CCSD TECHNICAL GUIDE AND BUSINESS RULES

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CCSD Technical guide and business rules

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Version control

This document will be reviewed annually, except where otherwise stated. Version history is shown in the table below. Within the Appendix of this document is detail of the changes made with each version.

Version	Date updated	Next routine update due
1	August 2023 (creation)	August 2024
2	September 2023 (update)	September 2024
3	December 2023 (update)	December 2024
4	February 2023 (addition of RAS coding guidance)	February 2024
5	October 2023 (addition of Gender Affirmation subchapter)	February 2024

1 Introduction and background

The Clinical Coding & Schedule Development (CCSD) Group was originally formed to oversee the improvement of coding standards for the private healthcare sector in order to enable accurate reimbursement and support wider healthcare management and analysis. This includes the development and maintenance of the CCSD Schedule which covers procedures, consultation codes, treatment codes and diagnostic tests, providing codes and narratives to reflect current medical practices.

A key purpose of the CCSD Group is to develop and maintain a common set of codes, clinical narratives and supporting rules for clinical activity delivered in the private and independent healthcare sector to:

- Drive transparency
- Aid understanding of the care delivered
- Support healthcare delivery & management
- Provide a mechanism for effective reimbursement and billing

The schedule represents a common language used to describe clinical activity, so that all users (including insurers, funders, providers, consultants, and customers) have a shared understanding of the care that has been delivered. These codes should support activity collection irrespective of funding source (such as private medical insurance, self-pay or other type of funding) This data can then used in many areas of healthcare provision including performance reporting, analysis, benchmarking, planning and payment.

The CCSD schedule(s) seek to ensure alignment of the principles and standards of NHS coding with the United Kingdom, although due to the differing purposes of these classifications there are occasions where differences occur.

The process of developing the coding schedule is independent of commercial or financial considerations, which are a matter for individual organisations to address through their own processes and governance. The eligibility, complexity structure used for reimbursement and fee attached to individual clinical events is a matter for each funder and provider to decide through contract management.

1.1 Procedure Schedule

The purpose of the Procedural Schedule is to set out codes, descriptions and classifications for those healthcare interventions that are commonly performed, improve data collection, and avoid ambiguity about procedures performed. Within this schedule there are also codes for consultations, assessments and some investigations.

1.2 Diagnostic Test Schedule

The purpose of the Diagnostic Test Schedule is to set out codes, descriptions and classifications for those diagnostic tests that are commonly performed, improve data collection, and avoid ambiguity about tests performed.

2 Purpose of this document

This document brings together the CCSD principles, business rules and the technical detail of the CCSD schedules to establish a robust framework to support user understanding of the Schedules and how it should be used in practice in order to drive accurate coding of clinical activity in the independent healthcare sector. Those who are new to using CCSD codes will be supported by following the guidance in this document. The technical rules within will help ensure that new codes adopted to the schedules are consistent and follow an underpinning guidance regarding how the authors of the schedules intend the codes to be interpreted and used.

This document forms part of a package of documents to support users of the CCSD schedules. Alongside this there are training materials including video and PDF how to guides to support CCSD members interacting with the code via the website.

How To guides available via the CCSD website.

- How to submit a new user application
- How to submit a new code request
- How to review a request and submit feedback
- How to submit a query
- How to review a query and submit feedback

- How to download a copy of the schedule
- Navigating the website

3 CCSD schedule structure

The CCSD procedure schedule is predominantly anatomically driven, meaning it is broadly linked to body systems in its organisation, rather than approach or procedure driven. There are a few chapters, such as Chemotherapy which are not anatomically driven. The diagnostic schedule chapters are arranged along speciality lines, for example Cardiac Diagnostic and Audiology Diagnostic.

Chapters and sub-chapters of existing codes are updated when there is an inconsistency in coding structure, and this is agreed by the Working Group. New Chapters and Sub-chapters are added where a new code does not fit in any current chapter, and this also has to be agreed by the Working Group. See section 7 for further details on the Working Group arrangements.

Some codes appear in both the Diagnostic and Procedural Schedules. This means that they have two different chapters and codes assigned to them.

For example

- E2500 Diagnostic nasolaryngopharynoscopy +/- biopsy, +/- cautery as a sole procedure.

This code is in chapter 5 of the Procedural schedule and chapter 35 of the Diagnostic schedule.

3.1 Chapter

Each chapter has a set of predefined rules to determine which codes should be included and in which section they should be. Below is an outline of the important factors to consider in each chapter.

The purpose of a chapter is to provide structure to schedule. When adding new codes, chapters should be in line with similar procedure/ diagnostic test codes where possible.

3.2 Sub-chapter

The purpose of the subchapter is to provide further structure to schedule, and it should be specific to a chapter. Sub-chapters are broadly linked to types of surgery within that anatomical area. For new codes, the sub-chapter should be in line with similar procedure/ diagnostic test codes where possible.

For example

Chapter 7 – Breast

7.1.0 Excision/Biopsy codes

7.2.0 Mastectomy

7.3.0 Reconstruction

7.4.0 Other

4 CCSD coding principles

4.1 Single code principle

All CCSD schedule users should use a single CCSD code to describe the majority of common clinical interventions. This single code will usually fully describe the procedure form start to finish. This includes covering the actual procedure and all its component parts and additional procedures which are routinely performed with it. For example:

- Pre-operative assessment
- Anaesthesia
- Intra-operative care
- Post-operative care
- Intensive care
- Wound dressing and care

- Immediate post operative analgesia

CCSD codes do not contain the granularity seen in NHS procedural and diagnostic codes. By having a single code, rather than building codes, numerous specialist clinical codes and complex systems are not needed to code with CCSD. Although there are limitations of lacking detail in some areas, the codes are set up such that the narratives are sufficient to describe and understand the activity in question and thus support quick reimbursement.

No common clinical intervention should routinely require more than one code, but occasionally two procedures undertaken at the same attendance may legitimately require two codes to fully describe them. In practice, each insurer has different contractual rules in place around the use of multiple codes so you should contact the insurer if you are considering using two procedure codes for this reason. If there is more than one code to describe a common clinical intervention, a new code request should be made so that a new single code may be developed.

In some instances it may be appropriate to use additional codes but you should check for any unacceptable combinations (rules which define when two codes should not be used together). See 5.7 for more detail.

Some codes contain specific guidance on how they should be used if other procedures are being performed at the same time. If this is the case this will shown clearly on the CCSD website. An example is shown below. In this case the guidance outlines that a more appropriate code is available as the procedures are commonly performed together but can also be performed as individual procedures.

Code	Description	Chapter / Sub-Chapter	Code Specific Guidance
G6500	Diagnostic oesophago-gastro-duodenoscopy (OGD) includes forceps biopsy, biopsy urease test and dye spray	10	If being performed with H2002, code G8082 should be used.

4.1.1 As a sole procedure

If a code has ‘as sole procedure’ in its narrative it means that it should not be coded in addition to another procedure. This will normally be because the procedure would only ever be performed in isolation or would ordinarily be part and parcel of another procedure, unless performed on its own.

For example

- W3100 Bone graft (as sole procedure) – this may be part and parcel of another procedure, such as V2950 Anterior discectomy, decompression and fusion (including bone grafting), and therefore would not require a separate code unless being performed on it’s own.

It does not mean that two procedures cannot be performed together from a clinical perspective, but that the code should only ever be used by itself to support accurate coding. Where procedures are carried out on completely different anatomical sites, these rules do not apply but the principles on use of multiple codes (section 5.2) will apply.

4.1.2 Therapeutic and Diagnostic Combinations on the Same Organ

Therapeutic procedures are prime procedures and are intended to include secondary diagnostic procedures on the same organ or the approach to that organ when performed at the same time as the therapeutic procedure. The purpose of the code is to capture the primary/most significant intervention, not every stage or step which is performed.

For example

- E4850 Therapeutic bronchoscopy for removal of foreign body

This code includes diagnostic elements and thus cannot be coded with E5180 Diagnostic bronchoscopy +/- biopsy.

4.1.3 Radical procedures

Radical procedures, extensive surgery involving multiple sites often associated with advanced or metastatic cancer, often involve operations on multiple sites and may include removal of lymph and blood supply. Radical procedures are listed within their relevant chapters and subchapters within CCSD. These codes clearly distinguish between the various potential radical procedures.

For example

- B2710 Radical mastectomy (including block dissection)
- B2742 Modified radical mastectomy (including lymph node sampling)

- B2743 Modified radical mastectomy excluding lymph node sampling
- B2744 Modified radical mastectomy *including lymph node clearance)

As detailed in section 5.7, unacceptable combinations are present against these codes and are listed as relevant for each.

4.2 Axis of the classification

The CCSD schedule is anatomically driven. Each code contains five characters, for the majority this is a letter followed by four numbers. Some codes, such as investigations and consultation codes, are made up of five numbers as they do not relate to specific anatomy. The letter at the start of the code pertains to the chapter that code sits within.

Chapter Number	Chapter Name	Corresponding CCSD code starting letter(s) Primary code letter listed with additional letters in brackets
Procedural schedule		
1	Investigations, simple procedures and consultation codes	5 numbers
2	Brain, cranium and other intracranial organs	A
3	Spine, spinal cord and peripheral nerves	V
4	Eye and orbital contents	C
5	Ear, Nose and Throat	D (A/E/F/T/V/W)
6	Face, Mouth, Salivary and Thyroid	F (S/V)
7	Breast	B (T)
8	Thorax and Intra-thoracic organs	L and K (A/B/G/T/X/W)
9	Vascular system	L (X)
10	Endoscopic GIT procedures	G (H/J)
11	Abdomen (excluding urinary and re-productive organs)	H (A/G/J/T)
12	Urinary system and male reproductive organs	M (J/N)
13	Pregnancy and confinement	R
14	Female reproductive organs	Q (J/P/X)
15	Skin and subcutaneous tissue	S (T/W)
16	Bones, Joints and connective tissue/tendon muscle	T/W
17	Interventional radiology	X (J/T)
18	Chemotherapy	X (A)
19	Haematology	U (X)
20	Radiotherapy	X (A/B)
21	Cosmetic codes	Z
Diagnostic schedule		
30	Audiology diagnostic	A
31	Cardiac diagnostic	CD/K
32	Ophthalmology	C/O
33	Respiratory diagnostic	R
34	Pathology	See 5.3.1

35	Miscellaneous Diagnostic	I/M
36	Radiology	IM

4.2.1 Pathology codes

Pathology codes within the CCSD Diagnostic schedule are based on the NHS codes from the National Laboratory Medicine Catalogue (NLMC), and as such follow a different structure to other CCSD codes. The NLMC is a national catalogue of pathology tests.

The pathology coding structure was developed to ease identification of specimen sample which can be used for a particular test, this letter code forms the last letter of the code. The specimen abbreviations used in the pathology codes are listed below.

A – Calculus

B – Blood

C – Cerebrospinal fluid

D – Blood spot

F – Faeces

H – Hair

L – Saliva

M – Bone marrow

O – Other body fluid

S – Skin

T – Tissue

U – Urine

4.2.2 Code narrative structure

Each code narrative is structured according to the following rules in the order described below

- Approach
- Action
- Anatomy/target site
- Additional activity/procedure information
- Clarifying information may be included in brackets at the end of the code wording

For example

- Excision of acoustic neuroma (vestibular schwannoma) – tumours more than 2.5cm or compressing brain stem (performed by a single surgeon)

For the above example

- Approach: *Not specified*
- Action: *Excision*
- Anatomy/target site: *Acoustic neuroma*
- Additional activity/procedure information: *tumours more then 2.5cm or compressing brain stem*
- Clarifying information may be included in brackets at the end of the code wording: *Performed by single surgeon*

4.3 Acceptable terminology

4.3.1 Eponyms

Eponyms are sometimes used when a surgeon or piece of equipment has been used to name the procedure or surgery in question. These can cause confusion over time as modifications are made to techniques and approaches, and some names can apply to more than one procedure or surgery. To ensure coding reflects the procedure undertaken eponyms should not be used with the CCSD schedule.

If an eponym is used within clinical notes please take care to ensure you are clear which procedure has been carried out in order to accurately code activity using the CCSD schedule. If you are unsure please speak to the responsible consultant to ensure it is coded correctly.

4.3.2 Abbreviations

Abbreviations are not used in the CCSD schedule, but as with eponyms are sometimes used in notes recording clinical activity. Within the chapter specific guidance is a list of relevant abbreviations commonly used in the corresponding area. This list is not exhaustive and should be used for guidance only. If you are unsure what an abbreviation pertains to please speak to the responsible consultant to ensure the procedure it is coded correctly.

CCSD schedules do not use the commonly used OPCS terms However Further Qualified, Not Elsewhere Qualified, Not Otherwise Classifiable or Not Further Qualified.

4.3.3 Brand names

Brand names should not be used in CCSD codes. Some interventions may be known by their association with branded equipment, this is not present within CCSD codes, instead generic terms are used. Where these are common place they are outlined in the Chapter specific guidance section of this document. If you are unsure what a brand name pertains to, please consult the surgeon/team involved to ensure you understand what is being referenced.

4.4 Approach

Where the approach to a procedure may vary you will find codes contain specific detail about the approach. If the approach is not otherwise specified within the code narrative it is assumed to be open. Most of these codes are contained within their anatomically relevant chapter.

For example

- H0210 Appendicectomy
- H0280 Laparoscopic appendicectomy

Endoscopic Gastro-Intestinal (GIT) procedures are contained within their own chapter, chapter 10. There are no specific sub-chapters within this chapter. Individual codes are introduced with the approach first followed by the procedure undertaken. In some instances these are also distinguished between therapeutic and diagnostic procedures.

For example

- G8082 Diagnostic oesophago-gastro-duodenoscopy (OGD) and immediate colonoscopy includes forceps, biopsy test and dye spray (as a sole procedure)
- G8083 Therapeutic oesophago-gastro-duodenoscopy (OGD) and immediate colonoscopy includes forceps, biopsies and dye spray (as a sole procedure)

4.4.1 Approach conversion

Where a minimally invasive access or percutaneous procedure is abandoned and converted to open in the same visit the final approach to the procedure or surgery should be coded. This follows the principle of coding the primary/most significant intervention. CCSD does not contain specific codes for failed or converted procedures.

4.4.2 Excision and Biopsy

When excisions and biopsies are performed on the same site and the same time they're coded together. There are currently a small number of explicit excision biopsy codes within CCSD.

For example

- B2880 Excision biopsy of breast lesion after localization
- T8700 Excision biopsy of lymph node for diagnosis (cervical, inguinal or axillary)

In other cases excision is listed as the action without biopsy, but it can be assumed a biopsy will also be occurring.

For example

- D1900 Middle ear tumour excision

4.4.3 Endoscopic procedures

Diagnostic endoscopy – endoscopy to determine the nature of disease within an organ

In line with other CCSD principles, the final/most significant intervention performed should be coded. Where multiple sites are examined during an endoscopy, the furthest (most distal) site examined should be used for coding. Coding closer (more proximal) sites alongside this would create an unacceptable combination, see 5.7.

If an endoscopy is carried out alongside a biopsy, then the biopsy takes priority over pure inspection, even if the biopsy was at a more proximal location. In most cases biopsy is included as a possibility alongside the endoscopy.

For example

- H2510 Rigid sigmoidoscopy (including proctoscopy and biopsy)

Therapeutic endoscopy – endoscopy to treat/administer treatment for disease in a specified organ

4.5 Incomplete, unfinished, abandoned and failed procedures

Abandoned, failed or incomplete procedures (excluding those converted to open approaches, see 5.5.1) should be coded to the stage reached at the abandonment of the procedure, not the intention. However, if the procedure has reached its final stages then it should be codes as it the whole procedure has been completed. This may mean that a different code should be used to the code anticipated on booking the procedure or surgery. In other cases the booking code may remain appropriate.

For example

If a proctoscopy was performed but biopsy was not possible then H6260 Proctoscopy (+/- biopsy) would still be appropriate.

4.6 Unacceptable combinations

In order to maintain the principles discussed within this document and aid interpretation and use by the sector, some codes within the schedule have unacceptable combinations. These combinations should support interpretation and use of the schedule and may not be purely clinical in their origin. This means that there are codes which should not be used in combination (sometimes called unbundling). These are clearly shown on the CCSD website. The black circular symbol below denotes that a code has no unacceptable combinations. The green circular symbol with the white arrow within it denotes that unacceptable combinations are present, clicking the relevant code will show a list of the unacceptable combinations against that code.

Code	Description	Chapter	Guidance	Coding Principles
F4300	Transoral laser microsurgery, including pharyngotomy, partial laryngectomy, partial glossectomy and/ or tracheostomy	5		
F4301	Transoral robot assisted surgery, including pharyngotomy, partial laryngectomy, partial glossectomy and/ or tracheostomy	5		
D0110	Total excision of pinna	5.1		
D0140	Excision of preauricular sinus	5.1		

Specific examples of unacceptable combinations are listed in the sub-sections below, including sections outlining how terminology used with a code result in unacceptable combinations. CCSD focuses on ensuring unacceptable combination are listed for procedures commonly coded together. This means the unacceptable combination lists are not comprehensive but the principles behind them should be applied when coding.

4.6.1 Impossible

Procedures which cannot be performed in conjunction with each other.

For example

- C0212 Excision of lesion of orbit – anterior approach

- C0213 Excision of lesion of orbit – lateral orbitomy

4.6.2 Part and parcel

Where one procedure may commonly include another, if broken down into its component parts.

For example

- Q1280 Introduction of a Mirena coil. This should not be coded with Q1800 – Hysteroscopy (including biopsy, dilatation, curettage and resection of polyp(s) +/- Mirena coil insertion). For Q1800 Mirena coil introduction is already included in the code so should not be coded separately.

4.6.3 Another/better code available

Another code either more accurately describes the procedure or amalgamates different components of the procedure, for example if two codes are used where a single code exists.

For example

- G6500 Diagnostic oesophago-gastro-duodenoscopy (OGD) includes forceps biopsy, biopsy urase test and dye spray.

  If being performed with H2002 (Diagnostic colonoscopy, included forceps biopsy of colon and ileum) code G8082 should be used.

4.6.4 Either/Or

Both codes describe the same procedure, although may be different techniques or approaches.

For example

- H0210 Appendicectomy
- H0280 Laparoscopic appendicectomy

4.6.5 Diagnostic and therapeutic procedure combinations

Coding more than one diagnostic procedure for the same organ or the approach to that organ creates an inappropriate combination of codes

Coding more than one therapeutic procedure for the same organ or the approach to that organ creates an inappropriate combination of codes

4.6.6 Open, Endoscopic and Percutaneous code combinations

If a procedure code narrative does not specify whether it is an open or an endoscopic procedure, then its use with another code with a narrative that does specify it as endoscopic creates an inappropriate combination of codes.

For example

M2930 Removal of prosthesis from ureter + M3000 Endoscopic examination of ureter

The use of a combination of an open and an endoscopic procedure code for the same organ creates an inappropriate combination of codes.

For example

- M0610 Open removal of calculus from kidney + M1000 Therapeutic endoscopic operations on kidney (include cystoscopy and retrograde catheterisation)

The use of a combination of an open and a percutaneous procedure to the same organ creates an inappropriate combination of codes.

For example

- M0610 Open removal of calculus from kidney + M0940 Percutaneous nephrolithotomy (including cystoscopy and retrograde catheterisation)

A combination of procedure codes with the same approach (open, endoscopic or percutaneous) to the same organ specified in the narrative creates an inappropriate combination of codes.

For example

- M0610 Open removal of calculus from kidney + M0800 Other open operations on kidney

4.7 Relational terms

Within CCSD codes relational terms such as and, or, with and without are often used to clarify the situations when a code can be used. These are particularly pertinent when defining whether a procedure had unacceptable combinations. Careful attention should be paid to the exact narrative of a code to ensure it is the best code to describe the procedure in question.

For example

- F4300 Transoral laser microsurgery, including pharyngotomy, partial laryngectomy, partial glossectomy and/or tracheostomy
- C1513 Correction of lower lid ectropion with graft/flap
- C1512 Correction of lower lid ectropion without graft/flap

4.8 Complications around planned procedures

Procedures which occur as a result of complications should follow other CCSD rules when they are coded; the final intervention performed should be the one which is coded. There may be local policies around coding for complications and users should consult with relevant insurers to ensure they also follow their policies.

Chapter 1 of the CCSD Procedural schedule includes some emergency consultation codes.

For example

- 20330 Inpatient consultation by second specialist or for emergency
- 17180 Professional attendance on (initiation of care of) patient requiring intensive care in an emergency 2-3 hours

4.9 Special circumstances

4.9.1 Professional(s) performing the procedure/surgery

CCSD primarily codes the procedure being performed, not who is performing the procedure or surgery. For a small number of codes the professional performing the surgery is specifically defined in order to aid interpretation of the schedule.

For example

- Y3811 Removal of indwelling pleural catheter performed by consultant

4.9.2 Device placement

Where a prosthetic device is placed with the intention of removing it later e.g. a non-tunneled central venous catheter or percutaneous insertion of nephrostomy tube (M1360), the term “insertion” is used to include insertion and later removal. Such devices would be typically removed by paramedical staff.

When a prosthetic device is placed with the intention of leaving it in situ e.g. a Cardiac pacemaker system introduced through vein (single chamber) (K6000) or X-Ray guided Insertion of tunneled central venous catheter (XR915), the term “implantation” is used to include insertion but not removal. If this is subsequently removed, it should be coded separately e.g. K6082 Removal of pacing system (generator only) would typically be removed by a Medical Specialist.

4.9.3 Laterality

For some codes laterality is an important clarifying detail, and the codes exist in both unilateral and bilateral form. For other codes there is only a bilateral option. This distinction is dependent on the clinical procedure and the need for unilateral and bilateral codes is considered on a case by case basis. Where relevant specific guidance related to certain parts of the anatomy is contained within the chapter guidance at the end of this document.

For example

- C7214 Paediatric cataract involving lens aspiration and implant – unilateral
- C7215 Paediatric cataract involving lens aspiration and implant – bilateral
- F3400 Tonsilectomy – child (and bilateral)

In radiology codes the laterality is not mentioned for limbs, only the part of the body and the number of views taken.

For example

- IM300 XR Femur (2 or more views)
- IM307 XR Knee (3 or more views)

4.9.4 Paediatric and adult interventions

In the case of some interventions the procedure in question is listed separately for paediatric patients and adult patients. Where there is no distinction the code may be used for patients of any age; paediatric codes are only created where the difference in intervention is clinically different such that distinguishing is important.

For example

- W7580 - Open surgical stabilisation of patella, including soft tissue/tendon transfer or release, +/- application of cast (adult)
- W7582 - Open surgical stabilisation of patella, including soft tissue/tendon transfer or release, +/- application of cast (child)

4.9.5 Anaesthetic

The type or method of delivery of anaesthetic used should not be referenced in the narrative of a code.

5 CCSD code changes

5.1 Who can submit a code change and how it is done

Over time medical practice changes and new techniques are developed. In order to keep the schedule up to date changes are required to reflect current interventions and tests. CCSD members can submit change requests as they see fit in order to maintain the schedule. [How to guides on the website take members through the step required to request code changes].

When a change is requested to the schedule via the website, whether as a new code (this is the addition of a code to describe a procedure or diagnostic test that is otherwise not listed in the schedule), unacceptable combination (this is the bundling of a code with an existing code to ensure that both cannot be used in conjunction to one another), inactivation, reactivation or a narrative change (this is a change in the description of the code), these pass through a request form that must be completed by the user. The below section outlines the types of code changes possible. Appendix C and D contain a table summarising the information required in order to make a code change request.

5.2 Types of code change

The types of possible request for changes to codes within the CCSD schedule are briefly outlined below. The information required when filling out the request forms on the CCSD website is described within the appendix of this document.

For code requests relating to the same set of codes or a specific specialty, we recommend not making separate submissions. Instead, submit a single query through the CCSD website which allows the Working Group to evaluate these requests within a broader context, ensuring an effective and unified review before changes are made to the wider set of codes.

New/novel procedures

CCSD will consider applications for new codes for new/novel interventions, in order to help promote the accurate capture of clinical activity. These applications will still be evaluated on sufficient supporting information and evidence. However, the adoption of these codes will be down to individual insurers.

The following principles will be used to help Working Group make decisions around the adoption of new codes into the schedule(s) and ensure that decisions are evidence based and fair. They are intended to help distinguish between codes which merit inclusion in the CCSD schedule(s) and one-off interventions, to avoid the schedule(s) becoming unmanageable.

- Sufficient current activity in the UK to warrant a new code, such that an intervention should be performed at more than one provider and/or by more than one practitioner.
- Evidence to suggest this is an evolving area of medicine where a new code would help capture activity at an early adoption stage
- Evidence of the safety and efficacy of the intervention in the new code. For example, through NICE or Royal College guidance or peer reviewed papers in UK journals such as BMJ (there will not be a definitive list supplied of acceptable publications, those listed are exemplar).

5.2.1 New code request

New code requests are additions of codes which are not currently described in the CCSD schedule This may represent changes in clinical activity or new procedures.

5.2.2 Unacceptable combination request

As described in section 5 of this document, there are multiple reasons why unacceptable combinations may be necessary. Requests for unacceptable combinations can be to add or take away combinations. It should be noted that unacceptable

combinations should be reciprocal, for example if A is deemed unacceptable against B then B should be marked unacceptable against A.

Therefore, when submitting a request for unacceptable code combinations, it's crucial to consider the reciprocal nature of these changes. For instance, if Code A is marked as unacceptable when combined with Code B, then, to maintain consistency, Code B should also be marked as unacceptable when combined with Code A. Hence, while submitting such requests, it's essential to review and identify any other codes that may require a similar adjustment to reflect this reciprocal relationship.

5.2.3 Narrative change request

Narrative change requests are changes to the wording of codes which currently exist within the CCSD schedule. This may be to add clarity to an existing code or bring it inline with CCSD coding principles.

We approach narrative changes in two ways. If the proposed modification to the narrative is minor, such as a simple change in wording, we can implement it while retaining the existing code. However, if the proposed narrative change would substantially alter the scope or meaning of the code, we would need to associate the revised narrative with a new, distinct code.

5.2.4 Inactivation request

Inactivation requests are made against codes which currently exist in the schedule. If accepted, this means that the code would no longer appear in the CCSD schedule. These requests may represent changes in clinical practice and codes which have fallen out of use or may represent where a code has been replaced with a new code in order to split a code to gain more granularity. Where a code has been inactivated it will still be shown on the CCSD website but will be 'greyed out' to show it is no longer in use. An example is shown below.

B2810	Segmental resection or quadrantectomy	7.1	Inactive July 2010	

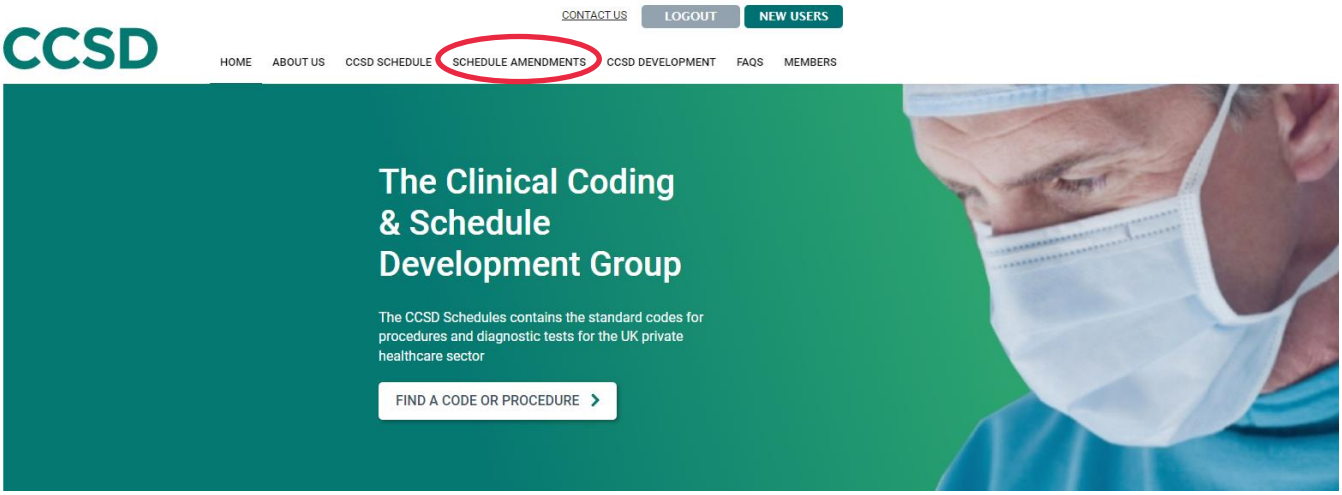
5.2.5 Re-instatement request

Re-instatement requests bring back into use the 'greyed out' codes which remain visible on the CCSD website.

5.3 Amendment history

CCSD members can see the amendment history of the CCSD schedule through the members area of the CCSD website. This allows members to download a csv file which list over time the accepted change requests which have been submitted to the CCSD group.

Recent amendment history can also be visualised through the 'schedule amendments' tab on the CCSD website. Through this tab the most recent CCSD bulletins are accessible, these bulletins summarise the accepted changes from the CCSD Working Group.



Recent requests can also be viewed through the 'recent requests' section within the 'schedule amendments' tab. This shows all amendment requests submitted to the CCSG Group along with their status (submitted, approved, published or rejected).

6 Working group role and decision criteria

6.1 Working Group overview

The Working Group are responsible for the ongoing technical maintenance and development of the CCSD schedule, including reviewing requests for changes to codes within the CCSD schedule.

The Working Group meets six times a year, on a bi-monthly basis. The CCSD website contains a summary of the Working Group's yearly timetable and this can be used to plan activity around when code requests are discussed and updated to the schedule (if approved).

The majority of code review and discussion takes place between meetings and the Working Group meeting will be reserved to:

- Discuss coding queries and requests of change where no consensus has been reached.
- Request and review input from the Technical Code Set Review Group on coding queries and requests for change
- Agree and plan specialty coding reviews.
- Agree findings and actions from specialty coding reviews.
- Further development and maintenance of CCSD Schedule Business Rules outlining schedule structure and business rules for coding structures.
- Delivery of CCSD strategy

6.2 Working Group decision criteria

The precise decision criteria used by the Working Group for each code request type is listed in Appendix A. This is the criteria used by the Working Group to determine whether a new change request is approved.

Additional to the specific criteria in Appendix A are additional considerations. The following points should be considered:

- Clinical and scientific evidence provided for change, potentially including input from clinical experts
- Anticipated or existing volume of usage of the suggested procedure or diagnostic test and whether clear identification of the clinical activity would add value to the sector
- Clinical approach including techniques and staff skill mix required for procedure or test. For example, whether the oversight or supervision of a consultant is required for the procedure or test.
- If a discrete clinical activity is described and how this is different in approach to existing codes in techniques used, staff skill mix required and equipment needed. It is encouraged to use a single code to describe a single procedure or test.
- For unacceptable combinations, it should be discussed which criteria applies and what clinical evidence and rationale for it is. These combinations should support interpretation and use of the schedule and may not be purely clinical in their origin. Where possible, unacceptable combinations should be considered upon addition of a new code to the Schedule.
- Coding narratives should only be updated to provide further clarity and not be used to update clinical activity of code, an inactivation and new code requests should be considered in this case.

6.2.1 Timeline and publication overview

An overview of the timeframes and yearly timetable followed by the Working Group is available on the CCSD website.

Following Working Group meetings decision bulletins are produced. These show the codes changes which have been accepted by the Working Group. Bulletins are published on the CCSD website and CCSD license holders are notified of this updated via email Bulletins also include a recommended timeframe for adopting code changes into locally held schedules.

7 CCSD schedule adoption and implementation

This section outlines the principles for users of the CCSD Schedules to support the adoption and implementation across the sector. The CCSD Schedules provides a common language and a common standard of codes and narratives that reflect current practice within the independent healthcare sector. The Schedules are designed to be the industry standard of codes to help drive standardisation of clinical coding in the sector and to support reimbursement.

7.1 Principles

The guiding principles are set out below:

1 The CCSD Schedule is beneficial for the sector as it ensures comparability and reduces duplication of effort amongst stakeholders. The CCSD group is not a regulator but establishes best practice and all stakeholders agree to use the codes to drive improvement in the sector. Therefore, whilst the CCSD Group does not have any regulatory powers to force such use, all users of the CCSD Schedule are encouraged to adopt the full, unaltered Schedule (where possible).

2 The inclusion of a code and/or its associated 'unacceptable combinations' in the CCSD Schedule means that it has been agreed by the CCSD Technical Working Group to be applied by all users of the CCSD Schedule. The inclusion of a code does not imply endorsement, but all users of the Schedule will in good faith, work to a single sector-wide code set (where possible). Overall:

   a Inclusion of a code means that there is agreement across the sector around the narrative which describes the activity taking place in practice. The associated 'unacceptable combinations' includes a set of activities which are deemed to be dependent for an activity to take place and supports interpretation of the code set so that in the majority of cases, a single code describes the clinical activity in its entirety.

   b Each individual payer decides whether the activity will be reimbursed and each provider decides whether they provide a particular activity. There will still need to be agreement between insurers and providers of adoption for commercial purposes. These decisions have no bearing on the development of CCSD code sets.

3 The adoption of 'local', non-CCSD approved codes is discouraged. Reduction of local, non-CCSD codes will reduce the possibility of different versions of coding schedules across the sector.

4 The unacceptable combinations are guidelines only, designed to support Schedule interpretation and use. Each payer and provider may choose to go into discussions on whether or not to offer reimbursement or services to a patient for a combination of codes in practice.

5 To aid smooth implementation and ensure the sector adopts changes to the CCSD Schedule(s) in a co-ordinated manner, the CCSD Working Group currently recommends that changes agreed by CCSD are adopted within 2 months of being published to the Schedule (where possible).

6 The CCSD group will ensure that information related to the CCSD Schedule, as noted above, will be provided in a meaningful way to users of the Schedule and other stakeholders, on their website and/or by other relevant and appropriate means.

7 The CCSD schedules shall always be available online as a reference point for best practice. All queries can be directed to the CCSD Support Service.

8 The Schedules are constantly evolving and payers, providers and specialists are expected to contribute to the development of the schedule. The codes, associated narratives, and unacceptable combinations are developed against rigours governance principles, and associated technical guidance to ensure appropriate and consistent updating of the Schedule.

8 CCSD chapter specific guidance

[This section is a placeholder, and is to be updated as the CCSD chapter review is rolled out]

8.1 Procedural

8.1.1 Investigations, simple procedures and consultation codes

8.1.2 Brain, cranium and other intracranial organs

8.1.3 Spine, Spinal Cord and Peripheral Nerves

8.1.4 Eye and Orbital contents

8.1.5 Ear, Nose and Throat

8.1.6 Face, Mouth, Salivary and Thyroid

8.1.7 Breast

8.1.8 Thorax and Intra-thoracic organs

8.1.9 Vascular system

8.1.10 Endoscopic GIT procedures

8.1.11 Abdomen (excluding urinary and reproductive organs)

8.1.12 Urinary system and male reproductive organs

8.1.13 Pregnancy and confinement

8.1.14 Female reproductive organs

8.1.15 Skin and subcutaneous tissue

8.1.16 Bones, Joints and Connective Tissue/Tendon

8.1.17 Interventional Radiology

8.1.18 Chemotherapy

8.1.19 Haematology

8.1.20 Radiotherapy

8.1.21 Cosmetic codes

8.1.22 Gender Affirmation

Development of codes for gender affirmation

In early 2023 the CCSD Board commissioned the development of a comprehensive set of gender affirmation CCSD codes for use by the sector. At the time there were no specific codes available specifically for gender affirmation in the CCSD schedule.

This subchapter of the Technical Guide sets out the core principles which underpin the development and use of gender affirmation codes. These principles sit alongside the core principles outlined earlier in this document.

Codes were developed by a CCSD Working Group sub-group, with suggested codes collated and shared with the Working Group to vote on. Accepted codes were then added to the CCSD schedule in line with CCSD code approval processes.

Gender affirmation codes within the CCSD Schedule

Gender affirmation codes have been assigned to a new chapter in the CCSD Schedule – *Chapter 22 Gender Affirmation*

Codes within chapter 22 for gender affirmation are split into subchapters based on body region with head and neck, chest and torso and genitourinary system surgery grouped together.

Codes from chapter 22 will begin with the letter combination GA. Gender affirmation codes have been given their own specific chapter to avoid confusion with similar procedures which are undertaken to treat other conditions rather than gender affirmation. Codes from this chapter are to be used in the primary position and should not be confused with OPCS chapter Y codes which are used as secondary procedure codes.

For example, mastectomy codes in chapter Y are for gender affirmation, and mastectomy codes from chapter B pertain to surgery for all other conditions,

B2819 – Mastectomy and immediate reconstruction of breast using expandable prosthesis and acellular dermal matrix (ADM) – bilateral

Y3001 – Subcutaneous mastectomy with related chest reconstruction for gender affirmation – bilateral

Within Chapter 22, the codes follow a structured breakdown as set out below:

GA1xx – associated with sperm/egg collection

GA2xx - gonadal

GA3xx - chest

GA4xx – head and neck

GA5xx – abdomen and genitalia

Unacceptable combinations

New gender affirmation codes also have unacceptable combination rules added for similar surgeries in other areas of the schedule which are intended for use when treating other conditions and not for gender affirmation. This is in addition to other basic unacceptable combination rules around laterality and different techniques of the same procedure.

Development moving forward

Whilst this initial development of the gender affirmation chapter has covered procedures identified and put forward for approval by a CCSD sub-group, it acknowledges that this is a specialist area which will require regular review to ensure codes available

in the CCSD Schedule are appropriate and reflect current surgical practices. Therefore an annual review of these codes has been included in the CCSD Schedule Development Plan to ensure these new codes are maintained appropriately.

Robotic assisted surgery codes (NB: these codes are spread through the schedule and are not a discrete subchapter)

Robotic code development

In Q3 of 2023 the CCSD Board commissioned the development of a comprehensive set of CCSD codes for use by the sector. At the time there were existing codes within the CCSD Schedule, but these did not follow a unified structure and there was evidence from the sector that more robotic assisted surgical procedures were being performed than there were available CCSD codes for.

This subchapter of the Technical Guide sets out the core principles which underpin the development and use of RAS coding. These principles sit alongside the core principles outlined earlier in this document.

As part of the code development, non-RAS codes were also reviewed to ensure sets of codes aligned across the different approaches.

Robotic assisted surgery (RAS) codes within the CCSD Schedule

RAS codes are located anatomically within the CCSD Schedule, this means that they sit alongside their non-robotic approach counterparts (which include open surgery, and surgery performed using another minimal access technique, e.g., laparoscopic surgery).

During the development of RAS codes, some stakeholders reflected that port sites was an area of difference within surgical approaches. it was decided that the distinction of the number of port sites was not a necessary part of a narrative at this stage. This means that a code and narrative should be selected which best fit the procedure performed; there will be no breakdown to a code between the number of ports used.

For example:

- E5430 Pulmonary lobectomy (including segmental resection)
- E5433 Robotic assisted pulmonary lobectomy

Code structure

Robotic Assisted Surgery (RAS)

For robotic surgery coding the term 'robotic assisted' surgery is used within the narrative of the code. This denotes the use of robotic equipment within the intervention described. The use of this terminology was selected to best describe how robotics are used within the sector and to clearly distinguish robotic assisted surgery codes from other approaches for the same interventions.

Transoral for ENT

For robotic assisted surgery codes for ENT, these will start with the prefix 'transoral' to reflect the approach taken in these interventions.

For example:

- F4301 Transoral robotic assisted surgery, including pharyngotomy, partial laryngectomy, partial glossectomy and/or tracheostomy (as sole procedure)

Unacceptable combinations

To support the application and use of RAS codes in the sector, the following core unacceptable combinations are applied to RAS codes:

- A unilateral code is unacceptable with a bilateral code
- A partial code is unacceptable with a total code
- A RAS code is unacceptable with other approaches for the same narrative

Where there are adult and paediatric non-RAS codes assumptions will not be made around the need for both in RAS codes. The unacceptable combinations for an adult RAS procedure will not automatically be applied to the paediatric similar narrative.

8.2 Diagnostic

8.2.1 Audiology

8.2.2 Cardiac

8.2.3 Ophthalmology

8.2.4 Respiratory Diagnostic

8.2.5 Pathology

8.2.6 Miscellaneous Diagnostic

8.2.7 Radiology

9 Competition requirements

Please note that CCSD must be compliant with competition law. This means that CCSD discussions and documents need to comply with the detail described below:

- The CCSD Group is committed to competition law compliance. The consequences of non-compliance are grave – the organisations and individuals involved can be fined and individuals may even be sent to jail.
- All CCSD documents, must avoid areas that might fall foul of competition law. Examples include discussion of cartel arrangements, fee or price setting, standard conditions or contract negotiations, the exchange of commercially sensitive market information, or the sharing-out of markets.
- These parameters apply to all CCSD members and stakeholders equally, regardless of organisation type (i.e. insurer, provider or other)
- If any CCSD member has similar concerns at any time, they should raise them immediately with the CCSD group.

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Appendix A

Decision Criteria

	New codes	Unacceptable combinations	Narrative changes	Inactivation	Reinstatement
Purpose	Recording of discrete clinical activities not currently covered by existing codes	Support application of codes and narratives to clinical activity and aid interpretation of codes	Clear description of clinical activity code relates to	Removal of existing codes	Reinstatement of a code that has been previously removed but is still required.
Criteria	• Describe a discrete clinical activity, avoiding brand names • Clinically different from existing codes requiring either different: • Approach • Technique • Staff skill mix • Equipment • There is (anticipated) sufficient volume or a need to clearly identify it from existing codes • Has proven efficacy and/or benefit through independent research • In principle a single CCSD code should describe the whole clinical activity	• Procedure cannot be performed in conjunction • One procedure commonly includes another • Another code more accurately describes the procedure or amalgamates different components of the procedure • Both codes describe the same procedure using different techniques or approaches	• Coding narratives should only be updated to provide further clarity and not be used to expand the scope of the clinical activity that the code is describing. Instead, consider an inactivation and new code request.	• Clinical practice has evolved and therefore the existing codes do not reflect current clinical practice • Evidence base for test or procedure has changed • There are no longer sufficient volumes to support coding • Code has been replaced with a more appropriate code	• Clinical practice has evolved, resulting in procedure or test becoming relevant again • Clinically different from other codes requiring either different: • Approach • Technique • Staff skill mix • Equipment • Evidence base for test or procedure or test has changed, resulting in procedure or test becoming relevant again

	New codes	Unacceptable combinations	Narrative changes	Inactivation	Reinstatement
Coding narratives and considerations for all codes	• Be clear and not be open to interpretation and clearly describe procedure or diagnostic test • Ambiguous terms like suspicious, simple, complex, small, large etc. should be avoided • Avoid brand names • Avoid abbreviations • Avoid eponyms • Follow the coding narrative structure • Should be independent of commercial concerns				

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Appendix B

Request Details – Procedure Schedule

Criteria with an asterisk are compulsory, with the remainder being optional but the more information included would be deemed helpful for consideration by the Working Group.

New codes	Unacceptable combinations	Coding narratives	Inactivation	Reinstatement
• Name of procedure* • Suggested code, this should be in line with existing coding structure • Suggest narrative, following narrative criteria outlined above* • Detailed description of procedure, including anatomy* • Clinical rationale for request. This should be supported with clinical evidence in the form of publications, guidelines etc.* • Chapter* • Sub-chapter* • Point of delivery • Information on anaesthetics • Information on length of stay and time in theatre • Information on staff skill mix required for procedure • Equipment and room types	• Code and related additions or deletions of combinations* • Reason for new coding principle, should be one of the criteria listed above* • Any supporting clinical evidence	• Code* • Suggested narrative* • Reason why narrative requires updating* • How proposed narrative will provide further clarity*	• Code to be inactivated* • Clinical rationale to inactivate code, including supporting evidence*	• Code to reinstated* • Clinical rationale to inactivate code, including supporting evidence* • Point of delivery • Information on anaesthetics • Information on length of stay and time in theatre • Information on staff skill mix required for procedure • Equipment and room types required for procedure • Condition(s) that the procedure is treating • Other actions that are performed that are part and parcel of this procedure

required for procedure • Condition(s) that the procedure is treating • Other actions that are performed that are part and parcel of this procedure				

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Appendix C

Request Details – Diagnostic Schedule

New codes	Unacceptable combinations	Coding narratives	Inactivation	Reinstatement
• Name of test or profile* • Suggested code, this should be in line with existing coding structure • Detailed description of test* • Clinical rationale for request. This should be supported with clinical evidence in the form of publications, guidelines etc.* • Breakdown of all tests included in the profile, with associated codes* • Clinical rationale as to why that combination is being carried out together. This should be supported with clinical evidence in the form of publications, guidelines etc.* • Chapter* • Sub-chapter* • Condition(s) that is looking to be diagnosed or ruled out (where possible)	• Code and related additions or deletions of combinations* • Reason for new coding principle* • Any supporting clinical evidence	• Code* • Suggested narrative* • Reason why narrative requires updating* • How proposed narrative will provide further clarity	• Code to be inactivated* • Clinical rationale to inactivate code, including supporting evidence*	• Code to reinstated* • Clinical rationale for request. This should be supported with clinical evidence in the form of publications, guidelines etc. * • Breakdown of all tests included in the profile, with associated codes* • Clinical rationale as to why that combination is being carried out together. This should be supported with clinical evidence in the form of publications, guidelines etc.* • Condition(s) that is looking to be diagnosed or ruled out

Appendix D

In the table below the changes made as this document is updated over time are outlined.

Version	Date updated	Key changes made
1	March 2023	First iteration of document.
2	September 2023	Update to document following Board and Working Group review.

Appendix E

CCSD Terminology

Term	Definition
CCSD schedule	The CCSD schedule is the collection of individual codes which when combined create a cohesive set of codes which can be used to describe medical interventions.
CCSD code	A CCSD code is an individual code within either the diagnostic or procedural schedule. The code and its associated narrative follow certain rules, which are set out in this document and allows for the recording of clinical activity in the private healthcare sector.
CCSD code narrative	This is the description which following the alphanumeric code. It gives the detail of the intervention or test which is being coded.
Chapter	Sub section of the schedule containing codes linked by commonality, such as anatomical area.
Unacceptable combination/Coding principle	This is the principle of using the code, designed to support interpretation and use of the schedule rather, as opposed to being driven specifically by clinical activity. Codes which are unacceptable to one another cannot be used together. The term coding principles is used as an umbrella term to included unacceptable combinations and cases where no unacceptable combinations exist.
Healthcare intervention	Interventions carried out on patients undergoing treatment: • For the prevention, diagnosis, care or relief of disease; • For the correction of deformity, deficit or appearance including those performed for cosmetic reasons; and • Associated with pregnancy, childbirth, contraceptive or procreative management These will typically be surgical in nature, carry a procedural risk, carry an anaesthetic risk, require specialist training or require special facilities or equipment.