2015-2016

McKESSON

Clear Coverage™

Provider Resource Guide

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

Excellus

A nonprofit independent licensee of the Blue Cross Blue Shield Association

B-4641-10/15

NOTES

"Proprietary and Confidential All Rights Reserved. Copyright © 2015 McKesson Corporation and/or one of its subsidiaries."

TABLE OF CONTENTS

What is Clear Coverage ™?	**Page 4**
Clear Coverage™ Quick Reference Guide	**Page 6**
Logging in: Provider Portal	**Page 8**
Benefit & Eligibility Check	**Page 10-12**
Logging into Clear Coverage™	**Page 14-17**
Home Page Menu Bar	**Page 18**
Home Page	**Page 20-21**
Logging Out	**Page 22**
Timing Out	**Page 23**
Patient Search	**Page 24-26**
Creating a New Authorization request: Completing the Six Accordion Sections	**Page 28-43**
Cancelling a Request	**Page 44**
Requesting Additional Visits/Units	**Page 46-47**
Requesting a Date of Service Change	**Page 48-49**
Home Page Activity Descriptions	**Page 50-51**
Tips	**Page 52**
FAQ's	**Page 54-57**

NOTES

What is Clear Coverage™?

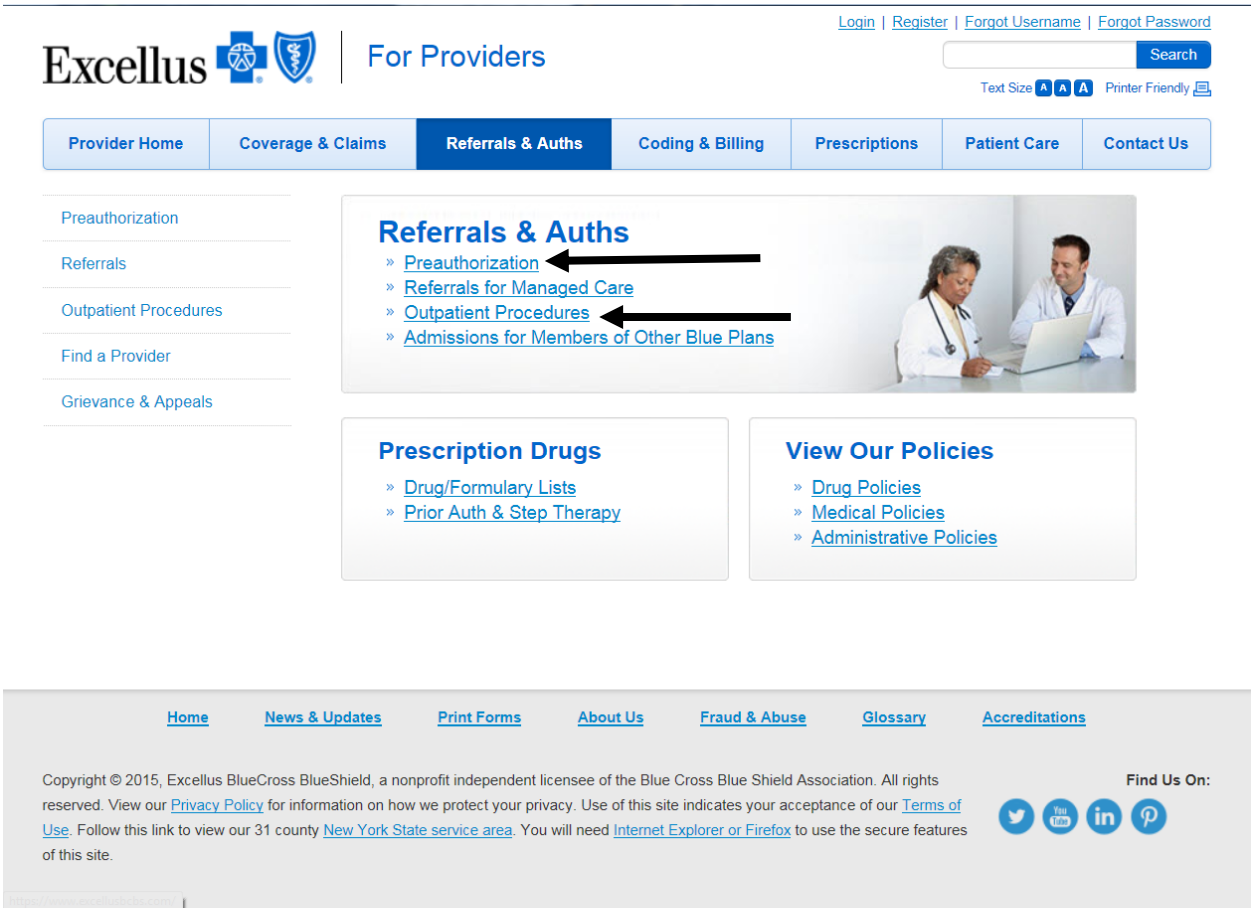
Clear Coverage™ is an automated system developed by McKesson that allows providers and Excellus BlueCross BlueShield to manage authorizations for services. McKesson was engaged to integrate this system with Excellus BCBS business rules, and enables the provider to receive an instant decision of either an *approval* or *pend* for a medical necessity review by the Health Plan.

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

Clear Coverage™ includes an interactive question and answer medical review, based on Excellus BCBS-specific or InterQual® evidence-based criteria.

Only items that are on the Prior Authorization List will be available on Clear Coverage™ for review, including:

- Specialty referrals
- Outpatient services
- Elective Procedures/surgery performed **inpatient or outpatient**. Please reference the prior authorization list that is located on the provider portal



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 NPI**.

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

Clear Coverage™ involves the completion of six brief sections – called accordions – in order to submit a preauthorization request.

1. **Patient Information Accordion**
   What you'll need: select the patient's correct coverage for whom you are requesting the preauthorization based on your patient search results.

2. **Requesting Information Accordion**
   What you'll need: the date of service and the name and address of the physician requesting the preauthorization.

3. **Diagnosis Accordion**
   What you'll need: the patient's primary diagnosis, with up to three additional supporting diagnoses.

4. **Service Accordion**
   What you'll need: the CPT code, HCPCS code or description of the service for which you are requesting the preauthorization.

5. **Service Information Accordion**
   What you'll need: the name of the provider or facility where the service will be rendered; the clinical criteria to support the preauthorization request; modifiers and/or CPT codes, if applicable.

6. **Additional Notes Accordion**
   What you'll need: this provides a free text section allowing you to attach additional information pertinent to the preauthorization request.

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

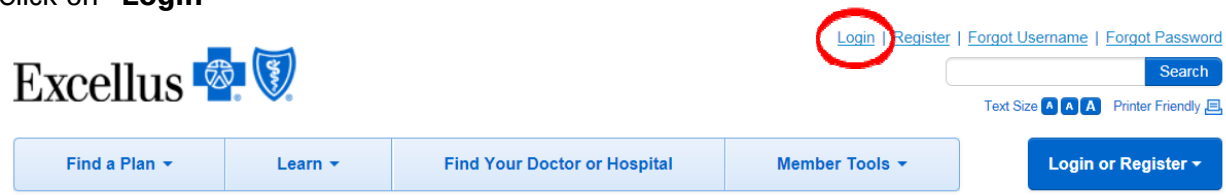
NOTES

LOGGING IN: PROVIDER PORTAL

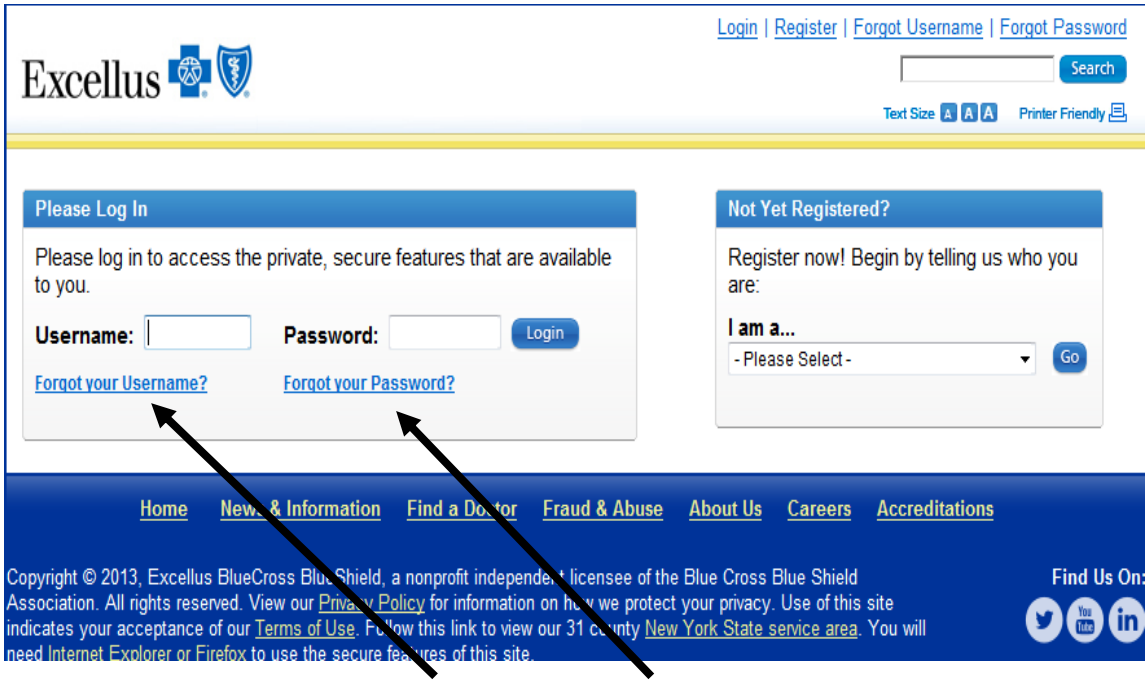
1. Type the provided Web address in your browser address box or log in to the provider portal

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

2. Click on **"Login"**



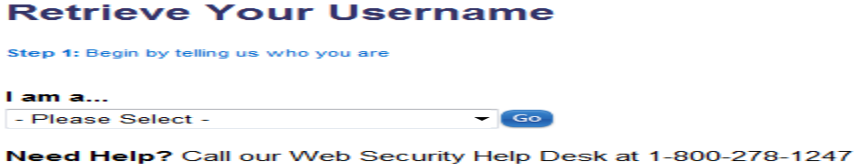
3. Enter assigned Username and Password and click on "Login":



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-site 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)

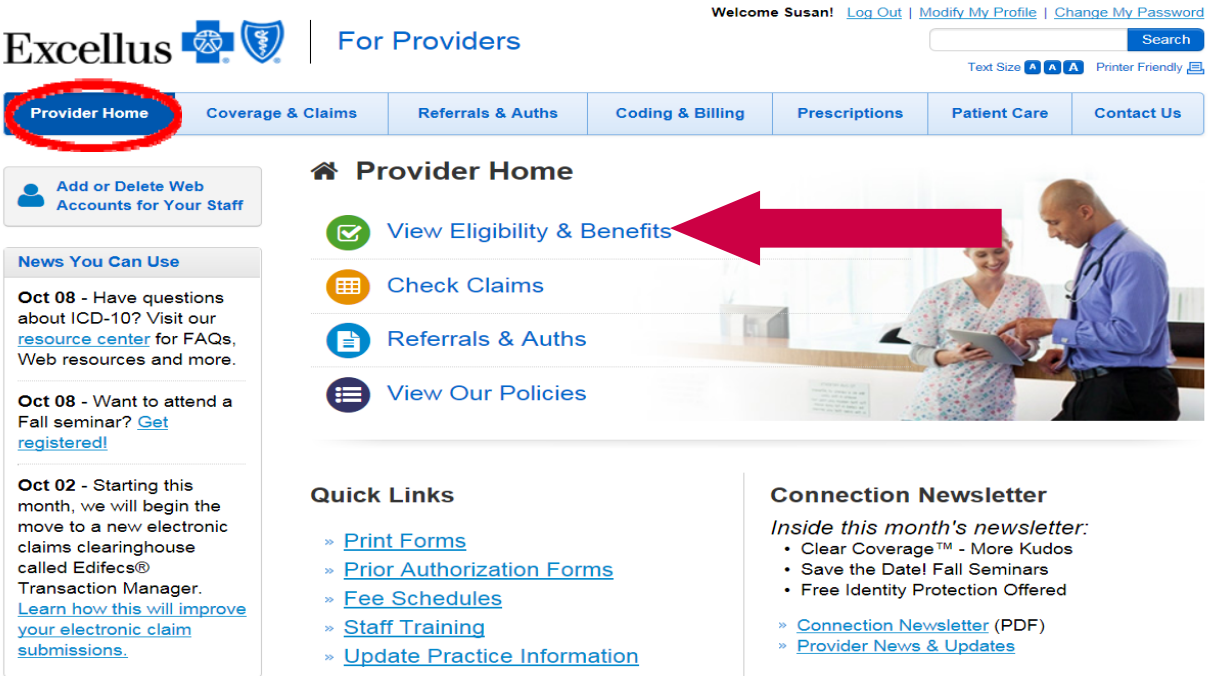


NOTES

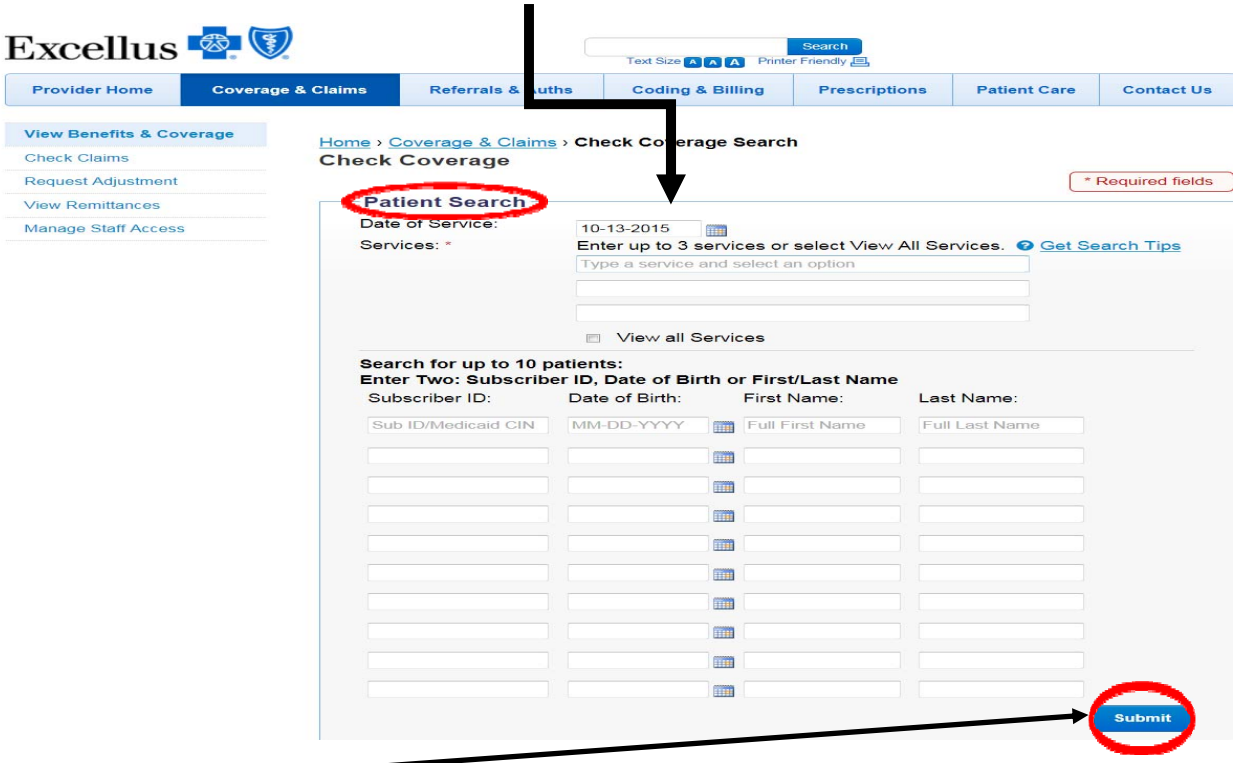
BENEFIT/ELIGIBILITY CHECK

From the **Provider Home** tab:

1. Click on **"View Eligibility & Benefits"**

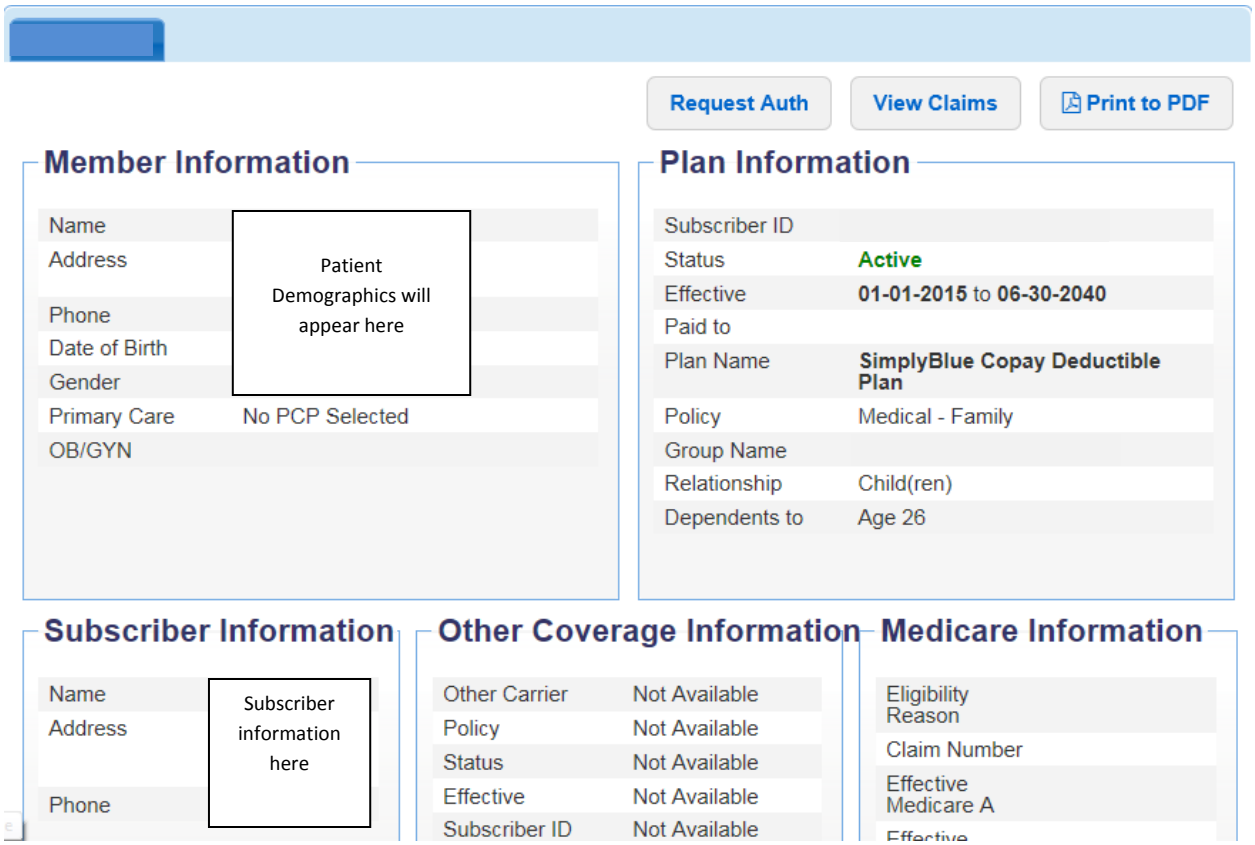


2. Enter the date of service, type of service and patient information within the "**Patient Search**" box

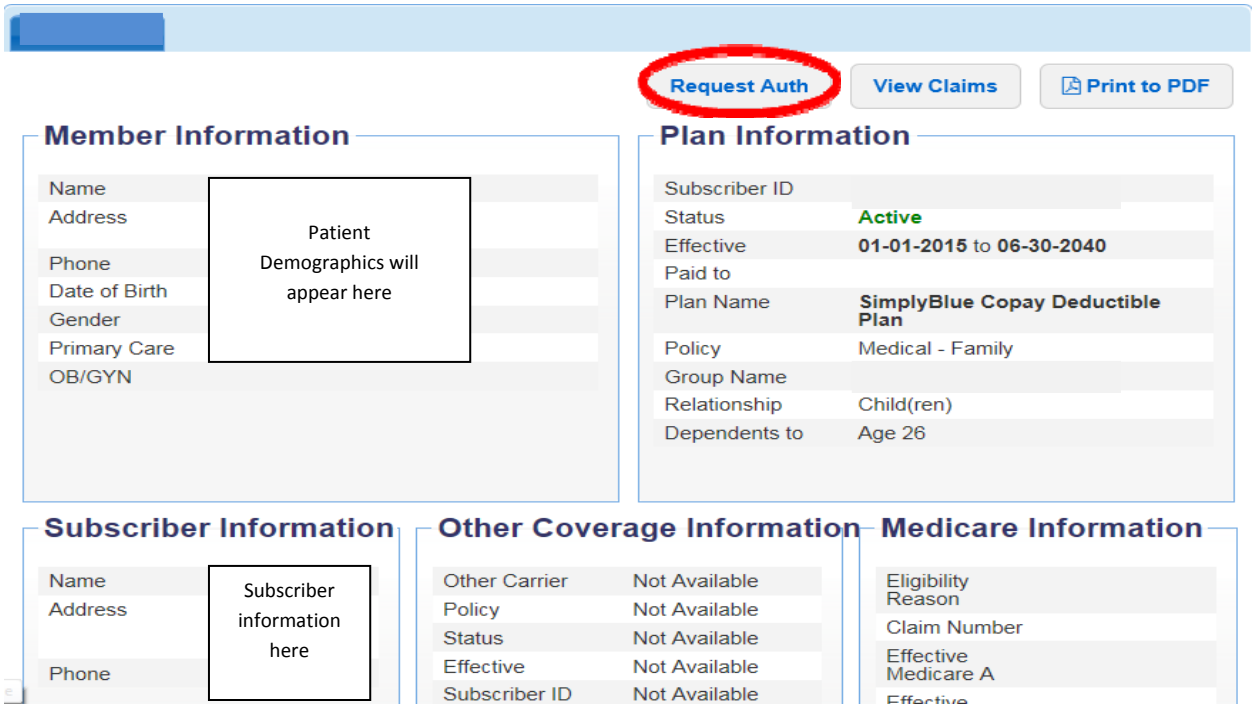


3. Click "**Submit**"

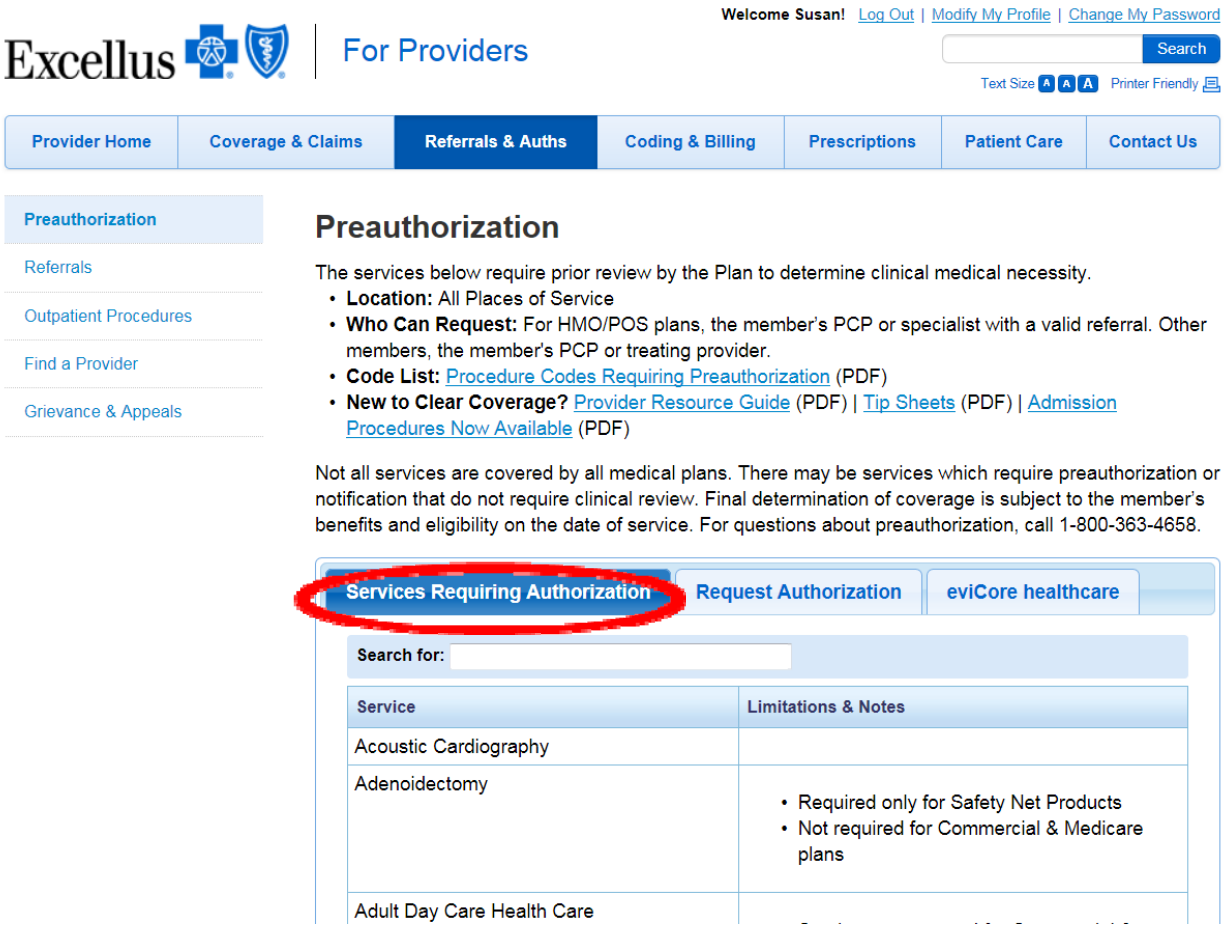
4. Review eligibility



5. If the patient is eligible, click the **"Request Auth"** button at the top of the page



6. Review the **"Services Requiring Preauthorization"** list



7. If the service requires preauthorization, click the "**Request Authorization**" tab to begin the Clear Coverage™ authorization entry. See page 30.

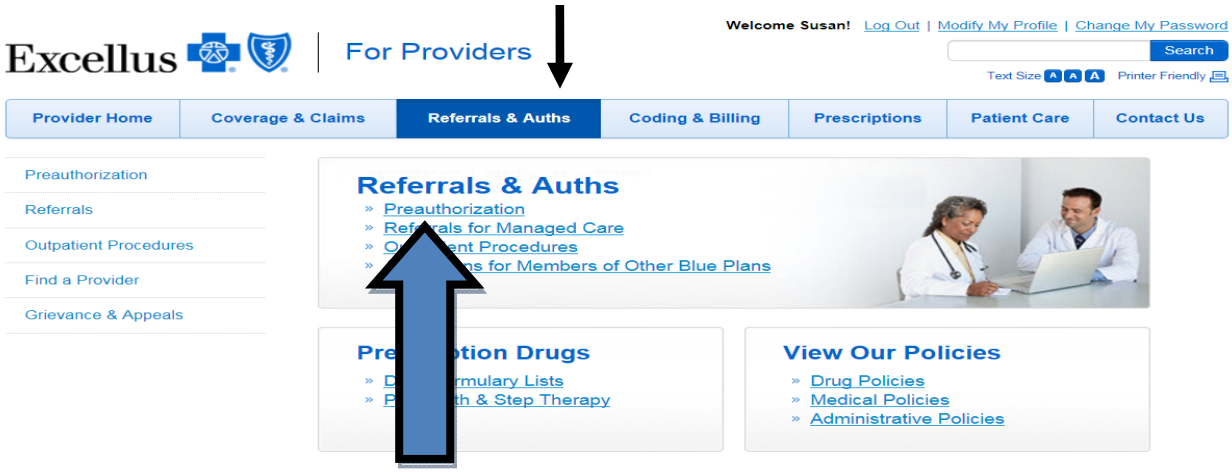
NOTES

LOGGING IN: CLEAR COVERAGE

Providers are required to perform an eligibility and benefit check prior to entering any authorization requests into Clear Coverage™.

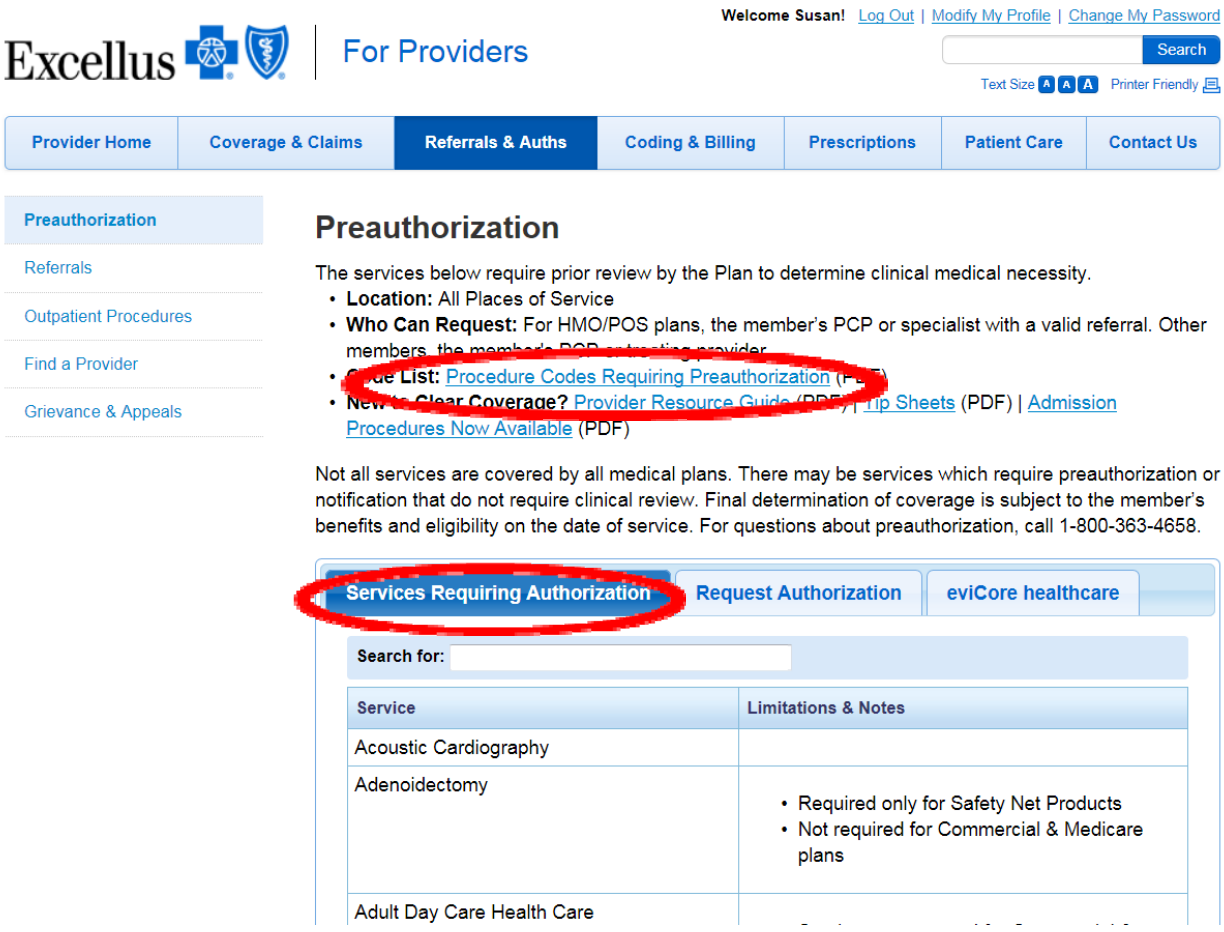
Once you have checked the patient's "Eligibility and Benefits" and would like to enter an authorization request:

1. Go to the **"Referrals and Auths"** tab

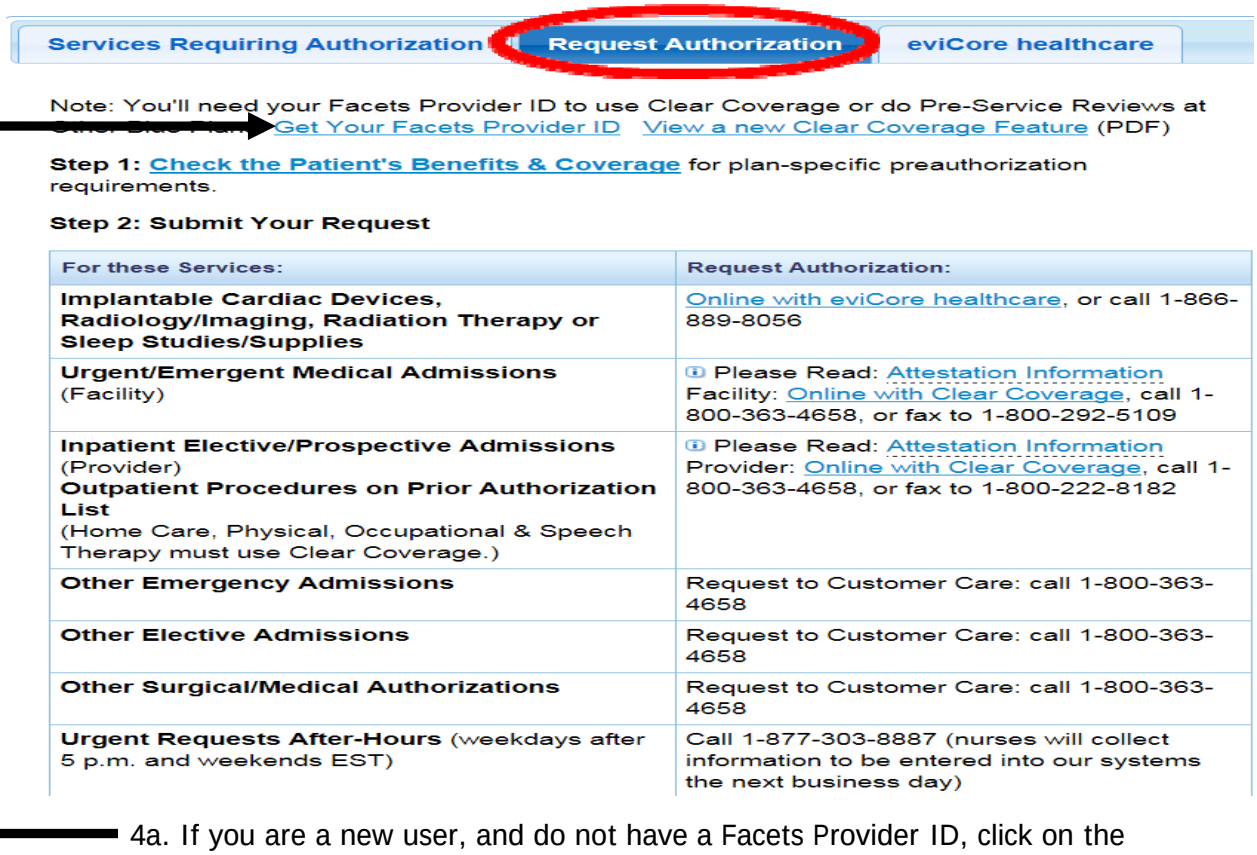


2. Click **"Preauthorization"**

3. Review the **"Services Requiring Preauthorization"** and/or **"Procedure Codes Requiring Preauthorization"** list(s)

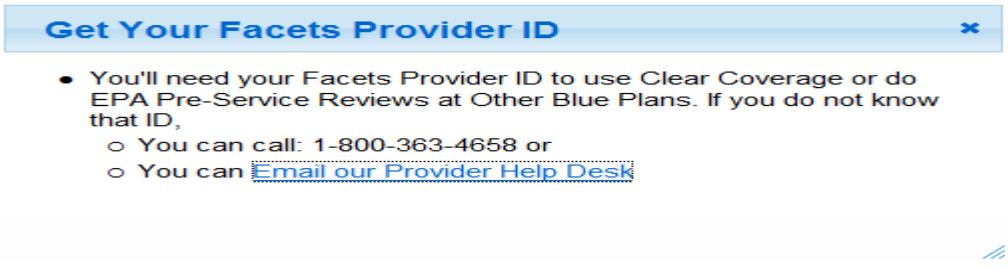


4. If the service requires preauthorization, click the "**Request Authorization**" tab.



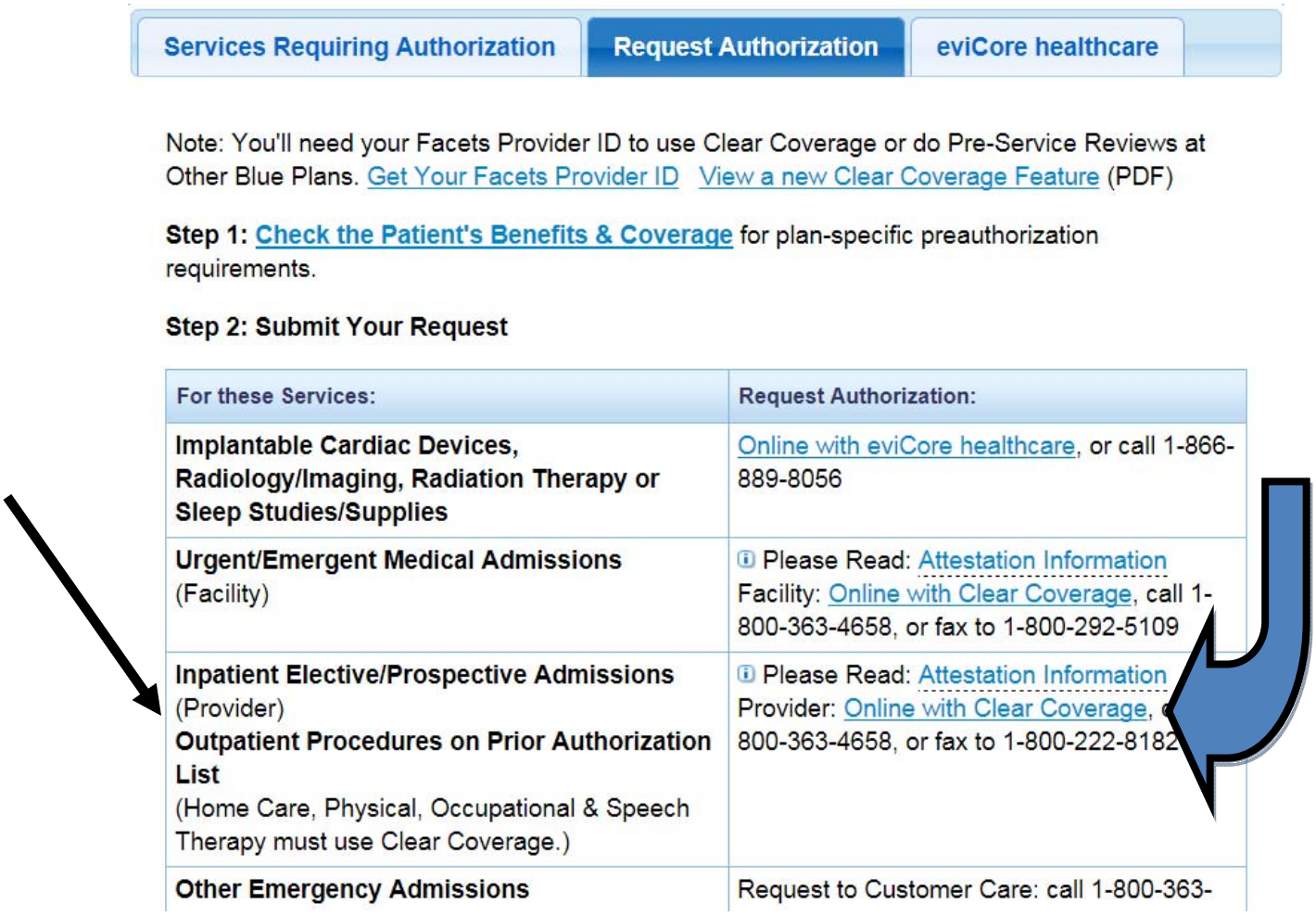
4a. If you are a new user, and do not have a Facets Provider ID, click on the "**Get Your Facets Provider ID**" link.

This box will appear. Click on the "**Email our Provider Help Desk**" button or call the phone number listed.

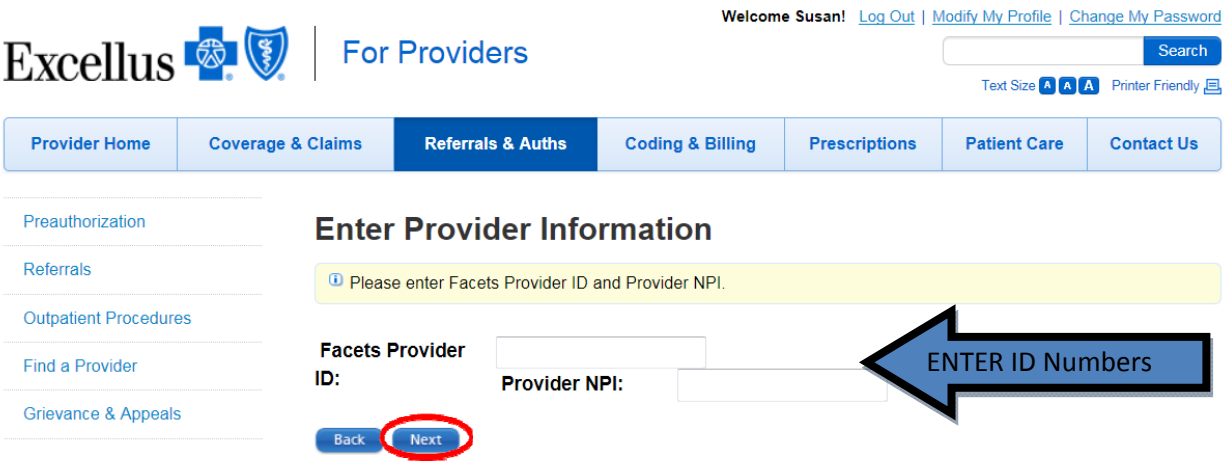


4b. Complete the form. The Help Desk will contact you with an ID number.

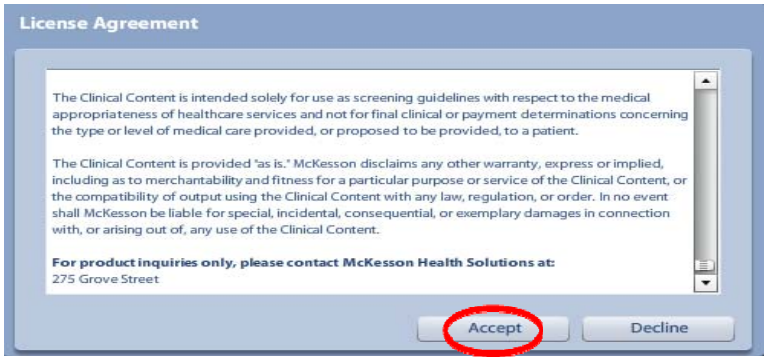
5. Click on the **"Online with Clear Coverage"** link in the Inpatient Elective/Prospective Admissions and Outpatient Procedures on Prior Authorization List column



6. Enter your Facets Provider ID and Provider NPI number and click "**Next**"

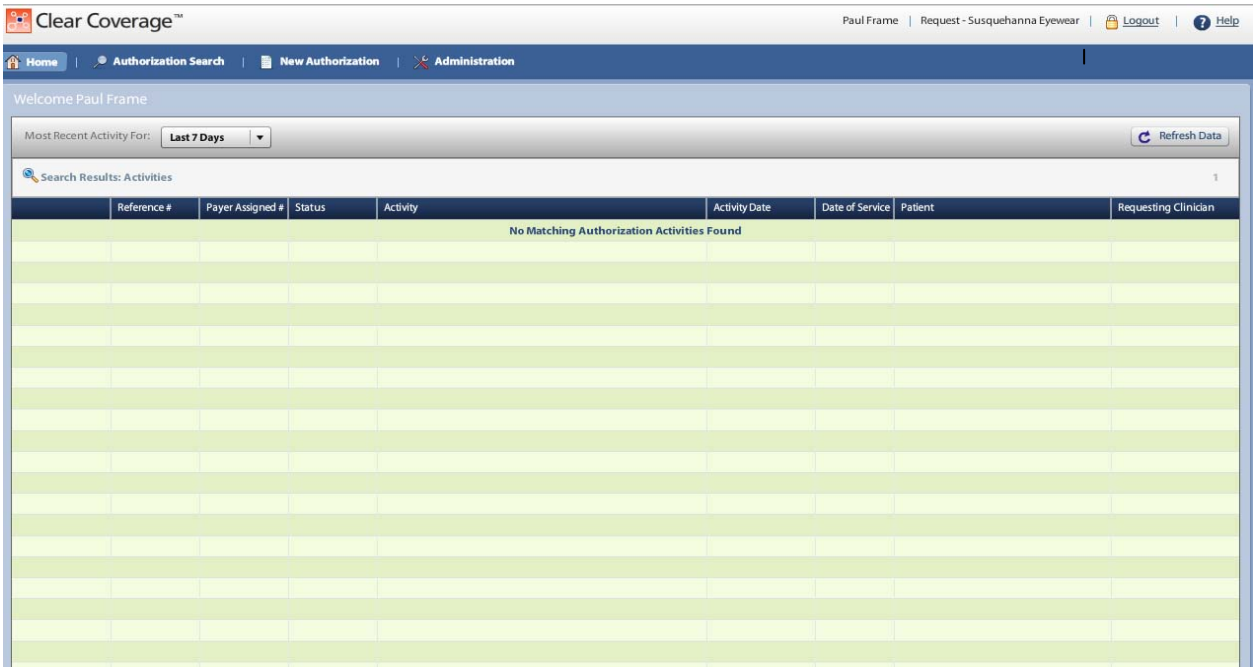


7. The first time you log in you will need to accept the license agreement. Click "**Accept"**.



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

When you have successfully logged into Clear Coverage™, the "home page" will display.



Menu Bar:

1. **Home-**Enables you to view and access submitted authorization requests. See next section for more detailed information

2. **Authorization Search**-Enables you to find *existing* authorizations

3. **New Authorization**-Enables you to enter and submit an authorization request

4. **Log Out**-Enables you to close the application

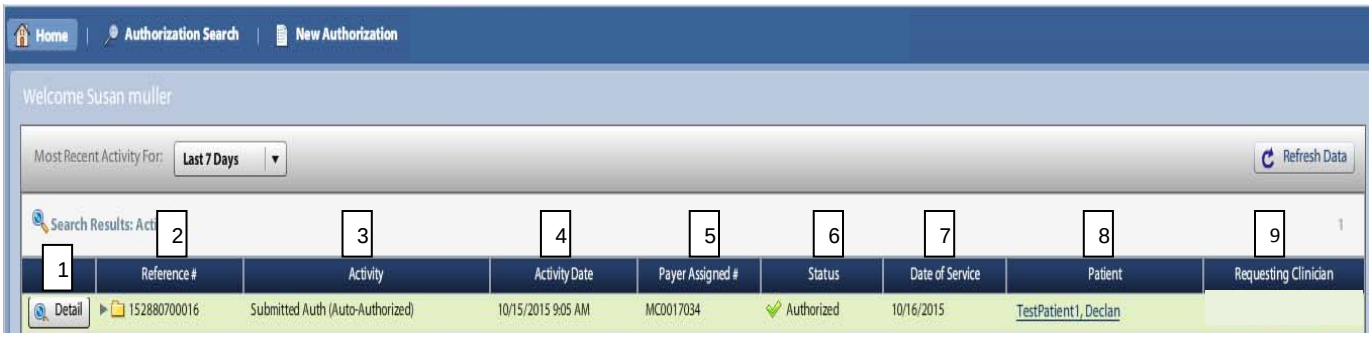
5. **Help**-for additional, generic Clear Coverage™ information

6. **Refresh Data**-refreshes the displayed data

NOTES

HOME PAGE

The **Home page** displays the following information about authorization requests:



1. **Detail** = allows you to open the individual authorization for viewing or editing

2. **Reference #** = A system-generated identification number that is assigned to a request when it is *submitted.* This is **NOT** the authorization number

3. **Activity-**Description of the activity performed on a request

4. **Activity Date-**Date activity was performed on the authorization request

5. **Payer Assigned # =** An identification number that is assigned to a request when it is *authorized.* **This IS the authorization number**

6. **Status =** Current status of a request. Includes the following statuses:
   - **Pending** -Submitted request is ***pending further action*** by Excellus BCBS
   - **Authorized** -Service is ***authorized*** to be performed. This status is either a system-generated authorization when a request is submitted or authorization from Excellus BCBS
   - **Auth Denied** -Request has been ***denied*** by Excellus BCBS
   - **Cancelled** - Request has been ***cancelled*** either by the requesting clinician or Excellus BCBS
   - **Expired** - Date range of the authorization has expired
   - **Incomplete** - Provider has begun to enter an authorization request, but the request has not been completed

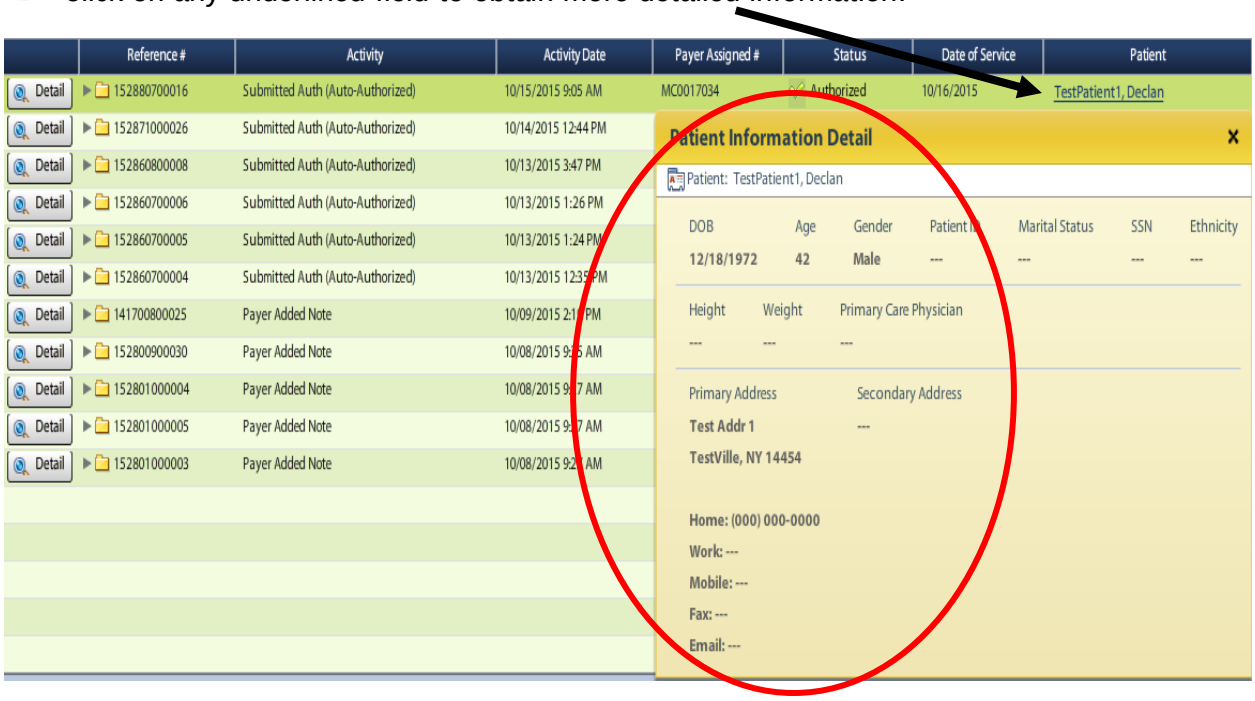
It is important for the provider to look for status and activity updates if a request has been pended. If additional information has been requested from Excellus BCBS or a determination has been rendered, the status updates will appear on the home page. The provider will also receive written notification in the mail from Excellus BCBS.

7. **Date of Service-**Date the service was rendered

8. **Patient-**Name of the patient on a request

9. **Requesting Clinician-**Name of the clinician requesting the procedure/service

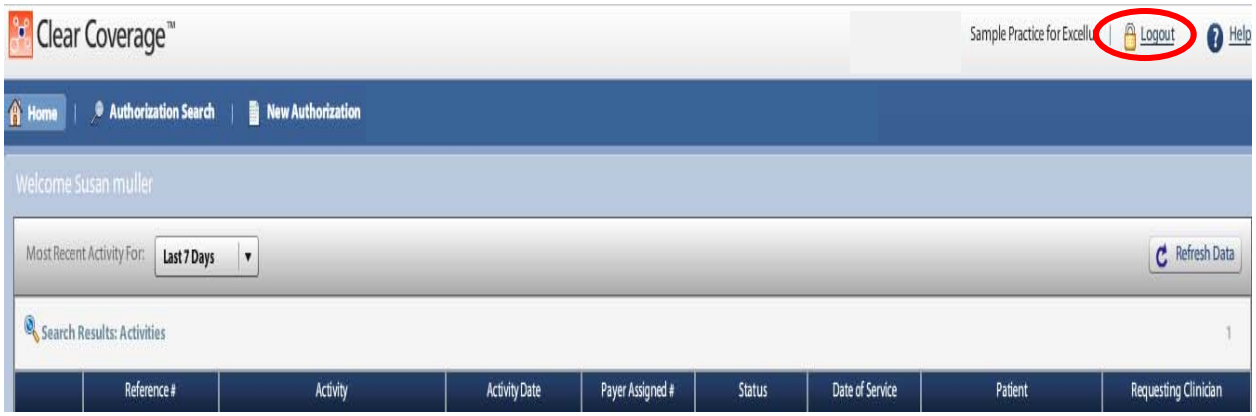
Click on any underlined field to obtain more detailed information:



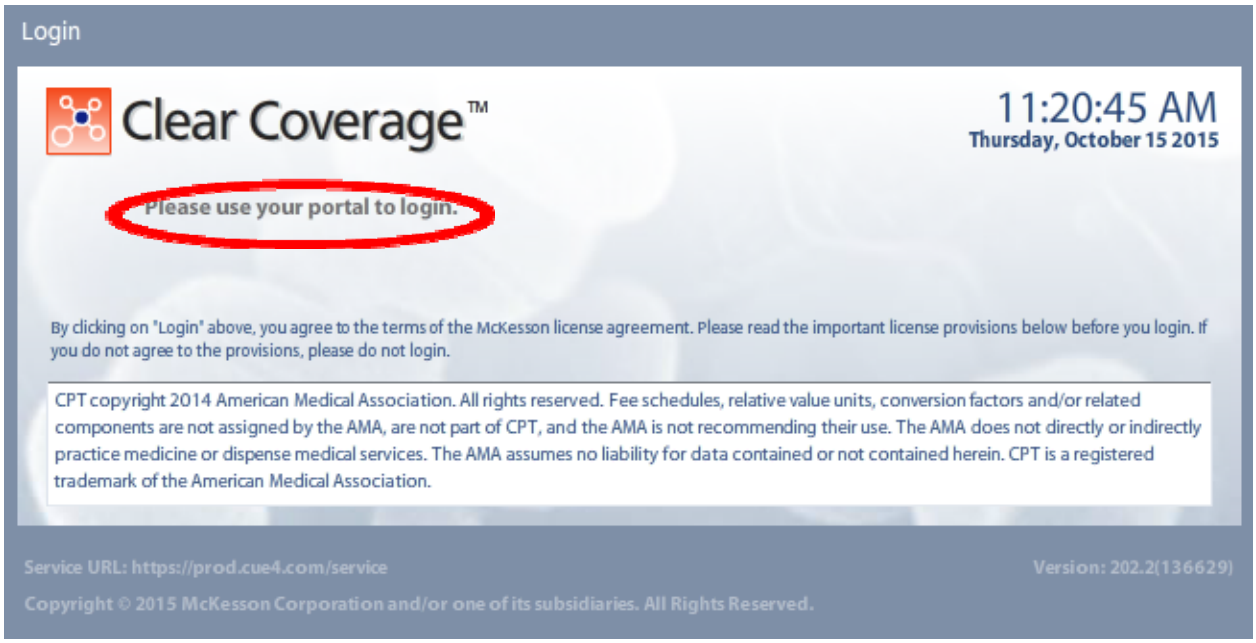
LOGGING OUT

To end your session, you must log out

In the **menu bar**, click **“Logout”**

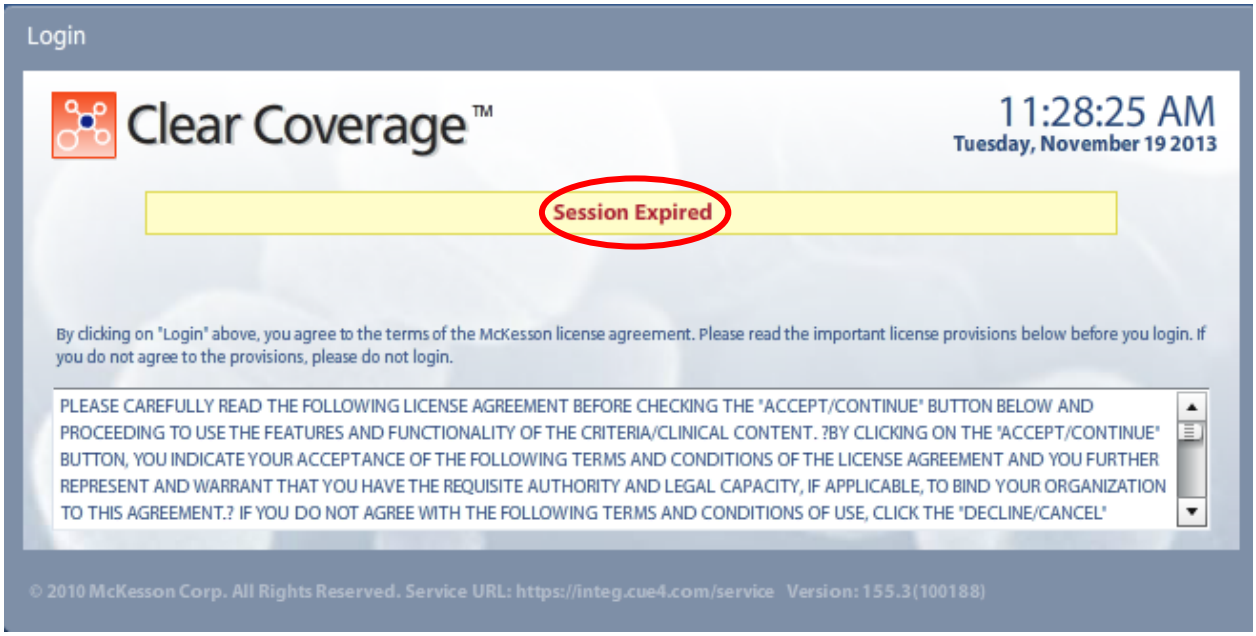


Your session ends. The user must return to the provider portal to log in again.



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.

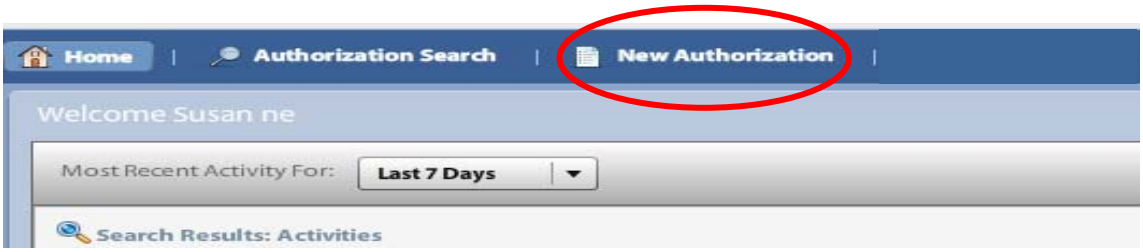


If this message is received, return to the provider portal and follow the “Log In” steps.

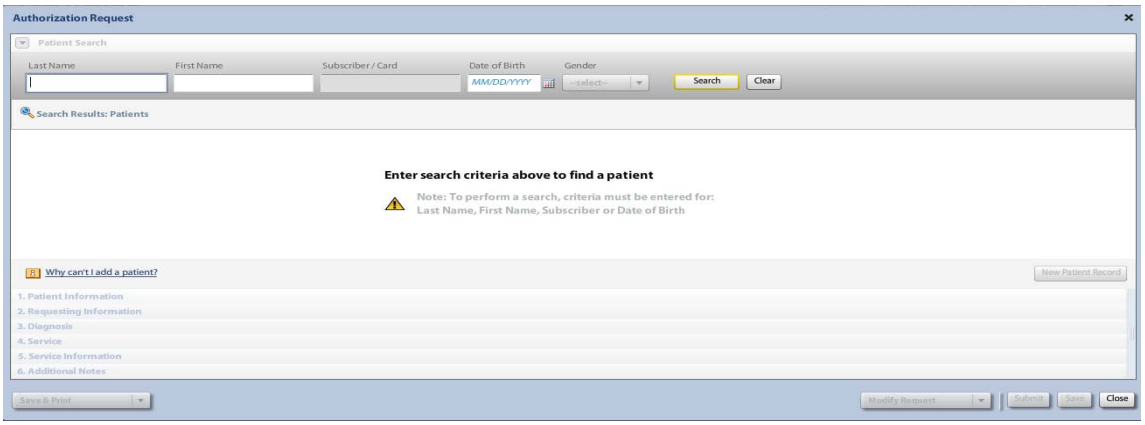
PATIENT SEARCH

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.

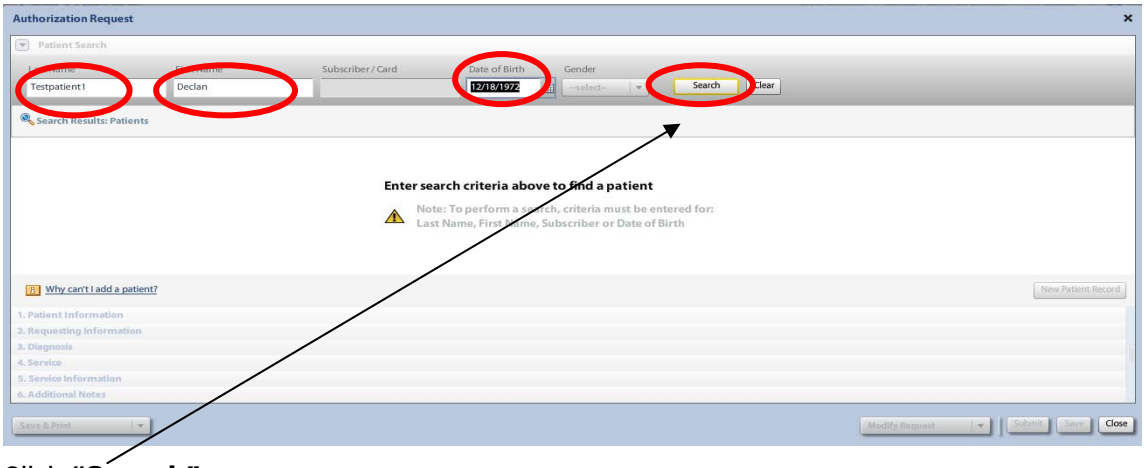
1. Begin by clicking on **"New Authorization"** on the menu bar



The Patient Search displays:

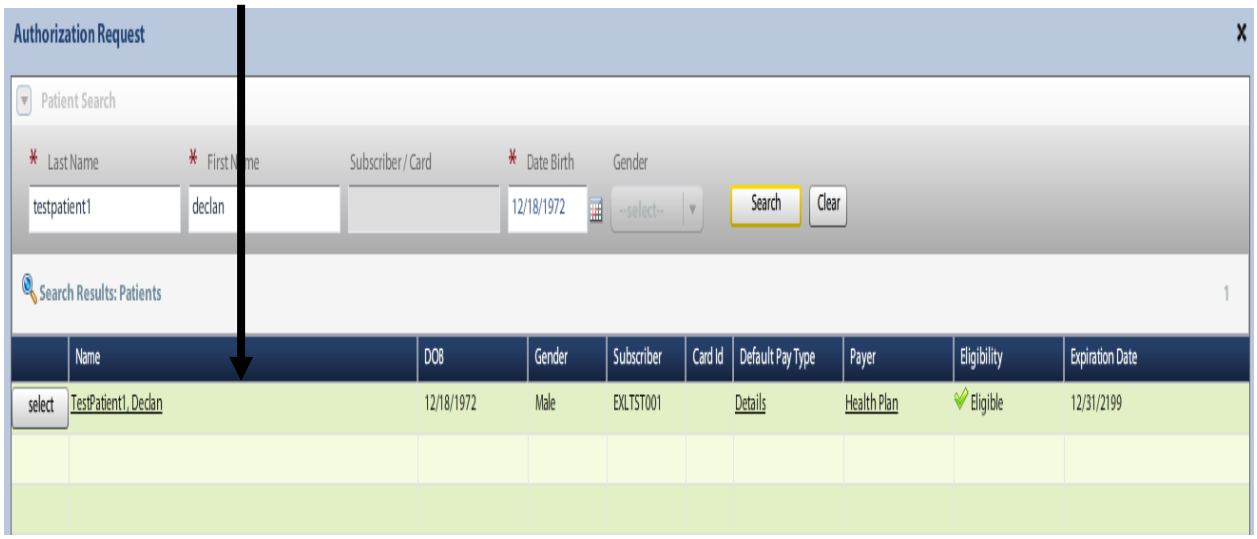


2. In the Patient Search, enter the patient's last name, first name and date of birth (TIP: this MUST be an exact match, so verify correct spelling)



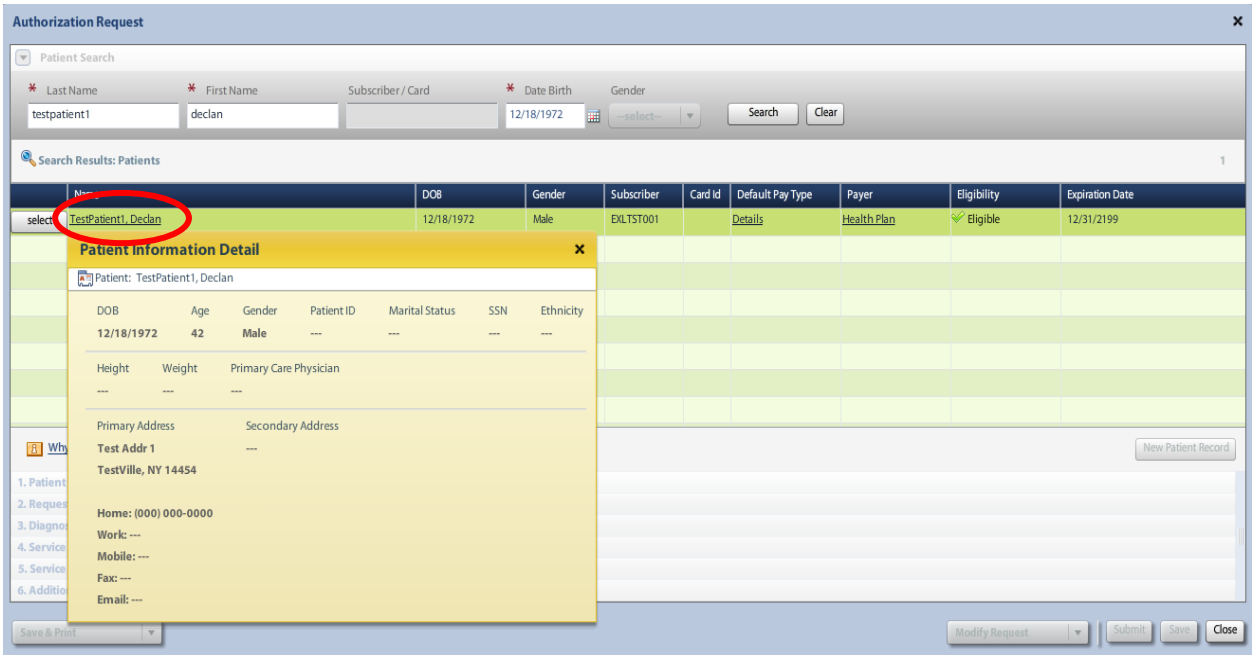
3. Click **"Search"**

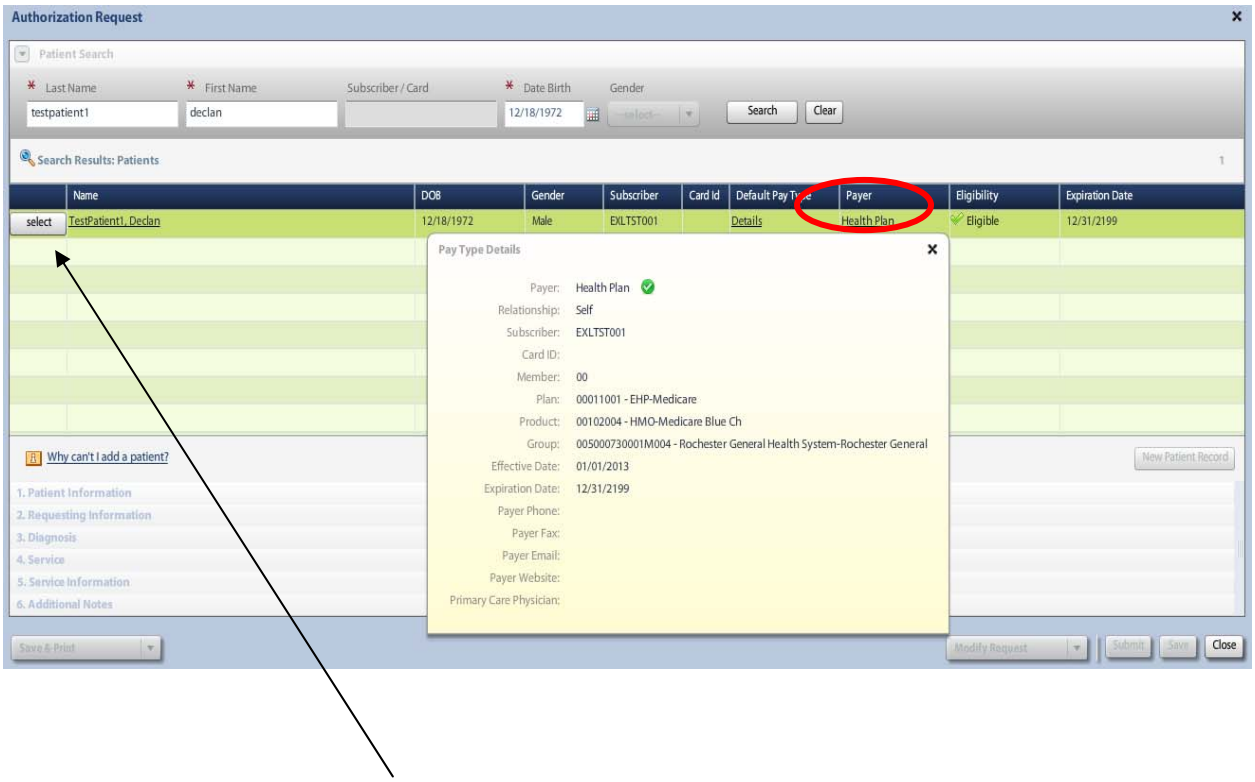
Results that match your search appear:



4. If the patient's name does not appear:
   - 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 2 and 3
     - If the patient's name still does not appear, call our Customer Care department

Click on any underlined field for additional information





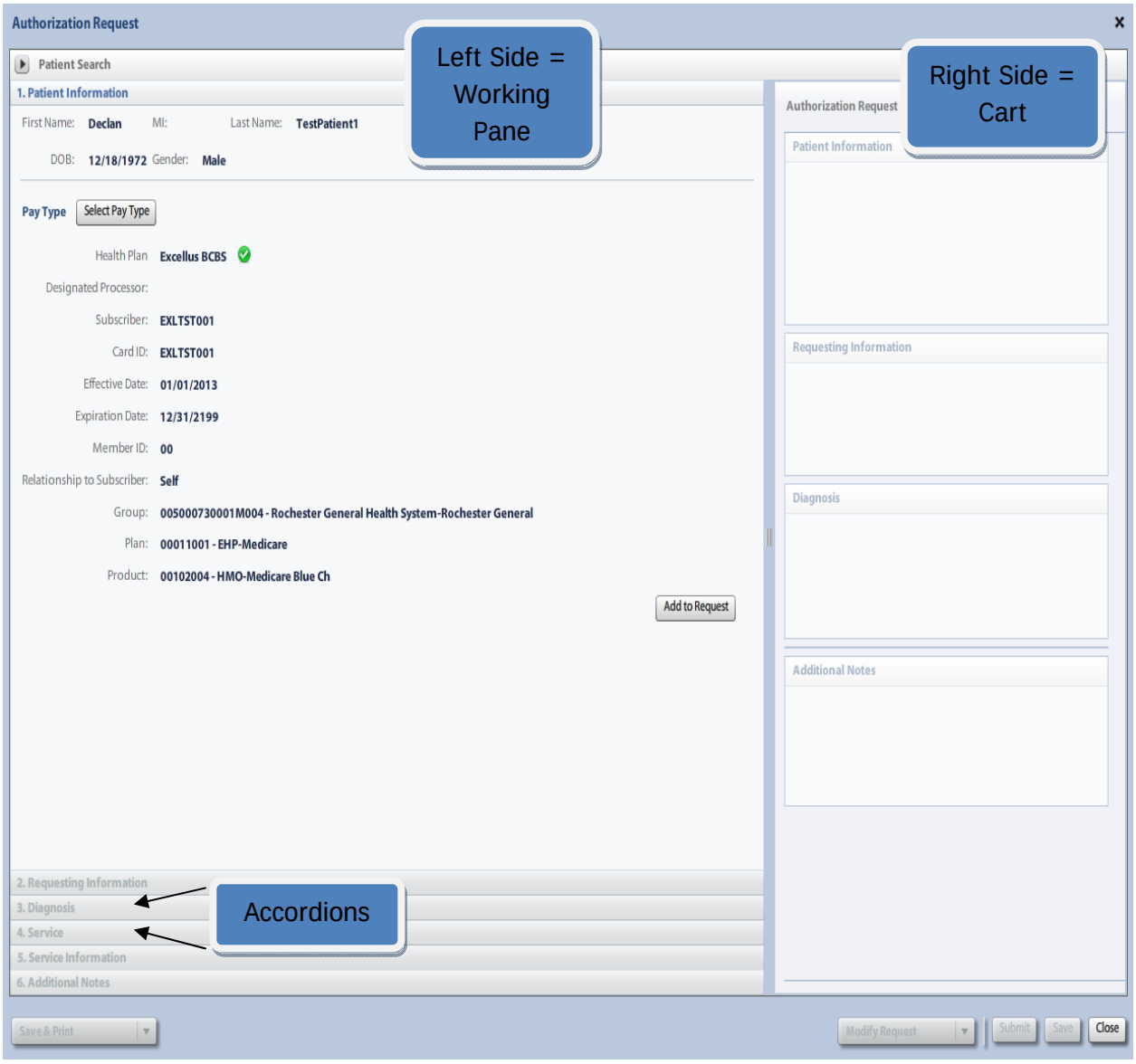
5. Choose a patient by clicking **"Select"** to the left of the patient's name.

NOTES

CREATING A NEW AUTHORIZATION REQUEST

Once you have successfully located and selected the correct patient, the patient information will appear and you can begin creating an authorization request.

The information you provide is added to the authorization request. This process will build a complete authorization request with all required information, which is then either auto approved or submitted to Excellus BCBS for a determination.



The LEFT side of the page is the working side. You will open each accordion and build the authorization. As each accordion is completed, it can be added to the RIGHT side of the page, which is the **"cart"**. That is the actual building of the authorization request.

Accordions:

Each accordion will need to be opened in consecutive order, completed and added to the "**cart**".

1. **Patient information** accordion - this information auto populates when the user selects the patient.

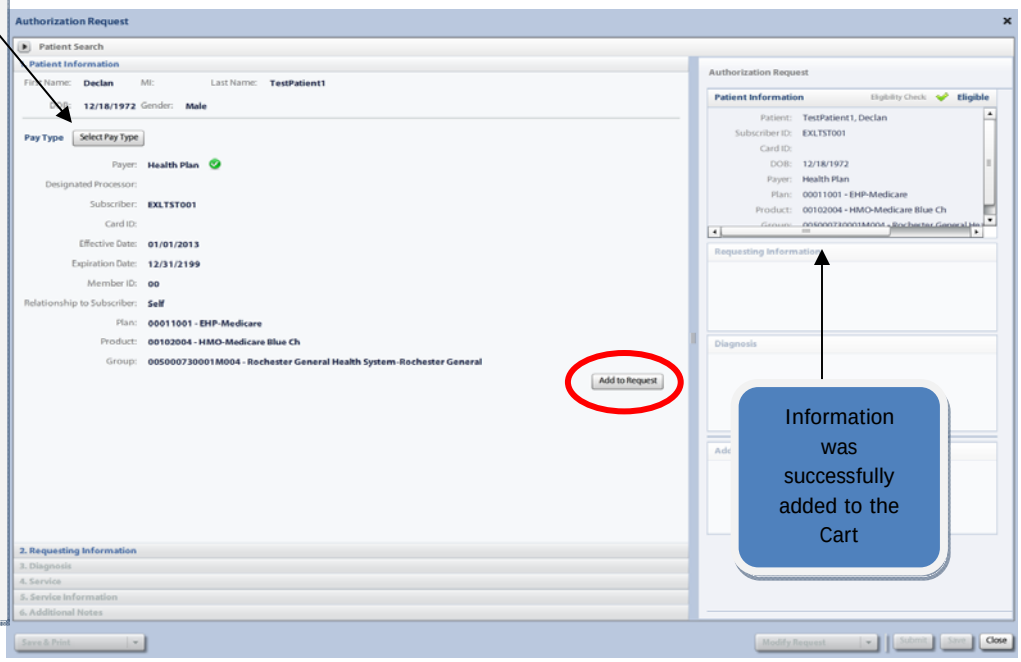
You must click **"Add to Request"** so that the information is added to the cart.

SELECT PAY 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.

The request for the second contract will always pend.



2. **Requesting Information** accordion - Complete required fields. *The facility name defaults to your group or individual provider name.

2A. The requesting clinician (the name of the physican who **requested/ordered** the service):

a) Click **"Select Other Clinician"**

b) Enter search criteria

c) Choose **"In-Plan"**

d) Click **"Search"**

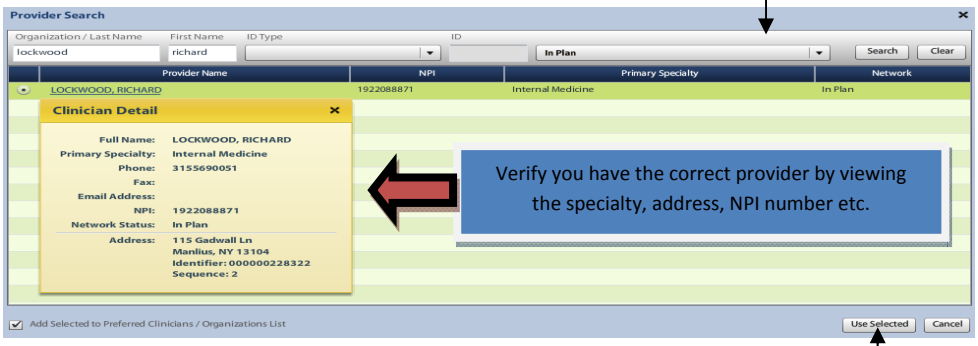
e) If the clinician name does not appear, click **"Clear"** and repeat the search

f) If the clinician name appears, select the clinician by clicking in the circle to the left of the name

g) You have the option of adding the selected clinician to the preferred clinician list by selecting the "**Add Selected to Preferred Clinician List**"

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

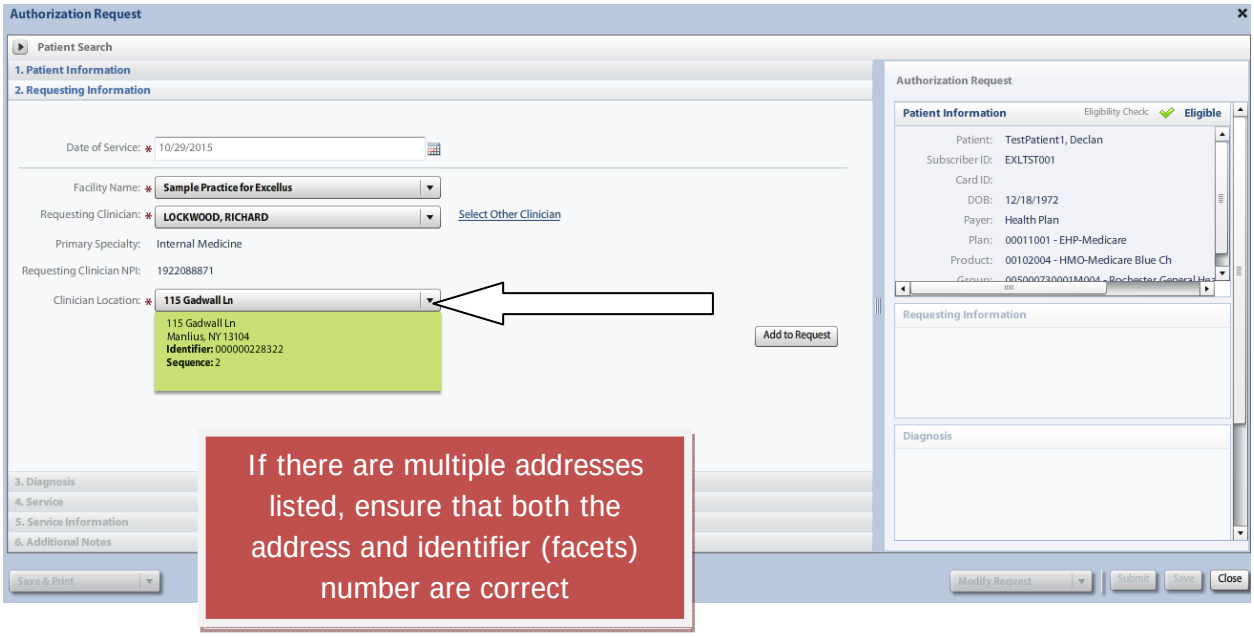
h) Verify that the correct provider has been selected. Clinician should be "in-plan". Verify specialty, NPI etc.



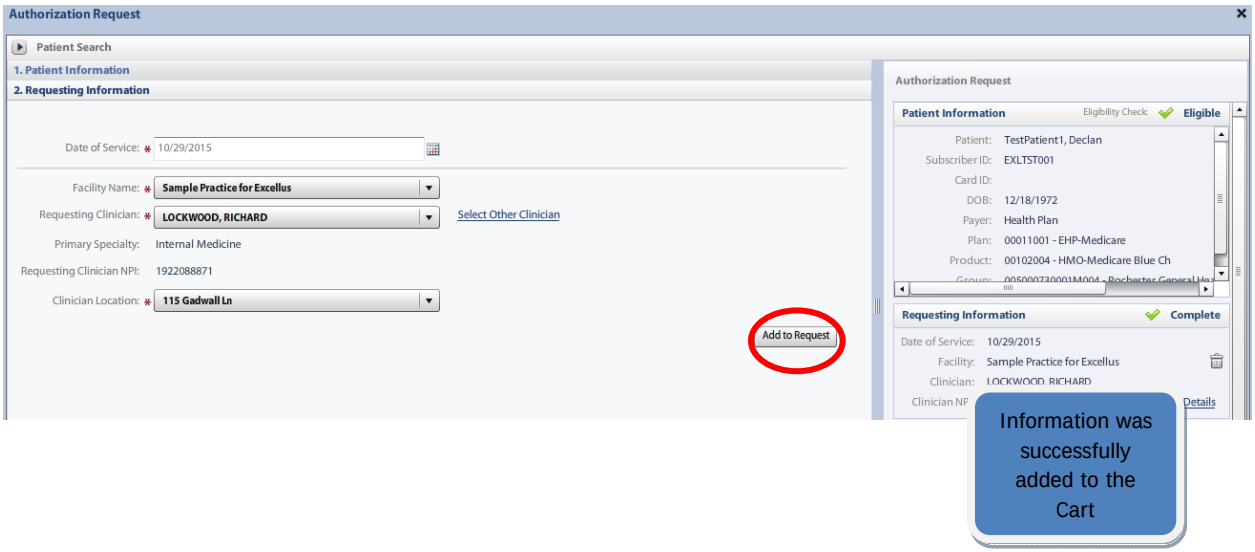
i) Click "**Use Selected**"

2B. Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

NOTE: There may be more than one "Sequence: 2" address. Scroll down as needed to ensure that you have chosen the correct address.



2C. Once all required field are completed, click "**Add to Request"**

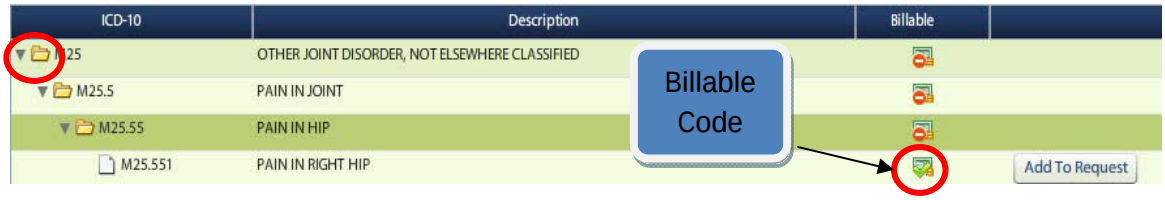


3. **Diagnosis** accordion:

You can enter the actual ICD 10 diagnosis code or the description. TIP: If code is known, please enter the actual code

Always add the primary diagnosis code first

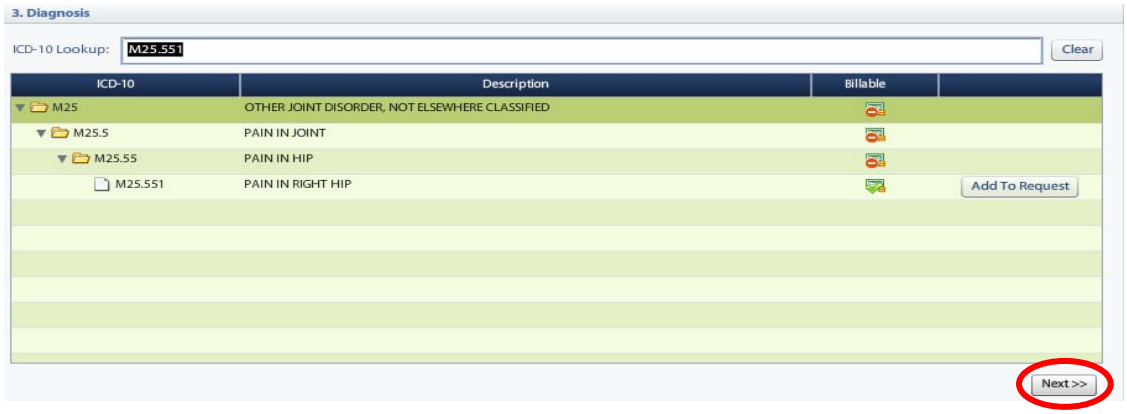
You must ensure that you choose a "billable" code. A billable code will have a green checkmark . If the code has a red line through it , it is not a billable code. Click on the icon to expand the section to search for a billable code:



3A. Click **"Add To Request"** to add the appropriate code

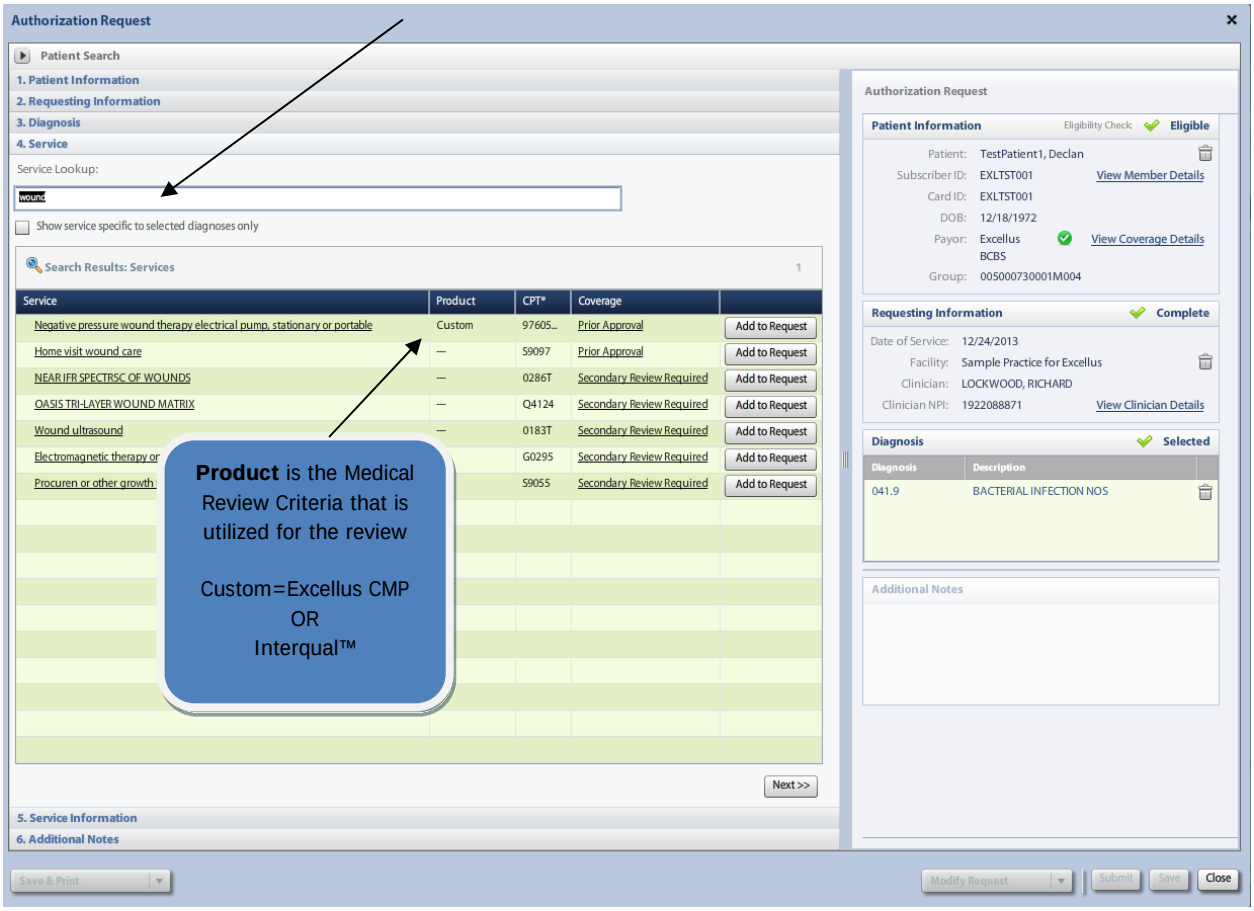
3B. Repeat step 3 to add additional codes (you can add a maximum of 4-four codes)

3C. Click **"Next"** to move to the next accordion when all codes have been added

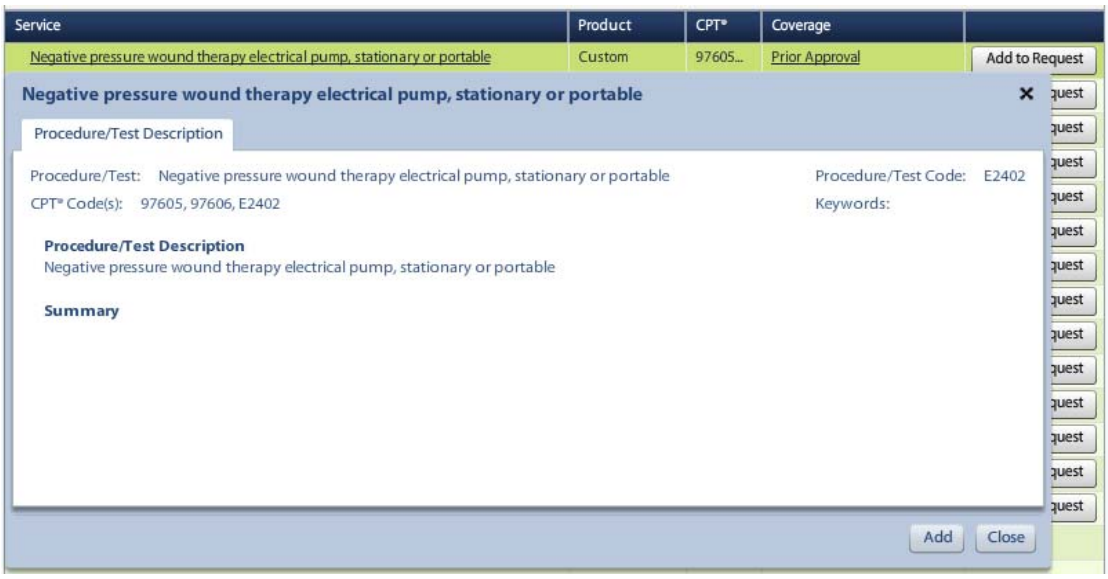


4. **Service** accordion:

4A. Search for the **Service** by CPT, HCPCS or description

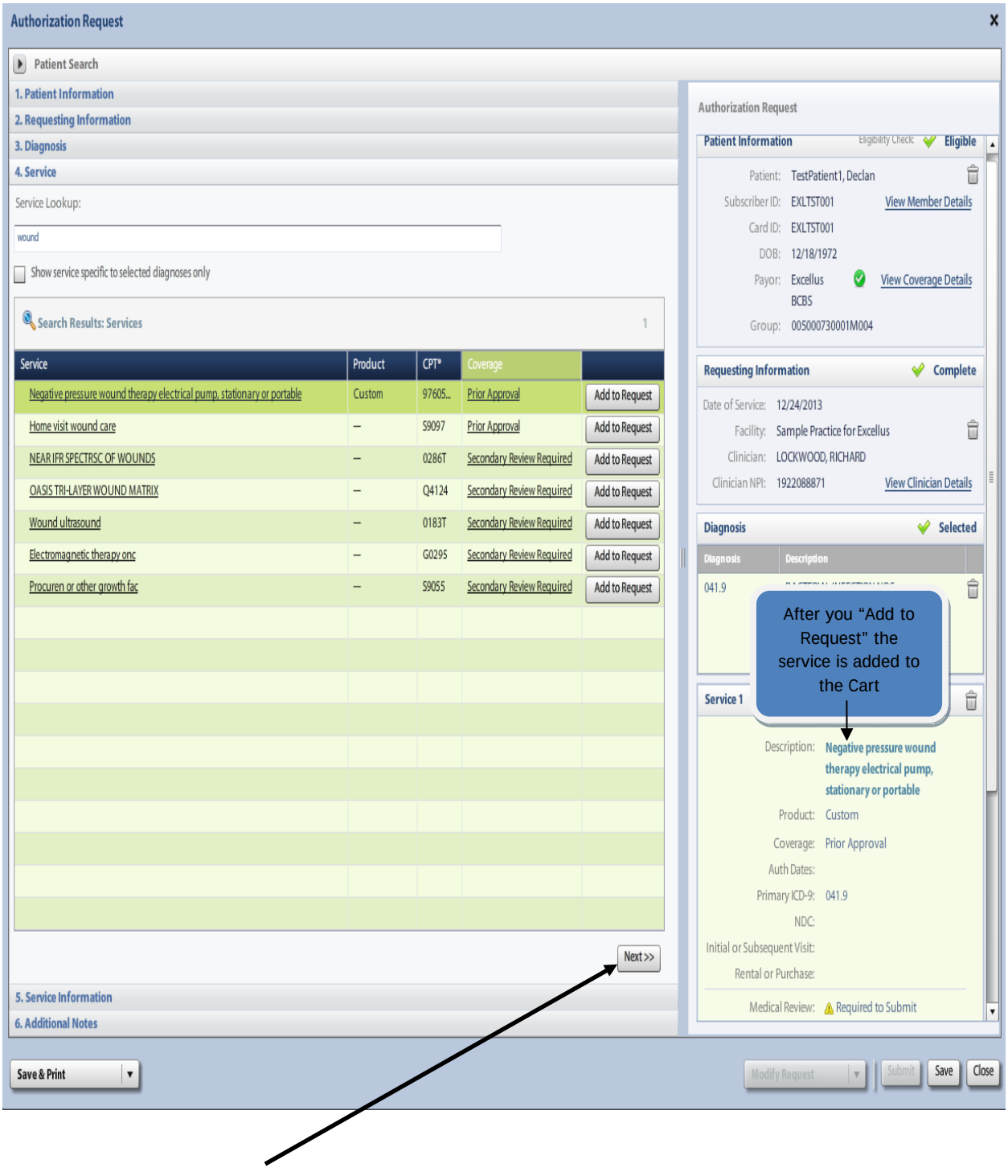


4B. Click on the service description to bring up details as needed



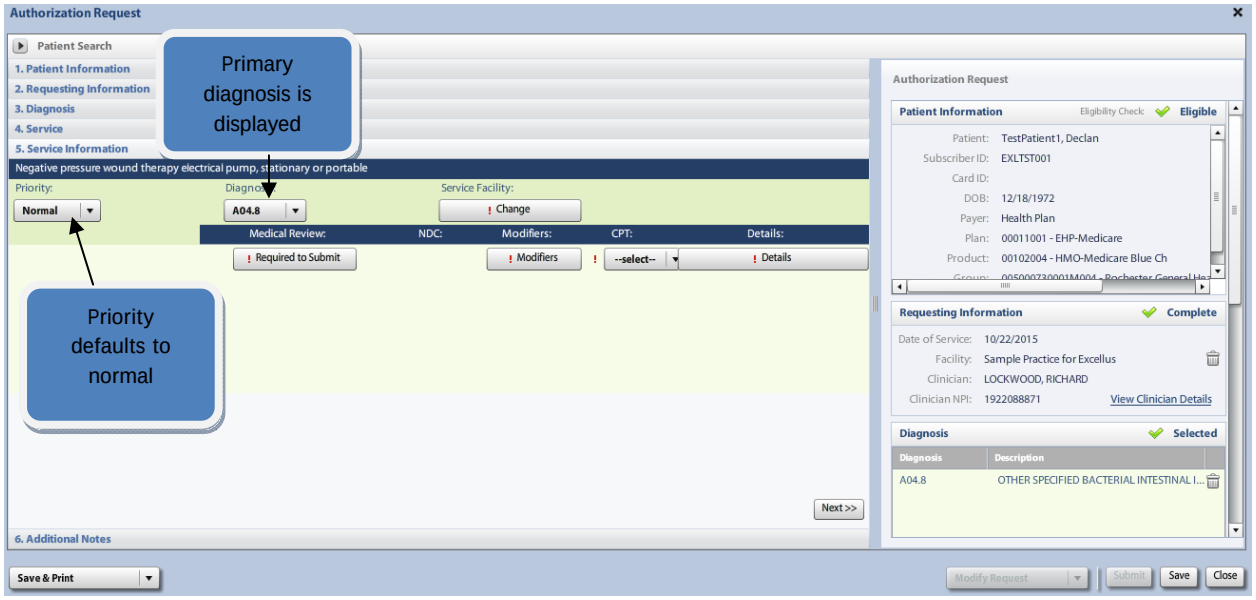
4C. Click "**Add to Request**"

You may add an unlimited number of codes from the **same service group**. Codes that are in different service groups require separate authorization requests



4D. Click the **"Next"** button

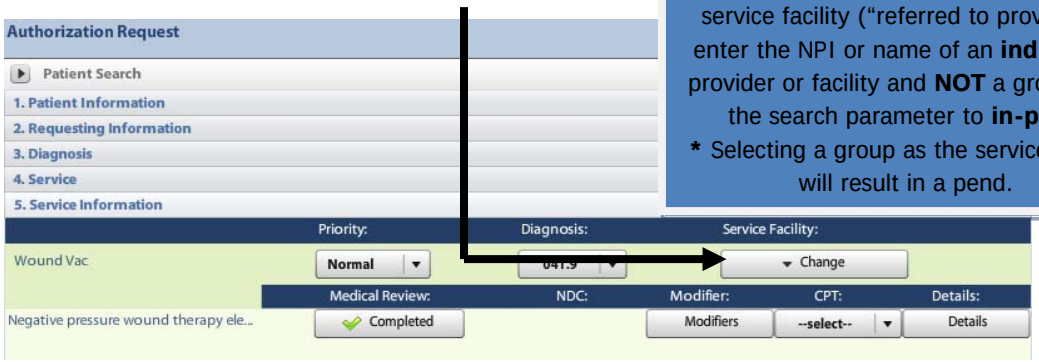
5. **Service Information** accordion (specifies information related to the service, such as the facility where the service will be performed, number of units/visits etc.)



5A. **Priority** – Defaults to "Normal" (if you change to urgent/emergent, rule will prevent submission. Please call Customer Care for any service that is urgent)

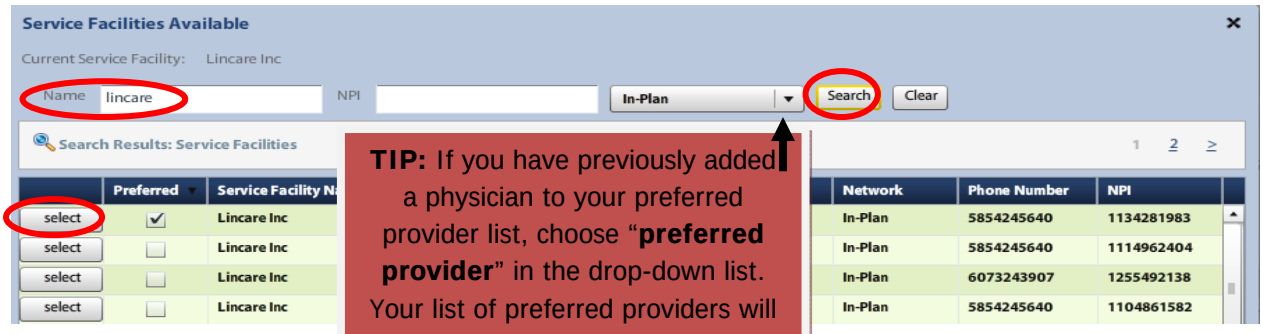
5B. Click on the **"Service Facility"** button

IMPORTANT NOTE:
When you conduct a search for the service facility ("referred to provider"), enter the NPI or name of an **individual** provider or facility and **NOT** a group. Set the search parameter to **in-plan.**
***** Selecting a group as the service facility will result in a pend.



5C. Type in name **OR** NPI number of the servicing facility/provider for an individual provider or facility

5D. Click the **"Search"** button

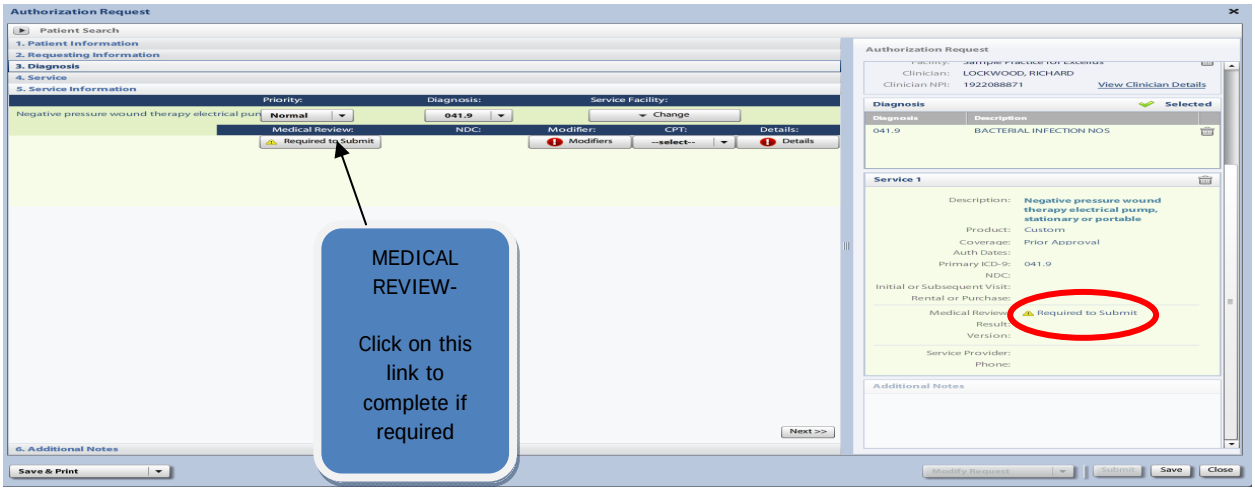


TIP: If you have previously added a physician to your preferred provider list, choose "**preferred provider**" in the drop-down list. Your list of preferred providers will then populate

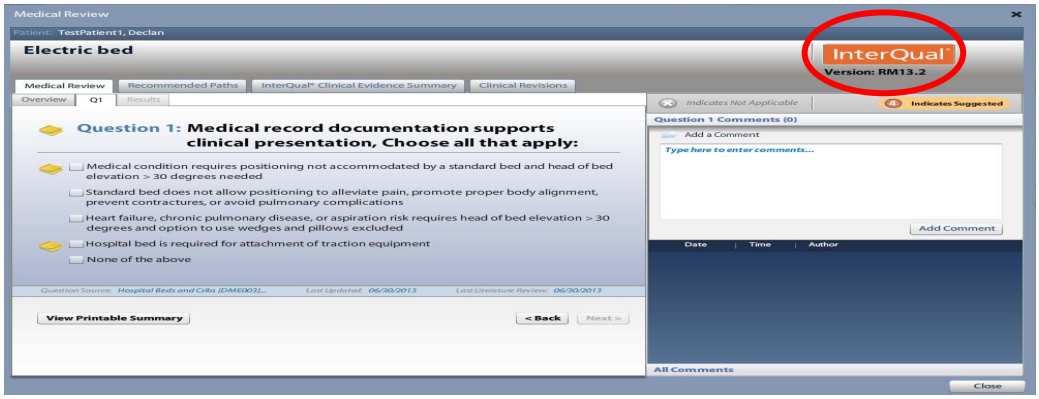
5E. Place a check in the correct facility/provider "preferred" box if you would like to add the user to the preferred list for future use (if it was not previously added). Then click the **"Select"** button

If you are selecting a facility for an inpatient procedure, ensure that the facility chosen has this symbol: I to the left of the Service Facility Name.

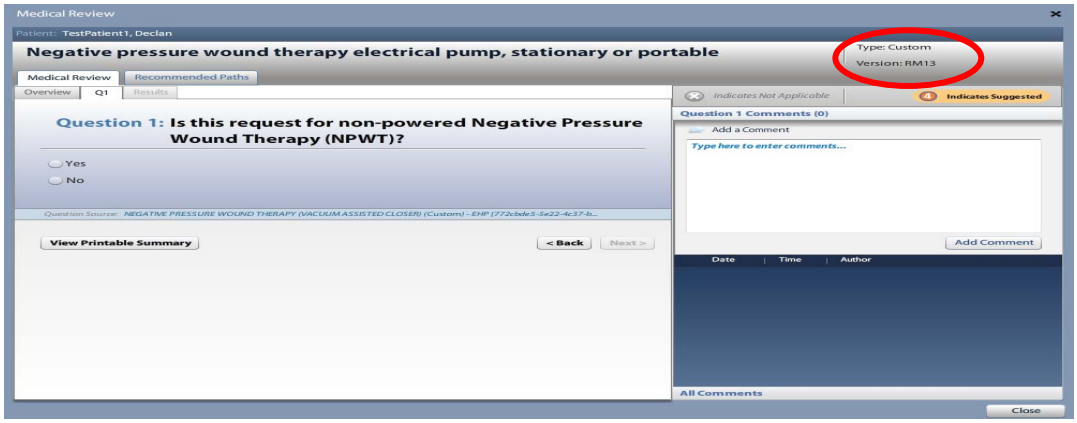
5F. **Medical Review** – Click on this link to complete the Medical Review. When required this launches a medical review in which InterQual® Criteria OR Excellus BCBS Corporate Medical Policy is used to assist in determining the medical appropriateness of the selected service. Follow prompts to complete the review.



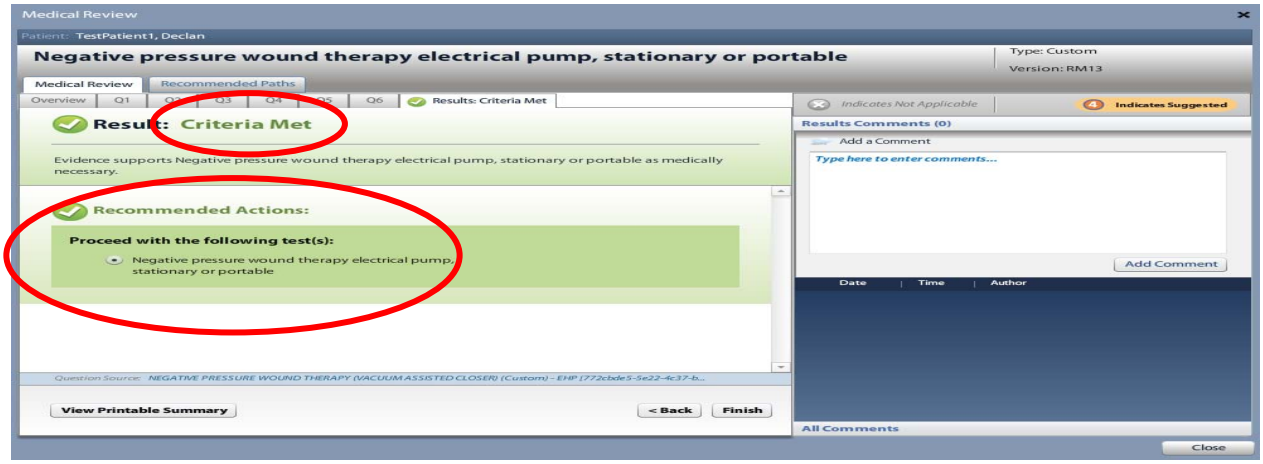
Example of **InterQual™** criteria review:



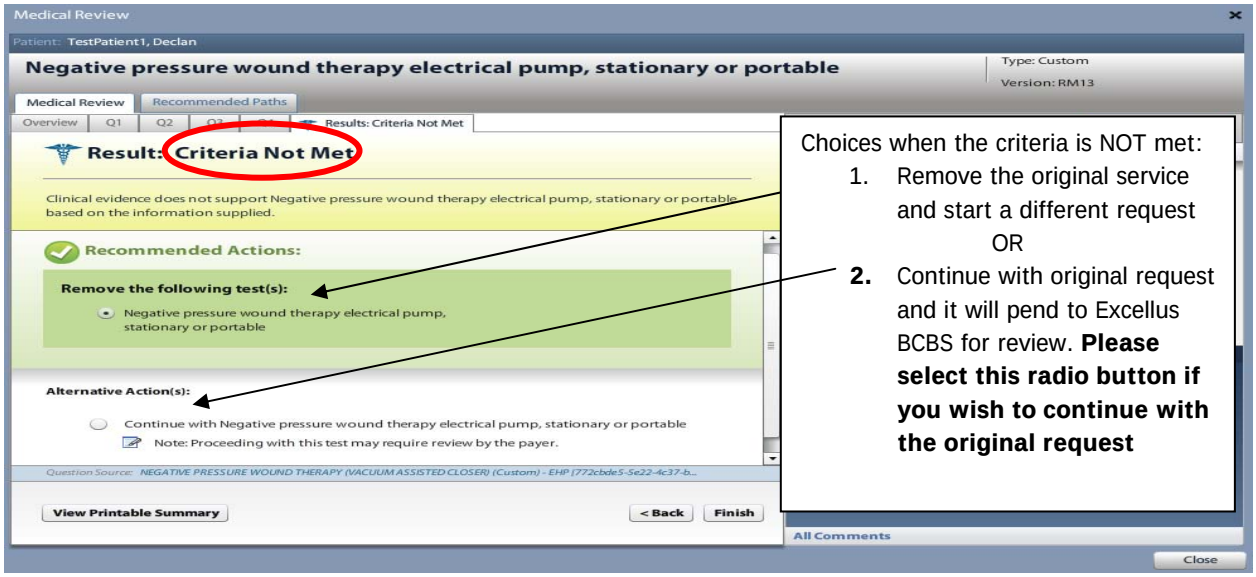
Example of an **Excellus BCBS Corporate Medical Policy** criteria review:



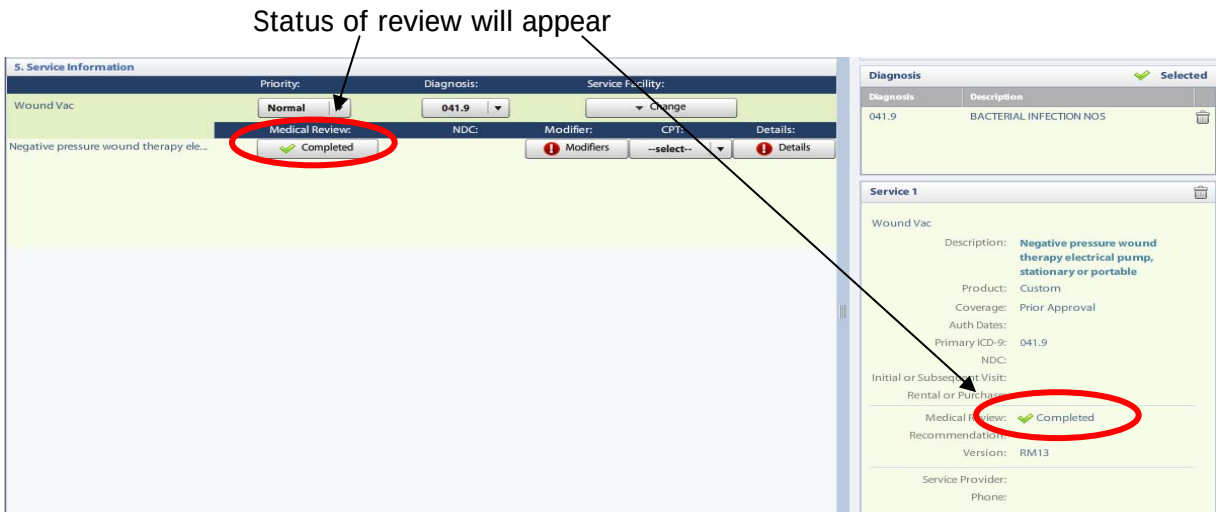
The Interqual™ and Excellus BCBS Corporate Medical Policy reviews will produce results with either "**Criteria Met"**;



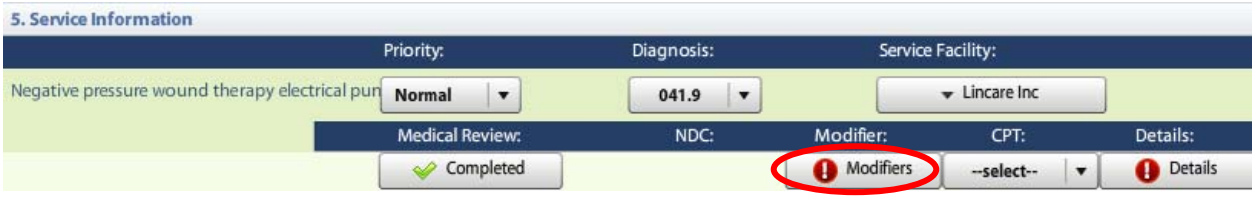
Or **"Criteria Not Met";** (if criteria is not met, you may receive a suggestion):



5G. Click **"Finish"**



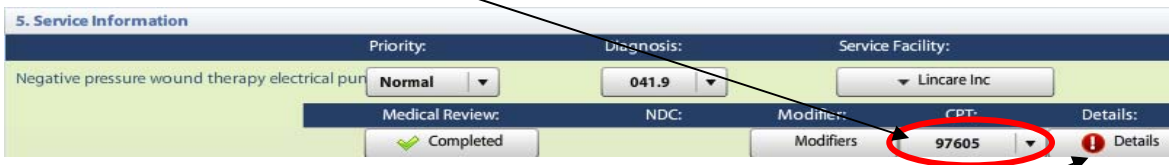
5H. Click the **"Modifiers"** button, if applicable



5I. Select appropriate drop down choices, if applicable

5J. Click "**OK"**

5K. Select the correct CPT, if applicable:

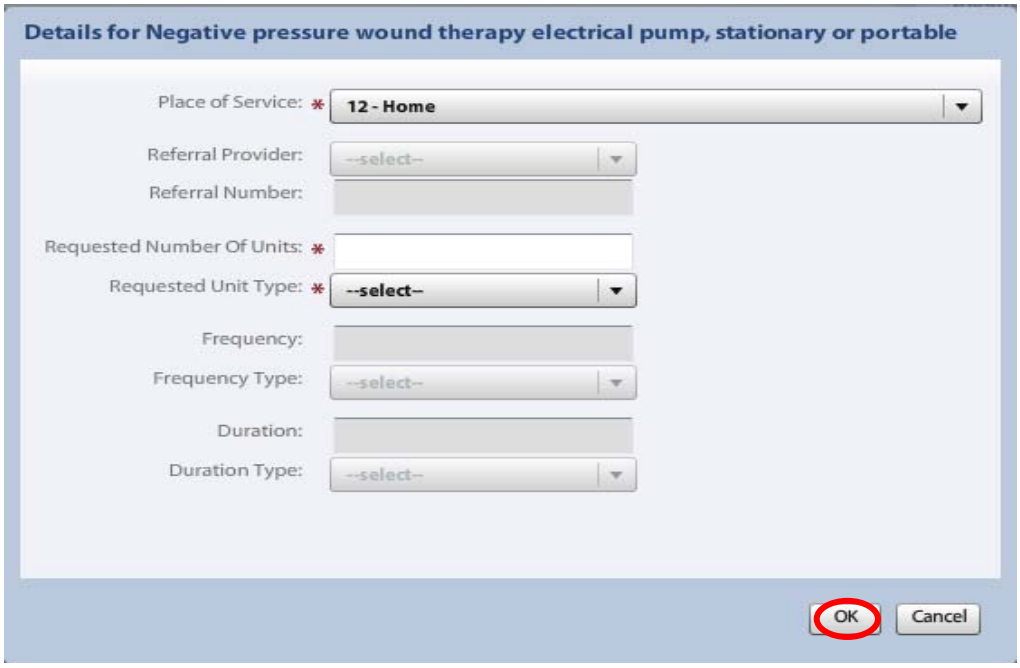


5L. Click on **"Details"** button

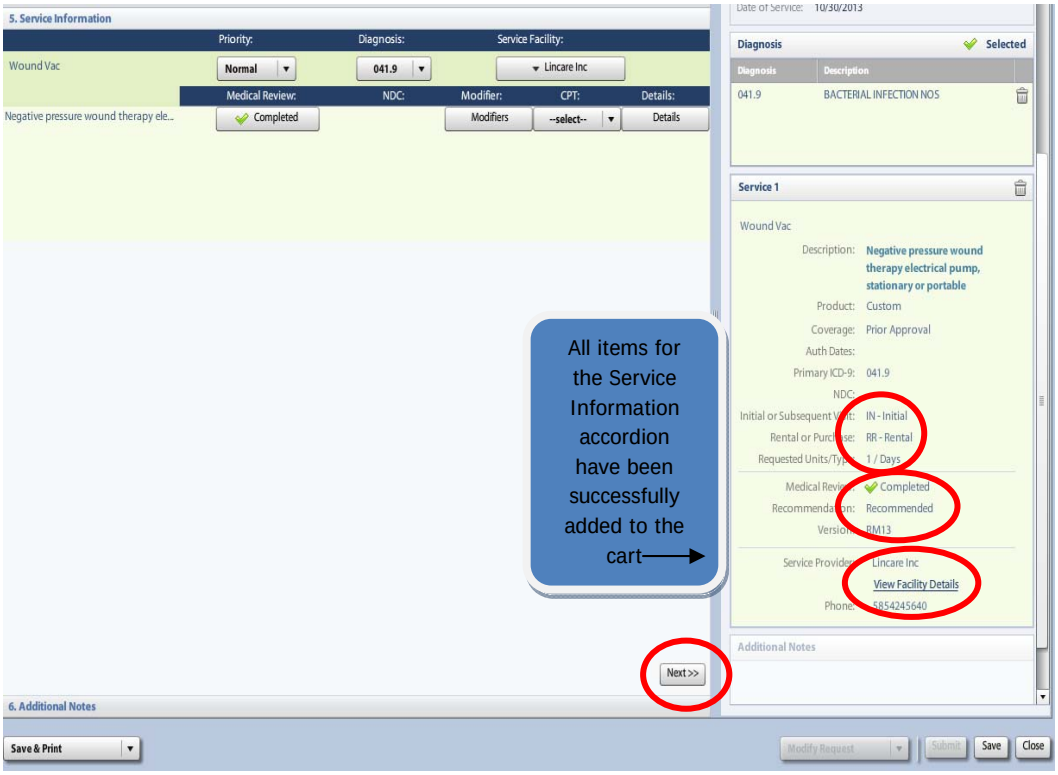
This is where you will identify the place of service, units requested and the unit type (e.g., units, visits, days, hours, months)

5M. Make appropriate selections

5N. Click **"OK"**



5O. Click the **"Next"** button

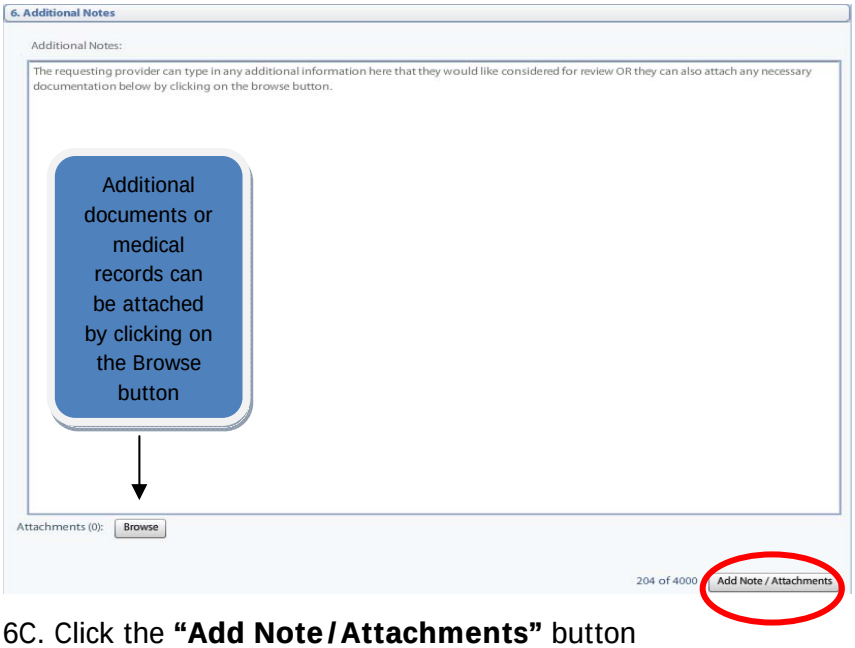


6. **Additional Notes** accordion - you can add additional information in the form of notes and/or attach documents that support the authorization request.

6A. Type free text note in the free text field

And/or:

6B. Click the **"Browse"** button to add attachments as needed

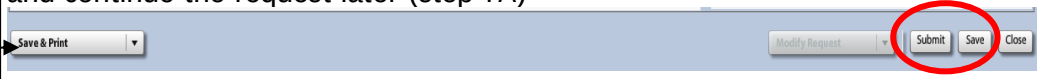


6C. Click the **"Add Note/Attachments"** button

7. Click the **"Submit"** button (bottom ride side of page)

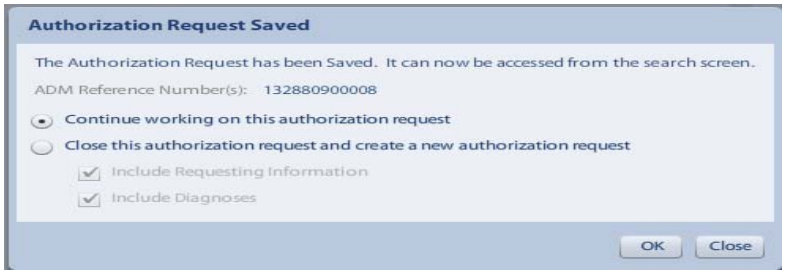
If you select "save and print", this does NOT mean the request has been "submitted"

If you are not ready to submit the request, you can click the **"Save" button and continue the request later (step 7A)



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.

7A. If you click "**Save**" (instead of submit), the options are as follows:

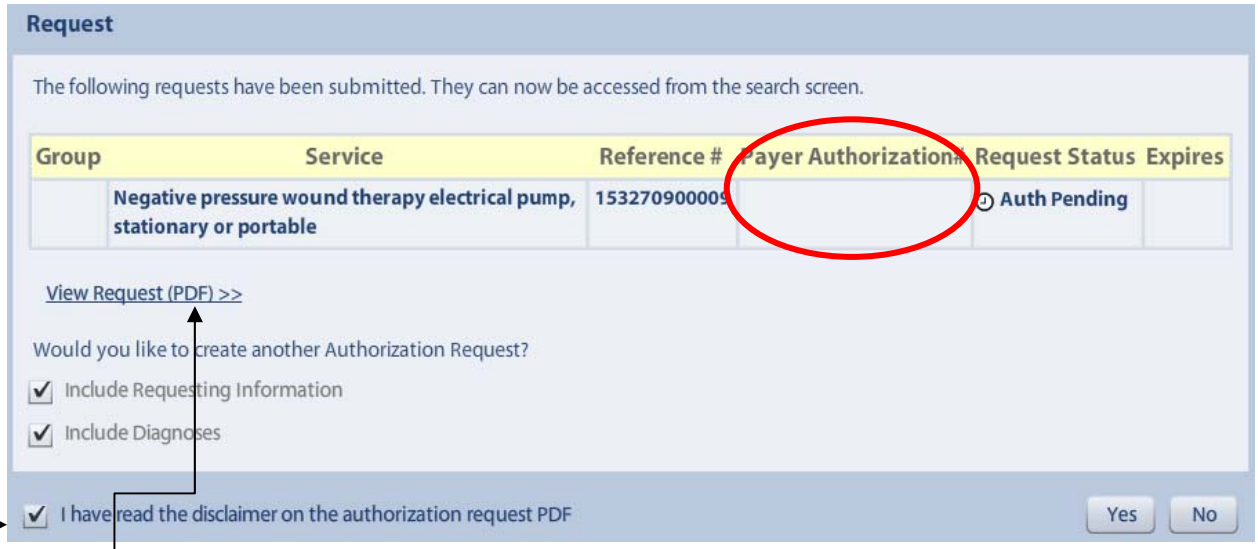


8. Add a phone number (name auto populates) and click the **"Submit"** button

This information box will appear. If the request is auto-approved, the reference number AND the payer authorization number will appear.

Click on **"View Request"** for a summary of the authorization and to read the disclaimer statement. The summary can be printed or saved electronically in the patient's medical record.

The payer authorization number field will be blank if the request was pended to Excellus BCBS.



9. Click **"View Request (PDF)>>"** to read the payment disclaimer and to view and/or save a copy of the authorization request
10. Click **"I have read the disclaimer on the authorization request PDF"**
11. Click "**NO"** if you have finished entering authorizations for **THIS** patient.

If you have additional authorization requests to enter for **THIS** patient, put a check mark in the appropriate boxes on the left-hand side of the box and then click the "**YES"** button

If the request was for an elective inpatient surgey AND the auth was approved, two (2) authorization numbers will be generated. One auth is for the procedure and one authorization is for the inpatient stay.

The authorization request process is now complete. If the request was pended, you must monitor the home page or the patient's individual 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.). The provider will also receive a letter in the mail and verbal notification if the authorization was approved or denied.

Search Results: Activities

1 2 3 4 5 >

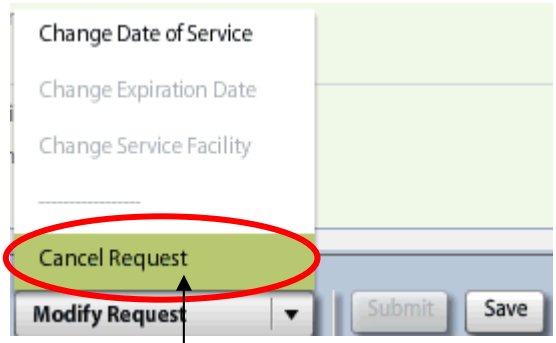
	Reference #	Payer Assigned #	Status	Activity	Activity Date	Date of Service	Patient	Requesting Clinician
Detail	132880900008		Auth Pending	Requester Added Note	Tue Oct 15 13:17:55 G	Wed Oct 30 00:	TestPatient1, Declan	MOORE, NATHAN
Detail	132880900008		Auth Pending	Requester Added Note	Tue Oct 15 13:17:55 G	Wed Oct 30 00:	TestPatient1, Declan	MOORE, NATHAN
Detail	132880900008		Auth Pending	Requester Added Note	Tue Oct 15 13:17:55 G	Wed Oct 30 00:	TestPatient1, Declan	MOORE, NATHAN
Detail	132880900008		Auth Pending	Submitted Auth (Auto-Pended)	Tue Oct 15 13:17:55 G	Wed Oct 30 00:	TestPatient1, Declan	MOORE, NATHAN

Once an authorization request has been submitted, the provider can-not change the servicing provider. If a change needs to be made, please call Customer Care.

CANCELLING A REQUEST

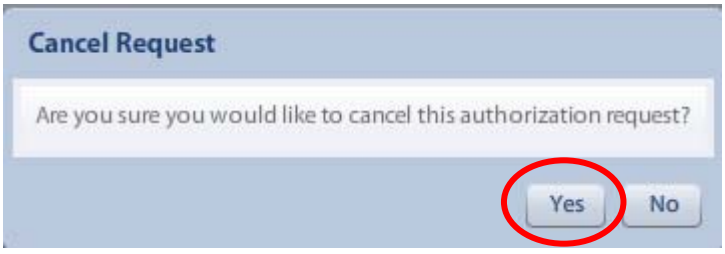
1. Locate the authorization (conduct authorization search)
2. Click on **"Detail"** button

3. Click on **"Modify Request"** (bottom right side of screen)

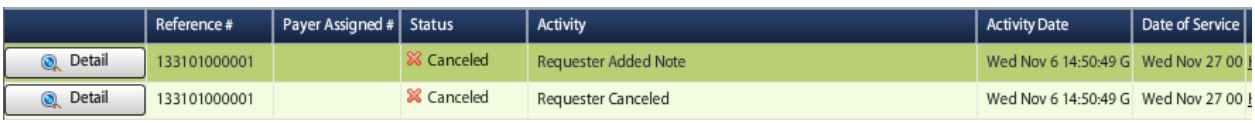


4. Click **"Cancel Request"**

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



6. The request has been cancelled and the status is automatically updated on the home page



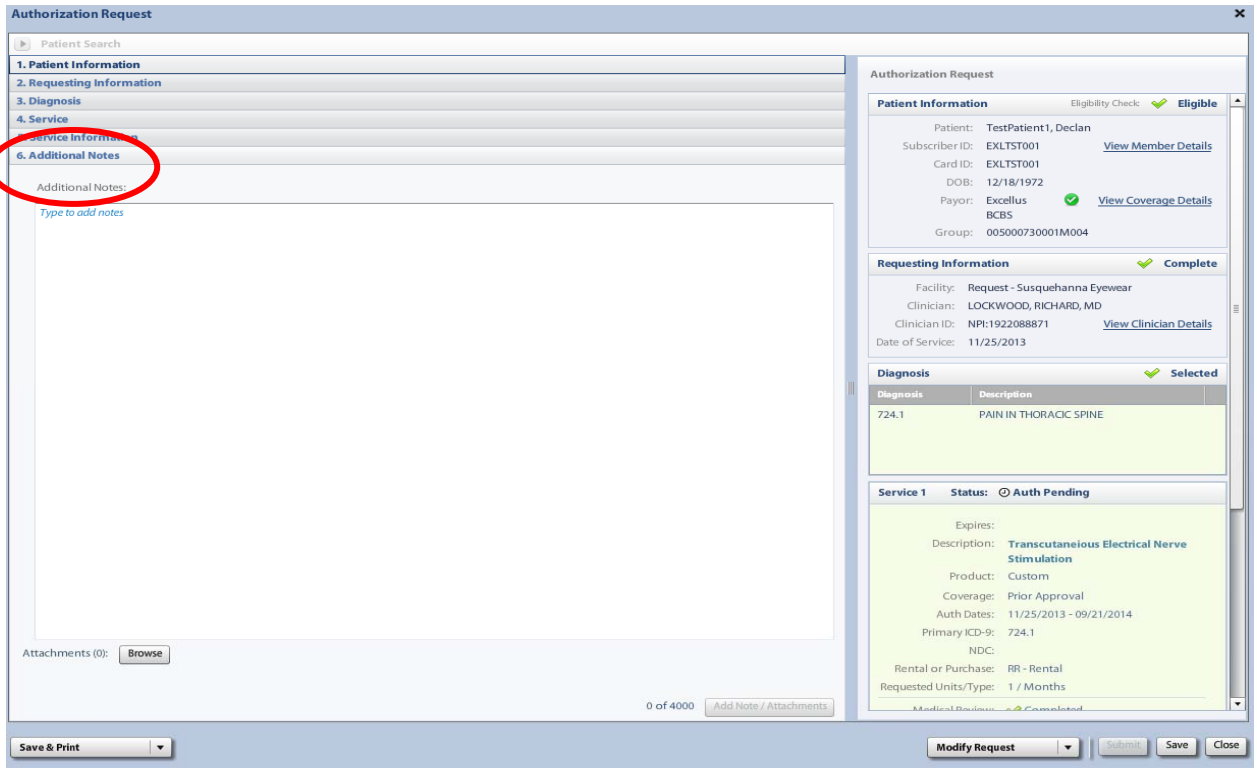
NOTES

REQUESTING ADDITIONAL VISITS

If you need to request additional units or visits on a **previously approved Clear Coverage™** authorization:

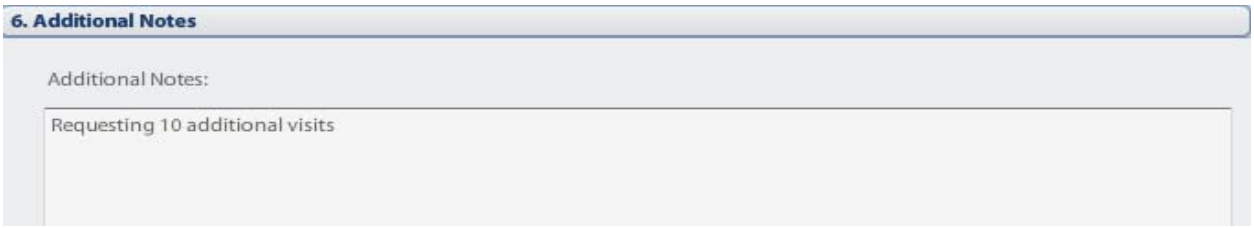
1. Locate authorization by conducting authorization search
2. Click on **"Detail"** button

3. Click on the **"Additional Notes"** accordion



4. Insert cursor into the free text field and type "Requesting (insert # of visits) additional visits"

Please be sure to include how many additional visits you are requesting



5. Click the **"Browse"** button to attach supporting documentation, if applicable

6. Click the **"Add Note/Attachment"** button

7. Click **"Save"** (bottom right of screen)

Request for additional visits will be sent to Excellus BCBS for review.

The original status of the note will remain as approved, so you'll have to monitor the home page for "payer added note". Once the "payer added note" appears, you can open the authorization to determine the new status of the request for additional visits.

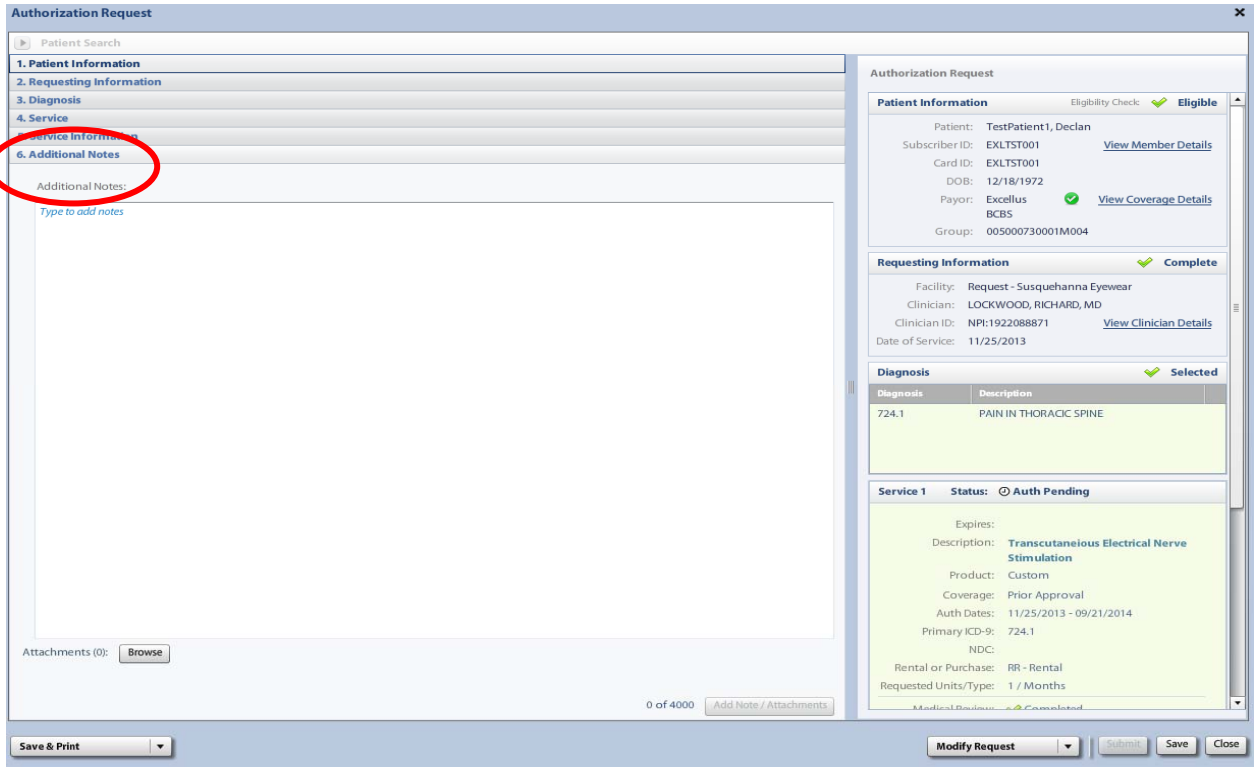
Excellus BCBS will also notifiy the provider via written and verbal notification.

REQUESTING DATE OF SERVICE CHANGE

If you need to change a date of service on a **previously approved Clear Coverage™** authorization:

1. Locate authorization by conducting authorization search
2. Click on **"Detail"** button

3. Click on the **"Additional Notes"** accordion



4. Insert cursor into the free text field and type "Requesting date of service change. Change date of service from_____ to _____"

Please be sure to include the new date of service

5. Click the **"Add Note/Attachment"** button

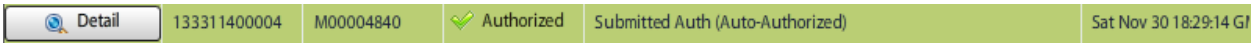
6. Click **"Save"** (bottom right of screen)

Request for date of service change will be sent to Excellus BCBS.

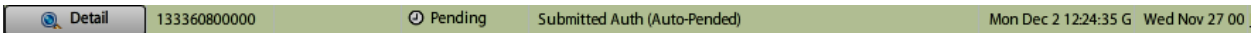
Excellus BCBS will update the authorization to the new date.

HOME PAGE ACTIVITY DESCRIPTIONS

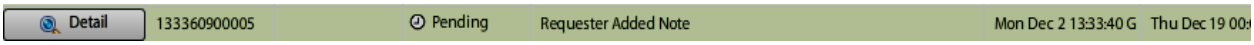
- Submitted Auth (**Auto Authorized**) - Authorization was submitted successfully and was **Auto Authorized** so no review was required by Excellus BCBS



- Submitted Auth (**Auto Pended**) - Authorization was submitted successfully but is **Pended** for Medical Necessity review by Excellus BCBS



- Requester Added Note – **Provider** added a note to the authorization request

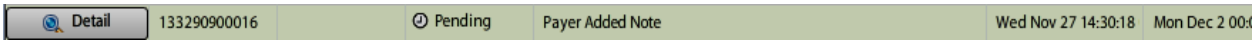


To view the note:

a. Click on the Details tab
b. Open the authorization
c. Scroll down to the "Additional Notes" notes section (bottom right side) to review the note

- Requester Cancelled – **Provider** cancelled the initial authorization request

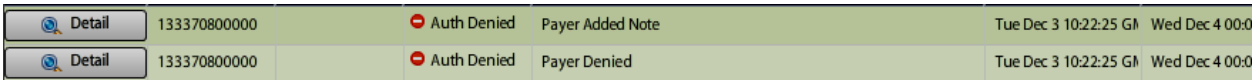
- Payer Added Note - Note was added to the request by Excellus BCBS for the **Provider to review**



To view the note:

a. Click on the Details tab
b. Open the authorization
c. Scroll down to the "Additional Notes" section to review the note

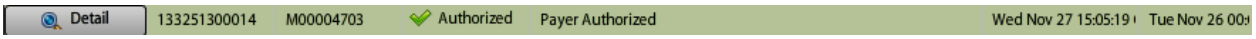
- Payer Denied - Status that is returned to the provider when Excellus BCBS **denies** the authorization request. Excellus BCBS may also add a note describing the reason for denial



To view the note:

a. Click on the Details tab
b. Open the authorization
c. Scroll down to the "Additional Notes" section to review the note

- Payer Authorized - Status that is returned to the provider when Excellus BCBS **approves** the authorization request

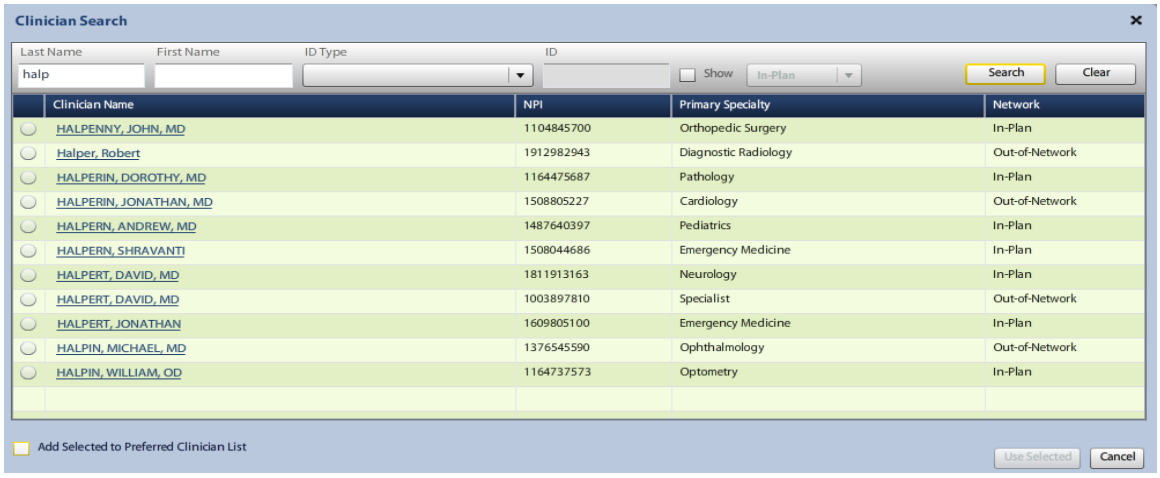


TIPS

- Click on the **"Save"** button often in the event that the system is idle for an extended period. Your request will be saved and the request process will not have to start over
- Always check patient's eligibility and benefits in the provider portal ***PRIOR*** to accessing Clear Coverage™
- Underlined fields can be selected to obtain additional information:

- Trash can that is located within the "cart" can be used to delete unnecessary or incorrect items:

- Ensure that the correct provider is chosen. This is imperative for claim payment. Double-check that you have the correct NPI, specialty etc.:



NOTES

CLEAR COVERAGE FAQ's

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 the 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 Customer Care.

6. **If the patient appears to have multiple coverage in Clear Coverage™ under the Patient Information accordion (pay type), which coverage do I select?**
   You should select the coverage that corresponds to the information on the ID card that the patient presented. Secondary contracts that require preauthorization will require you to enter a separate authorization request. Secondary contract requests will always pend for review. Please include the authorization number obtained from the primary request.

Clinical Information

7. **If a non-clinical person enters the initial information (patient, provider, diagnosis, type of service) and saves it, can the person completing the medical review update the diagnosis and service 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 notes, upload clinical information or cancel the request.

Workflow/Processes

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

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

10. **What happens if a patient has called prior to "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. **If I am entering an authorization request for a provider, but a different provider displays on the provider screen, can I change the provider?**
    Yes, you will want to select the correct ordering provider.

13. **How do I search for an alternate provider?**
    On the provider screen, click on the "Select Other Clinician" button. Select Other Clinician

14. **Can an authorization be entered retrospectively?**
    Yes. Authorizations may be entered retrospectively. The time frame for retrospective entries is five calendar days. If the procedure has been performed and it has been longer than five calendar days, please submit the claim for a retrospective review.

15. **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.

16. **How many diagnosis codes do I need to enter?**
    You must enter a minimum of one diagnosis code for an authorization. You can add up to 4-four diagnosis codes and have the ability to indicate the primary diagnosis code for a service.

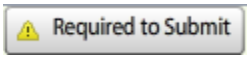
17. **In Clear Coverage™, what is the function of the trash can next to the service requested?**
    Clicking on the trash can will remove the item from the cart. For example, if you entered an incorrect diagnosis, click on the trash can to remove this diagnosis from the cart.

18. **If there is already an existing authorized service in Clear Coverage™, can I add additional units/visits to that authorization or make changes to dates of service or providers?**
    Yes, you can add additional units (visits, days, etc.) to an already authorized service. The request will pend to Excellus BCBS for review. Follow the designated workflow process for adding additional visits/units to a request.
    You can not change service dates or providers on authorizations once they have been submitted, but you can submit a note within the original authorization and Excellus BCBS will change the date of service for you.

19. **What if I have an urgent request? Can I enter that into Clear Coverage™?**
    Clear Coverage™ does not accept urgent authorization requests. All urgent requests must be made directly to Excellus BCBS.

Service Folder

20. **If I have multiple authorization requests for the same patient, do I need to enter these separately?**
    Multiple requests can be made on one authorization when the services requested are all from the **same service group**. (e.g., a wheelchair with multiple parts). Multiple requests cannot be made on one authorization for services from multiple service groups (e.g., a wheelchair cannot be requested on the same authorization as a surgical procedure).

21. **What does the "Required to Submit" button** 

require me to do?
    It requires you to answer the clinical questions associated with the medical review for the requested procedure or service.

22. **If I make an error when answering a clinical review question can I go back and re-answer the questions?**
    Yes, you are able to change your responses, but the request may pend for Excellus BCBS review.

23. **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 (for approvals, denials and pends) and will also receive a call (for approvals and denials). The provider may also check the status and/or activity column on the Clear Coverage™ home page for *a real-time decision*.

24. **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.

25. **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

26. **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.

27. **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" or "Requires Health Plan Review" message. Providing supporting clinical information for the request will facilitate Excellus BCBS's review of the request.

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

29. **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.

30. **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

31. **Who can I call with questions?**
    Customer Care 1-800-926-2357