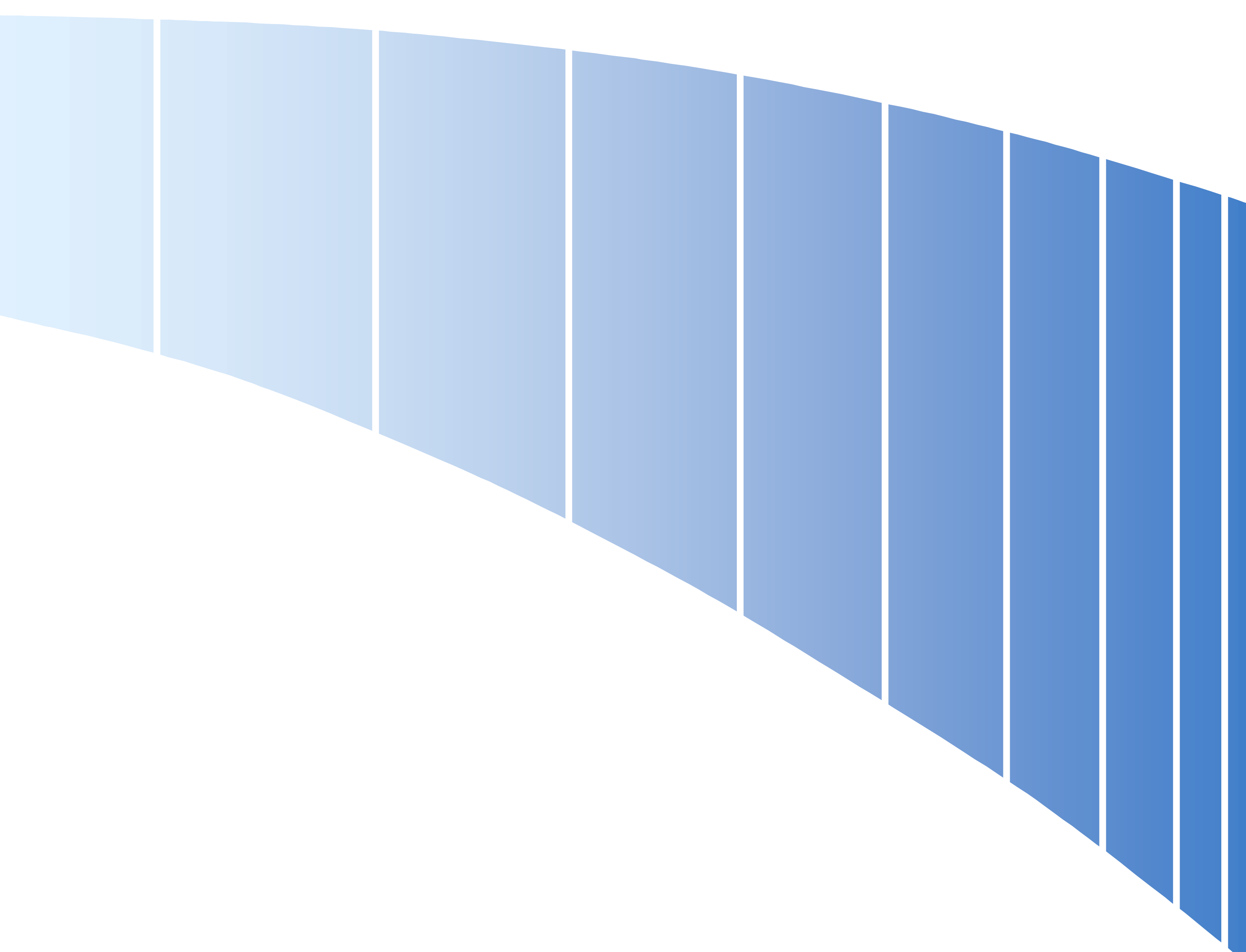
NHS

Payment by Results FAQs for 2011-12



Department of Health

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Contents

Contents 3
Background 4
Admitted patient care 5
Emergency readmissions 5
Outpatient care 11
Urgent care 11
Best practice tariffs 12
Exclusions 14
Non-mandatory prices 17
Dialysis away from base 18
Other operational issues 20

Background

The Payment by Results (PbR) guidance for 2011-12 and supporting materials at www.dh.gov.uk/pbr will enable organisations to operate PbR and the national tariff in 2011-12. We have provided the following frequently asked questions (FAQs) and answers in response to:

- feedback during the road test of the national tariff between 22 December 2010 and 21 January 2011 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 18 February 2011
- feedback at the Healthcare Financial Management Association (HFMA) PbR event on 1 March 2011.

As we noted in the guidance, it is neither desirable nor possible for this 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 should be directed as follows:

- PCTs and NHS trusts should contact their SHA PbR leads[1]
- NHS foundation trusts, SHAs and other organisations should contact the PbR team via PbRComms@dh.gsi.gov.uk.

References to paragraph numbers are to paragraphs in the PbR guidance for 2011-12.

[1] www.dh.gov.uk/en/Managingyourorganisation/Financeandplanning/NHSFinancialReforms/DH_4000363

Admitted patient care

Q1. The clinical coding for a baby admitted solely because its mother has been admitted for care is Z76.2 (persons encountering health services in other circumstances) which groups to HRG WA13Y (convalescent or other relief care). Can we charge our commissioner the WA13Y tariff for the baby's care?

A1. No. The cost of caring for the baby should be recorded against the mother's HRG costs. The admission for the baby is for administrative purposes not for healthcare, and there should be no charge against the commissioner. The same happens when a baby is admitted and the parent gets a bed. The system must account for the bed but there is no justification for reimbursement against an HRG for the costs incurred against the adult. Note also that the WA13 HRGs have been removed from the 2009-10 Reference Costs Grouper and will therefore be unavailable for the 2012-13 tariff.

Q2. What responsibilities do hospitals have to supply drugs to patients on discharge?

A2. The issue of supply of drugs to patients on discharge from hospital is being reviewed in the context of the transfer to acute providers from 2012-13 of the responsibility and funding for patients in the 30 days after discharge. In the meantime, practice should be informed by National Prescribing Centre guidance[2] and by local interface prescribing policies.

Q3. How does the tariff recognise outreach services, where a tertiary care provider sends a team to a secondary care provider to provide specialised children's care?

A3. The tariff is not able to recognise this scenario. We recommend that a specialised service top-up payment is made to the secondary provider when the tertiary provider is on the eligibility list and regardless of whether the secondary provider is on the eligibility list. Both organisations will then need to negotiate payment locally, recognising that both incur costs.

Emergency readmissions

Q4. Can you clarify the following statement from paragraph 60 of the guidance: "where commissioners accept that a readmission is clearly unrelated, they may also continue to reimburse providers"?

A4. In 2010 the Government signalled its intent that hospitals would not be paid for any emergency readmissions within 30 days. Despite taking extensive advice from NHS clinicians and managers, we concluded it is not possible to have certainty about which readmissions will or will not be related to the original admission. Even after allowing for the service exclusions from the policy, there will still be obvious anomalies. For example, a healthy young man who breaks his neck playing rugby requiring £50,000 of critical care, two weeks after a routine day case operation.

The intention behind this flexibility is that where commissioners accept that a readmission is clearly and unambiguously unrelated and material, they will exceptionally continue to reimburse providers. This is not in any way intended and

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[2] *Payment by Results and medicines* (September 2010) available at www.npc.nhs.uk/local_decision_making/resources/PbR.pdf

nor should providers use it as an opportunity to establish processes to systematically review readmissions and make representations as to why the policy should be waived for a majority of readmissions. Our expectation is that the application of this flexibility should be limited to a small number of high cost readmissions following electives.

Where a commissioner accepts the provider's view that a readmission is clearly unrelated to the original admission, they must pay the provider.

Where a commissioner does not share the provider's view that a readmission is unrelated to the original admission, the commissioner has the discretion not to pay for the readmission.

These principles apply whether the readmission was at the same provider as the first admission, or whether the readmission was at a different provider. These principles also apply to non-contract as well as contract activity.

Both commissioners and providers must act in good faith and not lose sight of the policy goals:

- of ensuring that patients receive the best possible pre- and post-discharge care so that the need for readmission diminishes,
- of reinvesting savings in post-discharge support and
- of minimising management and transactional costs.

Q5. Does the maternity and childbirth exclusion at paragraph 59(b) include problems in early pregnancy, miscarriage and other ICD-10 codes between O00 and O99?

A5. No. It includes only initial admissions or readmissions in HRG subchapter NZ.

Q6. Does the maternity and childbirth exclusion at paragraph 59(b) include activity in TFC 501 (obstetrics), TFC 502 (gynaecology), or TFC 560 (midwife episode)?

A6. No. It includes only initial admissions or readmissions in HRG subchapter NZ.

Q7. Can you clarify the cancer exclusion at paragraph 59(c) "where the initial admission or readmission includes a spell first mentioned or primary diagnosis of cancer (ICD-10 codes C00-C97 and D37-D48)?"

A7. We mean where cancer is the primary diagnosis in the PbR spell.

Q8. Does the cancer exclusion at paragraph 59(c) include spells where cancer is not in the primary diagnosis position?

A8. No. The clinical advice we have received is to limit rather than extend this exclusion in future years.

Q9. Does the cancer exclusion at paragraph 59(c) include other activity in TFC 370 (medical oncology)?

A9. No. The clinical advice we have received is to limit rather than extend this exclusion in future years.

Q10. In relation to the transport accidents exclusion at paragraph 59(f), ICD-10 codes in higher positions than spell secondary diagnosis are not available in the SUS PbR spell extract. How should we identify these?

A10. For spells with more than one secondary diagnosis code (identified by the field

NUMBER_DIAGNOSIS), users will need to look at the SUS PbR episode extract or supplementary extract.

Q11. Can you clarify the exclusion for cross border activity?

A11. The readmission policy only applies where the admission and readmission take place in a hospital in England AND the patient's responsible commissioner is in England (including where residency is in Wales and GP registration is in England).

Q12. Are renal dialysis patients excluded from the 30 day emergency readmissions non-payment rules?

A12. Renal dialysis does not have a national tariff in 2011-12. It has a mandatory currency with a mandatory 50% transition to national tariff in 2011-12. It will have a mandatory national tariff in 2012-13. It is therefore excluded, as is any readmission which does not have a national tariff.

Renal dialysis patients are not excluded from the policy. Therefore, if a patient is regularly attending three times a week for dialysis and requires an emergency admission at any time, then this would be a readmission which in theory would not receive payment. But the commissioner discretion at paragraph 60 applies equally to renal dialysis patients as to other patient groups.

Q13. Are readmissions following an elective diagnostic procedure excluded?

A13. No, unless the readmission falls into one of the exempt categories listed in the guidance.

Q14. Does the following sentence at paragraph 55 – "for clarity, readmissions following outpatient procedures or A&E attendances are excluded from this rule" – mean that the readmission rule does not apply when there is an A&E or outpatient attendance between the admission and readmission spells?

A14. No. The purpose of this sentence is to remind organisations that outpatient procedures and A&E attendances do not constitute an admission. If an outpatient procedure or A&E attendance is sequenced between an emergency readmission and an admission in the previous 30 days, this does not itself exclude the readmission from the application of the rule.

Q15. Are community hospitals excluded from the readmissions rules?

A15. Community hospital is an ill defined term. The policy applies to patients whose care is reported and coded to generate an HRG which is then used as a basis for payment, and which is covered under a standard NHS contract.

Q16. What additional rules should we adopt to exclude emergency transfers of an admitted patient from another provider (included in admission method code 28, which also includes other admissions)?

A16. This is a local decision. East Midlands have implemented the following additional rules to flag emergency transfer activity:

The Discharge Date of the source spell (at the transferring provider) is equal to the Admission Date of the transfer spell (at the receiving provider)

AND EITHER

The Discharge Destination on the source spell (as recorded by the transferring provider) indicates the patient has transferred to another provider AND the Admission Source on the transfer spell (as recorded by the receiving provider) indicates that the patient has transferred from another provider, irrespective of which emergency Admission Method code is record (21, 22, 23, 24, 25 or 28).

OR

The Admission Source on the transfer spell (as recorded by the receiving provider) indicates that the patient has transferred from another provider AND the emergency Admission Method code 28 has been used

For any spells which have been identified as an emergency transfer based on the above rules, then the transfer spell (at the receiving provider) is only flagged as being a 30 day emergency readmission if the source spell (at the transferring provider) has itself been flagged as a 30 day emergency readmission.

Q17. Should patients for whom we have agreed a year of care tariff be excluded from the threshold rate?

A17. Yes.

Q18. How should we calculate the year of care tariffs suggested at paragraph 64?

A18. A year of care tariff is not supposed to be simply the sum of all expected admissions but a considered estimate of the cost of providing a care package for that patient which would have, as one of its aims, reducing the number of admissions to hospital. Personal healthcare budgets are a good model, because they have a mix of social and healthcare funding based on limited numbers of complex patients that span acute and social care. Pending more sophisticated approaches to identifying patient need over a given period of time, it is acceptable for commissioners and providers to estimate and agree an anticipated number of admissions per year. Once agreed, we would expect these year of care tariffs to be fixed and not subject to an end of year adjustment for actual activity.

Q19. Paragraph 58 allows for the total price associated with the continuous inpatient readmission spell to be withheld or recharged. If this includes a transfer with costs that are part of block contract (e.g. rehabilitation), what cost should be attached to the continuous inpatient readmission spell?

A19. Where there is a currency for these associated costs, then local prices or reference costs should be added to the total price. Otherwise, this is for local agreement.

Q20. How do we group all the admissions into one continuous inpatient spell? Can you please give an example?

A20. This could be achieved by grouping spells that are for the same patient into chronological order and identifying spells where there is no break (i.e. same dates of admission and discharge).

Q21. Should the local threshold rate for emergency readmissions following non-elective admissions be calculated and implemented based on activity or the monetary contract value of that activity?

A21. The policy is about reducing the number of readmissions, not reducing the cost of readmissions (e.g from £4 million to £3 million) irrespective of their number. In practice this means applying a percentage threshold rate to current year non-elective

admissions that delivers at least a 25% reduction on the previous year's readmission rate. Table 1 illustrates. Provider 1 will not be paid for spell number 751 onwards, provider 2 from spell number 601, and provider 3 from spell number 1,126.

Table 1: Setting the threshold rate

		Provider 1	Provider 2	Provider 3
A	Baseline non-electives	10,000	10,000	10,000
B	Emergency readmissions following non-electives	1,000	1,000	1,000
C=B/A	Baseline readmissions rate	10.0%	10.0%	10.0%
D=C*75%	Target readmissions threshold rate	7.5%	7.5%	7.5%
E	Actual non-electives	10,000	8,000	15,000
F=D*E	No. of readmissions above which payment ceases	750	600	1,125

Q22. When calculating local threshold rates for emergency readmissions following non-elective admissions, should the readmission baseline and improvement target for each associate at each provider be set individually, or should the global total rate of the provider across all commissioners be used?

A22. Consider the following example:
Provider A has 300 spells.
100 spells from Commissioner 1 who have previously invested little in post acute community care, with a readmission rate of 12%.
100 spells from Commissioner 2 who have previously invested greatly in post acute community care with a readmission rate of 10%.
100 spells from Commissioner 3 who have previously invested little in post acute community care, but use other providers and have a less acute case mix, and have a readmission rate of 10%.
The provider's total readmission rate is therefore 10.67%.

Table 2: Baseline and targets

	Baseline	Individual target	Global target
Commissioner 1	12%	9%	8%
Commissioner 2	10%	7.5%	8%
Commissioner 3	10%	7.5%	8%
Provider Total	10.67%	8%	8%

At the end of the contract year, the readmissions rate of commissioner 1 has reduced to 9%, commissioner 2 has reduced to 7% and commissioner 3 remains at 10%.

Table 3: Individual achievement - individual target

	Actual performance	
Commissioner 1	9%	(9% - 9%) 0% of spells attract no payment
Commissioner 2	7%	(7% - 7.5%) 0% of spells attract no payment
Commissioner 3	10%	(10% - 7.5%) 2.5% of spells attract no payment
Provider Total	8.67%	2.5 spells out of 300 attract no payment

Table 4: Individual achievement - global target

	Actual performance	
Commissioner 1	9%	(9% - 8%) 1% of spells attract no payment
Commissioner 2	7%	(7% - 8%) 0% of spells attract no payment
Commissioner 3	10%	(10% - 8%) 2% of spells attract no payment
Provider Total	8.67%	3 spells out of 300 attract no payment

Table 5: Global achievement - global target

	Actual performance	
Commissioner 1	9%	(8.67% - 8%) 0.67% of spells attract no payment
Commissioner 2	7%	(8.67% - 8%) 0.67% of spells attract no payment
Commissioner 3	10%	(8.67% - 8%) 0.67% of spells attract no payment
Provider Total	8.67%	2 spells out of 300 attract no payment

Commissioners have the right to agree individual thresholds based on their own baseline for activity with the provider (Table 3), supporting individual target setting and achievement. However, if all commissioners and provider agree, a global target and global achievements may be used (Table 5)

Q23. If we contract at PCT, local and Specialised Commissioning Group level should we set the 25% reduction by individual contract or globally?

A23. The answer to Q22 shows that global target setting is the least challenging from a provider perspective (because over performing for one commissioner offsets under performing for another). Individual target setting is more challenging to the provider and more complex to administer. Targets should therefore be set across all activity at either individual PCT or global level. There should not be further sub-division.

Q24. Can commissioners and providers enter into a risk sharing agreement to reflect that the financial value of the spells above the threshold rate could be significantly greater or lower than the casemix of spells below it?

A24. The default position is that the deduction is for the actual cost of spells after the threshold. However, if both commissioners and provider agree, then a variation on this which may be more consistent with other locally agreed contract terms would be allowable.

Q25. When we calculate and monitor the threshold rate for emergency readmissions following non-elective admissions, may we only take account of contracted activity where the provider for the initial admission and readmission are the same, ignoring contracted activity where the providers are different?

A25. Yes you may. Consider the following example for a PCT and two providers with whom they contract.

Table 6: Baseline activity

	Provider for readmission		
Provider for initial admission	Provider A	Provider B	Total
Provider A	1000	100	1100
Provider B	200	700	900
Total	1200	800	2000

For the purpose of calculating the threshold rate for Provider A, only the 1,000 spells where it was responsible for both the initial admission and readmission are considered. The 200 readmissions to Provider A following initial admissions at Provider B are ignored.

Table 7: Thresholds

	Provider for readmission		
Provider for initial admission	Provider A	Provider B	Total
Provider A	750		750
Provider B		525	525
Total	750	525	1275

Where patients are readmitted to Provider A during the course of the year having previously been admitted as a non-elective to Provider B, the PCT should pay Provider A and, where Provider B is above its threshold rate, deduct the readmission tariff from Provider B as per paragraph 60. But these readmissions will not score against Provider B's threshold.

Q26. How should we monitor the threshold for emergency readmission following non-electives?

A26. On a monthly or quarterly basis in line with contractual arrangements, and with a year-end reconciliation.

Q27. Should we deduct an estimate for anticipated readmissions from the contract value at the start of the contract and adjust for variances to this estimate at reconciliation, or should we include the full PbR value in the contract and make all adjustments at reconciliation?

A27. This is for local agreement. Where commissioners and providers agree an anticipated deduction, this may be used in contract plans and should be accurately adjusted at reconciliation each month.

Outpatient care

Q28. Should the first consultant-led attendance in TFC 501 (obstetrics) and the first midwife-led attendance in TFC 560 (midwife episode) both attract the first outpatient attendance tariff?

A28. Yes, assuming responsibility for the patient has transferred.

Q29. Paragraph 143 states "the multi-disciplinary attendance definition does not apply to multi-disciplinary meetings, where care professionals meet in the absence of the patient". Have you bundled the reference costs for cancer multi-disciplinary teams (MDT) into the 2011-12 outpatient attendance tariff? If not, should the costs be treated as an overhead to the tariff, or should we make local arrangements for reimbursement?

A29. We have not bundled cancer MDT costs into the outpatient attendance tariff. Local arrangements for reimbursement should apply.

Urgent care

Q30. Is there a list of designated major trauma centres?

A30. No. The work on designating major trauma centres is being led by SHAs not the Department. Respective SHA trauma leads should be able to provide an update.

Best practice tariffs[3]

Q31. Why are some of the interventional radiology and vascular prices lower than in 2010-11?

A31. There are four main reasons why some of the interventional radiology and vascular prices are lower than in 2010-11.

Firstly, the unit cost for QZ13 (Vascular Access for Renal Replacement Therapy with/without CC) showed a significant decrease in the reported reference costs from 2007-08 to 2008-09. We investigated this further and found that the unit cost was in line with the 2009-10 reference costs which suggests that the cost of the procedure has decreased.

Secondly, the HRGs within QZ16 (Diagnostic Vascular Radiology and other transluminal diagnostic procedures with major/intermediate/without CC) were affected by a change in design which has resulted in some higher cost activity from QZ16 moving to HRG QZ15 (Therapeutic Endovascular procedures with major/intermediate/without CC) and being paid for at a higher rate. The OPCS codes which are affected by this design change are
L71.2 (percutaneous transluminal embolectomy of artery),
L71.5 (percutaneous transluminal dilation of artery),
L71.6 (percutaneous transluminal thrombolysis of artery) and
L71.7 (percutaneous transluminal atherectomy).
The activity that remains in QZ16 is therefore lower cost and now also includes
L26.1 (percutaneous transluminal balloon angioplasty of aorta) from QZ04,
L26.4 (Aortography) from QZ15 and
L26.8 (other specified transluminal operations on aorta) from QZ15.

Thirdly, best practice tariffs (BPTs) have been introduced in chapter RC (interventional radiology), which affect some of the tariffs in chapter QZ. The interventional radiology best practice tariffs apply to two procedures: endovascular aortic repair (EVAR) and uterine fibroid embolisation (UFE).This again means that some activity will be paid for at a higher rate in chapter RC.

Fourthly, when devices are excluded from tariff we remove the costs from the relevant HRGs and make the appropriate costing adjustments. We have sought to improve the mapping process for this which has meant a greater impact to the following HRGs:
QZ01 (Aortic or Abdominal surgery with/without CC)
QZ02 (Lower limb arterial surgery with/without CC)
QZ15 (Therapeutic endovascular procedures with major/intermediate/without CC)
QZ16 (Diagnostic vascular radiology and other transluminal diagnostic procedures with major/intermediate/without CC).
In these cases, it is important to bear in mind that the devices will be paid for in addition to the tariff.

[3] There are further FAQs about the introduction of PbR for renal dialysis at http://www.kidneycare.nhs.uk/_Resourcestodownload-FAQs.aspx

Q32. What impact will the best practice tariffs have on reimbursement for interventional radiology?

A32. The interventional radiology BPTs apply to two procedures: endovascular aortic repair (EVAR) and uterine fibroid embolisation (UFE). The BPTs are based on HRGs in the new interventional radiology sub-chapter RC.

EVAR activity used to group to QZ01 (Aortic or Abdominal surgery with/without CC) but now groups to RC11 to RC13 (see table below). The tariff for RC11 (for ruptured aneurysms), along with the non-elective prices for RC12 and RC13, is set as a weighted average of the relevant QZ prices. Bottom up costing was used to price the elective prices for the RC12 and RC13, which are the BPTs.

UFE activity used to group to QZ15B (Therapeutic Endovascular procedures with Intermediate CC) and C but now groups to RC41Z (see table below). The elective tariff for RC41Z is a BPT and uses bottom up costing which involved looking at a breakdown of all the costs that are incurred in carrying out this activity. The non-elective tariff is based on a weighted average of QZ15B and C prices.

The impact of these BPTs may mean that reimbursement could be higher than it would have been prior to the introduction of these BPTs.

Table 8: Interventional radiology tariff in 2011-12

HRG code	HRG name	Combined Daycase / Elective tariff (£)	Non-elective spell tariff (£)
RC11	Endovascular stent-graft for ruptured abdominal aortic aneurysm	6,049	6,526
RC12	Infrarenal or aortio-uniilac endovascular stent-graft for non-ruptured abdominal aortic aneurysm	6,667	6,187
RC13	Other endovascular stent-graft for non-ruptured abdominal aortic aneurysm	6,667	6,187
RC41Z	Interventional Radiology - Obs & Gynae - Uterine Fibroid Embolisation	2,483	3,916

Note that RC11, 12 and 13 have five splits each depending on number and type of stent-grafts. Because devices are excluded prices are the same across the splits so Table 8 shows only root HRGs.

Q33. How will PbR support the development of interventional radiology?

A33. The aim of the new BPTs is to encourage the provision of innovative procedures by making them more visible in the payment system. Over time we are hoping to develop more BPTs and work is ongoing to progress this further.

The interventional radiology chapter is under development as we work closely with clinicians and key stakeholders to improve the tariffs. We are also undertaking an exercise to review the cost adjustments that we make to tariffs for different HRGs when devices are excluded. This will involve reviewing the mapping of which devices are used in which HRGs. Alongside this is the need for improved costing and coding from the service to make sure the tariffs can be improved.

Q34. Are the best practice prices for primary total hip and knee replacements for the admitted patient care event only and not the whole pathway? Some organisations have suggested that the quoted reduction in tariff will fund the whole pathway of the patients.
A34. They are for the admitted patient care element only and not the whole pathway.

Q35. Does the best practice tariff for primary total hip and knee replacements also pay for the pre-operative assessment (where it occurs prior to admission)?
A35. No.

Q36. Does the Short Stay Emergency Adjustment apply to the acute stroke and fragility hip fracture best practice tariffs?
A36. No, it is not intended that the adjustment applies to the acute stroke and fragility hip fracture best practice tariffs (BPTs).

For the acute stroke BPT, the adjustment is not applicable in order to accommodate the new models of care that have been introduced in response to the National Stroke Strategy. Some health economies have adopted a 'hub and spoke' approach to stroke services, where designated providers receive patients during the hyper-acute phase of the pathway, and repatriate patients out to local providers for the acute phase and then potentially onto a different provider for the rehabilitation phase. The 2011-12 PbR Guidance (paragraphs 244- 250) provides additional guidance to help organisations to sub-divide the acute tariff to reimburse for the various elements of the pathway.

It is acknowledged that the flow diagrams in Annex A are ambiguous in this regard and a known issue in that the SUS-PbR automatically makes the adjustment. These are known issues and will be resolved for 2012-13.

For fragility hip fracture, as HA11-14 and VA11-12 are procedure-based HRGs they do not meet the Short Stay Emergency Adjustment criteria.

Q37. Is there national support for implementing the cataract BPT?
A37. Yes. This is set out in paragraph 200.

Q38. Should the MFF be applied to best practice additional payments?
A38. Yes.

Exclusions

Q39. While NICE guidance on drugs is in draft stage, is the cost outside of tariff?
A39. 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.

Q40. Are drugs on the exclusion list also excluded from non-mandatory prices?
A40. Yes. The general principle is that where a drug is a named exclusion it is excluded from both mandatory tariffs and non-mandatory prices.

Q41. How should we manage the funding of drugs that you have excluded from PbR 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?

A41. Commissioners and providers should agree locally how to apply a discount, rebate or other variation.

Q42. If a drug is not listed as an exclusion from PbR can providers and commissioners still agree extra funding for the drug?

A42. Yes. Further details regarding PbR flexibilities can be found in the PbR guidance.

Q43. Have you excluded herceptin from the scope of PbR?

A43. Yes. Herceptin is a biological cancer therapy. Taking the definition of cancer therapies in the NHS costing manual, it is outside the current scope of PbR and therefore subject to local prices.

Q44. Why have you excluded some chemotherapy drugs from PbR and not others?

A44. Because it is the chemotherapy service that we have excluded, including drugs when used for chemotherapy, but not the drugs per se. Some chemotherapy drugs (e.g. rituximab), which are also used for non-chemotherapy indications, are excluded from tariff regardless of use. But if a chemotherapy drug is not on the exclusions list, and is used for other indications, then it is in the tariff for these indications.

Q45. Have you excluded drugs that are used to treat the side effects of chemotherapy drugs?

A45. Yes. Because we have excluded chemotherapy and chemotherapy covers the treatment costs, i.e. chemotherapy drugs and other drugs for the side effects of the chemotherapy drugs themselves.

Q46. Are supportive drugs for chemotherapy excluded from PbR?

A46. Yes. The drugs are included in the chemotherapy procurement HRGs and are therefore excluded as a part of the chemotherapy service exclusion.

Q47. Are hormonal or hormone antagonist drug treatments for cancer excluded from PbR?

A47. 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.

Q48. For which indications have you excluded the drug lenalidomide in 2011-12?

A48. Drugs that we have excluded from the national tariff, and which are therefore subject to local payment, are excluded regardless of usage or indication, unless stated otherwise. Lenalidomide does not have any qualifying criteria and so is excluded for all indications.

Q49. 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?

A49. 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 i.e. exclusions relate to payment issues and are subsequent to prior approvals schemes which relate to pathway issues.

Q50. Parenteral nutrition is excluded after 14 days or when the patient is receiving parenteral nutrition prior to admission. What does this mean?

A50. 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, i.e. 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 (e.g. 2 months) and stops receiving it during that period for a few days (e.g. 2 days) in the same admission (e.g. owing to a line infection and resiting the line) then the exclusion continues to apply when it is restarted.

Q51. 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"?

A51. BNF section 2.11 does not exhaustively cover blood products. But, 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.

Q52. We deliver some drugs through home care arrangements. Are these drugs excluded from PbR always, or only where they are listed exclusions from PbR?

A52. All home care drugs, where there is no associated admission or attendance, are excluded from PbR regardless of whether the drugs are listed as PbR exclusions or not.

Q53. Are there any tariffs for drug home care arrangements?
A53. No. However, there is currently some work ongoing looking into setting a tariff for the administrative costs of contracting, ordering, invoice matching and payment for home care drug arrangements.

Q54. Are renal dialysis drugs (e.g. epoetin alfa, cinacalcet) excluded from PbR?
A54. If drugs are specifically listed as an exclusion, or where they are in a BNF section/sub-section that is wholly excluded from PbR then the drugs are excluded otherwise they are not excluded. These renal dialysis drugs are not on the exclusion list.

However, due to the variation in funding and prescription practices across the country, the tariffs for renal dialysis and outpatient nephrology are not intended to fund the following drugs in 2011-12:

- ESAs
- Darbopoetin alfa
- Epoetin alfa, beta, theta and zeta
- drugs for mineral bone disorders
- Cinacalcet
- Sevelamer
- Lanthanum.

Therefore, funding arrangements for these drugs are for local agreement, and will depend on whether these drugs were specifically included or excluded from local prices.

Q55. Amifampridine phosphate is excluded from PbR. Does this also cover 3,4-diaminopyridine?
A55. No. Only amifampridine phosphate is excluded from PbR and not the unlicensed (different salt) version of 3,4-diaminopyridine.

Q56. Why have you removed video capsule for endoscopy from the exclusions list?
A56. Video capsule for endosocopy was removed from the exclusions list as there is now a specific HRG that relates only to wireless capsule endoscopy. The cost of this device is included in the core HRG (FZ42Z).

Non-mandatory prices

Q57. Can you provide a definition for the acute phase and post-acute phase of rehabilitation?
A57. The acute phase of rehabilitation is provided before transfer to a discrete rehabilitation unit i.e. specifically to a rehabilitation unit, or to a rehabilitation speciality either within the same trust or a different trust. The non-mandatory tariffs only relate to the acute phase. The post acute phase of care, on the other hand, is usually provided outside an acute setting for a longer period.

Q58. Why are you no longer providing a non-mandatory price for AA22Z in 2011-12?
A58. Paragraphs 244 - 250 make the case for unbundling the acute tariff and we are working with the Stroke Improvement Programme to put together case studies on how organisations may wish to unbundle the tariff to pay for different aspects of the stroke pathway. This is a more appropriate approach given the many changes to the

stroke pathway and organisation of services introduced since the National Stroke Strategy.

Dialysis away from base

Q59. How should dialysis away from base (DAFB) be reimbursed in 2011-12?

A59. The 2011-12 PbR Guidance sets out the funding policy for renal dialysis. The guidance is available here: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_126157.pdf

The paragraphs relevant to DAFB are pasted in the table below for convenience.

170. As part of the BPT programme, we are introducing a mandatory currency with mandatory transition from local prices to national tariff for adult renal dialysis for patients with chronic renal failure. The tariff covers adult haemodialysis and peritoneal dialysis. 193. It is important that patients can dialyse away from home. The introduction of a mandatory tariff is intended to make it easier to arrange dialysis away from home by providing a consistent basis for financial flows. The tariff prices and transitional arrangements apply equally for patients at or away from home. Dialysis away from base should be funded within the non-contract activity framework. 197. In 2011-12, it will be mandatory for organisations to commission and report on the basis of the chapter LD HRGs. For reimbursement, it will be mandatory for all organisations to move 50% towards the national tariff prices from 2010-11 locally agreed prices or equivalent if commissioning on block contracts (Figure 3 illustrates). For dialysis away from base, the price paid by commissioners will be the same as that set for regular dialysis of their local population. However, in the case of the small number of providers of purely away from base dialysis, which do not hold local contracts presently, the starting point for the calculation of a 50% move towards tariff will be the prices charged in 2010-11. In 2012-13, the national tariff price will be mandatory. We will review the situation during 2011-12 with respect to dialysis away from home.

Q60. Why is there a tariff for dialysis away from base (DAFB)?

A60. It is important that patients can dialyse away from base. The introduction of a mandatory tariff should make it easier to arrange DAFB by providing a consistent basis for financial flows. Patients who need time away for reasons of business, education, family emergencies, bereavement or other reasons should be able to arrange what they require. The NHS is encouraged to develop agreed local policies for DAFB which will ensure equity while minimising the impact of renal failure on patients' mobility and these policies need to operate within the framework of the DH guidance mentioned below.

Q61. What can be done if there is a lack of capacity in the NHS in the area the patient wants to travel to?

A61. Haemodialysis capacity is often a constraining factor which may limit where DAFB can be offered. The responsibility of the NHS for funding can include paying for

dialysis (but not accommodation) privately if the NHS does not have the capacity locally.

Q62. What can be done about the charges imposed by private providers which are usually considerably more than the PbR tariff? In addition, some private providers require patients to supply their own dialysers, thereby adding further costs to the base unit.

A62. Where the NHS is paying for DAFB from a private contractor there is no scope for exceeding the tariff price or transitional arrangements for 2011-12 except where there is an existing contract at a higher price. When the contract is renewed this should be paid for at tariff price from 2012-13. Transitional arrangements apply in 2011-12 for both regular and away from base dialysis (set out in paragraph 197 of the 2011-12 PbR Guidance)

If dialysers are not included in the service provided, but are supplied by the home unit, the amount payable to the away unit would have to be reduced by the cost of these and the balance should be paid to the home unit.

Q63. What about NHS providers charging considerably more than the PbR tariff for DAFB?.

A63. There is no scope for NHS providers to charge additional fees over and above the tariff price or transitional arrangements in 2011-12.

Q64. Won't the base unit lose out financially as they have to pick up the cost of the shortfall between the holiday DAFB cost and the PbR tariff?

A64. Funding arrangements for DAFB, prior to the introduction of tariff for dialysis, have been on a unit-to-unit basis. The home unit agreed the funding level with the away unit and paid accordingly from the block contract it received from the Specialised Commissioning Group or Primary Care Trust.

From April 2011, dialysis will be paid for on a sessional basis. As with other services within the scope of Payment by Results, commissioners will contract for dialysis, making monthly instalments against the contract value, adjusted for actual levels. The arrangement for DAFB will be to follow that already used elsewhere in Payment by Results for Non-Contract Activity. Providers of the away from base dialysis rather than the base unit should invoice the *responsible* Specialised Commissioning Group or PCT on a monthly basis for the DAFB activity provided.

Q65. Is guidance forthcoming as to whether patients should be expected to pay for the shortfall between DAFB and PbR tariffs?

A65. Funding for temporary dialysis in England used to be provided by the referring unit and this remained the case until the end of March 2011. As mentioned above, from 1 April 2011 this will be paid for by the relevant Specialised Commissioning Group or PCT. Top-up fees cannot be imposed on the patient under any circumstances as the rules about NHS services being free at the point of delivery apply. For the same reasons patients cannot be charged for the costs of drugs. However, if a patient arranges private treatment without getting approval from their home unit (or possibly specialised commissioner – dependent on the policy locally) the patient will be responsible for the full costs of the dialysis.

Q66. If patients are expected to pay for some or the entire shortfall, is there any mechanism whereby patients can receive some financial support? (such as a

"dialysis-leave budget": if the patient uses up his or her budget, they then have to pay the extra cost).

A66. As mentioned above, there are no circumstances in which a patient can be asked to pay top-up fees for services provided by, or on behalf of, the NHS except where this is provided for in regulations.

Q67. Can there be a national register as to what capacity exists within the NHS for DAFB, and what each unit currently charges for DAFB?

A67. As mentioned above, units will only be able to charge tariff price (from April 2012) and from April 2011 they have to move 50% towards tariff price from their existing price in 2010/11. Units may wish to decide locally to develop a register but we have no plans to set one up nationally at present. You may be interested in the Dialysis Freedom website as an example of information that is already available nationally:

http://www.freedom-apartments.com/

Q68. Can NHS units charge an administration fee for providing DAFB?

A68. There is currently no scope for payment of an administration fee on top of the tariff price.

Q69. Can assurance be given that patients dialysing via a central line will not be refused DAFB in another NHS unit, and that the cost for such patients will remain the PbR tariff plus reasonable administration fee?

A69. It is not possible to charge an administration fee at present. Units should offer dialysis where there is a clinical need and where they have the capacity regardless of the means of access the patient has. In the same way as for patients dialysing in their home unit, those dialysing away from base via a line should be paid for at the rate for those using a line.

Q70. Can clarification be given as to who is responsible for supplying or paying for ESA's, and that if dialysers are to be supplied by the base unit this cost is deducted from the DAFB cost?

A70. ESAs are currently not included in the tariff price (we will be exploring whether it will be possible to include them in the future). Specialised Commissioning Groups or PCTs should pay for these on top of the tariff and patients cannot be charged a top-up fee for their cost. Specialised commissioners will need to consider paying the home or away from base unit for dialysers and where the home unit supplies these, the cost should be deducted from the tariff price paid to the away unit.

Q71. What will happen in future years?

A71. During 2011/12 we will be assessing the impact on dialysis away from base on the introduction of a tariff for dialysis to see if any changes need to be made to next year's guidance.

Other operational issues

Q72. Can you clarify the reporting and payment arrangements for non-contract activity (NCA) in 2011-12?

A72. Providers should submit NCA to SUS PbR in line with the monthly reporting dates in table 38, paragraph 460. Providers should submit monthly invoices to responsible commissioners, which should be agreed and paid as far as reasonably possible in

line with the standard timescales set out in the standard NHS contract for acute services. Commissioners have a responsibility to identify NCA patients assigned to them within SUS PbR for whom they are not the responsible commissioner. Commissioners and providers should make every effort to resolve disputes bilaterally, but may be referred to mediation or adjudication at the request of either party in line with the provisions of the standard NHS contract.

Q73. Do the monthly reporting and payment arrangements set out in paragraphs 458 to 460 of the 2011-12 PbR Guidance also apply to cross-border non-contract activity in 2011-12?

A73. No. The four-country agreement on cross-border emergency treatment[4] (September 2006, Gateway ref. 7057) remains in force. This agreement states that for patients registered with a GP in England treated by providers in the devolved administrations and for patients resident in the devolved administrations treated by providers in England, NCA invoices are to be sent once a quarter, ideally within 30 days of the quarter end.

Q74. Must prior approval be sought and obtained for cross-border elective and outpatient treatment?

A74. Yes. Paragraphs 4 to 9 of the document published in June 2007 'Supporting information for the resolution of outstanding issues relating to the cross-border emergency treatment agreement' (Gateway ref. 8409)[5] sets out expectations. Please note that the reference at paragraph 13 of this document to 'outstanding invoices' refers to those outstanding at the time of the document's publication in June 2007. This paragraph does not apply to invoices raised since its publication.

Q75. Does CQUIN apply to cross-border elective activity?

A75. The CQUIN framework applies only to services that are financed by the NHS in England. Therefore it is not mandatory for commissioners in Northern Ireland, Scotland or Wales to contribute to CQUIN schemes for English providers. However they may wish to be involved in the development and finance of CQUIN schemes for English providers if they agree locally that it is appropriate.

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[4] Available at http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139150

[5] Available at: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4139150