Sharing the benefits of healthy living

# VitalityHealth Billing Standards

## For all clinicians working with us and our members

**Updated 31 May 2023**

## Definitions

**In these Billing Standards, unless the context otherwise requires, the following words and expressions shall have the following meanings:**

**Member**
Means the person that you provide healthcare services to.

**Us/Our/We**
Means Vitality Corporate Services Limited, trading as VitalityHealth.

**You/Your**
Means the consultant who provides healthcare services to members.

**Recognised Therapist**
Means the healthcare professional who is recognised by VitalityHealth.

**Recognised Consultant**
Means consultants recognised by VitalityHealth.

**Believers in best practice**

To protect our members' interests and the reputation of our brand, we choose to work only with Clinicians who show a total commitment to providing quality and affordable healthcare. Part of this commitment is an agreement to our Terms of Recognition www.vitality.co.uk/healthcare-providers/i-am-a-consultant/

## Summary of our Billing Standards:

- We offer full refund plans so there are no unexpected shortfalls from Clinicians for our members, however we expect you to bill appropriately and within our published fee ranges.
- We expect you to respond to any queries we may have within 5 working days. This is to support our members during their treatment and not burden them with unnecessary hold ups or put barriers in the way of their treatment due to disputes over fees.
- We expect you to have a working understanding of the key features of private medical insurance, what is usually covered and the options that are available to members if treatment is not covered.
- We value the fact that our Clinicians interact with us with honesty, integrity, and transparency. On occasion, if we spot a billing behaviour that is unusual or unexpected, we will contact you to obtain further information.
- We expect you to operate within the Billing Standards listed in this document and the fees published on our Fee Finder.
- We expect you to provide us with medical records that are dated, and readable. A typed copy will be requested alongside the originals if we are not able to easily read them.
- It is your responsibility to ensure all codes that you provide us with and bill for, are accurate; if you delegate this task to someone else you will still be responsible for errors or omissions.
- You should promptly create a profile for publication on the Private Healthcare Information Network's (PHIN's) website www.phin.org.uk/
- We do not expect to be billed for follow up consultations that are purely for giving results or administrative in nature.
- Where a CCSD coded diagnostic test takes place on the same day as a consultation, and you carry out the test as well as reporting the results, we expect these to form part of the charge for the consultation.
- Sole Procedure CCSD codes are only to be used in isolation.
- Publication of a code and/or fee in our Fee Finder does not necessarily mean this CCSD code will be eligible, and you should always check with us that this procedure has been authorised.

## 1. Fees

### 1.1 Pre-authorisation

- All treatment must pre-authorised with us prior to treatment taking place and our member should provide you with their pre-authorisation code.

### 1.2 Consultations

**Recognised Consultants:**

- Our members value their time with you and you should provide them with as much detail and care as possible so that they are comfortable with your diagnosis, planned tests and treatment plan.
- Following the consultation, the member should be provided with all relevant CCSD codes to ensure further pre-authorisation is not delayed.
- Consultations should be billed using the correct CCSD code www.ccsd.org.uk/ and at the correct fee www.vitality.co.uk/healthcare-providers/fee-finder/
- The consultation fee is irrespective of the time taken with the patient.
- The consultation charge is all inclusive and we should not receive additional charges to cover your costs, including but not limited to your costs of staff or room hire.
- It would not be standard practice to see a patient for two consultations on the same day and we would not expect to be billed as such.
- **We do not expect to be billed for follow up consultations that are purely for giving results or administrative in nature.**

- **If the patient is coming in for a planned procedure, then we would not expect to be billed in addition for a follow up consultation on the same date.**
- During chemotherapy/immunotherapy regimes, we would not expect to be billed for additional consultations as this is included in the supervision of chemotherapy CCSD codes.
- We do not pay for writing prescriptions.
- We will not pay for consultation fees from Clinical Radiologists, Anaesthetists, Neurophysiologists or Pathologists.
- All consultations should be accurately documented.
- **We will not fund more than one out-patient consultation per patient in a single week, more than two per month, or more than 10 in one year, unless agreed in writing in advance, or at our discretion.**
- **Where a CCSD coded diagnostic test takes place on the same day as a consultation, and you carry out the test as well as reporting the results, we expect these to form part of the charge for the consultation.**

**Recognised Therapists:**

- **Only one session per member per day, and three sessions per week, except where written authorisation has been provided in advance.**
- The consultation fee is irrespective of the time taken with the patient.
- We do not pay for writing prescriptions.
- We do not expect to be billed for follow up sessions that are for giving results or administrative in nature.
- The session charge is all inclusive and we should not receive additional charges to cover your costs of staff or room hire etc.
- All sessions should be accurately documented

**1.3 Diagnostics**

- We expect that most diagnostic tests will be undertaken and billed by the hospital or clinic that you work from.
- We will have a separate agreement with a facility and so would not expect you to bill for these tests also.
- In rare instances, where there is no option for the facility to bill, you will need to get a written agreement to bill for diagnostics.
- If you have a written agreement with us that you can bill your own diagnostic tests, at your own premises, with your own equipment that you operate, insure, and maintain, then we would expect you to code these accurately using the CCSD diagnostic code schedule.
- We will not pay for report writing.
- Fees for interpretation of any diagnostic tests are not covered.
- Do not make a charge if you did not perform the diagnostic test yourself, or where a hospital facility has invoiced for a test which includes a Recognised Consultant component.

**1.4 Procedures**

- The fee that we pay for a procedure is all inclusive, we would not expect to be billed in addition for any extras, such as fees for:

| Service provided | Reason we won't pay extra |
|---|---|
| Pre- and post-operative care including analgesia, such as putting in of IV lines, drips, dressing changes, admission and discharge of the patient | Unbundling |
| Minor complications: such as wound care, dressing changes, re-suturing, change of cast. | Unbundling |
| Anaesthesia provided by you as the main operator, such as local anaesthetic, topical anaesthetic, IV sedation or any form of sedation. | Unbundling |
| Additional procedures that are integral to the procedure being performed, such as creating laparoscopic access or closing the wound. | Unbundling |
| Surgical assistants | Paid to the Facility |
| Routine postoperative care, such as daily ward care, wound checks, suture removal, dressing changes | Unbundling |
| Follow-up consultations in the first 28 days after the date of surgery | Unbundling |
| Histopathology | Paid to the Facility |
| Diagnostic imaging | Paid to the Facility |
| Pathology | Paid to the Facility |
| Consultations on the same day as any planned procedures | Unbundling |
| Remote monitoring | Unbundling |
| Phlebotomy | Paid to the Facility |
| Room hire | Unbundling |
| Consumables | Unbundling |
| Daily intensive care for procedures for where it is expected | Unbundling |
| Being on call | Unbundling |

### 1.5 Multiple CCSD codes

- For most clinical interventions you can use a single CCSD code to describe the procedure from start to finish.

- If it is appropriate to use additional CCSD codes, you should check for any unacceptable combinations or sole procedure wording before submitting them as this would be classed as **'unbundling'.**

- We define unbundling as the breaking down of a surgical procedure into components normally considered part of that procedure and then charging for each component in addition. In layman's terms, this would be like ordering a cup of tea from a café and then being billed separately for the tea bag, hot water, milk, sugar and the cup and spoon!

- We won't pay additionally for:
  **Procedures considered integral to a specific procedure – for example:**

  - Osteotomy of long bone during total hip replacement
  - Cardiac catheterisation prior to coronary angioplasty
  - Diagnostic arthroscopy with therapeutic arthroscopic procedures
  - Bilateral oophorectomy and salpingectomy as part of total abdominal hysterectomy
  - Endoscopic examination of ureter with endoscopic retrograde pyelography
  - Radiographic imaging for procedures usually performed under X-ray control.

**Procedures integral to a wide range of procedures – for example:**

- Phlebotomy
- Insertion of intravenous access for medication administration;
- Primary suturing of a wound and removal of sutures;
- Application and management of post-operative dressings and analgesic devices (e.g., patient-controlled analgesia).

**Procedures for gaining access to the target organ system or operation site – for example:**

- Clearance of impacted wax prior to myringotomy
- Adhesiolysis or exploratory laparotomy prior to intra-abdominal procedures;
- Urethroscopy or cystoscopy with other endoscopic intravesical or nephro-ureteric procedures;
- Bronchoscopy prior to thoracic surgery where the diagnosis has already been established.
- Cutting through adhesions

**Endoscopic procedures done as part of an open procedure or converted to an open procedure – for example:**

- Laparoscopic cholecystectomy converted to an open procedure.

**Procedures for postoperative analgesia performed by the anaesthesia**

### 1.6 Sole procedure CCSD codes

- Sole Procedure CCSD codes are only to be used in isolation.
- You cannot use CCSD codes that the CCSD narrative classifies 'as sole procedure' in combination with any other CCSD code.
- The only exception is when procedures are performed at completely different anatomical sites.
- Sole Procedure CCSD codes are defined and set by CCSD and are industry standard, for more details see CCSD www.ccsd.org.uk/

### 1.7 Multiple procedure billing

- If appropriate, our fee structure allows you to bill for more than one procedure on a member during the same operating session. In these cases, we will normally increase payments by a percentage of the most complex procedure.
- **Where the same operator carries out two procedures during the same operating session, we'll pay up to 25% over the maximum for the most complex procedure.**
- **Where the same operator carries out three or more procedures during the same operating session, we'll pay up to 40% over the maximum for the most complex procedure.**
- In the rare instances where the same operator carries out two different procedures on the same day but not in the same operating session, we'll pay up to 100% of the eligible maximum for both procedures.
- We won't consider paying for unbundled procedures in any circumstances.

### 1.8 Bilateral procedures

- CCSD has created bilateral codes for procedures that are commonly or invariably performed bilaterally.
- If there is a bilateral CCSD code, then we expect you to use it and not submit an invoice with the unilateral CCSD code listed twice. Where the same CCSD code is charged for twice or more in one invoice, we will only pay for one CCSD code.
- We will pay up to the published fee maximum if there is a CCSD code for the bilateral procedure (e.g., bilateral mastectomy), for that CCSD code only.
- Where there is no bilateral procedure CCSD code and only where the procedure in question is not often, typically, or always undertaken bilaterally, we will pay up to an additional 50% of the fee for the unilateral procedure.

### 1.9 Multiple specialists

- **Our procedures are priced for the procedure itself and are not for multiple operators to claim.**

- **If the procedure is unusually complex or where clinical guidelines from a UK national professional body is that multiple operators are needed please request via the form on our website,** https://www.vitality.co.uk/healthcare-providers/contact-us/

- We would not expect our member to be involved in any dispute over fees or codes, treatment should proceed without delay if pre-authorisation has been given. Fee issues will be resolved in retrospect and should not impact the treatment plan when pre-authorised.

- If our member's care is compromised as a result of financial negotiations, then we will review your recognition status with us. Please refer to the GMC Good Practice Guide page 24 for clarification of your professional guidelines regarding financial dealings.

**1.10 Unproven treatment**

- **We will not routinely cover unproven or experimental treatment.**

- If you feel that this type of treatment would be the most effective treatment approach for our member then you must contact us in advance of treatment and provide us with full details so our Medical Policy team can review your request.

- We may cover at our discretion, provided there is evidence of safety and efficacy of the proposed treatment. These requests will be assessed on a case by case and you should not go ahead until this has been confirmed in writing by us.

- You should never use a conventional treatment CCSD code to invoice for unproven treatment. For new procedures that are uncoded you should contact CCSD directly to obtain a CCSD code as you will be best placed to provide details of the treatment www.ccsd.org.uk/

**1.11 Fee Finder**

- We aim to agree fees which are a true representation of time and complexity comparing against both market rates and sustainable against medical inflation.

- We provide a fee range for each procedure and these can be found on our Fee Finder www.vitality.co.uk/healthcare-providers/fee-finder/

- The Fee Finder provides you with information on what our fees are for the procedures which we may cover.

- If a search returns no results and you should contact us before proceeding to clarify if the procedure you are planning is covered on our member's policy.

- Publication of a code and/or fee in our Fee Finder does not mean this CCSD code will be eligible, and you should always check that this procedure has been authorised.

**1.12 Fee uplifts**

- We reserve the right to reject any proposed increase from our published rates and due to the full refund promise we give our members; we would not expect any shortfall in what you were expecting to be passed to the patient.

- Once you have a decision on a fee-uplift request, we ask that you submit your invoice to us within 30 calendar days.

- We would not expect our members to be involved in any dispute over fees or codes, treatment should proceed without delay if pre-authorisation has been given. Fee issues will be resolved in retrospect and should not impact the treatment plan when pre-authorised.

- If our member's care is compromised as a result of financial negotiations, then we will review your recognition status with us. Please refer to the GMC Good Practice Guide page 24 for clarification of your professional guidelines regarding financial dealings.

### 1.13 Fee challenge

- We will challenge invoices where the rate billed is higher than our published fees.
- In these cases, we'll always work with you to understand the circumstances with the aim that our member is not placed in the middle of any discussions surrounding costs.

## 2. Invoicing and Clinical Coding

### 2.1 Healthcode

- It's always our aim to pay your fees quickly and in full. To facilitate this process, invoices should be electronically submitted within 3 months of treatment to Healthcode electronic billing for practitioners. This is a highly secure method with a number of benefits for you, including high levels of accuracy and greater speed of payment.

### 2.2 Invoice Form

- As well as Healthcode, we also have an invoice form on our website www.vitality.co.uk/healthcare-providers/i-am-a-consultant/. Please note that this process could be much slower as you can only submit one invoice at a time.

### 2.3 Clinical Coding - Procedures

- In the NHS, you will use OPCS coding for your procedures, in private practice you cannot use OPCS coding.
- All private health insurers and facilities use CCSD coding for all procedure and diagnostic coding.
- We expect you to use this industry standard CCSD Schedule code set.
- Without the correct CCSD code, your invoice will be held up and potentially unpaid.
- You should regularly check the CCSD website (https://www.ccsd.org.uk/) for updates and participate in submitting new codes for review.
- Updates are typically made every 1 to 3 months.
- All our recognised providers must comply with CCSD coding principles, please check their website for full details.
- We fully support and are active in the development of CCSD coding principles to define unacceptable code combinations.
- These can be found on the CCSD website www.ccsd.org.uk/

### 2.4 Clinical Coding – Diagnosis

- ICD coding is a worldwide coding system and spans both private and NHS work.
- You should include a diagnosis code on your invoice using the correct ICD 10 coding. This should align with your NHS practice.
- ICD coding is important for patient record keeping and data analysis of outcomes and should not be overlooked.

## 3. Clinician Quality

### 3.1 Requests for information

- We may request information from you at any time. This includes, but is not limited to, a claim for treatment, an invoice received or a clinical complaint.
- We will not cover any fees for correspondence and report writing.
- We expect that you respond within 5 working days so as not to delay our member's treatment.
- It is your responsibility to make sure that all the information you provide is accurate.
- We will only accept official documentation, signed by you, such as clinic letters or operation notes or completed forms.
- Letters written to us directly are not accurate representations of clinical activity.
- We will not pay you to complete a form or provide us with documentation.

### 3.2 Misrepresentation - Fraud & Audit

- The Fraud Act 2006 sets out the legal definition of fraud and creates offences of fraud by false misrepresentation, fraud by omission and fraud by abuse of position.
- A person who makes a false statement, omits material facts or misuses a position of trust with the intention of causing loss to a third party is guilty of fraud even if they do not personally gain and even if the deception fails.
- We're an active member of the Health Insurer Counter Fraud Group. We share information with other insurers for the detection and prevention of fraud subject to the provisions of the Data Protection Act 2018. https://hicfg.org.uk/
- We consider all the following to represent fraud:

| Billing practice | Examples |
|---|---|
| Up-coding to maximise payment | Such as billing a procedure of higher complexity than the one performed |
| Unbundling to maximise payment | Such as additional billing for component parts of a complex procedure |
| Billing for services that were not provided | Such as billing for the services of an anaesthetist |
| Billing for services that were not medically necessary | Such as additional scans or blood tests |
| Altering dates, description of services or medical records to secure payment | Such as billing for a Psychiatric consultation when CBT was delivered. |
| Misrepresentation of diagnoses or procedures | Such as identifying the claim as malignant when it is benign. Billing for an unproven procedure using conventional treatment codes. |

- We are committed to preserving the integrity of the private healthcare sector and we continuously monitor claims trends and variant billing for signs of irregular billing patterns.
- Should you show up as an outlier in your billing then we will expect you to readily provide us with full details on your practice and charges billed to assist us in any audit or investigation.
- We do this to protect our members' financial interests and protect them from harm.
- Any non-compliance with these Billing Standards could trigger a review of your recognition status with us.

## 4. Governance

### 4.1 Clinical complaints

- We take all clinical complaints extremely seriously.
- Our aim is to manage clinical complaints in an efficient and structured manner as to ensure that our members are provided with the quality of care that we expect from our healthcare providers.
- Individual clinical complaints will be reviewed and investigated accordingly thoroughly as to protect the safety of our members and the integrity of our organisation.
- We will begin a review of your practice if you have three service complaints in one year or one clinical complaint or serious incident logged against you.
- Auditing and analysis of clinical complaints will be completed at intervals to enable continued improvement to the quality of care provided.
- We are at liberty to take appropriate actions where appropriate, including referring to your responsible officer, referring to the hospital for investigation and can review your recognition status as a result of a serious clinical complaint.

### 4.2 Quality measures

- As well as billing metrics we also will use quality measures to help us guide our members to the best quality providers using sophisticated profiling techniques.
- Information such as consultation data, surgery conversion ratios, length of stay data, Patient Reported Outcome Measures (PROMs) and complaints data will be used to create a quality score.
- We will also combine this with any data submitted to the National Joint Registry, Spinal Registry, or any other registry relevant to your speciality.

**4.3 Important updates:**

- Should we make any updates regarding anything contained in this document, we will publish these on the website for reference purposes, we expect that you will check there periodically.

**4.4 PHIN - Private Healthcare Information Network (PHIN)**

- The CMA have advised that consultants providing private healthcare services shall update PHIN with the following information:

  (a) Outpatient consultation fees, which may be expressed as either a fixed fee or an hourly rate.

  (b) the standard procedure fee for the 50 types of procedure most frequently undertaken by the consultant; and

  (c) standard terms and conditions, plus any exclusions or caveats, expressed in a standard form as determined by the information organisation.

- This information is important to patients when assessing the affordability of accessing healthcare in the private sector.

- You should create a profile for publication on PHIN's website www.phin.org.uk/

- Research indicates that information about consultants is of primary value to patients.

- Patients want to see information about a consultant's training, areas of specialisation, the procedures they perform and the locations at which they practise.

- The profile provides an opportunity vehicle for patients when assessing access to and affordability of private healthcare.