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## CUSTOMIZATION TO CARE GUIDELINES 23rd EDITION

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**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.*
- *Publish Date: June 24, 2019 for MCG care guidelines 23rd edition and corresponding customized guidelines for ISC, GRG, RFC, CCG and BHG.*

**INDEX** (CTRL + Click to follow link)

### CUSTOMIZATIONS - BACKGROUND INFORMATION

### CUSTOMIZATIONS - INPATIENT & SURGICAL CARE (ISC) GUIDELINES

- **CARDIOLOGY**
  - Angioplasty, Percutaneous Coronary Intervention (W0120)
  - Atrial Fibrillation (W0114)

- Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion (W0011)
- Electrophysiologic Study and Intracardiac Catheter Ablation (W0012)
- Left Atrial Appendage Closure, Percutaneous (W0157)
- **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**
  - Preoperative Days (W0130)
  - Venous Thrombosis and Pulmonary Embolism: (W0136)
- **GENERAL SURGERY**
  - Fundoplasty, Esophagogastric, by Laparoscopy (W0158)
  - 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)
  - Hiatal Hernia Repair, Abdominal (W0159)
  - Hiatal Hernia Repair, Transthoracic (W0160)
  - 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**
  - 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 Discectomy or Microdiscectomy, 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 Discectomy, 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)
  - Fundoplasty, Esophagogastric, by Laparoscopy, Pediatric (W0161)
  - Heart Transplant, Pediatric (W0123)
  - Liver Transplant, Pediatric (W0124)
  - Lung Transplant, Pediatric (W0125)
  - Renal Transplant, Pediatric (W0126)
  - Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156)
- **THORACIC SURGERY AND PULMONARY DISEASE**
  - Deep Venous Thrombosis of Lower Extremities (W0135)
  - Lung Transplant (W0076)
  - Pulmonary Embolism (W0134)
- **UROLOGY**
  - Prostatectomy, Transurethral, Alternatives to Standard Resection (W0029)
  - Renal Transplant (W0027)

#### **CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)**

- **BODY SYSTEM GRG**
  - 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)
- **GENERAL RECOVERY GUIDELINES TOOLS SECTION**
  - Inpatient Palliative Care Criteria (W0086)
- **PROBLEM ORIENTED GRG**
  - Medical Oncology GRG (W0074)

#### **CUSTOMIZATIONS – BEHAVIORAL HEALTH CARE (BHG) GUIDELINES**

- **TESTING PROCEDURES**
  - Urine Toxicology Testing (W0150)
- **THERAPEUTIC SERVICES**
  - Applied Behavioral Analysis (W0153)
  - Transcranial Magnetic Stimulation (W0151)

#### **CUSTOMIZATION HISTORY**

## Subject: Customizations to Care Guidelines 23rd Edition

[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
<b>Cardiology</b> <a href="#">Return to Index</a>	
<b>Cardiology -</b> Angioplasty, Percutaneous Coronary Intervention (W0120)	<b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u> <ul style="list-style-type: none"><li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li></ul> <u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u> <ul style="list-style-type: none"><li>• Included note under Clinical Indications for Procedure: For elective, non-emergent percutaneous coronary intervention, see Cardiology Program Clinical Guidelines</li><li>• Revised Clinical Indications for Procedure:<ul style="list-style-type: none"><li>○ Removed MCG clinical indications for elective PCI</li></ul></li></ul>
<b>Cardiology -</b> Atrial Fibrillation	<b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u>

**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
(W0114)	<ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>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)</li> </ul>
Cardiology - Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion (W0011)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For electrophysiologic study and insertion of implantable cardioverter-defibrillator, see the following:               <ul style="list-style-type: none"> <li>CG-SURG-97 Cardioverter Defibrillators</li> <li>CG-SURG-63 Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure</li> </ul> </li> </ul>
Cardiology - Electrophysiologic Study and Intracardiac Catheter Ablation (W0012)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>For electrophysiologic study and intracardiac catheter ablation, see the following:                   <ul style="list-style-type: none"> <li>CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation</li> </ul> </li> <li>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:                   <ul style="list-style-type: none"> <li>CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)</li> </ul> </li> </ul> </li> </ul>
Cardiology - Left Atrial Appendage Closure, Percutaneous (W0157)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For percutaneous left atrial appendage closure, see the following:               <ul style="list-style-type: none"> <li>SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention</li> </ul> </li> </ul>
<p><b>Cardiovascular Surgery</b> <a href="#">Return to Index</a></p>	
CV Surgery - Abdominal Aortic Aneurysm, Endovascular Repair (W0084)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For abdominal aortic aneurysm, endovascular repair, see the following:               <ul style="list-style-type: none"> <li>CG-SURG-86 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection</li> </ul> </li> </ul>
CV Surgery - Aortic Valve Replacement, Transcatheter (W0133)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For transcatheter aortic valve replacement, see the following:</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	<ul style="list-style-type: none"> <li>o SURG.00121 Transcatheter Heart Valve Procedures</li> </ul>
<b>CV Surgery - Cardiac Septal Defect: Atrial, Transcatheter Closure (W0016)</b>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> </ul>
<b>CV Surgery - Cardiac Septal Defect: Ventricular, Repair (W0093)</b>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> </ul>
<b>CV Surgery - Cardiac Valve Replacement or Repair (W0089)</b>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> </ul>
<b>CV Surgery - Heart Transplant (W0017)</b>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For heart transplant, see the following:               <ul style="list-style-type: none"> <li>o TRANS.00026 Heart/Lung Transplantation</li> <li>o TRANS.00033 Heart Transplantation</li> </ul> </li> </ul>
<b>CV Surgery - Percutaneous Revascularization, Lower Extremity (W0121)</b>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For percutaneous revascularization, lower extremity, see the following:               <ul style="list-style-type: none"> <li>o CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities</li> </ul> </li> </ul>
<b>CV Surgery - Sympathectomy by Thoracoscopy or Laparoscopy (W0044)</b>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For treatment of hyperhidrosis, see CG-MED-63 Treatment of Hyperhidrosis</li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>o Removed MCG clinical indication for hyperhidrosis</li> </ul> </li> </ul>
<b>Common Complications and Conditions</b> <a href="#">Return to Index</a>	
<b>Common Complications and Conditions</b>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul>



**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</b>
Preoperative Days (W0130)	<p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Revised Clinical Indications for Inpatient Care:                             <ul style="list-style-type: none"> <li>○ 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</li> </ul> </li> <li>• Added reference</li> </ul>
<b>Common Complications and Conditions</b> Venous Thrombosis and Pulmonary Embolism (W0136)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters</li> <li>• Revised Clinical Indications for Inpatient Care:                             <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for vena cava filter placement</li> </ul> </li> </ul>
<b>General Surgery</b> <a href="#">Return to Index</a>	
<b>General Surgery -</b> Fundoplasty, Esophagogastric, by Laparoscopy (W0158)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair</li> </ul>
<b>General Surgery -</b> Gastric Restrictive Procedure with Gastric Bypass  Title change to: Gastric Restrictive Procedure with or without Gastric Bypass (W0054)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Title changed from Gastric Restrictive Procedure with Gastric Bypass to indicate Gastric Restrictive Procedure with or without Gastric Bypass</li> <li>• Revised Clinical Indications for Procedure: For gastric restrictive procedure with or without gastric bypass, see the following:                             <ul style="list-style-type: none"> <li>○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity</li> </ul> </li> <li>• Updated Coding section with the following:                             <ul style="list-style-type: none"> <li>○ Added ICD-10 Procedure codes: 0D190ZB, 0DB60Z3, 0DV60CZ, 0DW60CZ</li> <li>○ Added CPT® codes: 43842, 43843, 43845, 43848</li> </ul> </li> </ul>
<b>General Surgery -</b> Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy (W0014)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For gastric restrictive procedure with gastric bypass by laparoscopy, see the following:                             <ul style="list-style-type: none"> <li>○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity</li> </ul> </li> <li>• Updated Coding section with the following:                             <ul style="list-style-type: none"> <li>○ Added ICD-10 Procedure codes: 0D164Z9, 0DB64ZZ</li> </ul> </li> </ul>
<b>General Surgery -</b> Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy (W0033)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p>

**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC)</b> <b>Customizations</b>
	<ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For gastric restrictive procedure without gastric bypass by laparoscopy, see the following:               <ul style="list-style-type: none"> <li>○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity</li> </ul> </li> </ul>
<b>General Surgery - Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy (W0102)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For gastric restrictive procedure, sleeve gastrectomy, by laparoscopy, see the following:               <ul style="list-style-type: none"> <li>○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity</li> </ul> </li> </ul>
<b>General Surgery - Hiatal Hernia Repair, Abdominal (W0159)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair</li> </ul>
<b>General Surgery - Hiatal Hernia Repair, Transthoracic (W0160)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair</li> </ul>
<b>General Surgery - Liver Transplant (W0034)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For liver transplant, see the following:               <ul style="list-style-type: none"> <li>○ TRANS.00008 Liver Transplantation</li> </ul> </li> </ul>
<b>General Surgery - Mastectomy, Complete (W0002)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications:                   <ul style="list-style-type: none"> <li>▪ Personal history of breast cancer</li> <li>▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia)</li> <li>▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible</li> </ul> </li> </ul> </li> <li>• 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</li> <li>• Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory</li> <li>• Under the Goal Length of Stay (GLOS) section added:               <ul style="list-style-type: none"> <li>○ Reason: Organization approved 2 day stay</li> <li>○ Context: Organization accepted variance of 2 days</li> </ul> </li> <li>• Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory</li> <li>• Added references</li> </ul>
<b>General Surgery - Mastectomy, Complete, with Insertion of Breast</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p>



**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</b>
Prosthesis or Tissue Expander (W0022)	<ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:                             <ul style="list-style-type: none"> <li>○ For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications:                                     <ul style="list-style-type: none"> <li>▪ Personal history of breast cancer</li> <li>▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia)</li> <li>▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible</li> </ul> </li> </ul> </li> <li>• 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</li> <li>• Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory or 1 day postoperative</li> <li>• Under the Goal Length of Stay (GLOS) section added:                             <ul style="list-style-type: none"> <li>○ Reason: Organization approved 2 day stay</li> <li>○ Context: Organization accepted variance of 2 days</li> </ul> </li> <li>• Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory or Inpatient</li> <li>• Added references</li> </ul>
<b>General Surgery - Mastectomy, Complete, with Tissue Flap Reconstruction (W0023)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:                             <ul style="list-style-type: none"> <li>○ For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications:                                     <ul style="list-style-type: none"> <li>▪ Personal history of breast cancer</li> <li>▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia)</li> <li>▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible</li> </ul> </li> </ul> </li> <li>• 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</li> <li>• Added references</li> </ul>
<b>General Surgery - Mastectomy, Partial (Lumpectomy) (W0008)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory</li> <li>• Under the Goal Length of Stay (GLOS) section added:                             <ul style="list-style-type: none"> <li>○ Reason: Organization approved 2 day stay</li> <li>○ Context: Organization accepted variance of 2 days</li> </ul> </li> <li>• Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory</li> </ul>
<p><b>Neonatal Facility Levels and Admission Guidelines</b>  <a href="#">Return to Index</a></p>	
<b>Neonatal Facility Levels and Admission Guidelines – Neonatal Facility Levels of Care Guidelines</b> <ul style="list-style-type: none"> <li>• Neonatal Facility, Level I</li> <li>• Neonatal Facility, Level II</li> <li>• Neonatal Facility, Level III</li> <li>• Neonatal Facility, Level IV</li> </ul>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Removed the MCG Neonatal Facility Levels and Admission Guidelines in the 23rd edition</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</b>
<p><u>Neonatal Care Admission Guidelines</u></p> <ul style="list-style-type: none"> <li>• Neonatal Admission Levels Comparison Chart</li> <li>• Neonatal Care, Routine Care, Level 1</li> <li>• Neonatal Care, Continuing Care, Level 2</li> <li>• Neonatal Care, Intermediate Care, Level 3</li> <li>• Neonatal Care, Intensive Care, Level 4</li> </ul>	
<p><b>Neonatology</b>  <a href="#">Return to Index</a></p>	
<p><b>Neonatology – Newborn Care, Routine (W0087)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> </ul>
<p><b>Neonatology – Newborn Care, Term, with Severe Illness or Abnormality (W0106)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Admission to Inpatient Care: For newborn care, term, with severe illness or abnormality, see the following: <ul style="list-style-type: none"> <li>○ CG-MED-26 Neonatal Levels of Care</li> </ul> </li> </ul>
<p><b>Neonatology – Sepsis, Neonatal, Confirmed (W0107)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, confirmed, see the following: <ul style="list-style-type: none"> <li>○ CG-MED-26 Neonatal Levels of Care</li> </ul> </li> </ul>
<p><b>Neonatology – Sepsis, Neonatal, Suspected, Not Confirmed (W0108)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, suspected, not confirmed, see the following: <ul style="list-style-type: none"> <li>○ CG-MED-26 Neonatal Levels of Care</li> </ul> </li> </ul>
<p><b>Neurology</b>  <a href="#">Return to Index</a></p>	
<p><b>Neurology –</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b></p>

**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
EEG, Video Monitoring (W0115)	<p><u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For EEG video monitoring, see the following:               <ul style="list-style-type: none"> <li>CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring</li> </ul> </li> </ul>
<p><b>Obstetrics and Gynecology (OB / GYN)</b> <a href="#">Return to Index</a></p>	
<p><b>OB / GYN -</b> Cesarean Delivery (W0045)</p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>Retained MCG clinical indications for emergency cesarean delivery</li> <li>Added clinical indications for early elective cesarean delivery</li> <li>Revised MCG clinical indications for elective cesarean delivery</li> </ul> </li> <li>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</li> <li>Added references</li> <li>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</li> </ul>
<p><b>OB / GYN -</b> Hysterectomy, Abdominal (W0109)</p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>For abnormal uterine bleeding:                   <ul style="list-style-type: none"> <li>Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless <b>1 or more</b> of the following conditions exist:                       <ul style="list-style-type: none"> <li>Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition</li> <li>Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated</li> <li>Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition</li> </ul> </li> <li>Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of <b>1 or more</b> of the following:                       <ul style="list-style-type: none"> <li>It is contraindicated</li> <li>It was tried but did not adequately treat patient's condition</li> <li>It is not appropriate for severity of patient's condition (eg, severe persistent bleeding)</li> </ul> </li> <li>"Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of <b>1 or more</b> of the following:                       <ul style="list-style-type: none"> <li>For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable</li> </ul> </li> <li>For endometrial ablation, removed indications,                       <ul style="list-style-type: none"> <li>Procedure not appropriate for severity of patient's condition</li> <li>Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation)</li> </ul> </li> <li>Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references</li> </ul> </li> <li>For leiomyoma ("fibroid"):                   <ul style="list-style-type: none"> <li>"Investigation (eg, endometrial sampling) has ruled out other causes for symptoms" changed to "Investigation has ruled out other causes for symptoms"</li> <li>"Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of <b>1 or more</b> of the following:" changed to: "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal</li> </ul> </li> </ul> </li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

<p><b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b></p>	<p><b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</b></p>
	<p>therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of <b>1 or more</b> of the following reasons:"</p> <ul style="list-style-type: none"> <li>○ For pelvic organ prolapse: <ul style="list-style-type: none"> <li>▪ "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of <b>1 or more</b> 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 <b>1 or more</b> of the following reasons:"</li> </ul> </li> <li>• Added indication for when abdominal hysterectomy is considered not medically necessary: <ul style="list-style-type: none"> <li>○ <b>Abdominal hysterectomy</b> is considered <b>not medically necessary</b> 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: <ul style="list-style-type: none"> <li>▪ To improve detection of adnexal masses, or</li> <li>▪ To prevent impairment of renal function, or</li> <li>▪ To rule out malignancy</li> </ul> </li> </ul> </li> <li>• Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: <ul style="list-style-type: none"> <li>○ Oral tranexamic acid is Contraindicated or not tolerated, <b>or</b></li> <li>○ Oral tranexamic acid is not appropriate for the severity of patient's condition, <b>or</b></li> <li>○ The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable</li> </ul> </li> </ul>
<p><b>OB / GYN - Hysterectomy, Laparoscopic</b></p> <p><u>Title change to:</u> Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted (W0010)</p>	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Title changed from Hysterectomy, Laparoscopic to indicate Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted</li> <li>• Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> <li>○ For abnormal uterine bleeding: <ul style="list-style-type: none"> <li>▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless <b>1 or more</b> of the following conditions exist: <ul style="list-style-type: none"> <li>• Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition</li> <li>• Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated</li> <li>• Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition</li> </ul> </li> <li>▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of <b>1 or more</b> of the following: <ul style="list-style-type: none"> <li>• It is contraindicated</li> <li>• It was tried but did not adequately treat patient's condition</li> <li>• It is not appropriate for severity of patient's condition (eg, severe persistent bleeding)</li> </ul> </li> <li>▪ "Uterine-sparing procedure (eg, endometrial ablation)" changed to "Endometrial ablation" cannot be used because of <b>1 or more</b> of the following: <ul style="list-style-type: none"> <li>• For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable</li> <li>• For endometrial ablation, removed indications, <ul style="list-style-type: none"> <li>• Procedure not appropriate for severity of patient's condition</li> <li>• Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation)</li> </ul> </li> </ul> </li> <li>▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references</li> </ul> </li> <li>○ For leiomyoma ("fibroid"): <ul style="list-style-type: none"> <li>▪ "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms" changed to "Investigation has ruled out other causes for symptoms"</li> <li>▪ "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of <b>1 or more</b> 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 <b>1 or more</b> of the following reasons:"</li> </ul> </li> </ul> </li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC)</b> <b>Customizations</b>
	<ul style="list-style-type: none"> <li>○ For pelvic organ prolapse:               <ul style="list-style-type: none"> <li>▪ “Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of <b>1 or more</b> 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 <b>1 or more</b> of the following reasons:”</li> </ul> </li> <li>• Added indication for when laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy is considered not medically necessary:               <ul style="list-style-type: none"> <li>○ <b>Laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy</b> is considered <b>not medically necessary</b> 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:                   <ul style="list-style-type: none"> <li>▪ To improve detection of adnexal masses, or</li> <li>▪ To prevent impairment of renal function, or</li> <li>▪ To rule out malignancy</li> </ul> </li> </ul> </li> <li>• Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless:               <ul style="list-style-type: none"> <li>○ Oral tranexamic acid is Contraindicated or not tolerated, <b>or</b></li> <li>○ Oral tranexamic acid is not appropriate for the severity of patient's condition, <b>or</b></li> <li>○ The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable</li> </ul> </li> </ul>
<b>OB / GYN - Hysterectomy, Vaginal (W0110)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <b><u>March 21, 2019 MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><b><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></b></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ For abnormal uterine bleeding:                   <ul style="list-style-type: none"> <li>▪ Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless <b>1 or more</b> of the following conditions exist:                       <ul style="list-style-type: none"> <li>• Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition</li> <li>• Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated</li> <li>• Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition</li> </ul> </li> <li>▪ Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of <b>1 or more</b> of the following:                       <ul style="list-style-type: none"> <li>• It is contraindicated</li> <li>• It was tried but did not adequately treat patient's condition</li> <li>• It is not appropriate for severity of patient's condition (eg, severe persistent bleeding)</li> </ul> </li> <li>▪ “Uterine-sparing procedure (eg, endometrial ablation)” changed to “Endometrial ablation” cannot be used because of <b>1 or more</b> of the following:                       <ul style="list-style-type: none"> <li>• For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable</li> </ul> </li> <li>▪ For endometrial ablation, removed indications,                       <ul style="list-style-type: none"> <li>• Procedure not appropriate for severity of patient's condition</li> <li>• Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation)</li> </ul> </li> <li>▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references</li> </ul> </li> <li>○ For leiomyoma (“fibroid”):                   <ul style="list-style-type: none"> <li>▪ “Investigation (eg, endometrial sampling) has ruled out other causes for symptoms” changed to “Investigation has ruled out other causes for symptoms”</li> <li>▪ “Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of <b>1 or more</b> 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 <b>1 or more</b> of the following reasons:”</li> </ul> </li> <li>○ For pelvic organ prolapse:</li> </ul> </li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	<ul style="list-style-type: none"> <li>▪ “Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of <b>1 or more</b> 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 <b>1 or more</b> of the following reasons:”</li> <li>• Added indication for when vaginal hysterectomy is considered not medically necessary:               <ul style="list-style-type: none"> <li>○ <b>Vaginal hysterectomy</b> is considered <b>not medically necessary</b> 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:                   <ul style="list-style-type: none"> <li>▪ To improve detection of adnexal masses, or</li> <li>▪ To prevent impairment of renal function, or</li> <li>▪ To rule out malignancy</li> </ul> </li> </ul> </li> <li>• Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless:               <ul style="list-style-type: none"> <li>○ Oral tranexamic acid is Contraindicated or not tolerated, <b>or</b></li> <li>○ Oral tranexamic acid is not appropriate for the severity of patient’s condition, <b>or</b></li> <li>○ The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable</li> </ul> </li> </ul>
<p><b>OB / GYN -</b> Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0026)</p>	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included the following notes under Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ For laparoscopic surgical ablation of uterine fibroids, see SURG.00077 Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques</li> <li>○ For the evaluation of infertility, see CG-SURG-34 Diagnostic Infertility Surgery</li> </ul> </li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ "Prophylactic bilateral salpingo-oophorectomy" changed to "Risk-reducing salpingo-oophorectomy"</li> <li>○ For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "Bilateral oophorectomy" changed to "Risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy"</li> <li>○ Additional indication listed for oophorectomy:                   <ul style="list-style-type: none"> <li>▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (eg, mother, sister, daughter) <b>or</b> one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer</li> </ul> </li> <li>○ Removed MCG indications for infertility evaluation or treatment</li> </ul> </li> </ul>
<p><b>OB / GYN -</b> Laparotomy, for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0025)</p>	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ "Prophylactic bilateral salpingo-oophorectomy" changed to "Risk-reducing salpingo-oophorectomy"</li> <li>○ For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "Bilateral oophorectomy" changed to "Risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy"</li> <li>○ Additional indication listed for oophorectomy:                   <ul style="list-style-type: none"> <li>▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (eg, mother, sister, daughter) <b>or</b> one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer</li> </ul> </li> </ul> </li> </ul>
<p><b>OB / GYN -</b> Vaginal Delivery (W0047)</p>	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for when induction of labor is appropriate</li> </ul> </li> </ul>



**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC)</b> <b>Customizations</b>
	<ul style="list-style-type: none"> <li>o Added clinical indications for elective induction of labor</li> <li>o Added clinical indications for early elective induction of labor</li> <li>• 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</li> <li>• Added references</li> <li>• 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</li> </ul>
<b>OB/GYN - Vaginal Delivery, Operative (W0048)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For early elective vaginal delivery, see W0047 Vaginal Delivery</li> <li>• 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</li> </ul>
<b>Orthopedics</b> <a href="#">Return to Index</a>	
<b>Orthopedics - Acromioplasty and Rotator Cuff Repair (W0139)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For acromioplasty and rotator cuff repair, see the following: <ul style="list-style-type: none"> <li>o Musculoskeletal Program Clinical Guidelines Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> </ul> </li> <li>• 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</li> </ul>
<b>Orthopedics - Ankle Arthroscopy (W0155)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> <li>o Removed MCG clinical indication for osteochondral lesions</li> </ul> </li> <li>• 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</li> </ul>
<b>Orthopedics - Cervical Discectomy or Microdiscectomy, Foraminotomy, Laminotomy (W0071)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> <li>o Removed MCG clinical indications for elective, non-emergent cervical discectomy or microdiscectomy, foraminotomy, laminotomy</li> </ul> </li> <li>• Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent cervical discectomy or microdiscectomy, foraminotomy, laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> </ul>
<b>Orthopedics - Cervical Fusion, Anterior</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</b>
(W0111)	<p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent anterior cervical fusion</li> </ul> </li> <li>• 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</li> </ul>
<b>Orthopedics - Cervical Fusion, Posterior (W0112)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent posterior cervical fusion</li> </ul> </li> <li>• 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</li> </ul>
<b>Orthopedics - Cervical Laminectomy (W0097)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent cervical laminectomy</li> </ul> </li> <li>• 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</li> </ul>
<b>Orthopedics - Hip Arthroplasty (W0105)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>○ 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</li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent hip arthroplasty not due to developmental dysplasia of hip</li> </ul> </li> <li>• 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</li> </ul>
<b>Orthopedics - Hip Arthroscopy (W0096)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications except for (a) fracture amenable to arthroscopic repair and (b) debridement and lavage of septic hip</li> </ul> </li> <li>• 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</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>Inpatient &amp; Surgical Care (ISC)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</b>
<b>Orthopedics - Hip Resurfacing (W0098)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For hip resurfacing, see the following:               <ul style="list-style-type: none"> <li>CG-SURG-85 Hip Resurfacing</li> </ul> </li> <li>Updated Coding section with the following:               <ul style="list-style-type: none"> <li>Added CPT® code: 27299*</li> <li>*CPT® 27130 and 27299 [when specified as partial or total hip resurfacing]</li> </ul> </li> </ul>
<b>Orthopedics - Knee Arthroplasty, Total (W0081)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>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</li> <li>Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>Removed MCG clinical indications for elective, non-emergent total knee arthroplasty not due to congenital deformity</li> </ul> </li> <li>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</li> </ul>
<b>Orthopedics - Knee Arthroscopy (W0113)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For knee arthroscopy, see the following:               <ul style="list-style-type: none"> <li>Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> </ul> </li> <li>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</li> </ul>
<b>Orthopedics - Knee Arthrotomy (W0140)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>Removed MCG clinical indications except for debridement, drainage, or lavage for osteomyelitis or infected joint</li> </ul> </li> <li>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 infected joint, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> </ul>
<b>Orthopedics - Lumbar Discectomy, Foraminotomy, or Laminotomy (W0091)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>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</li> <li>Revised Clinical Indications for Procedure:</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	<ul style="list-style-type: none"> <li>○ Removed: MCG clinical indications for elective, non-emergent lumbar discectomy, foraminotomy, or laminotomy</li> <li>• Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar discectomy, foraminotomy, or laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> </ul>
Orthopedics - Lumbar Fusion (W0072)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included the following notes under Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery</li> <li>○ For axial lumbar interbody fusion, see SURG.00111 Axial Lumbar Interbody Fusion</li> </ul> </li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent lumbar fusion</li> </ul> </li> <li>• 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</li> </ul>
Orthopedics - Lumbar Laminectomy (W0100)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent lumbar laminectomy</li> </ul> </li> <li>• 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</li> </ul>
Orthopedics - Shoulder Arthroplasty (W0137)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent shoulder arthroplasty</li> </ul> </li> <li>• 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</li> </ul>
Orthopedics - Shoulder Hemiarthroplasty (W0138)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for elective, non-emergent shoulder hemiarthroplasty</li> </ul> </li> <li>• 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</li> </ul>
Orthopedics - Spine, Scoliosis, Posterior Instrumentation	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
(W0116)	<p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For posterior instrumentation, spine, scoliosis, see the following:               <ul style="list-style-type: none"> <li>○ Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> </ul> </li> <li>• 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</li> </ul>
<p><b>Pediatrics</b> <a href="#">Return to Index</a></p>	
<p><b>Pediatrics - Diabetes, Pediatric (W0117)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Extended Stay: Added               <ul style="list-style-type: none"> <li>○ Need to receive comprehensive patient, parent or caregiver education <b>and</b> comprehensive diabetic education programs are not available on an outpatient basis in the community                   <ul style="list-style-type: none"> <li>▪ Expect minimal stay extension</li> <li>▪ Note: Obtain verbal or written attestation from provider regarding lack of outpatient diabetic education resources</li> </ul> </li> </ul> </li> </ul>
<p><b>Pediatrics – EEG, Video Monitoring, Pediatric (W0122)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For pediatric EEG video monitoring, see the following:               <ul style="list-style-type: none"> <li>○ CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring</li> </ul> </li> </ul>
<p><b>Pediatrics – Fundoplasty, Esophagogastric, by Laparoscopy, Pediatric (W0161)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair</li> </ul>
<p><b>Pediatrics - Heart Transplant, Pediatric (W0123)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For pediatric heart transplant, see the following:               <ul style="list-style-type: none"> <li>○ TRANS.00026 Heart/Lung Transplantation</li> <li>○ TRANS.00033 Heart Transplantation</li> </ul> </li> </ul>
<p><b>Pediatrics - Liver Transplant, Pediatric (W0124)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For pediatric liver transplant, see the following:               <ul style="list-style-type: none"> <li>○ TRANS.00008 Liver Transplantation</li> </ul> </li> </ul>
<p><b>Pediatrics - Lung Transplant, Pediatric (W0125)</b></p>	<p><b><u>Publish Date: June 24, 2019</u></b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For pediatric lung transplant, see the following:</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	<ul style="list-style-type: none"> <li>o TRANS.00009 Lung and Lobar Transplantation</li> <li>o TRANS.00026 Heart/Lung Transplantation</li> </ul>
<b>Pediatrics -</b> Renal Transplant, Pediatric (W0126)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For pediatric renal transplant, see the following:             <ul style="list-style-type: none"> <li>o CG-TRANS-02 Kidney Transplantation</li> </ul> </li> </ul>
<b>Pediatrics -</b> Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For pediatric posterior instrumentation, spine, scoliosis, see the following:             <ul style="list-style-type: none"> <li>o Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> </ul> </li> <li>• 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</li> </ul>
<b>Thoracic Surgery and Pulmonary Disease</b> <a href="#">Return to Index</a>	
<b>Thoracic Surgery and Pulmonary Disease -</b> Deep Venous Thrombosis of Lower Extremities (W0135)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters</li> <li>• Revised Clinical Indications for Admission to Inpatient Care:             <ul style="list-style-type: none"> <li>o Removed MCG clinical indications for vena cava filter placement</li> </ul> </li> </ul>
<b>Thoracic Surgery and Pulmonary Disease -</b> Lung Transplant (W0076)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For lung transplant, see the following:             <ul style="list-style-type: none"> <li>o TRANS.00009 Lung and Lobar Transplantation</li> <li>o TRANS.00026 Heart/Lung Transplantation</li> </ul> </li> </ul>
<b>Thoracic Surgery and Pulmonary Disease -</b> Pulmonary Embolism (W0134)	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters</li> <li>• Revised Clinical Indications for Admission to Inpatient Care:             <ul style="list-style-type: none"> <li>o Removed MCG clinical indications for vena cava filter placement</li> </ul> </li> </ul>
<b>Urology</b> <a href="#">Return to Index</a>	
<b>Urology -</b> Prostatectomy, Transurethral, Alternatives to Standard Resection	<p><b>Publish Date: June 24, 2019</b> <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p>



**Subject: Customizations to  Care Guidelines 23rd Edition**

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
(W0029)	<ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For alternatives to standard transurethral prostatectomy resection, see the following:                             <ul style="list-style-type: none"> <li>SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions</li> </ul> </li> </ul>
Urology - Renal Transplant (W0027)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Revised Clinical Indications for Procedure: For renal transplant, see the following:                             <ul style="list-style-type: none"> <li>CG-TRANS-02 Kidney Transplantation</li> </ul> </li> </ul>

[Return to Index](#)

**CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)**

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
<p><b>Body System GRG</b>  <a href="#">Return to Index</a></p>	
<p><b>Body System</b>                      Cardiovascular                      Surgery or Procedure                      GRG                      (W0099)</p>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Included note under Clinical Indications for Procedure: For additional information on cardiovascular surgeries or procedures see the applicable clinical document</li> <li>Revised Clinical Indications for Procedure:                             <ul style="list-style-type: none"> <li>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</li> </ul> </li> </ul>
<p><b>Body System</b>                      General Surgery or                      Procedure GRG                      (W0142)</p>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery</li> <li>Revised Clinical Indications for Procedure:                             <ul style="list-style-type: none"> <li>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</li> </ul> </li> </ul>
<p><b>Body System</b>                      Musculoskeletal                      Surgery or Procedure                      GRG                      (W0118)</p>	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>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</li> <li>Revised Clinical Indications for Procedure:                             <ul style="list-style-type: none"> <li>For medial or lateral unicompartmental knee arthroplasty:</li> </ul> </li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

<b>General Recovery Guideline (GRG)</b> <b>Guideline Title</b>	<b>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC)</b> <b>Customizations</b>
	<ul style="list-style-type: none"> <li>▪ 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</li> <li>▪ Removed MCG clinical indications for elective, non-emergent medial or lateral unicompartmental knee arthroplasty</li> <li>○ For patellofemoral arthroplasty:               <ul style="list-style-type: none"> <li>▪ Added note: For elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines, Level of Care Guidelines and Preoperative Admission Guidelines</li> <li>▪ Removed MCG clinical indications for elective, non-emergent patellofemoral arthroplasty</li> </ul> </li> <li>○ Removed MCG clinical indications for:               <ul style="list-style-type: none"> <li>▪ ankle arthroplasty</li> <li>▪ minimally invasive sacroiliac joint fusion</li> </ul> </li> <li>• Included the following note under both Operative Status Criteria and Benchmark Length of Stay (BLOS):               <ul style="list-style-type: none"> <li>○ 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</li> </ul> </li> </ul>
<b>Body System</b> Neurosurgery or Procedure GRG (W0119)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> </ul>
<b>Body System</b> Obstetric and Gynecologic Surgery or Procedure GRG (W0143)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery</li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for oophorectomy (usually with hysterectomy and salpingectomy) appropriate in context of female-to-male gender reassignment</li> </ul> </li> </ul>
<b>Body System</b> Urologic Surgery or Procedure GRG (W0141)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Included note under Clinical Indications for Procedure: For sex reassignment surgery, see CG-SURG-27 Sex Reassignment Surgery</li> <li>• Revised Clinical Indications for Procedure:               <ul style="list-style-type: none"> <li>○ 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</li> </ul> </li> </ul>
<b>General Recovery Guidelines Tools Section</b> <a href="#">Return to Index</a>	
<b>General Recovery Guidelines Tools Section</b> Inpatient Palliative Care Criteria (W0086)	<p><b>Publish Date: June 24, 2019</b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Alternatives to Admission</li> </ul>

**Subject: Customizations to  Care Guidelines 23rd Edition**

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	<ul style="list-style-type: none"> <li>○ For Home hospice added the following:               <ul style="list-style-type: none"> <li>▪ Outpatient: Continuous Home Care (CHC)</li> <li>▪ Outpatient: Routine Home Care</li> <li>▪ Patients who may benefit from hospice care</li> <li>▪ Nursing care</li> </ul> </li> <li>• Added reference</li> </ul>
<b>Problem Oriented GRG</b> <a href="#">Return to Index</a>	
<b>Problem Oriented Medical Oncology GRG (W0074)</b>	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• 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</li> <li>• Revised Clinical Indications for Admission to Inpatient Care:               <ul style="list-style-type: none"> <li>○ Removed MCG clinical indications for allogeneic and autologous hematopoietic stem cell transplant</li> </ul> </li> </ul>

[Return to Index](#)

**CUSTOMIZATIONS – BEHAVIORAL HEALTH CARE GUIDELINES (BHG)**

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
<b>Testing Procedures</b> <a href="#">Return to Index</a>	
<b>Testing Procedures</b> Urine Toxicology Testing (W0150)	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For urine toxicology testing, see the following:               <ul style="list-style-type: none"> <li>○ CG-LAB-09 Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain</li> </ul> </li> </ul>
<b>Therapeutic Services</b> <a href="#">Return to Index</a>	
<b>Therapeutic Services</b> Applied Behavioral Analysis (W0153)	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For applied behavioral analysis (ABA), see the following:               <ul style="list-style-type: none"> <li>○ CG-BEH-02 Adaptive Behavioral Treatment for Autism Spectrum Disorder</li> </ul> </li> </ul>
<b>Therapeutic Services</b> Transcranial Magnetic Stimulation (W0151)	<p><b><u>Publish Date: June 24, 2019</u></b>  <u>March 21, 2019 MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Approval of March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review</li> </ul> <p><u>March 4, 2019 Third Party Criteria Subcommittee of the MPTAC review:</u></p> <ul style="list-style-type: none"> <li>• Revised Clinical Indications for Procedure: For Transcranial Magnetic Stimulation, see the following:               <ul style="list-style-type: none"> <li>○ BEH.00002 Transcranial Magnetic Stimulation</li> </ul> </li> </ul>

[Return to Index](#)

<b>CUSTOMIZATION HISTORY</b>
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<b>Date</b>	<b>Action</b>	<b>Reason</b>
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.

[Return to Index](#)