

**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).

<sup>1</sup>Total Provider Complaints Received

| <b>Calendar Quarter</b> | <b>Number of Complaints</b> |
|-------------------------|-----------------------------|
| First Quarter           | 1,505                       |
| Second Quarter          | 2,139                       |
| Third Quarter           | 2,975                       |
| Fourth Quarter          | 2,831                       |

<sup>2</sup>Total Funds Recovered

| <b>Calendar Quarter</b> | <b>Amount</b>  |
|-------------------------|----------------|
| First Quarter           | \$1,726,884.20 |
| Second Quarter          | \$1,344,590.70 |
| Third Quarter           | \$881,174.35   |
| Fourth Quarter          | \$2,321,084.50 |

<sup>3</sup>Total of Provider Complaints Received by Provider Type

| <b>Provider Type</b>      | <b>First Quarter</b> | <b>Second Quarter</b> | <b>Third Quarter</b> | <b>Fourth Quarter</b> |
|---------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 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                    |

<sup>1</sup> Total Provider Complaints Received

Data represents provider complaints received during the reporting period.

<sup>2</sup> Total Funds Recovered

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

<sup>3</sup> Total of Provider Complaints Received by Provider Type

Data represents provider complaints received during the reporting period.

| <b>Provider Type</b>                 | <b>First Quarter</b> | <b>Second Quarter</b> | <b>Third Quarter</b> | <b>Fourth Quarter</b> |
|--------------------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 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                     |
| <b>Total</b>                         | <b>1,505</b>         | <b>2,139</b>          | <b>2,975</b>         | <b>2,831</b>          |

<sup>4</sup>Total of Provider Complaints Received by Health Plan

| <b>Health Plan</b>              | <b>First Quarter</b> | <b>Second Quarter</b> | <b>Third Quarter</b> | <b>Fourth Quarter</b> |
|---------------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 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                    |

<sup>4</sup> Total Provider Complaints Received by Health Plan

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

|                                   |              |              |              |              |
|-----------------------------------|--------------|--------------|--------------|--------------|
| Inter Valley Health Plan          | 0            | 0            | 0            | 4            |
| 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            |
| <b>Total</b>                      | <b>1,505</b> | <b>2,139</b> | <b>2,975</b> | <b>2,831</b> |

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**

| <b><sup>5</sup>Provider Complaint Dispute Issues Identified</b>                                                                                                                                          | <b>First Quarter</b> | <b>Second Quarter</b> | <b>Third Quarter</b> | <b>Fourth Quarter</b> |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 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                    |

<sup>5</sup> 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.

| <b><sup>5</sup>Provider Complaint Dispute Issues Identified</b>                                                                                                                                                                                                                                                                                                                | <b>First Quarter</b> | <b>Second Quarter</b> | <b>Third Quarter</b> | <b>Fourth Quarter</b> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 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 1300.71 of 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 1300.71 of Title 28 of the California Code of Regulations.                                                                                                                                          | 44                   | 0                     | 3                    | 12                    |
| 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 1300.71 of Title 28 of the California Code of Regulations.                                                                                                                   | 44                   | 0                     | 1                    | 4                     |

| <b><sup>5</sup>Provider Complaint Dispute Issues Identified</b>                                                                                                                                                                                  | <b>First Quarter</b> | <b>Second Quarter</b> | <b>Third Quarter</b> | <b>Fourth Quarter</b> |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 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                     |
| 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                    |

| <b><sup>5</sup>Provider Complaint Dispute Issues Identified</b>                                                                                                                                             | <b>First Quarter</b> | <b>Second Quarter</b> | <b>Third Quarter</b> | <b>Fourth Quarter</b> |
|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------|-----------------------|----------------------|-----------------------|
| 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                    |