National Spinal Cord Injury Strategy Board

Commissioning Classifications Sub-Group

Specialised Spinal Cord Injury

CODING HANDBOOK

Second Edition

Containing Definitions of Commissioning Classifications (Currencies)

for Commissioning and Procurement

of Spinal Cord Injury Services

provided by Specialised Spinal Cord Injury Centres in England

Version 21 draft 8

18th September 2012

FOR USE in CONTRACTS 2013/14

Introduction

Purpose of this Handbook

Because of the complexity and range of the service, Specialised Spinal Cord Injury is outside the scope of Payment by Results. PbR tariffs, rules, inclusions and exclusions do not apply to the service.

The purpose of this Handbook is to set out the national codes to be used in classifying activity in the Specialised Spinal Cord Injury Service, with definitions and rules.

This will be the final version for use in 2013/14 Contracts.

Why is such a complex coding system required?

The specialised Spinal Cord Injury Service provides not only care following injury, which usually lasts many months, but life-long care for patients living with spinal cord injury. In people with no sensation below the level of injury, the body learns to function in unusual ways. Illness can go undiagnosed, and problems which would not be serious in another patient can become life-threatening. The spinal cord injury centres therefore provide an extensive range of medical and allied health services to patients, not only those which are obviously related to the spine.

In effect, the SCICs provide a microcosm of the NHS to a small set of people whose medical needs differ significantly from those of the general population.

Most SCICs 'entered the market' on block or simple bed-day contracts, and had not progressed beyond that point. None of the SCICS had a tariff system that was fit for good-quality commissioning. There was little data collection in most SCICs. This situation put the service outside the Scope of PbR, yet it badly needed a payment system which linked payment to need, cost and quality, and removed perverse incentives.

With the endorsement of the DH PbR Team, the Currencies Group embarked on the task, initially of classifying SCIC activity into clinically meaningful codes, and then of developing tariffs, for use as the National Tariffs for the Specialised SCI Service.

Scope, Inclusions and Exclusions

The codes in this Handbook apply to all activity within the Scope of the Specialised Spinal Cord Injury Service as defined in the 2013/14 Service Specification. For full details of the Scope of the Specialised Spinal Cord Injury Service please refer to the 2013/14 Service Specification.

In order to assist in development and costing, some items which are outside the scope of the specialised Spinal Cord Injury Service have SCI codes. This is explained further in Sections 1, 2 and 9.

Accountability

This Handbook has been developed by the Commissioning Classifications (Currencies) Sub-Group of the National Spinal Cord injury Board, with the participation of the eight specialised Spinal Cord Injury Centres, Commissioners and service users. The NSCISB is accountable to the National Specialised Commissioning Group.

This project is a DH PbR Development Site.

The Second Edition of this Handbook was approved by the **National Spinal Cord Injury Strategy Board** on 24th August 2012 as reflecting progress to that point.

It was approved by the **SCI Clinical Reference Group** on 21st August 2012 for procurement of the service in 2013/14.

Development

The Handbook been changed many times during development, and this has resulted in some anomalies in the numbering of codes. It has been agreed that it would be inconvenient to change these codes at the present time, but it may be possible to rationalise them when the National SCI Database begins to produce the reports. A few codes are shown in large font to highlight this.

There is a separate Costing Handbook which was written for this project by the DH PbR Team.

The Commissioning Classifications (Currencies) Sub-Group is allowed by its Terms of Reference to make continuous improvements to reflect development and refinement of the codes and definitions. It is expected that as the body of activity and cost data increases, changes will be made to the codes for 2014/15 Contracts and beyond.

The Packages

In-patient activity has been classified into clinically meaningful ‘packages’ which are not necessarily the equivalent of a ‘spell.’ A patient may have more than one package during an admission.

There are also packages for non-admitted care.

Details of what is included in the packages are set out in the main body of the Service Specification. For the avoidance of doubt everything required to treat the patient is included in the package and tariff, unless the Service Specification states that the item is chargeable as a separate SCI package, or chargeable to a different specialised service or purchaser.

Where an item is not expected to be provided from within the package tariff, it has been given a separate code. Example: certain implantable devices can be charged to SCI contracts at purchase price, but the procedure and bed days required to implant the device will be included in the relevant inpatient package.

Tariffs

This Handbook does not include tariffs, which are listed separately. In 2013/14, contracts will be based on national commissioning classifications, and local tariffs (meaning tariffs specific to the individual provider).

The use of local tariffs recognises that there are historic differences in the model of service in the different SCICs. However, the aim is to work towards common tariffs, in parallel with progress towards full compliance with the model of care set out in the National SCI Pathways, and a programme to measure outcomes.

Some notes about tariff methodology are provided within the Sections.

Contracting in 2013/14

The packages and codes in this Handbook will be used in contracts for specialised spinal cord injury services in 2013/14. There will be no local variations to the codes, definitions, rules, inclusions or exclusions, unless formally approved by the NHS Commissioning Board and the Currencies Sub-Group.

The codes and definitions in this Handbook will cover most activity. Occasionally a patient may follow an exceptional pathway. In such cases either the provider or the commissioner may refer the case to the Coding Panel, which will advise the most appropriate code.

The Terms of Reference of the Coding Panel are attached as Appendix 1.

National SCI Database

In the development stage, activity has been assigned to the codes 'manually' by staff in the Spinal Cord Injury Centres.

The SCI codes cannot currently flow through the NHS Secondary Uses Service, and are unlikely to do so in the near future. The DH PbR Team therefore recommended that a database be built to capture and classify the data.

One of the primary functions of the National SCI Database, now under development by the National Spinal Cord Injury Strategy Board, is to act as the 'grouper' and produce contract activity reports.

Abbreviations

SCI	Spinal Cord Injury
SCIC	Spinal cord Injury Centre
PbR	Payment by Results
NSCISB	National Spinal Cord Injury Strategy Board

Summary of Sections

ADMITTED CARE

Section 1 **Page 12**

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI.

The codes cover people with conditions which are outside the scope of the specialised SCI service. In many cases these patients are within the scope of another specialised service, and they will be classified and charged accordingly.

In other cases these patients are not within the scope of any specialised service and they will be 'put through the grouper' and charged at the PbR tariff.

These codes are used for costing and administrative purposes only and will not appear in contracts.

Section 2 **Page 13**

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI.

The codes cover non-clinical delayed discharges ie people who have completed their treatment and are clinically fit for discharge. The Currencies Group will set a daily tariff for these which will be charged to the local responsible commissioner.

Further information about the prevention of non-clinical delayed discharges is contained in Appendix 2 of the Service Specification.

These codes are used for costing and administrative purposes only and will not appear in contracts.

Section 3 **Page 14**

This section covers the initial admission of the patient to a SCIC after their injury. It contains

Acute management, which can be either

32 Surgical

33 Non-surgical

34. Rehabilitation

350 ITU (which can also be used in further admissions)

36. Ventilation (which can also be used in further admissions)

Section 4 **Page 24**

Further admissions, ie the admission of a person living with spinal cord injury.

These are grouped into several types.

NON ADMITTED CARE

Section 5 **Page 30**

Not in use

Section 6 **Page 30**

Outpatient attendances

Section 7 **Page 34**

Outreach clinics

Section 8 **Page 35**

Outreach visits

Section 9 **Page 36**

Outside the scope of the specialised SCI service. Used for classifying transport costs.

These codes are used for costing and administrative purposes only and will not appear in contracts.

Section 10 **Page 36**

Not in use

Section 11 **Page 36**

Not in use

Section 12 **Page 37**

Restricted list of items or services which can be charged to SCI contracts but which would not be 'Exclusions to PbR'. Some conditions apply.

Section C **Page 39**

Restricted list of items which can be charged to SCI contracts. Includes some items corresponding to the current national 'PbR Exclusions' list. Some conditions apply.

General Rules

The following rules apply to all SCI codes.

Contracts in 2012/13

Until commissioners and providers formally change to contracting in the new currencies, existing contracting arrangements and tariffs apply.

Shadow monitoring of activity in the new currencies is taking place throughout 2012/13.

Banding

The codes and bandings attributed to the patient are derived from the condition of the individual patient, and never from the bed or ward in which the patient is accommodated.

Children and Adolescents

The suffix P is added to codes to indicate the patient is under 19 years at the commencement of the package, but only if:

> The child was accommodated in a dedicated paediatric or adolescent environment

And

> The service was delivered in compliance with the Service Specifications for Specialised Paediatric Services.

To avoid repetition, the definitions are not shown against the P codes. The definition and any rules applying the adult code also applies to the P Code. This is not intended to imply that the same tariff will apply to adults and children.

Where no P code is shown in the Handbook, children will be coded to the adult code.

Age of Patient

Wherever the age of the patient is a factor, the age at **commencement of the package** will apply.

Currently the only codes dependent on age are the assignment of ‘P’ codes to patients under 19.

Age is reported for all packages, as it may be required for further analysis of data, and tariff development.

Definition of 'Fit for Rehabilitation'

For the purposes of these classifications rehabilitation packages will commence when the patient is:

Able to sit up in a wheelchair for four hours

and fit for rehabilitation

and has

either been weaned (if previously ventilated)

or has ventilation requirements which permit full participation in rehabilitation.

Definition of Ventilation and Tracheostomy

For the purposes of these classifications

SCI Ventilation

means respiratory support delivered to a person with SCI, who is not in intensive/critical care (as defined for code 350), by any mechanical/electronic means, regardless of whether the air/oxygen is delivered via tracheostomy or mask, or with the assistance of a phrenic nerve stimulator.

Not ventilated, but is dependent on tracheostomy

means the patient is not ventilated, but is entirely dependent on the tracheostomy for breathing and would die at once without it. Such cases are expected to be rare.

Definition of Central Cord Syndrome

For the purposes of these classifications, Central Cord Syndrome is marked by a disproportionately greater impairment of motor strength in the upper extremities than in the lower ones, (ie a difference equal to or greater than 10 in the AIS motor score), as well as by bladder dysfunction and a variable amount of sensory loss below the level of injury.

Definition of Cauda Equina

Patients with Cauda Equina will only be classified to codes in this Handbook, if:

- They meet the criteria set out in the Service Specification for Spinal Cord Injury, which are:

  Services provided to adults and children with Cauda Equina Syndrome which results in

  - *Either Motor and sensory effects on bowel and bladder function resulting in retention/incontinence of bowel and/or bladder*
  - *Or Loss of safe upright mobility.*

- And they are treated by the specialised Spinal Cord Injury Service

Inclusions

The services defined by the SCI Commissioning Classifications codes include all equipment, staffing, surgery, outpatient procedures, drugs, devices, orthotics, functional electrical stimulation ('FES'), consumables and costs, including items required to treat co-morbidities, required by in-patients and patients being followed up by the SCIC, unless:

- Additional payment is explicitly allowed under the latest version of this Handbook ,

Or

- The item is outside the scope of the specialised SCI service as defined in paragraph 2.4 of the Service Specification.

Reporting of Dates and Counting of Bed Days

No package (apart from 350 ITU, Sub-Section 36 Ventilation and items classified to Section 12 and Section C) can occur at the same time as another package.

For all packages, except 350, and devices and drugs in Section 12 and Section C:

Commencement will be the date on which the patient commenced the package. End date will be the date on which the patient ended the package. The duration of the package (or length of stay) will be the latter, minus the former.

This method will also apply to counting for any package or top-up for which the tariff is a daily rate, such as Section 2, Sub-Section 36, Sub-Section 45 and code 124, but **not** to 350 ITU.

Example:

	Start Date	End Date	Total Length of Stay
First package	01/01/2009	05/01/2009	4
Second package	05/01/2009	07/01/2009	2
Third package	07/01/2009	01/02/2009	25
			31

Packages during which the patient was transferred to ITU package 350

These will be counted as follows:

Example:

	Start Date	End Date	Total Length of Stay
343	01/01/2009	31/01/2009	30-8=22
350	10/01/2009	17/01/2009	8

This is consistent with the way ITU is reported under PbR.

Devices and drugs in Section 12 and Section C

The date reported will be the date on which the device or drug was supplied. This will enable reconciliation with any associated admission or attendance.

Additional Rules

Where rules apply only to a Section, or to a Code, they are set out in the relevant Section or Sub-Section.

Section 1: Non SCI Patients

Not within the Scope of Specialised SCI.

Advice

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI. These codes are used for costing and administrative purposes only and will not appear in contracts.

These patients are treated by the SCI service in some locations, and may have been charged to SCI contracts prior to 2013/14.

Section Rules (see also General Rules)

In many cases these patients are within the scope of another specialised service, and they will be classified and charged accordingly.

In other cases these patients are not within the scope of any specialised service and they will be 'put through the grouper' and charged at the PbR tariff.

Codes

100/ 100P Patients with injury to spinal column but intact neurology (with the exception of up to two nerve roots) admitted to spinal cord injury departments.

101/ 101P In-patients in the SCIC who are outside the scope of specialised SCI but are not covered by code 100 or 100P

10 Non-admitted care by the spinal cord injury centre of patients who are outside the scope of specialised SCI.

Tariffs

There are no SCI tariffs for this Section. Activity in this section is classified to the appropriate codes and tariffs for the diagnosis and activity, and charged to the appropriate specialised or non-specialised services contracts.

Section 2: Non-Clinical Delayed Discharge Bed Days

Not within the Scope of Specialised SCI.

Advice

Contains codes for services which are provided in the SCIC but are outside the Scope of Specialised SCI. These codes are used for costing and administrative purposes only and will not appear in contracts.

The codes cover non-clinical delayed discharges ie people who have completed their treatment and are clinically fit for discharge. The Currencies Group will set a daily tariff for these which will be charged to the local responsible commissioner.

Further information about the prevention of non-clinical delayed discharges is contained in Appendix 2 of the Service Specification.

Section Rules (see also General Rules)

These classifications commence on the day on which the patient became fit for discharge.

The package is a single day, and patients are banded according to their condition and age at 00.01 am on that day.

For counting of bed days, see General Rules,

If a delayed discharge patient becomes unwell to the extent that it would not be safe to discharge him/her, he/she will be coded to the appropriate Section 4 package until he/she is fit for discharge again.

Codes

201/201 P Delayed discharge bed-day – patient on SCI Ventilation but not in ITU. **Patient is ventilated for 24 hours in 24**

202/202P Delayed discharge bed-day – patient on SCI Ventilation but not in ITU. **Patient is ventilated for less than 24 hours in 24**

203/203P Delayed discharge bed-day – patient not in ITU - Patient is not ventilated, but is **dependent on tracheostomy**. Only used in the rare circumstances where a patient is not ventilated, but is entirely dependent on the tracheostomy for breathing and would die without it.

204/204P Delayed discharge bed-day – tetraplegic C8 and above

205/205P Delayed discharge bed-day – paraplegic and cauda equina

Tariffs

Per bed-day. Chargeable to local commissioner at tariffs set by Currencies Group. See Service Specification for details.

Section 3: Newly Injured Patients

Multidisciplinary management of newly injured SCI patients from admission until the end of the rehabilitation phase.

Advice

Because a patient may join the pathway at various points, depending on the treatment provided in a previous setting, Section 3 is broken down into sub-sections.

There are two possible pathways in the acute recovery phase – surgical and non-surgical: the patient will not have both.

Surgical management implies that the spine has been surgically stabilised / re-aligned / decompressed, and a period of **recovery** follows before the patient commences **rehabilitation**.

Non-surgical management means the patient has been stabilised by bed rest and/or external fixation.

The surgical and non-surgical pathways converge when the patient has recovered sufficiently to commence rehabilitation.

Rehabilitation should strictly commence almost immediately after injury, but for the purposes of this document there is a rule which defines the commencement of the rehabilitation. The full wording is in the General Rules.

The packages in this Section are broken down further to reflect the different dependency levels of different levels of injury. These distinctions are referred to as ‘bandings’.

The use of codes 329, 339 and 349 prevents double charging for interrupted packages. There will be £0 tariffs for these code, as the costs will be recovered in the tariff for the recovery package. There is therefore no need to split the ‘interrupted’ codes into levels of injury, adult/child etc.

Section Rules

Only newly spinal cord injured patients and patients with new cauda equina syndrome meeting the criteria in the SCI Service Specification will be coded to Section 3 codes.

A patient will only experience the Section 3 pathway once in their life-time. The only exception to this rule is the use of code 350 ITU and codes 360, 365 and 369 Ventilation in further admissions.

A patient will only experience one Section 3 recovery package and one Section 3 rehabilitation package in their lifetime. The only exception is for interrupted packages, as defined in these classifications.

(A possible additional exception to these rules is a patient living with SCI who incurs a second spinal cord injury later in life at a higher level of the spine. Such a case would be referred to the coding panel.)

A patient admitted shortly after injury will usually experience:

either 321 (surgery) **and** 322/323 (surgical management)

or 331/2 (non-surgical management).

No patient will be coded to both the pathways above. If there is a change in intended management, it will be necessary to change the code retrospectively.

If admitted after stabilisation/re-alignment/decompression surgery elsewhere and not yet ready for rehabilitation, the patient will experience 322/323.

If the patient arrives at the SCIC ready to commence rehabilitation, the patient will begin with Sub-Section 34. The use of codes 322/323 or 331/2 for a few days between admission and commencement of rehabilitation is not appropriate in these circumstances.

With the exception of 321, any surgery during the first admission following injury is part of the recovery or rehabilitation package, and is included in the tariff for recovery or rehabilitation. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.

If it is decided to manage the patient non-surgically, but a decision is taken **later in the recovery period** to stabilise the spine surgically, the coding will be changed retrospectively to 321 and the relevant recovery package.

If the patient is initially managed non-surgically, but it is decided **during the rehabilitation package** to carry out surgical stabilisation of the spine, the coding will be as follows:

33* (* = appropriate banding) Non-surgical management, followed by

34* (*= appropriate banding) Rehabilitation, followed by

321 Spinal Surgery to stabilise the spinal fracture, followed by

349 Continuation of interrupted rehabilitation

Section Tariffs

Surgery to stabilise, re-align or decompress the spine, and surgery for Cauda Equina Syndrome. The tariff will be per package.

There will be four price bands for surgery, and a list will be issued of which procedures map to which bands.

Recovery: The tariff will be per package.

Tariffs will apply to the entire recovery package , including any 329 or 339 ‘continuation’ activity. There will however be an outlier bed day rate for short or long stays. Short stays will be paid at the outlier bed day rate only. Long stays will be paid at the package rate plus the outlier rate for bed-days beyond the threshold.

The tariffs for Section 3 packages include treatment of any pressure sore present on the arrival of the patient in a newly injured patient, including any surgery required, but exclude the daily cost of pumps and consumables for Negative Pressure Wound Therapy (NPWT) which can be classified as **code 124.**

Section Rules for Banding

For recovery packages commencing with the numbers 322, 323, 331 and 332:-

The patient will be assigned to the most appropriate package to reflect his/her level of impairment on the **28th day after the date of his/her injury** or on the final day of the package, whichever is earlier.

Prior to Day 28 patients will be assigned provisionally to the most suitable package, but this will be changed retrospectively to the package corresponding to the condition of the patient at Day 28, or on the final day of the package, whichever is earlier. This will determine the classification at which the patient's recovery will be charged.

Any admission for recovery after injury commencing within three months of the last day of a previous recovery package is deemed to be Continuation of an interrupted package for the purposes of these Classifications.

For rehabilitation packages commencing with the numbers 342, 343, 344 and 345

The patient will be assigned to the most appropriate package to reflect his/her level of impairment on the 28th day after the date of injury, or on the final day of the package if this is earlier.

Prior to Day 28 patients will be assigned provisionally to the most suitable package, but this will be changed retrospectively to the package corresponding to the condition of the patient at Day 28 (or the final day of the package if this is earlier), and this will determine the classification at which the patient's rehabilitation will be charged.

For any Interrupted Packages

The rules about banding apply even if the package has been interrupted.

Sub-Section 31

This section was withdrawn in 2011 but code 310 will appear on activity reports for the earlier part of 2011/12.

For coding of ITU please refer to Sub-Section 35, code 350.

Sub-Section 32 – Surgical Management following Injury

This Sub-Section contains:

Surgery to stabilise/re-align/decompress the spine

The 'recovery' phase between surgery and rehabilitation.

Sub-Section Rules

Banding: see Section Rules

Package 321

This commences on admission. It ends immediately after surgery.

Code 321 is only used for surgery to stabilise/realign/decompress the spine following spinal cord injury, and surgery for cauda equina syndrome, but not for any other surgery. (See Section Rules). Two-stage fusion is counted as a single procedure and is assigned to the date on which the first stage was carried out.

If a patient experiences spinal surgery within the SCIC host Trust, the surgery will be classified to the codes in this Handbook only if the patient is diagnosed with spinal cord injury or Cauda Equina Syndrome as defined in the Service Specification (see General Rules).

If the spinal cord injury is of iatrogenic origin and occurred in the SCIC's host Trust, the patient will only be classified to a Spinal Cord Injury code at the point at which spinal cord injury rehabilitation commences.

322 and 323 Packages

These commence:

immediately after spinal surgery to stabilise/re-align/decompress the spine (where undertaken in the SCIC) or Cauda Equina Surgery (where undertaken in the SCIC).

or

on admission, if stabilisation/re-alignment/decompression or Cauda Equina Surgery has been undertaken elsewhere.

They end when the patient is fit to commence rehabilitation, as defined in the General Rules, or if the patient is discharged.

They include, where applicable :

all necessary investigations,

full MDT management,

any surgery other than package 321. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.

any urological procedures

all investigations and multidisciplinary management

the management of any co-existing pathology or complications

maintenance of any equipment provided

They exclude:

The definitive spinal column or cauda equina surgery (see 321)

Items which have been given their own classification in this document (see Sections 12 and C)

See Section Rules for treatment of pressure sores.

Codes

321 /321P Spinal Surgery to stabilise/re-align/decompress the spine or cauda equina surgery. The package includes the surgical procedure including operation, and orthoses used in surgery. It includes bed days between admission and surgery.

There will be four cost bands. A list of which procedures map to which banding will follow.

321-1	High
321-2	Medium High
321-3	Medium Low
321-4	Low

322-2 /322-2P Recovery post surgery – high tetraplegic (neurological deficit C4 and above)

322-3 /322-3P Recovery post surgery – low tetraplegic (neurological deficit C5-C8)

323-1 /323-1P Recovery post surgery – paraplegic, AIS D and Cauda Equina

329 Continuation of interrupted recovery package – para or tetra

This code is used in circumstances where the period of recovery from stabilisation surgery (ie 322 or 323) has been interrupted by another event. This could be, for example, transfer out to another hospital for treatment.

Any recovery package commencing within three months of the last day of a previous recovery package is be deemed to be Continuation of an interrupted package for the purposes of these Classifications.

Sub-section 33 ***– Non-Surgical Management of newly injured patients who have not been stabilised surgically***

Advice

Non-surgical management is sometimes referred to as 'Conservative' management.

Sub-Section Rules

Patients with external stabilisation, such as halo or plaster, will be classified as 'non-surgical management' (ie not Section 32) even if a general anaesthetic is used during stabilisation.

Late decisions to stabilise the spine – see Section Rules

Banding: see Section Rules

331 and 332 packages

These commence on admission.

They end when the patient is fit to sit up in a wheelchair for four hours.

and has

either been weaned (if previously ventilated)

or has ventilation requirements which permit full participation in rehabilitation.

They include, where applicable:

all necessary investigations,

full MDT management,

any surgery other than package 321. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.

any urological procedures

all investigations and multidisciplinary management

the management of any coexisting pathology or complications

They exclude:

Items which have been given their own classification in this document (see Sections 12 and C)

See Section Rules for treatment of pressure sores.

Codes

331-2 /331-2P	Acute non-surgical management – high tetraplegic (neurological deficit C4 and above)
331-3 /331-3P	Acute non-surgical management – low tetraplegic (neurological deficit C5-C8)
332-1 /332-1P	Acute non-surgical management – paraplegic, AIS D and Cauda Equina
339	Continuation of interrupted package of acute non-surgical management (para or tetra)

This code is used in circumstances where the period of conservative management following injury has been interrupted by another event. This could be, for example, transfer out to another hospital for treatment.

Any recovery package commencing within three months of the last day of a previous recovery package is be deemed to be Continuation of an interrupted package for the purposes of these Classifications.

Sub-Section 34 - Rehabilitation following injury

Advice

For definition of commencement of rehabilitation please refer to Section Rules

Sub-Section Rules

Banding: see Section Rules

Section 34 packages will include, where applicable:

all necessary investigations,

full MDT management,

any surgery other than package 321. This applies whether the surgery is a return to theatre for further spinal surgery or any other kind of surgery.

any urological procedures

all investigations and multidisciplinary management

the management of any coexisting pathology or complications

They exclude:

Items which have been given their own classification in this document (see Sections 12 and C)

See Section Rules for treatment of pressure sores

Sub-Section Tariffs

Tariffs for this section will apply to the entire rehabilitation package, including any 349 'continuation' activity. There will however be an outlier bed day rate for short or long stays. Short stays will be paid at the outlier bed day rate only. Long stays will be paid at the package rate plus the outlier rate for bed-days beyond the threshold.

Codes

342-2 /342-2P Rehabilitation trauma and non trauma – high tetraplegic (neurological deficit C4 and above)

342-3 /342-3P Rehabilitation trauma and non trauma – low tetraplegic (neurological deficit C5-C8) –

343 /343P Rehabilitation trauma and non trauma – paraplegic

344 /344P Rehabilitation trauma and non trauma – patients assessed as AIS D unless classified as 345 OR patients assessed as Cauda Equina Syndrome as defined in the SCI Service Specification (see General Rules).

345 /345P Rehabilitation trauma and non trauma – patients assessed as AIS D central cord syndrome

349 Continuation of interrupted rehabilitation

This code is used in circumstances where the period of rehabilitation following injury has been interrupted by another event.

This could be for, example **late spinal stabilisation surgery** (see Section Rules)

Any admission for rehabilitation commencing within three months of the last day of a previous rehabilitation package is deemed to be Continuation of an interrupted package for the purposes of these Classifications.

Sub-Section 35 – ITU (Critical Care)

Advice

The rules about coding of ITU were changed with effect from 1st November 2011, after it became clear that Trusts were defining ITU differently. It was also decided to bring the counting of ITU bed-days more into line with how they are recorded under national PbR.

Prior to October 2011, packages were interrupted when the patient went into ITU. The old codes 310 and 410 will be found on earlier reports. For the earlier rules please refer to Handbook version 19.

'Ventilated beds', High dependency beds, 'Spinal ITU' beds and similar are not counted as ITU, and the costs of treating patients on ventilation are reflected in the top-up in Sub-Section 36.

Sub-Section Rules

ITU is defined within International Critical Care Guidelines as Level 3 care. A different definition is required for patients with spinal cord injury.

For patients in the specialised SCI service, code 350 means:

> **Patients requiring: advanced respiratory support *together with* support of at least one other organ system**
>
> **or basic respiratory support *together with* support of at least two organ systems**.

All patients not covered by this definition will be coded to the appropriate package dependent on their level of impairment.

Code 350 is used for ITU, whether occurring during the first admission following injury or during further admissions.

A patient cannot be coded to 350 and a sub-section 36 (ventilation) code simultaneously.

The 'package' for this code is a single bed day.

For counting of ITU activity, please refer to General Rules

Codes

350 ITU bed day as defined in the Sub-Section Rules

Sub-Section Tariffs

Notes to be added

Sub-Section 36 – SCI Ventilation

Advice

The rules about Ventilation were changed in September 2012. Prior to September 2012, ventilated patients in recovery, rehabilitation and some further admission packages were banded (as High tetraplegics, low tetraplegics, paraplegics etc continue to be). The old codes will be found on earlier reports. For the earlier rules please refer to Handbook version 21 draft 4.

Sub-Section Rules

For the definition of SCI Ventilation and 'dependent on tracheostomy', please refer to the General Rules.

Sub-section 36 codes are used for ventilation, whether occurring during recovery, rehabilitation or further admissions.

The ventilation codes differ from 350 ITU as they are daily top-ups. They are chargeable in addition to the recovery, rehabilitation or further admission package, for those bed-days on which the patient was ventilated, and do not replace or interrupt the package.

A patient cannot be coded to 350 ITU and a sub-section 36 code simultaneously.

The 'package' for these codes is a single day.

For counting of Sub-Section 36 activity, please refer to General Rules. Warning: Counting is **not** the same as for 350 ITU.

Codes

Code 360 (Bed-day) is used for patients who are ventilated less than 24 hours in 24.

Code 365 (Bed-day) is used for patients who are ventilated 24 hours out of 24.

Code 369 (Bed-day) is used for a patient who is not ventilated, but **is dependent on a tracheostomy.** This means the patient is not ventilated, but is entirely dependent on the tracheostomy for breathing and would die at once without it. Such cases are expected to be rare.

Section 4 –Admissions of Patients with Pre-Existing SCI.

These may be referred to as 'further admissions'

Advice

Code 110 was withdrawn with effect from 1st November 2011 and all further admissions are now classified to section 4.

Code 410 ITU in further admissions was withdrawn with effect from 1st November 2011. Please refer to code 350.

Patients in further admissions who are ventilated are eligible for the daily top-ups described in Sub-Section 36.

In many cases these people will have previously been managed as described in Section 3, but prior admission to a specialised SCIC is not a pre-requisite of being coded to Section 4. A person who was spinal cord injured in the past but not admitted to a SCIC at the time will be coded to Section 4.

An algorithm will be required in order for the National SCI Database to assign patients to these groups. It will probably first identify 45s, then 43s, then 44s, then 46s, and others will default to code 420.

Section Rules

These codes apply to people living with spinal cord injury.

Any admission for recovery after injury commencing within three months of the last day of a previous recovery package is deemed to be Continuation of an interrupted package for the purposes of these Classifications. Please refer to Section 3.

Any admission for rehabilitation commencing within three months of the last day of a previous rehabilitation package is deemed to be Continuation of an interrupted package for the purposes of these Classifications. Please refer to Section 3.

No two packages Section 4 packages will occur concurrently.

The patient will not normally have more than one Section 4 package in a spell.

Exceptionally, should two Section 4 packages occur consecutively the commissioner will expect the provider to provide evidence to support classifying the activity to two packages in a single admission.

Sub-Section 42   Other further admissions

Sub-Section Rules

This code is used for all further admissions which are not Sub-Sections 43, 44, 45 or 46

Codes

420 /420P   Further inpatient management of people living with SCI, not covered by Sub-Sections 43, 44, 45 or 46

Sub-Section Tariffs

The tariff will be per package, with outlier daily rate for short and long stays.

Sub-Section 43   Further Rehabilitation

This may also be referred to as second-stage rehabilitation.

Sub-Section Rules

This code is used only for an elective admission,

with a pre-planned duration,

and with the primary purpose of working towards defined goals,

and which involves daily multidisciplinary input.

See Section rules about interrupted packages.

Codes

430 /430P   Further rehabilitation.

Sub-Section Tariffs

The tariff will be per week. Stays will be rounded up or down to the nearest week.

Sub-Section 44   Multi-disciplinary Review and Assessment (patient admitted).

Sub-Section Rules

The patient is admitted, not for clinical need, but to facilitate the Review. This is the equivalent service to code 610 with the addition of 'bed and breakfast'

This code will only apply to elective admissions.

This code applies to pre-planned systematic review by:

  one or more doctors

and

  nurses or therapists.

during which the patient experiences

  invasive and/or exploratory investigations or procedures,

and

  6 month, 12 month, or 24 month SCIM assessment

  6 month, 12 month, or 24 month ASIA assessment

and

  any other assessments currently mandated under contractual quality and outcomes programmes.

For patients who are ventilated this additionally includes:

  Formal review of respiratory capacity and ventilation parameters

Codes

440 /440P   Review / assessment

Sub-Section Tariffs

The tariff will be per package. The rate will be the same as for an outpatient review, plus a sum in recognition of the overnight stay.

Sub-Section 45   Pressure Ulcer Management

Advice

The Currencies Group and/or the Clinical Reference Group, will as part of the QIPP programme for 2013/14, develop ‘unbundling’ or further coding to cover situations where the patient is managed in the community, and admitted to the SCIC for active treatment. To facilitate ‘unbundling’ the package for this sub-section is, exceptionally, a bed-day in 2013/14.

Sub-Section Rules

The codes are for patients admitted for the primary purpose of managing a pressure ulcer.

These codes are not used for newly injured patients admitted with a pressure ulcer.

These codes are not used for a patient who has acquired a pressure ulcer whilst an in-patient in the SCIC.

Sub-Section Codes

450 /450/P	Patient admitted for pressure sore management (bed-day)
124	(see Section 12) Daily supplement for pumps and consumables used in Negative Pressure Wound Therapy (NPWT)

Sub-Section Tariffs

For 2013/14 the package will be a single bed-day. However there is an expectation that all SCICs will develop plans for more cost-efficient ways of managing pressure sores.

The packages include any surgery, rehabilitation and everything else carried out or provided during the admission, with the exception of 350 ITU, Section 36 Ventilation, any items attributable to Section 12 or Section C, (see code 124).

Sub-Section 46 Urology

Advice

Urological problems are a common complication of spinal cord injury.

Sub-Section Rules

These codes are used for people admitted for the primary purpose of urological assessment and/or treatment.

These codes are not used for people who have urological treatment in the course of a Sub-Section 43, 44 or 45 admission.

The codes include everything else carried out or provided during the admission, with the exception of 350 ITU, Sub-Section 36 Ventilation, or any items attributable to Section 12 or Section C.

Codes

460 /460P Urology, excluding day cases

462 /462P Urology day case

Sub-Section Tariffs

The package will be per package with outlier daily rate for short and long stays.

Sub-Section 47 Maternity

Advice

This code has been added in October 2012 in case it is needed in 2013/14.   It wa **not** used in the costing exercise being carried out in October/November 2012. It may prove necessary to identify this activity, because of the introduction of the proposed single payment for maternity under PbR.

Sub-Section Rules

These codes are used when the primary purpose of the admission is the ante-natal, delivery or post-natal care in a woman with SCI or Cauda Equina syndrome as defined in the General Rules.

Codes

470	Maternity, except day cases
472	Maternity day case

Sub-Section Tariffs

The implications of the new PbR tariff for maternity needs to be investigated, as payment cannot be duplicated.

It appears that where the woman registers for maternity care with the host Trust of the SCI there is no problem, as the Trust will claim the maternity tariff (probably the 'Complex Maternity' tariff.) Any cross-charging would be an internal matter.

However if the woman registers with another Trust, the SCIC Trust will need to request unbundling of the tariff from that hospital.

Section 5

Not used

Outpatient multi-disciplinary reviews are now in Section 6.

Section 6 - Outpatient attendances

Advice

It is good practice for the patient to see as many staff as they need to see in one visit, and not to have to make multiple visits.

The four sub-sections 610, 620, 630, and 640 below therefore accommodate patients who may be seen by multiple staff-groups on one occasion. The highest tariff applies to code 610, then 620, then 630, then 640.

The algorithm will sort attendances to identify 610s, then 620s, then 630s, and all attendances not meeting the criteria for higher classification will default to 640.

Section Rules

The services in this Section all apply outpatient activity only.

No patient will experience more than one of the following packages in a day: 610, 620, 630, 640.

All packages include the elements defined in the Sub-Section Rules, or any other services provided to the patient and any other staff seen on that day, unless

The service provided has a Section 12 or Section C code.

Sub-Section 61 Multi-disciplinary Review and assessment.

Advice

Sub-Section 44 is the same service, when it is necessary for operational reasons to admit the patient.

Sub Section Rules

This code applies to pre-planned systematic review by:

> one or more doctors
>
> and
>
> nurses or therapists.

during which the patient experiences

> invasive and/or exploratory investigations or procedures,
>
> 6 month, 12 month, or 24 month ASIA assessment
>
> And 6 month, 12 month, or 24 month SCIM assessment
>
> And any other assessments currently mandated under contractual quality and outcomes programmes.

The code 611/611P additionally includes:

> Formal review of respiratory capacity and ventilation parameters

Codes

610/610P Multi-disciplinary Review and assessment

611/611P Multi-disciplinary Review and assessment. in Ventilated Patient.

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 62 Outcomes Assessment .

Advice

Sub-Section Rules

This is an outpatient visit during which the patient sees at least one consultant, and experiences

> 6 month, 12 month, or 24 month ASIA assessment
>
> And 6 month, 12 month, or 24 month SCIM assessment
>
> And any other assessments currently mandated under contractual quality and outcomes programmes.

Unless the attendance meets the criteria for Code 610/611

Codes

620 /620P Outcomes Assessment

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 63 Outpatient Visits to Doctor

Sub-Section Rules

This is an outpatient visit during which the patient sees at least one doctor, unless the visit meets the criteria for code 620 or 610.

Codes

630/630P Outpatient Visit – Doctor

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 64 Outpatient Visits to Nurse and/or Therapist

Sub-Section Rules

This is an outpatient visit during which the patient sees at least one nurse or therapist, unless the visit meets the criteria for code 630, 620 or 610.

Codes

640 /640P   Outpatient Visit – Nurse or therapist

Sub-Section Tariffs

Tariffs will be per package

Sub-Section 64 Outpatient Visits for Maternity

Sub-Section Rules

See explanation under Sub-Section 47

This is an outpatient visit for ante-natal or post-natal care.

Codes

470   Outpatient visit – Materntity

Sub-Section Tariffs

Under consideration

Section 7: Outpatient Attendances which have taken place at an Outreach Clinic

Advice

It is considered worthwhile, for strategic and planning purposes, to distinguish this activity from activity taking place on SCIC premises.

Section Rules

This applies only to activity which takes place in regular NHS **Clinics** organised and held by the SCIC outside the premises of the SCIC provider Trust.

Any activity for which the host organisation charges is excluded.

The provider will identify the location of the Clinics to the Commissioner.

This section excludes visits to individual patients in the community, or visits to patients who are in-patients in other hospitals.

Codes

This section mirrors Section 6 in all respects, except that 7 is substituted for 6 at the beginning of the code.

Section Tariffs

Tariffs will be per package

Section 8: Outreach Visits

Advice

Consideration will be given, under the QIPP programme for 2013/14, to developing a code and tariff for 'intensive' visits to patients being managed in the community for a pressure ulcer, as part of 'unbundling' Sub-Section 44.

There is also a proposal to continue in 2013/14 the CQUIN under which outreach visits were incentivised. If this Cquin is approved for contracts, the tariff for Outreach Visits will remain in the Currencies handbook, but the tariff will be set at £0 for the year.

Section Rules

This section includes face-to-face visits made by SCIC staff to individual patients.

Each visit is counted only once, regardless of the number and grade of staff who visit.

The visit will include any additional visits made to family, carers, employer, GP, health workers etc.

Only one visit will be counted in any 24 hour period.

Codes

810	Visit to newly injured patient in a hospital which is not part of the same Trust as the SCIC
820	Visit to patient living with spinal cord injury who is an in-patient in a hospital which is not part of the same Trust as the SCIC.
830	Visit to patient in the community.

Section Tariffs

Tariffs will be per package

Section 9: Patient Transport

Not within the Scope of Specialised SCI.

Advice

Contains codes for services which are outside the Scope of Specialised SCI. These codes are used for costing and administrative purposes only and will not appear in contracts.

The NSCISB has issued Guidance on applying the national guidelines to people with SCI needing patient transport services.

Rules

Applies to people treated by the specialised SCI service who are eligible for patient transport services or HTCS.

Codes

910	Patient transport services for those with a clinical need for transport.
920	Reimbursements under the Hospital Travel Costs Scheme (HTCS)

Section 10

Not in use.

Non-admitted care for patients who are outside the scope of the specialised SCI service is now shown in Section 1.

Section 11

Not in use.

All further admissions are now in Section 4

Section 12: Restricted list of items or services which can be charged to SCI contracts

Advice

These items would not be 'exclusions to PbR'.

These items have individual codes because the cost would otherwise distort SCI package tariffs.

It should be noted that until commissioners and providers formally change to contracting in the new currencies, existing contracting arrangements and tariffs apply to these items.

National Commissioning Policies are being developed for some of these products/services, and their inclusion in this list is not intended to imply that they will be commissioned in 2013/4 without restrictions.

Section Rules

These devices are charged to contracts at purchase price, but the hospital stay and the procedure to implant the device is included in the relevant inpatient package

Some contractual conditions may apply to the use of these products: please refer to Service Specification.

Any drug or device not listed in this section or Section C is included in package prices.

Codes

122 Artificial sphincter

123 Phrenic nerve stimulator

124 Daily supplement for pump, dressings and associated consumables used in Negative Pressure Wound Therapy (NPWT)

Likely to be a in the region of £24 per day

This code only applies to patients with pressure ulcers present on admission to the SCIC. In the case of pressure ulcers acquired in the SCIC, the cost will be borne by the provider and may not be charged to the commissioner.

Tariffs

The daily supplement for NPWT is likely to be in the region of £24 per day.

Implants will be charged at the (reasonable) rate the provider paid. Providers should expect to use the most cost-effective products, and to provide if requested by commissioners a copy invoice or other agreed voucher.

There will be a facility on the National SCI Database to enter, against the patient record, the date an item was provided and the cost. The database will then calculate the sums to be charged to contracts for these codes.

For pressure ulcers, there will be an algorithm in the database.

Section C: Restricted list of items or services which can be charged to SCI contracts

Advice

The items in C2 are items are on the national PbR exclusions list and although PbR does not apply to the specialised SCI tariffs, it was decided to exclude these items from SCI package tariffs, on the basis that the items would otherwise distort package prices.

It should be noted that until commissioners and providers formally change to contracting in the new currencies, existing contracting arrangements and tariffs apply to these items.

National Commissioning Policies are being developed for some of these products/services, and their inclusion in this list is not intended to imply that they will be commissioned in 2013/4 without restrictions.

Additional notes on PbR Exclusions

Currently the entirety of services provided in SCICs is outside PbR, even when the service would attract a PbR tariff if delivered in another setting. So the concept of a PbR exclusion in SCI does not apply.

This means that the annual national list of PBR 'Exclusions' comprising services, drugs and devices does not apply to the specialised SCI Service.

The four items listed under C2 below do happen to be in the PbR exclusions list, but that is for the same reasons that they have a C2 code – they would otherwise distort tariff prices.

Section Rules

Code C1 provides for exceptional circumstances, including occasions when it is unavoidable to deploy agency staff to ensure the safety of staff or patient. These cases are expected to occur very rarely. The code is not used when SCI Trust staff are deployed. In all cases the provider will contact the commissioner in advance to discuss the options and to agree the extent and duration of the relevant service. The provider will, if requested by the commissioner, provide copies of invoices paid.

Code C2 devices and drugs are charged to contracts at purchase price, but any related hospital stay or any procedure to implant a device is included in the relevant inpatient package.

Some contractual conditions may apply to the use of these products: please refer to the Service Specification.

Any drug or device not listed in this section or Section 12 is included in package prices.

Codes

C1 Daily rate.

Exceptional staffing to support patients with severe mental health problems or learning disability of a challenging nature, or posing serious risk to self or others.

C2 Intrathecal drug delivery pumps

Botulinum toxin

Sacral nerve stimulators

Spinal Cord stimulators

Tariffs

In all cases, items in this section will be charged at the (reasonable) rate the provider has paid. Providers should expect to use the most cost-effective products, and to provide if requested by commissioners a copy invoice or other agreed voucher.

There will be a facility on the National SCI Database to enter, against the patient record, the date(s) the item was provided and the cost. The database will then calculate the sums to be charged to contracts for these codes.

Version control

V18	Approved 30/9/2010
V19	Changes to definition in 'scope', interrupted readmissions, 'readmission' changed to 'further admission' and additional explanations
V19a	Central cord syndrome instead of injury
V20	Changes agreed on 28th October 2011, affecting particularly the definition of ITU.
V21	**New Edition**
V21 D1	Changes affecting non-admitted care
V21 D2	Following Currencies meeting 25th July 2012
V22 (renamed V21 D3)	Following CRG 21st Aug and NSCISB 24th Aug 2012
V21 D4	10th Sept 2012
V21 D5	11th Sept 2012 to CRG and Currencies Group
V21 D6	18th Sept 21012 Change agreed at Currencies teleconference, affecting particularly the coding of ventilation.
V21 D7	20th October 2012. Corrections and addition of maternity codes.

Appendix 1

National Spinal Cord Injury Strategy Board (NSCISB)

Approved on 4th March 2011

COMMISSIONING CLASSIFICATIONS ('Currencies') SUBGROUP

SCI Coding Reference Group

Terms of Reference

Background

There are occasional cases which fall outside the usual pattern of service.

The Trusts have a problem with coding such patients as they do not match the agreed coding structure contained in the Coding Handbook.

Example 1:

Patient was managed non-surgically in the recovery package. After two months of rehabilitation, a late decision was made to surgically fix the spine.

Example 2.

While patient was having recovery package, plans were made to transfer him to a SCIC nearer home for rehabilitation. He was classed as fit to commence rehabilitation in line with the definition in the Coding Handbook. 2 days later he transferred to the other SCIC, where he undertook his rehabilitation.

Although the Coding Handbook has been refined in the light of data collected, and this will continue, it is unlikely that every possible eventuality will be captured in advance of it occurring.

Proposal

The NSCISB is requested to approve the setting up of a small Reference Group or Panel.

Purpose

The purpose of the panel is :

1. To advise any SCIC which asks for informal advice about how to code an unusual case.

2. To advise any commissioner which asks for informal advice on a specific coding issue.

2. To provide a formal expert opinion in disputes between a SCIC Trust and a commissioner about the assignment of codes.

3. To report to the Commissioning Classifications Sub-Group

The membership of the panel will be:

One SCI commissioner – to act as chair and convener.

One SCI commissioning accountant

One SCIC clinician

Each member will have one or more deputies.

One of the group will act as secretary.

Members and deputies will be appointed by the Commissioning Currencies Sub-Group.

A pre-requisite of membership will be familiarity with, and involvement in the development of, the coding handbook, and understanding of the costing implications of decisions.

Procedure

- The Reference Group will normally meet when needed, by conference call or e-mail.
- The panel will be a sub-group of the NSCISB Commissioning Classifications Sub-Group, and therefore accountable to the NSCISB.
- Any SCIC or commissioner can request advice or an opinion. It will be the responsibility of the SCIC to provide the Panel with a short written report on the circumstances of the case.
- The panel will take into account the cost implications of its decision, in the light of the methodology used to develop the SCI Tariff.
- If the panel recommends a wider discussion, it will refer the matter to the full Commissioning Classifications Sub-Group.
- If the panel cannot agree on a matter referred to it for arbitration, it will refer the matter to the NSCISB for a decision.
- All decisions and recommendations will be recorded, and reported in writing to the parties, and to the NSCISB Commissioning Classifications Sub-Group, which will report all significant decisions to the NSCISB.
- The panel may request that clarifications be incorporated into future editions of the Coding Handbook.
- It is expected that all parties will accept as final all decisions about coding which have been endorsed by the NSCISB. (note this is consistent with the ToR of the Commissioning Classifications Sub-Group).