East Staffordshire Clinical Commissioning Group
Cannock Chase Clinical Commissioning Group
South East Staffordshire and Seisdon Peninsula Clinical Commissioning Group
Stafford and Surrounds Clinical Commissioning Group

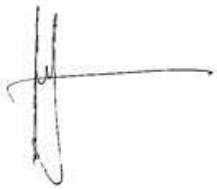
Excluded and Restricted Procedures Policy 2017

Agreed at Cannock Chase CCG

Signature:

Designation: Chair of Cannock Chase CCG
Date: 28th August 2017

Agreed at South East Staffordshire & Seisdon Peninsula CCG



Signature:
Designation: Chair of South East Staffordshire & Seisdon Peninsula CCG
Date: 28th August 2017

Agreed at Stafford and Surrounds CCG

Signature:
Designation: Chair of Stafford & Surrounds CCG
Date: 28th August 2017

Agreed at East Staffordshire CCG

Signature:
Designation: East Staffordshire CCG
Date:

Excluded and Restricted Procedures Policy 2017

Policy number	
Version number	6.0
Responsible Executive Lead	Mark Seaton Director of Commissioning Jonathan Bletcher CCG Director
Author(s)	Barry Weaver Senior Improvement Manager IFR
Date approved by SES Locality Boards	Lichfield 13/6/17 Tamworth 13/6/17 Seisdon Peninsula 14/6/17
Date ratified by Governing Body	Joint Governing Body 7/9/17 (SES&SP Virtual Approval 11/9/17)
Date issued	
Review date	01/08/2017
Date approved by Equality Impact Assessment	25/0820/17
Target audience	CCGs, Acute Hospital Provider Trusts, GPs, Public

HISTORY OF CHANGES		
Old version number	**Significant changes**	**New version number**
Version 1.0 to version 5	2015 PoLCV change logs are available on request and contain all policy comments and recommendations for thresholds	
Version 1.0 to version 4	Supersedes the PoLCV policy - ERP change logs detailing changes for each procedure are available on request and document all changes, recommendations and additional policies since PoLCV V5 was published	Version 5
Version 5	Altered text : **Page 1** authorisation from ESCCG added to those of the other 3 CCGs **Page 7** changed to read “this policy applies to Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula CCG; East Staffordshire CCG and Stafford and Surrounds CCG unless otherwise indicated. Where the term CCG is used, this applies to all four CCGs listed, above unless otherwise indicated **5.3.2 Umbilical and Para-umbilical Hernia** Line added to read: “all other circumstances will be subject to IFR”.	Version 6

SUMMARY

The Policy describes the framework to demonstrate that the CCG decision making processes for treatments have been made fair, equitable, ethical and legally sound.

Treatments or procedures are categorised as Excluded or Restricted.

- Excluded treatments or procedures will not be funded by the NHS Commissioners, and are only available in exceptional circumstances via the Individual Funding Request process.
- Restricted treatments or procedures will only be funded for those patients where an appropriate threshold for the intervention as stated in this Policy has been met.
- Low Priority Treatments: interventions identified as being either marginally effective or ineffective with limited health gain benefit

The policy details the criteria for low priority treatments for the CCG to follow which follows evidence based guidance from organisations including NICE, and Public Health clinicians from across Staffordshire and the West Midlands

The Policy is implemented by GPs and Primary Care health professionals when advising and referring patients and by providers when considering the treatment options for patients. Those making referrals should not refer to any provider for a treatment or procedure covered by this Policy before gaining Prior Approval via the Individual Funding department.

Restricted procedures and treatments are not commissioned by the NHS Commissioners except where an individual patient satisfies the threshold statement or criteria against a procedure or treatment. Clinicians considering offering a patient a restricted procedure or treatment should satisfy themselves that the threshold statement or criteria against the procedure or treatment are satisfied.

Providers should not suggest, recommend or otherwise offer excluded treatments or procedures covered by this Policy to any patient before gaining Prior Approval via the Individual Funding department. Providers should only suggest, recommend or otherwise offer restricted treatments or procedures covered by this Policy to patients who satisfy the appropriate threshold statement for that treatment or procedure.

Excluded procedures and treatments are not commissioned by the NHS Commissioners. Where individual patient circumstances require the escalation of their care and a procedure or treatment classified as excluded is being proposed then providers should refer to the Individual Funding Request Policy and Procedure.

Contents

This policy applies to Cannock Chase CCG, South East Staffordshire & Seisdon Peninsula CCG, Stafford and Surrounds CCG and East Staffordshire CCG unless otherwise indicated. Where the term CCG is used, this applies to all four CCGs listed above, unless otherwise indicated.

1.0 Introduction

1.1 Purpose

1.1.1 The purpose of this Commissioning Policy is to clarify the commissioning intentions of the Clinical Commissioning Groups (CCG) across South Staffordshire who consist of: NHS Cannock Chase CCG, NHS Stafford & Surrounds CCG, NHS South East Staffs & Seisdon Peninsula CCG, NHS East Staffordshire CCG.

1.1.2 This policy supersedes the Procedures of Low Clinical Value (2015) V5 and any local variations of that policy.

1.1.3 This policy supports the decision making process associated with the allocation of resources for commissioning. It will be used to support the development of effective, efficient and ethical Service Level Agreements with provider organisations, and the procurement of interventions on an exceptional basis.

1.2 Introduction

1.2.1 The Policy establishes the framework within which the CCGs can demonstrate that their decision making processes are fair, equitable, ethical and legally sound.

1.2.2 NHS Commissioners receive funding to commission health services for their resident population and make decisions within the context of statutes, statutory instruments, regulations and guidance. NHS Commissioners have a responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them.

1.2.3 NHS Commissioners are required to commission comprehensive, effective, accessible services which are free to users at the point of entry (except where there are defined charges) within a finite resource. It is, therefore, necessary to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the population.

1.2.4 This Policy is designed to help the CCGs to meet their obligation in providing equitable access to health care. It aims to achieve this by supporting a robust decision making process that is reasonable and open to scrutiny.

2.0 Scope

2.1 A number of national organisations, such as NICE, and Public Health clinicians from across Staffordshire and the West Midlands have developed evidence-based advice

to inform commissioning decisions on low priority treatments. Throughout this Policy these treatments or procedures are categorised as Excluded or Restricted. Excluded treatments or procedures will not be funded by the NHS Commissioners, and are only available in exceptional circumstances via the Individual Funding Request process. Restricted treatments or procedures will only be funded for those patients where an appropriate threshold for the intervention as stated in this Policy has been met.

2.2 Evidence for treatment effectiveness and efficacy is available from many sources, including NICE, the Cochrane Institute, Royal Colleges, other professional guidelines, and sources such as peer reviewed journals or technical notes. Evidence varies in its robustness, ranging from meta-analyses of randomised control trials with large populations of participants, to traditional consensus about best practice. The NHS Commissioners in arriving at this Policy have taken advice from Public Health locally on the source, extent and quality of the evidence in reaching their decisions.

2.3 The NHS Commissioners have Prioritisation Frameworks which are reviewed on an ongoing basis. Utilisation of these prioritisation frameworks informs the review of this policy and the procedures and treatments that it covers.

3.0. Definitions

Low Priority Treatments: interventions identified as being either marginally effective or ineffective with limited health gain benefit
Prioritisation the process of ranking competing items, CCG Clinical Commissioning Group
NHS: National Health Service
Providers: Acute Secondary Care hospitals and Community Trusts
ERPs: Excluded and restricted Procedures
PoLCVs: Policies of Low Clinical Value, previous policies now superseded
CPAG: Clinical Priorities Advisory Group

4.0 Roles & Responsibilities

4.1 <u>The CCG Governing Body</u>
The CCGs' Governing Body has overall responsibility for the policy making process. Delegated authority will be given to the formal sub Committees of the Governing Body to approve polices.

4.2 <u>The CCG Committees</u>
The CCG Committees have delegated responsibility from the Governing Body to review and approve policies. The approving Committee should scrutinise the stakeholders that have been involved ensuring sufficient time has been provided, seek assurance that the policy meets statutory duty, and ensure groups of patients, staff or any others are not excluded.

4.3 <u>Providers</u>
In their dealings with patients and the public providers should, if necessary, make it clear that the decision by NHS Commissioners to consider treatments or procedures to be of low priority under this policy is a considered decision made against their responsibility to seek the greatest health advantage possible for local populations using the resources allocated to them and that it is necessary for the NHS Commissioners to make decisions regarding the investment of resources in interventions which achieve the greatest health gain for the local population.

5.0 Main Body

General principles of all the following Excluded and Restricted Policies (ERPs):

- Suspicion of malignancy is a universal acceptance criterion for any relevant procedure
- Where more than one specialty may undertake a procedure the original policy is referenced
- If a separate commissioning policy exists, or is planned, this is referenced or quoted within the policy

5.1. Dermatology and Plastics

5.1.1 Minor Skin Lesions

Treatment of benign Minor Skin Lesions including benign pigmented moles, comedones, corns/callous. lipoma, milia, molluscum contagiosum, seborrhoeic keratosis, skin tags including anal tags, spider naevus, warts, xanthelasma and neurofibromata, epidermoid / Pilar (sebaceous) cysts will not be routinely commissioned in secondary care.

Exceptions: For cases where the lesion is causing significant functional impairment, significant interference with activities of daily living, recurrent infections and prescribed antibiotic use and/or pain with prescribed analgesia use funding may be considered.
Prior approval must be sought from the relevant CCG IFR team

5.1.2 Congenital vascular abnormalities (inc. Port Wine Stain, Paediatric haemangioma)

Laser or surgical treatment for birthmarks or other vascular abnormalities is not routinely commissioned.
Exceptions:
Paediatric haemangioma can have surgical treatment offered for those which:

- Threaten life or function, including compromising eyesight, respiratory, cardiac or hepatic functions
- Other internal lesions sited in an area liable to scar
- Large facial haemangioma that have failed to regress by school age
- Show a tendency to bleed or to become infected
- Kasabach-Merritt syndrome (coagulopathy)

5.1.3 Rosacea

Laser or surgical treatment for rosacea is not routinely commissioned. Severe cases of rhinophyma may be considered by the CCG when there is evidence of severe nasal airway obstruction**.**

5.1.4 Abdominoplasty /Apronectomy / Panniculectomy

This procedure will ONLY be routinely commissioned in the following circumstances:

- Weight loss of at least 10 points on BMI
  AND
- An abdominoplasty /apronectomy has not already been performed
  AND
- Presence of a large abdominal fold hanging below the level of the mons pubis
  AND
- Documented evidence of clinical pathology due to the excess overlying skin e.g. recurrent infections, intertrigo which has led to ulceration requiring repeated courses of treatment with anti-fungal and other topical skin products for a minimum period of one year or disability resulting in severe restrictions in activities of daily living
  AND
- The patients current BMI must be between 18kg/m2 and 25kg/m2
  AND
- The patients weight must have been stable and within this range for a minimum of 1 year as measured and formally recorded by an NHS service
  OR
- If this weight range is not possible due to the weight of excess skin, the patient must have lost 50% of their excess weight and significant functional disturbance is also evident and the clinician must confirm that no further reduction in BMI will be possible without the removal of excess skin.

5.1.5 Cosmetic operations on external ear including split earlobes, excision of lesion of external ear, pinnaplasty ("bat ears")

Not routinely commissioned

5.1.6 Breast Enlargement (Augmentation mammoplasty)

Not routinely commissioned for small breasts, congenital absence of breast or breast asymmetry.

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- As reconstructive surgery following mastectomy for either suspected or proven malignancy

*Treatment of the unaffected breast following cancer surgery shall not be routinely commissioned

5.1.7 Breast Reduction

This procedure will **ONLY** be routinely commissioned if the following criteria are met in full:

- The patient is suffering from functional problems: neck ache, backache and/or intertrigo, where any possible causes of these conditions have been considered and excluded
  AND
- Symptoms are not relieved by physiotherapy and a professionally fitted brassiere has not relieved symptoms AND
- The patient has a body mass index (BMI) within the range 18kg/m2 and 25kg/m2
  AND
- Have a cup size of F+
  AND
- Be 21 years of age or over
- Patients should have an initial assessment prior to an appointment with a consultant plastic surgeon to ensure that these criteria are met. At, or following, this assessment, there should be access to a trained bra fitter (where there is one available).
  AND
- There is an expected need to remove at least 500g of tissue from each breast

5.1.8 Breast Lift (Mastopexy)

Not routinely commissioned

5.1.9 Breast Implant Revision Surgery

Breast revision surgery will **ONLY** be supported if the original augmentation procedure was commissioned by the NHS and at least one of the following applies:

- Breast disease
- Implants with capsule formation that interferes with mammography
- Implants complicated by recurrent infection
- Implants with Baker Class IV contracture associated with pain
- Intra or extra capsular rupture of silicone gel filled implants

*Breast implants will **ONLY** be replaced when the patient meets the acceptance criteria of the current breast augmentation policy**.** In all other patients faulty or problematic implants will be removed and not replaced.

5.1.10 Surgery to Correct Nipple Inversion

Not routinely commissioned

5.1.11 Removal of Supernumerary Nipples (Polymastia)

Not routinely commissioned

5.1.12 Gynaecomastia Surgery (Male breast reduction)

Not routinely commissioned, however if malignancy (either breast or testicular) is suspected, then normal cancer pathways should be followed. Chronic liver disease, thyroid disease, and renal disease should also be excluded.

5.1.13 Skin Resurfacing

Not routinely commissioned

5.1.14 Scars and Keloid Refashioning (Including "Stretch Marks")

Not routinely commissioned

5.1.15 Silicone Gel Sheeting for Preventing or Treating Hypertrophic Scarring and Keloids

Not routinely commissioned

5.1.16 Buttock/Thigh/Arm lift or body contouring
Not routinely commissioned

5.1.17 Cosmetic excision of skin of head or neck – e.g. face lift, brow lifts, rhinoplasty and blepharoplasty to treat the natural process of ageing
Not routinely commissioned

5.1.18 Liposuction
Not routinely commissioned

5.1.19 Blepharoplasty
This procedure will **ONLY** be routinely commissioned in the following circumstances:
Only for the **upper lids** in the presence of:

- Visual field impairment (reducing visual field to 120□ laterally and 40□vertically)

OR

- Severe congenital ptosis

Note: Excessive skin in the **lower lid** may cause "eyebags" but this does not affect function of the eyelid or vision and therefore does not need correction.

Blepharoplasty type procedures may form part of the treatment of pathological conditions of the lid or overlying skin and will not be funded for cosmetic reasons.
Other lesions on the eye lid – see 1.1 Minor Skin Lesions

5.1.20 Correction of Hair Loss including male/female pattern baldness and hair transplant
Surgical and medical treatments are not routinely commissioned
See also NHS Wig Provision
http://www.nhs.uk/NHSEngland/Healthcosts/Pages/Wigsandfabricsupports.aspx

5.1.21 Depilation Techniques for Excess Body Hair, Facial Hirsutism or Hypertrichosis
Not routinely commissioned

5.1.22 Tattoo removal
Not routinely commissioned

5.1.23 Botox for Axillary Hyperhidrosis (Excessive Sweating
Not routinely commissioned

5.1.24 Botox for Facial Aging or Excessive Wrinkles
Not routinely commissioned

5.1.25 Facial Atrophy – new fill procedures
Not routinely commissioned

5.2. Ear Nose & Throat

5.2.1 Tonsillectomy (Adults and Children)

This procedure will **ONLY** be routinely commissioned in line with the SIGN 2010 guidance:

- Seven or more well documented, clinically significant, adequately treated sore throats in the preceding year, or
- Five or more such episodes in each of the preceding two years or
- Three or more such episodes in each of the preceding three years
- Sore throats are due to acute tonsillitis
- The episodes of sore throat are disabling and prevent normal functioning

NB A child is considered to be under the age of 16 for the purpose of tonsillectomy
An eligible episode must have at least three of the following criteria:

- Tonsillar exudates
- Tender anterior cervical lymph nodes
- History of fever
- Absence of cough

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

5.2.2 Myringotomy With/Without Grommets for Otitis Media

A) Adult Grommets:

This procedure will **ONLY** be routinely commissioned for patients where their consultant considers:

- There is development of a retraction pocket and grommet would help prevent cholesteatoma
  AND
- The patient is experiencing persistent hearing loss affecting work or socialisation

B) Grommets in Children:

- Children with persistent bilateral OME documented over a period of 3 months
  AND
- A hearing level in the better ear of 25-30 dBHL
  OR
- The worse ear averaged at 0.5, 1,2 and 4 kHz (or equivalent dBA where dNHL not available)

Children should only be considered for grommet insertion if:-

- The child has experienced persistent hearing loss for more than a year with deficit estimated to be more than 25 decibels
  OR
- More than 6 episodes of acute otitis media in previous 12 months
  OR
- The child has developmental impairment (e.g. speech/ language/ cognitive/ behavioural) likely to be due to, or exacerbated by, clinically suspected hearing loss
  OR
- Poor progress at school directly attributable to this condition, the child has proven hearing loss, plus a second disability such as Down's Syndrome or cleft palate

5.2.3 Adenoidectomy

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- Adenoidectomy if undertaken in conjunction with Tonsillectomy and/or Grommets (Please refer to policies above for Tonsillectomy and/or Grommets).

5.2.4 Treatments for Snoring

(Including, but not restricted to Uvulopalatopharyngoplasty, Uvulopalatoplasty, Palate Implants and Radiofrequency Ablation of the Soft Palate):
Not routinely commissioned.

5.2.5 Rhinoplasty and Septal Surgery

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- In the presence of functional airway obstruction (reduction of at least 30% air intake to one or more of the nares)
  OR
- For the correction of a congenital abnormality (e.g. cleft lip)

5.2.6 Surgery for obstructive sleep apnoea

A) Surgery for obstructive sleep apnoea; Adults

Not routinely commissioned except following failure of CPAP.

- Patients must have Epworth Sleepiness Score 15-18
  OR
- Patient sleepy in dangerous situations such as driving
  AND
- Patient must have significant sleep disordered breathing (as measured during sleep study, usually by the Apnoea/ Hypopnoea Index: 15-30/hr. = moderate, >30/hr. = severe
  AND
- Patient must have already tried CPAP unsuccessfully for 6 months prior to being considered for surgery OR patient has major side effects to CPAP such as significant nose bleeds
  AND
- A clinical decision is that the patient will significantly benefit
  AND
- The patient is fully informed as to the limited effectiveness of procedures, the lack of long term outcomes and likely adverse effects including pain following surgery

B) Surgery for obstructive sleep apnoea; Children

This procedure will ONLY be routinely commissioned in the following circumstances:

- When diagnosis of SDB in children is confirmed based on history, physical examination, audio/video taping, pulse oximetry, and limited or full-night PSG. AHI>5 indicative diagnosis OSA

5.2.7 Surgical management of Acute Otitis Media

Not routinely commissioned

5.2.8 Surgical Treatment of Meniere's disease

Not routinely commissioned

5.2.9 Open wound of ear drum Tympanoplasty

This procedure will ONLY be routinely commissioned in the following circumstances:

- For a chronic discharging ear, with deafness

5.2.10 Surgical Treatment of Chronic Sinusitis

Not routinely commissioned

5.3. General Surgery

5.3.1 Inguinal Hernia

Note: **The following can be managed conservatively at primary care level:**

- Patients with occult/asymptomatic/minimally symptomatic primary or recurrent inguinal hernias
  AND
- Who have significant co-morbidity (ASA 3 or 4)
  AND
- Who do not want to have surgical repair (after appropriate information provided)

Surgical repair will **ONLY** be routinely commissioned when patients meet one of the following criteria:

- Incarcerated hernia or not amenable to simple reduction
  OR
- Symptomatic inguinal hernia
  OR
- Strangulated hernia (emergency surgery)

*All children <18 years with inguinal hernia should be referred to a paediatric surgical provider

*All hernias in women should be referred urgently to a specialist

*Patients who are undergoing or plan to undergo peritoneal dialysis should be referred

5.3.2 Umbilical and Para-umbilical Hernia

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- To avoid incarceration or strangulation of bowel

*Patients who are undergoing or plan to undergo peritoneal dialysis should be referred.

All other circumstances are subject to IFR.

5.3.3 Incisional Hernia

Asymptomatic incisional hernias will not be routinely commissioned except:

- Where peritoneal dialysis is planned.

Symptomatic incisional hernias will **ONLY** be considered for funding depending on:

- Location,
- Size of protrusion
- Size of “hole”
- Length of time hernia has been present
- Risk of strangulation
- Significant disruption to activities of daily living

Prior approval should be sought from the relevant CCG IFR team

5.3.4 Laparoscopic hernia repair

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- Bilateral hernia repair with external swelling on clinical examination
  OR
- Recurrent hernia

5.3.5 Haemorrhoidectomy

Surgical treatment is only commissioned in the following circumstances:

- Recurrent grade 3 or grade 4 combined internal/external haemorrhoids with persistent pain or bleeding
  OR
- Irreducible and large external haemorrhoids

5.3.6 Endoscopic radiofrequency ablation for Gastro Oesophageal Reflux Disease (GORD)

Not routinely commissioned

5.3.7 Linx for Gastro Oesophageal Reflux Disease GORD

Not routinely commissioned

5.3.8 Cholecystectomy

Cholecystectomy for Asymptomatic Gallstones is not routinely commissioned.

Cholecystectomy for Symptomatic Gallstones is **ONLY** commissioned in the following:

- Patients with diabetes mellitus/transplant recipient patients/patients with cirrhosis who have been managed conservatively and subsequently develop symptoms
  OR
- Where there is clear evidence of patients being at risk of gallbladder carcinoma
  OR
- Where there is clear evidence of patients being at risk of gallbladder complications
  OR
- 1 previous confirmed episode of gall stone induced pancreatitis
  OR
- 1 episode of obstructive jaundice caused by biliary calculi
  OR
- 1 confirmed episode of cholecystitis by the presence of one or more of the following symptoms:
  - Pain in the right upper quadrant or epigastric region, initially intermittent, but later may present as constant and severe. The pain may be referred pain that is felt in the right scapula rather than the right upper quadrant or epigastric region (Boas' sign). It may also correlate with eating greasy, fatty, or fried foods.
  - Gallbladder may be tender and distended
  - An inflammatory component (fever, increased white cell count)
  - Diarrhoea, vomiting, and nausea
  - Murphy sign (however this is not just specific for cholecystitis)

5.3.9 Treatment of non-neonatal achalasia via pneumatic dilation or Heller myotomy and fundoplication (Heller Myotomy)

Not routinely commissioned

5.3.10 Gastroelectrical stimulation for gastoparesis

Not routinely commissioned

5.3.11 Implantation of a Duodenal-Jejunal Bypass (DJBL) Liner for Managing Type 2 Diabetes

Not routinely commissioned

5.3.12 Treatment of Salmonella Enteritis (non-severe) faecal transplant
Not routinely commissioned

5.3.13 ERCP Management of Pancreatitis
Not routinely commissioned for pancreatitis

5.3.14 Endoscopic Drainage of Pancreatic Pseudocyst
Not routinely commissioned

5.3.15 Surgical Drainage of Pancreatic Pseudocyst
Not routinely commissioned

5.3.16 Surgical Treatment of Divarication of Recti (DRAM)
This procedure will **ONLY** be routinely commissioned in the following circumstances:

- Where the Divarication of Recti is disabling and causes significant functional impairment.

*Significant functional impairment is defined as where it is affecting the patient's ability to carry out normal activities of daily living.

5.4. Obstetrics and Gynaecology

5.4.1 Dilatation and curettage (D&C) in women under 40 for Menorrhagia
Not routinely commissioned

5.4.2 Hysterectomy for Menorrhagia
This procedure will **ONLY** be routinely commissioned in the following circumstances:

- There has been an unsuccessful trial with a levonorgestrel intrauterine system (e.g. Mirena®) and it has failed to relieve symptoms unless it is medically inappropriate, or contraindicated
  AND
- 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 Experience (NICE) guidelines:
  - Non-steroidal anti-inflammatory agents
  - Tranexamic acid
  - Other hormone methods (injected progesterones, combined oral contraceptives, Gn-RH analogue)
  - AND
  - Surgical treatments such as endometrial ablation or myomectomy have failed to relieve symptoms, or are not appropriate, or are contra-indicated

5.4.3 Hysteroscopy
This procedure will **ONLY** be routinely commissioned within an outpatient setting unless clinically indicated. Prior approval must be sought to perform this in any other setting

5.4.4 Planned Caesarean Section

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- With a singleton breech presentation at term, for whom external cephalic version is contraindicated or has been unsuccessful,
- In twin pregnancies where the first twin is breach
- A placenta that partly or completely covers the internal cervical os (minor or major placenta praevia)
- A previous caesarean section where it is clinically indicated
- With injury/tears to the vagina during previous labour
- With orthopaedic anomalies impeding the patient's ability of having a vaginal delivery
- In patients with HIV who:
  - are not receiving any anti-retroviral therapy or
  - are receiving any anti-retroviral therapy and have a viral load of 400 copies per ml or more
- With both hepatitis C virus and HIV
- With primary genital herpes simplex virus (HSV) infection occurring in the third trimester of pregnancy

*Pregnant women who may require a planned caesarean section should have consultant involvement in the decision-making process.

5.4.5 Preservation of Fertility

Gametes:

This will **ONLY** be routinely commissioned in the following circumstances:

- For patients undergoing treatment for organic illness that may render them infertile. Any funding requests for cryopreservation other than in patients suffering from cancer will be subject to prior approval. There is no lower age limit for eligibility under these circumstances. There will be an annual review to ensure that patients still meet the criteria and wish to continue to have their semen, oocytes or embryos stored. Patients who no longer fulfil the criteria will be offered the option to self-fund continued storage of their semen, oocytes or embryos in line with the HFEA guidance around maximum storage times. Longer terms may be requested, and will be individually reviewed depending on the case.

Ovarian Tissue:

Not routinely commissioned and all requests are subject to Individual Funding Request

5.4.6 Intra Uterine Contraceptive Devices (IUCDs) including mirena coils

Insertion, removal and checks of IUCDs should only be undertaken within primary care except in the following circumstances:

- In those GP Practices where that is not available
- In those patients requiring a fitting within secondary care for clinical reasons and where a fitting in primary care is not possible.
- Removals of lost or displaced IUCDs will be commissioned within secondary care where circumstances dictate that this cannot be managed within primary care
- IUCDs fitted as a secondary procedure/OPCS code will be commissioned within secondary care

5.4.7 Vaginal Ring Pessaries

Insertion and removal of vaginal ring pessaries will only be commissioned within primary care. First fitting will be commissioned as part of a first outpatient appointment where clinically necessary and will be commissioned for follow up if complications arise.

5.4.8 Vaginal Shelf Pessaries

Insertion and removal of shelf pessaries will be commissioned within secondary care but **ONLY** within an outpatient setting. The original shelf pessary plus subsequent replacements will be routinely commissioned.

5.4.9 Routine Doppler ultrasound of umbilical and uterine artery in low risk pregnancies

Not routinely commissioned

5.5. Ophthalmology

5.5.1 Surgery for Cataracts

Commissioned when a patient meets the following criteria for each affected eye:

- Visual Acuity:
  - Metres 6/9 or worse
  - US 20/30 or worse
  - Decimal 0.66 or worse
  - Log Mar 0.18 or worse
  - VAS 91 or worse

  AND
- The cataract affects the patient's lifestyle:
  - Difficulty carrying out everyday tasks such as recognising faces, watching TV, cooking, playing sport/cards etc.
  - Reduced mobility, unable to drive or experiencing difficulty with steps or uneven ground.
  - Ability to work, give care or live independently is affected

*The Visual Acuity should clearly indicate which eye is refers to and which eye the cataract removal is being requested for.

Other indications for cataract surgery include; facilitating treatment for one or more of the following;

- Monitoring posterior segment disease e.g. diabetic retinopathy
- Correcting anisometropia
- Patient with Glaucoma who require cataracts surgery to counteract intraocular pressure

Patients with Single Sight (Monocular Vision):
The indications for cataract surgery in patients with monocular vision and those with severe reduction in one eye e.g. dense amblyopia are the same as for patients with binocular vision, but the ophthalmologist should explain the possibility of total blindness if severe complications occur.

5.5.2 Laser Treatment of Myopia (short sightedness)

Not routinely commissioned

5.5.3 Implantable Intraocular Lens Systems for Age-Related Macular Degeneration

Not routinely commissioned

5.5.4 Screening for diabetic retinopathy by consultant ophthalmologists

Not routinely commissioned

5.5.5 Screening for glaucoma by consultant ophthalmologists

Not routinely commissioned

5.6. Trauma & Orthopaedics

*Note see separate MSK Policies for shoulder, foot and back policies (insert link when available)

5.6.1 Dupuytren's Disease – Palmar Fasciectomy

ALL patients referred into secondary care MUST have been through the MSK service UNLESS

- Severe deformity is disabling
- If the MCP joint contracture reaches 30 degrees or
- If PIP joint contracture occurs at any degree.

The Hueston table top test is a good indication for referral to the MSK service.

Surgery will **ONLY** be routinely commissioned in the following circumstances:

- Function is impaired
  AND
- Contracture is progressing
  AND
- There has been failure to respond to conservative measures such as a steroid injection
  OR
- The patient has a fixed deformity that is non-correctable

5.6.2 Carpal Tunnel Syndrome (CTS)

All patients referred into secondary care must have been through the MSK or AQP Primary Care Service to optimise access to conservative treatment unless CTS is severe.

Carpal tunnel surgery will **ONLY** be routinely commissioned in the following circumstances:

- Patient has acute, severe symptoms that persist for more than three months after conservative therapy in MSK/AQP service, treated with either local corticosteroid injection and/or nocturnal splinting
  OR
- There is neurological deficit or median nerve denervation for example sensory blunting, muscle wasting or weakness of thenar abduction
  AND
- Severe symptoms significantly interfering with daily activities and sleep which have been assessed.

5.6.3 Surgical release of trigger finger

Surgical treatment will **ONLY** be routinely commissioned in the following circumstances:

- Steroid injection has not worked
  OR
- There is a relapse
  OR
- Patient has fixed deformity that cannot be corrected (*severe–fixed contracture or failed non operative treatment)

For patients with **moderate trigger finger** (triggering with: difficulty actively extending finger/need for passive finger extension/loss of complete active flexion) the treatment option is steroid injection to flexor sheath. The patient should be counselled that failure/relapse occurs after injection treatment in 42-57% and in 1% of open or percutaneous release.

5.6.4 Excision of ganglia

The CCGs do not commission treatment of asymptomatic ganglia.
Surgical treatment will **ONLY** be routinely commissioned in the following circumstances:

- Where there is documented evidence of neurovascular compromise

Removal of seed ganglia at base of digits:
Surgical treatment will **ONLY** be routinely commissioned in the following circumstances:

- Where patients report significant pain and the request is supported by a clinical decision that removal is required

Surgical Removal of mucoid cysts at DIP joint:
Surgical treatment will **ONLY** be routinely commissioned in the following circumstances:

- Where nail growth is disturbed and the cysts have a reported history of producing discharge

5.6.5 Injections in Secondary Care

A) Trigger Point Injections for Pain

Not commissioned in a sterile theatre unless x-ray screening or general anaesthesia is required and where they are performed with other procedures i.e. nerve blocks or manipulation.
Trigger point injections of therapeutic substances into peripheral nerves for persistent non-specific neck/back pain are not routinely commissioned
It is important to note this policy does not cover back pain due to malignancy, infection, fracture, ankylosing spondylitis and other inflammatory conditions, radicular pain resulting from nerve root compression or cauda equina syndrome

B) General Joint Injections

Not routinely commissioned in a sterile theatre unless:

- X-ray screening or general anaesthesia is required
  AND
- Where they are being performed with other procedures i.e. nerve blocks or manipulation.

Not routinely commissioned when a patient could be a candidate for joint replacement in the next 6-12 months except

- As a diagnostic tool prior to joint replacement in order to confirm the joint as the major source of pain/ symptoms
  AND
- For patients who are currently unfit or unsuitable for surgery or who do not wish to proceed to surgery

5.6.6 Autologous Chondrocyte Implantation in the Ankle

Not routinely commissioned

5.6.7 Bone Stimulators for Non-Union (LIPUS)

Not routinely commissioned

5.6.8 Bone Stimulators for Non-Union (PEMF- Pulsed Electromagnetic Field)

Not routinely commissioned

5.6.9 Modular Rotating Hinge Knee System

Not routinely commissioned

5.6.10 Intramedullary Nail in Lower Limb Length Discrepancy
Not routinely commissioned

5.6.11 Hyaluronic acid injections into the knees
Not routinely commissioned

5.6.12 Implantation of a Shock or Load Absorber for Mild to Moderate Symptomatic Medial Knee Osteoarthritis
Not routinely commissioned

5.6.13 Allograft reconstruction for glenoid bone loss in glenohumeral instability
Not routinely commissioned – see shoulder policy

5.6.14 Surgical treatment of synovitis and tenosynovitis
Not routinely commissioned

5.6.15 Treatment for Pectus Excavatum
A) Orthotic Treatment for Pectus Excavatum
Not routinely commissioned

B) Surgical Treatment for Pectus Excavatum
Not routinely commissioned

5.6.16 Lycra splinting for the prevention and correction of upper limb contractures for patients with neurological dysfunction
Must have prior approval with follow up of outcomes and patient concordance

5.6.17 Bespoke Knee Prosthetic
Not routinely commissioned

5.6.18 Therapeutic ultrasound in physiotherapy
Not routinely commissioned

5.7. Urology

5.7.1 Male Circumcision (all ages)
Male Circumcision for cosmetic, social, cultural and religious reasons is not routinely commissioned.
Male Circumcision will **ONLY** be routinely commissioned in the following medical circumstances for adults and children:

- Pathological phimosis
- 3 documented episodes of balanoposthitis

Relative indications for circumcision or other foreskin surgery include the following:
- Prevention of urinary tract infection in patients with an abnormal urinary tract
- Recurrent paraphimosis
- Trauma (e.g. zipper injury)
- Tight foreskin causing pain on arousal/ interfering with sexual function
- Congenital abnormalities

5.7.2 Drug Treatment for Erectile Dysfunction

A) Injection of therapeutic substance into penis

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- As 3rd-line treatment in diabetes etc. after lifestyle & phosphodiesterase inhibitors. Patients must have tried at least 2 oral PDE5 inhibitors prior to referral

B) Erectile Dysfunction Medical Management

Referrals to secondary care should not be made for the purposes of NHS prescribed medication. Medical management of erectile dysfunction should only be undertaken in accordance with current national restrictions reflected in GMS/PMS contract.

5.7.3 Penile Implants

Not routinely commissioned

5.7.4 Reversal of Sterilisation (Male and Female)

Not routinely commissioned

5.7.5 Stress Incontinence Surgery

The CCG will only agree to fund the first episode of primary surgical treatment of urinary incontinence as NHS England is now responsible for the commissioning of Stress Incontinence Surgery where previous surgery has failed.
http://www.england.nhs.uk/wp-content/uploads/2013/06/e10-comp-gynae-recur-pro-urina-incon.pdf

5.7.6 Sacral Nerve Stimulation

A) Sacral Nerve Stimulation for Urinary or Faecal incontinence

Not routinely commissioned by CCGs. NHS England is now responsible for the commissioning of Sacral Nerve Stimulation for Urinary or Faecal incontinence
http://www.england.nhs.uk/wp-content/uploads/2013/08/a08-p-b.pdf

B) Sacral Nerve Stimulation for constipation

Not routinely commissioned

5.7.7 Cosmetic Surgery to Genitals

Female genital procedures for cosmetic purposes are not routinely commissioned.
This procedure will **ONLY** be routinely commissioned in the following circumstances:

- Labiaplasty is required secondary to other medical conditions such as cancer **OR**
- Where repair of the labia is required after trauma.

5.7.8 Gender Dysphoria

Not routinely commissioned by CCGs. Gender Reassignment is now the responsibility of NHS England and commissioned through specialised commissioning. GPs can refer directly to their contracted services
http://www.nhs.uk/livewell/transhealth/pages/local-gender-identity-clinics.aspx

5.7.9 Treatment of Atherosclerosis of Renal Artery

Not routinely commissioned

5.8. Vascular surgery

5.8.1 Surgical Treatment of Uncomplicated Varicose Veins

Surgery (stripping of veins) will **ONLY** be routinely commissioned in the following circumstances:

- Varicose veins which have bled and are at risk of bleeding again
  OR
- A history of varicose ulceration
  OR
- Signs of prolonged venous hypertension (haemasiderin pigmentation, eczema, induration lipodermatosclerosis), or significant oedema associated with skin changes)
  OR
- Superficial thrombophlebitis in association with varicose veins
  OR
- Significant symptoms attributable to chronic venous insufficiency which are resulting in significant functional impairment.

5.8.2 Geko device for reducing the risk of venous thromboembolism

Not routinely commissioned

5.9. Cardiology

5.9.1 Closure of Patent Foramen Ovale (PFO) for migraine headache

Not routinely commissioned

5.9.2 Closure of Patent Foramen Ovale (PFO) for prevention of CVA

Not routinely commissioned

5.10 Neurology

5.10.1 Sympathectomy for Raynaud's disease

Only commissioned on a prior approval basis following submission of evidence that all other options had been explored and that the patient has been fully informed of the risks associated with the treatment

5.10.2 Trans-magnetic stimulation TMS for Migraine

Not routinely commissioned

5.10.3 Percutaneous Electro Neuro Stimulation (PENS) for neuropathic pain

Not routinely commissioned

5.11 Mental Health

5.11.1 In Patient treatment of Chronic Fatigue syndrome, Borderline Personality Disorder and Conversion Disorder

Not routinely commissioned

5.11.2 Behaviour Therapy for Gilles de la Tourette syndrome and tic disorders

Not routinely commissioned

5.11.3 Psychological Therapy for Dissociative disorders

Not routinely commissioned

5.12 Complementary therapies

5.12.1 Acupuncture

Acupuncture will only be commissioned as an adjunct to pain management and only through specialist pain clinics

5.12.2 Complementary Therapies/medicines including but not restricted to:

Alexander technique	Applied Kinesiology
Aromatherapy	Autogenic training
Ayurveda	Chiropractic
Environmental medicine	Osteopathy
Healing	Herbal **medicines**
Hypnosis	Homeopathy
Massage	Meditation
Naturopathy	Nutritional therapy
Reflexology	Reiki
Shiatsu	Gerson Therapy
Chelation Therapy	Radiation Therapy

Complementary Therapies/medicines are not routinely commissioned.

5.13 Respiratory

5.13.1 Non Invasive Ventilation

This intervention will **ONLY** be routinely commissioned in the following circumstances:

- Patient has type II respiratory failure
  AND
- Has had a successful home trial of NIV
  AND
- Shows improvement in blood gases and demonstrates compliance with equipment at Out Patient review after at least 6 weeks

5.13.2 Insertion of Endobronchial Nitinol coils to Improve Lung Function in Emphysema

Not routinely commissioned

5.13.3 Cough Assist Therapy (Adults)

Mechanical insufflation-exsufflation (MI-E) therapy, or Cough Assist, will **ONLY** be routinely commissioned for patients who present with:

- An established diagnosis of paralytic /restrictive disorder
  AND
- Patient is unable to cough or clear secretions effectively with a PCF less than 180 (or 160 as per Walsall) L/min using LVR with bag, GPB or volume ventilator (& assisted cough manoeuvre when indicated)
  AND
- Patient is overly fatigued when performing LVR with the resuscitation bag, GPB or volume ventilator.

5.13.4 Sinus X ray

Not routinely commissioned

5.14 Haematology

5.14.1 Home Monitoring of INR

Not routinely commissioned

5.15 Diagnostics

5.15.1 MRI – wide bore or open upright scanner access

This procedure will **ONLY** be routinely commissioned in the following circumstances:

- Prior approval only following:
  - Confirmation of a diagnosis of claustrophobia
    AND
  - Investigation is clinically required and will directly inform diagnosis or treatment
    OR
  - In patients where there is no alternative option (severe contractures, inability to lie flat etc.)

*Upright Open MRI requests will be dealt with on a case by case basis, and the claustrophobia diagnosis is not required

5.16 Endocrinology

5.16.1 Continuous Blood Glucose Monitoring

Continuous Glucose Monitoring (CGM) Device for Patients with Type 1 Diabetes Mellitus who have disabling hypoglycaemia despite optimal self-management by secondary care specialist team. The request should come from a Consultant Diabeteologist and the patient must meet ALL the following criteria:

- Must have more than 2 episodes a week asymptomatic hypoglycaemia that is causing problems with daily activities
  AND
- Must have been successfully trialled with CBGM - HbA1c can be sustained at or below 53 mmol/mol (7%) and/or there has been a fall in HbA1c of 27 mmol/mol (2.5%) or more
  AND
- Must have complete loss of awareness of hypoglycaemia?
  AND
- Must have extreme fear of hypoglycaemia
  AND
- Must have had more than 1 episode a year of severe hypoglycaemia with no obviously preventable precipitating cause
  OR
- Have gestational diabetes (funding will only be up to the time the expectant mother has given birth and is no longer breastfeeding. Further funding will be subject to the above criteria being met in full)

Integrated Insulin Pump Therapy

Applications via the IFR route only. For such cases the provider shall provide an individual case to the commissioner for approval, clearly stating the clinical rationale.

6.0 Policy Implementation

6.1 The schedule showing low priority treatments is set within this policy. This can be incorporated into contractual and service level agreements. NHS Commissioners will require primary and secondary care service providers and other organisations acting on behalf of NHS Commissioners to embrace and abide by the policy and to advise patients accordingly.

6.2 The Policy is implemented by GPs and Primary Care health professionals when advising and referring patients and by providers when considering the treatment options for patients. Those making referrals should not refer to any provider for a treatment or procedure covered by this Policy. Providers should not suggest, recommend or otherwise offer excluded treatments or procedures covered by this Policy to any patient. Providers should only suggest, recommend or otherwise offer restricted treatments or procedures covered by this Policy to patients who satisfy the appropriate threshold statement for that treatment or procedure.

6.3 Within the policy, and as stated against individual treatments or procedures listed in Appendix 1, treatments and procedures are classified as Excluded or Restricted. Unless specifically stated all treatments and procedures are classified as Excluded or Restricted by both NHS Commissioners.

6.4 Excluded procedures and treatments are not commissioned by the NHS Commissioners. Where individual patient circumstances require the escalation of their care and a procedure or treatment classified as excluded is being proposed then providers should refer to the Policy and Procedure for the Authorisation and Management of Individual Funding Requests.

6.5 Restricted procedures and treatments are not commissioned by the NHS Commissioners except where an individual patient satisfies the threshold statement or criteria against a procedure or treatment. Clinicians considering offering a patient a restricted procedure or treatment should satisfy themselves that the threshold statement or criteria against the procedure or treatment are satisfied. Where a patient satisfies the threshold statement or criteria the procedure or treatment is prior approved and can be undertaken. Where the threshold statement or criteria are not met then the procedure or treatment is excluded for that patient and paragraph 5.5.4 above applies.

6.6 This Policy is distributed to all providers, primary care contractors and CCG Localities.

7.0 Equality Impact Assessment

Completed and passed 25/8/17

The South Staffordshire CCGs have a duty to have regard to the need to reduce health inequalities in access to health services and health outcomes achieved as enshrined in the Health and Social Care Act 2012.The CCGs are committed to ensuring equality of access and non-discrimination, irrespective of age, gender, disability (including learning disability), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex (gender) or sexual orientation. In carrying out its functions, the CCGs will have due regard to the different needs of protected equality groups, in line with the Equality Act 2010. This document is compliant with the NHS Constitution and the Human Rights Act 1998. This applies to all activities for which they are responsible, including policy development, review and implementation.

8.0 Quality Impact Assessment

Completed and passed at QIA sub group 27/6/17 and Joint Quality Committee 10/8/17.

9.0 Training

Not applicable, Providers and GPs have been aware of NHS Commissioning policies that have excluded and restricted procedures and have processes in place to apply for them.

10.0 References

An 80 page reference book is available on request.

11.0 Monitoring and Evaluation

13.1 NHS Commissioners will monitor the adherence to this policy through the contractual process, using contractual levers where breaches of the Policy are identified.

13.2 Referrals to secondary care that are outside of this Policy will be routinely monitored by the Commissioning Management and the Contracts Management Teams of the NHS Commissioners.

13.3 NHS Commissioners will provide periodic reports to their Boards reporting the number and nature of breaches of the Policy, by provider and by procedure.

13.4 Where there are defined thresholds, the compliance with the criteria will be subject to regular clinical audits carried out or organised by NHS Commissioners. The audit process will require providers to produce patient specific evidence that confirms the threshold criteria for procedures were satisfied at the time the decision to offer the procedure to the patient was taken. Where audit shows that the evidence is not available or is deficient or fails to satisfy the auditor that the threshold criteria were met at the time the decision to perform the procedure was taken, then the default will be to consider the procedure was excluded and therefore it will not attract payment from the NHS Commissioners.

.

13.5 NHS Commissioners reserve the right to reduce the value of all payments for procedures with OPCS codes that match those for Excluded and Restricted procedures (as listed within this policy)

13.6 Any procedures marked as 'Requires Prior Approval' must be approved by CCGs before the surgery is undertaken using the agreed form. Commissioners will not pay for any procedures undertaken without the required approval from the responsible commissioner.

12.0 Review

NHS Commissioners will abide by this policy when making decisions relating to the provision of low priority treatments. Specifically, the role of the NHS Commissioners is to:

- Monitor the implementation of the Policy and the impact it has on clinical decision making;
- Inform referrers of the Policy;
- Inform all service providers with whom the NHS Commissioners have formal contractual arrangements of the Policy;
- Review the policy and the accompanying schedule on an ongoing basis and/or where an urgent consideration of new evidence is justified.

13.0 Appendices

APPENDIX 1 OPCS Procedure Codes and delivery settings

S051 S052 S053 S054 S055 S058 S059 S061 S062 S063 S064 S065 S066 S067 S068 S069 S081 S082 S083 S088 S089 S091 S092 S093 S098 S099 S101 S102 S103 S104 S105 S108 S109 S111 S112 S113 S114 S115 S118 C 12.1 S11.4, S11.8, S11.9	**1.1 Minor Skin Lesions**	**Outpatient**
	1.2 Congenital Vascular Abnormalities (inc. port wine stain and paediatric haemangiomas)	**Outpatient**
	1.3 Rosacea	**Outpatient**
S021 S022 S028 S029	**1.4 Abdominoplasty / Apronectomy / Panniculectomy**	**Inpatient**
D031 D032 D033 D034 D038 D039	**1.5 Cosmetic operations on external ear Pinnaplasty (also referred to as 'bat ears') Split earlobes, excision of lesion of external ear**	**N/A**
B312	**1.6 Breast Enlargement (Augmentation Mammoplasty)**	**Inpatient**
B311	**1.7 Breast Reduction**	**Inpatient**
B313	**1.8 Breast Lift (Mastopexy)**	**N/A**
B295	**1.9 Breast Implant Revision Surgery**	**Inpatient**
B354 B361	**1.10 Surgery to Correct Nipple Inversion**	**N/A**
B352	**1.11 Removal of Supernumerary Nipples (Polymastia)**	**N/A**
B311 (MALE)	**1.12 Gynaecomastia Surgery**	**N/A**
See 1.1 – 1.5	**1.13 Skin Resurfacing**	**N/A**
See 1.1 – 1.5	**1.14 Scars and Keloid Refashioning (Including "Stretch Marks")**	**N/A**
N/A	**1.15 Silicone Gel Sheeting for Preventing or Treating Hypertrophic Scarring and Keloids**	**N/A**
S011 S012 S013 S014 S015 S016 S018 S019	**1.16 Buttock/Thigh/Arm lift or body contouring**	**N/A**
S011 S012 S013 S014 S015 S016 S018 S019 E036 E073	**1.17 Cosmetic excision of skin of head or neck – e.g. face lift, brow lifts, rhinoplasty and blepharoplasty to treat the natural process of ageing**	
S621 S622	**1.18 Liposuction**	**N/A**
C131 C132 C133 C134	**1.19 Blepharoplasty**	**Outpatient**
S211 S212 S218 S219 S331 S332 S333 S338 S339	**1.20 Correction of Hair Loss**	**N/A**
S606 S607	**1.21 Depilation Techniques for Excess Body Hair, Facial Hirsutism or Hypertrichosis**	**N/A**
See 1.1-1.5	**1.22 Tattoo removal**	**N/A**

S53.2 with X85.1 (to identify Botulinum Toxin) and Z49.2	**1.23 Botox for Axillary Hyperhidrosis (Excessive Sweating)**	**N/A**
X85.1 with Z60.1, with or without X37.5 X375	**1.24 Botox for Facial Aging or Excessive Wrinkles**	**N/A**
Not applicable	**1.25 Facial Atrophy – new fill procedures**	**N/A**
F341 F342 F343 F344 F345 F346 F347 F348 F349 F361 F362	**2.1 Tonsillectomy**	**Inpatient**
D151	**2.2 Myringotomy With/Without Grommets for Otitis Media**	**Inpatient**
E201	**2.3 Adenoidectomy**	**Inpatient**
F324 F325 F326 F32.8 Other specified other operations on palate Y02.1 Implantation of prosthesis into organ NOC Y11.4 Radiofrequency controlled thermal destruction of organ NOC ICD10: R065 - snoring OPCS: F325 - Uvulopalatopharygoplasty	**2.4 Treatments for Snoring**	**N/A**
E023 E024 E025 E026	**2.5 Rhinoplasty and Septal Surgery**	**Daycase**
ICD10: G473 OPCS: U331 - polysonography A847: sleep studies - includes polysonography, electroencephalography, electroculography and surface electromyography. This procedure would only be carried out by a specialist I neurosciences. Surgical intervention would be a UPPP - F325 E036 E073	**2.6 Surgery for obstructive sleep apnoea** **2.61 Adults** **2.62 Children**	**N/A**
ICD10: H669 - otitis media OPCS: a common surgical treatment for this is D151 - myringotomy with insertion of ventilation tube through tympanic membrane	**2.7 Surgical management of Otitis Media**	**N/A**
2015/16 ICD-10-CM Diagnosis Code H81.01 (right ear) H81.02 (left ear) H81.03 (bi-lateral) ICD10: H810 Meniere's disease OPCS: Surgical procedures that may be performed are D151 - grommets D264 - vestibular neurectomy D26's - operations on vestibular apparatus	**2.8 Surgical Treatment of Meniere's Disease**	**N/A**
2015/16 ICD-10-CM Diagnosis Code S01.309A ICD10: S092 - traumatic rupture of eardrum	**2.9 Open wound of ear drum**	**Daycase**

ICD10: J329 - chronic sinusitis OPCS: possible procedures E142 - ethmoidectomy E133 - maxillary antrostomy	**2.10 Surgical Treatment of Chronic Sinusitis**	**N/A**
T201 T202 T203 T204 T208 T209	**3.1 Inguinal Hernia**	**Inpatient**
T241 T242 T243 T244 T248 T249	**3.2 Umbilical and Para-umbilical Hernia**	**Inpatient**
T251 T252 T253 T258 T259	**3.3 Incisional Hernia**	**Inpatient**
	3.4 Laparoscopic hernia repair	**Inpatient**
H511 H482 H524 H568	**3.5 Haemorrhoidectomy**	**Inpatient**
O111	**3.6 Endoscopic radiofrequency ablation for Gastro Oesophageal Reflux Disease (GORD)**	**N/A**
G24.8, Y75.2	**3.7 Linx for Gastro Oesophageal Reflux Disease GORD**	**N/A**
J181 J182 J183 J184 J185	**3.8 Cholecystectomy**	**Inpatient**
ICD10: K220 - achalasia OPCS: T832 - division of muscle Z271 - oesophagus	**3.9 Treatment of non-neonatal achalasia via pneumatic dilation or Heller myotomy and fundoplication (Heller Myotomy)**	**N/A**
ICD10: K318 - other specified disease of stomach and duodenum A70.1 Implantation of neurostimulator into peripheral nerve Z27.2 Stomach	**3.10 Gastroelectrical stimulation for gastoparesis**	**N/A**
G54.3 Endoscopic insertion of tubal prosthesis into duodenum Y70.5 Temporary operations In addition a code from the ICD-10 category E11 Non-insulin-dependent diabetes mellitus would be recorded. The Clinical Classifications Service has advised NICE that currently these are the most suitable OPCS-4 codes to describe this procedure. The OPCS-4 classification is designed to categorise procedures for analysis ant it is not always possible to identify a procedure uniquely. E11 Non-insulin-dependent diabetes mellitus	**3.11 Implantation of a Duodenal-Jejunal Bypass (DJBL) Liner for Managing Type 2 Diabetes**	**N/A**
ICD10: A020 - salmonella enteritis	**3.12 Treatment of Salmonella Enteritis (non-severe) faecal transplant**	**N/A**

J42.8 Other specified therapeutic endoscopic retrograde operations on pancreatic duct Z31.2 Pancreatic duct If a stent is inserted during the procedure this would also be coded by assigning a code from category Y14 Placement of stent in organ NOC after code Y13.4. ICD10: K859 - acute pancreatitis or K861 - chronic pancreatitis J439 - ERCP	**3.13 ERCP Management of Pancreatitis**	**N/A**
J57.- Other partial excision of pancreas Y76.3 Endoscopic approach to other body cavity or Y76.4 Endoscopic ultrasound approach to other body cavity ICD10: K862 - cyst of pancreas OPCS: J424 - endoscopic retrograde drainage of lesion of pancreas	**3.14 Endoscopic Drainage of Pancreatic Pseudocyst**	**N/A**
Y75.2 Laparoscopic approach to abdominal cavity NEC J57.- Other partial excision of pancreas ICD10: K862 - cyst of pancreas OPCS: J614 drainage cyst of pancreas	**3.14 Surgical Drainage of Pancreatic Pseudocyst**	**N/A**
ICD10: M6208 OPCS: T288 - other specified other repair of anterior abdominal wall	**3.15 Surgical Treatment of Divarication of Recti (DRAM)**	**Inpatient**
Q10.1, Q10.3, Q10.8, Q10.9 Q352	**4.1 4.1 Dilatation and curettage (D&C) in women under 40 for Menorrhagia**	**N/A**
Q072 Q074 Q075 Q082 Q089 Q352	**4.2 Hysterectomy for Menorrhagia**	**Inpatient**
Q18.1 Q18.8 Q18.9 Y41.2 or Y76.3 with Z45.1 Z45.8 Z45.9 Q18.8, Q18.9	**4.3 Hysteroscopy**	**N/A**
R171 R172 R178R179	**4.3 Planned Caesarean Section**	**N/A**
	4.4 Preservation of Fertility	**Outpatient**
Q12.1, Q12.2, Q12.3, Q12.4, Q12.8, Q12.9	**4.5 Intra Uterine Contraceptive Devices (IUCDs) including mirena coils**	**Day case**
P26.2, P26.3	**4.6 Vaginal Ring Pessaries**	**Outpatient**
P26.2, P26.3	**4.7 Vaginal Shelf Pessaries**	**Outpatient**
R42.1, R42.2	**4.8 Routine Doppler ultrasound of umbilical and uterine artery in low risk pregnancies**	**N/A**
C751	**5.1 Surgery for Cataracts**	**Outpatient**
C44.2, 44.4, 44.5, 46.1. plus ICD 10 Code for high myopia H52.1	**5.2 Laser Treatment of Myopia (short sightedness)**	**N/A**
	5.3 Implantable Intraocular Lens Systems for Age-Related Macular Degeneration	**N/A**
	5.4 Screening for diabetic retinopathy by consultant ophthalmologists	**N/A**
	5.5 Screening for glaucoma by consultant ophthalmologists	**N/A**

T521 T525 T541	**6.1 Dupuytren's Disease – Palmer Fasciectomy**	**Day case**
A651	**6.2 Carpal Tunnel Syndrome**	**Outpatient**
T691 T692 T698 T699 T701 T702 T718 T719 T723 T728 T729	**6.3 Surgical release of trigger finger**	**Outpatient**
T591 T592 T593 T594 T598 T599 T601 T602 T603 T604 T608 T609	**6.4 Excision of ganglia**	**Outpatient**
W903 W904	**6.5.1 Trigger Point Injections for Pain 6.5.2 General Joint Injections**	**Outpatient**
Not Available	**6.6 Autologous Chondrocyte Implantation in the Ankle**	**N/A**
Not Available	**6.7 Bone Stimulators for Non-Union (LIPUS)**	**N/A**
Not Available	**6.8 Bone Stimulators for Non-Union (PEMF- Pulsed Electromagnetic Field)**	**N/A**
Not Available	**6.9 Modular Rotating Hinge Knee System**	**N/A**
Not Available	**6.10 Intramedullary Nail in Lower Limb Length Discrepancy**	**N/A**
ICD10: M179 - OA knee OPCS: W903 - injection of therapeutic substance into joint Z846 - knee joint + Z94's laterality	**6.11 Hyaluronic acid injections into the knees**	**N/A**
W81.8 Other specified other open operations on joint Y02.1 Implantation of prosthesis into organ NOC Z84.6 Knee joint Z94.- Laterality of operation ICD-10 categories M17 Gonarthrosis [arthrosis knee] or M15 Polyarthrosis would be recorded	**6.12 Implantation of a Shock or Load Absorber for Mild to Moderate Symptomatic Medial Knee Osteoarthritis**	**N/A**
ICD10: M859 - disorder of bone density OPCS: W588 - other specified reconstruction of joint W322 - allograft bone Z813 - glenohumeral joint Z42 - laterality	**6.13 Allograft reconstruction for glenoid bone loss in glenohumeral instability**	**N/A**
2015/16 ICD-10-CM Diagnosis Code M67.369 grouped within Diagnostic Related Group(s) (MS-DRG v30.0): 557 Tendonitis, myositis and bursitis with mcc 558 Tendonitis, myositis and bursitis without mcc	**6.14 Surgical treatment of synovitis and tenosynovitis**	**N/A**
Pectus excavatum (congenital) Q67.6 acquired M95.4	**6.15 Orthotic Treatment for Pectus Excavatum**	**Outpatient**
ICD10: G709 - myoneural disorder OPCS: X491 - application of splint	**6.16 Lycra splinting for the prevention and correction of upper limb contractures for patients with neurological dysfunction.**	**Outpatient**

	6.17 Bespoke Knee Prosthetic	**N/A**
	6.18 Therapeutic ultrasound in physiotherapy	**N/A**
	6.19 Hallux valgus	**Inpatient**
N303	**7.1 Male Circumcision**	**Day case**
Not Available	**7.2 Erectile Dysfunction** **7.2.1 Injection of therapeutic substance into penis** **7.2.2 Medical Management**	**Outpatient**
N291	**7.3 Penile Implants**	**Inpatient**
Q371 Q378 Q379 N181	**7.4 Reversal of Sterilisation (Male and Female)**	**Day case**
Not Applicable	**7.5 Stress Incontinence Surgery**	**N/A**
Not Applicable	**7.6.1 Urinary or Faecal incontinence** **7.6.2 Constipation**	**N/A**
P055 P056 P057 P058 P059	**7.7 Cosmetic Surgery to Genitals**	**Day case**
Not Applicable	**7.8 Gender Dysphoria**	**N/A**
ICD-10-CM Diagnosis Code I70.1	**7.9 Treatment of Atherosclerosis of Renal Artery**	**N/A**
L848 L849 L851 L852 L853 L858 L859 L841 L861 L862 L882	**8.1 Surgical Treatment of Uncomplicated Varicose Veins**	**Inpatient**
	8.2 Geko device for reducing the risk of venous thromboembolism	**N/A**
K16.5 and Y53	**9.1 Closure of Patent Foramen Ovale (PFO) for migraine headache**	**N/A**
K16.5 and Y53	**9.2 Closure of Patent Foramen Ovale (PFO) for prevention of CVA**	**N/A**
ICD10: I730 - Raynaud syndrome OPCS: A759 - sympathectomy	**10.1 Sympathectomy for Raynaud's disease**	**Inpatient**
ICD10: G43's – migraine A09.8 Other specified neurostimulation brain	**10.2 Trans-magnetic stimulation TMS for Migraine**	**N/A**
ICD10: M792 - neuralgia and neuritis A707 Application of transcutaneous electrical nerve stimulator	**10.3 Percutaneous Electro Neuro Stimulation (PENS) for neuropathic pain**	**N/A**
2015/16 ICD-10-CM Diagnosis Code F44.9, 2015/16 ICD-10-CM F44.9 Dissociative and conversion disorder, unspecified	**11.1 Inpatient Stays for Chronic Fatigue, Borderline Personality Disorder, Conversion Disorder**	**N/A**
ICD10: F952 - Tourette's syndrome F95's - all other tic disorders	**11.2 Behaviour Therapy for Gilles de la Tourette syndrome and tic disorders**	**N/A**
2015/16 ICD-10-CM F44.9 Dissociative and conversion disorder, unspecified	**11.3 Psychological therapies for Dissociative disorders**	**N/A**
X61.1, X61.2, X61.3, X61.4, X61.8, X61.9	**12.1 Acupuncture**	**N/A**
X61.2, X61.3, X61.4, X61.8, X61.9, Y33.1.	**12.2 Complementary Therapies/medicines**	**N/A**
OPCS: E852 - non-invasive ventilation	**13.1 Non Invasive Ventilation**	**Outpatient**

E48.8 Other specified therapeutic fibreoptic endoscopic operations on lower respiratory tract Y36.2 Introduction of therapeutic implant into organ NOC Y53.4 Approach to organ under fluoroscopic control Z24.6 Lung In addition a code from the ICD-10 category J43 Emphysema would be recorded.	**13.2 Insertion of Endobronchial Nitinol coils to Improve Lung Function in Emphysema**	**N/A**
Not Applicable	**13.3 Cough Assist Therapy**	**Outpatient**
U06.1	**13.4 Sinus X ray**	**N/A**
ICD10: R798 raised INR (possible diagnosis) + Z921 personal history of long term (current) use of anticoagulants	**14.1 Home Monitoring of INR**	**N/A**
OPCS: U211 - MRI Nec + Y97 if with contrast + Y 98 radiological procedure	**15.1 MRI – wide bore or open upright scanner access**	**Outpatient**
	16.1 Continuous blood glucose monitoring	**Outpatient**