Department of Managed Health Care
Provider Complaint Unit Statistics
January 1, 2012 – December 31, 2012

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).

[1]Total Provider Complaints Received

Calendar Quarter	Number of Complaints
First Quarter	1072
Second Quarter	932
Third Quarter	1143
Fourth Quarter	1306

[2]Total Funds Recovered

Calendar Quarter	Amount
First Quarter	$499,080.50
Second Quarter	$1,484,963.09
Third Quarter	$552,033.01
Fourth Quarter	$756,848.05

[3]Total of Provider Complaints Received by Provider Type

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Ambulance	18	3	7	18
Anesthesiology	2	6	13	7
Chiropractic	8	0	1	10
Dental	8	16	6	12
Durable Medical Equipment	16	5	9	10
ER Physician	24	28	137	28
Family/General Practice	14	4	18	6
Home Health Services	1	2	34	25
Hospital-based Physician	119	55	225	107
Hospital/Institutional	451	600	506	690
Internal Medicine	8	32	15	5
Laboratory Services	4	8	3	4
Mental Health	12	51	8	24

[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.

Provider Type	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
OB/GYN	75	17	31	4
On Call Physicians (Not ER)	17	15	13	3
Other Ancillary Service Providers	63	15	3	11
Other Specialist Providers	130	63	85	103
Pediatrics	99	9	13	95
Pharmacy	1	0	6	103
Physical/Speech/Occupational Therapy	1	0	9	13
Skilled Nursing Facility	0	3	1	27
Vision	1	0	0	1
Total	**1,072**	**932**	**1143**	**1306**

[4]Total of Provider Complaints Received by Health Plan

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Access Dental Plan	0	0	0	0
ACN Group of California	0	0	0	0
Aetna Health	37	197	51	207
AIDS Healthcare Foundation	0	0	0	0
Alameda Alliance for Health	0	0	0	0
American Specialty Health Plans	8	0	1	0
Arcadian Health Plan	0	0	0	0
Arta Medicare Health Plan	1	8	0	0
Blue Cross	339	166	264	175
Blue Shield	63	55	53	58
Bravo Health Company	0	0	1	0
California Dental Network	0	0	0	1
Care 1st	61	38	53	53
CareMore Health Plan	1	1	2	0
Central Health Plan of CA	1	1	1	0
Chinese Community Health Plan	0	0	0	1
Choice Physicians Network	0	0	0	0
Cigna Behavioral Health	0	2	1	0
Cigna Dental Health	0	0	1	0
Cigna HealthCare	16	10	24	30
Cigna Health Care Pacific	0	0	0	0
Community Health Group	94	11	29	342
Contra Costa County	0	2	8	0
County of Los Angeles	35	14	6	44
County of Ventura	0	1	1	0
Delta Dental	6	14	6	8
Dental Benefit Providers of CA	0	0	0	2

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

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Dental Health Services	0	0	0	0
Easy Choice Health Plan	0	1	2	0
Express Scripts	0	0	0	1
GemCare Health Plan	1	0	0	0
Golden West Health Plan	0	0	0	0
Great-West Health Care	0	0	0	0
Health and Human Resource Ctr.	0	0	0	0
Health Net	200	162	453	225
Health Spring Life and Health	0	0	0	0
Heritage Provider Network	0	0	1	0
Honored Citizens Choice Health Plan	1	0	0	0
Humana	1	0	0	6
Inland Empire	14	2	5	3
Inter Valley Health Plan	0	0	0	0
Kaiser	13	131	56	22
Kern Health Systems	0	0	0	1
Liberty Dental	0	1	0	0
Local Initiative Health Authority	32	17	5	41
Magellan Health Service of CA	0	1	0	1
Managed Health Network	3	4	7	9
MD Care, Inc.	0	0	0	0
Molina Healthcare	56	15	14	19
Monarch Health Plan	0	0	0	0
Orange County Health Authority	2	7	4	4
PCBH	0	0	0	0
PacifiCare	0	0	0	0
Partnership Health Plan of CA	1	0	2	1
Premier Health Plan Services	28	0	0	0
PRIMECARE Medical Network	0	0	2	0
SafeGuard Health Plans	1	0	0	0
San Francisco Community Auth	0	0	0	0
San Mateo Health Commission	0	0	0	0
San Miguel Health Plan	0	0	0	0
Santa Barbara/SLO Health Plan	0	0	0	0
Santa Clara County Health	0	0	0	0
Scan Health Plan	2	1	1	1
Sharp Health Plan	0	0	2	0
Sistemas Medicos Nacionales	0	0	0	0
US Behavioral	12	17	2	0
United Concordia Dental Plan	0	0	0	1
United Health Care of CA	41	48	85	50
Universal Care	0	1	0	0
ValueOptions of CA	0	1	0	0
Vision Service Plan	1	0	0	0
WellCare Prescription Insurance	0	0	0	0

Health Plan	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
Western Dental	0	1	0	0
Western Health Advantage	1	2	0	0
Total	**1072**	**932**	**1143**	**1306**

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, 2012 – December 31, 2012

[5]Provider Complaint Dispute Issues Identified	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.	13	18	17	17
2) The payer failed to accept a late claim submission upon the demonstration of good cause for the delay.	81	92	45	34
3) The payer failed to forward a misdirected claim to the appropriate capitated provider within 10 working days of receipt of the claim.	29	12	28	30
4) The payer failed to acknowledge the receipt of an electronic claim within 2 working days or a paper claim within 15 working days.	57	35	289	76
5) The payer failed to reimburse a complete claim with the correct payment.	640	516	645	768
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.	431	272	539	747
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.	196	135	249	598
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.	19	2	6	1
9) The payer failed to reimburse provider(s) for emergency services and care.	47	110	254	197
10) The payer failed to reimburse the hospital for care following the stabilization of an emergency medical condition.	9	23	23	25
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	113	46	54	108

[5] 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.

[5]Provider Complaint Dispute Issues Identified	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
minutes to a request for authorization.				
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.	78	24	148	87
13) The payer failed to provide a clear and accurate written explanation for the claims adjudication decision.	328	68	180	254
14) The payer rescinded or modified an authorization for health care services after the provider rendered the service in good faith.	79	74	59	41
15) The payer reimbursed a non-contracted provider's claim at less than "reasonable and customary value."	114	163	112	57
16) The payer reimbursed a contracting provider's claim at less than the "contract rate."	320	354	294	620
17) General claim processing issues.	606	607	604	1022
18) The provider's contract requires the provider to submit medical records that are not reasonably relevant for the adjudication of the claim.	3	3	32	23
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.	39	17	123	67
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.	3	3	0	3
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.	0	4	6	42
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.	1	5	4	64
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.	2	4	2	0
24) General contract term issues.	13	43	21	99
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.	13	7	2	2

[5]Provider Complaint Dispute Issues Identified	First Quarter	Second Quarter	Third Quarter	Fourth Quarter
26) The payer unilaterally deducted a claim overpayment without providing notice.	9	1	1	9
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.	4	2	3	5
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	3	12	11
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	3	1	11
29.2) even though the provider reimbursed the overpayment within 30 working days of the payer's notice of the overpayment; or	1	1	1	0
29.3) without allowing 30 working days for the provider to reimburse the overpayment; or	1	2	2	0
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	2	3	5
30) General overpayment issues.	15	15	26	9
31) The payer failed to provide the required Notice to Provider of Dispute Resolution Mechanism(s) for an adjusted or contested claim.	38	19	113	89
32) The payer imposed filing deadline of less than 365 calendar days for the filing of a provider dispute.	24	19	45	46
33) The payer failed to acknowledge the receipt of an electronic dispute within 2 working days or a paper dispute within 15 working days.	38	18	162	70
34) The payer failed to issue a written determination for a provider dispute within 45 working days from the date of receipt.	65	37	229	147
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.	10	3	5	10
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.	30	26	18	46
37) General dispute resolution issues.	93	124	183	166