

Clear Coverage™



Automating Authorization and Coverage Decisions in Real Time

To help ensure the right medical services at the right time and cost, providers need real-time access to coverage, network and medical appropriateness rules at the point of care. But the underlying processes are often not efficient, consistent or integrated. Manual, time-intensive authorization processes typically result in \$50-100 payor costs per authorization,¹ manual medical reviews can take 3-4+ days², and inconsistent decision-making can lead to inappropriate care and avoidable cost.

A major contributor to these challenges is that providers and members don't have or don't know payors' coverage policy or network options. These unknowns result in unnecessary costs as well as wasted time and frustration for payors, providers and members.

In addition, all providers must follow the same process – even those with optimal utilization patterns – which drives unnecessary administrative costs and time to manage activity that could be avoided with provider-specific intelligence. Further, current processes do not provide timely data to inform ongoing changes in utilization and network policy.

It is critical to tackle these preauthorization, coverage determination and

network compliance challenges to reduce administrative costs and inappropriate medical spend. Health plans need better tools to ensure automated, consistent, and optimal application of health plan coverage, network policy and medical appropriateness criteria, in real time, at the point of care.

McKesson's Clear Coverage is a clinical and financial decision-support software-as-a-service solution that helps payors lower administrative costs and inappropriate medical spend. A powerful utilization management, coverage determination and network compliance platform, Clear Coverage incorporates InterQual® Criteria in a fully automated, interactive workflow to support shared decision-making between a payor and its network providers.

Clear Coverage enables automated medical review, authorization, notification, eligibility and direction of members to in-network service providers. Providers have immediate access to coverage, medical appropriateness and network rules, driving the consistent application of evidence-based medicine.

Clear Coverage is an offering within McKesson's Advanced Diagnostics Management™, a suite of solutions that transforms traditional benefit management and reduces costs by bringing clinical and financial decision-making to the point of care.

¹ McKinsey analysis proprietary to McKesson, Preauthorization: Preliminary Sizing, 2007

² McKesson analyses of business case data from customers 2009-2010

Clear Coverage: Automated, Intelligent Decision Support

- Supports entire authorization process – including fully automated medical review
- Provides real-time, encounter-specific eligibility, benefits and other coverage information
- Informs providers of in-network facilities that deliver the best care at the best cost
- Enables targeted, timely provider intervention and adjustment of coverage policies

Benefits

- **Reduces costs** – Reduces authorization costs 50-70% and determines medically appropriate alternatives.
- **High ROI** – Delivers a 5X+ ROI from administrative and medical cost reductions.
- **Quick time to value** – Low implementation, operating and maintenance costs shortens time-to-value with a fully hosted, Web-based solution.
- **Empowers providers** – Enables transparent, immediate access to coverage, medical appropriateness and network rules for real-time authorization decisions.
- **Consistent decisions** – Drives consistent application of evidence-based criteria and in-network referral.
- **Timely UM analysis** – Provides timely, complete data on utilization and network leakage trends.
- **Facilitates provider gold/red carding** – Supports real-time, targeted interventions to optimize payors' resource use.
- **Exception-based UM** – Automation of all rules-driven utilization management activity enables payors to focus resources on managing authorization requests that require a care manager's expertise and time.

Features

- **Advanced automated authorization** – Performs real-time medical appropriateness review at the point of care.
- **Basic automated authorization** – Provides data necessary for manual medical review via Smart Queries.
- **Service notification** – Automates provider notification to payors about intent to perform or order a medical service when authorization is not required, enabling monitoring of utilization to help payors determine if a management program is required for a specific service.
- **Targeted coverage determination and network compliance** – Gives clinicians and patients encounter-specific coverage information before services are provided and directs them to the optimal network facilities, lowering medical costs.
- **Optimized policy and outcomes management** – Enables early visibility for services in real time via pre-service notification and aggregates all of the clinical and financial data that flows through the system on provider-specific activities to create targeted rules that can support emerging incentive payment models such as episodes of care.

McKesson Health Solutions

275 Grove Street
Newton, MA 02466-2274

MHS@McKesson.com
www.McKesson.com
800.782.1334
Twitter: McKesson_MHS

For more information, please contact your McKesson Health Solutions Sales or Account Executive.

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