Georgia Medicaid Common Denials Presentation

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

Live YouTube Link: https://youtu.be/rexZyvN7D7I

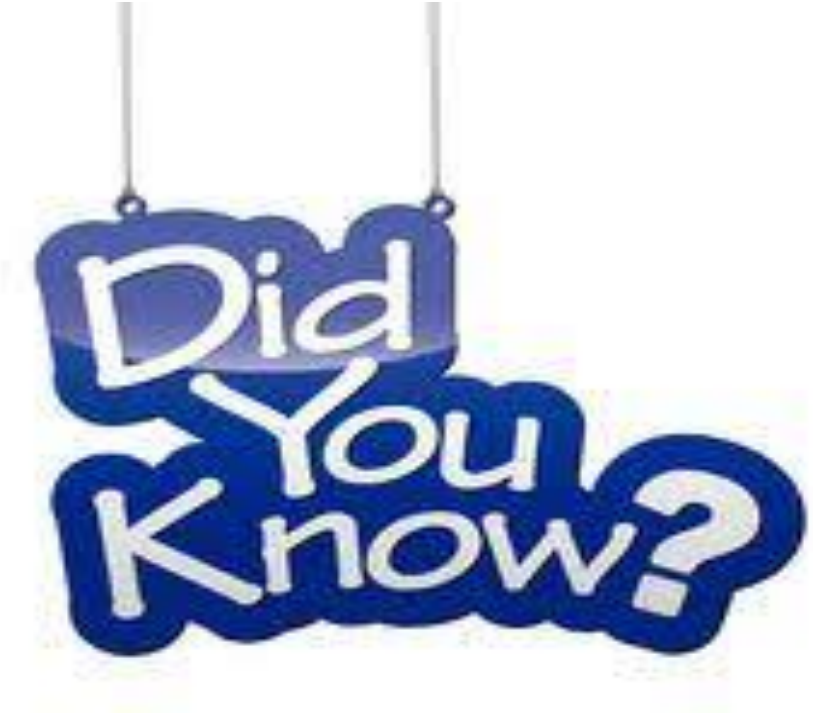
Georgia Department of Community Health

gainwell

Agenda

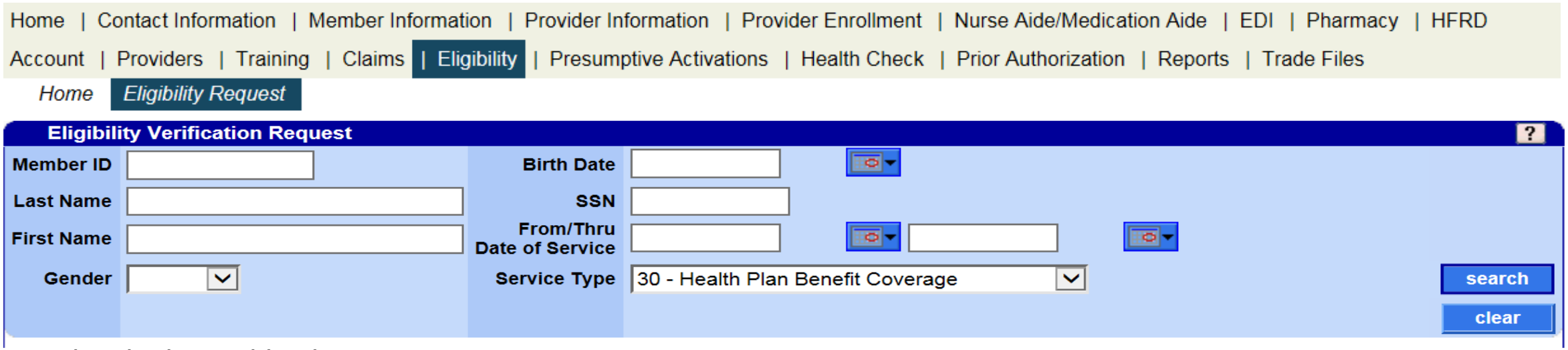
- Common Eligibility Denials
- Common Procedure Code Denials
- Common Hospital Denials
- Common Miscellaneous Denials
- Contacting Gainwell Technologies
- Closing - Questions and Answers

Common Eligibility Denials



- The most common eligibility denials come from NOT checking the member's eligibility.
- Over the last 3 months there have been more than 500,000 eligibility denials.

Common Eligibility Denials



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 only partial eligibility was found on detail DOS.

Edit 2017/2019 - 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)

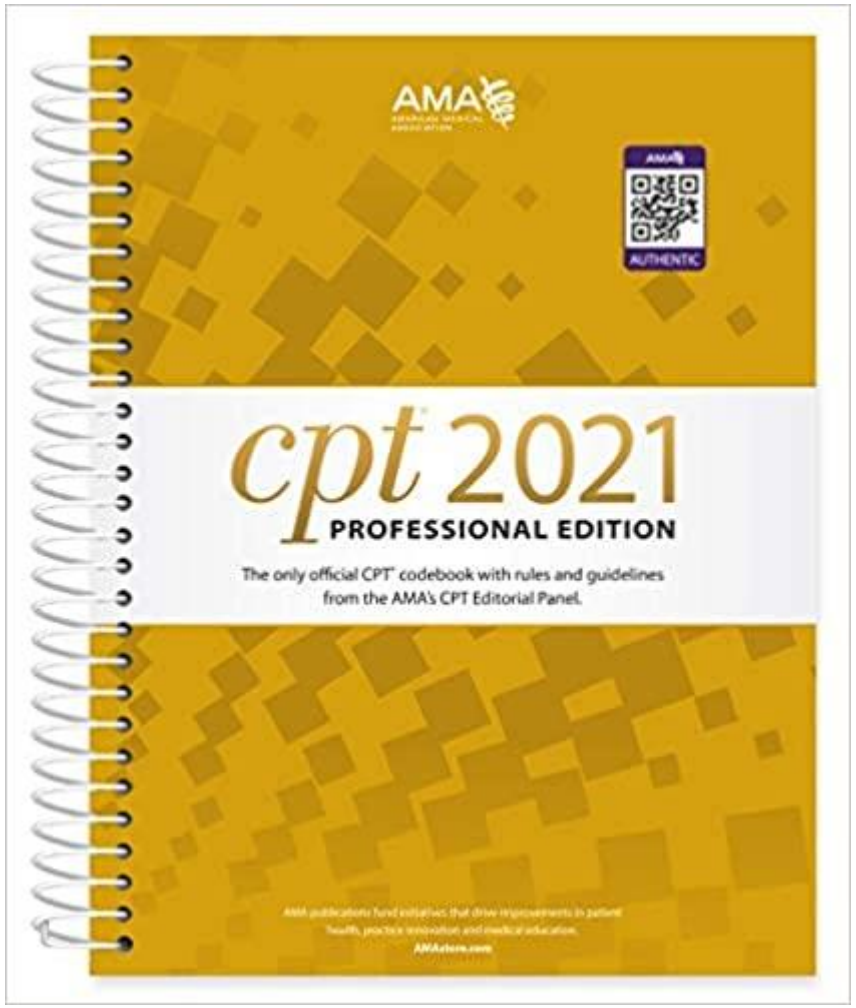
COB Updates

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 at www.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.

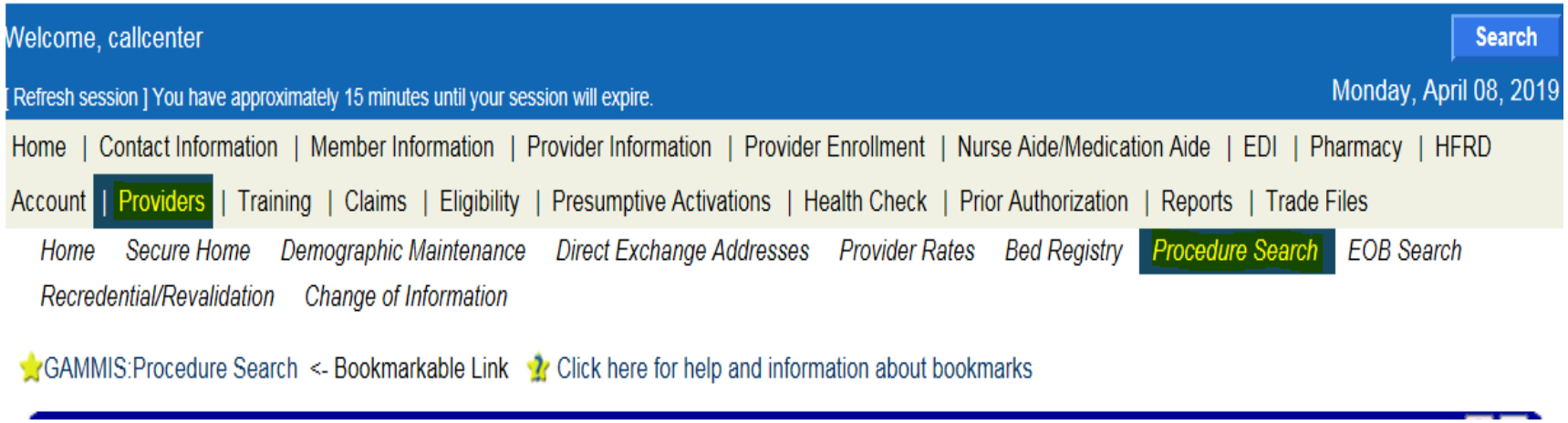
Note: Providers need to continue using the paper DMA-410-Form for Section I: Co-Payment Notification, and Section II: COB Non-Coverage Affidavit.

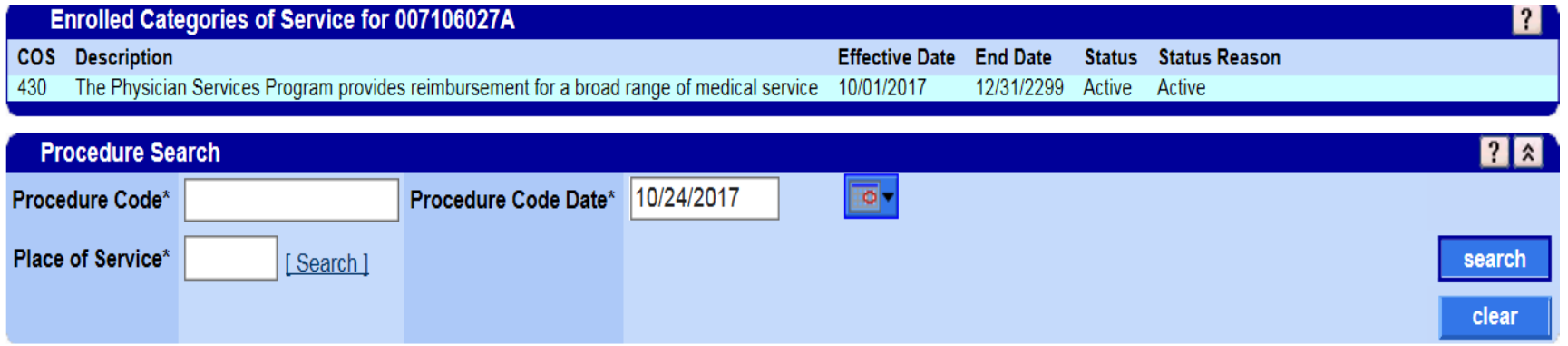
Common Procedure Code Denials



Common Procedure Code Denials

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)

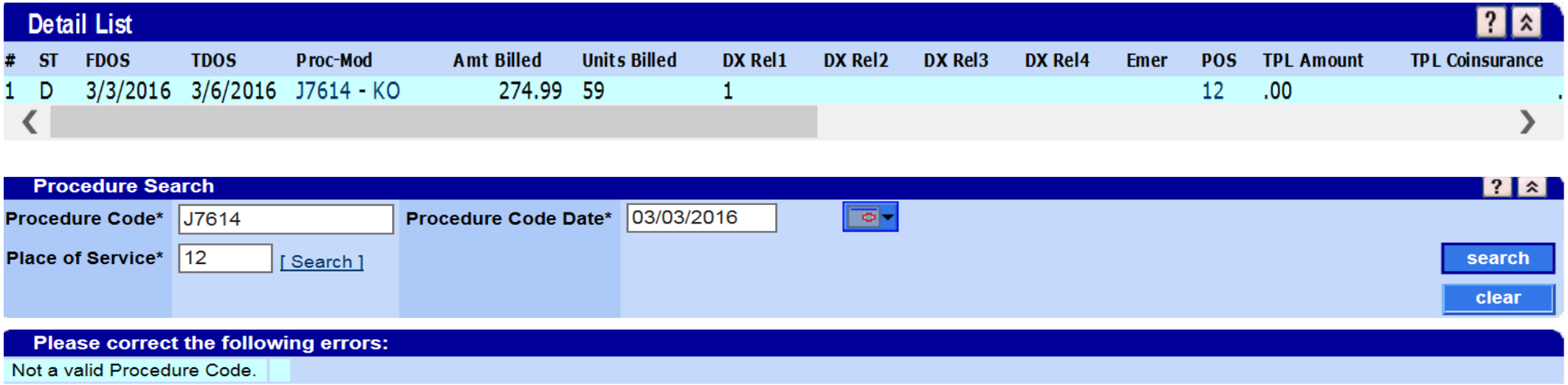
COS	Claim Type	Modifiers	Min Age	Max Age	Gender	From	Thru	PA Required
010						01/01/2000	12/31/2299	Z - Yes Precert is required
070		Including 0-3 from 95 GQ GT				01/01/2017	12/31/2299	N - No PA is not required
080						01/01/2000	12/31/2299	N - No PA is not required
200	C					07/01/2000	12/31/2299	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.



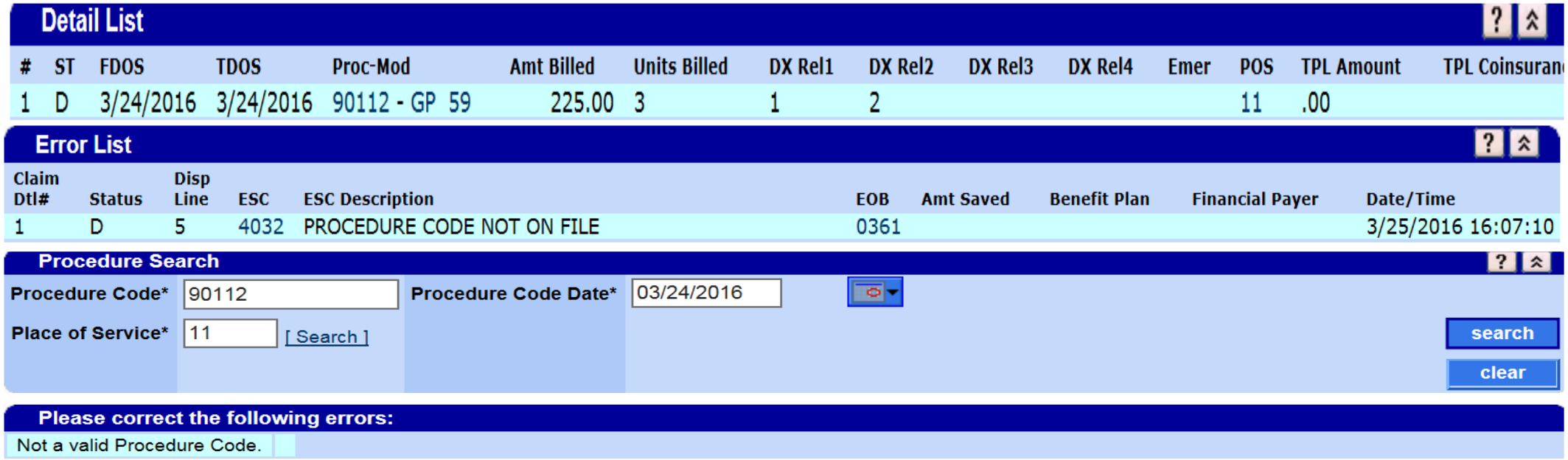
Method of Correction - Review the Part 2 program specific manual to determine what codes are billable and check the Procedure Search panel to determine the billing rules for the code**.**

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.

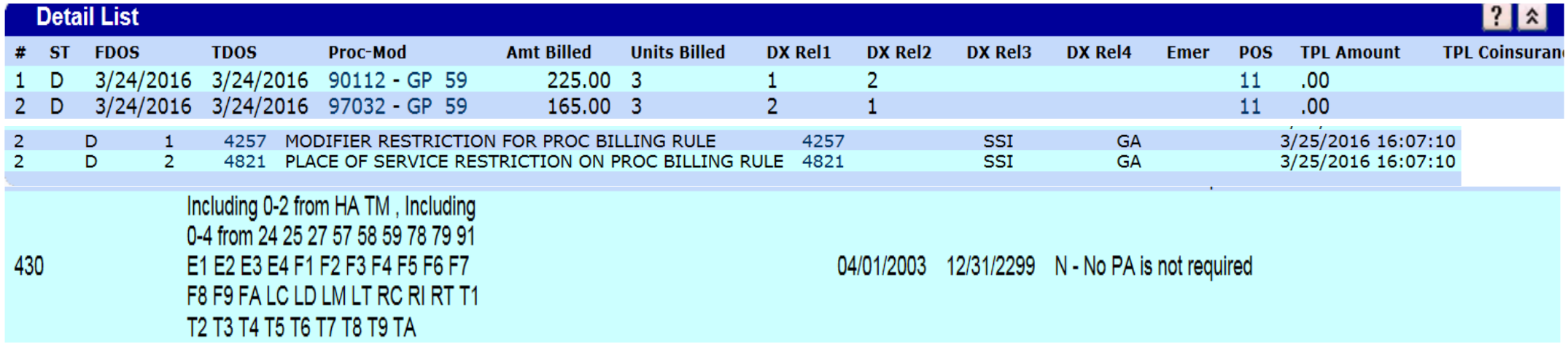
Method of Correction -Review the Part 2 program specific manual to determine what codes are billable and also check the Procedure Search panel to determine the billing rules for the code**.**

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 Hospital Denials

Common Hospital Denials - Diagnosis

Edit 4039 - Diagnosis Cannot Be Used As Principal Diagnosis

This edit is triggered when the diagnosis code on the claim is not allowed to be used as a principal diagnosis.

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time
0	D	2	4039	DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS	4039				1/7/2020 13:33:28

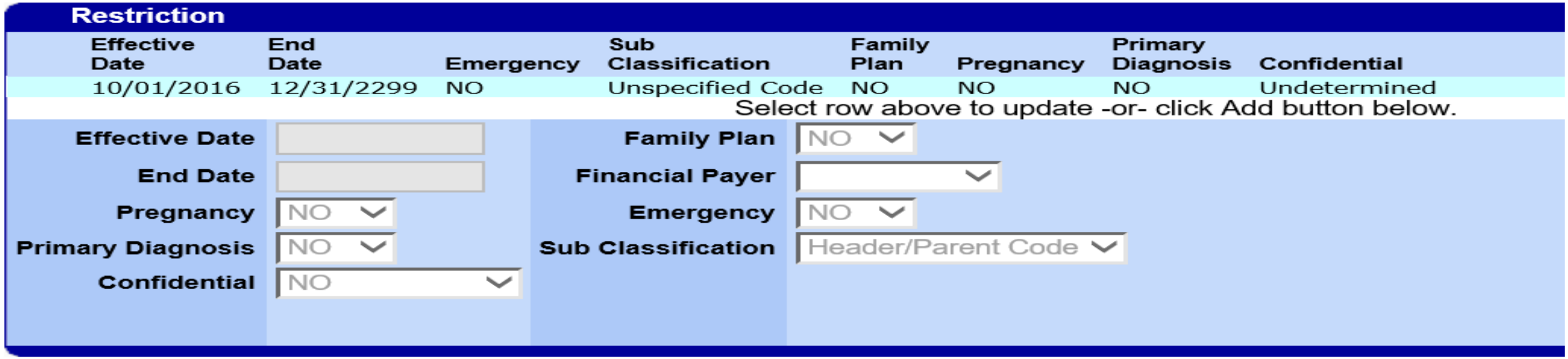
Claim Diagnosis

Seq Code	Diagnosis Code	ICD	Description	Qualifier	POA
1	O34.219	ICD-10	MATERNAL CARE FOR UNSP TYPE SCAR FROM PREVIOUS CESAREAN DEL	ABK	Y - Yes
2	Z37.0	ICD-10	SINGLE LIVE BIRTH	ABF	W-Clinically Undetermined(4010) / Not Applicable(5010)
3	Z20.822	ICD-10	CONTACT WITH AND (SUSPECTED) EXPOSURE TO COVID-19	ABF	Y - Yes
4	O76	ICD-10	ABNLT IN FETAL HEART RATE AND RHYTHM COMP LABOR AND DELIVERY	ABF	N-No
5	O77.0	ICD-10	LABOR AND DELIVERY COMPLICATED BY MECONIUM IN AMNIOTIC FLUID	ABF	Y - Yes
6	Z3A.39	ICD-10	39 WEEKS GESTATION OF PREGNANCY	ABF	W-Clinically Undetermined(4010) / Not Applicable(5010)
7	O34.73	ICD-10	MATERNAL CARE FOR ABNLT OF VULVA AND PERINEUM, THIRD TRI	ABF	Y - Yes
8	N90.812	ICD-10	FEMALE GENITAL MUTILATION TYPE II STATUS	ABF	Y - Yes
99	775			DR	
A	O80	ICD-10	ENCOUNTER FOR FULL-TERM UNCOMPLICATED DELIVERY	ABJ	

Common Hospital Denials - Diagnosis

Edit 4039 - Diagnosis Cannot Be Used As Principal Diagnosis

This edit is triggered when the diagnosis code on the claim is not allowed to be used as a principal diagnosis.



Method of Correction -

1. Confer with Coding Dept. to review diagnosis is appropriate
2. Resubmit the claim with the appropriate code

Common Hospital Denials – Inpatient Part B Only

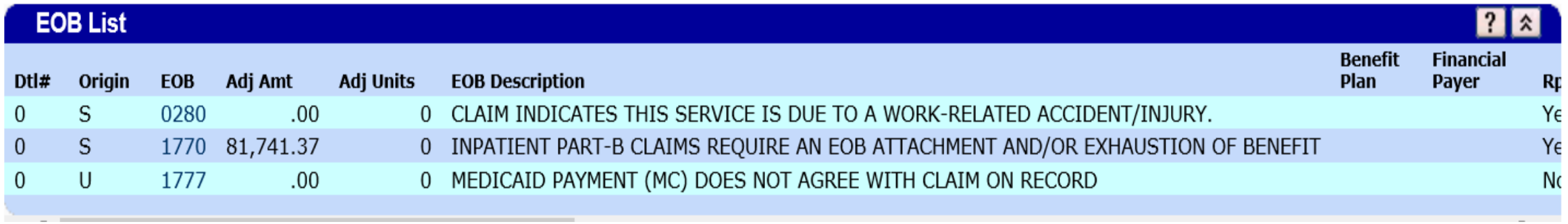
Edit 1770 - Inpatient Part-B Claims Require an EOB Attachment
Edit 1771 - Inpatient Part-B Claims Req Valid Medicare (MB) Prior Payment Amount
Edit 1772 - Inpatient Part-B Claims Req Valid Medicaid (MC) Prior Payment Amount
Edit 1774 – One of the following attachments is missing:
Medicare Part B EOMB for dos or exhaustion of Benefits letter/DMA460
Edit 1775- DOS on claim does not match dos on EOB
Edit 1776 – Medicare payment (MB) does not agree with EOB
Edit 1777 – Medicaid Payment (MC) does not agree with EOB

These edits are triggered when an Inpatient Part B claim requires additional information

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description	Benefit Plan	Financial Payer	F
0	S	3394	.00	0	TOTAL CHARGES EXCEED THRESHOLD AMOUNT			Y
0	S	1770	628,062.00	0	INPATIENT PART-B CLAIMS REQUIRE AN EOB ATTACHMENT AND/OR EXHAUSTION OF BENEFIT			Y
0	U	1776	.00	0	MEDICARE PAYMENT (MB) DOES NOT AGREE WITH EOB			N

Common Hospital Denials – Inpatient Part B Only



EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description	Benefit Plan	Financial Payer	Rp
0	S	0280	.00	0	CLAIM INDICATES THIS SERVICE IS DUE TO A WORK-RELATED ACCIDENT/INJURY.			Ye
0	S	1770	81,741.37	0	INPATIENT PART-B CLAIMS REQUIRE AN EOB ATTACHMENT AND/OR EXHAUSTION OF BENEFIT			Ye
0	U	1777	.00	0	MEDICAID PAYMENT (MC) DOES NOT AGREE WITH CLAIM ON RECORD			Nc

Method of Correction - Attach the required documentation to the Inpatient Part B Only claim.

Medicare EOB (MB) for the Part B payment
Medicaid EOB (MC) for the Part B payment.
This should be done even if the payment is zero.

There is an Inpatient Part B Only presentation available on the GAMMIS website August 2020 under Provider Information > Provider Notices.

Common Hospital Denials - Eligibility

EDIT 2078 - Member has Partial Eligibility for Detail DOS

This edit is triggered when only partial eligibility was found on detail DOS.

The member was admitted into the hospital as Medicaid. The member's primary insurance effective date occurred after date of admission. The Medicaid eligibility effective date was 01/01/2021. The primary insurance (XYZ) was effective 01/15/2021. The member was admitted into the hospital on 01/01/2021 and was discharged 02/17/2021.

Method of correction:

- Submit the claim to the primary payor first
- Obtain the precertification from Medicaid for the entire stay
- DOS should be from 01/01/2021 to 02/17/2021, the exact dates that the member was eligible for Medicaid
- Enter the amount paid by XYZ health insurance
- Attach EOB from primary payer

Multiple Authorizations on Same Date of Service

EDIT 3050 - Procedure code in claim not on PA file

This edit is triggered when Providers receive multiple authorizations due to the location that services are being rendered

Method of Correction:

Claims must be submitted separately to GA Medicaid. Each claim should contain the services related to that authorization.
One of the claims will pay- the other claim will deny as an (edit 5190) exact duplicate.
Submit a DMA-520 to Gainwell Technology stating why the claim is not a duplicate claim.

Note: Both claims should have the same date of service.

Common Miscellaneous Denials

Common Miscellaneous Denials

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

Edit 1823 – HDR Attend 1 Prov Cannot Order/Refer/Prescribe-HDR

This edit is triggered when the attending provider is not active for the category of service.

Error List

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB
0	D	1	1823	HDR ATTEND 1 PROV CANNOT ORDER/REFER/PRESCRIBE-HDR	1823
0	P	1	3394	TOTAL CHARGES EXCEED THRESHOLD AMOUNT - IN STATE	3394
0	P	3	4605	NEVER EVENT IDENTIFIED BY HAC DIAGNOSIS - HDR	4605
1	D	1	1822	HDR ATTEND 1 PROV CANNOT ORDER/REFER/PRESCRIBE-DTL	1822
1	D	5	3427	HCPCS CODE MUST BE LABORATORY	3427
2	D	1	1822	HDR ATTEND 1 PROV CANNOT ORDER/REFER/PRESCRIBE-DTL	1822

Search Results (2 rows returned)

National Provider ID	Medicaid Provider ID	Base Provider ID	Tax ID	Contract	Contract Status	Contract Effective Date	Name	Address	City	State	Zip	County
				998	Active	07/01/2017						
				430	Active	09/01/2021						

Common Miscellaneous Denials

Method of Correction - Verify the providers contract category of service 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.

Ordering, Prescribing and Referring (OPR)

- Affordable Care Act requirement to mitigate waste, fraud, and abuse.
- Will require ordering practitioners to enroll as Ordering Providers only (not billable) in GAMMIS.
- All services must be recommended (“ordered”) by a physician or other appropriately licensed practitioner. The practitioner(s) authorized to recommend/order specific services may be found within:

Part I Policies and Procedures For Medicaid/Peachcare For Kids Manual

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**.** Please be advised that the 10 allotted office visits are shared amongst ALL providers, with the exception of providers that have obtained an individual prior authorization for additional visits.

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.

Timely Filing

Common Timely Filing Denials

Edit: 512 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

A claim is considered a new claim if there are any changes made to the claim after the initial submission (total charges, dates of service, revenue codes, etc.). Therefore, the six months for timely filing will apply to the claim that has been edited. Regardless if the prior submitted claims were kept timely in the system.

One Year (365 Days) Claim Submission New

Edit: 515 for DTL and 516 for HDR

Example:

	Original Submit Claim	1st Resubmit	2nd Adjustment
DOS	**Denied Date:**	**Adjustment**	**(365 days)**
July 1, 2020	December 30, 2020	March 31, 2021	June 30, 2021

- 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

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.
- Resubmit claims in a timely manner.

Denials = revenue delay, revenue loss

You should now know…

- 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
- How to understand and correct Common Hospital 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

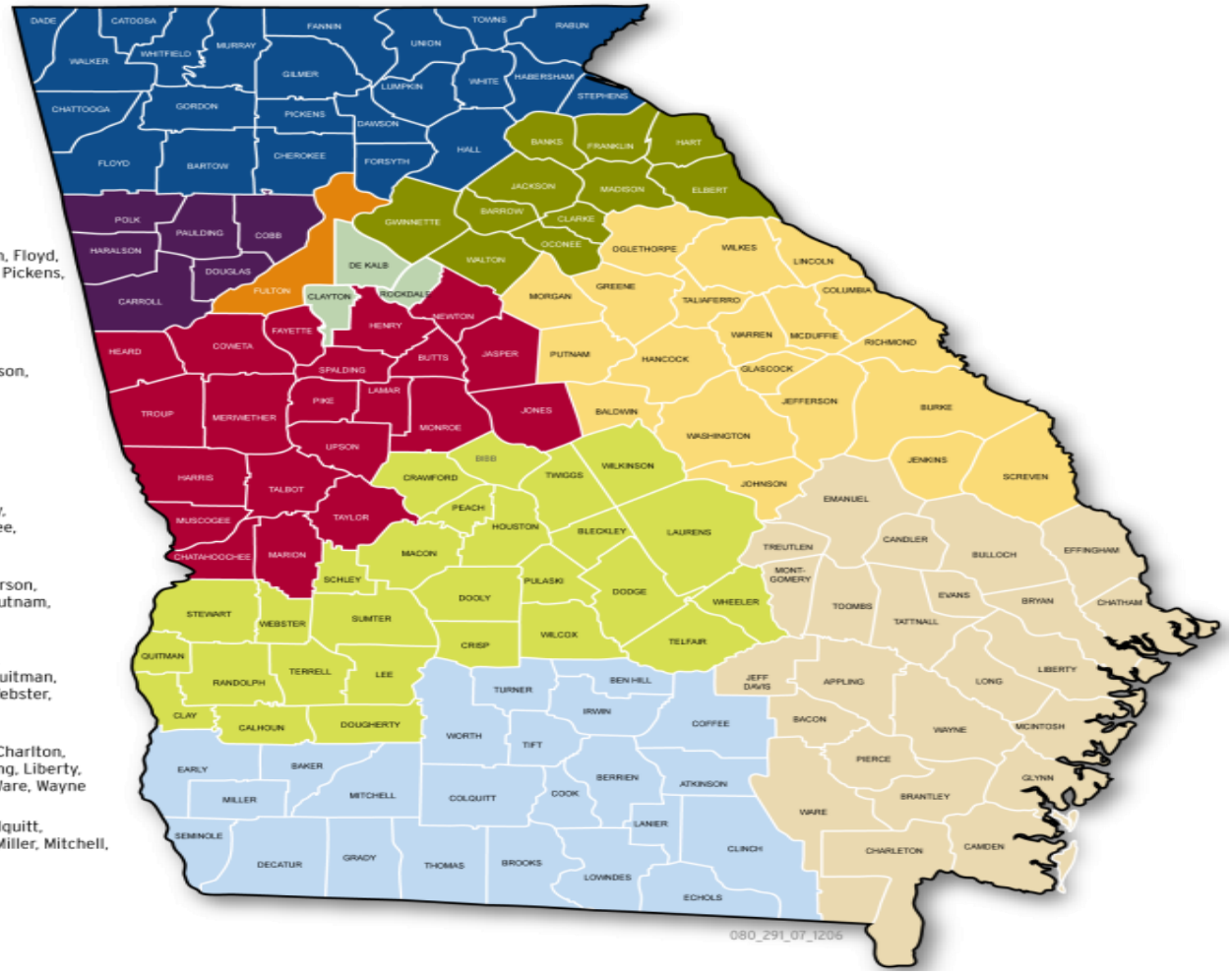
Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

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	Mercedes Liddell
2	Fulton	DeAndre Murray
3	NE Georgia	Carolyn Thomas
4	NW Georgia	Vacant
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 Bentley
South	Hospital Rep	Janey Griffin

Provider Relations Field Services Representatives

State-Wide Consultants

Sharée C. Daniels
Brenda Hulette
Danny Williams

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
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