Georgia Medicaid Common Denials Presentation

For access to this presentation, please visit: www.mmis.georgia.gov -> Provider Information -> Provider Notices –“Presentation –Medicaid Common Denials”

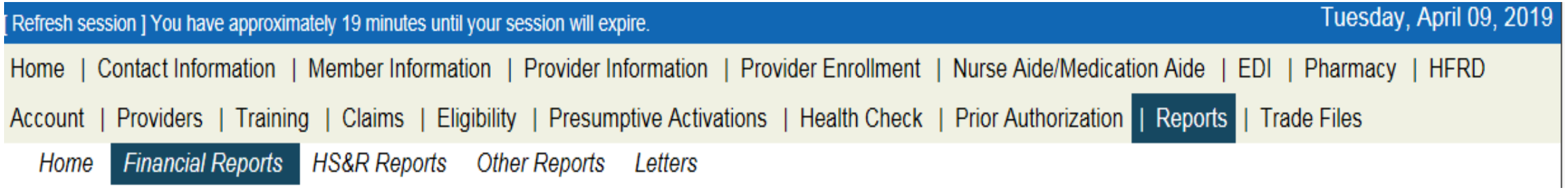
Georgia Department of Community Health

gainwell

Agenda

- Remittance Advice
- Common Eligibility Denials
- Common Procedure Code Denials
- Common Prior Authorization and Precertification Denials
- Common Miscellaneous Denials (NCCI, ICD-10, EMA, etc.)
- Contacting Gainwell Technologies
- Closing - Questions and Answers

Remittance Advice



The Remittance Advice (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 Remittance Advice is generated weekly if you have any claims activity within that week's cycle.

Remittance Advice

(continued)

REPORT: CRA-PHDN-R
RA#: 49601

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
CLAIM TYPE M - CMS 1500 DENIED

DATE: 02/15/2019
PAGE: 9

CLINIC, INC.
PO BOX
ATLANTA, GA

PAYEE ID:
NPI ID:
PAYMENT NUMBER: 533650
ISSUE DATE: 02/18/2019
RECEIVER ID:

RENDERING PROVIDER: MCD NPI

ICN	MEMBER ID	MEMBER NAME	BILLED DTE	P AUTH NO	PATIENT NUMBER			
COS	FROM DTE - THRU DTE	BILLED	ALLOWED	COPAY/DEDUCT	PT LIAB	COB	TOTAL PAID	
2319	111		02132019					
430	12312018 12312018	8,196.00	0.00	0.00	0.00	0.00	0.00	DENY

LNN	FROM DTE-THRU DTE	POS	SPEC	PROC CD	M1	M2	M3	M4	UNITS BILLED/ALLWD	BILLED	ALLOWED	COB	PAID	STATUS
1	12312018 12312018	21	263	33361	62				1.00 0.00	8,196.00	0.00	0.00	0.00	DENY

DETAIL EOBS: 4257 CO:182 8196.00- 4821 CO:5
REMARK CODES: N519 N428

TOTAL CMS 1500 CLAIMS DENIED: 8,196.00 0.00 0.00 0.00 0.00 0.00
TOTAL CMS 1500 DENIED CLAIMS WRITTEN: 1

Remittance Advice

(continued)

REPORT: CRA-EOBM-R
RA#:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH
MEDICAID MANAGEMENT INFORMATION SYSTEM
PROVIDER REMITTANCE ADVICE
EOB CODE DESCRIPTIONS

DATE: 02/15/2019
PAGE: 10

CLINIC, INC.
PO BOX
ATLANTA, GA

PAYEE ID:
NPI ID:
PAYMENT NUMBER: 33650
ISSUE DATE: 02/18/2019
RECEIVER ID:

RENDERING PROVIDER: MCD NPI

REASON CODE/ EOB CODE	REASON CODE DESCRIPTION/ EOB CODE DESCRIPTION
4257	INVALID PROCEDURE CODE MODIFIER
4821	PLACE OF SERVICE RESTRICTION ON PROC BILLING RULE

HIPAA REASON CODE	HIPAA ADJ REASON CODE DESCRIPTION
182	Payment adjusted because the procedure modifier was invalid on the date of service
5	The procedure code/bill type is inconsisten with the place of service.

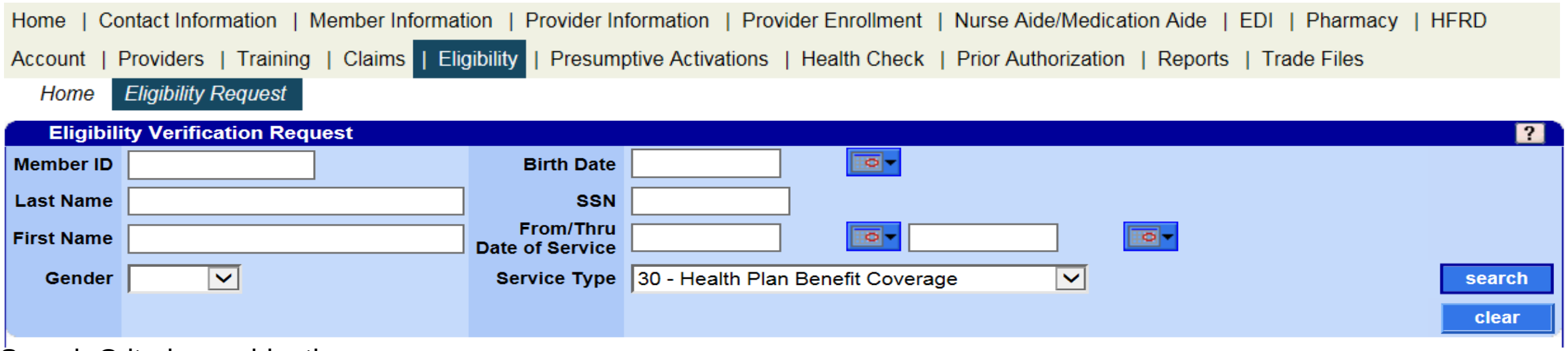
HIPAA REMARK CODE	HIPAA REMARK CODE DESCRIPTION
N428	Service/procedure not covered when performed in this place of service.
N519	Invalid combination of HCPCS modifiers.

Common Eligibility Denials

- **The most common eligibility denials come from NOT checking eligibility.**
- **You can check a future date of eligibility.**

Common Eligibility Denials

(continued)



Search Criteria combinations:

- [Medicaid ID and Date of Service Span]
- [Last Name/First Name, Gender, Birth Date, and Date of Service Span]
- [Birth Date, Social Security number, and Date of Service Span]
- [Last Name/First Name, Social Security number, Date of Service Span]

Common Eligibility Denials

(continued)

Edit 2003 -Member Ineligible on Detail Date of Services
This edit is triggered when the claim detail dates of service do not fall within or are equal to the beginning and ending dates in any recipient eligibility segment.

EDIT 2078 –Member has Partial Eligibility for Detail DOS
This edit is triggered when if only partial eligibility was found on detail DOS.

Edit 2017 -Member Services are Covered by CMO Plan
This edit is triggered when a member has a lock-in segment with one of the CMOs (WellCare, Amerigroup, PeachState, CareSource).
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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	03/01/2016	03/31/2016	MC - Medicaid	135 - Newborn Child	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	03/01/2016	03/31/2016	MC - Medicaid	135 - Newborn Child	0.00	

Managed Care

Provider Name	Plan Name	Provider Phone	Effective Date	End Date
WELLCARE HEALTH PLANS, INC - ATL	Georgia Families	(866)231-1821	01/01/2016	01/02/2016

Common Eligibility Denials

(continued)

Edit 4021 -No coverage for billed procedure

Edit 4924/4925-Diagnosis not covered for Benefit Plans

These edits are triggered if a member's benefit plan coverage rule is not found.

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	04/01/2016	04/25/2016	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)

Method of Correction —Eligibility should be verified prior to rendering services to a member. In this example, the member has SLMB coverage where Medicaid will only pay the Medicare premium. Therefore, the member does not have Medicaid coverage. **Note**: Aid Categories 661-663 plans only cover the member's Medicare premium. These edits are commonly used for these aid categories but are also used in other circumstances. Verifying eligibility is your best way of knowing.

Common Eligibility Denials

(continued)

Edit 2504 -Member Covered by Private Insurance; no attachments

This edit is triggered if the member has private coverage that is not exhausted using the header FDOS-TDOS Span. There is no claim attachment and the TPL amount on the claim is zero.

COB

Coverage Type	Payer Identifier	Carrier Name	Carrier Address	Policy Number	Effective Date	End Date
PBM/Drug	0000006574	WELLPOINT PHARMACY MANAGEMENT	PO BOX 9080, OXNARD, CA, 93031	257219533	01/01/2016	01/31/2016
Mental Health/Behav MGD Care	000000A074	BCBS GEORGIA	PO BOX 9907, COLUMBUS, GA, 31908	XKQ361A6465103	01/01/2016	01/31/2016
MGD Care/Standard	000000A074	BCBS GEORGIA	PO BOX 9907, COLUMBUS, GA, 31908	XKQ361A6465103	01/01/2016	01/31/2016

Method of Correction -Verify the COB information and bill the claim to the appropriate Insurance Carrier first or re-submit your claim with the Primary Carrier's EOB information or resubmit your claim with the DMA-410 COB notification form. **Medicaid is always the payer of last resort**.

Common Eligibility Denials

(continued)

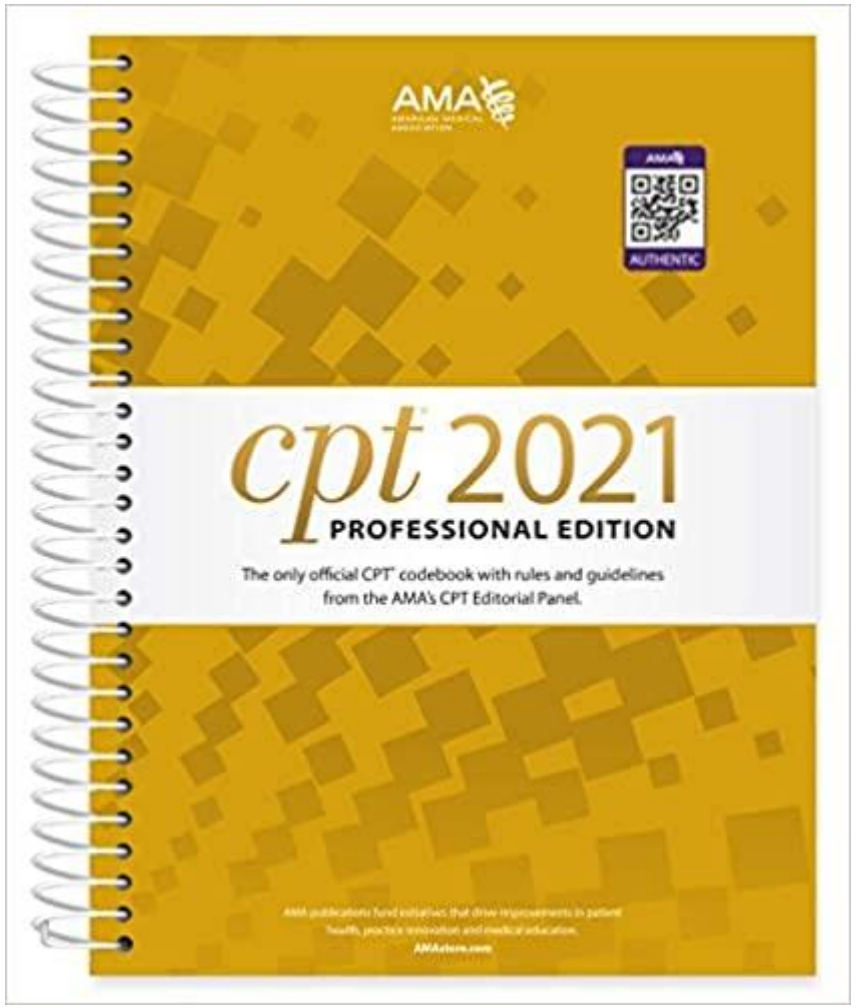
COB Updates

Effective February 23, 2017, the DMA-410: EB-TPL form will need to be submitted via the GAMMIS Web Portal when updating a member's COB information.

To provide this information, upload a scanned image of the member’s insurance card for COB updates to the GAMMIS Web Portal atwww.mmis.georgia.gov. Perform an eligibility request for the member in question, select the new Member Transactions button and follow the instructions provided on the member transactions page.

Note: Providers need to continue using the paper DMA-410-Form for Section I: Co-Payment Notification, and Section II: COB Non-Coverage Affidavit.

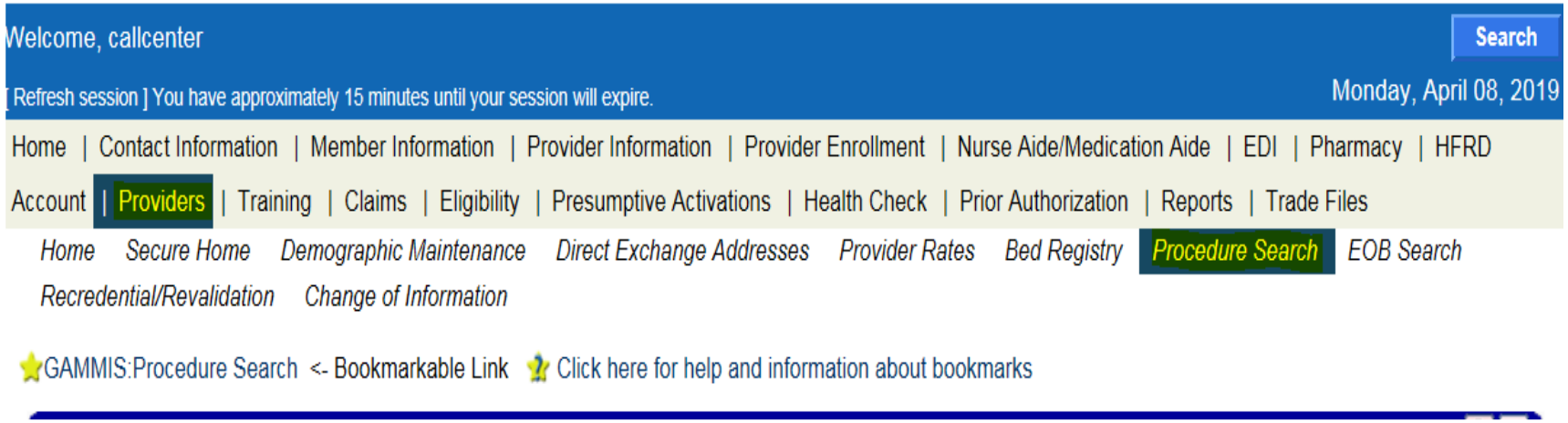
Common Procedure Code Denials

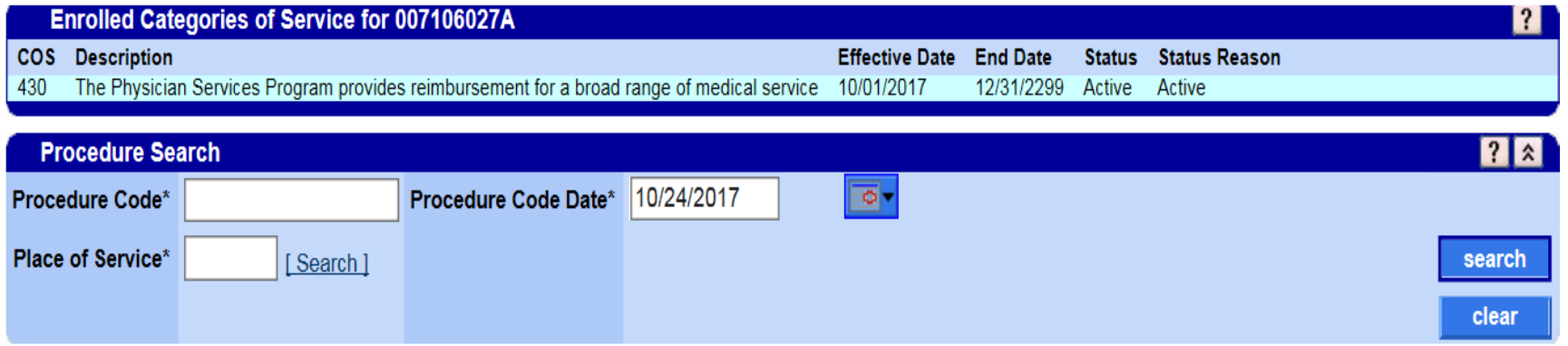


Common Procedure Code Denials

(continued)

The most common procedure denials come from NOT performing a procedure code search.





Note: All fields are required.

Common Procedure Code Denials

(continued)

COS	Description	Effective Date	End Date	Status	Status Reason
430	The Physician Services Program provides reimbursement for a broad range of medical service	12/01/1973	12/31/2299	Active	Medicare Only

Procedure Search

Procedure Code*	99213	**Procedure Code Date***	04/08/2019
Place of Service*	11 [Search]		

Procedure Information

Procedure Code	99213	**Description**	OFFICE/OUTPATIENT VISIT EST
Gender		**PA Required**	The PA Required column will indicate whether the service requires either a Precert
Minimum Age			Prior Authorization. The possible values are:
Maximum Age			N - No PA is not required
			Y - Yes PA is required
			X - Yes PA is required
			Z - Yes Precert is required

Covered Categories of Service (29 rows returned)

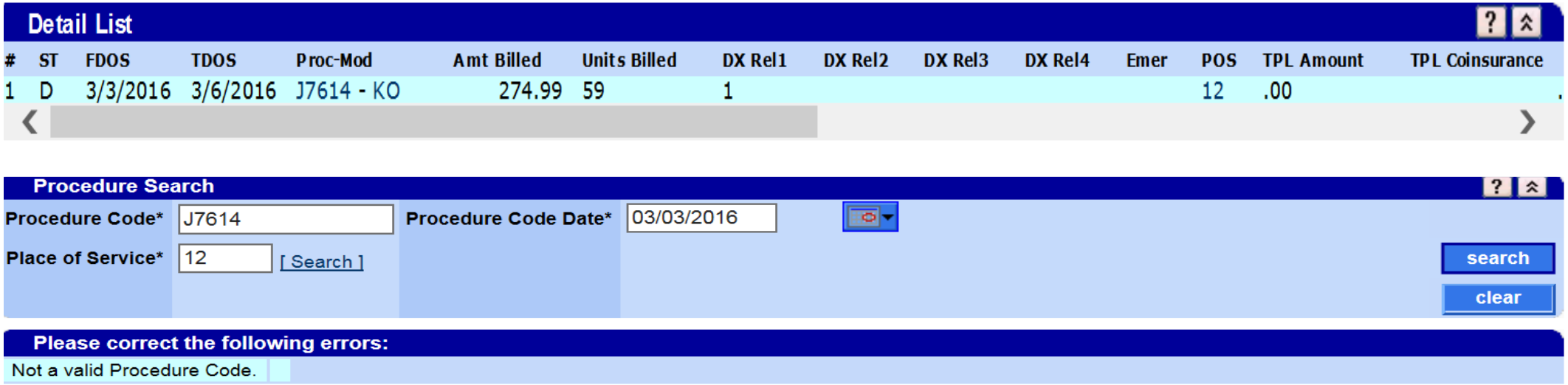
COS	Claim Type	Modifiers	Min Age	Max Age	Gender	From	Thru	PA Required
010						01/01/2000	12/31/2299	Z - Yes Precert is required
070		Including 0-3 from 95 GQ GT				01/01/2017	12/31/2299	N - No PA is not required
080						01/01/2000	12/31/2299	N - No PA is not required
200	C					07/01/2000	12/31/2299	N - No PA is not required
230	B,M	Including 0-4 from 24 25 52 57 AJ FP GT U1				01/01/2006	12/31/2299	N - No PA is not required
270		Including 1-1 from FP , Including 0-1 from U1				01/01/2013	12/31/2299	N - No PA is not required
430	M	Including 0-1 from 52 AJ FP GT HA TM , Including 0-4 from 24 25 27 57 58 59 78 79 91 95 E1 E2 E3 E4 F1 F2 F3 F4 F5 F6 F7 F8 F9 FA GQ LC LD LM LT RC RI RT T1 T2 T3 T4 T5 T6 T7 T8 T9 TA				01/01/2017	12/31/2299	N - No PA is not required

Common Procedure Code Denials

(continued)

Edit 4013 -Proc not allowed for Service Date

This edit is triggered when the date of service on the claim is not within the effective dates and end dates on the procedure restrictions table in GAMMIS.



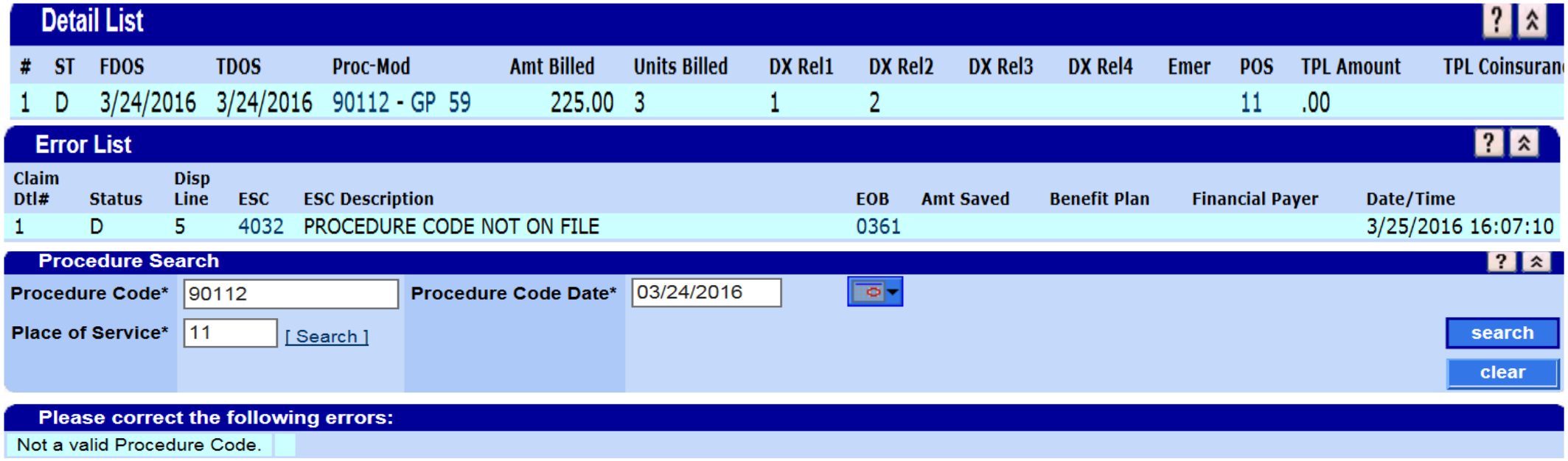
Method of Correction -Review the Part 2 program specific manual to determine what codes are billable and also check the Procedure Search panel to determine the billing rules for the code**.**

Common Procedure Code Denials

(continued)

Edit 4032 -Procedure Code Not On File

This edit is triggered when the line item procedure code on the claim does not exist on the reference database in GAMMIS.



Detail List

#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed	DX Rel1	DX Rel2	DX Rel3	DX Rel4	Emer	POS	TPL Amount	TPL Coinsuran
1	D	3/24/2016	3/24/2016	90112 - GP 59	225.00	3	1	2				11	.00	

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time
1	D	5	4032	PROCEDURE CODE NOT ON FILE	0361				3/25/2016 16:07:10

Procedure Search

Procedure Code* 90112 Procedure Code Date* 03/24/2016

Place of Service* 11 [Search]

search

clear

Please correct the following errors:

Not a valid Procedure Code.

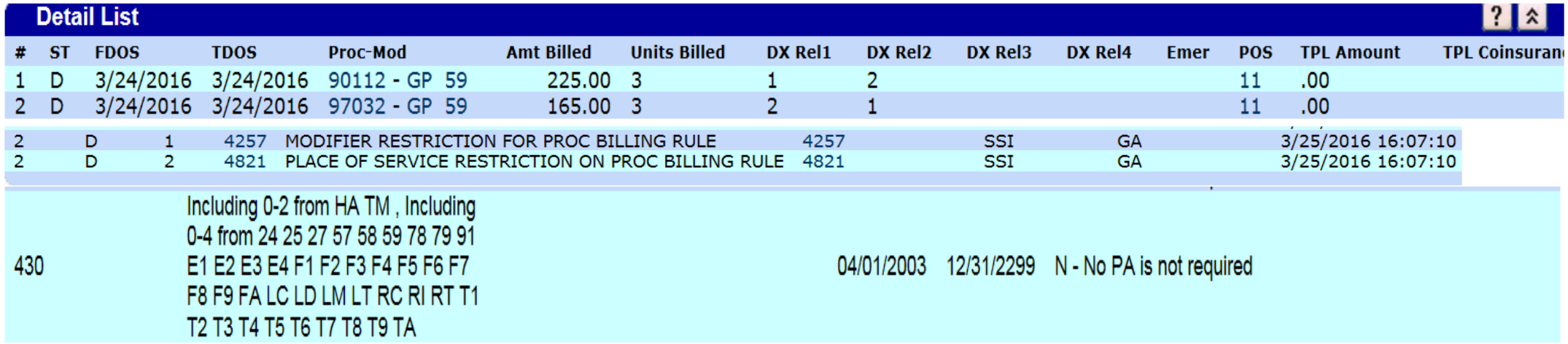
Method of Correction -Review the Part 2 program specific manual to determine what codes are billable and also check the Procedure Search panel to determine the billing rules for the code**.**

Common Procedure Code Denials

(continued)

Edit 4257 -Modifier Restriction For Proc Billing Rule

This edit is triggered when the claim modifier does not meet the procedure billing rule modifier configuration in GAMMIS.



Detail List

#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed	DX Rel1	DX Rel2	DX Rel3	DX Rel4	Emer	POS	TPL Amount	TPL Coinsuran
1	D	3/24/2016	3/24/2016	90112 - GP 59	225.00	3	1	2				11	.00	
2	D	3/24/2016	3/24/2016	97032 - GP 59	165.00	3	2	1				11	.00	

2	D	1	4257	MODIFIER RESTRICTION FOR PROC BILLING RULE	4257	SSI	GA		3/25/2016 16:07:10
2	D	2	4821	PLACE OF SERVICE RESTRICTION ON PROC BILLING RULE	4821	SSI	GA		3/25/2016 16:07:10

430	Including 0-2 from HA TM , Including 0-4 from 24 25 27 57 58 59 78 79 91 E1 E2 E3 E4 F1 F2 F3 F4 F5 F6 F7 F8 F9 FA LC LD LM LT RC RI RT T1 T2 T3 T4 T5 T6 T7 T8 T9 TA	04/01/2003	12/31/2299	N - No PA is not required

Method of Correction -Review the Part 2 program specific manual to determine what codes are billable and also check the Procedure Search panel to determine the billing rules for the code. The procedure search results will show the applicable COSs, associated modifiers, claim types, age restrictions, and if a PA/Precert is required. Once reviewed, submit or resubmit the claim. In this example, the modifier(s) can be corrected on the GAMMIS Web Portal.

Common Procedure Code Denials

(continued)

Edit 4801 -Billing Rule Not Found for Billed Proc

This edit is triggered when there are no billing rules for the procedure under the provider contract for the date of service in GAMMIS.

Edit 4871 -Claim Type Restriction on Proc Billing Rule

This edit is triggered when claim type is not within the claim type restriction of the billing rule for the Procedure Code in GAMMIS.

Detail List

#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed	DX Rel1	DX Rel2	DX Rel3	DX Rel4	Emer	POS	TPL Amount
1	D	3/24/2016	3/24/2016	3066F -	.01	1	3					11	.00

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer
1	D	1	4801	BILLING RULE NOT FOUND FOR THE BILLED PROCEDURE	4801		TXIX	GA
1	D	3	4871	CLAIM TYPE RESTRICTION ON PROC BILLING RULE	4871			

Method of Correction -Review the Part 2 program specific manual to determine what codes are billable and also check the Procedure Search panel to determine the billing rules for the code. The procedure search results will show the applicable COSs, associated modifiers, claim types, age restrictions, and if a PA/Precert is required. Once reviewed, submit or resubmit the claim.

Common Procedure Code Denials

(continued)

Edit 4316 -Diagnosis Restriction for Billed Procedure

This edit is triggered when the diagnosis is not allowed for the billed procedure in GAMMIS.

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time	User ID
1	D	1	4316	DIAG RESTRICTION FOR BILLED PROC	4316		SSI	GA	3/24/2016 21:07:24	
1	D	6	4714	AGE RESTRICTION ON PROC BILLING RULE	4714		SSI	GA	3/24/2016 21:07:24	

Method of Correction -Review the diagnosis associated with the procedure in question. Correct the diagnosis if applicable. If the diagnosis is correct, your claim has denied because the procedure you are billing for is only payable to a certain diagnosis code.

Common Prior Authorization and Precertification Denials

→ **Prior Authorization is not a guarantee payment.**

Common Prior Authorization and Precertification Denials

(continued)

There are several reasons why a claim may be denied after it is submitted even if prior authorization was obtained.

1. The member has become ineligible for services and is no longer covered by the health plan.
2. Services are not billed with the CPT/HCPCS code identified in the prior authorization.
3. Additional services, not included in the initial prior authorization that also require prior authorization are submitted on the claim.

The final determination of whether to pay for service is made by thoroughly reviewing the member's plan *and* the payers medical coverage policy on the day of service.

Common PA/Precert. Denials

(continued)

Edit 3011 - DOS Not Within PA/Precert Effective Dates
This edit is triggered when the date on the claim is outside the approved dates on the PA/Precert.

Method of Correction - Providers may submit a Change Request Form to Alliant Health/GMCF through the Medical Review Portal within 30 days of the PA request date or within 30 days of the date of service.

Edit 3052 - PA Units/Amount Exhausted
This edit is triggered when the approved number of units have all been used.

Method of Correction - Check PA/Precert for accuracy. Provider may need to submit a request for a new authorization or a request for more units.

Edit 3001 - PA Not On File
This edit is triggered when the PA number entered on the claim is invalid or the PA has not crossed over into GAMMIS.

Method of Correction - Correct PA number on the GAMMIS web portal then resubmit claim. If the PA number is valid notify a Gainwell Technologies representative.

Common PA/Precert. Denials

(continued)

Edit 3044 -Provider Number Does Not Match Prior Authorization

This edit is triggered when GAMMIS can not make an ID match to the rendering provider ID on the claim and the rendering provider ID on the prior authorization.

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer
1	D	1	3044	PROVIDER NUMBER DOES NOT MATCH PRIOR AUTHORIZATION	3044			

Method of Correction -Review the authorization to determine the correct provider ID to bill on the claim. If the authorization was obtained with the wrong provider ID, a Change Request Form may be submitted to Alliant Health/GMCF through the Medical Review Portal within 30 days of the requested date or date of service.

Common Miscellaneous Denials

Common Miscellaneous Denials - NCCI Procedure to Procedure

Edit 5928 - NCCI procedure to procedure (PTP) (Service not payable with another service on the same date)

This edit is triggered when:

- Same Rendering provider, member, and date of service appear on a history claim.
- Composite (greater) procedure exists on history claim and component (lesser) procedure exists on the current claim.
- The procedure pair is found in the NCCI Procedure to Procedure panel for the detail DOS.
- Appropriate NCCI modifier is not used on the claim.

NCCI Procedure-to-Procedure (PTP) files are sent by CMS each quarter. Visit the CMS website to familiarize yourself with NCCI methodology.

Common Miscellaneous Denials -MUE

Edit 5930 - NCCI Medically Unlikely Edit – Practitioner
This edit is triggered when billed units of service exceed the NCCI Medically Unlikely Edit.

Method of Correction - Review Code information to determine the billable units. Correct units billed and resubmit the claim.

Edit 5932 - Service Allowed Inpatient Setting Only
This edit is triggered when the POS on the claim is not a facility.

Method of Correction - Services must be rendered in an inpatient setting (POS 21) only.

Note: MUEs are updated quarterly by CMS. Visit the CMS website to familiarize yourself with MUE methodology.

Common Miscellaneous Denials - ICD-10

Edit 4280/4281/4282/4283 -ICD-10 DIAGNOSIS CODE IS NOT SPECIFIED

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time
1	D	2	4280	1ST ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1430			GA	3/25/2016 10:07:34
1	D	2	4281	2ND ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1431			GA	3/25/2016 10:07:34
1	D	2	4282	3RD ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1432			GA	3/25/2016 10:07:34
1	D	2	4283	4TH ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1433			GA	3/25/2016 10:07:34

Claim Diagnosis

Seq Code	Diagnosis Code	ICD	Description	Qualifier
1	M25.569	ICD-10	PAIN IN UNSPECIFIED KNEE	ABK
2	M25.579	ICD-10	PAIN IN UNSPECIFIED ANKLE AND JOINTS OF UNSPECIFIED FOOT	ABF
3	M25.539	ICD-10	PAIN IN UNSPECIFIED WRIST	ABF
4	M25.519	ICD-10	PAIN IN UNSPECIFIED SHOULDER	ABF

Method of Correction-Review the diagnosis code set for each diagnosis and use the most accurate code for patient diagnosis.

Note: Some Unspecified Codes may be used as a 1st diagnosis if there is not a more specified diagnosis code. Please note that some unspecified codes when billed may deny in the GAMMIS.

Common Miscellaneous Denials

(continued)

Edit 1002 -Rendering Provider not eligible to render service

This edit is triggered when the rendering provider is either not enrolled for the detail dates of service (DOS) span or is not enrolled in the assigned provider program/category of service.

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time
1	D	2	1002	REND PROV NOT ELIGIBLE TO RENDER SVC ON THIS PGM	0096				3/20/2017 12:44:34

Method of Correction-Verify the providers contract effective date via the Demographic Maintenance Panel.

Note: If a provider is suspended or terminated, service will not be reimbursed for payment. If the determined provider file is suspended, the provider should send a Change of Information form requesting re-activation of the account. If terminated, the provider will need to submit a new enrollment application.

Common Miscellaneous Denials - Service Restriction

Edit 5115 -Service Not Allowed During Hospital Stay

This edit is triggered when a claim in history has a paid status and a COS of 010 Same Member, and Same or Overlapping DOS and Different Rendering Provider, and COS is one of the following 020, 070, 080, 200, 540, 541, 542, 590, 660, 680, 681, 770, 840, 930, 960, 970, 971, or 972**.**

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time	U
0	D	1	608	ADJUSTMENT WAS AUTODENIED	0639				9/13/2016 04:28:29	
1	D	2	5115	SERVICE NOT ALLOWED DURING HOSPITAL STAY - DTL	5115		SSI	GA	9/13/2016 04:28:29	

Method of Correction -Review Billed Dates on claim against the Service Provided Dates. Correct DOS and resubmit claim.

Note: Although a claim may have originally been paid for one of the above COSs, the system is set to automatically audit claims. This auditing may result in a reprocessing of claim and recoupment of money.

Common Miscellaneous Denials – EMA

Edit 2274 -Emergency Medical Assistance No Attachment

This edit is triggered when services for an EMA member are billed and no attachments are included.

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time
1	D	2	2274	EMERGENCY MEDICAL ASSISTANCE - NO ATTACHMENT - DTL	2278		EMA	GA	3/28/2016

Method of Correction -Review EMA Guidelines in the Part 1 Policy and Procedures Manual Section 208.

Note: Documentation must be submitted in the order it appears in section 208.
History and Physical, Admission Notes, Discharge Summary, Operative Report (if applicable), Physician Progress Notes, Deliveries or C-section claims only; Anesthesia claims only; Anesthesia report and L&D or C-Section Op reports.

Common Miscellaneous Denials – Sterilization

Edit 3402 -Sterilization Form Required -DTL (CMS 1500)

This edit is trigged at the detail level for CMS1500 claims and the header level for UB04 claims when the DMA-69 form is not attached for review.

DMA-69 Form -Informed Consent for Voluntary Sterilization.
DMA-69 Form -MUST be completed in its entirety on the first submission.

•Providers are NOT allowed to submit a corrected DMA-69 form.
•Guidelines can be found on the GAMMIS Web Portal under the Provider Information sub-category Provider Manuals.

Common Miscellaneous Denials – Inpatient Part B

Edit 1770 –Inpatient Part B Claims

This edit is triggered when an Inpatient Part B claim is received without the required EOB attachment

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer
0	D	0	1770	Inpatient Part-B Claims Require an EOB Attachment	1770			
0	P	1	3357	SERVICE IS DUE TO TRAUMA/ACCIDENT - ALERT TPL	0280			

Method of Correction –Attached the required documentation to the Inpatient Part B claim, for example, Medicare EOB for the Part B payment and Medicaid RA for the Part B payment).

If you can not locate the paid claim, contact Gainwell Technologies.

Common Timely Filing Denials

Edit: 512, 516, and 545 - Timely Filing

These edits are triggered when a claim is submitted outside of the six month or one year timeframe.

- Claim submission -Within six months of the DOS
- Claim adjustment -Within three months of the month of payment
- Claim resubmission -Within three months of the month the denial occurred
- Crossover claim -Within 12 months of MOS
- Secondary/TPL claim -Within 12 months of MOS

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.

One Year (365 Days) Claim Submission New Edits - 515 for DTL and 516 for HDR

(continued)

Example:

`

	Original Submit Claim	1st Resubmit	2nd Adjustment
DOS	**Denied Date:**	**Adjustment**	**(365 days)**
July 1, 2020	December 30, 2020	March 31, 2020	June 30, 2020

- All claim submissions and adjustments to denied claims are to be completed according to policy by 365 days. Other timely submission and resubmission system edits will remain in GAMMIS according to policy (there is no time limit for adjusting a claim that reverses payment back to the Department of Community Health).
- Please refer to the Georgia Medicaid Part 1 - Policies and Procedures Manual, Chapter 200. The Timely Resubmission policy outlined in Section 204 will still be enforced to include this new one year or 365 days guideline.

*Banner Message posted April 12, 2018

Common Service Limit Denials

Edit 6259 - Calendar Year Office Visits Exceeded

This edit is triggered when the member has exceeded 10 office visits within one year.

Method of Correction: Verify data on claim was captured correctly.

Note: Verify under Member Eligibility on the GAMMIS Web-Portal Service Limits Panel prior to the rendering of these services to avoid denial**.**

Edit 6694 - One Preventative Visit Per Calendar Year

This edit is triggered when the member has received more than one preventative visit within one calendar year**.**

Method of Correction: Verify data on claim was captured correctly**.**

Note: Verify under Member Eligibility on the GAMMIS Web Portal Service Limits Panel prior to the rendering of these services to avoid denial.

Common Miscellaneous Denials - Duplicate

Edit 5646/5042/5048 - Exact Duplicate

This edit is triggered when claim has the same member information, DOS, procedure code, modifier, and provider number as a history claim.

ICN	Member ID	Rendering Provider ID	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
[redacted]			02/09/2016	02/09/2016	PROFESSIONAL XOVER CLAIMS	DENIED	03/28/2016	$200.00	$0.00
			02/09/2016	02/09/2016	PROFESSIONAL XOVER CLAIMS	PAID	03/28/2016	$200.00	$0.00

Method of Correction - No correction is needed. Claim is an exact duplicate of a claim in the history file. Search claim panel with member ID, DOS, and Claim Type to locate paid claim in history.

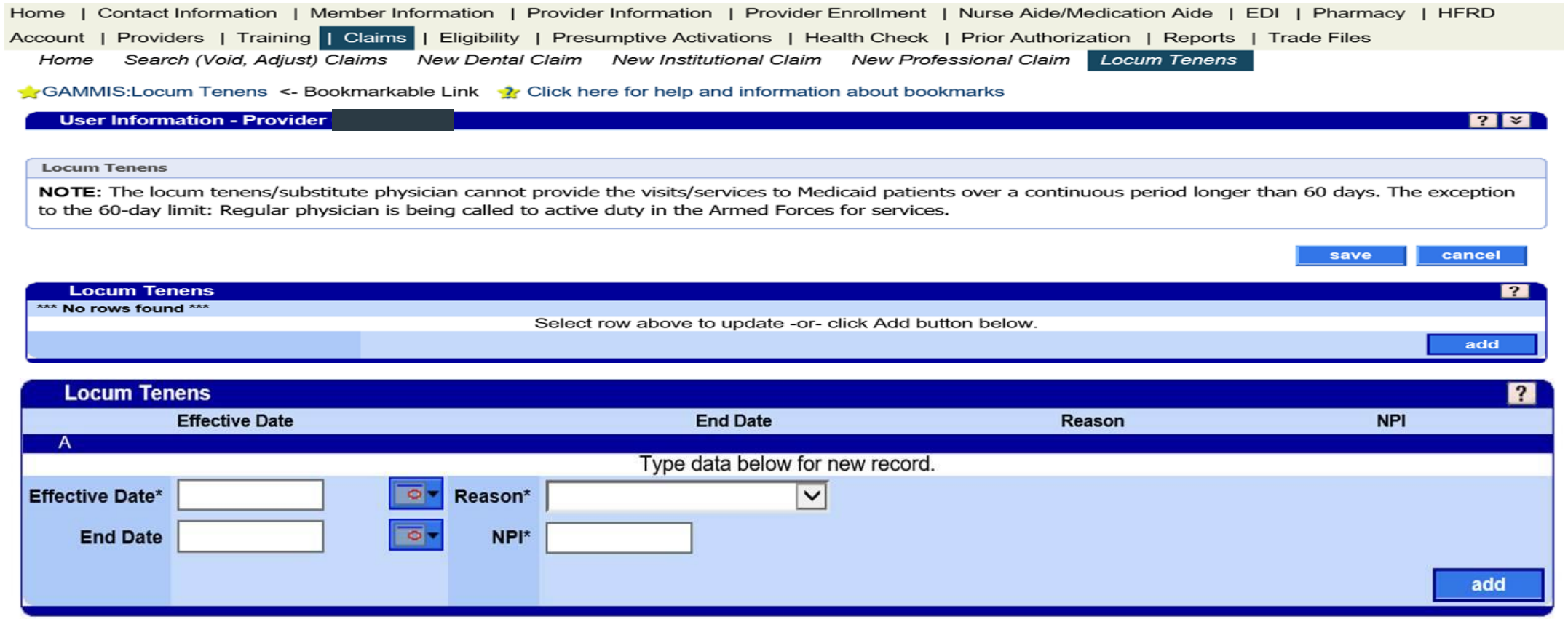
If you can not locate the paid claim, contact Gainwell Technologies.

Common Miscellaneous Denials – Locum Tenens

- Locum Tenens physicians are substitute physicians who take over regular physician's professional practices when the regular physician is absent.
- The regular physician pays the locum tenens physician for services provided on a per diem or similar fee-for-time basis.
- The locum tenens physician does not provide the visit services to Medicaid patients for a period of time exceeding 60 consecutive days.
- The locum tenens physician must be an enrolled Medicaid provider. The regular physician must place the locum tenens physician's provider number on the CMS1500 claim form.
- Services provided by locum tenens physician must be identified in the member's medical record held by the regular physician and must be available for inspection.
- Service furnished by Locum Tenens Physicians should be represented with the Q6 modifier.

Common Miscellaneous Denials – Locum Tenens

(continued)



Common Miscellaneous Denials – Inmate Claims

The Georgia Medicaid Management and Information System (GAMMIS) has not been configured to accept inmate claims; however, the Medicaid team is working with GDC to ensure that all eligible claims are processed and reimbursed. Once an inmate has been determined eligible, claims must be submitted to traditional (fee-for-service) Medicaid.

DCH is aware that the configuration challenges may result in multiple submissions of claims and timely refiling, prior approval/pre-certification and CMO denials. DCH will override timely filing edits, prior authorization/pre-certification edits, and CMO edits. All other denials must be properly corrected and updated before claims can be reconsidered. For GDC inmate claims to be processed, the Community Hospital and/or Provider must submit denied claims to DCH (Bridgette Drumwright at bdrumwright@dch.ga.gov **or** 404-463-2790.

All claim denials must be submitted on an Excel spreadsheet with the following information: Inmate's name, Medicaid identification number, GDC number, Date of Service, Denied ICN, Provider or Hospital name, and total claim amount. Please allow three pay cycles for the claim to reprocess for payment. The inmate claims are submitted on a weekly basis once received. The Hospital and/or Community Provider may recheck GAMMIS to research the claim status.
In reference to eligibility problems, contact **Rosalind Watson**, GCHC Eligibility specialist, at 706-721-5776 and/or **Sandra Duncan**, GCHC Medical Services Coordinator, at 706-721-5775.

Reimbursement is limited to services provided to inmates that have been admitted as an inpatient hospital stay greater or equal to 24 hours to a community hospital.

Working Your Denied Claims

Claims Management Tips

Reviewing, correcting, and re-submitting denied claims is central to your revenue management.

- Assign dedicated staff person to denials if possible.
- Document receipt of denials, reasons for denied payment and deadline for resubmission.
- Always review denial reasons (read twice, act once.)
- Make corrections involving missing or inaccurate info.
- Review clinical reasons for denial (service, diagnosis, etc.) with treating provider.
- Make any corrections possible.
- Re-submit claims in a timely manner.

Denials = revenue delay, revenue loss

You should now know…

- How to translate EOB/Remark codes
- How to avoid some Common Eligibility Denials by utilizing the Member Verification Panel
- How to avoid some Common Procedure Denials by utilizing the Procedure Search Panel
- How to understand and correct Common Claim Denials

Georgia Field Territories

Territory 1 N GA
Bartow, Catoosa, Chatooga, Cherokee, Dade, Dawson, Fannin, Floyd, Forsyth, Gilmer, Gordon, Habersham, Hall, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, Union, Walker, White, Whitfield

Territory 2 Atlanta
Fulton

Territory 3 NE GA
Banks, Barrow, Clarke, Elbert, Franklin, Gwinnett, Hart, Jackson, Madison, Oconee, Walton

Territory 4: NW GA
Carroll, Cobb, Douglas, Haroldson, Paulding, Polk

Territory 5: SE Metro
Clayton, DeKalb, Rockdale

Territory 6: Middle GA
Butts, Chattahoochee, Coweta, Fayette, Harris, Heard, Henry, Jasper, Jones, Lamar, Marion, Meriwether, Monroe, Muscogee, Newton, Pike, Spalding, Talbot, Taylor, Troup, Upson

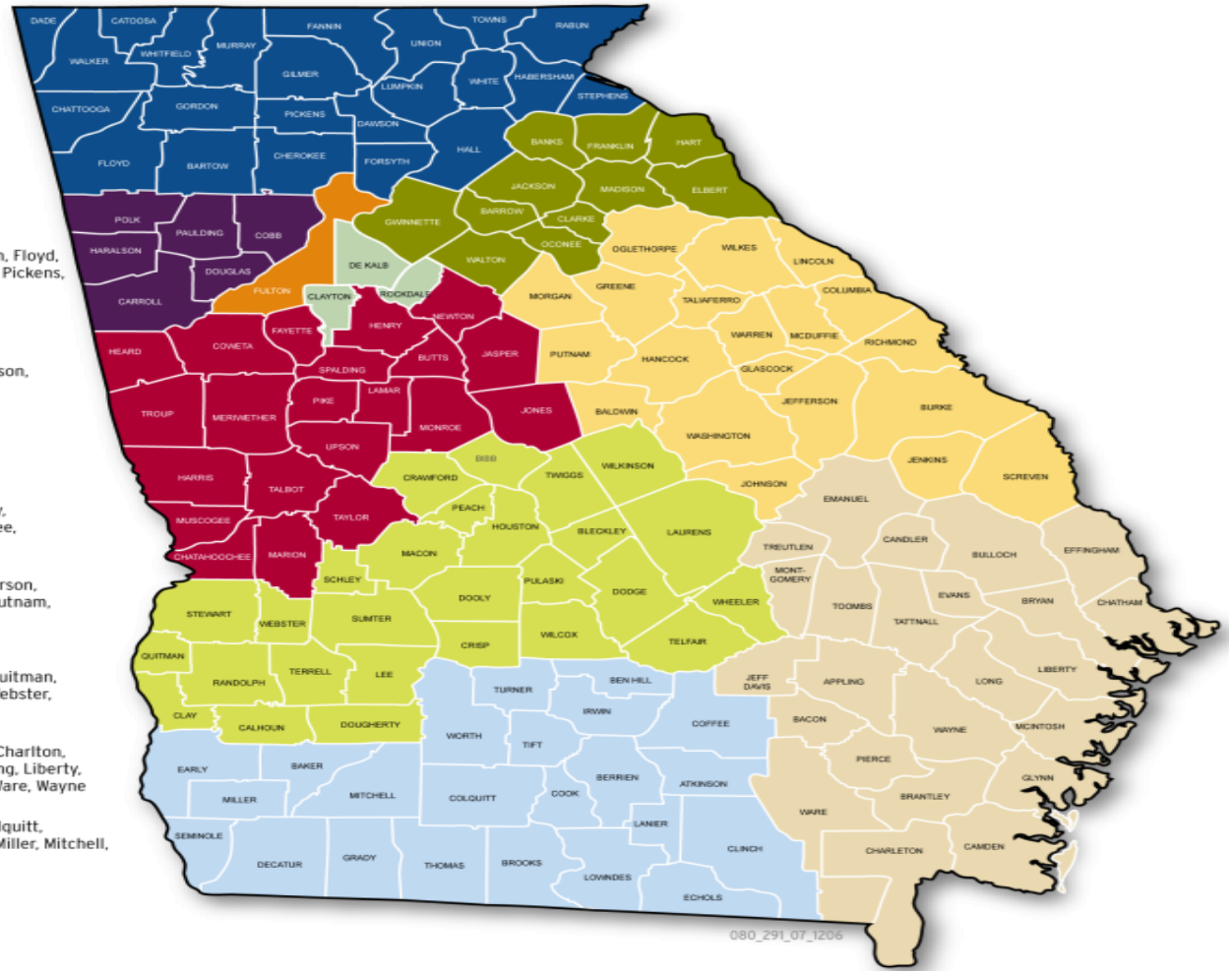
Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Territory 8: SW GA
Bibb, Bleckley, Calhoun, Clay, Crawford, Crisp, Dodge, Dooly, Dougherty, Houston, Laurens, Lee, Macon, Peach, Pulaski, Quitman, Randolph, Stewart, Schley, Sumter, Telfair, Terrell, Twiggs, Webster, Wheeler, Wilcox, Wilkinson

Territory 9: SE GA
Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Emanuel, Evans, Glynn, Jeff Davis, Long, Liberty, McIntosh, Montgomery, Pierce, Tattnall, Toombs, Treutlen, Ware, Wayne

Territory 10: South GA
Atkinson, Baker, Ben Hill, Barrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Tift, Turner, Worth

Territory 11 State Wide
Hospital Field Representative



Provider Relations Field Services Representatives

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	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

Provider Relations Field Services Representatives

State-Wide Consultants

Anita Hester
Sharée C. Daniels
Brenda Hulette

IVRS Overview

The Interactive Voice Response System (IVRS) allows users to call and conduct inquiries or transactions on the Georgia Medicaid Management Information System (GAMMIS) using a touch-tone telephone.

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

Contact Us

Our Provider Services Contact Center (PSCC)

can be reached at

800-766-4456

and is available 7 a.m. to 7 p.m. EST

Monday through Friday (except state holidays) for service inquiries**.**

Please note the Web Portal is available 24/7

Questions?

Thank you

Contact
brand@gainwelltechnologies.com
gainwelltechnologies.com

Gainwell Technologies
1775 Tysons Blvd.
McLean, VA 22102