Department of Managed Health Care
Provider Complaint Unit 2009 Statistics

The information below represents data gathered from the Provider Complaint Unit's database. Each report's data collection represents different criteria therefore data is not transposable from one report to the other.

Average Number of Calendar Days to Close a Provider Complaint (1)

Calendar Quarter	Days
First Quarter	106.70
Second Quarter	121.42
Third Quarter	132.86
Fourth Quarter	136.50

Total Provider Complaints Received (2)

Calendar Quarter	Number
First Quarter	1,758
Second Quarter	1,580
Third Quarter	3,520
Fourth Quarter	2,173

Total Provider Complaints Closed (3)

Calendar Quarter	Number
First Quarter	1,481
Second Quarter	2,029
Third Quarter	744
Fourth Quarter	1,121

Closed Cases by Health Plan or Medical Group (4)

Calendar Quarter	Health Plan	Medical Group	Both	Other	Total
First Quarter	1,400	2	55	24	**1,481**
Second Quarter	1,819	83	93	34	**2,029**
Third Quarter	629	3	83	29	**744**
Fourth Quarter	912	5	173	31	**1,121**

Total Additional Recovered Funds (5)

Calendar Quarter	Amount
First Quarter	$1,331,627.50
Second Quarter	$3,154,865.29
Third Quarter	$1,004,001.99
Fourth Quarter	$1,122,075.08

Total of Provider Complaints Received by Type of Provider (6)

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Ambulance	38	24	58	11
Anesthesiology	10	11	20	23
Chiropractic	0	0	0	0
Dental	10	8	17	5
Durable Medical Equipment	3	5	3	10
ER Physician	16	21	536	528
Family/General Practice	6	19	3	2
Home Health Services	3	1	19	32
Hospital-based Physician	136	291	191	139
Hospital/Institutional	761	763	2375	1139
Internal Medicine	2	5	2	1
Laboratory Services	0	14	4	6
Mental Health	31	40	91	35
OB/GYN	7	4	24	7
On Call Physicians (Not ER)	0	24	4	4
Other Ancillary Service Providers	73	94	33	25
Other Specialist Providers	614	227	113	178
Pediatrics	2	1	6	11
Pharmacy	7	0	3	0
Physical/Speech/Occupational Therapy	36	17	10	9
Skilled Nursing Facility	3	11	8	8
Vision	0	0	0	0
Total	**1,758**	**1,580**	**3,520**	**2,173**

Total of Provider Complaints Received by Health Plan (7)

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Access Dental Plan	0	1	1	0
Aetna Dental	0	1	0	0
Aetna Health	245	74	180	99
Arcadian Health Plan	0	1	1	1
Arta Medicare Health Plan	1	4	0	0
Blue Cross	621	373	1229	400
Blue Shield	191	80	165	221
California Benefits Dental	0	0	1	0
Care 1st Health	3	23	25	104
CareMore Health Plan	0	0	1	0
Cigna Behavioral	0	1	0	3
Cigna Dental	1	0	0	0
Cigna Health	51	10	28	0
Community Health Group	2	4	18	17

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Concern EAP	0	0	1	64
County of Los Angeles	0	2	3	0
County of Ventura	0	0	1	2
Delta Dental	3	4	10	0
Dental Benefit Providers of	1	0	0	2
Dental Health Services	0	1	1	0
First Dental Health	0	0	0	3
Golden West Health	1	0	0	0
Great West Health	2	0	1	1
Health Net	156	87	507	351
Heritage Provider Network	3	3	63	4
Humana	0	0	14	1
Inland Empire	6	1	23	41
Inter Valley Health Plan	0	0	1	1
Kaiser	147	741	865	674
Kern Health Systems	1	2	0	0
Lakeside Comprehensive	1	0	0	1
Magellan Health	1	1	0	0
Managed Dental Care	0	0	1	0
Managed Health Network	122	2	6	0
MD Care	1	0	0	0
Molina	48	26	14	35
Monarch Health Plan	0	16	7	0
Orange County Health Authority	3	6	18	3
PacifiCare Behavioral	9	2	4	1
PacifiCare of California	58	101	232	103
Premier Health Plan Services	0	0	0	1
PRIMECARE Medical Network	0	0	1	1
SafeGuard	0	0	3	3
San Joaquin County Health	4	0	0	0
San Miguel Health Plan	0	0	5	0
Scan	69	7	12	24
Scripps Health Plan Services	0	1	0	0
Sharp Health Plan	0	1	4	5
SilverScript Insurance	0	0	0	1
Universal Care	1	2	2	2
US Behavioral	2	2	71	2
Value Options	1	0	0	2
Western Dental	3	0	0	0
Western Health Advantage	0	0	1	0
Total	**1,758**	**1,580**	**3,520**	**2,173**

1) Average Number of Calendar Days to Close a Provider Complaint
Data represents provider complaint cases closed during the reporting period.

2) Total Provider Complaints Received
Data represents provider complaint cases received during the reporting period.

3) Total Provider Complaints Closed
Data represents provider complaint cases closed during the reporting period.

4) Closed Cases by Health Plan or Medical Group
Data represents provider complaint cases closed during the reporting period.

5) Total Additional Recovered Funds
Recovered amounts are based on provider complaint cases closed during the reporting period.

6) Total of Provider Complaints Received by Type of Provider
Data represents provider complaint cases received during the reporting period.

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

This information is provided for statistical purposes only. Mere fact that a provider submitted a complaint against a health care service plan does not mean, in of itself, that the health care service plan is in violation of any law that the Department of Managed Health Care enforces.

Provider Complaint Unit
Dispute Issues Selected by Providers
2009 Calendar Year

Provider Complaint Dispute Issues Identified (8)	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.	10	24	132	54
2) The payer failed to accept a late claim submission upon the demonstration of good cause for the delay.	44	118	140	19
3) The payer failed to forward a misdirected claim to the appropriate capitated provider within 10 working days of receipt of the claim.	72	45	17	133
4) The payer failed to acknowledge the receipt of an electronic claim within 2 working days or a paper claim within 15 working days.	679	107	272	219
5) The payer failed to reimburse a complete claim with the correct payment.	1129	654	2126	1638
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.	1046	497	1223	707
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.	295	142	366	250
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.	1	12	9	39
9) The payer failed to reimburse provider(s) for emergency services and care.	374	218	575	364

10) The payer failed to reimburse the hospital for care following the stabilization of an emergency medical condition.	28	20	17	37
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.	14	37	158	58
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.	466	103	274	267
13) The payer failed to provide a clear and accurate written explanation for the claims adjudication decision.	665	258	433	676
14) The payer rescinded or modified an authorization for health care services after the provider rendered the service in good faith.	104	77	64	94
15) The payer reimbursed a non-contracted provider’s claim at less than “reasonable and customary value.”	257	279	502	885
16) The payer reimbursed a contracting provider’s claim at less than the “contract rate.”	316	105	270	73
17) General claim processing issues.	854	803	2104	686
18) The provider’s contract requires the provider to submit medical records that are not reasonably relevant for the adjudication of the claim.	340	18	165	6
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.	368	50	292	23
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	1	11	0

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.	3	4	126	2
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.	3	28	125	1
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.	1	14	1	0
24) General contract term issues.	21	22	31	20
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.	0	23	37	3
26) The payer unilaterally deducted a claim overpayment without providing notice.	0	1	2	0
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.	1	0	9	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	1	8	30	4
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	2	1	4	3

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	1	0	3
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	0	7	0
30) General overpayment issues.	13	14	18	8
31) The payer failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) for an adjusted or contested claim.	32	31	138	54
32) The payer imposed filing deadline of less than 365 calendar days for the filing of a provider dispute.	1	3	124	41
33) The payer failed to acknowledge the receipt of an electronic dispute within 2 working days or a paper dispute within 15 working days.	286	34	157	28
34) The payer failed to issue a written determination for a provider dispute within 45 working days from the date of receipt.	156	101	204	99
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.	361	0	3	5
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.	87	23	153	63
37) General dispute resolution issues.	218	124	71	90

(8) Data represents provider complaint cases received during the reporting period; except cases with a close reason of consumer, invalid, duplicate, multiple claims and non-jurisdictional. This information is provided for statistical purposes only. The mere fact that a provider submitted a complaint against a health care service plan does not mean, in of itself, that the health care service plan is in violation of any law that the Department of Managed Health Care enforces.