Criteria Revised for Diagnosis and Treatment of Obstructive Sleep Apnea for Adults

Highmark Blue Cross Blue Shield has revised the coverage criteria for the Diagnosis and Treatment of Obstructive Sleep Apnea for Adults. This revised Medical Policy will apply to both professional provider and facility claims. The effective date is February 26, 2018.

Portable devices using less than 4 recording channels (e.g., Watch-Pat) are considered experimental/investigational and, therefore, non-covered due to lack of published peer reviewed literature.

Please refer to Highmark Medical Policy Z-8, Diagnosis and Treatment of Obstructive Sleep Apnea for Adults, for additional information.
Criteria Revised for Electrical Nerve Stimulation

Highmark Blue Cross Blue Shield has revised the coverage position regarding Electrical Nerve Stimulators. These revised criteria will apply to both professional provider and facility claims. The effective date is February 26, 2018.

StimRouter Neuromodulation System is an implanted peripheral nerve stimulator that may be considered medically necessary when used to alleviate chronic intractable neurogenic pain.

Nonimplantable vagus nerve stimulation devices (i.e., gammaCore) is considered Experimental/Investigational and, therefore, non-covered for all indications. There is lack of long term evidence based literature to confirm the efficacy and safety of these devices.

Please refer to Medical Policy Z-7, Electrical Nerve Stimulation for additional information.

Coverage Criteria Revised for Obesity

Highmark Blue Cross Blue Shield has revised the coverage criteria for Obesity (bariatric surgery). This revised policy will apply to both professional provider and facility claims. The effective date is February 26, 2018.

Experimental/investigational procedures added:

- Aspiration therapy devices;
- Endoscopic gastroplasty;
- Gastric balloons.

The following procedures have been replaced with *gastric balloons*.

- ReShape Integrated Dual Balloon System;
- ORBERA Intragastric Balloon System.

Please refer to Medical Policy G-24, Obesity, for additional information.
Revised Criteria for Implantable Pulmonary Artery Pressure Measurement Device

Highmark Blue Cross Blue Shield has revised the coverage criteria for the Implantable Pulmonary Artery Pressure Measurement Device. This revised Medical Policy will apply to both professional provider and facility claims. The effective date is February 26, 2018.

CardioMEMS™ Heart Failure (HF) System coverage criteria has been relocated from Medical Policy M-54 Ambulatory and Outpatient Cardiac Hemodynamic Monitoring of Heart Failure to Medical Policy M-81, Implantable Pulmonary Artery Pressure Measurement Device.

The CardioMEMS HF System may be considered medically necessary for individuals that meet ALL of the following indications:

- Diagnosis of New York Heart Association (NYHA) Class III heart failure symptoms predominantly present over the previous months, despite maximally tolerated guideline directed medical and device therapies; and
- At least ONE HF related hospitalization within the previous 12 months; and
- Able to take dual antiplatelet or anticoagulants for one month post-implant; and
- Greater than or equal to 18 years of age; and
- Diagnosis of HF greater than or equal to three months, with either preserved or reduced left ventricular ejection fraction; and
- Body mass index (BMI) less than or equal to 35; or
- If BMI is greater than 35, a measurement of chest circumference at axillary level is required. If the chest circumference is greater than 165 cm, the sensor should not be implanted due to poor signal strength; and
- PA branch diameter sized between 7 mm and 15 mm.

Monitoring must occur at least once weekly in all individuals implanted with CardioMEMS™. Weekly monitoring is acceptable as long as the individual maintains acceptable PA pressure (opti-volemic).

If PA pressure is not opti-volemic:

- Monitoring must occur at least TWO-THREE times per week until opti-volemic in cases where the individual has elevated PA pressure (hyper-volemic) or low PA pressure (hypo-volemic); and
- Monitoring must occur at least TWO-THREE times per week until pressure stabilizes in cases where the individual receives medication modifications or exhibits significant deviations in trend data.

The CardioMEMS HF System is considered experimental/investigational and, therefore, non-covered for any other indication. The safety and/or effectiveness cannot be established by review of the published peer-reviewed literature.

**Place of Service:** Inpatient/Outpatient

Please refer to Medical Policy M-81, Implantable Pulmonary Artery Pressure Measurement Device, for additional information.
Revised Criteria for Coronary Revascularization

Highmark Blue Cross Blue Shield has revised the coverage criteria for Coronary Revascularization. This revised Medical Policy will apply to both professional provider and facility claims. The effective date is February 26, 2018.

Percutaneous transluminal coronary angioplasty (PTCA), including laser and/or balloon techniques may be considered medically necessary for the treatment of obstructions in the coronary arteries, when ANY of the following criteria are met:

- As an alternative to coronary artery bypass grafting (CABG), in stable individuals with significant (greater than or equal to 50% diameter) coronary artery stenoses in unprotected left main CAD with BOTH of the following:
  - Clinical characteristics that predict a significantly increased risk of adverse surgical outcomes from CABG; and
  - Anatomic conditions associated with a low risk of procedural complications and a high likelihood of good long-term outcome.

  OR

- Symptomatic individuals with (one) 1 or more significant (greater than or equal to 70% diameter) coronary artery stenoses when amenable to revascularization and with Class II, III or IV angina refractory to maximal medical therapy; or

- Symptomatic individuals with 1 or more significant (greater than or equal to 70% diameter) coronary artery stenoses (either a native coronary artery or bypassed graft vessel)* with history of previous CABG, and with Class II, III or IV angina refractory to maximal medical therapy; or

- Symptomatic individuals with (one) 1 or more intermediate (50% to 69% diameter) coronary artery stenoses with a Fractional Flow Reserve (FFR*) of less than or equal to 0.80, and with Class II, III or IV angina refractory to maximal medical therapy.

Please refer to Medical Policy S-181, Coronary Revascularization, for additional information.
Coverage Criteria Revised for Transforaminal Epidural Injection

Highmark Blue Cross Blue Shield has revised coverage criteria for Transforaminal Epidural Injections. The revised policy will apply to both professional provider and facility claims. The effective date is February 26, 2018.

The following criteria have been added to diagnostic purposes:

- Presurgical planning for negative (and possibly positive) predictive value regarding surgical outcome;
- Lumbosacral radicular pain in patients whose clinical features do not implicate a particular, single spinal nerve as responsible for their symptoms, and in whom medical imaging suggests that symptoms could be arising from more than one particular segment.

Revised frequency limitations:

Therapeutic transforaminal epidural injections are typically administered no more frequently than once every three or more weeks. Repeat injections at the same levels are indicated only if there is documented pain relief of 50% or more for two or more consecutive weeks.

- Diagnostic: Two (2) epidural injection treatment sessions maximum, performed a minimum interval of two (2) days apart;
- Therapeutic: One (1) bilateral or one (1) two-level unilateral transforaminal epidural steroid injections may be repeated no less than every three or more weeks providing there is 50% or more relief for two consecutive weeks. Therapeutic injections are limited to no more than four injections per side (right or left) per region (cervical vs. thoracic vs. lumbosacral) AND no more than 16 therapeutic epidural steroid injections (without regard to spinal region) in a 12 month period (365 days).

Blockade in cancer pain treatment may be more frequent.

Please refer to Medical Policy S-189, Transforaminal Epidural Injection, for additional information.
Revised Criteria for Transcatheter Aortic Valve Replacement (TAVR)

Highmark Blue Cross Blue Shield has revised the coverage criteria for Transcatheter Aortic Valve Replacement (TAVR). This revised Medical Policy will apply to professional providers only. The effective date is February 26, 2018.

The following statement has been revised for TAVR performed via the transfemoral or transapical approach, for severe aortic stenosis, using a Food and Drug Administration (FDA)-approved Transcatheter Heart Valve System, may be considered medically necessary when ALL of the following criteria are met:

- The individual is not an operable candidate for open surgery, as determined by at least two cardiovascular specialists (cardiologist and/or cardiac surgeon); or individual is an operable candidate but is at intermediate risk or high risk for open surgery.

TAVR with a transcatheter heart valve system approved for use for repair of a degenerated bioprosthetic valve may be considered medically necessary when ALL of the following conditions are present:

- Failed (stenosed, insufficient, or combined) of a surgical bioprosthetic aortic valve;
- NYHA heart failure class II, III or IV symptoms;
- Left ventricular ejection fraction greater than 20%; and
- The individual is not an operable candidate for open surgery, as determined by at least two cardiovascular specialists (cardiologist and/or cardiac surgeon); or individual is an operable candidate but is at intermediate risk or high risk for open surgery.

TAVR is considered not medically necessary when performed for indications other than those listed in the above criteria.

Please refer to Medical Policy S-232, Transcatheter Aortic Valve Replacement (TAVR), for additional information.
**Coverage Criteria Revised for Paravertebral Facet Joint Nerve Blocks**

Highmark Blue Cross Blue Shield has revised coverage criteria for Paravertebral Facet Joint Nerve Blocks. This revised policy will apply to both professional provider and facility claims. The effective date is February 26, 2018.

Paravertebral facet joint nerve blocks may be considered medically necessary when ALL of the following criteria are met:

- Back or neck pain* (cervical, thoracic, lumbar) for at least three (3) months that has not responded to conservative therapy (i.e., physical/chiropractic therapy, activity modification, non-steroidal anti-inflammatory drugs (NSAIDs), muscle relaxants, and analgesics); and
- Pain is interfering with functional activities; and
- There is no prior history of posterior fusion at the levels being treated; and
- Pain is exacerbated by extension and prolonged standing/sitting and is relieved by rest; and
- The paravertebral facet joint injections or facet joint nerve (medial branch) block injections meet the criteria for EITHER of the injections below.

* Conditions:
Backache; cervicalgia; cervicocranial syndrome; cervical, thoracic, lumbar sprain or strain; disc degeneration; dorsalgia; dorsopathies; fracture-late effects; low back pain; lumbago with sciatica; muscle spasm of back; occipital neuralgia; pain in thoracic spine; post-laminectomy syndrome; sciatica; spinal enthesopathy; spondylosis spondylolisthesis; or spondylopathy.

**DIAGNOSTIC facet/zygapophysial joint nerve (medial branch/dorsal ramus blocks) may be considered medically necessary for DIAGNOSTIC purposes when:**
- Performed to determine whether the source of chronic pain (three or more months) is of facet/zygapophysial joint origin.

The injections should not exceed three joints unilaterally (four medial branches/dorsal ramus) or two joints bilaterally. The block injection is considered positive if there is 50% or greater pain relief with the ability to perform previously painful maneuvers/activities. If positive, one confirmatory block may be performed to minimize the chance of a false-positive.

If negative, no further facet/zygapophysial joint nerve (medial branch/dorsal ramus blocks) injections should be performed at the same levels. Documentation should include a written procedure report, documentation of the response to the block, and images of the procedure in at least two views with contrast (unless there is a documented medical reason for not using contrast).
In some individuals, the facet/zygapophysial joint nerve (medial branch/dorsal ramus blocks) injections yield prolonged pain relief (three months or longer). In these individuals, repeat facet/zygapophysial joint nerve (medial branch/dorsal ramus blocks) injections could be performed (with or without corticosteroid) not to exceed four injections per joint per year.

THERAPEUTIC facet joint (intra-articular) injections with local anesthetic and/or corticosteroid can be performed when the following criteria are met:

• A facet joint cyst is compressing a spinal nerve resulting in radiculopathy/radicular pain; or
• Diagnostic facet joint nerve blocks were positive, but there are contraindications to radiofrequency neurotomy such as implanted devices, etc.; or
• There is documented prolonged (three months or greater) relief from a previous facet joint intraarticular injection; or

The injection frequencies are limited to three joints unilaterally or two joints bilaterally every three months per spinal region (cervical, thoracic, lumbosacral).

All other indications are denied as not medically necessary.

Please refer to Medical Policy Z-61, Paravertebral Facet Joint Nerve Blocks, for additional information.

---

Coverage Criteria Revised for Diagnosis and Treatment of Sacroiliac Joint Pain

Highmark Blue Cross Blue Shield has revised coverage criteria for Diagnosis and Treatment of Sacroiliac Joint Pain. The revised policy will apply to both professional provider and facility claims. The effective date is February 26, 2018.

SIJ injections for the treatment of sacroiliac joint pain may be considered medically necessary when ALL of the following criteria are met:

• Pain has failed to respond to three (3) months of conservative management*; and
• The injection is performed under image guidance; and
• The frequency of SIJ injections does NOT exceed the limitations described elsewhere in this policy.

Injection for the purpose of diagnosing SIJ pain may be considered medically necessary when ALL the following criteria have been met:

• Pain has failed to respond to three (3) months of conservative management*; and
• Dual (controlled) diagnostic blocks** with two (2) local anesthetic agents with differing durations of action are used; and
• The injections are performed under image guidance.

* Conservative management for the duration specified should include ALL of the following:
• Use of prescription strength analgesics for several weeks at a dose sufficient to induce a therapeutic response:
  o Analgesics should include anti-inflammatory medications with or without adjunctive medications such as nerve membrane stabilizers or muscle relaxants; and
• Participation in at least six (6) weeks of physical therapy (including active exercise) or documentation of why the patient could not tolerate physical therapy; and
• Evaluation and appropriate management of associated cognitive, behavioral, or addiction issues (if appropriate).

**A successful trial of controlled diagnostic SIJ intra-articular injections (blocks) consists of two (2) separate positive blocks (50% or more pain relief post-injection when compared to the immediate preinjection pain intensity) on different days with local anesthetic only (no corticosteroids or other drugs), using image guidance, that has resulted in pain relief for the duration of the local anesthetic (also referred to as the double-block paradigm.)

Frequency and Maximum Number of Sacroiliac Joint Injections

• Diagnostic: Two (2) SIJ injections maximum per side. If either injection performed on that side does NOT relieve the pain by at least 50% an SIJ injection (diagnostic or therapeutic) is NOT repeated.
• Therapeutic: One (1) SIJ injection on each side (right or left) performed no more frequently than once every two months providing there is at least 50% relief for six weeks.

No more than four therapeutic SIJ injections per side should be performed in a 12-month period.

SIJ injections are considered not medically necessary when the above criteria and/or the frequency and maximum number requirements are not met.

When SIJ pain is present in conjunction with other primary pain generators (such as lumbar radiculitis secondary to degenerative disc disease), treatment should first address the non-sacroiliac joint pain generators, as pain localized to the SIJ region may resolve once these pain generators have been successfully treated.

Please refer to Medical Policy Z-62, Diagnosis and Treatment of Sacroiliac Joint Pain, for additional information.
Clarification to Vitamin D Assay

Highmark Blue Cross Blue Shield has provided clarification for the criterion for chronic kidney disease for Vitamin D Assay. This clarification will apply to both professional provider and facility claims. The effective date is December 25, 2017.

Measurement of cholecalciferol 25-hydroxyvitamin D [25 (OH) D] levels may be considered medically necessary for individuals with:

- Chronic kidney disease (CKD), stage 3 or greater.

Please refer to Medical Policy L-63, Vitamin D Assay, for additional information.

Correction: Title and Criteria Revised for Cardiac Computed Tomography (Cardiac CT)

Highmark Blue Cross Blue Shield has revised the title to CTA Coronary Arteries and Fractional Flow Reserve CT. This will apply to both professional provider and facility claims. The effective date is January 1, 2018.

Criteria revised: A pretest probability of 20-50% (low-to-moderate) prior to CCTA and was selected for evaluation with CCTA as a non-invasive test for significant CAD. The CCTA result shows lesions of greater than or equal to 50%.

Please refer to Medical Policy X-54, CTA Coronary Arteries and Fractional Flow Reserve CT for additional information.

Coverage Guidelines for Physical Medicine

Highmark Blue Cross Blue Shield has revised and established coverage guidelines for physical medicine. These coverage guidelines will apply to both professional provider and facility claims. The effective date is February 26, 2018.

Hot/Cold Packs are considered integral and are not eligible as a distinct and separate service.

The following are considered not medically necessary:

- Dry hydrotherapy (also known as hydromassage, aquamassage, water massage); and
- Dry needling/trigger point dry needling (intramuscular manual therapy (IMT)).

The following are considered experimental/investigational and, therefore, non-covered.
Scientific evidence does not support the use of these treatments.

- Taping techniques (examples include, but are not limited to, Kinesio® taping (kinesiology), McConnell taping techniques); and
- Vertebral axial decompression (examples include, but are not limited to, VAX-D, DRX9000, Spine Med, Tru-Trac Traction Table).

Please refer to medical policy Y-1, Physical Medicine for additional information.

Coverage Guidelines for Manipulation Services

Highmark Blue Cross Blue Shield has revised and established coverage guidelines for manipulation services. These coverage guidelines will apply to both professional provider and facility claims. The effective date is February 26, 2018.

Spinal and extraspinal manipulation therapy (EMT) provided for either the initial treatment of an acute condition (e.g., acute mechanical joint pain) related to an acute medical episode, or the initial treatment of a reinjury or aggravation of a chronic condition (i.e., the additional permanent impairment or worsening of a previous injury or illness) may be considered medically necessary when BOTH of the following are met:

- The patient has a neuromusculoskeletal condition; and
- The manipulations performed have a direct therapeutic relationship to the patient’s condition.

In the absence of progressive worsening of a condition within the first two (2)-week course of treatment, the chiropractic treatment may be modified and performed for another two (2)-week course of treatment. If the condition has stabilized or reached plateau after four (4)-weeks of treatment even with modifications, additional treatment is considered not medically necessary.

Medical necessity for manipulative therapy services should be supported by three (3) elements of documentation:

- Presence of a spinal subluxation; and
- Evidence of the subluxation by X-ray or physical examination; and
- Documentation of the initial and subsequent visits.

Manipulative therapy is considered experimental/investigational and, therefore, non-covered for the following:

- Non-musculoskeletal disorders (e.g., asthma, otitis media, infantile colic, etc.); and
- Prevention/maintenance/custodial care; and
- Internal organ disorders (e.g., gallbladder, spleen, intestinal, kidney, or lung disorders); and
- Temporomandibular joint (TMJ) disorder; and
Scoliosis correction; and
Manipulation of infants, less than or equal to 12 months.

Scientific evidence does not support the use of the items mentioned above.

Hot/Cold Packs are considered integral and are not eligible as a distinct and separate service.

Dry needling/trigger point dry needling [intramuscular manual therapy (IMT)] are considered not medically necessary.

The following services are considered experimental/investigational and, therefore, non-covered. Scientific evidence does not support the use of these services. This is not an all-inclusive list:

- Phonophoresis; and
- Qi-Gong; and
- Cranial Manipulation/Cranio-sacral therapy; and
- Vertebral Axial Decompression (examples include, but are not limited to, VAX-D, DRX9000, Spine Med, Tru-Trac Traction Table); and
- Taping Techniques (examples include, but are not limited to, Kinesio Taping (kinesiology), McConnell taping techniques); and
- Post Isometric Relaxation (PIR) and Active Release Technique (ART).

Please refer to medical policy Y-9, Manipulation Services for additional information.
Coverage Criteria Established for Omalizumab (Xolair)

Highmark’s Medicare Advantage products have established coverage criteria for omalizumab (Xolair). These new criteria will apply to both professional provider and facility claims. The effective date is February 26, 2018.

Omalizumab (Xolair) may be considered medically necessary for either of the following indications:

- Moderate to severe persistent asthma in patients 6 years of age and older with a positive skin test or in vitro reactivity to a perennial aeroallergen and symptoms that are inadequately controlled with inhaled corticosteroids; or
- Chronic idiopathic urticaria in adults and adolescents 12 years of age and older who remain symptomatic despite H1 antihistamine treatment.

Please refer to Medical Policy I-53, Omalizumab (Xolair®) for additional information.

New Policy Established for Leadless Pacemakers

Highmark’s Medicare Advantage products has established new coverage criteria for Leadless Pacemakers. This new criteria will apply to professional and facility claims. The effective date was January 18, 2017.

Please refer to Medical Policy N-254, Leadless Pacemakers- NCD 20.8.4 for additional information.

Correction: Medical Policy I-90, Abatacept (Orencia) IV

Highmark’s Medicare Advantage products have revised coverage criteria for abatacept (Orencia®) IV. Statements appearing in the October 2017 Medical Policy Update article for treatment with infliximab (Remicade), golimumab (Simponi Aria), adalimumab (Humira) and etanercept (Enbrel) have been removed. The corrected coverage criteria will apply to both professional provider and facility claims. The effective date is January 1, 2018.

Rheumatoid Arthritis (RA)

Abatacept IV may be considered medically necessary for the treatment of moderately to severely active RA when the individual has a history of beneficial response to abatacept IV; or
When ALL of the following indications are met:

- Abatacept IV is to be used in reducing the signs and symptoms and inhibiting the progression of structural damage in adults (greater than or equal to 18 years of age) with moderate to severe active rheumatoid arthritis; and
- Treatment with at least one (1) non-biologic disease modifying anti-rheumatic drug (DMARD) (e.g. methotrexate, leflunamide, sulfasalazine, hydroxychloroquine, or cyclosporine) was ineffective or not tolerated, or all nonbiologic DMARDs are contraindicated; and

Juvenile Idiopathic Arthritis (JIA)/Juvenile Rheumatoid Arthritis (JRA)

Abatacept IV may be considered medically necessary for the treatment of moderately to severely active JIA/JRA when the individual has a history of beneficial response to abatacept IV; or

When the following indication is met:

- Abatacept IV is to be used reducing the signs and symptoms of moderately to severely active JIA/JRA in patients greater than or equal to six (6) years of age

Psoriatic Arthritis (PsA)

Abatacept IV may be considered medically necessary for the treatment of active psoriatic arthritis when the individual has a history of beneficial response to abatacept IV; or

When ALL of the following are met:

- Abatacept IV is to be used for the treatment of adults with psoriatic arthritis; and
- When treatment with at least one nonbiologic DMARD (e.g. methotrexate, leflunomide, sulfasalazine, hydroxychloroquine, cyclosporine) was ineffective or not tolerated, or all nonbiologic DMARDs are contraindicated.

Abatacept is considered not medically necessary for an individual with ANY ONE of the following:

- Using abatacept in combination with tumor necrosis factor (TNF) antagonists or other biologic RA therapy, such as anakinra (Kineret); or
- Tuberculosis or other active serious infections or a history of recurrent infections; or
- Individual has not had a tuberculin skin test (TST) or Centers for Disease Control (CDC)-recommended equivalent to rule out latent tuberculosis; or
- The patient tests positive for the hepatitis B virus.

Abatacept is considered experimental/investigational and therefore not medically necessary for ALL other indications. Scientific evidence does not support its use for any other indications.

Place of Service: Outpatient

Please refer to Medical Policy I-90, Abatacept (Orencia) IV, for additional information.
Comments on these new medical policies?
We want to know what you think about our new medical policy changes. Send us an email with any questions or comments that you may have on the new medical policies in this edition of Medical Policy Update.

Write to us at medicalpolicy@highmark.com.

Contents
Criteria Revised for Diagnosis and Treatment of Obstructive Sleep Apnea for Adults ....................................................... 1
Criteria Revised for Electrical Nerve Stimulation .................................................................................................................. 2
Coverage Criteria Revised for Obesity .................................................................................................................................. 2
Revised Criteria for Implantable Pulmonary Artery Pressure Measurement Device .......................................................... 3
Revised Criteria for Coronary Revascularization .................................................................................................................. 4
Coverage Criteria Revised for Transforaminal Epidural Injection ........................................................................................ 5
Revised Criteria for Transcatheter Aortic Valve Replacement (TAVR) .................................................................................. 6
Coverage Criteria Revised for Paravertebral Facet Joint Nerve Blocks ................................................................................ 7
Coverage Criteria Revised for Diagnosis and Treatment of Sacroiliac Joint Pain .............................................................. 8
Clarification to Vitamin D Assay ........................................................................................................................................... 10
Correction: Title and Criteria Revised for Cardiac Computed Tomography (Cardiac CT) ................................................ 10
Coverage Guidelines for Physical Medicine .......................................................................................................................... 10
Coverage Guidelines for Manipulation Services .................................................................................................................. 11
Coverage Criteria Established for Omalizumab (Xolair) ...................................................................................................... 13
New Policy Established for Leadless Pacemakers .................................................................................................................. 13
Correction: Medical Policy I-90, Abatacept (Orencia) IV ..................................................................................................... 13
Comments on these new medical policies? .......................................................................................................................... 15
Contents.................................................................................................................................................................................. 15

Save yourself valuable time with e-Subscribe! Sign up today and you’ll begin receiving email notifications with a direct link to the latest issue of Medical Policy Update.

About this newsletter
Medical Policy Update is the monthly newsletter for most health care professionals (and office staff) and facilities who participate in our networks and submit claims to Highmark using the 837P HIPAA transaction or the CMS 1500 form, or the 837I HIPAA transaction.

Medical Policy Update focuses only on medical policy and claims administration updates, including coding guidelines and procedure code revisions, and is the sole source for this information. For all other news, information and updates, be sure to read Provider News, available on the Provider Resource Center at www.highmarkbcbs.com.

Inquiries about Eligibility, Benefits, Claims Status or Authorizations
For inquiries about eligibility, benefits, claim status or authorizations, Highmark Blue Cross Blue Shield encourages providers to use the electronic
resources available to them - Navinet® and the applicable HIPAA transactions – prior to placing a telephone call to the Provider Service Center at
1-800-242-0514.

Acknowledgement

The five-digit numeric codes that appear in Medical Policy Update were obtained from the Current Procedural Terminology (CPT), as contained in CPT-
2017, Copyright 2016, by the American Medical Association. Medical Policy Update includes CPT descriptive terms and numeric procedure codes and
modifiers that are copyrighted by the American Medical Association. These procedure codes and modifiers are used for reporting medical services and
procedures.