Nottingham and Nottinghamshire
Clinical Commissioning Group

Service Restriction Policy
(Additional Information document)

NHS Nottinghamshire and Nottinghamshire CCG

Document Control

Date	Version	Comments
25/07/2018	1.0	Final version, approved by the Nottinghamshire Joint Commissioning Committee, circulated to providers on 03/08/2018
15/08/2018	1.1	Under 'Joint injection completed in Secondary Care (excluding spinal injections)' amended to include; Flare of inflammatory disease in a pre-existing inflammatory arthritis
22/08/2018	1.2	Amended the wording "Specific criteria apply to lipomas and epidermoid / sebaceous cysts (see later sections)" under Benign skin lesion excision to; Specific criteria apply to lipomas (see later section). Epidermoid / sebaceous cysts are included in the "benign skin lesions" criteria
29/08/2018	1.3	Gamete storage; Clarification on the inclusion of transgender patients – removed until 2018 EMACC policy review completed.
June 2020	N&N Com-004 (v0.1)	Additional Information document to be read in conjunction with the Policy N&N COM-004 adopted by Nottingham and Nottinghamshire CCGs in April 2020.
21/09/2020	N&N Com-004 (v0.2)	Gamete and Embryo storage: Amended to include reference to the prior approval form developed which includes the eligibility criteria which will be used until the EMACC policy for gamete and embryo storage has been adopted.

Contents

ARTHROSCOPIC SUBACROMIAL DECOMPRESSION (FOR SUBACROMIAL SHOULDER PAIN) 5
BENIGN SKIN LESION EXCISION 6
BIOLOGICAL MESH 7
BLEPHAROPLASTY 8
BREAST IMPLANT REMOVAL (+/- RE-INSERTION) 9
BREAST ASYMMETRY 10
BREAST REDUCTION 11
BREAST ENLARGEMENT FEMALE 12
CARPAL TUNNEL SURGERY 13
CATARACTS 14
CHOLECYSTECTOMY (ASYMPTOMATIC GALLSTONES) 16
CIRCUMCISION 17
CONGENITAL PIGMENTED LESIONS (TREATMENT OF) 18
DILATION AND CURETTAGE FOR MENORRHAGIA 19
DUPUYTRENS CONTRACTURE (SURGICAL TREATMENT) 20
DUPYTRENS CONTRACTURE (COLLAGENASE INJECTIONS AND RADIATION THERAPY) 21
EPIDURAL INJECTIONS (FOR LOW BACK PAIN) 22
MEDIAL BRANCH BLOCK (FOR LOW BACK PAIN) 23
FUNCTIONAL ELECTRICAL STIMULATION (ORTHOTIC) 23
GAMETE STORAGE 24
GANGLION CYST EXCISION 25
GROMMET INSERTION 26
HAEMORRHOIDECTOMY 27
HALLUX VALGUS (SURGICAL TREATMENT) 28
HIP ARTHROSCOPY 29
HIP REPLACEMENT (PRIMARY) 30
HYSTERECTOMY FOR MENORRHAGIA 31
INGUINAL / UMBILICAL / VENTRAL HERNIA REPAIR 32
INSULIN PUMP 33
IUI / AI / DI (PRIOR TO IVF) 34

IVF **35**
JOINT INJECTION COMPLETED IN SECONDARY CARE **36**
JOINT PROSTHESES (OTHER) **37**
KNEE ARTHROSCOPY **38**
KNEE REPLACEMENT (PRIMARY) **39**
LASER TREATMENT – SKIN (INCLUDING TATTOO REMOVAL) **40**
LIPOMA **41**
MICROSUCTION FOR THE REMOVAL OF EAR WAX **42**
MIRENA IUS / IUD INSERTION IN SECONDARY CARE **43**
MRI FOR BACK PAIN **44**
OCCULOPLASTIC PROCEDURES **45**
PELVIC ORGAN PROLAPSE **47**
SEPTO-RHINOPLASTY **48**
SHOULDER ARTHROSCOPY **49**
SURGICAL DISCECTOMY / LUMBAR DECOMPRESSION SURGERY FOR SCIATICA (STANDARD OR MICRO-DISCECTOMY) **52**
SPINAL FUSION / LUMBAR DECOMPRESSION **53**
STERILISATION IN MEN (VASECTOMY) AND WOMEN **54**
SURROGACY **55**
TONSILLECTOMY AND ADENOIDECTOMY **56**
TRIGGER FINGER **58**
VARICOSE VEINS **59**
NOT COMMISSIONED PROCEDURES **60**

Arthroscopic subacromial decompression (for subacromial shoulder pain)

Surgical intervention may be commissioned where the following criteria are met:

- Significant and persistent pain resulting in loss of function
- A 12 week course of physiotherapy has been completed
- A sub acromial steroid injection has been considered
- A shared decision episode has included discussion of the most current and robust evidence available for this procedure

Benign skin lesion excision (also see Congenital pigmented lesions (treatment of))

Surgical removal, or cryotherapy of benign skin lesions are ONLY commissioned if there is at least one of:

- Significant functional disability resulting in severe restriction of Activities of Daily Living (ADL) or a risk to a critical life sustaining function.
- Recurrent infection (at least 2 courses of antibiotics)
- Recurrent bleeding/trauma (at least 3 documented episodes)
- There is a risk on future malignancy (especially with respect to lesions in children)

Benign skin lesions are only commissioned for removal in a secondary care setting where the site, nature of the lesion (e.g. suspicion of malignancy) or age of patient (especially children) requires specialist skills

Biopsy of benign lesions is commissioned where the nature of the lesion is uncertain (especially in children –in secondary care)
In case of diagnostic uncertainty in adults consider tele-dermatology pathway.
In case of rapid growth or other features suspicious of dysplasia/ malignancy use 2ww pathway.

All other benign skin lesions meeting the criteria should be removed in primary care.

- **Specific criteria apply to lipomas (see later section).**
- **Epidermoid / sebaceous cysts are included in the "benign skin lesions" criteria**

Biological mesh

Use of biological mesh is only commissioned for the following indications:

- Hernia
  - Primary ventral and inguinal hernia repair in non-infected fields
  - Recurrent hernias, reinforced hernia repair
  - Hernia prophylaxis
  - Hernia repair in the contaminated or potentially contaminated fields (most widely used)
  - Complex abdominal wall hernia repair
- Breast reconstruction:
  - Mastectomy
  - Reconstructive surgery
- Pelvic organ prolapse:
  - Pelvic organ prolapse (POP)
  - Laparoscopic ventral mesh rectopexy (rectal prolapse)

Other indications will require Individual Funding Requests (IFR)

Blepharoplasty (also see Oculoplastic procedures)

Surgical treatment commissioned if one or more applies:

- Excess tissue or drooping (ptosis) of the upper eyelid causing functional visual impairment (reduction of visual field).
- To repair defects predisposing to corneal or conjunctival irritation:
- Entropion or ectropion if specific commissioning criteria are met
- Periorbital sequelae of thyroid disease or nerve palsy or trauma
- Prosthesis problems in an anophthalmia socket
- Painful symptoms of blepharospasm resistant to conservative management

Only blepharoplasty for upper eyelids (not lower eyelids) will be funded.

Breast implant removal (+/- re-insertion)

Removal of breast implants is only commissioned for the following indications in patients who have undergone cosmetic augmentation mammoplasty performed either in the NHS or privately:

- Breast disease
- Implants complicated by recurrent infections
- Implants with capsule formation that is associated with severe pain
- Implants with capsule formation that interferes with mammography
- Intra or extra capsular rupture of silicone gel-filled implants

For women whose breast implants are removed in strict compliance with the criteria above AND whose original surgery was NHS funded the insertion of replacement implants is also commissioned.

The insertion of replacement implants where the original surgery was funded privately is not commissioned.

Breast Asymmetry

The Commissioner will only fund breast reduction surgery to correct breast asymmetry when ALL the following criteria are met:

- Sexual maturation has been reached.
- BMI as measured by the NHS is between 18 and 25 and has been within this range for 1 year as measured and recorded by the NHS
- Confirmed non-smoker and/or documented abstinence prior to procedure
- Asymmetry equal to, or greater, than 30% difference in volume between the breasts as measured by 3D body scan to assess breast volume*

Please Note: Clinical photographs are NOT required for this procedure.

Surgical outcomes (e.g. wound healing, complications etc.) can be adversely affected by smoking. To ensure the best outcomes, patients should have stopped smoking prior to procedure. Smoking status may be validated at pre-operative appointment using an appropriate test. Support to stop smoking is available to patients through a range of NHS stop smoking services.

Breast reduction

Surgical treatment is commissioned if ALL criteria are met:

- Sexual maturation has been reached*
- Causing back pain which has not responded to 1 year of documented conservative management such as physiotherapy
- Symptoms not relieved by appropriately measured brassiere fitted by a trained bra fitter
- BMI as measured by the NHS is between 18 and 25 and has been within this range for 1 year as measured and recorded by the NHS
- Confirmed non-smoker and/or documented abstinence prior to procedure
- Mean breast size is equal to or greater than 1000 cc*
- Ratio of combined breast volume to adjusted partial torso volume is equal to or greater than 13% as measured by 3D body scan to assess breast volume
- The patient and surgeon understand that only one cycle of breast reduction will be commissioned

* Young women with juvenile macromastia (juvenile gigantomastia) can be treated prior to reaching sexual maturation.

Breast Enlargement Female

The Commissioner will only routinely fund breast enlargement (augmentation mammoplasty) surgery if one of the following criteria is met:

- Developmental failure resulting in unilateral or bilateral absence of breast tissue/asymmetry e.g. Poland Syndrome/ Tuberous Breast Deformity
- To correct breast asymmetry due to trauma or as a result of surgery (mastectomy or lumpectomy) that results in a significant deformity.

In all other circumstances, The Commissioner will only fund breast augmentation surgery to correct breast asymmetry when ALL the following criteria are met:

- Sexual maturation has been reached.
- BMI as measured by the NHS is between 18 and 25 and has been within this range for 1 year as measured and recorded by the NHS
- Confirmed non-smoker and/or documented abstinence prior to procedure
- Asymmetry equal to, or greater, than 30% difference in volume between the breasts as measured by 3D body scan to assess breast volume.

Carpal tunnel surgery

Surgery may be commissioned if at least ONE of the following criteria applies:

- The symptoms are interfering with activities of daily living **AND** the patient has not responded to a minimum of 6 months of conservative management, including:
    - >8 weeks of night-time use of wrist splints
    - Appropriate analgesia
    - Corticosteroid injections (given at least twice prior to referral) in appropriate patients
    - A shared decision making process / tool discussing treatment options is clearly documented
- Objective Neurological deficit consistent with CTS i.e. constant sensory blunting or weakness of thenar abduction (wasting or weakness of abductor pollicis brevis).
- Rheumatoid disease
- Recent wrist trauma
- Previous wrist surgery

The referral must detail conservative methods tried and the length of time that each of these was carried out.

Nerve conduction studies (EMG) are generally **NOT** needed to confirm the diagnosis.

Patients with wasting of the hand muscles should be urgently referred and are outside the scope of this policy.

Cataracts

Cataracts approval is assessed by retrospective audit.

Before referral is made the referred must confirm

- The patient wishes to have surgery if offered

First cataract commissioned where there is a visual acuity of 6/12 (corrected) in the worst eye, or for:

- Patients for whom it is vital to have good visual acuity in the worse eye for the purpose of fulfilling essential occupational responsibilities (e.g. watchmaker)
- Patients with posterior subcapsular cataracts and those with cortical cataracts who experience problems with glare and a reduction in acuity in bright conditions
- Driving: the legal requirement for driving falls between 6/9 and 6/12 (strictly speaking it is based on the number plate test). It is anticipated that the threshold will not render the majority of people unable to drive as it applies to the worst eye only.

Exceptions to this include:

- Patients who need to drive but experience significant difficulty due to the cataract.
- Patients for whom it is vital to drive at night for the purpose of fulfilling essential domestic, carer or occupational responsibilities, and who experience glare that is related to cataract;
- Patients with visual field defects borderline for driving, in whom cataract extraction would be expected to significantly improve the visual field.
- Patients with glaucoma who require cataract surgery to control intra ocular pressure
- Patient with diabetes who require clear views of their retina to look for retinopathy

Cataract Second Eye

- Where the cataract procedure on the first eye has achieved a VA of 6/9 or better, and the VA for the second eye is 6/24 or better, then the patient should be **discharged**, unless receiving treatment for any other eye condition. The patient should be advised to attend an optometrist for a sight test annually or earlier if they notice any deterioration of vision. It is not acceptable for these patients to be retained until vision in the second eye deteriorates.
- If the first eye does not achieve a VA of 6/9 or better, then the second eye should be dealt with on clinical merit, taking into account any directly related essential responsibilities (i.e. the requirement for night driving).
- There are circumstances, where despite good acuities, there may still be a clinical need to operate on the second eye fairly speedily e.g. where there is resultant anisometropia (a large refractive difference between the two eyes) which would result in poor binocular vision or even diplopia. In these circumstances, the notes should clearly record this so that it can be identified during any future clinical audit.

Cholecystectomy (asymptomatic gallstones)

Prophylactic cholecystectomy for patients with silent (asymptomatic) gallstones will be commissioned ONLY if the patient also has at least *one* of the following indications:

- Where there is clear evidence of patients being at risk of Gallbladder Carcinoma.
    - With family history of carcinoma gallbladder
    - With single solitary gallstone of > 3 cm size
    - With Porcelain gallbladder
    - Gallbladder polyps >10 mm size
- With Sickle cell disease and other chronic haemolytic diseases
- Immunocompromised patients and transplant recipient patients
- Cholecystectomy can be performed in a patient who is undergoing abdominal surgery for other indications (e.g. cirrhosis of the liver or other Gastro-intestinal indications)

SYMPTOMATIC gallstones will be funded

Circumcision

Before referral is made the referrer must confirm

- The patient wishes to have surgery if offered

Commissioned ONLY for medical and NOT cosmetic or religious reasons.

One of the following commissioning criteria must be met:

- Lichen sclerosus (chronic inflammation leading to a rigid fibrous foreskin) in males aged 9 years and over
- Distal scarring of the preputial orifice (a short course of topical corticosteroids might help with mild scarring)
- Painful erections secondary to a tight foreskin
- Recurrent infection (balanitis / balanoposthitis)
- Redundant prepuce, phimosis (inability to retract the foreskin due to a narrow prepucial ring) sufficient to cause ballooning of the foreskin on micturition; and paraphimosis (inability to pull forward a retracted foreskin)
- Traumatic injury e.g. zipper damage.
- Congenital urological abnormalities when skin is required for grafting

Prior approval is required for any child younger than 5 years old being considered for circumcision stating the reason for not delaying surgery until older than 5 years old. (As per GIRFT)

Congenital pigmented lesions (treatment of) (see also Benign Skin Lesions)

Treatment commissioned only if ALL of the following criteria are met:

- The patient is aged less than 18 years at the time of referral
- The child (not just the parent/carer) expresses concern
- The lesion is located on the face
- The lesion is at least 1cm in size

Dilation and Curettage for menorrhagia

D&C (including hysteroscopy) is not commissioned as a diagnostic tool or as a therapeutic treatment for menorrhagia. It may be commissioned in the following cases:

- As an investigation for structural and histological abnormalities where hysteroscopy and ultrasound has been used as a first line diagnostic tool and where the outcomes are inconclusive.
- Post-dilatation, pre-procedure when undertaking endometrial ablation.

Dupuytrens contracture (surgical treatment)

Before referral is made the referrer must confirm

- The patient wishes to have surgery if offered

Surgical intervention only commissioned where one or more of the criteria are met:

- Metacarpophalangeal (MCP) joint contracture of 30° (inability to place hand flat on table), or
- Any degree of proximal interphalangeal (IP) joint contracture, or
- First web contracture, or
- Significant functional loss which prevents activities of daily living, e.g. washing, dressing

Dupuytrens contracture (Collagenase injections and radiation therapy)

Collagenase (clostridium histolyticum- CCH) injections as an option for treating Dupuytren's contracture, with a PALPABLE cord, may be commissioned in adults if **ALL** the following criteria apply:

- There is evidence of moderate disease (defined a-d) in up to 2 affected joints:
  - Functional problems
  - Metacarpophalangeal joint contracture of 30° to 60°
  - Proximal interphalangeal joint contracture of less than 30°
  - First web contracture
- Percutaneous needle fasciotomy (PNF) is not considered appropriate, but limited fasciectomy is considered appropriate by the treating hand surgeon.
- The choice of treatment (CCH or limited fasciectomy) is made on an individual basis after discussion between the responsible hand surgeon and the patient about the risks and benefits of the treatments available.
- One injection is given per treatment session by a hand surgeon in an outpatient setting.

The Commissioner does NOT fund radiation therapy for early Dupuytrens

Epidural injections (for low back pain)

The CCG commissions epidural injections when ONE of the following criteria have been met:

- The patient has undergone discectomy – a single injection will be commissioned.
- Patient has acute (up to 12 weeks duration) and severe sciatica and is being treated as part of an integrated MSK pain management pathway

Not commissioned for patients who have non-specific / axial low back pain.
Not commissioned for patients with failed back pain surgery syndrome

Medial branch block (for low back pain)

May be commissioned as diagnostic tool (maximum of two diagnostic MBB injections) prior to radiofrequency denervation or surgery in order to show probability of benefit.

Therapeutic facet joint injections are not commissioned.

Not commissioned for non-specific lumbar back pain

Functional electrical stimulation (Orthotic)

The CCG will commission in line with the FES EMACC policy.

Gamete storage

The CCG will commission in line with the EMACC policy (in development) when approved.

Until this time patients requesting gamete storage will be considered against the eligibility criteria within the prior approval form. The CCG will commission fertility preservation for patients on a variety of different treatment pathways where they are at risk of permanent infertility, including those receiving cancer treatments and those who are receiving treatment for gender dysphoria.

Storage will not be funded for patients who simply wish to avoid future fertility issues with no other contributing factors.

Ganglion cyst excision

Before referral is made the referrer must confirm

- The patient wishes to have surgery if offered

Referral to orthopaedics for excision of symptomatic ganglia commissioned only if:

- Ganglion on wrist – with evidence of neurovascular compromise or functional disability
- Seed ganglia at base of digits – with significant pain
- Mucoid cysts at DIP joint – nail growth disrupted, cysts tend to discharge
- A shared decision making process / tool discussing treatment options is clearly documented

No referrals are commissioned for cosmetic surgery for ganglion cysts

Grommet insertion

Grommets for patients with otitis media with effusion (OME) may be funded where ALL the criteria apply:

- There has been a period of at least three months watchful waiting from the date of the first appointment with an audiologist, ENT Specialist or GP with special interest in ENT.
- The patient (who must be over three years of age) suffers from **at least one** of the following:
  - At least 5 recurrences of acute otitis media in a year.
  - Evidence of delay in speech development.
  - Educational or behavioural problems attributable to persistent hearing impairment, with a hearing loss of at least 25dB particularly in the lower tones (low frequency loss).
  - A significant disability such as Downs syndrome.

Haemorrhoidectomy

Before referral is made the referrer must confirm

- The patient wishes to have surgery if offered

NICE guidance is that haemorrhoids should be treated by band ligation. In the case of failed band ligation the commissioning criteria apply. One criteria must be met:

- Grade I or II haemorrhoids with severe symptoms which include bleeding, faecal soiling, itching or pain which have failed to respond to conservative management for 6 months.
- Grade III or IV haemorrhoids (i.e. prolapsed)

Hallux valgus (surgical treatment)

Before referral is made the referrer must confirm

- The patient wishes to have surgery if offered

Requests for the removal of symptomatic bunions will ONLY be commissioned where:

- Conservative measures have failed (these include trying accommodative footwear, considering orthoses and using appropriate analgesia.)
- The patient suffers from severe pain on walking (not relieved by chronic standard analgesia) that causes significant functional impairment
- Severe deformity (with or without lesser toe deformity) that causes significant functional impairment OR prevents them from finding adequate footwear
- Recurrent or chronic ulceration or infection

The clinician should ensure that the patient fulfils all the criteria before they are referred to secondary care. Before referral patients should be informed that:

- They will be in plaster for 6 weeks and unable to drive and it will take at least a further 2 months to regain full function
- The prognosis for treated and untreated HV is very variable

URGENT referral should be considered where HV may be compromising the foot in association with skin ulceration, diabetes or peripheral limb ischemia (or peripheral vascular disease).

Hip arthroscopy

The use of hip arthroscopy for the management of Hip Impingement Syndrome or other indications is covered by a separate policy.

See **East Midlands Commissioning Policy Arthroscopy** of the Hip

In summary, commissioned only for:

- Treatment of sepsis,
- Loose bodies (radio-graphically proven)
- Excision of radiological proven labral tears in the absence of osteoarthritis or other pathology for patients meeting the policy criteria.

Hip replacement (Primary)

Commissioned if ALL criteria apply:

- Radiologically proven osteoarthritis
- Patient co-morbidities optimised for surgery
- Documented evidence of appropriate discussion of benefits and complications by use of a shared decision making tool
- Conservative treatments where appropriate including lifestyle modification, analgesia, exercise, physiotherapy and steroid injections have been tried for at least three months
- Patient has been assessed by the CCG MSK hub for that specific joint
- A separate referral is required for each hip

Hysterectomy for menorrhagia

Hysterectomy for heavy menstrual bleeding may be commissioned only when the patient has had a documented shared decision making episode and each of the following conditions are satisfied:

- After an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) for at least 6 months and it has failed to relieve symptoms (or where it is inappropriate or contraindicated)
- At least two of the following treatments have failed, are not appropriate or are contra-indicated in line with the National Institute for Health and Clinical Excellence (NICE) guidelines:
    - Non-steroidal anti-inflammatory agents.
    - Tranexamic acid
    - Other hormone methods (injected progesterone, combined oral contraceptives, Gn-RH analogue)

- An alternative surgical treatment such as endometrial ablation, uterine artery embolisation or myomectomy has been offered or has failed to relieve symptoms (or are not appropriate/contra-indicated).

In addition, hysterectomy for heavy menstrual bleeding due to fibroids greater than 3 cm may be commissioned when the following criteria are satisfied:

- Other symptoms (e.g. pressure symptoms) are present.
- Other pharmaceutical options have failed.
- Patient has been offered myomectomy and/or uterine artery embolisation (unless medically contraindicated).

The responsible clinician must evidence any reason for an open laparotomy as opposed to a laparoscopic procedure

Inguinal / Umbilical / Ventral hernia repair

Elective surgical treatment will be commissioned following evidence of shared decision making and ONE or more of the following:

- An additional risk factor for incarceration including:
  - A history of incarceration of, or real difficulty reducing, the hernia.
  - An inguino-scrotal hernia.
  - An inguinal hernia in a female patient
- Increase in size month to month.
- Pain or discomfort significantly interfering with ADL.
- Work related issues e.g. of work/missed work/unable to work/on light duties due to hernia or heavy manual labour.
- Comorbidity which does not render the patient unfit for elective surgery currently, but which is likely to significantly increase the risks associated with future surgery

Repair of suspected femoral hernias are commissioned.

Insulin Pump

Initiation of continuous subcutaneous insulin infusion or ‘insulin pump’ therapy as a treatment for adults and children 12 years and over with type 1 diabetes mellitus will be funded if the patient has attended a Diabetes educational course approved by the CCG, such as DAFNE, and ONE of the following criteria are met:

- Attempts to reach target haemoglobin A1c (HbA1c) levels with multiple daily injections result in the person having ‘disabling hypoglycaemia’
- HbA1c levels have remained high (69 mmol/mol or above) with multiple daily injections (including using long-acting insulin analogues if appropriate) despite the person and/or their carer carefully trying to manage their diabetes

Insulin pump therapy should only be started by a trained specialist team. This team should include a doctor who specialises in insulin pump therapy, a diabetes nurse and a dietician (someone who can give specialist advice on diet). They should provide a structured education programme and advice on diet, lifestyle and exercise that is suitable for people using insulin pumps.

Insulin pump therapy is not recommended for people with type 2 diabetes mellitus

IUI / AI / DI (prior to IVF)

The CCG commissions in line with the 2011 document:
Nottinghamshire County Assisted Conception Policy

IVF

The CCG commissions in line with the 2014 document:
Commissioning Policy for In Vitro Fertilisation (IVF)/ Intracytoplasmic Sperm Injection (ICSI) within tertiary Infertility Services

Joint injection completed in Secondary Care (excluding spinal injections)

Joint injections for symptom control should be carried out in primary care or by inter-practice referral wherever possible.

Steroid joint injections in secondary care are commissioned where ONE of the following criteria are met:

- Under 18 years old
- As a diagnostic tool prior to joint replacement to confirm the source of symptoms
- As a therapy where patients are unfit / unsuitable for surgery AND cannot be provided in primary care.
- Flare of inflammatory disease in a pre-existing inflammatory arthritis

(NB there will be a maximum tariff price, which reflects carrying out in an aseptic theatre and not a sterile theatre).

Joint prostheses (other)

Joint replacement commissioned for people who:

- Experience joint symptoms (pain, stiffness and reduced function)
- Are refractory to non-surgical treatment.
- Have a substantial impact on their quality of life

Documented evidence of appropriate discussion of benefits and complications by use of a shared decision making tool if available

Knee arthroscopy

Knee arthroscopy may be commissioned if all criteria are met:

- Arthroscopy of the knee can be undertaken where a competent clinical examination and MRI scan have demonstrated clear evidence of an internal joint derangement (acute meniscal tear, ligament rupture or loose body)
- Where conservative treatment has failed or where it is clear that conservative treatment will not be effective.

Knee Arthroscopy for degenerative meniscal tears is not commissioned

Knee replacement (Primary)

Commissioned if ALL criteria apply:

- Radiologically proven osteoarthritis
- Patient co-morbidities optimised for surgery
- Documented evidence of appropriate discussion of benefits and complications by use of a shared decision making tool
- Conservative treatments where appropriate including lifestyle modification, analgesia, exercise, physiotherapy and steroid injections have been tried for at least three months
- Patient has been assessed by the CCG MSK hub for that specific joint
- A separate referral is required for each knee

Laser treatment – Skin (including tattoo removal)

Only commissioned if at least one of following:

- Port wine stains - on the face only (not scalp or neck) unless single lesion can be treated in a single session
- Rare genodermatosis e.g. Tuberose Sclerosis causing functional disability
- Translocation of hair bearing skin during surgery but NOT for excessive hair growth (hirsutism)
- Intractable and recurrent pilonidal sinus.
- Tattoo removal if one of the following two criteria are met:
    - Iatrogenic
    - Result of trauma inflicted against the will of the patient where referral for removal has been sought within one year of the tattoo being performed

Lipoma

Surgical treatment commissioned if ONE of the criteria apply and the patient has had a documented shared decision making episode

- Lipoma diameter over 5cms
- Causes significant functional disability resulting in severe restriction of Activities of Daily Living (ADL) or is a function critical to sustaining life
- Causes recurrent trauma due to size and/or position.

Lipomas that are under 5cms should be observed only, using Soft Tissue Sarcoma Guidelines (SIGN 2003).

Lipomas located on the body that are over 5cms in diameter, or in a sub-facial position, which have also shown rapid growth and/or are painful should be referred to an appropriate Sarcoma clinic).

Microsuction for the removal of ear wax Adult

Removal of earwax by microsuction in primary or secondary care is restricted.

If removal of earwax is required to carry out a procedure or to gain a view of the tympanic membrane this is considered as part of the overall outpatient tariff.

Microsuction to remove earwax may be commissioned in primary/secondary care where a patient has ONE of the following contraindications to ear irrigation:

- The patient has previously experienced complications following this procedure or it has been repeatedly ineffective.
- There is a history of a middle ear infection in the last six weeks.
- The patient has undergone ANY form of ear surgery (apart from grommets that have extruded at least 18 months previously and the patient has been discharged from the ENT Department).
- The patient has a perforation or there is a history of a mucous discharge in the last year.
- The patient has a cleft palate (repaired or not).
- In the presence of acute otitis externa with pain and tenderness of the pinna.
- Two attempts at Irrigation of the ear canal in primary care are unsuccessful

Mirena IUS / IUD insertion in Secondary Care

ONE of the following commissioning criteria must be met for IUS / IUD to be commissioned in secondary care.

- Specific medical issue which prevents fitting by primary care
- Fitted as part of contraception provided in conjunction with Termination of Pregnancy.
- In combination with secondary care hysteroscopic investigation/treatment or to manage risk such as hyperplasia

No commissioning criteria exist in primary care.

MRI for back pain

MRI of lumbar spine for low back pain is commissioned in the following circumstances:

- Red flag symptoms:
  - Spinal malignancy
  - Infection
  - Fracture
  - Cauda equina syndrome
  - Ankylosing spondylitis or another inflammatory disorder
  - Suspected osteoporotic fracture.
- In the context of a referral/assessment for spinal surgery

Occuloplastic procedures (see also blepharoplasty)

Occuloplastic procedures are mostly for cosmetic reasons and are not commissioned. However there are a number of conditions which affect vision and functionality affecting activities of daily living and quality of life which may be considered if criteria met.

The following eyelid surgery procedures will NOT be commissioned unless there is any diagnostic uncertainty:

- Removal of eyelid papilloma‘s or skin tags
- Surgery for pingueculum
- Excision of other lid lumps
- Surgery for cosmetic reasons

The following conditions are NOT routinely commissioned unless specific criteria are met:

Ectropion / Entropion

Typically a consequence of advanced age, in which the eyelid is turned outwards away from the eyeball or inwards toward the eyeball

- Conservative management has been exhausted
- Evidence of significant impairment of the punctum
- There is recurrent infection in surrounding skin.

Epiphora

Overflow of tears onto the face- a clinical sign or condition that constitutes insufficient tear film drainage from the eyes in that tears will drain down the face rather than through the nasolacrimal system)

- Despite undergoing conservative management, the patient is experiencing a daily impact of significant watering of the eyes indoors and outdoors
- Affecting visual function
- Interfering markedly with quality of life.

Chalazion / Meibomian cyst

A chalazion is a developing swelling that forms due to blockage and swelling of an oil gland in the eyelid.

Surgical interventions are commissioned if one of the following criteria are met:

- The chalazion has been present for 6 months and conservative management has been exhausted
- The chalazion is symptomatic – painful and has recurrent infection treated with antibiotics (at least 2 episodes)
- There is significant impact on vision affecting functionality

N.B. for diagnostic uncertainty or suspicious symptoms to be referred under the 2 week wait.

Blepharitis

Blepharitis is a common condition where the edges of the eyelids (margins) become red and swollen (inflamed).
Referral to secondary care for simple blepharitis is NOT commissioned.
If lids remain persistently swollen consider alternative diagnosis (e.g. malignancy) and refer under the appropriate pathway.

Pelvic Organ Prolapse (see biological mesh)

Surgical repair of pelvic organ prolapse will only be commissioned when the patient has received a documented shared decision making episode and ONE of following criteria are met:

- The prolapse is below the level of the introitus
- The prolapse is symptomatic, has not responded to three months of specialist physiotherapy and pessary use has been tried or considered

Septo-rhinoplasty

May be commissioned when a patient has:

- Obstructive symptoms persisting despite conservative management for three months or longer,
- An external nasal deformity, preoperative photographs showing the standard 4-way view – base of nose, anterior-posterior, and right and left lateral views
- A relevant history of accidental or surgical trauma, congenital defect or disease
- Documentation of duration and degree of symptoms related to nasal obstruction and results of conservative management.

And ONE or more of the following criteria are met:

- Continuous nasal airway obstruction that results in significantly impaired nasal breathing associated with septal or lateral nasal wall deformities or vestibular stenosis.
- Asymptomatic nasal deformity that prevents access to other intranasal areas when such access is required to perform medically necessary surgical procedures (e.g. ethmoidectomy)

Shoulder Arthroscopy

Shoulder arthroscopy will only be commissioned for patients with adhesive capsulitis ('frozen shoulder') if ONE of the following Criteria has been met;

- Conservative treatments, listed below, have ALL been tried and failed;
  - Activity modification
  - Physiotherapy and exercise programme
  - Oral analgesics including NSAIDs (unless contraindicated)
  - Intra-articular steroid injection Repeated injections are NOT commissioned unless there is documented evidence of clear benefit from previous injections Manipulation under anaesthetic (carefully consider use following a fracture as undertaking manipulation under anaesthetic increases the risk of a re-fracture)
- There are red flag symptoms (see below)

If there is diagnostic uncertainty despite competent examination or if there are "red flag" symptoms/signs/conditions then an MRI scan might be indicated.

Red flag symptoms or signs include; recent trauma, constant progressive non-mechanical pain (particularly at night), previous history of cancer, long term oral steroid use, history of drug abuse or HIV, fever, being systematically unwell, recent unexplained weight loss, persistent severe restriction of joint movement, widespread neurological changes, and structural deformity.

Red flag conditions include infection, carcinoma, nerve root impingement, bony fracture and avascular necrosis.
The clinician must provide full details to support prior approval.

Sleep studies

The CCG only commissions sleep studies for patients with suspected sleep apnoea syndrome, complex sleep disorders or where necessary to confirm a diagnosis of narcolepsy.

Prior approval must be sought before referral for sleep studies.

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Sleep apnoea (defined as)

- Fighting sleepiness during the day, at work, or while driving
- History of heavy snoring
- Witnessed breathing pauses whilst asleep
- Sometimes waking with choking / coughing episodes

If sleep apnoea is suspected patients should be referred if they have red flag symptoms or relevant comorbid conditions (see below).

Those without red flag symptoms or relevant comorbid condition must meet BOTH the following criteria prior to referral to the sleep unit:

- Daytime sleepiness (rather than tiredness) assessed by Epworth score of 10 or more
- Symptoms and / or signs indicating significant sleep apnoea.

Red flag symptoms:

- cor pulmonale
- respiratory failure/severe pulmonary disease
- vigilance critical occupations (pilots, professional drivers, operators of heavy machinery)
- extreme sleepiness leading to risk of danger to self or others
- planned general anaesthetic

Relevant comorbid conditions:

- respiratory failure/severe pulmonary disease
- significant neurological or neuromuscular disease
- uncontrolled hypertension
- unstable angina/ischaemic heart disease
- pregnancy
- recent cerebrovascular disease

- congestive heart failure

Where nasal obstruction is an issue, patients should be referred for nasoendoscopic assessment of their upper airways prior to referral for sleep studies to exclude any structural cause for obstruction.

The CCG does not commission sleep studies for parasomnia, periodic limb syndrome

Surgical discectomy / Lumbar decompression surgery for sciatica (standard or micro-discectomy)

Non-acute spinal surgery will only be commissioned if the following criteria are met:

- The patient has had magnetic resonance imaging, showing disc herniation (protrusion, extrusion, or sequestered fragment) at a level and side corresponding to the clinical symptoms;
- Symptoms persist despite non-operative treatment for at least 12 weeks (e.g. analgesia, physical therapy, bed rest etc.).
- The patient meets one of the following criteria:
  - The patient has a corresponding neurologic deficit (asymmetrical depressed reflex, decreased sensation in a dermatomal distribution, or weakness in a myotomal distribution, altered bowel or bladder function)
  - The patient has radicular pain (below the knee for lower lumbar herniations, into the anterior thigh for upper lumbar herniations) consistent with the level of spinal involvement

This does not apply to those with red flag symptoms or symptoms suggestive of cauda equina

Spinal fusion / Lumbar Decompression

Surgical treatment may be commissioned if one of the following criteria are met and the indication is not found in the Surgery for Sciatica statement:

- Unequivocal root compression
- Spinal stenosis
- Instability
- Spondylolithesis causing severe and persistent pain or neurological deficits and not responding to conservative approaches

Sterilisation in men (vasectomy) and women

Surgical Male Sterilisation:

The following criteria for commissioning apply to vasectomies performed in primary care:

- The patient has been counselled about the nature of the operation and the limitations of reversibility including funding.

The following criteria for commissioning apply to vasectomies performed in secondary care:

- The patient has been counselled about the nature of the operation and the limitations of reversibility including funding.
- Medical reasons preventing the procedure being performed in a primary/community setting are present

Surgical Female sterilisation

The following criteria for commissioning apply to this procedure.

Patients must have a documented shared decision making episode, have been counselled and meet ONE of the following criteria:

- Has tried an IUS/IUD for 12 months and found it unsuitable.
- Sterilisation is to take place at the time of another clinically appropriate gynaecological procedure such as caesarean section
- Where there is a clinical contraindication to the use of a Mirena / Nexplanon
- Where there is an absolute clinical contraindication to pregnancy, including but not limited to:
  - young women (under 45 years of age) undergoing endometrial ablation for heavy periods
  - women with severe diabetes
  - women with severe heart disease

Surrogacy

The CCG will commission services in line with the appropriate EMACC policy.

Until the EMACC policy is released the CCG continues to commission in line with the 2010 Nottinghamshire County Commissioning statement relating to Surrogacy

Tonsillectomy and adenoidectomy

Tonsillectomy and Adenoidectomy may be commissioned if the following criteria are met:

- There has been significant severe impact on quality of life indicated by documented evidence of absence from school/work;
- Failure to thrive.
- Documentation of recurrence meeting ONE of the following requirements:
  - 7 or more episodes in the last year
  - 5 or more episodes in EACH of the last two years
  - 3 or more episodes in EACH of the last 3 years

Each of the episodes must be documented in the patient's notes, appropriately treated and characterised by at least one of the following:

- Oral temperature of at least 38.3 C
- Tender anterior cervical lymph nodes
- Tonsillar exudates
- Positive culture of group A beta haemolytic streptococci
- The episodes are disabling and prevent normal functioning (school / work)
- Tonsillar enlargement giving rise to symptoms of obstruction

(Recurrent attacks are a succession of definite episodes, as opposed to chronic tonsillitis)

The Commissioner will consider funding for tonsillectomy/adenoidectomy for sleep apnoea syndrome in children when one or more of the following apply:

- Positive sleep study.
- Significant impact on quality of life demonstrated.
- Strong clinical history suggestive of sleep apnoea.

Note: The case is much more likely to be approved where there is supporting evidence such as sleep studies, growth charts, letters from GPs and letters from employer and school.

Unequivocal indications for tonsillectomy/adenoidectomy without need for prior approval:

- Suspected malignancy
- Per-tonsillar abscess (Quinsy)
- Acute upper airways obstruction

Trigger Finger

Surgical treatment of trigger finger may be commissioned if ALL the following criteria are met:

- Symptoms are persistent and have a functional impact on ADL
- At least two steroid injections have been tried without improvement in the six months prior to surgery
- Conservative measures including splinting have been tried and failed

Varicose veins

Referral to and management in secondary care (including sclerotherapy) may be commissioned if ONE of the following criteria are met:

- Varicose eczema
- Lipodermatosclerosis or a varicose ulcer
- At least two episodes of documented superficial thrombophlebitis
- A major episode of bleeding from the varicosity.

Not commissioned procedures

The procedures listed below are not commissioned in any circumstance by the CCG due to their cosmetic/aesthetic nature, or due to lack of evidence of clinical or cost effectiveness. Clinicians are expected to direct patients to access these procedures privately if their shared decision is that there would be benefit to the individual.

In EXCEPTIONAL circumstances (see previous section) funding could be considered by the IFR process, although clinicians and patients are reminded that the threshold for exceptionality is high and approval would not normally be expected.

Abdominoplasty
Acupuncture for all purposes
Aesthetic operations on umbilicus
Alexander technique
Alternative therapies not explicitly listed in this policy
Anal rectal skin tags
Any other purely cosmetic/aesthetic procedure that is not mentioned within this policy
Applied kinesiology
Aromatherapy
Autogenic training
Autologous chondrocyte implantation
Ayurveda
Back pain - X-ray for axial low back pain
Benign Skin Lesions – removal for cosmetic reasons
Body contouring
Botulinum toxin for wrinkles, frown lines or aging neck
Brachioplasty – upper arm lift
Breast uplift (mastopexy)
Buttock lift
Calf implants
Cheek implants (A) except in post-trauma cases and/or as part of planned reconstruction following surgery (e.g. for cancer)
Chemical peels

Chin implant (genioplasty, mentoplasty)
Chinese medicine
Chiropractic therapy
Circumcision for non-medical reasons
Collagen implant except in post-trauma cases and / as part of planned reconstruction following surgery (e.g. For cancer)
Cosmetic surgery (unless specified elsewhere in document)
Cranial banding for positional plagiocephaly
Diagnostic investigations for IBS
Divarication of abdominal rectus
Dupuytrens – radiation treatment for early disease
Earlobe repair
Electrolysis treatment for any condition
Endoscopic thoracic sympathectomy
Environmental medicine
Epidural injections non-radicular / axial pain and failed back surgery syndrome
Excimer laser – astigmatism and xanthelasma
Excimer laser for corneal erosions
Exogen bone healing
Extracorporeal shockwave therapy for plantar fasciitis
Facelifts - unless part of the treatment of facial nerve palsy/congenital facial abnormalities/ treatment of specific facial skin condition (e.g. cutis laxa)
Facet joint injections (therapeutic – low back pain)
Fat grafts
Forearm implants
Gender reassignment procedures not part of the original package of care
Gynaecomastia (male breast enlargement) surgery
Hair depilation (removal) for excessive hair growth (hirsutism)
Hair transplantation
Complimentary Healing Therapy
Herbal medicine
Hip resurfacing
Homeopathy
Hydrotherapy unless specifically included as part of a contracted service

Hymen reconstruction
Hyperhydrosis treatments, non-pharmacological (Botulinum toxin treatment, iontophoresis or surgical treatments for axillary hyperhidrosis)
Hypnosis
Joint revisions, using non-standard prostheses specifically mentioned in contractual agreement, including hip and knee
Knee – diagnostic arthroscopy
Labiaplasty
Laser for skin conditions causing scarring - including post-acne and post-traumatic scarring
Laser treatment – myopia
Laser treatment / therapy / tunable dye laser for aesthetic reasons
Laser treatment for cosmetic reason
Laser treatment for facial hyperpigmentation unless meets the specified criteria
Lizarov treatment / Taylor spatial frame
Lymphoedema treatment in private specialist units
Massage
Meditation
Myopia (short sighted) – surgical treatment
Naturopathy
Neck lift
Nipple inversion correction
Nutritional therapy
Out Of Area (OOA) referrals for chronic fatigue / ME treatment
Out Of Area referrals to independent sector for autism
Osteopathy
Patella resurfacing
Penile implants
Phalloplasty
Pinnaplasty
Reflexology
Reiki
Removal of excess skin following weight loss by whatever means
Removal of supernumerary nipples
Repair of chronic clefts due to avulsion of body piercing
Residential pain management programmes

Respirate device for hypertension
Resurfacing Botulinum Toxin for the following indications: wrinkles, frown lines and ageing neck
Reversal of female or male (vasectomy) sterilisation
Rhinophyma - Surgical correction
Sacral nerve stimulation
Shiatsu
Sleep studies for parasomnia, periodic limb movement disorder or chronic insomnia
Snoring- surgical treatment including reduction of the tongue
Spinal injections for low back pain other than the two restricted procedures; medial branch block injection and epidural injection
Suction assisted lipectomy (liposuction) except as part of planned reconstruction surgery for the treatment of cancer or a congenital syndrome
Therapeutic community method for borderline personality
Therapeutic use of ultrasound in hip and knee OA
Tonic intraocular lens implant for astigmatism
Tonsillectomy as a treatment for snoring
Vaginoplasty