Provider Dispute Resolution

CalOptima offers the Provider Dispute Resolution (PDR) for Providers to resolve claims issues (The PDR process has replaced the Resubmission process):

- **Underpayment/Overpayment – examples listed below**
  - If claim has been underpaid per Medi-Cal rates or contract terms.
  - Claim was overpaid due to a payment or billing error.
  - Procedures which were denied as inclusive to another procedure in error.
  - Corrected claims where a previous payment was made. (If a previous payment has not been made claim should be submitted as an original claim not as a dispute.)

- **Timelines**
  - Provider disputes should be sent within one year of the last determination for timely consideration.
  - CalOptima will send an acknowledgement letter to the Provider within 15 working days of receipt.
  - If additional information is required for resolution, a written request will be sent within 15 working days of receipt. The request will indicate specific information needed to complete review of dispute.
  - Provider disputes will be resolved and a resolution letter indicating disposition of the dispute will be sent to the Provider within 45 working days of receipt.

The Provider Dispute Resolution process has been put into place at CalOptima to ensure that best practices are used for proper feedback and resolution of claim payment/denial discrepancies. The Provider Dispute Resolution process should be used prior to formal appeals to the Grievance Appeals Resolution (GARS) unit. Claim issues that should be forwarded to the GARS unit would include: i.e. retro authorization requests for denied days or level of care discrepancies that require Medical and/or Authorization review. For the GARS process please refer to General Information for Physicians section.

PROVIDER DISPUTE RESOLUTION REQUEST

INSTRUCTIONS

- x Please complete this form. Fields with an asterisk (*) are required.
- x Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME.
- x Provide additional information to support the description of the dispute.
- x For routine follow-up regarding claims status, please contact the CalOptima Claims Provider Line: **714-246-8885**
- x Mail the completed form to: CalOptima Claims Provider Dispute
  P.O. Box 57015
  Irvine, CA 92619

PRODUCT TYPE: ☐ MEDI-CAL ☐ MEDICARE ☐ COMMERCIAL	
*** PROVIDER NPI:**	*** PROVIDER TAX ID # / Medicare ID #:**
*** PROVIDER NAME:**	**CONTRACTED:** ☐ YES ☐ NO
PROVIDER ADDRESS:	

PROVIDER TYPE ☐ MD ☐ Mental Health Professional ☐ Mental Health Institutional ☐ Hospital ☐ ASC
☐ SNF ☐ DME ☐ Rehab ☐ Home Health ☐ Ambulance ☐ Other _____
(please specify type of "other")

CLAIM INFORMATION ☐ Single ☐ Multiple "**LIKE**" Claims (complete attached spreadsheet) Number of claims:_____

*** Patient Name:**		**Date of Birth:**
*** Health Plan ID Number:**	**Patient Account Number:**	**Original Claim ID Number:** (If multiple claims, use attached spreadsheet)
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement of Overpayment Disputes)	**Original Claim Amount Billed:**	**Original Claim Amount Paid:**

DISPUTE TYPE

- ☐ Claim
- ☐ Appeal of Medical Necessity / Utilization Management Decision
- ☐ Disputing Request for Reimbursement of Overpayment
- ☐ Seeking Resolution of a Billing Determination
- ☐ Contract Dispute
- ☐ Other:

*** DESCRIPTION OF DISPUTE:**

EXPECTED OUTCOME:

Contact Name (please print) | **Title** | **( ) Phone Number**

Signature | **Date** | **( ) Fax Number**

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple.)**

For Health Plan Use Only

TRACKING #_____ PROV ID#_____
CONTRACTED_____ NON-CONTRACTED _____

PROVIDER DISPUTE RESOLUTION REQUEST

Tracking Form

(For Optional Use by Health Plan/Delegated Provider)

Number	* Patient Name		Date of Birth	* Health Plan ID Number	Original Claim ID Number	* Service From/To Date	Original Claim Amount Billed	Original Claim Amount Paid	Expected Outcome
	Last	First							
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									

☐ **CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)**