

DEXA SCAN CRITERIA BASED ACCESS (CBA) POLICY

Version:	2223.v3c
Recommendation by:	NHS Somerset ICB Clinical Commissioning Policy Forum (CCPF)
Date Ratified:	April 2022
Name of Originator/Author:	EBI Service
Approved by Responsible Committee/Individual:	NHS Somerset ICB Clinical Executive Committee (CEC)
Publication/issue date:	May 2022
Review date:	Earliest of either NICE publication or 3 years from issue
Target audience:	<p>NHS Somerset ICB:</p> <ul style="list-style-type: none"> • NHS Providers • GP Practices • Contracts Team <p>Medical Directors:</p> <ul style="list-style-type: none"> • Somerset Foundation Trust • Yeovil District Hospital NHS FT • Royal United Hospitals Bath NHS FT
Application Form	EBI Generic application form if appropriate to apply

**DEXA SCAN
CRITERIA BASED ACCESS (CBA) POLICY**

Section	CONTENTS	Page
	Version Control	1
1	General Principles	2
2	Policy Criteria	3-4
3	Targeting Risk Assessment (CG146)	4-5
4	Evidence Based Interventions Application Process	5-6
5	Access To Policy	6
6	References	7

VERSION CONTROL

Document Status:	Current policy
Version:	2223.v3c

DOCUMENT CHANGE HISTORY

Version	Date	Comments
1718.v2	September 2020	Rebranding from IFR to EBI
1920.v3	April 2022	3-year review, no amendments to clinical criteria, additional inclusion of 2.7 under policy criteria
2223.v3a	July 2022	Amendment from SCCG to NHS Somerset ICB. New PALS email address
2223.v3b	March 2023	Wording change 4.6

Equality Impact Assessment (EIA) Form OR EIA Screening Form completed. Date:	April 2018
Quality Impact Assessment QIA. Date:	October 2021
Sponsoring Director:	
Document Reference:	2223.v3c

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 ICB's Evidence Based Interventions Service (EBI) by submission of an EBI application form
- 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 / community care without them meeting the criteria or funding approval not 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 ICB 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 meet 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 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
- 1.8 Patients with an elevated BMI of 30 or more may experience more post-surgical complications including post-surgical wound infection so should be encouraged to lose weight further prior to seeking surgery.
<https://www.sciencedirect.com/science/article/pii/S1198743X15007193>
(Thelwall, 2015)
- 1.9 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

- 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 at 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 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-year probability of osteoporotic fragility fracture of at least 1% **and** the result of the DEXA scan will clinically influence whether 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 If there is no intention to change the patient's treatment based on DXA result, then DXA scanning is not required and will not be routinely funded
- 2.8 DEXA scans **are commissioned** for patients to assess their NICE criteria for Denosumab or Teriparatide treatment (without the need for a baseline DEXA scan)

Patients who are not eligible for treatment under this policy, please refer to section 4 EVIDENCE BASED INTERVENTIONS APPLICATION PROCESS on how to apply for funding with evidence of clinical exceptionality

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
- c) 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

3.2 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

3.3 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)

3.4 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

3.5 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

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

- 3.7 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
- 3.8 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
- 3.9 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)
- 3.10 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
- 3.11 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
- 3.12 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)
- 3.13 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 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 patient's GP or Consultant is required
- 4.3 Applications cannot be considered from patients personally
- 4.4 Only electronically completed EBI applications will be accepted to the EBI Service
- 4.5 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 EBI service. This will reassure the service that the patient has a reasonable expectation of the outcome of the application and its context
- 4.6 EBI applications are reviewed and considered against clinical exceptionalality

For further information on 'clinical exceptionalality' please refer to the NHS Somerset ICB website and input into the 'Search this website' box clinical exceptionalality.

Social, Emotional and Environmental factors *i.e. income, housing, environmental pollution, access to services, family, friends, ethnicity, life experiences etc.* CANNOT be considered with an application

- 4.7 Where appropriate photographic supporting evidence can be forwarded with the application form
- 4.8 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 ICB, Freepost RRKL-XKSC-ACSG, Yeovil, Somerset, BA22 8HR or **Email** us: somicb.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>