



1441 Main Street
Suite 900
Columbia, SC 29201

Provider Disputes Frequently Asked Questions (FAQ)

What is a provider dispute?

Disputes are between a provider and Absolute Total Care (Medicare-Medicaid Plan). **Contracted providers** may dispute any adverse action including the denial or reduction of claims for services included on a clean claim. Contracted providers may also dispute Absolute Total Care's policies, procedures, rates, contract disputes and any aspects of Absolute Total Care's administrative functions. **Non-contracted** providers may dispute the nonpayment, denial or reduction of a covered service rendered out of network, including emergency care.

When does a dispute need to be received?

Providers are allowed 60 calendar days from the receipt of notice of an adverse action to file a written dispute with supporting documentation. The written dispute request must include the Provider Dispute Form, found on our website at mmp.absolutetotalcare.com.

Where are provider disputes sent?

Absolute Total Care (Medicare-Medicaid Plan)
Attn: Provider Disputes
P.O. Box 3060
Farmington, MO 63640-3822

What is not considered a valid provider dispute?

- Absolute Total Care's decision not to contract with provider.
- Absolute Total Care's decision to terminate a contract with provider.
- Service denials due to payment adjustments for National Correct Coding Initiative (NCCI).
- Grievances and Appeals related to provider acting as an Authorized Representative of our member (pre-service medical necessity denials will be handled as a member appeal).
- Services that are not covered by Medicare and/or the South Carolina Department of Health and Human Service's contract with Absolute Total Care.

What is the turnaround time for dispute resolutions?

Resolutions will be provided 30 calendar days from the date the dispute was received. If additional information is required to render a decision on the dispute, Absolute Total Care may extend the timeframe by 15 calendar days based on mutual agreement of the provider with Absolute Total Care.

What is a claim adjustment?

A claim adjustment is when a provider requests review or reconsideration of a claims disposition. Providers may call the Provider Relations Department at 1-855-735-4398 to discuss amount reimbursed or denial of a particular service. Providers may also submit a claim adjustment in writing, with all necessary documentation, including the Explanation

of Payment (EOP) for consideration of additional reimbursement. Written claims submitted for adjustment must be clearly marked as "CORRECTED CLAIM" and include the original claim number.

Where are claim adjustments mailed?

Absolute Total Care (Medicare-Medicaid Plan)
ATTN: Corrected Claims
P.O. Box 3060
Farmington, MO 63640-3822

What is the deadline for submitting claim adjustments?

All adjustments and corrections to processed claims must be received within 365 days from the date of service.

Is a member appeal the same as a provider dispute?

No, a member appeal is the request for review of an "Adverse Benefit Determination" or a request to change a previous decision made by Absolute Total Care. An "Adverse Benefit Determination" is:

- The denial or limited authorization of a requested service, including the type or level of service.
- The reduction, suspension, or termination of a previously authorized service.
- The denial, in whole or part of payment for a service.
- The failure to provide services in a timely manner, as defined by the State of South Carolina.
- The failure of Absolute Total Care to act within authorization time frame requirements.
- For a member who is a resident of a rural area with only one MCO, the denial of the Medicare-Medicaid member's request to exercise his or her right to obtain services outside Absolute Total Care's network.
- The denial of a member's request to dispute a financial liability, including cost sharing, copayments, premiums, deductibles, coinsurance, and other enrollee financial liabilities.

Only a member or a member's authorized representative can file an appeal with Absolute Total Care. A member can give permission for a person or a provider to act on their behalf in writing or by completing the Appointment of Authorized Representative Form found on Absolute Total Care's website at mmp.absolutetotalcare.com. Requests for an appeal that are received without the member consent cannot be processed. Additional information on the member appeal process can be found on the website and in the Provider Manual.

Is a member grievance the same as a provider dispute?

No, a member grievance is an expression of dissatisfaction about any matter other than an "Adverse Benefit Determination," such as wait time to see a doctor, rudeness of a provider or office staff, and unclean facilities. Only a member or a member's authorized representative can file a grievance with Absolute Total Care. A member can give permission for a person or a provider to act on their behalf in writing or by completing the Appointment of Authorized Representative Form found on the Absolute Total Care website at mmp.absolutetotalcare.com. Additional information on the member grievance process can be found on the website and in the Provider Manual.