



<b>Policy and Procedure No: CL 16.5</b>		<b>Revision No: 5</b>
<b>Division: Care Management</b>		
<b>Department: Claims Operations</b>		
<b>Title: PHC-CA Provider Dispute Resolution</b>		
<b>Effective Date: 1/1/2010</b>		
<b>Supersedes Policy No: CL 16.0, CL 16.1, CL 16.2, CL 16.3, CL 16.4</b>		
<b>Reviewed/Revised by: Nataliya Topuriya</b>		<b>Review/Revision Date: 12/15/2025</b>
<b>Approving Committee: Member Provider Committee</b>		<b>Date: 12/15/2025</b>
<b>Executive Oversight Committee Date: 12/16/2025</b>		

**Purpose:**

To describe the Health Plan’s (PHC California) process to address, resolve, monitor and track provider claim disputes.

**Policy:**

1. The Health Plan shall afford any provider who renders service to Plan enrollees the right to file a dispute challenging, appealing or requesting reconsideration of a claim or multiple “like” claims that have been denied, adjusted or contested by the Plan. The Health Plan shall also afford providers the right to submit a dispute regarding the timeliness of reimbursement on an uncontested clean claim and any interest the Health Plan is required to pay on claims reimbursement. The Health Plan shall inform providers of its dispute resolution process, regardless of contracting status, by posting a description of the process on the Health Plan’s website.
2. The Health Plan shall address the receipt, handling and disposition of provider claim disputes and provider complaints in accordance with applicable statutes, regulations, contractual requirements and the terms and conditions of this policy.
3. The Health Plan’s Claims Department shall be responsible for tracking Provider Claim Disputes, ensuring resolution and communication to all appropriate parties.
4. The Health Plan shall ensure that there is no discrimination against a provider on the grounds that such provider filed a complaint and maintains confidentiality throughout the Provider Complaint process.
5. The Health Plan shall not request duplicative information or supporting documents from providers that were previously submitted in the pursuit of resolving a PDR.
6. The Health Plan shall submit a Provider Dispute Resolution Report annually to the Department of Health Care Services (DHCS). This report shall include information on the number of providers who utilized the dispute resolution mechanism and a summary of the disposition of those disputes, in accordance with H&S Code section 1367(h)(3). The report shall delineate network providers, out-of-network providers and subcontractors.
7. On an annual basis, the Health Plan shall assess providers, network providers and subcontractors that regularly utilize the provider dispute resolution process to identify trends and systemic issues. The Health Plan shall submit the results of its annual assessment to DHCS with discussion on how it is addressing trends and systemic issues identified based on the assessment.

**Procedure:**

Provider Claim Disputes

1. Provider Dispute Requirements. Each provider dispute must contain, at a minimum the following information:

Required Information	Example
Billing/Submitting Provider name	Legal entity name of billing provider
Billing/Submitting provider identification number	NPI & Tax ID
Billing/Submitting provider contact Information	Address, Fax, Phone Number
Enrollee full name and date of birth	John Snow, MMDD/CCYY
Enrollee ID	Health Plan Assigned member ID
Date of Service	Date of Service of rendered services
Claim Number	Listed on Remittance Advice
Charge amount	Bill charge amount submitted on the claim
Payment issue summary	Summary describing over/underpayment of claims in question
Disputed monetary amount	Amount of money the provider identifies as owed
Additional information	<p>Example: Claim denied for no authorization, but Provider has authorization number and provides it to the Plan or a copy of the authorization.</p> <p>Retro authorization request: claim denied due to lack of authorization (Inpatient admission, out-of-network provider, unaware of auth requirement, etc.) provide the medical records and identify as Retro authorization request</p> <p>Contract language or source of pricing difference.</p>

2. If the provider dispute concerns a claim or a request for reimbursement of an underpayment of a claim from the Health Plan to a provider, the request must provide:
  - i. a clear identification of the disputed item
  - ii. the date of service
- b. A clear explanation of the basis upon which the provider believes the payment amount, request for additional information, request for reimbursement for the overpayment of a claim, contest, denial, adjustment or other action is incorrect; If the provider dispute is not about a claim, a clear explanation of the issue and the provider’s position on such issue;



- c. If the provider dispute involves an enrollee or group of enrollees, the name and identification number(s) of the enrollee or enrollees, a clear explanation of the disputed item, including date of service and provider's position on the dispute, and an enrollee's written authorization for provider to represent said enrollees.
  - d. Sending a Provider Dispute to the Plan: Provider disputes submitted to the Plan must include the information listed in Section 1, above, for each provider dispute. All provider disputes must be sent to the attention of the Health Plan's California's Claims Department in writing on the Provider Dispute Resolution Request Form (Attachments A & B) for single or multiple "Like" claim disputes to the following
3. Filing Substantially Similar Provider Disputes: Substantially similar with multiple claims, billing or contractual disputes may be filed in batches as a single dispute, provided that such disputes are submitted in the following format:
    - a. Provide a cover letter for the entire submission describing each provider dispute with references to the template.
    - b. Utilize Plan's [template](#), (excel format is preferred)
    - c. Sort provider disputes by similar issue.
  4. Time Period for Submission of Provider Disputes. Provider disputes must be received by the Plan within three-hundred and sixty-five (365) days from Plan's action that led to the dispute (or the most recent action if there are multiple actions that led to the dispute), or in the case of the Plan's inaction, provider disputes must be received by the Plan within three-hundred and sixty-five (365) days after the provider's time for contesting or denying a claim (or most recent claim if there are multiple claims) has expired.
  5. Lack required information resubmission: Provider disputes that do not include all required information as set forth above in Section 1 may be returned to the submitter for completion. An amended provider dispute that includes the missing information may be submitted to the Plan within thirty (30) working of the date of receipt of a returned provider dispute describing the missing information.
  6. Non-clean claims: Provider disputes submitted where the original claim did not meet "clean claim" criteria and were administratively denied (rejected) require a corrected claim for the dispute to be processed.
    - a. "Non-clean" claims are flagged as non-clean, denied, and interest shall not apply.
    - b. If in good faith, the provider submits the required corrections to the claim, the claims examiner shall update the receive date to the date the corrected claim or new information was received.
      - i. Contracted Provider: If the corrected claim is submitted outside the contractual timely filing guidelines, the Plan as a courtesy and may pay the provider in good faith for services rendered, interest shall not apply. The Health Plan may also deny the dispute based on the contractual timely filing requirements of a clean claim and good cause exception was not met.
      - ii. Non-contracted providers: If the corrected claim is submitted beyond three-hundred and sixty-five (365) days post-service, the Plan as a courtesy may pay the provider in good faith for services rendered, interest shall not apply. The Health Plan may also deny the dispute based on timely filing requirement of three-hundred and sixty-five (365) days to submit a clean claim and good cause exception was not met.

7. Acknowledgement of Provider Disputes: The Plan will acknowledge receipt of all provider disputes as follows:
  - a. Electronic provider disputes will be acknowledged by the Plan within two (2) working days of the date of receipt by the Plan.
  - b. Paper provider disputes will be acknowledged by the Plan within fifteen (15) working days from the date of receipt by the Plan.
8. Time-Period for Resolution and Written Determination of a Provider Dispute. The Plan will issue a written determination stating the pertinent facts and explaining the reasons for its determination within forty-five (45) working days after the date of receipt of the provider dispute or the amended provider dispute.

The Plan categories PDR's:

9. Administrative review
  - a. Administrative review is required when the provider asserts a claim was underpaid or denied in error, or not paid according to the contracted reimbursement rate.
  - b. A Claims Examiner takes the following steps:
    - i. Checks whether denials are accurate and correct
    - ii. Compares the provider's contracted reimbursement rate with the amount actual paid
    - iii. Considers copays that were applied, sequestration that was deducted.
  - c. If the Claims Examiner or designee determines the claim was paid correctly, the examiner advised the provider in writing of the Plan's resolution and explanation to the provider. See resolution section <insert>
  - d. If the Claims Examiner or designee determines the claim was paid incorrectly
    - i. Examiner notifies the provider of the dispute's resolution and the amount to be paid
    - ii. Examiner changes the status of the claim from "denied" to "allowed"
    - iii. Allowed claims are processed for payment and the payment and EPP/RA are generated and issued in the following check run.
10. Medical Necessity Review(s) (MNR)
  - a. Medical necessity review is required when the provider asserts payment or authorization was improperly denied or partially denied for medically necessary care.
  - b. If the Plan Medical Director made the initial organizational determination, the examiner shall route the dispute to another designated Medical Director to perform a medical necessity review.
  - c. If the Medical Director affirms that the original claim determination is to be upheld, examiner notifies the provider of the Medical Director's decision and rationale with a written resolution letter. See resolution section <insert>

- d. If the Medical Director decides to overturn the denial or partial denial in full:
  - i. UM Department updates the authorization
  - ii. Examiner notifies the provider of the decision
  - iii. Examiner changes claim status to “allowed”
  - iv. Allowed claims are processed for payment and the payment and EPP/RA are generated and issued in the following check run.

#### 11. Retroactive Authorization Review

- a. Retroactive authorization review is required when the provider requests post-service authorization of a denied or partially denied claim
- b. Request is routed to the UM Department
  - i. If UM Medical Director denies the retroactive authorization in full, the Claims Examiner notifies the provider of the UM decision and rationale. See resolution section <insert>
- c. If UM grants retroactive authorization in full:
  - i. UM Department updates the authorization
  - ii. Examiner notifies the provider of the decision. See resolution section <insert>
  - iii. Examiner changes claim status to “allowed”
  - iv. Allowed claims are processed for payment and the payment and EPP/RA are generated and issued in the following check run.
- d. If UM grants retroactive authorization in part (approving some additional days of inpatient care but some days are still denied)
  - i. UM Department updates the authorization
  - ii. Examiner notifies the provider to submit a corrected claim for all authorized days

#### 12. Provider Dispute Resolution Determinations:

- a. Fully Favorable: dispute case resolution is in favor of the Provider. The Plan shall reprocess payment in favor of the Provider.
- b. Partially Favorable: dispute case resolution is partially favorable to the Provider (for example, billed CPT’s weren’t on the original authorization and were retroactively approved, but some of the CPT’s billed are not covered under Medi-Cal).

13. Upheld: dispute case resolution is not in favor of the Provider. The Plan upholds the initial or last determination of the claim.

14. Dismissal: A dispute case is duplicative or filed outside the time limit for filing and the Plan shall dismiss the case and rules considers the case closed.



- a. Non-clean: The Plan shall notify the Provider in writing of its decision and rationale and advise the Provider to submit a corrected claim. If the dispute is related to medical necessity, and the Provider supplies latest information relevant to the claim within thirty (30) days of resolution, the Plan will consider a subsequent dispute.

15. Dispute Payments. If the provider dispute or amended provider dispute involves a claim and is determined in whole or in part in favor of the provider, the Health Plan will pay any outstanding monies determined to be due, and all interest and penalties required by law or regulation, within five (5) working days of the issuance of the written determination.

### **Definitions:**

1. Contracted Provider Dispute A contracted provider dispute is a provider's written notice to the Plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.
2. Non-Contracted Provider Dispute: A non-contracted provider dispute is a provider's written notice to the Health Plan challenging, appealing or requesting reconsideration of a claim (or a bundled group of substantially similar multiple claims that are individually numbered) that has been denied, adjusted or contested seeking resolution of a billing determination or other contract dispute or disputing a request for reimbursement of an overpayment of a claim.

### **Monitoring:**

This Policy and Procedure is reviewed annually, and as necessary, by the Member Provider Committee.

### **References:**

1. DHCS AHF Operational Readiness (OR) Contract #22-20597, Exhibit A, Attachment III, 3.2.2.2 "Provider Dispute Resolution Mechanism", pp. 162-3.
2. California Health and Safety Code § 1367
3. California Health and Safety Code §1300.71.38(d)(3)
4. Policy and Procedure PHC-CA Claims Compliance Timeliness
5. Policy and Procedure PHC-CA Provider Reimbursement
6. Policy and Procedure PHC-CA Emergency Services
7. Standard Operating Procedure: PHC-California Claims Examiner Provider Dispute Resolution
8. [Claim Dispute Template](#)

**Regulatory Agency Approval(s):**

<b>Date</b>	<b>Version</b>	<b>Agency/Purpose</b>	<b>Purpose</b>	<b>Response</b>
7/12/2023	16.2	Department of Health Care Services (DHCS)	2024 Operational Readiness (O/R) R.0077	AIR1
8/31/2023	16.2	DHCS	O/R R.0077.1	Approved
8/9/2023	16.3	DHCS	O/R R.0077 AIR1	Approved
12/17/2025	16.4	Department of Managed Health Care (DMHC)	Filing 20254196-4	Comment Table
12/18/2025	16.5	DMHC	Filing 20254196-5	Pending

