

Authorization Request Overview for Physical, Occupational, and Speech Therapy Services

Provider Orientation for Security Health Plan

July 2023



Security Health Plan Prior Authorization Services

eviCore manages prior authorization requests for therapy services for Security Health Plan

Applicable Membership	Prior authorization applies to the following services	Prior authorization does NOT apply to services performed in
<ul style="list-style-type: none">• Commercial• Medicare• Medicaid	<ul style="list-style-type: none">• Outpatient• Elective/Non-emergent	<ul style="list-style-type: none">• Emergency Rooms• Observation Services• Inpatient Stays

Providers should verify member eligibility and benefits via the eligibility Lookup tool on the eviCore portal, or through Security Health Plan's eligibility confirmation process.

Program Goals

- Authorize **medically necessary** services which require the knowledge and skills of a licensed professional
- Promote **evidence-based practice**
- Identify and review treatment interventions where evidence is not present or does not support use
- Provide evidence-based guidelines to support authorization decisions and educate practitioners
- **Decrease or eliminate unexplained practice variation** and unnecessary visits
- Manage costs efficiently so members can **continue to receive quality care and skilled services**

Medical Necessity

To be considered medically necessary:

- The services must be specific and effective treatment for the condition.
- The condition is expected to improve significantly in a reasonable (and generally predictable) period of time. Therapy duration should be reasonable and not ongoing without end.
 - **Exception** – Medicare members
- The amount, frequency, and length of the services must be reasonable under accepted standards of practice.
- Services shall be of such a level of complexity and sophistication that they can only be performed by a therapist or therapy assistant.

Medical Necessity for Medicare

- Medical necessity based on the need for skilled services not on progress or lack of
- Documentation should explain why the skills of a therapist are necessary
- Skilled maintenance therapy services are covered for members if the specialized skill, knowledge and judgment of a qualified therapist are required to:
 - To establish or design a maintenance program appropriate to the capacity and tolerance of the member
 - To educate/instruct the member or appropriate caregiver regarding the maintenance program
 - Perform periodic re-evaluations of the maintenance program
 - Provide reasonable and necessary care to prevent or slow further deterioration. Coverage will not be denied based on the absence of potential for improvement or restoration as long as skilled care is required.

Submitting Requests



Prior Authorization Process

What are the ways to request authorization through eviCore?

- Web - Preferred Method
 - Opportunity for real time decision for the initial and second request
 - Use worksheets as a guide to prepare to answer questions on the web
 - After the initial request, you have the ability to upload clinical documentation if patient is complex or not progressing as expected
- Phone
 - Opportunity for real time decision for the initial and second request
 - Use worksheets as a guide to prepare to answer questions on the web
 - Providing answers to the questions posed on the web to a non-clinical agent
- Fax
 - Least desired form of submission
 - Eliminates opportunity for a real time decision
 - Old technology so it is prone to transmission errors
 - Complete worksheet
 - Only send clinical notes if patient is complex or not progressing as expected.

Necessary Information for Prior Authorization

To obtain prior authorization on the very first submission, the provider submitting the request will need to gather information within four categories:

Member

- Health Plan ID
- Member name
- Date of birth (DOB)

Rendering Facility

- Facility name
- Address
- National provider identifier (NPI)
- Tax identification number (TIN)
- Phone & fax number



Referring (Ordering) Physician

- Physician name
- National provider identifier (NPI)
- Phone & fax number

Supporting Clinical

- Pertinent clinical information to substantiate medical necessity for the requested service
- CPT/HCPCS Code(s)
- Diagnosis Code(s)
- Previous test results

Prior Authorization Process

Clinical Information – What eviCore needs and why we need it

- Clinical information is required to determine whether the services requested are medically necessary
- Use clinical worksheets located at eviCore.com as a guide to determine what clinical information is required.
- Be prepared to provide patient reported functional outcome measures with your submission (for example: ODI, NDI, DASH/QuickDASH, LEFS, HOOS JR, KOOS JR)
- Clinical information should be current – typically something collected within 14 days prior of the request
 - Exception – for peds neurodevelopmental, information may be up to 20 days old and the standardized testing should have been completed within up to one year prior to the requested start date.
- **Missing or incomplete clinical information will delay case processing.**
- **Medicare cases with incomplete or missing information will receive special handling. CMS allows eviCore to reach out multiple times over a 14 day period to obtain the information required to complete our review.**

Prior Authorization Process

corePath

- Simplified approach to clinical collection attempting to reduce administrative efforts for providers
- Improves the ability to receive a real time decision when submitting a request via the web or phone
- “Gets out of the way” of providers who are practicing efficiently and effectively
- Adds quality measures via inclusion of patient reported functional outcomes
- Uses data collected over the years from claims data (managed and unmanaged) to set the average # of visits for a condition
- Acknowledges complexities that may require a greater frequency or intensity of care
- Allows therapists to provide additional information for cases that are not “average”

Pathway Questions

- Questions are included in the pathway to help eviCore create a case correctly
- For example, you may be asked questions about the site (location) of the service
 - Reason – Prior authorization may not be required for some sites of service
 - Example – Emergency Department, Inpatient Services
- Is the care requested following a mastectomy?
 - Should present only when the request is for a cervical or upper extremity condition.
 - Presents for both males and females since mastectomy applies to both.
 - There is a federal mandate related to post-mastectomy care.

Prior Authorization Process

What is used to determine if services are medically necessary?

- Clinical Criteria
 - Available 24/7 @ www.evicore.com
 - Synthesis of research, guidelines, expert consensus
 - Updated annually and approved by the Health Plan
- Clinical Information
 - Should be current
 - Adult within the prior 10 days
 - Peds within the prior 20 days; standardized tests 1x/year
 - Complete the questions
 - **If there is no information or information has gaps, it will delay the decision**
 - Worksheets are available at www.evicore.com to guide your clinical collection

Prior Authorization Process

Requesting Authorization

- For the first request
 - Evaluate the member before you request prior authorization
 - Evaluation codes do not require prior authorization
 - Submit your request within 7 days of the requested start date
- If additional care is needed
 - You may submit your request as early as 7 days prior to the requested start date
 - This allows time for the request to be reviewed and prevents a gap in care
 - Remember to provide complete, current clinical information including patient reported functional outcome measures
- Notes: Requests with a start date of > than 7 days in the future will not be accepted. If the member is away from therapy, reassess the condition once therapy has resumed. This allows you to provide current information to allow eviCore to determine medical necessity of ongoing therapy.

Prior Authorization Process

Timely Filing

- Security Health Plan allows providers to evaluate and treat at the initial visit.
- The evaluation code does not require prior authorization but treatment does.
- If treatment is provided during the evaluation visit, you have 7 days from the date of service to submit your request for authorization for the initial treatment.
- Authorization for treatment beyond the initial visit must be requested prior to providing care.
- Retrospective requests will be accepted up to 7 calendar days. Please note that any cases after 7 calendar days will be expired.

Insufficient Clinical | Additional Documentation Needed

If during case build all required pieces of documentation are not received, or are insufficient for eviCore to reach a determination, the following will occur:

A hold letter will be faxed to the requesting provider requesting additional documentation.

The provider must submit the additional information to eviCore.

eviCore will review the additional documentation and reach a determination.

The hold letter will inform the provider about what clinical information is needed as well as the **date by which it is needed**.

Requested information must be received within the timeframe as specified in the hold letter, or eviCore will render a determination based on the original submission.

Determination notifications will be sent.

Treating Multiple conditions within the same auth period

- If you are treating multiple conditions within the same period, there is no need to request authorization for treatment for each condition.
- The authorization covers all conditions treated within the same period of time.
- If you are treating more than 1 condition, advise eviCore to ensure adequate visits and units are approved
 - When submitting by the web, you will be asked if you are treating a second condition.
 - Answer = Yes; report information specific to the second condition
 - When requesting authorization over the phone, inform the agent that you are requesting authorization for two conditions
 - If submitting by fax, complete clinical worksheets for both conditions

Duplicate Care

- eviCore will approve care by two different providers within the same period only when it is medically necessary
- Examples – PT and OT for therapy following a CVA; PT treating a knee condition and PT treating a vestibular condition
- eviCore will not approve care by two providers within the same period if the care is duplicative
- If a provider submits a request for authorization and there is an existing authorization for the same condition with a different provider, eviCore will reach out to the second provider to ask if the member has discontinued care with their original therapist. If this has occurred, please provide the date of discharge from the original therapist.
- If the condition being treated is the same and the member has not discontinued care with their original provider, the request for duplicate care will be denied.

Date Extensions

Date extensions are available if you are unable to use all visits within the approved period

- Must be requested prior to the expiration of the authorization
- All therapy cases with a date of service after 5/1/2019 need a new authorization from eviCore. eviCore cannot extend authorizations originally provided by SHP.
- Available by phone 888-444-6185 or online at:
<https://carriers.carecorenational.com/PreAuthorization/screens/CreateCase.aspx>
- One date extension is available per case
- You may extend a case for up to an additional 30 days

Attention!

Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy, Chiropractic Care, and Acupuncture services are eligible for case duplication and date extensions. Are you requesting one of these services?

Date Extension

Continuing Care

Continue to Build a New Case

Requests for Spine Surgery, Joint Replacement, Arthroscopy, and Pain Management, please select "Continue to Build a New Case"



Prior Authorization Outcomes, Special Considerations & Post-Decision Options



Prior Authorization Determination Outcomes

Determination Outcomes

- **Approved Requests:** Depending on the condition, authorizations are valid for between 60 - 180 days from the treatment start date.
- **Partially Approved Requests:** The determination letter will specify what has been approved, as well as post-decision options for what has been denied.
- **Denied Requests:** If a request is determined as inappropriate based on evidence-based guidelines, a notification with the rationale for the decision and post-decision/ appeal rights will be issued.

Notifications

- Authorization letters will be faxed to the ordering physician.
- Web-initiated cases will receive e-notifications if a user opted in to this method.
- Members will receive a letter by mail.
- Approval information can be printed on demand from the [eviCore portal](#).



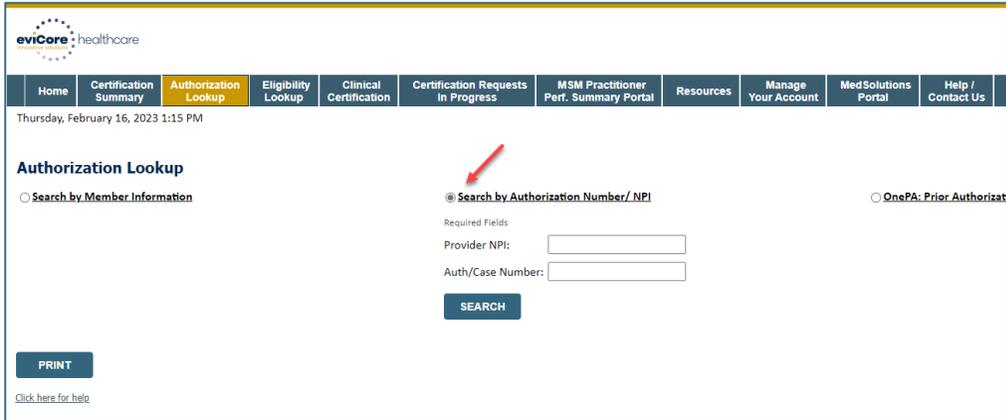
Notifications

- **Read the letters!** They include information to explain any adverse determination (reduction or denial)
 - Clinical Rationale related to the clinical decision
 - Written in terms the member understands
 - Does not include medical jargon
 - Reconsideration and Appeal Information
 - Provides information on requesting a Peer to Peer (P2P) discussion
 - P2P discussions are allowed for Medicare cases and will impact the determination only if it occurs prior to the official determination being rendered. Once the official determination has been rendered on a Medicare case, eviCore cannot change the determination. In that case, an appeal must be made to the health plan.

Clinical Consultation/Peer to Peer

Clinical Consultation/Peer to Peer

- Provides the ability to review clinical aspects of the case with a peer
- Be prepared to provide information that was not submitted previously
- Recall that P2P discussions are allowed for Medicare cases and will impact the determination only if it occurs prior to the official determination being rendered. Once the official determination has been rendered on a Medicare case, eviCore cannot change the determination. In that case, an appeal must be made to the health plan.
- Schedule the P2P directly on the eviCore portal via the Authorization Lookup feature:



The screenshot shows the eviCore healthcare portal interface. At the top, there is a navigation bar with the following tabs: Home, Certification Summary, Authorization Lookup (highlighted), Eligibility Lookup, Clinical Certification, Certification Requests In Progress, MSM Practitioner Perf. Summary Portal, Resources, Manage Your Account, MedSolutions Portal, and Help / Contact Us. Below the navigation bar, the page title is "Authorization Lookup". There are three radio button options: "Search by Member Information", "Search by Authorization Number / NPI" (which is selected and has a red arrow pointing to it), and "OnePA: Prior Authorization". Below these options, there are two input fields labeled "Provider NPI:" and "Auth/Case Number:". A "SEARCH" button is located below the input fields. In the bottom left corner, there is a "PRINT" button and a link that says "Click here for help".

- Or click this link to request that eviCore contacts you to schedule the P2P:
<https://www.evicore.com/Pages/requestaconsultation.aspx>

Special Circumstances

Retrospective Authorization Requests

- Must be submitted within 7 business days from the date of services
- Any submitted beyond this timeframe will be administratively denied
- Reviewed for **clinical urgency** and medical necessity
- Processed within 2 business days
- When authorized, the start date will be the submitted date of service

Urgent Prior Authorization Requests

- Generally with therapies an urgent request will be very rare; however if you have an urgent request for commercial members eviCore has up to 72 hours for review-Medicare/Medicaid up to 24 hours for the review after receipt of all relevant clinical information.
- Reviewed for **clinical urgency** and medical necessity
- A provider can either call in an urgent request or submit via web. Please note the eviCore standard is for a turn around time of 4 hours.



Post-Decision Options

Commercial & Medicaid Members

My case has been denied. What's next?

Your determination letter is the best immediate source of information to assess what options exist on a case that has been denied.

You may also call eviCore at 888-444-6185 to speak with an agent who can provide available option(s) and instruction on how to proceed.

Alternatively, select 'All Post Decisions' under the authorization lookup function on [eviCore.com](https://www.eviCore.com) to see available options.

Reconsiderations

- Reconsiderations must be requested within 10 business days after the determination date.
- Reconsiderations can be requested in writing or verbally via a Clinical Consultation with an eviCore physician.

Appeals

- eviCore will not process appeals. Please refer to your denial letter for instructions on how to file an appeal.



Post-Decision Options

Medicare Members

My case has been denied. What's next?

Clinical Consultation

- Providers can request a Clinical Consultation with an eviCore physician to better understand the reason for denial.
- Once a denial decision has been made, however, the decision cannot be overturned via Clinical Consultation.

Reconsideration

- Medicare cases do not include a reconsideration option

Appeals

- eviCore will not process appeals. Please refer to your denial letter for instructions on how to file an appeal.



eviCore Provider Portal



eviCore Provider Portal | Features

Eligibility Lookup

- Confirm if patient requires clinical review

Clinical Certification

- Request a clinical review for prior authorization on the portal

Prior Authorization Status Lookup

- View and print any correspondence associated with the case
- Search by member information OR by case number with ordering national provider identifier (NPI)
- Review post-decision options, submit appeal, and schedule a peer-to-peer

Certification Summary

- Track recently submitted cases



eviCore Provider Portal | Access and Compatibility

Most providers are already saving time submitting clinical review requests online vs. telephone

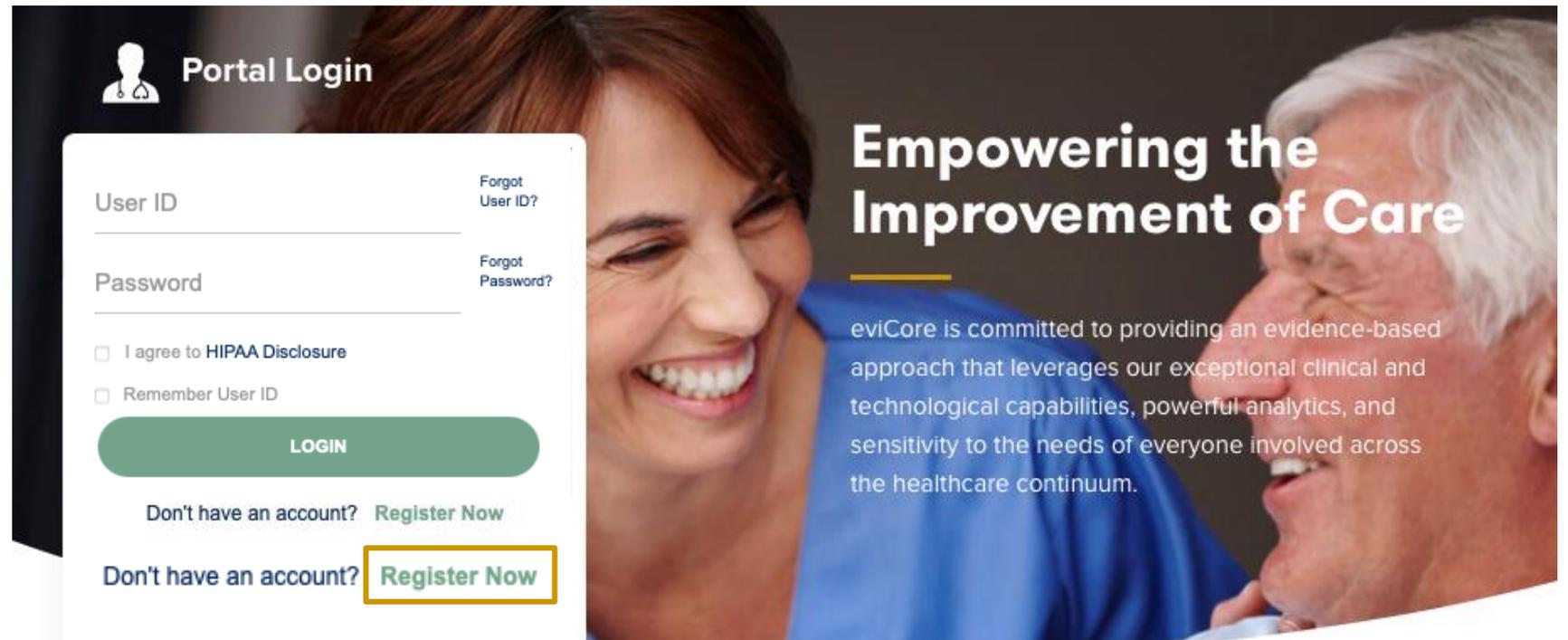
To access resources on the eviCore Provider Portal, visit evicore.com/provider

Already a user?

Log in with User ID & Password

Don't have an account?

Click **Register Now**



eviCore's website is compatible with all web browsers. If you experience issues, you may need to disable pop-up blockers to access the site.

Creating an eviCore Provider Portal Account

Select **CareCore National** as the Default Portal.

Complete the User Information section in full and **Submit Registration**.

You will immediately be sent an email with a link to create a password. Once you have created a password, you will be redirected to the login page.

eviCore healthcare
innovative solutions

* Required Field

Web Portal Preference

Please select the Portal that is listed in your provider training material. This selection determines the primary portal that you will using to submit cases over the web.

Default Portal*: --Select--

User Information

All Pre-Authorization notifications will be sent to the fax number and email address provided below. Please make sure you provide valid information.

User Name*:	<input type="text"/>	Address*:	<input type="text"/> <input type="text"/>	Phone*:	<input type="text"/>
Email*:	<input type="text"/>	City*:	<input type="text"/>	Ext:	<input type="text"/>
Confirm Email*:	<input type="text"/>	State*:	Selec ↓	Zip*:	<input type="text"/>
First Name*:	<input type="text"/>	Office Name:	<input type="text"/>		
Last Name*:	<input type="text"/>				

Next

Web Support 800-646-0418

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Setting Up Multi-Factor Authentication (MFA)

To safeguard your patients' private health information (PHI), we have implemented a multi-factor authentication (MFA) process.

After you log in, you will be prompted to register your device for MFA.

Choose which authentication method you prefer: Email or SMS. Then, **enter your email address or mobile phone number.**

Select **Send PIN**, and a 6-digit pin will be generated and sent to your chosen device.

After entering the provided PIN in the portal display, you will successfully be authenticated and logged in. **Your MFA authentication will expire after five hours of inactivity.** After this time, you will be automatically logged out and need to log in again.

The screenshot displays a web interface for setting up two-factor authentication. At the top, it says "Set up Two Factor Authentication". Below this, there are two radio button options: "Email" (which is selected) and "SMS". Underneath, the label "Register Email Address" is followed by a text input field containing "meh****@evicore.com". A green "Send PIN" button is positioned below the input field. Further down, the label "Please enter PIN sent to your Email Address" is followed by another text input field containing "768342". A green "Submit" button is located below this second input field. At the bottom of the form, there is a grey "Skip" button.

eviCore Provider Portal | Add Providers



Providers will need to be added to your account prior to case submission

- Click the **Manage Your Account** tab to add provider information
- Select **Add Provider**
- Enter the NPI, state, and zip code to search for the provider
- Select the matching record based upon your search criteria
- Once you have selected a practitioner, your registration will be complete
- You can also click **Add Another Practitioner** to add another provider to your account
- You can access the **Manage Your Account** at any time to make any necessary updates or changes

Manage Your Account

Office Name: **CHANGE PASSWORD** **EDIT ACCOUNT**

Address:

Primary Contact:
Email Address:

ADD PROVIDER

Click Column Headings to Sort

No providers on file

CANCEL

Add Practitioner

Enter Practitioner information and find matches.
*If registering as rendering genetic testing Lab site, enter Lab Billing NPI, State and Zip

Practitioner NPI:

Practitioner State:

Practitioner Zip:

FIND MATCHES **CANCEL**

Portal Case Submission



Clinical Certification Request | Initiating a Case

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Request an Authorization

To begin, please select a program below:

- Durable Medical Equipment(DME)
- Gastroenterology
- Lab Management Program
- Medical Oncology Pathways
- Musculoskeletal Management
- Radiation Therapy Management Program (RTMP)
- Radiology and Cardiology
- Sleep Management
- Specialty Drugs

CONTINUE

[Click here for help](#)

- Click **Clinical Certification** to begin a new request
- Select the **Program** for your certification
- Select **Requesting Provider Information**

Attention!

Physical Therapy, Occupational Therapy, Speech Therapy, Massage Therapy, Chiropractic Care, and Acupuncture services are eligible for case duplication and date extensions. Are you requesting one of these services?

Date Extension

Continuing Care

Continue to Build a New Case

Requests for Spine Surgery, Joint Replacement, Arthroscopy, and Pain Management, please select "Continue to Build a New Case"

Clinical Certification Request | Search for and Select Provider

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Requesting Provider Information

Select the provider for whom you want to submit an authorization request. If you don't see them listed, click [Manage Your Account](#) to add them.

Filter Last Name or NPI:

	Provider
<input type="button" value="SELECT"/>	12312312 - Provider Name

[Click here for help](#)

Search for and select the **Practitioner/Group** for whom you want to build a case

Clinical Certification Request | Select Health Plan

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal
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Wednesday, July 05, 2023 1:14 PM

Choose Your Insurer

Requesting Provider: DANIELSON, DAVID, NPI 1679885974

Please select the insurer for this authorization request.

SECURITY HEALTH PLAN

BACK CONTINUE

[Click here for help](#)

Urgent Request? You will be required to upload relevant clinical info at the end of this process. [Learn More.](#)

Don't see the insurer you're looking for? Please call the number on the back of the member's card to determine if an authorization

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- Choose the appropriate **Health Plan** for the request
- Select the appropriate provider address from the drop down menu.
- Select **CONTINUE**

Clinical Certification Request | Enter Contact Information

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Add Your Contact Info

Provider's Name:* [?]

Who to Contact:* [?]

Fax:* [?]

Phone:* [?]

Ext.: [?]

Cell Phone:

Email: @.c

Receive notification of case status changes

BACK

CONTINUE

[Click here for help](#)

carriers.carecorenational.com says

Please review the fax and phone numbers presented for accuracy. Change as necessary and click CONTINUE to confirm they are correct. Changes apply only to this specific case. If you wish the change to be permanent, please contact the Health Plan.

OK

- Enter the **Provider's name** and appropriate information for the point of contact individual
- Provider name, fax and phone will pre-populate, edit as necessary

The e-notification box is checked by default so that updates for any case status changes can be shared without having to send faxes. If you prefer to receive faxes, make sure to uncheck this box.

Clinical Certification Request | Enter Member Information

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Patient Eligibility Lookup

Patient ID:*

Date Of Birth:* MM/DD/YY

Patient Last Name Only:*

ELIGIBILITY LOOKUP

BACK

[Click here for help](#)

Attention!

Time:

What is the expected procedure date or treatment start date for this request? (MM/DD/20YY)

If the Date of Service is unknown, please enter today's date.

SUBMIT

Enter the expected treatment start date, and then enter **member information**, including: patient ID number, date of birth, and last name then click **ELIGIBILITY LOOKUP**

Search Results

	Patient ID	Member Code	Name	DOB	Gender	Address
SELECT	000000000		WATSON, JANEEN	6/28/1962	F	100 WATSON RD SPRINGVILLE, TN 37154

Confirm your patient's information and click **SELECT** to continue

BACK

Clinical Certification Request

Enter Requested Procedure and Diagnosis

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Requested Service + Diagnosis

This procedure will be performed on 7/21/2023.

[CHANGE](#)

Musculoskeletal Management Procedures

Select a Procedure by CPT Code[?] or Description[?]

MSMOT | OCCUPATIONAL THERAPY

Don't see your procedure code or type of service? [Click here](#)

Diagnosis

Primary Diagnosis Code: **S12.110D**

Description: **Anterior displaced Type II dens fracture, subsequent encounter for fracture with routine healing**

[Change Primary Diagnosis](#)

Select a Secondary Diagnosis Code (Lookup by Code or Description)

Secondary diagnosis is optional for Musculoskeletal Management

[LOOKUP](#)

[BACK](#)

[CONTINUE](#)

[Click here for help](#)

Select the procedure by selecting MSMPT (for physical therapy), MSMOT (for occupational therapy), and MSMST (for speech therapy). Then select the primary and secondary (if applicable) **Diagnosis codes**

Clinical Certification Request | Verify Service Selection

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Requested Service + Diagnosis

Confirm your service selection.

Procedure Date: 7/21/2023
CPT Code: MSMOT
Description: OCCUPATIONAL THERAPY
Primary Diagnosis Code: S12.110D
Primary Diagnosis: Anterior displaced Type II dens fracture, subsequent encounter for fracture
Secondary Diagnosis Code:
Secondary Diagnosis:
[Change Procedure or Primary Diagnosis](#)
[Change Secondary Diagnosis](#)

Attention!

Will the procedure be performed in your office?

[Click here for help](#)

- Tell us whether services will be performed in office or some other place of service.
- Then verify requested service & diagnosis
- Edit any information if needed by selecting **Change Procedure** or **Primary Diagnosis**
- Click **CONTINUE** to confirm your selection

Clinical Certification Request | Site Selection

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account	Med Solutions Portal	Help / Contact Us
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Wednesday, Ju

Log Off (L)

Add Site of Service

Specific Site Search

Use the fields below to search for specific sites. For best results, search by NPI or TIN. Other search options are by name plus zip or name plus city. You may search a partial site name by entering some portion of the name and we will provide you the site names that most closely match your entry.

NPI:

Zip Code:

Site Name:

TIN:

City:

- Exact match
 Starts with

LOOKUP SITE

BACK

[Click here for help](#)

- The **Site of Service** screen will likely pre-populate with the referring provider office NPI and zip code, and click “Lookup site” to select the site.
- If need be, search for where the procedure will be performed (for best results, search with **NPI and zip code**)

80% Complete

Provider and NPI
[REDACTED]
1
(SECURITY HEALTH PLAN)

Patient
[REDACTED] [EDIT](#)

Service
7/21/2023 [EDIT](#)
MSMOT OCCUPATIONAL THERAPY
S12.110D Anterior displaced Type II dens fracture, subsequent

Feedback

Clinical Certification Request | Clinical Certification

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Proceed to Clinical Information

You are about to enter the clinical information collection phase of the authorization process.

Once you have clicked "Continue," you will not be able to edit the Provider, Patient, or Service information entered in the previous steps. Please be sure that all this data has been entered correctly before continuing.

In order to ensure prompt attention to your on-line request, be sure to click SUBMIT CASE before exiting the system. This final step in the on-line process is required even if you will be submitting additional information at a later time. Failure to formally submit your request by clicking the SUBMIT CASE button will cause the case record to expire with no additional correspondence from eviCore.

BACK

CONTINUE

- Verify that all information is entered and correct
- **You will not have the opportunity to make changes after this point**

Clinical Certification Request | Standard or Urgent Request?

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
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Proceed to Clinical Information

Urgency Indicator

If the case you are submitting is found NOT to meet one of the two conditions below, your case will be processed as a standards/routine, non Urgent request. If you have clinical information and this request meets the criteria for urgent, please indicate below.
In order for eviCore to process this case as clinically urgent you must upload clinical documentation relevant to this case. If you are unable to upload clinical documentation at this time contact eviCore to process this case as urgent.

Please indicate if any of the following criteria are true regarding urgency of this request :

- A delay in care could seriously jeopardize the life or health of the patient or patient's ability to regain maximum function.
- A delay in care would subject the member to severe pain that cannot be adequately managed without the care or treatment requested in the prior authorization.
- None of the above

Clinical Upload

In order for eviCore to process this case as clinically urgent you must upload clinical documentation relevant to this case.
If you are unable to upload clinical documentation at this time contact eviCore to process this case as urgent.

Browse for file to upload (max size 5MB, allowable extensions .DOC,.DOCX,.PDF,.PNG):

Choose File No file chosen

UPLOAD

Proceed to Clinical Information

Is this case Routine/Standard?

YES

NO

- If the case is **standard**, select **Yes**
- If your request is **urgent**, select **No**
- When a request is submitted as urgent, you will be **required** to upload relevant clinical information
- Upload up to **FIVE documents** (.doc, .docx, or .pdf format; max 25MB size)
- Your case will only be considered urgent if there is a successful upload

Proceed to Clinical Information – Example of Questions

Proceed to Clinical Information

Please select the Place of Service in which this procedure will be performed:

- 11 - Office
- 12 - Patients home
- 22 - Outpatient Hospital

SUBMIT

Finish Later

Did you know?
You can save a certification request to finish later.

CANCEL

[Click here for help](#)

Will an MD/DO be treating?

- Yes
- No

SUBMIT

Note: Prior authorization is only required for physical therapists/occupational therapists/speech pathologists performing physical, occupational, speech therapy. Medical Doctors (MD) and Doctors of Osteopathic Medicine (DO) do not require pre-authorization through eviCore Healthcare

Clinical Certification questions may populate based upon the information provided

Note: You can save your request and finish later that day if needed.

You may be able to resume a saved request by going to “Certification Requests in Progress,” or call intake to complete the case.

Sample Therapy corePathSM Pathway

Initial Requests

1

This request is for treatment of:

New condition that has not had previous treatment

An existing condition that has had previous treatment

Unknown

2

Please indicate the primary area of treatment (Choose only one):

Lumbar / Lower Thoracic Spine / Pelvis / Sacrum

Is there a second area being treated? If so, please indicate below.

No second area being treated

3

You requested a start date of 04/15/2022.

Please enter the date of initial evaluation*

(NOTE: The clinical information may be considered out-of-date if the "date of initial evaluation" is greater than 10 days prior to the "treatment start date" for this request. Cases with out-of-date clinical information may be placed on hold awaiting current clinical information. This may delay an authorization decision.

Case related questions:

- Identify new care vs. continuing care based on treatment area, not time
- Identify primary area of treatment
- First indicator of complexity – second unrelated treatment area

Many screens have imbedded messages that help you understand the criteria

Sample Therapy corePathSM Pathway

Initial Requests, continued....

If the ODI or RMDQ or FOTO Low Back test was performed, please enter the score; if the test was NOT performed, please leave the Default value in place

Please indicate the functional assessment used:

- FOTO Low Back (Focus On Therapeutic Outcomes)
- ODI (Oswestry Disability Index)
- Other functional assessment / No functional assessment
- RMDQ (Roland Morris Disability Questionnaire)

Please enter the (for ODI in %; for RMDQ 0-24; for FOTO 0-100. Leave the listed score value in place if the score is not available)

101

Enter the number of LBP episode(s) in the past 3 years:

- 0 or N/A
- 1
- 2
- 3
- 4 or more

Does your patient demonstrate either of the following: (Choose all that apply)

- Weakness, sensory changes, or radiating pain below the knee
- Tinetti Gait / Balance score less than 24 OR Berg Balance test <40 OR TUG test >13.5 seconds

Initial clinical questions:

- Enter functional score, if available
 - Oswestry Index
 - Neck Disability Index
 - LEFS
 - Dash / QuickDASH
- Incorporates ROM, Strength, Pain, etc.
- Complexity:
 - Neural signs
 - Chronicity

High Potential for Immediate Approval When Pathway is Completed!

Sample Therapy corePathSM Pathway

Follow-up request

Follow-up clinical questions:

- Current and previous functional score
- Complexity question – neural signs
- Progress
 - Validated scores have MCD (minimal clinical difference) as progress indicator
 - Clinical assessment

1

Please enter the Oswestry Disability Index score (in %)

41

2

Please enter the previous ODI score

46

3

Does your patient have radiating pain below the knee?

Yes No

Has your patient progressed as expected?

Yes No

Submit

High potential for immediate approval when pathway is completed.

Sample Therapy corePathSM Pathway

Follow-up request – Lack of progress identified

i You indicated that your patient is NOT progressing as expected. Please indicate if any of the following occurred:

- Patient "overdid" activities or exercise resulting in temporary increase in symptoms New injury resulting in significant change
 Symptoms progressed despite treatment Patient did not participate in clinical visits or home program

i Please indicate the nature of the new injury OR overuse incident.

N/A

Lack of progress:

- Categories of explanations
- Used in algorithm to determine care
- Future, additional pathway to identify details

Criteria not met

If criteria is not met based on clinical questions, you will receive a request for additional info:

? Is there any additional information specific to the member's condition you would like to provide?

- I would like to upload a document after the survey
- I would like to enter additional notes in the space provided
- I would like to upload a document and enter additional notes
- I have no additional information to provide at this time

SUBMIT

Summary of Your Request

Please review the details of your request below and if everything looks correct click SUBMIT

Your case has been sent to clinical review. You will be notified via fax within 2 business days if additional clinical information is needed. If you wish to speak with eviCore at anytime, please call 888-333-8641.

Provider Name:	DR. BRADLEY MARK WARDEN MD/FA	Contact:	1-888-333-8641
Provider Address:	1000 W. 10th St Suite 1000, Tulsa, OK 74106	Phone Number:	918-436-1000
		Fax Number:	918-436-1000
Patient Name:	WARDEN, BRADLEY	Patient Id:	123456789
Insurance Carrier:	WELLS FARGO		
Site Name:	WELLS FARGO BANK, N.A.	Site ID:	123456789
Site Address:	1000 W. 10th St Suite 1000, Tulsa, OK 74106		
Primary Diagnosis Code:	99.02	Description:	Recurrent pregnancy loss
Secondary Diagnosis Code:		Description:	
Date of Service:	Not provided		
CPT Code:	99201	Description:	OB Ultrasound
Case Number:	123456789		
Review Date:	5/13/2020 2:36:00 PM		
Expiration Date:	N/A		
Status:	Your case has been sent to clinical review. You will be notified via fax within 2 business days if additional clinical information is needed. If you wish to speak with eviCore at anytime, please call 1-888-333-8641.		

Tips:

- You may upload clinical notes on the portal
- Enter additional notes only when necessary
- Additional information uploaded to the case will be sent for clinical review
- Print out summary of request that includes the case # and indicates ‘Your case has been sent to clinical review’

Clinical Certification Request | Request for Clinical Upload

Home	Certification Summary	Authorization Lookup	Eligibility Lookup	Clinical Certification	Certification Requests In Progress	MSM Practitioner Perf. Summary Portal	Resources	Manage Your Account
------	-----------------------	----------------------	--------------------	------------------------	------------------------------------	---------------------------------------	-----------	---------------------

Proceed to Clinical Information

Clinical Upload

Please upload any additional clinical information that justifies the medical necessity of this request.

Browse for file to upload (max size 5MB, allowable extensions .DOC,.DOCX,.PDF,.PNG):

Test clinical.docx

No file chosen

If **additional information** is required, you will have the option to upload more clinical information for review.

Tips:

- Providing clinical information via the web is the fastest and most efficient method
- Enter additional notes in the space provided only when necessary
- Additional information uploaded to the case will be sent for clinical review
- Print out a summary of the request that includes the case # and indicates 'Your case has been sent to clinical review'

Criteria Met

If your request is authorized during the initial submission you can print out the summary of the request for your records.

Summary of Your Request

Please review the details of your request below and if everything looks correct click SUBMIT

Your case has been Approved.

Provider Name:	DR. BHARATH MANU ANKARA VEETHI	Contact:	1400
Provider Address:	1200 6TH AVE N SAINT CLOUD, MN 56301	Phone Number:	(320) 734-1000
		Fax Number:	(320) 734-1000
Patient Name:	WILLIAM WILSON	Patient Id:	100000000
Insurance Carrier:	WILLIAM WILSON		
Site Name:	COMBINE MEDICAL PC	Site ID:	100000000
Site Address:	875 COMBINE ROAD SE COMBINE, AL 36712		
Primary Diagnosis Code:	[REDACTED]	Description:	Other general symptoms and signs
Secondary Diagnosis Code:	[REDACTED]	Description:	[REDACTED]
Date of Service:	Not provided	Description:	[REDACTED]
CPT Code:	73721		
Authorization Number:	[REDACTED]		
Review Date:	5/13/2020 1:52:08 PM		
Expiration Date:	6/27/2020		
Status:	Your case has been Approved.		

CANCEL PRINT CONTINUE

Tips to Improve Efficiency



Medical necessity and patient-focused care

The member's needs determine medical necessity.

- The member's clinical presentation and specific needs are the primary factors considered when determining medical necessity.
- The physician's prescription for therapy frequency and duration does not demonstrate medical necessity.

Review medical necessity regularly.

- The member's response to care should be evaluated each visit to allow modification of the treatment plan based on the member's current status.
- Complete a review of continuing medical necessity at least every 30 days. This allows you to assess how the member is responding to therapy.
- Clinical documentation should include the member's response to care, functional improvement, and remaining functional deficits.
- Consider whether the skills of a therapist are still necessary and if it is, identify the specific interventions that require that skill

Scheduling Visits

Members have different needs.

- Evaluate and determine each member's specific needs. Members with the same or similar diagnoses have different needs based on their own circumstances. Avoid following "cookbook" protocols.

Once or twice a week may work.

- Many members do not need therapy three times a week. Members may be seen once or twice a week as they work toward their goals following their comprehensive home program.

Let progress determine frequency.

- Do not schedule an entire series of visits at a set frequency. Instead, determine the date of the member's next visit based on the member's progress after each visit. Set goals for the member's next visit during each therapy appointment.

Decrease frequency during strengthening and stretching phase.

- Strengthening and stretching take time. After instructing the member in a strengthening and/or flexibility home program, allow time for the member to work on the exercises. The intensity of care should be decreased during this phase. Often the member needs to be seen only once or twice a week to update the home program.

Passive-motion and passive modalities

Passive motion can be taught.

- Passive-motion exercises can be taught to a family member or other caregiver. After providing a home program in passive motion, check with the member once or twice weekly to monitor progress.

Reduce passive modalities.

- Reduce or eliminate passive modalities after the acute phase of therapy.

Members' independent work

Responsibility for success.

Let members know they will be responsible for the success of their therapy program. Inform members of their responsibilities and reinforce them at each visit or as necessary. Have the member demonstrate the home program at each visit to ensure that it is being done correctly and that the member is compliant.

Warming up is not billable.

Using a bicycle or treadmill to warm up prior to treatment is not skilled care and should not be a billed procedure. The member can usually be taught to do warm-up exercises independently.

Independent exercise can be done without skilled supervision.

Once a member is able to complete an exercise safely, make it part of the member's independent program. Time spent exercising independently is not reimbursable.

Eliminate repetitive exercise.

Eliminate repetitive exercise under skilled supervision. The member should do this independently.

Long-term modality can be done at home.

For members who need a long-term modality such as electrical stimulation, paraffin wax, contrast baths, etc., instruct them in this for home use.

Instruct the member about edema reduction and pain management.

Instruct the member in a home program for edema reduction and pain management.

Provider Resources



Contact eviCore's Dedicated Teams

Client and Provider Services

For eligibility issues (member or provider not found in system) or transactional authorization related issues requiring research.

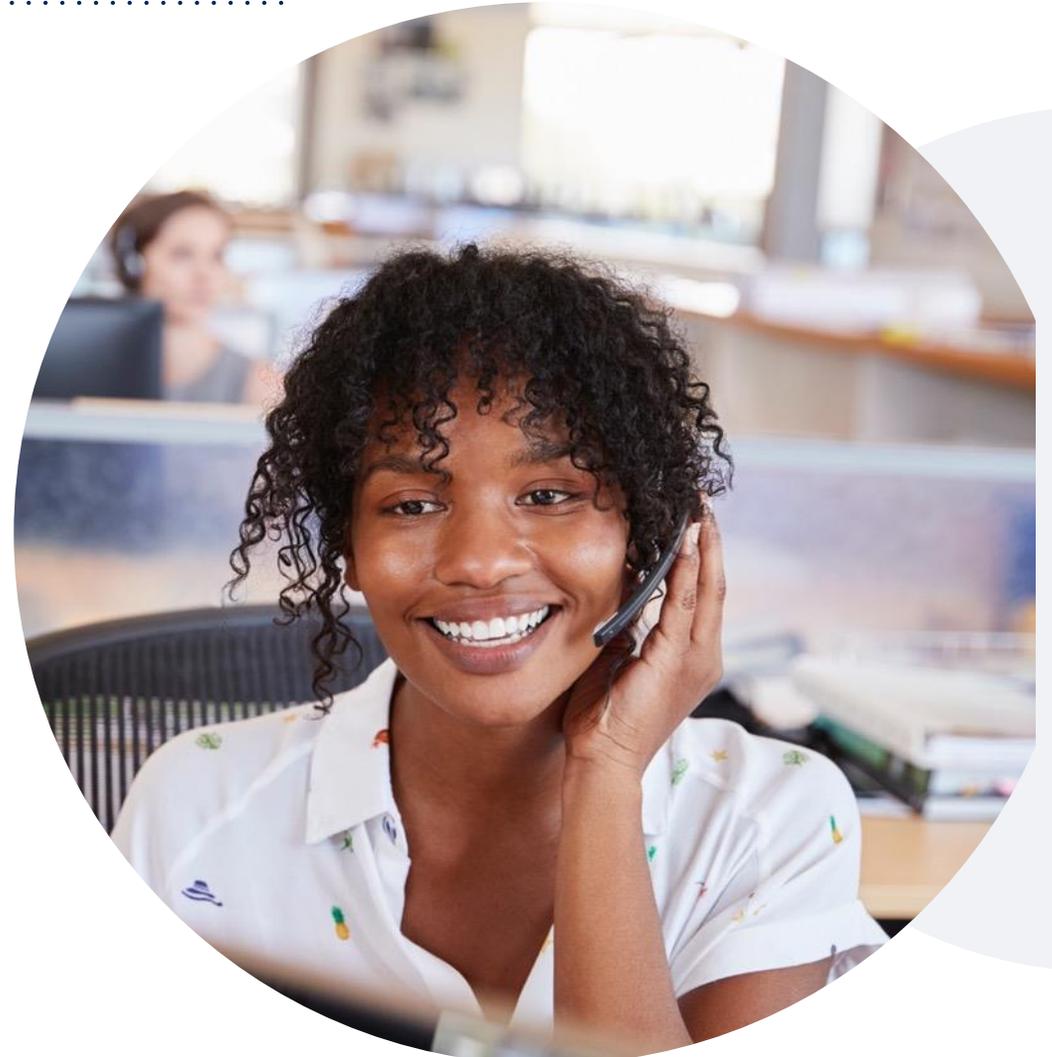
- Email: clientservices@evicore.com
- Phone: (800) 646-0418 (option 4).

Web-Based Services and Portal Support

- Live chat
- Email: portal.support@evicore.com
- Phone: 800-646-0418 (option 2)

Call Center

- Call 888-444-6185 representatives are available from 7 a.m. to 7 p.m.



Provider Resource Website

eviCore's Client and Provider Services team maintains provider resource pages that contain client- and solution-specific educational materials to assist providers and their staff on a daily basis.

This page will include:

- Frequently asked questions
- Quick reference guides
- Provider training
- CPT code list

To access these helpful resources, visit:
<https://www.evicore.com/healthplan/shp>

Musculoskeletal Online Resources

PROVIDERS: Check Prior Authorization Status Login Resources ^

Resources

CLINICAL GUIDELINES

- Clinical Worksheets
- Network Standards/Accreditations
- Provider Playbooks
- Training Resources

I Would Like To

- Request a Consultation with a Clinical Peer Reviewer
- Request an Appeal or Reconsideration
- Receive Technical Web Support
- Check Status Of Existing Prior Authorization
- Check Eligibility Status
- Access Claims Portal

Learn How To

- Submit A New Prior Authorization
- Upload Additional Clinical
- Find Contact Information

GO TO PROVIDER'S HUB >

Clinical Guidelines, PT and OT Worksheets, FAQ's, Online Forms, and other important resources can be accessed at www.evicore.com.

- The worksheets are very helpful tools to help familiarize the user of the types of questions that will be asked in the clinical pathway.

Provider Resource Review Forum

The eviCore website contains multiple tools and resources to assist providers and their staff during the prior authorization process.

We invite you to attend a **Provider Resource Review Forum** to learn how to navigate [eviCore.com](https://www.eviCore.com) and understand all the resources available on the Provider's Hub.

Learn how to access:

- eviCore's evidence-based clinical guidelines
- Clinical worksheets
- Existing prior authorization request status information
- Search for contact information
- Podcasts & insights
- Training resources

Register for a Provider Resource Review Forum:

Provider's Hub > Scroll down to eviCore Provider Orientation Session Registrations > Upcoming



eviCore's Provider Newsletter

Stay up-to-date with our free provider newsletter

To subscribe:

- Visit [eviCore.com](https://www.eviCore.com)
- Scroll down to the section titled **Stay Updated With Our Provider Newsletter**
- Enter a valid email address



Peer-to-Peer (P2P) Scheduling Tool

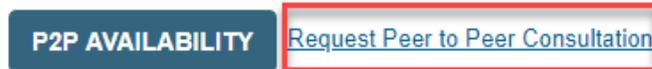


Provider Resources | Schedule a P2P Request

If your case is eligible for a Peer-to-Peer (P2) consultation, a link will display, allowing you to proceed to scheduling without any additional messaging

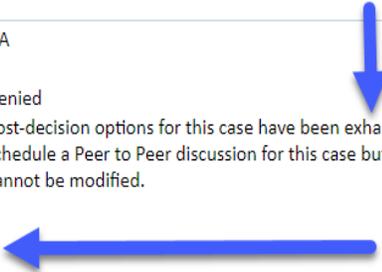
Authorization Lookup

Authorization Number:	NA
Case Number:	
Status:	Denied
P2P Status:	



Authorization Lookup

Authorization Number:	NA
Case Number:	
Status:	Denied
P2P Eligibility Result:	Post-decision options for this case have been exhausted or are not delegated to eviCore. You may continue to schedule a Peer to Peer discussion for this case but it will be considered consultative only and the original decision cannot be modified.
P2P Status:	



- Log-in to your account at [eviCore.com](https://www.eviCore.com)
- Perform **Clinical Review Lookup** to determine the status of your request
- Click on the **P2P AVAILABILITY** button to determine if your case is eligible for a Peer-to-Peer consultation
- Note carefully any messaging that displays*

*In some instances, a Peer-to-Peer consultation is allowed, but the case decision can not be changed. In such cases, you can still request a **Consultative-Only Peer-to-Peer**. You can also click on the **ALL POST-DECISION OPTIONS** button to learn what other action can be taken.

Once the **Request Peer-to-Peer Consultation** link is selected, you will be transferred to our scheduling software via a new browser window.

Provider Resources | Schedule a P2P Request (con't.)

Case Info Questions Schedule Confirmation

New P2P Request

eviCore healthcare P2P Portal

Case Reference Number Case information will auto-populate from prior lookup

Member Date of Birth

+ Add Another Case

Lookup Cases >

- Upon first login, you will be asked to confirm your default time zone
- You will be presented with the Case Number and Member Date of Birth
- Add another case for the same Peer-to-Peer appointment request by selecting **Add Another Case**
- To proceed, select **Lookup Cases**

- You will receive a confirmation screen with member and case information, including the Level of Review for the case in question
- Click **Continue** to proceed

New P2P Request

eviCore healthcare P2P Portal

Case Ref #: Remove P2P Eligible

! Reconsideration allowed through eviCore until 11/11/2020 12:00:00 AM.

Member Information	Case P2P Information
Name	Episode ID
DOB	P2P Valid Until 2020-11-11
State	Modality MSK Spine Surgery
Health Plan	Level of Review Reconsideration P2P
Member ID	System Name ImageOne

Continue

Provider Resources | Schedule a P2P Request (con't.)

Case Info

1st Case

Case #
Episode ID
Member Name
Member DOB
Member State
Health Plan
Member ID
Case Type MSK Spine Surgery
Level of Review Reconsideration P2P

Questions

Please indicate your availability

Preferred Days

Mon	Tues	Wed	Thurs	Fri
✓	✓	✓	✓	✗

Preferred Times

Morning					Afternoon						
7:00 to 8:00	8:00 to 9:00	9:00 to 10:00	10:00 to 11:00	11:00 to 12:00	12:00 to 1:00	1:00 to 2:00	2:00 to 3:00	3:00 to 4:00	4:00 to 5:00	5:00 to 6:00	6:00 to 7:00
✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Time Zone
US/Eastern

[Continue >](#)

- You will be prompted with a list of eviCore Physicians / Reviewers and appointment options
- Select any of the listed appointment times to continue
- You will be prompted to identify your preferred days and times for a Peer-to-Peer consultation (all opportunities will be automatically presented)
- Click on any **green checkmark** to **deselect** that option and then click **Continue**

The list of physicians returned are all trained and prepared to have a Peer to Peer discussion for this case.

← Prev Week 5/18/2020 - 5/24/2020 (Upcoming week) Next Week →

1st Priority by Skill

Mon 5/18/20	Tue 5/19/20	Wed 5/20/20	Thu 5/21/20	Fri 5/22/20	Sat 5/23/20	Sun 5/24/20
6:15 pm EDT 6:30 pm EDT 6:45 pm EDT	-	-	-	-	-	-

1st Priority by Skill

Mon 5/18/20	Tue 5/19/20	Wed 5/20/20	Thu 5/21/20	Fri 5/22/20	Sat 5/23/20	Sun 5/24/20
3:30 pm EDT 3:45 pm EDT 4:00 pm EDT 4:15 pm EDT Show more...	2:00 pm EDT 2:15 pm EDT 2:30 pm EDT 2:45 pm EDT Show more...	4:15 pm EDT 4:30 pm EDT 4:45 pm EDT 5:00 pm EDT Show more...	3:15 pm EDT 3:30 pm EDT 3:45 pm EDT 4:00 pm EDT Show more...	-	-	-

Provider Resources | Schedule a P2P Request (con't.)

P2P Info

Date: Mon 5/18/20
Time: 6:30 pm EDT
Reviewing Provider

Case Info

1st Case

Case #
Episode ID
Member Name
Member DOB
Member State
Health Plan
Member ID
Case Type: MSK Spine Surgery
Level of Review: Reconsideration P2P

P2P Contact Details

Name of Provider Requesting P2P: Dr. Jane Doe

Contact Person Name: Office Manager John Doe

Contact Person Location: Provider Office

Phone Number for P2P: (555) 555-5555
Phone Ext.: 12345

Alternate Phone: (xxx) xxx-xxxx
Phone Ext.: Phone Ext.

Requesting Provider Email: droffice@internet.com

Contact Instructions: Select option 4, ask for Dr. Doe

Submit

Scheduling

Scheduled

Mon 5/18/20 - 6:30 pm EDT

SCHEDULED

Update the following fields to ensure the correct person is contacted for the Peer-to-Peer appointment:

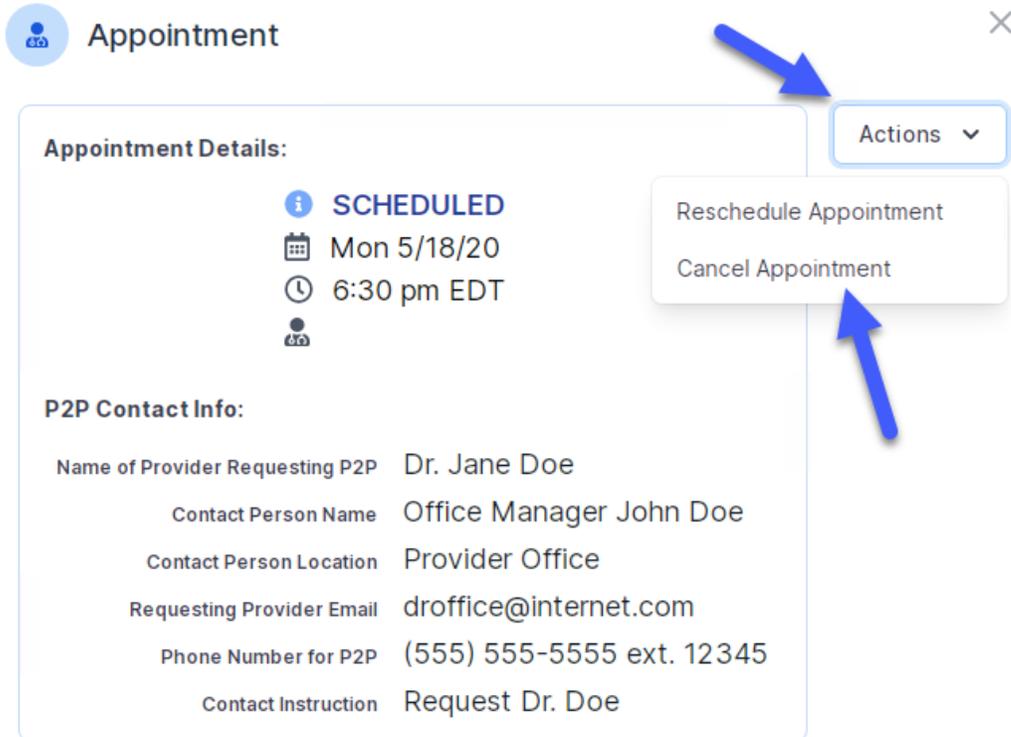
- Name of Provider Requesting P2P
- Phone Number for P2P
- Contact Instructions

Click **Submit** to schedule the appointment

You will be presented with a summary page containing the details of your scheduled appointment

Confirm contact details

Provider Resources | Cancel or Reschedule a P2P Appointment



The screenshot shows a window titled "Appointment" with a close button (X) in the top right corner. The window is divided into two main sections: "Appointment Details" and "P2P Contact Info".

Appointment Details:

- Status: **SCHEDULED** (indicated by an information icon 'i')
- Date: **Mon 5/18/20** (indicated by a calendar icon)
- Time: **6:30 pm EDT** (indicated by a clock icon)

P2P Contact Info:

Name of Provider Requesting P2P	Dr. Jane Doe
Contact Person Name	Office Manager John Doe
Contact Person Location	Provider Office
Requesting Provider Email	droffice@internet.com
Phone Number for P2P	(555) 555-5555 ext. 12345
Contact Instruction	Request Dr. Doe

On the right side of the "Appointment Details" section, there is an "Actions" drop-down menu. A blue arrow points to this menu. The menu is open, showing two options: "Reschedule Appointment" and "Cancel Appointment". A second blue arrow points to the "Cancel Appointment" option.

To cancel or reschedule an appointment:

- Access the scheduling software and select **My P2P Requests** on the left-pane navigation
- Select the request you would like to modify from the list of available appointments
- When the request appears, click on the schedule link. An appointment window will open
- Click on the **Actions** drop-down and choose the appropriate action
 - **If choosing to reschedule**, select a new date or time as you did initially
 - **If choosing to cancel**, input a cancellation reason
- Close the browser once finished

Thank You

