Clear Coverage Preauthorization: Background & FAQs

Background

In December 2013, we implemented McKesson's Clear Coverage™ decision support tool for prior authorization of genetic testing services. Our goal was to provide an online evidence-based decision support tool that makes the prior authorization process easier for providers and our members. Feedback has been that it improves efficiency when an authorization is required. Since that time, we have been working with McKesson to expand the number and types of services offered through Clear Coverage. This web-based tool automates and simplifies the prior authorization process.

How Prior Authorization is Becoming Easier

On December 1, 2014, we transitioned most of our current BCBSRI web-based/fax prior authorization processes to Clear Coverage. Please see "Prior Authorization for Services Through Clear Coverage" below.

Clear Coverage's fully automated web-based system includes real-time decision support features. Here are some highlights:

- *Automated authorization*: Real-time approval for services that meet clinical criteria
  - Immediate proof of authorization while patients are in your office
  - Printable confirmation with an authorization number
  - Ability to submit requests 24/7
  - Minimal need for phone calls, faxes, and providing additional clinical information

- *Clinical decision support*: Automated interactive tool with InterQual® Criteria
  - Confirms evidence basis for requested service or recommends alternatives
  - Easily and clearly verifies if authorization is required for specific types of services by CPT or service type
  - Printable clinical evidence summaries for use in your practice

Prior Authorization for Services Through Clear Coverage

For a full list of the services that are to be submitted for prior authorization through Clear Coverage effective December 1, 2014, please review the following policies in the Provider section of BCBSRI.com:

- Preauthorization via Web-Based Tool for Procedures
- Preauthorization via Web-Based Tool for Durable Medical Equipment

If you obtain preauthorization before December 1, 2014 for dates of service on or after December 1, 2014, you do not need to obtain it again through this new tool.

Please note:

- Inpatient admissions, speech therapy, private duty nursing, and pulmonary rehab will continue to go through BCBSRI's traditional web-based/fax prior authorization process.
- High-tech radiology prior authorization requests will continue to go through MedSolutions, Inc., our radiology management vendor.

- Behavioral health prior authorization requests will continue to go through ValueOptions, our behavioral health management vendor.

The Preauthorization Quick Reference Guide provides a comprehensive list of services requiring prior authorization. This can be accessed in the Preauthorization section on the provider home page.

Provider Education & Training
For your convenience, you will be able to receive training for Clear Coverage in the following ways:

- *Webinars* – Through December 18, 2014, we will offer three webinars per week:
  - Tuesdays at 7:30 a.m.
  - Wednesdays at 12:00 p.m.
  - Thursdays at 4:00 p.m.
- *On-site training in your office* – Please contact the Physician & Provider Service Center to schedule.

Participants interested in attending any of these webinars should email their request to BCBSRIWebinar@bcbsri.org. Enrollment will be confirmed via email, and instructions to access the webinar will be provided.

How to Access Clear Coverage on BCBSRI.com
Providers will need to log in to the Provider section of BCBSRI.com to initiate the preauthorization process through Clear Coverage. Once logged on, click on Preauthorization, which is located on the left-hand navigation. If you currently have a log-in for BCBSRI.com, you will be able to access Clear Coverage immediately.

If you (or your practice) do not currently have a log-in for BCBSRI.com, please follow these steps:

1. Click "Sign up for a log-in" on the lower right-hand side of the Provider home page.
2. Follow the prompts to register as a participating provider and request a PIN. Please note that the information you provide online will be populated in a pdf that you will need to print, sign, and fax to BCBSRI.
3. In order to have single sign-on access through BCBSRI.com, the staff account must have 'Preauthorization' selected as a preference. The System Administrator can make this update by going to "Account Access," then "Manage Staff Accounts."

FAQS

When are providers required to start using the Clear Coverage online tool for preauthorization requests?
The effective date is December 1, 2014.

Once an approved authorization is obtained, how long is it valid for?
Preauthorization requests are valid from the date of service requested through 180 days for procedures and 305 days for durable medical equipment.

What if the request is urgent?
Urgent requests can be indicated when submitting a preauthorization request through Clear Coverage. Those authorizations are only valid for 30 days from the date of service on the request.

How far back can I do a retrospective review through Clear Coverage?
To avoid unnecessary appeals, we allow 180 days for retrospective reviews through Clear Coverage. This applies to procedures and durable medical equipment.

What if the patient receives the service after the authorization has expired?
Preauthorization requests are valid for 180 days from the date of service requested. If the date of service is rescheduled to a date past the 180-day range, then the request should be cancelled. A new request should be submitted.

What if the service was rendered without an approved authorization?
A retrospective request should be done through Clear Coverage. We allow retrospective reviews to be done through Clear Coverage up to 180 days after the service to avoid any unnecessary appeals.

My retrospective preauthorization review was approved by Clear Coverage, but I still received a claim denial because the authorization wasn't on file when I submitted the claim. What should I do?
You don't need to submit an appeal. Please resubmit the claim once authorization is obtained.

My patient received the procedure/test at a different hospital or facility than the one I selected on the preauthorization request. Will the claim be paid?
As long as the service is rendered within the approved time period, our claims system will only look for an authorization. Therefore, the claim will pay accordingly regardless of where the service is rendered. Please note that in-network and out-of-network levels of coverage are considered, and standard claims processing policies apply.

Where can I find a list of services requiring preauthorization?
You can find it in the Preauthorization Quick Reference Guide. After logging in to the secure Provider section of BCBSRI.com, please visit the Preauthorization page. The list of services requiring preauthorization is also included in November *Provider Update*.

Does a medical director review all requests?
A medical director reviews all requests that don't meet the InterQual criteria. Requests that pend are first reviewed by a nurse to determine if the supporting clinical information meets the criteria. If the criteria are met, the nurse can approve the request. If the criteria are not met, the nurse refers the case to a medical director. In accordance with regulatory requirements, only a medical director can deny a request.

Why does the requester have to enter their phone number every time a new authorization is submitted?
If the preauthorization request pends for medical necessity review, it is important we have your contact information. Our medical director may need to talk with you about your request.

Can the rendering hospital or facility access the status of the ordering provider's preauthorization request from Clear Coverage?
While this capability is not currently available, we are working with McKesson to provide this access to our rendering hospitals and facilities. In the interim, we suggest obtaining the authorization approval information from the ordering provider prior to rendering services.

What if the employee(s) who is requesting the preauthorization does not have the clinical knowledge to accurately answer medical criteria questions through Clear Coverage?
The practice may need to review existing processes and adjust accordingly to ensure the person requesting the preauthorization can provide clinical answers through the prompted questions in the Clear Coverage online tool.