Medicaid MMIS Web Portal Basics

gainwell

Agenda

- MMIS Web Portal Basics
- Member Eligibility
- Prior Authorization Research
- Claim Submission & Claim History Research
- Timely Filing
- Provider Claim Appeal
- Accessing the Remittance Advice
- Contacting Gainwell Technologies
- Overview of the Interactive Voice Response
- Session Review
- Closing, Questions, and Answers

MMIS Web Portal Basics

Eligibility Verification

(continued)

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

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

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

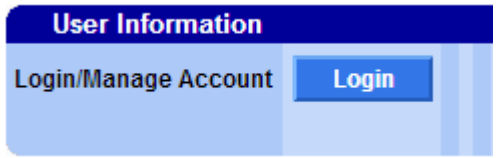
Eligibility Verification

- 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?
  - Is the member in a CMO? If so, which CMO?

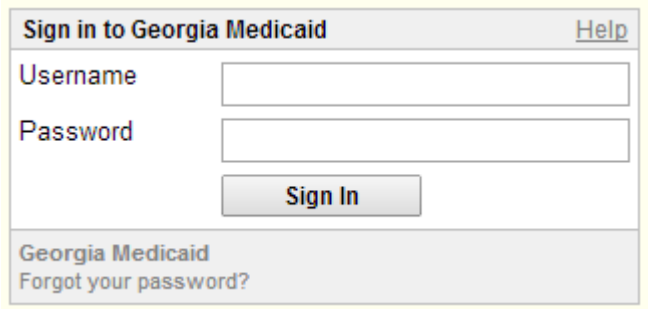
Logging into the Secure Web Portal

To get started, login to the secure GAMMIS Web Portal at www.mmis.georgia.gov.

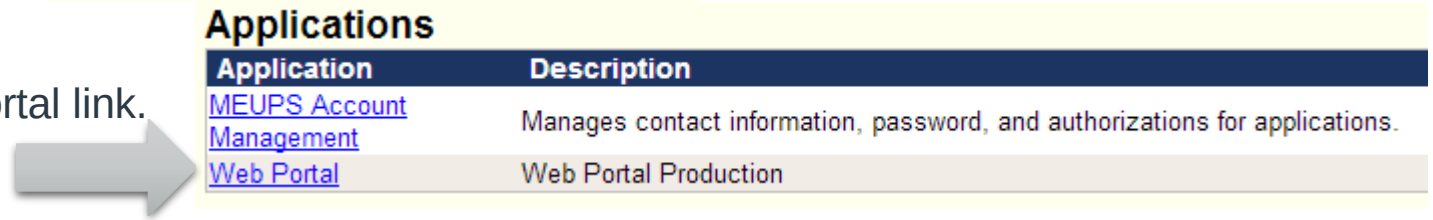
Click the Login button.



1. Enter your Username and Password and click the Sign In button.



2. Click the Web Portal link.

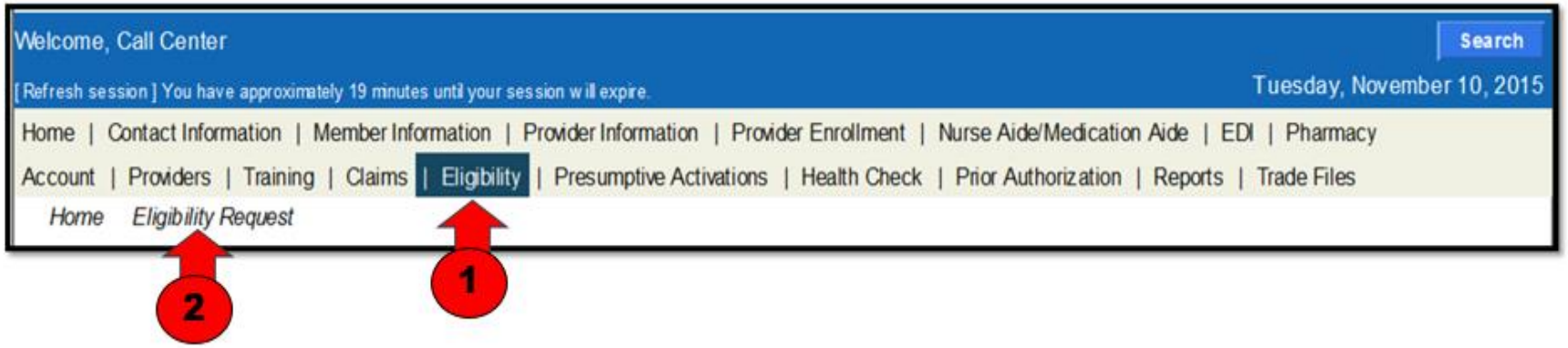


NOTE: If acting as a billing agent, please select the appropriate provider ID from the Switch Provider panel to begin navigating on behalf of that provider.

Eligibility Verification

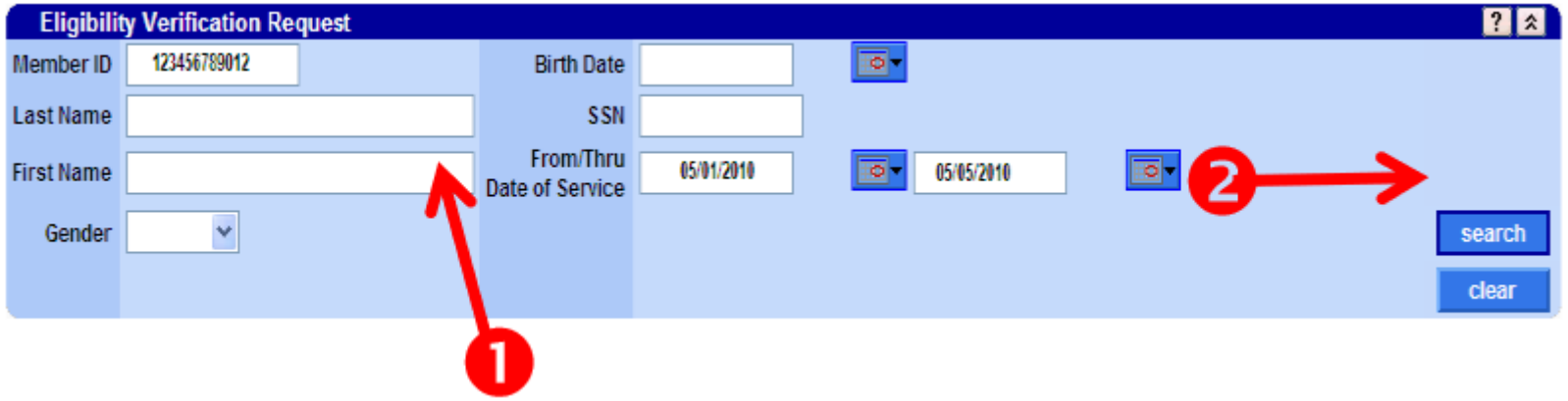
(continued)

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



Eligibility Verification

(continued)



Member ID Information

Member ID	[redacted] Member Transactions	First Name	TEST MEMBER
Birth Date	04/14/1991	Last Name	MEDICAID FAIR
Address 1	2 PEACHTREE ST NW	Middle Initial	
Address 2(County)	060 - FULTON	Name Suffix	
City	ATLANTA	Gender	F
State	GA	Transaction Date/Time	06/05/2019 09:27:45
Zip	30303-3141	Confirmation #	19156000EN

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	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	MEDICAID

Managed Care

Provider Name	Plan Name	Provider Phone	Effective Date	End Date
PEACH STATE HEALTH PLAN - ATLANTA	Georgia Families	(866)674-0633	06/05/2019	06/05/2019

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	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	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	06/05/2019	06/05/2019				
Active	35 - Dental Care	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	
Active	47 - Hospital	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	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	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	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	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	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	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	
Active	88 - Pharmacy	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	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	98 - Professional (Physician) Visit - Office	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	2.00	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	AL - Vision (Optometry)	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	1.00	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	MH - Mental Health	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	
Active	UC - Urgent Care	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	

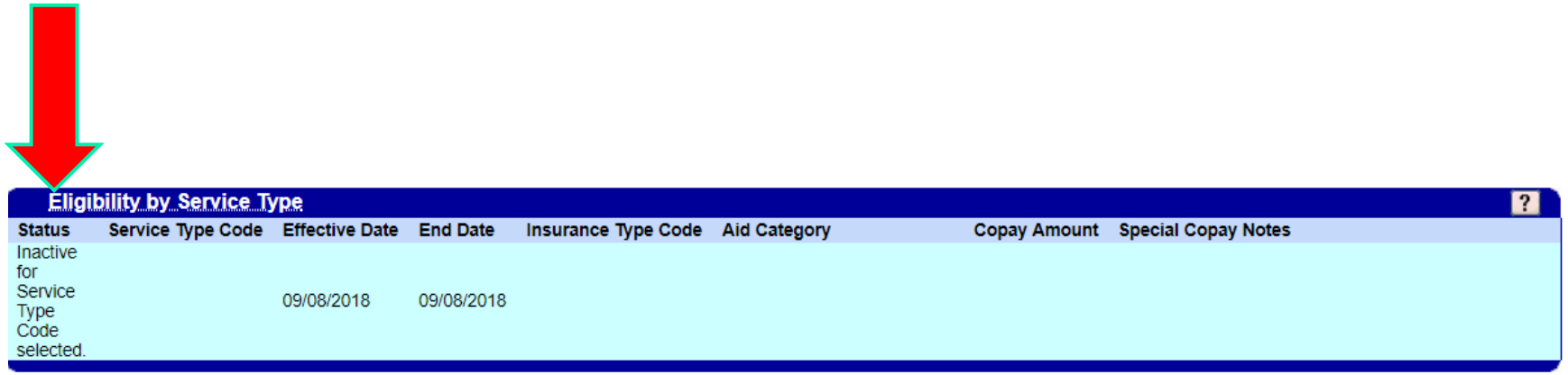
Service Limits

Benefit Information	Procedure Code	Units/Amount Allowed	Units/Amount Used	Time Period
6259 CALENDAR YEAR OFFICE VISITS EXCEEDED		10	3	23 - 1 Calendar Years

Eligibility Verification

(continued)

Member's Eligibility is Inactive with no Medicaid Benefits.



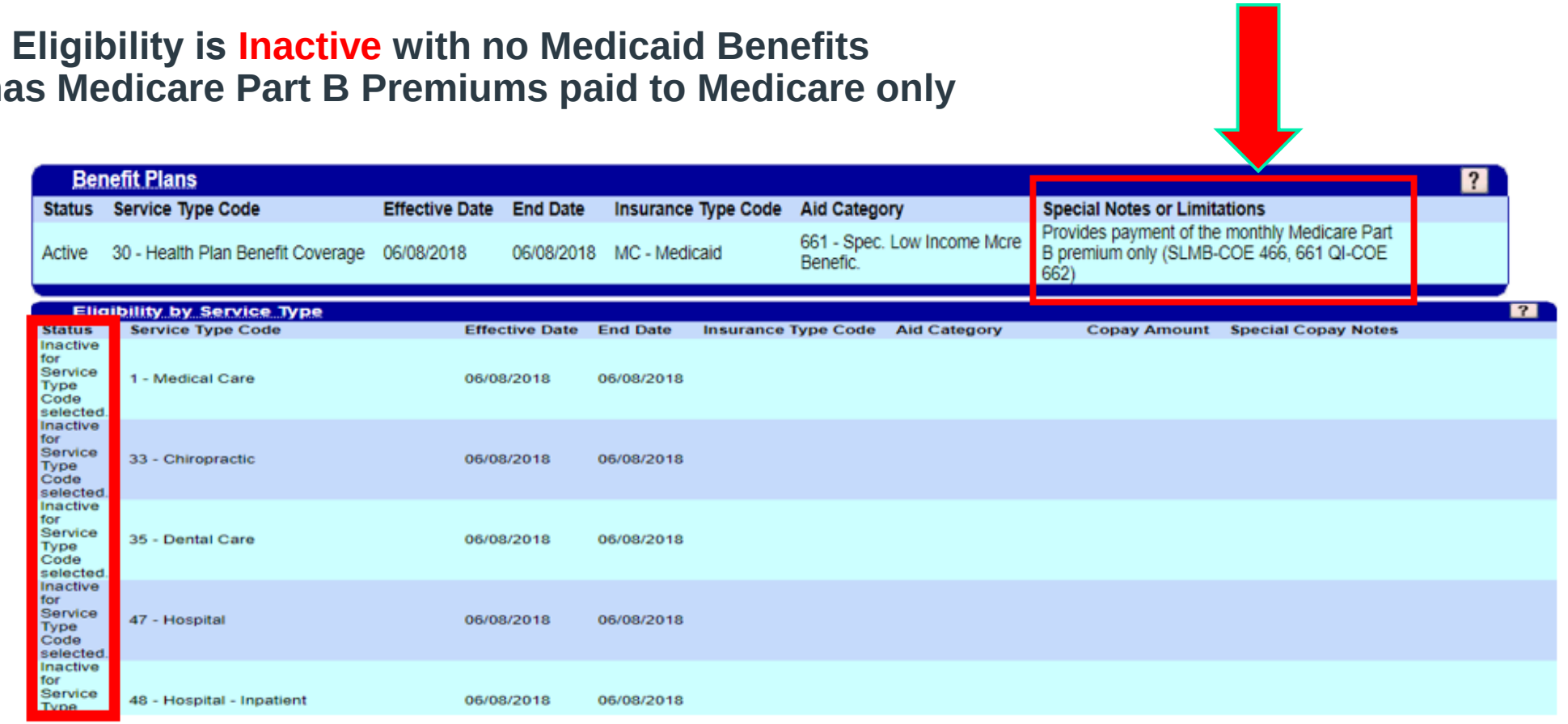
Eligibility by Service Type

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				

Eligibility Verification

(continued)

Member's Eligibility is Inactive with no Medicaid Benefits
Member has Medicare Part B Premiums paid to Medicare only



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				

Eligibility Verification

(continued)

- ***This member has CCSP Medicaid – Payment for CCSP Services***
- ***QMB Medicare Part A and Medicaid as secondary & covers coinsurance and deductible up to Medicaid allowed amount only.***

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.)

CCSP Benefits

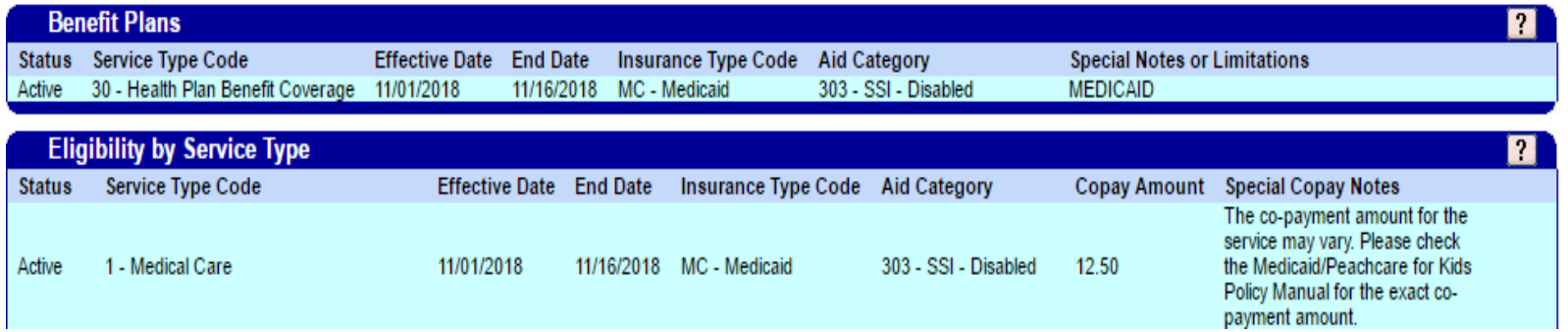
Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	1 - Medical Care	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.

Eligibility Verification

(continued)

Member has Active SSI Medicaid Benefits



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.

Eligibility Verification

(continued)

Retroactive eligibility claims must be received by the division within (six) months after the date in which the determination of retroactive eligibility was made.

Retroactive Eligibility

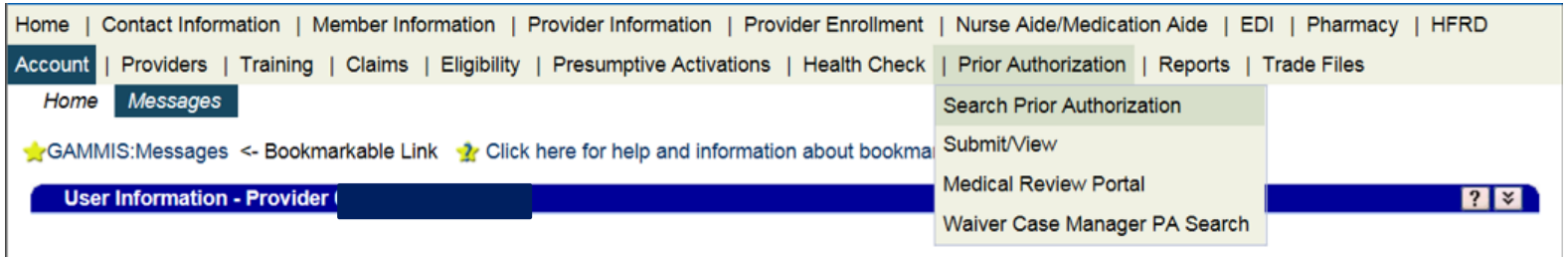
Retroactive Begin Date	Retroactive End Date	Retroactive Eff (Update) Date
06/08/2018	06/08/2018	08/11/2018

Prior Authorization Search

Prior Authorization Search

Visit: www.mmis.georgia.gov

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



Prior Authorization Search

(continued)

Visit: www.mmis.georgia.gov

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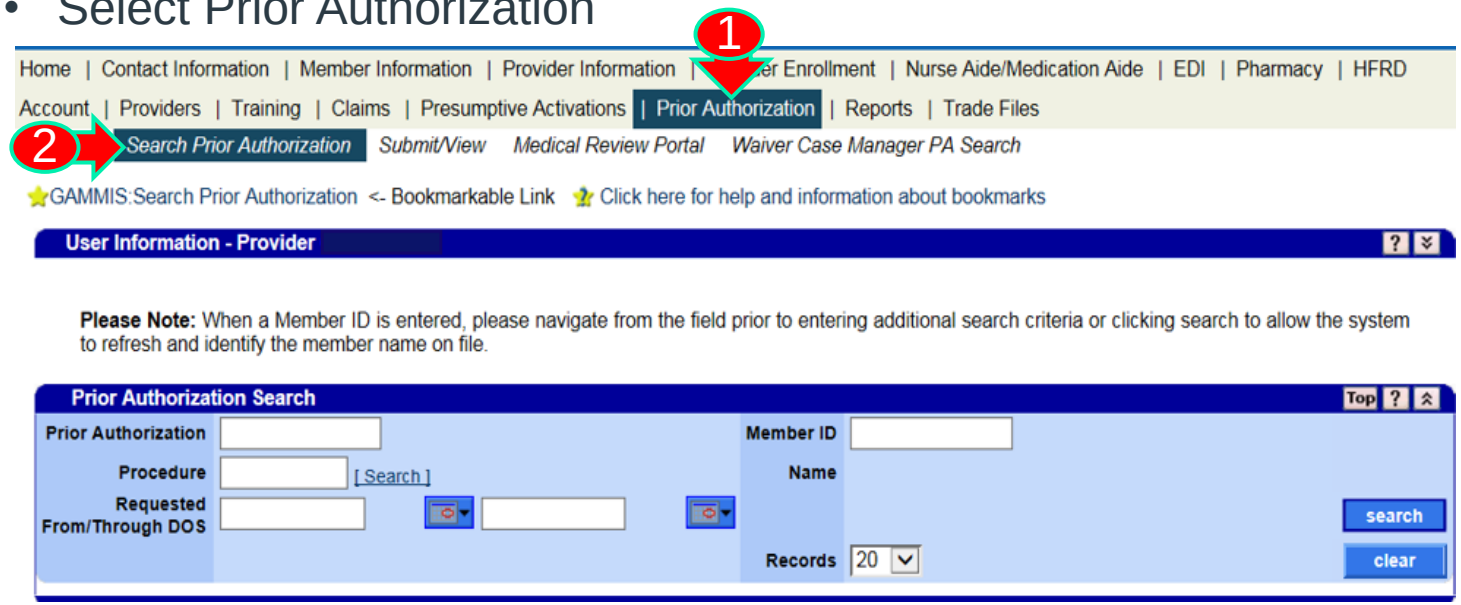


Search for a Prior Authorization 1 of 2 ways:

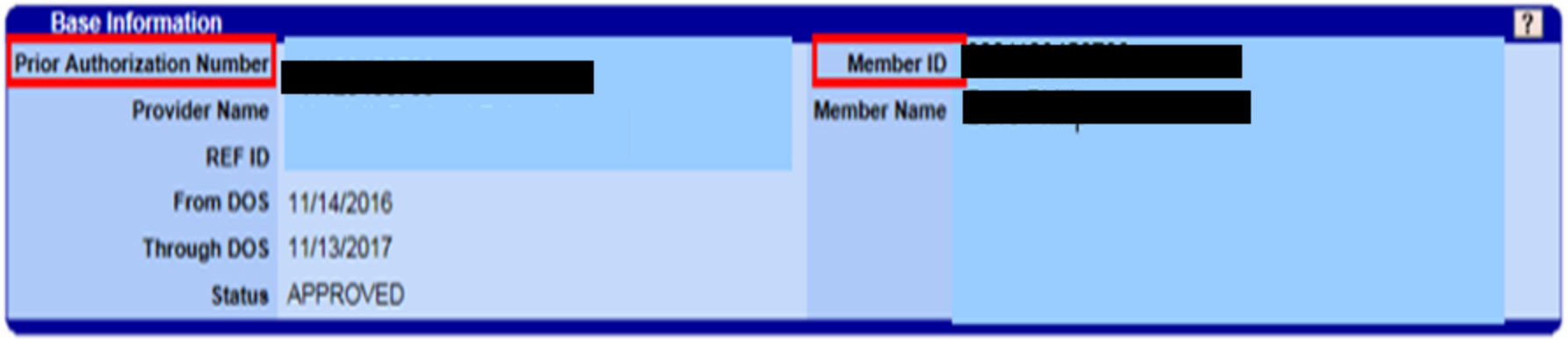
- Enter the member's prior authorization number and select search

Or

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

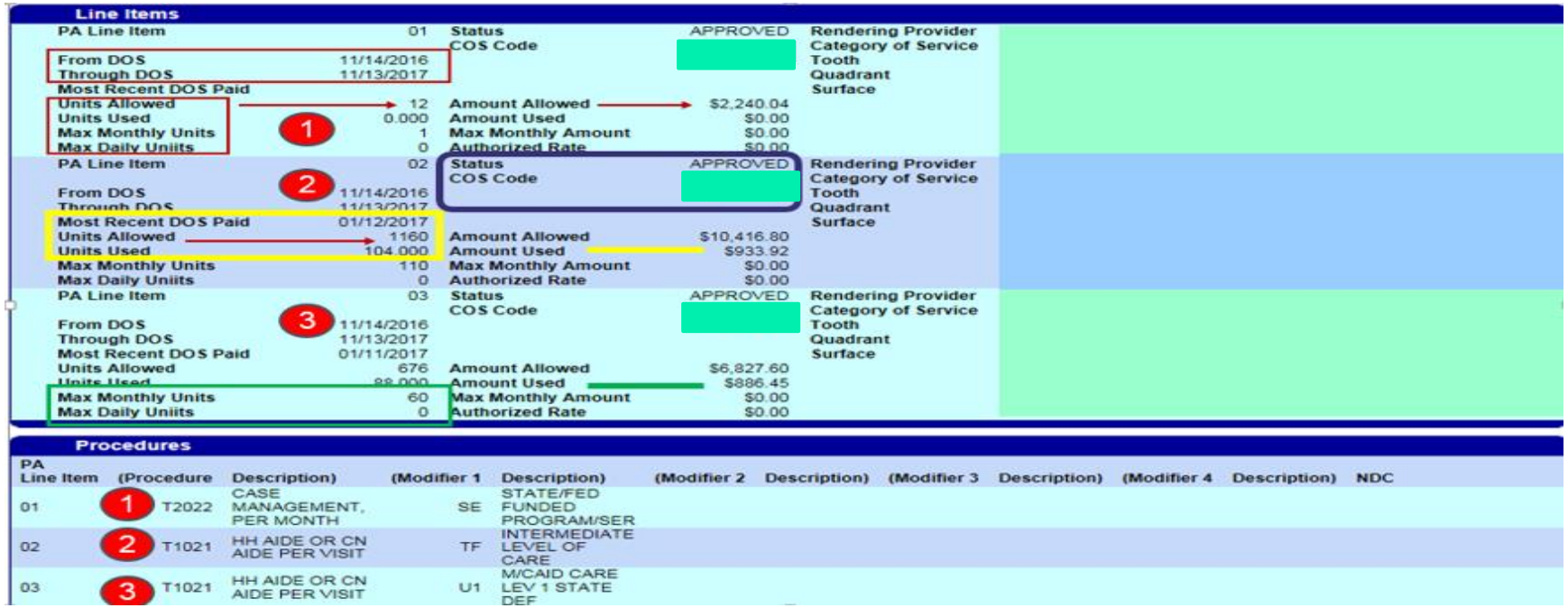
Prior Authorization Search

(result example)



Prior Authorization Search

(continued)



Acceptable Claim Types and Submissions

The provider can submit the following claim types:

- Professional – CMS 1500

Claims, Claim adjustments, and Claim resubmissions can be submitted via:

- Electronically through a clearinghouse (None PSS & CLS Services)
- Through the Georgia Medicaid Web Portal (None PSS & CLS Services)
- EVV Software (PSS and CLS claims)

Personal Support Services (PSS) or Community Living Supports (CLS) through SOURCE, CCSP, NOW, COMP, ICWP, and / or GAPP, all Electronic Visit Verification (EVV)-related claims as designated by the 21st Century Cures Act are required to include EVV information and be submitted via the State EVV solution, Netsmart software

Rate and Unit References

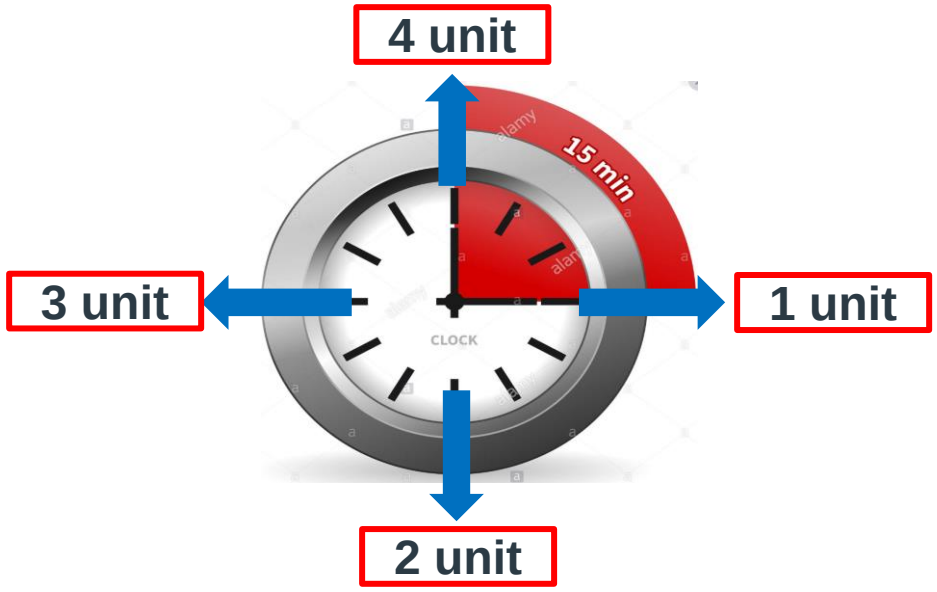
- Comprehensive Support Waiver Program Manual Chapters 1300 – 3600
  Appendix A – Reimbursement Rates for “COMP” Services

- New Options Waiver Program Manual Chapters 1300 – 3400
  Appendix A – Reimbursement Rates for “NOW” Services

Billing and Unit Calculation Example

- **NOW/Comp Example:**

Description	Procedure Code	Modifier	Rate
Community Living Support	T2025	U5	$6.35 per 15 minutes
Community Access	T2025	HQ	$3.10 per 15 minutes Daily limit is 24 units, Monthly 504 units Annual Limit 5760 units



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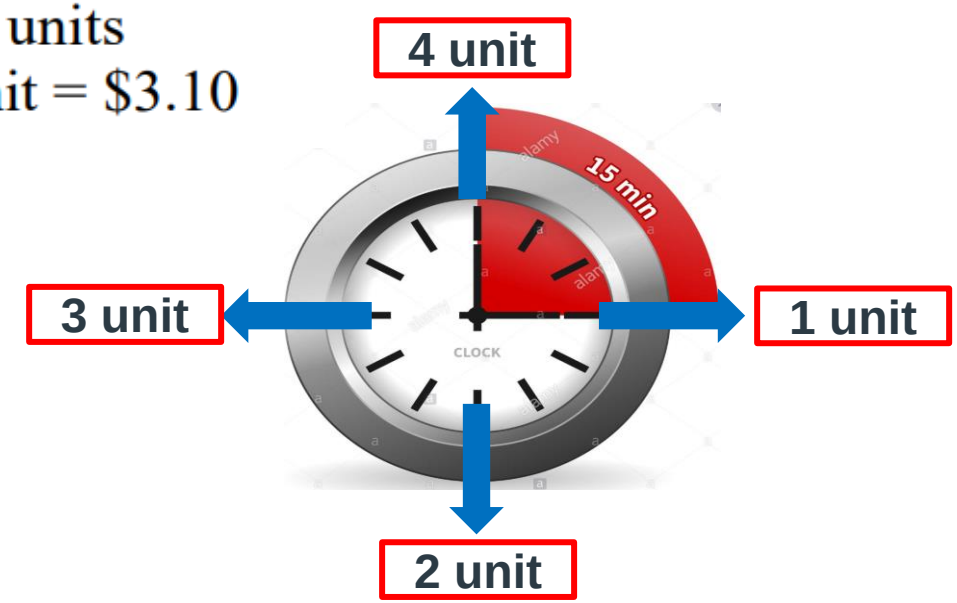
Billing and Unit Calculation Example

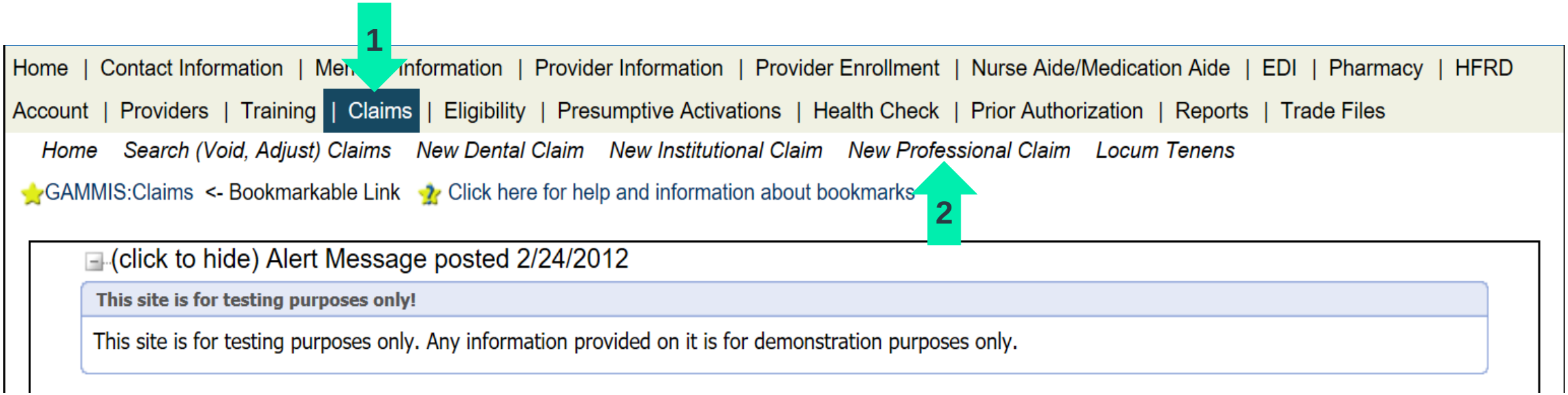
(continued)

Prevocational Services:

Prevocational Services (T2015)
Unit = 15 minutes
Daily Limit = 24 units
Monthly Limit = 504 units
Annual Limit = 5760 units
Maximum rate per unit = $3.10



New Professional Claim Billing Information



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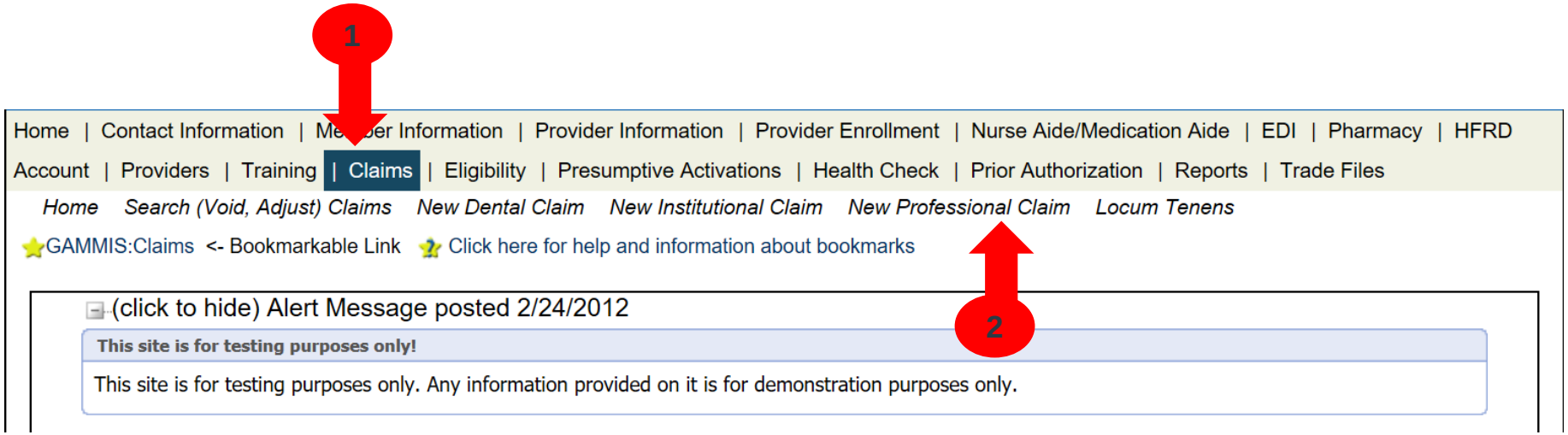
MMIS Web Claim Submissions

(**PSS & CLS services must be submitted using the EVV software**)

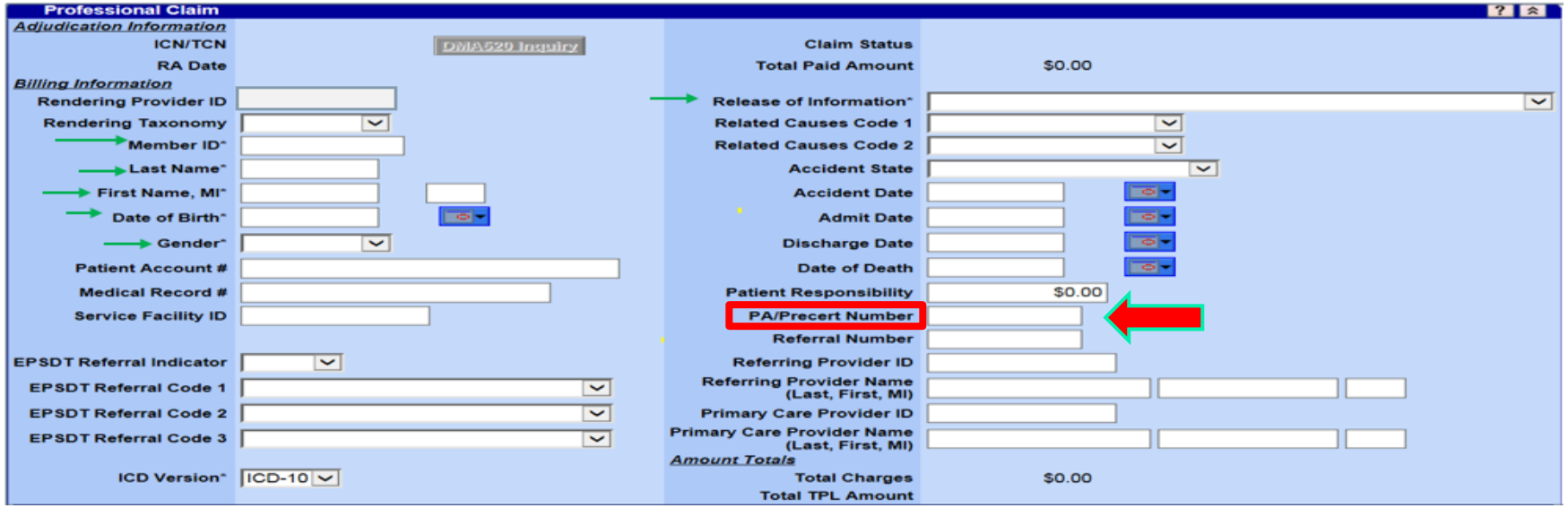
Professional Billing Information



Professional Billing Information

Section 1

Enter the required information and as much optional information as possible (some required fields are the Member ID, Last Name, First Name, and Middle Initial).



An asterisk (*) indicates required information, all other fields are optional.

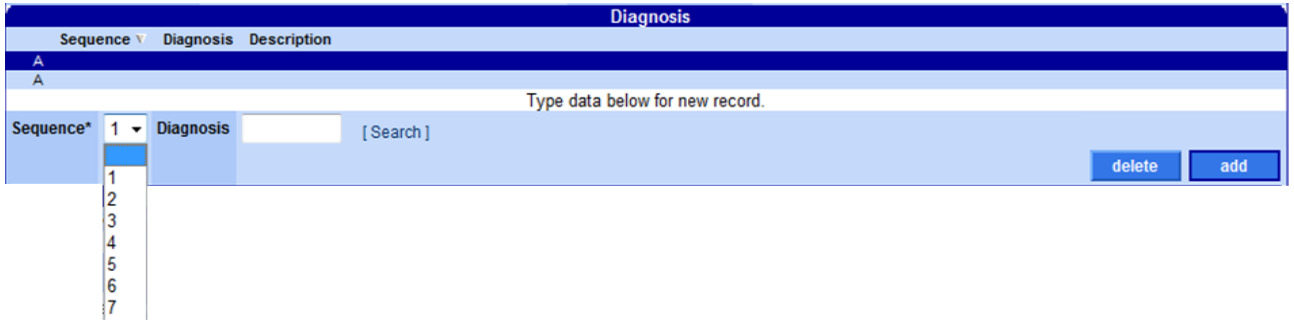
(PSS & CLS services must be submitted using the EVV software)

Diagnosis

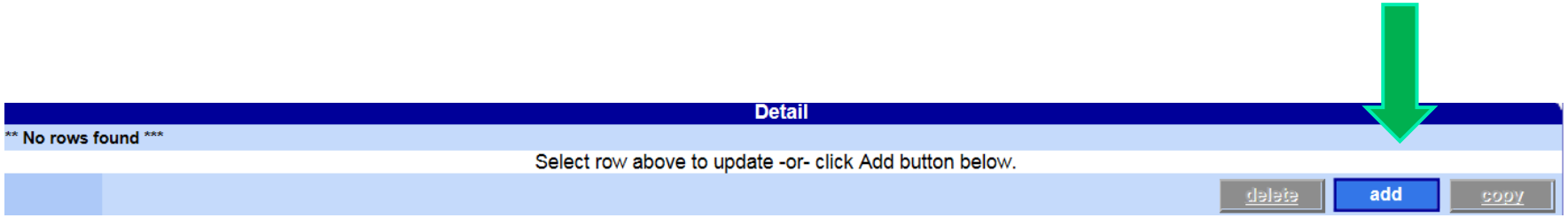
Section 2

Allows entry of up to 10 diagnoses

- Click add to activate the diagnosis section for **each additional diagnosis** to be entered.
- Enter the diagnosis (to find a diagnosis code, use the [Search] feature).
- Enter the sequence (diagnosis code pointer) number.

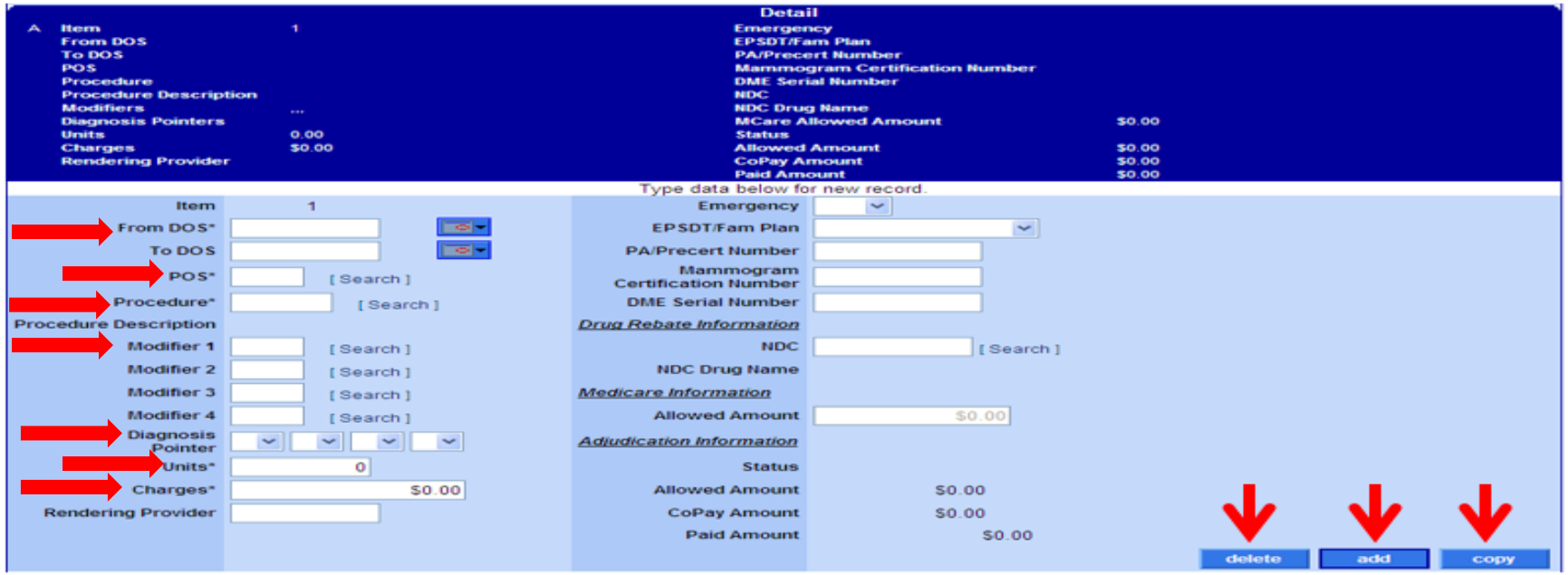


Detail

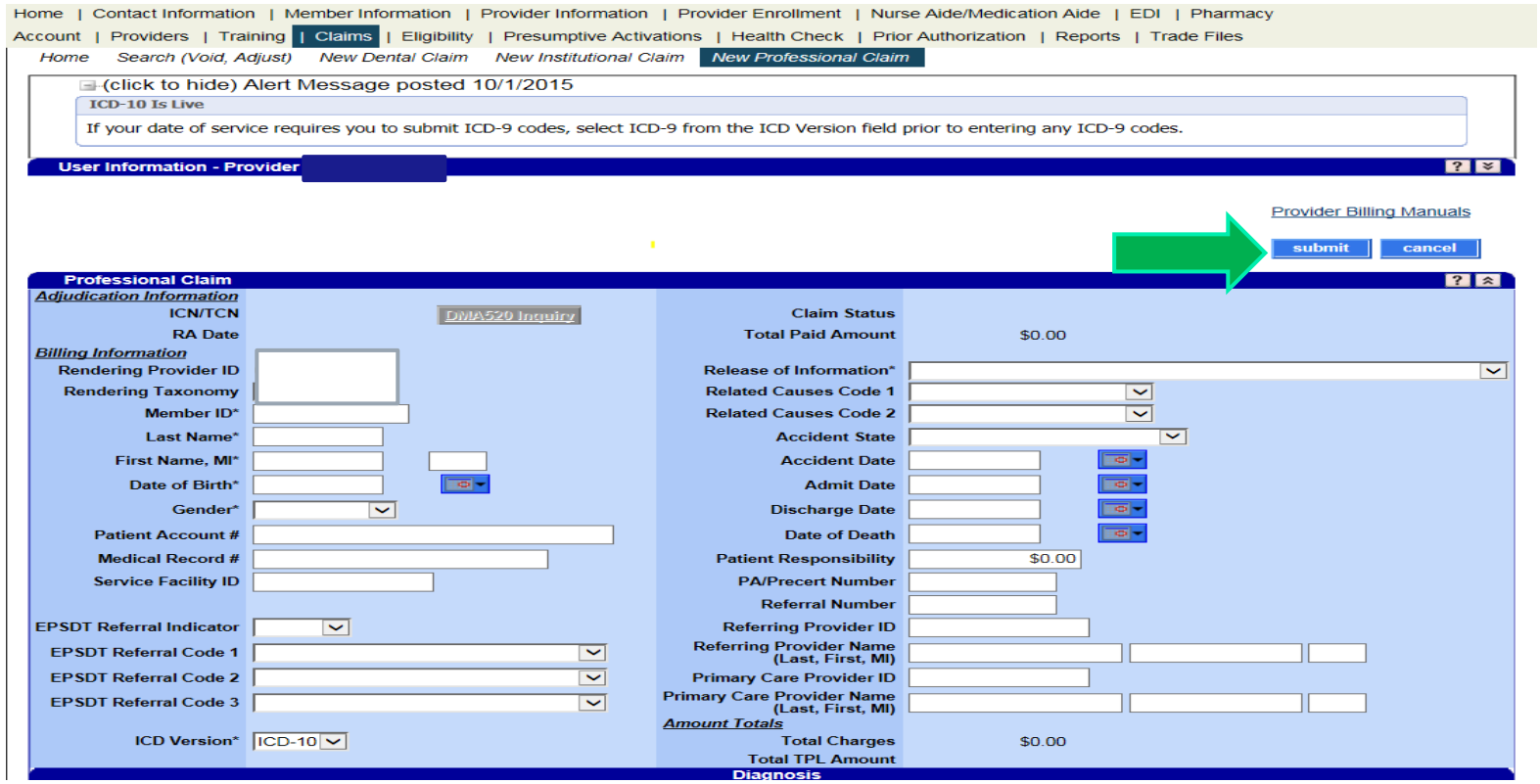


Claims Detail

Click add to add up to 50 lines > Click copy to duplicate information > Click delete to delete the details entered



Submit



Internal Control Number (Claim Number)

- The ICN is a 13-digit number that is unique to each claim, no matter the status.

22	12010	999	999
Region	**Julian Date**	**Batch**	**Sequence**
Claim Type	*Year and Day*	Internal Use Only	

- The region or claim type is determined by how the claim was submitted.

Claims Status

Once a claim has been processed, its status will be:

- **Paid:** Some or all services may be reimbursable.
- **Denied:** No part of the claim was found to be reimbursable.
- **Suspended:** Further processing is needed. The final determination may be dependent upon further review or receipt of additional information.

New Claim, Not Submitted

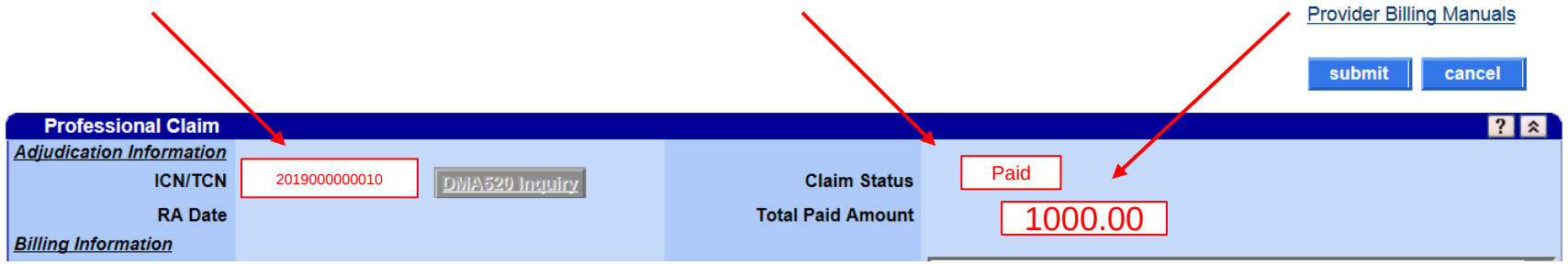
- If the claim is new and has not been submitted, the submit and cancel buttons appear.

Claim Status – Top of the Claim

Claim number – Internal Control Number (ICN)

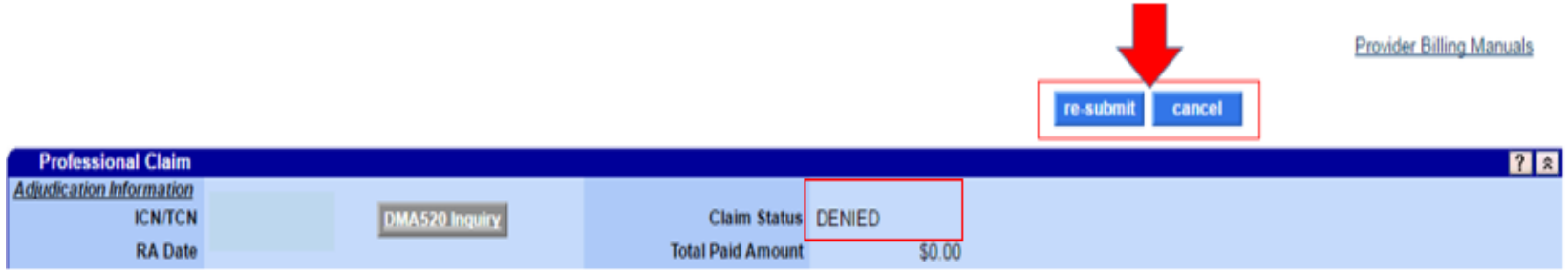
Status – Paid, Denied or Suspended

Total Paid amount



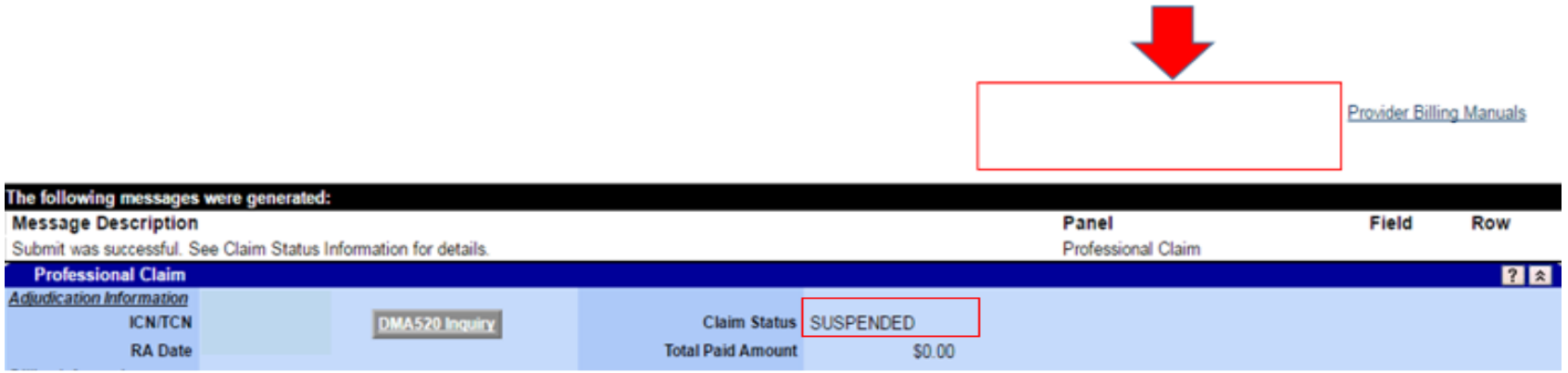
Denied Claim

- If denied, the re-submit and cancel buttons appear.



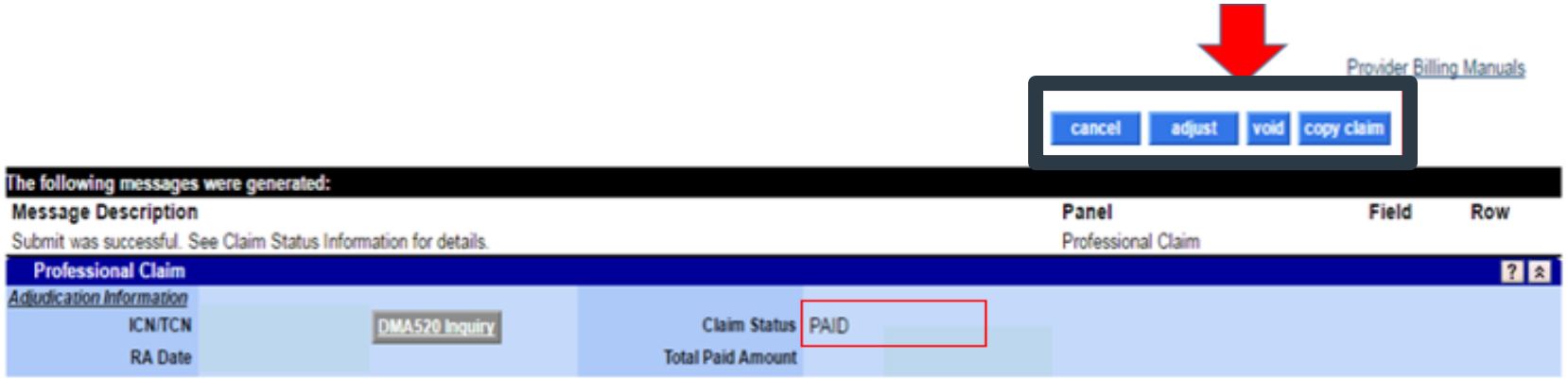
Suspended Claim

- If suspended, no buttons will appear. (Manual Review Required)



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**.

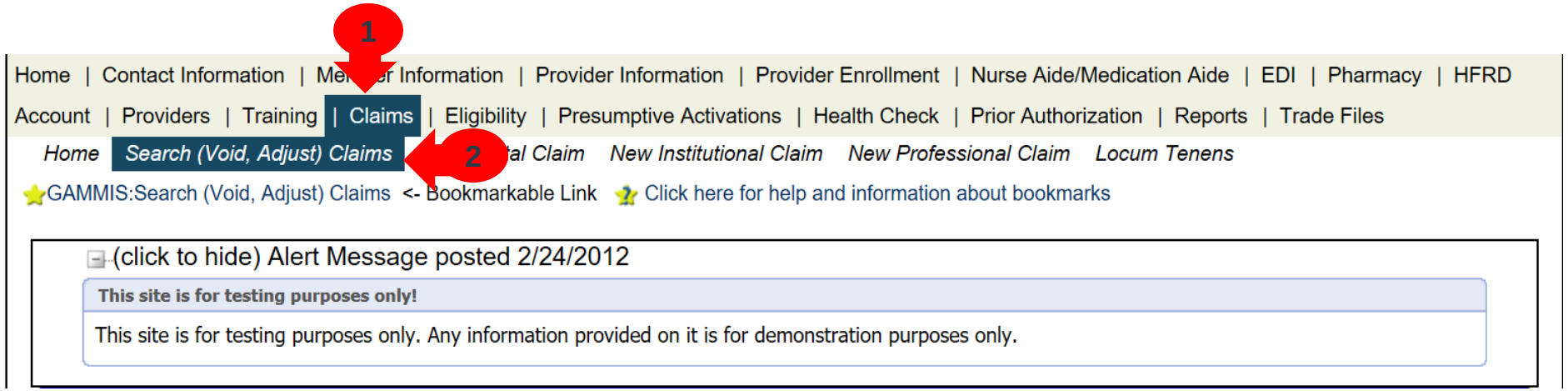


Common Denials

- 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

Claims History Research

Claims History Search



Claims History Search

(continued)

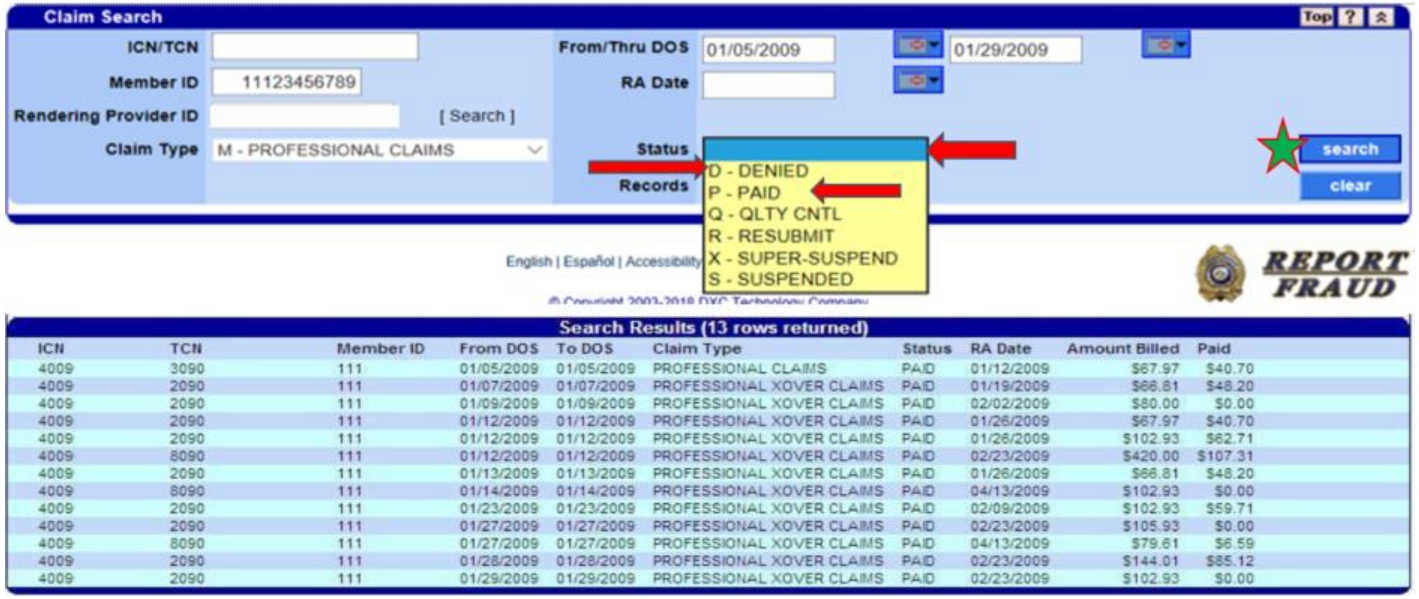
- ICN (Search)
- Member ID, FDOS -> TDOS, Claim Type (Search)
- Member ID, FDOS -> TDOS, Status Type (Search)
- Member ID, Claim Type, RA Date (Search)

Claim Type = Professional

Status Type Options = Paid, Denied, Suspended

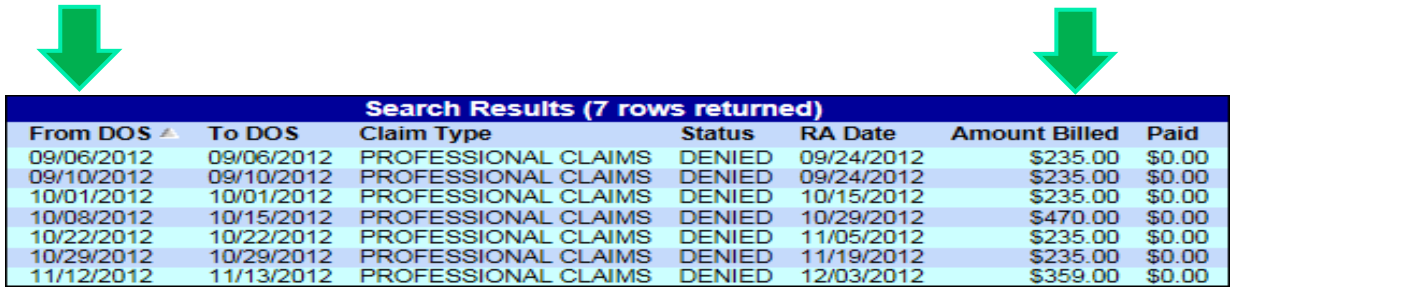
Claims History Search

(continued)



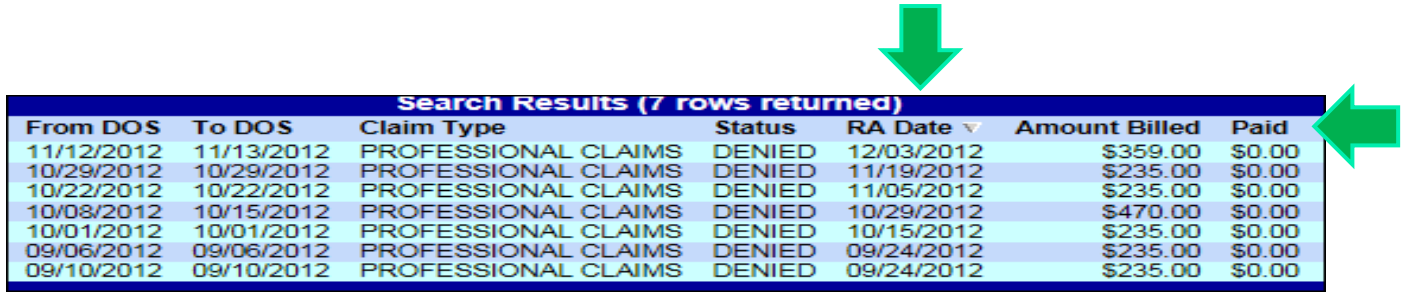
ICN	TCN	Member ID	From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
4009	3090	111	01/05/2009	01/05/2009	PROFESSIONAL CLAIMS	PAID	01/12/2009	$67.97	$40.70
4009	2090	111	01/07/2009	01/07/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/19/2009	$66.81	$48.20
4009	2090	111	01/09/2009	01/09/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/02/2009	$80.00	$0.00
4009	2090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	$67.97	$40.70
4009	2090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	$102.93	$62.71
4009	8090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$420.00	$107.31
4009	2090	111	01/13/2009	01/13/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	$66.81	$48.20
4009	8090	111	01/14/2009	01/14/2009	PROFESSIONAL XOVER CLAIMS	PAID	04/13/2009	$102.93	$0.00
4009	2090	111	01/23/2009	01/23/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/09/2009	$102.93	$59.71
4009	2090	111	01/27/2009	01/27/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$105.93	$0.00
4009	8090	111	01/27/2009	01/27/2009	PROFESSIONAL XOVER CLAIMS	PAID	04/13/2009	$79.61	$6.59
4009	2090	111	01/28/2009	01/28/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$144.01	$85.12
4009	2090	111	01/29/2009	01/29/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	$102.93	$0.00

Sort Claims by DOS, RA Date, Billed, or Paid



Search Results (7 rows returned)

From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
09/06/2012	09/06/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00
09/10/2012	09/10/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00
10/01/2012	10/01/2012	PROFESSIONAL CLAIMS	DENIED	10/15/2012	$235.00	$0.00
10/08/2012	10/15/2012	PROFESSIONAL CLAIMS	DENIED	10/29/2012	$470.00	$0.00
10/22/2012	10/22/2012	PROFESSIONAL CLAIMS	DENIED	11/05/2012	$235.00	$0.00
10/29/2012	10/29/2012	PROFESSIONAL CLAIMS	DENIED	11/19/2012	$235.00	$0.00
11/12/2012	11/13/2012	PROFESSIONAL CLAIMS	DENIED	12/03/2012	$359.00	$0.00



Search Results (7 rows returned)

From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
11/12/2012	11/13/2012	PROFESSIONAL CLAIMS	DENIED	12/03/2012	$359.00	$0.00
10/29/2012	10/29/2012	PROFESSIONAL CLAIMS	DENIED	11/19/2012	$235.00	$0.00
10/22/2012	10/22/2012	PROFESSIONAL CLAIMS	DENIED	11/05/2012	$235.00	$0.00
10/08/2012	10/15/2012	PROFESSIONAL CLAIMS	DENIED	10/29/2012	$470.00	$0.00
10/01/2012	10/01/2012	PROFESSIONAL CLAIMS	DENIED	10/15/2012	$235.00	$0.00
09/06/2012	09/06/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00
09/10/2012	09/10/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	$235.00	$0.00

Claim Corrections

Search and locate your most current claim number (ICN), select it

- Move down to your **detail** line and select the line that needs to be corrected
- Make your corrections to your detail line

Example 1: if you billed 20 units and it should be 40 units, correct to 40 units and total charge

Example 2: If you billed 40 units and it should have been 20 units, correct to 20 units and total charge

- Move to the top and select **Adjust**

Note: Adjustments must be made within 90 days of paid date

Timely Filing Rules

For most providers, timely filing is six months from the month of service (MOS) – the month the service was rendered by the provider. However, there are variations which you should be aware:

- 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) Claims Submission Edit (NEW)

One Year (365 Days) Claim Submission Edit

Example:

	Original Submit Claim	1st Resubmit	2nd Adjustment
DOS	**Denied Date:**	**Adjustment**	**(365 days)**
July 1, 2016	December 30, 2016	March 31, 2017	June 30, 2017

- 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).
- 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 June 14, 2017

DMA-520 Initial General Claim Denial Review

How to appeal denied claims

DMA-520 Claim Inquiry Guidelines

- Only one DMA-520 form may be electronically submitted per inquiry. All data fields must be completed on the e-form in Georgia Medicaid Management Information System (GAMMIS).
- For new inquiries, a Contact Tracking Number (CTN) will be provided. Please use this CTN and the Claim ICN to track your appeal request.
- For previously submitted inquiries, the status will be provided along with the option to electronically upload supporting documentation. **Include ALL supporting documentation for your appeal via the CTN.**
- If the CTN status is CLOSED, you will not be able to upload supporting documentation.

DMA-520 Commonly Reviewed Edits – Gainwell Technologies

535 ADJUSTMENT EXCEEDS TIMELY FILING PERIOD	5087 SVC BILLED INCL IN HLTH CHCK SEPARATE BILL NOT CVD.
5674 SERVICE NOT ALLOWED DURING HOSPITAL STAY	3051 PA/PRECERT HEADER STATUS IS DENIED OR SUSPENDED
607 ATTACHMENT INDICATED BUT NOT YET RECEIVED	1087 MEMBER NOT ELIGIBLE FOR NH ON DOS
1018 NO/PARTIAL PRICING SEGMENT ON FILE FOR PROVIDER	1825 ORDERING PROV NOT ACTIVE/ELIGIBLE
2505 MEMBER COVERED BY PRIVATE INSURANCE	4027 DIAGNOSIS NOT ALLOWED FOR DATE OF SERVICE
2502 MEMBER COVERED BY MEDICARE B - NO ATTACHMENT	6704 MCARE PART-B DEDUCT GREATER THAN YEARLY ALLOWABLE
5628 POSSIBLE DUPLICATE	3423 DIAGNOSIS BILLED IS NOT VALID FOR COS
1770 INPATIENT PART-B CLAIMS REQUIRE AN EOB ATTACHMENT:	4801 BILLING RULE NOT FOUND FOR THE BILLED PROCEDURE
2017 MEMBER SERVICES COVERED BY CMO PLAN:	2521 MEDICARE PART B WILL COVER SOME INPATIENT SERVICES
545/512 TIMELY FILING – HEADER	3041 PA/PRECERT LINE STATUS IS DENIED OR SUSPENDED
2003 MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE	4039 DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS
4038 THE NATIONAL DRUG CODE IS NOT VALID FOR THE DOS:	5934 SERVICE ALLOWED IN INPATIENT SETTING ONLY

Tips

- Bill claims within six months from the date of service. Keep up with your denials and submitted documentation.
- Research your claims denials.
- Review the Part 1 and Part 2 policy manuals and applicable fee schedules.
- Contact the Gainwell Technologies' Call Center for questions.
- Consult with your assigned Gainwell Technologies Field Representative.

DMA-520 Documentation

Examples:

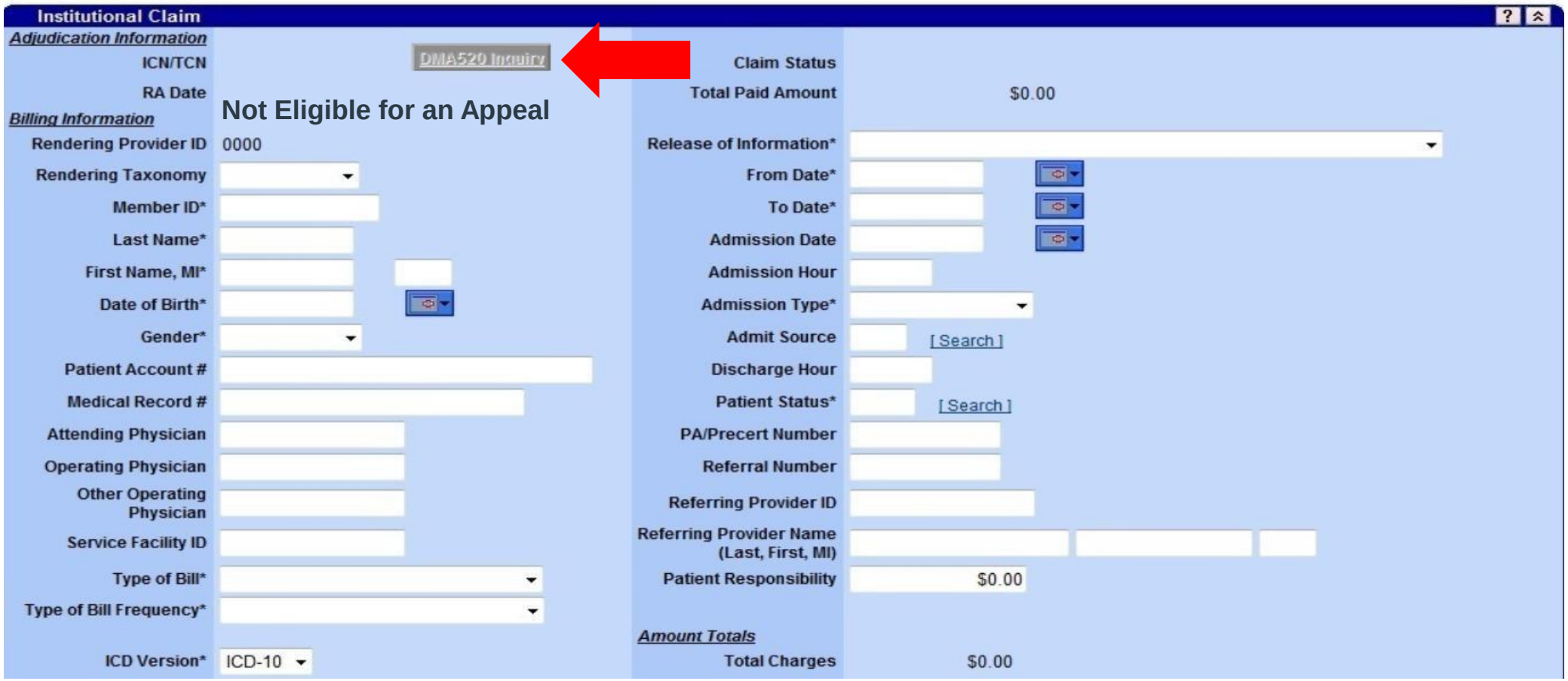
- EOBs (If Applicable)

- Claims Submissions History - Timely Filing (If Applicable)

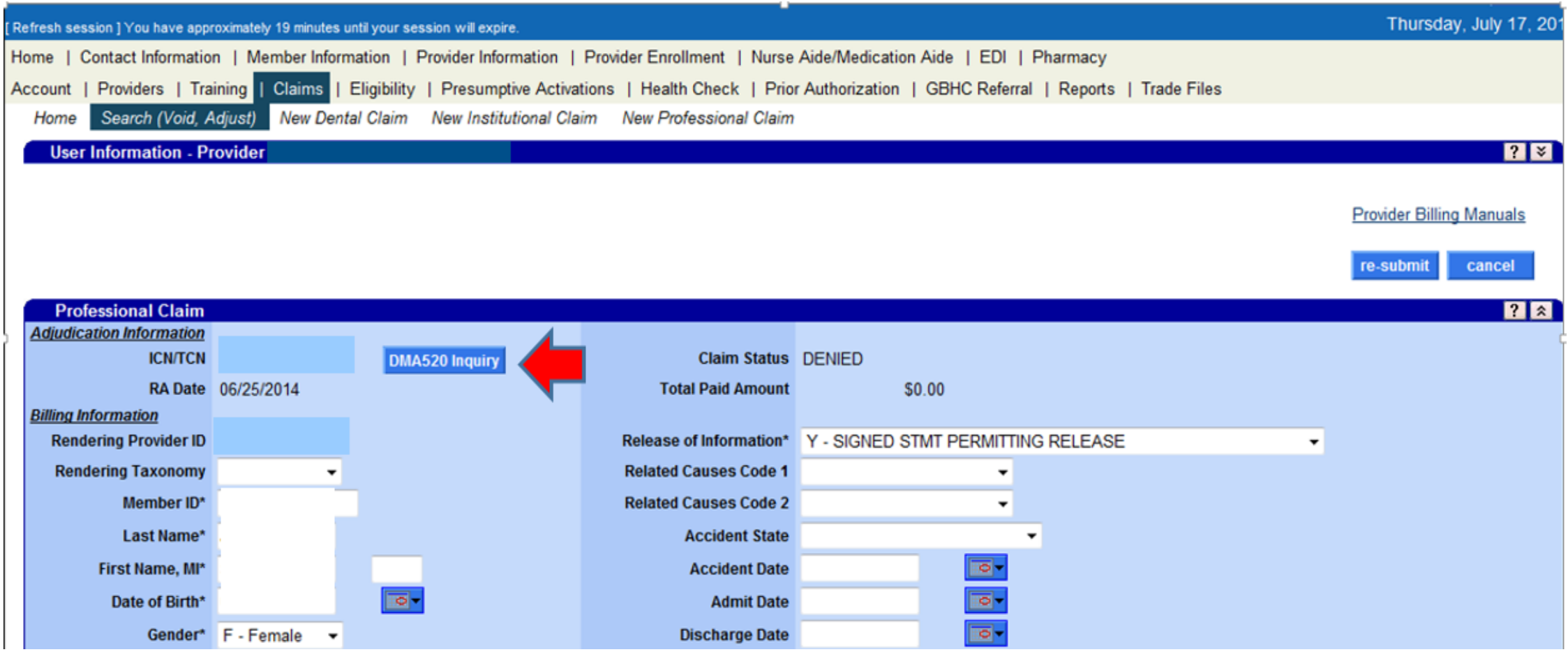
DMA-520 Form (Gainwell Technologies) - Initial Provider Review

- The DMA-520(s) must be submitted via the GAMMIS Web Portal at: www.mmis.georgia.gov.
  - Claims must complete the payment cycle.
  - Search for your denied ICN.
  - Select DMA-520 and complete all required fields.
- DMA-520 appeal request must be requested within **30 days** of the claim's denial or adverse action.
- (**Blue DMA-520** Option will appear if timely)

DMA-520 – Not Appeal Eligible



DMA-520 - Appeal Eligible



DMA-520 Form

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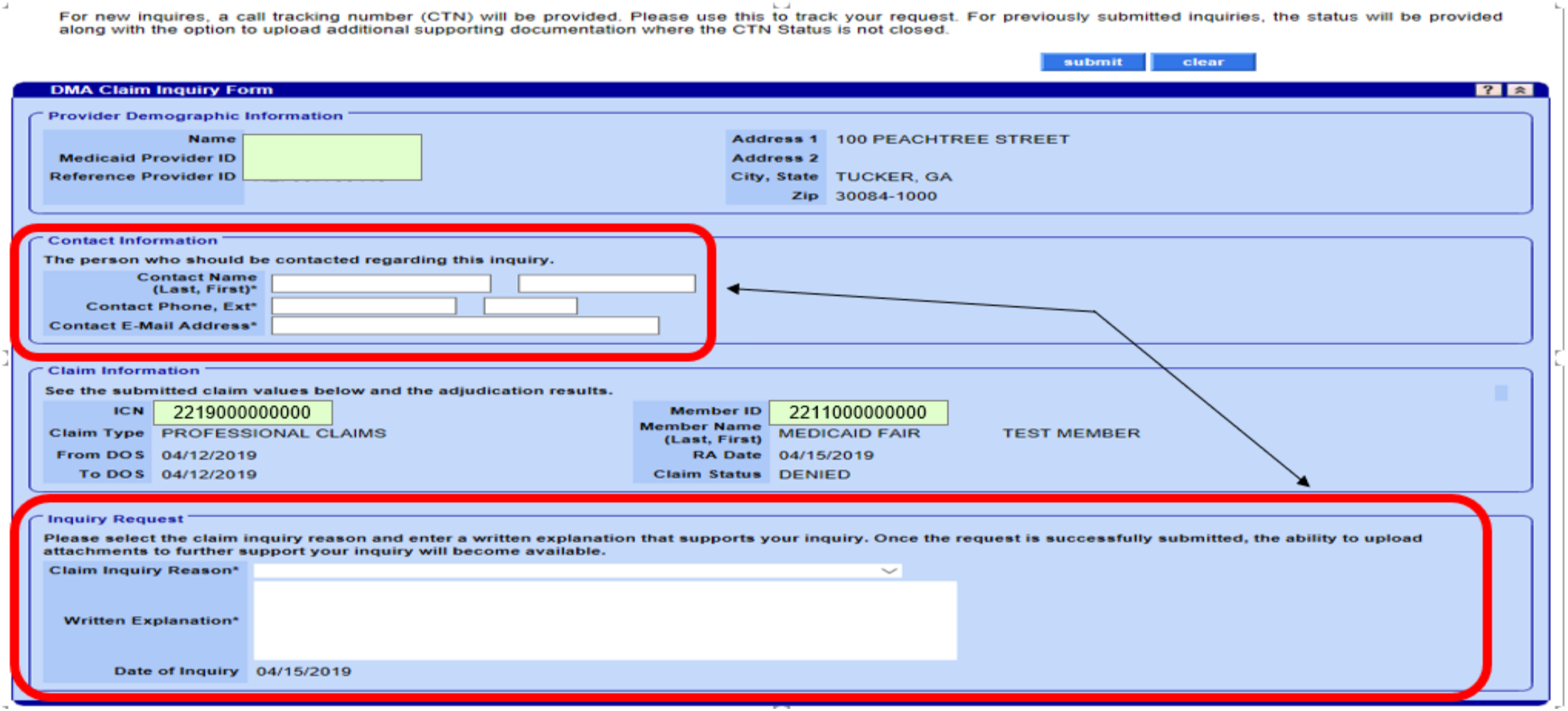


DMA-520 Inquiry Requirements

- ✓ Contact Name (Last, First)
- ✓ Contact Phone, Extension
- ✓ Contact Email Address
- ✓ Claim Inquiry Reason*
- ✓ Written Explanation

- **Example:**

- Member Eligible For CMO/Retro Eligibility
- Other Inquiry Not listed
- Procedure Not Covered
- Timely Filing

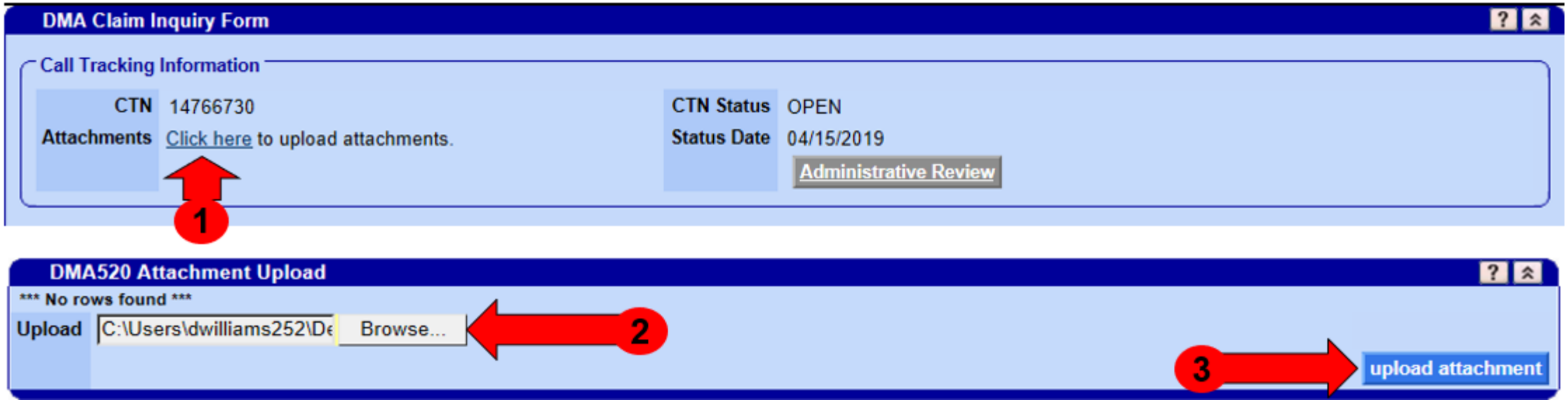
Submit DMA-520

- Submit your DMA-520
- CTN Tracking number is received
- Upload any supporting documents

DMA-520 Upload Attachments

The DMA-520 Attachment upload panel allows the user to add documents to inquiries.

1. Click here to indicate you will be submitting an attachment.
2. Select the browse button to allow you to choose a file to upload to your inquiry (file type: jpg, tif or pdf).
3. Select the upload attachment button to associated your file to the provider inquiry.



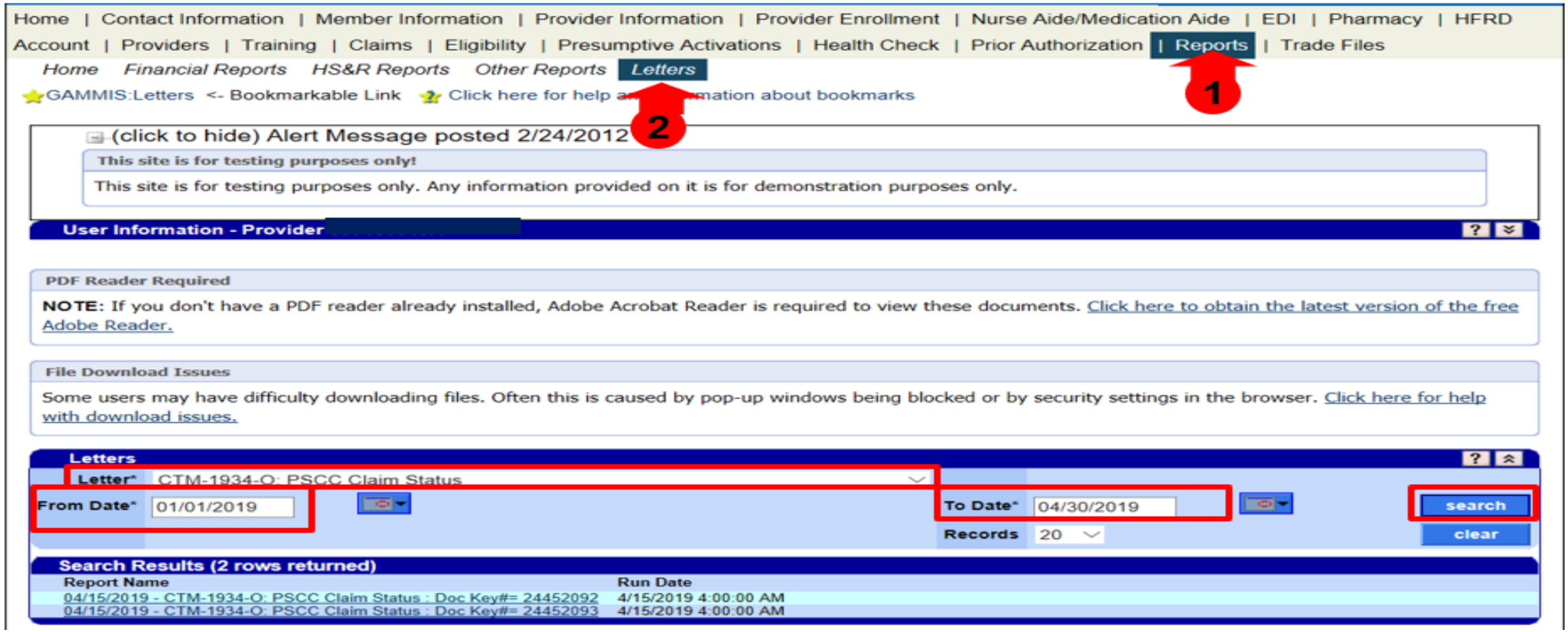
DMA-520 E-mail Notification

You will receive an e-mail from DoNotReply@gammis.com notifying you here is a response regarding the submitted DMA-520.

Georgia DCH Email Request -

Email Link:	Click here to access the GAMMIS web portal.
From:	State of Georgia DCH
Reference Provider ID:	REF007790440
CTN:	14766730-1
Details:	This link was sent on 4/15/2019 10:32:29 AM You will need to have a valid user name and password to access the letter on the DCH website. Once authenticated on the GAMMIS Web portal, navigate to the "Reports" menu, then select "Letters". Choose the letter CTM-1934-O:PSCC Claim Status Letter from the list and click the search button. Letters are sorted by date, so select the letter with the date of 4/15/2019 . **Notice: Online letters may not be available for viewing for up to one business day.**

DMA-520 Response Letter



DMA-520 Response Letter

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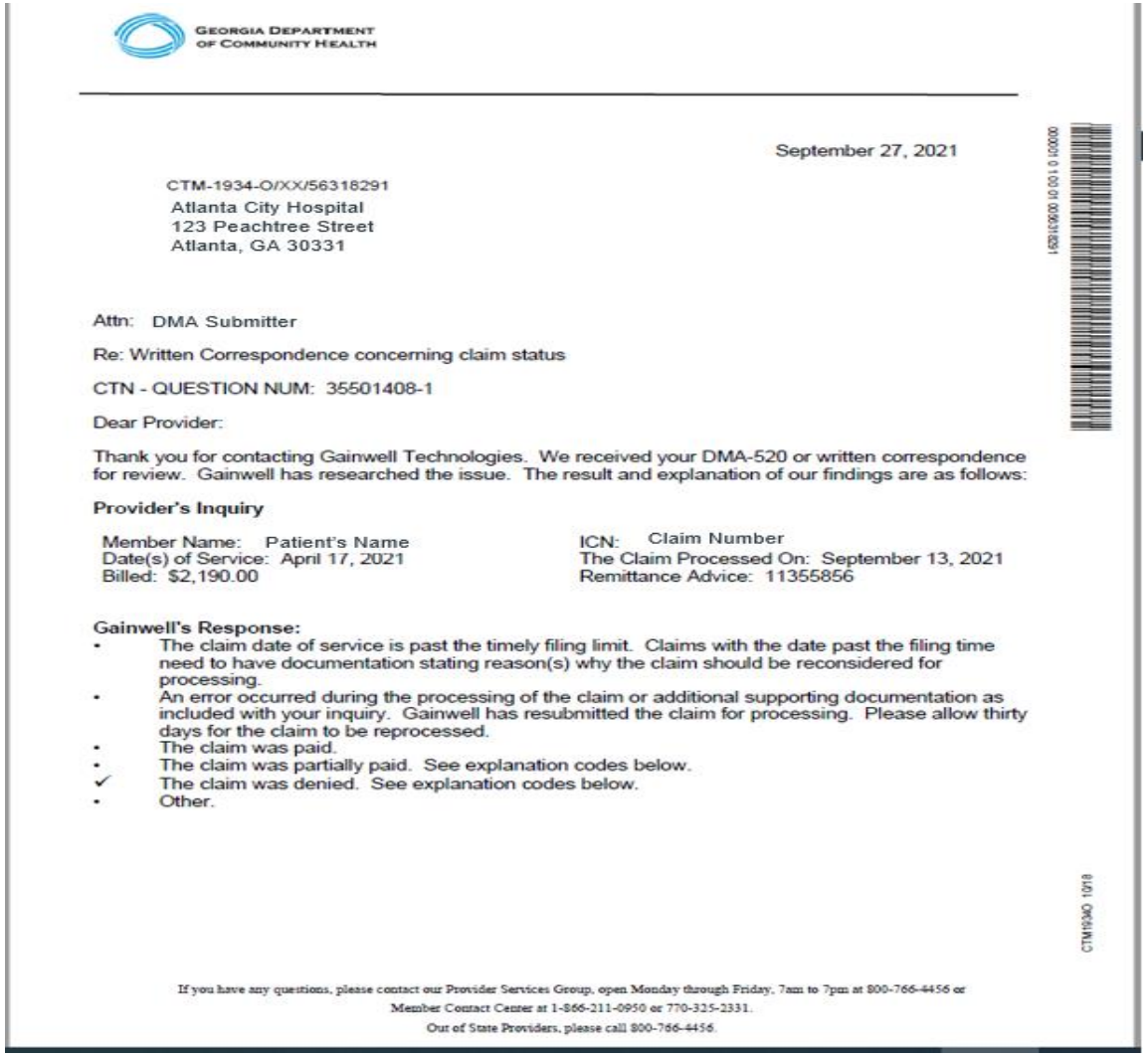

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

September 27, 2021

CTM-1934-O/XX/56318291
Atlanta City Hospital
123 Peachtree Street
Atlanta, GA 30331

Attn: DMA Submitter

Re: Written Correspondence concerning claim status

CTN - QUESTION NUM: 35501408-1

Dear Provider:

Thank you for contacting Gainwell Technologies. We received your DMA-520 or written correspondence for review. Gainwell has researched the issue. The result and explanation of our findings are as follows:

Provider's Inquiry

Member Name: Patient's Name
Date(s) of Service: April 17, 2021
Billed: $2,190.00

ICN: Claim Number
The Claim Processed On: September 13, 2021
Remittance Advice: 11355856

Gainwell's Response:

- The claim date of service is past the timely filing limit. Claims with the date past the filing time need to have documentation stating reason(s) why the claim should be reconsidered for processing.
- An error occurred during the processing of the claim or additional supporting documentation as included with your inquiry. Gainwell has resubmitted the claim for processing. Please allow thirty days for the claim to be reprocessed.
- The claim was paid.
- The claim was partially paid. See explanation codes below.
- ✓ The claim was denied. See explanation codes below.
- Other.

If you have any questions, please contact our Provider Services Group, open Monday through Friday, 7am to 7pm at 800-766-4456 or Member Contact Center at 1-866-211-0950 or 770-325-2331.
Out of State Providers, please call 800-766-4456.

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DMA-520 Administrative Review

DCH Second Level Appeal

DMA-520 Administrative Review
(DCH – Provider Review)

2nd Level Administrative Review Inquiry Guidelines

The Department Of Community Health offers any provider the opportunity to request an administrative (2nd level) review associated with a DMA-520 Inquiry form [Claim denial for payment or proposed adverse action (i.e. untimely filing, procedure code invalid)]. It must be submitted electronically through GAMMIS at www.mmis.georgia.gov.

- Must be requested/received within 30 days of the date of the proposed adverse action notification (the blue Administrative review option will appear if timely).
- Once the status of your DMA-520 shows as “CLOSED,” the option to request an Administrative/2nd Level review will appear. There is no appeal rights once the Administrative Review button is grayed out.

Administrative Review Supporting Documentations

- EOBs (if applicable)
- Claims Submissions History – Timely Filing (if applicable)
- Member Eligibility Screen Print (if applicable)
- Member Lock in and Member update information – fax time stamp to member services (if applicable)
- EOBs from Primary (if applicable)

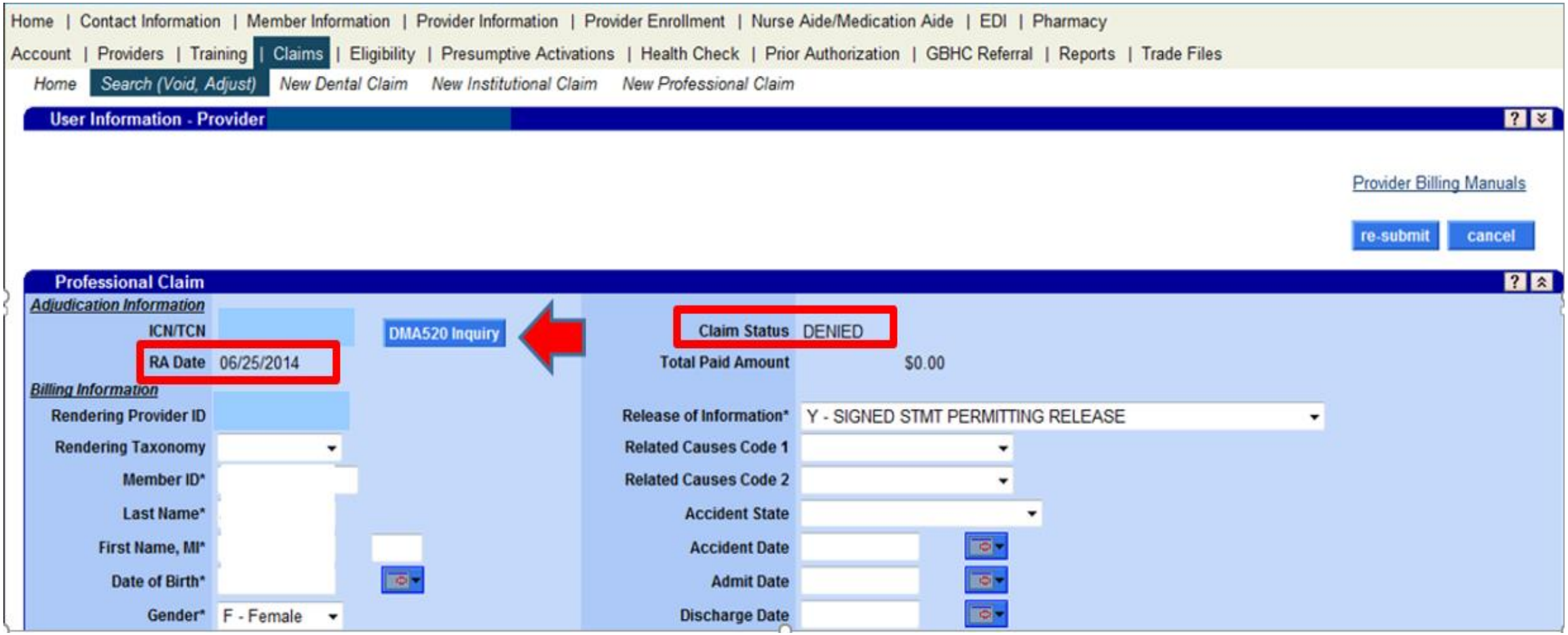
2nd Level/Administrative Review

- To initiate the Administrative Review, Search for your Claim ICN and click the DMA-520 button and then the Administrative Review button.
- The information previously indicated on the DMA-520 Claim Inquiry Form will auto populate into the Administrative Review.
- Make sure the contact information is up to date.
- Add information in the Written Explanation box to explain the reason for the administrative review.
- Submit your online request and a new CTN will be assigned.
- The CTN status will be “OPEN” and you will have the option to upload supporting attachments/documentation.

- Note: The DCH does not have a time limit to respond to Administrative Reviews.

2nd Level/Administrative Review

(continued)



2nd Level/Administrative Review

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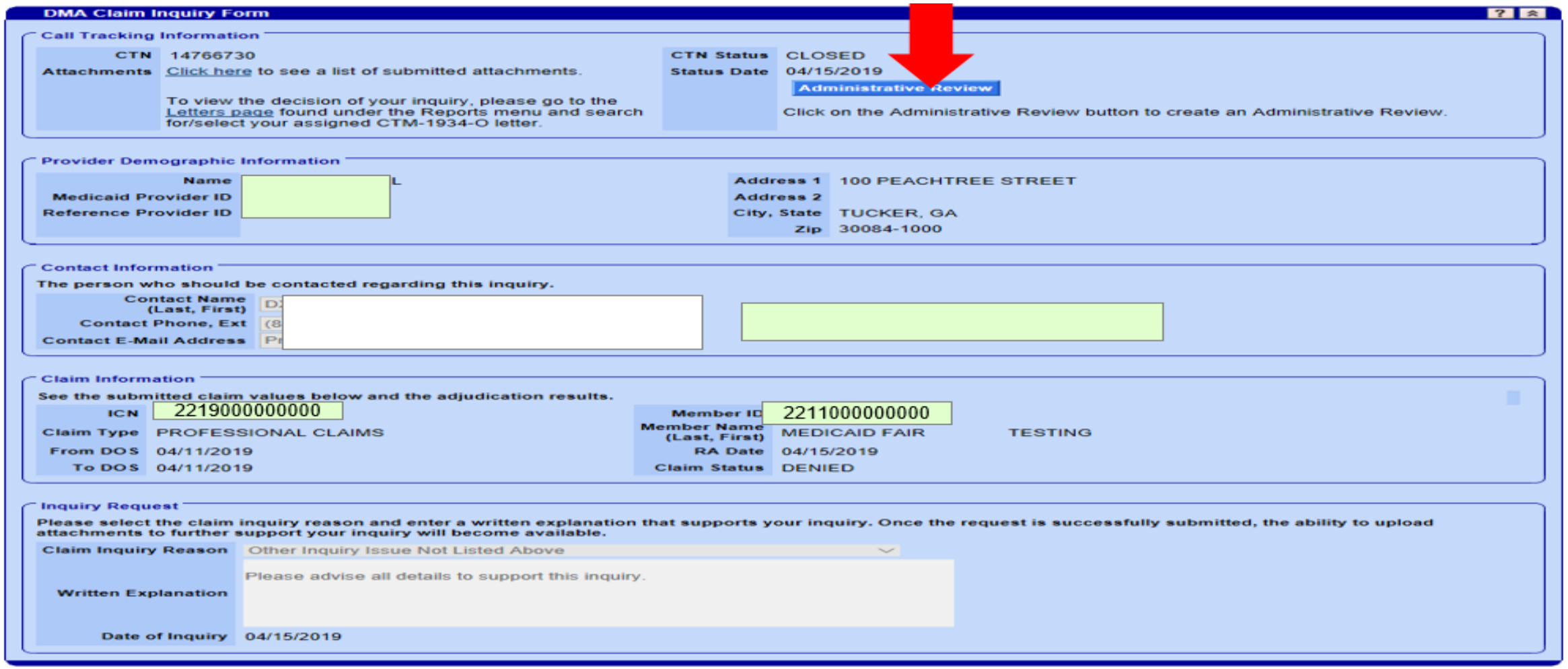

2nd Level/Administrative Review

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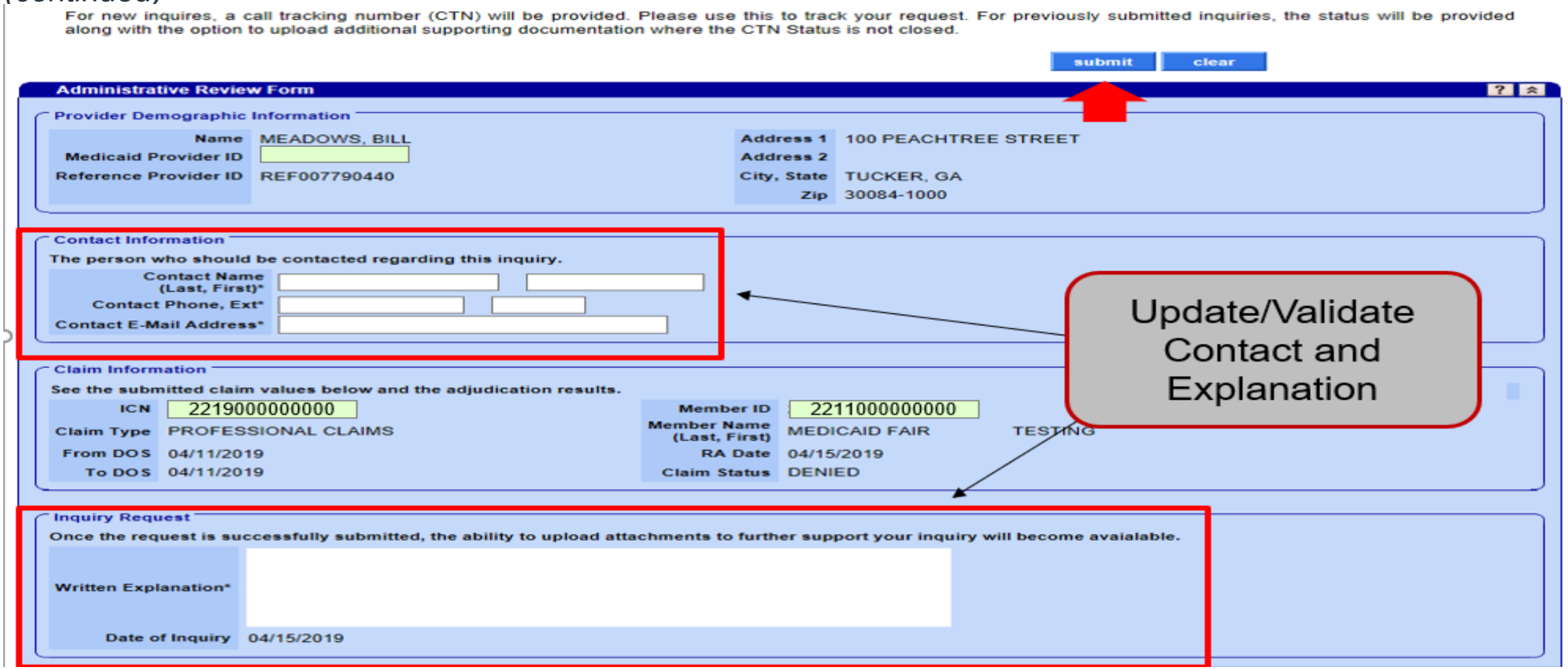

2nd Level/Administrative Review

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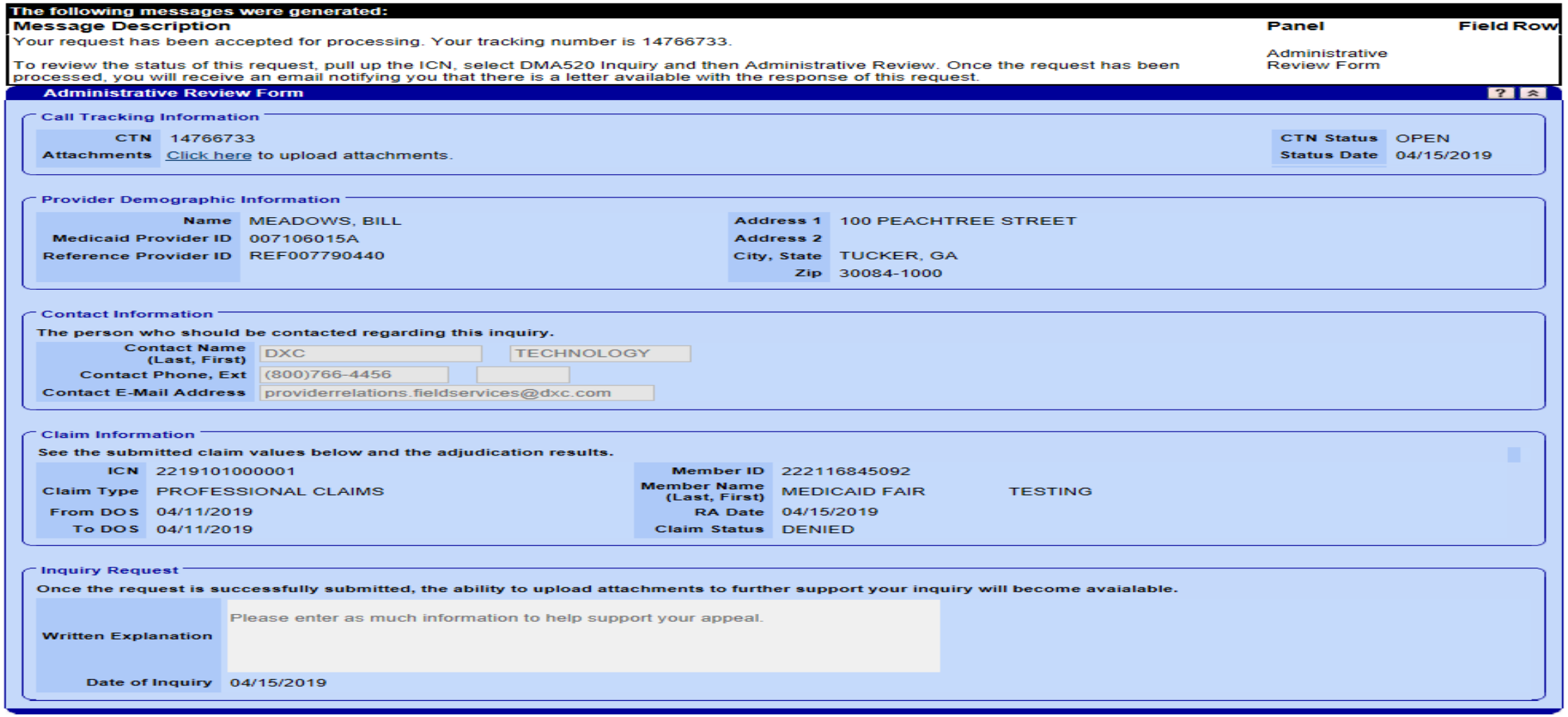


The following messages were generated:

Message Description	Panel	Field Row
Your request has been accepted for processing. Your tracking number is 14766733. To review the status of this request, pull up the ICN, select DMA520 Inquiry and then Administrative Review. Once the request has been processed, you will receive an email notifying you that there is a letter available with the response of this request.	Administrative Review Form	

Administrative Review Form

Call Tracking Information

CTN	14766733	CTN Status	OPEN
Attachments	Click here to upload attachments.	Status Date	04/15/2019

Provider Demographic Information

Name	MEADOWS, BILL	Address 1	100 PEACHTREE STREET
Medicaid Provider ID	007106015A	Address 2	
Reference Provider ID	REF007790440	City, State	TUCKER, GA
		Zip	30084-1000

Contact Information

The person who should be contacted regarding this inquiry.

Contact Name (Last, First)	DXC	TECHNOLOGY
Contact Phone, Ext	(800)766-4456	
Contact E-Mail Address	providerrelations.fieldservices@dxc.com	

Claim Information

See the submitted claim values below and the adjudication results.

ICN	2219101000001	Member ID	222116845092	
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR	TESTING
From DOS	04/11/2019	RA Date	04/15/2019	
To DOS	04/11/2019	Claim Status	DENIED	

Inquiry Request

Once the request is successfully submitted, the ability to upload attachments to further support your inquiry will become avaialable.

Written Explanation	Please enter as much information to help support your appeal.
Date of Inquiry	04/15/2019

2nd Level/Administrative Review

(continued)

Upload ALL supporting documentation that is applicable to the request for Administrative Review.

2nd Level/Administrative Review Status

- To review the status of your request, search for your Denied ICN, select DMA-520 Inquiry and then select Administrative Review.
- Once your request has been processed, you will receive an e-mail notifying you that there is a letter with the response for the request.

DMA-520 Inquiry Requirements

- ✓ Contact Name (Last, First)
- ✓ Contact Phone, Extension
- ✓ Contact Email Address
- ✓ Claim Inquiry Reason*
- ✓ Written Explanation

- **Example:**

- Member Eligible For CMO/Retro Eligibility
- Other Inquiry Not listed
- Procedure Not Covered
- Timely Filing

Administrative Law Hearing

Administrative Law Hearing

(continued)

- Whenever the opportunity for Administrative Review is available to the provider, the Administrative Review process must be completed for the provider to be entitled to a hearing. Issues at hearings are limited to those issues that have been reviewed/addressed through the Administrative Review process.

- A request for a hearing must be in writing and received by the Administrative Review division within 15 business days after the date the provider received the decision from the division.

Administrative Law Hearing

(continued)

The Request for Hearing must include the following information:

1. A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an Administrative Law hearing. Identification of the adverse Administrative Review decision or other division action being appealed and all issues that will be addressed at hearing. Issues at hearing are limited to those issues that have been submitted for Administrative review.
2. A copy of the Adverse Action Letter, Administrative Review Response, or Final Denial Notice.
3. A specific statement of why the provider believes the Administrative Review decision or other Division action is wrong.
4. A statement of the relief sought.

Administrative Law Hearing

(continued)

- **Request for hearing must be sent to:**

Georgia Department of Community Health Legal Services Section

40th Floor, 2 Peachtree Street, NW

Atlanta, GA 30303-3159

Part I Policy Section: 506 Medicaid/PeachCare for Kids Provider Administrative Law Hearing

References

- Part I Policies and Procedures for Medicaid/PeachCare for Kids® Manual; Chapter 500 for the policies on Appeals.
- Provider Notices, Provider Messages and quarterly Provider manual updates
- DCH iNewsletter at www.dch.Georgia.gov/publications

Claim Supporting Documentation Attachment Codes

Attachment Code	Description
03	Report Justifying Treatment Beyond Utilization Guidelines
04	Drugs Administered
05	Treatment Diagnosis
06	initial assessment
07	Functional Goals
08	Plan of Treatment
09	Progress Report
10	Continued Treatment
11	Chemical Analysis
13	Certified Test Report
15	Justification for Admission
21	Recovery Plan
77	Completed Referrral Form
A3	Allergies/Sensitivities Document
A4	Autopsy Report
AM	Ambulance Certification
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Hospice Referral Form - Medical Review
BR	Benchmark Testing Results
BS	Baseline
BT	Blanket Test Results
CB	Chiropractic Justification
CK	Consent Form(s)
CT	Certfication
D2	Drug Profile Document
DA	Dental Models
DB	Durable Medical Equipment Prescription
DG	Diagnostic Report
DJ	Discharge Monitoring Report
DS	Discharge Summary
EB	EOB (Coordination of Benefits or Medicare Secondary Payor)
HC	Health Certificate
HR	Health Clinic Records

Attachment Code	Description
I5	Immunization Record
IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
MT	Models
NN	Nursing Notes
OB	Operative Note
OC	Oxygen Content Averaging Report
OD	Orders and Treatments Document
OE	Objective Physical Examination (including vital signs) Document
OX	Oxygen Therapy Certification
OZ	Support Data for Claim
P4	Pathology Report
P5	Patient Medical History Document
P6	Periodontal Charts
PE	Parenteral or Enteral Certification
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PQ	Paramedical Results
PY	Physician's Report
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report
RX	Renewable Oxygen Content Averaging Report
SG	Symptoms Document
V5	Death Notification
XP	Photographs

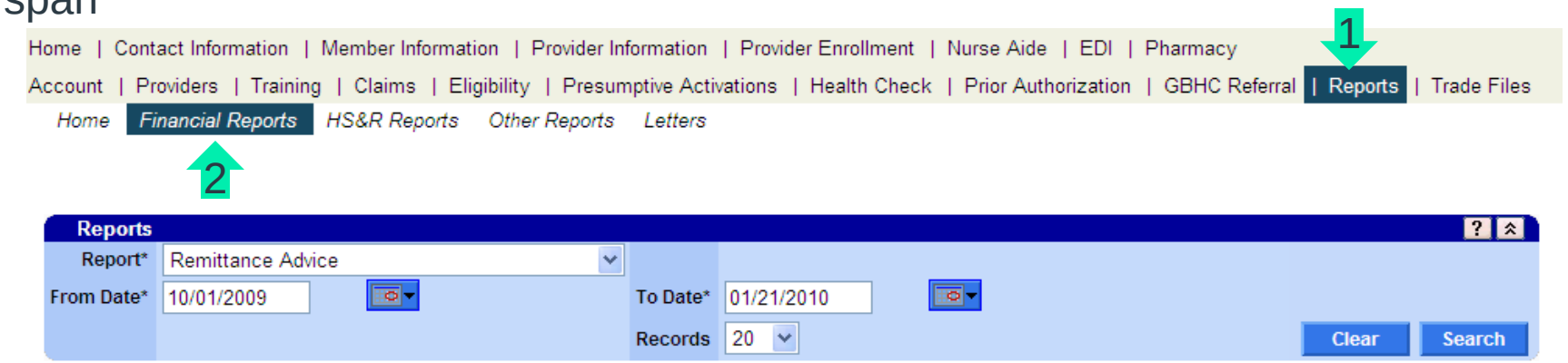
DMA-520/Administrative Review Timelines

General Claim Appeal -> DMA-520 -> Administrative Review -> Administrative Law Hearing		Time Frames
Claim Denys	General Claim Denial	
Step 1	Correct Claim via the MMIS Web Portal, Check with the Call Center/Field Services Rep.	
Step 2	Submit DMA-520 via your denied claim on the MMIS Web Portal	within 30 days of your claim denial date
GWT - MMIS Response	DMA-520 Denial Letter is Returned	worked within 72 business hours
Step 3	Submit an Administrative Review via your denied claim on the MMIS Web Portal by selecting DMA-520	within 30 days from the DMA-520 denial letter
DCH Response	Administrative Review decision letter (if denied, can request an Admin. Law Hearing)	No time frames
Step 4	Administrative Law Hearing (Must include DMA-520 & Administrative Review Denial Letter and may include any and all supporting documentation	Request must be submitted within 15 days from the Administrative Review denial letter

Accessing the Remittance Advice

Accessing the Remittance Advice

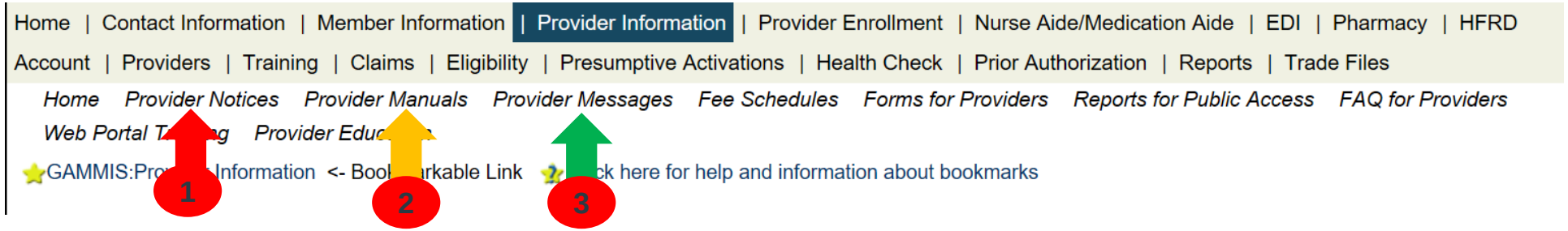
- Select **Report**, then **Financial Reports** from the menu. Next, select **Remittance Advice** from the Report drop down menu.
- Enter the date span
- Click Search



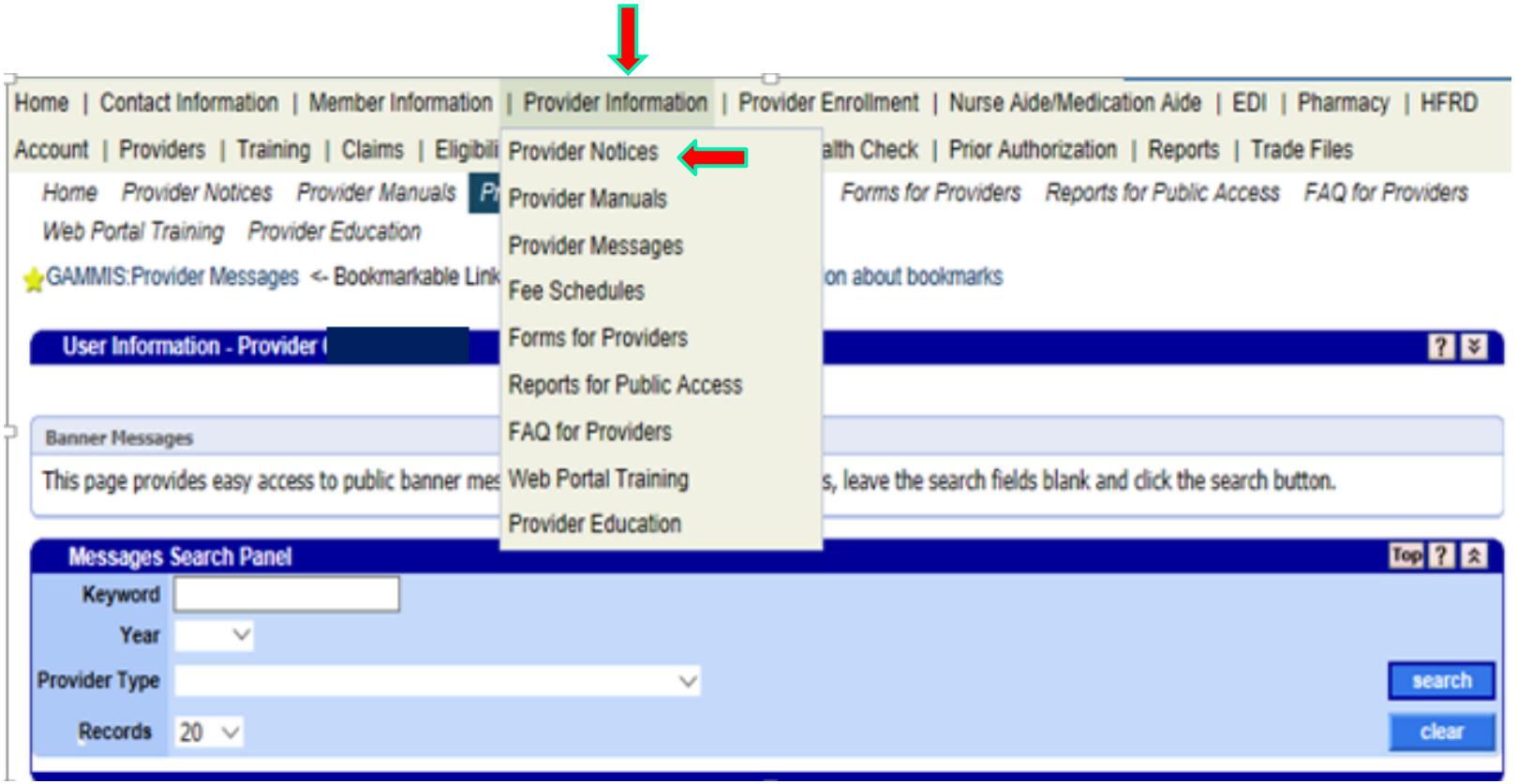
- For a full comprehensive Remittance Advice with all details, please access using your Payee ID Account info. For help, contact EDI at: 1-877-261-8785 or speak to your local Field services rep for assist.

Policy Information

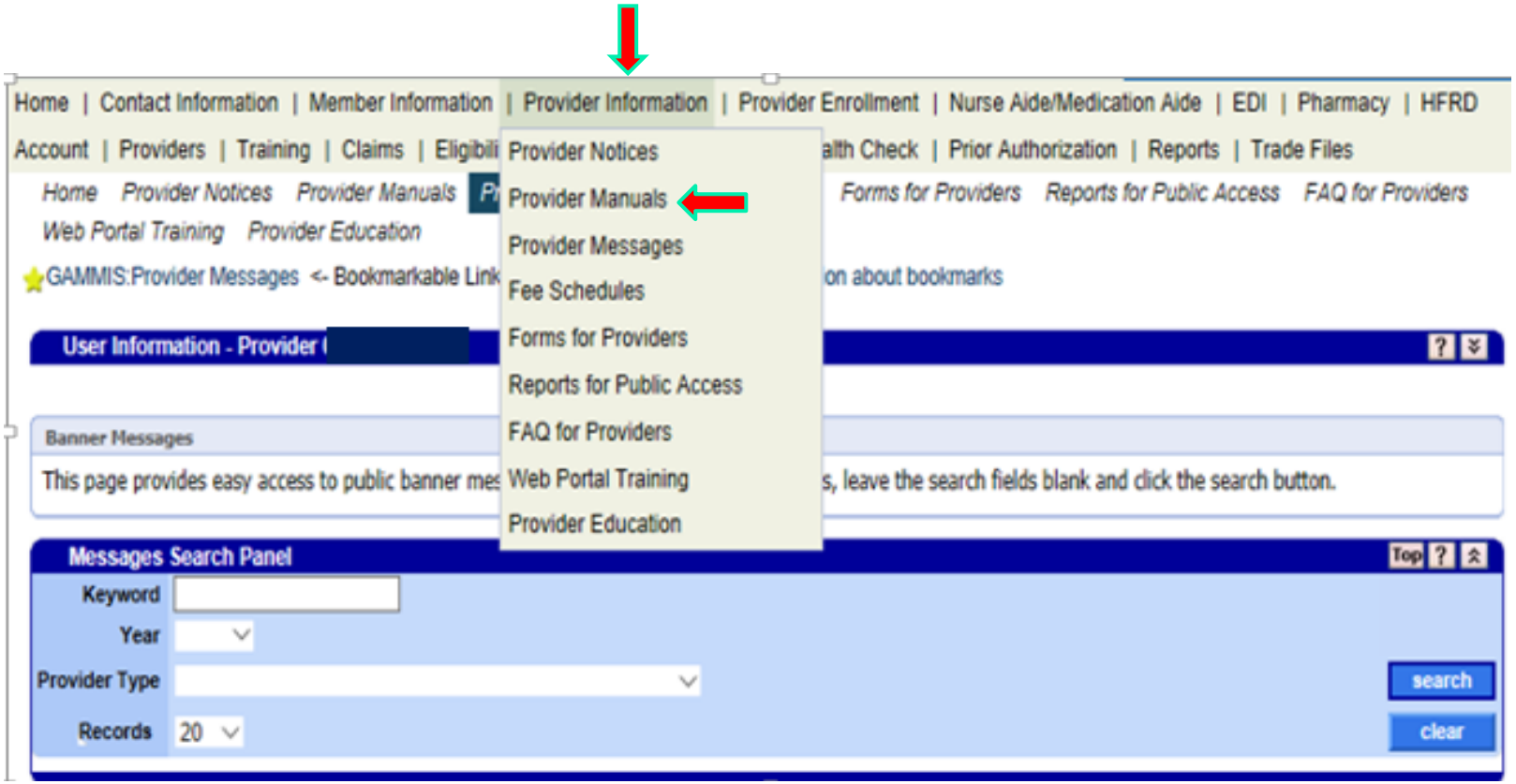
Policy Information and Updates



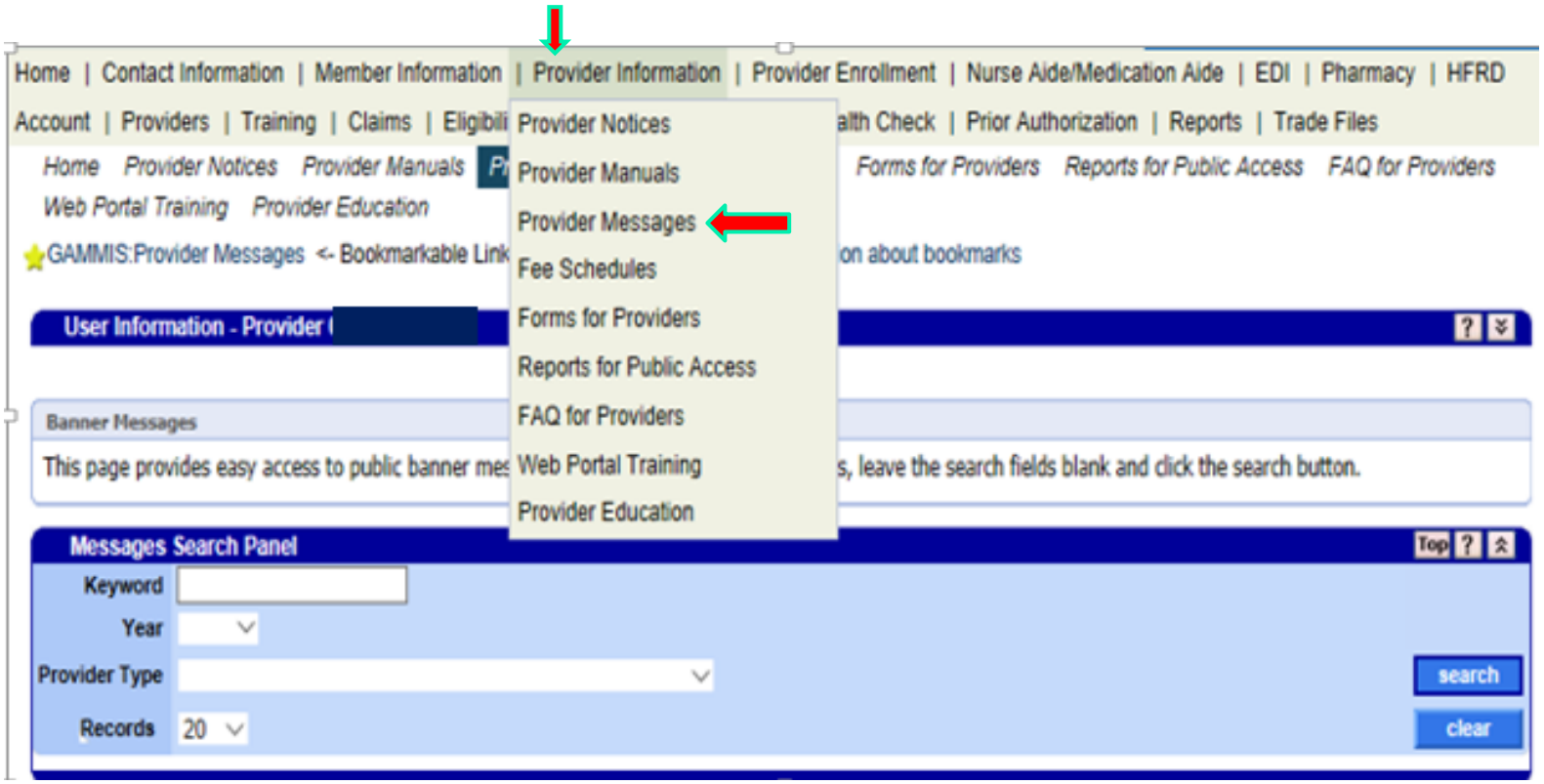
Provider Information and Provider Notices



Provider Information and Provider Manuals



Provider Information and Provider Messages



Provider Information and Provider Messages

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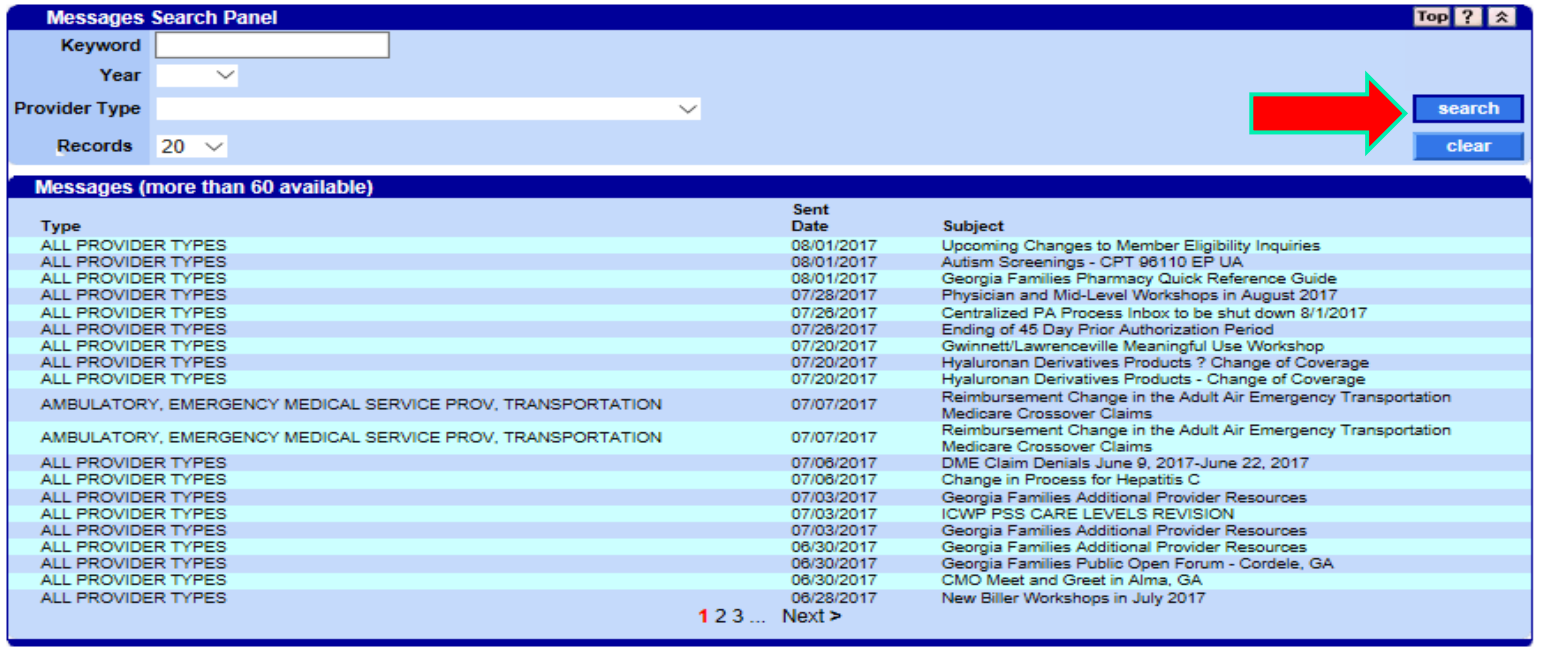

IVRS Overview

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.

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

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	Tierra Johnson
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

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Provider Relations Field Services

(continued)

State-Wide Consultants

Brenda Hulette

Danny Williams

Sharée C. Daniels

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

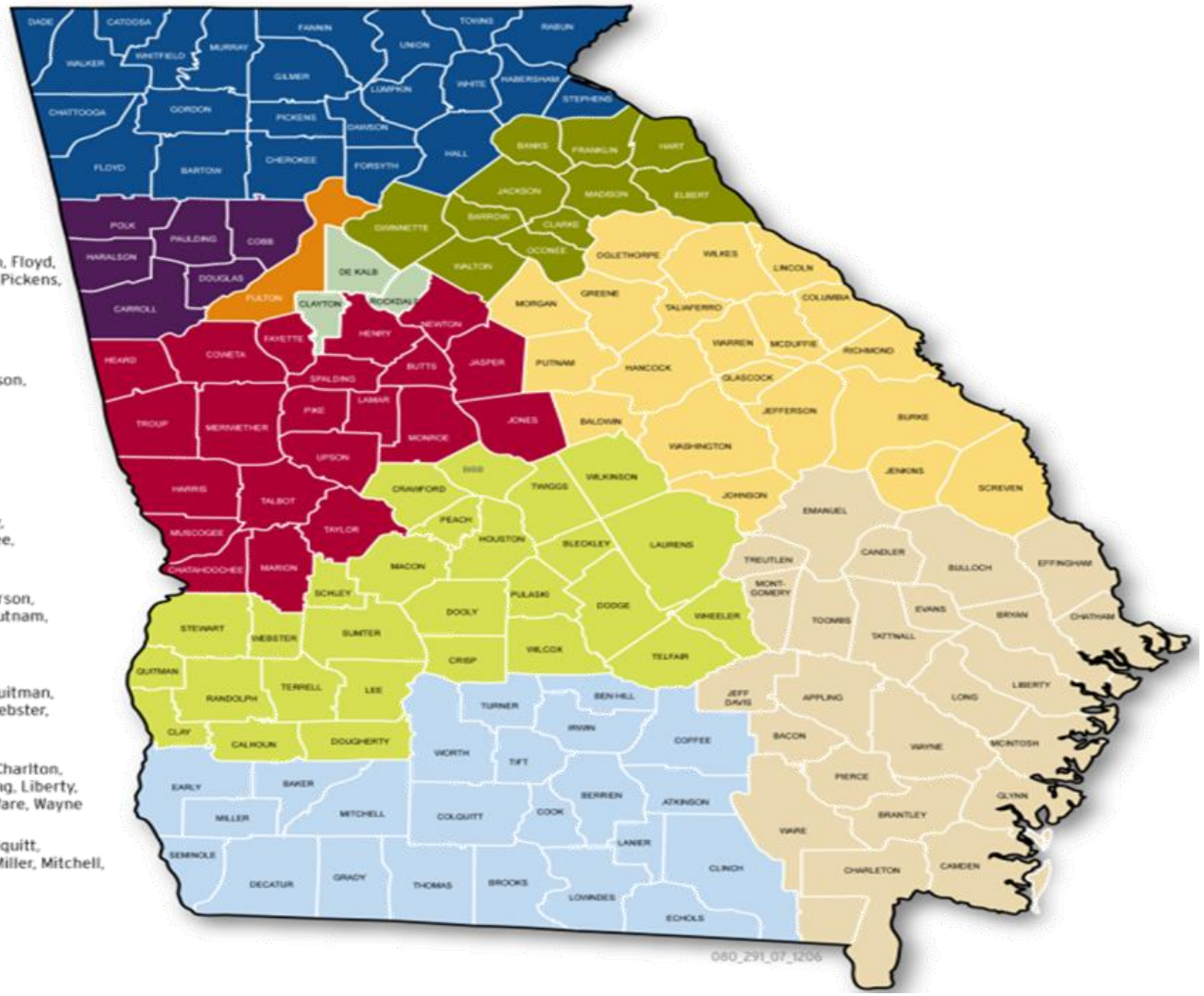
Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

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



Contact My Provider Rep Directly

Login to the MMIS system with your username and password

Contact My Provider Rep Directly

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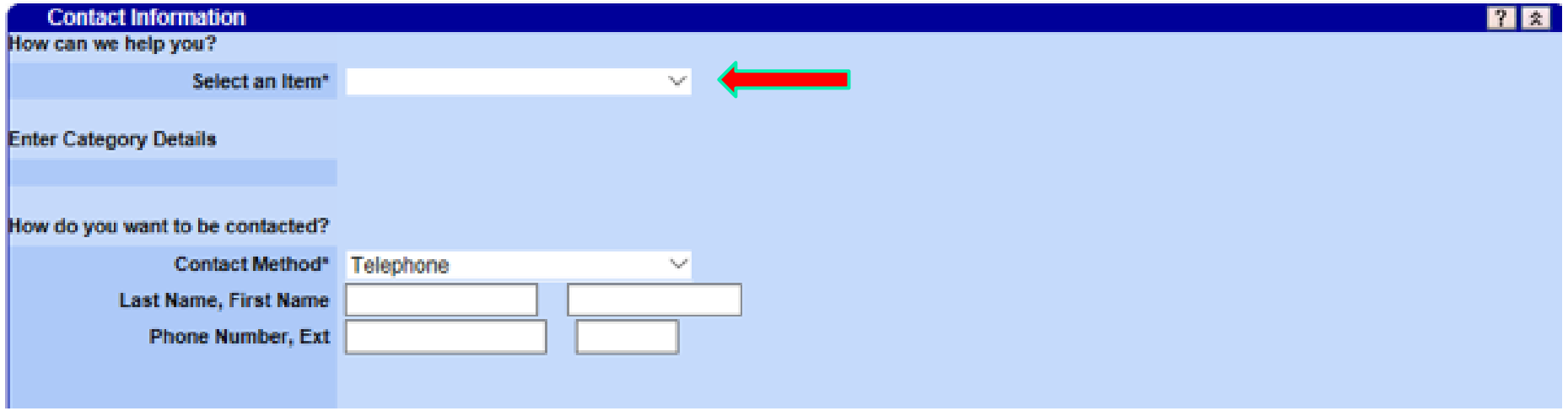

Contact My Provider Rep Directly

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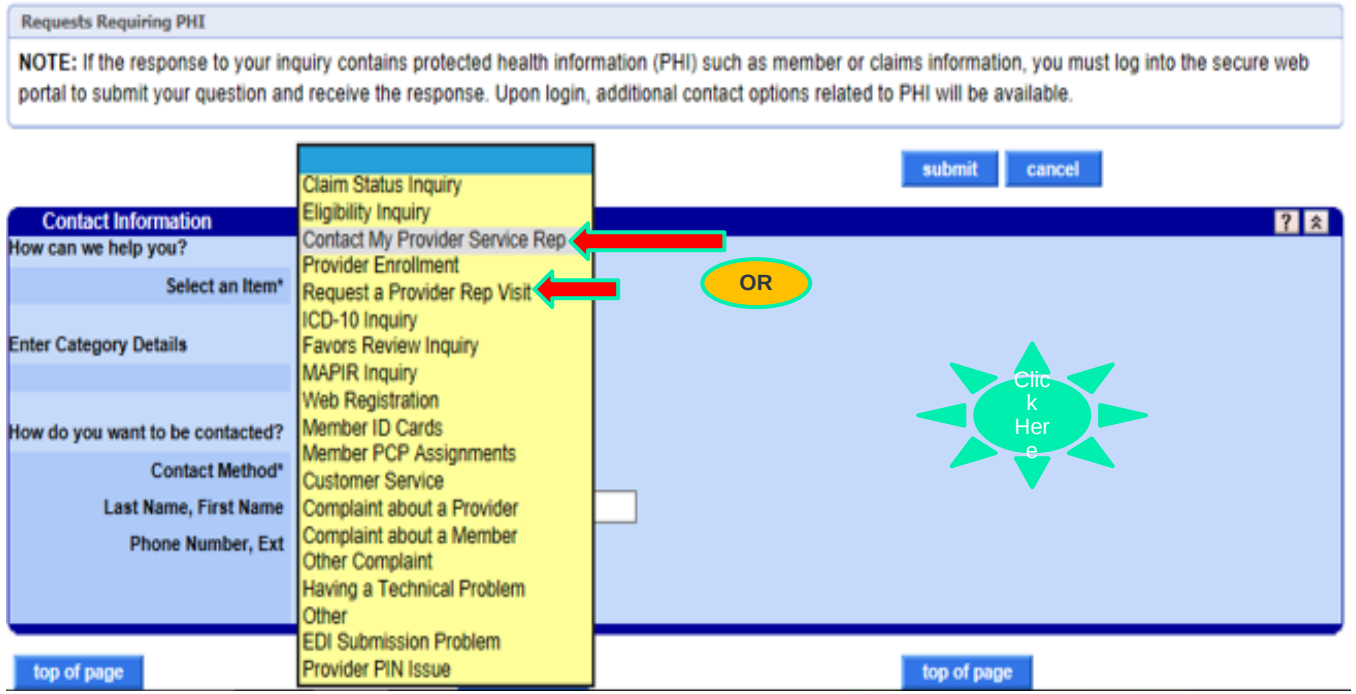

Contact My Provider Rep Directly

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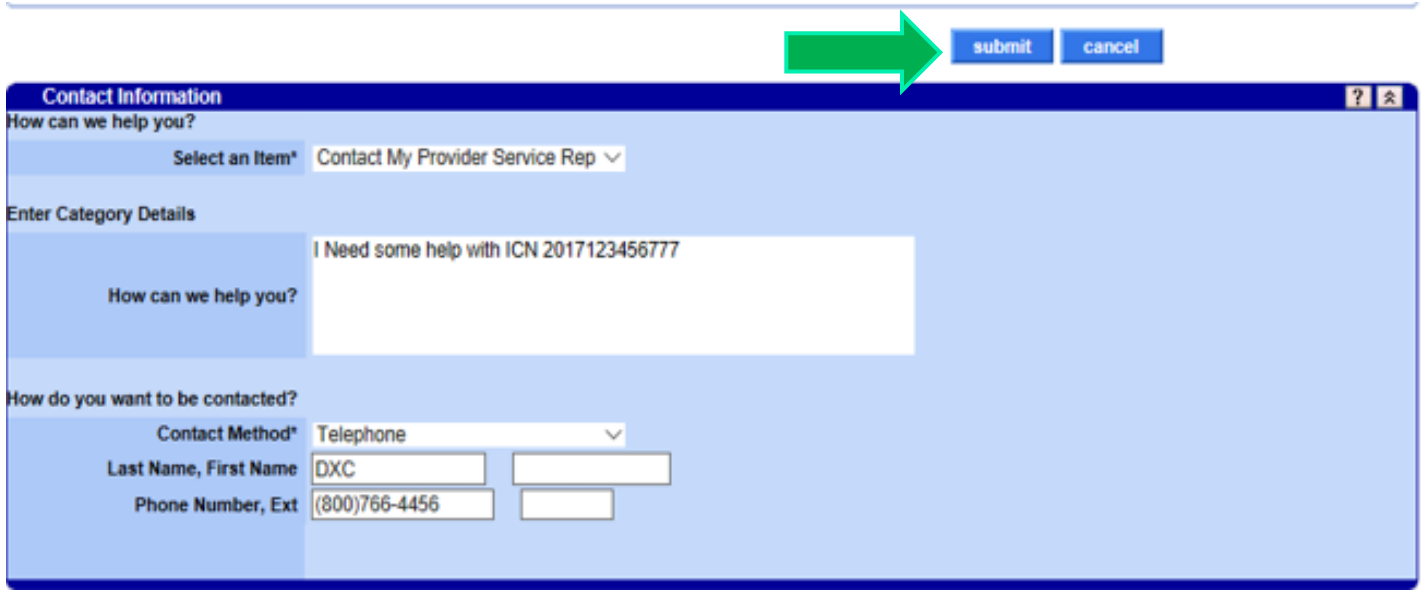

Session Review

You should now be able to:

- Utilize the GAMMIS
- Understand timely filing policy
- How to submit a Claim Appeal
- Access the Remittance Advice
- Understand how to obtain Policy Information and Updates
- Contact Gainwell Technologies about information concerning Georgia Medicaid

Thank you

Closing

Questions & Answers

Contact
brand@gainwelltechnologies.com
gainwelltechnologies.com

Gainwell Technologies
1775 Tysons Blvd.
McLean, VA 22102