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CUSTOMIZATION TO mcg CARE GUIDELINES
21st EDITION

Issue Date:	**Original Date**:
December 8, 2017	**February 7, 2017**

NOTE:

- ***Anthem licenses and utilizes MCG care guidelines. The four (4) 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 (CC): 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.***
- ***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 21st 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 21st edition of the MCG care guidelines and corresponding customized guidelines will take effect May 1, 2017.***
- ***The August 3, 2017 review date reflects review and approval or update of the following new customizations to the 21st edition:***
    - ***GRG Cardiovascular Surgery or Procedure GRG***
    - ***ISC Angina***
    - ***ISC Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy***
    - ***ISC Chest Pain***
    - ***ISC Gastric Restrictive Procedure with or without Gastric Bypass***
    - ***ISC Vaginal Delivery***

- ***The September 13, 2017 review date reflects review and approval or update of the following new customizations to the 21st edition:***
    - ***GRG Cardiovascular Surgery or Procedure GRG***
    - ***ISC Deep Venous Thrombosis of Lower Extremities***
    - ***ISC Pulmonary Embolism***
    - ***ISC Venous Thrombosis and Pulmonary Embolism: Common Complications and Conditions***
- ***The November 2, 2017 review date reflects review and approval or update of the following new customizations to the 21st edition:***
    - ***GRG Cardiovascular Surgery or Procedure GRG***
    - ***GRG Musculoskeletal Surgery or Procedure GRG***
    - ***GRG Neurosurgery or Procedure GRG***
    - ***ISC Acromioplasty and Rotator Cuff Repair***
    - ***ISC Atrial Fibrillation***
    - ***ISC Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy***
    - ***ISC Cervical Fusion, Anterior***
    - ***ISC Cervical Fusion, Posterior***
    - ***ISC Cervical Laminectomy***
    - ***ISC EEG, Video Monitoring***
    - ***ISC EEG, Video Monitoring, Pediatric***
    - ***ISC Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion***
    - ***ISC Electrophysiologic Study and Intracardiac Catheter Ablation***
    - ***ISC Hip Arthroplasty***
    - ***ISC Hip Arthroscopy***
    - ***ISC Knee Arthroplasty, Total***
    - ***ISC Knee Arthroscopy***
    - ***ISC Knee Arthrotomy***
    - ***ISC Lumbar Diskectomy, Foraminotomy, or Laminotomy***
    - ***ISC Lumbar Fusion***
    - ***ISC Lumbar Laminectomy***
    - ***ISC Rib Fracture***
    - ***ISC Shoulder Arthroplasty***
    - ***ISC Shoulder Hemiarthroplasty***
    - ***ISC Spine, Scoliosis, Posterior Instrumentation***
    - ***ISC Sympathectomy by Thoracoscopy or Laparoscopy***

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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.

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CUSTOMIZATIONS INPATIENT & SURGICAL CARE (ISC) GUIDELINES

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Behavioral Health Return to Index	
Behavioral Health (BH) - 21st Ed: Anorexia Nervosa	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 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.

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• 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) - 21st Ed: Delirium	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 Behavioral Health Subcommittee review: • Continue to reinstate guideline for *Delirium*
Behavioral Health (BH) - 21st Ed: Substance-Related Disorders	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 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 - 21st Ed: Angina	August 3, 2017 review: • Revised Note under Clinical Indications for Admission to Inpatient Care: o "RAD.00035" to "CG-MED-58 Coronary Artery Imaging: Contrast-Enhanced CT Angiography, Fractional Flow Reserve derived from CT, Coronary MRA, and Cardiac MRI" February 2, 2017 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 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 - 21st Ed: Angioplasty, Percutaneous	February 2, 2017 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:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Coronary Intervention	o Removed MCG clinical indications for elective PCI o Retained MCG clinical indications for non-elective, emergent PCI
Cardiology - 21st Ed: Atrial Fibrillation	November 2, 2017 MPTAC review: • Revised note under Clinical Indications for Admission to Inpatient Care: o "MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)" to "CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)" February 2, 2017 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 - 21st Ed: Chest Pain	August 3, 2017 review: • Revised Note under Clinical Indications for Admission to Inpatient Care: o "RAD.00035" to "CG-MED-58 Coronary Artery Imaging: Contrast-Enhanced CT Angiography, Fractional Flow Reserve derived from CT, Coronary MRA, and Cardiac MRI" February 2, 2017 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 - 21st Ed: Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion	November 2, 2017 MPTAC review: • Revised a) Clinical Indications for Procedure, and b) Related Guidelines: o "SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure" to "CG-SURG-63 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure" February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For electrophysiologic study (EPS) and insertion of implantable cardioverter-defibrillator (ICD) see the following: o SURG.00033 Cardioverter Defibrillators o SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (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 Cardioverter Defibrillators o SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure
Cardiology - 21st Ed: Electrophysiologic Study and Intracardiac Catheter Ablation	November 2, 2017 MPTAC review: • Revised a) note under Clinical Indications for Procedure, and b) Related 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)" to "CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)" • Revised Related Guidelines:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	○ "SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure" to "CG-SURG-63 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure" February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For electrophysiologic study and intracardiac catheter ablation, see the following: ○ CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation • 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 ○ MED.00064 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation) ○ SURG.00033 Cardioverter Defibrillators ○ SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure ○ CG-SURG-05 Maze Procedure
Cardiovascular Surgery Return to Index	
CV Surgery - 21st Ed: Abdominal Aortic Aneurysm, Endovascular Repair	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For abdominal aortic aneurysm, endovascular repair, see the following: ○ SURG.00054 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection
CV Surgery - 21st Ed: Cardiac Septal Defect: Atrial, Transcatheter Closure	February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For transcatheter closure of patent foramen ovale (PFO) and left atrial appendage for stroke prevention, see SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention
CV Surgery - 21st Ed: Cardiac Septal Defect: Ventricular, Repair	February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For transmyocardial/perventricular device closure of ventricular septal defects, see SURG.00123 Transmyocardial/Perventricular Device Closure of Ventricular Septal Defects
CV Surgery - 21st Ed: Cardiac Valve Replacement or Repair	February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: When the procedure uses the transcatheter approach (as opposed to open), see SURG.00121 Transcatheter Heart Valve Procedures
CV Surgery - 21st Ed: Carotid Endarterectomy	February 2, 2017 MPTAC review: • Revised Alternatives to Procedure: ○ 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.
CV Surgery - 21st Ed: Heart Transplant	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For heart transplant, see the following: ○ TRANS.00026 Heart/Lung Transplantation ○ TRANS.00033 Heart Transplantation

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
CV Surgery - 21st Ed: Percutaneous Revascularization, Lower Extremity	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For percutaneous revascularization, lower extremity, see the following: o CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities
CV Surgery - 21st Ed: Sympathectomy by Thoracoscopy or Laparoscopy	November 2, 2017 MPTAC review: • Revised note under Clinical Indications for Procedure: o "MED.00032 Treatment of Hyperhidrosis" to "CG-MED-63 Treatment of Hyperhidrosis" February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For treatment of hyperhidrosis, see MED.00032 Treatment of Hyperhidrosis • Revised Clinical Indications for Procedure: o Removed: • Hyperhidrosis and **ALL** of the following: • Patient has severe disabling symptoms. • Nonsurgical management options have been tried and failed or are not appropriate (eg, medication, botulinum toxin injection). • Ventricular arrhythmia and **ALL** of the following: • Medical therapy has been tried and failed (eg, beta-blockers, antiarrhythmics). • Other procedural methods have failed (eg, electrophysiologic ablation, recurrent appropriate ICD shocks) or are not appropriate. • Revised Alternatives to Procedure: o Removed: • For ventricular arrhythmia: • Medical therapy • Electrophysiologic study and ablation • ICD implantation
CV Surgery - 21st Ed: Aortic Valve Replacement, Transcatheter	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For transcatheter aortic valve replacement, see the following: o SURG.00121 Transcatheter Heart Valve Procedures
Common Complications and Conditions Return to Index	
Common Complications and Conditions 21st Ed: Alcohol and Psychoactive Substance Withdrawal	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 Behavioral Health Subcommittee review: • Revised Clinical Indications for Inpatient Care: o For ongoing inpatient care due to substance withdrawal see the following: • CG-BEH-04 Substance-Related and Addictive Disorder Treatment o For delirium due to alcohol or sedative withdrawal is present, see the following: • See Mental Status Change: Common Complications and Conditions ISC as needed o For ongoing inpatient care due to substance withdrawal with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-03 Psychiatric Disorder Treatment. • Revised: Alternatives to Inpatient Care o Added: See CG-BEH-04 Substance-Related and Addictive Disorder Treatment • Revised: Discharge o Removed: MCG indications for extended stay o Added note: For extended stay beyond goal length of stay for primary condition, see CG-BEH-04 Substance-Related and Addictive Disorder Treatment.

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Common Complications and Conditions 21st Ed: Preoperative Days	February 2, 2017 MPTAC review: • Revised Clinical Indications for Inpatient Care: o For inpatient preoperative days, added indication, Conversion from warfarin (Coumadin®) to IV heparin for patients with mechanical heart valves or other high risk patients with contraindications to low-molecular-weight heparin (LMWH) or fractionated heparin (one to two days inpatient stay before elective surgery)
Common Complications and Conditions 21st Ed: Psychiatric Disorders	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 Behavioral Health Subcommittee review: • Revised Clinical Indications for Inpatient Care: o For ongoing inpatient care due to psychiatric disorders see the following: • CG-BEH-03 Psychiatric Disorder Treatment o For ongoing inpatient care due to psychiatric disorders with co-occurring conditions, please refer to other guidelines as appropriate, including MCG guidelines or other clinical documents such as CG-BEH-04 Substance-Related and Addictive Disorder Treatment. • Revised: Alternatives to Inpatient Care o Added: See CG-BEH-03 Psychiatric Disorder Treatment • Revised: Discharge o Removed: MCG indications for extended stay o Added note: For extended stay beyond goal length of stay for primary condition, see CG-BEH-03 Psychiatric Disorder Treatment.
Common Complications and Conditions 21st Ed: Venous Thrombosis and Pulmonary Embolism	September 13, 2017 MPTAC review: • Revised Clinical Indications for Inpatient Care: o For vena cava filter placement needed: • Removed "(eg, unable to anticoagulate)" • Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters
Gastroenterology Return to Index	
Gastroenterology 21st Ed: Liver Disease Complications	February 2, 2017 MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For acute hepatitis, revised bilirubin greater than 20 mg/dL (342 micromoles/L) to indicate bilirubin greater than 10 mg/dL (171 micromoles/L)
General Surgery Return to Index	
General Surgery - 21st Ed: Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure, sleeve gastrectomy, by laparoscopy see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Revised Alternatives to Procedure: Removed: o Intragastric balloon o Biliopancreatic diversion
General Surgery - 21st Ed: Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure with gastric bypass by laparoscopy, see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Revised Alternatives to Procedure: Removed: o Intragastric balloon o Biliopancreatic diversion • Updated Coding section with the following: o Added ICD-10 Procedure codes: 0D164Z9, 0DB64ZZ

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
General Surgery - 21st Ed: Gastric Restrictive Procedure with Gastric Bypass Title change to: Gastric Restrictive Procedure with or without Gastric Bypass	August 3, 2017 review: • Updated Coding section with the following: o Added CPT® code: 43633*** o Added "and 43633" to ***CPT® 43632 and 43633 considered investigational and not medically necessary [when specified as bariatric surgery]. February 2, 2017 MPTAC review: • Title changed from Gastric Restrictive Procedure with Gastric Bypass to indicate Gastric Restrictive Procedure with or without Gastric Bypass • Revised Clinical Indications for Procedure: For gastric restrictive procedure with or without gastric bypass, see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Revised Alternatives to Procedure: Removed: o Intragastric balloon o Biliopancreatic diversion • Updated Coding section with the following: o Added ICD-10 Procedure codes: 0D190ZB, 0DB60Z3, 0DP60CZ, 0DP60DZ**, 0DV60CZ, 0DV60DZ**, 0DV67DZ**, 0DV68DZ** 0DW60CZ o Added CPT® codes: 43632***, 43842, 43843, 43845, 43848 o *ICD-10 Procedure code 0D160ZA considered investigational and not medically necessary [when specified as Billroth II with the diagnosis of obesity]. o **ICD-10 Procedure codes 0DP60DZ, 0DV60DZ, 0DV67DZ, 0DV68DZ considered investigational and not medically necessary. o ***CPT® 43632 considered investigational and not medically necessary [when specified as bariatric surgery].
General Surgery - 21st Ed: Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For gastric restrictive procedure without gastric bypass by laparoscopy, see the following: o SURG.00024 Bariatric Surgery and Other Treatments for Clinically Severe Obesity • Revised Alternatives to Procedure: Removed: o Intragastric balloon o Biliopancreatic diversion • Update the Coding Section with the following: o Added ICD-10 procedure codes: 0DB68Z3, 0DP63DZ*, 0DP64CZ, 0DP64DZ*, 0DP67DZ*, 0DP68DZ*, 0DV63DZ*, 0DV64DZ* o Added CPT® codes: 0312T**, 0314T**, 0315T**, 0316T**, 0317T**, 43659***, 43771, 43772, 43773, 43774, 43886, 43887, 43888, 43999**** o *ICD-10 Procedure codes 0DP63DZ, 0DP64DZ, 0DP67DZ, 0DP68DZ, 0DV63DZ, 0DV64DZ considered investigational and not medically necessary. o **CPT® 0312T, 0314T, 0315T, 0316T, 0317T considered investigational and not medically necessary. o ***CPT® 43659 considered investigational and not medically necessary [when specified as gastric plication (laparoscopic greater curvature plication [LGCP]) with or without gastric banding]. o ****CPT® 43999 considered investigational and not medically necessary [when specified as endoluminal gastric restrictive surgery].
General Surgery - 21st Ed: Liver Transplant	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For liver transplant, see the following: o TRANS.00008 Liver Transplantation • Update the Coding Section with the following: o Added ICD-10 procedure codes: 5A1C00Z*, 5A1C60Z* o *ICD-10 Procedure codes 5A1C00Z and 5A1C60Z considered investigational and not medically necessary.
General Surgery - 21st Ed: Mastectomy, Complete	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: • Personal history of breast cancer

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• Noninvasive histology indicating risk (e.g., lobular carcinoma in situ or atypical hyperplasia) • Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible o For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should be considered possibly in women with LCIS. • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory • Under the Goal Length of Stay (GLOS) section added: o Reason: Organization approved 2 day stay o Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory • Added references: o Society of Surgical Oncology: Position Statement on Prophylactic Mastectomy o ACOG Practice Bulletin No. 122 Breast Cancer Screening o National Cancer Institute PDQ Breast Cancer Treatment o Society of Surgical Oncology Breast Disease Working Group Statement on Prophylactic (Risk-Reducing) Mastectomy
General Surgery - 21st Ed: Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: • Personal history of breast cancer • Noninvasive histology indicating risk (e.g., lobular carcinoma in situ or atypical hyperplasia) • Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible o For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should be considered possibly in women with LCIS. • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory or 1 day postoperative • Under the Goal Length of Stay (GLOS) section added: o Reason: Organization approved 2 day stay o Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory or Inpatient • Added references: o Society of Surgical Oncology: Position Statement on Prophylactic Mastectomy o ACOG Practice Bulletin No. 122 Breast Cancer Screening o National Cancer Institute PDQ Breast Cancer Treatment o Society of Surgical Oncology Breast Disease Working Group Statement on Prophylactic (Risk-Reducing) Mastectomy
General Surgery - 21st Ed: Mastectomy, Complete, with Tissue Flap Reconstruction	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: • Personal history of breast cancer • Noninvasive histology indicating risk (e.g., lobular carcinoma in situ or atypical hyperplasia) • Extensive mammographic abnormalities (e.g., calcifications) exist such that adequate biopsy is impossible o For risk-reduction mastectomy and significantly elevated risk of breast cancer, Footnote A, revised to include: risk-reduction mastectomy should be considered possibly in women with LCIS. • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references: o Society of Surgical Oncology: Position Statement on Prophylactic Mastectomy o ACOG Practice Bulletin No. 122 Breast Cancer Screening o National Cancer Institute PDQ Breast Cancer Treatment

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	○ Society of Surgical Oncology Breast Disease Working Group Statement on Prophylactic (Risk-Reducing) Mastectomy
General Surgery - 21st Ed: Mastectomy, Partial (Lumpectomy)	February 2, 2017 MPTAC review: • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under 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
Neonatal Facility Levels and Admission Guidelines Return to Index	
Neonatal Facility Levels and Admission Guidelines – 21st 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	February 2, 2017 MPTAC review: • Removed the MCG Neonatal Facility Levels and Admission Guidelines in the 21st edition. Anthem will not be using the MCG Neonatal Facility Levels and Admission Guidelines. • Anthem will continue to use CG-MED-26 Neonatal Levels of Care.
Neonatology Return to Index	
Neonatology – 21st Ed: Newborn Care, Routine	February 2, 2017 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

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Neonatology – 21st Ed: Newborn Care, Term, with Severe Illness or Abnormality	February 2, 2017 MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For newborn care, term, with severe illness or abnormality, see the following: o CG-MED-26 Neonatal Levels of Care
Neonatology – 21st Ed: Sepsis, Neonatal, Confirmed	February 2, 2017 MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, confirmed, see the following: o CG-MED-26 Neonatal Levels of Care
Neonatology – 21st Ed: Sepsis, Neonatal, Suspected, Not Confirmed	February 2, 2017 MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: For neonatal sepsis, suspected, not confirmed, see the following: o CG-MED-26 Neonatal Levels of Care
Neurology Return to Index	
Neurology – 21st Ed: EEG, Video Monitoring	November 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o "CG-MED-46 Ambulatory and Inpatient Video Electroencephalography" to "CG-MED-46 Ambulatory Electroencephalography and Video Electroencephalography" February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For EEG video monitoring, see the following: o CG-MED-46 Ambulatory and Inpatient Video Electroencephalography
Obstetrics and Gynecology (OB / GYN) Return to Index	
OB / GYN - 21st Ed: Cesarean Delivery	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o Retained MCG clinical indications for emergency cesarean delivery o Added clinical indications for early elective cesarean delivery o Revised MCG clinical indications for elective cesarean delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Updated Coding section
OB / GYN - 21st Ed: Hysterectomy, Abdominal	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: • Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition. • Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated. • It was tried but did not adequately treat patient's condition. • It is not appropriate for severity of patient's condition (eg, severe persistent bleeding). • "Uterine-sparing procedure (eg, endometrial ablation)" changed to "endometrial ablation" cannot be used because of **1 or more** of the following:

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	• For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable. • For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) • Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): • "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms." changed to "Investigation has ruled out other causes for symptoms." • "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to: "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: • "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to: "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when abdominal hysterectomy is considered not medically necessary: o **Abdominal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: • To improve detection of adnexal masses, or • To prevent impairment of renal function, or • To rule out malignancy • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs) • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate **or** acceptable.
OB / GYN - 21st Ed: Hysterectomy, Laparoscopic Title change to: Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: • Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition. • Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated. • It was tried but did not adequately treat patient's condition. • It is not appropriate for severity of patient's condition (eg, severe persistent bleeding). • "Uterine-sparing procedure (eg, endometrial ablation)" changed to "endometrial ablation" cannot be used because of **1 or more** of the following: • For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable. • For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition

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	• Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation) • Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): • "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms." changed to "investigation has ruled out other causes for symptoms." • "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to: "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: • "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to: "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy is considered not medically necessary: o **Laparoscopic vaginal hysterectomy; laparoscopically-assisted vaginal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: • To improve detection of adnexal masses, or • To prevent impairment of renal function, or • To rule out malignancy • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs) • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate **or** acceptable.
OB / GYN - 21st Ed: Hysterectomy, Vaginal	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o For abnormal uterine bleeding: • Added indication, Alternative hormonal medical treatment has been considered including the levonorgestrel-releasing intrauterine system or systemic hormonal therapy unless **1 or more** of the following conditions exist: • Either the levonorgestrel-releasing intrauterine system or systemic hormonal therapy was tried but did not adequately treat patient's condition. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are Contraindicated or not tolerated. • Both the levonorgestrel-releasing intrauterine system and systemic hormonal therapy are not appropriate for the severity of patient's condition. • Removed indication, Hormonal therapy (eg, intrauterine delivery system or systemic hormonal therapy) cannot be used because of **1 or more** of the following: • It is contraindicated. • It was tried but did not adequately treat patient's condition. • It is not appropriate for severity of patient's condition (eg, severe persistent bleeding). • "Uterine-sparing procedure (eg, endometrial ablation)" changed to "endometrial ablation" cannot be used because of **1 or more** of the following: • For endometrial ablation, added indication, The patient or her physician has determined that endometrial ablation is not appropriate or acceptable. • For endometrial ablation, removed indications, • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation)

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	• Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references o For leiomyoma ("fibroid"): • "Investigation (eg, endometrial sampling) has ruled out other causes for symptoms." changed to "investigation has ruled out other causes for symptoms." • "Alternative treatment (eg, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following:" changed to: "Alternative treatment (eg, one or more of the following treatments, myomectomy, hormonal therapy, hysteroscopic resection, uterine artery embolization) cannot be used because of **1 or more** of the following reasons:" o For pelvic organ prolapse: • "Uterine-sparing treatment (eg, pessary, apical (uterine) vault prolapse suspension) cannot be used because of **1 or more** of the following:" changed to: "Uterine-sparing treatment (eg, one or more of the following treatments, pessary, pelvic floor physical therapy, uterine suspension procedure) cannot be used because of **1 or more** of the following reasons:" • Added indication for when vaginal hysterectomy is considered not medically necessary: o **Vaginal hysterectomy** is considered **not medically necessary** for all other indications not listed above, including but not limited to, the treatment of asymptomatic leiomyomata when performed for any of the following reasons: • To improve detection of adnexal masses, or • To prevent impairment of renal function, or • To rule out malignancy • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs) • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: o Oral tranexamic acid is Contraindicated or not tolerated, **or** o Oral tranexamic acid is not appropriate for the severity of patient's condition, **or** o The patient or her physician has determined that oral tranexamic acid is not appropriate **or** acceptable.
OB / GYN - 21st Ed: Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy	February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For laparoscopic surgical ablation of uterine fibroids, see SURG.00077 Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques • Included note under Clinical Indications for Procedure: For the evaluation of infertility, see CG-SURG-34 Diagnostic Infertility Surgery • Revised Clinical Indications for Procedure: o "Bilateral prophylactic salpingo-oophorectomy" changed to "risk-reducing salpingo-oophorectomy" o For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "bilateral oophorectomy" changed to "risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy" o Additional indication listed for oophorectomy: • Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (e.g., mother, sister, daughter) **or** one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer o Removed: • Infertility evaluation or treatment needed, as indicated by **ALL** of the following: • Infertility, as indicated by **1 or more** of the following: o Inability to conceive after regular unprotected sexual intercourse for 6 months or more for female older than 35 years o Inability to conceive after regular unprotected sexual intercourse for at least 1 year for female 35 years or younger • Appropriate laboratory hormone levels (eg, prolactin, follicle-stimulating hormone, mid-luteal progesterone) • Imaging (transvaginal ultrasound and hysterosalpingogram or sonohysterography) nondiagnostic or demonstrates pathology amenable to surgical treatment (eg, endometriosis) • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs)

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OB / GYN - 21st Ed: Laparotomy, for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o "Bilateral prophylactic salpingo-oophorectomy" changed to "risk-reducing salpingo-oophorectomy" o For premenopausal female with estrogen or progesterone receptor-positive breast cancer, "bilateral oophorectomy" changed to "risk-reducing oophorectomy or risk-reducing salpingo-oophorectomy" o Additional indication listed for oophorectomy: • Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (e.g., mother, sister, daughter) **or** one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer • Added Black Box Warning and Contraindications - Laparoscopic Power Morcellators (LPMs)
OB / GYN - 21st Ed: Vaginal Delivery	August 3, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o Added ":" to "Fetal indication as indicated by **1 or more** of the following:" February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o Removed clinical indications for when induction of labor is appropriate o Added clinical indications for elective induction of labor o Added clinical indications for early elective induction of labor • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Updated Coding section
OB/GYN - 21st Ed: Vaginal Delivery, Operative	February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For early elective vaginal delivery, see W0047 Vaginal Delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section
Orthopedics Return to Index	
Orthopedics - 21st Ed: Acromioplasty and Rotator Cuff Repair	November 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For acromioplasty and rotator cuff repair, see the following: o Musculoskeletal Program Clinical Guidelines
Orthopedics - 21st Ed: Cervical Diskectomy or Microdiskectomy, Foraminotomy, Laminotomy	November 2, 2017 MPTAC review: • Removed the following notes under Clinical Indications for Procedure: o For cervical total disc arthroplasty, see CG-SURG-60 Cervical Total Disc Arthroplasty o When the procedure uses recombinant human bone morphogenetic protein, see SURG.00059 Recombinant Human Bone Morphogenetic Protein o When the procedure uses bone graft substitutes, see CG-SURG-45 Bone Graft Substitutes • Included note under Clinical Indications for Procedure: For elective, non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective non-emergent cervical diskectomy or microdiskectomy, foraminotomy, laminotomy • Revised Alternatives to Procedure: o Removed: For information on cervical disk arthroplasty, see CG-SURG-60 Cervical Total Disc Arthroplasty • Removed Related Guidelines section August 3, 2017 review: • Revised a) Note under Clinical Indications for Procedure, b) Alternatives to Procedure, and c) Related Guidelines: o Revised: "SURG.00055 Cervical Total Disc Arthroplasty" to "CG-SURG-60 Cervical Total Disc Arthroplasty"

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	February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For cervical total disc arthroplasty, see SURG.00055 Cervical Total Disc Arthroplasty. • 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 bone morphogenetic protein, see SURG.00059 Recombinant Human Bone Morphogenetic Protein • Included note under Clinical Indications for Procedure: When the procedure uses bone graft substitutes, see CG-SURG-45 Bone Graft Substitutes • Revised Alternatives to Procedure: o For information on cervical disk arthroplasty, see SURG.00055 Cervical Total Disc Arthroplasty. • Revised Goal Length of Stay to indicate Ambulatory or 1 day postoperative rather than Ambulatory • Revised Operative Status Criteria to indicate: o Ambulatory: Procedure without postoperative drain in place o Inpatient: Drain management may require an overnight stay • Revised Extended Stay to include: o Drain management may require minimal stay extension • 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
Orthopedics - 21st Ed: Cervical Fusion, Anterior	November 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent anterior cervical fusion, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed note: For anterior cervical fusion, see the following: • CG-SURG-42 Cervical Fusion o Reinstated MCG clinical indications for non-elective, emergent anterior cervical fusion February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For anterior cervical fusion, see the following: o CG-SURG-42 Cervical Fusion
Orthopedics - 21st Ed: Cervical Fusion, Posterior	November 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent posterior cervical fusion, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed: For posterior cervical fusion, see the following: • CG-SURG-42 Cervical Fusion • Reinstated MCG clinical indications and references for non-elective, emergent posterior cervical fusion February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For posterior cervical fusion, see the following: o CG-SURG-42 Cervical Fusion
Orthopedics - 21st Ed: Cervical Laminectomy	November 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent cervical laminectomy other than (a) biopsy or excision of spinal lesions or (b) infection of cervical spine requiring decompression or debridement, see Musculoskeletal Program Clinical Guidelines

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	• Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective non-emergent cervical laminectomy February 2, 2017 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
Orthopedics - 21st Ed: Hip Arthroplasty	November 2, 2017 MPTAC review: • Removed the following notes under Clinical Indications for Procedure: o For elective total hip arthroplasty not due to developmental dysplasia, see CG-SURG-53 Elective Total Hip Arthroplasty o 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 elective, non-emergent hip arthroplasty not due to developmental dysplasia, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for partial hip arthroplasty February 2, 2017 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 • 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: 0SW90JZ, 0SW93JZ, 0SW94JZ, 0SW9XJZ, 0SWB0JZ, 0SWB3JZ, 0SWB4JZ, 0SWBXJZ
Orthopedics - 21st Ed: Hip Arthroscopy	November 2, 2017 MPTAC review: • Removed note under Clinical Indications for Procedure: For surgical treatment of femoroacetabular impingement syndrome (FAIS), see SURG.00109 Surgical Treatment of Femoroacetabular Impingement Syndrome • Included note under Clinical Indications for Procedure: For hip arthroscopy other than debridement and lavage of septic hip, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indication except for debridement and lavage of septic hip February 2, 2017 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
Orthopedics - 21st Ed: Hip Resurfacing	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For hip resurfacing, see the following: o SURG.00051 Hip Resurfacing • Updated Coding section with the following: o Added CPT® code: 27299* o *CPT® 27130 and 27299 [when specified as partial or total hip resurfacing].
Orthopedics - 21st Ed:	November 2, 2017 MPTAC review:

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Knee Arthroplasty, Total	• Removed note under Clinical Indications for Procedure: For elective total knee arthroplasty not due to congenital deformity or replacement (revision) of previous arthroplasty, see CG-SURG-54 Elective Total Knee Arthroplasty • Included the following notes under Clinical Indications for Procedure o For unicondylar interpositional spacer, see SURG.00053 Unicondylar Interpositional Spacer o For elective, non-emergent total knee arthroplasty not due to congenital deformity, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o For non-elective, emergent total knee arthroplasty, removed indication, Failure of previous proximal tibial or distal femoral osteotomy February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For elective total knee arthroplasty not due to congenital deformity or replacement (revision) of previous arthroplasty, see CG-SURG-54 Elective Total Knee Arthroplasty • 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 bicompartmental knee arthroplasty, see SURG.00105 Bicompartmental Knee Arthroplasty • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective total knee arthroplasty not due to congenital deformity and replacement (revision) of previous arthroplasty o Retained MCG clinical indications for a) total knee arthroplasty due to congenital deformity and b) non-elective, emergent knee arthroplasty • Updated Coding section with the following: o Added ICD-10 Procedure codes: 0SWC0JZ, 0SWC3JZ, 0SWC4JZ, 0SWCXJZ, 0SWD0JZ, 0SWD3JZ, 0SWD4JZ, 0SWDXJZ
Orthopedics - 21st Ed: Knee Arthroscopy	November 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For knee arthroscopy other than debridement, drainage, or lavage needed for infected joint, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed note: For knee arthroscopy, see the following: • CG-SURG-43 Knee Arthroscopy o Reinstated MCG clinical indications and references for debridement, drainage, or lavage needed for infected joint February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For knee arthroscopy, see the following: o CG-SURG-43 Knee Arthroscopy
Orthopedics - 21st Ed: Knee Arthrotomy	November 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For knee arthrotomy other than debridement, drainage, or lavage for osteomyelitis or infected joint, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications except for debridement, drainage, or lavage for osteomyelitis or infected joint
Orthopedics - 21st Ed: Lumbar Diskectomy, Foraminotomy, or Laminotomy	November 2, 2017 MPTAC review: • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For elective, non-emergent lumbar diskectomy, foraminotomy, or laminotomy, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed: For lumbar diskectomy, foraminotomy, or laminotomy, see the following: • CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy and/or Discectomy o Reinstated MCG clinical indications and references for non-elective, emergent lumbar diskectomy, foraminotomy, or laminotomy

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For lumbar diskectomy, foraminotomy, or laminotomy, see the following: o CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy Laminotomy and/or Discectomy
Orthopedics - 21st Ed: Lumbar Fusion	November 2, 2017 MPTAC review: • Title changed from Lumbar Fusion or Lumbar Total Disc Arthroplasty to indicate Lumbar Fusion • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For axial lumbar interbody fusion, see SURG.00111 Axial Lumbar Interbody Fusion o For elective, non-emergent lumbar fusion, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed: For lumbar fusion or lumbar total disc arthroplasty, see the following: • CG-SURG-33 Lumbar Fusion and Lumbar Total Disc Arthroplasty (TDA) o Reinstated MCG clinical indications for non-elective, emergent lumbar fusion • Updated Coding section with the following: o Removed ICD-10 procedure codes: 0SR20JZ, 0SR40JZ, 0SW20JZ, 0SW23JZ, 0SW24JZ, 0SW40JZ, 0SW43JZ, 0SW44JZ o Removed CPT® codes: 0163T*, 0165T*, 22857, 22862 o Removed *CPT® 0163T and 0165T always considered not medically necessary [each additional lumbar interspace, arthroplasty]. February 2, 2017 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: o CG-SURG-33 Lumbar Fusion and Lumbar Total Disc Arthroplasty (TDA) • Updated Coding section with the following: o Added ICD-10 procedure codes: 0SR20JZ, 0SR40JZ, 0SW20JZ, 0SW23JZ, 0SW24JZ, 0SW40JZ, 0SW43JZ, 0SW44JZ o Added CPT® codes: 0163T*, 0165T*, 22857, 22862 o *CPT® 0163T and 0165T always considered not medically necessary [each additional lumbar interspace, arthroplasty].
Orthopedics - 21st Ed: Lumbar Laminectomy	November 2, 2017 MPTAC review: • Included the following notes under Clinical Indications for Procedure: o When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery o For elective, non-emergent lumbar laminectomy other than lumbar laminectomy with dorsal rhizotomy for spasticity, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed: For lumbar diskectomy, laminectomy, see the following: • CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy and/or Discectomy o Reinstated MCG clinical indications and references for (a) lumbar laminectomy for dorsal rhizotomy for spasticity and (b) non-elective, emergent lumbar laminectomy February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For lumbar laminectomy, see the following: o CG-SURG-38 Lumbar Laminectomy, Hemi-Laminectomy, Laminotomy and/or Discectomy • Updated Coding section with the following: o Added ICD-10 Procedure codes: 008Y0ZZ, 008Y4ZZ, 018B4ZZ
Orthopedics - 21st Ed: Shoulder Arthroplasty	November 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent shoulder arthroplasty, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective non-emergent shoulder arthroplasty

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Orthopedics - 21st Ed: Shoulder Hemiarthroplasty	November 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For elective, non-emergent shoulder hemiarthroplasty, see Musculoskeletal Program Clinical Guidelines • Revised Clinical Indications for Procedure: o Removed MCG clinical indications for elective non-emergent shoulder hemiarthroplasty
Orthopedics - 21st Ed: Spine, Scoliosis, Posterior Instrumentation	November 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For posterior instrumentation, spine, scoliosis, see the following: o Musculoskeletal Program Clinical Guidelines February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For posterior instrumentation, spine, scoliosis, see the following: o CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity
Pediatrics Return to Index	
Pediatrics - 21st Ed: Cranioplasty, Pediatric	February 2, 2017 MPTAC review: • Revised Alternatives to Procedure: o For information on helmets, see CG-OR-PR-04 Cranial Remodeling Bands and Helmets (Cranial Orthotics).
Pediatrics - 21st Ed: Diabetes, Pediatric	February 2, 2017 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 - 21st Ed: EEG, Video Monitoring, Pediatric	November 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o "CG-MED-46 Ambulatory and Inpatient Video Electroencephalography" to "CG-MED-46 Ambulatory Electroencephalography and Video Electroencephalography" February 2, 2017 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 - 21st Ed: Heart Transplant, Pediatric	February 2, 2017 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 - 21st Ed: Liver Transplant, Pediatric	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For pediatric liver transplant, see the following: o TRANS.00008 Liver Transplantation • Update the Coding Section with the following: o Added ICD-10 procedure codes: 5A1C00Z*, 5A1C60Z* o *ICD-10 Procedure codes 5A1C00Z and 5A1C60Z considered investigational and not medically necessary.
Pediatrics - 21st Ed: Lung Transplant, Pediatric	February 2, 2017 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 - 21st Ed:	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For pediatric renal transplant, see the following:

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Renal Transplant, Pediatric	o CG-TRANS-02 Kidney Transplantation
Thoracic Surgery and Pulmonary Disease Return to Index	
Thoracic Surgery and Pulmonary Disease - 21st Ed: Deep Venous Thrombosis of Lower Extremities	September 13, 2017 MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o For vena cava filter placement needed: • Removed "(eg, unable to anticoagulate)" • Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Extended Stay: o For recurrent thromboembolism: • Removed "if patient is judged to be anticoagulation failure" for inferior vena caval procedure • Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters
Thoracic Surgery and Pulmonary Disease - 21st Ed: Lung Transplant	February 2, 2017 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 - 21st Ed: Pulmonary Embolism	September 13, 2017 MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: o For vena cava filter placement needed: • Removed "(eg, unable to anticoagulate)" • Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters • Revised Extended Stay: o For recurrent thromboembolism: • Added note: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters
Thoracic Surgery and Pulmonary Disease - 21st Ed: Rib Fracture	November 2, 2017 MPTAC review: • Revised note under Clinical Indications for Admission to Inpatient Care: o "For the open treatment of rib fracture(s) requiring internal fixation, see SURG.00120 Open Treatment of Rib Fracture(s) Requiring Internal Fixation" to "For the open treatment of rib fracture(s) using an internal fixation system, see SURG.00120 Internal Rib Fixation Systems" February 2, 2017 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 - 21st Ed: Prostatectomy, Transurethral, Alternatives to Standard Resection	February 2, 2017 MPTAC review: • Included note under Clinical Indications for Procedure: For additional information on surgical and minimally invasive procedures for benign prostatic hyperplasia (BPH) considered medically necessary, not medically necessary, or investigational and not medically necessary, including water-induced thermotherapy (WIT), also known as thermourethral hot-water therapy, when used as an alternative to open prostatectomy or transurethral resection of the prostate (TURP) for the treatment of benign prostatic hyperplasia, see SURG.00028 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions. • 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.

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Urology - 21st Ed: Prostatectomy, Transurethral Resection (TURP)	February 2, 2017 MPTAC review: • 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 - 21st Ed: Renal Transplant	February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: For renal transplant, see the following: o CG-TRANS-02 Kidney Transplantation

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CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Body System GRG Return to Index	
Body System 21st Ed: Behavioral Health GRG	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 Behavioral Health Subcommittee review: • Continue to remove guideline for *Behavioral Health GRG*
Body System 21st Ed: Cardiovascular Surgery or Procedure GRG	November 2, 2017 MPTAC review: • Revised note under Clinical Indications for Procedure: o "SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure" to "CG-SURG-63 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure" September 13, 2017 MPTAC review: • Revised note under Clinical Indications for Procedure: o Added: CG-SURG-59 Vena Cava Filters • Revised Clinical Indications for Procedure: o Removed indications for when surgery or other procedures are indicated for vena cava filter August 3, 2017 review: • Revised Note under Clinical Indications for Procedure: o Added: SURG.00150 Leadless Pacemaker February 2, 2017 MPTAC review: • Revised Clinical Indications for Procedure: o 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: o SURG.00019 Transmyocardial Revascularization o SURG.00032 Transcatheter Closure of Patent Foramen Ovale and Left Atrial Appendage for Stroke Prevention o SURG.00033 Cardioverter Defibrillators

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	○ SURG.00054 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection ○ SURG.00064 Cardiac Resynchronization Therapy (CRT) with or without an Implantable Cardioverter Defibrillator (CRT/ICD) for the Treatment of Heart Failure ○ SURG.00121 Transcatheter Heart Valve Procedures ○ SURG.00133 Alcohol Septal Ablation for Treatment of Hypertrophic Cardiomyopathy ○ SURG.00145 Mechanical Circulatory Assist Devices (Ventricular Assist Devices, Percutaneous Ventricular Assist Devices and Artificial Hearts) ○ CG-SURG-44 Coronary Angiography in the Outpatient Setting ○ CG-SURG-48 Elective Percutaneous Coronary Interventions (PCI) ○ CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities ○ CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation
Body System 21st Ed: Musculoskeletal Surgery or Procedure GRG	November 2, 2017 MPTAC review: • Revised Note under Clinical Indications for Procedure: ○ Added: Musculoskeletal Program Clinical Guidelines ○ Removed: CG-SURG-47 Surgical Interventions for Scoliosis and Spinal Deformity • Revised Clinical Indications for Procedure: ○ For medial or lateral unicompartmental knee arthroplasty: • Added note: For elective, non-emergent medial or lateral unicompartmental knee arthroplasty, see Musculoskeletal Program Clinical Guidelines • Removed MCG clinical indications for elective non-emergent medial or lateral unicompartmental knee arthroplasty ○ For patellofemoral arthroplasty: • Added note: For elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Guidelines • Removed MCG clinical indications for elective non-emergent patellofemoral arthroplasty February 2, 2017 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 21st Ed: Neurosurgery or Procedure GRG	November 2, 2017 MPTAC review: • Removed 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 • Included note under Clinical Indications for Procedure: For additional information on spinal surgeries or procedures, see Musculoskeletal Program Clinical Guidelines February 2, 2017 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 21st Ed: Behavioral Health Levels of Care	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 Behavioral Health Subcommittee review: • Continue to remove guideline for *Behavioral Health Levels of Care*
Case Management GRG Return to Index	

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Case Management 21st Ed: Behavioral Health Case Management GRG	February 2, 2017 MPTAC review: • Approval of January 20, 2017 Behavioral Health Subcommittee review January 20, 2017 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 21st Ed: Inpatient Palliative Care Criteria	February 2, 2017 MPTAC review: • Revised Alternatives to Admission o For Home hospice added the following: • Outpatient: Continuous Home Care (CHC) • Outpatient: Routine Home Care • Patients who may benefit from hospice care • Nursing care • Added reference 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 21st Ed: Medical Oncology GRG	February 2, 2017 MPTAC review: • Revised Clinical Indications for Admission to Inpatient Care: 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 • Included note under Clinical Indications for Admission to Inpatient Care: For hematopoietic stem cell transplantation, see the following: o TRANS.00023 Hematopoietic Stem Cell Transplantation for Multiple Myeloma and Other Plasma Cell Dyscrasias o TRANS.00024 Hematopoietic Stem Cell Transplantation for Select Leukemias and Myelodysplastic Syndrome o TRANS.00028 Hematopoietic Stem Cell Transplantation for Hodgkin Disease and non-Hodgkin Lymphoma o TRANS.##### Additional clinical documents in transplant as applicable • Included note under Clinical Indications for Admission to Inpatient Care: For transcatheter arterial embolization, see the following: o RAD.00011 Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Treating Primary or Metastatic Liver Tumors o RAD.00059 Transcatheter Arterial Chemoembolization (TACE) and Transcatheter Arterial Embolization (TAE) for Malignant Lesions Outside the Liver except Central Nervous System (CNS) and Spinal Cord • Included note under Clinical Indications for Admission to Inpatient Care: o For radioactive implant treatments needing inpatient environment, added note for inpatient admission for radiation therapy for cervical or thyroid cancer, see CG-MED-38 Inpatient Admission for Radiation Therapy for Cervical or Thyroid Cancer

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CUSTOMIZATION HISTORY

Date	Action	Reason
12/08/2017	Release document for Customizations to MCG Care Guidelines 21st Edition	Updated document for Customizations to MCG Care Guidelines 21st Edition based on September 13, 2017 and November 2, 2017 review dates.

Date	Action	Reason
11/08/2017	Release document for Customizations to MCG Care Guidelines 21st Edition	Updated the NOTE section with information regarding the MCG products licensed and utilized by Anthem.
09/15/2017	Release document for Customizations to MCG Care Guidelines 21st Edition	Updated document for Customizations to MCG Care Guidelines 21st Edition based on August 3, 2017 review date.
02/07/2017	Release document for Customizations to MCG Care Guidelines 21st Edition	New document for Customizations to MCG Care Guidelines 21st Edition. The 21st edition of the MCG care guidelines and corresponding customized guidelines will take effect May 1, 2017.

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