Clear Coverage - Radiology™
User Guide

McKesson Health Solutions, a division of McKesson Technologies, Inc.
www.mckesson.com

Clear Coverage™ is a product of McKesson, an independent company providing preauthorization services for Blue Cross and Blue Shield of Nebraska, an independent licensee of Blue Cross and Blue Shield Association.
Important Note: Clear Coverage is a web-based tool for radiology preauthorizations for Blue Cross and Blue Shield of Nebraska members.

Getting Started:

After your user account has been set up, use the following link to access Clear Coverage to submit preauthorization requests for Blue Cross and Blue Shield of Nebraska members:

www.nebraskablue.com/clearcoverage

• Logging In
  1. On the Login screen, enter your username and password.
  2. Click Login.
  3. Select a facility and then click Continue.

Note: If you are logged in but not using the application it will automatically log you out after 10 minutes of inactivity.

• Logging Out
  When you finish your work in Clear Coverage, you can log out.
  Click Logout in the upper right corner.
- **Creating an Authorization Request / Authorization Request Workflow**

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<td>Provides additional information about the case.</td>
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**Click New Authorization to access the authorization workflow.**

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Step 1: Find the Patient

Creating an authorization request starts with finding the patient.

Search for a patient by entering information such as the Subscriber ID or the patient’s first and last name as it appears on the member ID card in the search fields. Required fields are marked with a red asterisk (*).

1. Enter search criteria in the required fields, as indicated by the red asterisks (*).
2. Click Search or press the Enter key.
3. Click Select next to the patient name.

Verify the Patient Information

1. Verify the patient’s health plan information, and then click Add to Request.

The Patient Information is added to the Authorization Request summary, and Clear Coverage advances to the Requesting Information tab.
Step 2: Select a Requesting Provider

1. Enter the **Date of Service** by clicking the calendar icon 📆 and selecting a date.
2. The **Facility Name** automatically defaults to that of the user account to which you logged in. If appropriate, select a different facility from the drop-down list.
3. Click the **Requesting Clinician** drop-down list and select the provider requesting the Authorization.
   a. If the Requesting Clinician drop-down list is blank or if you want to select a different provider, click **Select Other Clinician**. In the Provider Search, enter a name in the Last Name field and click **Search**. Once you locate the provider, click **Use Selected** (as shown below).
   b. Click the **Add Selected to Preferred Clinicians/Organizations List** check box to add the selected provider to the Requesting Clinician drop-down list for future authorizations.
4. Click **Add to Request**.
   
   The Requesting Information is added to the Authorization Request summary and Clear Coverage advances to the Diagnosis Tab.

![Provider Search](image)

Step 3: Select a Diagnosis

The Diagnosis Tab enables you to choose one or more diagnoses that are appropriate for the service for which you are requesting authorization.

1. Search for the diagnosis by entering one of the following in the ICD-10 Lookup:
   a. Part of the clinical diagnosis description (for example, “low back pain”)
   b. ICD-10 code (for example, “M54.5” for low back pain)
2. When you find the appropriate diagnosis code, click **Add to Request** next to the diagnosis.
3. Repeat steps 1-2 to include additional diagnoses, if necessary.
4. Click **Next**. The Diagnosis(es) is added to the Authorization Request summary and Clear Coverage advances to the Service tab.

**Step 4: Select a Service**

The Service Tab enables you to select the service for which you are requesting authorization.

1. Search for a service by entering one of the following in the Service Lookup:
   
   a. Enter a complete CPT®/HCPCS code (for example, “72148”)
   
   b. Enter a portion of the service name (for example, “MRI Lumbar Spine”)

   The **Coverage** column will indicate whether a procedure or service requires an authorization.

   2. Click **Add to Request** to add the procedure to the Authorization Request.

   3. Repeat steps 1-2 until you have added all the services you want authorized for this patient.

   4. Click **Next**.

If you select the wrong service, click the trash can icon next to the service to delete it from your list and then choose again.
Step 5: Enter Service Information

1. The **Service Information** tab is where you can determine the **Priority** of care (blue box #1). The default is Normal. However, if your request is urgent or emergent, you can use the drop down to make your selection. The majority of preauthorizations are “normal” priority.

   ![Priority dropdown](image)

   - Normal
   - Urgent
   - Emergent

2. Selecting the **Servicing Facility** (blue box #2): This has a filter to select All Providers, Tier I Providers or Preferred Providers. The Preferred Provider option is a customized list of your favorite Servicing Facilities. Searches can be done by name or National Provider Identifier (NPI).

   ![Facilities](image)
3. The **Medical Review** button (blue box #3): Initially you will see the Overview Screen with informational data and the medical questions for the review. To begin the InterQual medical review, click the Q1 tab (default for age of patient). Tab Q2 and other Q tabs are questions based on ICD-10 and the CPT procedure code. Best practice is to have the patient’s medical chart available to perform the review.

4. After answering criteria questions, click **Next**.
5. When the criteria has been met, you will see this image. At this point, you may click on View Printable Summary for the full preauthorization letter or click Finish to move to the next screen. You always have the option of printing the approval letters from the Home page.
6. **Submit** your request:

![Submit button]

7. **Contact Details** are required for all authorizations. Provide contact information and click **Submit**.

![Contact details input fields]

8. Here is a **Request** that shows care was auto-approved. **Payer Authorization #** is present, **Request Status** is Auto Authorized and an **Expiration** date is provided. To read the disclaimer, click **View Request (PDF)>>**, then click to indicate you have read the disclaimer at the bottom of the page. Click “**No**” unless you want to add another procedure for the same patient.

![Request details]

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**Step 6: Adding a Note or Attaching a Document for Criteria Not Met.**

1. If Clear Coverage advises **Criteria Not Met**, your screen will show **Recommended Actions**. You may chose the **Recommended Action** or continue with the **Alternative Actions** as noted. If you want to continue with **Alternative Actions**, click the radio button and then click **Finish**.
2. This will bring up Tab 6 – Additional Notes. Here it is required to add text in the Additional Notes box and then click the Browse button to attach medical records. Click Add Note/Attachment and the Submit button will be enabled on your screen.

3. Submit your request:

4. Contact Details are required for all authorizations. Provide information and click Submit.

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5. Here is a Request that indicates that care is in a Pending Status. Payer Authorization # is not present, Request Status is Auth Pending and there is no Expiration date. Clicking “No” in the Request box takes the user back to the home screen. Here you will see all authorizations for the practice.
6. Click on the **Details** button to retrieve the authorization just completed for the patient.

7. In the lower left corner is the **Save & Print** box. Options available: Print the approved **Authorization Summary**, **Authorization Full** version or a **Fax Cover Sheet**.

8. Example of **Authorization Summary** letter, normally 2-3 pages. **Authorization Full** version could be up to 12 pages long.
**Step 7: Faxing Medical Records**

1. If uploading electronic medical records is not an option, print a *unique Fax Cover* sheet for the individual authorization. The *Fax Cover* sheet is only for the specific patient listed.
1) Print this page.
2) Confirm the glyph (bar code) is clear and not blurry.
3) Use this page as a cover sheet (must be the FIRST page) for the documents to be faxed.
4) Fax cover sheet and associated pages to Clear Coverage: *(855) 698-4152.
5) Confirm in Clear Coverage that the documents are attached to the authorization.
6) NEVER reuse this cover sheet for another authorization!
Step 8: Canceling an Authorization Request

1. If an authorization needs to be cancelled, find the authorization on the Home page. Click the Detail button.

2. Use the Modify Request button (right hand bottom corner) and select Cancel Request.

3. Choose the most appropriate reason to cancel the services.

4. Confirm your Cancel Request
Resources for your Clear Coverage tool:

Please refer to the MedPolicy Blue manual for any questions regarding what services need to be preauthorized. This will work for radiology and all other medical services. Do not contact the Customer Service Department for this determination.

- Link: medicalpolicy.nebraskablue.com/home

Provider Solutions: 800.821.4787, option 4, option 1 or 402.982.7711, option 4, then option 1.

Provider Relationship Managers – please refer to area map on nebraskablue.com.

- Link: www.nebraskablue.com/providers/resource-center/contacts-for-providers

Medical Support Department: 402.982.8870 or 888.236.3870. This is used for clinical questions.