

CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR TREATMENTS FOR RADIATION THERAPY FOR PALMAR FIBROMATOSIS

Applies to: Commercial - HMO POS PPO Medicare Advantage

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

Effective September 1, 2024, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are updating the criteria for Radiation Therapy for Palmar Fibromatosis.

Explanation of the change:

Clinical review criteria for Radiation Therapy for Palmar Fibromatosis are being revised to require clinical review and Prior Authorization for this service.

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/dupuytrens.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
Kaiser Foundation Health Plan of Washington Options, Inc.
Provider Communications, RCR-A3W-04
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