



Dear Provider:

This communication is intended to give health providers the information they need to know about the Mutual of Omaha & United of Omaha Companies. Specifically, we will be sharing with you in this communication information about our Claims Appeal Process.

### **Claims Appeal Process**

If a Health Care Provider wishes to appeal a claims determination by Companies, the following procedures shall be followed:

1. Health Care Provider shall send an appeal request outlining the Health Care Provider's grievance to the Companies at the address identified on the explanation of payment.
2. The internal review of such claims determination shall be conducted by an individual who is not responsible for claims payment on a day-to-day basis and shall be provided at no cost to the Health Care Provider.
3. The individual conducting the internal review shall obtain all information related to the appeal and request and review any additional information needed to resolve the issue.
4. The internal review shall be conducted and its results communicated in writing to the Health Care Provider within 10 business days of Companies' receipt of the appeal request. The letter shall include:
  - (a) The names, titles, and qualifying credentials of the person(s) participating in the internal review;
  - (b) A statement of the Health Care Provider's grievance;
  - (c) The decision of the review along with a detailed explanation of the contractual and/or medical basis for such decision(s);
  - (d) A description of the evidence or documentation which supports the decision; and
  - (e) If the decision is adverse to the Health Care Provider, a description of the method to obtain an external review of the decision.
5. If the Health Care Provider is not satisfied with the results of the internal appeal, Health Care Provider shall be entitled to an independent external review.
  - (a) Health Care Provider shall submit a request for an external review to the address identified in the decision letter.
  - (b) Companies shall submit the dispute to a mediator who is mutually selected by Companies and Health Care Provider. Each party shall submit a written statement of their position to the mediator within 30 days of the submission. The mediator will confer with both

parties following receipt of their written statement and attempt to facilitate a voluntary resolution of the dispute. If both parties agree, the mediation process may be conducted by telephone or electronically. In the event that the parties are unable to reach a voluntary resolution within 10 days of the mediation conference, the mediator shall declare an impasse.

- (c) In the event a dispute cannot be resolved by mediation, such dispute shall be submitted to non-binding arbitration to be conducted in accordance with the Commercial Arbitration Rules of the American Arbitration Association. An arbitrator shall be mutually selected by Companies and Health Care Provider. If the parties cannot agree on an arbitrator, Companies and the Health Care Provider shall each select an arbitrator, with the third chosen by the arbitrators selected by Companies and the Health Care Provider. The arbitrator(s) shall conduct such evidentiary or other hearings as they deem necessary or appropriate and shall make their determination within 30 days after receipt by the arbitrator(s) of all documentation necessary to complete the review, as determined by the arbitrator(s).
  - (e) The cost of the external review process shall be borne equally by the parties.
  - (f) The decision of the external review shall be non-binding unless the parties agree otherwise.
6. If the dispute cannot be resolved to the satisfaction of both parties following the process identified in Section 5 above, either party may pursue any legal or equitable remedies available to it.
7. The process described herein shall relate only to disputes regarding claims payment decisions. It shall not apply to any other appeals, including, but not limited to, medical necessity determinations.