations and miscarriages is paid via PbR through non-NZ HRGs.

What if a woman joins the pathway late?

35. It is the responsibility of commissioners and public health organisations to ensure women access maternity care as soon as they realise they are pregnant. Evidence shows that outcomes are worse for late entrants to the maternity pathway.

36. Providers and commissioners should agree thresholds in their contract for the proportion of known first trimester pregnant women who have a late booking appointment.

37. Providers should not be penalised for late entrants, although an antenatal payment is not payable for a woman who enters the system when in labour.

Two prices – "with" or "without" complications or comorbidities

The prices are set to account for all types of births and are subdivided by whether there are any complications or co-morbidities

38. There are two delivery pathway prices, split by whether there were complications and co-morbidities (CC) or not.

39. The prices set already take into account the higher-cost types of births, such as caesarean sections. The price includes all postpartum care of mother and well baby until transfer to community postnatal care.

40. The complications and co-morbidities are diagnosis codes based on ICD and are listed in the NHS Information Centre's Grouper documentation for Chapter NZ HRGs, covering list NZ_CC and the codes listed for postpartum surgery, list PP_Surgery.

Market forces factor is payable

41. The responsible commissioner pays the birth spell price plus the market forces factor.

Commissioners will pay the birth price according to coding

42. Providers will continue to code their delivery spells as now and payment will continue to be via SUS to the organisations that codes the birth.

43. Trim points and excess bed day charges will be published and will apply.

Pathway providers must not cherry-pick

44. A requisite of the licence to deliver maternity care is that all pathway providers must be able to provide all care, either themselves or with their partner organisations/within their network.

45. A provider must not decline pathway responsibility on the basis that the care or delivery may be expensive.

It is up to providers to agree a fair split of the income where care is shared

46. Commissioners will only pay once per intrapartum episode, to the organisation that delivers the baby/babies. This organisation is the lead provider financially responsible for the whole post-partum care period up to transfer of responsibility to community postnatal care.

47. The delivery spell payment includes all postpartum care up to the point of discharge to community postnatal care.

48. Where more than one provider shares the care (e.g., the

		woman delivers at one provider while another provides postpartum in-hospital care), it is the responsibility of the providers to agree a fair split of the income.

POSTNATAL CARE PATHWAY

Commissioners only pay once for community postnatal care after transfer	49.	A commissioner will make one payment for all postnatal pathway care included in the scope. In general this is after transfer from the intrapartum episode, but in some cases the specific care may be provided to a woman who remains in hospital because of other circumstances.
	50.	Payment is based on the postnatal lead pathway provider flowing information to the commissioner about the relevant characteristics and factors that assign each woman to their relevant pathway after discharge from postnatal care.
	51.	The information for the commissioner must include the woman's NHS number and the organisation that will be the lead postnatal provider. If a woman does not have an NHS number, further information will need to be provided to the commissioner.
	52.	Quality postnatal care is dependent on the postnatal provider having immediate access to information that stems from both the antenatal and intrapartum periods. It is the responsibility of providers to ensure this full information is available for every woman, irrespective who provides the postnatal care.
Market forces factor is payable	53.	Commissioners pay the pathway price plus the market forces factor.
What if a woman receives some of her care from a different provider?	54.	Where a woman chooses to use a different provider for an element of her postnatal care (an investigation, spell or appointment, etc), or where the woman is referred to a different provider for any reason, it is the responsibility of the lead pathway provider to pay the other organisation.
	55.	Prices will continue to be published for maternity activity.

Published prices (see Q&A 2 - PbR HRGs including trim points and excess bed day charges, outpatient attendances, and prices for other pathway activities) should be used, plus MFF. Prices for activities that are not covered by a published price should be agreed between the two organisations for any maternity care.

56. Providers should not attempt to claim NZ HRG payments or elements of postnatal maternity care costs from local commissioners other than the few instances recorded below. Instead they should invoice the relevant pathway provider.

Some major complications are paid separately through PbR

57. After the woman has been discharged to community postnatal care, NICE guidance identifies some potential postnatal complications that require immediate urgent acute care. These are listed below and are not included in the postnatal care pathway payment.

i. Intervention for postpartum haemorrhage
ii. Intervention for genital tract sepsis
iii. Intervention for venous thromboembolism
iv. Intervention for breast mastitis, abscess
v. Postnatal wound infection requiring surgery
vi. Pulmonary embolism

58. Payment will be based on PbR HRGs from coding. Usually these do not code to NZ HRGs.

59. Where these interventions are undertaken prior to discharge from hospital after the birth, their costs are already included within the birth payment. In these circumstances, providers are not able to claim payment for these interventions instead of, or in addition to, the birth payment.

60. Commissioners and providers should determine whether there are any activities during the maternity pathway that could reduce the incidence of such complications arising, or whether any local policies contribute to the incidence of complications arising. CQUIN or QIPP indicators could be developed locally.

Postnatal care ends when it is clinically safe to transfer responsibility from midwife-led care to

61. There is no defined time period during which community postnatal care is provided by the maternity team.

62. The pathway continues until responsibility for ongoing

primary care/health visitor		maternity health care is transferred to primary care / the health visitor.
	63.	All pathway care, as defined in NICE Guidance, including the 6-week postnatal care review if undertaken by the maternity team, is included in pathway payments even if ongoing maternity health care has already been transferred to primary care / the health visitor.
	64.	Commissioners should introduce local outcome and patient experience indicators to ensure the highest quality care and the timing for handover of responsibility is safe.

Q&A 1 : What happens if the woman changes their lead pathway provider and/or commissioner?

The estimated proportion of the pathway remaining unspent depending on the time a woman changes their pathway provider is given in Table 1 below.

This information has been developed through analysis of the pathway costing data provided by NHS Trusts and Foundation Trusts during Spring and Summer 2011.

Table 1: Proportion of pathway tariff to refund or transfer on change of pathway provider

Transfer time (gestational age)	Refund by Lead Provider A to Commissioner A / Payment to Lead Provider B by Commissioner B / Payment by Lead Provider A to Lead Provider B
Prior to 20 weeks 0 days	63%
Between 20 weeks 0 days & 24 weeks 6 days	48%
Between 25 weeks 0 days & 30 weeks 6 days	33%
Between 31 weeks 0 days & 35 weeks 6 days	20%
After 36 weeks 0 days	10%

Refunds to commissioners are on the basis of the original categorisation at the booking appointment i.e., if the original payment was "standard", the proportion of refund is based on the standard payment tariff.

Transfers to new lead pathway providers are on the basis of the latest information i.e., if the original payment was "standard", but there was the onset of (for example) gestational diabetes prior to transfer, this means the new provider is entitled to a payment based on a proportion of the "Intensive" payment amount.

The same method can be used between providers and commissioners for the initial transfer over of payment systems as at April 2013 for women who are already undertaking their pregnancy pathway.

Examples are provided below to aid understanding of this issue.

Example 1

Woman categorised as Standard based on Booking Appointment information	Payment of e.g., £1,200 for Standard antenatal care by commissioner A to provider A after Booking Appointment
Woman develops gestational diabetes week 23	Onset of gestational diabetes (diabetes is one of the "Intensive" factors)
Woman moves house in week 29, new provider and new commissioner	Change in commissioner and provider
Refund	Provider A refunds 33% of Standard payment of £1,200 to Commissioner A - £400
New Payment	Payment of 33% of Intensive payment (e.g., £3,000 * 33% = £1000) from Commissioner B to Provider B

Example 2

Woman categorised as Standard based on Booking Appointment information	Payment of e.g., £1,200 for Standard antenatal care by commissioner A to provider A after Booking Appointment
Woman develops gestational diabetes week 23	Onset of gestational diabetes (one of the "Intensive" factors)
Woman moves lead provider in week 29, no change in commissioner	Change in provider
Payment transfer	Lead Provider A pays 33% of Intensive tariff (e.g., £3,000 * 33% = £1000) to Lead Provider B

Q&A 2 : What happens if the woman chooses to use, or is referred to, a different provider than the lead pathway provider for an element of maternity care?

In these cases, it will be the responsibility of the lead pathway provider who has received the pathway tariff to pay the "sub-contracting" provider for the care they provided.

In some cases, one organisation undertakes the initial booking appointment but is not chosen as the lead pathway provider. Again, this organisation needs to be paid for its activity by the provider who receives the antenatal pathway payment.

These non-mandatory prices (excluding MFF) or sources in Table 2 are being made available for use when determining the amount to be invoiced and paid.

The Market Forces Factor of the provider delivering the care should be added to the payment.

Table 2: Pricing activity at other providers

Type of activity	Standard	Intermediate	Intensive
Booking Appointment	£ 187	£ 288	£ 288
Pathway Antenatal Check - with full blood count	£ 47	£ 47	£ 47
Pathway Antenatal Check - without full blood count	£ 28	£ 47	£ 47
Pathway Postnatal Check	£ 42	£ 46	£ 46
Pathway ultrasound scans	Use PbR Outpatient Procedure prices		
Outpatient attendances	Use PbR Outpatient Attendance prices		
Outpatient procedures	Use PbR Outpatient Procedure prices		
Inpatient spells	Use PbR Admitted Patient Care HRG prices		
Drug and device costs excluded from PbR	Excluded from PbR - payable separately		
Critical Care	Excluded from PbR - payable separately		

Q&A 3 : When does the lead provider need to return information to trigger payment?

The Department is not being prescriptive in this area, although the same reconciliation process timetable as used in SUS PbR could be followed.

Monthly payments between commissioners and providers will continue to be made based on contracted plans, and your local agreement will determine your local process for reconciling the level of actual payment.

Q&A 4 : What about women who double-book?

Commissioners will only pay one lead provider per woman for each of the three modules (antenatal care, birth spell, postnatal care) of the maternity pathway on the basis of their NHS number (or other personal information where an NHS number is unable to be found or acquired).

Providers will need to put in place mechanisms to assure themselves that the woman has not already commenced a pathway and chosen a different lead provider.

Where a woman has double-booked and both providers believe they are the lead provider, the commissioner and respective providers will need to coordinate with the woman who is delivering her care and is lead provider.

Q&A 5 : What if a woman requires elements of care as defined in Specialised Services National Definitions Sets (SSNDS)?

The specialised services defined in the published datasets are outside the pathway payment system and commissioning should continue to be agreed as now between tertiary providers and their Specialised Commissioning Group (SCG).

Payment for specialised services care should not be claimed from the lead provider, but should be claimed from the relevant SCG.

Q&A 6 : What if a woman requires all her care to be delivered by a tertiary centre because of characteristics defined in the Specialised Services National Definitions Sets (SSNDS)?

In these circumstances, the tertiary centre is the lead pathway provider and is entitled to the relevant pathway payment and then specific care as defined in the SSNDS is payable via the SCG.

Q&A 7 : What if a woman receives all her postnatal care while she is still in hospital?

Commissioners should be aware that there is an expectation to pay all 3 modules of the pathway for each pregnancy that leads to a birth.

If the pathway postnatal care happens to be provided while the woman remains in hospital, the provider remains entitled to payment for that element of the pathway.

Q&A 8 : What about payments for the birth and postnatal modules for still births?

Both the birth payment and the postnatal payment remain applicable for all births that reach the requisite definitional threshold of gestation age.

Q&A 9 : What are the complications and co-morbidities that trigger the higher level of birth payments?

The list of complications and co-morbidities is reproduced below in Table 3.

This list is used in the current allocation of PbR HRGs, and is published by the NHS Information Centre as part of its Casemix products suite.

Table 3 : ICD Codes of Complications and Comorbidities in Maternity

List NZ_CC

O10.1 Pre-exist hyperten heart dis comp preg childbth and puerp
O10.2 Pre-exist hyperten renal dis comp preg childbth and puerp
O10.3 Pre-exist hyperten heart renal dis comp preg chdbth/puerp
O10.4 Pre-exist sec hypertens comp preg childbth and puerprum
O10.9 Unspec pre-exist hypertens compl pregn childbth puerprum
O11.X Pre-exist hypertens disorder with superimposed proteinuria
O14.0 Moderate pre-eclampsia
O14.1 Severe pre-eclampsia
O14.9 Pre-eclampsia, unspecified
O15.0 Eclampsia in pregnancy
O15.1 Eclampsia in labour
O15.2 Eclampsia in the puerperium
O15.9 Eclampsia, unspecified as to time period
O16.X Unspecified maternal hypertension
O22.3 Deep phlebothrombosis in pregnancy
O24.0 Pre-existing diabetes mellitus, insulin-dependent
O24.1 Pre-existing diabetes mellitus, non-insulin-dependent
O24.2 Pre-existing malnutrition-related diabetes mellitus
O24.3 Pre-existing diabetes mellitus, unspecified
O24.4 Diabetes mellitus arising in pregnancy
O24.9 Diabetes mellitus in pregnancy, unspecified
O26.2 Pregnancy care of habitual aborter
O26.6 Liver disorders in pregnancy, childbirth and the puerperium
O26.7 Sublux of symphysis (pubis) in preg childbirth and puerp
O30.0 Twin pregnancy

O30.1 Triplet pregnancy
O30.2 Quadruplet pregnancy
O30.8 Other multiple gestation
O30.9 Multiple gestation, unspecified
O42.2 Premature rupture of membranes, labour delayed by therapy
O43.0 Placental transfusion syndromes
O43.1 Malformation of placenta
O43.8 Other placental disorders
O44.0 Placenta praevia specified as without haemorrhage
O44.1 Placenta praevia with haemorrhage
O45.0 Premature separation of placenta with coagulation defect
O45.8 Other premature separation of placenta
O45.9 Premature separation of placenta, unspecified
O46.0 Antepartum haemorrhage with coagulation defect
O60.X Preterm delivery
O67.0 Intrapartum haemorrhage with coagulation defect
O67.8 Other intrapartum haemorrhage
O67.9 Intrapartum haemorrhage, unspecified
O70.2 Third degree perineal laceration during delivery
O70.3 Fourth degree perineal laceration during delivery
O71.0 Rupture of uterus before onset of labour
O71.1 Rupture of uterus during labour
O71.2 Postpartum inversion of uterus
O71.6 Obstetric damage to pelvic joints and ligaments
O71.7 Obstetric haematoma of pelvis
O71.8 Other specified obstetric trauma
O72.0 Third-stage haemorrhage
O72.1 Other immediate postpartum haemorrhage
O72.2 Delayed and secondary postpartum haemorrhage
O72.3 Postpartum coagulation defects
O73.0 Retained placenta without haemorrhage
O73.1 Ret portions of placenta and membranes without haemorrhage
O74.0 Asp pneumonitis due to anaesthesia during labour and deliv
O74.1 Other pulmonary comps anaesthesia during labour and deliv
O74.2 Cardiac comps of anaesthesia during labour and delivery
O74.3 CNS comps of anaesthesia during labour and delivery
O74.4 Toxic reaction to local anaesthesia during labour and deliv
O74.5 Spin and epidural anesth-induced headache dur lab/deliv
O74.6 Oth comps of spinal and epidural anaesthesia dur lab/deliv
O74.7 Failed or difficult intubation during labour and delivery
O75.0 Maternal distress during labour and delivery
O75.1 Shock during or following labour and delivery
O75.2 Pyrexia during labour, not elsewhere classified
O75.3 Other infection during labour
O75.4 Other complications of obstetric surgery and procedures
O85.X Puerperal sepsis
O86.0 Infection of obstetric surgical wound
O86.1 Other infection of genital tract following delivery
O86.2 Urinary tract infection following delivery
O86.3 Other genitourinary tract infections following delivery
O86.4 Pyrexia of unknown origin following delivery
O86.8 Other specified puerperal infections
O87.1 Deep phlebothrombosis in the puerperium
O88.0 Obstetric air embolism
O88.1 Amniotic fluid embolism
O88.2 Obstetric blood-clot embolism
O89.4 Spinal/epidural anaesth-induced headache during puerp
O89.5 Oth comps of spinal and epidural anaesthesia during puerp
O90.0 Disruption of caesarean section wound
O90.1 Disruption of perineal obstetric wound

O90.2 Haematoma of obstetric wound
O90.3 Cardiomyopathy in the puerperium
O90.4 Postpartum acute renal failure
O98.4 Viral hepatitis comp pregnancy, childbirth & the puerperium
O99.2 Endocrine nutritional metabolic dis comp preg birth puerp
O99.3 Mental disord dis of nervous system comp preg/birth/puerp
O99.4 Dis circulatory sys comp pregnancy, childbirth/puerperium
O99.5 Dis resp syst comp pregnancy, childbirth & puerperium
R06.0 Dyspnoea
R07.3 Other chest pain
R07.4 Chest pain, unspecified
R33.X Retention of urine
R75.X Laboratory evidence of human immunodefiency virus [HIV]
T81.0 Haemorrhage and haematoma complicating a procedure NEC

List PP_Surgery – Procedure Code indicating Postpartum Surgery

R28.1 Curettage of delivered uterus
R28.8 Other specified instrumental removal of products of conception from delivered uterus
R28.9 Unspecified instrumental removal of products of conception from delivered uterus
R29.1 Manual removal of placenta from delivered uterus
R29.8 Other specified manual removal of products of conception from delivered uterus
R29.9 Unspecified manual removal of products of conception from delivered uterus
R30.3 Instrumental exploration of delivered uterus NEC
R32.1 Repair of obstetric laceration of uterus or cervix uteri
R32.2 Repair of obstetric laceration of perineum and sphincter of anus
R32.5 Repair of obstetric laceration of perineum and sphincter and mucosa of anus

Q&A 10 : Will this system lead to hospitals refusing to refer women to appropriate pathways in other organisations for important complications?

The payment itself is only one aspect of the system. Commissioners will need to judge providers on their outcomes, quality and patient experience and implement penalties and incentives.

It will prove a false economy to organisations to prevent required care or choice from being delivered.

Q&A 11 : Isn't this new system just a way of cutting costs?

No. This system ensures that the full costs of maternity care are taken into account in the pricing methodology.

This new system gives providers the opportunity to revisit how they deliver their care from a more proactive and woman-centred focus within the full envelope of funding.

The Department will not be telling providers how to deliver their care, but will solely judge providers on the results of their care.

The NHS Institute for Innovation and Improvement has produced a number of strategies for improving maternity care, and these are available at http://www.institute.nhs.uk/quality_and_value/introduction/improving_maternity_care.html