Provider Complaint Summary Report

Health Plan ID: 2162438
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Report Period Start Date: 7/1/2012
Report Period End Date: 7/31/2012

BAYOU HEALTH Reporting

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Document Name: **PROVIDER COMPLAINT SUMMARY REPORT**
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Subject Matter: Informatics (I)

Reporting Period	COMPLAINT STATUS	Total # of Complaints	# of COMPLAINTS by ISSUE CATEGORY							# Pending or Closed 31 to 90 Days Post File Date[1]	# Pending or Closed >90 Days Post File Date[1]
			Claims/ Payment	Covered Services	PAs/Referrals	PCP Auto-Assign/ Linkages	Provider Registry/ Directory	Lack of Information /Response	Other		
Jul-2012	**Complaints Received this Month**	30	21		4	2		2	1		
	Total Closed this Month	13	4		4	2		2	1		
	Withdrawn by Provider										
	Per Internal Plan Complaint Process	13	4		4	2		2	1		
	Per DHH Review										
	Other										
	Total Pending (cumulative as of month end)	17	17								
	Information needed from Provider										
	Internal Plan Review	17	17								
	Referred to DHH										
	Other										
2012 Year to Date (YTD)	**Total Complaints Received YTD**	95									
	Total Closed YTD	78									
	Withdrawn by Provider										
	Per Internal Plan Complaint Process	28*									
	Per DHH Review	2*									
	Other										

This purpose of this report is to capture and track the volume, type and status of PROVIDER complaints. A complaint includes any provider dispute of the CCN's policies, procedures, or any aspect of the CCNs administrative functions. **It DOES NOT include any provider appeals for the denial, reduction or suspension of medically necessary services nor any grievances or appeals filed by providers on behalf of members**, those are reported on the State Fair Hearing reports. Complaints should be relevant to Health Plan specific policies and practices and NOT to individual claim items. Please refer to Definitions for status & category details.

* These metrics were not required in the report format proir to the utilization of the current format and only include metric counts for July, 2012. Further, the definition of "Provider Complaints" has recently been expanded while we still await the Companion Guide for more detailed reporting instructions. Before the new format and expanded definition of "complaint," it was clear in our instructions that it did not include any issues involving claims payments, but now does. Our current interpretations of "complaints" that should include claims issues are only those that are systemic in nature, confined to our system configurations and required us to begin to track these issues as of 7/1/2012. We do, however, take the position that many of the systemic configuration challenges are more related to the anomolies programmed into the Molina system configurations that are outside of the realm of industry-accepted standardization of the processing of health care claims. As of 7/31/2012, the end of this reporting period, no other issues had gone past the 30-day period for resolution. With the report in August, we will report on any issue that, as of 8/31/2012, has exceeded the 30 to 90 day window within the expanded definition of "complaints" to include "Claims/Payments" issues.

[1]You must submit a complaint summary sheet detailing all pending or closed (A1) complaints not resolved within 30 to 90 days a(see format on "SI 182-attachment" TABS)