PROVIDER DISPUTE RESOLUTION REPORTING TEMPLATE

Submission Information

Managed Care Plan (MCP) Name:

Reporting Quarter and Year:

Point-of-Contact Name and Title:

Point-of-Contact Email:

Quarterly Data Reporting

The Department of Health Care Services (DHCS) will use the data provided herein to monitor: (1) the disposition of MCPs' contractually required Provider Dispute Resolution (PDR) mechanism; (2) trends of Provider disputes related to billing and payment by Provider category and Provider type; (3) the timely resolution of Provider disputes; and (4) timely payment compliance.

Number of Claims Payment/Billing Disputes Filed (Aggregate Across All Provider Types)	Total In Favor of Provider	Total In Favor of MCP	Total Pending Resolution
Number of Disputes from Network Providers			
Number of Disputes from Out-of-Network Providers			

Number of Authorization Disputes and Other Disputes	Total In Favor of Provider	Total In Favor of MCP	Total Pending Resolution
Number of Authorization Disputes			
Number of Other Disputes			

Number of Disputes Processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s)	Total
Number of Claims Payment/Billing Disputes	
Number of Authorization Disputes	
Number of Other Disputes	

Number of Claims Payment/Billing Disputes by Provider Category	Total
Professional Providers	
Facility Providers	
Other Providers	

Number of Claims Payment/Billing Disputes by Provider Type	Total
Ancillary Providers	
Core Specialists	
Durable Medical Equipment Providers	
Hospitals (Inpatient)	
» Designated Public Hospitals	
» Private and Non-Designated Public Hospitals	
Long Term Care Providers	
» Community Based Adult Services Providers	
» Intermediate Care Facility for Developmentally Disabled (ICF/DD) Homes	
» Skilled Nursing Facilities (SNFs)	
» Subacute Care Facilities	
Mandatory Providers	

Number of Claims Payment/Billing Disputes by Provider Type	Total
Non-Specialty Mental Health Providers	
Non-Traditional Providers	
» Enhanced Care Management (ECM)	
» Community Supports	
Primary Care Providers	
Transportation Providers	
Other Providers	

Number of Disputes	Total
Number of Disputes Filed	
Number of Disputes Resolved within 45 Working Days	
Number of Disputes Resolved beyond 45 Working Days	
Number of Disputes Resulting in Written Determination	

Number of Providers that Used the PDR Mechanism	Total
Number of Network Providers that Used the PDR Mechanism	
Number of Out-of-Network Providers that Used the PDR Mechanism	

Timely Payment of Clean Claims	Total
Number of Clean Claims Paid	
Number of Clean Claims Paid within 30 Calendar Days	
Number of Clean Claims Paid beyond 30 Calendar Days	

Timely Payment Compliance Rates	Percentage
30-Day Timely Payment Compliance Rate	

Quarterly Narrative Reporting

MCPs are expected to synthesize their internal data of Provider disputes and timely payments to highlight recurring concerns, root causes, and any corrective actions taken or planned.

1. For disputes that are pending resolution, please provide the number that have aged beyond 45 Working Days, and the reason(s) why the disputes have aged beyond 45 Working Days.
2. For entries in the Number of Disputes processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s), please provide the name(s) of the Subcontractor(s) or Downstream Subcontractor(s) that are included in the data.
3. For entries in the "Other Providers" by Provider Category (Professional, Facility, Other), please specify which Provider categories are included in the data.
4. For entries in the "Other Providers" by Provider Type (e.g., Ancillary, Core Specialists, Durable Medical Equipment Providers, etc.), please specify which Provider types are included in the data.
5. Provide a summary of any emerging trends or recurring concerns. Describe how this information is being used to identify root causes. Identify and describe whether recurring concerns disproportionately affect certain Provider Types.
6. Provide a summary of any process changes or actions taken to address the recurring concerns and issues identified through PDR and Timely Payments oversight, along with the outcomes of those changes. Describe Provider-specific remediation steps and measurable outcomes.
7. Provide the dates of monthly office hours held this quarter, Provider types attended, and a summary of the nature of concerns raised by Providers. The response must include resulting action items and outcomes from the meetings (e.g., publication of a Frequently Asked Questions document, meeting minutes, etc.).

Disputes Pending Resolution	Narrative
Number beyond 45 Working Days	
Reason(s) why the disputes have aged beyond 45 Working Days	

Number of Disputes processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s)	Total

"Other Providers" by Provider Category	Narrative

"Other Providers" by Provider Type	Narrative
Specific Provider types included in the data	

Emerging Trends or Recurring Concerns	Narratives
Summary of emerging trends or recurring concerns	
Description of how this information is being used to identify root causes	
Identification and description of whether recurring concerns disproportionately affect certain Provider Types	
Summary of any process changes or actions taken to address the recurring concerns and issues identified through PDR and Timely Payments oversight	
Summary of the outcomes of those process changes or actions taken	
Description of Provider-specific remediation steps and measurable outcomes	

Office Hours Requirement	Narratives
Dates of monthly office hours held this quarter	
Provider types attended, and a summary of concerns raised by Providers	
Resulting action items and outcomes from the meetings (e.g., publication of a Frequently Asked Questions document, meeting minutes, etc.)	

To be included with Q4 Submissions only:

1. Provide a summary of: (1) the key trends, systemic issues, and root causes identified through the MCP's evaluation of its PDR and Timely Payments process during the reporting year; and (2) how those trends and issues have been and/or are being addressed by the MCP.
2. Describe how the MCP monitors the PDR and Timely Payments processes of its Subcontractors and Downstream Subcontractors. Provide a summary of the trends and systemic issues identified through this monitoring, and describe any remediation efforts and other corrective actions implemented with its Subcontractors and Downstream Subcontractors.

Q4 Specific Requirements	Narrative Summaries
» The key trends, systemic issues, and root causes identified through the MCP's evaluation of its PDR and Timely Payments process during the reporting year	
» How those trends and issues have been and/or are being addressed by the MCP	
Description of how the MCP monitors the PDR and Timely Payments processes of its Subcontractors and Downstream Subcontractors	
Summary of the trends and systemic issues identified through this monitoring involving	

Q4 Specific Requirements	Narrative Summaries
Subcontractors and Downstream Subcontractors	
Description of any remediation efforts and other corrective actions implemented with its Subcontractors and Downstream Subcontractors	

Provider Dispute Resolution Reporting Instructions

The Provider Dispute Resolution (PDR) Report is due 45 calendar days after the end of each quarter and must be submitted to MQCMD@dhcs.ca.gov. The file naming convention for the report is MCP Name, PDR, year, calendar year quarter, for example: MCPName.PDR.2025.Q1.

The Quarterly Data Reporting and Quarterly Narrative Reporting sections are required to be completed and submitted every quarter, while the Annual Narrative Reporting section must be completed and submitted along with quarter four (Q4) submissions on an annual basis. Any questions regarding the PDR Report must be sent to MCQMD@dhcs.ca.gov.

Submission Information

Provide the requested information including the MCP's name, reporting quarter and year, and point-of-contact's (for the PDR Report) name, title, and email.

Quarterly Data Reporting

Number of Claims Payment/Billing Disputes Filed (aggregate across all Provider types)

A claim payment or billing dispute is a Provider complaint concerning an MCP's failure to fully and accurately reimburse a claim, including the required automatic payment of any applicable interest and penalties.

Number of Disputes from Network Providers – Enter the total number of claims payment/billing disputes from Network Providers that were filed during the reporting period and are in favor of Provider, in favor of MCP, and pending resolution. Use the Provider's rendering National Provider Identifier and Provider Name for these Provider counts.

Number of Disputes from Out-of-Network Providers - Enter the total number of claims payment/billing disputes from out-of-Network Providers that were filed during the reporting period and are in favor of Provider, in favor of MCP, and pending resolution. Use the Provider's rendering National Provider Identifier and Provider Name for these Provider counts.

Number of Authorization Disputes – Enter the total number of authorization disputes that were filed during the reporting period and are in favor of Provider, in favor of MCP, and pending resolution. Authorization disputes are Provider complaints relating to Utilization Management, authorization determinations, and Medical Necessity.

Number of Other Disputes – Enter the total number of other disputes (not related to Claims Payment/Billing or Authorizations) that were filed during the reporting period and are in favor of Provider, in favor of MCP, and pending resolution. Disputes described in APL 25-015 may fall into this category.

Number of Disputes Processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s)

Report disputes that were processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s). These disputes include those received by the MCP erroneously and then forwarded to the correct delegated downstream entity, and disputes that were received directly by the Subcontractor or Downstream Subcontractor.

Number of Claims Payment/Billing Disputes – Enter the total number of claims payment/billing disputes processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s) during the reporting period. If the MCP has more than one Subcontractor or Downstream Subcontractor, please provide the sum of claim payment/billing disputes. A claim payment or billing dispute is a Provider complaint concerning an MCP's failure to fully and accurately reimburse a claim, including the required automatic payment of any applicable interest and penalties.

Number of Authorization Disputes – Enter the total number of authorization disputes processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s) during the reporting period. If the MCP has more than one Subcontractor or Downstream Subcontractor, please provide the sum of authorization disputes. Authorization disputes are Provider complaints relating to Utilization Management, authorization determinations, and Medical Necessity.

Number of Other Disputes – Enter the total number of other disputes processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s) during the reporting period. If the MCP has more than one Subcontractor or Downstream Subcontractor, please provide the sum of other disputes.

Number of Claims Payment/Billing Disputes by Provider Category

Professional Providers – Enter the total number of claims payment/billing disputes from professional Providers that were filed during the reporting period. A professional Provider is an individual licensed to provide health care services and bills for their services using the CMS-1500 claim form or 837P.

Facility Providers – Enter the total number of claims payment/billing disputes from facility Providers that were filed during the reporting period. A facility Provider is a health facility as defined in California Health and Safety Code Section 1250 – 1250.3 and bills for its services using the UB-04 claim form or 837I.

Other Providers – Enter the total number of claims payment/billing disputes from Providers that do not fall under the category of professional or facility Providers that were filed during the reporting period.

Number of Claims Payment/Billing Disputes by Provider Type

Ancillary Providers – Enter the total number of claims payment/billing disputes from ancillary Providers that were filed during the reporting period. Ancillary Providers are Providers of diagnostic and therapeutic services, such as, but not limited to laboratory, infusion, radiology, imaging, pulmonary testing, and cardiac rehabilitation, renal dialysis, occupational therapy, speech therapy, physical therapy, and applied behavior analysis.

Core Specialists – Enter the total number of claims payment/billing disputes from core Specialists that were filed during the reporting period. A core Specialist is defined as a "specialist" per time and distance requirements: dermatology; cardiology/interventional cardiology; endocrinology; ear, nose, and throat/otolaryngology; gastroenterology; general surgery; hematology; HIV/AIDS specialists/infectious diseases; nephrology; neurology; obstetrics and gynecology specialty care, oncology; ophthalmology; orthopedic surgery; physical medicine and rehabilitation; psychiatry; and pulmonology. Core Specialists are defined using the DHCS Managed Care Network Adequacy Taxonomy Crosswalk.[1]

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1 The DHCS Managed Care Network Adequacy Taxonomy Crosswalk is located at: https://networks-gis.dhcs.ca.gov/datasets/CADHCS::managed-care-network-adequacy-taxonomy-crosswalk/explore.

Durable Medical Equipment Providers – Enter the total number of claims payment/billing disputes from durable medical equipment Providers that were filed during the reporting period. Durable medical equipment Providers are Providers of Medically Necessary medical equipment as defined by 22 California Code of Regulations section 51160.

Hospitals (Inpatient) – Enter the total number of claims payment/billing disputes from hospitals that were filed during the reporting period. Types of hospitals include, but are not limited to, general acute care and long-term acute care hospitals, inpatient rehabilitation hospitals, children's hospitals and rural hospitals. Include a breakdown of claims payment/billing disputes from Designated Public Hospitals (DPHs) and Private/Non-Designated Public Hospitals (NDPHs).

Long-Term Care Providers – Enter the total number of claims payment/billing disputes from long term care Providers (in the aggregate) that were filed during the reporting period. Long-Term Care Providers include Community Based Adult Services (CBAS) Providers, Intermediate Care Facility for Developmentally Disabled (ICF-DD) homes, Skilled Nursing Facilities (SNFs), and Subacute Care Providers. In the subsequent four rows, include a breakdown of claims payment/billing disputes from each of these Long-Term Care Provider types.

Mandatory Providers – Enter the total number of claims payment/billing disputes from mandatory Providers that were filed during the reporting period. Mandatory Providers include Federally Qualified Health Centers, Rural Health Centers, Freestanding Birth Centers, Indian Health Care Providers, Certified Nurse Midwives, and Licensed Midwives.

Non-Specialty Mental Health Providers – Enter the total number of claims payment/billing disputes from non-specialty mental health Providers that were filed during the reporting period. Non-specialty mental health Providers are Providers of Non-Specialty Mental Health Services (NSMHS) except for psychiatrists, which are core Specialists.

Non-Traditional Providers – Enter the total number of claims payment/billing disputes from non-traditional Providers (in the aggregate) that were filed during the reporting period. Non-traditional Providers include Doulas, Enhanced Care Management (ECM) Providers, Community Supports Providers, and Community Health Workers (CHW). In the subsequent two rows, include a breakdown of claims payment/billing disputes from ECM and Community Supports Providers only.

Primary Care Providers – Enter the total number of claims payment/billing disputes from Primary Care Providers that were filed during the reporting period. Primary Care Providers are Providers of Primary Care and obstetrics and gynecology Primary Care.

Transportation Providers – Enter the total number of claims payment/billing disputes from transportation Providers that were filed during the reporting period. Transportation Providers are Providers of emergency transportation, Non-Emergency Medical Transportation (NEMT), and Non-Medical Transportation (NMT).

Other Providers – Enter the total number of claims payment/billing disputes from all other Providers not already specified in previous Provider type definitions, that were filed during the reporting period.

Number of Disputes

Number of Disputes Filed – Enter the total number of disputes received by the MCP during the reporting period (i.e., all Provider disputes received during the reporting quarter).

Number of Disputes Resolved within 45 Working Days – Enter the total number of disputes that were resolved during the reporting period within 45 Working Days, regardless of when the dispute was received.

Number of Disputes Resolved beyond 45 Working Days – Enter the total number of disputes that were resolved during the reporting period beyond 45 Working Days, regardless of when the dispute was received.

Number of Disputes Resulting in Written Determination – Enter the total number of disputes that were resolved during the reporting period and resulted in a written determination, regardless of when the dispute was received.

Number of Network and Out-of-Network Providers that Used the PDR Mechanism

Number of Network Providers that Used the PDR Mechanism – Enter the total number of network Providers that used the PDR Mechanism during the reporting period.

Number of Out-of-Network Providers that Used the PDR Mechanism – Enter the total number of out-of-Network Providers that used the PDR Mechanism during the reporting period.

Timely Payment of Clean Claims

Number of Clean Claims Paid – Enter the total number of all Clean Claims paid during the reporting period. A Clean Claim is a claim that can be processed without obtaining additional information from the Provider or from a third party, including bills, or invoices that meet DHCS established billing and invoicing requirements.

Number of Clean Claims Paid within 30 Calendar Days – Enter the total number of Clean Claims paid during the reporting period within 30 calendar days of submission date.

Number of Clean Claims Paid beyond 30 Calendar Days – Enter the total number of Clean Claims paid during the reporting period beyond 30 calendar days of submission date.

Timely Payment Compliance Rates

Timely Payment Compliance Rates are based on the MCP's total Clean Claims that were paid during reporting period, regardless of when the claim was received.

30-Day Timely Payment Compliance Rate - To calculate, use the following formula:

- (Number of Clean Claims Paid within 30 Calendar Days during the reporting period / Total Number of all Clean Claims Paid during the reporting period) x 100 = Percentage

Quarterly Narrative Reporting

1. For disputes that are pending resolution, please provide the number that have aged beyond 45 Working Days, and the reason(s) why the disputes have aged beyond 45 Working Days. – Report the number of disputes that are pending resolution and have aged beyond 45 Working Days from receipt. Provide the reason(s) why the dispute(s) aged beyond 45 Working Days (e.g., the dispute is relating to rate

production and the MCP has 90 calendar days to process the dispute, as described in APL 25-015).

2. For entries in the Number of Disputes processed by the MCP's Subcontractor(s) or Downstream Subcontractor(s), please provide the name(s) of the Subcontractor(s) or Downstream Subcontractor(s) that are included in the data – List the names of the Subcontractors or Downstream Subcontractors that received and processed Provider disputes.
3. For entries in the "Other Providers" by Provider Category (Professional, Facility, Other), please specify which Provider categories are included in the data – List the other Provider categories that are included in the total for number of claims payment/billing disputes from "Other Providers".
4. For entries in the "Other Providers" by Provider Type (e.g., Ancillary, Core Specialists, Durable Medical Equipment Providers, etc.), please specify which Provider types are included in the data – List the Provider types that are included in the total for number of claims payment/billing disputes from "Other Providers".
5. Provide a summary of any emerging trends or recurring concerns. Describe how this information is being used to identify root causes. Identify and describe whether recurring concerns disproportionately affect certain Provider types – Give a concise description of any emerging patterns or recurring concerns of PDR submissions and Timely Payments. Describe how this information is being used to determine the root causes. Assess and report whether recurring concerns disproportionately impact specific Provider types.
6. Provide a summary of any process changes or actions taken to address the recurring concerns and issues identified through PDR and Timely Payments oversight, along with the outcomes of those changes. Describe Provider-specific remediation steps and measurable outcomes – Give a concise description of any process changes or actions taken to resolve the recurring concerns and root causes of PDR submissions, and noncompliance with Timely Payments requirements. For recurring concerns that were identified to impact specific Provider types, report on Provider-specific remediation steps and measurable outcomes. This may include changes to the MCP's capacity, plan-Provider relations, and policies and procedures. Describe the outcomes of those changes (e.g., improved quality care, faster claim payments, reduced or removal of barriers for specific Provider types, etc.).
7. Provide the dates of monthly office hours held this quarter, Provider types attended, and a summary of the nature of concerns raised by Providers. The response must include resulting action items and outcomes from the meetings (e.g., publication of a

Frequently Asked Questions document, meeting minutes, etc.) – List the dates of the monthly office hours offered during the reporting period. List the types of Providers who attended the monthly office hours. Describe the nature of concerns raised by the Providers, resulting action items, and outcomes from the meetings.

To be included with Q4 Submissions only:

1. Provide a summary of: (1) the key trends, systemic issues, and root causes identified through the MCP's evaluation of its PDR and Timely Payments process during the reporting year; and (2) how those trends and issues have been and/or are being addressed by the MCP – Give a concise description of the key trends, systemic issues, and root causes that were identified through the MCP's assessment of its PDR mechanism and Timely Payments process during the reporting year. Describe how the trends, systemic issues, and root causes were/are being remedied (e.g., corrective actions taken).
2. Describe how the MCP monitors the PDR and Timely Payments processes of its Subcontractors and Downstream Subcontractors. Provide a summary of the trends and systemic issues identified through this monitoring, and describe any remediation efforts and other corrective action implemented with its Subcontractors and Downstream Subcontractors – Explain how the MCP monitors and provides oversight of its Subcontractors and Downstream Subcontractors' PDR mechanism and Timely Payments process. Give a concise description of the key trends, systemic issues, and root causes that were identified through the MCP's monitoring of Subcontractors and Downstream Subcontractors during the reporting year, including the name(s) of its Subcontractors and Downstream Subcontractors that required remediation efforts. Describe how these trends, systemic issues, and root causes were/are being remedied (e.g., corrective actions taken) with its Subcontractors and Downstream Subcontractors.