Clinical Information Requirements

The following list identifies situations where Highmark Blue Shield may routinely require submission of clinical information before or after payment of a claim. Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list.

- Care Management activities reviewed for medical necessity on a precertification, concurrent or retrospective basis including:
    - Procedures requiring an authorization
    - Procedures that are potentially experimental/investigational
    - Procedures that are cosmetic
    - Requests for mental health and substance abuse services
    - Requests involving provider appeals
    - Requests requesting peer-to-peer review
- Claims for individuals involved in case management or condition management. Please see Chapter 4, Unit 1 of the Highmark Blue Shield Office Manual for more information.
- Certain medications requiring prior authorization. For a list of drugs that require prior authorization, please visit the Pharmacy/Formulary Information page within the Provider Resource Center, and select Highmark Pharmacy Policies.
- Other situations in which clinical information might routinely be requested:
    - Claims containing Not Otherwise Classified (NOC) Codes
    - Claims with a 22 modifier
    - Claims rejected for concurrent care
    - Corrected claims submitted with the 59 modifier
    - Claims with contractual requirements such as rider or Administrative Services Only (ASO) account that requires review of medical records to determine coverage
    - Claims from the face of which we cannot determine whether a Covered Service is involved, thus requiring a review of medical records in order to make a benefit determination (including but not limited to pre-existing condition issues, emergency service-prudent layperson reviews, and specific benefit exclusions).
    - Services rejected that require clinical review to consider eligible for payment.
    - Claims with questionable Medical Necessity. Please see Chapter 4, Unit 1 for Highmark's definition.

Potentially Cosmetic Procedures

Some procedures are considered potentially cosmetic, meaning that they can either be denied as cosmetic or covered as reconstructive, depending on the indications for which they're performed.

Please see Highmark Medical Policy Bulletin S-28 for guidelines related to cosmetic vs reconstructive services. When requesting coverage for these procedures, please follow these guidelines for any applicable clinical documentation requirements.

Procedures of Questionable Current Usefulness

Procedures of Questionable Current Usefulness are procedures which can be paid only if clinical documentation accompanies the claim or inquiry and satisfactorily demonstrates the medical necessity of the individual case. The list of Procedures of Questionable Current Usefulness is addressed on Highmark Medical Policy Bulletin G-21.

Individual Consideration

The Individual Consideration edit identifies those procedure codes which require manual review in order to determine pricing and/or eligibility. Additional information may be required in order to process the claim. This additional information may include Medical Records, Operative Report, Pathology or Radiology Reports as applicable for the service performed. For Durable Medical Equipment, the purchase invoice, Certificate of Medical Necessity or prescription may be required. Following is a list of procedure codes currently requiring individual consideration (this list excludes Unlisted procedure codes):

12007	12018	12037	12047	12057	15770	15824	15825	15826	15828	15829	15851	15876
15877	15878	15879	20982	21076	21077	21080	21081	21082	21083	21084	21085	21086
21087	32820	33254	33255	33256	33257	33258	33259	33265	33266	33536	34839	35390
43647	43648	43881	43882	44705	55970	55980	65760	65765	65767	77520	77522	77523
43881	43882	44705	55970	55980	65760	65765	65767	77520	77522	77523	77525	81287
81410	81411	81412	81415	81416	81417	81425	81426	81427	81430	81431	81432	81433
81434	81435	81436	81437	81438	81440	81442	81455	81460	81465	81470	81471	81504
81525	81538	81540	81545	81595	86950	89290	89291	89346	90287	90288	90296	90393
90476	90477	90581	90644	90653	90672	90673	90685	90686	92950	97607	97608	0001U
0002U	0003U	0004M	0006M	0007M	0009M	0058T	0106T	0107T	0108T	0109T	0110T	0222T
0232T	0238T	0346T	0357T	0377T	0378T	0379T	0380T	0397T	0419T	0420T	A4211	A4220
A4300	A4326	A4459	A4470	A4648	A4651	A4652	A4653	A4657	A4671	A4672	A4673	A4674
A4706	A4707	A4708	A4709	A4714	A4719	A4720	A4721	A4722	A4723	A4724	A4725	A4726
A4728	A4736	A4737	A4740	A4766	A4911	A4929	A6501	A6513	A8002	A9285	A9286	A9500

Clinical Information Requirements Related to Medical Policy and/or Reimbursement

A9501	A9509	A9512	A9529	A9530	A9531	A9550	A9554	A9555	A9569	A9570	A9571	A9575
A9580	A9582	A9583	A9900	D1999	D5988	D7920	D9985	E0350	E0487	E0985	E1220	E1500
E1540	E1575	E1580	E1592	E1600	E1615	E1620	E1625	E1630	E1632	E1634	E1635	E1636
E1637	E1639	E1812	E2230	E2373	E2378	E2511	G0129	G0151	G0152	G0153	G0276	G0429
G0458	G0460	J0390	J0520	J0571	J0695	J0714	J0887	J0888	J1560	J1710	J2940	J3535
J7182	J7328	J7624	J7635	J7636	J7642	J7643	J7647	J7650	J7657	J7660	J9218	K0008
K0013	K0669	K0864	K0870	K0871	L5859	L6694	L6695	L6696	L6697	L6698	L6715	L6880
L8614	L8690	L8691	M0301	P9023	P9031	P9032	P9033	P9070	P9071	P9072	Q0507	Q0508
Q0509	Q2026	Q2028	Q3001	Q4116	Q4121	Q4122	Q4124	Q4132	Q4133	Q4164	Q5010	Q5101
Q5102	Q9954	Q9955	Q9956	Q9969	Q9982	Q9983	S0034	S0194	S0197	S0285	S0311	S0812
S2080	S2095	S2401	S2402	S2403	S2404	S2405	S2411	S3708	S3800	S3841	S3842	S3844
S3845	S3846	S3865	S3870	S3902	S3904	S4011	S4013	S4014	S4015	S4016	S4017	S4018
S4020	S4021	S4022	S4023	S4025	S4028	S4035	S4037	S4990	S4993	S4995	S5000	S5001
S5013	S5014	S8035	S8080	S9007	S9055	S9056	S9098	S9128	S9129	S9131	S9435	V2025
V2600	V2610	V2615	V2718	V2730	V2744	V2755	V2780	V5014	V5050	V5060	V5095	V5130
V5140												