Commissioning policies for 2022 to 2023

Each commissioning policy has an individual review date.
**Document control sheet**

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- Second cohort - commissioning priorities group and Governing body  
- Third cohort - quality and performance committee  
- 4A cohort - quality and performance committee  
- 4B cohort - quality and performance committee  
- Cohort 5 - quality and performance committee  
- 2020 to 2021 policies finance and performance committee  
- 2021 to 2022 policies finance and performance committee  

**Review frequency:** Each policy will be reviewed every 3 years or earlier if new guidance is issued  

**To be reviewed by date:** See individual policy for review date  
**Target audience:** Service providers, referrers and members of the public  

**Can this policy be released under FOI?** Yes

### Version control

The version history of this policy shown below represents changes made since 2020. History, prior to this time, is available on request via the NHS Kernow planned care team.

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<td>- skin surface applied functional electrical stimulation for an orthotic effect to correct foot drop of central neurological origin</td>
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**Version number** | **Revision date** | **Revision by** | **Nature of revisions**
--- | --- | --- | ---
17.0 | 6 April 2022 | Anna White | Changes made to:
- flash glucose monitors – changes made to the criteria
- surgical treatment for hair loss policy title has been renamed from hair grafting - male pattern baldness
Changes to clinical coding only:
- paediatric speech and language therapy in secondary care

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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 medicines optimisation team or the 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.

Purpose

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 several other commissioning policy documents; the full list can be found on our individual funding requests webpage.

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

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.

Definitions

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

1. There is evidence that they are ineffective or do more harm than good.
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, for example through ethically approved research.
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.
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.
Responsibilities

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

NHS funds

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 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 or 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 and other treatments (this document).

**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.

**Implementation plans and monitoring effectiveness**

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 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 criteria based access procedure has been identified. This means that assessment against the 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 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 criteria based access 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.
Update and review

All policies and similar documents must be dated when approved and a review date also included. This will usually be 3 years unless there is an indication to the contrary. It is the responsibility of the author (or nominated officer) to be aware of influencing factors and to initiate reviews promptly within the 3 years if appropriate.

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.

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.

National Institute for Health and Care Excellence guidance and recommendations

During the process of guidance development, National Institute for Health and Care Excellence’s (NICE) 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.
Commissioning policies

General surgery

Alfa pumps for the removal of ascites due to liver disease

When patients suffer from liver disease, the liver and kidneys stop working properly and fluid stops being exchanged within the cells in the way it should. This leads to ascites, an excess of fluid, which gathers in the abdomen. There is no way for this fluid to be removed from the body naturally and up to 15 litres of it can gather around patients’ abdominal organs. Ascites can make patients look pregnant, as well as being painful, often causing hernias, and can take away the appetite, making patients weak and leading to malnutrition. These patients may have to make weekly trips to the hospital to have the fluid drained from their abdomen.

The alfa pump, a CE-marked device, which is implanted beneath the skin of the abdomen, works by pumping fluid from the abdomen into the bladder, where it is removed from the body naturally through urination. The fully implantable, battery powered, pump system eliminates the build-up of ascites and the onset of associated symptoms. In alcoholic cirrhotic patients once the symptoms of liver disease are reduced or eliminated, the liver has a better chance of recovery, as long as patients abstain from drinking alcohol (McCune, 2015).

Criteria

Alfa pumps for the removal of ascites 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:

- patient must have the ability to operate the device
- patient must have cirrhosis of the liver defined by histological and/or clinical, and/or radiological criteria
- patient must present with refractory ascites* and require periodic large volume paracentesis (large volume defined as more than 5 litres in accordance with the clinical guidance of European Association for the Study of the Liver (EASL), which recommends withdrawal of 5 litres should precipitate administration of albumin)

* Definition of refractory ascites [Moore and Aithal, Gut 2006 Oct; 55 Suppl 6: vi1-12] Ascites that cannot be mobilised or early recurrence of which (that is, after therapeutic paracentesis) cannot be satisfactorily prevented by medical therapy.

This includes 2 different subgroups:

1. Diuretic resistant ascites: ascites that are refractory to dietary sodium restriction and intensive diuretic treatment (spironolactone 400mg per day) and frusenide 160 mg
per day for at least 4 weeks, and a salt restricted diet of less than 90 mmol per day (5.2g of salt) per day).

2. Diuretic intractable ascites: ascites that is refractory to therapy due to the development of diuretic induced complications that preclude the use of an effective diuretic dosage.

Alfa pumps will not be commissioned on any of the following indications:

- patient has had a gastrointestinal haemorrhage over the last 7 days
- renal failure defined as serum creatinine higher than or equal to 2mg per decilitre
- severe coagulopathy defined as prothrombin time greater than 40% more than upper limit of normal (as determined locally)
- platelet count of less than 40,000 per microliter unless platelet therapy is given at the time of surgery
- clinical evidence of recurring bacterial peritonitis, defined as 2 or more episodes over the last 6 months or a single episode within the last 2 weeks
- clinical evidence of recurring urinary infections, defined as 2 or more episodes over the last 6 months or a single episode within the last 2 weeks
- clinical evidence of loculated ascites
- advanced hepatocarcinoma defined as one which exceeds Milan criteria
- obstructive uropathy, residual urinary volume exceeding 100ml, or any bladder anomaly which might contraindicate implantation of the device
- other concomitant disease or condition likely to significantly decrease life expectancy or present anaesthetic risk (for example moderate to severe congestive heart failure)
- immuno-modulatory treatment (including zothiaprin, methotrexate, anti-tumour necrosis factor (TNF) therapies) used within last 4 months
- known as suspected hepatic or extra hepatic malignancy, unless adequately treated or in complete remission for more than 3 years
- body mass index (BMI) more than 40 presenting a risk for surgery and tunnelled lines
- patients with contraindications for general anaesthesia

Codes

Procedures challenged in this policy
T462 Drainage of ascites

Diagnoses challenged in this policy
ICD10 Code: C22, C221, C240, I500, K922, K658, K659, K650, N130, N138, N139
C22.0 Malignant neoplasm: Liver cell carcinoma
C22.1 Malignant neoplasm: Intrahepatic bile duct carcinoma
C22.9 Malignant neoplasm: Liver, unspecified
C24.0 Malignant neoplasm: Extrahepatic bile duct
I50.0 Congestive heart failure
K92.2 Gastrointestinal haemorrhage, unspecified
K65.0 Acute peritonitis
K65.8 Other peritonitis
K65.9 Peritonitis, unspecified
N13.8 Other obstructive and reflux uropathy
N13.9 Obstructive and reflux uropathy, unspecified
N19.X Unspecified kidney failure
E66.8 Other obesity

**Diagnoses for which the above procedures are permitted**
R18.X Ascites
K74.6 Other and unspecified cirrhosis of liver + R18.X ascites
K70.3 Alcoholic cirrhosis of liver + R18.X ascites

**Date approved**: April 2018 and July 2021.
**Review date**: July 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Chronic fatigue syndrome or myalgic encephalomyelitis referral for treatment**

Chronic fatigue syndrome (CFS) or myalgic encephalomyelitis (ME) comprises a range of symptoms that includes fatigue, malaise, headaches, sleep disturbances, difficulties with concentration and muscle pain. A person’s symptoms may fluctuate in intensity and severity, and there is also great variability in the symptoms different people experience. CFS or ME is characterised by debilitating fatigue that is unlike everyday fatigue and does not improve with sleep or rest and can be triggered by minimal activity. This raises especially complex issues in adults and children with CFS or ME (NICE CG53).

**Criteria**

Funding for treatment will only be commissioned where patients meet the criteria below (if under 16 must be under the care of a paediatrician), the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

Adult patients should have:

Fatigue lasting for more than 4 months, with all of the following features:

- new or had a specific onset fatigue (that is, it is not lifelong)
- persistent and/or recurrent
- unexplained by other conditions
- has resulted in a substantial reduction in activity level characterised by post-exertional malaise and/or fatigue (typically delayed, for example by 24 hours, with slow recovery over several days or longer)

And 1 or more of the following symptoms:

- difficulty with sleeping, such as insomnia, hypersomnia, unrefreshing sleep, a disturbed sleep-wake cycle
- muscle and/or joint pain that is multi-site and without evidence of inflammation
• headaches
• painful lymph nodes without pathological enlargement
• sore throat
• cognitive dysfunction, such as difficulty thinking, inability to concentrate, impairment of short-term memory, and difficulties with word-finding, planning or organising thoughts and information processing
• physical or mental exertion makes symptoms worse
• general malaise or flu-like symptoms
• dizziness and/or nausea
• palpitations in the absence of identified cardiac pathology
• sensitivities to light, noise, motion, foods, chemicals

And meet all of the following criteria:

1. No major psychiatric illness with psychotic or manic features.
2. No history of failed CFS or ME services (or specific new reasons why referral should be reconsidered).
3. Not receiving concurrent rehabilitation from another provider.
4. No ongoing medical investigation for other conditions.

Exclusions: Inpatient CFS or ME therapy is not routinely commissioned. Referral to alternative providers or services for CFS or ME which are not commissioned by the NHS in line with this policy is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
OPCS Code: There are no appropriate OPCS Codes.

**Diagnoses challenged in this policy**
ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria.

**Date approved**: April 2018, April 2020 and January 2022.
**Review date**: January 2025 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Cholecystectomy**

Cholecystectomy is the surgical removal of the gall bladder. This is normally performed using keyhole (laparoscopic) surgery as a day case procedure. Whilst the commonest indication for cholecystectomy is gallstone disease, other indications exist and are outlined below.

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.
NHS guidance states: “Gallstone disease occurs when hard fatty or mineral deposits (gallstones) form in the gallbladder. Approximately 15% of the adult population are thought to have gallstone disease, and most of these people experience no symptoms. For a small proportion of people with gallstone disease, the stones irritate the gallbladder or block part of the biliary system, and this can cause symptoms such as pain, infection and inflammation. If these symptoms are left untreated, gallstones can cause more serious and, in some cases, life-threatening conditions such as cholecystitis, cholangitis, pancreatitis and jaundice”.

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 gastroenterology or surgery.

This guidance applies to adults aged 19 years and over.

**Criteria**

Cholecystectomy 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 gallbladder stones
- confirmed episode of gallstone induced pancreatitis*
- confirmed episode of cholecystitis*
- episode of obstructive jaundice caused by biliary calculi.
- where there is clear evidence of patients being at risk of gallbladder carcinoma (for example porcelain gallbladder, gallbladder polyp >1cm)
- where there is clear evidence of patients being at risk of gallbladder complications
- gallbladder polyps that are symptomatic, associated with risk factors for malignancy or demonstrate rapid growth
- biliary dyskinesia

*Note: For patients admitted to hospital with acute cholecystitis or mild gallstone pancreatitis, interval and index cholecystectomy are routinely commissioned.

**References**

1. AUGIS. Pathway for the management of acute gallstone diseases. AUGIS 2015
2. NICE. Gallstone disease: diagnosis and initial management. 2014 (CG188)
Codes

Procedures challenged in this policy
J18.1 Total cholecystectomy and excision of surrounding tissue
J18.2 Total cholecystectomy and exploration of common bile duct
J18.3 Total cholecystectomy NEC
J18.4 Partial cholecystectomy and exploration of common bile duct
J18.5 Partial cholecystectomy NEC
J18.8 Other specified excision of gallbladder
J18.9 Unspecified excision of gallbladder

Relevant diagnoses for this policy
K80.5 Calculus of bile duct without cholangitis or cholecystitis
K82.8 Other specified diseases of gallbladder

Diagnoses for which the above procedures are permitted
K80.0 Calculus of gallbladder with acute cholecystitis
K80.1 Calculus of gallbladder with other cholecystitis
K80.2 Calculus of gallbladder without cholecystitis
K81.0 Acute cholecystitis
K81.1 Chronic cholecystitis
K81.8 Other cholecystitis
K81.9 Cholecystitis, unspecified
K85.1 Biliary acute pancreatitis
Cancer diagnoses are a global exclusion

Date approved: August 2017, September 2019 and January 2022.
Review date: January 2025 or earlier if new guidance is issued.
JCIA: Yes, completed.

Circumcision

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

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 prepuce)
- paraphimosis (inability to pull forward a retracted foreskin)
- balanitis xerotica obliterans (chronic inflammation leading to a rigid fibrous foreskin)
• balanoposthitis (recurrent bacterial infection of the prepuce, more than 3 documented episodes)
• carcinoma of the penis

It will not be considered on social or religious grounds on the basis that:

• the Department of Health advises that the legality of male circumcision for religious reasons could 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
• General Medical Council (GMC) and British Medical Association (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 non-therapeutic reasons

Neither the BMA nor GMC take a view as regards the lawfulness or appropriateness of circumcision for non-therapeutic reasons.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
D07.4, D40.7, D29.0, N47.X, N48.0, N48.1, N48.6, C60. or C60.0 C60.1 C60.2 C60.8 C60.9

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: November 2016 and April 2021.
Review date: April 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Correction of chest wall deformity for cosmetic purposes

Criteria

Correction of chest wall deformity for cosmetic purposes is not routinely commissioned. Note, non-cosmetic thoracic surgery is commissioned by NHS England and NHS Improvement.
Codes

Procedures challenged in this policy
T021, T018, T019, T028, T029, T053, T058

Relevant diagnoses for this policy
- M95.4 Acquired deformity of chest and rib.
- Q67.8 Other congenital deformities of chest.

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: November 2016 and April 2021.
Review date: April 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Divarication of recti

The rectus abdominus muscles pass from the ribs and breastbone to the pubic bones. They are the most superficial of the abdominal muscles. Below them are the oblique muscles and transversus abdominus. A ligamentous band called the linea alba holds the recti together. This separation is called diastasis or divarication of the recti.

Counselling should be discussed and offered to all patients before correction of a divarication of recti if there is a view that the patient is requesting this intervention solely based on being unhappy with their appearance.

This intervention is not offered for cosmetic concerns.

Criteria

Surgery to correct a divarication of recti 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. Patient has a clinical need for reconstructive surgery following trauma-pregnancy is not considered a traumatic event and muscle separation following normal pregnancy is common.
2. Patient has a congenital divarication of recti.
3. Divarication of recti is disabling and causes significant functional impairment*.

* Significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Note: this policy is not for hernia repair as this has own policy and associated criteria.
Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
• M620 Diastasis of muscle.
• No code for divarication.
• Q79.5 Congenital diastasis recti (please note this code is not exclusive to this condition and may be used to capture another diagnosis).

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018; November 2018 – significant functional impairment definition amended only and April 2021.
Review date: April 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Haemorrhoid surgery

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 and fixative interventions and rubber band ligation. Surgical haemorrhoidectomy can be used for third or fourth degree haemorrhoids.

Criteria

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)
• non-opioid analgesia and/or topical haemorrhoid preparations for symptomatic relief

If these treatments are unsuccessful many patients will respond to outpatient treatment (non-surgical measures).

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:
Surgical treatment should only be considered for those that do not respond to the above conservative management techniques or if the haemorrhoids are more severe, specifically:

- recurrent grade 3 or grade 4 combined internal or external haemorrhoids with persistent pain or bleeding
- irreducible and large external haemorrhoids that are too large for non-surgical measures

In cases where there is significant rectal bleeding the patient should be examined internally by a specialist.

Note, the removal of anal skin tags is not routinely commissioned by NHS Kernow

**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
- persistent bleeding
- failure of documented conservative management techniques after at least 3 months

**Codes**

**Procedures challenged in this policy**
H511, H512, H513, H518, H519

**Diagnoses for which the above procedures are permitted**
C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99

**Date approved**: August 2017 and November 2019.
**Review date**: November 2022 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Hernia management and repair in adults**

This policy covers the management of inguinal, umbilical, incisional and femoral hernias, and lists the criteria for referral.
This guidance applies to adults aged 19 years and over.

Criteria

The referral letter and patient’s medical record need to clearly evidence how these criteria are met:

Initial management of patients with hernia

Patients with BMI more than 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 3 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: Minimally symptomatic inguinal hernia in men can be managed safely with watchful waiting after assessment. Conservative management should therefore be considered in appropriately selected patients, who are to be counselled about the natural cause of a hernia and the surgical risks in repairing it under informed consent.

In women all suspected groin hernias should be urgent referrals.

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, for example symptoms are such that they cause significant functional impairment*
- the hernia is difficult or impossible to reduce (for example history of incarceration or real difficulty reducing the hernia confirmed by ultrasound)
- inguino-scrotal hernia
- 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 or discomfort that causes significant functional impairment*
• increase in size month on month
• to avoid incarceration or strangulation of bowel in at risk patients, for example 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 or discomfort that causes significant functional impairment*
• conservative management has been tried first, for example weight reduction where appropriate

**Femoral**

All suspected femoral hernias are routinely commissioned for a referral to secondary care due to the increased risk of incarceration or strangulation.

**Impalpable hernia and groin pain**

Impalpable hernia and groin pain not routinely commissioned.

Hernia surgery is not commissioned in patients with groin pain and 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 commissioned for:

• primary unilateral groin hernia repair
• bilateral groin hernia repair
• recurrent hernia
• incisional hernia

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 a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

**Codes**

**Procedures permitted in this policy**

For laparoscopic repairs add Y75.2 in secondary position directly after one of the below codes.

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
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</thead>
<tbody>
<tr>
<td>T20.1</td>
<td>Primary repair of inguinal hernia using insert of natural material</td>
</tr>
<tr>
<td>T20.2</td>
<td>Primary repair of inguinal hernia using insert of prosthetic material</td>
</tr>
<tr>
<td>T20.3</td>
<td>Primary repair of inguinal hernia using sutures</td>
</tr>
<tr>
<td>T20.4</td>
<td>Primary repair of inguinal hernia and reduction of sliding hernia</td>
</tr>
<tr>
<td>T20.8</td>
<td>Other specified primary repair of inguinal hernia</td>
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<td>T20.9</td>
<td>Unspecified primary repair of inguinal hernia</td>
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<td>T25.1</td>
<td>Primary repair of incisional hernia using insert of natural material</td>
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<td>T25.2</td>
<td>Primary repair of incisional hernia using insert of prosthetic material</td>
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<tr>
<td>T25.3</td>
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<td>T25.8</td>
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<td>Repair of recurrent inguinal hernia using insert of natural material</td>
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<tr>
<td>T21.2</td>
<td>Repair of recurrent inguinal hernia using insert of prosthetic material</td>
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<tr>
<td>T21.3</td>
<td>Repair of recurrent inguinal hernia using sutures</td>
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<tr>
<td>T21.4</td>
<td>Removal of prosthetic material from previous repair of inguinal hernia</td>
</tr>
<tr>
<td>T21.8</td>
<td>Other specified repair of recurrent inguinal hernia</td>
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<td>T21.9</td>
<td>Unspecified repair of recurrent inguinal hernia</td>
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<tr>
<td>T23.1</td>
<td>Repair of recurrent femoral hernia using insert of natural material</td>
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<td>Repair of recurrent femoral hernia using insert of prosthetic material</td>
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<td>Repair of recurrent femoral hernia using sutures</td>
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<td>Removal of prosthetic material from previous repair of femoral hernia</td>
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<td>Other specified repair of recurrent femoral hernia</td>
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<td>T23.9</td>
<td>Unspecified repair of recurrent femoral hernia</td>
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<td>T26.1</td>
<td>Repair of recurrent incisional hernia using insert of natural material</td>
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<td>Repair of recurrent incisional hernia using sutures</td>
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<td>T26.4</td>
<td>Removal of prosthetic material from previous repair of incisional hernia</td>
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<td>T26.8</td>
<td>Other specified repair of recurrent incisional hernia</td>
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<td>T26.9</td>
<td>Unspecified repair of recurrent incisional hernia</td>
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<tr>
<td>T97.1</td>
<td>Repair of recurrent umbilical hernia using insert of natural material</td>
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</tbody>
</table>
T97.2 Repair of recurrent umbilical hernia using insert of prosthetic material
T97.3 Repair of recurrent umbilical hernia using sutures
T97.8 Other specified repair of recurrent umbilical hernia
T97.9 Unspecified repair of recurrent umbilical hernia

**Relevant diagnoses for this policy**
K40.2 Bilateral inguinal hernia, without obstruction or gangrene
K40.9 Unilateral or unspecified inguinal hernia, without obstruction or gangrene
K42.9 Umbilical hernia without obstruction or gangrene
K43.2 Incisional hernia without obstruction or gangrene
K41.2 Bilateral femoral hernia, without obstruction or gangrene
K41.9 Unilateral or unspecified femoral hernia, without obstruction or gangrene

**Diagnoses for which the above procedures are permitted**
Cancer diagnoses are a global exclusion

**Date approved**: August 2017, March 2018 and November 2018 – significant functional impairment definition amended only and July 2021.

**Review date**: July 2024 or earlier if new guidance is issued.

**JCIA**: Yes, completed.

**Hyperhidrosis treatment**

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**

**Procedures challenged in this policy**

X851

**Relevant diagnoses for this policy**

R61

**Diagnoses for which the above procedures are permitted**

There are no appropriate codes for the clinical criteria.

**Date approved**: November 2016 and February 2019.

**Review date**: February 2022 or earlier if new guidance is issued.

**JCIA**: Yes, completed.
Laparoscopic ventral rectopexy and stapled transanal rectal resection (STARR)

Criteria

Laparoscopic ventral rectopexy and STARR in the management of internal rectal prolapse and obstructed defecation syndrome 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:

- treatment for full thickness prolapse can often present as an emergency and does not require prior approval
- each patient to be considered by a multidisciplinary pelvic floor team, consisting of a gynaecological surgeon, a colorectal surgeon and pelvic floor physiologists and will not be quorate unless a representative from each of these groups is present

The multi-disciplinary team (MDT) confirms that:

- they recommend this treatment for this patient over all alternatives
- the potential benefit outweighs potential harms
- the MDT is satisfied that the necessary capacity and expertise available to handle this intervention is in place in the proposed delivery setting

Conservative management has been tried and has failed. This includes a selection of the following appropriate for the individual:

- dietary advice; pelvic floor exercises; osmotic and stimulant laxatives; bulking agents and antispasmodics; glycerine and bisacodyl suppositories and biofeedback
- the patient has unresolved faecal incontinence or obstructed defecation syndrome
- symptoms cause significant functional impairment*

*Note: significant functional impairment is defined as

- a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing
- the risks, benefits, and side effects of the procedure have been discussed with the patient, and the patient wishes to be considered for this treatment

If the MDT agrees ventral mesh rectopexy or STARR is the most appropriate treatment for the patient’s condition, a request for prior approval should be made to the relevant commissioner.
Codes

Procedures challenged in this policy
Primary procedure code of H41.5 or primary procedure code H35.5 and Y75.2 in a secondary position.

Relevant diagnoses for this policy
K623

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018; November 2018 – significant functional impairment definition amended only and March 2021.
Review date: March 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

SpyGlass direct visualisation cholangioscopy in complex hepatopancreato-biliary disease
Policy under review.

Criteria
SpyGlass direct visualisation cholangioscopy in complex hepatopancreato-biliary 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:

- indeterminate pancreato-biliary lesions, including:
  - suspected cholangiocarcinoma
  - suspected pancreatic carcinoma
- patients with primary sclerosing cholangitis
- inconclusive diagnostic results from initial standard endoscopic tissue acquisition techniques, such as endoscopic retrograde cholangiopancreatography (ERCP), biliary ductal brush or cytology and endoscopic ultrasound-guided fine needle aspiration (EUS-FNA)
- have been reviewed and referred via the MDT for hepatopancreato-biliary (HPB) disease
- benign emergency referrals, including migrated pancreatic duct stents that otherwise require opened surgery (note this group of patients is expected to be approximately less than 10% of the cohort of the patients within this policy)

Exclusions
Treatment of bile duct stones is excluded from this policy.
Codes

Procedures challenged in this policy
U168, U169

Relevant diagnoses for this policy
Treatment bile duct stones: C220, C221, C222, C223, C224, C227, C229, C240, D015, D135, K803, K804, K805

Diagnoses for which the above procedures are permitted, if in the same attendance.

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed.

Tongue tie division

Policy under review.

Tongue-tie (ankyloglossia) is a problem affecting some babies with a tight piece of membrane between the underside of their tongue and the floor of their mouth (lingual frenulum). It can sometimes affect the baby’s feeding, making it hard for them to attach properly to their mother’s breast.
Criteria

Treatment in primary care

Treatment in primary care will only be provided by the clinical commissioning group (CCG) for infants who are considered suitable by the midwifery service, meeting the criteria set out below.

- infant is aged 12 weeks* or younger (*age corrected)
- infant has a tongue tie which is persistently preventing successful feeding, which could result in the infants faltering growth and that is not helped by additional infant feeding support
- infant has not undergone a previous tongue tie division
- there are no signs of infection

Treatment in secondary care

Opinion only from secondary care will be provided by the CCG for infants aged 12* weeks or younger (*age corrected) who have congenital abnormalities (such as cleft lip or palate, trisomy 21, trisomy 18).

Infants who have one or more of the following are not suitable for treatment in the primary care service setting. Referral to secondary care for opinion and subsequent treatment must meet the criteria set out below:

- the tongue is thick and vascular
- there are aberrant structures beneath the tongue
- there is a family history of coagulation disorder
- the infant has congenital abnormalities, such as cleft lip or palate, trisomy 21, trisomy 18, and an opinion from ENT, orthodontics, oral and maxillofacial surgery has been sought confirming there is a need for tongue tie division

Infants older than 12 weeks old up to and including adults

Treatment for all patients older than 12 weeks (*age corrected), is not routinely commissioned.

Lip tie

The surgical correction of lip tie, where the lip is connected too tightly to the upper gum, is not routinely commissioned.

*Age corrected, or adjusted age, is your premature baby’s chronological age minus the number of weeks or months he was born early. For example, a 1-year-old who was born 3 months early would have a corrected age of 9 months. (Raising Children, 2016)
Codes

Procedures challenged in this policy
F228, F262, F263

Relevant diagnoses for this policy
Q381

Diagnoses for which the above procedures are permitted
Q383, Q900, Q901, Q910, Q911, Q912, Q36, Q361, Q369, Q37, Q370, Q371, Q373, Q374, Q375, Q378, Q379

Date approved: February 2019.
Review date: February 2022 or earlier if new guidance is issued.
JCIA: Available upon request.

Varicose veins

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 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, for example, exercise, weight loss and elevation of the leg 2 to 3 times daily. Varicose eczema, if severe or inflamed, can be treated effectively with topical steroids.

Interventional procedures such as surgical stripping or ligation, radio-frequency ablation, endoscopic procedures and sclerotherapy for example 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

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 marked eczema which has not responded to conservative measures
• 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% at presentation)
• a lower limb venous ulcer not healed within 2 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
• bleeding varicose veins

Patients not suitable for referral to vascular surgical clinics for NHS treatment:

• do not fulfil the above criteria
• whose concerns are cosmetic only
• pain or ache only, itch, mild swelling, minor changes of skin eczema and haemosiderosis

**Codes**

**Procedures challenged in this policy**

**Relevant diagnoses for this policy**
I80, I83

**Diagnoses for which the above procedures are permitted**
There is no code to identify those which have bled or are at risk of bleeding again. Codes for the other clinical criteria are any one of I830 or I832; I872; I800 or I801 or I802 or I803 or I809 or I831. There is no appropriate code to identify impact on quality of life.

**Date approved**: November 2016; November 2018 addition to the eligibility criteria included only; March 2019 review date extension approved only; July 2019 further review date extension approved only and January 2020.

**Review date**: January 2023 or earlier if new guidance is issued.

**JCIA**: Yes, completed.

**Venous angioplasty for multiple sclerosis**

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**

**Procedures challenged in this policy**  
L946, L947, L948, L949, L991

**Relevant diagnoses for this policy**  
G35, G350, G35X, G35XD

**Diagnoses for which the above procedures are permitted**  
There are no relevant codes for the clinical criteria.

**Date approved**: August 2017 and September 2019.  
**Review date**: September 2022 or earlier if new guidance is issued.  
**JCIA**: Yes, completed.

**Ears, nose and throat (ENT)**

**Removal of adenoids (adenoidectomy)**

Adenoids are lymphatic tissue that reside in the postnasal space and arise from the roof of the nasopharynx. Adenoids are only usually present in children and tend to grow from birth, reaching the largest size when a child is between 3 and 5 years of age, before slowly shrinking away by adulthood.

**Criteria**

**Removal of adenoids in children with glue ear**

NICE guidance recommends that adjuvant adenoidectomy in people under 18 years of age should not be performed for the treatment of glue ear in the absence of persistent and/or frequent upper respiratory tract symptoms.

When children have persistent glue ear that affects hearing, one option for treatment of the hearing loss is with grommet insertions (ventilation tubes) and guidance for this intervention is already set out in the NHS Kernow grommets policy. In some circumstances, when a child is undergoing surgery to insert grommets, the adenoids may also be partially resected at the same time. The aim of adenoidectomy is to improve eustachian tube function and therefore reduce the recurrence of glue ear after grommets fall out.
Adjuvant adenoidectomy should not be routinely performed in children undergoing grommet insertion for the treatment of otitis media with effusion. Adjuvant adenoidectomy for the treatment of glue ear should only be offered when one or more of the following clinical criteria are met:

- child has persistent and/or frequent nasal obstruction which is contributed to by adenoidal hypertrophy (enlargement)
- child is undergoing surgery for re-insertion of grommets due to recurrence of previously surgically treated otitis media with effusion
- child is undergoing grommet surgery for treatment of recurrent acute otitis media.

This guidance only refers to children undergoing adenoidectomy for the treatment of glue ear.

**Removal of adenoids in children or adults for other conditions**

Adenoidectomy will be funded in either a child or an adult:

- as part of treatment for obstructive sleep apnoea or sleep disordered breathing in children (for example as part of adenotonsillectomy)
- as part of the treatment of chronic rhinosinusitis in children
- for persistent nasal obstruction in children and adults with adenoidal hypertrophy
- for biopsy purposes in adults or children for the suspicion of cancer and where the adenoids are asymmetrical and/or suspicious lesions are present
- in preparation for speech surgery in conjunction with the cleft surgery team

**Codes**

**Procedures challenged in this policy**
E20.1 Total adenoidectomy
E20.4 Suction diathermy adenoidectomy
E20.8 Other specified operations on adenoid
E20.9 Unspecified operations on adenoid
With D15.1 Myringotomy with insertion of ventilation tube through tympanic membrane

**Relevant diagnoses for this policy**
H65.2 Chronic serous otitis media
H65.3 Chronic mucoid otitis media
H65.4 Other chronic nonsuppurative otitis media
H65.9 Unspecified nonsuppurative otitis media
H66.1 Chronic tubotympanic suppurative otitis media
H66.3 Other chronic suppurative otitis media
H66.4 Suppurative otitis media, unspecified
H66.9 Otitis media, unspecified
H68.1 Obstruction of Eustachian tube
H69.8 Other specified disorders of Eustachian tube
H69.9 Unspecified Eustachian tube disorder
Diagnoses for which the above procedures are permitted
G47.3 Sleep apnoea
J32.0 Chronic maxillary sinusitis
J32.1 Chronic frontal sinusitis
J32.2 Chronic ethmoidal sinusitis
J32.3 Chronic sphenoidal sinusitis
J32.4 Chronic pansinositis
J32.8 Other chronic sinusitis
J32.9 Chronic sinusitis, unspecified
Q35.1 Cleft hard palate
Q35.3 Cleft soft palate
Q35.5 Cleft hard palate with cleft soft palate
Q35.7 Cleft uvula
Q35.9 Cleft palate, unspecified
Q37.0 Cleft hard palate with bilateral cleft lip
Q37.1 Cleft hard palate with unilateral cleft lip
Q37.2 Cleft soft palate with bilateral cleft lip
Q37.3 Cleft soft palate with unilateral cleft lip
Q37.4 Cleft hard and soft palate with bilateral cleft lip
Q37.5 Cleft hard and soft palate with unilateral cleft lip
Q37.8 Unspecified cleft palate with bilateral cleft lip
Q37.9 Unspecified cleft palate with unilateral cleft lip
Cancer diagnoses are a global exclusion

Date approved: April 2018 and July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Congenital ear deformity correction surgery including pinnaplasty

Congenital ear deformity surgery or pinnaplasty surgery is a cosmetic procedure normally performed on a child to correct the absence of a helix formation in one or both ears.

Criteria

Congenital ear deformity correction surgery is not routinely commissioned.

This policy does not apply to the hearing loss associated with microtia and congenital aural atresia.

Codes

Procedures challenged in this policy
D03.1, D03.2, D03.3, D03.4, D03.8, D03.9
Relevant diagnoses for this policy
Q17.5 Prominent ear including bat ear
Q17.8 Other specified congenital malformations of ear
Q17.9 Congenital malformation of ear, unspecified
0 to 18-year-olds only.

Diagnoses for which the above procedures are permitted
No relevant codes listed

Date approved: April 2018; February 2021.
Review date: February 2024.
JCIA: Yes, completed.

Continuous positive airway pressure for the treatment of obstructive sleep apnoea or hypopnoea syndrome

Continuous positive airway pressure (CPAP) for the treatment of obstructive sleep apnoea or hypopnoea syndrome (OSAHS) is not routinely funded and is subject to this restricted policy.

CPAP is a treatment for obstructive sleep apnoea. It uses air pressure generated by a machine, delivered through a tube into the mask that fits over the nose or mouth.

Criteria

CPAP is commissioned where patients meet the criteria below, the referral letter and patient’s medical record to clearly evidence how these criteria are met:

CPAP devices

Funding for treatment including the issuing of a single CPAP device will only be provided for patients meeting the criteria set out below.

The patient has been diagnosed with:

1. OSAHs (including mild, moderate or severe OSAHs) and either:
   - conservative management has been fully engaged in and complied with for period of at least 6 months by the patient and has not proven successful in reducing the impact of OSAHS
   - conservative management is inappropriate before commencing treatment (note: would not expect conservative management to be inappropriate in many cases and where conservative management is inappropriate patients will be expected to fully engage with conservative management once treatment has commenced
2. And the patient is experiencing significant functional impairment which is likely to be corrected or significantly improved by treatment. Significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal,
social or occupational demands. Please state the impairment the individual is experiencing.

3. And the patient has signed an agreement to appropriately insure and maintain the CPAP device and return it to the service upon cessation of treatment or reimburse the full replacement cost of the device to the NHS.

**Treatment cessation**

Patients will have been considered to have failed to comply with treatment with a CPAP if over a 6 month period and the patient has failed to use the device on average for:

- 70% of days
- 4 hours per night when used

Patients who fail to comply with these treatment requirements, must cease treatment and return the device to the provider for reimbursement and reissue to another patient where appropriate or reimburse the NHS the full replacement cost of the device.

Patients who do not receive adequate benefit from the treatment (for example there is little or no improvement in their apnoea and hypopnoea index or Epworth sleepiness scale scores should also be assessed to establish whether it is appropriate for their treatment to continue.

**Codes**

**Procedures challenged in this policy**
E85.6 continuous positive airway pressure

**Diagnoses challenged in this policy**
ICD10 codes: G473

**Date approved**: April 2018, November 2018 significant functional impairment definition amended only and January 2022.

**Review date**: January 2025 or earlier if new guidance is issued.

**JCIA**: Yes, completed.

**Grommets including in the treatment of glue ear**

The medical term for glue ear is otitis media with effusion (OME). Grommets can help drain fluid out of the middle ear.

Glue ear is a common childhood condition in which the middle ear becomes filled with fluid. It can sometimes present in adults.

The NHS Kernow policy identifies when grommets will be commissioned in both children and adults and in cases where there is or is not present OME.
Criteria

Children with OME

Referral of children with glue ear should be made to the paediatric audiology service which will undertake a diagnostic hearing test and then complete a further period of watchful waiting of 12 weeks before referral to ENT services for treatment.

Insertion of grommets in children with OME 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 6 weeks watchful waiting in primary care to the date of referral.
- Hearing level in the better ear of 25 to 30dbHL or worse averaged at 0.5, 1, 2, and 4kHz.
- Exceptionally, healthcare professionals should consider surgical intervention in children with persistent bilateral OME with a hearing loss less than 25 to 30dbHL where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant.
- Healthcare professionals should also consider surgical intervention in children who cannot undergo standard assessment of hearing thresholds where there is clinical and tympanographic evidence of persistent glue ear and where the impact of the hearing loss on a child’s developmental, social or educational status is judged to be significant.
- The guidance is different for children with Down’s syndrome and cleft palate, these children may be offered grommets after a specialist MDT assessment in line with NICE guidance.
- Treatment for OME will be considered in children where grommets will facilitate investigation for congenital sensorineural hearing loss who also have glue ear. This is to support auditory brain response (ABR) hearing test under general anaesthetic in line with national hearing screening policies. It may also be considered to facilitate medical and surgical treatments (cochlear implants) for congenital deafness in children.

It is good practice to ensure glue ear has not resolved once a date of surgery has been agreed, with tympanometry as a minimum.

Children without OME

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.

- The child has acute otitis media when there have been at least 5 recurrences of acute otitis media, which required medical assessment and/or treatment, in the previous year.
Adults with glue ear

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:

- middle ear effusion causing measured conductive hearing loss of 30dbHL or worse averaged at 0.5, 1, 2 and 4kHz, persisting for at least 6 months and resistant to medical treatments
  - in addition, the patient must have significant functional impairment the possible alternative treatment option of a hearing aid should be discussed, at the discretion of the clinician
- 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

Insertion of grommets is not routinely commissioned for pain in the ears (for example, on flying), for Eustachian tube dysfunction (in the absence of other qualifying symptoms or signs (for example, middle ear effusion) or for the treatment of Meniere’s disease.

Codes

Procedures challenged in this policy
Dominant procedure code starts D151 and primary diagnosis code is 1 of:

- H652 Chronic serious otitis media
- H653 Chronic mucoid otitis media
- H661 Chronic tubotympanic suppurative otitis media
- H662 Chronic atticoantral suppurative otitis media
- H663 Other chronic suppurative otitis media
- H664 Suppurative otitis media, unspecified
- H669 Otitis media, unspecified, this includes acute and chronic

Dominant procedure code starts D151 and the primary diagnosis code is H92.1 middle ear effusion with H90.0,1,2.

Relevant diagnoses for this policy
Dominant procedure code starts: D151 and the primary diagnosis code is H92.1 middle ear effusion with H90.0,1,2.

Diagnoses for which the above procedures are permitted
Q90.0,1,2,9 Down syndrome
Q35.1,3,5,7,9 Cleft palate

Review date: March 2024
**Laryngeal or voice box surgery**

Laryngeal surgery has the primary aim of improving or restoring the quality of a person’s voice. It does not include surgery where the primary aim is to treat other symptoms and disease of the larynx, for example, malignancy.

**Criteria**

Laryngeal 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:

The patient has significant dysphonia, defined as:

1. Their voice has unexpectedly changed (in terms of quality, pitch, loudness or vocal effort).
2. The voice change has significantly limited their ability to communicate with others.
3. The patient is experiencing significant functional impairment* which is likely to be corrected or significantly improved by surgery. *Note: significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.
4. The patient has completed a course of voice therapy via an NHS provided speech and language therapist.
5. The dysphonia is due to organic pathology for which surgical intervention will be effective.

Note voice box surgery is not commissioned by the CCG as part of the treatment for patients undertaking the gender dysphonia pathway.

**Codes**

**Procedures challenged in this policy**

E314, E315

**Relevant diagnoses for this policy**

R49.0

**Procedures for which the above procedures are permitted**

If in the same attendance:

Diagnoses for which the above procedures are permitted
A155, A164, C320, C321, C322, C323, C328, C329, D020, D141, D380, J380, J381, J382, J383, J384, J385, J386, J387, Q310, Q311, Q312, Q313, Q315, Q318, Q319, S110, S170, T173, T270, T271, T274, T275

Date approved: April 2018, November 2018 – significant functional impairment definition amended only and February 2021.
Review date: February 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Removal of ear wax in secondary care

Ear wax may be wet or dry and is a normal physiological substance that protects the ear canal. It has several functions including aiding removal of keratin from the ear canal by naturally migrating out of the ear from movement of the jaw. It cleans, lubricates, and protects the lining of the ear canal, trapping dirt and repelling water.

In the vast majority of people, persistent use of ear wax softeners will be sufficient enough to resolve any issues they experience with ear wax. Full details on the use of ear wax softeners can be found in the NHS Kernow patient information leaflet.

Although wax can obscure the view of the tympanic membrane, it does not cause permanent hearing impairment.

This policy outlines the criteria for when referral to secondary care for ear wax removal can be made.

Criteria

Removal of ear wax in secondary care is only commissioned in certain circumstances – the GP will need to provide documented evidence that the patient meets the criteria outlined below:

Ear wax remains troublesome following use of the ear wax softener standardised regime and:

- there is a clearly documented active ear infection
- or active ear disease including eczema or dermatitis of the ear canal or external ear
- or a known tympanic perforation
- or there is a past history ear surgery for example stapedotomy, myringoplasty or mastoid surgery
- or there is a healed tympanic membrane perforation where an aural care or ENT specialist has documented the advice to avoid treatment outside of secondary care; for example, the tympanic membrane is very thin and at risk of perforation from irrigation.
**Codes**

**Procedures challenged in this policy**
OPCS Code: D07.1,  
D07.1 - Irrigation of external auditory canal for removal of wax  
D07.2 - Removal of wax from external auditory canal NEC

**Relevant diagnoses for this policy**
ICD10 Code: None

**Diagnoses for which the above procedures are permitted**
ICD10 code:
H61.2 with 1 of the following:  
H60.5 eczema or dermatitis of external ear.  
Tympanic membrane perforation - H72.0, H72.1, H72.2, H72.8, H72.9

Active ear infection:  
• middle ear = H66.9  
• external ear = H60.3  
• inner ear (labyrinthitis) = H83.0
H66.0 - Acute suppurative otitis media  
H66.1 - Chronic tubotympanic suppurative otitis media  
H66.2 - Chronic atticoadtural suppurative otitis media  
H66.3 - Other chronic suppurative otitis media  
H66.4 - Suppurative otitis media, unspecified  
H66.9 - Otitis media, unspecified  
H65.0 - Acute serous otitis media  
H65.1 - Other acute nonsuppurative otitis media  
H65.2 - Chronic serous otitis media  
H65.3 - Chronic mucoid otitis media  
H65.4 - Other chronic nonsuppurative otitis media  
H65.9 - Nonsuppurative otitis media, unspecified  
H60.8 - Other otitis externa  
H60.9 - Otitis externa, unspecified

The codes below will be linked to another ICD-10 code to explain the other disease it’s linked to:  
H62.0 - Otitis externa in bacterial diseases classified elsewhere  
H62.1 - Otitis externa in viral diseases classified elsewhere  
H62.2 - Otitis externa in mycoses  
H62.3 - Otitis externa in other infectious and parasitic diseases classified elsewhere  
H62.4 - Otitis externa in other diseases classified elsewhere  
H67.0 - Otitis media in bacterial diseases classified elsewhere  
H67.1 - Otitis media in viral diseases classified elsewhere  
H67.8 - Otitis media in other diseases classified elsewhere

**Date approved**: September 2019, March 2021 and January 2022.
Review date: January 2025 or earlier if new guidance is issued.
JCIA: Yes, completed.

Replacement hearing aid policy

NHS Kernow commissions several providers to fit hearing aids to people who have an aidable hearing loss following hearing assessment. This policy applies to replacement hearing aids via both any qualified provider (AQP) and non-AQP pathways.

Hearing aid providers will inform each user of the replacement aid policy that is in place in the NHS Kernow area and include a copy of this policy within the persons individual management plans.

Criteria

Hearing aid replacement due to failure or defectiveness within manufacturer warranty (3 years)

The hearing aid dispenser or audiologist should check the date of supply of the hearing aid to the person is within 3 years. The warranty expiry date is also printed on the housing of the hearing aid. They should check that the aid is defective or failed because of manufacturer failure as opposed to poor handling by the user.

Where these criteria are met, replacement aid(s) are provided free of charge to the user. The defective hearing aid will be returned by the provider under the manufacturer’s warranty and replaced free of charge to the provider for a new or reconditioned instrument with a new 3-year warranty. NHS Kernow will not pay for any hearing aids meeting this criteria.

Defective hearing aid(s) should be swapped at the providers location or at the user’s home (if domiciliary) for a new like for like product as initially dispensed. They should be programmed to the last stored setting for the original instrument. Where possible this is done at the time the faulty instrument is returned, otherwise a fitting appointment should be made at the soonest convenience for the hearing aid user.

Hearing aid has failed or is defective outside of the manufacturer’s warranty (after 3 years)

The hearing aid dispenser or audiologist should check the date of supply of the hearing aid to the person is not within the 3-year warranty period. The warranty expiry date is also printed on the housing of the hearing aid.

They should check that the aid is defective or failed as consequence of the aid as opposed to poor handling by the user.

Where these criteria are met, the replacement aid(s) tariff outlined in the provider contracts can be invoiced to NHS Kernow. It must be made clear on the invoice the
charge is being made because of failure or defectiveness outside of manufacturers guarantee.

Defective hearing aid(s) should be swapped at the provider’s location or at the user’s home (if domiciliary) for a new like for like product as initially dispensed. They should be programmed to the last stored setting for the original instrument. Where possible this is done at the time the faulty instrument is returned, otherwise a fitting appointment should be made at the soonest convenience for the hearing aid user.

**Hearing aid damaged or lost through patient careless or use for other than intended purpose**

If the hearing aid(s) are lost or damaged beyond repair and this is due to neglect or carelessness of the user or use for other than intended purpose, NHS Kernow will not pay for any replacement. In these circumstances the cost is chargeable by the provider to the hearing aid user. They should only be charged the NHS replacement tariff for the replacement hearing aid (currently £68 per aid). Hearing aid users should be made explicitly aware of this policy at the initial fitting stage of the pathway.

**Exclusions**

- People under 18 years old.
- User has a documented diagnosis of dementia or learning disability.
- Aid is lost or damaged through road traffic collision with police incident number.
- Aid is lost through theft with police incident number unless patient or carer is happy to claim back through insurance.
- User is in receipt of guaranteed Pension Credit (proof is required).
- User is in receipt of Universal Credit (proof is required) which replaces the following benefits:
  - Child Tax Credit
  - Housing Benefit
  - Income Support
  - income-based Jobseekers’ Allowance
  - income-related Employment and Support Allowance
  - Working Tax Credit
- Has a valid tax exception certificate on presentation of certificate.
- Has a valid HC2 or HC3 certificate on presentation of certificate.
- Has documented evidence of dual sensory loss (registered partially sighted or registered blind).

In the case of these exclusions, the provider will invoice NHS Kernow the replacement aid tariff outlined in their contract and in line with process for Hearing aid has failed or is defective outside of the manufacturer’s warranty (after 3 years). The invoice should clearly illustrate that the policy exclusion criteria has been met. Evidence must be made available within the users records as this policy will be subject to audit processes.
Invoice classification:

- replacement or lost aid outside of manufacturer warranty
- replacement or lost aid policy exclusions evidenced

**Codes**

**Procedures challenged in this policy**
There are ICD-10 codes for failed or defective hearing aids.

NHS Kernow will use invoicing data and routine audit with our providers to ensure compliance against the criteria listed above.

**Diagnoses challenged in this policy**
No relevant diagnosis codes

**Diagnoses for which the above procedures are permitted**
No relevant diagnosis codes

**Date approved:** March 2021, July 2021 and January 2022.
**Review date:** January 2025 or earlier if new guidance is issued.
**JCIA:** Yes, completed.

**Septorhinoplasty**

Septorhinoplasty is a combination of both a septoplasty and rhinoplasty. Whilst rhinoplasty is often performed for purely cosmetic reasons, septoplasty is conducted to alleviate nasal obstruction. In some instances, it may be necessary to improve the appearance of the nose to also alleviate the nasal obstruction and this procedure is called a septorhinoplasty.

**Criteria**

Rhinoplasty is not routinely commissioned.

Septorhinoplasty for cosmetic reasons is not routinely commissioned.

Exceptions for commissioning are:

- where the nasal obstruction cannot be managed by medical therapy
- the nasal obstruction cannot be reasonably addressed by septoplasty and/or reduction of inferior turbinates alone

**Codes**

**Procedures challenged in this policy**
E023, E073, E024
Diagnoses challenged in this policy
There are no relevant ICD10 codes for the clinical criteria

Diagnoses for which the above procedures are permitted
There are no relevant ICD10 codes for the clinical criteria

Date approved: July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Shave or surgical rhinophyma

Criteria

Shave or surgical rhinophyma is not routinely commissioned.

Codes

Procedures challenged in this policy
There are no appropriate procedure codes.

Relevant diagnoses for this policy
L711

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and February 2021.
Review date: February 2024 or earlier if new guidance issued.
JCIA: Yes, completed.

Snoring in the absence of obstructive sleep apnoea

Snoring is a noise that occurs during sleep that can be caused by vibration of tissues of the throat and palate. It is very common and as many as one in 4 adults snore, if it is not complicated by periods of apnoea (temporarily stopping breathing) it is not usually harmful to health, but can be disruptive, especially to a person’s partner. Please note this guidance only relates to patients with snoring in the absence of obstructive sleep apnoea (OSA) and should not be applied to the surgical treatment for people who snore and have proven OSA who may benefit from surgical intervention as part of OSA treatment.

Surgical treatments including uvulopalatopharyngoplasty (UVPP) for isolated snoring are not routinely commissioned.

It is important to note that snoring can be associated with multiple other causes such as being overweight, smoking, alcohol or blockage elsewhere in the upper airways (for
example, nose or tonsils) and often these other causes can contribute to the noise alongside vibration of the tissues of the throat and palate.

**Alternative treatments**

There are several alternatives to surgery that can improve the symptom of snoring. These include:

- weight loss
- stopping smoking
- reducing alcohol intake
- medical treatment of nasal congestion (rhinitis)
- mouth splints (to move jaw forward when sleeping)

**Criteria**

Surgery for isolated snoring is not routinely commissioned.

Further guidance on surgical intervention for snoring in people with OSA is below:

- continuous positive airway pressure (CPAP) is recommended as a treatment option for adults with moderate or severe symptomatic obstructive sleep apnoea or hypopnoea syndrome (OSAHS) in accordance with NICE technology appraisal 139
- ENT surgery (including tonsillectomy) 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 or hypopnoea syndrome (OSAHS), tonsillectomy may be recommended as a treatment option (please review guidance)

**Codes**

**Procedures challenged in this policy**
F324, F325, F326

**Relevant diagnoses for this policy**
Not like: G473 and patient age is between 18 and 120

**Diagnoses for which the above procedures are permitted**
G473

**Date approved**: August 2017, February 2019 and November 2019.
**Review date**: November 2022 or earlier if new guidance is issued.
**JCIA**: Yes, completed.
Surgical intervention for chronic rhinosinusitis

Chronic rhinosinusitis (CRS) is defined as inflammation (swelling) of the nasal sinuses that last longer than 12 weeks. The sinuses are mucus secreting, air filled cavities in the face and head that drain into the nose; their normal function may be disrupted by environmental, infectious or inflammatory conditions which damage the epithelial lining and disturb the balance of the natural microbial community. Patients report several symptoms including nasal blockage, discharge, alteration to smell, and facial pressure or pain. They often have a relapsing course, with recurrence after treatment commonplace. Absenteeism and presenteeism are widespread.

It is a common chronic condition that affects approximately 11% of adults and has a significant detrimental effect on the quality of life of those affected, thus creating a significant disease burden. CRS as a term encompasses a wide range of phenotypes but can broadly be divided into 2 main types:

1. Chronic rhinosinusitis with nasal polyposis (CRSwNP).
2. Chronic rhinosinusitis without nasal polyposis (CRSsNP).

First-line treatment is with appropriate medical therapy, which should include intranasal steroids and nasal saline irrigation. In the case of CRSwNP a trial of a short course of oral steroids should also be considered. Where first-line medical treatment has failed patients should be referred for diagnostic confirmation and they then may be considered for endoscopic sinus surgery. This involves surgery using a telescope via the nasal cavity to open the sinuses and, if present, remove nasal polyps, both improving the effectiveness of ongoing medical therapy and relieving obstruction.

The surgery is usually undertaken under general anaesthetic as a day-case procedure in otherwise healthy individuals.

This guidance applies to adults and children.

Criteria

Patients are eligible to be referred for specialist secondary care assessment in any of the following circumstances:

- a clinical diagnosis of CRS has been made (as set out in RCS or ENT-UK commissioning guidance) in primary care and patient still has moderate or severe symptoms after a 3-month trial of intranasal steroids and nasal saline irrigation
- in addition, for patients with bilateral nasal polyps there has been no improvement in symptoms 4 weeks after a trial of 5 to 10 days of oral steroids (0.5mg per kg to a max of 60 mg)
- patient has nasal symptoms with an unclear diagnosis in primary care
- any patient with concerning clinical findings as outlined within the nasal and sinus red flags guidelines should be referred urgently via ENT nasal pathway.
No investigations, apart from clinical assessment, should take place in primary care or be a pre-requisite for referral to secondary care (for example X-ray or CT scan). There is no role for prolonged courses of antibiotics in primary care.

Patients can be considered for endoscopic sinus surgery when the following criteria are met:

- a diagnosis of CRS has been confirmed from clinical history and nasal endoscopy and/or CT scan
- disease-specific symptom patient reported outcome measure (for example a sino-nasal outcome test (SNOT-22) or specialist consultation confirms moderate to severe symptoms after trial of appropriate medical therapy (this should include counselling on technique and compliance as outlined in RCS and ENT-UK commissioning guidance recommended secondary care pathway)
- pre-operative CT sinus scan has been performed and confirms presence of CRS note: a CT sinus scan does not necessarily need to be repeated if performed sooner in the patient’s pathway
- patient and clinician have undertaken appropriate shared decision-making consultation regarding undergoing surgery including discussion of risks and benefits of surgical intervention
- in patients with recurrent acute sinusitis, nasal examination is likely to be relatively normal; ideally, the diagnosis should be confirmed during an acute attack if possible, by nasal endoscopy and/or a CT sinus scan

There are a number of medical conditions whereby endoscopic sinus surgery may be required outside the above criteria and in these cases they should not be subjected to the above criteria and continue to be routinely funded:

- any suspected or confirmed neoplasia
- emergency presentations with complications of sinusitis (for example orbital abscess, subdural or intracranial abscess)
- patients with immunodeficiency
- fungal sinusitis
- patients with conditions such as primary ciliary dyskinesia, cystic fibrosis or NSAID-eosinophilic respiratory disease (NSAID-ERD, Samter'sTriad aspirin sensitivity, asthma or CRS)
- treatment with topical and/or oral steroids contra-indicated.
- as part of surgical access or dissection to treat non-sinus disease (for example pituitary surgery, orbital decompression for eye disease, nasolacrimal surgery)

**Codes**

**Procedures challenged in this policy**
Y76.1 Functional endoscopic sinus surgery
Y76.2 Functional endoscopic nasal surgery
E12.1 Ligation of maxillary artery using sublabial approach
E12.2 Drainage of maxillary antrum using sublabial approach
E12.3 Irrigation of maxillary antrum using sublabial approach
E12.4 Transantral neurectomy of vidian nerve using sublabial approach
E12.8 Other specified operations on maxillary antrum using sublabial approach
E12.9 Unspecified operations on maxillary antrum using sublabial approach
E13.1 Drainage of maxillary antrum NEC
E13.2 Excision of lesion of maxillary antrum
E13.3 Intranasal antrostomy
E13.4 Biopsy of lesion of maxillary antrum (we will leave in unless we hear otherwise)
E13.5 Closure of fistula between maxillary antrum and mouth
E13.6 Puncture of maxillary antrum
E13.7 Neurectomy of vidian nerve NEC
E13.8 Other specified other operations on maxillary antrum
E13.9 Unspecified other operations on maxillary antrum
E14.1 External frontoethmoidectomy
E14.2 Intranasal ethmoidectomy
E14.3 External ethmoidectomy
E14.4 Transantral ethmoidectomy
E14.5 Bone flap to frontal sinus
E14.6 Trephine of frontal sinus
E14.7 Median drainage of frontal sinus
E14.8 Other specified operations on frontal sinus
E14.9 Unspecified operations on frontal sinus
E15.1 Drainage of sphenoid sinus
E15.2 Puncture of sphenoid sinus
E15.3 Repair of sphenoidal sinus
E15.4 Excision of lesion of sphenoid sinus
E15.8 Other specified operations on sphenoid sinus
E15.9 Unspecified operations on sphenoid sinus
E16.1 Frontal sinus osteoplasty
E16.2 Drainage of frontal sinus NEC
E16.8 Other specified other operations on frontal sinus
E16.9 Unspecified other operations on frontal sinus
E17.1 Excision of nasal sinus NEC
E17.2 Excision of lesion of nasal sinus NEC
E17.3 Biopsy of lesion of nasal sinus NEC
E17.4 Lateral rhinotony into nasal sinus NEC
E17.8 Other specified operations on unspecified nasal sinus
E17.9 Unspecified operations on unspecified nasal sinus
E08.1 Polypectomy of internal nose

Relevant diagnoses for this policy
J32.0 Chronic maxillary sinusitis
J32.1 Chronic frontal sinusitis
J32.2 Chronic ethmoidal sinusitis
J32.3 Chronic sphenoidal sinusitis
J32.4 Chronic pansinusitis
J32.8 Other chronic sinusitis
J32.9 Chronic sinusitis, unspecified
J33.0 Polyp of nasal cavity
J33.1 Polypoid sinus degeneration
J33.8 Other polyp of sinus
J33.9 Nasal polyp, unspecified

**Diagnoses for which the above procedures are permitted**

Cancer diagnoses are a global exclusion

Exclude any patients admitted as a non-elective admission

**Date approved**: July 2021.
**Review date**: July 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Tonsillectomy for recurrent tonsillitis**

Policy under review.

These criteria are in line with Scottish Intercollegiate Guidelines Network ([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**

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:

- 7 or more episodes of tonsillitis* in the last year
- 5 episodes per year in the preceding 2 years
- 3 episodes per year in the preceding 3 years
- there has been significant severe impact on quality of life indicated by documented evidence of absence from school or work
- failure to thrive in children that has been assessed by their GP or health visitor

In children with obstructive sleep apnoea or hypopnoea syndrome (OSAHS), tonsillectomy may be recommended as a treatment option (please review guidance).

There are several medical conditions where episodes of tonsillitis can be damaging to health or tonsillectomy is required as part of the ongoing management. In these
instances, tonsillectomy may be considered beneficial at a lower threshold than this
guidance after specialist assessment. These are:

- acute and chronic renal disease resulting from acute bacterial tonsillitis
- as part of the treatment of severe guttate psoriasis
- metabolic disorders where periods of reduced oral intake could be dangerous to
  health
- PFAPA (periodic fever, aphthous stomatitis, pharyngitis, cervical adenitis)
- severe immune deficiency that would make episodes of recurrent tonsillitis dangerous

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 6-month period of
watchful waiting is recommended.

* Definition of tonsillitis: Using the SIGN (SIGN 34 (April 2010) management of sore
throat and indications for tonsillectomy) list as indicative of bacterial infection, an eligible
episode of tonsillitis must have 3 points, 1 each for any of the 5 criteria documented:

1. History of fever (more than 38.3C).
2. Tender anterior cervical lymph nodes.
3. Tonsillar exudate.
5. Age under 15.
6. But age 45+ subtracts a point or positive culture of group A beta haemolytic
   streptococci.

Tonsillectomy for tonsil stones, tonsilloliths or halitosis is not routinely commissioned.

Codes

Procedures challenged in this policy
F341, F342, F343, F344, F345, F346, F347, F348, F349, F361

Relevant diagnoses for this policy
There are no appropriate codes for the clinical criteria.

Diagnoses for which the above procedures are permitted
C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16,
C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32,
C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48,
C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64,
C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80,
Musculoskeletal health

Bunion surgery (hallux valgus)

A bunion (hallux valgus) is a bony swelling at the base of the big toe. Not all people with bunions have symptoms.

Criteria

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 measures methods have been tried and documented to have failed
- moderate to severe deformity (omit overriding toes) is causing significant (documented) functional impairment* or prevents patients from finding comfortable footwear
- severe pain is causing significant functional impairment*
- recurrent infection
- recurrent ulcers
- the patient is willing to consider surgery

*Note significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

Codes

Procedures challenged in this policy
W792

Relevant diagnoses for this policy
M201

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.
Carpal tunnel syndrome release

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 to moderate symptoms should be managed conservatively in the first instance.

Criteria

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 (constant altered sensation, muscle wasting, or weakness of thenar abduction: refer at first presentation)
- primary care management has failed (local corticosteroid injection and/or nocturnal splinting as per referral management guidelines (see primary care management for carpal tunnel)
- there is significant functional impairment*
- symptoms are more than 6 months in duration

*Note significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

Codes

Procedures challenged in this policy
A651, A659

Relevant diagnoses for this policy
G560

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Direct access DXA scanning to help target treatment in adults at potential risk of osteoporotic (fragility) fracture

Direct access DXA scanning to help target treatment in adults at potential risk of osteoporotic (fragility) fracture.

Criteria

Note: If there is no intention to change the patient’s treatment based on DXA result, then DXA scanning is not required and will not be routinely commissioned.

Direct access DXA scans is commissioned where patients suspected to be at relatively high risk of fragility fracture meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

1. The patient’s absolute risk of having a fracture in the next 10 years has been estimated using FRAX or QFracture and assessed as intermediate or high.

Note: For patients above the age limits recognised by the tools, consider patients to be high risk; below the age ranges (less than 40 years) covered by these tools see the last bullet below, or consider specialist advice.

2. Patient had a DXA scan over 5 years ago and a repeat DXA scan would be helpful in reassessing the need for ongoing treatment.

3. Patient had a DXA scan over 3 years ago and a repeat DXA scan would be helpful in reassessing the need to start (or restart) treatment.

4. Patient has been formally diagnosed with coeliac disease within the previous 12 months and has not previously undergone DXA scanning or where a previous DXA scan was indicative of osteoporosis following which the patient has been on a gluten free diet for a minimum of 3 years.

5. Patient is commencing or has received drug treatment for cancer which might have adversely affected bone mineral density (for example aromatase inhibitors or anti-androgen therapy).

6. The patient is aged under 40 with a major risk factor for fracture, defined as:

   - a history of multiple fragility fracture
   - history of hip or vertebral fracture
   - current or recent use of high-dose oral or high-dose systemic glucocorticoids (more than 7.5mg prednisolone or equivalent per day for 3 months or longer)

Note: Patients assessed as low risk should be reassured that a DXA scan is not necessary and advised on general measures to maintain bone health.

In patients whose previous assessment did not lead to treatment and who now require reassessment to judge whether treatment thresholds are now met, fracture risk may be
reassessed including DXA scan provided the access criteria in this policy are still met and an interval of at least 3 years has passed since their last DXA scan.

**Codes**

**Procedures challenged in this policy**
OPCS code: U13.1

**Diagnoses challenged in this policy**
There are no appropriate ICD10 codes challenged under this policy.

**Diagnoses for which the above procedures are permitted**

M80. M81.

M82 is an asterisk code which means it must be paired with another code (dagger code). They provide dual classification showing the underlying disease (dagger code) and the manifestation (asterisk code). M82 can be in a primary position if it is the main condition treated. If not, it will be in the secondary position sequenced after the dagger code

**Date approved**: April 2018 and July 2021.
**Review date**: July 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Dupuytren’s contracture release in adults**

Dupuytren’s contracture is caused by fibrous bands in the palm of the hand which draw the finger(s) (and sometimes the thumb) into the palm and prevent them from straightening fully. If not treated the finger(s) may bend so far into the palm that they cannot be straightened. All treatments aim to straighten the finger(s) to restore and retain hand function for the rest of the patient’s life. However, none cure the condition which can recur after any intervention so that further interventions are required. Splinting and radiotherapy have not been shown to be effective treatments of established dupuytren’s contractures.

Several treatments are available: collagenase injections, needle fasciotomy, fasciectomy and dermofascietomy. None is entirely satisfactory with some having slower recovery periods, higher complication rates or higher reoperation rates (for recurrence) than others. The need for, and choice of intervention should be made on an individual basis and should be a shared decision between the patient and a practitioner with expertise in the various treatments of dupuytren’s contractures.

No-one knows which interventions are best for restoring and maintaining hand function throughout the rest of the patient’s life, and which are the cheapest and most cost-effective in the long term. Ongoing and planned National Institute for Health Research studies aim to address these questions.
Criteria

Interventions are collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy.

Treatment is not indicated in cases where there is no contracture, and in patients with a mild (less than 20 degrees) contractures, or one which is not progressing and does not impair function.

An intervention (collagenase injections, needle fasciotomy, fasciectomy and dermofasciectomy) for Dupuytren’s 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 metacarpophalangeal joint (MCPJ) deformity which causes significant functional impairment*
- a proximal interphalangeal joint (PIPJ) deformity greater than 20º
- multiple joints with significant functional impairment*
- recurrence after surgery with significant functional impairment*

*Note significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

Codes

Procedures challenged in this policy
T521, T522, T525, T526, T541

Relevant diagnoses for this policy
M720 and patient age is between 18 and 20

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2017, November 2018 – significant functional impairment definition amended only and November 2019.
Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.
Excision of acromio-clavicular joint or arthroscopic surgical decompression for sub-acromial shoulder pain

Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.

Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only be offered in appropriate cases. To be clear, pure subacromial shoulder impingement means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative treatment such as physiotherapy and exercise programmes are effective and safe in many cases.

Criteria

For patients who have persistent or progressive symptoms, despite adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention.

Excision of acromio-clavicular joint or arthroscopic surgical decompression for sub-acromial shoulder pain 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 of conservative treatment (including physiotherapy and exercise)
- if a temporary improvement has been demonstrated using injection surgery
- if there has been successful surgical treatment of the contralateral side following appropriate conservative management

Codes

Procedures challenged in this policy
W844+shoulder or O291 with Y767 as a secondary procedure

Relevant diagnoses for this policy
M754, M2551

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and November 2019.
Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.
Exogen ultrasound bone healing system

The long bones are those longer than they are wide.

The long bones considered by NICE during the review of clinical evidence include the:

- femora
- tibiae and fibulae of the legs
- the humerus, radius and ulnae of the arms

This policy refers only to these bones and not the other long bones, including metacarpals and metatarsals of the hands and feet, the phalanges of the fingers and toes, and the clavicles or collar bones. The latter were not considered under the NICE evidence review.

Criteria

Exogen ultrasound bone healing system 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. To treat long bone fractures with non-union, defined as a non-healing fracture at 6 months with no progression or signs of fracture healing
2. Surgery may be required to correct the non-union of the long bone fracture. This includes primary and revision surgery where primary surgery has failed
3. The patient would be eligible, fit and appropriate for surgery to treat the non-union
4. Patients must be able and willing to fully comply with the treatment regime of administering the device for 20 minutes per days for a minimum of 120 days either through self-management or with the help of carers
5. The patients and clinicians must confirm that they will comply with the terms of the warranty provided by the suppliers. This includes registering the device within 14 days of commencing treatment, complying with the treatment regime of using the device for 20 minutes a day for a minimum 120 days and returning the device to the suppliers at the end of treatment, whether the treatment is successful or not

Exclusions

Funding approval will not normally be commissioned where the patients meets the following criteria as the clinical evidence reviewed by NICE does not support the provision of exogen:

1. The patient has delayed healing.
2. The patient has non-union of a fracture in a short bone, flat bone, irregular bone, scaphoid bone or sesamoid bone or other long bones not subject to a clinical evidence review by NICE.
3. The patient has not reached skeletal maturity, for example the growth plates of children or adolescents that have not fully matured or closed, a normal finding in the x-rays of young people.
4. The patient has an unstable surgical fixation, not well aligned or where inter-fragment gap is more than 10mm.
5. The patient has an infection in the fracture.
6. The patient is pregnant, has a pacemaker or vertebral or skull fracture.
7. Surgery is contra-indicated for the patient for any other reason.

Codes

Procedures challenged in this policy
OPCS code: There is not a specific OPCS code for exogen US bone healing as a procedure, there is only a code for ultrasound scan of bone or joint U13.2 but the latter is not an accurate way of identifying exogen healing. Desktop exercise required to audit against this policy.

Diagnoses challenged in this policy

S42.2 Fracture of upper end of humerus
S42.3 Fracture of shaft of humerus
S42.4 Fracture of lower end of humerus
S52.0 Fracture of upper end of ulna
S52.1 Fracture of upper end of radius
S52.2 Fracture of shaft of ulna
S52.3 Fracture of shaft of radius
S52.4 Fracture of shafts of both ulna and radius
S52.5 Fracture of lower end of radius
S52.6 Fracture of lower end of both ulna and radius
S52.7 Multiple fractures of forearm
S52.8 Fracture of other parts of forearm
S52.9 Fracture of forearm, part unspecified
S72.0 Fracture of neck of femur
S72.1 Pertochanteric fracture
S72.2 Subtrochanteric fracture
S72.3 Fracture of shaft of femur
S72.4 Fracture of lower end of femur
S72.9 Fracture of femur, part unspecified
S82.1 Fracture of upper end of tibia
S82.2 Fracture of shaft of tibia
S82.3 Fracture of lower end of tibia
S82.4 Fracture of fibula alone

Diagnoses for which the above procedures are permitted
M84.02 Malunion of fracture, upper arm
Ganglion excision

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%).

Reassurance should be the first therapeutic intervention. Aspiration alone can be successful, but recurrence rates are up to 70%. Surgical excision is the most invasive therapy but recurrence rates of up to 40% 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 referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- persistent pain (for example, pain without spontaneous resolution within 1 to 1 years)
- significant functional Impairment*
- evidence of nerve compression

*Note significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.
Codes

Procedures challenged in this policy
T591, T592, T598, T599, T601, T602, T608, T609

Relevant diagnoses for this policy
M674

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Hip impingement syndrome

Policy under review.

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

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
- where hip arthroscopy is supported in the washout of an infected native hip joint in patient's 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 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 more than 6 months
- aged between 18 and 50 years likely to gain most benefit
*Note: significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Evidence of functional impairment must be supplied with the referral documentation.

**Codes**

**Procedures challenged in this policy**  
W581, Z843, or W844 with Z843

**Relevant diagnoses for this policy**  
M248, Q658

**Diagnoses for which the above procedures are permitted**  
M16, M160, M161, M162, M163, M164, M165, M166, M167, M168, M169

**Date approved**: August 2017, November 2018 – significant functional impairment definition amended only and September 2019.  
**Review date**: September 2022 or earlier if new guidance is issued.  
**JCIA**: Yes, completed.

**Injections for non-specific low back pain without sciatica**

Spinal injections of local anaesthetic and steroid are not routinely commissioned in Cornwall and Isles of Scilly for patients with non-specific low back pain (NSLBP).

NSLBP is defined as low back pain that is not associated with serious or potentially serious causes. NSLBP is frequently described in the literature as non-specific, mechanical, musculoskeletal or simple low back pain.

For people with NSLBP the following injections should not be offered:

- facet joint injections
- therapeutic medial branch blocks
- intradiscal therapy
- prolotherapy
- trigger point injections with any agent, including botulinum toxin
- epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis
- any other spinal injections not specifically covered above

Alternative and less invasive options have been shown to work, for example exercise programmes, behavioural therapy and attending a specialised pain clinic. Alternative options are suggested in line with the national lower back and radicular back pain pathway.
Epidurals (local anaesthetic and steroid) should be considered in patients who have severe lumbar sciatica who meet the criteria detailed in the spinal injections for sciatica commissioning policy.

Radiofrequency denervation may be offered to patients with NSLBP who meet the criteria detailed in the NHS Kernow radiofrequency denervation commissioning policy.

NHS England and NHS Improvement evidence-based interventions guidance notes that NICE guidelines recommend that spinal injections should not be offered for non-specific low back pain.

Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be considered in some cases in line with the NHS Kernow commissioning policy.

Criteria

Spinal injections of local anaesthetic and steroid are not routinely commissioned in Cornwall and Isles of Scilly for patients with NSLBP.

Codes

Procedures challenged in this policy

Relevant diagnoses for this policy
• M541, M511 + G55.1 (radiculopathy and lumbar and other intervertebral disc disorders with radiculopathy).
• M545 (chronic low back pain)

Diagnoses for which the above procedures are permitted
• A521, A522, A577 + Z07.1 – Cervical spine, Z07.2 – Thoracic spine, Z07.3 – Lumbar spine, Z07.8 – Other specified with a diagnosis code M541, M511 +G55.1
• V544 +V55. +Z675 with a diagnosis code M545
• V485 + V55. with a diagnosis code M545

Date approved: 26 January 2021.
Review date: 26 January 2024 or earlier if new guidance issued.
JCIA: Yes, completed.
Knee arthroscopy for patients with osteoarthritis

Arthroscopic washout of the knee is an operation where an arthroscope (camera) is inserted into the knee along with fluid. Occasionally loose debris drains out with the fluid, or debridement, (surgical removal of damaged cartilage) is performed, but the procedure does not improve or function of the knee joint.

More effective treatment includes exercise programmes (for example, ESCAPE pain), losing weight (if necessary) and managing pain. Osteoarthritis is relatively common in older age groups. Where symptoms do not resolve after non-operative treatment, referral for consideration of knee replacement, or joint preserving surgery such as osteotomy is appropriate.

Criteria

Arthroscopic knee washout (lavage and debridement) should not be used as a treatment for osteoarthritis because it is clinically ineffective.

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:

- arthroscopic washout (lavage) and debridement in osteoarthritis:
  - referral for arthroscopic lavage and debridement should not be offered as part of treatment for osteoarthritis unless the person has knee osteoarthritis with a clear history of mechanical locking

For further information, please see NICE guidance, evidence overview and NICE arthroscopic knee guidance

Codes

Procedures challenged in this policy

Relevant diagnoses for this policy
Not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99
and primary diagnosis ICD 10 code is like: M15, M17
**Diagnoses for which the above procedures are permitted**

C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99

and primary diagnosis ICD 10 code is like: M15, M17

**Date approved**: November 2016, February 2019 and November 2019.
**Review date**: November 2022 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Knee arthroscopy diagnostic and therapeutic**

**Criteria**

Diagnostic arthroscopy unless 1 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
- suspected malignancy, infection, nerve root impingement, bony fracture or avascular necrosis

Therapeutic arthroscopy: Unless all 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)
- where conservative treatment has failed or where it is clear that conservative treatment will not be effective

**Codes**

**Procedures challenged in this policy**


**Relevant diagnoses for this policy**

Not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63,
Diagnoses for which the above procedures are permitted

C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99

Primary diagnosis ICD 10 code is like: M15, M17

Patient age is between 18 and 120.


Review date: November 2022 or earlier if new guidance is issued.

JCIA: Yes, completed.

Musculoskeletal corticosteroid injections

Criteria

NHS Kernow commissions musculoskeletal (MSK) corticosteroid injections in secondary care where patients meet the criteria below. The referral letter and patient’s medical record need to clearly evidence how these criteria are met.

- COVID-19 risk counselling discussion has taken place with the patient prior to referral
- if steroid injection has failed in primary care, a referral may be considered to orthopaedic services as per the condition-specific referral management service (RMS) orthopaedic guidelines, for example:
  - the musculoskeletal interface service (shoulder, knee or soft tissue hip); the service can arrange ultrasound-guided injections if deemed necessary
  - other orthopaedic services (hand, elbow, foot or ankle)

The RMS orthopaedic guidelines state the number of steroid injections recommended for each MSK condition prior to referral to secondary care for steroid injection.

For these conditions it is expected that the steroid injection is performed in primary care either by the patient’s own GP practice or another practice able to perform the injection, unless:

- the recommended number of landmark-sited injections have been undertaken in primary care and have failed
- a single blind attempt has been made and failed in those with indiscernible landmarks
Practices that are unable to provide an in-house MSK steroid injection can refer to other practices for the MSK steroid injections listed below via inter-practice referral.

Primary care services are available for the following MSK steroid injections:

- hands (trigger finger, tenosynovitis, carpal tunnel syndrome, thumb first carpometacarpal joint osteoarthritis)
- shoulders (gleno-humeral joint, sub-deltoid or acromial space, acromioclavicular joint)
- trochanteric bursa
- knee
- ankle and foot (plantar fasciitis, toe joints, tendon sheaths, bursa, Morton’s neuroma)
- elbow (golfer’s elbow, tennis elbow)

Steroid injection for these conditions is not routinely recommended and should only be offered for severe refractory symptoms not responding to conservative measures.

This policy is specific to referrals for steroid injection. The RMS guidelines give detailed information about when referral for specialist input may be appropriate.

**Exclusions**

Children, patients on a cancer pathway, sacrococcygeal injections. Please note that inclusions and exclusions relating to lumbar spine injections including facet joint injections are covered under the CCG policies spinal injections for sciatica, injections for non-specific low-back pain without sciatica and radiofrequency denervation.

**Codes**

**Procedures challenged in this policy**
OPCS code: S521, X382

**Diagnoses for which the above procedures are permitted**
ICD10 code: M653, M680, M659, M658, G560, M710, M713, M714, M722, M18, G57.6, M533
M65.3 Trigger finger
M68.0 Synovitis and tenosynovitis in bacterial diseases classified elsewhere
M65.94 Synovitis and tenosynovitis, unspecified, Hand
M65.84 Other synovitis and tenosynovitis, Hand
G56.0 Carpal tunnel syndrome
M71.0 Abscess of bursa
M71.3 Other bursal cyst
M71.4 Calcium deposit in bursa
M72.2 Plantar fascial fibromatosis
M70.3 Other bursitis of elbow
M18 Arthrosis of first carpometacarpal joint
G57.6 Lesion of plantar nerve
M70.3 Other bursitis of elbow
M533 Sacrococcygeal injections (conducted in pain clinic under x-ray for coccydynia)

**Date approved:** April 2018 and July 2021.
**Review date:** July 2024 or earlier if new guidance is issued.
**JCIA:** Yes, completed.

## Radiofrequency ablation for barretts oesophagus

Barrett’s oesophagus is a condition in which changes occur to the cells lining the lower part of the oesophagus (gullet), usually because of the abnormal backflow of stomach acid into the oesophagus. These cells can develop an abnormality called dysplasia which may progress to become cancer. Most patients with Barrett’s oesophagus do not develop cancer of the oesophagus, but because the risk is increased people with this condition usually have checks on a regular schedule. If a high-grade type of dysplasia is found, the standard treatment advised is surgery to remove the oesophagus (oesophagectomy) to reduce the risk of the development and spread of cancer. This is a major operation with associated significant risks.

The use of heat energy applied from a tube passed into the oesophagus has been shown to destroy the changed cells in a high proportion of patients. This technique of radiofrequency ablation carries less risk of serious complications than having the oesophagus removed. The long-term effectiveness of the technique is not known, and patients must have regular checks of the oesophagus after successful treatment.

### Criteria

Radiofrequency ablation is commissioned as an option to patients with high grade dysplasia as an alternative to oesophagectomy in suitable patients or for patients in whom oesophagectomy is not an option. This should be provided in accordance with NICE CG106 and IPG344.

### Codes

#### Procedures challenged in this policy
- G14.5 - Fibreoptic endoscopic destruction of lesion of oesophagus NEC +
- Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC
- G17.8 - Other specified endoscopic extirpation of lesion of oesophagus using rigid oesophagoscope +
- Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC
- G04.3 - Open destruction of lesion of oesophagus NEC +
- Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC
- G43.5 - Fibreoptic endoscopic destruction of lesion of upper gastrointestinal tract NEC +
- Y13.4 - Radiofrequency controlled thermal destruction of lesion of organ NOC +
- Z27.1 - Oesophagus
Relevant diagnoses for this policy
C150, C151, C152, C153, C154, C155, C158, C159, D130, K227, K228, K229

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and October 2021.
Review date: October 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Radiofrequency denervation

NICE guidance for low back pain (NG56) recommends the use of radiofrequency denervation for patients with chronic low back pain who meet the criteria detailed within the policy.

A health economic model developed by NICE to inform this guideline suggests that radiofrequency denervation is cost effective provided the duration of pain relief exceeds 16 months.

Criteria

Radiofrequency denervation is routinely commissioned in Cornwall and Isles of Scilly for patients with chronic low back pain when the following criteria are met:

- the use of non-pharmacological (including self-management) and pharmacological interventions has failed to control pain
- the main source of pain is thought to come from structures supplied by the medial branch nerve
- they have moderate or severe levels of localised back pain (rated as 50% or more on a visual analogue or numeric rating scale) at the time of referral
- only performed on patients with chronic low back pain when there has been a positive response to a diagnostic medial branch block (local anaesthetic +/- steroid)

A positive response to a diagnostic medial branch block is defined as more than 50% immediate benefit in agreed pain score, compared to baseline immediately prior to the procedure.

Repeated radiofrequency denervation will only be funded when the:

- previous procedure was performed more than 16 months earlier
- origin of the pain is in the same location
Codes

Procedures challenged in this policy
Z675: Lumbar intervertebral joint
Z676: Lumbosacral joint
Z677: Sacrococcygeal joint
Z993: Intervertebral disc of lumbar spine

Relevant diagnoses for this policy
M545 (chronic low back pain)

Diagnoses for which the above procedures are permitted
Codes as recommended in the clinical coding guidelines for spinal policies:
V485 + V55 + with a diagnosis code M545

Date approved: 26 January 2021.
Review date: 26 January 2024 or earlier if new guidance issued.
JCIA: Yes, completed.

Skin surface applied functional electrical stimulation for an orthotic effect to correct foot drop of central neurological origin

Electrical stimulation from skin surface electrodes to the peroneal nerve, timed to the swing phase of step, has been shown to improve walking speed to a greater extent than physiotherapy alone in patients suffering foot drop that persisted at least 6 months following a stroke (NICE Interventional Procedures Guidance IPG278, January 2009).

Criteria

The use of skin surface applied functional electrical stimulation (FES) as an orthotic intervention to improve walking impaired by foot drop of central neurological origin is commissioned where patients meet the criteria below, the referral letter and patient’s medical record to clearly evidence how these criteria are met

FES delivered by skin surface electrodes may be offered by service providers under contractual provisions for physiotherapy services to patients for whom ankle foot orthoses (AFO) have not been suitable. This will include assessment by physiotherapists trained to provide FES and AFO as part of the complete physiotherapy service offered; early assessment of benefit; ongoing accessible patient review; and annual audit results communicated to commissioners.
Codes

Procedures challenged in this policy

OPCS code:
A70.8 Other specified neurostimulation of peripheral nerve
Z12.1 Popliteal nerve

Diagnoses challenged in this policy

ICD10 code: M21.37- Wrist or foot drop (acquired), Ankle and foot + one of the following codes:
I69.0 Sequelae of subarachnoid haemorrhage
I69.1 Sequelae of intracerebral haemorrhage
I69.2 Sequelae of other nontraumatic intracranial haemorrhage
I69.3 Sequelae of cerebral infarction
I69.4 Sequelae of stroke, not specified as haemorrhage or infarction

Date approved: January 2018 and January 2022.
Review date: January 2025 or earlier if new guidance is issued.
JCIA: Yes, completed.

Spinal cord stimulation for chronic pain

Policy under review.

Spinal cord stimulators stimulate the dorsal columns of the spinal cord with an implanted device, with the aim of modifying the perception of pain.

NICE has assessed them as cost-effective in neuropathic pain, with more recent reviews identifying subgroups where they are cost-effective.

NICE technology appraisal guidance (TA159) spinal cord stimulation for chronic pain of neuropathic or ischaemic origin, 22 October 2008.

Criteria

Spinal cord stimulation as a treatment option for adults with chronic pain of neuropathic origin is commissioned where patients meet the criteria below:

- continue to experience chronic pain (measuring at least 50mm on a 0 to 100 mm visual analogue scale) for at least 6 months despite appropriate conventional medical management
- who have had a successful trial of stimulation as part of an assessment by a multidisciplinary team experienced in chronic pain assessment and management of people with spinal cord stimulation devices, including experience in the provision of ongoing monitoring and support of the person assessed
Codes

Procedures challenged in this policy
A483, A487

Relevant diagnoses for this policy
G905, M960, M961, M962, M963, M964, M965, M966, M968, M969, R521, R522

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed.

Spinal fusion for chronic non-specific low back pain

There is a body of evidence demonstrating that spinal fusion is no more clinically effective or cost-effective than a multi-disciplinary rehabilitation programme (physiotherapy, exercise and psychological input) for chronic, (less than 1 year) non-specific, degenerative low back pain.

Criteria

Spinal fusion for chronic degenerative low back pain 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 patient has been assessed by a clinician trained in the diagnosis and management of chronic low back pain
• the low back pain has lasted more than 1 year and is documented as causing significant functional impairment*
• conservative treatments, undertaken after assessment by a pain management specialist, have failed

Note there are several other exclusions to this statement, recognising indications other than chronic degenerative low back pain for spinal fusion. These are:

• clear cut root compression
• spinal stenosis

* Significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.
Codes

Procedures challenged in this policy
V38.2 to 38.6, 39.3 to 39.7, (V38.8, 38.9, 39.8, 39.9, 40.1, 40.4, 40.8 or 40.9 with Z06.3 or Z67.6)

Relevant diagnoses for this policy
M54.5, M51.2 or (M47.8, 48.5, 48.9, 51.3, 51.8, 51.9, 54.8 or 54.9 with site code 5,6,7 or 8). There are no appropriate codes for the clinical criteria for those provided as an N.b. the ICD10 codes are: M51.0, 51.1 54.1, 54.4, 47.1 47.2, or (G55.1, 55.2, 55.3 or 99.2 with site codes 5,6,7 or 8); M48.0; M53.2

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: November 2018.
Review date: November 2021 or earlier if new guidance is issued.
JCIA: Yes, completed.

Spinal injections for sciatica

Sciatica is used to describe leg pain secondary to lumbosacral nerve root pathology and includes radicular pain and radiculopathy.

Assessments and interventions should be undertaken in line with NICE guideline, NG59.

The list of non-recommended non-pharmacological and pharmacological interventions listed in the NICE guideline NG59 are not routinely commissioned by NHS Kernow.

NICE guidance for sciatica considers epidural injection, whether administered under image guidance or without, is a relatively safe and routinely used procedure for which there is some evidence of the effectiveness of local anaesthetic and steroid demonstrated by placebo-controlled trials. There is evidence suggesting that epidural injection may reduce the number of people with severe sciatica requiring surgical intervention. The NHS getting it right first time (GIRFT) spinal services report (2019) recommends that epidural injections and nerve root blocks should only be repeated if 6 months of pain relief and functional improvement is achieved.

NG59 only mentions epidural injection, but nerve root blocks are included within the NICE endorsed national low back pain and radicular pain pathway.

Criteria

Epidural or nerve root block is routinely commissioned in Cornwall and Isles of Scilly when patients meet the following criteria:

- patient has severe sciatica with or without low back pain
• patient has sciatica consistent with the level of spinal involvement based on clinical assessment and concordant diagnostic imaging
• the use of non-pharmacological (including self-management) and pharmacological interventions has failed to control symptoms
• the injections are part of an MDT management plan

Do not use epidural injections for neurogenic claudication in people who have central spinal canal stenosis.

A maximum of 2 epidurals or nerve root blocks (including diagnostic) will be funded before case discussion in the appropriate MDT meeting.

Spinal injections for sciatica should not be routinely repeated if the previous procedure was performed less than 6 months earlier.

For patients with persistent sciatica (pain for more than 6 months) where there is a concordant surgical target on imaging and the patient wishes to explore surgical intervention, the patient should be discussed in the appropriate MDT meeting and directed to the most clinically appropriate service and/or intervention.

Alternative, less invasive options to spinal injections such as exercise programs, behavioural therapy, and attending a specialised pain clinic have been shown to be successful for patients with acute and severe sciatica.

Codes

Procedures challenged in this policy

Relevant diagnoses for this policy
M541, M511 +G55.1 (radiculopathy and lumbar and other intervertebral disc disorders with radiculopathy)

Diagnoses for which the above procedures are permitted
A521, A522, A577 + Z07.1 – Cervical spine, Z07.2 – Thoracic spine, Z07.3 – Lumbar spine, Z07.8 – Other specified with a diagnosis code M541, M511 +G55.1

Date approved: 26 January 2021.
Review date: 26 January 2024 or earlier if new guidance issued.
JCIA: Yes, completed.

Trigger finger release in adults

Trigger digit, or stenosing tenosynovitis, is a condition where abnormal gliding of the flexor tendons within their flexor sheath results in snagging or locking of the affected digit in flexion or, occasionally, in extension. Triggering of the affected tendon results in
difficulty in flexing or extending the finger and is frequently associated with pain the palm of the hand.

Treatment for trigger finger can be divided into non-operative and operative.

Non-operative management includes activity modification, NSAIDs, hand therapy, splinting and cortisteroid injection.

Operative management is by release of the A1 pulley, either percutaneously or with open surgery.

The British Society for Surgery of the Hand has produced a recommendation for clinical practice to treat trigger finger: based on the current available evidence, it is reasonable to offer cortisteroid and local anaesthetic injection as the first line of treatment (moderate evidence).

If symptoms fail to resolve, then the next line of treatment may be either an open or percutaneous release of the constricted pulley (high evidence).

Other treatment modalities are not currently supported.


Criteria

Open or closed percutaneous release for treatment of 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, corticosteroid and local anaesthetic injection as the first line of treatment), see primary care management for trigger finger
- patients with diabetes, following a trial of one steroid injections (recurrence of symptoms is more common)

Note other treatment modalities are not currently supported.

Codes

Procedures challenged in this policy
T692+HAND, T691+HAND, T698+HAND, T699+HAND, T701+HAND, T702+HAND, T718+HAND, T719+HAND, T723+HAND, T728+HAND, T729+HAND, Z894+HAND, Z895+HAND, Z896+HAND, Z897+HAND

Relevant diagnoses for this policy
M653 and patient age is between 18 and 120.
Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Urological genitary problems

Artificial urinary sphincters for men with post-prostatectomy incontinence

Urinary symptoms following prostatic surgery should be managed with involvement of specialist continence services. Initial management may include coping strategies, pelvic floor muscle re-education, bladder retraining and appropriate pharmacotherapy.

Some men are left with intractable stress incontinence for which an artificial urinary sphincter (AUS) is a potential treatment option. The AMS 800 device is designed to mimic the 2 functions of the biological urinary sphincter by providing a competent closed bladder outlet during urinary storage and an open unobstructed outlet to permit voluntary voiding. It is reserved for treatment of complex or severe stress urinary incontinence. It consists of an inflatable cuff that compresses the urethra, connected to a control pump usually placed in the scrotum that can be activated by the patient.

Criteria

Artificial urinary sphincters for men with post-prostatectomy incontinence is commissioned where patients meet the criteria below, the referral letter and patient’s medical record to clearly evidence how these criteria are met:

- men who suffer intractable stress incontinence following prostatectomy

The balance between benefit and disadvantages in other patient groups will need to be assessed on case-by-case basis.

Codes

Procedures challenged in this policy
M642

Relevant diagnoses for this policy
Primary diagnosis code of N393 + Y83.6 in a secondary position

Diagnoses for which the above procedures are permitted
No appropriate codes for the clinical criteria.

Date approved: April 2018 and March 2021.
**Review date**: March 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Assisted conception (includes IVF)**

NHS Kernow will commission specialist assisted reproduction techniques in accordance with the criteria outlined in this policy. In the context of limited resources, the purpose of this policy is to make the provision of fertility treatment fair, clear and explicit. Treatment is aimed towards those with the most need and the greatest chance of success.

The specialist fertility treatments within the scope of this policy include superovulation and intrauterine insemination (SO/IUI In), *vitro* fertilisation (IVF), intracytoplasmic sperm injection (ICSI), donor Insemination (DI), egg donation, and cryopreservation to preserve fertility.

The specialist fertility services considered within this policy are deemed level 3 (tertiary) services. Preliminary services (levels 1 and 2) are provided and commissioned within primary and secondary care (such as acute trusts). Before referral to specialist level 3 services all couples should undergo the appropriate investigations and assessments in level 1 and 2.

Referral to level 3 services will be via a consultant gynaecologist. Referring and treating clinicians should ensure that couples meet the criteria contained within this policy. Couples will be offered a choice of designated providers that have been commissioned by NHS Kernow. Providers who are not directly commissioned by NHS Kernow should seek prior approval from NHS Kernow before assessing and treating the couples (full details can be found on the NHS Kernow website).

**Criteria**

Fertility assessment and treatment will be commissioned where the clinical criteria are met as outlined below.

**Section 1: Fertility assessment**

**Referral for fertility assessment**

A woman who has not conceived after 1 year of unprotected vaginal sexual intercourse, in the absence of any known cause of infertility, should be referred to secondary care for further clinical assessment and investigation.

A woman who is using artificial insemination to conceive should be referred to secondary care for further clinical assessment and investigation, if she has not conceived after 6 cycles of treatment within the past 12 months, in the absence of any known cause of infertility.

Patients should not be referred to secondary care outside these limits, unless there is a known clinical cause of infertility or a history of predisposing factors for infertility (such as...
amenorrhoea or oligomenorrhoea, pelvic inflammatory disease, undescended testes, previous treatment for cancer).

**Recurrent miscarriage**
Recurrent miscarriage is not an indication for patients to access fertility services although patients should be considered for referral for gynaecological investigations and treatments as appropriate.

**Section 2: Fertility treatment for eligible couples**

**Referral for specialist fertility treatment**
All couples must undergo the fertility investigations in primary and secondary care appropriate to them before eligibility for NHS funded assisted reproduction services in tertiary care is considered.

Couples with unexplained infertility who meet the criteria of this policy may be considered for specialist treatments if:

- they have not conceived after 2 years of regular unprotected intercourse
- they are using artificial insemination to conceive and have not become pregnant after 12 cycles (where 6 or more are by intrauterine insemination)

**Treatment plan**
Fertility treatment should be offered in the least invasive format appropriate: investigation and assessment, followed by assisted conception (SO/IUI) and finally IVF or ICSI. Up to 4 cycles of SO/IUI and 1 cycle of IVF may be funded per couple, who would be expected to have a more than 10% chance of live birth per cycle.

All couples must follow the agreed algorithm, not just progress to IVF without going through the other stages first, unless clinically indicated.

**Ovarian reserve assessment**
At the time of treatment, the prospective mothers’ overall chance of successful pregnancy should be assessed to predict the likely ovarian response to gonadotrophin stimulation. The preferred test is anti-Mullerian hormone (AMH). The results can be used in conjunction with other clinical measures as an indication that the chance of live birth is less than 10% per cycle. Treatment should not be provided where the clinician believes the chance of live birth is less than 10% per cycle.

**SO/IUI**
Each couple to be offered up to 4 treatment cycles of SO/IUI, where the clinician believes the chance of live birth is in the region of 10% per cycle.

**IVF**
1 full cycle of IVF will be offered to couples where other assisted conception techniques have failed and the clinician believes the chance of live birth is more than 10% per cycle.
For the purposes of this policy, a cycle of IVF is defined as 1 fresh and 1 frozen implantation of embryos.

A full IVF treatment cycle includes:

- diagnostic tests, scans and pharmacological therapy
- counselling session
- stimulation of prospective mother’s ovaries to produce oocytes
- harvesting of the oocytes
- fertilisation using IVF (assisted hatching is not provided)
- 1 fresh embryo transfer
- a follow up consultation with fertility services post IVF treatment

If the fresh embryo transfer is unsuccessful a frozen embryo transfer will be available from the remaining frozen embryos if deemed clinically appropriate. A frozen embryo transfer will only be available where embryos suitable for freezing were generated from the fresh cycle

The NHS in Cornwall and the Isles of Scilly will fund cryopreservation of embryos remaining because of IVF treatment for up to 1 year. Patients who wish to store embryos beyond 1 year will be required to fund the storage themselves.

**Embryo transfer strategies in IVF**
- When considering the number of fresh and frozen embryos to transfer in IVF treatment, single embryo transfer should be undertaken if 2 or more top quality embryos are available.
- Consider double embryo transfer only if there are no top-quality embryos.
- No more than 2 embryos should be transferred per transfer episode.

**ICSI**
Couples should only be offered ICSI if:

- there are few sperm in the man’s semen or they are of poor quality
- there are no sperm in the man’s semen (either because of a blockage or another cause) but there are sperm in their testes which can be recovered surgically
- they have already tried IVF but there was no fertilisation of the eggs or no embryos suitable for transfer (see abandoned IVF or ICSI cycles)

**Donor insemination**
Donor insemination is funded where there is:

- severe male factor infertility
- severe deficits in semen quality in couples who do not wish to undergo ICSI (intracytoplasmic sperm injection)
- a high risk of transmitting a genetic disorder to the offspring
• where there is a high risk of transmitting infectious disease to the offspring or woman from the man
• severe rhesus isoimmunisation
• also, following IVF egg retrieval when there is no living sperm produced on the day of treatment. NHS funding covers transport of sperm and storage for the NHS funded cycle only
• use of donor sperm should follow the same algorithm as outlined above

Receiving egg donation
The use of egg donation is funded where there is:

• premature ovarian failure
• gonadal dysgenesis including Turner syndrome
• bilateral oophorectomy
• ovarian failure following chemotherapy or radiotherapy
• a high risk of transmitting a genetic disorder to the offspring

Egg donors
Egg donors must meet Human Fertilisation and Embryology Authority (HFEA) criteria. Donation must be altruistic: the NHS will not fund the payment of egg donors. Egg sharing is funded if the NHS does not subsidise treatment for the donor beyond that which is required for treatment of the recipient.

Abandoned SO/IUI cycle
An additional SO/IUI cycle will be funded where an SO/IUI cycle has been abandoned and the clinician believes the chance of live birth is in the region of 10%.

Abandoned IVF or ICSI cycle
An additional IVF or ICSI procedure will be funded where:

• the cycle has been abandoned for clinical reasons prior to egg retrieval
• there was failed fertilisation of the eggs or no embryo suitable for transfer

1 further fresh IVF cycle will be funded after an abandoned cycle. ICSI may be offered if clinically appropriate (see ICSI for criteria). Further IVF cycles will not be funded after any subsequent abandoned cycle.

Abandoned fresh embryo transfer
If a fresh embryo transfer is not possible after oocyte retrieval for clinical reasons, storage (cryopreservation) for up to 1 year and up to 2 frozen embryo transfers will be funded.

Abandoned frozen embryo transfer
If a frozen embryo transfer was intended but is not possible for clinical reasons and the treatment is cancelled prior to warming the embryo, storage (cryopreservation) for up to 1 year and 1 further transfer of up to 2 frozen embryos will be funded.
**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 5 years or until 1 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.

**Same sex couples**
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 (for same sex female couples) or for funding of surrogacy arrangements (for same sex male couples). 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.

**Other medical grounds**
Assisted conception treatment may be denied on other medical grounds not explicitly covered in this document.

**Section 3: General principles**

Eligibility criteria for NHS funded assisted conception.

**Residency**
Both partners should be registered with a GP in the NHS Kernow area.

**Stable relationship**
All couples must have been in a stable, financially interdependent relationship for a period of 2 years. A stable relationship is defined as 2 years, to fit with the definition of infertility.

**Previous children**
Assisted conception treatment is restricted to couples where:

- there are no living children from the current relationship
- at least 1 partner does not have any living children from previous relationships

This includes biological and legally adopted children and offspring who are adults.

**Welfare of the child**
The welfare of any resulting children is paramount. In order to take into account the welfare of the child, the clinician should consider factors which are likely to cause serious physical, psychological or medical harm. This is a requirement of the licencing body, the HFEA. There is an explicit and recorded assessment that the social circumstances of the family unit have been considered within the context of the assessment of the welfare of
the child. This will include consideration of factors such as parental smoking, alcohol and recreational drug use.

Age
Assisted conception treatment is restricted to women aged up to 40 years.

**Body mass index (BMI)**
Men and women must have a BMI of between 19 and 29.9 at the time of referral for specialist assisted reproduction assessment and at the time of any specialist treatment. 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.

In individuals with a BMI between 30 and 34.9 where there is a question regarding lean muscle mass, requests for funding may be submitted to the individual funding request (IFR) panel for review. Please include:

- BMI
- waist measurement with the following guidance:
  - find bottom of ribs and top of hips
  - measure waist between these points
  - breathe out naturally before taking measurement
- photographs optional and with patient consent, should exclude face (front and side breathe out naturally)

**Smoking**
Couples and individuals who smoke (including use of e-cigarettes) will not be eligible for assisted conception treatment. Individuals 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 6 months before either partner is offered treatments. If the 6 months takes them outside the age criteria a clinical decision may be taken to proceed with treatment earlier.

**Previous assisted conception**
Assisted conception treatment is restricted to couples where neither partner has had previous NHS funded specialist fertility treatment. No couple may receive an NHS funded IVF cycle if they have previously received a total of 3 self-funded cycles. This is because the overall chance of a live birth following IVF treatment falls as the number of unsuccessful cycles increases.

**Previous sterilisation**
Assisted conception will not be funded where 1 or both partners have previously been sterilised even if self-funded reversal has been successful.

**Section 4: Cryopreservation to preserve fertility**
Cryopreservation is a technique used to preserve fertility by banking gametes (eggs or sperm) or embryos prior to a treatment which may make a patient permanently infertile.
NHS funded cryopreservation may be done by banking gametes (eggs or sperm), or embryos for future fertility treatment. The request for cryopreservation must be supported by the NHS consultant providing the patient’s care.

**Cryopreservation**
Routine funded for patients under 40 years old who are about to start treatment:

- where there is a significant likelihood, the patient may become permanently infertile as an unwanted effect of the treatment, for example chemotherapy for cancer; radical surgery; or transgender pathway
- which causes harmful effects on sperm or egg production, impotence or has possible teratogenic effects, which is likely to continue for their reproductive life and in whom stopping treatment for a prolonged period of time to enable conception is not an option
- there is no lower age limit applied in this policy, however all individuals including those aged under 16 years must be able to understand the procedure being carried out and considered competent to give informed consent

Not routinely funded for individuals who:

- have previously been sterilised, even if sterilisation has been reversed
- have living offspring and therefore do not qualify for NHS funding for fertility treatment as defined in previous children section; an adopted child has the same status as an individual's biological child
- request cryostorage for personal lifestyle reasons, such as wishing to delay trying to conceive; this includes concerns over future fertility (for example, low ovarian reserve)
- have previously received an NHS funded cycle of fertility treatment or a total of 3 self-funded IVF cycles (and therefore do not qualify for NHS funding for assisted conception)

**Duration of storage and funding**

- Funded for an initial period of 5 years, or up to the upper-age threshold of 40, whichever is reached first.
- Storage may be renewed in further 5-year periods until the patient reaches the upper-age limit of 40.
- Renewal is subject to discussion with the patient’s clinician to confirm continued storage is required and that the patient meets all criteria for storage (as detailed in this policy).

NHS funding for storage will cease where:

- the patient reaches the upper age limit (40 years)
- fertility is established through tests
- a live birth has occurred
• the patient has had 1 NHS funded cycle of infertility treatment even if the treatment is unsuccessful (the patient will be given the option of self-funding in line with the fertility provider’s policy)
• at the patient’s request

Funding for storage will cease twelve months following the death of the patient.

Once the period of NHS funding ceases, patients or their family can elect to self-fund for a further period, not to exceed appropriate HFEA regulations on length of storage.

**Eligibility for NHS funded assisted conception**

The funding of cryopreservation does not automatically entitle people to funding for assisted conception. Individuals will be required to meet the eligibility criteria for fertility treatment in place at the time they wish to apply for NHS funded assisted conception.

**Codes**

**Procedures challenged in this policy**
Y961, Y962, Y963, Y964, Y965, Y966, Y968, Y969.
There are no specific codes for cryopreservation.
No specific codes to indicate single embryo transfer

**Relevant diagnoses for this policy**
F640, F641, F642, F649, N970, N971, N972, N973, N974, N978, N979, O028, O029, Q103, Q108, Q109, Z302, Z312, Z313

**Diagnoses for which the above procedures are permitted**
No appropriate codes for the clinical criteria.

**Date approved**: November 2016, March 2019 review date extension approved only, July 2019 further review date extension approved only and November 2019.
**Review date**: November 2022 or earlier if new guidance is issued.
**JCIA**: Available upon request.
Cystoscopy for men with uncomplicated lower urinary tract symptoms

Cystoscopy is a diagnostic procedure used to examine the lining of the bladder and urethra. Either a rigid or flexible endoscope may be used, under general or local anaesthesia, respectively. Rigid cystoscopy is undertaken when flexible cystoscopy offers insufficiently clear views, or when biopsy is indicated.

Cystoscopy can cause temporary discomfort, occasionally pain and haematuria and is associated with a small risk of infection.

In the context of male lower urinary tract symptoms (LUTS), cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example).

This guidance applies to male adults aged 19 years and over.

In the context of male LUTS, cystoscopy may offer indirect evidence regarding an underlying cause (commonly prostatic enlargement, for example). However, no evidence was discovered in preparing NICE guideline CG97 to suggest any benefit, in terms of outcome, related to performing cystoscopy in men with uncomplicated LUTS (for example LUTS with no clinical evidence of underlying bladder pathology). The consensus opinion of the NICE guideline development group therefore aligned with the position that unless likely to uncover other pathology, cystoscopy should not be performed in men presenting with LUTS.

The European Association of Urology guideline on the management of nonneurogenic male LUTS summarises evidence demonstrating a lack of clear correlation between findings on cystoscopy and findings on investigations into bladder function (urodynamic assessment).

Criteria

Assessment of men with LUTS should focus initially on a thorough history and examination, complemented by use of a frequency – volume chart, urine dipstick analysis and international prostate symptom score where appropriate. This assessment may be initiated in primary care settings.

Specialist assessment should also incorporate a measurement of flow rate and post void residual volume.

Cystoscopy should be offered to men with LUTS only when clinically indicated, for example, in the presence of the following features from their history:

- recurrent infection
- sterile pyuria
- haematuria
- profound symptoms
• pain

Additional contextual information may also inform clinical decision-making around the use of cystoscopy in men with LUTS. Such factors might include, but not be limited to:

• smoking history
• travel or occupational history suggesting a high risk of malignancy
• previous surgery.

Other adjunct investigations may become necessary in specific circumstances and are dealt with in the NICE guideline. It may be reasonable to undertake flexible cystoscopy before doing some urological surgical interventions.

**Codes**

**Procedures challenged in this policy**
M45.1 Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder NEC
M45.2 Diagnostic endoscopic examination of bladder and biopsy of lesion of prostate NEC
M45.3 Diagnostic endoscopic examination of bladder and biopsy of lesion of bladder using
M45.4 Diagnostic endoscopic examination of bladder and biopsy of lesion of prostate using
M45.5 Diagnostic endoscopic examination of bladder using rigid cystoscope
M45.8 Other specified diagnostic endoscopic examination of bladder
M45.9 Unspecified diagnostic endoscopic examination of bladder

**Diagnoses for which the above procedures are permitted**
LUTS = ICD 10 code R39.8 Other and unspecified symptoms and signs involving the urinary system
Cancer diagnoses are a global exclusion

**Date approved**: July 2021.
**Review date**: July 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Dilatation and curettage for heavy menstrual bleeding in women**

Dilatation and curettage (D and C) is a minor surgical procedure where the opening of the womb (cervix) is widened (dilatation) and the lining of the womb is scraped out (curettage).

NICE guidelines recommend the replacement of D and C with endometrial biopsy for investigation of menorrhagia, and do not support its use as a therapeutic procedure.
Criteria

Dilatation and curettage for heavy menstrual bleeding is not routinely commissioned.

D and C should not be used for diagnosis or treatment for heavy menstrual bleeding in women because it is clinically ineffective.

Ultrasound scans and camera tests with sampling of the lining of the womb (hysteroscopy and biopsy) can be used to investigate heavy periods.

Medication and intrauterine systems (IUS) can be used to treat heavy periods. For further information, please see NICE guidance and alternatives to hysterectomy

Codes

Procedures challenged in this policy
Dominant procedure code starts: Q103 and diagnosis code (any position) is not like: O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75, O76, O77, O78, O79

Relevant diagnoses for this policy
And diagnosis code (any position) is not like: O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75, O76, O77, O78, O79

Diagnoses for which the above procedures are permitted
O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75, O76, O77, O78, O79

Date approved: August 2017 and November 2019.
Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Elective caesarean section for non-clinical reasons

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

Procedures challenged in this policy
R171, R172, R178, R179

Relevant diagnoses for this policy
N92, N920, N921, N922, N923, N924, N925, N926, N927, N928, N929

Diagnoses for which the above procedures are permitted
Please note that this list is not exhaustive.

Date approved: November 2016 and February 2019.
Review date: February 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Female sterilisation

Sterilisation is a procedure that permanently removes an individual’s fertility. Sterilisation for a female normally involves tubal occlusion.

Criteria

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 that 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*
- 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.
* 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.

**Codes**

**Procedures challenged in this policy**
Q271, Q272, Q278, Q279, Q281, Q282, Q283, Q284, Q288, Q289, Q351, Q352, Q353, Q358, Q359, Q361, Q362, Q368, Q369, Q354

**Relevant diagnoses for this policy**
Z302

**Diagnoses for which the above procedures are permitted**
There are no relevant codes for the clinical criteria.

**Date approved:** August 2017 and September 2019.
**Review date:** September 2022 or earlier if new guidance is issued.
**JCIA:** Yes, completed.

**Hydroceles in males**

Hydroceles (fluid collection around the testicles) may be present at birth and are common, affecting around 1 male baby in every 10. They do not usually require treatment as they often disappear on their own during the first 2 years of life, NICE.

Less commonly, hydroceles can develop in adult men and may follow infection, injury or radiotherapy.

Referral for another opinion should be made where there is diagnostic uncertainty. For example, in the case of apparent hydrocele in a child that has not been present from infancy. Such cases should be referred to a consultant urologist who covers paediatric urology.

Hydroceles may occur in both genders; however this policy only considers hydroceles in males over 2 years old.

**Criteria**

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:

- patient is over 2 years of age
- discomfort and/or disfigurement have resulted in significant functional impairment which prevents the individual from fulfilling work, study, carer or domestic responsibilities
• in the case of a child, discomfort and/or disfigurement resulting in an inability to participate in normal social, educational or work activity

Hydroceles can vary greatly in size. Consideration for removal of a hydrocele will not be given based on size alone.

**Codes**

**Procedures challenged in this policy**
N111, N112, N113, N114, N115, N116, N118, N119

**Relevant diagnoses for this policy**
N430, N431, N432, N433, P835

**Diagnoses for which the above procedures are permitted**
There are no relevant codes for the clinical criteria

**Date approved**: April 2018 and March 2021.
**Review date**: March 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Hysterectomy for heavy menstrual bleeding**

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**

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, for example, Mirena (unless contraindicated), has failed to relieve symptoms
• other less invasive treatment options have been tried for a minimum of 3 months and documented to have failed (for example, non-steroidal anti-inflammatory agents, tranexamic acid, endometrial ablation, uterine-artery embolization, hormonal therapies), or are not appropriate or are contraindicated

**Codes**

**Procedures challenged in this policy**
Q072, Q074, Q078, Q079, Q082, Q088, Q089
Relevant diagnoses for this policy
And Diagnosis code (any position) is not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99, O00, O01, O02, O03, O04, O05, O06, O07, O08, O60, O61, O62, O63, O64, O65, O66, O67, O68, O69, O70, O71, O72, O73, O74, O75

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria

Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Male sterilisation (vasectomy)
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

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 or 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
- 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
- the patient is on anticoagulation therapy
Codes

Procedures challenged in this policy
N171, N172, N178, N179

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019.
Review date: September 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Mirena coils

The IUS (intrauterine system) is a long-acting reversible contraceptive (LARC) method. It works for 5 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

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

Procedures challenged in this policy
P315, Q121, Q122, Q123, Q124, Q128, Q129

Relevant diagnoses for this policy
Z301, Z305

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019.
Review date: September 2022 or earlier if new guidance is issued
JCIA: Yes, completed.
Percutaneous tibial nerve stimulation for urinary incontinence

Criteria

Percutaneous tibial nerve stimulation for urinary incontinence is not routinely commissioned.

There is currently insufficient evidence of clinical and cost effectiveness of this treatment.

Codes

Procedures challenged in this policy
A70.4 + Z12.2 percutaneous tibial nerve stimulation.

Relevant diagnoses for this policy
N393, N394, R32X

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: April 2018 and April 2021.
Review date: April 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Reversal of female sterilisation

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

Procedures challenged in this policy
Q291, Q292, Q293, Q294, Q295, Q296, Q297, Q298, Q299, Q30, Q300, Q301, Q302, Q303, Q308, Q309, Q371, Q378, Q379

Relevant diagnoses for this policy
Z310, Z31
Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2016 and November 2018.
Review date: November 2021 or earlier if new guidance is issued.
JCIA: Yes, completed.

Reversal of male sterilisation

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

Procedures challenged in this policy
N181, N182, N188, N189

Relevant diagnoses for this policy
Z310

Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2016 and November 2018.
Review date: November 2021 or earlier if new guidance is issued.
JCIA: Yes, completed.

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

Procedures challenged in this policy
R421, R422

Relevant diagnoses for this policy
Z35
Diagnoses for which the above procedures are permitted
There are no relevant codes for the clinical criteria.

Date approved: August 2017 and September 2019.
Review date: September 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Sperm washing

Policy under review.

Criteria

Sperm washing is commissioned where patients meet the criteria below, the referral letter and patient’s medical record to clearly evidence how these criteria are met:

- 1 sperm washing procedure will be funded within the local NHS for couples where the man is HIV positive and either he is not compliant with highly active antiretroviral therapy (HAART) or his plasma viral load is 50 copies per ml or greater and where the female is HIV negative
- where the procedure is successful, couples may access IUI or IVF, with or without ICSI, depending on their clinical circumstances, in line with the relevant policy
- to access NHS funded sperm washing and subsequent assisted conception treatments, patients will be required to fulfil relevant eligibility criteria
- sperm washing is normally indicated for couples who wish to have a child where the male is HIV-positive and the female is HIV-negative, or to minimise the risk of transmission of resistant virus in HIV seroconcordant couples
  - the use of sperm washing has also been proposed in couples where the male is hepatitis C positive and the female is negative

According to NICE CG156, the evidence showed that sperm washing appears to be very effective in reducing viral transmission; no cases of seroconversion of the woman or the baby have been documented.

Sperm washing is unavailable on the NHS for couples where the male is hepatitis C positive, because NICE CG156 recommends that couples who want to conceive and where the man has hepatitis C should be advised that the risk of transmission through unprotected sexual intercourse is thought to be low.

Codes

Procedures challenged in this policy
There are no appropriate codes.
Relevant diagnoses for this policy

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed.

Surgical intervention for benign prostatic hyperplasia

Transurethral resection of prostate (TURP) is a therapeutic procedure involving removal of tissue from the inner aspect of the prostate using diathermy, via an endoscopic approach. It is commonly undertaken for voiding lower urinary tract symptoms (LUTS) presumed secondary to benign prostatic hyperplasia (BPH).

TURP is undertaken on an in-patient basis, with a catheter left in-situ for 24-48 hours post-op for the purpose of irrigation. TURP may be undertaken under either general or spinal anaesthesia.

TURP causes temporary discomfort, occasionally pain, haematuria and is associated with small risks of infection and acute urinary retention after removal of the catheter. There is also a risk of sexual dysfunction following TURP. There are small but significant risks of significant harm, including severe fluid and electrolyte imbalances associated with absorption of large volumes of irrigating fluid (TUR syndrome). TUR syndrome can be avoided by using bipolar diathermy, a variant of the standard technology.

TURP is the longest established of a range of endoscopic surgical procedures for benign enlargement of the prostate, with varying indications and potential complications. These include, among others:

- transurethral incision of the prostate (TUIP) or Bladder Neck Incision (BNI)
- holmium LASER enucleation of the prostate
- 532 nm (‘Greenlight’) laser vapourisation of the prostate
- uroLift
- transurethral needle ablation of the prostate (TUNA)
- transurethral vaporisation of the prostate (TUVP)
- transurethral water vapour therapy (Rezum).

Open simple or benign prostatectomy is uncommonly undertaken in men with very large prostates and problematic symptoms. Newer ablative therapies are currently under evaluation.

This guidance applies to male adults aged 19 years and over.
NICE guidance provides clear evidence, in clinical and cost-effectiveness terms, that patients voiding LUTS presumed secondary to BPH, should be offered surgical intervention, only when those symptoms are severe, or when conservative management options have been unsuccessful.

TURP has long been the mainstay of surgical treatment for voiding LUTS presumed secondary to BPH. The newer surgical modalities outlined above have therefore been evaluated in comparison with TURP, as well as conservative management. NICE CG97 accordingly incorporated a comprehensive matrix of comparative studies between treatment modalities within its evidence review. This reflects increasing complexity in decision making around surgical intervention, increasingly involving ‘which’, as well as ‘when’ or ‘whether’ surgery should be offered.

The recommendation proposed here reflects the full breadth of comparative studies between surgical intervention and conservative management, as well as between different modalities of surgical intervention forming the basis of NICE CG97.

Criteria

Only men with severe voiding symptoms, or in whom conservative management options and drug treatment have been unsuccessful, should be offered surgical intervention. Surgery is indicated (in healthy men) in complicated BPH, for example chronic retention with renal impairment as evidenced by hydronephrosis and impaired GFR, and in most cases of acute retention secondary to BPH.

As such, a staged approach to managing voiding LUTS is recommended:

- conservative, or lifestyle interventions should be discussed
- drug therapy should then be considered, in the context of more bothersome LUTS, or LUTS not responding to simple lifestyle interventions
- where bothersome LUTS persist alongside high, or unchanged international prostate symptom scores, or in the context of urinary tract infections, bladder stones or urinary retention, surgical intervention should be considered using a shared decision-making approach

Men considering surgical intervention should be counselled thoroughly regarding alternatives to and outcomes from surgery. The quality of this counselling is deemed to be of major importance with respect to men’s future experience and outcomes.

Following a discussion about whether to intervene surgically, men should be counselled about their preferred and most suitable surgical modality, incorporating reference to available evidence. Practical concerns, including the distance required to travel to pursue a given modality of surgical treatment are also important.
Appropriate support should be provided to make shared decisions pertinent to physical, emotional, psychological and sexual health. If appropriate, carers should be informed and involved.

**Surgical modality**

- The UroLift system relieves lower urinary tract symptoms while avoiding the risk to sexual function and should be considered as an alternative to current surgical procedures for use in a day-case setting in men who are aged 50 years and older and who have a prostate of less than 100 ml without an obstructing middle lobe.
- TURP, TUVP (including laser prostatic vaporisation) or HoLEP should be offered to men with voiding LUTS presumed secondary to BPH.
- HoLEP should be performed within centres specialising in the technique, or where mentorship arrangements are in place.
- TUIP should be offered to men with a prostate estimated to be smaller than 30ml.
- Open prostatectomy should only be offered as an alternative to endoscopic surgery, to men with prostates estimated to be larger than 80 to 100ml.
- Transurethral needle ablation, transurethral microwave thermotherapy, high-intensity focused ultrasound, transurethral ethanol ablation of the prostate should not be offered as alternative surgical treatments for voiding LUTS presumed secondary to BPH.
- Prostatic artery embolisation, a minimally invasive procedure that can be performed as a local anaesthetic daycase in parallel to Urolift, the following criteria would need to be met:
  - demonstrable BOOP (ideally with flow dynamics)
  - IPSS score of more than 17
  - no upper limit of prostate size
  - can treat medium sized medium lobes

Of note, some men with bothersome LUTS will have undergone multichannel cytometry, establishing clear evidence of bladder outlet obstruction. These men are the most likely to benefit from surgery, with guidance on when to undertake such assessment covered elsewhere in NICE and European guidelines.

**Codes**

**Procedures challenged in this policy**
M61.1 Total excision of prostate and capsule of prostate
M61.2 Retropubic prostatectomy
M61.3 Transvesical prostatectomy
M61.4 Perineal prostatectomy
M61.8 Other specified open excision of prostate
M61.9 Unspecified open excision of prostate
M64.1 Open resection of outlet of male bladder
M65.1 Endoscopic resection of prostate using electrotome
M65.2 Endoscopic resection of prostate using punch
M65.3 Endoscopic resection of prostate NEC
M65.4 Endoscopic resection of prostate using laser
M65.5 Endoscopic resection of prostate using vapotrode
M65.8 Other specified endoscopic resection of outlet of male bladder
M65.9 Unspecified endoscopic resection of outlet of male bladder
M66.1 Endoscopic sphincterotomy of external sphincter of male bladder
M66.2 Endoscopic incision of outlet of male bladder NEC
M68.1 Endoscopic insertion of prostatic stent
M68.3 Endoscopic insertion of prosthesis to compress lobe of prostate
M70.7 Transurethral radiofrequency needle ablation of prostate

Diagnoses for which the above procedures are permitted
Please note N40.X must be in a primary position
N40 +/- R39.8 Hyperplasia of prostate +/- LUTS
N40.X + R33.X BPH + urinary retention
N40.X + N13.3 + N19.X BPH + hydronephrosis + renal impairment
Cancer diagnoses are a global exclusion

Date approved: July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Surgical removal of kidney stones

Urinary tract stones are amongst the most common condition dealt with by urologists with an estimated 6,000 patients admitted to hospital per year with the condition. Shockwave lithotripsy (SWL) is a non-surgical technique for treating these stones in the kidney or ureter. The technique uses high energy shockwaves to break the stones into smaller fragments which can then pass spontaneously.

Stones can be observed to see if they pass spontaneously, or treated with shockwave lithotripsy, or surgical techniques such as ureteroscopy (URS) and percutaneous stone surgery (PCNL), both of which may involve placing a stent.

The optimal management depends on the type, size and location of the stone as well as patient factors such as co-morbidity and pregnancy. For appropriate stones SWL is advantageous as it is non-invasive and so has fewer major adverse events than surgery.

This guidance applies to adults aged 19 years and over.

Criteria

Please refer to NICE NG118 (recommendation 1.5) for full details on the assessment and management of renal and ureteric stones.

Adult renal stones

- Less than 5mm: If asymptomatic consider watchful waiting.
• 5 to 10mm: If not suitable for watchful waiting offer SWL as first-line treatment (unless contra-indicated or not targetable).
• 10 to 20mm: Consider SWL as first-line treatment if treatment can be given in a timely fashion. URS can also be considered if SWL is contraindicated or ineffective.
• Over 20mm (including staghorn): Offer percutaneous nephrolithotomy (PCNL) as first-line treatment.

Adult ureteric stones

• Less than 5mm: If asymptomatic consider watchful waiting with medical therapy, for example alpha blocker for use with distal ureteric stones.
• 5 to 10mm: Offer SWL as first-line treatment where it can be given in a timely fashion (unless contra-indicated or not targetable).
• 10 to 20mm: Offer URS but consider SWL if local facilities allow stone clearance within 4 weeks.

Primary uroscopy

• Uretoric stones causing significant pain and in the absence of infection. These patients can be offered emergency extracorporeal shockwave lithotripsy.

Emergency extracorporeal shockwave lithotripsy could involve several trips to Derriford Hospital, Plymouth over a short period.

Codes

Procedures challenged in this policy
M07.1 Ureteroscopic laser fragmentation of calculus of kidney
M07.2 Ureteroscopic extraction of calculus of kidney NEC
M09.1 Endoscopic ultrasound fragmentation of calculus of kidney
M09.2 Endoscopic electrohydraulic shockwave fragmentation of calculus of kidney
M09.3 Endoscopic laser fragmentation of calculus of kidney
M09.4 Endoscopic extraction of calculus of kidney NEC
M09.8 Other specified therapeutic endoscopic operations on calculus of kidney
M09.9 Unspecified therapeutic endoscopic operations on calculus of kidney
M14.1 Extracorporeal shock wave lithotripsy of calculus of kidney
M14.8 Other specified extracorporeal fragmentation of calculus of kidney
M14.9 Unspecified extracorporeal fragmentation of calculus of kidney
M26.1 Nephroscopic laser fragmentation of calculus of ureter
M26.2 Nephroscopic fragmentation of calculus of ureter NEC
M26.3 Nephroscopic extraction of calculus of ureter
M27.1 Ureteroscopic laser fragmentation of calculus of ureter
M27.2 Ureteroscopic fragmentation of calculus of ureter NEC
M27.3 Ureteroscopic extraction of calculus of ureter
M28.4 Endoscopic catheter drainage of calculus of ureter
M28.5 Endoscopic drainage of calculus of ureter by dilation of ureter
M28.8 Other specified endoscopic removal of calculus from ureter
M28.9 Unspecified other endoscopic removal of calculus from ureter
M31.1 Extracorporeal shockwave lithotripsy of calculus of ureter
M31.8 Other specified extracorporeal fragmentation of calculus of ureter
M31.9 Unspecified extracorporeal fragmentation of calculus of ureter

**Relevant diagnoses for this policy**
N20.0 Calculus of kidney
N20.1 Calculus of ureter
N20.2 Calculus of kidney with calculus of ureter
N20.9 Urinary calculus, unspecified

**Diagnoses for which the above procedures are permitted**
Cancer diagnoses are a global exclusion

**Date approved:** July 2021.
**Review date:** July 2024 or earlier if new guidance is issued.
**JCIA:** Yes, completed.

**Testicular prosthesis**

A testicular prosthesis is a replica testicle made from silicone, which replaces your own testicle(s) if one or both have been removed. The removal of a testicle (orchidectomy) is most commonly performed due to testicular cancer; however, some men have one or both testicles removed for other reasons such as undescended testes, trauma, severe torsion (twisted testicle) or as a treatment option for advanced prostate cancer (Guy’s and St Thomas’ NHS Foundation Trust, 2014).

**Criteria**

Insertion of testicular prostheses is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
Bilateral testes excisions N051, N052, N053, N05.8, N05.9
Other or unilateral testis excisions N061, N063, N066, N06.8, N06.9
N10.1 Insertion of prosthetic replacement for testis
N10.2 Removal of prosthetic replacement for testis
N10.8 Other specified prosthesis of testis

**Relevant diagnoses for this policy**
N44X, N500, Q530, Q531, Q532, Q539, Q550

**Diagnoses for which the above procedures are permitted**
C620, C621, C629, C61.X Prostate cancer

**Date approved:** April 2018 and April 2021.
Review date: April 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Eye problems

Cataract surgery

Policy under review.

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 because 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 the thresholds set out below will not render most people unable to drive. This policy also recognises the increasing body of evidence that second eye surgery does indeed benefit patients.

Criteria

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:

- a best corrected visual acuity of 6/12 or worse in the affected eye (please ensure best corrected visual acuity information included with referral)
- have difficulty in carrying out their employment duties due to a need for good acuity
- with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions
- who need to drive at night who experience significant glare due to cataracts which affects driving
- have difficulty with reading, or recognising faces, due to lens opacities
- with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field
- with significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye
- with glaucoma who require cataract surgery to control intra ocular pressure
- with diabetes who require clear views of their retina to look for retinopathy
• with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (for example, treatment with anti-VEGFs)

Please note the reasons why the patient’s vision and lifestyle are adversely 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**

**Procedures challenged in this policy**
C711, C712, C713, C714, C715, C716, C717, C718, C719, C72, C720, C721, C722, C723, C724, C725, C726, C727, C728, C729, C741, C742, C743, C744, C745, C746, C747, C748, C749, C75, C750, C751, C752, C753, C754, C755, C756, C757, C758, C759, C73, C730, C731, C732, C733, C734, C735, C736, C737, C738, C739

**Relevant diagnoses for this policy**
H25, H250, H26, H260, H280, H281, H282, Q120

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved:** August 2017 and March 2018.
**Review date:** March 2020 or earlier if new guidance is issued.
**JCIA:** Yes, completed.

**Laser surgery for short sight (myopia)**

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**

**Procedures challenged in this policy**
C442, C444, C445, C461

**Relevant diagnoses for this policy**
The code for short sightedness (high myopia) is H521.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.
Date approved: November 2018.
Review date: November 2021 or earlier if new guidance is issued.
JCIA: Yes, completed.

Multifocal intraocular lenses in treatment of adults with cataracts

Policy under review.

Criteria

Multifocal intraocular lenses in treatment of adults with cataracts is not routinely commissioned.

Current evidence indicates that compared with standard treatment using monocular lenses, the balance of costs, adverse effects and benefits does not support commissioning for adults with cataracts.

Requests to fund multi-focal intraocular lenses for children with rare cataract conditions will be considered on an individual patient basis.

Codes

Procedures challenged in this policy
C751, C754, C758, C759

Relevant diagnoses for this policy

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed.

Raised intraocular pressure

Policy under review.

The policy has been developed in line with NICE guideline NG81, glaucoma: diagnosis and management, November 2017.

Criteria

Important note, if a patient’s IOP is measured by a community optometrist at 32 mmHg or over with:
• symptoms of primary angle closure the patient should be referred as an emergency to the hospital eye services (HES)
• no symptoms then an urgent referral to the HES should be carried out

All patients with one or more of the following detected during GOS or private sight test should be referred to the HES:

• suspect visual field
• suspicious optic nerve head
• suspicious anterior chamber angle found during GOS or private sight test

Referral of patients with raised ocular pressure following a repeat IOP reading via slit lamp GAT and full threshold or suprathreshold perimetry to specialist hospital services should be made only when intraocular pressure during a repeat IOP measurement is 24-32mmHg.

Codes

Procedures challenged in this policy
No appropriate codes, this is a diagnostic.

Relevant diagnoses for this policy
There are no appropriate codes for the clinical criteria.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed.

Surgical correction of strabismus or amblyopia in adults

Strabismus (including Estopropia, Exotropia, Hypertropia or Hypotropia) “Strabismus, or squint means a misalignment of the 2 eyes. It may arise for a variety of reasons and may be present from birth or arise at any time in life. If strabismus arises after the visual system matures (around the age of 8), strabismus usually results in diplopia (double vision). If it arises at an earlier age, the brain adapts by suppressing the image from the squinting eye, so that diplopia is no longer a problem, but this adaptation comes at the price of loss of stereopsis (detailed depth perception) and sometimes at the price of reduced visual acuity in 1 eye (amblyopia or lazy eye).

Strabismus and amblyopia are common and the treatment of these conditions is covered in the specialty training of ophthalmologists. Many general ophthalmologists continue to manage these conditions including surgery for strabismus. Strabismus does not always require surgery. Correction of a hyperopic refractive error with spectacles or contact
lenses may sometimes allow the eyes to straighten completely or to a cosmetically satisfactory degree. Weak convergence may respond to convergence exercises. Some people may be quite untroubled by a squint which others would regard as intolerable.

Surgery for strabismus varies from procedures which are technically straightforward (for example recession or resection of the horizontal rectus muscles for simple convergent or divergent squint) to much more complex adjustments, perhaps involving several muscles, or muscles that have had previous surgery. Most surgery takes place under general anaesthesia (Royal College of Ophthalmologists, 2016).

**Surgery for cosmetic concern**

In addition, the Royal College states: “Surgery for strabismus is most commonly undertaken to improve the appearance of the eyes or to eliminate diplopia but is sometimes also undertaken to improve a restricted range of eye movement or to eliminate an abnormal head posture which has been adopted to avoid diplopia. A squint that is obvious to others can be psychologically distressing and is rightly regarded as a disfiguring condition for which treatment should be offered if the patient wishes it. It should not therefore be classified as a low priority treatment for funding” (Royal College of Ophthalmologists, 2016).

Whilst noting this view and recognising the impact of cosmetic concerns, the CCG does not routinely commission surgeries or treatments for other cosmetic concerns.

**Criteria**

Surgical correction of strabismus or amblyopia in adults 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 is suffering from strabismus which is:

1. Causing intractable significant diplopia, as evidenced in either the GP’s referral letter or consultant’s clinic letter.
2. All appropriate conservative methods have been exhausted and have failed to resolve the diplopia (note patients suffering from intractable diplopia are suffering from significant functional impairment), as evidenced in either the GP’s referral letter or consultant’s clinic letter.

Patients who are concerned with their cosmetic appearance due to strabismus or connected conditions should be managed conservatively and advised that surgery to correct a cosmetic defect is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**  
C351, C352, C353, C358, C359
Relevant diagnoses for this policy

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed.

Vitreous floaters

Floaters are small shapes that some people see floating in their field of vision. They can be different shapes and sizes and may look like:

- tiny black dots
- small, shadowy dots
- larger cloud-like spots
- long, narrow strands

Patients may have many small floaters in their field of vision or just 1 or 2 larger ones. Most floaters are small and quickly move out of the field of vision. Floaters are often most noticeable when looking at a light-coloured background, such as a white or clear sky.

Floaters are small pieces of debris that float in the eye’s vitreous humour. Vitreous humour is a clear, jelly-like substance that fills the space in the middle of the eyeball.

The debris casts shadows on to the retina (the light-sensitive tissue lining the back of the eye). If you have floaters, it is these you will see.

Floaters can occur as eyes change with age. In most cases, they do not cause significant problems and do not require treatment.

In rare cases, floaters may be a sign of a retinal tear or retinal detachment (where the retina starts to pull away from the blood vessels that supply it with oxygen and nutrients).

Individuals should seek medical attention immediately if they notice an increase or sudden change in the floaters, particularly if they notice white flashes and some loss of vision.

Criteria

Treatments for vitreous floaters are not routinely commissioned. This includes:

- vitrectomy
• laser vitreolysis
• eye drops and medications

Codes

Procedures challenged in this policy
C791, C792, C793, C794, C797, C798, C799

Relevant diagnoses for this policy
H43, H432, H433, H438, H439, H430, H431, H45, H450, H458, Q140

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and February 2019.
Review date: February 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

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 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 to the practitioner who originally carried out the procedure. Where there is a complication of treatment originally undertaken outside of the NHS for example, 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 for example. defective breast implants may be removed but not replaced.
Abdominoplasty or apronectomy

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

Procedures challenged in this policy
OPCS code: S021, S022, S028, S029

Diagnoses challenged in this policy
ICD10 code: L98.7 Excessive and redundant skin and subcutaneous tissue

Diagnoses for which the above procedures are permitted
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.

Date approved: August 2016, November 2018 and July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed

Annual MRI breast screening

Criteria

Annual MRI breast screening is commissioned where patients meet the criteria below, the referral letter and patient’s medical record to clearly evidence how these criteria are met:

MRI scans are not normally offered to patients before their 20th birthday.

MRI surveillance should be considered for the following women with no personal history of breast cancer.

Patients aged 20 to 29

MRI scans are available for those at exceptionally high risk, for example women:

- with a known TP53 mutation
- who have not been tested but have a greater than 30% probability of carrying a TP53 mutation
Patients aged 30 to 49

- Women with a known TP53 mutation.
- Women who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier.
- Women with a known BRCA1 or BRCA2 mutation.
- Women who have not had a genetic test but have a greater than 30% probability of being a BRCA carrier.

Patients aged 50 to 69

- Women with a known TP53 mutation.
- Women with a known BRCA1 or BRCA2 mutation AND have dense breast pattern on mammography.
- Women who have not had a genetic test but have a greater than 30% probability of being a BRCA carrier AND have a dense breast pattern on mammography.

Aged 70 and above

Not normally offered.

MRI surveillance

MRI surveillance should be considered for the following women with a personal history and family history of breast cancer.

Women aged 20 to 29:

- with a known TP53 mutation
- who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier

Women aged 30 to 49:

- at high risk of breast cancer*

*Women with a known BRCA1, BRCA 2 and/or TP53 mutations or greater than 30% probability of being carriers. Rare conditions that carry an increased risk of breast cancer such as Peutz-Jegher syndrome, Cowden and familial diffuse gastric cancer.

Women aged 50 to 69:

- with a dense breast pattern on mammography
- with a known TP53 mutation
- who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier
Not normally offered to women aged 70 and above.

**Codes**

**Procedures challenged in this policy**
There are no appropriate codes.

**Relevant diagnoses for this policy**
Z803

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes.

**Date approved**: April 2018.
**Review date**: April 2020 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Blepharoplasty**

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**

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))
- correction of ectropion or entropion with ocular irritation and causing functional implications (evidence of functional implications must be supplied with the referral documentation)

**Codes**

**Procedures challenged in this policy**
C131, C132, C133, C134, C138, C139, C161, C162, C163, C164, C165, C168, C169

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.
**Botox injection for the ageing face**

**Criteria**

Botox Injection for the ageing face is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
OPCS code:
- S53.2 - Injection of therapeutic substance into skin
- Z60.1 - Muscle of face or if injected into skin:
- Z47.1 - Skin of forehead
- Z47.2 - Skin of temple
- Z47.3 - Skin of cheek
- Z47.4 - Skin of nasolabial area
- Z47.5 - Skin of chin
- Z47.8 - Specified skin of face NEC
- Z47.9 - Skin of face NEC

**Diagnoses challenged in this policy**
ICD10 Code: None

**Diagnoses for which the above procedures are permitted**
ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria

**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.

**Codes**

**Procedures challenged in this policy**
B301, B302, B304, B308, B309, B312, B314, B375

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C509D, Z853

**Date approved**: August 2016 and November 2018.
**Review date**: November 2021 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Breast augmentation**

Breast augmentation or 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 or enlargement is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
B301, B302, B304, B308, B309, B312, B314, B375

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C509D, Z853

**Date approved**: August 2016 and November 2018.
**Review date**: November 2021 or earlier if new guidance is issued.
**JCIA**: Yes, completed.
Breast lift (mastopexy)

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.

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

Procedures challenged in this policy
B313, B314, (B314 is also included in breast asymmetry and breast augmentation above)

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016 and November 2018.
Review date: November 2021 or earlier if new guidance is issued.
JCIA: Yes, completed.

Breast reduction

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.
**Codes**

**Procedures challenged in this policy**
B311

**Relevant diagnoses for this policy**
Diagnosis code (any position) is not like: C01, C02, C03, C04, C05, C06, C07, C08, C09, C10, C11, C12, C13, C14, C15, C16, C17, C18, C19, C20, C21, C22, C23, C24, C25, C26, C27, C28, C29, C30, C31, C32, C33, C34, C35, C36, C37, C38, C39, C40, C41, C42, C43, C44, C45, C46, C47, C48, C49, C50, C51, C52, C53, C54, C55, C56, C57, C58, C59, C60, C61, C62, C63, C64, C65, C66, C67, C68, C69, C70, C71, C72, C73, C74, C75, C76, C77, C78, C79, C80, C81, C82, C83, C84, C85, C86, C87, C88, C89, C90, C91, C92, C93, C94, C95, C96, C97, C98, C99

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: August 2016, November 2018 and November 2019.
**Review date**: November 2022 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Closure of patent foramen ovale for migraine**

The foramen ovale is hole in the wall that divides the 2 upper chambers of the heart. The hole is present in the heart of a developing fetus, but normally closes up soon after the baby is born. If it fails to close it is known as a patent foramen ovale (PFO). In most people, this does not cause any problems but some studies have suggested that there could be a link between having a PFO and recurrent migraines. This procedure involves passing a device through a large vessel in the groin up into the heart and closing or blocking the hole in the wall of the heart.

**Criteria**

Closure of patent foramen ovale for migraine is not routinely commissioned.

Use of this procedure should be restricted to patients who are severely affected by recurrent, refractory migraine.

This policy does not apply to closure of patent foramen for stroke prevention.

**Codes**

**Procedures challenged in this policy**
OPCS Code: K165

**Diagnoses challenged in this policy**
Q21.1 - Atrial septal defect
ICD10 Code: G430, G431, G432, G433, G438, G439

**Date approved**: April 2018 and January 2022.
**Review date**: January 2025 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Congenital vascular lesions**

**Criteria**

Laser treatment for congenital vascular lesions is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
None.

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: August 2016 and November 2018.
**Review date**: November 2021 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Cosmetic genital procedures**

**Criteria**

Cosmetic genital procedures are not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
055, P056, P057

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: August 2016, November 2018 and March 2019 – rename of policy and updated OPCS codes approved only.
**Review date**: November 2021 or earlier if new guidance is issued.
**JCIA:** Yes, completed.

**Desensitising light therapy in the management of severe polymorphic light eruption**

Polymorphic light eruption (PMLE) is a common skin rash trigged by exposure to sunlight or artificial ultraviolet (UV) light. An itchy or burning rash appears within hours, or up to 2 to 3 days after exposure to sunlight. It lasts for up to 2 weeks, healing without scarring. The rash appears on the parts of the skin exposes to sunlight, typically the head and neck, chest and arms (the face is not always affected). PMLE is thought to affect about 10% to 15% of the UK population (nhs.uk, 2015).

Photosensitivity, including PMLE, is usually managed conservatively by reducing exposure to sunlight and where this brings insufficient improvement, by use of topical or systematic therapies. Patients should be advised to follow the top sun safety tips as advised by the British Association of Dermatologists (BAD) to manage their condition.

**Criteria**

A defined course of desensitizing light therapy in the management of severe polymorphic light eruption using UVB or PUVA is commissioned where patients meet the criteria below, the referral letter and patient’s medical record to clearly evidence how these criteria are met:

1. The diagnosis of PMLE has been confirmed by a consultant dermatologist.
2. A consultant dermatologist assessment considers light therapy likely to significantly improve the impact of the patient’s PMLE.
3. The patient’s PMLE is judged severe, for example the patient has recurrent, extensive, itchy rash for most of the UK summer.
4. Symptoms remain severe despite comprehensive use of prevention, first and second line treatments in line with the BAD guidance including:
   - the patient is using protective clothing and broad-spectrum sun protection factor 30+ semi-opaque sunscreen frequently to all uncovered skin
   - the patient has been advised and tried gradually increasing exposure to sunlight without relief
   - the patient has tried recommended drug therapies for PMLE (*please include a detailed history of this treatment within this application*)
5. Symptoms from PMLE rash are causing significant functional impairment*

* Significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Note being unable to sunbathe, swim or take part in other recreational activities due to the impact of PMLE is unlikely to satisfy the commissioner that the patient is suffering from significant functional impairment.
Codes

**Procedures challenged in this policy**
S121, S122, S123, S124

**Relevant diagnoses for this policy**
L564

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: April 2018, November 2018 – significant functional impairment definition amended only and February 2021.  
**Review date**: February 2024 or earlier if new guidance is issued.  
**JCIA**: Yes, completed.

**Dermatology: acne and psoriasis**

**Criteria**

Acne pulse-dye laser treatment is not routinely commissioned.  
Psoriasis care pathway for the use of Fumaderm is criteria-based access.  
Commissioned for the treatment of severe psoriasis for patients who are resistant to or have contra-indications to the standard treatments.

Codes

**Procedures challenged in this policy**
S071, S072, S078, S079

**Relevant diagnoses for this policy**

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: April 2018 and February 2021.  
**Review date**: February 2024 or earlier if new guidance is issued.  
**JCIA**: Yes, completed.

**Face lift or brow lift**

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**

Procedures challenged in this policy

OPCS Code: S011, S012, S013, S014, S015, S016, S018, S019

**Diagnoses challenged in this policy**

ICD10 Code: L98.7 - Excessive and redundant skin and subcutaneous tissue

**Diagnoses for which the above procedures are permitted**

ICD10 Code Q183, Q189, Q670, Q671, Q672, Q673, Q674, G51, G510, Q828, Q85, Q850

- Q18.3 - Webbing of neck
- Q18.9 - Congenital malformation of face and neck, unspecified
- Q67.0 - Facial asymmetry
- Q67.1 - Compression facies
- Q67.2 - Dolichocephaly
- Q67.3 - Plagiocephaly
- Q67.4 - Other congenital deformities of skull, face and jaw
- G51.0 - Bell palsy
- Q82.8 - Other specified congenital malformations of skin
- Q85.0 - Neurofibromatosis (nonmalignant)
- G51.1 - Geniculate ganglionitis
- G51.2 - Melkersson syndrome
- G51.3 - Clonic hemifacial spasm
- G51.4 - Facial myokymia
- G51.8 - Other disorders of facial nerve
- G51.9 - Disorder of facial nerve, unspecified
- Q85.0 - Neurofibromatosis (nonmalignant)
- Q85.1 - Tuberous sclerosis
- Q85.8 - Other phakomatoses, not elsewhere classified
- Q85.9 - Phakomatosis, unspecified

**Date approved**: August 2016, November 2018 and January 2022.

**Review date**: January 2025 or earlier if new guidance is issued.

**JCIA**: Yes, completed.
Epididymal cysts

An epididymal cyst is a fluid filled sac which grows at the top end of the testicle. It is benign not caused by cancer. Some men only get one; others get several on both testicles. Rarely, they can be associated with illness that causes cysts in other parts of the body. Small cysts do not need treatment. Larger ones can be removed by a surgeon, especially if painful. Drainage using a needle (aspiration) is another option but it is not done very often.

Men are more likely to get an epididymal cyst around the age of 40. Children rarely get them before they become teenagers (Patient Info, 2014).

Criteria

If there is any uncertainty whether the cyst may be malignant in nature, refer the patient via the 2-week wait referral route.

The removal of benign epididymal cysts 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:

- it is large enough to cause a change to the shape and size of the scrotum
- the cyst is putting pressure on other structures in the testes
- there is documented clinical evidence that the cyst has been continuously present for more than 6 months
- the cyst is causing significant functional impairment*

* Significant functional impairment is defined as a restriction or interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.

Codes

Procedures challenged in this policy
N153, N15.6

Relevant diagnoses for this policy
N50.8 epididymal cyst (please note this code is not exclusive to this condition and may be assigned for another diagnosis).

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018, November 2018 – significant functional impairment definition amended only and March 2021.
Review date: March 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.
Hair depilation (hair removal)

Hair depilation can be used for excess hair in a normal distribution pattern, or for abnormally placed hair. It is usually achieved permanently by electrolysis or laser therapy.

Criteria

Hair depilation is not routinely commissioned.

Exclusion

Post hair bearing flap reconstructions

Codes

Procedures challenged in this policy
S606, S607 or S608 with Y089

Relevant diagnoses for this policy
L68, L68X, L680, Q842

Diagnoses for which the above procedures are permitted
Polycystic ovaries E282, Pilonidal cyst L05, L050, L059, and burns T20, T200, T201, T202, T203, T310, T311, T312, T313, T314, T315, T316, T317, T318, T318

Date approved: August 2017 and November 2018.
Review date: November 2021 or earlier if new guidance is issued.
JCIA: Yes, completed.

Hymenorrhaphy

Criteria

Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure and is not routinely commissioned.

Codes

Procedures challenged in this policy
None.

Relevant diagnoses for this policy
None.
**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: August 2016 and November 2018.
**Review date**: November 2021 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Inverted nipple correction**

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. This policy relates to cosmetic procedures and explicitly excludes investigation or management of suspected malignancy.

**Codes**

**Procedures challenged in this policy**
B354, B356

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: August 2016 and November 2018.
**Review date**: November 2021 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Labiaplasty**

**Criteria**

Labiaplasty is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
P055, P056, P057

**Relevant diagnoses for this policy**
None.
Laser hair removal for pilonidal disease

Pilonidal disease is a skin disease usually found in the midline of the natal cleft. Active pilonidal disease can progress to chronic or recurrent disease, and approximately 50% of acute pilonidal abscesses may develop into chronic discharging pilonidal disease despite treatment of the acute abscess (CKS, 2015). Pilonidal disease may recur after surgical treatment, depending on the surgical method used (CKS, 2015).

Criteria

Laser hair removal for pilonidal disease is not routinely commissioned. As studies show similar results to other conservative treatment.

Exclusion

Where the pilonidal disease has occurred on a post hair bearing flap reconstruction, laser hair removal will be commissioned

Codes

Procedures challenged in this policy
H60.8 + Y08.8 (where diagnosis contains pilonidal cyst codes L05.0, L05.9)

Relevant diagnoses for this policy
If in the primary position:
- L05.0 Pilonidal cyst with abscess
- L05.9 Pilonidal cyst without abscess

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and April 2021.
Review date: April 2024.
JCIA: Yes, completed.
**Liposuction**

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**

**Procedures challenged in this policy**
OPCS code: S621, S622

**Diagnoses challenged in this policy**
ICD10 code: L98.7 - Excessive and redundant skin and subcutaneous tissue

**Diagnoses for which the above procedures are permitted**
ICD10 code: There are no appropriate ICD10 Codes for the clinical criteria.

**Date approved**: August 2016; November 2018 and July 2021.
**Review date**: July 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Male breast reduction surgery for gynaecomastia**

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.

**Codes**

**Procedures challenged in this policy**
B311
Relevant diagnoses for this policy
N62, N620

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2016 and November 2018.
Review date: November 2021 or earlier if new guidance is issued.
JCIA: Yes, completed.

Meibomian cysts (chalazia) removal

Meibomian cysts (Chalazia) are benign, granulomatous lesions of the upper or lower eyelid that will normally resolve within 6 months with conservative management.

Criteria

Incision and curettage of meibomian cysts 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 meibomian cyst has been present continuously for more than 6 months
- where conservative treatment has failed*

*Conservative treatment consists of regular (4 times a day) application of heat packs and massage (for 4 weeks) and is either:

- present on the upper eyelid and significantly interfering with vision
- the meibomian cyst is regularly infected (for example, 2 times within a 6-month period) and in need of medical treatment for infection

Indications for direct referral

- Recurring cysts: Meibomian cysts that keep recurring or have atypical features require biopsy to rule out malignancy.
- Diagnostic uncertainty: Suspected eyelid malignancy should be referred for specialist opinion (please refer to the provider directory of services for guidance as to which clinics these patients should be investigated).

Once it is established that a lesion is a simple meibomian cyst and that it is not malignant its removal will not normally be funded by the NHS though a clinician may request exceptional funding. Clinicians referring on this basis should make the patient explicitly aware that removal of the lesion may not occur.
Exceptions

- Children under the age of 10: Meibomian cysts may cause astigmatism and visual development could potentially be at risk up until the age of 10. In these circumstances the removal of the cyst may be undertaken as an exception to the decision not the fund the procedure.

Note surgery to improve appearance alone is not commissioned.

Codes

Procedures challenged in this policy
Code starts C121, C122, C124, C191, C198

Relevant diagnoses for this policy
And primary diagnosis code is like H001

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and November 2019.
Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

One-step nucleic acid amplification as an intra-operative diagnostic method for detecting metastasis in breast cancer

One-step nucleic acid amplification (OSNA) is a promising emerging technique as one of the sentinel node biopsy techniques and as such is still under evaluation. Its benefits are identification of lymph node metastasis during the initial breast surgery and therefore enabling decision and undertaking of further lymph node resection (or not) during that initial surgery, avoiding thus the need for a second surgery and reducing the length of hospital stay. Current evidence identifies that the main uncertainty with OSNA is the potential over diagnosis of breast cancer metastasis. For example, higher proportion of micro-metastasis identified using OSNA than histopathology.

Criteria

OSNA is commissioned for all patients being surgically treated for breast cancer to allow evaluation of the diagnostic technique for a period of one year until further evidence becomes available.

Codes

Procedures challenged in this policy
OPCS Code:
Sentinal Axillary Lymph Node Biopsy with Isotope (OSNA) = T87.3 + Y39.2 + O14.2

**Diagnoses for which the above procedures are permitted**
ICD10 Code: C500, C501, C502, C503, C504, C505, C506, C508, C509

D05.0 - Lobular carcinoma in situ
D05.1 - Intraductal carcinoma in situ
D05.7 - Other carcinoma in situ of breast
D05.9 - Carcinoma in situ of breast, unspecified

**Date approved**: April 2018 and January 2022.
**Review date**: January 2025 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Pinnaplasty**

Pinnaplasty is performed for the correction of prominent ears or bat ears.

**Criteria**

Pinnaplasty is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
D033

**Relevant diagnoses for this policy**
Q175

**Diagnoses for which the above procedures are permitted**
None.

**Date approved**: August 2016, November 2018 and February 2021.
**Review date**: February 2024 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Removal of benign skin lesions**

The removal of a benign skin lesion, wherever it appears on the body, is regarded as a procedure of low clinical priority. Surgery to improve appearance alone is not provided.

Benign skin lesions include a wide range of skin disorders such as (this list is not exhaustive):

- anal skin tags.
- benign pigmented melanocytic naevi (moles).
- corn or callous
- dermatofibromas (skin growths)
- lipomata (fat deposits underneath the skin)
- milia
- molluscum contagiosum
- port wine stains
- post acne scarring
- sebaceous cysts (pillar and epidermoid cysts); (patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis)
- seborrheic keratoses (benign skin growths, basal cell papillomas, warts)
- skin tags
- solar comedones
- spider naevi
- telangiectasia
- thread veins
- warts and plantar warts; (genital and anal warts are excluded)
- xanthelasmas (cholesterol deposits underneath the skin)

Skin lesions are often referred for specialist opinion because of concerns that there may be malignancy. Suspected malignancy should be referred via the 2-week suspected cancer system (except for suspected basal cell carcinoma).

**Criteria**

Removal of benign skin lesions is not routinely commissioned.

**Exclusions**

Removal of benign skin lesions will be commissioned where patients meet the criteria below. The referral letter and patient’s medical record need to clearly evidence (with accompanying photographs) how these criteria are met.

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.

Benign eyelid mass surgery to improve appearance alone should not be undertaken. The following conditions are regarded as exceptions and will therefore be commissioned:

- benign eye lid lesions with persistent or recurrent infection
- benign eye lid lesions causing significant functional impairment for example affecting vision, recurrent bleeding, pain

Benign skin lesions that are large enough to affect the individual wearing either glasses or a hearing aid (for example on the bridge of the nose or ear) are exceptions and will be commissioned.
Codes

Procedures challenged in this policy
Dominant procedure code starts: S063, S064, S065, S066, S067, S068, S069, S081, S082, S083, S088, S089, S091, S092, S093, S094, S095, S098, S099, S101, S102, S111, S112, D021, D022, D028, D029

Relevant diagnoses for this policy
Code (any position) is not like: C43, C44, C46, C49

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: August 2017 and November 2019.
Review date: November 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Removal of tattoos

A tattoo can be removed by laser, surgical excision, or dermabrasion.

Criteria

Tattoo removal is not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS Code: S091, S092, S108, S109, S601, S602

Diagnoses challenged in this policy
ICD10 Code: L818

Diagnoses for which the above procedures are permitted
ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria.

Date approved: August 2016; November 2018 and July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Repair of lobe of external ear (split earlobes)

The external ear lobe can be damaged partially or completely as result of trauma or wearing earrings. Correction of split earlobes is not always successful, and the earlobe is a site where poor scar formation is a recognised risk.
Criteria

Repair of lobe of external ear is not routinely commissioned.

Codes

Procedures challenged in this policy
OPCS code: D062

Diagnoses challenged in this policy
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria

Diagnoses for which the above procedures are permitted
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria

Date approved: August 2016; November 2018 and July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.
**Resurfacing procedures: dermabrasion, chemical peels and laser treatment**

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**

**Procedures challenged in this policy**
OPCS code: S091, S092, S103, S113, S601, S602

**Diagnoses challenged in this policy**
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.

**Diagnoses for which the above procedures are permitted**
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.

**Date approved**: August 2016; November 2018 and July 2021.
**Review date**: July 2024 or earlier if new guidance is issued
**JCIA**: Yes, completed.

**Revision mammoplasty (including prosthesis removal or replacement)**

The term mammoplasty refers to both breast reduction and breast augmentation procedures. Revision mammoplasty may be indicated if desired results are not achieved or because of problem with implants.

**Criteria**

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
- baker grade IV capsular contracture
- implants with capsule formation that interferes with mammography
- implant is a PiP implant

This commissioning decision applies regardless of the funding source of the original surgery (for example, 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.

* 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**

**Procedures challenged in this policy**
B302, B303, B304, B314

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C509, Z853

**Date approved**: November 2016 and February 2019.
**Review date**: February 2022 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Rhinoplasty**

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**

**Procedures challenged in this policy**
OPCS Code: E023, E024, E025, E026, E073

**Diagnoses challenged in this policy**
There are no appropriate ICD10 Codes for the clinical criteria

**Diagnoses for which the above procedures are permitted**
There are no appropriate ICD10 Codes for the clinical criteria

**Date approved**: August 2016; November 2018 and July 2021.
Review date: July 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Scars and keloids

Criteria

Treatment for scars and keloids is not routinely commissioned.

Codes

Procedures challenged in this policy


S06.3 - Shave excision of lesion of skin of head or neck
S06.4 - Shave excision of lesion of skin NEC
S06.5 - Excision of lesion of skin of head or neck NEC
S08.1 - Curettage and cauterisation of lesion of skin of head or neck
S08.2 - Curettage and cauterisation of lesion of skin NEC
S09.1 - Laser destruction of lesion of skin of head or neck
S09.2 - Laser destruction of lesion of skin NEC
S10.1 - Cauterisation of lesion of skin of head or neck NEC
S10.2 - Cryotherapy to lesion of skin of head or neck
S10.8 - Other specified other destruction of lesion of skin of head or neck
S10.9 - Unspecified other destruction of lesion of skin of head or neck
S11.1 - Cauterisation of lesion of skin NEC
S11.2 - Cryotherapy to lesion of skin NEC
S11.8 - Other specified other destruction of lesion of skin of other site
S11.9 - Unspecified other destruction of lesion of skin of other site
S60.4 - Refashioning of scar NEC
Y06.4 - Excision of scar tissue NOC – this code would only ever be in a secondary position.

Diagnoses challenged in this policy
ICD10 Code: L905, L910 in the primary position

Diagnoses for which the above procedures are permitted
ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria

Date approved: August 2016, November 2018 and January 2022.
Review date: January 2025 or earlier if new guidance is issued.
JCIA: Yes, completed.
Skin camouflage services

Patients with disfiguring facial scars, birthmarks and other skin conditions can seek to disguise these conditions with skin camouflage, with advice from skin camouflage services in acute trust hospitals.

Criteria

One advice session within acute trust skin camouflage clinic services 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. The patient is suffering from significant facial disfigurement.
2. The deformity is capable of being camouflaged, disguised or minimised with camouflage products.
3. The patient has accessed charity services provided in the community without any benefit (a report from the service setting out why they have been unable to benefit the patient will aid decision making).

Patients with funding approval will receive advice on techniques and products to use to manage their disfigurement.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
Birthmark = Q82.5
Scar or disfigurement due to scar = L90.5

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and February 2021.
Review date: February 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Surgical treatment for hair loss

Introduction

Hair loss may occur naturally, or it may be related to disease or the use of certain medications. Symptoms of hair loss vary depending on the cause of the condition and range from a small bald patch to a complete loss of all body hair.

This policy replaces the previous male pattern baldness commissioning policy.
Criteria

Surgical treatment for hair loss is not routinely commissioned. This includes hair loss in all genders and is inclusive of conditions such as male pattern baldness, alopecia, hair thinning or hair loss and treatments such as grafting and transplants. This is because surgical treatments for hair loss is deemed to be a cosmetic procedure.

Codes

Procedures challenged in this policy

S21.1 - Hair bearing flap of skin to scalp for male pattern baldness
S21.2 - Hair bearing flap of skin to scalp NEC
S21.3 - Hair bearing flap of skin to nasolabial area
S21.4 - Hair bearing flap of skin to chin area
S21.8 - Other specified hair bearing flap of skin
S21.9 - Unspecified hair bearing flap of skin
S33.1 - Hair bearing punch graft to scalp for male pattern baldness
S33.2 - Hair bearing strip graft to scalp for male pattern baldness
S33.3 - Hair bearing graft to scalp for male pattern baldness NEC
S33.8 - Other specified hair bearing graft of skin to scalp
S33.9 - Unspecified hair bearing graft of skin to scalp
S34.1 - Hair bearing graft to nasolabial area
S34.2 - Hair bearing graft to chin area
S34.8 - Other specified hair bearing graft of skin to other site
S34.9 - Unspecified hair bearing graft of skin to other site
C10.2 - Hair bearing flap to eyebrow
C10.3 - Hair bearing graft to eyebrow

Diagnoses challenged in this policy

The ICD10 Codes for male pattern baldness are L648, L649

L63.0 - Alopecia (capitis) totalis
L63.1 - Alopecia universalis
L63.2 - Ophiasis
L63.8 - Other alopecia areata
L63.9 - Alopecia areata, unspecified
L64.0 - Drug-induced androgenic alopecia
L64.8 - Other androgenic alopecia
L64.9 - Androgenic alopecia, unspecified
L65.0 - Telogen effluvium
L65.1 - Anagen effluvium
L65.2 - Alopecia mucinosa
L65.8 - Other specified nonscarring hair loss
L65.9 - Nonscarring hair loss, unspecified  
L66.0 - Pseudopelade  
L66.1 - Lichen planopilaris  
L66.2 - Folliculitis decalvans  
L66.3 - Perifolliculitis capitis abscedens  
L66.4 - Folliculitis ulerythematoso reticulata  
L66.8 - Other cicatricial alopecia  
L66.9 - Cicatricial alopecia, unspecified

**Diagnoses for which the above procedures are permitted**

**Date approved:**  
August 2016, November 2018 and March 2022.  
**Review date:** March 2025 or earlier if new guidance issued  
**JCIA:** Yes. Completed

**Thigh lift, buttock lift and arm lift, excision of redundant skin or fat**

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**

**Procedures challenged in this policy**  
OPCS code: S031, S032, S033, (S038, S039 with Z495 or Z501)

**Diagnoses challenged in this policy**  
L98.7 excessive and redundant skin and subcutaneous tissue

**Diagnoses for which the above procedures are permitted**

There are no appropriate ICD10 codes for the clinical criteria.

**Date approved:** August 2016; November 2018 and July 2021.  
**Review date:** July 2024 or earlier if new guidance is issued.  
**JCIA:** Yes, completed.
**Vaginoplasty**

**Criteria**

Non-reconstructive vaginoplasty or vaginal rejuvenation used to restore vaginal tone and appearance is not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
P213, P214, P215

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: August 2016 and November 2018.
**Review date**: November 2021 or earlier if new guidance is issued
**JCIA**: Yes, completed.

**Miscellaneous**

**Complementary medicines or therapies**

Policy under review.

**Criteria**

Complementary therapies such as acupuncture, chiropractic therapy, homeopathy, hypnotherapy or osteopathy are not routinely commissioned.

**Codes**

**Procedures challenged in this policy**
X612, X613, X614, X618, X619, A706

**Relevant diagnoses for this policy**
None.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.

**Date approved**: August 2016, November 2018 and November 2019.
**Review date**: November 2022 or earlier if new guidance is issued.
**JCIA**: Yes, completed.
Complex and specialised metabolic and bariatric surgery

Policy under review.

Metabolic and bariatric surgery is a treatment for appropriate, selected patients with severe and complex obesity and/or type 2 diabetes that has not responded to all other non-invasive therapies. Within these patient groups bariatric surgery has been shown to be highly cost effective.

Patients for this surgery should have a BMI of 40kgs per m2 or more, or a BMI of 35-40kgs per m2 together with obesity related co-morbidity or have type 2 diabetes of 10 or less years duration and a BMI of 30-34.9kg per m2, 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

Complex and specialised metabolic and bariatric surgery will only be considered as a treatment option for people with morbid obesity providing all the following criteria are fulfilled:

- consider an assessment for bariatric surgery for people with a BMI of 30-34.0 who have recent-onset type 2 diabetes (for example within 10 years) if they are also receiving or will receive assessment in a tier 3 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 if they are also receiving or will receive assessment in a tier 3 service (or equivalent)
- there must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases and should include identification, diagnosis, severity or complexity assessment, risk stratification or scoring and appropriate specialist referral for medical management (such medical evaluation is mandatory prior to entering a surgical pathway)
- morbid or severe obesity has been present for at least 5 years
- the individual has recently received and complied with a local specialist obesity service weight loss programme (non-surgical tier 3 or 4), described below.

This will have been for duration of 6 months. For patients with BMI more than 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is 6 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 3 or 4 service may be community or hospital-based but will have as their role:

- education
- dietary advice or support (which may be delivered through specialist obesity dieticians, or slimming clubs, Weight Watchers, Slimming World)
- enabling access to appropriate level of physical activity where not limited due to obesity related problems such as osteoarthritis, cardiorespiratory disease
- exclusion of underlying contributory disease, for example hypothyroidism, Cushing’s
- evaluation of co-morbidities (diabetes, sleep disorder breathing, and others) 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 3 or 4 service engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of 5% to 10% or maintaining constant weight whilst stopping smoking).
- the patient has been assessed and referred by the lead physician or clinician for the specialist obesity weight loss multi-disciplinary team
- the patient has been unable to lose clinically significant weight (for example 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 3 or 4. In some locations there may be close liaison (and perhaps even overlap of personnel) between non-surgical tier 3 or 4 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 3 or 4 services
• the anaesthetic and other peri-operative risks have been appropriately minimised
• the patient has engaged in appropriate support or education groups or 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:
  o safety of the patient
  o best clinical outcome is obtained and then maintained
  o change eating behaviour
  o change physical behaviour as advised
• 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 or 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 or procedure, an application for exceptional funding through the individual funding request (IFR) process should be made in the first instance.

**Codes**

**Procedures challenged in this policy**

**Relevant diagnoses for this policy**
E66, E660, E66X

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes for the clinical criteria.
Continuous glucose monitors

These are devices that allow for people with type 1 diabetes to see their (or their children’s) glucose values continuously, enabling immediate therapeutic adjustments based on real time glucose results. The device has a sensor which is fitted subcutaneously and measures interstitial glucose, the sensors are time limited (usually 5 to 7 days) and thus need to be replaced regularly. The real-time monitor shows trends in glucose levels on an LCD display and indicates the rate of glucose change using arrows (the device can be a user’s smartphone). They have predictive alarms for high or low glucose level and warn of impending hypoglycaemia or hyperglycaemia by sounding alarm.

Criteria

Continuous glucose monitors (CGM) are commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how the criteria is met.

Principles

1. The use of a CGM device must be supported by a multidisciplinary specialist diabetic team.
2. CGM devices should not be routinely offered to all type 1 diabetic patients.
3. All patients should have followed the clinical pathway of usual interventions such as dietetic care, structured education and, where necessary, specialist psychological support to manage their diabetes.
4. Patients must be willing to commit to use their CGM device at least 70% of the time.
5. Devices will be issued for a 24-month period only after which the device should be considered for withdrawal.
6. Devices will be considered by the specialist team if the criteria 1 to 5 are met and the person meets the criteria as appropriate to their age as below.

12 years old and over:

- 2 or more severe hypoglycaemic episodes within 12 months: where severe equals seizure or unconscious and unable to take oral treatment, with evidence that 999 will have been called), or for patients under the paediatric diabetes service, that the out of hours advice line will have been contacted at the time of the event with expectation that glucagon will have been administered
- in adults, an expectation that if these severe hypos occurred during the day that they will have informed the DVLA who will then make medical enquiries
Under 12 years old:

- under 5 years of age (age 4 years and below)*
- for 5-to-11-year age group either:
  - 1 severe hypoglycaemic episode where severe equals seizure or unconscious and unable to take oral treatment, with evidence that 999 has been called, or that the out of hours advice line has been contacted at the time of the event and an expectation that glucagon will have been administered
  - unawareness of hypoglycaemia resulting in fear of hypoglycaemia evidenced by checking blood glucose level between midnight and 5am on at least 4 nights per week for at least 2 months

These proposed criteria for funding of real-time continuous glucose monitoring (CGM) are based on the most high-risk scenarios in the following guidance:

- NICE Quality Standard 125, Diabetes in children and young people
- NICE Guideline NG18, Diabetes (type 1 and type 2) in children and young people
- NICE Guideline NG17, Type 1 diabetes in adults: diagnosis and management
- NICE Diagnostics Guidance 21, Integrated sensor-augmented pump therapy systems for managing blood glucose levels in type 1 diabetes (the MiniMed Paradigm Veo system and the Vibe and G4 platinum CGM system)
- NICE Medtech innovation briefing 51, MiniMed 640G system with SmartGuard for managing blood glucose levels in people with type 1 diabetes
- Association of Children’s Diabetes Clinicians guideline for CGM and flash glucose scanners in April 2017

*ACDC says for all children who are of preschool age and below, but the use of an age cut-off is fairer. ACDC says about this group: Younger children are unable to recognise and respond to hypoglycaemia. They are at increased risk of neurocognitive sequelae because of hypoglycaemia and the risk of hypoglycaemic seizures is greatest in younger children. CGM studies in the pre-school children confirmed that most hypoglycaemia events were asymptomatic and only 32% were being detected despite plasma glucose levels being checked 10 times per day.

Children under the age of 6 years with hypoglycaemia unawareness have 6 times the risk of a severe hypoglycaemic episode when compared to those without hypoglycaemia unawareness.

Note Freestyle Libre not licensed for use under the age of 4 years.

Codes

**Procedures challenged in this policy**
There are no appropriate codes.

**Relevant diagnoses for this policy**
Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: February 2019.
Review date: February 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Enhanced external counterpulsation for patients with severe ischaemic heart disease

Ischaemic heart disease (coronary artery disease or CAD) is a condition in which fatty deposits build up in the linings of the walls of the coronary arteries. This causes a narrow artery and reduced blood flow to the heart muscle. Myocardial ischaemia results in central chest pain, causing stable angina, unstable angina and myocardial infarction.

Enhanced external counterpulsation (EECP) is a non-invasive method which has been used, mainly in the US, to treat patients with refractory angina pectoris, ineligible for further drug or surgical intervention. Pneumatic cuffs are applied to the lower limbs and controlled to inflate sequentially in time with the heartbeat during the time when the chambers of the heart fill, a process designed to increase coronary blood flow and improve heart output.

Criteria
EECP for patients with severe ischaemic heart disease is not routinely commissioned.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
I210, I211, I212, I213, I214, I219 - acute MI’s
I220, I221, I228, I229 - subsequent MI’s
I200, I201, I208, I209 - angina
I240, I241, I248, I249 - acute ischaemic heart disease
I250, I251, I252, I253, I254, I255, I256, I258, I259 - chronic ischaemic heart disease

Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018 and October 2021.
Review date: October 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.
Extracorporeal shockwave therapy

Extracorporeal shockwave therapy (ESWT) is a non-invasive treatment in which a device is used to pass acoustic shockwaves through the skin to the affected area. Ultrasound guidance can be used to assist with positioning of the device. It may be applied in one or several sessions and local anaesthesia may be used because high-energy ESWT can be painful.

NICE guidance exists in relation to ESWT as treatment for several conditions:

- refractory tennis elbow (NICE, IPG 313)
- refractory achilles tendinopathy (NICE, IPG 571)
- refractory plantar fasciitis (NICE, IPG 311)
- refractory greater trochanteric pain syndrome (NICE, IPG 376)
- peyronie’s disease (NICE, IPG 29)
- calcific tendonitis (tendinopathy) of the shoulder (NICE, IPG 21)

NICE guidance for all but "Calcific tendonitis (tendinopathy) of the shoulder (NICE, IPG 21)" states that for each condition: “The evidence on extracorporeal shockwave therapy (ESWT) raises no major safety concerns; however, current evidence on its efficacy is inconsistent.”

Although NICE guidance for calcific tendonitis (tendinopathy) of the shoulder (NICE, IPG 21) states that "current evidence on the safety and efficacy of extracorporeal shockwave lithotripsy for calcific tendonitis of the shoulder appears adequate to support the use of the procedure, provided that normal arrangements are in place for consent, audit and clinical governance," the use of this treatment is not routinely commissioned by NHS Kernow.

Criteria

Extracorporeal shockwave therapy is not routinely commissioned for the following conditions:

- refractory tennis elbow
- refractory Achilles tendinopathy
- refractory Plantar fasciitis.
- refractory greater trochanteric pain syndrome.
- peyronie’s disease.
- calcific tendonitis (tendinopathy) of the shoulder

Codes

Procedures challenged in this policy
OPCS Code: T74.5 - Extracorporeal shockwave lithotripsy of calculus of tendon
**Diagnoses challenged in this policy**
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria.
M77.1 - Lateral epicondylitis (tennis elbow)
M67.8 - Other specified disorders of synovium and tendon
M72.2 - Plantar fascial fibromatosis
M70.6 - Trochanteric bursitis
N48.6 - Induratio penis plastica
M75.3 - Calcific tendinitis of shoulder

**Diagnoses for which the above procedures are permitted**
ICD10 code: There are no appropriate ICD10 codes for the clinical criteria

**Date approved:** April 2018 and July 2021.
**Review date:** July 2024 or earlier if new guidance is issued.
**JCIA:** Yes, completed.

**Flash glucose monitors**

The NHS long term plan announced that the NHS will ensure that, access should be expanded to flash glucose monitors, where clinically appropriate, to those living with type 1 diabetes given the evidence that the technology improves diabetes control and reduces hospital admissions.

The flash glucose monitoring system is a device for the self-monitoring of glucose levels. Unlike traditional finger-prick devices (that measure the glucose level in the blood), this device measures the glucose level in the interstitial fluid, via a sensor that sits just under the skin. It updates readings every minute and stores data every 15 minutes giving a near-continuous record of measurements which can be accessed on demand. These devices do not provide real-time continuous glucose monitoring. There are models of flash glucose monitor which have a hypoglycaemia alarm, and these should be offered where licensed to do so.

FreeStyle Libre is a flash glucose monitor licensed for adults and children above the age of 4.

**Criteria**

**Routinely commissioned:**
1. Patients on insulin who are living with a learning disability, as recorded on their GP learning disability register
2. A 12 month use of FreeStyle Libre is routinely commissioned in pregnant women with type 1 diabetes, inclusive of post-delivery period.

**Commissioned with criteria:**
Flash glucose monitors are commissioned for a 6-month trial initially where patients meet one of the criteria below and agree to the patient contract.
The referral letter and patient’s medical record need to clearly evidence how this criteria is met:
1. People with type 1 diabetes OR with any form of diabetes on haemodialysis and on insulin treatment who, in either of the above, are clinically indicated as requiring intensive monitoring more than 8 times daily, as demonstrated on a meter download or review over the past 3 months.
2. People with type 1 diabetes unable to routinely self-monitor blood glucose due to disability, who require carers to support glucose monitoring and insulin management.
3. People who meet the nice criteria for a pump who have:
   - an haemoglobin A1c (HbA1c) in excess of 8.5% on multiple daily injection insulin therapy despite a high level of care.
   - People whose attempts to achieve target HbA1c levels with multiple daily insulin injections results in the patient experiencing disabling hypoglycaemia.

For the purpose of this guidance, disabling hypoglycaemia is defined as the repeated and unpredictable occurrence of hypoglycaemia that results in persistent anxiety about recurrence and is associated with a significant adverse effect on quality of life.

Other requirements, also known as the patient contract:
The person with diabetes must agree to
1. Take part in education on flash glucose monitoring, if appropriate (online or in person).
2. Scan glucose levels no less than 8 times per day and use the sensor more than 70% of the time.
3. Attend regular reviews with the local clinical team.
4. Attend a NICE approved type 1 diabetes structured education programme, if appropriate and if person has not previously received structured education.

Longer term use of flash glucose monitors, (after 6 month trial)
Continuing prescription for long-term use of flash glucose monitoring after the initial 6 months would be dependent on evidence of meeting the patient contract and that:
- on-going use of the flash glucose monitoring is demonstrably improving an individual’s diabetes self-management: for example improvement of HbA1c or time in range; improvement in symptoms such as diabetic ketoacidosis (DKA) or hypoglycaemia; or improvement in psycho-social wellbeing.
- the person is actively engaging in regular outpatient reviews with the clinical team, should an adult patient miss two consecutive specialist follow up appointments without notice then the continuing prescription should be discontinued and a letter sent to the person’s GP accordingly.

- Better care for health conditions, Diabetes
- Diabetes UK consensus guideline for flash glucose
- FreeStyle Libre for glucose monitoring

Please note Freestyle Libre is not licensed for use under the age of 4 years.
Hyperbaric oxygen therapy

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

Procedures challenged in this policy
X521

Relevant diagnoses for this policy
None.

Diagnoses for which the above procedures are permitted
T703, T58, T58X, T580, T790, T79, T79X, K627, O880 This list is not exhaustive.

Date approved: September 2019.
Review date: September 2022 or earlier if new guidance is issued.
JCIA: Yes, completed.

Multiple chemical sensitivity and clinical ecology and environmental medicine

Multiple chemical sensitivity and clinical ecology or environmental medicine.

Clinical ecology relies on the concept that multiple symptoms are caused by hypersensitivity to minute amounts of common foods and chemicals. MCS is also known
as environmental illness, total allergy syndrome and idiopathic environmental intolerance (IEI).

Treatment usually emphasizes avoidance of suspect substances with lifestyle changes for example, diet modification and to avoid synthetic items. Clinical ecologists often advise many patients to take vitamin, mineral, and other supplements. They can also offer the specific treatment of enzyme potentiated desensitisation (EPD), which allegedly boosts the immune response against minute doses of allergens. To date, no clinical studies have been conducted which compare EPD to standard allergy immunotherapy (multiple chemical sensitivity).

Criteria

Investigation of multiple chemical sensitivity (MCS) and/or treatment with clinical ecology or environmental medicine is not routinely commissioned.

Codes

Procedures challenged in this policy
There are no appropriate codes.

Relevant diagnoses for this policy
There are no appropriate codes for the clinical criteria.

Diagnoses for which the above procedures are permitted
There are no appropriate codes for the clinical criteria.

Date approved: April 2018 and March 2021.
Review date: March 2024 or earlier if new guidance is issued.
JCIA: Yes, completed.

Open magnetic resonance imaging (MRI) scanning

Referral for open MRI scanning of greater than 0.7T - 70cm bore and 250kg as an alternative to conventional MRI in secondary care.

Criteria

Prior approval must be gained before referral. A prior approval form should be completed. This should be undertaken by the referring GP or consultant.

• patients who suffer from claustrophobia where an oral prescription anxiolytics or sedative has not been effective (flexibility in the route of sedative administration may be required in paediatric patients as oral prescription may not be appropriate). Where there is clinical rationale for sedation being contra-indicated or inappropriate, for example an allergy or psychological disorders, then this must be stated for the referral to be approved by the commissioner
patients who are obese or cannot fit comfortably in conventional MRI scanners

Standing, upright, weight-bearing or positional MRI will not be commissioned.

**Codes**

**Procedures challenged in this policy**
There are no appropriate OPCS codes for open MRI machine.

**Diagnoses challenged in this policy**
There are no appropriate OPCS codes for open MRI machine.

**Diagnoses for which the above procedures are permitted**
ICD10 code: E660, E661, E662, E668, E669, F402

**Date approved**: April 2018 and July 2021.  
**Review date**: February 2024 or earlier if new guidance is issued.  
**JCIA**: Yes, completed.

**Paediatric speech and language therapy in secondary care**

The speech and language therapy service specialises in helping children who have difficulties in communicating and swallowing.

This policy relates to children aged 18 years and under only.

**Criteria**

Paediatric speech and language therapy in secondary care is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how the criteria is met:

- the patient has feeding and swallowing difficulties (dysphagia)

Where a child or young person is in receipt of speech and language therapy ongoing into hospital, please contact the main speech and language therapy service for further information and support on 01208 834488.

Children experiencing voice difficulties, including a total loss of voice or a change to the voice including quality, pitch, resonance and volume will be seen by the paediatric community speech and language therapy team. Referral forms can be found on the early help hub

Referral to the ENT department is required for all paediatric voice cases. Patients cannot refer themselves directly.
Please note the service excludes children and young people who are inpatients and who are not or have not been known to the paediatric community speech and language therapy service prior to their admission. Where they are already known to the service the relevant clinician will follow them into hospital.

Adults (18 plus) with a clinical need can access speech and language therapy routinely.

**Codes**

**Procedures challenged in this policy**
There are no appropriate codes.

**Relevant diagnoses for this policy**
F80.0 - Specific speech articulation disorder
F80.1 - Expressive language disorder
F80.2 - Receptive language disorder
F80.3 - Acquired aphasia with epilepsy [Landau-Kleffner]
F80.8 - Other developmental disorders of speech and language
F80.9 - Developmental disorder of speech and language, unspecified
R47.0 - Dysphasia and aphasis
R47.1 - Dysarthria and anarthria
R47.8 - Other and unspecified speech disturbances
R49.0 – Dysphonia (hoarseness)
R49.1 – Aphonia (loss of voice)
R49.2 - Hypernasality and hyponasality
R49.8 - Other and unspecified voice disturbances (inc. change in voice)
R63.3 - Feeding difficulties and mismanagement
R13.X – Dysphagia

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes.

**Date approved**: February 2019 and February 2022  
**Review date**: February 2025 or earlier if new guidance is issued.  
**JCIA**: Yes, completed.

**Polysomnography for children**

Polysomnography for children.

**Criteria**

Inpatient polysomnography (sleep studies) as a clinical intervention is appropriate for children in only a limited number of cases, and 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 use of polysomnography for children has been established in a number of pathways to investigate the following conditions:

- sleep disordered breathing or obstructive sleep apnoea syndrome (including children with underlying neuromuscular or cranio-facial disorders)
- congenital central hypoventilation syndrome
- apparent life-threatening events in infancy
- sleep related neurological disorders (REM parasomnias, sleep related epilepsy, narcolepsy or idiopathic hypersomnia)
- children with excessive daytime sleepiness, or circadian rhythm disturbance
- regular review of children with Down’s syndrome who are at high risk of obstructive sleep apnoea or sleep disordered breathing (up to 30% of children or young people with Down’s syndrome have such problems)

In the majority of cases a sleep study should take place in the home. Inpatient polysomnography will only be commissioned where:

- the home sleep study produces a negative result for sleep apnoea and further investigation is required
- it is not clinically safe to undertake a sleep study in the home, for example ventilated children
- there are complications with a home sleep study, or problems with compliance

Polysomnography will not be commissioned for the investigation of hypersomnia related to chronic fatigue syndrome or periodic limb movement disorder.

**Codes**

**Procedures challenged in this policy**
OPCS Code: U331

**Diagnoses for which the above procedures are permitted**
ICD10 Code: F510, F511, F512, F513, F514, F515, F518, F519, G470, G471, G472, G473, G474, G478, G479, Q900, Q901, Q902, Q909

- F51.0 - Nonorganic insomnia
- F51.1 - Nonorganic hypersomnia
- F51.2 - Nonorganic disorder of the sleep-wake schedule
- F51.3 - Sleepwalking [somnambulism]
- F51.4 - Sleep terrors [night terrors]
- F51.5 - Nightmares
- F51.8 - Other nonorganic sleep disorders
- F51.9 - Nonorganic sleep disorder, unspecified
- G47.0 - Disorders of initiating and maintaining sleep [insomnias]
- G47.1 - Disorders of excessive somnolence [hypersomnias]
- G47.2 - Disorders of the sleep-wake schedule
- G47.3 - Sleep apnoea
G47.4 - Narcolepsy and cataplexy
G47.8 - Other sleep disorders
G47.9 - Sleep disorder, unspecified
Q90.0 - Trisomy 21, meiotic nondisjunction
Q90.1 - Trisomy 21, mosaicism (mitotic nondisjunction)
Q90.2 - Trisomy 21, translocation
Q90.9 - Down syndrome, unspecified

**Date approved**: April 2018 and January 2022.
**Review date**: January 2025 or earlier if new guidance is issued.
**JCIA**: Yes, completed.

**Population screening outside of national screening committee guidelines**

This policy is to confirm the UK national screening programme for conditions where screening is recommended, and that the CCG continue to support patients in line with the national screening policy. The CCG will not commission any screening which is not recommended by the national screening committee.

Screening is the process of identifying healthy people who may have an increased chance of a disease or condition. The screening provider then offers information, further tests and treatment. This is to reduce associated problems or complications.

Identification through this process can show that the patient may have the condition screened for. The patient may need further confirmatory diagnostic tests.

At each stage of the screening process, patients can make their own choices about further:

- tests
- treatment
- advice
- support

**Criteria**

Population screening outside of national guidelines is not routinely commissioned and is subject to this restricted policy.

Screening will only be commissioned by the NHS for patients meeting the criteria:

1. UK national screening committee advises on policy for screening for a wide range of population health problems and the CCG commissions screening programmes in line with these recommendations.
2. Commissioner does not commission population screening for conditions where the UK national screening committee has said that it is not recommended.
Read the full list of the UK national screening committee policies and recommendations.

**Codes**

**Procedures challenged in this policy**
There are no appropriate codes.

**Relevant diagnoses for this policy**
Z13.6 Abdominal aortic aneurysm
Z12.1 Bowel cancer
Z12.3 Breast cancer
Z12.4 Cervical cancer
Z13.5 Congenital cataract
Z13.7 Congenital heart disease
Z13.8 Congenital hypothyroidism
Z13.7 Cryorchidism
Z13.8 Cystic fibrosis (newborn)
Z13.7 Developmental dislocation of the hip (if congenital)
Z13.5 Diabetic retinopathy
Z13.7 Down’s syndrome
Z13.7 Fetal anomalies
Z13.7 GA1
Z13.3 Growth for developmental disorder or disease or Z13.4 for developmental disorder in early childhood
Z13.7 HCU
Z13.5 Hearing (child)
Z13.5 Hearing (newborn)
Z11.5 Hepatitis B
Z11.4 Human immunodeficiency virus
Z13.7 IVA
Z13.7 MCADD
Z13.7 MSUD
Z13.7 Neural tube defect
Z13.7 PKU
Z13.0 Sickle cell and thalassaemia
Z13.0 Sickle cell disease (newborn)
Z11.3 Syphilis
Z13.7 T18 and T13
Z13.5 Vision defects

Please note any of the codes above will only be assigned in a primary position where no diagnosis, abnormal finding or symptom, injury or complication has been documented. If any of these are documented a code will be assigned for these instead and the Z code would not be assigned.

**Diagnoses for which the above procedures are permitted**
There are no appropriate codes.
**Revisional metabolic and bariatric surgery**

Policy under review.

Metabolic and bariatric surgery is a specialised treatment for severe and complex obesity, to be offered after a comprehensive weight management pathway that comprises MDT assessment, advice, education and counselling and includes specialised non-invasive interventions delivered by multidisciplinary obesity specialists, which may also include drug treatment.

The latter pathway is delivered within tier 3 services with non-specialist elements delivered by tier 1 and tier 2 services. In patients who have failed to lose weight using this pathway and are eligible according to NICE criteria, metabolic and bariatric surgery has been shown to be a cost-effective therapy that achieves significant and rapid excess weight loss and resolution of co-morbidities. However, to ensure the latter outcomes, patients need adequate pre-surgical input to ensure that they are well informed, prepared and ready to comply with surgical changes and accept the impact that it will have on their eating habits. Also essential will be compliance with post-operative follow up to monitor dietary and physical activity adherence, nutritional replacement and early detection and treatment of post-surgical medical and surgical complications.

**Criteria**

Group 1, 2 and 4a patients will be routinely commissioned. Groups 3 and 4b patients will not be routinely commissioned.

**Group 1**

Patients presenting with a clinical history, symptoms and/or signs that suggest acute medical and/or surgical complications that are related to their primary obesity operation.

Patients must be triaged and treated immediately if classified as emergency. Patients triaged by an MDT and may be assessed as ‘clinically urgent’ if they are judged to have a subsequent risk of developing emergency complications if they remain untreated. This category will include patients with adverse anatomical complications of the primary surgery.

This corrective surgery, or in rare cases reversal surgery, would routine and considered as good clinical practice. Providers should triage referral letters from GPs, hospital consultants on this basis.
Examples would include:

1. If there is a band complication, for example, slippage then the band can be repositioned or replaced. Conversion can be considered if the criteria as stipulated in the NHS Kernow policy on complex and specialised obesity surgery are met, the patient is on regular follow up and MDT review agrees.
2. If there is a band erosion then band removal can be followed up by a bypass after 6 months if the criteria as stipulated in the NHS Kernow policy on complex and specialised surgery are met, the patient is on regular follow up and MDT review agrees.
3. If there is severe band intolerance with gastro-oesophageal reflux, oesophageal dysmotility, or persistent vomiting then the same as 1 and 2 above.

However, if NHS Kernow criteria are not met and/or there has been poor response to primary bariatric surgery (insufficient weight loss or weight regain in the absence of surgical complication), then NHS Kernow will only fund for band removal.

Medical emergencies might include profound macro and micronutrient deficiencies anaemia; malnutrition and metabolic abnormalities such as disabling intractable hypoglycaemia; and intractable diarrhoea.

**Group 2**

Patients in whom a 2-stage procedure was clinically recommended by an MDT (often in super-obese patients) in which case further surgery is a planned, timely event.

The receiving trust’s triage and MDT approval process for the second operation will require evidence of patient compliance with the prescribed post-surgical (first stage operation) dietary and lifestyle regimen and progress with pre-set clinical targets.

**Group 3**

The patient has failed to achieve expected average weight loss targets for the primary obesity procedure performed or regained their pre-operative weight. This category will include patients who following a gastric bypass develop a dilated gastric pouch or gastro-jejunal anastomotic dilatation. This category will not include patients who have previously had vertical banded gastroplasty.

The above group will not be routinely funded. If the treating clinician feels strongly that there are clinically exceptional reasons that are relevant to a particular case such as technical failure or other special circumstances in patients who have complied with planned follow up, then an application for funding can be made to the individual funding request (IFR) panel.

**Group 4**

1. Some patients may have had their primary obesity surgery outside of NHS contracts at private providers (in Europe, or within the UK) but subsequently present at NHS
facilities as clinical emergencies. The NHS has a duty of care for these patients and will fund emergency and clinically urgent treatment on a similar basis as group 1 patients.

2. Many of these patients may not have met the full NHS Kernow criteria and guidance for their primary obesity surgery and may not have been adequately followed up. These patients should be referred to the tier 2 or 2 weight management services.

Any request for further (up to 2 years only) band filling and/or routine outpatient follow-up care (not associated with an acute, non-elective episode for these patients) will require the agreement of a commissioner at NHS Kernow and will need to demonstrate that the patient has met NHS Kernow’s eligibility criteria for obesity surgery. The patient’s GP and private provider will therefore be required to collaborate to provide evidence on:

1. Weight management service attendance including tier 3.
2. NHS Kernow criteria and guidance fulfilment.
3. Primary obesity operation.
4. Follow-up attendance.
5. Response to primary operation defined by progress with reduction of excess weight at 1 and 2 years including impact on co-morbidities.

Audit criteria

The following audit criteria will be required for all revision surgery:

1. Referral source and reason for application.
2. Previous obesity procedure, when carried out and by which provider (NHS, private, NHS contracted provider).
3. Indication for operation and fulfilment of NHS Kernow criteria.
4. Classification of admission (urgent, emergency, planned second stage, elective).
5. Revision procedure undertaken and provider.
6. Discharge destination.

Applications for funding to the IFR panel may be required for groups 3 and 4b, if it is felt that individualised or exceptional circumstances apply.

Codes

Procedures challenged in this policy

Relevant diagnoses for this policy
Diagnoses for which the above procedures are permitted
There are no appropriate codes.

Date approved: April 2018.
Review date: April 2020 or earlier if new guidance is issued.
JCIA: Yes, completed.

Equality impact assessment
The impact assessment for each individual commissioning policy is available on request.

Pre-ratification checklist
The NHS Kernow commissioning policies have been drafted in line with the NHS Kernow planned care team standard operating procedure for commissioning policy ratification.