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Kaiser Foundation Health Plan of Washington
Kaiser Foundation Health Plan of Washington Options, Inc.

CHANGES TO MEDICAL NECESSITY REVIEW CRITERIA FOR GENETIC SCREENING AND TESTING

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

Effective January 1, 2027, Kaiser Foundation Health Plan of Washington and Kaiser Foundation Health Plan of Washington Options, Inc. (Kaiser Permanente) are updating the Genetic Screening and Testing criteria.

Explanation of the change:

Kaiser Permanente is implementing new medical necessity criteria for the genetic tests listed below and will use the associated MCG guidelines to determine coverage. This update changes these tests from non-covered services, due to uncertain clinical utility, to services with defined coverage criteria.

- 5-Fluorouracil and Capecitabine Pharmacogenetics (DPYD Gene) – MCG A-0665
- Irinotecan Pharmacogenetics (UGT1A1 Gene) – MCG A-0624

To review the Genetic Screening & Testing clinical review criteria, please visit the Kaiser Permanente provider website at:
https://wa-provider.kaiserpermanente.org/static/pdf/hosting/clinical/criteria/pdf/genetic_screening.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.

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