CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR SACRAL NERVE STIMULATOR

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

Effective April 1, 2025, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are updating the medical necessity criteria for Sacral Nerve Stimulators.

Explanation of the change:

Kaiser Permanente is updating medical necessity review criteria for Sacral Nerve Stimulators for non-Medicare members, using the hybrid MCG KP-0645 04012025 policy that clarifies trialed conservative therapy.

To view the Treatments for Urinary Incontinence 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.

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
PO Box 34262, Seattle, WA 98124-1262

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