SPECIAL eBULLETIN

FOR PROFESSIONAL AND FACILITY PROVIDERS **MARCH 1, 2018**

FOUR HCPCS CODES TO REQUIRE PRIOR AUTHORIZATION, EFFECTIVE MAY 1, 2018

This bulletin has been revised and republished.

Effective with dates of service of May 1, 2018, and beyond, the four HCPCS Level II procedure codes below will require prior authorization before providing the services to Highmark members.

Highmark will revise its **List of Procedures/DME Requiring Authorization** by adding the following procedure codes on May 1, 2018:

Procedure Code	Description
A0431	Ambulance service, conventional air services, transport, one way (rotary wing)
J0565	Injection, bezlotoxumab, 10 mg (Zinplava)
J9032	Injection, belinostat, 10 mg (Beleodaq)
J9039	Injection, blinatumomab, 1 microgram (Blincyto)

Note: The codes will not require authorization and will not appear on the all-inclusive authorization list on the Provider Resource Center until the effective date, May 1, 2018.

The **List of Procedures/DME Requiring Authorization** for Highmark is subject to change. During the year, Highmark makes several adjustments to the full list of outpatient procedures, services, durable medical equipment, and drugs requiring authorization.

For more information on obtaining prior authorization or viewing the current list, please visit the Provider Resource Center and look under the **Claims, Payment & Reimbursement** option. The Resource Center is accessible via our Highmark NaviNet® system or under **Helpful Links** on our website.

In order for benefits to be paid, the member must be eligible on the date of service and the service must be a covered benefit.

Providers should use NaviNet or the applicable HIPAA electronic transactions to check member benefits and eligibility, to verify if an authorization is required, and to obtain authorization for services.

Providers who don't have NaviNet or access to the HIPAA transactions should call Clinical Services to obtain authorization for services.

HIGHMARK.