McKESSON

Care Providers and Payers

Point-of-Care Decision Support Solutions

Clear Coverage
Automating Authorization and Coverage Decisions in Real Time

Payers and providers are trying to solve the same problem: how to reduce healthcare costs while achieving appropriate resource utilization and high-quality care. Traditional health plan approaches, however, have burdened providers. Costs to providers of administering payer processes, such as utilization management, have been estimated at $31 billion annually.[1] The time and effort required to process authorization requests, combined with a response time of several days or more, slow productivity. According to an American Medical Association survey, 95% of physicians think that eliminating preauthorization hassles is important or very important.[2]

At the same time, these processes are also inefficient for payers. For example, 90% of preauthorizations require phone or fax communications, which take time and on average add up to $50 to $100 in payer costs per authorization.[3] In addition, they fail to deliver the desired results. Experts estimate that 17% to 20% of medical care is unwarranted, including unnecessary hospitalizations, duplicative tests and unproven treatments.[4] A key contributor to these avoidable costs is the inconsistency in clinical decision making that often occurs when payers rely on manual utilization management processes.

Another barrier to addressing this problem is incomplete coverage and network information at the point of decision. When providers and members do not know payers' coverage policies or in-network options at the point of decision, opportunities to avoid unnecessary care or use lower-cost, high-quality providers are missed.

To tackle these challenges and help payers and providers collaborate more effectively, McKesson offers Clear Coverage™, a robust utilization management, coverage determination and network compliance solution that transforms traditional benefit management by bringing clinical and financial decision making to the point of decision.

Clear Coverage incorporates InterQual® Criteria to enable you to work towards an automated, interactive workflow to support shared decision making between you and your network providers. The availability of clinical content with an automated platform enables health plans to more effectively leverage clinical criteria, creating the opportunity for improved coverage determination processes and more appropriate medical spending. Also, by facilitating the optimal application of health plan benefits coverage, network policies and medical appropriateness criteria in real time, Clear Coverage can help streamline processes and lower administrative costs, for both your plan and your provider networks.

Available in Clear Coverage

InterQual Criteria Sets

- Acute
- Durable Medical Equipment
- Imaging
- Molecular Diagnostics
- Procedures
- Specialty Rx

Smart Queries

- Home Care
- Physical Therapy, Occupational Therapy and Speech/Language Pathology
- General Pharmacy
- Behavioral Health Outpatient Treatment Record

Clear Coverage helps you:

- **Reduce administrative costs.** Automated medical review, authorization, service notification, coverage checking and direction of members to in-network service providers have been shown to reduce utilization management costs up to 64%.[5]
- **Increase efficiency.** The rules-driven utilization management activity enables you to increase auto-authorization rates and focus resources on requests that require a care manager's expertise and time.
- **Lower medical cost.** Clear Coverage enables you to drive in-network referrals and facilitate the consistent application of evidence-based criteria at the point of decision.
- **Improve collaboration.** A common clinical decision support platform for real-time authorization decisions helps strengthen your partnerships with providers.
- **Lessen network leakage.** When paired with an analytics tool, Clear Coverage data on utilization trends can help reduce referrals to non-network providers by up to 20%.[6]
- **Optimize outcomes.** You can create targeted rules to support programs that address outlier behavior, reward high performing providers or incent optimal care planning, informed by pre-service notifications and aggregate clinical and financial data on provider-specific activities.

Clear Coverage offers you:

- **Advanced business rules to automate authorizations.** Real-time review at the point of decision increases the number of automated authorizations, which helps to reduce your administrative costs.
- **Basic authorization.** Interactive Q&A interviews, called Clear Coverage Smart Queries™, allow your care managers to gather the data necessary to complete an InterQual review.
- **Payer notification.** Notifications allow providers to inform you about their intent to perform or order a medical service when authorization is not required, so you can monitor utilization and determine if a management program is needed for a specific service.
- **Encounter-specific coverage and network information.** Clinicians are able to access eligibility, benefits and other coverage information before services are provided. In addition, Clear Coverage can help assist clinicians direct patients to in-network facilities to help manage costs.
- **Integration capability.** The ability to integrate Clear Coverage with your organization's utilization management/case management and claims systems allows information from providers' service requests to be readily available within decision making, reporting and adjudication processing workflows.

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