For the BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA Managed Medicaid Program

AMERIGROUP PARTNERSHIP PLAN, LLC.

CUSTOMIZATION TO mcg CARE GUIDELINES 22nd EDITION

Issue Date:	**Original Date**:
January 16, 2019	**March 26, 2018**

NOTE:

- ***The five (5) products licensed include the following:***
  - ***Inpatient & Surgical Care (ISC): Manage, review, and assess people facing hospitalization or surgery proactively with nearly 400 condition-specific guidelines, goals, optimal care pathways, and other decision-support tools.***
  - ***General Recovery Care (GRG): Effectively manage complex cases where a single Inpatient & Surgical Care guideline or set of guidelines is insufficient, including the treatment of people with diagnostic uncertainty or multiple diagnoses.***
  - ***Recovery Facility Care (RFC): Coordinate an effective plan for transitioning people to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).***
  - ***Chronic Care (CCG): Evaluate needs, identify goals, develop personalized care plans, and support effective self-care. The modular design supports quick and efficient assessments and enables you to manage multiple comorbidities and behavioral health conditions.***
  - ***Behavioral Health Care (BHG): Provides evidence-based guidelines to help healthcare professionals guide the effective treatment of patients with psychiatric disorders.***
- ***This document provides a high level summary of customizations and modifications made to MCG care guidelines (hereinafter referred to as "customized guidelines").***
- ***Customized guidelines are available on request.***
- ***Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the customized guidelines. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, as well as applicable state and/or federal law. The customized guidelines do not constitute plan authorization or a guarantee of payment, nor are they an explanation of benefits.***
- ***We reserve the right to review and modify the MCG care guidelines 22nd edition or customized guidelines at any time.***
- ***No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.***
- ***Publish Date: May 7, 2018 for MCG care guidelines 22nd edition and corresponding customized guidelines for ISC, GRG, RFC and CCG.***
- ***Publish Date: June 22, 2018 for MCG care guidelines 22nd edition and corresponding customized or updated guidelines for ISC, GRG, RFC, CCG and the addition of BHG. The June 22, 2018 publish date reflects review and approval of the following new customizations or updates to MCG care guidelines 22nd edition:***
  - ***ISC Anorexia Nervosa (W0127)***
  - ***ISC Substance-Related Disorders (W0079)***

  - ***ISC Common Complications and Conditions Alcohol and Psychoactive Substance Withdrawal (W0131)***
  - ***ISC Common Complications and Conditions Psychiatric Disorders (W0132)***
  - ***Care Management Tool: Behavioral Health Levels of Care (CMT-0006)***
  - ***GRG Behavioral Health GRG (BG-BHG)***
  - ***BH Eating Disorders, Inpatient Behavioral Health Level of Care, Adult (W0144)***
  - ***BH Eating Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent (W0145)***
  - ***BH Anorexia Nervosa, Adult: Inpatient Care (W0146)***
  - ***BH Anorexia Nervosa, Child or Adolescent: Inpatient Care (W0147)***
  - ***BH Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Adult: Inpatient Care (W0148)***
  - ***BH Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Child or Adolescent: Inpatient Care (W0149)***
  - ***BH Urine Toxicology Testing (W0150)***
  - ***BH Applied Behavioral Analysis (W0153)***
  - ***BH Transcranial Magnetic Stimulation (W0151)***
  - ***BH Medication-Assisted Opioid Withdrawal (W0152)***
- ***The October 31, 2018 publish date reflects review and approval of the following new customizations or updates to MCG care guidelines 22nd edition:***
  - ***ISC Abdominal Aortic Aneurysm, Endovascular Repair (W0084)***
  - ***ISC EEG, Video Monitoring (W0115)***
  - ***ISC EEG, Video Monitoring, Pediatric (W0122)***
  - ***ISC Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion (W0011)***
  - ***ISC Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy (W0014)***
  - ***ISC Gastric Restrictive Procedure with or without Gastric Bypass (W0054)***
  - ***ISC Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy (W0033)***
  - ***ISC Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy (W0102)***
  - ***ISC Hip Resurfacing (W0098)***
- ***The January 16, 2019 publish date reflects review and approval of the following new customizations or updates to MCG care guidelines 22nd edition:***
  - ***ISC Ankle Arthroscopy (W0155)***
  - ***ISC Cervical Laminectomy (W0097)***
  - ***ISC Lumbar Laminectomy (W0100)***
  - ***ISC Neonatal Abstinence Syndrome (W0154)***
  - ***BH Medication-Assisted Opioid Withdrawal (W0152)***

INDEX (CTRL + Click to follow link)

- Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion (W0011)
- Electrophysiologic Study and Intracardiac Catheter Ablation (W0012)

- **CARDIOVASCULAR SURGERY**
  - Abdominal Aortic Aneurysm, Endovascular Repair (W0084)
  - Aortic Valve Replacement, Transcatheter (W0133)
  - Cardiac Septal Defect: Atrial, Transcatheter Closure (W0016)
  - Cardiac Septal Defect: Ventricular, Repair (W0093)
  - Cardiac Valve Replacement or Repair (W0089)
  - Heart Transplant (W0017)
  - Percutaneous Revascularization, Lower Extremity (W0121)
  - Sympathectomy by Thoracoscopy or Laparoscopy (W0044)
- **COMMON COMPLICATIONS AND CONDITIONS**
  - Alcohol and Psychoactive Substance Withdrawal (W0131)
  - Preoperative Days (W0130)
  - Psychiatric Disorders (W0132)
  - Venous Thrombosis and Pulmonary Embolism: (W0136)
- **GENERAL SURGERY**
  - Gastric Restrictive Procedure with or without Gastric Bypass (W0054)
  - Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy (W0014)
  - Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy (W0033)
  - Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy (W0102)
  - Liver Transplant(W0034)
  - Mastectomy, Complete (W0002)
  - Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander(W0022)
  - Mastectomy, Complete, with Tissue Flap Reconstruction (W0023)
  - Mastectomy, Partial (Lumpectomy) (W0008)
- **NEONATAL FACILITY LEVELS AND ADMISSION GUIDELINES**
- **NEONATOLOGY**
  - Neonatal Abstinence Syndrome (W0154)
  - Newborn Care, Routine (W0087)
  - Newborn Care, Term, with Severe Illness or Abnormality (W0106)
  - Sepsis, Neonatal, Confirmed (W0107)
  - Sepsis, Neonatal, Suspected, Not Confirmed (W0108)
- **NEUROLOGY**
  - EEG, Video Monitoring (W0115)
- **OBSTETRICS AND GYNECOLOGY**
  - Cesarean Delivery (W0045)
  - Hysterectomy, Abdominal (W0109)
  - Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted (W0010)
  - Hysterectomy, Vaginal (W0110)
  - Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0026)
  - Laparotomy for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0025)
  - Vaginal Delivery (W0047)
  - Vaginal Delivery, Operative (W0048)
- **ORTHOPEDICS**
  - Acromioplasty and Rotator Cuff Repair (W0139)
  - Ankle Arthroscopy (W0155)
  - Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy (W0071)
  - Cervical Fusion, Anterior (W0111)
  - Cervical Fusion, Posterior (W0112)
  - Cervical Laminectomy (W0097)

- Hip Arthroplasty (W0105)
- Hip Arthroscopy (W0096)
- Hip Resurfacing (W0098)
- Knee Arthroplasty, Total (W0081)
- Knee Arthroscopy (W0113)
- Knee Arthrotomy (W0140)
- Lumbar Diskectomy, Foraminotomy, or Laminotomy (W0091)
- Lumbar Fusion (W0072)
- Lumbar Laminectomy (W0100)
- Shoulder Arthroplasty (W0137)
- Shoulder Hemiarthroplasty (W0138)
- Spine, Scoliosis, Posterior Instrumentation (W0116)

- **PEDIATRICS**
  - Diabetes, Pediatric (W0117)
  - EEG, Video Monitoring, Pediatric (W0122)
  - Heart Transplant, Pediatric (W0123)
  - Liver Transplant, Pediatric (W0124)
  - Lung Transplant, Pediatric (W0125)
  - Renal Transplant, Pediatric (W0126)
- **THORACIC SURGERY AND PULMONARY DISEASE**
  - Deep Venous Thrombosis of Lower Extremities (W0135)
  - Lung Transplant (W0076)
  - Pulmonary Embolism (W0134)
  - Rib Fracture (W0101)
- **UROLOGY**
  - Prostatectomy, Transurethral, Alternatives to Standard Resection (W0029)
  - Renal Transplant (W0027)

CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)

- **BODY SYSTEM GRG**
  - Behavioral Health GRG (BG-BHG)
  - Cardiovascular Surgery or Procedure GRG (W0099)
  - General Surgery or Procedure GRG (W0142)
  - Musculoskeletal Surgery or Procedure GRG (W0118)
  - Neurosurgery or Procedure GRG (W0119)
  - Obstetric and Gynecologic Surgery or Procedure GRG (W0143)
  - Urologic Surgery or Procedure GRG (W0141)
- **CARE MANAGEMENT TOOLS**
  - Behavioral Health Levels of Care (CMT-0006)
- **CASE MANAGEMENT GRG**
  - Behavioral Health Case Management GRG (BG-BHG-CM)
- **GENERAL RECOVERY GUIDELINES TOOLS SECTION**
  - Inpatient Palliative Care Criteria (W0086)
- **PROBLEM ORIENTED GRG**
  - Medical Oncology GRG (W0074)

CUSTOMIZATIONS – RECOVERY FACILITY CARE (RFC) GUIDELINES

- Behavioral Health related guidelines

CUSTOMIZATIONS – BEHAVIORAL HEALTH CARE (BHG) GUIDELINES

- **BEHAVIORAL HEALTH LEVEL OF CARE GUIDELINES**
  - Eating Disorders, Inpatient Behavioral Health Level of Care, Adult (W0144)
  - Eating Disorders, Inpatient Behavioral Health Level of Care Comparison Chart, Adult

- Eating Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent (W0145)
- Eating Disorders, Inpatient Behavioral Health Level of Care Comparison Chart, Child or Adolescent
- Medication-Assisted Opioid Withdrawal (W0152)

- **CARE GUIDELINES FOR BEHAVIORAL HEALTH**
  - Anorexia Nervosa, Adult: Inpatient Care (W0146)
  - Anorexia Nervosa, Child or Adolescent: Inpatient Care (W0147)
  - Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Adult: Inpatient Care (W0148)
  - Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Child or Adolescent: Inpatient Care (W0149)
- **TESTING PROCEDURES**
  - Urine Toxicology Testing (W0150)
- **THERAPEUTIC SERVICES**
  - Applied Behavioral Analysis (W0153)
  - Transcranial Magnetic Stimulation (W0151)

CUSTOMIZATION HISTORY

Return to Index

CUSTOMIZATIONS – BACKGROUND INFORMATION

Types of Customizations:

1. Customizations to MCG care guidelines clinical indications based on integration with our medical policy and clinical UM guidelines and other third party criteria.

2. Customizations to MCG care guidelines clinical indications with changes to the original MCG criteria which include adding or revising appropriateness criteria.

3. Customizations to MCG care guidelines goal length of stay with changes to the original MCG criteria.

4. Other customizations to MCG care guidelines may include adding reference(s), or other changes to MCG care guidelines.

Review and Approval of Customizations:
The Medical Policy & Technology Assessment Committee (MPTAC) reviews and approves all customizations to MCG care guidelines. In addition, when a new edition of MCG care guidelines is released, the new edition is approved by the MPTAC.

Disclaimer:
Customized guidelines include a disclaimer at the top of the guideline after the guideline title indicating: *This guideline contains custom content that has been modified from the standard care guidelines and has not been reviewed or approved by MCG Health, LLC.*

Guideline History:
All customized guidelines include a "Guideline History" section that provides (1) the date of the Medical Policy & Technology Assessment Committee (MPTAC) meeting review and approval of the customization, and (2) a summary of the customization to the MCG care guidelines.

Return to Index

CUSTOMIZATIONS INPATIENT & SURGICAL CARE (ISC) GUIDELINES

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Behavioral Health Return to Index	
Behavioral Health (BH) - Anorexia Nervosa (W0127)	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Removed prior customization and reinstated original MCG guideline with exception of the following change to BMI or weight loss for inpatient level of care. o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently." **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o For anorexia nervosa, see the following: ▪ CG-BEH-05 Eating and Feeding Disorder Treatment o For admission to inpatient care due to anorexia nervosa with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-03 Psychiatric Disorder Treatment. • Revised: Alternatives to Admission o Added: See CG-BEH-05 Eating and Feeding Disorder Treatment. • Included note under the Goal Length of Stay (GLOS) section: For continued stay criteria, see CG-BEH-05 Eating and Feeding Disorder Treatment • Revised: Extended Stay o Removed: ▪ MCG indications for extended stay ▪ See Common Complications and Conditions ISC for further information. o Added note: For extended stay criteria, see CG-BEH-05 Eating and Feeding Disorder Treatment. • Revised: Discharge Destination o Added: See CG-BEH-05 Eating and Feeding Disorder Treatment.
Behavioral Health (BH) - Substance-Related Disorders (W0079)	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Removed prior customization and reinstated original MCG guideline. **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o For substance-related disorders, see the following: ▪ CG-BEH-04 Substance-Related and Addictive Disorder Treatment o For delirium due to alcohol or sedative withdrawal is present, see the following: ▪ Delirium ISC guideline o For admission to inpatient care due to substance-related disorders with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-03 Psychiatric Disorder Treatment. • Revised: Alternatives to Admission o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment. • Included note under the Goal Length of Stay (GLOS) section: For continued stay criteria, see CG-BEH-04 Substance-Related and Addictive Disorder Treatment • Revised: Extended Stay o Removed: ▪ MCG indications for extended stay ▪ See Common Complications and Conditions ISC for further information. o Added note: For extended stay criteria, see CG-BEH-04 Substance-Related and Addictive Disorder Treatment • Revised: Discharge Destination. o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment
Cardiology Return to Index	
Cardiology - Angioplasty, Percutaneous Coronary Intervention (W0120)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent percutaneous coronary intervention, see Cardiology Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective PCI
Cardiology - Atrial Fibrillation (W0114)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
Cardiology - Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion (W0011)	**Publish Date: October 31, 2018** September 13, 2018 MPTAC review: • Revised Clinical Indications for Procedure: o "CG-SURG-63 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure" to "CG-SURG-63 Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• Revised Clinical Indications for Procedure: For electrophysiologic study (EPS) and insertion of implantable cardioverter-defibrillator (ICD), see the following: o SURG.00033 Cardioverter Defibrillators o CG-SURG-63 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
Cardiology - Electrophysiologic Study and Intracardiac Catheter Ablation (W0012)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For electrophysiologic study and intracardiac catheter ablation, see the following: ▪ CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation o For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see the following: ▪ CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
Cardiovascular Surgery Return to Index	
CV Surgery - Abdominal Aortic Aneurysm, Endovascular Repair (W0084)	**Publish Date: October 31, 2018** July 26, 2018 MPTAC review: • Approval of June 21, 2018 Third Party Criteria Subcommittee of the MPTAC review June 21, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o "SURG.00054 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection" to "CG-SURG-86 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For abdominal aortic aneurysm, endovascular repair, see the following: o SURG.00054 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection
CV Surgery - Aortic Valve Replacement, Transcatheter (W0133)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For transcatheter aortic valve replacement, see the following: o SURG.00121 Transcatheter Heart Valve Procedures
CV Surgery - Cardiac Septal Defect: Atrial, Transcatheter Closure (W0016)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For transcatheter closure of patent foramen ovale (PFO) and left atrial appendage for stroke prevention, see SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
CV Surgery - Cardiac Septal	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Defect: Ventricular, Repair (W0093)	March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For transmyocardial/perventricular device closure of ventricular septal defects, see SURG.00123 Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
CV Surgery - Cardiac Valve Replacement or Repair (W0089)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the transcatheter approach (as opposed to open), see SURG.00121 Transcatheter Heart Valve Procedures
CV Surgery - Heart Transplant (W0017)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For heart transplant, see the following: o TRANS.00026 Heart/Lung Transplantation o TRANS.00033 Heart Transplantation
CV Surgery - Percutaneous Revascularization, Lower Extremity (W0121)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For percutaneous revascularization, lower extremity, see the following: o CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities
CV Surgery - Sympathectomy by Thoracoscopy or Laparoscopy (W0044)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For treatment of hyperhidrosis, see CG-MED-63 Treatment of Hyperhidrosis. • Revised Clinical Indications for Procedure: o Removed: ▪ Hyperhidrosis and **ALL** of the following; ▪ Patient has severe disabling symptoms. ▪ Nonsurgical management options have been tried and failed or are not appropriate (eg, medication, botulinum toxin injection).
Common Complications and Conditions Return to Index	
Common Complications and Conditions Alcohol and Psychoactive Substance Withdrawal (W0131)	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Removed prior customization and reinstated original MCG guideline. **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Inpatient Care: o For ongoing inpatient care due to substance withdrawal see the following: ▪ CG-BEH-04 Substance-Related and Addictive Disorder Treatment o For delirium due to alcohol or sedative withdrawal is present, see the following: ▪ See Mental Status Change: Common Complications and Conditions ISC as needed o For ongoing inpatient care due to substance withdrawal with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-03 Psychiatric Disorder Treatment. • Revised: Alternatives to Inpatient Care o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment • Revised: Discharge o Removed: MCG indications for extended stay o Added note: For extended stay beyond goal length of stay for primary condition, see CG-BEH-04 Substance-Related and Addictive Disorder Treatment.
Common Complications and Conditions Preoperative Days (W0130)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Inpatient Care: For preoperative days for select musculoskeletal services reviewed with Musculoskeletal Program Clinical Guidelines, see Musculoskeletal Program Clinical Appropriateness Guidelines: Preoperative Admission • Revised Clinical Indications for Inpatient Care: o For inpatient preoperative days, added indication, Conversion from warfarin (Coumadin®) to IV heparin for patients with mechanical heart valves or other high risk patients with contraindications to low-molecular-weight heparin (LMWH) or fractionated heparin • Added reference
Common Complications and Conditions Psychiatric Disorders (W0132)	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Removed prior customization and reinstated original MCG guideline. **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Inpatient Care: o For ongoing inpatient care due to psychiatric disorders see the following: ▪ CG-BEH-03 Psychiatric Disorder Treatment o For ongoing inpatient care due to psychiatric disorders with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-04 Substance-Related and Addictive Disorder Treatment. • Revised: Alternatives to Inpatient Care o Added: See CG-BEH-03 Psychiatric Disorder Treatment. • Revised: Discharge o Removed: MCG indications for extended stay o Added note: For extended stay beyond goal length of stay for primary condition, see CG-BEH-03 Psychiatric Disorder Treatment.
Common Complications and Conditions Venous Thrombosis and	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Pulmonary Embolism (W0136)	• Revised Clinical Indications for Inpatient Care: o For vena cava filter placement needed: ▪ Removed MCG clinical indications ▪ Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters
General Surgery Return to Index	
General Surgery - Gastric Restrictive Procedure with Gastric Bypass Title change to: Gastric Restrictive Procedure with or without Gastric Bypass (W0054)	**Publish Date: October 31, 2018** July 26, 2018 MPTAC review: • Approval of July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o "SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" to "CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Title changed from Gastric Restrictive Procedure with Gastric Bypass to indicate Gastric Restrictive Procedure with or without Gastric Bypass • Revised Clinical Indications for Procedure: For gastric restrictive procedure with or without gastric bypass, see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Updated Coding section with the following: o Added ICD-10 Procedure codes: 0D190ZB, 0DB60Z3, 0DV60CZ, 0DW60CZ o Added CPT® codes: 43842, 43843, 43845, 43848
General Surgery - Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy (W0014)	**Publish Date: October 31, 2018** July 26, 2018 MPTAC review: • Approval of July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o "SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" to "CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure with gastric bypass by laparoscopy, see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Updated Coding section with the following: o Added ICD-10 Procedure codes: 0D164Z9, 0DB64ZZ
General Surgery - Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy (W0033)	**Publish Date: October 31, 2018** July 26, 2018 MPTAC review: • Approval of July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o "SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" to "CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure without gastric bypass by laparoscopy, see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Update Coding Section with the following: o Added CPT® codes: 43771, 43773, 43886, 43888
General Surgery - Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy (W0102)	**Publish Date: October 31, 2018** July 26, 2018 MPTAC review: • Approval of July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review July 18, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o "SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" to "CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure, sleeve gastrectomy, by laparoscopy, see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
General Surgery - Liver Transplant (W0034)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For liver transplant, see the following: o TRANS.00008 Liver Transplantation
General Surgery - Mastectomy, Complete (W0002)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (e.g., lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible o For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should be considered possibly in women with LCIS. • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory • Under the Goal Length of Stay (GLOS) section added: o Reason: Organization approved 2 day stay o Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory • Added references
General Surgery - Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
(W0022)	o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (e.g., lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible o For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should be considered possibly in women with LCIS. • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory or 1 day postoperative • Under the Goal Length of Stay (GLOS) section added: o Reason: Organization approved 2 day stay o Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory or Inpatient • Added references
General Surgery - Mastectomy, Complete, with Tissue Flap Reconstruction (W0023)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (e.g., lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible o For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should be considered possibly in women with LCIS. • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references
General Surgery - Mastectomy, Partial (Lumpectomy) (W0008)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory • Under the Goal Length of Stay (GLOS) section added: o Reason: Organization approved 2 day stay o Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory
Neonatal Facility Levels and Admission Guidelines Return to Index	
Neonatal Facility Levels and Admission Guidelines – Neonatal Facility Levels of Care Guidelines • Neonatal Facility, Level I • Neonatal Facility, Level II • Neonatal Facility, Level III	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Removed the MCG Neonatal Facility Levels and Admission Guidelines in the 22nd edition.

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
• Neonatal Facility, Level IV Neonatal Care Admission Guidelines • Neonatal Admission Levels Comparison Chart • Neonatal Care, Routine Care, Level 1 • Neonatal Care, Continuing Care, Level 2 • Neonatal Care, Intermediate Care, Level 3 • Neonatal Care, Intensive Care, Level 4	
Neonatology Return to Index	
Neonatology – Neonatal Abstinence Syndrome (W0154)	**Publish Date: January 16, 2019** November 8, 2018 MPTAC review: • Approval of October 18, 2018 Third Party Criteria Subcommittee of the MPTAC review October 18, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following note under both Clinical Indications for Admission to Inpatient Care and Goal Length of Stay (GLOS): o For neonatal levels of care, see CG-MED-26 Neonatal Levels of Care
Neonatology – Newborn Care, Routine (W0087)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section
Neonatology – Newborn Care, Term, with Severe Illness or Abnormality (W0106)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For newborn care, term, with severe illness or abnormality, see the following: o CG-MED-26 Neonatal Levels of Care
Neonatology – Sepsis, Neonatal, Confirmed (W0107)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, confirmed, see the following: o CG-MED-26 Neonatal Levels of Care

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Neonatology – Sepsis, Neonatal, Suspected, Not Confirmed (W0108)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, suspected, not confirmed, see the following: o CG-MED-26 Neonatal Levels of Care
Neurology Return to Index	
Neurology – EEG, Video Monitoring (W0115)	**Publish Date: October 31, 2018** September 13, 2018 MPTAC review: • Revised Clinical Indications for Procedure: o "CG-MED-46 Ambulatory Electroencephalography and Video Electroencephalography" to "CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For EEG video monitoring, see the following: o CG-MED-46 Ambulatory Electroencephalography and Video Electroencephalography
Obstetrics and Gynecology (OB / GYN) Return to Index	
OB / GYN - Cesarean Delivery (W0045)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Retained MCG clinical indications for emergency cesarean delivery o Added clinical indications for early elective cesarean delivery o Revised MCG clinical indications for elective cesarean delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Included note under Codes: Additional ICD-10 diagnosis codes may apply to this guideline when the requested service is for early elective delivery. This is not an all-inclusive list of codes that may apply.
OB / GYN - Hysterectomy, Abdominal (W0109)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: ▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition. ▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated. • It was tried but did not adequately treat patient's condition.

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• It is not appropriate for severity of patient's condition (eg, severe persistent bleeding). ▪ "Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of **1 or more** of the following: ▪ For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable. ▪ For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) ▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): ▪ "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms." changed to "Investigation has ruled out other causes for symptoms." ▪ "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to: "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: ▪ "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to: "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when abdominal hysterectomy is considered not medically necessary: o **Abdominal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs) • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable.
OB / GYN - Hysterectomy, Laparoscopic Title change to: Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted (W0010)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Title changed from Hysterectomy, Laparoscopic to indicate Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: ▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition. ▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated. • It was tried but did not adequately treat patient's condition.

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• It is not appropriate for severity of patient's condition (eg, severe persistent bleeding). ▪ "Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of **1 or more** of the following: ▪ For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable. ▪ For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) ▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): ▪ "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms." changed to "Investigation has ruled out other causes for symptoms." ▪ "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to: "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: ▪ "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to: "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy is considered not medically necessary: o **Laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs) • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable.
OB / GYN - Hysterectomy, Vaginal (W0110)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: ▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition. ▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated. • It was tried but did not adequately treat patient's condition. • It is not appropriate for severity of patient's condition (eg, severe persistent bleeding).

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	▪ "Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of **1 or more** of the following: ▪ For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable. ▪ For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) ▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): ▪ "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms." changed to "Investigation has ruled out other causes for symptoms." ▪ "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to: "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: ▪ "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to: "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when vaginal hysterectomy is considered not medically necessary: o **Vaginal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs) • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable.
OB / GYN - Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0026)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For laparoscopic surgical ablation of uterine fibroids, see SURG.00077 Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques • Included note under Clinical Indications for Procedure: For the evaluation of infertility, see CG-SURG-34 Diagnostic Infertility Surgery • Revised Clinical Indications for Procedure: o "Bilateral prophylactic salpingo-oophorectomy" changed to "Risk-reducing salpingo-oophorectomy" o For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "Bilateral oophorectomy" changed to "Risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy" o Additional indication listed for oophorectomy: ▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (e.g., mother, sister, daughter) **or** one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer o Removed: ▪ Infertility evaluation or treatment needed, as indicated by **ALL** of the following: • Infertility, as indicated by **1 or more** of the following:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	○ Inability to conceive after regular unprotected sexual intercourse for 6 months or more for female older than 35 years ○ Inability to conceive after regular unprotected sexual intercourse for at least 1 year for female 35 years or younger • Appropriate laboratory hormone levels (eg, prolactin, follicle-stimulating hormone, mid-luteal progesterone) • Imaging (transvaginal ultrasound and hysterosalpingogram or sonohysterography) nondiagnostic or demonstrates pathology amenable to surgical treatment (eg, endometriosis) • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs)
OB / GYN - Laparotomy, for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0025)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: ○ "Bilateral prophylactic salpingo-oophorectomy" changed to "Risk-reducing salpingo-oophorectomy" ○ For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "Bilateral oophorectomy" changed to "Risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy" ○ Additional indication listed for oophorectomy: ▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (e.g., mother, sister, daughter) **or** one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs)
OB / GYN - Vaginal Delivery (W0047)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: ○ Removed MCG clinical indications for when induction of labor is appropriate ○ Added clinical indications for elective induction of labor ○ Added clinical indications for early elective induction of labor • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Included note under Codes: Additional ICD-10 diagnosis codes may apply to this guideline when the requested service is for early elective delivery. This is not an all-inclusive list of codes that may apply.
OB/GYN - Vaginal Delivery, Operative (W0048)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For early elective vaginal delivery, see W0047 Vaginal Delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section
Orthopedics Return to Index	
Orthopedics - Acromioplasty and Rotator Cuff Repair (W0139)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For acromioplasty and rotator cuff repair, see the following:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	o Musculoskeletal Program Clinical Guidelines Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For acromioplasty and rotator cuff repair, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Ankle Arthroscopy (W0155)	**Publish Date: January 16, 2019** November 8, 2018 MPTAC review: • Approval of October 18, 2018 Third Party Criteria Subcommittee of the MPTAC review October 18, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For ankle arthroscopy for osteochondral lesions, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines. • Revised Clinical Indications for Procedure: o Removed MCG clinical indication for osteochondral lesions • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For ankle arthroscopy for osteochondral lesions, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy (W0071)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For elective, non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Cervical Fusion, Anterior (W0111)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent anterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent anterior cervical fusion • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent anterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Cervical Fusion, Posterior (W0112)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent posterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	o Removed MCG clinical indications for elective, non-emergent posterior cervical fusion • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent posterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Cervical Laminectomy (W0097)	**Publish Date: January 16, 2019** September 13, 2018 MPTAC review: • Approval of August 15, 2018 Third Party Criteria Subcommittee of the MPTAC review August 15, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): o "For elective, non-emergent cervical laminectomy other than (a) biopsy or excision of spinal lesions or (b) infection of cervical spine requiring decompression or debridement" to "For elective, non-emergent cervical laminectomy" • Revised Clinical Indications for Procedure: o Removed MCG clinical indication for ▪ biopsy or excision of spinal lesions ▪ infection of cervical spine requiring decompression or debridement **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For elective, non-emergent cervical laminectomy other than (a) biopsy or excision of spinal lesions or (b) infection of cervical spine requiring decompression or debridement, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent cervical laminectomy • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent cervical laminectomy other than (a) biopsy or excision of spinal lesions or (b) infection of cervical spine requiring decompression or debridement, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Hip Arthroplasty (W0105)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o For computer-assisted musculoskeletal surgical navigational procedures, see SURG.00082 Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System o For elective, non-emergent hip arthroplasty not due to developmental dysplasia, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent hip arthroplasty not due to developmental dysplasia of hip • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent hip arthroplasty not due to developmental dysplasia, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Hip Arthroscopy (W0096)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For hip arthroscopy other than (a) fracture amenable to arthroscopic repair or (b) debridement and lavage of septic hip, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications except for (a) fracture amenable to arthroscopic repair and (b) debridement and lavage of septic hip • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For hip arthroscopy other than (a) fracture amenable to arthroscopic repair or (b) debridement and lavage of septic hip, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Hip Resurfacing (W0098)	**Publish Date: October 31, 2018** July 26, 2018 MPTAC review: • Approval of June 21, 2018 Third Party Criteria Subcommittee of the MPTAC review June 21, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o "SURG.00051 Hip Resurfacing" to "CG-SURG-85 Hip Resurfacing" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For hip resurfacing, see the following: o SURG.00051 Hip Resurfacing • Updated Coding section with the following: o Added CPT® code: 27299* o *CPT® 27130 and 27299 [when specified as partial or total hip resurfacing].
Orthopedics - Knee Arthroplasty, Total (W0081)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o For unicondylar interpositional spacer, see SURG.00053 Unicondylar Interpositional Spacer o For computer-assisted musculoskeletal surgical navigational procedures, see SURG.00082 Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System o For bicompartmental knee arthroplasty, see SURG.00105 Bicompartmental Knee Arthroplasty o For elective, non-emergent total knee arthroplasty not due to congenital deformity, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent total knee arthroplasty not due to congenital deformity • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent total knee arthroplasty not due to congenital deformity, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Knee Arthroscopy (W0113)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• Included note under Clinical Indications for Procedure: For knee arthroscopy other than debridement, drainage, or lavage needed for infected joint, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications except for debridement, drainage, or lavage needed for infected joint • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For knee arthroscopy other than debridement, drainage, or lavage needed for infected joint, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Knee Arthrotomy (W0140)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For knee arthrotomy other than debridement, drainage, or lavage for osteomyelitis or infected joint, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications except for debridement, drainage, or lavage for osteomyelitis or infected joint • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For knee arthrotomy other than debridement, drainage, or lavage needed for infected joint, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Lumbar Diskectomy, Foraminotomy, or Laminotomy (W0091)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For elective, non-emergent lumbar diskectomy, foraminotomy, or laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed: MCG clinical indications for elective, non-emergent lumbar diskectomy, foraminotomy, or laminotomy • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent lumbar diskectomy, foraminotomy, or laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Lumbar Fusion (W0072)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For axial lumbar interbody fusion, see SURG.00111 Axial Lumbar Interbody Fusion o For elective, non-emergent lumbar fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent lumbar fusion • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent lumbar fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Orthopedics - Lumbar Laminectomy (W0100)	**Publish Date: January 16, 2019** September 13, 2018 MPTAC review: • Approval of August 15, 2018 Third Party Criteria Subcommittee of the MPTAC review August 15, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): o "For elective, non-emergent lumbar laminectomy other than lumbar laminectomy with dorsal rhizotomy for spasticity" to "For elective, non-emergent lumbar laminectomy" • Revised Clinical Indications for Procedure: o Removed MCG clinical indication for ▪ dorsal rhizotomy for spasticity **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For elective, non-emergent lumbar laminectomy other than lumbar laminectomy with dorsal rhizotomy for spasticity, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent lumbar laminectomy except for lumbar laminectomy with dorsal rhizotomy for spasticity • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent lumbar laminectomy other than lumbar laminectomy with dorsal rhizotomy for spasticity, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Shoulder Arthroplasty (W0137)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent shoulder arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent shoulder arthroplasty • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent shoulder arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Shoulder Hemiarthroplasty (W0138)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent shoulder hemiarthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent shoulder hemiarthroplasty • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For elective, non-emergent shoulder hemiarthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Orthopedics - Spine, Scoliosis, Posterior Instrumentation (W0116)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For posterior instrumentation, spine, scoliosis, see the following: o Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included the following note under both Operative Status Criteria and Goal Length of Stay (GLOS): o For posterior instrumentation, spine, scoliosis, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Pediatrics Return to Index	
Pediatrics - Diabetes, Pediatric (W0117)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Extended Stay: Added o Need to receive comprehensive patient, parent or caregiver education **and** comprehensive diabetic education programs are not available on an outpatient basis in the community. ▪ Expect minimal stay extension. ▪ **Note:** Obtain verbal or written attestation from provider regarding lack of outpatient diabetic education resources.
Pediatrics – EEG, Video Monitoring, Pediatric (W0122)	**Publish Date: October 31, 2018** September 13, 2018 MPTAC review: • Revised Clinical Indications for Procedure: o "CG-MED-46 Ambulatory Electroencephalography and Video Electroencephalography" to "CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring" **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric EEG video monitoring, see the following: o CG-MED-46 Ambulatory Electroencephalography and Video Electroencephalography
Pediatrics - Heart Transplant, Pediatric (W0123)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric heart transplant, see the following: o TRANS.00026 Heart/Lung Transplantation o TRANS.00033 Heart Transplantation
Pediatrics - Liver Transplant, Pediatric (W0124)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric liver transplant, see the following: o TRANS.00008 Liver Transplantation
Pediatrics - Lung Transplant, Pediatric (W0125)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric lung transplant, see the following: o TRANS.00009 Lung and Lobar Transplantation o TRANS.00026 Heart/Lung Transplantation
Pediatrics - Renal Transplant, Pediatric (W0126)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric renal transplant, see the following: o CG-TRANS-02 Kidney Transplantation
Thoracic Surgery and Pulmonary Disease Return to Index	
Thoracic Surgery and Pulmonary Disease - Deep Venous Thrombosis of Lower Extremities (W0135)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o For vena cava filter placement needed: ▪ Removed MCG clinical indications ▪ Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Extended Stay: o For recurrent thromboembolism: ▪ Removed "if patient is judged to be anticoagulation failure" for inferior vena caval procedure ▪ Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters
Thoracic Surgery and Pulmonary Disease - Lung Transplant (W0076)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For lung transplant, see the following; o TRANS.00009 Lung and Lobar Transplantation o TRANS.00026 Heart/Lung Transplantation
Thoracic Surgery and Pulmonary Disease - Pulmonary Embolism (W0134)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o For vena cava filter placement needed: ▪ Removed MCG clinical indications ▪ Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Extended Stay: o For recurrent thromboembolism: • Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters
Thoracic Surgery and Pulmonary Disease - Rib Fracture (W0101)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For the open treatment of rib fracture(s) using an internal fixation system, see SURG.00120 Internal Rib Fixation Systems
Urology Return to Index	

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Urology - Prostatectomy, Transurethral, Alternatives to Standard Resection (W0029)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For additional information on surgical and minimally invasive procedures for benign prostatic hyperplasia (BPH) considered medically necessary, not medically necessary, or investigational and not medically necessary, including water-induced thermotherapy (WIT), also known as thermourethral hot-water therapy, when used as an alternative to open prostatectomy or transurethral resection of the prostate (TURP) for the treatment of benign prostatic hyperplasia, see SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions.
Urology - Renal Transplant (W0027)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For renal transplant, see the following: o CG-TRANS-02 Kidney Transplantation

Return to Index

CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Body System GRG Return to Index	
Body System Behavioral Health GRG (BG-BHG)	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Reinstate with publication of Behavioral Health Module **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Continue to remove guideline for *Behavioral Health GRG*
Body System Cardiovascular Surgery or Procedure GRG (W0099)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For additional information on cardiovascular surgeries or procedures see the applicable clinical document. • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for when surgery or other procedures are indicated for (a) Transmyocardial or percutaneous laser revascularization, (b) Catheter-based valve repair or implantation (eg, prosthetic cardiac valve), (c) Vena cava filter placement, and (d) Ventricular assist device

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Body System General Surgery or Procedure GRG (W0142)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for a) Mastectomy appropriate in the context of female to male gender reassignment and b) Breast augmentation mastoplasty appropriate in context of male-to-female gender reassignment
Body System Musculoskeletal Surgery or Procedure GRG (W0118)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For additional information on musculoskeletal surgeries or procedures, see the applicable clinical document, including but not limited to the following: o SURG.00053 Unicondylar Interpositional Spacer o SURG.00105 Bicompartmental Knee Arthroplasty o SURG.00127 Sacroiliac Joint Fusion o Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Revised Clinical Indications for Procedure: o For medial or lateral unicompartmental knee arthroplasty: ▪ Added note: For elective, non-emergent medial or lateral unicompartmental knee arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines ▪ Removed MCG clinical indications for elective, non-emergent medial or lateral unicompartmental knee arthroplasty o For patellofemoral arthroplasty: ▪ Added note: For elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines ▪ Removed MCG clinical indications for elective, non-emergent patellofemoral arthroplasty o Removed MCG clinical indications for minimally invasive sacroiliac joint fusion • Included the following note under both Operative Status Criteria and Benchmark Length of Stay (BLOS): o For (a) elective, non-emergent medial or lateral unicompartmental knee arthroplasty and (b) elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Body System Neurosurgery or Procedure GRG (W0119)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For additional information on spinal surgeries or procedures, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Body System Obstetric and Gynecologic Surgery or Procedure GRG (W0143)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for oophorectomy (usually with hysterectomy and salpingectomy) appropriate in context of female-to-male gender reassignment

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Body System Urologic Surgery or Procedure GRG (W0141)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for a) Orchiectomy appropriate in context of male-to-female gender reassignment, b) Genital reconstructive surgery (eg, vaginoplasty, penectomy, labioplasty, clitoroplasty) appropriate in context of male-to-female gender reassignment and c) genital reconstructive surgery (eg, vaginectomy, metoidioplasty, scrotoplasty, phalloplasty, urethroplasty, placement of testicular prosthesis) appropriate in context of female-to-male gender reassignment
Care Management Tools Return to Index	
Care Management Behavioral Health Levels of Care (CMT-0006)	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Reinstate with publication of Behavioral Health Module **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Continue to remove guideline for *Behavioral Health Levels of Care*
Case Management GRG Return to Index	
Case Management Behavioral Health Case Management GRG (BG-BHG-CM)	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Reinstate with publication of Behavioral Health Module **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Continue to remove guideline for *Behavioral Health Case Management GRG*
General Recovery Guidelines Tools Section Return to Index	
General Recovery Guidelines Tools Section Inpatient Palliative Care Criteria (W0086)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Revised Alternatives to Admission o For Home hospice added the following:

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	▪ Outpatient: Continuous Home Care (CHC) ▪ Outpatient: Routine Home Care ▪ Patients who may benefit from hospice care ▪ Nursing care • Added reference for Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, Ch 9 Coverage of hospice services under hospital insurance
Problem Oriented GRG Return to Index	
Problem Oriented Medical Oncology GRG (W0074)	**Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For hematopoietic stem cell transplantation or transcatheter arterial chemoembolization, see the applicable clinical document. • Revised Clinical Indications for Admission to Inpatient Care: o Removed MCG clinical indications for when admission is indicated for (a) Transcatheter arterial chemoembolization (b) Allogeneic bone marrow or peripheral blood stem cell transplantation and (c) Autologous bone marrow or peripheral blood stem cell transplant • Included note under Clinical Indications for Admission to Inpatient Care: o For radioactive implant treatments needing inpatient environment, added note for inpatient admission for radiation therapy for cervical or thyroid cancer, see CG-MED-38 Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer

Return to Index

CUSTOMIZATIONS – RECOVERY FACILITY CARE GUIDELINES (RFC)

Recovery Guideline (RFC) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Subacute/Skilled Nursing Facility (SNF) Return to Index	
Behavioral Health • Anorexia Nervosa (M-5585) • Autism Spectrum Disorders (M-7075) • Bipolar Disorders (M-7080) • Delirium (M-5590) • Dementia • (M-7060) • Depressive Disorders • (M-7065) • Schizophrenia Spectrum Disorders • (M-7085) • Substance-Related Disorders (M-5595) • Substance-Related Disorders and	**Publish Date: June 22, 2018** MPTAC (03/22/2018); Third Party Criteria Subcommittee of the MPTAC (03/01/2018); Behavioral Health Subcommittee of the MPTAC (02/23/2018) review. • Reinstate with publication of Behavioral Health Module **Publish Date: May 7, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Continue to remove the MCG Behavioral Health related guidelines in the Recovery Care Facility Guidelines

Recovery Guideline (RFC) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Depression - Comorbidity Management (CMG-025-RF)	

Return to Index

CUSTOMIZATIONS – BEHAVIORAL HEATLH CARE GUIDELINES (BHG)

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Behavioral Health Level of Care Guidelines Return to Index	
BH Level of Care Guidelines Eating Disorders, Inpatient Behavioral Health Level of Care, Adult (W0144)	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Admission Guidelines: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
BH Level of Care Guidelines Eating Disorders, Inpatient Behavioral Health Level of Care Comparison Chart, Adult	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • For Eating Disorders, Inpatient Behavioral Health Level of Care, Adult BHG, revised Admission Guidelines: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
BH Level of Care Guidelines Eating Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
(W0145)	March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Admission Guidelines: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
BH Level of Care Guidelines Eating Disorders, Inpatient Behavioral Health Level of Care Comparison Chart, Child or Adolescent	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • For Eating Disorders, Inpatient Behavioral Health Level of Care, Child or Adolescent BHG, revised Admission Guidelines: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
BH Level of Care Guidelines Medication-Assisted Opioid Withdrawal (W0152)	**Publish Date: January 16, 2019** November 8, 2018 MPTAC review: • Approval of October 18, 2018 Third Party Criteria Subcommittee of the MPTAC review October 18, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Removed prior customization and reinstated original MCG guideline Clinical Indications. **Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Included note under Clinical Indications: For medication-assisted withdrawal treatment using buprenorphine and naltrexone, see the following: o CG-DRUG-21 Naltrexone (Vivitrol®) Injections for the Treatment of Alcohol and Opioid Dependence o CG-DRUG-89 Implantable and Extended Release Buprenorphine-containing Products • Removed MCG clinical indications for a) Office-based opioid treatment program with buprenorphine (weekly or monthly prescription) and b) Naltrexone for relapse prevention (using observed dosing by clinicians with experience in this method)
Care Guidelines for Behavioral Health Return to Index	

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Care Guidelines for BH Anorexia Nervosa, Adult: Inpatient Care (W0146)	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
Care Guidelines for BH Anorexia Nervosa, Child or Adolescent: Inpatient Care (W0147)	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
Care Guidelines for BH Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating Disorders, Adult: Inpatient Care (W0148)	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
Care Guidelines for BH Bulimia Nervosa, Binge-Eating Disorder, and Other Specified Feeding or Eating	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review:

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Disorders, Child or Adolescent: Inpatient Care (W0149)	• Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care:: o Changed "Severe low weight indicated by BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex" to "Severe low weight indicated by BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex" o Changed "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 14 or weight less than 75% of expected body weight for height, age, and sex) will be reached imminently." to "Documented weight-loss rate indicating severe low-weight threshold (BMI less than 16 or weight less than 85% of expected body weight for height, age, and sex) will be reached imminently."
Testing Procedures Return to Index	
Testing Procedures Urine Toxicology Testing (W0150)	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For urine toxicology testing, see the following: o CG-LAB-09 Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain
Therapeutic Services Return to Index	
Therapeutic Services Applied Behavioral Analysis (W0153)	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For applied behavioral analysis (ABA), see the following: o CG-BEH-02 Adaptive Behavioral Treatment for Autism Spectrum Disorder
Therapeutic Services Transcranial Magnetic Stimulation (W0151)	**Publish Date: June 22, 2018** March 22, 2018 MPTAC review: • Approval of March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review March 1, 2018 Third Party Criteria Subcommittee of the MPTAC review: • Approval of February 23, 2018 Behavioral Health Subcommittee of the MPTAC review February 23, 2018 Behavioral Health Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For Transcranial Magnetic Stimulation, see the following: o BEH.00002 Transcranial Magnetic Stimulation

Return to Index

CUSTOMIZATION HISTORY

Date	Action	Reason
01/16/2019	Release document for Customizations to MCG Care Guidelines 22nd Edition	Updated document for Customizations to MCG Care Guidelines 22nd Edition based on January 16, 2019 Publish Date.
10/31/2018	Release document for Customizations to MCG Care Guidelines 22nd Edition	Updated document for Customizations to MCG Care Guidelines 22nd Edition based on October 31, 2018 Publish Date.
05/25/2018	Release document for Customizations to MCG Care Guidelines 22nd Edition	Updated the NOTE section with information regarding the MCG products licensed. Publish Date: June 22, 2018 for MCG care guidelines 22nd edition and corresponding customized or updated guidelines for ISC, GRG, RFC, CC and the addition of BHG.
03/26/2018	Release document for Customizations to MCG Care Guidelines 22nd Edition	New document for Customizations to MCG Care Guidelines 22nd Edition. Publish Date: May 7, 2018 for MCG care guidelines 22nd edition and corresponding customized guidelines for ISC, GRG, RFC and CC.

Return to Index