

## **CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR DERMAL FILLERS FOR FACIAL LIPOATROPHY**

This notification applies to the following networks: Commercial HMO, POS, and PPO

A listing of all networks can be found on the provider website at <https://wa-provider.kaiserpermanente.org/communications/letters>

**Effective October 1, 2021**, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are updating the clinical review criteria for dermal fillers for facial lipoatrophy for non-Medicare members.

### **Explanation of the change:**

Clinical review criteria for dermal fillers for facial lipoatrophy have been revised to include indications for coverage for patients with a diagnosis of facial lipodystrophy related to HIV treatment with highly active antiretroviral therapy (HAART).

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

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

- KFHPWA Health Maintenance Organization (HMO) members: Prior authorization is required.
- KFHPWAO Point of Service (POS) members: Prior authorization is required for in-network coverage.
- KFHPWAO Preferred Provider Organization (PPO) members: Prior authorization is required.

Questions: Please contact the Provider Assistance Unit at 509-241-7206 or 1-888-767-4670, Monday through Friday, 8 a.m. to 5 p.m.

**Kaiser Foundation Health Plan of Washington**  
**Kaiser Foundation Health Plan of Washington Options, Inc.**

<CONTRACT MANAGER NAME>

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