A New Way to Request Authorizations

• Beginning on July 1, 2012, there will be three options for requesting authorization for DME, Med/Surg Supplies, Orthotics & Prosthetics:
  – Via our new web-based portal: Clear Coverage,
  – Via fax at 203.265.3994
  – Via telephone by dialing 1.800.440.5071

• This webinar has been created to introduce you to our new Clear Coverage Online Authorization Request System.
Overview

Clear Coverage is an online authorization request tool, which:

- Lowers authorization turnaround time
- Improves workflow by decreasing administrative tasks
- Automates the clinical evaluation process
Clear Coverage Functionality

- Provides a web-based solution for authorization requests
- Allows providers to search authorization requests for up to 365 days
- Enables providers to review eligibility of members in real time
- Creates authorization requests
- Only CMAP providers are visible in Clear Coverage
- Allows providers to attach the supporting clinical documentation to authorization requests
Minimum Computer Requirements

Minimum Requirements for Clear Coverage

- An Internet Browser
- Adobe Reader
- Standard Screen Resolution
- Reliable High Speed Internet Access
Logging in to Clear Coverage

The link to Clear Coverage can be accessed by using www.ct.gov/husky. Select “For Providers” in the left menu.
Logging in to Clear Coverage

The provider page contains a Clear Coverage link at the right of the screen. Clicking the link will display the Clear Coverage Login Screen.
The Clear Coverage Login Screen

CHNCT will be providing the user name and password required to sign into Clear Coverage via a secure email.

For any Technical Issues, please contact the CHNCT Help Desk at **1.877.606.5172**. Please press Prompt #2 for Clear Coverage Technical Support regarding login or technical issues. Users may also contact the Help Desk via email at Clearcoveragehelpdesk@chnct.org, or by fax at 203.265.3533.
First Log On

Upon the first log on, Clear Coverage will prompt the user to create a new password.
Home Tab
New Authorization

The user must have the member’s Medicaid ID number and date of birth to search for a member in Clear Coverage.

Enter search criteria above to find a patient

Note: To perform a search, criteria must be entered for: Last Name, First Name, Subscriber or Date of Birth
Patient Eligibility

The user must have the member’s Medicaid ID number and date of birth to search for a member in Clear Coverage.

This eligibility lookup does not replace the DSS’s AVES system, please continue to use the DSS’s AVES system if a record of the transaction is required.
Administration
Authorization Request Overview

Clear Coverage offers six steps to successful completion of an Authorization Request:

1. Select the member
2. Select the clinician (Requesting Provider)
3. Add the diagnosis codes (Up to four)
4. Select the service needed (DME, Med/Surg Supplies, Orthotics, Prosthetics)
5. Select the service information (Servicing Agency)
6. Add notes and attachments
Step One

Select the Member

Must use the Member ID and date of birth.
Authorization Panes

Clear Coverage Authorization Panes

The pane on the left side of the screen allows the user to select the information required for the authorization.

The pane on the right side of the screen displays all of the information selected.
Step Two

Select the Clinician (Requesting Provider)
### Default Provider

#### Clinician Search

<table>
<thead>
<tr>
<th>Clinician Name</th>
<th>NPI</th>
<th>Primary Specialty</th>
<th>Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Default Provider, Provider</td>
<td></td>
<td></td>
<td>In-Network</td>
</tr>
</tbody>
</table>

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*Why can’t I select some clinicians?*
Step Three

- Add Diagnosis Codes (up to four)
## Step Three

**Billable vs. Non-Billable Code Symbols**

<table>
<thead>
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<th>Non-Billable</th>
<th>Add</th>
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<tbody>
<tr>
<td>Billable</td>
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<tr>
<td></td>
<td>Add</td>
</tr>
<tr>
<td></td>
<td>Add</td>
</tr>
</tbody>
</table>
Step Four

• Select the Service (DME, Med/Surg Supplies, Orthotics & Prosthetics).

  Note: If a code or description is entered and nothing is returned by Clear Coverage, please refer to the DSS Fee Schedule to ascertain that it requires pre-authorization. If it does not, please include the item and its code in the “Additional Notes” section (Step Six). CHNCT will include the item in the authorization letter noting that it does not require pre-authorization.
Step Five: Select Service Information

The agency that will provide the service and the Medical Review

This area contains basic questions that must be answered to assist CHNCT to more quickly process your request.
Step Five: Answer Medical Review Questions

**Question 2:** Mobility-related ADL or primary role function cannot be met due to mobility limitation, Choose all that apply:

- [ ] Unable to safely and efficiently ambulate with a cane
- [ ] Unable to safely and efficiently ambulate with a walker
- [ ] Unable to safely and efficiently self-propel appropriate manual wheelchair
- [ ] Unable to safely and efficiently operate a power operated vehicle
- [ ] Other clinical information (add comment)
Step Six

Adding Notes or Attachments

Use this section to provide:
- Facility contact (name, contact information)
- Clinical documentation attachment
- Modifiers

Click here to attach documents (PDF or Word format)

When finished with notes and attachments, click here to add to the request

Then Click Submit!
Final Steps

Add contact information and click “Submit”

- View the reference number (begins with “KC”)
- Click “Yes” if you want to continue with the same member
  – The member’s information will reload
- Click “No” to move to another member or finish
- To view all lines requested, click “View Request PDF”
Clear Coverage Printing

The Authorization Request may be printed with all information the user has entered.

- Access the authorization request by clicking on the **Detail** button to the left of the desired request
- Then click the **Save and Print** button at the bottom left of the screen
- Select **Authorization Summary** for an abbreviated printout, or **Authorization (Full)** for a more detailed printout that includes the Medical Review questions.

**Authorization Request Overview**

- Payor Assigned #: KC00007616
- External Reference #: Pending
- Authorization Status: Pending
Faxing from Clear Coverage

From the Print tab, a selection is available for a Fax Cover sheet.

Cover sheet is member- and Authorization-specific and cannot be used for multiple or different members or authorizations.

The fax is transmitted to McKesson and is auto-loaded as a note into the authorization request.

CHNCT will be notified that additional information has been added to the request.
Home Tab

Displays the requests entered

<table>
<thead>
<tr>
<th>ADMA</th>
<th>Payor Assigned #</th>
<th>Status</th>
<th>Activity</th>
<th>Activity Date</th>
<th>Date of Service</th>
<th>Patient</th>
<th>Requesting Clinician</th>
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Service URL: https://integ.cue4.com/service
Memory Usage: 248 MB © 2009 McKesson Corp. All Rights
Clear Coverage

• An authorization request number is generated as a reference number and is not an indication of approval.

• Providers can be notified of the status of their authorization request via letter, phone or the Clear Coverage web portal.
Durable Medical Equipment Process
Durable Medical Equipment Requests

• As of July 1, 2012, the Hewlett-Packard (HP) Interchange system will no longer accept requests for authorization for durable medical equipment and medical supplies. At that time, providers will have three options for submitting requests:

• Submit requests via Clear Coverage, the secure online web portal.
• For phone requests: 1.800.440.5071; follow the prompts for authorization.
• Fax: 203.265.3994; please include a completed CHNCT Outpatient Prior Authorization Form. The form can be found on the HUSKY Health website www.ct.gov/husky
Clear Coverage Limitations

Clear Coverage cannot be used for:

• Requests for changes or updates to existing authorizations or requests to exceed quantity limitations.
  – Please fax these requests to 203.265.3994

• Requests for Medicare/HUSKY C (dual eligible) clients. Prior authorization is not required from CHNCT if Medicare covers the equipment.
Durable Medical Equipment Authorization Process

• Requests must be submitted prior to the start date/delivery date of the requested supplies or equipment.
  – To accommodate for holiday weekends, the system will allow for submission up to 5 days after the start date of the services.

• Requests with a start date greater than 5 days beyond the date of submission must be made by phone or fax.
Durable Medical Equipment Authorization Process

The DME fee schedule outlines what HCPCS codes are currently allowed to be billed, the quantity limit and, if the code requires, prior authorization. The updated fee schedule can be accessed and downloaded by going to the Connecticut Medical Assistance Website at www.ctdssmap.com. From this web page, go to “Provider Fee Schedule Download,” then to “MEDS” in order to locate the MEDS (Medical Equipment, Devices and Supplies) fee schedules.
Durable Medical Equipment Authorization Process

• All requests that exceed monthly quantity limits are to be faxed directly to CHNCT at 203.265.3994. Only the amounts *in excess of the monthly quantity limit need to be requested.*

• Each HCPCS code requested will require that a separate Service Type Request be submitted under the member in Clear Coverage.
Durable Medical Equipment Process

• All PA requests shall include the documentation of medical need and must be signed by the prescribing licensed practitioner and the supplier.

• A copy of the prescription from the licensed practitioner may be attached in lieu of the actual signature on the PA form.

• For custom equipment and miscellaneous codes, the vendor should continue to obtain and attach manufacturer’s quotes along with the invoice. Allowable amounts will be calculated based on the manufacturer’s suggested retail price.
Determinations

• Determination letters will continue to be mailed to the requesting and servicing providers until further notice.

• Authorization status may continue to be viewed in the HP portal. There is a one-day lag from the time that a determination is made for the file transfer from Clear Coverage to the HP system to complete.
Retrospective Review Process

This process applies only when client or provider eligibility is granted retrospectively. These review requests cannot be submitted via Clear Coverage:

- Requests must be faxed to 203.265.3994.
- Requests must be submitted with Verification of Eligibility (VOE) and clinical information.
- Retrospective reviews will not be performed for late submissions.
Questions