

March 1, 2010

Clinical Submissions Categories

The following is a list of claims categories which we may routinely require submission of clinical information before or after payment of a claim.

- Claims involving precertification/prior authorization/predetermination (or some other form of utilization review) including, but not limited to:
 - Claims pending for lack of precertification or prior authorization
 - Claims involving medical necessity or experimental/investigative determinations
 - Claims for pharmaceuticals requiring prior authorization
- Claims involving certain modifiers including, but not limited to Modifier 22
- Claims involving unlisted codes
- Claims for which we cannot determine from the face of the claim whether it involves a covered service, thus the benefit determination cannot be made without reviewing medical records (including, but not limited to pre-existing condition issues, emergency service-prudent layperson reviews and specific benefit exclusions). A prudent layperson is a person who possesses an average knowledge of health and medicine.
- Claims that we have reason to believe involve inappropriate (including fraudulent) billing
- Claims that are the subject of an audit (internal or external) including high-dollar claims
- Claims for individuals involved in case management or disease management
- Claims that have been appealed (or that are otherwise the subject of a dispute, including claims being mediated, arbitrated, or litigated)
- Other situations in which clinical information might routinely be requested:
 - Requests relating to underwriting (including, but not limited to member or physician misrepresentation/fraud reviews and stop loss coverage issues)
 - Accreditation activities
 - Quality improvement/assurance activities
 - Credentialing
 - Coordination of benefits
 - Recovery/subrogation

Examples provided in each category are for illustrative purposes only and are not meant to represent an exhaustive list within the category.