NHS
Somerset
Clinical Commissioning Group

DEXA SCAN POLICY
CRITERIA BASED ACCESS

Version:	1920.v3
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Application Form	EBI Generic application form if appropriate to apply

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VERSION CONTROL

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DOCUMENT CHANGE HISTORY		
Version	**Date**	**Comments**
1718.v2	September 2020	Rebranding from IFR to EBI

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	April 2018
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1 GENERAL PRINCIPLES (CBA)

1.1 Treatment should only be given in line with these general principles. Where patients are unable to meet these principles, in addition to the specific treatment criteria set out in this policy, funding approval may be sought from the CCG's Evidence Based Interventions Panel (EBIP) by submission of an EBI application

1.2 Clinicians should assess their patients against the criteria within this policy prior to a referral and/or treatment

1.3 Treatment should only be undertaken where the criteria have been met and there is evidence that the treatment requested is effective and the patient has the potential to benefit from the proposed treatment. Where the patient has previously been provided with the treatment with limited or diminishing benefit, it is unlikely that they will qualify for further treatment

1.4 Referring patients to secondary care without them meeting the criteria or funding approval having been secured not only incurs significant costs in out-patient appointments for patients that may not qualify for surgery, but inappropriately raises the patient's expectation of treatment

1.5 On limited occasions, the CCG may approve funding for an assessment only in order to confirm or obtain evidence demonstrating whether a patient meets the criteria for funding. In such cases, patients should be made aware that the assessment does not mean that they will be provided with surgery and surgery will only be provided where it can be demonstrated that the patients meets the criteria to access treatment in this policy

1.6 Patients should be advised being referred does not confirm that they will receive treatment or surgery for a condition as a consent discussion will need to be undertaken with a clinician prior to treatment

1.7 The CCG does not commission surgery for cosmetic purposes alone

1.8 The policy does not apply to patients with suspected malignancy who should continue to be referred under 2 week wait pathway rules for assessment and testing as appropriate

1.9 Patients with an elevated BMI of 30 or more are likely to receive fewer benefits from surgery and should be encouraged to lose weight further prior to seeking surgery. In addition, the risks of surgery are significantly increased (Thelwall, 2015)

1.10 Patients who are smokers should be referred to smoking cessation services in order to reduce the risk of surgery and improve healing

2 POLICY CRITERIA BASE ACCESS

2.1 DEXA scans **are not** commissioned to assess fracture risk **without** prior

assessment using FRAX (without bone mineral density) or QFRACTURE

2.2 DEXA scans **are not** routinely required before the option of commencing treatment on oral bisphosphonate for patients with a 10-year probability of osteoporotic fragility fracture of a t least 1% is considered (see NICE TA 464). The decision whether to initiate treatment should be made after discussion between the responsible clinician and the patient about the advantages and disadvantages

2.3 DEXA scans **are commissioned** following risk assessment with FRAX (without a BMD value) or QFRACTURE, if the fracture risk is in the region of an intervention threshold for a proposed treatment, **and** the result of the DEXA scan will clinically influence whether or not treatment is commenced

2.4 DEXA scans **are commissioned** for patients before starting treatments that may have a rapid adverse effect on bone density (for example, sex hormone deprivation for treatment for breast or prostate cancer) and do not already have a 10-probability of osteoporotic fragility fracture of at least 1% **and** the result of the DEXA scan will clinically influence whether or not treatment is commenced

2.5 DEXA scans **are commissioned** for assessment of fracture risk in people aged under 40 years who have a major risk factor, such as history of multiple fragility fracture, major osteoporotic fracture, or current or recent use of high-dose oral or high-dose systemic glucocorticoids (more than 7.5 mg prednisolone or equivalent per day for 3 months or longer) **and** the result of the DEXA scan will clinically influence whether or not treatment is commenced

2.6 DEXA scans **are commissioned** for patients who have a 10-year probability of osteoporotic fragility fracture of < 1%, but there is a clinical concern that the fracture risk assessment has underestimated the risk because the patient has a medical condition or other factors that may not be included in the risk tool, for example living in a care home or taking drugs that may impair bone metabolism (such as anti-convulsants, selective serotonin reuptake inhibitors, thiazolidinediones, proton pump inhibitors and antiretroviral drugs) **and** result of the DEXA scan will clinically influence whether or not treatment is commenced

2.7 DEXA scans **are commissioned** for patients to assess their NICE criteria for Denosumab or Teriparatide treatment (without the need for a baseline DEXA scan)

3 TARGETING RISK ASSESSMENT (CG146)

3.1 Consider assessment of fracture risk:

In all women aged 65 years and over and all men aged 75 years and over in women aged under 65 years and men aged under 75 years in the presence of risk factors, for example:

a) Previous fragility fracture current use or frequent recent use of oral or systemic glucocorticoids
b) History of falls
b) Family history of hip fracture
d) Other causes of secondary osteoporosis
e) Low body mass index (BMI) (less than 18.5 kg/m2)
f) Smoking
g) Alcohol intake of more than 14 units per week for women and more than 21 units per week for men

3.3 Do not routinely assess fracture risk in people aged under 50 years unless they have major risk factors (for example, current or frequent recent use of oral or systemic glucocorticoids, untreated premature menopause or previous fragility fracture), because they are unlikely to be at high risk

3.4 Estimate absolute risk when assessing risk of fracture (for example, the predicted risk of major osteoporotic or hip fracture over 10 years, expressed as a percentage)

3.5 Use either FRAX (without a bone mineral density [BMD] value if a dual-energy X-ray absorptiometry [DEXA] scan has not previously been undertaken) or QFracture, within their allowed age ranges, to estimate 10-year predicted absolute fracture risk when assessing risk of fracture. Above the upper age limits defined by the tools, consider people to be at high risk

3.6 Interpret the estimated absolute risk of fracture in people aged over 80 years with caution, because predicted 10-year fracture risk may underestimate their short-term fracture risk

3.7 Do not routinely measure BMD to assess fracture risk without prior assessment using FRAX (without a BMD value) or QFracture

3.8 Following risk assessment with FRAX (without a BMD value) or QFracture, consider measuring BMD with DEXA in people whose fracture risk is in the region of an intervention threshold for a proposed treatment, and recalculate absolute risk using FRAX with the BMD value

3.9 Consider measuring BMD with DEXA before starting treatments that may have a rapid adverse effect on bone density (for example, sex hormone deprivation for treatment for breast

3.10 Measure BMD to assess fracture risk in people aged under 40 years who have a major risk factor, such as history of multiple fragility fracture, major osteoporotic fracture, or current or recent use of high-dose oral or high-dose systemic glucocorticoids (more than 7.5 mg prednisolone or equivalent per day for 3 months or longer)

3.11 Consider recalculating fracture risk in the future: if the original calculated risk was in the region of the intervention threshold for a proposed treatment

and only after a minimum of 2 years, or when there has been a change in the person's risk factors

3.12 Take into account that risk assessment tools may underestimate fracture risk in certain circumstances, for example if a person:

- Has a history of multiple fractures
- Has had previous vertebral fracture(s)
- Has a high alcohol intake
- Is taking high-dose oral or high-dose systemic glucocorticoids or prostate cancer (More than 7.5 mg prednisolone or equivalent per day for 3 months or longer)
- Has other causes of secondary osteoporosis

3.13 Take into account that fracture risk can be affected by factors that may not be included in the risk tool, for example living in a care home or taking drugs that may impair bone metabolism (such as anti-convulsants, selective serotonin reuptake inhibitors, thiazolidinediones, proton pump inhibitors and antiretroviral drugs)

3.14 All DEXA requests are vetted by a qualified healthcare professional to meet IRMER requirements. Requests with insufficient information may be returned for further details, if this is not provided scan requests may be refused. If scans are requested but felt to be inappropriate, the request will be returned with an explanation regarding the grounds for refusal

4 EVIDENCE BASED INTERVENTIONS PANEL APPLICATION PROCESS

4.1 Patients who are not eligible for treatment under this policy may be considered on an individual basis where their GP or Consultant believes exceptional circumstances exist that warrant deviation from the rule of this policy

4.2 Completion of a **Generic EBI Application Form** by a GP or Consultant may be put forward

4.3 Applications cannot be considered from patients personally

4.4 It is expected that clinicians will have ensured that the patient, on behalf of who they are forwarding the application for, is appropriately informed about the existing policies prior to an application to the EBIP. This will reassure the Panel that the patient has a reasonable expectation of the outcome of the application and its context

4.5 EBI applications are reviewed and considered for clinical exceptionality

For further information on 'clinical exceptionality' please refer to the NHS England IFR policy https://www.england.nhs.uk/wp-content/uploads/2017/11/comm-policy-indivdual-funding-requests.pdf

4.6 An application put forward for consideration must demonstrated some unusual or unique clinical factor about the patient that suggests they are exceptional as defined below:

- Significantly different to the general population of patients with the condition in question

- Likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition

5 ACCESS TO POLICY

5.1 If you would like further copies of this policy or need it in another format, such as Braille or another language, please contact the Patient Advice and Liaison Service on Telephone number: 08000 851067

5.2 **Or write to us**: NHS Somerset Clinical Commissioning Group, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somccg.pals@nhs.net

6 REFERENCES

The following sources have been considered when drafting this policy:

6.1 https://www.nice.org.uk/guidance/cg146

6.2 https://www.nice.org.uk/guidance/ta464/resources/decision-support-from-nice-information-to-help-people-with-osteoporosis-and-their-health-professionalsdiscuss-the-options-pdf-4608867565

6.3 https://www.nice.org.uk/guidance/ta464