NOTE:

- This document provides a high-level summary of customizations and modifications made to MCG (part of the Hearst Health network) 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 20th 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.
- The 20th edition of the MCG care guidelines and corresponding customized guidelines will take effect May 2, 2016.
- The May 5, 2016 review date reflects review and approval or update of the following new customizations to the 20th edition:
  - GRG Cardiovascular Surgery or Procedure GRG
  - ISC Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy
  - ISC Electrophysiologic Study and Intracardiac Catheter Ablation
  - ISC Hysterectomy, Abdominal
  - ISC Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted
  - ISC Hysterectomy, Vaginal
- The August 4, 2016 review date reflects review and approval or update of the following new customizations to the 20th edition:
  - ISC Psychiatric Disorders: Common Complications and Conditions
- The November 3, 2016 review date reflects review and approval or update of the following new customizations to the 20th edition:
  - GRG Cardiovascular Surgery or Procedure GRG
  - ISC Cesarean Delivery
  - ISC Vaginal Delivery
  - ISC Vaginal Delivery, Operative
CUSTOMIZATIONS - BACKGROUND INFORMATION

CUSTOMIZATIONS - INPATIENT & SURGICAL CARE (ISC) GUIDELINES

- **BEHAVIORAL HEALTH**
  - Anorexia Nervosa
  - Delirium
  - Substance-Related Disorders

- **CARDIOLOGY**
  - Angina
  - Angioplasty, Percutaneous Coronary Intervention
  - Atrial Fibrillation
  - Chest Pain
  - Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion, Transvenous
  - Electrophysiologic Study and Intracardiac Catheter Ablation

- **CARDIOVASCULAR SURGERY**
  - Abdominal Aortic Aneurysm, Endovascular Repair
  - Cardiac Septal Defect: Atrial, Transcatheter Closure
  - Cardiac Septal Defect: Ventricular, Repair
  - Cardiac Valve Replacement or Repair
  - Carotid Endarterectomy
  - Heart Transplant
  - Percutaneous Revascularization, Lower Extremity
  - Sympathectomy by Thoracoscropy or Laparoscopy

- **COMMON COMPLICATIONS AND CONDITIONS**
  - Alcohol and Psychoactive Substance Withdrawal
  - Preoperative Days
  - Psychiatric Disorders

- **GASTROENTEROLOGY**
  - Liver Disease Complications

- **GENERAL SURGERY**
  - Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy
  - Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy
  - Gastric Restrictive Procedure with or without Gastric Bypass
  - Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy
  - Liver Transplant
  - Mastectomy, Complete
  - Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander
  - Mastectomy, Complete, with Tissue Flap Reconstruction
  - Mastectomy, Partial (Lumpectomy)

- **NEONATAL FACILITY LEVELS AND ADMISSION GUIDELINES**
  - Neonatal Level of Care Guidelines

- **NEONATOLOGY**
  - Newborn Care, Routine
  - Newborn Care, Term, with Severe Illness or Abnormality
  - Sepsis, Neonatal, Confirmed
  - Sepsis, Neonatal, Suspected, Not Confirmed

- **NEUROLOGY**
  - EEG, Video Monitoring

- **OBSTETRICS AND GYNECOLOGY**
  - Cesarean Delivery
Subject: Customizations to mcg Care Guidelines 20th Edition

- Hysterectomy, Abdominal
- Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted
- Hysterectomy, Vaginal
- Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy
- Laparotomy for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy
- Vaginal Delivery
- Vaginal Delivery, Operative

- ORTHOPEDICS
  - Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy
  - Cervical Fusion, Anterior
  - Cervical Fusion, Posterior
  - Cervical Laminectomy
  - Hip Arthroplasty
  - Hip Arthroscopy
  - Hip Resurfacing
  - Knee Arthroplasty, Total
  - Knee Arthroscopy
  - Lumbar Diskectomy, Foraminotomy, or Laminotomy
  - Lumbar Fusion or Lumbar Total Disc Arthroplasty
  - Lumbar Laminectomy
  - Spine, Scoliosis, Posterior Instrumentation

- PEDIATRICS
  - Cranioplasty, Pediatric
  - Diabetes, Pediatric
  - EEG, Video Monitoring, Pediatric
  - Heart Transplant, Pediatric
  - Liver Transplant, Pediatric
  - Lung Transplant, Pediatric
  - Renal Transplant, Pediatric

- THORACIC SURGERY AND PULMONARY DISEASE
  - Lung Transplant
  - Rib Fracture

- UROLOGY
  - Prostatectomy, Transurethral, Alternatives to Standard Resection
  - Prostatectomy, Transurethral Resection (TURP)
  - Renal Transplant

CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)

- BODY SYSTEM GRG
  - Behavioral Health GRG
  - Cardiovascular Surgery or Procedure GRG
  - Musculoskeletal Surgery or Procedure GRG
  - Neurosurgery or Procedure GRG

- CARE MANAGEMENT TOOLS
  - Behavioral Health Levels of Care

- CASE MANAGEMENT GRG
  - Behavioral Health Case Management GRG

- GENERAL RECOVERY GUIDELINES TOOLS SECTION
  - Inpatient Palliative Care Criteria
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.
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), adding a Related Guidelines section with our related medical policy or clinical UM guidelines or other changes to MCG care guidelines (e.g. revision to Alternatives for Procedure).

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.
<table>
<thead>
<tr>
<th>Inpatient &amp; Surgical Care (ISC)</th>
<th>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</th>
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</thead>
</table>
| Behavioral Health (BH) - 20th Ed: Anorexia Nervosa | February 4, 2016 MPTAC review:  
  • Approval of January 29, 2016 Behavioral Health Subcommittee review  
January 29, 2016 Behavioral Health Subcommittee review:  
  • Revised Clinical Indications for Admission to Inpatient Care:  
    o For anorexia nervosa, see the following:  
      • CG-BEH-05 Eating and Feeding Disorder Treatment  
    o For admission to inpatient care due to anorexia nervosa with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-03 Psychiatric Disorder Treatment.  
  • Revised: Alternatives to Admission  
    o Added: See CG-BEH-05 Eating and Feeding Disorder Treatment.  
  • Included note under the Goal Length of Stay (GLOS) section: For continued stay criteria, see CG-BEH-05 Eating and Feeding Disorder Treatment.  
  • Revised: Extended Stay  
    o Removed:  
      • MCG indications for extended stay  
      • See Common Complications and Conditions ISC for further information.  
    o Added note: For extended stay criteria, see CG-BEH-05 Eating and Feeding Disorder Treatment.  
  • Revised: Discharge Destination  
    o Added: See CG-BEH-05 Eating and Feeding Disorder Treatment. |
| Behavioral Health (BH) - 20th Ed: Delirium | February 4, 2016 MPTAC review:  
  • Approval of January 29, 2016 Behavioral Health Subcommittee review  
January 29, 2016 Behavioral Health Subcommittee review:  
  • Continue to reinstate guideline for Delirium |
| Behavioral Health (BH) - 20th Ed: Substance-Related Disorders | February 4, 2016 MPTAC review:  
  • Approval of January 29, 2016 Behavioral Health Subcommittee review  
January 29, 2016 Behavioral Health Subcommittee review:  
  • Revised Clinical Indications for Admission to Inpatient Care:  
    o For substance-related disorders, see the following:  
      • CG-BEH-04 Substance-Related and Addictive Disorder Treatment  
    o For delirium due to alcohol or sedative withdrawal is present, see the following:  
      • Delirium ISC guideline  
    o For admission to inpatient care due to substance-related disorders with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-03 Psychiatric Disorder Treatment.  
  • Revised: Alternatives to Admission  
    o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment.  
  • Included note under the Goal Length of Stay (GLOS) section: For continued stay criteria, see CG-BEH-04 Substance-Related and Addictive Disorder Treatment.  
  • Revised: Extended Stay  
    o Removed:  
      • MCG indications for extended stay  
      • See Common Complications and Conditions ISC for further information.  
    o Added note: For extended stay criteria, see CG-BEH-04 Substance-Related and Addictive Disorder Treatment.  
  • Revised: Discharge Destination  
    o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment. |
| Cardiology | Return to Index |
| Cardiology - 20th Ed: Angina | February 4, 2016 MPTAC review:  
  • Included note under Clinical Indications for Admission to Inpatient Care: For coronary computed tomography angiography (CCTA), coronary magnetic resonance angiography (MRA), or cardiac |

Issue Date: December 9, 2016 R4
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<tr>
<td>magnetic resonance imaging (MRI), see RAD.00035 Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI)</td>
<td></td>
</tr>
</tbody>
</table>
| **Cardiology - 20th Ed:** Angioplasty, Percutaneous Coronary Intervention | February 4, 2016 MPTAC review:  
- Included note under Clinical Indications for Procedure: For elective percutaneous coronary intervention, see CG-SURG-48 Elective Percutaneous Coronary Interventions (PCI)  
- Revised Clinical Indications for Procedure:  
  o Removed MCG clinical indications for elective PCI  
  o Retained MCG clinical indications for non-elective, emergent PCI |
| **Cardiology - 20th Ed:** Atrial Fibrillation | February 4, 2016 MPTAC review:  
- Included note under Clinical Indications for Admission to Inpatient Care: For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation) |
| **Cardiology - 20th Ed:** Chest Pain | February 4, 2016 MPTAC review:  
- Included note under Clinical Indications for Admission to Inpatient Care: For computed tomography to detect coronary artery calcium, see RAD.00001 Computed Tomography to Detect Coronary Artery Calcification  
- Included note under Clinical Indications for Admission to Inpatient Care: For coronary computed tomography angiography (CCTA), coronary magnetic resonance angiography (MRA), or cardiac magnetic resonance imaging (MRI), see RAD.00035 Coronary Artery Imaging: Contrast-Enhanced Coronary Computed Tomography Angiography (CCTA), Coronary Magnetic Resonance Angiography (MRA), and Cardiac Magnetic Resonance Imaging (MRI) |
| **Cardiology - 20th Ed:** Electrophysiologic Study and Implantable Cardiodefibrillator (ICD) Insertion, Transvenous | February 4, 2016 MPTAC review:  
- Revised Clinical Indications for Procedure: For electrophysiologic study (EPS) and transvenous insertion of implantable cardioverter-defibrillator (ICD) see the following:  
  o SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardiodefibrillator (CRT/ICD) for the Treatment of Heart Failure  
- Added Related Guidelines section with related medical policy  
  o DME.00032 Automated External Defibrillators for Home Use  
  o MED.00055 Wearable Cardioverter Defibrillators  
  o SURG.00033 Cardiodefibrillators  
  o SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardiodefibrillator (CRT/ICD) for the Treatment of Heart Failure |
| **Cardiology - 20th Ed:** Electrophysiologic Study and Intracardiac Catheter Ablation | May 5, 2016 MPTAC review:  
- Revised Clinical Indications for Procedure: For electrophysiologic study and intracardiac catheter ablation, see the following:  
  o CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation  
February 4, 2016 MPTAC review:  
- Included note under Clinical Indications for Procedure: For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)  
- Added Related Guidelines section with related medical policy and clinical UM guidelines  
  o MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)  
  o SURG.00033 Cardiodefibrillators  
  o SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardiodefibrillator (CRT/ICD) for the Treatment of Heart Failure  
  o CG-SURG-05 Maze Procedure |
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<tr>
<td>CV Surgery - 20th Ed: Abdominal Aortic Aneurysm, Endovascular Repair</td>
<td>February 4, 2016 MPTAC review:</td>
</tr>
<tr>
<td></td>
<td>• Revised Clinical Indications for Procedure: For abdominal aortic aneurysm, endovascular repair, see the following:</td>
</tr>
<tr>
<td></td>
<td>• SURG.00054 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transsection</td>
</tr>
<tr>
<td>CV Surgery - 20th Ed: Cardiac Septal Defect: Atrial, Transcatheter Closure</td>
<td>February 4, 2016 MPTAC review:</td>
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<tr>
<td></td>
<td>• Included note under Clinical Indications for Procedure: For transcatheter closure of patent foramen ovale (PFO) and left atrial appendage for stroke prevention, see SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention</td>
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<tr>
<td>CV Surgery - 20th Ed: Cardiac Septal Defect: Ventricular, Repair</td>
<td>February 4, 2016 MPTAC review:</td>
</tr>
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<td></td>
<td>• 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</td>
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<td>CV Surgery - 20th Ed: Cardiac Valve Replacement or Repair</td>
<td>February 4, 2016 MPTAC review:</td>
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<td></td>
<td>• 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</td>
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<tr>
<td>CV Surgery - 20th Ed: Carotid Endarterectomy</td>
<td>February 4, 2016 MPTAC review:</td>
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<tr>
<td></td>
<td>• Revised Alternatives to Procedure:</td>
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<tr>
<td></td>
<td>• For information on carotid artery stent placement with or without angioplasty, see SURG.00001 Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty.</td>
</tr>
<tr>
<td>CV Surgery - 20th Ed: Heart Transplant</td>
<td>February 4, 2016 MPTAC review:</td>
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<tr>
<td></td>
<td>• Revised Clinical Indications for Procedure: For heart transplant, see the following:</td>
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<tr>
<td></td>
<td>• TRANS.00026 Heart/Lung Transplantation</td>
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<tr>
<td></td>
<td>• TRANS.00033 Heart Transplantation</td>
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<tr>
<td>CV Surgery - 20th Ed: Percutaneous Revascularization, Lower Extremity</td>
<td>February 4, 2016 MPTAC review:</td>
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<tr>
<td></td>
<td>• Revised Clinical Indications for Procedure: For percutaneous revascularization, lower extremity, see the following:</td>
</tr>
<tr>
<td></td>
<td>• CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities</td>
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<tr>
<td>CV Surgery - 20th Ed: Sympathectomy by Thoracoscopy or Laparoscopy</td>
<td>February 4, 2016 MPTAC review:</td>
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<td>• Included note under Clinical Indications for Procedure: For treatment of hyperhidrosis, see MED.00032 Treatment of Hyperhidrosis</td>
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<td></td>
<td>• Revised Clinical Indications for Procedure:</td>
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<td>• Removed:</td>
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<td>• Hyperhidrosis and ALL of the following:</td>
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<td>• Patient has severe disabling symptoms.</td>
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<td>• Nonsurgical management options have been tried and failed or are not appropriate (eg, medication, botulinum toxin injection).</td>
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<td>• Ventricular arrhythmia and ALL of the following:</td>
</tr>
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<td></td>
<td>• Medical therapy has been tried and failed (eg, beta-blockers, antiarrhythmics).</td>
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<tr>
<td></td>
<td>• Other procedural methods have failed (eg, electrophysiologic ablation, recurrent appropriate ICD shocks) or are not appropriate.</td>
</tr>
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<td>• Revised Alternatives to Procedure:</td>
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<tr>
<td></td>
<td>• Removed:</td>
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<td>• For ventricular arrhythmia:</td>
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### Customizations to Care Guidelines 20th Edition

**Inpatient & Surgical Care (ISC) Guideline Title**

<table>
<thead>
<tr>
<th>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</th>
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| - Medical therapy  
- Electrophysiologic study and ablation  
- ICD implantation |

#### Common Complications and Conditions

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<td><strong>Alcohol and Psychoactive Substance Withdrawal</strong></td>
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<td><strong>Approval of January 29, 2016 Behavioral Health Subcommittee review</strong></td>
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<td><strong>January 29, 2016 Behavioral Health Subcommittee review:</strong></td>
</tr>
<tr>
<td></td>
<td><strong>Revised Clinical Indications for Inpatient Care:</strong></td>
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<tr>
<td></td>
<td>o For ongoing inpatient care due to substance withdrawal see the following:</td>
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<tr>
<td></td>
<td>- CG-BEH-04 Substance-Related and Addictive Disorder Treatment</td>
</tr>
<tr>
<td></td>
<td>o For delirium due to alcohol or sedative withdrawal is present, see the following:</td>
</tr>
<tr>
<td></td>
<td>- See Mental Status Change: Common Complications and Conditions as needed</td>
</tr>
<tr>
<td></td>
<td>o For ongoing inpatient care due to substance withdrawal with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-03 Psychiatric Disorder Treatment.</td>
</tr>
<tr>
<td></td>
<td><strong>Revised: Alternatives to Inpatient Care</strong></td>
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<tr>
<td></td>
<td>o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment</td>
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<td></td>
<td><strong>Revised: Discharge</strong></td>
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<tr>
<td></td>
<td>o Removed: MCG indications for extended stay</td>
</tr>
<tr>
<td></td>
<td>o Added note: For extended stay beyond goal length of stay for primary condition, see CG-BEH-04 Substance-Related and Addictive Disorder Treatment.</td>
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<td><strong>Preoperative Days</strong></td>
<td><strong>February 4, 2016 MPTAC review:</strong></td>
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<td></td>
<td><strong>Revised Clinical Indications for Inpatient Care:</strong></td>
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<tr>
<td></td>
<td>o For inpatient preoperative days, added indication, Conversion from warfarin (Coumadin®) to IV heparin for patients with mechanical heart valves or other high risk patients with contraindications to low-molecular-weight heparin (LMWH) or fractionated heparin (one to two days inpatient stay before elective surgery)</td>
</tr>
<tr>
<td></td>
<td><strong>Revised: Alternatives to Inpatient Care</strong></td>
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<tr>
<td></td>
<td>o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment</td>
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<td></td>
<td>o Removed: MCG indications for extended stay</td>
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<td></td>
<td>o Added note: For extended stay beyond goal length of stay for primary condition, see CG-BEH-04 Psychiatric Disorder Treatment.</td>
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<td><strong>Psychiatric Disorders</strong></td>
<td><strong>August 4, 2016 MPTAC review:</strong></td>
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<td><strong>July 29, 2016 Behavioral Health Subcommittee review:</strong></td>
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<tr>
<td></td>
<td><strong>Revised Clinical Indications for Inpatient Care:</strong></td>
</tr>
<tr>
<td></td>
<td>o For ongoing inpatient care due to psychiatric disorders see the following:</td>
</tr>
<tr>
<td></td>
<td>- CG-BEH-03 Psychiatric Disorder Treatment</td>
</tr>
<tr>
<td></td>
<td>o For ongoing inpatient care due to psychiatric disorders with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-04 Substance-Related and Addictive Disorder Treatment.</td>
</tr>
<tr>
<td></td>
<td><strong>Revised: Alternatives to Inpatient Care</strong></td>
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<tr>
<td></td>
<td>o Added: See CG-BEH-03 Psychiatric Disorder Treatment</td>
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<td>o Removed: MCG indications for extended stay</td>
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<td></td>
<td>o Added note: For extended stay beyond goal length of stay for primary condition, see CG-BEH-03 Psychiatric Disorder Treatment.</td>
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<td><strong>Liver Disease Complications</strong></td>
<td><strong>February 4, 2016 MPTAC review:</strong></td>
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<td><strong>Revised Clinical Indications for Admission to Inpatient Care:</strong> For acute hepatitis, revised bilirubin greater than 20 mg/dL (342 micromoles/L) to indicate bilirubin greater than 10 mg/dL (171 micromoles/L)</td>
</tr>
<tr>
<td>Inpatient &amp; Surgical Care (ISC) Guideline Title</td>
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<td><strong>General Surgery</strong></td>
<td><strong>February 4, 2016 MPTAC review:</strong></td>
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<td><strong>General Surgery - 20th Ed:</strong></td>
<td>- Revised Clinical Indications for Procedure: For gastric restrictive procedure, sleeve gastrectomy, by laparoscopy see the following:</td>
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<tr>
<td>Gastric Restrictive Procedure, Sleeve</td>
<td>o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity</td>
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<td>Gastrectomy, by Laparoscopy</td>
<td>- Revised Alternatives to Procedure: Removed:</td>
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<tr>
<td></td>
<td>o Intragastric balloon</td>
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<td>o Biliopancreatic diversion</td>
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<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>- Revised Clinical Indications for Procedure: For gastric restrictive procedure with gastric bypass by laparoscopy, see the following:</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure with Gastric</td>
<td>o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity</td>
</tr>
<tr>
<td>Bypass by Laparoscopy</td>
<td>- Revised Alternatives to Procedure: Removed:</td>
</tr>
<tr>
<td></td>
<td>o Intragastric balloon</td>
</tr>
<tr>
<td></td>
<td>o Biliopancreatic diversion</td>
</tr>
<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>- Title changed from Gastric Restrictive Procedure with Gastric Bypass to indicate Gastric Restrictive Procedure with or without Gastric Bypass</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure with Gastric</td>
<td>- Revised Clinical Indications for Procedure: For gastric restrictive procedure with or without gastric bypass, see the following:</td>
</tr>
<tr>
<td>Bypass with Gastric Bypass by Laparoscopy</td>
<td>o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity</td>
</tr>
<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>- Revised Alternatives to Procedure: Removed:</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure without</td>
<td>o Intragastric balloon</td>
</tr>
<tr>
<td>Gastric Bypass by Laparoscopy</td>
<td>o Biliopancreatic diversion</td>
</tr>
<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>- Updated Coding section with the following:</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure without</td>
<td>o Added ICD-10 Procedure codes: 0D190ZB, 0DB60Z3, 0DP60CZ, 0DP60DZ**, 0DV60CZ, 0DV60DZ**, 0DW60CZ</td>
</tr>
<tr>
<td>Gastric Bypass by Laparoscopy</td>
<td>o Added CPT® codes: 43632***, 43842, 43843, 43845, 43848</td>
</tr>
<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>o 1ICD-10 Procedure code 0D190ZB considered investigational and not medically necessary [when specified as Billroth II with the diagnosis of obesity].</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure with or without</td>
<td>o **ICD-10 Procedure codes 0DP60DZ and 0DV60DZ considered investigational and not medically necessary.</td>
</tr>
<tr>
<td>Gastric Bypass</td>
<td>o ***CPT® 43632 considered investigational and not medically necessary [when specified as bariatric surgery].</td>
</tr>
<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>- Revised Clinical Indications for Procedure: For gastric restrictive procedure without gastric bypass by laparoscopy, see the following:</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure without</td>
<td>o Intragastric balloon</td>
</tr>
<tr>
<td>Gastric Bypass by Laparoscopy</td>
<td>o Biliopancreatic diversion</td>
</tr>
<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>- Update the Coding Section with the following:</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure without</td>
<td>o Added ICD-10 procedure codes: 0DB68Z3, 0DP63DZ*, 0DP64CZ, 0DP64DZ*, 0DP67DZ*, 0DP68DZ*, 0DV63DZ*, 0DV64DZ*, 0DV67DZ*, 0DV68DZ*</td>
</tr>
<tr>
<td>Gastric Bypass by Laparoscopy</td>
<td>o Added CPT® codes: 43659**, 43771, 43772, 43773, 43774, 43886, 43887, 43888, 43999***</td>
</tr>
<tr>
<td><strong>General Surgery - 20th Ed:</strong></td>
<td>o 1ICD-10 Procedure codes 0DP63DZ, 0DP64DZ, 0DP67DZ, 0DP68DZ, 0DV63DZ, 0DV64DZ, 0DV67DZ, 0DV68DZ considered investigational and not medically necessary.</td>
</tr>
<tr>
<td>Gastric Restrictive Procedure without</td>
<td>o **CPT® 43659 considered investigational and not medically necessary [when specified as endoluminal gastric restrictive surgery].</td>
</tr>
<tr>
<td>Gastric Bypass by Laparoscopy</td>
<td>o ***CPT® 43999 considered investigational and not medically necessary [when specified as endoluminal gastric restrictive surgery].</td>
</tr>
<tr>
<td>Inpatient &amp; Surgical Care (ISC) Guideline Title</td>
<td>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</td>
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<td>-----------------------------------------------</td>
<td>--------------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **General Surgery - 20th Ed: Liver Transplant** | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure: For liver transplant, see the following:  
    - TRANS.00008 Liver Transplantation |
| **General Surgery - 20th Ed: Mastectomy, Complete** | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure:  
    - For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications:  
      - Personal history of breast cancer  
      - Atypical hyperplasia as an example of noninvasive histology  
      - Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible  
      - Patient received therapeutic thoracic irradiation before age 30  
    - For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should generally be considered only in women with compelling family history, or possibly with LCIS or prior thoracic radiation therapy at less than 30 years of age.  
  - Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section  
  - Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory  
  - Under the Goal Length of Stay (GLOS) section added:  
    - Reason: Organization approved 2 day stay  
    - Context: Organization accepted variance of 2 days  
  - Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory  
  - Added reference, Society of Surgical Oncology: position statement on prophylactic mastectomy |
| **General Surgery - 20th Ed: Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander** | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure:  
    - For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications:  
      - Personal history of breast cancer  
      - Atypical hyperplasia as an example of noninvasive histology  
      - Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible  
      - Patient received therapeutic thoracic irradiation before age 30  
    - For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should generally be considered only in women with compelling family history, or possibly with LCIS or prior thoracic radiation therapy at less than 30 years of age.  
  - Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section  
  - Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory or 1 day postoperative  
  - Under the Goal Length of Stay (GLOS) section added:  
    - Reason: Organization approved 2 day stay  
    - Context: Organization accepted variance of 2 days  
  - Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory or Inpatient  
  - Added reference, Society of Surgical Oncology: position statement on prophylactic mastectomy |
| **General Surgery - 20th Ed: Mastectomy, Complete, with Tissue Flap Reconstruction** | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure:  
    - For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications:  
      - Personal history of breast cancer  
      - Atypical hyperplasia as an example of noninvasive histology  
      - Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible  
      - Patient received therapeutic thoracic irradiation before age 30  
    - For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should generally be considered only in women with compelling family history, or possibly with LCIS or prior thoracic radiation therapy at less than 30 years of age.  
  - Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section  
  - Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory  
  - Under the Goal Length of Stay (GLOS) section added:  
    - Reason: Organization approved 2 day stay  
    - Context: Organization accepted variance of 2 days  
  - Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory or Inpatient  
  - Added reference, Society of Surgical Oncology: position statement on prophylactic mastectomy |
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<tr>
<td>General Surgery - 20th Ed: Mastectomy, Partial (Lumpectomy)</td>
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<tr>
<td>• Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory</td>
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| Neonatal Facility Levels and Admission Guidelines | February 4, 2016 MPTAC review: |
| Neonatal Facility Levels and Admission Guidelines – 20th Ed: Neonatal Facility Levels of Care Guidelines | |
| • Neonatal Facility, Level I | |
| • Neonatal Facility, Level II | |
| • Neonatal Facility, Level III | |
| • Neonatal Facility, Level IV | |
| Neonatal Care Admission Guidelines | |
| • Neonatal Admission Levels Comparison Chart | |
| • Neonatal Care, Routine Care, Level 1 | |
| • Neonatal Care, Continuing Care, Level 2 | |
| • Neonatal Care, Intermediate Care, Level 3 | |
| • Neonatal Care, Intensive Care, Level 4 | |
| Neonatology – 20th Ed: Newborn Care, Routine | |
| • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section | |
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---|---
**Neonatology – 20th Ed:** Newborn Care, Term, with Severe Illness or Abnormality | February 4, 2016 MPTAC review:
- Revised Clinical Indications for Admission to Inpatient Care: For newborn care, term, with severe illness or abnormality, see the following:
  - CG-MED-26 Neonatal Levels of Care

**Neonatology – 20th Ed:** Sepsis, Neonatal, Confirmed | February 4, 2016 MPTAC review:
- Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, confirmed, see the following:
  - CG-MED-26 Neonatal Levels of Care

**Neonatology – 20th Ed:** Sepsis, Neonatal, Suspected, Not Confirmed | February 4, 2016 MPTAC review:
- Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, suspected, not confirmed, see the following:
  - CG-MED-26 Neonatal Levels of Care

**Neurology**
[Return to Index](#)

**Neurology – 20th Ed:** EEG, Video Monitoring | February 4, 2016 MPTAC review:
- Revised Clinical Indications for Procedure: For EEG video monitoring, see the following:
  - CG-MED-46 Ambulatory and Inpatient Video Electroencephalography

**Obstetrics and Gynecology (OB / GYN)**
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**OB / GYN - 20th Ed:** Cesarean Delivery | November 3, 2016 MPTAC review:
- Revised Clinical Indications for Procedure:
  - Retained MCG clinical indications for emergency cesarean delivery
  - Added clinical indications for early elective cesarean delivery
  - Revised MCG clinical indications for elective cesarean delivery
  - Added references
  - Updated Coding section

February 4, 2016 MPTAC review:
- Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section

**OB / GYN - 20th Ed:** Hysterectomy, Abdominal | May 5, 2016 MPTAC review:
- Revised Clinical Indications for Procedure:
  - For abnormal uterine bleeding:
    - "Alternative medical treatment" changed to "alternative hormonal medical treatment"
  - For leiomyoma ("fibroid"):
    - "Alternative treatments (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following:" changed to:
      - "Alternative treatments (for example, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following reasons:" changed to:
      - For pelvic organ prolapse:
        - "Uterine-sparing treatments (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of 1 or more of the following:" changed to:
          - "Uterine-sparing treatment(s) (for example, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of 1 or more of the following reasons:"
  - Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless:
    - Oral tranexamic acid is Contraindicated or not tolerated, or
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--- | ---

- Oral tranexamic acid is not appropriate for the severity of patient's condition, or
- The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable.

February 4, 2016 MPTAC review:

- **Revised Clinical Indications for Procedure:**
  - For abnormal uterine bleeding:
    - Investigation (eg, endometrial sampling, laboratory studies, hysteroscopy, imaging) has not identified specific etiology (eg, endometrial hyperplasia, leiomyoma) changed to: Investigation has been performed including **ALL** of the following:
      - Laboratory studies
      - Imaging or hysteroscopy with or without endometrial sampling
    - Added indication, Investigation has not identified a specific etiology (eg, endometrial hyperplasia, leiomyoma ("fibroid") - see criteria for other specific indications below).
    - Added indication, Alternative medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless 1 or more of the following conditions exist:
      - Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition.
      - Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are contraindicated or not tolerated.
      - Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition.
  - Removed indication, Hormonal therapy cannot be used because of **1 or more** of the following:
    - It is contraindicated.
    - It was tried but did not adequately treat patient's condition.
    - It is not appropriate for severity of patient's condition (eg, severe persistent bleeding).
  - Removed indication, Uterine-sparing procedures (eg, endometrial ablation) cannot be used because of **1 or more** of the following:
    - They were tried but did not adequately treat patient's condition.
    - They are not appropriate for severity of patient's condition.
    - Hysterectomy is preferred (eg, concern about recurrence after endometrial ablation)
  - Added indication, Endometrial ablation cannot be used because of **1 or more** of the following:
    - It is contraindicated.
    - It was tried but did not adequately treat patient's condition.
    - The patient or her physician has determined that endometrial ablation is not appropriate or acceptable.
  - Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy and related references
  - For pelvic pain due to endometriosis,
    - Added indication, Endometriosis and **1 or more** of the following:
      - Histology confirmed by biopsy
      - Endometrial implants visualized on laparoscopy
      - Endometrioma(s) on transvaginal ultrasound
  - Added indication for when abdominal hysterectomy is considered not medically necessary:
    - Abdominal hysterectomy is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons:
      - To improve detection of adnexal masses, or
      - To prevent impairment of renal function, or
      - To rule out malignancy
  - Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs)
  - Added references:
    - ACOG Practice Bulletin for the management of abnormal uterine bleeding associated with ovulatory dysfunction
    - ACOG Practice Bulletin for endometrial ablation
    - FDA Immediately in Effect Guidance Document: product labeling for laparoscopic power morcellators
<table>
<thead>
<tr>
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</thead>
</table>
| **OB / GYN - 20th Ed:** Hysterectomy, Laparoscopic | **May 5, 2016 MPTAC review:**  
- Revised Clinical Indications for Procedure:  
  - For abnormal uterine bleeding:  
    - "Alternative medical treatment" changed to "alternative hormonal medical treatment"  
    - For leiomyoma ("fibroid"):  
      - Alternative treatments (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following: changed to:  
        - "Alternative treatments (for example, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following reasons:"  
      - For pelvic organ prolapse:  
        - "Uterine-sparing treatments (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of 1 or more of the following:" changed to:  
          - "Uterine-sparing treatment(s) (for example, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of 1 or more of the following reasons:"  
    - Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless:  
      - Oral tranexamic acid is Contraindicated or not tolerated, or  
      - Oral tranexamic acid is not appropriate for the severity of patient's condition, or  
      - The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable. |

| **February 4, 2016 MPTAC review:** |  
- Revised Clinical Indications for Procedure:  
  - For abnormal uterine bleeding:  
    - Investigation (eg, endometrial sampling, laboratory studies, hysteroscopy, imaging) has not identified specific etiology (eg, endometrial hyperplasia, leiomyoma) changed to:  
      - Investigation has been performed including ALL of the following:  
        - Laboratory studies  
        - Imaging or hysteroscopy with or without endometrial sampling  
    - Added indication, Investigation has not identified a specific etiology (eg, endometrial hyperplasia, leiomyoma ("fibroid") - see criteria for other specific indications below).  
    - Added indication, Alternative medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless 1 or more of the following conditions exist:  
      - Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition.  
      - Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are contraindicated or not tolerated.  
      - Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition.  
    - Removed indication, Hormonal therapy cannot be used because of 1 or more of the following:  
      - It is contraindicated.  
      - It was tried but did not adequately treat patient's condition.  
      - It is not appropriate for severity of patient's condition (eg, severe persistent bleeding).  
    - Removed indication, Uterine-sparing procedures (eg, endometrial ablation) cannot be used because of 1 or more of the following:  
      - They were tried but did not adequately treat patient's condition.  
      - They are not appropriate for severity of patient's condition.  
      - Hysterectomy is preferred (eg, concern about recurrence after endometrial ablation).  
    - Added indication, Endometrial ablation cannot be used because of 1 or more of the following:  
      - It is contraindicated.  
      - It was tried but did not adequately treat patient's condition.  
      - The patient or her physician has determined that endometrial ablation is not appropriate or acceptable.  
    - Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy and related references.  
      - For pelvic pain due to endometriosis. |
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- Added indication, Endometriosis and 1 or more of the following:
  - Histology confirmed by biopsy
  - Endometrial implants visualized on laparoscopy
  - Endometrioma(s) on transvaginal ultrasound
- Added indication for when laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy is considered not medically necessary:
  - Laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy is considered not medically necessary for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomatata when performed for any of the following reasons:
    - To improve detection of adnexal masses, or
    - To prevent impairment of renal function, or
    - To rule out malignancy
- Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs)
- Added references:
  - ACOG Practice Bulletin for the management of abnormal uterine bleeding associated with ovulatory dysfunction
  - Society of Gynecologic Surgeons Systematic Review Group. A systematic review comparing hysterectomy with less-invasive treatments for abnormal uterine bleeding
  - ACOG Practice Bulletin for endometrial ablation
  - FDA Immediately in Effect Guidance Document: product labeling for laparoscopic power morcellators

### OB / GYN - 20th Ed:

**Hysterectomy, Vaginal**

**May 5, 2016 MPTAC review:**

- **Revised Clinical Indications for Procedure:**
  - For abnormal uterine bleeding:
    - "Alternative medical treatment" changed to "alternative hormonal medical treatment"
  - For leiomyoma ("fibroid"):
    - "Alternative treatments (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following:"
      - "Alternative treatments (for example, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of 1 or more of the following reasons:"
  - For pelvic organ prolapse:
    - "Uterine-sparing treatments (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of 1 or more of the following:"
      - "Uterine-sparing treatment(s) (for example, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of 1 or more of the following reasons:"
  - Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless:
    - Oral tranexamic acid is Contraindicated or not tolerated, or
    - Oral tranexamic acid is not appropriate for the severity of patient's condition, or
    - The patient or her physician has determined that oral tranexamic acid is not appropriate or acceptable.

**February 4, 2016 MPTAC review:**

- **Revised Clinical Indications for Procedure:**
  - For abnormal uterine bleeding:
    - Investigation (eg, endometrial sampling, laboratory studies, hysteroscopy, imaging) has not identified specific etiology (eg, endometrial hyperplasia, leiomyoma) changed to:
      - Investigation has been performed including ALL of the following:
        - Laboratory studies
        - Imaging or hysteroscopy with or without endometrial sampling
    - Added indication, Investigation has not identified a specific etiology (eg, endometrial hyperplasia, leiomyoma ("fibroid") - see criteria for other specific indications below).
    - Added indication, Alternative medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless 1 or more of the following conditions exist:
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<td>- Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition.</td>
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<td>- Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are contraindicated or not tolerated.</td>
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<td>- Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition.</td>
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<td>- Removed indication, Hormonal therapy cannot be used because of 1 or more of the following:</td>
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<td>- It was tried but did not adequately treat patient's condition.</td>
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<td>- It is not appropriate for severity of patient's condition (eg, severe persistent bleeding).</td>
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<td>- Removed indication, Uterine-sparing procedures (eg, endometrial ablation) cannot be used because of 1 or more of the following:</td>
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<td>- They were tried but did not adequately treat patient's condition.</td>
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<td>- Hysterectomy is preferred (eg, concern about recurrence after endometrial ablation)</td>
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<td>- Added indication, Endometrial ablation cannot be used because of 1 or more of the following:</td>
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<td>- The patient or her physician has determined that endometrial ablation is not appropriate or acceptable.</td>
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<td>- Added indication, Endometriosis and 1 or more of the following:</td>
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<tr>
<td>- Added indication for when vaginal hysterectomy is considered not medically necessary:</td>
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<td>- <strong>Vaginal hysterectomy</strong> is considered not medically necessary for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons:</td>
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### OB / GYN - 20th Ed:
Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy

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<tbody>
<tr>
<td>- Included note under Clinical Indications for Procedure: For laparoscopic surgical ablation of uterine fibroids, see SURG.00077 Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques</td>
</tr>
<tr>
<td>- Included note under Clinical Indications for Procedure: For the evaluation of infertility, see CG-SURG-34 Diagnostic Infertility Surgery</td>
</tr>
<tr>
<td>- Revised Clinical Indications for Procedure:</td>
</tr>
<tr>
<td>- &quot;Bilateral prophylactic salpingo-oophorectomy&quot; changed to &quot;risk-reducing salpingo-oophorectomy&quot;</td>
</tr>
<tr>
<td>- For premenopausal female with estrogen or progesterone receptor-positive breast cancer, &quot;bilateral oophorectomy&quot; changed to &quot;risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy&quot;</td>
</tr>
<tr>
<td>- Additional indication listed for oophorectomy:</td>
</tr>
<tr>
<td>- Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (e.g., mother, sister, daughter) or one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer</td>
</tr>
<tr>
<td>- Removed:</td>
</tr>
<tr>
<td>- Infertility evaluation or treatment needed, as indicated by ALL of the following:</td>
</tr>
</tbody>
</table>
### Inpatient & Surgical Care (ISG)

**Guideline Title:**

Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations

- Infertility, as indicated by 1 or more of the following:
  - Inability to conceive after regular unprotected sexual intercourse for 6 months or more for female older than 35 years
  - Inability to conceive after regular unprotected sexual intercourse for at least 1 year for female 35 years or younger
- Appropriate laboratory hormone levels (eg, prolactin, follicle-stimulating hormone, mid-luteal progesterone)
- Imaging (transvaginal ultrasound and hysterosalpingogram or sonohysterography) nondiagnostic or demonstrates pathology amenable to surgical treatment (eg, endometriosis)

#### OB / GYN - 20th Ed: Laparotomy, for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy

**February 4, 2016 MPTAC review:**

- Revised Clinical Indications for Procedure:
  - "Bilateral prophylactic salpingo-oophorectomy" changed to "risk-reducing salpingo-oophorectomy"
  - For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "bilateral oophorectomy" changed to "risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy"
  - Additional indication listed for oophorectomy:
    - Risk-reducing salpingo-oophorectomy for the presence of more or equal to two first degree relatives (e.g., mother, sister, daughter) or one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer
- Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs)
- Added reference, FDA Immediately in Effect Guidance Document: product labeling for laparoscopic power morcellators

#### OB / GYN - 20th Ed: Vaginal Delivery

**November 3, 2016 MPTAC review:**

- Revised Clinical Indications for Procedure:
  - Added clinical indications for elective induction of labor
  - Added clinical indications for early elective induction of labor
- Added references
- Updated Coding section

**February 4, 2016 MPTAC review:**

- Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section

#### OB/GYN - 20th Ed: Vaginal Delivery, Operative

**November 3, 2016 MPTAC review:**

- Included note under Clinical Indications for Procedure: For early elective vaginal delivery, see W0047 Vaginal Delivery

**February 4, 2016 MPTAC review:**

- Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section

### Orthopedics

**Return to Index**

#### Orthopedics - 20th Ed: Cervical Discectomy or Microdiscectomy, Foraminotomy, Laminotomy

**May 5, 2016 MPTAC review:**

- Included note under Clinical Indications for Procedure: For cervical total disc arthroplasty, see SURG.00055 Cervical Total Disc Arthroplasty
- Revised Alternatives to Procedure:
  - For information on cervical disk arthroplasty, see SURG.00055 Cervical Total Disc Arthroplasty.

**February 4, 2016 MPTAC review:**

- Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery
- Included note under Clinical Indications for Procedure: When the procedure uses recombinant human
<table>
<thead>
<tr>
<th>Inpatient &amp; Surgical Care (ISC) Guideline Title</th>
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</thead>
<tbody>
<tr>
<td>bone morphogenetic protein, see SURG.00059 Recombinant Human Bone Morphogenetic Protein</td>
<td>Included note under Clinical Indications for Procedure: When the procedure uses bone graft substitutes, see CG-SURG-45 Bone Graft Substitutes</td>
</tr>
<tr>
<td>Revised Goal Length of Stay to indicate Ambulatory or 1 day postoperative rather than Ambulatory</td>
<td>Revised Operative Status Criteria to indicate: o Ambulatory: Procedure without postoperative drain in place o Inpatient: Drain management may require an overnight stay</td>
</tr>
<tr>
<td>Revised Extended Stay to include: o Drain management may require minimal stay extension</td>
<td>Added Related Guidelines section with related medical policy and clinical UM guidelines o RAD.00053 Cervical and Thoracic Discography o SURG.00052 Intradiscal Annuloplasty Procedures (Percutaneous Intradiscal Electrothermal Therapy [IDET], Percutaneous Intradiscal Radiofrequency Thermocoagulation [PIRFT] and Intradiscal Biacuplasty [IDB]) o SURG.00055 Cervical Total Disc Arthroplasty o SURG.00059 Recombinant Human Bone Morphogenetic Protein o SURG.00071 Percutaneous and Endoscopic Spinal Surgery o SURG.00092 Implanted Devices for Spinal Stenosis o CG-SURG-42 Cervical Fusion o CG-SURG-45 Bone Graft Substitutes</td>
</tr>
<tr>
<td>Orthopedics - 20th Ed: Cervical Fusion, Anterior</td>
<td>February 4, 2016 MPTAC review: • Revised Clinical Indications for Procedure: For anterior cervical fusion, see the following: o CG-SURG-42 Cervical Fusion</td>
</tr>
<tr>
<td>Orthopedics - 20th Ed: Cervical Fusion, Posterior</td>
<td>February 4, 2016 MPTAC review: • Revised Clinical Indications for Procedure: For posterior cervical fusion, see the following: o CG-SURG-42 Cervical Fusion</td>
</tr>
<tr>
<td>Orthopedics - 20th Ed: Cervical Laminectomy</td>
<td>February 4, 2016 MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery</td>
</tr>
<tr>
<td>Orthopedics - 20th Ed: Hip Arthroplasty</td>
<td>February 4, 2016 MPTAC review: • Included note under Clinical Indications for Procedure: For elective total hip arthroplasty not due to developmental dysplasia, see CG-SURG-53 Elective Total Hip Arthroplasty (effective date: 5/02/2016) • Included note under Clinical Indications for Procedure: For partial hip arthroplasty due to displaced fracture of femoral neck, see Hip: Displaced Fracture of Femoral Neck, Hemiarthroplasty ISC guideline • Included note under Clinical Indications for Procedure: For computer-assisted musculoskeletal surgical navigational procedures, see SURG.00082 Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures of the Appendicular System • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective total hip arthroplasty not due to developmental dysplasia of hip o Retained MCG clinical indications for a) hip arthroplasty due to developmental hip dysplasia, b) non-elective, emergent total hip arthroplasty and c) partial hip arthroplasty • Updated Coding section with the following: o Added ICD-10 Procedure codes: 0SW93JZ, 0SW9XJZ, 0SWB3JZ, 0SWBXJZ</td>
</tr>
<tr>
<td>Orthopedics - 20th Ed: Hip Arthroscopy</td>
<td>February 4, 2016 MPTAC review: • Included note under Clinical Indications for Procedure: For surgical treatment of femoroacetabular impingement syndrome (FAIS), see SURG.00109 Surgical Treatment of Femoroacetabular Impingement Syndrome</td>
</tr>
<tr>
<td>Orthopedics - 20th Ed: Hip Resurfacing</td>
<td>February 4, 2016 MPTAC review: • Revised Clinical Indications for Procedure: For hip resurfacing, see the following: o SURG.00051 Hip Resurfacing</td>
</tr>
<tr>
<td>Inpatient &amp; Surgical Care (ISC) Guideline Title</td>
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</tr>
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<td>------------------------------------------------</td>
<td>----------------------------------------------------------------------------</td>
</tr>
</tbody>
</table>
| **Orthopedics - 20th Ed:** Knee Arthroplasty, Total | February 4, 2016 MPTAC review:  
- Included note under Clinical Indications for Procedure: For elective total knee arthroplasty or replacement (revision) of previous arthroplasty, see CG-SURG-54 Elective Total Knee Arthroplasty (effective date: 5/02/2016)  
- 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  
- Included note under Clinical Indications for Procedure: For bicompartimental knee arthroplasty, see SURG.00105 Bicompartimental Knee Arthroplasty  
- Revised Clinical Indications for Procedure:  
  - Removed MCG clinical indications for elective total knee arthroplasty and replacement (revision) of previous arthroplasty  
  - Retained MCG clinical indications for non-elective, emergent knee arthroplasty  
- Updated Coding section with the following:  
  - Added CPT® code: 27299*  
  - *CPT® 27130 and 27299 [when specified as partial or total hip resurfacing]. |
| **Orthopedics - 20th Ed:** Knee Arthroscopy | February 4, 2016 MPTAC review:  
- Revised Clinical Indications for Procedure: For knee arthroscopy, see the following:  
  - CG-SURG-43 Knee Arthroscopy |
| **Orthopedics - 20th Ed:** Lumbar Diskectomy, Foraminotomy, or Laminotomy | February 4, 2016 MPTAC review:  
- Revised Clinical Indications for Procedure: For lumbar discectomy, foraminotomy, or laminotomy, see the following:  
  - CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy Laminotomy and/or Discectomy |
| **Orthopedics - 20th Ed:** Lumbar Fusion | February 4, 2016 MPTAC Review:  
- Title changed from Lumbar Fusion to indicate Lumbar Fusion or Lumbar Total Disc Arthroplasty  
- Revised Clinical Indications for Procedure: For lumbar fusion or lumbar total disc arthroplasty, see the following:  
  - CG-SURG-33 Lumbar Fusion and Lumbar Total Disc Arthroplasty (TDA)  
- Updated Coding section with the following:  
  - Added ICD-10 Procedure codes: 0SR20JZ, 0SR40JZ, 0SRW0JZ, 0SW23JZ, 0SW24JZ, 0SW40JZ, 0SW43JZ, 0SW44JZ  
  - Added CPT® codes: 0163T*, 0165T*  
  - *CPT® 0163T and 0165T always considered not medically necessary [each additional lumbar interspace, arthroplasty]. |
| **Orthopedics - 20th Ed:** Lumbar Laminectomy | February 4, 2016 MPTAC review:  
- Revised Clinical Indications for Procedure: For lumbar laminectomy, see the following:  
  - CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy Laminotomy and/or Discectomy  
- Updated Coding section with the following:  
  - Added ICD-10 Procedure codes: 008Y0ZZ, 008Y4ZZ, 018B4ZZ |
| **Orthopedics - 20th Ed:** Spine, Scoliosis, Posterior Instrumentation | February 4, 2016 MPTAC review:  
- Revised Clinical Indications for Procedure: For posterior instrumentation, spine, scoliosis, see the following:  
  - CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity |

**Pediatrics - 20th Ed:**

- Revised Alternatives to Procedure:  
  - Return to Index
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<tbody>
<tr>
<td>Cranioplasty, Pediatric</td>
<td>o For information on helmets, see CG-OR-PR-04 Cranial Remodeling Bands and Helmets (Cranial Orthotics).</td>
</tr>
</tbody>
</table>
| Pediatrics - 20th Ed: Diabetes, Pediatric     | February 4, 2016 MPTAC review:  
  - Revised Extended Stay: Added  
    o Need to receive comprehensive patient, parent or caregiver education and comprehensive diabetic education programs are not available on an outpatient basis in the community.  
    - Expect minimal stay extension.  
    - Note: Obtain verbal or written attestation from provider regarding lack of outpatient diabetic education resources. |
| Pediatrics - 20th Ed: EEG, Video Monitoring, Pediatric | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure: For pediatric EEG video monitoring, see the following:  
    o CG-MED-46 Ambulatory and Inpatient Video Electroencephalography |
| Pediatrics - 20th Ed: Heart Transplant, Pediatric | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure: For pediatric heart transplant, see the following:  
    o TRANS.00026 Heart/Lung Transplantation  
    o TRANS.00033 Heart Transplantation |
| Pediatrics - 20th Ed: Liver Transplant, Pediatric | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure: For pediatric liver transplant, see the following:  
    o TRANS.00008 Liver Transplantation |
| Pediatrics - 20th Ed: Lung Transplant, Pediatric | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure: For pediatric lung transplant, see the following:  
    o TRANS.00009 Lung and Lobar Transplantation  
    o TRANS.00026 Heart/Lung Transplantation |
| Pediatrics - 20th Ed: Renal Transplant, Pediatric | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure: For pediatric renal transplant, see the following:  
    o CG-TRANS-02 Kidney Transplantation |

Thoracic Surgery and Pulmonary Disease  
Return to Index

Thoracic Surgery and Pulmonary Disease - 20th Ed: Lung Transplant | February 4, 2016 MPTAC review:  
  - Revised Clinical Indications for Procedure: For lung transplant see the following:  
    o TRANS.00009 Lung and Lobar Transplantation  
    o TRANS.00026 Heart/Lung Transplantation  
  - Revised Alternatives to Procedure: For lung volume reduction surgery, see SURG.00022 Lung Volume Reduction Surgery. |

Thoracic Surgery and Pulmonary Disease - 20th Ed: Rib Fracture | February 4, 2016 MPTAC review:  
  - Included note under Clinical Indications for Admission: For the open treatment of rib fracture(s) requiring internal fixation, see SURG.00120 Open Treatment of Rib Fracture(s) Requiring Internal Fixation |

Urology  
Return to Index

Urology - 20th Ed: Prostatectomy, Transurethral, Alternatives to Standard Resection | February 4, 2016 MPTAC review:  
  - Included note under Clinical Indications for Procedure: For additional information on surgical and minimally invasive procedures for benign prostatic hyperplasia (BPH) considered medically necessary, not medically necessary, or investigational and not medically necessary, including water-induced thermotherapy (WIT), also known as thermourethral hot-water therapy, when used as an alternative to open prostatectomy or transurethral resection of the prostate (TURP) for the treatment of benign prostatic hyperplasia, see SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostate Hyperplasia. |
### Customizations to Care Guidelines 20th Edition

<table>
<thead>
<tr>
<th>Inpatient &amp; Surgical Care (ISC) Guideline Title</th>
<th>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</th>
</tr>
</thead>
</table>
| Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions. | - Revised Alternatives to Procedure:  
  o For information on the placement of temporary prostatic stents, see SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions.  
  o For information on urethral lift procedure, see SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions. |

| Urology - 20th Ed: Prostatectomy, Transurethral Resection (TURP) February 4, 2016 MPTAC review: | Revised Alternatives to Procedure:  
  - For information on the placement of temporary prostatic stents, see SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions.  
  - For information on urethral lift procedure, see SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions. |

| Urology - 20th Ed: Renal Transplant February 4, 2016 MPTAC review: | Revised Clinical Indications for Procedure: For renal transplant, see the following:  
  - CG-TRANS-02 Kidney Transplantation |

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### Customizations - General Recovery Care Guidelines (GRG)

<table>
<thead>
<tr>
<th>General Recovery Guideline (GRG) Guideline Title</th>
<th>Date of Medical Policy &amp; Technology Assessment Committee (MPTAC) Customizations</th>
</tr>
</thead>
</table>
| Behavioral Health GRG | February 4, 2016 MPTAC review:  
  - Approval of January 29, 2016 Behavioral Health Subcommittee review  
  January 29, 2016 Behavioral Health Subcommittee review:  
    - Continue to remove guideline for Behavioral Health GRG |

| Cardiovascular Surgery or Procedure GRG | November 3, 2016 MPTAC review:  
  - Revised Note under Clinical Indications for Procedure:  
    - "TRANS.00014" changed to "SURG.00145"  
    - Corrected error in the Guideline History section:  
      - "05/06/2016" changed to "05/05/2016"  
  May 5, 2016 MPTAC review:  
    - Revised Note under Clinical Indications for Procedure:  
      - "CG-SURG-44 Coronary Angiography and Cardiac Catheterization in the Outpatient Setting" changed to "CG-SURG-44 Coronary Angiography in the Outpatient Setting"  
      - Added: CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation  
  February 4, 2016 MPTAC review:  
    - Revised Clinical Indications for Procedure:  
      - Removed 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) and (c) Ventricular assist device  
      - Included note under Clinical Indications for Procedure: For additional information on cardiovascular surgeries or procedures see the applicable clinical document, including but not limited to the following:  
        - SURG.00019 Transmyocardial Revascularization |
<table>
<thead>
<tr>
<th>General Recovery Guideline (GRG)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention</td>
<td></td>
</tr>
<tr>
<td>SURG.00033 Cardioverter Defibrillators</td>
<td></td>
</tr>
<tr>
<td>SURG.00054 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection</td>
<td></td>
</tr>
<tr>
<td>SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure</td>
<td></td>
</tr>
<tr>
<td>SURG.00121 Transcatheter Heart Valve Procedures</td>
<td></td>
</tr>
<tr>
<td>SURG.00133 Alcohol Septal Ablation for Treatment of Hypertrophic Cardiomyopathy</td>
<td></td>
</tr>
<tr>
<td>TRANS.00014 Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts)</td>
<td></td>
</tr>
<tr>
<td>CG-SURG-44 Coronary Angiography and Cardiac Catheterization in the Outpatient Setting</td>
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</tr>
<tr>
<td>CG-SURG-48 Elective Percutaneous Coronary Interventions (PCI)</td>
<td></td>
</tr>
<tr>
<td>CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities</td>
<td></td>
</tr>
</tbody>
</table>

**Body System 20th Ed:** Musculoskeletal Surgery or Procedure GRG

*February 4, 2016 MPTAC review:*  
- Included note under Clinical Indications for Procedure: For additional information on musculoskeletal surgeries or procedures see the applicable clinical document, including but not limited to the following:  
  - SURG.00053 Unicondylar Interpositional Spacer  
  - SURG.00105 Bicompartmental Knee Arthroplasty  
  - CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity

**Body System 20th Ed:** Neurosurgery or Procedure GRG

*February 4, 2016 MPTAC review:*  
- Included note under Clinical Indications for Procedure: For surgical interventions for scoliosis and spinal deformity, see the following:  
  - CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity

**Care Management Tools**  
*Return to Index*

**Care Management 20th Ed:** Behavioral Health Levels of Care

*February 4, 2016 MPTAC review:*  
- Approval of January 29, 2016 Behavioral Health Subcommittee review

*January 29, 2016 Behavioral Health Subcommittee review:*  
- Continue to remove guideline for Behavioral Health Levels of Care

**Case Management GRG**  
*Return to Index*

**Case Management 20th Ed:** Behavioral Health Case Management GRG

*February 4, 2016 MPTAC review:*  
- Approval of January 29, 2016 Behavioral Health Subcommittee review

*January 29, 2016 Behavioral Health Subcommittee review:*  
- Continue to remove guideline for Behavioral Health Case Management GRG

**General Recovery Guidelines Tools Section**  
*Return to Index*

**General Recovery Guidelines Tools Section 20th Ed:** Inpatient Palliative Care Criteria

*February 4, 2016 MPTAC review:*  
- Revised Alternatives to Admission  
  - For Home hospice added the following:  
    - Outpatient: Continuous Home Care (CHC)  
    - Outpatient: Routine Home Care  
    - Patients who may benefit from hospice care  
    - Nursing care  
  - Added reference for Centers for Medicare and Medicaid Services, Medicare Benefit Policy Manual, Ch 9 Coverage of hospice services under hospital insurance

**Problem Oriented GRG**  
*Return to Index*

**Problem Oriented**  
*February 4, 2016 MPTAC review:*
# Customizations to MCG Care Guidelines 20th Edition

## General Recovery Guideline (GRG) Guideline Title

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<tbody>
<tr>
<td>20th Ed: Medical Oncology GRG</td>
</tr>
<tr>
<td>• Revised Clinical Indications for Admission to Inpatient Care:</td>
</tr>
<tr>
<td>o Removed indications for when admission is indicated for (a) Allogeneic bone marrow or peripheral blood stem cell transplantation and (b) Autologous bone marrow or peripheral blood stem cell transplant</td>
</tr>
<tr>
<td>• Included note under Clinical Indications for Admission to Inpatient Care: For hematopoietic stem cell transplantation, see the following:</td>
</tr>
<tr>
<td>o TRANS.00023 Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias</td>
</tr>
<tr>
<td>o TRANS.00024 Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome</td>
</tr>
<tr>
<td>o TRANS.00028 Hematopoietic Stem Cell Transplantation for Hodgkin Disease and non-Hodgkin Lymphoma</td>
</tr>
<tr>
<td>o TRANS.##### Additional clinical documents in transplant as applicable</td>
</tr>
<tr>
<td>• Included note under Clinical Indications for Admission to Inpatient Care:</td>
</tr>
<tr>
<td>o For radioactive implant treatments needing inpatient environment, added note for inpatient admission for radiation therapy for cervical or thyroid cancer, see CG-MED-38 Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer</td>
</tr>
</tbody>
</table>

## Customization History

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<th>Action</th>
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