Case Management Complaint Escalation Process

Medica case management teams must not prohibit providers from submitting claims or making benefit determinations for any type of service. To ensure this does not occur, Medica has set up a process for providers to report and escalate complaints when any provider believes a case management team member is acting to prohibit a provider from submitting a claim or making a benefit determination.

The process is as follows:

1. Provider submits the complaint regarding actions believed to have occurred by case management team members using the Medica Case Management Complaint Reporting form
2. The complaint is escalated for review by the Quality Operations Department to the Medica Quality Review Oversight Committee (QROC), an internal peer review body, who directs and oversees the quality-of-care complaint program and the case management complaint program.
3. When the QROC meets, all case management complaints will be reviewed, and monitoring will occur to ensure case managers are not engaging in activities that prohibit providers from submitting claims or making benefit determinations for any type of service.

Issues or questions regarding this complaint process may be directed to the Provider Service Center at 1 (800) 458-5512.