100 Center Point Circle
Columbia, SC 29210

Provider Disputes
Frequently Asked Questions (FAQ)

What is a provider dispute?
Disputes are between a provider and Absolute Total Care and are submitted when a provider has received an unsatisfactory response to a previous reconsideration request. **In-network providers** may dispute any adverse action including the denial or reduction of claims for services included on a clean claim. In-network providers may also dispute Absolute Total Care's policies, procedures, rates, contract disputes, and any aspects of Absolute Total Care's administrative functions. **Out-of-network 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 have 60 calendar days from the receipt of notice of an adverse action to file a written dispute. Disputes must be submitted in writing to the address below and include a Provider Dispute Form and supporting documentation. The Provider Dispute Form can be found on the Provider Manuals and Forms page of our website.

Where are provider disputes sent?
Absolute Total Care
Provider Disputes
P.O. Box 3050
Farmington, MO 63640-3821

What is not considered a valid provider dispute?
- Absolute Total Care's decision not to contract with a provider.
- Absolute Total Care's decision to terminate a contract with a 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 under 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 are claim adjustments (corrections/resubmissions) and claim reconsiderations?
Claim adjustments (corrections/resubmissions) are requests to change the initial claim.
- To correct a billing error (invalid or incorrect information) in the initial claim submission.
- To reprocess a previous partially denied claim. Adjustment requests related to partially denied claims should be submitted in their entirety as originally filed.

Claim reconsiderations are submitted when a provider disagrees with how a clean or adjusted claim was processed. Examples include but are not limited to:

- Denials related to code edit or authorization. Requests related to code edit or authorization denial require medical records and must accompany the request for reconsideration.
- Payment amount which does not align with expected payment.

How are claim adjustments and claim reconsiderations submitted?
Adjustment or reconsideration requests may be submitted via EDI or the secure provider portal found on our website at absolutetotalcare.com. They can also be mailed to the address below.

Absolute Total Care
Attn: Corrected Claims
P.O. Box 3050
Farmington, MO 63640-3821

Requests submitted via mail must include a completed Provider Claim Adjustment/Reconsideration Form and supporting documentation. The Provider Claim Adjustment/Reconsideration Form can be found on the Provider Manuals and Forms page of our website.

What is the deadline for submitting claim adjustments and claim reconsiderations?
Submitters have 365 calendar days from the date of service (as confirmed on the EOP) to file a timely adjustment or reconsideration request.

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 Managed Care Organization (MCO), the denial of the 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 the Provider Manuals and Forms page of our website. Requests for an appeal that are received without the member consent cannot be processed.

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 member, or 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, which can be found on the Provider Manuals and Forms page of our website.

Additional information on disputes, adjustments, reconsiderations, and member grievance and appeals processed can be found on our website at absolutetotalcare.com, in the Provider Manual, or by calling Provider Services at 1-866-433-6041.