

## **CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR SHOULDER ARTHROSCOPY**

Applies to: Commercial - HMO  POS  PPO  Medicare Advantage

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

**Effective March 1<sup>st</sup>, 2025**, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are implementing medical necessity review criteria for Shoulder Arthroscopy procedures.

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

Kaiser Permanente is implementing a new medical necessity review requirement for Shoulder Arthroscopy procedures for both Medicare and non-Medicare members using MCG KP-S-1045. A medical necessity review will be required in addition to the preexisting review requirement for the level of care.

**Note:** CPT codes 23800 and 23802 will have a new review requirement for ASC Site of Care and Level of Care in addition to the new medical necessity review requirement.

To review the Shoulder Arthroscopy clinical review criteria, please visit the Kaiser Permanente provider website at:

<https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/shoulder-arthroscopy.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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Provider Communications, RCR-A3W-04  
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