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

CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR GENETIC SCREENING AND TESTING

Applies to: Commercial - HMO ☒ POS ☒ PPO ☒ Medicare Advantage ☐
Network list: https://wa-provider.kaiserpermanente.org/communications/letters

Effective July 1, 2024, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are updating the Genetic Screening and Testing Criteria.

Explanation of the change:

Hereditary Retinal Disorders analysis panel (CPT 81434) clinical criteria are being updated from a position of non-coverage to adopting clinical criteria using MCG KP-0912.

To view the Genetic Screening and Testing clinical review criteria, please visit the Kaiser Permanente provider website at:
https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/genetic_screening.pdf

Is prior authorization required?

- 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: Contact Provider Assistance Unit at 1-888-767-4670, Monday through Friday, 8 a.m. to 5 p.m.

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