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CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR ELECTIVE TOTAL HIP REPLACEMENT IN AN INPATIENT HOSPITAL SETTING

Dear Provider,

Effective April 1, 2020, Kaiser Permanente will implement medical necessity criteria for elective total hip replacements performed in an inpatient hospital setting for all members.

Prior authorization requests will require a medical necessity review for this procedure in an inpatient hospital setting. Prior authorization requests will not require a pre-service medical necessity review for this procedure performed under ambulatory status at a hospital or an ambulatory surgery center.

Criteria are as follows:

For total hip replacement CPT code 27130 to be approved as inpatient, **ONE** of the following criteria must be met:

- Bilateral total hips
- Patient has had a prior hip surgery on the same side
- Revision of hip replacement (CPT codes 27132, 27134, 27137, or 27138)
- Coexisting neurologic condition (multiple sclerosis, history of stroke, or other neurologic conditions) where the expected length of stay is planned to be longer than 2 midnights

If the orthopedist has a patient who does not meet one of the criteria above but has determined that the procedure should be performed in an inpatient setting, the orthopedist can submit a separate explanation with the request that will be reviewed by clinical staff on a case-by-case basis.

If a patient is approved for ambulatory status under the prior authorization request but ends up staying longer than expected, the authorization can be adjusted to inpatient status with appropriate notification and if deemed appropriate.

This policy is pertinent only to elective total hip replacements in an inpatient hospital setting and does not apply to unplanned or urgent/emergent procedures.

Clinical review criteria can be found on the Kaiser Permanente provider website at **https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/ip_totalhip.pdf.**

Medicare Advantage coverage will be reviewed against the Medicare 2-Midnight Rule.

What will I need to do differently for my patients with the following Kaiser Permanente health plans?

- **Kaiser Foundation Health Plan of Washington Core and SoundChoice Health Maintenance Organization (HMO) members:** Prior authorization is required. Kaiser Permanente will notify the ordering provider, the member, and the member's personal physician of the coverage decision in writing. If services are provided without receiving prior authorization, Kaiser Permanente will not reimburse the provider for these services.

- **Kaiser Foundation Health Plan of Washington Options, Inc. Options Point of Service (POS) members:** Prior authorization is required for in-network coverage. Kaiser Permanente will notify the ordering provider, the member, and the member's personal physician of the coverage decision in writing. If services are provided without receiving prior authorization, Kaiser Permanente will not reimburse the provider for these services.
- **Kaiser Foundation Health Plan of Washington Options, Inc. Access PPO and Elect PPO Preferred Provider Organization (PPO) members:** Prior authorization is not required for coverage. Notification for all inpatient services is required. Please contact the Provider Assistance Unit at 509-241-7206 or toll-free at 1-888-767-4670. Kaiser Permanente will review the claim for medical necessity. If the claim is denied, Kaiser Permanente will not reimburse the contracted provider for these services and the contracted provider cannot bill the member.
- **Kaiser Foundation Health Plan of Washington Options, Inc., Options Federal PPO Preferred Provider Organization (PPO) members:** Prior authorization is 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.
- **Medicare Advantage**: Prior authorization is required. Kaiser Permanente will notify the ordering provider, the member, and the member's personal physician of the coverage decision in writing. If services are provided without receiving prior authorization, Kaiser Permanente will not reimburse the provider for these services.

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 the Kaiser Permanente Provider website at **https://wa-provider.kaiserpermanente.org** under the header "Authorization & Clinical Review."

If you have any questions about these changes, please contact the Provider Assistance Unit at 509-241-7206 or toll-free at 1-888-767-4670, Monday – Friday from 8 am to 5 pm.

Sincerely,

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