Georgia Medicaid

Elderly and Disabled Waiver Program
CCSP/SOURCE

DXC Proprietary and Confidential

DXC.technology

Agenda

- Objectives
- Elderly and Disabled Waiver Program (EDWP)
  - Community Care Services (CCSP) and Service Options using Resources in the Community Environment (SOURCE) Programs
- General Billing Rules, Accessing Remit Advice and PA Search
- Claim Adjustments
- Common Denials and Outstanding Issues
- Policy Information and Updates
- Interactive Voice Response System (IVRS) Overview
- Session Review
- Closing, Questions and Answers

Objectives

The information presented will enable providers to:

- Understand the EDWP program (CCSP and SOURCE)
- Identify general member eligibility and billing information
- Review options on the IVRS System
- Identify and understand the common claim denials
- Understand where to find provider policy and updates

Provider Enrollment

- Provider Information session requirement: All providers must attend an information session prior to submitting a Notice of Intent and applying to become a CCSP or SOURCE provider.
  - Sessions are held in February and August, prior to enrollment periods of March and September.
  - Contact: ccsp.messages@dch.ga.gov

- For the CCSP and SOURCE Program, providers should apply through the Department of Community Health. *See Section 601.2 of the CCSP General Services Manual.*

- Information on how to apply for SOURCE is available under *Provider Enrollment* on the Medicaid Web Portal or contact ccsp.messages@dch.ga.gov.

- Letter of Support for SOURCE application is no longer required.

Provider Enrollment

(continued)

When enrolled, providers are assigned a Category of Service (COS) or contract.

- 590 – CCSP
- 930 – SOURCE

Member Eligibility

- Members served must need a nursing home level of care.
- Members must be SSI Medicaid approved or potentially eligible for waiver Medicaid.
- EDWP Medicaid is determined by the Department of Family and Children Services after referral from Case Management and upon the receipt of waivered services.
- Service providers must be state licensed from the Healthcare Facility Regulation for the service type and have a Medicaid Provider ID for each waiver service category provided by the Enrollment process at DCH.

Eligibility Verification

- **Eligibility verification is the first and most important step in billing any claim.**
- **Eligibility should be verified prior to each visit to the office or facility, or dispensing of any equipment or treatment.**

Verifying eligibility allows you to determine:

- Is the member currently eligible?
- Is the member eligible for *this* service?
- Does the member have other coverage?
- Has the member reached coverage limitations?
- Does the member have a spend-down or patient liability that will affect the claim?

Eligibility Verification
(continued)

There are three ways Georgia Medicaid provides verification of member eligibility:

- Interactive Voice Response System (IVRS)
- GAMMIS website www.mmis.georgia.gov
- Provider Services Contact Center (PSCC)

The IVRS and the GAMMIS website are available 24 hours a day.

Eligibility Verification
(continued)

- GAMMIS website www.mmis.georgia.gov (secure Web Portal only)
- Eligibility
- Eligibility Request

Welcome, Call Center
Search
[Refresh session] You have approximately 19 minutes until your session will expire.
Tuesday, November 10, 2015
Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy
Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files
Home Eligibility Request

1

2

Eligibility Verification
(continued)

Eligibility Verification Request

Member ID 123456789012

Last Name

First Name

Gender

Birth Date

SSN

From/Thru Date of Service 05/01/2010 05/05/2010

search

clear

1

2

No Medicaid Benefits
(continued)

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Inactive for Service Type Code selected.		09/08/2018	09/08/2018				

SLQ1 Medicare Premium Only “No” Medicaid Benefits
(continued)

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	661 - Spec. Low Income Mcre Benefic.	Provides payment of the monthly Medicare Part B premium only (SLMB-COE 466, 661 QI-COE 662)

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Inactive for Service Type Code selected.	1 - Medical Care	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	33 - Chiropractic	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	35 - Dental Care	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	47 - Hospital	06/08/2018	06/08/2018				
Inactive for Service Type	48 - Hospital - Inpatient	06/08/2018	06/08/2018				

CCSP Medicaid & QMB Benefits

(continued)

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	259 - Community Care Waiver	MEDICAID
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	Provides payment of Medicare Part A premium for those individuals who must pay a premium for Part A, Medicare coinsurance, deductible and Medicare Part B premium only. QMB will not cover any medical service that is not covered by Medicare. (QMB- COE 460 or 660.)

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	1 - Medical Care	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Inactive for Service Type Code selected.	33 - Chiropractic	06/08/2018	06/08/2018				
Active	35 - Dental Care	06/08/2018	06/08/2018	MC - Medicaid	259 - Community Care Waiver	0.00	
Active	47 - Hospital	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	48 - Hospital - Inpatient	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	50 - Hospital - Outpatient	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	3.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	86 - Emergency Services	06/08/2018	06/08/2018	MC - Medicaid	259 - Community Care Waiver	0.00	
Active	88 - Pharmacy	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	3.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.

SSI Medicaid Benefits
(continued)

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	11/01/2018	11/16/2018	MC - Medicaid	303 - SSI - Disabled	MEDICAID

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	1 - Medical Care	11/01/2018	11/16/2018	MC - Medicaid	303 - SSI - Disabled	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.

Retro Medicaid Benefits
(continued)

Retroactive Eligibility		
Retroactive Begin Date	Retroactive End Date	Retroactive Eff (Update) Date
06/08/2018	06/08/2018	08/11/2018

Claims must be received by the Division within six (6) months after the date in which the determination of retroactive eligibility was made at the address used for regular claims submission.

Georgia Medicaid
Elderly and Disabled Waiver

- Community Care Services Program (CCSP)
- Service Options Using Resources in the Community Environment Program (SOURCE)

Elderly and Disabled Waiver

CCSP and SOURCE

Both programs:

- Serve the elderly (65 or older) or (under 65) with a primary functional disability who need assistance to stay in the community.

- Provide services at home or in community to avoid nursing home placement.

- Includes Adult Day Health, Alternative Living Services, ERS (Emergency Response System), Home Delivered Meals (HDM), Personal Support Services (aids and nurses/including the consumer direct option), Skilled Nursing Service/Home Delivered Service, Structured Family Care and Respite Care.

Elderly and Disabled Waiver/CCSP

- Participants can be determined eligible for Medicaid under the EDWP/CCSP Medicaid class/category 259 of assistance by DFCS or be an SSI recipient.

- Applicable members must share in the cost of services (*CCSP members only/ amount determined by DFCS).*

- Requires a Prior Authorization (PA).

- CCSP Care Coordinator enters Service Authorization Form (SAF)
  SAF is loaded into MMIS as a PA.

Elderly and Disabled Waiver/SOURCE

- Must have SSI or public law Medicaid eligibility/Source only.
- Service PA is required and must be included on the claim to receive reimbursement for (Source).
- Source case management enters service Prior authorizations on the GAMMIS portal.

General Rules

- Bill only for authorized services that have actually been rendered.
- Personal Support Service and Home Delivered Meal Providers should bill no more than weekly to avoid conflicts with hospital stays – EOB 5115 (if the provider has billed and was paid and there is a hospital claim DCH will recoup the monies and pay the hospital).
- Bill directly from service records.
- Keep up with your billing and bill on time.
- Check and print your remittance advice every Monday to compare claims submitted prior week to money that will be deposited that coming Wednesday.

Accessing the Remittance Advice (RA)

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy
Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | GBHC Referral | Reports | Trade Files
Home Financial Reports HS&R Reports Other Reports Letters

Reports
Report* Remittance Advice
From Date* 10/01/2009 To Date* 01/21/2010
Records 20 Clear Search

- Select **Report**, then **Financial Reports** from the menu. Next, select **Remittance Advice** from the Report drop down menu.
- Enter the date span.
- Click Search.

Remittance Advice (RA)

The RA is comprised of several document types in this order:

- Banner Messages (if applicable)
- Claims Activity/Status (if applicable)
- Financial Transactions – Expenditures (system generated only) and Accounts Receivable
- EOB Descriptions (if applicable)
- Summary Page

The RA is generated each claims payment cycle. RAs are only received if there is activity during the claims cycle.

Before You Bill

Verify the member's Medicaid eligibility

- Check the Web Portal
- Call the IVRS
- Check for PA
- If eligible but no PA, check with care coordinator or case manager

Paid Claim with the Adjust Option

If paid, the adjust, void, copy claim, and cancel buttons appear. (If the paid claim has already been adjusted, the void and adjust buttons are no longer available). This claim can be adjusted within 90 days of the paid date.

The following messages were generated:

Message Description	Panel	Field	Row
Submit was successful. See Claim Status Information for details.	Professional Claim		

Professional Claim

Adjudication Information

ICN/TCN DMA520 Inquiry Claim Status PAID

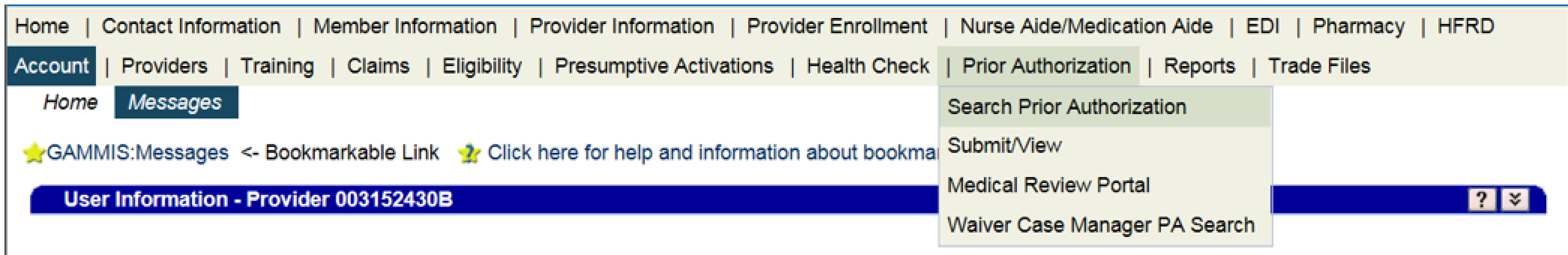
RA Date Total Paid Amount

Prior Authorization Research

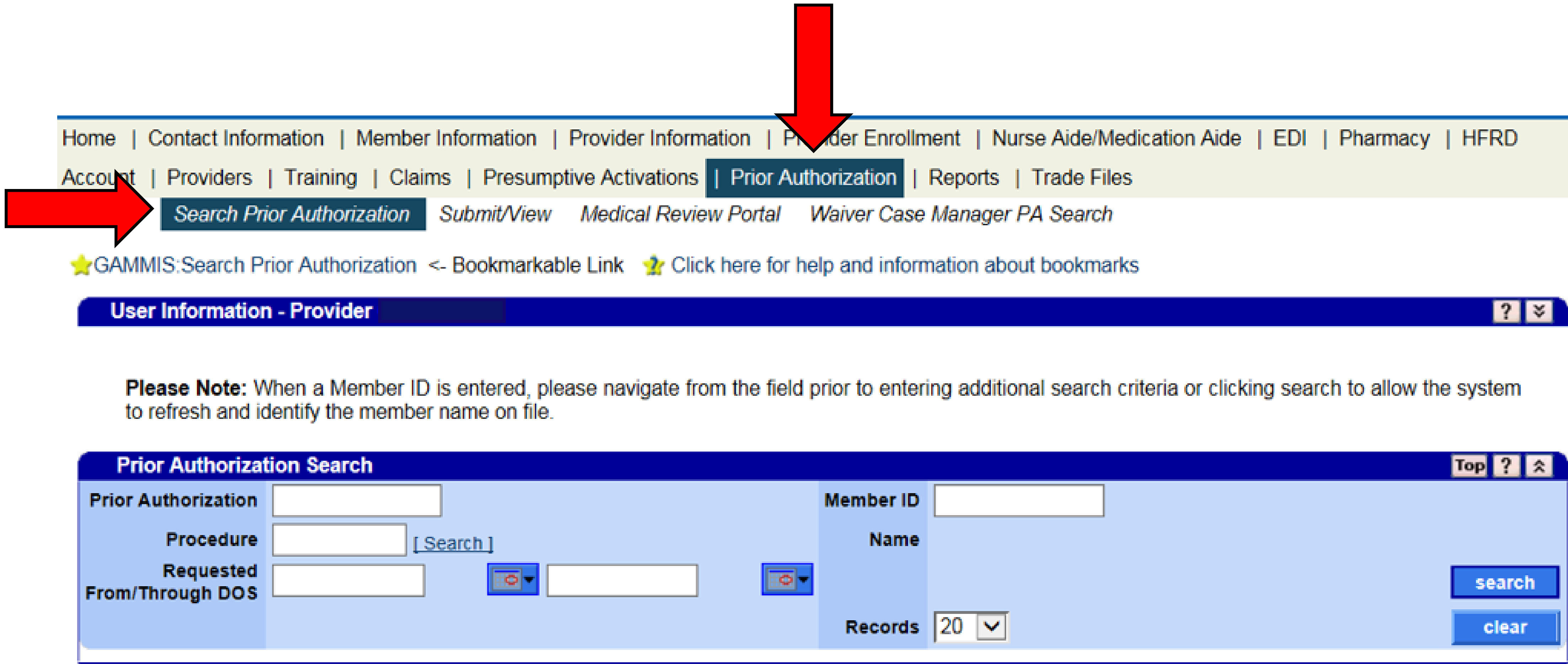
Prior Authorization Search

Visit: www.mmis.georgia.gov

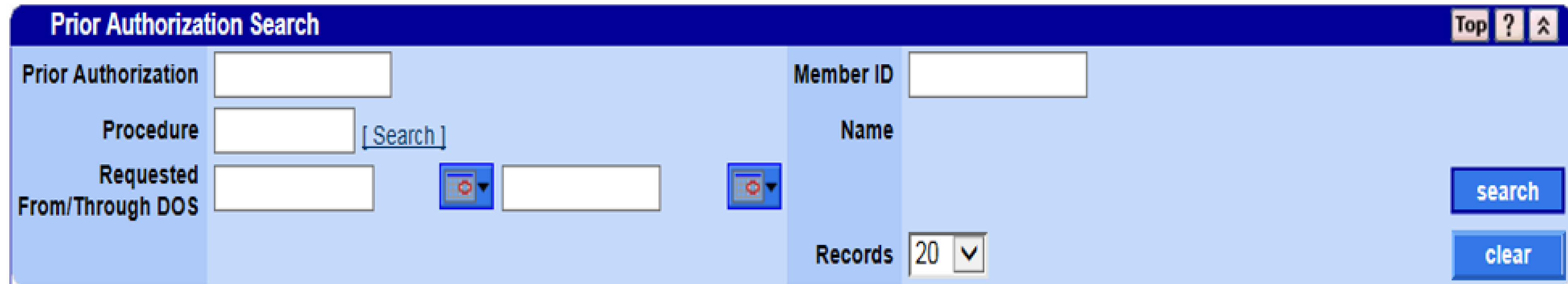
- Log in with your username and password
- Select Web Portal



Prior Authorization Search
(continued)



Prior Authorization Search
(continued)



A Prior Authorization search can be done in either of the following ways:

- Enter the member’s prior authorization number and select search

Or

- Enter the Member ID and the requested from/through date of service and select search

Prior Authorization Search

(result example)

Base Information			
Prior Authorization Number	11111120000	Member ID	11
Provider Name	HOSPITAL	Member Name	W C G
REF ID	REF000000		
From DOS	04/26/2011		
Through DOS	07/25/2011		
Status	DENIED		

Prior Authorization Search
(continued)

Line Items

PA Line Item	01	Status	APPROVED	Rendering Provider
		COS Code	660	Category of Service
From DOS	11/14/2016			Tooth
Through DOS	11/13/2017			Quadrant
Most Recent DOS Paid				Surface
Units Allowed	12	Amount Allowed	$2,240.04	
Units Used	0.000	Amount Used	$0.00	
Max Monthly Units	1	Max Monthly Amount	$0.00	
Max Daily Uniits	0	Authorized Rate	$0.00	
PA Line Item	02	Status	APPROVED	Rendering Provider
		COS Code	660	Category of Service
From DOS	11/14/2016			Tooth
Through DOS	11/13/2017			Quadrant
Most Recent DOS Paid	01/12/2017			Surface
Units Allowed	1160	Amount Allowed	$10,416.80	
Units Used	104.000	Amount Used	$933.92	
Max Monthly Units	110	Max Monthly Amount	$0.00	
Max Daily Uniits	0	Authorized Rate	$0.00	
PA Line Item	03	Status	APPROVED	Rendering Provider
		COS Code	660	Category of Service
From DOS	11/14/2016			Tooth
Through DOS	11/13/2017			Quadrant
Most Recent DOS Paid	01/11/2017			Surface
Units Allowed	676	Amount Allowed	$6,827.60	
Units Used	88.000	Amount Used	$886.45	
Max Monthly Units	60	Max Monthly Amount	$0.00	
Max Daily Uniits	0	Authorized Rate	$0.00	

Procedures

PA Line Item	(Procedure	Description)	(Modifier 1	Description)	(Modifier 2	Description)	(Modifier 3	Description)	(Modifier 4	Description)	NDC
01	T2022	CASE MANAGEMENT, PER MONTH	SE	STATE/FED FUNDED PROGRAM/SER							
02	T1021	HH AIDE OR CN AIDE PER VISIT	TF	INTERMEDIATE LEVEL OF CARE							
03	T1021	HH AIDE OR CN AIDE PER VISIT	U1	M/CAID CARE LEV 1 STATE DEF							

Common Denials

- 535: Adjustment exceeds timely filing period
- 3000: PA units exhausted or partially available
- 3011: DOS not within PA/Precert effective dates
- 4021: No Coverage for Billed Procedure
- 5035, 5037 or 5042: Exact Duplicate
- 5038 or 5043: Possible Duplicate
- 5044: Possible conflict (with another waiver)
- 5115: Service not allowed during hospital stay

Important Changes

- The DCH has implemented a paperless environment and requires that all claims be submitted through the Georgia Medicaid Management Information System (www.mmis.georgia.gov).

- Any claim submitted on paper will be destroyed.

Timely Claim Submission

- Submit claims within six months of the date of service.
  - Overrides can be sent to DCH if applicable

- Adjust claims within 90 days of paid date.

- See the Medicaid Policy and Procedures Manual, Part I, Chapter 200 for detailed information on Timely Submission.

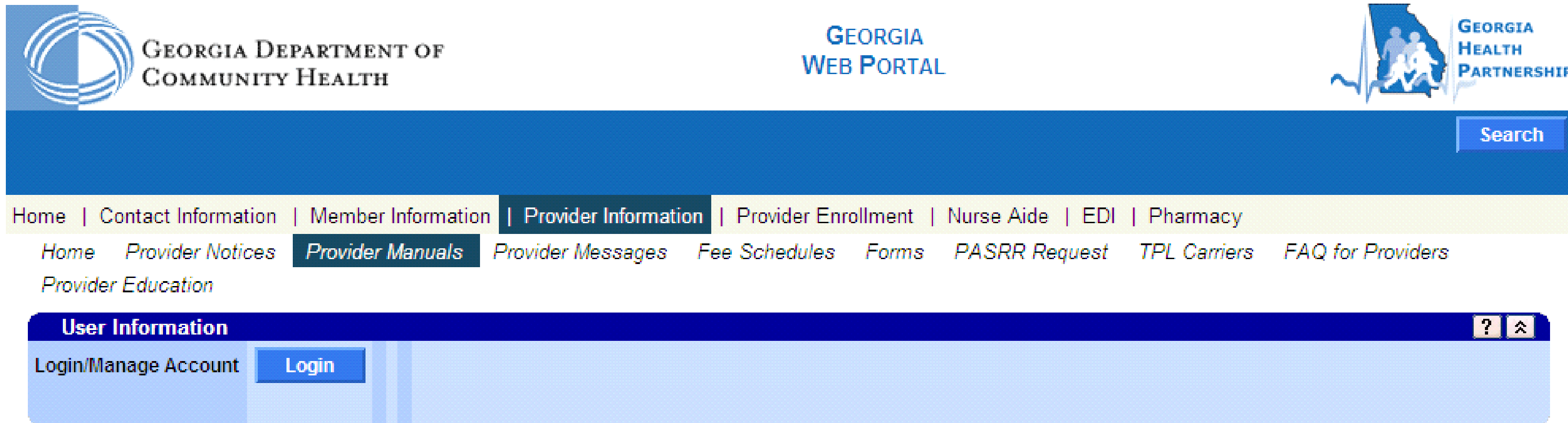
Medicaid Provider Policy Information

Available at http://www.mmis.georgia.gov/

Medicaid Provider Manuals

- Click “Provider Information” tab on the home page of the Web Portal
- Click “Provider Manuals”
- Choose from the list of manuals
- No login ID required

Policy Information



NOTE: Adobe Acrobat Reader is required to view these documents. Click here to obtain the latest version of the free Adobe Reader. To save a document from this list, right click the link and then select "Save Target As...".

Provider Manuals (16 rows returned)

Title	Size (KB)	Release Date
ACSBNR12062007_2_GHP_Portal_Upgrades	29	20081231
ACSBNR12062007_2_GHP_Portal_Upgrades	29	20081231
FMMIS_Secure_Web_Portal_User_Guide_v1_0.	3148.20	20081231
FMMIS_Secure_Web_Portal_User_Guide_v1_0.	3148.20	20081231
Georgia_ADA_Dental_v0.6.	4647.50	20081231
Georgia_CMS_1500_v0_11	4790.70	20081231
Georgia_UB_04_Billing_Manual_v0.9	5425.70	20081231
GHP_Web_User_Guide_2007-08-08	4635.70	20081231
GHP_Web_User_Guide_2007-08-08	4635.70	20081231
Member_and_Provider_IVR_Flows	163.90	20081231

1 2 Next >

Policy Information

(continued)

- For additional questions concerning policy information, contact the Provider Services Contact Center (PSCC) at 800-766-4456.
- The PSCC can also be reached by initiating a “Contact Us” inquiry on the Web Portal.

Policy Updates

- One Year (365 Days) Claim Submission Edit.
- New system enhancements will be made to limit a claim's life cycle to a maximum of one year (365 days). The claim life cycle is the timeline for the total claims process from the date of service to original submission and through the last date by which resubmission (provider adjustment) must occur to remain timely.

This system modification means that the new one year timely submission and resubmission processes requires the following:

- The original claims to be submitted within 180 days or six months from date of service.
- A claim that was denied for missing or erroneous information be resubmitted to correct the misinformation within three months from the month of the date of service or when the denial occurred, whichever is later.
- Banner Message posted June 14, 2017. Please visit www.mmis.georgia.gov.

IVRS Overview

800-766-4456	
• Option 1	Member Eligibility
• Option 2	Claims Status
• Option 3	Payment Information
• Option 4	Provider Enrollment
• Option 5	Prior Authorization
• Option 6	GAMMIS website password reset, Pharmacy Benefits, the Nurse Aide Registry or Nurse Aide Training program, PeachCare for Kids®, EDI submission or electronic claim submission, or a system overview

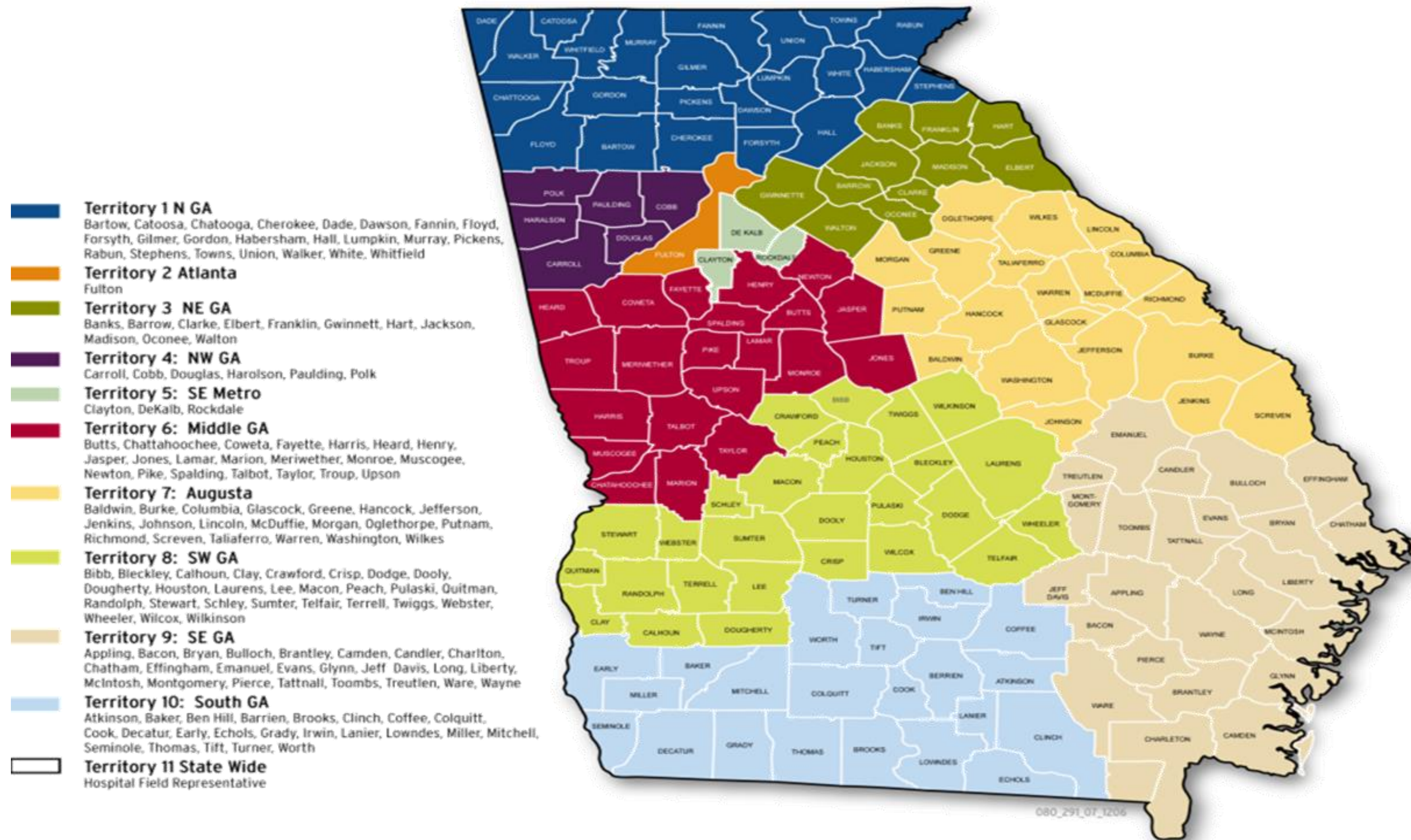
Provider Relations Field Services

Territory	Region	Rep
1	North Georgia	Deandre Murray
2	Fulton	Adrian Hogan
3	NE Georgia	Carolyn Thomas
4	NW Georgia	Danny Williams
5	SE Metro	Ebony Hill
6	Middle Georgia	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Vacant
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

State-Wide Consultants

Brenda Hulette
Anita Hester
Sharée C. Daniels

Georgia Field Territories



Contact My Provider Rep Directly

Login to the MMIS system with your username and password

Contact My Provider Rep Directly

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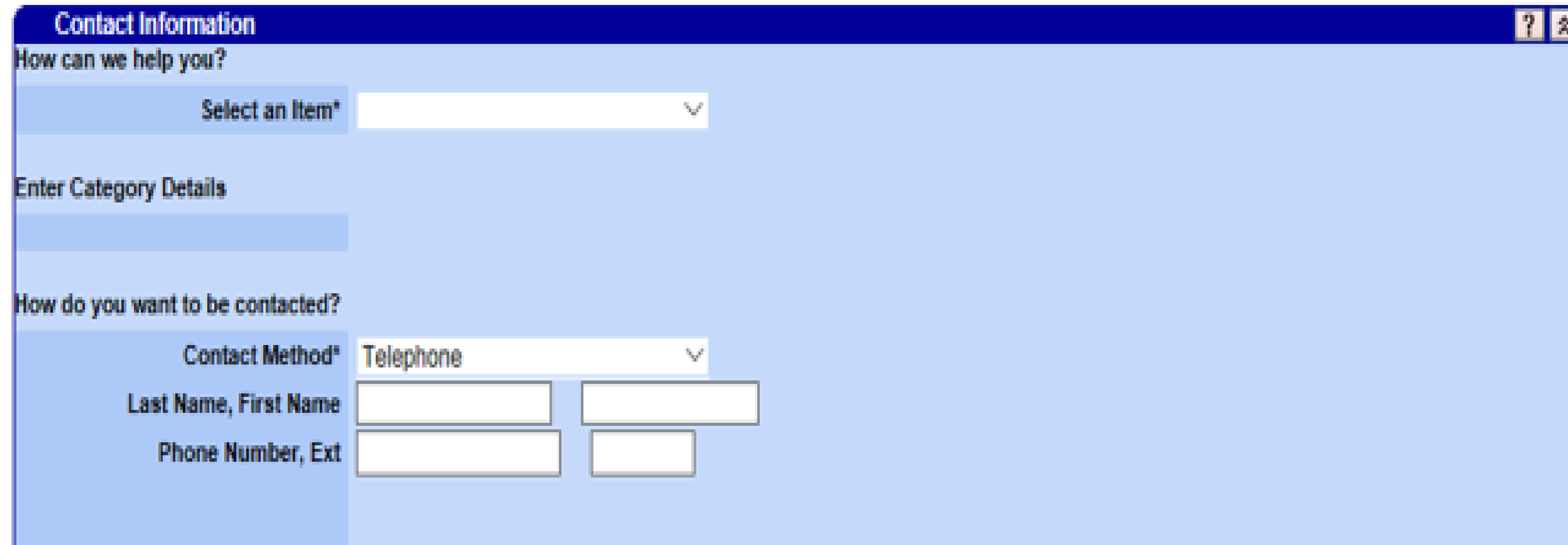


Contact My Provider Rep Directly

(continued)

Requests Requiring PHI

NOTE: If the response to your inquiry contains protected health information (PHI) such as member or claims information, you must log into the secure web portal to submit your question and receive the response. Upon login, additional contact options related to PHI will be available.

submit cancel

Contact Information

How can we help you?

Select an Item*

- Claim Status Inquiry
- Eligibility Inquiry
- Contact My Provider Service Rep
- Provider Enrollment
- Request a Provider Rep Visit
- ICD-10 Inquiry
- Favors Review Inquiry
- MAPIR Inquiry
- Web Registration
- Member ID Cards
- Member PCP Assignments
- Customer Service
- Complaint about a Provider
- Complaint about a Member
- Other Complaint
- Having a Technical Problem
- Other
- EDI Submission Problem
- Provider PIN Issue

Enter Category Details

How do you want to be contacted?

Contact Method*

Last Name, First Name

Phone Number, Ext

top of page top of page

Contact My Provider Rep Directly

(continued)

Requests Requiring PHI

NOTE: If the response to your inquiry contains protected health information (PHI) such as member or claims information, you must log into the secure web portal to submit your question and receive the response. Upon login, additional contact options related to PHI will be available.

submit cancel

Contact Information

How can we help you?

Select an Item* Contact My Provider Service Rep

Enter Category Details

How can we help you?

How do you want to be contacted?

Contact Method* Telephone

Last Name, First Name

Phone Number, Ext

Contact My Provider Rep Directly

(continued)

submit | cancel

Contact Information

How can we help you?

Select an Item* Contact My Provider Service Rep

Enter Category Details

How can we help you?

How do you want to be contacted?

Contact Method*
- E-Mail
- Fax
- Mail
- Anonymous/No response needed
- Telephone

Last Name, First Name

Phone Number, Ext

Contact My Provider Rep Directly

(continued)

submit | cancel

Contact Information

How can we help you?

Select an Item*	Contact My Provider Service Rep

Enter Category Details

How can we help you?	I Need some help with ICN 2017123456777

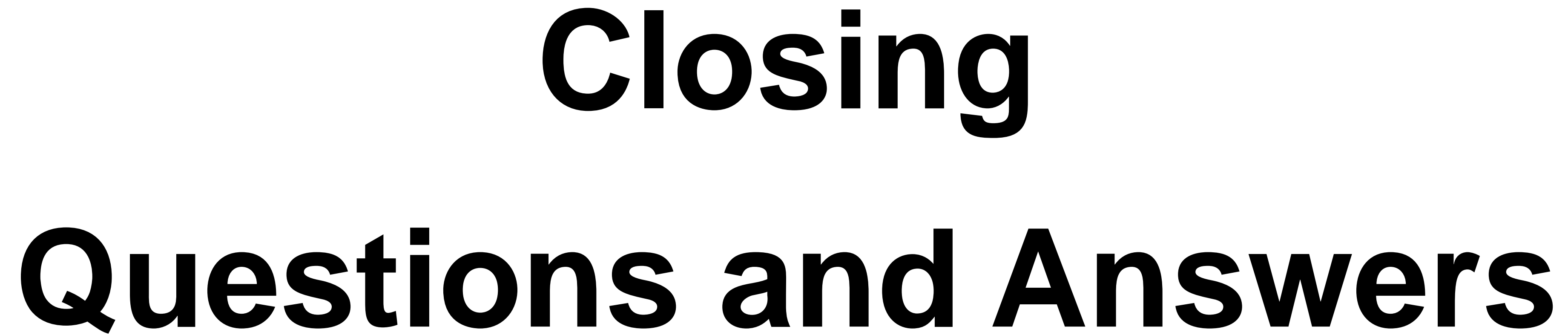
How do you want to be contacted?

Contact Method*	Telephone	
Last Name, First Name	DXC	
Phone Number, Ext	(800)766-4456	

Session Review

You should now be able to:

- Understand the Claims Edits
- Understand general billing information
- Understand where to find the most up to date policy information on the Georgia Medicaid Web Portal
- Identify and understand the common denials
- Understand the options of the IVRS system


Closing
Questions and Answers