**Department of Managed Health Care**
**Provider Complaint Unit Statistics**
**January 1, 2014 – December 31, 2014**

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). The submission of a provider complaint itself does not mean that the health care service plan has violated applicable provisions of California law.

Total Provider Complaints Received[1]

| Calendar Quarter | Number of Complaints |
|---|---|
| First Quarter | 839 |
| Second Quarter | 696 |
| Third Quarter | 1,072 |
| Fourth Quarter | 888 |

Total Funds Recovered[2]

| Calendar Quarter | Amount Recovered |
|---|---|
| First Quarter | $794,450.67 |
| Second Quarter | $782,026.44 |
| Third Quarter | $2,094,268.59 |
| Fourth Quarter | $955,711.24 |

[1] Total Provider Complaints Received
Data represents provider complaint cases received during the reporting period.
[2] Total Funds Recovered
Recovered amounts are based on provider complaint cases closed during the reporting period.

## Total Provider Complaints Received by Provider Type[3]

| Provider Type | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---|---|---|---|---|
| Ambulance | 2 | 25 | 275 | 13 |
| Anesthesiology | 1 | 15 | 1 | 0 |
| Chiropractic | 0 | 0 | 1 | 12 |
| Dental | 4 | 50 | 23 | 3 |
| Durable Medical Equipment | 15 | 26 | 4 | 14 |
| ER Physician | 16 | 7 | 6 | 10 |
| Family/General Practice | 32 | 9 | 15 | 49 |
| Home Health Services | 52 | 11 | 6 | 9 |
| Hospital/Institutional | 222 | 162 | 288 | 144 |
| Laboratory Services | 56 | 21 | 21 | 1 |
| Mental Health | 91 | 79 | 56 | 21 |
| On Call Physicians (Not ER) | 0 | 14 | 0 | 3 |
| Other Specialist Providers | 128 | 118 | 108 | 198 |
| Pediatrics | 88 | 74 | 167 | 317 |
| Pharmacy | 13 | 1 | 1 | 0 |
| Physical/Speech/Occupational Therapy | 1 | 5 | 5 | 0 |
| Skilled Nursing Facility | 42 | 21 | 16 | 31 |
| Vision | 0 | 0 | 0 | 0 |
| **Total** | **839** | **696** | **1,072** | **888** |

[3] Total Provider Complaints Received by Provider Type
Data represents provider complaint cases received during the reporting period.

## Total of Provider Complaints Received by Health Plan[4]

| Health Plan | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---|---|---|---|---|
| Access Dental | 2 | 5 | 4 | 1 |
| Aetna Dental | 0 | 0 | 4 | 0 |
| Aetna Healthcare of CA | 27 | 60 | 22 | 47 |
| American Specialty Health Plans | 0 | 0 | 2 | 0 |
| Adventist Health | 0 | 0 | 0 | 0 |
| Alameda Alliance for Health | 0 | 0 | 0 | 0 |
| Americas Health Plan | 0 | 0 | 0 | 0 |
| Arcadian Health Plan | 1 | 0 | 0 | 0 |
| Arta Medicare Health Plan | 0 | 0 | 0 | 0 |
| Blue Cross | 185 | 176 | 405 | 245 |
| Blue Shield | 82 | 66 | 112 | 40 |
| Bravo Health Insurance | 0 | 0 | 0 | 0 |
| California Health and Wellness | 0 | 1 | 7 | 5 |
| Care 1st Health Plan | 32 | 38 | 52 | 117 |
| Central Health Plan | 1 | 0 | 1 | 0 |
| Chinese Community Health Plan | 0 | 1 | 0 | 0 |
| Cigna Behavioral Health | 1 | 0 | 1 | 1 |
| Cigna HealthCare of California | 8 | 9 | 11 | 13 |
| Community Care Health Plan | 3 | 0 | 0 | 0 |
| Community Health Group | 16 | 8 | 0 | 1 |
| Contra Costa County Medical Service | 0 | 1 | 3 | 0 |
| County of Los Angeles- CHP | 32 | 6 | 42 | 1 |
| County of Ventura | 0 | 0 | 2 | 1 |
| Delta Dental of California | 0 | 2 | 5 | 0 |
| Easy Choice Health Plan | 6 | 0 | 0 | 0 |
| Health Net of California | 149 | 69 | 202 | 211 |
| Human Affairs International of CA | 0 | 0 | 1 | 0 |
| Inland Empire Health Plan | 1 | 40 | 1 | 7 |
| Inter Valley Health Plan | 1 | 0 | 0 | 0 |
| Kaiser Foundation Health Plan, Inc. | 13 | 65 | 101 | 7 |
| Kern Health Systems | 0 | 0 | 1 | 0 |
| Local Initiative Health Authority for L.A. County | 7 | 23 | 3 | 21 |
| L A Care Health Plan Joint Power Authority | 93 | 8 | 40 | 73 |
| Liberty Dental Plan | 0 | 0 | 1 | 0 |
| Magellan Health Services | 2 | 1 | 1 | 15 |
| Managed Health Network | 1 | 6 | 7 | 0 |

[4] Total Provider Complaints Received by Health Plan
Data represents provider complaint cases received during the reporting period broken out by health plan.

| Health Plan | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---|---|---|---|---|
| Medi-Excel SA | 0 | 5 | 0 | 0 |
| Molina Healthcare of CA | 43 | 22 | 19 | 27 |
| Monarch Health Plan | 0 | 1 | 0 | 0 |
| Orange County Health Authority (Cal Optima) | 2 | 2 | 0 | 3 |
| Partnership Health Plan of California | 0 | 4 | 0 | 2 |
| Prospect Health Plan | 0 | 3 | 0 | 0 |
| Safeguard Health Plan | 1 | 0 | 0 | 0 |
| San Francisco Community Health Authority | 0 | 0 | 0 | 1 |
| San Joaquin County Health Commission | 10 | 0 | 1 | 7 |
| Scan Health Plan | 0 | 0 | 5 | 3 |
| Sistemas Medicos | 0 | 0 | 0 | 2 |
| Sutter Health Plan | 0 | 0 | 0 | 5 |
| United Concordia Dental Plan | 1 | 1 | 1 | 0 |
| United Health Care Community of CA | 0 | 0 | 0 | 5 |
| United HealthCare Plan | 54 | 66 | 4 | 0 |
| Value Options of California | 0 | 0 | 0 | 1 |
| Vision Service Plan | 1 | 0 | 2 | 0 |
| Western Health Advantage | 0 | 1 | 0 | 0 |
| **Totals** | **839** | **696** | **1,072** | **888** |

# Provider Complaint Unit
# Dispute Issues Selected by Providers
# 2014 Calendar Year

| Provider Complaint Dispute Issues Identified | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---|---|---|---|---|
| The payer failed to accept a late claim submission upon the demonstration of good cause for the delay. | 2 | 13 | 17 | 14 |
| The payer failed to forward a misdirected claim to the appropriate capitated provider within 10 working days of receipt of the claim. | 0 | 2 | 0 | 0 |
| Payor rescinded or modified an authorization after services were provided | 0 | 5 | | |
| 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. | 120 | 134 | 62 | 84 |
| 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. | 0 | 5 | 0 | 0 |
| The payer reimbursed a non-contracted provider's claim at less than "reasonable and customary value." | 34 | 9 | 273 | 29 |
| The payer reimbursed a contracting provider's claim at less than the "contract rate." | 145 | 128 | 79 | 59 |
| General claim processing issues. | 106 | 93 | 62 | 153 |
| The provider's contract requires the provider to submit medical records that are not reasonably relevant for the adjudication of the claim. | 0 | 0 | 0 | 11 |
| 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. | 12 | 53 | 2 | 0 |
| 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. | 9 | 3 | 4 | 1 |

| Provider Complaint Dispute Issues Identified | First Quarter | Second Quarter | Third Quarter | Fourth Quarter |
|---|---|---|---|---|
| Payor failed to pay a Medi-Cal claim at the amount required under the governing statute, regulation, all-plan letter, or other applicable document. | 131 | 70 | 214 | 308 |
| Payor denied the claim as not medically necessary, non-emergent/urgent or investigational/experimental. | 52 | 53 | 75 | 63 |
| **Totals** | **839** | **696** | **1,072** | **888** |