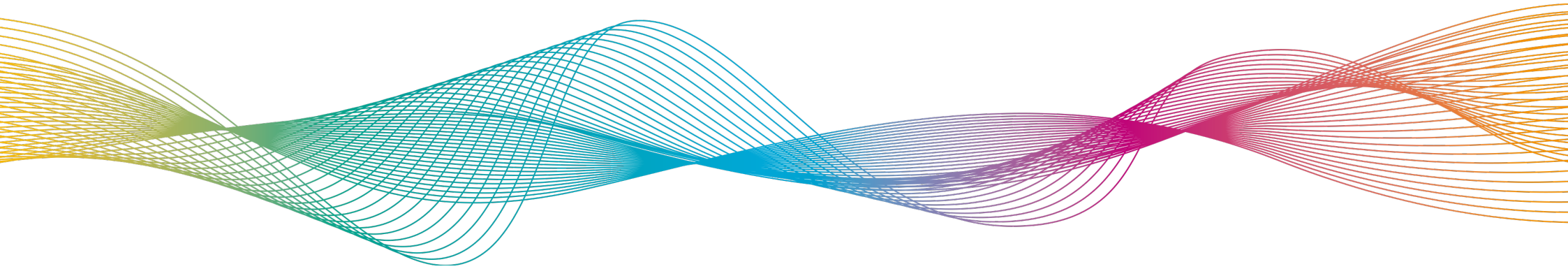
NHS
St Helens
Clinical Commissioning Group

Criteria Based Clinical Treatments

Version 6 – September 2023



Document Description

Organisation	NHS St Helens Clinical Commissioning Group (CCG)
Document Name	Criteria Based Clinical Treatments (CBCT) : A collaboration of policies for: NHS Halton CCG; NHS Liverpool CCG; NHS Southport and Formby CCG; NHS South Sefton CCG; NHS St Helens CCG; NHS Warrington CCG;
Version	Version 6 – September 2023
Document Status	Final
Document Development	**Version 6 – September 2023** has been produced by the Midlands and Lancashire Commissioning Support Unit to support the transition from individual Clinical Commissioning Group (CCG) policies to a single suite of Cheshire and Merseyside Integrated Care Board (ICB) policies. This policy is amended to reflect the ICB policy position as individual ICB policies are completed and published.
Document Editor(s)	Midlands and Lancashire Commissioning Support Unit, Policy Development Service
Publication Date	September 2023
Document Purpose	To publish arrangements for making decisions and adopting policies on how particular healthcare interventions are to be accessed.
Target Audience	This document is intended for patients, clinicians, and other referrers in primary and secondary care. It sets out the eligibility criteria under which the CCG will commission specific treatments or interventions.
Superseded Document	Criteria Based Clinical Treatments (CBCT) - Version 4 October 2022
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Approved By	Governing Body / Quality Committee
Ratified By	Governing Body
Date Ratified	March 2022 / amended September 2023
Date of Issue via Internet/Intranet	September 2023
Date of Review	This policy will be subject to continued monitoring and review with subsequent updates being issued as individual policies are reviewed.
Lead Officer (CCG)	Tony.McLeod@sthelensccg.nhs.uk

Contents

1. Purpose and Scope

1.1 The CCG is legally obliged to have in place and publish arrangements for making decisions and adopting policies on how particular healthcare interventions are to be accessed. This document is intended to be a statement of such arrangements made by the CCG is a document for patients, clinicians, and other referrers in primary and secondary care. It sets out the eligibility criteria under which the CCG will commission the treatments and interventions listed.

1.2 This policy describes the eligibility criteria under which the CCG will commission treatments or interventions classified as 'Criteria Based Clinical Treatments' (CBCT). The term Criteria Based Clinical Treatments refers to procedures and treatments that are of value, but only in the right clinical circumstances. Previously, they were referred to as Procedures of Low Clinical Priority (PLCP).

1.3 In making these arrangements, the CCG has given due regard to relevant legislation and NHS guidance, including their duties under the National Health Service Act 2006, the Health and Social Care Act 2012, Equality legislation – duties discharged under the Public Sector Equality Duty 2011, the National Health Service Commissioning Board and Clinical Commissioning Group's (Responsibilities and Standing Rules) Regulations 2012, the Joint Strategic Needs Assessment, relevant guidance issued by NHS England and the NHS Constitution.

2. Context

2.1 CCGs have been established under the National Health Service Act 2006 as the statutory bodies charged with the function of commissioning healthcare for patients for whom they are statutorily responsible. CCGs receive a fixed resource allocation from NHS England to enable them to fulfil their duties and must decide how and where to allocate resources to best meet the healthcare needs of their population.

2.2 It is evident that the need and demand for healthcare is greater than the resources available to a society to meet it. Therefore, it will not be possible for CCGs to commission all the healthcare needs of the population they serve. As a result, CCGs need to prioritise their commissioning intentions to ensure their limited resources are allocated effectively and based on the needs of the local population.

2.3 The CCG's intention is always to ensure access to NHS resources is equal and fair, whilst considering the needs of the overall population.

2.4 Using the CBCT policies as presented in this document, the CCG will prioritise their resources using evidence that determines what is clinically and cost effective and likely to provide the greatest proven health gain for the whole of the CCG's population.

2.5 The main objective for having CBCT policies is to ensure that:

- Patients receive appropriate and effective health treatments in the right place and at the right time
- Treatments with no or a very limited clinical evidence base are not routinely undertaken; and
- Treatments with minimal health gain are restricted.

2.6 This also means that certain procedures will not be commissioned by the CCG unless patients meet all the criteria set out in relation to a procedure or treatment; or exceptional clinical circumstances can be demonstrated.

2.7 The CCG recognises there may be exceptional clinical circumstances where it may be clinically effective to fund the procedures listed in this policy for individual patients. Either where:

- The clinical threshold criteria as specified by this policy is not met; or
- The procedure is not routinely commissioned

To be clear, this means clinical features which make that patient different to the rest of the cohort of patients with that condition. It does not refer to social circumstances.

2.8 In accordance with the CCG's Individual Funding Request (IFR) process, the patient's clinical situation and relevant history should be evidenced in an application made by the patient's clinician will be considered on a case-by-case basis. This position is supported by each CCG's Ethical Framework.

3. Principles

3.1 Commissioning decisions by CCG Commissioners are made in accordance with the commissioning principles set out as follows:

- CCG Commissioners require clear evidence of clinical effectiveness before NHS resources are invested in the treatment.
- CCG Commissioner require clear evidence of cost effectiveness before NHS resources are invested in the treatment.
- The cost of the treatment for this patient and others within any anticipated cohort is a relevant factor.
- CCG Commissioners will consider the extent to which the individual or patient group will gain a benefit from the treatment.
- CCG Commissioners will balance the needs of an individual patient against the benefit which could be gained by alternative investment possibilities to meet the needs of the community.
- CCG Commissioners will consider all relevant national standards and consider all proper and authoritative guidance.
- Where a treatment is approved CCG Commissioners will respect patient choice as to where a treatment is delivered.
- Commissioning decisions will give 'due regard' to promote equality and uphold human rights. Decision making will follow robust procedures to ensure that decisions are fair and are made within legislative frameworks.

3.2 This policy aims to improve consistency by bringing together a common set of criteria for treatments and procedures across the region. CCGs across Merseyside and Warrington have collaborated to develop a harmonised core set of commissioning criteria where agreed. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for patients.

3.3 At the time of publication, the evidence presented per procedure/treatment was the most current available. Where reference is made to older publications these still represent the most up to date view.

4. Core eligibility criteria

4.1 There are a number of circumstances where a patient may meet a 'core eligibility criterion' which means they are eligible to be referred for the procedures and treatments listed within this policy, regardless of whether they meet the criteria; or the procedure or treatment is not routinely commissioned.

4.2 These core clinical eligibility criteria are as follows:

- Any patient who needs 'urgent' treatment will always be treated.
- All NICE Technology Appraisals Guidance (TAG), for patients that meet all the eligible criteria listed in a NICE TAG will receive treatment.
- Any lesion that has features suspicious of malignancy (including but not limited to skin, head and neck, breast and sarcoma), must be referred to an appropriate specialist for urgent assessment under the 2-week rule.
  NOTE: Funding of interventions for all solid and haematological cancers are now the responsibility of NHS England.
- Reconstructive surgery post cancer or trauma including burns.
- Operations on congenital anomalies of the face and skull are usually routinely commissioned by the NHS. Some conditions are considered highly specialised and are commissioned in the UK through the National Specialised Commissioning Advisory Group (NSCAG). As the incidence of some cranio-facial congenital anomalies is small and the treatment complex, specialised teams, working in designated centres and subject to national audit, should carry out such procedures.
- Tissue degenerative conditions requiring reconstruction and/or restoring function e.g. leg ulcers, dehisced surgical wounds, necrotising fasciitis.
- For patients wishing to undergo Gender reassignment, this is the responsibility of NHS England and patients should be referred to a Gender Identity Clinic (GIC) as outlined in the Interim NHS England Gender Dysphoria Protocol and Guideline 2013/14.

5. Referral/Treatment Listing Processes (CBCT Listed Procedures)

Primary Care

5.1 Referrals for treatment should not be made unless the patient clearly meets the criteria as this can raise unrealistic expectations for the patient and lead to disappointment. If a General Practitioner/Optometrist/Dentist considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the General Practitioner/Optometrist/Dentist should follow the process for referral. NB. This may be via a referral management or prior approval team.

5.2 If in doubt over the local process, the referring clinician should contact the relevant CCG, IFR Team or Referral Management Team for guidance. Failure to comply with the local process may delay a decision being made.

5.3 Any referral letter should include specific information regarding the patient's potential eligibility. If the referral letter does not clearly outline how the patient meets the criteria, then the letter should be returned to the referrer for more information.

5.4 In cases where there may be an element of doubt the General Practitioner/Optometrist/Dentist should discuss the case with the IFR Team in the first instance.

Secondary Care

5.5 The secondary care consultant will also determine whether the procedure is clinically appropriate for a patient and whether the eligibility criteria for the procedure are fulfilled or not. The consultant may also request additional information before seeing the patient.

5.6 If a secondary care consultant considers a patient might reasonably fulfil the eligibility criteria for a restricted procedure, as detailed in this document (i.e. they meet the specific criteria listed for each treatment) the consultant should follow the listing process for treatment. NB. For some CCGs this will involve following a process of prior approval. If in doubt over the CCG requirements, the consultant should contact the relevant CCG or the IFR Team for guidance. Failure to comply with the CCGs' processes may delay a patient's treatment and/or release of funding resources.

5.7 Patients who fulfil the criteria may then be placed on a waiting list according to their clinical need. The patient's notes should clearly reflect exactly how the criteria were fulfilled including prior approval authorisation where relevant. This will allow for case note audit to support contract management.

5.8 Should the patient not meet the eligibility criteria this should be recorded in the patient's notes and the consultant should return the referral back to the General Practitioner/Optometrist/Dentist, explaining why the patient is not eligible for treatment.

6. Individual Funding Request (Exceptional Case) Approval (IFR) Application

6.1 An Individual Funding Request (Exceptional Case) application is used to demonstrate an individual patient's clinical exceptional circumstances with the purpose of obtaining approval to proceed with a specific clinical treatment or intervention.

6.2 An IFR (Exceptional Case) application is generally completed on behalf of a patient when a patient does not meet all the criteria outlined for a procedure or treatment restricted by this policy; the procedure or treatment is not routinely commissioned in accordance with this policy; or, the procedure or treatment is new/rare and a commissioning position has not yet been determined.

6.3 For example, should a patient not fulfil the 'minimum clinical eligibility' criteria, but the referring clinician believes there are clinically exceptional circumstances; and as the patient's responsible clinician they are willing to support the application as clinically exceptional; their request once submitted will follow the IFR assessment and decision-making processes. The patient's responsible clinician, completing the IFR application, can be a patient's consultant or GP. Often the patient's consultant will be best placed to demonstrate clinical exceptionality given their specialist subject knowledge, and their understanding about the standard cohort of patients for which the treatment or intervention is commissioned.

6.4 In dealing with clinically exceptional requests for an intervention that is considered to be a poor use of NHS resources, the CCG has endorsed through the CCG Alliance the following description of exceptionality contained in a paper by the NW Medicines and Treatment Group:

- The patient has a clinical picture that is significantly different to the general population of patients with that condition;

AND as a result of that difference

- The patient is likely to derive greater benefit from the intervention than might normally be expected for patients with that condition.

6.5 The CCG is of the opinion that exceptionality should be defined solely in clinical terms. To consider social and other non-clinical factors automatically introduces inequality, implying that some patients have a higher intrinsic social worth than others with the same condition. It runs contrary to a basic tenet of the NHS, namely that people with equal need should be treated equally. Therefore, non-clinical factors will not be considered except where this policy explicitly provides otherwise.

6.6 The CCG must justify the grounds upon which it is choosing to fund treatment for a particular patient when the treatment is unavailable to others with the condition.

6.7 Individual Funding Requests should only be sent to the respective NHS.net accounts as below. Guidance regarding IFRs and an application form; can be found on the CCGs websites.

6.8 IFR contact information follows, however please refer to the CCG IFR policy for more information:

Individual Funding Request Case Manager
Midlands and Lancashire Commissioning Support Unit (MLCSU)
1829 Building
Countess of Chester Health Park
Liverpool Road
Chester
CH2 1HJ Telephone: 01244 650 305 Email: IFR.manager@nhs.net

Personal data

6.9 In making referrals to the IFR Team, clinicians and other referrers in primary and secondary care should bear in mind their obligations under the Data Protection Act 1998 and their duty of confidence to patients. Where information about patients (including photographs) is sent to the IFR Team and is lost or inadvertently disclosed to a third party before it is safely received by the IFR Team, the referrer will be legally responsible for any breach of the Data Protection Act 1998 or the law of confidence.

6.10 Therefore, please consider taking the following precautions when using the Royal Mail to forward any information about patients including photographic evidence:

- Clearly label the envelope to a named individual i.e. first name and surname, and job title.
- Where your contact details are not on the items sent, include a compliment slip indicating the sender and their contact details in the event of damage to the envelope or package.
- Use the Royal Mail Signed for 1st Class service, rather than the ordinary mail, to reduce the risk of the post going to the wrong place or getting lost.

6.11 Costs incurred will be the responsibility of the referrer, this includes photographic evidence.

Photographic evidence

6.12 Photographic evidence may be required in cases which are being considered for clinical exceptionality in line with the IFR processes. However, photographic evidence will not be accepted for consideration unless it is impossible to make the case in any other way.

6.13 The decision to submit photographic evidence remains with the patient and responsible clinician and must meet the CCGs criteria for submission as outlined by the CCGs IFR Policy.

6.14 If photographs are accepted for consideration in accordance with the CCGs criteria, they will be examined by clinical members of the IFR team. In the course of the work for the case the applicant should be aware that other members of the IFR Panel, IFR Process Reviews Panel or IFR team who prepare the papers may need to handle or see the photographs.

7. Cosmetic Surgery

7.1 Cosmetic surgery is often carried out to change a person's appearance to achieve what a person perceives to be a more desirable look.

7.2 Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.

7.3 A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx

8. Diagnostic Procedures

8.1 Diagnostic procedures to be performed with the sole purpose of determining whether or not a restricted procedure is feasible should not be carried out unless the eligibility criteria are met, or approval has been given by the CCG or GP (as set out in the approval process of the patients responsible CCG) or as agreed by the IFR Panel as a clinically exceptional case.

8.2 Where a General Practitioner/Optometrist/Dentist requests only an opinion the patient should not be placed on a waiting list or treated, but the opinion given and the patient returned to the care of the General Practitioner/Optometrist/Dentist, in order for them to make a decision on future treatment.

9. Psychological factors

9.1 Psychological distress alone will not be accepted as a reason to fund surgery. Only very rarely is surgical intervention likely to be the most appropriate and effective means of alleviating disproportionate psychological distress. In these cases, ideally an NHS psychologist with expertise in body image or an NHS Mental Health Professional (depending on locally available services) should detail all treatment(s) previously used to alleviate/improve the patient's psychological wellbeing, their duration and impact. The clinician should also provide evidence to assure the IFR Panel that a patient who has focused their psychological distress on some particular aspect of their appearance is at minimal risk of having their coping mechanism removed by inappropriate surgical intervention.

9.2 Psychological assessment and intervention may be appropriate for patients with severe psychological distress in respect of their body image, but it should not be regarded as a route into aesthetic surgery.

10. Lifestyle Factors and Surgery

10.1 Lifestyle factors can have an impact on the functional results of some elective surgery, e.g. smoking affects healing, especially bone-healing, and good nutrition is essential to healing in general. The rates of postoperative complication and length of stay are higher in patients who are overweight or who smoke. Therefore, to ensure optimal outcomes, all patients who smoke or have a body mass index of 35 or greater and are being considered for referral to secondary care, should be able to access CCG and Local Authority Public Health commissioned smoking cessation and weight reduction management services prior to surgery.

10.2 Patient engagement with these "preventive services" may influence the immediate outcome of surgery. While failure to quit smoking or lose weight will not be a contraindication for surgery, GPs and surgeons should ensure patients are fully informed of the risks associated with the procedure in the context of their lifestyle.

11. Medicines

11.1 Prior approval or advice about the appropriate funding route for treatment, may need to be sought from the responsible Medicine Management Team or the CCG directly when using medicines as follows:

- Any new PbR excluded drug where the drug has not yet been approved/prioritised for use in agreement with the local CCG
- Any existing PbR excluded drugs to be used outside of previously agreed clinical pathways/indication
- Any PbR excluded drugs that are being used out with the parameters set by NICE both in terms of disease scores or drug use. It must not be assumed that a new drug in the same class as one already approved by NICE can be used, this must be subject to the process in Point 1
- Any drug used out with NICE Guidance (where guidance is in existence)
- Any proposed new drug/new use of an existing drug (whether covered by NICE or PBR excluded or not) should first be approved by the relevant Area Medicines Management Committee, and funding (where needed) agreed in advance of its use by the relevant CCG
- Any medicines that are classed by the CCG as being of limited clinical value
- Any medicines that will be supplied via a homecare company agreement

12. Clinical Trials

12.1 The CCG does not expect to provide funding for patients to continue treatment commenced as part of a clinical trial unless arrangements have been agreed with the CCG prior to initiation. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

13. Equality Analysis

13.1 An Equality Impact Analysis has been undertaken for each policy at the time of its review. For more information please contact Andy.woods3@nhs.net

14. Monitoring and review

14.1 This policy will be subject to continued monitoring using a mix of the following approaches:

- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

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

14.3 From time to time, CCGs may need to make commissioning decisions that may suspend some treatments/criteria currently specified within this policy.

14.4 For more detailed information about the development/review of each individual policy within this document please contact communications.ccg@sthelensccg.nhs.uk

15. Copies of this document

15.1 Electronic copies of this policy can be found on the CCG website.

16. Contact details

16.1 Enquiries relating to this document and the policies within should be sent to communications.ccg@sthelensccg.nhs.uk

17. Policy Categories

17.1 Each procedure/treatment is categorised as either 'not routinely commissioned' or 'restricted' and these are defined as follows:

1. **Category 1 - Not routinely commissioned (NRC)** – This means the CCG does not routinely commission the treatment and will only commission this treatment for an individual patient where an Individual Funding Request (IFR) Exceptional Case application in line with the CCG's IFR process, demonstrates clinical exceptionality.

    - **Individual Funding Request (Exceptional Case) Approval (IFR) – Approval Required** – The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without prior funding approval from commissioners. Exceptional circumstances must be demonstrated.

2. **Category 2 - Restricted** – This means the CCG will commission the treatment where the patient meets the specific criteria as set out within this Commissioning Policy. Where a patient does not meet the specific criteria specified the CCG will only commission this treatment for an individual patient where an IFR application in line with the CCG's IFR process, demonstrates clinical exceptionality:

    - **Monitored Approval (MA) – Prior Approval Not Required** – **Only applies if the patient meets the policy criteria –** The specific treatment may be undertaken in line with agreed policy criteria/routine commissioning arrangements provided the policy criteria is met, clinicians can refer patients without seeking approval. If the patient does not meet the policy criteria clinicians should apply for Individual Funding Request (Exceptional Case) Approval. Audits may be undertaken to ensure adherence with agreed commissioning arrangements.

    - **Prior Approval (PA) – Prior Approval Required** – The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without prior funding approval from commissioners. Exceptional circumstances do not always have to be demonstrated.

    - **Individual Funding Request (Exceptional Case) Approval (IFR) – Prior Approval Required** – The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without prior funding approval from commissioners. Exceptional circumstances must be demonstrated.

18. Policies

Funding Approval Category		Approval Required	Notes
1	**Individual Funding Request (Exceptional Case) Approval (IFR)**	**Yes**	A decision has been taken not to commission a specific treatment. Funding will only be approved if there is evidence of clinical exceptional circumstances.
2	**Prior Approval (PA)**	**Yes**	The Commissioner has specifically requested that funding is sought for a particular treatment. The treatment must not be undertaken without funding approval from commissioners. Exceptional circumstances do not always have to be demonstrated.
3	**Monitored Approval (MA)** ***NOTE: Only applies if the patient meets the policy criteria.***	**No**	The specific treatment may be undertaken in line with agreed EUR policy criteria/routine commissioning arrangements provided the policy criteria is met, clinicians can refer patients without seeking approval. If the patient does not meet the policy criteria clinicians should apply for Individual Funding Request (Exceptional Case) Approval. Audits may be undertaken to ensure adherence with agreed commissioning arrangements

Guidance for Clinicians:
Refer to Section 4 'core eligibility criterion' before applying policy specific criteria. An IFR (Exceptional Case) application should only be submitted if the patient's circumstances are deemed clinically exceptional when compared to the general cohort of patients to which the policy applies; OR the treatment or intervention required is considered new/rare.

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
1	Complementary Therapies	1.1		Complementary and Alternate Treatments e.g. Acupuncture, Homeopathy, Aromatherapy, Meditation, Colonic Irrigation. Osteopathy, Herbal Medicines etc.	22	3	Monitored Approval	2014/2015
2	Dermatology	2.1		Skin Resurfacing: Laser Dermabrasion and Chemical Peels	23	3	Monitored Approval	2014/2015
		2.2		Benign Skin Lesions: Surgical Removal (NHS England Evidence Based Intervention)	24	3	Monitored Approval	18/02/2019
		2.4		Skin Pigment Disorder: Biopsy or Camouflage	24	3	Monitored Approval	2014/2015
		2.5		Viral Warts (Excluding Genital Warts): Surgical/Laser Therapy from Secondary Care Providers	24	3	Monitored Approval	2014/2015
3	Diabetes	3.1	a	Continuous Glucose Monitors (Adults): Type 1 Diabetes	25	3	Monitored Approval	11/03/2020
		3.1	b	Continuous Glucose Monitors (Children and Young People): Type 1 Diabetes	25	3	Monitored Approval	19/01/2022

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		3.2		Insulin Pump Therapy (Continuous Sub-Cutaneous Insulin Infusion (CSII) Therapy: Type 1 Diabetes (including Cystic Fibrosis Related Diabetes)	25	3	Monitored Approval	11/03/2020
4	ENT	4.1		Adenoidectomy	25	3	Monitored Approval	20/02/2018
		4.2		Pinnaplasty/Otoplasty: Prominent Ears	25	3	Monitored Approval	14/07/2020
		4.3	a	Grommets Insertion (Children): Otitis Media with Effusion/Glue Ear (NHS England Evidence Based Intervention)	28	3	Monitored Approval	18/02/2019
			b	Grommets Insertion (Adults): Otitis Media with Effusion/Glue Ear	28	3	Monitored Approval	2014/2015
		4.4		Tonsillectomy: Recurrent Tonsillitis (NHS England Evidence Based Intervention)	29	3	Monitored Approval	18/02/2019
		4.5		External Ear Lobe Surgical Remodelling	29	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		4.6		Sinus X-Ray: Rhinosinusitis or Sinusitis	29	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		4.7	a	Rhinoplasty/Septoplasty: Nose Reconstruction for Non-Cosmetic/Other Reasons	29	3	Monitored Approval	20/02/2018
			b	Rhinoplasty/Septoplasty: Nose Reconstruction for Cosmetic Reasons	30	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		4.8		Rhinophyma Surgery or Laser Treatment	31	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
5	Equipment	5.1		Lycra Suits: Cerebral Palsy Posture Management	31	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
6	Fertility	6.1		Infertility Treatment e.g. Medicines, Surgical Procedures and Assisted Conception. This Also Includes Reversal of Vasectomy or Female Sterilisation	32	3	Monitored Approval	2014/2015
7	Gastroenterology	7.1		Haemorrhoids Surgical Removal (NHS England Evidence Based Intervention)	32	3	Monitored Approval	18/02/2019
		7.2	a	Hernias - Incisional and Ventral (Asymptomatic) Surgical Treatment	32	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
			b	Diastasis of the Recti Surgical Correction	33	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		7.3		Gallstones (Asymptomatic) Surgical Treatment	33	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		7.4		Gallstones Lithotripsy	33	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		7.5		Transanal Irrigation	33	3	Monitored Approval	11/03/2020
8	Gynaecology	8.1	a	Hysterectomy: Heavy Menstrual Bleeding – Fibroids <3cm, or Suspected/Diagnosed Adenomyosis, or No Identified Pathology (NHS England Evidence Based Intervention)	35	3	Monitored Approval	18/02/2019
			b	Hysterectomy: Heavy Menstrual Bleeding – Fibroids ³3cm In Diameter (NHS England Evidence Based Intervention)	36	3	Monitored Approval	18/02/2019
			c	Hysterectomy: Heavy Menstrual Bleeding with Submucosal Fibroids (NHS England Evidence Based Intervention)	36	3	Monitored Approval	18/02/2019
		8.2		Dilatation and Curettage (D&C): Heavy Menstrual Bleeding (NHS England Evidence Based Intervention)	36	1	Individual Funding Request (Exceptional Case) Approval	18/02/2019
9	Mental Health	9.1		Chronic Fatigue Syndrome (CFS) Inpatient Care and Treatment	36	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		9.3		Drug and Alcohol Rehabilitation: Non-NHS Commissioned Services	37	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		9.4		Private Mental Health Care	37	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
10	Neurology	10.1		Bobath Therapy: Neurological Conditions	38	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		10.2		Trophic Electrical Stimulation: Idiopathic Facial/Bell's Palsy	38	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		10.3	a	Functional Electrical Stimulation (FES): Foot Drop of Central Neurological Origin e.g. Stroke, MS, Spinal Cord Injury	38	3	Monitored Approval	2014/2015
			b	Functional Electrical Stimulation (FES): Lower Motor Neurone Lesions	39	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
11	Ophthalmology	11.1		Blepharoplasty: Upper Eyelid Correction	40	3	Monitored Approval	2014/2015
		11.2		Blepharoplasty: Lower Eyelid Correction	41	3	Monitored Approval	2014/2015

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		11.4		Short Sightedness (Myopia) or Long Sightedness (Hypermetropia) Correction Surgery or Laser Treatment	41	3	Monitored Approval	2014/2015
		11.5		Cataract Surgery	41	3	Monitored Approval	14/09/2016
		11.6		Coloured Filters: Irlens Syndrome/Dyslexia	43	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		11.7		Intra Ocular Telescope Implants: Advanced Age-Related Macular Degeneration	44	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		11.8		Chalazia (Meibomian Cyst) Surgical Removal (NHS England Evidence Based Intervention)	44	3	Monitored Approval	18/02/2019
12	Oral Surgery	12.1		Temporo-Mandibular Joint Dysfunction Syndrome Surgical Replacement	44	3	Monitored Approval	2014/2015
13	Paediatrics	13.1		Cranial Banding: Positional Plagiocephaly	45	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
14	Plastic Surgery	14.1	a	Bilateral Breast Reduction Surgery: Breast Macromastia (NHS England Evidence Based Intervention)	45	3	Monitored Approval	18/02/2019
			b	Unilateral Breast Reduction Surgery: Breast Asymmetry (NHS England Evidence Based Intervention)	45	3	Monitored Approval	18/02/2019
			c	Breast Reduction Surgery: Gynaecomastia (NHS England Evidence Based Intervention)	46	3	Monitored Approval	20/02/2018
		14.2		Breast Enlargement Surgery/Augmentation/Mammoplasty: Breast Micromastia	46	3	Monitored Approval	20/02/2018
		14.3	a	Breast Implant Removal Surgery: Silicone Breast Reconstruction	47	3	Monitored Approval	20/02/2018
			b	Breast Implant Replacement Surgery (Cosmetic or Non-Cosmetic Purposes): Silicone Breast Reconstruction	48	3	Monitored Approval	20/02/2018
		14.4		Mastopexy: Breast Lift Surgery	48	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.5		Nipple Inversion Surgical Correction	48	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.7		Electrolysis/Laser Therapy: Hair Removal	48	3	Monitored Approval	20/02/2018
		14.8		Pectus Anomaly (Pigeon Chest or Sunken Chest) Surgical Correction	49	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		14.9		Scar Revision Surgery	49	3	Monitored Approval	20/02/2018
		14.10		Tattoo Laser Removal	51	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.11		Abdominoplasty/Apronectomy: Surgical Excision of Redundant Skin or Fat	51	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.12		Thigh, Buttock or Arm Lift: Surgical Excision of Redundant Skin or Fat	52	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.13		Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)	52	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.16		Labiaplasty, Vaginoplasty and Hymenorrhaphy	54	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.17		Liposuction: Removal of Excess/Unwanted Fat	55	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		14.18		Rhytidectomy: Face or Brow Lift	56		Monitored Approval	20/02/2018
15	Respiratory	15.1		Snoring in the Absence of OSA Surgery (Adult) (NHS England Evidence Based Intervention)	56	1	Individual Funding Request (Exceptional Case) Approval	18/02/2019
16	Trauma and Orthopaedics	16.1	a	Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica	56	3	Monitored Approval	20/02/2018
			b	Opioids (Including Tramadol and Capasicin Cream): Low Back Pain Management	59	3	Monitored Approval	20/02/2018
			c	Capsaicin Cream, Cannabis Sativa Extract, Capsaicin Patch, Lacosamind, Lamotrigine, Levetiracetam, Morphine, Oxcarbazepine, Topiramate, Tramadol (For Long-Term Use), Venlafaxine: Lower Back Neuropathic Pain Treatment	59	3	Monitored Approval	20/02/2018
			d	TENS, PENS, Ultrasound, Interferential and Laser Therapy: Low Back Pain and Sciatica	60	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
			e	Paracetamol (Used Alone), SSRIS, Serotonin, Tricyclic Antidepressants, Anti-Convulsants: Back Pain without Neuropathic Pain	61	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		16.2	a	Spinal Imaging Emergency Referral: Low Back Pain	61	3	Monitored Approval	20/02/2018
			b	Spinal Priority Imaging (Protocol Led MRI Whole Spine Unless Contraindicated): Low Back Pain	62	3	Monitored Approval	20/02/2018
		16.3	a	Epidurals (Local Anaesthetic and Steroid): Low Back Pain (Non-Specific i.e. Mechanical)	63	3	Monitored Approval	18/02/2019

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
				(NHS England Evidence Based Intervention)				
			b	Radiofrequency Denervation: Low Back Pain Without Sciatica (Non-Specific i.e. Mechanical) (NHS England Evidence Based Intervention)	65	3	Monitored Approval	18/02/2019
			c	Spinal Injections (NHS England Evidence Based Intervention)	66	1	Individual Funding Request (Exceptional Case) Approval	18/02/2019
		16.4		Peripheral Nerve-Field Stimulation (PNFS): Chronic Low Back Pain	67	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		16.5		Therapeutic Endoscopic Division of Epidural Adhesions: Low Back Pain	67	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		16.6		Spinal Fusion; Non-Rigid Stabilisation Techniques; Lateral Body Fusion in the Lumbar Spine; Trans axial Interbody Lumbosacral Fusion; Anterior Lumbar Interbody Fusion (ALIF); Posterior Lumbar Interbody Fusion (PLIF); or Any Other Combination of Approach where Surgical Fixation is Performed: Spinal Fixation	67	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		16.7		Laminectomy, Discectomy, Facetectomy and Foraminotomy: Spinal Decompression	68	3	Monitored Approval	20/02/2018
		16.8		Bone Morphogenetic Protein (Dibotermin Alfa and Eptotermin Alfa): Non-Healing Fractures	70	3	Monitored Approval	2014/2015
		16.9		Hyaluronic Acid and Derivatives Injections: Peripheral Joint Pain	71	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		16.10		Steroid Joint Injections (Secondary Care Administered): Joint Pain	71	3	Monitored Approval	11/03/2020
		16.11	a	Hip Replacement Surgery	71	3	Monitored Approval	20/02/2018
			b	Hip Resurfacing	73	3	Monitored Approval	20/02/2018
		16.12		Hip Arthroscopy: Hip Impingement Syndrome/Femoro–Acetabular Impingement	73	3	Monitored Approval	2014/2015
		16.13		Knee Arthroplasty: Knee Replacement	74	3	Monitored Approval	20/02/2018
		16.14	a	Diagnostic Knee Arthroscopy: Knee Arthritis (Without Osteoarthritis)	76	3	Monitored Approval	2014/2015
			b	Diagnostic Knee Arthroscopy: Knee Arthritis (With Osteoarthritis)	76	3	Monitored Approval	2014/2015
		16.15		Knee Arthroscopy: Knee Osteoarthritis (NHS England Evidence Based Intervention)	76	3	Monitored Approval	18/02/2019

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		16.16		Uni-compartmental Knee Replacement (Patient Specific): Knee Osteoarthritis	76	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		16.17		Total Knee Replacement (Patient Specific)	77	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		16.18		Trigger Finger/Thumb Surgical Release (NHS England Evidence Based Intervention)	77	3	Monitored Approval	18/02/2019
		16.19	a	Collagenase Injection: Dupuytren's Contracture Release (Adults) (NHS England Evidence Based Intervention)	77	3	Monitored Approval	18/02/2019
			b	Needle Fasciotomy, Fasciectomy and Dermo-Fasciectomy: Dupuytren's Contracture Release (Adults) (NHS England Evidence Based Intervention)	77	3	Monitored Approval	18/02/2019
		16.20		Carpal Tunnel Syndrome Surgical Release (NHS England Evidence Based Intervention)	77	3	Monitored Approval	18/02/2019
		16.21		Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) Surgical Removal	77	3	Monitored Approval	2014/2015
		16.22		Ganglia Surgical Excision: Wrist or Hand (Seed and Mucous Cysts) (NHS England Evidence Based Intervention)	78	3	Monitored Approval	18/02/2019
		16.23		Bunion or Lesser Toe Deformity Surgery	78	3	Monitored Approval	2014/2015
		16.24		Morton's Neuroma Surgical Treatment	78	3	Monitored Approval	2014/2015
		16.25		Plantar Fasciitis Surgical Treatment	78	3	Monitored Approval	2014/2015
		16.26		Extracorporeal Shock Wave Therapy or Autologous Blood or Platelet Injections: Plantar Fasciitis, Achilles Tendinopathy, Refractory Tennis Elbow	79	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		16.27		Shoulder Arthroscopic Decompression: Pure Subacromial Shoulder Impingement (NHS England Evidence Based Intervention)	80	3	Monitored Approval	18/02/2019
17	Urology	17.1	a	Circumcision for Medical Reasons	81	3	Monitored Approval	20/02/2018
			b	Circumcision for Social, Cultural, or Religious Reasons	82	1	Individual Funding Request (Exceptional Case) Approval	20/02/2018
		17.3		Male Sterilisation Reversal: Infertility	82	1	Individual Funding Request (Exceptional Case) Approval	2014/2015

Specialty		Procedure / Treatment / Policy			Page No.	Funding Approval Category		Version (Date)
		17.4		Extracorporeal Shockwave Therapy (ESWT): Prostadynia or Pelvic Floor Syndrome	82	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		17.5		Hyperthermia Treatment: Prostadynia or Pelvic Floor Syndrome	83	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		17.6	a	Prostatism/Lower Urinary Tract Specialist Assessment Referral	83	3	Monitored Approval	11/03/2020
			b	Prostatism Surgery	84	3	Monitored Approval	11/03/202
18	Vascular Surgery	18.1		Endoscopic Thoracic Sympathectomy (Surgical Resection): Hyperhidrosis (Extreme Sweating)	85	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		18.2		Chelation Therapy: Vascular Occlusions	85	1	Individual Funding Request (Exceptional Case) Approval	2014/2015
		18.3	a	Vascular Service Referrals: Varicose Veins (Legs Only) (NHS England Evidence Based Intervention)	85	3	Monitored Approval	18/02/2019
			b	Compression Hosiery Treatment: Varicose Veins (NHS England Evidence Based Intervention)	85	3	Monitored Approval	18/02/2019
19	Other	19.1	a	Botulinum Toxin A	86	3	Monitored Approval	11/03/2020
			b	Botulinum Toxin B	90	1	Individual Funding Request (Exceptional Case) Approval	11/03/2020

1. Complementary Therapies

1.1 Complementary and Alternate Treatments e.g. Acupuncture, Homeopathy, Aromatherapy, Meditation, Colonic Irrigation. Osteopathy, Herbal Medicines etc.

CATEGORY 2 - RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ There is NICE Guidance for the proposed complementary or alternate therapy. ☐ This patient has a diagnosis for which NICE Guidance recommends the use of the requested therapy. ☐ A suitably qualified practitioner has been identified to deliver the therapy, who holds a contract with the NHS. **PLEASE NOTE:** Complementary and alternative medicines (CAMs) are treatments that fall outside of mainstream healthcare and in most cases the NHS will not offer these treatments. The National Institute for Health and Care Excellence (NICE) recommends the use of CAMs in a limited number of circumstances.	**Policy Statement** Complementary and alternate treatments e.g. acupuncture, homeopathy, aromatherapy, meditation, colonic irrigation. osteopathy, herbal medicines etc. are restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Complementary and alternate treatments, for example, acupuncture, homeopathy, aromatherapy, meditation, colonic irrigation. osteopathy, herbal medicines etc.) **Minimum eligibility criteria** Recommended by NICE guidance	***Version:*** *2014/2015* ***Clinical Coding:*** *OPCS only (Procedure driven): X611, X612, X613, X614, X618, X619, Y331, A705, A706*

Evidence for inclusion and threshold

1. Complementary and alternative medicine – NHS Choices 2012.
2. http://www.parliament.uk/business/committees/committees-a-z/commons-select/science-and-technology-committee/inquiries/homeopathy-/

2. Dermatology

2.1 Skin Resurfacing: Laser Dermabrasion and Chemical Peels

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has severe scarring on their head or neck as a result of acne, and the active disease is controlled.
- ☐ The patient has severe scarring on their head or neck as a result of chicken pox.
- ☐ The patient has severe scarring on their head or neck caused by trauma (including post-surgical).

PLEASE NOTE: This intervention is only routinely commissioned for the patient's head and/or neck area. If treatment is required for other areas of the body an Individual Funding Request must be completed. If the treatment is requested as a non-core procedure for a patient with gender dysphoria the Gender Identity Clinic should apply to the CCG for funding for the treatment.

Policy Statement
Skin resurfacing techniques including laser dermabrasion and chemical peels are restricted in accordance with the minimum eligibility criteria.

Minimum eligibility criteria
Procedures will only be performed on the head and neck area in cases of Severe scarring following:

- Acne once the active disease is controlled.

OR

- Chicken pox.

OR

- Trauma (including post-surgical).

Where the provision of "non-core" surgeries is appropriate, the GIC should apply for treatment funding through the CCG; the GIC should endeavour to work in partnership with the CCG.

Version: *2014/2015*

Clinical Coding:
OPCS only (Procedure driven): S103, S113, S601, S602

Evidence for inclusion and threshold

1. Modernisation Agency's Action on Plastic Surgery 2005.
2. Hædersdal, M., Togsverd-Bo, K., & Wulf, H. (2008). Evidence-based review of lasers, light sources and photodynamic therapy in the treatment of acne vulgaris. *Journal of the European Academy of Dermatology and Venereology*, *22*, 267–78.
3. Department of Dermatology, Bispebjerg Hospital, University of Copenhagen, Copenhagen, Denmark. Collated on NHS evidence website suggests that short-term efficacy from optical treatments for acne vulgaris with the most consistent outcomes for PDT.
4. www.evidence.nhs.uk
5. Interim Gender Dysphoria Protocol & Service Guidelines 2013/14. NHS England interim protocol NHS England (2013) - Pages 13 & 14 describe non-core NHS England & CCG commissioning responsibilities.
6. Non-core procedure Interim Gender Dysphoria Protocol & Service Guidelines 2013/14.

2.2 Benign Skin Lesions: Surgical Removal

Including: benign moles (excluding large congenital naevi); solar comedones; corn/callous; dermatofibroma; lipomas; milia; molluscum contagiosum (non-genital); epidermoid and pilar cysts (sometimes incorrectly called sebaceous cysts); seborrhoeic keratoses (basal cell papillomata); skin tags (fibroepithelial polyps) including anal tags; spider naevi (telangiectasia); non-genital viral warts in immunocompetent patients; xanthelasmata; neurofibromata.
(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin005 – Benign skin lesions, removal v1 01/04/2023

2.4 Skin Pigment Disorder: Biopsy or Camouflage

This policy has been superseded by ICB Policy CMICB_Clin009 – Camouflage Treatment for Skin Pigmentation and other disorders v1 01/04/2023

2.5 Viral Warts (Excluding Genital Warts): Surgical/Laser Therapy from Secondary Care Providers

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following the following statements:

- ☐ The patient is experiencing severe pain which is substantially interfering with functional abilities.
- ☐ The patient's warts have persisted for at least 2 years and they are spreading and have been refractive to at least 3 months of primary care or community treatment.
- ☐ The patient has extensive warts.
- ☐ The patient has facial warts.

PLEASE NOTE: Community treatments such as cryosurgery, curettage and prescription only topical treatments should be considered before referral to secondary care for surgical treatment. A referral to a Dermatologist for assessment should be considered for patients who are immuno-suppressed who have severe pain and/or persistent or extensive warts.

Policy Statement
Surgical/laser therapy for viral warts (excluding genital warts) from secondary care providers, are restricted in accordance with the minimum eligibility criteria.

Minimum eligibility criteria

- Severe pain substantially interfering with functional abilities.
- Persistent and spreading after 2 years and refractive to at least 3 months of primary care or community treatment.
- Extensive warts (particularly in the immune-suppressed patient).
- Facial warts.
- Patients with the above exceptional symptoms may need specialist assessment, usually by a dermatologist.

Rationale
Most viral warts will clear spontaneously or following application of topical treatments.
65% are likely to disappear spontaneously within 2 years.
There are numerous OTC preparations available.
Community treatments such a cryosurgery, curettage, prescription only topical treatment should be considered before referral to secondary care.

Version: *2014/2015*

Clinical Coding:
ICD-10 Only (Diagnosis driven):
B07X

Evidence for inclusion and threshold

1. Modernisation Agency's Action on Plastic Surgery 2005.
2. Nongenital warts: recommended approaches to management Prescriber 2007 18(4) p33-44.

2.5 Viral Warts (Excluding Genital Warts): Surgical/Laser Therapy from Secondary Care Providers

3. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
4. patient.co.uk/doctor/viral-warts-excluding-verrucae
5. http://www.patient.co.uk/doctor/verrucae

3. Diabetes

3.1a Continuous Glucose Monitors (Adults): Type 1 Diabetes

This local policy has been removed. Please refer directly to NICE guidance.

3.1b Continuous Glucose Monitors (Children and Young People): Type 1 Diabetes

This local policy has been removed. Please refer directly to NICE guidance.

3.2 Insulin Pump Therapy (Continuous Sub-Cutaneous Insulin Infusion (CSII)) Therapy: Type 1 Diabetes (Including Cystic Fibrosis Related Diabetes):

This local policy has been removed. Please refer directly to NICE guidance.

4. ENT

4.1 Adenoidectomy

This policy has been superseded by ICB Policy CMICB_Clin002 – Adenoidectomy v1 01/04/2023

4.2 Pinnaplasty / Otoplasty: Prominent Ears

CATEGORY 2 - RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ The patient is age ≥ 7 years to ≤ 18 years ☐ The patient has prominent ear, upper 3rd mastoid – helical distance is ≥21.5 mm	**Policy Statement** Pinnaplasty is restricted in accordance with the Minimum Eligibility Criteria. **Summary of intervention** Ear correction surgery is cosmetic surgery to alter the size or shape of the ears or pin them back if they stick out/protrude.	***Version:*** *09/12/2020* ***Clinical Coding:*** *OPCS only (Procedure driven): D033*

4.2 Pinnaplasty / Otoplasty: Prominent Ears

☐ The patient is suffering from significant psychological distress due to their prominent ears as determined by a consultant surgeon (confirmed by documentary evidence if available), **OR** is experiencing significant functional difficulties such as inability to keep a hearing aid in place or ears folding over when asleep causing pain. ☐ The child and parent understand the risks, likely outcome and are motivated to proceed with surgery.	Protruding ears can be distressing to the individual who has them. This procedure aims to improve the appearance of the ear without cutting into the skin. A hollow needle is used to divide the ear cartilage, and stitches buried under the skin are used to remould the ear. Pinning back the ears is known as an otoplasty, or pinnaplasty. It is usually carried out on children and young teenagers, although adults may wish to have it done, too. An otoplasty is not suitable for children younger than five as their ears will still be growing and developing. Most people are happy with the results of an otoplasty, and generally it is a safe procedure. But it can be expensive and there are risks that need considering. Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/ear-correction-surgery.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx **Minimum Eligibility Criteria** Children with prominent ears should be offered Pinnaplasty/Otoplasty according to the following criteria: • Age ≥ 7 years to ≤ 18 years AND • Prominent ear, upper 3rd mastoid – helical distance is ≥21.5 mm AND • During the clinical assessment, a consultant surgeon is able to verify that the child is suffering from significant psychological distress due to their prominent ears (provision of documented evidence, e.g. from the child's school will complement this assessment but is not essential) AND • The child and parent understand the risks, likely outcome and are motivated to proceed with surgery. With the exception of functional reasons e.g. to keep a hearing aid in place or ears folding over when asleep causing pain, all other cases of pinnaplasty will not be commissioned. **Rationale for restriction** Pinnaplasty is generally regarded as a cosmetic procedure in the majority of cases. This is particularly so in adults. Even in children, not all patients with prominent ear will benefit from surgery. Therefore, this policy is restricted to those children most likely to benefit i.e. those suffering significant psychological distress due to their prominent ears. These criteria were	

4.2 Pinnaplasty / Otoplasty: Prominent Ears		
	developed following a critical appraisal of the literature (Sept 2020) and in conjunction with local surgeons. The principal entrance criterion, a prominent ear, upper 3rd mastoid – helical distance of ≥21.5 mm), is based on a literature definition of a "normal" ear and this was confirmed as clinically appropriate by local surgeons. The upper age limit of 18 years is consistent with Royal College of Surgeons' guidance for this procedure. However, the lower age limit of 7 years in this policy has also been specified by local surgeons on grounds of a local audit which demonstrated a greater number of complications in the younger age group.	

Evidence for inclusion and threshold

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2. Nazarian R, Eshraghi AA. Otoplasty for the protruded ear. Seminars in plastic surgery 2011;25(4):288-94. doi: 10.1055/s-0031-1288921
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6. Fioramonti P, Serratore F, Tarallo M, et al. Otoplasty for prominent ears deformity. European review for medical and pharmacological sciences 2014;18(21):3156-65.
7. Walker FDL, Kubba H, Clement WA. Use of facial proportions in pinnaplasty assessment. Journal of plastic, reconstructive & aesthetic surgery : JPRAS 2011;64(8):1110-13. doi: 10.1016/j.bjps.2011.03.007
8. Yugueros P, Friedland JA. Otoplasty: the experience of 100 consecutive patients. Plastic and reconstructive surgery 2001;108(4):1045.
9. Petersson RS, Friedman O. Current trends in otoplasty. Current opinion in otolaryngology & head and neck surgery 2008;16(4):352-58. doi: 10.1097/MOO.0b013e328304b40d
10. Stewart KJ, Lancerotto L. Surgical Otoplasty: An Evidence-Based Approach to Prominent Ears Correction. Facial plastic surgery clinics of North America 2018;26(1):9-18. doi: 10.1016/j.fsc.2017.09.002
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13. Incisionless otoplasty. Interventional procedures guidance. London: National Institute for health and care excellence, 2012.
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15. Horlock N, Vogelin E, Bradbury ET, et al. Psychosocial outcome of patients after ear reconstruction: a retrospective study of 62 patients. Ann Plast Surg 2005;54(5):517-24. [published Online First: 2005/04/20]
16. Gasques JAL, Pereira de Godoy JM, Cruz EMTN. Psychosocial effects of otoplasty in children with prominent ears. Aesthetic plastic surgery 2008;32(6):910-14. doi: 10.1007/s00266-008-9179-x
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18. Braun T, Hainzinger T, Stelter K, et al. Health-related quality of life, patient benefit, and clinical outcome after otoplasty using suture techniques in 62 children and adults. Plastic and reconstructive surgery 2010;126(6):2115-24. doi: 10.1097/PRS.0b013e3181f449c7

4.2 Pinnaplasty / Otoplasty: Prominent Ears

19. Bermueller C, Kirsche H, Sebert A, et al. Quality of life and patients' satisfaction after otoplasty. European archives of oto-rhino-laryngology : official journal of the European Federation of Oto-Rhino-Laryngological Societies (EUFOS) : affiliated with the German Society for Oto-Rhino-Laryngology - Head and Neck Surgery 2012;269(11):2423-31. doi: 10.1007/s00405-012-2060-1
20. Hao W, Chorney JM, Bezuhly M, et al. Analysis of health-related quality-of-life outcomes and their predictive factors in pediatric patients who undergo otoplasty. Plastic and reconstructive surgery 2013;132(5):811e. doi: 10.1097/PRS.0b013e3182a3c133
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4.3a Grommets Insertion (Children): Otitis Media with Effusion/Glue Ear

(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin023 – Grommets for glue ear in children v1 1/04/2023

4.3b Grommets Insertion (Adults): Otitis Media with Effusion/Glue Ear

CATEGORY 2 - RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient is an adult with significant negative middle ear pressure measured on two sequential appointments and has significant ongoing associated pain. ☐ The patient is an adult and has unilateral middle ear effusion where a post-nasal space biopsy is required to exclude an underlying malignancy.	**Policy Statement** Insertion of grommets for glue ear (otitis media with effusion) in adults is restricted in accordance with the minimum eligibility criteria. **Minimum eligibility criteria** • Significant negative middle ear pressure measured on two sequential appointments. **AND** • Significant ongoing associated pain. **OR** • Unilateral middle ear effusion where a postnasal space biopsy is required to exclude an underlying malignancy.	***Version:*** *2014/2015* ***Clinical Codes:*** *ICD-10 inclusion: H652, H653, H66** *Age qualifier: >=18* *OPCS with ICD Inclusions (Procedure driven), requires additional age qualifier:* *OPCS4: D151, D289*

4.3b Grommets Insertion (Adults): Otitis Media with Effusion/Glue Ear		
PLEASE NOTE: It is not necessary to obtain authorisation to insert grommets for patients with recurrent acute otitis media or atrophic tympanic membranes, or in order to access the middle ear for transtympanic instillation of medication, or to investigate unilateral glue ear in adults.		
Evidence for inclusion and threshold		
1. http://www.rcseng.ac.uk/healthcare-bodies/docs/published-guides/ome - Royal College of Surgeons (2013). 2. http://www.england.nhs.uk/wp-content/uploads/2013/11/N-SC015.pdf		

4.4 Tonsillectomy: Recurrent Tonsillitis **(NHS England Evidence Based Intervention)**
This policy has been superseded by ICB Policy CMICB_Clin046 – Tonsillectomy v1 1/04/2023

4.5 External Ear Lobe: Surgical remodelling
This policy has been superseded by ICB Policy CMICB_Clin45 – Split (cleft) Earlobe, surgical repair v1 1/04/2023

4.6 Sinus X-ray: Rhinosinusitis or Sinusitis
This policy has been superseded by ICB Policy CMICB_Clin44 – Sinus X-Ray v1 1/04/2023

4.7a Rhinoplasty / Septoplasty: Nose Reconstruction for Non-Cosmetic/Other Reasons		
CATEGORY 2 - RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient has documented medical breathing problems caused by obstruction of the nasal airway. ☐ The surgery is being undertaken to correct a complex congenital conditions e.g. cleft lip and palate.	**Policy Statement** Rhinoplasty/Septoplasty for non-cosmetic/other reasons is restricted in accordance with the Minimum Eligibility Criteria. **Summary of intervention** Rhinoplasty, commonly known as a 'nose job', is a plastic surgery procedure for correcting and reconstructing the form, restoring the functions, and aesthetically enhancing the nose by resolving nasal trauma (blunt, penetrating, blast), congenital defect, respiratory impediment, or a failed primary rhinoplasty. **Minimum eligibility criteria**	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with both ICD Inclusions and Exclusions.* *OPCS4: E023, E024, E025, E026, E028, E073, E022, E027, E029, E036, E037, E071, E072, E078, E079* *ICD-10 exclusions: Z411,* *ICD-10 inclusions: Q351, Q353, Q355, Q357, Q359, Q360, Q361,*

4.7a Rhinoplasty / Septoplasty: Nose Reconstruction for Non-Cosmetic/Other Reasons		
	The CCG will fund this treatment if the patient meets the following criteria: • Documented medical breathing problems caused by obstruction of the nasal airway **OR** • Correction of complex congenital conditions e.g. Cleft lip and palate This means **(for patients who DO NOT meet the above criteria or require the procedure for cosmetic reasons)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. **Rationale** This is because if you have a blocked nose because your nasal bones are crooked or damaged, or the bone and cartilage between your nostrils is deviated (bent) a septoplasty can improve how you breathe. Cosmetic surgery is often carried out to change a person's appearance in order to achieve what a person perceives to be a more desirable look. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.	*Q369, Q370, Q371, Q372, Q373, Q374, Q375, Q378, Q379, J348, S022, S099, J342, M950*
Evidence for inclusion and threshold		
1. Royal College of Surgeons – Rhinoplasty Guide - Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/nose-job/		

4.7b Rhinoplasty / Septoplasty: Nose Reconstruction for Cosmetic Reasons		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 4.7a Rhinoplasty/Septoplasty for cosmetic reasons is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with both ICD Inclusions & Exclusions.* *OPCS4: E023, E024, E025, E026, E028, E073, E022, E027, E029, E036, E037, E071, E072, E078, E079* *ICD-10 inclusions: Z411, J342, M950* *ICD-10 exclusions: Q351, Q353, Q355, Q357, Q359, Q360, Q361, Q369, Q370, Q371, Q372, Q373, Q374, Q375, Q378, Q379, J348, S022, S099*
Evidence for inclusion and threshold		
Please refer to 4.7a		

4.8 Rhinophyma Surgery or Laser Treatment

This policy has been superseded by ICB Policy CMICB_Clin41 - Rhinophyma, surgical management v1 1/04/2023

5. Equipment

5.1 Lycra Suits: Cerebral Palsy Posture Management

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Lycra suits for postural management of cerebral palsy is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Rationale** Lycra Suits are not normally commissioned for postural management of cerebral palsy. Evidence does not support routine commissioning of Lycra suits in the management of Cerebral Palsy. Any application for exceptional funding should include a comprehensive assessment of the child's postural management needs with clear outcome goals and time frames.	***Version:*** *2014/2015* ***Clinical Coding:*** *Not driven by clinical coding*

Evidence for inclusion and threshold

1. What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy? Health Improvement Scotland, May 2013.
2. Blackmore AM, Garbellini SA, Buttigieg P & Wells J. (2006) A systematic review of the effects of soft splinting on upper limb function in people with cerebral palsy. *An AACPDM Evidence Report*
3. Coghill JE & Simkiss DE. (2010) Do Lycra garments improve function and movement in children with cerebral palsy. *Archives of Disease in Childhood* 95: 393-396.
4. Corn K, Imms C, Timewell G, Carter C, Collins L, Dubbeld S, Schubiger S & Froude E. (2009) Impact of second skin Lycra splinting on the quality of upper limb movement in children. *British Journal of Occupational Therapy*, October 2003, vol.66/10(464-472), 0308-0226
5. Eddison N & Chockalingam N. (2013) The effect of tuning ankle foot orthoses-footwear combination on the gait parameters of children with cerebral palsy. *Prosthetics and Orthotics International*, vol.37/2(95-107), 0309-3646;1746-1553
6. Elliott CM, Reid SL, Alderson JA & Elliott BC. (2011) Lycra arm splints in conjunction with goal-directed training can improve movement in children with cerebral palsy. *NeuroRehabilitation*. vol.28/1(47-54), 1053-8135;1878-6448
7. Figueiredo EM, Ferreira GB, Maia Moreira RC, Kirkwood RN & Fetters L. (2008) Efficacy of ankle-foot orthoses on gait of children with cerebral palsy: systematic review of literature. *Pediatric physical therapy : the official publication of the Section on Pediatrics of the American Physical Therapy Association*, vol.20/3(207-223), 1538-005X
8. Flanagan A, Krzak J, Peer M, Johnson P & Urban M. (2009) Evaluation of short-term intensive orthotic garment use in children who have cerebral palsy *Pediatric Physical Therapy*, 21: 201-4.
9. Health Improvement Scotland (2013). *What is the clinical and cost effectiveness of dynamic elastomeric fabric orthoses (DEFOs) for cerebral palsy*?
10. Knox V. (2003) The use of Lycra garments in children with cerebral palsy: A report of a descriptive clinical trial. *British Journal of Occupational Therapy*, vol.66/2(71-77), 0308-0226.
11. Matthews MJ, Watson M & Richardson B. (2009) Effects of dynamic elastomeric fabric orthoses on children with cerebral palsy. *Prosthetics and Orthotics International* 33 (4): 339-347.
12. Mol EM, Monbaliu E, Ven M, Vergote M & Prinzie P. (2012) The use of night orthoses in cerebral palsy treatment: sleep disturbance in children and parental burden or not?. *Research in Developmental Disabilities* 33: 341-9.

5.1 Lycra Suits: Cerebral Palsy Posture Management

13. Morris C, Bowers R, Ross K, Stevens P & Phillips D. (2011) Orthotic management of cerebral palsy: recommendations from a consensus conference. *Neurorehabilitation*, 28 :37-46.
14. Nicholson JH, Morton RE, Attfield S & Rennie D. (2001) Assessment of upper-limb function and movement in children with cerebral palsy wearing Lycra garments. *Developmental Medicine & Child Neurology* 43: 384-91.
15. Raper J, Horridge K.A, Prudhoe S, Morrison A & Thorley A. (2011) Dynamic Lycra splints for children and young people with cerebral palsy: Do parents and professionals think they make a positive difference?. *Developmental Medicine and Child Neurology*, vol.53/(37), 0012-1622
16. Williamson EM, Mobley J, Kidd K. (2009) The effect of orthotic devices on gait symmetry of children with spasticity in the lower extremities. *Developmental Medicine and Child Neurology* 51/(64), 0012-1622.

6. Fertility

6.1 Infertility Treatment

e.g. medicines, surgical procedures and assisted conception. This also includes reversal of vasectomy or female sterilisation

See separate standalone CCG document - Assisted Conception / Subfertility Policy.

7. Gastroenterology

7.1 Haemorrhoids Surgical Removal

(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin024 – Haemorrhoids, surgical management v1 01/04/2023

7.2a Hernias Incisional and Ventral (Asymptomatic) Surgical Treatment

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Surgery to treat asymptomatic incisional and ventral hernias is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Summary of Intervention** A hernia occurs when an internal part of the body pushes through a weakness in the muscle or surrounding tissue wall. A hernia usually develops between your chest and hips. In many cases, it causes no or very few symptoms, although you may notice a swelling or lump in your tummy (abdomen) or groin.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with both ICD Inclusions and Exclusions (Procedure driven):* *OPCS4: T25*, T27*, T288* *ICD-10 exclusions: K430, K431* *ICD-10 inclusion: K432*

7.2a Hernias Incisional and Ventral (Asymptomatic) Surgical Treatment		
	The lump can often be pushed back in or disappears when you lie down. Coughing or straining may make the lump appear. **Rationale** These procedures are highly specialised and techniques for treatment are not well developed making treatment complicated. A good summary about treating hernias is provided by NHS Choices:Weblink: http://www.nhs.uk/conditions/hernia/Pages/Introduction.aspx A good summary about Disatasis Recti is provided by NHS Choices: Weblink: http://www.nhs.uk/conditions/pregnancy-and-baby/pages/your-body-after-childbirth.aspx?tabname=pregnancy#separated	
Evidence for inclusion and threshold		
1. A systematic review on the outcomes of correction of diastasis of the recti - Hernia, December 2011, Volume 15, Issue 6, pages 607-614, Hickey et al.		

7.2b Diastasis of the Recti Surgical Correction
This policy has been superseded by ICB Policy CMICB_Clin014 – Diastasis (divarication) of the Recti Repair v1 1/04/2023

7.3 Gallstones (Asymptomatic) Surgical Treatment
This policy has been superseded by ICB Policy CMICB_Clin021 – Gallstones (Asymptomatic), Surgical Management v1 1/04/2023

7.4 Gallstones Lithotripsy		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Lithotripsy for gallstones is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. **Rationale** Lithotripsy rarely performed as rate of recurrence high.	***Version:*** *2014/2015* ***Clinical Coding:*** *OPCS only (Procedure driven): J261*

7.5 Transanal Irrigation		
CATEGORY 2 – Restricted **Monitored Approval** The CCG will only fund this treatment in **ALL** the following circumstances:	**Policy Statement** Transanal irrigation is restricted in accordance with the minimum eligibility criteria. **Summary of Intervention**	***Version: 11/03/2020*** ***Clinical Coding:***

7.5 Transanal Irrigation

☐ The patient suffers with one of the following conditions: • Neurogenic bowel dysfunction; • Post anterior resection syndrome; • Congenital bowel malformations; • Slow transit bowel; • Obstructive defaecation; • Faecal incontinence. ☐ The patient has undergone an adequate trial of all other less invasive management options such as diet, lifestyle, defecation dynamics, pelvic floor re-education, bowel retraining, cognitive behavioural therapy and drug therapy and although these have been maximised they proved unsuccessful. ☐ The patient has tried all appropriate laxatives at adequate doses and for several months at a time. ☐ The patient has undergone all appropriate investigations, including sigmoidoscopy, colonoscopy, defecating proctogram, biofeedback to strengthen the sphincter or transit studies. ☐ The treatment has been prescribed initially by a consultant-led multidisciplinary specialist service which will: -commit to using the most cost-effective system -use a balloon pump rather than an electric pump for all patients, with the exception of those with very poor dexterity -establish patients on alternate day use and gain agreement from the patient to use the irrigation system regularly and -re-evaluate the treatment at 8-12 weeks should a reliable and effective routine not be established -Make arrangements for ongoing structured patient and Primary Care clinician support, including: • Patient, carers and NHS staff specialist training in the use of the irrigation system.	Transanal irrigation systems are a highly specialist management option and should not be initiated by GPs in primary care, without specialist management. Comprehensive training for the individual plus on-going structured support is essential for safe and efficient long-term use of rectal irrigation[1]. Rectal irrigation should only be used after medication has been tried (oral drugs, suppositories and enemas), changes to the diet have been made and various physiotherapy and retraining sessions have taken place. Patients must be motivated and determined to succeed with rectal irrigation. The evidence is weak[2]. The best evidence comes from a trial of 87 patients with neurogenic bowel dysfunction as a result of spinal cord injury[3] but even this is limited as the outcome measures are reported by the patients. The NICE costing model is based on adults with neurogenic bowel dysfunction from the trial above and NICE admits there is considerable uncertainty in the costing. The estimated savings are £2,867 per patient over 37 years, based on it being used every other day. The savings are based on fewer hospital visits, fewer healthcare professional visits, less carer time, reduced faecal incontinence leading to fewer incontinence pads and fewer urinary tract infections. **Minimum Eligibility Criteria** Transanal irrigation is commissioned for adults and children with neurogenic bowel dysfunction, post anterior resection syndrome, congenital bowel malformations, slow transit bowel, obstructive defaecation and a limited number of patients with faecal incontinence. All patients should meet the eligibility criteria below. ALL the following criteria must be met and apply to all patients whether referred to the specialist service by the GP or by another secondary care specialty: Only commissioned for adults and children who have already undergone an adequate trial of all other less invasive management options such as diet, lifestyle, defecation dynamics, pelvic floor re-education, bowel retraining, cognitive behavioural therapy and drug therapy and these have been maximised but proved unsuccessful. • All appropriate laxatives should have been tried at adequate doses and for several months at a time. See Pan Mersey Constipation Guidelines . • All appropriate investigations should have been carried out, including sigmoidoscopy, colonoscopy, defecating proctogram, biofeedback to strengthen the sphincter or transit studies. • Prescribing should be initiated by a consultant-led multidisciplinary specialist service and the most cost-effective system should be used. • The patient, carers and NHS staff supporting the patient should receive specialist training in the use of the irrigation system.	

7.5 Transanal Irrigation		
• Written information for both the patient, their carer and the Primary Care clinician, advising of risk awareness and action to take including relevant and appropriate specialist service contact telephone numbers for advice and guidance. • Primary Care clinician support material to enable monitoring of compliance and effectiveness and ongoing prescribing and supervision.	• Ongoing structured patient support including written information, risk-awareness and action to take and contact telephone numbers must be established before the specialist requests a transfer of prescribing to primary care. • The patient's Primary Care Clinician must be supplied with enough written supporting material to monitor compliance and effectiveness and to be able to provide ongoing prescribing and supervision, plus a contact telephone number. GPs do not have to take over prescribing if they do not feel confident and competent to do so. • The specialist service should be available for advice and support for both patients and Primary Care Clinicians. • A balloon pump should be used if possible. Electric pumps should only be used for patients that meet all the other criteria but have very poor dexterity e.g. as a result of spinal injury, MS or CVA and are unable to use a balloon pump. The patient should be established on alternate day use by the specialist service and the irrigation system should be stopped if the patient does not use it regularly or does not want to continue with it. There should be a demonstrable improvement in validated measures of bowel function such as the Cleveland Clinic constipation scoring system, St Mark's faecal incontinence score or neurogenic bowel dysfunction score It may take 4-12 weeks to establish a reliable and effective routine. If success has not been achieved by 8-12 weeks, a re-evaluation needs to be undertaken. The specialist service should retain prescribing until the training and support criteria have been met.	

Evidence for inclusion and threshold

1. PrescQIPP Bulletin 171 February 2017. Rectal Irrigation (DROP-List)
2. NICE Medical Technology Guidance February 2018. Peristeen transanal irrigation system for managing bowel dysfunction.
3. Christenson P et al. A randomized, controlled trial of transanal irrigation versus conservative bowel management in spinal cord-injured patients. Gastroenterology 2006;131:738-747

8. Gynaecology

8.1a Hysterectomy: Heavy Menstrual Bleeding – Fibroids <3cm, or Suspected/Diagnosed Adenomyosis, or No Identified Pathology
(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy v1 01/04/2023

8.1b	Hysterectomy: Heavy Menstrual Bleeding – Fibroids ≥3cm in Diameter (NHS England Evidence Based Intervention)
This policy has been superseded by ICB Policy CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy v1 01/04/2023	

8.1c	Hysterectomy: Heavy Menstrual Bleeding with Submucosal Fibroids (NHS England Evidence Based Intervention)
This policy has been superseded by ICB Policy CMICB_Clin026 – Heavy Menstrual Bleeding, Hysterectomy v1 01/04/2023	

8.2	Dilatation and Curettage (D&C): Heavy Menstrual Bleeding (NHS England Evidence Based Intervention)
This policy has been superseded by ICB Policy CMICB_Clin025 - Heavy Menstrual Bleeding, Dilatation and Curettage v1 1/04/2023	

9. Mental Health

9.1 Chronic Fatigue Syndrome (CFS) Inpatient Care and Treatment

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Inpatient care for treatment of chronic fatigue syndrome (CFS) is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Rationale** Care of persons with CFS should take place in a community setting under the care of a specialist in CFS if necessary. NICE section 1.915 states: Most people with CFS will not need hospital admission. However, there may be circumstances when a planned admission should be considered. The decision to admit should be made with the person with CFS and their family, and be based on an informed consideration of the benefits and disadvantages. For example, a planned admission may be useful if assessment of a management plan and investigations would require frequent visits to the hospital.	***Version:*** *2014/2015* ***Clinical Coding*** *ICD-10 only (Diagnosis driven): G933*
Evidence for inclusion and threshold		

9.1 Chronic Fatigue Syndrome (CFS) Inpatient Care and Treatment

1. *Chronic fatigue syndrome/myalgic encephalomyelitis (or encephalopathy): diagnosis and management of CFS/ME in adults and children* – NICE 2007, CG53.
2. *Cognitive behaviour therapy for chronic fatigue syndrome in adults* - Cochrane Depression, Anxiety and Neurosis Group 2008.
3. *Adaptive pacing, cognitive behaviour therapy, Graded exercise, and specialist medical care for chronic fatigue syndrome: A cost-effectiveness analysis* - . PLoS ONE 7(8): e40808. doi:10.137.
4. *Cost-effectiveness of counselling, graded-exercise and usual care for chronic fatigue: evidence from a randomised trial in primary care* - BMC Health Services Research 2012, 12:264.

9.3 Drug and Alcohol Rehabilitation: Non-NHS Commissioned Services

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Non-NHS Drug and Alcohol Rehabilitation (non-NHS commissioned services) is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional.	***Version:*** *2014/2015* ***Clinical Coding*** *Not driven by Clinical Coding*

Evidence for inclusion and threshold

1. Interventions to reduce substance misuse among vulnerable young people – NICE Public Health Guidance 4 (2007)
2. Drug misuse: psychosocial interventions – NICE Clinical Guideline 51 (2007).
3. Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence – NICE Clinical Guideline 115 (2011).

9.4 Private Mental Health Care

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Private Mental Health Care is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Rationale** Private Mental Health Care is not routinely commissioned because most mental health conditions can be managed in the community with input from Community Mental Health teams. NHS England Specialist Commissioning provides NHS specialist services for various conditions including PTSD, eating disorders and severe OCD. There is also a specialist NHS Mental Health service provided for affective disorders.	***Version:*** *20/02/2018* ***Clinical Coding*** *Not driven by Clinical Coding*

10. Neurology

10.1 Bobath Therapy: Neurological conditions

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Bobath Therapy is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. by the NHS. **Rationale** The evidence base is poor for both children and adults.	***Version:*** *2014/2015* ***Clinical Coding*** *Not driven by Clinical Coding*

Evidence for inclusion and threshold

1. The Effectiveness of the Bobath Concept in Stroke Rehabilitation: What is the Evidence? Stroke, 2009; 40:e89-e97.
2. Can physiotherapy after stroke based on the Bobath Concept result in improved quality of movement compared to the motor relearning programme - Physiotherapy Research International - Volume 16, Issue 2, pages 69–80, June 2011.
3. Bobath Concept versus constraint-induced movement therapy to improve arm functional recovery in stroke patients: a randomized controlled trial Clinical Rehabilitation, 2012 Aug;26(8):705-15.
4. http://www.cambridgeshireandpeterboroughccg.nhs.uk/downloads/CCG/GB%20Meetings/2013/05%20March/Agenda%20Item%202.5a%20-%20Bobath%20Therapy%20for%20Cerebal%20Palsy.pdf Cambridge CCG (2013).
5. A rapid review of the evidence for the effectiveness of Bobath therapy for children and adolescents with cerebral palsy National Public Health Service for Wales (2008).

10.2 Trophic Electrical Stimulation: Idiopathic Facial/Bell's Palsy

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Trophic electrical stimulation for idiopathic facial/Bell's palsy is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. by the NHS.	***Version:*** *2014/2015* ***Clinical Coding*** *OPCS with ICD Inclusions (Diagnosis driven):* *OPCS4: A338 with secondary OPCS4: Y901 & Z035* *ICD-10 inclusions: G510*

Evidence for inclusion and threshold

1. Physical therapy for Bell's palsy (idiopathic facial paralysis). Cochrane Database of Systematic Reviews. Issue 12 (2011).

10.3a Functional Electrical Stimulation (FES): Foot Drop of Central Neurological Origin e.g. Stroke, MS, Spinal Cord Injury

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient's foot drop is of central neurological origin such as stroke, MS, spinal cord injury.
- ☐ The patient has receptive cognitive abilities.
- ☐ The patient DOES NOT have fixed contractures of the joints associated with the muscles to be stimulated.
- ☐ The patient DOES NOT have chronic oedema the site to be stimulated.
- ☐ The patient DOES NOT have deep vein thrombosis.
- ☐ The patient DOES NOT have receptive dysphasia (the inability to understand instructions).
- ☐ The patient DOES NOT have complete peripheral nerve damage.
- ☐ The patient DOES NOT have a pacemaker in situ.
- ☐ The patient is NOT pregnant and has no intention to become pregnant.
- ☐ The patient DOES NOT have active cancer.
- ☐ The patient DOES NOT have uncontrolled epilepsy.
- ☐ The patient DOES NOT have metal (e.g. a pin or plate) in the region to be stimulated.

Policy Statement
Functional Electrical Stimulation (FES) for foot drop of central neurological origin e.g. stroke, MS, spinal cord injury is restricted in accordance with the minimum eligibility criteria.

Minimum eligibility criteria
Commissioned for foot drop of central neurological origin, such as stroke, MS, spinal cord injury.
It is not routinely commissioned for lower motor neurone lesions.
It is under review by NICE for dysphagia and muscle recovery chronic disease.
Patients must have receptive cognitive abilities.

Exclusion Criteria:

- Fixed contractures of joints associated with muscles to be stimulated. Broken or poor condition of skin.
- Chronic oedema at site of stimulation.
- Diagnosis of deep vein thrombosis.
- Receptive dysphasia (unable to understand instructions).
- Complete peripheral nerve damage.
- Pacemaker in situ.
- Pregnancy or intention to become pregnant.
- Active cancer.
- Uncontrolled epilepsy.
- Metal in region of stimulation e.g.: pin and plate.
- Ataxic and polio patients are generally poor responders although there are exceptions.

Version: *2014/2015*

Clinical Coding
OPCS with ICD exclusions (Procedure driven):
OPCS4: A701, A704, A708
ICD exclusions: M213

Evidence for inclusion and threshold

1. Functional Electric Stimulation (FES) for Children with Cerebral Palsy: Clinical Effectiveness – CADTH Rapid Response Service, 2011.
2. Children with cerebral palsy: a systematic review and meta-analysis on gait and electrical stimulation. Clinical Rehabilitation. 2010 Nov; 24(11):963-78.
3. Interventions for dysphagia and nutritional support in acute and subacute stroke Cochrane Database of Systematic Reviews 2012, Issue 10.
4. Functional electrical stimulation for drop foot of central neurological origin - NICE, 2009.
5. Functional electrical stimulation for rehabilitation following spinal cord injury Centre for Reviews and Dissemination, NIHR, 2011.

10.3b Functional Electrical Stimulation (FES): Lower Motor Neurone Lesions

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 10.3a Functional Electrical Stimulation (FES) for lower motor neurone lesions is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *2014/2015* ***Clinical Coding*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: A701, A704, A708* *ICD exclusions: M213*

Evidence for inclusion and threshold

Please refer to 10.3a

11. Ophthalmology

11.1 Blepharoplasty: Upper Eyelid Correction

CATEGORY 2 - RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ The patient has excess skin in the upper eyelid. ☐ The excess skin is interfering with the patient's visual field. ☐ The requirement for surgical correction has been confirmed by an appropriate specialist.	**Policy Statement** Upper Eyelid Blepharoplasty is restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Excess skin in the upper eyelids can accumulate due to ageing and is thus normal. Hooded lids causing significant functional impaired vision confirmed by an appropriate specialist can warrant surgical treatment. **Minimum Eligibility Criteria** Only commissioned in the following circumstances: • Eyelid function interferes with visual field.* *Impairment to visual field to be documented.	***Version:*** *2014/2015* ***Clinical Coding*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: C132* *ICD exclusions: H534*

Evidence for inclusion and threshold

1. Eyelid Surgery
2. The British Association of Aesthetic Plastic Surgeons 2011.
3. Modernisation Agency's Action on Plastic Surgery 2005.
4. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base
5. London Health Observatory 2010.

11.2 Lower Eyelid Correction: Blepharoplasty

CATEGORY 2 - RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The surgery is required to treat the patient's ectropion or entropion, which is threatening the health of the affected eye.
- ☐ The surgery is required to remove a lesion on the patient's eyelid or eyelid margin.
- ☐ The treatment is required as rehabilitative surgery for thyroid eye disease.

Policy Statement
Lower Eyelid Blepharopasty is restricted in accordance with the minimum eligibility criteria.

Minimum Eligibility Criteria
Only commissioned in any of the following circumstances:

- Correction of ectropion or entropion which threatens the health of the affected eye.
- Removal of lesions of eyelid skin or lid margin.
- Rehabilitative surgery for patients with thyroid eye disease.

Rationale
Excessive skin in the lower lid may cause "eye bags" but does not affect function of the eyelid or vision and therefore does not need correction.

Version: *2014/2015*

Clinical Coding
OPCS with ICD exclusions (Procedure driven):
OPCS4: C131, C133, C134, C138, C139
ICD exclusions: H020, H021, H023, H024, H025, H026, H027, H028, H029, H010, Q100, H534

Evidence for inclusion and threshold

1. *Eyelid Surgery*
2. The British Association of Aesthetic Plastic Surgeons 2011.
3. Local PCT consensus – review conducted 2007.
4. Modernisation Agency's Action on Plastic Surgery 2005.
5. Procedures of Limited Clinical Effectiveness Phase 1 - Consolidation and repository of the existing evidence-base - London Health Observatory 2010.

11.4 Short Sightedness (Myopia) or Long Sightedness (Hypermetropia) Correction: Surgery or Laser Treatment

This policy has been superseded by ICB Policy CMICB_Clin034 - Myopia, Hyperopia and Astigmatism, Laser Treatment v1 01/04/2023

11.5 Cataract Surgery

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ **First eye** – the referral for cataract surgery has been initiated by an optometrist **AND** the patient has not previously had cataract surgery to either eye; **AND** the patient has sufficient cataract to account for visual symptoms; **AND** has best corrected visual acuity of 6/9 (Snellen) or +0.2 (Logmar) or worse in the poorer

Policy Statement
Cataract surgery is restricted in accordance with the Minimum Eligibility Criteria.

Summary of Intervention
A Cataract exists when the lens of an eye becomes cloudy and may affect vision. Cataracts most commonly occur in older people and develop gradually. Cataracts can usually be treated with a routine day case operation where the cloudy lens is removed and is replaced with an artificial plastic lens (an Intraocular Implant).

The Royal College of Ophthalmologists' National Ophthalmology Database indicates that in 2006-2010 (before restrictions on access to cataract surgery based

Version: *20/02/2018*

NOTE: separate policy in place for:
NHS South Sefton CCG
NHS Southport and Formby CCG

Clinical Coding
OPCS with ICD inclusions (Procedure driven):
OPCS4: C71, C72*, C73*, C74* with secondary OPCS4: C75*, C77**

11.5 Cataract Surgery

eye; **AND** the patient understands what a cataract surgical procedure involves and wishes to be referred for surgery; **AND** there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid for Cataract. ☐ **First eye** - the referral for cataract surgery is/has been initiated by an optometrist; **AND** the patient has not previously had cataract surgery to either eye; **AND** the patient has sufficient cataract to account for visual symptoms; **AND** the reduced visual acuity is impairing the patient's lifestyle e.g. the patient is: a. at significant risk of falls b. the patient's vision is affecting their ability to access their chosen mode of transport including driving c. the impact of symptoms is compromising the patient's independence d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces. f. the patient is experiencing disabling glare. **AND** the patient understands what a cataract surgical procedure involves and wishes to be referred for surgery, **AND** there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid for Cataract. ☐ **Second eye** - the referral for cataract surgery is/has been initiated by an optometrist; **AND** the patient has previously had cataract surgery to the other eye; **AND** the patient has sufficient cataract in their second eye to account for visual symptoms despite one eye having been operated upon; **AND** has best corrected visual acuity of 6/9 (Snellen) or +0.2 (Logmar) or worse in the poorer eye; **AND** the patient understands what a cataract surgical procedure involves and wishes to be referred for surgery on their second eye; **AND** there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid for Cataract.	on visual acuity were commonplace), for eyes undergoing cataract surgery preoperative following percentages of cataract patients had visual acuities of better than or equal to: • 6/6 Snellen (3% of cataract surgery patients) • 6/9 Snellen (5% of cataract surgery patients) • 6/12 Snellen (36% of cataract surgery patients) So eyes with visual acuities of 6/9 or better, accounted for only about 10% of cataract surgery. The presence of a cataract does not indicate a need for surgery. It is intended that all patients should be fully assessed and counselled as to the risks and benefits of surgery. This assessment will usually be undertaken by an accredited community optometrist prior to referral. Where both eyes are affected by cataract, the first eye referred for cataract surgery is usually expected to be the eye where cataract has caused the greatest reduction in visual acuity. This policy does not extend to cataract removal incidental to the management of other eye conditions. **Minimum eligibility criteria** Referral of patients to ophthalmologists for cataract surgery should be based on the following indications: 1. The patient has sufficient cataract to account for visual symptoms. It is strongly recommended that only those cases with **best corrected visual acuity of 6/9** (Snellen) **or +0.2** (Logmar**) or worse** in the poorer eye be referred. However, exception may be made where the impact of symptoms is such that the patient's quality of life is significantly impaired. A description of the impact on quality of life must be documented and accompany the referral information for all cases. Examples of the Impact on quality of life may include any of the following factors, although this is not an exhaustive list: a. the patient is at significant risk of falls b. the impact of the visual symptoms is affecting the patient's ability to access their chosen mode of transport including driving c. the impact of symptoms is compromising the patient's independence d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities	*ICD inclusions: H25*, H26*, H28*, Q120*

11.5 Cataract Surgery

☐ **Second eye** - the referral for cataract surgery is/has been initiated by an optometrist; **AND** the patient has not previously had cataract surgery to the other eye; **AND** the patient has sufficient cataract in their second eye to account for visual symptoms despite one eye having been operated upon; **AND** the reduced visual acuity is impairing the patient's lifestyle e.g. the patient is: a. at significant risk of falls b. the patient's vision is affecting their ability to access their chosen mode of transport including driving c. the impact of symptoms is compromising the patient's independence d. the impact of the visual symptoms is affecting the patient's ability to continue their employment or undertake caring responsibilities e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces. f. the patient is experiencing disabling glare. **AND** the patient understands what a cataract surgical procedure involves and wishes to be referred for surgery on their second eye, **AND** there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid for Cataract.	e. the impact of the visual symptoms is substantially affecting the patient's ability to undertake daily activities such as reading, watching television, leaving the house or recognising faces. f. the patient is experiencing disabling glare. **AND** 2. Where the referral has been initiated by an optometrist, there has been a discussion on the risks and benefits of cataract surgery based around the Patient Decision Aid for Cataract. http://sdm.rightcare.nhs.uk/pda/cataracts/ **AND** 3. The patient has understood what a cataract surgical procedure involves and wishes to have surgery **Guidance for second eye surgery in patients with bilateral cataracts** **The second eye criteria is:** 1. As for the first eye i.e. the impact of visual symptoms is sufficiently impairing the patient's quality of life despite one eye having been operated upon.	

Evidence for Inclusion and threshold

1. Atlas of Variation *Tacking Unwarranted Variation in Healthcare across the NHS* Public Health England, NHS Right Care and NHS England September 2015
2. *Evidence Review Cataract Surgery* –ChaMPs May 2014
3. Royal College of Ophthalmologists *Commissioning Guide for Cataract Surgery* February 2015
4. NHS Choices
5. NHS Patient Decision Aids – Cataract

11.6 Coloured filters: Irlens Syndrome/Dyslexia

This policy has been superseded by ICB Policy CMICB_Clin017 - Dyslexia Treatment using Coloured (Irlen) Filters v1 01/04/2023

11.7 Intra Ocular Telescope Implants: Advanced Age-Related Macular Degeneration

This policy has been superseded by ICB Policy CMICB_Clin003 - Age-Related Macular Degeneration (AMD), implantable miniature telescope (IMT) v1 01/04/2023

11.8 Chalazia (Meibomian Cyst) Surgical Removal

(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin011 - Chalazia (meibomian cysts), removal v1 01/04/2023

12. Oral Surgery

12.1 Temporo-Mandibular Joint Dysfunction Syndrome Surgical Replacement

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **All** of the following statements: ☐ The patient has one or more of the following symptoms: restricted mouth opening <35mm; dietary score of <5/10 (liquid scores 0, full diet scores 10); occlusal collapse (anterior open bite or retrusion); excessive condylar resorption and loss of height of vertical ramus; the patient is experiencing significant quality of life issues. ☐ Conservative treatments have been attempted and failed to adequately resolve the patient's symptoms. ☐ Other temporo-mandibular joint modification surgery has already been attempted and has failed to resolve symptoms OR is inappropriate.	**Policy Statement** Surgical Replacement of the Temporo-Mandibular Joint, Temporo-Mandibular Joint Dysfunction Syndrome and Joint Replacement is restricted in accordance with the minimum eligibility criteria. **Minimum Eligibility Criteria** Only commissioned in the following circumstances: Any or a combination of the following symptoms are present: • Restricted mouth opening <35mm) • Dietary score of< 5/10 (liquid scores 0, full diet scores 10) • Occlusal collapse (anterior open bite or retrusion) • Excessive condylar resorption and loss of height of vertical ramus • Pain score > 5 out of 10 on visual analogue scale (and combined with any of the other symptoms) • Other significant quality of life issues **AND** • Evidence that conservative treatments have been attempted and failed to adequately resolve symptoms and other TMJ modification surgery (if appropriate) has also been attempted and failed to resolve symptoms. • TMJ replacement for patients with relative contraindications may be considered where a risk assessment of the benefits of TMJ replacement has been undertaken and reported	***Version:*** *2014/2015* ***Clinical Coding*** *OPCS with ICD inclusions (Procedure driven):* *OPCS4: V20** *ICD inclusions: K076*

12.1 Temporo-Mandibular Joint Dysfunction Syndrome Surgical Replacement		
	• Revision surgery cases where the previous TMJ replacement has failed due to long term wear / mechanical failure or where there has been shorter term failure due to infection or allergy and necessary steps / investigations have been undertaken to mitigate against the cause of failure.	

Evidence for inclusion and threshold

1. Total prosthetic replacement of the Temporomandibular joint (IPG329) NICE 2009
2. http://www.patient.co.uk/doctor/temporomandibular-joint-dysfunction-and-pain-syndromes
3. Fourteen year follow up of a patient fitted Temporomandibular joint reconstruction system. Mercuri L et al, J. Oral Maxillofacial surgery.65, 2007
4. Biomet microfixation TMJ replacement system: 3 year follow up of patients treated 1995-2005. Giannakopoulos H et al, J Oral and Maxillofacial surgery 70, 2012
5. Total reconstruction of the temperomandibular joint. Up to 8 years of patients treated with Biomet total joint replacement. Westermark A, Int Journal of oral and maxillofacial surgery 39, 2010
6. Artificial Temperomandibular Joint replacement. NICE interventional procedures guidance no 329, December2009
7. Sidebottom A.J. - *Guidelines for the replacement of temperomandibiular joints in the United Kingdom* – British Journal of Oral and Maxillofacial Surgery – 46 (2008); 146 - 147

13. Paediatrics

13.1 Cranial Banding: Positional Plagiocephaly

This policy has been superseded by ICB Policy CMICB_Clin039 - Positional Plagiocephaly/brachycephaly in children, helmet therapy v1 1/04/2023

14. Plastic Surgery

14.1a Bilateral Breast Reduction Surgery: Breast Macromastia
(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin007 – Breast Reduction v1 1/04/2023

14.1b Unilateral Breast Reduction Surgery: Breast Asymmetry
(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin007 – Breast Reduction v1 1/04/2023

14.1c Breast Reduction Surgery: Gynaecomastia
(NHS England Evidence Based Intervention)

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ The patient is male and has >2cm of palpable, firm, subareolar gland and ductal breast tissue (gynaecomastia). ☐ The patient's gynaecomastia has been caused by medication prescribed or treatment undertaken for a diagnosed medical condition e.g. prostate cancer.	**Policy Statement** Please refer to 14.1a Male breast reduction surgery (gynaecomastia) is restricted in accordance with the minimum eligibility criteria. Surgery for gynaecomastia is not routinely funded by the NHS. This recommendation does not cover surgery for gynaecomastia caused by medical treatments such as treatment for prostate cancer.	***Version:*** *18/02/2019* ***Clinical Coding:*** *OPCS with ICD inclusions (Diagnosis driven):* *OPCS4: B275, B311* *ICD inclusions: N62X* *Codes as per 14.1a with an additional qualifier needed to denote sex (sex=1)*
Evidence for inclusion and threshold		
Please refer to 14.1a		

14.2 Breast Enlargement Surgery/Augmentation/Mammoplasty: Breast Micromastia

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ The patient has a congenital absence of breast tissue unilaterally (affecting one breast only) of three or more cup size difference as measured by a specialist. ☐ The patient's BMI is under 25 and has been stable for at least 12 months. ☐ The patient is at least 18 years old.	**Policy Statement** Breast enlargement surgery (augmentation mammoplasty) is restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Breast Augmentation/enlargement involves inserting artificial implants behind the normal breast tissue to improve its size and shape. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx **Minimum eligibility criteria** Augmentation Mammoplasty will be funded if the patient meets ALL the following criteria: • There is congenital absence of breast tissue unilaterally ***(affecting one breast only)*** of three or more cup size difference as measured by a specialist. **AND** • The patient's BMI is under 25 and has been stable for at least 12 months **AND** • Aged over 18 years old.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions and inclusions (Procedure driven):* *OPCS4: B301, B312, B375, B301, B302, B303, B304, B308, B309* *ICD exclusions: C500, C501, C502, C503, C504, C505, C506, C508, C509, Z803, Z853, T857, T814* *ICD inclusions: Z411*

14.2 Breast Enlargement Surgery/Augmentation/Mammoplasty: Breast Micromastia

Evidence for inclusion and threshold

1. NICE CG80 - Early and locally advanced breast cancer: diagnosis and treatment (2009). Weblink: https://www.nice.org.uk/guidance/cg80
2. NICE Quality Standard 12 – Breast Cancer (2016) - Weblink: https://www.nice.org.uk/guidance/qs12
3. British Association of Plastic Reconstructive and Aesthetic Surgeons – Oncoplastic Breast Reconstruction Best Practice Guidelines (2012) - Weblink: http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/final-oncoplastic-guidelines---healthcare-professionals.pdf?sfvrsn=0
4. Breast Cancer Care – Breast Reconstruction - Weblink: https://www.breastcancercare.org.uk/information-support/facing-breast-cancer/going-through-treatment-breast-cancer/surgery/breast-reconstruction
5. Dixon, J, et al, 1994, ABC of breast diseases: congenital problems and aberrations of normal breast development and involution, Br Med J, 309, 24 September, 797-800
6. Freitas, R, et al, 2007, Poland's Syndrome: different clinical presentations and surgical reconstructions in 18 cases, Aesthet Plast Surg, 31, 140-46.
7. Heimberg, D, et al, 1996, The tuberous breast deformity: classification and treatment, Br J Plast Surg, 49, 339-45.
8. Pacifico, M, et al, 2007, The tuberous breast revisited, J Plast Reconstruct Aesthet Surg, 60, 455-64.
9. North Derbyshire, South Derbyshire and Bassetlaw Commissioning Consortium, 2007, Norcom commissioning policy – specialist plastic surgery procedures", 5-7. moderngov.rotherham.gov.uk/documents/s14201/Plastic%20Surgery%20report.pdf
10. Sadove, C, et al, 2005, Congenital and acquired pediatric breast anomalies: a review of 20 years experience, Plast Reconstruct Surg, April, 115(4), 1039-1050.
11. *Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service*

14.3a Silicone Breast Implant Removal Surgery: Breast Reconstruction

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has a silicone breast implant that has ruptured or failed, and the original surgery was carried out by the NHS.
- ☐ The patient has a silicone breast implant that has ruptured or failed, and the original surgery was undertaken at a private clinic/hospital which no longer exists.
- ☐ The patient has a silicone breast implant that has ruptured or failed, and the original surgery was undertaken at a private clinic/hospital who have refused a request to remove the implants.

Policy Statement
Silicone breast implant removal is restricted in accordance with the minimum eligibility criteria.

Minimum eligibility criteria
The removal of **ruptured** silicone implants will only be commissioned in the following circumstances:

- Where a patient has implants that have ruptured or failed, the patient should be referred back to the provider of the implants. If the clinic no longer exists or refuses to remove the implants, the NHS will remove ruptured implants or implants that have failed only but will **not** replace them.

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.

Version: *20/02/2018*

Clinical Coding:
OPCS with ICD exclusions (Procedure driven):
OPCS4: B303
ICD exclusions: T854

14.3a Silicone Breast Implant Removal Surgery: Breast Reconstruction

Evidence for inclusion and threshold

1. Poly Implant Prothèse (PIP) breast implants: final report of the Expert Group - Department of Health (June 2012).
2. NHS Choices: PIP breast implants - http://www.nhs.uk/Conditions/PIP-implants/Pages/Introduction.aspx
3. NHS Choices: Breast Enlargement - http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/breast-enlargement.aspx
4. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

14.3b Breast Reconstruction Surgery: Silicone Breast Implant Replacement (Cosmetic or Non-Cosmetic Purposes)

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 14.3a Silicone breast implant replacement for cosmetic or non-cosmetic purposes is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD inclusions (Procedure driven):* *OPCS4: B302, B303, B304* *ICD exclusions: T854*

Evidence for inclusion and threshold

Please refer to 14.3a

14.4 Mastopexy: Breast Lift Surgery

This policy has been superseded by ICB Policy CMICB_Clin030 – Mastopexy (breast lift) v1 1/04/2023

14.5 Nipple Inversion Surgical Correction

This policy has been superseded by ICB Policy CMICB_Clin035 – Nipple inversion, surgical correction v1 1/04/2023

14.7 Electrolysis/Laser Therapy: Hair Removal

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient has undergone reconstructive surgery leading to abnormally located hair-bearing skin.	**Policy Statement** Hair removal using electrolysis/laser therapy is restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Hair depilation can be used for excess hair (hirsutism) in a normal distribution pattern, or for abnormally placed hair. Permanent depilation may be achieved by electrolysis or laser therapy.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD inclusions (Diagnosis driven):* *OPCS4: S606, S607* *ICD inclusions: L680, L681, L682, L683, L688, L689*

14.7 Electrolysis/Laser Therapy: Hair Removal

☐ The patient is undergoing treatment for pilonidal sinuses, to reduce recurrence.	Hirsutism essentially means that an individual grows too much body or facial hair in a male pattern. Although hirsutism sometimes occurs in males, it is more difficult to detect because of the wide range of normal hair growth in men. Hirsutism affects approximately 10% of women in Western societies and is commoner in those of Mediterranean or middle eastern descent. **Minimum eligibility criteria** The CCG will fund this treatment if the patient meets the following criteria: • Has undergone reconstructive surgery leading to abnormally located hair-bearing skin **OR** • Is undergoing treatment for pilonidal sinuses to reduce recurrence This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG. A range of treatment options are available: • Patients can self-fund options such as shaving, waxing, depilatories (hair removal creams) and bleaching creams. They can also self-fund the physical treatments listed below. • Co-cyprindiol tablets (anti-androgen) may be prescribed. It should be noted however that eflornithine cream has Black status on the Pan Mersey formulary and is not recommended for prescribing. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.	

Evidence for inclusion and threshold

1. British Association of Dermatologists - hirsuitism patient information leaflet - Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=89&itemtype=document
2. NHS Choices – Laser Hair Removal - Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/laser-hair-removal.aspx
3. Pan Mersey APC Guidance for Eflornithine: http://www.panmerseyapc.nhs.uk/recommendations/documents/PS158.pdf?UNLID=3067063562016122111329

14.8 Pectus Anomaly (Pigeon Chest or Sunken Chest) Surgical Correction

This policy has been superseded by ICB Policy CMICB_Clin038 – Pectus Deformity, surgical treatment v1 01/04/2023

14.9 Scar Revision Surgery

CATEGORY 2 – RESTRICTED **Monitored Approval**	**Policy Statement** Surgical revision of scars is restricted in accordance with the minimum eligibility criteria.	***Version:*** *20/02/2018* ***Clinical Coding:***

14.9 Scar Revision Surgery

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has severe post-burn scarring.
- ☐ The patient has severe traumatic scarring.
- ☐ The patient requires revision surgery for scars following complications of surgery.
- ☐ The patient requires revision surgery for keloid formation or other hypertrophic scar formation as the scarring is causing significant functional disability.
- ☐ The patient requires revision surgery for keloid formation or other hypertrophic scars to restore normal function.

Summary of Intervention

The different types of scars include:

- **Flat, pale scars** – these are the most common type of scar and are due to the body's natural healing process. Initially, they may be red or dark and raised after the wound has healed but will become paler and flatter naturally over time. This can take up to two years.
- **Hypertrophic scars** – red, raised scars that form along a wound and can remain this way for a number of years.
- **Keloid scars** – these are caused by an excess of scar tissue produced at the site of the wound, where the scar grows beyond the boundaries of the original wound, even after it has healed.
- **Pitted (atrophic or "ice-pick") scars** – these have a sunken appearance.
- **Contracture scars** – these are caused by the skin shrinking and tightening, usually after a burn, which can restrict movement.

Treating scars

Depending on the type and age of a scar, a variety of different treatments may help make them less visible and improve their appearance. Scars are unlikely to disappear completely, although most will gradually fade over time. If scarring is unsightly, uncomfortable or restrictive, treatment options may include:

- pressure dressings
- corticosteroid injections
- cosmetic camouflage (make-up)
- surgery

It is often the case that a combination of treatments can be used.

Minimum eligibility criteria

The CCG will fund this treatment if the patient meets the following criteria:

- For severe post burn cases or severe traumatic scarring
  OR
- Revision surgery for scars following complications of surgery, keloid formation or other hypertrophic scar formation will only be commissioned where they are significantly functionally disabling or to restore normal function

Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.

This means **(for patients who DO NOT meet the above criteria)** the CCG will **only** fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.

OPCS with ICD inclusions (Diagnosis driven):
OPCS4: S604
ICD inclusions: L905, L910

Evidence for inclusion and threshold

14.9 Scar Revision Surgery

1. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
2. NHS Choices – Scars – Treatment - http://www.nhs.uk/Conditions/Scars/Pages/Treatment.aspx

14.10 Tattoo Laser Removal

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Laser tattoo removal is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. **Summary of Intervention** Tattoo fading involves using a laser to target tattoo ink in the skin. The laser heats the ink particles, so they break up and allow the body to absorb them. The amount of treatment needed varies, depending on the individual tattoo. However, it can take up to 12 sessions to treat a professional tattoo, which usually takes place once every eight weeks. The results can vary, depending on the individual tattoo and the type or colour of ink used. Indian ink tattoos are usually easier to treat, and black and red inks tend to fade better. Some inks do not respond to treatment at all. **Rationale** Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. A good summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmeticsurgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD inclusions (Diagnosis driven):* *OPCS4: S091, S092* *ICD inclusions: L818*

Evidence for inclusion and threshold

1. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
2. Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
3. NHS Choices – The NHS Guide to cosmetic procedures - Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tattoo-removal.aspx

14.11 Abdominoplasty/Apronectomy: Tummy Tuck

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Abdominoplasty/apronectomy (tummy tuck) is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS only (Procedure driven):* *OPCS4: S021, S022, S028, S029*

14.11 Abdominoplasty/Apronectomy: Tummy Tuck

	Summary of Intervention 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. **Rationale** Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. A summary of Cosmetic Surgery is provided by NHS Choices. Weblink: http://www.nhs.uk/conditions/Cosmetic-surgery/Pages/Introduction.aspx and http://www.nhs.uk/Conditions/Cosmetic-surgery/Pages/Procedures.aspx	

Evidence for inclusion and threshold

1. A systematic review of outcomes of abdominoplasty. Staalesen et al. Journal of Plastic Surgery and Hand Surgery, 09 2012, vol./is. 46/3-4(139-44).
2. Royal College of Surgeons - Cosmetic Surgery Categorisation - Weblink: https://www.rcseng.ac.uk/surgeons/surgical-standards/working-practices/cosmetic-surgery/documents/cosmetic-surgery-categorisation-and-requirements/at_download/file
3. Royal College of Surgeons – Abdominplasty Guide - Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/tummy-tuck-abdominoplasty/
4. NHS Choices: Tummy Tuck (abdominoplasty) - http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/tummy-tuck.aspx
5. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

14.12 Thigh, Buttock or Arm Lift Surgery: Excision of Redundant Skin or Fat

This policy has been superseded by ICB Policy CMICB_Clin006 – Body Contouring and other excisions - Buttock lift, thigh lift (thighplasty) and arm lift (brachioplasty) v1 01/04/2023

14.13 Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Surgical treatments for alopecia and male pattern baldness, including hair transplantation and hair intralace systems, are not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. The NHS has a policy for Wigs which may be an alternative option for patients: http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx The current cost is £67.75 for an acrylic wig with 2 allowed per year. There is no charge for chemotherapy patients.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: S211, S212, S331, S332, S333, S338, S339, S218, S219* *ICD exclusions: Z410, L630, L631, L632, L638, L639, L640, L648, L649, L650, L651, L652, L658, L659*

14.13 Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)

Alopecia

Alopecia areata causes patches of baldness about the size of a large coin. They usually appear on the scalp but can occur anywhere on the body. It can occur at any age, but mostly affects teenagers and young adults.

In most cases of alopecia areata, hair will grow back in a few months. At first, hair may grow back fine and white, but over time it should thicken and regain its normal colour.

Some people go on to develop a more severe form of hair loss, such as:

- Alopecia totalis (no scalp hair)
- Alopecia universalis (no hair on scalp or body)

Alopecia areata is caused by a problem with the immune system (the body's natural defence against infection and illness). It is more common among people with other autoimmune conditions, such as an overactive thyroid (hyperthyroidism), diabetes or Down's syndrome.

It is also believed some people's genes make them more susceptible to alopecia areata, as one in five people with the condition have a family history of the condition.

Alopecia areata can occur at any age, although it's more common in people aged 15-29. It affects one or two people in every 1,000 in the UK.

Further information can be found at following link:
http://www.alopeciaonline.org.uk/treatments-and-wigs.asp

Hair transplantation

A hair transplant is a procedure to move hair from an area unaffected by hair loss to an area of thinning or baldness. It is suitable for people with androgenetic alopecia (male- and female-pattern baldness) or scarring resulting from injury or burns. It is not usually appropriate for other types of hair loss, such as alopecia areata. A hair transplant is not normally available on the NHS, as it is regarded as cosmetic surgery.

Male Pattern Baldness

Male-pattern baldness is the most common type of hair loss, affecting around half of all men by 50 years of age. It usually starts around the late twenties or early thirties and most men have some degree of hair loss by their late thirties.

It generally follows a pattern of a receding hairline, followed by thinning of the hair on the crown and temples, leaving a horseshoe shape around the back and sides of the head. Sometimes it can progress to complete baldness, although this is uncommon.

Male-pattern baldness is hereditary, which means it runs in families. It's thought to be caused by oversensitive hair follicles, linked to having too much of a certain male hormone.

14.13 Alopecia and Male Pattern Baldness Surgical Treatments (Including Hair Transplantation and Hair Intralace Systems)		
	Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner.	

Evidence for inclusion and threshold

1. British Association of Dermatologists - alopecia areata patient information leaflet - Weblink: http://www.bad.org.uk/shared/get-file.ashx?id=1975&itemtype=document
2. Interventions for alopecia areata – Cochrane Library 2008.
3. http://www.bad.org.uk/library-media%5Cdocuments%5CAlopecia_areata_guidelines_2012.pdf
4. Only one study which compared two topical corticosteroids showed significant short-term benefits. No studies showed long-term beneficial hair growth. None of the included studies asked participants to report their opinion of hair growth or whether their quality of life had improved with the treatment.
5. No evidence of effective treatments for alopecia – Cochrane Pearls 2008.
6. NICE Clinical Knowledge Summaries 2014. https://cks.nice.org.uk/alopecia-areata
7. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service
8. Modernisation Agency's Action on Plastic Surgery 2005. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
9. NHS Choices – Guide to Hair Loss Treatment - Weblink: http://www.nhs.uk/Conditions/Hair-loss/Pages/Treatment.aspx
10. **Hair transplantation -** *A trial on subcutaneous pedicle island flap for eyebrow reconstruction* – Mahmood & Mehri. Burns, 2010, Vol. 36(5), p692-697.
11. Modernisation Agency's Action on Plastic Surgery 2005.
12. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2

14.16 Labiaplasty, Vaginoplasty and Hymenorrhaphy		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Labiaplasty, Vaginoplasty and Hymenorrhaphy are not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. **Labiaplasty** A labiaplasty is a surgical procedure to reduce the size of the labia minora – the flaps of skin either side of the vaginal opening. **Vaginoplasty** Vaginoplasty is a reconstructive plastic surgery and cosmetic procedure for the vaginal canal and its mucous membrane, and of vulvo-vaginal structures that might be absent or damaged because of congenital disease (e.g., vaginal hypoplasia) or because of an acquired cause (e.g., childbirth physical trauma, cancer). The term vaginoplasty generally describes any such cosmetic reconstructive and corrective vaginal surgery, and the term neovaginoplasty specifically describes the procedures of either partial or total construction or reconstruction of the vulvo-vaginal complex.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS only (Procedure driven):* *OPCS4: P055, P056, P057, P213, P214, P215, P218, P219, P153*

14.16 Labiaplasty, Vaginoplasty and Hymenorrhaphy

	Hymenorrhaphy Hymenorrhaphy or hymen reconstruction surgery, is a cosmetic procedure. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx	

Evidence for inclusion and threshold

1. rcog.org.uk/globalassets/documents/guidelines/ethics-issues-and-resources/rcog-fgcs-ethical-opinion-paper.pdf (RCOG Statement 6).
2. http://www.britspag.org/sites/default/files/downloads/Labiaplasty%20%20final%20Position%20Statement.pdf
3. NHS Choices – Guide to Labiaplasty - Weblink: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/labiaplasty.aspx
4. Clinical characteristics of well women seeking labial reduction surgery: a prospective study. BJOG; 2011 Nov;118(12):1507-10.
5. Liao, L-M; Michala, L; Creighton, SM. (2010). Labial Surgery for Well Women; a review of the literature.
6. Goodman, M. P. (2009). Female Cosmetic Genital Surgery. *Obstetrics and Gynaecology; 113: 154-159*
7. Bramwell R, Morland C, Garden A. (2007). Expectations and experience of labial reduction: a qualitative study. *BJOG* 2007; 114:1493-1499.
8. Department for Education and Skills. (2004). *Local Authority Social Services Letter. LASSAL (2004)4,* London, DfES.

14.17 Liposuction: Excess/Unwanted Fat Removal

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Liposuction is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Summary of Intervention** 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. Cosmetic surgery/treatments are regarded as procedures of low clinical priority and therefore **not routinely commissioned** by the CCG Commissioner. A good summary of Cosmetic Surgery is provided by NHS Choices. http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: S621, S622* *ICD inclusions: C**

Evidence for inclusion and threshold

1. Royal College of Surgeons – Liposuction: Weblink: https://www.rcseng.ac.uk/patient-care/cosmetic-surgery/about-your-procedure/liposuction/

14.17 Liposuction: Excess/Unwanted Fat Removal

2. NHS Choices: Liposuction: http://www.nhs.uk/Conditions/cosmetic-treatments-guide/Pages/liposuction.aspx
3. Liposuction for chronic lymphoedema: NICE 2008.
4. Modernisation Agency's Action on Plastic Surgery 2005.
5. http://www.bapras.org.uk/docs/default-source/commissioning-and-policy/information-for-commissioners-of-plastic-surgery-services.pdf?sfvrsn=2
6. Health Commission Wales. 2008 Commissioning Criteria – Plastic Surgery. Procedures of Low Clinical Priority/ Procedures not usually available on the National Health Service

14.18 Rhytidectomy: Face or Brow Lift

This policy has been superseded by ICB Policy CMICB_Clin042 – Rhytidectomy v1 01/04/2023

15. Respiratory

15.1 Snoring in the Absence of OSA Surgery (Adult)

(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin043 – Simple snoring, surgical management v1 1/04/2023

16. Trauma and Orthopaedics

16.1a Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ The patient has low back pain (with or without sciatica). ☐ The treatment is being requested as part of a treatment package which includes exercise (with or without psychological therapy).	**Policy Statement** Spinal mobilisation, manipulation, soft tissue techniques and massage for back pain with or without sciatica is restricted in accordance with the Minimum Eligibility Criteria. **Summary of Intervention** Low back pain is soreness or stiffness in the back, between the bottom of the rib cage and the top of the legs. Most people's low back pain is described as 'non-specific'. That means the pain is unlikely to be caused by an infection, a fracture or a disease like cancer. Some people also get back symptoms radiating down one or both legs (radicular symptoms/sciatica). Radicular symptoms are caused, when the nerves from the back, are irritated causing pain, numbness or tingling down the leg. This pain, may vary from mild to severe, may be related to or triggered by a particular movement or action or it may be spontaneous. Most people will tend to suffer from back pain at some point in their lives and indeed it may recur.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD inclusions (Diagnosis driven):* *OPCS4: A706, V501, V509, X613 with secondary coding for levels of spine V55** *ICD inclusions: M545, M5450, M5455, M5456, M5457, M5458, M5459, M544, M5440, M5445, M5446, M5447, M5448, M5449, M5416*

16.1a Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica		
	Most back pain usually improves enough within few days to few weeks, to be able to return to normal activities. For such pain, it is best to continue with normal activities as much as possible, although you may need to return to them in stages, as the back pain steadily recovers. Getting back to work helps your recovery and employers will often arrange lighter duties to get you back sooner. Continuing with normal life as much as you can helps to take your mind off the pain and avoid you getting stiff and weak. Rest lying down, only when that is the only way to stop pain building up. Complete or prolonged bed rest is not advised at all as it is associated with delayed recovery. If needed, simple analgesics (pain killers) help people with back pain or radicular pain keep active. Many of these are available over the counter. If advice is required then the local pharmacist or GP can help. Early advice from your GP should be sought if the low back pain does not respond to the measures described above, gets worse and certainly if it does not improve after six weeks. If you are on steroid medication, are at risk of osteoporosis or experience unsteadiness when you walk you should also contact your doctor. **Minimum Eligibility Criteria** **Acupuncture** Acupuncture for low back pain and sciatica is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. **Manual Therapy** The following procedures are **not routinely commissioned**: • Lumbar traction • Technology Assisted Micromobilisation and Reflex Stimulation (TAMARS) • Manual therapy (spinal mobilisation, manipulation, soft tissue techniques and massage) in isolation. Note: Consider manual therapy (spinal manipulation, mobilisation or soft tissue techniques such as massage) for managing low back pain with or without sciatica, but only as part of a treatment package including exercise, with or without psychological therapy. **Orthotics** The following are **not routinely commissioned**: • Foot orthotics	

16.1a Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica

- Rocker shoes
- Belts and corsets

Electrotherapy
The following are **not routinely commissioned:**

- Transcutaneous electrical nerve stimulation (TENS)
- Percutaneous electrical nerve stimulation (PENS)
- Ultrasound
- Interferential
- Laser therapy

Pharmacological interventions
The CCG **does not routinely commission** the following in the treatment of low back pain without Neuropathic pain:

- Paracetamol used alone
- Selective serotonin re-uptake inhibitors (**SSRIs**)
- Serotonin– norepinephrine reuptake inhibitors
- Tricyclic antidepressants
- Anti-convulsants
- Opioids for the management of acute back pain (if NSAIDs are contraindicated, ineffective or not tolerated then weak opioids may be given +/- paracetamol)

Patients with neuropathic pain should be managed in line with NICE CG 173:
Offer a choice of amitriptyline, duloxetine, gabapentin or pregabalin as initial treatment for neuropathic pain (except trigeminal neuralgia)
1.1.9 If the initial treatment is not effective or is not tolerated, offer one of the remaining 3 drugs, and consider switching again if the second and third drugs tried are also not effective or not tolerated.
1.1.10 Consider tramadol only if acute rescue therapy is needed (see recommendation 1.1.12 about long-term use).
1.1.11 Consider capsaicin cream for people with localised neuropathic pain who wish to avoid, or who cannot tolerate, oral treatments.

Treatments that should not be used
1.1.12 Do not start the following to treat neuropathic pain in non-specialist settings, unless advised by a specialist to do so:

- cannabis sativa extract
- capsaicin patch

16.1a Spinal Mobilisation, Manipulation, Soft Tissue Techniques and Massage: Back Pain with or without Sciatica		
	• lacosamide • lamotrigine • levetiracetam • morphine • oxcarbazepine • topiramate • tramadol (this is referring to long-term use; see recommendation 1.1.10 for short-term use) • venlafaxine.	

Evidence for inclusion and threshold

1. Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59
2. National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf
3. Osteoarthritis: the care and management of osteoarthritis in adults https://www.nice.org.uk/guidance/cg59
4. The effect of TAMARS treatments on chronic back pain, disability and quality of life - Lyndsey Mountain BSc Physiotherapy MCSP (Oct 2012) - http://tamars.co.uk/wp/wp-content/uploads/2012/10/21stCenturyBackCare.pdf
5. Final_TAMARS_report[1].pdf

16.1b Opioids (including Tramadol): Low Back Pain Management:		
CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet ONE of the following statements: ☐ Weak opioids are being requested as the patient has acute back pain and NSAIDS are contraindicated, ineffective or cannot be tolerated. ☐ The patient requires tramadol for acute rescue therapy only.	**Policy Statement** Please refer to 16.1a Opioids for management of low back pain including tramadol is restricted in accordance with the minimum eligibility criteria.	***Version:*** *20/02/2018* ***Clinical Coding:*** *Medication – no codes applicable.*

Evidence for inclusion and threshold

Please refer to 16.1a

16.1c Capsaicin Cream, Cannabis Sativa Extract, Capsaicin Patch, Lacosamind, Lamotrigine, Levetiracetam, Morphine, Oxcarbazepine, Topiramate, Tramadol (for Long-Term Use), Venlafaxine: Lower Back Neuropathic Pain Treatment		
CATEGORY 2 – RESTRICTED **Monitored Approval**	**Policy Statement** Please refer to 16.1a	***Version:*** *20/02/2018* ***Clinical Coding:***

16.1c Capsaicin Cream, Cannabis Sativa Extract, Capsaicin Patch, Lacosamind, Lamotrigine, Levetiracetam, Morphine, Oxcarbazepine, Topiramate, Tramadol (for Long-Term Use), Venlafaxine: Lower Back Neuropathic Pain Treatment		
The patient's clinical presentation must meet **ONE** of the following statements: ☐ The requested treatment is capsaicin cream (only), and the patient has localised neuropathic pain and wishes to avoid or cannot tolerate oral treatments. ☐ The treatment requested is cannabis sativa extract, capsaicin patch, lacosamind, lamotrigine, levetiracetam, morphine, oxcarbazepine, topiramate, tramadol (for long-term use) or venlafaxine AND the treatment has been initiated or advised for this patient by a secondary or tertiary care specialist.	Capsaicin cream, cannabis sativa extract, capsaicin patch, lacosamind, lamotrigine, levetiracetam, morphine, oxcarbazepine, topiramate, tramadol (for long-term use), venlafaxine as treatments for neuropathic pain is restricted in accordance with the minimum eligibility criteria.	*Medication – no codes applicable.*
Evidence for inclusion and threshold		
Please refer to 16.1a		

16.1d TENS, PENS, Ultrasound, Interferential and Laser Therapy: Low Back Pain and Sciatica		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 16.1a TENS, PENS, Ultrasound, Interferential and Laser therapy for low back pain and sciatica are not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions and inclusions (Diagnosis driven):* *OPCS4: A704, A707 with secondary coding for levels of spine V55** *A704 (Insertion of neurostimulator electrodes into peripheral nerve)* *A707 (Application of transcutaneous electrical nerve stimulator)* *ICD inclusions: M545, M5450, M5455, M5456, M5457, M5458, M5459, M544, M5440, M5445, M5446, M5447, M5448, M5449, M5416*
Evidence for inclusion and threshold		
Please refer to 16.1a		

16.1e Paracetamol (Used Alone), SSRIS, Serotonin, Tricyclic Antidepressants, Anti-Convulsants: Back Pain without Neuropathic Pain

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 16.1a Paracetamol (used alone), SSRIs, Serotonin, tricyclic antidepressants, anti-convulsants as treatments for back pain without neuropathic pain are not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional.	***Version:*** *20/02/2018* ***Clinical Coding:*** *Medication – no codes applicable.*

Evidence for inclusion and threshold

Please refer to 16.1a

16.2a Spinal Imaging Emergency Referral: Low Back Pain

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient has gait disturbance, multilevel weakness in the legs and/or arms and spinal cord neurology is suspected. ☐ The patient has acute urinary disturbance and/or altered perianal and/or genital sensation and/or reduced anal tone and squeeze (if circumstances permit) and Impending Cauda Equina Syndrome is suspected. ☐ The patient has major motor radiculopathy. ☐ It is suspected that the patient has a spinal infection.	**Policy Statement** Emergency spinal imaging referral for patients presenting with low back pain is restricted in accordance with the minimum eligibility criteria. **Minimum Eligibility Criteria** X rays, MRI and CT scans are **NOT routinely commissioned** in non-specialist settings. For patients with non-urgent presentations consider imaging in specialist musculoskeletal settings for people with low back pain with or without sciatica only if the result is likely to change management i.e. prior to surgery. Imaging is only commissioned where patients present with red flags (see below) or concerns of serious underlying pathology (cancer, infection etc.) and requires urgent management. Emergency Spinal Referral • Suspected spinal cord neurology (gait disturbance, multilevel weakness in the legs and /or arms) • Impending Cauda Equina Syndrome (Acute urinary disturbance, altered perianal and/or genital sensation, (reduced anal tone and squeeze – if circumstances permit) • Major motor radiculopathy • Suspected Spinal Infection Priority Spine imaging (Protocol led MRI whole spine unless contraindicated) • Past history of cancer *(new onset spinal pain) • Recent unexplained weight loss	***Version:*** *20/02/2018* ***Clinical Coding:*** *Diagnostics - No codes applicable*

16.2a Spinal Imaging Emergency Referral: Low Back Pain

	• Objectively unwell with spinal pain • Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity , CRP , ESR (according to local practice) • Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids). • Prolonged steroid use * • Known osteoporosis, with new severe spinal pain • Age <15, or >60 years new onset axial back pain *Statistically significant red flags. Although the others listed may not be **Rationale** Imaging does not often change the initial management and outcomes of someone with back pain. This is because the reported imaging findings are usually common and not necessarily related to the person's symptoms. Many of the imaging findings (for example, disc and joint degeneration) are frequently found in asymptomatic people. Requests for imaging by non-specialist clinicians, where there is no suspicion of serious underlying pathology, can cause unnecessary distress and lead to further referrals for findings that are not clinically relevant.	

Evidence for inclusion and threshold

1. Low back pain and sciatica in over 16s: assessment and management (November 2016) - https://www.nice.org.uk/guidance/ng59
2. Low back pain and sciatica in over 16s: assessment and management (November 2016) - Quality statement 2: Referrals for imaging - https://www.nice.org.uk/guidance/qs155/chapter/Quality-statement-2-Referrals-for-imaging
3. National Low Back and Radicular Pain Pathway 2017 - http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf
4. NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173

16.2b Spinal Priority Imaging (Protocol Led MRI Whole Spine Unless Contraindicated): Low Back Pain

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient has a history of cancer with new onset spinal pain. ☐ The patient has low back pain and recent unexplained weight loss. ☐ The patient is objectively unwell with spinal pain.	**Policy Statement** Please refer to 16.2a Priority Spine Imaging for patients presenting with low back pain (protocol led MRI whole spine unless contraindicated) is restricted in accordance with the minimum eligibility criteria. Priority Spine imaging (Protocol led MRI whole spine unless contraindicated) • Past history of cancer *(new onset spinal pain) • Recent unexplained weight loss	***Version:*** *20/02/2018* ***Clinical Coding:*** *Diagnostics - No codes applicable*

16.2b Spinal Priority Imaging (Protocol Led MRI Whole Spine Unless Contraindicated): Low Back Pain		
☐ The patient has raised inflammatory markers (relative to range anticipated for their age), plasma viscosity, CRP, ESR. ☐ The patient may have immunosuppression (IVDU, HIV, chemotherapy, steroids) and they have new spinal pain. ☐ The patient has low back pain and prolonged steroid use. ☐ The patient is known to have osteoporosis and has new spinal pain. ☐ The patient is younger than 15 years of age and has new onset axial back pain. ☐ The patient is over 60 years of age and has new onset axial back pain.	• Objectively unwell with spinal pain • Raised inflammatory markers (relative to range anticipated for age) Plasma viscosity , CRP , ESR (according to local practice) • Possible immunosuppression with new spinal pain (IVDU, HIV, Chemotherapy, Steroids). • Prolonged steroid use * • Known osteoporosis, with new severe spinal pain • Age <15, or >60 years new onset axial back pain *Statistically significant red flags. Although the others listed may not be	
Evidence for inclusion and threshold		
Please refer to 16.1a		

16.3a Epidurals (Local Anaesthetic and Steroid): Low Back Pain (Non-Specific i.e. Mechanical) **(NHS England Evidence Based Intervention)**		
CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet ALL of the following statements: ☐ The patient has acute and severe lumbar radiculopathy. ☐ The treatment is NOT being requested to treat chronic low back pain. ☐ The treatment is NOT being requested to treat neurogenic claudication in patients with central spinal canal stenosis.	**Policy Statement** Epidural injections (local anaesthetic and steroid) for non-specific (i.e. mechanical) lower back pain are restricted in accordance with the minimum eligibility criteria. Spinal injections of local anaesthetic and steroid should not be offered for patients with non-specific low back pain. For people with non-specific low back pain the following injections should not be offered: • facet joint injections • therapeutic medial branch blocks • intradiscal therapy • prolotherapy • Trigger point injections with any agent, including botulinum toxin • Epidural steroid injections for chronic low back pain or for neurogenic claudication in patients with central spinal canal stenosis • Any other spinal injections not specifically covered above Epidurals (local anaesthetic and steroid) should be considered in patients who have acute and severe lumbar radiculopathy at time of referral.	***Version:*** *18/02/2019* ***Clinical Coding:*** *OPCS with ICD inclusions (Procedure driven):* *OPCS4: A521, A522, A528, A529* *ICD inclusions: M545, M5450, M5455, M5456, M5457, M5458, M5459, G834, G551, M518, M519, M549* *NB: coding is not medication specific.*

16.3a Epidurals (Local Anaesthetic and Steroid): Low Back Pain (Non-Specific i.e. Mechanical)

(NHS England Evidence Based Intervention)

	Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway. For further information, please see: https://www.nice.org.uk/guidance/ng59 NICE guidelines recommend that spinal injections should not be offered for non- specific low back pain. Exclusion criteria for the NICE (NG59) include: Conditions of a non-mechanical nature, including: • Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera) • Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse) • Neurological disorders (including cauda equina syndrome or mononeuritis) Adolescent scoliosis Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease) Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction, Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis. NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica in over 16s • Do not offer spinal injections for managing nonspecific low back pain. **Rationale** NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work - https://www.nice.org.uk/guidance/ng59	

Evidence for inclusion and threshold

1. NICE guidance: https://www.nice.org.uk/guidance/ng59,
2. United Kingdom Spine Societies Board: https://www.ukssb.com/improving- spinal-care-project
3. Benyamin RM, Manchikanti L, Parr AT, Diwan S, Singh V, Falco FJ, et al.The effectiveness of lumbar interlaminar epidural injections in managing chronic low back and lower extremity pain. Pain Physician. 2012 Jul- Aug;15(4):E363-404

16.3a Epidurals (Local Anaesthetic and Steroid): Low Back Pain (Non-Specific i.e. Mechanical)
(NHS England Evidence Based Intervention)

4. Choi HJ, Hahn S, Kim CH, Jang BH, Park S, Lee SM, et al. Epidural steroid injection therapy for low back pain: a meta-analysis. Int J Technol Assess Health Care. 2013 Jul;29(3):244-53.
5. Cohen SP, Bicket MC, Jamison D, Wilkinson I, Rathmell JP. Epidural steroids: a comprehensive, evidence-based review. Reg Anesth Pain Med. 2013 May- Jun;38(3):175-200.
6. Royal College of Anaesthetists: https://www.rcoa.ac.uk/document-store/core-standards-pain-management-services-the-uk

16.3b Radiofrequency Denervation: Low Back Pain without Sciatica (Non-Specific i.e. Mechanical)
(NHS England Evidence Based Intervention)

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient has moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral that has improved in response to a diagnostic medial branch block.
- ☐ Non-surgical treatment has not worked for this patient.
- ☐ The main source of pain is thought to come from structures supplied by the medial branch nerve.

Policy Statement

Radiofrequency denervation for non-specific (i.e. mechanical) lower back pain without sciatica is restricted in accordance with the minimum eligibility criteria.

Radiofrequency denervation (to destroy the nerves that supply the painful facet joint in the spine) can be considered in some cases as per NICE guidance.

Consider referral for assessment for radiofrequency denervation for people with non-specific low back pain when:

- non-surgical treatment has not worked for them and the main source of pain is thought to come from structures supplied by the medial branch nerve and they have moderate or severe levels of localised back pain (rated as 5 or more on a visual analogue scale, or equivalent) at the time of referral.
- Only perform radiofrequency denervation in people with non-specific low back pain after a positive response to a diagnostic medial branch block.
- Do not offer imaging for people with non-specific low back pain with specific facet join pain as a prerequisite for radiofrequency denervation.

Minimum Eligibility Criteria

Radiofrequency denervation can be offered according to NICE guideline (NG59) if all non-surgical and alternative treatments have been tried and there is moderate to severe chronic pain that has improved in response to diagnostic medical branch block.

Rationale
NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work - https://www.nice.org.uk/guidance/ng59

Version: *18/02/2019*

Clinical Coding:
No codes available at present but would suggest the following:
OPCS with ICD inclusions (Procedure driven):
OPCS4:V481, V483, V485, V487, V62, V63* with secondary coding for levels of spine V55**
ICD inclusions: G834, G551, M518, M519, M545, M5450, M5455, M5456, M5457, M5458, M5459, M549

Evidence for inclusion and threshold

Please refer to 16.3a

16.3c Spinal Injections including Facet Joint Injections, Therapeutic Medial Branch Blocks (i.e. Not Diagnostic), Intradiscal Therapy, Prolotherapy and Trigger Point Injections (excluding Epidurals): Low Back Pain (Non-Specific i.e. Mechanical)

(NHS England Evidence Based Intervention)

CATEGORY 1 – NOT ROUTINELY COMMISSIONED
Individual Funding Request (Exceptional Case) Approval

Policy Statement

Spinal injections to treat non-specific (i.e. mechanical) low back pain including facet joint injections, therapeutic medial branch blocks (i.e. not diagnostic), intradiscal therapy, prolotherapy and trigger point injections (excluding epidurals) are not routinely commissioned.

For people with non-specific low back pain the following injections should not be offered:

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

Alternative and less invasive options have been shown to work e.g. exercise programmes, behavioural therapy, and attending a specialised pain clinic. Alternative options are suggested in line with the National Back Pain Pathway.

For further information, please see: https://www.nice.org.uk/guidance/ng59
NICE guidelines recommend that spinal injections should not be offered for non- specific low back pain.
Exclusion criteria for the NICE (NG59) include: Conditions of a non-mechanical nature, including:

- Inflammatory causes of back pain (for example, ankylosing spondylitis or diseases of the viscera)
- Serious spinal pathology (for example, neoplasms, infections or osteoporotic collapse)
- Neurological disorders (including cauda equina syndrome or mononeuritis) Adolescent scoliosis

Not covered were conditions with a select and uniform pathology of a mechanical nature (e.g. spondylolisthesis, scoliosis, vertebral fracture or congenital disease) Other agreed exclusions by the GDG are: Pregnancy-related back pain, Sacroiliac joint dysfunction,

Version: *18/02/2019*

Clinical Coding:
OPCS with ICD inclusions (Procedure driven):
OPCS4: A577, A735, V544, W903
ICD inclusions: M545, M5450, M5455, M5456, M5457, M5458, M5459, G834, G551, M518, M519, M549

16.3c Spinal Injections including Facet Joint Injections, Therapeutic Medial Branch Blocks (i.e. Not Diagnostic), Intradiscal Therapy, Prolotherapy and Trigger Point Injections (excluding Epidurals): Low Back Pain (Non-Specific i.e. Mechanical) (NHS England Evidence Based Intervention)		
	Adjacent-segment disease, Failed back surgery syndrome, Spondylolisthesis and Osteoarthritis. NICE recommends the following approach for non-surgical invasive treatments for low back pain and sciatica in over 16s • Do not offer spinal injections for managing nonspecific low back pain. **Rationale** NICE recommends that spinal injections should not be offered for non-specific low back pain. Alternative options like pain management and physiotherapy have been shown to work - https://www.nice.org.uk/guidance/ng59	
Evidence for inclusion and threshold		
Please refer to 16.3a		

16.4 Peripheral Nerve-Field Stimulation (PNFS): Chronic Low Back Pain
This policy has b This policy has been superseded by ICB Policy CMICB_Clin012 – Chronic Low Back Pain, Peripheral Nerve Field Stimulation v1 01/04/2023

16.5 Therapeutic Endoscopic Division of Epidural Adhesions: Low Back Pain
This policy has been superseded by ICB Policy CMICB_Clin019 – Epidural Adhesions, Therapeutic Endoscopic Division v1 01/04/2023

16.6 Spinal Fusion; Non-Rigid Stabilisation Techniques; Lateral Body Fusion in the Lumbar Spine; Transaxial Interbody Lumbrosacral Fusion; Anterior Lumbar Interbody Fusion (ALIF); Posterior Lumbar Interbody Fusion (PLIF); or Any Other Combination of Approach where Surgical Fixation is Performed: Spinal Fixation:		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Spinal Fusion (Including: Fusion; Non-rigid stabilisation techniques; Lateral body fusion in the lumbar spine; Transaxial interbody lumbrosacral fusion; Anterior lumbar interbody fusion (ALIF); Posterior lumbar interbody fusion (PLIF); Or any other combination of approach where surgical fixation is performed) is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS only (Procedure driven):* *OPCS4: V333, V335, V382, V383, V384, V385, V386, V511*

16.6 Spinal Fusion; Non-Rigid Stabilisation Techniques; Lateral Body Fusion in the Lumbar Spine; Transaxial Interbody Lumbrosacral Fusion; Anterior Lumbar Interbody Fusion (ALIF); Posterior Lumbar Interbody Fusion (PLIF); or Any Other Combination of Approach where Surgical Fixation is Performed: Spinal Fixation:		
	is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Summary of Intervention** Spinal fusion is used to join two or more vertebrae together by placing an additional section of bone in the space between them. This helps to prevent excessive movements between two adjacent vertebrae, lowering the risk of further irritation or compression of the nearby nerves and reducing pain and related symptoms. The additional section of bone can be taken from somewhere else in your body (usually the hip) or from a donated bone. More recently, synthetic (man-made) bone substitutes have been used. To improve the chance of fusion being successful, some surgeons may use screws and connecting rods to secure the bones. Afterwards, the surgeon will close the incision with stitches or surgical staples. http://www.nhs.uk/Conditions/Lumbardecompressivesurgery/Pages/surgery.aspx **Minimum eligibility criteria** The following procedures are not routinely commissioned: • Fusion • Non-rigid stabilisation techniques • Lateral body fusion in the lumbar spine • Transaxial interbody lumbrosacral fusion • Anterior lumbar interbody fusion (ALIF) • Posterior lumbar interbody fusion (PLIF) • Or any other combination of approach where surgical fixation is performed	

Evidence for inclusion and threshold

1. Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59
2. National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf
3. NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173
4. IPG 387: https://www.nice.org.uk/guidance/ipg387 Transaxial interbody lumbosacral fusion

16.7 Laminectomy, Discectomy, Facetectomy and Foraminotomy: Spinal Decompression		
CATEGORY 2 – RESTRICTED **Monitored Approval**	**Policy Statement**	***Version:*** *20/02/2018*

16.7 Laminectomy, Discectomy, Facetectomy and Foraminotomy: Spinal Decompression

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient presents with severe and acute sciatica.
- ☐ The patient has failed to respond to conservative intervention.
- ☐ Imaging findings are concordant with clinical presentation.
- ☐ The treatment being requested is NOT one of the following: endoscopic laser foraminoplasty; endoscopic lumbar decompression; percutaneous disc decompression using coblation for lower back pain; percutaneous intradiscal laser ablation in the lumbar spine; automated percutaneous mechanical lumbar discectomy; prosthetic interverterbal disc replacement in the lumbar spine; intradiscal electro thermal annuloplasty; or percutaneous intradiscal radiofrequency thermocoagulation.

Spinal decompression i.e. laminectomy, discectomy, facetectomy and foraminotomy are restricted in accordance with the minimum eligibility criteria.

Summary of Intervention

Lumbar decompression surgery is a type of surgery used to treat compressed nerves in the lower (lumbar) spine.
It is only recommended when non-surgical treatments have not helped.
The surgery aims to improve symptoms such as persistent pain and numbness in the legs caused by pressure on the nerves in the spine.
Lumbar decompression surgery is often used to treat:

- spinal stenosis – narrowing of a section of the spinal column, which puts pressure on the nerves inside
- a slipped disc and sciatica – where a damaged spinal disc presses down on an underlying nerve
- spinal injuries – such as a fracture or the swelling of tissue
- metastatic spinal cord compression – where cancer in one part of the body, such as the lungs, spreads into the spine and presses on the spinal cord or nerves.

Minimum eligibility criteria

Spinal decompression i.e. laminectomy, discectomy, facetectomy, foraminotomy, is commissioned where:

- Patient presents with severe and acute sciatica

AND

- have failed to respond to conservative intervention

AND

- have imaging findings concordant with clinical presentation

Patient outcome data must be entered onto the international registry database Spine Tango and providers are expected to regularly participate in the Cheshire and Mersey MDT Spinal Network.
The following procedures are NOT routinely commissioned:

- Endoscopic Laser Foraminoplasty
- Endoscopic Lumbar Decompression
- Percutaneous Disc Decompression using Coblation for Lower Back Pain
- Percutaneous Intradiscal Laser Ablation in the Lumbar Spine
- Automated Percutaneous Mechanical Lumbar Discectomy
- Prosthetic Intervertebral Disc Replacement in the Lumbar Spine
- Intradiscal Electro Thermal Annuloplasty (IDET)
- Percutaneous Intradiscal Radiofrequency Thermocoagulation (PIRFT)

Clinical Coding:
OPCS with ICD exclusions (Procedure driven):
OPCS4: V25, V528 (with secondary qualifier of Y261), V563, V603, V623*
ICD exclusions: G551, M511, M512

16.7 Laminectomy, Discectomy, Facetectomy and Foraminotomy: Spinal Decompression

Evidence for inclusion and threshold

1. Low back pain and sciatica in over 16s: assessment and management (November 2016) https://www.nice.org.uk/guidance/ng59
2. National Low Back and Radicular Pain Pathway 2017 http://www.ukssb.com/assets/PDFs/2017/February/National-Low-Back-and-Radicular-Pain-Pathway-2017_final.pdf
3. NICE CG173 Neuropathic pain in adults: pharmacological management in non-specialist settings (2014) https://www.nice.org.uk/guidance/cg173
4. IPG31 Endoscopic laser foraminoplasty: guidance NICE 2003 (confirmed 2009)
5. Reviewed October 2011 – Decision taken that this policy does not require update.
6. IPG570: https://www.nice.org.uk/guidance/ipg570 Epiduroscopic lumbar discectomy through the sacral hiatus for sciatica (December 2016)
7. IPG543: https://www.nice.org.uk/guidance/ipg543 Percutaneous coblation of the intervertebral disc for low back pain and sciatica
8. IPG:357 https://www.nice.org.uk/guidance/ipg357 Percutaneous intradiscal laser ablation in the lumbar spine
9. IPG141: https://www.nice.org.uk/guidance/ipg141 Automated percutaneous mechanical lumbar discectomy
10. IPG 306: Prosthetic intervertebral disc replacement in the lumbar spine NICE 2009.

16.8 Bone Morphogenetic Protein (Dibotermin Alfa and Eptotermin Alfa): Non-Healing Fractures

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The requested treatment is Dibotermin Alfa, to be used as an adjunct to standard care of acute tibial fractures, including open fracture reduction and intramedullary unreamed nail fixation for a patient aged 18+ ☐ The requested treatment is Eptotermin Alfa to treat non-union of a fracture of the tibia which occurred secondary to trauma and has persisted for at least 9 months, where previous treatment with autograft has failed or is unfeasible and the patient is skeletally mature.	**Policy Statement** Dibotermin Alfa and Eptotermin Alfa (bone morphogenetic protein) for non-healing fractures are restricted in accordance with the minimum eligibility criteria.	***Version:*** *2014/2015* ***Clinical Coding:*** *OPCS with ICD inclusions (Procedure driven):* *OPCS4: X923* *ICD inclusions: M8416, S822*

Evidence for inclusion and threshold

1. Clinical effectiveness and cost-effectiveness of bone morphogenetic proteins in the non-healing of fractures and spinal fusion: a systematic review Health Technology Assessment NHS R&D HTA Programme, 2007.
2. Clinical effectiveness and cost-effect... [Health Technol Assess. 2007] - PubMed - NCBI
3. Annals of Internal Medicine | Safety and Effectiveness of Recombinant Human Bone Morphogenetic Protein-2 for Spinal Fusion: A Meta-analysis of Individual-Participant Data June 2013
4. BMPs: Options, indications, and effectiveness – Journal of Orthopaedic Trauma. 2010 Mar;24 Suppl 1:S9-16.

16.9 Hyaluronic Acid and Derivatives Injections: Peripheral Joint Pain

This policy has been superseded by ICB Policy CMICB_Clin036 – Osteoarthritic induced changes in peripheral joints (knee, hips, ankle & thumb), intra-articular hyaluronan (hyaluronic acid) v1 01/04/2023

16.10 Steroid Joint Injections (Secondary Care Administered): Joint Pain

This policy has been superseded by ICB Policy CMICB_Clin037 – Osteoarthritis-induced joint pain, secondary care administration of intra-articular corticosteroids v1 01/04/2023

16.11a Hip Replacement Surgery: Hip Joint Damage

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient complains of severe joint pain AND has functional limitations, despite the use of non-surgical treatments e.g. adequate doses of NSAID analgesia, weight control treatments and physical therapies.
- ☐ The patient complains of mild to moderate joint pain AND has severe functional limitations, despite the use of non-surgical treatments e.g. adequate doses of NSAID analgesia, weight control treatments and physical therapies.

Policy Statement
Hip Replacement Surgery is restricted in accordance with the Minimum Eligibility Criteria.

Summary of Intervention
A hip replacement is a common type of surgery where a damaged hip joint is replaced with an artificial one (known as a prosthesis). The hip joint is one of the largest joints in the human body and is what is known as a "ball and socket joint". In a healthy hip joint, the bones are connected to each other with bands of tissue known as ligaments. These ligaments are lubricated with fluid to reduce friction. Joints are also surrounded by a type of tissue called cartilage that is designed to help support the joints and prevent bones from rubbing against each other.
The main purpose of the hip joints is to support the upper body when a person is standing, walking and running, and to help with certain movements, such as bending and stretching.
Some common reasons why a hip joint can become damaged include:

- osteoarthritis – so-called "wear and tear arthritis", where the cartilage inside a hip joint becomes worn away, leading to the bones rubbing against each other
- rheumatoid arthritis – this is caused by the immune system (the body's defence against infection) mistakenly attacking the lining of the joint, resulting in pain and stiffness
- hip fracture – if a hip joint becomes severely damaged during a fall or similar accident it may be necessary to replace it

Many of the conditions treated with a hip replacement are age-related so hip replacements are usually carried out in older adults aged between 60 and 80. However, a hip replacement may occasionally be performed in younger people.
The purpose of a new hip joint is to:

- relieve pain
- improve the function of your hip

Version: *20/02/2018*

Clinical Coding:
OPCS only (Procedure driven):
OPCS4: W371, W378, W379, W381, W388, W389, W391, W398, W399, W461, W468, W469, W471, W478, W479, W481, W488, W489
The following must also be accompanied by Z843: W551, W558, W559, W562, W568, W569, W581, W588, W589

16.11a Hip Replacement Surgery: Hip Joint Damage		
	• improve your ability to move around • improve your quality of life Referral for elective hip surgery should be considered for people with osteoarthritis who experience the following joint symptoms- • Pain • Stiffness • reduced function Patients should be informed that the decision to have surgery can be a dynamic process and a decision to not undergo surgery now, does not exclude them from having surgery at a future point in time. **Minimum eligibility criteria** Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Referral criteria for <u>Total Hip Replacements (THR)</u>** should be based on the level of pain and functional impairment suffered by the patient. Funding is available for patients who fulfil the following criteria: 1. Patient complains of severe joint pain. **AND** 2. Functional limitation, despite the use of non- surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. **OR** 3. Patient complains of mild to moderate joint pain AND has severe functional limitation, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. The CCGs will fund hip resurfacing for those who otherwise qualify for primary total hip replacement, but are likely to outlive conventional primary hip replacements as restricted by NICE Guidance Hip disease - metal on metal hip resurfacing (TA44).	
Evidence for inclusion and threshold		
1. Royal College of Surgeons – Painful Hip Commissioning Guide https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/painful-hip-guide/ 2. NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014) Weblink: https://www.nice.org.uk/guidance/cg177 3. NHS Choices – Hip replacement - Weblink: http://www.nhs.uk/Conditions/Hip-replacement/Pages/Introduction.aspx		

16.11b Hip Resurfacing: Hip Joint Damage

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient complains of severe joint pain AND has functional limitations, despite the use of non-surgical treatments e.g. adequate doses of NSAID analgesia, weight control treatments and physical therapies and having regard to the patient's age, activity and underlying hip physiology the patient is more suited to hip resurfacing, as opposed to hip replacement(s). ☐ The patient complains of mild to moderate joint pain AND has severe functional limitations, despite the use of non-surgical treatments e.g. adequate doses of NSAID analgesia, weight control treatments and physical therapies and having regard to the patient's age, activity and underlying hip physiology the patient is more suited to hip resurfacing, as opposed to hip replacement(s).	**Policy Statement** Please refer to 16.11a Hip resurfacing is restricted in accordance with the minimum eligibility criteria.	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS only (Procedure driven):* *OPCS4: W371, W378, W379, W381, W388, W389, W391, W398, W399, W461, W468, W469, W471, W478, W479, W481, W488, W489* *The following must also be accompanied by Z843: W551, W558, W559, W562, W568, W569, W581, W588,* *W589*
Evidence for inclusion and threshold		
Please refer to 16.21a		

16.12 Hip Arthroscopy: Hip Impingement Syndrome/Femoro–Acetabular Impingement

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ALL** the following statements: ☐ An orthopaedic surgeon who specialises in young adult hip surgery has, in collaboration with a specialist musculoskeletal radiologist, diagnosed the patient as having femoro-acetabular impingement (hip impingement syndrome) having regard to appropriate investigations e.g. X-ray, MRI and CT scans.	**Policy Statement** Hip arthroscopy for femoro-acetabular impingement is restricted in accordance with the minimum eligibility criteria. **Minimum Eligibility Criteria** CCGs routinely commission hip arthroscopy (from surgeons with specialist expertise in this type of surgery) in line with the requirements stipulated by NICE IPG 408, and only for patients who fulfil ALL the following criteria: • A definite diagnosis of hip impingement syndrome/femoro-acetabular impingement (FAI) has been made by appropriate investigations, X-rays, MRI and CT scans. • An orthopaedic surgeon who specialises in young adult hip surgery has made the diagnosis in collaboration with a specialist musculoskeletal radiologist. • The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months.	***Version:*** *2014/2015* ***Clinical Coding:*** *OPCS with ICD inclusions (Procedure driven):* *OPCS4: W84* with Z756* *ICD inclusions: M2585*

16.12 Hip Arthroscopy: Hip Impingement Syndrome/Femoro–Acetabular Impingement

☐ The patient has had severe FAI symptoms (restriction of movement, pain and 'clicking') or significantly compromised functioning for at least 6 months. ☐ The patient's symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy.	• The symptoms have not responded to all available conservative treatment options including activity modification, drug therapy (NSAIDs) and specialist physiotherapy. **Rationale** Current evidence on the efficacy of arthroscopic femoro–acetabular surgery for hip impingement syndrome is adequate in terms of symptom relief in the short and medium term. With regard to safety, there are well-recognised complications. Therefore this procedure may be used provided that normal arrangements are in place for clinical governance, consent and audit with local review of outcomes.	

Evidence for inclusion and threshold

1. IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance – NICE, 2011.
2. http://www.hullccg.nhs.uk/uploads/policy/file/22/hip-arthroscopy-hull-ccg.pdf NHS Hull Clinical Commissioning Group 2012.
3. Vijay D Shetty, Richard N Villar. Hip arthroscopy: current concepts and review of literature. British Journal of Sports Medicine, 2007;41:64–68.
4. Macfarlane RJ, Haddad FS The diagnosis and management of femoro-acetabular impingement. Annals of the Royal College of Surgeons of England, July 2010, vol/iss 92/5(363-7).
5. Ng V Y et al.. Efficacy of Surgery for Femoro-acetabular Impingement: A Systematic Review. American Journal of Sports Medicine, November 2010,38 2337-2345.
6. Commissioning Guide: Painful osteoarthritis of the hip Royal College of Surgeons (2013).
7. IPG408 Arthroscopic femoro-acetabular surgery for hip impingement syndrome: guidance NICE, 2011

16.13 Knee Arthroplasty

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient's BMI is less than 40 AND the patient complains of moderate joint pain AND has moderate to severe functional limitations that have a substantial impact on their quality of life despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies AND has radiological features of severe disease. ☐ The patient's BMI is less than 40 AND the patient complains of moderate joint pain AND has moderate to severe functional limitations that have a substantial impact on quality of life despite the use of non-surgical	**Policy Statement** Knee replacement surgery (arthroplasty) is restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Knee replacement surgery (arthroplasty) involves replacing a damaged, worn or diseased knee with an artificial joint. It's a routine operation for knee pain most commonly caused by arthritis. More than 70,000 knee replacements are carried out in England and Wales each year, and the number is rising. Most people who have a total knee replacement are over 65 years old. For most people, a replacement knee lasts over 20 years, especially if the new knee is cared for properly and not put under too much strain. There are two main types of surgery, depending on the condition of the knee: • total knee replacement (TKR) – both sides of your knee joint are replaced • partial (half) knee replacement (PKR) – only one side of your joint is replaced in a smaller operation with a shorter hospital stay and recovery period The most common reason for knee replacement surgery is osteoarthritis. Other conditions that cause knee damage include:	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS only (Procedure driven):* *OPCS4: W401, W408, W409, W411, W418, W419, W421, W428, W429*

16.13 Knee Arthroplasty

treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies AND has radiological features of moderate disease with limited mobility or instability of the knee joint.	• rheumatoid arthritis • haemophilia • gout • knee injury A knee replacement is major surgery, so is normally only recommended if other treatments, such as physiotherapy or steroid injections, haven't helped reduce pain or improve mobility. You may be offered knee replacement surgery if: • You have severe pain, swelling and stiffness in your knee joint and your mobility is reduced • your knee pain is so severe that it interferes with your quality of life and sleep • everyday tasks, such as shopping or getting out of the bath, are difficult or impossible • you cannot work or have a normal social life Referral for joint replacement surgery should be considered for people with osteoarthritis who experience all of the following joint symptoms; • Pain • Stiffness • Reduced function **Minimum eligibility criteria** Referral is based on local referral pathways. Where MCAS services are in place the patient needs to be seen in an MCAS service before referral to a consultant. **Funding for <u>total or partial knee replacement</u> <u>surgery</u> is available if the following criteria are met** 1. Patients with BMI <40. **AND** 2. Patient complains of moderate joint pain AND moderate to severe functional limitations that has a substantial impact on quality of life, despite the use of non-surgical treatments such as adequate doses of NSAID analgesia, weight control treatments and physical therapies. **AND** 3. Has radiological features of severe disease. **OR** 4. Has radiological features of moderate disease with limited mobility or instability of the knee joint.	

16.13 Knee Arthroplasty

Evidence for inclusion and threshold

1. Royal College of Surgeons - Commissioning Guide for Painful Osteoarthritis of the Knee (2017) - Weblink: https://www.rcseng.ac.uk/-/media/files/rcs/standards-and-research/commissioning/boa--painful-oa-knee-guide-final-2017.pdf?la=en
2. NICE – Clinical Guidance 177: Osteoarthritis: care and management (2014) - Weblink: https://www.nice.org.uk/guidance/cg177
3. Journal of Arthroplasty, 2013, 28(5), p714-721, A workgroup of the American Association of Hip and, Obesity and total joint arthroplasty: a literature based review
4. Saif Salih* and Paul Sutton (2013). Obesity, knee osteoarthritis and knee arthroplasty: a review. BMC Sports Science, Medicine and Rehabilitation:5(25) - Weblink: (http://www.biomedcentral.com/2052-1847/5/25)
5. NHS Choices – Knee replacement - Weblink: http://www.nhs.uk/conditions/Knee-replacement/Pages/Kneereplacementexplained.aspx

16.14a Diagnostic Knee Arthroscopy: Knee Arthritis without Osteoarthritis

This policy has been superseded by ICB Policy CMICB_Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears v1 01/04/2023

16.14b Diagnostic Knee Arthroscopy: Knee Arthritis with Osteoarthritis

This policy has been superseded by ICB Policy CMICB_Clin004 – Arthroscopic Surgery of the Knee for Meniscal Tears v1 01/04/2023

16.15 Knee Arthroscopy: Knee Osteoarthritis

(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement v1 01/04/2023

16.16 Uni-compartmental Knee Replacement (Patient Specific): Knee Osteoarthritis

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Patient specific uni-compartmental knee replacement is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. Referral should be made to specialist centres only.	***Version:*** *2014/2015* ***Clinical Coding:*** *OPCS only (Procedure driven):* *OPCS4: W581 with a secondary code of Z844, Z845*

Evidence for inclusion and threshold

1. IPG317 Individually magnetic resonance imaging- designed unicompartmental interpositional implant insertion for osteoarthritis of the knee: guidance NICE, 2009

16.17 Total Knee Replacement (Patient Specific)
This policy has been superseded by ICB Policy CMICB_Clin047 – Total Knee Arthroplasty, patient specific instrumentation/implants v1 01/04/2023

16.18 Trigger Finger/Thumb Surgical Release (NHS England Evidence Based Intervention)
This policy has been superseded by ICB Policy CMICB_Clin048 – Trigger Finger release in adults v1 01/04/2023

16.19a Collagenase Injection: Dupuytren's Contracture Release (Adults) (NHS England Evidence Based Intervention)
This policy has been superseded by ICB Policy CMICB_Clin016 – Dupuytren's Contracture release in adults v1 01/04/2023

16.19b Needle Fasciotomy, Fasciectomy And Dermo-Fasciectomy: Dupuytren's Contracture Release (Adults): (NHS England Evidence Based Intervention)
This policy has been superseded by ICB Policy CMICB_Clin016 – Dupuytren's Contracture release in adults v1 01/04/2023

16.20 Carpal Tunnel Syndrome Surgical Release (NHS England Evidence Based Intervention)
This policy has been superseded by ICB Policy CMICB_Clin010 – Carpal Tunnel interventions and surgery v1 01/04/2023

16.21 Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) Surgical Removal
This policy has been superseded by ICB Policy CMICB_Clin033 – Mucoid Cysts of the Fingers at the Distal Interphalangeal (DIP) Joint, surgical removal v1 01/04/2023

16.22 Ganglia Surgical Excision: Wrist or Hand (Seed and Mucous Cysts)

(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin022 – Ganglia, surgical removal and general management v2 01/04/2023

16.23 Bunion or Lesser Toe Deformity Surgery

This policy has been superseded by ICB Policy CMICB_Clin008 – Bunions, surgical removal v1 01/04/2023

16.24 Morton's Neuroma Surgical Treatment

This policy has been superseded by ICB Policy CMICB_Clin028 – Knee Osteoarthritis, Arthroscopic Lavage and Debridement v1 01/04/2023

16.25 Plantar Fasciitis Surgical Treatment

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient is experiencing significant pain or their symptoms are having a serious impact on their daily life.
- ☐ The patient has been referred to a podiatrist or physiotherapist.
- ☐ The patient has had 3 months of conservative treatments including footwear modification, stretching exercises, ice packs and weight loss (if patient is overweight) and has failed to respond to these treatments.
- ☐ The patient has not responded to corticosteroid injections.

Policy Statement
Surgical treatment of plantar fasciitis is restricted in accordance with the minimum eligibility criteria.

Minimum Eligibility Criteria
Surgical Treatment is not routinely commissioned unless the following pathway has been followed:

- Patient has documented evidence that they are not responding to conservative treatments
- Patient is experiencing significant pain or it is having a serious impact on their daily life and has completed the following:
  - Three months of conservative therapy such as footwear modification, stretching exercises, ice packs, weight loss
  - Been referred to a podiatrist or physiotherapist
  - Not responded to corticosteroid injections

Version: *2014/2015*

Clinical Coding:
OPCS with ICD inclusions (Diagnosis driven):
OPCS4: T542, T523
ICD inclusions: M722

Evidence for inclusion and threshold

1. Heel pain--plantar fasciitis: clinical practice guidelines linked to the international classification of function, disability, and health from the orthopaedic section of the American Physical Therapy Association - Journal of Orthopaedic & Sports Physical Therapy. 2008:38(4):A1-A18.
2. Plantar fasciitis - NICE Clinical Knowledge Summaries (2009).

16.25 Plantar Fasciitis Surgical Treatment

3. Plantar fasciitis - BMJ 2012;345:e6603.

16.26 Extracorporeal Shock Wave Therapy / Autologous Blood or Platelet Injections: Plantar Fasciitis, Achilles Tendinopathy, Refractory Tennis Elbow

This policy has been superseded by ICB Policy CMICB_Clin001 - Achilles Tendinopathy, Refractory Tennis Elbow and Plantar Fasciitis: treatment with extracorporeal shockwave therapy, autologous blood or platelet rich plasma injections v1 01/04/2023

16.27 Shoulder Arthroscopic Decompression: Pure Subacromial Shoulder Impingement

(NHS England Evidence Based Intervention)

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ALL** the following statements:

- ☐ The patient has persistent or progressive symptoms.
- ☐ The patient has received adequate non-operative treatments such as physiotherapy and exercise programmes which have not resolved their symptoms.

Policy Statement
Arthroscopic decompression for subacromial shoulder impingement is restricted in accordance with the minimum eligibility criteria.

Summary of Intervention
Arthroscopic sub-acromial decompression is a surgical procedure that involves decompressing the sub-acromial space by removing bone spurs and soft tissue arthroscopically.
In order to facilitate non-operative treatment in primary and intermediate care, BESS and Getting It Right First Time programme have produced patient exercise rehab videos and booklets for GPs and patients to use. http://www.bess.org.uk/index.php/public-area/shpi-videos
Patients suffering with persistent symptoms, despite appropriate non-operative management, should be given the option to choose decompression surgery.
Treating clinicians and surgeons should refer to the 2015 BESS/BOA/NICE commissioning guidelines (guideline update due in 2018/19) for details of appropriate treatment of these patients. https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/subacromial-shoulder-pain--commissioning-guide.pdf
Recent research has indicated that in patients with pure subacromial impingement (with no other associated diagnoses such as rotator cuff tears, calcific tendinopathy and acromio-clavicular joint pain), non-operative management with a combination of exercise and physiotherapy is effective in the majority of cases.

Minimum eligibility criteria
Arthroscopic subacromial decompression for pure subacromial shoulder impingement should only offered in appropriate cases. To be clear, 'pure subacromial shoulder impingement' means subacromial pain not caused by associated diagnoses such as rotator cuff tears, acromio-clavicular joint pain, or calcific tendinopathy. Non-operative

Version: *18/02/2019*

Clinical Coding:
OPCS with ICD inclusions and exclusions (Diagnosis driven):
OPCS4: O291, W844
With secondary codes of Y767 plus one from the following list: Z045, Z081, Z082, Z083, Z088, Z089, Z091, Z098, Z099, Z492, Z496, Z541, Z542, Z543, Z544, Z545, Z548, Z549, Z681, Z682, Z683, Z684, Z685, Z688, Z689, Z691, Z692, Z693, Z694, Z698, Z699, Z811, Z812, Z813, Z814, Z818, Z819, Z891, Z892, Z898, Z899
ICD inclusions: M754, M2551
ICD exclusions: M751, M753

16.27 Shoulder Arthroscopic Decompression: Pure Subacromial Shoulder Impingement
(NHS England Evidence Based Intervention)

	treatment such as physiotherapy and exercise programmes are effective and safe in many cases. For patients who have persistent or progressive symptoms, in spite of adequate non-operative treatment, surgery should be considered. The latest evidence for the potential benefits and risks of subacromial shoulder decompression surgery should be discussed with the patient and a shared decision reached between surgeon and patient as to whether to proceed with surgical intervention **Rationale** Number of CCG interventions in 2017/18 – 13,930 Recruiting patients with pure subacromial impingement and no other associated diagnosis, a recent randomised, pragmatic, parallel group, placebo-controlled trial investigated whether subacromial decompression compared with placebo (arthroscopy only) surgery improved pain and function[1]. While statistically better scores were reached by patients who had both types of surgery compared to no surgery, the differences were not clinically significant, which questions the value of this type of surgery. On the other hand, a more recent prospective randomised trial comparing the long-term outcome (10 year follow up) of surgical or non-surgical treatment of sub acromial impingement showed surgery to be superior to non-surgical treatment[3] Other studies of limited quality identify certain patients with impingement syndrome that improve with surgical subacromial decompression if non-operative management fails.[4,5] There is also some evidence to show the benefit of surgery when used selectively and applying national clinical guidelines.[6] A review of the literature identified one further systematic review that looked at the effectiveness of surgery.[2] The review was limited by the quality of evidence but their findings showed no difference between patients treated with surgery and those treated with non-surgical options. Healthcare professionals treating patients with subacromial pain should be familiar with the NICE approved commissioning and treatment guidelines for the management of subacromial pain.7 Risks associated with arthroscopic sub-acromial decompression are low but include infection, frozen shoulder, ongoing pain, potential damage to blood vessels or nerves and those associated with having a general anaesthetic.	

Evidence for inclusion and threshold

1. Beard DJ, Rees JL, Cook JA, Rombach I, Cooper C, Merritt N, Shirkey BA, Donovan JL, Gwilym S, Savulescu J, Moser J, Gray A, Jepson M, Tracey I, Judge A, Wartolowska K, Carr AJ; CSAW Study Group. Arthroscopic subacromial decompression for subacromial shoulder pain (CSAW): a multicentre, pragmatic, parallel group, placebo-controlled, three-group, randomised surgical trial. Lancet. 2018 Jan 27;391(10118):329-338. doi: 10.1016/S0140-6736(17)32457-1. Epub 2017 Nov 20. PubMed PMID: 29169668; PubMed Central PMCID: PMC5803129.

16.27 Shoulder Arthroscopic Decompression: Pure Subacromial Shoulder Impingement
(NHS England Evidence Based Intervention)

2. Dorrestijn O, Stevens M, Winters JC, van der Meer K, Diercks RL. Conservative or surgical treatment for subacromial impingement syndrome? A systematic review. J Shoulder Elbow Surg 2009; 18: 652–60.
3. Farfaras S, Sernert N, Rostgard Christensen L, Hallström EK, Kartus JT. Subacromial Decompression Yields a Better Clinical Outcome Than Therapy Alone: A Prospective Randomized Study of Patients With a Minimum 10-Year Follow-up. Am J Sports Med. 2018 May;46(6):1397-1407
4. Holmgren T, Björnsson Hallgren H, Öberg B, Adolfsson L, Johansson K. Effect of specific exercise strategy on need for surgery in patients with subacromial impingement syndrome: randomised controlled study. BMJ. 2012 Feb 20;344:e787. doi: 10.1136/bmj.e787
5. Magaji SA, Singh HP, Pandey RK. Arthroscopic subacromial decompression is effective in selected patients with shoulder impingement syndrome. J Bone Joint Surg Br. 2012 Aug;94(8):1086-9
6. Jacobsen JR, Jensen CM, Deutch SR. Acromioplasty in patients selected for operation by national guidelines. J Shoulder Elbow Surg. 2017 Oct;26(10):1854-1861.
7. https://www.rcseng.ac.uk/-/media/files/rcs/library-and-publications/non-journal-publications/subacromial-shoulder-pain--commissioning-guide.pdf

17. Urology

17.1a Circumcision for Medical Reasons

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The patient has Balantis xerotica obliterans.
- ☐ The patient has had a traumatic foreskin injury/scarring where it cannot be salvaged.
- ☐ The patient has had 3 or more episodes of balanitis/balanoposthitis.
- ☐ The patient has pathological phimosis.
- ☐ The patient has irreducible paraphimosis.
- ☐ The patient has had recurrent proven Urinary Tract Infections and has an abnormal urinary tract.
- ☐ The patient has a tight foreskin which causes pain on arousal and/or is interfering with sexual function.

Policy Statement
Circumcision for medical reasons is restricted in accordance with the minimum eligibility criteria. This procedure is not commissioned by the NHS for social, cultural or religious reasons.

Rationale
This is because non-medical circumcisions do not confer any health gain but do carry health risk, if the patient does not meet the medical indications specified by the criteria.

Summary of Intervention
Male circumcision is the surgical removal of the foreskin.
The foreskin is the retractable fold of skin that covers the end of the penis. It is a continuation of the skin that covers the whole penis.
Further information can be found at:
http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx

Minimum eligibility criteria
Circumcision will be funded in the following medical circumstances only:
- Balantis xerotica obliterans.
- Traumatic foreskin injury/scarring where it cannot be salvaged.
- 3 or more episodes of balanitis/balanoposthitis.
- Pathological phimosis.

Version: *20/02/2018*

Clinical Coding:
OPCS with ICD exclusions (Procedure driven):
OPCS4: N303
ICD exclusions: N47X, N480, N483, Q540, Q541, Q542, Q543, Q544, Q548, Q549, N481, Q556, N133, N137

17.1a Circumcision for Medical Reasons		
	• Irreducible paraphimosis. • Recurrent proven Urinary Tract. Infections (UTIs) with an abnormal urinary tract. • Tight foreskin causing pain on arousal/ interfering with sexual function	
Evidence for inclusion and threshold		
1. 2008 UK National Guideline on the Management of Balanoposthitis – Clinical Effectiveness Group British Association for Sexual Health and HIV (2008). Balanitis 2. NICE Clinical Knowledge Summaries 2015 - I don't know, let's try some canestan: an audit of non-specific balanitis treatment and outcomes -Sexually Transmitted Infections 2012;88:A55-A56 3. Balanitis - Patient.co.uk. https://www.rcseng.ac.uk/-/.../rcs/.../foreskin-conditions--commissioning-guide.pdf - Foreskin Conditions: Royal College of Surgeons guidance (2013). 4. NHS Choices – Circumcision - Weblink: http://www.nhs.uk/Conditions/Circumcision/Pages/Introduction.aspx 5. Male Circumcision: Guidance for Healthcare Practitioners -Royal College of Surgeons, 2000 - https://www.rcseng.ac.uk/library-and-publications/college-publications/docs/male-circumcision/		

17.1b Circumcision for Social, Cultural or Religious Reasons		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 17.1a Circumcision for social, cultural or religious reasons is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *20/02/2018* ***Clinical Coding:*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: N303* *ICD exclusions: N47X, N480, N483, Q540, Q541, Q542, Q543, Q544, Q548, Q549, N481, Q556, N133, N137*
Evidence for inclusion and threshold		
Please refer to 17.1a		

17.3 Male Sterilisation Reversal: Infertility
This policy has been superseded by ICB Policy CMICB_Clin040 – Reversal of Male Sterilisation v1 01/04/2023

17.4 Extracorporeal Shockwave Therapy (ESWT): Prostadynia or Pelvic Floor Syndrome		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** ESWT (extracorporeal shockwave therapy) for Prostadynia or Pelvic Floor Syndrome is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Rationale** There is limited clinical evidence of effectiveness.	***Version:*** *2014/2015* ***Clinical Coding:*** *No specific clinical coding*

17.4 Extracorporeal Shockwave Therapy (ESWT): Prostadynia or Pelvic Floor Syndrome

Evidence for inclusion and threshold

1. Guidelines on chronic pelvic pain European Association of Urology (2012).

17.5 Hyperthermia Treatment: Prostadynia or Pelvic Floor Syndrome

CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Hyperthermia Treatment for Prostadynia or Pelvic Floor Syndrome is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Rationale** There is limited clinical evidence of effectiveness.	***Version:*** *2014/2015* ***Clinical Coding:*** *No specific clinical coding*

Evidence for inclusion and threshold

1. Guidelines on chronic pelvic pain European Association of Urology (2012).
2. https://www.rcog.org.uk/globalassets/documents/guidelines/gtg_41.pdf

17.6a Prostatism/Lower Urinary Tract Specialist Assessment Referral

CATEGORY 2 – RESTRICTED **Monitored Approval** The patient's clinical presentation must meet **ONE** of the following statements: ☐ The patient has lower urinary tract symptoms complicated by recurrent or persistent urinary tract infections. ☐ The patient has retention. ☐ The patient has renal impairment and lower urinary tract dysfunction is suspected. ☐ Urological cancer is suspected. ☐ The patient has stress urinary incontinence. ☐ The patient has failed a trial of appropriate drug therapies or conservative management options.	**Policy Statement** Treatments for Prostatism or Lower Urinary Tract symptoms are restricted in accordance with the minimum eligibility criteria. **Summary of Intervention** Prostate problems are common, particularly in men aged over 50. The prostate is a small gland found only in men. It surrounds the tube that carries urine out of the body (urethra). The prostate gland produces a thick, white fluid that gets mixed with sperm to create semen. The prostate gland is about the size and shape of a walnut but tends to get bigger as you get older. It can sometimes become swollen or enlarged by conditions such as: • prostate enlargement • prostatitis (inflammation of the prostate) • prostate cancer **Minimum Eligibility Criteria**	***Version:*** *11/03/2020* ***Clinical Coding:*** *No specific clinical coding*

17.6a Prostatism/Lower Urinary Tract Specialist Assessment Referral		
	Refer patients for **specialist assessment** if they have one or more of the following symptoms: • lower urinary tract symptoms complicated by recurrent or persistent urinary tract infections • retention • renal impairment you suspect is caused by lower urinary tract dysfunction • suspected urological cancer • stress urinary incontinence • Failed a trial of the appropriate drug therapies or conservative management options. **Surgery** for Prostatism will only be funded under the following circumstances: • **For Voiding Symptoms** only if voiding symptoms are severe AND • conservative management options have failed or are not appropriate **For Storage Symptoms** only if conservative management options have failed or are not appropriate In both scenarios refer to https://pathways.nice.org.uk/pathways/lower-urinary-tract-symptoms-in-men#content=view-index&path=view%3A/pathways/lower-urinary-tract-symptoms-in-men/lower-urinary-tract-symptoms-in-men-overview.xml for guidance **Rationale** This is because LUTS are a major burden for the ageing male population. Age is an important risk factor for LUTS and the prevalence of LUTS increases as men get older. Bothersome LUTS can occur in up to 30% of men older than 65 years. This is a large group potentially requiring treatment.	

Evidence for inclusion and threshold
1. NHS Choices – Prostate Problems - https://www.nhs.uk/conditions/prostate-problems/ 2. Lower urinary tract symptoms in men: management Clinical guideline [CG97] Published date: May 2010 Last updated: June 2015 https://www.nice.org.uk/guidance/cg97/chapter/Introduction 3. See overview of NICE's recommendations for the treatment of lower urinary tract symptoms in men: https://pathways.nice.org.uk/pathways/lower-urinary-tract-symptoms-in-men

17.6b Prostatism Surgical Intervention		
CATEGORY 2 – RESTRICTED **Monitored Approval**	**Policy Statement** Please refer to section 17.6a	***Version: 11/03/2020*** ***Clinical Coding:***

17.6b Prostatism Surgical Intervention		
The patient's clinical presentation must meet **ONE** of the following statements: ☐ The surgery is for severe voiding symptoms and conservative management options have failed or are not appropriate. ☐ The surgery is for storage symptoms and conservative management options have failed or are not appropriate.	Prostatism Surgery is restricted in accordance with the minimum eligibility criteria.	*No specific clinical coding*
Evidence for inclusion and threshold		
Please refer to section 17.6a		

18. Vascular Surgery

18.1 Endoscopic Thoracic Sympathectomy (Surgical Resection): Hyperhidrosis (Extreme Sweating)

This policy has been superseded by ICB Policy CMICB_Clin027 – Hyperhidrosis (excessive sweating), Surgical Management v1 01/04/2023

18.2 Chelation Therapy: Vascular Occlusions

This policy has been superseded by ICB Policy CMICB_Clin015 – Disodium Ethylenediaminetetraacetic Acid (EDTA) in prevention of Cardiovascular Events in patients with a previous Myocardial Infarction v1 01/04/2023

18.3a Vascular Service Referrals: Varicose Veins (Legs Only)
(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin049 – Varicose Veins v1 01/04/2023

18.3b Varicose Veins: Compression Hosiery Treatment
(NHS England Evidence Based Intervention)

This policy has been superseded by ICB Policy CMICB_Clin049 – Varicose Veins v1 01/04/2023

19. Other

19.1a Botulinum Toxin A

Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

CATEGORY 2 – RESTRICTED
Monitored Approval

The patient's clinical presentation must meet **ONE** of the following statements:

- ☐ The treatment is for anal fissure which have not healed in response to a minimum of eight weeks of topical management with lifestyle advice and topical pharmaceutical products and they have NOT already completed 2 courses of botulinum toxin A injections to treat their fissure(s).
- ☐ The treatment is for severe axillary hyperhidrosis which has not been adequately controlled by topical chloride or other extra-strength antiperspirants AND they do not have a social anxiety disorder. They have a baseline score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS), AND the patient has NOT already completed 2 courses of botulinum toxin A.
- ☐ Botulinum toxin type A will be prescribed and administered under the supervision of a specialist designation neurological centre for a patient diagnosed with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine) who has not responded to at least three prior pharmacological prophylaxis therapies AND their condition is appropriately managed for medication overuse AND the treatment requested is in line with NICE TA260.
- ☐ The patient has a blepharospasm and hemifacial spasm.
- ☐ The patient has multiple sclerosis with probable contracture of joint and Botulinum Toxin A is to be

Policy Statement
Botulinum Toxin A is restricted in accordance with the minimum eligibility criteria.
Botulinum Toxin B is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional.

Botulinum toxin is a protein produced by clostridium botulinum bacteria and related species. When injected into the body it affects the nervous system and it can be used to treat a number of disorders that cause excessive or abnormal muscle movement. These include spasticity that results from a stroke or a spinal cord injury, and spasms in the head and neck, eyelid, vagina, limbs, jaw or vocal cords. Botox can also be used to relax clenched muscles (for example, when people grind their teeth in their sleep) and to correct eye alignment ("crossed eyes").

A number of botulinum toxin type A products are commercially available (including Botox®, Dysport®, Xeomin®). Other brands are available but are only licensed for cosmetic procedures (Allergan).

Minimum Eligibility Criteria

Botulinum Type A
Botulinum toxin type A is not routinely commissioned in the following indications:

- Canthal lines (crow's feet) and glabellar (frown) lines.
- Any other indication that is not listed below.

The use of Botulinum type A is commissioned for the following indications and provided the eligibility criteria are met:

Anal fissures
A maximum of two courses of Botulinum toxin type A is recommended as a treatment option in patients with chronic anal fissure that has not healed despite at least 8 weeks of topical management.
It has a similar mechanism of action to topical products. The preferred first line topical product is 0.4% glyceryl trinitrate (GTN) ointment, the only licensed non-surgical option available in the UK. Unlicensed topical 2% diltiazem oitment and unlicensed topical 0.2% GTN ointment are

Version: *01/10/2020*

Clinical Coding:
OPCS with ICD exclusions (Procedure driven):
OPCS4: S532 with a secondary code of X851
ICD exclusions: G243, G245, G248, G35X, G43, G513, K117, K601, N328, Q438*
NB: coding is not medication specific.

19.1a Botulinum Toxin A

Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

used in line with NICE Clinical Guideline 186 i.e. where other measures are inappropriate or ineffective; AND in conjunction with prolonged stretching modalities. ☐ The patient has focal dystonia and other treatment measures are inappropriate or ineffective. ☐ The patient has focal spasticity with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries or other neurodegenerative disease, where other measures are inappropriate or ineffective. ☐ The patient has idiopathic cervical dystonia (spasmodic torticollis). ☐ The patient is a woman with urinary incontinence caused by refractory detrusor overactivity where conservative therapy and conventional drug treatment has failed to control symptoms AND the patient is able and willing to self-catheterise AND treatment will be in line with NICE Clinical Guideline 171. ☐ The patient is a man with urinary incontinence caused by refractory detrusor overactivity where conservative therapy and conventional drug treatment has failed to control symptoms AND the patient is able and willing to self-catheterise AND treatment will be in line with NICE Clinical Guideline 97. ☐ The patient has sialorrhoea (excessive salivary drooling) and all other treatments have failed. ☐ The patient is to be treated with Xeomin (botulinum neurotoxin type A) in line with NICE TA 605, AND is an adult with chronic sialorrhoea (excessive salivary drooling) caused by neurological condition AND all other treatments have failed.	alternatives if there has been a partial response to topical 0.4% GTN but intolerance such as headache has necessitated discontinuation. For patients who proceed to treatment with botulinum toxin type A and whose fissure has not healed after one course of injections, alternative options for on-going management should be considered. However, where the specialist determines there has been a partial response to the first course, a second course may be considered particularly for patients where surgery is less suitable. To assist with healing and prevention of recurrence of fissures, patients should be encouraged to eat a high fibre diet and use laxatives if necessary. For the use of Botulinum toxin type A in treating Anal Fissures, refer also to the Pan Mersey Area Prescribing Committee Prescribing policy statement ***BOTULINUM TOXIN Type A injection for chronic anal fissure***: https://www.panmerseyapc.nhs.uk/media/1568/botulinum_anal.pdf **Hyperhidrosis** *A maximum of two courses of Botulinum toxin type A is recommended as a treatment option in patients with severe axillary hyperhidrosis that has not been adequately controlled by topical aluminium chloride or other extra-strength antiperspirants*. Severe axillary hyperhidrosis is indicated by a baseline score of 3 or 4 on the Hyperhidrosis Disease Severity Scale (HDSS). The first line treatment for primary axillary hyperhidrosis is aluminium chloride hexahydrate 20% solution, the only licensed treatment that can be prescribed in primary care in the UK. Unlicensed or off label topical and oral treatments may be considered under specialist recommendation but there is weak evidence of their effectiveness. For patients who proceed to treatment with botulinum toxin type A and who do not have a clinical response after one treatment session, consider alternative options for on-going management. A clinical response is indicated by more than a 2-point improvement from baseline on the HDSS scale or more than a 4-point improvement from baseline on the Dermatology Life Quality Index (DLQI). Botulinum toxin type A should not be offered to treat hyperhidrosis in people with social anxiety disorder - NICE CG159 (May 2013). For the use of Botulinum toxin type A in treating Hyperhidrosis, refer also to the Pan Mersey Area Prescribing Committee Prescribing policy statement ***BOTULINUM TOXIN TYPE A injection for Severe Axillary Hyperhidrosis:*** https://www.panmerseyapc.nhs.uk/media/1067/botulinum_hyperhidrosis.pdf BOTULINUM TOXIN TYPE A is not routinely commissioned for non-axillary hyperhidrosis.	

19.1a Botulinum Toxin A Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.		
	Migraine Botulinum toxin type A is recommended as a treatment option for the prophylaxis of headaches in adults with migraine in accordance with NICE TA 260 (June 2012). NICE recommend Botulinum toxin type A as an option for the prophylaxis of headaches in adults with chronic migraine (defined as headaches on at least 15 days per month of which at least 8 days are with migraine): • that has not responded to at least three prior pharmacological prophylaxis therapies AND • whose condition is appropriately managed for medication overuse. Treatment with botulinum toxin type A should be stopped in people whose condition: • is not adequately responding to treatment (defined as less than a 30% reduction in headache days per month after two treatment cycles) OR • has changed to episodic migraine (defined as fewer than 15 headache days per month) for three consecutive months. Botulinum toxin type A for the prophylaxis of migraine will be prescribed and administered under the supervision of a specialist designation neurological centre. **Botulinum Toxin A is also commissioned in the following indications:** Blepharospasm and hemifacial spasm Probable contracture of joint in multiple sclerosis, in conjunction with prolonged stretching modalities where other measures are inappropriate or ineffective (i.e. in line with NICE Clinical Guideline 186). https://www.nice.org.uk/guidance/cg186 Focal dystonia, where other measures are inappropriate or ineffective. Focal spasticity in patients with upper motor neurone syndrome, caused by cerebral palsy, stroke, acquired brain injury, multiple sclerosis, spinal cord injuries and neurodegenerative disease, where other measures are inappropriate or ineffective. Idiopathic cervical dystonia (spasmodic torticollis). Urinary incontinence due to refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 (updated November 2015) and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 (updated June 2015)where conservative therapy and conventional drug treatment has failed to control symptoms and the patient is able and willing to self-catheterise. Sialorrhoea (excessive salivary drooling), when other treatments have failed. In addition, Xeomin® (botulinum neurotoxin type A), is recommended as an option for treating chronic sialorrhoea caused by neurological conditions in adults. https://www.nice.org.uk/guidance/ta605	

19.1a Botulinum Toxin A

Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.

	https://www.panmerseyapc.nhs.uk/media/2323/botulinum_sialorrhoea.pdf **Botulinum Type B** The use of Botulinum toxin type B is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. . **Rationale** Botulinum toxin can be used to treat various medical conditions and is an effective way to reduce pain and decrease muscle spasms. It is not commissioned for cosmetic reasons.	

Evidence for inclusion and threshold

1. NICE Technology Appraisal 159 relating to the treatment of hyperhidrosis in people with social anxiety disorder: https://www.nice.org.uk/guidance/cg159
2. Pan Mersey Area Prescribing Committee (APC) Prescribing Policy Statement relating to the treatment of severe axillary hyperhidrosis: https://www.panmerseyapc.nhs.uk/media/1067/botulinum_hyperhidrosis.pdf
3. Pan Mersey Area Prescribing Committee (APC) Prescribing Policy Statement relating to the treatment of Chronic anal fissure: https://www.panmerseyapc.nhs.uk/media/1568/botulinum_anal.pdf
4. NICE Technology Appraisal 260 relating to the treatment of migraines: https://www.nice.org.uk/guidance/ta260
5. Spasticity in under 19s: management (CG145 Updated November 2015) https://www.nice.org.uk/guidance/cg145/chapter/1-guidance
6. NHS Choices: Dystonia
7. http://www.nhs.uk/conditions/dystonia/Pages/Introduction.aspx
8. MHRA Report on Botox produced by Allergan (?)
9. http://www.mhra.gov.uk/home/groups/par/documents/websiteresources/con108643.pdf
10. Multiple sclerosis in adults: management, Clinical guideline [CG186] Published date: October 2014
11. https://www.nice.org.uk/guidance/cg186
12. Refractory detrusitor overactivity, only line with NICE Clinical Guideline 171 (women) http://guidance.nice.org.uk/CG171 (updated November 2015) and Clinical Guideline 97 (men) http://guidance.nice.org.uk/CG97 (updated June 2015)
13. Pan Mersey Area Prescribing Committee (APC) Prescribing Policy Statement relating to the treatment of chronic sialorrhoea caused by neurological conditions in adults
14. https://www.panmerseyapc.nhs.uk/media/2323/botulinum_sialorrhoea.pdf
15. Xeomin (botulinum neurotoxin type A) for treating chronic sialorrhoea in line with NICE TA605 (October 2019) https://www.nice.org.uk/guidance/ta605

19.1b Botulinum Toxin B Used in several types of procedures e.g. to treat muscle disorders, excessive sweating (hyperhidrosis) and migraine.		
CATEGORY 1 – NOT ROUTINELY COMMISSIONED **Individual Funding Request (Exceptional Case) Approval**	**Policy Statement** Please refer to 19.1a Botulinum Toxin B is not routinely commissioned unless the patient meets one of the "core eligibility criterion" or an IFR (Exceptional Case) application is submitted and the IFR Panel confirm that the patient's circumstances are clinically exceptional. .	***Version:*** *01/10/2020* ***Clinical Coding:*** *OPCS with ICD exclusions (Procedure driven):* *OPCS4: S532 with a secondary code of X851* *ICD exclusions: G243, G245, G248, G35X, G43*, G513, K117, K601, N328, Q438* *NB: coding is not medication specific.*
Evidence for inclusion and threshold		
Please refer to 19.1a		

Appendix 1 – Glossary

Term	Meaning
Analgesics	Painkillers.
Asymptomatic	Without symptoms.
Augmentation	Increasing in size, for example breast augmentation.
Benign	Does not invade surrounding tissue or spread to other parts of the body; it is not cancerous.
Binocular vision	Vision in both eyes.
Body Mass Index (BMI)	Body Mass Index - a measure that adults can use to see if they are a healthy weight for their height.
CCG	Clinical Commissioning Group. CCGs are groups of General Practices that work together to plan and design local health services in England. They do this by 'commissioning' or buying health and care services.
Chronic	Persistent
Co-morbidities	Other risk factors alongside the primary problem.
Congenital	Present from birth
Conservative treatment	The management and care of a patient by less invasive means; these are usually non-surgical
DOH	Department of Health
Eligibility/Threshold	Whether someone qualifies. In this case, the minimum criteria to access a procedure.
Exceptional clinical circumstances	A patient who has clinical circumstances which, taken as a whole, are outside the range of clinical circumstances presented by a patient within the normal population of patients, with the same medical condition and at the same stage of progression as the patient.
Functional health problem/difficulty/impairment	Difficulty in performing, or requiring assistance from another to perform, one or more activities of daily living.
GP	General Practitioner.
Histology	The structure of cells or tissue under a microscope.
Individual Funding Request (IFR)	A request received from a provider or a patient with explicit support from a clinician, which seeks funding for a single identified patient for a specific treatment.
Irreducible	Unable to be reduced.
Malignant/malignancy	Harmful.
Monocular vision	Vision in one eye only.
Multi-disciplinary	Involving several professional specialisms for example in a Multi-disciplinary team (MDT).
NICE guidance	The guidance published by the National Institute for Health and Care Excellence.
Not routinely funded (a procedure)	This means the CCG will only fund the treatment if an Individual Funding Request (IFR) application proves exceptional clinical need and that is supported by the CCG.
NSAIDS	Non-steroidal anti-inflammatory drugs – medication that reduces pain, fever and inflammation.

Term	Meaning
Paediatric(ian)	Medical care concerning infants, children and adolescents usually under 18.
Pathology/pathological	The way a disease or condition works or behaves. This may for example include examination of bodily fluids or tissue e.g. blood testing.
PCT	Primary Care Trust (PCTs were abolished on 31 March 2013, and replaced by Clinical Commissioning Groups).
PLCP	Procedures of Lower Clinical Priority; routine procedures that are of value, but only in the right circumstances.
Precipitates	Brings about/triggers.
Primary care	a patient's first point of interaction with NHS services e.g. a GP surgery.
Rationale	Explanation of the reason why.
Restricted (a procedure)	This means CCG will fund the treatment if the patient meets the stated clinical threshold for care.
Secondary care	Services provided by medical specialists, who generally do not have the first contact with a patient e.g. hospital services.
Stakeholders	Individuals, groups or organisations who are or will be affected by this consultation, e.g. patients who currently use the service, carers, specific patient groups, etc.
Symptomatic	Something causing or exhibiting symptoms.

Appendix 2 – Document Version Control

Document version control			
Version	**Version**	**Version**	**Version**

2.0	• Format edited for clarity and ease of reference:
	  • Amalgamation and removal of Sections A and B so policies are aligned to specialties
	  • Creation of a quick reference table of policies
	  • Content Page Update
	  • NHS England Evidence Based Interventions highlighted
	  • Policy Titles format consistency where possible – Intervention : Condition
	  • Policy Statements
	  • Policy Category Clarification
	  • Policy Monitoring Criteria
	  • Addition of Cosmetic treatments policy position statement
	  • Move of IFR Process diagram to Appendix 1
	  • Move of Glossary to Appendix 2
	  • Move of Version history to Appendix 3
	  • Re-numbering of Section 16 – Trauma and Orthopaedics
	• Inclusion of suite 3 policy revisions:
	  3.1 Continuous Glucose Monitoring Systems
	  3.2 Insulin Pumps (NEW)
	  4.2 Pinnaplasty
	  16.10 Secondary Care administered steroid peripheral joint injections policy (previously 16.20)
	  17.2 Trans Anal Irrigation Policy (NEW)
	  17.6 Surgery for Prostatism
	  19.1 Botulinum Toxin A & B
	• Removal of Policy 11.3 Surgical treatments for Xanthelasma Palpebrum (fatty deposits on the eyelids) policy as included in Benign Skin Lesions Policy.
	• Removal of IFR Process Flowchart as it does not apply equally to all of the collaboration
		MLCSU Policy Development Team	01/10/2020

5.0	Produced by the Midlands and Lancashire Commissioning Support Unit in collaboration with Cheshire and Merseyside ICB sponsors to support the transition from individual Clinical Commissioning Group (CCG) policies to a single suite of Cheshire and Merseyside Integrated Care Board (ICB) policies. This policy is amended to reflect the ICB policy position as individual ICB policies are completed and published. This version involves the redaction of the following policies:	MLCSU Policy Development Team	01/04/2023

Document version control			
Version	**Version**	**Version**	**Version**
	2.2 Benign Skin Lesions: Surgical Removal 2.4 Skin Pigment Disorder: Biopsy or Camouflage 4.1 Adenoidectomy 4.3a Grommets Insertion (Children): Otitis Media with Effusion/Glue Ear 4.4 Tonsillectomy: Recurrent Tonsillitis 4.5 External Ear Lobe: Surgical remodelling 4.6 Sinus X-ray: Rhinosinusitis or Sinusitis 4.8 Rhinophyma Surgery or Laser Treatment 7.1 Haemorrhoids Surgical Removal 7.2b Diastasis of the Recti Surgical Correction 7.3 Gallstones (Asymptomatic) Surgical Treatment 8.1a Hysterectomy: Heavy Menstrual Bleeding – Fibroids <3cm, or Suspected/Diagnosed Adenomyosis, or No Identified Pathology 8.1b Hysterectomy: Heavy Menstrual Bleeding – Fibroids ≥3cm in Diameter 8.1c Hysterectomy: Heavy Menstrual Bleeding with Submucosal Fibroids 8.2 Dilatation and Curettage (D&C): Heavy Menstrual Bleeding 11.4 Short Sightedness (Myopia) or Long Sightedness (Hypermetropia) Correction: Surgery or Laser Treatment 11.6 Coloured filters: Irlens Syndrome/Dyslexia 11.7 Intra Ocular Telescope Implants: Advanced Age-Related Macular Degeneration 11.8 Chalazia (Meibomian Cyst) Surgical Removal 13.1 Cranial Banding: Positional Plagiocephaly 14.1a Bilateral Breast Reduction Surgery: Breast Macromastia 14.1b Unilateral Breast Reduction Surgery: Breast Asymmetry 14.4 Mastopexy: Breast Lift Surgery 14.5 Nipple Inversion Surgical Correction 14.8 Pectus Anomaly (Pigeon Chest or Sunken Chest) Surgical Correction 14.12 Thigh, Buttock or Arm Lift Surgery: Excision of Redundant Skin or Fat 14.18 Rhytidectomy: Face or Brow Lift 15.1 Snoring in the Absence of OSA Surgery (Adult) 16.4 Peripheral Nerve-Field Stimulation (PNFS): Chronic Low Back Pain 16.5 Therapeutic Endoscopic Division of Epidural Adhesions: Low Back Pain 16.9 Hyaluronic Acid and Derivatives Injections: Peripheral Joint Pain 16.10 Steroid Joint Injections (Secondary Care Administered): Joint Pain		

Document version control			
Version	**Version**	**Version**	**Version**
	16.14a Diagnostic Knee Arthroscopy: Knee Arthritis without Osteoarthritis 16.14b Diagnostic Knee Arthroscopy: Knee Arthritis with Osteoarthritis 16.15 Knee Arthroscopy: Knee Osteoarthritis 16.17 Total Knee Replacement (Patient Specific) 16.18 Trigger Finger/Thumb Surgical Release 16.19a Collagenase Injection: Dupuytren's Contracture Release (Adults) 16.19b Needle Fasciotomy, Fasciectomy And Dermo-Fasciectomy: Dupuytren's Contracture Release (Adults): 16.20 Carpal Tunnel Syndrome Surgical Release 16.21 Mucoid Cysts at Distal Inter Phalangeal Joint (DIP) Surgical Removal 16.22 Ganglia Surgical Excision: Wrist or Hand (Seed and Mucous Cysts) 16.23 Bunion or Lesser Toe Deformity Surgery 16.24 Morton's Neuroma Surgical Treatment 16.26 Extracorporeal Shock Wave Therapy / Autologous Blood or Platelet Injections: Plantar Fasciitis, Achilles Tendinopathy, Refractory Tennis Elbow 17.3 Male Sterilisation Reversal: Infertility 18.1 Endoscopic Thoracic Sympathectomy (Surgical Resection): Hyperhidrosis (Extreme Sweating) 18.2 Chelation Therapy: Vascular Occlusions 18.3a Vascular Service Referrals: Varicose Veins (Legs Only) 18.3b Varicose Veins: Compression Hosiery Treatment		
6.0	Policy document amended to include hyperlinks to ICB policies.	MLCSU Policy Development Team	09/2023