
CUSTOMIZATION TO CARE GUIDELINES

24th EDITION

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NOTE:

- *The five (5) products licensed include the following:*
 - ***Inpatient & Surgical Care (ISC):** Manage, review, and assess people facing hospitalization or surgery proactively with nearly 400 condition-specific guidelines, goals, optimal care pathways, and other decision-support tools.*
 - ***General Recovery Care (GRG):** Effectively manage complex cases where a single Inpatient & Surgical Care guideline or set of guidelines is insufficient, including the treatment of people with diagnostic uncertainty or multiple diagnoses.*
 - ***Recovery Facility Care (RFC):** Coordinate an effective plan for transitioning people to skilled nursing facilities (SNFs) and inpatient rehabilitation facilities (IRFs).*
 - ***Chronic Care (CCG):** Evaluate needs, identify goals, develop personalized care plans, and support effective self-care. The modular design supports quick and efficient assessments and enables you to manage multiple comorbidities and behavioral health conditions.*
 - ***Behavioral Health Care (BHG):** Provides evidence-based guidelines to help healthcare professionals guide the effective treatment of patients with psychiatric disorders.*
- *This document provides a high level summary of customizations and modifications made to MCG care guidelines (hereinafter referred to as “customized guidelines”).*
- *Customized guidelines are available on request.*
- *Benefit plans vary in coverage and some plans may not provide coverage for certain services discussed in the customized guidelines. Coverage decisions are subject to all terms and conditions of the applicable benefit plan, including specific exclusions and limitations, as well as applicable state and/or federal law. The customized guidelines do not constitute plan authorization or a guarantee of payment, nor are they an explanation of benefits.*
- *We reserve the right to review and modify the MCG care guidelines 24th edition or customized guidelines at any time.*
- *No part of this publication may be reproduced, stored in a retrieval system or transmitted, in any form or by any means, electronic, mechanical, photocopying, or otherwise, without permission from the health plan.*
- *Issue Date: February 21, 2020 / Publish Date: June 26, 2020 for MCG care guidelines 24th edition and corresponding customized guidelines for ISC, GRG, RFC, CCG and BHG.*

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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 and other third party criteria.
2. Customizations to MCG care guidelines clinical indications with changes to the original MCG criteria which include adding or revising appropriateness criteria.
3. Customizations to MCG care guidelines goal length of stay with changes to the original MCG criteria.
4. Other customizations to MCG care guidelines may include adding reference(s), or other changes to MCG care guidelines.

Review and Approval of Customizations:

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

Disclaimer:

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

Guideline History:

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

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CUSTOMIZATIONS INPATIENT & SURGICAL CARE (ISC) GUIDELINES

Inpatient & Surgical Care (ISC) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Cardiology Return to Index	
Cardiology - Angioplasty, Percutaneous Coronary Intervention (W0120)	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review:</p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For elective, non-emergent percutaneous coronary intervention, see Cardiology Program Clinical Guidelines • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for elective PCI
Cardiology - Atrial Fibrillation (W0114)	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Admission to Inpatient Care: For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in

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	the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
Cardiology - Electrophysiologic Study and Implantable Cardioverter-Defibrillator (ICD) Insertion (W0011)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For electrophysiologic study and insertion of implantable cardioverter-defibrillator, see the following: <ul style="list-style-type: none"> ○ CG-SURG-97 Cardioverter Defibrillators ○ CG-SURG-63 Cardiac Resynchronization Therapy with or without an Implantable Cardioverter Defibrillator for the Treatment of Heart Failure
Cardiology - Electrophysiologic Study and Intracardiac Catheter Ablation (W0012)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ For electrophysiologic study and intracardiac catheter ablation, see the following: <ul style="list-style-type: none"> ▪ CG-SURG-55 Intracardiac Electrophysiological Studies (EPS) and Catheter Ablation ○ For transcatheter ablation of arrhythmogenic foci in the pulmonary veins as a treatment of atrial fibrillation or atrial flutter (radiofrequency and cryoablation), see the following: <ul style="list-style-type: none"> ▪ CG-MED-64 Transcatheter Ablation of Arrhythmogenic Foci in the Pulmonary Veins as a Treatment of Atrial Fibrillation or Atrial Flutter (Radiofrequency and Cryoablation)
Cardiology - Left Atrial Appendage Closure, Percutaneous (W0157)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For left atrial appendage closure with closure device, see the following: <ul style="list-style-type: none"> ○ SURG.00032 Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
Cardiovascular Surgery Return to Index	
CV Surgery - Abdominal Aortic Aneurysm, Endovascular Repair (W0084)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For abdominal aortic aneurysm, endovascular repair, see the following: <ul style="list-style-type: none"> ○ CG-SURG-86 Endovascular/Endoluminal Repair of Aortic Aneurysms, Aortoiliac Disease, Aortic Dissection and Aortic Transection
CV Surgery - Aortic Valve Replacement, Transcatheter (W0133)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For transcatheter aortic valve replacement, see the following: <ul style="list-style-type: none"> ○ SURG.00121 Transcatheter Heart Valve Procedures
CV Surgery - Cardiac Septal Defect: Atrial, Transcatheter Closure (W0016)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For closure of patent foramen ovale, see SURG.00032 Patent Foramen Ovale and Left Atrial Appendage Closure Devices for Stroke Prevention
CV Surgery - Cardiac Septal Defect: Ventricular, Repair (W0093)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For transmyocardial/periventricular device closure of ventricular septal defects, see SURG.00123 Transmyocardial/Periventricular Device Closure of Ventricular Septal Defects
CV Surgery - Cardiac Valve Replacement or Repair (W0089)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • 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 - Carotid Artery Stenting (W0165)	<u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For carotid artery stenting, see the following: <ul style="list-style-type: none"> ○ CG-SURG-76 Carotid, Vertebral and Intracranial Artery Stent Placement with or without Angioplasty

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CV Surgery - Heart Transplant (W0017)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For heart transplant, see the following: <ul style="list-style-type: none"> TRANS.00026 Heart/Lung Transplantation TRANS.00033 Heart Transplantation
CV Surgery - Percutaneous Revascularization, Lower Extremity (W0121)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For percutaneous revascularization, lower extremity, see the following: <ul style="list-style-type: none"> CG-SURG-49 Endovascular Techniques (Percutaneous or Open Exposure) for Arterial Revascularization of the Lower Extremities
CV Surgery - Sympathectomy by Thoracoscopy or Laparoscopy (W0044)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Included note under Clinical Indications for Procedure: For treatment of hyperhidrosis, see CG-MED-63 Treatment of Hyperhidrosis Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indication for hyperhidrosis
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Common Complications and Conditions Preoperative Days (W0130)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Inpatient Care: <ul style="list-style-type: none"> For inpatient preoperative days, added indication, Bridging anticoagulation that requires inpatient treatment, for example, conversion from warfarin (Coumadin®) to IV heparin for patients with mechanical heart valves or other high risk patients with contraindications to low-molecular-weight heparin (LMWH) or fractionated heparin Added reference
Common Complications and Conditions Venous Thrombosis and Pulmonary Embolism (W0136)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Included note under Clinical Indications for Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters Revised Clinical Indications for Inpatient Care: <ul style="list-style-type: none"> Removed MCG clinical indications for vena cava filter placement
<p>General Surgery Return to Index</p>	
General Surgery - Fundoplasty, Esophagogastric, by Laparoscopy (W0158)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed: In conjunction with laparoscopic paraesophageal hernia repair
General Surgery - Gastric Restrictive Procedure with Gastric Bypass Title change to: Gastric Restrictive Procedure with or without Gastric Bypass (W0054)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity Updated Coding section with the following: <ul style="list-style-type: none"> Added ICD-10 Procedure codes: 0D190ZB, 0DB60Z3, 0DV60CZ, 0DW60CZ Added CPT® codes: 43842, 43843, 43845, 43848
General Surgery - Gastric Restrictive Procedure with Gastric Bypass by Laparoscopy (W0014)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For gastric restrictive procedure with gastric bypass by laparoscopy, see the following: <ul style="list-style-type: none"> CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity Updated Coding section with the following: <ul style="list-style-type: none"> Added ICD-10 Procedure codes: 0D164Z9, 0DB64ZZ

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<p>General Surgery - Gastric Restrictive Procedure without Gastric Bypass by Laparoscopy (W0033)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For gastric restrictive procedure without gastric bypass by laparoscopy, see the following: <ul style="list-style-type: none"> ○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
<p>General Surgery - Gastric Restrictive Procedure, Sleeve Gastrectomy, by Laparoscopy (W0102)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For gastric restrictive procedure, sleeve gastrectomy, by laparoscopy, see the following: <ul style="list-style-type: none"> ○ CG-SURG-83 Bariatric Surgery and Other Treatments for Clinically Severe Obesity
<p>General Surgery - Hiatal Hernia Repair, Abdominal (W0159)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed: Paraesophageal hernia
<p>General Surgery - Hiatal Hernia Repair, Transthoracic (W0160)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed: Paraesophageal hernia
<p>General Surgery - Liver Transplant (W0034)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For liver transplant, see the following: <ul style="list-style-type: none"> ○ TRANS.00008 Liver Transplantation
<p>General Surgery - Mastectomy, Complete (W0002)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: <ul style="list-style-type: none"> ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory • Under the Goal Length of Stay (GLOS) section added: <ul style="list-style-type: none"> ○ Reason: Organization approved 2 day stay ○ Context: Organization accepted variance of 2 days • Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory • Added references
<p>General Surgery - Mastectomy, Complete, with Insertion of Breast Prosthesis or Tissue Expander (W0022)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: <ul style="list-style-type: none"> ▪ Personal history of breast cancer ▪ Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia) ▪ Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Revised Goal Length of Stay (GLOS) to indicate 2 days postoperative rather than Ambulatory or 1 day postoperative • Under the Goal Length of Stay (GLOS) section added: <ul style="list-style-type: none"> ○ 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

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	<ul style="list-style-type: none"> Added references
General Surgery - Mastectomy, Complete, with Tissue Flap Reconstruction (W0023)	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> For risk-reduction mastectomy and significantly elevated risk of breast cancer, added indications: <ul style="list-style-type: none"> Personal history of breast cancer Noninvasive histology indicating risk (eg, lobular carcinoma in situ or atypical hyperplasia) Extensive mammographic abnormalities (eg, calcifications) exist such that adequate biopsy is impossible Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section Added references
General Surgery - Mastectomy, Partial (Lumpectomy) (W0008)	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Reason: Organization approved 2 day stay Context: Organization accepted variance of 2 days Revised Operative Status Criteria to indicate Inpatient rather than Ambulatory
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Hematology - Oncology - Chemotherapy (W0162)	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p> <ul style="list-style-type: none"> Revised Clinical Indications for Admission: <ul style="list-style-type: none"> Added examples for: <ul style="list-style-type: none"> Aggressive hydration needs that cannot be managed in an infusion center Prolonged marrow suppression Added Regimens that cannot be managed as an outpatient with examples Added references Added footnotes
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<ul style="list-style-type: none"> Neonatal Facility Levels and Intensity of Care Criteria 	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p> <ul style="list-style-type: none"> Removed the MCG Neonatal Facility Levels and Intensity of Care Criteria in the 24th edition listed below <p>Neonatal Intensity of Care Criteria</p> <ul style="list-style-type: none"> Neonatal Intensity of Care Criteria Comparison Chart Intensity of Care Criteria 1 - Routine Care Intensity of Care Criteria 2 - Continuing Care Intensity of Care Criteria 3 - Intermediate Care Intensity of Care Criteria 4 - Intensive Care <p>Neonatal Facility Levels of Care Guidelines</p> <ul style="list-style-type: none"> Neonatal Facility Levels of Care Comparison Chart Neonatal Facility, Level I Neonatal Facility, Level II Neonatal Facility, Level III Neonatal Facility, Level IV
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Neonatology – Newborn Care, Routine (W0087)	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p> <ul style="list-style-type: none"> Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section
Neonatology –	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p>

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Newborn Care, Term, with Severe Illness or Abnormality (W0106)	<ul style="list-style-type: none"> • Included note under Clinical Indications for Admission to Inpatient Care: See CG-MED-26 Neonatal Levels of Care to determine nursery level for neonates meeting admission and continued stay criteria. • Revised Clinical Indications for Admission to Inpatient Care: <ul style="list-style-type: none"> ◦ Changed “Higher-level neonatal care (ie, other than Level I nursery)” is needed to indicate “Inpatient neonatal care” is needed
Neonatology – Sepsis, Neonatal, Confirmed (W0107)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Admission to Inpatient Care: See CG-MED-26 Neonatal Levels of Care to determine nursery level for neonates meeting admission and continued stay criteria.
Neonatology – Sepsis, Neonatal, Suspected, Not Confirmed (W0108)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Admission to Inpatient Care: See CG-MED-26 Neonatal Levels of Care to determine nursery level for neonates meeting admission and continued stay criteria.
<p>Neurology Return to Index</p>	
Neurology – EEG, Video Monitoring (W0115)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For EEG video monitoring, see the following: <ul style="list-style-type: none"> ◦ CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring
<p>Obstetrics and Gynecology (OB / GYN) Return to Index</p>	
OB / GYN - Cesarean Delivery (W0045)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ◦ Retained MCG clinical indications for emergency cesarean delivery ◦ Added clinical indications for early elective cesarean delivery ◦ Revised MCG clinical indications for elective cesarean delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Included note under Codes: Additional ICD-10 diagnosis codes may apply to this guideline when the requested service is for early elective delivery. This is not an all-inclusive list of codes that may apply
OB / GYN - Hysterectomy, Abdominal (W0109)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ◦ For abnormal uterine bleeding: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> • 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, Medical therapy (eg, intrauterine delivery system, systemic hormonal therapy, tranexamic acid) cannot be used because of 1 or more of the following: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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, <ul style="list-style-type: none"> • Procedure not appropriate for severity of patient's condition • Hysterectomy preferred (eg, patient concern about recurrence after endometrial ablation)

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	<ul style="list-style-type: none"> ▪ Added contraindications for levonorgestrel-releasing intrauterine system or systemic hormonal therapy or oral tranexamic acid and related references ○ For leiomyoma ("fibroid"): <ul style="list-style-type: none"> ▪ "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:" ○ For pelvic organ prolapse: <ul style="list-style-type: none"> ▪ "Uterine-sparing treatment (eg, pessary, pelvic floor muscle training, 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 muscle training, 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: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: <ul style="list-style-type: none"> ○ 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
<p>OB / GYN - Hysterectomy, Laparoscopic</p> <p><u>Title change to:</u> Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted (W0010)</p>	<p>Publish Date: June 26, 2020 February 20, 2020 MPTAC review</p> <ul style="list-style-type: none"> • Title changed from Hysterectomy, Laparoscopic to indicate Hysterectomy, Laparoscopic; Hysterectomy, Vaginal, Laparoscopically-Assisted • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ For abnormal uterine bleeding: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> • 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, Medical therapy (eg, intrauterine delivery system, systemic hormonal therapy, tranexamic acid) cannot be used because of 1 or more of the following: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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, <ul style="list-style-type: none"> • 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 ○ For leiomyoma ("fibroid"): <ul style="list-style-type: none"> ▪ "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:"

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	<ul style="list-style-type: none"> ○ For pelvic organ prolapse: <ul style="list-style-type: none"> ▪ “Uterine-sparing treatment (eg, pessary, pelvic floor muscle training, 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 muscle training, 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: <ul style="list-style-type: none"> ○ 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: <ul style="list-style-type: none"> ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: <ul style="list-style-type: none"> ○ 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
<p>OB / GYN - Hysterectomy, Vaginal (W0110)</p>	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ For abnormal uterine bleeding: <ul style="list-style-type: none"> ▪ 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: <ul style="list-style-type: none"> • 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, Medical therapy (eg, intrauterine delivery system, systemic hormonal therapy, tranexamic acid) cannot be used because of 1 or more of the following: <ul style="list-style-type: none"> • 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: <ul style="list-style-type: none"> • 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, <ul style="list-style-type: none"> • 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 ○ For leiomyoma (“fibroid”): <ul style="list-style-type: none"> ▪ “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:” ○ For pelvic organ prolapse: <ul style="list-style-type: none"> ▪ “Uterine-sparing treatment (eg, pessary, pelvic floor muscle training, 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 muscle training, 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: <ul style="list-style-type: none"> ○ 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:

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	<ul style="list-style-type: none"> ▪ To improve detection of adnexal masses, or ▪ To prevent impairment of renal function, or ▪ To rule out malignancy <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For abnormal uterine bleeding, oral tranexamic acid may be considered unless: <ul style="list-style-type: none"> ○ 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
OB / GYN - Laparoscopic Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0026)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included the following notes under Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ For laparoscopic surgical ablation of uterine fibroids, see SURG.00077 Uterine Fibroid Ablation: Laparoscopic or Percutaneous Image Guided Techniques ○ For the evaluation of infertility, see CG-SURG-34 Diagnostic Infertility Surgery • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ "Prophylactic bilateral 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: <ul style="list-style-type: none"> ▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (eg, mother, sister, daughter) or one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer ○ Removed MCG indications for infertility evaluation or treatment
OB / GYN - Laparotomy, for Gynecologic Surgery, Including Myomectomy, Oophorectomy, and Salpingectomy (W0025)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ "Prophylactic bilateral 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: <ul style="list-style-type: none"> ▪ Risk-reducing salpingo-oophorectomy for the presence of two or more first degree relatives (eg, mother, sister, daughter) or one first degree relative and one or more second degree relatives (maternal or paternal grandmother, aunt or niece) with a history of ovarian cancer
OB / GYN - Vaginal Delivery (W0047)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for when induction of labor is appropriate ○ Added clinical indications for elective induction of labor ○ Added clinical indications for early elective induction of labor • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section • Added references • Included note under Codes: Additional ICD-10 diagnosis codes may apply to this guideline when the requested service is for early elective delivery. This is not an all-inclusive list of codes that may apply
OB/GYN - Vaginal Delivery, Operative (W0048)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For early elective vaginal delivery, see W0047 Vaginal Delivery • Information regarding Federal or State mandates will supersede the guideline Length of Stay when applicable included under both Clinical Indications section and Goal Length of Stay (GLOS) section
Orthopedics Return to Index	
Orthopedics - Acromioplasty and Rotator Cuff Repair (W0139)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For acromioplasty and rotator cuff repair, see the following: <ul style="list-style-type: none"> ○ Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines

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	<ul style="list-style-type: none"> Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For acromioplasty and rotator cuff repair, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Ankle Arthroscopy (W0155)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indication for osteochondral lesions Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For ankle arthroscopy for osteochondral lesions, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Cervical Discectomy or Microdiscectomy, Foraminotomy, Laminotomy (W0071)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indications for elective, non-emergent cervical discectomy or microdiscectomy, foraminotomy, laminotomy Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent cervical discectomy or microdiscectomy, foraminotomy, laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Cervical Fusion, Anterior (W0111)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indications for elective, non-emergent anterior cervical fusion Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent anterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Cervical Fusion, Posterior (W0112)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indications for elective, non-emergent posterior cervical fusion Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent posterior cervical fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Cervical Laminectomy (W0097)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indications for elective, non-emergent cervical laminectomy Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent cervical laminectomy, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Hip Arthroplasty (W0105)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> 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: <ul style="list-style-type: none"> Removed MCG clinical indications for elective, non-emergent hip arthroplasty not due to developmental dysplasia of hip Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent hip arthroplasty not due to developmental dysplasia, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Hip Arthroscopy (W0096)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure:

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	<ul style="list-style-type: none"> ○ Removed MCG clinical indications except for (a) fracture amenable to arthroscopic repair and (b) debridement and lavage of septic hip ● Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For hip arthroscopy other than (a) fracture amenable to arthroscopic repair or (b) debridement and lavage of septic hip, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Hip Resurfacing (W0098)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> ● Revised Clinical Indications for Procedure: For hip resurfacing, see the following: <ul style="list-style-type: none"> ○ CG-SURG-85 Hip Resurfacing ● Updated Coding section with the following: <ul style="list-style-type: none"> ○ Added CPT® code: 27299* ○ *CPT® 27130 and 27299 [when specified as partial or total hip resurfacing]
Orthopedics - Knee Arthroplasty, Total (W0081)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> ● Included note under Clinical Indications for Procedure: For (a) bicompartamental knee arthroplasty and (b) computer-assisted musculoskeletal surgical navigational procedures, see the applicable clinical document ● Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for elective, non-emergent total knee arthroplasty not due to congenital deformity ● Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent total knee arthroplasty not due to congenital deformity, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Knee Arthroscopy (W0113)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> ● Revised Clinical Indications for Procedure: For knee arthroscopy, see the following: <ul style="list-style-type: none"> ○ Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines ● Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For knee arthroscopy, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Knee Arthrotomy (W0140)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> ● Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications except for debridement, drainage, or lavage for rheumatoid arthritis, osteomyelitis or infected joint ● Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For knee arthrotomy other than debridement, drainage, or lavage for rheumatoid arthritis, osteomyelitis or infected joint, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Lumbar Discectomy, Foraminotomy, or Laminotomy (W0091)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> ● Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery ● Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed: MCG clinical indications for elective, non-emergent lumbar discectomy, foraminotomy, or laminotomy ● Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar discectomy, foraminotomy, or laminotomy, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Orthopedics - Lumbar Fusion (W0072)	<p><u>Publish Date: June 26, 2020</u> <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> ● Included the following notes under Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery ○ For axial lumbar interbody fusion, see SURG.00111 Axial Lumbar Interbody Fusion ● Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for elective, non-emergent lumbar fusion ● Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar fusion, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines

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<p>Orthopedics - Lumbar Laminectomy (W0100)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: When the procedure uses the percutaneous or endoscopic approach (as opposed to open with direct visualization), see SURG.00071 Percutaneous and Endoscopic Spinal Surgery • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for elective, non-emergent lumbar laminectomy • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent lumbar laminectomy, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
<p>Orthopedics - Shoulder Arthroplasty (W0137)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for elective, non-emergent shoulder arthroplasty • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent shoulder arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
<p>Orthopedics - Shoulder Hemiarthroplasty (W0138)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for elective, non-emergent shoulder hemiarthroplasty • Included note under Clinical Indications for Procedure, Operative Status Criteria and Goal Length of Stay (GLOS): For elective, non-emergent shoulder hemiarthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
<p>Orthopedics - Spine, Scoliosis, Posterior Instrumentation (W0116)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For posterior instrumentation, spine, scoliosis, see the following: <ul style="list-style-type: none"> ○ Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines • Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For posterior instrumentation, spine, scoliosis, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
<p>Pediatrics Return to Index</p>	
<p>Pediatrics - Diabetes, Pediatric (W0117)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Extended Stay: Added <ul style="list-style-type: none"> ○ Need to receive comprehensive patient, parent or caregiver education and comprehensive diabetic education programs are not available on an outpatient basis in the community <ul style="list-style-type: none"> ▪ Expect minimal stay extension ▪ Note: Obtain verbal or written attestation from provider regarding lack of outpatient diabetic education resources
<p>Pediatrics – EEG, Video Monitoring, Pediatric (W0122)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For pediatric EEG video monitoring, see the following: <ul style="list-style-type: none"> • CG-MED-46 Electroencephalography and Video Electroencephalographic Monitoring
<p>Pediatrics – Fundoplasty, Esophagogastric, by Laparoscopy, Pediatric (W0161)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For paraesophageal hernia repair, see CG-SURG-92 Paraesophageal Hernia Repair • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed: In conjunction with laparoscopic paraesophageal hernia repair
<p>Pediatrics - Heart Transplant, Pediatric (W0123)</p>	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For pediatric heart transplant, see the following: <ul style="list-style-type: none"> ○ TRANS.00026 Heart/Lung Transplantation ○ TRANS.00033 Heart Transplantation

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Pediatrics - Liver Transplant, Pediatric (W0124)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For pediatric liver transplant, see the following: <ul style="list-style-type: none"> TRANS.00008 Liver Transplantation
Pediatrics - Lung Transplant, Pediatric (W0125)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For pediatric lung transplant, see the following: <ul style="list-style-type: none"> TRANS.00009 Lung and Lobar Transplantation TRANS.00026 Heart/Lung Transplantation
Pediatrics - Renal Transplant, Pediatric (W0126)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For pediatric renal transplant, see the following: <ul style="list-style-type: none"> CG-TRANS-02 Kidney Transplantation
Pediatrics - Spine, Scoliosis, Posterior Instrumentation, Pediatric (W0156)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For pediatric posterior instrumentation, spine, scoliosis, see the following: <ul style="list-style-type: none"> Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines Included note under both Operative Status Criteria and Goal Length of Stay (GLOS): For pediatric posterior instrumentation, spine, scoliosis, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Thoracic Surgery and Pulmonary Disease Return to Index	
Thoracic Surgery and Pulmonary Disease - Deep Venous Thrombosis of Lower Extremities (W0135)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters Revised Clinical Indications for Admission to Inpatient Care: <ul style="list-style-type: none"> Removed MCG clinical indications for vena cava filter placement
Thoracic Surgery and Pulmonary Disease - Lung Transplant (W0076)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For lung transplant, see the following: <ul style="list-style-type: none"> TRANS.00009 Lung and Lobar Transplantation TRANS.00026 Heart/Lung Transplantation
Thoracic Surgery and Pulmonary Disease - Pulmonary Embolism (W0134)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Included note under Clinical Indications for Admission to Inpatient Care: For vena cava filter placement, see CG-SURG-59 Vena Cava Filters Revised Clinical Indications for Admission to Inpatient Care: <ul style="list-style-type: none"> Removed MCG clinical indications for vena cava filter placement
Urology Return to Index	
Urology - Prostatectomy, Transurethral, Alternatives to Standard Resection (W0029)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For alternatives to standard transurethral prostatectomy resection, see the following: <ul style="list-style-type: none"> CG-SURG-107 Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH)
Urology - Renal Transplant (W0027)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> Revised Clinical Indications for Procedure: For renal transplant, see the following: <ul style="list-style-type: none"> CG-TRANS-02 Kidney Transplantation

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CUSTOMIZATIONS - GENERAL RECOVERY CARE GUIDELINES (GRG)

General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Body System GRG Return to Index	
Body System Cardiovascular Surgery or Procedure GRG (W0099)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For additional information on cardiovascular surgeries or procedures, see the applicable clinical document • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for when surgery or other procedures are indicated for (a) Transmyocardial or percutaneous laser revascularization, (b) Catheter-based valve repair or implantation (eg, prosthetic cardiac valve), (c) Vena cava filter placement, (d) Reinsertion, adjustment, replacement, or removal of pacemaker, defibrillator, or associated hardware, and (e) Ventricular assist device
Body System General Surgery or Procedure GRG (W0142)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For gender reassignment surgery, see CG-SURG-27 Gender Reassignment Surgery • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ Removed MCG clinical indications for (a) Mastectomy appropriate in the context of female-to-male gender reassignment and (b) Breast augmentation mastoplasty appropriate in context of male-to-female gender reassignment
Body System Musculoskeletal Surgery or Procedure GRG (W0118)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For (a) ankle arthroplasty, (b) bicompartmental knee arthroplasty, and (c) sacroiliac joint fusion, see the applicable clinical document • Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> ○ For medial or lateral unicompartmental knee arthroplasty: <ul style="list-style-type: none"> ▪ Added note: For elective, non-emergent medial or lateral unicompartmental knee arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines ▪ Removed MCG clinical indications for elective, non-emergent medial or lateral unicompartmental knee arthroplasty ○ For patellofemoral arthroplasty: <ul style="list-style-type: none"> ▪ Added note: For elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines ▪ Removed MCG clinical indications for elective, non-emergent patellofemoral arthroplasty ○ Removed MCG clinical indications for: <ul style="list-style-type: none"> ▪ ankle arthroplasty ▪ minimally invasive sacroiliac joint fusion • Included the following note under both Operative Status Criteria and Benchmark Length of Stay (BLOS): <ul style="list-style-type: none"> ○ For (a) elective, non-emergent medial or lateral unicompartmental knee arthroplasty and (b) elective, non-emergent patellofemoral arthroplasty, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Body System Neurosurgery or Procedure GRG (W0119)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> • Included note under Clinical Indications for Procedure: For additional information on spinal surgeries or procedures, see Musculoskeletal Program Clinical Appropriateness Guidelines and Level of Care Guidelines
Body System	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p>

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General Recovery Guideline (GRG) Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Obstetric and Gynecologic Surgery or Procedure GRG (W0143)	<ul style="list-style-type: none"> Included note under Clinical Indications for Procedure: For gender reassignment surgery, see CG-SURG-27 Gender Reassignment Surgery Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indications for oophorectomy (usually with hysterectomy and salpingectomy) appropriate in context of female-to-male gender reassignment
Body System Urologic Surgery or Procedure GRG (W0141)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Included note under Clinical Indications for Procedure: <ul style="list-style-type: none"> For gender reassignment surgery, see CG-SURG-27 Gender Reassignment Surgery For male circumcision, see CG-SURG-103 Male Circumcision Revised Clinical Indications for Procedure: <ul style="list-style-type: none"> Removed MCG clinical indications for (a) Male circumcision, (b) Orchiectomy appropriate in context of male-to-female gender reassignment, (c) Genital reconstructive surgery (eg, vaginoplasty, penectomy, labioplasty, clitoroplasty) appropriate in context of male-to-female gender reassignment and (d) Genital reconstructive surgery (eg, vaginectomy, metoidioplasty, scrotoplasty, phalloplasty, urethroplasty, placement of testicular prosthesis) appropriate in context of female-to-male gender reassignment
General Recovery Guidelines Tools Section Return to Index	
General Recovery Guidelines Tools Section Inpatient Palliative Care Criteria (W0086)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Revised Alternatives to Admission <ul style="list-style-type: none"> For Home hospice added the following: <ul style="list-style-type: none"> Outpatient: Continuous Home Care (CHC) Outpatient: Routine Home Care Patients who may benefit from hospice care Nursing care Added reference
Problem Oriented GRG Return to Index	
Problem Oriented Medical Oncology GRG (W0074)	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Included note under Clinical Indications for Admission to Inpatient Care: For (a) chimeric antigen receptor (CAR) T-cell therapy, (b) transcatheter arterial chemoembolization, (c) high-dose radioactive iodine or radioactive implant treatments needing inpatient admission, and (d) hematopoietic stem cell transplantation, see the applicable clinical document Revised Clinical Indications for Admission to Inpatient Care: <ul style="list-style-type: none"> Removed MCG clinical indications for allogeneic and autologous hematopoietic stem cell transplant

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CUSTOMIZATIONS – BEHAVIORAL HEALTH CARE GUIDELINES (BHG)

Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
Level Of Care Guidelines: Opioid Management Return to Index	
Medications	<p>Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u></p> <ul style="list-style-type: none"> Removed the MCG Behavioral Health Level of Care: Opioid Management – Medications guidelines in the 24th edition listed below <ul style="list-style-type: none"> Buprenorphine Extended-Release Injection Buprenorphine Implant Buprenorphine-Naloxone

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Behavioral Health Guideline (BHG) Title Guideline Title	Date of Medical Policy & Technology Assessment Committee (MPTAC) Customizations
	<ul style="list-style-type: none"> ○ Long-Acting Opioids ○ Naltrexone Extended-Release Injection ○ Naltrexone Implant
Testing Procedures Return to Index	
Testing Procedures Urine Toxicology Testing (W0150)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For urine toxicology testing, see the following: <ul style="list-style-type: none"> ○ CG-LAB-09 Drug Testing or Screening in the Context of Substance Use Disorder and Chronic Pain
Therapeutic Services Return to Index	
Therapeutic Services Applied Behavioral Analysis (W0153)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For Adaptive Behavioral Treatment (ABT) such as Intensive Behavioral Intervention (IBI) or Applied Behavioral Analysis (ABA) for Autism Spectrum Disorder (ASD), see the following: <ul style="list-style-type: none"> ○ CG-BEH-02 Adaptive Behavioral Treatment for Autism Spectrum Disorder ○ Note: In addition to Clinical Indications, see CG-BEH-02 for additional important information about application of CG-BEH-02, Coding, Discussion/General Information, Definitions, References, Websites for Additional Information, Index and History • Revised Evidence Summary and References to see CG-BEH-02 Adaptive Behavioral Treatment for Autism Spectrum Disorder • Removed Alternatives to Procedure, Definitions and Footnotes • Revised section for Codes
Therapeutic Services Deep Brain Stimulation (DBS): Behavioral Health Care (W0164)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For deep brain stimulation, see the following: <ul style="list-style-type: none"> ○ SURG.00026 Deep Brain, Cortical, and Cerebellar Stimulation • Revised Evidence Summary and References to see SURG.00026 Deep Brain, Cortical, and Cerebellar Stimulation
Therapeutic Services Trigeminal Nerve Stimulation, Transcutaneous: Behavioral Health Care	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Removed the MCG Trigeminal Nerve Stimulation, Transcutaneous: Behavioral Health Care (B-820-T) guideline in the 24th edition
Therapeutic Services Vagus Nerve Stimulation, Implantable: Behavioral Health Care (W0166)	Publish Date: June 26, 2020 <u>February 20, 2020 MPTAC review</u> <ul style="list-style-type: none"> • Revised Clinical Indications for Procedure: For vagus nerve stimulation, see the following: <ul style="list-style-type: none"> ○ SURG.00007 Vagus Nerve Stimulation • Revised Evidence Summary and References to see SURG.00007 Vagus Nerve Stimulation

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CUSTOMIZATION HISTORY

Date	Action	Reason
02/21/2020	Release document for Customizations to MCG Care Guidelines 24th Edition	New document for Customizations to MCG Care Guidelines 24th Edition.

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Date	Action	Reason
		Publish Date: June 26, 2020 for MCG care guidelines 24th edition and corresponding customized guidelines for ISC, GRG, RFC, CCG and BHG.

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