NHS
Kernow
Clinical Commissioning Group

Commissioning policies 2017/18

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		amendments made to benign skin lesions policy. Added NHS England specialist commissioning policy on complex and specialised obesity surgery following transfer of commissioning responsibilities to NHS Kernow.	

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NHS Kernow Clinical Commissioning Group

Contents

NHS Kernow Clinical Commissioning Group

Patient guide to the policy and why your doctor has to observe it

NHS funds

- NHS Kernow Clinical Commissioning Group (NHS Kernow) buys healthcare on behalf of the local population of Cornwall and Isle of Scilly. The money for this comes from a fixed budget. By law, we are required to keep within this budget.
- Demand for healthcare is greater than can be funded from this fixed budget. Unfortunately, this means that some healthcare which patients might wish to receive and which professionals might wish to offer cannot be funded.
- This has always been the situation since the start of the NHS.

Assessing what the overall population most needs

- Our approach to this situation is to prioritise what we spend, so that the local population gets access to the healthcare that is most needed.
- This assessment of need is made across the whole population and, wherever possible, on the basis of best evidence about what works. We aim to do this in a way that is fair, so that different people with equal need have equal opportunity to access services. We also aim to ensure that treatments which research shows are not effective, and may not even cause harm, are not offered to our population.
- This approach is not new. It is consistent with other NHS organisations who buy healthcare for their local populations.
- One result of this kind of assessment is a list of some of the treatments which can only be paid for by the local NHS in certain restricted circumstances, and also a number of treatments which don't work well enough to justify any use within the local NHS. A similar list has been drawn up for medications, to ensure that the local NHS gets the greatest possible value for the local population. We aim to review these lists to ensure that they reflect the best available evidence and are affordable and fair.

Implications for you

- This may mean that your doctor is not able to offer you a certain treatment because it would not be funded by the local NHS.
- Although most doctors recognise the need for some kind of policy like this, she/he may be uncomfortable because of its implications for you as an individual.
- Even so, your doctor has to observe the policy because it is the policy of the local NHS, and is the best way to ensure that local NHS funds are spent on the things that will bring greatest overall benefit to local people in a way that is affordable and fair.

For a full list of all treatments and applicable exclusions and criteria, please refer to the NHS Kernow commissioning policy covering access to procedures of limited clinical priority (PLCP) and other treatments (this document).

Introduction

The purpose of this policy is to ensure that NHS Kernow Clinical Commissioning Group (NHS Kernow), the Commissioner for Cornwall and Isle of Scilly fund treatment only for clinically effective interventions delivered to the right patients. It sets out the treatments deemed to be of insufficient priority to justify funding from the available fixed budget.

Approved prescribing of medicines falls outside the scope of this document and is covered in the guidelines and protocols produced by the Cornwall and Isle of Scilly Prescribing Committee. Further information can be obtained from the Prescribing and Medicines Optimisation team (kccg.prescribing@nhs.net) or online: Cornwall and Isles of Scilly Joint Formulary.

This policy will be kept under regular review, to ensure that it reflects developments in the evidence base regarding clinical and cost effectiveness

Definitions

In general, treatments are deemed to be of low value and therefore a low priority for funding where:

1. There is clear evidence that they are ineffective or do more harm than good, or
2. There is no evidence of effectiveness and they are not being delivered in a context that would allow the gathering of an evidence base to judge effectiveness, i.e. through ethically approved research, or
3. There is evidence of effectiveness but they are being offered to patients whose characteristics are different from the characteristics of the patients in the research studies which produced the evidence for effectiveness, or
4. They use resources that would produce more value, namely a better balance of benefit to harm, if invested in some other service for the same group of patients.

Scope

This policy sets out those procedures which are not normally commissioned due to their low clinical priority, and some others for which strict criteria apply. NHS Kernow has a number of other commissioning policy documents, the full list can be found here: www.kernowccg.nhs.uk/get-info/individual-funding-requests/treatment-policies

Policy development is an on-going process and future policy will be produced and published periodically.

Principles

Commissioning decisions about a procedure are made with reference to the evidence of its clinical effectiveness, cost effectiveness, the affordability of equitable provision, and best value for money.

Exceptionality

NHS Kernow commission according to the policy criteria. Requests for individual funding will not normally be considered, unless the circumstances fulfil the strict criteria for exceptionality as defined within the current policy for determining Individual Funding Requests (IFR), in which case they may be submitted for consideration with the framework and process outlined in the IFR policy (available here: www.kernowccg.nhs.uk/get-info/individual-funding-requests).

Implementation

Commissioners, general practitioners, service providers and clinical staff treating residents of Cornwall and Isle of Scilly will implement this policy. When interventions are undertaken on the basis of meeting criteria specified within the policy, this should be clearly documented within the clinical notes.

Criteria Based Access (CBA) applies to treatments that are considered appropriate for patients in certain circumstances provided that specific pre-determined and evidence based access criteria have been met. Assessment of the patient against the relevant criteria can be made at any point in the patient pathway prior to treatment, but should be undertaken at the earliest possible stage in the pathway once the need for a CBA procedure has been identified. This means that assessment against the CBA criteria will either be made by the referrer prior to referral, or by the secondary care clinician following triage or initial assessment in secondary care.

Where the responsible clinician believes that a patient demonstrably meets the criteria set out in the policy, the patient can proceed for treatment. If the assessment is undertaken by a referring general practitioner, that general practitioner must ensure that details of this are included within their referral. Secondary care providers must ensure that evidence that the patient meets the CBA criteria is included within the patient's medical record for audit purposes.

Responsibility for adherence to the Commissioning Policy lies with the referring **and** treating clinicians. On any occasion where a provider undertakes procedures which are not routinely funded, or CBA activity where the patient does not meet the relevant criteria, that provider will not be paid for the associated activity. This policy is formally incorporated into contracts and will be subject to routine monitoring for compliance.

The schedule of procedures

The schedule is set out below and is incorporated into contractual agreements. NHS Kernow will require all providers in primary and secondary care to embrace and abide by the policy, advising patients accordingly.

This policy should be read in conjunction with other policies published by NHS Kernow.

NHS Kernow Clinical Commissioning Group

Private funding

If patients choose to privately fund an intervention that is not normally funded by NHS Kernow, they will retain their entitlement to other elements of NHS care. For example, if they privately fund a cancer drug or cancer intervention not normally funded by NHS Kernow they will retain their entitlement to all the other elements of cancer care that other residents of Cornwall and Isle of Scilly receive free of charge. However when patients are privately funding an intervention, they are responsible for all the costs associated with that intervention, including Consultant costs and diagnostics. They are therefore unable to receive a mixture of privately funded and NHS Kernow's funded care within the same appointment or intervention - they cannot 'top-up' NHS Kernow's funded appointment or intervention by paying for an additional intervention to be provided or monitored during the same consultation.

NICE guidance and recommendations about "do not do"

During the process of guidance development, NICE's independent advisory bodies often identify NHS clinical practices that they recommend should be discontinued completely or should not be used routinely. Such recommendations may be due to evidence that the practice is not on balance beneficial or a lack of evidence to support its continued use. NICE has collated these recommendations into the 'do not do' recommendations database.

Commissioners do not routinely fund interventions identified in the "do not do" recommendations database. A copy of the database is maintained here.

Commissioning policies

General surgery

Anal skin tag removal	
Introduction	Skin tags are small flesh-coloured or brown growths that hang off the skin and look a bit like warts. They are very common and harmless. Skin lesions are often referred for specialist opinion because of concerns that there may be a malignancy. This should be done through the appropriate referral route if malignancy is suspected. Once it is established that a skin lesion is not malignant its removal will not normally be funded, though a surgeon may request funding in exceptional cases.
Criteria	**Removal of anal skin tags is regarded as a procedure of low clinical value and is therefore not routinely commissioned.**
Codes	OPCS Code: H48.2, 48.8, 48.9 ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued.
JCIA	Available upon request.

Circumcision	
Introduction	Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications. Sometimes it is requested on cultural, social and religious reasons. These non-medical circumcisions do not confer any health gain but do carry measurable health risk.
Criteria Based Access	Circumcision is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Phimosis (inability to retract the foreskin due to a narrow prepucial ring); • Paraphimosis (inability to pull forward a retracted foreskin); • Balanitis Xerotica Obliterans (chronic inflammation leading to a rigid fibrous foreskin); • Balanoposthis (recurrent bacterial infection of the prepuce, >3 documented episodes); • Carcinoma of the penis. It will not be considered on social or religious grounds on the basis that: • The DH advises that the legality of male circumcision for religious reasons could be in conflict with the human rights act and current child protection legislation; • The issue of informed consent when a young child is involved is unclear and complex; • The risks associated with routine circumcision, such as infection and bleeding outweigh the benefits; • GMC and BMA guidance reflects society's disagreement as to whether circumcision is a beneficial, neutral or harmful procedure and recognises the complex issues that arise for doctors when considering whether to circumcise male children for nontherapeutic reasons. Neither the BMA nor GMC take a view as regards the lawfulness or appropriateness of circumcision for non-therapeutic reasons.
Codes	OPCS Code: N30.3 ICD10 Codes for the specified clinical criteria are any one of: N47; N48.1 (>3 documented episodes); N48.6; C60 (suspected or proven); N48.3. However there are no appropriate ICD10 codes unresponsive dermatological disorders or congenital abnormalities requiring skin for grafting.
Date approved	November 2016
Review date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Haemorrhoidectomy	
Introduction	Haemorrhoids, also known as piles, are enlarged and swollen blood vessels in or around the lower rectum and anus. They can occur at any age and affect both sexes. Conservative management consists of high fibre diet, exercise, weight loss and topical preparations, followed by non-surgical ablative/fixative interventions and rubber band ligation. Surgical haemorrhoidectomy can be used for third or fourth degree haemorrhoids.
Criteria Based Access	Haemorrhoidectomy is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • The haemorrhoids are prolapsed and incarcerated, and cannot be reduced (Fourth degree haemorrhoids); **or** • The haemorrhoids are recurrent and associated with persistent bleeding; **and** • There is failure of documented conservative management techniques after at least three months. Conservative management techniques include: • Dietary and lifestyle advice (increase fluid and insoluble fibre intake, discourage straining); • Bulk forming laxative (or osmotic laxative or stool softener); or • Non-opioid analgesia and/or topical haemorrhoid preparations for symptomatic relief. **Non-surgical treatment** Non-surgical measures (rubber band ligation, injection sclerotherapy or infra-red coagulation) is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Recurrent haemorrhoids; **and** • Persistent bleeding; **and** • Failure of documented conservative management techniques after at least three months. **Surgical treatment** Surgical treatment (haemorrhoidectomy, stapled haemorrhoidopexy or haemorrhoidal artery ligation) is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Fourth-degree haemorrhoids; **or** • Third-degree haemorrhoids associated with persistent bleeding that have

Haemorrhoidectomy	
	not responded to non-surgical treatment in line with the above policy statement, or which are too large for non-surgical measures; **or** • Second-degree haemorrhoids associated with persistent bleeding that have not responded to non-surgical treatment in line with the above policy statement. Please note the removal of anal skin tags is not routinely commissioned by NHS Kernow.
Codes	OPCS Code: H51.1, 51.2, 51.3, 51.8, 51.9 The ICD10 Code for haemorrhoids is I84. The Codes to identify persistent pain or bleeding are any one of: I84.1, I84.4, I84.8. However there are no appropriate ICD 10 codes for recurrent third or fourth degree haemorrhoids or failure of conservative treatment
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request.

Hernia management and repair in adults	
Introduction	This policy covers the management of inguinal, femoral, umbilical, ventral and incisional hernias, and lists the criteria for referral. The referral letter and patient's medical record need to clearly evidence how these criteria are met:
Criteria	**Initial management of patients with hernia** Patients with BMI >35 - the decision to refer requires particular care, as the benefits of intervention may well be outweighed by risks of surgical intervention, including poorer healing and higher complication rates. If in doubt, the clinician may refer the patient, but should advise them that surgery may not be an appropriate option for them. Referral to local weight management programmes should be offered. Patients who smoke should be warned of clinical advice that hernia recurrence rates are three times higher in smokers than non-smokers. All patients who smoke should be encouraged to stop and offered information on local cessation support services. **Inguinal** Criteria Based Access: For asymptomatic or minimally symptomatic hernias, the commissioner advocates a watchful waiting approach including providing reassurance, pain management etc, under informed consent. Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Symptomatic i.e. symptoms are such that they cause significant functional impairment*;

Hernia management and repair in adults	
	or • The hernia is difficult or impossible to reduce, (i.e. history of incarceration or real difficulty reducing the hernia confirmed by ultrasound); **or** • Inguino-scrotal hernia; **or** • The hernia increases in size month on month. **Umbilical** Criteria Based Access: Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met: • Pain/discomfort that causes significant functional impairment*; **or** • Increase in size month on month; **or** • To avoid incarceration or strangulation of bowel – in at risk patients e.g. in cases where the hernia is difficult or impossible to reduce. **Incisional** Criteria Based Access**:** Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met: • Pain/discomfort that causes significant functional impairment*; **and** • Conservative management has been tried first e.g. weight reduction where appropriate. **Femoral** Does not require prior approval**:** All suspected femoral hernias are approved for a referral to secondary care due to the increased risk of incarceration/ strangulation and **do not require prior approval** to be sought. **Impalpable hernia and groin pain** **Not Routinely Commissioned:** • Hernia surgery is not commissioned in patients with groin pain, but no visible external swelling. Patients presenting with groin pain who are found to have an impalpable hernia on ultrasound should not be referred for hernia repair. • Management of persistent groin pain that has not resolved after a period of watchful waiting should be based on individual clinical assessment. Where groin pain is severe and persistent with diagnostic uncertainty, options include referral for musculoskeletal assessment or imaging. Ultrasound should not be routinely requested in the early management of groin pain. **Laparoscopic hernia repair** • Laparoscopic hernia repair **is not commissioned** for primary unilateral

Hernia management and repair in adults	
	hernia repair; • Laparoscopic hernia repair **is commissioned only for bilateral hernia repair**: o Where the patient has bilateral hernias with external swelling on clinical examination); **or** o For recurrent hernia. Note: Hernia surgery is not commissioned for impalpable hernias found incidentally during laparoscopic repair of a hernia on the other side. ***Note: Significant Functional Impairment is defined as:** • Symptoms that result in an inability to sustain employment despite reasonable occupational adjustment, or act as a barrier to employment or undertake education; • Symptoms preventing the patient carrying out self-care, maintaining independent living or carrying out carer activities. **Evidence of functional impairment must be supplied with the referral documentation.**
Codes	OPCS Code: T19.1 - 21.3, 21.8, 21.9. Also subsidiary codes Y75.1 - 75.9 in association with ICD 10 code K40 The ICD10 Code for inguinal hernia is K40. Codes for symptomatic inguinal hernias are any K40.0, 40.1, 40.3 or 40.4
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Hyperhidrosis treatment	
Introduction	Hyperhidrosis can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, and the face of otherwise healthy people.
Criteria	**Botulinum Toxin for the treatment of hyperhidrosis is not routinely commissioned.**
Codes	OPCS Code: A75.2, 76.2, 77.2, 78.2, 79.2 The ICD10 Code for hyperhidrosis is R61
Date approved	November 2016
Review date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Surgery of gallstones (asymptomatic)	
Introduction	Gallstones are small stones, usually made of cholesterol, that form in the

Surgery of gallstones (asymptomatic)	
	gallbladder. In most cases they do not cause any symptoms. Gallstone disease is relatively straightforward to treat. The most widely used treatment is keyhole surgery to remove the gallbladder. Doctors refer to this as a laparoscopic cholecystectomy. Cholecystectomy is the surgical removal of the gall bladder. Prophylactic cholecystectomy is not indicated in most patients with asymptomatic gallstones. The removal of the gallbladder for asymptomatic gall stones is regarded as a procedure of low clinical value and therefore not routinely funded by the Commissioner. Note: Patients with suspected gallbladder carcinoma or severe complications should be referred immediately, without delay. (Patients with asymptomatic Common Bile Duct (CBD) stones or dilated CBD without stones should be referred to surgery).
Criteria Based Access	Surgery of Gallstones (asymptomatic) is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Where there is clear evidence of patients being at risk of gallbladder carcinoma; • Where there is clear evidence of patients being at risk of gallbladder complications; • Confirmed episode of gall stone induced pancreatitis; • Confirmed episode of cholecystitis; • Episode of obstructive jaundice caused by biliary calculi.
Codes	OPCS Code: J18.1—5, 18.8, 18.9. Subsidiary codes Y751 - 759 in association with ICD10 Code K80.2 or K80.5. The ICD10 Code for gallstones is K80. However there are no appropriate Codes to identify asymptomatic gallstones from those with a history of symptomatic gallstones, nor are there Codes to identify those at risk of malignancy or complications
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Varicose veins	
Introduction	Varicose veins are dilated superficial veins in the leg. They are caused by incompetent valves, commonly in the long and short saphenous veins and their branches, although varicosities may be secondary to deep venous disease. They are not to be confused with intra-dermal spider veins or thread veins which lie within the skin. Asymptomatic or mild varicose veins present as a few isolated, raised palpable veins with no associated pain, discomfort or any skin changes. Moderate varicose veins present as local or generalised dilatation of subcutaneous veins

Varicose veins	
	with associated mild pain or discomfort and slight ankle swelling. Severe varicose veins may present with phlebitis, ulceration, haemorrhage, significant oedema or haemosiderin staining. Most varicose veins respond to conservative management, i.e. exercise, weight loss and elevation of the leg two to three times daily. Varicose eczema, if severe or inflamed, can be treated effectively with topical steroids. Consider class one or two compression stockings (Note: NICE CG 168 recommends - Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable). Interventional procedures such as surgical stripping or ligation, radio-frequency ablation, endoscopic procedures and sclerotherapy (e.g. 'foaming') can improve symptoms in the short term but are less effective in the longer term, and are associated with a significant recurrence rate. Interventional procedures for mild and moderate varicose veins will not normally be commissioned by NHS Kernow.
Criteria Based Access	Varicose vein treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Lower-limb skin varicose eczema, thought to be caused by chronic venous insufficiency; • Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence; • Recurrent or ascending superficial phlebitis (DVT risk may be as high as 10 to 20 per cent at presentation); • A lower limb venous ulcer not healed within two weeks, with or without obvious varicose veins; • A healed venous leg ulcer; • Severe swelling or pitting oedema; • Symptomatic varicose veins in the presence of arterial insufficiency (absent pedal pulses); • Lipodermatosclerosis; • Incipient ulceration with erythema and skin induration. Patients not suitable for referral to vascular surgical clinics for NHS treatment: • Patients with no symptoms or skin changes associated with venous disease; • Patients whose concerns are cosmetic including telangectasia and reticular veins; • Patients with mild symptoms including itch, ache, mild swelling, minor changes of skin eczema and haemosiderosis.
Codes	OPCS Code: L83.2 - 88.9. Subsidiary codes X30.5, X30.8 or X30.9 with codes Z39.5 or Z39.8 The ICD10 Code for varicose veins of lower extremities is I80 There is no Code to identify those which have bled or are at risk of bleeding

Varicose veins	
	again. Codes for the other clinical criteria are any one of I83.0 or I83.2; I87.2; I80.0 or I80.1 or I80.2 or I80.3 or 180.9. There is no appropriate code to identify impact on quality of life.
Date approved	November 2016
Review date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Venous angioplasty for multiple sclerosis	
Introduction	The effectiveness of venous angioplasty for stenotic and occlusive lesions in the extracranial venous systems of patients with MS has not yet been demonstrated in clinical trials. The American Academy of Neurology currently recommends that patients only use this treatment as part of a well-designed clinical trial.
Criteria	**Venous angioplasty for the treatment of Multiple Sclerosis is not routinely commissioned**
Codes	OPCS Code: L94.6, 94.7, 94.8, 94.9 ICD10 Code for Multiple Sclerosis is G35
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Ears, nose and throat (ENT)

Insertion of grommets	
Introduction	Glue ear is a common childhood condition in which the middle ear becomes filled with fluid. The medical term for glue ear is otitis media with effusion. Grommets can help drain fluid out of the middle ear.
Criteria Based Access	**Children** Insertion of grommets in children is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • OME persists after a period of at least three months watchful waiting from the date that the problem was first identified by the GP to the date of referral; **and** • The child is three years or older; **and** • There is significant hearing loss (of at least 25dB) - particularly in the lower tones (low frequency loss) - and evidence of a disability as a result of this hearing loss on at least two documented occasions (following repeat testing after six to twelve weeks) with either: • Delay in speech development; **or**

Insertion of grommets	
	• Educational or behavioural problems attributable to the hearing loss; **or** • A significant second disability that may itself lead to developmental problems e.g. Down's syndrome, Turner's syndrome or cleft palate; • The CCG will fund treatment for grommets in children with acute otitis media when there have been at least five recurrences of acute otitis media, which required medical assessment and/or treatment, in the previous year. **Adults** Insertion of grommets in adults is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Grommet insertion during examination under anaesthetic with/without a biopsy of the post nasal space as indicates a suspicion of cancer; • A middle ear effusion causing measured conductive hearing loss, persisting for at least six months and resistant to medical treatments. The patient must be experiencing disability due to deafness. The possible option of a hearing aid may be discussed, at the discretion of the clinician; • Persistent eustachian tube dysfunction resulting in pain (e.g. flying); • As one possible treatment for Meniere's disease; • Severe retraction of the tympanic membrane if the clinician feels that this may be reversible and reversing it may help avoid erosion of the ossicular chain or the development of cholesteatoma.
Codes	OPCS Code: D15.1, D15.8, 15.9, 20.2, 20.3, 20.8, 20.9, 28.8, 28.9 ICD10 Codes for those meeting the clinical criteria are any of: H65.0 (5 or > documented episodes), 65.1 (5 or > documented episodes), 65.3 or 65.4. There are no appropriate codes for hearing level, hearing loss or effects on the child
Date approved	November 2016
Review date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Removal of ear wax	
Introduction	This policy relates to the removal of ear wax.
Criteria Based Access	Removal of Ear Wax in secondary care is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • The person has (or is suspected to have) a chronic perforation of the tympanic membrane; • There is a past history of ear surgery; • There is a foreign body, including vegetable matter, in the ear canal; • Ear drops have been unsuccessful and irrigation is contraindicated; • The patient is suffering from significant symptoms due to ear wax build up including hearing loss or pain and the patient's condition warrants

Removal of ear wax	
	microsuction; • Has a recent history of otalgia and /or middle ear infection (in past six weeks); • Has had previous documented complications following ear irrigation including perforation of the ear drum, severe pain, deafness, or vertigo; • Two attempts at irrigation of the ear canal in primary care are unsuccessful (please state why irrigation has failed). Earwax should only be removed if earwax is totally occluding the ear canal and any of the following are present: • Hearing loss; • Earache; • Tinnitus; • Vertigo; • If the tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis; • If the person wears a hearing aid, wax is present and an impression needs to be taken of the ear canal for a mould, or if wax is causing the hearing aid to whistle.
Codes	OPCS Code: D07.1, D08.5 ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Snoring	
Introduction	This policy explicitly refers to isolated snoring. Surgical treatments for isolated snoring are not routinely commissioned It is recognised that some patients may have snoring in conjunction with obstructive sleep apnoea/hypopnoea syndrome (OSAHS): • Continuous positive airway pressure (CPAP) is recommended as a treatment option for adults with moderate or severe symptomatic obstructive sleep apnoea/hypopnoea syndrome (OSAHS) in accordance with NICE technology appraisal 139; • ENT surgery will only be considered for snoring in OSAHS to improve compliance with CPAP; or with nasal pathology such as nasal polyps or deviated septum; • In children with obstructive sleep apnoea/hypopnoea syndrome (OSAHS), tonsillectomy may be recommended as a treatment option (please review guidance).
Criteria	**Surgery for isolated snoring is not routinely commissioned**

Snoring	
Codes	OPCS Code: F32.4, 32.5, 32.6 There are no ICD10 Codes for snoring, but for those meeting clinical criteria the codes are G47.3 or G47.9
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Tonsillectomy	
Introduction	These criteria are in line with SIGN 2010 guidance. It should be noted that there is no high quality evidence in adults for the effectiveness of tonsillectomy as a treatment for recurrent sore throats, and benefits may be outweighed by the morbidity associated with surgery in children who are not severely affected.
Criteria Based Access	Tonsillectomy is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: Recurrent sore throat where the following **documented evidence** applies: • Seven or more episodes of tonsillitis***** in the last year; **or** • Five episodes per year in the preceding two years; **or** • Three episodes per year in the preceding three years; **and** • There has been significant severe impact on quality of life indicated by documented evidence of absence from school/work; **and/or** • Failure to thrive. Referral for tonsillectomy is automatically commissioned in the following circumstances: • Suspected malignancy; • Peri-tonsillar abscess (Quinsy); • Tonsillar enlargement causing acute upper airways obstruction. When in doubt as to whether a tonsillectomy would be beneficial, a six month period of watchful waiting is recommended. * Definition of tonsillitis Using the SIGN[1] list as indicative of bacterial infection, an eligible episode of tonsillitis must have three points, one each for any of the five criteria documented: a) History of fever (>38.3C);

[1] SIGN 34 (Scottish Intercollegiate Guidelines Network) (April 2010) Management of Sore Throat and Indications for Tonsillectomy

Tonsillectomy	
	b) Tender anterior cervical lymph nodes; c) Tonsillar exudate; d) Absence of cough; e) Age under 15; f) But age 45+ subtracts a point **or** positive culture of group A beta haemolytic streptococci.
Codes	OPCS Code: F34.1 – 34.9, 36.1. Subsidiary Codes Y08.1 - 08.9 and Y10.1 - 13.9 with code Z25.7. The ICD10 Code for acute sore throat is J02 and for acute tonsillitis is J03, but the number of episodes cannot be captured by ICD10 Codes, and there are no appropriate codes for impact on normal functioning. Codes for the other funded indications are any one of: J36; G47.3 or G47.9; C09 (suspected or proven).
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JCIA	Available upon request.

Musculo-skeletal health

Bunion surgery (hallux valgus)	
Introduction	A bunion (Hallux valgus) is a bony swelling at the base of the big toe. Not all people with bunions are symptomatic (have symptoms).
Criteria Based Access	Surgical removal of bunions is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Conservative methods have been tried and documented to have failed; **and** • Severe deformity (overriding toes) is causing significant (documented) functional impairment*; **or** • Severe pain is causing significant functional impairment*; **or** • Recurrent infection; **or** • Recurrent ulcers. ***Note: significant functional impairment is defined as:** • Symptoms that result in an inability to sustain employment despite reasonable occupational adjustment, or act as a barrier to employment or undertake education; • Symptoms preventing the patient carrying out self-care, maintaining independent living or carrying out carer activities. **Evidence of functional impairment must be supplied with the referral documentation.**
Codes	OPCS Code: W79.2 ICD10 Code: M201

Bunion surgery (hallux valgus)	
Date approved	November 2016
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JCIA	Available upon request.

Carpal tunnel syndrome	
Introduction	Carpal tunnel syndrome is a relatively common condition that affects the nerves of the hand causing pain, numbness and a burning or tingling sensation in the hand and fingers. Symptoms can be intermittent, and range from mild to severe. Patients with intermittent or mild/moderate symptoms should be managed conservatively in the first instance.
Criteria Based Access	Carpal tunnel surgery is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met: • There is a fixed neurological deficit (refer at first presentation); **or** • Primary care management has failed (local corticosteroid injection and/or nocturnal splinting as per referral management guidelines (see primary care management for carpal tunnel). **and** • Symptoms are > six months duration; **and** • There is significant functional impairment*. ***Note: significant functional impairment is defined as:** • Symptoms that result in an inability to sustain employment despite reasonable occupational adjustment, or act as a barrier to employment or undertake education; • Symptoms preventing the patient carrying out self-care, maintaining independent living or carrying out carer activities. **Evidence of functional impairment must be supplied with the referral documentation.**
Codes	OPCS Code: A65.1, 65.9 The ICD 10 Code for Carpal Tunnel syndrome is G56.0, but there are no appropriate Codes for the clinical criteria.
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Dupuytren's disease	
Introduction	Dupuytren's Disease can be managed conservatively with physiotherapy, wrist splints, NSAIDs, and steroid injections. There are recognised criteria where surgical release may be beneficial.
Criteria Based Access	Surgery for Dupuytrens contracture is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met: • The patient has a metacarpophalanageal joint (MCPJ) deformity which causes significant functional impairment*; **or** • A proximal interphalangeal joint (PIPJ) deformity greater than 30º; **or** • Multiple joints with significant functional impairment*; **or** • Recurrence after surgery with significant functional impairment* ***Note: significant functional Impairment is defined as:** • Symptoms that result in an inability to sustain employment despite reasonable occupational adjustment, or act as a barrier to employment or undertake education; • Symptoms preventing the patient carrying out self-care, maintaining independent living or carrying out carer activities. **Evidence of functional impairment must be supplied with the referral documentation.**
Codes	OPCS Code: T52.1, 52.2, 52.5, 52.6, 54.1, Z89.4, 89.5, 89.6, 89.7 ICD10 Code: M720
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Ganglion	
Introduction	Ganglia are benign fluid filled, firm and rubbery in texture lumps. They occur most commonly around the wrist, but also around fingers, ankles and the top of the foot. They are usually painless and completely harmless. Many resolve spontaneously especially in children (up to 80 per cent. Reassurance should be the first therapeutic intervention. Aspiration alone can be successful but recurrence rates are up to 70 per cent. Surgical excision is the most invasive therapy but recurrence rates of up to 40 per cent have been reported. Complications of surgical excision include scar sensitivity, joint stiffness and distal numbness.
Criteria	Removal of ganglia is commissioned where patients meet the criteria below, the

Ganglion	
Based Access	referral letter and patient's medical record need to clearly evidence how these criteria are met: • Persistent pain (i.e. pain without spontaneous resolution within one to two years); **or** • Significant Functional Impairment*; **or** • Evidence of nerve compression. ***Note: significant functional Impairment is defined as:** • Symptoms that result in an inability to sustain employment despite reasonable occupational adjustment, or act as a barrier to employment or undertake education; • Symptoms preventing the patient carrying out self-care, maintaining independent living or carrying out carer activities. **Evidence of functional impairment must be supplied with the referral documentation.**
Codes	OPCS Code: T59.1 - 59.4, T59.8, T59.9, T60.1 – T60.4, T60.8, T60.9 The ICD10 Code for Ganglion is M67.4, but there are no appropriate ICD10 Codes for the clinical criteria
Date approved	November 2016
Review date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Hip impingement syndrome	
Introduction	Hip impingement syndrome is caused by unwanted contact between abnormally shaped parts of the head of the thigh bone and the hip socket. This results in limited hip movement and pain.
Criteria Based Access	Open or arthroscopic femoro-acetabular surgery for hip impingement in the absence of osteoarthritis is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Labral tear or impingement has been confirmed on MRI; **and** • Where hip arthroscopy is supported in the washout of an infected native hip joint in patients refractory to medical management, patients with underlying disease or patients who are immunosuppressed; • Where hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies; • The clinician has ensured that the patient understands what is involved, is aware of the serious known complications outlined in NICE patient

Hip impingement syndrome	
	information and agrees to the treatment knowing that there is only evidence for relief of the symptoms in the short and medium term; • All available conservative methods have failed including activity modification, pharmacological intervention and specialist physiotherapy; • Patient has severe symptoms causing pain or significant functional impairment* lasting > six months; • Aged between 18 and 50 years **likely to gain most benefit**. ***Note: significant functional impairment is defined as:** • Symptoms that result in an inability to sustain employment despite reasonable occupational adjustment, or act as a barrier to employment or undertake education; • Symptoms preventing the patient carrying out self-care, maintaining independent living or carrying out carer activities. **Evidence of functional impairment must be supplied with the referral documentation.**
Codes	OPCS Code: W58.1, Z84.3 ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Knee arthroscopy	
Introduction	As less invasive investigations have become more readily accessible the role of diagnostic arthroscopy is diminishing.
Criteria Based Access	Knee Arthroscopy is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: 1. **Washout and debridement in osteoarthritis:** Unless there are documented mechanical features of locking which is associated with severe pain, arthroscopic debridement and washout is not routinely commissioned for chronic pain relief of osteoarthritis of the knee. 2. **Diagnostic arthroscopy:** Unless one or more of the following criteria are met diagnostic arthroscopy of the knee is not routinely commissioned: • Knee pain with diagnostic uncertainty following an MRI scan; **or** • Suspected malignancy, infection, nerve root impingement, bony fracture or avascular necrosis. 3. **Therapeutic arthroscopy:** Unless all of the following criteria are met therapeutic arthroscopy of the knee is not routinely commissioned: • Clinical examination by a consultant specialist or an MRI scan has demonstrated clear evidence of an internal joint derangement (meniscal tear, ligament rupture or loose body); **and**

Knee arthroscopy	
	• Where conservative treatment has failed or where it is clear that conservative treatment will not be effective.
Codes	**1. Washout and debridement in Osteoarthritis:** • OPCS Codes: W82.2, 82.3, 83.3, 83.6, 85.2, 85.8, 85.9. • The ICD10 Code for Osteoarthritis is M15.0, but there are no appropriate Codes for the clinical criteria. **2. Diagnostic arthroscopy:** • OPCS Codes: W87.1, 87.8, 87.9 • ICD10 Codes for the clinical criteria are any one of (suspected): M36.1; M00 or M01; S72.4 or S72.8 or S72.9 or S82.1 or S82.9; M87. • There is no appropriate Code for diagnostic uncertainty, but MRI is U13.3 or U21.1, with Z84.6. **3. Therapeutic arthroscopy:** • OPCS Codes: W82.1 - 82.9, 85.1 - 85.9, (W83.1 - 84.9 with Z84.6) • The ICD10 Code for internal derangement of the knee is M23. There are no appropriate Codes for conservative management.
Date approved	November 2016
Review date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Trigger finger	
Introduction	Trigger Finger (also known as stenosing tenosynovitis or stenosing tenovaginosis)
Criteria Based Access	Trigger Finger surgery is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • failure to respond to conservative measures (for example, steroid or hydrocortisone injections, see primary care management for trigger finger); **or** • patients with diabetes, following a trial of steroid injections (recurrence of symptoms is more common).
Codes	OPCS Codes: T69.1, 69.2, 69.8, 69.9, 70.1, 70.2, 71.8, 71.9, 72.3, 72.8, 72.9 with any one of Z89.4, 89.5, 89.6, 89.7 The ICD10 Code for Trigger Finger is M65.3, but there are no appropriate ICD10 Codes for the clinical criteria.
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Urological - Genitary problems

Assisted conception (includes IVF)	
Introduction	Infertility is defined as failure to conceive after regular unprotected sexual

Assisted conception (includes IVF)	
	intercourse for two years in the absence of known reproductive pathology. The treatment of infertility is to assist a couple in conception where such difficulties have been identified. Patients should not be referred to secondary care, outside this time frame, unless there are extenuating reasons. For women over the age of 35, this threshold can be reduced to one year. In the context of limited resources, treatment should be targeted at those with the most need and the greatest chance of success. Up to four cycles of IUI (Intrauterine insemination) and one cycle of IVF (In vitro fertilisation) may be funded per couple, who would be expected to have a >10% chance of live-birth per cycle. All couples must follow the agreed algorithm, not just progress to IVF without going through other stages first, unless clinically indicated. The elective single embryo transfer policy and cryopreservation of gametes or embryos policy can be found on our website.
Criteria	**In vitro fertilisation (IVF) will be commissioned where the clinical criteria are met – as outlined below:** **Age:** Restricted to women aged between 23 and 40 years: When a woman has reached her 40th birthday she is no longer eligible to access NHS infertility treatment even if she is already on a care pathway. **Weight:** Men and Women must have a BMI (body mass index) of between 19 and 29.9 for all treatments requiring gonadotrophins: Women with a BMI below 19 or individuals with a BMI above 29.9 should be offered advice and support on increasing or decreasing their weight via their GP. **Smoking:** Men and Women must have stopped smoking for six months (or use of illicit drugs) before being offered treatments requiring gonadotrophins: Both partners, if necessary, should be strongly encouraged to stop smoking. Self-referral to stop smoking advisors via their GP surgery is recommended. Both partners must be able to declare that they have ceased smoking for at least six months before either partner is offered treatments. If the six months takes them outside the age criteria a clinical decision may be taken to proceed with treatment earlier. **Previous children:** Restricted to couples with no experience of children living with them, as their place of residency (where children are classed as under 18): The aim of this criterion is to give priority to those couples with limited or no experience of parenting. An adopted child has the same status as a biological child. **Couple's relationship:** Restricted to couples in a stable relationship: A stable relationship is defined as two years, to fit with the definition of infertility. **Previous assisted conception:** Restricted to couples who have had no previous NHS cycles of IVF.

Assisted conception (includes IVF)	
	Ovarian reserve test or poor cycle response: Restrict where clinician believes chance of live-birth is <10% per cycle: Preferred test is AMH (anti-mullerian hormone) A result of 5 or under can be used in conjunction with other clinical indicators as an indicator that the **chance of live-birth is <10%** **Previous sterilisation:** Assisted conception will not be funded where one or both partners have previously been sterilised **-** even if self-funded reversal has been successful. **Rare scenarios in infertility (revised June 2010):** The following procedures are approved for funding in the specified circumstances and where the Access Criteria are met. **General anaesthetic for egg collection:** A clear medical indication. **Only available at Exeter Unit**. **Surgical sperm retrieval:** TESA (Testicular sperm aspiration) as clinically indicated – MESA (Microsurgical sperm aspiration) not funded. Not for previous vasectomy. **Donor insemination:** Severe male factor infertility, Genetic disorder in male, Couple decline ICSI (intracytoplasmic sperm injection). Following IVF egg retrieval when no living sperm produced on day of treatment. The tariff covers transport of sperm; and storage for the NHS funded cycle only **Cryopreservation for abandoned cycles:** If treatment is abandoned after oocyte retrieval and the embryos cannot be replaced. Storage for up to one year and replacement of frozen embryos for the one funded NHS cycle. **GnRH pump:** Congenital absence of GnRH (Gonadotropin releasing hormone). **Receiving egg donation:** Premature menopause – that is menopause before the age of 40, defined as no natural menarche for two years. Genetic disorder in female. Previous chemotherapy or radiotherapy for cancer. **Egg donors:** Must meet HFEA (Human fertilisation and embryology authority) criteria. Altruistic donation. Egg sharing as long as the NHS does not subsidise treatment for the donor beyond that which is required for treatment of the recipient. **Abandoned IVF or ICSI cycle:** One further NHS cycle to be funded if greater than 10 per cent chance of success where the cycle has been abandoned prior to egg retrieval or cryopreserved replacement. This includes where the cycle was abandoned due to hyperstimulation. One cycle of ICSI where there is failed fertilisation in IVF and ISCI would be expected to resolve this. **Abandoned IUI cycle:** One further NHS cycle to be funded if greater than 10 per cent chance of success.

Assisted conception (includes IVF)	
	Cryopreservation: Funded under certain circumstances, see separate cryopreservation of gametes or embryos policy. Patient can self-fund cryopreservation of embryos resulting from NHS-funded cycle. **Surrogacy:** If required due to congenital absence of the uterus or malignancy. Funding is approved for the creation of eggs or embryos and storage for five years or until one implantation has been performed (whichever is the sooner). Funding is not approved for finding a suitable surrogate, implantation in the surrogate mother or subsequent treatment. **Preimplantation Genetic Diagnosis (PGD):** If a couple have a life limiting condition (or are carriers of such) and there is a gene marker meaning that pre-implantation genetic testing would be beneficial, and the couple meet all of the eligibility criteria, then one cycle of PGD would be approved **Female couples:** To be eligible for NHS funded fertility treatment female same sex couples should be demonstrably sub-fertile. Female same sex couples will be assessed if insemination on at least twelve non-stimulated cycles over a period of two years has failed to lead to a pregnancy, in the absence of known reproductive pathology. They should have access to professional consultation, independent advice and counselling in reproductive medicine to obtain advice and information on the options available to them. If a same sex couple has a diagnosed fertility problem on investigation then their sub fertility will be treated but NHS funding will not be available for either donor insemination or for funding of surrogacy arrangements. This is on the basis that unless they are medically sub fertile their childlessness is due to the absence of gametes of the opposite sex and not due to both a medical cause and related healthcare need. The clinician should discuss with the couple the feasibility and preparedness of the other partner trying to conceive before proceeding to interventions involving the sub-fertile partner.
Codes	OPCS Code: Y96.1, 96.2, 96.3, 96.4, 96.5, 96.6, 96.8, 96.9 ICD10 Code: O028, O029
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JCIA	Available upon request.

Dilatation and curettage for menorrhagia	
Introduction	Dilatation and curettage (D&C) is a common gynaecological operation performed for both diagnostic and therapeutic purposes for a range of conditions including menorrhagia. NICE guidelines recommend the replacement of D&C with endometrial biopsy for investigation of menorrhagia, and do not support its use as a therapeutic procedure.
Criteria Based	Dilatation of cervix uteri and curettage of uterus for the investigation or management of menorrhagia is commissioned where patients meet the criteria

Dilatation and curettage for menorrhagia	
Access	below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Molar pregnancy • Failed endometrial preparation for re-section
Codes	OPCS Code: Q10.3, 10.8, 10.9 ICD10 Code: There are no relevant ICD 10 Codes.
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JCIA	Available upon request

Elective caesarean section for non-clinical reasons	
Introduction	Elective caesarean section for non-clinical reasons is a low priority and will not normally be funded by the CCG. Maternal request is not on its own an indication for caesarean section. Intervention is approved according to criteria established in the guidelines issued jointly by NICE and the National Collaborating Centre for Women and Children's Health.
Criteria	**Elective Caesarean Section for Non-Clinical Reasons is not routinely commissioned.**
Codes	OPCS Codes: R17.1, 17.2, 17.8, 17.9 The ICD10 codes for clinical criteria include B20-24, O32, 33, 34, 34.2, Q44, Z21. Please note that this list exhaustive
Date approved	November 2016
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JCIA	Available upon request.

Female sterilisation	
Introduction	Sterilisation is a procedure that permanently removes an individual's fertility. Sterilisation for a female normally involves tubal occlusion.
Criteria Based Access	Female sterilisation should only be carried out as a stand-alone procedure or during a caesarean section in women who meet all of the following criteria and this has been documented by the referring or treating clinician. The referral letter and patient's medical record need to clearly evidence how these criteria are met: • The woman understands fgthat the sterilisation procedure is irreversible and the reversal of sterilisation operation would not be routinely funded on the NHS; • She is certain that her family is complete OR that she will never want children; • She has sound mental capacity for making the decision. Additional care must be taken when counselling people under 30 years of age or people without children who request sterilisation; this should include attempts to identify coercion;

Female sterilisation	
	• She understands that vasectomy in the partner is a valid alternative option; • She has received counselling about all other forms of contraceptives and has undergone a trial of long-acting contraceptives OR she has declined a trial of long-acting reversible contraception after counselling; • She understands that she will be required to avoid sex or use effective contraception until the menstrual period following the operation and that sterilisation does not prevent against the risk of sexually transmitted infections. Female sterilisation could also be considered in women who have a medical condition making pregnancy dangerous.
Codes	OPCS Code: Q27.1, Q27.2, Q27.8, Q27.9, Q28.2, Q28.3, Q28.4, Q28.8, Q28.9, Q35.1, Q35.2, Q35.3, Q35.8, Q35.9, Q36.1, Q36.2, Q36.8, Q36.9 ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Hysterectomy +/- Oophrectomy	
Introduction	Hysterectomy is an effective procedure for treatment of heavy menstrual bleeding (menorrhagia), but is associated with more complications compared to treatment with progestogens and should not be used as a first-line treatment.
Criteria Based Access	Hysterectomy +/- oophrectomy for non-cancerous heavy menstrual bleeding is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • A prior trial with a levonorgestrel intrauterine system e.g. Mirena® (unless contraindicated), has failed to relieve symptoms; **and** • Other less invasive treatment options have been tried for a minimum of three months and documented to have failed (e.g. non-steroidal anti-inflammatory agents, tranexamic acid, endometrial ablation, uterine-artery embolization, hormonal therapies), or are not appropriate or are contraindicated.
Codes	OPCS Codes for hysterectomy: Q07.2, 07.4, 07.8, 07.9, 08.2, 08.8, 08.9, with or without subsidiary Code Y50.3 The ICD10 Codes for the clinical criteria are: C54, 55, 56, 57, 58; D25 (with failure of conservative treatment); N80 (with failure of conservative management); N92.0, 92.1, 92.2, 92.4 (with failure of conservative management)
Date approved	November 2016
Review date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Male sterilisation (vasectomy)	
Introduction	Sterilisation is a procedure that permanently removes an individual's fertility. Sterilisation that can be carried out for a male is known as vasectomy.
Criteria Based Access	**GP based vasectomies under local anaesthetic:** GP Based local anaesthetic vasectomy for male sterilisation is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Their partner/spouse is not currently pregnant; • They understand the procedure should be considered irreversible; • The patient has been advised that reversal would not be funded by the CCG; • They are able to have the procedure carried out under local anaesthetic. **Secondary care based vasectomies under general anaesthetic:** Vasectomies performed under general anaesthetic is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Previous documented adverse reaction to local anaesthesia; **or** • Scarring or deformity distorting the anatomy of the scrotal sac or content making identification and/or manipulation of the spermatic cord through the skin difficult to achieve; **or** • The patient is on anticoagulation therapy.
Codes	OPCS Code: N17.1, N17.2, N17.8, N17.9 ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request.

Mirena coils	
Introduction	The IUS (intrauterine system) is a long-acting reversible contraceptive (LARC) method. It works for five years and is a small, T-shaped plastic device that is inserted into the womb (uterus) by a specially trained doctor or nurse. The brand name of the IUS used in the UK is Mirena.
Criteria Based Access	Referrals should not be made for the routine fitting of Mirena as this should normally be offered in primary care. Exceptions are where fitting or removal has failed or where there are issues specific to an individual patient that require secondary care insertion. For example, during termination of pregnancy, or as part of an operative procedure such as hysteroscopy.
Codes	OPCS Code: P31.5, Q12.1-12.4, 12.8, 12.9 ICD10 Code: There are no relevant ICD10 Code for the clinical criteria
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Mirena coils	
JCIA	Available upon request

Reversal of female sterilisation	
Introduction	Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.
Criteria	**Reversal of female sterilisation is not routinely commissioned.**
Codes	OPCS Code: Q29.1 - 30.3, 30.8, 30.9, 37.1, 37.8, 37.9 ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2016
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JCIA	Available upon request.

Reversal of male sterilisation	
Introduction	Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the *vas deferens*. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled that the procedure is intended to be permanent.
Criteria	**Reversal of male sterilisation is not routinely commissioned.**
Codes	OPCS Code: N18.1, 18.2, 18.8, 18.9. ICD10: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2016
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JCIA	Available upon request.

Routine doppler ultrasound of umbilical + uterine artery in antenatal care	
Introduction	Routine Doppler Ultrasound Of Umbilical + Uterine Artery In Antenatal Care
Criteria	**Routine doppler ultrasound of umbilical and uterine arteries for low risk pregnancies is not routinely commissioned.**
Codes	OPCS Code: R42.1, 42.2 ICD10 Code for high-risk pregnancy is Z35
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Treatment for erectile dysfunction	
Introduction	Pharmacological treatment will be provided in line with the latest guidance. This policy refers to non-pharmacological treatment.

Treatment for erectile dysfunction	
	Erectile dysfunction affects 30-50% of men aged 40-70 years, with age, smoking and obesity being the main risk factors, although 20% of cases have psychological causes. Evidence suggests that drugs such as sildenafil, tadalafil, vardenafil, intracavernosal alprostadil, intraurethral alprostadil, and intracavernosal papaverine improve erections and increase the likelihood of successful intercourse. Sublingual apomorphine, ginseng and yohimbine may increase successful erections and intercourse compared with placebo. Vacuum devices may be as effective as intracavernosal alprostadil at increasing rigidity, but less effective for orgasm, and may block ejaculation. There is consensus that penile prostheses may be beneficial, but they can cause infections and are therefore are not routinely commissioned. Psychosexual counselling and cognitive behavioural therapy may improve sexual functioning in men with psychological erectile dysfunction, but few good quality studies have been found.
Criteria Based Access	Medical and surgical treatment for erectile dysfunction is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Diabetes, multiple sclerosis, Parkinson's disease, poliomyelitis; • Prostate cancer, prostatectomy, radical pelvic surgery, severe pelvic injury renal failure treated by dialysis or transplant; • Single gene neurological disease, spinal cord injury, spina bifida
Codes	OPCS Code: L97.1, N32.4, 32.6 The ICD10 Code for erectile dysfunction is F52.2 ICD 10 Codes for the clinical criteria are: E10-14, G35, G20, B91; C61, with no ICD10 Codes for prostatectomy, pelvic surgery or injury; N18, N19 with (X401 or 402 or 403 or 405 or 406 or 408 or 409 or Z94.0); S14.1, S24.1, S34.1, S34.4, S34.5, Q05
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Eye problems

Cataract surgery	
Introduction	Since the level of visual acuity that an individual requires to function without altering their lifestyle varies, measurements of visual acuity do not necessarily reflect the degree of visual disability that patients may experience as a result of cataracts. The criteria set out below attempt to explicitly take that into account. The legal visual requirement for driving falls somewhere between 6/9 and 6/12 (strictly speaking it is based on the number plate test) and it is anticipated that

Cataract surgery	
	the thresholds set out below will not render the majority of people unable to drive. This policy also recognises the increasing body of evidence that second eye surgery does indeed benefit patients.
Criteria Based Access	**This policy applies to both first and second eyes with a best corrected visual acuity of 6/12 or worse in the affected eye being used as the threshold for cataract surgery.** A best corrected visual acuity of better than 6/12 in the affected eye, will not normally be funded. Cataract Surgery is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Patients with a best corrected visual acuity of 6/12 or worse in the affected eye (please ensure best corrected visual acuity information included with referral); **and** • Patients who are still working in an occupation in which good acuity is essential to their ability to continue to work (e.g. watchmaker); **or** • Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions; **or** • Patients who need to drive at night who experience significant glare due to cataracts which affects driving; **or** • Patients who have difficulty with reading, or recognising faces, due to lens opacities; **or** • Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field; **or** • Patients with significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye; **or** • Patients with glaucoma who require cataract surgery to control intra ocular pressure; **or** • Patient with diabetes who require clear views of their retina to look for retinopathy; **or** • Patients with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with anti-VEGFs). **Please note**: the reasons why the patient's vision and lifestyle are adversely

Cataract surgery	
	affected by cataracts and the likely benefits the patient would gain from having surgery, or any other exceptional circumstances, must be clearly documented in the clinical records.
Codes	OPCS Code: C71.1 - 72.9, 74.1 - 75.9. The ICD10 Codes for cataracts are H25 and H26, but there are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2017
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JCIA	Available upon request

Laser surgery for short sight (Myopia)	
Introduction	Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious in appropriately selected patients. However there are alternative methods of correction such as spectacles and contact lenses.
Criteria	**Laser surgery for correction of short sight is not routinely commissioned.**
Codes	OPCS Code: C44.2, 44.4, 44.5, 46.1 The ICD10 Code for short sightedness (high myopia) is H52.1
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Aesthetic surgery

General guidelines

1. NHS Kernow considers all lives of all patients whom they serve to be of equal value and, in making decisions about funding treatment for patients, will seek not to discriminate on the grounds of sex, age, sexual orientation, ethnicity, educational level, employment, marital status, religion or disability save where a difference in the treatment options made available to patients is directly related to the patient's clinical condition.

2. Aesthetic surgery in patients who are considered to be within the normal morphological range will be considered as purely cosmetic and therefore not funded on the NHS and referrals from GPs for these reasons will not be accepted.

3. Patients requiring reconstructive surgery to restore normal or near normal appearance or function following cancer treatment or post trauma are eligible for NHS funding and therefore not included in this policy.

4. Aesthetic surgery will not be routinely funded to alleviate psychological distress alone. Where there is concern that a patient presenting with an apparently simple aesthetic problem may have an underlying medical or severe psychiatric problem the GP should consider referring the patient for an appropriate opinion relating to that problem.

5. Referrals for the revision of treatments originally performed outside the NHS will not normally be supported, and should be referred back to the practitioner who originally carried out the procedure. Where there is a complication of treatment originally undertaken outside of the NHS e.g. breast capsulotomy following breast augmentation, these will be considered through NHS Kernow's Individual Funding Request (IFR) Process. Such cases will not however be automatically eligible for repeat surgery under the NHS i.e. defective breast implants may be removed but not replaced.

Abdominoplasty or apronectomy	
Introduction	Abdominoplasty and apronectomy are surgical procedures performed to remove excess fat and skin from the mid and lower abdomen. Many people develop loose abdominal skin after pregnancy or substantial weight loss, whether it be due to surgical or dietary weight loss.
Criteria	**Abdominoplasty and apronectomy are not routinely commissioned.**
Codes	OPCS Code: S02.1, 02.2, 02.8, 02.9. ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Benign skin lesions	

Introduction	Benign skin lesions include a wide range of skin disorders such as **(this list is not exhaustive)**:
	
	• Benign pigmented melanocytic naevi (moles);
	• Dermatofibromas (skin growths);
	• Lipomata (fat deposits underneath the skin);
	• Molluscum Contagiosum;
	• Port wine stains;
	• Post acne scarring;
	• 'Sebaceous' cysts (pilar and epidermoid cysts); (patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis);
	  ○ Sebaceous cysts (a collection of sebum) are rarely truly infected
	  ○ In lesions with evidence of persistent or recurrent infection, the removal of the lesion may be undertaken as an **exception** to the decision not to fund the removal of benign lesions
	• Seborrheic keratoses (benign skin growths, basal cell papillomas, warts);
	• Skin tags;
	• Spider naevi;
	• Telangectasia;
	• Thread veins;
	• Warts and Plantar Warts; (genital and anal warts are excluded);
	• Xanthelasmas (cholesterol deposits underneath the skin);
	• Anal skin tags
	
	The removal of a benign skin lesion, wherever it appears on the body, is

Benign skin lesions	
	regarded as a procedure of low clinical priority. Surgery to improve appearance alone is not provided. Suspected malignancy (should be referred through via the two week suspected cancer system with the exception of suspected basal cell carcinoma). Skin lesions are often referred for specialist opinion because of concerns that there may be malignancy.
Criteria	**Removal of benign skin lesions is not routinely commissioned.**
Codes	OPCS Code: S06.3 - 06.9, 08.1 - 08.9, 09.1 - 09.9, 10.1, 10.2, 11.1, 11.2, and D02 ICD10 Codes for the clinical criteria are C43, 44, 46.0, 49.0 for relevant malignancies; there are no appropriate ICD10 Codes for the other clinical criteria
Date approved	August 2017
Review Date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request.

Blepharoplasty	
Introduction	Blepharoplasty is a surgical procedure performed to correct puffy bags below the eyes and droopy upper eyelids. It can improve appearance and widen the field of peripheral vision.
Criteria Based Access	Blepharoplasty is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Impairment of visual fields in the relaxed, non-compensated state. Evidence will be required that eyelids impinge on visual fields, reducing field to 120 degrees laterally and 40 degrees vertically (20 above and 20 below); **or** • Correction of ectropion or entropion with ocular irritation and causing functional implications (**evidence of functional implications must be supplied with the referral documentation**).
Codes	OPCS Code: C13.1 - 13.4, C13.8 – 9, C16.1 – 16.5, C16.8 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date Approved	November 2016
Review Date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Botox injection for the ageing face	
Introduction	Botox injection for the ageing face
Criteria	**Botox Injection for the Ageing Face is not routinely commissioned.**
Codes	OPCS Code: X85.1 with Z60.1 (with or without X37.5) ICD10 Code: There are no appropriate ICD10 Codes
Date	August 2016

Botox injection for the ageing face	
approved	
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Breast asymmetry	
Introduction	Breast Asymmetry
Criteria	**Cosmetic breast surgery is not routinely commissioned.** Exclusions: This policy does not cover breast reconstruction following surgery for breast cancer. Clinicians are not required to seek prior approval in these circumstances. For applications for exceptions to this policy, please refer to the notes in Appendix one.
Codes	OPCS Code: B30.1, 30.2, 30.4, 30.8, 30.9, 31.2, 31.4, 37.5 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Breast augmentation	
Introduction	Breast augmentation/enlargement is the most popular cosmetic procedure. It involves inserting artificial implants behind the normal breast tissue to improve its size and shape.
Criteria	**Cosmetic breast augmentation/enlargement is not routinely commissioned.**
Codes	OPCS Code: B30.1, 30.2, 30.4, 30.8, 30.9, 31.2, 31.4, 37.5 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria Exclusions: This policy does not cover breast reconstruction following surgery for breast cancer. Clinicians are not required to seek prior approval in these circumstances.
Date approved	August 2016
Review Date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Breast lift (mastopexy)	
Introduction	This is included as part of the treatment of breast asymmetry but will not be available for purely cosmetic reasons, for example post lactation or age related breast ptosis (drooping). Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss.

Breast lift (mastopexy)	
Criteria	**Breast Lift (Mastopexy) is not routinely commissioned.** Exclusions: This policy does not cover breast reconstruction following surgery for breast cancer. Clinicians are not required to seek prior approval in these circumstances.
Codes	OPCS Code: B31.3, 31.4. ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Breast reduction	
Introduction	Excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape.
Criteria	**Breast reduction is not routinely commissioned.** For applications for exceptions to this policy, please refer to the notes in Appendix one.
Codes	OPCS Code: B31.1, 30.3 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Complex and specialised obesity surgery	
Introduction	Bariatric surgery is a treatment for appropriate, selected patients with severe and complex obesity that has not responded to all other non-invasive therapies. Within these patient groups bariatric surgery has been shown to be highly cost effective. The patient has a BMI of 40kgs/m2 or more, or a BMI of 35-40kgs/m2 plus other significant disease that could be improved with weight loss, or the patient has a BMI of 30-34.0 who have recent-onset type 2 diabetes, in whom surgical intervention is considered appropriate. However, it will be required that these patients also fulfil the criteria below. Selection criteria of patients for bariatric surgery should prevent perverse incentives for example patients should not become more eligible for surgery by increasing their body weight. Similarly the selection criteria should not forbid bariatric surgery for patients who have lost weight with non-surgical methods
Criteria Based Access	**Complex and Specialised Obesity Surgery will only be considered as a treatment option for people with morbid obesity providing all of the following criteria are fulfilled:** • Consider an assessment for bariatric surgery for people with a BMI of 30-

Complex and specialised obesity surgery	
	34.0 who have recent-onset type 2 diabetes as long as they are also receiving or will receive assessment in a tier three service (or equivalent) • Consider an assessment for bariatric surgery for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations as long as they are also receiving or will receive assessment in a tier three service (or equivalent) • There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include identification, diagnosis, severity/complexity assessment, risk stratification/scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway. • Morbid/severe obesity has been present for at least five years. • The individual has recently received and complied with a local specialist obesity service weight loss programme (non-surgical tier three / four), described as follows: This will have been for duration of six months. For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months. The specialist obesity weight loss programme and MDT should be decided locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity. There are different models of local MDT structure. Important features are the multidisciplinary, structured and organised approach, lead professional, assessment of evidence that all suitable non-invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care the service will select and refer appropriate patients for consideration for bariatric surgery. The non-surgical tier three / four service may be community or hospital-based but will have as their role: • Education; • Dietary advice/support (which may be delivered through specialist obesity dieticians, or slimming clubs – Weight Watchers, Slimming World etc.); • Enabling access to appropriate level of physical activity where not limited due to obesity related problems such as osteoarthritis, cardio respiratory disease; • Exclusion of underlying contributory disease e.g. hypothyroidism, Cushing's; • Evaluation of co-morbidities (diabetes, sleep disorder breathing, etc) and instigation of appropriate management plans; • Evaluation of patient's engagement with non-surgical measures; • Evaluation of psychological factors relevant to obesity, eating behaviour, physical activity and patient engagement; • There is evidence of attendance, engagement and full participation in the above non-surgical tier three / four service engagement can be judged by attendance records and achievement of pre-set individualised targets (for

Complex and specialised obesity surgery	

	example steady and sustained weight loss of 5-10%, or maintaining constant weight whilst stopping smoking);
	• The patient has been assessed and referred by the lead physician/ clinician for the specialist obesity weight loss MDT;
	• The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of intervention. Patients who lose sufficient weight to fall beneath the NICE guidance should not be considered appropriate for surgery.
	
	The final decision on whether an operation is indicated should be made by the specialist hospital bariatric MDT. For all bariatric surgery candidates, an individual risk benefit evaluation will be done by the Bariatric Surgery MDT, this will be informed by their own clinical assessment and information provided by primary care and by non-surgical tier three / four. In some locations there may be close liaison (and perhaps even overlap of personnel) between non-surgical tier three / four and Bariatric Surgery MDT. For example, a specialist bariatric physician would be on both MDTs.
	
	The risk: benefit evaluation will consider:
	
	• Existing co-morbidities and their reversibility;
	• Risk of future co-morbidities and their reversibility;
	• Patients age and general level of health;
	• Anticipated weight reduction;
	• Alternatives if bariatric surgery is not undertaken;
	• Peri-operative mortality;
	• Post-operative complications of bariatric surgery.
	
	The Bariatric Surgery team will satisfy itself that:
	
	• Bariatric surgery is in accordance with relevant guidelines;
	• There are no specific clinical or psychological contraindications to this type of surgery;
	• The individual is aged 18 years or above;
	• The patient has engaged with non-surgical tier three / four services;
	• The anaesthetic and other peri-operative risks have been appropriately Minimised;
	• The patient has engaged in appropriate support or education groups/schemes to understand the benefits and risks of the intended surgical procedure;
	• The patient is likely to engage in the follow up programme that is required after any bariatric surgical procedure to ensure:
	  ○ Safety of the patient;
	  ○ Best clinical outcome is obtained and then maintained.
	• Change eating behaviour;
	• Change physical behaviour as advised;

Complex and specialised obesity surgery	
	• The overall risk: benefit evaluation favours bariatric surgery. Revisional procedures will only be considered electively for clinical reasons due to complications and will require prior approval unless they are required on an acute emergency basis. Any new/novel bariatric surgery procedures outside of this policy will not be routinely commissioned. Where a clinician wishes to make a request for a new device/procedure, an application for exceptional funding through the Individual Funding Request (IFR) process should be made in the first instance.
Codes	OPCS Code: G27.1-9, G28.1-9, G30.1-4, G30.8-9, G31.0-6, G31.8-32.5, G32.8-33.3, G33.5-6, G33.8-9, G38.7-8, G48.1-2, G71.6 ICD10 Code: E66 (Obesity) in the primary diagnosis position
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request.

Congenital vascular lesions	
Introduction	Congenital vascular lesions
Criteria	**Laser treatment for congenital vascular lesions is not routinely commissioned.**
Codes	OPCS Code: There are no relevant OPCS Codes ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Face lift or brow lift	
Introduction	These surgical procedures are performed to lift the loose skin of face and forehead to get a firm and smoother appearance of the face.
Criteria	**Cosmetic face lift or brow lift are not routinely commissioned.**
Codes	OPCS Code: S01.1, 01.2, 01.3, 01.4, 01.5, 01.6, 01.8, 01.9 ICD 10 Codes for the clinical criteria are Q18.3, 18.9, 67.0 - 67.4; G51; Q82.8, 85. There are no appropriate Codes for trauma or deformity following surgery
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Hair depilation (Hair removal)	
Introduction	Hair depilation can be used for excess hair in a normal distribution pattern, or

Hair depilation (Hair removal)	
	for abnormally placed hair. It is usually achieved permanently by electrolysis or laser therapy.
Criteria	**Hair depilation is not routinely commissioned** Exclusions include recurrent pilonidal sinus and post hair bearing flap reconstructions
Codes	OPCS Code: S60.6, 60.7 The ICD10 Codes for excess hair are L68 and Q84.2. There are no appropriate ICD10 Codes for the clinical criteria other than polycystic ovaries (E28.2)
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Hair grafting - male pattern baldness	
Introduction	Male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Hair grafting is mostly done for aesthetic reasons.
Criteria	**Hair grafting for male pattern baldness is not routinely commissioned.**
Codes	OPCS Code: S21.1, 21.2, 21.8, 21.9, 33.1, 33.2, 33.3, 33.8, 33.9 The ICD10 Codes for male pattern baldness are L64.8, 64.9
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Hymenorrhaphy	
Introduction	Hymenorrhaphy
Criteria	**Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely commissioned.**
Codes	OPCS Code: There are no appropriate Codes ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Inverted nipple correction	
Introduction	Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons.
Criteria	**Inverted Nipple Correction is not routinely commissioned.** Note: This policy relates to **cosmetic** procedures and explicitly excludes investigation or management of suspected malignancy.
Codes	OPCS Code: B35.4, 35.6

Inverted nipple correction	
	ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Labiaplasty	
Introduction	Labiaplasty
Criteria	**Labiaplasty is not routinely commissioned.**
Codes	OPCS Code: P05.5, 05.6, 05.7 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Liposuction	
Introduction	Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures.
Criteria	**Liposuction is not routinely commissioned.**
Codes	OPCS Code: S62.1, 62.2 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Male breast reduction surgery for gynaecomastia	
Introduction	Most cases of gynaecomastia are idiopathic. It can also occur during puberty, when it tends to resolve as the post-pubertal fat distribution is complete. It can also occur secondary to medication such as oestrogens, gonadotrophins, digoxin, spironolactone and cimetidine, as well as anabolic steroids. More rarely it can be due to endocrinological disorders and malignancy.
Criteria	**Male breast reduction surgery for gynaecomastia is not routinely commissioned.** Note: This policy relates to **cosmetic** procedures and explicitly excludes investigation or management of suspected malignancy For applications for exceptions to this policy, please refer to the notes in Appendix one.
Codes	OPCS Code: B31.1

Male breast reduction surgery for gynaecomastia	
	The ICD10 Code for gynaecomastia is N62, but there are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Penile implants and labial trimming and cosmetic genital procedures	
Introduction	Trimming of labia majora and minora are considered cosmetic procedures.
Criteria	**Penile implants, labial trimming and other cosmetic genital procedures are not routinely commissioned.**
Codes	OPCS Code: N29.1, 29.2, 29.8, 29.9, P05.5, 05.6, 05.7 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Pinnaplasty	
Introduction	Pinnaplasty is performed for the correction of prominent ears or bat ears.
Criteria	**Pinnaplasty is not routinely commissioned.**
Codes	OPCS Code: D03.3. The ICD10 Code for bat ears is Q17.5, but there are no appropriate Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Removal of tattoos	
Introduction	A tattoo can be removed by laser, surgical excision, or dermabrasion.
Criteria	**Tattoo removal is not routinely commissioned.**
Codes	OPCS Code: S09.1, 09.2, 10.8, 10.9, 60.1, 60.2 The ICD10 Code for tattoos is L81.8
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Repair of lobe of external ear (split earlobes)	
Introduction	The external ear lobe can be damaged partially or completely as result of trauma or wearing ear rings. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised

Repair of lobe of external ear (split earlobes)	
	risk.
Criteria	**Repair of lobe of external ear is not routinely commissioned.**
Codes	OPCS Code: D06.2, 06.3 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Resurfacing procedures: dermabrasion, chemical peels and laser treatment	
Introduction	Dermabrasion, involves removing the top layer of the skin to make it look smoother and healthier. Scarring and permanent discolouration of skin are rare complications.
Criteria	**Resurfacing procedures: dermabrasion, chemical peels and laser treatment are not routinely commissioned**
Codes	OPCS Code: S09.1, 09.2, 10.3, 11.3, 60.1, 60.2 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Revision mammoplasty (including prosthesis removal or replacement)	
Introduction	The term mammoplasty refers to both breast reduction and breast augmentation procedures. Revision mammoplasty may be indicated if desired results are not achieved or as a result of problem with implants.
Criteria Based Access	Revision mammoplasty (including prosthesis removal or replacement) is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met: • Implant is proven to be ruptured; **or** • Baker Grade IV capsular contracture; **or** • Implants with capsule formation that interferes with mammography; **or** • Implant is a PiP implant This commissioning decision applies regardless of the funding source of the original surgery (i.e. whether funded by the NHS or on a private basis*). Patients will be offered the choice of removing both prostheses in the event that only one has been ruptured with the intention of ensuring symmetry. **Replacement of breast implants is not routinely commissioned.** This policy does not apply to women who have undergone breast reconstruction following surgery for cancer.

Revision mammoplasty (including prosthesis removal or replacement)	
	* Please note in the first instance the patient should be directed back to the original private provider for the procedure. In the event the private provider is unable to support the patient, the NHS will undertake removal only. However the CCG reserves the right to seek reimbursement from the provider.
Codes	OPCS Code: B30.2, 30.3, 30.4, 31.4 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	November 2016
Review Date	November 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Rhinoplasty	
Introduction	Rhinoplasty is a surgical procedure performed on the nose to change its size or shape or both. People often ask for this procedure to improve self-image.
Criteria	**Rhinoplasty is not routinely commissioned.**
Codes	OPCS Code: E02.3, 02.4, 02.5, 02.6 07.3 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Scars and keloids	
Introduction	Scars and keloids
Criteria	**Treatment for scars and keloids is not routinely commissioned.**
Codes	OPCS Code: S06.3, 06.4, 06.5, 08.1, 08.2, 09.1, 09.2, 10.1, 10.2, 10.8, 10.9, 11.1, 11.2,11.8, 11.9, 60.4, Y06.4 The ICD10 Codes for scars and keloids are L90.5 and 91.0, but there are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Thigh lift, buttock lift and arm lift, excision of redundant skin or fat	
Introduction	These surgical procedures are performed to remove loose skin or excess fat to reshape body contours.
Criteria	**Thigh lift, buttock lift, and arm lift, excision of redundant skin or fat are not routinely commissioned.**
Codes	OPCS Code: S03.1, 03.2, 03.3, (S03.8 or 03.9 with Z49.5 or 50.1) ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016

Thigh lift, buttock lift and arm lift, excision of redundant skin or fat	
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Vaginoplasty	
Introduction	Vaginoplasty
Criteria	**Non-reconstructive vaginoplasty or "vaginal rejunivation" used to restore vaginal tone and appearance is not routinely commissioned.**
Codes	OPCS Code: P21.3, 21.4, 21.5 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review Date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Miscellaneous

Complementary medicines/therapies	
Introduction	Complementary medicines/therapies
Criteria	**Complementary therapies such as homeopathy, acupuncture, osteopathy and chiropractic therapy are not routinely commissioned**
Codes	OPCS Code: X61.2, X61.3, X61.4, X61.8, X61.9, Y33.1 ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria
Date approved	August 2016
Review date	August 2018 or earlier if new guidance is issued
JCIA	Available upon request.

Hyperbaric oxygen therapy	
Introduction	Despite the increasing use of Hyperbaric Oxygen Therapy (HBOT) in a range of conditions there is very little evidence from clinical trials regarding its clinical effectiveness or cost effectiveness. In line with findings from the review of HBOT by NHS Quality Improvement Scotland, NHS Kernow will fund its use for conditions where there is a theoretical basis for its effectiveness, sufficient empirical evidence and clinical consensus.
Criteria	**Hyperbaric Oxygen Therapy is not routinely commissioned**
Codes	OPCS Code: X52.1 ICD10 Codes for the clinical criteria are T70.3 (acute); T58 (acute); O88.0 or T79.0 (both acute); K62.7
Date approved	August 2017
Review date	August 2019 or earlier if new guidance is issued
JCIA	Available upon request

Appendix one

All applications for exceptions to the breast reduction policy, gynaecomastia (male breast reduction) policy and breast asymmetry policy must include:

For gynaecomastia:

- Photos only.

Otherwise:

- Measurements:
  - Height in metres;
  - Weight in kg;
  - Measurement around the rib cage;
  - Measurement over bust (around fullest part);
  - Waist;
  - Hip;
  - Bra size.

- For breast asymmetry:
  - Disparity between breasts;
  - Distance of clavicle to nipple;
  - Waist;
  - Hip.

- Photographs (if acceptable to the patient):
  - Face excluded;
  - Standing position;
  - Neck to hip with arms held naturally at side;
  - Front and side view.