2015

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

McKESSON

Clear Coverage™

Provider Resource Guide for Acute Medical/Surgical Inpatient Admission Authorizations

A general overview guide for facilities/providers when accessing the inpatient Clear Coverage™ System for the Excellus BlueCross BlueShield member.

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What is Clear Coverage™?

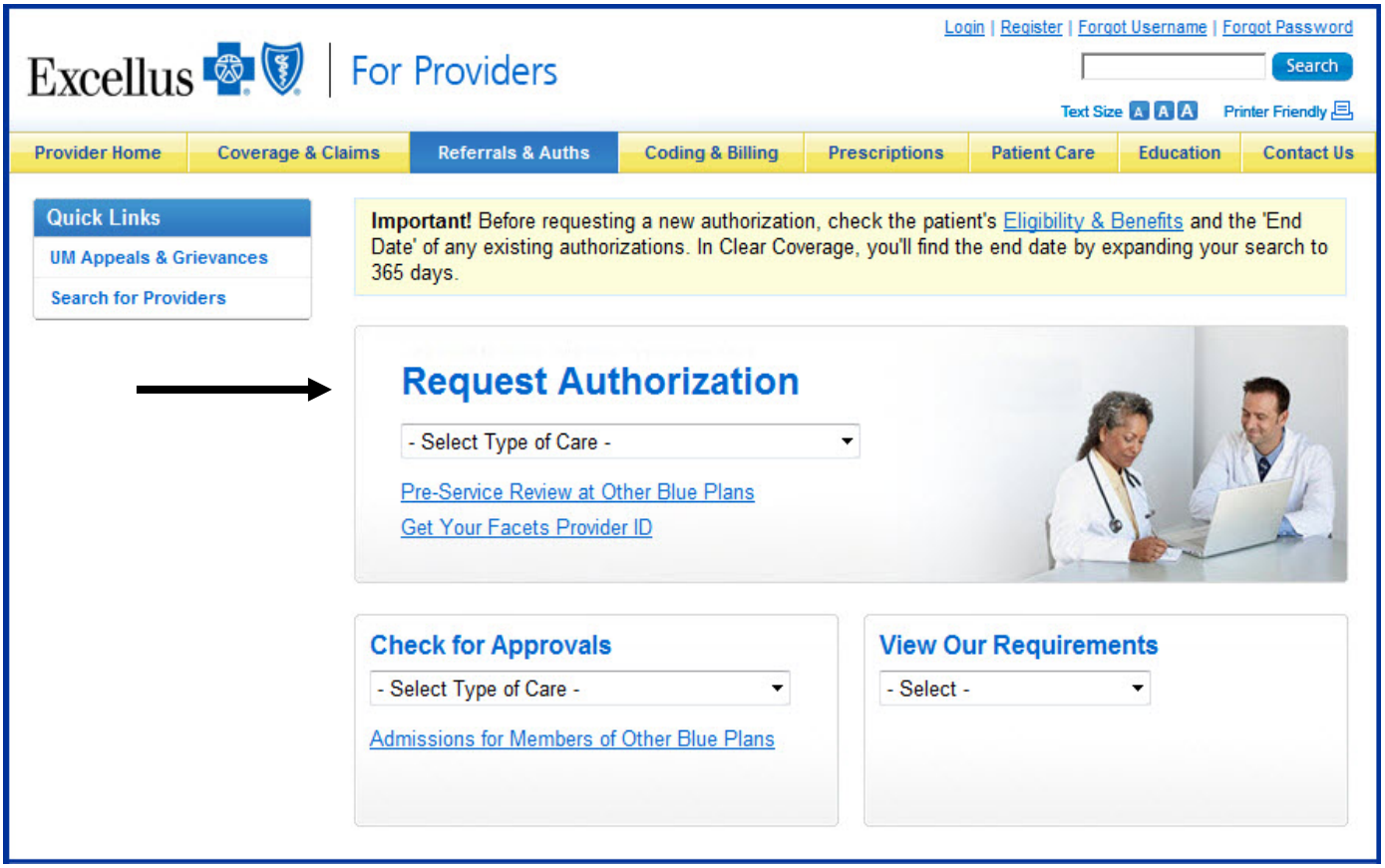
Excellus BlueCross Blue Shield has partnered with McKesson, an independent company to manage hospital inpatient admission authorizations for services through McKesson's automated system, Clear Coverage™. McKesson was engaged to integrate this system with Excellus BCBS business rules, and enables the provider to receive an instant decision of either an *approval* or *pend* for a medical necessity review by the Health Plan.

Clear Coverage™ is a Web-based real-time software program, and is accessible via the provider portal of the Excellus BlueCross BlueShield website.

Clear Coverage™ includes InterQual® evidence-based criteria.

Clear Coverage™ allows for flexibility for creating requests (i.e. time, date, and staff).

It also enables users to print or electronically save a PDF for proof of authorization.



NOTES

Login to **ExcellusBCBS.com** using your exclusive **username** and **password**.

Check member eligibility to ensure active coverage and review member benefits.

Login to the Clear Coverage™ E-Auth Tool using your **Facets Provider ID** number and your **Provider/Facility NPI**.

Click **"New Authorization"** and conduct a patient search.

Clear Coverage™ involves the completion of six brief sections – called accordions – in order to submit an admission authorization request.

1. **Patient Accordion**
   What you'll need: the correct spelling of the patient's first and last name and the patient's date of birth.

2. **Provider Accordion**
   What you'll need: the admission date, the name of the admitting physician and the type of unit (e.g., elective chemo, elective epilepsy, medical).

3. **Admission Diagnosis Accordion**
   What you'll need: the patient's primary diagnosis ICD code and admission type (chemo, urgent or elective).

4. **Admission Criteria Accordion**
   What you'll need: criteria that will be used for the inpatient admission.

5. **Admission Review Accordion**
   What you'll need: the clinical criteria to support the admission request.
   *******Note: Not mandatory for notifications***

6. **Comments|Attachments Accordion**
   What you'll need: this provides a free text section allowing you to type, copy/paste and/or attach additional information pertinent to the admission request. This information is mandatory for any admission that does not meet the criteria in the admission review accordion. This is not mandatory for notifications.

A detailed and in-depth description of each Clear Coverage™ step is included in the following pages.

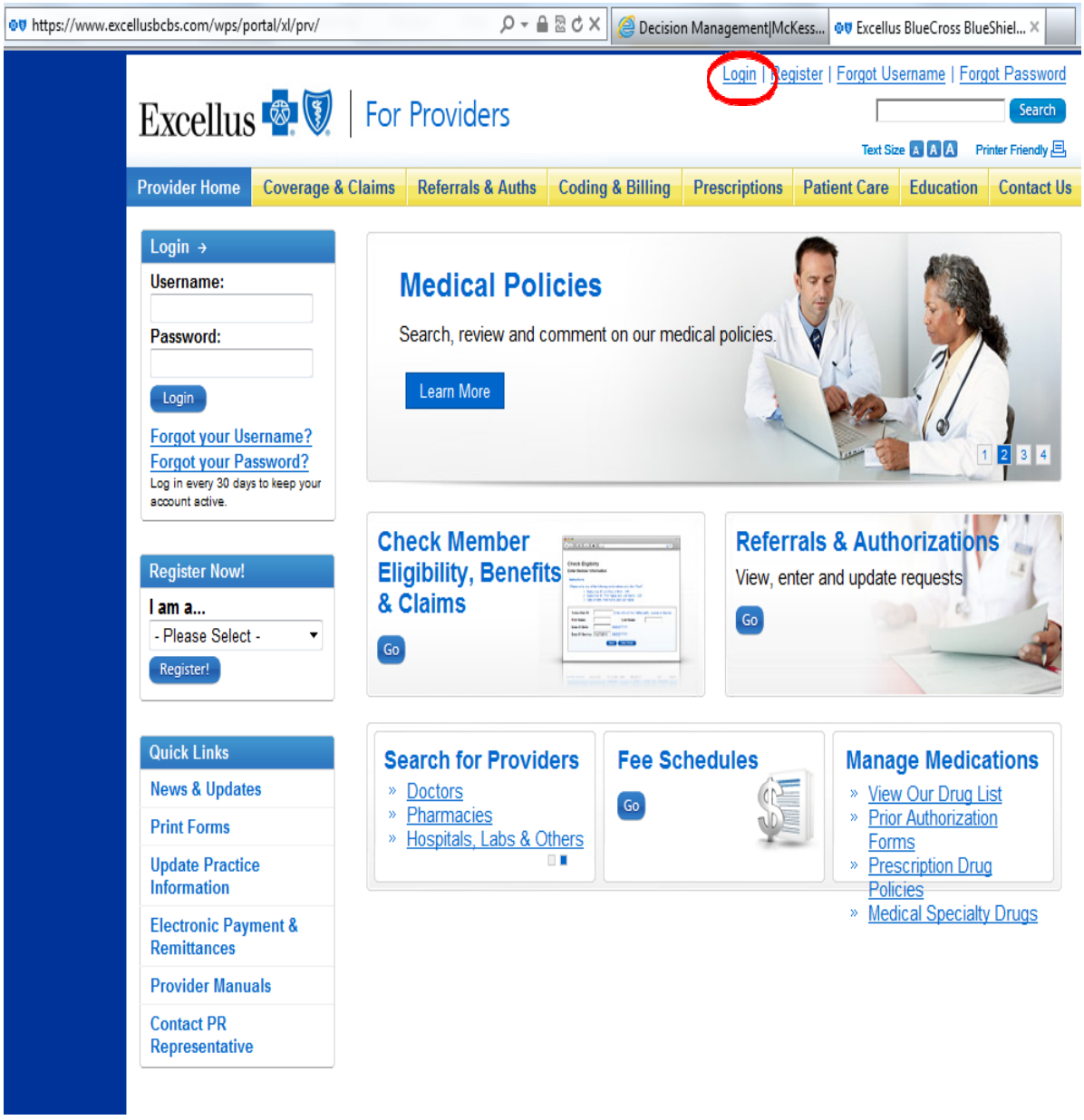
NOTES

LOGGING IN: PROVIDER PORTAL

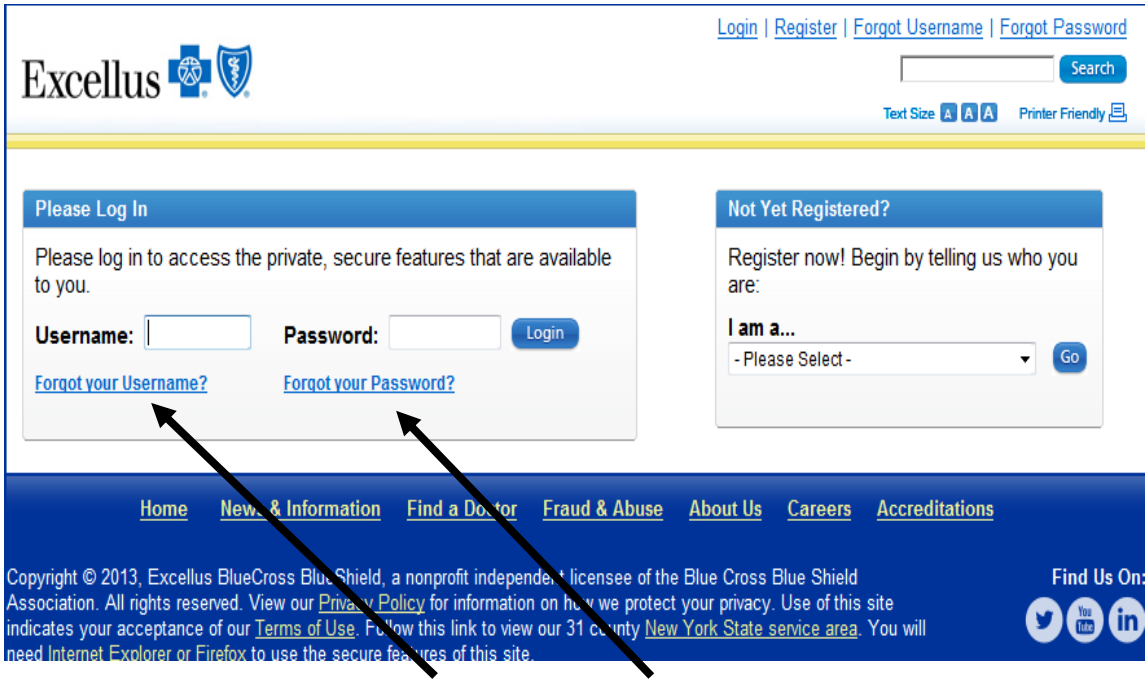
1. Type the provided Web address in your browser address box or log in to the provider portal

https://www.excellusbcbs.com/wps/portal/xl/prv/

2. Click on **"Login"**



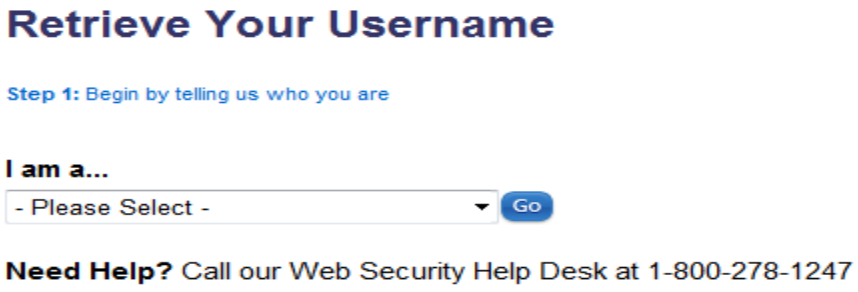
3. Enter assigned Username and Password:



3a. If you have forgotten your Username and/or Password, you may click on the **"Forgot your Username"** or **"Forgot your Password"** links

3b. If you experience web-site problems/issues, call our **Web Security Help Desk 1-800-278-1247**

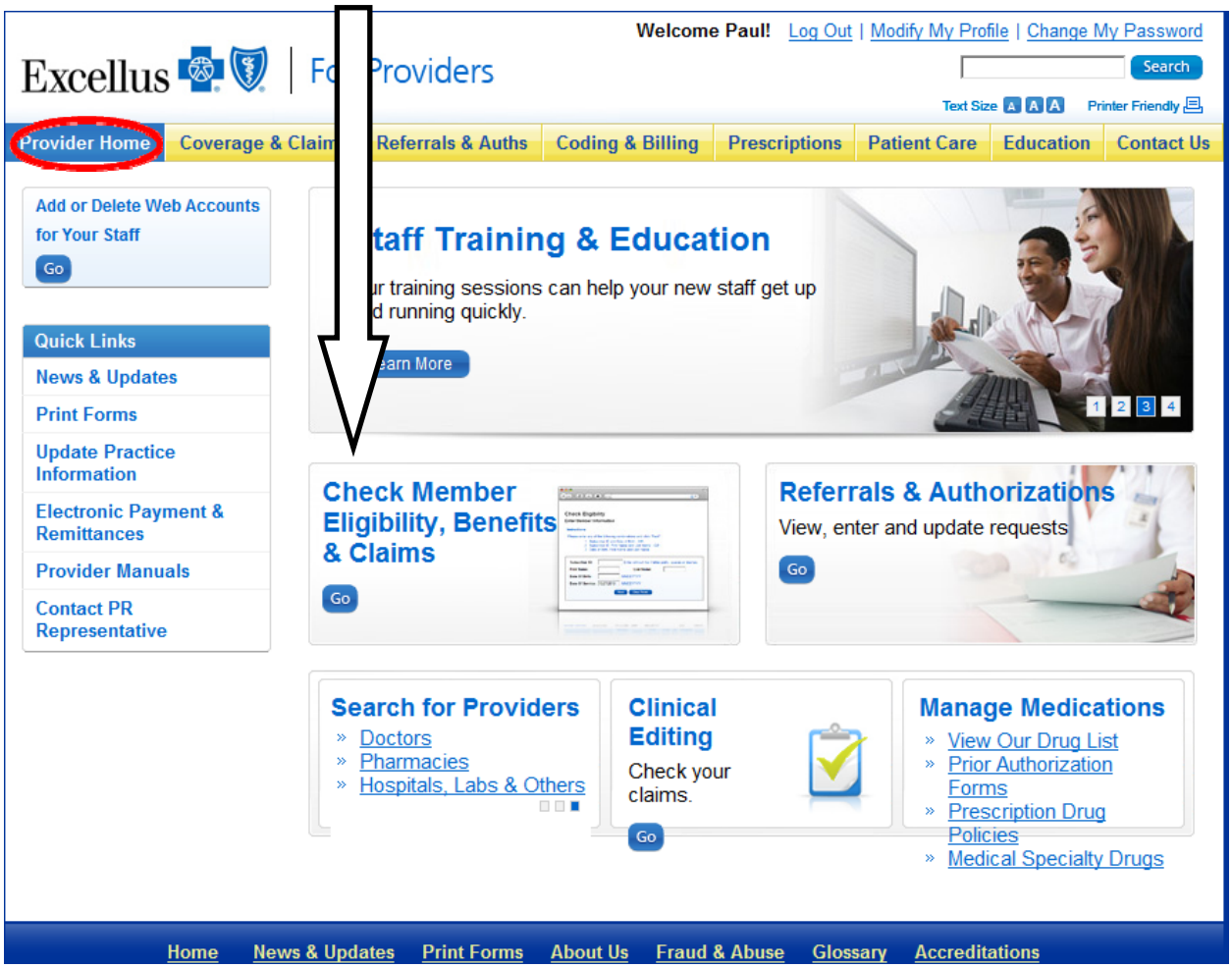
(Monday-Thursday 8 a.m. to 4:30 p.m. or Friday, 9 a.m. to 4:30 p.m. EST)



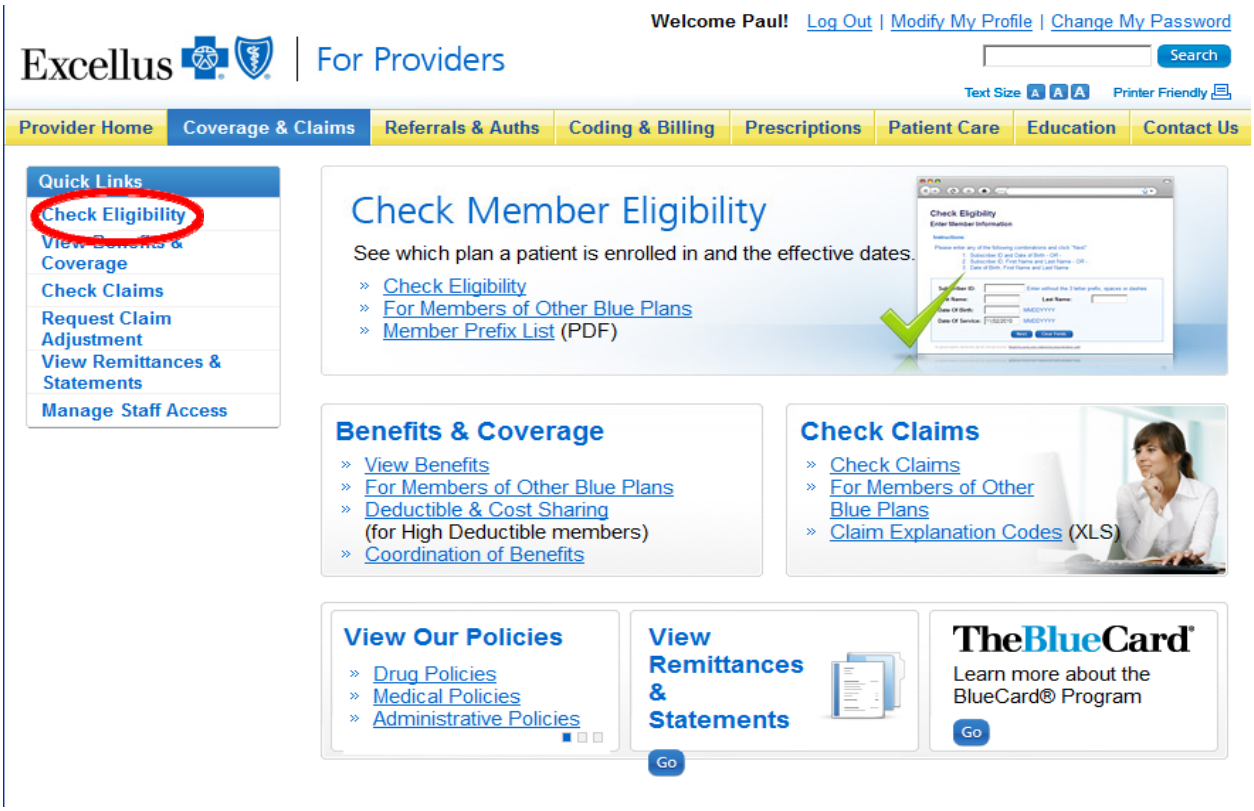
BENEFIT/ELIGIBILITY CHECK

From the Provider Home tab:

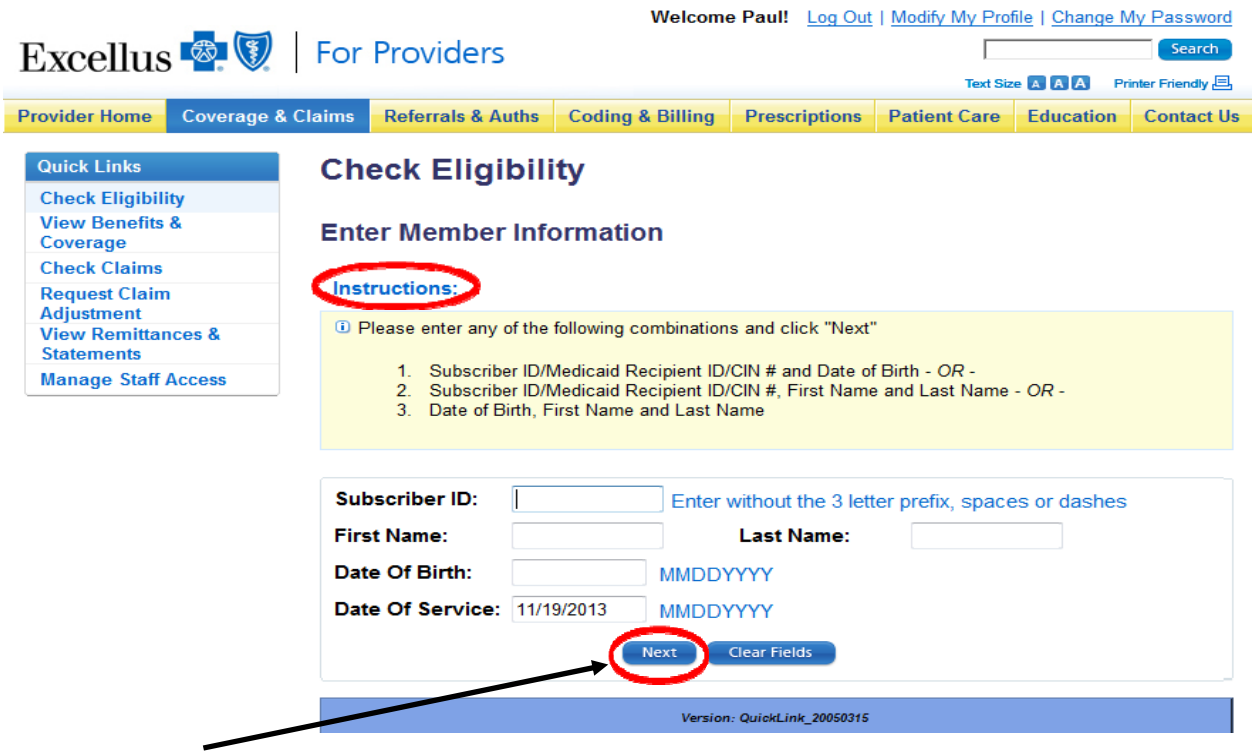
1. Click on **"Check Member Eligibility, Benefits and Claims"**



2. Click on "**Check Eligibility**"



3. Enter all required subscriber information and date of service:



4. Click "**Next**"

5. Review eligibility

Check Eligibility

Results

Subscriber Name:	Patient Name & ID		**Address:**	Patient Address & Phone	
Subscriber ID:		**Suffix:**	0		
			Phone:		
Date of Service:	11/19/2013				

indemnity

Contract Information			
Contract Coverage:	HealthyBlue High Deductible Health Plan	**Effective Date:**	09/01/2012
PFX:	VYI	**Term Date:**	12/31/2199

Group Information			
Group Name:	Elm Chevrolet, inc.	**Contract Type:**	Subscriber and Spouse
Indemnity Waiver:			
Dependent Age:	19		

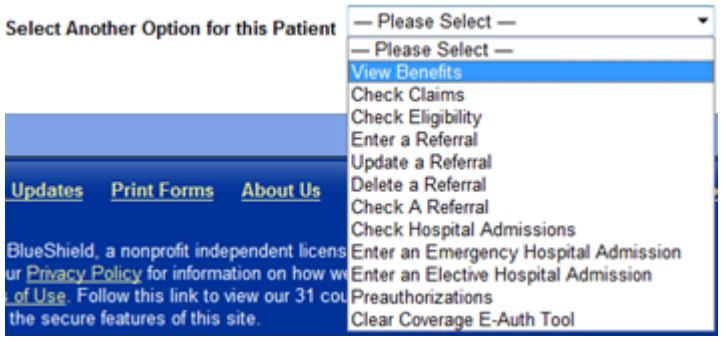
Member Information			
Member Name:	Patient Name & Birthdate	**Effective Date:**	09/01/2012
Member Suffix:		**Term Date:**	12/31/2199
Birth Date:		**Gender Relationship:**	FSUB

Other Coverage Information
No Coordination of Benefit information could be found for this member.

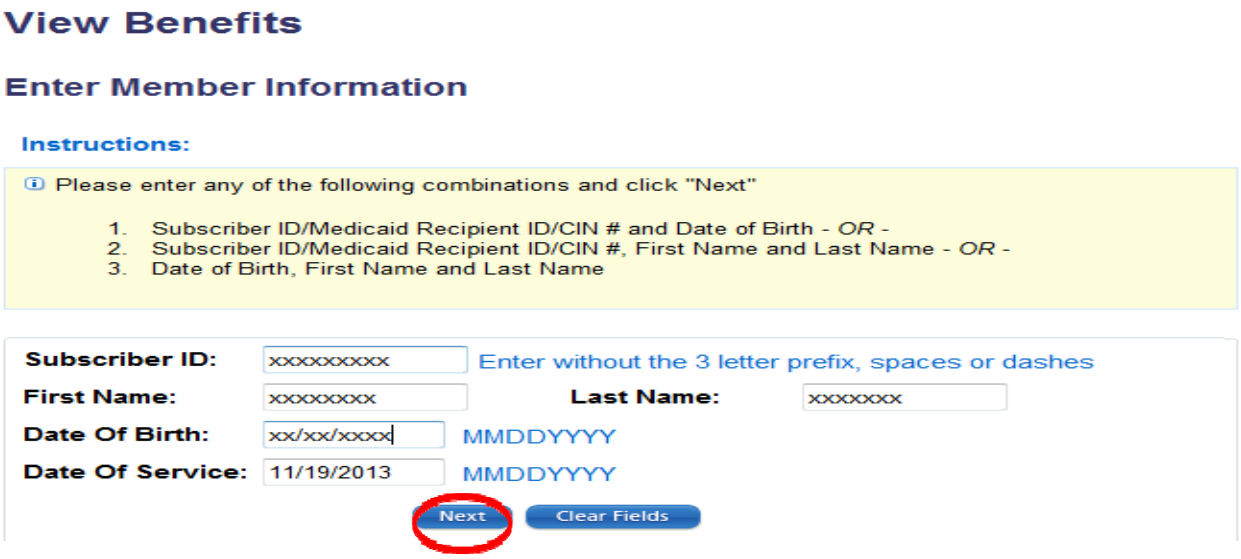
Multiple Contracts

Select Another Option for this Patient — Please Select —

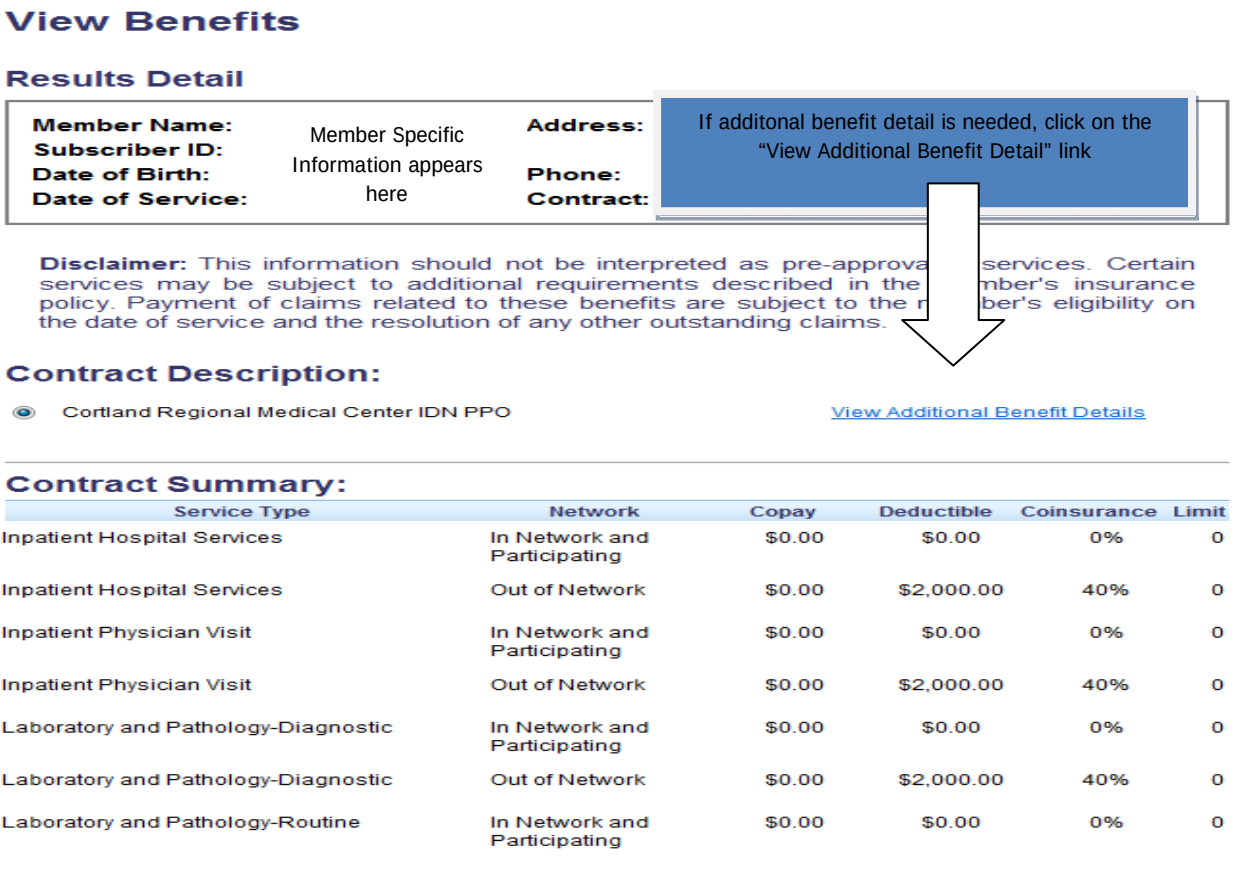
6. If the patient is eligible, click the **dropdown arrow** and select "**View Benefits**" (if benefit check is applicable)



7. Patient information will be autopopulated. Click on "**Next**"

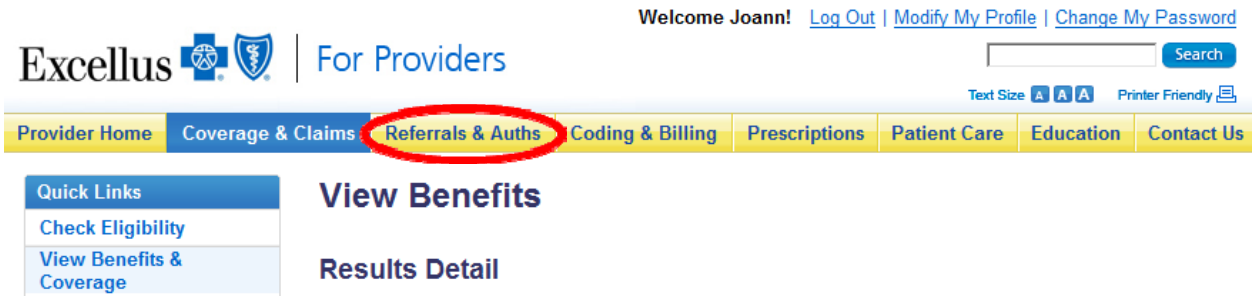


8. A comprehensive benefit list will appear. Verify that the patient has the benefit for the service requested



Service Type	Network	Copay	Deductible	Coinsurance	Limit
Inpatient Hospital Services	In Network and Participating	$0.00	$0.00	0%	0
Inpatient Hospital Services	Out of Network	$0.00	$2,000.00	40%	0
Inpatient Physician Visit	In Network and Participating	$0.00	$0.00	0%	0
Inpatient Physician Visit	Out of Network	$0.00	$2,000.00	40%	0
Laboratory and Pathology-Diagnostic	In Network and Participating	$0.00	$0.00	0%	0
Laboratory and Pathology-Diagnostic	Out of Network	$0.00	$2,000.00	40%	0
Laboratory and Pathology-Routine	In Network and Participating	$0.00	$0.00	0%	0

9. Scroll back to top of screen and click on the “Referrals and Auths” tab



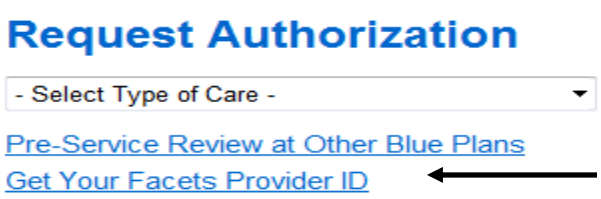
NOTES

LOGGING IN: CLEAR COVERAGE

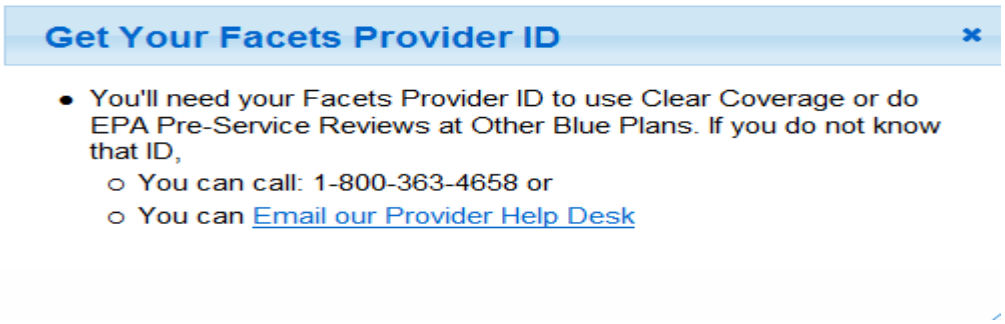
Once you have checked the patient's "Eligibility and Benefits" and would like to enter an inpatient authorization request:

1. Go to the "Referrals & Auths" tab

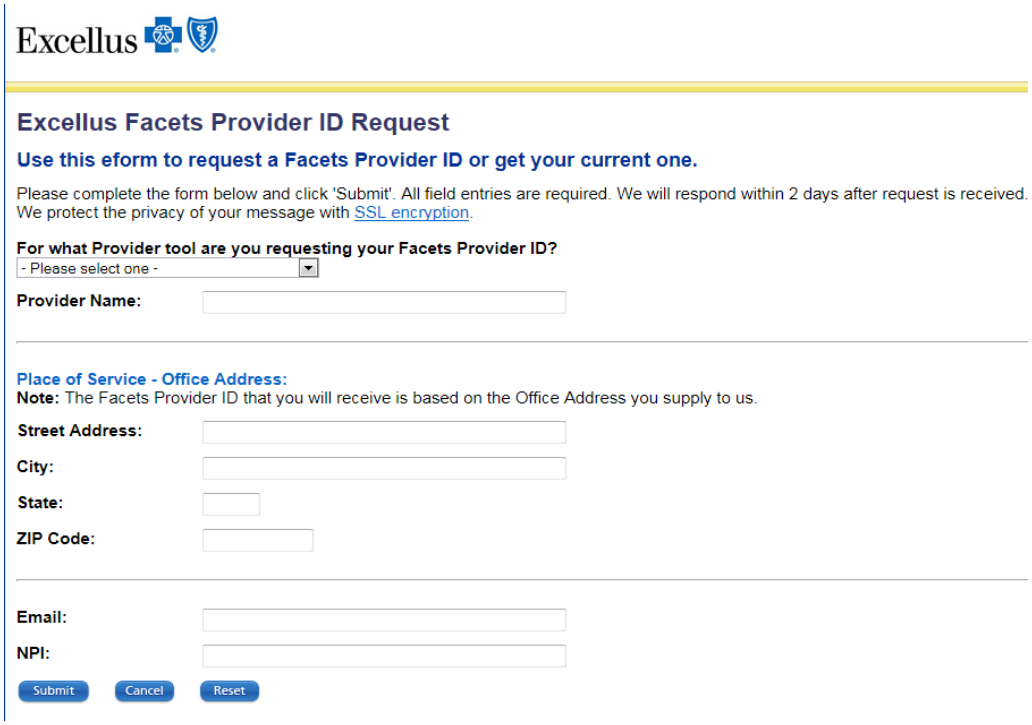
1a. If you are a new user, and do not have a Facets Provider ID, click on the "**Get Your Facets Provider ID"** link.



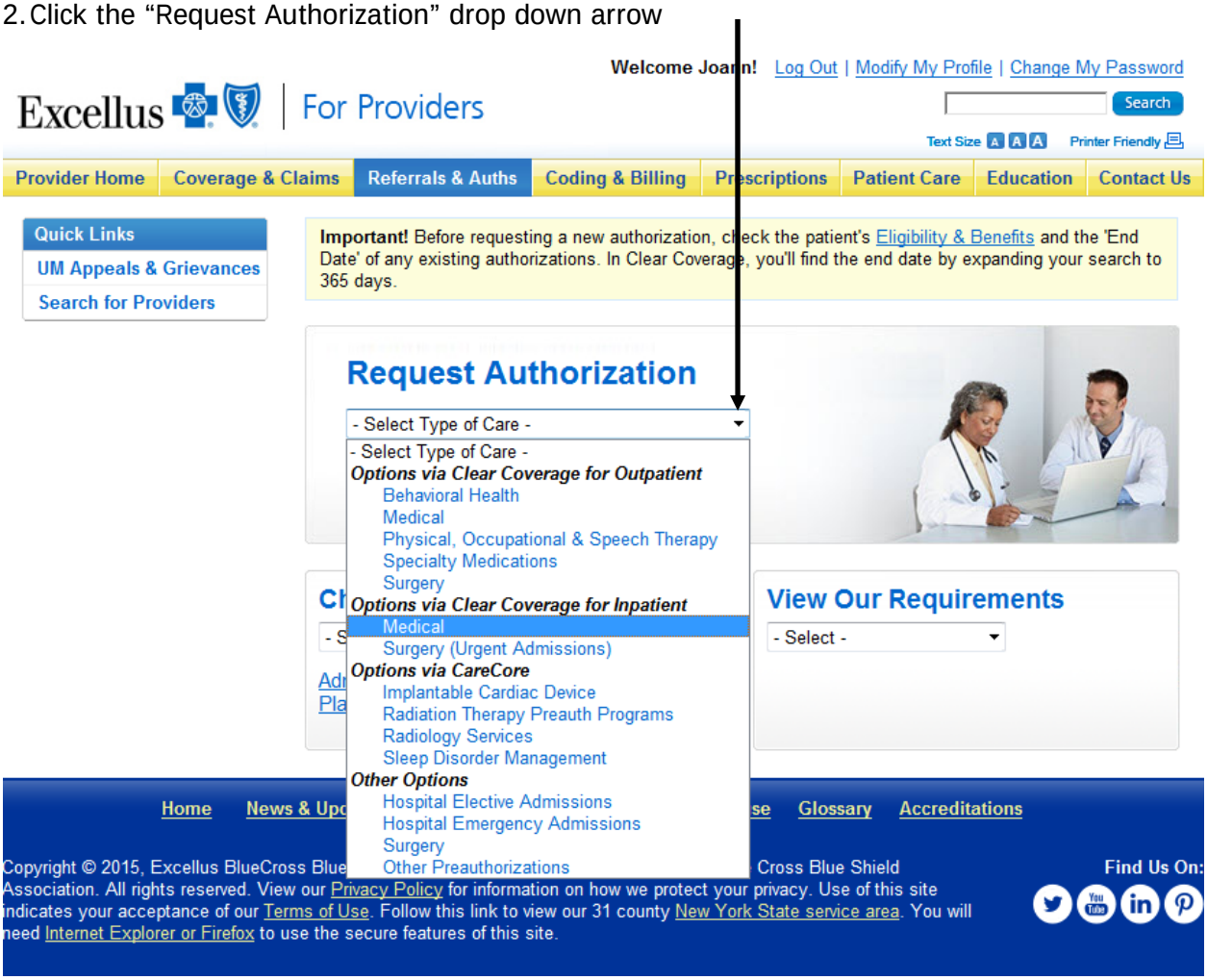
This box will appear. Click on the "**Email our Provider Help Desk**" button.



1b. Complete the form. The Help Desk will contact you with an ID number within 2 days after the request is received.

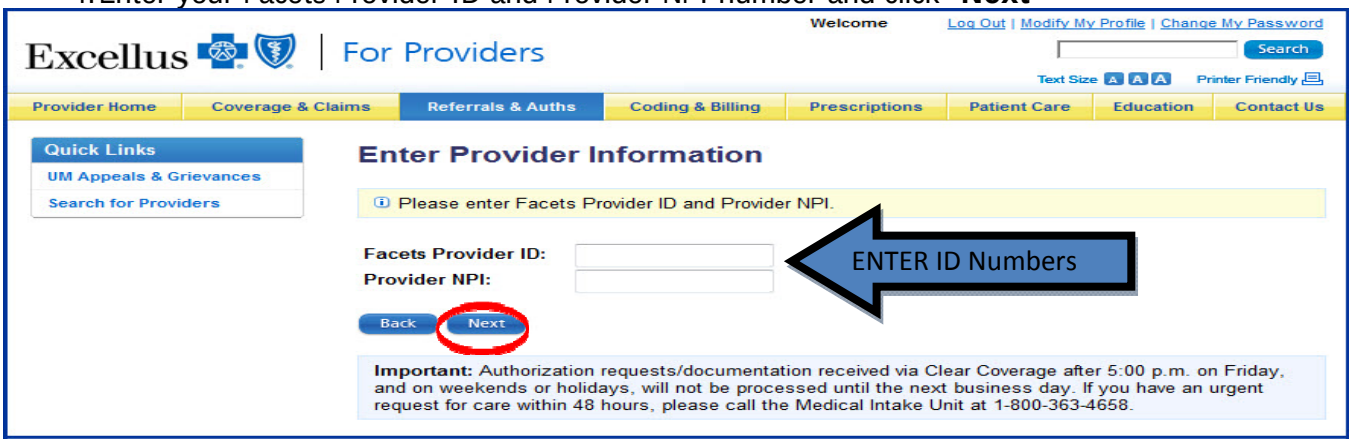


2. Click the “Request Authorization” drop down arrow

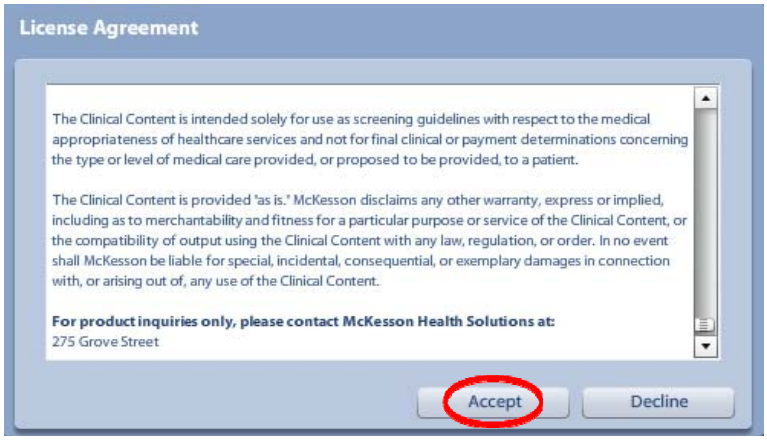


3. Click “Options via Clear Coverage for Inpatient -Medical”

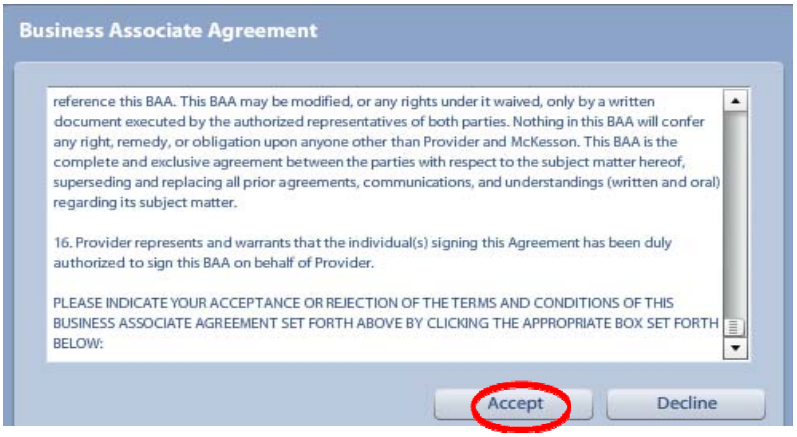
4. Enter your Facets Provider ID and Provider NPI number and click “**Next**”



5. The first time you log in you will need to accept the license agreement. Click "**Accept"**.



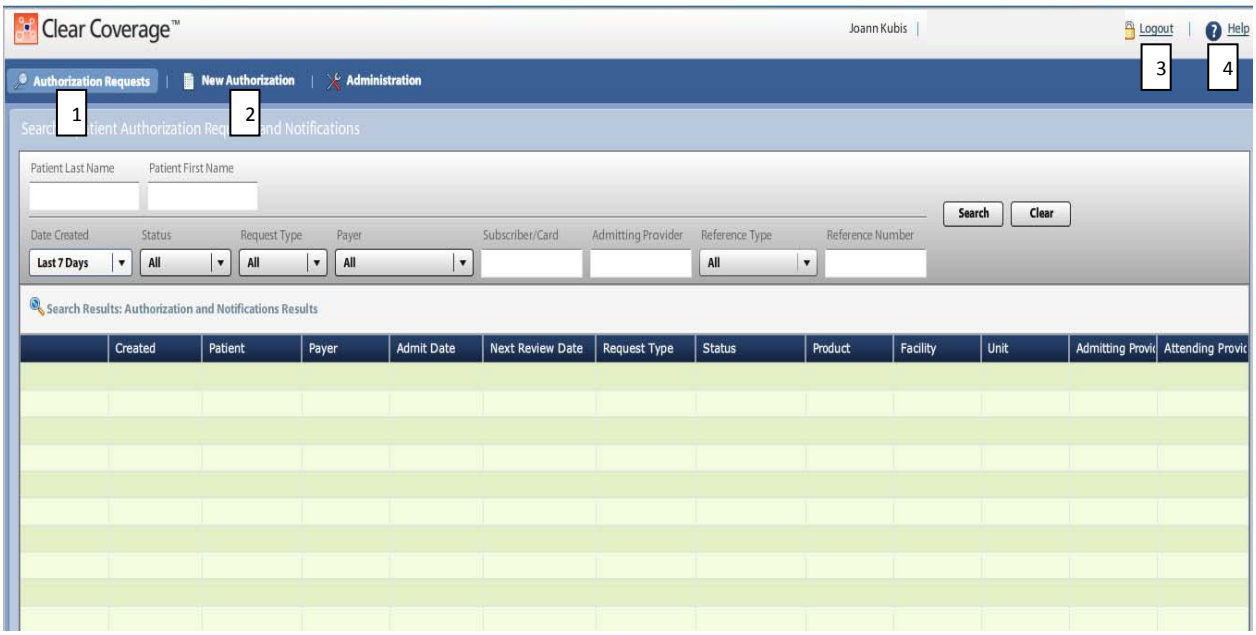
6. The first time you log in you will need to accept the Business Asscociate agreement. Click **"Accept".**



NOTES

AUTHORIZATION MENU SCREEN

When you have successfully logged into Clear Coverage™, the “Authorization” page will display.



You will use the following tabs to manage and view requests:

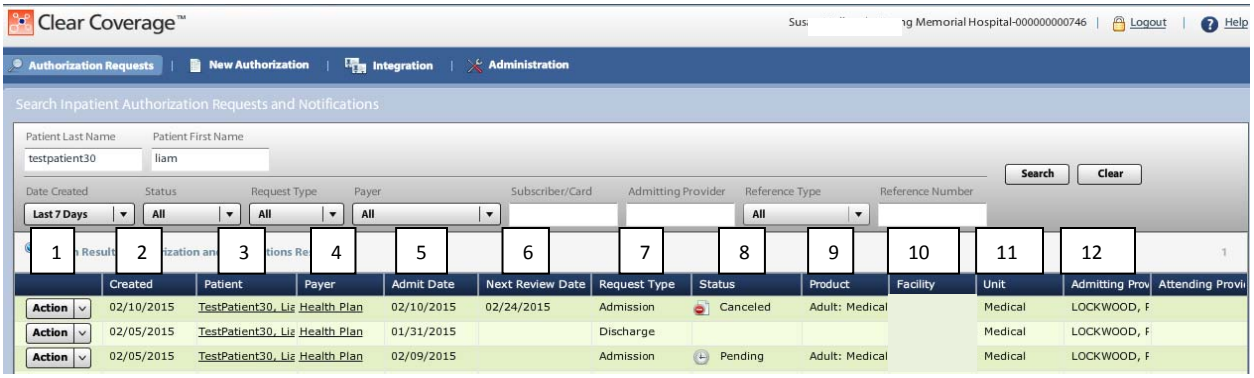
1. **Authorization Requests** - Enables you to find “saved” (incomplete) and submitted authorization requests
2. **New Authorization** - Enables you to enter and submit an authorization request
3. **Log Out** - Enables you to close the application
4. **Help** - for additional, generic Clear Coverage™ information

NOTES

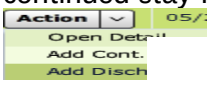
AUTHORIZATION REQUESTS PAGE

The **Authorization Requests page** enables you to find authorizations that have been saved (not yet submitted) as well as requests that have been submitted.

You can filter by name, date created, patient name etc.



1. **Action-**allows you to open the individual authorization for viewing or editing, perform a continued stay review or discharge



2. **Created -**Date the request was created

3. **Patient-**Name of the patient

4. **Payer-**Provides detailed information of the patient's health plan (e.g., ID number, group, product type, effective date)

5. **Admit Date-**the date of the actual admission

6. **Next Review Date-**the date that a continued stay review is required, if applicable

7. **Request Type -** Type of request (admission, continued stay, or discharge)

8. **Status-** Current status of a request

9. **Product-**specifies the InterQual™ product that was used for the review, if applicable

10. **Facility-**the name of the facility that entered the authorization request

11. **Unit-**n/a

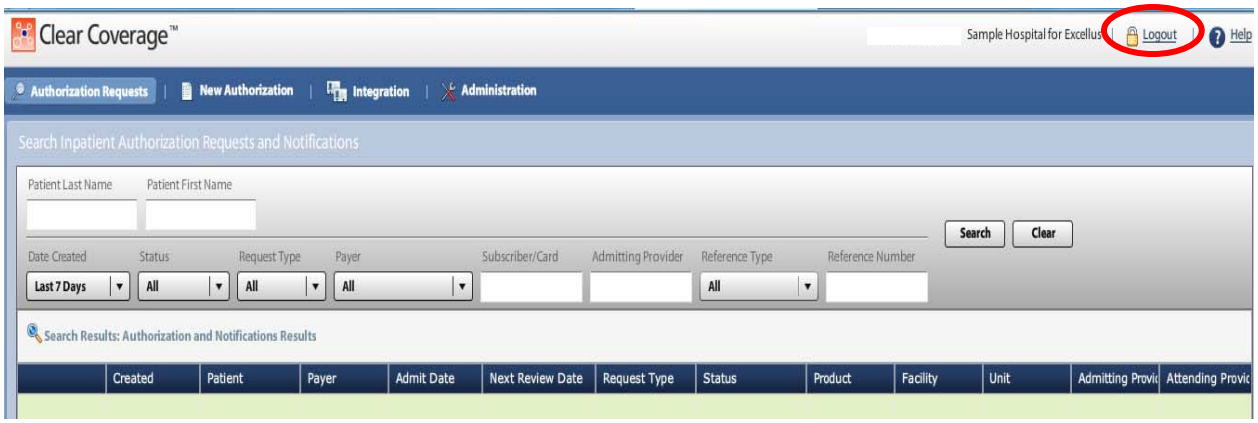
12. **Admitting Provider-**name of the admitting physician

NOTES

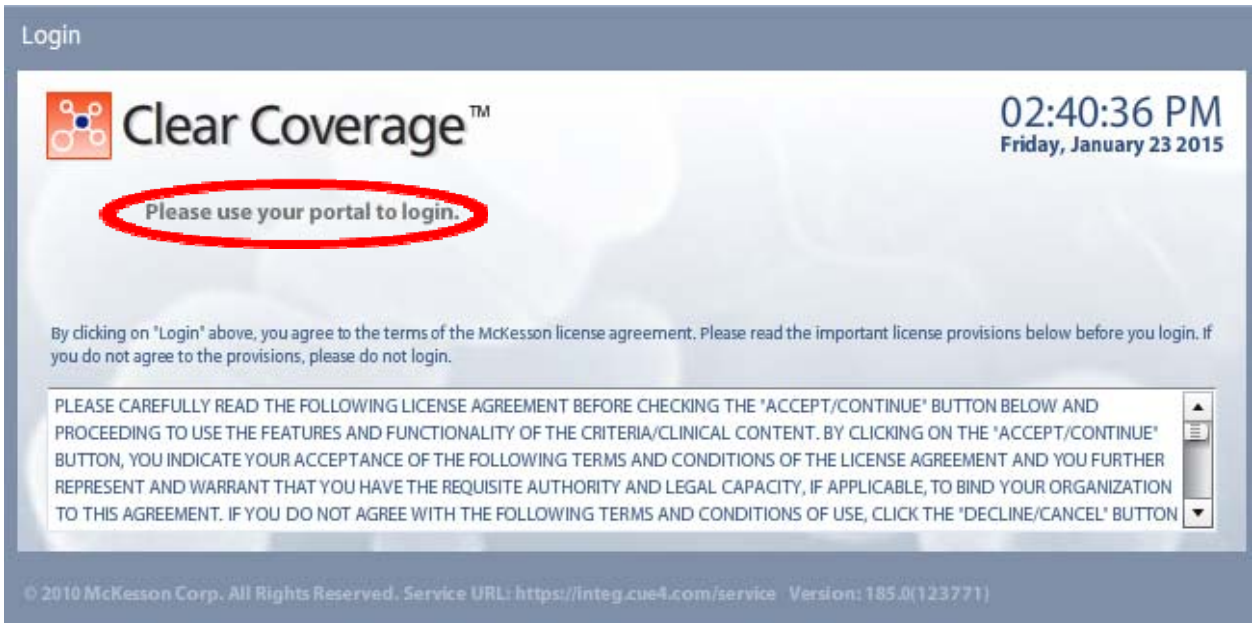
LOGGING OUT

To end your session, you must log out.

In the **menu bar**, click **"Logout"**



Your session ends. You must return to the provider portal to log in again.



TIMING OUT:

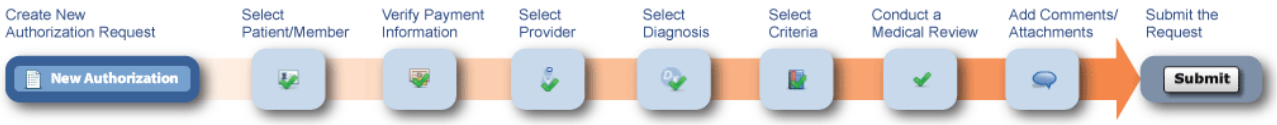
One of the settings within Clear Coverage™ specifies how long Clear Coverage™ can be left inactive before it automatically ends the session. If you are logged in but not using the application, you may see a message stating that the session has expired.

If this message is received, return to the provider portal and follow the “Log In” steps.

CREATING A NEW AUTHORIZATION REQUEST

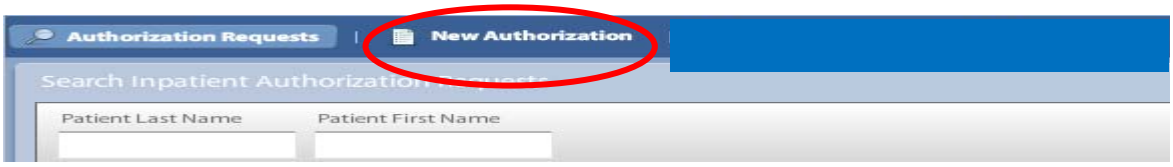
The first step in creating a new authorization request is to check the patient's eligibility within the provider portal (**see benefits/eligibility section). Once you have verified the patient's eligibility/benefits, you can begin the authorization process for the patient within the Clear Coverage™ application. This process will build a complete authorization request with all required information, which is then either notification, auto approved or submitted to Excellus BCBS for a determination.

Steps to create an Inpatient Authorization Admission request



A.

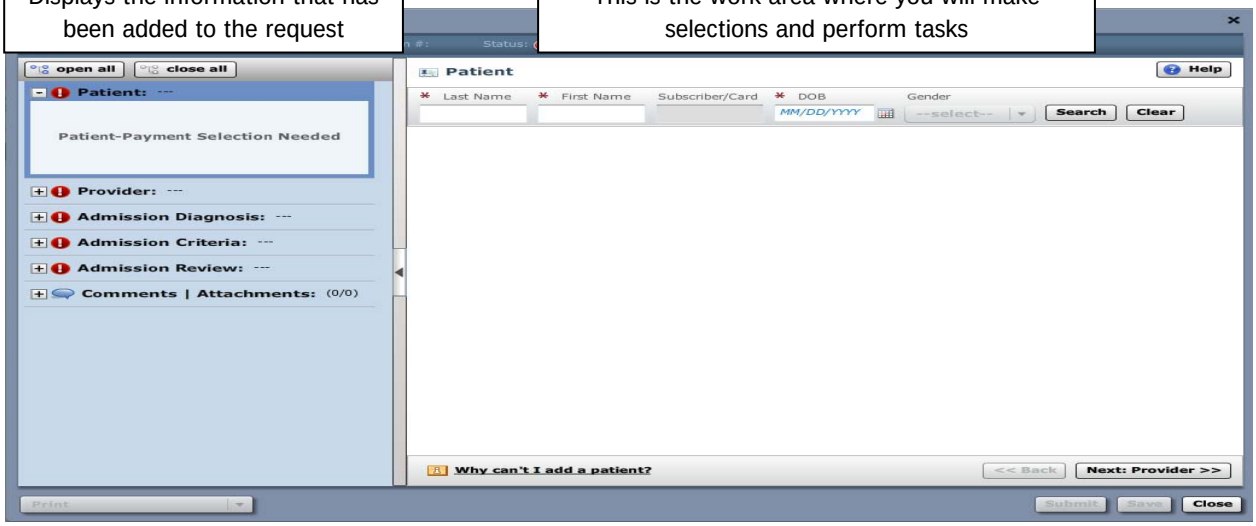
1. From the main screen, click on **"New Authorization"**



The Inpatient Admission Authorization Request screen appears

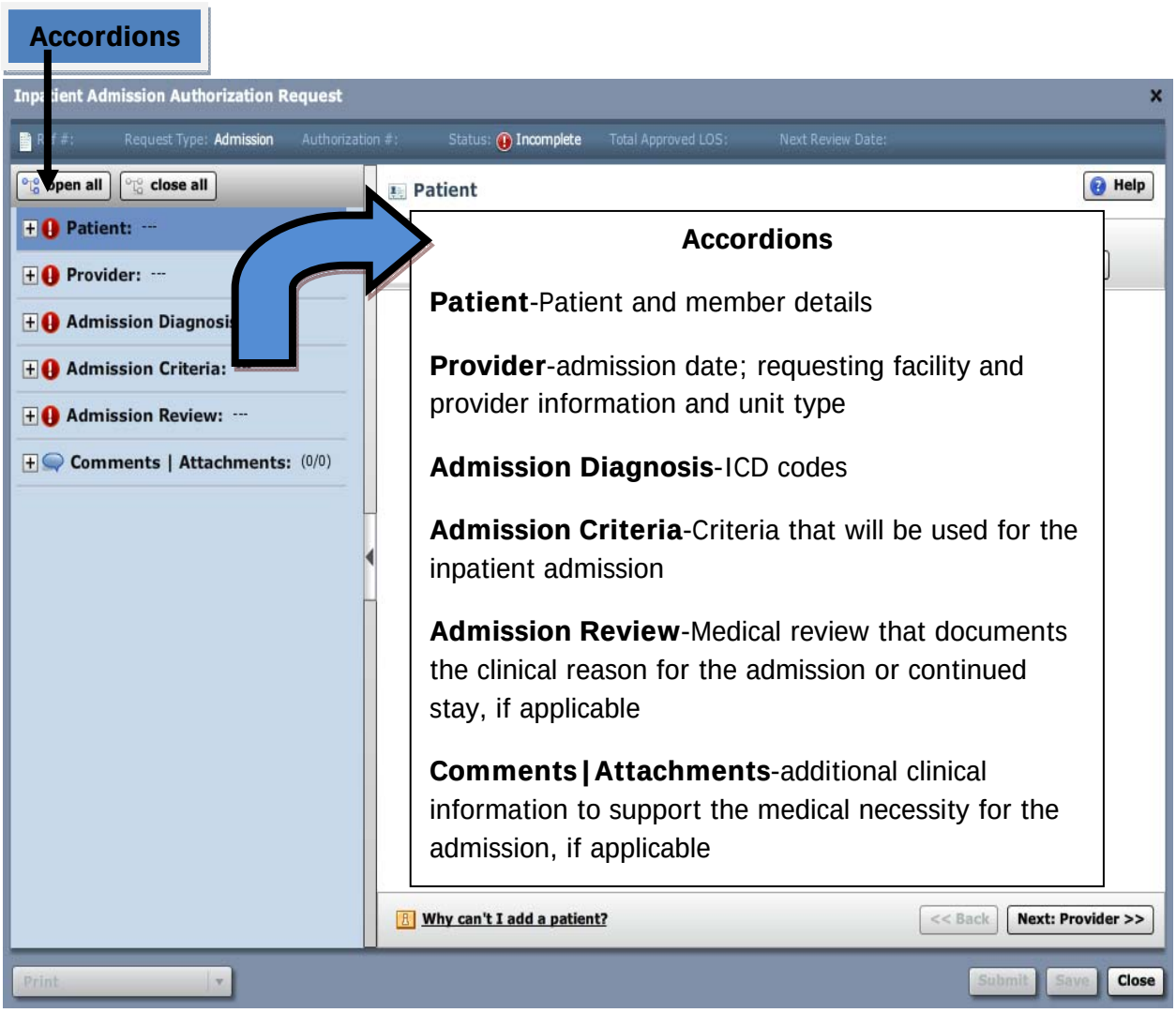
LEFT SIDE
Displays the information that has been added to the request

RIGHT SIDE
This is the work area where you will make selections and perform tasks



Accordions:

Each accordion will need to be opened in consecutive order, completed and added to the "**work area"** on the right side.

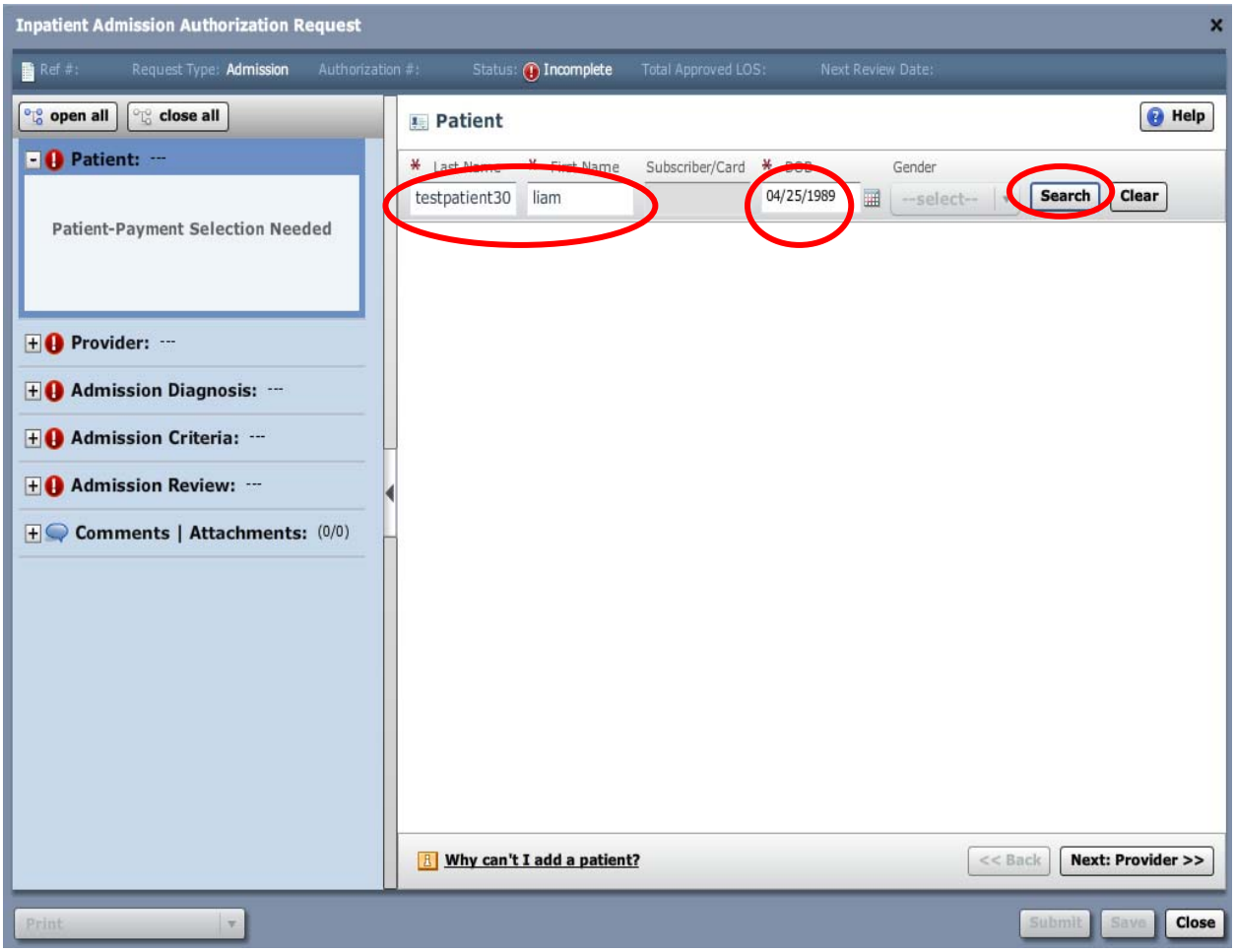


The ! indicates a mandatory field.

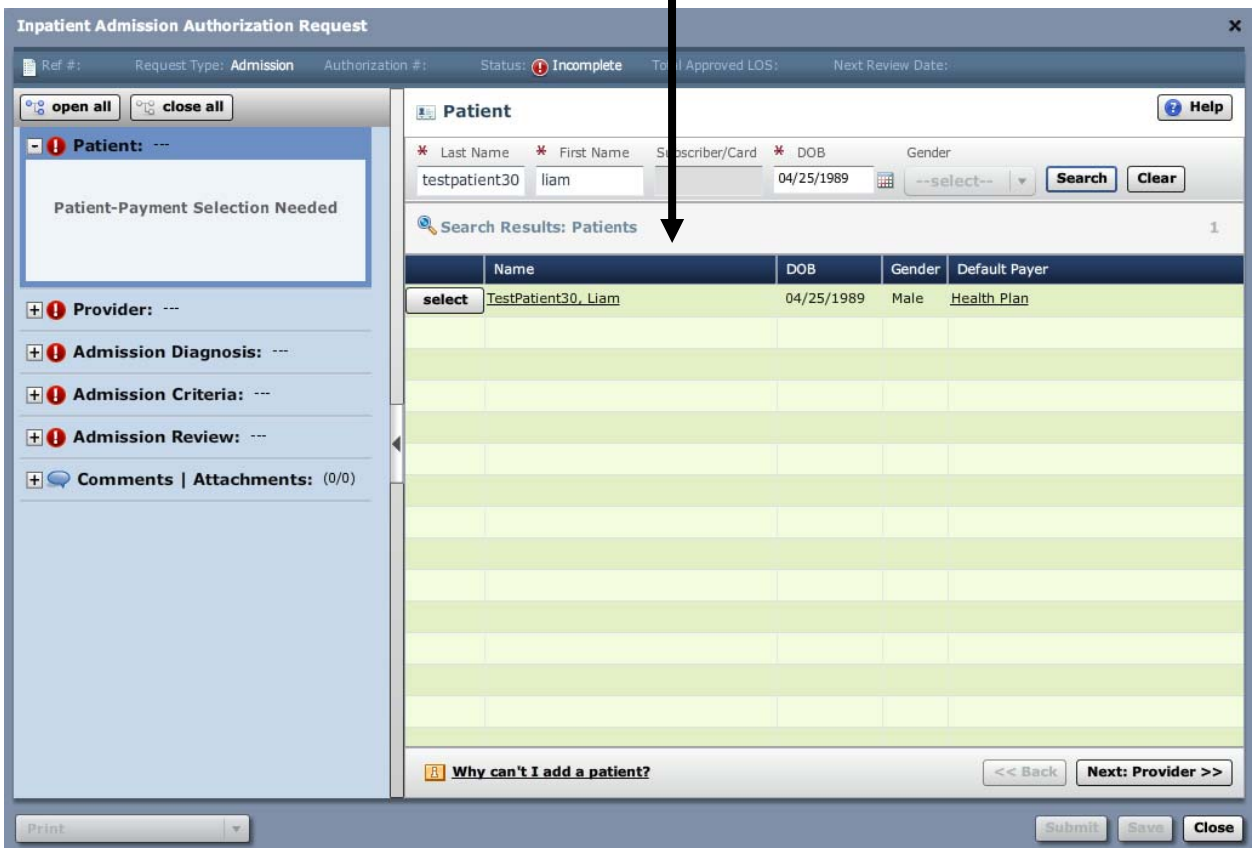
B.

1. In the search fields, enter the patient's last name, first name and date of birth

2. Click **"Search"**



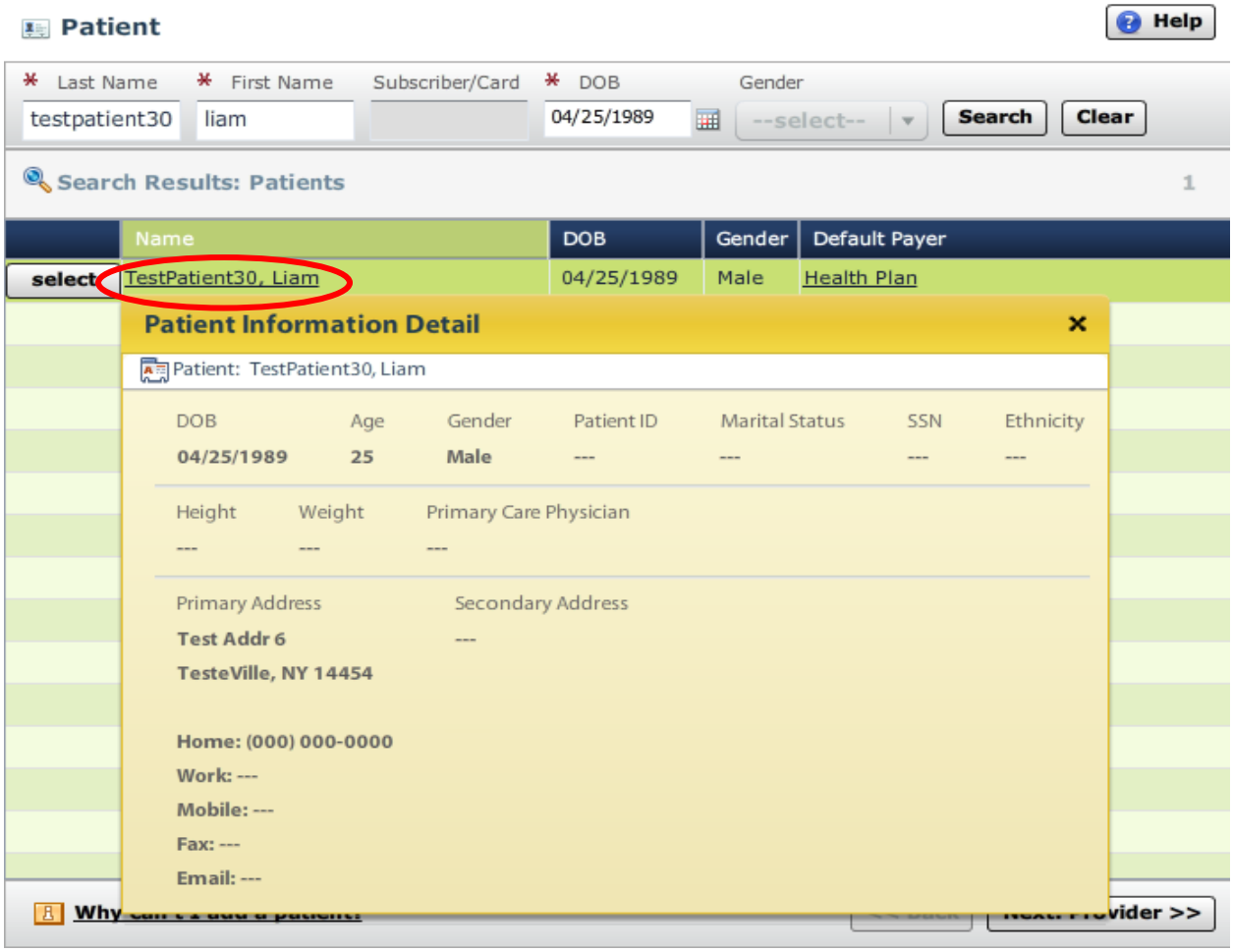
Results that match your search appear:



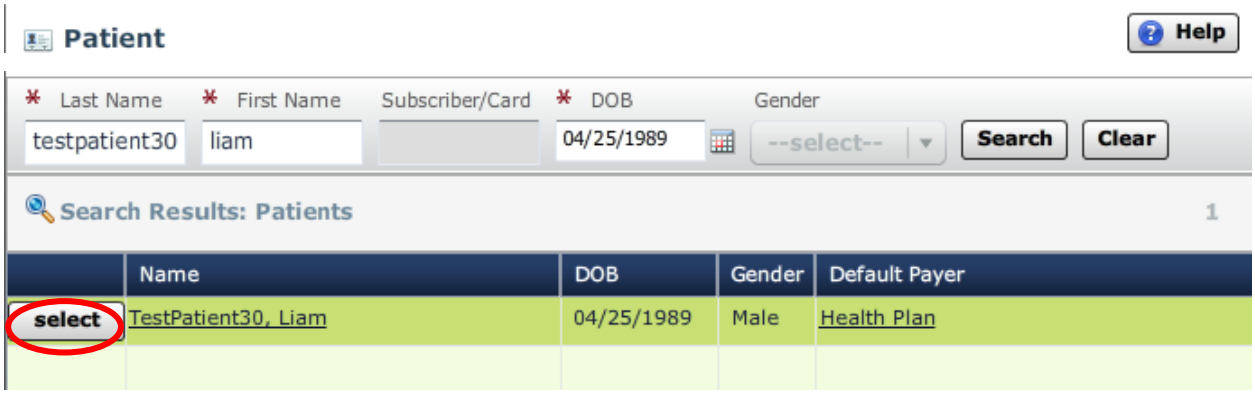
3. If the patient's name does not appear, you can:
    1. Verify that the patient's name is spelled correctly AND that the correct date of birth was entered. If information entered was incorrect:
        - Click "**Clear**" and start a new search by repeating steps 1 and 2
        - If the patient's name still does not appear, call the Excellus BlueCross Blue Shield Customer Care department: 1-800-363-4658

C.

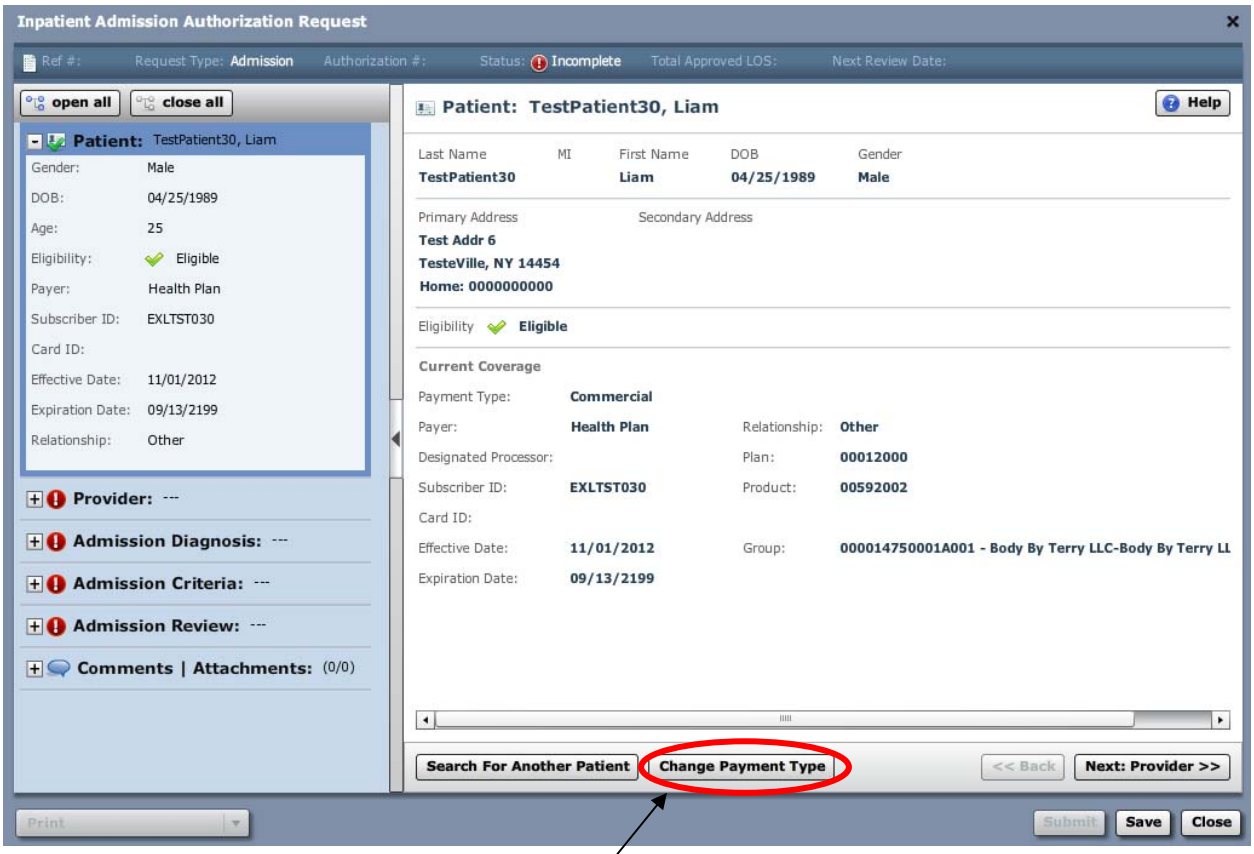
1. Click on the patients name for additional information and to ensure you have chosen the correct patient



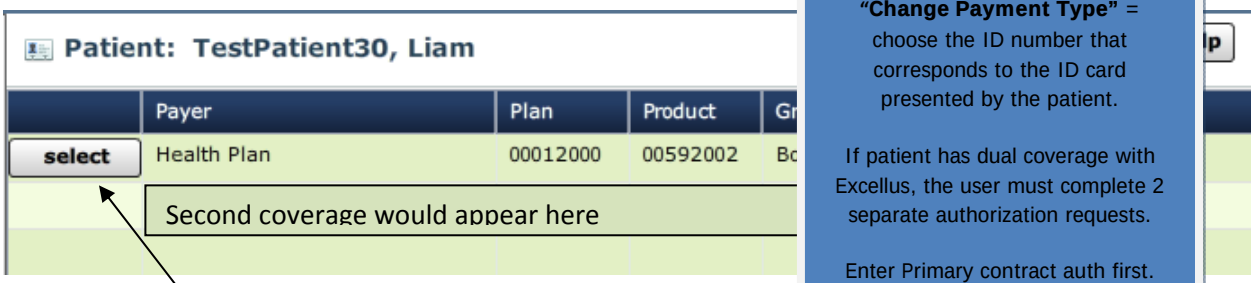
2. Choose the correct patient by clicking **"Select"** to the left of the patient's name.



The selected patient and their payment information will appear:



3. Click on "**Change Payment Type.**" If patient has "dual coverage" with Excellus BlueCross BlueShield, all contracts will appear:



"Change Payment Type" = choose the ID number that corresponds to the ID card presented by the patient.

If patient has dual coverage with Excellus, the user must complete 2 separate authorization requests.

Enter Primary contract auth first.

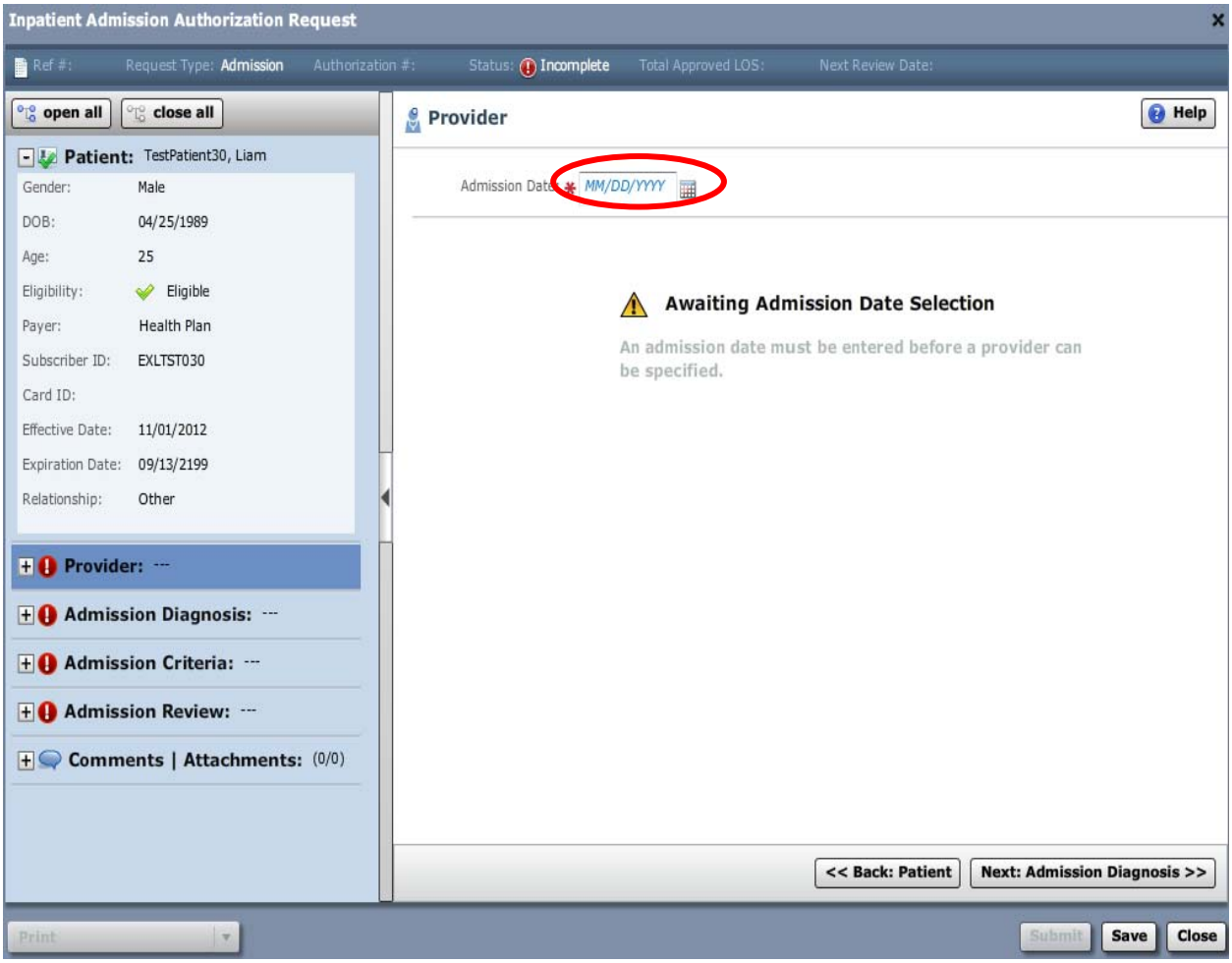
3a. Select the correct contract

4. Click "**Next: Provider>>**" to continue.

D. 

1. Select and enter the "**Admission Date**"

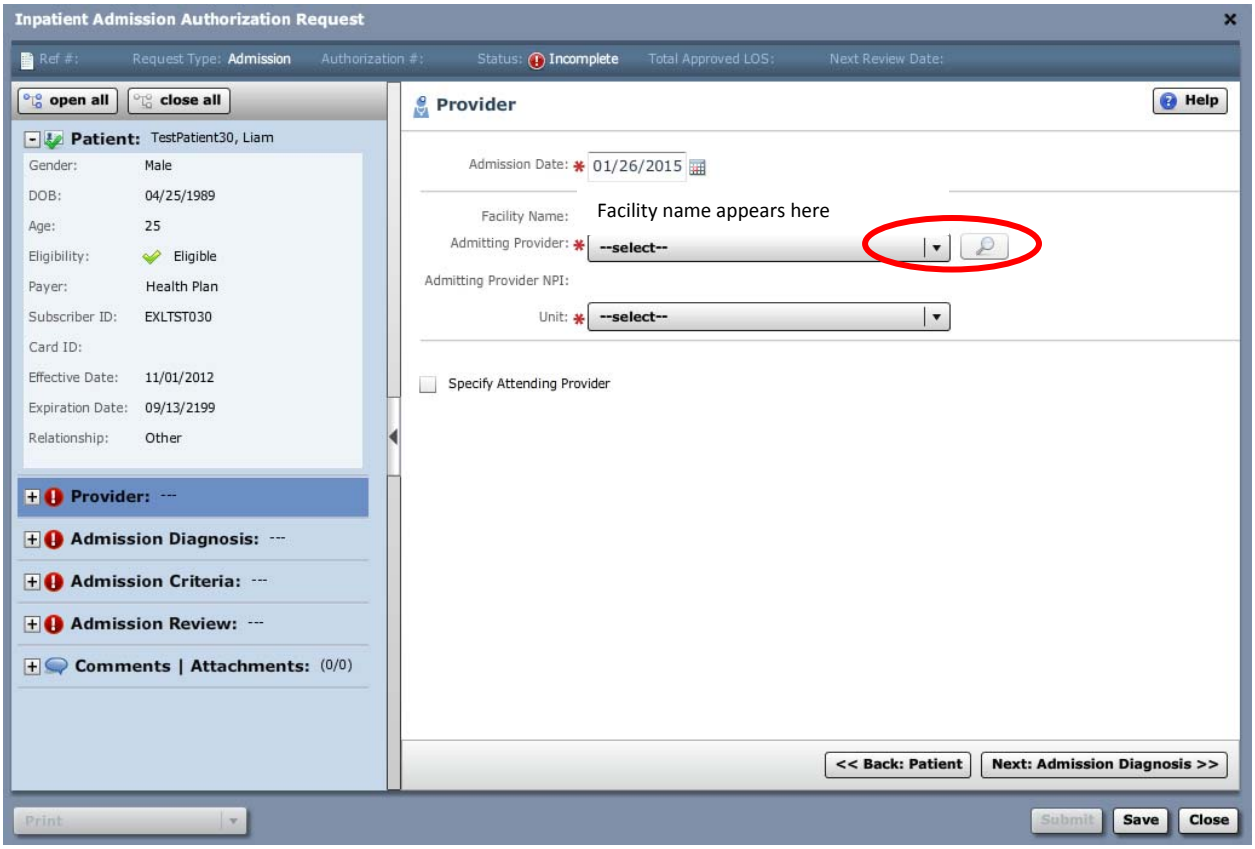
   Note: Can backdate 5 days or go forward 90 days



2. Conduct admitting provider search:

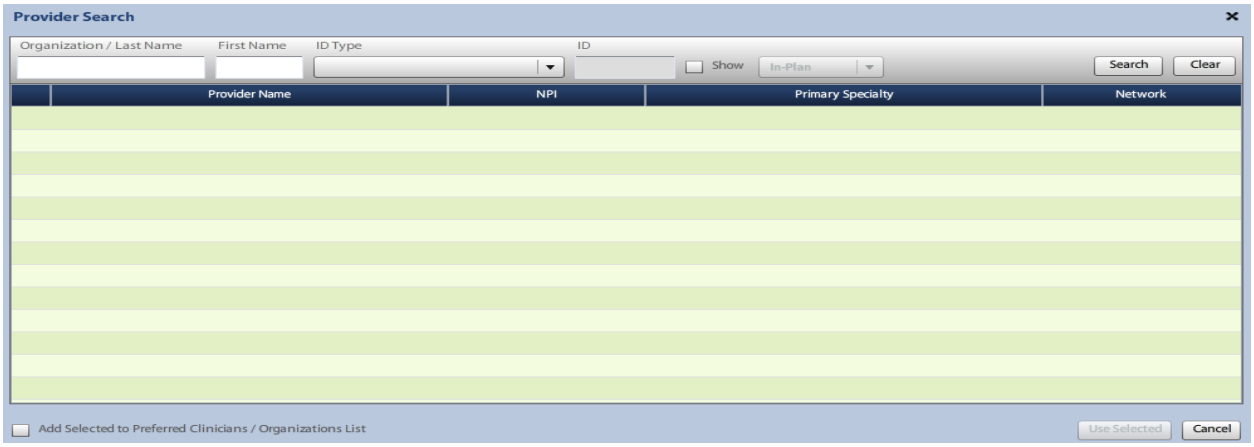
   2a. Select the name of the admitting provider from the "**Admitting Provider**" drop-down list **OR**,

   Click the Search icon  to the right of the Admitting Provider field.

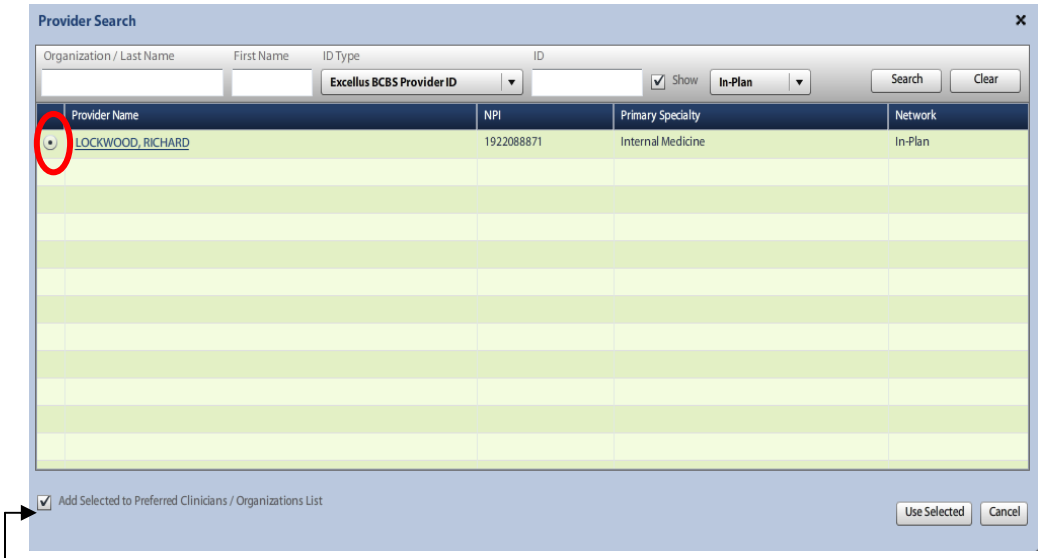


   2b. Enter search criteria, such as last name, first name.

   2c. Click "**Search**"



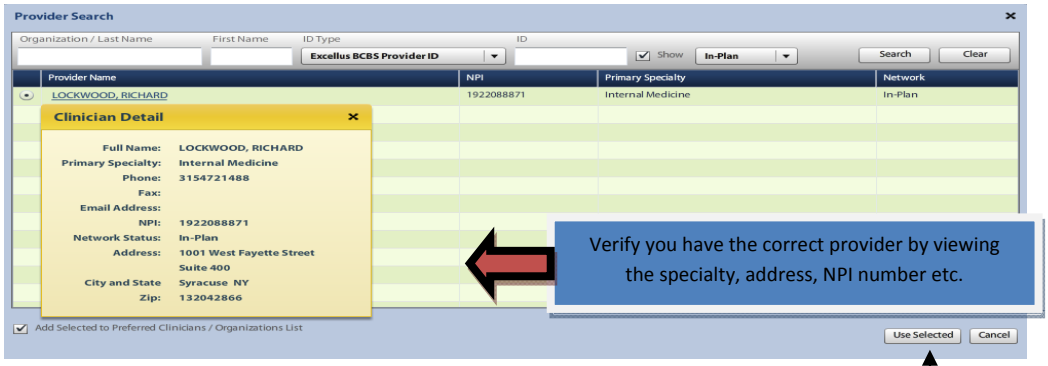
2d. If the clinician name appears, select the clinician by clicking in the circle to the left of the name



You have the option of adding the selected clinician to the preferred clinician list by selecting the "**Add Selected to Preferred Clinicians/Organizations List**"

Note: Selecting the **"Add Selected to Preferred Clinicians/Organizations List"** option will make the clinician available for future authorization requests from the requesting clinician drop-down list.

2e. Verify that the correct provider has been selected. Verify specialty, NPI etc.



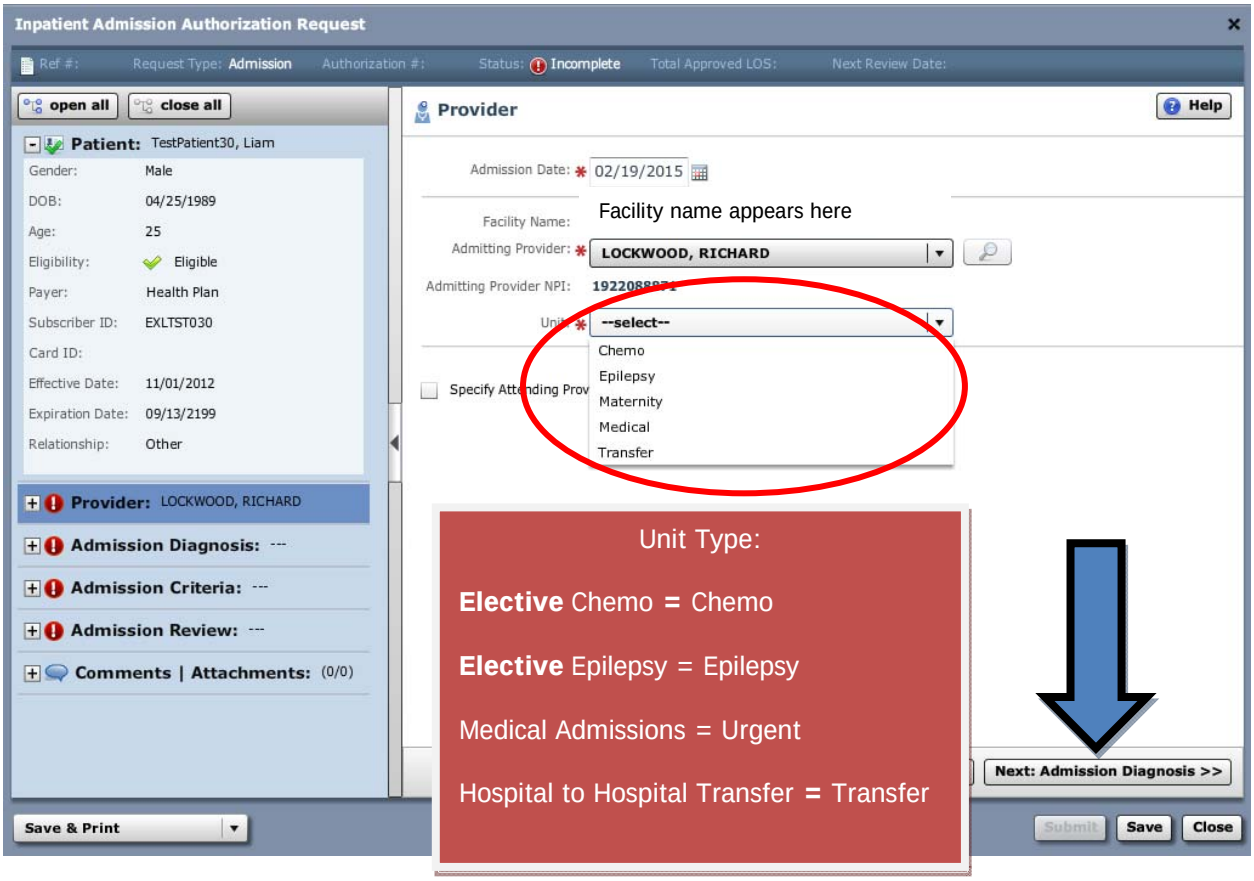
2f. Click "**Use Selected**"

3. Select the unit type from the "**Unit**" drop-down list

   The choice of Chemo and Epilepsy should be selected for Elective Chemo or Elective Epilepsy admissions only

   If the admission is for urgent chemo or epilepsy, choose "Medical"

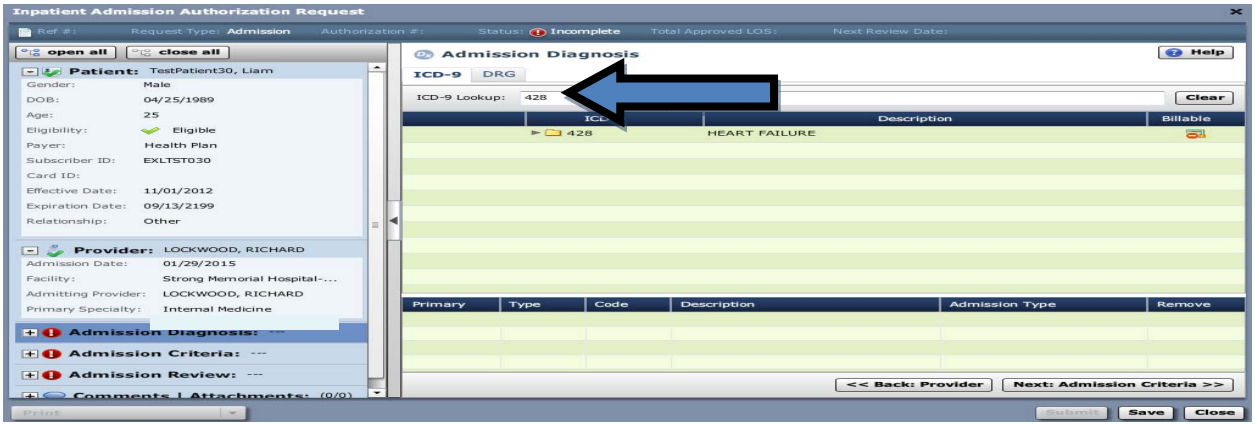
4. Click "**Next: Admission Diagnosis**"



E. 

1. Enter the diagnosis code or key word into the search field

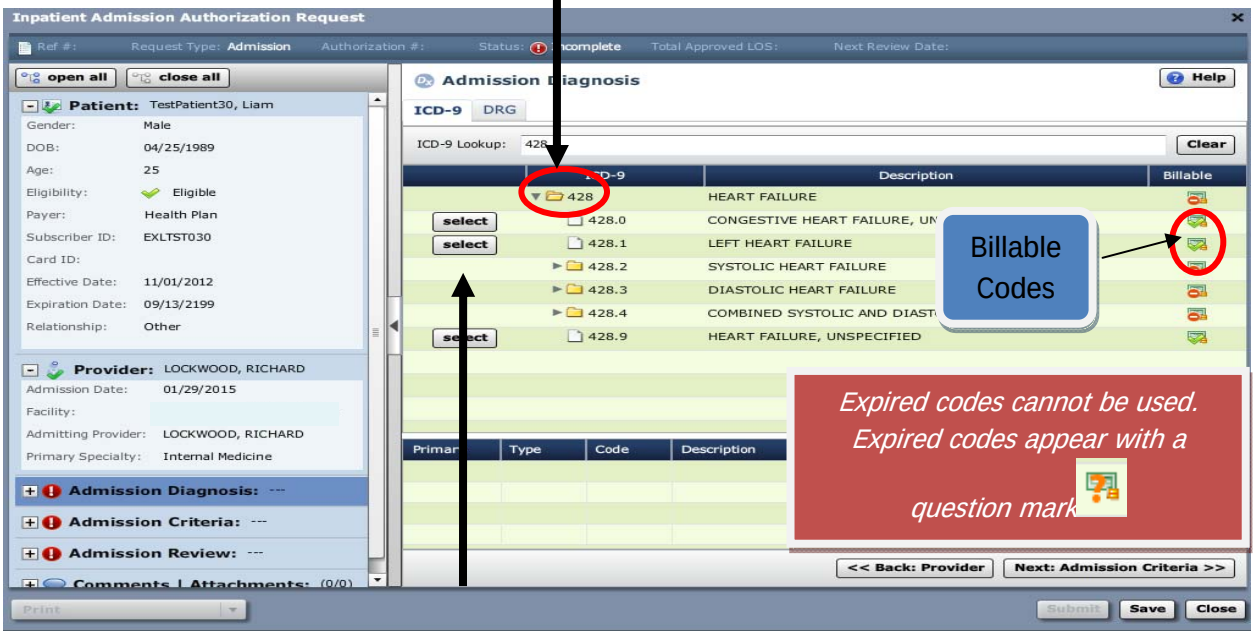
   TIP: If code is known, please enter the actual code



Enter the primary diagnosis code only

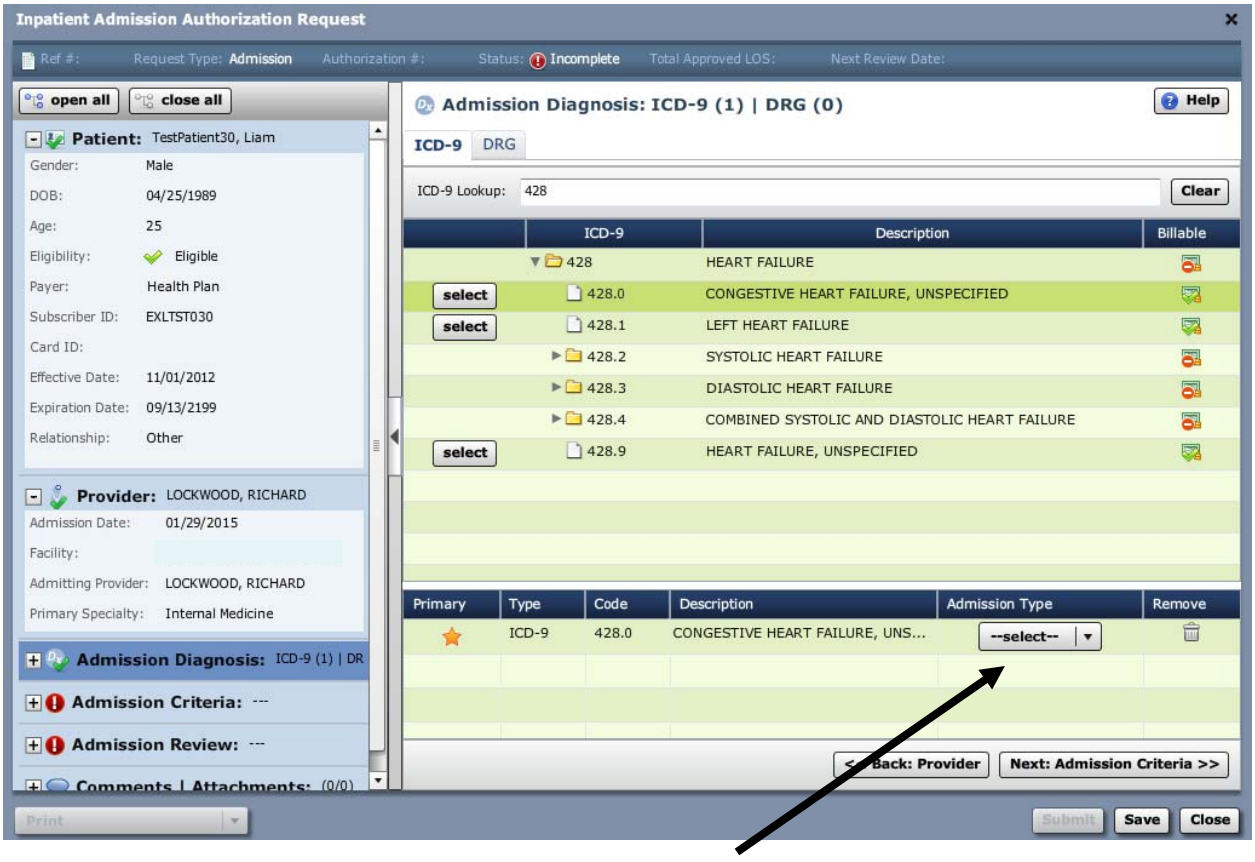
You must ensure that you choose a "billable" code. A billable code will have a green checkmark  .

1a. If the code has a red line through it  , it is not a billable code. Click on the icon to expand the section to search for a billable code:



2. Click **"Select"** to add the primary diagnosis code.

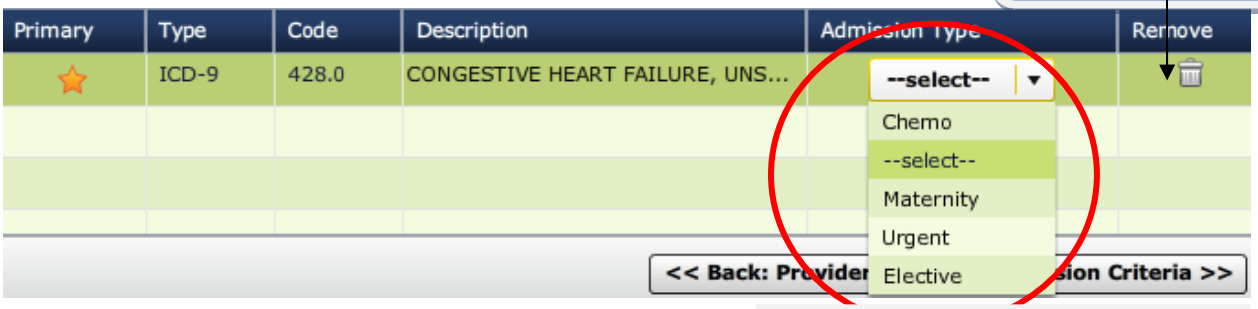
CREATING A NEW AUTHORIZATION REQUEST



3. Click the "**Admission Type**" drop down.

3a. Select the appropriate "Admission Type"

If an incorrect diagnosis is chosen, you can use the "trash can" to remove the incorrect code.



4. Click **"Next: Admission Criteria>>"**

Admission Type:

Elective Chemo = Chemo

Elective Epilepsy = Elective

Medical Admissions = Urgent

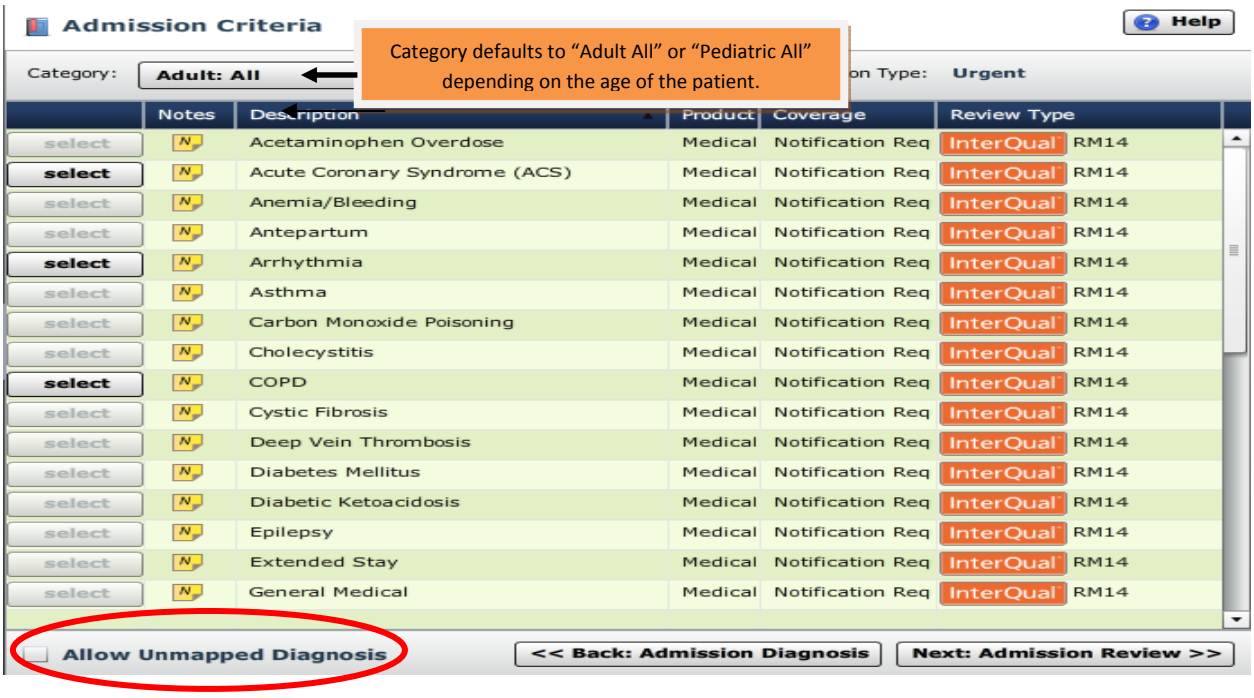
Hospital to Hospital Transfer = Urgent

F.

Completion of a medical review tool is required for certain diagnoses only

All other admissions will require **notification only** . A selection must be made in this section but completion of the medical review tool is not required.

1. Select the appropriate criteria subset for the review



- If the criteria is not "mapped" to the diagnosis that was entered as the primary admission diagnosis, it is not available to select. Select "**Allow Unmapped Diagnosis**" if needed, to use a different criteria set.

A criteria subset page will display pertinenet information regarding the criteria selected.

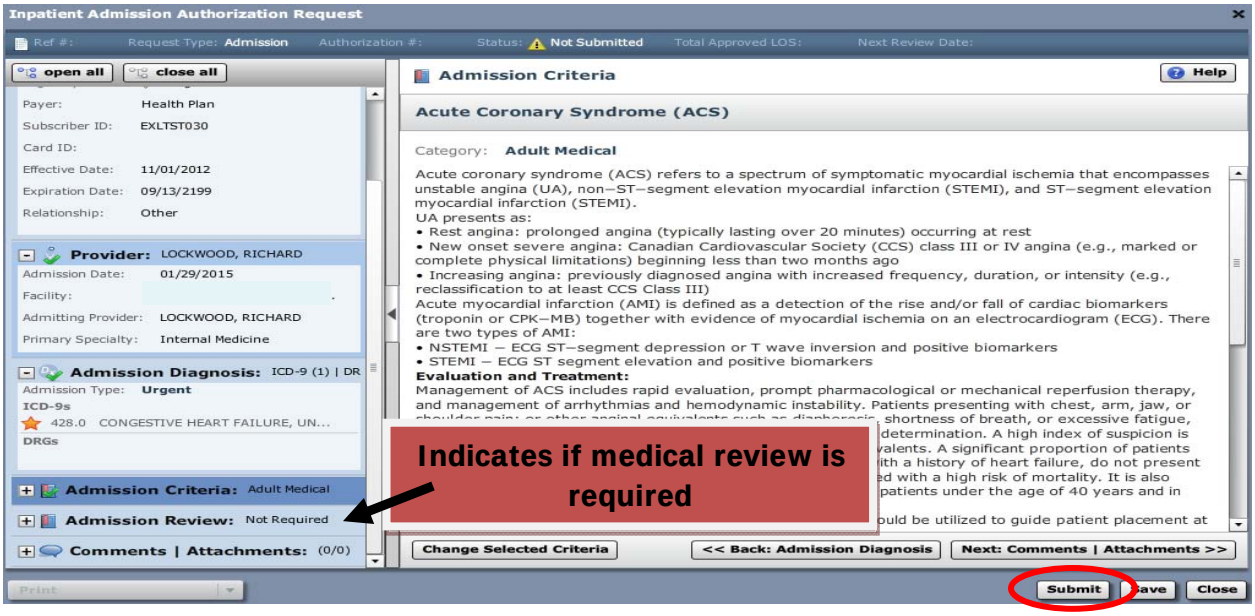
If you selected an incorrect criteria set, return to the "Admission Criteria" accordion and change the selected criteria.

2. For admissions that do **not** require completion of the medical review tool:

   A. Select the most appropriate criteria subset

   B. Click "**Submit**"

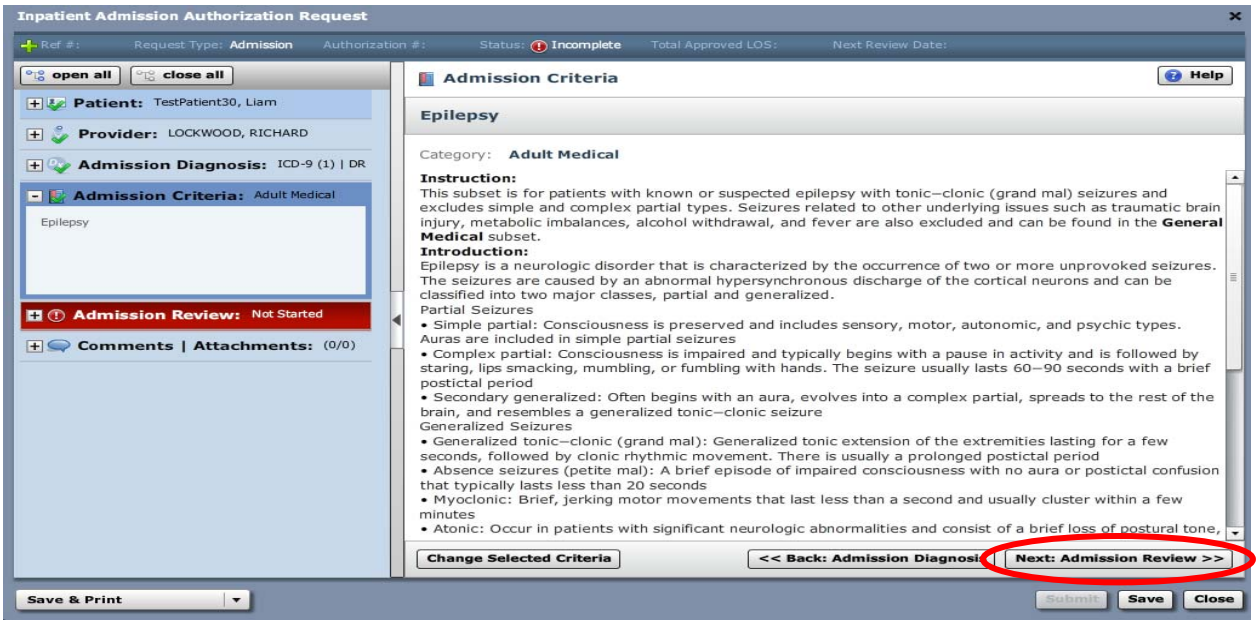
   C. Skip to page 45



3. For admissions that do require completion of the medical review tool:

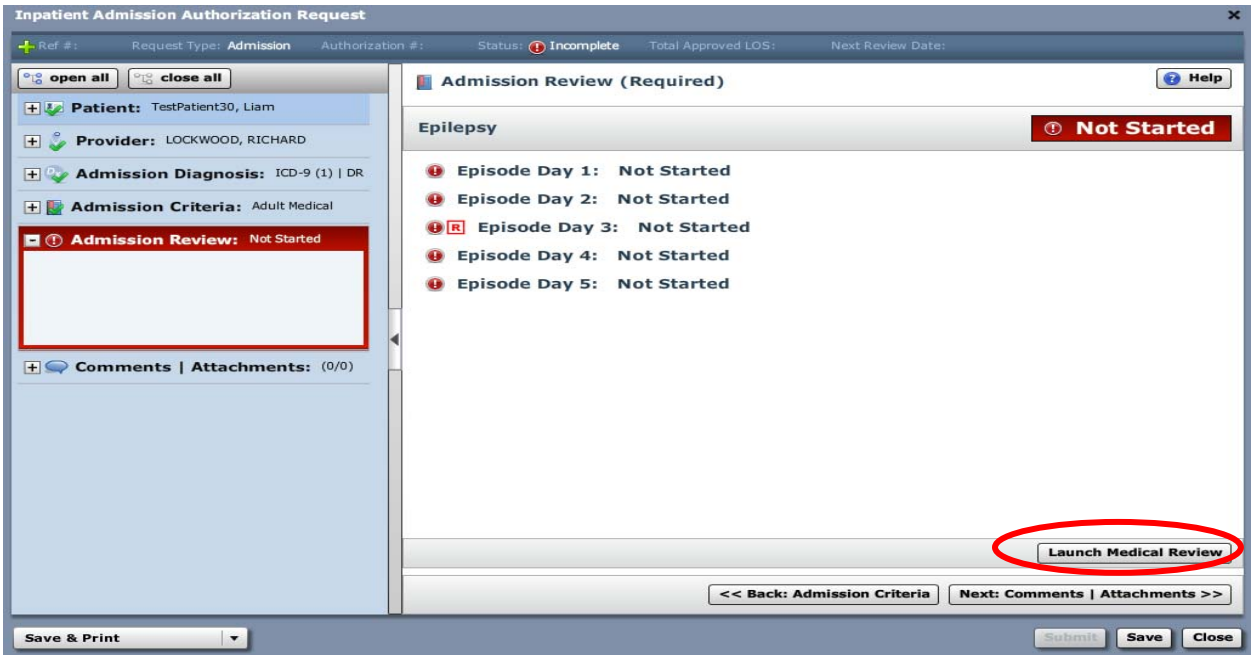
   A. Click on "**Next: Admission Review>>**"

   B. Begin medical review (see next page)

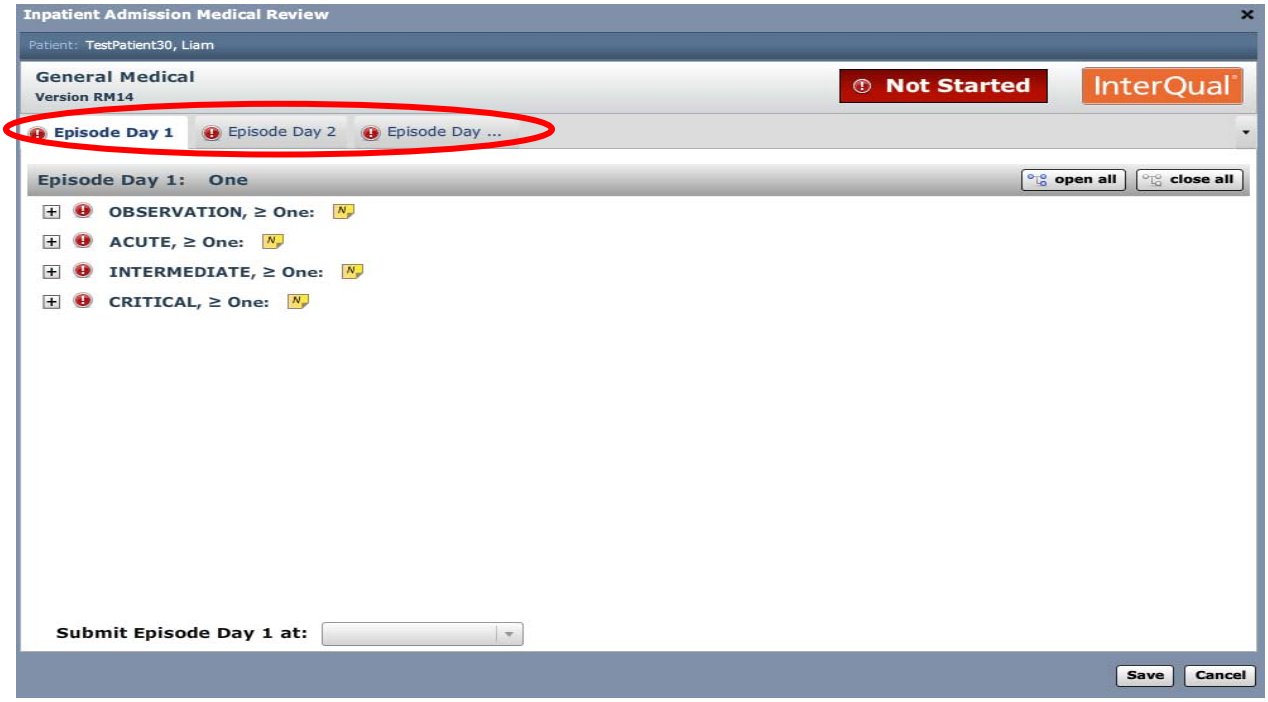


G.

1. Click on "**Launch Medical Review**"

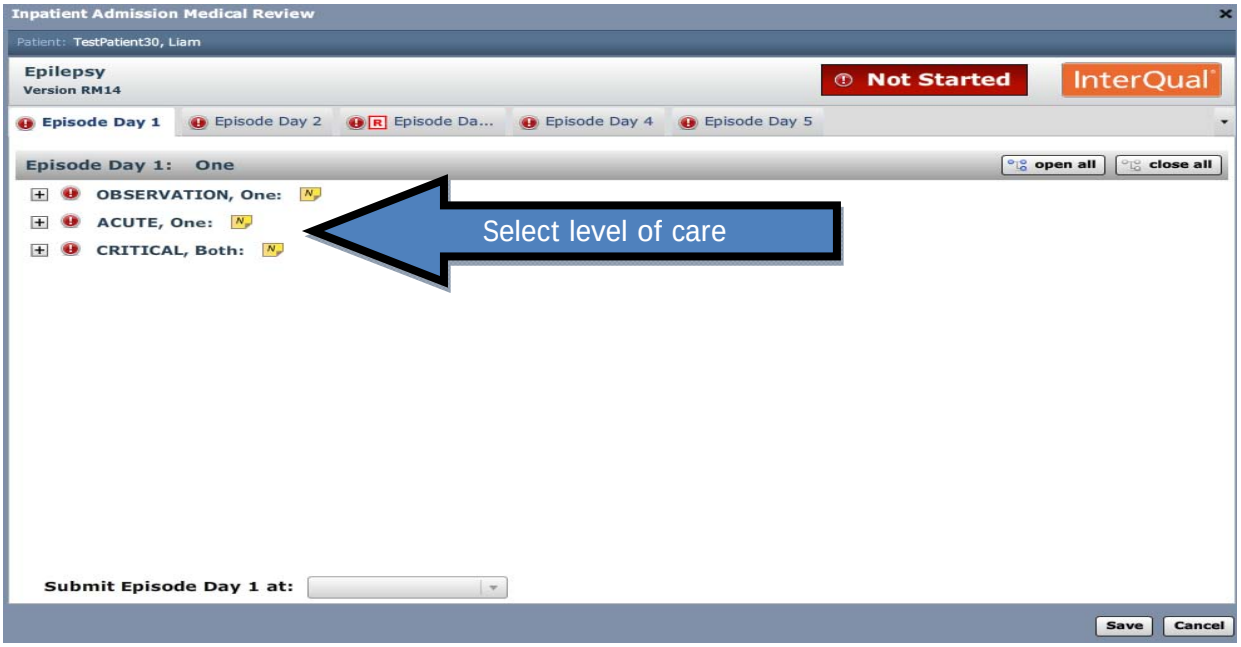


2. Select the appropriate Episode Day

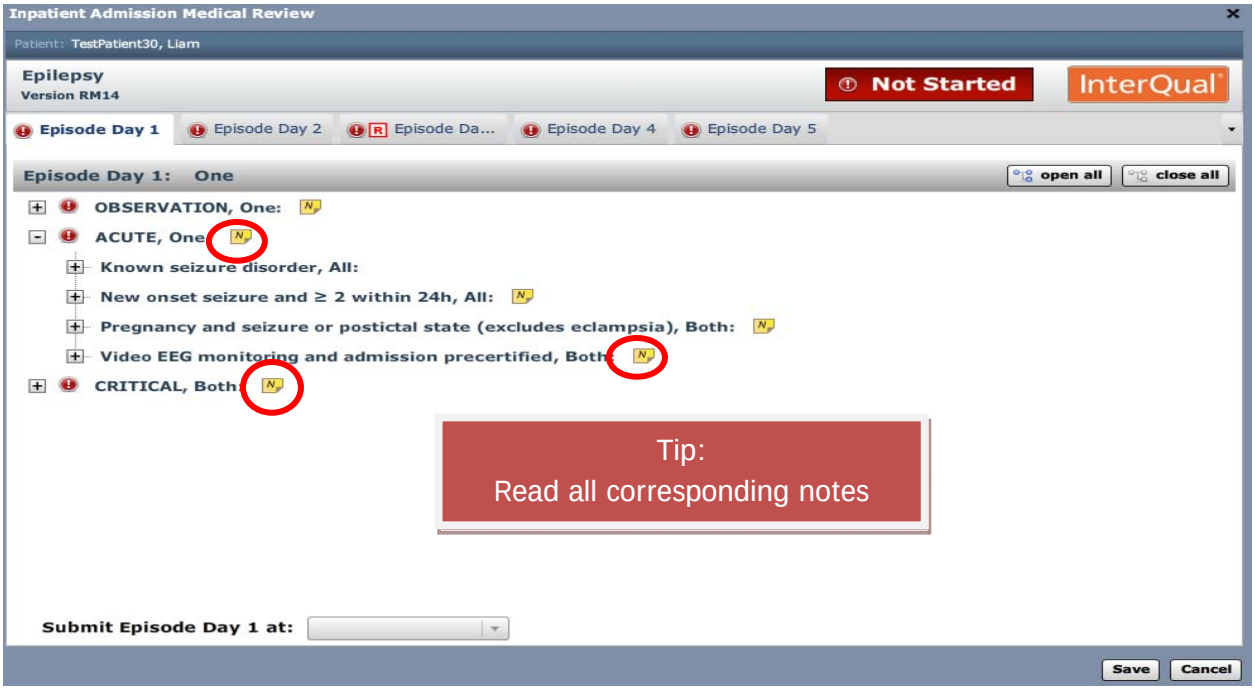


3. Select the most appropriate level of care

   Do **NOT** choose Observation level of care



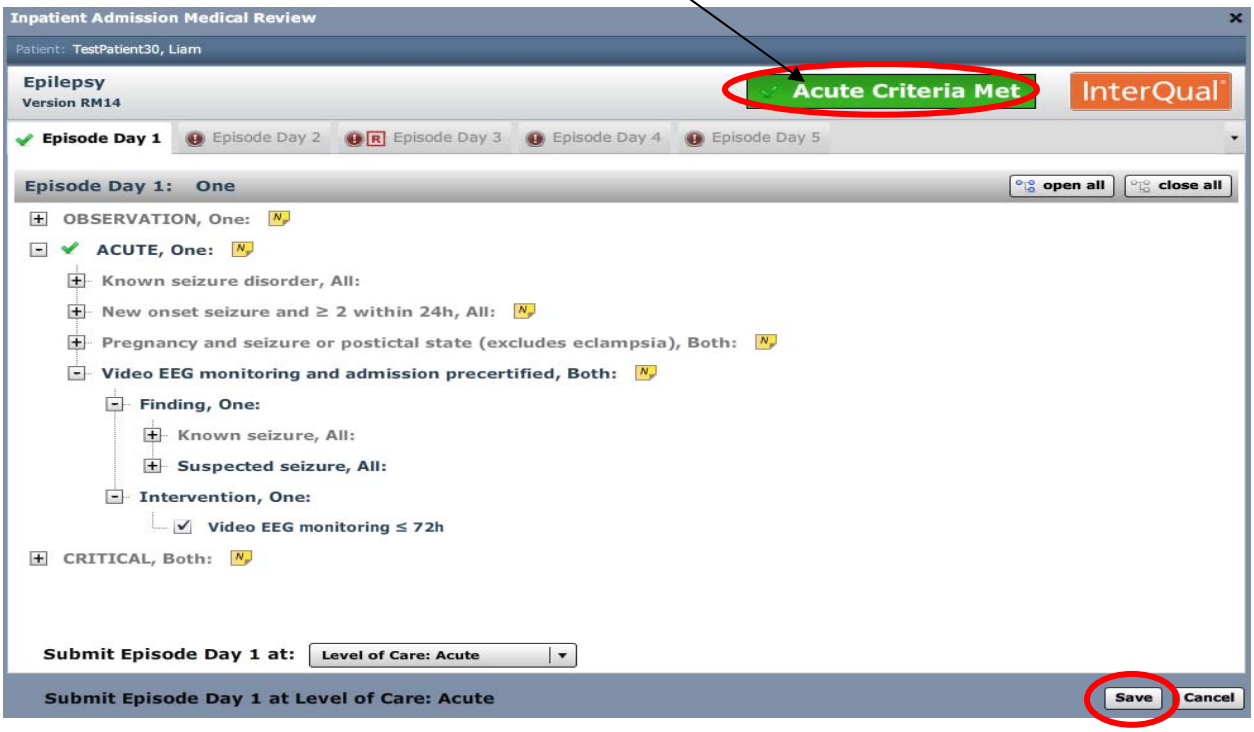
4. Conduct medical review in accordance with the InterQual™ Acute Criteria Review Process for the subset selected



H.

1. If "**Acute Criteria Met**": (If "Acute Criteria Not Met", skip to step 2)

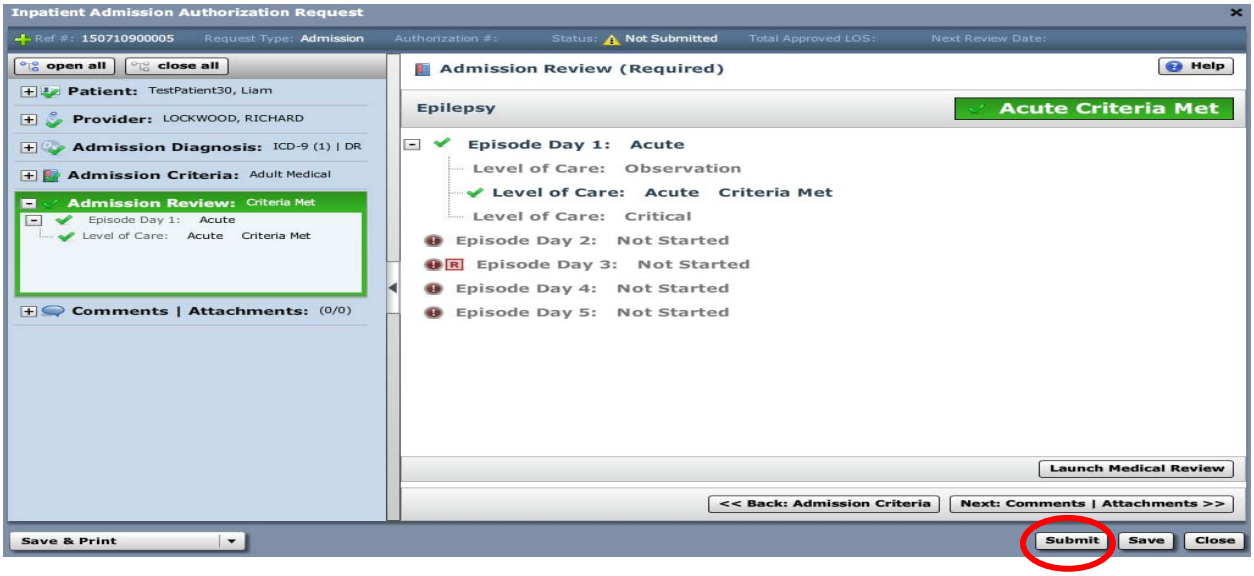
1a. Click the "**Save**" button



The completed medical review outcome will display:

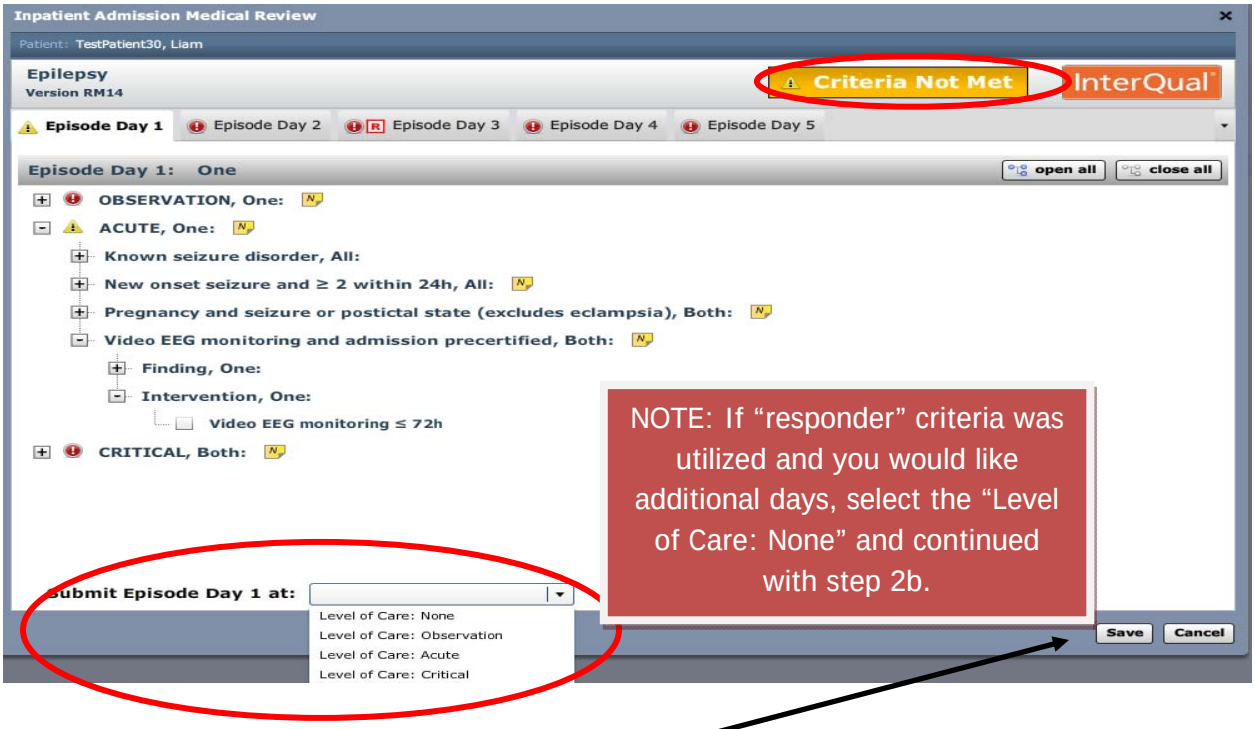
1b. Click the "**Submit**" button

1c. Go to Step 3



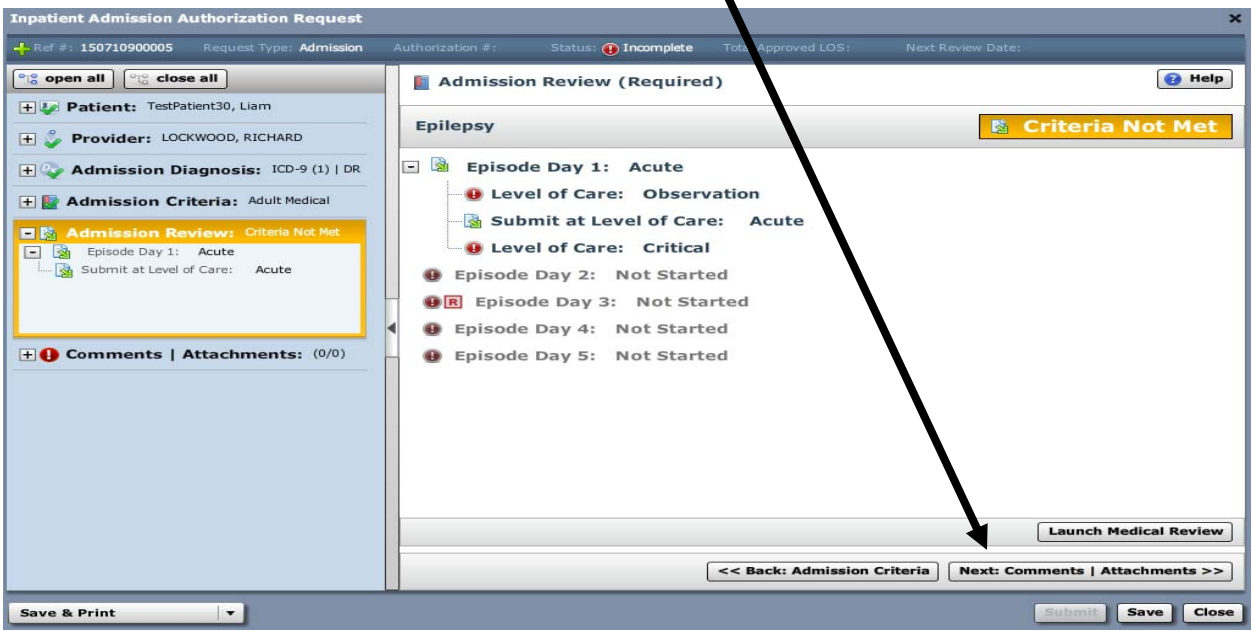
2. If "**Acute Criteria Not Met**":

2a. Click on the "**Submit Episode Day 1 at**:" dropdown and select the level of care



2b. Click "**Save**"

2c. Click "**Next: Comments | Attachments**"

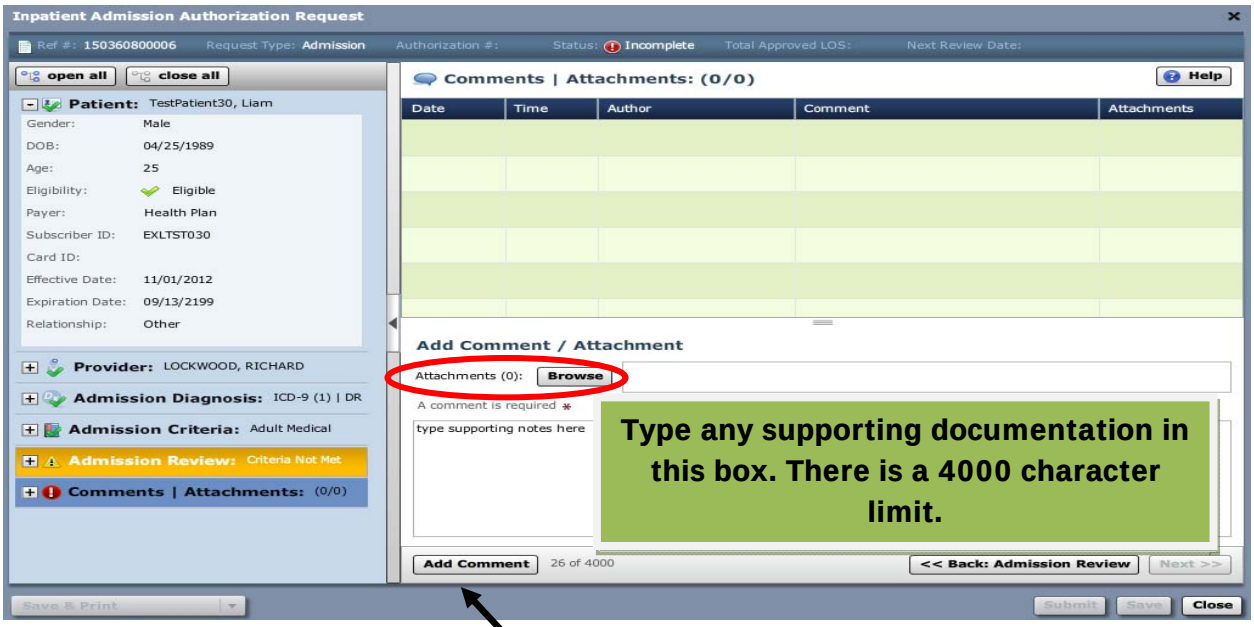


2d. **Comments | Attachments** - additional information in the form of notes and/or attached documents that support the authorization request is always required when the "criteria is not met".

- Type free text note in the free text field

And/or:

- Click the **"Browse"** button to add attachments as needed

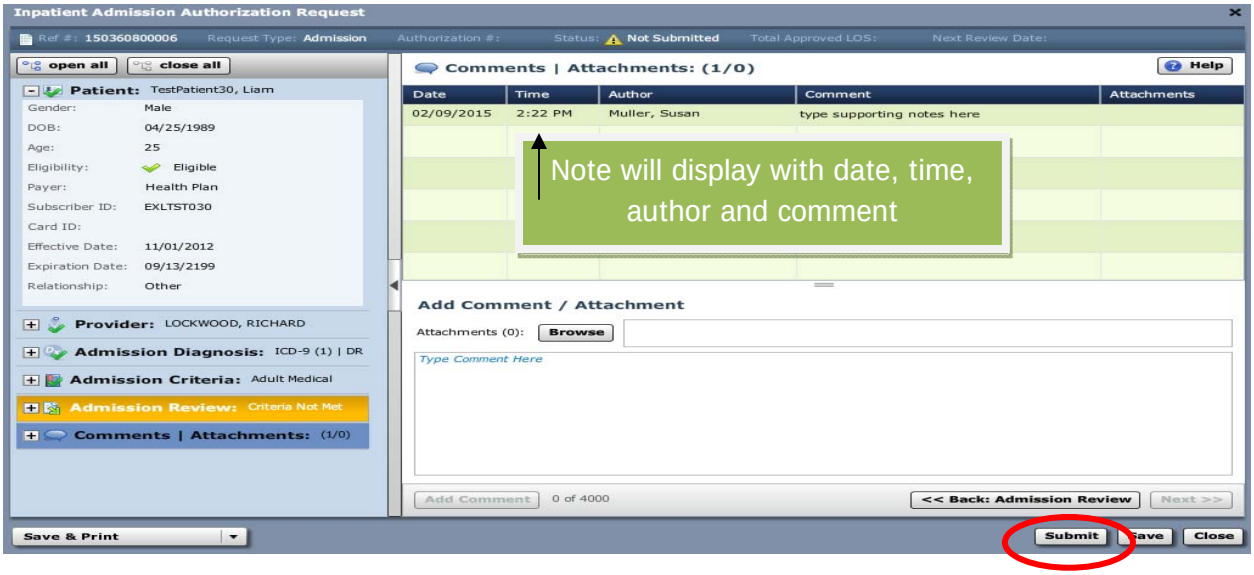


2e. Click "**Add Comment**"

2f. Click "**Submit**"

*If you are not ready to submit the request, you can click the **"Save"** button and continue the request later

Note: If the SUBMIT button is grayed out, hover over it and it will show what is missing and needs to be completed prior to submitting the request.

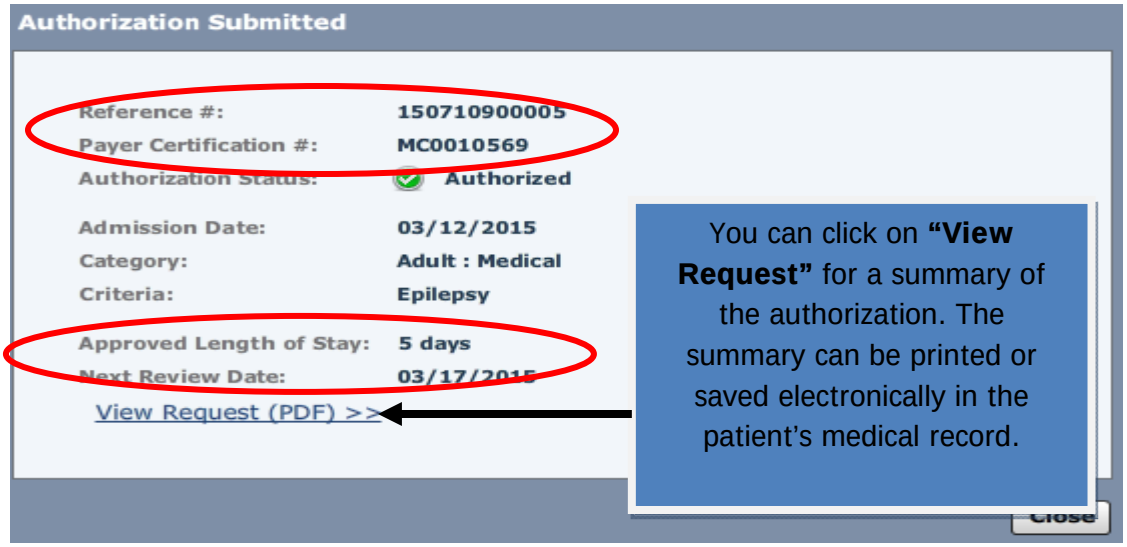


3. Add a phone number (name auto populates) and click the **"Submit"** button

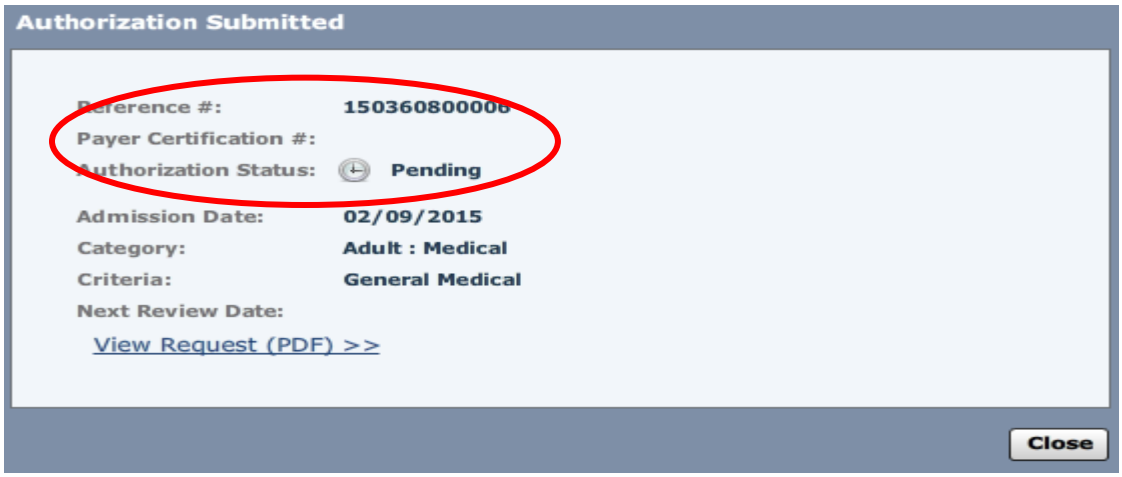
   Note: Name can be manually changed, as needed.

4. An information box will appear. If the request is auto-approved, the reference number AND the payer authorization number will appear as well as the length of stay and the next review date (if applicable).

   Click "**Close**"

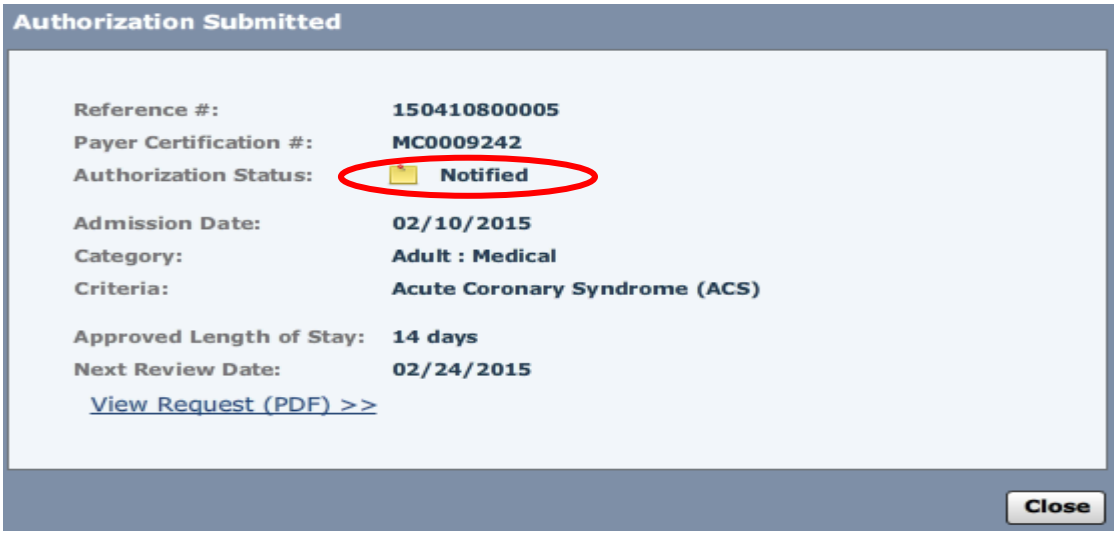


If the authorization is pended, The "Payer Certification #" field will be blank.

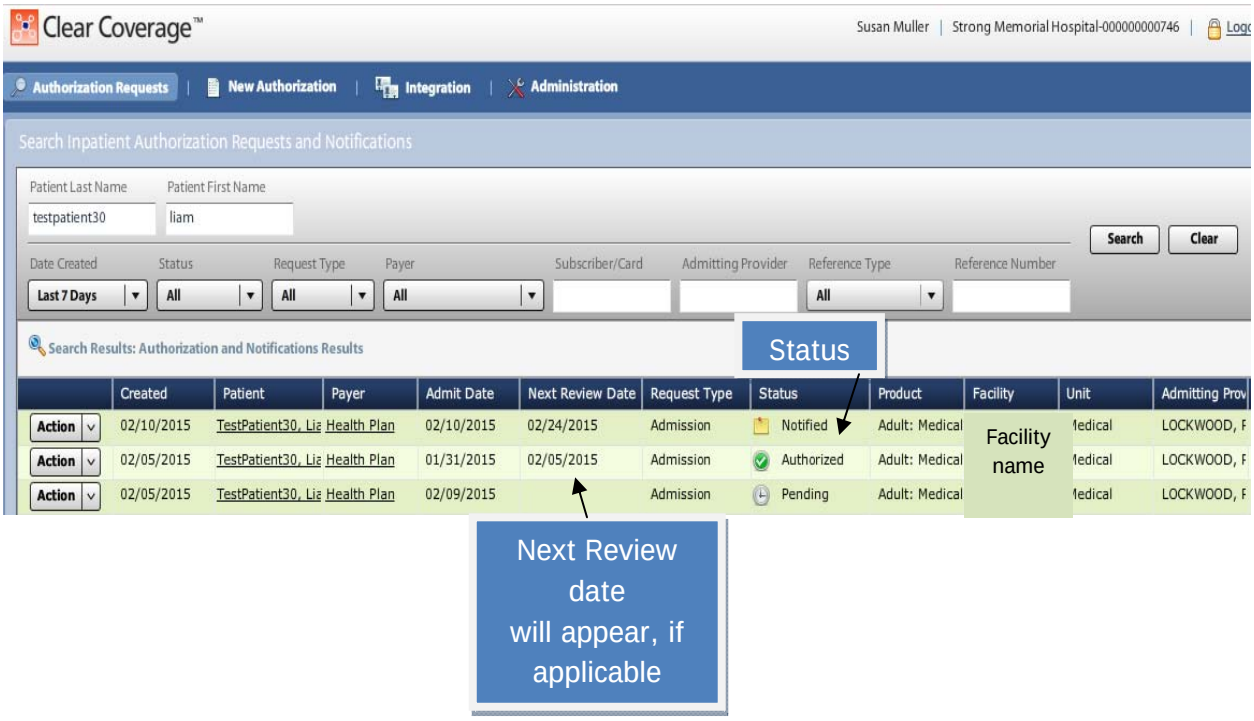


CREATING A NEW AUTHORIZATION REQUEST

If the authorization request, did not require a medical review, the authorization status will be “Notified” and you will receive a reference # and payer certification #



The authorization request process is now complete. If the request was pended, you must monitor the home page for any status change and/or activity (Excellus BCBS will update this information if further records are needed or if the request has been approved, denied, etc.). You will also receive a letter in the mail and verbal notification if the authorization was approved or denied.



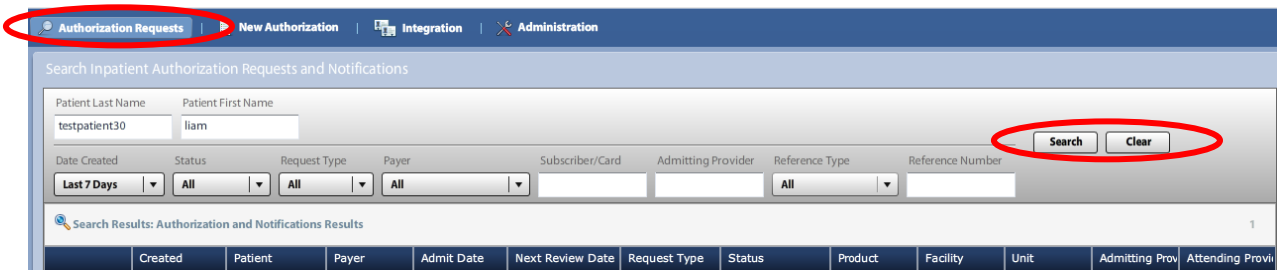
NOTES

CREATING A CONTINUED STAY REQUEST

Note: multiple continued stay requests can be added during the course of a single admission.

Not all admissions will require a continued stay review.

1. Locate patient by conducting an authorization search. Click "**Authorization Requests**" button on the menu bar.



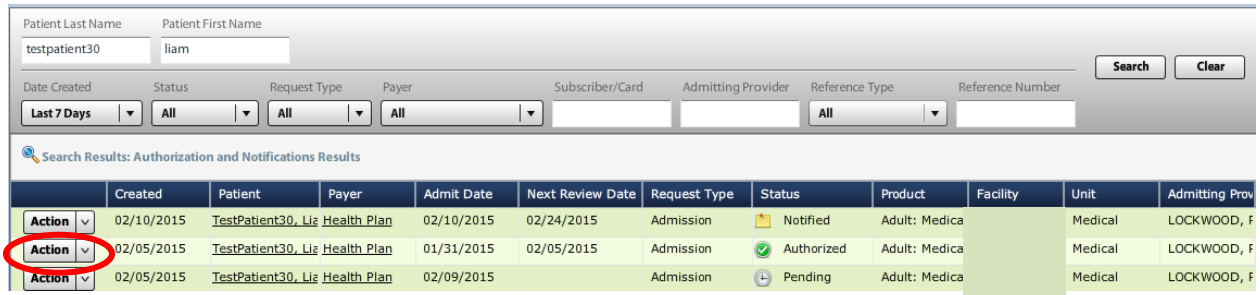
2. Enter search criteria such as: first and/or last name, susbscriber ID, reference number.

3. Click "**Search**"

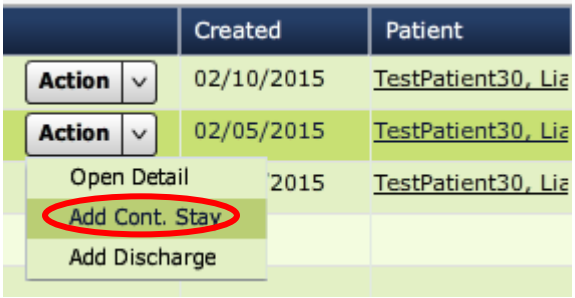
   3a. If the patients name does not display, click "**Clear**" to begin a new search.

4. Locate the correct authorization.

   - click the "**Action**" button drop down arrow.



5. Select "**Add Cont. Stay**"

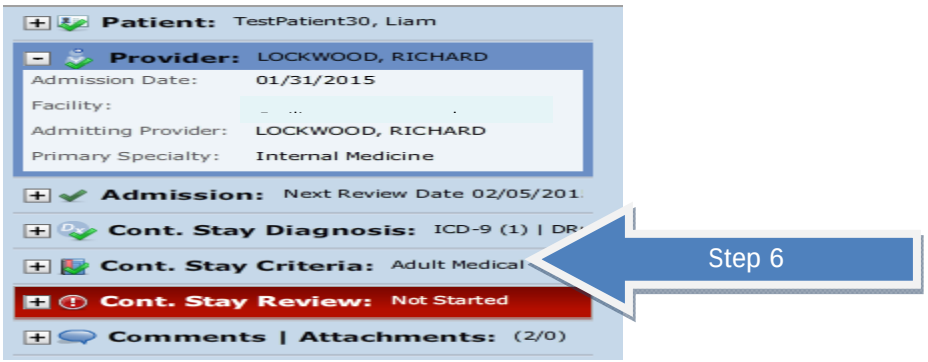


6. Click "**Cont. Stay Criteria**" accordion.

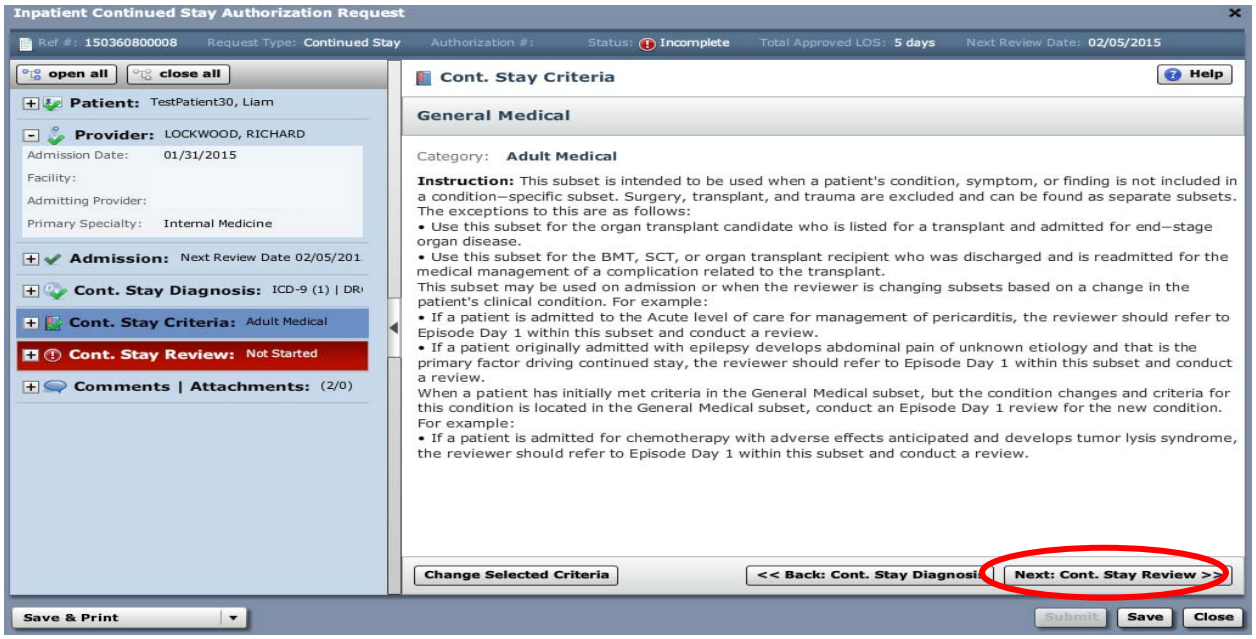
   This will default to the criteria subset that was used for the admission or from a previous continued stay request.

   6A. If the selected subset is no longer clinically appropriate due to a change in condition, select a different subset by clicking "**Change Selected Criteria**";

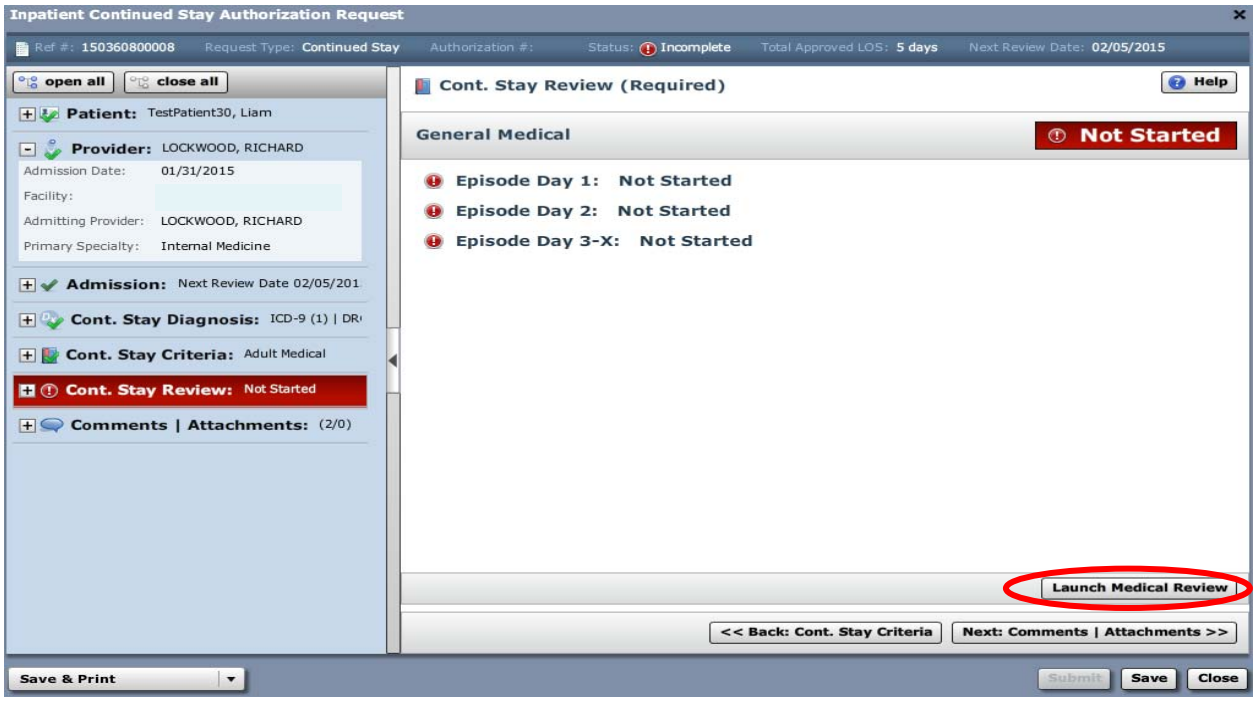
   - Click "**Select**" for the new subset and go to step 7.



7. Click "**Next: Cont. Stay Review > >**"



8. If a medical review is required, Click "**Launch Medical Review**"



9. Click on appropriate "**Episode Day**"

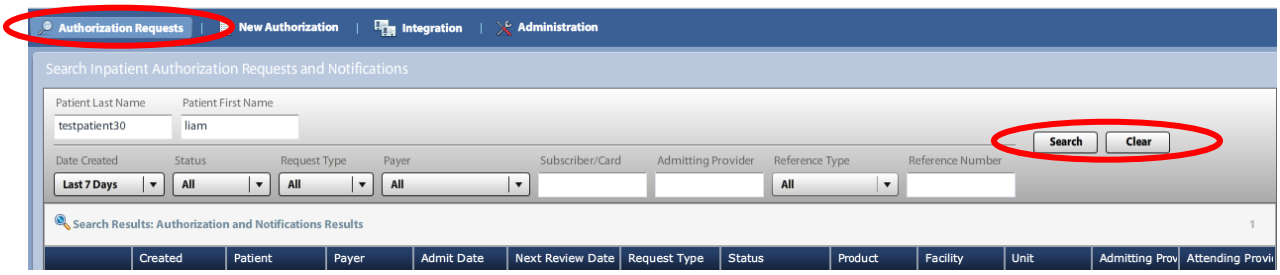
10. Conduct medical review in accordance with the InterQual™ Acute Criteria Review Process for the subset selected. See pages 40-46.

NOTES

ADDING DISCHARGE DATE

Do NOT add a discharge date until the patient has left the facility

1. Locate patient by conducting an authorization search. Click "**Authorization Requests**" button on the menu bar.



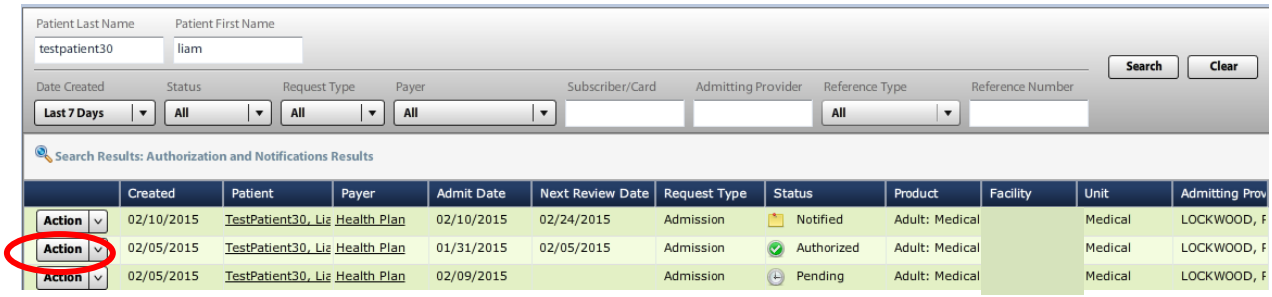
2. Enter search criteria such as: first and/or last name, susbscriber ID, reference number.

3. Click "**Search**"

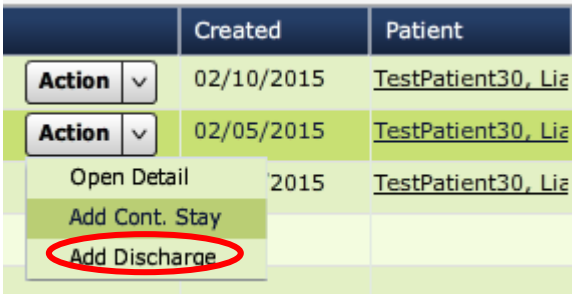
   3a. If the patient's name does not display,click "**Clear**" to begin a new search

4. Locate the correct authorization.

   - Click the "**Action**" button drop down arrow.

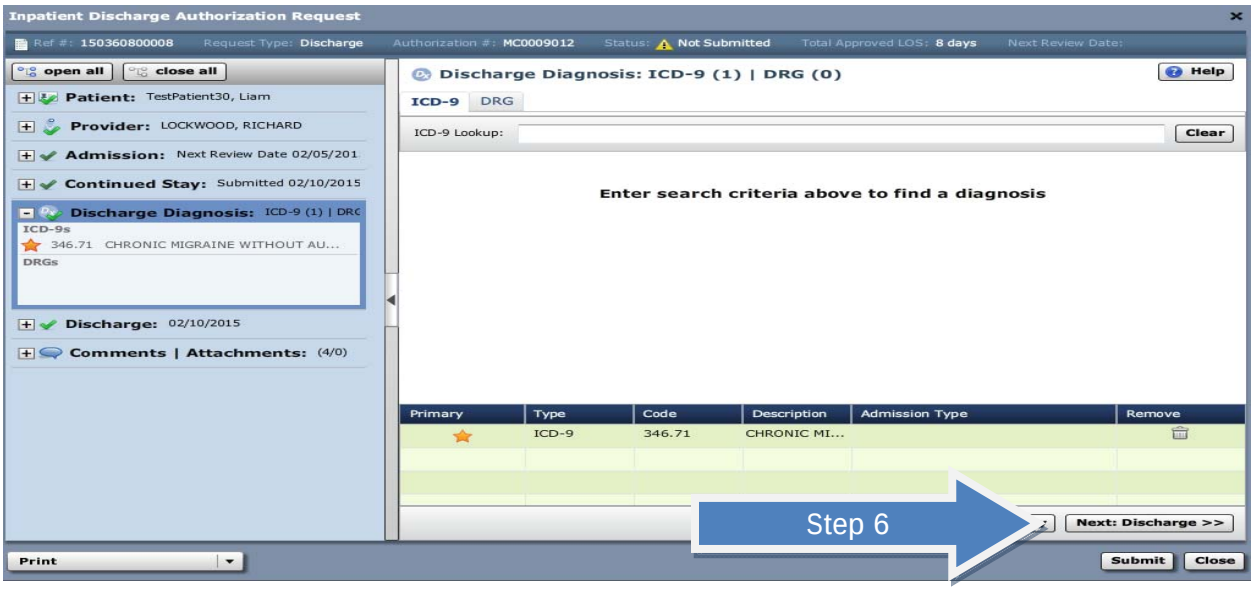


5. Select "**Add Discharge**"

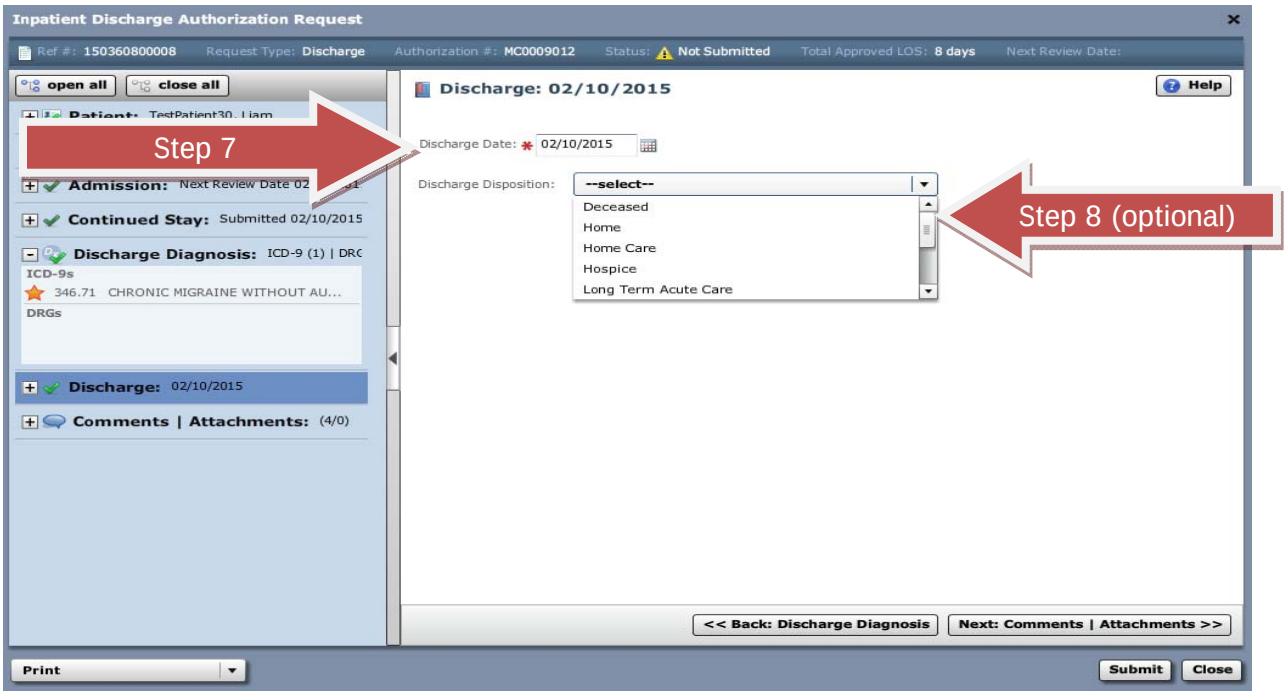


ADDING DISCHARGE DATE

6. Click "**Next: Discharge >>**"



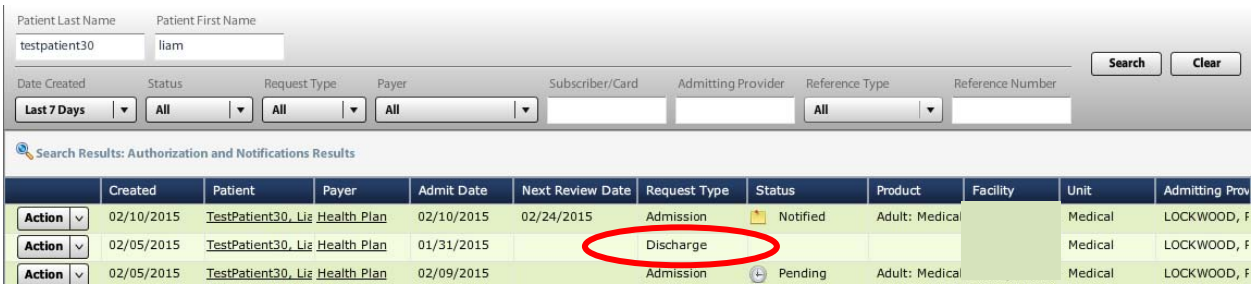
7. Enter **"Discharge Date"**



8. Optional: click the "**Discharge Disposition**" drop down arrow.
   - Select appropriate disposition.
9. Click "**Submit**"

ADDING DISCHARGE DATE

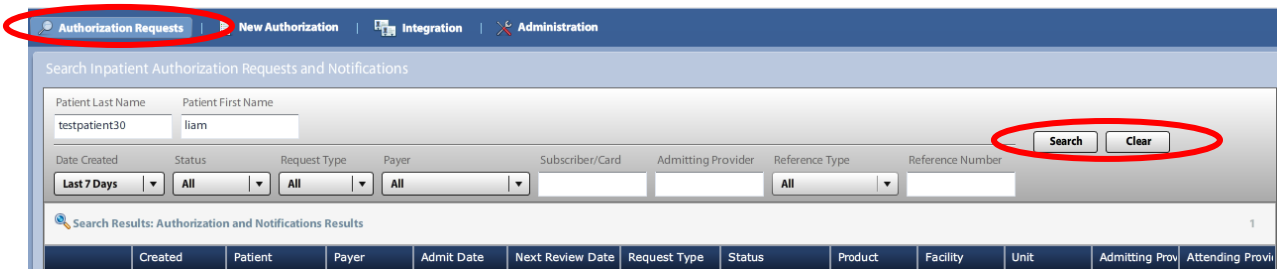
Status is updated on the patients authorization history page:



NOTES

CANCELLING A REQUEST

1. Locate patient by conducting an authorization search. Click "**Authorization Requests**" button on the menu bar.



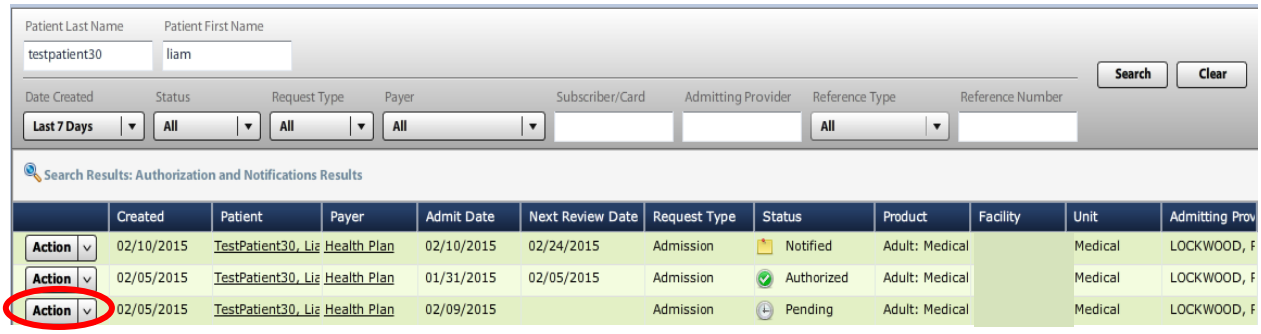
2. Enter search criteria such as: first and/or last name, susbscriber ID, reference number.

3. Click "**Search**"

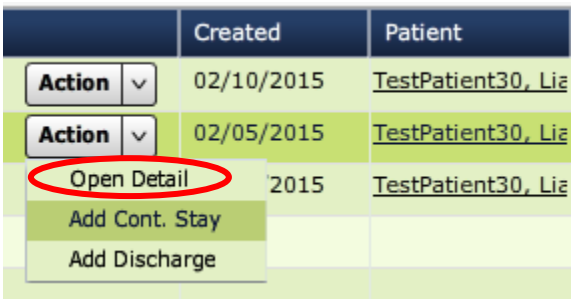
   3a. If the patient's name does not display,click "**Clear**" to begin a new search

4. Locate the correct authorization.

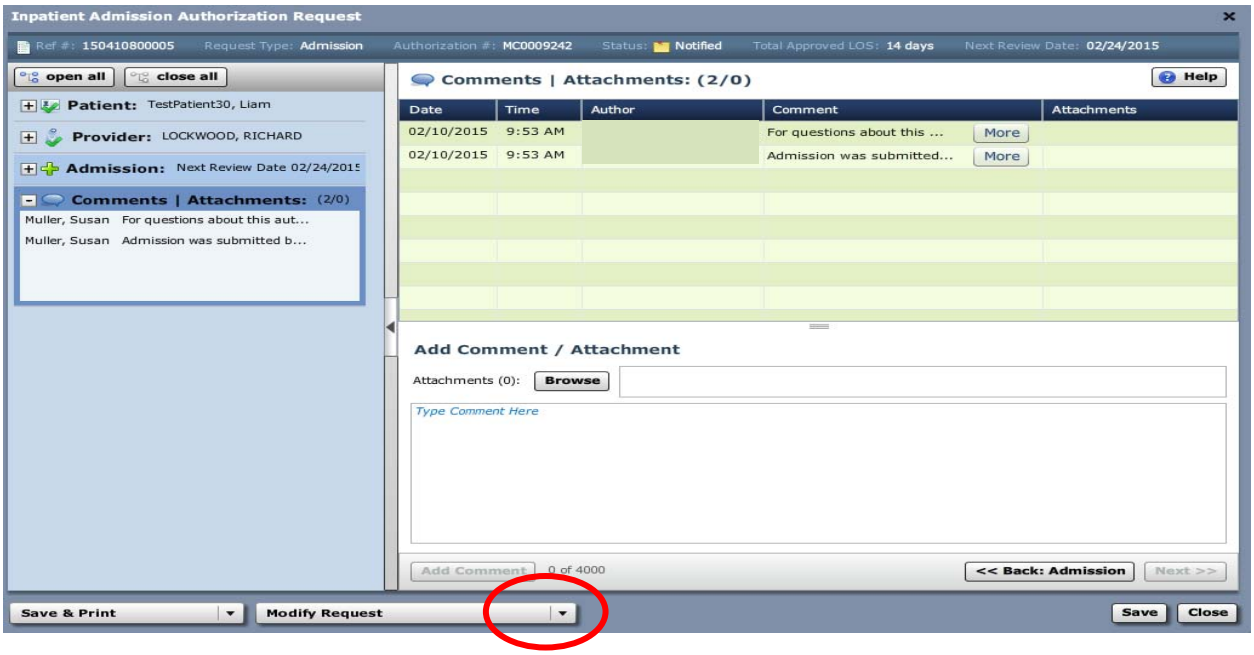
   - Click the "**Action**" button drop down arrow.



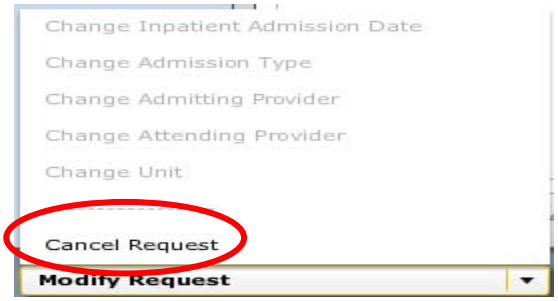
5. Select "**Open Detail**"



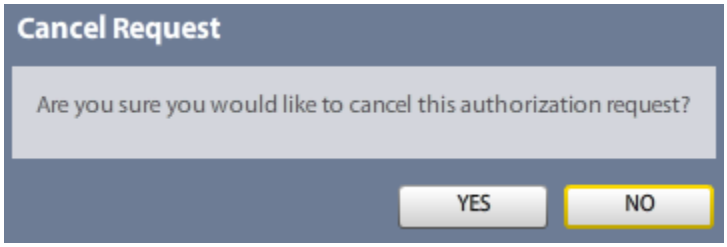
6. Click on "**Modify Request**" drop down arrow.



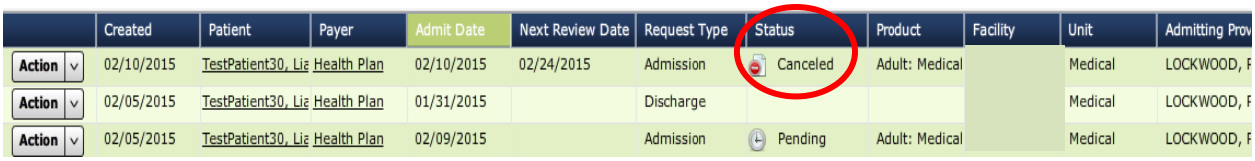
7. Select "**Cancel Request**"



8. A popup box appears. Click **"Yes"**

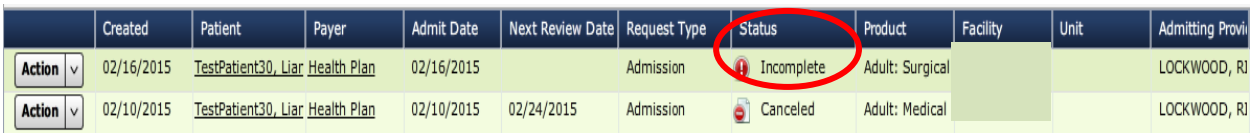


9. The request has been cancelled and the status is automatically updated.



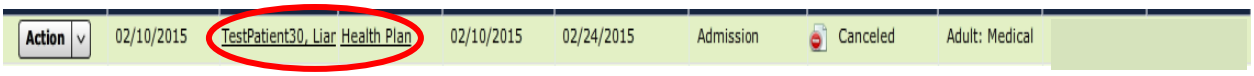
TIPS

- Always check patient's eligibility and benefits in the provider portal ***PRIOR*** to accessing Clear Coverage™.
- Authorizations can be "saved" without submitting. Check daily for "incomplete" authorizations. The "submit" button must be clicked or the request will not be sent to Excellus BlueCross BlueShield.



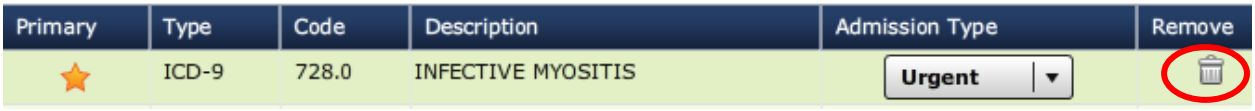
	Created	Patient	Payer	Admit Date	Next Review Date	Request Type	Status	Product	Facility	Unit	Admitting Provi
Action	02/16/2015	TestPatient30, Liar	Health Plan	02/16/2015		Admission	Incomplete	Adult: Surgical			LOCKWOOD, RI
Action	02/10/2015	TestPatient30, Liar	Health Plan	02/10/2015	02/24/2015	Admission	Canceled	Adult: Medical			LOCKWOOD, RI

- If the "submit" button is not visible, click F11.
- If the "submit" button is gray, hover over it to determine what is missing in the authorization request.
- Underlined fields can be selected to obtain additional information:



Action	02/10/2015	TestPatient30, Liar	Health Plan	02/10/2015	02/24/2015	Admission	Canceled	Adult: Medical

- Trash can icon can be used to delete unnecessary or incorrect items:



Primary	Type	Code	Description	Admission Type	Remove
★	ICD-9	728.0	INFECTIVE MYOSITIS	Urgent	🗑

- Hospital to hospital transfers must be requested by the receiving hospital. These requests will always pend for review. Attach supporting documentation to the request.
- Requests for all FEP contracts will always pend for review. Attach supporting documentation to the request.

NOTES

CLEAR COVERAGE FAQs

Password Requirements

1. **Do I need a separate user ID and password to access Clear Coverage™ from the provider portal?**
   Yes. You will need to log into the provider portal and verify patient eligibility and benefits. From that screen, if you wish to enter an authorization or check a Clear Coverage™ authorization status, select a link and enter your Facets provider ID and password (NPI number) to log into Clear Coverage™.

2. **How do I search for a patient within Clear Coverage™?**
   Searching for a patient requires the patient's last name, first name and date of birth. This must be an exact match.

3. **Even though I have entered in the patient's last name, first name and date of birth, what should I do if the patient is not found?**
   If the search does not result in the expected patient, contact Customer Care.

4. **How do I determine whether the patient has coverage for the requested service?**
   Upon logging into the provider portal and prior to accessing Clear Coverage™, conduct an eligibility and benefit search.

5. **Why can't I add a patient in Clear Coverage™?**
   Excellus BCBS does not allow providers to add patients to the system. All patient information is updated on a regular basis. If the patient does not come up when you search, contact Excellus BlueCross BlueShield Customer Care at 1-800-363-4658.

6. **If the patient appears to have multiple coverages listed in Clear Coverage™ under the Patient accordion ("Change payment type button"), which coverage do I select?**
   You should select the coverage that corresponds to the information on the ID card that the patient presented.

Clinical Information

7. **If a non-clinical person enters the initial information (patient, provider, admission date, diagnosis) and saves it, can the person completing the medical review update the diagnosis if it is incorrect (or incomplete)?**
   Yes. Any of the information entered can be updated as long as the request has not been submitted. Once the request has been submitted the requester can only add a continued stay request, add discharge date or cancel the request.

Workflow/Processes

8. **What does the green check  mean?**
   A green check means that all required information is present or has been entered for that specific section (e.g., patient, provider, diagnosis etc.).

9. **What does the red exclamation point  mean?**
   A red exclamation point indicates that additional information is required for that section.

10. **What happens if a provider has called prior to the patient's "active" coverage?**
    Preauthorization cannot be obtained until after the patient's eligibility is in Clear Coverage™. If the patient does not have active coverage, the patient's name will not be displayed in the patient search.

11. **How are appeals managed within Clear Coverage™?**
    Appeals will not be managed in Clear Coverage™. Appeals will be managed by Excellus BCBS via the normal appeals process.

12. **Can an authorization be entered retrospectively?**
    Yes. Authorizations can be backdated five calendar days.

13. **How far into the future can a preauthorization be conducted?**
    Excellus BCBS allows preauthorization to be conducted up to 90 days prior to the date of service.

14. **How many diagnosis codes do I need to enter?**
    You must enter the primary diagnosis code only for an authorization.

15. **In Clear Coverage™, what is the function of the trash can  ?**
    Clicking on the trash can will remove the item from the authorization request. For example, if you entered an incorrect diagnosis, click on the trash can to remove this diagnosis from the request.

16. **How will I know the final authorization determination when a request requires Excellus BCBS review?**
    Excellus BCBS will continue to follow current-day processes for all decisions. The provider will receive a letter and will also receive a phone call. The provider may also check the status and/or activity column within Clear Coverage™ for *a real-time decision*.

17. **What do I do if I don't have all of the required clinical information to complete the request?**
    You can save your request, gather the required information, locate and select the incomplete request and complete the review.

18. **Does the system auto-deny requests?**
    There are no auto-denials. Any request requiring Excellus BCBS review will result in a "pending" status and will be reviewed by Excellus BCBS. Any request resulting in a denial requires medical director review prior to a final denial determination.

Documenting Notes and Uploading Clinical Documentation

19. **Can I add medical review notes that provide information supporting the necessity of the request?**
    Yes, providers can add notes within the medical review and can upload copies of the medical record in support of the authorization request. Notes must be added before submitting the request.

20. **When should I attach clinical information to an authorization request?**
    You should consider attaching clinical information anytime the medical review results in a "Criteria Not Met" message. Providing supporting clinical information for the request will facilitate Excellus BCBS's review of the request.

21. **What types of files can be attached to Clear Coverage™?**
    You can attach a document, PDF or JPG file.

22. **How do I print the authorization approval so it can be included in the patient's record and /or provided to the patient?**
    After entering the authorization request, select the **"View Request (PDF)"** link in the request box.

23. **Can a provider add information to a denied request to have it re-reviewed?**
    No. Once an authorization request has been denied, the normal appeal/grievance process must be followed.

Help

24. **Who can I call with questions?**
    Excellus BlueCross BlueShield Customer Care 1-800-363-4658

NOTES