



Department  
of Health

# Payment by Results Q&A for 2013-14

July 2013

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## Background

The Payment by Results (PbR) guidance for 2013-14 and supporting materials at <https://www.gov.uk/government/organisations/department-of-health/series/payment-by-results-2013-14> will enable organisations to operate PbR and the national tariff in 2013-14. We have provided the following Q&As in response to:

- feedback during the road test of the tariff and guidance between 19 December 2012 and 25 January 2013 which we were not able to address in the guidance
- questions sent to our PbRComms mailbox since the publication of the final PbR package on 28 February 2013
- feedback at the Healthcare Financial Management Association (HFMA) PbR event on 26 March 2013.

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

With this in mind, further questions about PbR in 2013-14 should be directed to [PbRComms@dh.gsi.gov.uk](mailto:PbRComms@dh.gsi.gov.uk).

2013-14 is the final year for which the Department was responsible for developing the national tariff. Monitor and NHS England have responsibility for the tariff, currency design and price setting for future years.

References to paragraph numbers are to paragraphs in the PbR guidance for 2013-14.

## Emergency readmissions

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

A: Both those patients that have been readmitted subsequent to a transplant and those receiving renal dialysis are excluded from the emergency readmissions policy in 2013-14. Commissioners and providers should determine locally which activity should/should not be covered by this exclusion.

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

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

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

Q3: For organisations that have not yet agreed the amount of non-payment for emergency readmissions in 2013-14, how should the threshold from the clinical reviews be operationalised?

A: This should be determined locally but all clinical reviews (where they are to be undertaken again for 2013-14) should be completed by the end of Q1. Organisations could choose to roll over arrangements from 2012-13 until the review takes place and make a retrospective adjustment to payments following a reconciliation.

## Marginal rate

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

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

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

A: This was discussed in planning for the 2013-14 tariff and it was decided not to change the baseline year for this year.

Q6: How can we group historic data for business planning purposes or calculation of the marginal rate through the 2013-14 local payment grouper?

A: Some historic data may 'error' when run through the 2013-14 local payment grouper owing to the changes to the ICD10 codes that were implemented in the groupers from 2012-13. Where this causes an issue for organisations locally they may wish to use some other means to group the data.

## Diagnostic imaging

Q7: The PbR guidance talks about accessing iView and iRefer to support work on diagnostic imaging. How do independent sector organisations gain access to these systems?

A: At the moment anyone who submits data to the Diagnostic Imaging Dataset is given automatic access to the 'DID submitter view' and 'DID community view' within iView. The submitter view gives the data they have provided and the community view gives data for all organisations. Anyone else within the organisation wishing to get their own access to iView needs to get a sponsor from the NHS, and we would suggest contacting one of your commissioners about this.

As the PbR guidance sets out, access to iRefer is available to NHS providers and commissioners. This is because the NHS (not the Department of Health) has paid to have this access. Independent sector providers will need to arrange their own access to iRefer through the Royal College of Radiologists.

Q8: The PbR guidance says that we should use the mapping on TRUD to convert NICIP imaging codes to OPCS4 procedure codes, in order to use the grouper. What should we do if we think there is a problem with the mapping held on TRUD?

A: If you think there is a problem with the mapping between NICIP and OPCS4 codes for a particular type of scan, please contact the Classification Service's helpdesk on [Datastandards@nhs.net](mailto:Datastandards@nhs.net) and mark the enquiry as Imaging or NICIP.

## Best practice tariffs

Q9: Are all Best practice tariffs (BPTs) structured the same way?

A: There is no 'one-size fits all' approach to the development of a BPT. Each BPT is priced and/or structured independently in order to improve 'Quality' and 'Value for Money' for the chosen service area.

Q10: Why are some BPTs at a sub-HRG level?

A: In order to target specific activity / codes within a HRG it is sometimes necessary to apply the best practice tariff price at a sub-HRG level.

In these circumstances, the Grouper generates an identification flag for the relevant HRG/ICD/OPCS-4 codes. Further information on the BPT flags can be found in the *tariff information spreadsheet*.

Q11: What changes have been made to the BPT flags and BPT sections of the tariff information spreadsheet?

A: There are several changes to the operation of BPT flags in 2013-14. These are:

- the Grouper will only generate a BPT flag for the HRGs relevant to the BPT;
- the Grouper and SUS PbR will generate a BPT flag for all of the same day emergency care BPTs, irrespective of whether the tariff applies at the sub-HRG level, in order to facilitate the consistent automation of payment within SUS PbR;
- the format of the BPT flag sheet has been amended to more closely reflect the HRG Code to Group spreadsheet issued by the Health and Social Care Information Centre (HSCIC).

Q12: The list of trigger codes for BPT flags is available in the PbR documentation. How is this implemented in the grouper?

A: As a part of the 2013-14 Local Payment Grouper documentation the Health and Social Care Information Centre published a document called "HRG4 2013/14 Local Payment Grouper Guide to Best Practice Flags". This details all of the various different logic steps in the generation of the BPT flags. Please note that details for some of the flags does differ from the list contained in the tariff information spreadsheet, this is owing to how the flags have been implemented in the grouper (in particular to take account of the hierarchy where multiple BPTs have the same HRG eligibility) and will not impact on which trigger codes generate which flags. This document is available from the HSCIC website: <http://www.hscic.gov.uk/article/2580/HRG4-201314-Local-Payment-Grouper>

Q13: Are all BPTs mandatory?

A: With the exception of the Cataracts BPT, all the BPTs are mandatory for payment. This means that where a provider satisfies the BPT criteria detailed in the guidance, then the commissioner should pay the BPT price.

The Cataracts BPT is non-mandatory for 2013-14 to reflect feedback from the service in relation to the operational issues described in paragraph 352 of the 2013-14 Guidance.

Q14: Where a provider and commissioner have a locally agreed best practice service and this differs from the BPT criteria, which takes precedence?

A: The introduction of a BPT is intended to support innovation in service delivery. Where there are existing locally agreed examples of best practice we would expect these to continue irrespective of the introduction of a BPT, unless this is contradictory to the BPT criteria.

Where we are aware of existing local examples of best practice, we have tried to reference these in the supporting guidance for the relevant BPT area. A good example of this is the BPT for Same Day Emergency Care. We are aware that some providers have already implemented best practice in this area, providing ambulatory care outside of the traditional hospital bed base.

To ensure that this can continue and be adequately reimbursed, we would expect that there would be a local arrangement for funding.

Providers and commissioners should refer to section 13 of the 2013-14 PbR guidance for further information around potential flexibilities that are applicable to the national tariff, including best practice.

Q15: What are the new BPT areas for 2013-14?

A: There are six new areas for 2013-14 as follows:

- Diabetic Ketoacidosis and hypoglycaemia
- Early inflammatory arthritis
- Endoscopy procedures
- Paediatric Epilepsy
- Parkinson's Disease
- Pleural Effusion

Further information on each of these can be found in section 8 of the *PbR guidance for 2013-14* and in the *tariff information spreadsheet*.

Q16: Why are there new BPTs that are outside of SUS, as this increases admin burden?

A: It has been our intention in selecting and developing BPT areas to minimise any additional administrative burden that is placed on organisations to operate BPTs.

All proposals are discussed with PbR advisory groups and stakeholders to understand and minimise the additional burden prior to any BPT being implemented.

Each of the BPTs is monitored and reviewed annually to address feedback from the NHS ahead of future tariff cycles. See question 5 for an example of where we have amended a BPT to reflect such feedback.

Q17: In light of NHS England requirements for reporting major trauma activity to the Trauma Audit and Research Network (TARN) in 25 calendar days of discharge, has the reporting timeframe for achieving the major trauma best practice tariff changed?

A: No, the reporting timeframe for TARN data for the BPT is within 40 days of discharge.

Q18: Who should we contact where there are disputes over meeting BPT criteria?

A: In the majority of circumstances, we would anticipate that these disputes would be resolved locally. Should there be any questions relating to the 2013-14 tariffs that require further clarification then please direct these to the PbR Comms mailbox:

[pbrcomms@dh.gsi.gov.uk](mailto:pbrcomms@dh.gsi.gov.uk)

## Exclusions

Q19: While NICE guidance on drugs is in draft form, is the cost outside of tariff?

A: Unless a drug is excluded, or is used within an excluded service, it is still in the scope of tariff even before it has been considered by NICE. Drugs which are introduced without



consideration by NICE or in advance of NICE guidance are funded through the general inflation uplift.

Q20: Are drugs on the exclusion list also excluded from non-mandatory prices?

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

Q21: How should we manage the funding of drugs when they are also part of a patient access scheme that proposes a discount, rebate or other variation from the list price of a medicine?

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

Q22: If a drug is not listed as an exclusion from PbR, can commissioners and providers still agree extra funding for the drug?

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

Q23: Have you excluded drugs that are used to treat the side effects of chemotherapy drugs?

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

Q24: Are supportive drugs for chemotherapy excluded from PbR?

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

Q25: Are hormonal or hormone antagonist drug treatments for cancer excluded from PbR?

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

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

Q26: We use botulinum toxin for a variety of conditions. You have excluded drugs used to treat torsion dystonias and involuntary movements without listing particular drugs. Do we have to request prior approval for the use of botulinum toxin?

A: Commissioners and providers should agree payments for excluded drugs used for particular indications. Our exclusions list indicates that all drugs in BNF section "4.9.3 > Torsion dystonias and other involuntary movements", which includes botulinum toxin, are

excluded. Therefore, botulinum toxin is excluded for any indication. Whilst we understand that there is often overlap between prior approvals schedules and PbR exclusions, the two should not be confused and should ultimately act independently of each other ie exclusions relate to payment issues and are subsequent to prior approvals schemes which relate to pathway issues.

Q27: Parenteral nutrition is excluded after 14 days or when the patient is receiving parenteral nutrition prior to admission. What does this mean?

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

Q28: Can you clarify your statement in the guidance that “all blood products are excluded from PbR regardless of whether or not they are listed in the BNF”?

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

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

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

Q29: Capsaicin patch (Qutenza) is not listed as an exclusion but the cost of this preparation is more than the tariff. Should this treatment be excluded?

A: No. Under PbR, cost of drugs, that are not excluded, are averaged out over tariffs. Where providers charge PbR tariff and when the income of the provider is based on a range of specialties, such costs of drugs will not materially change the value of the tariff. Where providers and commissioners re-design a service (which may change or reduce the activity charge) OR where a provider sees a disproportionately high number of patients requiring a particular treatment, providers and commissioners may agree appropriate additional remuneration, under local flexibilities, as outlined in PbR Guidance.

Q30: Please can you help us understand section 619 of the guidance relating to complex cardiac ablation procedures as it is unclear what excluded activity can be charged for and under what heading?

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

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

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

should read:

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

Q31: Are TFCs 199 and 499 excluded from PbR?

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

## Maternity pathway payments

Q32: Can a woman be allocated to a different pathway during the antenatal period if circumstances change?

A: Women are allocated to the antenatal pathway on the basis on information gathered at the antenatal assessment visit and its associated tests/scans. Most of the factors that trigger the intermediate or intensive pathway relate to existing medical conditions or disabilities, complex social factors or problems associated with previous pregnancies. Information about all of these should be available at the booking visit. The only factor affecting allocation associated with the current pregnancy is whether or not it is a multiple pregnancy. This will be determined by the first scan.

Some women develop complications during their pregnancy that mean that their care is more expensive than could have been predicted at the assessment visit. The tariff for the standard pathway has been calculated to take account of this. It is an average of the cost of care for the bulk of women whose care is standard and the minority who develop a complication.

Q33: What about early pregnancy units?

A: The antenatal pathway starts at the assessment visit. Most early pregnancy attendance activity, including Ectopic Pregnancy, is coded to TFC 502 and is excluded from the pathway. Early pregnancy procedures and admissions code the MA\* HRGs and are also

excluded. This activity will be reimbursed separately from the pathway payments. Attendance activity coded to TFC501 or 560 and all NZ HRGs whatever the Treatment Function Code are included in the pathway payments and should not be reimbursed separately.

Q34: When are the antenatal payments triggered?

A: Payment for the antenatal pathway is based on the commissioner receiving the information from the provider on which the allocation to the pathway is based from the lead provider. When the Maternity Information System is fully operational, this will be when the deadline for the activity period in which the assessment visit has taken place is reached. The payment is due, whether or not the pregnancy continues to term.

Q35: Does this mean that providers will receive extra income in the transitional year for maternity services?

A: Yes. Providers may continue to be paid under the old system for women who had already started their antenatal care on 31 March 2013. Payments will also be due for all women who start their antenatal pathway between April 2013 and March 2014 (where information has been submitted by the lead provider). Since these payments are due on submission of the information and are not when all the care is delivered, this will inevitably mean that in the financial year 2013-14 trusts will be due more payments than usual. Providers and commissioners will need to manage this impact on their income/expenditure through flexibilities.

Q36: Who is the lead provider?

A: In many areas, provision of antenatal care is shared between providers. Under the new system there can only be one lead provider. The payment will be made to the lead provider on submission of the information gathered at the antenatal assessment visit. Determining which provider should be the lead must be a local issue. To guide discussions, however:

- the lead provider should have overall accountability for the care provided to the commissioner, with any other provider accountable for any care delivered to the lead provider.
- the lead provider will submit the information from the assessment visit, and it will therefore be easiest if the provider with this information acts as the lead provider.

## Mental health

Q37: Have there been any developments on the algorithm to assign users to clusters?

A: A national algorithm has been published with the 2013-14 PbR guidance. In testing it assigned to the correct cluster with a high degree of accuracy. We will be seeking feedback from users of the algorithm during the year to agree what further amendments may be required.

Q38: The use of an algorithm could cause problems if the clinician disagrees with the assignment, what should we do?

A: The clinician's decision is the final one, and the algorithm is only a tool to help support that decision. However, organisations should put in place their own quality assurance procedures to review clustering decisions, and to improve confidence in the use of the clustering tool. The Audit Commission work on data assurance with mental health providers and commissioners makes recommendations about steps that should be put in place to improve data quality.

Q39: What is the right level of compliance with assigning service users to clusters using the clustering tool and its rules?

A: There is no right level as the clinician's decision is final. However, experience shows that for many clusters around 80 per cent of service user scores will match the suggested cluster profile. We will be undertaking further analysis on this subject.

Q40: Is there anyone we can speak to for help with the costing process?

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

Q41: Where should costs incurred before the initial assessment to clusters be coded?

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