

CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR TREATMENTS FOR URINARY INCONTINENCE

Applies to: Commercial - HMO POS PPO Medicare Advantage

Network list: <https://wa-provider.kaiserpermanente.org/communications/letters>

Effective August 1, 2024, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are updating the criteria for Treatments for Urinary Incontinence.

Explanation of the change:

Clinical review criteria for sling procedures for urinary incontinence are being revised to require medical necessity review using MCG KP-S-850 08012024 criteria. Clinical review criteria for urethral bulking agents for the treatment of urinary incontinence are being revised to require medical necessity review using MCG KP-0268. Clinical review criteria for biofeedback for treatment of urinary incontinence will no longer require medical necessity review.

To review the clinical review criteria please visit the Kaiser Permanente provider website at: https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/treatment_urinary_incontinence.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.
- Medicare Advantage: Prior authorization is required.

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

Kaiser Foundation Health Plan of Washington
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