

Special Bulletin

For professional and facility providers

November 17, 2023

Prior Authorization Changes Occurring on March 1, 2024

Effective **March 1, 2024**, the following additions will be made to the prior authorization list:

- 17 codes related to hysterectomy procedures and services.
- One code for a hypoglossal nerve stimulator.

There's also one other change: A code for the ligation and stripping of varicose veins will be removed from the prior authorization list. That change will be effective **January 1, 2024**.

Codes to be Added to Prior Authorization List

The codes below will not appear on the Prior Authorization list on the Provider Resource Center until the effective date of **March 1, 2024**.

Procedure Code	Description
64582	Open implantation of hypoglossal nerve neurostimulator array, pulse generator, and distal respiratory sensor electrode or electrode array
51597	Pelvic exenteration, complete, for vesical, prostatic, or urethral malignancy, with removal of bladder and ureteral transplantsations, with or without hysterectomy and/or abdominoperineal resection of rectum and colon and colostomy, or any combination thereof
58200	Total abdominal hysterectomy, including partial vaginectomy, with para-aortic and pelvic lymph node sampling, with or without removal of tube(s), with or without removal of ovary(s)
58210	Radical abdominal hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with or without removal of tube(s), with or without removal of ovary(s)
58260	Vaginal hysterectomy, for uterus 250 g or less;
58262	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s)
58263	Vaginal hysterectomy, for uterus 250 g or less; with removal of tube(s), and/or ovary(s), with repair of enterocele
58267	Vaginal hysterectomy, for uterus 250 g or less; with colpo-urethrocytopexy (Marshall-Marchetti-Krantz type, Pereyra type) with or without endoscopic control
58270	Vaginal hysterectomy, for uterus 250 g or less; with repair of enterocele
58275	Vaginal hysterectomy, with total or partial vaginectomy;
58280	Vaginal hysterectomy, with total or partial vaginectomy; with repair of enterocele
58285	Vaginal hysterectomy, radical (Schauta type operation)
58290	Vaginal hysterectomy, for uterus greater than 250 g;

58291	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s)
58292	Vaginal hysterectomy, for uterus greater than 250 g; with removal of tube(s) and/or ovary(s), with repair of enterocele
58548	Laparoscopy, surgical, with radical hysterectomy, with bilateral total pelvic lymphadenectomy and para-aortic lymph node sampling (biopsy), with removal of tube(s) and ovary(s), if performed
58575	Laparoscopy, surgical, total hysterectomy for resection of malignancy (tumor debulking), with omentectomy including salpingo-oophorectomy, unilateral or bilateral, when performed
59525	Subtotal or total hysterectomy after cesarean delivery (List separately in addition to code for primary procedure)

Code to be Removed from Prior Authorization List

Effective January 1, 2024, the procedure — represented by the CPT/HCPCS code below — will no longer require prior authorization for Highmark Blue Shield (BS) members.

Highmark BS will revise its [List of Procedures/DME Requiring Authorization](#) by removing the following code, currently managed by eviCore, on **January 1, 2024**:

Procedure Code	Description
37735	Ligation and division and complete stripping of long or short saphenous veins with radical excision of ulcer and skin graft and/or interruption of communicating veins of lower leg, with excision of deep fascia

Note: This procedure will continue to require authorization and will appear on the authorization list on the Provider Resource Center until **January 1, 2024**.

Important Information for Acquiring Prior Authorization

The [List of Procedures/DME Requiring Authorization](#) for Highmark BS is subject to change. During the year, Highmark BS makes several adjustments to its full list of outpatient procedures, services, durable medical equipment, and drugs requiring authorization. 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 [Availity](#)[®], [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 before they are rendered.

Providers who don't have Availity, NaviNet, or access to the HIPAA transactions should call or fax Highmark's [Clinical Services](#) to obtain authorization for services.

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