Department of Managed Health Care
Provider Complaint Unit Statistics
January 1, 2010 – December 31, 2010

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	1,505
Second Quarter	2,139
Third Quarter	2,975
Fourth Quarter	2,831

Total Funds Recovered (2)

Calendar Quarter	Amount
First Quarter	$1,726,884.20
Second Quarter	$1,344,590.70
Third Quarter	$881,174.35
Fourth Quarter	$2,321,084.50

Total of Provider Complaints Received by Provider Type (3)

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Ambulance	5	26	18	12
Anesthesiology	57	11	40	88
Chiropractic	1	0	0	69
Dental	6	3	14	3
Durable Medical Equipment	2	2	1	5
ER Physician	134	293	1037	1630
Family/General Practice	6	4	17	14
Home Health Services	2	0	148	6
Hospital-based Physician	123	28	50	64
Hospital/Institutional	791	1172	699	350
Internal Medicine	20	73	29	11
Laboratory Services	6	10	6	10
Mental Health	39	20	14	49

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
OB/GYN	9	179	387	21
On Call Physicians (Not ER)	28	36	56	6
Other Ancillary Service Providers	24	17	32	19
Other Specialist Providers	183	238	380	176
Pediatrics	33	18	25	28
Pharmacy	25	1	10	0
Physical/Speech/Occupational Therapy	9	4	3	264
Skilled Nursing Facility	1	3	9	6
Vision	1	1	0	0
Total	**1,505**	**2,139**	**2,975**	**2,831**

Total of Provider Complaints Received by Health Plan (4)

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Access Dental Plan	7	0	0	1
ACN Group of California	1	0	0	0
Aetna Health	82	91	81	101
AIDS Healthcare Foundation	0	1	0	0
American Specialty Health Plans	0	0	0	2
Arcadian Health Plan	1	4	0	0
Blue Cross	289	521	863	714
Blue Shield	160	136	306	127
Bravo Health Company	0	1	0	0
Care 1st	21	9	70	84
Central Health Plan of CA	0	0	1	0
Chinese Community Health Plan	0	0	0	2
Choice Physicians Network	0	0	0	263
Cigna Behavioral Health	0	0	2	0
Cigna HealthCare	24	71	41	124
Community Health Group	6	10	60	14
Contra Costa County	0	0	1	0
County of Los Angeles	3	32	52	36
Delta Dental	3	1	6	3
Dental Benefit Providers of CA	2	0	3	0
Dental Health Services	0	1	0	0
Great-West Health Care	0	1	1	0
Health and Human Resource Ctr.	0	0	2	0
Health Net	286	436	779	758
Heritage Provider Network	1	0	0	11
Humana	1	0	0	1
Inland Empire	17	8	3	15
Inter Valley Health Plan	0	0	0	4

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Kaiser	221	548	41	66
Kern Health Systems	25	1	4	1
Liberty Dental	1	0	0	0
Local Initiative Health Authority	0	24	32	54
Managed Health Network	1	0	18	1
MD Care, Inc.	1	2	1	2
Molina Healthcare	23	93	359	38
Monarch Health Plan	44	0	0	0
Orange County Health Authority	5	0	9	2
PCBH	3	2	1	3
PacifiCare	264	76	151	162
PRIMECARE Medical Network	0	8	0	0
SafeGuard Health Plans	0	1	0	0
San Mateo Health Commission	0	1	0	0
Santa Clara County Health	0	39	71	198
Scan Health Plan	5	3	12	9
Sharp Health Plan	1	8	0	1
Sistemas Medicos Nacionales	0	0	0	4
US Behavioral	3	7	2	22
United Health Care of CA	2	0	2	7
Universal Care	1	1	0	1
ValueOptions of CA	0	1	0	0
Vision Service Plan	0	1	0	0
WellCare Prescription Insurance	0	0	1	0
Western Health Advantage	1	0	0	0
Total	**1,505**	**2,139**	**2,975**	**2,831**

(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, 2010 – December 31, 2010

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.	9	67	52	116
2) The payer failed to accept a late claim submission upon the demonstration of good cause for the delay.	15	51	88	66
3) The payer failed to forward a misdirected claim to the appropriate capitated provider within 10 working days of receipt of the claim.	25	7	60	114
4) The payer failed to acknowledge the receipt of an electronic claim within 2 working days or a paper claim within 15 working days.	151	211	230	170
5) The payer failed to reimburse a complete claim with the correct payment.	867	1487	2101	1846
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.	348	537	1117	599
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.	80	111	142	178
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.	22	11	28	4
9) The payer failed to reimburse provider(s) for emergency services and care.	310	158	546	341
10) The payer failed to reimburse the hospital for care following the stabilization of an emergency medical condition.	8	6	29	29

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.	46	27	29	62
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.	83	118	493	283
13) The payer failed to provide a clear and accurate written explanation for the claims adjudication decision.	177	106	505	189
14) The payer rescinded or modified an authorization for health care services after the provider rendered the service in good faith.	32	37	206	81
15) The payer reimbursed a non-contracted provider’s claim at less than “reasonable and customary value.”	86	261	289	206
16) The payer reimbursed a contracting provider’s claim at less than the “contract rate.”	73	60	129	177
17) General claim processing issues.	609	819	1762	2141
18) The provider’s contract requires the provider to submit medical records that are not reasonably relevant for the adjudication of the claim.	3	0	13	22
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.	6	10	22	86
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.	0	0	0	11
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.	44	0	3	12

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.	44	0	1	4
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.	23	0	1	0
24) General contract term issues.	10	3	167	26
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.	8	2	5	18
26) The payer unilaterally deducted a claim overpayment without providing notice.	3	0	0	2
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	1	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	3	0	6	1
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	0	1	2	2
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	0	0	0	4

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.	0	1	0	0
30) General overpayment issues.	35	2	157	9
31) The payer failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) for an adjusted or contested claim.	44	22	123	17
32) The payer imposed filing deadline of less than 365 calendar days for the filing of a provider dispute.	9	6	27	69
33) The payer failed to acknowledge the receipt of an electronic dispute within 2 working days or a paper dispute within 15 working days.	64	86	283	69
34) The payer failed to issue a written determination for a provider dispute within 45 working days from the date of receipt.	152	102	368	139
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.	2	0	13	11
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.	27	48	56	31
37) General dispute resolution issues.	66	67	96	67

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