Greater Manchester Shared Services

Greater Manchester EUR Policy Statement on:

Correction of Dermatochalasis (Excess skin of the eyelids)

GM Ref: GM048
Version: 1.1 (6 June 2018)

This policy replaces GM047 Correction of Eyelid Ptosis

Greater Manchester Shared Services
Hosted by NHS Oldham CCG
on behalf of the Greater Manchester CCGs

Best Care • Best Health • Best Value

Commissioning Statement

<table>
<tr><th colspan="2">Correction of Dermatochalasis (Excess skin of the eyelids)</th></tr>
<tr><td>Policy Exclusions</td><td>Thyroid eye disease resulting in significant disfigurement.

Surgery such as levator aponeurosis advancement may be required in cases where there is significant aponeurotic blepharoptosis these cases are excluded from this policy and should be referred via the normal route, the surgical intervention(s) needed for this group of patients is at the discretion of the surgeon. Prior funding approval is not required as this is commissioned but is subject to audit under monitored approval.

This policy excludes children under the age of 18 years, who should be managed clinically as appropriate.

Treatment/procedures undertaken as part of an externally funded trial or as a part of locally agreed contracts / or pathways of care are excluded from this policy, i.e. locally agreed pathways take precedent over this policy (the EUR Team should be informed of any local pathway for this exclusion to take effect).</td></tr>
<tr><td>Policy Inclusion Criteria</td><td>Upper lid blepharoplasty will only be commissioned if the request comes from a specialist in secondary care.

Blepharoplasty procedures will <u>not</u> be commissioned for aesthetic reasons.

Lower lid or fat blepharoplasty is <u>not</u> commissioned.

Prior to referral

All possible underlying causes of visual field loss need to have been excluded or treated prior to requesting surgical intervention. Evidence should be provided to show that this has been done.

Conservative management appropriate to the condition should have been tried and failed, this may include:
• Eyelid hygiene
• Warm compress with massage
• Tear replacement therapy
• Omega 3 oil

Applications for referral to an occulo-ophthalmic opinion

Patients may be referred for an occulo-ophthalmic opinion if they meet the following criteria:
• the condition is symptomatic
AND
• conservative management has failed
AND
• it is likely that the symptoms experienced are attributable to the presence of dermatochalasis

Funding Mechanism

Individual prior approval provided the patient meets the above criteria. Requests</td></tr>
</table>

must be submitted with all relevant supporting evidence.

The following information must be included in the application:

- A timeline of the conservative measures tried with length of treatment and reason for stopping.

AND

- If present, all relevant details of the ocular surface disease, periocular dermatitis, upper lid entropion or symptomatic frontalis overaction (which can be attributable to the dermatochalasis and which has not responded to conservative treatment).

Consideration for Upper Lid Blepharoplasty

Skin only, or skin–muscle blepharoplasty may be performed in the presence of a symptomatic visual field defect, if other causes of field defect have been excluded. In some instances, there may be a clear history of reduction of vision in specific circumstances (e.g. when driving, reading or when tired), even in the absence of a formally demonstrated visual field defect where there is a clear description of visual signs and symptoms and their relation to the diagnosis. Other issues such as frontalis overaction should also be included in the application.

When symptoms of ocular surface disease or other symptoms persist despite conservative measures, a skin (+/- muscle) blepharoplasty may be undertaken, if it is likely that they are attributable to the presence of dermatochalasis.

Pre-operative clinical photos should be taken.

Upper lid blepharoplasty is only commissioned for adults (over the age of 18 years) where there is:

- Evidence of the presence of Wick Syndrome - the misdirection of tears laterally or along the upper eyelid skin crease causing epiphora.

OR

- Evidence on examination, or through formal visual field testing, of impairment of vision showing that the eyelids impinge on the individual's visual fields reducing that field to 120° laterally and/or 20° or less superiorly[1].

OR

- Ocular surface disease, periocular dermatitis, upper lid entropion or symptomatic frontalis overaction which can be attributable to the dermatochalasis and which has not responded to conservative treatment.

Funding Mechanism

Individual prior approval provided the patient meets the above criteria. Requests must be submitted with all relevant supporting evidence. **Applications for surgery must come from a specialist in Secondary Care.**

The following information must be included in the application:

- A description of symptoms and findings on examination as well as, for cases where conservative management was indicated, a timeline showing which conservative measures were tried, when and for how long.

AND

- Either a monocular field test showing the degree of obstruction to vision or a description from the clinician of the impact on vision relevant to the diagnosis, including any effect of the visual disruption on the individual's ability to function in

	their day to day life, e.g. risk of falls, impact on driving. **NOTE:** If the proposed surgery involves an excision into the septum orbitale: an individual funding request can be made if there is a good case for clinical exceptionality. Requests must be submitted with all relevant supporting evidence, including the information listed above, and clearly demonstrate why this is needed. **Consideration of brow lift to correct the visual loss or associated symptoms** If a brow lift is also required to correct the visual loss or associated symptoms, then the following should be included in the application: • a clear description of the extent of the brow ptosis and its impact on vision (accompanied by photographs if possible) • a statement as to whether or not the surgery could be done without the brow lift • a view as to the expected additional benefit the brow lift would bring to the outcome for this individual • a statement that the likely scarring as a result of the surgery has been fully explained to the patient and they have consented to this • if applicable, a statement to the effect that eye closure may not be fully achievable for the individual if blepharoplasty is done without brow lift **NOTE:** Endoscopic brow lift is considered to be an aesthetic procedure and is not commissioned. **Funding Mechanism** In all cases, other than those indicated in the policy exclusions: Individual prior approval provided the patient meets the above criteria. Requests must be submitted with all relevant supporting evidence. **Applications for surgery must come from a specialist in Secondary Care.** Clinicians can submit an individual funding request outside of this guidance if they feel there is a good case for clinical exceptionality. Requests must be submitted with all relevant supporting evidence.
Clinical Exceptionality	Clinicians can submit an Individual Funding Request (IFR) outside of this guidance if they feel there is a good case for exceptionality. Exceptionality means 'a person to which the general rule is not applicable'. Greater Manchester sets out the following guidance in terms of determining exceptionality; however the over-riding question which the IFR process must answer is whether each patient applying for exceptional funding has demonstrated that his/her circumstances are exceptional. A patient may be able to demonstrate exceptionality by showing that s/he is: • Significantly different to the general population of patients with the condition in question. ***and as a result of that difference*** • They are likely to gain significantly more benefit from the intervention than might be expected from the average patient with the condition.

Contents

Policy Statement

Greater Manchester Shared Services (GMSS) Effective Use of Resources (EUR) Policy Team, in conjunction with the GM EUR Steering Group, have developed this policy on behalf of Clinical Commissioning Groups (CCGs) within Greater Manchester, who will commission treatments/procedures in accordance with the criteria outlined in this document.

In creating this policy GMSS/GM EUR Steering Group have reviewed this clinical condition and the options for its treatment. It has considered the place of this treatment in current clinical practice, whether scientific research has shown the treatment to be of benefit to patients, (including how any benefit is balanced against possible risks) and whether its use represents the best use of NHS resources.

This policy document outlines the arrangements for funding of this treatment for the population of Greater Manchester.

This policy follows the principles set out in the ethical framework that govern the commissioning of NHS healthcare and those policies dealing with the approach to experimental treatments and processes for the management of individual funding requests (IFR).

Equality & Equity Statement

GMSS/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. GMSS/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, gender or sexual orientation. In carrying out its functions, GMSS/CCGs will have due regard to the different needs of protected characteristic 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.

In developing policy the GMSS EUR Policy Team will ensure that equity is considered as well as equality. Equity means providing greater resource for those groups of the population with greater needs without disadvantage to any vulnerable group.

The Equality Act 2010 states that we must treat disabled people as *more equal* than any other protected characteristic group. This is because their 'starting point' is considered to be further back than any other group. This will be reflected in GMSS evidencing taking 'due regard' for fair access to healthcare information, services and premises.

An Equality Analysis has been carried out on the policy. For more information about the Equality Analysis, please contact policyfeedback.gmscu@nhs.net.

Governance Arrangements

Greater Manchester EUR policy statements will be ratified by the Greater Manchester Association Governing Group (GMAGG) prior to formal ratification through CCG Governing Bodies. Further details of the governance arrangements can be found in the GM EUR Operational Policy.

Aims and Objectives

This policy document aims to ensure equity, consistency and clarity in the commissioning of treatments/procedures by CCGs in Greater Manchester by:

- reducing the variation in access to treatments/procedures.

- ensuring that treatments/procedures are commissioned where there is acceptable evidence of clinical benefit and cost-effectiveness.
- reducing unacceptable variation in the commissioning of treatments/procedures across Greater Manchester.
- promoting the cost-effective use of healthcare resources.

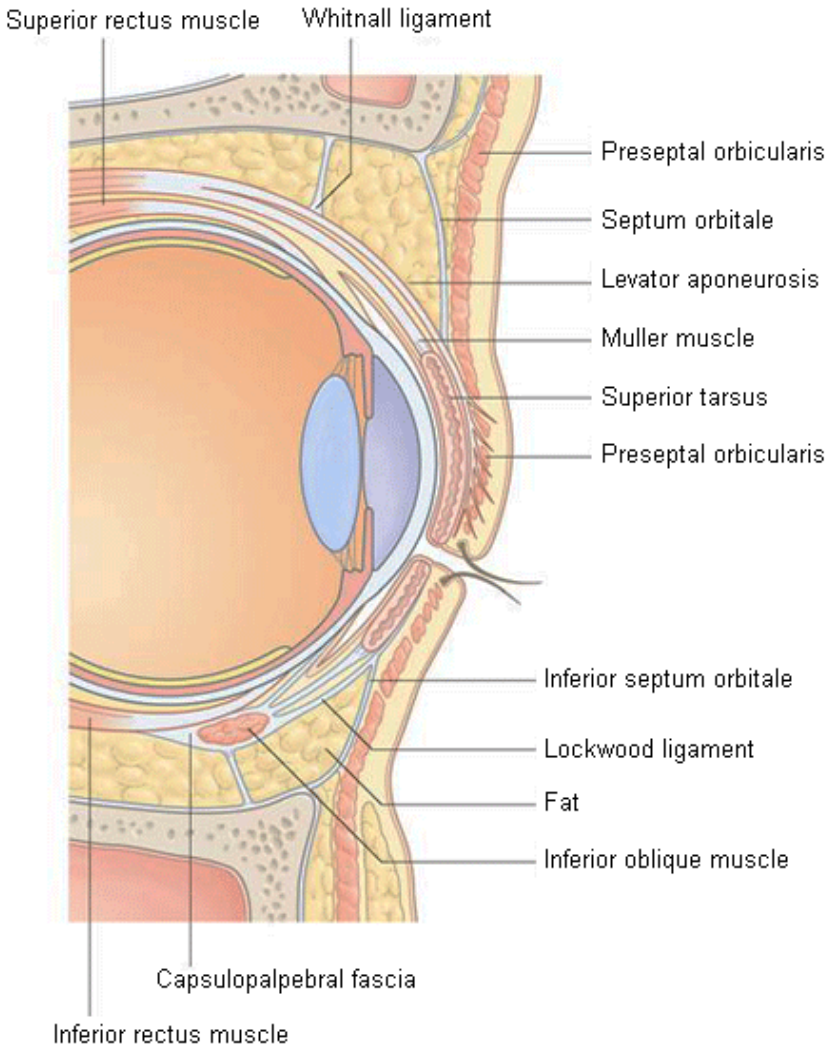
Treatment / Procedure

In this document dermatochalasis refers to the condition characterised by excess laxity of the skin and subcutaneous tissues of the upper eyelid. The skin of the upper lid may hang down over the lid margin causing a variety of symptoms, both cosmetic and functional.

Dermatochalasis is frequently associated with brow ptosis, and blepharoptosis, and occasionally with lacrimal gland prolapse.

Correction of dermatochalasis is frequently requested for aesthetic reasons; however, it is occasionally needed to address functional issues such as field defects or ocular surface discomfort. In addition it may form part of the surgical correction of dehiscence of the upper lid levator muscle (in these cases a Levator Aponeurosis advancement is needed).

Dermatochalasis is a term applied to drooping of the eyelid. It is characterised by excess laxity of the skin and subcutaneous tissues of the upper eyelid. The skin of the upper lid may hang down over the lid margin causing a variety of symptoms, both cosmetic and functional.



Blepharoplasty: Excision of excess skin (of the eyelid) or excess skin and orbicularis muscle. Blepharoplasty may also include excision of herniating orbital fat.

Levator aponeurosis: a thin, tendon-like sheath that connects the eye's main opening muscle, the levator muscle, to the upper eyelid's supporting structure (tarsal plate) and skin.

Cosmetic symptoms

- Alteration in the appearance of eyes
- Sagging of the upper eyelid
- Change in shape of palpebral aperture
- Disruption of skin crease, pretarsal lid hidden by overhanging skin
- Difficulty applying eye make up

Functional symptoms

- Superior visual field loss – patients may struggle to articulate the effect on vision, but often have particular problems with reading (mechanical ptosis more noticeable in downgaze) and driving. They may have a feeling of heaviness, or need to hold the skin out of the way.
- Frontalis overaction leading to headache or tiredness.
- Reduced visual acuity or contrast sensitivity due to lash ptosis (looking through eyelashes).
- Sore skin around the eye (periocular dermatitis).
- Wick syndrome – watering (epiphora) from lateral canthus or along upper lid skin crease
- Burning/itching/grittiness due to blepharitis causing evaporative dry eye and / or keratitis
- Ocular surface discomfort and pain due to upper eyelid entropion

Examination

Should include:

- Visual field (where suspected loss of visual field is the only significant symptom)
- Description / drawings of:
    - Frontalis action / overaction
    - Brow position
    - Dermatochalasis
    - Upper lid margin position and contour
    - Presence / absence of lacrimal gland prolapse
    - Skin crease
    - Lower lid position / laxity
    - Orbicularis function
- Measurement of:
    - Skin crease
    - Marginal reflex distance
    - Levator function
    - Tear meniscus
    - Tear break up time
- Presence / absence of:
    - Dermatitis
    - Blepharitis
    - Upper lid entropion

- Lash ptosis
- Floppy eyelid syndrome
- Lagophthalmos
- Bell's phenomenon
- Corneal staining

- If a field defect is present:
  - Intraocular pressure
  - Fundoscopy

Conservative treatment

Symptoms / signs of ocular surface disease should be treated conservatively before consideration of surgery. (In the presence of upper eyelid entropion secondary to dermatochalasis, it may be necessary to arrange more urgent surgery).

Conservative management may include:

- Eyelid hygiene
- Warm compress with massage
- Tear replacement therapy
- Omega 3 oil

Rationale behind the Policy Statement

Dermatochalasis is a common problem and most blepharoplasty procedures are aesthetic in nature. This policy has been developed to ensure that GM NHS funded interventions for the correction of dermatochalasis are targeted to those cases where there is a medical need for the procedure or a clearly documented functional problem e.g. impaired visual field.

Epidemiology and Need

Dermatochalasis is a common condition. The incidence increases with age. There is no race or gender predilection. Acquired eyelid ptosis can occur at any age. Congenital eyelid ptosis usually presents at birth but is sometimes detected within the first year of life.

Adherence to NICE Guidance

NICE have not currently issued guidance on this treatment.

Audit Requirements

There is currently no national database. Service providers will be expected to collect and provide audit data on request.

Date of Review

One year from the date of approval by Greater Manchester Association Governing Group and thereafter at a date agreed by the Greater Manchester EUR Steering Group, unless new evidence or technology is available sooner.

The evidence base for the policy will be reviewed and any recommendations within the policy will be checked against any new evidence. Any operational issues will also be considered at this time. All available additional data on outcomes will be included in the review and the policy updated accordingly. The policy will be continued, amended or withdrawn subject to the outcome of that review.

Glossary

Term	Meaning
Blepharoplasty	Surgical repair or reconstruction of an eyelid.
Congenital	Present from birth.
Dehiscence	Release of material by splitting open of an organ or tissue.
Epiphora	Excessive watering of the eye
Levator Aponeurosis	A thin, tendon-like sheath that connects the eye's main opening muscle, the levator muscle, to the upper eyelid's supporting structure (tarsal plate) and skin (see diagram above).
Lid Lag	Delay in moving the eyelid as the eye moves downwards.
Ptosis	A term applied to drooping of the eyelid. It can be unilateral or bilateral, complete or incomplete, acquired or congenital.
Visual field or Field of Vision	The entire area that a person is able to see when their eyes are fixed in one position.
Visual field test	Test that maps out an individual's visual field.
Wick syndrome	The misdirection of tears laterally or along the upper eyelid skin crease causing epiphora.

References

1. Greater Manchester Effective Use of Resources Operational policy
2. West Suffolk Clinical Commissioning Group Policy T20
3. This policy will replace the Correction of Eyelid Ptosis Policy (GM047): GM Correction of Eyelid Ptosis v2.4 FINAL DRAFT

Governance Approvals

Name	Date Approved
Greater Manchester Effective Use of Resources Steering Group	16/11/2016
Greater Manchester Chief Finance Officers / Greater Manchester Directors of Commissioning	12/12/2017
Greater Manchester Association Governing Group	09/01/2018
Bury Clinical Commissioning Group	09/01/2018
Bolton Clinical Commissioning Group	23/02/2018
Heywood, Middleton & Rochdale Clinical Commissioning Group	09/01/2018
Manchester Clinical Commissioning Group	14/03/2018
Oldham Clinical Commissioning Group	09/01/2018
Salford Clinical Commissioning Group	09/01/2018
Stockport Clinical Commissioning Group	09/01/2018

Tameside & Glossop Clinical Commissioning Group	09/01/2018
Trafford Clinical Commissioning Group	20/02/2018
Wigan Borough Clinical Commissioning Group	28/03/2018

Appendix 1 – Evidence Review

Correction of Dermatochalasis (Excess skin of the eyelids)
GM048

Search Strategy

The following databases are routinely searched: NICE Clinical Guidance and full website search; NHS Evidence and NICE CKS; SIGN; Cochrane; York; BMJ Clinical Evidence; and the relevant royal college websites. A Medline / Open Athens search is undertaken where indicated and a general google search for key terms may also be undertaken. The results from these and any other sources are included in the table below. If nothing is found on a particular website it will not appear in the table below:

Database	Result
NHS Evidence and NICE CKS	• Ptosis and lid lag, Patient.co.uk - not cited • NHS Modernisation Agency: Information for Commissioners of Plastic Surgery) - not cited
BMJ Best Practice	• Section on diagnosis and management of Blepheratosis (Ptosis) (not cited) • Ptosis: causes, presentation, and management, Finsterer J., Aesthetic Plast Surg. 2003 May-Jun;27(3):193-204. Epub 2003 Aug 21.
General Search (Google)	• Numerous provider websites - not cited • Occuloplastic Surgery (Google e-book) - not cited • Association of Upper-Eyelid Dermatochalasis and Tearing Inbal Avisar, MD; Jonathan H. Norris, FRCOphth; Dinesh Selva, FRACS, FRANZCO; Raman Malhotra, FRCOphth Arch Ophthalmol. 2012;130(8):1007-1012
Royal College Website	• Royal College of Opthalmologists website: Current issues and opportunities – Oculoplastic Surgery

Summary of the evidence

Evidence of effective is limited in availability as this is an established procedure carried out for both aesthetic and medical reasons. For aesthetic reasons it is considered a procedure of low clinical value.

It is an effective procedure and should be commissioned where there is a medical indication or significant impairment of the visual field causing functional issues.

The evidence

Levels of evidence	
Level 1	Meta-analyses, systematic reviews of randomised controlled trials
Level 2	Randomised controlled trials
Level 3	Case-control or cohort studies
Level 4	Non-analytic studies e.g. case reports, case series
Level 5	Expert opinion

1. LEVEL 5: EXPERT OPINION

Ptosis: causes, presentation, and management, Finsterer J., Aesthetic Plast Surg. 2003 May-Jun;27(3):193-204. Epub 2003 Aug 21.

Abstract

Drooping of the upper eyelid (upper eyelid ptosis) may be minimal (1-2 mm), moderate (3-4 mm), or severe (>4 mm), covering the pupil entirely. Ptosis can affect one or both eyes. Ptosis can be present at birth (congenital) or develop later in life (acquired). Ptosis may be due to a myogenic, neurogenic, aponeurotic, mechanical or traumatic cause. Usually, ptosis occurs isolated, but may be associated with various other conditions, like immunological, degenerative, or hereditary disorders, tumors, or infections. Besides drooping, patients with ptosis complain about tired appearance, blurred vision, and increased tearing. Patients with significant ptosis may need to tilt their head back into a chin-up position, lift their eyelid with a finger, or raise their eyebrows. Continuous activation of the forehead and scalp muscles may additionally cause tension headache and eyestrain. If congenital ptosis is not corrected, amblyopia, leading to permanently poor vision, may develop. Patients with ptosis should be investigated clinically by an ophthalmologist and neurologist, for blood tests, X-rays, and CT/MRI scans of the brain, orbita, and thorax. Treatment of ptosis depends on age, etiology, whether one or both eyelids are involved, the severity of ptosis, the levator function, and presence of additional ophthalmologic or neurologic abnormalities. Generally, treatment of ptosis comprises a watch-and-wait policy, prosthesis, medication, or surgery. For minimal ptosis, Müller's muscle conjunctival resection or the Fasanella Servat procedure are proposed. For moderate ptosis with a levator function of 5-10 mm, shortening of the levator palpebrae or levator muscle advancement are proposed. For severe ptosis with a levator function <5 mm, a brow/frontalis suspension is indicated. Risks of ptosis surgery infrequently include infection, bleeding, over- or undercorrection, and reduced vision. Immediately after surgery, there may be temporary difficulties in completely closing the eye. Although improvement of the lid height is usually achieved, the eyelids may not appear perfectly symmetrical. In rare cases, full eyelid movement does not return. In some cases, more than one operation is required.

2. LEVEL 5: GUIDANCE FOR COMMISSIONERS

Modernisation Agency Information for Commissioners of Plastic Surgery Services

Surgery on the upper eyelid (Upper lid blepharoplasty)

This procedure will be commissioned by the NHS to correct functional impairment (not purely for cosmetic reasons)

As demonstrated by:

- Impairment of visual fields in the relaxed, non-compensated state
- Clinical observation of poor eyelid function, discomfort, e.g.. headache worsening towards end of day and/or evidence of chronic compensation through elevation of the brow

Rationale: Many people acquire excess skin in the upper eyelids as part of the process of ageing and this may be considered normal. However if this starts to interfere with vision or function of the eyelid apparatus then this can warrant treatment.

Surgery on the lower eyelid (Lower lid blepharoplasty)

This is available on the NHS for correction of ectropion or entropion or for the removal of lesions of the eyelid skin or lid margin.

Rationale: Excessive skin in the lower lid may cause “eyebags” but does not affect function of the eyelid or vision and therefore does not need correction. Blepharoplasty type procedures however may form part of the treatment of disorders of the lid or overlying skin.

3. LEVEL 5: EXPERT OPINION

Royal College of Opthalmologists website: Current issues and opportunities - Oculoplastic Surgery

PCTs generally decline to provide funding for surgical procedures which are judged to be “cosmetic”, or provide funding only in exceptional circumstances. Brow lifts, blepharoplasty, ptosis correction, removal

of benign eyelid or skin lesions and procedures to treat watering eyes are often included on lists of procedures for which PCTs do not routinely provide funding.

Although this is an understandable response to difficult economic times, it is important that it does not hinder prompt assessment and treatment where there is a likelihood of malignancy, or where eyelid malposition threatens the ocular surface (eg where eyelashes are abrading the cornea or where the ocular surface is exposed). There should also be provision for treatment where brow droop or ptosis reduce the field of vision to the point where the ability to drive is compromised.

4. LEVEL 4: CASE SERIES UPPER-EYELID WICK SYNDROME

Association of Upper-Eyelid Dermatochalasis and Tearing, Inbal Avisar, MD; Jonathan H. Norris, FRCOphth; Dinesh Selva, FRACS, FRANZCO; Raman Malhotra, FRCOphth, Arch Ophthalmol. 2012;130(8):1007-1012

Objective: To highlight a case series of patients manifesting epiphora and misdirection of tears laterally or along the upper-eyelid skin crease. This association has been termed *upper-eyelid wick syndrome*. We describe the clinical features and outcomes of management of these patients.

Methods: A retrospective review of patients referred to 2 oculoplastic centers during a 6-year period for epiphora, who were considered to have misdirection of tears related in some way to upper-eyelid dermatochalasis.

Results: Nine patients (7 women and 2 men; mean [SD] age, 61.2 [11.3] years, range, 41-76 years) with bilateral epiphora and lateral spillover (100%), occasionally combined with upper-eyelid wetting (n=2). All patients had upper-eyelid dermatochalasis. Five patients had upper eyelid skin obscuring and in contact with the lateral canthus (type 1), and in 4 the lateral canthus was only partially obscured by upper-eyelid skin (type 2). Five patients (56%) had linear excoriation of skin in the lateral canthus. All patients underwent upper-eyelid blepharoplasty, 3 combined with ptosis repair and 3 combined with eyebrow-lift. All patients achieved 80% to 100% improvement in epiphora following surgical intervention to the upper eyelid. Themean (range) follow-up was 2.8 (1-6) years.

Conclusions: We defined *upper-eyelid wick syndrome* as the misdirection of tears laterally or along the upper eyelid skin crease causing epiphora, related in some way to upper-eyelid dermatochalasis. In all cases, epiphora improved with treatment of upper-eyelid dermatochalasis. Although recognized among physicians, this has never been formally described in the ophthalmic literature, to our knowledge.

Appendix 2 – Diagnostic and Procedure Codes

Correction of Dermatochalasis (Excess skin of the eyelids)
GM048

(All codes have been verified by Mersey Internal Audit's Clinical Coding Academy)

GM048 - Correction of Dermatochalasis	
OPCS-4 procedure codes	
Blepharolpasty of both eyelids	C13.1
Blepharolpasty NEC	C13.4
Blepharolpasty of lower eyelid	C13.2
Other specified excision of redundant skin of eyelid	C13.8
Browlift NEC	S01.4
Direct browlift	S01.5
Internal browlift	S01.6
Endoscopic approach to other body cavity (secondary to S01.4, S01.5 or S01.6)	Y76.3
Correction of ptosis of eyelid using levator muscle technique	C18.1
Correction of ptosis of eyelid using aponeurosis technique	C18.6
Other specified correction of ptosis of eyelid	C18.8
With the following ICD-10 diagnosis code(s):	
Blepharochalasis	H02.3
Congenital ptosis	Q10.0
Ptosis of eyelid	H02.4
Other specified disorders of eyelid	H02.8
ICD-10 Diagnostic Codes (Exceptions):	
Epiphora	H04.2
Dysthyroid exophthalmos (E05.-†)	H06.2*
Corneal pigmentations and deposits	H18.0
Other specified disorders of binocular movement	H51.8
Visual field defect	H53.4
Blindness, binocular	H54.0
Severe visual impairment, binocular	H54.1
Moderate visual impairment, binocular	H54.2
Mild or no visual impairment, binocular	H54.3
Blindness, monocular	H54.4

Severe visual impairment, monocular	H54.5
Moderate visual impairment, monocular	H54.6
Unspecified visual impairment (binocular)	H54.9
Keratopathy (bullous aphakic) following cataract surgery	H59.0

Appendix 3 – Version History

Correction of Dermatochalasis (Excess skin of the eyelids)
GM048

The latest version of this policy can be found here: GM Dermatochalasis (Correction of) policy

Version	Date	Summary of Changes
0.1	20/07/2016	GM EUR Steering Group agreed that due to the extent of the changes that needed to be made to the Correction of Eyelid Ptosis Policy (GM047) that this policy be withdrawn and replaced this policy, Correction of Dermatochalsis (GM048). The Correction of Dermatochalsis Policy will be treated as an entirely new policy and go back out for clinical engagement and back through the governance process.

0.2	16/11/2016	The GM EUR Steering Group agreed the following amendment to the policy following review of the clinical engagement feedback:
		• New policy format applied.
		• Policy Inclusion Criteria:
		  • 'Funding Mechanism' box added and text reworded for new policy format.
		  • Titles added for clarity
		  • *'Upper Lid'* added before 'Blepharoplasty', where this is needed, for clarity.
		  • Second bullet point under 'Upper Lid Blepharoplasty' amended to read *'Evidence on examination, or through formal visual field testing, of impairment of vision showing that the eyelids impinge on the individual's visual fields reducing that field to 120° laterally and/or 20° or less superiorly'.*
		• Policy Exclusions: Last paragraph amended to the new standard paragraph.
		• References: Amended to incorporate the previous policy format's 'Documents which have informed this policy' section and new reference added: *'West Suffolk Clinical Commissioning Group Policy'*
		Subject to the above changes being made the GM EUR Steering Group approved the policy to go through the CCG Governance Process.

1.0	09/01/2018	Approved by Greater Manchester Association Governing Group

1.1	06/06/2018	Appendix 2
		• Removed OPCS-4 code C05.2 Plastic repair of cavity of orbit
		• Added OPCS-4 code C13.3 Blepharoplasty of lower eyelid
		• Added the following ICD-10 codes to Exceptions:
		  ○ H04.2 Epiphora
		  ○ H06.2* Dysthyroid exophthalmos (E05.-†)
		  ○ H18.0 Corneal pigmentations and deposits
		  ○ H51.8 Other specified disorders of binocular movement
		  ○ H53.4 Visual field defect
		  ○ H54.0 Blindness, binocular
		  ○ H54.1 Severe visual impairment, binocular
		  ○ H54.2 Moderate visual impairment, binocular
		  ○ H54.3 Mild or no visual impairment, binocular
		  ○ H54.4 Blindness, monocular
		  ○ H54.5 Severe visual impairment, monocular
		  ○ H54.6 Moderate visual impairment, monocular
		  ○ H54.9 Unspecified visual impairment (binocular)

		○ H59.0 Keratopathy (bullous aphakic) following cataract surgery