CLEAR COVERAGE AUTHORIZATION TIP SHEETS

Click on the link below to access the tip sheet.

Bariatric Surgery

Blepharoplasty

Bone Growth Stimulator

CPAP/BIPAP (initial authorization)

CPAP/BiPAP (extension of initial authorization)

Hip/Knee Replacement

Home Care

Hysterectomy

Medical Specialty Drug

Physical Therapy

Specialty Referral Requests

Spine Surgery

TENS Unit

Varicose Vein

Wheelchair

Clear Coverage™
Bariatric Authorization Entry Tips

Medicare: review tool MUST be completed to provide clinical information to the Health Plan. Medicare requests will pend until this information is reviewed.

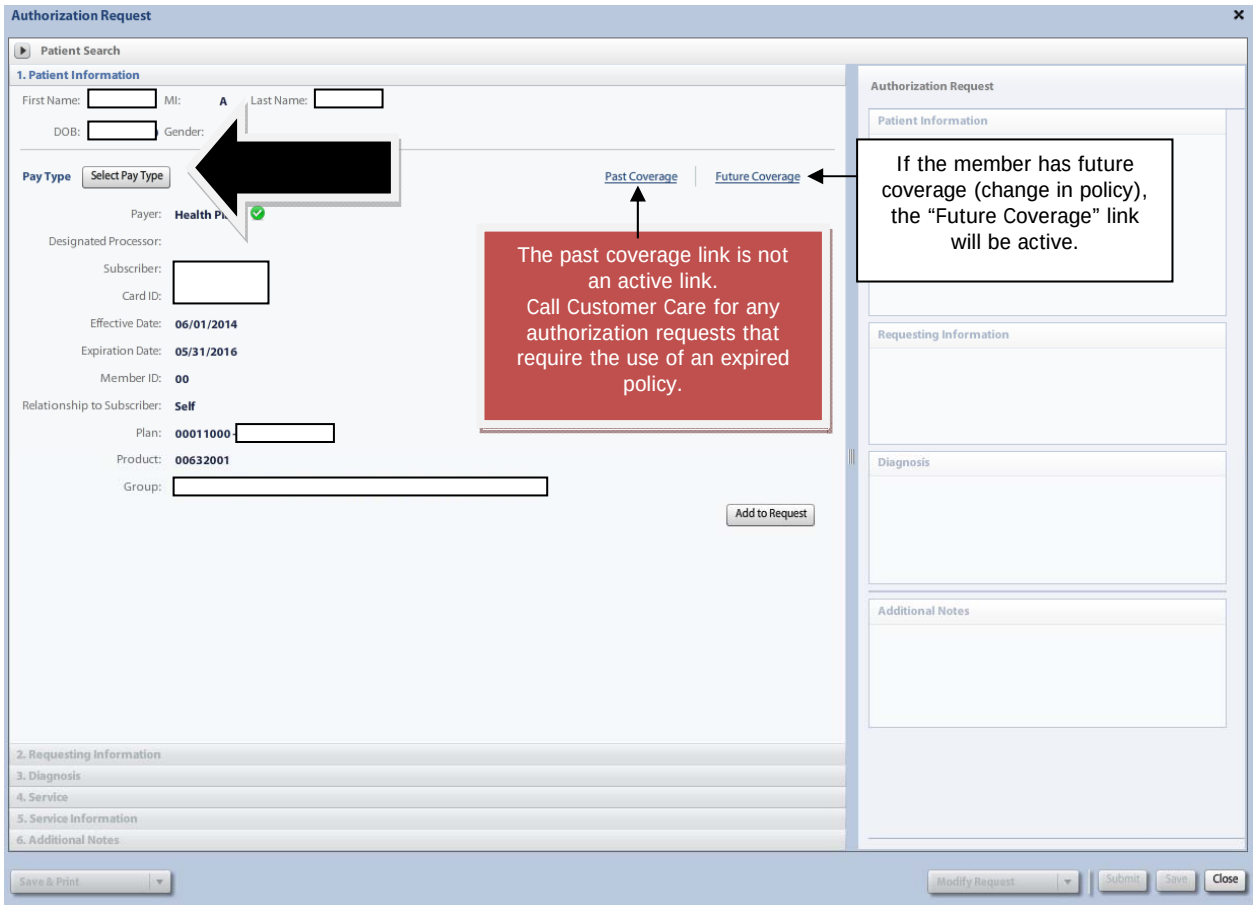
Commercial: will auto approve if criteria is met.

NOTE: If the request pends, the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

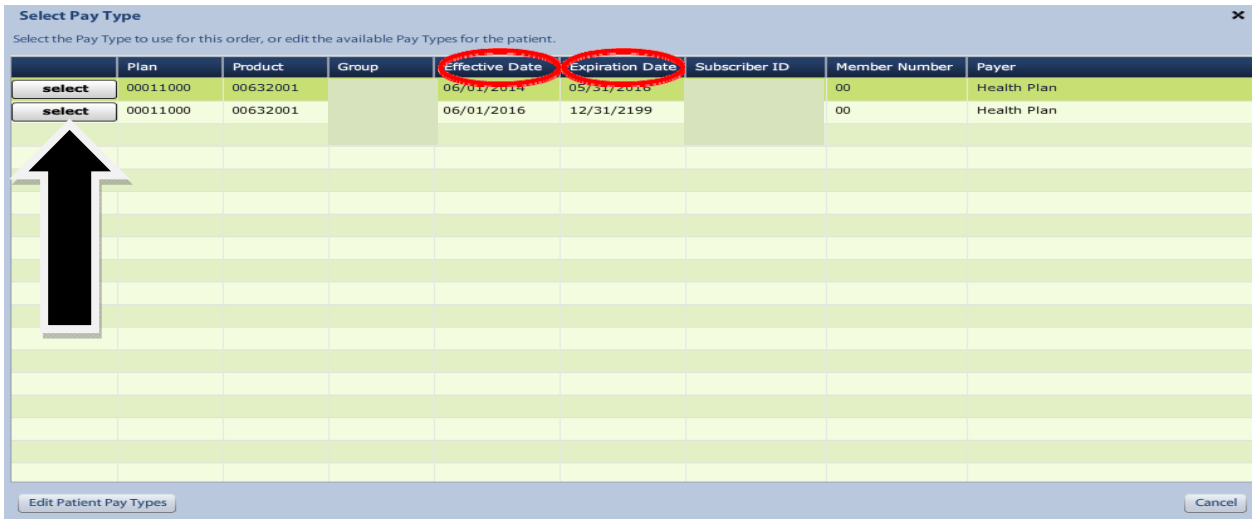


Clear Coverage™
Bariatric Authorization Entry Tips

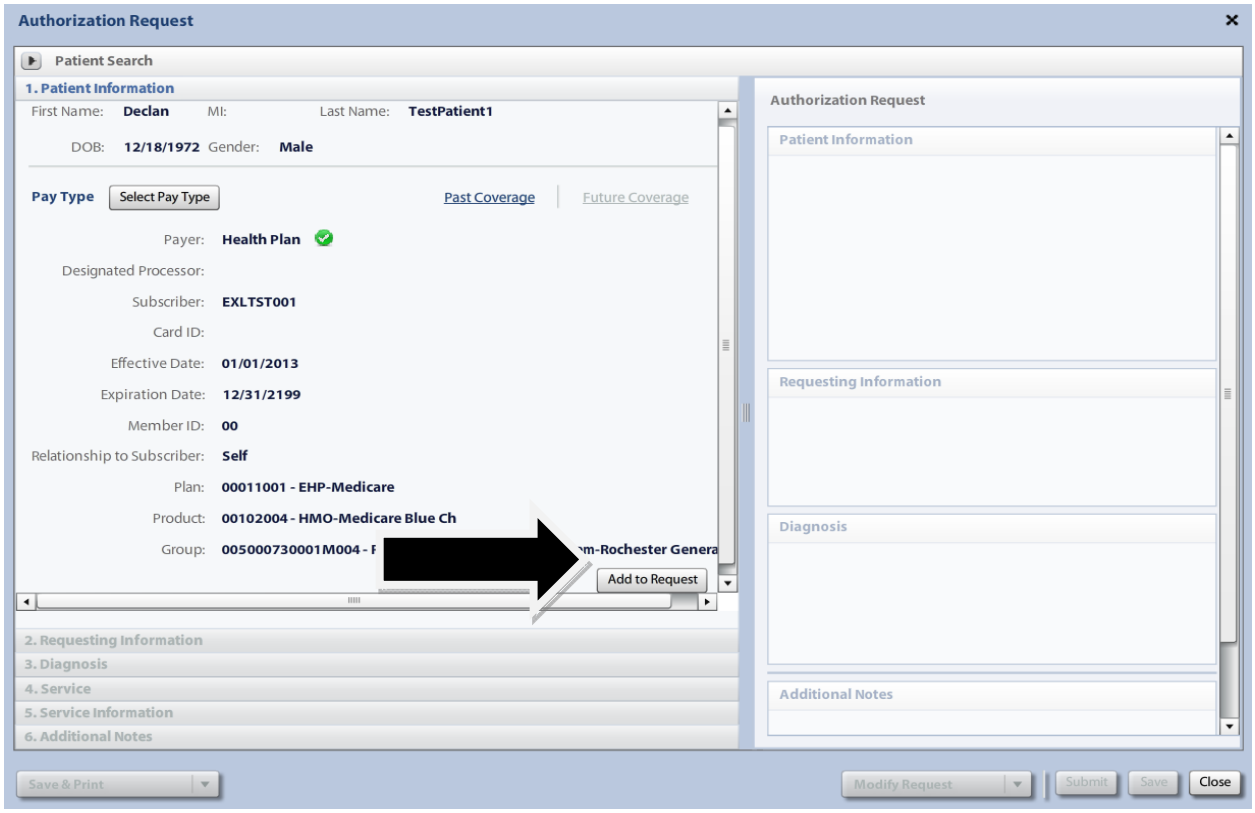
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

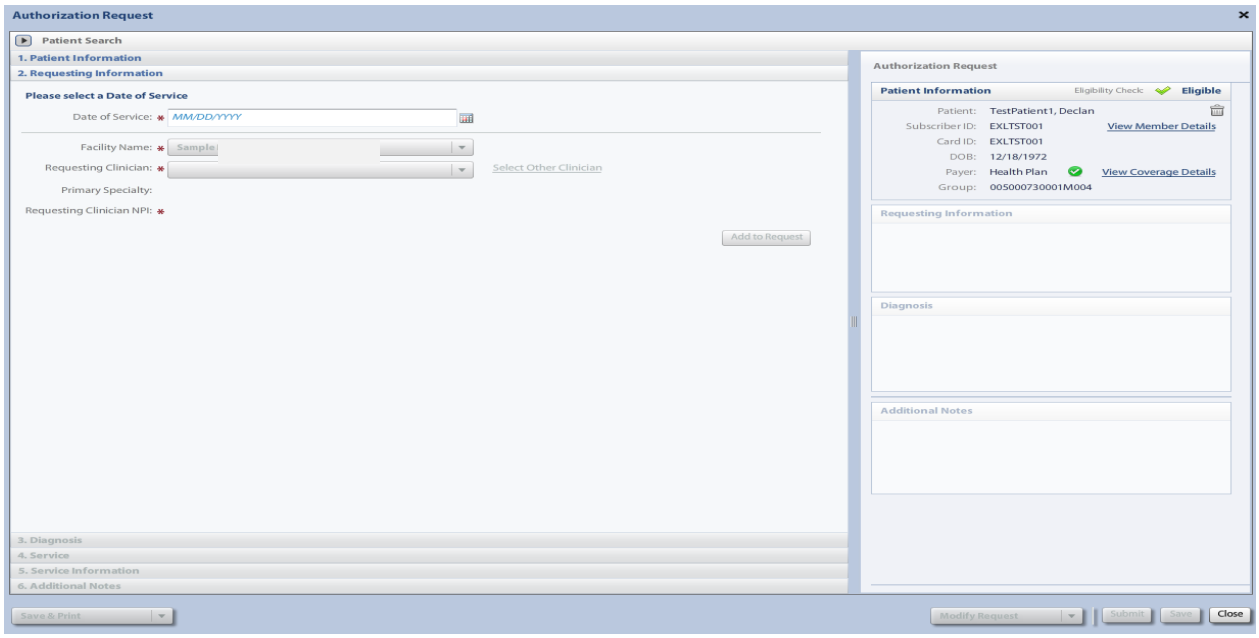


Clear Coverage™
Bariatric Authorization Entry Tips

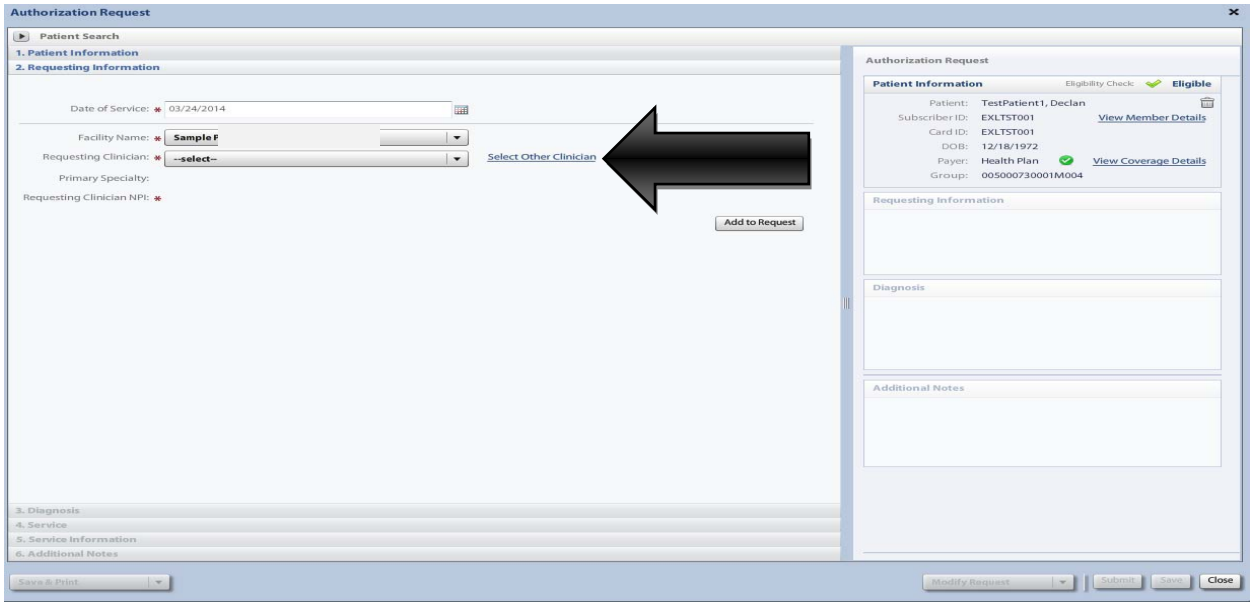
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

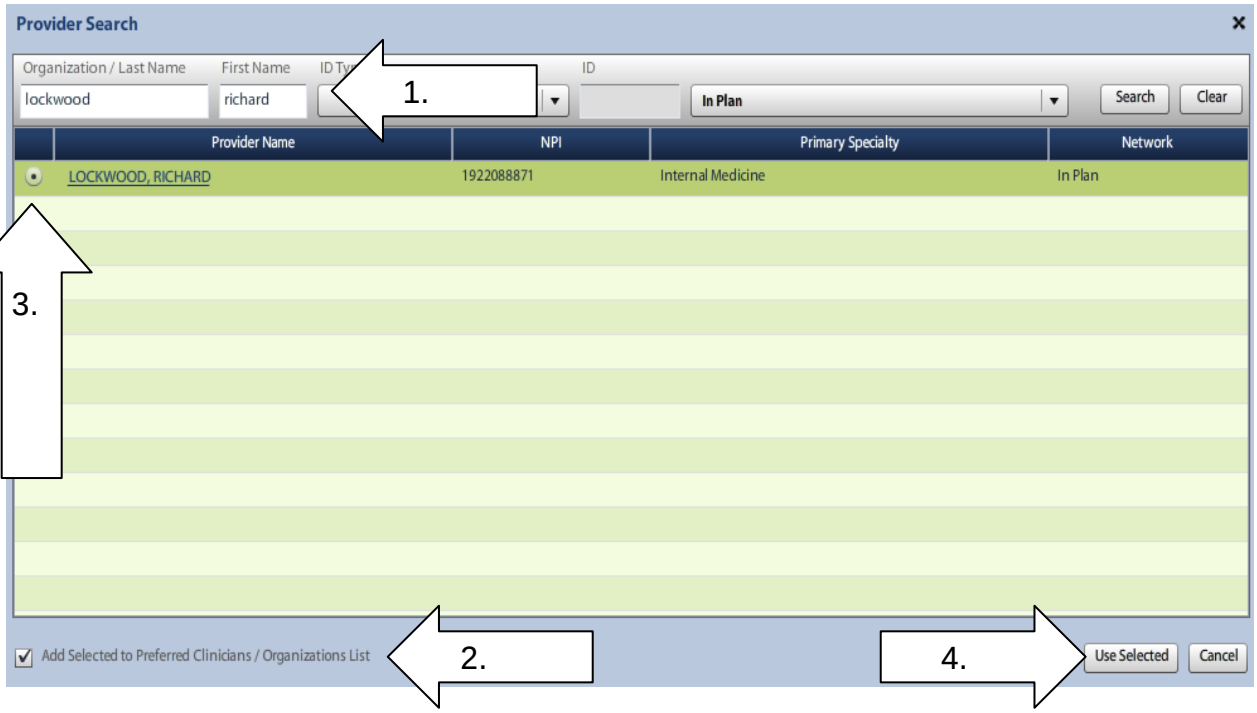


Clear Coverage™
Bariatric Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

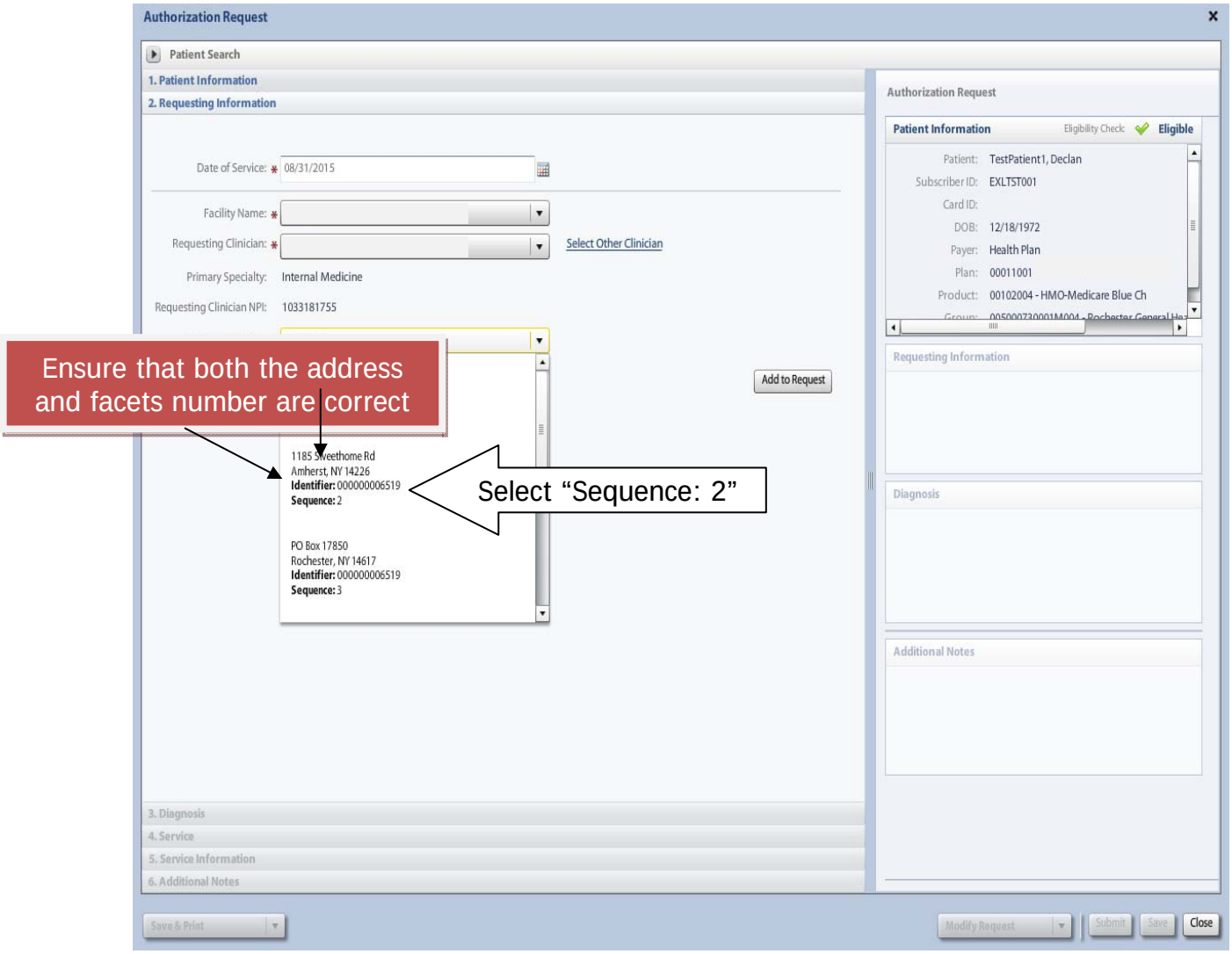
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Bariatric Authorization Entry Tips

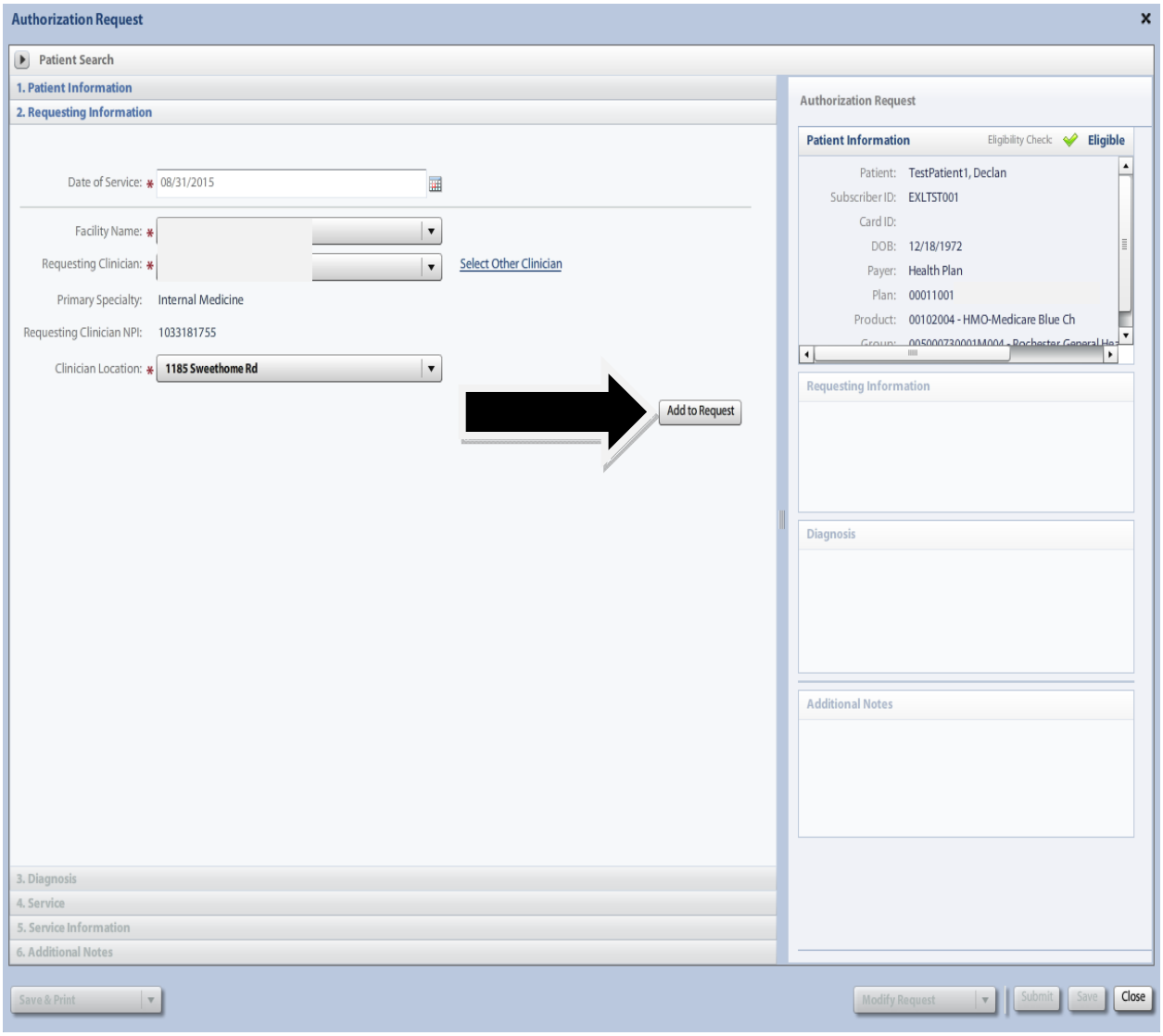
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Bariatric Authorization Entry Tips

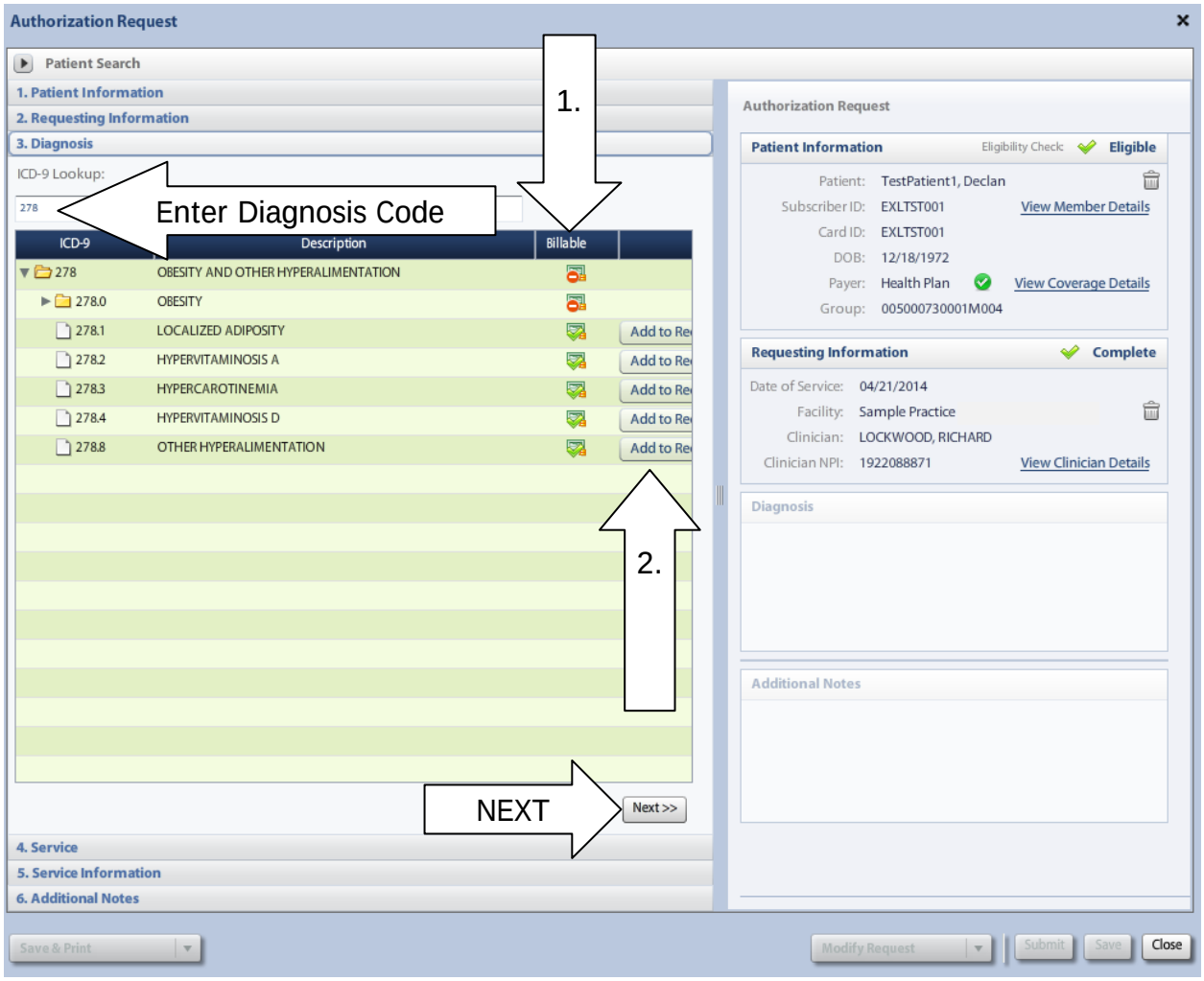
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Bariatric Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

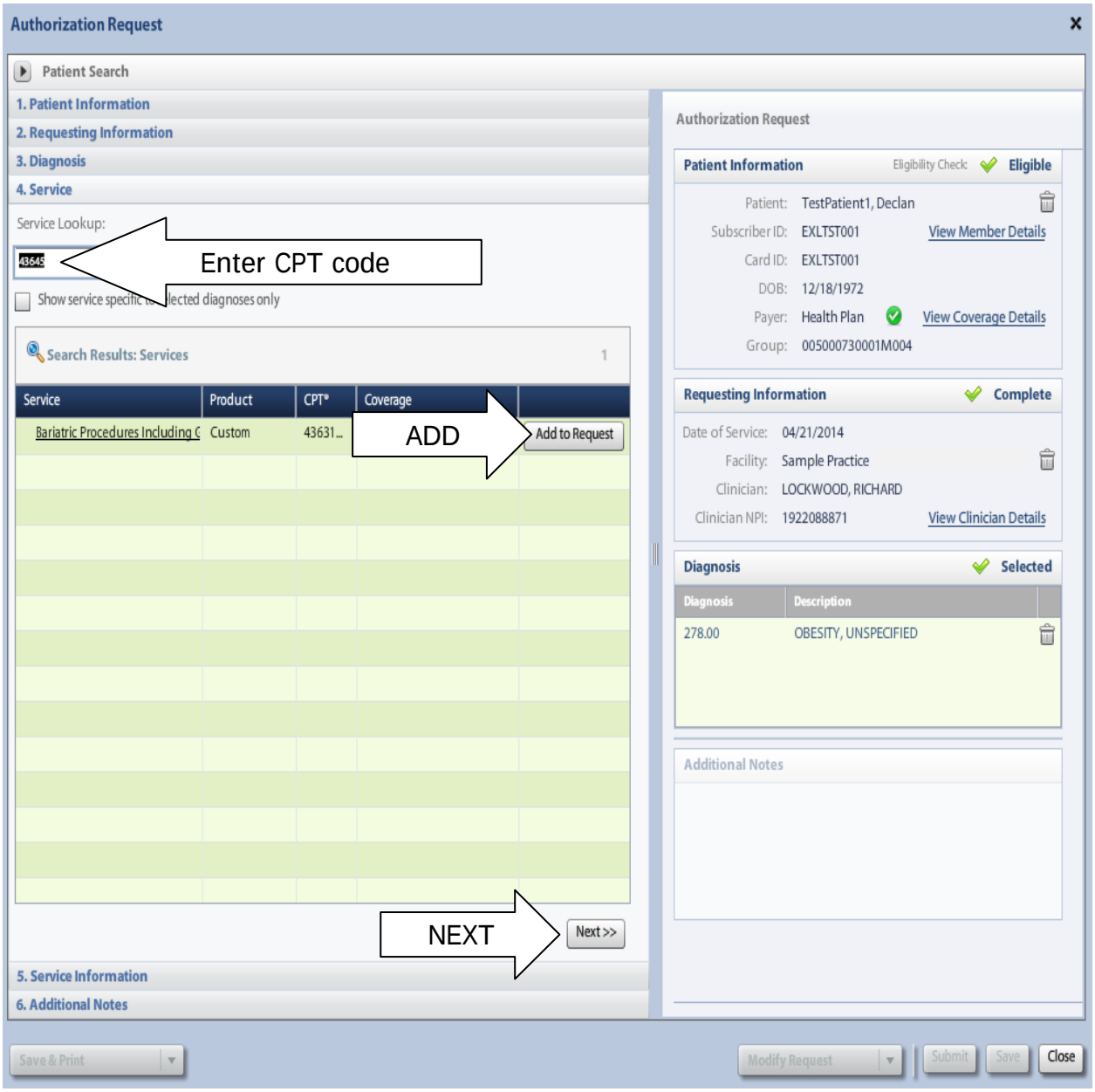


Clear Coverage™
Bariatric Authorization Entry Tips

Accordion 4: Services

Enter CPT code(s)

- Click the “Add to Request” button, then click “Next” once all codes have been added.



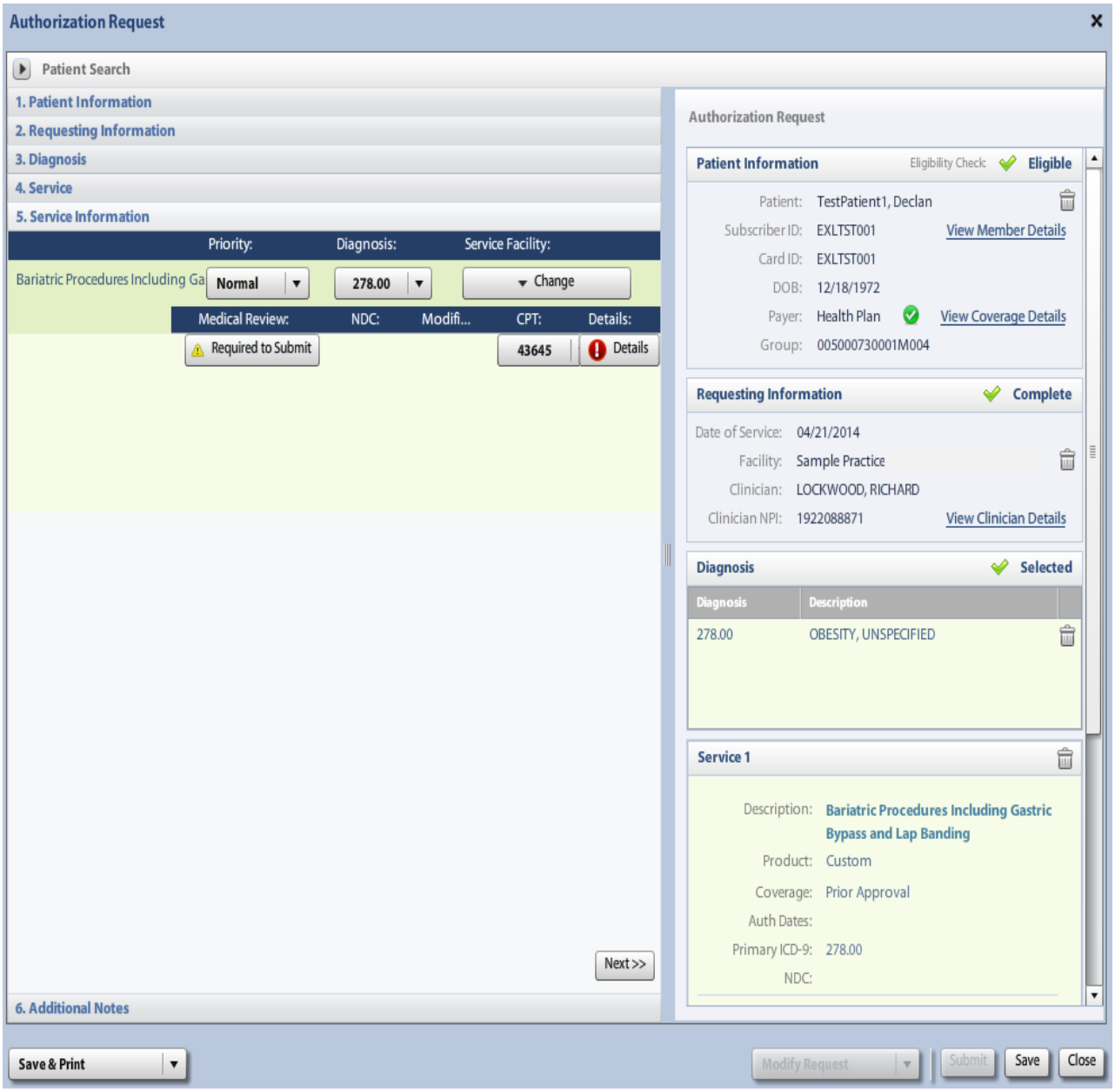
Clear Coverage™
Bariatric Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

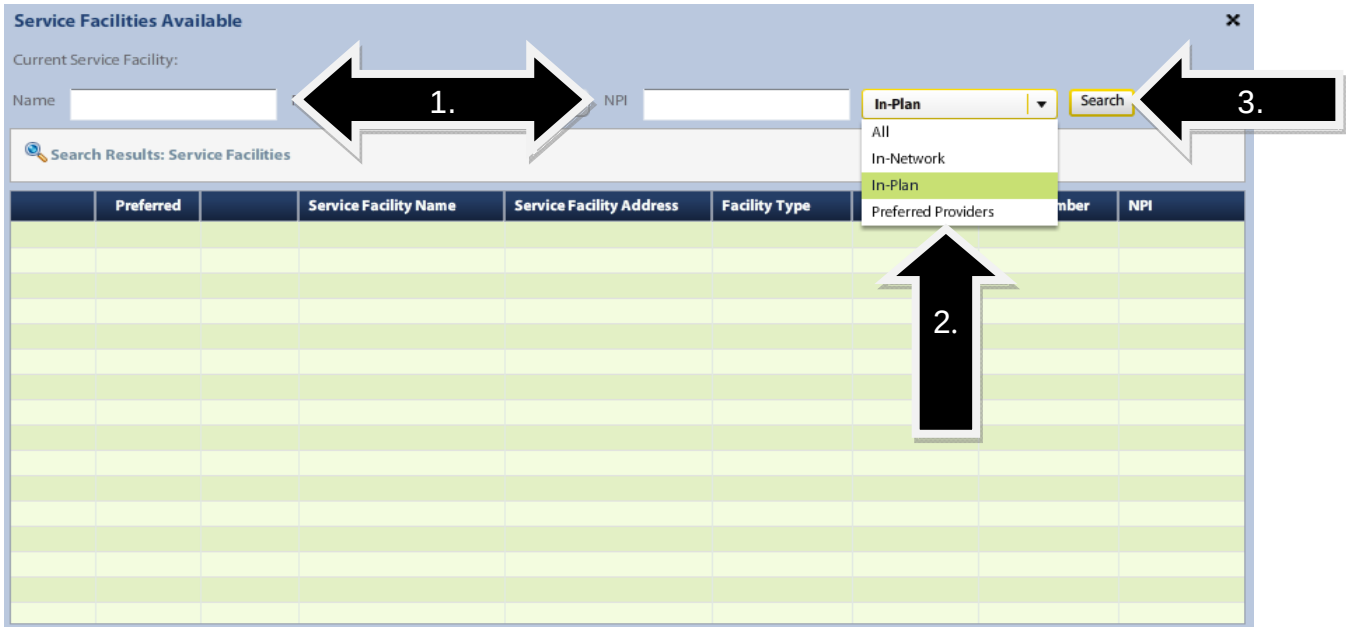
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service



Clear Coverage™
Bariatric Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend even if it meets criteria). Click the “Search” button (3).

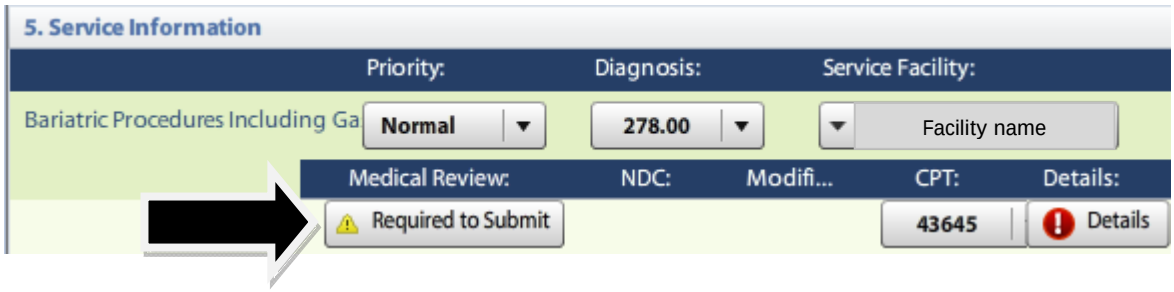


When the results display, select the appropriate provider.

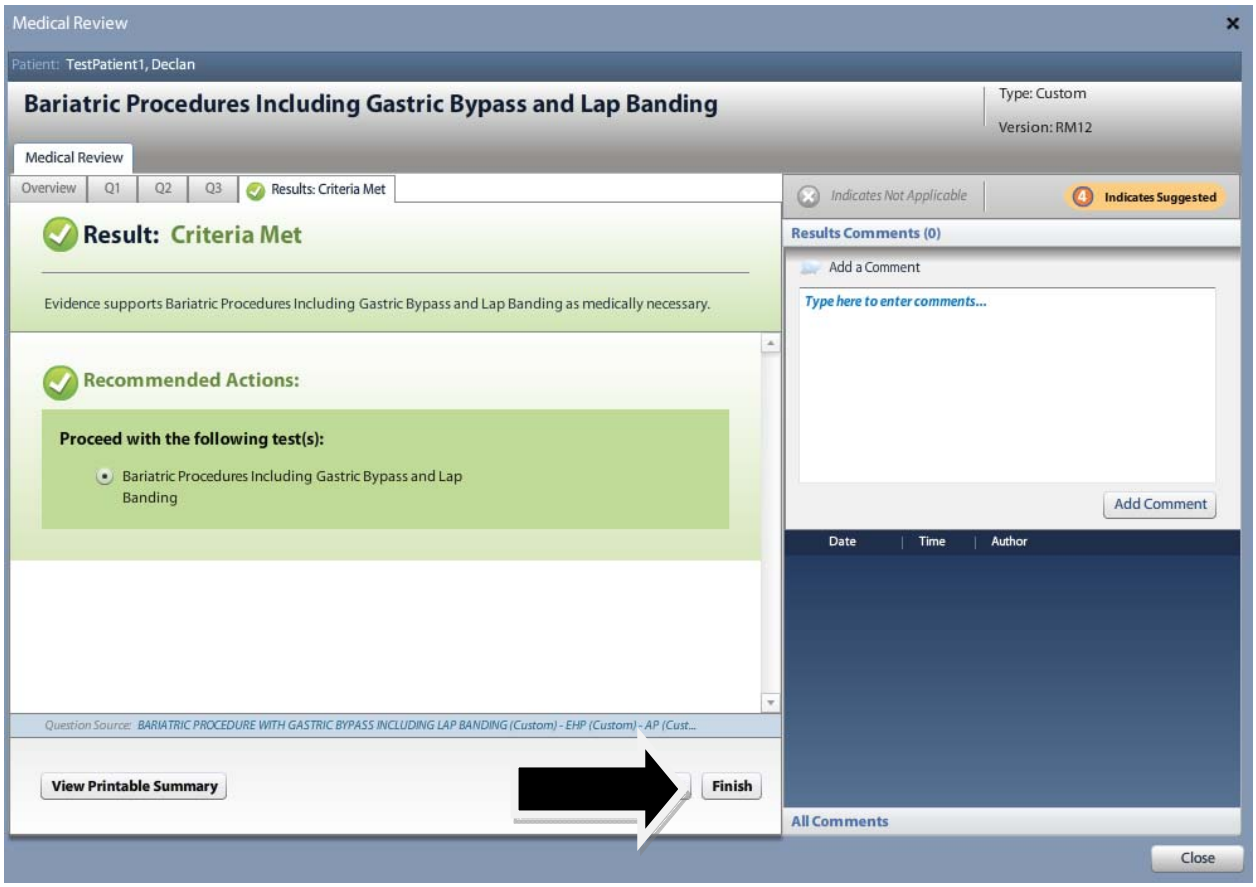
IMPORTANT NOTE: When selecting the facility, ensure that the facility chosen has this symbol: I to the left of the Service Facility Name.

Clear Coverage™
Bariatric Authorization Entry Tips

Click on the Medical Review "Required to Submit" tab and complete the review.



If criteria met: Click "Finish."

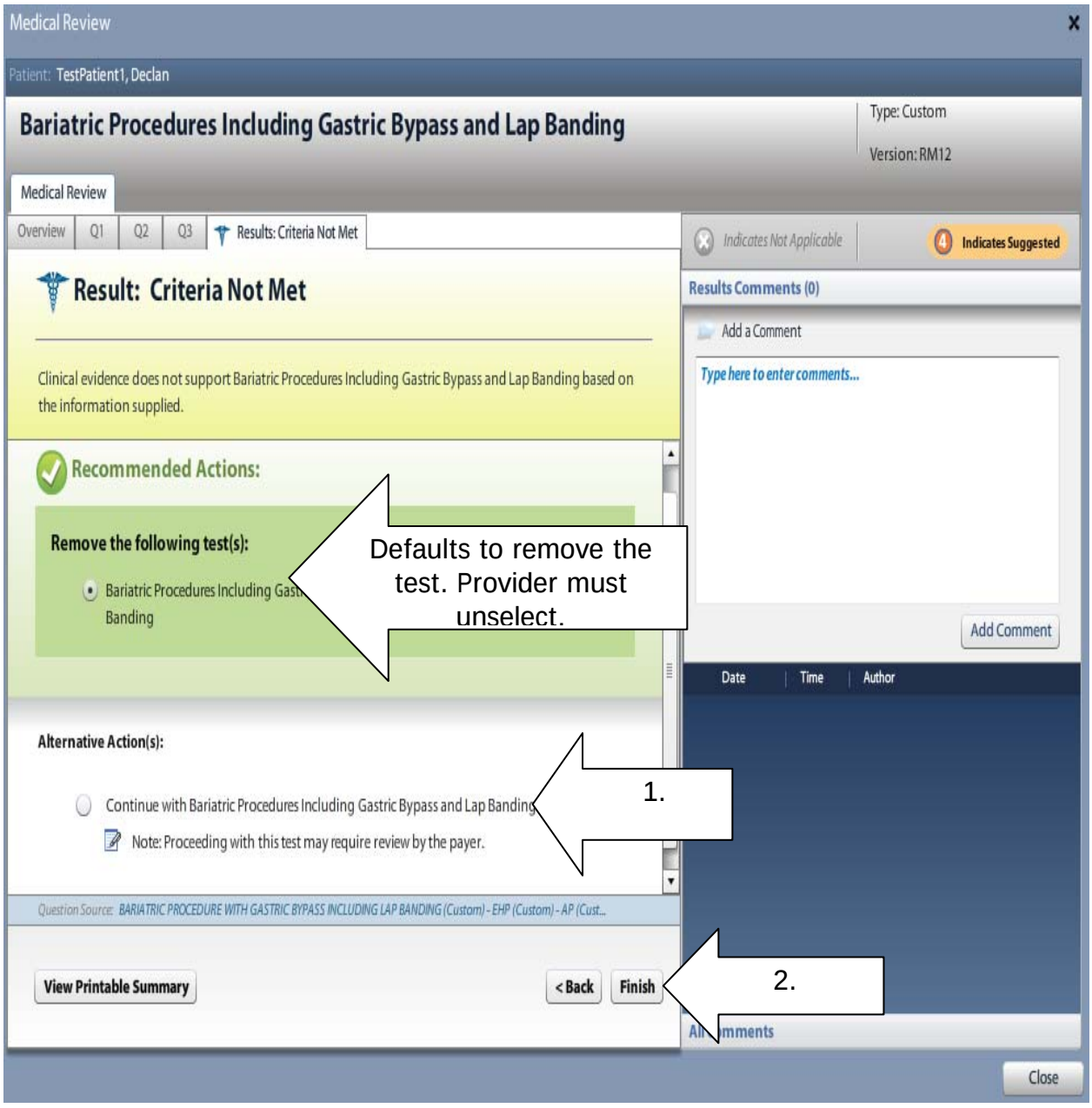


Clear Coverage™
Bariatric Authorization Entry Tips

If criteria not met:

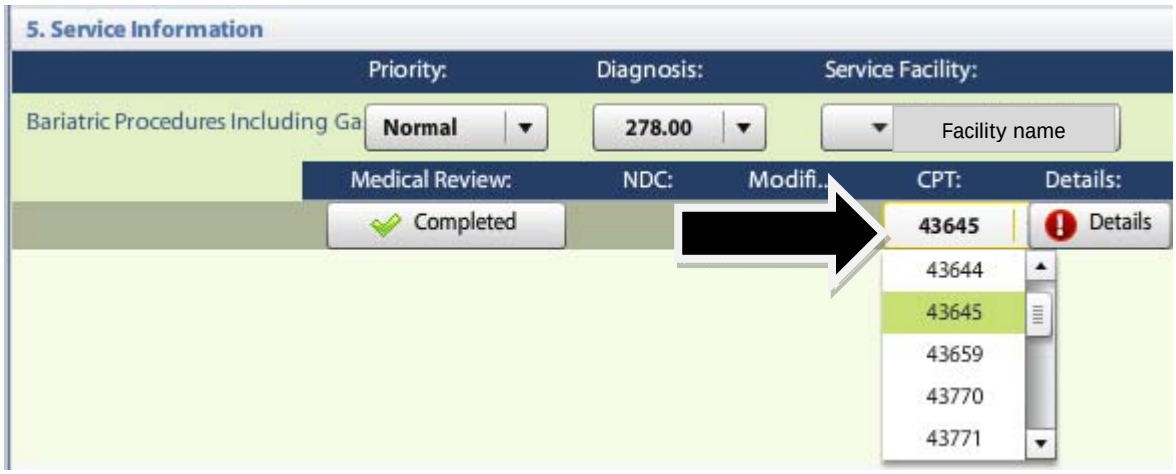
The default choice is to **remove** the item from the request.

1. You **must** click the button under Alternative Action(s) to “Continue with Bariatric Procedures including Gastric Bypass and Lap Banding” (or appropriate requested item) if you wish the request to pend to the Health Plan for review (1). Click “Finish.”

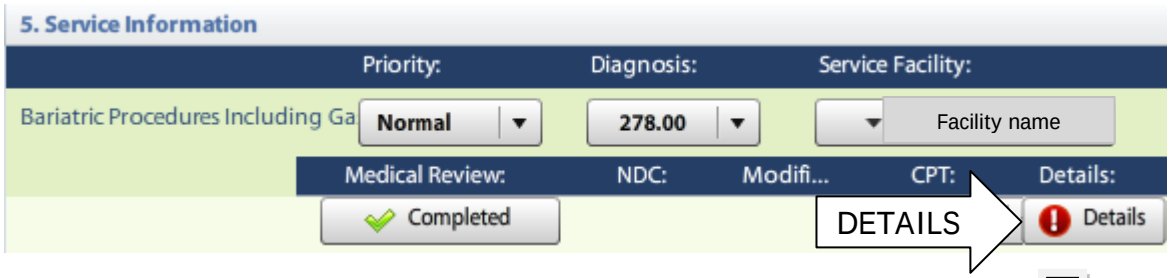


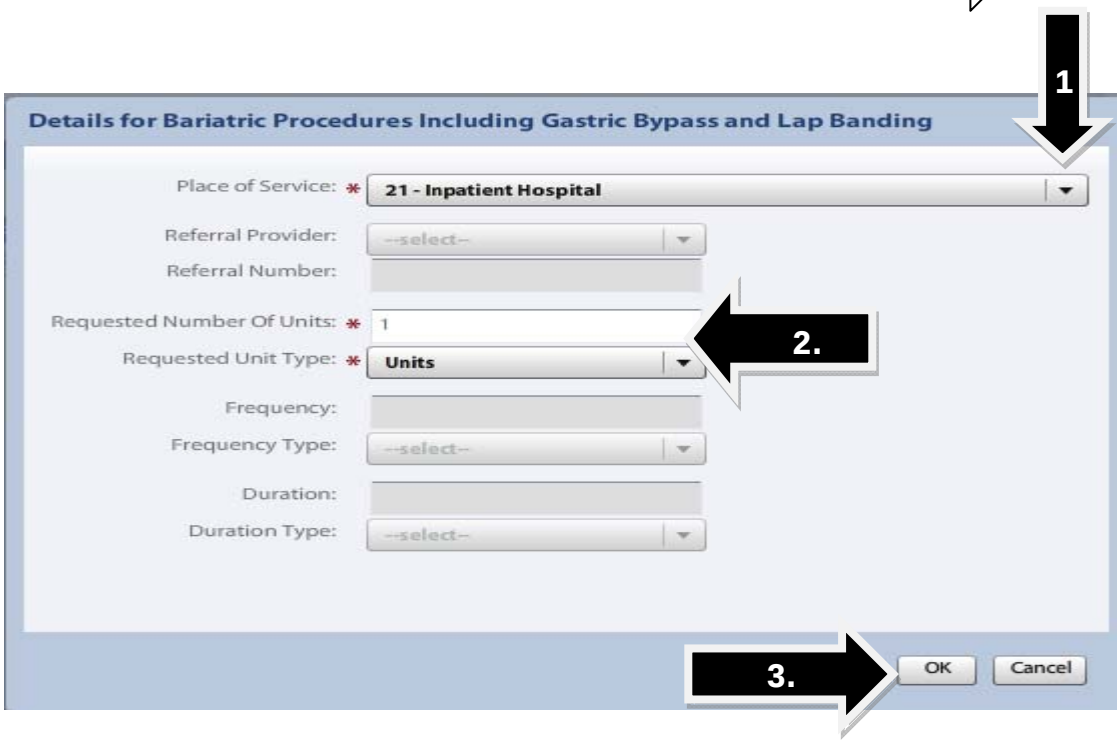
Clear Coverage™
Bariatric Authorization Entry Tips

Ensure the correct CPT code is populated:



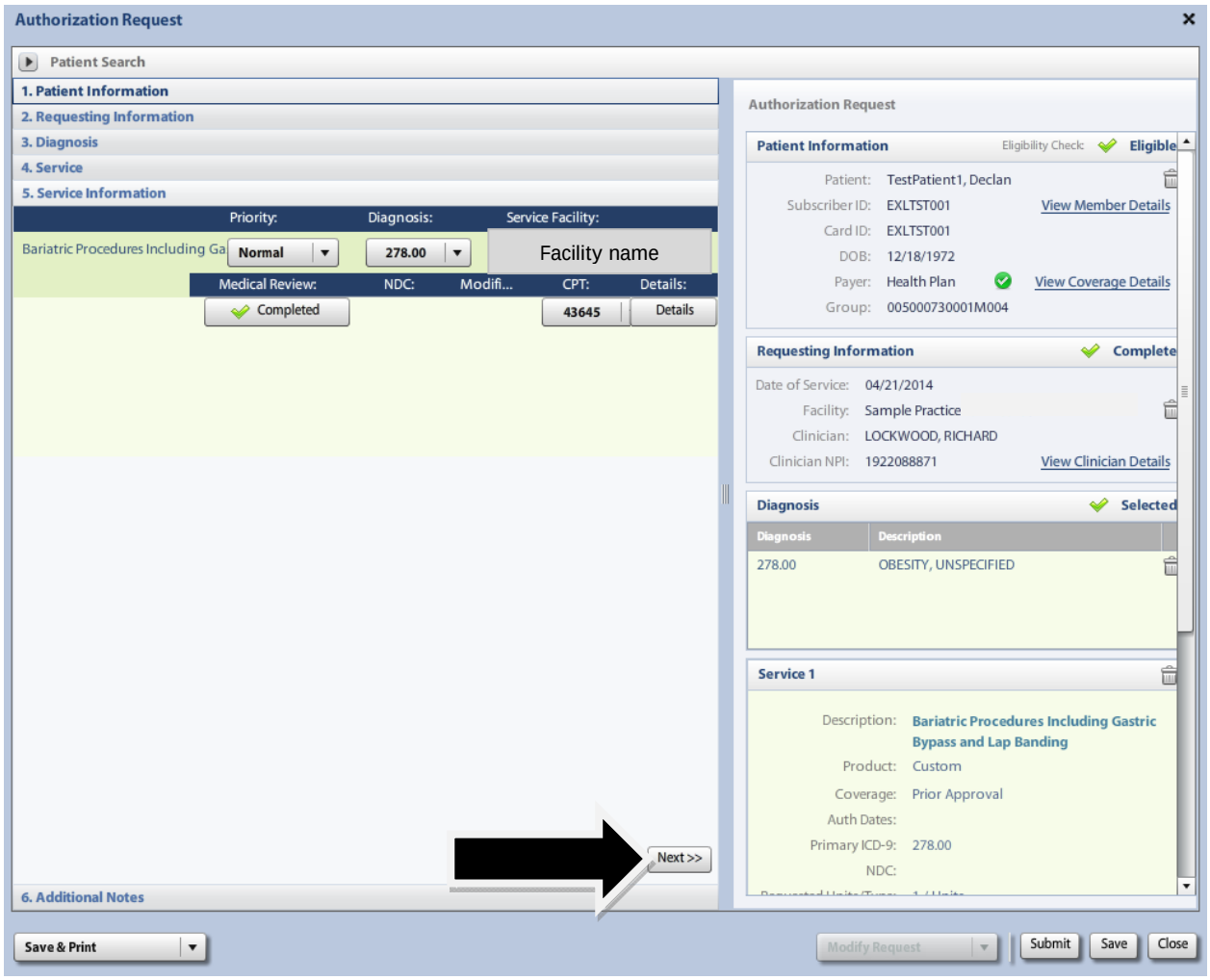
Details section: Must select: (1) Place of Service, (2) Requested Number of Units and Requested Unit Type**.** Click the "OK" button (3).





Clear Coverage™
Bariatric Authorization Entry Tips

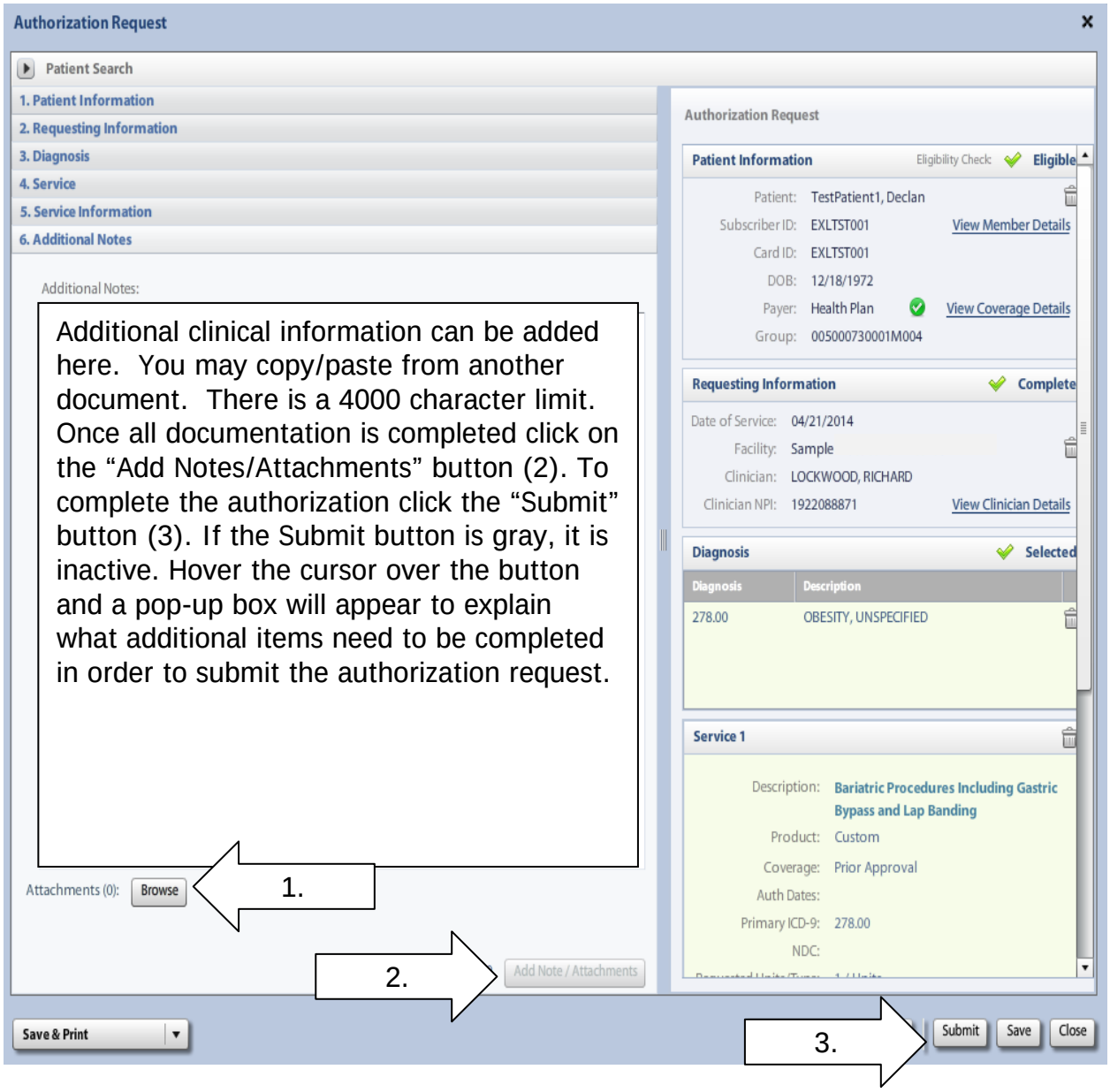
Click “Next.”



Clear Coverage™
Bariatric Authorization Entry Tips

Accordian 6: Additional Notes

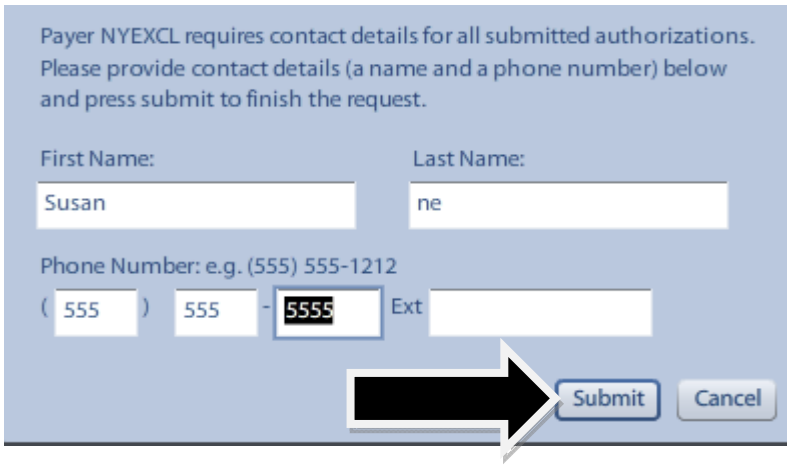
If criteria was <u>not</u> met, or if this is a Medicare, Medicaid or Safety Net patient, enter additional information and/or attach a note with supporting medical documentation (1). A note <u>must</u> be added in order to attach a document.



Clear Coverage™
Bariatric Authorization Entry Tips

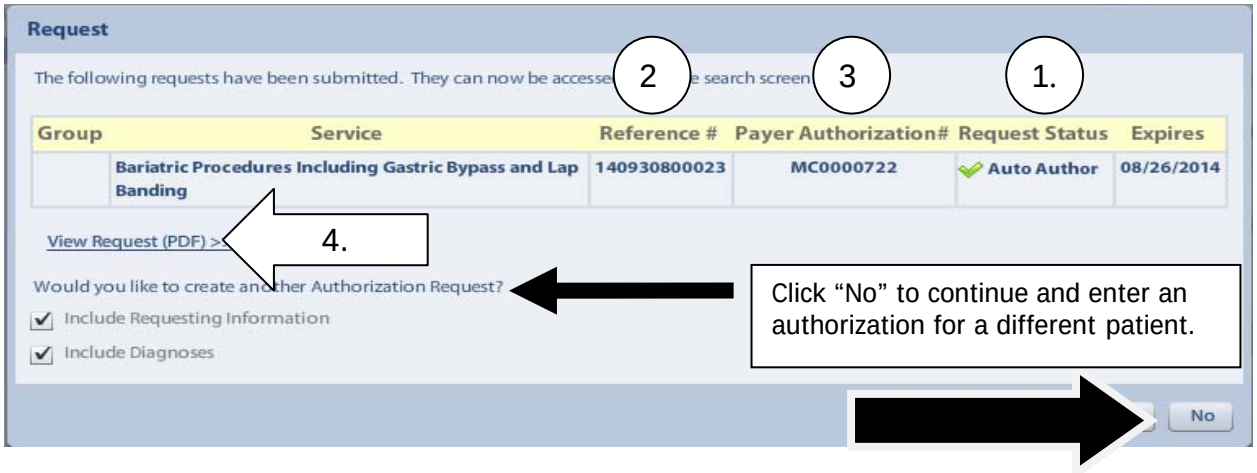
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Blepharoplasty Authorization Entry Tips

All requests for blepharoplasty's will pend for medical necessity review by the Health Plan. The review tool MUST be completed to provide clinical information and the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

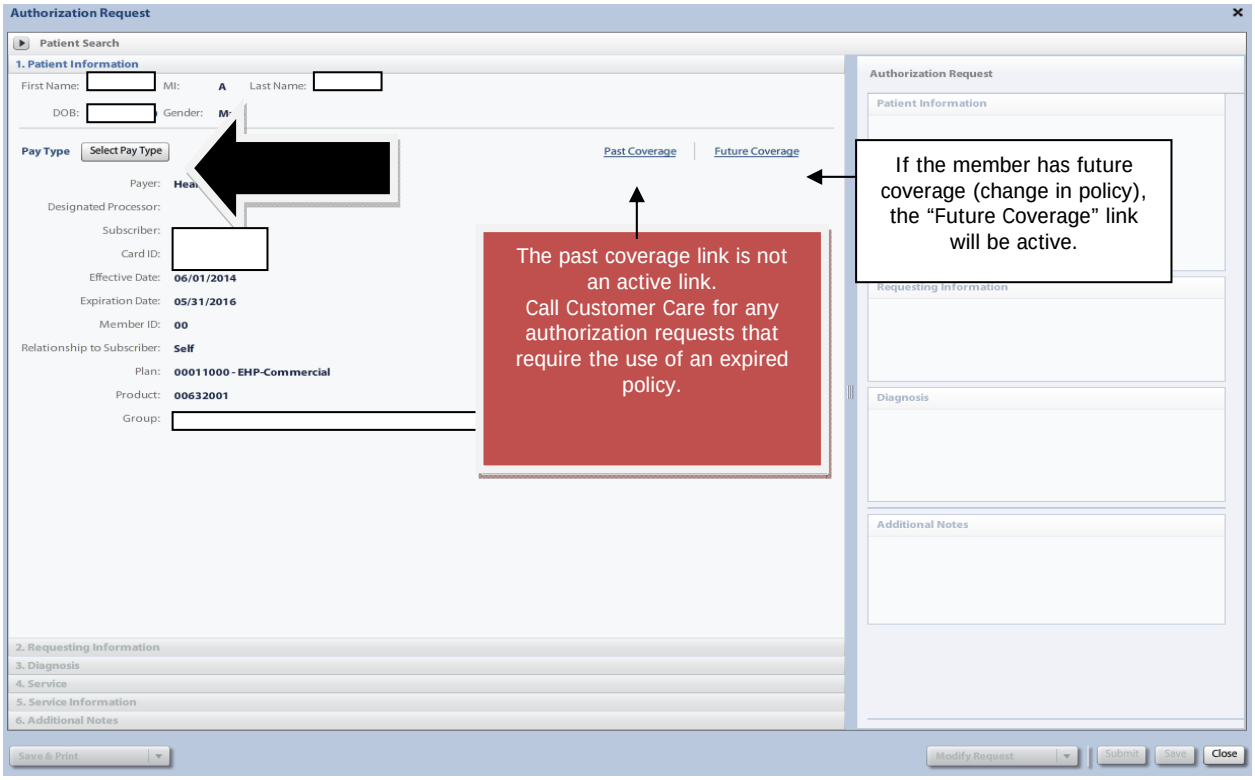
Photos are ALWAYS required! (attach in accordion 6)

Note: Any combination of requests for Blepharoplasty, Levator Advancement and Browpexy can be requested on the same authorization.

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

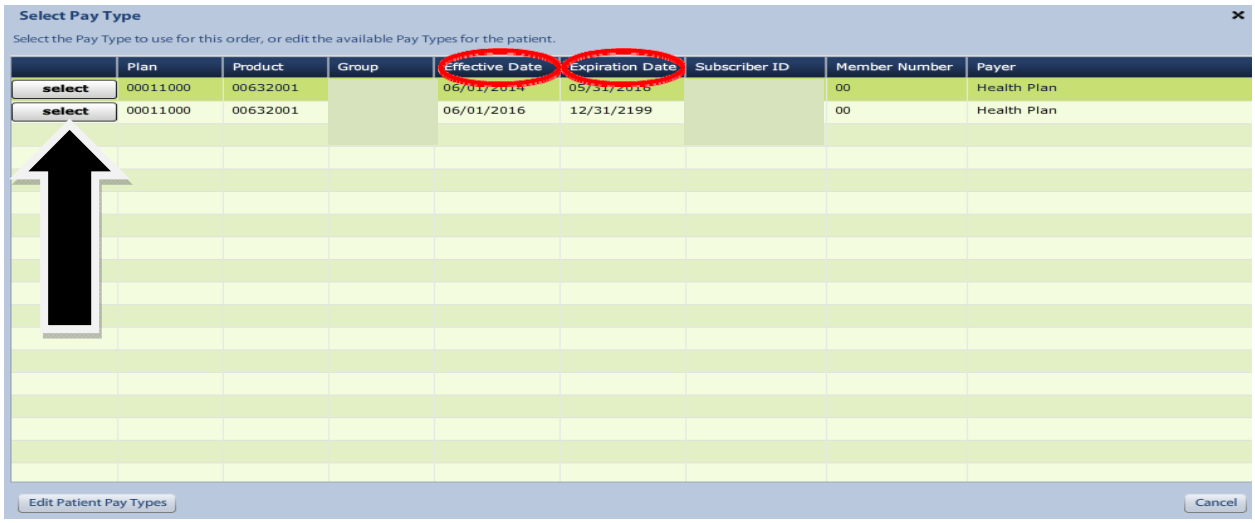


Clear Coverage™
Blepharoplasty Authorization Entry Tips

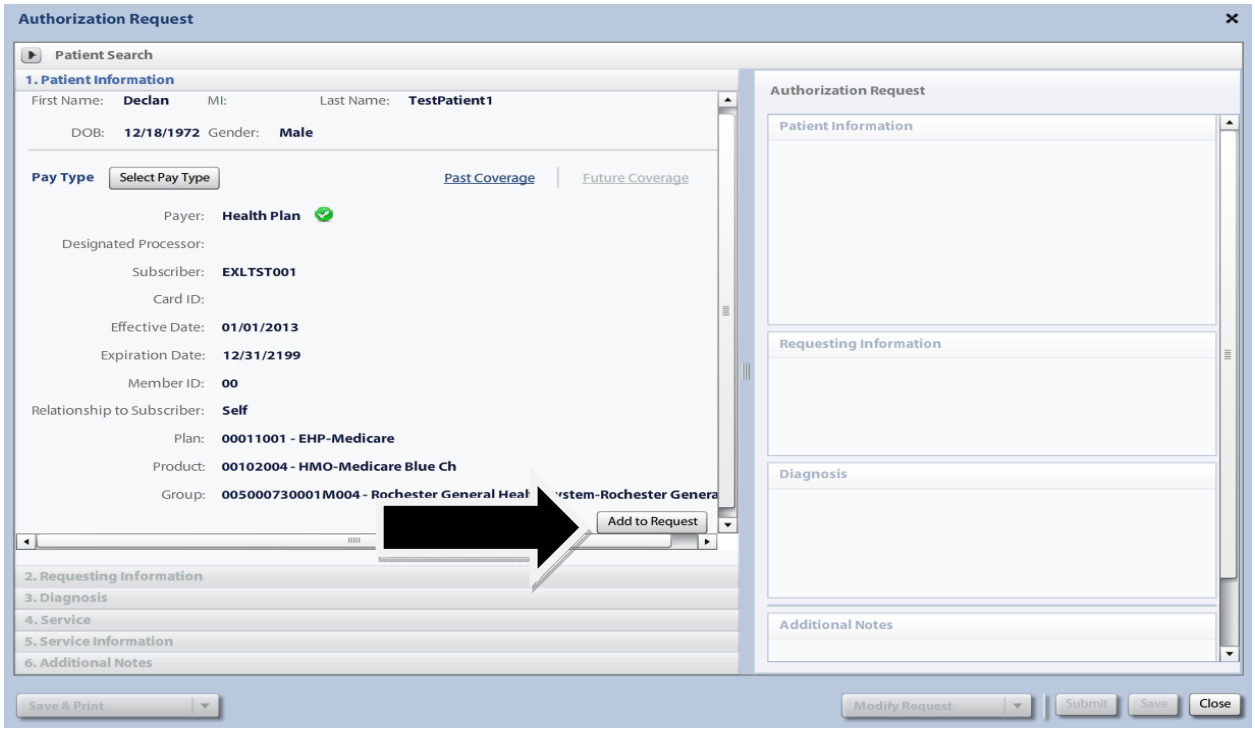
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

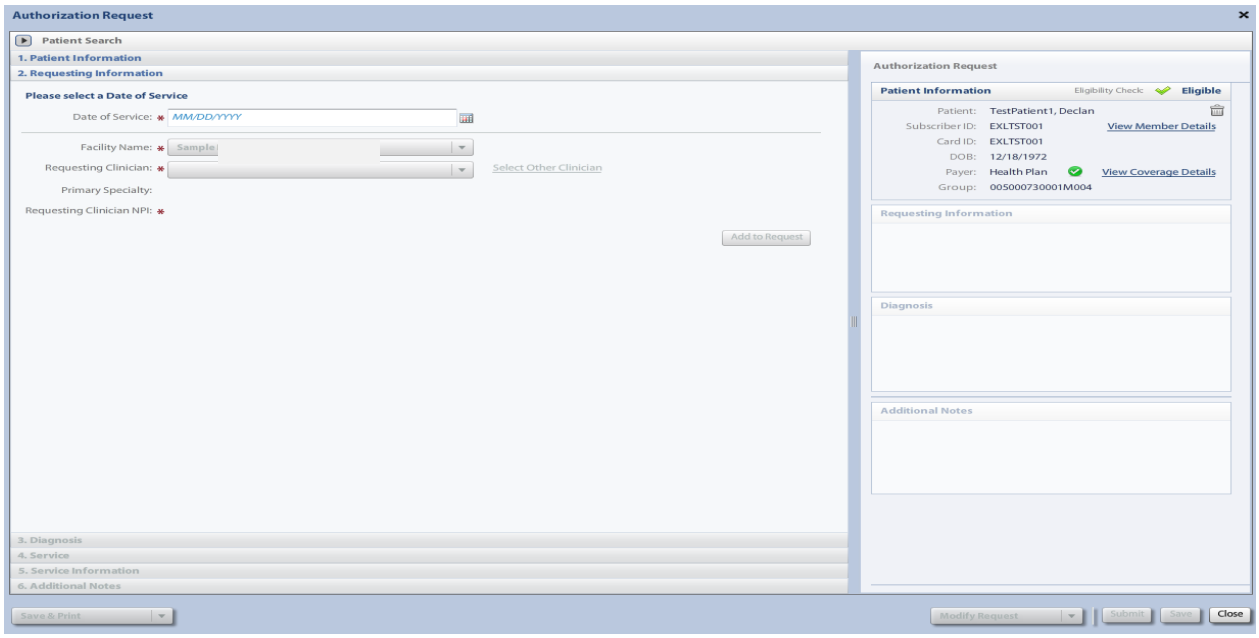


Clear Coverage™
Blepharoplasty Authorization Entry Tips

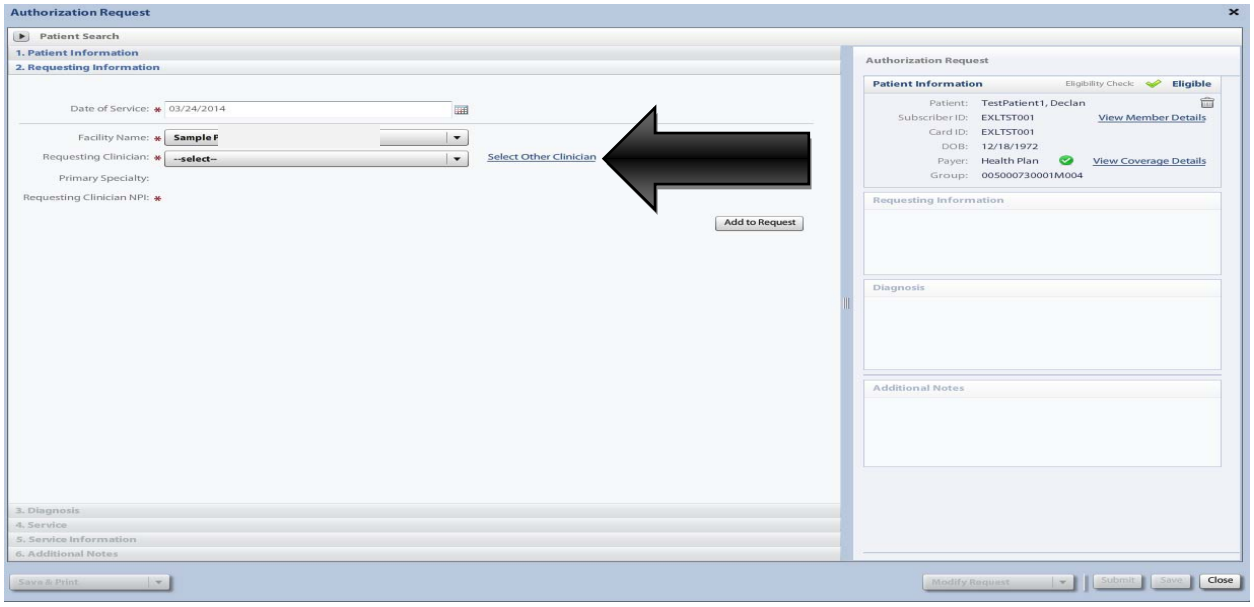
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

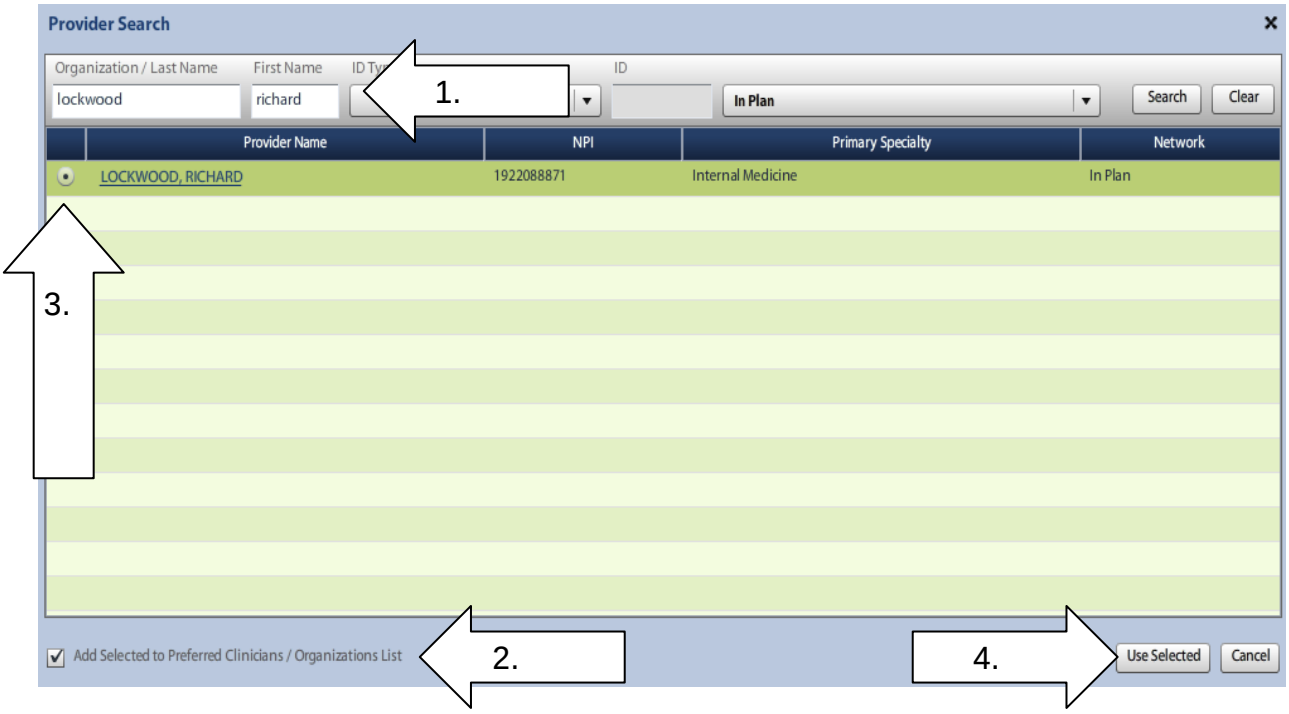


Clear Coverage™
Blepharoplasty Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

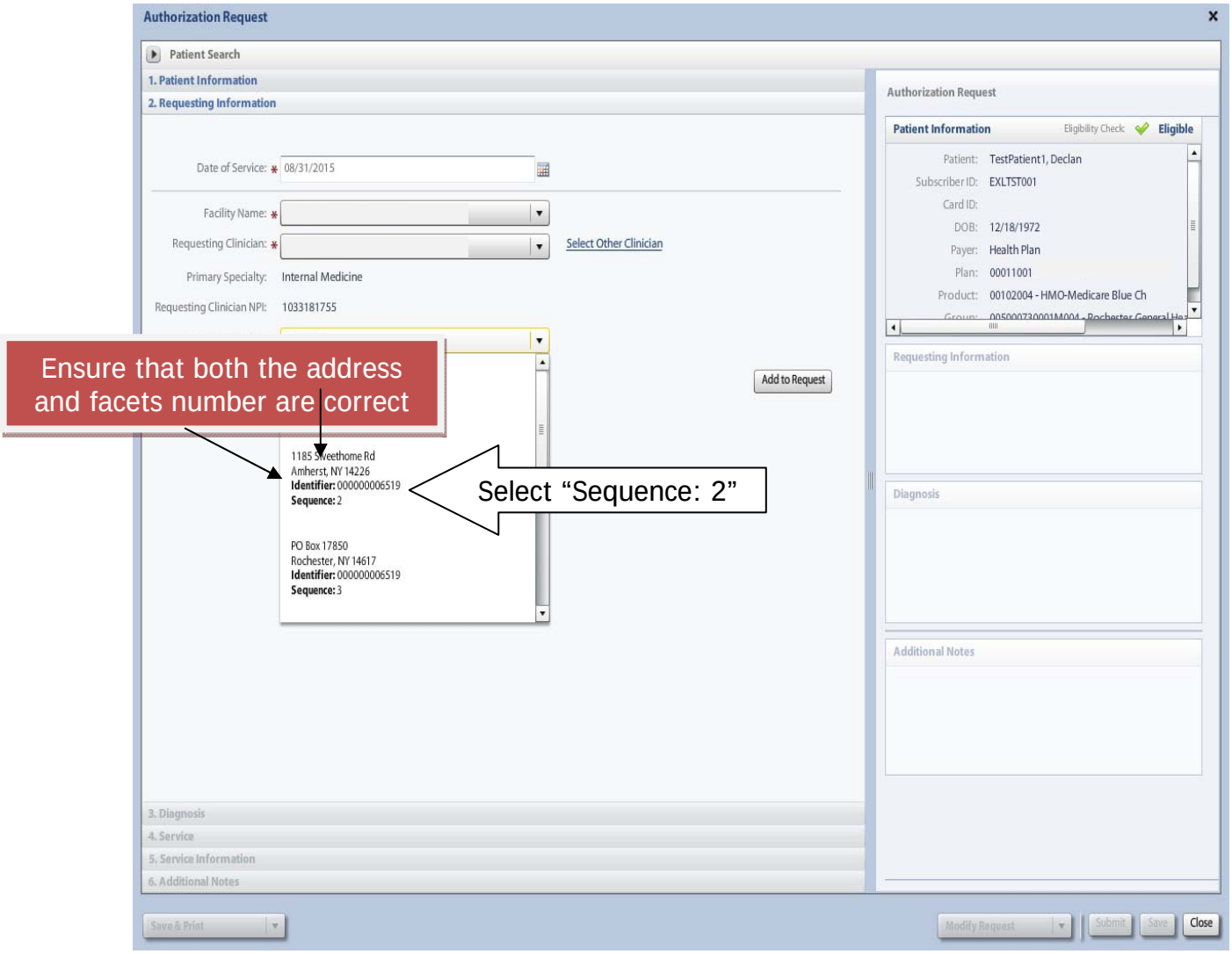
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Blepharoplasty Authorization Entry Tips

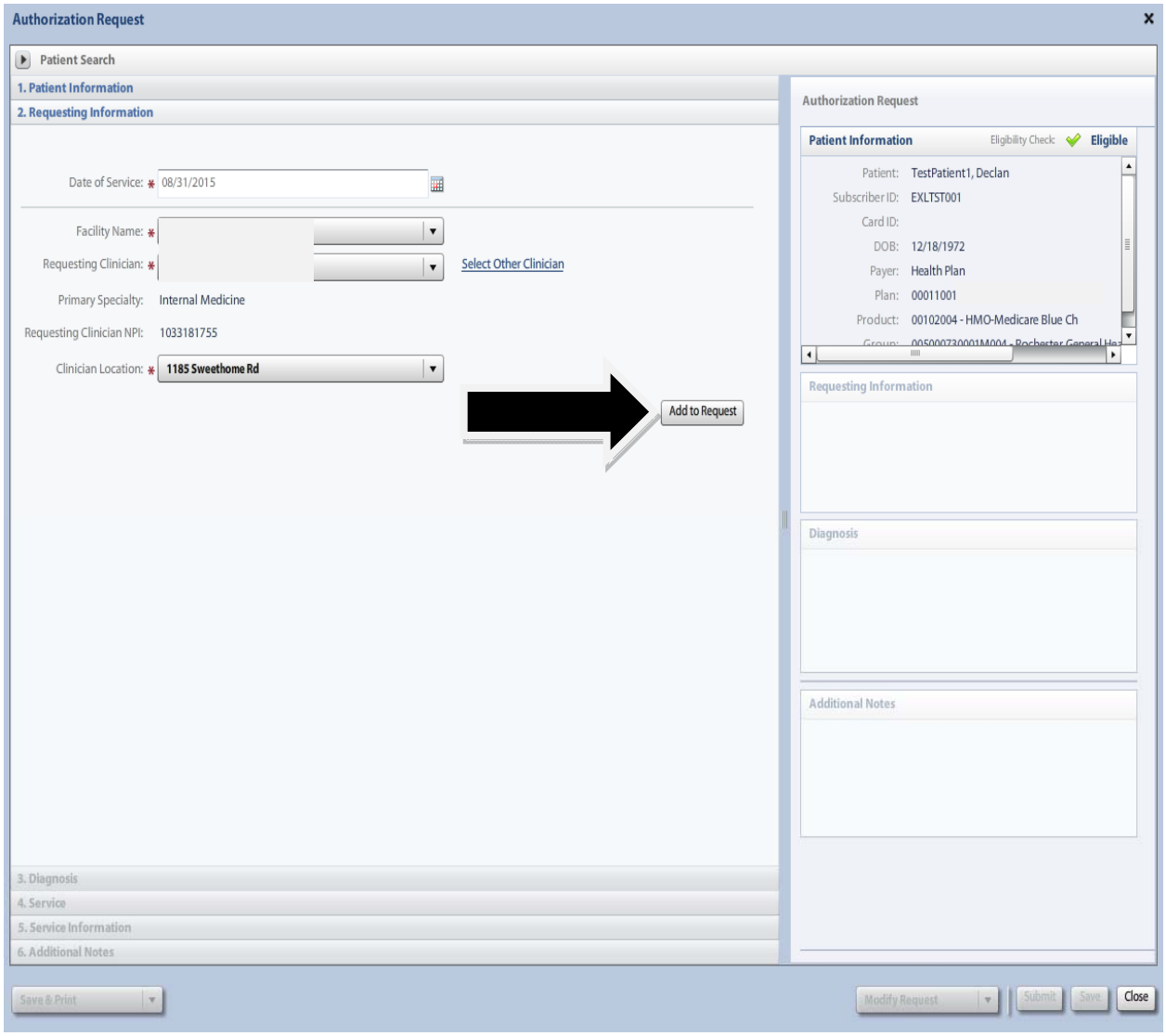
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Blepharoplasty Authorization Entry Tips

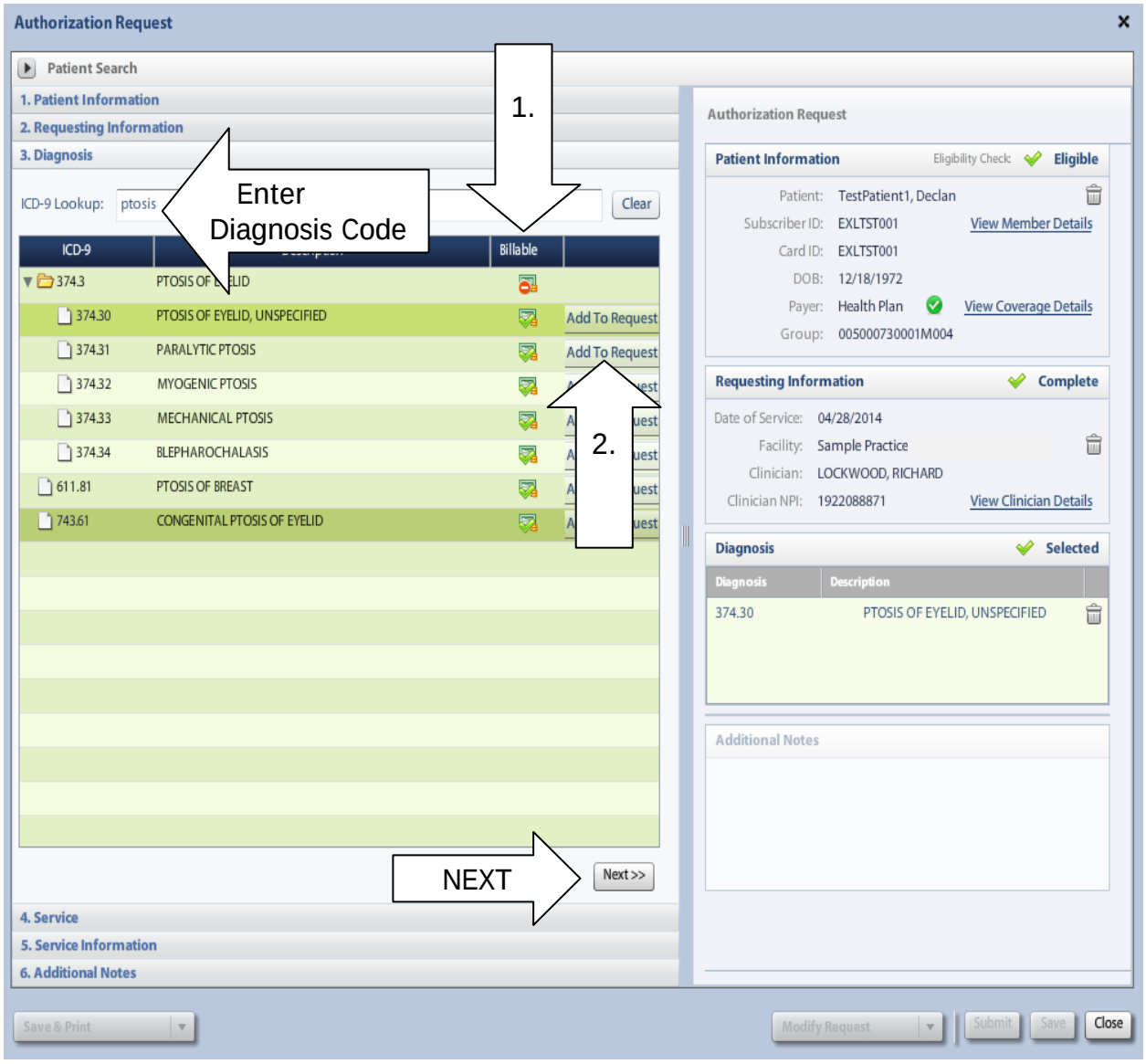
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Blepharoplasty Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

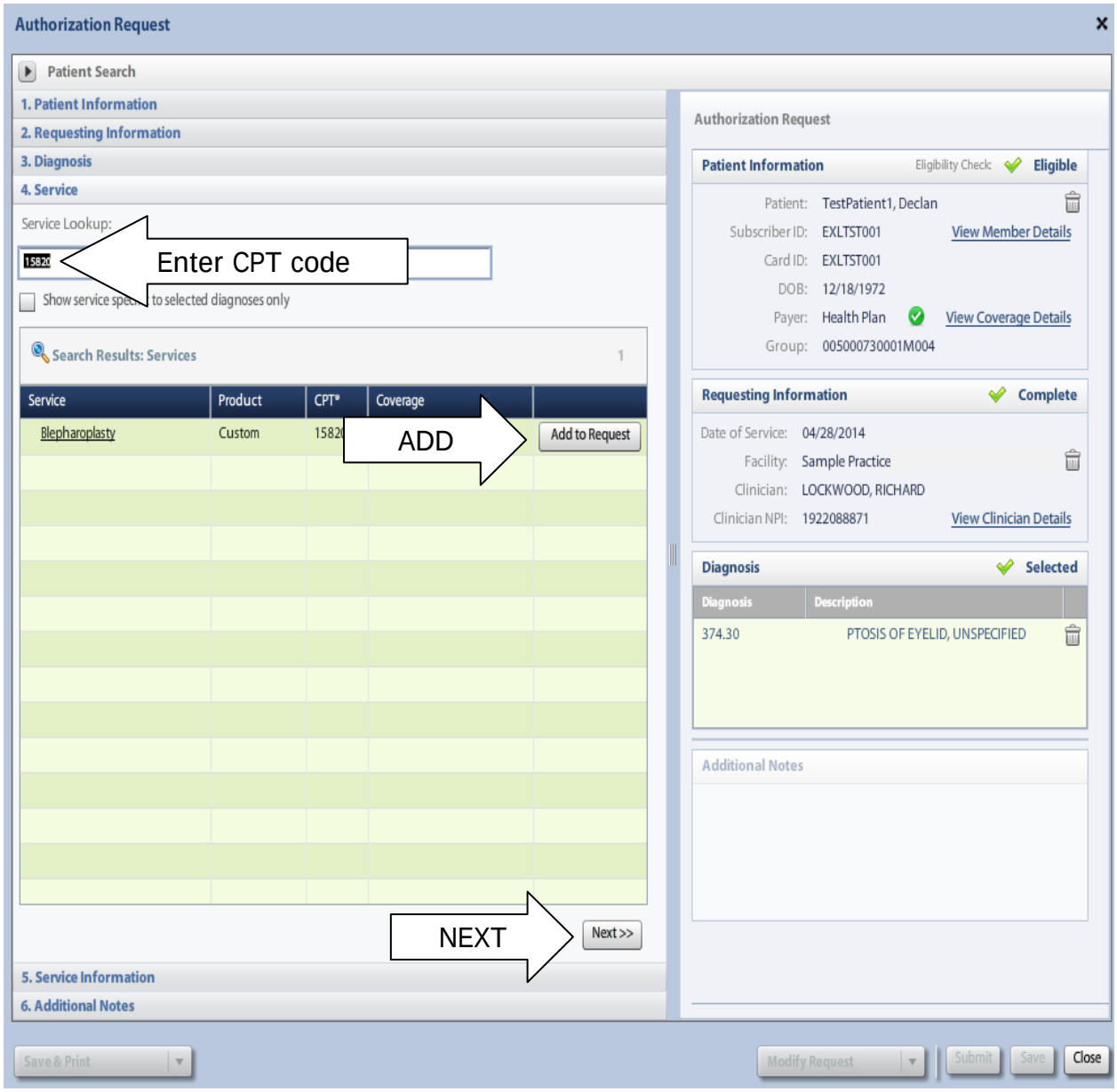


Clear Coverage™
Blepharoplasty Authorization Entry Tips

Accordion 4: Services

Enter CPT code(s)

- Click the “Add to Request” button, then click “Next” once all codes have been added.



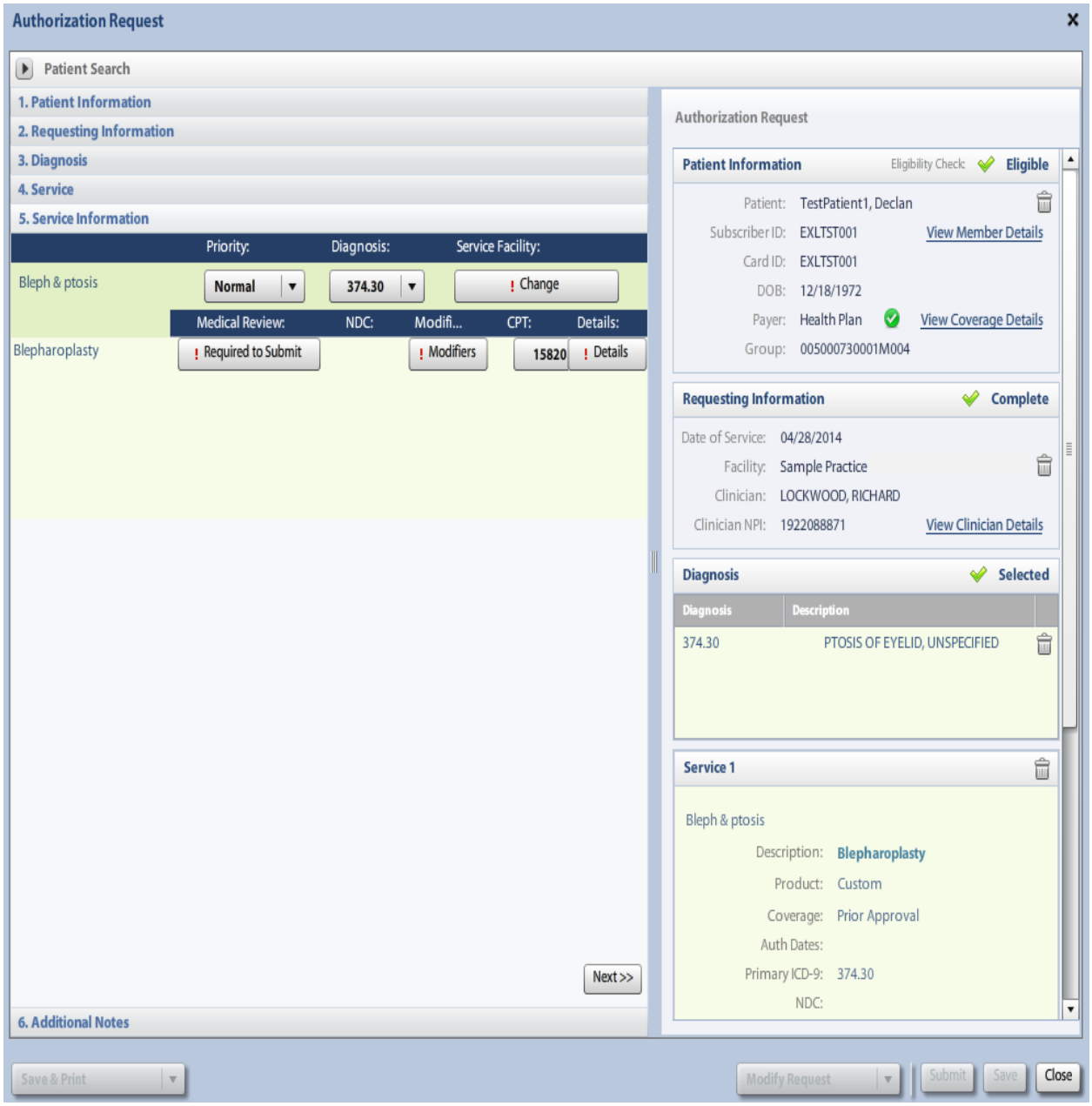
Clear Coverage™
Blepharoplasty Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

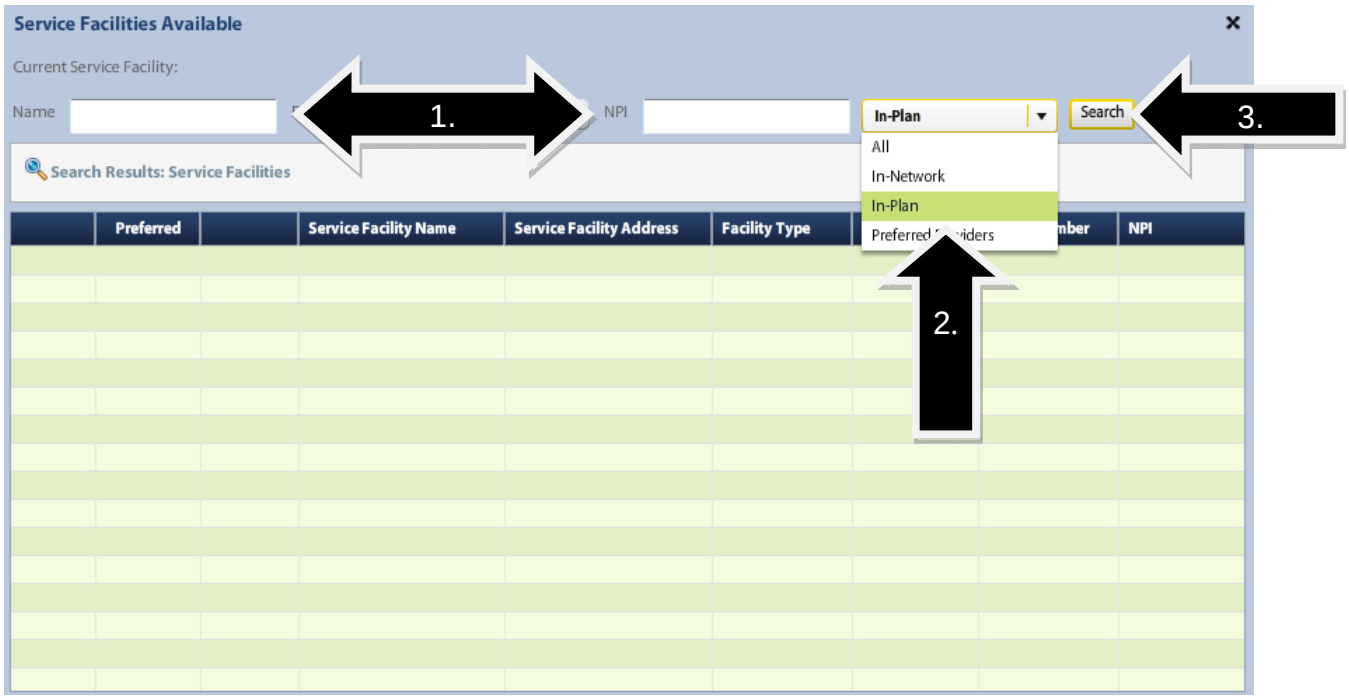
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service

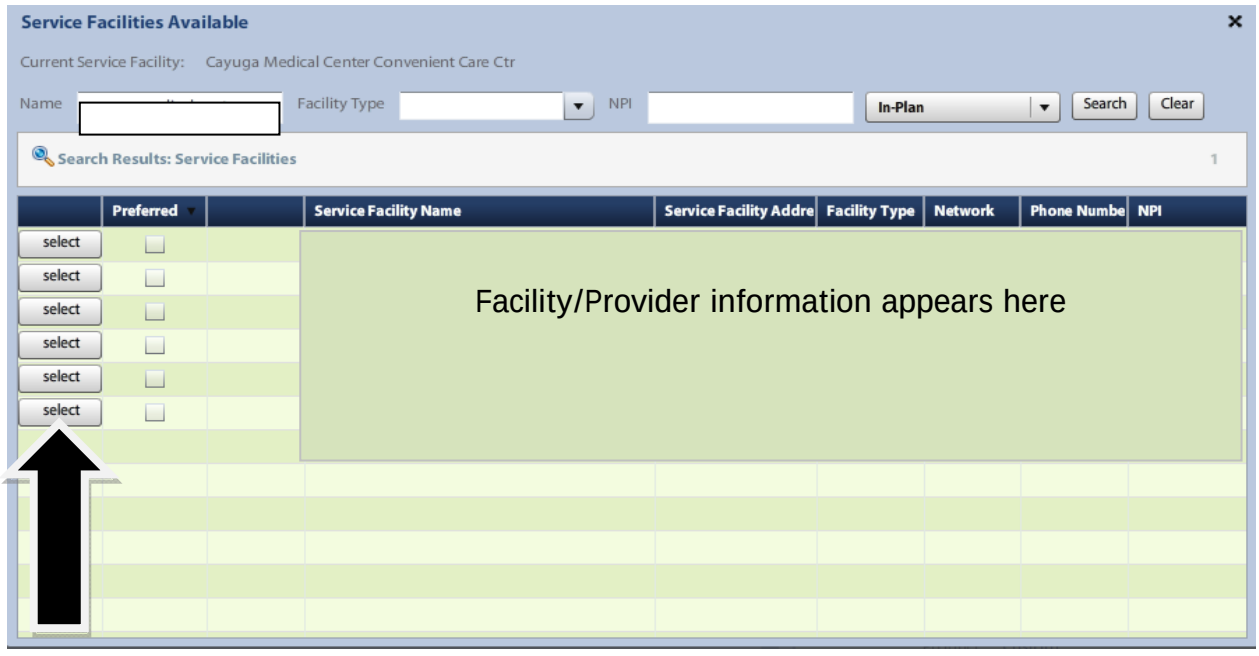


Clear Coverage™
Blepharoplasty Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).

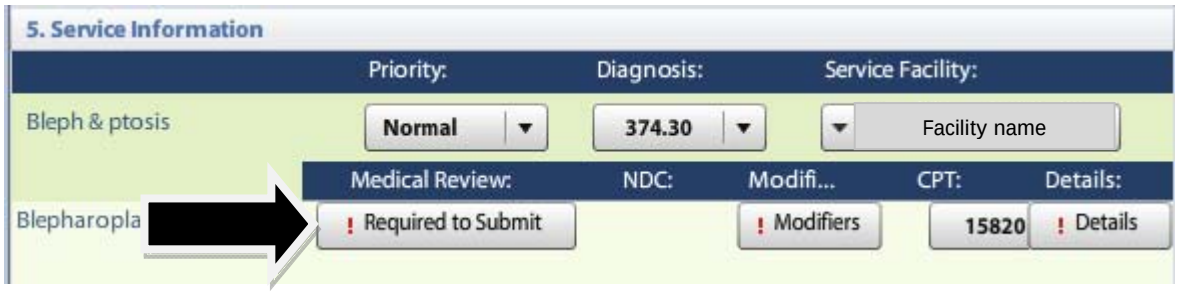


When the results display, select the appropriate provider.

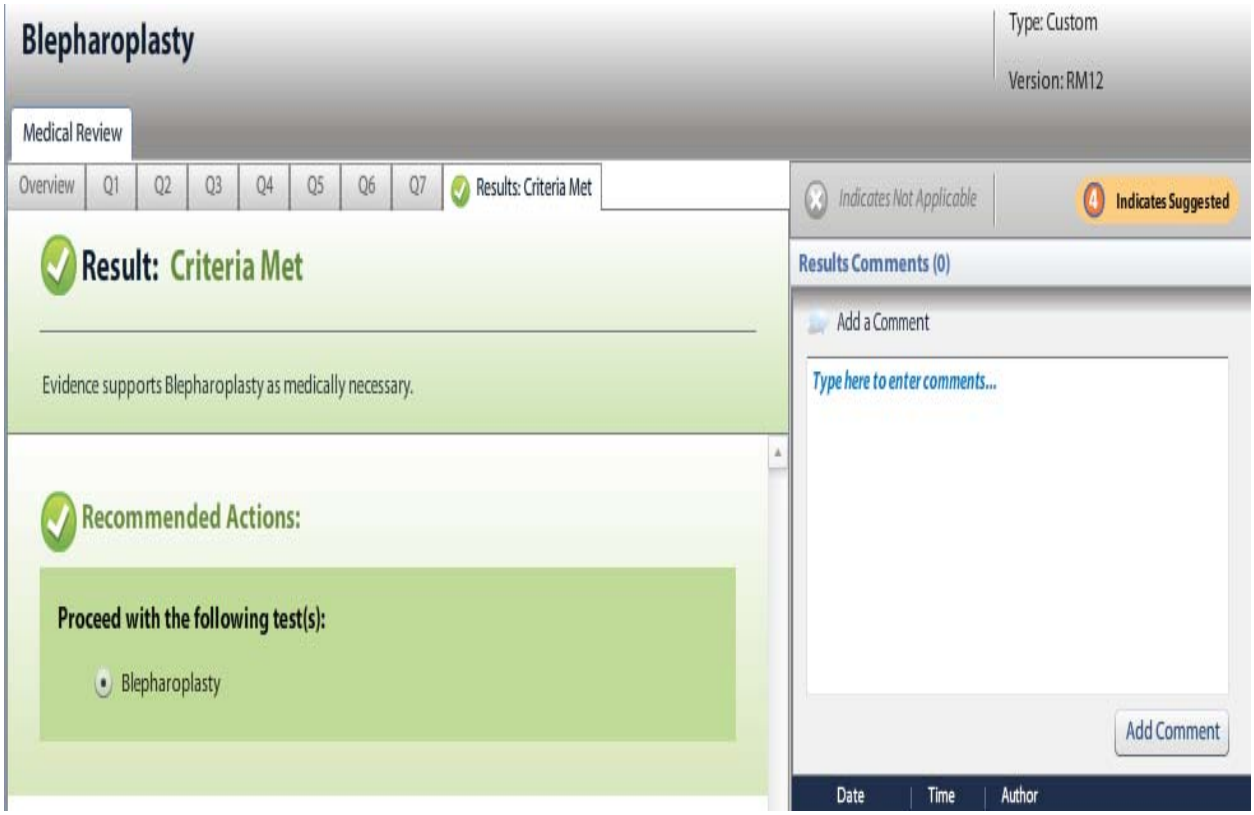


Clear Coverage™
Blepharoplasty Authorization Entry Tips

Click on the Medical Review “Required to Submit” tab and complete the review.



If criteria met: Click “Finish.”

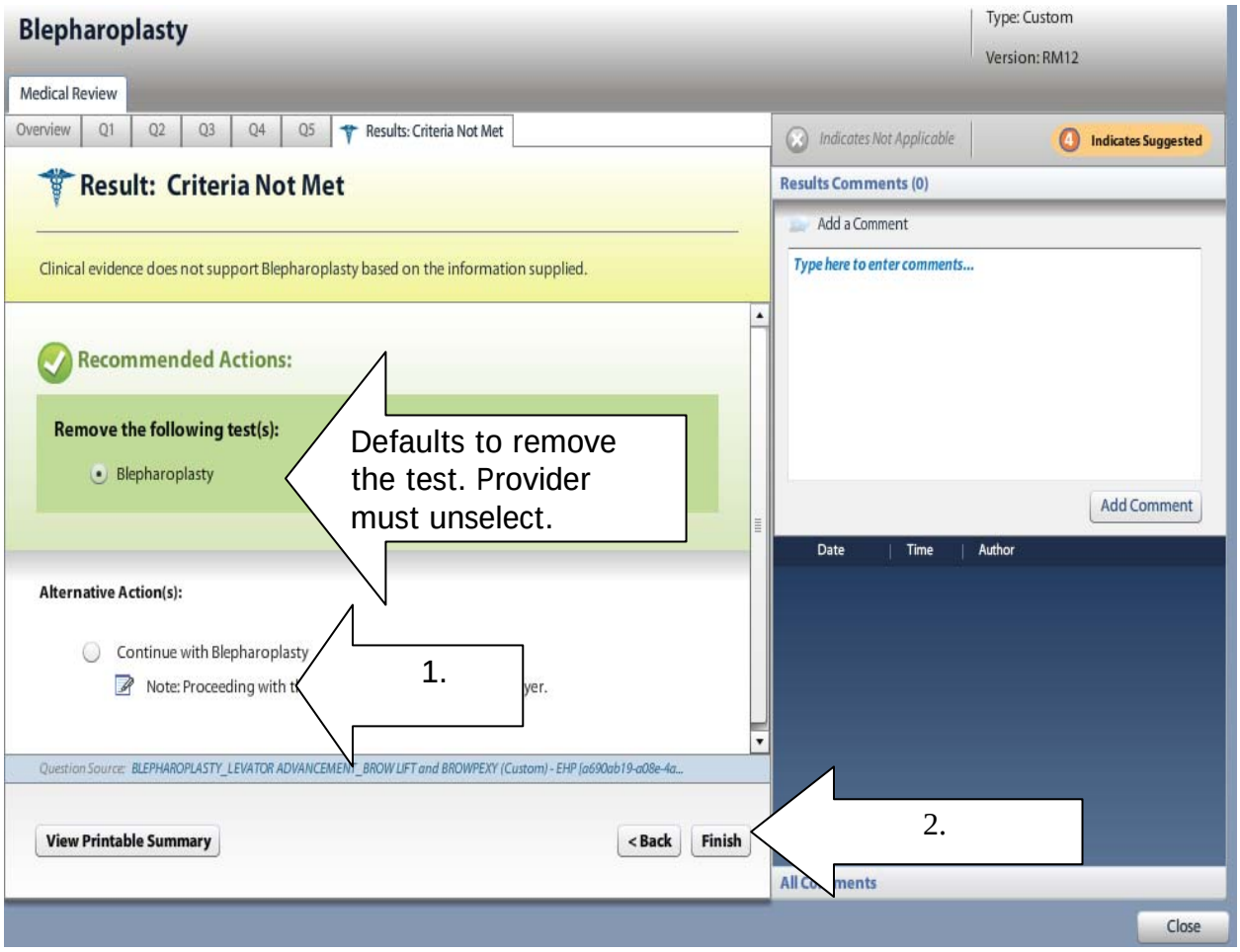


Clear Coverage™
Blepharoplasty Authorization Entry Tips

If criteria not met:

The default choice is to **remove** the item from the request.

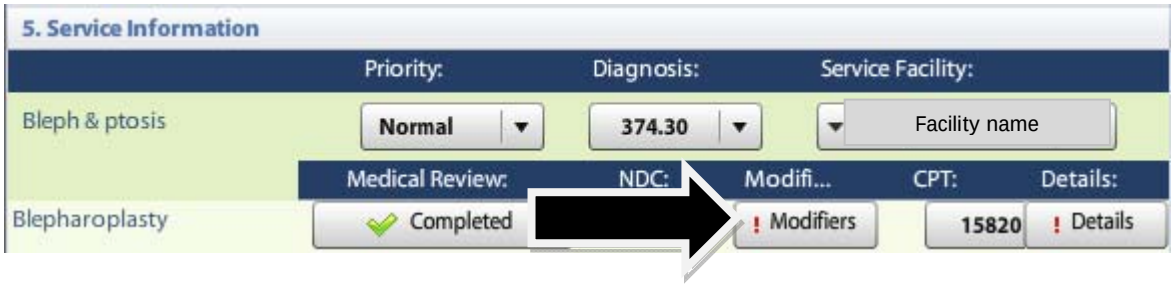
1. You **must** click the button under Alternative Action(s) to "Continue with Blepharoplasty" (or appropriate item) if you wish the request to pend to the Health Plan for review.



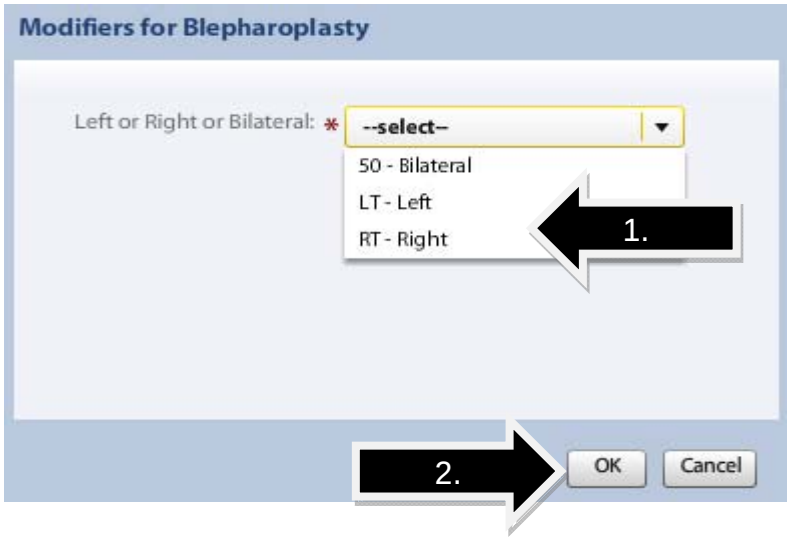
2. Click "Finish."

Clear Coverage™
Blepharoplasty Authorization Entry Tips

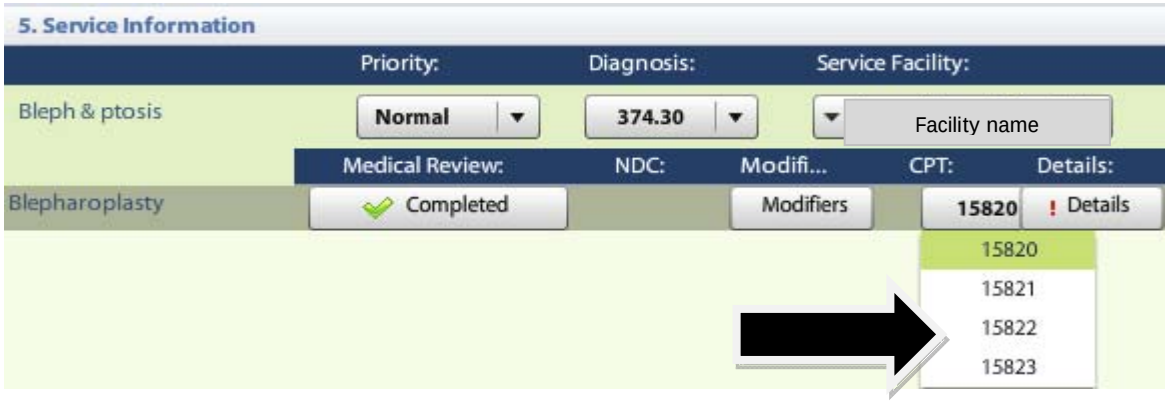
Modifiers: Click on the modifier tab (if there is more than one tab you must open and complete each tab).



Click on the drop down arrow and select if the procedure will be performed on the right, left or bilateral (1). Click “OK” (2).

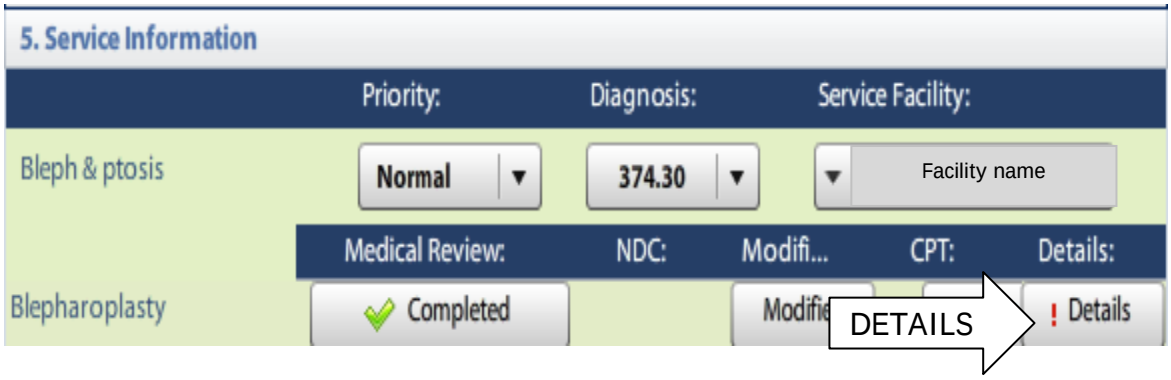


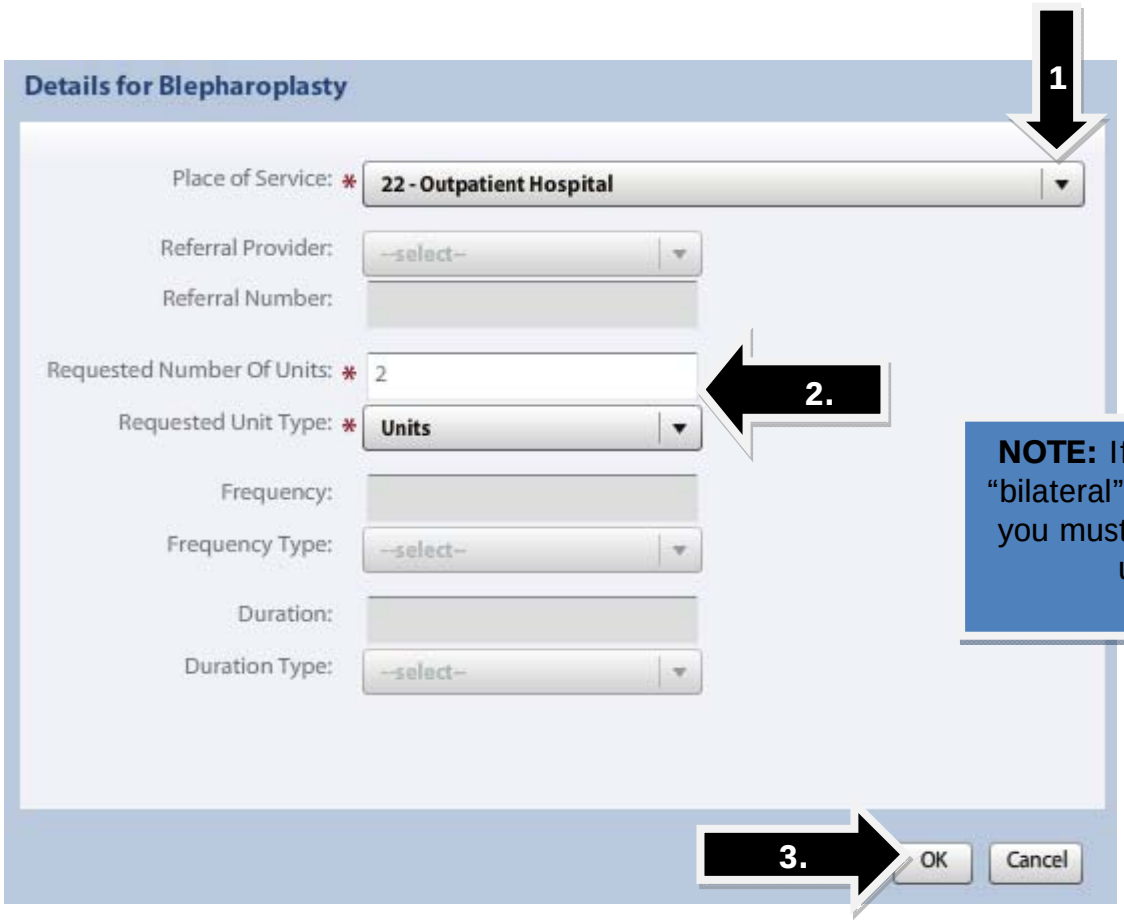
Ensure the correct CPT code is populated from the drop down menu:



Clear Coverage™
Blepharoplasty Authorization Entry Tips

Details section: Must select: (1) Place of Service, (2) Requested Number of Units and Requested Unit Type**.** Click the "OK" button (3).

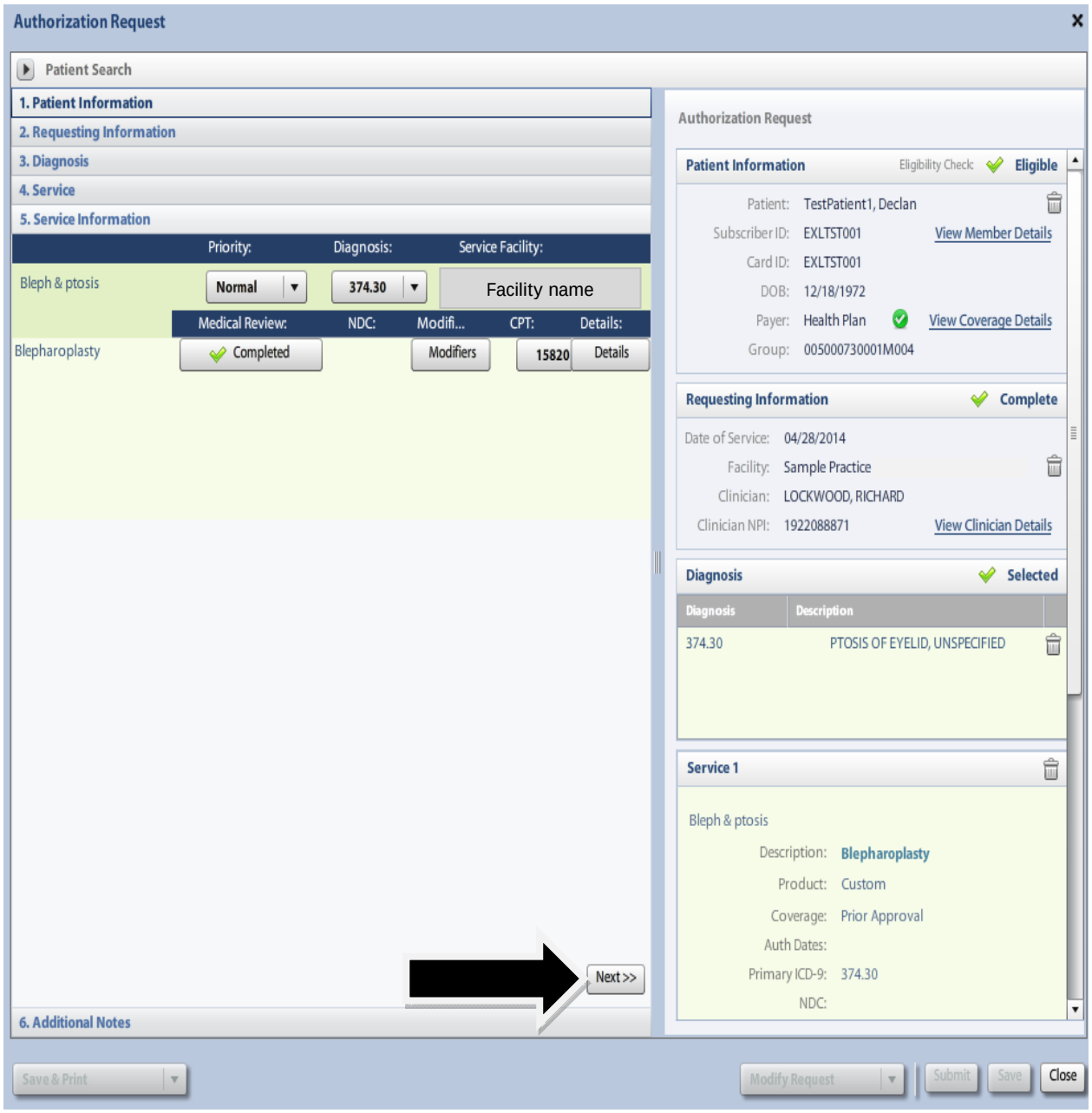




NOTE: If you selected "bilateral" as a modifier, you must request **two** units.

Clear Coverage™
Blepharoplasty Authorization Entry Tips

Click “Next”

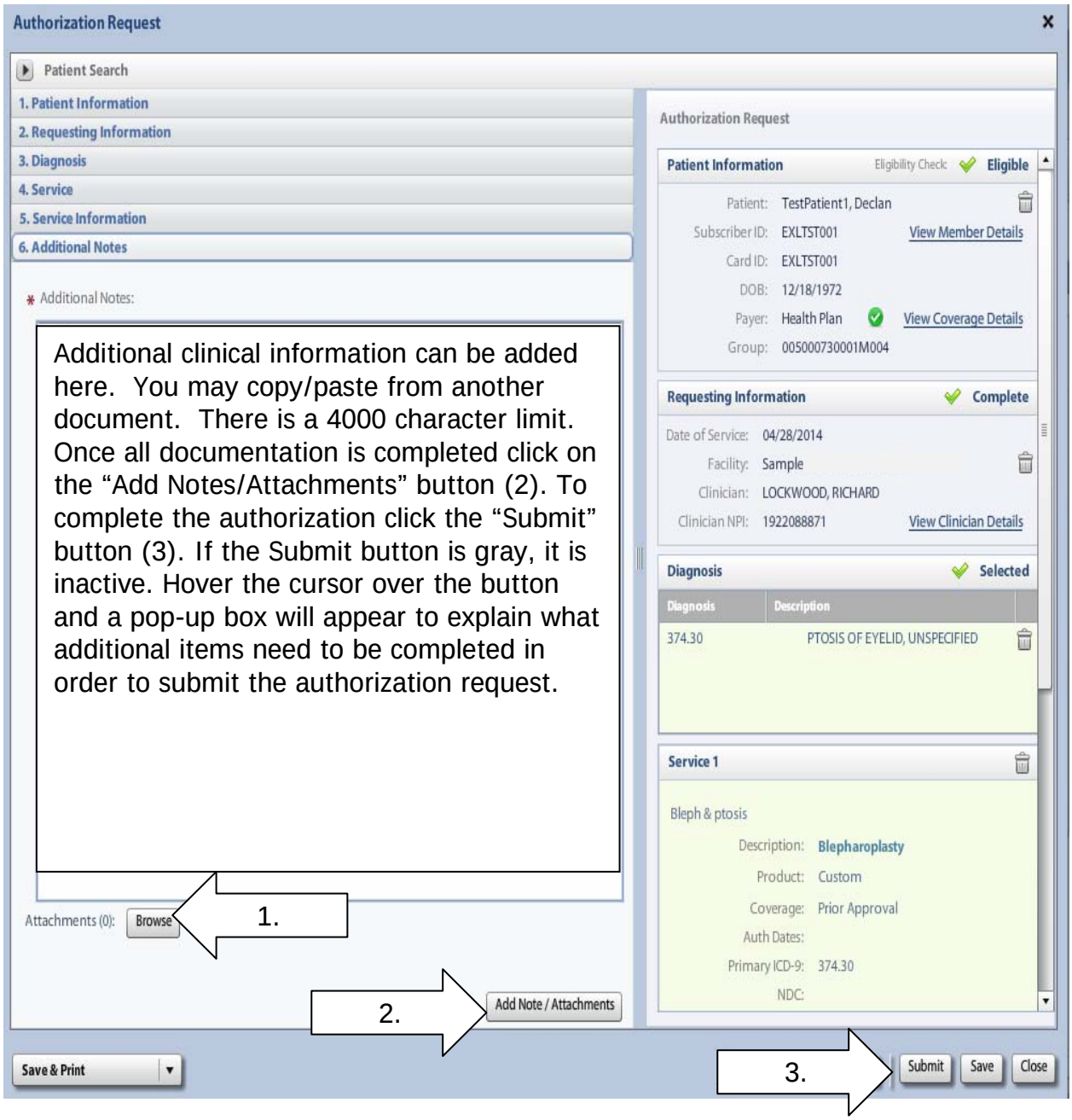


Clear Coverage™
Blepharoplasty Authorization Entry Tips

Accordian 6: Additional Notes

Type any additional clinical information in the “Additonal Notes” free text box and/or attach additional supporting medical documentation and the required photographs (1). A note must be added in order to attach a document.

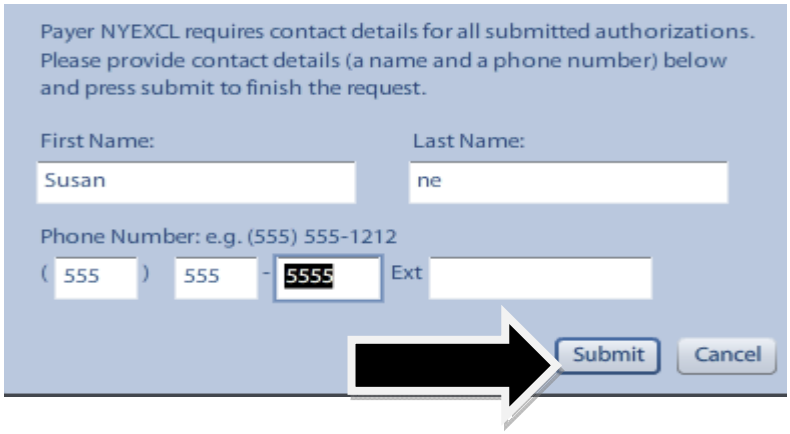
NOTE: All authorization requests require photographs to be submitted.



Clear Coverage™
Blepharoplasty Authorization Entry Tips

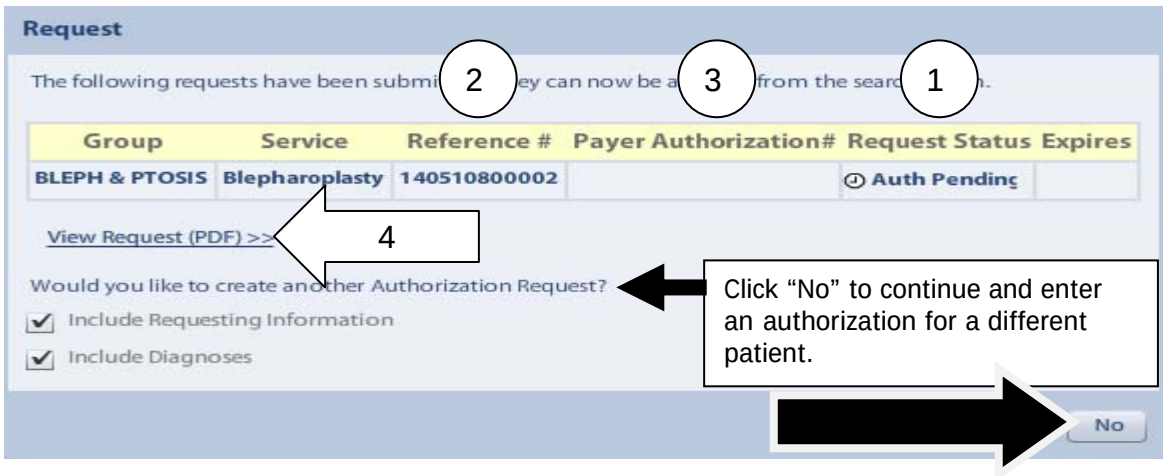
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

Medicare: review tool MUST be completed to provide clinical information to the Health Plan. Medicare requests will pend until this information is reviewed.

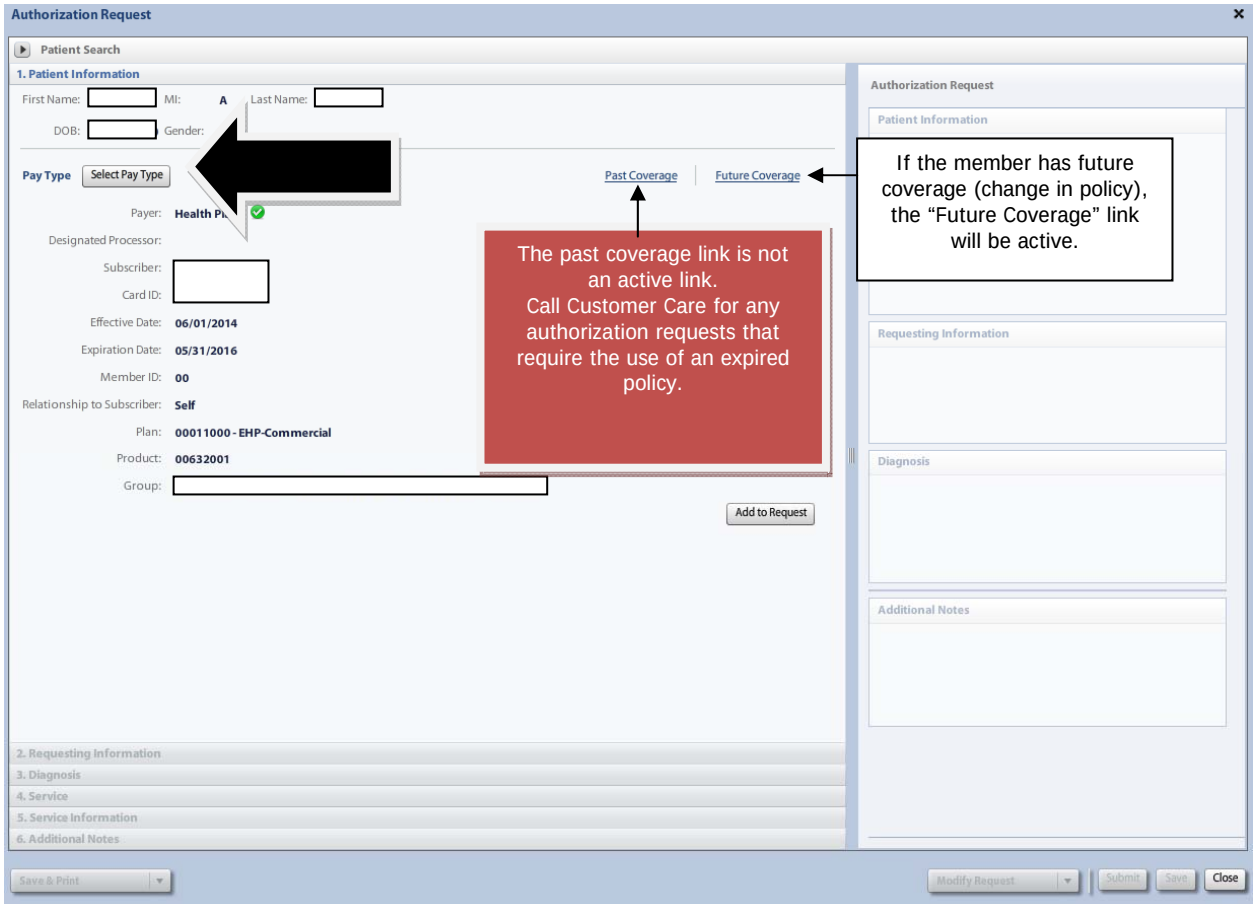
Commercial: will auto approve if criteria is met.

NOTE: If the request pends, the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

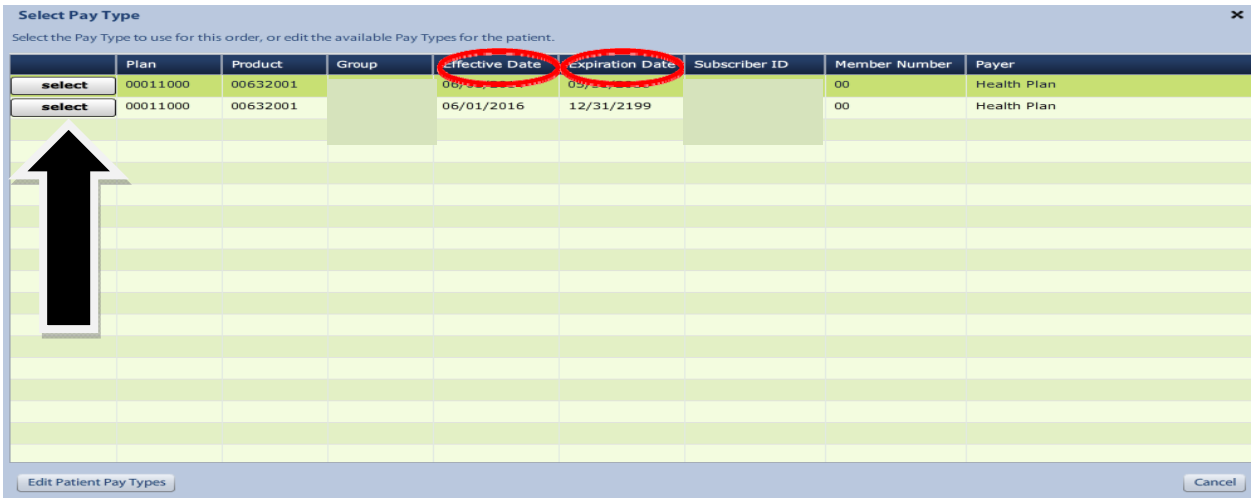


Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

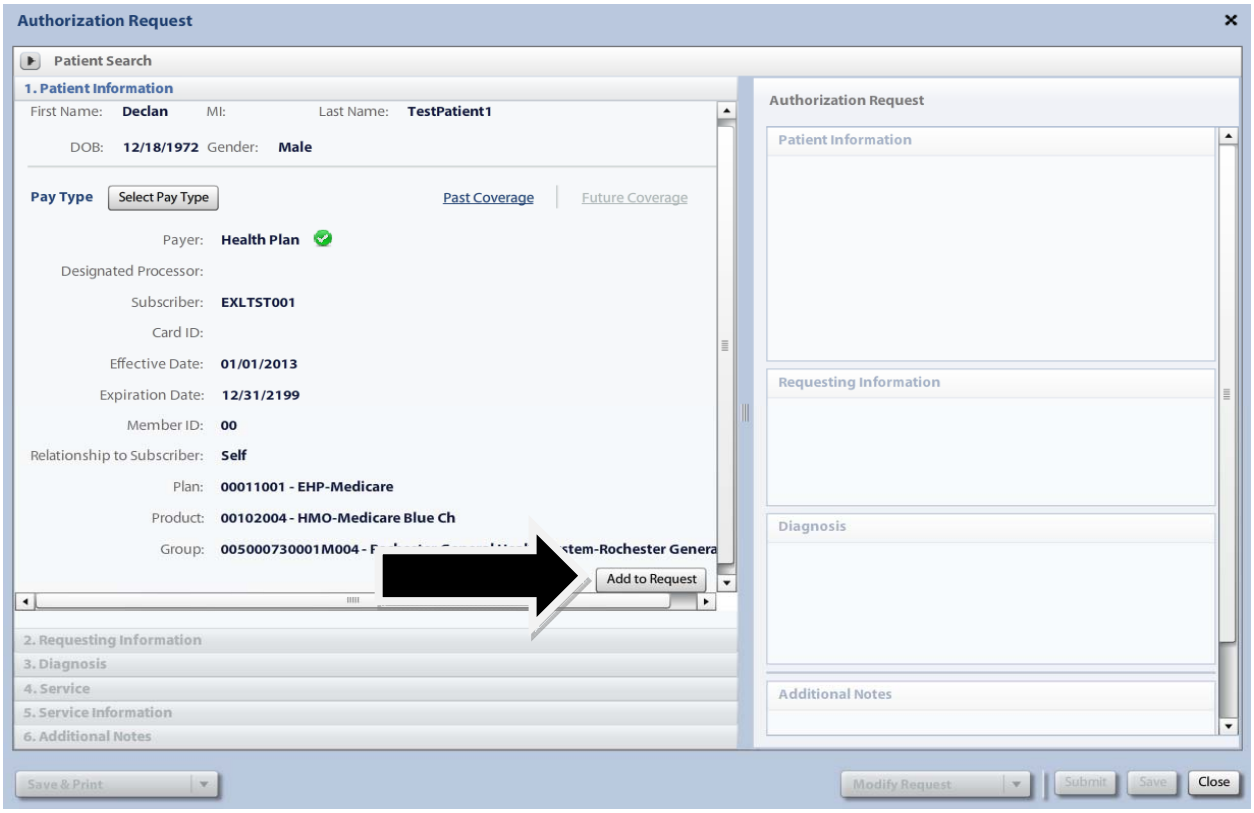
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

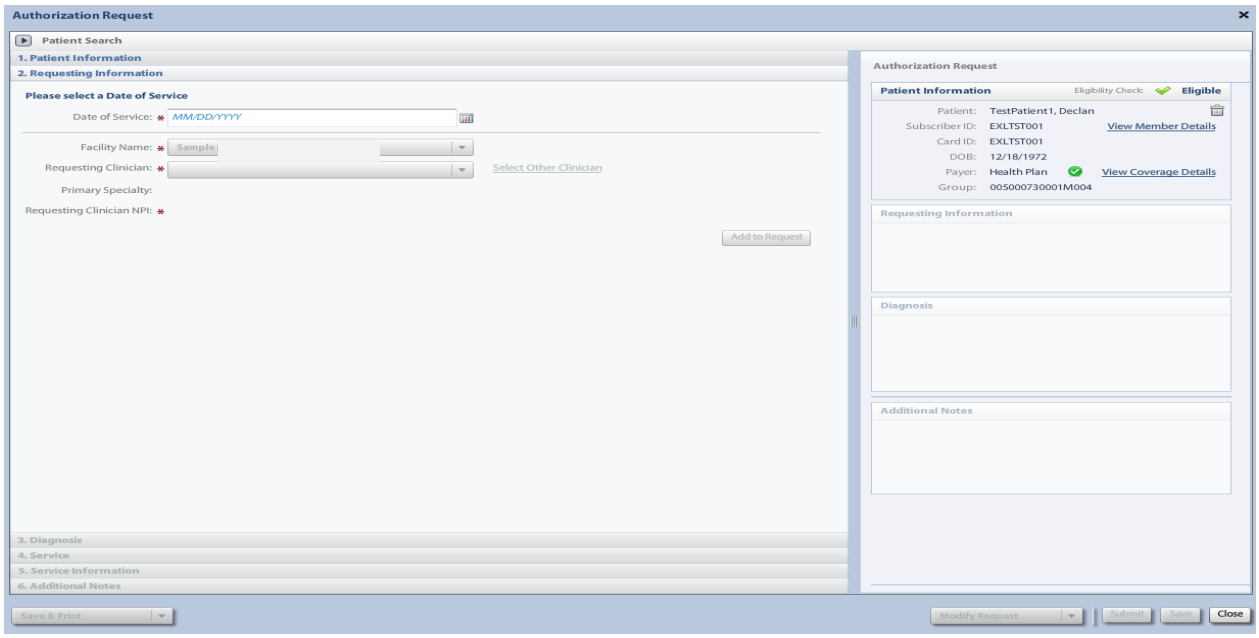


Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

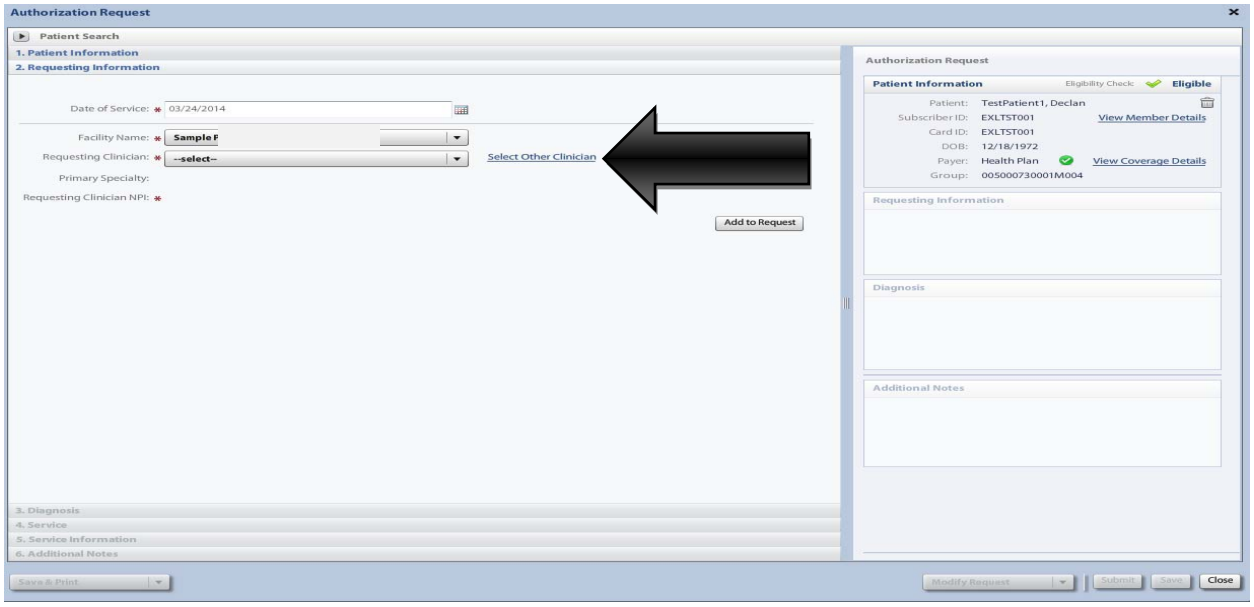
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

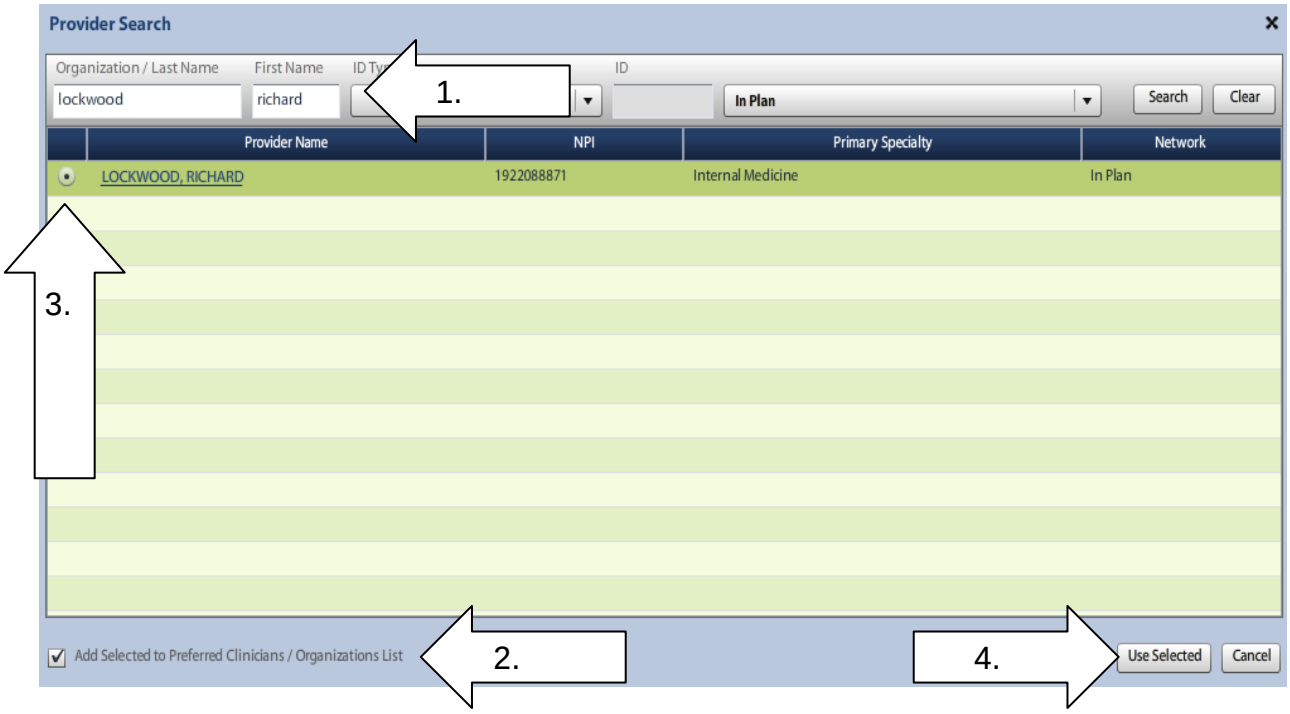


Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

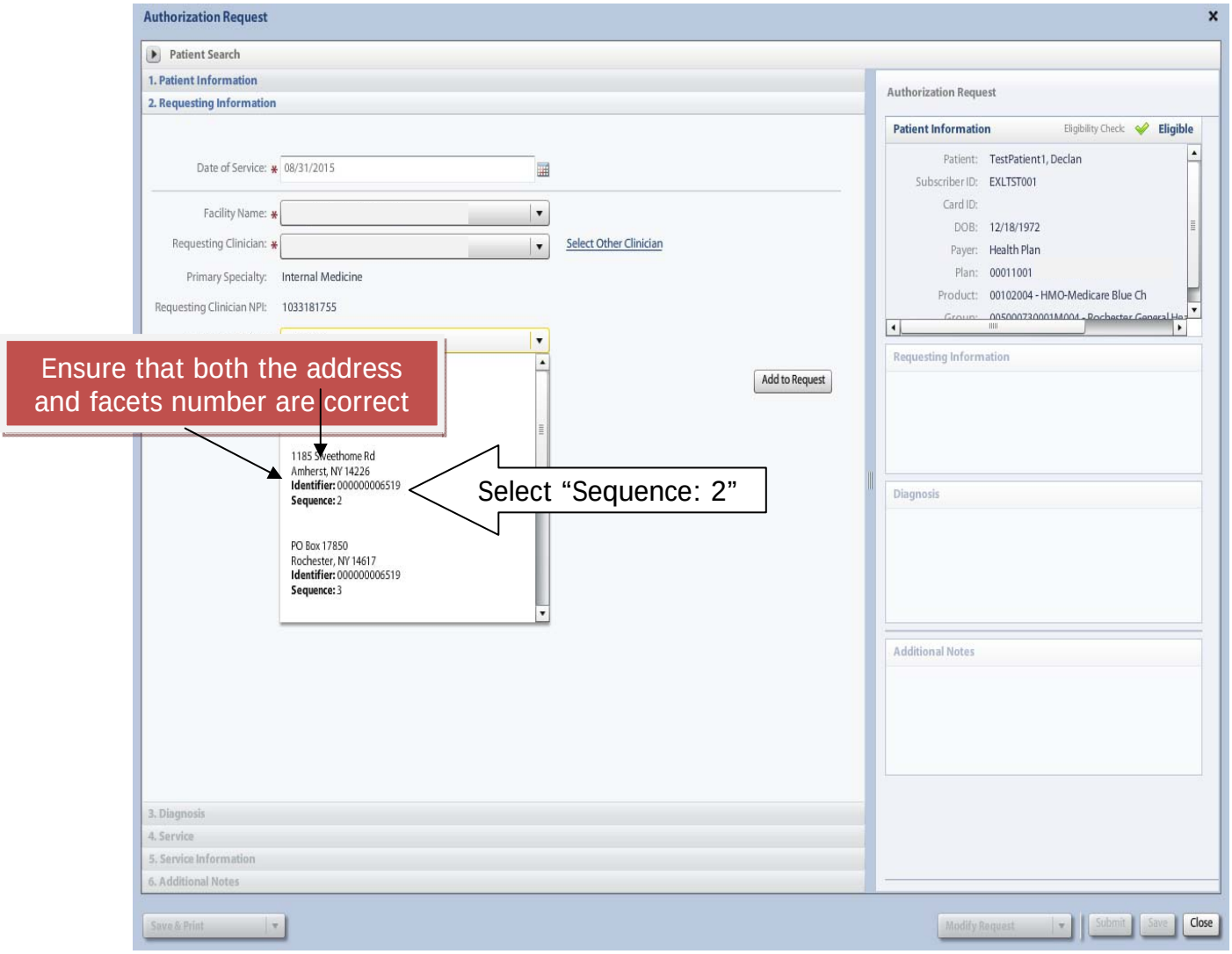
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

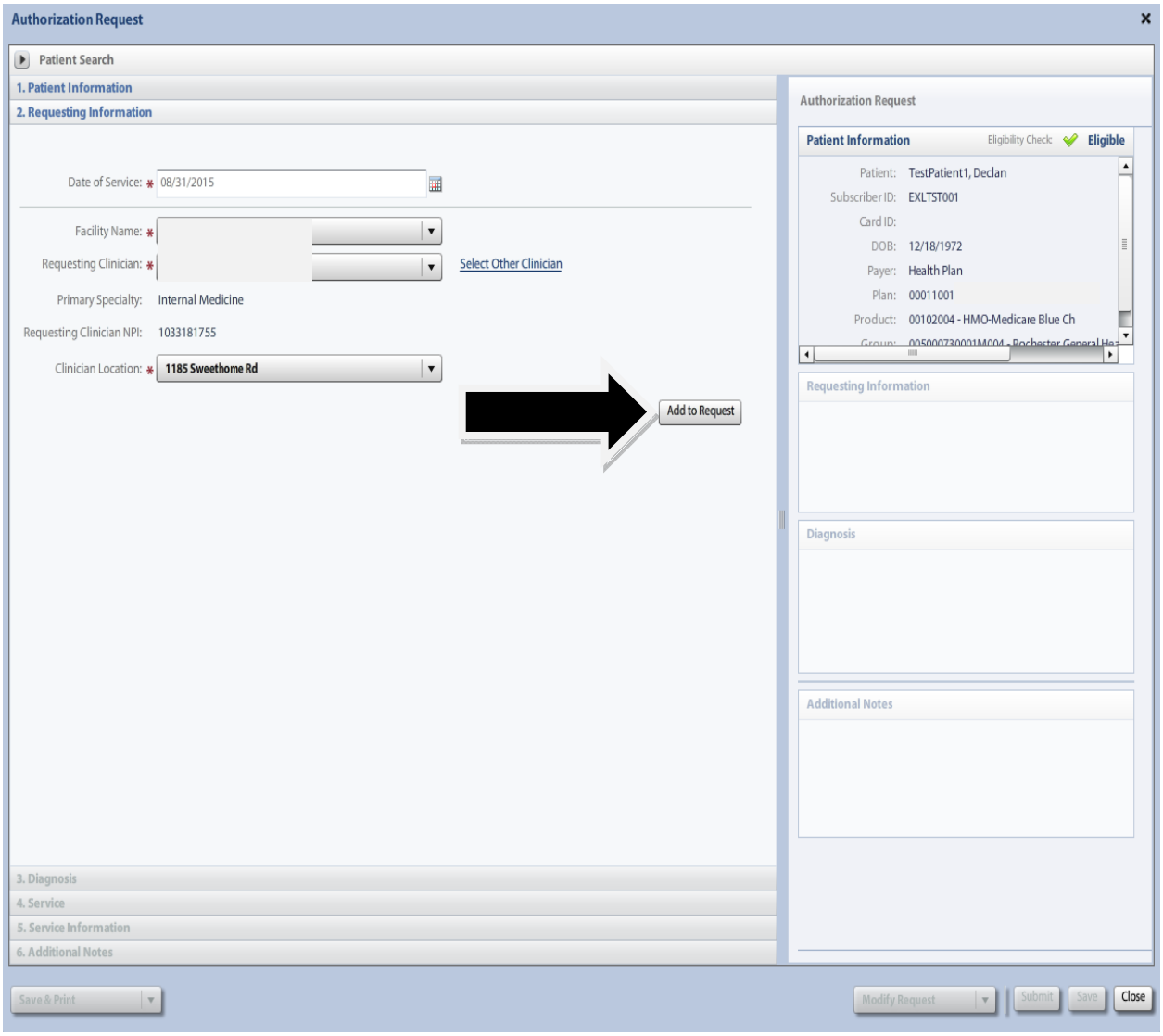
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

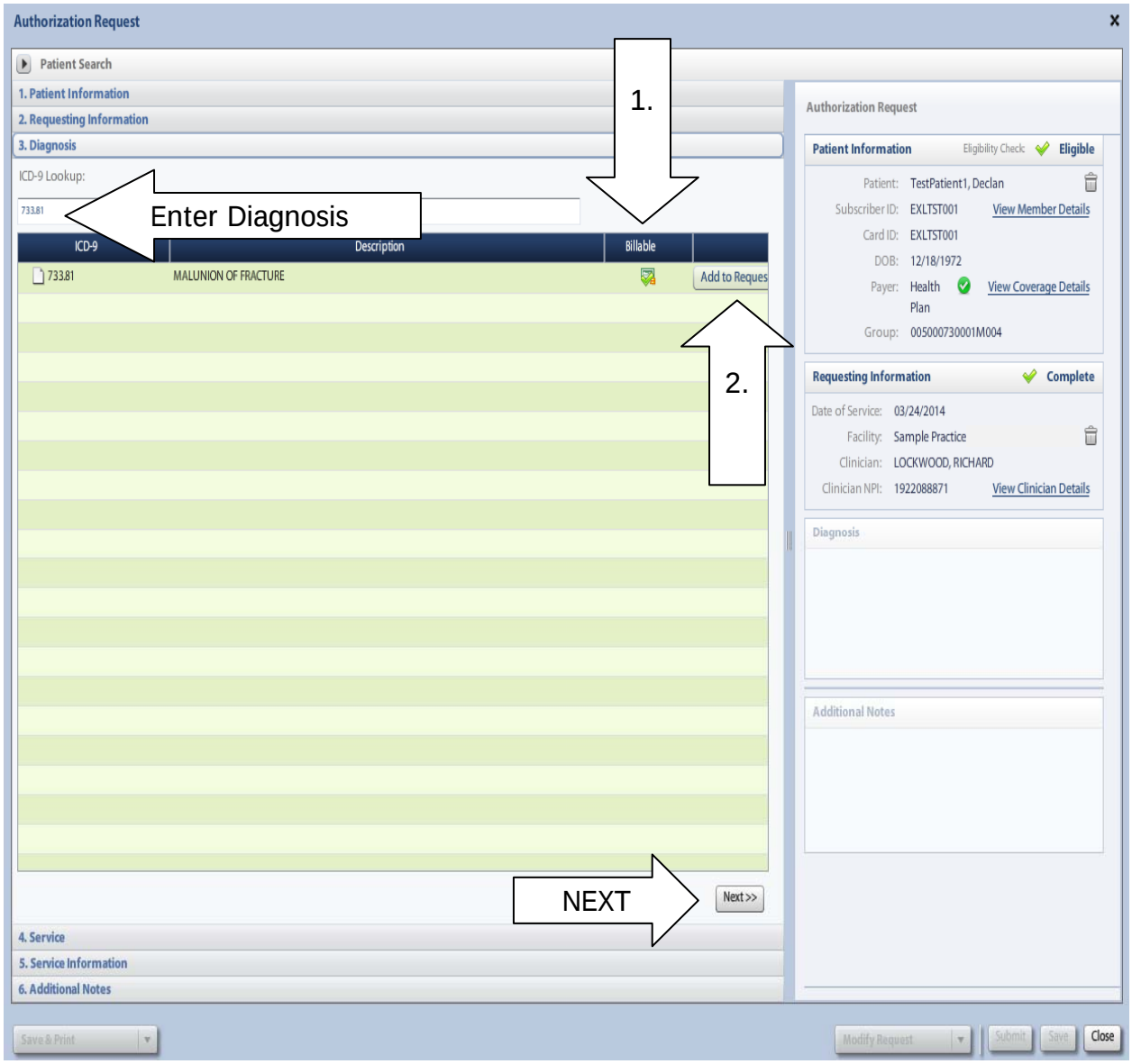
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

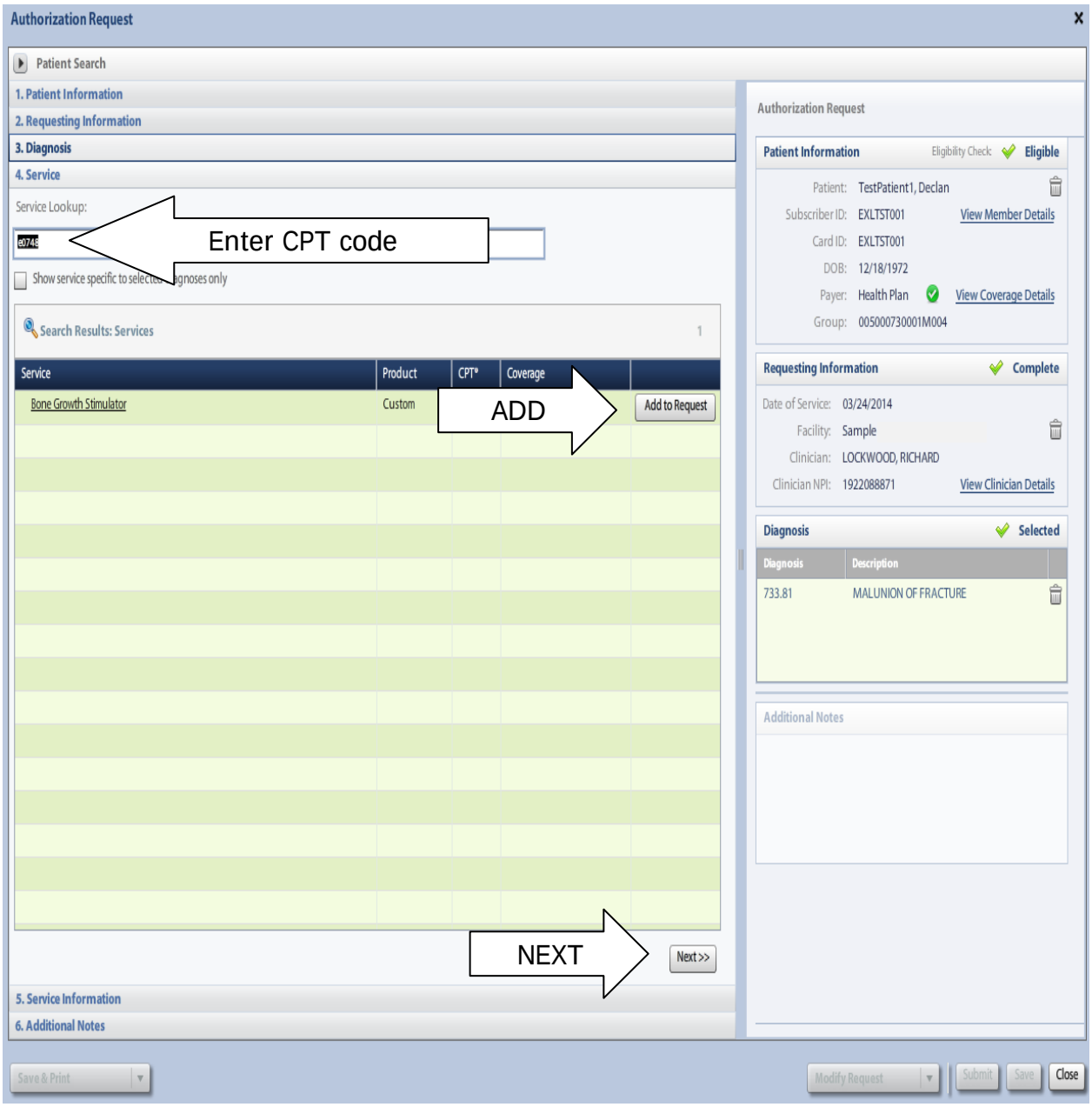


Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

Accordion 4: Services

Enter CPT code.

- Click the “Add to Request” button, then click “Next”.



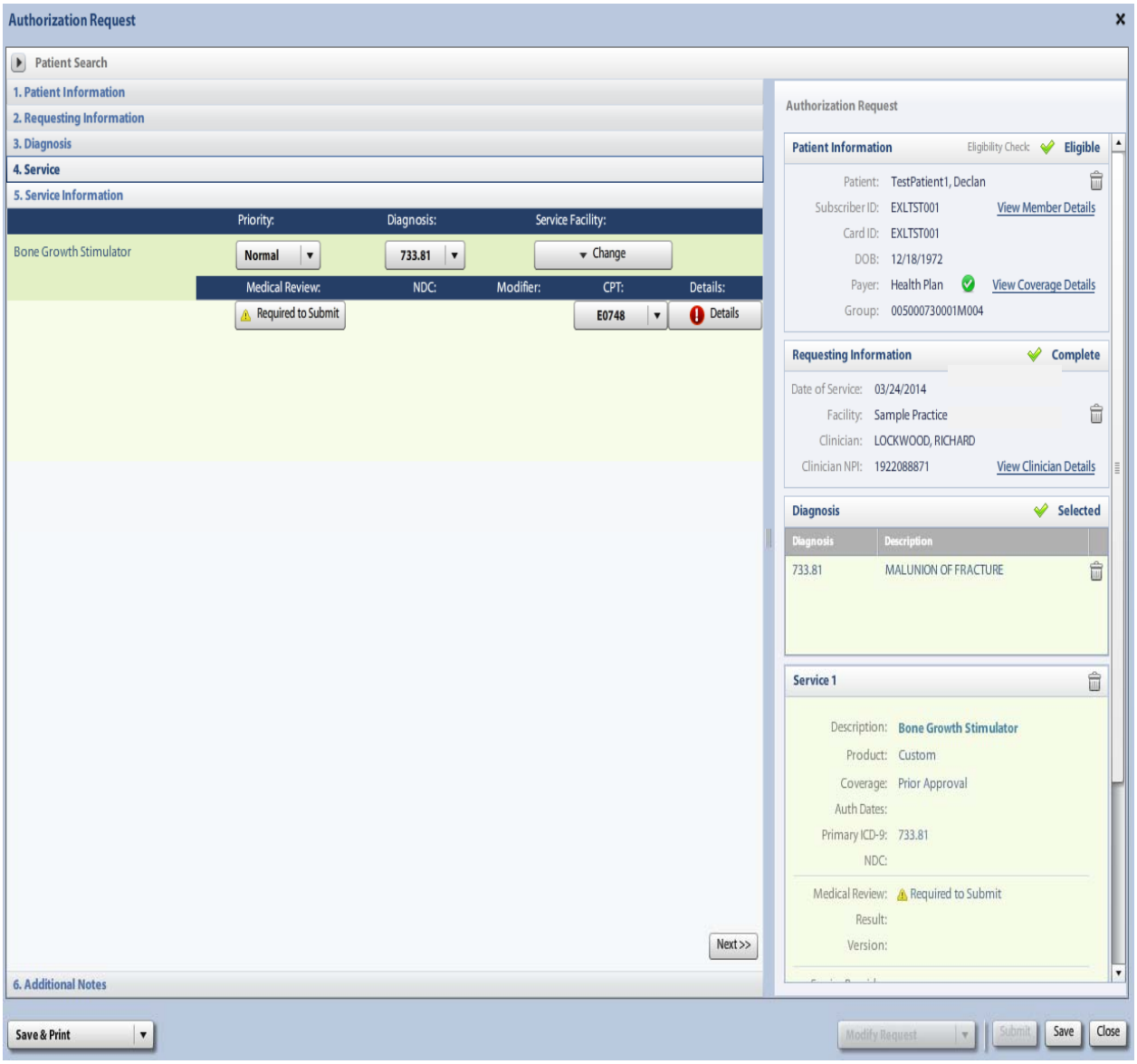
Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

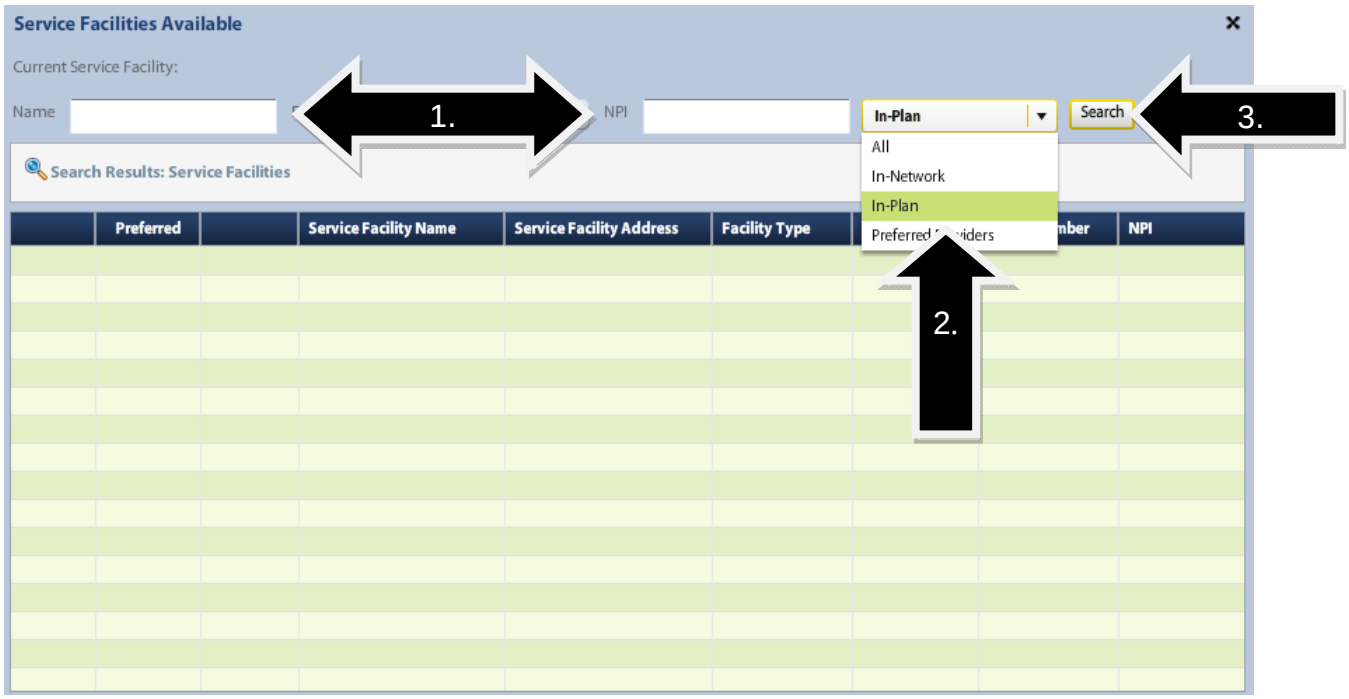
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service (or provider/vendor)

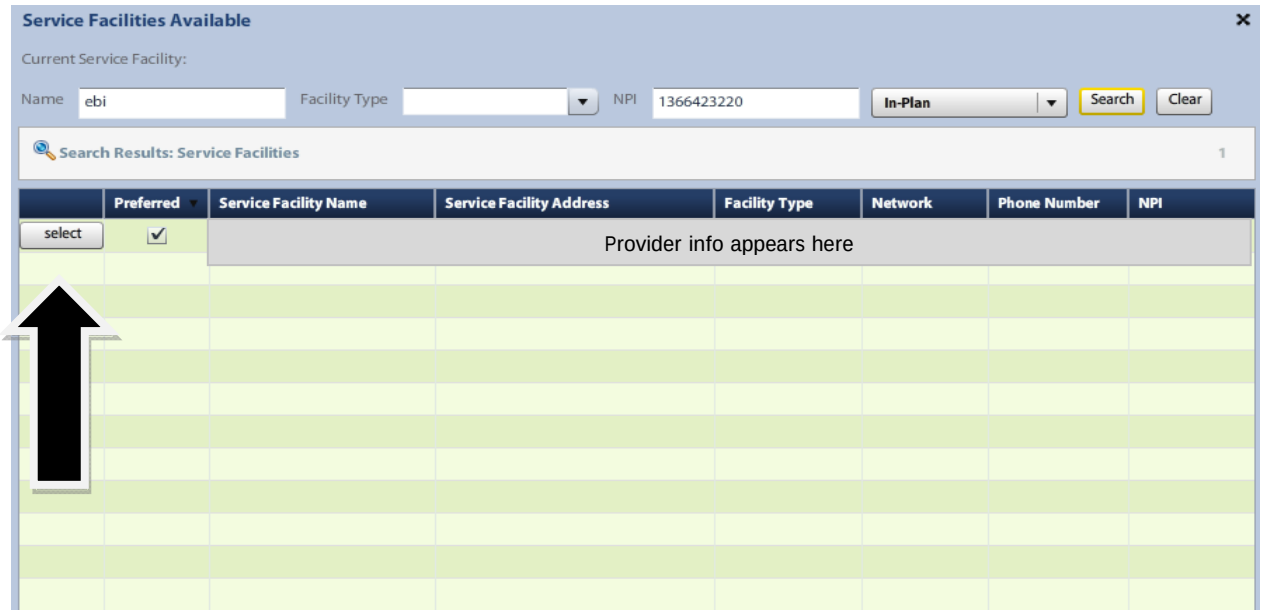


Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).

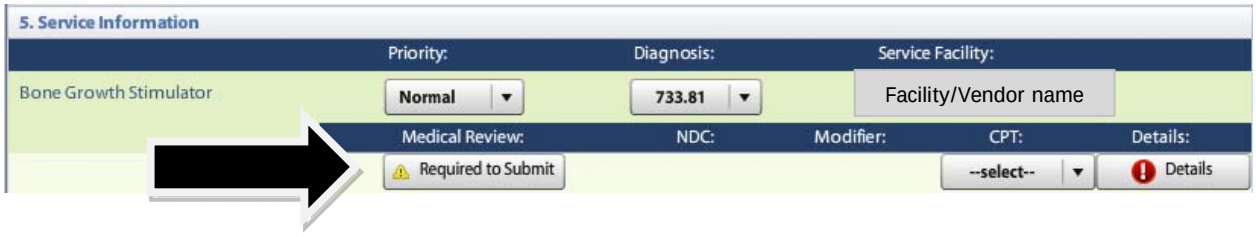


When the results display, select the appropriate provider.

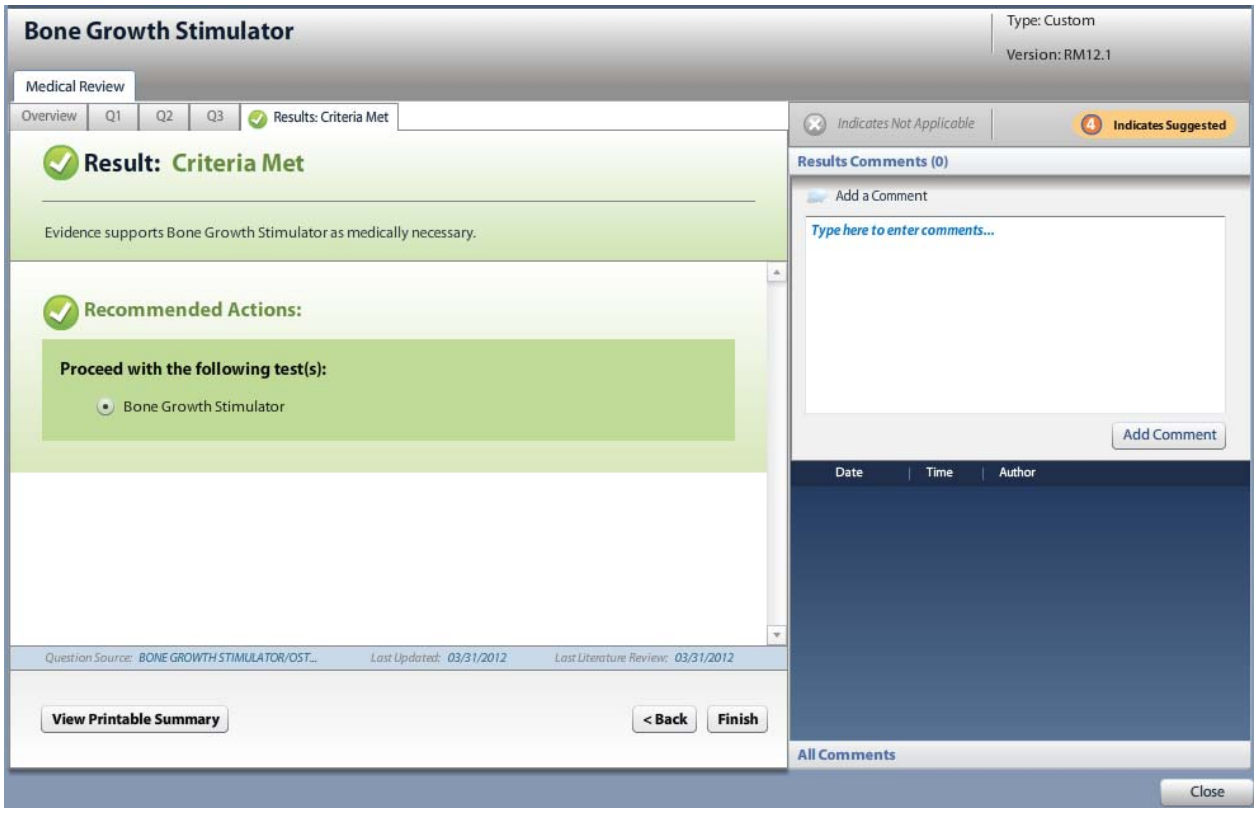


Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

Click on the Medical Review “Required to Submit” tab and complete the review.



If criteria met: Click “Finish.”

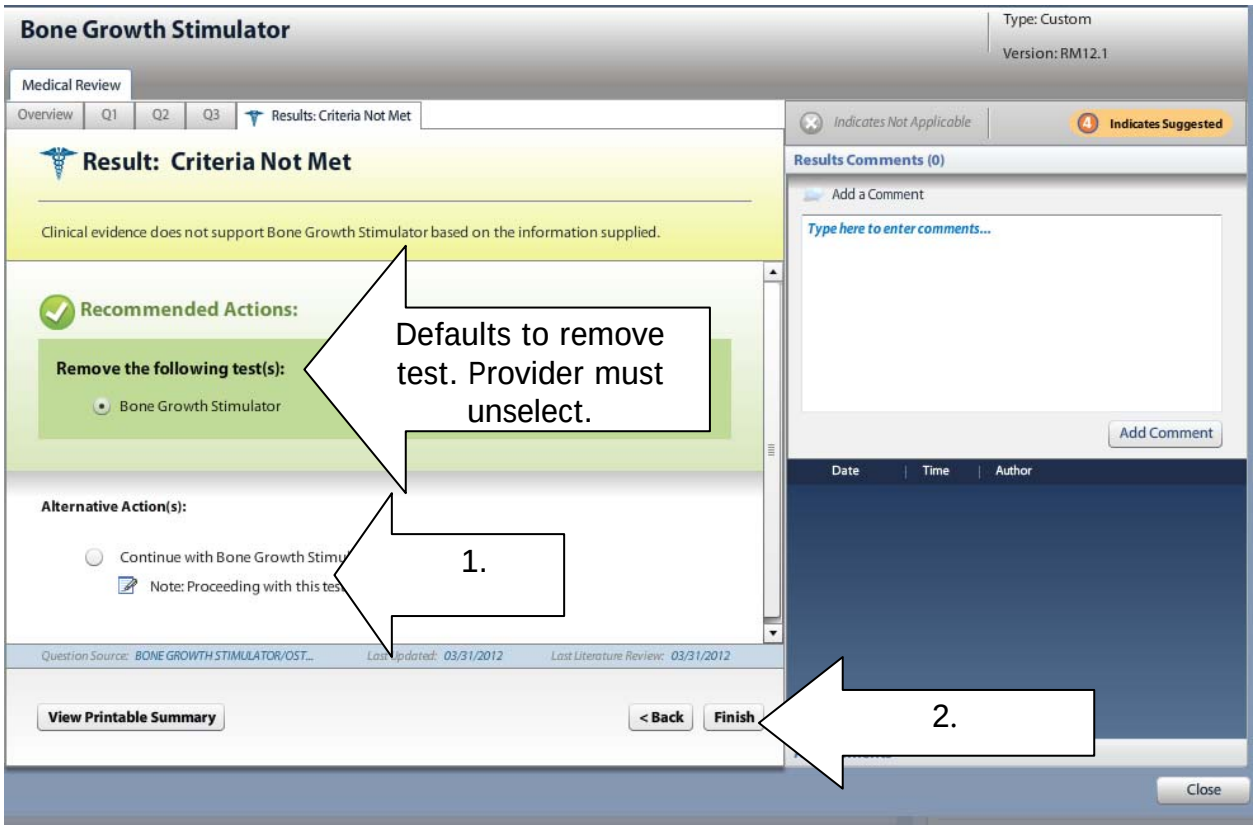


Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

If criteria not met:

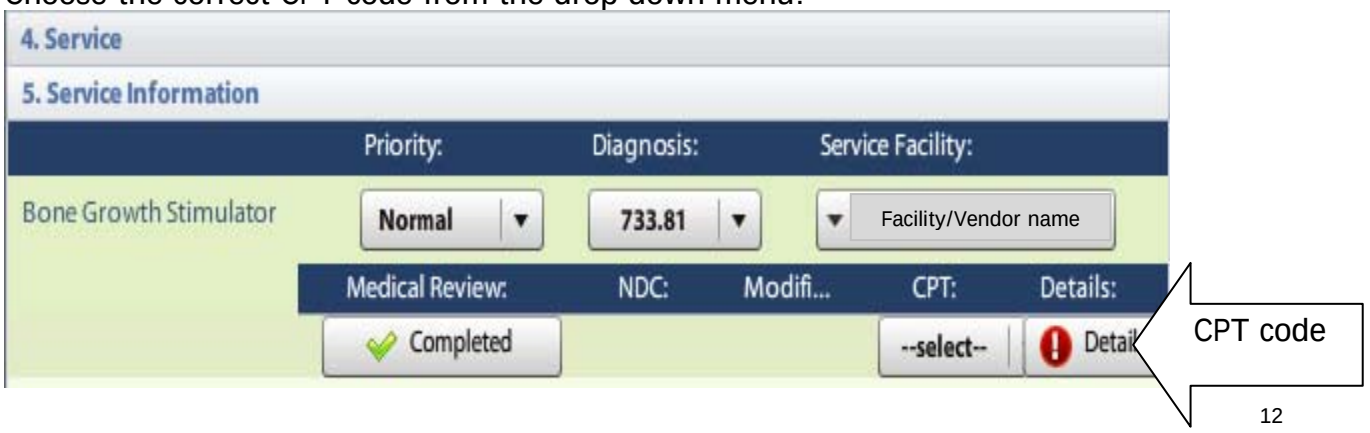
The default choice is to **remove** the item from the request.

1. You **must** click the button under Alternative Action(s) to "Continue with Bone Growth Stimulator" (or appropriate item) if you wish the request to pend to the Health Plan for review.



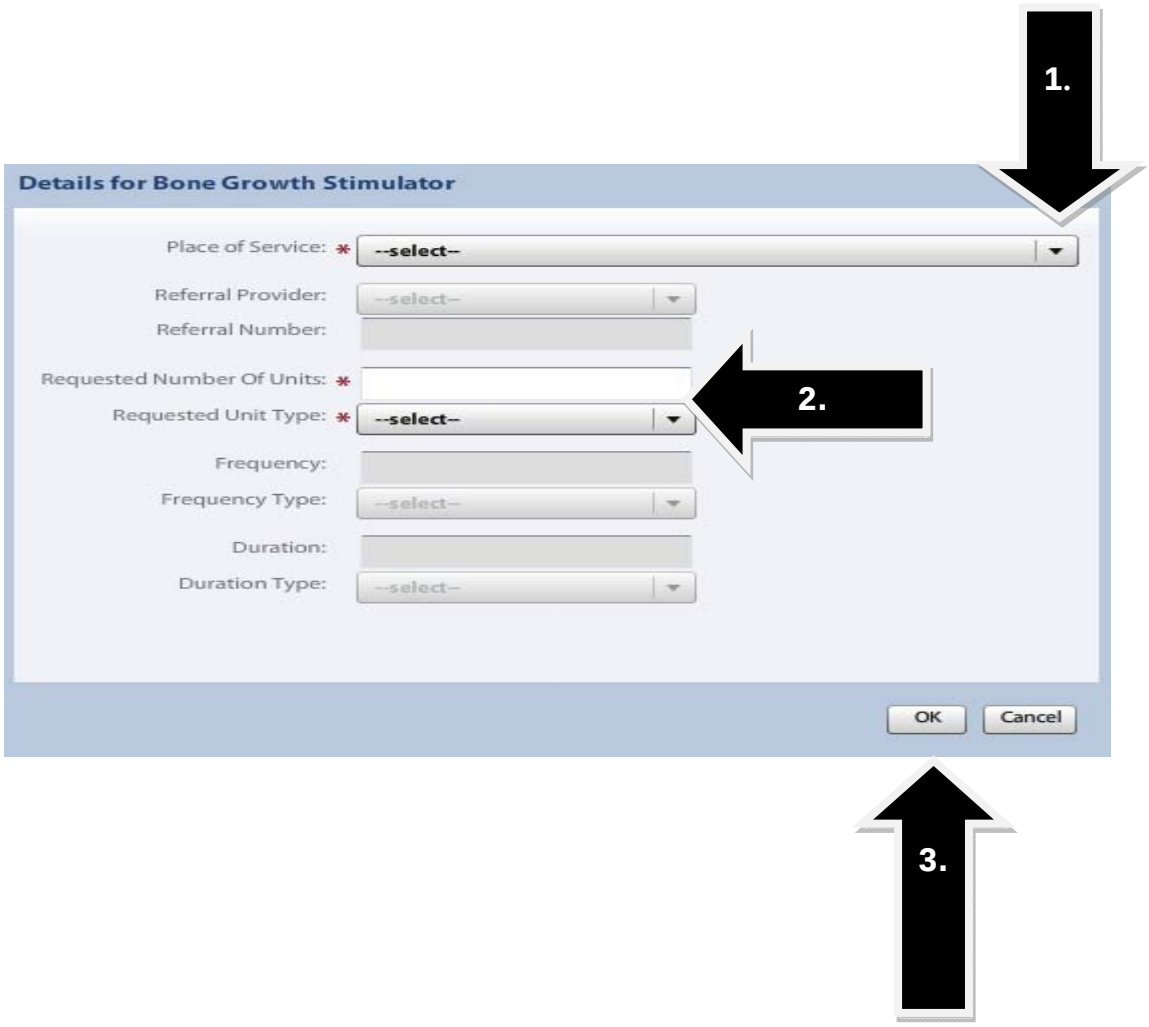
2. Click "Finish."

Choose the correct CPT code from the drop down menu:



Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

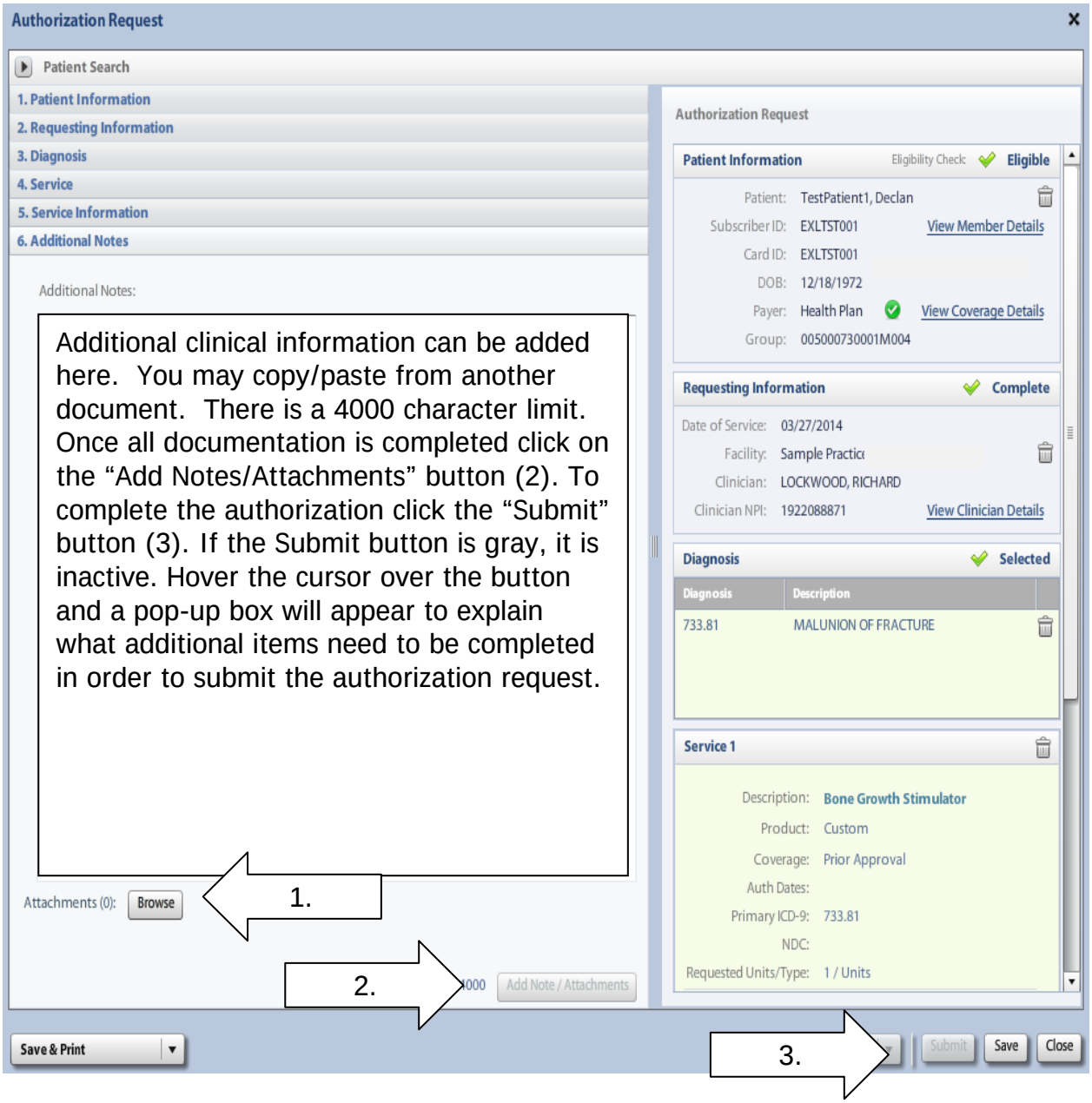
Details section: Must select: (1) Place of Service, (2) Requested Number of Units and Requested Unit Type**.** Click the "OK" button (3).



Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

Accordian 6: Additional Notes

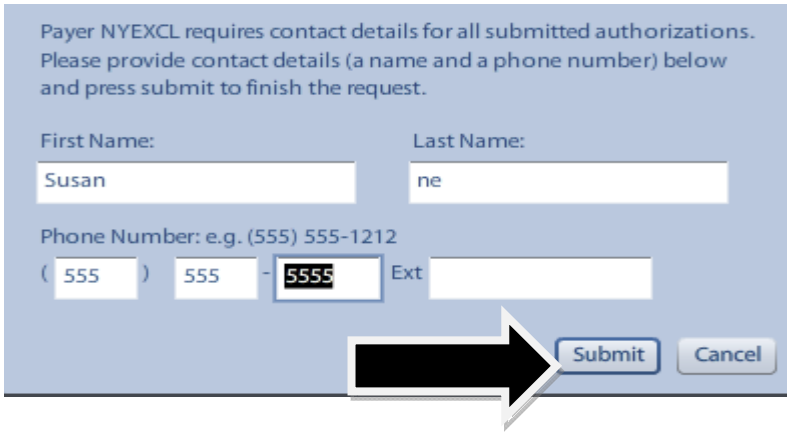
If criteria was <u>not</u> met, enter additional information and/or attach a note with supporting medical documentation (1).
A note <u>must</u> be added in order to attach a document.



Clear Coverage™
Bone Growth Stimulator Authorization Entry Tips

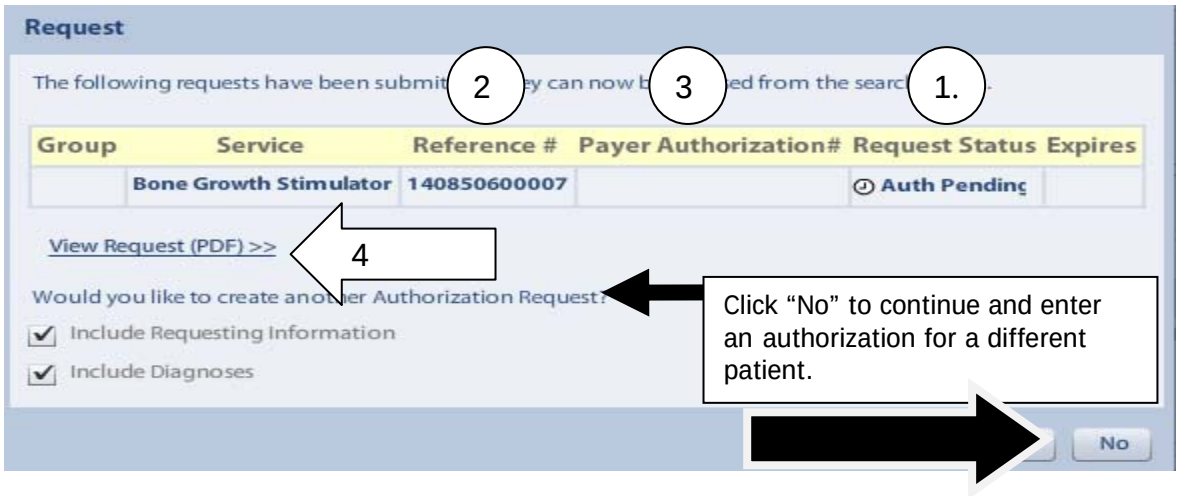
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
CPAP/BiPAP Authorization Entry Tips

Medicare/Medicaid: All requests will pend. Send supporting documentation within the Clear Coverage™ tool (Accordion 6).

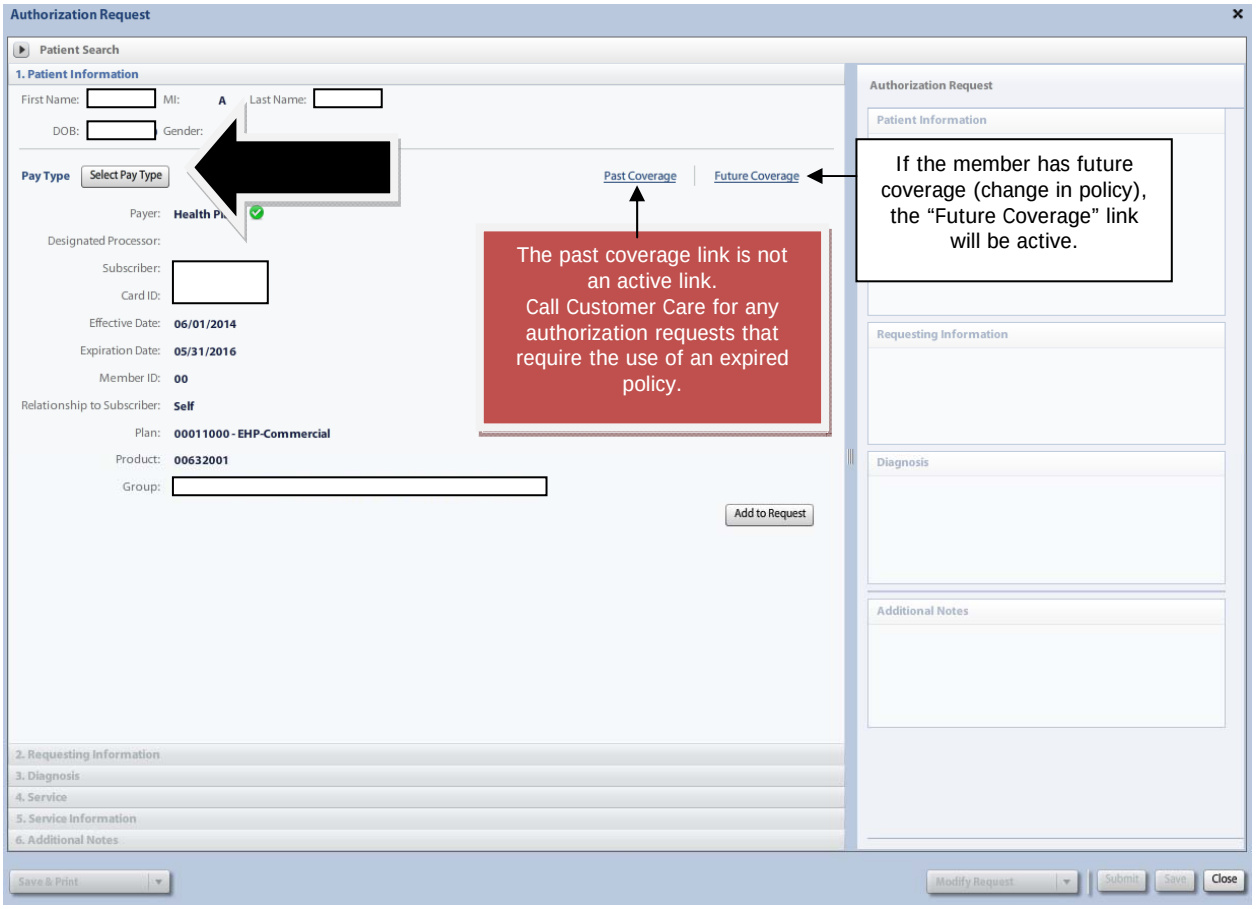
Commercial: will auto approve for 3 months if criteria is met. If the request pends, the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

If the request is for extension of rental, please refer to the "CPAP/BiPAP Extension Request" document.

After searching for and selecting the patient, the Authorization Request Entry Box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

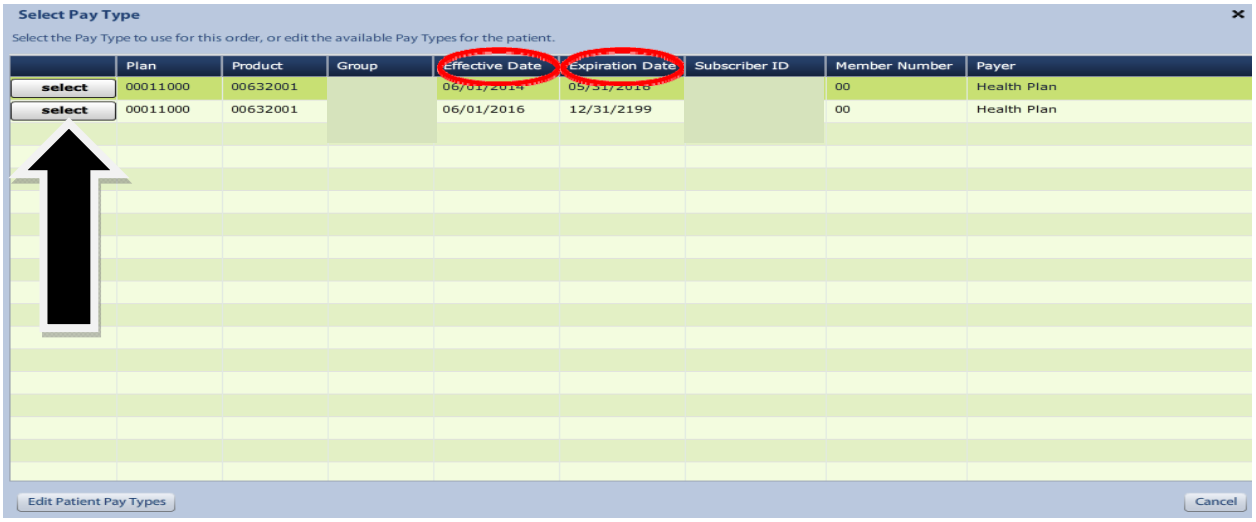


Clear Coverage™
CPAP/BiPAP Authorization Entry Tips

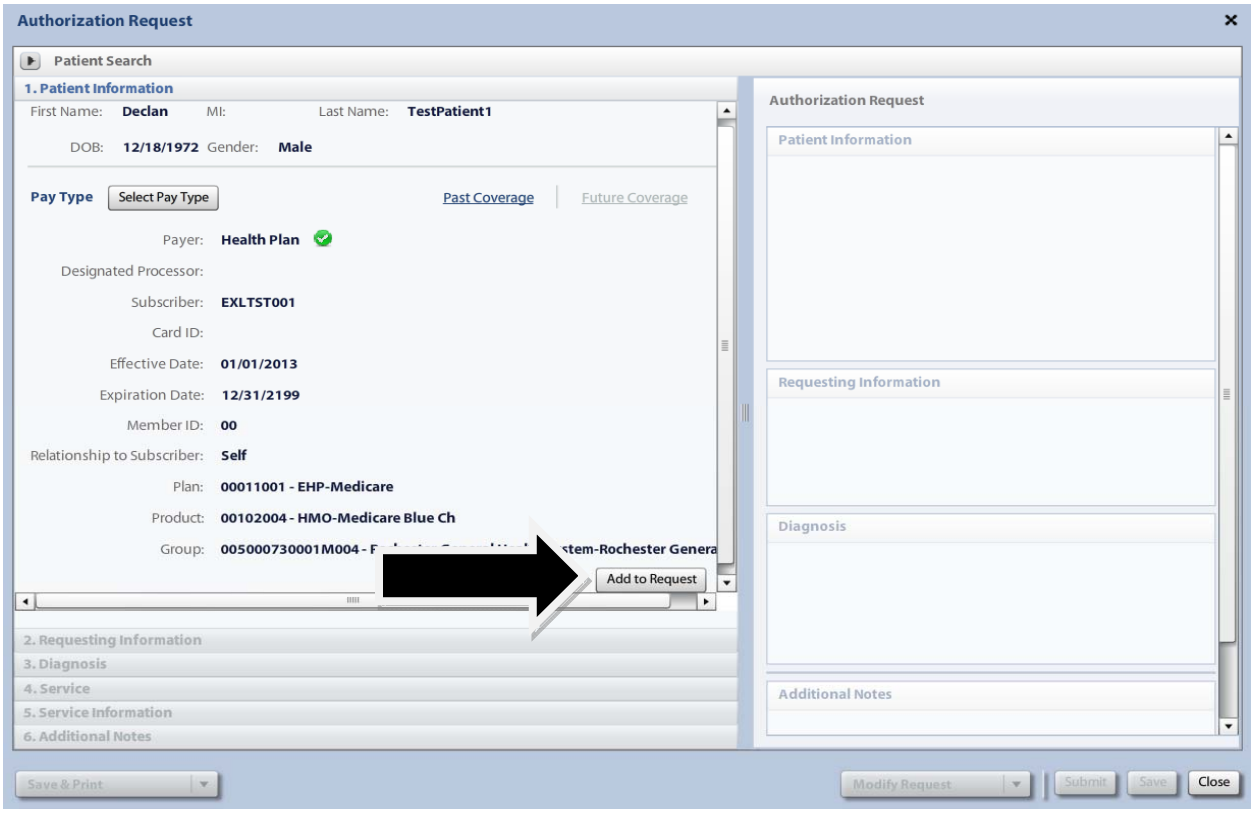
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



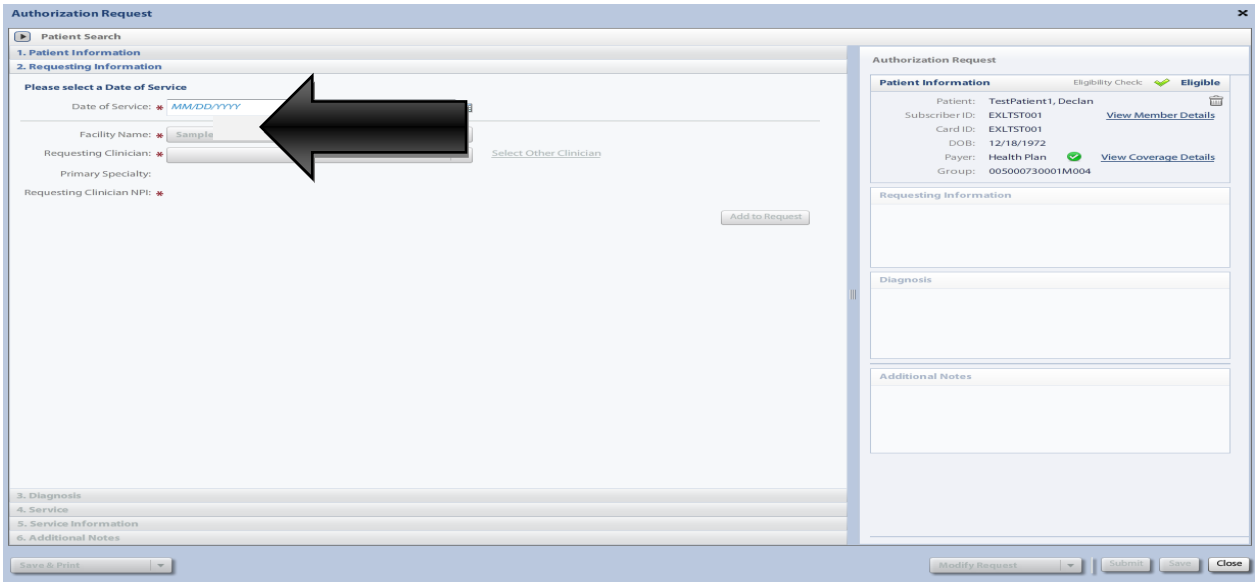
Click “Add to Request” to continue.



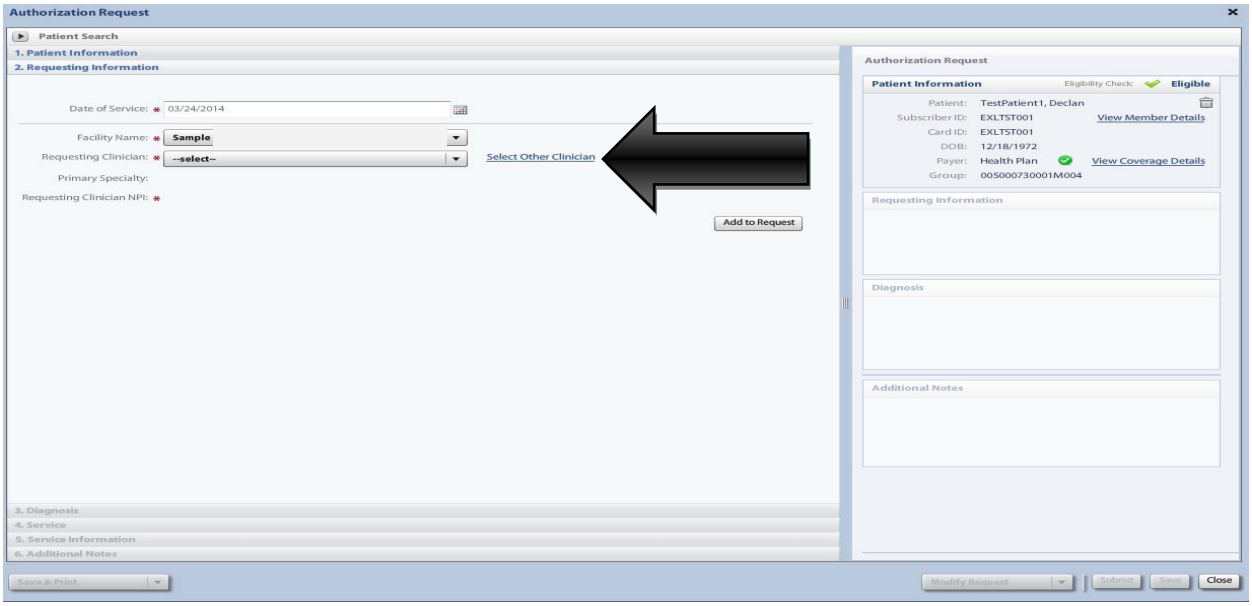
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



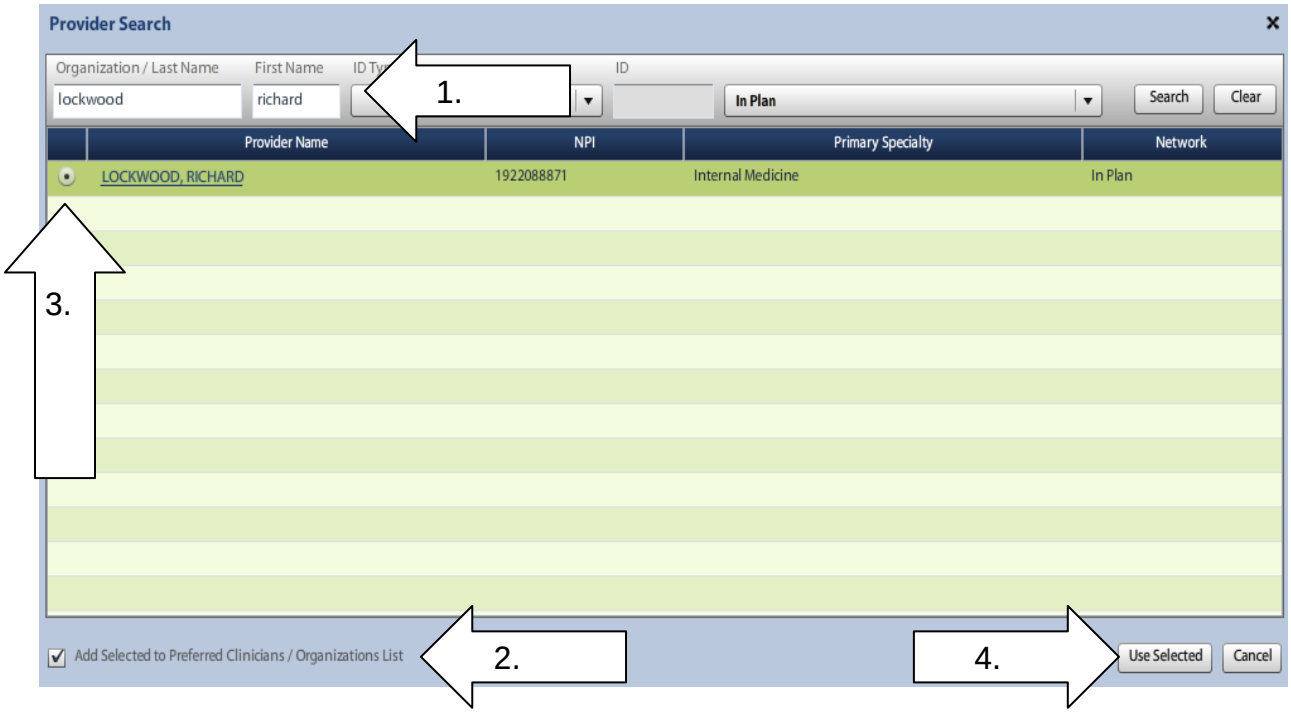
Requesting Clinician = Ordering **PHYSICIAN**. Do NOT enter a nurse practitioner, physician assistant or other provider. Click on "Select Other Clinician" to search.



Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

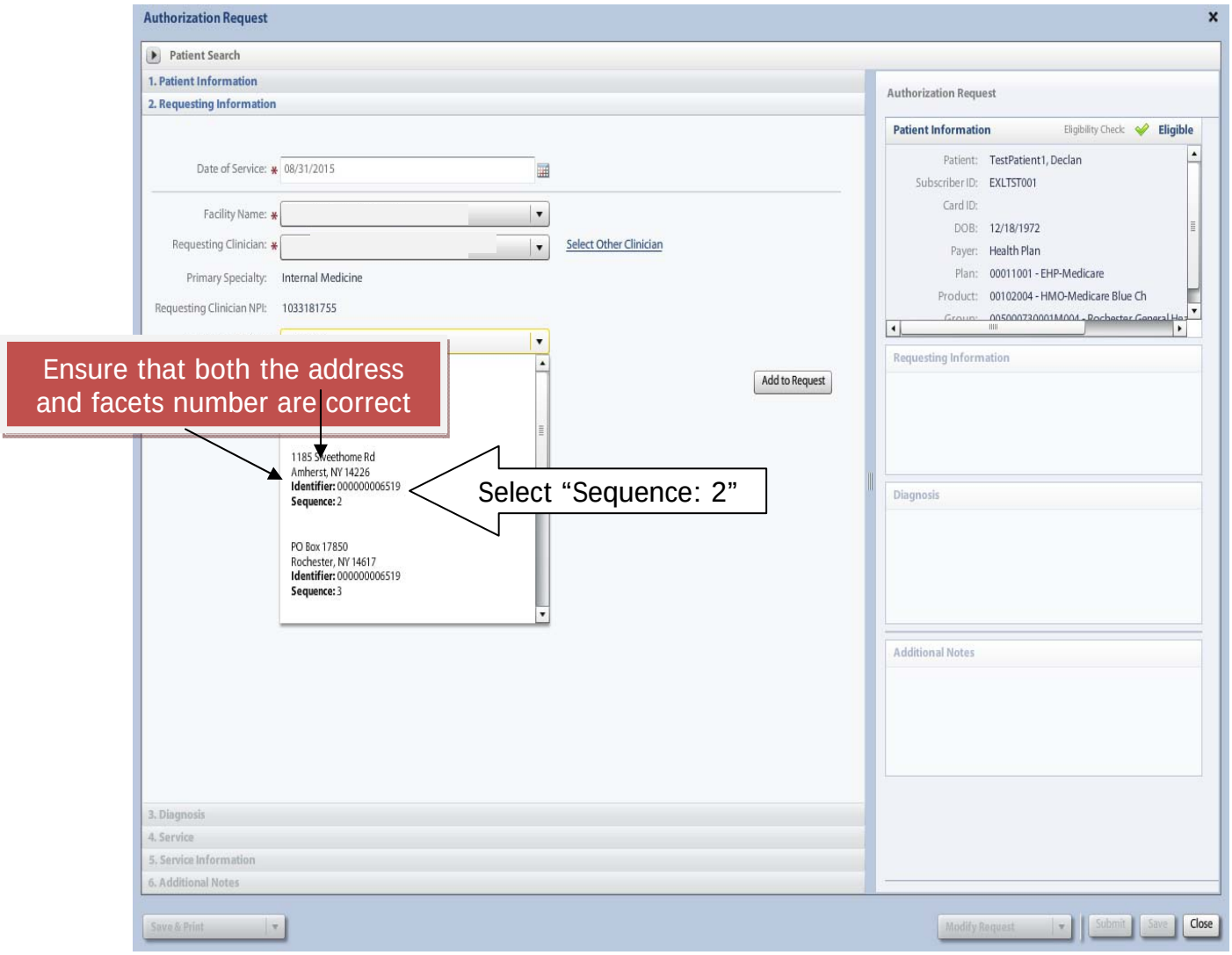
Select the provider using the radio button (3) then click the “Use Selected” button(4).



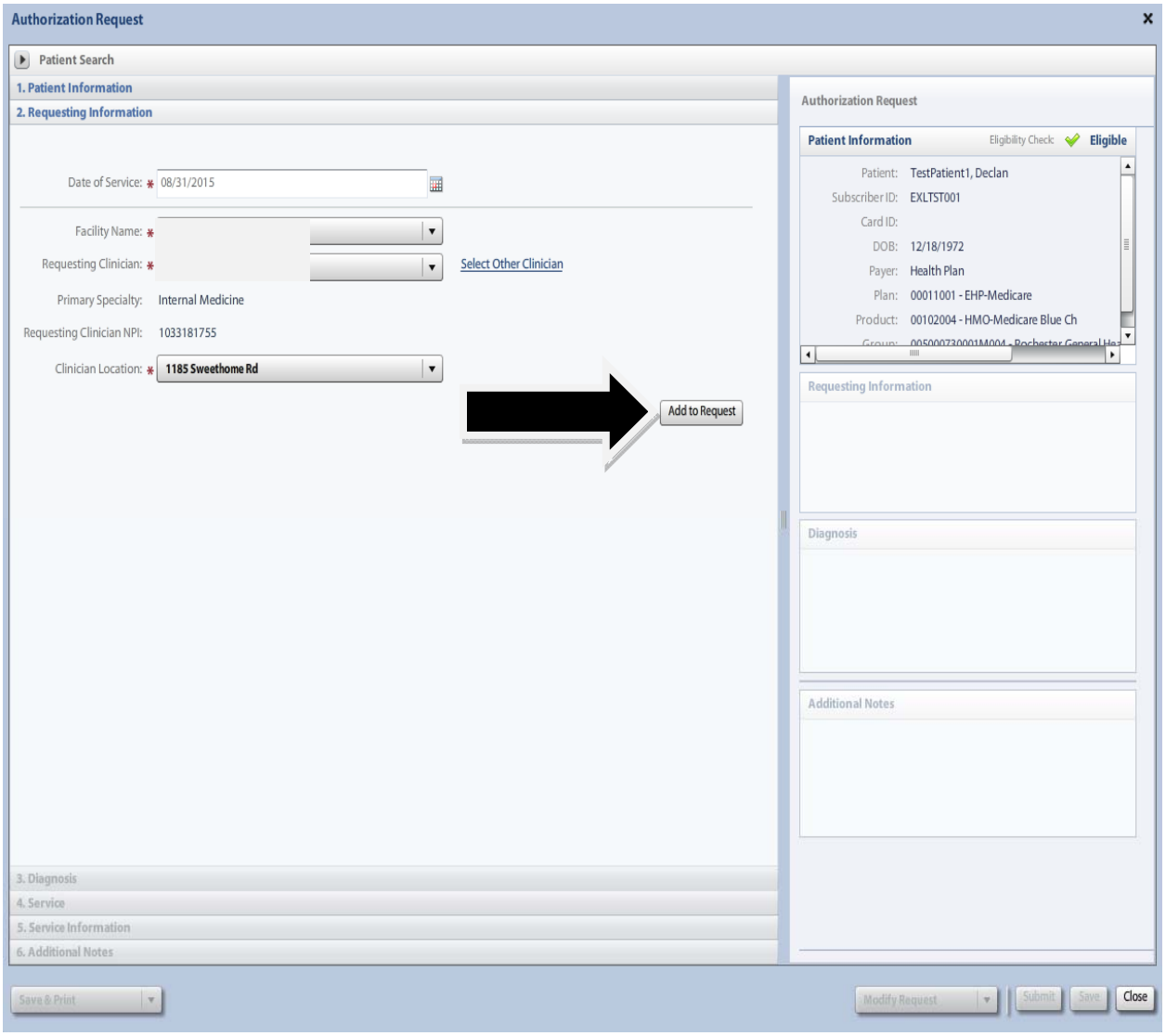
Clear Coverage™
CPAP/BiPAP Authorization Entry Tips

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.

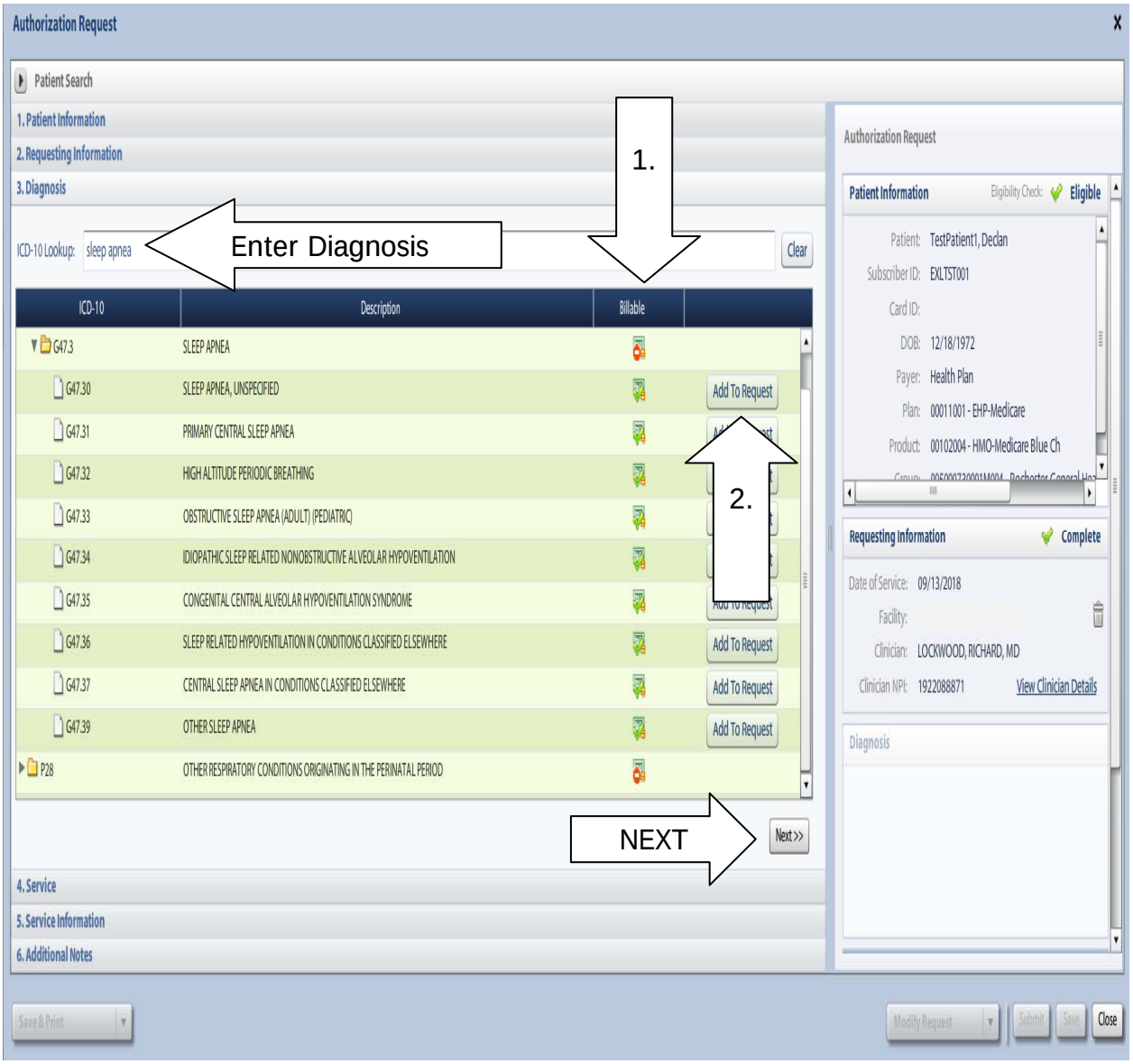


Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

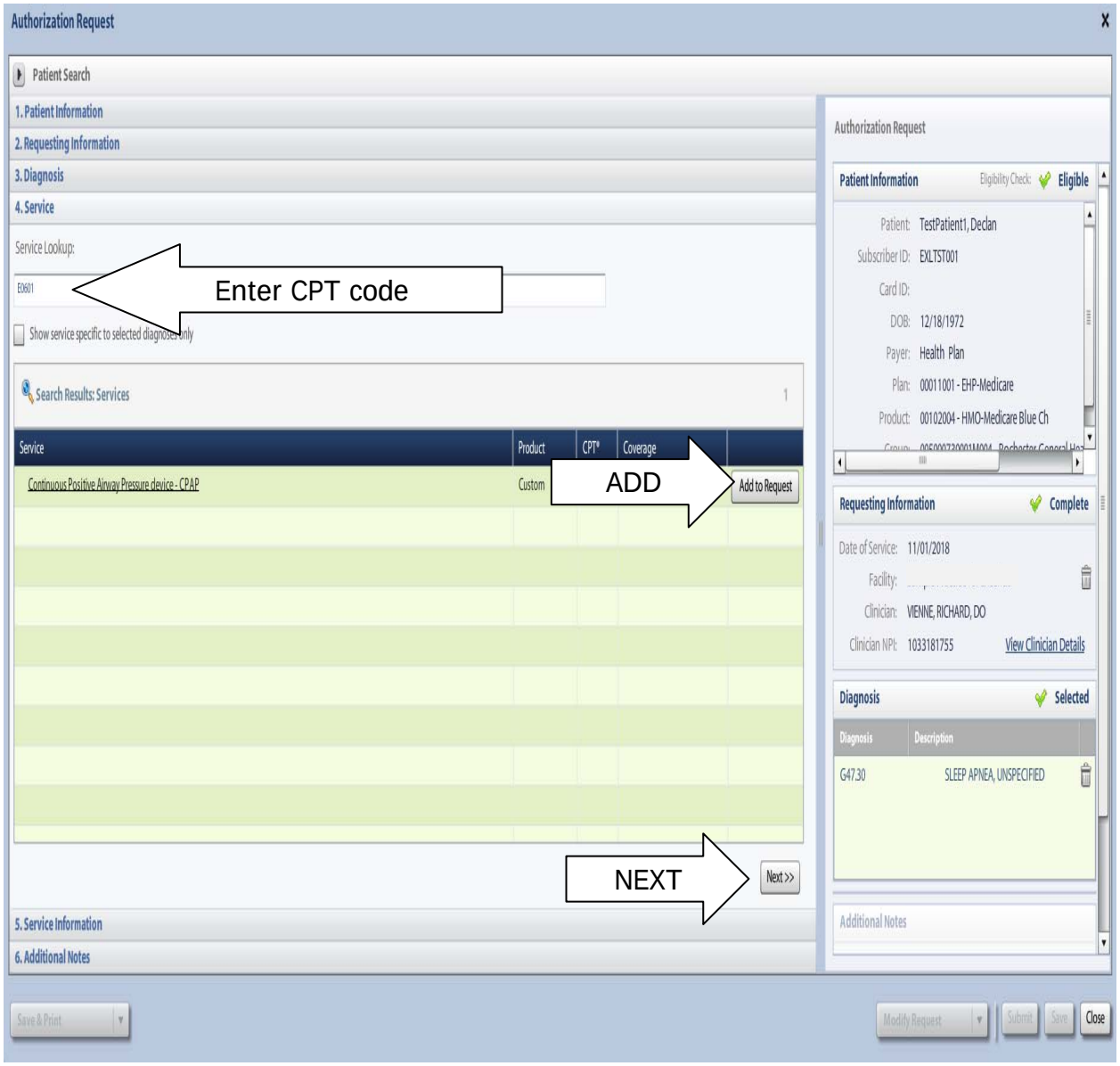


Accordion 4: Services

- Enter CPT code: CPAP E0601;
  BiPAP E0470; E0471; and/or
  heated humidifer: E0561; E0652 (humidifier can be added to CPaP auth)

- Click the “Add to Request” button

- Click “Next”

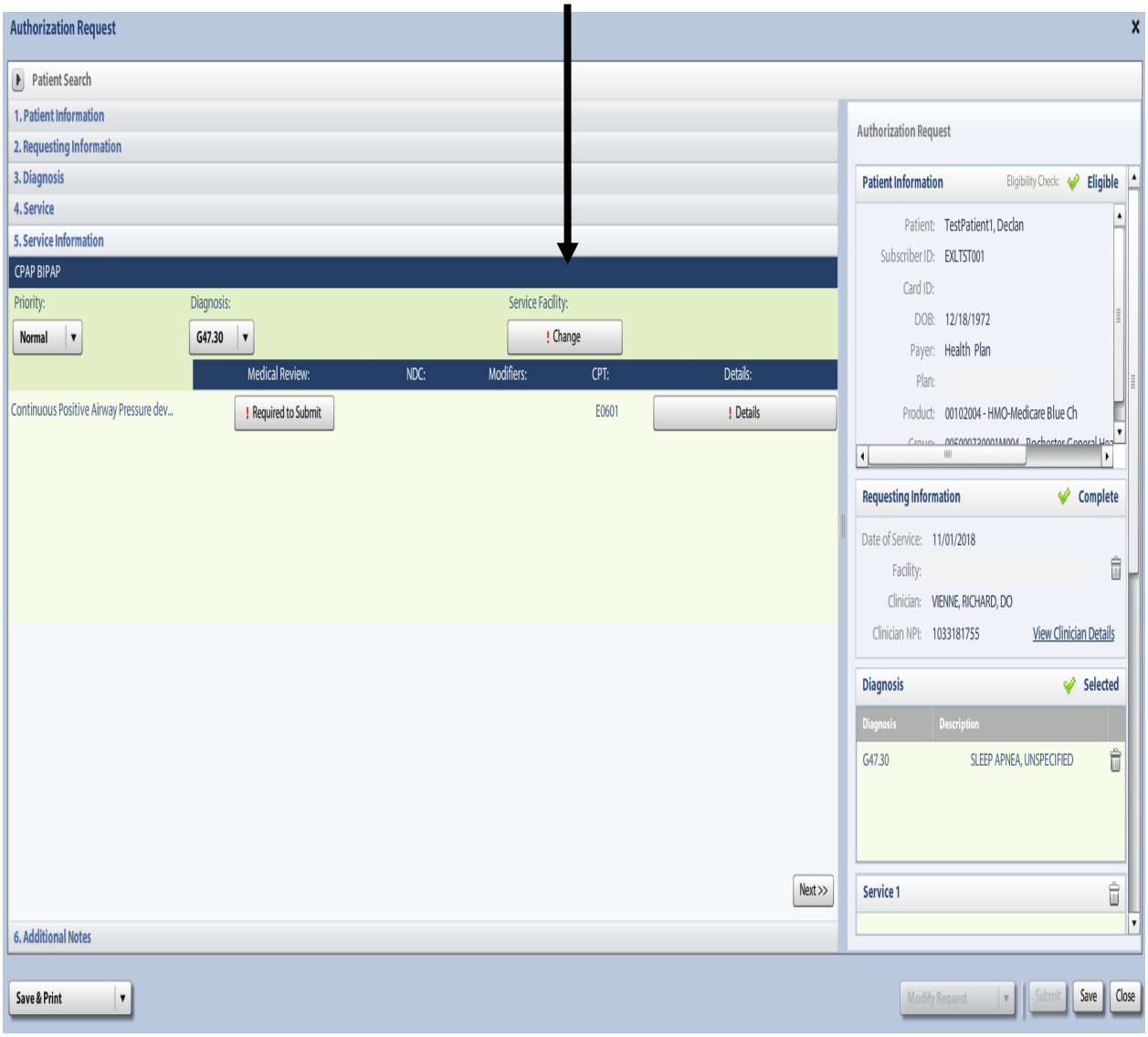


Accordion 5: Service

Priority - Normal (if request is urgent, call Customer Care)

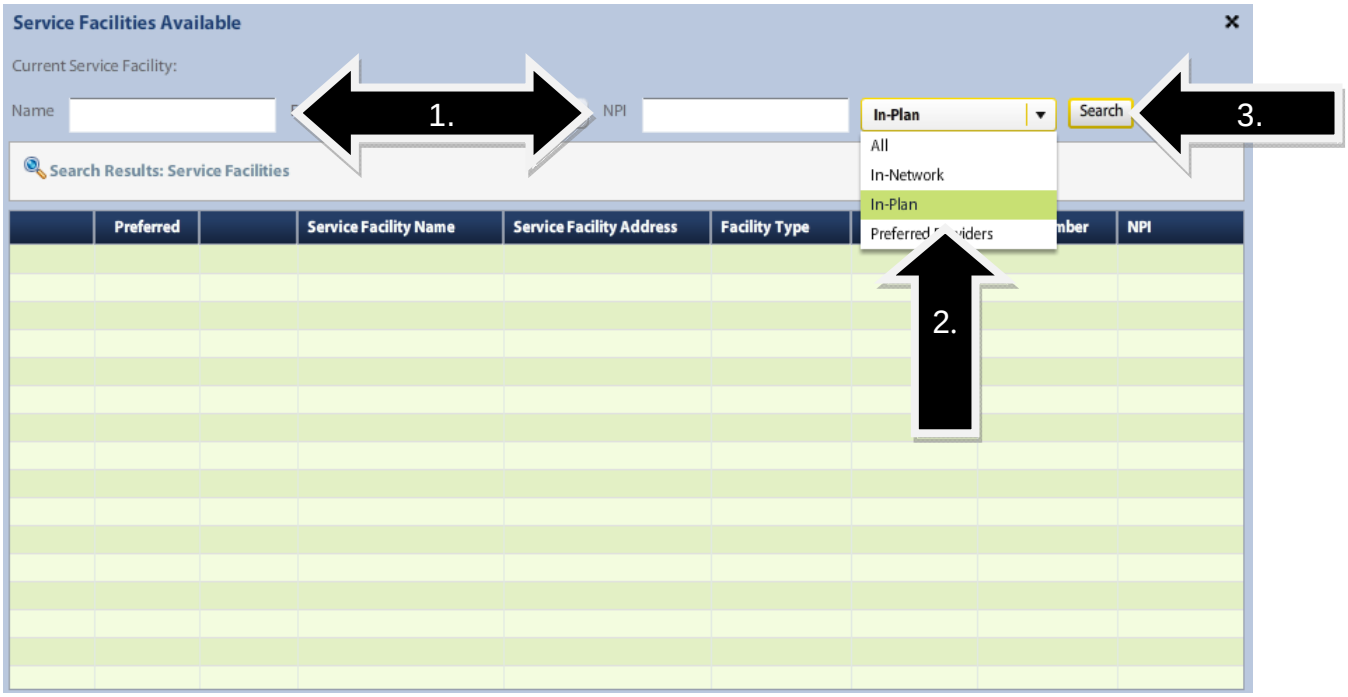
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service (or provider/vendor)-see next page

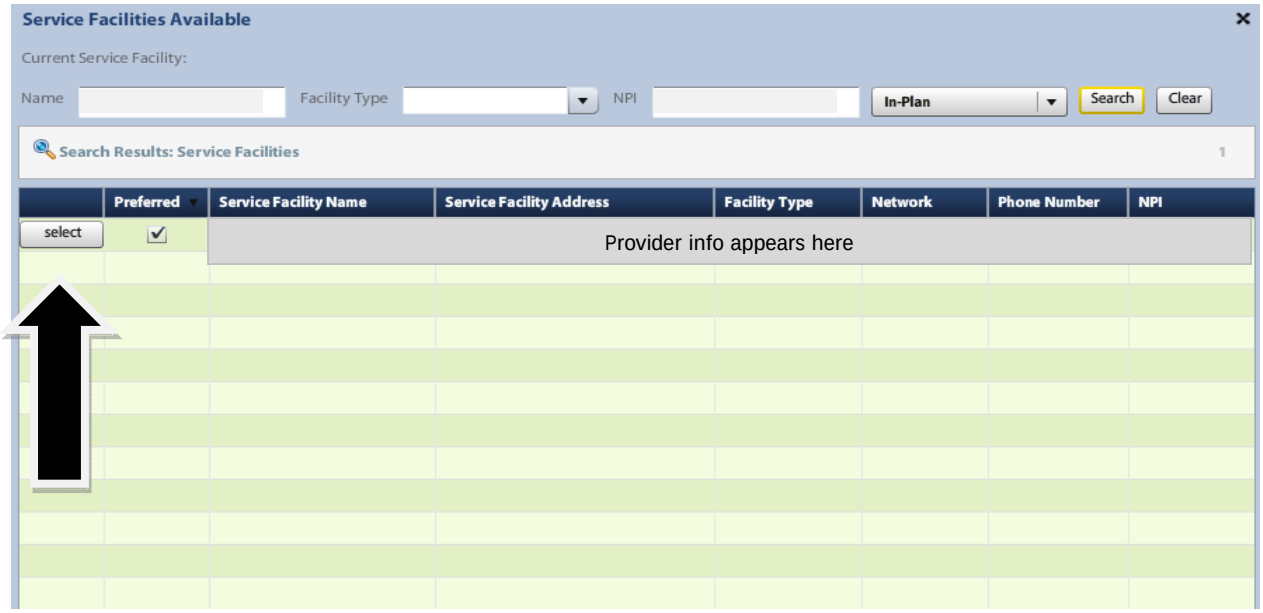


Clear Coverage™
CPAP/BiPAP Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).



When the results display, select the appropriate provider.



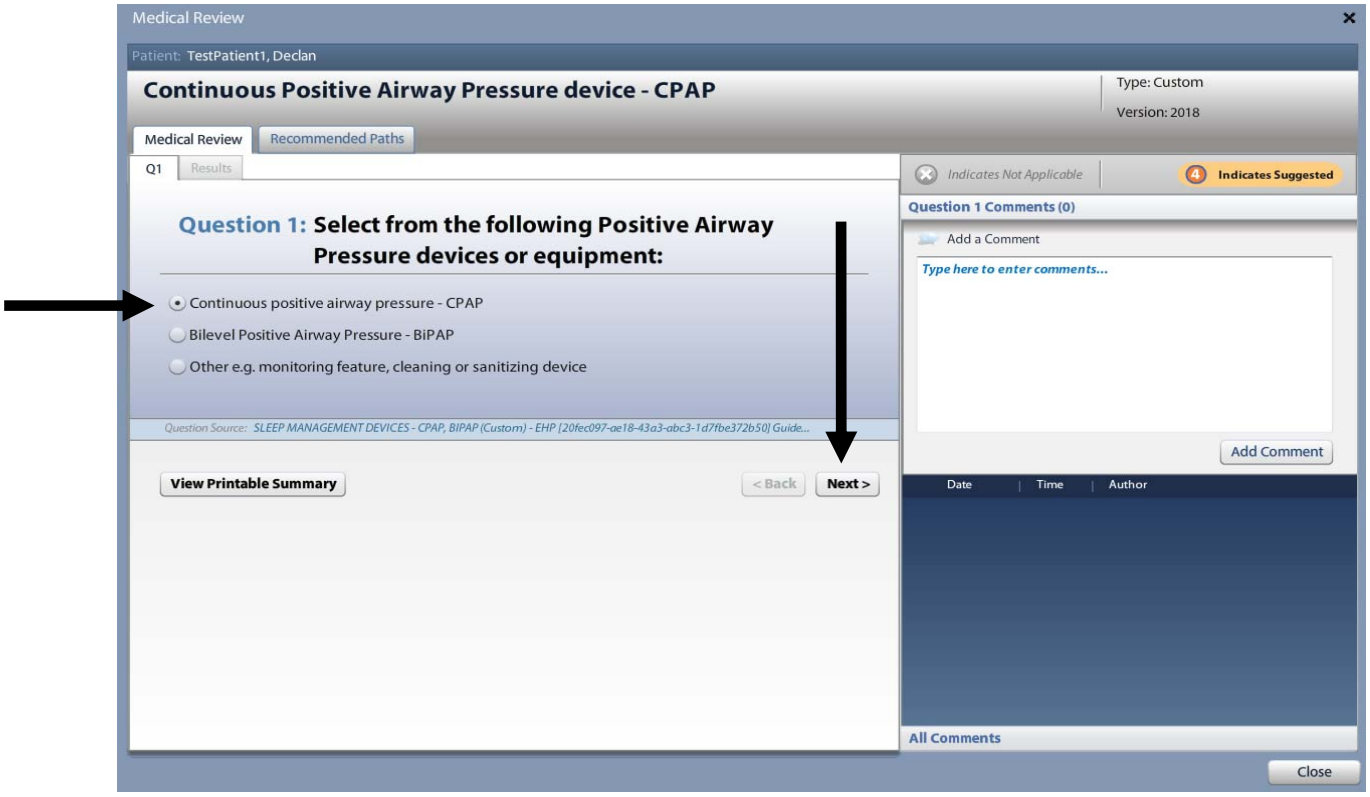
Medical Review: Click on the Medical Review "Required to Submit" tab.

MEDICAID: "Medical Review" is not required. Proceed to page 16.

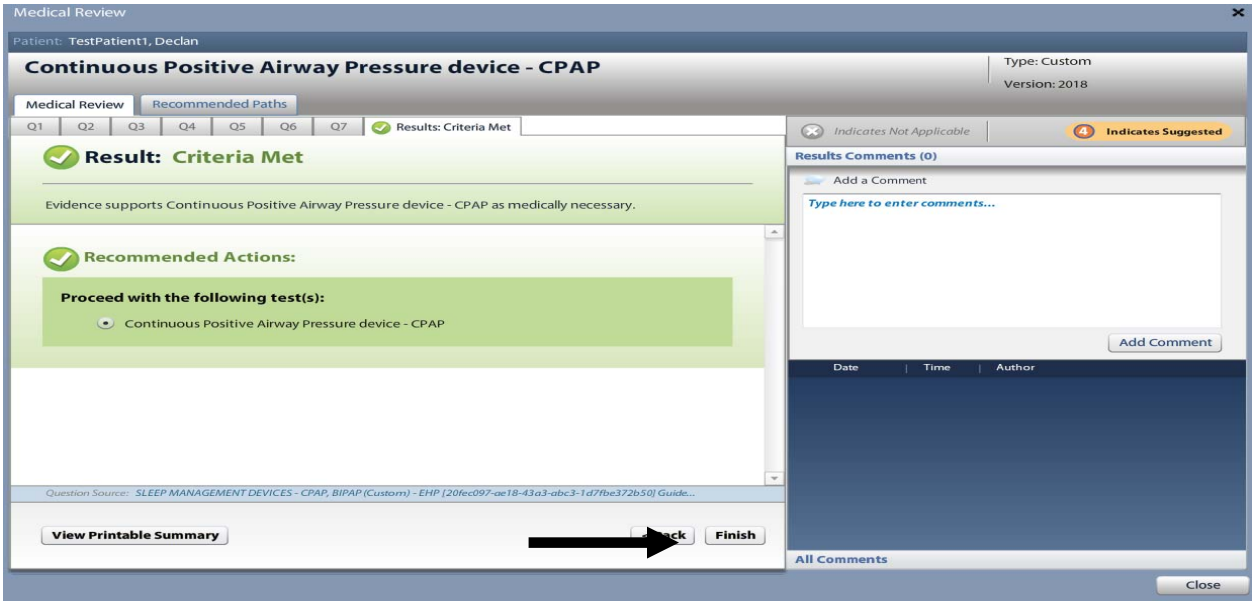
NOTE: If the patient already has an authorization entered into Clear Coverage™ for the initial period, and you would like to request an authorization for extension/continued rental of the CPaP/BiPaP, a note will need to be added or attached to the original authorization. Please see the "CPaP/BiPAP Extension Request" document for complete instructions.

Clear Coverage™
CPAP/BiPAP Authorization Entry Tips

Complete the review by answering each question and clicking “Next”.

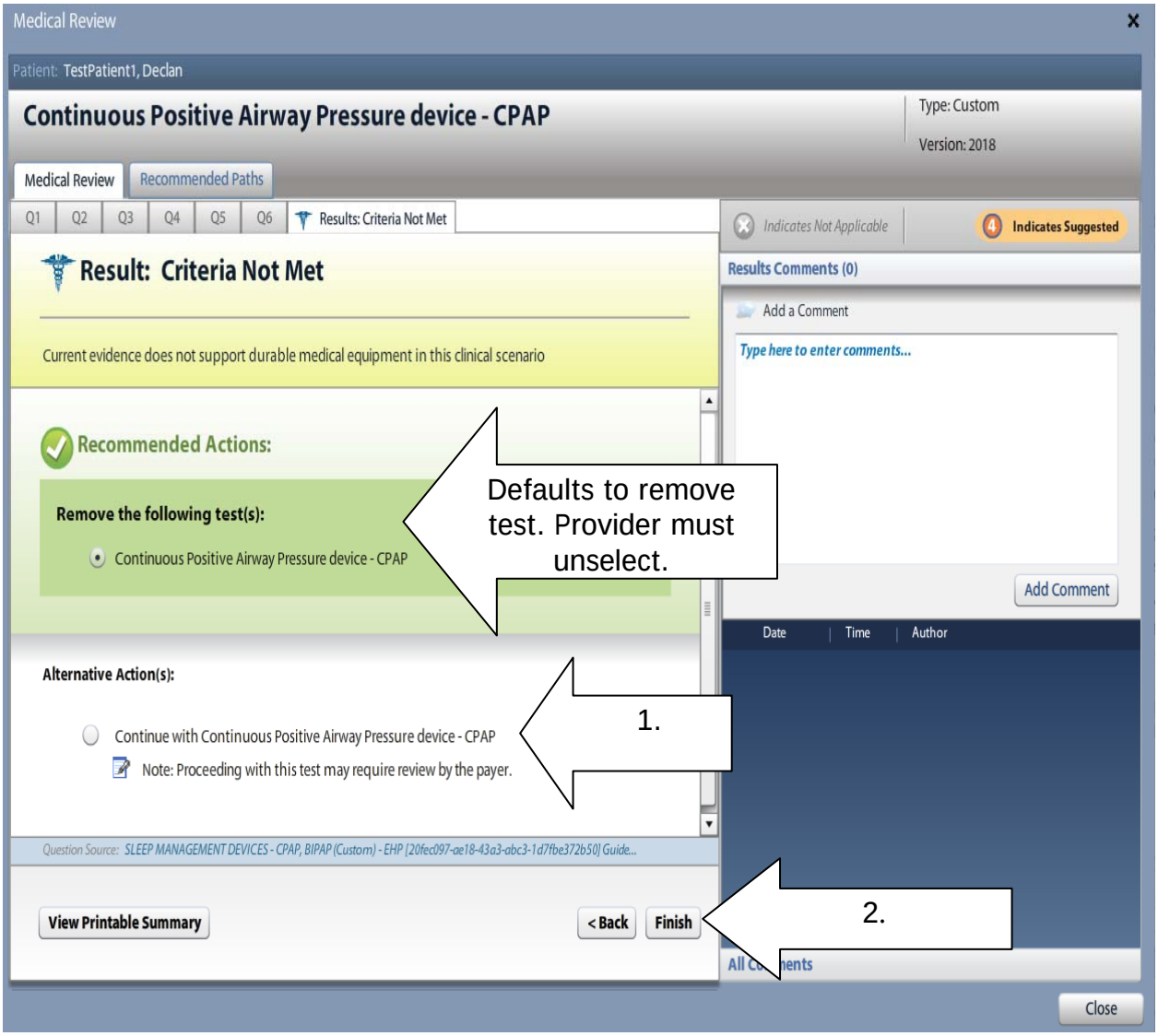


If criteria met: Click “Finish.”



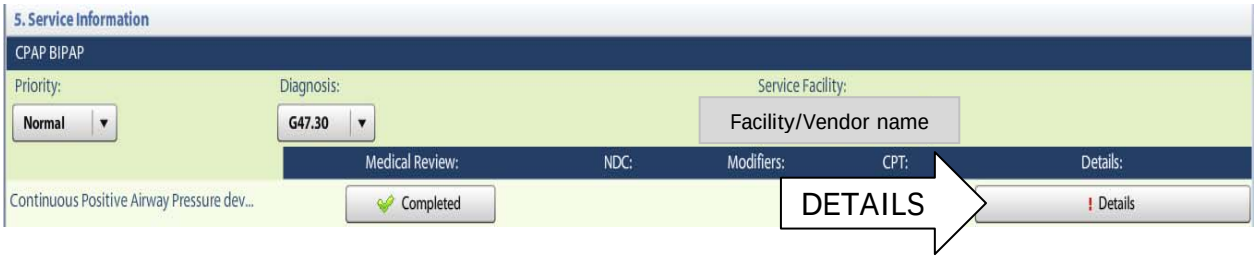
If criteria not met:
The default choice is to **remove** the item from the request.

1. You **must** click the button under Alternative Action(s) to "Continue with……." if you wish the request to pend to the Health Plan for review.

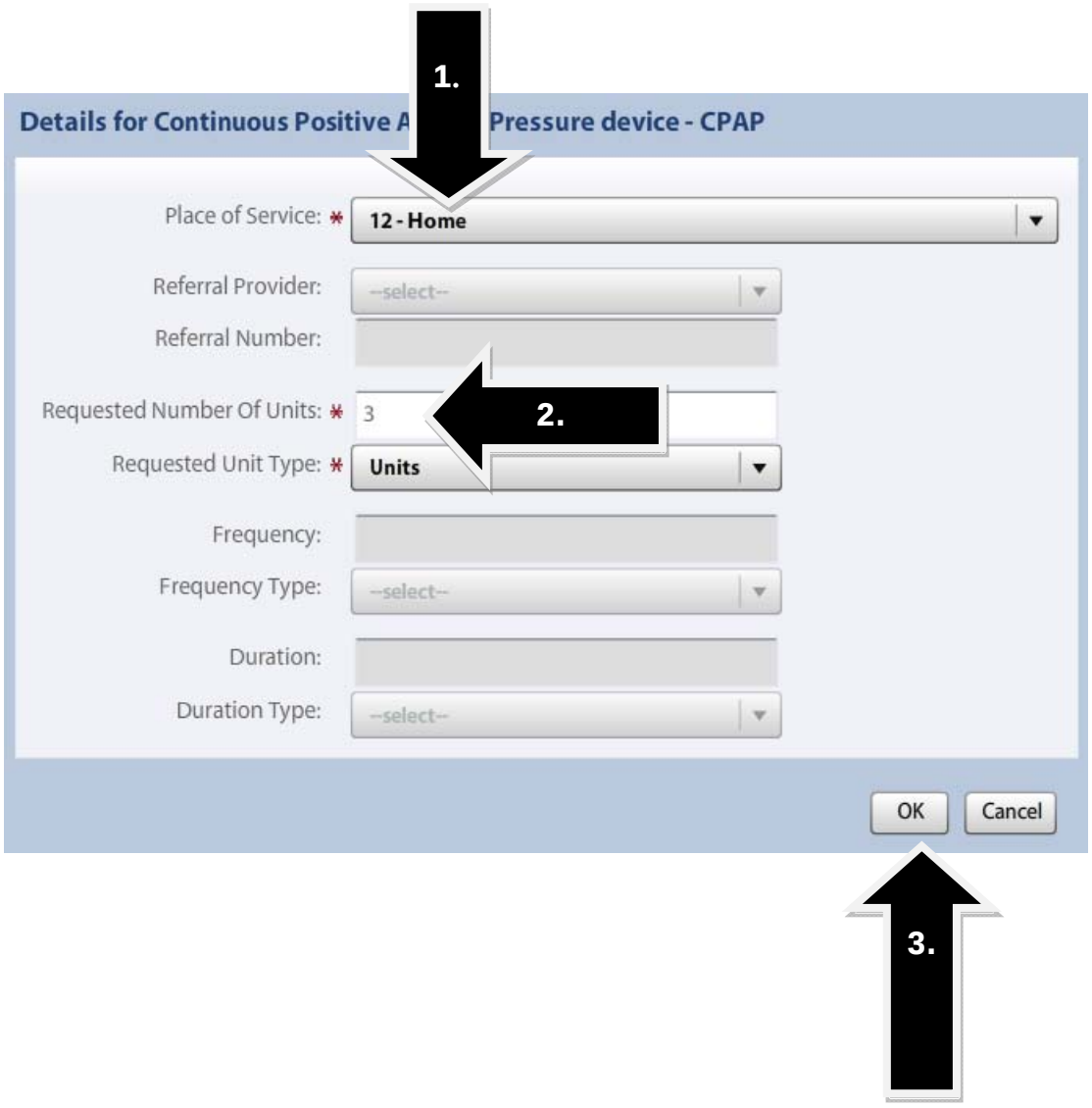


2. Click "Finish."

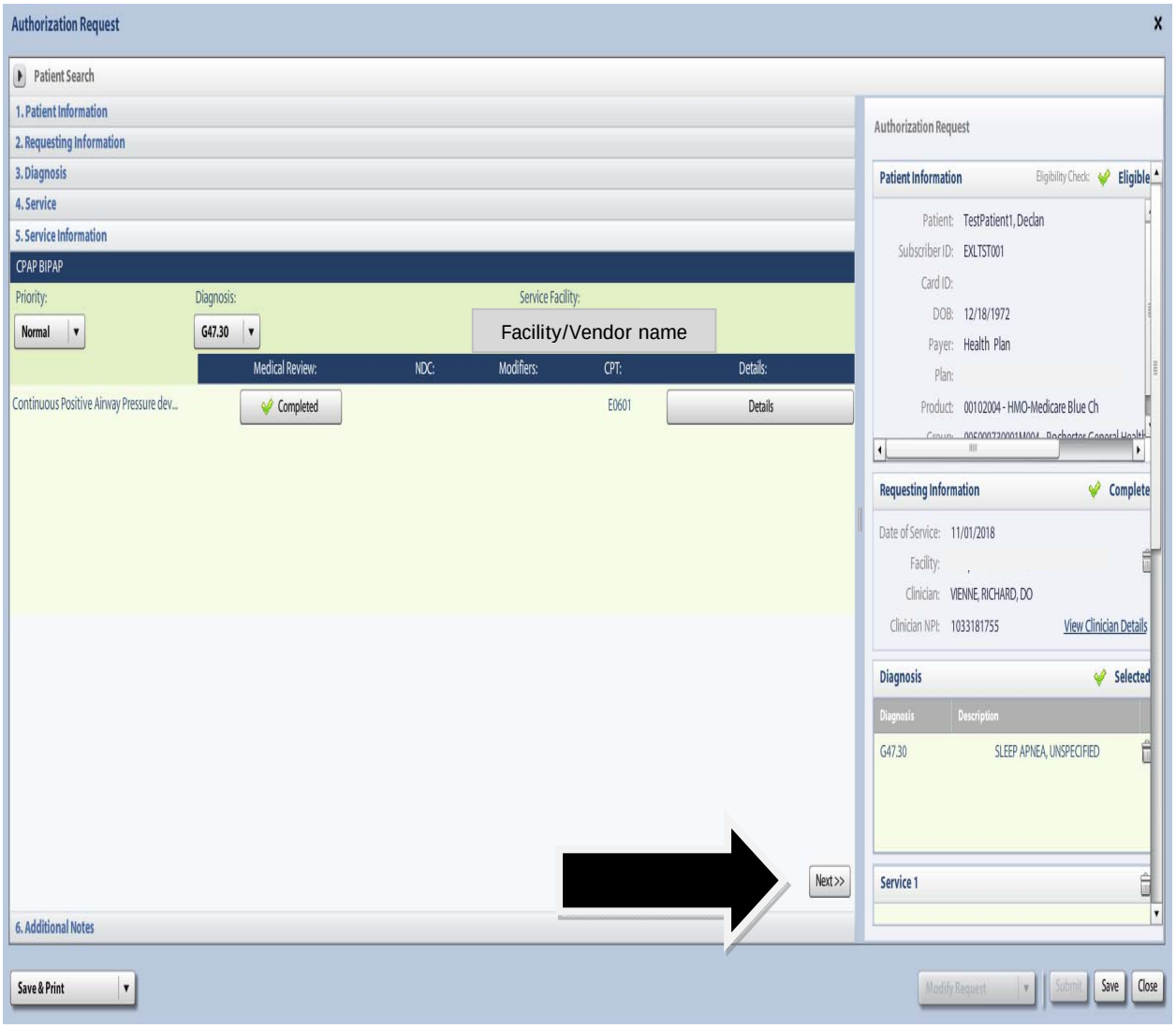
Details section:
Click on "!Details" button



Must select: (1) Place of Service, (2) **Requested Number of Units = 3** (do not request more than 3 units or the authorization will pend**).** Click the "OK" button (3)

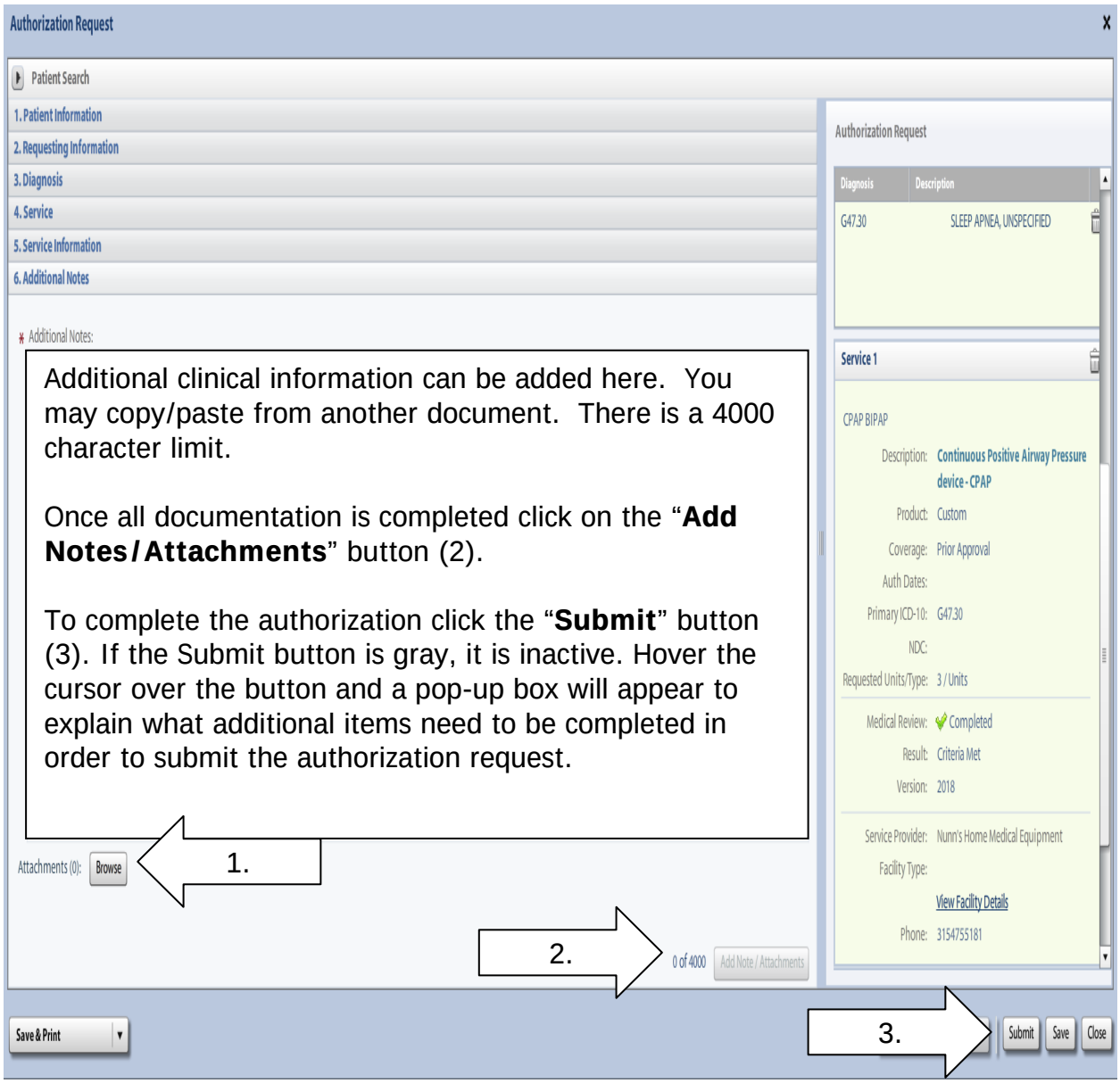


Click “Next”


Authorization Request
Patient Search
1. Patient Information
2. Requesting Information
3. Diagnosis
4. Service
5. Service Information
CPAP BIPAP
Priority:
Normal
Diagnosis:
G47.30
Service Facility:
Facility/Vendor name
Medical Review:
NDC:
Modifiers:
CPT:
Details:
Continuous Positive Airway Pressure dev...
Completed
E0601
Details
6. Additional Notes
Next>>
Save & Print
Authorization Request
Patient Information
Eligibility Check:
Eligible
Patient: TestPatient1, Declan
Subscriber ID: EXLTST001
Card ID:
DOB: 12/18/1972
Payer: Health Plan
Plan:
Product: 00102004 - HMO-Medicare Blue Ch
Requesting Information
Complete
Date of Service: 11/01/2018
Facility:
Clinician: VIENNE, RICHARD, DO
Clinician NPI: 1033181755
View Clinician Details
Diagnosis
Selected
Diagnosis
Description
G47.30
SLEEP APNEA, UNSPECIFIED
Service 1
Modify Request
Submit
Save
Close

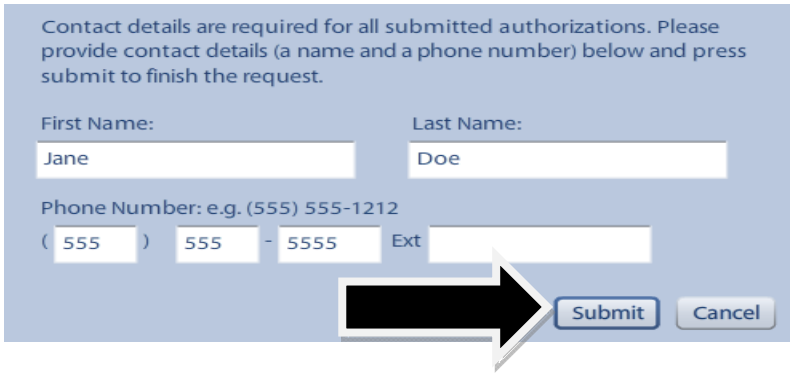
Accordian 6: Additional Notes

If the request is for a Medicare or Medicaid product or if criteria was not met, enter additional information and/or attach a note with supporting medical documentation (1). A note must be added in order to attach a document.



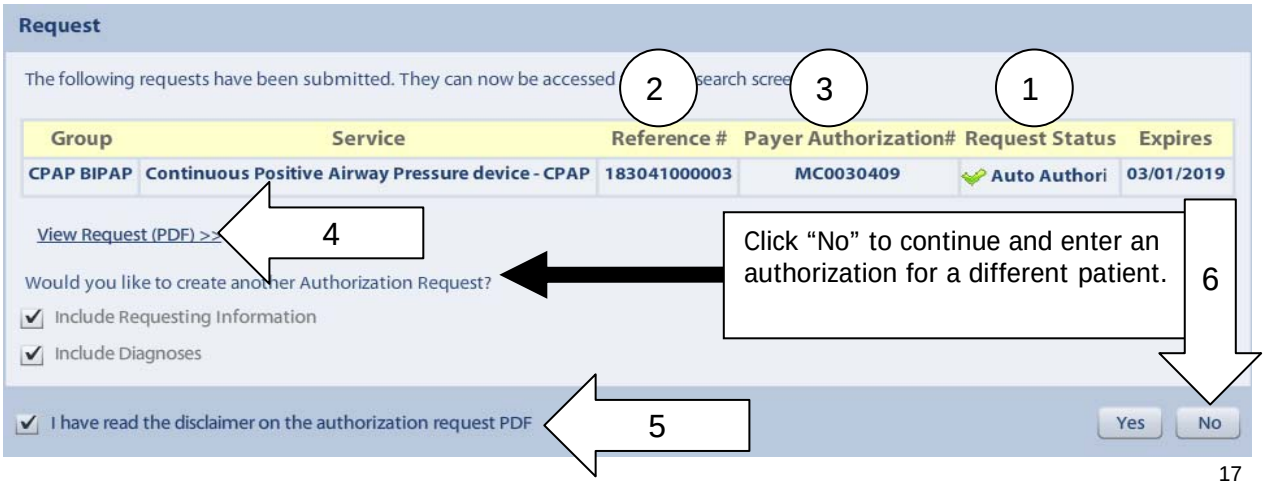
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Check the "I have read the disclaimer".... box
6. Click "No" to close this request



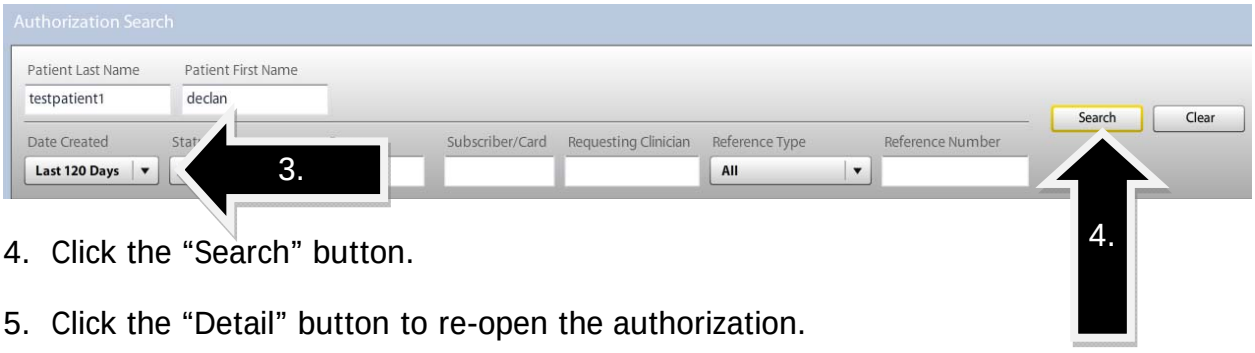
Clear Coverage™
CPAP/BiPAP Extension of Initial Authorization Entry Tips

When an initial authorization <u>has already been entered in Clear Coverage</u>™, DO NOT create a new authorization. Follow these steps:

1. Click the “Authorization Search” button.

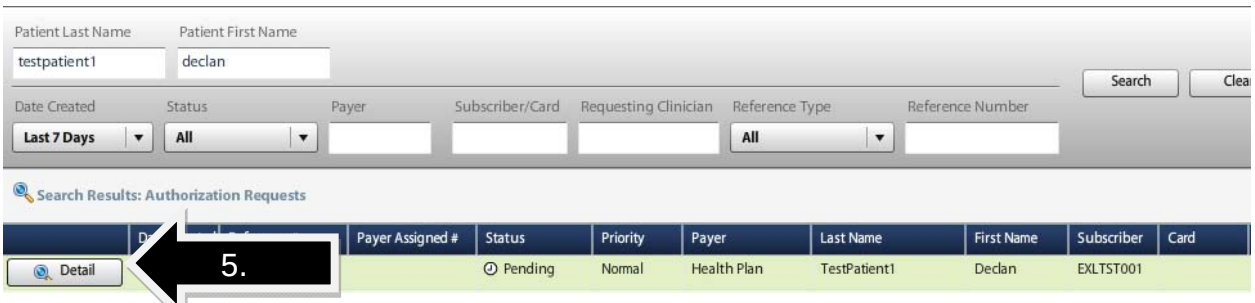
2. Locate the authorization by patient name and/or reference number.

3. Change the “Date Created” timeframe to “Last 120 days” (or further back if the original auth was created prior to 120 days ago).



4. Click the “Search” button.

5. Click the “Detail” button to re-open the authorization.



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Clear Coverage™
CPaP/BiPaP Extension of Initial Authorization Entry Tips

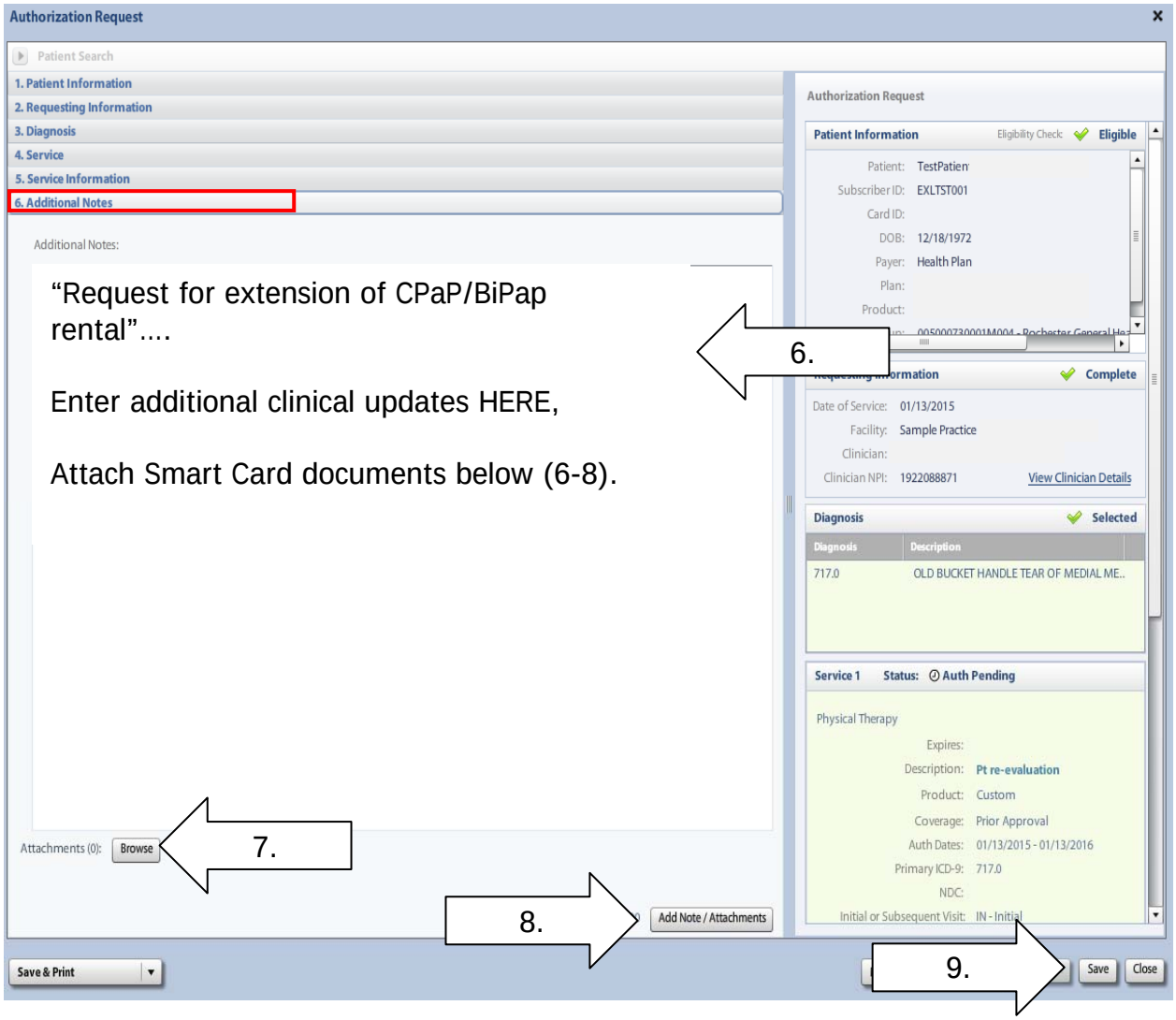
6. Proceed directly to **Accordion 6** and type in a note: "*Request for extension of CPaP/BiPap rental*" . Include clinical updates describing improvement and the need for additional rental.

7. Attach Smart Card to demonstrate compliance and improvement in AHI symptoms.

8. Click the "**Add Notes/Attachments**" button.

9. Click "**Save**".

10. Request will pend to the Health Plan for a medical necessity review.



Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Commercial and Medicare Contracts: will auto approve if criteria is met.

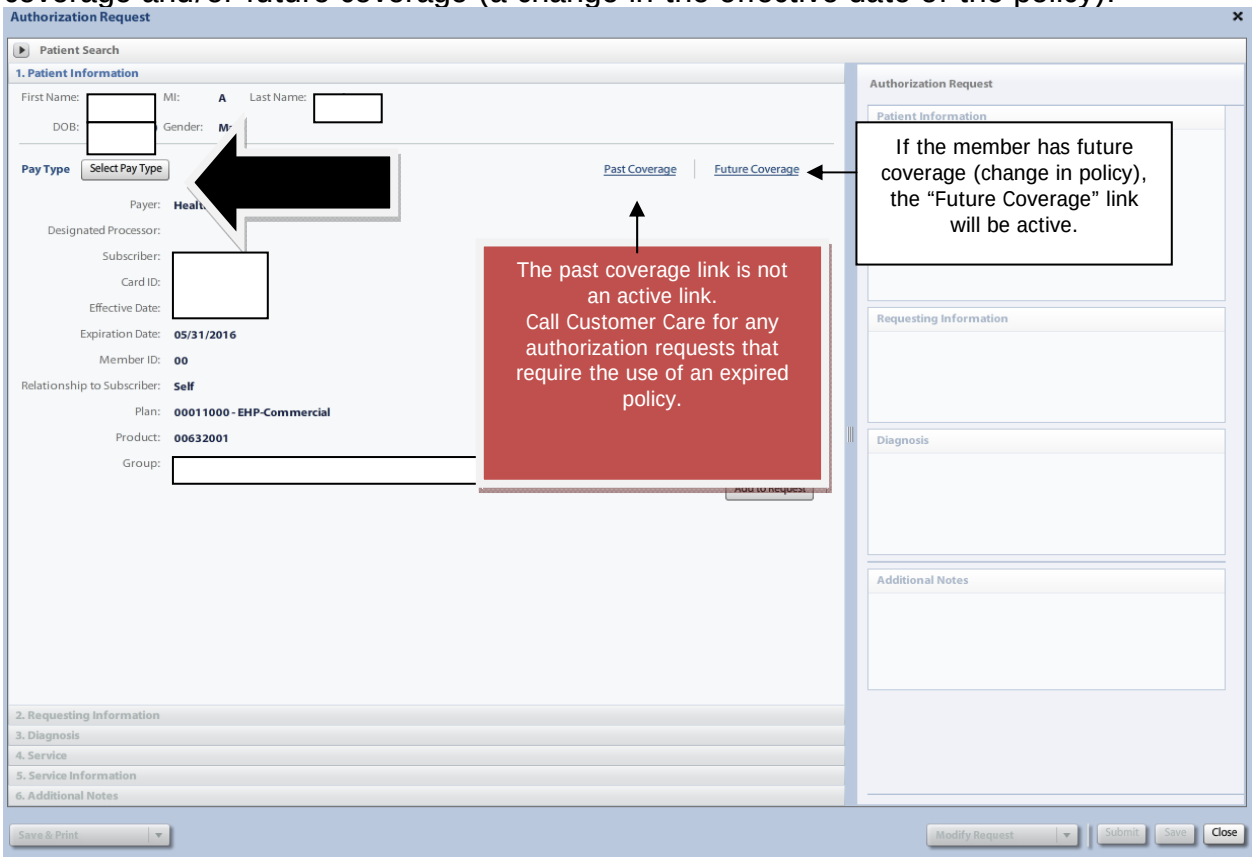
FEP Contracts: review tool MUST be completed to provide clinical information to the Health Plan. All FEP requests will pend until this information is reviewed.

NOTE: If the request pends, the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

After searching for and selecting the patient, the Authorization Request Entry Box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

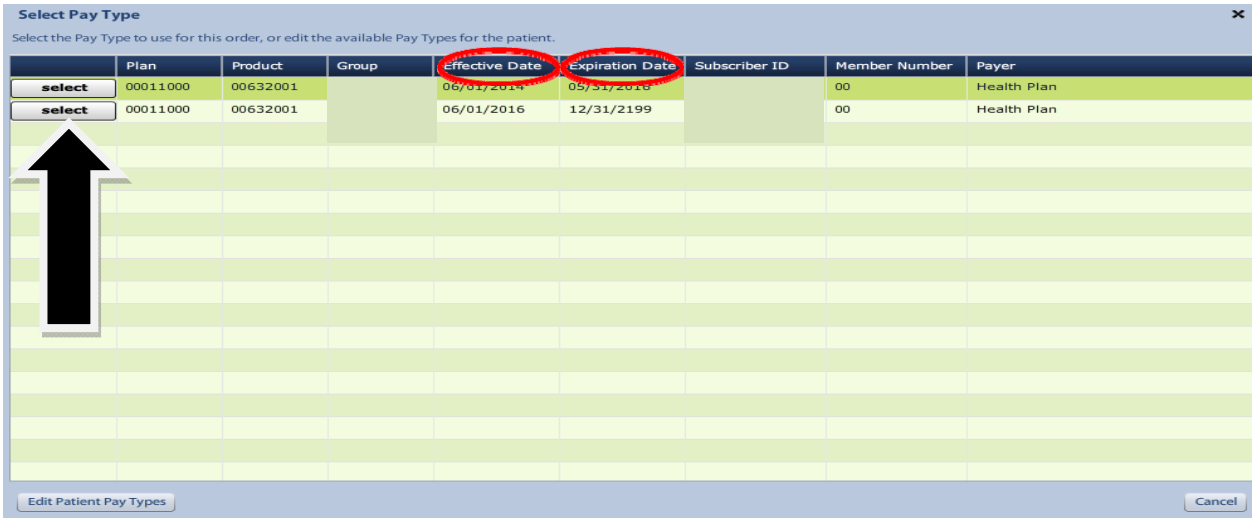


Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

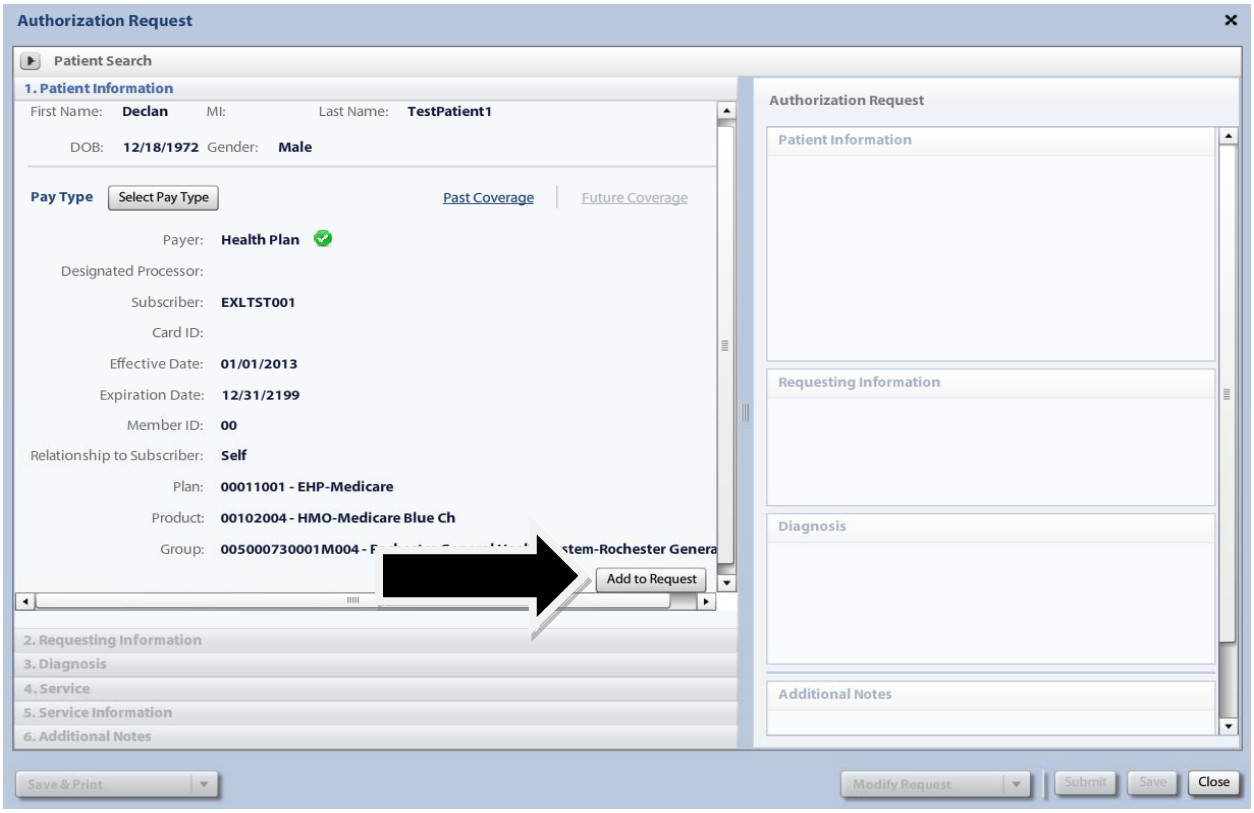
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

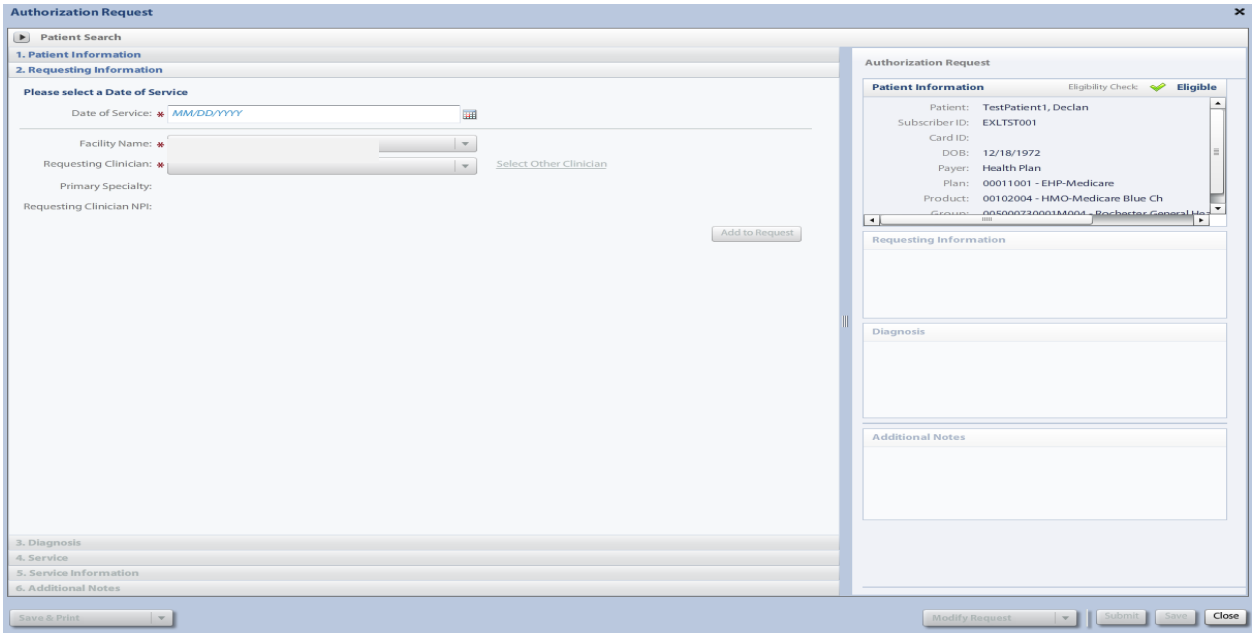


Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

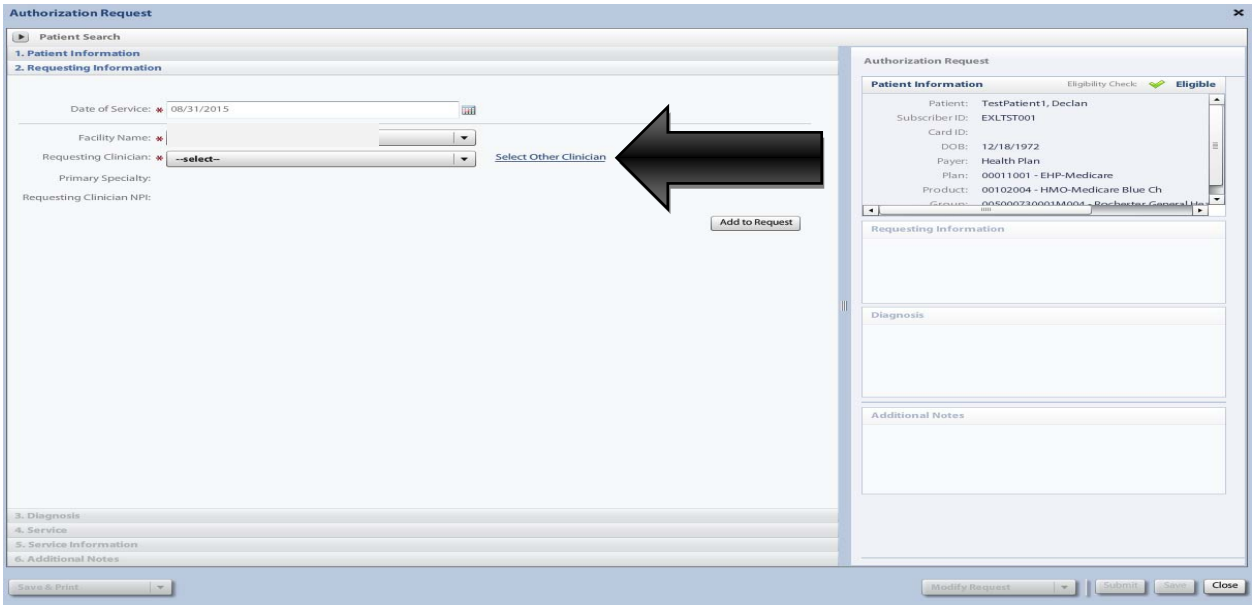
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do NOT enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

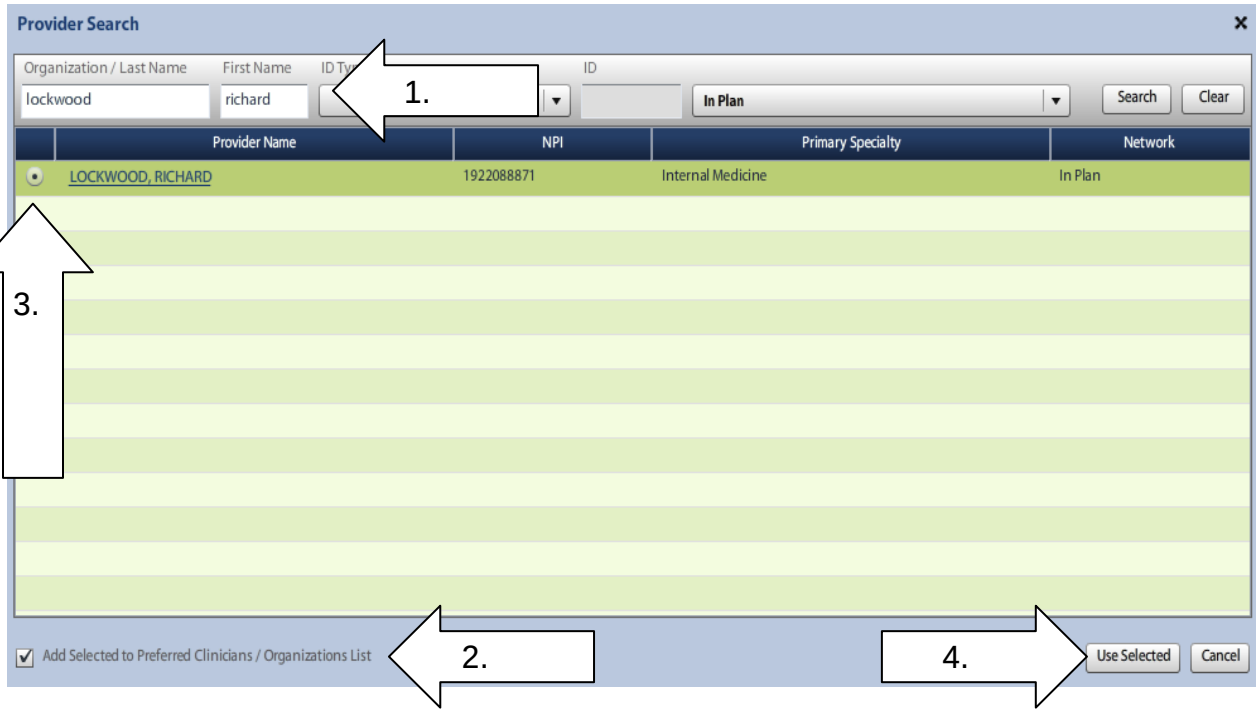


Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

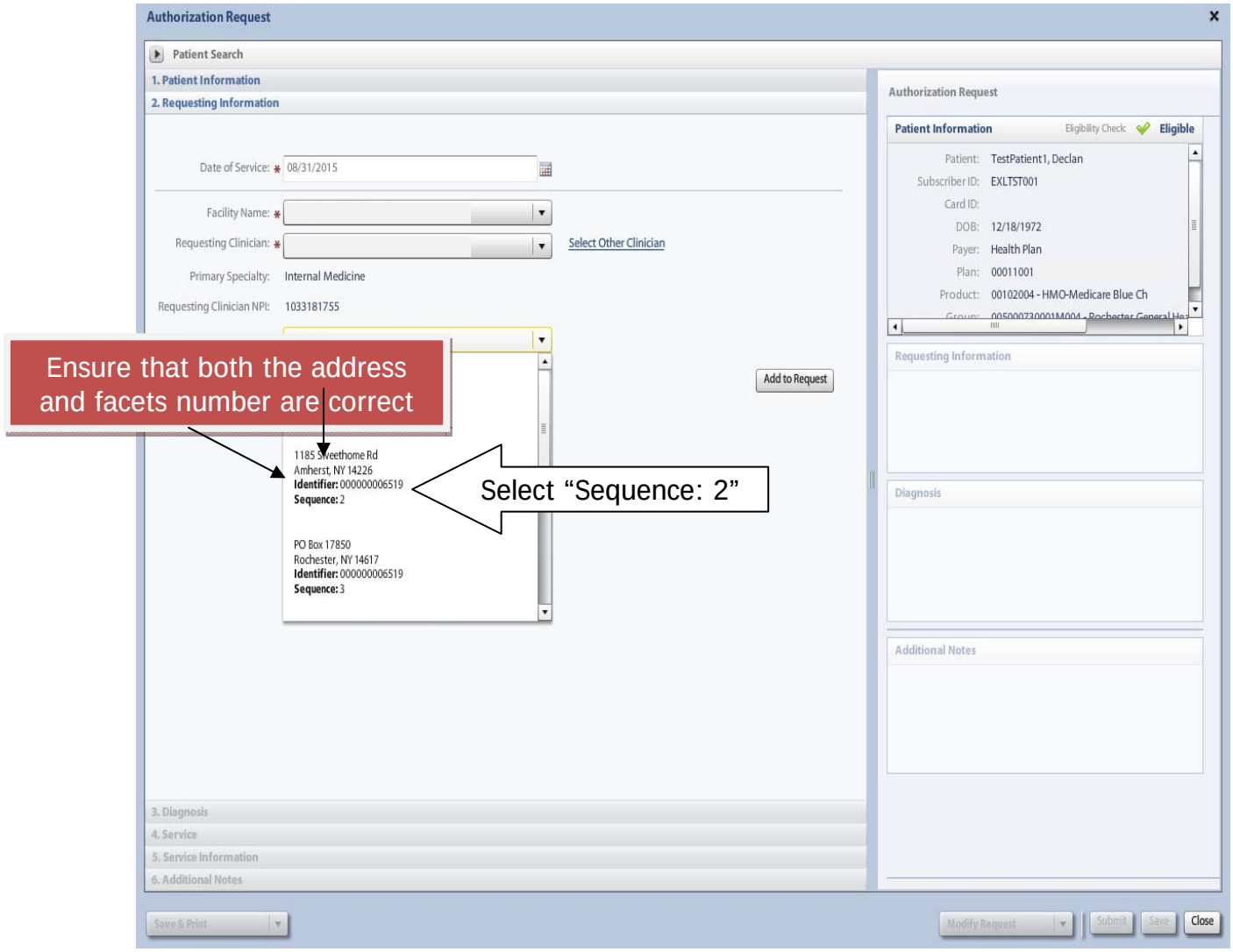
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

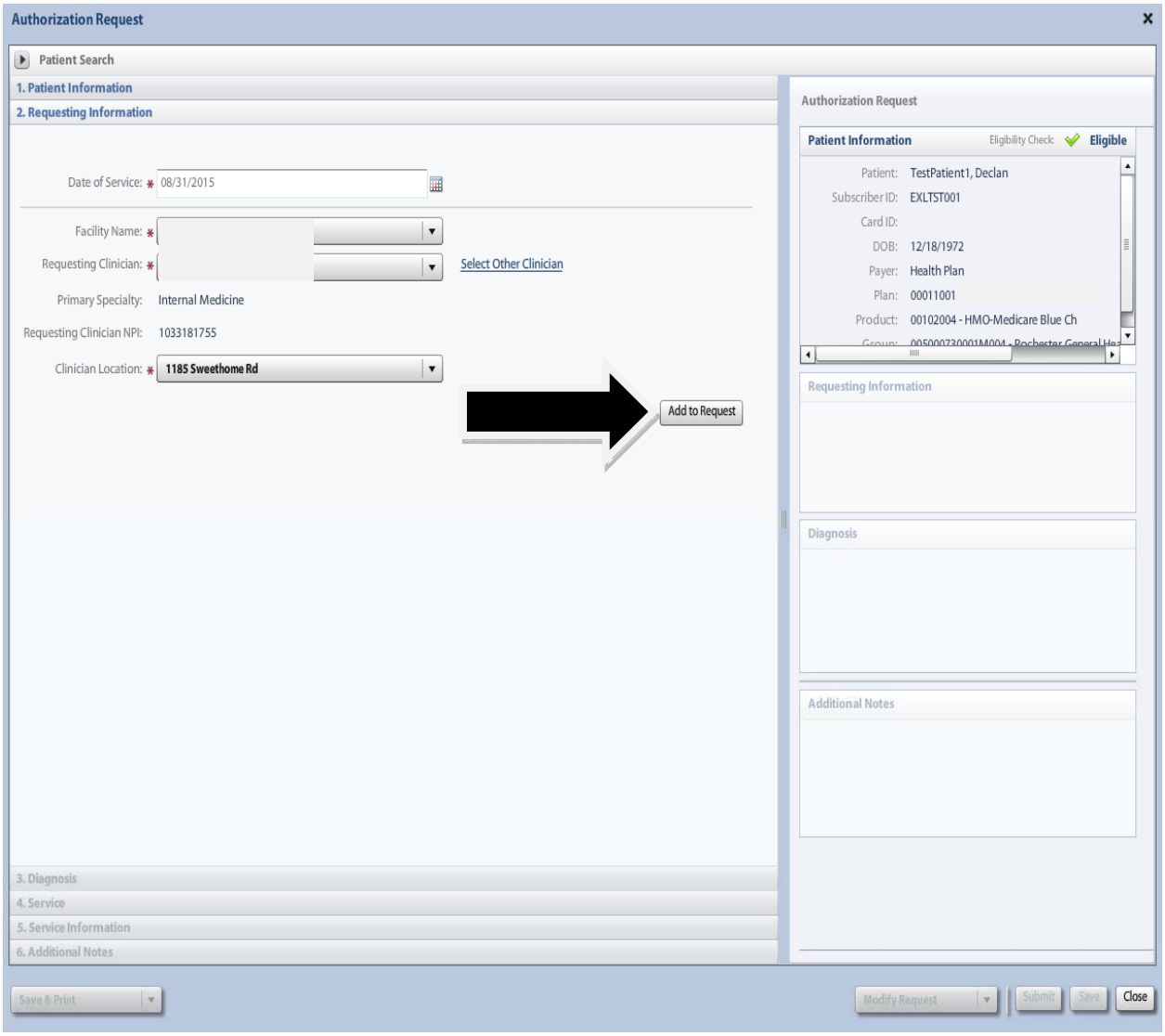
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

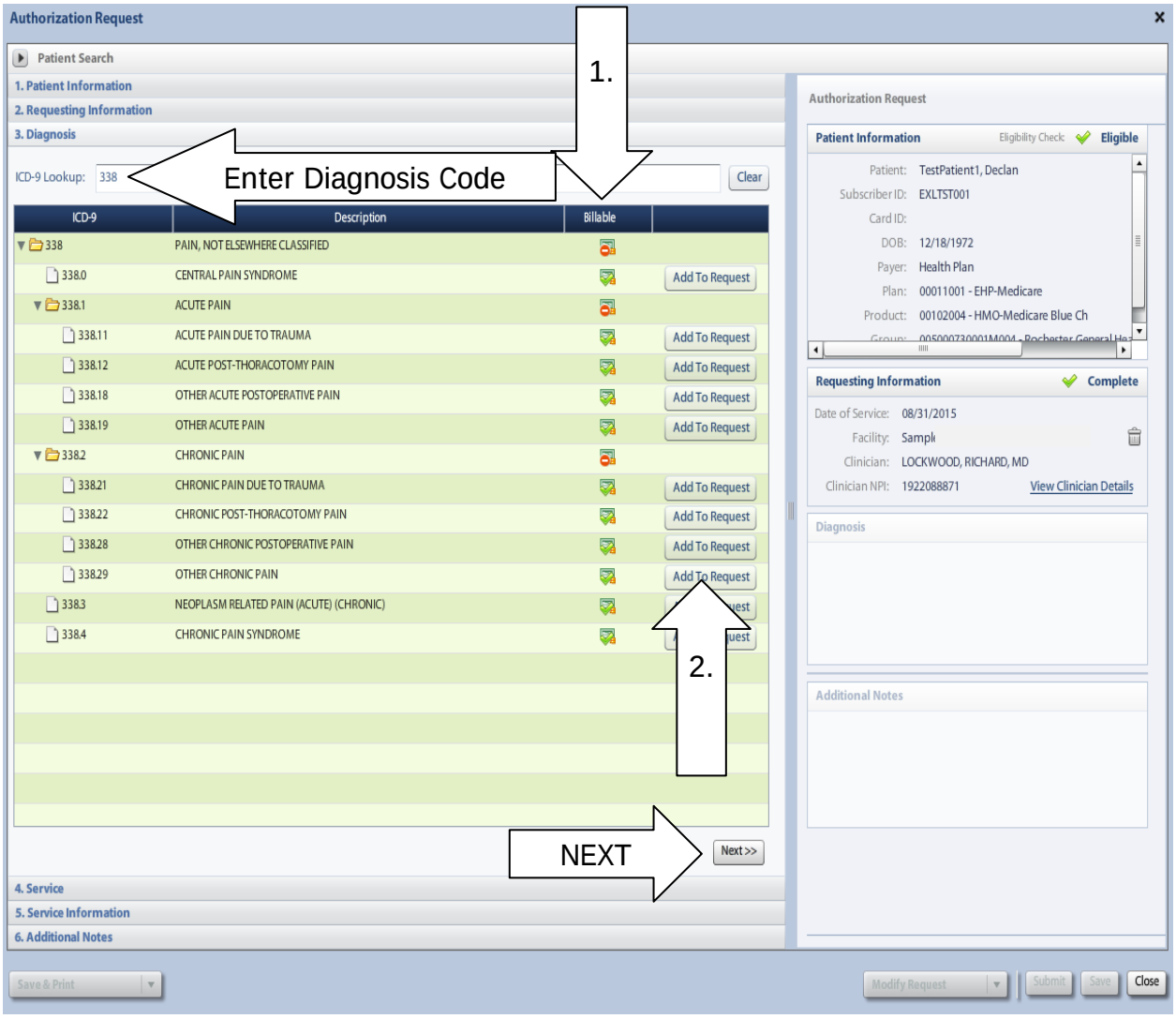
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

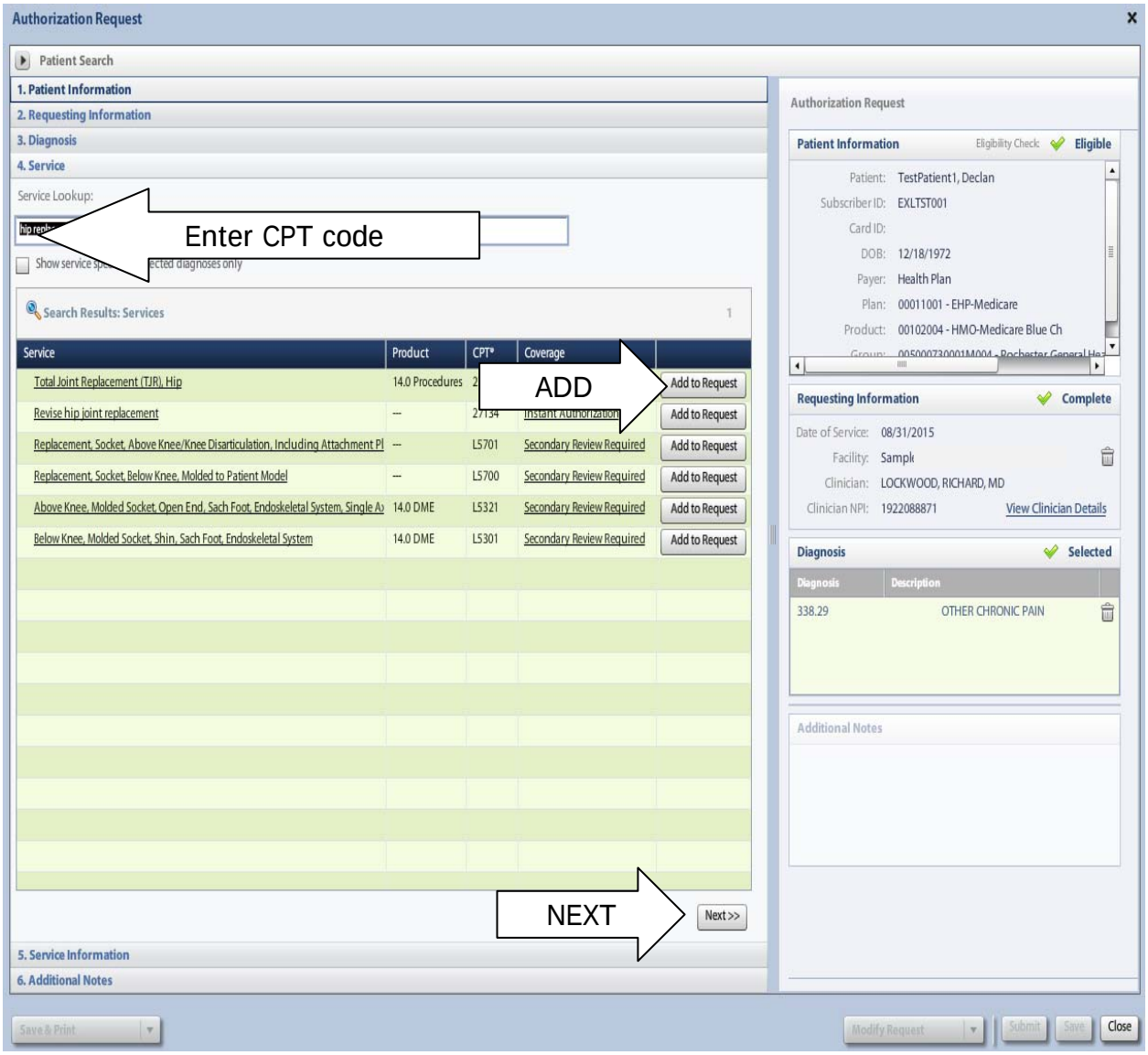


Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Accordion 4: Services

Enter CPT code(s)

- Click the “Add to Request” button, then click “Next” once all codes have been added.



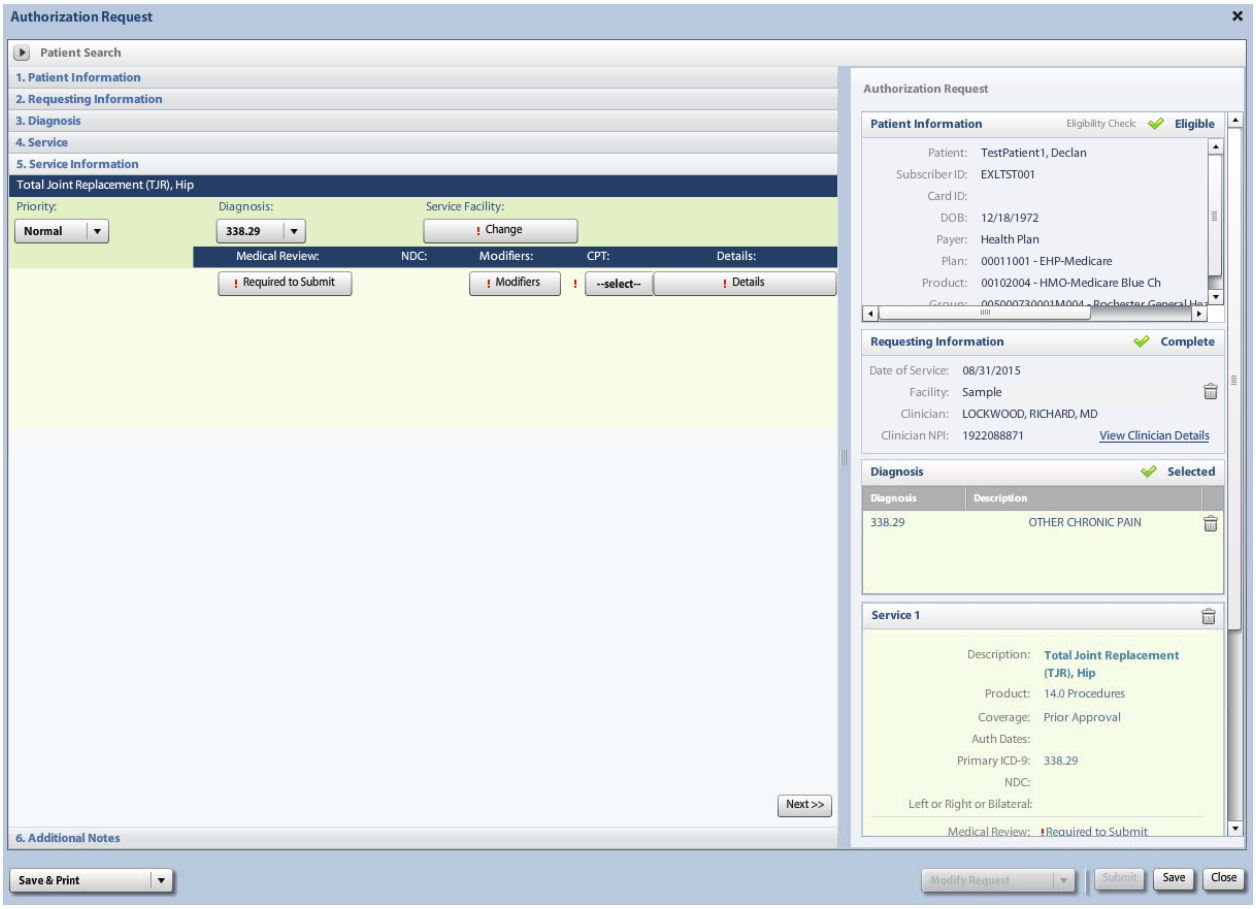
Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

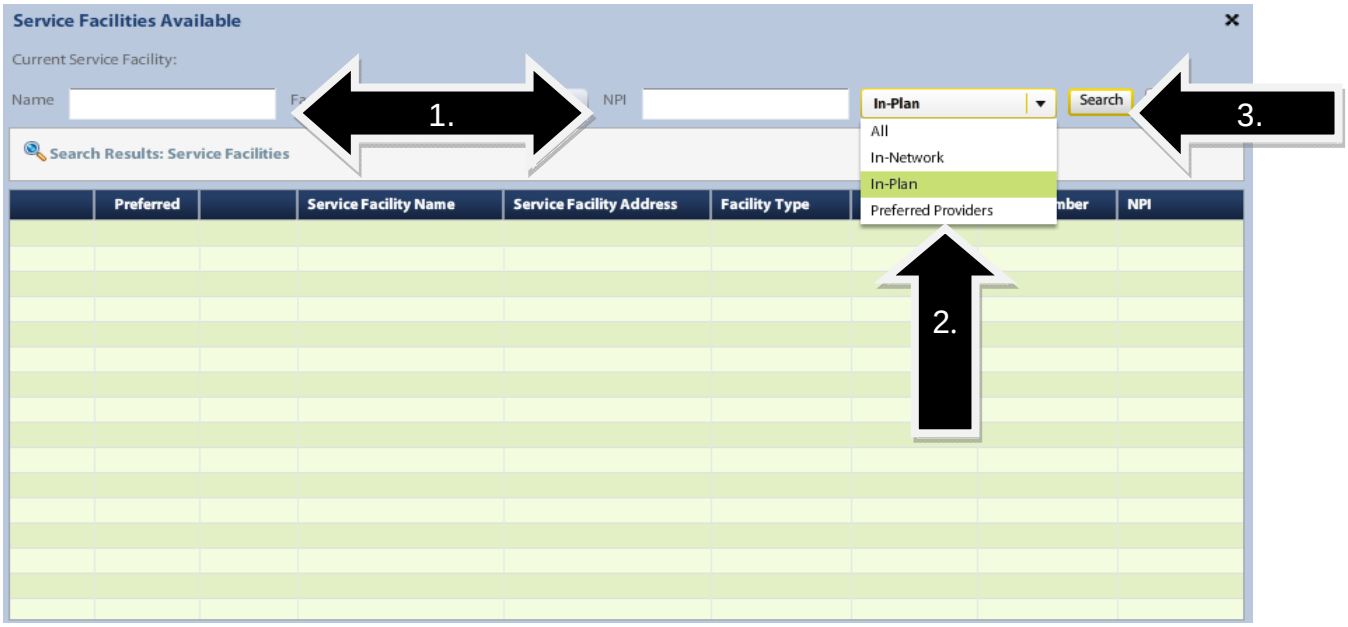
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service



Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate facility is not found, switch to “All” (when “All” is selected, request will pend even if it meets criteria). Click the “Search” button (3).

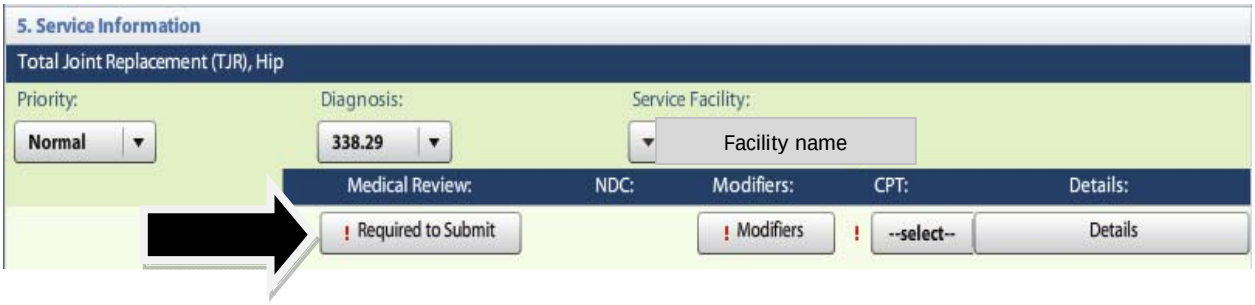


When the results display, select the appropriate facility.

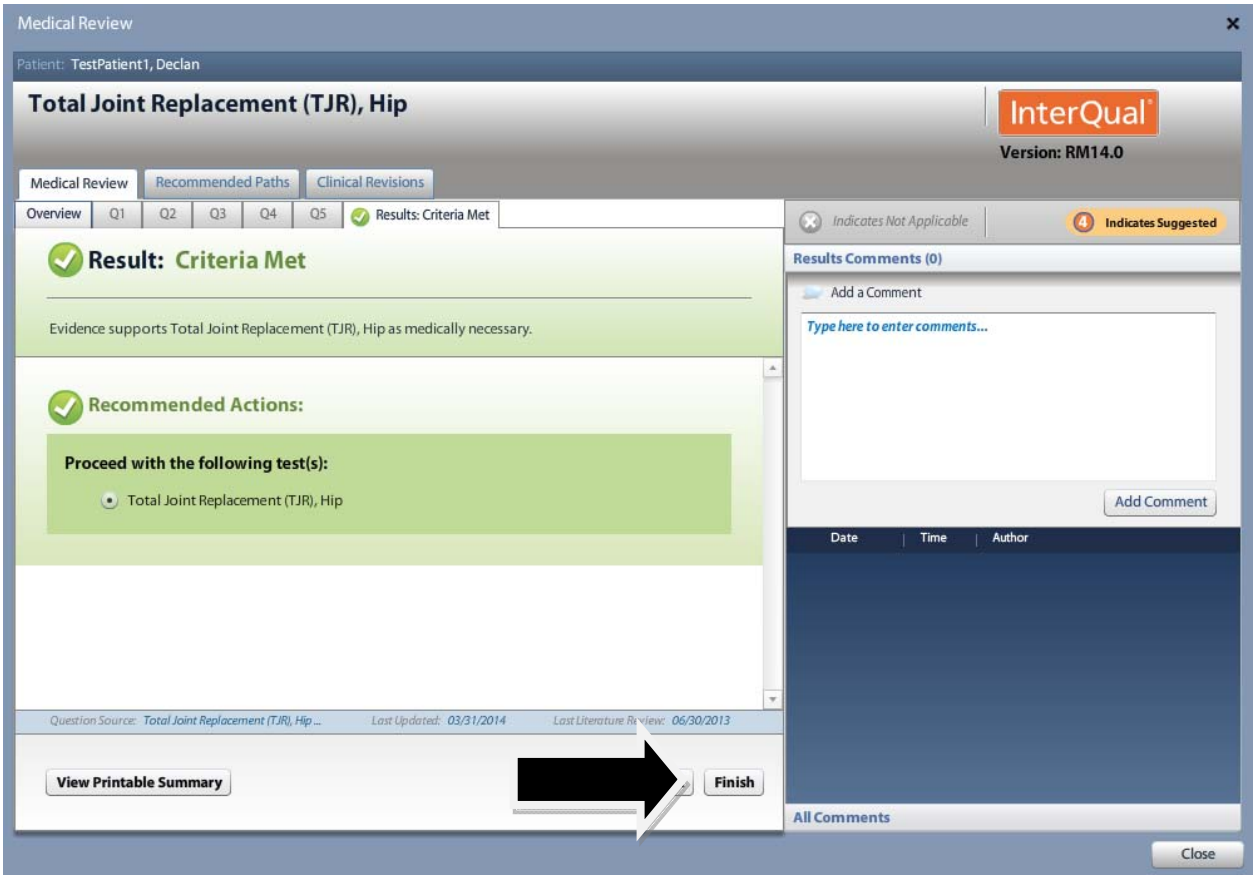
IMPORTANT NOTE: When selecting the facility, ensure that the facility chosen has this symbol: I to the left of the Service Facility Name.

Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Click on the Medical Review "Required to Submit" tab and complete the review.



If criteria met: Click "Finish." (skip to page 12).

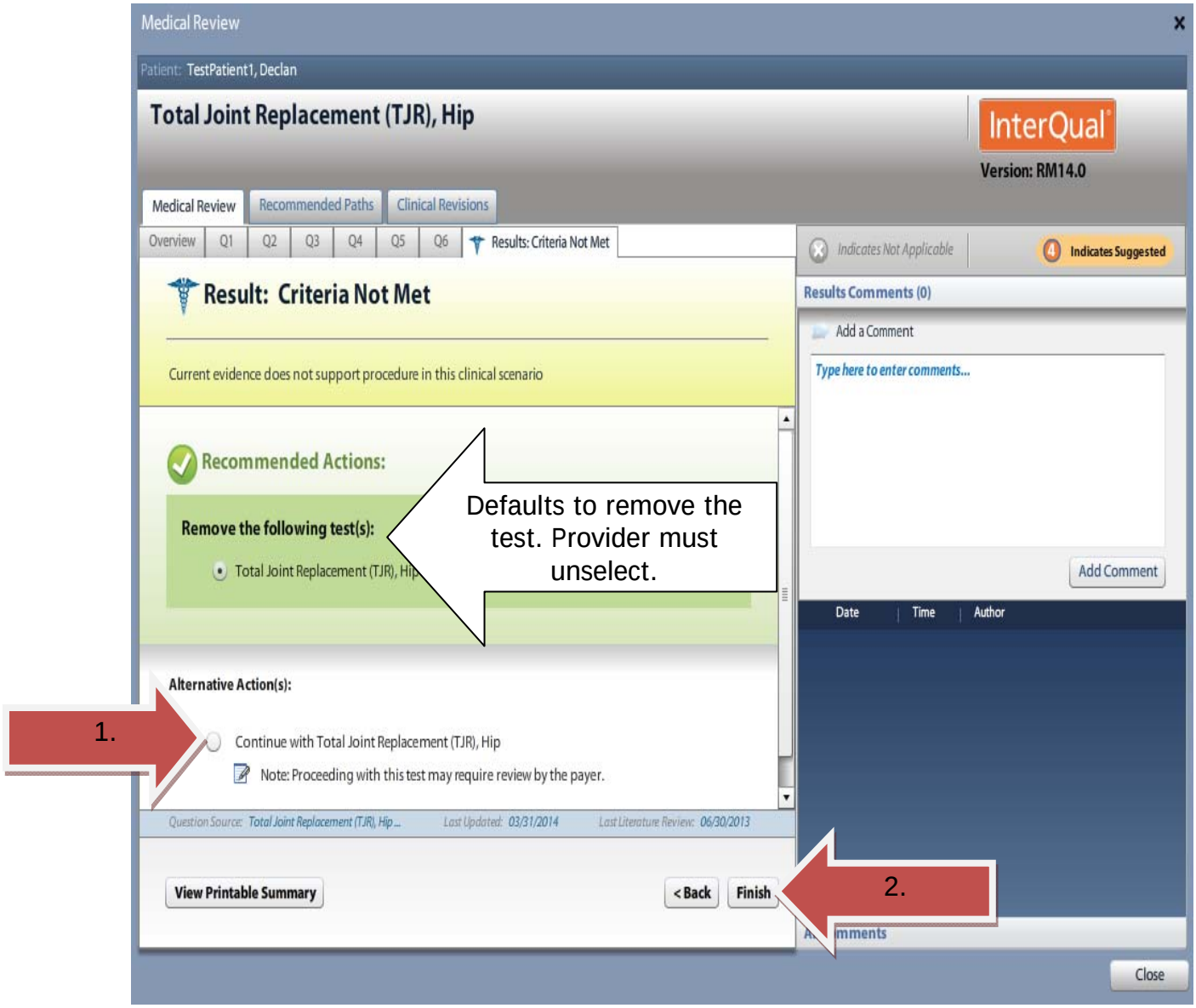


Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

If criteria not met:

The default choice is to **remove** the item from the request.

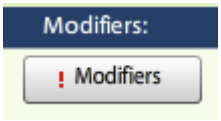
1. You **must** click the button under Alternative Action(s) to "Continue with Total Joint Replacement" (or appropriate requested item) if you wish the request to pend to the Health Plan for review (1). Click "Finish."



Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Modifiers:

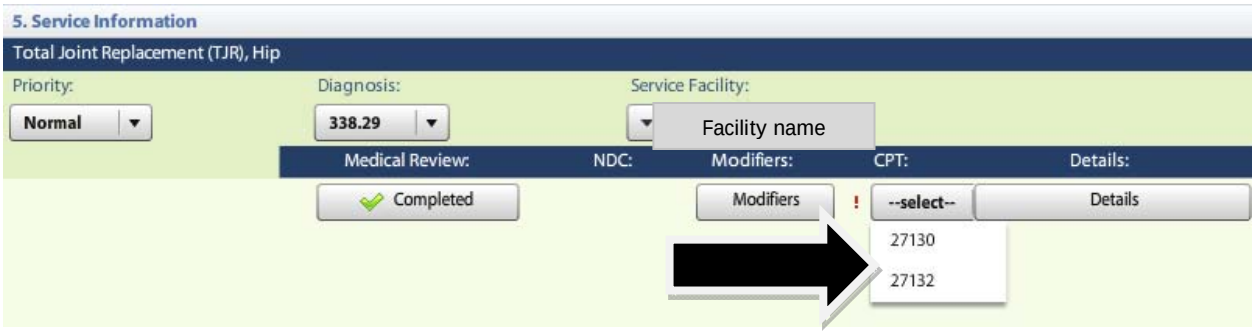
Click the “Modifiers” button



Select the correct side (right, left or bilateral), then click “OK”

CPT:

Ensure the correct CPT code is populated:



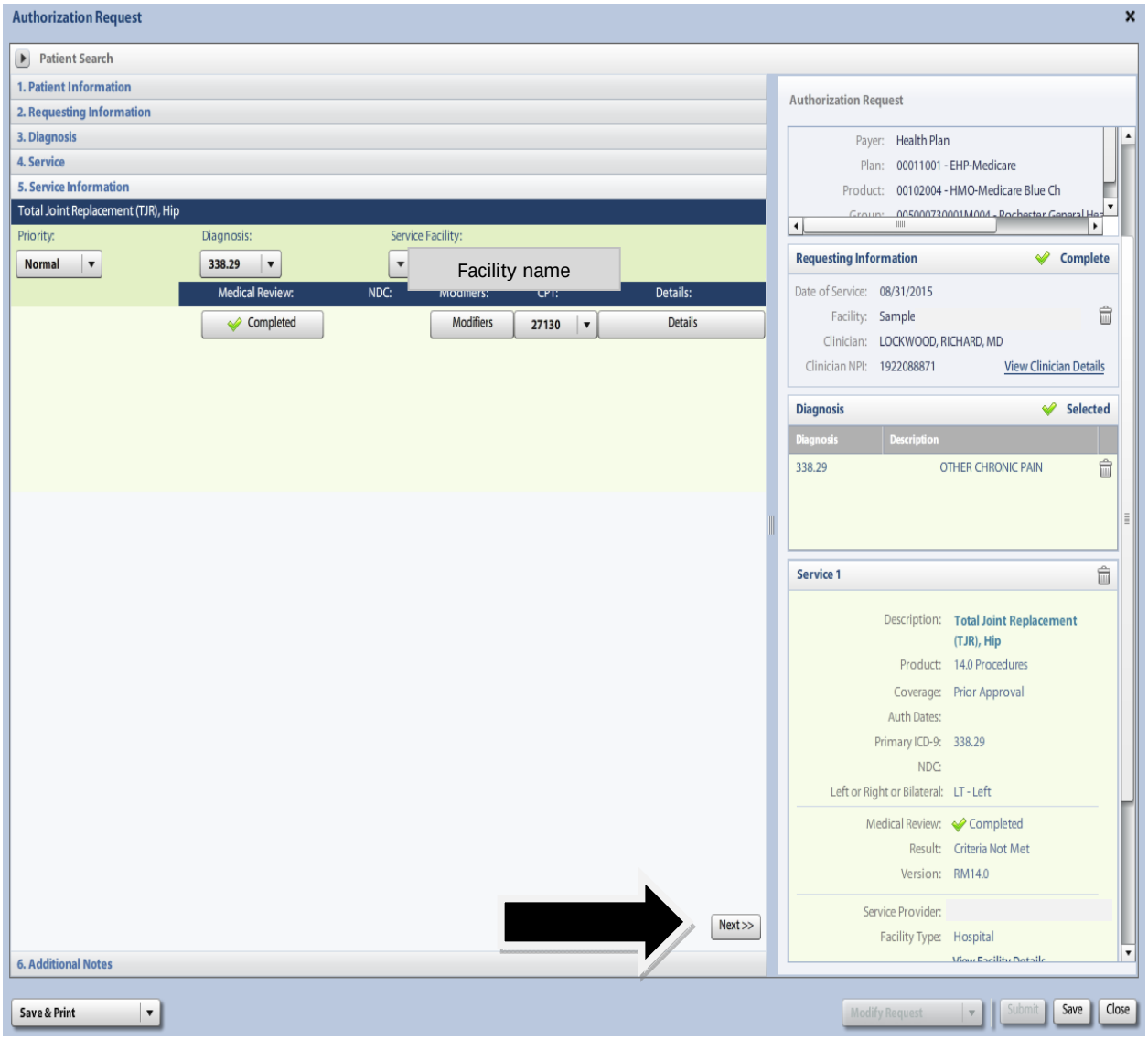
Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Details section:

Must select: (1) Place of Service, then click the "OK" button (2).

Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Click “Next.”

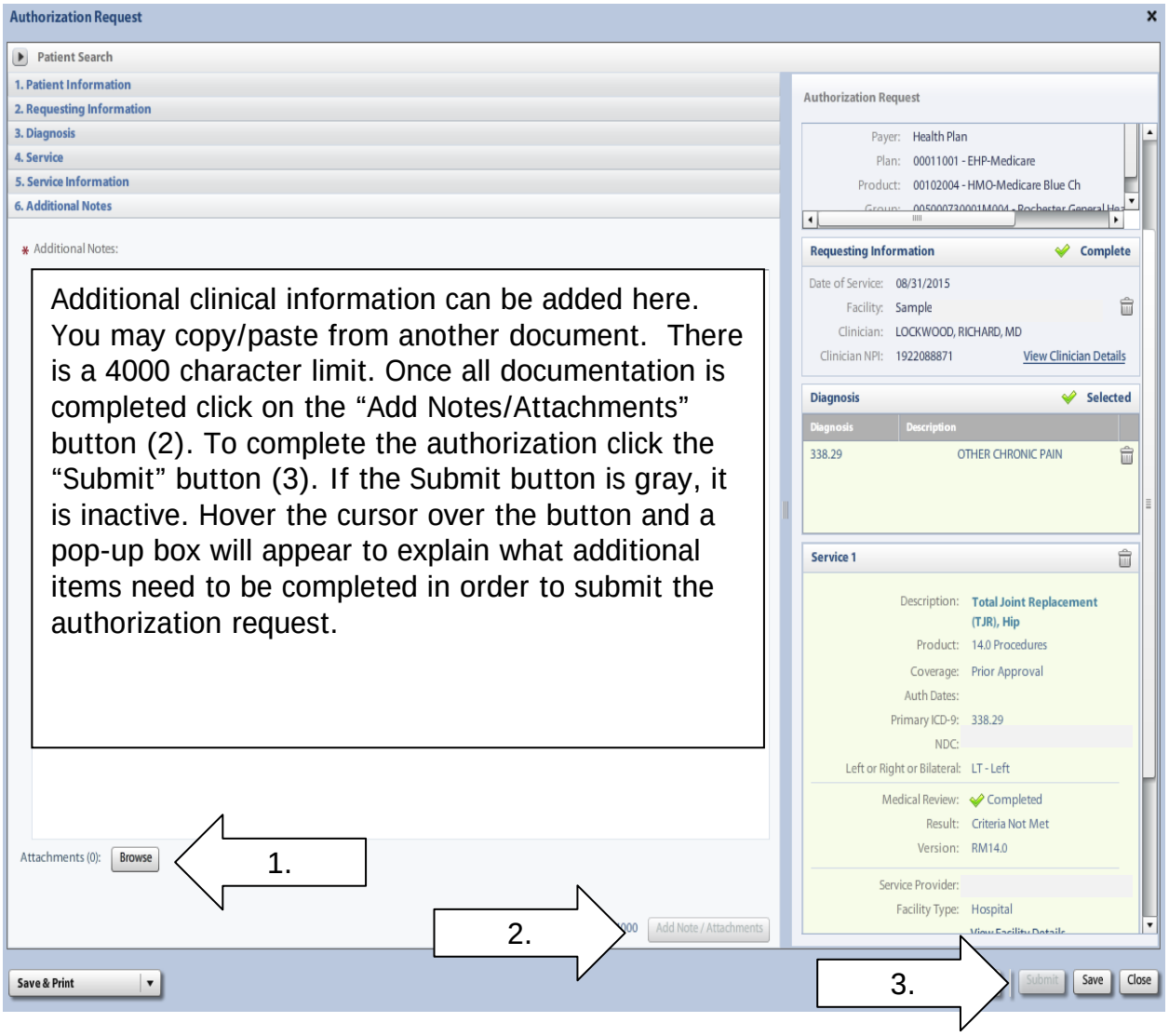


Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Accordian 6: Additional Notes

If criteria was <u>not</u> met, or if this is an FEP contract, enter additional information and/or attach a note with supporting medical documentation (1). Click on “Add Note/Attachment” (2). Click “Submit” (3).

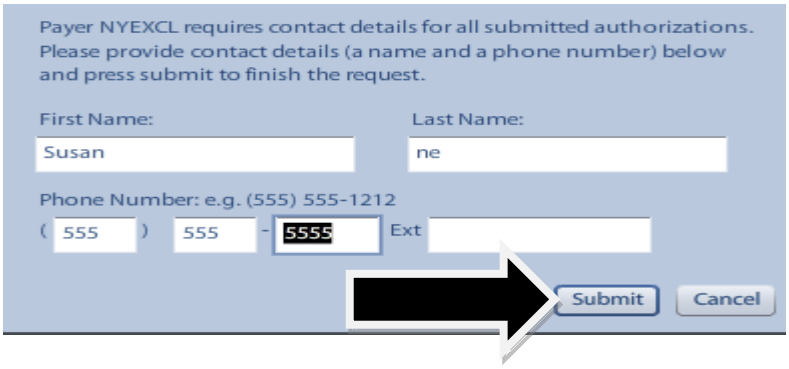
A note <u>must</u> be added in order to attach a document.



Clear Coverage™
Hip and Knee Replacement Surgery Authorization Entry Tips

Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #. If approved, there will be 2 authorization numbers. One is for the professional and one is for the inpatient stay.
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request

Clear Coverage™
Home Care Authorization Entry Tips

Commercial & Medicare Contracts: Initial requests for up to 20 visits for home care may receive an automatic approval. Subsequent visits and visits requested beyond 20 will pend for review.

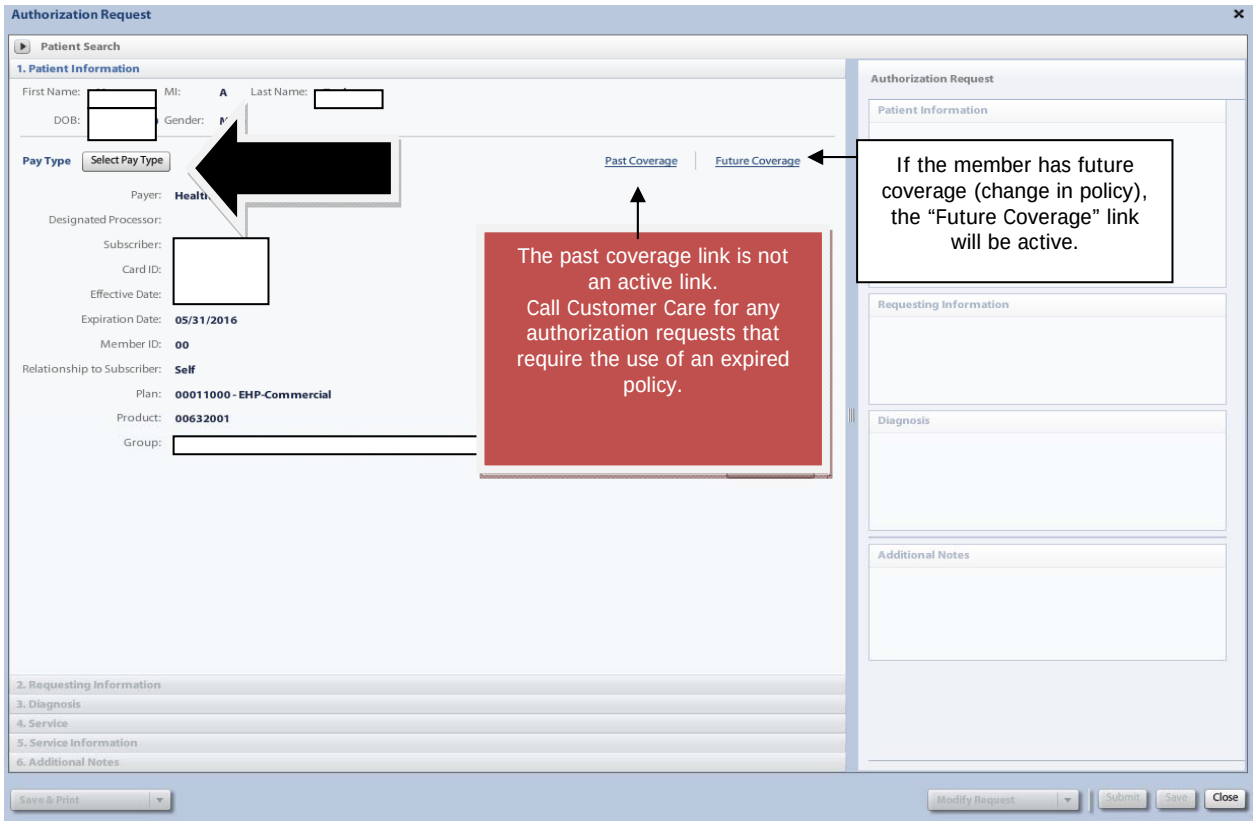
Diagnosis Codes: Enter the primary diagnosis code first.

CPT codes: Use **T1001** for all Home Care authorizations with the following EXCEPTIONS: personal care services and private duty nursing. Requests for personal care services and private duty nursing may be requested but will always pend and also require that additional information is attached in accordion six.

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).



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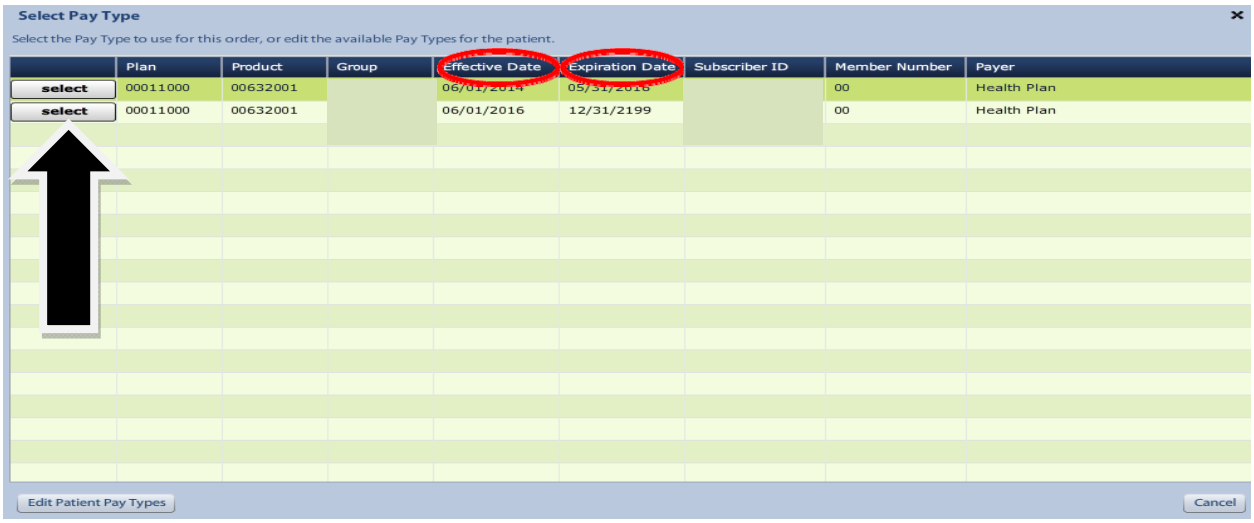
Clear Coverage™
Home Care Authorization Entry Tips

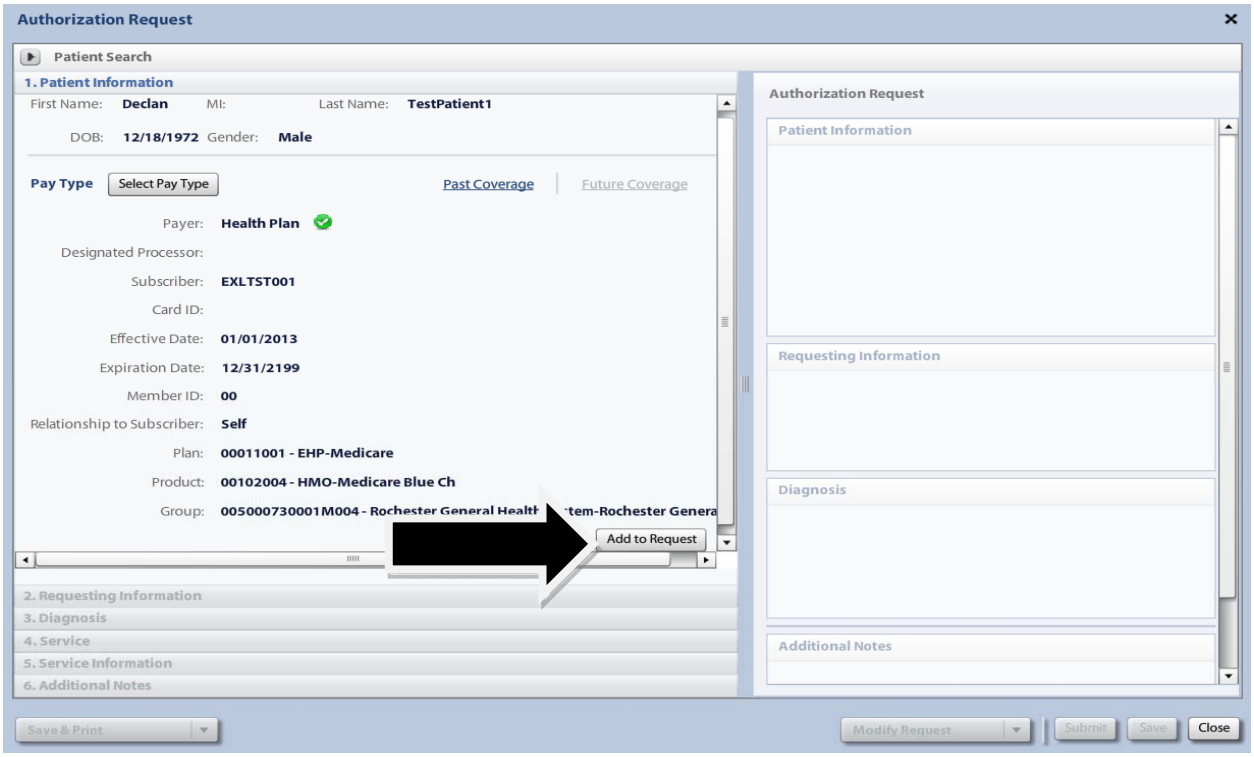
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

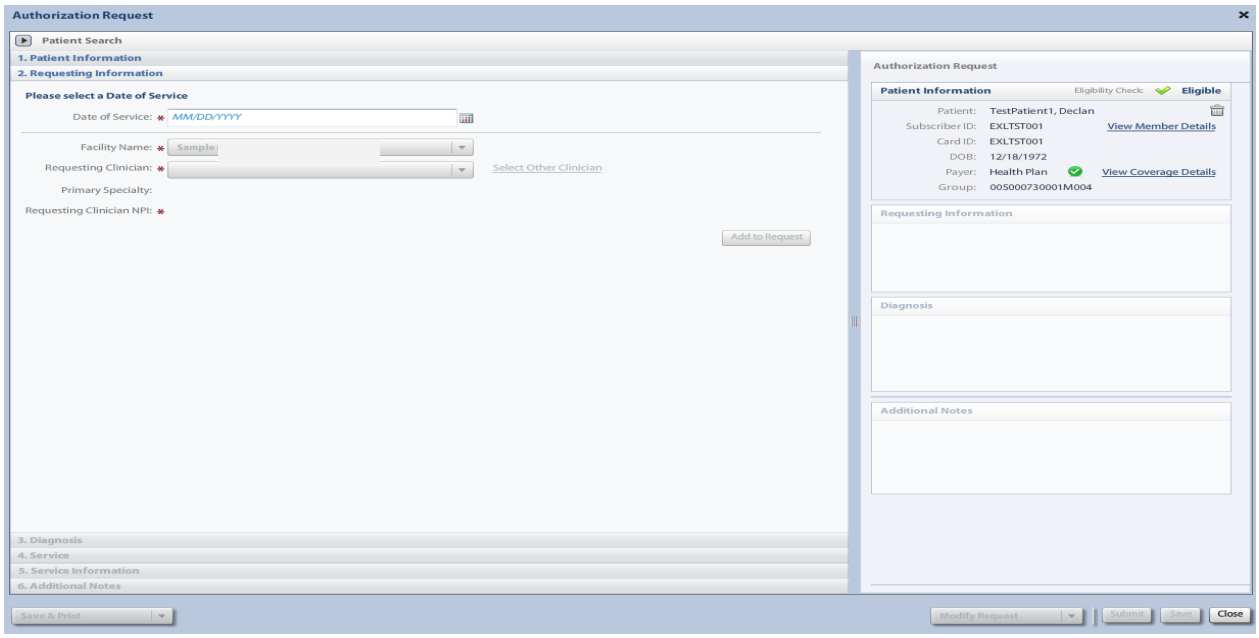


Clear Coverage™
Home Care Authorization Entry Tips

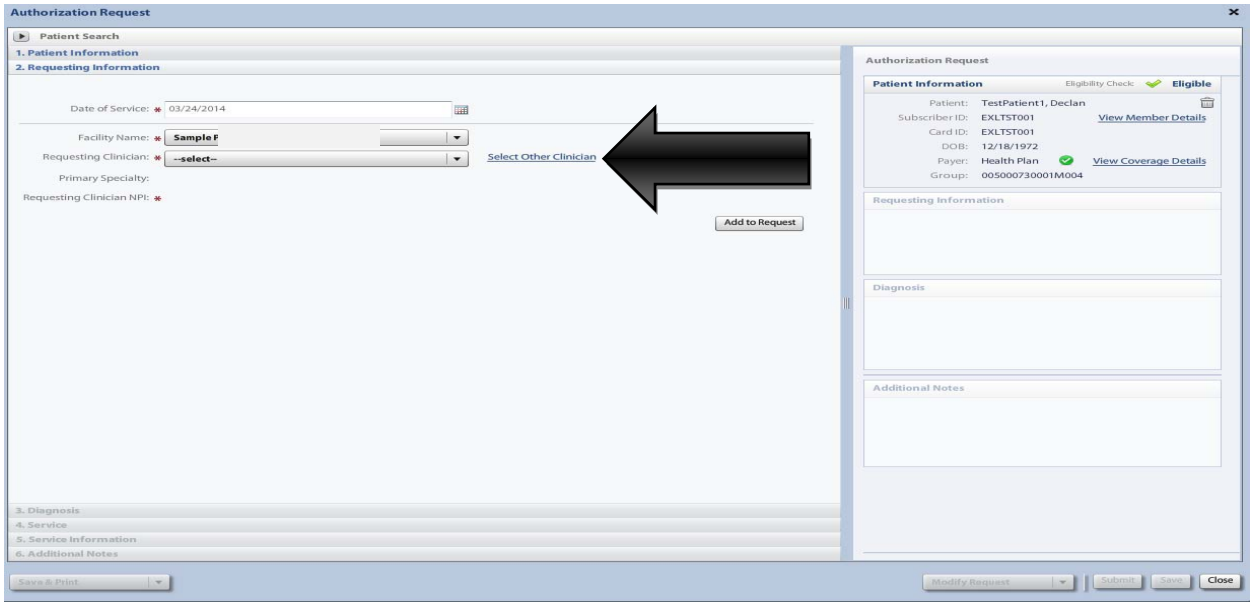
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

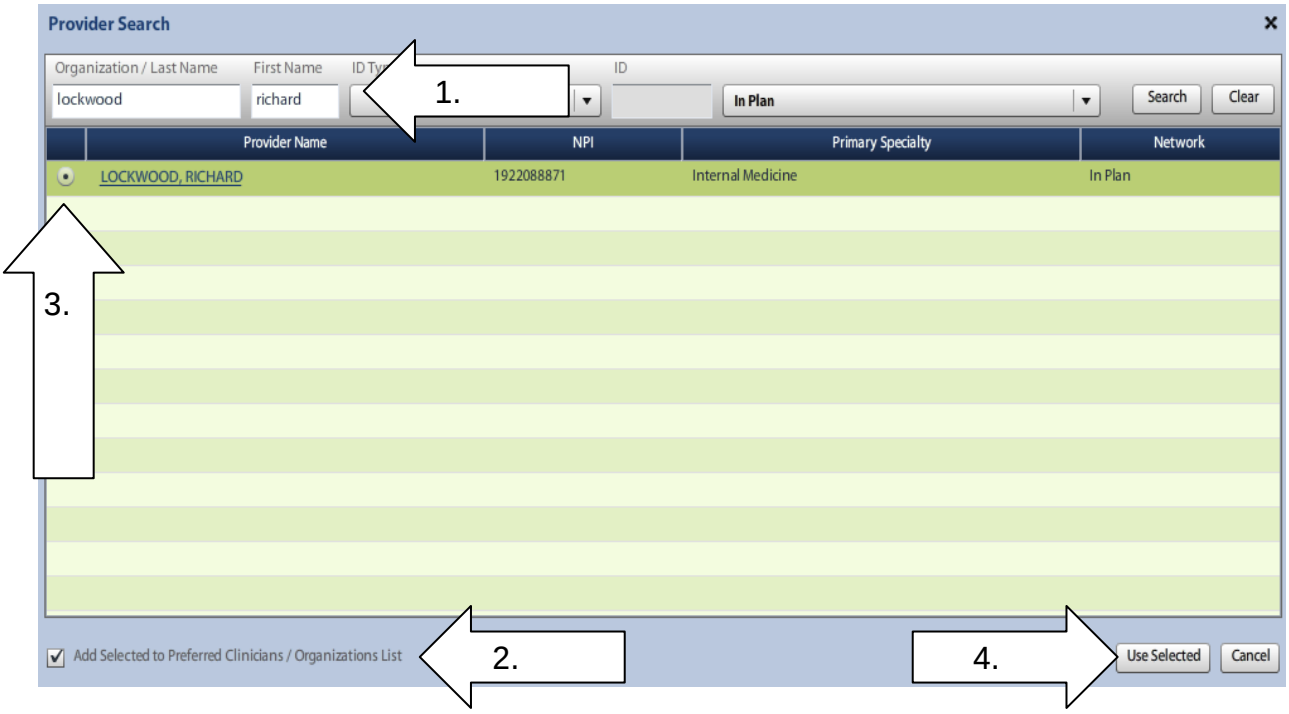


Clear Coverage™
Home Care Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

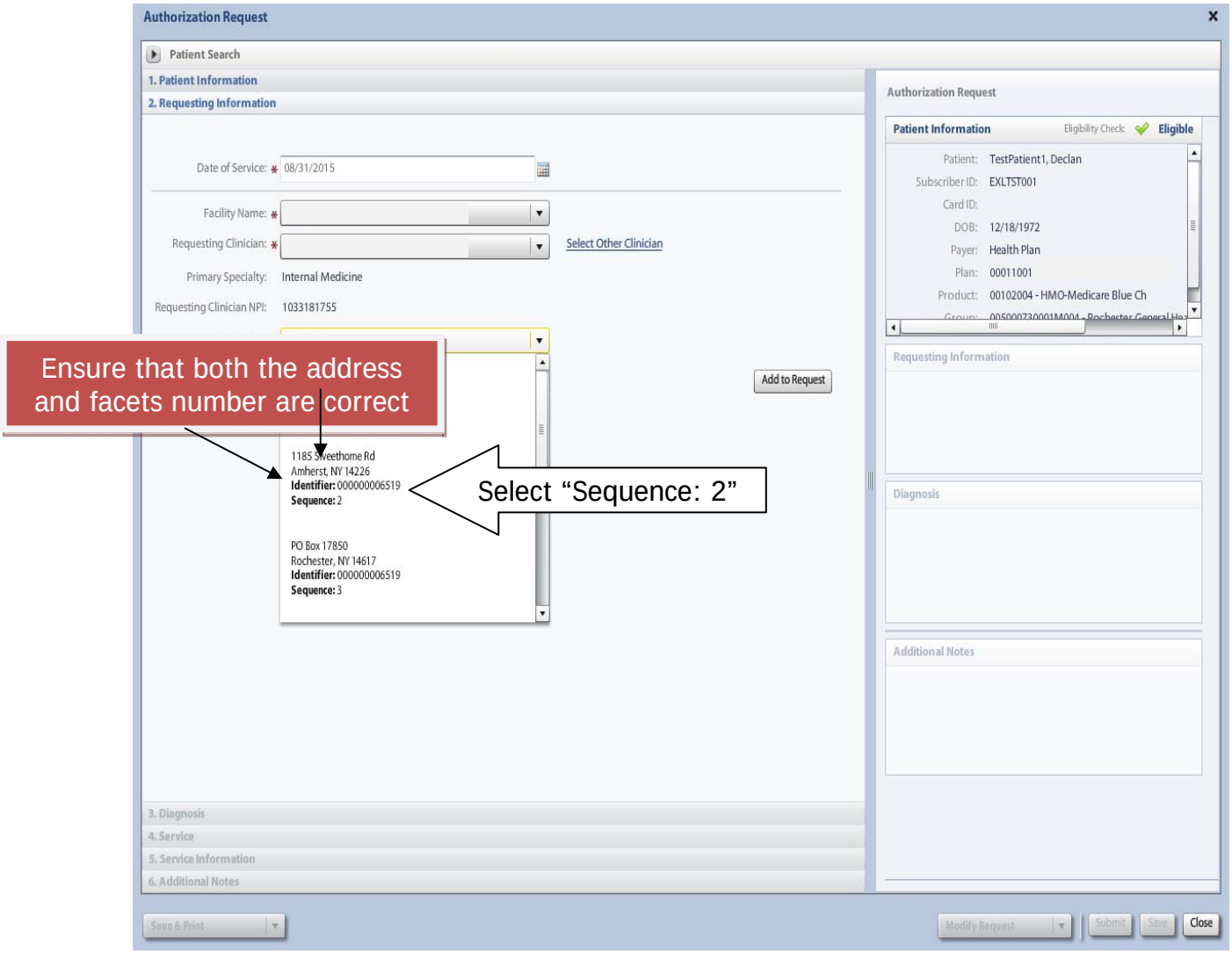
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Home Care Authorization Entry Tips

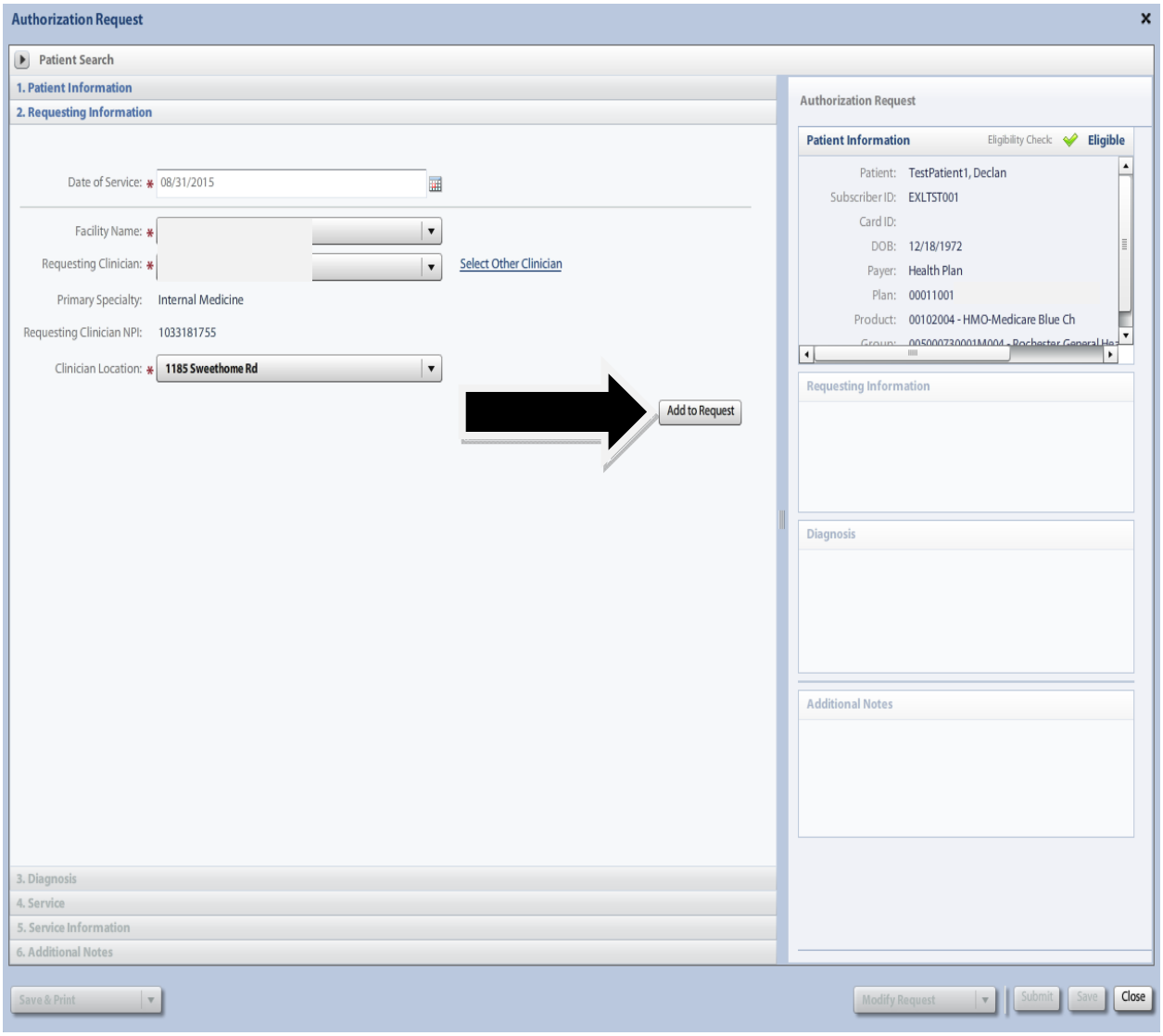
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Home Care Authorization Entry Tips

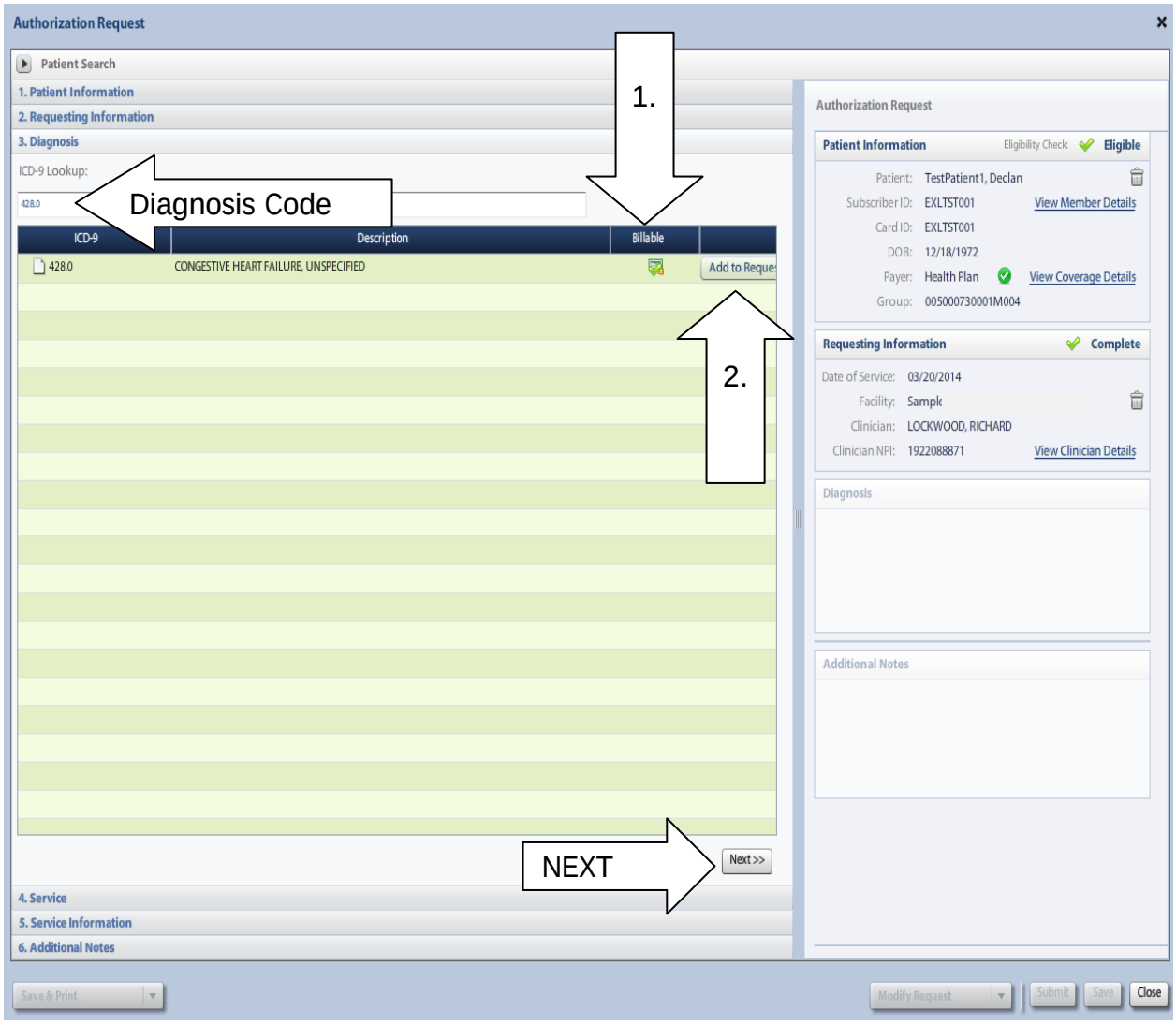
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Home Care Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."



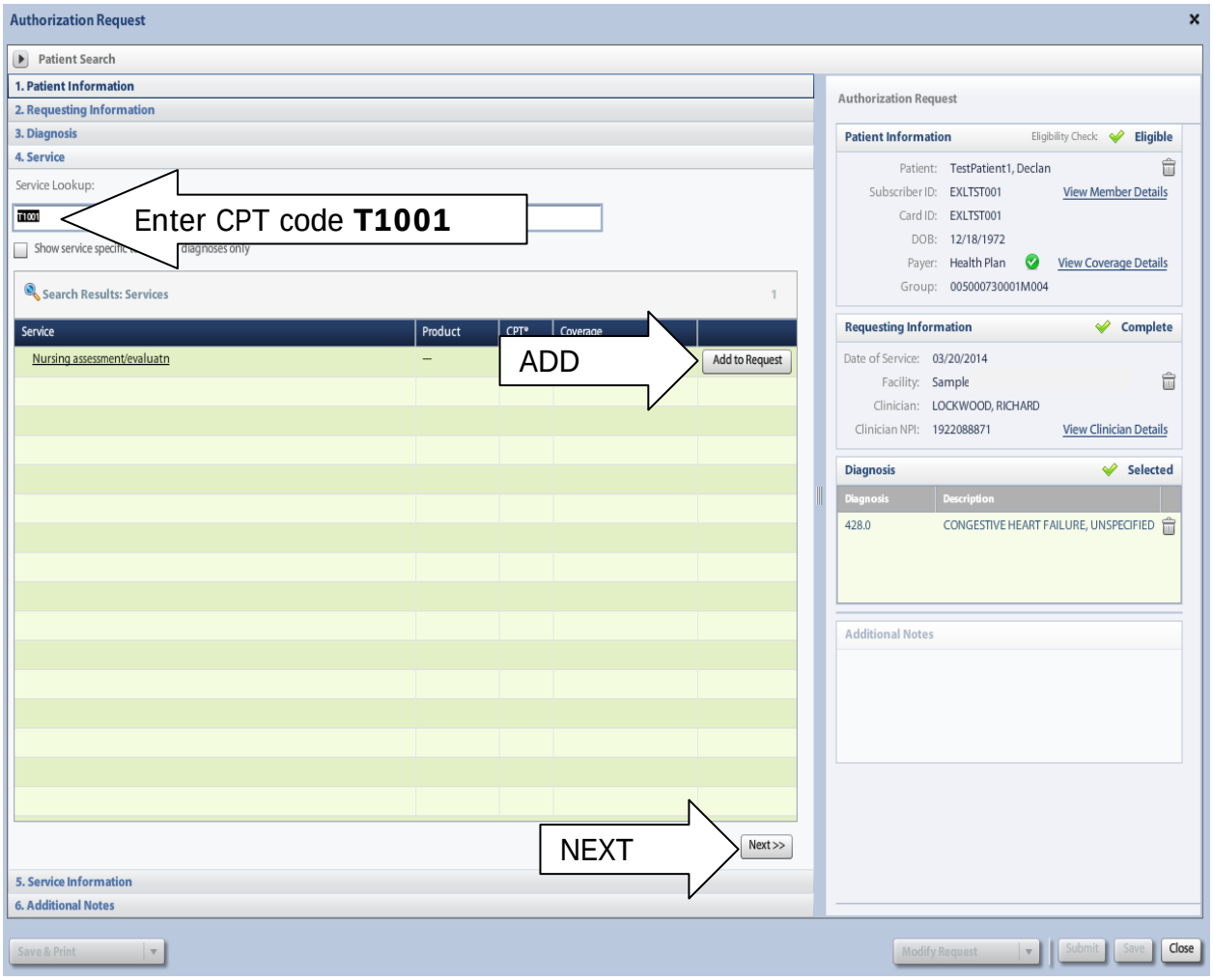
Clear Coverage™
Home Care Authorization Entry Tips

Accordion 4: Services

Enter procedure code only: **T1001.** All home care codes are included within this code (service group) with the exception of private duty nursing and personal care.

- If the authorization is entered for private duty nursing codes or personal care services codes, it will pend and clinical information **must be** submitted to the Health Plan in a note (accordion 6). Each of these codes must be submitted on separate authorization requests.

- Click the "Add to Request" button, then click "Next".



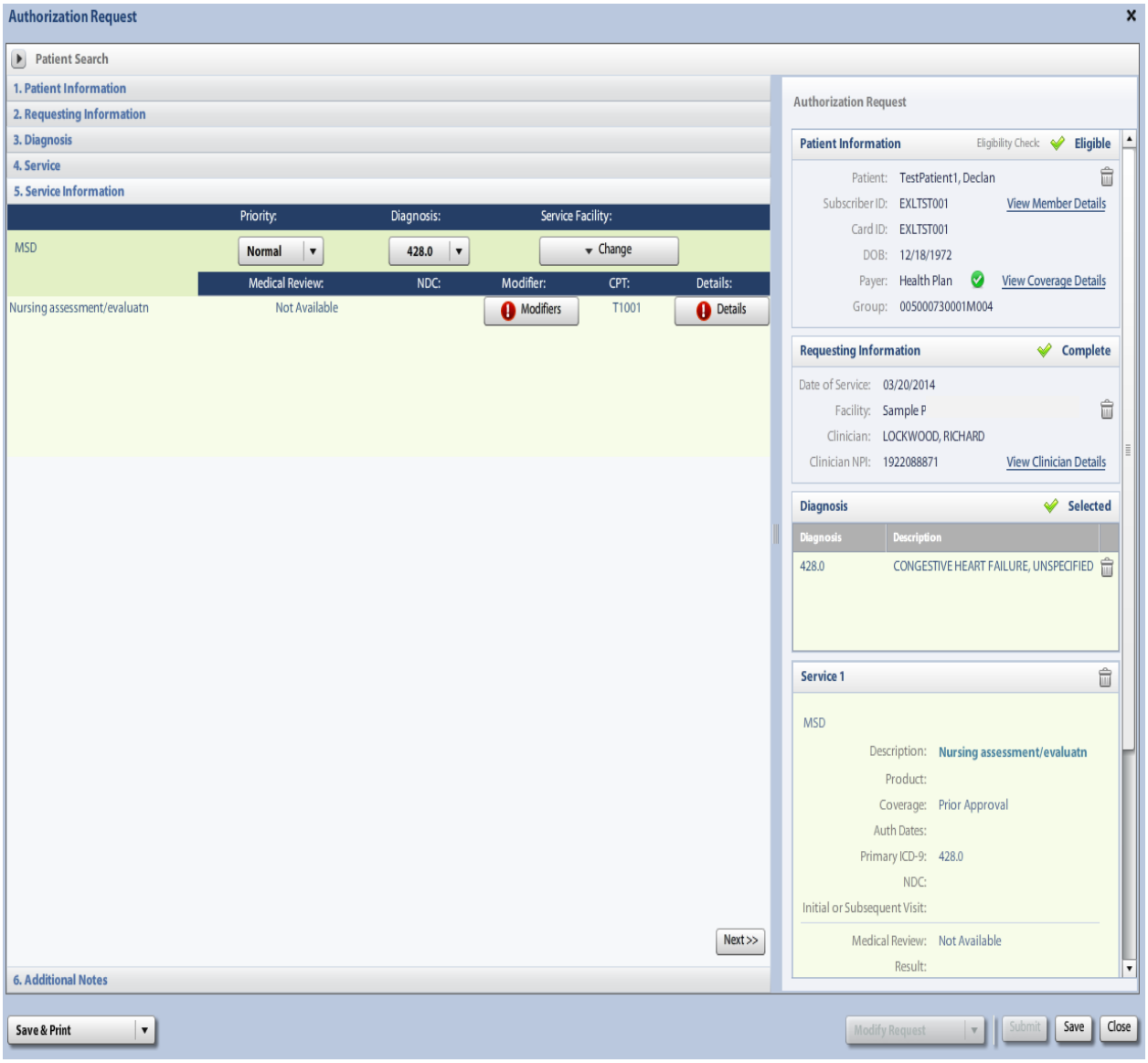
Clear Coverage™
Home Care Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

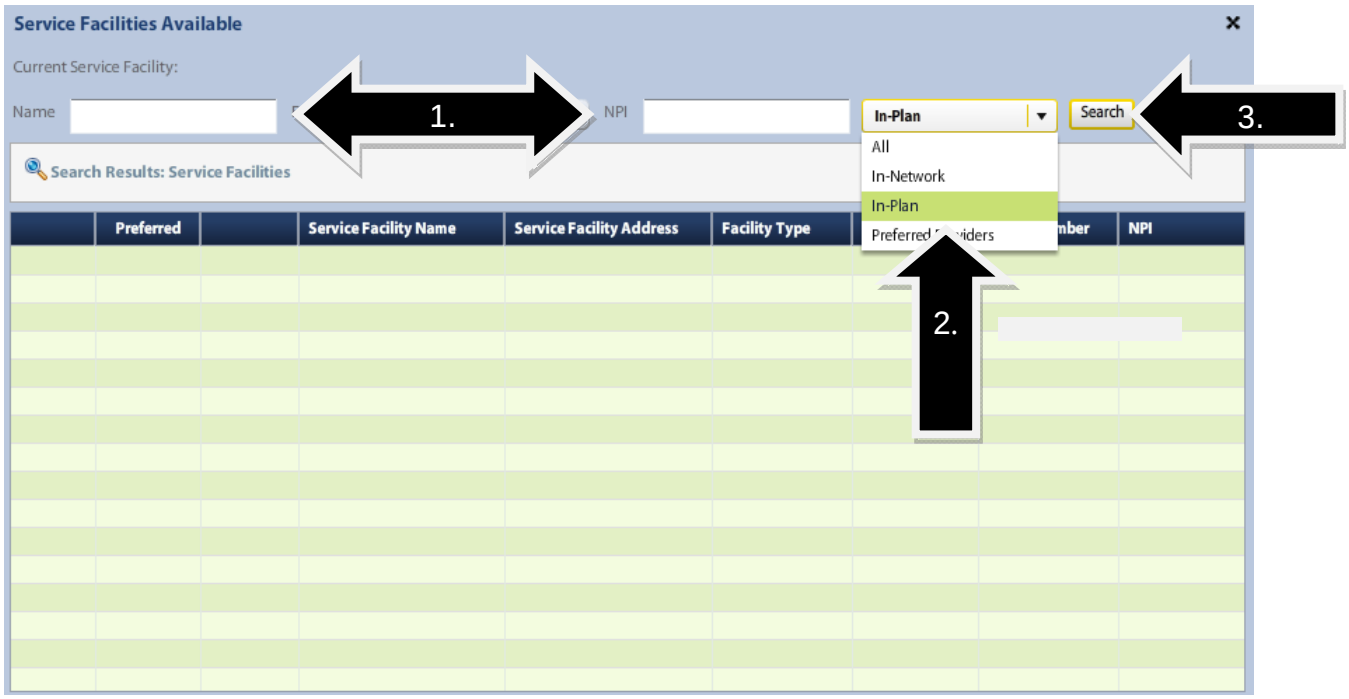
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service (or provider/vendor)

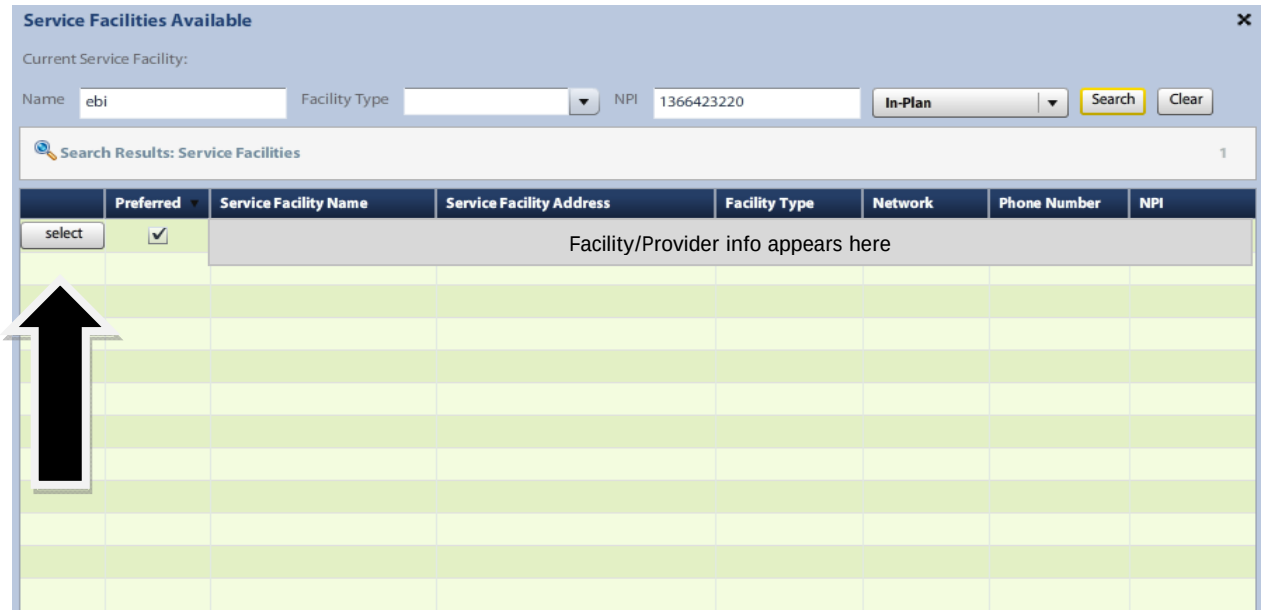


Clear Coverage™
Home Care Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number of your home care agency (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).



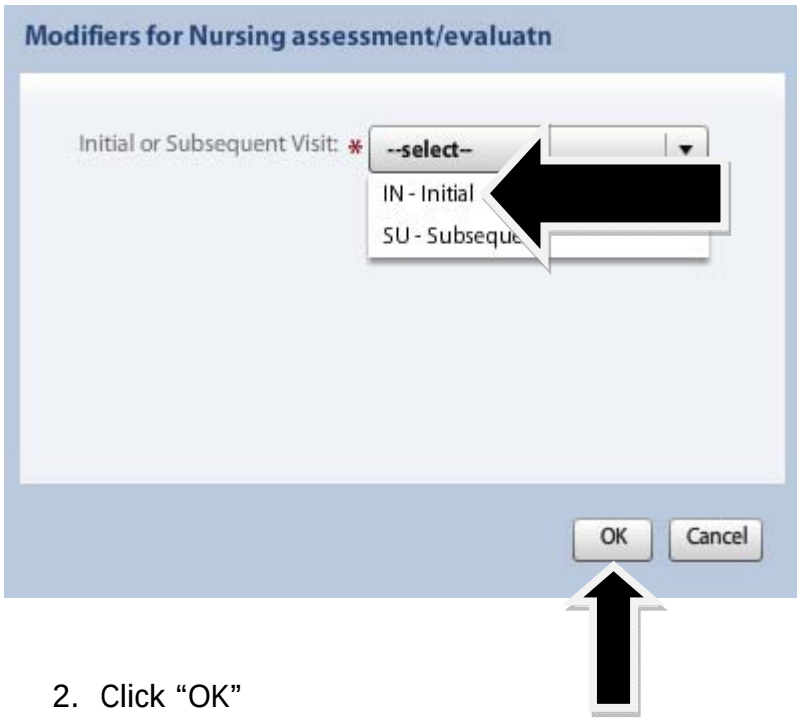
When the results display, select the appropriate provider.



Clear Coverage™
Home Care Authorization Entry Tips

Modifiers for Home Care:

1. Select “Initial”

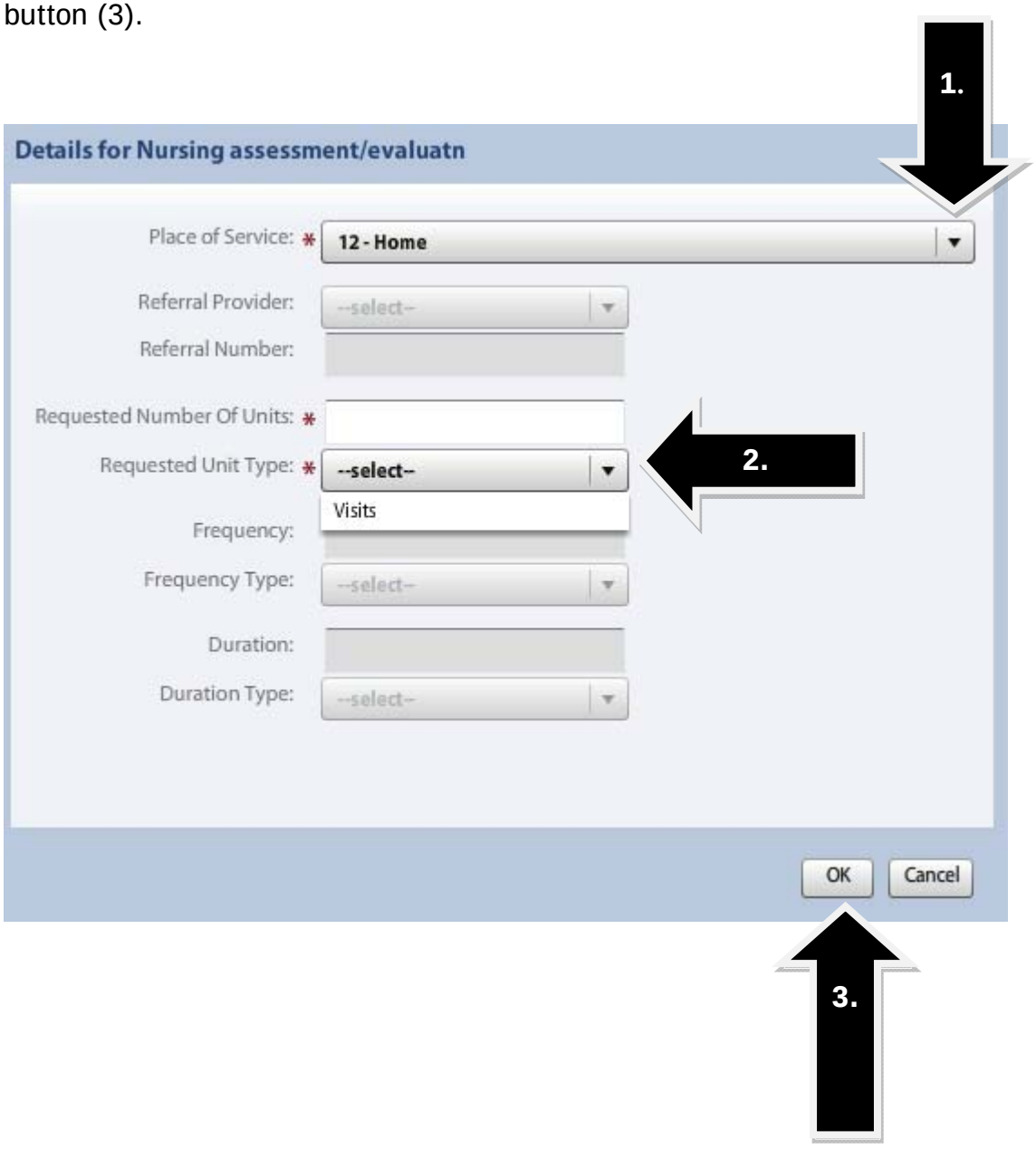


2. Click “OK”

Note: If an original authorization already exists in Clear Coverage™ and you wish to request additional visits for that same authorization, locate the authorization, see page 16-17 of this document for instructions.

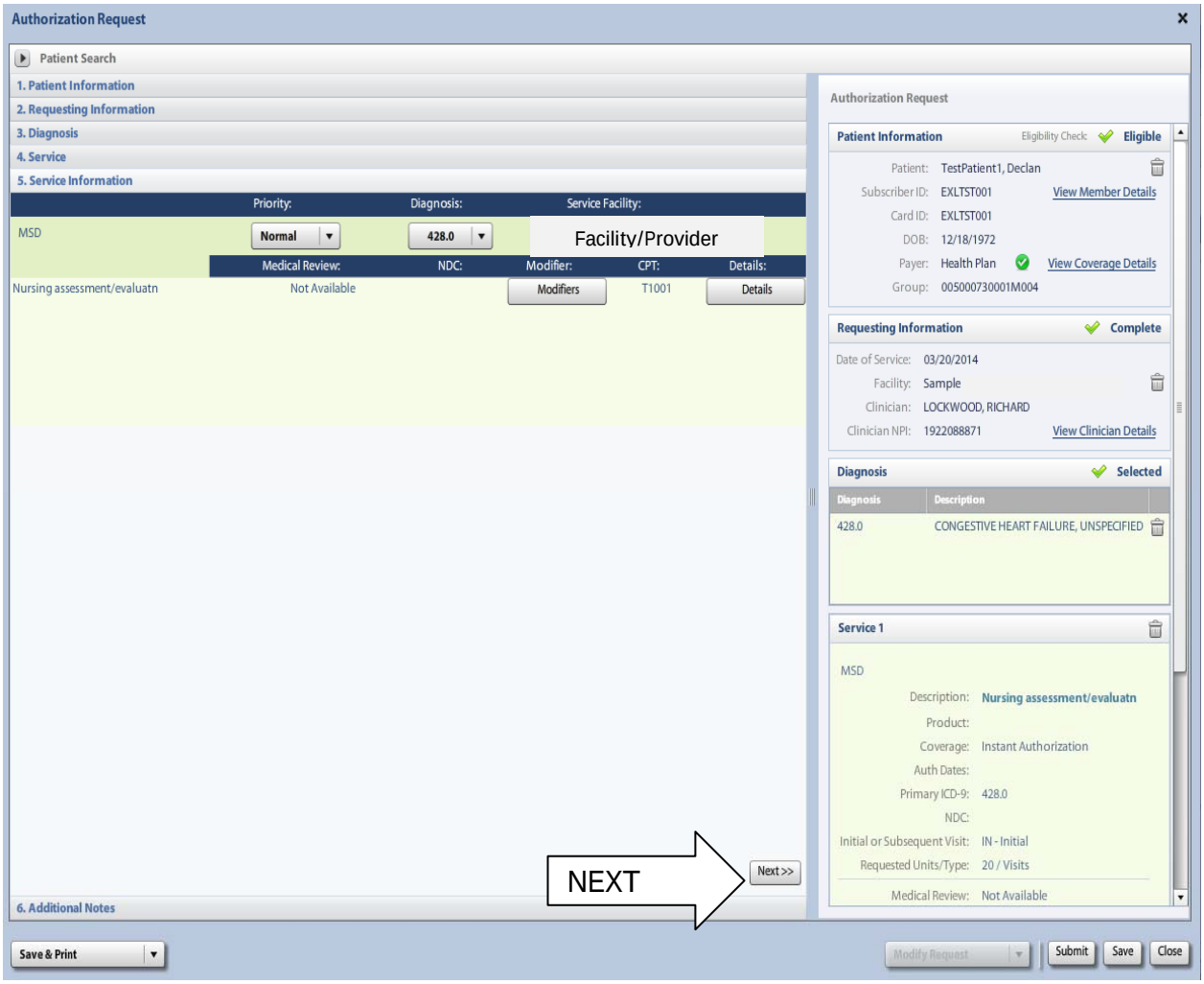
Clear Coverage™
Home Care Authorization Entry Tips

Details section: Must select: (1) Place of Service. (2) Number of Units (visits) and Requested Unit Type. "**Initial" authorizations may include 1-20 visits. Any number over 20 will result in a pended authorization.** When completed, click the "OK" button (3).



Clear Coverage™
Home Care Authorization Entry Tips

Once all of the Service information has been added, click the “Next” button.

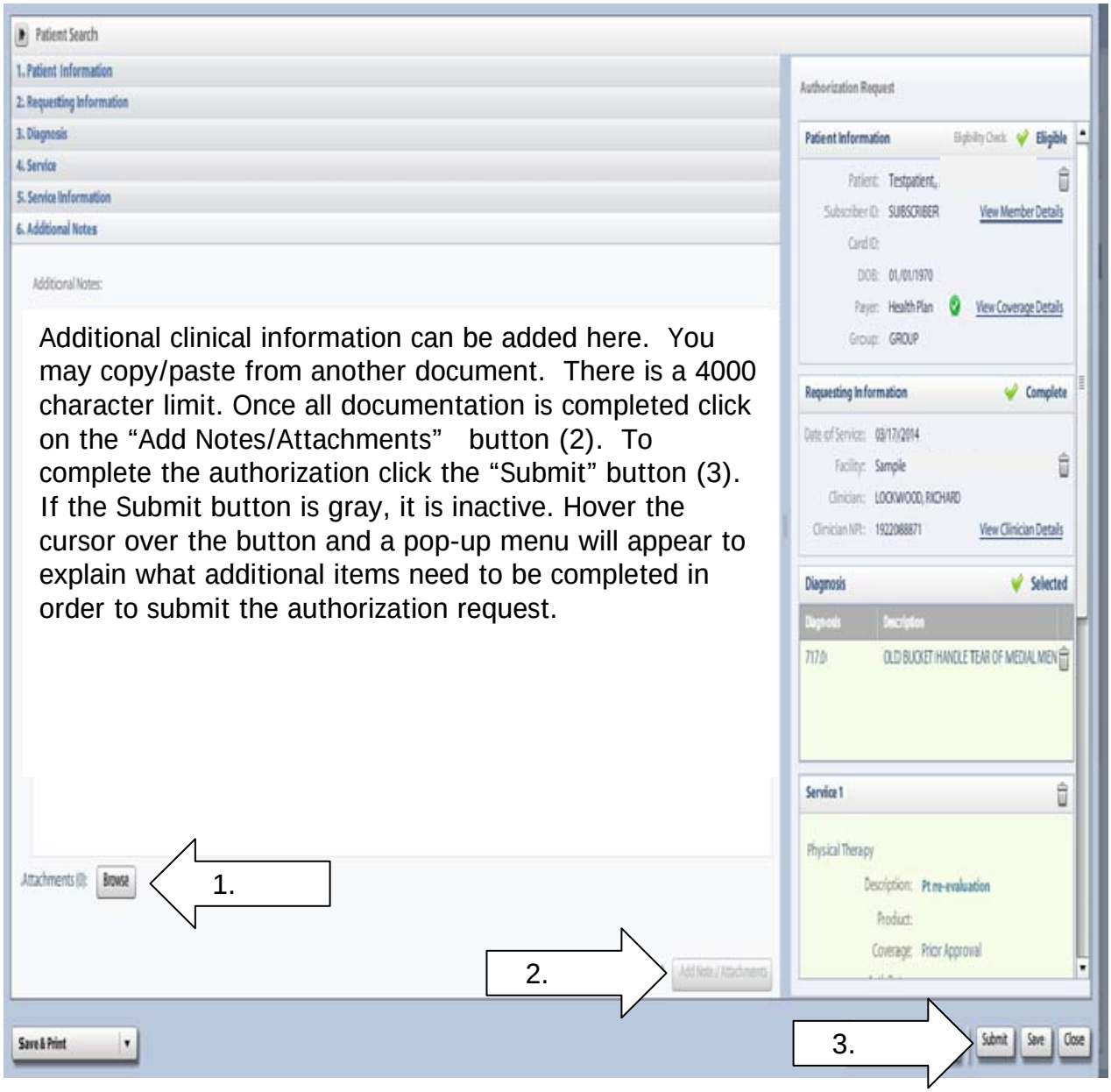


Clear Coverage™
Home Care Authorization Entry Tips

Accordian 6: Additional Notes

If needed, additional clinical information can be added in this section and documents can be attached (1). A note must be added in order to attach a document.

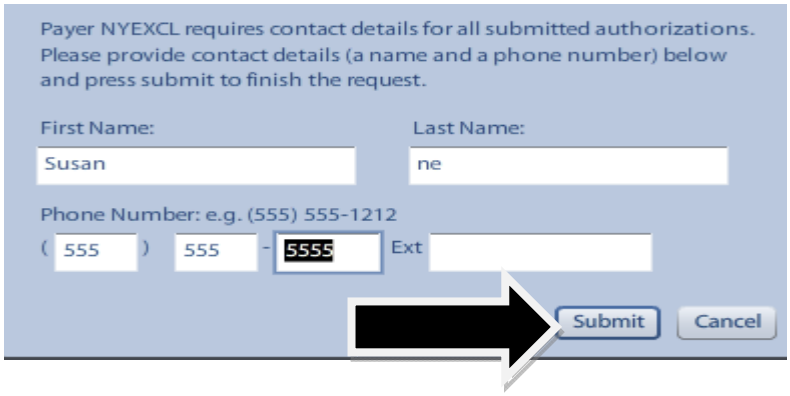
A note is required for ALL subsequent visit (additional visit) requests, visit requests beyond 20 and for requests for personal care services and private duty nursing.



Clear Coverage™
Home Care Authorization Entry Tips

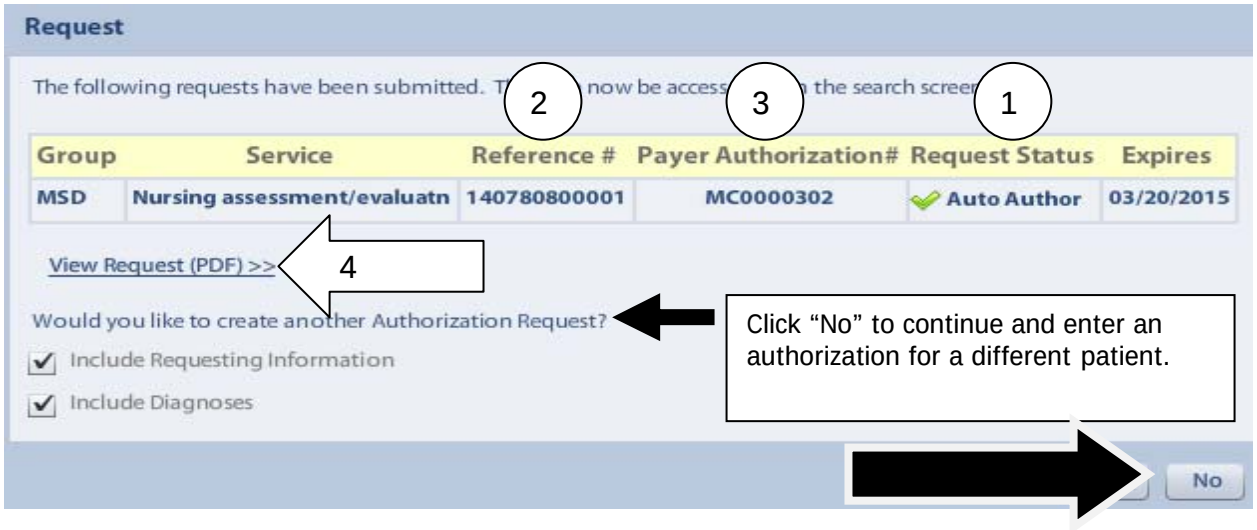
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request

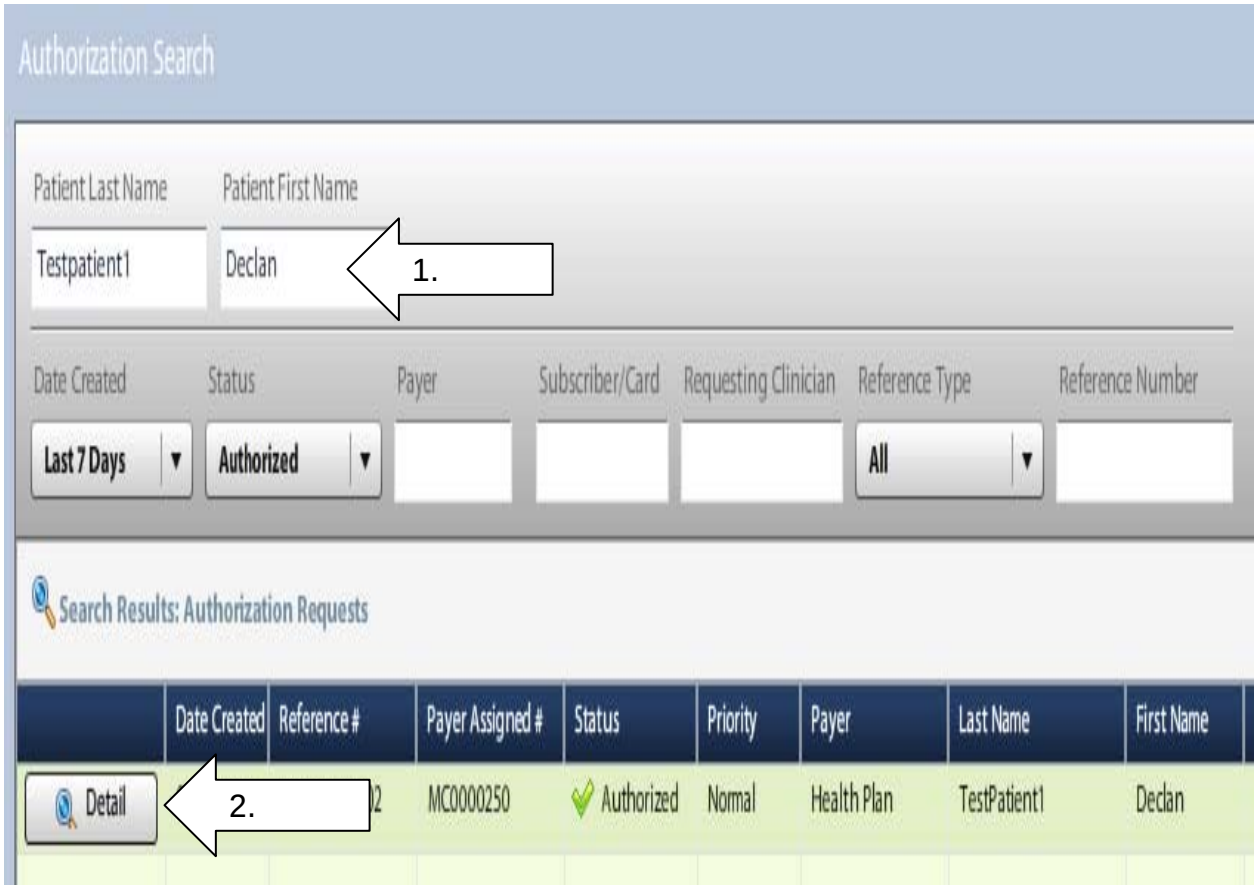


Clear Coverage™
Home Care Authorization Entry Tips

When an initial authorization <u>has already been entered in Clear Coverage</u>™, DO NOT create a new authorization. Follow these steps:

1. Locate the authorization by patient name and/or reference number.

2. Click the “Detail” button to re-open the authorization.



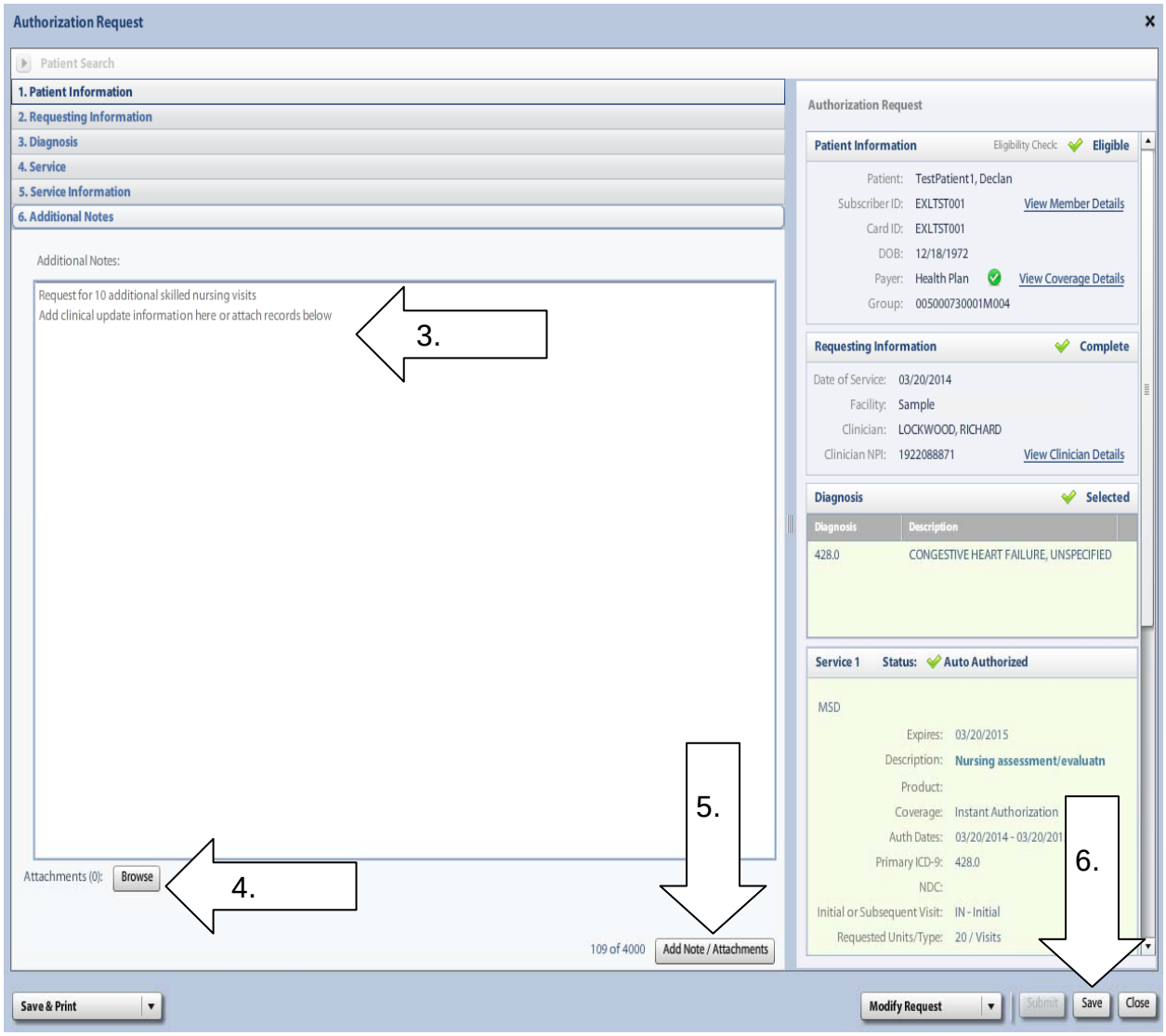
Clear Coverage™
Home Care Authorization Entry Tips

3. Proceed directly to accordion 6 and type in a note: "Request for xx additional visits" and include clinical updates describing the need for additional visits.

4. Attach documents, if appropriate.

5. Click the "Add Notes/Attachments" button.

6. Click "Save".



Clear Coverage™
Hysterectomy Authorization Entry Tips

- Requests for hysterectomies will auto approve for all lines of business if the required criteria is met.

- **Cancer Diagnosis** (when the diagnosis of cancer is directly related to the hysterectomy):

  Outpatient-no review is required

  Inpatient-an authorization must be entered into Clear Coverage™, however no criteria review is required.

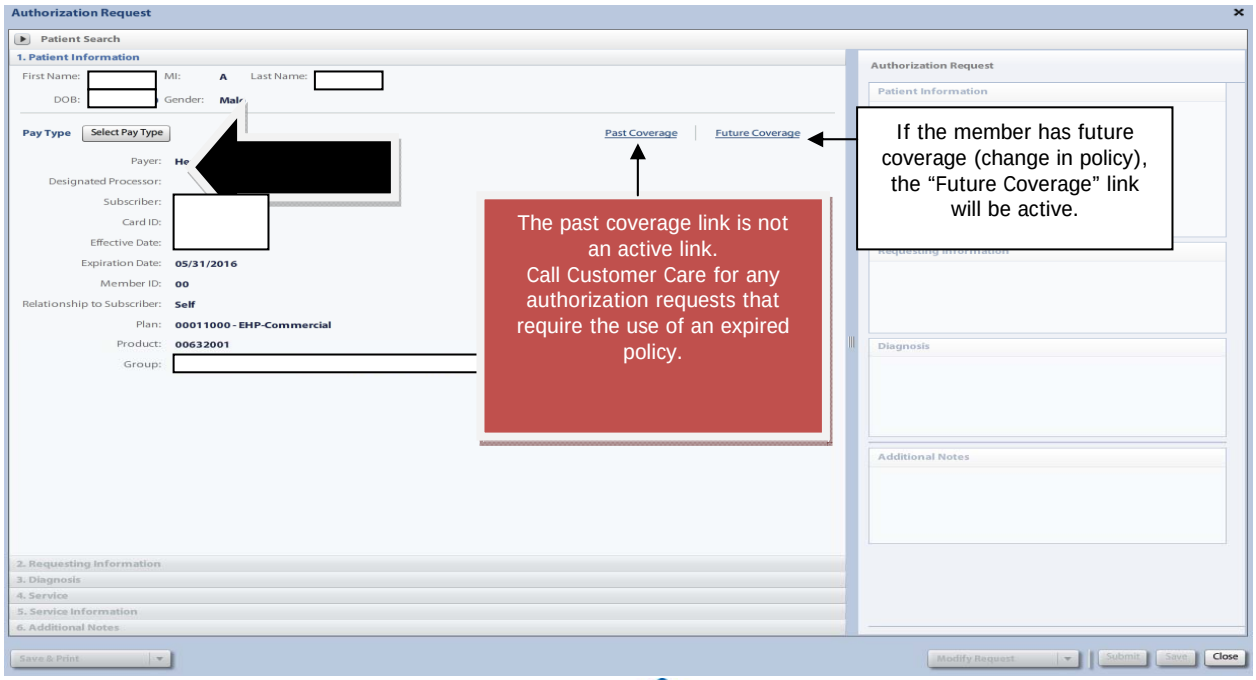
NOTE: If the request pends, you are required to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

NOTE: In the rare case that a hysterectomy is requested for a male patient, you will be required to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

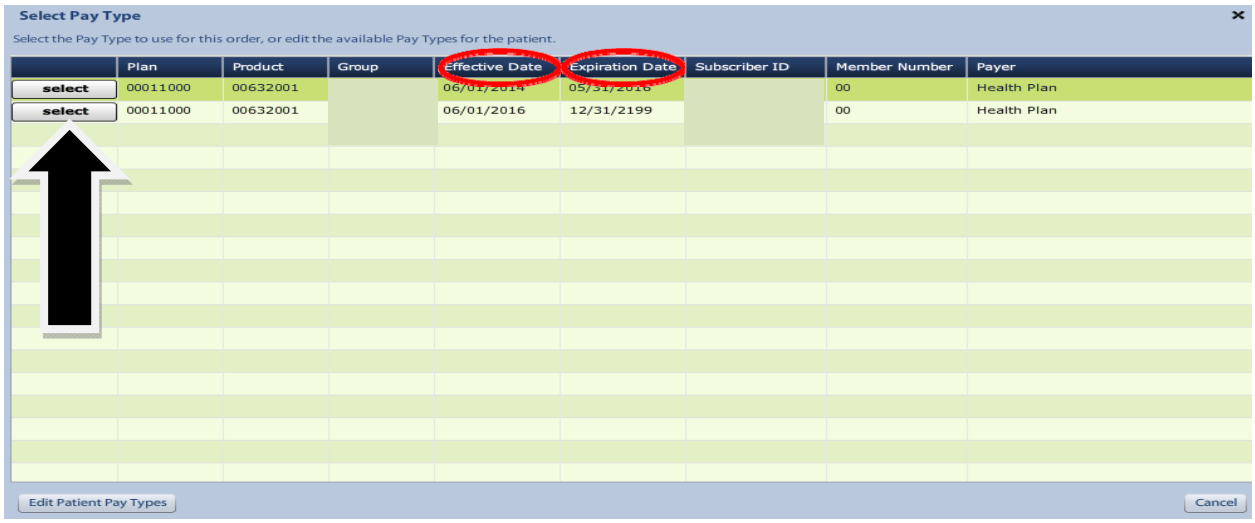


Clear Coverage™
Hysterectomy Authorization Entry Tips

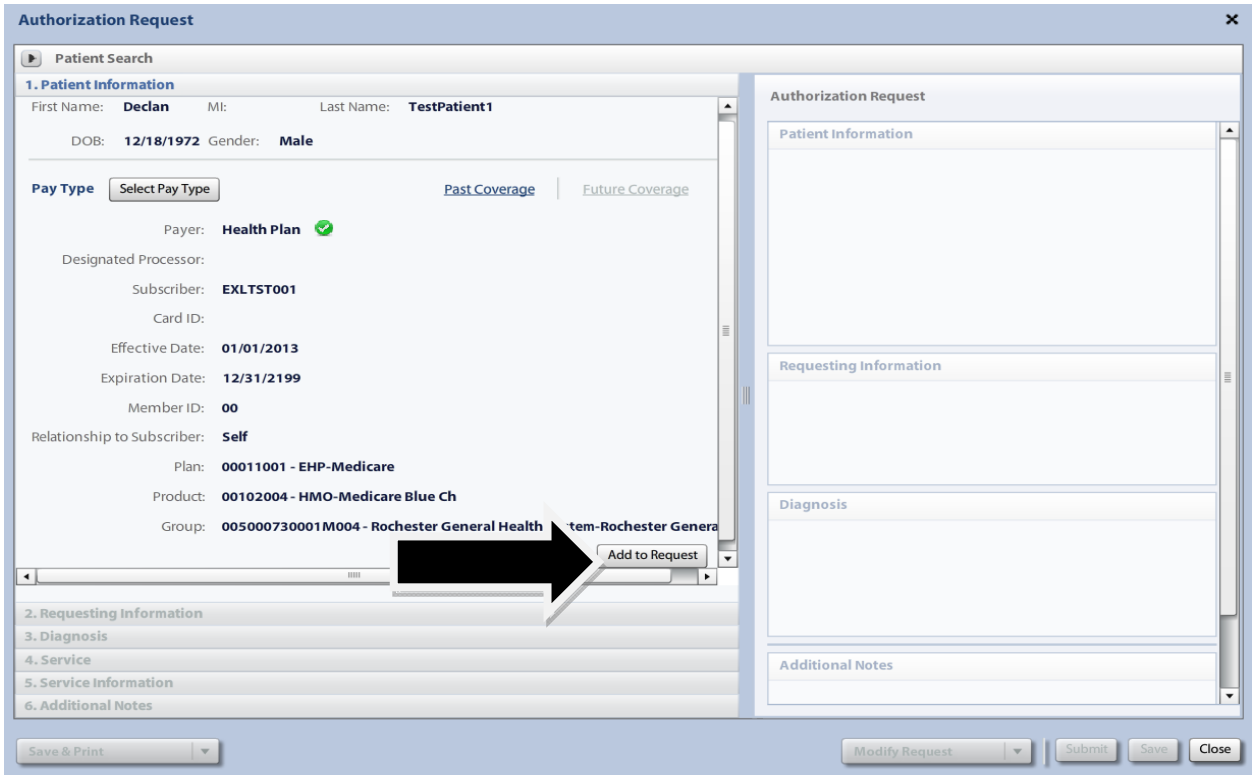
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

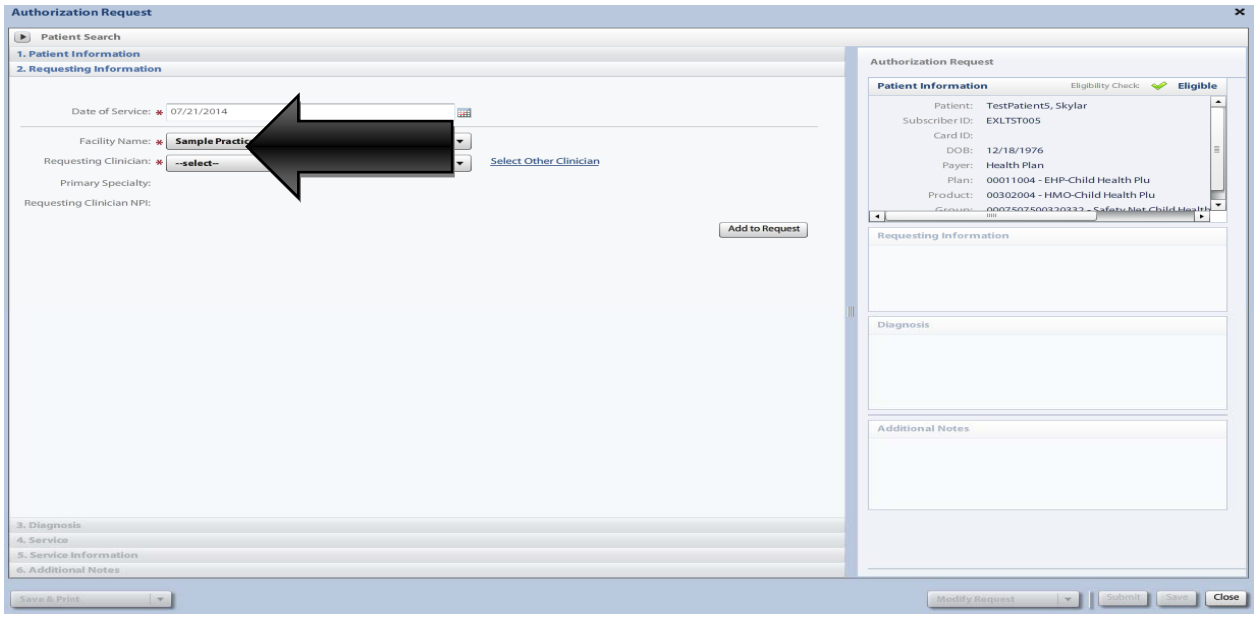


Clear Coverage™
Hysterectomy Authorization Entry Tips

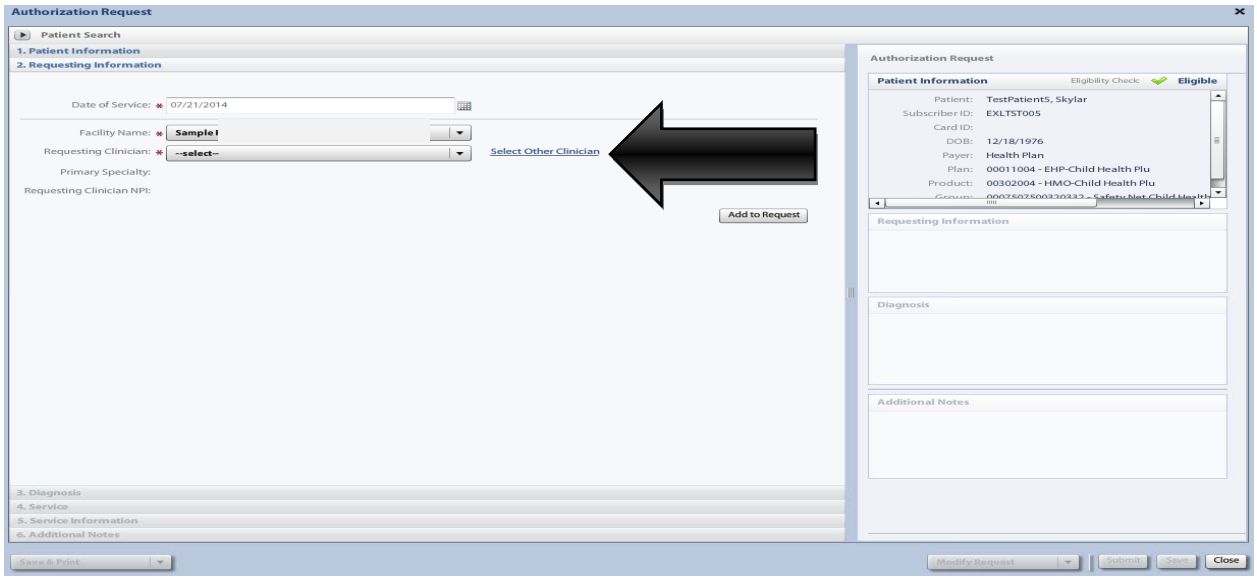
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

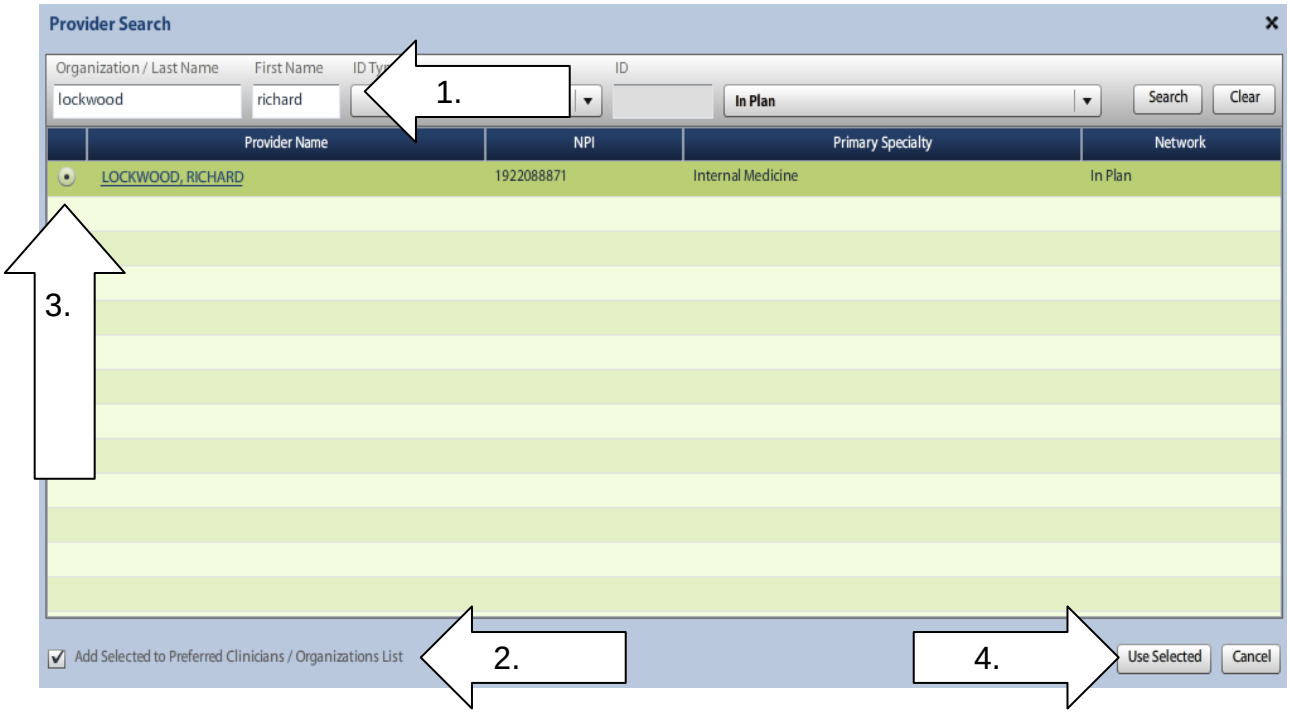


Clear Coverage™
Hysterectomy Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

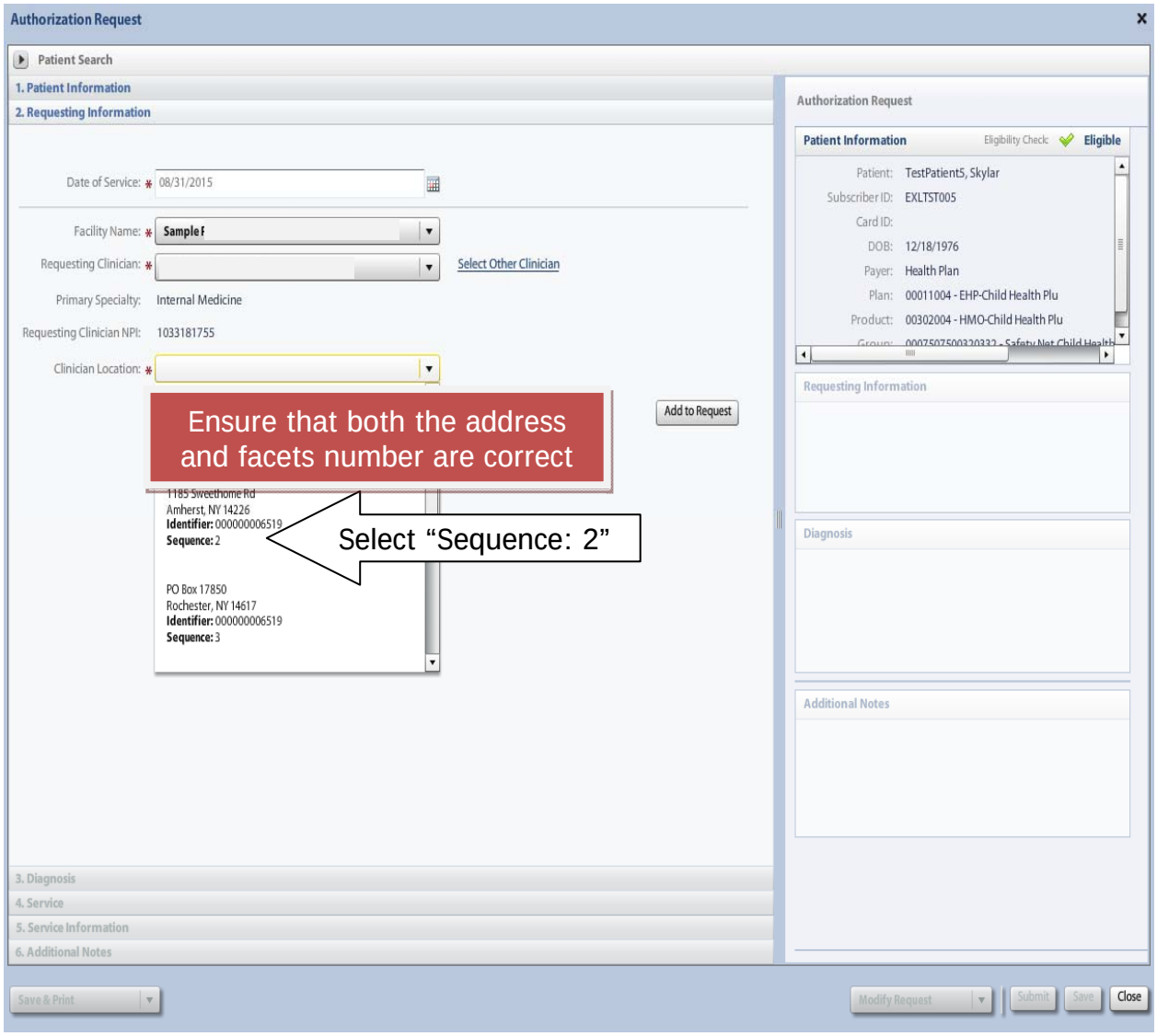
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Hysterectomy Authorization Entry Tips

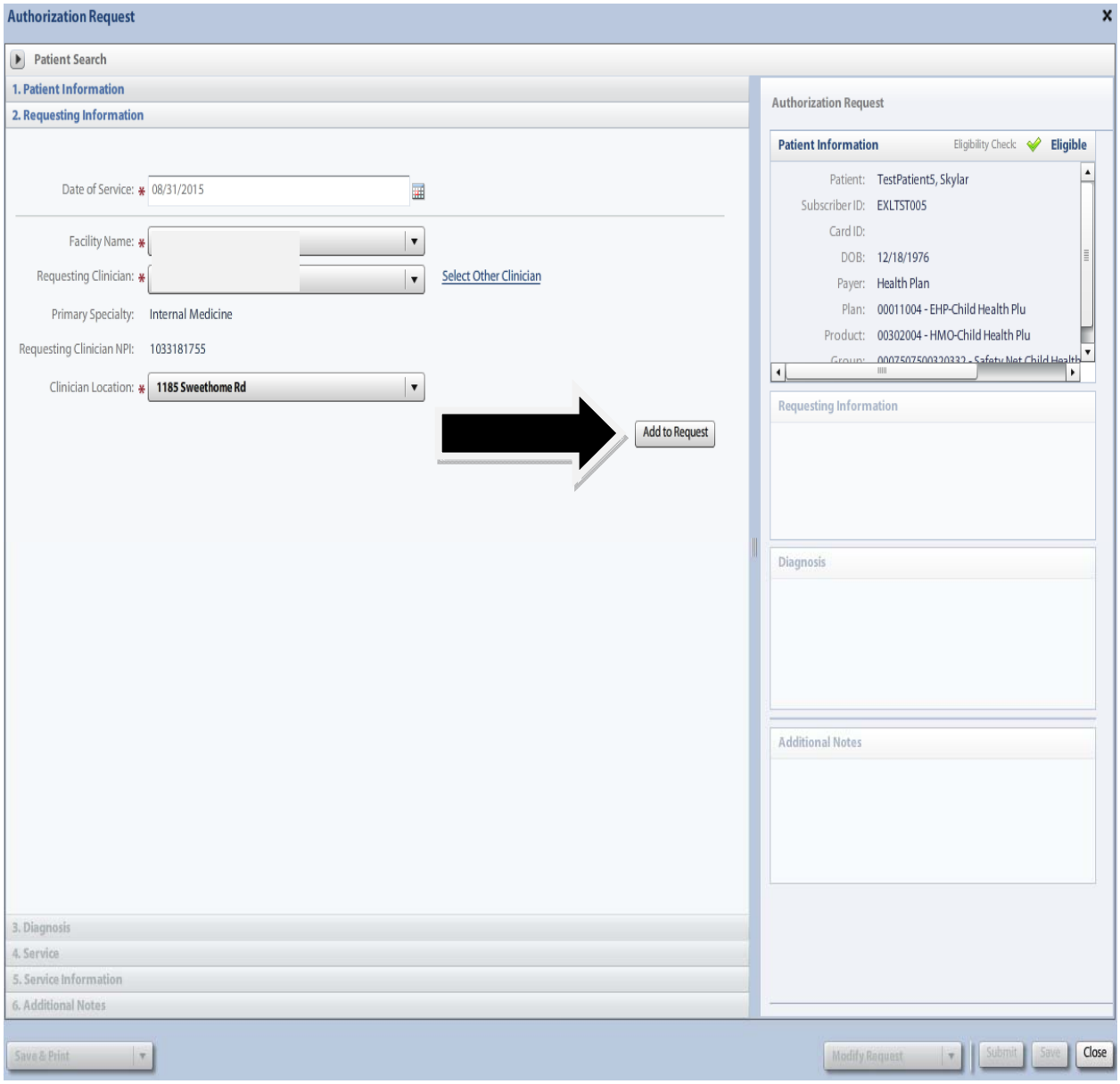
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Hysterectomy Authorization Entry Tips

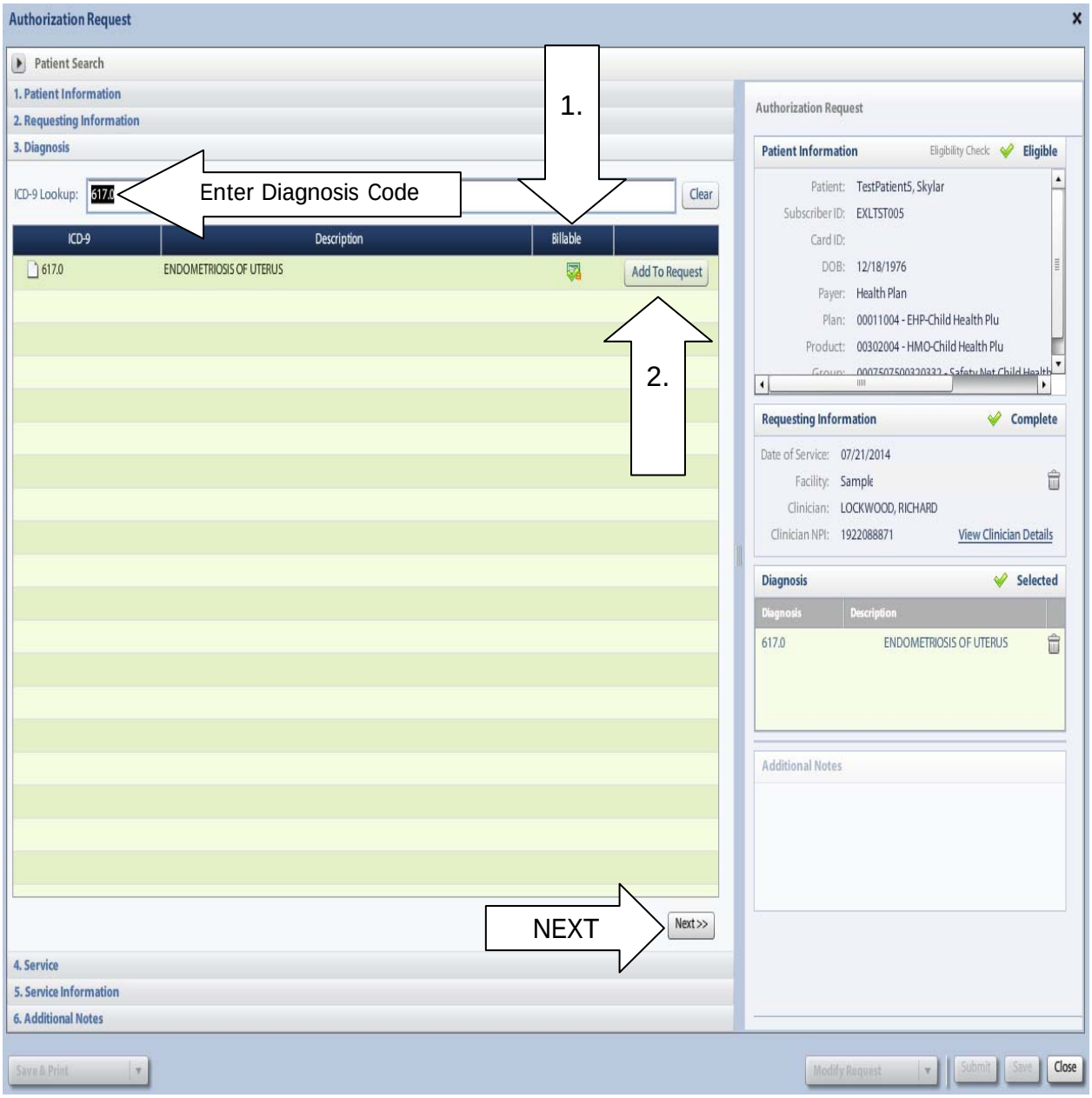
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Hysterectomy Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."



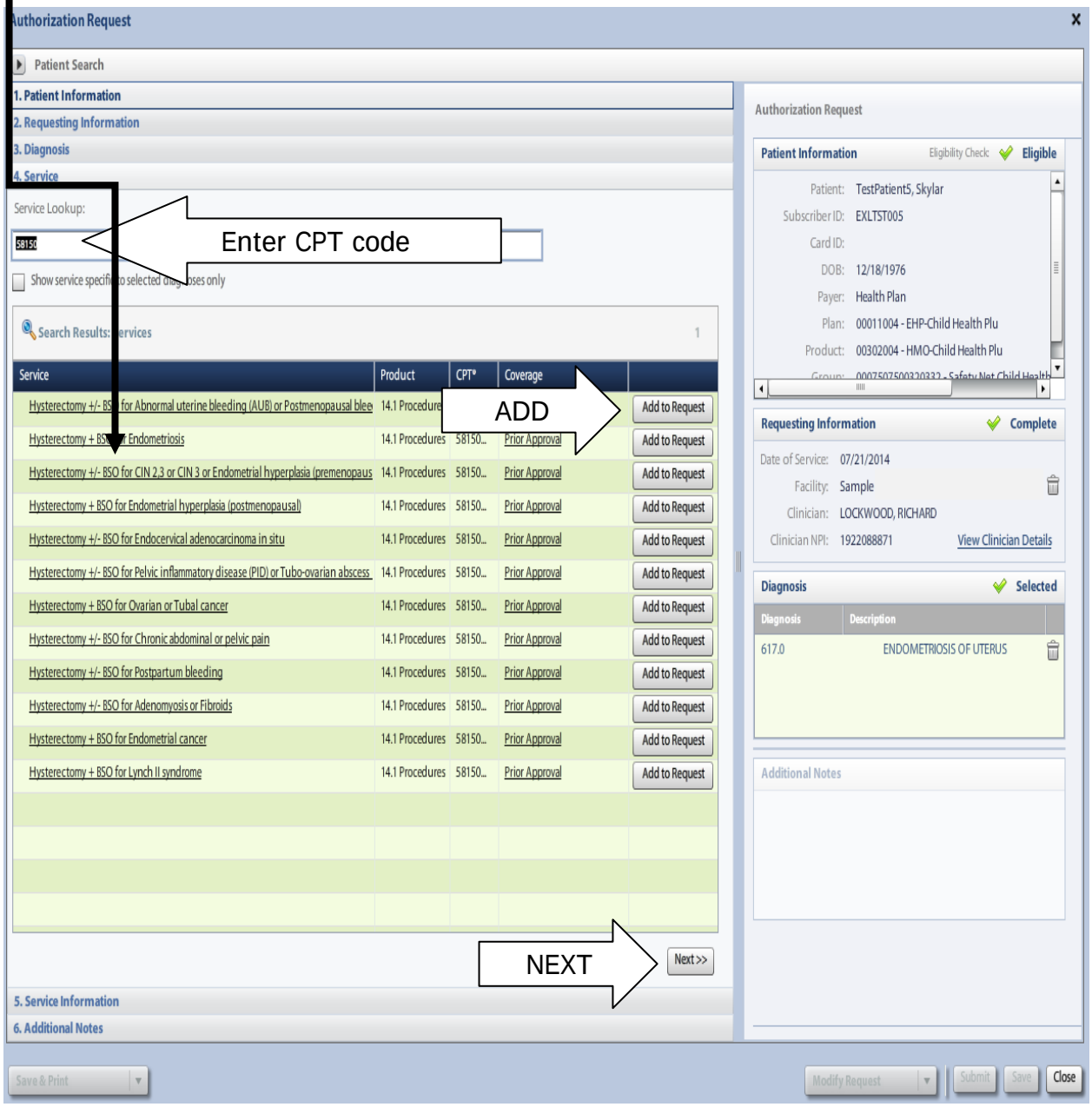
Clear Coverage™
Hysterectomy Authorization Entry Tips

Accordion 4: Services

Enter CPT code.

NOTE: There are often multiple procedures that populate with each service code; please ensure that the correct procedure is chosen. Read each question and potential answer carefully and choose the answer that meets the criteria for the service requested.

- Click the "Add to Request" button, then click "Next."



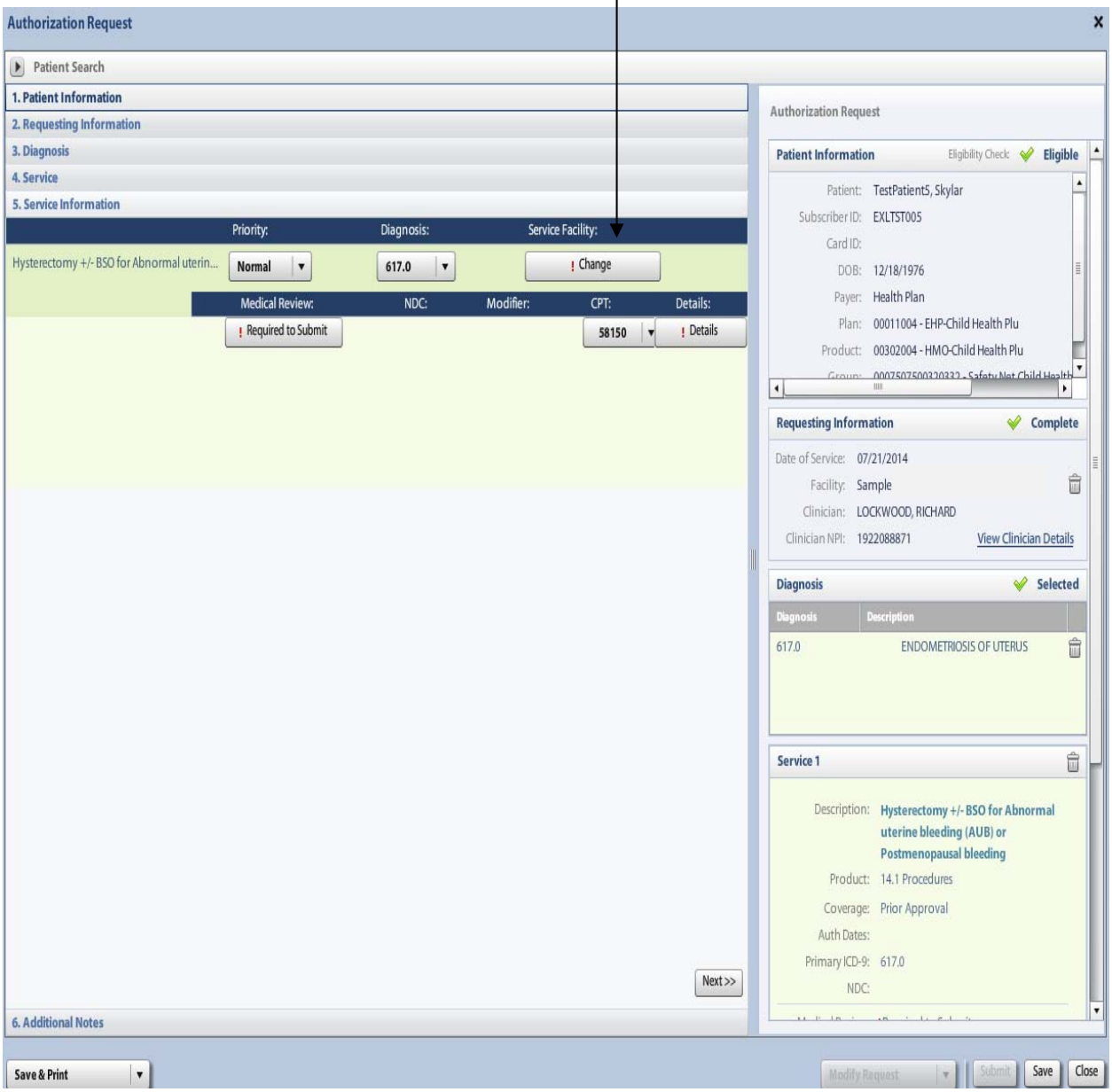
Clear Coverage™
Hysterectomy Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

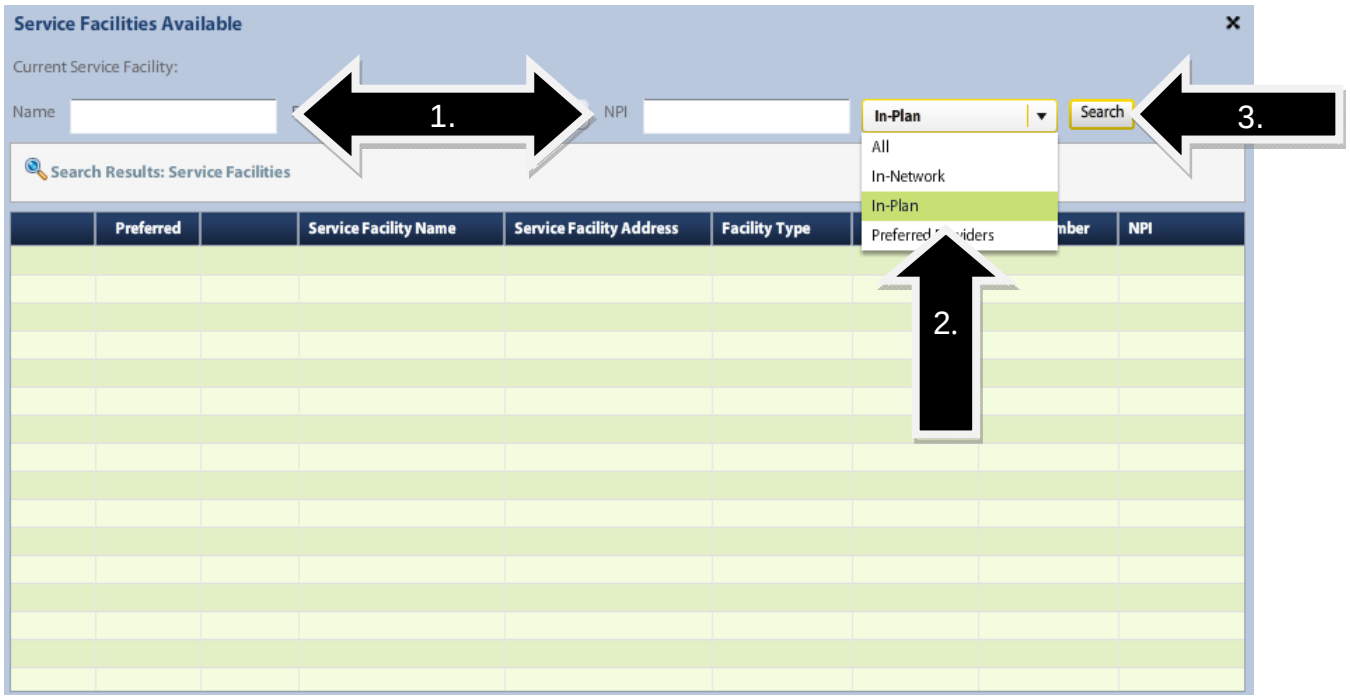
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility = place of service

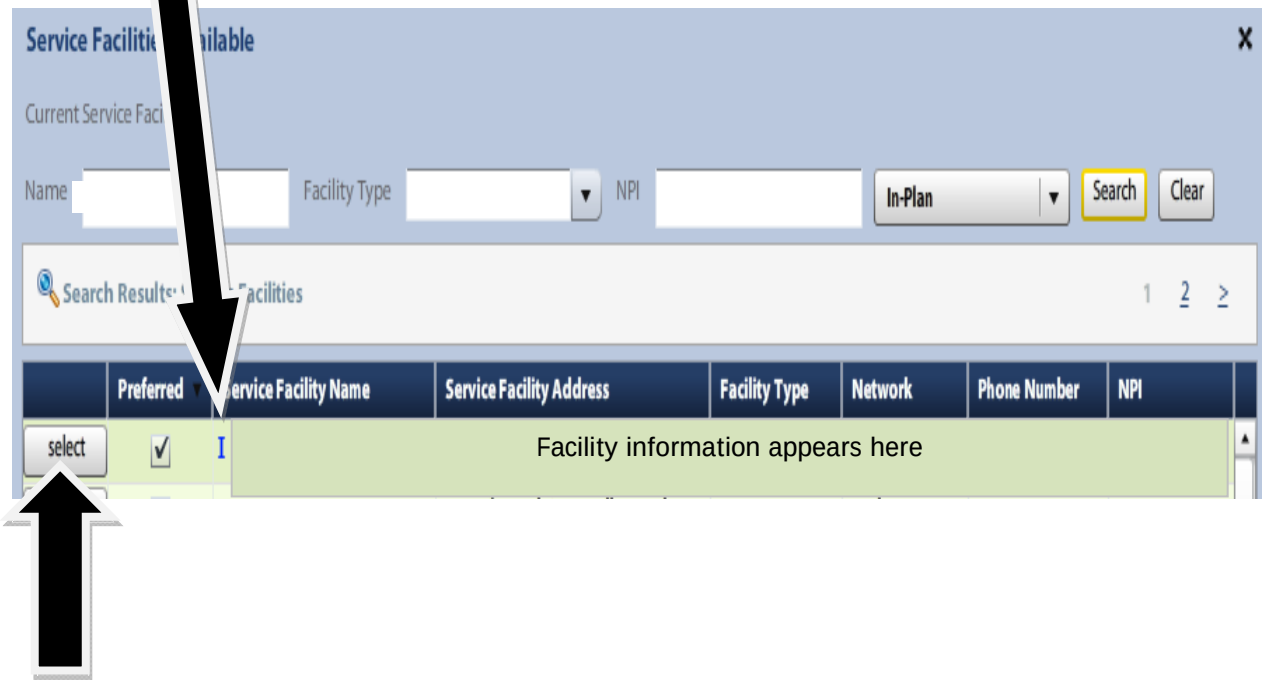


Clear Coverage™
Hysterectomy Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).



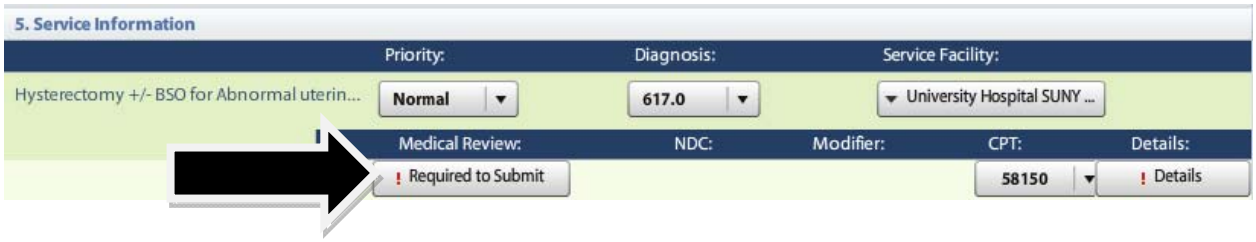
IMPORTANT NOTE: When selecting the facility, ensure that the facility chosen has this symbol: I to the left of the Service Facility Name.



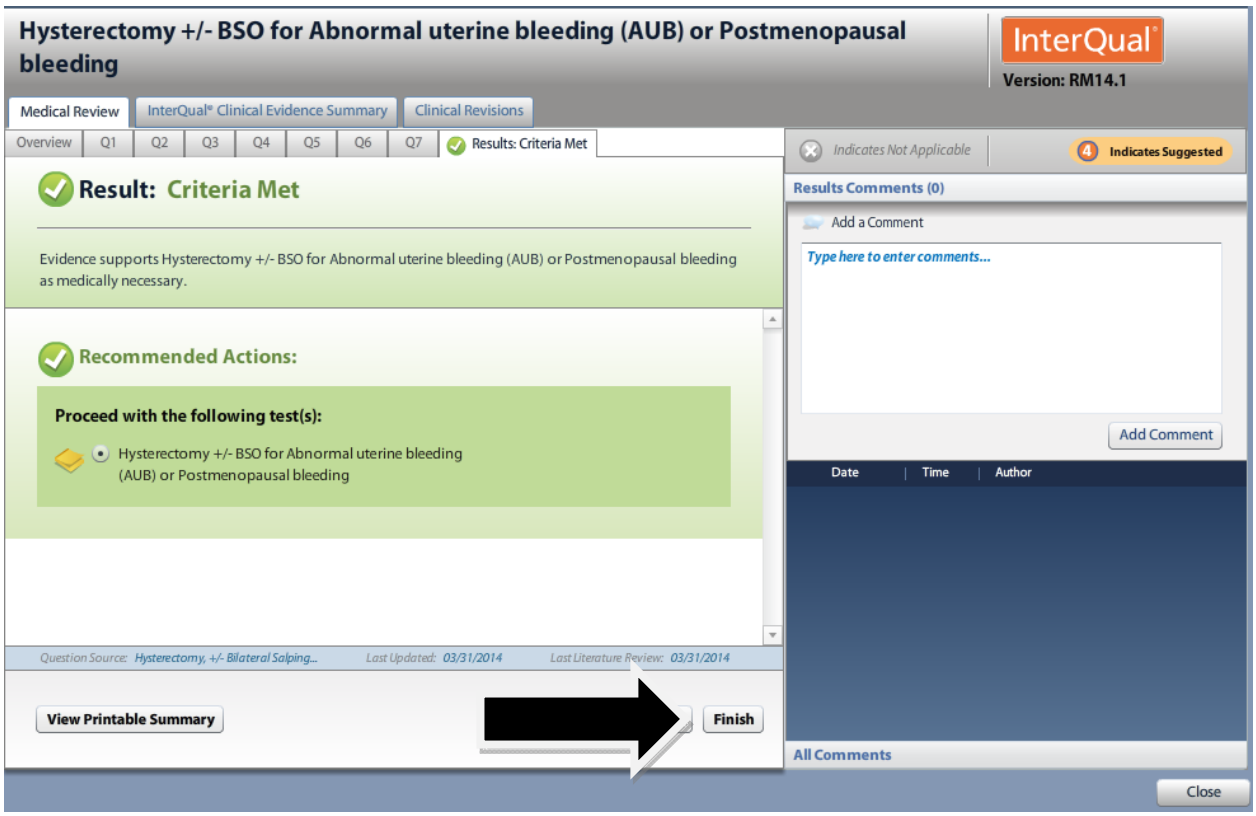
Clear Coverage™
Hysterectomy Authorization Entry Tips

Click on the Medical Review “Required to Submit” tab and complete the medical review.

Cancer Diagnosis: “Medical Review” is not required. Proceed to page 13.



If criteria met: Click “Finish.”

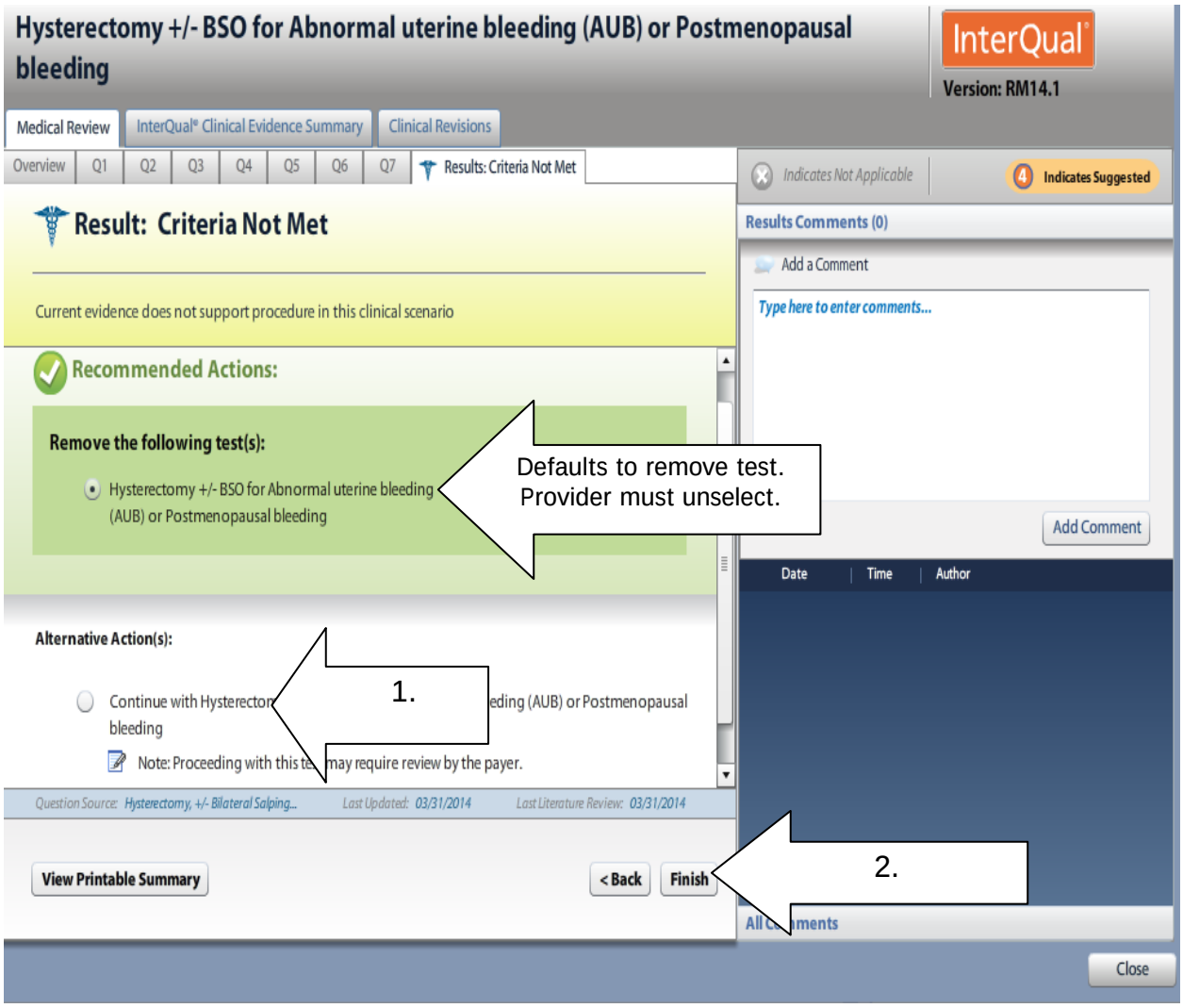


Clear Coverage™
Hysterectomy Authorization Entry Tips

If criteria not met:

The default choice is to **remove** the item from the request.

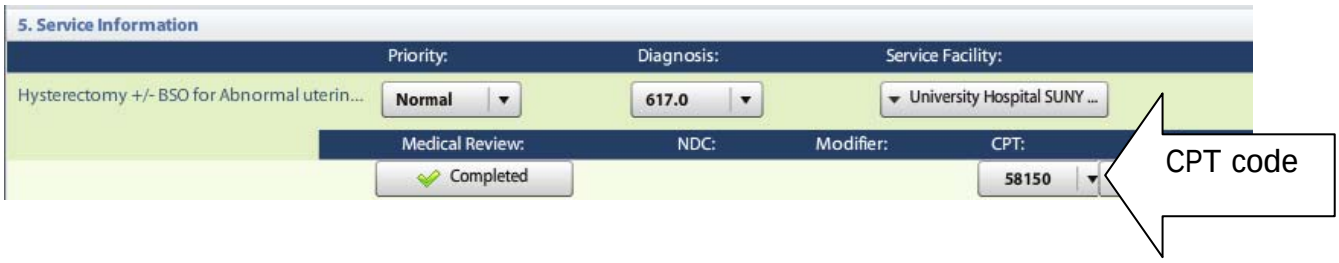
1. You **must** click the button under Alternative Action(s) to "Continue with Hysterectomy…." if you wish the request to pend to the Health Plan for review.



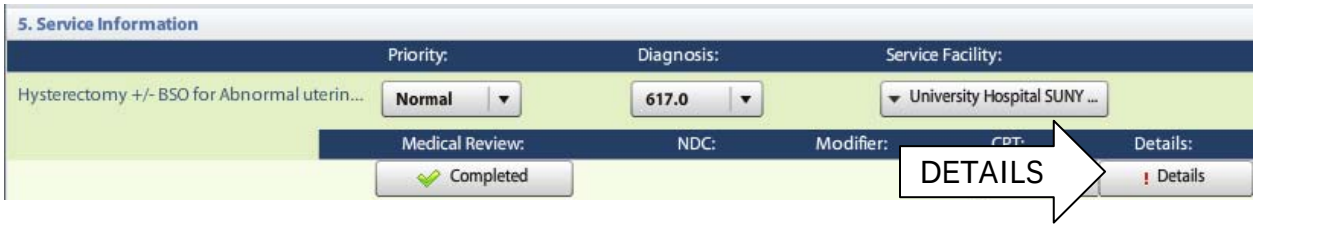
2. Click "Finish."

Clear Coverage™
Hysterectomy Authorization Entry Tips

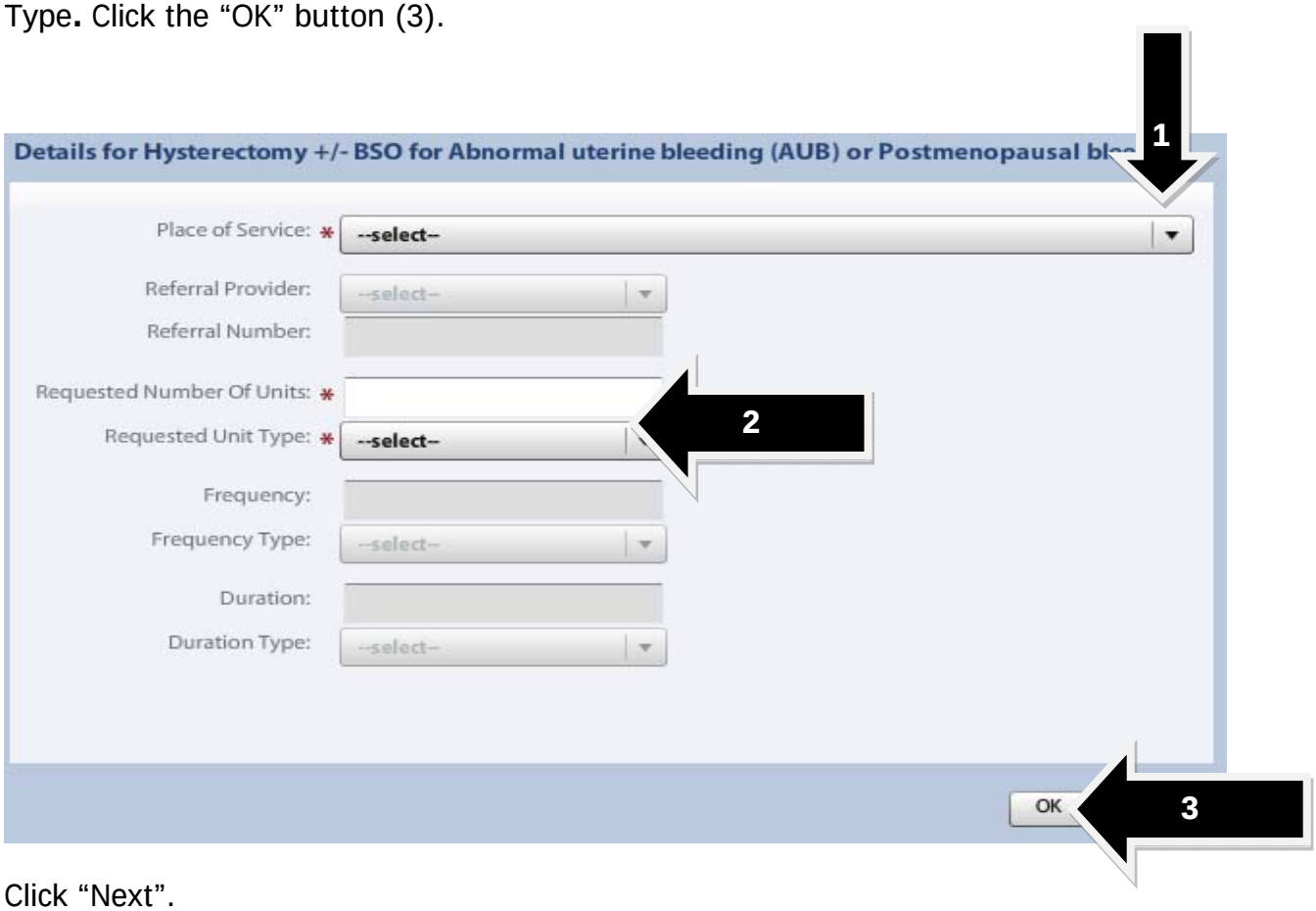
Choose the correct CPT code from the drop-down menu (if needed):



Details section:



Must select: (1) Place of Service, (2) Requested Number of Units and Requested Unit Type**.** Click the "OK" button (3).

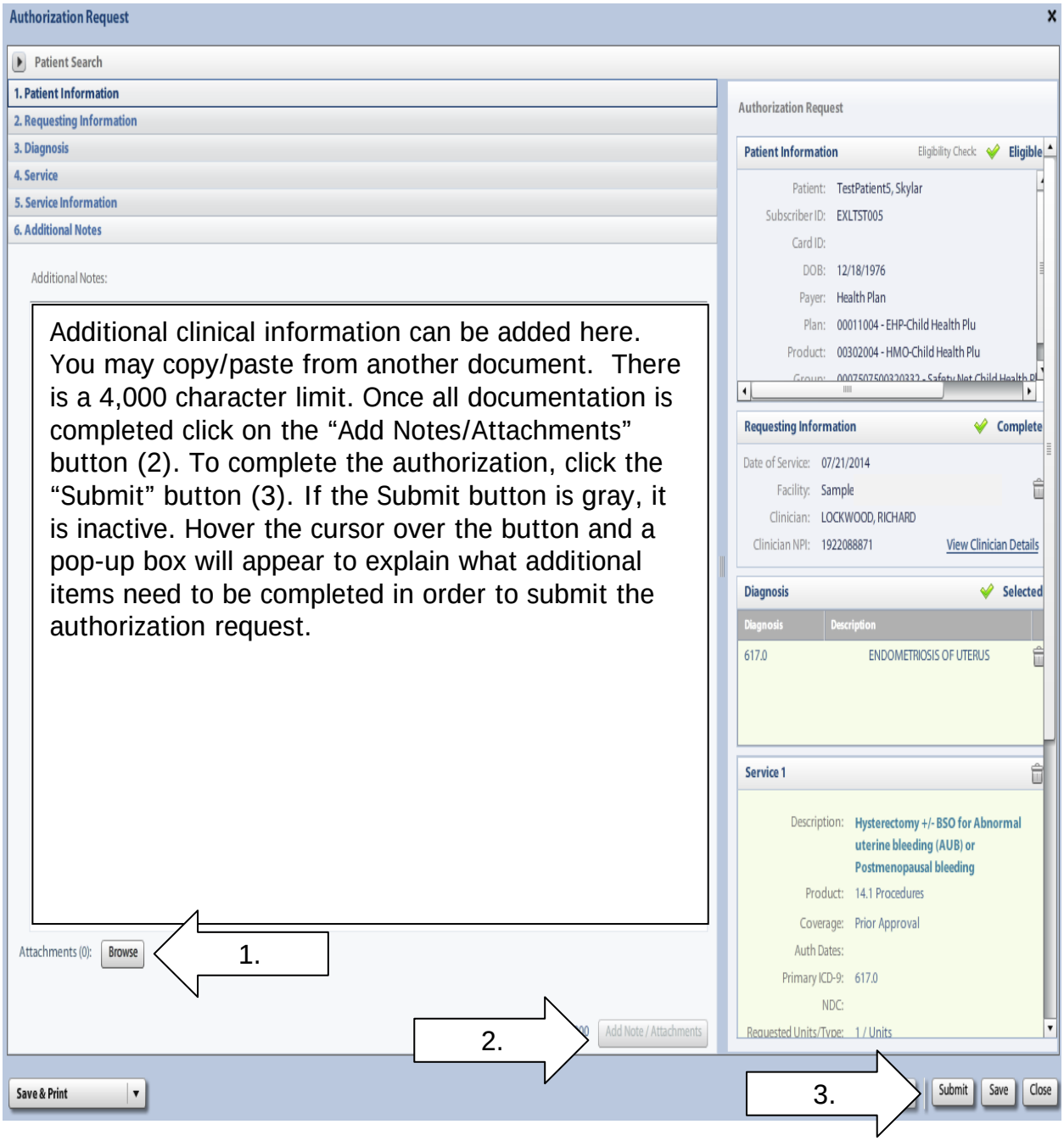


Click "Next".

Clear Coverage™
Hysterectomy Authorization Entry Tips

Accordian 6: Additional Notes

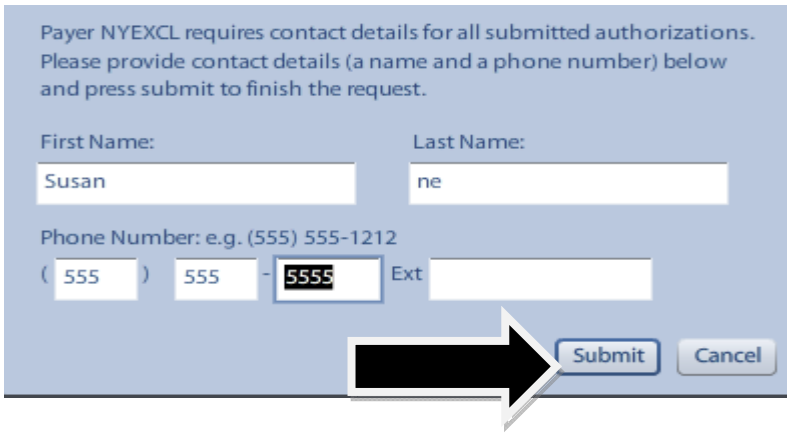
If criteria was <u>not</u> met, enter additional information and/or attach a note with supporting medical documentation (1).
A note <u>must</u> be added in order to attach a document.



Clear Coverage™
Hysterectomy Authorization Entry Tips

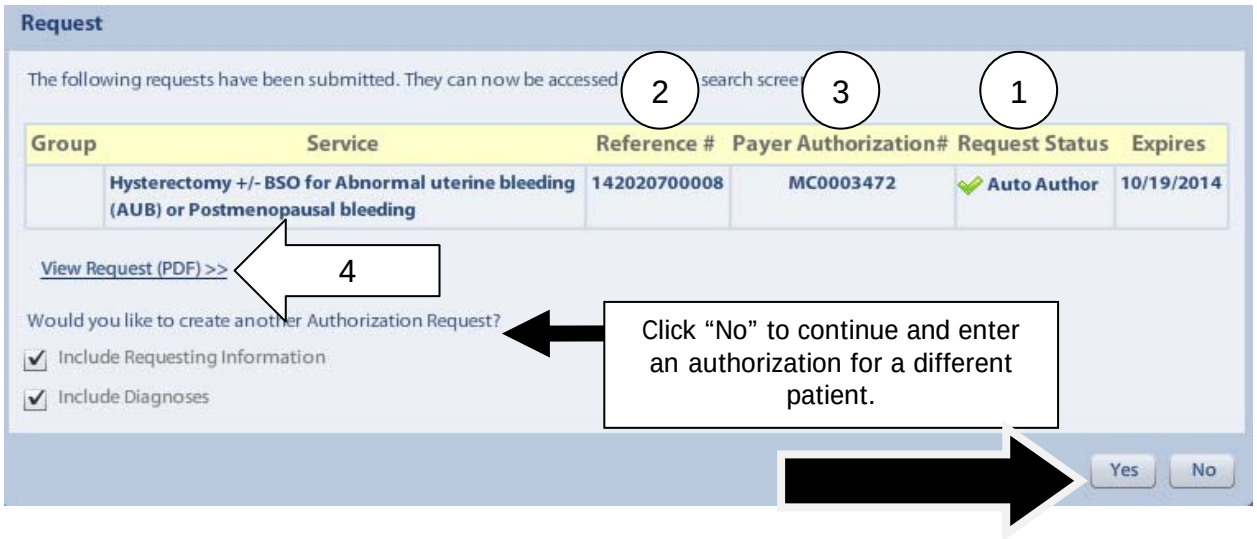
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

All requests for Specialty Pharmacy will pend for medical necessity review by the Health Plan.

Refer to the online list of drugs that require prior authorization:
Univera Preauthorization Requirements For Medical Specialty Medications

Please reference our website frequently for updates to this list as new drugs are added as they receive FDA approval and are available for use throughout the year.

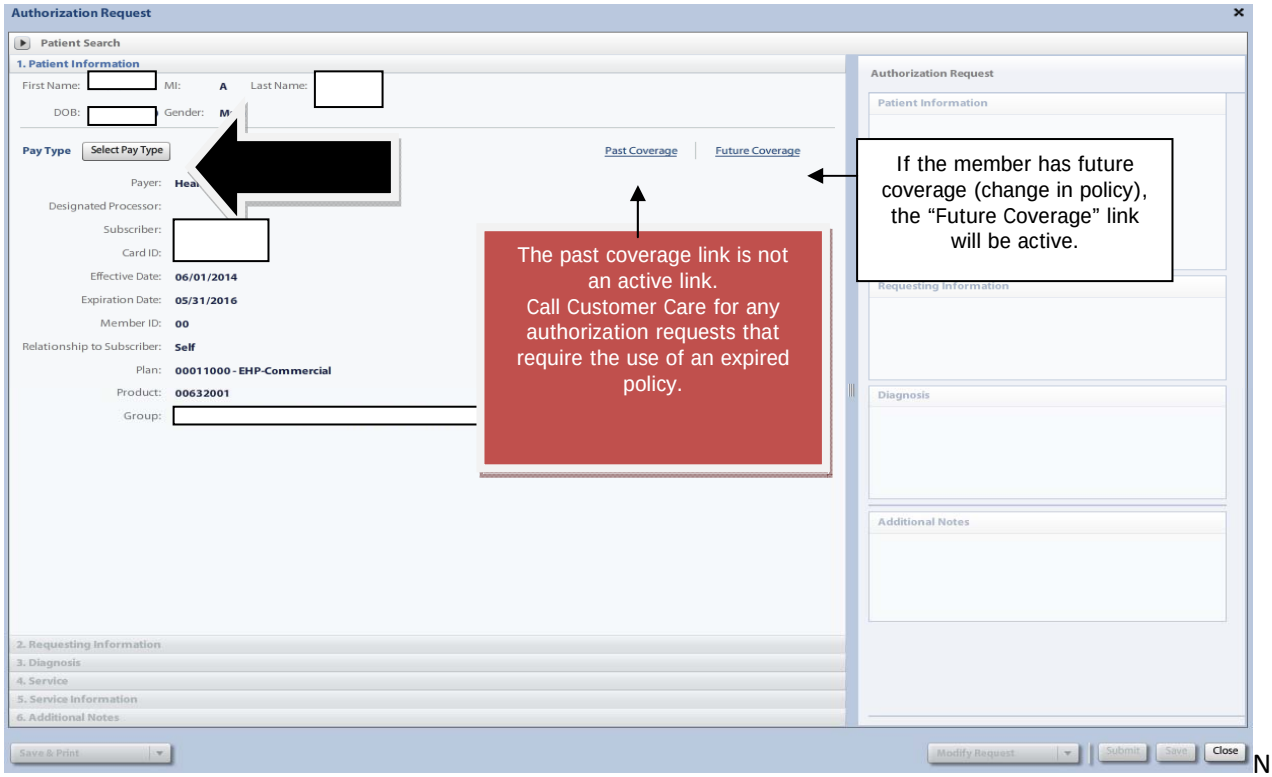
Reference the “drug prior authorization form” for specific clinical questions and include the answers as well as supporting documentation within the Clear Coverage™ tool (Accordion 6).

Reference the approval letter for authorization end dates, as they may differ from the Clear Coverage™ authorization end date.

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the “Select Pay Type” button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).



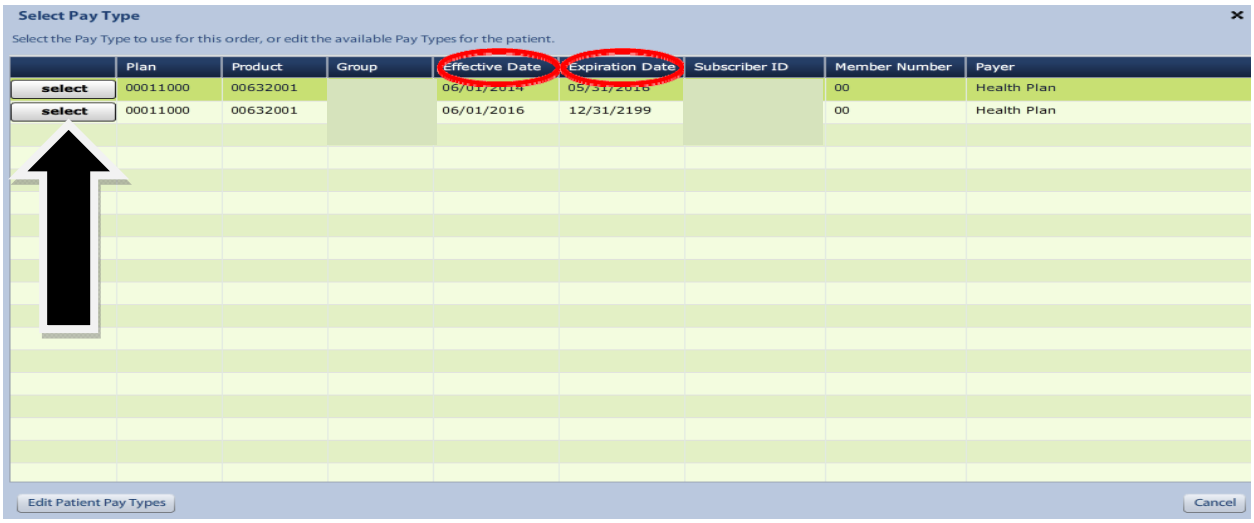
N

Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

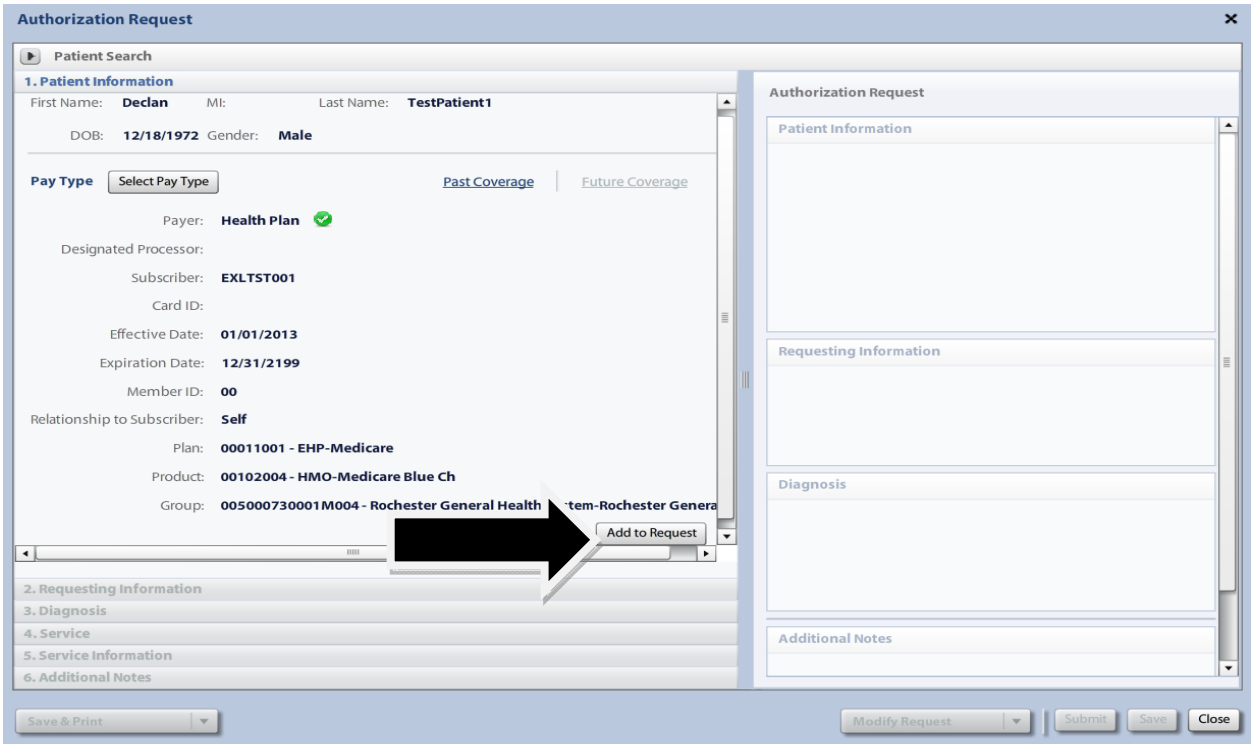
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

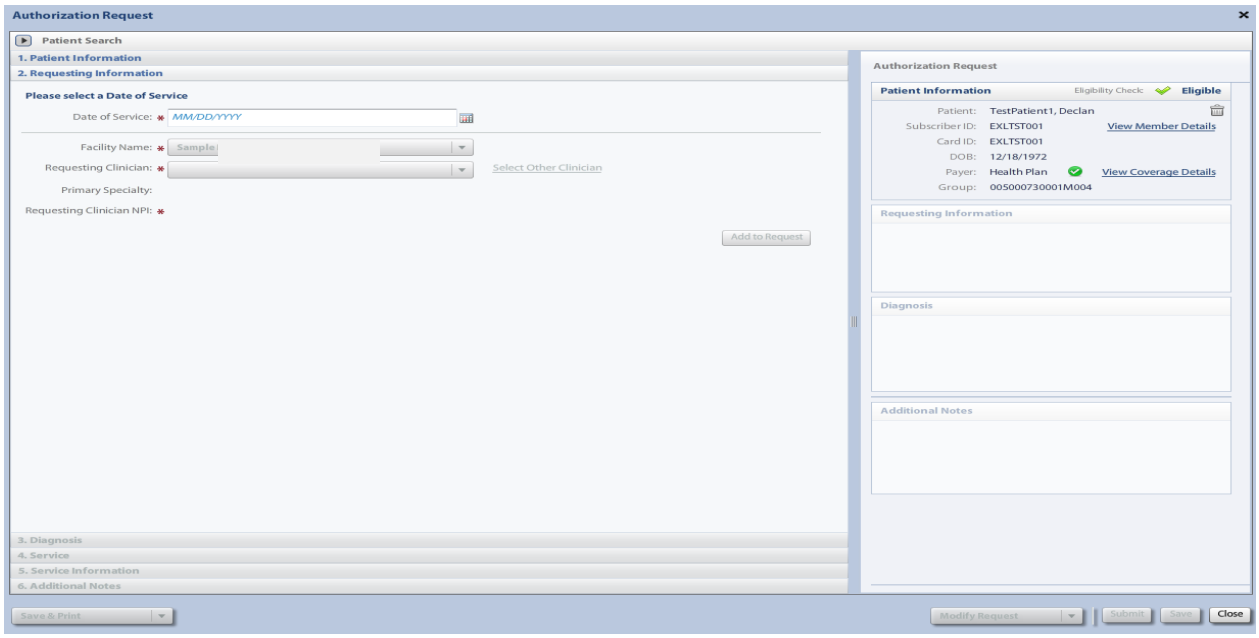


Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

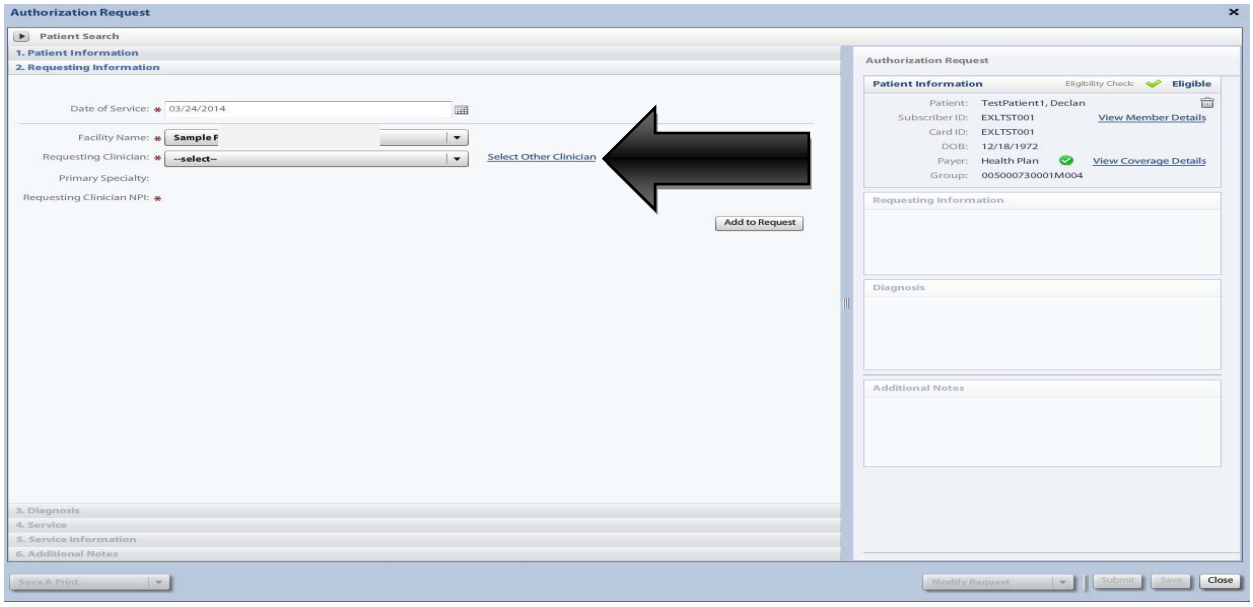
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do NOT enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

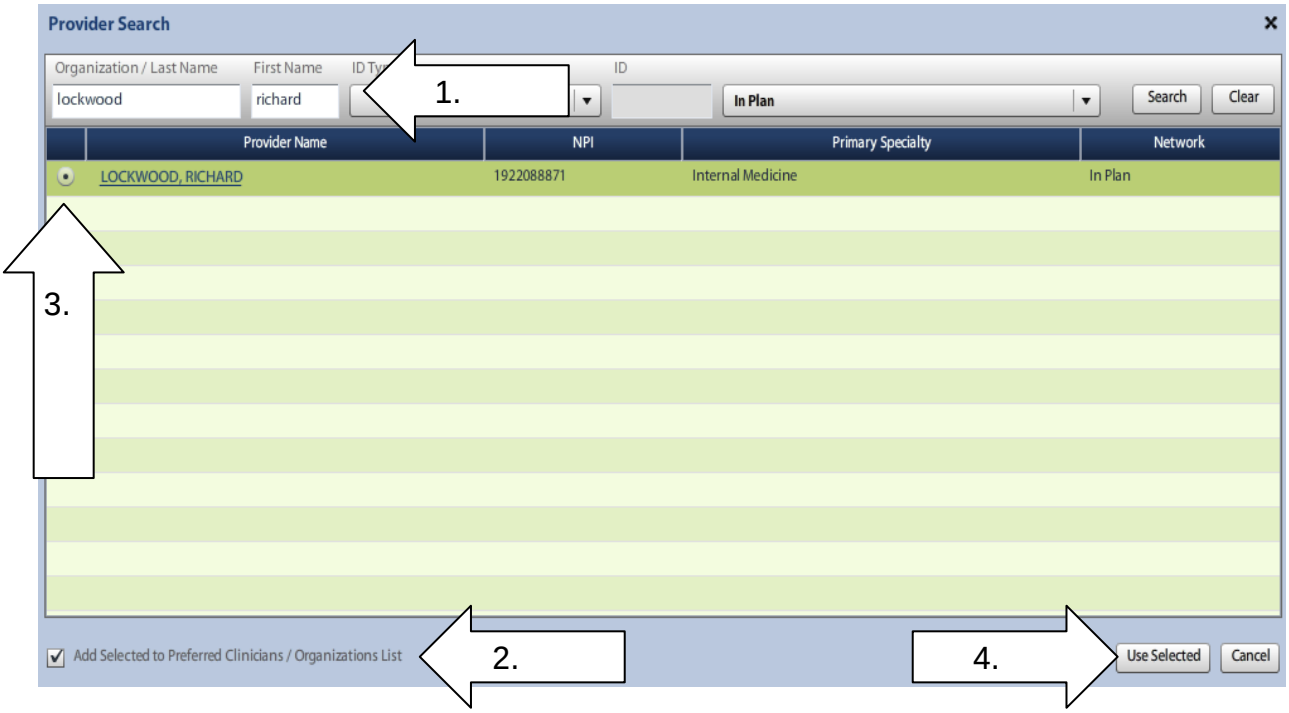


Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

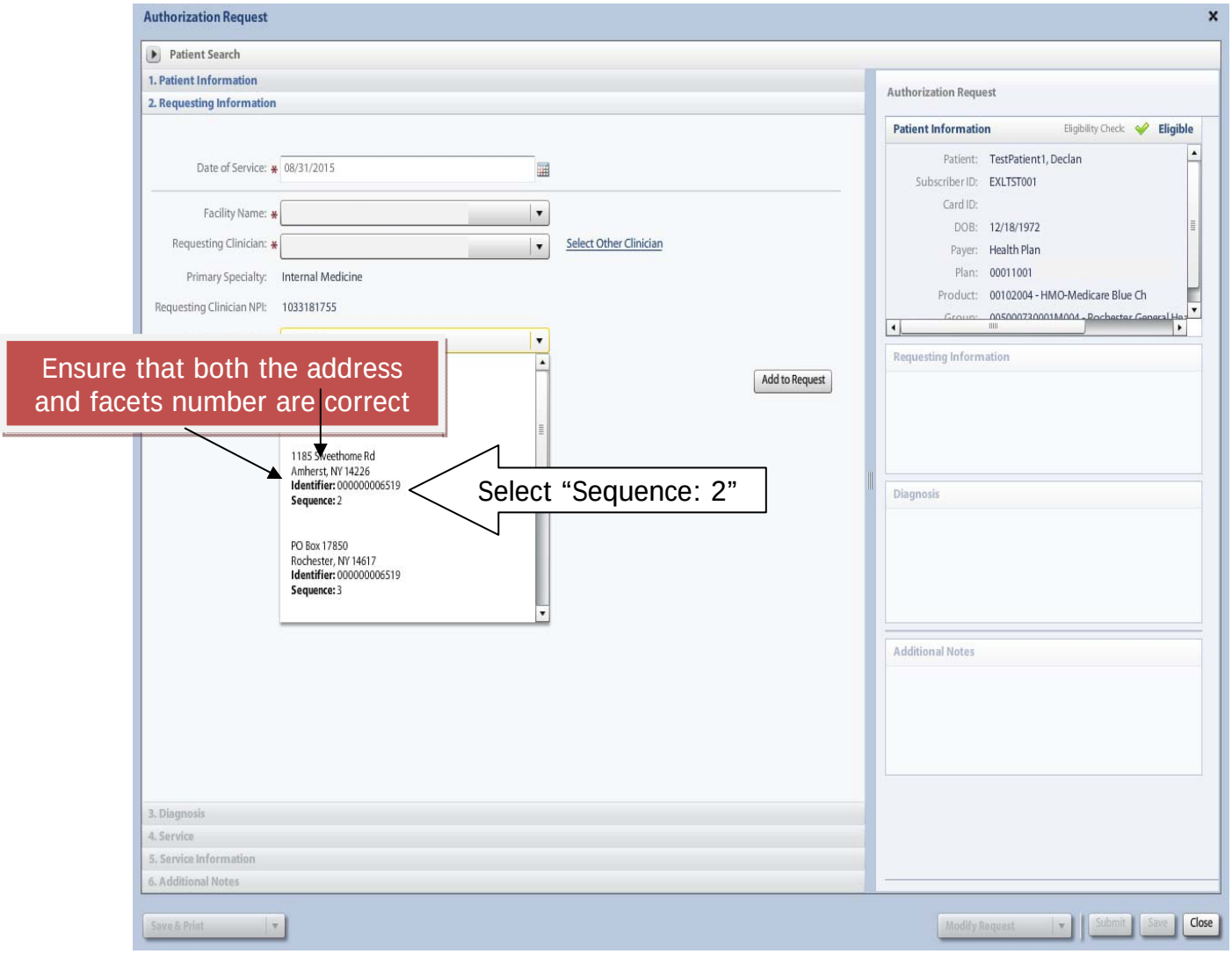
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

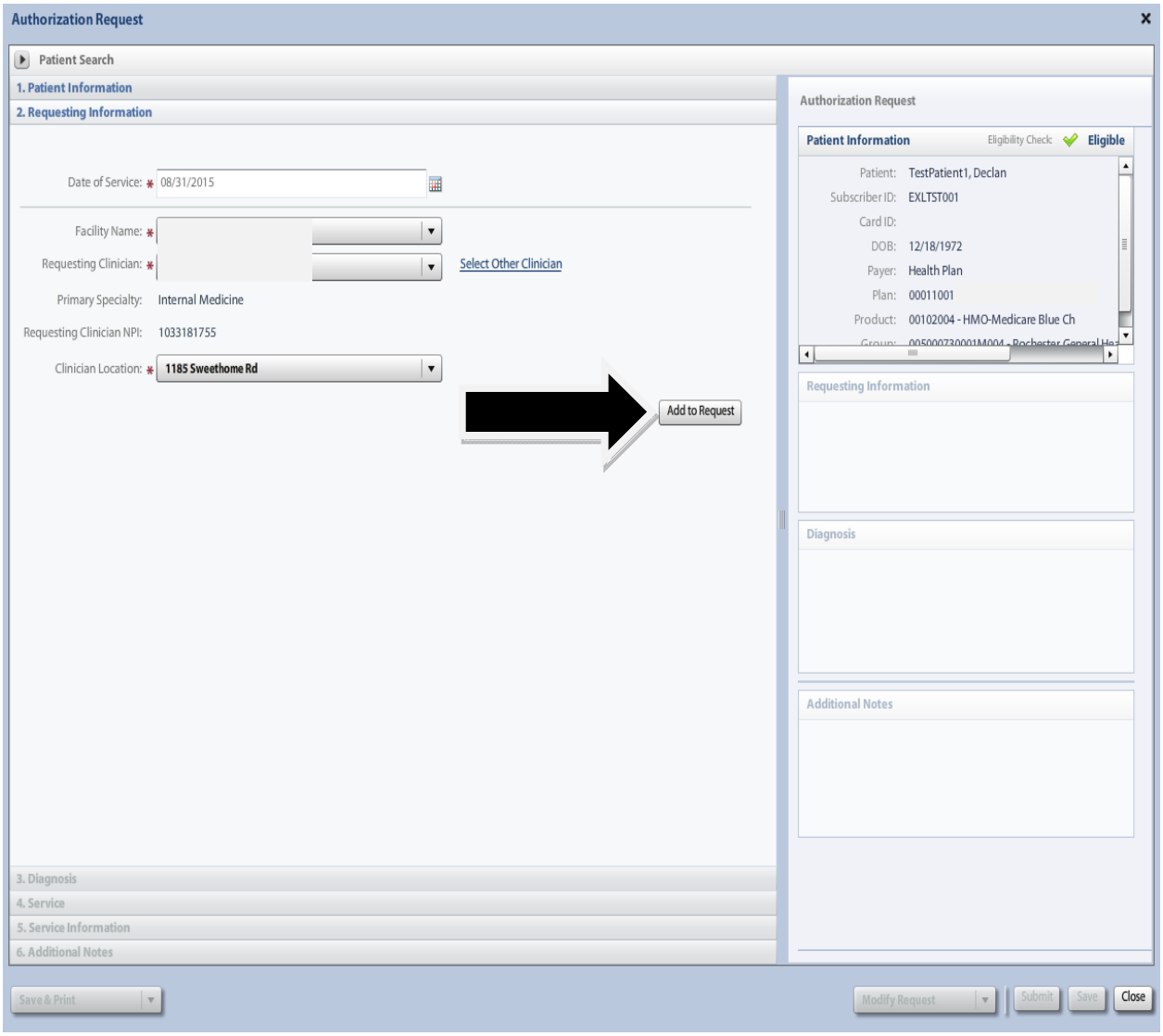
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



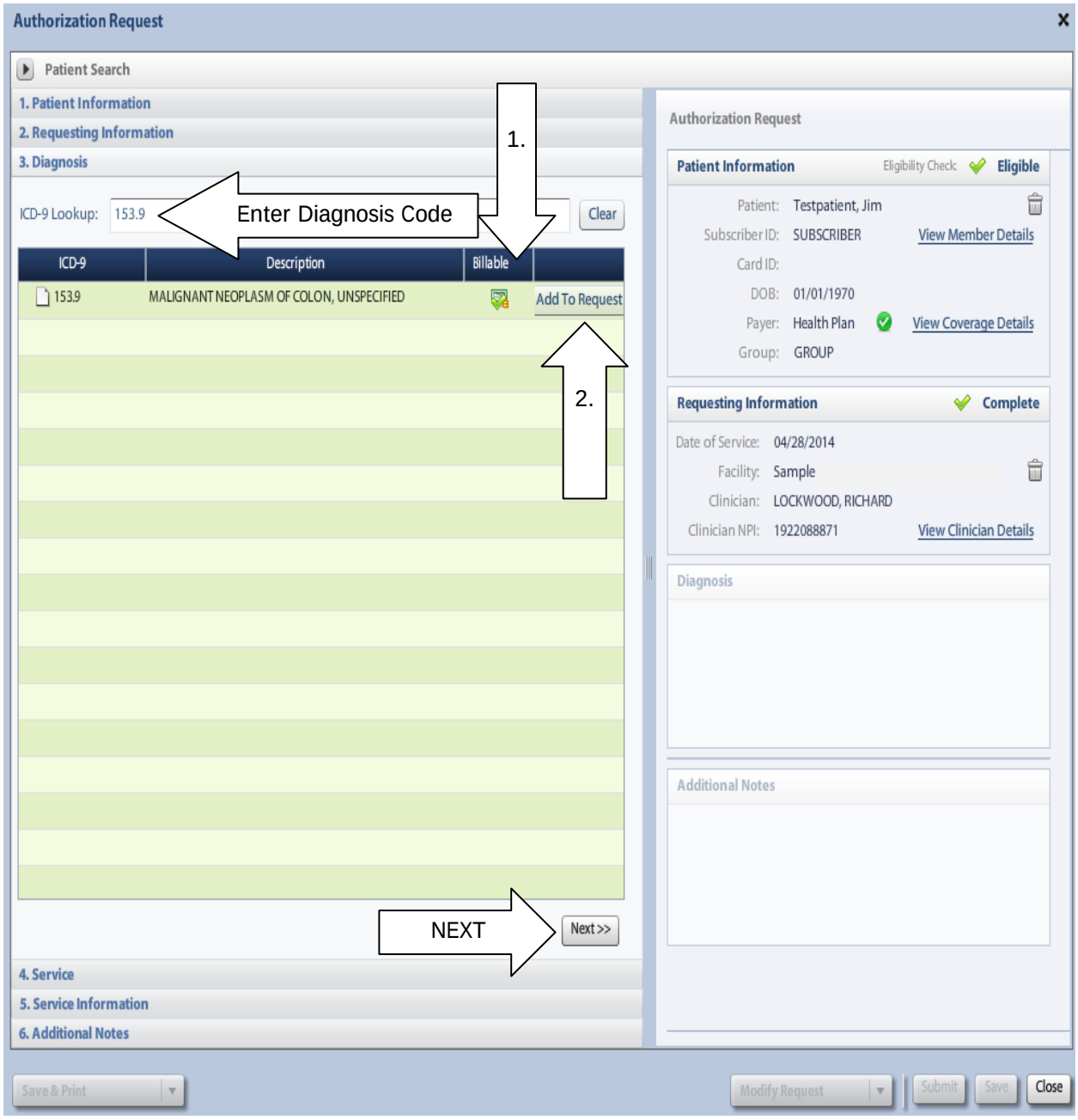
Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."



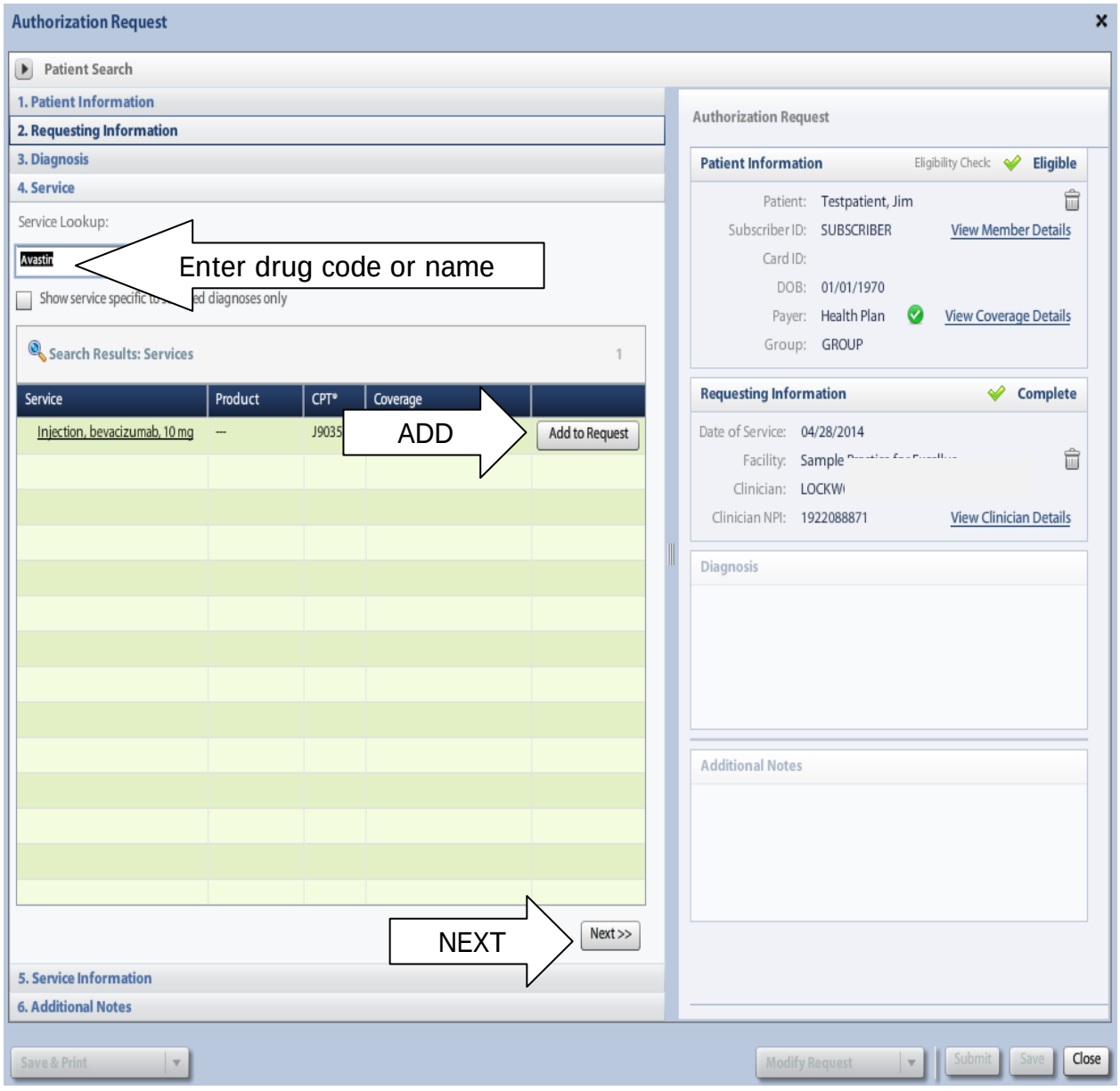
Accordion 4: Services

Enter the drug code or drug name.

- Click the “Add to Request” button, then click “Next”.

NOTE: If the drug has an unclassified code, you may search by the unclassified drug code, or by the drugs brand name.

If a newly added drug on the Medical Specialty Drug list is not found within Clear Coverage™, fax the request to the MSD unit at 1-800-306-0188.



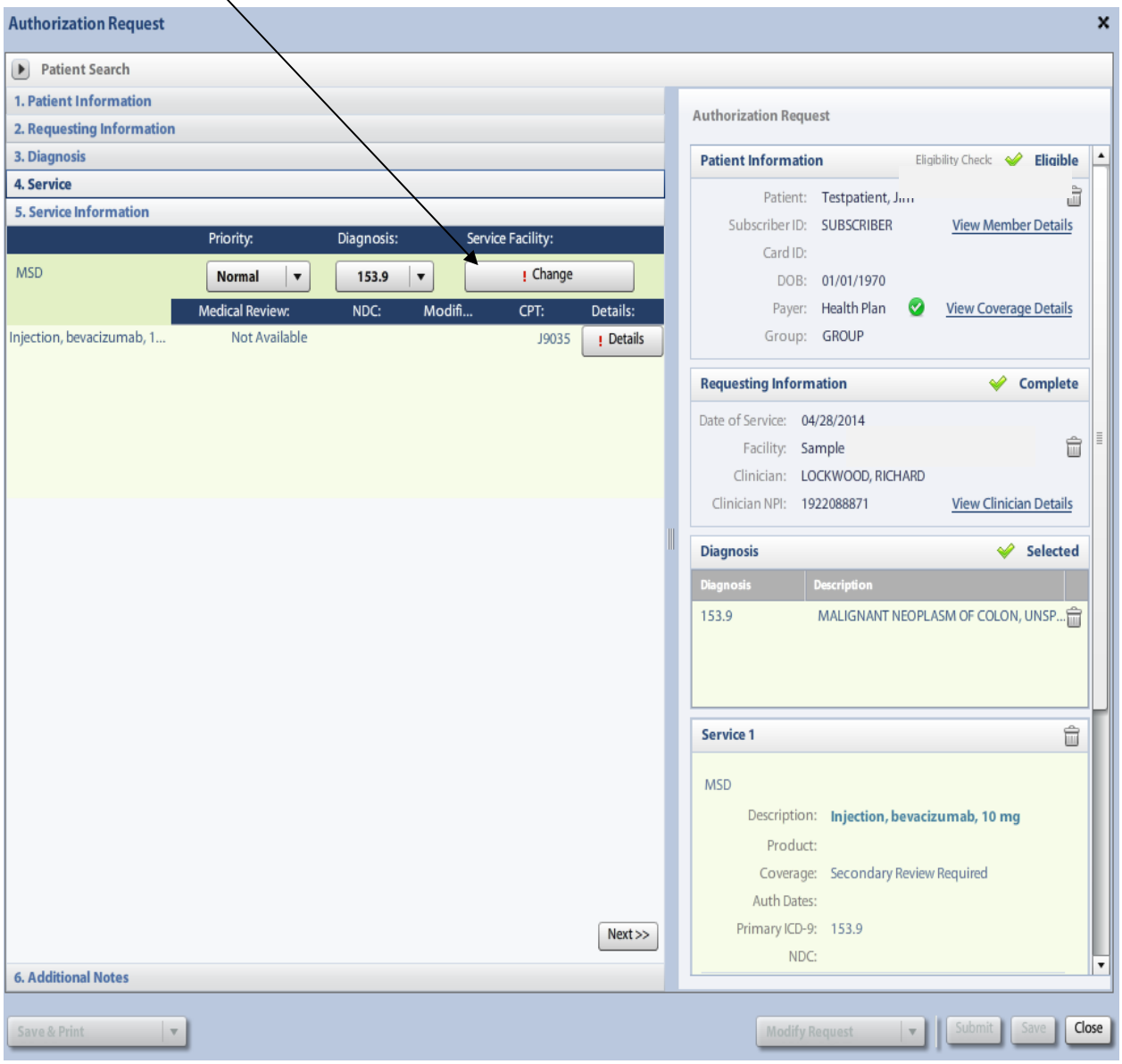
Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal
**If the request is urgent, call the Medical Specialty Drug Unit at 1-800-306-0151.*

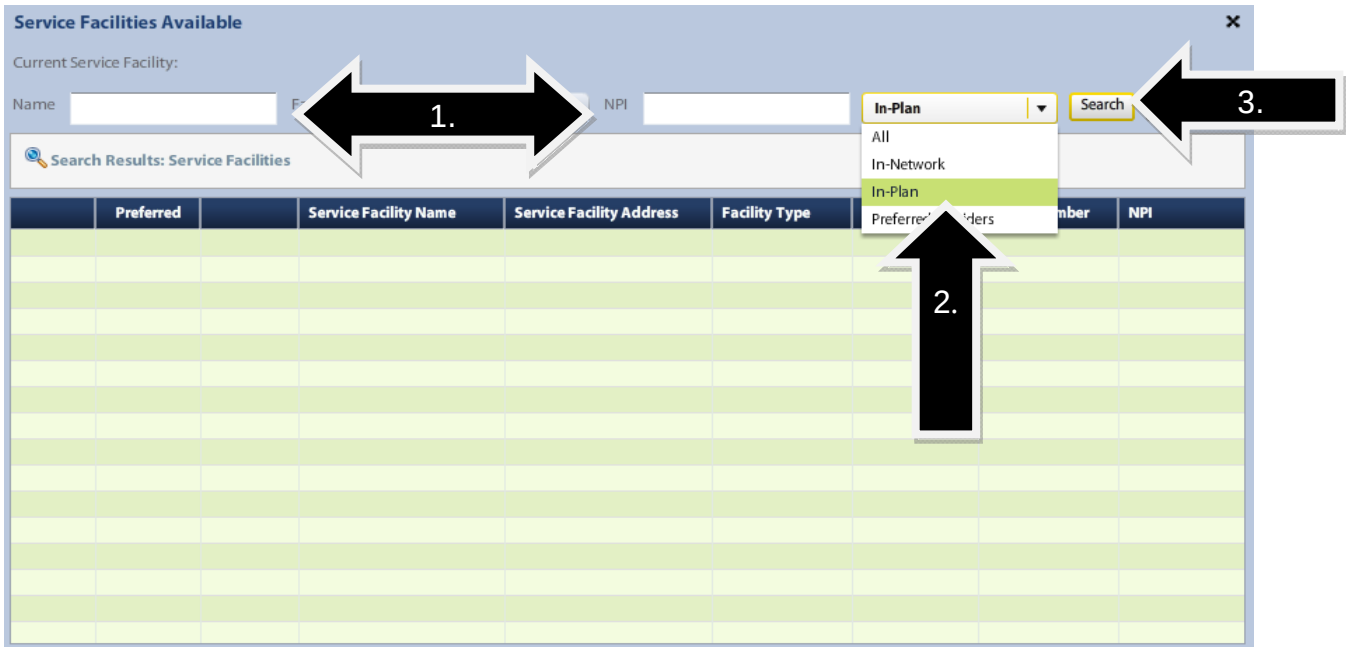
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3.

Service Facility = The provider who will be billing the Health Plan for the drug.

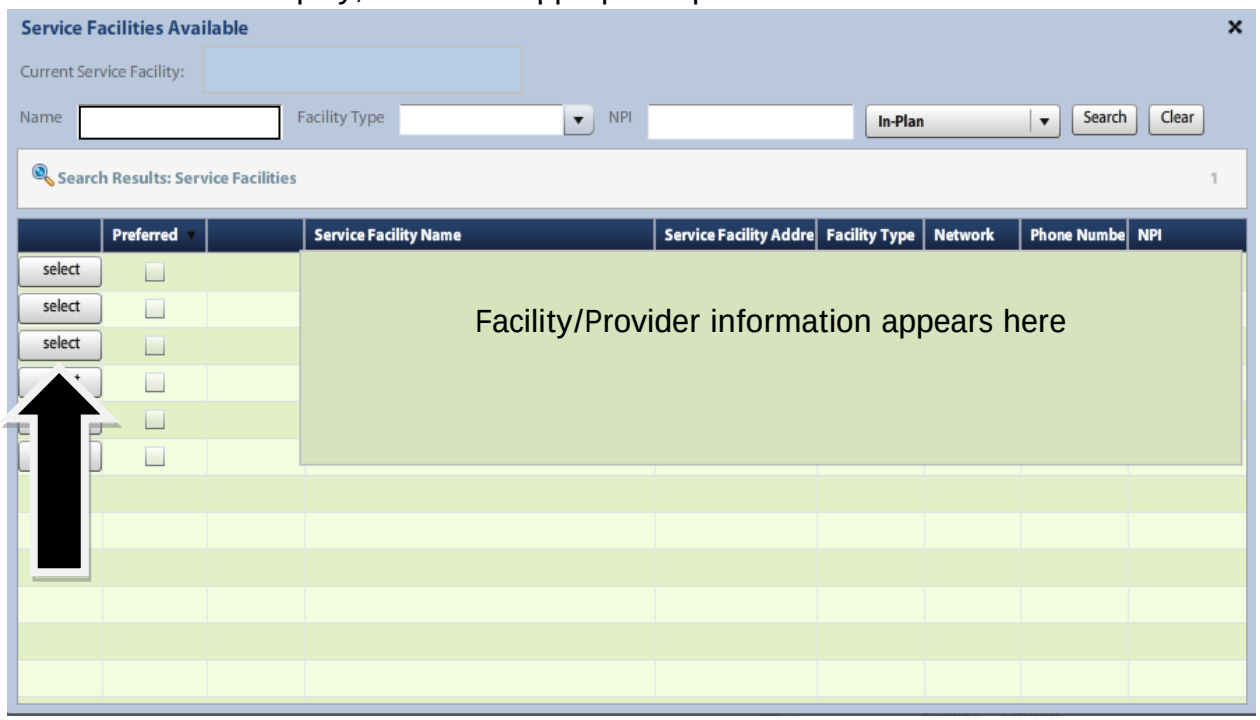


Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).

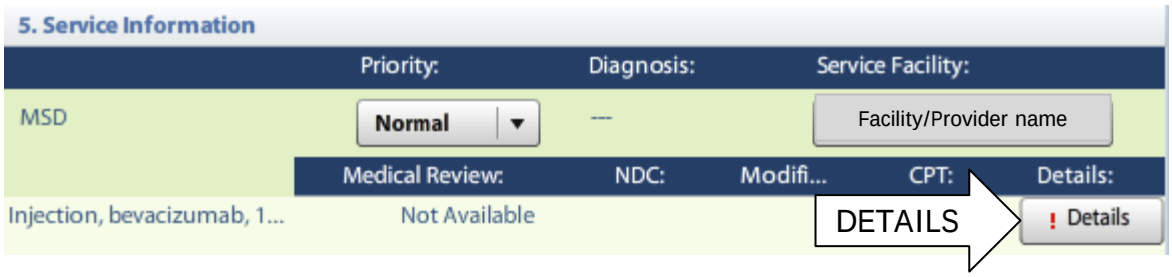


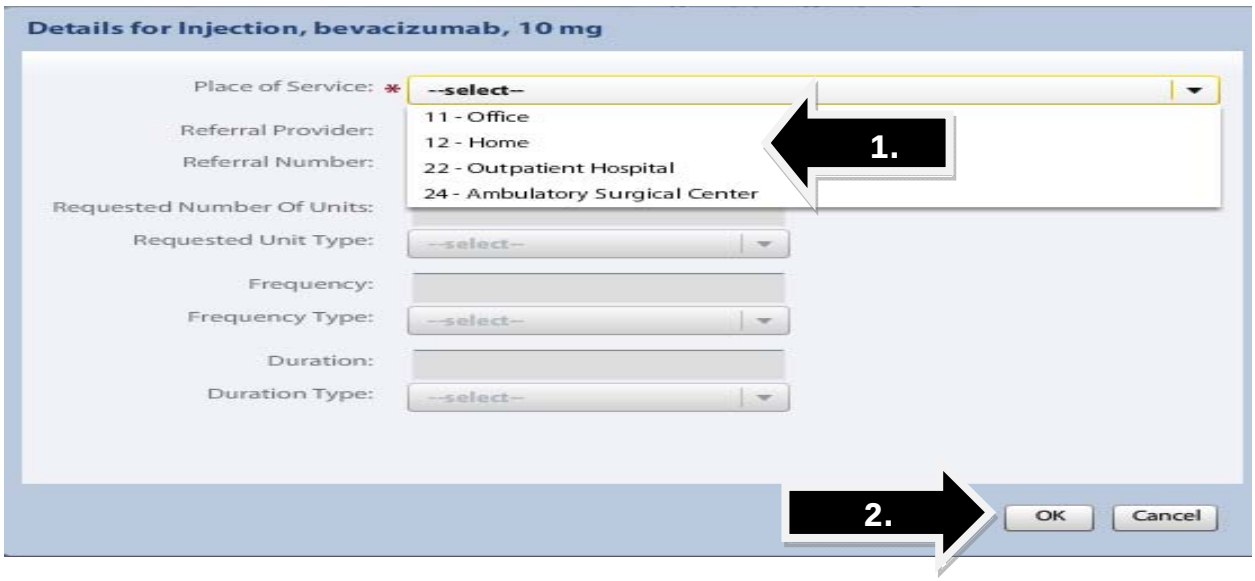
When the results display, select the appropriate provider.



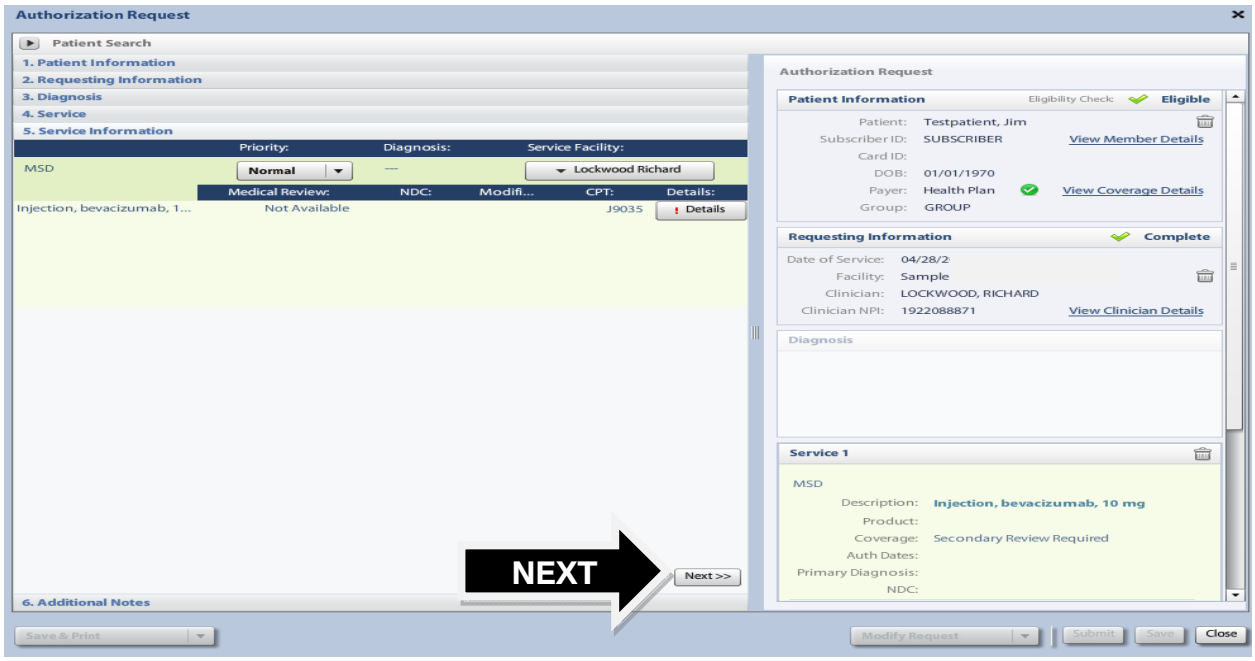
Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

Details section: Must select: (1) Place of Service, then click the "OK" button (2).





Click "Next."

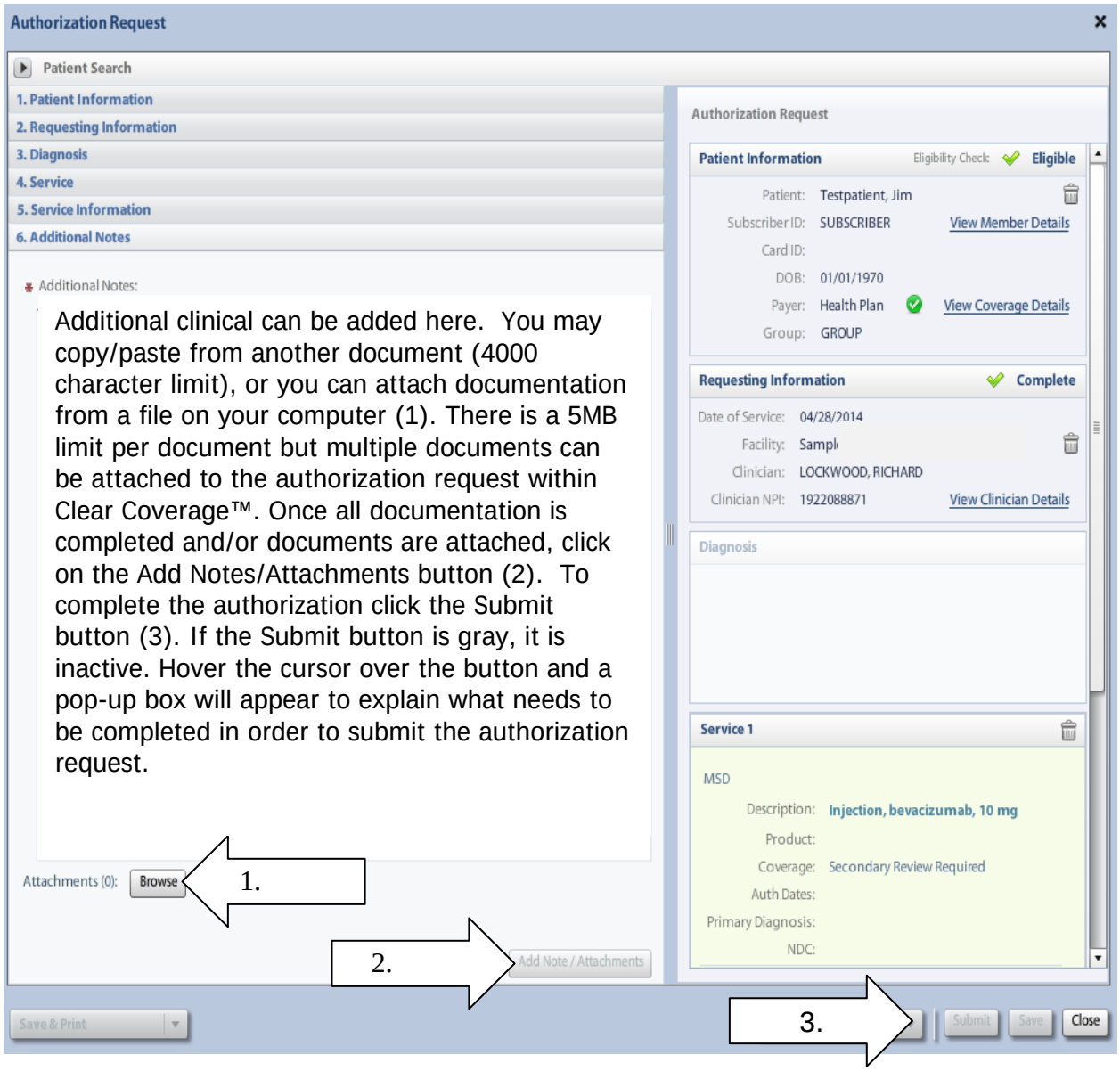


Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

Accordian 6: Additional Notes

Additional clinical can be added here and documents can be attached (1). A note must be added in order to attach a document.

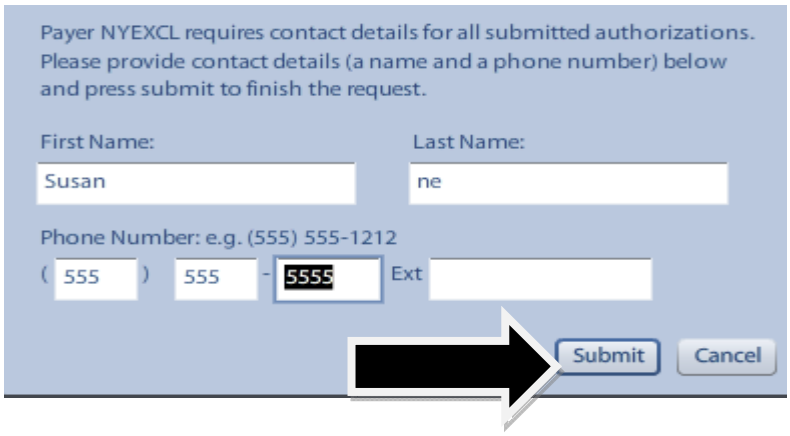
NOTE: Please reference the drug prior authorization form for specific clinical questions (include answers to the clinical questions in the additional notes box). Attach office notes and any other required clinical that is indicated on the drug prior authorization form. Attachment of this information is required for all medical specialty drug requests.



Clear Coverage™
Medical Specialty Drug Authorization Entry Tips

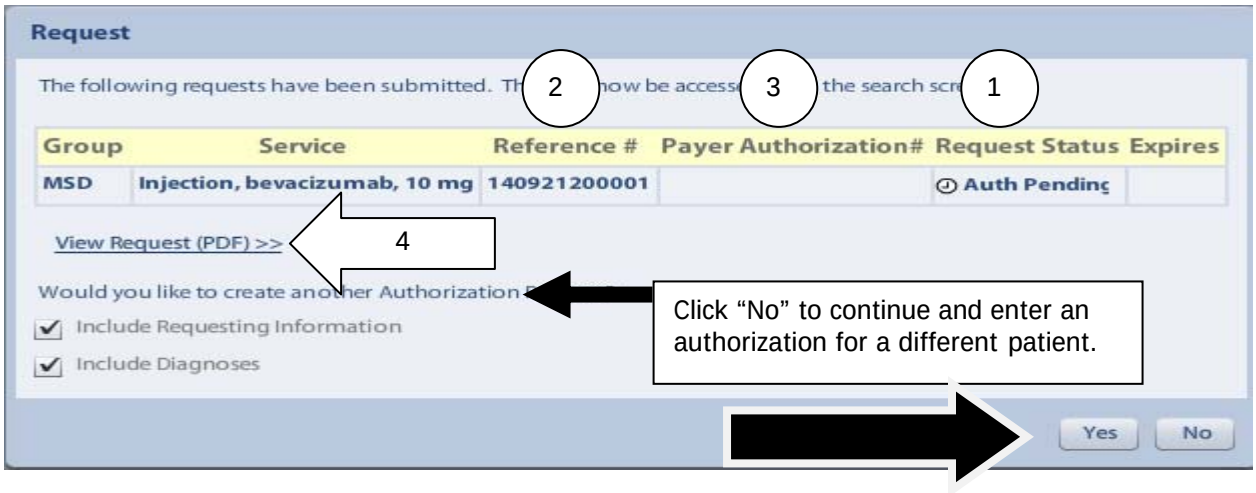
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Physical Therapy Authorization Entry Tips

Medicare Direct Pay- Authorization required effective March 6, 2019. See below.

Commercial & Medicare Contracts:

Initial requests for up to 10 medically necessary visits for physical therapy may receive an automatic approval. Subsequent visits and visits requested beyond 10 will pend for review.

If an original authorization exists in Clear Coverage™ and the provider wishes to request additional visits for that same authorization, see page 18 - 19 of this document for instructions.

For member's ages 0-3, initial requests for up to 10 visits for Early Intervention may receive an automatic approval. Subsequent visits and visits requested beyond 10 will pend for review.

Medicaid Contracts: No Pre-authorization is required. Physical therapy claims after the 21st visit will be reviewed retrospectively upon claim submission.

Diagnosis Codes: Enter the primary diagnosis code first.

CPT codes: Use 97164 for all PT authorizations.

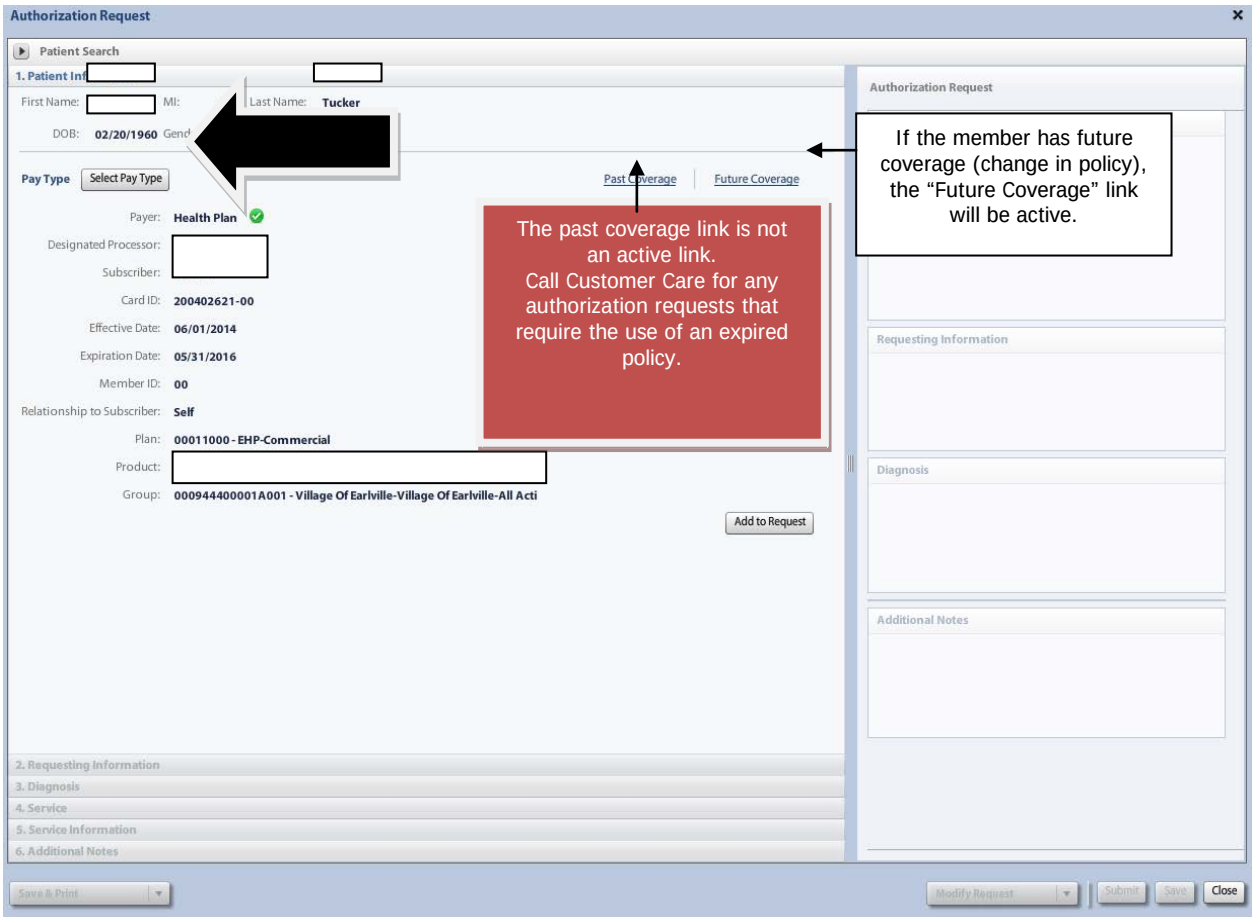
Note: Use CPT code 97168 for all Occupational Therapy authorizations.

Clear Coverage™
Physical Therapy Authorization Entry Tips

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the “Select Pay Type” button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

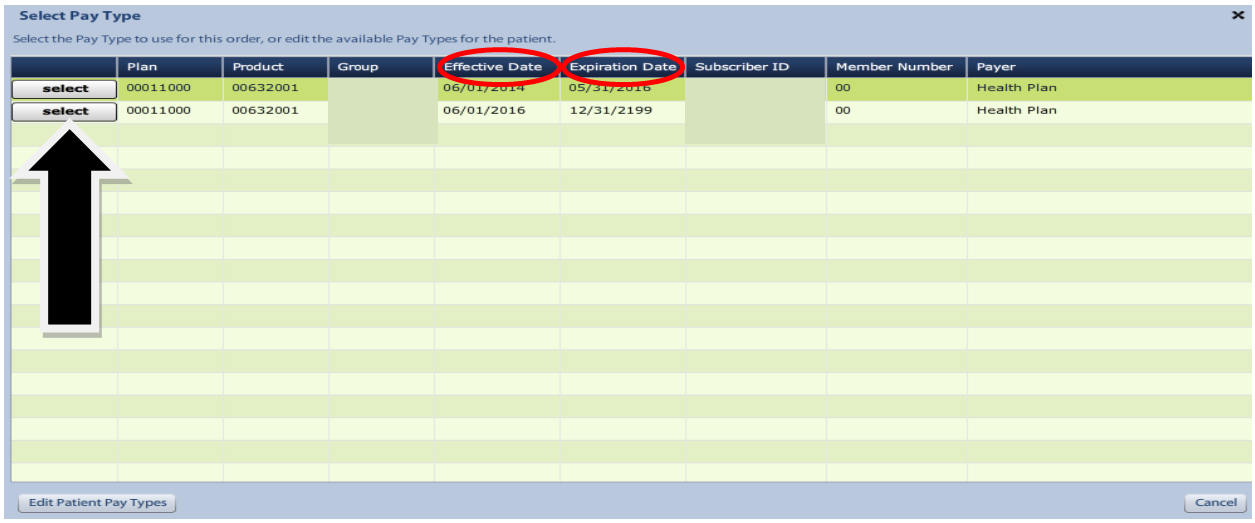


Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

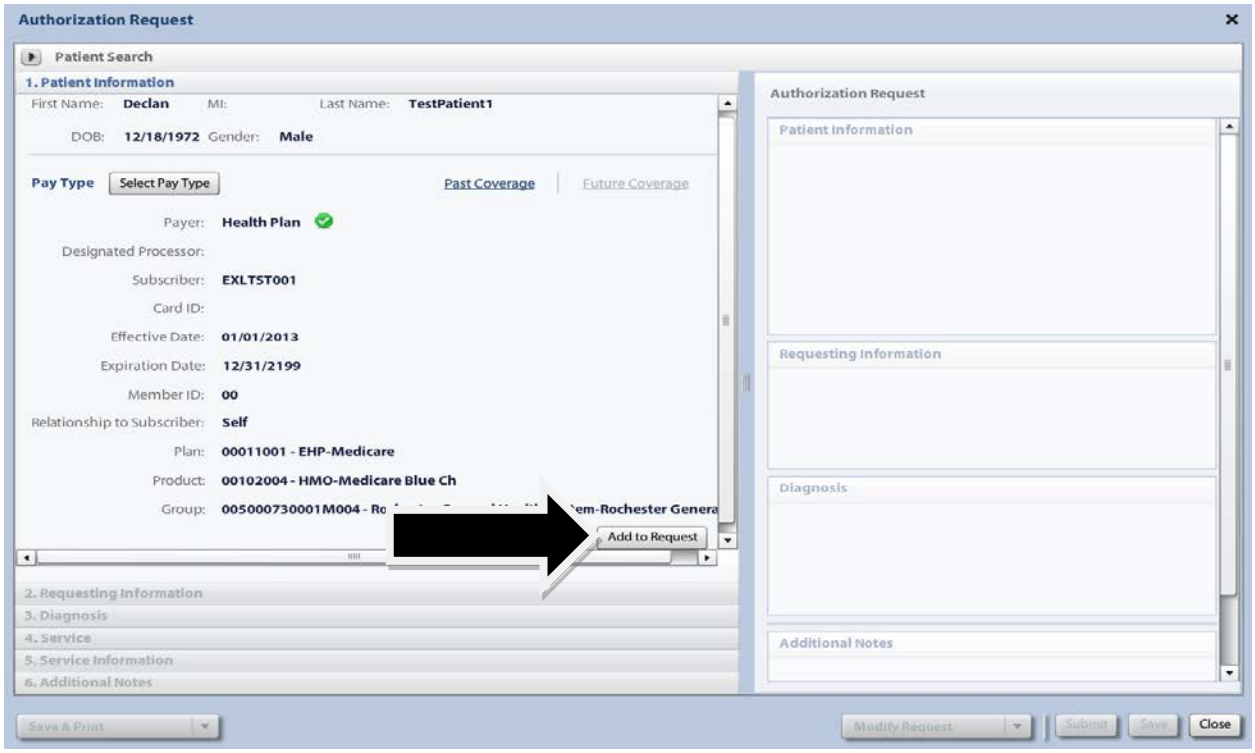
The request for the second contract will always pend.

Clear Coverage™
Physical Therapy Authorization Entry Tips

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

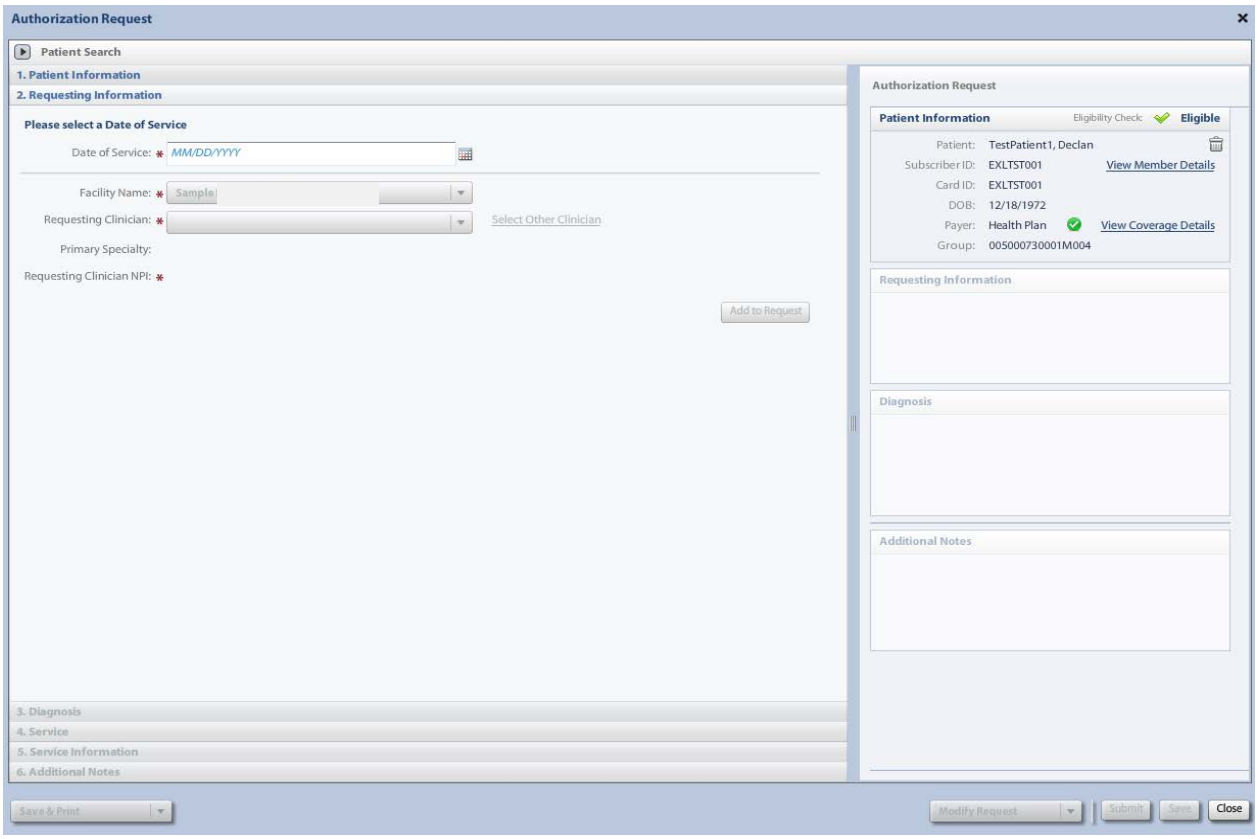


Clear Coverage™
Physical Therapy Authorization Entry Tips

Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

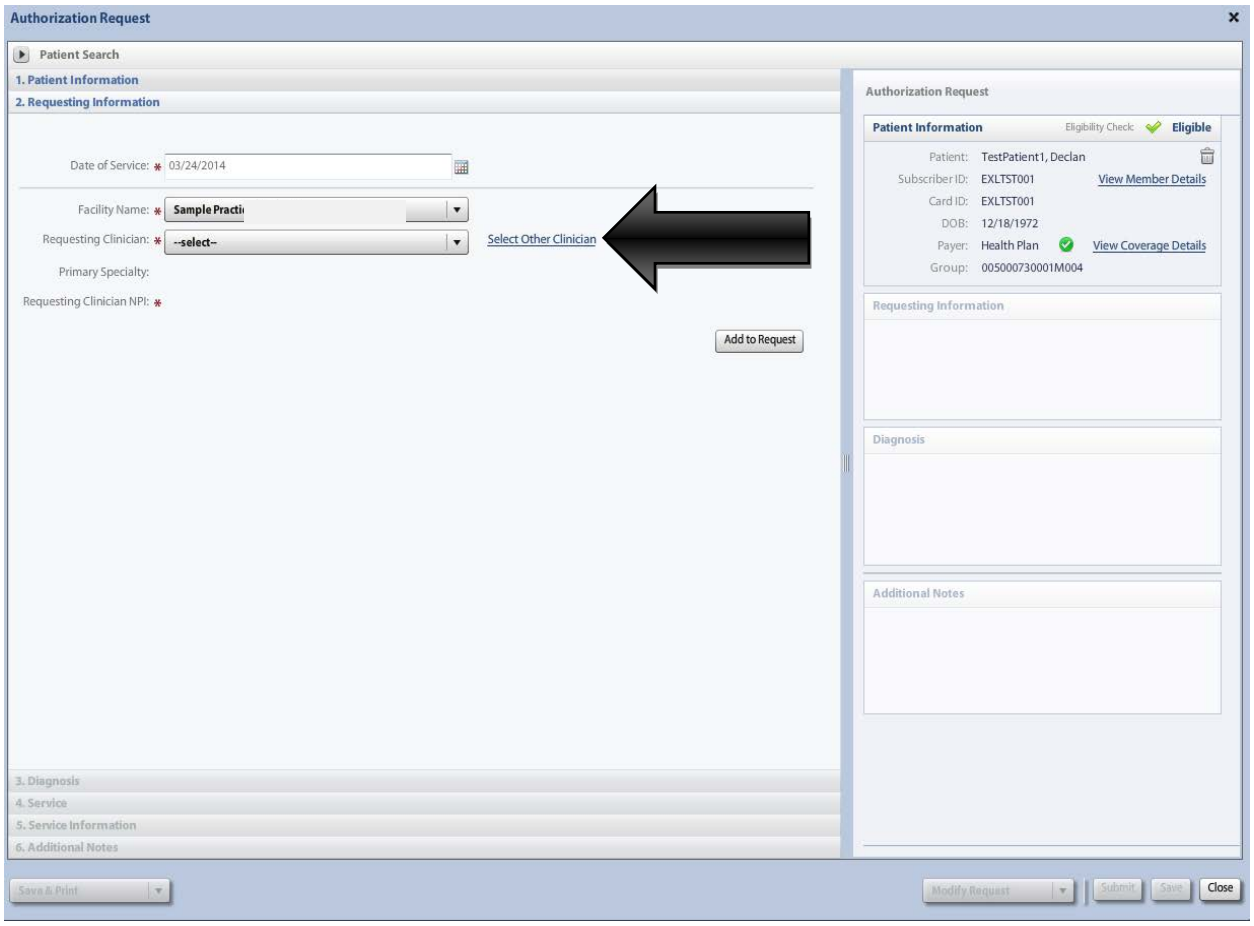
Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Clear Coverage™
Physical Therapy Authorization Entry Tips

Requesting Clinician = Ordering **PHYSICIAN**. Do NOT enter a nurse practitioner, physician assistant or other provider. Click on "Select Other Clinician" to search.

Note: you may enter a physical therapist if this is a self referral.

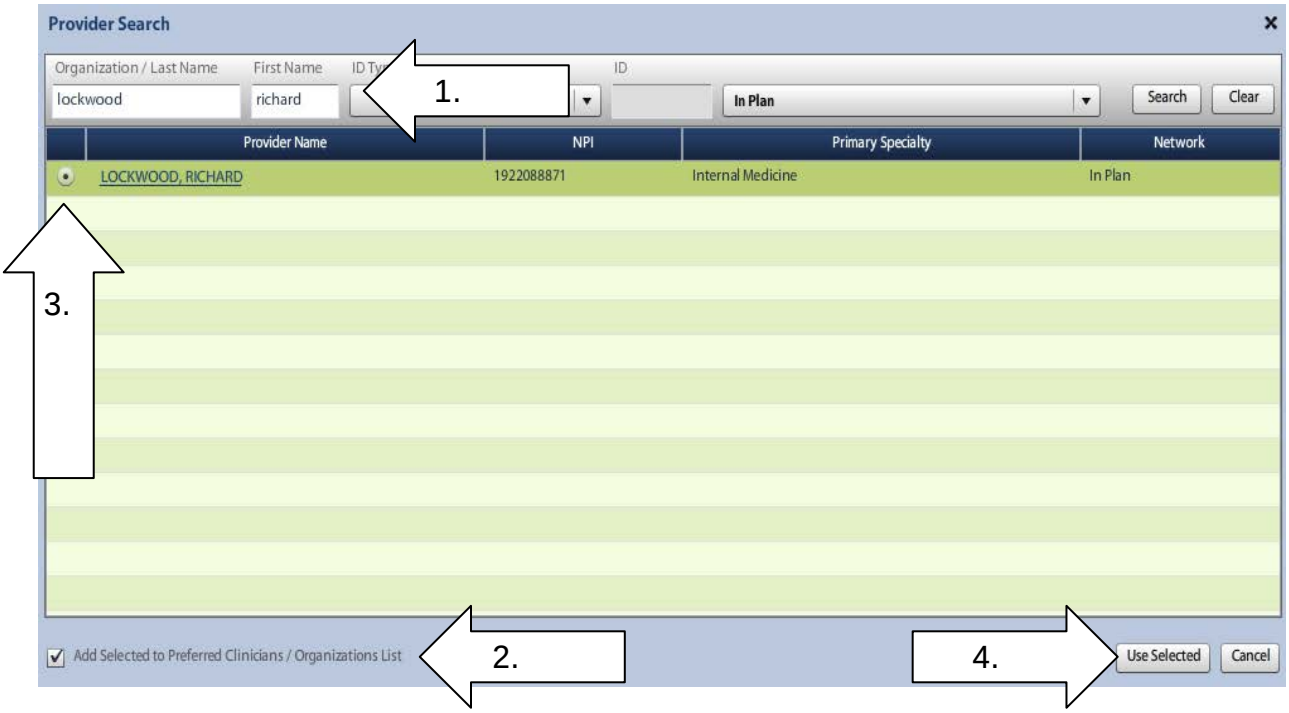


Clear Coverage™
Physical Therapy Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

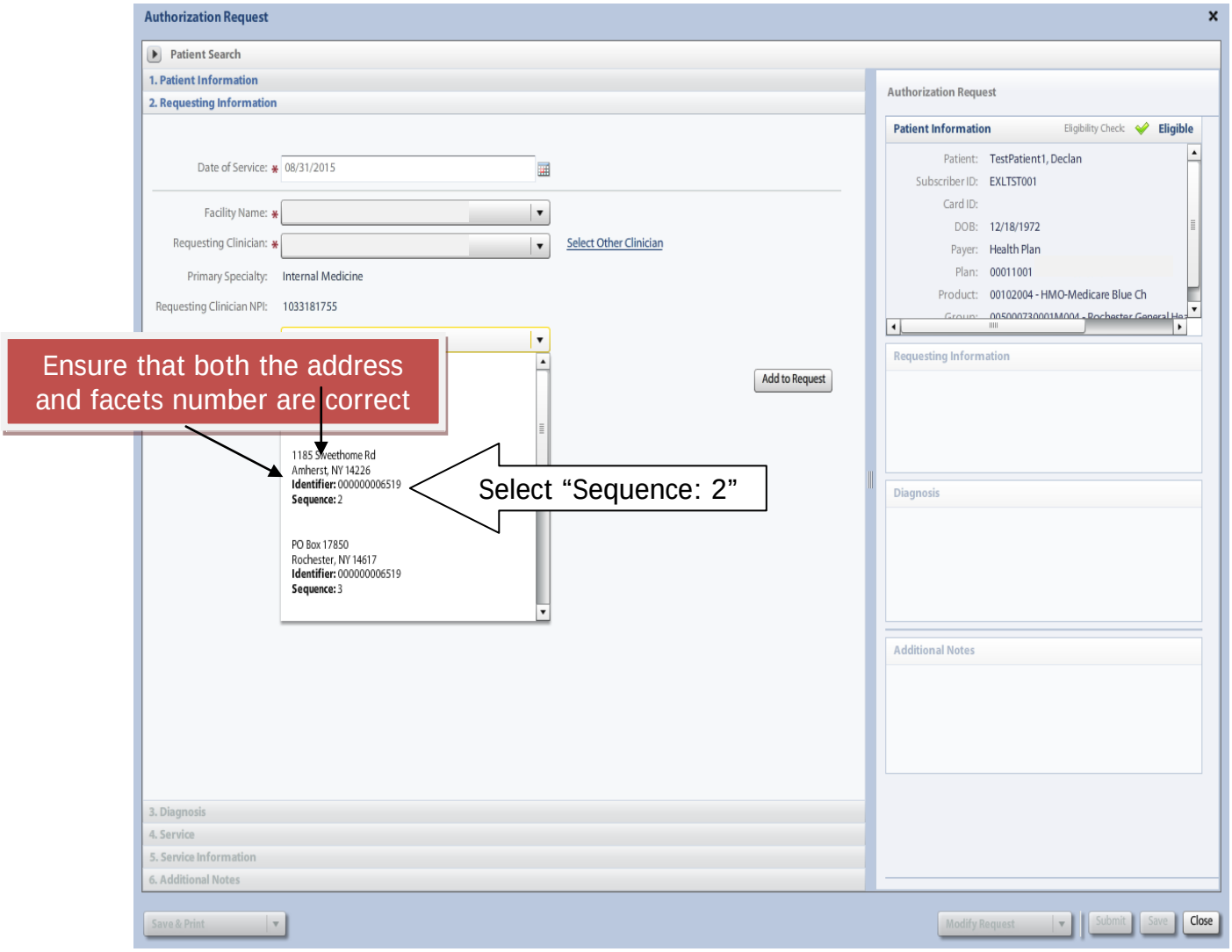
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Physical Therapy Authorization Entry Tips

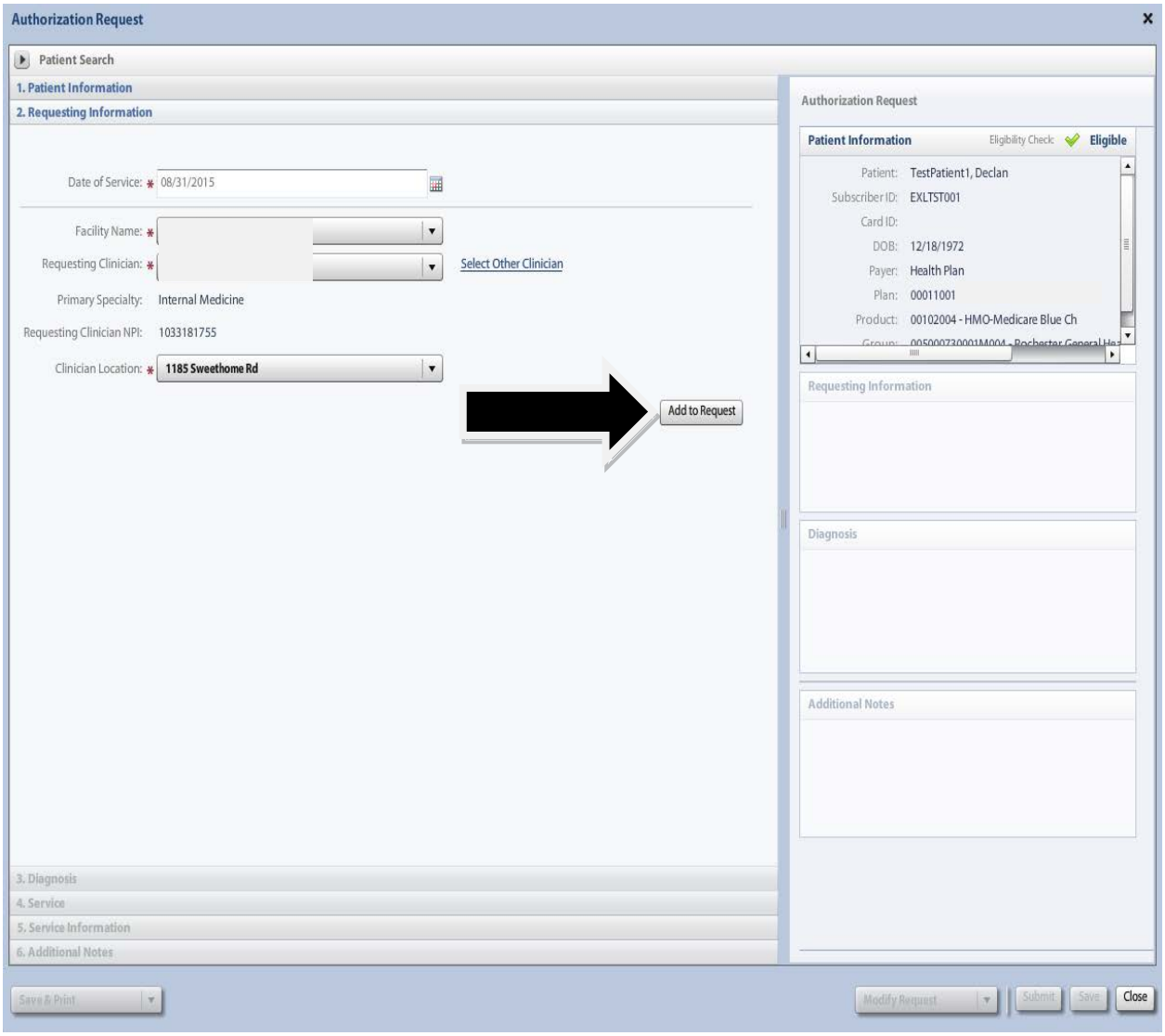
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Physical Therapy Authorization Entry Tips

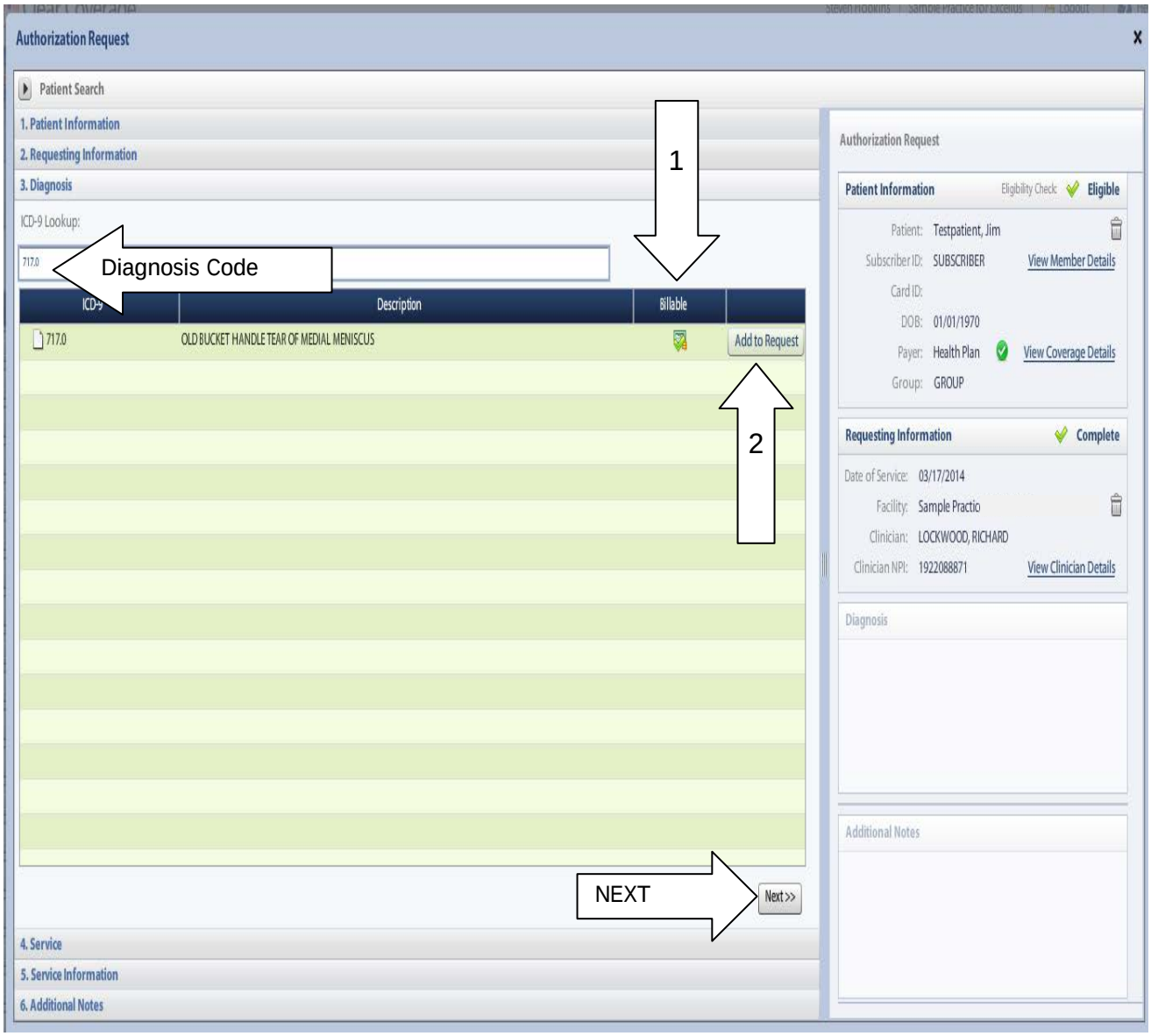
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Physical Therapy Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."



Clear Coverage™
Physical Therapy Authorization Entry Tips

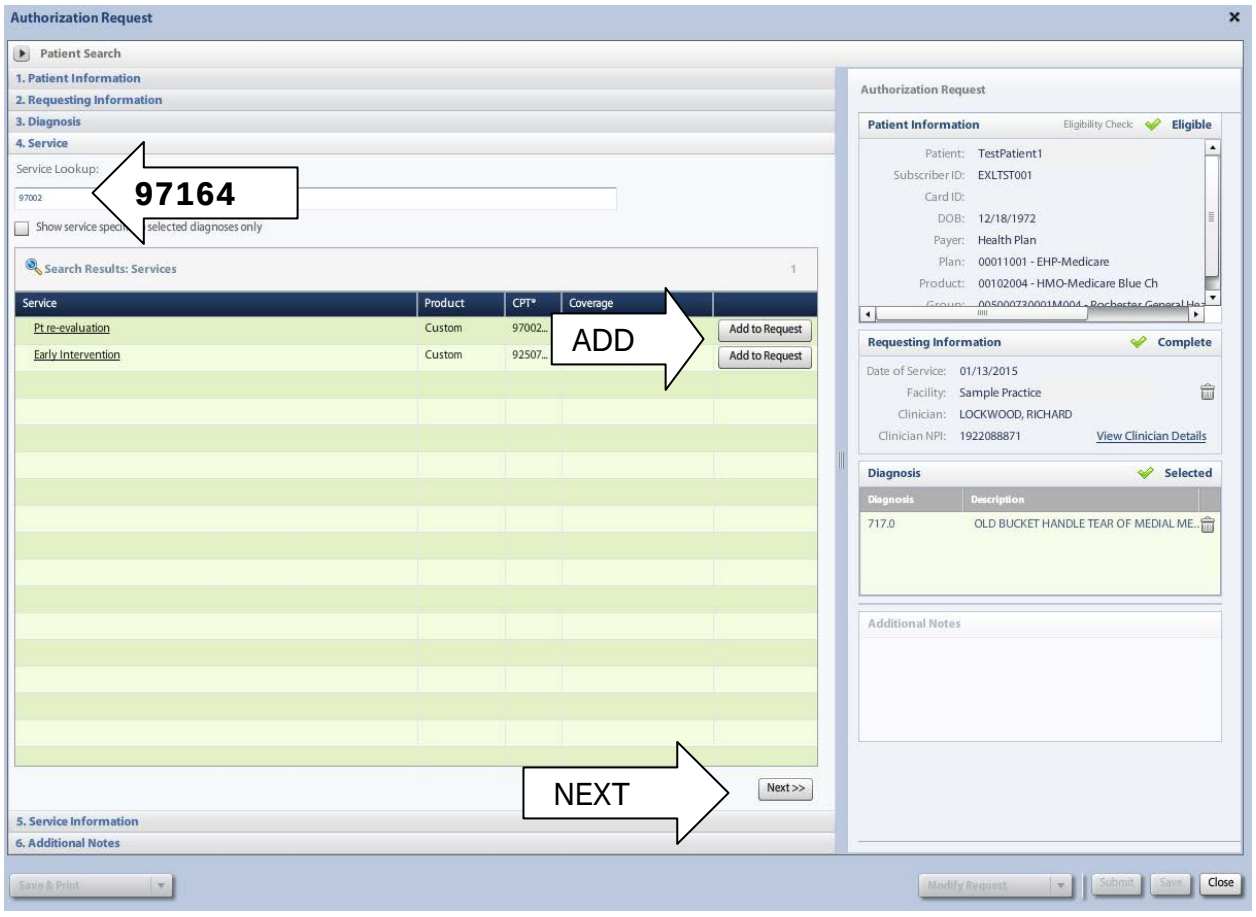
Accordion 4: Services

Enter one procedure code only: **97164**. Do not enter any other physical therapy codes. All physical therapy codes are included within this "service group".

Two choices will appear:

- Choose "PT re-evaluation" for all requests for patients ages 3 and over.
- Choose "Early Intervention" for all requests for patients ages 0-3.

Click the "Add to Request" button, then click "Next".



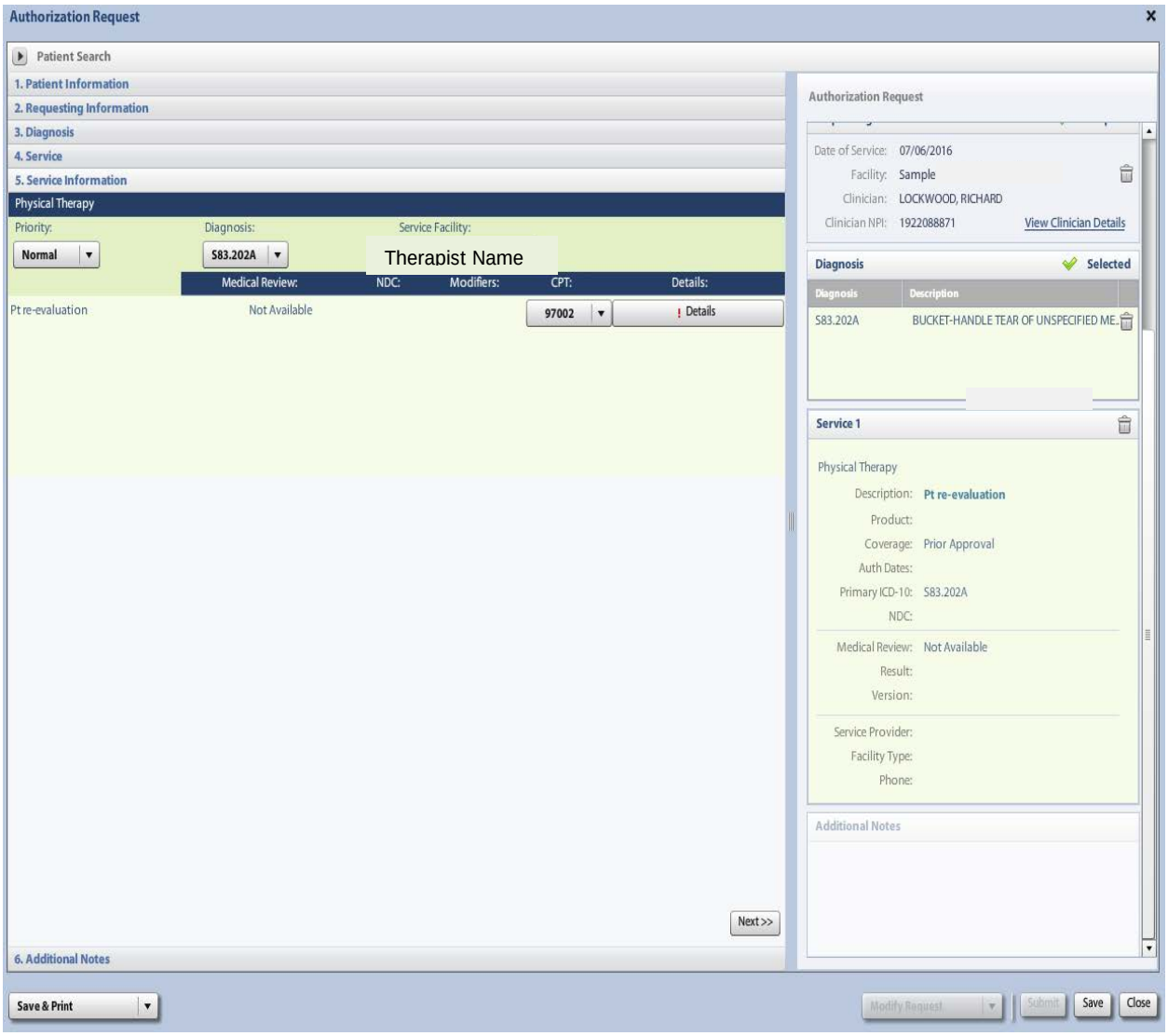
Clear Coverage™
Physical Therapy Authorization Entry Tips

Accordion 5: Service Information

Priority = Normal (if request is urgent, call Customer Care)

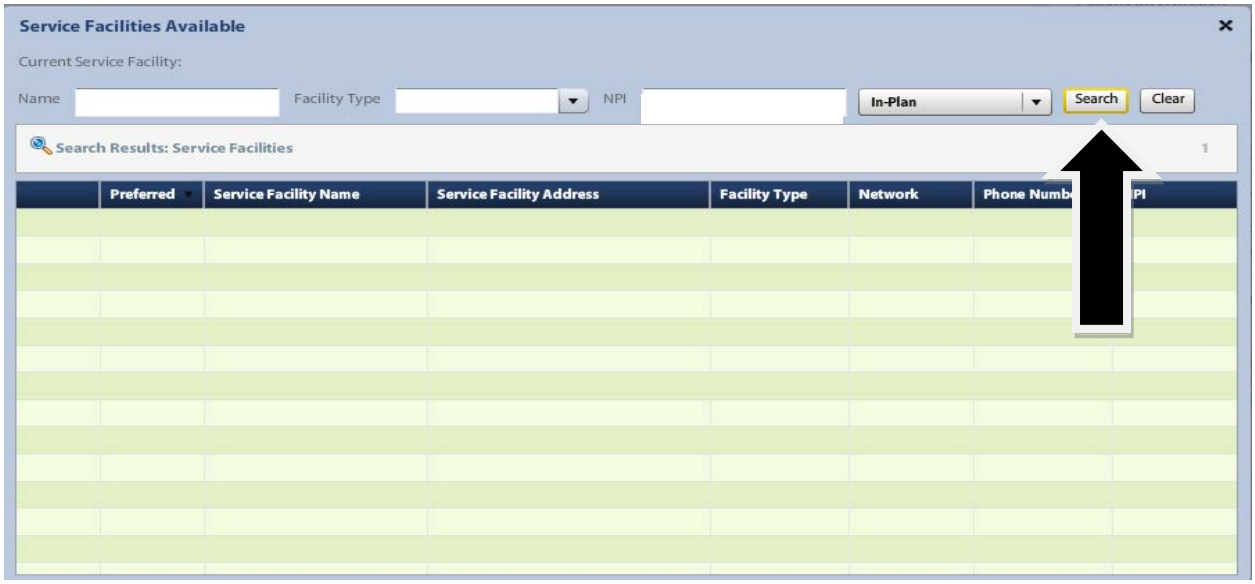
Diagnosis = defaults to primary code that was entered in accordion 3

Service Facility = enter the name of a physical therapist within your group. **DO NOT** enter the group name. If the group name is entered, the request may pend for review. *See next page.

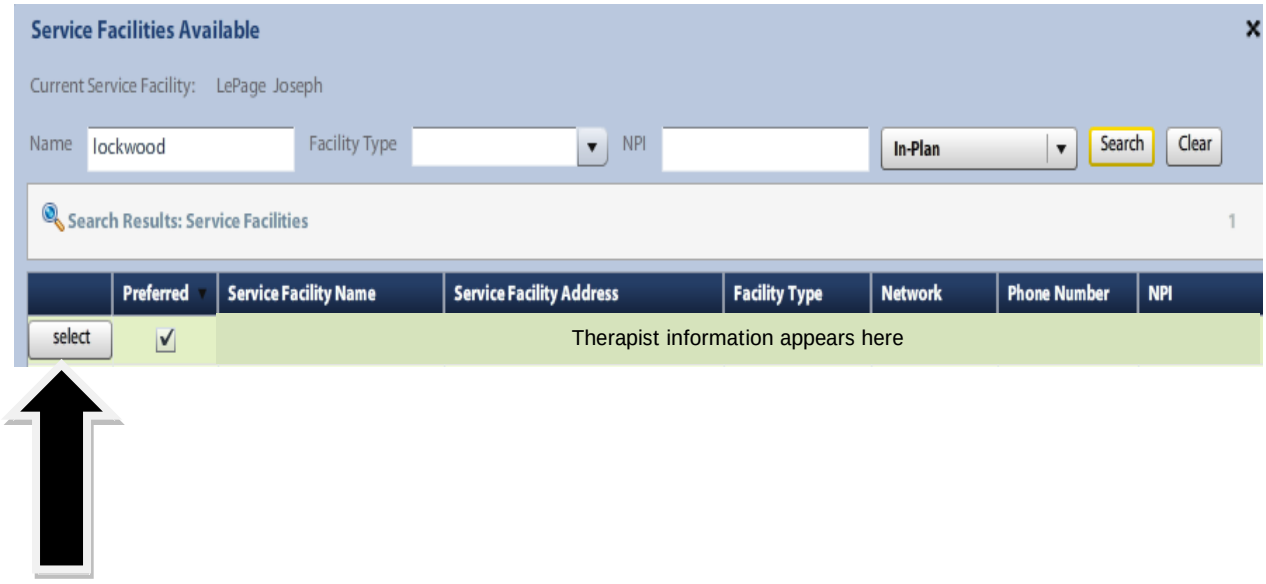


Clear Coverage™
Physical Therapy Authorization Entry Tips

When searching for Service Facility Name (Provider), enter the name of an individual therapist within your group or their NPI number and click the “Search” button.



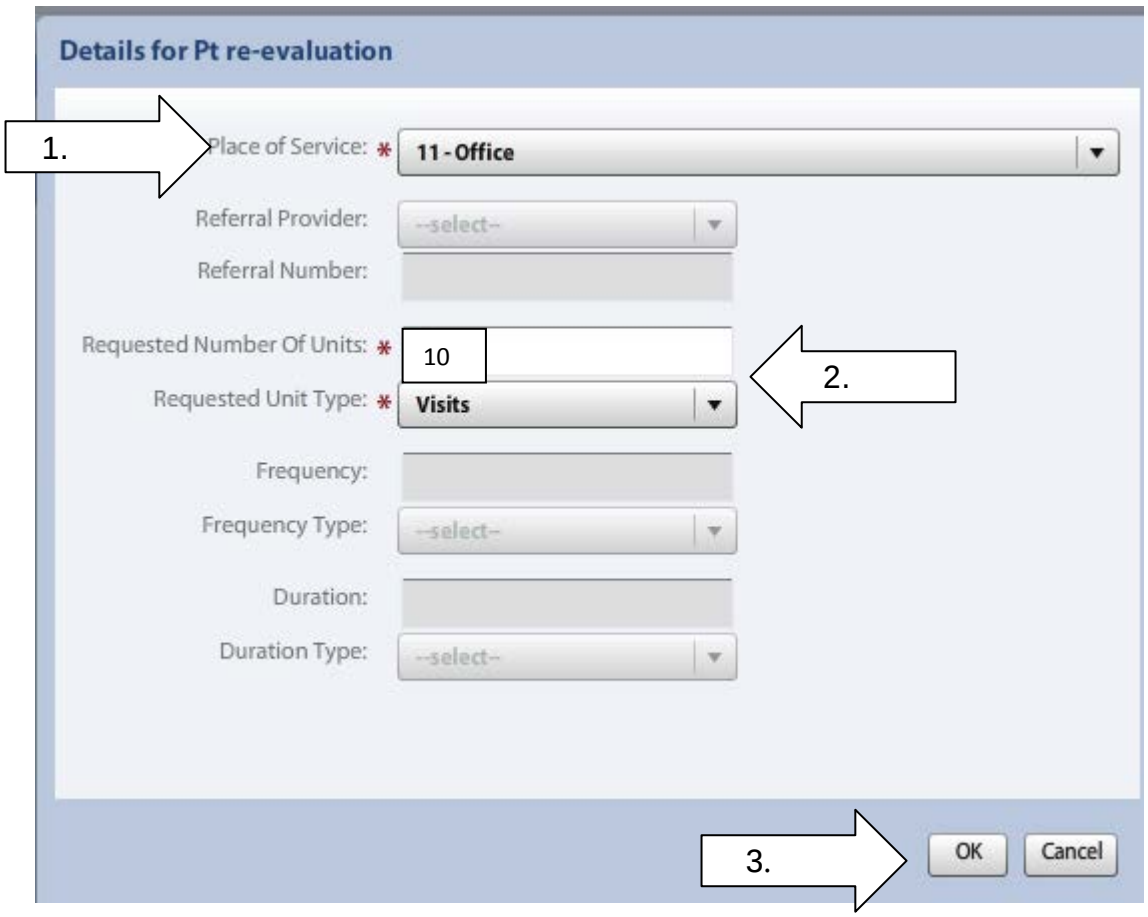
When the results display, select the provider.



Clear Coverage™
Physical Therapy Authorization Entry Tips

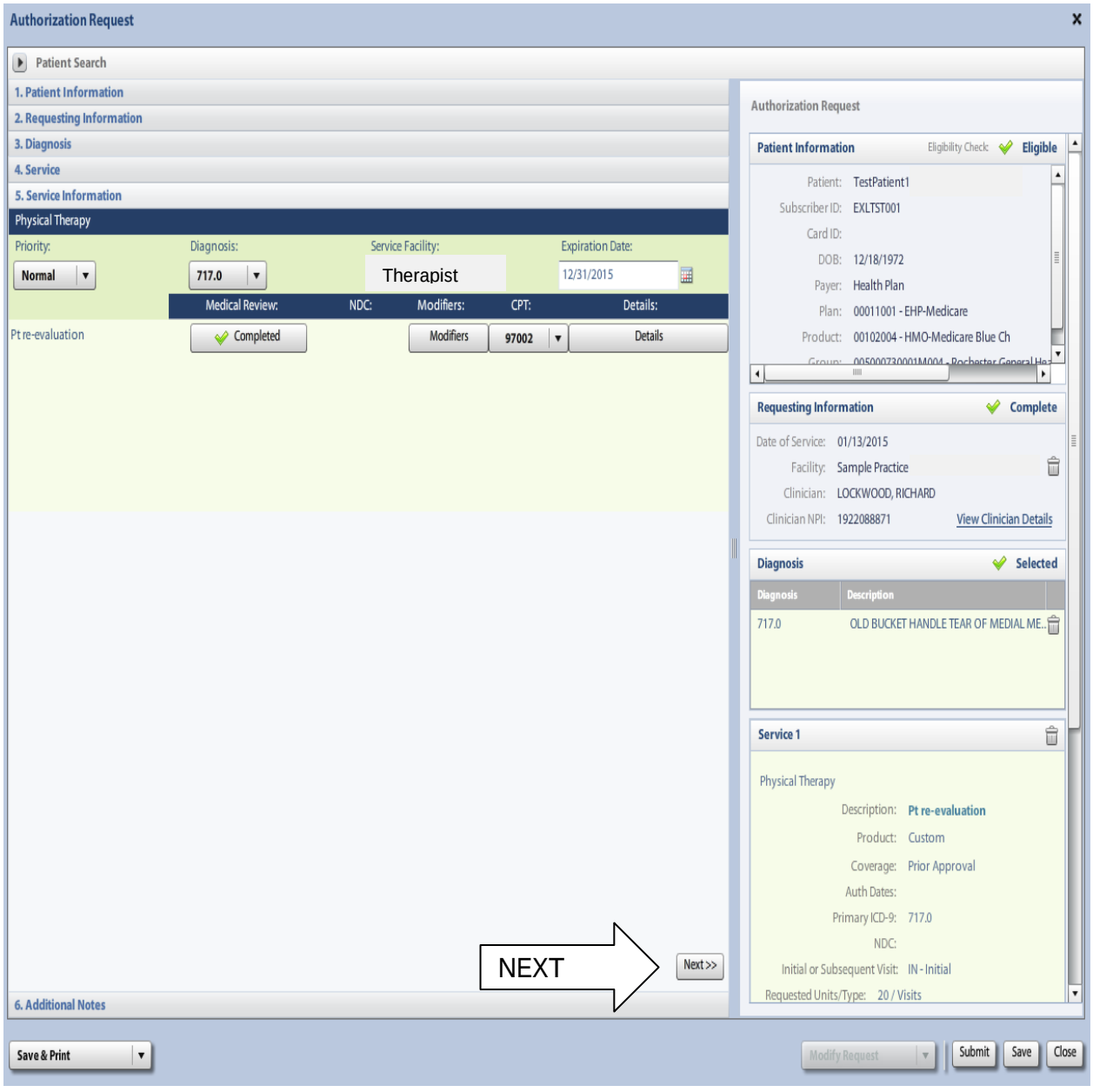
Details section: Must select: (1) Place of Service. (2) Number of Units (Visits) and Requested Unit Type. "**Initial" authorizations may include 1-10 visits. Any number over 10 will result in a pended authorization.**

When completed Click the "OK" button (3).



Clear Coverage™
Physical Therapy Authorization Entry Tips

Once all of the Service information has been added, click the “Next” button.

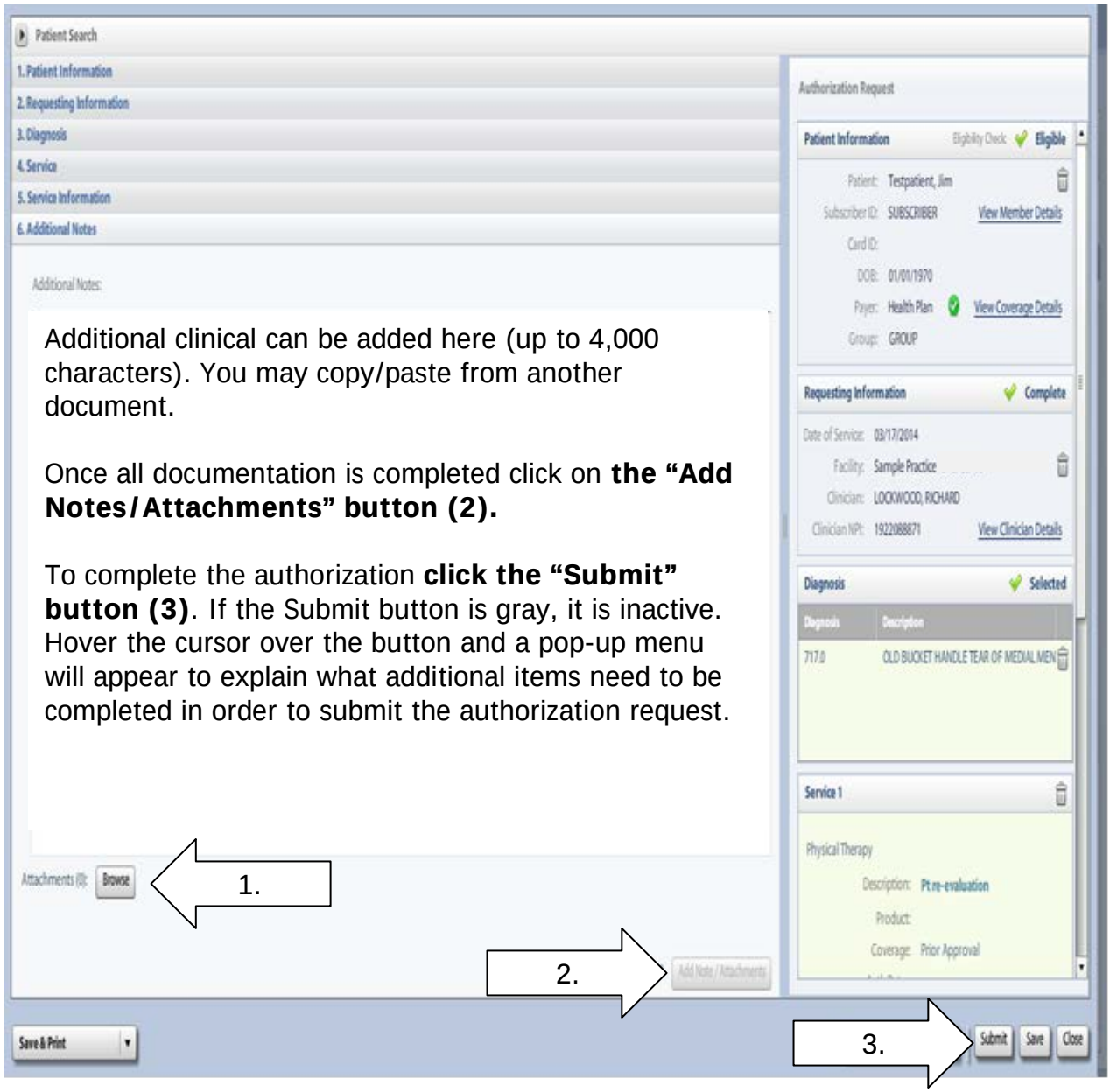


Clear Coverage™
Physical Therapy Authorization Entry Tips

Accordion 6: Additional Notes

If needed, additional clinical information can be added in this section and documents can be attached (1). A note must be added in order to attach a document.

A note is required for ALL subsequent visit (additional visit) requests, visit requests beyond 10 and requests for patients ages 3-21.



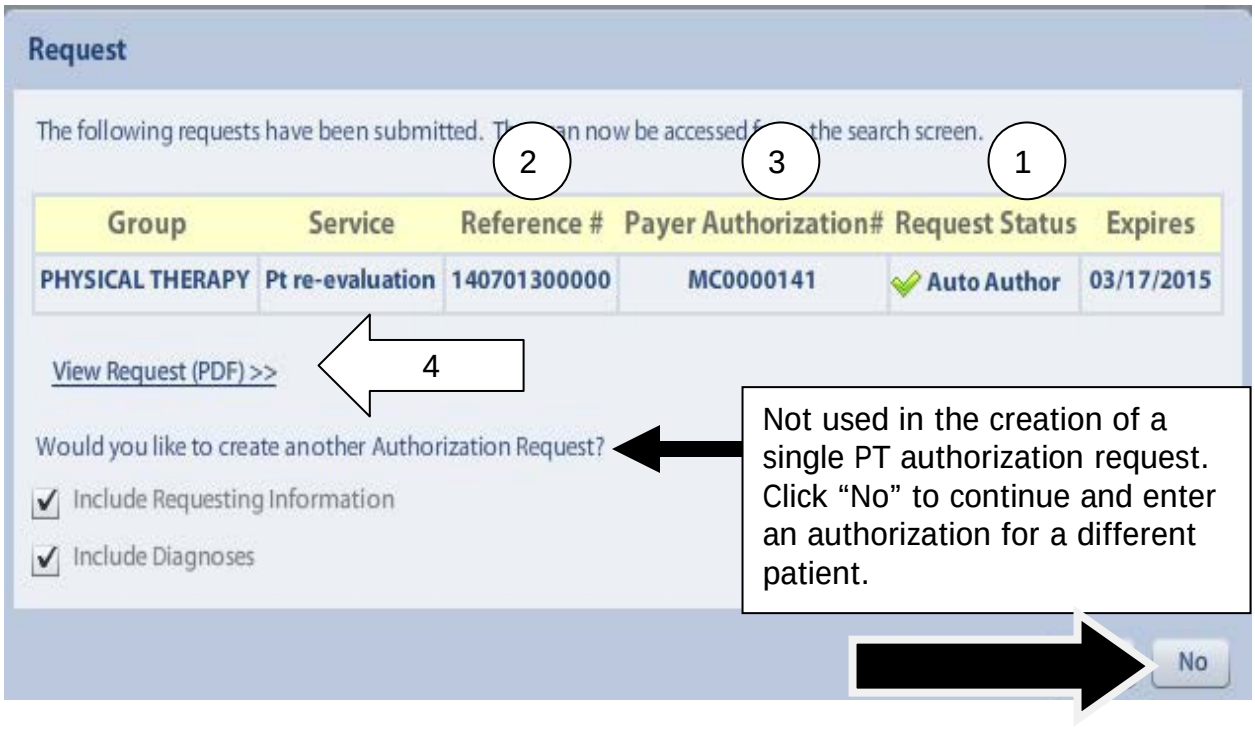
Clear Coverage™
Physical Therapy Authorization Entry Tips

Once the authorization has been submitted a contact information pop up displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the “Submit” button.

The Request Box will display. The request box allows you to see/access the following:

1. Status of the authorization
2. Reference number (used when a request is pended)
3. Payer Authorization number
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click “No” to close this request

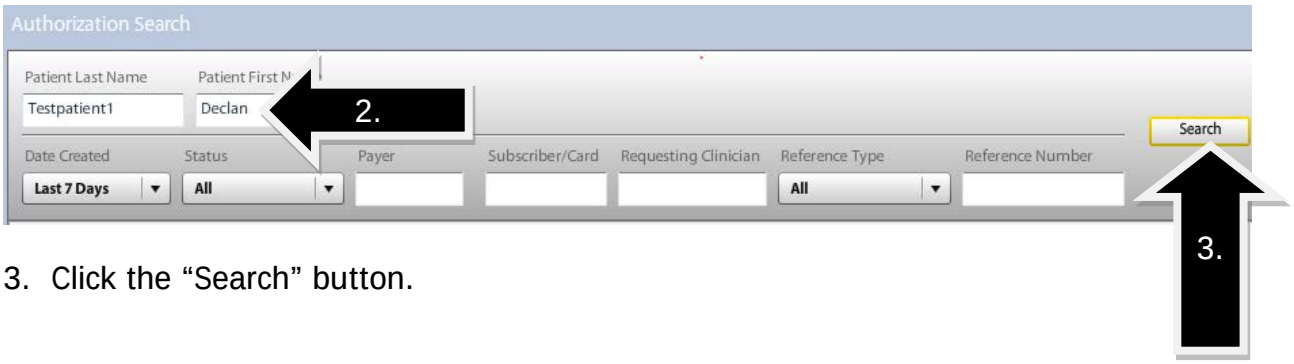


Clear Coverage™
Physical Therapy Authorization Entry Tips

When an initial authorization <u>has already been entered in Clear Coverage</u>™, DO NOT create a new authorization. Follow these steps:

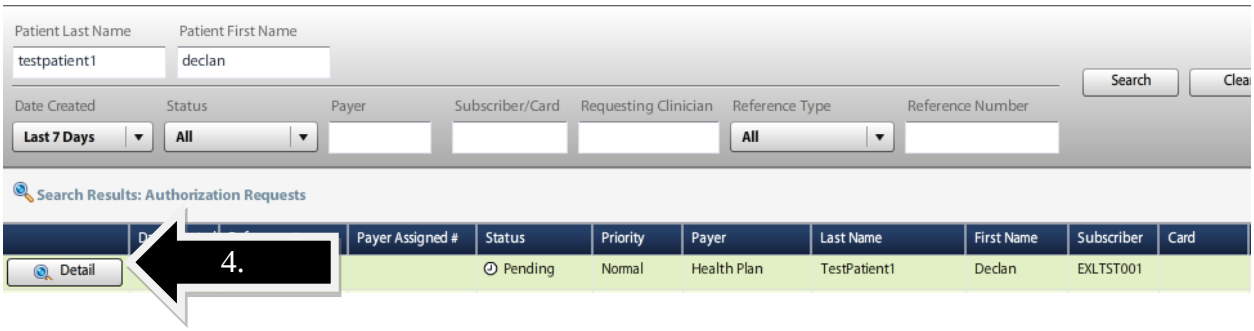
1. Click the “Authorization Search” button.

2. Locate the authorization by patient name and/or reference number.



3. Click the “Search” button.

4. Click the “Detail” button to re-open the authorization.



Clear Coverage™
Physical Therapy Authorization Entry Tips

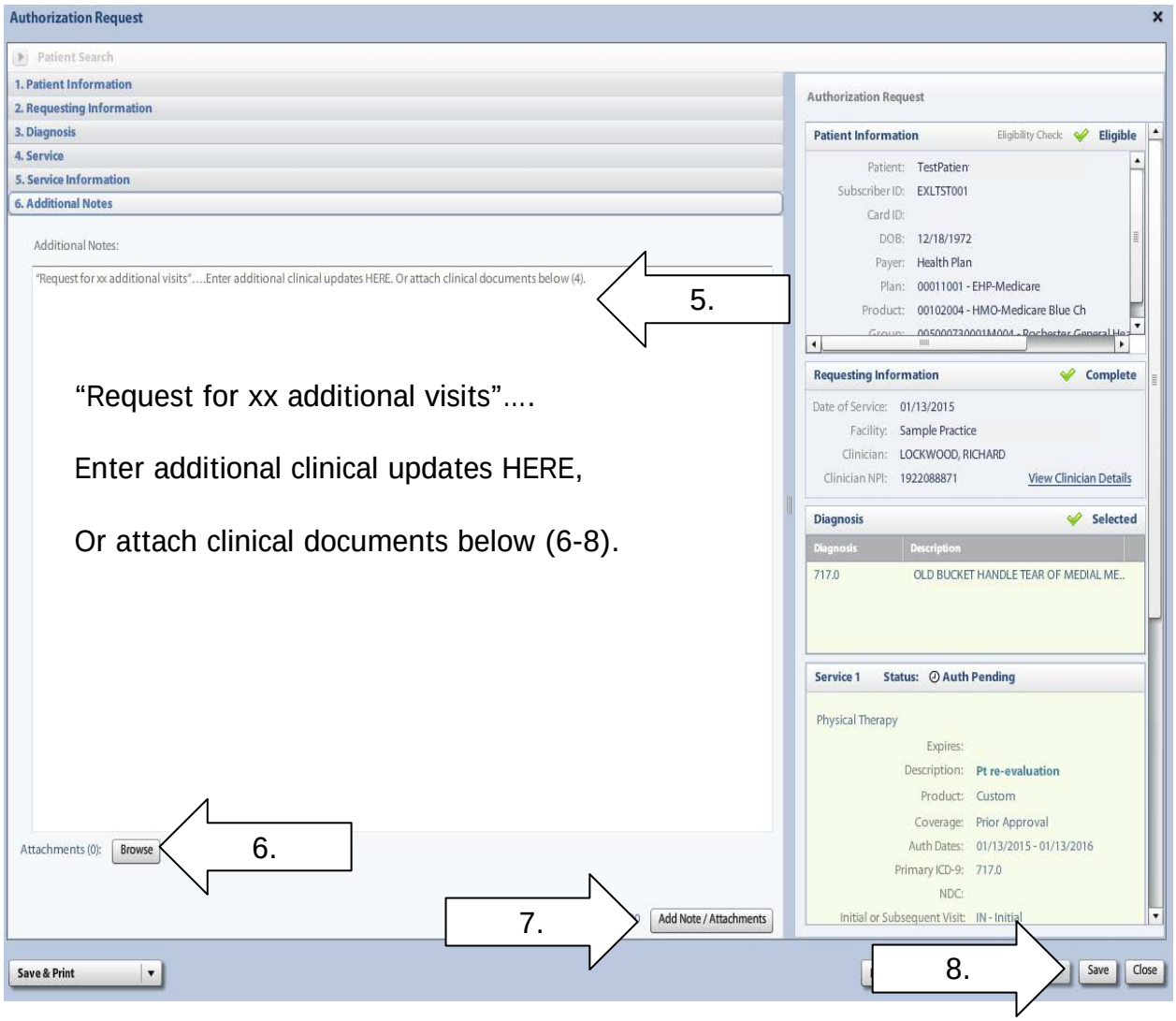
5. Proceed directly to **Accordion 6** and type in a note: "Request for xx additional visits" and include clinical updates describing the need for additional visits.

6. Attach documents, if appropriate.

7. Click the "**Add Notes/Attachments**" button.

8. Click "**Save**".

9. Request will pend to the Health Plan for a medical necessity review.



Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

Referrals are only required for the following contracts:

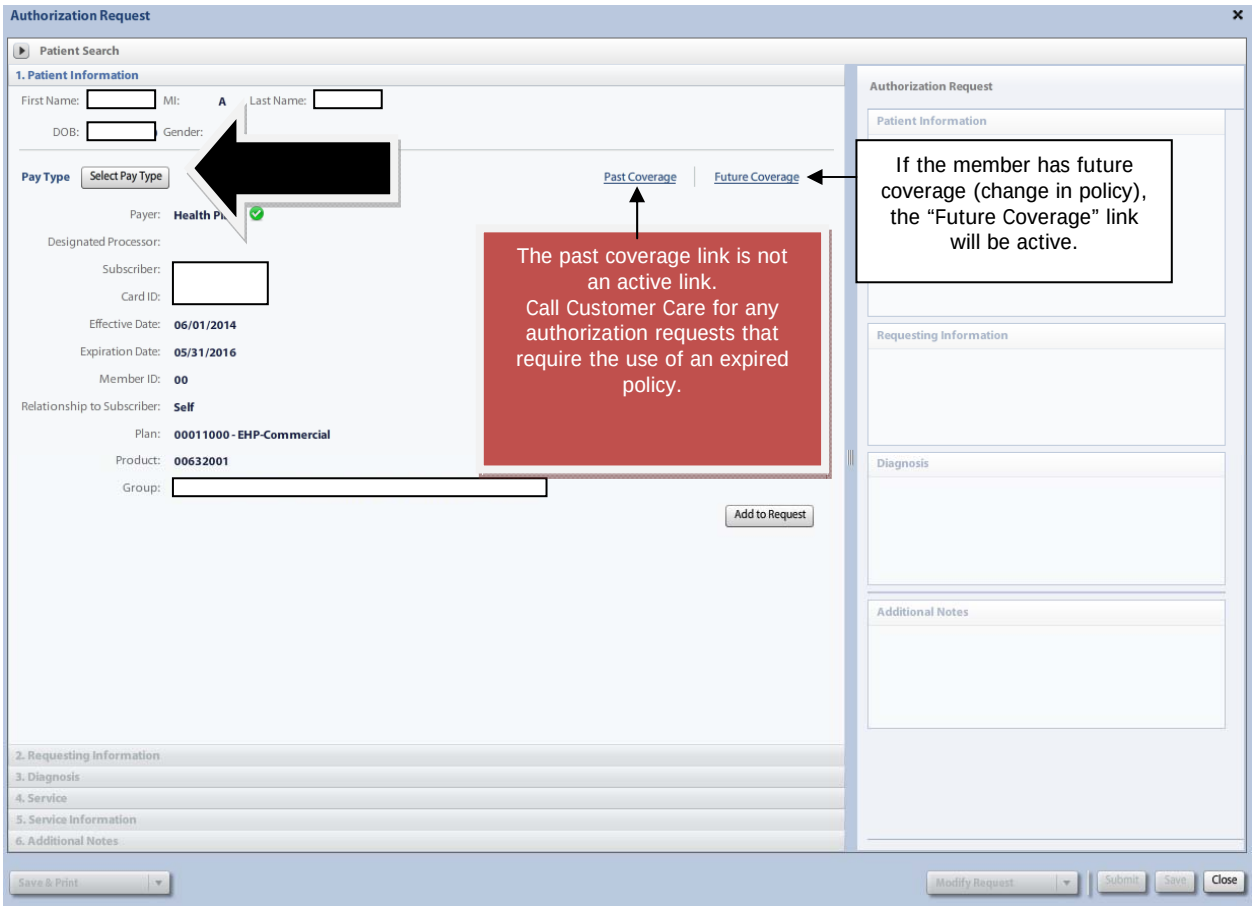
1. Medicare HMO
2. Verizon

NOTE: Please do not request a referral in Clear Coverage™ for any other product as it is not required.

After searching for and selecting the patient, the Authorization Request Entry Box will display.

Accordion 1: Patient Information

Review information. Click on the “Select Pay Type” button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

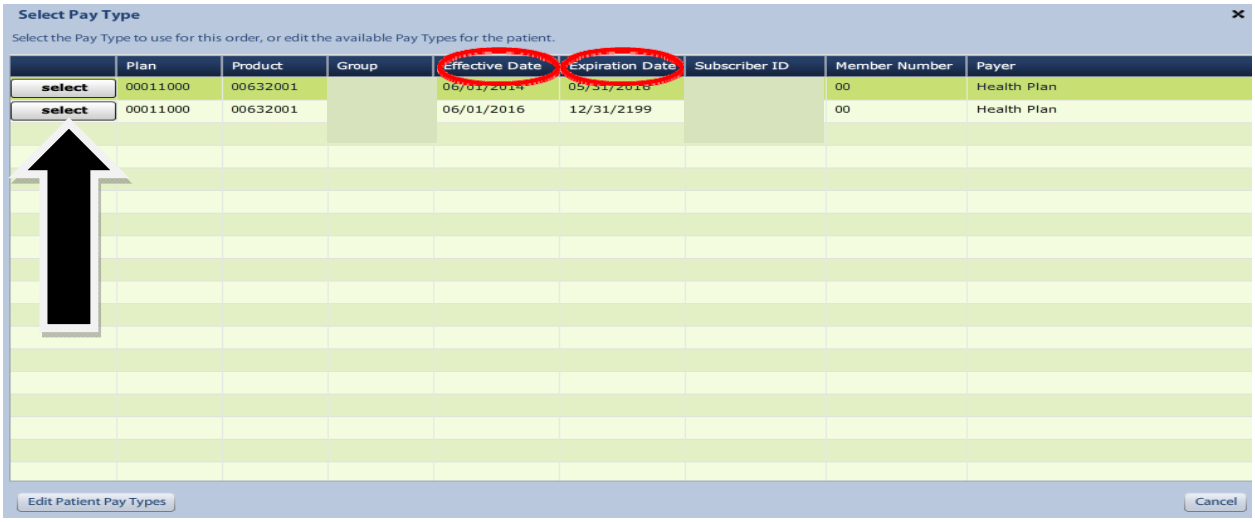


Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

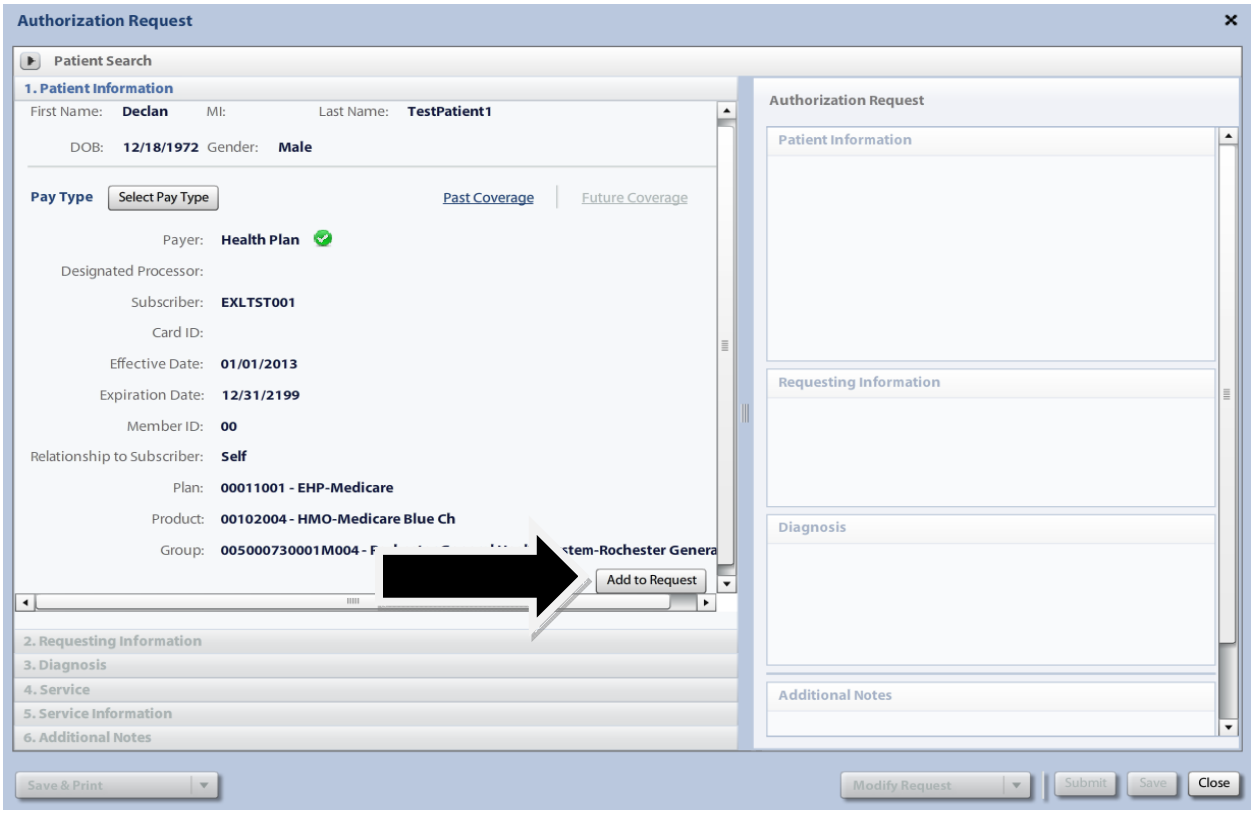
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

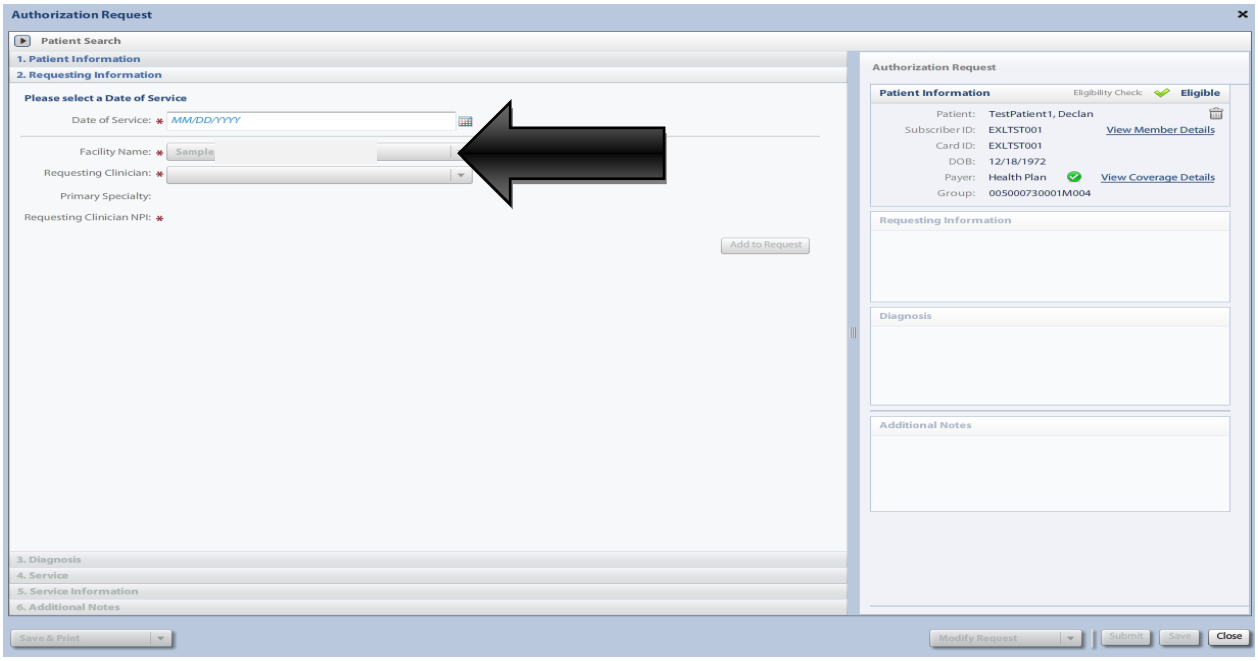


Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

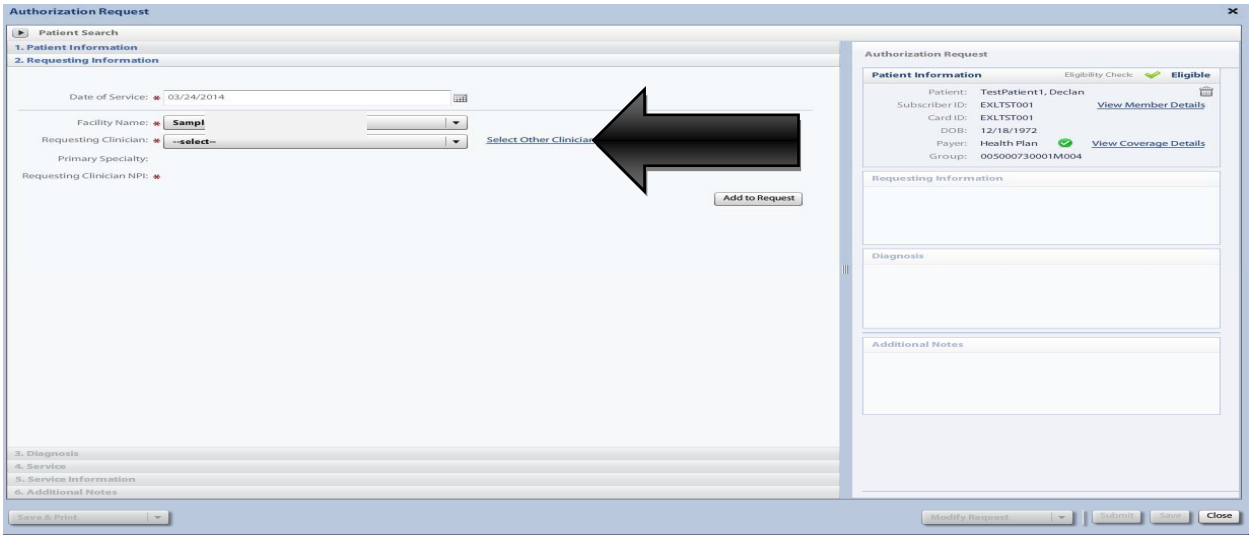
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to five days, or go forward 90 days. Note: if you need to backdate a request beyond five days, call Customer Care.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, physical therapist or other provider. Click on "Select Other Clinician" to search.

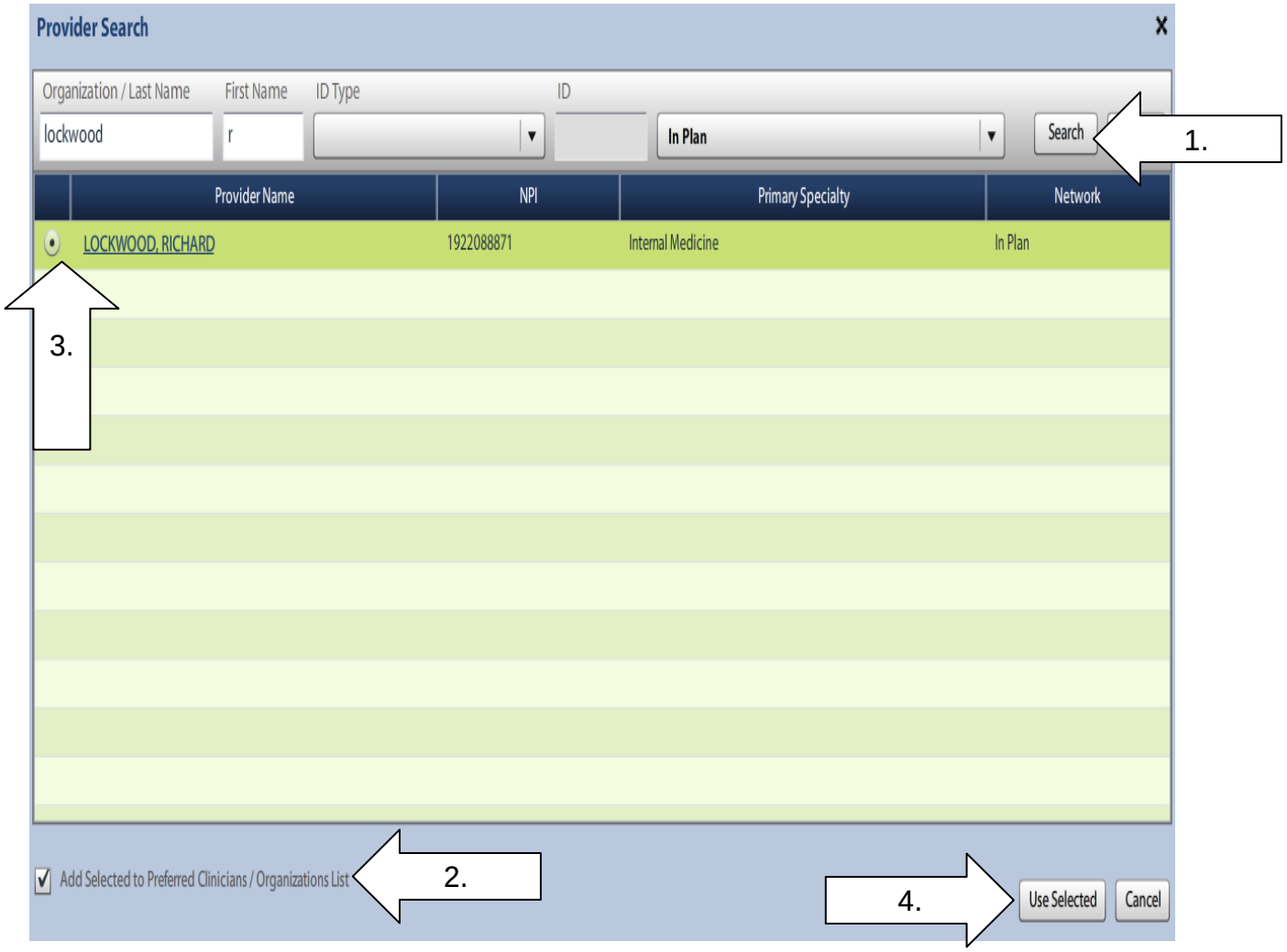


Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

Enter the search parameters and click the “Search” button (1).

The provider can be saved to the preferred provider list (2).

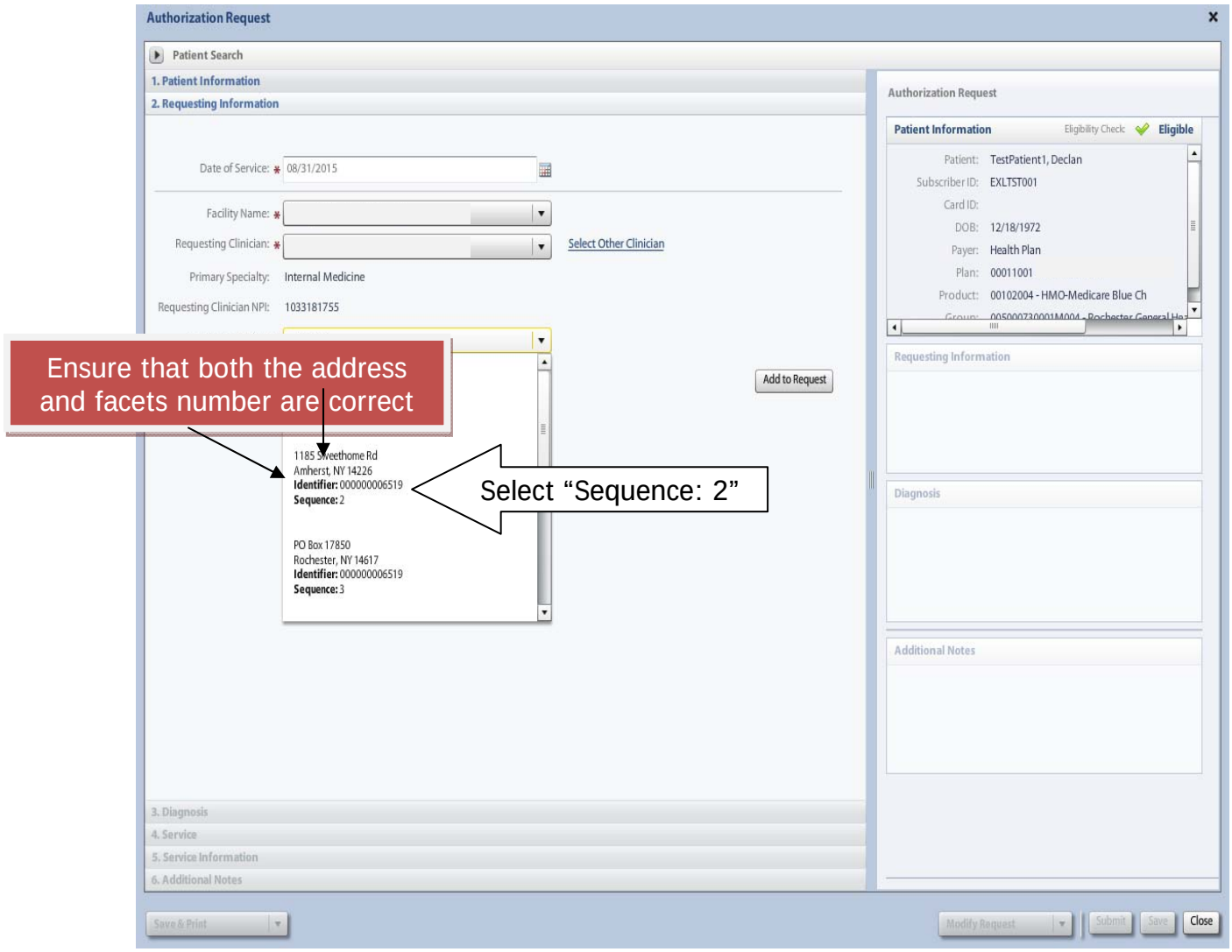
Select the provider using the radio button (3), then click the “Use Selected” button (4).



Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

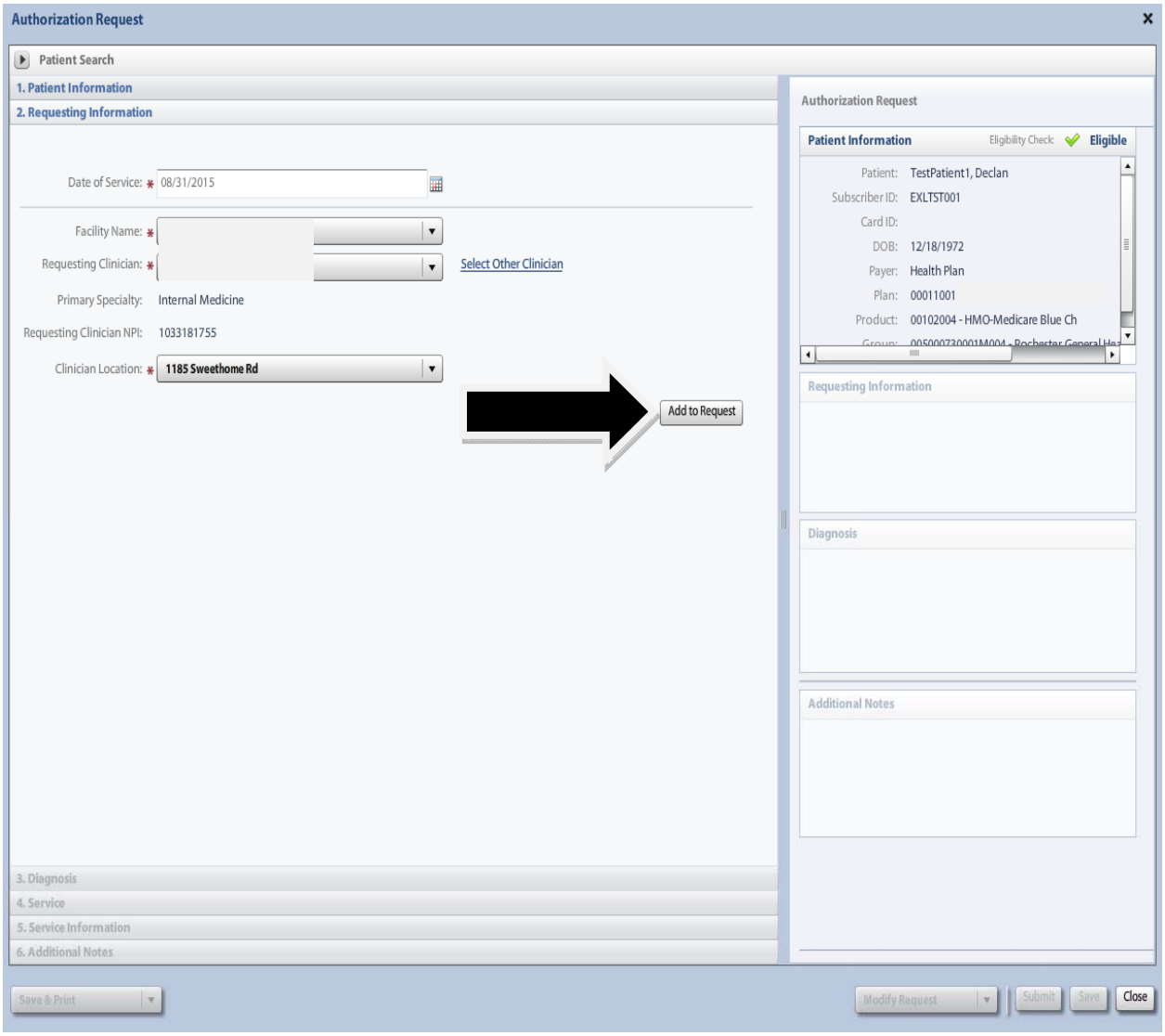
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

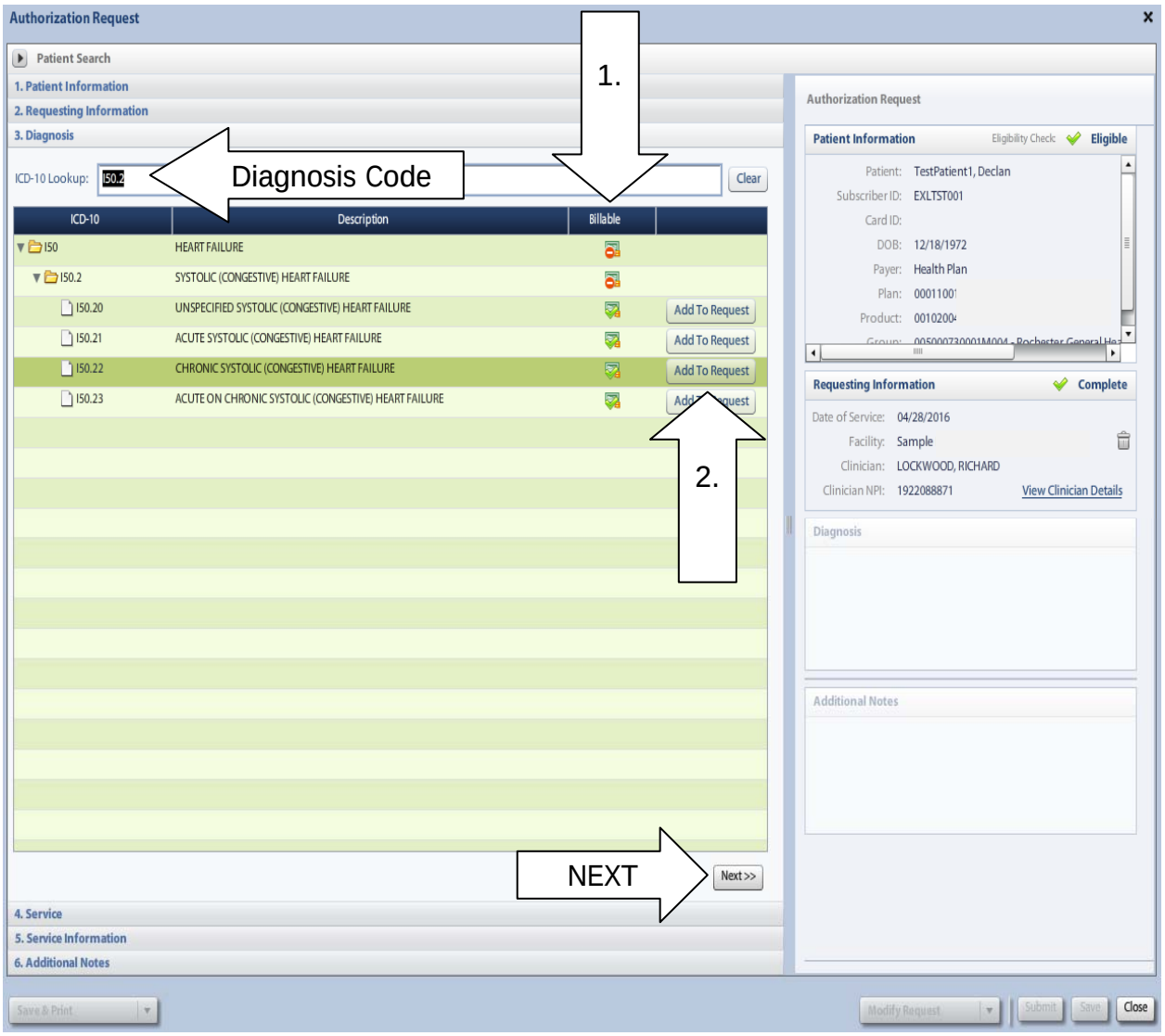
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

Accordion 3: Diagnosis

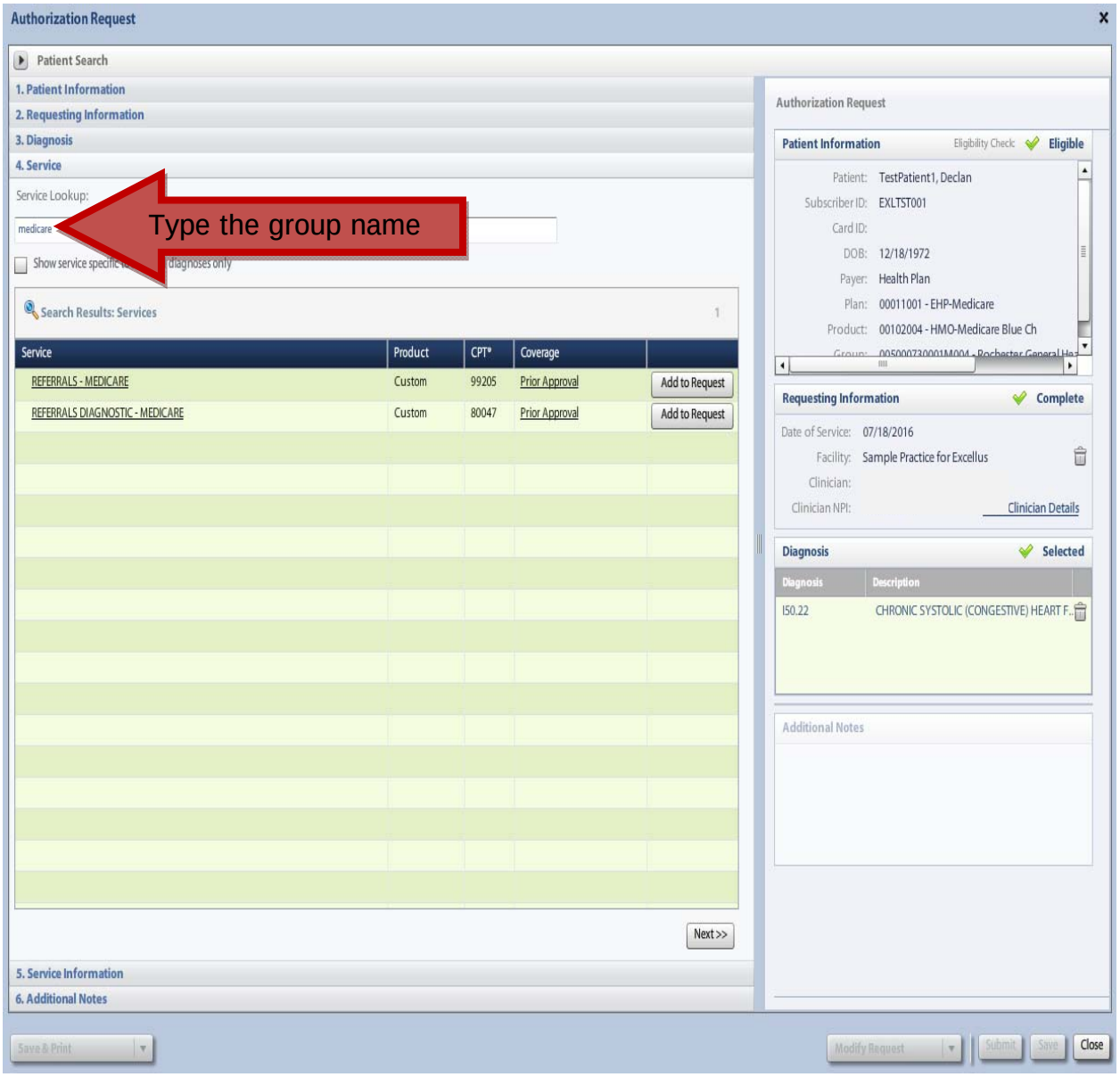
Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."



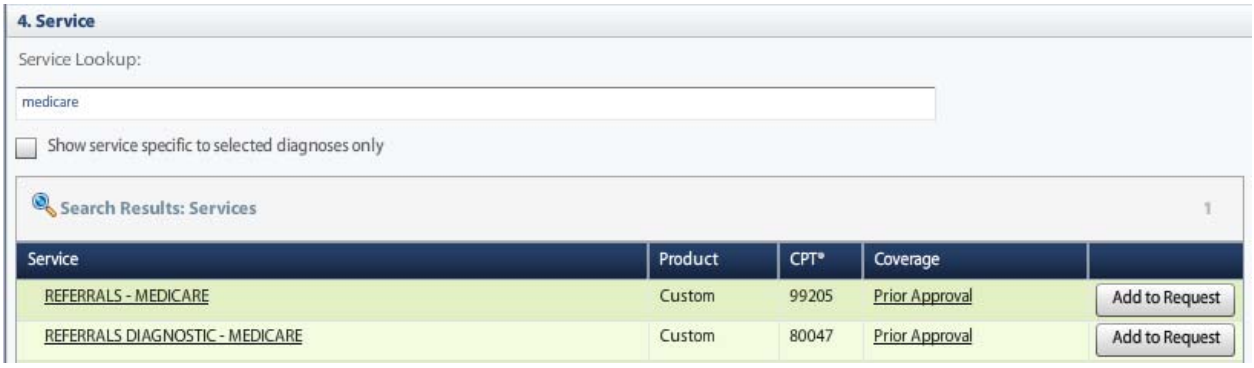
Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

Accordion 4: Services

1. Type the group name (Medicare or Verizon) in the free text box.



2. The provider must choose two services. The diagnostic service MUST be chosen **FIRST**. This provides the required detail for labs, tests, etc. that may need to be ordered (this must be completed even if not ordering tests).



Medicare HMO:

- "REFERRALS DIAGNOSTIC-MEDICARE"
  - Click "Add to Request"
- "REFERRALS – MEDICARE"
  - Click "Add to Request"

Verizon:

1. "Referral Diagnostic - Verizon **EHP**"
   - Click "Add to Request"
2. "Referral - Verizon **EHP**"
   - Click "Add to Request"

3. Click "Next."

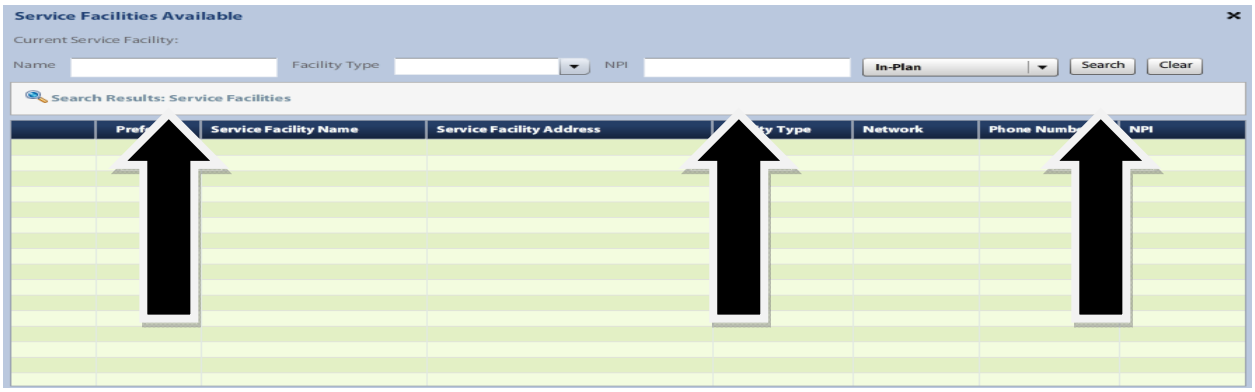
Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

Accordion 5: Service Information

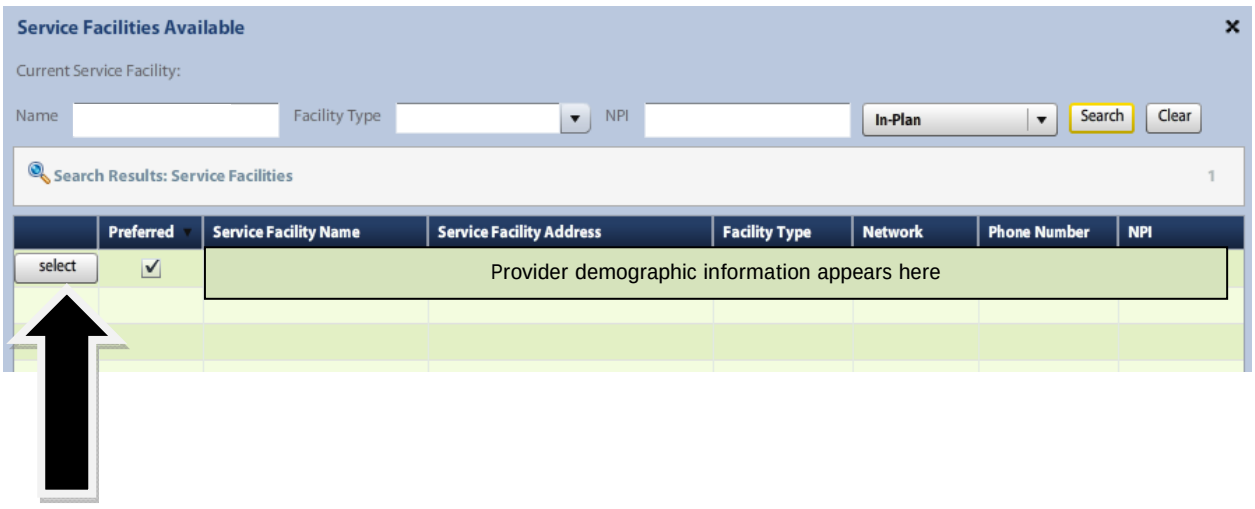
1. Priority - Normal (if request is urgent, call Customer Care)
2. Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3
3. Service Facility - enter the specialist to whom you are referring the patient. This must be an individual physician and **NOT** a group. Click “Select.”

NOTE: If a group is chosen, the auth will pend.

When searching for Service Facility Name (the provider you are referring the patient to), enter the name or the NPI number and click the “Search” button.



When the results display, select the provider.



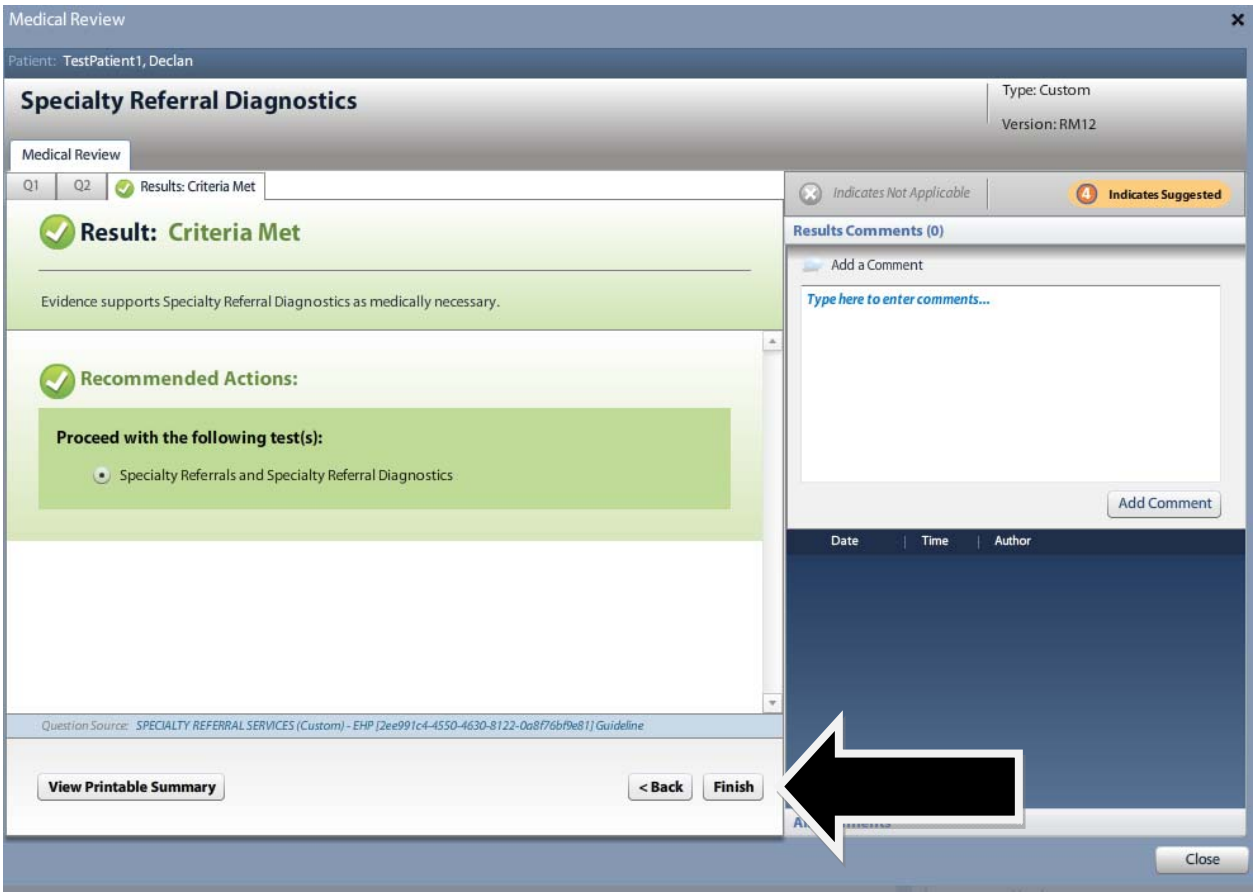
Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

4. Medical Review = Click “!Required to Submit”

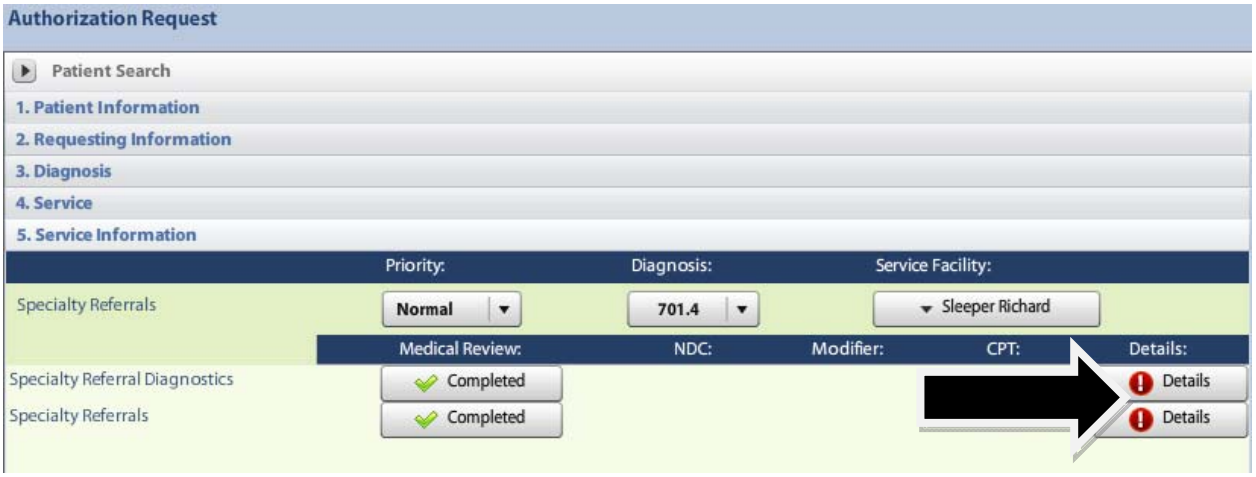
5. Answer “Medical Review” questions. Questions will vary dependent upon type of product (Medicare vs. Verizon) and type of referral requested.

6. Click “Next”

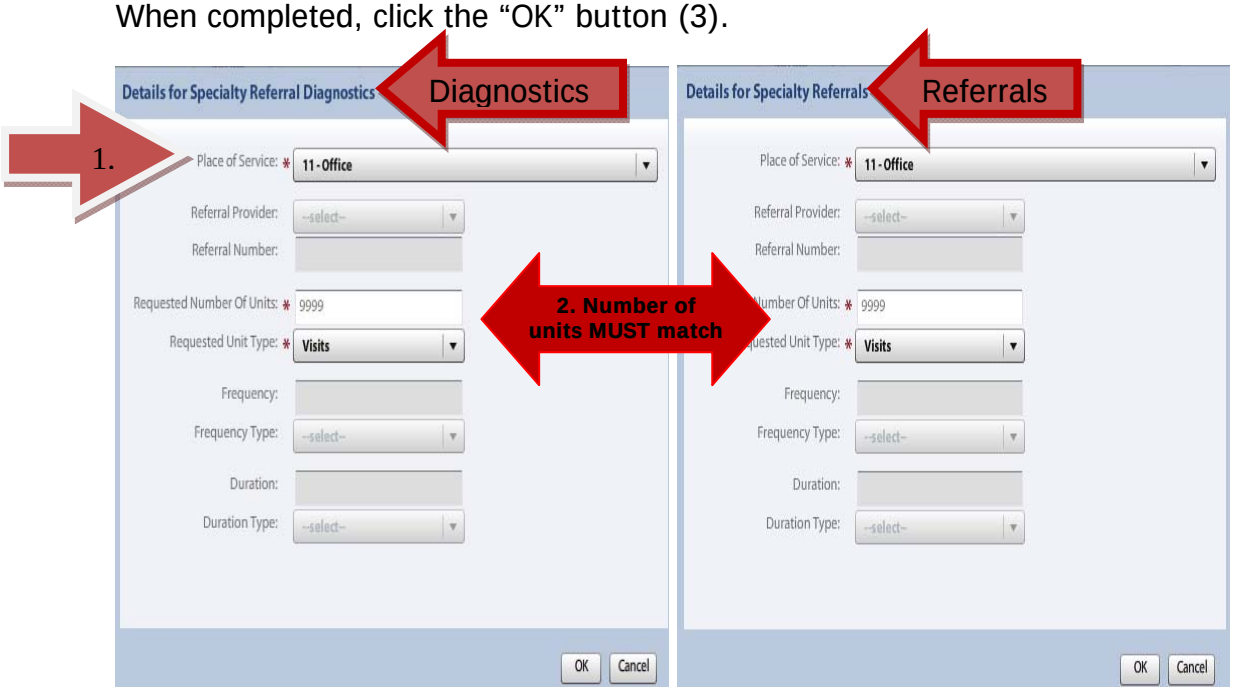
7. Click “Finish”



8. Details = click on each “Details” button (1).



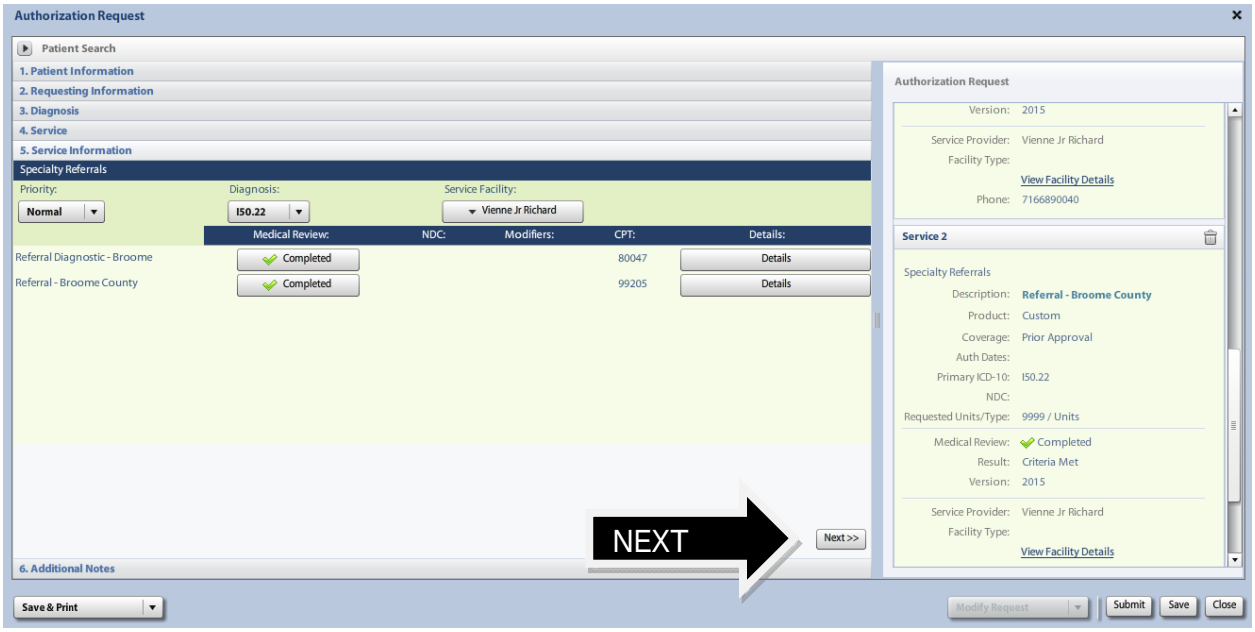
Details section: Must select: Place of Service (1), Number of Units (visits) and Requested Unit Type (2). The number of visits **MUST** match for the diagnostics and the referrals details.
When completed, click the “OK” button (3).



Medicare HMO and Verizon can request unlimited visits so input 9999 in each field.

EXCEPTIONS: For Medicare HMO: Nutritional Counseling-provider can request 1 visit

9. Click “Next.”



Accordian 6: Additional Notes

1. Add supporting documentation, if needed.
    - Click “Add Note/Attachments.”
    - Click “Submit.”

If no supporting documentation is needed, click “Submit” and follow prompts.

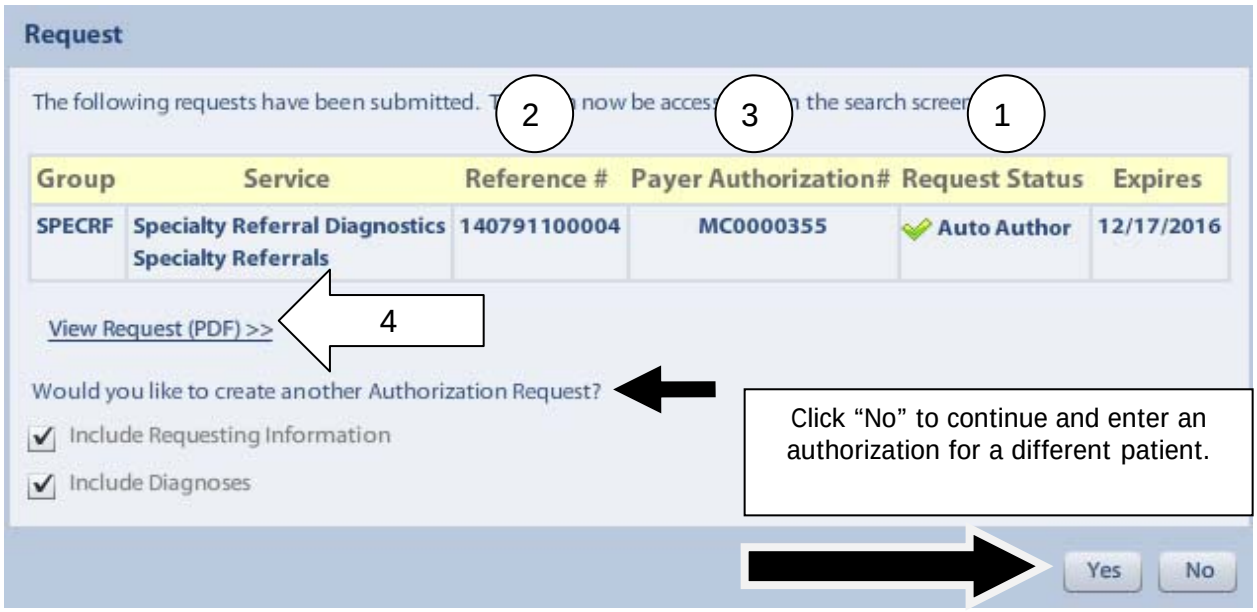
Clear Coverage™
Specialty Referral Requests Authorization Entry Tips

Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.

The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



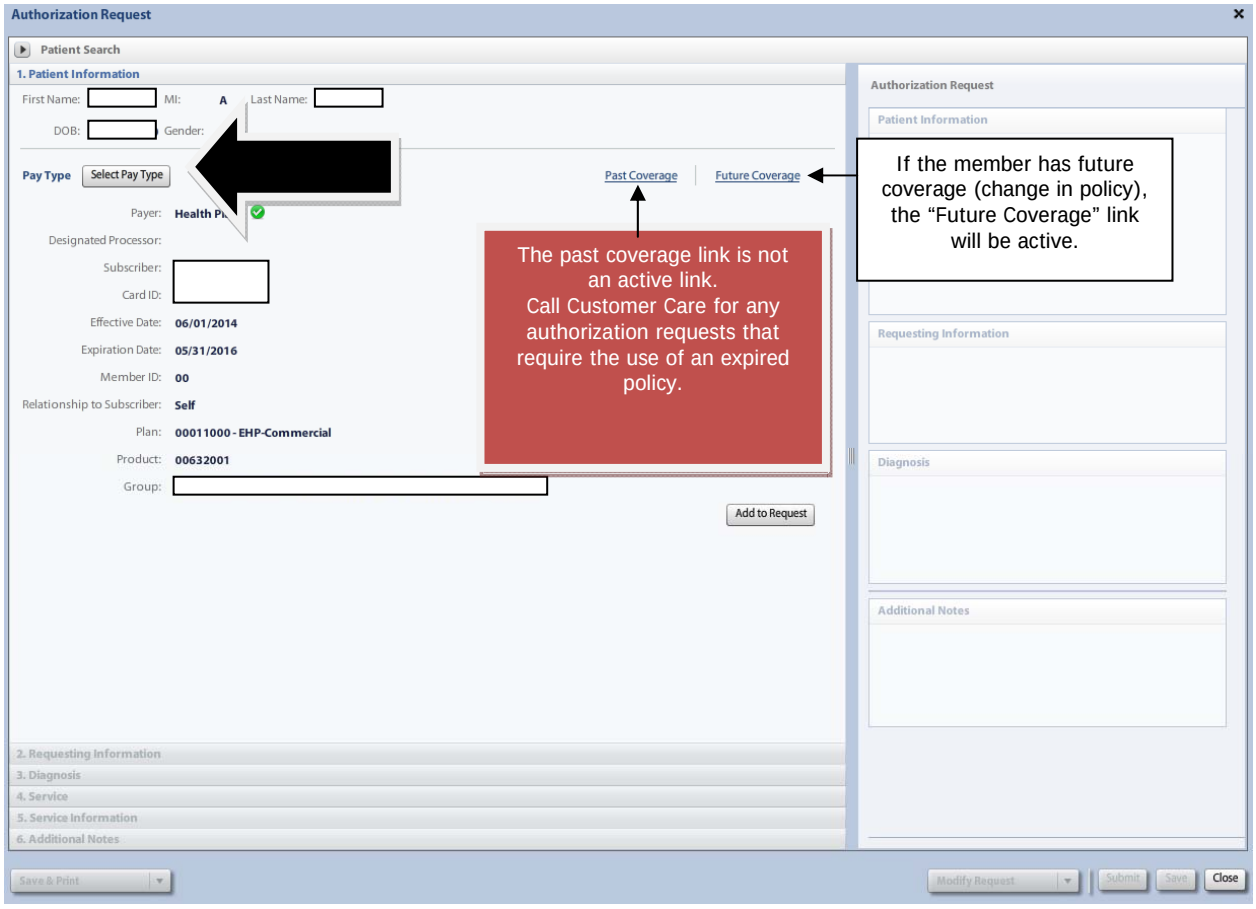
Clear Coverage™
Spine Surgery Authorization Entry Tips

All requests for Spine Surgery will pend for medical necessity review by the Health Plan. The review tool MUST be completed to provide clinical information and the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

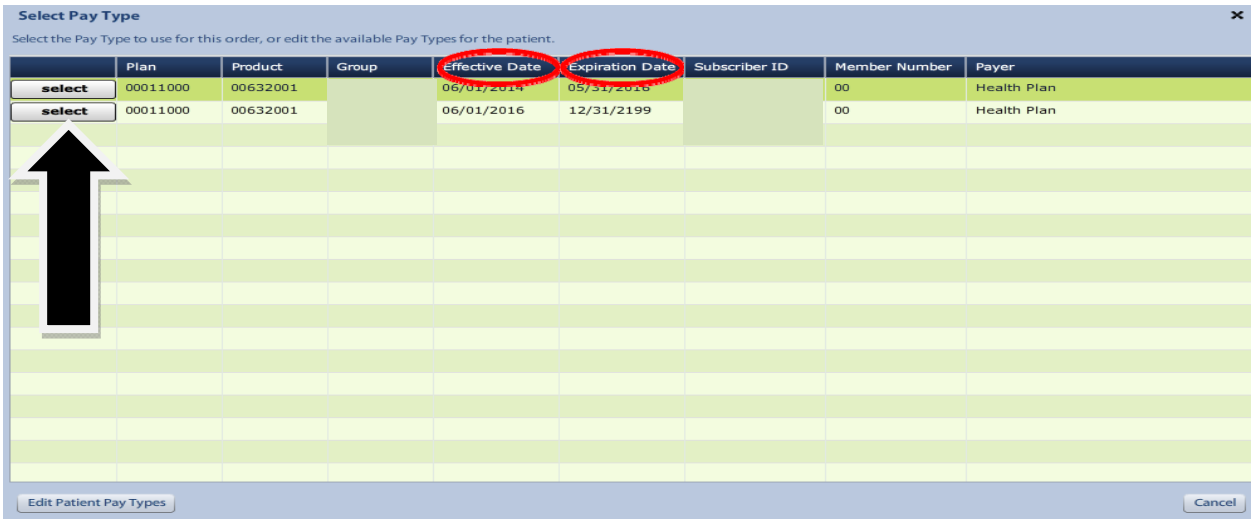


Clear Coverage™
Spine Surgery Authorization Entry Tips

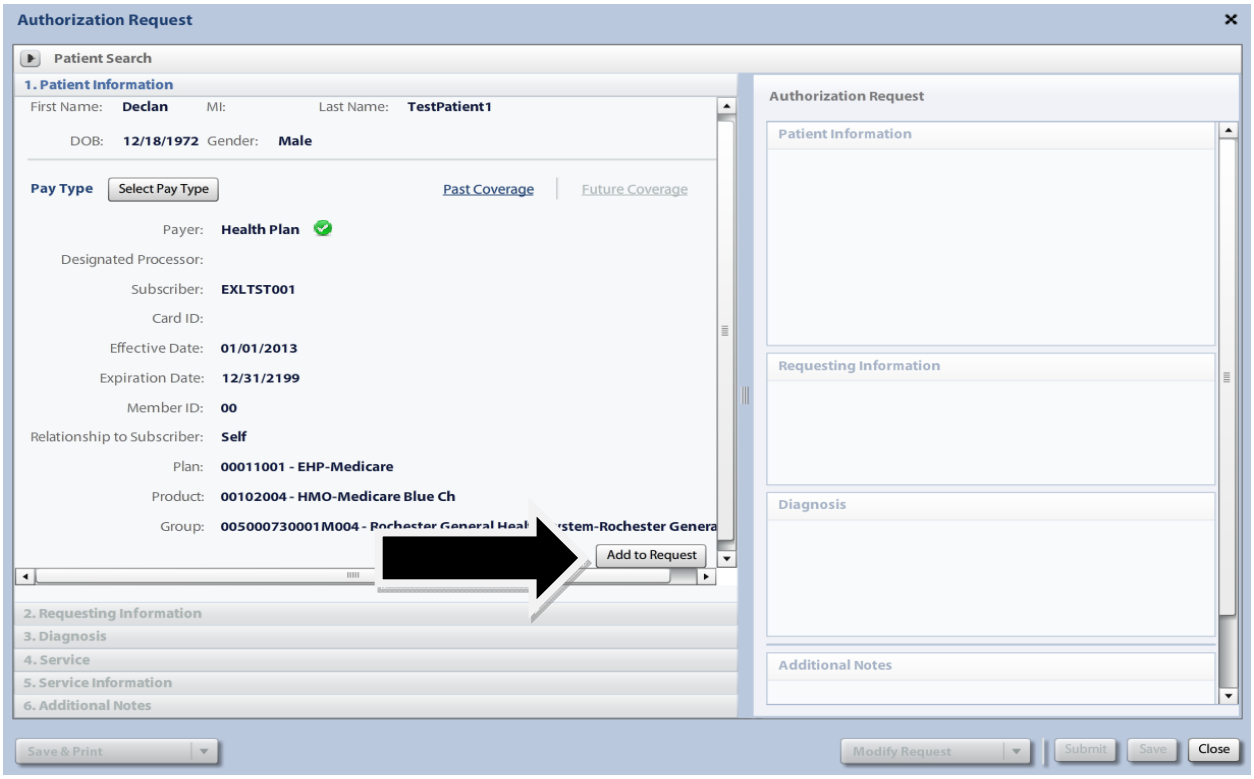
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

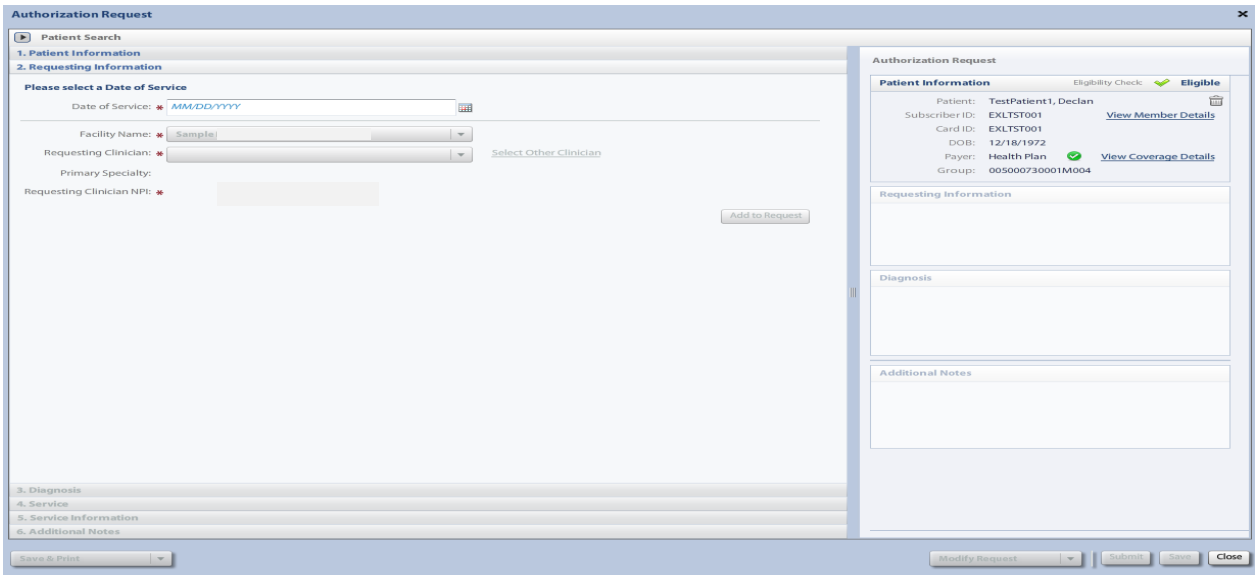


Clear Coverage™
Spine Surgery Authorization Entry Tips

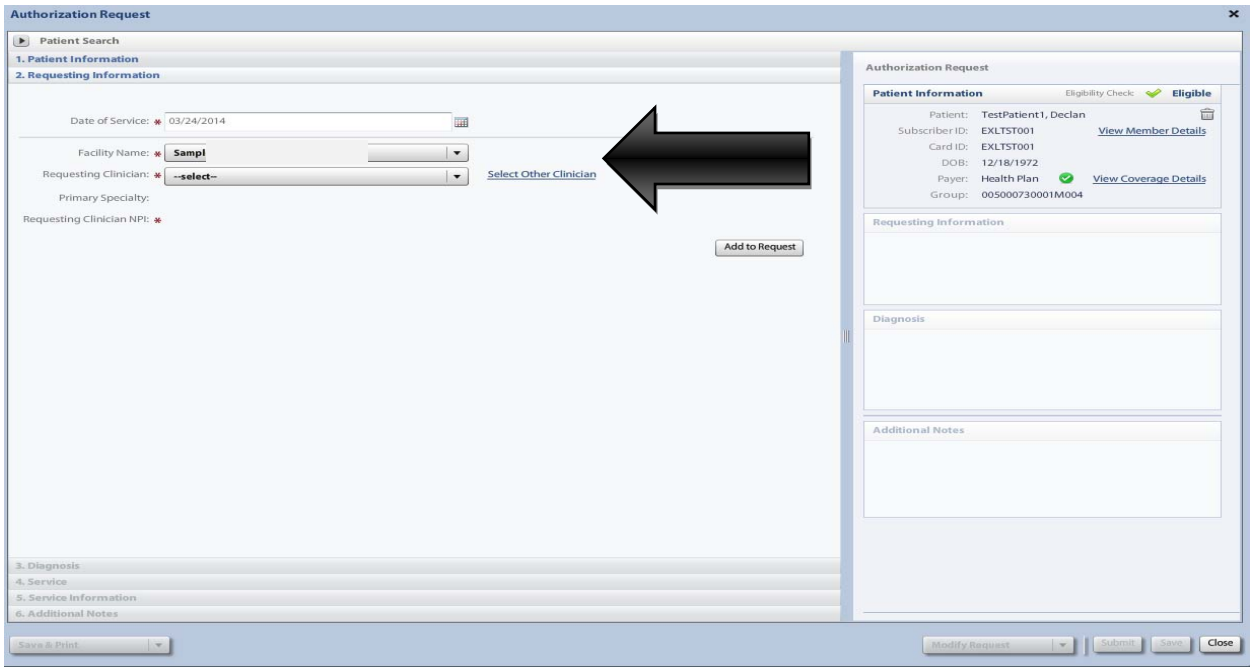
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

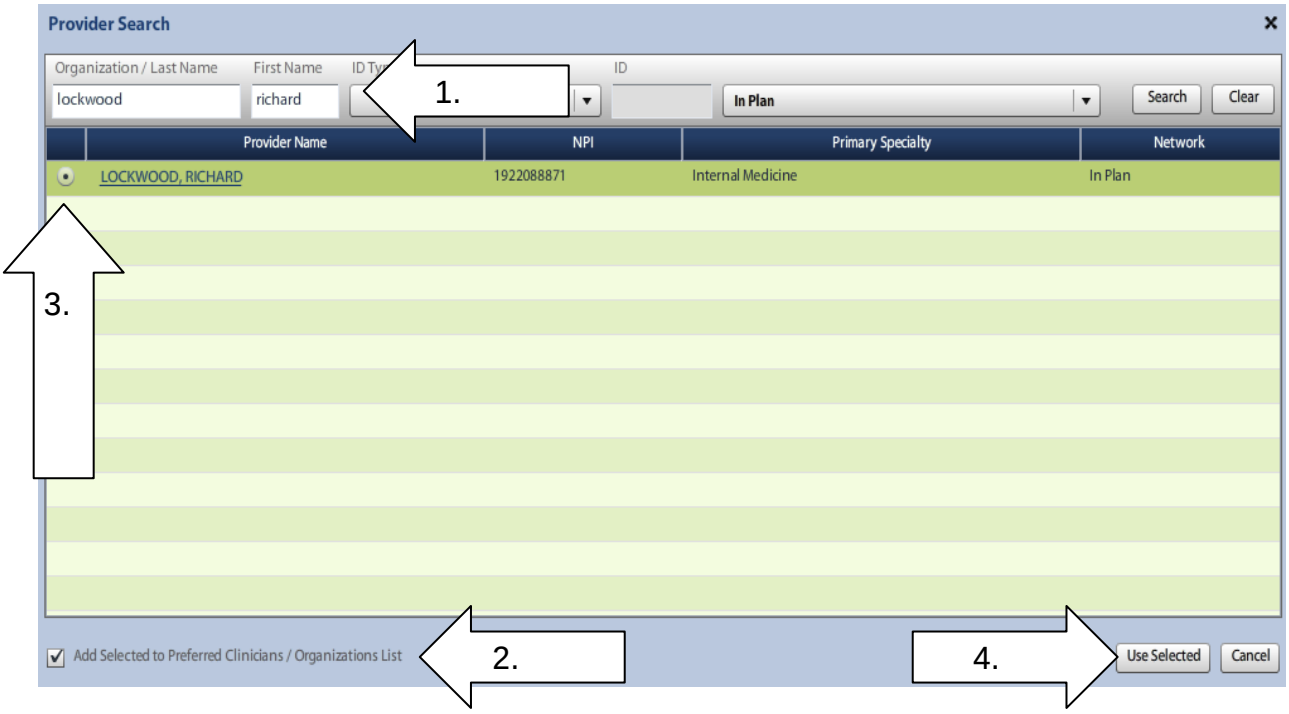


Clear Coverage™
Spine Surgery Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

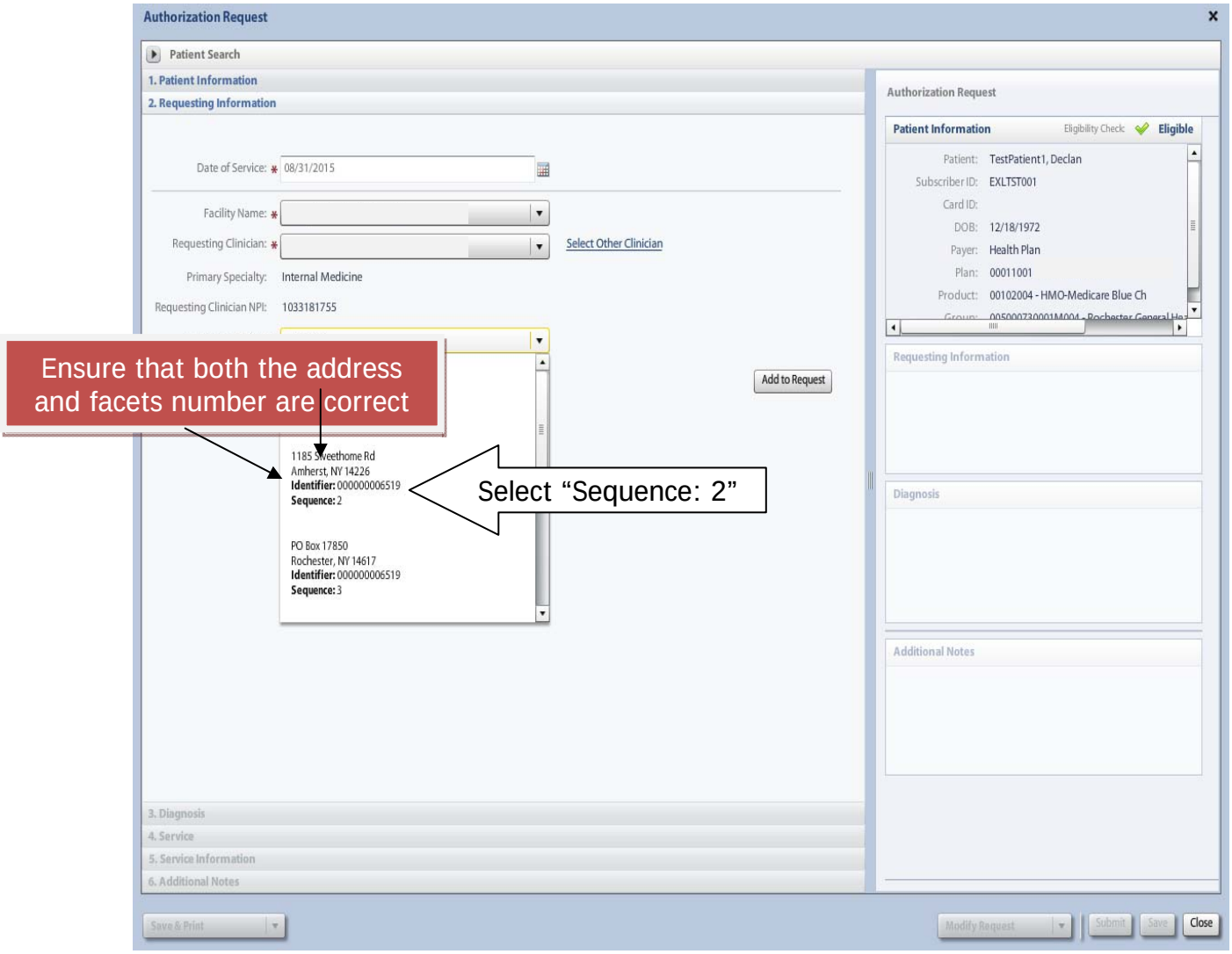
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Spine Surgery Authorization Entry Tips

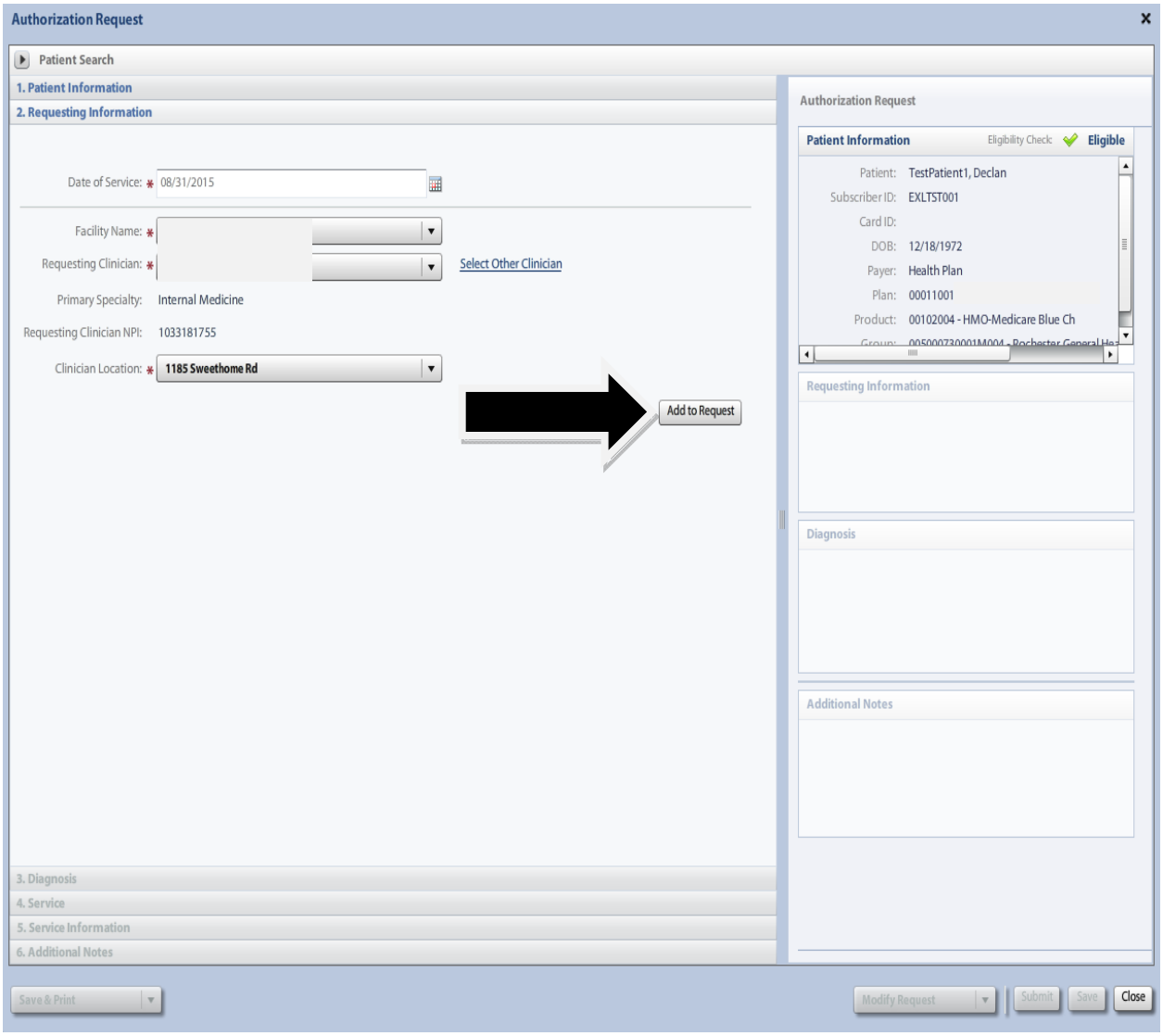
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Spine Surgery Authorization Entry Tips

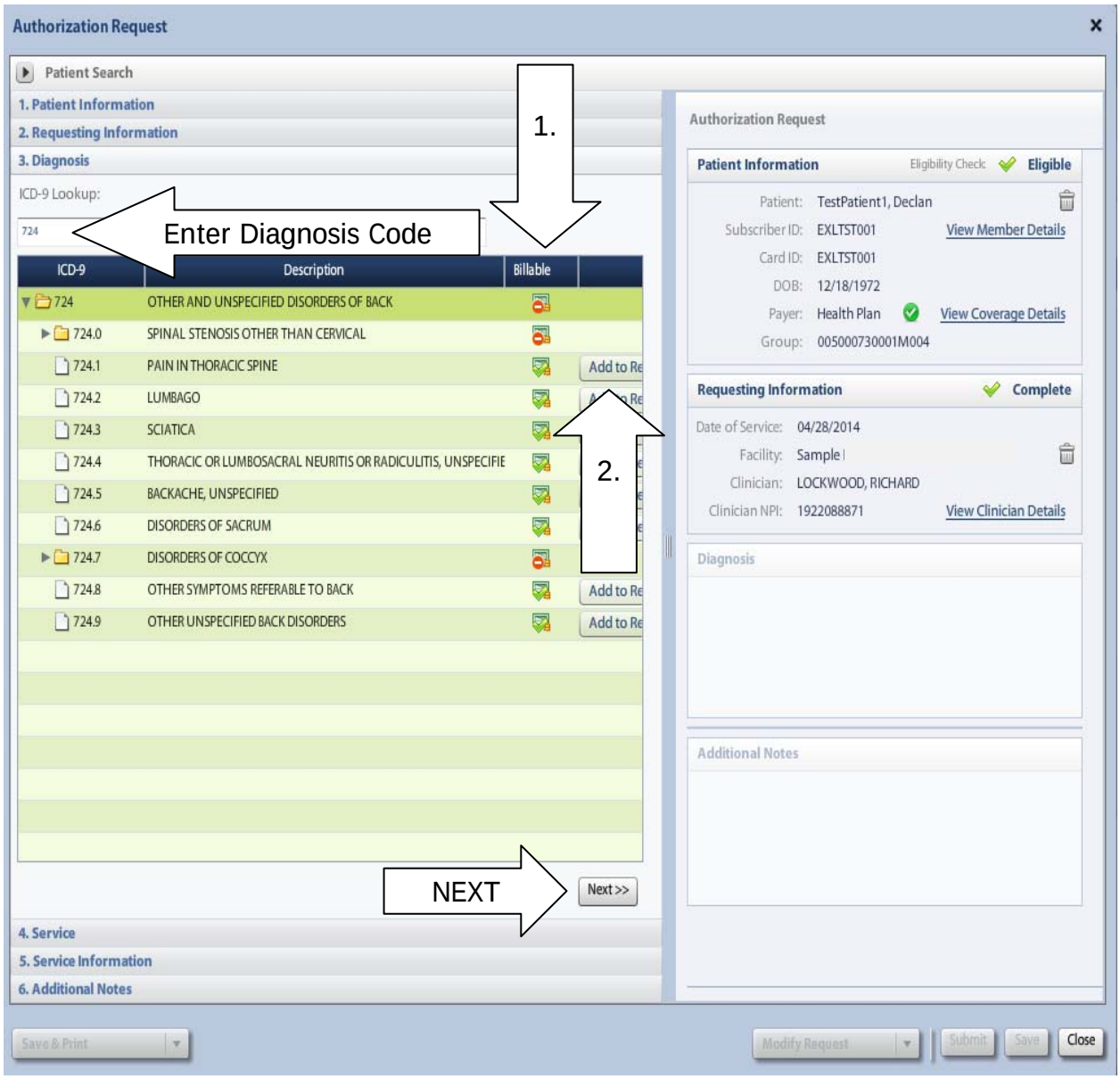
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Spine Surgery Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

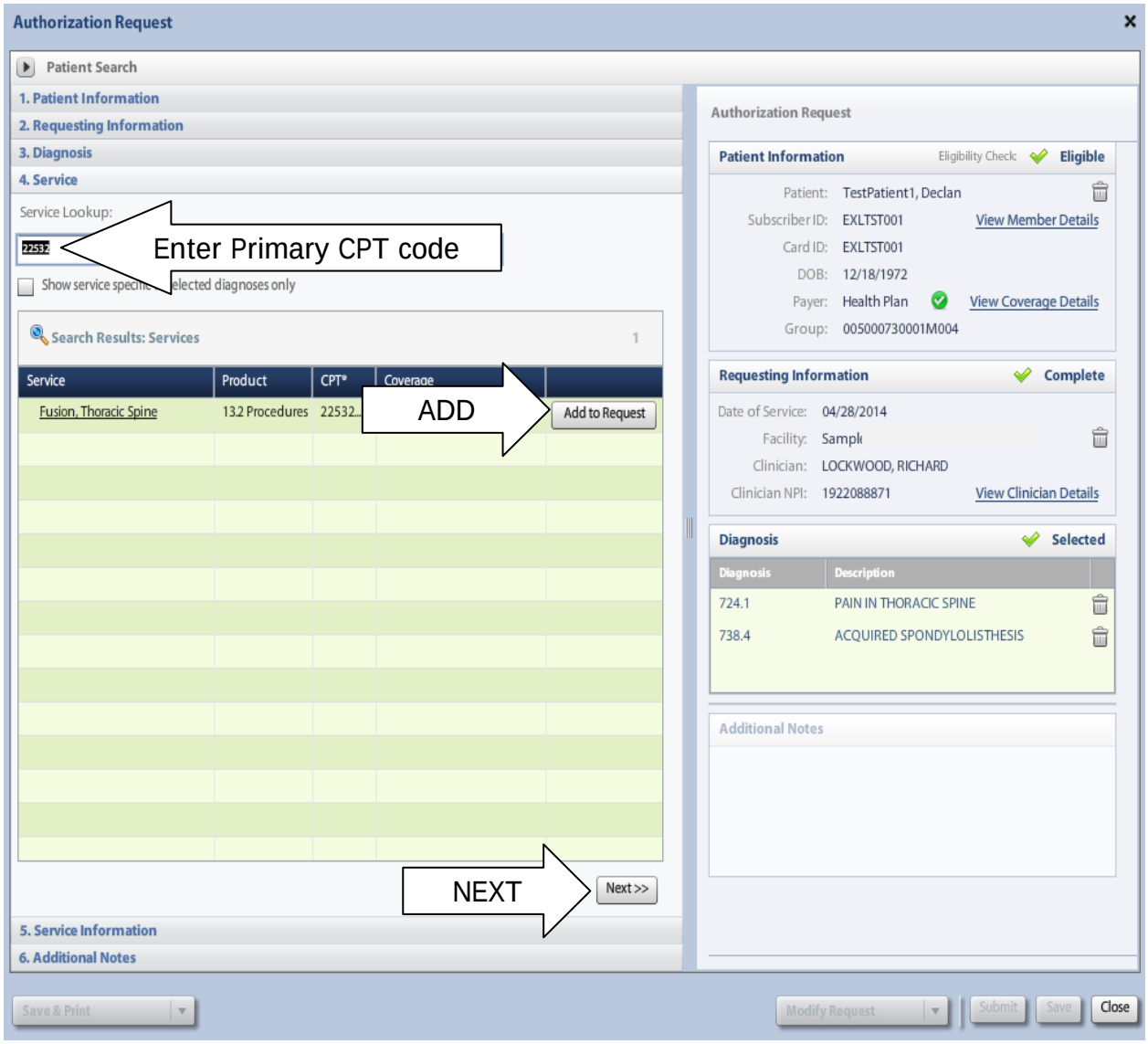


Clear Coverage™
Spine Surgery Authorization Entry Tips

Accordion 4: Services

Enter primary CPT code only. **Note:** All other CPT codes will be entered in accordion 6.

- Click the "Add to Request" button, then click "Next."



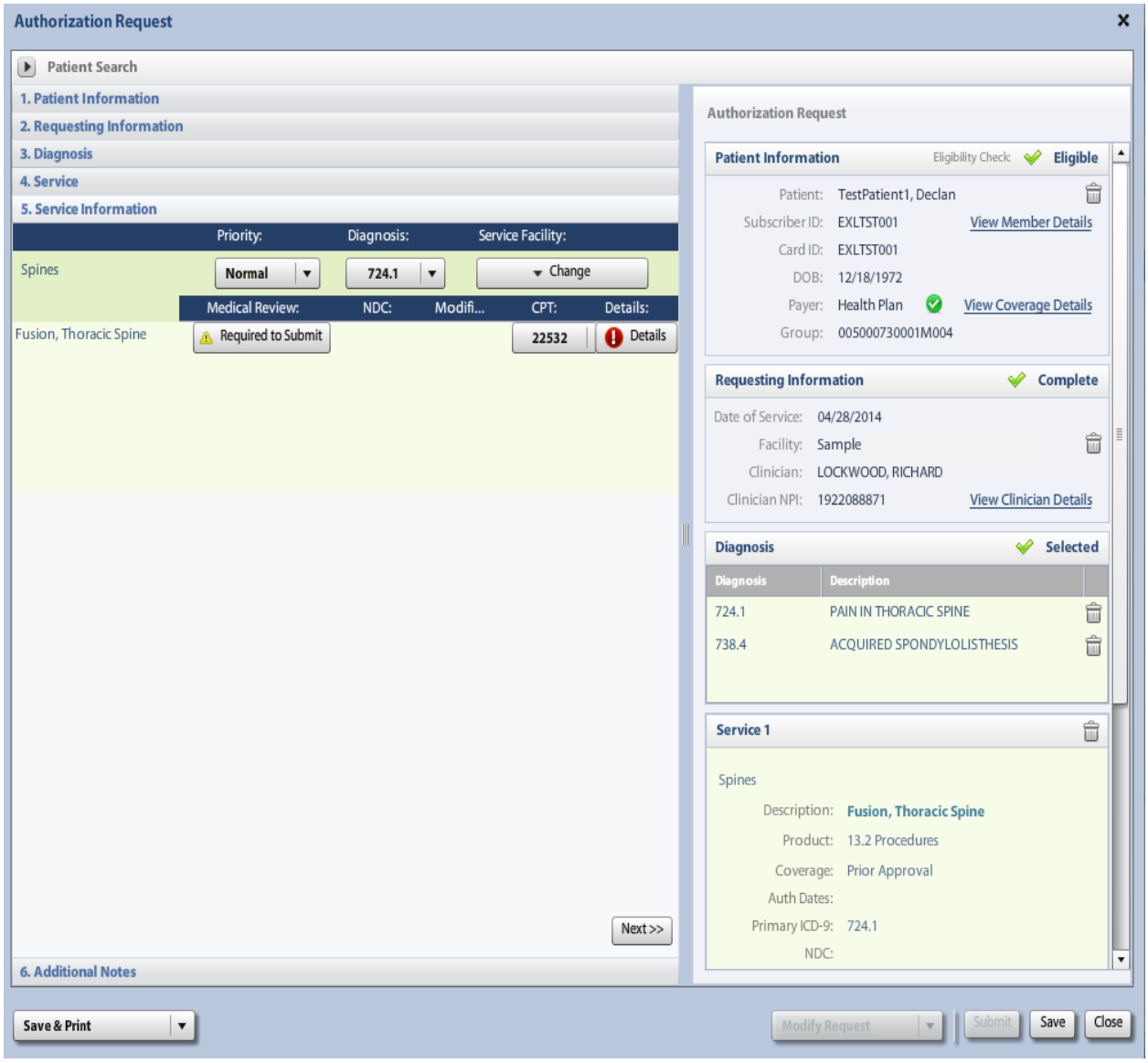
Clear Coverage™
Spine Surgery Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

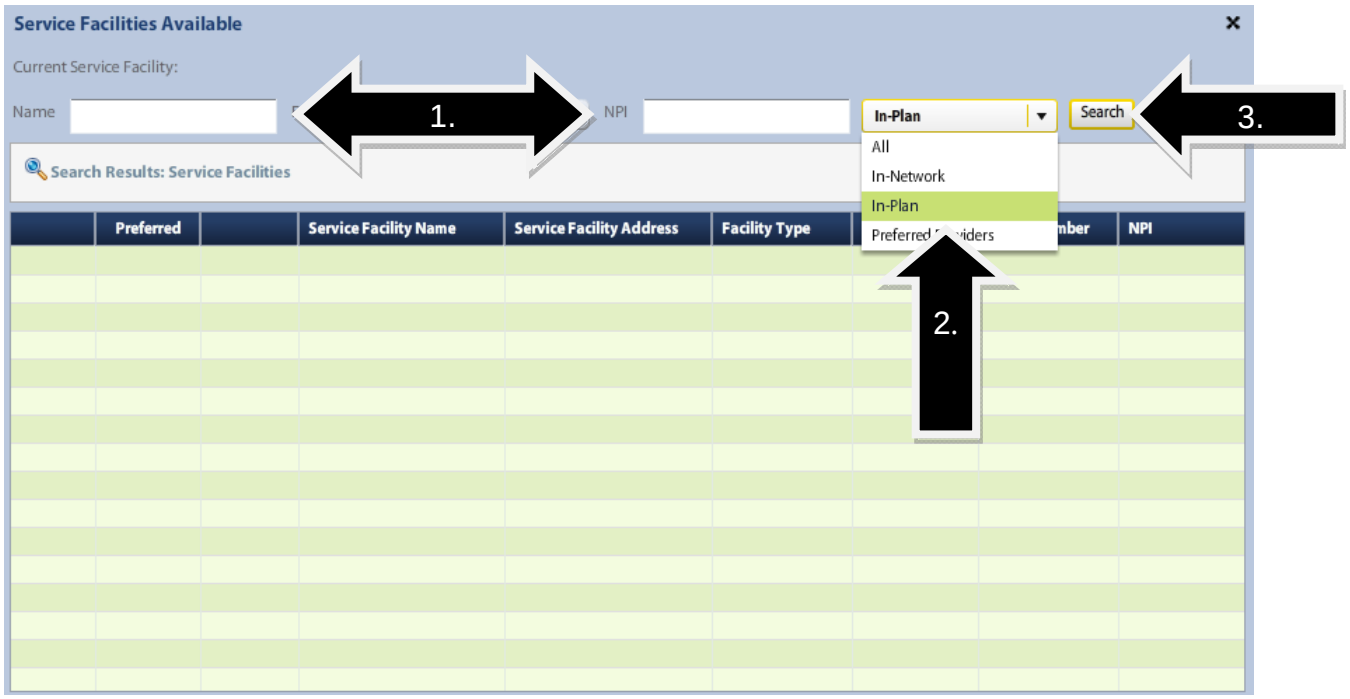
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service



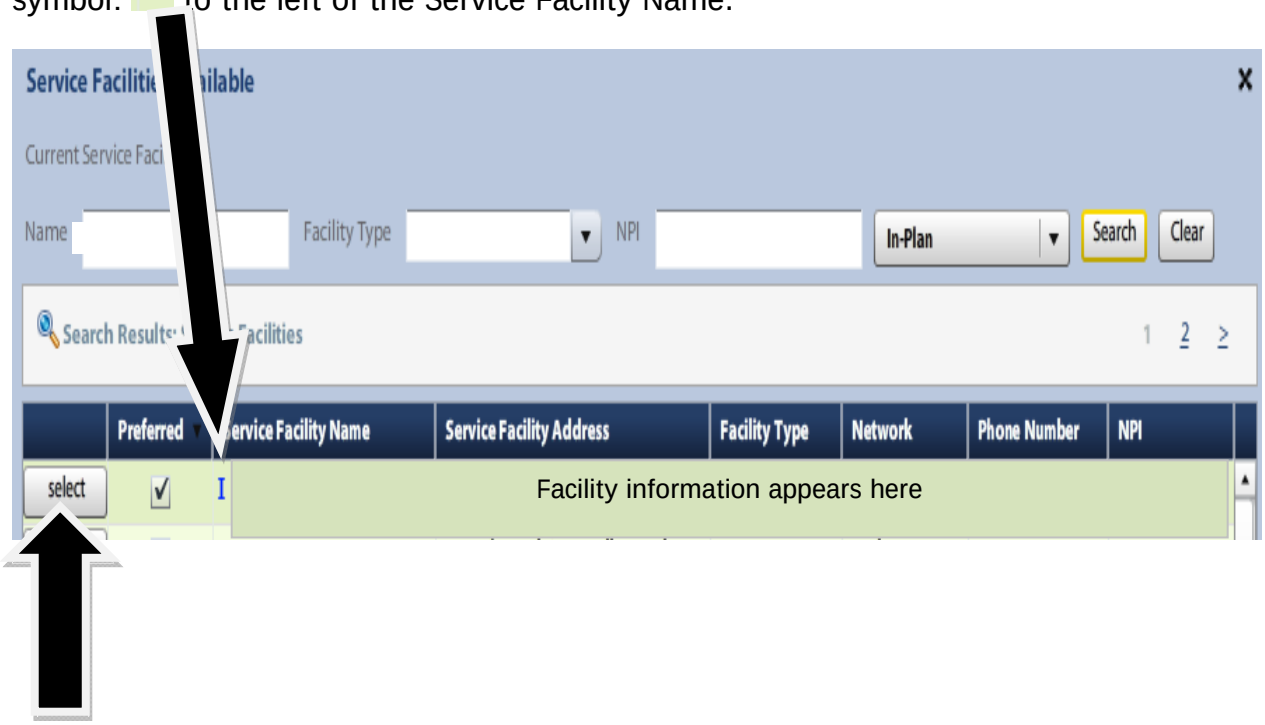
Clear Coverage™
Spine Surgery Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend even if it meets criteria). Click the “Search” button (3).



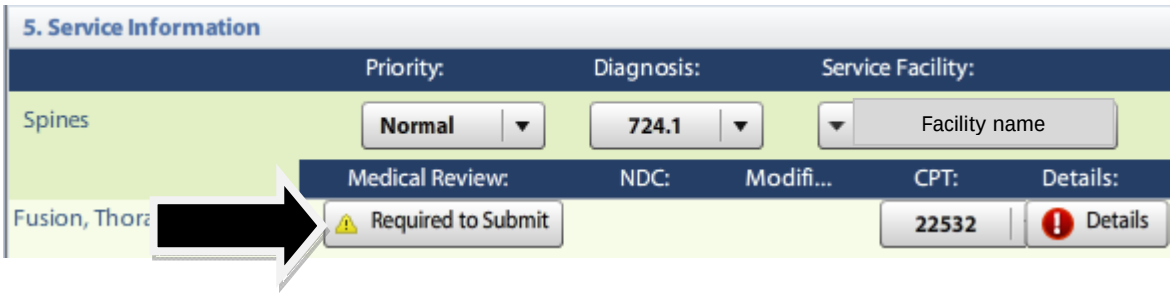
When the results display, select the appropriate provider.

IMPORTANT NOTE: When selecting the facility, ensure that the facility chosen has this symbol: I to the left of the Service Facility Name.

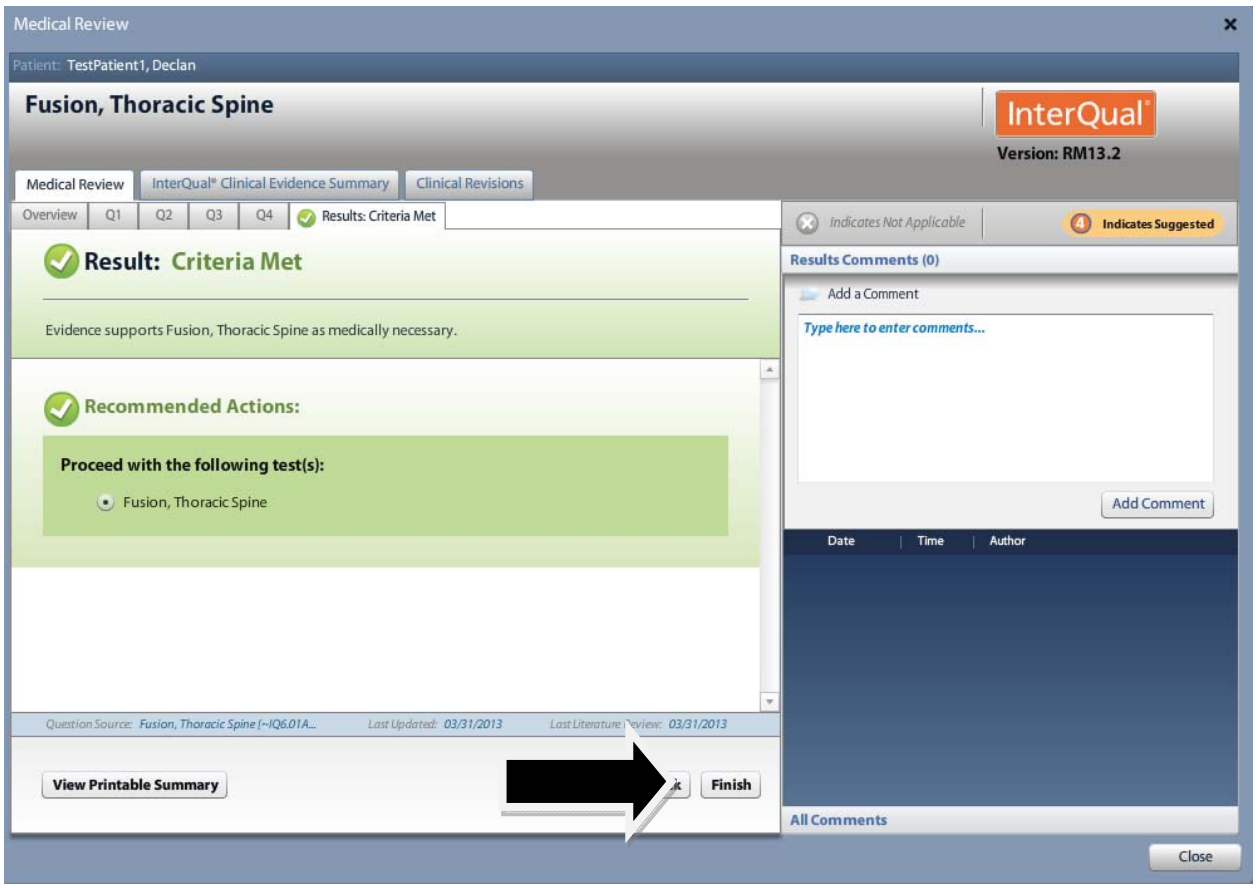


Clear Coverage™
Spine Surgery Authorization Entry Tips

Click on the Medical Review "Required to Submit" tab and complete the review.



If criteria met: Click "Finish."

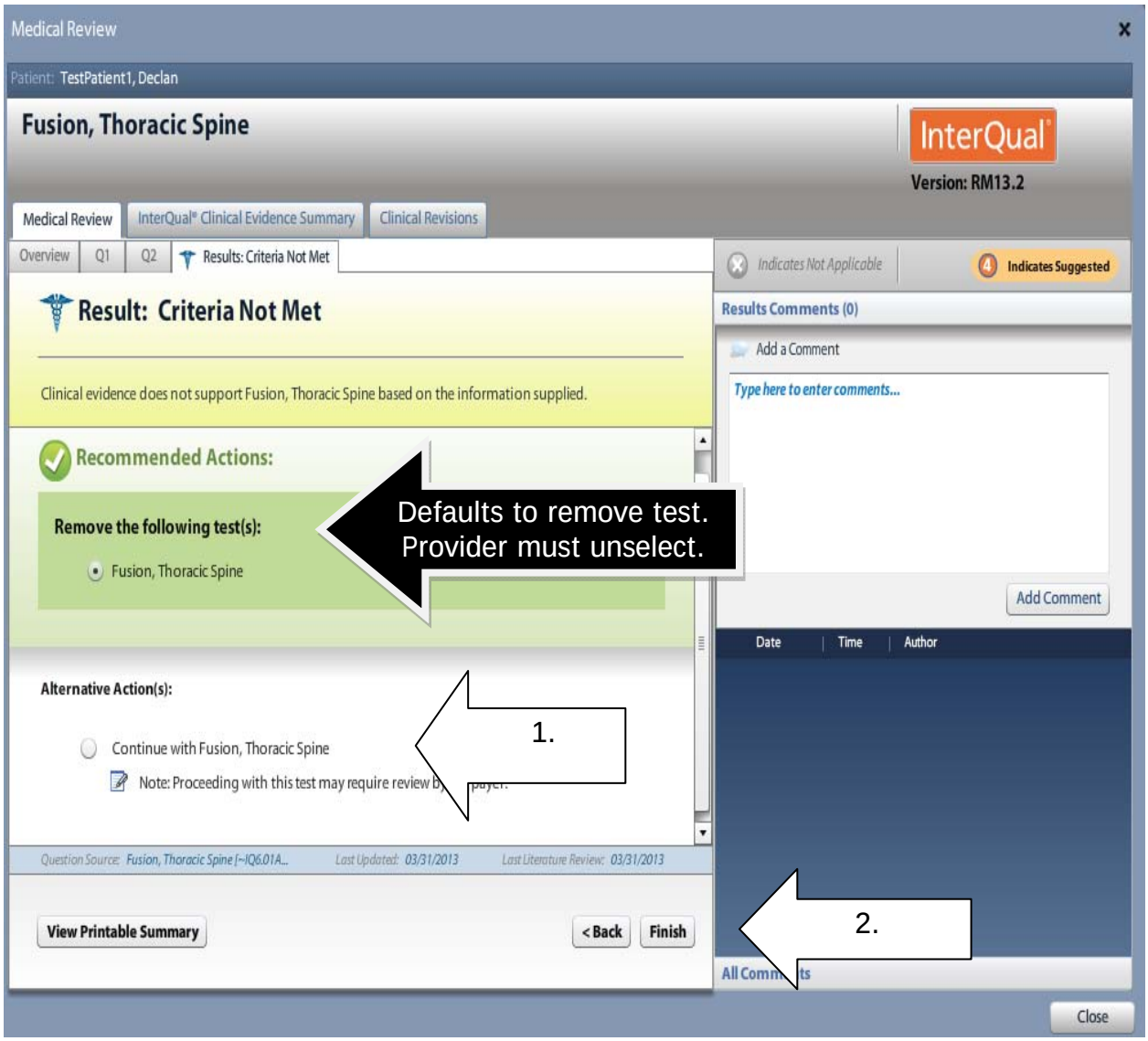


Clear Coverage™
Spine Surgery Authorization Entry Tips

If criteria not met:

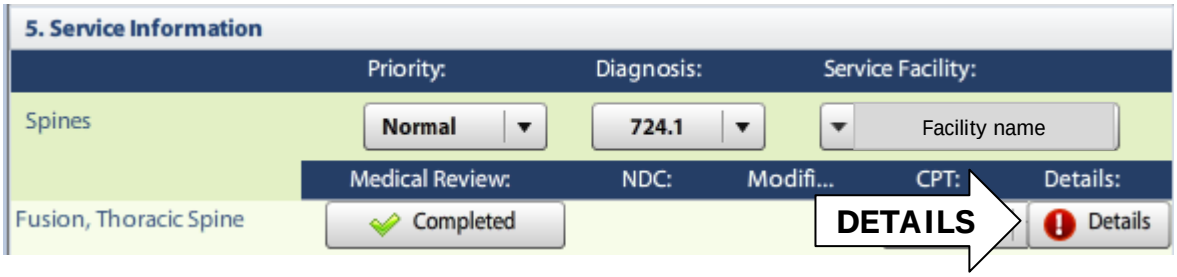
The default choice is to **remove** the item from the request.

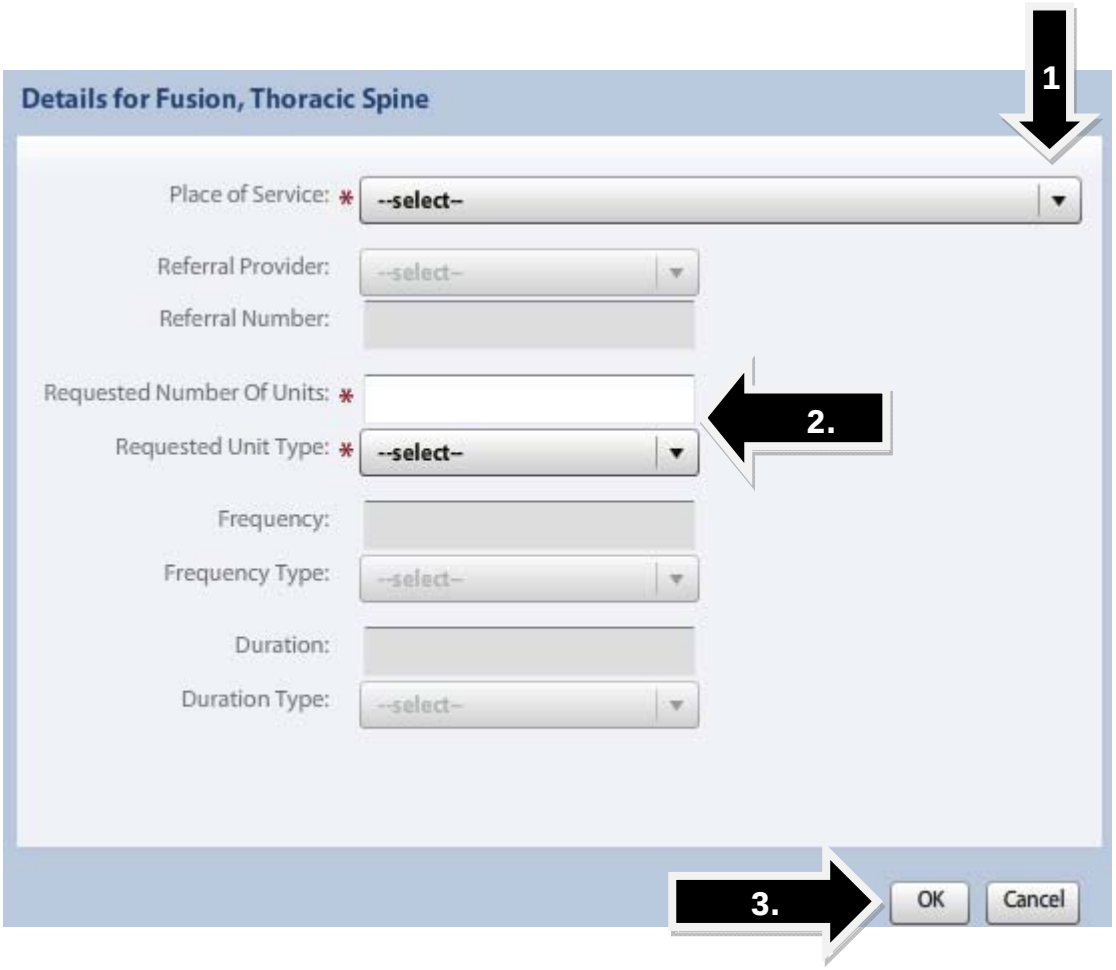
1. You **must** click the button under Alternative Action(s) to “Continue with Fusion, Thoracic Spine” (or appropriate requested item) if you wish the request to pend to the Health Plan for review (1). Click “Finish” (2).



Clear Coverage™
Spine Surgery Authorization Entry Tips

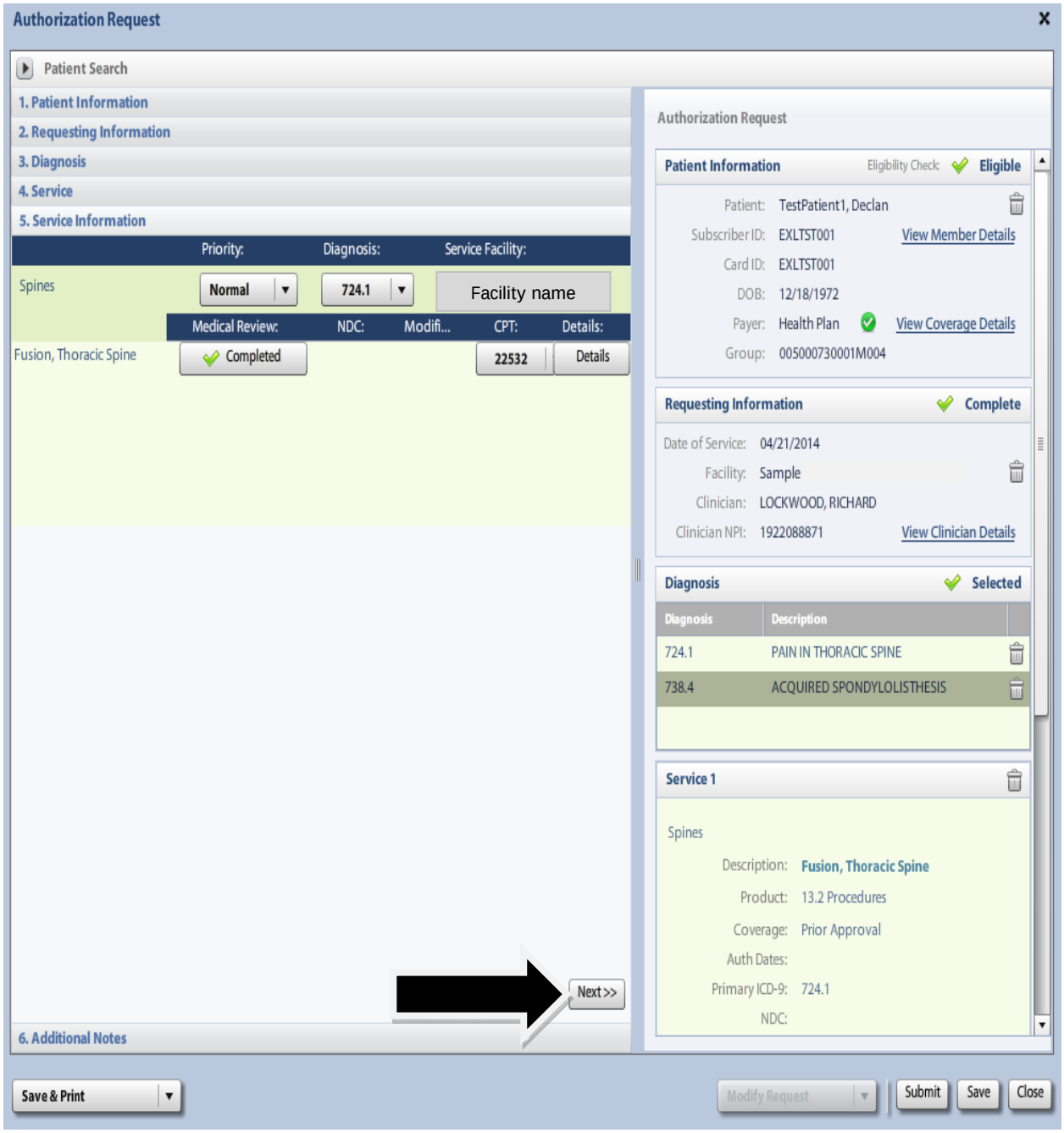
Details section: Must select: (1) Place of Service, (2) Requested Number of Units and Requested Unit Type**.** Click the "OK" button (3).





Clear Coverage™
Spine Surgery Authorization Entry Tips

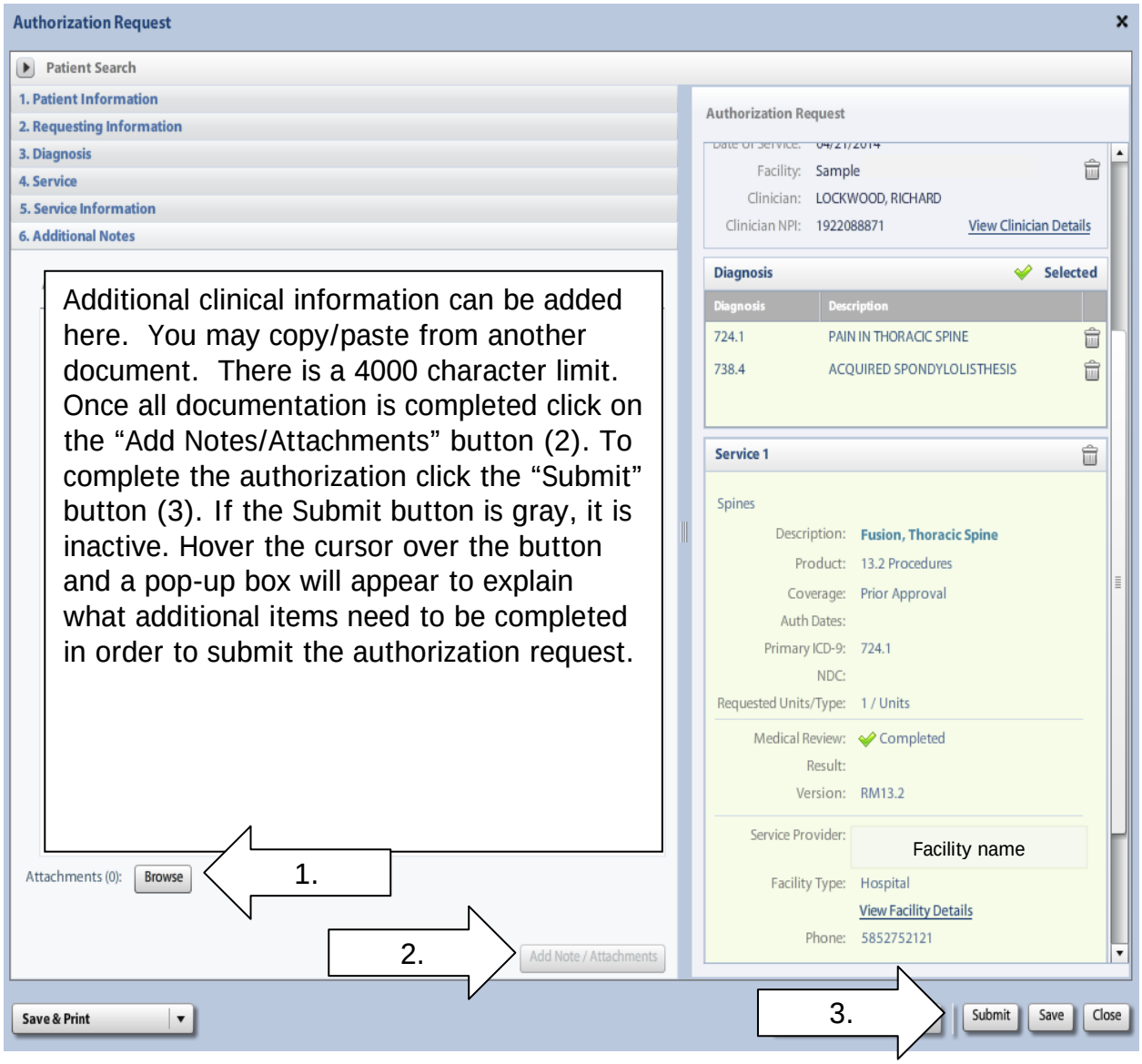
Click “Next.”



Clear Coverage™
Spine Surgery Authorization Entry Tips

Accordian 6: Additional Notes

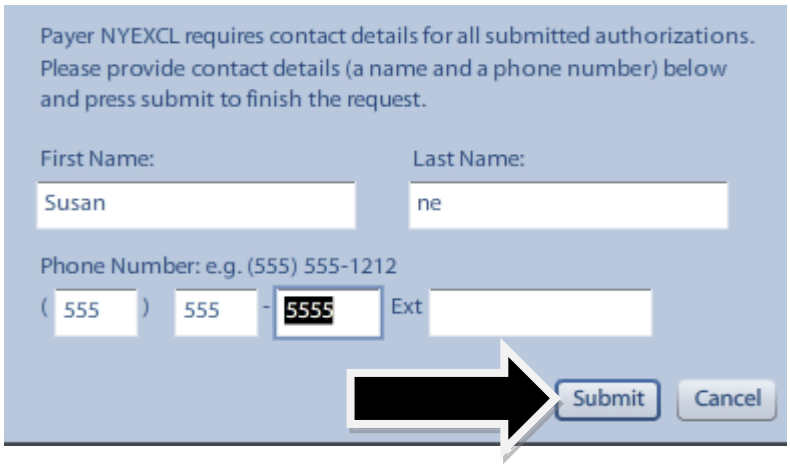
Enter all additional CPT codes in this section first. Next, add any additional clinical information and/or attach a note with supporting medical documentation (1). A note must be added in order to attach a document.



Clear Coverage™
Spine Surgery Authorization Entry Tips

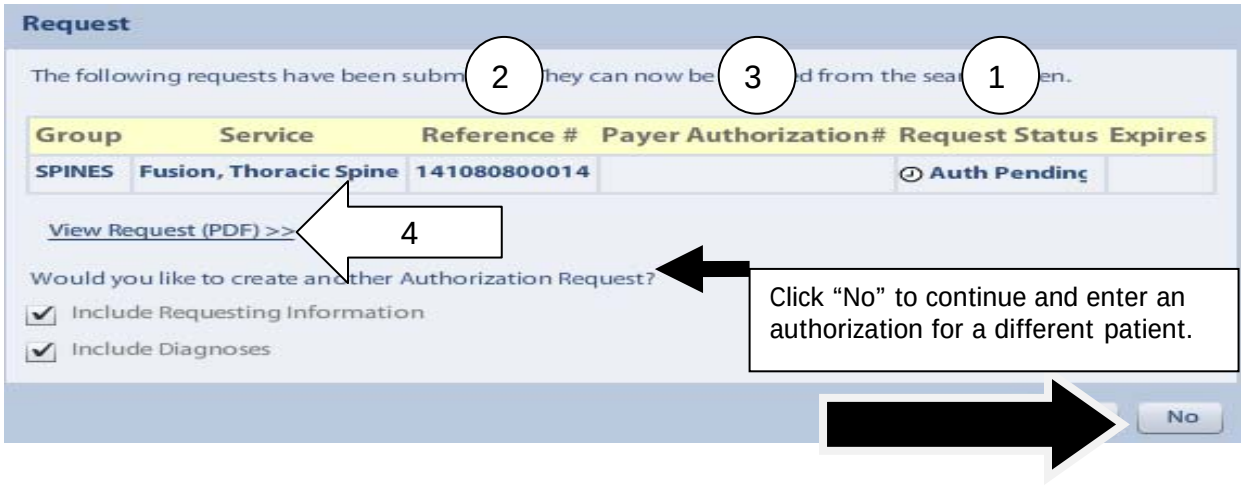
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Spine Surgery Authorization Entry Tips

Note: Once your request is reviewed by the Health Plan, your office will receive verbal and written notification of the status. You may also refer to the Clear Coverage™ "Home" page or conduct an authorization search for the status of the request.

If the request is for an approved inpatient procedure, you will receive two authorization numbers:

- The first authorization number is for the procedure(s).
- The second authorization number is for the inpatient stay at the servicing facility.

If the request is for a denied inpatient procedure, you will receive one authorization number beginning with "M".

If the request is for an approved or denied outpatient procedure, you will receive one authorization number beginning with "M".

Clear Coverage™
TENS Unit Authorization Entry Tips

Medicare: review tool MUST be completed to provide clinical information to the Health Plan. These requests will pend until this information is reviewed.

Commercial: will auto approve if criteria is met.

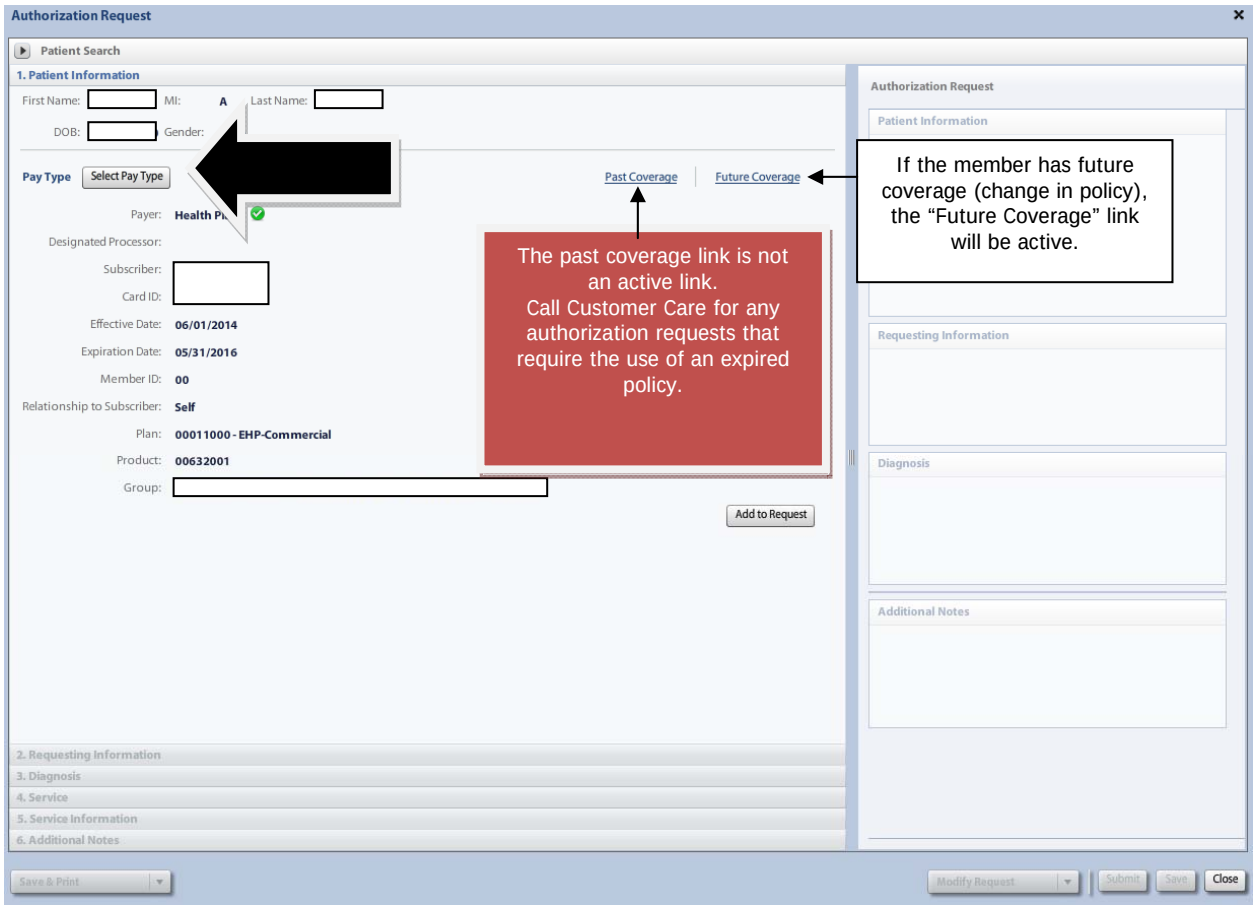
NOTE: If the request pends, the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

If the request is for **continued rental**, proceed to accordion 6 to attach a note (see page 18).

After searching for and selecting the patient, the Authorization Request Entry Box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

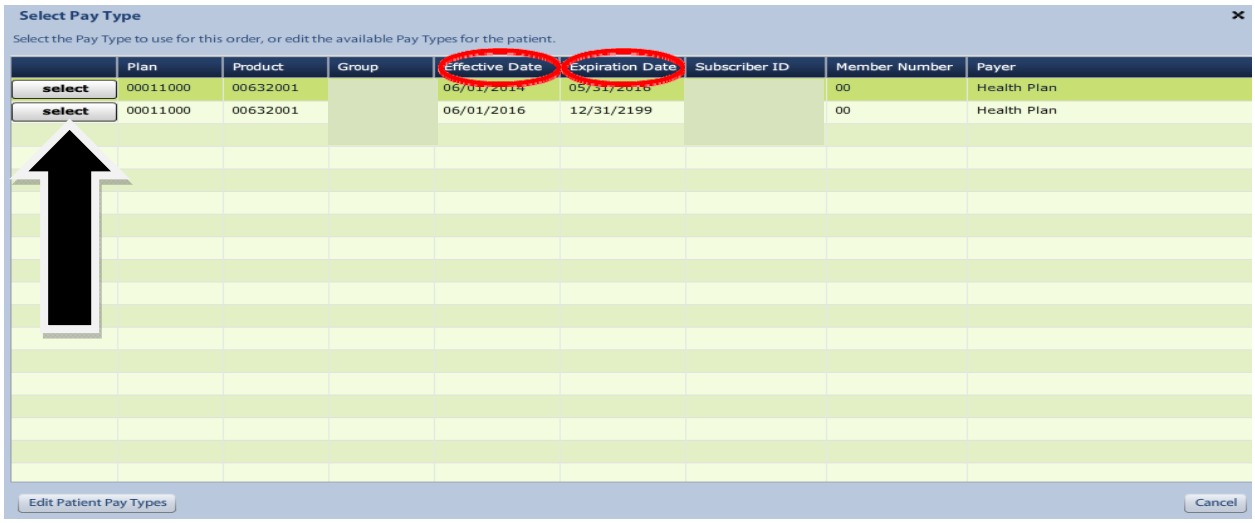


Clear Coverage™
TENS Unit Authorization Entry Tips

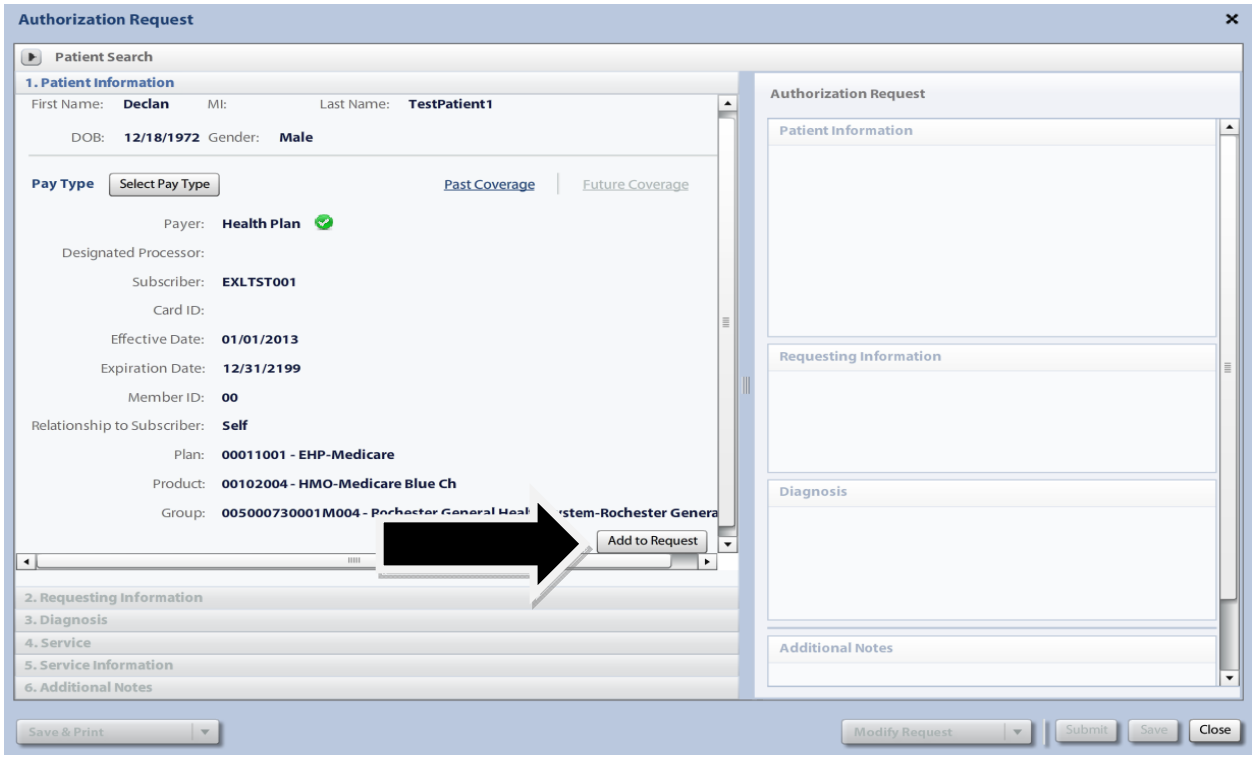
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

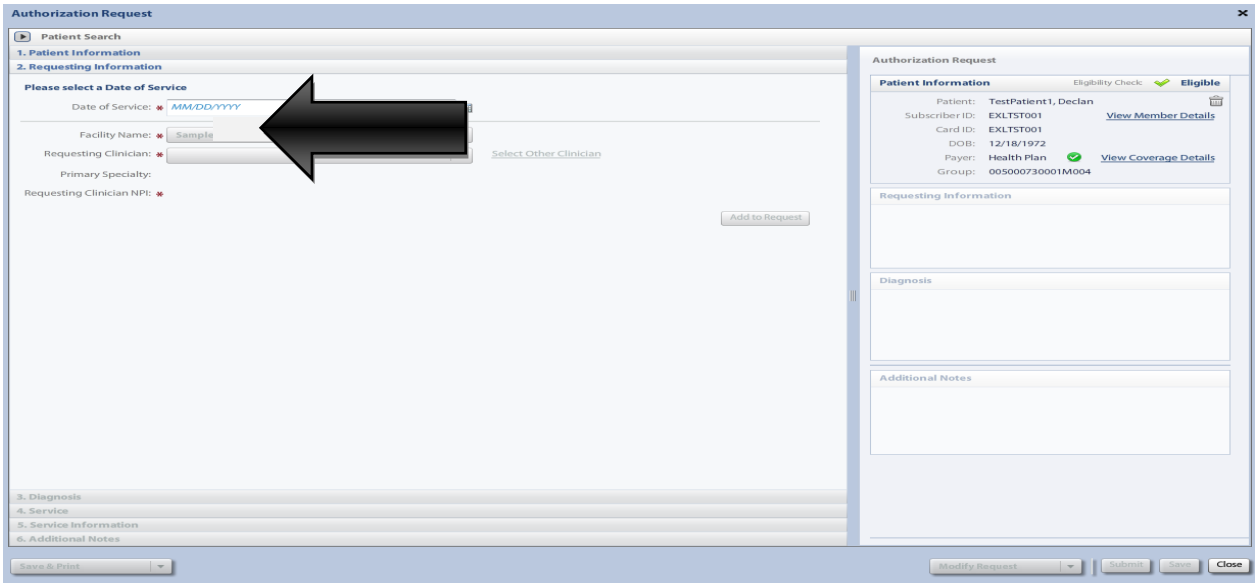


Clear Coverage™
TENS Unit Authorization Entry Tips

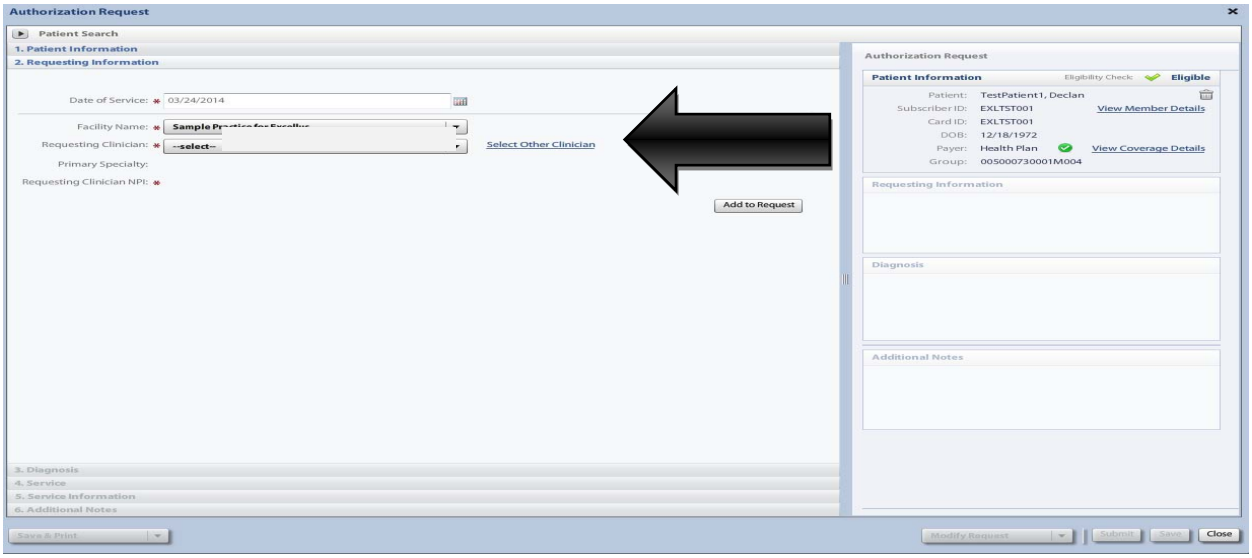
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do NOT enter a nurse practitioner, physician assistant, physical therapist or other provider. Click on "Select Other Clinician" to search.

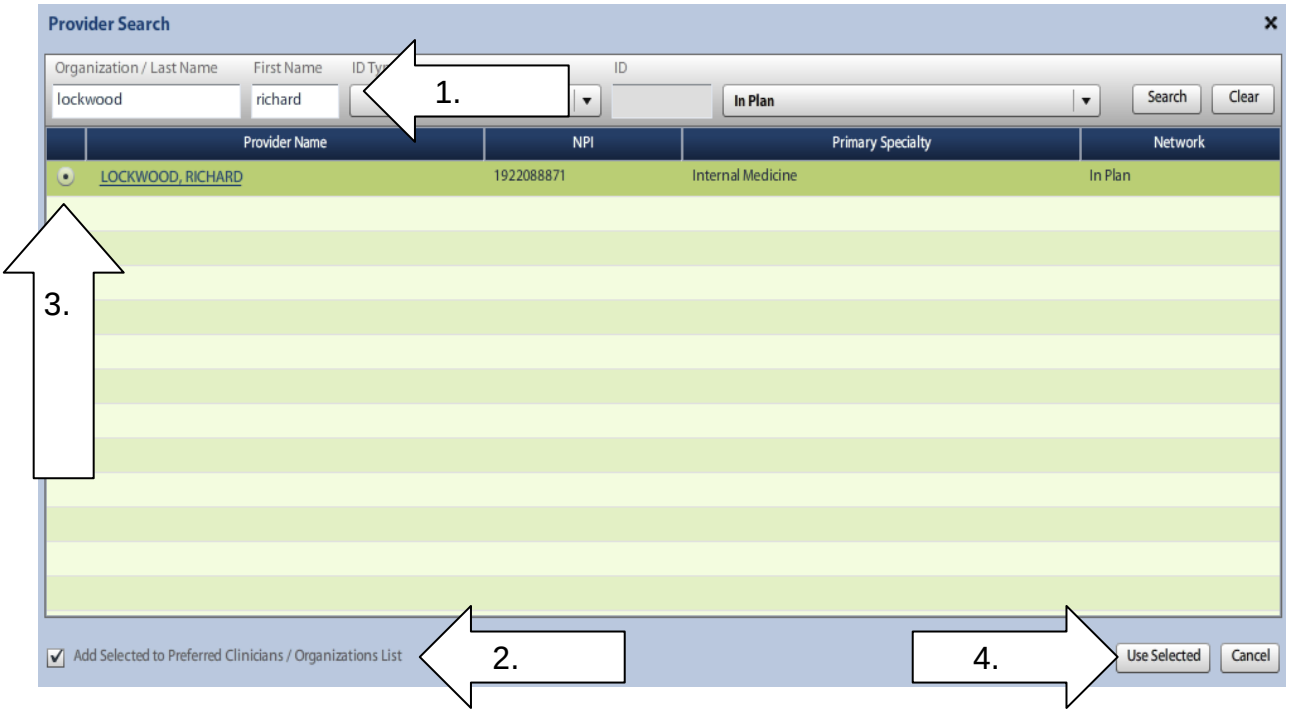


Clear Coverage™
TENS Unit Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

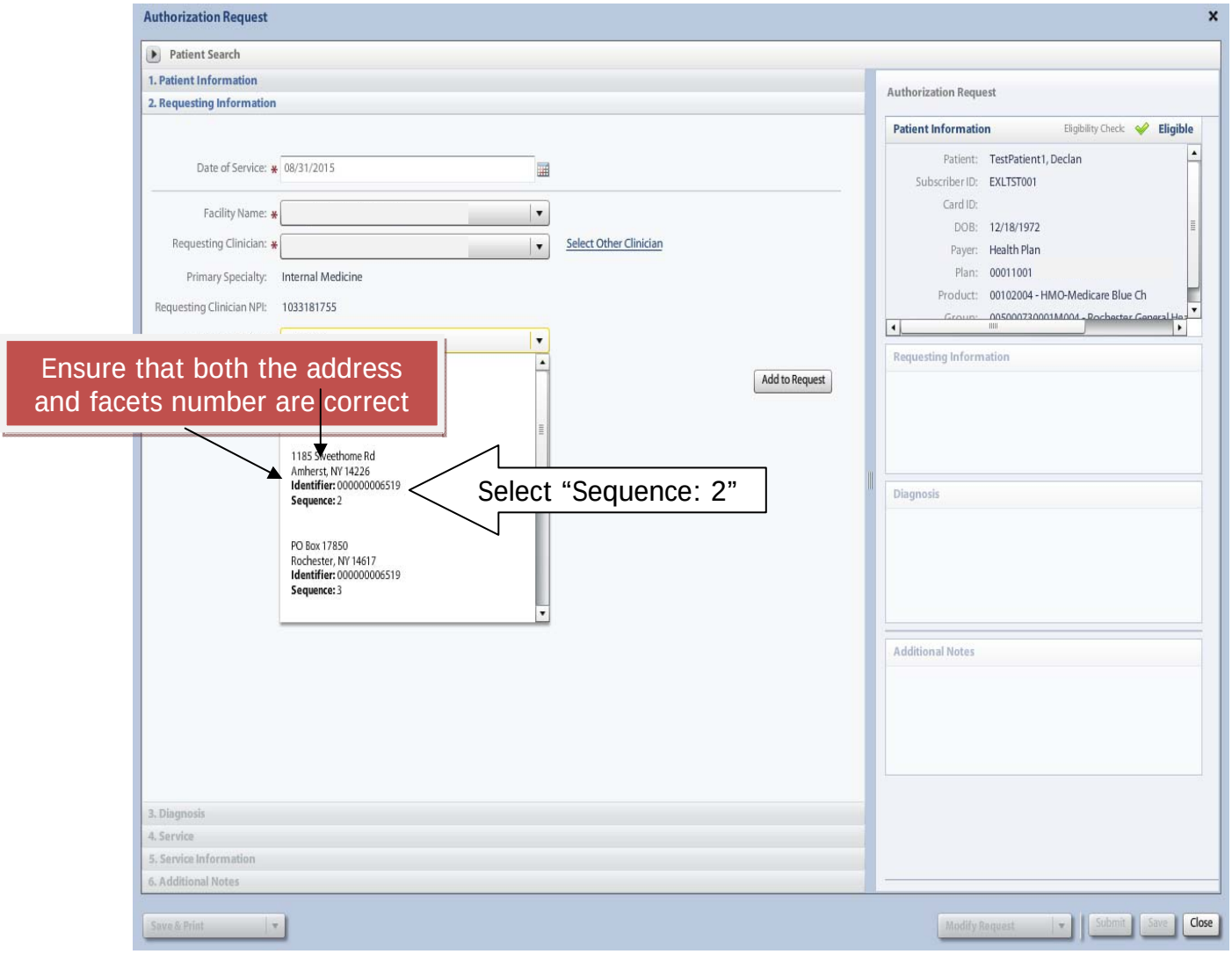
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
TENS Unit Authorization Entry Tips

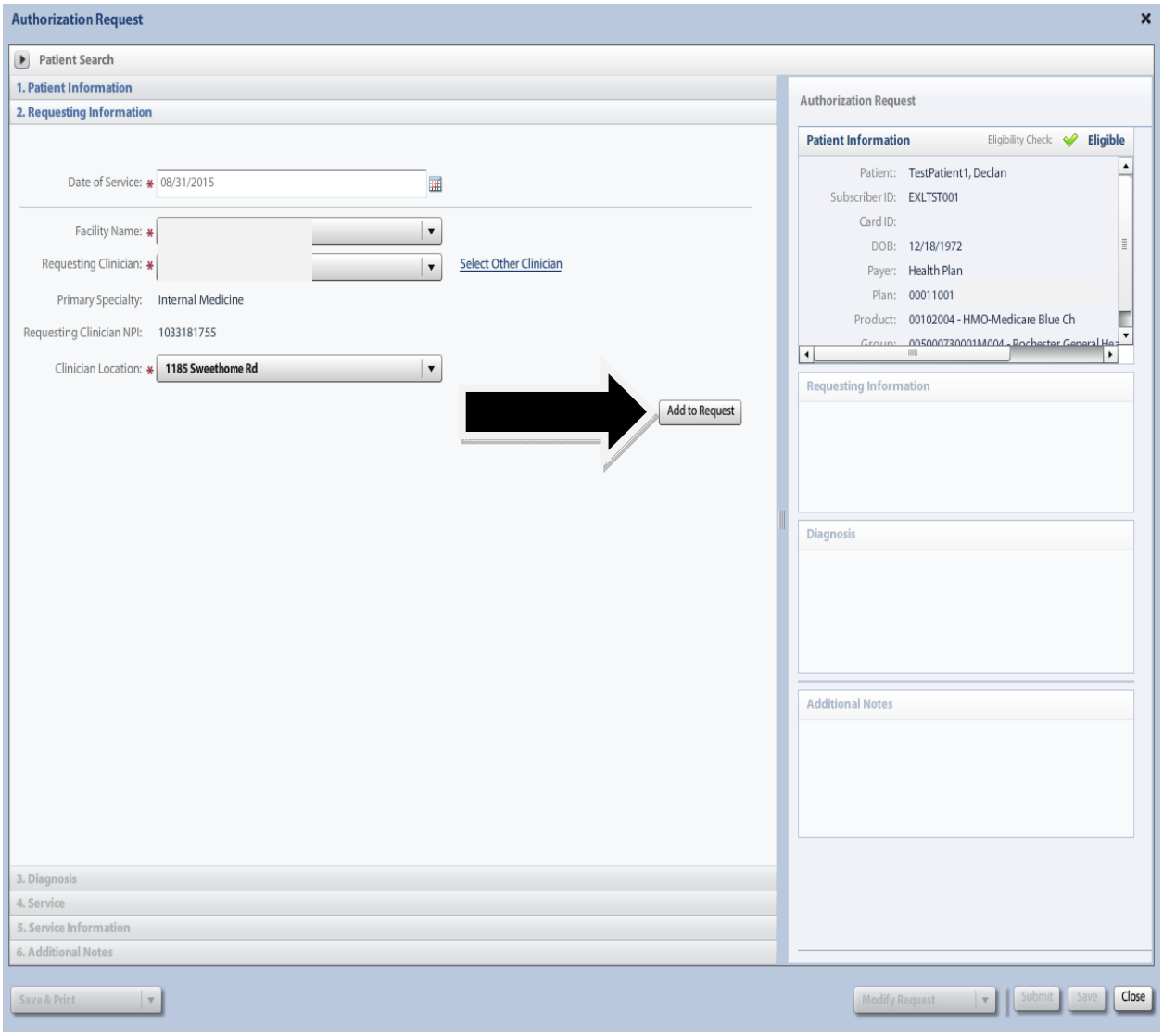
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
TENS Unit Authorization Entry Tips

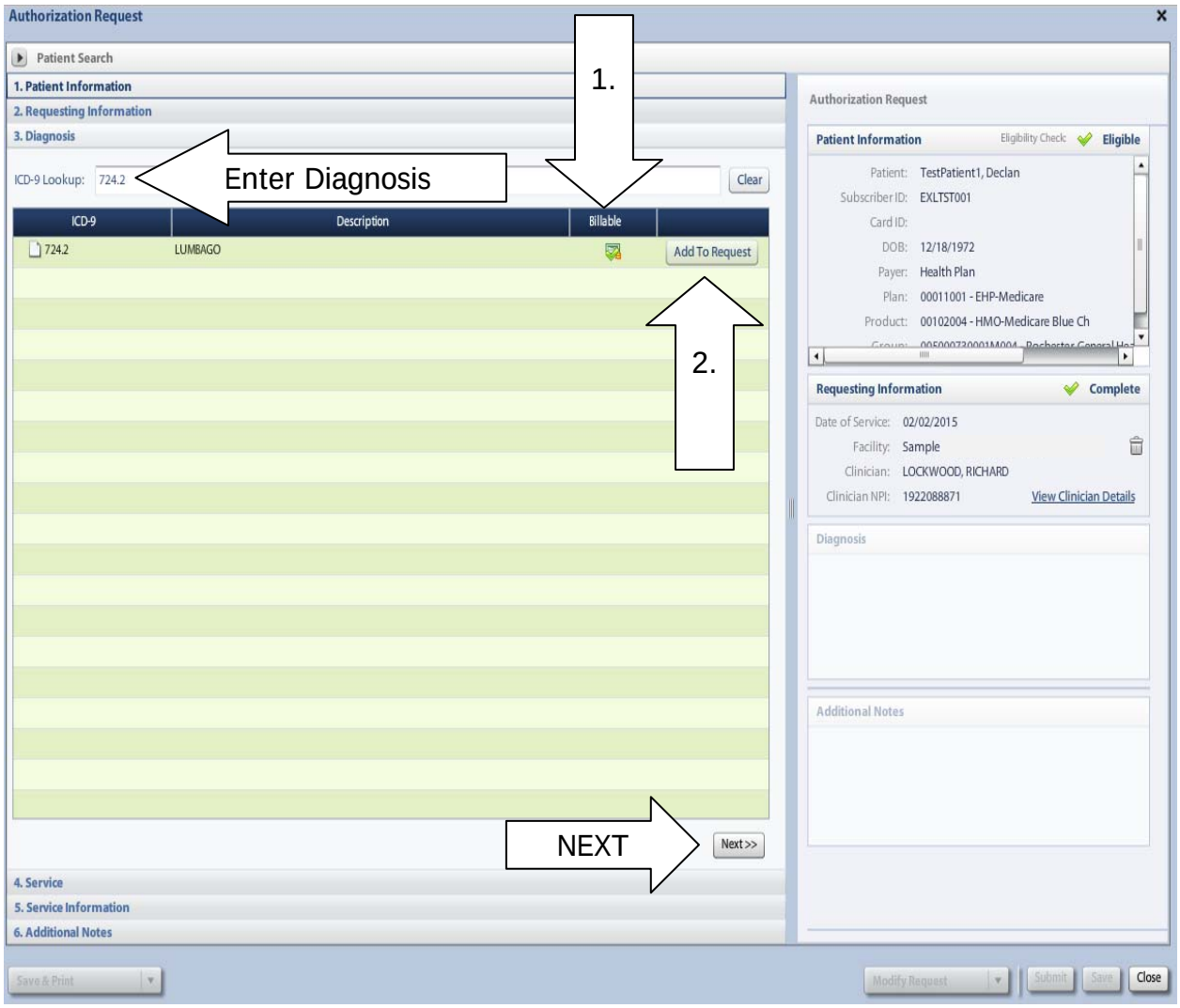
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
TENS Unit Authorization Entry Tips

Accordion 3: Diagnosis

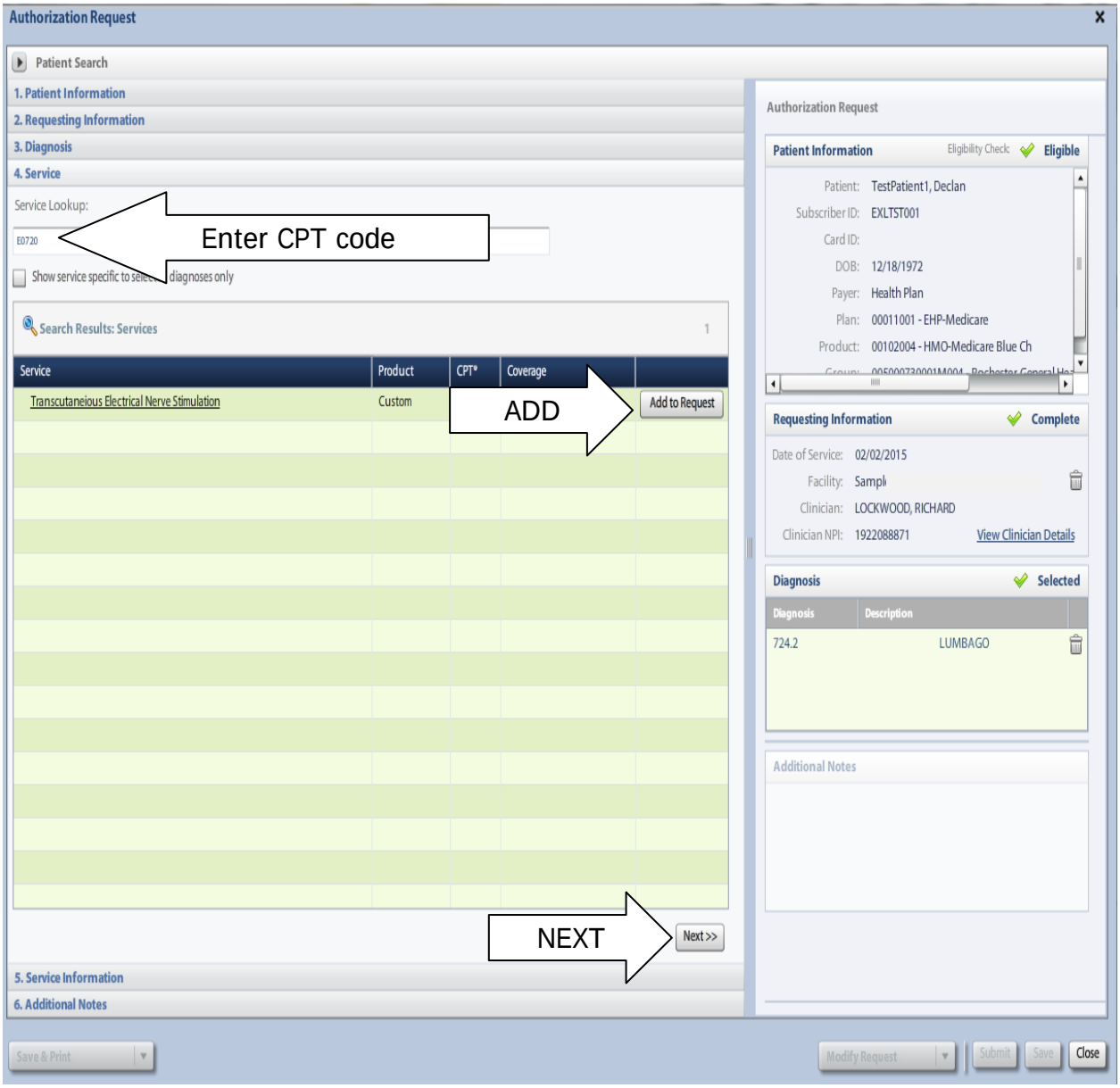
Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."



Clear Coverage™
TENS Unit Authorization Entry Tips

Accordion 4: Services

- Enter CPT code
- Click the “Add to Request” button
- Click “Next”



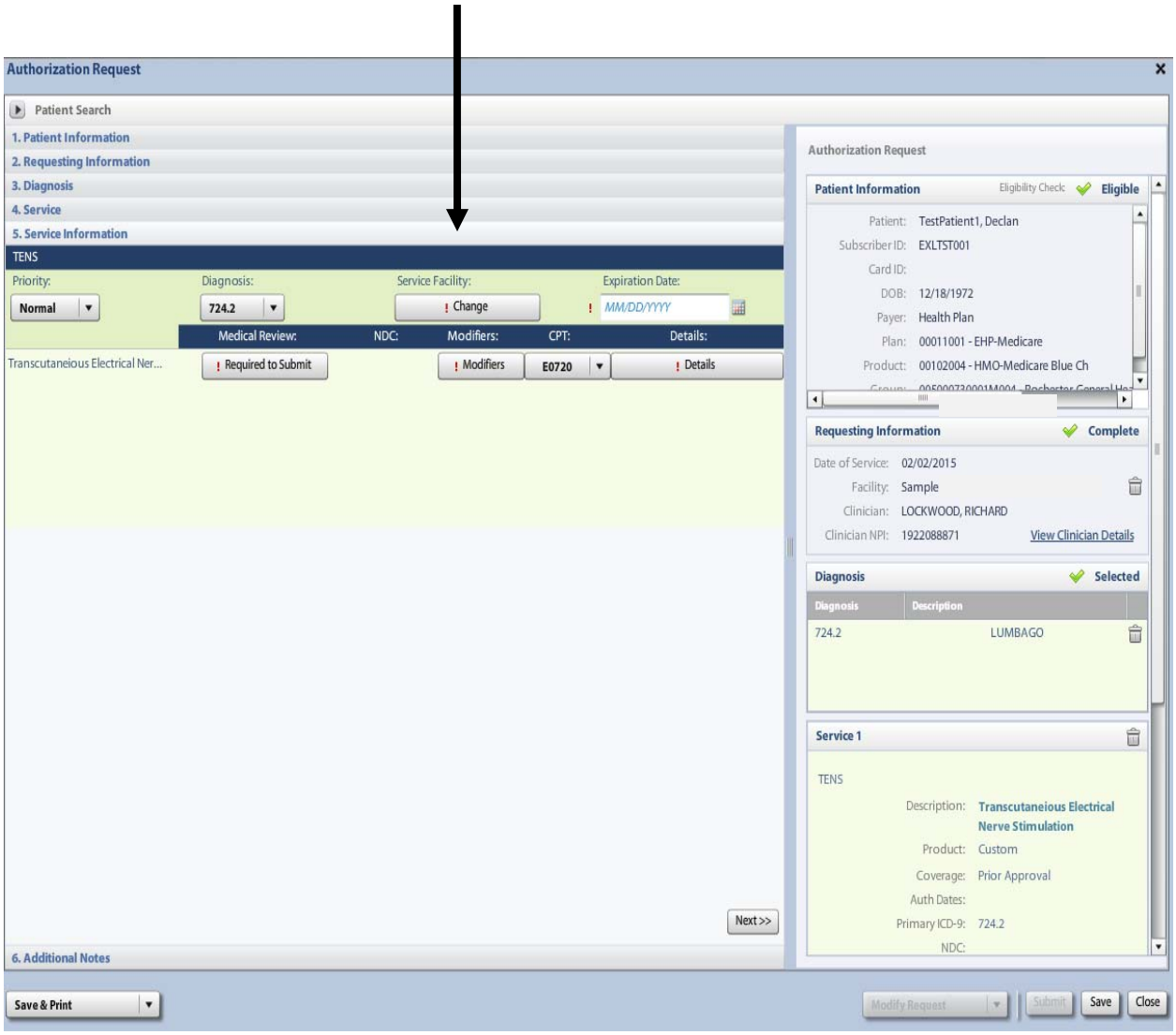
Clear Coverage™
TENS Unit Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

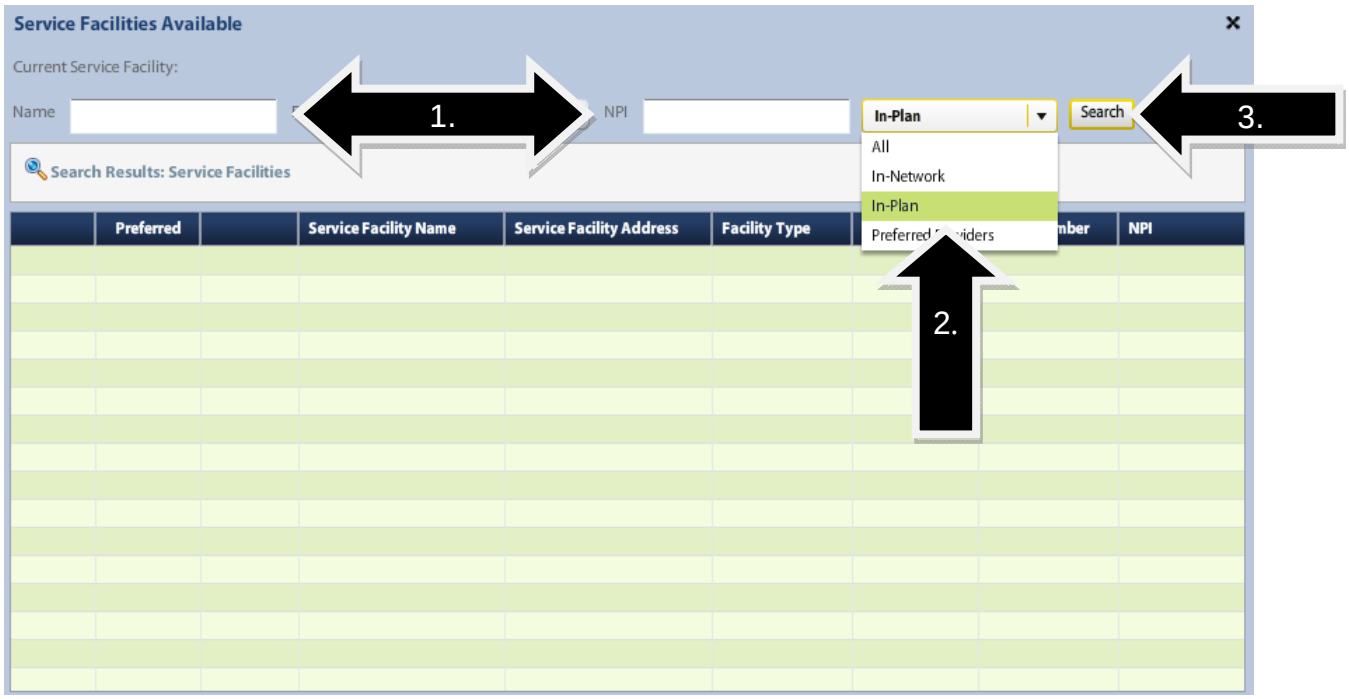
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility - place of service (or provider/vendor)-see next page

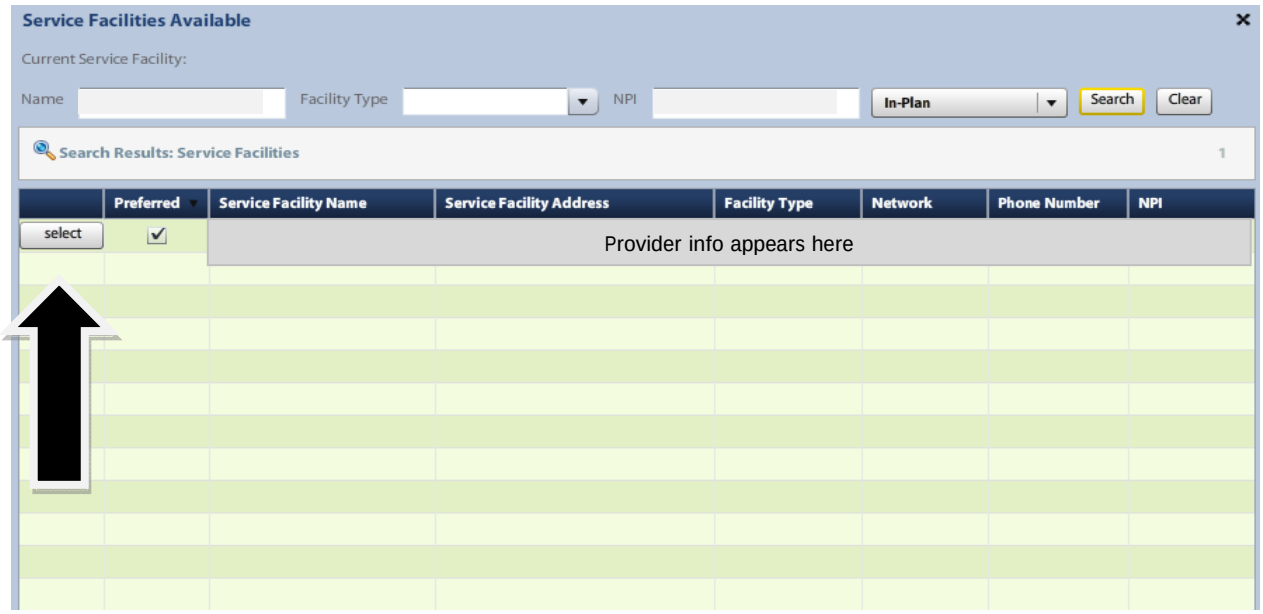


Clear Coverage™
TENS Unit Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).



When the results display, select the appropriate provider.



Clear Coverage™
TENS Unit Authorization Entry Tips

Expiration Date: For the **initial Trial request**, enter an expiration date of one month from the expected start date.

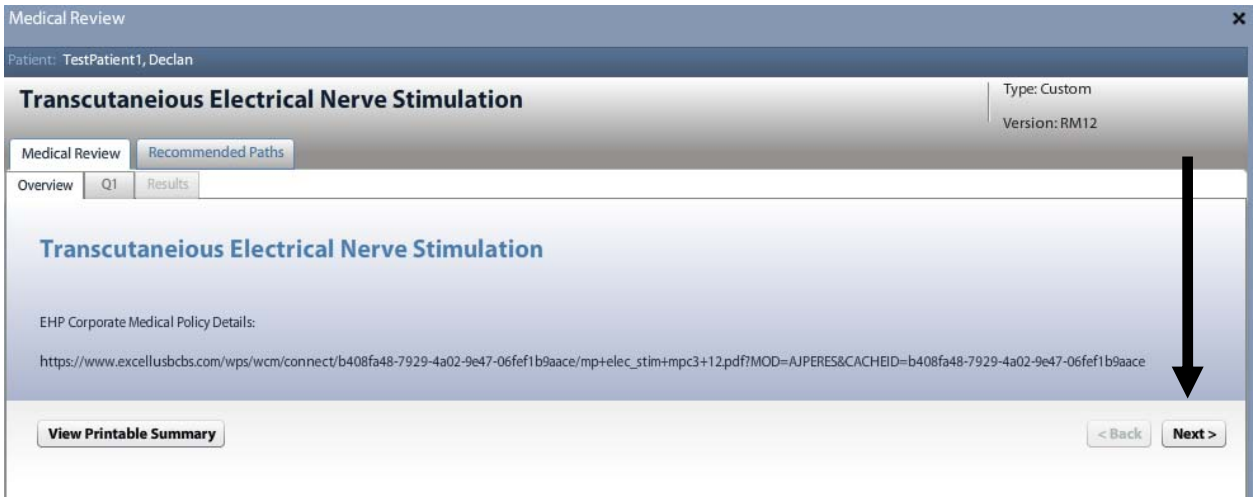
NOTE: If the patient already has an authorization entered into Clear Coverage™ for the trial, and you would like to request an authorization for purchase of the TENS unit, enter a new authorization request and set the expiration date to three months from the expected purchase start date.

If the request is for continued rental, a note will need to be added or attached. Do not change the expiration date in this field.

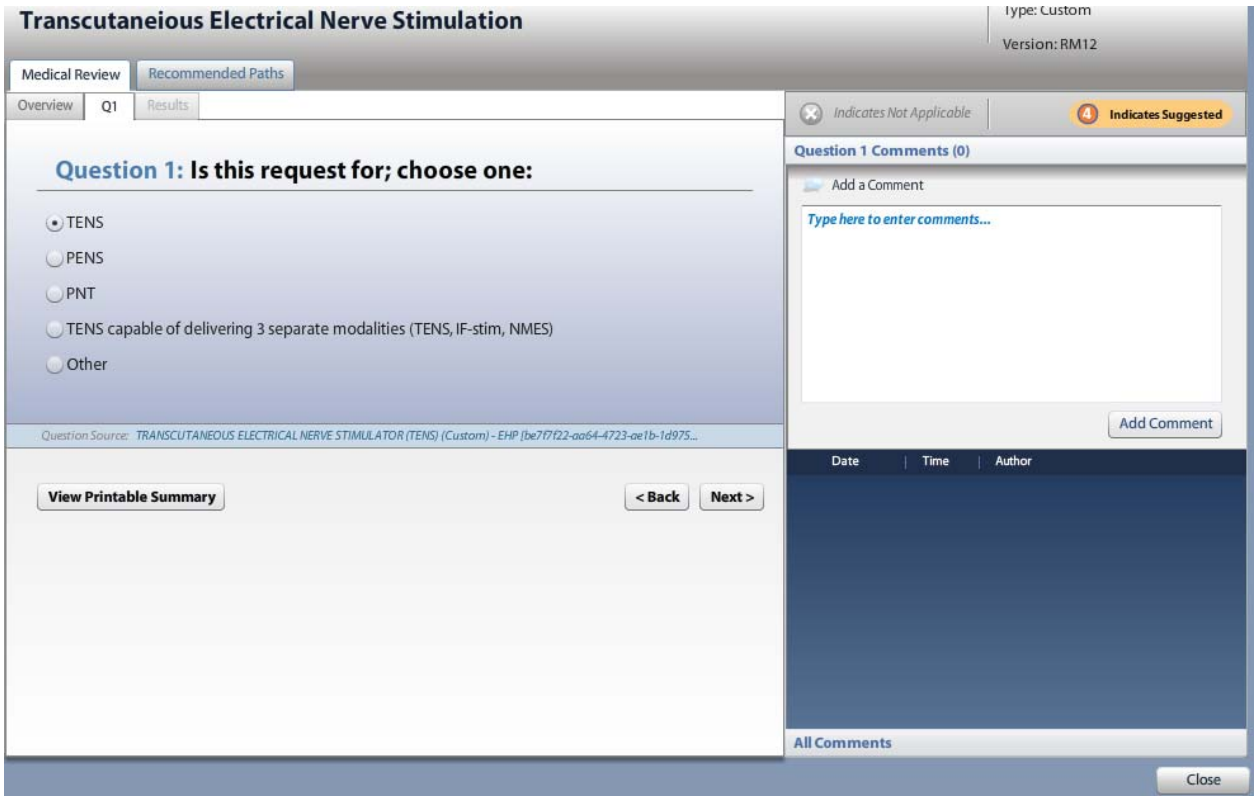
Medical Review: Click on the Medical Review "Required to Submit" tab.

Clear Coverage™
TENS Unit Authorization Entry Tips

Click “Next”

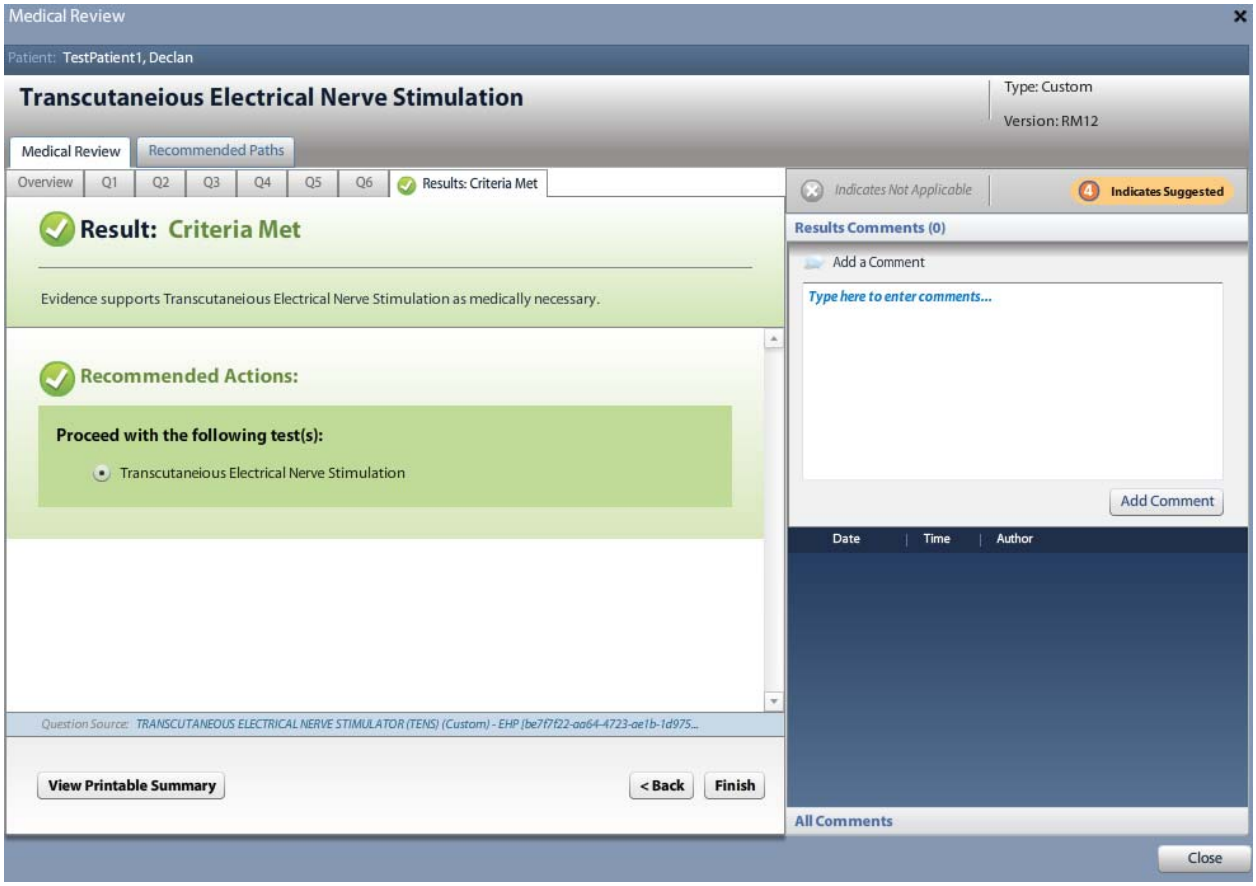


Complete the review by answering each question and clicking “Next”.



Clear Coverage™
TENS Unit Authorization Entry Tips

If criteria met: Click “Finish.”

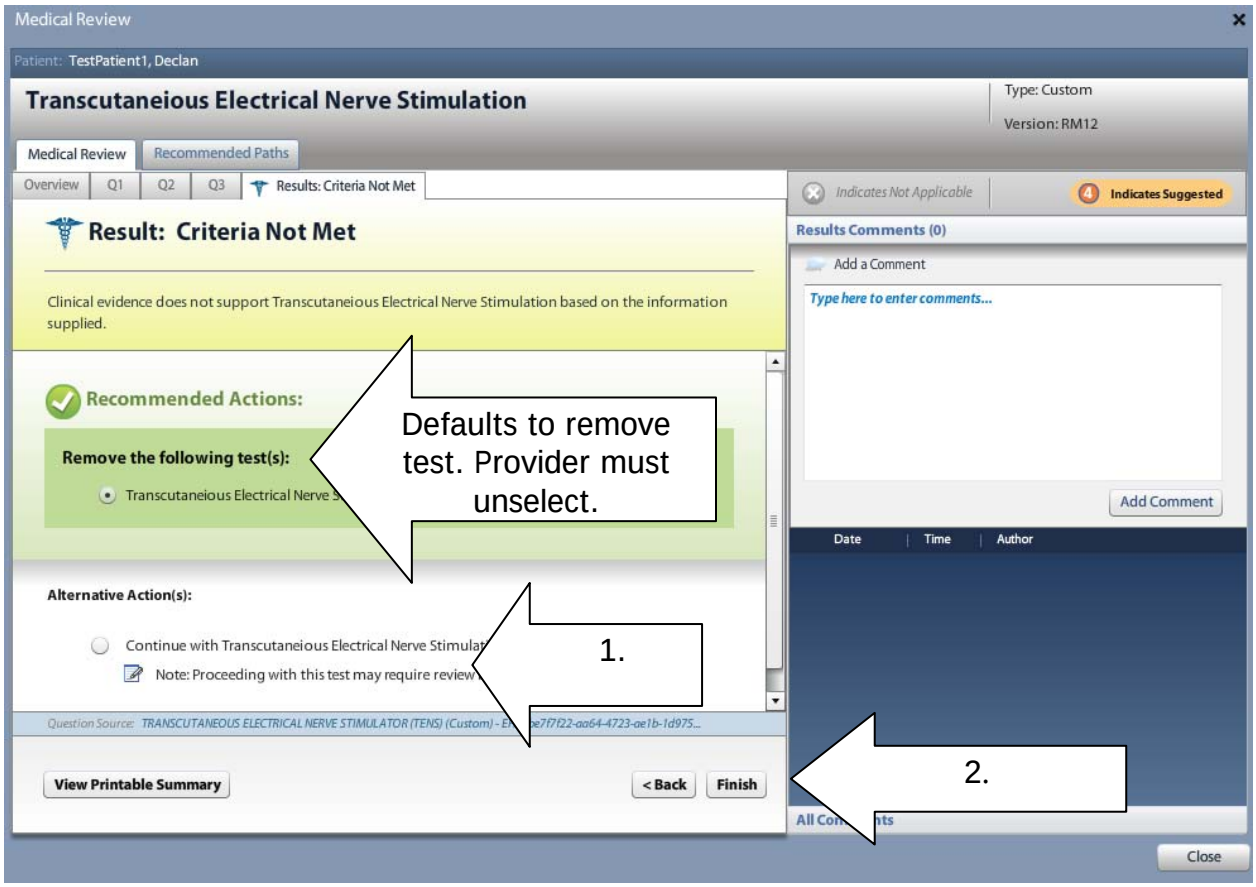


Clear Coverage™
TENS Unit Authorization Entry Tips

If criteria not met:

The default choice is to **remove** the item from the request.

1. You **must** click the button under Alternative Action(s) to "Continue with Transcutaneious Electrical Nerve Stimulation" if you wish the request to pend to the Health Plan for review.

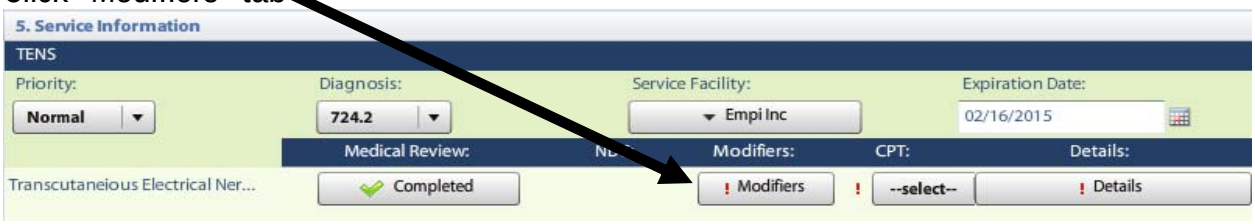


2. Click "Finish."

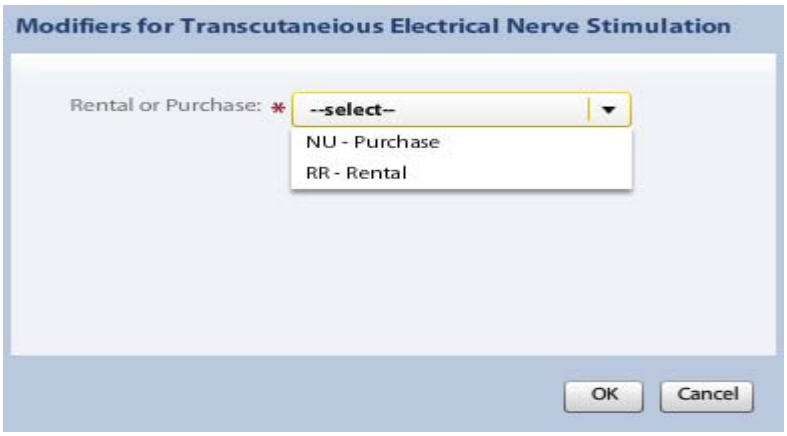
Clear Coverage™
TENS Unit Authorization Entry Tips

Modifiers:

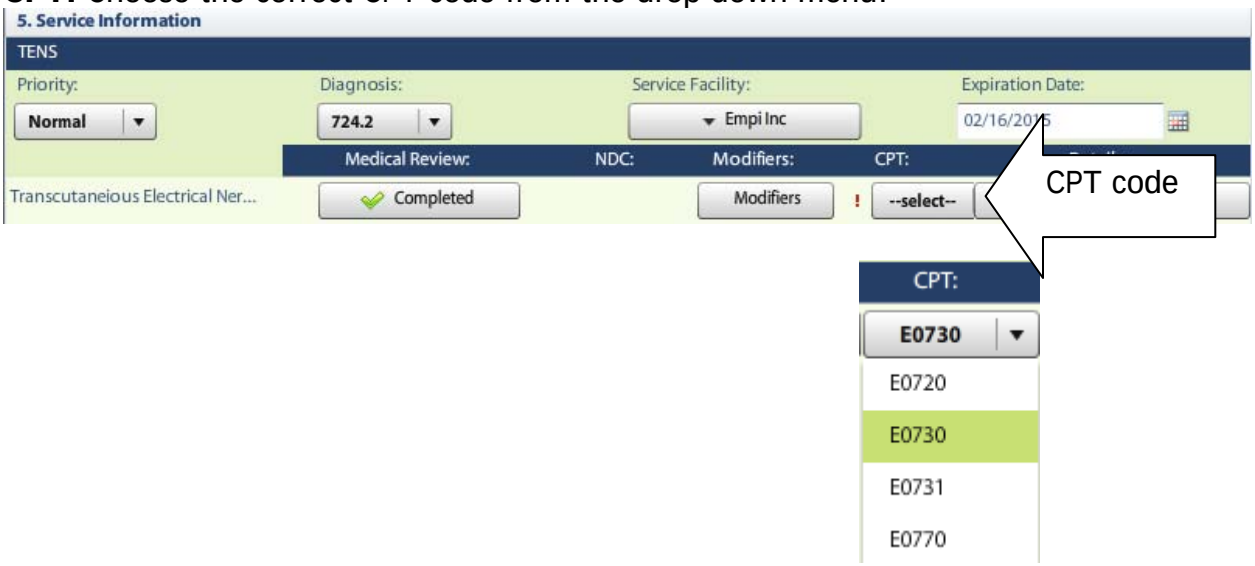
Click “Modifiers” tab



- Click “dropdown arrow”
- Choose:
  - NU – Purchase OR
  - RR – Rental
- Click “OK”

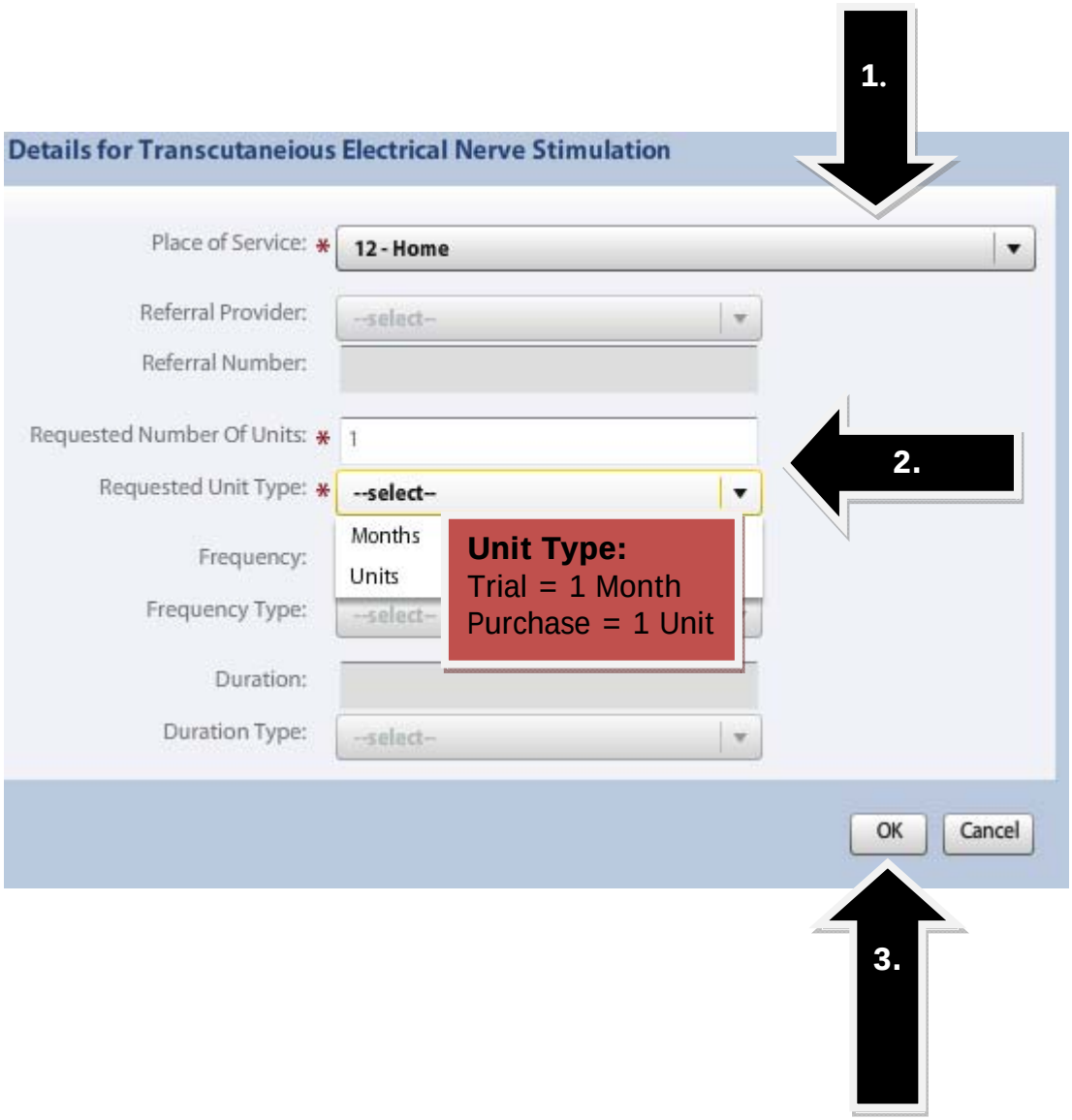


CPT: Choose the correct CPT code from the drop down menu:



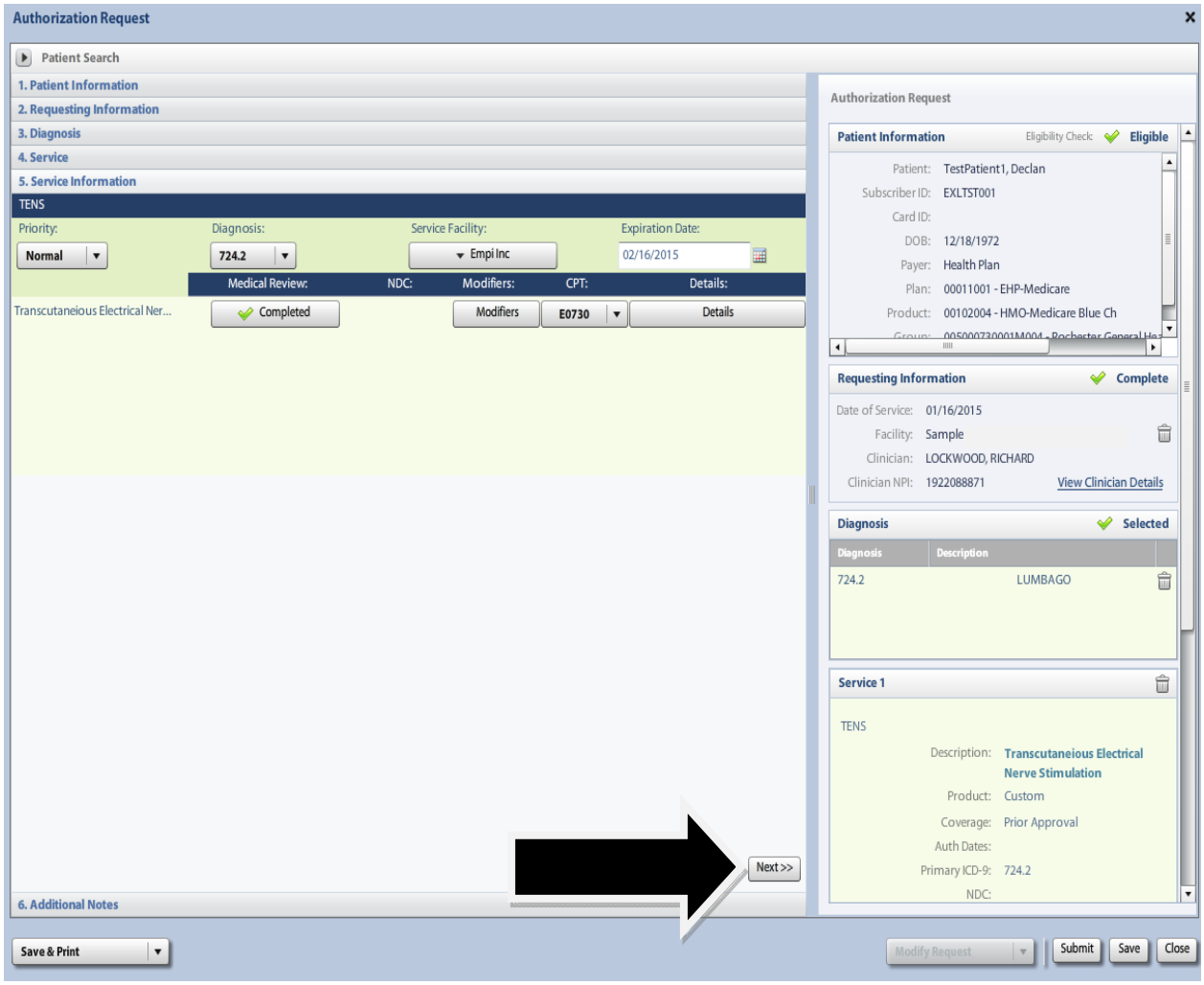
Clear Coverage™
TENS Unit Authorization Entry Tips

Details section: Must select: (1) Place of Service, (2) Requested Number of Units and Requested Unit Type**.** Click the "OK" button (3).



Clear Coverage™
TENS Unit Authorization Entry Tips

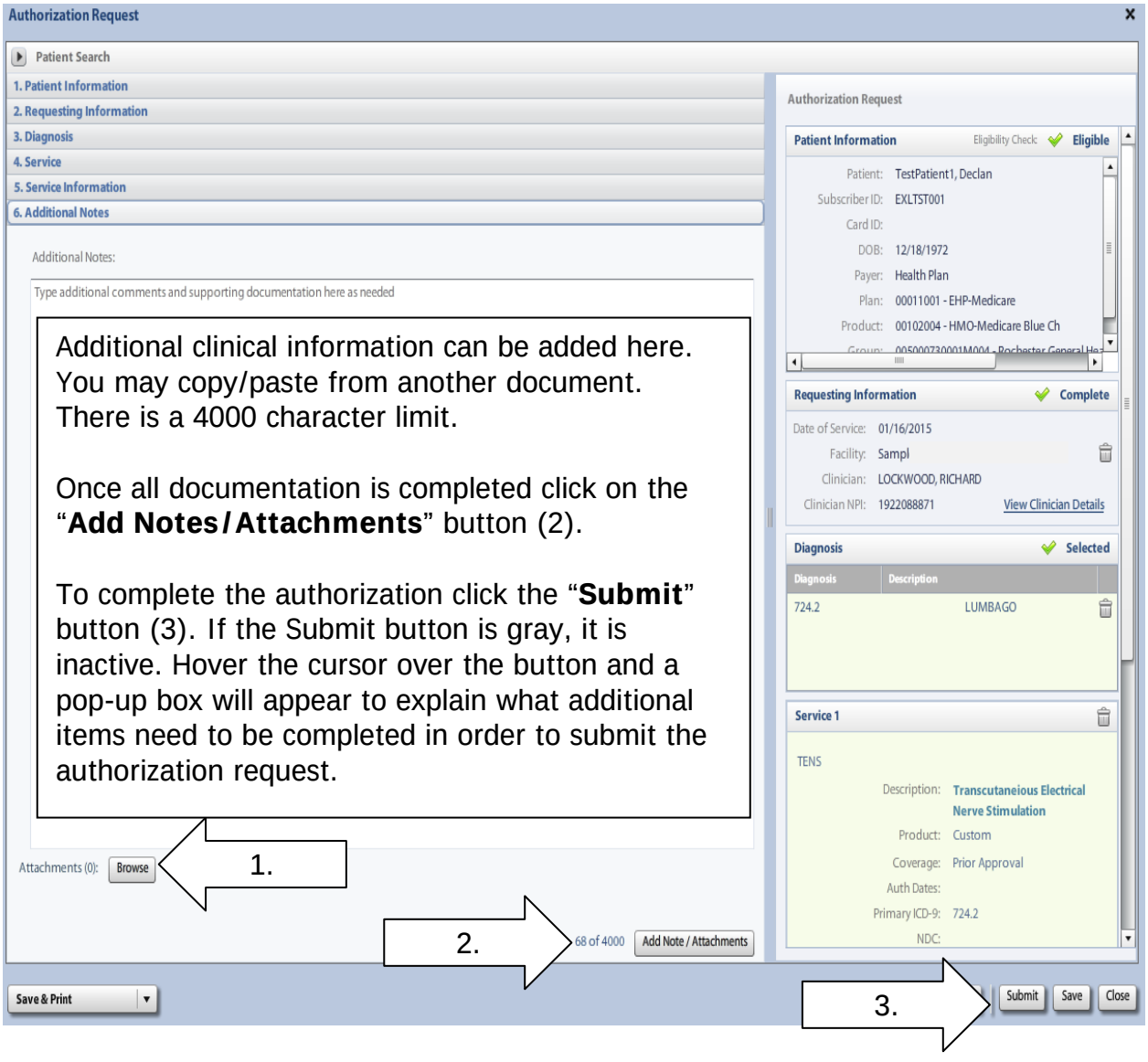
Click “Next”



Clear Coverage™
TENS Unit Authorization Entry Tips

Accordian 6: Additional Notes

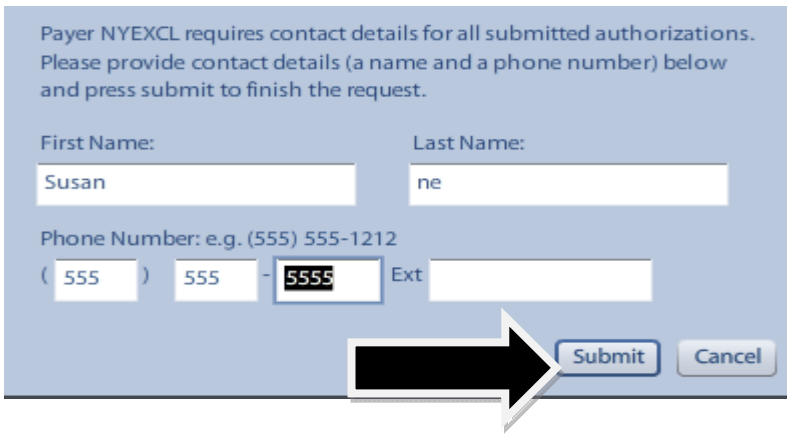
If the request is for a Medicare product or if criteria was not met, or if the request is for continued rental, enter additional information and/or attach a note with supporting medical documentation (1).
A note must be added in order to attach a document.



Clear Coverage™
TENS Unit Authorization Entry Tips

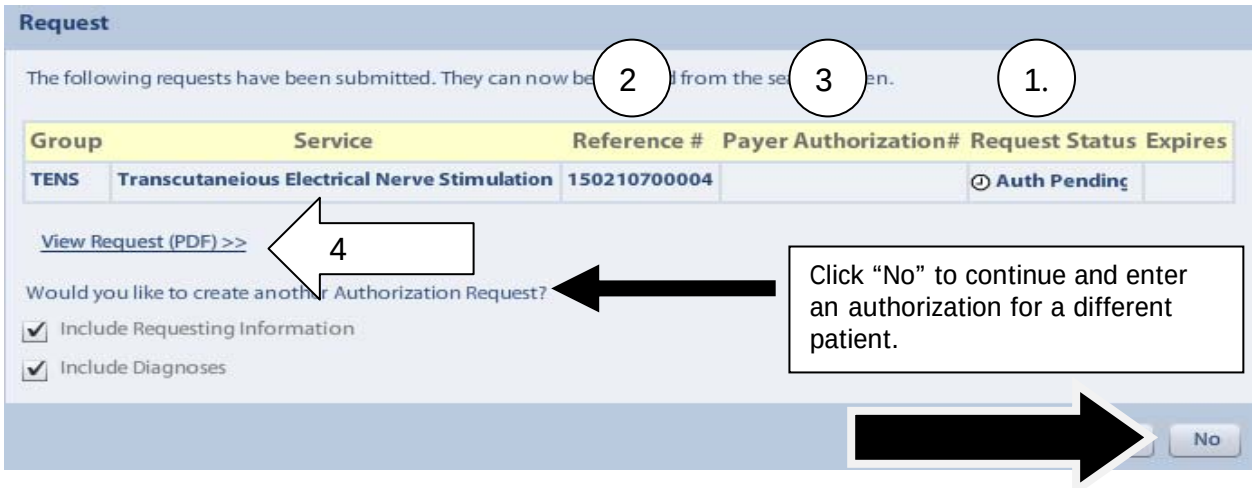
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Varicose Vein Authorization Entry Tips

Medicare: review tool MUST be completed to provide clinical information to the Health Plan. Medicare requests will pend until this information is reviewed.

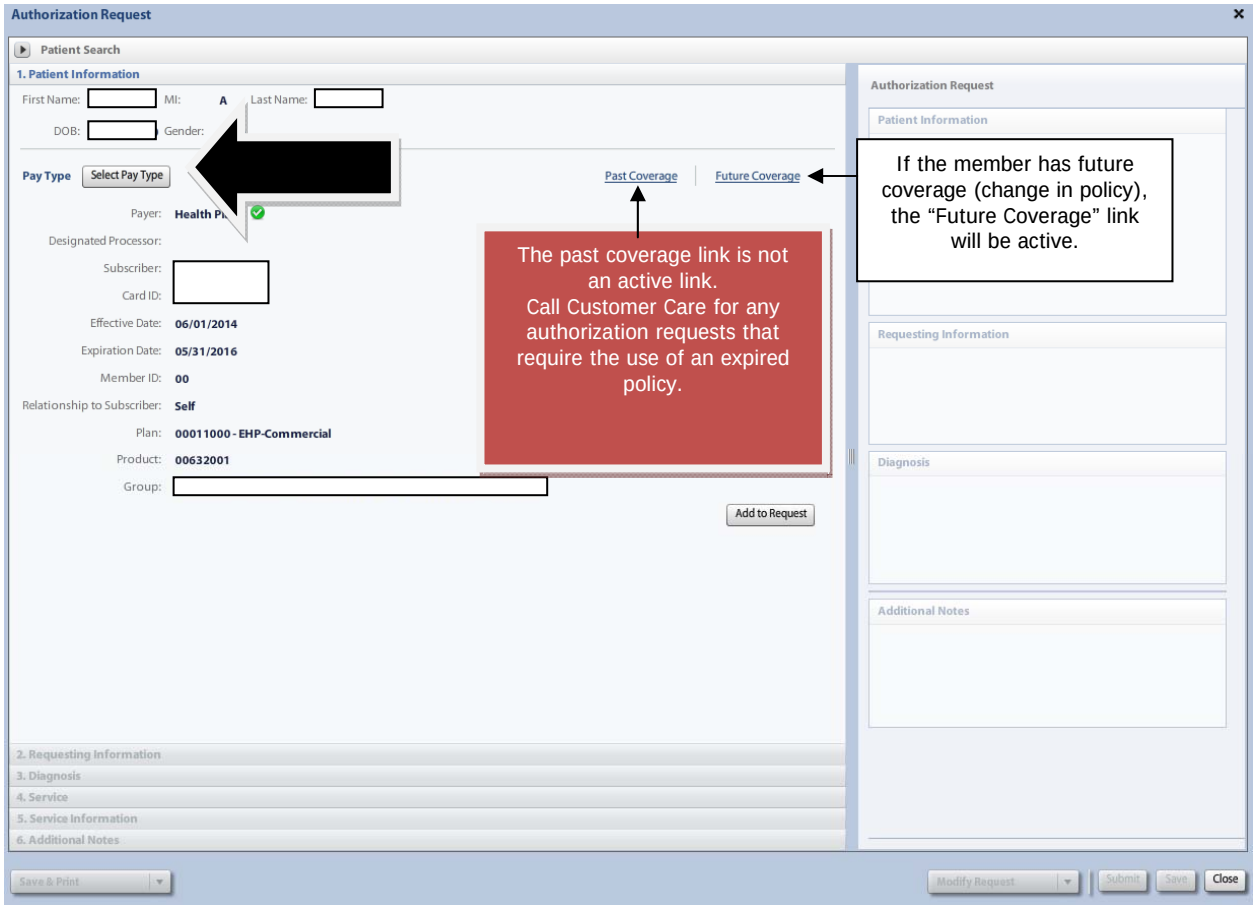
Commercial: will auto approve if criteria is met. Exception: CPT codes for cosmetic procedures will pend for review.

NOTE: If the request pends, the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

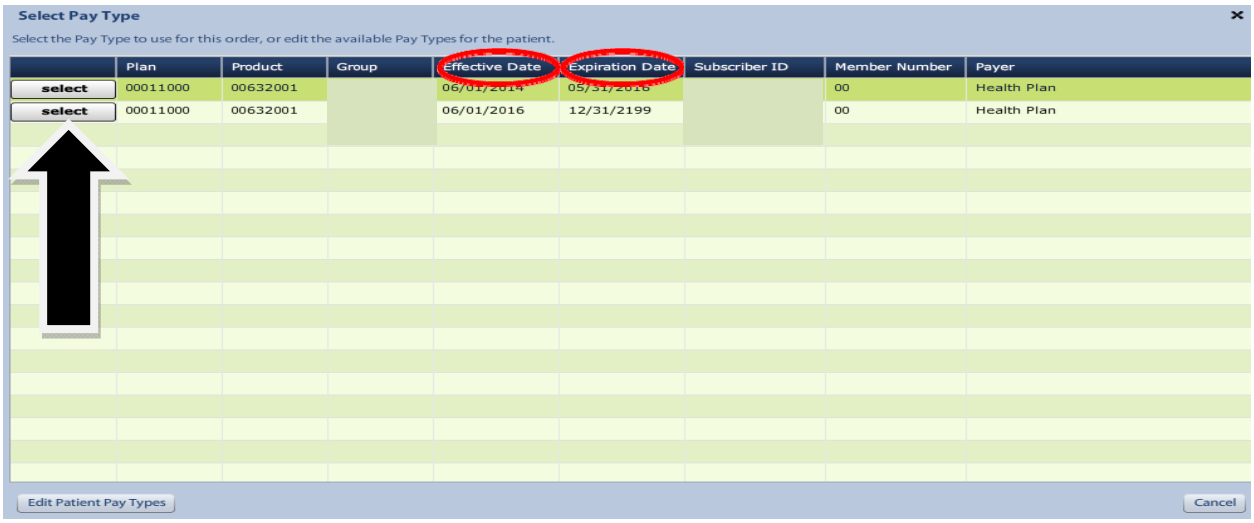


Clear Coverage™
Varicose Vein Authorization Entry Tips

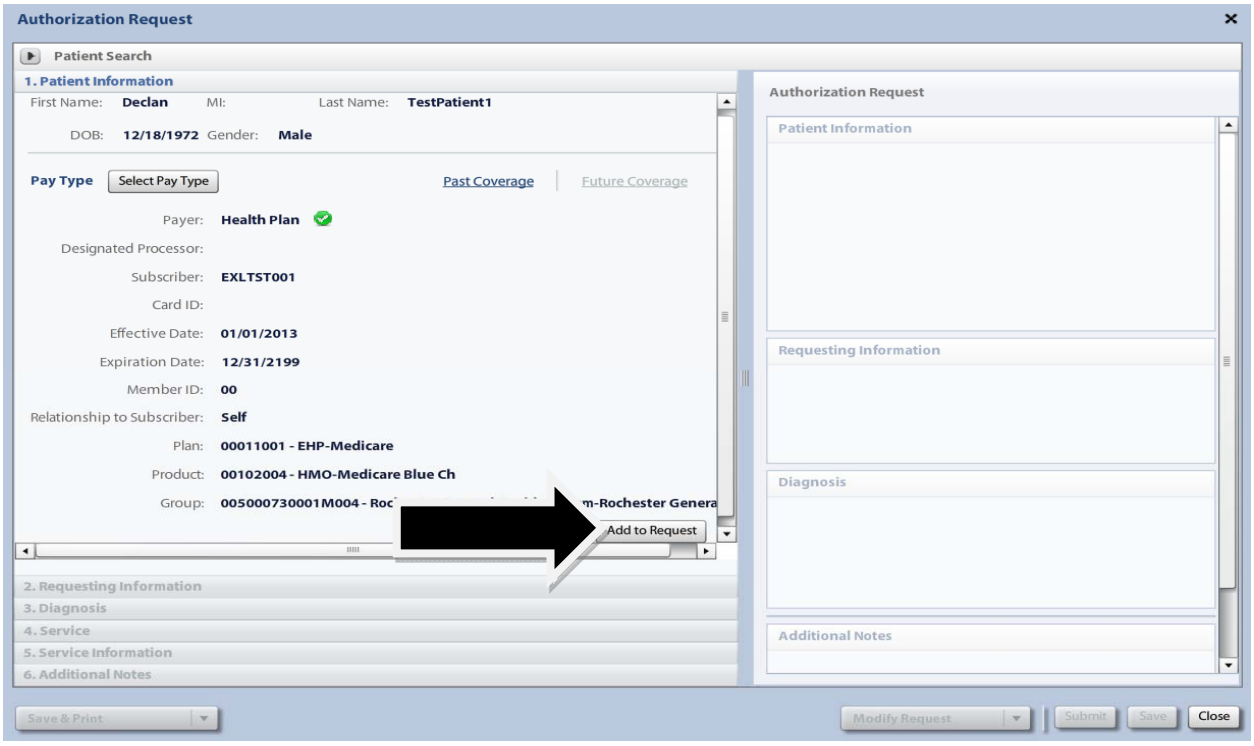
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

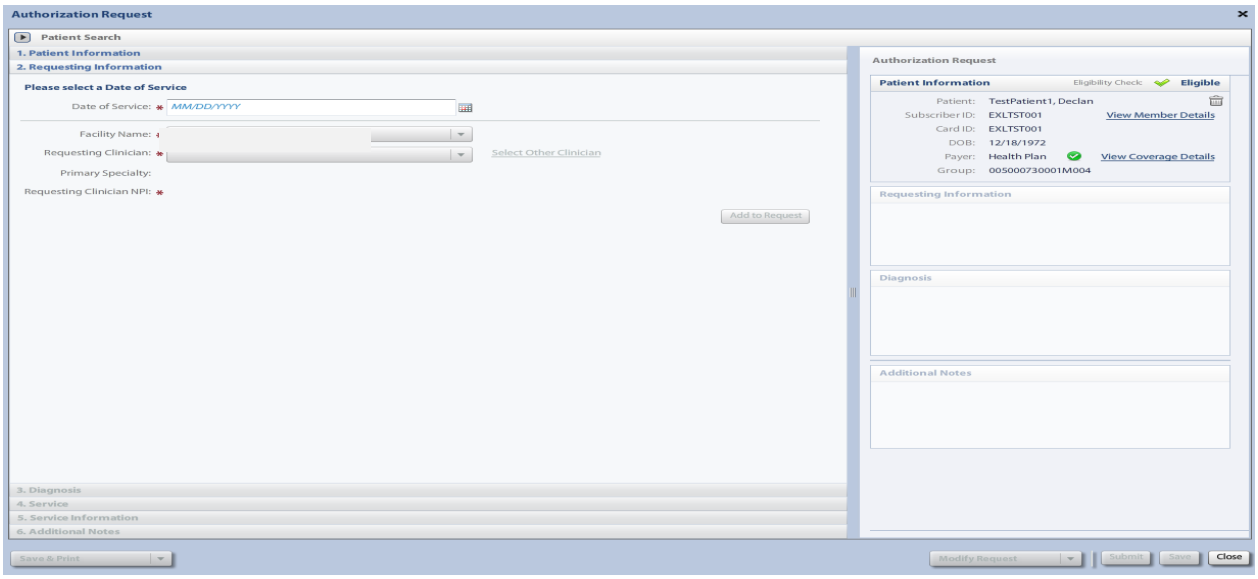


Clear Coverage™
Varicose Vein Authorization Entry Tips

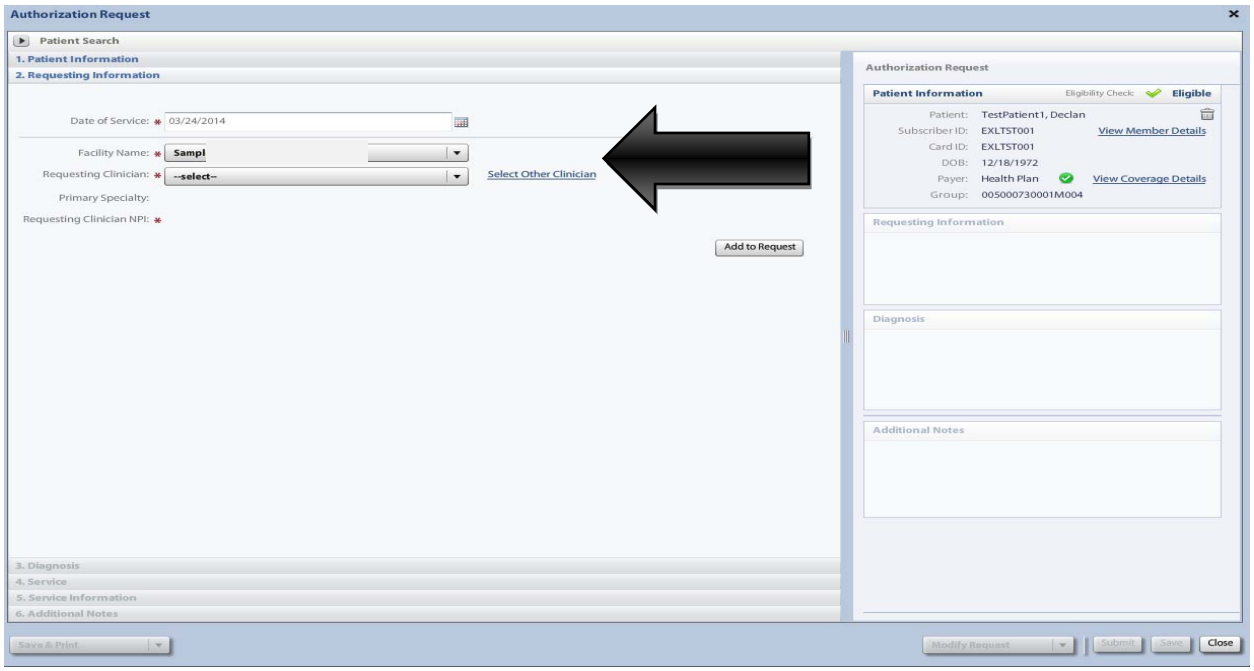
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.

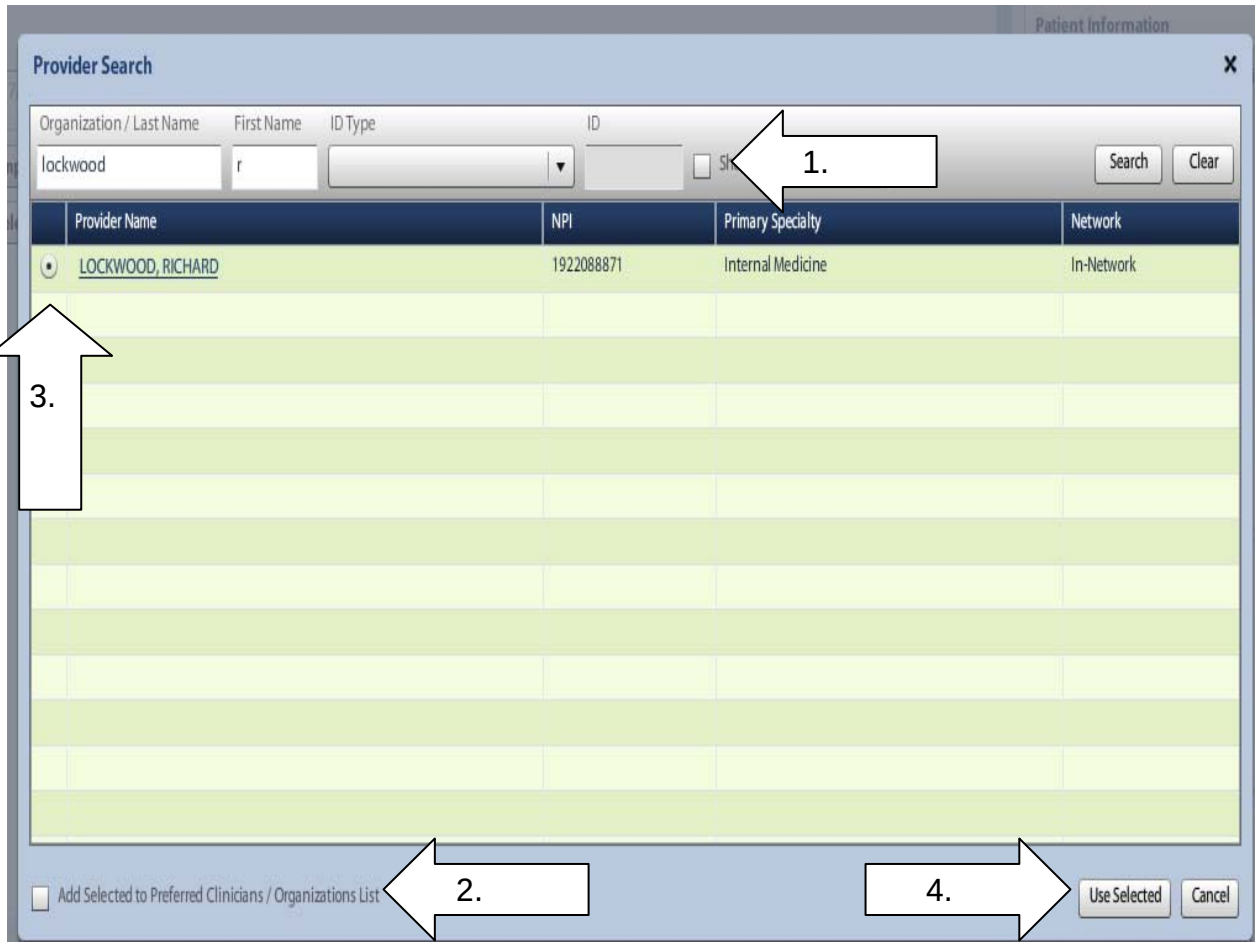


Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.



Clear Coverage™
Varicose Vein Authorization Entry Tips

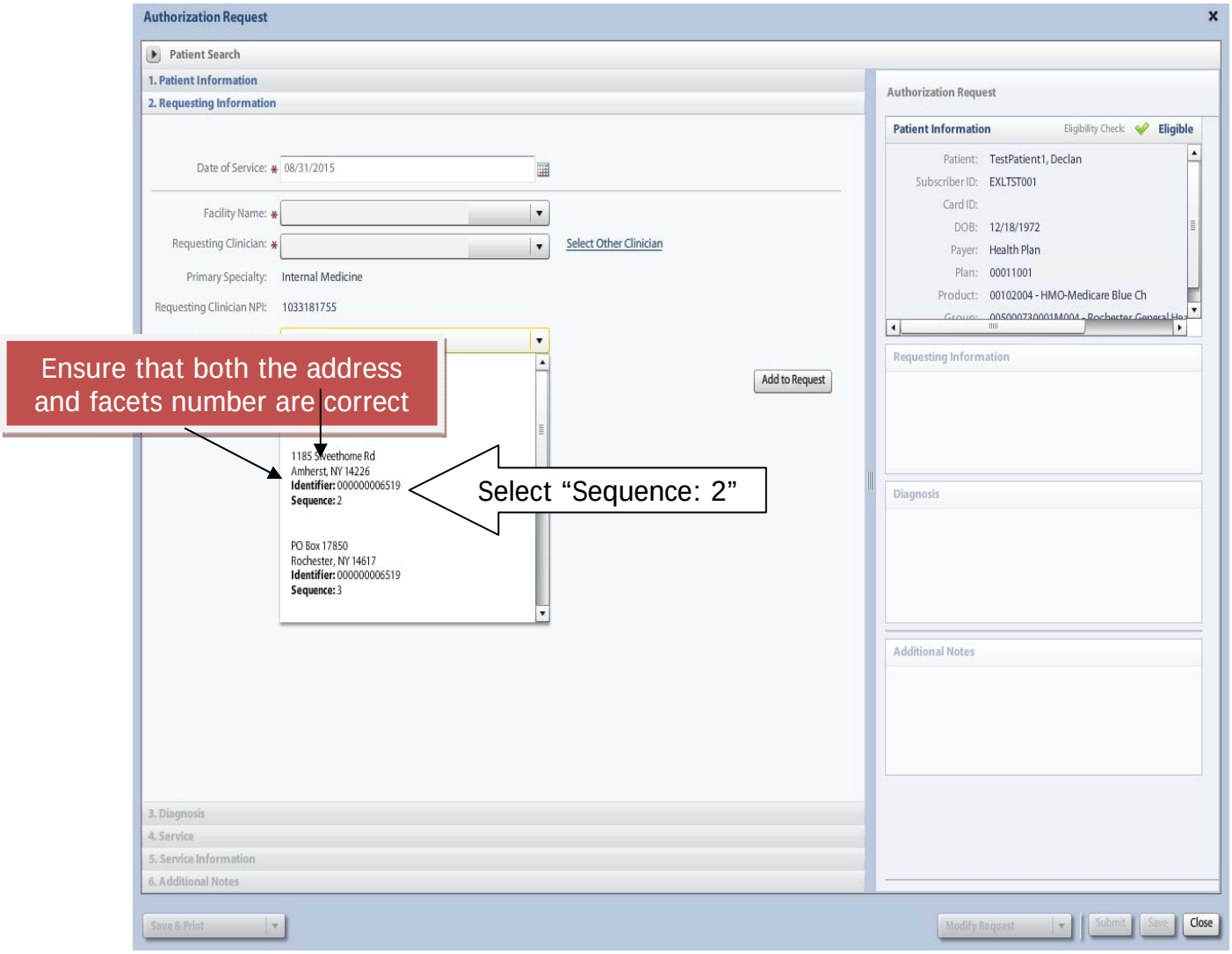
Enter the search parameters and place a check in the “Show” box (1). The provider can be saved to the preferred provider list (2). Select the provider using the radio button (3), then click the “Use Selected” button (4).



Clear Coverage™
Varicose Vein Authorization Entry Tips

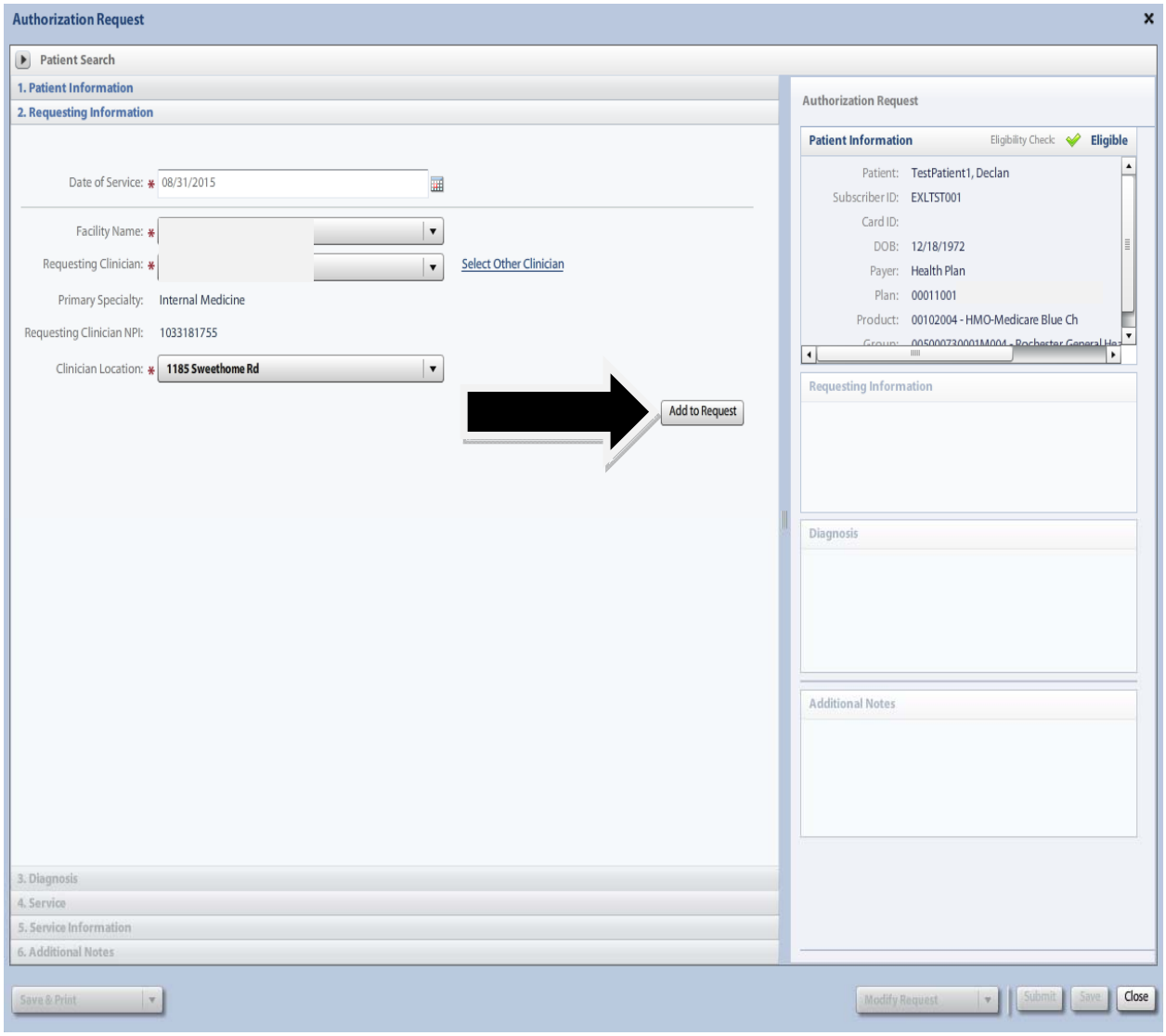
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Varicose Vein Authorization Entry Tips

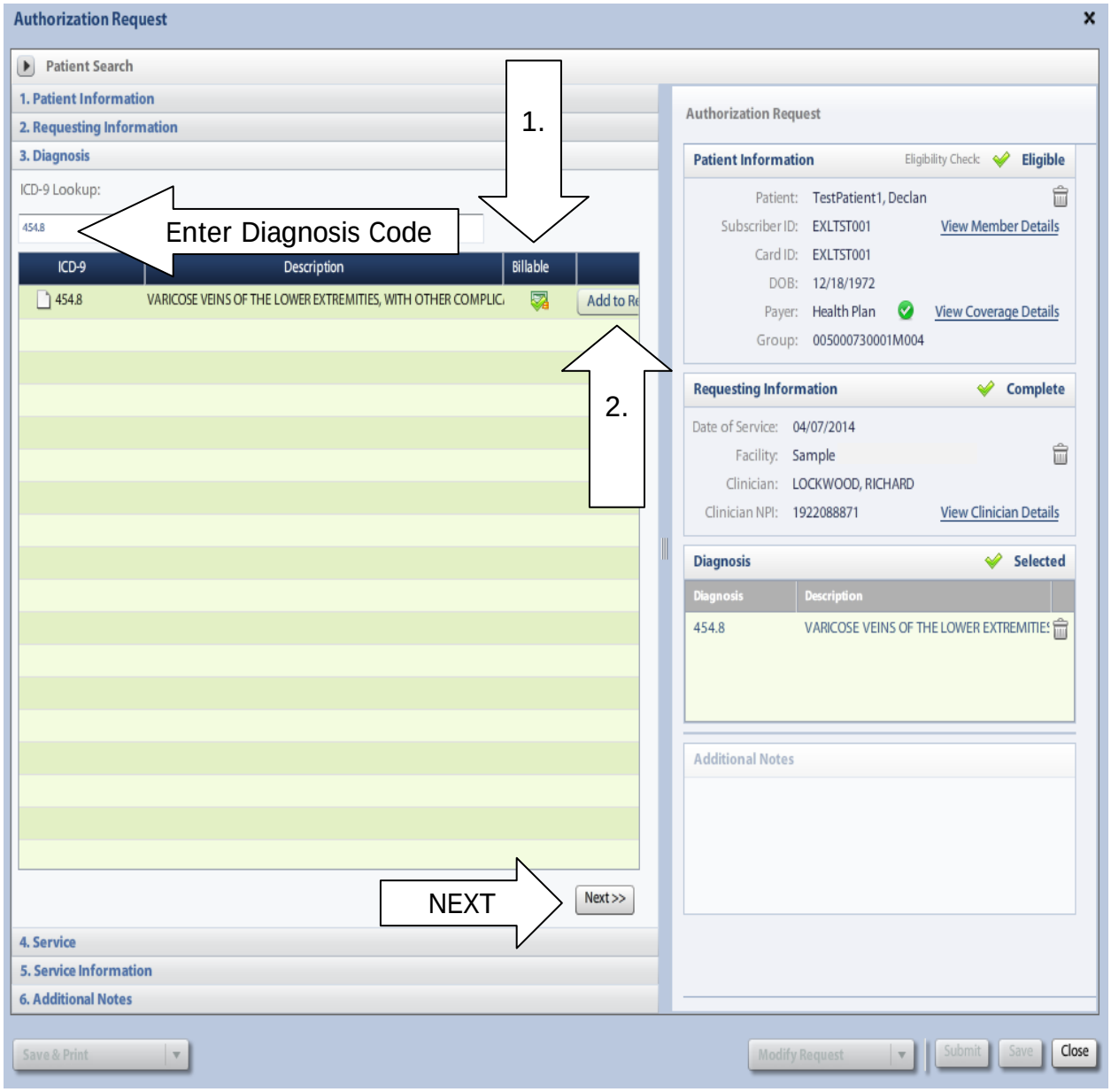
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Varicose Vein Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

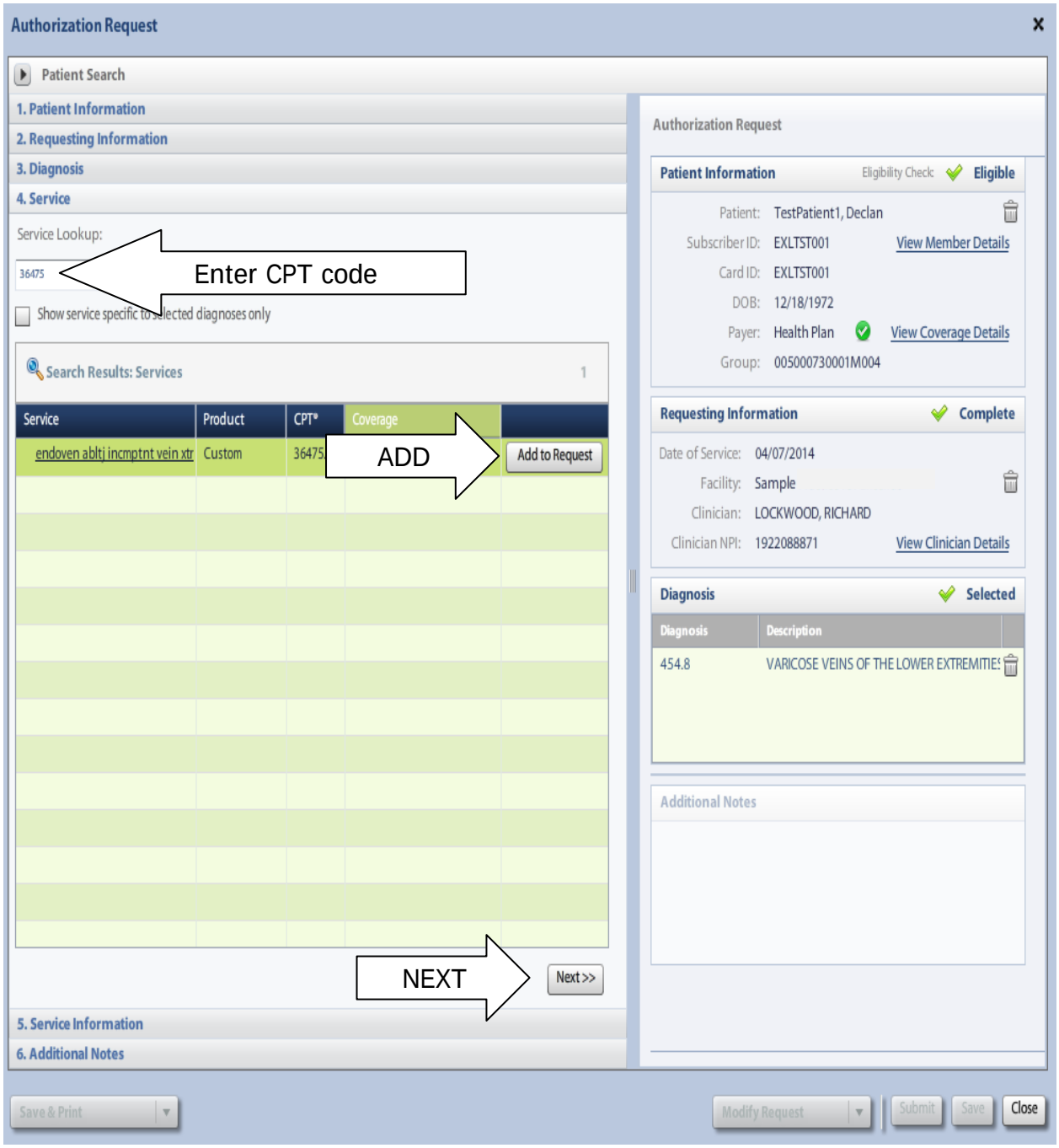


Clear Coverage™
Varicose Vein Authorization Entry Tips

Accordion 4: Services

Enter CPT code(s)

- Click the “Add to Request” button, then click “Next” once all codes have been added.



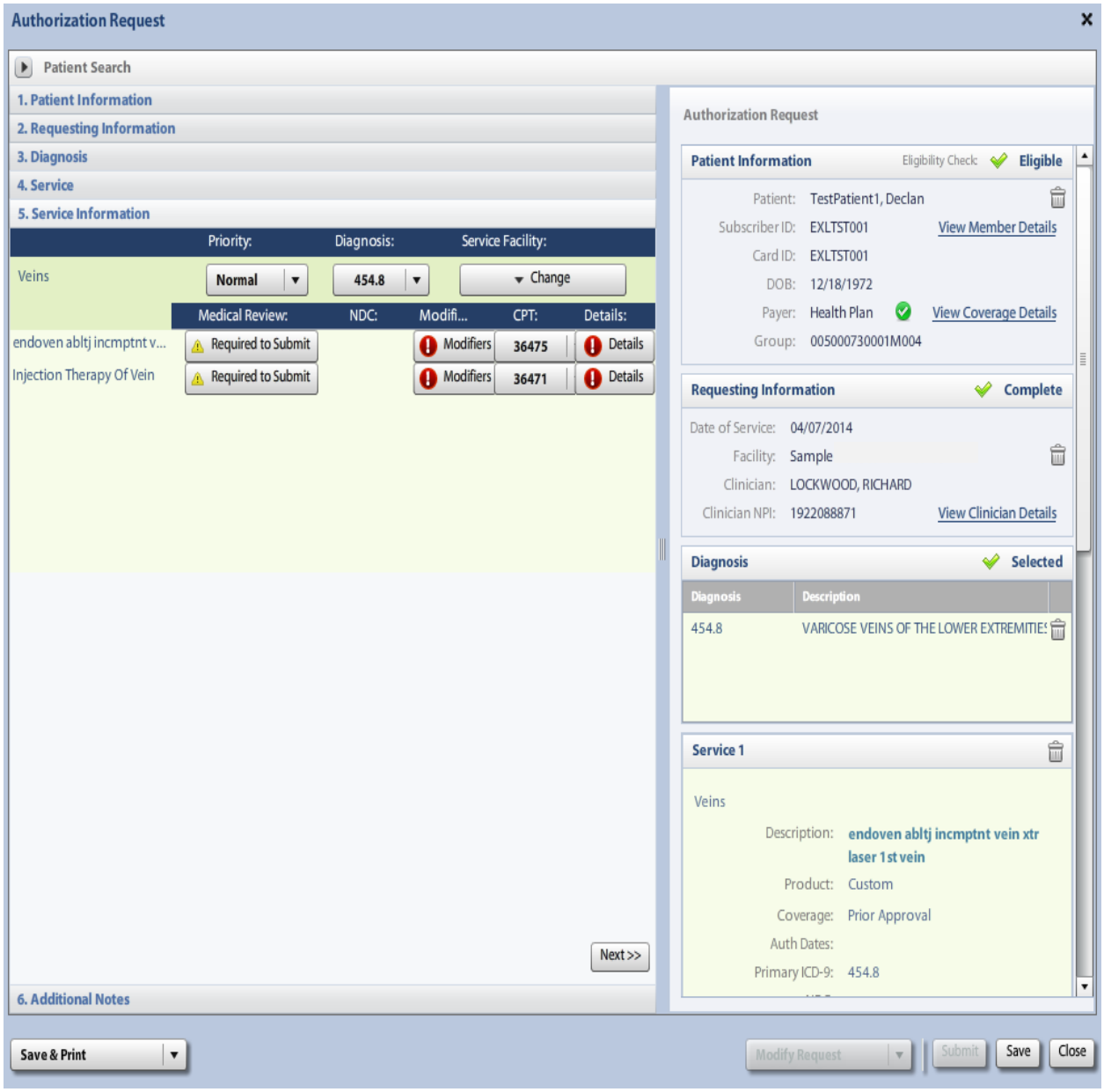
Clear Coverage™
Varicose Vein Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

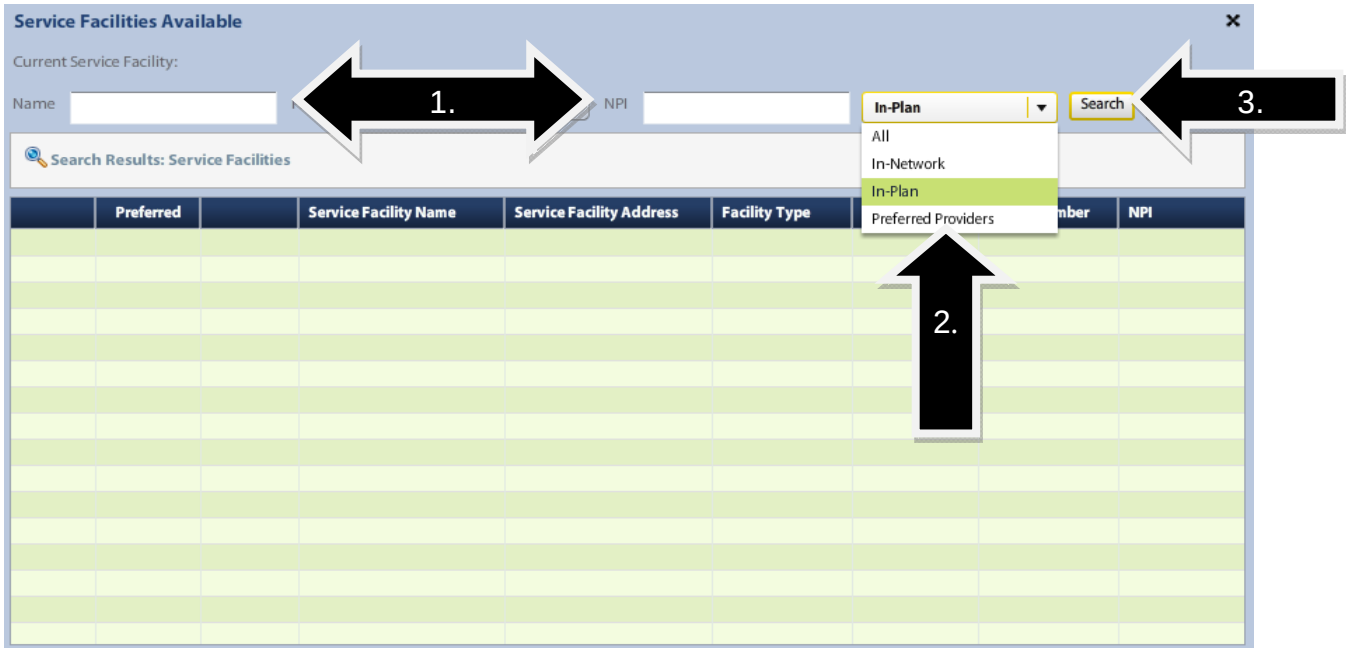
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility = place of service

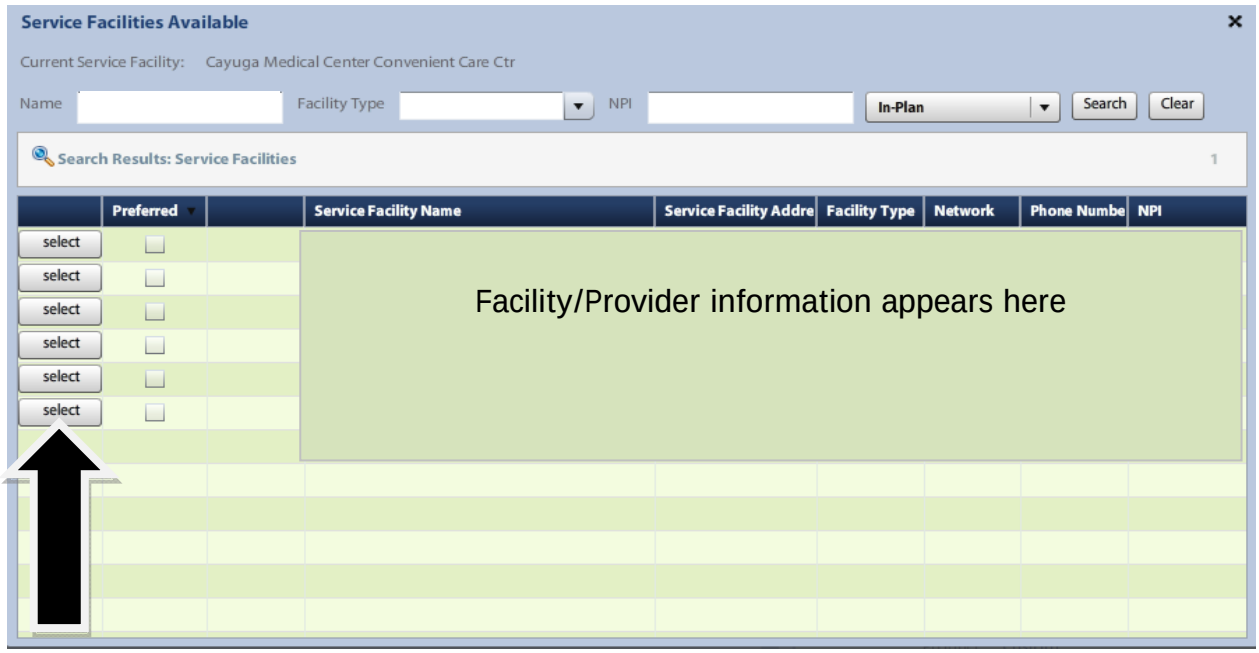


Clear Coverage™
Varicose Vein Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).

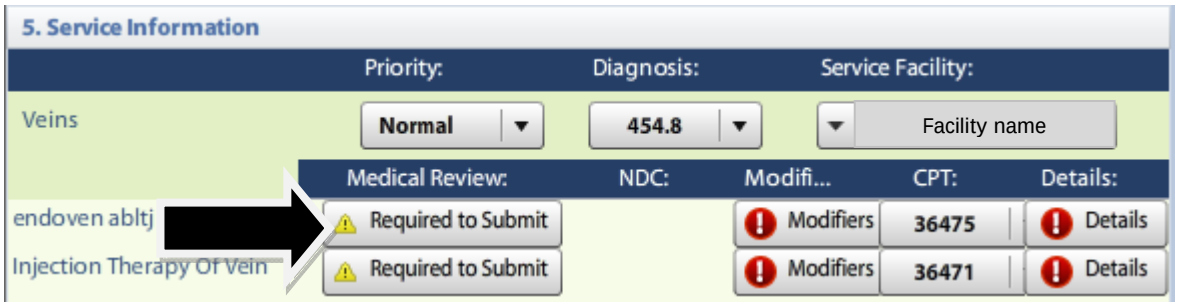


When the results display, select the appropriate provider.



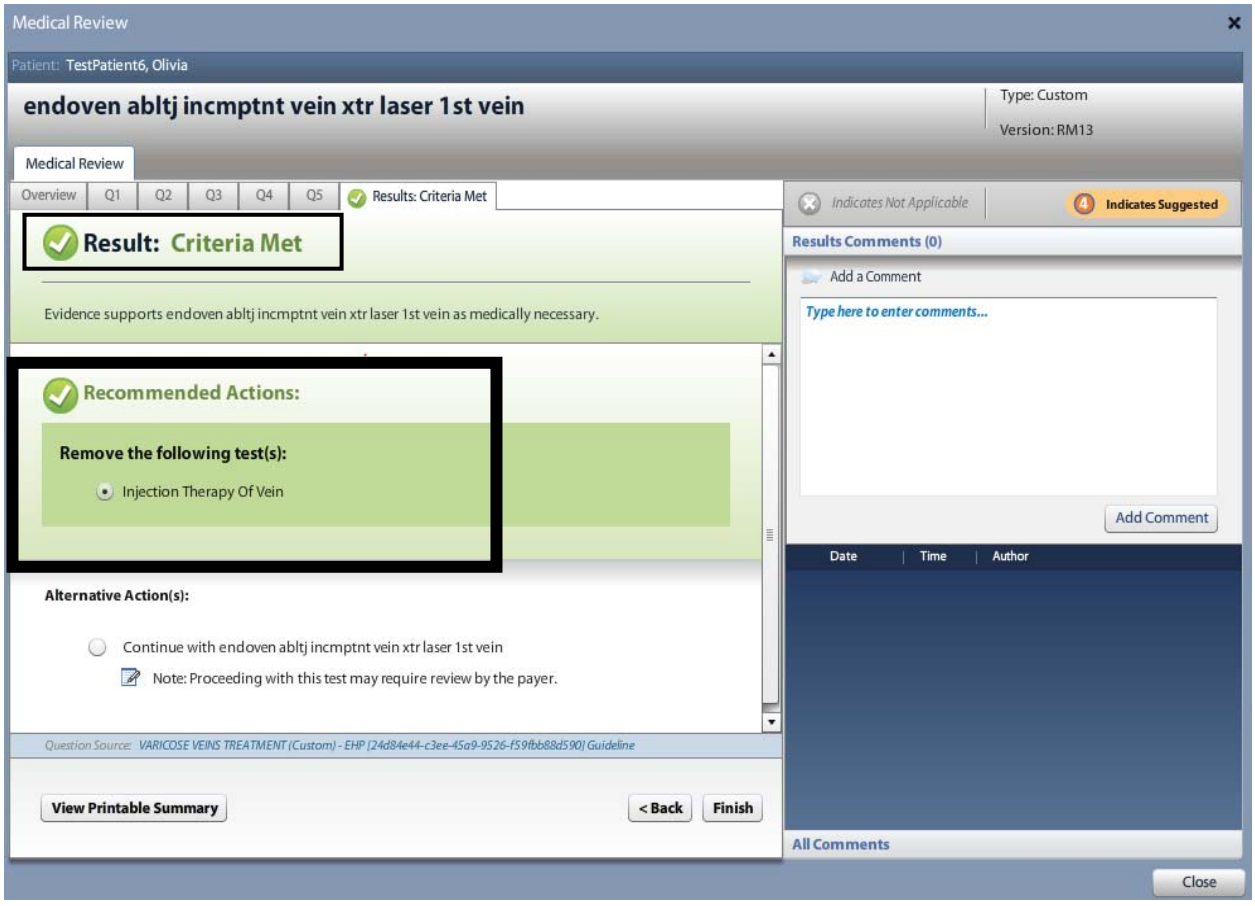
Clear Coverage™
Varicose Vein Authorization Entry Tips

Click on the Medical Review "Required to Submit" tab and complete the review.



NOTE: If criteria is met and the "Recommended Actions" is to proceed with the following test(s)-skip to page 12

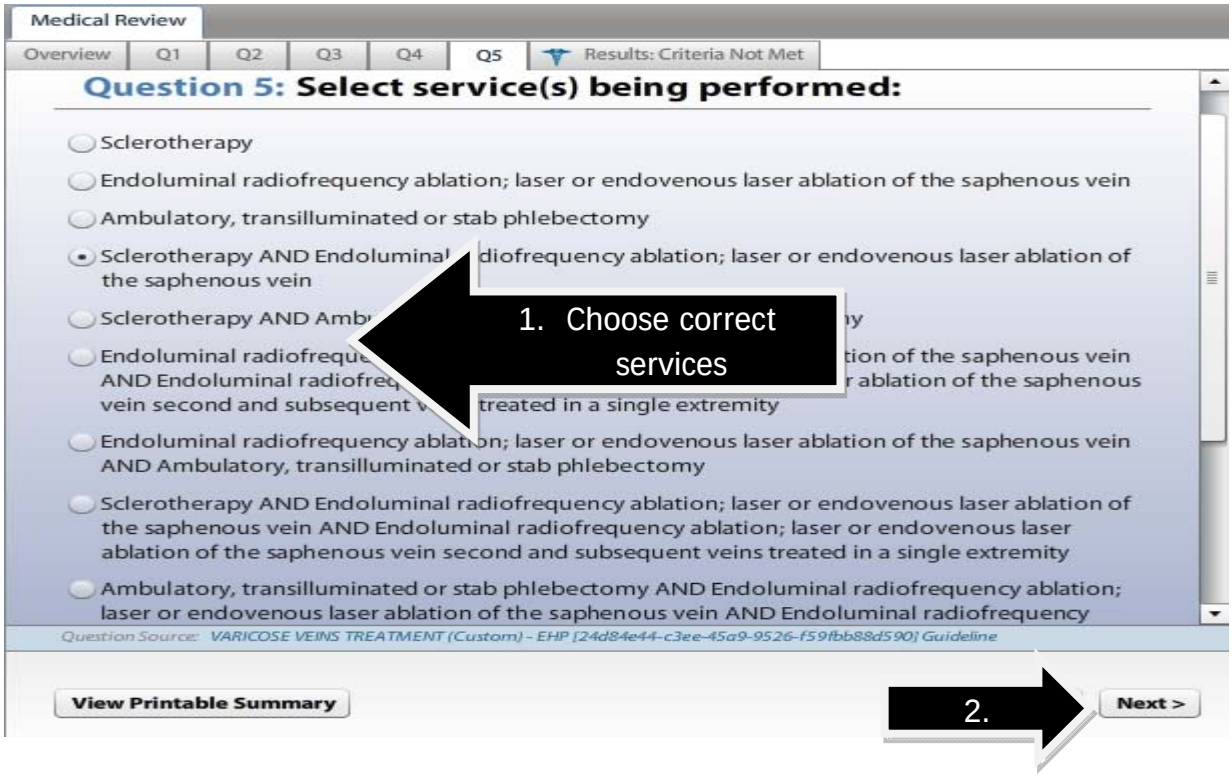
If criteria is met and the "Recommended Actions" is to "<u>Remove</u> the following test(s)":



Clear Coverage™
Varicose Vein Authorization Entry Tips

Return to “Q5” to ensure that you have chosen the correct services to be performed.

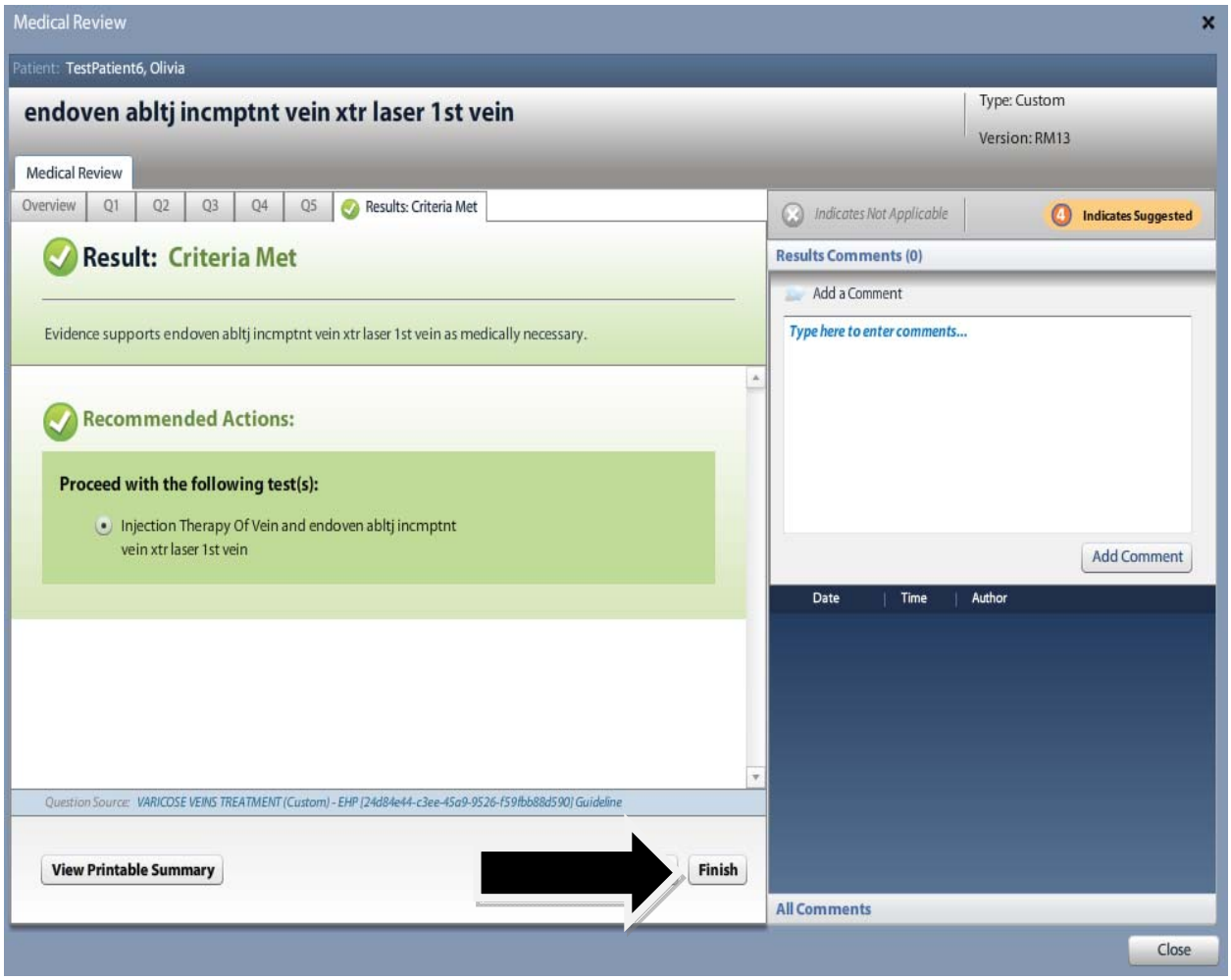
Click on correct services (1) and then click “Next” (2). Skip to page 14.



Clear Coverage™
Varicose Vein Authorization Entry Tips

If criteria is met and the "Recommended Actions" is to proceed with the following test(s):

Click "Finish." Skip to page 14

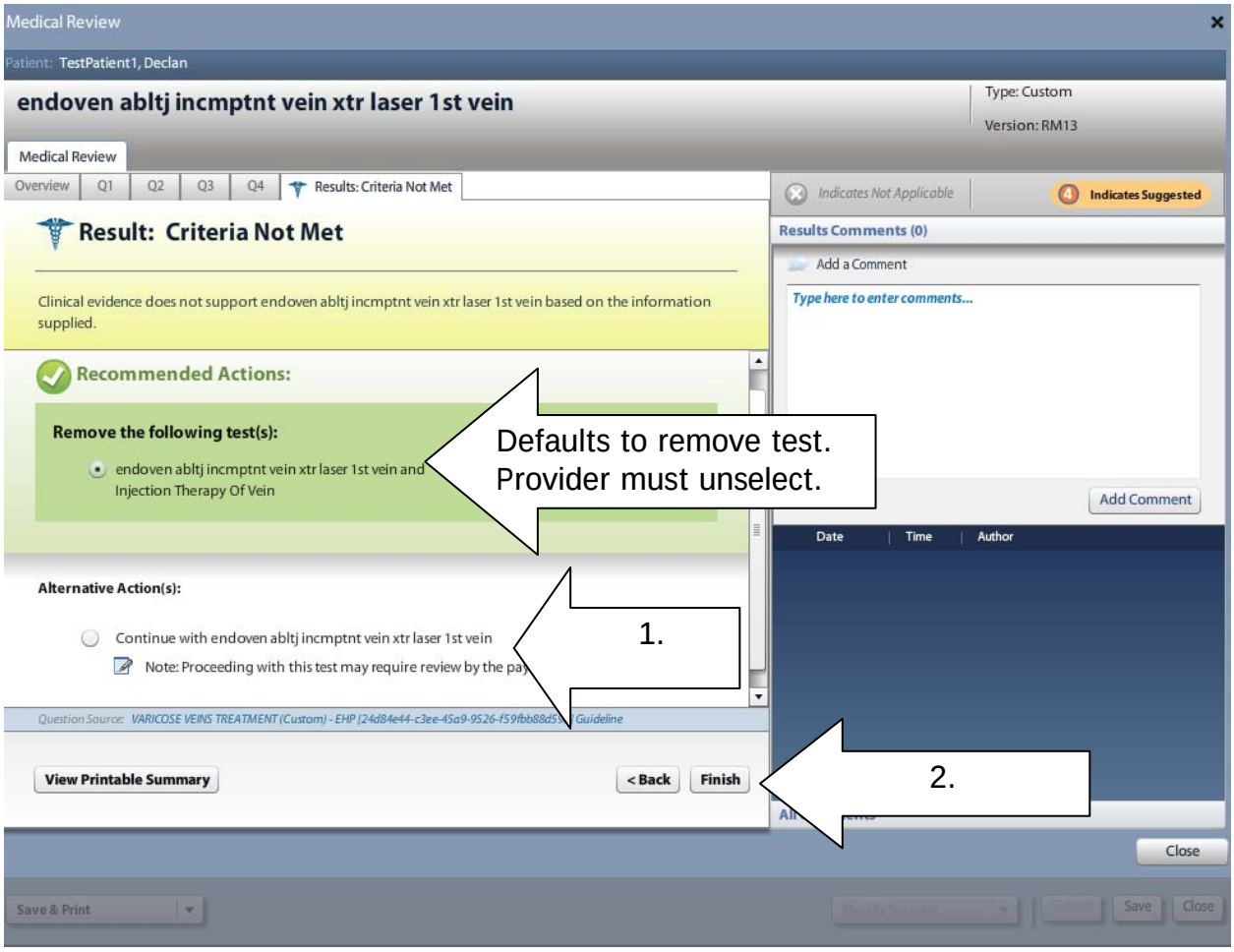


Clear Coverage™
Varicose Vein Authorization Entry Tips

If criteria not met:

The default choice is to **remove** the item from the request.

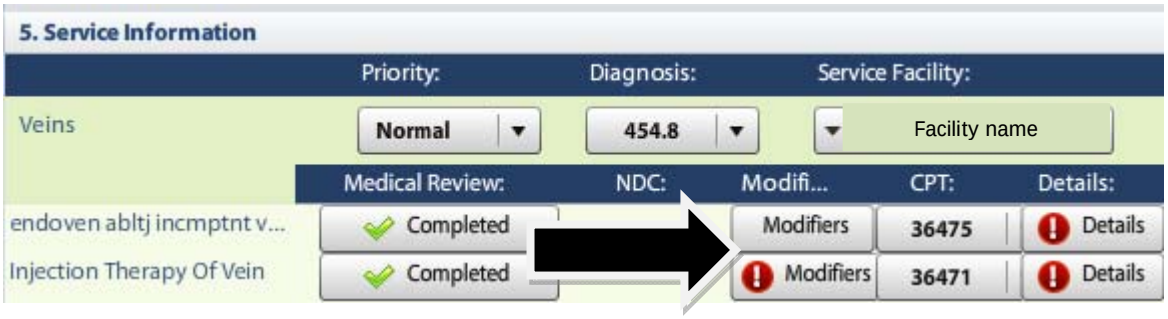
1. You **must** click the button under alternative action to “Continue with endoven abltj incmptnt xtr laser 1st vein” (or appropriate requested item) if you wish the request to pend to the Health Plan for review (1).



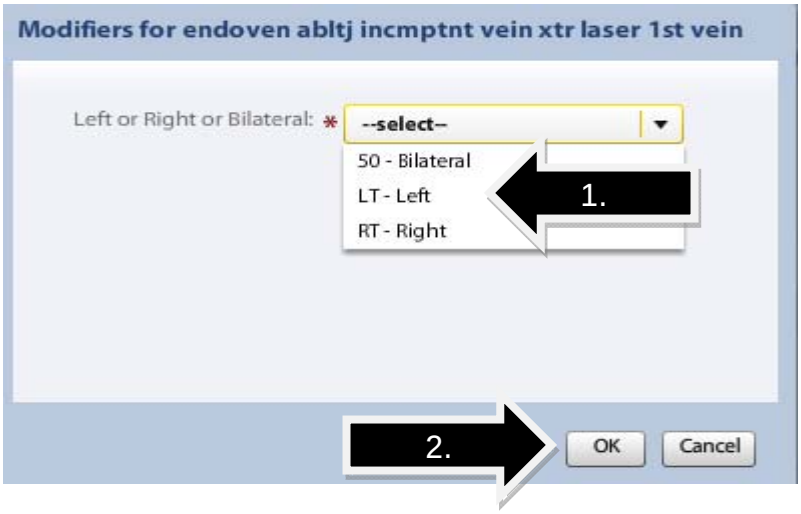
2. Click “Finish.”

Clear Coverage™
Varicose Vein Authorization Entry Tips

Modifiers: Click on the modifier tab (if there is more than one tab you must open and complete each tab).

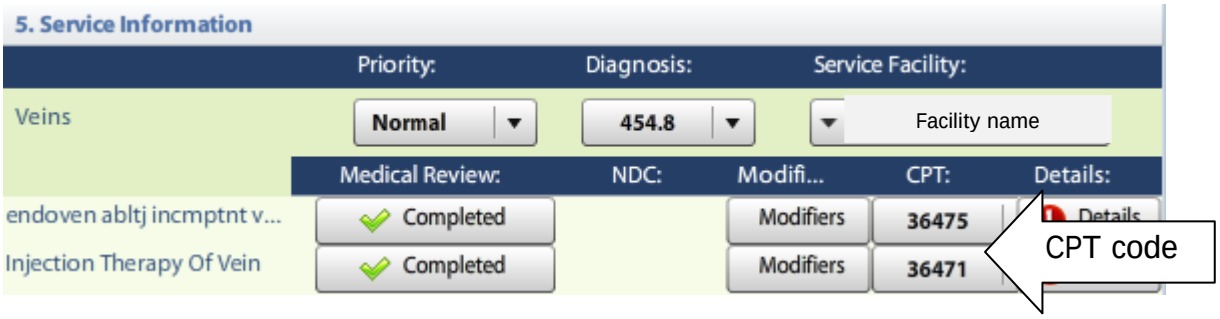


Click on the drop down arrow and select if the procedure will be performed on the right, left or bilateral (1). Click “OK” (2).



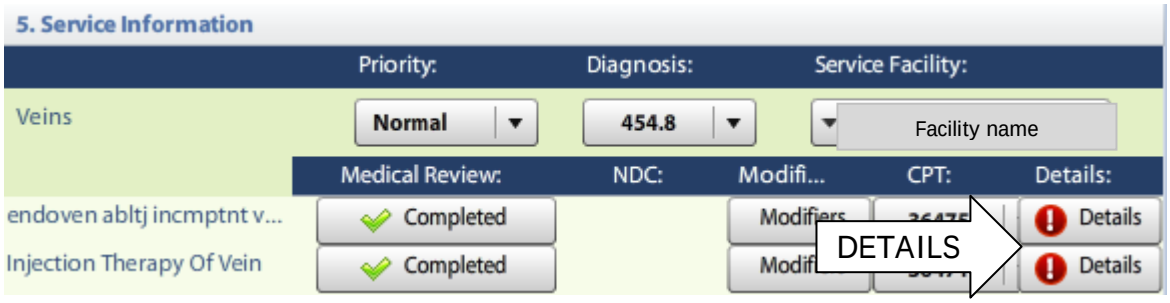
NOTE: Repeat above process until all “Modifiers” tabs have been completed.

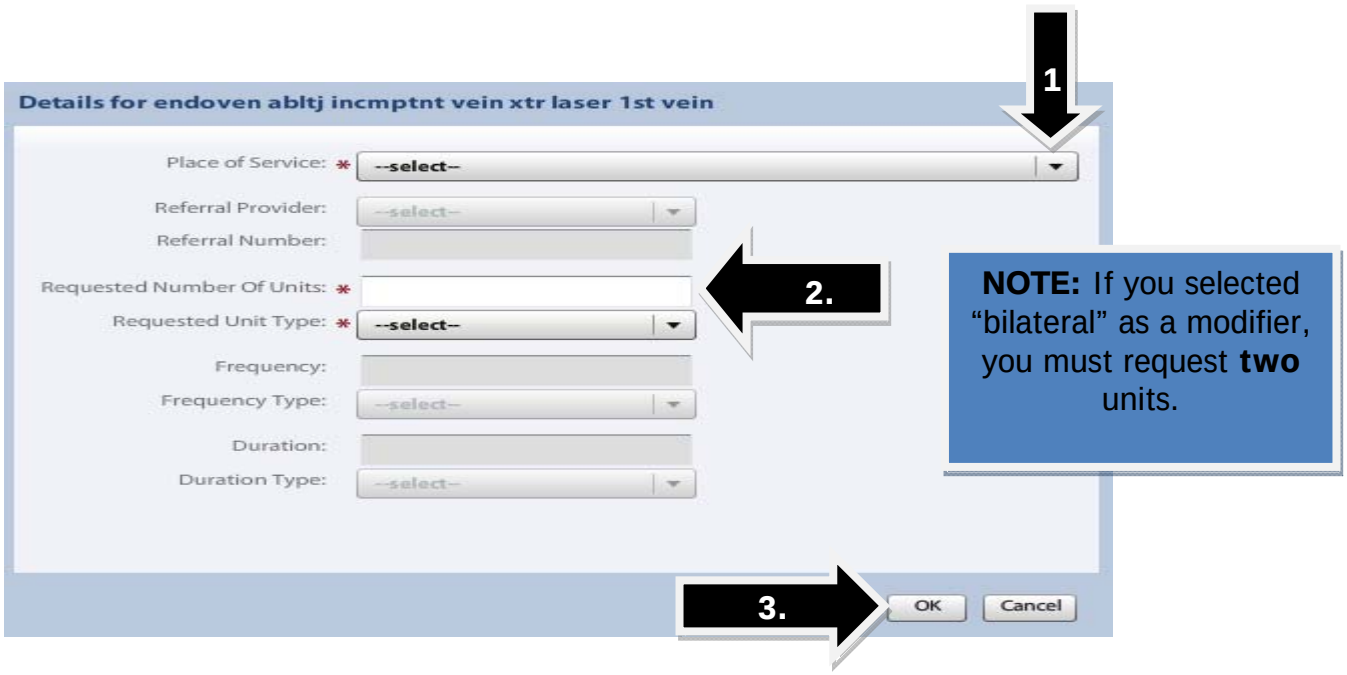
Ensure the correct CPT code is populated from the drop down menu:



Clear Coverage™
Varicose Vein Authorization Entry Tips

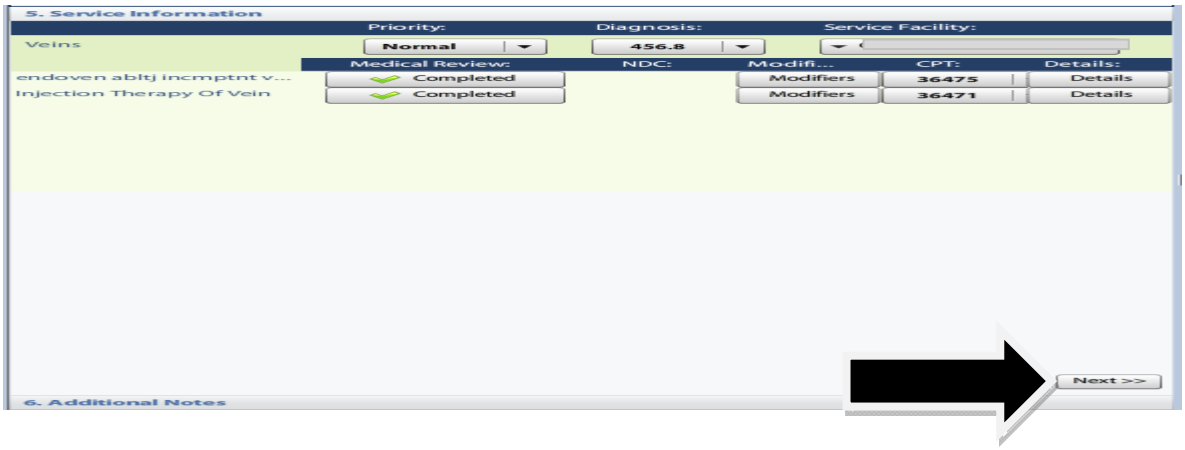
Details section: Must select: (1) Place of Service, (2) Requested Number of Units and Requested Unit Type**.** Click the "OK" button (3).





NOTE: Repeat above process until all "Details" tabs have been completed.

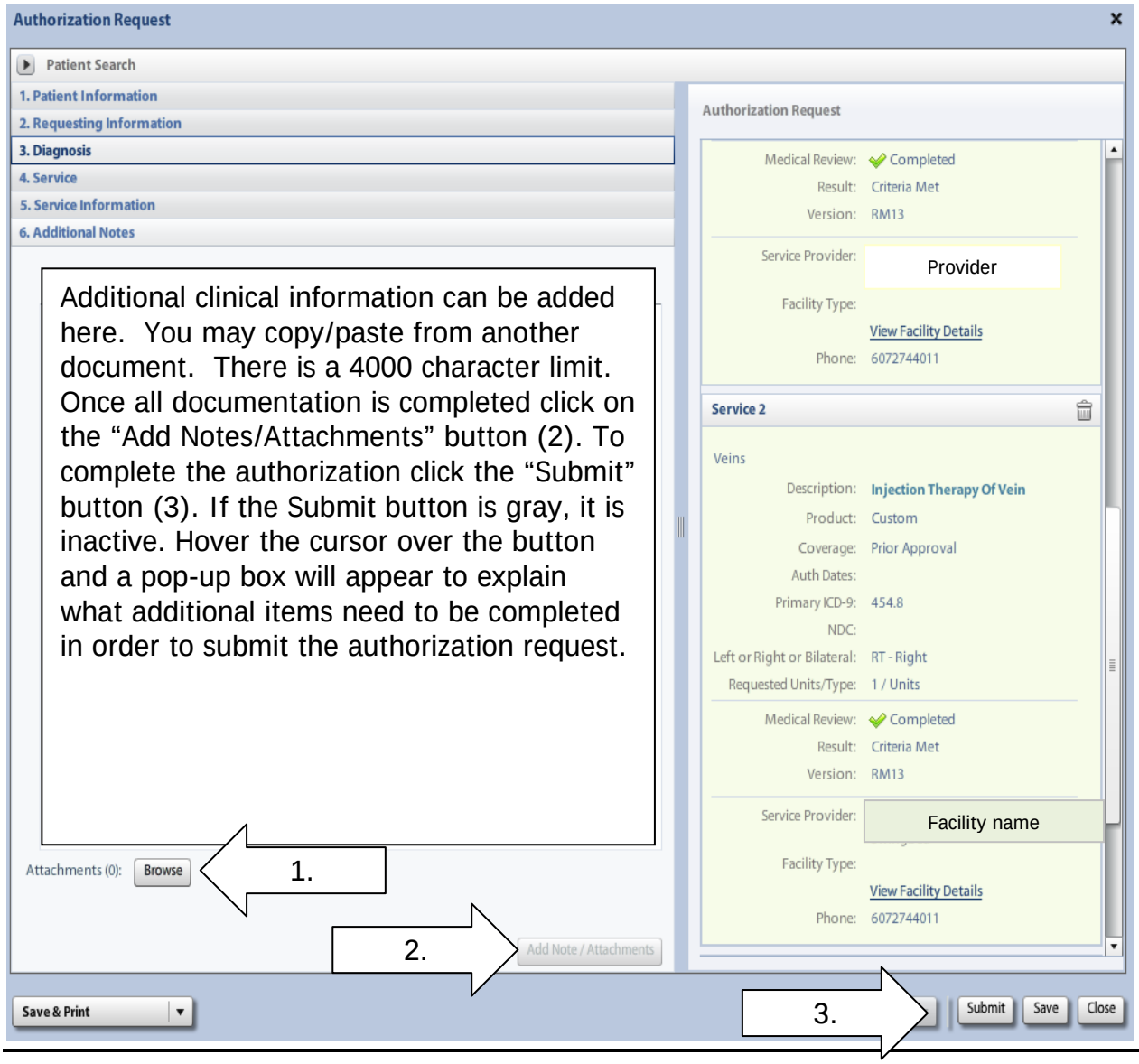
Click "Next."



Clear Coverage™
Varicose Vein Authorization Entry Tips

Accordian 6: Additional Notes

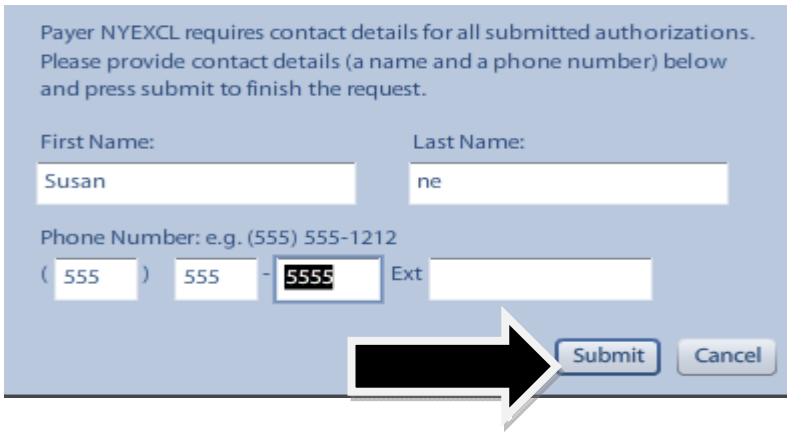
If criteria was <u>not</u> met, or if this is a Medicare patient, enter additional information and/or attach a note with supporting medical documentation (1).
A note <u>must</u> be added in order to attach a document.



Clear Coverage™
Varicose Vein Authorization Entry Tips

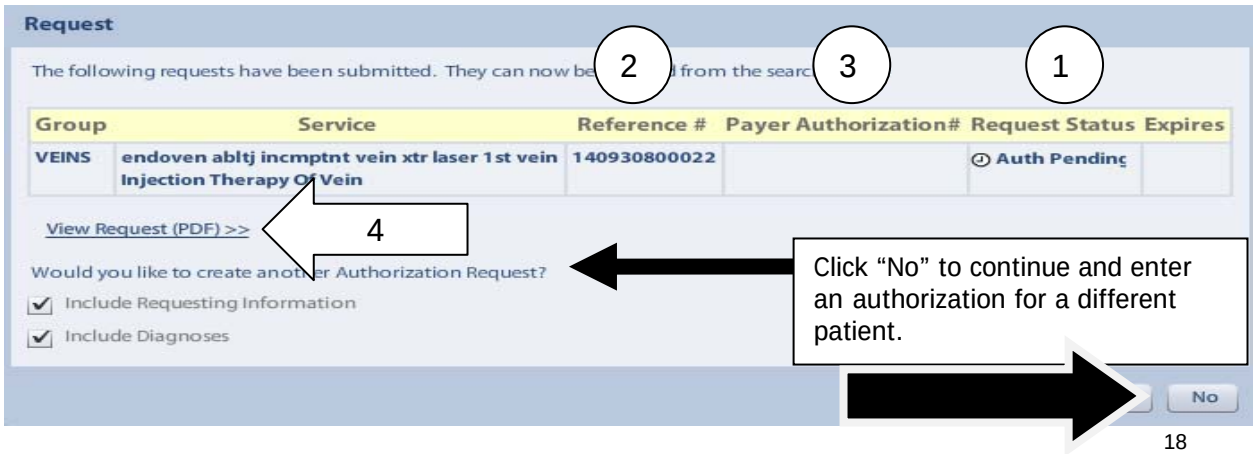
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Wheelchair Authorization Entry Tips

Medicare: review tool MUST be completed to provide clinical information to the Health Plan. Medicare requests will pend until this information is reviewed.

Commercial: will auto approve if criteria is met.

EXCEPTION: power wheelchairs, pediatric wheelchairs and requests with accessories. Review tool MUST be completed to provide clinical information to the Health Plan. Requests will pend until this information is reviewed.

NOTE: If the request pends, the provider needs to send supporting documentation within the Clear Coverage™ tool (Accordion 6).

After searching for and selecting the patient, the Authorization Request entry box will display.

Accordion 1: Patient Information

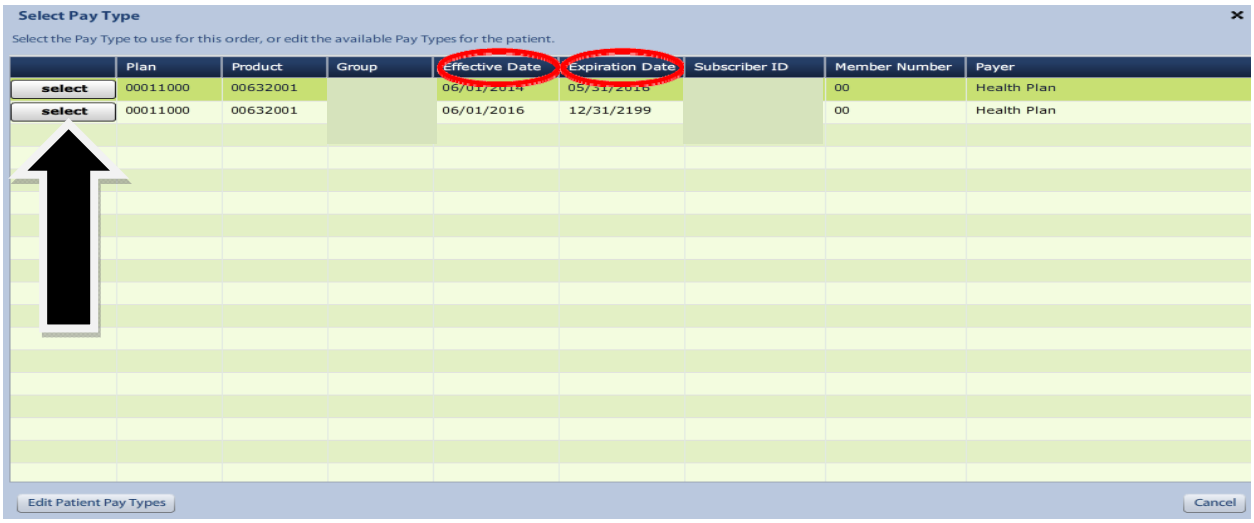
Review information. Click on the "Select Pay Type" button. Check pay type for dual coverage and/or future coverage (a change in the effective date of the policy).

Clear Coverage™
Wheelchair Authorization Entry Tips

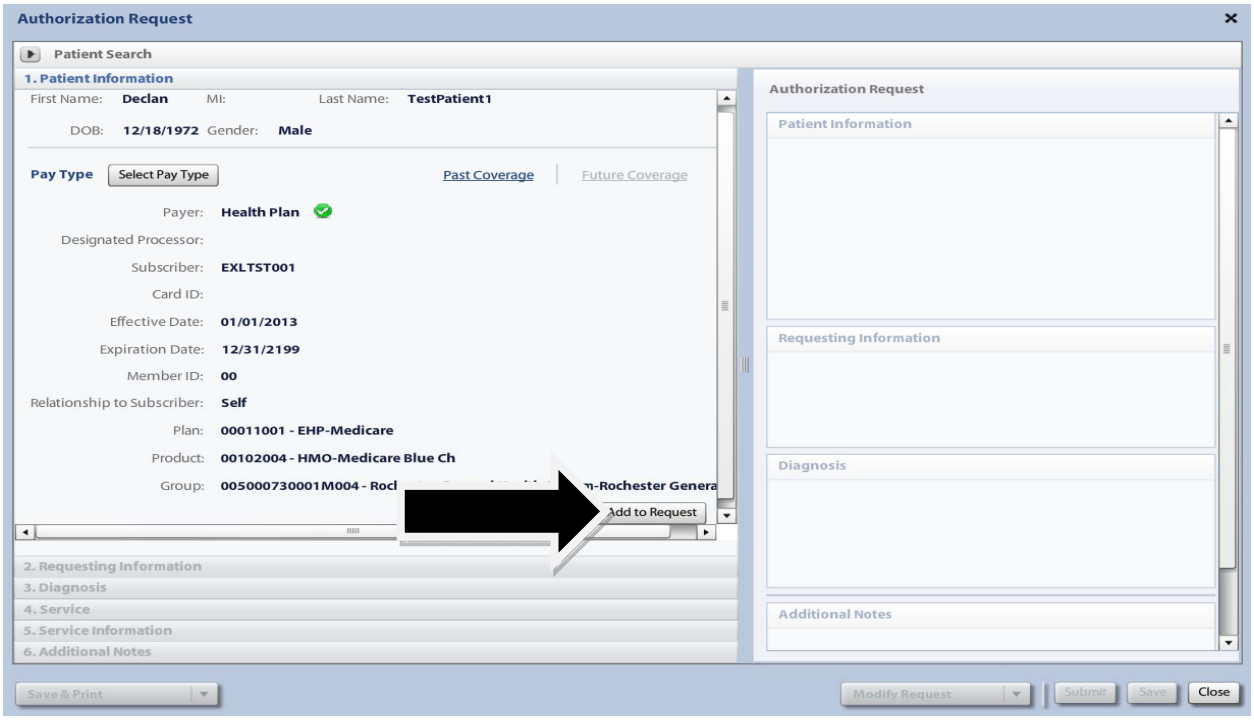
Note: If the patient has dual coverage with the Health Plan, separate authorizations will need to be entered for each active policy.

The request for the second contract will always pend.

Click “Select” for the correct coverage and correct effective dates.



Click “Add to Request” to continue.

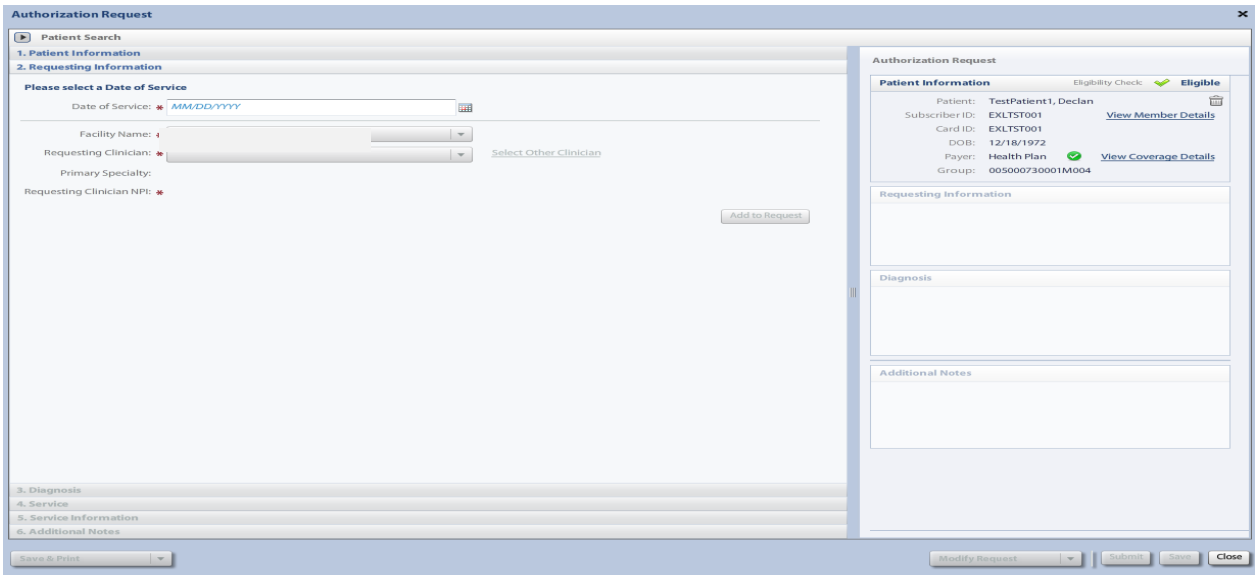


Clear Coverage™
Wheelchair Authorization Entry Tips

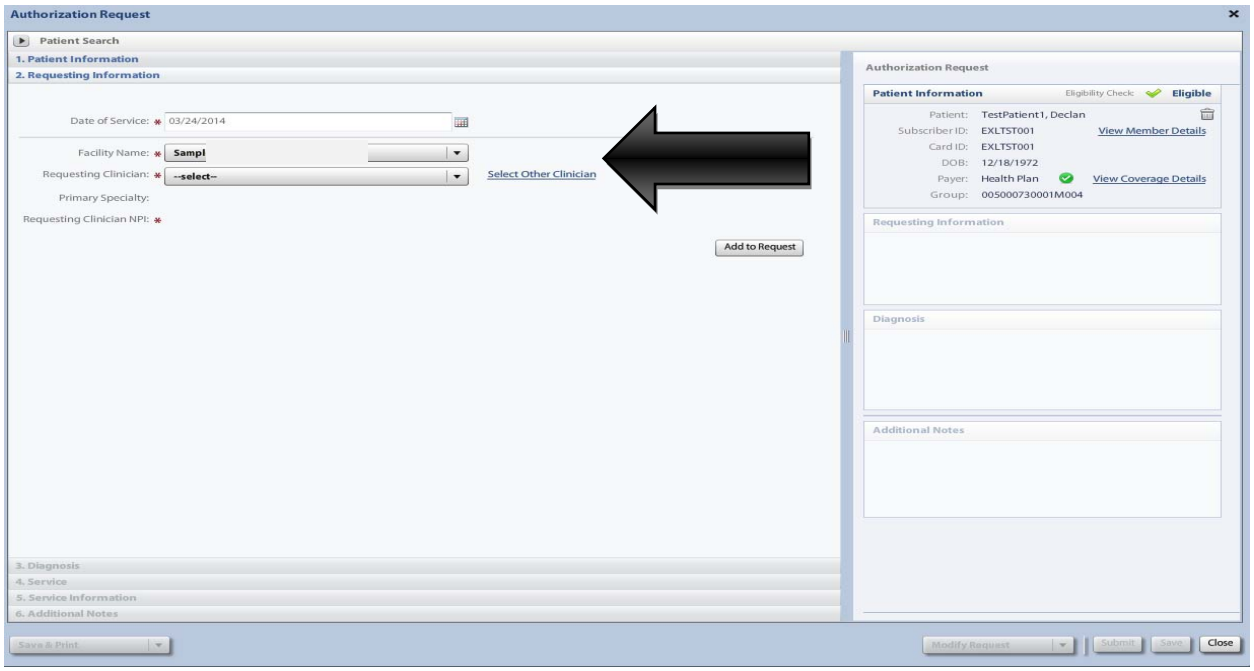
Accordion 2: Requesting Information

Date of Service - date range: can backdate up to 5 days, or go forward 90 days.

Facility Name = defaults to the Facets ID and NPI information that is associated with the provider currently logged into Clear Coverage™.



Requesting Clinician = Ordering **PHYSICIAN**. Do <u>NOT</u> enter a nurse practitioner, physician assistant, therapist or other provider. Click on "Select Other Clinician" to search.

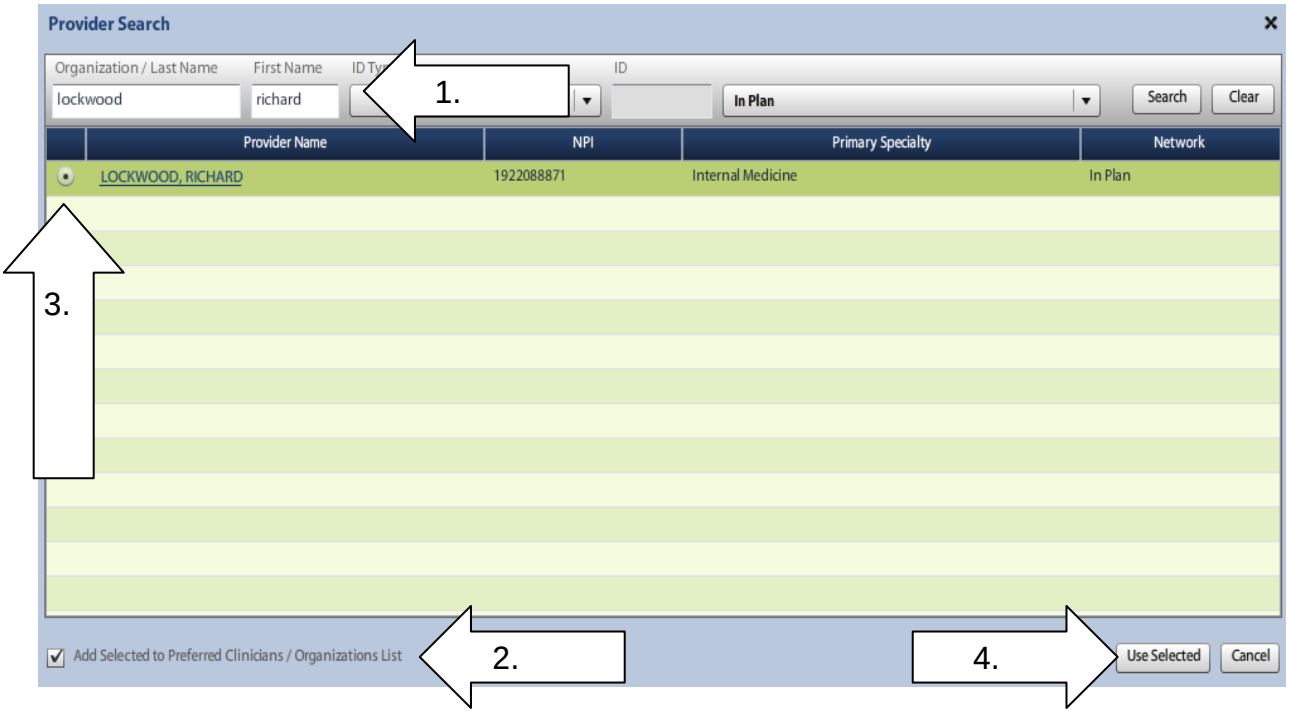


Clear Coverage™
Wheelchair Authorization Entry Tips

Enter the search parameters (1).

The provider can be saved to the preferred provider list (2).

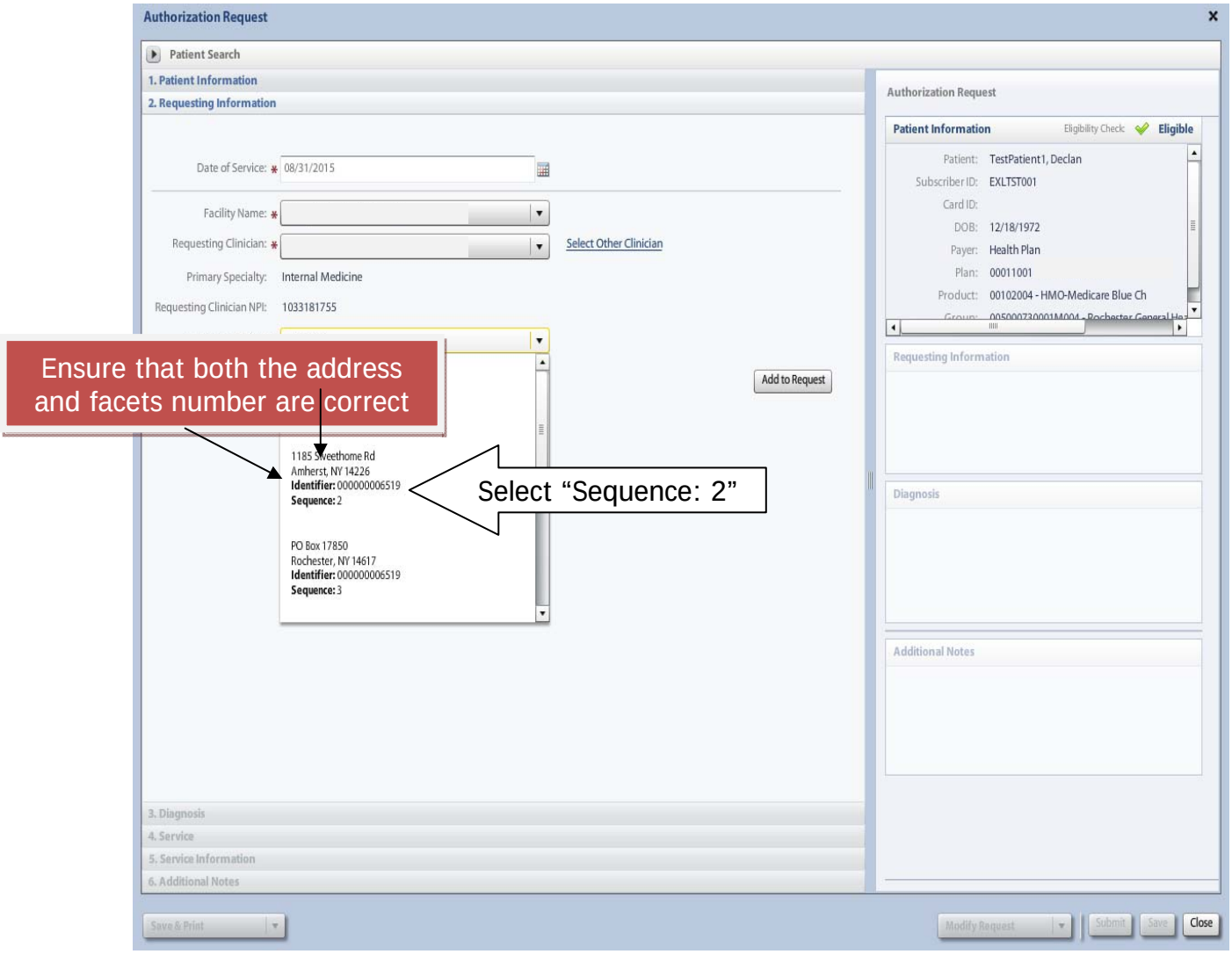
Select the provider using the radio button (3) then click the “Use Selected” button(4).



Clear Coverage™
Wheelchair Authorization Entry Tips

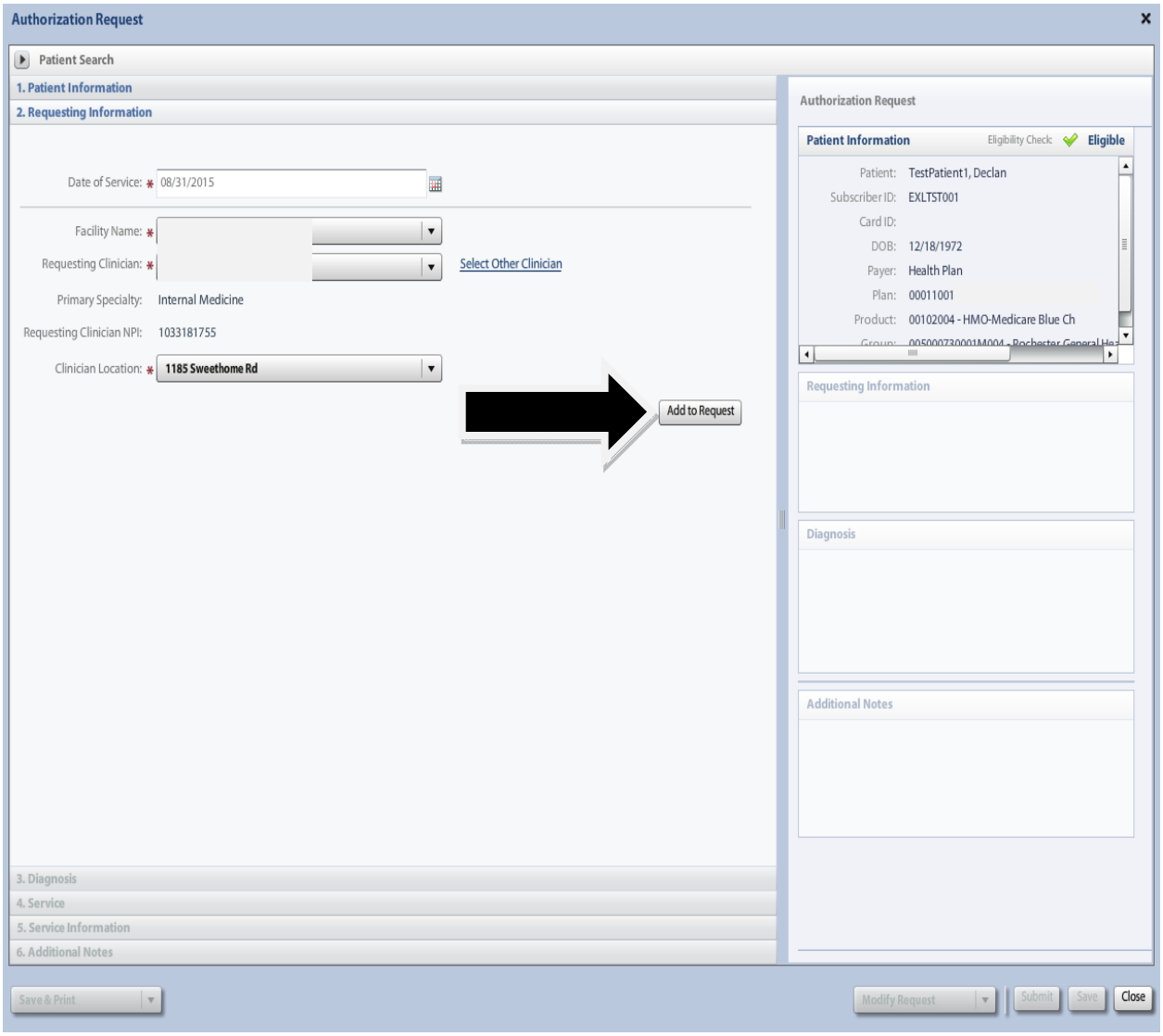
Click the dropdown arrow and select the "**Sequence: 2**" address that corresponds correctly with your assigned "Identifier" number (Facets number) and address.

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



Clear Coverage™
Wheelchair Authorization Entry Tips

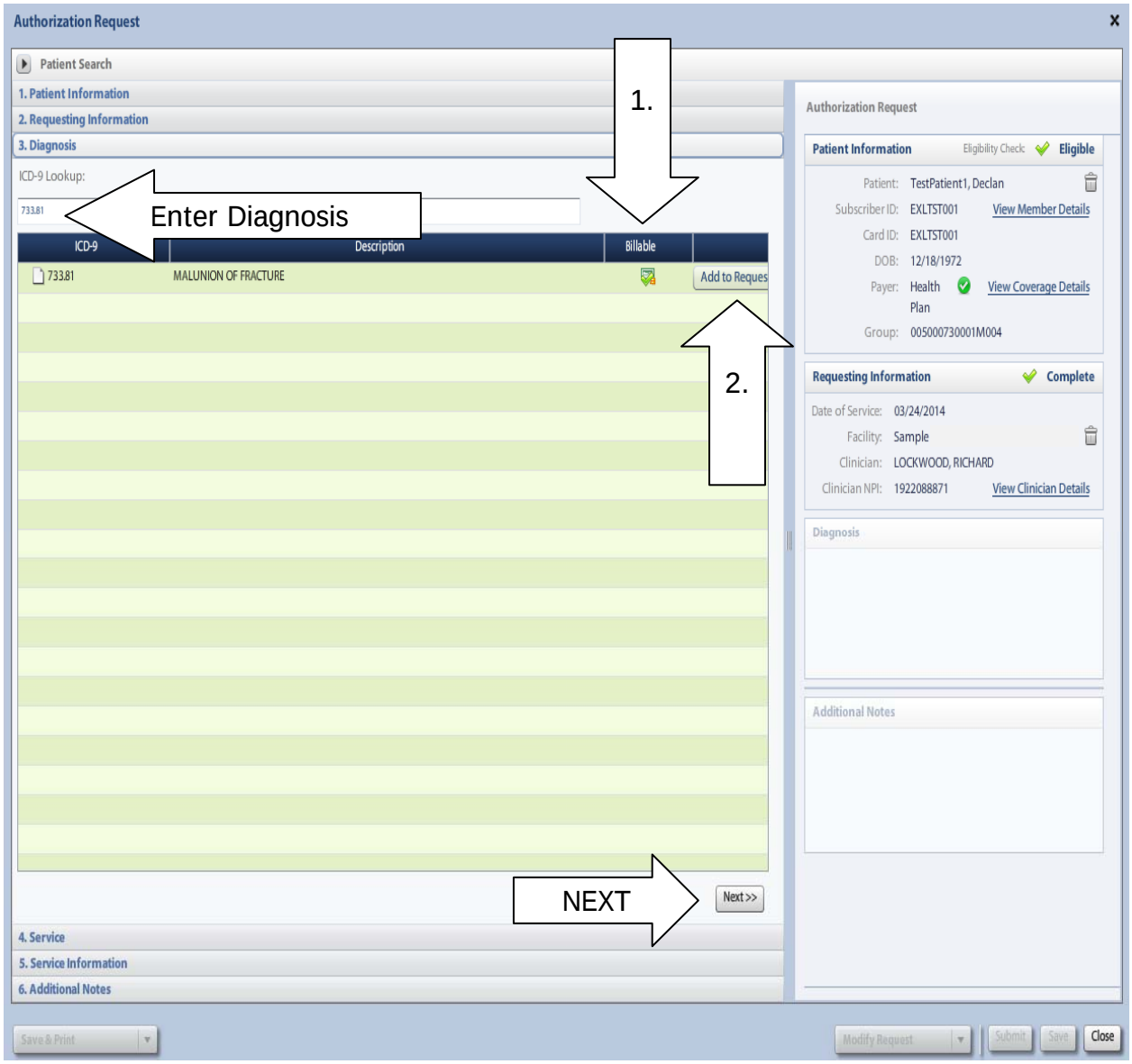
Click “Add to Request” to add this information to the authorization request “cart” that is located on the right side of the screen.



Clear Coverage™
Wheelchair Authorization Entry Tips

Accordion 3: Diagnosis

Add the patient's diagnosis(es). Check the Billable column (1) to ensure you are entering a billable code. This will be indicated by a green checkmark. Click the "Add to Request" button (2). Multiple diagnoses can be added to the request. Enter the primary diagnosis first. Once the diagnosis(es) have been added click "Next."

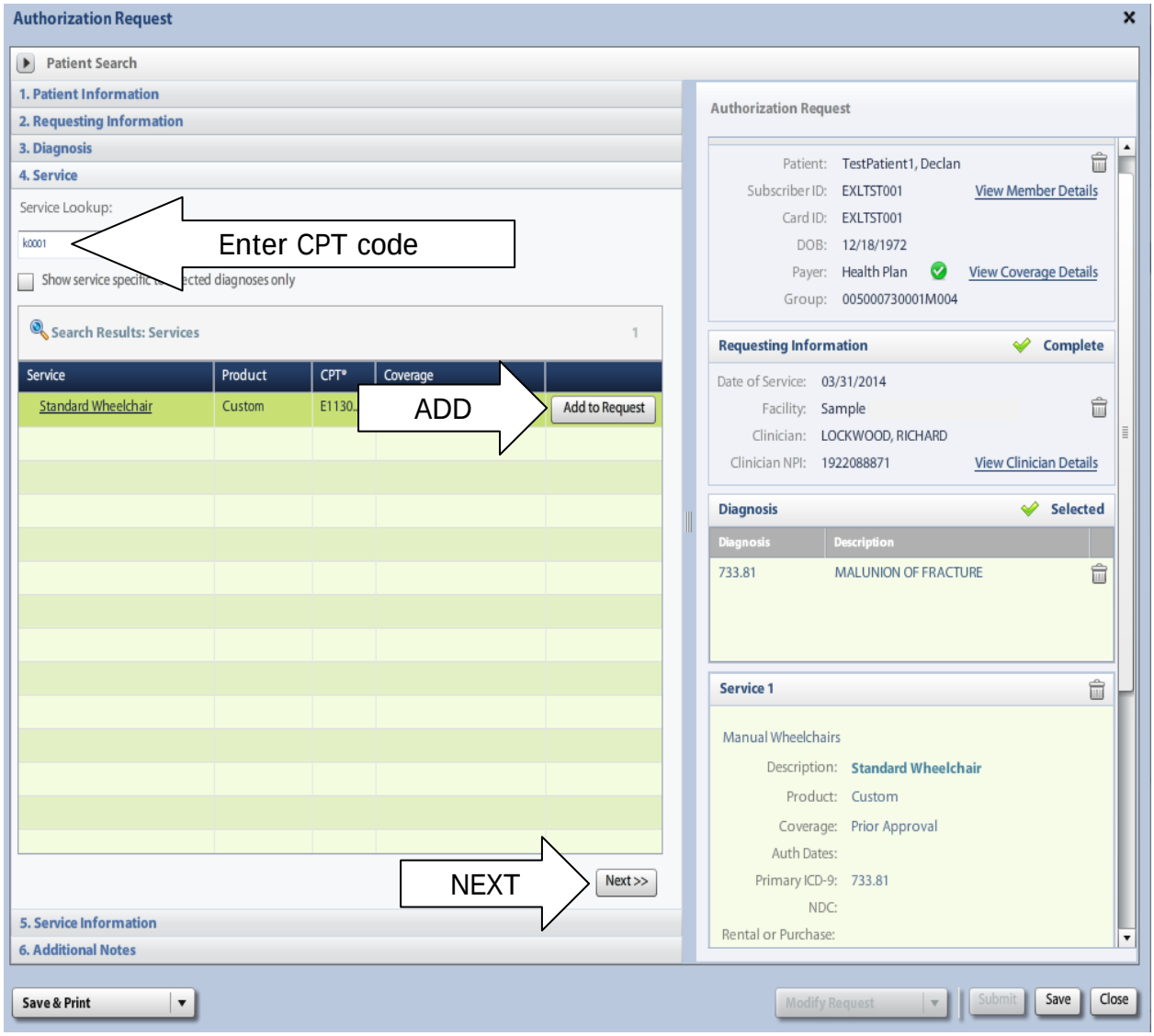


Accordion 4: Services

Enter CPT code.
NOTE: adding codes for additional accessories will cause the authorization request to pend to the Health Plan for medical review.

Process exception: When requesting the code **K0108** for **MANUAL** wheelchairs, do not add the code in accordion 4. This code will need to be added to the request later in the authorization process. Complete the authorization request process and then refer to page 15-16 of this document for instructions about adding code K0108 to the request.

- Click the "Add to Request" button, then click "Next."



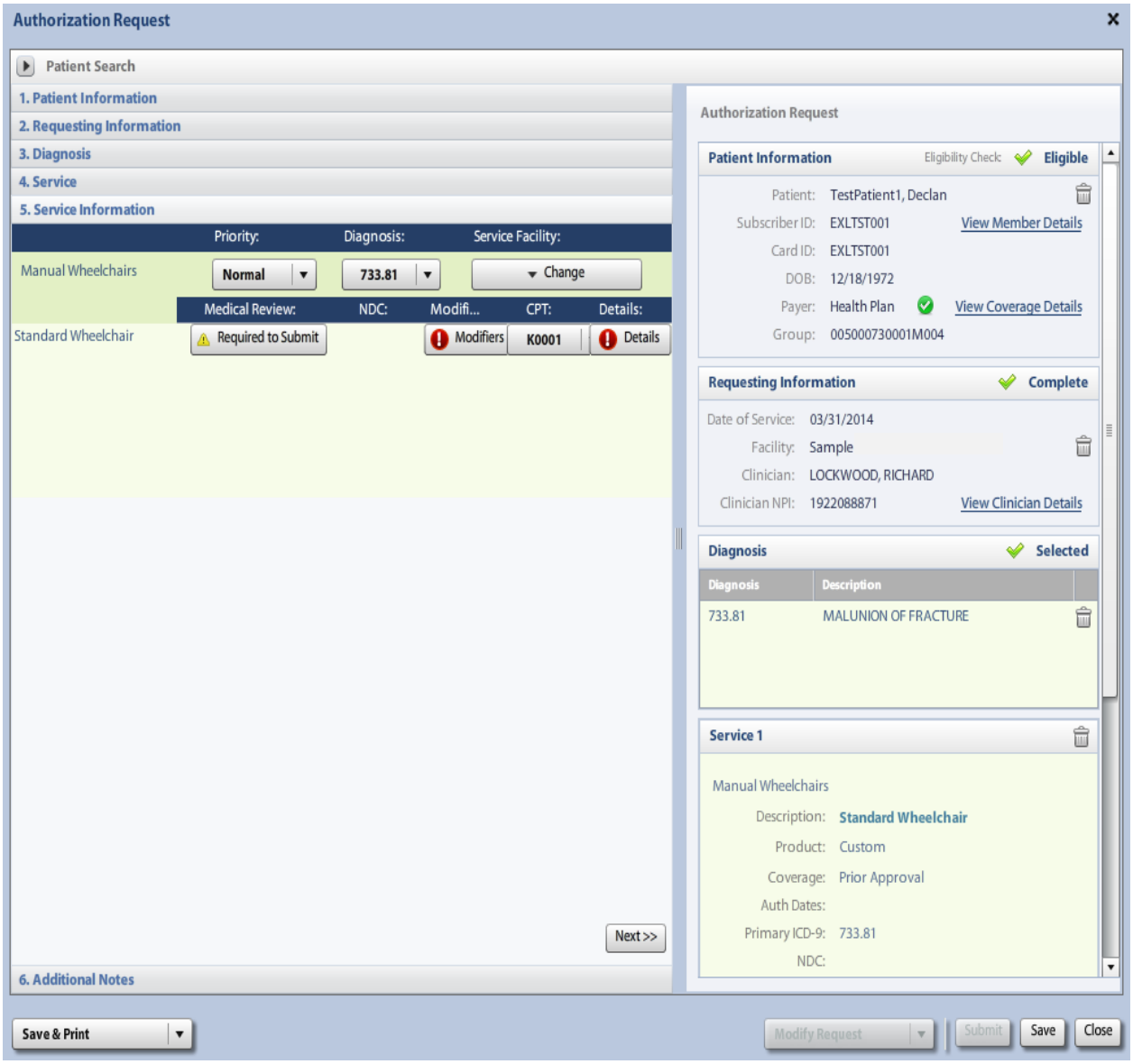
Clear Coverage™
Wheelchair Authorization Entry Tips

Accordion 5: Service Information

Priority - Normal (if request is urgent, call Customer Care)

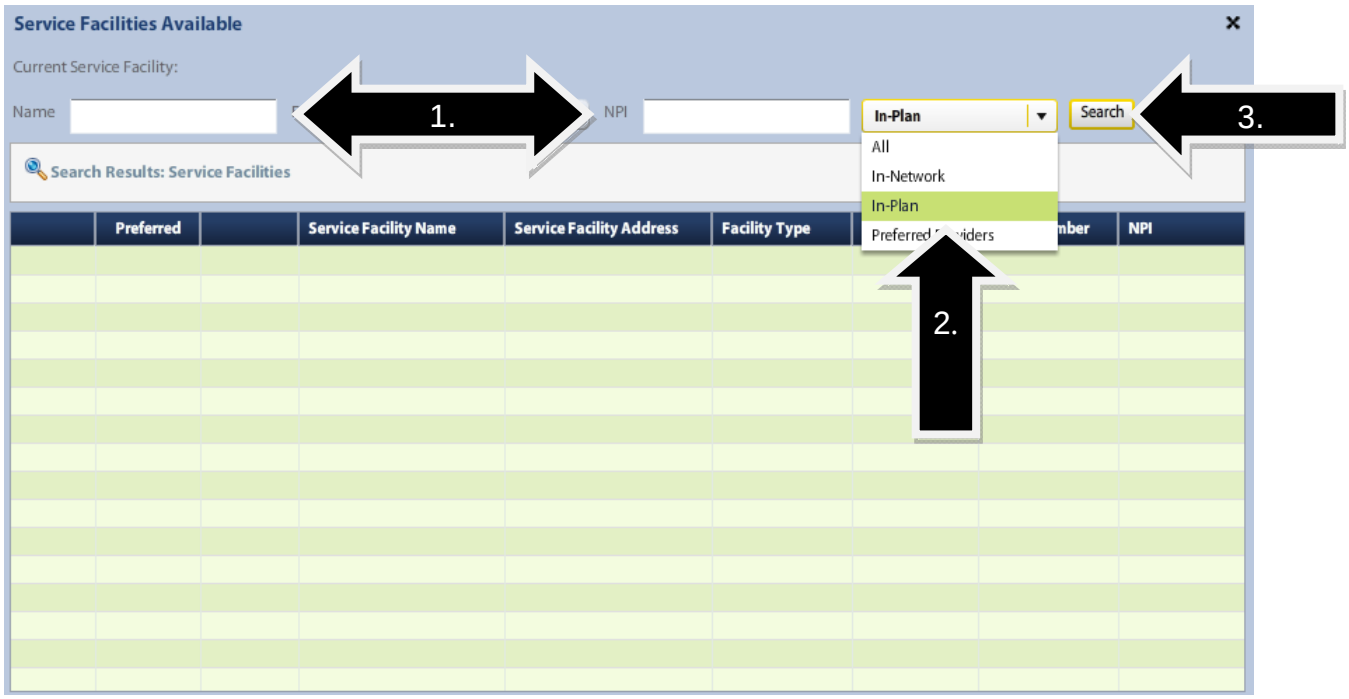
Diagnosis - defaults to the primary diagnosis code that was entered in accordion 3

Service Facility = place of service (or provider/vendor)

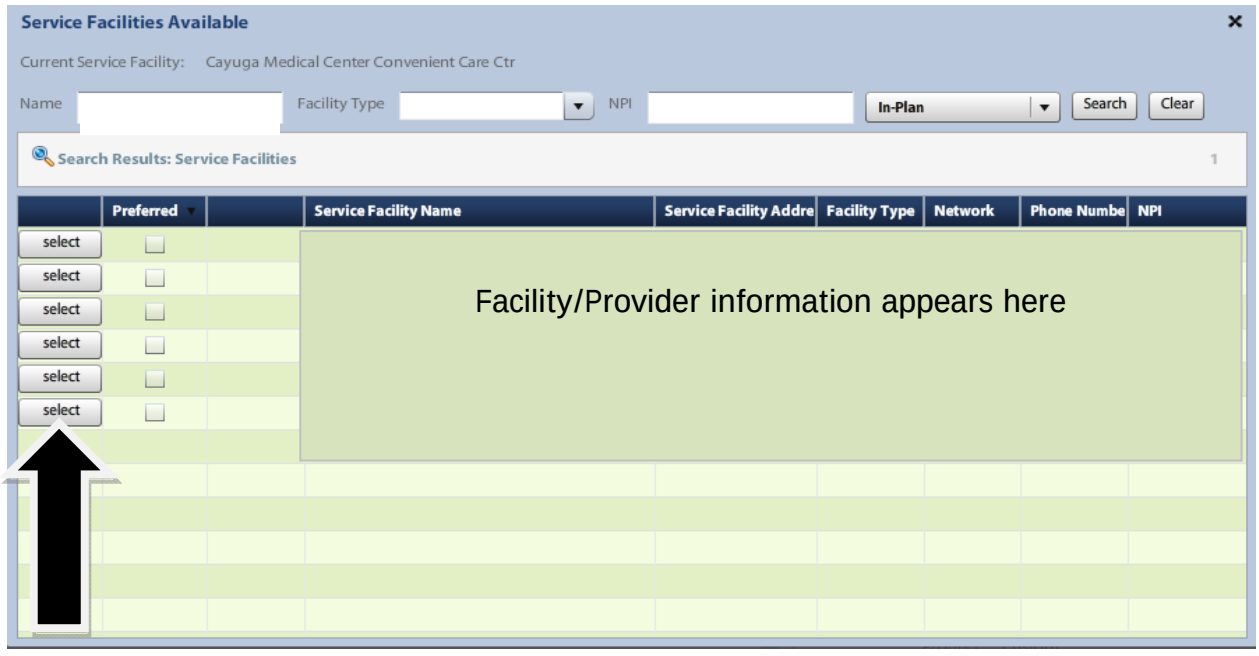


Clear Coverage™
Wheelchair Authorization Entry Tips

When searching for Service Facility Name (provider of service), enter the name or the NPI number (1), then select “In-Plan” (2). If the appropriate provider is not found, switch to “All” (when “All” is selected, request will pend, even if it meets criteria). Click the “Search” button (3).



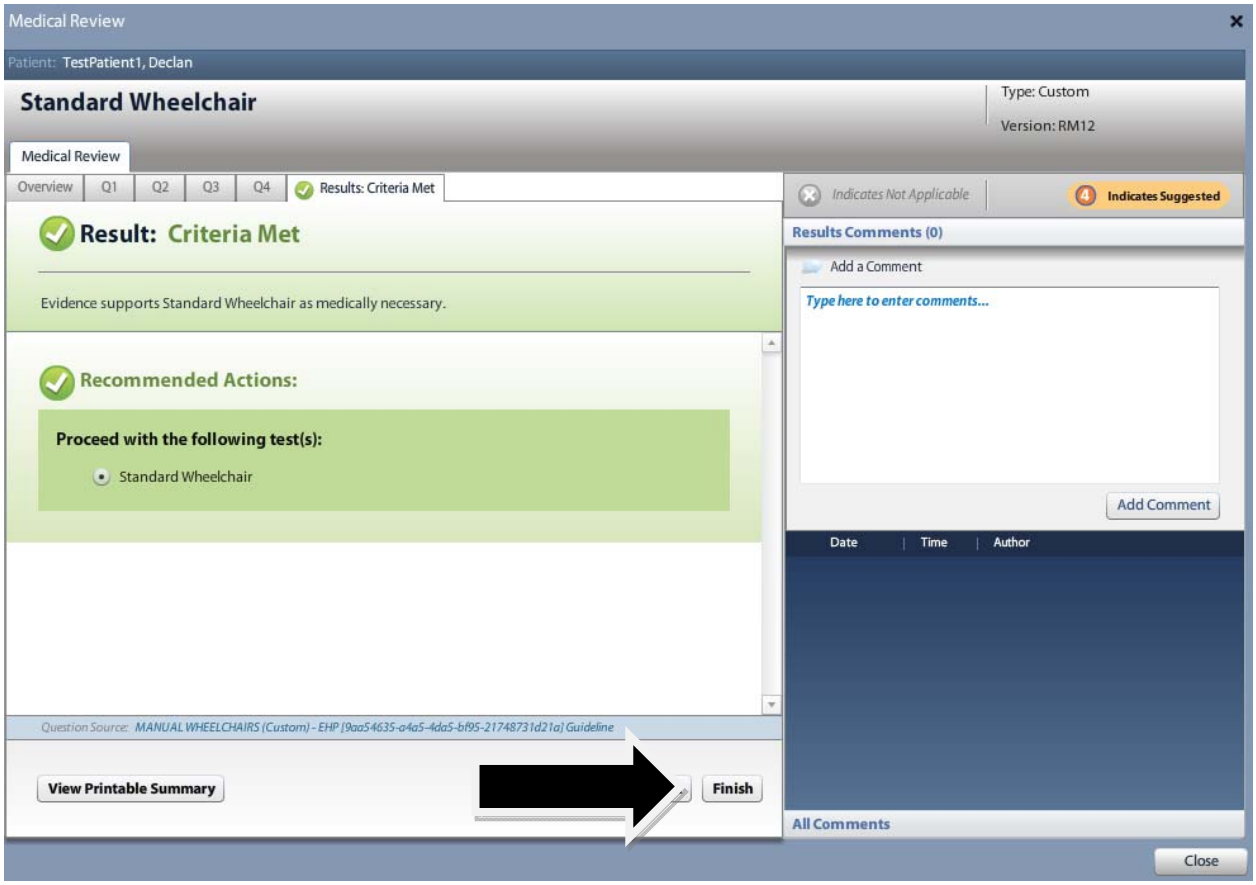
When the results display, select the appropriate provider.



Clear Coverage™
Wheelchair Authorization Entry Tips

Click on the Medical Review "Required to Submit" tab and complete the review.

If Result = Criteria Met, and the Recommneded Action is to "Proceed with the following test(s): Click "Finish."

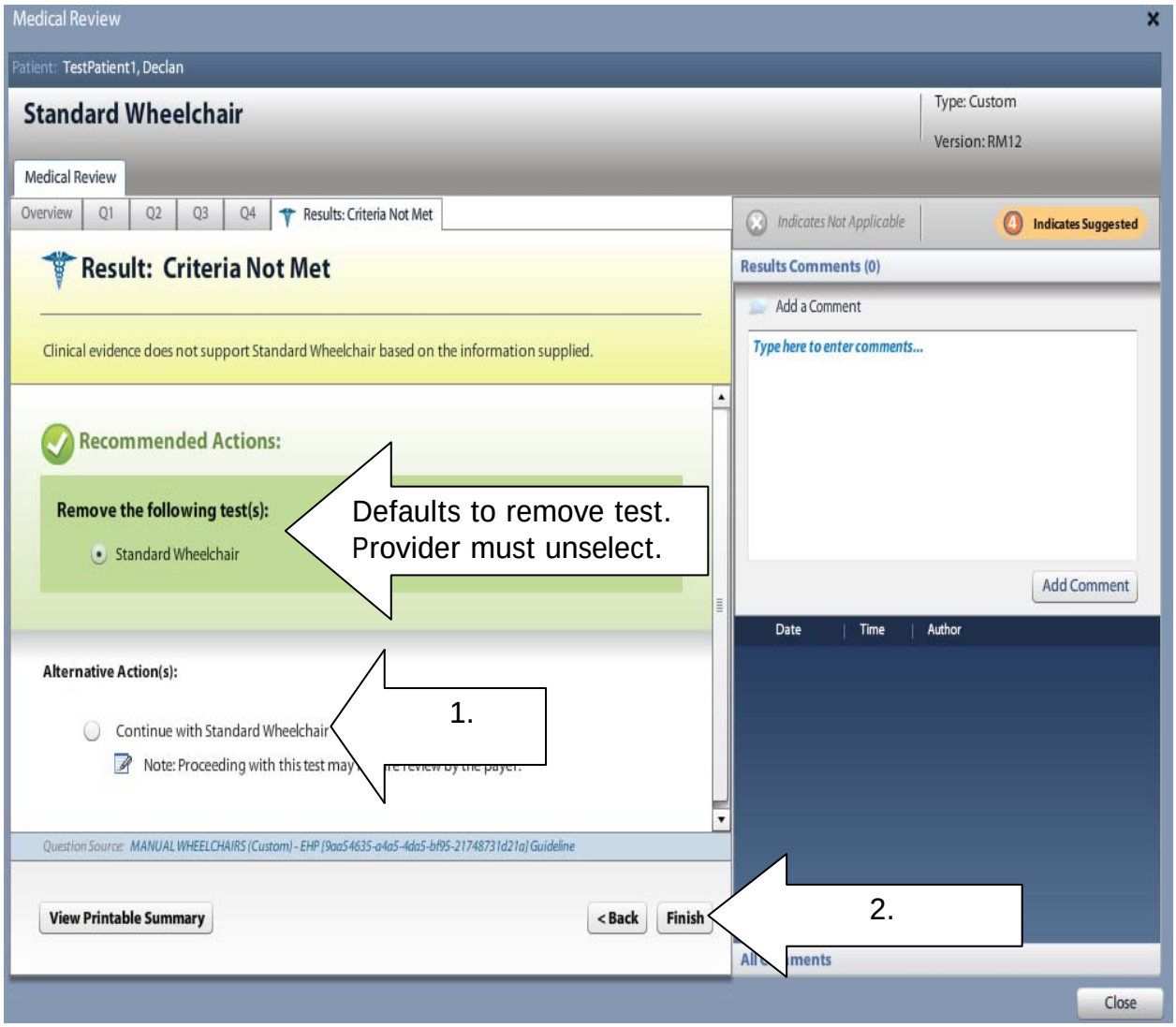


Clear Coverage™
Wheelchair Authorization Entry Tips

If criteria is not met:

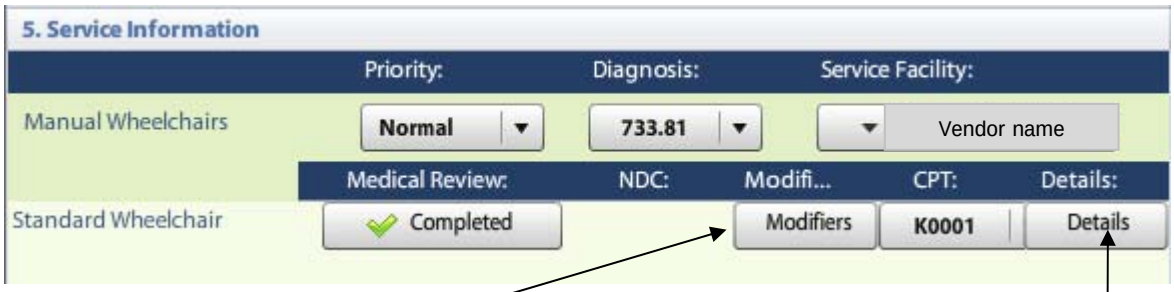
The default choice is to **remove** the item from the request.

1. You **must** click the button under alternative action to “Continue with Standard Wheelchair” (or appropriate item) if you wish the request to pend to the Health Plan for review.



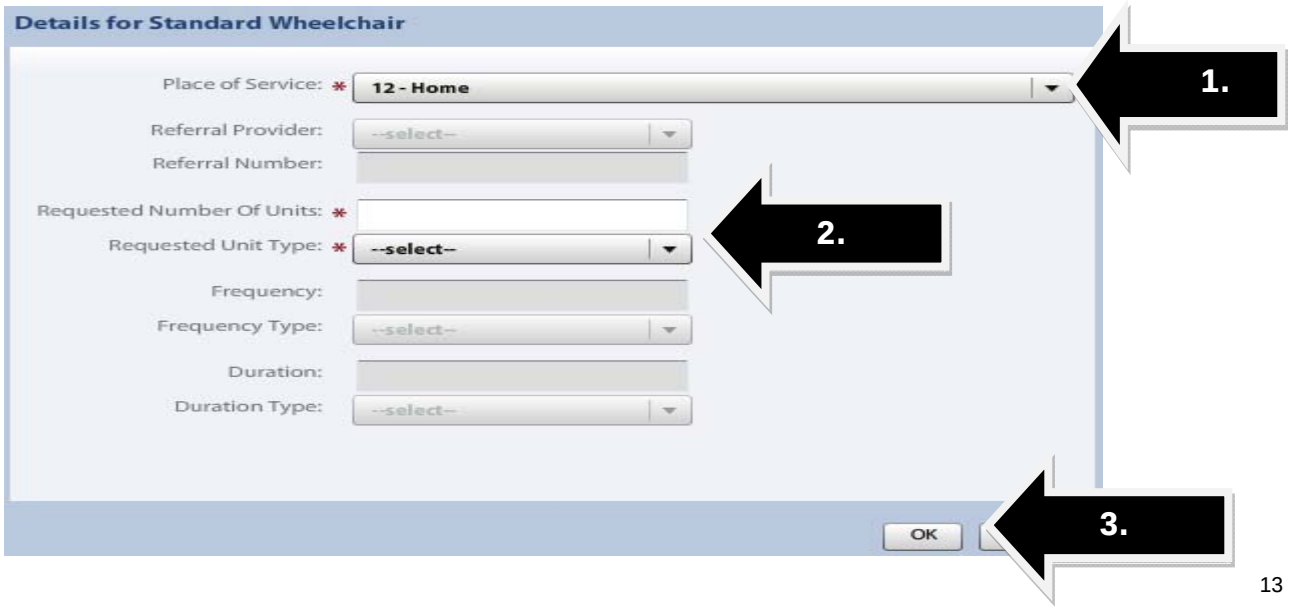
2. Click “Finish.”

Clear Coverage™
Wheelchair Authorization Entry Tips



Modifiers: Select NU - Purchase or RR – Rental, then click "OK."

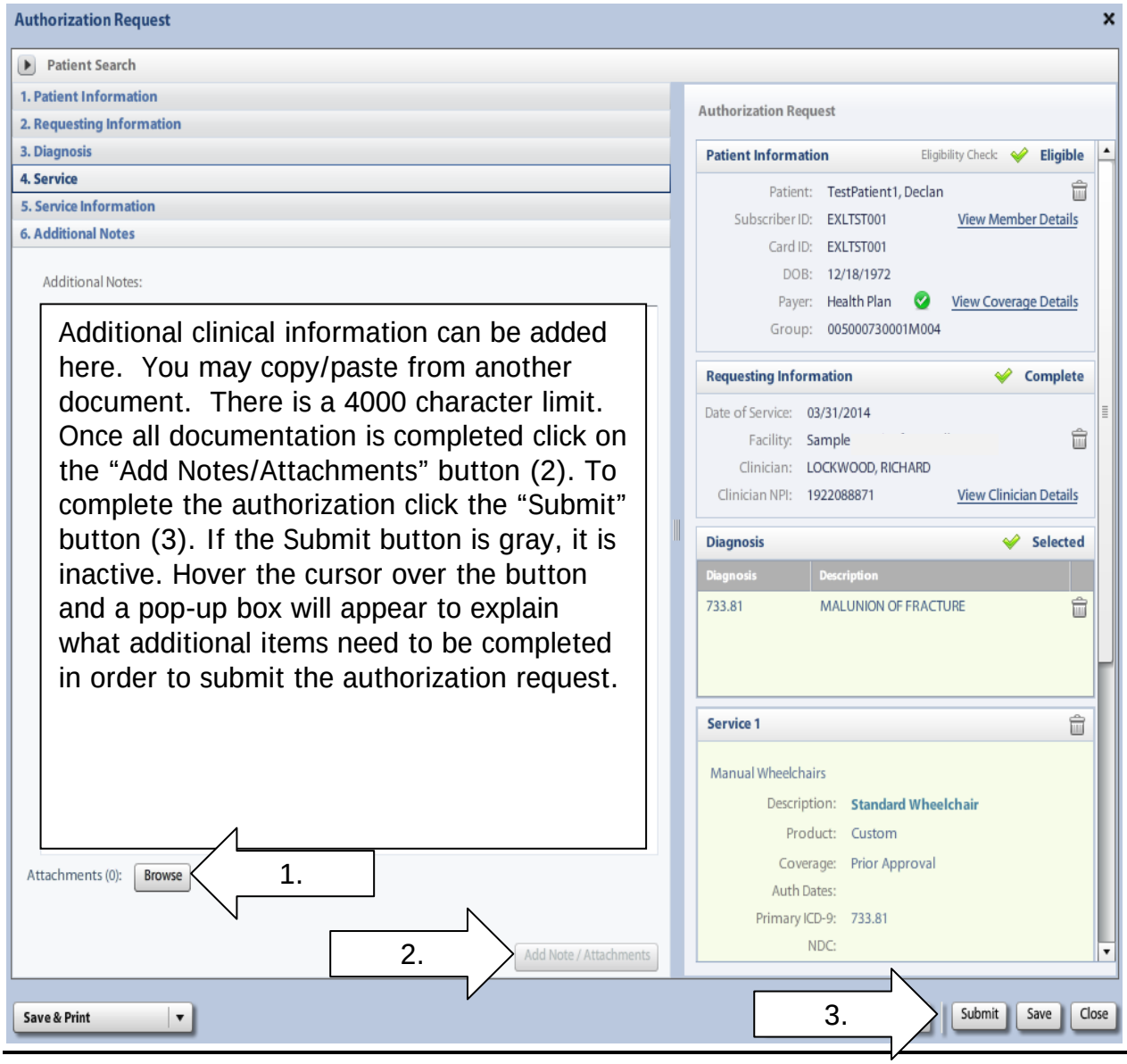
Details: Must select: (1) "Place of Service". (2) "Requested Number of Units" and "Requested Unit Type"**.** Click the "OK" button (3).



Accordian 6: Additional Notes

If criteria was not met, or additional codes were added to the request, a note is required. **NOTE:** if the request is for a manual wheelchair and you are also requesting code K0108, please see page 15-16 of this document.

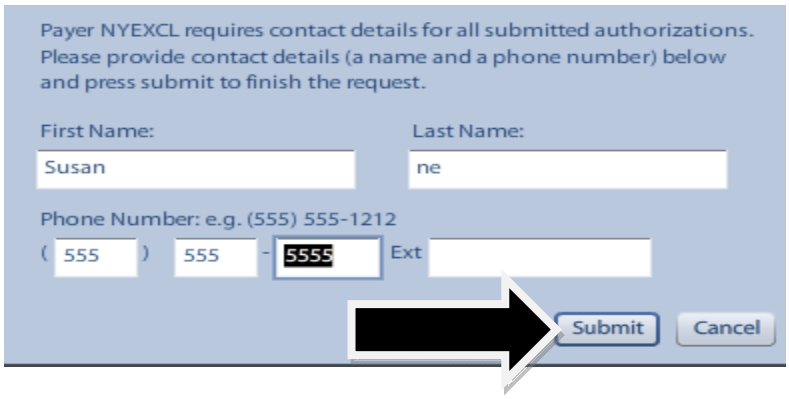
Enter additional information and/or attach a note with supporting medical documentation (1). A note must be added in order to attach a document.



Clear Coverage™
Wheelchair Authorization Entry Tips

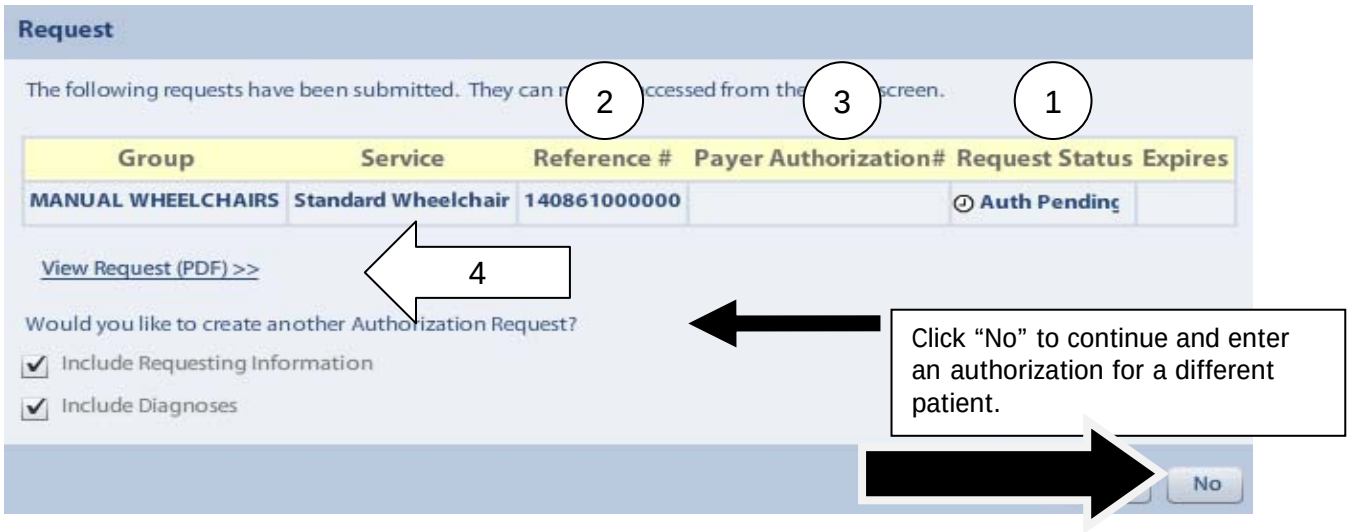
Once the authorization has been submitted, a contact information box displays. This provides information about whom the Health Plan should contact if additional information is needed to process the request.

The contact individual defaults to the name of the individual logged into the Health Plan provider portal. The contact name can be edited if necessary. Enter a contact telephone number. Click the "Submit" button.



The Request box will display. The Request box allows you to see/access the following:

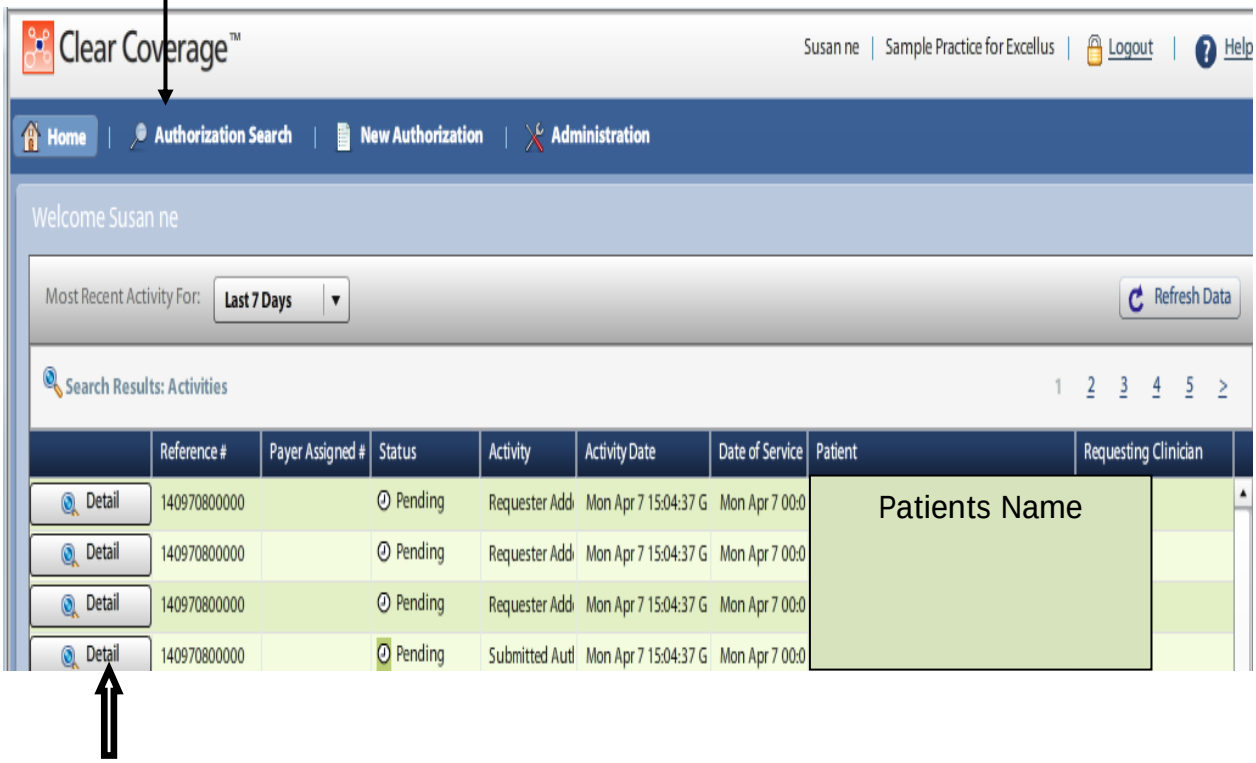
1. Status of the authorization
2. Reference # (used when a request is pended)
3. Payer Authorization #
4. A link to access a PDF copy of the request (can be printed or saved electronically)
5. Click "No" to close this request



Clear Coverage™
Wheelchair Authorization Entry Tips

NOTE: if the request is for a manual wheelchair and you are also requesting code K0108:

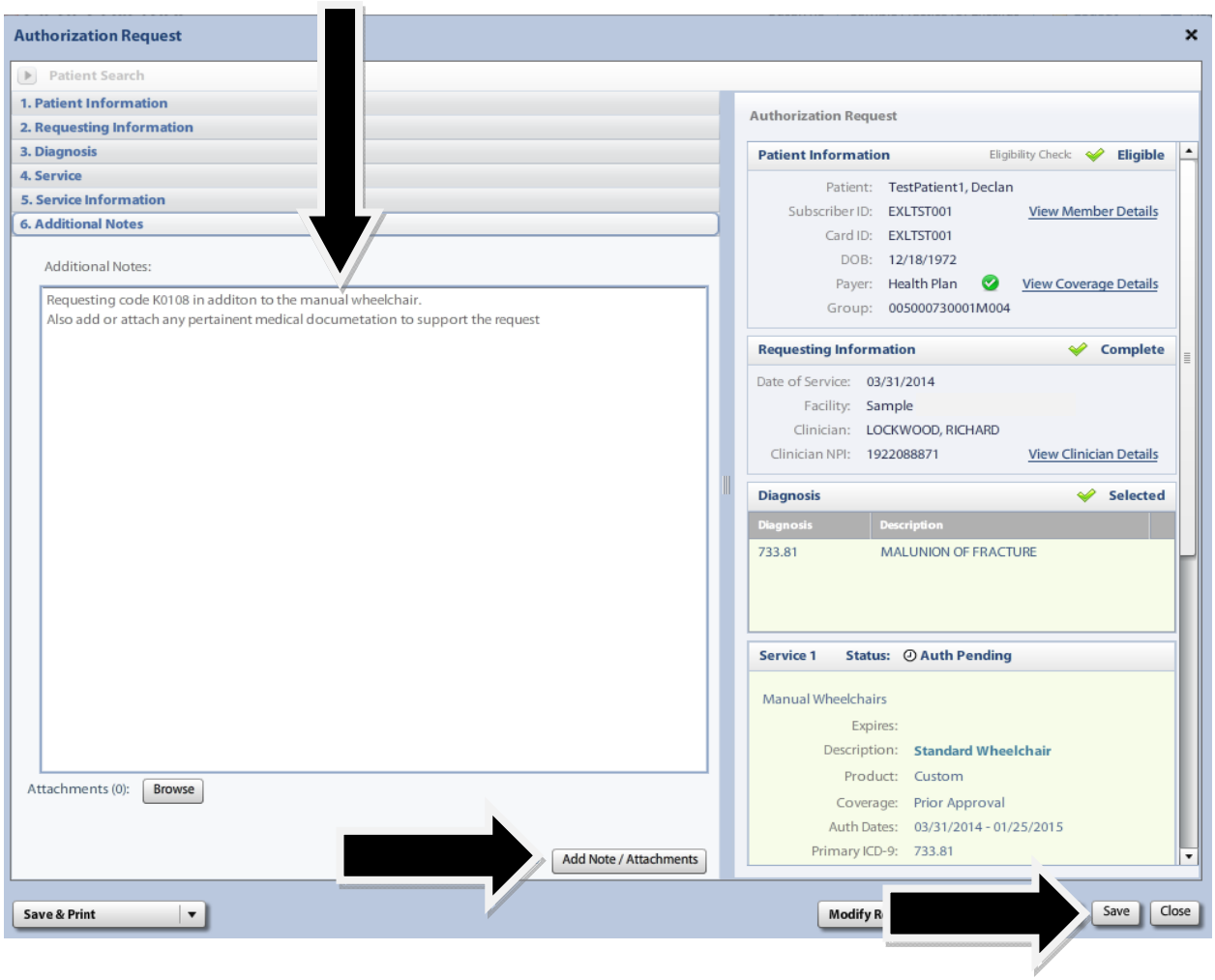
- Submit the authorization request for the manual wheelchair as per above instructions
- Return to the Clear Coverage™ home screen
- Locate the submitted authorization request on the Home Page OR;
    - Click in the Authorization Search Tab
    - Conduct a search for the authorization that was just submitted



- Click on the Detail tab

Clear Coverage™
Wheelchair Authorization Entry Tips

- Go to accordion 6 and add a note: “requesting code K0108 in addition to the manual wheelchair.” Add or attach any pertinent medical documentation to substantiate the request.



- Click “Save”
- Click “Close”
- Request will pend to the Health Plan for medical necessity review for the additional accessories.