

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

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.

User Information

Login/Manage Account

Login

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

Sign in to Georgia Medicaid

Username

Password

Sign In

Georgia Medicaid

Forgot your password?

2. Click the Web Portal link.



Applications

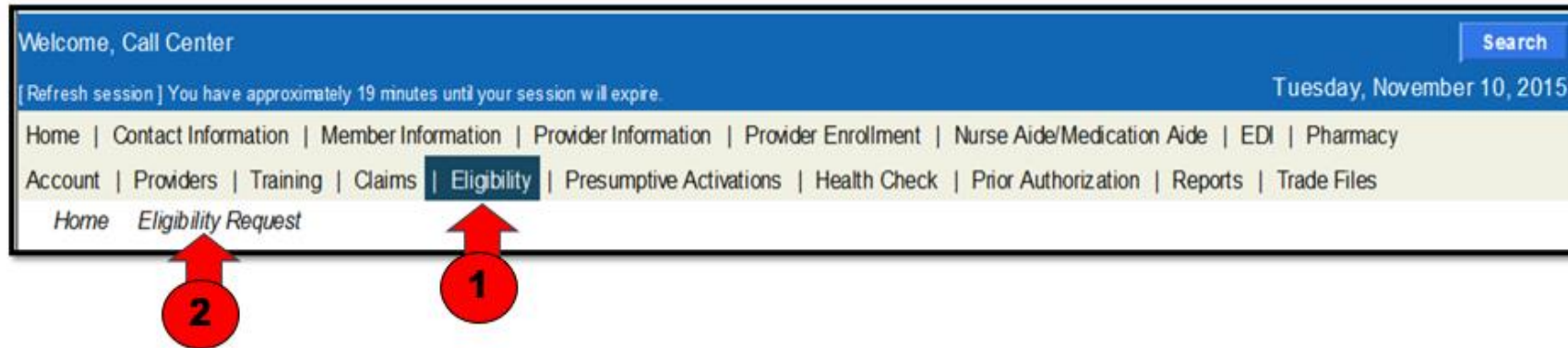
Application	Description
MEUPS Account Management	Manages contact information, password, and authorizations for applications.
Web Portal	Web Portal Production

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

Last Name

First Name

Gender

Birth Date

SSN

From/Thru
Date of Service

05/01/201005/05/2010

?

↑

1

2

search

clear

Member ID Information						
Member ID	04/14/1991		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

(continued)



**GEORGIA DEPARTMENT
OF COMMUNITY HEALTH**

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 Mcrc 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 Code selected.	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.

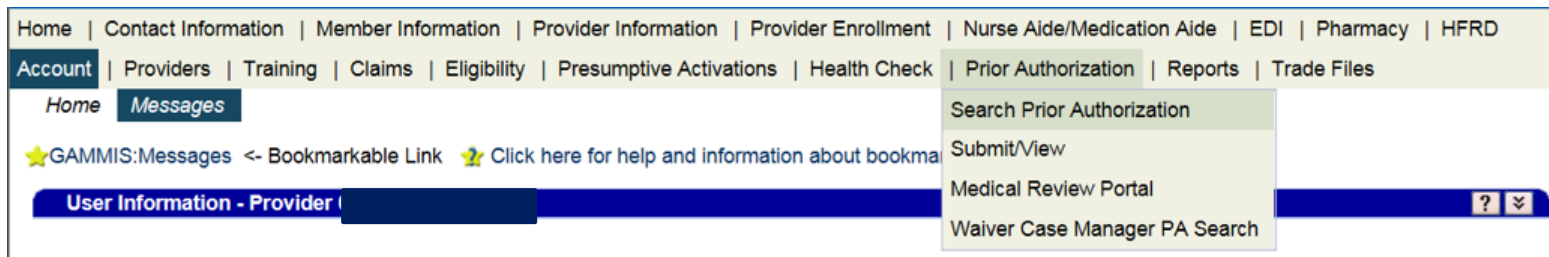
Retroactive Eligibility		
Retroactive Begin Date	Retroactive End Date	Retroactive Eff (Update) Date
06/08/2018	06/08/2018	08/11/2018

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

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

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

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

2 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 Top ?

Prior Authorization	<input type="text"/>	Member ID	<input type="text"/>
Procedure	<input type="text"/> [Search]	Name	<input type="text"/>
Requested From/Through DOS	<input type="text"/> <input type="text"/>		
		Records	20 <input type="text"/>
			<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]	Member ID	[REDACTED]	
Provider Name		Member Name	[REDACTED]	
REF ID				
From DOS	11/14/2016			
Through DOS	11/13/2017			
Status	APPROVED			

Prior Authorization Search

(continued)

Line Items											
PA Line Item	01	Status	COS Code	APPROVED	Rendering Provider						
From DOS	11/14/2016				Category of Service						
Through DOS	11/13/2017				Tooth						
Most Recent DOS Paid					Quadrant						
Units Allowed	12	Amount Allowed	\$2,240.04		Surface						
Units Used	0.000	Amount Used	\$0.00								
Max Monthly Units	1	Max Monthly Amount	\$0.00								
Max Daily Units	0	Authorized Rate	\$0.00								
PA Line Item	02	Status	COS Code	APPROVED	Rendering Provider						
From DOS	11/14/2016				Category of Service						
Through DOS	11/13/2017				Tooth						
Most Recent DOS Paid	01/12/2017				Quadrant						
Units Allowed	1160	Amount Allowed	\$10,416.80		Surface						
Units Used	104.000	Amount Used	\$933.92								
Max Monthly Units	110	Max Monthly Amount	\$0.00								
Max Daily Units	0	Authorized Rate	\$0.00								
PA Line Item	03	Status	COS Code	APPROVED	Rendering Provider						
From DOS	11/14/2016				Category of Service						
Through DOS	11/13/2017				Tooth						
Most Recent DOS Paid	01/11/2017				Quadrant						
Units Allowed	676	Amount Allowed	\$6,827.60		Surface						
Units Used	88.000	Amount Used	\$886.45								
Max Monthly Units	60	Max Monthly Amount	\$0.00								
Max Daily Units	0	Authorized Rate	\$0.00								
Procedures											
PA Line Item	(Procedure	Description)	(Modifier 1	Description)	(Modifier 2	Description)	(Modifier 3	Description)	(Modifier 4	Description)	NDC
01	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							
03	3	T1021 HH AIDE OR CN AIDE PER VISIT	U1	M/CAID CARE 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

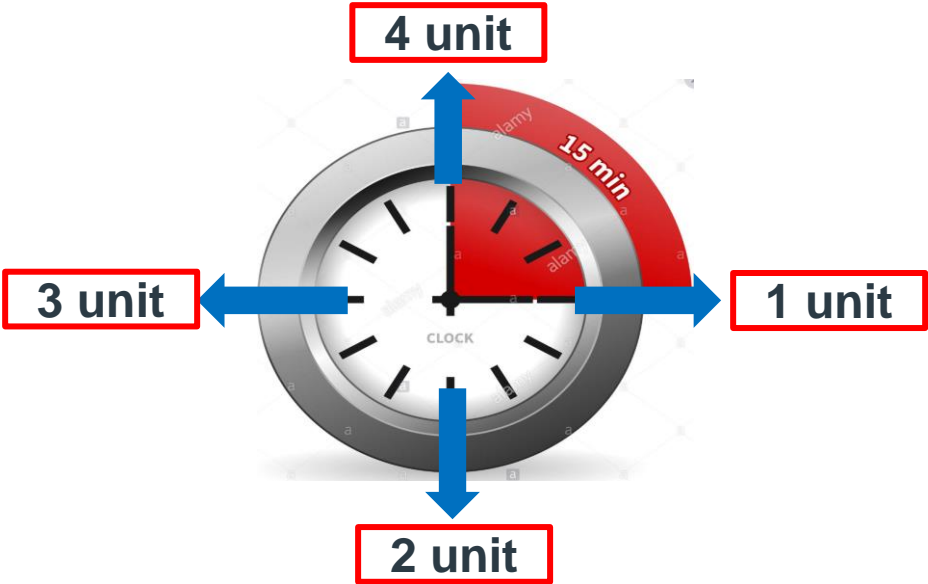
➤ New Options Waiver Program Manual Chapters 1300 – 3400

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)

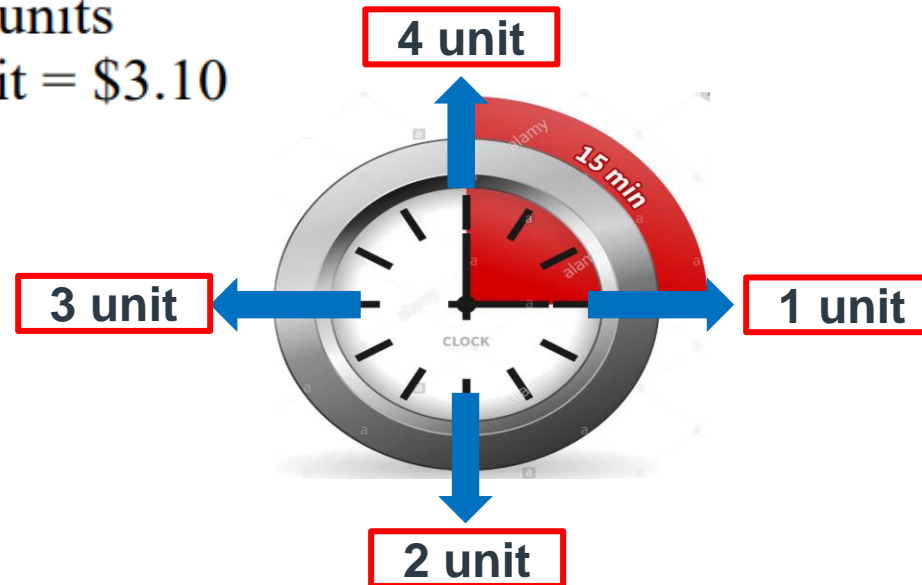
Unit = 15 minutes

Daily Limit = 24 units

Monthly Limit = 504 units

Annual Limit = 5760 units

Maximum rate per unit = \$3.10



New Professional Claim Billing Information

1

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](#)

2

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

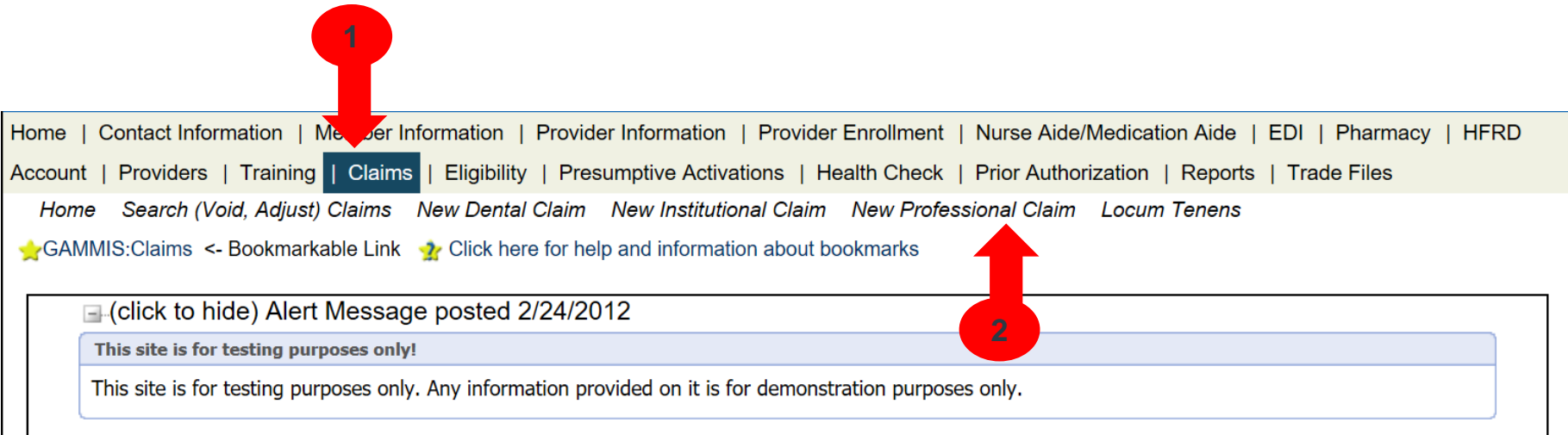
This site is for testing purposes only!

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

MMIS Web Claim Submissions

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

Professional Billing Information



The screenshot shows a web application interface for professional billing. A red arrow labeled '1' points to the 'Claims' link in the top navigation bar. Another red arrow labeled '2' points to an alert message box. The navigation bar includes links for 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, and Trade Files. Below the navigation bar, there are links for Home, Search (Void, Adjust) Claims, New Dental Claim, New Institutional Claim, New Professional Claim, and Locum Tenens. A star icon is next to the 'GAMMIS:Claims' link, followed by a link to bookmark it and a link for help and information about bookmarks. The alert message box contains the text: '(click to hide) Alert Message posted 2/24/2012' and '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 'Professional Claim' form with two main sections: 'Billing Information' on the left and 'Claim Status' on the right. The 'Billing Information' section includes fields for 'Rendering Provider ID', 'Rendering Taxonomy', 'Member ID*', 'Last Name*', 'First Name, MI*', 'Date of Birth*', 'Gender*', 'Patient Account #', 'Medical Record #', 'Service Facility ID', 'EPSTD Referral Indicator', 'EPSTD Referral Code 1', 'EPSTD Referral Code 2', 'EPSTD Referral Code 3', and 'ICD Version*' (set to ICD-10). The 'Claim Status' section includes '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' (\$0.00), 'PA/Precert Number' (highlighted with a red box and a red arrow), 'Referral Number', 'Referring Provider ID', 'Referring Provider Name (Last, First, MI)', 'Primary Care Provider ID', and 'Primary Care Provider Name (Last, First, MI)'. At the bottom right, 'Amount Totals' show 'Total Charges' and 'Total TPL Amount' as \$0.00. A green arrow points from the 'Member ID*' field in the 'Billing Information' section to the 'Release of Information*' field in the 'Claim Status' section.

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.

The screenshot shows a web-based form titled "Diagnosis". At the top, there is a header bar with the title "Diagnosis" and a sub-header with "Sequence", "Diagnosis", and "Description". Below this, there is a table with a single row labeled "A" in the "Sequence" column. The "Diagnosis" column contains a text input field with a "[Search]" button next to it. The "Description" column is empty. Below the table, there is a section labeled "Type data below for new record." with a "Sequence*" dropdown menu (currently showing "1") and a "Diagnosis" text input field. To the right of the input fields are "delete" and "add" buttons. A dropdown menu for the "Sequence*" field is open, showing a list of numbers from 1 to 7.

Detail

Detail


** No rows found **

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

delete

add

copy



Claims Detail

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

Item		Detail	
From DOS	1	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
		CoPay Amount	\$0.00
		Paid Amount	\$0.00

Type data below for new record.

Item	1	Emergency	
From DOS*		EPSDT/Fam Plan	
To DOS		PA/Precert Number	
POS*	[Search]	Mammogram Certification Number	
Procedure*	[Search]	DME Serial Number	
Procedure Description		<u>Drug Rebate Information</u>	
Modifier 1	[Search]	NDC	[Search]
Modifier 2	[Search]	NDC Drug Name	
Modifier 3	[Search]	<u>Medicare Information</u>	
Modifier 4	[Search]	Allowed Amount	\$0.00
Diagnosis Pointer		<u>Adjudication Information</u>	
Units*	0	Status	
Charges*	\$0.00	Allowed Amount	\$0.00
Rendering Provider		CoPay Amount	\$0.00
		Paid Amount	\$0.00

delete add copy

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 [redacted] ?

[Provider Billing Manuals](#)

submit **cancel**

Professional Claim ?

Adjudication Information

ICN/TCN [redacted]
RA Date [redacted]

Billing Information

Rendering Provider ID [redacted]
Rendering Taxonomy [redacted]
Member ID* [redacted]
Last Name* [redacted]
First Name, MI* [redacted]
Date of Birth* [redacted]
Gender* [redacted]
Patient Account # [redacted]
Medical Record # [redacted]
Service Facility ID [redacted]

EPSDT Referral Indicator [redacted]
EPSDT Referral Code 1 [redacted]
EPSDT Referral Code 2 [redacted]
EPSDT Referral Code 3 [redacted]

ICD Version* ICD-10

Claim Status

Total Paid Amount \$0.00

Release of Information* [redacted]
Related Causes Code 1 [redacted]
Related Causes Code 2 [redacted]
Accident State [redacted]
Accident Date [redacted]
Admit Date [redacted]
Discharge Date [redacted]
Date of Death [redacted]

Patient Responsibility \$0.00
PA/Precert Number [redacted]
Referral Number [redacted]
Referring Provider ID [redacted]
Referring Provider Name (Last, First, MI) [redacted]
Primary Care Provider ID [redacted]
Primary Care Provider Name (Last, First, MI) [redacted]

Amount Totals

Total Charges \$0.00
Total TPL Amount [redacted]

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>	<i>Internal Use Only</i>	

- 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.

Provider Billing Manuals

submit cancel

Professional Claim	
<u>Adjudication Information</u>	
ICN/TCN	DMA520 Inquiry
RA Date	
<u>Billing Information</u>	
Rendering Provider ID	
Rendering Taxonomy	
Claim Status	
Total Paid Amount	\$0.00
Release of Information*	Y - SIGNED STMT PERMITTING RELEASE
Related Causes Code 1	

Claim Status – Top of the Claim

Claim number – Internal Control Number (ICN)

Status – Paid, Denied or Suspended

Total Paid amount

Provider Billing Manuals

submit cancel

Professional Claim	
<u>Adjudication Information</u>	
ICN/TCN	2019000000010 DMA520 Inquiry
RA Date	
<u>Billing Information</u>	
Claim Status	Paid
Total Paid Amount	1000.00

Denied Claim

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

[Provider Billing Manuals](#)

re-submit

cancel

Professional Claim

?

⚙

Adjudication Information

ICN/TCN

RA Date

DMA520 Inquiry

Claim Status


DENIED

Total Paid Amount

\$0.00

Suspended Claim

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

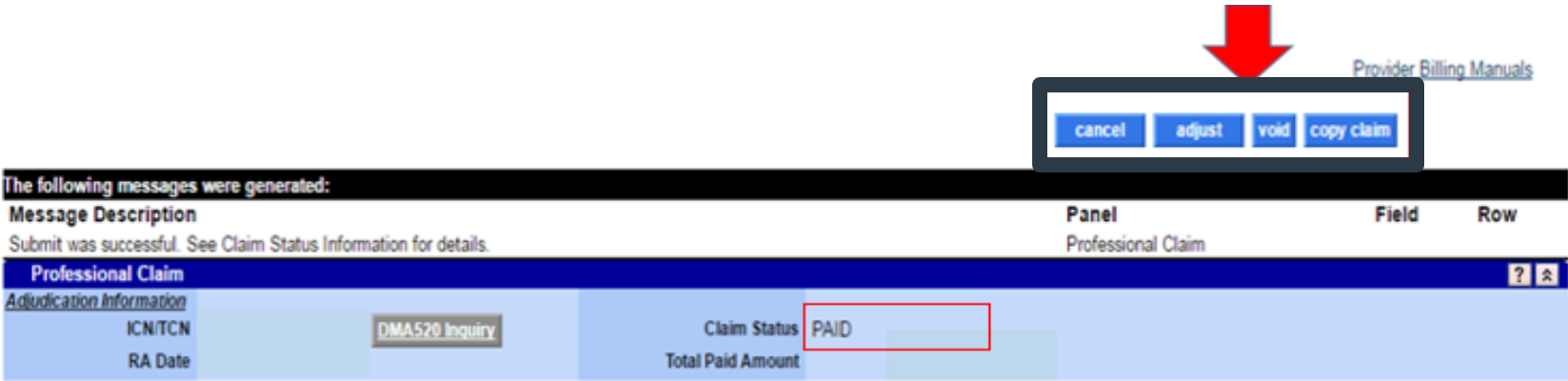


[Provider Billing Manuals](#)

The following messages were generated:				
Message Description		Panel		Field
Submit was successful. See Claim Status Information for details.		Professional Claim		Row
Professional Claim				? ^
Adjudication Information				
ICN/TCN	DMA520 Inquiry	Claim Status	SUSPENDED	
RA Date		Total Paid Amount	\$0.00	

Paid Claim with the Adjust Option

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



The following messages were generated:

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

Panel Professional Claim

Field Row

Professional Claim

Adjudication Information

ICN/TCN	DMA520 Inquiry	Claim Status	PAID
RA Date		Total Paid Amount	

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

The screenshot shows the top navigation bar of the system. A red circle with the number '1' and a downward arrow points to the 'Claims' link in the main navigation menu. Another red circle with the number '2' and a leftward arrow points to the 'Search (Void, Adjust) Claims' link in the sub-navigation menu.

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** Total 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


(continued)

Search Results (13 rows returned)										
ICN	TCN	Member ID	From DOS	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid	
4009	2090	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	\$66.61	\$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	\$66.61	\$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



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



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	
<u>Adjudication Information</u>	
ICN/TCN	DMA520 Inquiry ←
RA Date	
Not Eligible for an Appeal	
<u>Billing Information</u>	
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
<u>Claim Status</u>	
Total Paid Amount	\$0.00
<u>Release of Information*</u>	
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
<u>Amount Totals</u>	
Total Charges	\$0.00

DMA-520 - Appeal Eligible

[Refresh session] You have approximately 19 minutes until your session will expire.

Thursday, July 17, 2014

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-submitcancel

Professional Claim

?

Adjudication Information

ICN/TCN

RA Date06/25/2014

Billing Information

Rendering Provider ID

Rendering Taxonomy

Member ID*

Last Name*

First Name, MI*

Date of Birth*

Gender*F - Female

DMA520 Inquiry

Claim StatusDENIED

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		
Medicaid Provider ID		
Reference Provider ID		
Address 1	100 PEACHTREE STREET	
Address 2		
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	2219000000000	
Claim Type	PROFESSIONAL CLAIMS	
From DOS	04/12/2019	
To DOS	04/12/2019	
Member ID	2211000000000	
Member Name (Last, First)	MEDICAID FAIR	
RA Date	04/15/2019	
Claim Status	DENIED	
TEST MEMBER		
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	

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 associated your file to the provider inquiry.

The image shows two web interface panels. The top panel, titled "DMA Claim Inquiry Form", contains a "Call Tracking Information" section with fields for "CTN" (14766730), "Attachments" (with a link "Click here to upload attachments."), "CTN Status" (OPEN), "Status Date" (04/15/2019), and an "Administrative Review" button. A red arrow labeled "1" points to the "Click here" link. The bottom panel, titled "DMA520 Attachment Upload", shows a file input field with the path "C:\Users\dwilliams252\De" and a "Browse..." button. A red arrow labeled "2" points to the "Browse..." button. To the right of the file input is a blue button labeled "upload attachment". A red arrow labeled "3" points to the "upload attachment" button.

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

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

★ GAMMIS:Letters <- 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.

User Information - Provider

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

Letter* CTM-1934-O: PSSCC Claim Status

From Date* 01/01/2019

To Date* 04/30/2019

Records 20

Search

Search Results (2 rows returned)

Report Name	Run Date
04/15/2019 - CTM-1934-O: PSSCC Claim Status : Doc Key#= 24452092	4/15/2019 4:00:00 AM
04/15/2019 - CTM-1934-O: PSSCC Claim Status : Doc Key#= 24452093	4/15/2019 4:00:00 AM

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
RA Date 06/25/2014
DMA520 Inquiry ←
Claim Status DENIED
Total Paid Amount \$0.00

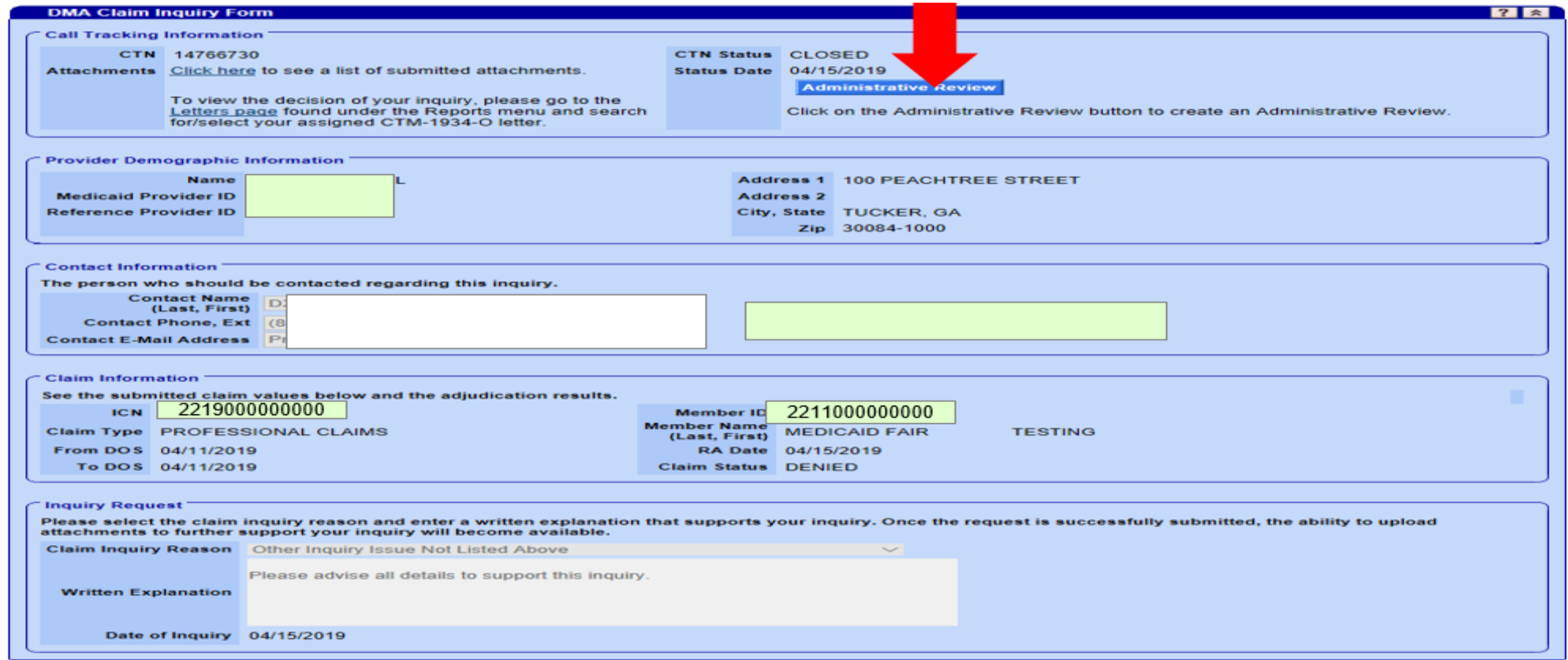
Billing Information

Rendering Provider ID
Rendering Taxonomy
Member ID*
Last Name*
First Name, MI*
Date of Birth*
Gender* F - Female

Release of Information* Y - SIGNED STMT PERMITTING RELEASE
Related Causes Code 1
Related Causes Code 2
Accident State
Accident Date
Admit Date
Discharge Date

2nd Level/Administrative Review

(continued)



DMA Claim Inquiry Form

Call Tracking Information

CTN 14766730

Attachments [Click here](#) to see a list of submitted attachments.

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.

CTN Status CLOSED

Status Date 04/15/2019

Administrative Review

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

Provider Demographic Information

Name [Redacted] L

Medicaid Provider ID [Redacted]

Reference Provider ID [Redacted]

Address 1 100 PEACHTREE STREET

Address 2

City, State TUCKER, GA

Zip 30084-1000

Contact Information

The person who should be contacted regarding this inquiry.

Contact Name (Last, First) [Redacted]

Contact Phone, Ext (8) [Redacted]

Contact E-Mail Address [Redacted]

Claim Information

See the submitted claim values below and the adjudication results.

ICN 22190000000000

Claim Type PROFESSIONAL CLAIMS

From DOS 04/11/2019

To DOS 04/11/2019

Member ID 22110000000000

Member Name (Last, First) MEDICAID FAIR TESTING

RA Date 04/15/2019

Claim Status 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 Other Inquiry Issue Not Listed Above

Written Explanation Please advise all details to support this inquiry.

Date of Inquiry 04/15/2019

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

Medicaid Provider ID

Reference Provider ID REF007790440

Address 1 100 PEACHTREE STREET

Address 2

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 2219000000000

Claim Type PROFESSIONAL CLAIMS

From DOS 04/11/2019

To DOS 04/11/2019

Member ID 2211000000000

Member Name (Last, First) MEDICAID FAIR TESTING

RA Date 04/15/2019

Claim Status 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. 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 Attachments Click here to upload attachments.		CTN Status OPEN Status Date 04/15/2019	
Provider Demographic Information Name MEADOWS, BILL Medicaid Provider ID 007106015A Reference Provider ID REF007790440 Address 1 100 PEACHTREE STREET Address 2 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 Claim Type PROFESSIONAL CLAIMS From DOS 04/11/2019 To DOS 04/11/2019 Member ID 222116845092 Member Name (Last, First) MEDICAID FAIR TESTING RA Date 04/15/2019 Claim Status 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 Browse...

1

2

upload attachment

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

<u>Attachment Code</u>	<u>Description</u>
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

<u>Attachment Code</u>	<u>Description</u>
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

The screenshot shows the Gainwell system interface. At the top is a navigation menu with links: 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, and Trade Files. A green arrow labeled '1' points to the 'Reports' link. Below this is a sub-menu with links: Home, Financial Reports, HS&R Reports, Other Reports, and Letters. A green arrow labeled '2' points to the 'Financial Reports' link. Below the sub-menu is a 'Reports' form. The form has a 'Report*' dropdown menu with 'Remittance Advice' selected. It also has 'From Date*' and 'To Date*' fields with dates '10/01/2009' and '01/21/2010' respectively. There is a 'Records' dropdown menu set to '20'. At the bottom right of the form are 'Clear' and 'Search' buttons.

- 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

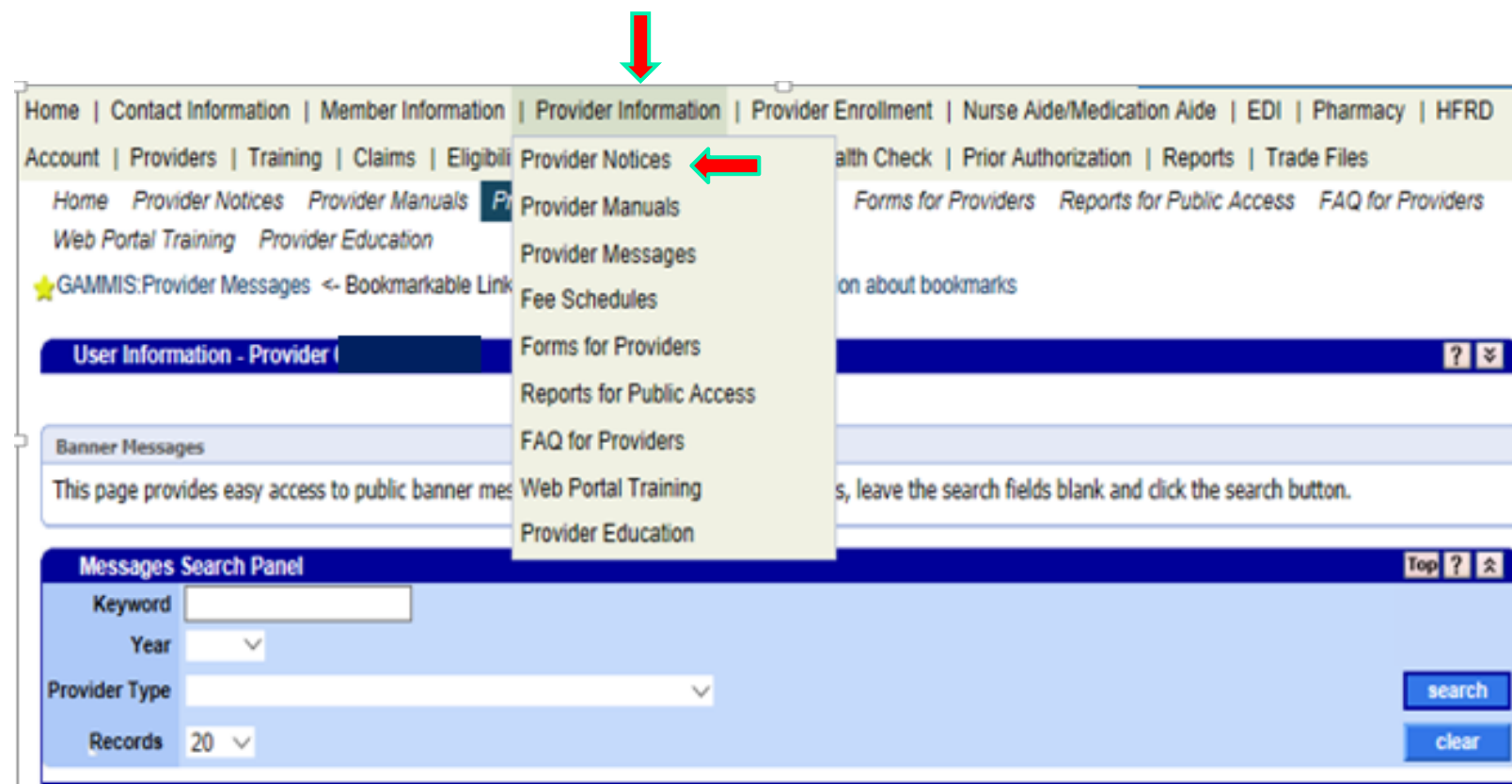
Home Provider Notices Provider Manuals Provider Messages Fee Schedules Forms for Providers Reports for Public Access FAQ for Providers

Web Portal Training Provider Education

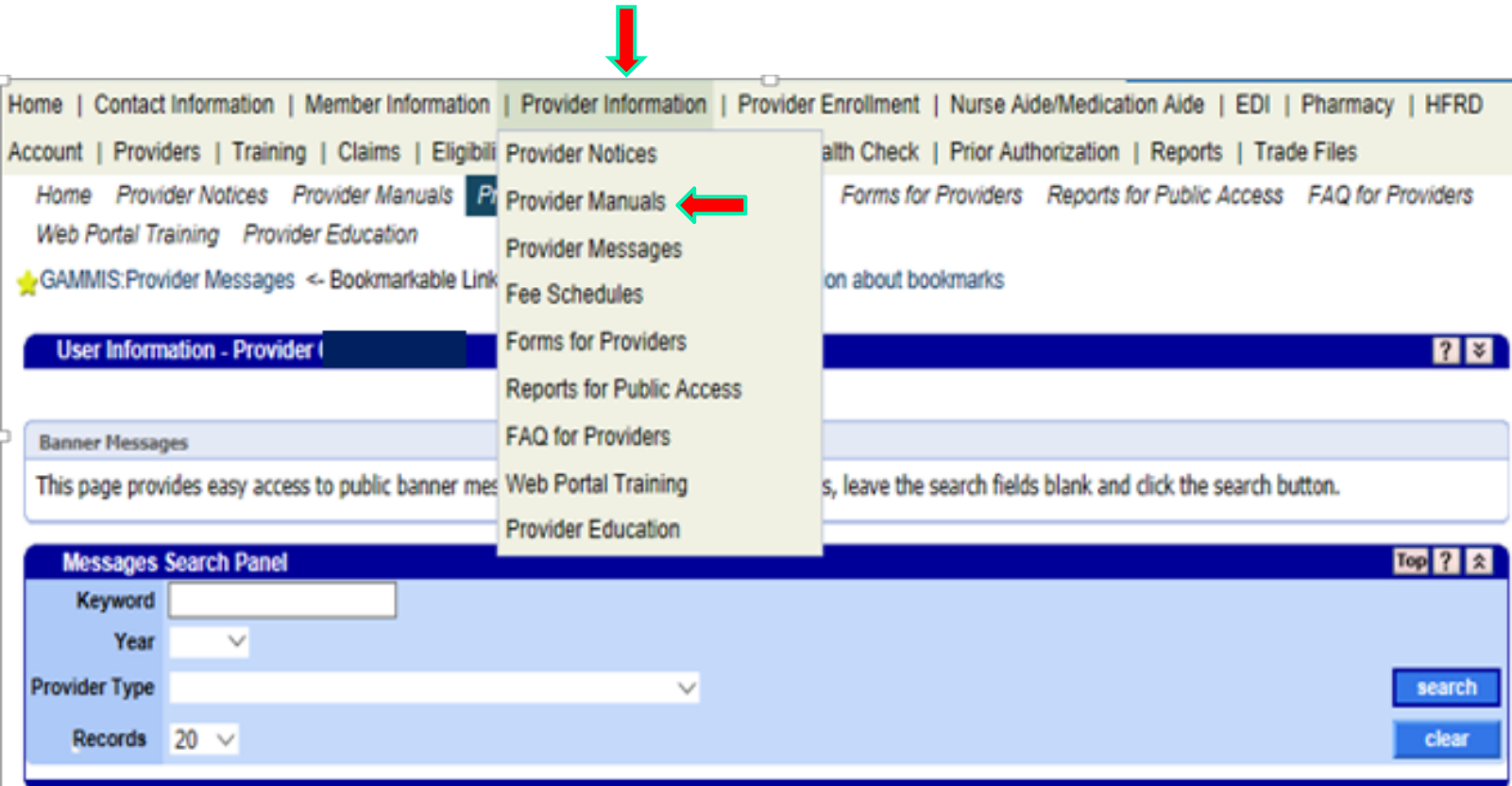
★GAMMIS:Provider Information <- Bookmarkable Link ★Click here for help and information about bookmarks

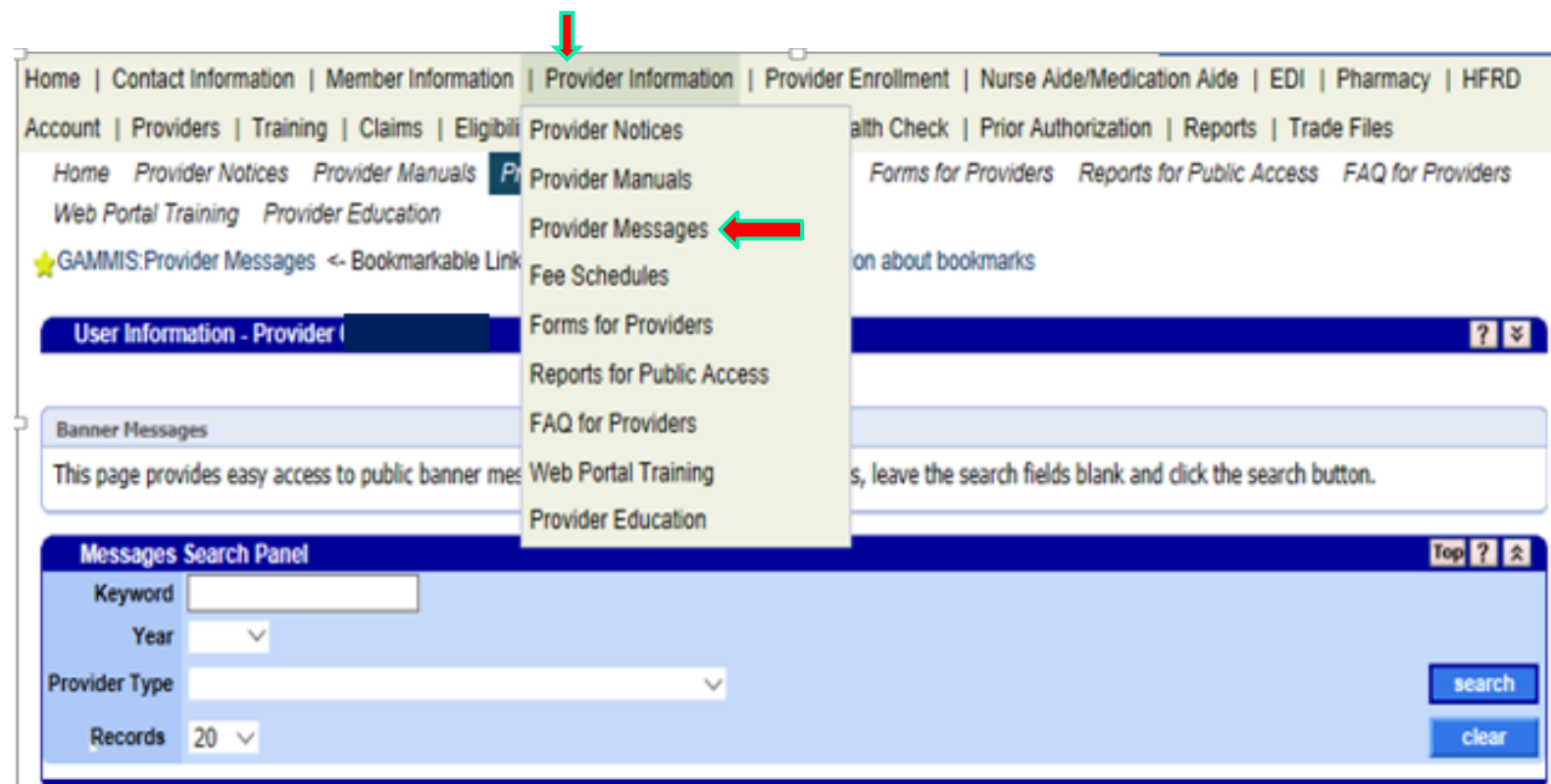
Provider Information and Provider Notices



Provider Information and Provider Manuals



Provider Information and Provider Messages



Provider Information and Provider Messages

(continued)

Messages Search Panel

Top ?

Keyword

Year

Provider Type

Records 20

search

clear

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 96110 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	07/28/2017	Centralized PA Process Inbox to be shut down 8/1/2017
ALL PROVIDER TYPES	07/28/2017	Ending of 45 Day Prior Authorization Period
ALL PROVIDER TYPES	07/20/2017	Gwinnett/Lawrenceville Meaningful Use Workshop
ALL PROVIDER TYPES	07/20/2017	Hyaluronan Derivatives Products ? Change of Coverage
ALL PROVIDER TYPES	07/20/2017	Hyaluronan Derivatives Products - Change of Coverage
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/07/2017	Reimbursement Change in the Adult Air Emergency Transportation Medicare Crossover Claims
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/07/2017	Reimbursement Change in the Adult Air Emergency Transportation 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	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

Provider Relations Field Services

(continued)

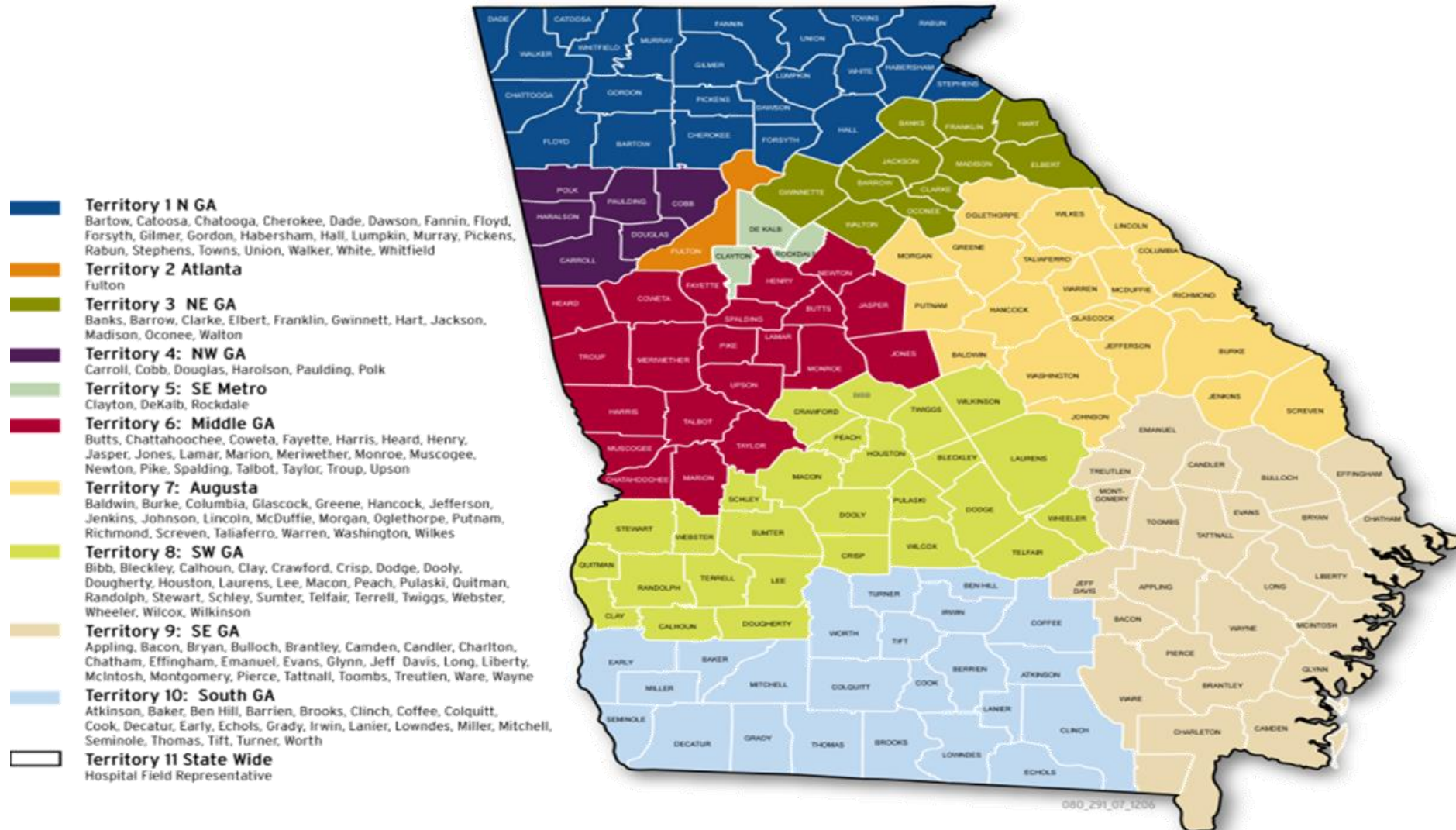
State-Wide Consultants

Brenda Hulette

Danny Williams

Sharée C. Daniels

Georgia Field Territories



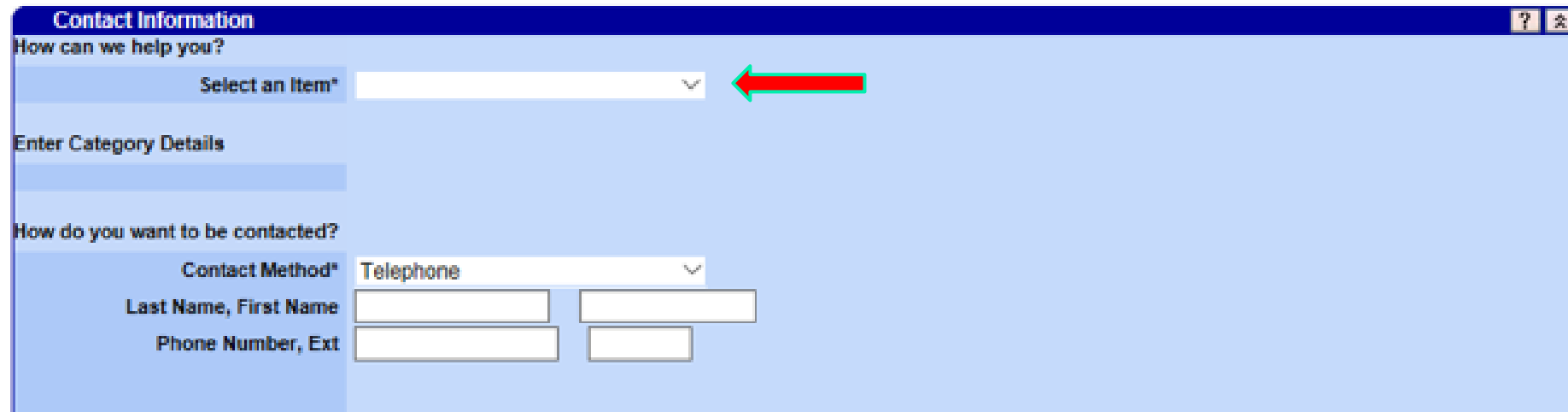
Contact My Provider Rep Directly

Login to the MMIS system with your username and password



Contact My Provider Rep Directly

(continued)



The screenshot shows a web form titled "Contact Information" with a dark blue header bar containing a question mark icon and a close button. The form has a light blue background and is divided into sections. The first section, "How can we help you?", contains a dropdown menu labeled "Select an Item*" with a red arrow pointing to it. Below this is a section titled "Enter Category Details" with a single text input field. The third section, "How do you want to be contacted?", contains a dropdown menu labeled "Contact Method*" with "Telephone" selected. Below this are two rows of text input fields: "Last Name, First Name" (two fields) and "Phone Number, Ext" (two fields).

Contact My Provider Rep Directly

(continued)

Requests Requiring PHI

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

submit cancel

Contact Information

How can we help you?

Select an Item*

Enter Category Details

How do you want to be contacted?

Contact Method*

Last Name, First Name

Phone Number, Ext

top of page

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

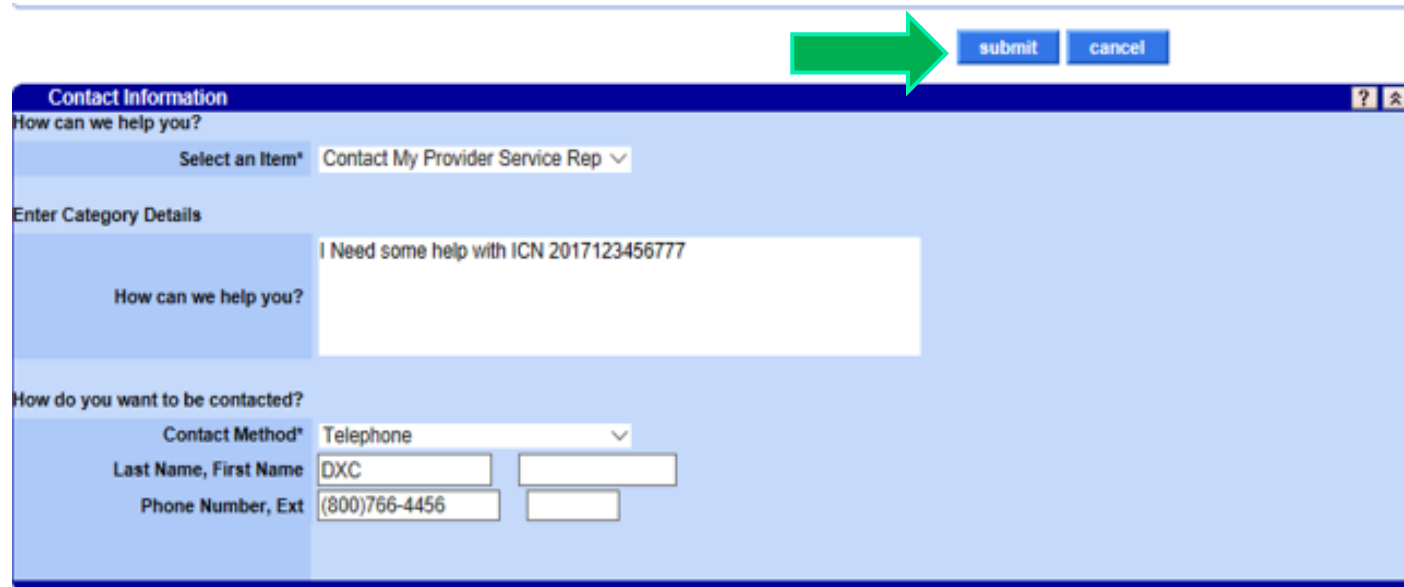
OR

Click Here

top of page

Contact My Provider Rep Directly

(continued)



The screenshot shows a web form titled "Contact Information" with a blue header bar. Above the form, there are "submit" and "cancel" buttons. A large green arrow points from the left towards the "submit" button. The form itself has a light blue background and contains the following sections:

- Contact Information** (header bar)
- How can we help you?** (question)
- Select an Item*** (dropdown menu showing "Contact My Provider Service Rep" with a downward arrow)
- Enter Category Details** (section header)
- How can we help you?** (text input field containing "I Need some help with ICN 201712345677")
- How do you want to be contacted?** (question)
- Contact Method*** (dropdown menu showing "Telephone")
- Last Name, First Name** (two text input fields, the first containing "DXC")
- Phone Number, Ext** (two text input fields, the first containing "(800)766-4456")

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