NHS
Cheshire and Merseyside

Clinical Commissioning Policy

Arthroscopic Surgery of the Knee for Meniscal Tears

Category 2 Intervention - Only routinely commissioned when specific criteria are met -

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Version:	1
Purpose	This document is part of a suite of policies that the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy in that suite is a separate public document in its own right but will be applied with reference to other policies in that suite.
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Author (inc Job Title):	
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Document control:		
Date:	**Version Number:**	**Section and Description of Change**
April 2023	1	Policy ratified by Cheshire & Merseyside ICB

1. Introduction

1.1 This policy relates to the commissioning of interventions which optimise clinical effectiveness and represent value for money.

1.2 This document is part of a suite of policies which the Integrated Care Board (ICB) uses to drive its commissioning of healthcare. Each policy is a separate public document in its own right but should be considered alongside all the other policies in the suite as well as the core principles outlined in Appendix 1.

1.3 At the time of publication, the evidence presented per procedure/treatment was the most current available.

1.4 This policy is based on NHS England's Evidence-Based Interventions (EBI) recommendations see link to programme below - accurate at the point of publication https://www.aomrc.org.uk/ebi/clinicians/knee-mri-for-suspected-meniscal-tears/.

2. Purpose

2.1 This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

3. Summary of intervention

3.1 Patients who have knee pain with persistent mechanical symptoms (locking, catching and intermittent sudden pain on movement) that has not responded to three months of initial non-operative care may have a symptomatic meniscal tear. These patients are referred to intermediate or secondary care and in these circumstances an MRI scan is the best investigation to determine the cause of symptoms.

3.2 Patients who have a clear history of a significant acute knee injury and mechanical symptoms or who have a locked knee require referral to intermediate or secondary care and should undergo MRI investigation.

3.3 The majority of patients who present to primary care with knee pain do not require initial investigation with an MRI scan once red flag symptoms and signs have been excluded.

3.4 **This applies to adults aged 19 years and over.**

4. Policy statement

4.1 Arthroscopic surgery for the management of degenerative meniscal tears is routinely commissioned if the criteria from the British Association for surgery of the knee (BASK) guidelines are followed.

4.2 The full URL for the (BASK) guidelines is available below: https://online.boneandjoint.org.uk/doi/pdf/10.1302/0301-620X.101B6.BJJ-2019-0126.R1 - accurate at the point of publication.

5. Exclusions

5.1 None

6. Rationale

6.1 Degenerate meniscal tears and OA are extremely common in the general population. MRI is not recommended for a suspected degenerative meniscal tear unless there are mechanical symptoms (e.g. locking) or lack of improvement with conservative treatment (e.g. exercise/therapy, weight loss, bracing, topical or oral analgesia). Acute knee injury can result in meniscal pathology that may require surgical intervention such as meniscal repair and an MRI scan is the investigation of choice in these cases. A locked knee requires urgent assessment and an MRI scan is the investigation of choice to define the cause.

7. Underpinning evidence

7.1 Choosing Wisely Canada (2015) sport and Exercise Medicine: https://choosingwiselycanada.org/wp-content/uploads/2017/05/Sport-and-exercise-medicine.pdf.

7.2 Arthritis Alliance of Canada. The Impact of Arthritis in Canada: Today and Over the Next 30 Years [Internet]. 2011 [cited 2017 May 5].

7.3 Buchbinder R, et al. Management of degenerative meniscal tears and the role of surgery. BMJ. 2015;350:h2212. PMID: 26044448.

7.4 Englund M. The role of the meniscus in osteoarthritis genesis. Rheum Dis Clin North Am. 2008;34:573-9. PMID: 18687273.

7.5 Englund M. Meniscal tear — a common finding with often troublesome consequences. J Rheumatol. 2009;36:1362-4. PMID: 19567632.

7.6 Englund M, et al. Incidental meniscal findings on knee MRI in middle-aged and elderly persons. N Engl J Med. 2008;359:1108-15. PMID: 18784100.

7.7 Strobel MJ. Manual of Arthroscopic Surgery. Springer: Verlag Berlin Heidelberg; 2002;1:99-200. US Department of Veteran Affairs. VA/DoD Clinical Practice Guidelines: The Non-Surgical Management of Hip & Knee Osteoarthritis (OA) [Internet]. 2014 [cited 2017 May 5].

7.8 G. F. Abram, D. J. Beard, A. J. Price, BASK Meniscal Working Group. Bone Joint J 2019;101-B:652–659. Arthroscopic meniscal surgery a national society treatment guideline and consensus statement. The Bone & Joint JournalVol. 101-B, No. 6, 2019. DOI: https://doi.org/10.1302/0301-620X.101B6.BJJ-2019-0126.R1.

8. Force

8.1 This policy remains in force until it is superseded by a revised policy or by mandatory NICE guidance or other national directive relating to this intervention, or to alternative treatments for the same condition.

9. Coding

9.1 This coding is relevant for suspected meniscal tears and when symptoms are suggestive of osteoarthritis.

Estimated activity

- 80,315 episodes during 2018/19
- Age/sex std rate per 100,000 – 135.2
- Reduction opportunity based on 25th percentile of activity across CCGs: not calculated
- Variation (age/sex std rates):
  - N-fold – 107.4
  - 10th percentile – 4.2
  - 25th percentile – 12.6
  - 50th percentile – 51.7
  - 90th percentile – 447.0

Codes

Procedure codes
U133: MRI bone/joint:

With site codes –

Z84.6 Knee joint

O13.2 Knee NEC

Diagnosis codes
Note – these diagnosis codes have been provided, but not reflected in the coding logic and example SQL code below, as the sparseness of OP diagnosis data means that this is less helpful in an OP setting. It is included here for information.

M170: Primary gonarthrosis, bilateral

M171 Other primary gonarthrosis, incl:

Primary gonarthrosis:
- *NOS*
- *Unilateral*

M179: Gonarthrosis, unspecified

Exclusions

M000, 1,2, 8 &9 infection

M050-9 rheumatoid

M060-9 inflammatory

M070-9 reactive

M020-9 arthropathies

M030-9 post infection

M100-9 gout

M120-9 other arthropathies

M130-9 other arthritis

M140-9 diabetic/ neuropathic

M150-9 polyarthrosis

M172, 3, 4 & 5: gonarthrosis resulting from trauma or other secondary

C402, 408, 409 neoplasm

D162 neoplasm

C765 neoplasm

(Note – cancer diagnoses are a global exclusion)

Any other criteria (e.g. patient age)
Adult (aged >=19 years)

Will the procedure be carried out in OP or as APC?
Outpatient

Coding logic
Procedure code in any position is:
U133
With procedure in any position:
Z84.6 OR
O13.2
AND
Patient age >=19 years

SQL code
```
WHEN opa.Der_Procedure_All like '%U133%'
AND (opa.Der_Procedure_All like '%Z846%' OR opa.Der_Procedure_All like '%O132%')
AND ISNULL(opa.Age_at_Start_of_Episode_SUS,opa.Der_Age_at_CDS_Activity_Date)
between 19 AND 120
THEN '2T_knee_MRI'
```

Global cancer exclusion
OPA
```
-- Cancer Diagnosis Exclusion Codes
AND (( opa.der_diagnosis_all not like '%C[0-9][0-9]%'
AND opa.der_diagnosis_all not like '%D0%'
AND opa.der_diagnosis_all not like '%D3[789]%'
AND opa.der_diagnosis_all not like '%D4[012345678]%')
OR opa.Der_Diagnosis_All IS NULL)
```

10. Monitoring And Review

10.1 This policy may be subject to continued monitoring using a mix of the following approaches:
- Prior approval process
- Post activity monitoring through routine data
- Post activity monitoring through case note audits

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

11. Quality and Equality Analysis

11.1 Quality and Equality Impact Analyses have been undertaken for this policy at the time of its review.

Appendix 1 - Core Objectives and Principles

Objectives

The main objective for having healthcare commissioning policies is to ensure that:

- Patients receive appropriate health treatments
- Treatments with no or a very limited evidence base are not used; and
- Treatments with minimal health gain are restricted.

Principles

This policy aims to ensure a common set of criteria for treatments and procedures across the region. This is intended to reduce variation of access to NHS services in different areas and allow fair and equitable treatment for all patients.

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

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

Core Eligibility Criteria

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

These core clinical eligibility criteria are as follows:

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

Cosmetic Surgery

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

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

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

Diagnostic Procedures

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

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

Clinical Trials

The ICB will not fund continuation of treatment commenced as part of a clinical trial. This is in line with the Medicines for Human Use (Clinical Trials) Regulations 2004 and the Declaration of Helsinki which stipulates that the responsibility for ensuring a clear exit strategy from a trial, and that those benefiting from treatment will have ongoing access to it, lies with those conducting the trial. This responsibility lies with the trial initiators indefinitely.

Clinical Exceptionality

If any patients are excluded from this policy, for whatever reason, the clinician has the option to make an application for clinical exceptionality. However, the clinician must make a robust case to the Panel to confirm their patient is distinct from all the other patients who might be excluded from the designated policy.

The ICB will consider clinical exceptions to this policy in accordance with the Individual Funding Request (IFR) Governance Framework consisting of: IFR Decision Making Policy; and IFR Management Policy.