MEDICAL MUTUAL OF OHIO®
And Its Family of Companies

Provider Action Request Instructions

CONSUMERS LIFE INSURANCE COMPANY® | 1ST MEDICAL NETWORK™ | CAROLINA CARE PLAN®

Providers may request corrective adjustments to any previous payment, using the Provider Action Request Form (PAR), and Medical Mutual of Ohio/Consumers Life Insurance Company/Carolina Care Plan (together known as The Company) may make such adjustments as necessary and appropriate. Please note, however, that The Company has no obligation to make any adjustment after 12 months from the date the initial claim was processed.

Required Information

The PAR Form is used to help process provider inquiries in a more timely manner. **All data fields must be completed.** Forms not completed properly or provider inquiries not submitted with a form will be returned. Original submissions should have only one inquiry per form. **Use a separate PAR Form for each patient.**

Provider Information

Fill in the defined fields: the provider and tax identification number; contact person and telephone number; and the mailing address, including zip code. Provide e-mail address when available.

Patient Information

All patient data must be given. If you are questioning an entire remittance or voucher, write *multiple* in the *Patient's Name* field. Always list the The Company claim number as well as dates of service. The *Explanation* field must clearly state the outcome or action being requested. The remittance or voucher must be attached. Please check the box indicating where services were rendered.

Type of Request

The PAR Form is used for all provider inquiries and provider **appeals related to reimbursement. Check one *Type of Request*** that best describes your request.

Medical Review: When questioning reimbursement due to medical necessity, claim copies are **not** needed unless the original claim form data is being changed as a part of the request. Medical records **must** be attached. The needed records have been grouped by services.

- *Allergy:* All office notes for the services in question and a description of all medications given, including dosage
- *Ambulance* — emergency room reports: **Air** — flight records, including a breakdown of charges that identify the number of air miles and a letter of medical necessity that substantiates the need for transfer; the place or origin of flight; and the destination; **Ground** — the run report from the ambulance company
- *Anesthesia:* Hospital anesthesia records and operative reports
- *Behavioral Health:* Inpatient medical records. For the medical care cases, physician's signed written progress notes for the services in question
- *Cardiology:* Medical history and test results

Type of Request *continued*
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- *Complex Surgery:* When questioning the level of reimbursement due to performance of additional services or services with a high level of difficulty, claim copies are not needed if the modifiers appear on the original claim submittal. It you are adding a modifying reason, you must submit a new claim form. Operative reports are required for Modifier 22. *Incidental procedure denials* require operative reports and/or office notes.
- *Concurrent Medical Care:* All physician's signed progress notes for the date of service in question
- *Cosmetic:* Operative notes and pre-op photos and clinical notes
- *Institutional Outpatient and Professional Dental:* Entire medical records, including operative notes, procedure notes, anesthesia records and/or the physician's office notes, and preoperative panorex x-rays. For lesion removals, the pathology reports **(required)**
- *Emergency Room:* Complete ER records with readable copies of physician's and nurse's notes
- *Durable Medical Equipment:* Complete description of the equipment and a valid HCPCS code, form or letter of medical necessity, detailed medical history, and approximate cost of the equipment
- *Ear, Nose and Throat:* Office notes, operative notes, medical history, and the test results
- *Home Health Care:* Physician notes, physician-signed treatment plan, and all notes for any services being performed by the agency
- *Institutional Inpatient:* All documentation related to the service in question (Also, refer to *When Not to Use the PAR Form* on page 3)
- *Laboratory:* Patient history and lab results
- *Medical Care Issues:* All office notes for the service in question. For cases involving denial of an office visit/consultation and for any case involving the submission of Modifier 25: office notes, a patient history, reason for testing, and testing outcomes. If the case involves medication or administration of medication: office notes, and a detailed description of the medication, including dosage
- *MRI:* The MRI report and a detailed patient history (Also, refer to *When Not to Use the PAR Form* on page 3)
- *Maternity:* Detailed patient medical history, antenatal records, test results, labor and delivery records
- *Private Duty Nursing:* Physician's orders and all hourly nursing documentation
- *Podiatry:* Operative reports and office notes for surgical cases, and lab/pathology reports
- *Radiology:* The radiology report; medical history for PET scans
- *Skilled Nursing:* All physician orders and progress notes, nursing notes, treatments, medication documentation, all therapy modalities, and any other relevant data (Also, refer to *When Not to Use the PAR Form* on page 3)
- *Surgery:* Operative/procedure notes, and pathology reports **(required)** for cases involving the removal of lesions
- *Therapy:* Progress notes; x-ray reports; re-exam findings; objective data, such as flow charts for any chiropractic, speech or occupational therapy service beyond the 10 treatments within a calendar year; and a completed Request Authorization Therapy form **(Z3233) (required)**
- *Transplant:* In the *Explanation* field, a comprehensive problem statement
- *Vascular Services:* Medical history and test results
- *Vision:* Office notes, test results (if appropriate), and medical necessity information

Claim Review: When the claim outcome varies from the benefits expected, for denial of services, for a claim payment error, or reconsideration of a payment recovery (take back) or interest calculation. Claim form copies are not needed unless there is a change from the original claim submitted.

COB: Requests related to the incorrect processing of COB or Medicare claims. (Note: If the original claim denied for another carrier's EOB (E22) or Medicare's EOB (MIM), it is not necessary to complete a PAR form. Submit a new claim attaching the needed EOB.)

Corrected Billing: Adjustment requests **require** a revised claim form. Examples of when to use this type of request: changing number of units or date of service. The Company claim number is required to enable The Company to access the original claim payment information.

Duplicate Payment or Denial: When a duplicate claim payment was made or claims were erroneously denied as a duplicate in error.

Requested Information Attached: Used for all claim denials related to the absence of data The Company needs for final adjudication. If the denial letter is attached to the medical records and attached to the PAR Form, there is no need to complete the *Explanation* field.

Timely Filing: Documentation that clearly shows The Company was in receipt of the claim (required). Acceptable documentation includes a Company professional or hospital electronic claims **Detail Accept/ Reject Report,** or fax receipt from The Company.

Pricing/UCR: When questioning the level of reimbursement. Examples include *fee too low, not my agreed-to reimbursement rate.* Claim copies are **not needed**.

DRG/APG/Outlier: When questioning the level of reimbursement related to DRGs, APGs or Outliers.

When NOT to Use the PAR Form:

- Do not use the PAR Form if you are attempting to verify the status of a claim. Use Claims Connect. Claims Connect may be accessed through The Company Web site at **medmutual.com, consumerslife.com, carolinacareplan.com.**

- Do not use the PAR Form if the claim has been returned unprocessed for additional data. Simply complete the claim form with the additional or corrected data and resubmit the claim as a new claim by mailing it to:

Medical Mutual of Ohio
P.O. Box 94917
Cleveland, Ohio 44101-4917

Consumers Life Insurance Company
P.O. Box 94875
Cleveland, Ohio 44101-4875

Carolina Care Plan
P.O. Box 100234
Columbia, South Carolina 29202-3234

- Do not use a PAR Form when requesting the review/appeal of a service that requires precertification and was denied for incomplete certification or lack of medical necessity. Those inquiries should be addressed to Care Management, 2060 East Ninth Street, MZ 01-5B-3984, Cleveland, Ohio 44115-1355.

- Do not use a PAR Form to submit a late charge. Submit late charges electronically.

Additional Information

You may obtain a PAR Form in one of three ways:

- You may electronically submit or print out a copy of the PAR from The Company Web sites, MedMutual.com, ConsumersLife.com, or CarolinaCarePlan.com.
- You may print out a copy of the PAR from the *Professional Provider Manual*.
- You may order printed copies. The PAR comes padded in quantities of 100 (Form number Z529). Fill out a Supply Requisition Form (PC103). (A copy of the Supply Requisition Form is located in the *Professional Provider Manual*.) Use pads as your quantity unit instead of individual forms when filling out your order.

  Then either mail or fax the Supply Requisition Form to:

Inventory Control, 18-5570
Medical Mutual of Ohio, Consumers Life Insurance Company, Carolina Care Plan
4601 Hinckley Industrial Parkway, Cleveland, Ohio 44109-6020
Fax: 216/749-8074 or 800/577-8026

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NOTE: Fill in the form completely. Be sure to print clearly, using black or blue ink only. Any blanks or incomplete information could delay or cause your request to be returned unprocessed. Submit only one inquiry per form. **Use a separate PAR form for each patient.**

Date: ____________________

Provider Information

Requester/Contact Name:

Telephone Number: ☐☐☐ – ☐☐☐ – ☐☐☐☐

NPI Number: ☐☐☐☐☐☐☐☐☐☐

Legacy ID Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Provider Name:

Mailing Address:

Street or P.O. Box | City | State | Zip Code ☐☐☐☐☐

Provider's Fax Number: ☐☐☐☐☐☐☐☐☐☐

Provider's e-mail address:

Patient Information

Identification Number: ☐☐☐☐☐☐☐☐☐☐☐☐

Patient Name:

The Company Claim Number: ☐☐☐☐☐☐☐☐☐☐☐☐☐

Service Date(s) Questioned:

For Internal Use Only

Reject Code: ____________

MCR Record ☐ No ☐ Yes

Services provided in: Ohio ☐ Pennsylvania ☐ Georgia ☐ South Carolina ☐ State____________ ☐

Type of Request

Explanation required for all the following, **except Medical review.**

- ☐ Medical review (records attached) ____________
- ☐ Claim review ____________
- ☐ COB ____________
- ☐ Corrected billing ____________
- ☐ Duplicate payment or denial ____________
- ☐ Requested information attached ____________
- ☐ Timely filing ____________
- ☐ Pricing ____________
- ☐ DRG/APG/Outlier ____________

Explanation