

Kaiser Foundation Health Plan of Washington  
Kaiser Foundation Health Plan of Washington Options, Inc.  
Provider Communications, RCR-A3W-04  
PO Box 34262, Seattle WA 98124-1262

September 1, 2023

## **CLARIFICATION: NEW MEDICALLY NECESSARY SERVICES CLINICAL REVIEW CRITERIA**

Dear Provider,

We heard from several of you that our notification of the “Medically Necessary Services” policy on our clinical criteria webpage left you with unanswered questions. We are sorry for the confusion. To clarify, we are NOT announcing a new requirement for prior authorization with this policy. We recognize that requirements for prior authorization are a significant burden on healthcare professionals. Our intent is to simplify existing requirements.

The Medically Necessary Services policy will apply to a finite number of service codes with little or no utilization. All applicable codes have been subject to separate policies, but due to the low utilization we are consolidating those existing policies into a single general policy. The relevant billing codes and names of policies being replaced are listed below.

*22586 - Axial Lumbar Interbody Fusion System*  
*G0428 - Collagen Meniscus Implant*  
*0198T, 0329T - Continuous 24-hour monitoring of Intraocular Pressure*  
*L8696 - Diaphragmatic/Phrenic Pacing*  
*K1007 - Exoskeleton*  
*22526, 22527 - Intradiscal Electrothermal Therapy (IDET)*  
*0072T - Magnetic Resonance Guided Focused Ultrasound for Treatment of Uterine Fibroids (MRgFUS)*  
*93025 - Microvolt T-Wave Alternans*  
*78800 - Radioimmunoscinigraphy*  
*0100T - Retinal (Implant) Prosthesis System*  
*S8080 - Scintimammography*  
*S2300 - Thermal Capsulorrhaphy for Shoulder Instability*  
*33140, 33141 - Transmyocardial Laser Revascularization for Treatment of Severe Angina*  
*91200 - Transient Elastography (FibroScan)*  
*0331T, 0332T - MIBG Imaging for Heart Failure*

You may view the original notification of this change that we sent you on our provider site at <https://wa-provider.kaiserpermanente.org/static/pdf/provider/communications/letters/20230821-general-medicine.pdf>, and view the Medically Necessary Services clinical review criteria at [https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/medically\\_necessary\\_services.pdf](https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/medically_necessary_services.pdf). Additionally, we have also developed an FAQ to answer your questions regarding this notification, which is attached to this letter. You may also view this FAQ on our provider website at <https://wa-provider.kaiserpermanente.org/static/pdf/provider/provider-support/medically-necessary-faq.pdf>.

At Kaiser Permanente, we take very seriously our responsibility to cover services that improve the health of our members and to take reasonable measures to promote the affordability of health insurance in the communities we serve. We are committed to reducing the burden of prior authorization requirements on our contracted network. In addition to simplifying medical policies and increasing transparency on our webpage, we are committed to modifying or eliminating policies that are determined to be unnecessary or counterproductive.

Sincerely,

A handwritten signature in black ink that reads "Peter Barkett MD". The signature is written in a cursive style with a large, stylized initial "P".

Peter Barkett, MD, Chair Medical Policy Committee

**Q1. What’s changing?**

A1. We have reorganized several rarely used medical policies into a single medically necessary services policy on our public facing website.

**Q2. Will Kaiser Permanente be requiring additional prior authorization requirements?**

A2. The medically necessary services policy is not introducing *new* prior authorization requirements on services, it is simply consolidating rarely used existing requirements to a single page.

**Q3. Why was I notified?**

A3. Washington State Law requires that we notify contracted providers when our medical policies change. When we consolidated policies, we eliminated the explicit criteria previously posted and replaced it with the general medical necessity criteria which warranted a notification.

**Q4. Which services are affected?**

A4. The specific services reviewed against this policy are listed on our clinical review criteria webpage. These services were consolidated because utilization is low. Many of the policies that were replaced had no claims in the last several years.

Date of Archive	Clinical Criteria	Codes
01/0/2024	Cryosurgery- Breast	19105
12/1/2023	Axial Lumbar Interbody Fusion System	22586
	Collagen Meniscus Implant	G0428
	Continuous 24-hour monitoring of Intraocular Pressure	0198T, 0329T
	Diaphragmatic/Phrenic Pacing	L8696
	Exoskeleton	K1007
	Intradiscal Electrothermal Therapy (IDET)	22526, 22527
	Magnetic Resonance Guided Focused Ultrasound for Treatment of Uterine Fibroids (MRgFUS)	0071T, 0072T
	Microvolt T-Wave Alternans	93025
	Radioimmunosciintigraphy	78800
	Retinal (Implant) Prosthesis System	0100T
	Scintimammography	S8080
	Thermal Capsulorrhaphy for Shoulder Instability	S2300
	Transmyocardial Laser Revascularization for Treatment of Severe Angina	33140, 33141
04/05/2022	Transient Elastography (FibroScan)	91200
03/01/2022	In Lieu of Hospital Admission to Skilled Nursing Facility (ILOH)	No specific codes
	MIBG Imaging for Heart Failure	0331T, 0332T
	Pneumatic Vest for Chronic Low Back Pain	No specific codes

**Q5. Why was the notice sent to so many providers?**

A5. While the services represented by this medical policy are rarely used they do represent a broad spectrum of clinical subjects potentially of interest to providers practicing in many specialties.