Department of Managed Health Care
Provider Complaint Unit Statistics
January 1, 2011 – December 31, 2011

The information below represents statistics related to provider complaints received by the Department's Provider Complaint Unit pursuant to Health and Safety Code Section 1371.39 (a).

Total Provider Complaints Received (1)

Calendar Quarter	Number of Complaints
First Quarter	1,643
Second Quarter	1,067
Third Quarter	909
Fourth Quarter	907

Total Funds Recovered (2)

Calendar Quarter	Amount
First Quarter	$931,991.11
Second Quarter	$543,611.74
Third Quarter	$556,474.97
Fourth Quarter	$1,768,382.18

Total of Provider Complaints Received by Provider Type (3)

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Ambulance	28	31	8	30
Anesthesiology	11	87	2	7
Chiropractic	0	4	3	129
Dental	17	32	2	9
Durable Medical Equipment	12	1	9	68
ER Physician	354	70	50	18
Family/General Practice	18	9	26	6
Home Health Services	3	1	6	10
Hospital-based Physician	56	38	41	19
Hospital/Institutional	355	373	304	335
Internal Medicine	3	44	14	8
Laboratory Services	6	4	11	11
Mental Health	49	26	14	34

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
OB/GYN	17	95	37	27
On Call Physicians (Not ER)	20	10	16	6
Other Ancillary Service Providers	17	55	7	13
Other Specialist Providers	611	161	192	93
Pediatrics	27	11	150	81
Pharmacy	17	5	2	0
Physical/Speech/Occupational Therapy	19	1	10	2
Skilled Nursing Facility	3	9	4	1
Vision	0	0	1	0
Total	**1,643**	**1,067**	**909**	**907**

Total of Provider Complaints Received by Health Plan (4)

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Access Dental Plan	2	0	0	0
ACN Group of California	0	0	0	0
Aetna Health	26	73	65	37
AIDS Healthcare Foundation	0	6	0	0
Alameda Alliance for Health	0	0	0	1
American Specialty Health Plans	3	1	1	5
Arcadian Health Plan	1	0	0	0
Arta Medicare Health Plan	1	0	0	0
Blue Cross	576	309	259	234
Blue Shield	50	74	65	53
Bravo Health Company	1	0	0	0
Care 1st	46	61	43	24
Central Health Plan of CA	0	0	0	0
Chinese Community Health Plan	0	0	0	0
Choice Physicians Network	0	0	0	0
Cigna Behavioral Health	1	0	1	0
Cigna HealthCare	128	19	17	129
Cigna Health Care Pacific	0	1	1	0
Community Health Group	1	11	41	49
Contra Costa County	4	0	0	0
County of Los Angeles	26	19	24	94
Delta Dental	10	16	2	3
Dental Benefit Providers of CA	0	0	0	1
Dental Health Services	0	0	0	0
Easy Choice Health Plan	0	1	0	0
GemCare Health Plan	0	1	0	0
Golden West Health Plan	0	0	0	1
Great-West Health Care	1	0	0	0

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Health and Human Resource Ctr.	0	0	0	1
Health Net	460	169	271	131
Health Spring Life and Health	0	0	1	0
Heritage Provider Network	10	1	0	0
Humana	1	2	4	0
Inland Empire	10	4	0	5
Inter Valley Health Plan	0	0	0	0
Kaiser	91	66	15	34
Kern Health Systems	0	8	2	0
Liberty Dental	5	13	0	1
Local Initiative Health Authority	25	15	12	18
Managed Health Network	4	9	3	1
MD Care, Inc.	3	0	2	1
Molina Healthcare	30	42	25	28
Monarch Health Plan	1	0	1	0
Orange County Health Authority	1	6	5	10
PCBH	0	0	0	0
PacifiCare	28	32	13	0
Partnership Health Plan of CA	0	0	1	0
Premier Health Plan Services	0	80	0	0
PRIMECARE Medical Network	0	0	0	1
SafeGuard Health Plans	0	0	0	1
San Francisco Community Auth	0	1	0	0
San Mateo Health Commission	0	0	0	0
San Miguel Health Plan	0	0	1	0
Santa Barbara/SLO Health Plan	1	0	1	0
Santa Clara County Health	78	0	0	0
Scan Health Plan	2	3	1	0
Sharp Health Plan	2	1	0	0
Sistemas Medicos Nacionales	0	0	0	0
US Behavioral	10	0	7	12
United Concordia Dental Plan	0	1	1	1
United Health Care of CA	3	19	24	24
Universal Care	1	3	0	7
ValueOptions of CA	0	0	0	0
Vision Service Plan	0	0	0	0
WellCare Prescription Insurance	0	0	0	0
Western Health Advantage	0	0	0	0
Total	**1,643**	**1,067**	**909**	**907**

(1) Total Provider Complaints Received

Data represents provider complaints received during the reporting period.

(2) Total Funds Recovered

Amounts are based on provider complaints closed during the reporting period.

(3) Total of Provider Complaints Received by Provider Type

Data represents provider complaints received during the reporting period.

(4) Total Provider Complaints Received by Health Plan

Data represents provider complaints received during the reporting period broken out by health plan.

This data is provided for informational purposes only. The mere fact that a provider submitted a complaint against a health care service plan does not mean, in and of itself, that the health care service plan may have, or has violated applicable provisions of California health care service plan law. The information set forth in this chart reflects dispute issues identified in connection with provider complaints submitted to the Department. In reviewing this report, it is important to remember that providers have the ability to choose more than one dispute issue per complaint submitted. This data is therefore provided for informational purposes only.

Provider Complaint Unit
Dispute Issues Selected by Providers
January 1, 2011 – December 31, 2011

Provider Complaint Dispute Issues Identified (5)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
1) The payer has imposed a Claims Filing Deadline less than 90 days for a contracted provider or 180 days for a non-contracted provider.	373	46	41	29
2) The payer failed to accept a late claim submission upon the demonstration of good cause for the delay.	177	69	44	43
3) The payer failed to forward a misdirected claim to the appropriate capitated provider within 10 working days of receipt of the claim.	51	24	341	60
4) The payer failed to acknowledge the receipt of an electronic claim within 2 working days or a paper claim within 15 working days.	438	112	166	99
5) The payer failed to reimburse a complete claim with the correct payment.	1,032	456	404	434
6) The payer failed to reimburse the complete claim, or portion thereof, within 30 working days for non-HMO services or 45 working days for HMO services.	646	269	404	434
7) The payer failed to include required interest and/or penalty amount(s) owed on claim(s) reimbursed beyond 30 working days for non-HMO services or 45 working days for HMO services.	209	103	119	264
8) The payer required prior authorization or refused to pay for ambulance or ambulance transport services provided to an enrollee as a result of a 911 emergency response system request for assistance.	0	9	6	2
9) The payer failed to reimburse provider(s) for emergency services and care.	428	153	320	272
10) The payer failed to reimburse the hospital for care following the stabilization of an emergency medical condition.	74	19	33	33

Provider Complaint Dispute Issues Identified (5)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
11) The payer failed to reimburse a claim for health care services that were provided in a licensed acute care hospital, were medically necessary and related to services that were previously authorized, were provided after the plan's normal business hours, and when the plan did not have a system or means to respond within 30 minutes to a request for authorization.	267	41	121	117
12) The payer failed to contest or deny the claim, or portion thereof, within 30 working days for non-HMO services or 45 working days for HMO services.	484	162	165	252
13) The payer failed to provide a clear and accurate written explanation for the claims adjudication decision.	406	173	203	325
14) The payer rescinded or modified an authorization for health care services after the provider rendered the service in good faith.	265	76	147	87
15) The payer reimbursed a non-contracted provider's claim at less than "reasonable and customary value."	231	101	59	31
16) The payer reimbursed a contracting provider's claim at less than the "contract rate."	181	98	209	163
17) General claim processing issues.	1,065	482	566	660
18) The provider's contract requires the provider to submit medical records that are not reasonably relevant for the adjudication of the claim.	64	9	5	13
19) The payer has requested medical records or other documentation that are not reasonably relevant or are in excess of the minimum amount of information necessary to adjudicate the claim.	112	109	73	200
20) The provider's contract does not include the mandated contractual provisions enumerated in section 1300.71of Title 28 of the California Code of Regulations.	1	0	3	1
21) The payer failed to provide the required "Information for Contracting Providers and the Fee Schedule and Other Required Information" disclosures enumerated in section 1300.71of Title 28 of the California Code of Regulations.	22	2	1	0

Provider Complaint Dispute Issues Identified (5)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
22) The payer failed to provide the required notice for “Modifications to the Information for Contracting Providers and to the Fee Schedule and Other Required Information” enumerated in section 1300.71of Title 28 of the California Code of Regulations.	7	1	1	0
23) The payer required the provider to waive any protections or to assume any obligation of the plan inconsistent with sections 1300.71 or 1300.71.38 of Title 28 of the California Code of Regulations.	0	0	0	1
24) General contract term issues.	30	66	5	10
25) The payer requested reimbursement of an overpaid claim more than 365 days from the date of payment of the overpaid claim, when the overpayment was not caused in whole or part by fraud or misrepresentation on the part of the provider.	12	4	5	7
26) The payer unilaterally deducted a claim overpayment without providing notice.	0	1	0	1
27) The payer issued a notice of reimbursement or overpayment that did not clearly identify the claim, the name of the patient, date of service and include a clear explanation of the basis for the payer’s belief that the claim was overpaid.	0	0	0	0
28) The payer failed to process a provider's contest of the payer's notice of overpayment as a provider dispute pursuant to regulation 1300.71.38	5	10	2	3
29) For a notice of overpayment issued by the payer but not contested by the provider, the payer took an offset:	0	0	0	0
29.1) without authorization from the provider; or	1	1	2	4
29.2) even though the provider reimbursed the overpayment within 30 working days of the payer's notice of the overpayment; or	0	0	0	0
29.3) without allowing 30 working days for the provider to reimburse the overpayment; or	1	0	0	0

Provider Complaint Dispute Issues Identified (5)	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
29.4) without providing a detailed written explanation identifying the specific overpayment or overpayments that have been offset against the specific current claim or claims.	1	1	0	0
30) General overpayment issues.	33	21	3	5
31) The payer failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) for an adjusted or contested claim.	176	80	59	140
32) The payer imposed filing deadline of less than 365 calendar days for the filing of a provider dispute.	32	10	7	8
33) The payer failed to acknowledge the receipt of an electronic dispute within 2 working days or a paper dispute within 15 working days.	152	65	112	72
34) The payer failed to issue a written determination for a provider dispute within 45 working days from the date of receipt.	315	110	150	225
35) The payer has engaged in discrimination or retaliation against a provider because the provider filed a contracted provider dispute or a non-contracted provider dispute.	1	8	3	131
36) Following a dispute determination in favor of a provider, the payer failed to pay all monies due, including interest and penalties, within 5 working days of the issuance of the Written Determination.	77	67	69	31
37) General dispute resolution issues.	153	81	104	274

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