Frequently Asked Questions: Clear Coverage™

What is Clear Coverage?

McKesson's Clear Coverage is a web-based system that provides an automated method for providers and health plans to manage authorizations for services at the point of care. Clear Coverage enables electronic authorization, notification, eligibility and direction of members to service providers.

- The automation incorporates Eligibility and Medical Necessity criteria.
- It employs an interactive question and answer medical review feature powered by InterQual® clinical criteria to automatically support treatment choices or recommend alternatives.
- The automation allows payer-specific business rules to generate an authorization based on the outcome of the medical review.

What are the benefits of Clear Coverage?

- Providers get immediate access to eligibility, medical appropriateness and network rules, driving the consistent application of evidence based medicine available 24/7.
- Providers have transparency into evidence-based medical necessity.
- Secure PHI transmission
  - Scanning and attaching only required elements from the medical record, reducing the need to print and fax
- Faster turnaround around times
  - Instant decision based on medical necessity, when applicable
  - Eliminates need for numerous call backs when clinical information is attached to the request

How do I get a user name and password for Clear Coverage?

Each person who would create authorizations within Clear Coverage should have their own user ID and password. Complete the form to get this process started.
Link to form: https://medicalpolicy.nebraskablue.com/clearcoverage

I have a user name and password for another insurance company that uses Clear Coverage. Do I need a separate user ID and password to access Clear Coverage for BCBSNE?

Yes, each individual that will access the BCBSNE Clear Coverage tool will need a unique user ID and password to protect PHI (Protected Health Information). Once you are added to the system, an email will be sent with the new user ID and a temporary password. Users are created using the link**:**
https://medicalpolicy.nebraskablue.com/clearcoverage

How long does it take to obtain a user password after completing the form?

An email will be sent to the address you provided with your password within 24 hours,

during regular business hours. If your information is submitted on a holiday or on a Friday, your user information will be sent the following business day. **Passwords will be valid for 90 days.** Users have five attempts to enter their password before they are locked out. If locked out, the password can be reset by Provider Solutions. Call 1-800-821-4787 and select option 4, then option 1, or call 402-982-7711 and select option 1.

If I am having issues signing into the application, what should I do?

Contact Provider Solutions at 1-800-821-4787 and select option 4, then option 1, or call 402-982-7711 and select option 4, then option 1.

What types of radiology services are included under this program?

This program includes outpatient elective CT scans (excluding CCTA), MRI, MRA, MRM, MRS, PET scans and Nuclear Cardiology studies.

What types of radiology services are excluded?

Imaging provided during emergency room visits, inpatient hospitalization and observation are excluded from the program and do not require a preauthorization.

Are there any members excluded from the radiology preauthorization process?

Members excluded from this requirement are the Department of Corrections, University of Nebraska Student Athletes and those members for whom Medicare is the primary health care coverage.

If a BCBSNE member lives outside the state of Nebraska, is preauthorization still required?

Yes, this program applies to all BCBSNE members except those specifically listed above, regardless of where they reside.

Are the Federal Employee Program (FEP) members exempt from the preauthorization requirements?

Services provided to FEP members will not be denied if preauthorization is not obtained. However, this is not a guarantee of payment. Blue Cross and Blue Shield plans must use FEP medical review policies to determine if services are medically necessary. This may be done prior to the service being rendered (by using Clear Coverage) or after the service is rendered once a claim is received. If Clear Coverage approval is NOT obtained, medical records will be requested and review for medical necessity will be completed. We encourage all providers to obtain prior approval using the Clear Coverage tool. Clear Coverage not only streamlines the adjudication of your claim, but it protects you and your patients from unexpected denials. FEP medical policies can be found here: https://www.fepblue.org/en/benefit-plans/benefit-plans-brochures-and-forms/medical-policies/.

If no FEP medical policy exists, BCBSNE will follow its medical review policies. If you have questions regarding FEP medical policy or member benefits, please contact the Federal Employee Program customer service line at 800-223-5584 or 402-390-1879.

Can a request be entered retroactively (after the service has been performed)?

No, the Clear Coverage tool will not allow a retroactive preauthorization. If the service has been performed and preauthorization has not been completed, you are required to submit the claim.

Does Clear Coverage deny requests?

No, there are no auto-denials. If your request does not meet criteria for medical necessity, it will be pended for review. Attach medical records to Tab 6 – Notes.

How long is the preauthorization approval valid?

The authorization is valid for 60 calendar days from **the date of submission**.

What if I don't know the exact date the service will be scheduled?

It is recommended that you enter the date you initiate the preauthorization, since the authorization is good for 60 days from the submission date.

Is a new preauthorization required if the servicing facility has changed?

No, an approved preauthorization is valid for the procedure, not the facility. The preauthorization does not need to be modified or deleted if the servicing facility has changed.

How do I search for a member?

Enter the three-letter prefix and the nine-digit ID number (for example, WXY123456789). If that does not produce your patient data, you can also search by the member's first and last names, as they appear on the identification card, and date of birth.

What should I do if the member is not found?

If the search is not successful, review the member identification card. Contact Customer Service at 800-635-0579 for questions on a Nebraska members' eligibility and coverage. Clear Coverage accessed from the BCBSNE website is only for BCBSNE members.

What if my requesting clinician is not available in the search?

Contact the Medical Support Department for assistance at 888-236-3870 or 402-982-8870.

Does the preauthorization include the professional and technical components?

Yes, the preauthorization is global.

Why is my fax failing when I send records?

Faxes will fail if the glyph (bar code) is not clear or if it is blurry. Please check your printer to make sure the quality is set on high.

What are the different preauthorization results?

- Criteria met:
  - One service is recommended – based on the current evidence, the service is medically appropriate
  - More than one service may be recommended
- An alternative service may be recommended.
- Criteria is not met for requested service. This indicates that the clinical evidence does not support the service. This authorization will be pended for clinical evidence from the user supporting the requested service.
- Some services may indicate direct contact with BCBSNE for preauthorization.
- Some services may indicate no preauthorization is required for the care.

Does Clear Coverage authorize associated service codes (for example, CT neck w/o contrast, w/ contrast and with and without contrast) or will the system authorize for the requested code only?

If criteria are met, other services may be included in the preauthorization. If the review includes associated codes you will not need to obtain a separate preauthorization for that care. This information will be visible in the Clear Coverage printable approval letter.

What is the best strategy for completing the preauthorization?

The best way to complete a preauthorization is to have all the medical records available as you begin the process. Have the medical chart available and assemble documented clinical indications for the requested service (for example, office notes, medication lists, previous treatment such as PT/OT and/or other testing conducted prior to the requested service). Responses should be specific and based on the patient's medical chart. If a response choice is not presented, you should select "Other" and add a comment.

Can I add more than one diagnosis code?

Yes, you can add multiple codes and you can indicate a primary diagnosis code for each service. Please make sure to pick the most appropriate and detailed ICD-10 code.

If I have multiple authorization requests for the same member, do I need to enter them separately?

No, if the member has multiple services requiring authorization, you can enter the information for all of the services in the same request. You will receive an authorization determination for each service.

If I do not have all of the required clinical information to complete the request, what do I do?

You can save your incomplete request while you gather the required information if you have advanced to the Service Tab (Tab 4) in the process. Click the Save button at the bottom right corner of your screen. When you have all the required information ready, open the incomplete request from your Home Page to complete the review and submit your request.

The authorization has pended in Clear Coverage, indicating “criteria not met.” What does that mean?

Proceed with the request and it will be reviewed by BCBSNE. Pended results do not indicate a denial of services. All services that do not auto-authorize will be reviewed by BCBSNE medical management staff.

Can I add supporting notes within the preauthorization?

Notes should only be added if criteria are not met and supporting documentation needs to be sent.

If the preauthorization in Clear Coverage is pended is there a way to indicate that the procedure is an urgent issue?

The authorization cannot be altered to add “urgent” to the request. When uploading medical records on Tab 6, a note should be added indicating the care is urgent.

When requesting an authorization, when should I attach clinical information or notes to the request?

You should attach clinical information ONLY if the medical review results are “criteria not met”. Please complete the InterQual questions and determine first if there is any issue with the preauthorization before making notes on Tab 6.

I am doing a bilateral/duplicate exam, the system will not allow me to enter the CPT code twice. How do I load this into Clear Coverage?

Please indicate right and left in the notes/comment box on Tab 6.

What types of files can be attached?

You can upload documents (for example, all Microsoft® Office file types), all image file types (for example, GIF, JPEG and PNG) as well as Portable Document Format (PDF). The maximum file size per attachment is 5 MB.

Can I fax information regarding my request?

Yes, you can fax information to BCBSNE. You must use the cover sheet available in the Clear Coverage tool. This fax cover sheet is unique to the member and is designed for one time use only.

Where is the fax form located?

Open the pended authorization by clicking on the detail button. The fax form is accessed by clicking the arrow on the **Save and Print** button found on the lower left hand side of the screen. This fax cover sheet is for one time use only.

Why is the Save button grayed out?

Hover over the **Save** button and a message will appear, indicating what is required in order to save the request.

Why is the Submit button grayed out?

Use your curser to hover over the **Submit** button and a message will appear indicating what is required in order to enable the **Submit** button.

How do I print the authorization approval so it can be included in the member record and/or given to the member?

Once you have completed the authorization request, click on the "view .pdf" link. Printing or saving the document can be done from here. Additionally, you can search for a specific approved authorization from the home page and print an Authorization (Full). This includes the InterQual® criteria or the Authorization Summary.

Why am I getting a duplication warning?

When a preauthorization for services has already been requested within a certain timeframe, you will receive a duplicate warning. You will still be able to submit the request; however, it will be pended for health plan review. You should attach medical records if you are going to submit a duplicate request.

If I would like additional training, what do I do?

For additional training on the use of the Clear Coverage tool, please contact your provider relationship manager to schedule time.

How will I request a reconsideration or an appeal?

No preauthorization request in Clear Coverage is denied outright. Providers will be advised that the request has been pended and to send additional information to the Medical Support Department. If care is denied, providers and members are given notification in writing which will advise of next steps.

I have radiology equipment in my office. Do I still need to obtain a preauthorization to perform CTs, MRs, nuclear cardiology exams and PET scans?

A preauthorization will need to be obtained for these services even when they can be performed in the office and/or by physician-owned equipment.

Is a preauthorization required in an emergency situation?

Services performed in conjunction with an emergency room visit do not require a preauthorization.

How can I submit a preauthorization after hours or during the weekend?

Clear Coverage is available online 24 hours a day and 7 days a week. If the authorization is pended requiring further review, it will be reviewed subject to BCBSNE's normal preauthorization program during regular business hours.

If I lose my internet connection, how do I obtain an authorization?

Call the Medical Support Department and advise the nurse of your situation. Medical Support can be reached at 888-236-3870 or 402-982-8870.

Is receiving a preauthorization approval a guarantee of claim payment?

No, the purpose of the authorization process is to verify medical necessity. Actual benefits are determined when the claim is received.

What do I do if I cannot find the preauthorization form I printed?

You can print a duplicate approval by logging in to Clear Coverage. Locate the preauthorization request. On the bottom left you will see the “Save & Print” function. Print options available are Authorization (Full) criteria or the Authorization Summary.

The Add to Request button is greyed out and says No Preauthorization Required under the service requested on the Service Tab 4. What action do I take?

Exit the preauthorization request and do not save. You can print the screen for your records.

If I am having issues with Clear Coverage, do I need to contact McKesson directly?

All questions and concerns should be addressed to BCBSNE.

How can I get additional information on BCBSNE’s medical policy?

Link: https://www.nebraskablue.com/providers/policies-and-procedures

How can I get additional information on Clear Coverage?

Link: https://medicalpolicy.nebraskablue.com/clearcoverage

To obtain benefits and claim status, create a NaviNet account if you do not already have one.

Link: https://www.nebraskablue.com/providers/resource-center/navinet-information
Click on “Sign up for or Login to NaviNet”