# Commissioning policies 2019/20

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The purpose of this policy is to ensure that NHS Kernow 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.

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Commissioning policies 2016/17  
Commissioning policies 2017/18  
Commissioning policies 2018/19

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**Ratified by:**  
- First cohort - Quality and Performance Committee  
- Second cohort - Commissioning Priorities Group and Governing Body  
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**Date of Ratification:** See individual policy for date approved date.  
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## History

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<td>17/05/2016</td>
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| 12/03/2018       | Anna White       | Updated the following policies due to further clinical feedback:  
- Complex and specialised metabolic and bariatric surgery (was previously named complex and specialised obesity surgery)  
- Cataract surgery  
- Hernia management and repair in adults  
- Carpal tunnel syndrome  
- Trigger finger  
Removed treatment for erectile dysfunction policy as all patients are now eligible for treatment without any other co-morbidity | 4.2     |
| 21/03/2018       | Emma Whitney     | Updates to ICD10 and OPCS codes following feedback                                                                                                                                                           | 4.3     |
| 05/04/2018       | Anna White       | Updated with additional CBA and NRF policies                                                                                                                                                                 | 5.0     |
| 30/05/2018       | Anna White       | Included a web-link to the prior approval form on open magnetic resonance imaging (MRI) scanning policy                                                                                                                                                       | 5.1     |
| 27/11/2018       | Anna White       | Updated with additional CBA policy – spinal fusion for chronic non-specific low back pain. Added bleeding varicose veins to varicose veins policy criteria. Removed recurrent pilonidal sinus from hair depilation policy criteria. Removed anal skin tag removal policy as incorporated into benign skin lesions policy. Removed excess treatment costs for non-commercial trials policy as NHS England have devised a new system and NHS Kernow are no longer responsible for considering non-commercial clinical trials in future - from 1 October 2018 NHS Kernow delegated authority to NEW Devon CCG under the new system. Updated significant functional impairment definition | 6.0     |
| 26/02/2019       | Anna White       | Updated with additional CBA policies – tongue tie division, and paediatric speech and language therapy in secondary care. Updated the following policies due to further clinical feedback:  
- Bunion surgery, insertion of grommets, tonsillectomy, snoring, and vitreous floaters | 7.0     |
<p>| 28/03/2019       | Anna White       | Updated OPCS codes to the penile implants and labial trimming cosmetic genital procedures as | 8.0     |</p>
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Patient guide to the policy and why your doctor has to observe it

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

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

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

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

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

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

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

Definitions

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

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

Scope

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

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

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

Exceptionality

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

Implementation

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

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

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

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

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

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

Private funding

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

NICE guidance and recommendations about “do not do”

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

Commissioners do not routinely fund interventions identified in the “do not do” recommendations database. A copy of the database is maintained here.
**Commissioning policies**

**General surgery**

| **Alfa pumps for the removal of ascites due to liver disease** |
|-----------------|--------------------------------------------------|
| **Introduction** | 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, 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 in order to have the fluid drained from their abdomen. |
| **Criteria** | 
| **Based on Access** | 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: |

- The patient must have the ability to operate the device.
- The patient must have cirrhosis of the liver – defined by histological and/or clinical, and/or radiological criteria.
- The patient must present with refractory ascites* and require periodic large volume paracentesis (large volume defined as $\geq 5$ L in accordance with the clinical guidance of European Association for the Study of the Liver (EASL), which recommends withdrawal of 5 L 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 two different subgroups: |

1. Diuretic resistant ascites – ascites that are refractory to dietary sodium restriction and intensive diuretic treatment (spironolactone 400mg/day) and furosemide 160 mg/day for at least one week, and a salt restricted diet of less than 90 mmol/day (5.2g of salt/day).
2. Diuretic intractable ascites – ascites that is refractory to therapy due to the
Alfa pumps for the removal of ascites due to liver disease

- 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 grounds:
- Patient has had a gastrointestinal haemorrhage over the last seven days.  
  - Renal failure defined as serum creatinine higher than or equal to 2mg/dl.  
  - Platelet count of less than 40,000 / uL unless platelet therapy is given at the time of surgery.  
- Clinical evidence of recurring bacterial peritonitis, defined as two or more episodes over the last six months or a single episode within the last two weeks.  
- Clinical evidence of recurring urinary infections, defined as two or more episodes over the last six months or a single episode within the last two 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 (e.g. moderate to severe congestive heart failure).  
- Immuno-modulatory treatment (including azothiaprine, methotrexate, anti-TNF therapies) used within last four months.  
- Known as suspected hepatic or extra hepatic malignancy, unless adequately treated or in complete remission for ≥ three years.  
- BMI>40 presenting a risk for surgery and tunnelled lines.  
- Patients with contraindications for general anaesthesia.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPCS Code: T462</td>
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<tr>
<td></td>
<td>Relevant diagnoses for this policy:</td>
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<tr>
<td></td>
<td>ICD10 Code: R18X</td>
</tr>
<tr>
<td></td>
<td>Diagnoses for which the above procedures are permitted:</td>
</tr>
</tbody>
</table>

| Date approved | April 2018 |
### Alfa pumps for the removal of ascites due to liver disease

<table>
<thead>
<tr>
<th>Review date</th>
<th>April 2020 or earlier if new guidance is issued.</th>
</tr>
</thead>
<tbody>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>

### Chronic fatigue syndrome/myalgic encephalomyelitis referral for treatment

**Introduction**

Chronic fatigue syndrome (CFS)/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/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/ME (NICE CG53).

**Criteria**

<table>
<thead>
<tr>
<th>Access</th>
<th>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:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adult patients should have:</td>
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<tr>
<td>Fatigue lasting for more than four months, with all of the following features:</td>
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<td>• New or had a specific onset fatigue (that is, it is not lifelong).</td>
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<td>• Persistent and/or recurrent.</td>
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<tr>
<td>• Unexplained by other conditions.</td>
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<tr>
<td>• 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).</td>
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<tr>
<td>and</td>
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<tr>
<td>One or more of the following symptoms:</td>
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<tr>
<td>• Difficulty with sleeping, such as insomnia, hypersomnia, unrefreshing sleep, a disturbed sleep-wake cycle.</td>
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<td>• Muscle and/or joint pain that is multi-site and without evidence of inflammation.</td>
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<tr>
<td>• Headaches.</td>
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<td>• Painful lymph nodes without pathological enlargement.</td>
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<tr>
<td>• Sore throat.</td>
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<tr>
<td>• Cognitive dysfunction, such as difficulty thinking, inability to concentrate, impairment of short-term memory, and difficulties with word-finding, planning/organising thoughts and information processing.</td>
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<tr>
<td>• Physical or mental exertion makes symptoms worse.</td>
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<tr>
<td>• General malaise or ‘flu-like’ symptoms.</td>
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<tr>
<td>• Dizziness and/or nausea.</td>
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<tr>
<td>• Palpitations in the absence of identified cardiac pathology.</td>
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<tr>
<td>• Sensitivities to light, noise, motion, foods, chemicals.</td>
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<tr>
<td>and</td>
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<tr>
<td>Meet all of the following criteria:</td>
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<tr>
<td>1. No major psychiatric illness with psychotic or manic features</td>
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<tr>
<td>and</td>
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<tr>
<td>2. No history of failed CFS/ME services (or specific new reasons why referral is necessary).</td>
<td></td>
</tr>
</tbody>
</table>
### Chronic fatigue syndrome/myalgic encephalomyelitis referral for treatment

| should be reconsidered) and  
| 3. Not receiving concurrent rehabilitation from another provider and  
| 4. No ongoing medical investigation for other conditions  

**Exclusions:** Inpatient CFS/ME therapy is not routinely commissioned. Referral to alternative providers or services for CFS/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  
  - **Relevant diagnoses for this policy:**  
    - **ICD10 Code:** There are no appropriate ICD10 Codes for the clinical criteria

**Date approved**

- April 2018

**Review date**

- April 2020 or earlier if new guidance is issued.

**JCIA**

- Yes - completed

---

### Circumcision

**Introduction**

Circumcision is a surgical procedure that involves partial or complete removal of the foreskin of the penis. It is an effective procedure and confers benefit for a range of medical indications. Sometimes it is requested on cultural, social and religious reasons. These non-medical circumcisions do not confer any health gain but do carry measurable health risk.

**Criteria Based Access**

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

- Phimosis (inability to retract the foreskin due to a narrow prepuceal ring).
- 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, > three documented episodes).
- Carcinoma of the penis.

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

- The DH advises that the legality of male circumcision for religious reasons could be in conflict with the human rights act and current child protection legislation.
- The issue of informed consent when a young child is involved is unclear and complex.
- The risks associated with routine circumcision, such as infection and bleeding outweigh the benefits.
- GMC and BMA guidance reflects society’s disagreement as to whether circumcision is a beneficial, neutral or harmful procedure and recognises the complex issues that arise for doctors when considering whether to circumcise.
Circumcision

| Introduction | male children for nontherapeutic reasons. Neither the BMA nor GMC take a view as regards the lawfulness or appropriateness of circumcision for non-therapeutic reasons. |
| Codes | Procedures challenged in this policy: OPCS Code: N303 Relevant diagnoses for this policy: ICD10 Code: None Diagnoses for which the above procedures are permitted: ICD10 Codes: D047, D407, D290, N47, N470, N48, N480, N481, N486, C60, C600, C601, C602, C608, C609, N48. However there are no appropriate ICD10 Codes for unresponsive dermatological disorders or congenital abnormalities requiring skin for grafting. The above does not take into account multiple occurrences of N481 – however the above codes relate to diagnoses recorded in secondary care only. |
| Date approved | November 2016 February 2019 |
| Review date | February 2022 or earlier if new guidance is issued |
| JCIA | Yes - completed |

Correction of chest wall deformity for cosmetic purposes

| Introduction | 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. |
| Codes | Procedures challenged in this policy: OPCS Code: T021, T018, T019, T028, T029, T053, T058, T059 Relevant diagnoses for this policy: ICD10 Code: M954 |
| Date approved | April 2018 |
| Review date | April 2020 or earlier if new guidance is issued. |
| JCIA | Yes - completed |

Divarication of recti

| Introduction | 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 Based | 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 |
### Divarication of recti

| Access | evidence how these criteria are met:
|        |   1. The 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.  
|        |   or
|        |   2. The patient has a congenital divarication of recti.  
|        |   and
|        |   3. The divarication of recti is disabling and causes significant functional impairment*.

*Note: significant functional impairment is defined as:
- A restriction of 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:  
| OPCS Code: There are no appropriate OPCS Codes  
| Relevant diagnoses for this policy:  
| ICD10 Code: M630, M620

### Date approved

| April 2018  
| Revised version approved November 2018 – significant functional impairment definition amended only

### Review date

| April 2020 or earlier if new guidance is issued.

### JCIA

| Yes - completed

### Haemorrhoidectomy

#### Introduction

Haemorrhoids, also known as piles, are enlarged and swollen blood vessels in or around the lower rectum and anus. They can occur at any age and affect both sexes. Conservative management consists of high fibre diet, exercise, weight loss and topical preparations, followed by non-surgical ablative/fixative interventions and rubber band ligation. Surgical haemorrhoidectomy can be used for third or fourth degree haemorrhoids.

#### Criteria

| Based Access | Haemorrhoidectomy is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:
|        | • The haemorrhoids are prolapsed and incarcerated, and cannot be reduced (Fourth degree haemorrhoids).  
|        | or
|        | • The haemorrhoids are recurrent and associated with persistent bleeding.  
|        | and
|        | • There is failure of documented conservative management techniques after at least three months.
### Haemorrhoidectomy

Conservative management techniques include:
- Dietary and lifestyle advice (increase fluid and insoluble fibre intake, discourage straining).
- Bulk forming laxative (or osmotic laxative or stool softener).
  - or
- Non-opioid analgesia and/or topical haemorrhoid preparations for symptomatic relief.

### Non-surgical treatment

Non-surgical measures (rubber band ligation, injection sclerotherapy or infra-red coagulation) is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- Recurrent haemorrhoids.
  - and
- Persistent bleeding.
  - and
- Failure of documented conservative management techniques after at least three months.

### Surgical treatment

Surgical treatment (haemorrhoidectomy, stapled haemorrhoidopexy or haemorrhoidal artery ligation) is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- Fourth-degree haemorrhoids.
  - or
- Third-degree haemorrhoids associated with persistent bleeding that have not responded to non-surgical treatment in line with the above policy statement, or which are too large for non-surgical measures.
  - or
- Second-degree haemorrhoids associated with persistent bleeding that have not responded to non-surgical treatment in line with the above policy statement.

Note: The removal of anal skin tags is not routinely commissioned by NHS Kernow.

### Codes

Procedures challenged in this policy:
- OPCS Code: H511, H512, H513, H518, H519

Relevant diagnoses for this policy:
- The ICD10 Code for haemorrhoids is K64.

Diagnoses for which the above procedures are permitted:
- ICD10 Codes: K640, K641, K642, K643, K648, K649 or L703 with Y532 and Z378.

However there are no appropriate ICD10 Codes for recurrent third of fourth degree haemorrhoids or failure of conservative treatment.

### Date

August 2017
### Hernia management and repair in adults

**Introduction**

This policy covers the management of inguinal, femoral, umbilical, ventral and incisional hernias, and lists the criteria for referral.

**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 >35 - the decision to refer requires particular care, as the benefits of intervention may well be outweighed by risks of surgical intervention, including poorer healing and higher complication rates. If in doubt, the clinician may refer the patient, but should advise them that surgery may not be an appropriate option for them. Referral to local weight management programmes should be offered.

Patients who smoke should be warned of clinical advice that hernia recurrence rates are three times higher in smokers than non-smokers. All patients who smoke should be encouraged to stop and offered information on local cessation support services.

**Inguinal**

Criteria Based Access: For asymptomatic or minimally symptomatic hernias, the commissioner advocates a watchful waiting approach including providing reassurance, pain management etc, under informed consent.

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

- Symptomatic i.e. symptoms are such that they cause significant functional impairment*.
- The hernia is difficult or impossible to reduce, (i.e. 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:
Hernia management and repair in adults

- Pain/discomfort that causes significant functional impairment*.
- Increase in size month on month.
- To avoid incarceration or strangulation of bowel – in at risk patients e.g. in cases where the hernia is difficult or impossible to reduce.

**Incisional**
Criteria based access: Surgical treatment is commissioned where patients meet the criteria below, the referral letter and patient's medical record to clearly evidence how these criteria are met:

- Pain/discomfort that causes significant functional impairment*.
- Conservative management has been tried first e.g. weight reduction where appropriate.

**Femoral**
Does not require prior approval: All suspected femoral hernias are approved for a referral to secondary care due to the increased risk of incarceration/strangulation and do not require prior approval to be sought.

**Impalpable hernia and groin pain not routinely commissioned:**
- Hernia surgery is not commissioned in patients with groin pain, but no visible external swelling. Patients presenting with groin pain who are found to have an impalpable hernia on ultrasound should not be referred for hernia repair.
- Management of persistent groin pain that has not resolved after a period of watchful waiting should be based on individual clinical assessment. Where groin pain is severe and persistent with diagnostic uncertainty, options include referral for musculoskeletal assessment or imaging. Ultrasound should not be routinely requested in the early management of groin pain.

**Laparoscopic hernia repair**
- Laparoscopic hernia repair is commissioned for primary unilateral hernia repair.
- Laparoscopic hernia repair is commissioned only for bilateral hernia repair:
  - Where the patient has bilateral hernias with external swelling on clinical examination).
  - For recurrent hernia.

Note: Hernia surgery is not commissioned for impalpable hernias found incidentally during laparoscopic repair of a hernia on the other side.

*Note: significant functional impairment is defined as:
- A restriction of interference with an individual’s capacity to meet personal, social...
### Hernia management and repair in adults

or occupational demands. Please state the impairment the individual is experiencing.

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

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
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<table>
<thead>
<tr>
<th>Date approved</th>
<th>August 2017</th>
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<tbody>
<tr>
<td></td>
<td>Revised version approved March 2018</td>
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<tr>
<td></td>
<td>Revised version approved November 2018 – significant functional impairment definition amended only</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Review date</th>
<th>March 2020 or earlier if new guidance is issued</th>
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<tbody>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
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</tbody>
</table>

### Hyperhidrosis treatment

**Introduction**

Hyperhidrosis can be generalised or focal. Generalised hyperhidrosis involves the entire body, and is usually part of an underlying condition, most often an infectious, endocrine or neurological disorder. Focal hyperhidrosis is an idiopathic disorder of excessive sweating that mainly affects the axillae, the palms, the soles of the feet, and the face of otherwise healthy people.

**Criteria**

*Botulinum Toxin for the treatment of hyperhidrosis is not routinely commissioned.*

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenge in this policy:</th>
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<tbody>
<tr>
<td></td>
<td>OPCS Code: X851</td>
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<tr>
<th>Date approved</th>
<th>November 2016</th>
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<td></td>
<td>February 2019</td>
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<tr>
<td>JCIA</td>
<td>Yes - completed</td>
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</tbody>
</table>

Relevant diagnoses for this policy:
The ICD10 Code for inguinal hernia is K40, K400, K401, K403, K404, K42, K420, K421, K422, K423, K424, K425, K426, K427, K428, K429, K431, K432

Diagnoses for which the above procedures are permitted:

ICD10 Codes: K40, K400, K401, K403, K404, K42, K420, K421, K422, K423, K424, K425, K426, K427, K428, K429, K431, K432

Relevant diagnoses for this policy:
The ICD10 Code for hyperhidrosis is R61

Diagnoses for which the above procedures are permitted:

ICD10 Codes: There are no appropriate Codes for the clinical criteria.
Laparoscopic ventral rectopexy and stapled transanal rectal resection (STARR)

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Laparoscopic ventral rectopexy and STARR</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria Based Access</td>
<td>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:</td>
</tr>
<tr>
<td>Treatment for full thickness prolapse can often present as an emergency and does not require prior approval.</td>
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</tbody>
</table>

- 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.  

  and

- The 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.  

  and

- 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.  

  and

  - The patient has unresolved faecal incontinence or obstructed defecation syndrome.  

  and

  - Symptoms cause significant functional impairment*.  

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

  and

- 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 multidisciplinary team 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:  
|---------------------|------------------------------------------|
| OPCS Code           | There are no appropriate OPCS Codes  
| Relevant diagnoses  | for this policy:  

Commissioning policies 2019/20 | Page 21 of 104
### Laparoscopic ventral rectopexy and stapled transanal rectal resection (STARR)

| Date approved | April 2018  
Revised version approved November 2018 – significant functional impairment definition amended only |
<table>
<thead>
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<tr>
<td>Review date</td>
<td>April 2020 or earlier if new guidance is issued.</td>
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<tr>
<td>JCIA</td>
<td>Yes - completed</td>
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</tbody>
</table>

### SpyGlass® direct visualisation cholangioscopy in complex hepatopancreaobiliary disease

#### Introduction
SpyGlass® direct visualisation cholangioscopy in complex hepatopancreaobiliary disease 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 pancreatico-biliary lesions, including:
  - Suspected cholangiocarcinoma.
  - Suspected pancreatic carcinoma.
  - Patients with primary sclerosing cholangitis.
  - and
- Inconclusive diagnostic results from initial standard endoscopic tissue acquisition techniques, such as ERCP, biliary ductal brush/cytology and EUS-FNA.
  - and
- Have been reviewed and referred via the multi-disciplinary team for HPB disease.
  - or
- 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.

#### Criteria Based Access

#### Codes

Procedures challenged in this policy:
OPCS Code: U168, U169

Relevant diagnoses for this policy: No appropriate codes

Diagnoses for which the above procedures are permitted:
ICD10 Code: (treatment bile duct stones): C220, C221, C222, C223, C224, C227, C229, C240, D015, D135, K803, K804, K805

Procedures for which the above procedures are permitted (if in the same attendance):

SpyGlass® direct visualisation cholangioscopy in complex hepatopancreaobiliary disease

<table>
<thead>
<tr>
<th>Date approved</th>
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<table>
<thead>
<tr>
<th>Surgery of gallstones (asymptomatic)</th>
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<tr>
<td><strong>Introduction</strong></td>
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<tr>
<td><strong>Criteria Based Access</strong></td>
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<tr>
<td>Surgery of gallstones (asymptomatic)</td>
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<tr>
<td><strong>Episode of obstructive jaundice caused by biliary calculi.</strong></td>
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</table>

**Codes**

Procedures challenged in this policy:

OPCS Code: J181, J182, J183, J184, J185, J188, J189 Subsidiary Y751, Y752, Y753, Y754, Y755, Y756, Y757, Y758, Y759 in association with ICD10 Code K802 or K805

Relevant diagnoses for this policy:

The ICD10 Code for gallstones: K80, K800

ICD10 Codes: There are no appropriate Codes to identify asymptomatic gallstones from those with a history of symptomatic gallstones, nor are there Codes to identify those at risk of malignancy or complications.

<table>
<thead>
<tr>
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<th>August 2017</th>
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</table>
**Tongue tie division**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>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.</th>
</tr>
</thead>
</table>
| Criteria Based Access | **Policy – criteria to access treatment – criteria based access (primary care)**  
Treatment in primary care will only be provided by the CCG for infants who are considered suitable by the midwifery service, meeting the criteria set out below.  
1. The infant is aged 12 weeks* or younger (*age corrected).  
and  
2. The 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.  
and  
3. The infant has not undergone a previous tongue tie division.  
and  
4. There are no signs of infection.  
---  
**Policy - Criteria to access treatment – criteria based access (secondary care)**  
1. 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/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.  
1. The tongue is thick and vascular.  
or  
2. There are aberrant structures beneath the tongue.  
or  
3. There is a family history of coagulation disorder.  
or  
4. The infant has congenital abnormalities (such as cleft lip/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...
**Tongue tie division**

the number of weeks or months he was born early. For example, a one-year-old who was born three months early would have a corrected age of nine months. (Raising Children, 2016)

| Codes | Procedures challenged in this policy:  
OPCS Code: F228, F262, F263  
Relevant diagnoses for this policy:  
ICD10 Code: Q381  
Procedures for which the above procedures are permitted (if in the same attendance):  
OPCS Code: F031, F032  
Diagnoses for which the above procedures are permitted:  
ICD10 Code: 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 (this policy is currently under review)**

**Introduction**

Varicose veins are dilated superficial veins in the leg. They are caused by incompetent valves, commonly in the long and short saphenous veins and their branches, although varicosities may be secondary to deep venous disease. They are not to be confused with intra-dermal spider veins or thread veins which lie within the skin.

Asymptomatic or mild varicose veins present as a few isolated, raised palpable veins with no associated pain, discomfort or any skin changes. Moderate varicose veins present as local or generalised dilatation of subcutaneous veins with associated mild pain or discomfort and slight ankle swelling. Severe varicose veins may present with phlebitis, ulceration, haemorrhage, significant oedema or haemosiderin staining.

Most varicose veins respond to conservative management, i.e. exercise, weight loss and elevation of the leg two to three times daily. Varicose eczema, if severe or inflamed, can be treated effectively with topical steroids. Consider class one or two compression stockings (Note: NICE CG 168 recommends - Do not offer compression hosiery to treat varicose veins unless interventional treatment is unsuitable).

Interventional procedures such as surgical stripping or ligation, radio-frequency ablation, endoscopic procedures and sclerotherapy (e.g. ‘foaming’) can improve symptoms in the short term but are less effective in the longer term, and are associated with a significant recurrence rate. Interventional procedures for mild and moderate varicose veins will not normally be commissioned by NHS Kernow.

**Criteria Based**

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
Varicose veins (this policy is currently under review)

Access criteria are met:

- Lower-limb skin varicose eczema, thought to be caused by chronic venous insufficiency.
- Superficial vein thrombosis (characterised by the appearance of hard, painful veins) and suspected venous incompetence.
- Recurrent or ascending superficial phlebitis (DVT risk may be as high as 10 to 20 per cent at presentation).
- A lower limb venous ulcer not healed within two weeks, with or without obvious varicose veins.
- A healed venous leg ulcer.
- Severe swelling or pitting oedema.
- Symptomatic varicose veins in the presence of arterial insufficiency (absent pedal pulses).
- Lipodermatosclerosis.
- Incipient ulceration with erythema and skin induration.
- Bleeding varicose veins.

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

- Patients with no symptoms or skin changes associated with venous disease.
- Patients whose concerns are cosmetic including telangectasia and reticular veins.
- Patients with mild symptoms including itch, ache, mild swelling, minor changes of skin eczema and haemosiderosis.

Codes

Procedures challenged in this policy:

Relevant diagnoses for this policy:
ICD10 Codes: I80, I800, I801, I802, I803, I808, I809, I831
Diagnoses for which the above procedures are permitted:
ICD10 Codes: 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
Revised version approved November 2018 - addition to the eligibility criteria included only
Revised version approved March 2019 - review date extension approved only
Revised version approved July 2019 - further review date extension approved only

Review date

November 2018 or earlier if new guidance is issued
June 2019
September 2019

JCIA

Yes - completed
### Venous angioplasty for multiple sclerosis

#### Introduction
The effectiveness of venous angioplasty for stenotic and occlusive lesions in the extracranial venous systems of patients with MS has not yet been demonstrated in clinical trials. The American Academy of Neurology currently recommends that patients only use this treatment as part of a well-designed clinical trial.

#### Criteria
**Venous angioplasty for the treatment of Multiple Sclerosis is not routinely commissioned.**

#### Codes
- Procedural codes: L946, L947, L948, L949, L991
- Relevant ICD10 codes: G35, G350, G35X, G35XD
- Diagnoses for which the above procedures are permitted: There are no relevant ICD10 Codes for the clinical criteria.

#### Dates
- Date approved: August 2017
- Review date: August 2019 or earlier if new guidance is issued
- JCIA: Yes - completed

### Ears, nose and throat (ENT)

#### Adenoidectomy

#### Introduction
Adenoids are lymphoid (glandular) tissue, much the same as tonsils. They are part of a ring of lymphoid tissue (Waldeyer's ring), which also includes tonsils. Adenoids are located at the back of the nose, at the roof of the throat, above and behind the soft palate. These lymphoid tissues are supposed to trap and destroy viruses and bacteria entering the breathing passages.

#### 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:
  - Adenoidectomies will normally only be provided to children 18 years or under. and
  - The adenoidectomy will be carried out in conjunction with a tonsillectomy in order to manage obstructive sleep apnoea (also known as an adenotonsillectomy). or
  - The adenoidectomy will be carried out in conjunction with the insertion of grommets to manage persistent otitis media.

#### Codes
- Procedural codes: E201, E204
- Relevant ICD10 diagnosis codes: No appropriate diagnosis codes
- Diagnoses for which the above procedures are permitted (if in the same attendance):
  - OPCS Code: D151, D158, D159, D202, D201, F341, F343, F347, F342

#### Dates
- Date approved: April 2018
### Adenoidectomy

| **Review date** | April 2020 or earlier if new guidance is issued. |
| **JCIA** | Yes - completed |

### Congenital ear deformity correction surgery – including pinnaplasty

| **Introduction** | Congenital ear deformity surgery/pinnaplasty surgery is a cosmetic procedure normally performed on a child in order 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:  
OPCS Code: D033, Q172  
Relevant diagnoses for this policy:  
ICD10 Code: No appropriate diagnosis codes. 11-18 year olds only. |
| **Date approved** | April 2018 |
| **Review date** | April 2020 or earlier if new guidance is issued. |
| **JCIA** | Yes - completed |

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

| **Introduction** | Continuous positive airway pressure (CPAP) for the treatment of obstructive sleep apnoea/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  
   1.1 Conservative management has been fully engaged in and complied with for period of at least six months by the patient and has not proven successful in reducing the impact of OSAHS.  
or  
   1.2 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).

and

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

and

3. 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 six month period:

- The patient has failed to use the device on average for 70 percent of days.
- The patient has failed to use the device on average for four 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 (i.e. there is little or no improvement in their apnoea/hypopnoea index (AHI) or Epworth Sleepiness Scale (ESS) scores should also be assessed to establish whether it is appropriate for their treatment to continue.

| Codes            | Procedures challenged in this policy:  
|------------------|---------------------------------------  
| Procedures       | OPCS Code: There are no appropriate OPCS Codes  
| Codes            | Relevant diagnoses for this policy:  
|                  | ICD10 Codes: G473  
| Date approved    | April 2018  
| Revised version  | Approved November 2018 – significant functional impairment definition amended only  
| Review date      | April 2020 or earlier if new guidance is issued.  
| JCIA             | Yes - completed  

Commissioning policies 2019/20 | Page 30 of 104
# Insertion of grommets

## Introduction
Glue ear is a common childhood condition in which the middle ear becomes filled with fluid.

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

## Criteria Based Access

### Children
Insertion of grommets in children is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met. 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 before referral to ENT services for treatment:

- OME persists after a period of at least six weeks watchful waiting in primary care to the date of referral.
- The child is three years or older.
- There is significant hearing loss (of at least 25dB) - particularly in the lower tones (low frequency loss) - and evidence of a disability as a result of this hearing loss on at least two documented occasions (following repeat testing after six to twelve weeks) with either:
  - Delay in speech development.
  - Educational or behavioural problems attributable to the hearing loss.
  - A significant second disability that may itself lead to developmental problems e.g. Down’s syndrome, Turner’s syndrome or cleft palate.
- The CCG will fund treatment for grommets in children with acute otitis media when there have been at least five recurrences of acute otitis media, which required medical assessment and/or treatment, in the previous year.
- Treatment for OME will be considered in children aged one or two years 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.

### Adults
Insertion of grommets in adults is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- Grommet insertion during examination under anaesthetic with/without a biopsy of the post nasal space as indicates a suspicion of cancer.
- A middle ear effusion causing measured conductive hearing loss, persisting for at least six months and resistant to medical treatments. The patient must be experiencing disability due to deafness. The possible alternative treatment...
- The 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 (e.g. on flying), for Eustachian tube dysfunction (in the absence of other qualifying symptoms/signs (e.g. middle ear effusion) or for the treatment of Meniere’s disease.

| Codes | Procedures challenged in this policy: OPCS Code: D151, D158, D159, D202, D201 Relevant diagnoses for this policy: ICD10 Code: None
Diagnoses for which the above procedures are permitted: ICD10 Codes: H65, H650, H651, H652, H653, H654 and H659 should be more than 5 episodes – not likely to be recorded in secondary care. There are no appropriate codes for hearing level, hearing loss or effects on the child. |
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### Laryngeal or voice box surgery

**Introduction**

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 e.g. malignancy.

**Criteria Based Access**

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).
   and
2. The voice change has significantly limited their ability to communicate with others.
   and
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 of interference with an individual’s capacity to meet personal, social or occupational demands. Please state the impairment the individual is experiencing.
   and
4. The patient has completed a course of voice therapy via an NHS provided speech and language therapist.
   and
Laryngeal or voice box surgery

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.

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<td>ICD10 Code: A155, A164, C320, C321, C322, C323, C328, C329, D020, D141, D380, J380, J381, J382, J383, J384, J385, J386, J387, Q310, Q311, Q312, Q313, Q314, Q318, Q319, S110, S170, T173, T270, T271, T274, T275</td>
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Date approved | April 2018 |
---|---|
Revised version approved | November 2018 – significant functional impairment definition amended only |
Review date | April 2020 or earlier if new guidance is issued. |
JCIA | Yes - completed |

Removal of ear wax

Introduction

This policy relates to the removal of ear wax.

Criteria Based Access

Removal of ear wax in secondary care is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- The person has (or is suspected to have) a chronic perforation of the tympanic membrane.
- There is a past history of ear surgery.
- There is a foreign body, including vegetable matter, in the ear canal.
- Ear drops have been unsuccessful and irrigation is contraindicated.
- The patient is suffering from significant symptoms due to ear wax build up including hearing loss or pain and the patient’s condition warrants microsuction.
- Has a recent history of otalgia and/or middle ear infection (in past six weeks).
- Has had previous documented complications following ear irrigation including perforation of the ear drum, severe pain, deafness, or vertigo.
- Two attempts at irrigation of the ear canal in primary care are unsuccessful (please state why irrigation has failed).

Earwax should only be removed if earwax is totally occluding the ear canal and any of the following are present:

- Hearing loss.
Removal of ear wax

- Earache.
- Tinnitus.
- Vertigo.
- If the tympanic membrane is obscured by wax but needs to be viewed to establish a diagnosis.
- If the person wears a hearing aid, wax is present and an impression needs to be taken of the ear canal for a mould, or if wax is causing the hearing aid to whistle.

### Codes

- Procedures challenged in this policy:
  - OPCS Code: D071, D085
- Relevant diagnoses for this policy:
  - ICD10 Code: None
- Diagnoses for which the above procedures are permitted:

### Date approved

- August 2017

### Review date

- August 2019 or earlier if new guidance is issued

### JCIA

- Yes - completed

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Shave or surgical rhinophyma

**Introduction**

Shave or surgical rhinophyma

**Criteria**

Shave or surgical rhinophyma is not routinely commissioned.

**Codes**

- Procedures challenged in this policy:
  - OPCS Code: There are no appropriate OPCS Codes
- Relevant diagnoses for this policy:
  - ICD10 Code: L710, L711, L718, L713D, L719

### Date approved

- April 2018

### Review date

- April 2020 or earlier if new guidance is issued.

### JCIA

- Yes - completed

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Snoring

**Introduction**

This policy explicitly refers to isolated snoring.

Surgical treatments (including Uvulopalatopharyngoplasty - UVPP) for isolated snoring are not routinely commissioned

It is recognised that some patients may have snoring in conjunction with obstructive sleep apnoea/hypopnoea syndrome (OSAHS):

- Continuous positive airway pressure (CPAP) is recommended as a treatment option for adults with moderate or severe symptomatic obstructive sleep apnoea/hypopnoea syndrome (OSAHS) in accordance with NICE technology appraisal 139.
**Snoring**

- 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/hypopnoea syndrome (OSAHS), tonsillectomy may be recommended as a treatment option ([please review guidance](#)).

**Criteria**

<table>
<thead>
<tr>
<th>Surgery for isolated snoring is not routinely commissioned.</th>
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**Codes**

- Procedures challenged in this policy:
  - OPCS Code: F324, F325, F326
- Relevant diagnoses for this policy:
  - ICD10 Code: None
- Diagnoses for which the above procedures are permitted:
  - ICD10 Codes: G473 or G479

**Date approved**

- August 2017
- February 2019

**Review date**

- February 2022 or earlier if new guidance is issued

**JCIA**

- Yes - completed

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**Tonsillectomy**

**Introduction**

These criteria are in line with SIGN 2010 guidance.

It should be noted that there is no high quality evidence in adults for the effectiveness of tonsillectomy as a treatment for recurrent sore throats, and benefits may be outweighed by the morbidity associated with surgery in children who are not severely affected.

**Criteria Based Access**

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

Recurrent sore throat where the following **documented evidence** applies:

- Seven or more episodes of tonsillitis* in the last year.
- or
- Five episodes per year in the preceding two years.
- or
- Three episodes per year in the preceding three years.
- and
- There has been significant severe impact on quality of life indicated by documented evidence of absence from school/work.
- and/or
- Failure to thrive.

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

Referral for tonsillectomy is automatically commissioned in the following circumstances:

- Suspected malignancy.
- Peri-tonsillar abscess (Quinsy).
- Tonsillar enlargement causing acute upper airways obstruction.

When in doubt as to whether a tonsillectomy would be beneficial, a six month period of watchful waiting is recommended.

* Definition of tonsillitis

Using the SIGN¹ list as indicative of bacterial infection, an eligible episode of tonsillitis must have three points, one each for any of the five criteria documented:

a) History of fever (>38.3C).
b) Tender anterior cervical lymph nodes.
c) Tonsillar exudate.
d) Absence of cough.
e) Age under 15.
f) But age 45+ subtracts a point or positive culture of group A beta haemolytic streptococci.

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

### Codes

| Procedures challenged in this policy: | OPCS Code: F341, F342, F343, F344, F345, F346, F347, F348, F349, F361 or Y081, Y082, Y083, Y084, Y085, Y086, Y087, Y088, Y089, Y101, Y102, Y103, Y104, Y105, Y106, Y107, Y108, Y109, Y10, Y11, Y100, Y110, Y111, Y112, Y113, Y114, Y115, Y116, Y117, Y118, Y119, Y120, Y121, Y122, Y123, Y124, Y125, Y126, Y127, Y128, Y129, Y130, Y132, Y133, Y134, Y135, Y136, Y137, Y138, Y139 with ICD10 Z257
| Relevant diagnoses for this policy: |
| ICD10 Code: None |
| Diagnoses for which the above procedures are permitted: |
| ICD10 Codes: For acute sore throat is J02, J020 and for acute tonsillitis is J03, J030 but the number of episodes cannot be captured by ICD10 Codes (and may not be recorded in secondary care), and there are no appropriate codes for impact on normal functioning. Codes for the other funded indications are any one of: J038, J039, J350, J360, G473, G479, C090, D000, D370, D104 |

### Date approved

- November 2016
- February 2019

### Review date

February 2022 or earlier if new guidance is issued

### JCIA

Yes - completed

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¹ SIGN 34 (Scottish Intercollegiate Guidelines Network) (April 2010) Management of Sore Throat and Indications for Tonsillectomy
Musculo-skeletal health

**Bunion surgery (hallux valgus)**

| Introduction | A bunion (Hallux valgus) is a bony swelling at the base of the big toe. Not all people with bunions are symptomatic (have symptoms). |
| Criteria Based Access | Surgical removal of bunions is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met: |
| | • Conservative measures methods have been tried and documented to have failed.  
| | and |
| | • Moderate to severe deformity (omit overriding toes) is causing significant (documented) functional impairment* or prevents patients from finding comfortable footwear.  
| | or |
| | • Severe pain is causing significant functional impairment*.  
| | or |
| | • Recurrent infection.  
| | or |
| | • Recurrent ulcers.  
| | and |
| | • The patient is willing to consider surgery.  

*Note: significant functional impairment is defined as:  
• A restriction of 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:  
| | OPCS Code: W792  
| | Relevant diagnoses for this policy:  
| | ICD10 Code: M201  
| | Diagnoses for which the above procedures are permitted:  
| | ICD10 Codes: There are no appropriate Codes for the clinical criteria. |

**Date approved**  
November 2016  
Revised version approved November 2018 – significant functional impairment definition amended only February 2019

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

**JCIA**  
Yes - completed
**Carpal tunnel syndrome**

**Introduction**

Carpal tunnel syndrome is a relatively common condition that affects the nerves of the hand causing pain, numbness and a burning or tingling sensation in the hand and fingers.

Symptoms can be intermittent, and range from mild to severe. Patients with intermittent or mild/moderate symptoms should be managed conservatively in the first instance.

**Criteria Based Access**

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

- There is a fixed neurological deficit (refer at first presentation).
  or
- Primary care management has failed (local corticosteroid injection and/or nocturnal splinting as per referral management guidelines [see primary care management for carpal tunnel](#)).
  or
- There is significant functional impairment*.
  and
- Symptoms are > six months duration.

*Note: significant functional impairment is defined as:

- A restriction of 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:
  - OPCS Code: A651
- Relevant diagnoses for this policy:
  - The ICD10 Code for Carpal Tunnel Syndrome is G560.
- Diagnoses for which the above procedures are permitted:
  - ICD10 Codes: There are no appropriate Codes for the clinical criteria.

**Date approved**

- August 2017
- Revised version approved March 2018
- Revised version approved November 2018 – significant functional impairment definition amended only

**Review date**

- March 2020 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

**Introduction**

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

**Criteria Based Access**

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 (<40 years) covered by these tools see the last bullet below, or consider specialist advice.

   or

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.

   or

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

or

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 three years.

   or

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

   or

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

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### Dupuytren's disease (this policy is currently under review)

#### Introduction

Dupuytren’s Disease can be managed conservatively with physiotherapy, wrist splints, NSAIDs, and steroid injections. There are recognised criteria where surgical release may be beneficial.

#### Criteria Based Access

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

- The patient has a metacarpophalangeal joint (MCPJ) deformity which causes significant functional impairment*.
  - or
- A proximal interphalangeal joint (PIPJ) deformity greater than 30°.
  - or
- Multiple joints with significant functional impairment*.
  - or
- Recurrence after surgery with significant functional impairment*.

*Note: significant functional impairment is defined as:

- A restriction of 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

<table>
<thead>
<tr>
<th>Procedures challenged in this policy: OPCS Code: T521, T522, T525, T526, T541, Z894, Z895, Z896, Z897</th>
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<tbody>
<tr>
<td>Relevant diagnoses for this policy: ICD10 Code: M720</td>
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<table>
<thead>
<tr>
<th>Date approved</th>
<th>August 2017</th>
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<table>
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<tr>
<th>Revised version approved</th>
<th>November 2018 – significant functional impairment definition amended only</th>
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<table>
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<tr>
<th>Review date</th>
<th>August 2019 or earlier if new guidance is issued</th>
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<tr>
<th>JCIA</th>
<th>Yes - completed</th>
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**Excision of acromio-clavicular joint or surgical decompression of sub-acromial space**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Excision of acromio-clavicular joint or surgical decompression of sub-acromial space (acromioplasty).</th>
</tr>
</thead>
</table>
| Criteria Based Access | Excision of Acromio-Clavicular Joint or Surgical Decompression of Sub-Acromial Space 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.  
  - If a temporary improvement has been demonstrated using injection surgery. |
| Codes | Procedures challenged in this policy:  
OPCS Code: O291  
Relevant diagnoses for this policy:  
ICD10 Code: S431, S435 |
| Date approved | April 2018 |
| Review date | April 2020 or earlier if new guidance is issued. |
| JCIA | Yes - completed |

**Exogen ultrasound bone healing system**

| Introduction | The long bones are those are 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 Based Access | 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 lone bone fractures of the femora, tibiae and fibulae of the legs or the humerus, radius and ulnae of the arms with non-union, defined as a non-healing fracture at six months with no progression or signs of fracture healing.  
and  
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.  
and  
3. The patient would be eligible, fit and appropriate for surgery to treat the non-union.  
and |
4. Patients must be able and willing to fully comply with the treatment regime of administering the device for 20 minutes per day for a minimum of 120 days either through self-management or with the help of carers.

and

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 of 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 meet the following criteria as the clinical evidence reviewed by NICE does not support the provision of Exogen:

1. The patient has delayed healing of less than nine months post fracture.

or

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.

or

3. The patient has not reached skeletal maturity, i.e. the growth plates of children or adolescents that have not fully matured or “closed”, a normal finding in the x-rays of young people.

or

4. The patient has an unstable surgical fixation, not well aligned or where inter-fragment gap is > 10mm.

or

5. The patient has an infection in the fracture.

or

6. The patient is pregnant, has a pacemaker or vertebral/skull fracture.

or

7. Surgery is contra-indicated for the patient for any other reason.

Codes

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

Relevant diagnoses for this policy:

Date approved

April 2018

Review date

April 2020 or earlier if new guidance is issued.

JCIA

Yes - completed
<table>
<thead>
<tr>
<th><strong>Ganglion</strong></th>
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<tbody>
<tr>
<td><strong>Introduction</strong></td>
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<td><strong>Criteria Based Access</strong></td>
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<td><strong>Criteria</strong></td>
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<td><strong>Evidence of functional impairment must be supplied with the referral documentation.</strong></td>
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<tr>
<td><strong>Codes</strong></td>
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<td><strong>Review date</strong></td>
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<tr>
<td><strong>JCIA</strong></td>
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</tbody>
</table>
## Hip impingement syndrome

### Introduction

Hip impingement syndrome is caused by unwanted contact between abnormally shaped parts of the head of the thigh bone and the hip socket. This results in limited hip movement and pain.

### Criteria Based Access

Open or arthroscopic femoro-acetabular surgery for hip impingement in the absence of osteoarthritis is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- Labral tear or impingement has been confirmed on MRI.
- Where hip arthroscopy is supported in the washout of an infected native hip joint in patients refractory to medical management, patients with underlying disease or patients who are immunosuppressed.
- Where hip arthroscopy is supported for the removal of radiologically proven loose bodies within the hip joint with an associated acute traumatic episode. Arthroscopy is not supported as a diagnostic tool where there is suspicion of loose bodies.
- The clinician has ensured that the patient understands what is involved, is aware of the serious known complications outlined in NICE patient information and agrees to the treatment knowing that there is only evidence for relief of the symptoms in the short and medium term.
- All available conservative methods have failed including activity modification, pharmacological intervention and specialist physiotherapy.
- Patient has severe symptoms causing pain or significant functional impairment* lasting > six months.
- Aged between 18 and 50 years likely to gain most benefit.

*Note: significant functional impairment is defined as:
- A restriction of 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:
  - OPCS Code: W581, Z843, or W844 with Z843
- Relevant diagnoses for this policy:
  - ICD10 Code: M248, Q658
- Diagnoses for which the above procedures are permitted:
  - ICD10 Codes: M16, M160, M161, M162, M163, M164, M165, M166, M167, M168, M169

### Date approved

- August 2017
- Revised version approved November 2018 – significant functional impairment definition amended only

### Review date

- August 2019 or earlier if new guidance is issued

### JCIA

- Yes - completed
Knee arthroscopy

<table>
<thead>
<tr>
<th>Criteria Based Access</th>
<th>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:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><strong>1. Washout and debridement in osteoarthritis:</strong> Unless there are documented mechanical features of locking which is associated with severe pain, arthroscopic debridement and washout is not routinely commissioned for chronic pain relief of osteoarthritis of the knee.</td>
</tr>
<tr>
<td></td>
<td><strong>2. Diagnostic arthroscopy:</strong> Unless one or more of the following criteria are met diagnostic arthroscopy of the knee is not routinely commissioned:</td>
</tr>
<tr>
<td></td>
<td>- Knee pain with diagnostic uncertainty following an MRI scan.</td>
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<td>- Suspected malignancy, infection, nerve root impingement, bony fracture or avascular necrosis.</td>
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<td><strong>3. Therapeutic arthroscopy:</strong> Unless all of the following criteria are met therapeutic arthroscopy of the knee is not routinely commissioned:</td>
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<tr>
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<td>- 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).</td>
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<td>and</td>
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<td>- Where conservative treatment has failed or where it is clear that conservative treatment will not be effective.</td>
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<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
</tr>
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<tbody>
<tr>
<td></td>
<td>ICD10 Code: None</td>
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<td>Diagnoses for which the above procedures are permitted:</td>
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<tr>
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<td>ICD10 Codes: M361, M00, M01, M010, S724, S728, S729, S821, S829, M87, M870, M17, M170, M171, M172, M173, M174, M175, M176, M177, M178, M179, S82, S820</td>
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| Date approved | November 2016 |
|              | February 2019 |
| Review date  | February 2022 or earlier if new guidance is issued |
| JCIA         | Yes - completed |
Musculoskeletal corticosteroid injections

Introduction

Musculoskeletal corticosteroid injections is commissioned 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:

- 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) guidelines e.g.:
  - The MSK interface service – shoulder/knee/soft tissue hip. They are able to arrange ultrasound-guided injections if deemed necessary.
  - Other orthopaedic services – hand/elbow/foot/ankle.

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

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 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 are able to refer to other Practices for the MSK steroid injections listed below – Inter-practice referral information.

Primary care services are available for the following MSK steroid injections:
- Hands (trigger finger, Tenosynovitis, carpal tunnel syndrome, thumb 1\textsuperscript{st} CMCJ OA).
- Shoulders (gleno-humeral joint, sub-deltoid/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) Note: steroid injection for these conditions is not routinely commissioned (see RMS guidelines).

Note: 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, spinal and facet joint.
Musculoskeletal corticosteroid injections

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
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<tbody>
<tr>
<td></td>
<td>OPCS Code: S521, X382</td>
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<td>Relevant diagnoses for this policy:</td>
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<td></td>
<td>ICD10 Code: M653, M680, M659, M658, G560, M710, M713, M714, M725, M722, M703</td>
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<td>Date approved</td>
<td>April 2018</td>
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<td>Review date</td>
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<tr>
<td>JCIA</td>
<td>Yes - completed</td>
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</table>

Radiofrequency ablation for barretts oesophagus

| Introduction | Barrett’s oesophagus is a condition in which changes occur to the cells lining the lower part of the oesophagus (gullet), usually as a result 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 Based Access | 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: |
|       | OPCS Code: There are no appropriate OPCS Codes |
|       | Relevant diagnoses for this policy: |
|       | ICD10 Code: C150, C151, C152, C153, C154, C155, C158, C159, D130, K227, K228, K229 |
| Date approved | April 2018                      |
| Review date | April 2020 or earlier if new guidance is issued. |
| JCIA | Yes - completed |
Skin surface applied functional electrical stimulation for an orthotic effect to correct foot drop of central neurological origin

**Introduction**

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 six months following a stroke (NICE Interventional Procedures Guidance IPG278, January 2009).

**Criteria Based Access**

The use of skin surface applied 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: There are no appropriate OPCS Codes
Relevant diagnoses for this policy:
ICD10 Code: M213

**Date approved**

April 2018

**Review date**

April 2020 or earlier if new guidance is issued.

**JCIA**

Yes - completed

Spinal cord stimulation for chronic pain

**Introduction**

Spinal cord stimulators stimulate the dorsal columns of the spinal cord with an implanted device, with the aim of modifying the perception of pain. They have been assessed by NICE 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 Based Access**

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 0-100 mm visual analogue scale) for at least six months despite appropriate conventional medical management.

and

- 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:
### Spinal cord stimulation for chronic pain

| OPCS Code: | A483, A487 |
| Relevant diagnoses for this policy: | ICD10 Code: G905, M960, M961, M962, M963, M964, M965, M966, M968, M969, R521, R522 |
| 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

| Introduction | 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, (>1 year) non-specific, degenerative low back pain. |
| Criteria Based Access | 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 one year and is documented as causing significant functional impairment.*
- Conservative treatments, undertaken after assessment by a pain management specialist, have failed.

Note: There are a number of 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.

*Note: significant functional impairment is defined as:

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

| Codes | OPCS Code: V38.2 - 38.6, 39.3 - 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) |
| The ICD10 Codes for low back pain are 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 |
| Date | November 2018 |
### Spinal fusion for chronic non-specific low back pain

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</table>

**Review date** November 2021 or earlier if new guidance is issued.

### Trigger finger

**Introduction**

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 corticosteroid 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 corticosteroid 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 Based Access

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](#).
  - or
- 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:

Urological – Genitary problems

**Artificial urinary sphincters for men with post-prostatectomy incontinence**

**Introduction**

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 options. The AMS 800 device is designed to mimic the two 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 Based Access**

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:

1. 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:

OPCS Code: M642

Relevant diagnoses for this policy:

ICD10 Code: N393
## Assisted conception (includes IVF) *(this policy is currently under review)*

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Infertility is defined as failure to conceive after regular unprotected sexual intercourse for two years in the absence of known reproductive pathology. The treatment of infertility is to assist a couple in conception where such difficulties have been identified. Patients should not be referred to secondary care, outside this time frame, unless there are extenuating reasons. For women over the age of 35, this threshold can be reduced to one year. In the context of limited resources, treatment should be targeted at those with the most need and the greatest chance of success. Up to four cycles of IUI (Intrauterine insemination) and one cycle of IVF (In vitro fertilisation) may be funded per couple, who would be expected to have a &gt;10% chance of live-birth per cycle. All couples must follow the agreed algorithm, not just progress to IVF without going through other stages first, unless clinically indicated. The <a href="#"><em>elective single embryo transfer policy</em></a> and <a href="#"><em>cryopreservation of gametes or embryos policy</em></a> can be found on our website.</th>
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</thead>
</table>
| Criteria | **In vitro fertilisation (IVF) will be commissioned where the clinical criteria are met – as outlined below:**

**Age:** Restricted to women aged between 23 and 40 years: When a woman has reached her 40th birthday she is no longer eligible to access NHS infertility treatment even if she is already on a care pathway.

**Weight:** Men and Women must have a BMI (body mass index) of between 19 and 29.9 for all treatments requiring gonadotrophins: Women with a BMI below 19 or individuals with a BMI above 29.9 should be offered advice and support on increasing or decreasing their weight via their GP.

**Smoking:** Men and Women must have stopped smoking for six months (or use of illicit drugs) before being offered treatments requiring gonadotrophins: Both partners, if necessary, should be strongly encouraged to stop smoking. Self-referral to stop smoking advisors via their GP surgery is recommended. Both partners must be able to declare that they have ceased smoking for at least six months before either partner is offered treatments. If the six months takes them outside the age criteria a clinical decision may be taken to proceed with treatment earlier.

**Previous children:** Restricted to couples with no experience of children living with them, as their place of residency (where children are classed as under 18): The aim of this criterion is to give priority to those couples with limited or no experience of parenting. An adopted child has the same status as a biological child.

**Couple’s relationship:** Restricted to couples in a stable relationship: A stable relationship is defined as two years, to fit with the definition of infertility.

**Previous assisted conception:** Restricted to couples who have had no previous NHS cycles of IVF. |
<table>
<thead>
<tr>
<th>Assisted conception (includes IVF) <em>(this policy is currently under review)</em></th>
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</thead>
</table>
| **Ovarian reserve test or poor cycle response:** Restrict where clinician believes chance of live-birth is <10% per cycle: Preferred test is AMH (anti-mullerian hormone) A result of 5 or under can be used in conjunction with other clinical indicators as an indicator that the **chance of live-birth is <10%**

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

**Rare scenarios in infertility (revised June 2010):** The following procedures are approved for funding in the specified circumstances and where the Access Criteria are met.

**General anaesthetic for egg collection:** A clear medical indication. **Only available at Exeter Unit.**

**Surgical sperm retrieval:** TESA (Testicular sperm aspiration) as clinically indicated – MESA (Microsurgical sperm aspiration) not funded. Not for previous vasectomy.

**Donor insemination:** Severe male factor infertility, Genetic disorder in male, Couple decline ICSI (intracytoplasmic sperm injection). Following IVF egg retrieval when no living sperm produced on day of treatment. The tariff covers transport of sperm; and storage for the NHS funded cycle only.

**Cryopreservation for abandoned cycles:** If treatment is abandoned after oocyte retrieval and the embryos cannot be replaced. Storage for up to one year and replacement of frozen embryos for the one funded NHS cycle.

**GnRH pump:** Congenital absence of GnRH (Gonadotropin releasing hormone).

**Receiving egg donation:** Premature menopause – that is menopause before the age of 40, defined as no natural menarche for two years. Genetic disorder in female. Previous chemotherapy or radiotherapy for cancer.

**Egg donors:** Must meet HFEA (Human fertilisation and embryology authority) criteria. Altruistic donation. Egg sharing as long as the NHS does not subsidise treatment for the donor beyond that which is required for treatment of the recipient.

**Abandoned IVF or ICSI cycle:** One further NHS cycle to be funded if greater than 10 per cent chance of success where the cycle has been abandoned prior to egg retrieval or cryopreserved replacement. This includes where the cycle was abandoned due to hyperstimulation. One cycle of ICSI where there is failed fertilisation in IVF and ISCI would be expected to resolve this.

**Abandoned IUI cycle:** One further NHS cycle to be funded if greater than 10 per cent chance of success.
### Assisted conception (includes IVF) *(this policy is currently under review)*

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

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td>OPCS Code: Y961, Y962, Y963, Y964, Y965, Y966, Y968, Y969</td>
<td>Relevant diagnoses for this policy:</td>
</tr>
<tr>
<td>ICD10 Code: O028, O029</td>
<td>Diagnoses for which the above procedures are permitted:</td>
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<tr>
<td></td>
<td>ICD10 Codes: No appropriate ICD10 Codes for the clinical criteria.</td>
</tr>
</tbody>
</table>

| Date approved | November 2016 |
| Revised version approved | March 2019 - review date extension approved only |
| Revised version approved | July 2019 - further review date extension approved only |

| Review date | November 2018 or earlier if new guidance is issued |
| June 2019 | September 2019 |

| JCIA | Yes - completed |
Cryopreservation (this policy is currently under review)

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Patients undergoing treatments such as chemotherapy for cancer or radical surgery may be made sterile by such treatments. Where there is a significant likelihood of making a patient permanently infertile as an unwanted effect of treatment, those patients will be eligible for NHS funded cryopreservation, provided they do not fall into one of the groups detailed in the criteria described below. This may be done by banking gametes (eggs or sperm), or embryos if they have a partner, prior to treatment. If the patient survives treatment these may be used to assist conception.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria Based Access</td>
<td>Where the following eligibility criteria are met, NHS funding will be available for an initial period of a maximum of 5 years storage, with the possibility to renew for a further period if the gametes have not been used within that time, by an application to NHS Kernow. Funding renewal would not normally be agreed after the age of 40 for women and after the age of 60 for men unless exceptional circumstances applied.</td>
</tr>
<tr>
<td>Previous children: Restricted to individuals with no children living with them or no experience of parenting</td>
<td>The aim of this criterion is to give priority to individuals with limited or no experience of parenting. An adopted child has the same status as an individual's biological child.</td>
</tr>
<tr>
<td>Age: Restricted to women under the age of 40 years and men under the age of 60 years</td>
<td>There is clinical evidence which demonstrates that a women’s fertility falls with age, and that chromosomal abnormality increases with age in men. There is no lower age limit applied in this policy.</td>
</tr>
<tr>
<td>Chance of success</td>
<td>Cryopreservation to be offered only where clinician believes chance of live-birth is greater than 10% per cycle. However, if there is insufficient time to make this assessment, it would be assumed that this criterion is met.</td>
</tr>
<tr>
<td>Previous sterilisation</td>
<td>Cryopreservation will not be funded where one or both partners have previously been sterilised.</td>
</tr>
<tr>
<td>Previous Assisted Conception</td>
<td>Access to NHS funded cryopreservation will not be affected by previous attempts at Assisted Conception.</td>
</tr>
<tr>
<td>Transgender patients</td>
<td>Cryopreservation will not be funded for patients on a transgender pathway. Once an individual is fit and able to proceed with Assisted Conception using their frozen gametes or embryo, they must then meet the eligibility criteria for Assisted Conception in force at that time. The funding of cryopreservation does not automatically entitle people to funding for Assisted Conception.</td>
</tr>
</tbody>
</table>

Codes: Procedures challenged in this policy:
### Cryopreservation (this policy is currently under review)

| OPCS Code: No specific codes for Cryopreservation | Relevant diagnoses for this policy: F640, F641, F642, F648, F649, Z302, Z312, Z313 |
| Date approved: April 2018 | Review date: April 2020 or earlier if new guidance is issued. | JCIA: Yes - completed |

### Dilatation and curettage for menorrhagia

**Introduction**

Dilatation and curettage (D&C) is a common gynaecological operation performed for both diagnostic and therapeutic purposes for a range of conditions including menorrhagia.

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

**Criteria Based Access**

Dilatation of cervix uteri and curettage of uterus for the investigation or management of menorrhagia 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:

- Molar pregnancy.
- Failed endometrial preparation for re-section.

**Codes**

Procedures challenged in this policy: OPCS Code: Q103, Q108, Q109

Relevant diagnoses for this policy:

ICD10 Code: None

Diagnoses for which the above procedures are permitted:

ICD10 Codes: No appropriate ICD10 Codes for the clinical criteria.

| Date approved: August 2017 | Review date: August 2019 or earlier if new guidance is issued | JCIA: Yes - completed |

### Elective caesarean section for non-clinical reasons

**Introduction**

Elective caesarean section for non-clinical reasons is a low priority and will not normally be funded by the CCG. Maternal request is not on its own an indication for caesarean section. Intervention is approved according to criteria established in the guidelines issued jointly by NICE and the National Collaborating Centre for Women and Children’s Health.

**Criteria**

**Elective caesarean section for non-clinical reasons is not routinely commissioned.**

**Codes**

Procedures challenged in this policy:

OPCS Codes: R171, R172, R178, R179

Relevant diagnoses for this policy:

ICD10 Code: N92, N920, N921, N922, N923, N924, N925, N926, N927, N928, N929

Diagnoses for which the above procedures are permitted:
**Elective caesarean section for non-clinical reasons**

<table>
<thead>
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<tbody>
<tr>
<td>Date approved</td>
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<tr>
<td>Review date</td>
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<tr>
<td>JCIA</td>
</tr>
</tbody>
</table>

**Elective single embryo transfer in the treatment of infertility (this policy is currently under review)**

**Introduction**

Elective single embryo transfer is successful in reducing the rates of multiple births from IVF treatment. By combining one cycle of elective single embryo transfer with one cycle of frozen embryo transfer the live birth rate is similar to one cycle of double embryo transfer.

**Criteria Based Access**

Elective single embryo transfer in the treatment of infertility 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:

- All women under 35 years of age at embryo transfer who have five or more top quality embryos are required to have no more than one fresh embryo replaced in their NHS funded cycle.
- For couples undergoing this treatment the NHS would fund freezing and storage of spare embryos for up to one year.
- If the single fresh embryo cycle is unsuccessful the woman can be offered a further cycle where no more than two frozen embryos are replaced. If the double frozen embryo cycle is unsuccessful no further cycles will be funded.
- In cases where it is considered extremely important for the woman not to risk a multiple pregnancy at the clinician’s judgement the woman can be offered a single frozen embryo rather than the double embryo. Where a single frozen embryo is chosen, if that is also unsuccessful a further single frozen embryo is funded. If this single frozen embryo transfer cycle is unsuccessful no further cycles will be funded.
- In the unlikely event that None of the frozen embryos survives the thawing, a further funded cycle of single fresh embryo transfer will be funded.
- Couples wishing to continue to store embryos beyond one year would be required to fund the storage themselves.
- Elective single embryo transfer must be offered to all women under 35 years of age at time of embryo transfer with five top quality embryos and may be offered to women aged 35-40 years of age at the clinician’s discretion.
- Clinicians should audit the outcomes from this policy.
- Once a woman has had a successful pregnancy she will not be eligible for any further NHS treatment i.e. if the single fresh embryo transfer is successful she may not have further NHS funded single or double embryo transfer, although...
**Elective single embryo transfer in the treatment of infertility (this policy is currently under review)**

- she may use the NHS frozen embryos for subsequent self-funded storage and treatment.

### Codes

<table>
<thead>
<tr>
<th>Procedures challenged in this policy:</th>
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<tbody>
<tr>
<td>OPCS Code: No specific codes to indicate single embryo transfer</td>
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<table>
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<tr>
<th>Relevant diagnoses for this policy:</th>
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</thead>
<tbody>
<tr>
<td>ICD10 Code: N970, N971, N972, N973, N974, N978, N979</td>
</tr>
</tbody>
</table>

### Date approved

- April 2018

### Review date

- April 2020 or earlier if new guidance is issued.

### JCIA

- Yes - completed

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**Female sterilisation**

### Introduction

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

### Criteria

**Based on Access**

Female sterilisation should only be carried out as a stand-alone procedure or during a caesarean section in women who meet all of the following criteria and this has been documented by the referring or treating clinician. The referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- The woman understands 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. 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.
- She understands that vasectomy in the partner is a valid alternative option.
- She has received counselling about all other forms of contraceptives and has undergone a trial of long-acting contraceptives or she has declined a trial of long-acting reversible contraception after counselling.
- She understands that she will be required to avoid sex or use effective contraception until the menstrual period following the operation and that sterilisation does not prevent against the risk of sexually transmitted infections.

Female sterilisation could also be considered in women who have a medical condition making pregnancy dangerous.

### Codes

<table>
<thead>
<tr>
<th>Procedures challenged in this policy:</th>
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</thead>
<tbody>
<tr>
<td>OPCS Code: Q271, Q272, Q278, Q279, Q281, Q282, Q283, Q284, Q288, Q289, Q351, Q352, Q353, Q358, Q359, Q361, Q362, Q368, Q369, Q354</td>
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<table>
<thead>
<tr>
<th>Relevant diagnoses for this policy:</th>
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<tbody>
<tr>
<td>ICD10 Code: Z302,Diagnoses for which the above procedures are permitted:</td>
</tr>
<tr>
<td>ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria.</td>
</tr>
</tbody>
</table>

### Date approved

- August 2017

### Review date

- August 2019 or earlier if new guidance is issued
**Hydroceles in males**

**Introduction**
Hydroceles (fluid collection around the testicles) may be present at birth and are common, affecting around one male baby in every 10. They do not usually require treatment as they often disappear on their own during the first two 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 e.g. 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 two 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 two 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:

Relevant diagnoses for this policy:
ICD10 Code: N430, N431, N432, N433, N434, P835

**Date approved**
April 2018

**Review date**
April 2020 or earlier if new guidance is issued.

**JCIA**
Yes - completed

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<table>
<thead>
<tr>
<th>Female sterilisation</th>
<th>JCIA</th>
<th>Yes - completed</th>
</tr>
</thead>
</table>

Commissioning policies 2019/20 | Page 59 of 104
Hysterectomy +/- Oophrectomy

Introduction
Hysterectomy is an effective procedure for treatment of heavy menstrual bleeding (menorrhagia), but is associated with more complications compared to treatment with progestogens and should not be used as a first-line treatment.

Criteria Based Access
Hysterectomy +/- oophrectomy for non-cancerous heavy menstrual bleeding is commissioned where patients meet the criteria below, the referral letter and patient's medical record need to clearly evidence how these criteria are met:

- A prior trial with a levonorgestrel intrauterine system e.g. Mirena® (unless contraindicated), has failed to relieve symptoms.
- Other less invasive treatment options have been tried for a minimum of three months and documented to have failed (e.g. non-steroidal anti-inflammatory agents, tranexamic acid, endometrial ablation, uterine-artery embolization, hormonal therapies), or are not appropriate or are contraindicated.

Codes
Procedures challenged in this policy:
OPCS Codes for hysterectomy: Q07, Q070, Q071, Q072, Q073, Q074, Q075, Q076, Q077, Q078, Q079, Q08, Q080, Q081, Q082, Q083, Q084, Q085, Q086, Q087, Q088, Q089
Relevant diagnoses for this policy:
ICD10 Code: None
Diagnoses for which the above procedures are permitted:
ICD10 Code: C54, C54X, C540, C55, C55X, C550, C56, C56X, C560, C57, C57X, C570, C58, C58X, C580, D25, D25X, D250 (with failure of conservative treatment); N80, N80X, N800 (with failure of conservative management); N92, N920, N921, N922, N924, N923, N925, N926 (with failure of conservative management) Audit required to determine failure of conservative treatments.

Date approved
November 2016
February 2019

Review date
February 2022 or earlier if new guidance is issued

JCIA
Yes - completed

Male sterilisation (vasectomy)

Introduction
Sterilisation is a procedure that permanently removes an individual's fertility. Sterilisation that can be carried out for a male is known as vasectomy.

Criteria Based Access
GP based vasectomies under local anaesthetic:
GP Based local anaesthetic vasectomy for male sterilisation is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how these criteria are met:

- Their partner/spouse is not currently pregnant.
- They understand the procedure should be considered irreversible.
- The patient has been advised that reversal would not be funded by the CCG.
- They are able to have the procedure carried out under local anaesthetic.

Secondary care based vasectomies under general anaesthetic:
Vasectomies performed under general anaesthetic is commissioned where patients...
### Male sterilisation (vasectomy)

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.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
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<tbody>
<tr>
<td></td>
<td>OPCS Code: N171, N172, N178, N179</td>
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</table>

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<tbody>
<tr>
<td>ICD10 Code: None</td>
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</table>

<table>
<thead>
<tr>
<th>Diagnoses for which the above procedures are permitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria.</td>
</tr>
</tbody>
</table>

**Date approved**: August 2017

**Review date**: August 2019 or earlier if new guidance is issued

**JCIA**: Yes - completed

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### Mirena coils

**Introduction**: The IUS (intrauterine system) is a long-acting reversible contraceptive (LARC) method. It works for five years and is a small, T-shaped plastic device that is inserted into the womb (uterus) by a specially trained doctor or nurse. The brand name of the IUS used in the UK is Mirena.

**Criteria Based Access**: Referrals should not be made for the routine fitting of Mirena as this should normally be offered in primary care. Exceptions are where fitting or removal has failed or where there are issues specific to an individual patient that require secondary care insertion. For example, during termination of pregnancy, or as part of an operative procedure such as hysteroscopy.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
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<tbody>
<tr>
<td></td>
<td>OPCS Code: P315, Q121, Q122, Q123, Q124, Q128, Q129</td>
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<th>Relevant diagnoses for this policy:</th>
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<tr>
<td>ICD10 Code: Z301, Z305</td>
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<table>
<thead>
<tr>
<th>Diagnoses for which the above procedures are permitted:</th>
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</thead>
<tbody>
<tr>
<td>ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria.</td>
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</tbody>
</table>

**Date approved**: August 2017

**Review date**: August 2019 or earlier if new guidance is issued

**JCIA**: Yes - completed
### Percutaneous tibial nerve stimulation for urinary incontinence

**Introduction**

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:
  - OPCS Code: No specific code for percutaneous tibial nerve stimulation
  - Relevant diagnoses for this policy:
    - ICD10 Code: N393, N394, R32X

**Date approved**

April 2018

**Review date**

April 2020 or earlier if new guidance is issued.

**JCIA**

Yes - completed

### Reversal of female sterilisation

**Introduction**

Reversal of sterilisation is a surgical procedure that involves the reconstruction of the fallopian tubes.

Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled (in accordance with RCOG guidelines) that the procedure is intended to be permanent.

**Criteria**

Reversal of female sterilisation is not routinely commissioned.

**Codes**

- Procedures challenged in this policy:
  - OPCS Code: Q291, Q292, Q293, Q294, Q295, Q296, Q297, Q298, Q299, Q30, Q300, Q301, Q302, Q303, Q308, Q309, Q371, Q378, Q379
  - Relevant diagnoses for this policy:
    - ICD10 Code: Z310, Z31
  - Diagnoses for which the above procedures are permitted:
    - ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria.

**Date approved**

August 2016

**Review date**

Revised version approved November 2018

**JCIA**

Yes - completed

### Reversal of male sterilisation

**Introduction**

Reversal of male sterilisation is a surgical procedure that involves the reconstruction of the *vas deferens*. Sterilisation procedures are available on the NHS and couples seeking sterilisation should be fully advised and counselled that the procedure is intended to be permanent.

**Criteria**

Reversal of male sterilisation is not routinely commissioned.

**Codes**

- Procedures challenged in this policy:
  - OPCS Code: N181, N182, N188, N189
  - Relevant diagnoses for this policy:
    - Z310
  - Diagnoses for which the above procedures are permitted:
### Reversal of male sterilisation

<table>
<thead>
<tr>
<th>Date approved</th>
<th>August 2016</th>
</tr>
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<tbody>
<tr>
<td>Revised version</td>
<td>November 2018</td>
</tr>
<tr>
<td>Review date</td>
<td>November 2021 or earlier if new guidance is issued</td>
</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>

ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria.

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### Routine doppler ultrasound of umbilical + uterine artery in antenatal care

**Introduction**

Routine Doppler Ultrasound Of Umbilical + Uterine Artery In Antenatal Care

**Criteria**

Routine doppler ultrasound of umbilical and uterine arteries for low risk pregnancies is not routinely commissioned.

**Codes**

- Procedures challenged in this policy:
  - OPCS Code: R421, R422
- Relevant diagnoses for this policy:
  - ICD10 Code for high-risk pregnancy is Z35
- Diagnoses for which the above procedures are permitted:
  - ICD10 Code: There are no relevant ICD10 Codes for the clinical criteria.

<table>
<thead>
<tr>
<th>Date approved</th>
<th>August 2017</th>
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<tbody>
<tr>
<td>Review date</td>
<td>August 2019 or earlier if new guidance is issued</td>
</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>

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### Sperm washing

**Introduction**

Sperm washing

**Criteria Based Access**

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:

- One 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/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.
- In order 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

Patients not included in these criteria are:
- 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:
OPCS Code: There are no appropriate OPCS Codes
Relevant diagnoses for this policy:

Date approved
April 2018

Review date
April 2020 or earlier if new guidance is issued.

JCIA
Yes - completed

Testicular prosthesis

Introduction
A testicular prosthesis is a replica testicle made out of 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 tests, 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:
OPCS Code: N051, N052, N053, N061, N063, N066, N101, N102, N108, N109
Relevant diagnoses for this policy:
ICD10 Code: C620, C621, C629, N44X, N500, Q530, Q531, Q532, Q539, Q550

Date approved
April 2018

Review date
April 2020 or earlier if new guidance is issued.

JCIA
Yes - completed

Eye problems

Cataract surgery

Introduction
Since the level of visual acuity that an individual requires to function without altering their lifestyle varies, measurements of visual acuity do not necessarily reflect the degree of visual disability that patients may experience as a result of cataracts. The criteria set out below attempt to explicitly take that into account.

The legal visual requirement for driving falls somewhere between 6/9 and 6/12 (strictly speaking it is based on the number plate test) and it is anticipated that the thresholds set out below will not render the majority of people unable to drive. This policy also recognises the increasing body of evidence that second eye surgery
## Cataract surgery

<table>
<thead>
<tr>
<th>Criteria Based Access</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A best corrected visual acuity of better than 6/12 in the affected eye, will not normally be funded.</td>
</tr>
<tr>
<td></td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• Patients with a best corrected visual acuity of 6/12 or worse in the affected eye (please ensure best corrected visual acuity information included with referral).</td>
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<td>• Patients that have difficulty in carrying out their employment duties due to a need for good acuity.</td>
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<tr>
<td></td>
<td>• Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions.</td>
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<tr>
<td></td>
<td>• Patients who need to drive at night who experience significant glare due to cataracts which affects driving.</td>
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<td></td>
<td>• Patients who have difficulty with reading, or recognising faces, due to lens opacities.</td>
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<td></td>
<td>• Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field.</td>
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<td>• Patients with significant optical imbalance (anisometropia or aniseikonia) following cataract surgery on the first eye.</td>
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<td>• Patients with glaucoma who require cataract surgery to control intra ocular pressure.</td>
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<td>• Patient with diabetes who require clear views of their retina to look for retinopathy.</td>
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<td></td>
<td>• Patients with wet macular degeneration or other retinal conditions who require clear views of their retina to monitor their disease or treatment (e.g. treatment with anti-VEGFs).</td>
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</table>

**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
Cataract surgery

surgery, or any other exceptional circumstances, must be clearly documented in the clinical records.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
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<tr>
<td></td>
<td>OPCS Code: 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</td>
</tr>
</tbody>
</table>

Relevant diagnoses for this policy:
The ICD10 Codes for cataracts are H25, H250, H26, H260, H280, H281, H282, Q120

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

Date approved August 2017
Revised version approved March 2018
Review date March 2020 or earlier if new guidance is issued
JCIA Yes - completed

Laser surgery for short sight (Myopia)

Introduction Current evidence suggests that photorefractive (laser) surgery for the correction of refractive errors is safe and efficacious in appropriately selected patients. However there are alternative methods of correction such as spectacles and contact lenses.

Criteria Laser surgery for correction of short sight is not routinely commissioned.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPCS Code: C442, C444, C445, C461</td>
</tr>
</tbody>
</table>

Relevant diagnoses for this policy:
The ICD10 Code for short sightedness (high myopia) is H521

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

Date approved August 2016
Revised version 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

Introduction Multifocal intraocular lenses in treatment of adults with cataracts

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.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
</tr>
</thead>
</table>
Multifocal intraocular lenses in treatment of adults with cataracts

OPCS Code: C751, C754, C758, C759
Relevant diagnoses for this policy:

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

Raised intraocular pressure

Introduction
Raised intraocular pressure.

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

Criteria Based Access

**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).
- If a patient’s IOP is measured by a community optometrist at 32 mmHg or over with 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/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:
OPCS Code: No appropriate OPCS codes, this is a diagnostic
Relevant diagnoses for this policy:
ICD10 Code: There are no appropriate ICD10 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**

| Introduction | Strabismus (including Estropia, Exotropia, Hypertropia or Hypotropia)  
|--------------|--------------------------------------------------------------------------|
|              | “Strabismus, or squint means a misalignment of the two 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 one 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 (e.g. 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 Based Access | 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. |

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Commissioning policies 2019/20 | Page 68 of 104
### Surgical correction of strabismus or amblyopia in adults

2. All appropriate conservative methods have been exhausted and have failed to resolve the diplopia (note – patients suffering from intractable diplopia are considered to be 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:  
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPCS Code: C351, C352, C353, C358, C359</td>
</tr>
<tr>
<td></td>
<td>Relevant diagnoses for this policy:</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date approved</th>
<th>April 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review date</td>
<td>April 2020 or earlier if new guidance is issued.</td>
</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>
## Vitreous floaters

### Introduction
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 one or two 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 osme 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:
OPCS Code: C791, C792, C793, C794, C797, C798, C799
Relevant diagnoses for this policy:
ICD10 Code: H43, H432, H433, H438, H439, H430, H45, H450, H458, Q140

### Date
- approved April 2018
- 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 considered to be within the normal morphological range will be considered as purely cosmetic and therefore not funded on the NHS and referrals from GPs for these reasons will not be accepted.

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

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

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

### Abdominoplasty or apronectomy

<table>
<thead>
<tr>
<th>Introduction</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Abdominoplasty and apronectomy are not routinely commissioned.</strong></td>
</tr>
<tr>
<td>Codes</td>
<td>Procedures challenged in this policy: OPCS Code: S021, S022, S028, S029 Relevant diagnoses for 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.</td>
</tr>
<tr>
<td>Date approved</td>
<td>August 2016 Revised version approved November 2018</td>
</tr>
<tr>
<td>Review date</td>
<td>November 2021 or earlier if new guidance is issued</td>
</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>
**Annual MRI breast screening**

<table>
<thead>
<tr>
<th>Criteria Based Access</th>
<th><strong>Annual MRI breast screening</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>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:</td>
</tr>
<tr>
<td><strong>MRI scans are not normally offered to patients before their 20th Birthday.</strong></td>
<td></td>
</tr>
<tr>
<td><strong>MRI surveillance should be considered for the following women with no personal history of breast cancer.</strong></td>
<td></td>
</tr>
<tr>
<td>Patients aged 20 to 29.</td>
<td></td>
</tr>
<tr>
<td>MRI scans are available for those at exceptionally high risk, for example:</td>
<td></td>
</tr>
<tr>
<td>• Women with a known TP53 mutation.</td>
<td></td>
</tr>
<tr>
<td>• Women who have not been tested but have a greater than 30% probability of carrying a TP53 mutation.</td>
<td></td>
</tr>
<tr>
<td>Patients aged 30 to 49:</td>
<td></td>
</tr>
<tr>
<td>• Women with a known TP53 mutation.</td>
<td></td>
</tr>
<tr>
<td>• Women who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier.</td>
<td></td>
</tr>
<tr>
<td>• Women with a known BRCA1 or BRCA2 mutation.</td>
<td></td>
</tr>
<tr>
<td>• Women who have not had a genetic test but have a greater than 30% probability of being a BRCA carrier.</td>
<td></td>
</tr>
<tr>
<td>Patients Aged 50-69:</td>
<td></td>
</tr>
<tr>
<td>• Women with a known TP53 mutation.</td>
<td></td>
</tr>
<tr>
<td>• Women with a known BRCA1 or BRCA2 mutation AND have dense breast pattern on mammography.</td>
<td></td>
</tr>
<tr>
<td>• 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.</td>
<td></td>
</tr>
<tr>
<td>Aged 70 and above: Not normally offered.</td>
<td></td>
</tr>
<tr>
<td>MRI surveillance should be considered for the following women with a personal history and family history of breast cancer.</td>
<td></td>
</tr>
<tr>
<td>Aged 20-29:</td>
<td></td>
</tr>
<tr>
<td>• Women with a known TP53 mutation.</td>
<td></td>
</tr>
<tr>
<td>• Women who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier.</td>
<td></td>
</tr>
<tr>
<td>Aged 30-49:</td>
<td></td>
</tr>
<tr>
<td>• Women at high risk of breast cancer*.</td>
<td></td>
</tr>
</tbody>
</table>

*Women with a known BRCA1, BRCA 2 and/or TP53 mutations or greater than 30% probability of being carriers. Rare conditions that carry and increased risk of
Annual MRI breast screening

<table>
<thead>
<tr>
<th>Aged 50-69:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Women with a dense breast pattern on mammography.</td>
</tr>
<tr>
<td>• Women with a known TP53 mutation.</td>
</tr>
<tr>
<td>• Women who have not had a genetic test but have a greater than 30% probability of being a TP53 carrier.</td>
</tr>
</tbody>
</table>

Aged 70 and above: Not normally offered.

Codes

- Procedures challenged in this policy: There are no appropriate OPCS Codes
- Relevant diagnoses for this policy: ICD10 Code: Z803

Date Approved

- April 2018

Review date

- April 2020 or earlier if new guidance is issued.

JCIA

- Yes - completed

Benign skin lesions

Introduction

Benign skin lesions include a wide range of skin disorders such as (this list is not exhaustive):

- Benign pigmented melanocytic naevi (moles).
- Dermatofibromas (skin growths).
- Lipomata (fat deposits underneath the skin).
- Molluscum Contagiosum.
- Port wine stains.
- Post acne scarring.
- ‘Sebaceous’ cysts (pilar and epidermoid cysts); (patients with multiple subcutaneous lipomata may need a biopsy to exclude neurofibromatosis):
  - Sebaceous cysts (a collection of sebum) are rarely truly infected.
  - In lesions with evidence of persistent or recurrent infection, the removal of the lesion may be undertaken as an exception to the decision not to fund the removal of benign lesions.
- Seborrheic keratoses (benign skin growths, basal cell papillomas, warts).
- Skin tags.
- Spider naevi.
- Telangectasia.
- Thread veins.
- Warts and Plantar warts; (genital and anal warts are excluded).
- Xanthelasmas (cholesterol deposits underneath the skin).
- Anal skin tags.

The removal of a benign skin lesion, wherever it appears on the body, is regarded as a procedure of low clinical priority. Surgery to improve appearance alone is not
## Benign skin lesions

<table>
<thead>
<tr>
<th>Criteria</th>
<th>Removal of benign skin lesions is not routinely commissioned.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Codes</td>
<td>Procedures challenged in this policy:</td>
</tr>
<tr>
<td>Date approved</td>
<td>August 2017</td>
</tr>
<tr>
<td>Review date</td>
<td>August 2019 or earlier if new guidance is issued</td>
</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>

## Blepharoplasty

<table>
<thead>
<tr>
<th>Introduction</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria Based Access</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• 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).</td>
</tr>
<tr>
<td></td>
<td>• Correction of ectropion or entropion with ocular irritation and causing functional implications (evidence of functional implications must be supplied with the referral documentation).</td>
</tr>
<tr>
<td>Codes</td>
<td>Procedures challenged in this policy:</td>
</tr>
<tr>
<td></td>
<td>OPCS Code: C131, C132, C133, C134, C138, C139, C161, C162, C163, C164, C165, C168, C169</td>
</tr>
<tr>
<td>Relevant diagnoses for this policy:</td>
<td>ICD10 Code: None</td>
</tr>
<tr>
<td>Diagnoses for which the above procedures are permitted:</td>
<td>C792</td>
</tr>
</tbody>
</table>
### Blepharoplasty

<table>
<thead>
<tr>
<th>ICD10 Code</th>
<th>There are no appropriate ICD10 Codes for the clinical criteria.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date</td>
<td>February 2019</td>
</tr>
<tr>
<td>Approved</td>
<td>February 2019</td>
</tr>
<tr>
<td>Review date</td>
<td>February 2022 or earlier if new guidance is issued</td>
</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>

### Botox injection for the ageing face

**Introduction**

Botox injection for the ageing face.

**Criteria**

Botox Injection for the ageing face is not routinely commissioned.

**Codes**

- Procedures challenged in this policy:
  - OPCS Code: X851 with Z601
  - Relevant diagnoses for 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.

**Date approved**

- August 2016
- Revised version approved November 2018

**Review date**

- November 2021 or earlier if new guidance is issued

**JCIA**

- Yes - completed

### Breast asymmetry

**Introduction**

Breast asymmetry.

**Criteria**

Cosmetic breast surgery is not routinely commissioned. Exclusions: This policy does not cover breast reconstruction following surgery for breast cancer. Clinicians are not required to seek prior approval in these circumstances.

**Codes**

- Procedures challenged in this policy:
  - OPCS Code: B301, B302, B304, B308, B309, B312, B314, B375
  - Relevant diagnoses for this policy:
    - ICD10 Code: None
  - Diagnoses for which the above procedures are permitted:
    - ICD10 Code: C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C509D, Z853

**Date approved**

- August 2016
- Revised version approved November 2018

**Review date**

- November 2021 or earlier if new guidance is issued

**JCIA**

- Yes - completed

### Breast augmentation

**Introduction**

Breast augmentation/enlargement is the most popular cosmetic procedure. It involves inserting artificial implants behind the normal breast tissue to improve its size and shape.

**Criteria**

Cosmetic breast augmentation/enlargement is not routinely commissioned.

**Codes**

- Procedures challenged in this policy:
  - OPCS Code: B301, B302, B304, B308, B309, B312, B314, B375
  - Relevant diagnoses for this policy:
Breast augmentation

ICD10 Code: None
Diagnoses for which the above procedures are permitted:
ICD10 Code: C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C590D, Z853

Date approved: August 2016
Revised version approved: November 2018
Review date: November 2021 or earlier if new guidance is issued
JCIA: Yes - completed

Breast lift (mastopexy)

Introduction
This is included as part of the treatment of breast asymmetry but will not be available for purely cosmetic reasons, for example post lactation or age related breast ptosis (drooping).

Mastopexy refers to the surgical correction of breasts that sag or droop. This can occur as part of the natural aging process, or pregnancy, lactation and substantial weight loss.

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:
OPCS Code: B313, B314, (B314 is also included in Breast Asymmetry/Breast Augmentation above)
Relevant diagnoses for 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.

Date approved: August 2016
Revised version approved: November 2018
Review date: November 2021 or earlier if new guidance is issued
JCIA: Yes - completed

Breast reduction

Introduction
Excessively large breasts can cause physical and psychological problems. Breast reduction procedures involve removing excess breast tissue to reduce size and improve shape.

Criteria
Breast reduction is not routinely commissioned.

Codes
Procedures challenged in this policy:
OPCS Code: B311, B303
Relevant diagnoses for this policy:
ICD10 Code: None
Diagnoses for which the above procedures are permitted:
ICD10 Code: C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C590D, Z853

Date: August 2016
**Breast reduction**

<table>
<thead>
<tr>
<th>approved</th>
<th>Revised version approved November 2018</th>
</tr>
</thead>
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<tr>
<td>Review date</td>
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</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>

**Closure of patent foramen ovale for migraine**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>The foramen ovale is hole in the wall that divides the two 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/blocking the hole in the wall of the heart.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Closure of patent foramen ovale for migraine is not routinely commissioned.</strong> 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.</td>
</tr>
<tr>
<td>Codes</td>
<td>Procedures challenged in this policy: OPCS Code: K165 Relevant diagnoses for this policy: ICD10 Code: G430, G431, G432, G433, G438, G439</td>
</tr>
<tr>
<td>Date approved</td>
<td>April 2018</td>
</tr>
<tr>
<td>Review date</td>
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</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
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</table>

**Congenital vascular lesions**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Congenital vascular lesions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Laser treatment for congenital vascular lesions is not routinely commissioned.</strong></td>
</tr>
<tr>
<td>Codes</td>
<td>Procedures challenged in this policy: OPCS Code: None Relevant diagnoses for 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.</td>
</tr>
<tr>
<td>Date approved</td>
<td>August 2016 Revised version approved November 2018</td>
</tr>
<tr>
<td>Review date</td>
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</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>
Cosmetic genital procedures

Introduction

Cosmetic genital procedures are not routinely commissioned.

Criteria

Procedures challenged in this policy:
OPCS Code: P055, P056, P057

Relevant diagnoses for 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.

Date approved

August 2016
Revised version approved November 2018
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

Densensitizing light therapy in the management of severe polymorphic light eruption

Introduction

Polymorphic light eruption [PMLE] is a fairly common skin rash trigged by exposure to sunlight or artificial ultraviolet (UV) light. An itchy or burning rash appears within hours, or up to two to three days after exposure to sunlight. It lasts for up to two 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 10-15% of the UK population (NHS Choices, 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 densensitizing 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.
   and
2. A consultant dermatologist assessment considers light therapy likely to significantly improve the impact of the patient’s PMLE.
   and
3. The patient's PMLE is judged ‘severe’: i.e. the patient has recurrent, extensive, itchy rash for most of the UK summer.
   and
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
Densensitizing light therapy in the management of severe polymorphic light eruption

sunlight without relief.

and

5. The patient has tried recommended drug therapies for PMLE.
   *Please include a detailed history of this treatment within this application.
   and

6. Symptoms from PMLE rash are causing significant functional impairment*.

*Note: significant functional impairment is defined as:
- A restriction of 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.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPCS Code: S121, S122, S123, S124</td>
</tr>
<tr>
<td></td>
<td>ICD10 Code: L564</td>
</tr>
</tbody>
</table>

Date approved: April 2018
Revised version approved November 2018 – significant functional impairment definition amended only

Review date: April 2020 or earlier if new guidance is issued.

JCIA: Yes - completed

Dermatology - acne and psoriasis

Introduction: Dermatology – acne and psoriasis.

Criteria: Acne – pulse-dye laser treatment – is not routinely commissioned.

Psoriasis – care pathway for the use of Fumaderm – criteria based access.

Commissioned for the treatment of severe psoriasis for patients who are resistant to or have contra-indications to the standard treatments.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>OPCS Code: S071, S072, S078, S079</td>
</tr>
</tbody>
</table>

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

JCIA: Yes - completed
### Epididymal cysts

**Introduction**
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 Based Access**
If there is any uncertainty whether the cyst may be malignant in nature, refer the patient via the two 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.
  and
- The cyst is putting pressure on other structures in the testes.
  or
- There is documented clinical evidence that the cyst has been continuously present for more than six months.
  and
- The cyst is causing significant functional impairment*.

*Note: significant functional impairment is defined as:
- A restriction of 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: OPCS Code: N153
- Relevant diagnoses for this policy: ICD10 Code: D292

**Date approved**
- April 2018
- Revised version approved November 2018 – significant functional impairment definition amended only

**Review date**
- April 2020 or earlier if new guidance is issued.

**JCIA**
- Yes - completed

---

### Face lift or brow lift

**Introduction**
These surgical procedures are performed to lift the loose skin of face and forehead to get a firm and smoother appearance of the face.

**Criteria**
**Cosmetic face lift or brow lift are not routinely commissioned.**

**Codes**
- Procedures challenged in this policy: OPCS Code: S011, S012, S013, S014, S015, S016, S018, S019
- Relevant diagnoses for this policy: ICD10 Code: None
## Face lift or brow lift

<table>
<thead>
<tr>
<th>Diagnoses for which the above procedures are permitted:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ICD10 Code Q183, Q189, Q670, Q671, Q672, Q673, Q674, G51, G51X, G510, Q828, Q85, Q85X, Q850</td>
</tr>
</tbody>
</table>

**Date approved**
- August 2016
- Revised version approved November 2018

**Review date**
- November 2021 or earlier if new guidance is issued

**JCIA**
- Yes - completed

## Hair depilation (hair removal)

**Introduction**
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:
- OPCS Code: S606, S607 or S608 with Y089

Relevant diagnoses for this policy:
- ICD10 Codes: L68, L68X, L680, Q842

Diagnoses for which the above procedures are permitted:
- ICD10 Code: 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
- Revised version approved November 2018

**Review date**
- November 2021 or earlier if new guidance is issued

**JCIA**
- Yes - completed

## Hair grafting - male pattern baldness

**Introduction**
Male pattern baldness is a common type of hair loss and for many men it is a normal process at whatever age it occurs. Almost all men have some baldness in their 60s. Hair grafting is mostly done for aesthetic reasons.

**Criteria**
Hair grafting for male pattern baldness is not routinely commissioned.

**Codes**
Procedures challenged in this policy:

Relevant diagnoses for this policy:
- The ICD10 Codes for male pattern baldness are L648, L649

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

**Date approved**
- August 2016
- Revised version approved November 2018

**Review date**
- November 2021 or earlier if new guidance is issued

**JCIA**
- Yes - completed

## Hymenorrhaphy

**Introduction**
Hymenorrhaphy

**Criteria**
Hymenorrhaphy, or hymen reconstruction surgery, is a cosmetic procedure
### Hymenorrhaphy

<table>
<thead>
<tr>
<th>and is not routinely commissioned.</th>
</tr>
</thead>
</table>

#### Codes
- Procedures challenged in this policy:
  - OPCS Code: None
- Relevant diagnoses for 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.

#### Date approved
- August 2016
- Revised version approved November 2018

#### Review date
- November 2021 or earlier if new guidance is issued

#### JCIA
- Yes - completed

### Inverted nipple correction

#### Introduction
Nipple inversion may occur as a result of an underlying breast malignancy and it is essential that this be excluded. This policy explicitly relates to correction of inverted nipples for cosmetic reasons.

#### Criteria

<table>
<thead>
<tr>
<th>Inverted nipple correction is not routinely commissioned.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Note: This policy relates to cosmetic procedures and explicitly excludes investigation or management of suspected malignancy.</td>
</tr>
</tbody>
</table>

#### Codes
- Procedures challenged in this policy:
  - OPCS Code: B354, B356
- Relevant diagnoses for 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.

#### Date approved
- August 2016
- Revised version approved November 2018

#### Review date
- November 2021 or earlier if new guidance is issued

#### JCIA
- Yes - completed

### Labiaplasty

#### Introduction
Labiaplasty

#### Criteria

| Labiaplasty is not routinely commissioned. |

#### Codes
- Procedures challenged in this policy:
  - OPCS Code: P055, P056, P057
- Relevant diagnoses for 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.

#### Date approved
- August 2016
- Revised version approved November 2018

#### Review date
- November 2021 or earlier if new guidance is issued

#### JCIA
- Yes - completed

### Laser hair removal for pilonidal disease

#### Introduction
Pilonidal disease is a skin disease usually found in the midline of the natal cleft.
Laser hair removal for pilonidal disease

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.

Codes Procedures challenged in this policy:
OPCS Code: E054, H608, H609 where diagnosis contains pilonidal cyst codes (L05, L050, L059)
Relevant diagnoses for this policy:
ICD10 Code: L05, L050, L059

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

Liposuction

Introduction Liposuction (also known as liposculpture), is a surgical procedure performed to improve body shape by removing unwanted fat from areas of the body such as abdomen, hips, thighs, calves, ankles, upper arms, chin, neck and back. Liposuction is sometimes done as an adjunct to other surgical procedures, such as cancer procedures.

Criteria **Liposuction is not routinely commissioned.**

Codes Procedures challenged in this policy:
OPCS Code: S621, S622
Relevant diagnoses for 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.

Date approved August 2016
Review date Revised version approved November 2018
JCIA Yes - completed

Male breast reduction surgery for gynaecomastia

Introduction Most cases of gynaecomastia are idiopathic. It can also occur during puberty, when it tends to resolve as the post-pubertal fat distribution is complete. It can also occur secondary to medication such as oestrogens, gonadotrophins, digoxin, spironolactone and cimetidine, as well as anabolic steroids. More rarely it can be due to endocrinological disorders and malignancy.

Criteria **Male breast reduction surgery for gynaecomastia is not routinely commissioned.**

Note: This policy relates to cosmetic procedures and explicitly excludes investigation or management of suspected malignancy.
**Male breast reduction surgery for gynaecomastia**

| Codes | Procedures challenged in this policy:  
| OPCS Code: B311  
| Relevant diagnoses for this policy:  
| ICD10 Code: N62, N620  
| Diagnoses for which the above procedures are permitted:  
| ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria. |

| Date approved | August 2016  
| Revised version approved | November 2018  
| Review date | November 2021 or earlier if new guidance is issued  
| JCIA | Yes - completed |

**Meibomian cysts (chalazia)**

**Introduction**

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

| Criteria Based Access | 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 six months.  
| • Where conservative treatment has failed*.  

*Conservative treatment consists of regular (four times a day) application of heat packs and massage. and is either  
| • Present on the upper eyelid and interfering with vision.  
| or  
| • The meibomian cyst is regularly infected (e.g. two times within six month time frame) 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 looked into).

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
### Meibomian cysts (chalazia)

- the decision not the fund the procedure.

Note: Surgery to improve appearance alone is not commissioned.

### Codes

- Procedures challenged in this policy:
  - OPCS Code: There are no appropriate OPCS Codes
  - Relevant diagnoses for this policy:
    - ICD10 Code: H000, H001

### Date approved

- April 2018

### Review date

- April 2020 or earlier if new guidance is issued.

### JCIA

- Yes - completed

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

**Introduction**

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, i.e. higher proportion of micro-metastasis identified using OSNA than histopathology.

### Criteria Based Access

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: There are no appropriate OPCS Codes
  - Relevant diagnoses for this policy:
    - ICD10 Code: C500, C501, C502, C503, C504, C505, C506, C508, C509

### Date approved

- April 2018

### Review date

- April 2020 or earlier if new guidance is issued.

### JCIA

- Yes - completed

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### Pinnaplasty

**Introduction**

Pinnaplasty is performed for the correction of prominent ears or bat ears.

**Criteria**

**Pinnaplasty is not routinely commissioned.**

### Codes

- Procedures challenged in this policy:
  - OPCS Code: D033
  - Relevant diagnoses for this policy:
    - ICD10 Code: Q175
  - Diagnoses for which the above procedures are permitted:
    - ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria.

### Date approved

- August 2016
  - Revised version approved November 2018

### Review date

- November 2021 or earlier if new guidance is issued
<table>
<thead>
<tr>
<th>Pinnaplasty</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>
**Removal of tattoos**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>A tattoo can be removed by laser, surgical excision, or dermabrasion.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Tattoo removal is not routinely commissioned.</strong></td>
</tr>
</tbody>
</table>
| Codes | Procedures challenged in this policy:  
OPCS Code: S091, S092, S108, S109, S601, S602  
Relevant diagnoses for 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  
Revised version approved November 2018 |
| Review date | November 2021 or earlier if new guidance is issued |
| JCIA | Yes - completed |

**Repair of lobe of external ear (split earlobes)**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>The external ear lobe can be damaged partially or completely as result of trauma or wearing ear rings. Correction of split earlobes is not always successful and the earlobe is a site where poor scar formation is a recognised risk.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Repair of lobe of external ear is not routinely commissioned.</strong></td>
</tr>
</tbody>
</table>
| Codes | Procedures challenged in this policy:  
OPCS Code: D062, D063  
Relevant diagnoses for 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. |
| Date approved | August 2016  
Revised version approved November 2018 |
| Review date | November 2021 or earlier if new guidance is issued |
| JCIA | Yes - completed |

**Resurfacing procedures: dermabrasion, chemical peels and laser treatment**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Resurfacing procedures: dermabrasion, chemical peels and laser treatment are not routinely commissioned.</strong></td>
</tr>
</tbody>
</table>
| Codes | Procedures challenged in this policy:  
OPCS Code: S091, S092, S103, S113, S601, S602  
Relevant diagnoses for 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. |
| Date approved | August 2016  
Revised version approved November 2018 |
| Review date | November 2021 or earlier if new guidance is issued |
| JCIA | Yes - completed |
Revision mammoplasty (including prosthesis removal or replacement)

<table>
<thead>
<tr>
<th>Introduction</th>
<th>The term mammoplasty refers to both breast reduction and breast augmentation procedures. Revision mammoplasty may be indicated if desired results are not achieved or as a result of problem with implants.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria Based Access</td>
<td>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:</td>
</tr>
<tr>
<td></td>
<td>• Implant is proven to be ruptured.</td>
</tr>
<tr>
<td></td>
<td>or</td>
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<tr>
<td></td>
<td>• Baker Grade IV capsular contracture.</td>
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<tr>
<td></td>
<td>or</td>
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<tr>
<td></td>
<td>• Implants with capsule formation that interferes with mammography.</td>
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<tr>
<td></td>
<td>or</td>
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<tr>
<td></td>
<td>• Implant is a PiP implant.</td>
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<tr>
<td></td>
<td>This commissioning decision applies regardless of the funding source of the original surgery (i.e. whether funded by the NHS or on a private basis*).</td>
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<tr>
<td></td>
<td>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.</td>
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<tr>
<td></td>
<td><strong>Replacement of breast implants is not routinely commissioned.</strong></td>
</tr>
<tr>
<td></td>
<td>This policy does not apply to women who have undergone breast reconstruction following surgery for cancer.</td>
</tr>
<tr>
<td></td>
<td><em>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.</em></td>
</tr>
<tr>
<td>Codes</td>
<td>Procedures challenged in this policy:</td>
</tr>
<tr>
<td></td>
<td>OPCS Code: B302, B303, B304, B314</td>
</tr>
<tr>
<td></td>
<td>Relevant diagnoses for this policy:</td>
</tr>
<tr>
<td></td>
<td>ICD10 Code: None</td>
</tr>
<tr>
<td></td>
<td>Diagnoses for which the above procedures are permitted:</td>
</tr>
<tr>
<td></td>
<td>ICD10 Code: C50, C500, C509, C501, C502, C503, C504, C505, C506, C507, C508, C509, Z853</td>
</tr>
<tr>
<td>Date approved</td>
<td>November 2016</td>
</tr>
<tr>
<td></td>
<td>February 2019</td>
</tr>
<tr>
<td>Review date</td>
<td>February 2022 or earlier if new guidance is issued</td>
</tr>
<tr>
<td>JClA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>
### Rhinoplasty

**Introduction**
Rhinoplasty is a surgical procedure performed on the nose to change its size or shape or both. People often ask for this procedure to improve self-image.

**Criteria**
**Rhinoplasty is not routinely commissioned.**

**Codes**
Procedures challenged in this policy:
- OPCS Code: E023, E024, E025, E026, E073

Relevant diagnoses for 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.

**Date approved**
August 2016

**Review date**
November 2021 or earlier if new guidance is issued

**JCIA**
Yes - completed

### Scars and keloids

**Introduction**
Scars and keloids

**Criteria**
**Treatment for scars and keloids is not routinely commissioned.**

**Codes**
Procedures challenged in this policy:

Relevant diagnoses for this policy:
- ICD10 Code: L905, L910

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

**Date approved**
August 2016

**Review date**
November 2021 or earlier if new guidance is issued

**JCIA**
Yes - completed

### Skin camouflage services

**Introduction**
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.
   
   and

2. The deformity is capable of being camouflaged, disguised or minimised with camouflage products.
   
   and

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).
### Skin camouflage services

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedures challenged in this policy: OPCS Code: There are no appropriate OPCS Codes Relevant diagnoses for this policy: ICD10 Code: There are no appropriate ICD10 Codes</th>
</tr>
</thead>
</table>

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

### Thigh lift, buttock lift and arm lift, excision of redundant skin or fat

**Introduction**

These surgical procedures are performed to remove loose skin or excess fat to reshape body contours.

**Criteria**

Thigh lift, buttock lift, and arm lift, excision of redundant skin or fat are not routinely commissioned.

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedures challenged in this policy: OPCS Code: S031, S032, S033, (S038, S039 with Z495 or Z501) Relevant diagnoses for 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.</th>
</tr>
</thead>
</table>

| Date approved | August 2016 Revised version approved November 2018 |
| Review date | November 2021 or earlier if new guidance is issued |
| JCIA | Yes - completed |

### Vaginoplasty

**Introduction**

Vaginoplasty

**Criteria**

Non-reconstructive vaginoplasty or “vaginal rejunivation” used to restore vaginal tone and appearance is not routinely commissioned.

<table>
<thead>
<tr>
<th>Code</th>
<th>Procedures challenged in this policy: OPCS Code: P213, P214, P215 Relevant diagnoses for 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.</th>
</tr>
</thead>
</table>

| Date approved | August 2016 Revised version approved November 2018 |
| Review date | November 2021 or earlier if new guidance is issued |
| JCIA | Yes - completed |
Miscellaneous

## Complementary medicines/therapies

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Complementary medicines/therapies</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Complementary therapies such as homeopathy, acupuncture, osteopathy and chiropractic therapy are not routinely commissioned.</strong></td>
</tr>
</tbody>
</table>
| Codes        | Procedures challenged in this policy:  
OPCS Code: X612, X613, X614, X618, X619, A706  
Relevant diagnoses for 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. |
| Date approved| August 2016  
Revised version approved November 2018 |
| Review date  | November 2021 or earlier if new guidance is issued |
| JCIA         | Yes - completed |

## Complex and specialised metabolic and bariatric surgery

| Introduction | 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/m2 or more, or a BMI of 35-40kgs/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/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 Based Access | **Complex and specialised metabolic and bariatric surgery will only be considered as a treatment option for people with morbid obesity providing all of the following criteria are fulfilled:**  
- Consider an assessment for bariatric surgery for people with a BMI of 30-34.0 who have recent-onset type 2 diabetes (i.e. within 10 years) as long as they are also receiving or will receive assessment in a tier three service (or equivalent).  
- Consider an assessment for bariatric surgery for people of Asian family origin who have recent-onset type 2 diabetes at a lower BMI than other populations as long as they are also receiving or will receive assessment in a tier three service (or equivalent).  
- There must be formalised MDT led processes for the screening of co-morbidities and the detection of other significant diseases. These should include identification, diagnosis, severity/complexity assessment, risk assessment and management plans. |

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Complex and specialised metabolic and bariatric surgery

- stratification/scoring and appropriate specialist referral for medical management. Such medical evaluation is mandatory prior to entering a surgical pathway.
- Morbid/severe obesity has been present for at least five years.
- The individual has recently received and complied with a local specialist obesity service weight loss programme (non-surgical tier three / four), described as follows: This will have been for duration of six months. For patients with BMI > 50 attending a specialist bariatric service, this period may include the stabilisation and assessment period prior to bariatric surgery. The minimum acceptable period is six months. The specialist obesity weight loss programme and MDT should be decided locally. This will be led by a professional with a specialist interest in obesity and include a physician, specialist dietician, nurse, psychologist and physical exercise therapist, all of whom must also have a specialist interest in obesity. There are different models of local MDT structure. Important features are the multidisciplinary, structured and organised approach, lead professional, assessment of evidence that all suitable non-invasive options have been explored and trialled and individualised patient focus and targets. In addition to offering a programme of care the service will select and refer appropriate patients for consideration for bariatric surgery.

The non-surgical tier three / four service may be community or hospital-based but will have as their role:

- Education.
- Dietary advice/support (which may be delivered through specialist obesity dieticians, or slimming clubs – Weight Watchers, Slimming World etc.).
- Enabling access to appropriate level of physical activity where not limited due to obesity related problems such as osteoarthritis, cardio respiratory disease.
- Exclusion of underlying contributory disease e.g. hypothyroidism, Cushing’s.
- Evaluation of co-morbidities (diabetes, sleep disorder breathing, etc) and instigation of appropriate management plans.
- Evaluation of patient’s engagement with non-surgical measures.
- Evaluation of psychological factors relevant to obesity, eating behaviour, physical activity and patient engagement.
- There is evidence of attendance, engagement and full participation in the above non-surgical tier three / four service engagement can be judged by attendance records and achievement of pre-set individualised targets (for example steady and sustained weight loss of five to ten percent, or maintaining constant weight whilst stopping smoking).
- The patient has been assessed and referred by the lead physician/clinician for the specialist obesity weight loss MDT.
- The patient has been unable to lose clinically significant weight (i.e. enough to modify co-morbidities) during the period of intervention. Patients who lose sufficient weight to fall beneath the NICE guidance should not be considered appropriate for surgery.

The final decision on whether an operation is indicated should be made by the
### Complex and specialised metabolic and bariatric surgery

Specialist hospital bariatric MDT. For all bariatric surgery candidates, an individual risk benefit evaluation will be done by the Bariatric Surgery MDT, this will be informed by their own clinical assessment and information provided by primary care and by non-surgical tier three / four. In some locations there may be close liaison (and perhaps even overlap of personnel) between non-surgical tier three / four and Bariatric Surgery MDT. For example, a specialist bariatric physician would be on both MDTs.

The risk: benefit evaluation will consider:
- Existing co-morbidities and their reversibility.
- Risk of future co-morbidities and their reversibility.
- Patients age and general level of health.
- Anticipated weight reduction.
- Alternatives if bariatric surgery is not undertaken.
- Peri-operative mortality.
- Post-operative complications of bariatric surgery.

The Bariatric Surgery team will satisfy itself that:
- Bariatric surgery is in accordance with relevant guidelines.
- There are no specific clinical or psychological contraindications to this type of surgery.
- The individual is aged 18 years or above.
- The patient has engaged with non-surgical tier three / four services.
- The anaesthetic and other peri-operative risks have been appropriately minimised.
- The patient has engaged in appropriate support or education groups/schemes to understand the benefits and risks of the intended surgical procedure.
- The patient is likely to engage in the follow up programme that is required after any bariatric surgical procedure to ensure:
  - Safety of the patient.
  - Best clinical outcome is obtained and then maintained.
- Change eating behaviour.
- Change physical behaviour as advised.
- The overall risk: benefit evaluation favours bariatric surgery.

Revisional procedures will only be considered electively for clinical reasons due to complications and will require prior approval unless they are required on an acute emergency basis.

Any new/novel bariatric surgery procedures outside of this policy will not be routinely commissioned. Where a clinician wishes to make a request for a new device/procedure, an application for exceptional funding through the Individual Funding Request (IFR) process should be made in the first instance.

<table>
<thead>
<tr>
<th>Codes</th>
<th>Procedures challenged in this policy:</th>
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</thead>
<tbody>
<tr>
<td>OPCS Code:</td>
<td>G271, G272, G273, G274, G275, G276, G277, G278, G279, G281,</td>
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</table>
## Continuous Glucose Monitors (CGM)

### Introduction

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 on the basis of “real time” glucose results. The device has a sensor which is fitted sub-cutaneously and measures interstitial glucose, the sensors are time limited (usually 5-7 days) and thus need to be replaced regularly. The real-time monitor shows trends in glucose levels on a 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 Based Access

Continuous glucose monitors is commissioned where patients meet the criteria below, the referral letter and patient’s medical record need to clearly evidence how this 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 1-5 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 = seizure/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. Expectation that glucagon will have been administered.
Continuous Glucose Monitors (CGM)

- 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 five years of age (age four years and below):*
- For 5 – 11 year age group: EITHER
  - 1 severe hypoglycaemic episode where severe = seizure/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.
    - or
  - 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 Guideline NG18, ‘Diabetes (type 1 and type 2) in children and young people: diagnosis and management’: [www.nice.org.uk/guidance/ng18](http://www.nice.org.uk/guidance/ng18)
- NICE Guideline NG17, ‘Type 1 diabetes in adults: diagnosis and management’: [https://www.nice.org.uk/guidance/ng17](https://www.nice.org.uk/guidance/ng17)

*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 as a consequence of hypoglycaemia and the risk of hypoglycaemic seizures is greatest in younger children. CGM studies in the preschool children confirmed that the majority of hypoglycaemia events were asymptomatic and only 32% were being detected despite plasma glucose levels
### Continuous Glucose Monitors (CGM)

| being checked 10 times per day. | Children under the age of six years with hypoglycaemia unawareness have six times the risk of a severe hypoglycaemic episode when compared to those without hypoglycaemia unawareness.' |

NB Freestyle Libre not licensed for use under the age of four years.

### Codes

| Procedures challenged in this policy: | OPCS Code: There are no appropriate OPCS Codes |
| Diagnoses for which the above procedures are permitted: | ICD10 Code: E100, E101, E102, E103, E104, E105, E106, E107, E108, E109 |

### 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

#### Introduction

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 United States, 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

**Enhanced external counterpulsation for patients with severe ischaemic heart disease is not routinely commissioned.**

#### Codes

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

#### Date approved

- April 2018

#### Review date

- April 2020 or earlier if new guidance is issued.

#### JCIA

- Yes - completed
Extracorporeal shockwave therapy (ESWT)

**Introduction**
Extracorporeal shockwave therapy 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 a number of 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: T745
Relevant diagnoses for this policy:
ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria

<table>
<thead>
<tr>
<th>Date approved</th>
<th>April 2018</th>
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<tbody>
<tr>
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<td>April 2020 or earlier if new guidance is issued.</td>
</tr>
<tr>
<td>JCIA</td>
<td>Yes - completed</td>
</tr>
</tbody>
</table>
**Hyperbaric oxygen therapy**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>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.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td><strong>Hyperbaric oxygen therapy is not routinely commissioned.</strong></td>
</tr>
<tr>
<td>Codes</td>
<td>Procedures challenged in this policy: OPCS Code: X521 Relevant diagnoses for this policy: ICD10 Code: None Diagnoses for which the above procedures are permitted: ICD10 Code: T703, T58, T58X, T580, T790, T79, T79X, K627, O880 This list is not exhaustive.</td>
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<tr>
<td>Date approved</td>
<td>August 2017</td>
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<tr>
<td>Review date</td>
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<tr>
<td>JCIA</td>
<td>Yes - completed</td>
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</tbody>
</table>

**Multiple chemical sensitivity and clinical ecology/environmental medicine**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Investigation of multiple chemical sensitivity (MCS) and/or treatment with clinical ecology/environmental medicine is not routinely commissioned.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria</td>
<td>Procedures challenged in this policy: OPCS Code: There are no appropriate OPCS Codes Relevant diagnoses for this policy: ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria</td>
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<tr>
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<tr>
<td>JCIA</td>
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</tbody>
</table>

**Open magnetic resonance imaging (MRI) scanning**

<table>
<thead>
<tr>
<th>Introduction</th>
<th>Referral for open MRI scanning of greater than 0.7T - 70cm bore and 250kg as an alternative to conventional MRI in secondary care.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Criteria Based Access</td>
<td>Prior approval must be gained before referral. A <a href="#">prior approval form</a> should be completed. This should be undertaken by the referring GP or Consultant.</td>
</tr>
<tr>
<td></td>
<td>- Patients who suffer from claustrophobia where an oral prescription 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, e.g. an allergy or psychological disorders, then this must be stated for the referral to be approved by the commissioner.</td>
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<tr>
<td></td>
<td>or</td>
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<td></td>
<td>- Patients who are obese or cannot fit comfortably in conventional MRI scanners.</td>
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</table>
Open magnetic resonance imaging (MRI) scanning

| Codes | Procedures challenged in this policy: OPCS Code: There are no appropriate OPCS Codes Relevant diagnoses for this policy: ICD10 Code: E660, E661, E662, E668, E669, F402 |
| Date approved | April 2018 |
| Review date | April 2020 or earlier if new guidance is issued. |
| JCIA | Yes - completed |

Paediatric speech and language therapy in secondary care

| Introduction | 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 Based Access | 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 this criteria is met: |
| | • The patient has feeding and swallowing difficulties (dysphagia). Where a child/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: www.cornwall.gov.uk/earlyhelphub |
| Codes | Procedures challenge in this policy: OPCS Code: There are no appropriate OPCS codes. Relevant diagnoses for this policy: F80, F800, F801, F802, F803, F808, F809, R47, R470, R471, R478 |
| Date approved | February 2019 |
| Review date | February 2022 or earlier if new guidance is issued. |

Standing, upright, weight-bearing or positional MRI will not be commissioned.
### Polysomnography for children

**Introduction**

Polysomnography for children.

**Criteria Based Access**

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/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/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/sleep disordered breathing (up to 30% of children/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.
- Where it is not clinically safe to undertake a sleep study in the home, for example ventilated children.
- Where 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 procedure(s) are appropriate for this policy: ICD10 Code: F510, F511, F512, F513, F514, F515, F518, F519, G470, G471, G472, G473, G474, G478, G479, Q900, Q901, Q902, Q909

**Date approved**

April 2018

**Review date**

April 2020 or earlier if new guidance is issued.

**JCIA**

Yes - completed
### Population screening outside of national screening committee guidelines

<table>
<thead>
<tr>
<th>Criteria Based Access</th>
<th>Population screening outside of national guidelines is not routinely commissioned and is subject to this restricted policy.</th>
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<tbody>
<tr>
<td></td>
<td>Screening will only be commissioned by the NHS for patients meeting the criteria:</td>
</tr>
<tr>
<td></td>
<td>1. The 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.</td>
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<tr>
<td></td>
<td>2. The Commissioner does not commission population screening for conditions where the UK National Screening Committee has said that it is not recommended.</td>
</tr>
<tr>
<td>Further information:</td>
<td>A full list of the UK National Screening Committee policies and recommendations is available at <a href="http://www.screening.nhs.k/policydb.php">http://www.screening.nhs.k/policydb.php</a> - see appendix A for list of programmes recommended or covered by NICE guidelines.</td>
</tr>
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<tr>
<td></td>
<td>OPCS Code: There are no appropriate OPCS Codes</td>
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<td></td>
<td>Relevant diagnoses for this policy:</td>
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<td></td>
<td>ICD10 Code: There are no appropriate ICD10 Codes for the clinical criteria</td>
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</tbody>
</table>
Revisional metabolic and bariatric surgery

**Introduction**

Metabolic and bariatric surgery is a specialised treatment for severe and complex obesity, to be offered after a comprehensive weight management pathway that comprises multi-disciplinary team (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 three services with non-specialist elements delivered by tier one and tier two services. In patients who have failed to lose weight using this pathway and are eligible according to National Institute for Care and Excellence (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.

<table>
<thead>
<tr>
<th>Criteria Based Access</th>
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<tbody>
<tr>
<td>Group 1, 2 and 4a patients will be routinely commissioned. Groups 3 and 4b patients will not be routinely commissioned.</td>
</tr>
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</table>

**Group 1**

Patients presenting with a clinical history, symptoms and/or signs that suggest acute medical and/or surgical complications – 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 i.e. slippage then the band can be repositioned/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 six 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 one and two above.
**Revisional metabolic and bariatric surgery**

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 two 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**
a) Some patients may have had their primary obesity surgery outside of NHS contracts at private providers (in Europe, or within the United Kingdom) 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.

b) 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 two or three weight management services.

Any request for further (up to two 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 require to collaborate to provide evidence on:
## Revisional metabolic and bariatric surgery

1. Weight management service attendance including tier three.
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 one and two 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 Individual Funding Request panel may be required for groups 3 and 4b, if it is felt that individualised or exceptional circumstances apply.

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| Date approved | April 2018 |
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