For the BLUECHOICE HEALTHPLAN OF SOUTH CAROLINA Managed Medicaid Program

AMERIGROUP PARTNERSHIP PLAN, LLC.

CUSTOMIZATION TO mcg CARE GUIDELINES 23rd EDITION

Issue Date:	**Original Date**:
June 7, 2019	**March 22, 2019**

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 23rd 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.***
- ***Issue Date: March 22, 2019 / Publish Date: June 24, 2019 for MCG care guidelines 23rd edition and corresponding customized guidelines for ISC, GRG, RFC, CCG and BHG.***
- ***The June 7, 2019 Issue Date reflects review and approval of the following new customization to MCG care guidelines 23rd edition based on November 1, 2019 Publish Date:***
  - ***ISC Chemotherapy (W0162)***

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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.

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Cardiology - Atrial Fibrillation (W0114)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For electrophysiologic study and insertion of implantable cardioverter-defibrillator, see the following: o CG-SURG-97 Cardioverter Defibrillators o CG-SURG-63 Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure
Cardiology - Electrophysiologic Study and Intracardiac Catheter Ablation (W0012)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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)
Cardiology - Left Atrial Appendage Closure, Percutaneous (W0157)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For percutaneous left atrial appendage closure, see the following: o SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
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CV Surgery - Abdominal Aortic Aneurysm,	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Endovascular Repair (W0084)	• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For abdominal aortic aneurysm, endovascular repair, see the following: o CG-SURG-86 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection
CV Surgery - Aortic Valve Replacement, Transcatheter (W0133)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For transcatheter closure of patent foramen ovale (PFO), see SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
CV Surgery - Cardiac Septal Defect: Ventricular, Repair (W0093)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
CV Surgery - Sympathectomy by Thoracoscopy or Laparoscopy (W0044)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 MCG clinical indication for hyperhidrosis
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Common Complications and Conditions Preoperative Days (W0130)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 Venous Thrombosis and Pulmonary Embolism (W0136)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Clinical Indications for Inpatient Care: o Removed MCG clinical indications for vena cava filter placement
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General Surgery - Fundoplasty, Esophagogastric, by Laparoscopy (W0158)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair
General Surgery - Gastric Restrictive Procedure with Gastric Bypass Title change to: Gastric Restrictive Procedure with or without Gastric Bypass (W0054)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 CG-SURG-83 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	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Procedure with Gastric Bypass by Laparoscopy (W0014)	• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 CG-SURG-83 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
General Surgery - Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy (W0102)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
General Surgery - Hiatal Hernia Repair, Abdominal (W0159)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair
General Surgery - Hiatal Hernia Repair, Transthoracic (W0160)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair
General Surgery - Liver Transplant (W0034)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• 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 (W0022)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible • 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible • 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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
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Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Hematology - Oncology - Chemotherapy (W0162)	**Publish Date: November 1, 2019** June 6, 2019 MPTAC review: • Approval of May 13, 2019 Third Party Criteria Subcommittee of the MPTAC review May 13, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Admission: o Added examples for: ▪ Aggressive hydration needs that cannot be managed in an infusion center ▪ Prolonged marrow suppression o Added Regimens that cannot be managed as an outpatient with examples o Added references o Added footnotes
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Neonatology – Newborn Care, Routine (W0087)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Neonatology – Newborn Care, Term, with Severe Illness or Abnormality (W0106)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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
Neonatology – Sepsis, Neonatal, Suspected, Not Confirmed (W0108)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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
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Neurology – EEG, Video Monitoring (W0115)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For EEG video monitoring, see the following: o CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring
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OB / GYN - Cesarean Delivery (W0045)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding:

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	▪ 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) ▪ "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 • 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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:

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	• 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) ▪ "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 • 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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

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	• 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) ▪ "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 • 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included the following notes under Clinical Indications for Procedure: o For laparoscopic surgical ablation of uterine fibroids, see SURG.00077 Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques o For the evaluation of infertility, see CG-SURG-34 Diagnostic Infertility Surgery • Revised Clinical Indications for Procedure: o "Prophylactic bilateral 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:

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	▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (eg, 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 MCG indications for infertility evaluation or treatment
OB / GYN - Laparotomy, for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0025)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o "Prophylactic bilateral 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 (eg, 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
OB / GYN - Vaginal Delivery (W0047)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for when induction of labor is appropriate o Added clinical indications for elective induction of labor o 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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
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Orthopedics - Acromioplasty and Rotator Cuff Repair (W0139)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For acromioplasty and rotator cuff repair, see the following: o Musculoskeletal Program Clinical Guidelines Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review

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	March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indication for osteochondral lesions • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent anterior cervical fusion • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent posterior cervical fusion • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent cervical laminectomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent cervical laminectomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Hip Arthroplasty	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review:

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(W0105)	• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: o Included note under Clinical Indications for Procedure: For computer-assisted musculoskeletal surgical navigational procedures, see SURG.00082 Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent hip arthroplasty not due to developmental dysplasia of hip • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • 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 note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For hip resurfacing, see the following: o CG-SURG-85 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For (a) bicompartmental knee arthroplasty and (b) computer-assisted musculoskeletal surgical navigational procedures, see the applicable clinical document • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent total knee arthroplasty not due to congenital deformity • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For knee arthroscopy, see the following: o Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

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	• Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For knee arthroscopy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Knee Arthrotomy (W0140)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications except for debridement, drainage, or lavage for osteomyelitis or infected joint • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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
Orthopedics - Lumbar Diskectomy, Foraminotomy, or Laminotomy (W0091)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed: MCG clinical indications for elective, non-emergent lumbar diskectomy, foraminotomy, or laminotomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent lumbar fusion • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Lumbar Laminectomy (W0100)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent lumbar laminectomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar laminectomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines

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Orthopedics - Shoulder Arthroplasty (W0137)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent shoulder arthroplasty • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective, non-emergent shoulder hemiarthroplasty • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent shoulder hemiarthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Orthopedics - Spine, Scoliosis, Posterior Instrumentation (W0116)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 note under both Operative Status Criteria and Goal Length of Stay (GLOS): For posterior instrumentation, spine, scoliosis, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
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Pediatrics - Diabetes, Pediatric (W0117)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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 Electroencephalography and Video Electroencephalographic Monitoring
Pediatrics – Fundoplasty, Esophagogastric, by Laparoscopy, Pediatric	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:

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(W0161)	• Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair
Pediatrics - Heart Transplant, Pediatric (W0123)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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
Pediatrics - Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For pediatric posterior instrumentation, spine, scoliosis, see the following: o Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines • Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For pediatric posterior instrumentation, spine, scoliosis, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines
Thoracic Surgery and Pulmonary Disease Return to Index	
Thoracic Surgery and Pulmonary Disease - Deep Venous Thrombosis of Lower Extremities (W0135)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Clinical Indications for Admission to Inpatient Care: o Removed MCG clinical indications for vena cava filter placement

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Thoracic Surgery and Pulmonary Disease - Lung Transplant (W0076)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Clinical Indications for Admission to Inpatient Care: o Removed MCG clinical indications for vena cava filter placement
Urology Return to Index	
Urology - Prostatectomy, Transurethral, Alternatives to Standard Resection (W0029)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For alternatives to standard transurethral prostatectomy resection, see the following: o SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
Urology - Renal Transplant (W0027)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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

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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 Cardiovascular Surgery or Procedure GRG (W0099)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	implantation (eg, prosthetic cardiac valve), (c) Vena cava filter placement, and (d) Ventricular assist device
Body System General Surgery or Procedure GRG (W0142)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Procedure: For (a) ankle arthroplasty, (b) bicompartmental knee arthroplasty, and (c) sacroiliac joint fusion, see the applicable clinical document • 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: ▪ ankle arthroplasty ▪ 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 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
General Recovery Guidelines Tools Section Return to Index	
General Recovery Guidelines Tools Section Inpatient Palliative Care Criteria (W0086)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Alternatives to Admission o For Home hospice added the following: ▪ Outpatient: Continuous Home Care (CHC) ▪ Outpatient: Routine Home Care ▪ Patients who may benefit from hospice care ▪ Nursing care • Added reference
Problem Oriented GRG Return to Index	
Problem Oriented Medical Oncology GRG (W0074)	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Included note under Clinical Indications for Admission to Inpatient Care: For (a) chimeric antigen receptor (CAR) T-cell therapy, (b) transcatheter arterial chemoembolization, (c) high-dose radioactive iodine or radioactive implant treatments needing inpatient admission, and (d) hematopoietic stem cell transplantation, see the applicable clinical document • Revised Clinical Indications for Admission to Inpatient Care: o Removed MCG clinical indications for allogeneic and autologous hematopoietic stem cell transplant

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CUSTOMIZATIONS – BEHAVIORAL HEATLH CARE GUIDELINES (BHG)

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Testing Procedures Return to Index	
Testing Procedures Urine Toxicology Testing	**Publish Date: June 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
(W0150)	March 4, 2019 Third Party Criteria 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 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria 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 24, 2019** March 21, 2019 MPTAC review: • Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review: • Revised Clinical Indications for Procedure: For Transcranial Magnetic Stimulation, see the following: o BEH.00002 Transcranial Magnetic Stimulation

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CUSTOMIZATION HISTORY

Date	Action	Reason
06/07/2019	Release document for Customizations to MCG Care Guidelines 23rd Edition	Updated document for Customizations to MCG Care Guidelines 23rd Edition based on November 1, 2019 Publish Date.
03/22/2019	Release document for Customizations to MCG Care Guidelines 23rd Edition	New document for Customizations to MCG Care Guidelines 23rd Edition. Publish Date: June 24, 2019 for MCG care guidelines 23rd edition and corresponding customized guidelines for ISC, GRG, RFC, CCG and BHG.

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