PARTNERSHIP HEALTHPLAN OF CALIFORNIA

POLICY / PROCEDURE

<table>
<tr><td colspan="4">Policy/Procedure Number: CLPM-41</td><td colspan="4">Lead Department: Claims</td></tr>
<tr><td colspan="4">Policy/Procedure Title: Provider Claims Dispute Resolution Mechanism</td><td colspan="4">☒External Policy
☐ Internal Policy</td></tr>
<tr><td colspan="3">Original Date: 9/1/25</td><td colspan="5">Next Review Date: 01/01/2027
Last Review Date: 10/1/26</td></tr>
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<tr><td rowspan="2">Reviewing Entities:</td><td colspan="2">☐ IQI</td><td colspan="2">☐ P & T</td><td colspan="4">☐ QUAC</td></tr>
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<tr><td rowspan="2">Approving Entities:</td><td colspan="2">☐ BOARD</td><td colspan="2">☐ COMPLIANCE</td><td colspan="2">☐ FINANCE</td><td>☐ PAC</td></tr>
<tr><td>☐ CEO</td><td>☐ COO</td><td colspan="2">☐ CREDENTIALING</td><td colspan="3">☒ DEPT. DIRECTOR/OFFICER</td></tr>
<tr><td colspan="4">Approval Signature: Lisa Malvo</td><td colspan="4">Approval Date: 11/1/26</td></tr>
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I. RELATED POLICIES:

A. N/A

II. IMPACTED DEPTS:

A. Claims

III. DEFINITIONS:

A. Provider Dispute – A provider's written notice to the plan challenging, appealing or requesting reconsideration of a claim that has been denied, adjusted or contested or seeking resolution of a billing determination or disputing a request for reimbursement of an overpayment.
B. RA – Remittance Advice
C. EOP – Explanation of Payment
D. SDP State Directed Payment

IV. ATTACHMENTS:

A. Claims Provider Dispute Resolution Form

V. PURPOSE:

To provide provider dispute resolution guidelines for the Partnership Claims Department and ensure consistent and accurate processing of provider disputes.

VI. POLICY / PROCEDURE:

Providers and subcontractors have the right to submit a payment dispute if they disagree with a claim decision regarding the denial or compensation of a claim. Providers and subcontractors may submit disputes via Provider Online Services or by mail. The Provider Claims Dispute Resolution Mechanism is a fair and cost-effective process used by contracted and non-contracted providers and subcontractors for disputes regarding invoices, billing determinations or other contractual or non-contractual issues.

A. Provider Claims Dispute Resolution Mechanism Overview

A claim dispute may be submitted in writing for the following reasons:

1. Resubmit a denied claim with billing corrections
2. Resubmit a denied claim that now has a retro authorization

3. Request adjustments such as overpayment or underpayment of claims
4. Request Share of Cost reimbursement for a previously paid claim
5. Request a status on a claim that has not appeared on a remittance advice or EOP
6. Request review of a denied service or review of the processing of a payment or non-payment of a claim
7. Request review of the timeliness of reimbursement of a clean claim and any applicable interest on said claim
8. The processing of retroactive rate or payment adjustments pursuant to the terms of a State Directed Payment (SDP) or other payment policy that is contractually required.

B. Provider Claims Dispute Submission and Resolution Timeframes

Providers and subcontractors have 365 calendar days to dispute a claim from the original date on the Partnership RA. For disputes related to retroactive rate or payment adjustments, the 365-day timeframe starts from the date Partnership was required to make the retroactive rate or payment adjustment under the terms of the SDP or other contractual requirement. If the provider or subcontractor feels this time frame is insufficient, they may submit additional documentation to justify being outside the time frame and these will be reviewed on a case-by-case basis.

Partnership will acknowledge receipt of the dispute within 2 working days of an electronic submission and within 15 working days of a paper submission. Partnership will respond with a Claims Dispute Response Letter indicating the outcome of the review within 45 working days. If the claim submitted with the initial dispute does not appear on an RA or a Claims Dispute Response Letter has not been received, the provider or subcontractor may file an Appeal. The provider or subcontractor must include all copies of the Claims Dispute Acknowledgement letter or Partnership dated correspondence with the Appeal. Dispute denials for timeliness cannot be appealed by the provider or subcontractor.

If the provider dispute was not received within 365 days from Partnership's action that led to the dispute, Partnership will dismiss the provider dispute and send a letter to the provider indicating that the provider dispute is denied/rejected due to late filing. Dispute denials for lack of timeliness cannot be appealed by the provider or subcontractor.

Any monies due to the provider or subcontractor after a determination has been made on a dispute must be paid, including all interest and penalties, within 5 working days of the written determination.

C. Provider Claims Dispute Process

All disputes must be submitted via Provider Online Services or in writing via mail to:

Partnership HealthPlan of California
Attn: Claims Department/Disputes
P.O. Box 1368
Suisun City, CA 94585-1368

Each provider dispute must contain at least the following information:
1. Provider's name and NPI
2. Provider contact information
3. Member name and ID
4. Documentation supporting the dispute

5. Original claim number
6. Reason for dispute

Substantially similar 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:

1. Sort disputes by similar issues/type and separate into batches. If dispute is related to claims, it must include the required information for each claim.
2. Provide cover sheet for each batch.
3. Number each cover sheet.
4. Provide a cover letter for the entire submission describing each provider dispute with references to the numbered cover sheets.

The provider or subcontractor must provide a clear identification of the disputed item and the date(s) of service. Provider or subcontractor must also explain clearly the basis for provider's belief that the payment, request for overpayment return, request for additional information, contest, denial or adjustment, or other action is incorrect.

Provider claim disputes that do not include all required information may be returned for additional information. Partnership will clearly identify in writing to provide the missing information necessary to resolve the dispute. Provider or subcontractor may submit an amended provider dispute setting forth the missing information within 30 working days of the request for additional information.

Partnership will not discriminate or retaliate against a provider or subcontractor, including but not limited to the cancellation of the provider's contract, because the provider filed a dispute.

All claim disputes received, handled and resolved by Partnership, will be done without charge to the provider or subcontractor.

D. Provider Dispute Intake Process for External Departments (non-Claims Department)

Provider disputes that are submitted by providers to Departments outside of the Claims Department will follow the Claims Provider Dispute Intake process.

1. Disputes will be logged by External Department Rep and date stamped.
2. Disputes will be reviewed for completeness and validity against defined Claims Provider Dispute minimum requirements.
3. If dispute is incomplete, dispute will be returned to Provider with a letter instructing providers on how to submit Provider Disputes to Partnership.
4. If dispute is valid and complete, external Departments Reps will submit the dispute to the Claims Provider Dispute Inbox within two (2) business days from the received date of the dispute.
5. Once submitted to Claims Inbox, dispute can be closed according to external Department log procedures.

E. Processing Complete Provider Disputes

Partnership's Claims Department will acknowledge all provider disputes within 2 business days for electronic disputes and within 15 business days for paper disputes. Disputes that do not meet minimum requirements for submission will be returned to the Provider within 15 business days with a letter

instructing providers on how to submit Provider Disputes to Partnership.

Partnership's Claims Department will review and resolve the provider dispute and issue a written determination within 45 business days of Partnership's receipt of the provider dispute as follows:

a. If Partnership determines that the original decision is to be overturned, Partnership will send a written resolution letter to the provider informing him/her that the original claim determination is overturned.
b. If Partnership determines that the original decision is to be upheld, Partnership will send a written resolution letter to the provider informing him/her that the original claim determination is upheld.
c. Partnership's decision on payment disputes will be resolved within 45 working days from the date the provider dispute is first received by Partnership.
d. All written resolution letters will include the resolution, upheld or overturned, and rationale pertaining to that decision.

F. Provider/Member Complaints and Grievances – State Fair hearings

A Partnership provider/member must first exhaust the Partnership Appeal/Provider Dispute process prior to proceeding with a State hearing.

Providers may see the sections above for the Provider Dispute process.

Members can see the Grievance and Appeals section of the Partnership website for more information:

https://partnershiphp.org/Members/Medi-Cal/Pages/GrievanceAndAppeals.aspx

Once the Partnership Appeal/Provider Dispute process has been exhausted, requests for State hearings must be submitted within 120 calendar days of an action which the provider/member is dissatisfied. For standard State hearings, the State will make a decision within 90 days of the request. A provider/member may request a hearing online at www.cdss.ca.gov or email the request to scopeofbenefits@dss.ca.gov . A member may mail the request to:

California Department of Social Services State Hearings Division
P.O. Box 944243, MS 9-21-37
Sacramento, CA 94244-2430

A provider/member can also ask for a hearing at their local Human Services county office.

G. Provider Claims Dispute Resolution Notification, Oversight and Reporting

1. The Provider Claims Dispute Resolution Mechanism is available for both contracted and non-contracted providers. Partnership HealthPlan will inform all providers and subcontractors that provide services to Partnership Members of its Provider Claims Dispute Resolution process, regardless of contracting status. The Provider Claim Dispute Resolution Mechanism process is detailed on both contracted providers, non-contracted providers and subcontractor's remittance advice (RA) and/or Explanation of Payment (EOP) documentation.
2. On an annual basis, Partnership will submit a Provider Claims Dispute Resolution Report to DHCS which includes the number of providers who utilized the dispute resolution mechanism, delineated

by providers and subcontractors and a summary of the disposition of those disputes, in accordance with H&S Code section 1367(h)(3). Effective 1/1/27, this report must be submitted to DHCS on a quarterly basis.

3. On an annual basis, Partnership will review and assess its providers, and subcontractors that regularly utilize the Provider Claims Dispute Resolution process to identify trends and systemic issues. Partnership will 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. Effective 1/1/27, this report must be submitted to DHCS on a quarterly basis.
4. On an annual basis, Partnership will conduct a Root Cause Analysis of its Upheld and Overturned PDR decisions. If the root cause of an Overturned PDR decision is identified as system related, Claims Leadership shall work with the appropriate departments (Finance, Configuration and IT) to ensure that the system is updated accurately to prevent future errors, which could result in incorrect payments or non-payment of services. Effective 1/1/27, this report must be submitted to DHCS on a quarterly basis.

VII. REFERENCES:

A. H & S Code Section 1367(h)(3)
B. APL 26-017

VIII. DISTRIBUTION:

A. PARTNERSHIP4ME PowerDMS Policies & Procedures

IX. POSITION RESPONSIBLE FOR IMPLEMENTING PROCEDURE: Senior Director, Claims Department

X. REVISION DATES: 9/1/25, 10/1/26