

## **CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR GASTRIC ELECTRICAL STIMULATION**

Applies to: Commercial - HMO  POS  PPO  Medicare Advantage

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

**Effective November 1, 2024**, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are updating the criteria for Gastric Electrical Stimulation.

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

Kaiser Permanente is updating the new medical necessity review requirement of Gastric Electrical Stimulation for both Medicare and non-Medicare members using MCG A-0395.

To review the Electrical Stimulation and Devices clinical review criteria, please visit the Kaiser Permanente Provider website at:

[https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/electrical\\_stimulation\\_devices.pdf](https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/electrical_stimulation_devices.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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