

Medicaid MMIS Web Portal Basics



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



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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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.

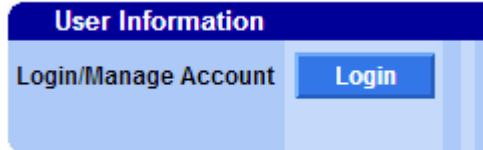
Eligibility Verification

- 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.

A screenshot of the 'Sign in to Georgia Medicaid' login page. It includes fields for 'Username' and 'Password', and a 'Sign In' button. Below the fields, there is a link for 'Forgot your password?'.

2. Click the Web Portal link.

A screenshot of a table titled 'Applications'. It has two columns: 'Application' and 'Description'. The 'Application' column contains links for 'MEUPS Account Management' and 'Web Portal'. The 'Description' column provides details for each: 'MEUPS Account Management' manages contact information, password, and authorizations for applications, and 'Web Portal Production' is for Web Portal Production.

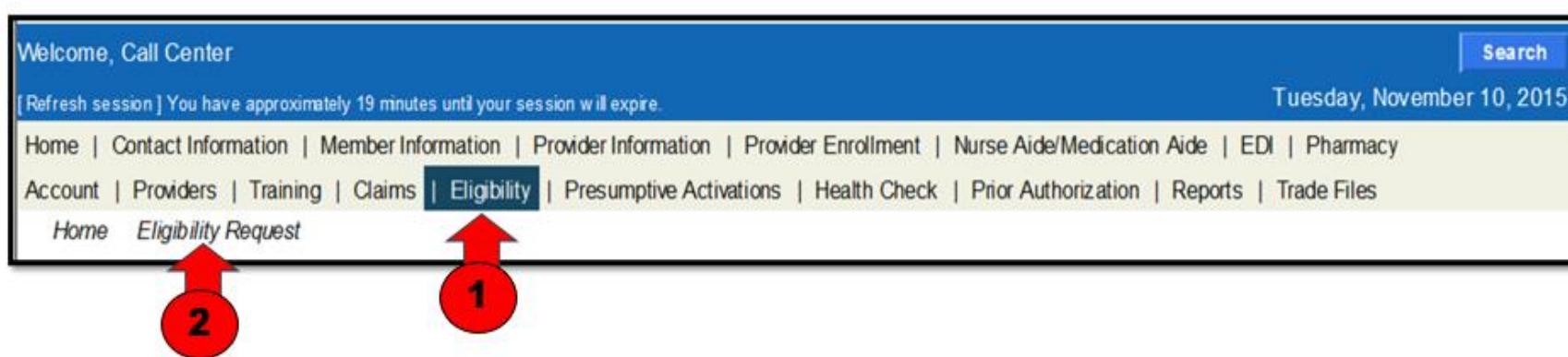
Application	Description
MEUPS Account Management	Manages contact information, password, and authorizations for applications.
Web Portal	Web Portal Production

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)

Eligibility Verification Request

Member ID	123456789012	Birth Date	<input type="text"/>	<input type="button" value="?"/>
Last Name	<input type="text"/>	SSN	<input type="text"/>	<input type="button" value="?"/>
First Name	<input type="text"/>	From/Thru	<input type="text" value="05/01/2010"/>	<input type="button" value="?"/>
Gender	<input type="text"/>	Date of Service	<input type="text" value="05/05/2010"/>	<input type="button" value="?"/>
<input type="button" value="search"/> <input type="button" value="clear"/>				

1 2

Member ID Information				Member Transactions			Personal Information			?	
Member ID	04141991	Birth Date	04/14/1991	Address 1	2 PEACHTREE ST NW	Address 2(County)	060 - FULTON	City	ATLANTA	State	GA
Zip	30303-3141	First Name	TEST MEMBER	Last Name	MEDICAID FAIR	Middle Initial		Name Suffix		Gender	F
		Transaction Date/Time	06/05/2019 09:27:45	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	PEACH STATE HEALTH PLAN - ATLANTA	Plan Name	Georgia Families	Provider Phone	(888)674-2034	Effective Date	06/05/2019	End Date	06/05/2019		
Eligibility by Service Type											
Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copy 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	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	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	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	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.

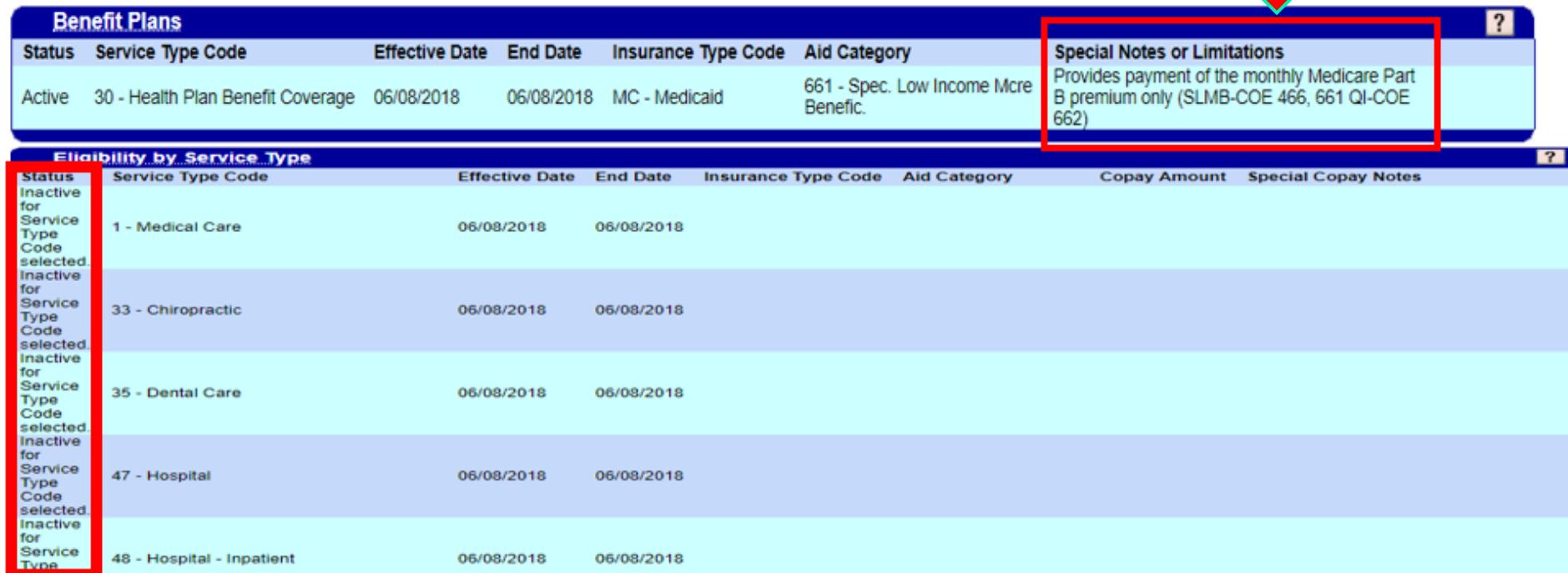


Eligibility by Service Type								?
Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes	
Inactive for Service Type Code selected.		09/08/2018	09/08/2018					

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.)
Emergency or Service Type						
Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount
Active	1 - Medical Care	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50
Inactive for Service Type Code selected.	33 - Chiropractic	06/08/2018	06/08/2018			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	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
Active	48 - Hospital - Inpatient	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50
Active	50 - Hospital - Outpatient	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	3.00
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

CCSP Benefits

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
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



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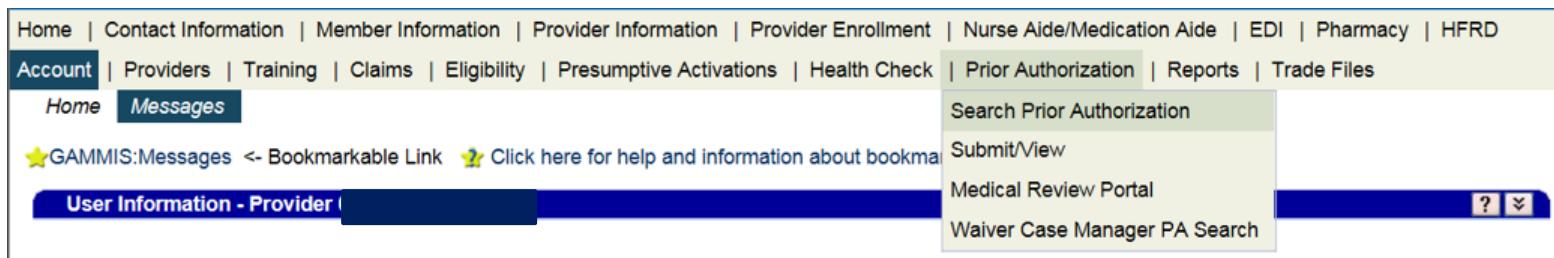
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Prior Authorization Search

Visit: www.mmis.georgia.gov

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

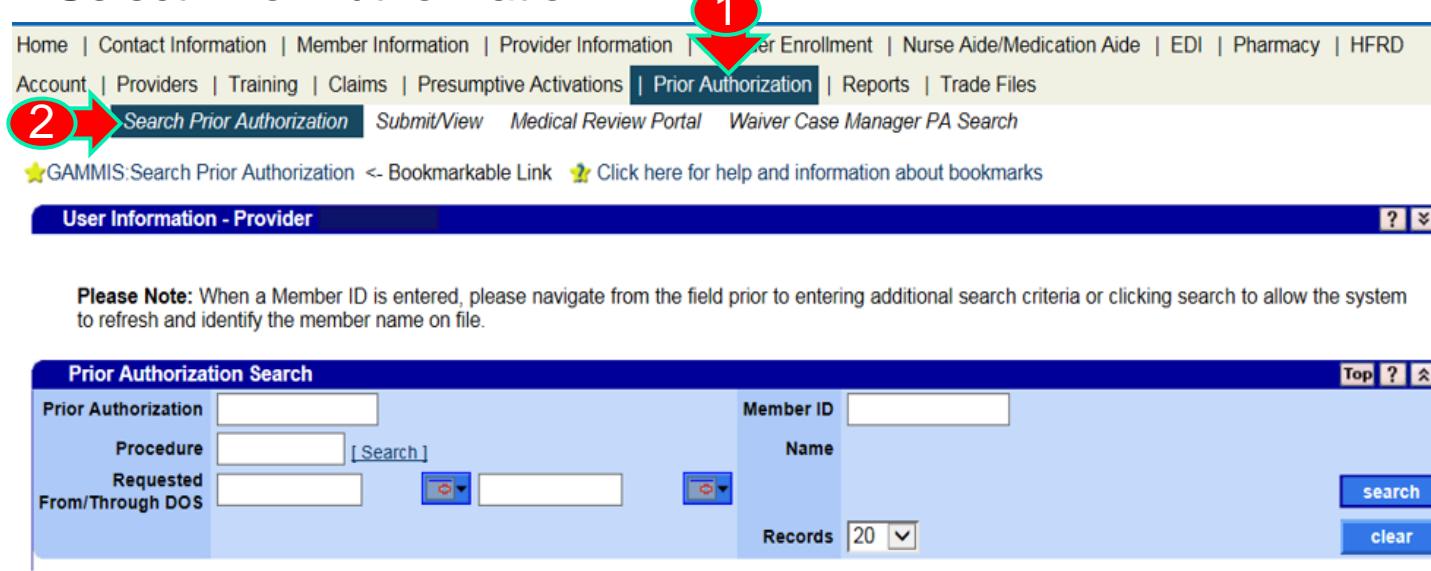


Prior Authorization Search

(continued)

Visit: www.mmis.georgia.gov

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



1

2

Home | Contact Information | Member Information | Provider Information | **Prior Enrollment** | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD
Account | Providers | Training | Claims | Presumptive Activations | **Prior Authorization** | Reports | Trade Files
Search Prior Authorization Submit/View Medical Review Portal Waiver Case Manager PA Search
★GAMMIS:Search Prior Authorization <- Bookmarkable Link Click here for help and information about bookmarks
User Information - Provider

Please Note: When a Member ID is entered, please navigate from the field prior to entering additional search criteria or clicking search to allow the system to refresh and identify the member name on file.

Prior Authorization Search

Prior Authorization	<input type="text"/>	Member ID	<input type="text"/>	Top	?	^
Procedure	<input type="text"/> <input type="button" value="Search"/>	Name				
Requested From/Through DOS	<input type="text"/> <input type="button" value="C"/> <input type="button" value="D"/>	Records	20	<input type="button" value="search"/>	<input type="button" value="clear"/>	

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)

Base Information	
Prior Authorization Number	[REDACTED]
Provider Name	[REDACTED]
REF ID	[REDACTED]
From DOS	11/14/2016
Through DOS	11/13/2017
Status	APPROVED
Member ID	[REDACTED]
Member Name	[REDACTED]

Prior Authorization Search

(continued)

Line Items											
PA Line Item	01	Status	COS Code	APPROVED	Rendering Provider	Category of Service	Tooth	Quadrant	Surface		
From DOS Through DOS Most Recent DOS Paid	11/14/2016 11/13/2017	Units Allowed Units Used Max Monthly Units Max Daily Units	12 0.000 1 0	Amount Allowed Amount Used Max Monthly Amount Authorized Rate	\$2,240.04 \$0.00 \$0.00 \$0.00	Rendering Provider	Category of Service	Tooth	Quadrant		
PA Line Item	02	Status	COS Code	APPROVED	Rendering Provider	Category of Service	Tooth	Quadrant	Surface		
From DOS Through DOS Most Recent DOS Paid Units Allowed Units Used	11/14/2016 11/13/2017 01/12/2017 1160 104.000	Max Monthly Units Max Daily Units	110 0	Amount Allowed Amount Used Max Monthly Amount Authorized Rate	\$10,416.80 \$933.92 \$0.00 \$0.00	Rendering Provider	Category of Service	Tooth	Quadrant		
PA Line Item	03	Status	COS Code	APPROVED	Rendering Provider	Category of Service	Tooth	Quadrant	Surface		
From DOS Through DOS Most Recent DOS Paid Units Allowed Units Used	11/14/2016 11/13/2017 01/11/2017 676 98.000	Max Monthly Units Max Daily Units	60 0	Amount Allowed Amount Used Max Monthly Amount Authorized Rate	\$6,827.60 \$886.45 \$0.00 \$0.00	Rendering Provider	Category of Service	Tooth	Quadrant		
Procedures											
PA Line Item	(Procedure)	Description	(Modifier 1)	Description	(Modifier 2)	Description	(Modifier 3)	Description	(Modifier 4)	Description	NDC
01	1	T2022 CASE MANAGEMENT, PER MONTH	SE	STATE/FED FUNDED PROGRAM/SER							
02	2	T1021 HH AIDE OR CN AIDE PER VISIT	TF	INTERMEDIATE LEVEL OF CARE M/CAID CARE							
03	3	T1021 HH AIDE OR CN AIDE PER VISIT	U1	LEV 1 STATE DEF							

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

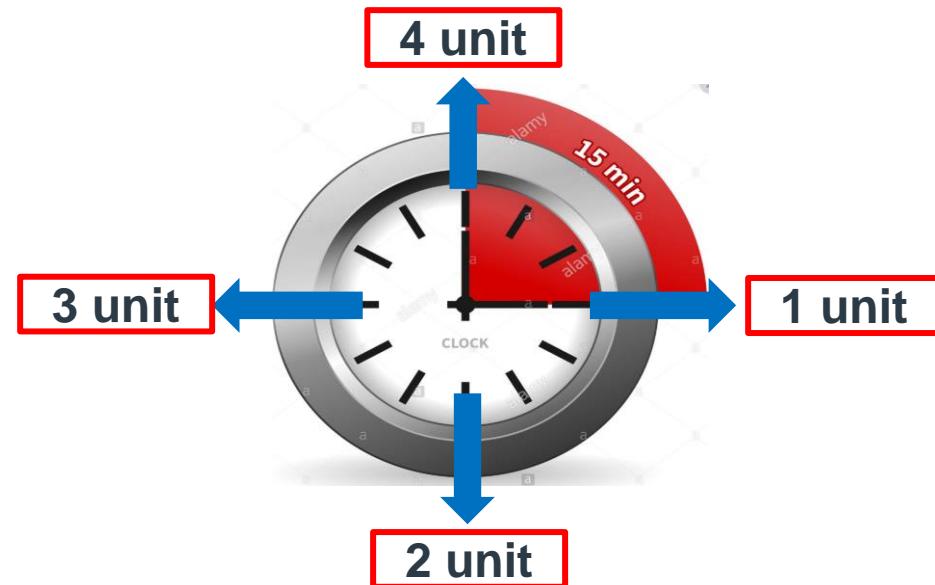
Rate and Unit References

- 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



Billing and Unit Calculation Example

(continued)

Prevocational Services:

Prevocational Services (T2015)

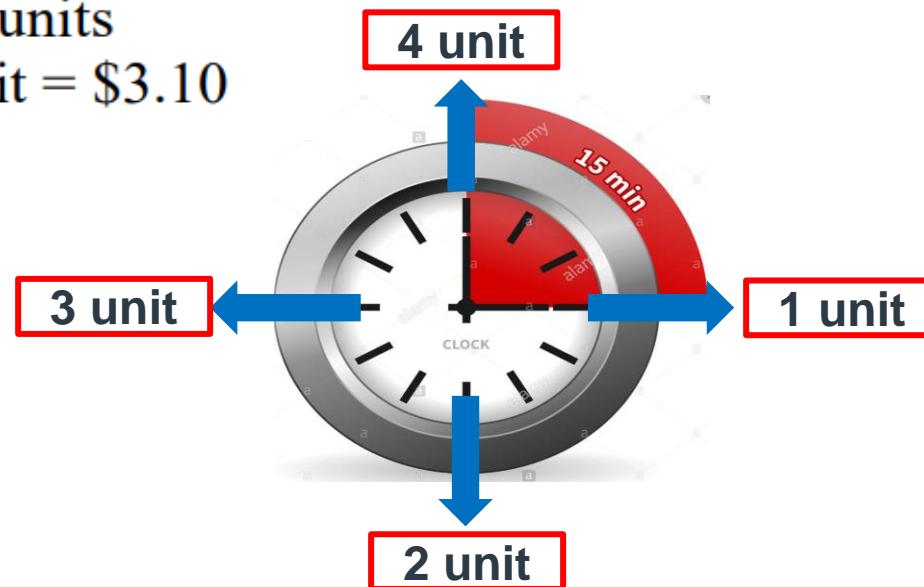
Unit = 15 minutes

Daily Limit = 24 units

Monthly Limit = 504 units

Annual Limit = 5760 units

Maximum rate per unit = \$3.10



New Professional Claim Billing Information

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD
Account | Providers | Training | **Claims** | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

Home *Search (Void, Adjust) Claims* *New Dental Claim* *New Institutional Claim* *New Professional Claim* *Locum Tenens*

 [GAMMIS:Claims](#) <- Bookmarkable Link  [Click here for help and information about bookmarks](#)

(click to hide) Alert Message posted 2/24/2012

This site is for testing purposes only!

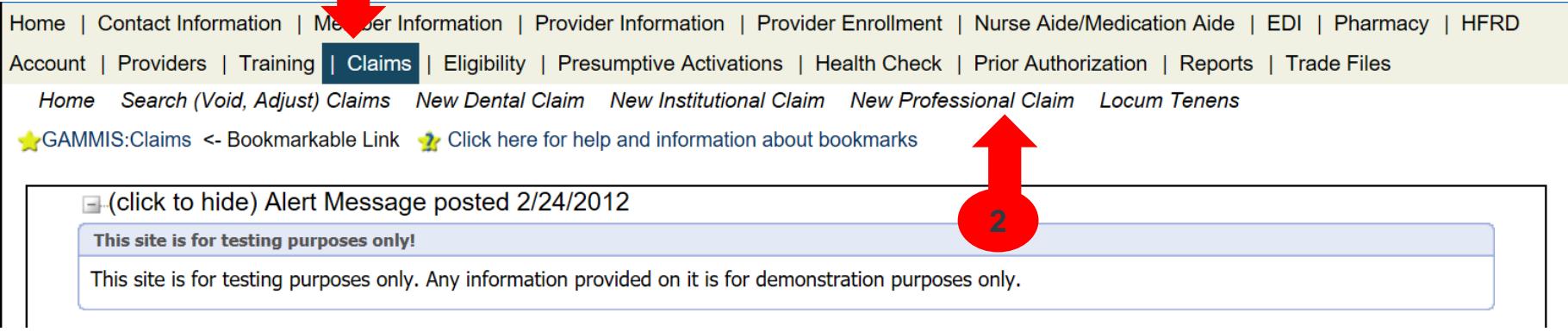
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MMIS Web Claim Submissions

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

Professional Billing Information



Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD
Account | Providers | Training | **Claims** | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files
Home Search (Void, Adjust) Claims New Dental Claim New Institutional Claim New Professional Claim Locum Tenens
★GAMMIS:Claims <- Bookmarkable Link ★ Click here for help and information about bookmarks

(click to hide) Alert Message posted 2/24/2012

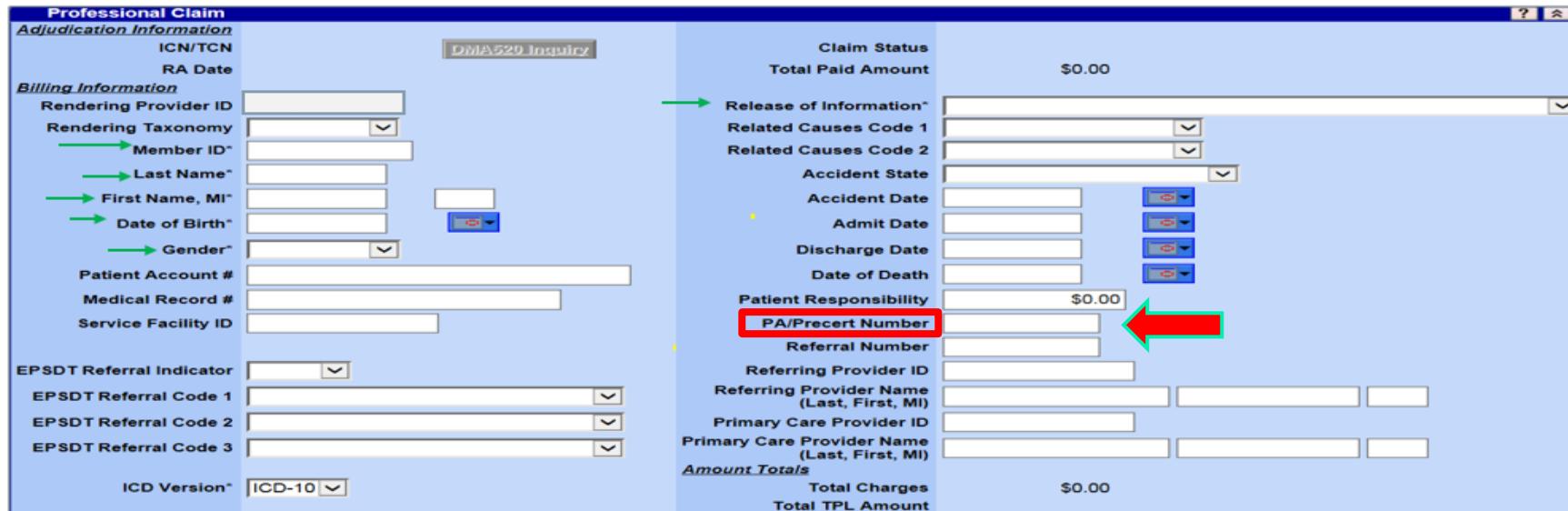
This site is for testing purposes only!

This site is for testing purposes only. Any information provided on it is for demonstration purposes only.

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).



The screenshot shows a software interface for a 'Professional Claim Adjudication Information' screen. The left side is labeled 'Billing Information' and contains fields for a rendering provider, taxonomy, and various patient identifiers (Member ID*, Last Name*, First Name, MI*, Date of Birth*, Gender*). The right side is labeled 'Claim Status' and shows a total paid amount of \$0.00. It includes sections for 'Release of Information' and 'Patient Responsibility'. A red box highlights the 'PA/Precert Number' field in the 'Patient Responsibility' section, with a red arrow pointing to it from the 'Member ID*' field on the left. A green arrow also points from the 'Member ID*' field to the 'PA/Precert Number' field.

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.

Diagnosis

Sequence	Diagnosis	Description
A	A	
Type data below for new record.		
Sequence*	1	Diagnosis [Search]
	1	
	2	
	3	
	4	
	5	
	6	
	7	

delete add

Detail

Detail

** No rows found ***

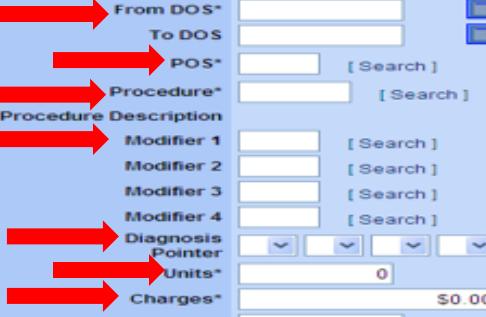
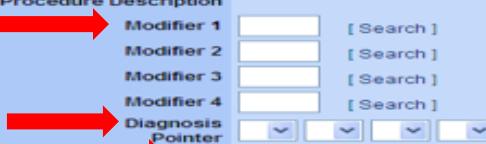
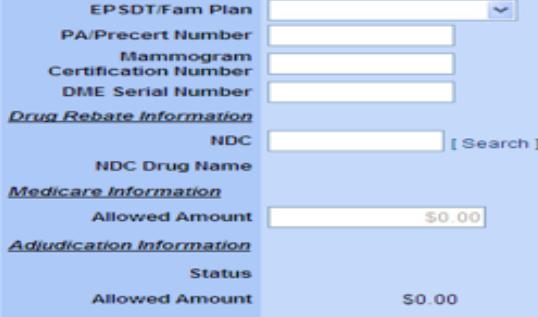
Select row above to update -or- click Add button below.

add



Claims Detail

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

A Item		1	Detail	
From DOS			Emergency	
To DOS			EPSDT/Fam Plan	
POS			PA/Precert Number	
Procedure			Mammogram Certification Number	
Procedure Description			DME Serial Number	
Modifiers	...		NDC	
Diagnosis Pointers			NDC Drug Name	
Units	0.00		MCare Allowed Amount	\$0.00
Charges	\$0.00		Status	
Rendering Provider			Allowed Amount	\$0.00
Type data below for new record.				
Item	1		CoPay Amount	\$0.00
From DOS*			Paid Amount	\$0.00
To DOS				
POS*		[Search]		
Procedure*		[Search]		
Procedure Description				
Modifier 1		[Search]		
Modifier 2		[Search]		
Modifier 3		[Search]		
Modifier 4		[Search]		
Diagnosis Pointer				
Units*	0			
Charges*	\$0.00			
Rendering Provider				
				
				
				
				
				

Submit

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy
Account | Providers | Training | **Claims** | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files
Home Search (Void, Adjust) New Dental Claim New Institutional Claim **New Professional Claim**

(click to hide) Alert Message posted 10/1/2015
ICD-10 Is Live
If your date of service requires you to submit ICD-9 codes, select ICD-9 from the ICD Version field prior to entering any ICD-9 codes.

User Information - Provider

Provider Billing Manuals

submit | cancel

Professional Claim

Adjudication Information

ICN/TCN

DMA520 Inquiry

RA Date

Billing Information

Rendering Provider ID

Rendering Taxonomy

Member ID*

Last Name*

First Name, MI*

Date of Birth*

Gender*

Patient Account #

Medical Record #

Service Facility ID

EPSDT Referral Indicator

EPSDT Referral Code 1

EPSDT Referral Code 2

EPSDT Referral Code 3

ICD Version* **ICD-10**

Claim Status

Total Paid Amount \$0.00

Release of Information*

Related Causes Code 1

Related Causes Code 2

Accident State

Accident Date

Admit Date

Discharge Date

Date of Death

Patient Responsibility

PA/Precert Number

Referral Number

Referring Provider ID

Referring Provider Name (Last, First, MI)

Primary Care Provider ID

Primary Care Provider Name (Last, First, MI)

Amount Totals

Total Charges \$0.00

Total TPL Amount

Diagnosis



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
<i>Claim Type</i>	<i>Year and Day</i>	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.



The screenshot shows a software interface for a 'Professional Claim'. The interface is divided into several sections: 'Professional Claim', 'Adjudication Information' (with fields for ICN/TCN and RA Date), 'Billing Information' (with fields for Rendering Provider ID and Rendering Taxonomy), 'DMA520 Inquiry' (button), 'Claim Status' (button), 'Total Paid Amount' (\$0.00), 'Release of Information*' (dropdown menu showing 'Y - SIGNED STMT PERMITTING RELEASE'), and 'Related Causes Code 1' (dropdown menu). At the bottom right, there is a red box containing the 'submit' and 'cancel' buttons, with a red arrow pointing to the 'submit' button.

Claim Status – Top of the Claim

Claim number – Internal Control Number (ICN)

Status – Paid, Denied or Suspended

Total Paid amount

The screenshot shows a software window titled "Professional Claim". The window is divided into sections: "Adjudication Information" (containing "ICN/TCN" with value "2019000000010" and "RA Date"), "Billing Information", and "Claim Status" (containing "Paid" and "Total Paid Amount" with value "1000.00"). On the right side, there are buttons for "Provider Billing Manuals", "submit", and "cancel". Red arrows point from the text labels on the left to the corresponding fields in the window.

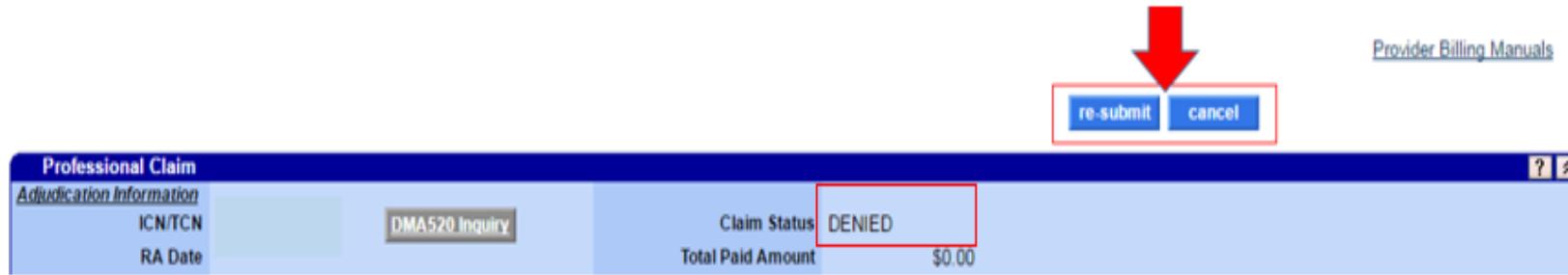
Professional Claim	
<i>Adjudication Information</i>	
ICN/TCN	2019000000010
RA Date	
<i>Billing Information</i>	
Claim Status	
Paid	
Total Paid Amount	
1000.00	

Provider Billing Manuals

submit cancel

Denied Claim

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



The screenshot shows a software interface for a 'Professional Claim'. At the top, there is a navigation bar with links for 'Provider Billing Manuals', a question mark icon, and a user icon. Below this is a toolbar with buttons for 'ICN/TCN', 'RA Date', 'DMA520 Inquiry', 'Claim Status' (which is set to 'DENIED'), and 'Total Paid Amount' (\$0.00). A red box highlights the 'DENIED' status. At the bottom right of the main area, there are two blue buttons: 're-submit' and 'cancel'. A large red arrow points down to the 're-submit' button, indicating it is the action to take when a claim is denied.

Suspended Claim

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



The following messages were generated:

Panel	Field	Row
Professional Claim	Professional Claim	

Message Description
Submit was successful. See Claim Status Information for details.

Professional Claim

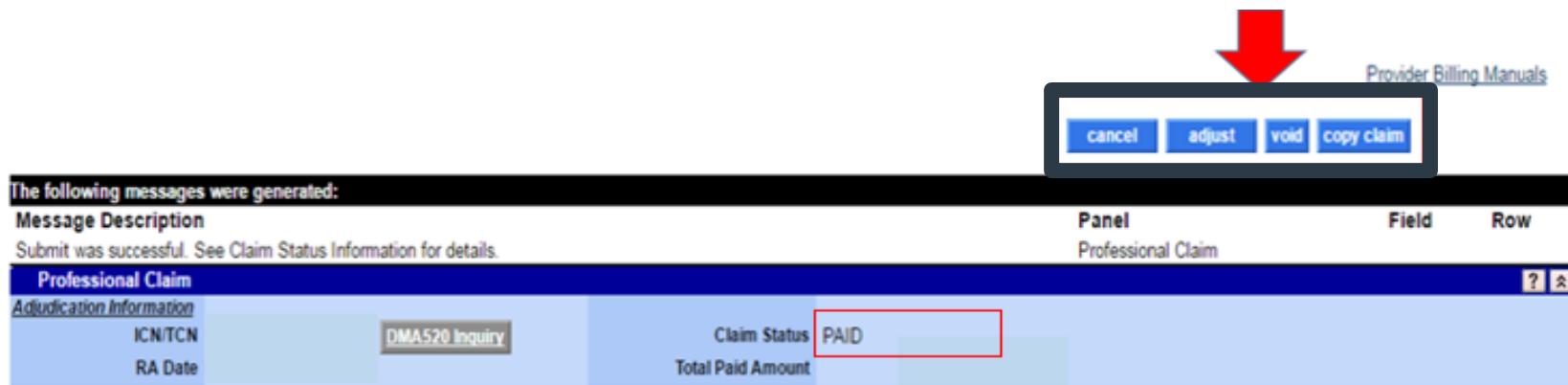
Adjudication Information

ICN/TCN	DMA520 Inquiry	Claim Status	SUSPENDED
RA Date		Total Paid Amount	\$0.00

Provider Billing Manuals

Paid Claim with the Adjust Option

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



The screenshot shows a software interface for managing claims. At the top, a red arrow points down to a row of buttons: 'cancel', 'adjust', 'void', and 'copy claim'. The 'adjust' button is highlighted with a red border. To the right of these buttons is the text 'Provider Billing Manuals'. Below this, a message box displays: 'The following messages were generated: Message Description Submit was successful. See Claim Status Information for details.' To the right, there are columns for 'Panel' (labeled 'Professional Claim'), 'Field', and 'Row'. A table below has a dark blue header row labeled 'Professional Claim' and 'Adjudication Information'. The table cells contain: 'ICN/TCN' (under Adjudication Information), 'DMA520 Inquiry' (under Adjudication Information), 'Claim Status' (with a red border around the word 'PAID'), and 'Total Paid Amount' (under Adjudication Information). The bottom right corner of the table has a question mark icon.

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



GEORGIA DEPARTMENT
OF COMMUNITY HEALTH

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gainwell

Claims History Search

1. A red circle with the number 1 is positioned above the 'Claims' link in the top navigation bar.

2. A red circle with the number 2 is positioned above the 'Search (Void, Adjust) Claims' link in the top navigation bar.

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD

Account | Providers | Training | **Claims** | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

[Home](#) [Search \(Void, Adjust\) Claims](#) [Partial Claim](#) [New Institutional Claim](#) [New Professional Claim](#) [Locum Tenens](#)

★ GAMMIS:Search (Void, Adjust) Claims <- Bookmarkable Link Click here for help and information about bookmarks

(click to hide) Alert Message posted 2/24/2012

This site is for testing purposes only!

This site is for testing purposes only. Any information provided on it is for demonstration purposes only.

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

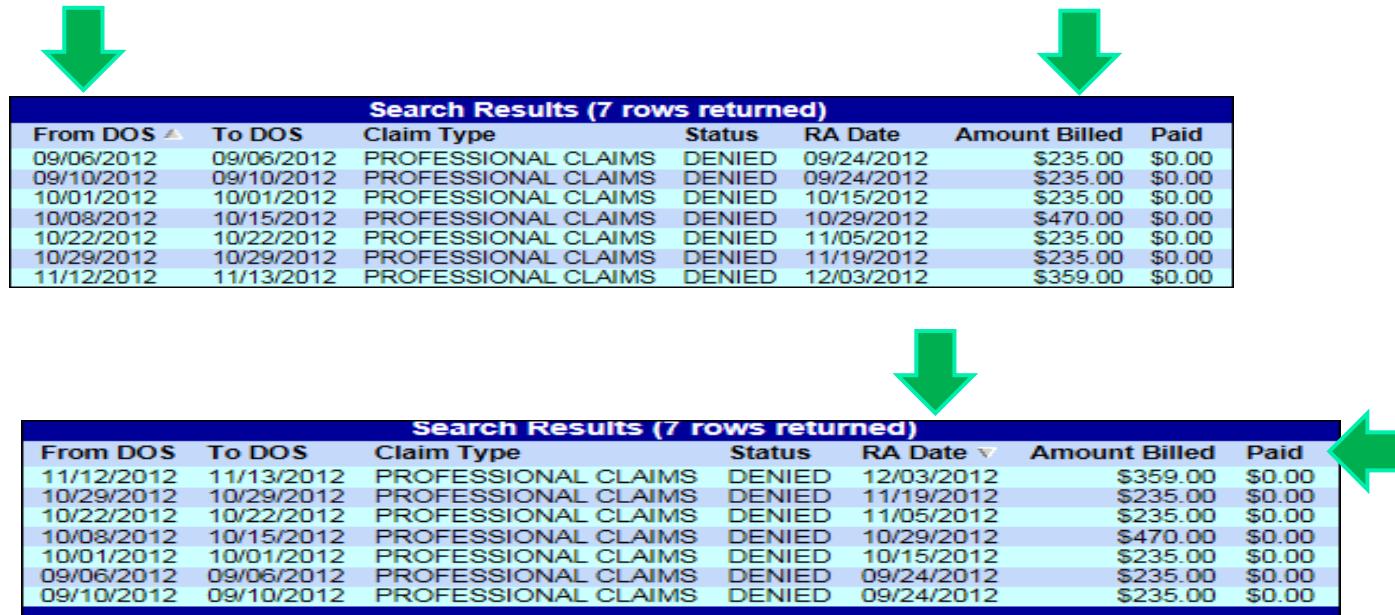
Claims History Search

(continued)

Claim Search

ICN/TCN	From/Thru DOS	Top	?	×					
Member ID	01/05/2009	01/29/2009							
Rendering Provider ID	RA Date								
Claim Type	M - PROFESSIONAL CLAIMS								
Status									
Records									
D - DENIED P - PAID Q - QLTY CNTL R - RESUBMIT X - SUPER-SUSPEND S - SUSPENDED									
[Search] clear									
REPORT FRAUD									
English Español Accessibility									
Search Results (13 rows returned)									
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	\$86.81	\$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	\$86.81	\$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



The diagram illustrates a sorting process for search results. It consists of two identical tables of search results, each with a green arrow pointing downwards from the top of the table to the bottom, indicating the direction of sorting. The tables are identical in structure and data.

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	1 st Resubmit	2 nd 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

**CLAIM
DENIED**

Tips for Writing Your Appeal

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

Institutional Claim

Adjudication Information

ICN/TCN

RA Date

Billing Information

Rendering Provider ID: 0000

Rendering Taxonomy

Member ID*

Last Name*

First Name, MI*

Date of Birth*

Gender*

Patient Account #

Medical Record #

Attending Physician

Operating Physician

Other Operating Physician

Service Facility ID

Type of Bill*

Type of Bill Frequency*

ICD Version*: ICD-10

DMA520 Inquiry

Not Eligible for an Appeal

Claim Status

Total Paid Amount: \$0.00

Release of Information*

From Date*: []

To Date*: []

Admission Date: []

Admission Hour: []

Admission Type*: []

Admit Source: [Search]

Discharge Hour: []

Patient Status*: [Search]

PA/Precert Number

Referral Number

Referring Provider ID

Referring Provider Name (Last, First, MI)

Patient Responsibility: \$0.00

Amount Totals

Total Charges: \$0.00



DMA-520 - Appeal Eligible

[Refresh session] You have approximately 19 minutes until your session will expire. Thursday, July 17, 201

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy
Account | Providers | Training | **Claims** | Eligibility | Presumptive Activations | Health Check | Prior Authorization | GBHC Referral | Reports | Trade Files
Home **Search (Void, Adjust)** New Dental Claim New Institutional Claim New Professional Claim

User Information - Provider ? ×

[Provider Billing Manuals](#)

re-submit cancel

Professional Claim ? ×

Adjudication Information

ICN/TCN	<input type="text"/>	DMA520 Inquiry ←
RA Date	06/25/2014	

Billing Information

Rendering Provider ID	<input type="text"/>
Rendering Taxonomy	<input type="text"/>
Member ID*	<input type="text"/>
Last Name*	<input type="text"/>
First Name, MI*	<input type="text"/>
Date of Birth*	<input type="text"/> ...
Gender*	F - Female ...

Claim Status DENIED

Total Paid Amount \$0.00

Release of Information* Y - SIGNED STMT PERMITTING RELEASE

Related Causes Code 1

Related Causes Code 2

Accident State

Accident Date ...

Admit Date ...

Discharge Date ...

DMA-520 Form

(continued)

For new inquiries, a call tracking number (CTN) will be provided. Please use this to track your request. For previously submitted inquiries, the status will be provided along with the option to upload additional supporting documentation where the CTN Status is not closed.

submit **clear**

DMA Claim Inquiry Form

Provider Demographic Information

Name	<input type="text"/>	Address 1	100 PEACHTREE STREET
Medicaid Provider ID	<input type="text"/>	Address 2	
Reference Provider ID	<input type="text"/>	City, State	TUCKER, GA
		Zip	30084-1000

Contact Information

The person who should be contacted regarding this inquiry.

Contact Name (Last, First)*	<input type="text"/>	<input type="text"/>
Contact Phone, Ext*	<input type="text"/>	<input type="text"/>
Contact E-Mail Address*	<input type="text"/>	

Claim Information

See the submitted claim values below and the adjudication results.

ICN	22190000000000	Member ID	22110000000000
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR
From DOS	04/12/2019	RA Date	04/15/2019
To DOS	04/12/2019	Claim Status	TEST MEMBER DENIED

Inquiry Request

Please select the claim inquiry reason and enter a written explanation that supports your inquiry. Once the request is successfully submitted, the ability to upload attachments to further support your inquiry will become available.

Claim Inquiry Reason*

Written Explanation*

Date of Inquiry 04/15/2019

A red box highlights the 'Contact Information' and 'Claim Information' sections. A black arrow points from the 'Contact Information' section to the 'Claim Information' section. Another black arrow points from the 'Claim Information' section to the 'Inquiry Request' section.

DMA-520 Inquiry Requirements

- Example:

- ✓ Contact Name (Last, First)
- ✓ Contact Phone, Extension
- ✓ Contact Email Address
- ✓ Claim Inquiry Reason*
- ✓ Written Explanation
- 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 associate your file to the provider inquiry.

DMA Claim Inquiry Form

Call Tracking Information

CTN 14766730
Attachments [Click here to upload attachments.](#)

CTN Status OPEN
Status Date 04/15/2019
Administrative Review

DMA520 Attachment Upload

*** No rows found ***

Upload C:\Users\dwilliams252\De

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

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.

Details: 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

The screenshot shows the Gammis system interface with the following highlights:

- Header:** Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | **Reports** (highlighted with a red arrow 1) | Trade Files
- Sub-Header:** Home Financial Reports HS&R Reports Other Reports **Letters** (highlighted with a red arrow 2)
- Alert Message:** (click to hide) Alert Message posted 2/24/2012 (highlighted with a red arrow 2)
- User Information - Provider:** This site is for testing purposes only! (highlighted with a red arrow 2)
- PDF Reader Required:** NOTE: If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. [Click here to obtain the latest version of the free Adobe Reader.](#)
- File Download Issues:** Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. [Click here for help with download issues.](#)
- Letters Report Search:** The search interface is highlighted with a red box. It includes fields for **Letter*** (CTM-1934-O: PSCC Claim Status), **From Date*** (01/01/2019), **To Date*** (04/30/2019), and a **search** button. The results table shows 2 rows returned.
- Search Results:** Report Name: 04/15/2019 - CTM-1934-O: PSCC Claim Status : Doc Key#= 24452092, Run Date: 4/15/2019 4:00:00 AM. Report Name: 04/15/2019 - CTM-1934-O: PSCC Claim Status : Doc Key#= 24452093, Run Date: 4/15/2019 4:00:00 AM.

DMA-520 Response Letter

(continued)



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.

000001 0 1 00 01 00 000318291

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.



GEORGIA DEPARTMENT OF COMMUNITY HEALTH

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)

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy
Account | Providers | Training | **Claims** | Eligibility | Presumptive Activations | Health Check | Prior Authorization | GBHC Referral | Reports | Trade Files
Home | **Search (Void, Adjust)** | New Dental Claim | New Institutional Claim | New Professional Claim

User Information - Provider ? ▾

[Provider Billing Manuals](#)

re-submit **cancel**

Professional Claim ? ▾

Adjudication Information

ICN/TCN	DMA520 Inquiry
RA Date 06/25/2014	Claim Status DENIED

Billing Information

Rendering Provider ID	Total Paid Amount \$0.00
Rendering Taxonomy	Release of Information* Y - SIGNED STMT PERMITTING RELEASE
Member ID*	Related Causes Code 1
Last Name*	Related Causes Code 2
First Name, MI*	Accident State
Date of Birth*	Accident Date
Gender* F - Female	Admit Date
	Discharge Date

A large red arrow points from the 'RA Date' field to the 'Claim Status' field.

2nd Level/Administrative Review

(continued)

DMA Claim Inquiry Form

Call Tracking Information

CTN	14766730	CTN Status	CLOSED
Attachments	Click here to see a list of submitted attachments.	Status Date	04/15/2019
To view the decision of your inquiry, please go to the Letters page found under the Reports menu and search for/select your assigned CTM-1934-O letter.			

Administrative Review

Click on the Administrative Review button to create an Administrative Review.

Provider Demographic Information

Name	L	Address 1	100 PEACHTREE STREET
Medicaid Provider ID		Address 2	
Reference Provider ID		City, State	TUCKER, GA
		Zip	30084-1000

Contact Information

The person who should be contacted regarding this inquiry.

Contact Name (Last, First)	D	
Contact Phone, Ext	(8	
Contact E-Mail Address	P	

Claim Information

See the submitted claim values below and the adjudication results.

ICN	22190000000000	Member ID	22110000000000
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR
From DOS	04/11/2019	RA Date	04/15/2019
To DOS	04/11/2019	Claim Status	TESTING

Inquiry Request

Please select the claim inquiry reason and enter a written explanation that supports your inquiry. Once the request is successfully submitted, the ability to upload attachments to further support your inquiry will become available.

Claim Inquiry Reason Other Inquiry Issue Not Listed Above

Please advise all details to support this inquiry.

Written Explanation

Date of Inquiry 04/15/2019

Administrative Review

Click on the Administrative Review button to create an Administrative Review.

2nd Level/Administrative Review

(continued)

For new inquiries, a call tracking number (CTN) will be provided. Please use this to track your request. For previously submitted inquiries, the status will be provided along with the option to upload additional supporting documentation where the CTN Status is not closed.

submit clear

Administrative Review Form

Provider Demographic Information

Name	MEADOWS, BILL	Address 1	100 PEACHTREE STREET
Medicaid Provider ID		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)*	
Contact Phone, Ext*	
Contact E-Mail Address*	

Claim Information
See the submitted claim values below and the adjudication results.

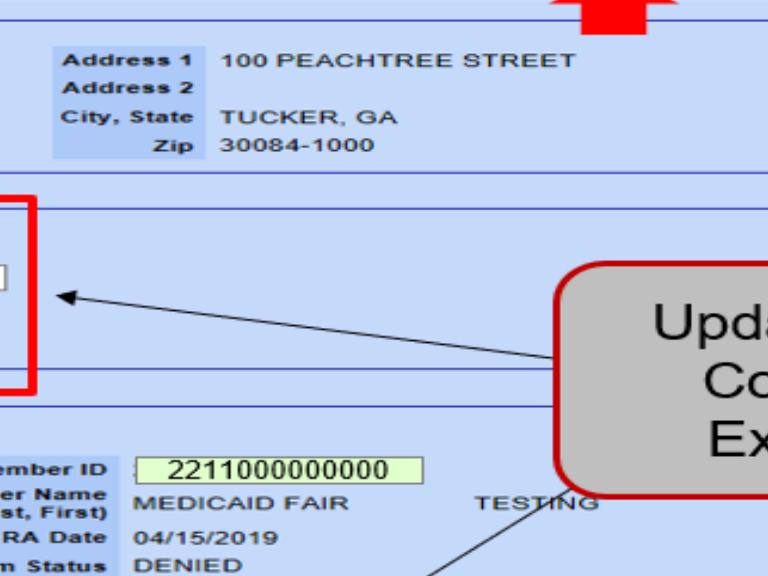
ICN	22190000000000	Member ID	22110000000000
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR
From DOS	04/11/2019	RA Date	04/15/2019
To DOS	04/11/2019	Claim Status	TESTING DENIED

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

Written Explanation*

Date of Inquiry 04/15/2019

Update/Validate
Contact and
Explanation



2nd Level/Administrative Review

(continued)

The following messages were generated:		Panel	Field Row
Message Description Your request has been accepted for processing. Your tracking number is 14766733.		Administrative Review Form	
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			
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
From DOS	04/11/2019	RA Date	04/15/2019
To DOS	04/11/2019	Claim Status	TESTING
			DENIED
Inquiry Request			
Once the request is successfully submitted, the ability to upload attachments to further support your inquiry will become available.			
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.

Administrative Review Attachment Upload

*** No rows found ***

Upload 1

2

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

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

Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide | EDI | Pharmacy
Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | GBHC Referral | **Reports** | Trade Files

Home **Financial Reports** HS&R Reports Other Reports Letters

Reports

Report* Remittance Advice

From Date* 10/01/2009 To Date* 01/21/2010

Records 20

- 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

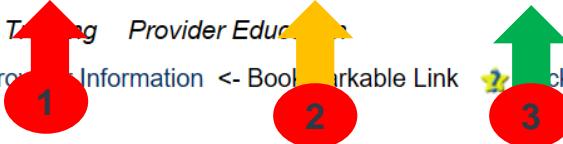


Policy Information and Updates

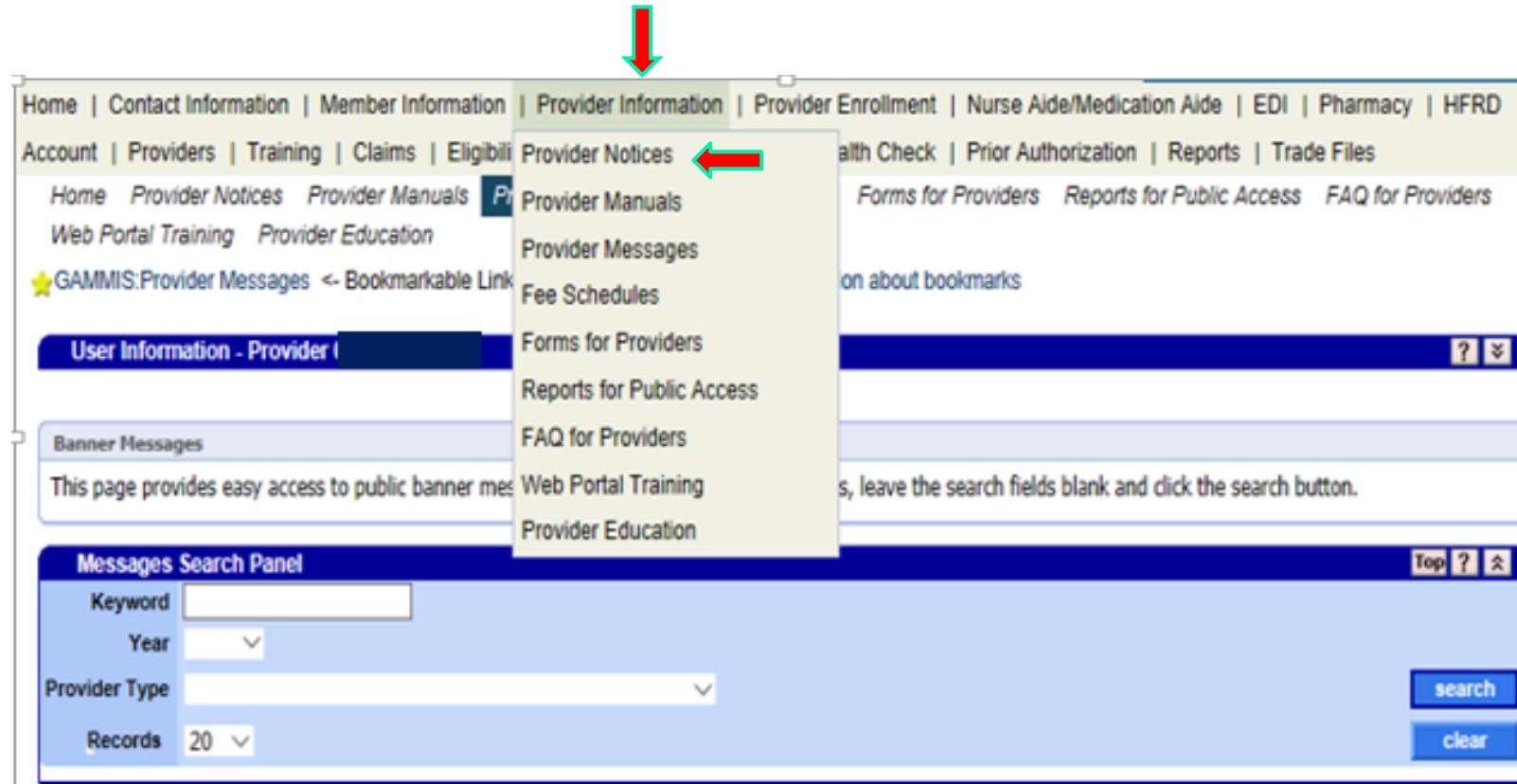
Home | Contact Information | Member Information | **Provider Information** | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD Account | Providers | Training | Claims | Eligibility | Presumptive Activations | Health Check | Prior Authorization | Reports | Trade Files

Home Provider Notices Provider Manuals Provider Messages Fee Schedules Forms for Providers Reports for Public Access FAQ for Providers Web Portal Training Provider Education

★ GAMMIS:Provider Information <- Bookmarkable Link ★ Click here for help and information about bookmarks



Provider Information and Provider Notices



Home | Contact Information | Member Information | **Provider Information** | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD

Account | Providers | Training | Claims | Eligibility | **Provider Notices** | Provider Manuals | Health Check | Prior Authorization | Reports | Trade Files

Home | Provider Notices | Provider Manuals | Provider Messages | Forms for Providers | Reports for Public Access | FAQ for Providers

Web Portal Training | Provider Education

Provider Notices

Provider Manuals

Provider Messages

Fee Schedules

Forms for Providers

Reports for Public Access

FAQ for Providers

Web Portal Training

Provider Education

User Information - Provider

Banner Messages

This page provides easy access to public banner messages. Use the search panel to find specific messages.

Messages Search Panel

Keyword:

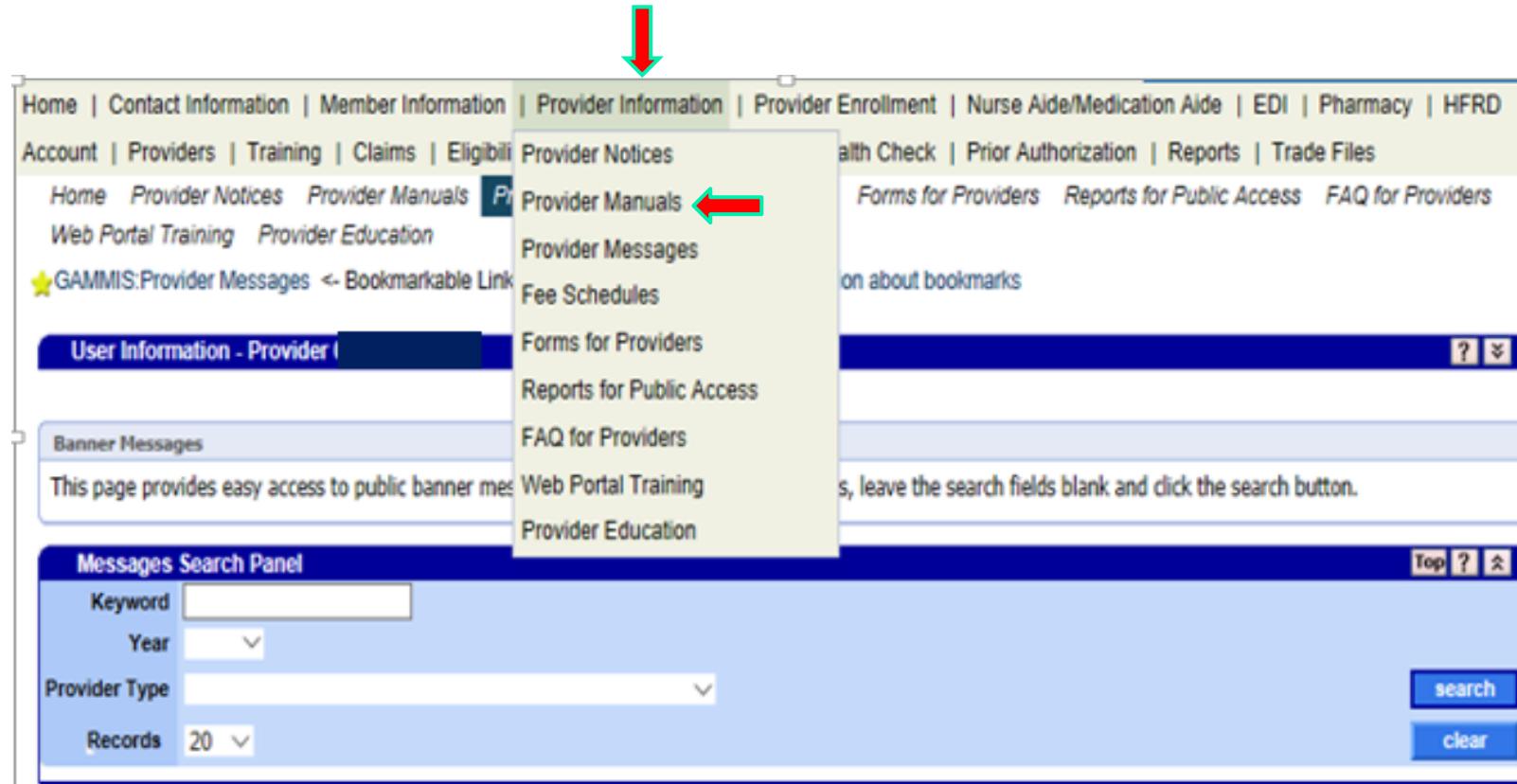
Year:

Provider Type:

Records: 20

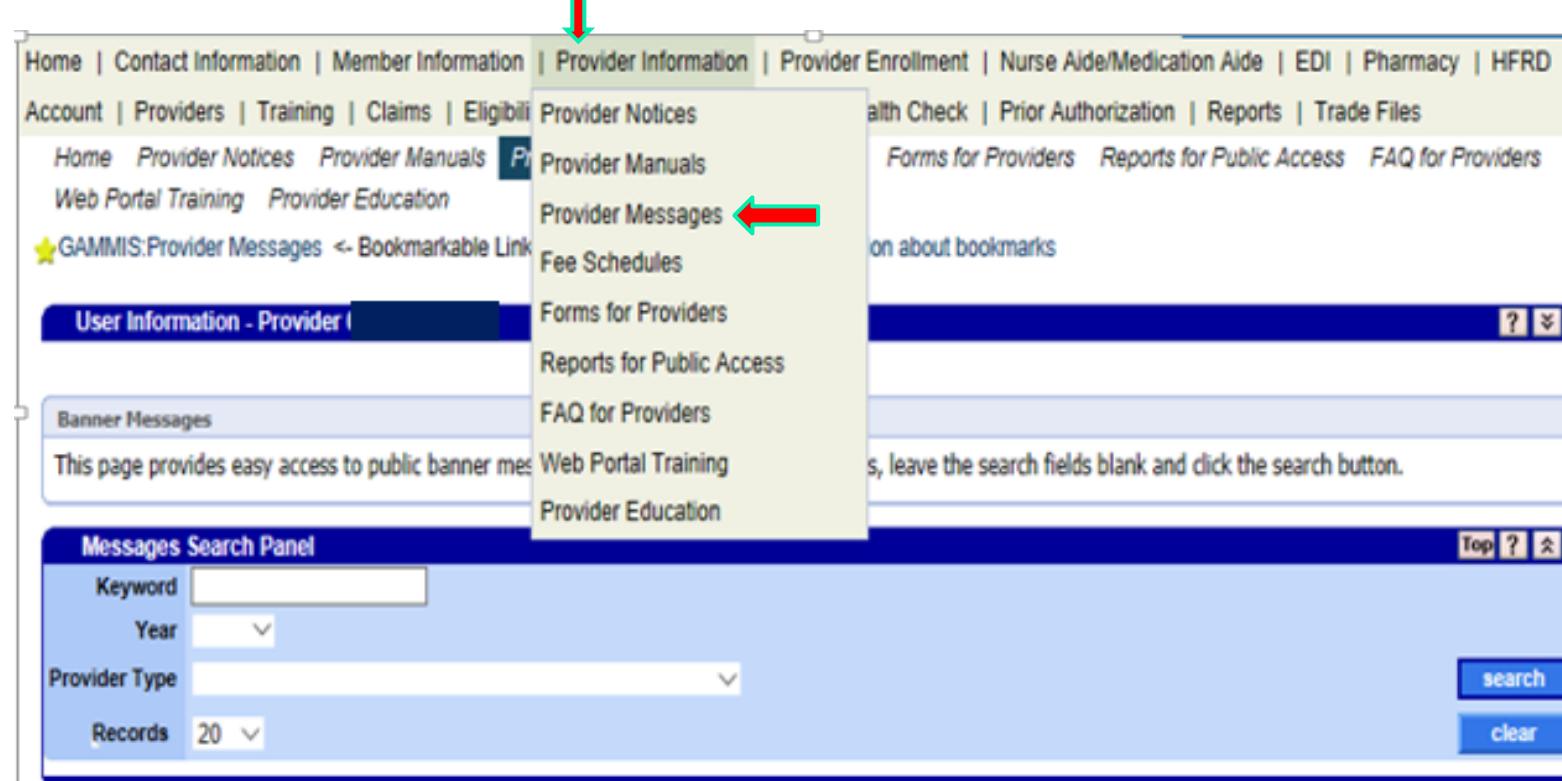
clear

Provider Information and Provider Manuals



The screenshot shows a web-based provider information system. At the top, there is a horizontal navigation bar with links: Home, Contact Information, Member Information, Provider Information (which is the active page, indicated by a blue border), Provider Enrollment, Nurse Aide/Medication Aide, EDI, Pharmacy, and HFRD. Below this is a secondary navigation bar with links: Account, Providers, Training, Claims, Eligibility, Home, Provider Notices, Provider Manuals (which is the active page, indicated by a blue border), Provider Notices, Provider Messages, Fee Schedules, Forms for Providers, Reports for Public Access, FAQ for Providers, Web Portal Training, and Provider Education. A red arrow points to the 'Provider Manuals' link in the second navigation bar. On the left side, there is a sidebar with a 'User Information - Provider' section and a 'Banner Messages' section. The 'Banner Messages' section contains the text: 'This page provides easy access to public banner messages. To search for messages, leave the search fields blank and click the search button.' At the bottom of the page is a 'Messages Search Panel' with fields for Keyword, Year, Provider Type, and Records, and buttons for search and clear.

Provider Information and Provider Messages



Home | Contact Information | Member Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD

Account | Providers | Training | Claims | Eligibility | Provider Notices | Provider Manuals | Provider Messages | Health Check | Prior Authorization | Reports | Trade Files

Home | Provider Notices | Provider Manuals | Provider Messages | Web Portal Training | Provider Education | Forms for Providers | Reports for Public Access | FAQ for Providers

★ GAMMIS: Provider Messages <- Bookmarkable Link | Fee Schedules | on about bookmarks

User Information - Provider

Banner Messages

This page provides easy access to public banner messages, leave the search fields blank and click the search button.

Messages Search Panel

Keyword:

Year:

Provider Type:

Records: 20

clear

Provider Information and Provider Messages

(continued)

Messages Search Panel

Keyword	<input type="text"/>
Year	<input type="text"/>
Provider Type	<input type="text"/>
Records	<input type="text"/> 20 <input type="button"/>

Messages (more than 60 available)

Type	Sent Date	Subject
ALL PROVIDER TYPES	08/01/2017	Upcoming Changes to Member Eligibility Inquiries
ALL PROVIDER TYPES	08/01/2017	Autism Screenings - CPT 98110 EP UA
ALL PROVIDER TYPES	08/01/2017	Georgia Families Pharmacy Quick Reference Guide
ALL PROVIDER TYPES	07/28/2017	Physician and Mid-Level Workshops in August 2017
ALL PROVIDER TYPES	07/26/2017	Centralized PA Process Inbox to be shut down 8/1/2017
ALL PROVIDER TYPES	07/26/2017	Ending of 45 Day Prior Authorization Period
ALL PROVIDER TYPES	07/20/2017	Gwinnett/Lawrenceville Meaningful Use Workshop
ALL PROVIDER TYPES	07/20/2017	Hyaluronic Derivatives Products ? Change of Coverage
ALL PROVIDER TYPES	07/20/2017	Hyaluronic Derivatives Products - Change of Coverage
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/07/2017	Reimbursement Change in the Adult Air Emergency Transportation
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/07/2017	Medicare Crossover Claims
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/07/2017	Reimbursement Change in the Adult Air Emergency Transportation
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/06/2017	Medicare Crossover Claims
ALL PROVIDER TYPES	07/06/2017	DME Claim Denials June 9, 2017-June 22, 2017
ALL PROVIDER TYPES	07/06/2017	Change in Process for Hepatitis C
ALL PROVIDER TYPES	07/03/2017	Georgia Families Additional Provider Resources
ALL PROVIDER TYPES	07/03/2017	ICWP PSS CARE LEVELS REVISION
ALL PROVIDER TYPES	07/03/2017	Georgia Families Additional Provider Resources
ALL PROVIDER TYPES	06/30/2017	Georgia Families Additional Provider Resources
ALL PROVIDER TYPES	06/30/2017	Georgia Families Public Open Forum - Cordele, GA
ALL PROVIDER TYPES	06/30/2017	CMO Meet and Greet in Alma, GA
ALL PROVIDER TYPES	06/28/2017	New Biller Workshops in July 2017

1 2 3 ... Next >



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	Shawntel 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

(continued)

State-Wide Consultants

Brenda Hulette

Danny Williams

Sharée C. Daniels

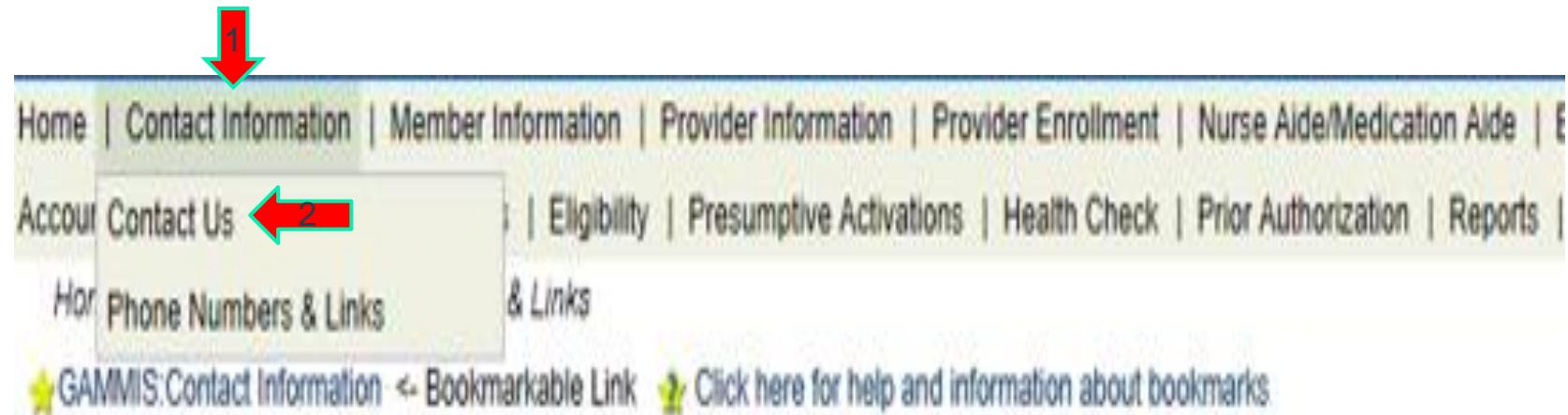
Georgia Field Territories

- Territory 1 N GA**
Bartow, Catoosa, Chattooga, 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, Haralson, 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

(continued)

Contact Information

How can we help you?

Select an Item* 

Enter Category Details

How do you want to be contacted?

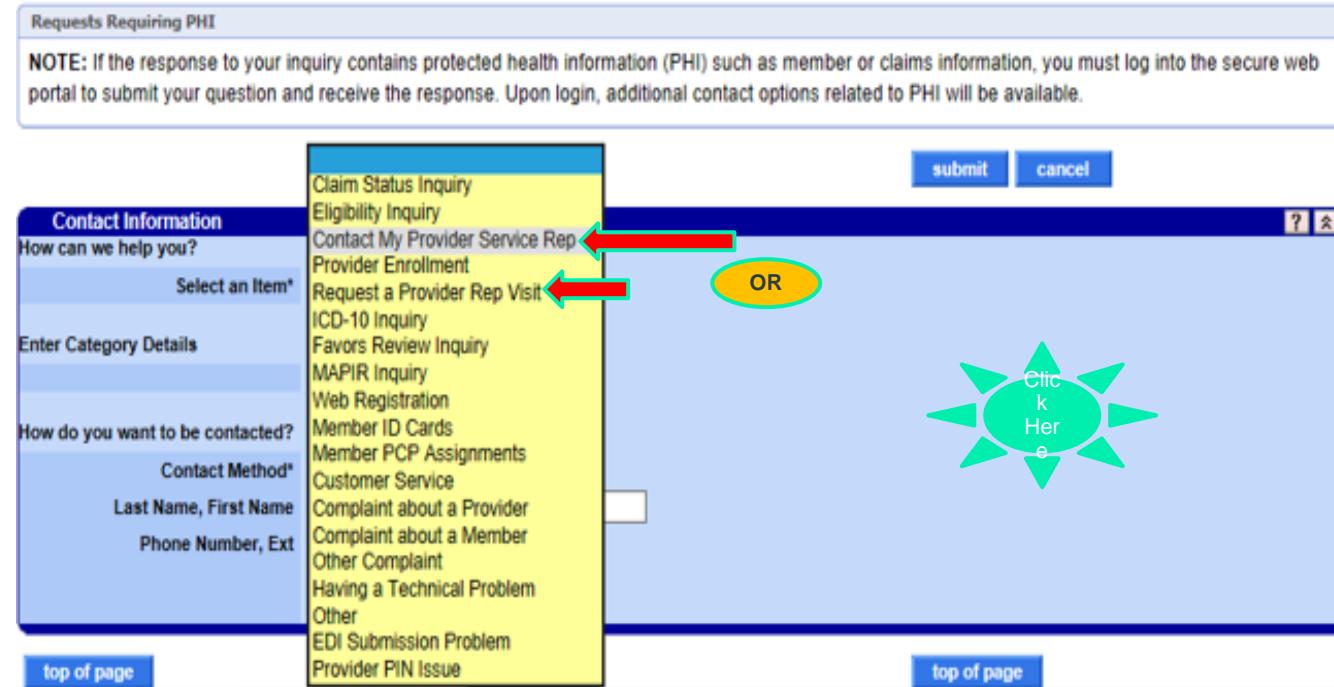
Contact Method* 

Last Name, First Name

Phone Number, Ext

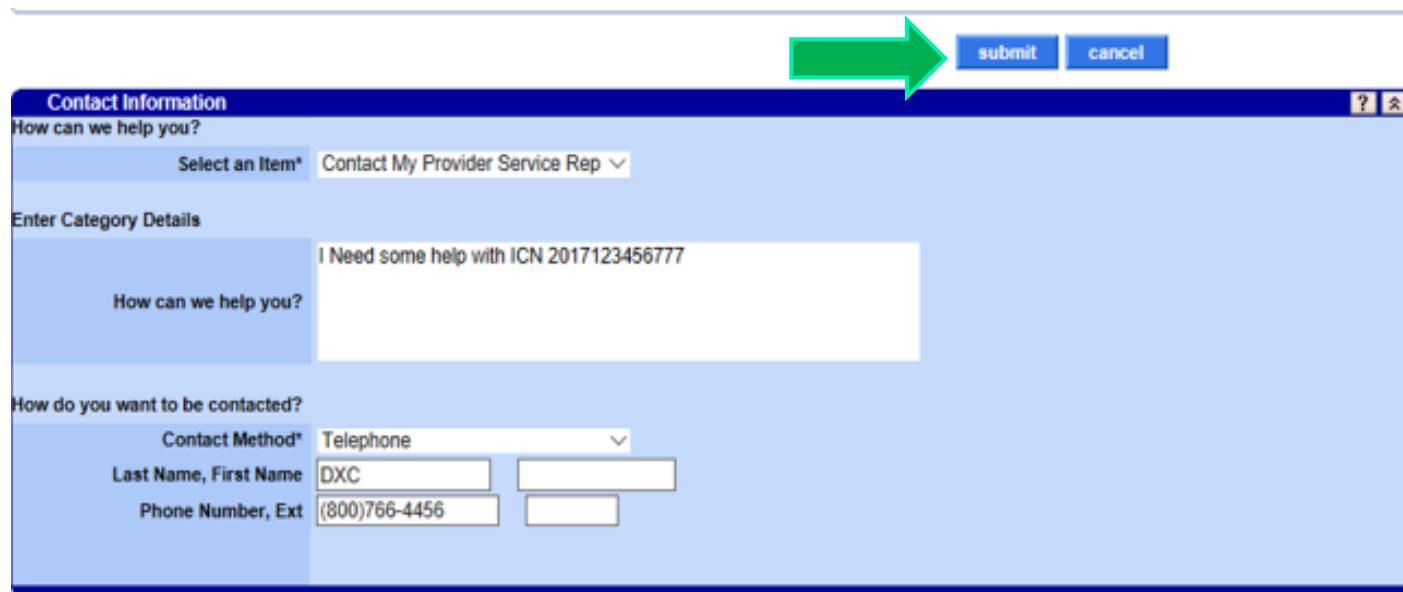
Contact My Provider Rep Directly

(continued)



Contact My Provider Rep Directly

(continued)



The screenshot shows a contact form titled "Contact Information" with a blue header. The header includes the title and a sub-instruction "How can we help you?". Below the header, a dropdown menu is set to "Contact My Provider Service Rep". The main body of the form is titled "Enter Category Details" and contains a text area with the placeholder "I Need some help with ICN 2017123456777". Below this, another "How can we help you?" field is empty. The next section, "How do you want to be contacted?", includes a "Contact Method*" dropdown set to "Telephone", and two text input fields for "Last Name, First Name" (containing "DXC") and "Phone Number, Ext" (containing "(800)766-4456"). A green arrow points to the "submit" button in the top right corner of the form.

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