

Kaiser Foundation Health Plan of Washington
CONTRACT MANAGER NAME
Provider Communications, RCB-C2W-02
PO Box 34262, Seattle WA 98124-1262

March 29, 2019

**CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR
TOTAL KNEE REPLACEMENT**

Dear Provider,

This letter replaces the previous letter regarding total knee replacement. This new notification changes the effective date to June 1, 2019 and defines review criteria for total knee replacements in an inpatient setting.

Effective June 1, 2019, Kaiser Permanente will implement medical necessity criteria for Total Knee replacements performed in an inpatient setting.

Prior authorization requests for this procedure to be performed in an Inpatient setting will require a medical necessity review and could be denied.

Criteria are as follows:

For elective total knee replacement (27438, 27446, 27447) to be approved as inpatient **ONE** of the following criteria must be met:

- Bilateral knee replacement
- Hardware revision (CPT 27486, 27487, 27488)
- Coexisting neurologic condition (multiple sclerosis, hemiparesis, severe Parkinson's or other neurologic conditions that would likely seriously affect ambulation)

If the orthopedist has a patient who does not meet the criteria above, yet they feel needs inpatient status, they can submit a separate explanation with the request that will be reviewed by clinical staff on a case by case basis.

The above policy is pertinent only to elective total knee replacement's and not for unplanned or urgent/emergent procedures.

If you have any questions, please contact Review Services at 1-800-289-1363.

What will I need to do differently for my patients with Kaiser Permanente coverage?

- **Kaiser Foundation Health Plan of Washington HMO patients:** prior authorization is required. If services are provided without receiving prior authorization, Kaiser Permanente will not reimburse you for these services. Kaiser Permanente will notify the ordering practitioner, the patient, and the patient's personal physician of the coverage decision in writing.
- **Kaiser Foundation Health Plan of Washington Options, Inc. Point of Service patients:** prior authorization is required. If services are provided without receiving prior authorization, Kaiser Permanente will not reimburse you for these services. Kaiser Permanente will notify the ordering practitioner, the patient, and the patient's personal physician of the coverage decision in writing.

- **Kaiser Foundation Health Plan of Washington Options, Inc. Access and Elect Preferred Provider Organization (PPO) patients:** prior authorization is not required. The claim will suspend for medical necessity review and, if approved, will be reimbursed. If the claim denies for medical necessity, the contracted provider will have to write off the charges.

Please refer to the provisions of your agreement with Kaiser Permanente, including obtaining the member's prior written agreement to be financially responsible for the specific non-covered service, to determine when providers may bill a member for non-covered services.

These criteria along with a complete list of Kaiser Permanente Clinical Review Criteria can be found on My Health Manager for Providers at <https://provider.ghc.org/open/> under Referrals & Clinical Review.

If you have any questions about these changes, please contact the Provider Assistance Unit toll-free at 1-888-767-4670.

Sincerely,

A handwritten signature in black ink, appearing to read 'm m' over 'w f'.

Dr. Marc Mora, MD
Senior Medical Director Networks and Care Management
Washington Permanente Medical Group