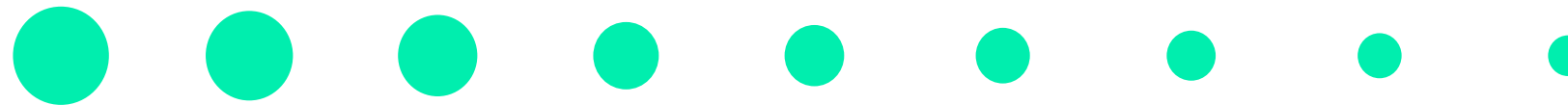


# DBHDD – GA Medicaid Web Portal Basics Web Portal Claim Submission

## Common Claim Denials & Remittance Advice Presentation



To access the PDF version of this presentation, please visit our website: [www.mmis.georgia.gov](http://www.mmis.georgia.gov) -> Provider Information -> Provider Notices – “Presentation – DBHDD – GA Medicaid Web Portal Basics.

# Agenda

- Overview of Georgia Medicaid
- Policy Information and Updates
- Common Denials
- Claims History Search
- Timely Filing Guidelines
- Accessing the Remittance Advice
- Contacting Gainwell Technologies
- Session Review
- Closing, Questions and Answers

# Georgia Medicaid Management Information System (GAMMIS), [www.mmis.georgia.gov](http://www.mmis.georgia.gov)

- GAMMIS is the biller's 24-hour resource for Georgia Medicaid information.
- Non-secure information, such as policy manuals, provider alerts, forms, and training materials is available anywhere with Internet access.

**With the use of the secure log-in available to each Georgia Medicaid provider, a biller can also verify HIPAA-related data and perform various functions on behalf of that provider, such as:**

- Verifying member eligibility
- Reviewing prior authorizations
- Submitting, reviewing, adjusting, or resubmitting claims
- Reviewing remittance advice

# Policy Information and Updates



How to stay informed

# Policy Information and Updates

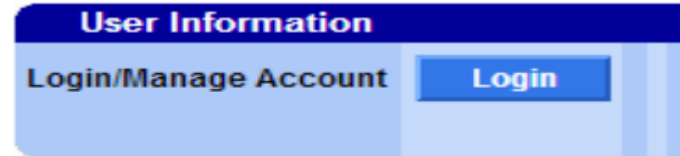


- Provider Notices: Program Specific Presentations
- Provider Manuals: Program Specific Policy Manuals
- Provider Messages: Additional Policy and Program alerts

# Logging into the Secure Web Portal

To get started, login to the secure GAMMIS Web Portal at [www.mmis.georgia.gov](http://www.mmis.georgia.gov).

Click the Login button.



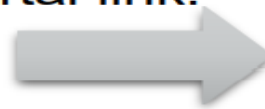
The screenshot shows a blue header with the text "User Information". Below the header, there is a link "Login/Manage Account" and a blue button labeled "Login".

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



The screenshot shows a form titled "Sign in to Georgia Medicaid" with a "Help" link. It contains two input fields: "Username" and "Password". Below the fields is a "Sign In" button. At the bottom, there is a link for "Forgot your password?".

2. Click the Web Portal link.



## Applications

Application	Description
<a href="#">MEUPS Account Management</a>	Manages contact information, password, and authorizations for applications.
<a href="#">Web Portal</a>	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.

# GAMMIS Secure Web Portal



Welcome, callcenter

Search

[ Refresh session ] You have approximately 17 minutes until your session will expire.

Monday, November 15, 202

[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](#) [Publication Search](#) [Site Map](#) [Site Settings](#) [Language Selection](#)

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



# 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.
- The most common eligibility denials come from **NOT** checking the member's eligibility.



# Eligibility Verification

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?

# Eligibility Verification

(continued)

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

- Provider Services Contact Center (PSCC) – 1-800-766-4456
- GAMMIS website [www.mmis.georgia.gov](http://www.mmis.georgia.gov)
- Interactive Voice Response System (IVRS)

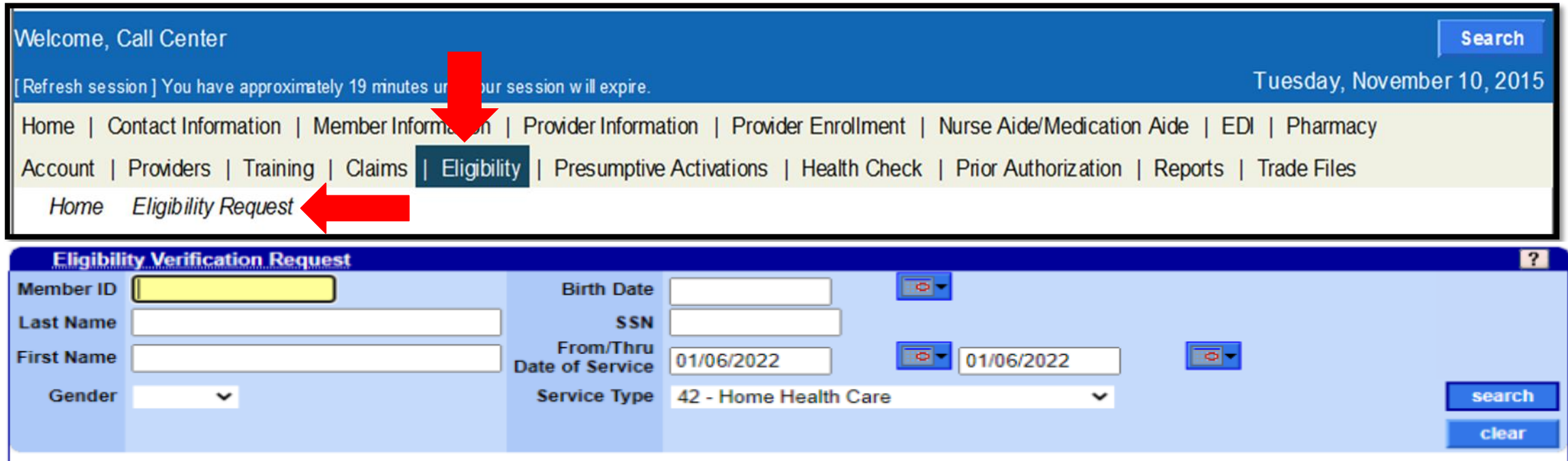
The IVRS and the GAMMIS website are available 24 hours a day.

# Common Medicaid Benefit Plans

Medicaid Benefit Plan	Plan Description
TXIX or Aged Blind Disabled	Provides Medicaid to individuals & families with low income - provided through DFCS
SSI	Provides Medicaid Benefits for those persons eligible for Supplemental Security Income benefits.
QMB	Provides payment for Medicare Part A premium. Co-insurance, deductible, and Medicare Part B premium only. QMB will not cover any medical services not covered by Medicare.
SLQI1	Provides payment for Medicare Part B Premium ONLY. No Medical Benefit. Aid Categories 446,661,662
Manager Care/Georgia Families	Benefits are received from 1 of the 3 CMO's: Peach State, Amerigroup, CareSource
Institutional Hospice	Providers Palliative Care to terminally ill Individuals.
Nursing Home	Providers coverage for Inpatient Nursing Home services.

# Eligibility Verification

(continued)



Welcome, Call Center Search

[ Refresh session ] You have approximately 19 minutes until your session will expire. Tuesday, November 10, 2015

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 *Eligibility Request*

---

### Eligibility Verification Request ?

Member ID	<input type="text"/>	Birth Date	<input type="text"/>	<input type="button" value="⊕"/>
Last Name	<input type="text"/>	SSN	<input type="text"/>	
First Name	<input type="text"/>	From/Thru Date of Service	<input type="text" value="01/06/2022"/>	<input type="button" value="⊕"/> <input type="text" value="01/06/2022"/> <input type="button" value="⊕"/>
Gender	<input type="button" value="v"/>	Service Type	<input type="text" value="42 - Home Health Care"/> <input type="button" value="v"/>	

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

# Eligibility Verification

(continued)

## “No” Medicaid Benefits

Eligibility by Service Type <span>?</span>							
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)

## SLQI1/SLMB Medicare Premium Only “No” Medicaid Benefits

Aid Category 661 & 662 = No 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	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 Code selected.	48 - Hospital - Inpatient	06/08/2018	06/08/2018					

# Eligibility Verification

(continued)

## QMB Medicare Premium Only “No” Benefits for Home Health Care Services



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	01/06/2022	01/06/2022	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.)	

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.	42 - Home Health Care	01/06/2022	01/06/2022					



# CCSP Medicaid & QMB 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	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.)	

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	01/06/2022	01/06/2022	MC - Medicaid	259 - Elderly and Disabled Waiver	MEDICAID	
Active	30 - Health Plan Benefit Coverage	01/06/2022	01/06/2022	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.)	

Eligibility by Service Type								?
Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes	
Active	42 - Home Health Care	01/06/2022	01/06/2022	MC - Medicaid	259 - Elderly and Disabled Waiver	0.00		



# Eligibility Verification

(continued)

## SSI Medicaid Benefits – Active

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	1/01/2018	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.	

Red arrows point from the top of the 'Benefit Plans' table to the 'Insurance Type Code' and 'Aid Category' columns, and from the 'Eligibility by Service Type' table to the 'Service Type Code' column.

# Eligibility Verification

(continued)

## Retro Medicaid Benefits

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

- **Claims must be received within six (6) months after the date in which the determination of retroactive eligibility was made.**

# Prior Authorization Search



# Prior Authorization Search

(continued)

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

Home | **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** ? ⌵

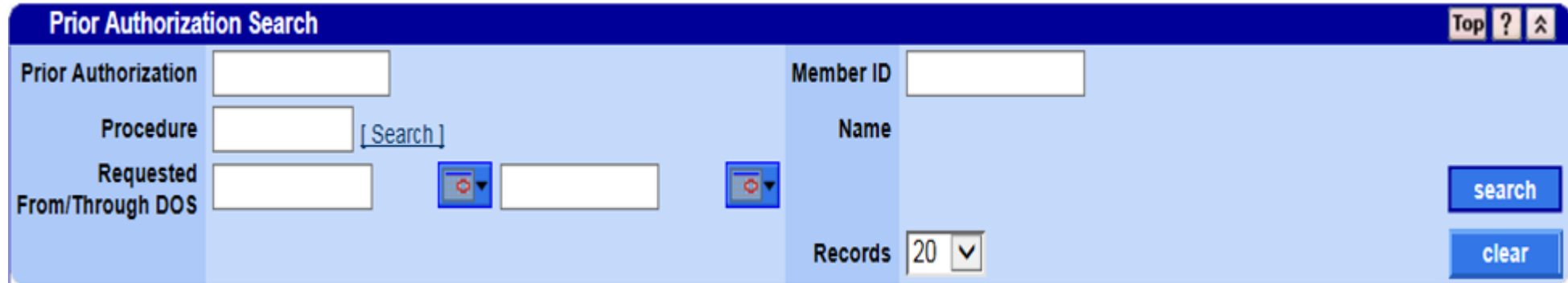
**Please Note:** When a Member ID is entered, please navigate from the field prior to entering additional search criteria or clicking search to allow the system to refresh and identify the member name on file.

**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"/> <span>⌵</span> <input type="text"/> <span>⌵</span>	Records	20 <span>⌵</span>
			<input type="button" value="search"/>
			<input type="button" value="clear"/>

# Prior Authorization Search

(continued)



The screenshot shows a web form titled "Prior Authorization Search" with a blue header bar. The form is divided into two main sections. The left section contains three input fields: "Prior Authorization" (a text box), "Procedure" (a text box with a "[ Search ]" button to its right), and "Requested From/Through DOS" (a date range selector with two text boxes and two calendar icons). The right section contains two input fields: "Member ID" (a text box) and "Name" (a text box). Below these fields is a "Records" dropdown menu set to "20". On the far right, there are two buttons: "search" and "clear". In the top right corner of the header bar, there are links for "Top", a question mark, and an upward arrow.

**Prior Authorization search can be done in either of the following ways:**

- Enter the member's prior authorization number and select search
- Enter the Member ID and the requested from/through date of service and select search

# Prior Authorization Search

(continued)

Base Information			
<b>Prior Authorization Number</b>	11123456789	<b>Member ID</b>	2221123456789
<b>Provider Name</b>	[REDACTED]	<b>Member Name</b>	Dave Phillip
<b>REF ID</b>	[REDACTED]		
<b>From DOS</b>	11/14/2016		
<b>Through DOS</b>	11/13/2017		
<b>Status</b>	APPROVED		

# Prior Authorization Search

(continued)

Line Items									
PA Line Item	01	Status	APPROVED	Rendering Provider					
From DOS	11/14/2016	COS Code	660	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	APPROVED	Rendering Provider					
From DOS	11/14/2016	COS Code	660	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	APPROVED	Rendering Provider					
From DOS	11/14/2016	COS Code	660	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						

# Medicaid Claims





# Acceptable Claim Types and Submissions

**The provider can submit the following claim types:**

- Professional – CMS 1500
- Institutional – UB 04
- Dental – 2006 ADA Dental claim

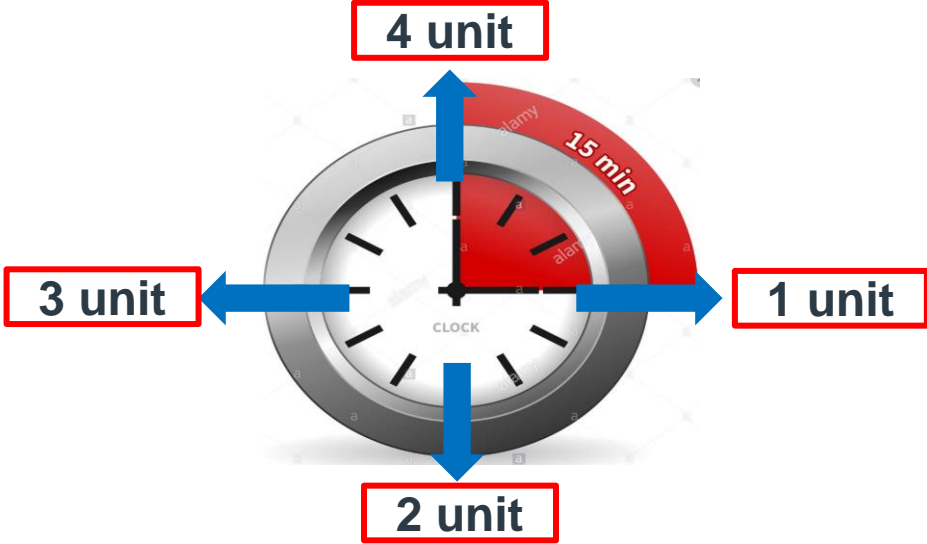
**Claims, Claim adjustments, and Claim resubmissions can be submitted in two ways:**

- Electronically through a clearinghouse
- Through the Georgia Medicaid Web Portal
- NetSmart – EVV Software Solution – (Personal Support 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

## Prevocational Services:

Prevocational Services (T2015)

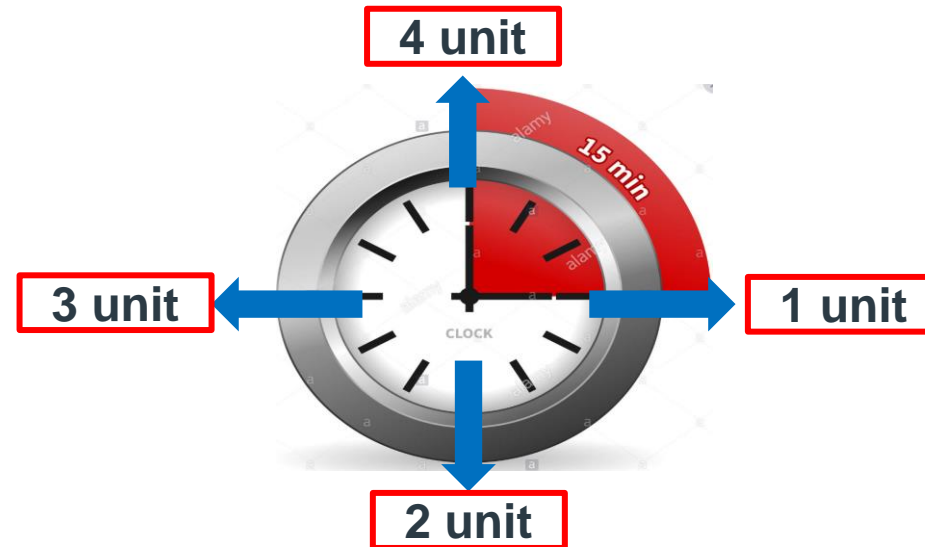
Unit = 15 minutes

Daily Limit = 24 units

Monthly Limit = 504 units

Annual Limit = 5760 units

Maximum rate per unit = \$3.10



# 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 Claim

## Header Panel 1

Enter the required information indicated by an asterisk (\*) on each panel and as much optional information as possible.

Professional Claim		Adjudication Information	
ICN/TCN		Claim Status	
RA Date	DMA520 Inquiry	Total Paid Amount	\$0.00
Billing Information		Release of Information*	
Rendering Provider ID	00	Related Causes Code 1	
Rendering Taxonomy		Related Causes Code 2	
Member ID*		Accident State	
Last Name*		Accident Date	
First Name, MI*		Admit Date	
Date of Birth*		Discharge Date	
Gender*		Date of Death	
Patient Account #		Patient Responsibility	\$0.00
Medical Record #		PA/Precert Number	
Service Facility ID		Referral Number	
EPSDT Referral Indicator		Referring Provider ID	
EPSDT Referral Code 1		Referring Provider Name (Last, First, MI)	
EPSDT ICD Version*	ICD-10	Primary Care Provider ID	
EPSDT Referral Code 3	ICD-9	Primary Care Provider Name (Last, First, MI)	
ICD Version*	ICD-9	Amount Totals	
		Total Charges	\$0.00
		Total TPL Amount	

# 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 web-based form titled "Professional Claim" with a blue header. The form is divided into several sections:

- Adjudication Information:** Includes fields for ICN/TCN (with a "DMA529 Inquiry" button), RA Date, and Claim Status.
- Billing Information:** Includes fields for Rendering Provider ID, Rendering Taxonomy, Member ID\*, Last Name\*, First Name, MI\*, Date of Birth\*, Gender\*, Patient Account #, Medical Record #, and Service Facility ID.
- EPSDT Referral Information:** Includes fields for EPSDT Referral Indicator, EPSDT Referral Code 1, 2, and 3, and ICD Version\* (set to ICD-10).
- Accident Information:** Includes fields for Accident State, Accident Date, Admit Date, Discharge Date, and Date of Death.
- Financial Information:** Includes Total Paid Amount (\$0.00), Patient Responsibility (\$0.00), and Amount Totals (Total Charges and Total TPL Amount, both \$0.00).
- Other Fields:** Includes Release of Information\*, Related Causes Code 1 and 2, Referral Number, Referring Provider ID and Name, and Primary Care Provider ID and Name.

A red box highlights the "PA/Precert Number" field, and a red arrow points to it from the right. A green arrow points to the "Member ID\*" field from the left.

# 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 containing "A" under "Sequence" and "A" under "Description". Below the table, there is a text input field with the placeholder text "Type data below for new record.". To the left of this field is a dropdown menu labeled "Sequence\*" with "1" selected. To the right of the text input field is a search button labeled "[Search]". At the bottom right of the form, there are two buttons: "delete" and "add".

# Detail

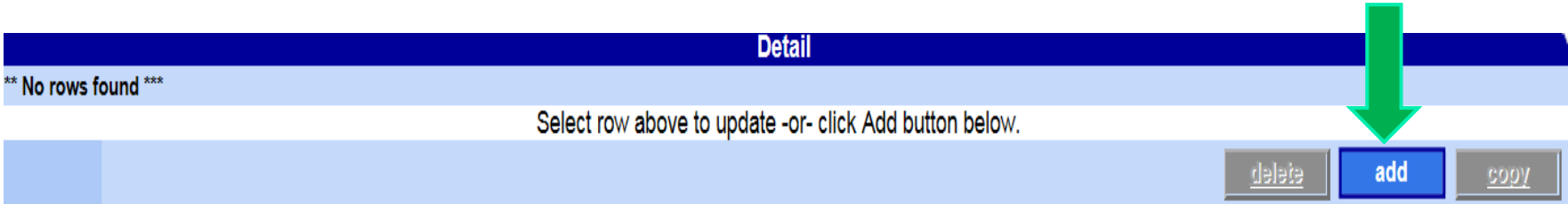
## Section 3

Detail

\*\* No rows found \*\*

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

delete add copy

A screenshot of a software interface. At the top, a dark blue header bar contains the word "Detail" in white. Below this, a light blue bar displays the text "\*\* No rows found \*\*". Underneath, a white bar contains the instruction "Select row above to update -or- click Add button below.". At the bottom, a light blue bar contains three buttons: "delete", "add", and "copy". The "add" button is highlighted in blue, and a large green arrow points down to it from above.



# Claims Detail

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

The screenshot shows a web-based form for entering claim details. It is divided into two main sections: a left-hand input area and a right-hand summary area. The left section contains fields for 'Item' (set to 1), 'From DOS', 'To DOS', 'POS', 'Procedure', 'Procedure Description', 'Modifiers', 'Diagnosis Pointers', 'Units' (set to 0), 'Charges' (set to \$0.00), and 'Rendering Provider'. Red arrows point to each of these fields. The right section, titled 'Detail', shows a summary of the entered data, including 'Emergency', 'EPSDT/Fam Plan', 'PA/Precert Number', 'Mammogram Certification Number', 'DME Serial Number', 'NDC', 'NDC Drug Name', 'MCare Allowed Amount' (\$0.00), 'Status', 'Allowed Amount' (\$0.00), 'CoPay Amount' (\$0.00), and 'Paid Amount' (\$0.00). Below this summary are three buttons: 'delete', 'add', and 'copy', each with a red arrow pointing down to it. A header bar at the top of the form contains a list of field names and their corresponding values or labels.

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] **DMA520 Inquiry**  
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] [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] [redacted]  
Admit Date [redacted] [redacted]  
Discharge Date [redacted] [redacted]  
Date of Death [redacted] [redacted]

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

Amount Totals  
Total Charges \$0.00  
Total TPL Amount [redacted]

Diagnosis

# Internal Control Number (ICN) and/or Claim Number

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

20	12010	999	999
Region	Julian Date	Batch	Sequence
<i>Claim Type</i>	<i>Year and Day</i>	<i>Internal Use Only</i>	

- EVV claims will always start with 20 - Example: 2022123456789
  - Web Portal keyed claims will start with 22 - 222212345678
- Corrected or Voided claims will start with 59 - Example: 5922123456789

\*Note\* The region or claim type is determined by how the claim was submitted.

# Claim Status

## Once a claim has been processed, its status could be:

- **Paid:** Partially or fully paid. Void, Copy, or Adjust. (Adjustments must be made within 90 days of paid date.)
- **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. (Check with your Field Rep. or call MMIS Call Center)



# Claim Status – Top of the Claim

- ✓ **Claim number** – Internal Control Number (ICN)
- ✓ **Status** – Paid, Denied or Suspended
- ✓ **Total Paid amount**

Professional Claim	
<i>Adjudication Information</i>	
ICN/TCN	20220000000 <a href="#">DMA520 Inquiry</a>
RA Date	
<i>Billing Information</i>	
Claim Status	Paid
Total Paid Amount	\$899.26

# Claim Denial Reason

- Claim denial reason, move to the bottom of the claim for denial explanation.

Claim Status Information		
Claim Status	DENIED	
Claim ICN	222100000001	
Denied Date	08/17/2020	
RA Paid Amount	\$0.00	

EOB Information		
Detail Number	Code	Description
1	0000	Claim Denial Reason
2	0000	Claim Denial Reason
3	0000	Claim Denial Reason

# Timely Filing Guidelines



# Timely Filing Guidelines

For most providers, timely filing is 6 months from the month the service was rendered by the provider. However, there are variations which you should be aware of:

- Claim submission -Within six months of the DOS
- Claim adjustment -Within three months of the month of payment
- Claim resubmission -Within three months of the month the denial occurred
- One Year (365 Days) Claim Submission Edit

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



# One Year (365 Days) Claim Submission

## Example:

	Original Submit Claim	1 <sup>st</sup> Resubmit	2 <sup>nd</sup> Adjustment
DOS	Denied Date:	Adjustment	(365 days)
July 1, 2021	December 30, 2021	March 31, 2022	June 30, 2022

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

\*Banner Message posted April 12, 2018

# Claims Billing Cycle Time Frames

## Weekly Claims Submission Deadlines

EVV Claim submissions using the Netsmart System
MMIS Web Portal Claim corrections/submissions
Week Remittance Advices Availability
EFT Payment Deposits

Due Midnight each Thursday
Due Midday (12N) on Friday
Monday
Thursday

# Common Claim Denials



# Common Claim Denials

- **0872:** First diagnosis code not on file
- **1072:** EVV Services must be Submitted to EVV Vendor
- **1410:** 1<sup>st</sup> ICD-10 Diagnosis is a header or Parent Code
- **1430:** 1<sup>st</sup> ICD-10 Diagnosis is not specific
- **2697:** QMB Member – Bill Medicare First
- **3001:** Prior Authorization/Precert Not on File
- **3011:** DOS not within PA/Precert effective dates
- **3043:** Prior Authorization/Procedure Code Modifier Conflict
- **3052:** Prior Authorization Units/Amount have been exhausted
- **5115:** Service not allowed during Hospital stay

# Common Claim Denials - EOB: 0872

(continued)

EOB List					
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
0	S	0872	95.00	0	FIRST DIAGNOSIS CODE NOT ON FILE

Claim Diagnosis	
Seq Code	Diagnosis Code
1	F71 F84

**Method of Correction** – Verify and resubmit claim with the correct diagnosis code.

Diagnosis Codes should be indicated within the members documentation or within the IDD Connect system.

# Common Claim Denials - EOB: 1072

(continued)

EOB List					
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description ▼
3	S	1072	22.32	0	EVV SERVICES MUST BE SUBMITTED TO EVV VENDOR

**Method of Correction** - Submit all claims via the EVV Netsmart system.

# Common Claim Denials - EOB: 1410

(continued)

EOB List					
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	1410	157.17	0	1ST ICD-10 DIAGNOSIS IS A HEADER OR PARENT CODE

**Method of Correction** - Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with the primary diagnosis code. The primary diagnosis should be indicated within the members documentation.

# Common Claim Denials EOB: 1430

(continued)

EOB List					
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	1430	76.67	0	1ST ICD-10 DIAGNOSIS IS NOT SPECIFIC

Claim Diagnosis			
Seq Code	Diagnosis Code	ICD	Description
1	M19.90	ICD-10	UNSPECIFIED OSTEOARTHRITIS, UNSPECIFIED SITE

**Method of Correction** - Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with a more specific diagnosis code. The specific diagnosis should be indicated within the members documentation.



# Common Claim Denials - EOB: 2697

(continued)

EOB List							
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description		
0	S	2697	496.10	0	QMB MEMBER - BILL MEDICARE FIRST		

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	01/06/2022	01/06/2022	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.)	

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.	42 - Home Health Care	01/06/2022	01/06/2022					

**Recommendation** – if member is a CCSP members, check with care coordinator to see if CCSP benefits can be applied for.

All other members, check with DFCS to see if eligibility can be reviewed.

# Common Claim Denials - EOB: 3001

(continued)

## EOB List

### EOB Description

PRIOR AUTHORIZATION/PRECERT NOT ON FILE

**Recommendation** – Double check the Prior Authorization number to ensure is it validation PA number.

**Method of Correction** - Resubmit a corrected claim with a valid PA Number.

# Common Claim Denials - EOB: 3011

(continued)

EOB List					
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	3011	94.71	0	DOS NOT WITHIN PA/PREPERT EFFECTIVE DATES

Detail List						
#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed
1	D	1/1/2022	1/1/2022	T1019 - TF	94.71	21
2	D	1/2/2022	1/2/2022	T1019 - TF	72.16	16

## Prior Authorization Start and Ending date:

Begin Date	07/07/2021	Authorized Eff. Date	07/07/2021
End Date	07/06/2022	Authorized End Date	07/06/2022

### -Procedure Codes-

Procedure Code	Modifier 1	Modifier 2	Modifier 3	Modifier 4
T1019				

**Recommendation** - Cross reference date of service billed and Prior Authorization approval dates and ensure they are within range.

**Method of Correction** - Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with the correction.

# Common Claim Denials - EOB: 3043

(continued)

## EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	3043	96.33	0	PRIOR AUTHORIZATION/PROCEDURE CODE MODIFIER CONFLICT

## Detail List

#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed
1	D	12/22/2021	12/22/2021	T1019 -	96.33	19

**Method of Correction** – Resubmit a corrected claim via the Web Portal or EVV Netsmart system (if applicable) with the procedure and modifier as approved on the members Prior Authorization.

# Common Claim Denials - EOB: 3052

(continued)

EOB List					
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	3052	81.18	0	PRIOR AUTHORIZATION UNITS/AMOUNT HAVE BEEN EXHAUSTED

**Recommendation** - Cross reference current Prior authorization and ensure that you have billed the current units on each date of service.

\*(For accurate Prior Authorization result, verify PAs via the MMIS Web Portal)

**Method of Correction** – If corrections should be made, submit a newly corrected claim via the Web Portal or EVV Netsmart system (if applicable).

# Common Claim Denials - EOB: 5115

(continued)

EOB List					
Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description
1	S	5115	376.07	0	SERVICE NOT ALLOWED DURING MEMBERS HOSPITAL STAY

**Recommendation** – member signed time sheet showing in and out time(s) may be requested to be attached to the claim via the MMIS Web portal. May also need hospital documentation to shows hospital visit.

**Method of Correction** – Must rebill and attach recommended documentation.

# Claim History Search

# Claims History Search

*(continued)*

## Ways to search for outstanding claims:

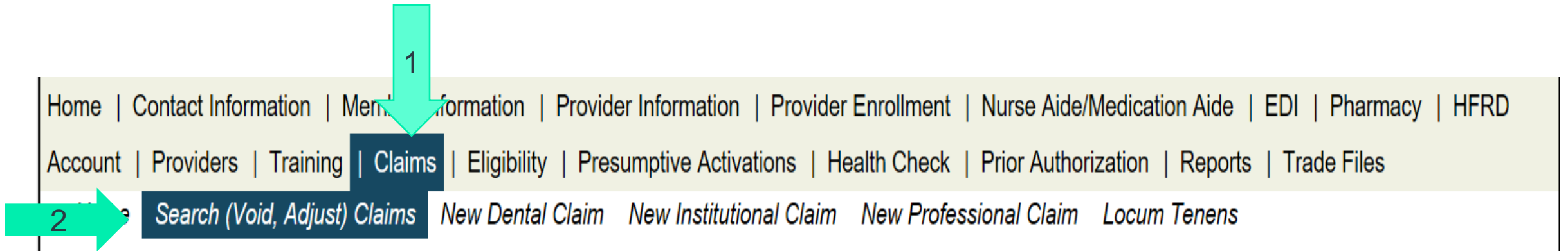
- ICN (Search)
- Member ID, FDOS -> TDOS, Claim Type (Search)
- Member ID, FDOS -> TDOS, Status Type (Search)
- Member ID, Claim Type, RA Date (Search)

Claim Type = Professional

Status Type Options = Paid, Denied, Suspended



# Claims History Search



## Ways to search for outstanding claims

- ICN
- Member ID, FDOS – TDOS, Claim Type
- Member ID, FDOS – TDOS, Status Type
- Member ID, Claim Type, RA Date

# Claims History Search

(continued)

**Claim Search** Top ? ↕

ICN/TCN

Member ID

Rendering Provider ID  [ Search ]

Claim Type

From/Thru DOS

RA Date

Status  **Records**

**search** **clear**

English | Español | Accessibility

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**REPORT FRAUD**



**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	\$66.81	\$48.20
4009	2090	111	01/09/2009	01/09/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/02/2009	\$80.00	\$0.00
4009	2090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	\$67.97	\$40.70
4009	2090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	\$102.93	\$62.71
4009	8090	111	01/12/2009	01/12/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	\$420.00	\$107.31
4009	2090	111	01/13/2009	01/13/2009	PROFESSIONAL XOVER CLAIMS	PAID	01/26/2009	\$66.81	\$48.20
4009	8090	111	01/14/2009	01/14/2009	PROFESSIONAL XOVER CLAIMS	PAID	04/13/2009	\$102.93	\$0.00
4009	2090	111	01/23/2009	01/23/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/09/2009	\$102.93	\$59.71
4009	2090	111	01/27/2009	01/27/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	\$105.93	\$0.00
4009	8090	111	01/27/2009	01/27/2009	PROFESSIONAL XOVER CLAIMS	PAID	04/13/2009	\$79.61	\$6.59
4009	2090	111	01/28/2009	01/28/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	\$144.01	\$85.12
4009	2090	111	01/29/2009	01/29/2009	PROFESSIONAL XOVER CLAIMS	PAID	02/23/2009	\$102.93	\$0.00



# Claims History Search

(continued)

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

Search Results (7 rows returned)						
From DOS ▲	To DOS	Claim Type	Status	RA Date	Amount Billed	Paid
09/06/2012	09/06/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	\$235.00	\$0.00
09/10/2012	09/10/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	\$235.00	\$0.00
10/01/2012	10/01/2012	PROFESSIONAL CLAIMS	DENIED	10/15/2012	\$235.00	\$0.00
10/08/2012	10/15/2012	PROFESSIONAL CLAIMS	DENIED	10/29/2012	\$470.00	\$0.00
10/22/2012	10/22/2012	PROFESSIONAL CLAIMS	DENIED	11/05/2012	\$235.00	\$0.00
10/29/2012	10/29/2012	PROFESSIONAL CLAIMS	DENIED	11/19/2012	\$235.00	\$0.00
11/12/2012	11/13/2012	PROFESSIONAL CLAIMS	DENIED	12/03/2012	\$359.00	\$0.00

Search Results (7 rows returned)						
From DOS	To DOS	Claim Type	Status	RA Date ▼	Amount Billed	Paid
11/12/2012	11/13/2012	PROFESSIONAL CLAIMS	DENIED	12/03/2012	\$359.00	\$0.00
10/29/2012	10/29/2012	PROFESSIONAL CLAIMS	DENIED	11/19/2012	\$235.00	\$0.00
10/22/2012	10/22/2012	PROFESSIONAL CLAIMS	DENIED	11/05/2012	\$235.00	\$0.00
10/08/2012	10/15/2012	PROFESSIONAL CLAIMS	DENIED	10/29/2012	\$470.00	\$0.00
10/01/2012	10/01/2012	PROFESSIONAL CLAIMS	DENIED	10/15/2012	\$235.00	\$0.00
09/06/2012	09/06/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	\$235.00	\$0.00
09/10/2012	09/10/2012	PROFESSIONAL CLAIMS	DENIED	09/24/2012	\$235.00	\$0.00

# Accessing and Understanding your Remittance Advice



# Remittance Advice (RA)

## Sections within the remittance advice

- Banner Messages
  - Claims Type M – CMS 1500 Paid
  - Claims Type M – CMS 1500 Denied
  - Financial Transactions (Non-Claim Specific Payouts, Refunds & Account Receivable)
  - Remittance Advise Summary Page (Indicates the total deposit to banking institutions)
  - EOB Code Descriptions
- The Remittance Advices (RA) are generated each claims payment cycle. RAs are only received if there were claim activity during the claims cycle.

# Accessing the Full Remittance Advice

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

Clear Search

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

\* For a full comprehensive remittance advice report including all page, please login and access using your payee ID user information.


\* (For assistance, contact our EDI department at: 1-877-267-8785)

# Remittance Advice (RA)

REPORT: CRA-BANN-R  
RA#: 8523480

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
BANNER MESSAGES

DATE:  
PAGE:

 PAYEE ID:  
NPI ID:  
PAYMENT NUMBER:  
ISSUE DATE:  
RECEIVER ID:

1

\*\*\*\*\*  
\*\*\*\*\*

BANNER MESSAGE TO HCBS WAIVER COS PROVIDERS 590, 660, 680, 681 FINANCIAL MANAGEMENT, CASE MANAGEMENT AND SUPPORT COORDINATION PROVIDERS

THIS BANNER MESSAGE SHALL SERVE AS A SELF-DIRECTION (A.K.A. CONSUMER-DIRECTION, PARTICIPANT-DIRECTION) POLICY UPDATE TO HOME AND COMMUNITY-BASED WAIVER SERVICES FOR THE INDEPENDENT CARE WAIVER PROGRAM, COMMUNITY CARE SERVICES PROGRAM, NEW OPTIONS WAIVER, AND COMPREHENSIVE SUPPORTS WAIVER EFFECTIVE 11/1/15.

THIS COMMUNICATION IS AN UPDATE REGARDING THE U.S. DEPARTMENT OF LABOR FINAL HOME CARE RULE (EFFECTIVE JANUARY 1, 2015) EXTENDING THE MINIMUM WAGE AND OVERTIME PROTECTIONS OF THE FAIR LABOR STANDARDS ACT TO MOST HOME CARE WORKERS. THE FINAL HOME CARE RULE LABOR STANDARDS ACT WAS UPHELD BY THE U.S. COURT OF APPEALS ON AUGUST 21, 2015. AS A RESULT, GEORGIA MEDICAID WILL BE MOVING FORWARD IMMEDIATELY TO COMPLY WITH THE RULE EFFECTIVE 11/1/15.

EFFECTIVE NOVEMBER 1, 2015 ALL PERSONAL SUPPORT AIDES MUST BE PAID OVERTIME FOR ANY HOURS THEY WORK THAT ARE OVER 40 IN A WORK WEEK. CURRENTLY AN AIDE WHO WORKS MORE THAN 40 HOURS A WEEK IS BEING PAID THE SAME HOURLY PAY RATE FOR THE OVERTIME HOURS AS THEY ARE FOR THE REGULAR HOURS. SERVICES ARE AUTHORIZED WITHIN THE WAIVER BASED ON MEMBER NEED WITHOUT PROVISIONS FOR OVERTIME. IT IS THE MEMBER'S RESPONSIBILITY AS THE EMPLOYER TO MAKE SURE HE/SHE HAS ENOUGH AIDES HIRED AND SCHEDULED SO THAT NO AIDE WILL WORK OVER 40 HOURS IN A WORK WEEK.

IF A MEMBER'S AIDE WORKS MORE THAN 40 HOURS IN A WEEK AFTER THIS CHANGE IS EFFECTIVE, THEY WILL HAVE TO BE PAID OVERTIME AT 1.5 TIMES THE NORMAL RATE BY THE FISCAL AGENT. THIS WILL AFFECT THE AMOUNT OF MONEY LEFT IN THE MEMBER'S BUDGET. IF ALL THE MONEY IN THE MEMBER'S BUDGET IS USED TO PAY OVERTIME, THE CARE COORDINATOR OR CASE MANAGER WILL NOT BE AUTHORIZED TO INCREASE THE BUDGET. IT WILL BE THE MEMBER'S RESPONSIBILITY AS THE EMPLOYER FOR PAYING THE AIDE FOR ANY ADDITIONAL SERVICES NEEDED. IF THE MEMBER DEMONSTRATES THAT HE OR SHE CANNOT STAY WITHIN THEIR SELF-DIRECTED BUDGET DUE TO LARGE AMOUNTS OF OVERTIME PAID OUT, THE MEMBER WILL RISK THEIR SELF-DIRECTED STATUS AND MAY BE REMOVED FROM THE SELF-DIRECTED PROGRAM AND REQUIRED TO RECEIVE PERSONAL SUPPORT SERVICES THROUGH A TRADITIONAL AGENCY.

# Remittance Advice (RA)

## Claims data lines includes:

- ICN, Member ID, Member Name, Billed Date, Prior Auth No, Patient account number (if provided on claim), COS, FDOS-TDOS, Billed Amount, Medicaid Allowed Amount, Copay, Pt Liability, COB, Total Paid

ICN	MEMBER ID	MEMBER NAME	BILLED DTE	P AUTH NO	PATIENT NUMBER				
COS	FROM DTE - THRU DTE		BILLED	MCD ALLOWED	COPAY	PT LIAB	COB	TOTAL PAID	

- Detail Line Number, FDOS-TDOS, POS, Provider Specialty, Procedure Code, Modifiers, Units Billed/Units Allowed, Billed Amount, Medicaid Allowed Amount, COB, Total Paid, Claim Status

LN	FROM DTE-THRU DTE	POS	SPEC	PROC CD	M1	M2	M3	M4	UNITS BILLED/ALLWD	BILLED	MCD ALLOWED	COB	PAID	STATUS
----	-------------------	-----	------	---------	----	----	----	----	--------------------	--------	-------------	-----	------	--------



# Remittance Advice (RA) – Paid Claims

REPORT:  
RA#:

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

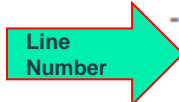
DATE:  
PAGE:

PAYEE ID:  
 NPI ID:  
 PAYMENT NUMBER:  
 ISSUE DATE:  
 RECEIVER ID:

RENDERING PROVIDER: MCD 000000000A NPI

ICN	MEMBER ID	MEMBER NAME	BILLED DTE	P AUTH NO	PATIENT NUMBER	COB	TOTAL PAID
COS	FROM DTE - THRU DTE	BILLED	ALLOWED	COPAY/DEDUCT	PT LIAB		
222222222221	111111111111	Medicaid, Man	01142022				
660	11012021 11012021	95.00	95.00	0.00	0.00	0.00	95.00

HEADER BOBS: 0280 OA:19



LNN	FROM DTE-THRU DTE	POS	SPEC	PROC CD	M1	M2	M3	M4	UNITS BILLED/ALLWD	BILLED	ALLOWED	COB	PAID	STATUS
1	11012021 11012021	12	216	T2040					1.00	1.00	95.00	95.00	0.00	95.00 PAID

DETAIL BOBS: 2517 CO:16  
REMARK CODES: MA64

# Remittance Advice (RA) – Denied Claims

REPORT:  
RA#:

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

DATE: :  
PAGE:

PAYEE ID:  
 NPI ID:  
 PAYMENT NUMBER:  
 ISSUE DATE:  
 RECEIVER ID:

RENDERING PROVIDER: NPI

ICN COS	MEMBER ID FROM DTE - THRU DTE	MEMBER NAME	BILLED	BILLED DTE ALLOWED	P AUTH NO COPAY/DEDUCT	PATIENT NUMBER PT LIAB	COB	TOTAL PAID	
2222222222221 660	111111111112 12012021 12012021	Medicaid, Lady	95.00	01142022 0.00	0.00	Medicaid, Lady 0.00	0.00	0.00	DENY

LNN	FROM DTE-THRU DTE	POS	SPEC	PROC CD	M1 M2 M3 M4	UNITS BILLED/ALLWD	BILLED	ALLOWED	COB	PAID	STATUS
1	12012021 12012021	12	216	T3040	UC	1.00 0.00	95.00	0.00	0.00	0.00	DENY

DETAIL EOB: 3001 CO:16 95.00- 2517  
 REMARK CODES: M62

EOB Denial  
Code(S)

# Remittance Advice (RA) – Claim Adjustments

REPORT:  
RA#:

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

DATE:  
PAGE:

PAYEE ID:  
NPI ID:  
PAYMENT NUMBER:  
ISSUE DATE:  
RECEIVER ID:

RENDERING PROVIDER: MCD 000000000A NPI

ICN COS	MEMBER ID FROM DTE - THRU DTE	MEMBER NAME	BILLED	BILLED DTE ALLOWED	P AUTH NO COPAY/DEDUCT	PATIENT NUMBER PT LIAB	COB	TOTAL PAID		
LNN FROM DTE-THRU DTE	POS	SPEC	PROC CD	M1 M2 M3 M4	UNITS BILLED/ALLWD	BILLED	ALLOWED	COB	PAID	STATUS
1 11012021 11302021	12	030	T2022		1.00 1.00	175.00	175.00	0.00	175.00	PAID
2222222222221	1111111111111	Medicaid, Man								
590 11012021 11302021					-175.00	-175.00	-0.00	-0.00	-175.00	
5922222222221	1111111111111	Medicaid, Man								
590 11012021 11302021					175.00	0.00	0.00	0.00	0.00	PAID
ADJ RSN: 8515 HEADER EOBS: 8515 OA:23 175.00- HEADER REMARK CODES: N142										
LNN FROM DTE-THRU DTE	POS	SPEC	PROC CD	M1 M2 M3 M4	UNITS BILLED/ALLWD	BILLED	ALLOWED	COB	PAID	STATUS
1 11012021 11302021	02	030	T2022		1.00 1.00	175.00	0.00	0.00	0.00	DENY
DETAIL EOBS: 2517 CO:16 REMARK CODES: MA64										



NET AMOUNT OWED TO STATE

175.00

# RA Account Receivable Financial Transactions

REPORT:  
RA#:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
FINANCIAL TRANSACTIONS

DATE: 12/10/2021  
PAGE: 203

PAYEE ID:  
NPI ID:  
PAYMENT NUMBER:  
ISSUE DATE:  
RECEIVER ID:

-----ACCOUNTS RECEIVABLE-----							
CURRENT CYCLE ARS							
AR NUMBER	SETUP DTE	RECOUPED THIS CYCLE	ORIGINAL	TOTAL RECOUPED	BALANCE	RSN CODE	
	12102021	525.00	525.00	525.00	0.00	0080	
RELATED ICN(S)/AMT:	20220A0000001	175.00	202200B000002	175.00		175.00	
				2022000C00003			
TOTAL CURRENT BALANCE					0.00		
PREVIOUS CYCLE ARS							
AR NUMBER	SETUP DTE	RECOUPED THIS CYCLE	ORIGINAL	TOTAL RECOUPED	BALANCE	RSN CODE	
NO PREVIOUS OUTSTANDING ACCOUNTS RECEIVABLE							
TOTAL PREVIOUS BALANCE					0.00		
TOTAL OUTSTANDING BALANCE					0.00		

# Financial Summary Page

This page is only accessible when logged into the Payee account

REPORT:  
RA#:

GEORGIA DEPARTMENT OF COMMUNITY HEALTH  
MEDICAID MANAGEMENT INFORMATION SYSTEM  
PROVIDER REMITTANCE ADVICE  
REMITTANCE ADVICE SUMMARY

DATE: 12/10/2021  
PAGE: 204

PAYEE ID:  
NPI ID:  
PAYMENT NUMBER:  
ISSUE DATE:  
RECEIVER ID:

-----CLAIMS DATA-----		
	CURRENT NUMBER	CURRENT AMOUNT
CLAIMS PAID	933	171,426.44
CLAIM ADJUSTMENTS POSITIVE	0	0.00
CLAIM ADJUSTMENTS NEGATIVE	4	(525.00)
TOTAL CLAIMS PAYMENTS	937	170,901.44
CLAIMS DENIED	28	
CLAIMS IN PROCESS	0	

-----EARNINGS DATA-----	
PAYMENTS:	
CLAIMS PAYMENTS	171,426.44
SYSTEM PAYOUTS (NON-CLAIM SPECIFIC)	0.00
ACCOUNTS RECEIVABLE (OFFSETS):	(525.00)
NET PAYMENT	170,901.44
REFUNDS:	
CLAIM SPECIFIC ADJUSTMENT REFUNDS	(0.00)
NON-CLAIM SPECIFIC REFUNDS	(0.00)
OTHER FINANCIAL:	
MANUAL PAYOUTS (NON-CLAIM SPECIFIC)	0.00
VOIDS	(0.00)
NET EARNINGS	170,901.44

# Provider Resources



# Contacting Gainwell Technologies

## We Are Always Here To Assist

- Chatbot
- Interactive Voice Response System (IVRS)
- Provider Services Contact Center (PSCC)
- Provider Relations Representatives

# What's New.... Chatbot

Some of the features will include:

## Providers

- How do I change my address?
- How do I reset my GAMMIS password?
- How do I update owners NPI or SSN or Tax ID?

## Members

- How do I reset my GAMMIS password?
- How do I apply for Medicaid?
- Where do I go to renew my Medicaid?

We look forward to this new enhancement!



# What's New.... Chatbot (continued)

The screenshot displays the top navigation bar of the GAMMIS website. On the left is the Georgia Department of Community Health logo. In the center is the GAMMIS logo (Georgia Medicaid Management Information System). On the right is the gainwell logo. Below the logos is a blue search bar with the text "Search". A status bar below the search bar indicates the session will expire in 18 minutes and shows the date "Monday, December 13, 2021". A main navigation menu includes links for Home, Contact Information, Member Information, Provider Information, Provider Enrollment, Nurse Aide/Medication Aide, EDI, Pharmacy, and HFRD. A secondary menu includes Home, Publication Search, Site Map, Site Settings, and Language Selection. Below the navigation is a bookmarkable link for "GAMMIS:Home" and a help link. The main content area features an alert message titled "Announcing the Georgia Medicaid Chatbot!". The message text reads: "In our effort to implement innovations that will benefit the overall productivity and quality of our provider and member call center experience, we have implemented a Chatbot feature!". It lists two main questions: "Where can I find it?" (with the answer: "This feature is located at the bottom of the home page.") and "What are the benefits of the Chatbot?" (with the answer: "This will make a positive impact to the provider/member community by reducing call volumes and wait times."). It also lists "Highlights of the Chatbot include answers to questions like:" followed by a list of questions for providers (password reset, address change, NPI/SSN/Tax ID update) and for members. A large red arrow points from the text to a blue chatbot icon in the bottom right corner of the page.

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GAMMIS  
GEORGIA MEDICAID MANAGEMENT INFORMATION SYSTEM

gainwell

Search

[ Refresh session ] You have approximately 18 minutes until your session will expire. Monday, December 13, 2021

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

Home Publication Search Site Map Site Settings Language Selection

★GAMMIS:Home <- Bookmarkable Link 🌟 Click here for help and information about bookmarks

(click to hide) Alert Message posted 11/3/2021

**Announcing the Georgia Medicaid Chatbot!**

In our effort to implement innovations that will benefit the overall productivity and quality of our provider and member call center experience, **we have implemented a Chatbot feature!**

- Where can I find it?
  - This feature is located at the bottom of the home page.
- What are the benefits of the Chatbot?
  - This will make a positive impact to the provider/member community by reducing call volumes and wait times.

Highlights of the Chatbot include answers to questions like:

- For providers
  - How do I reset my GAMMIS Password?
  - How do I change my address?
  - How do I update my owners NPI or SSN or Tax ID?
- For members

# 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.

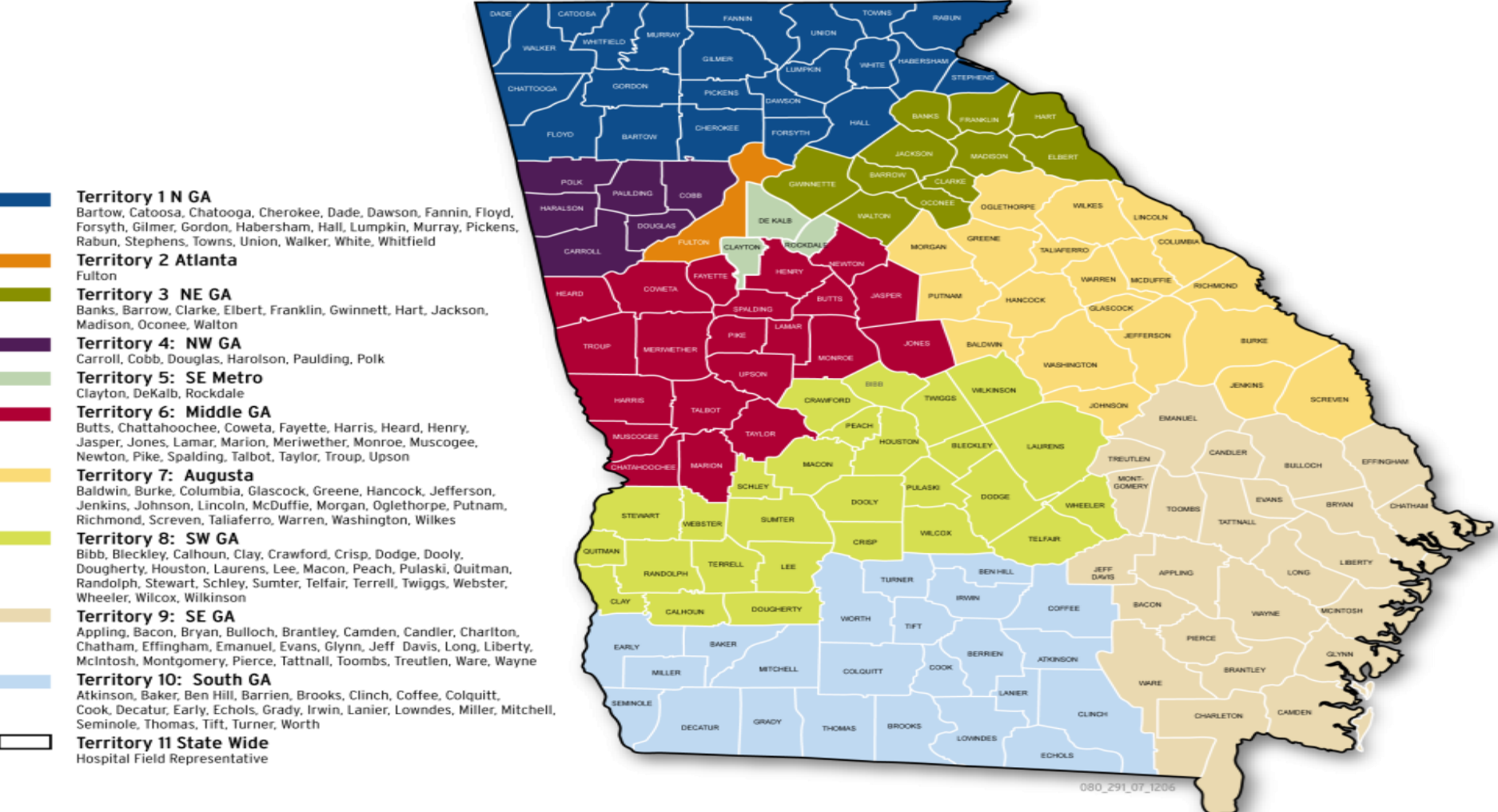
<b>800-766-4456</b>	
Option 1	Member Eligibility
Option 2	Claims Status
Option 3	Payment Information
Option 4	Provider Enrollment
Option 5	Prior Authorization
Option 6	GAMMIS website password reset, Pharmacy Benefits, the Nurse Aide Registry or Nurse Aide Training program, PeachCare for Kids® EDI submission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

# Provider Services Contact Center

**PSCC assists providers with inquiries regarding claims status, eligibility coverage, prior authorization, remittance advice, demographic changes, and other Medicaid questions. PSCC is available:**

- 1-800-766-4456
- Monday through Friday (excluding state holidays)
- 7 a.m. to 7 p.m. Eastern Standard Time
- Providers can also use the “Contact Us” link on GAMMIS

# Georgia Field Territories



# Provider Relations Field Services Representatives

Territory	Region	Rep
1	North Georgia	Mercedes Liddell
2	Fulton	Deandre Murray
3	NE Georgia	Carolyn Thomas
4	NW Georgia	Vacant
5	SE Metro	Ebony Hill
6	Middle Georgia	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

# Provider Relations Representatives

## State-Wide Consultants

**Sharée C. Daniels**  
**Brenda Hulette**  
**Danny Williams**

# Contact My Provider Rep Directly

After logging into the GAMMIS System, select Contact Information then Contact Us




# Contact My Provider Rep Directly

(continued)

## Select an Item

**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)

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

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 top of page

# 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

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

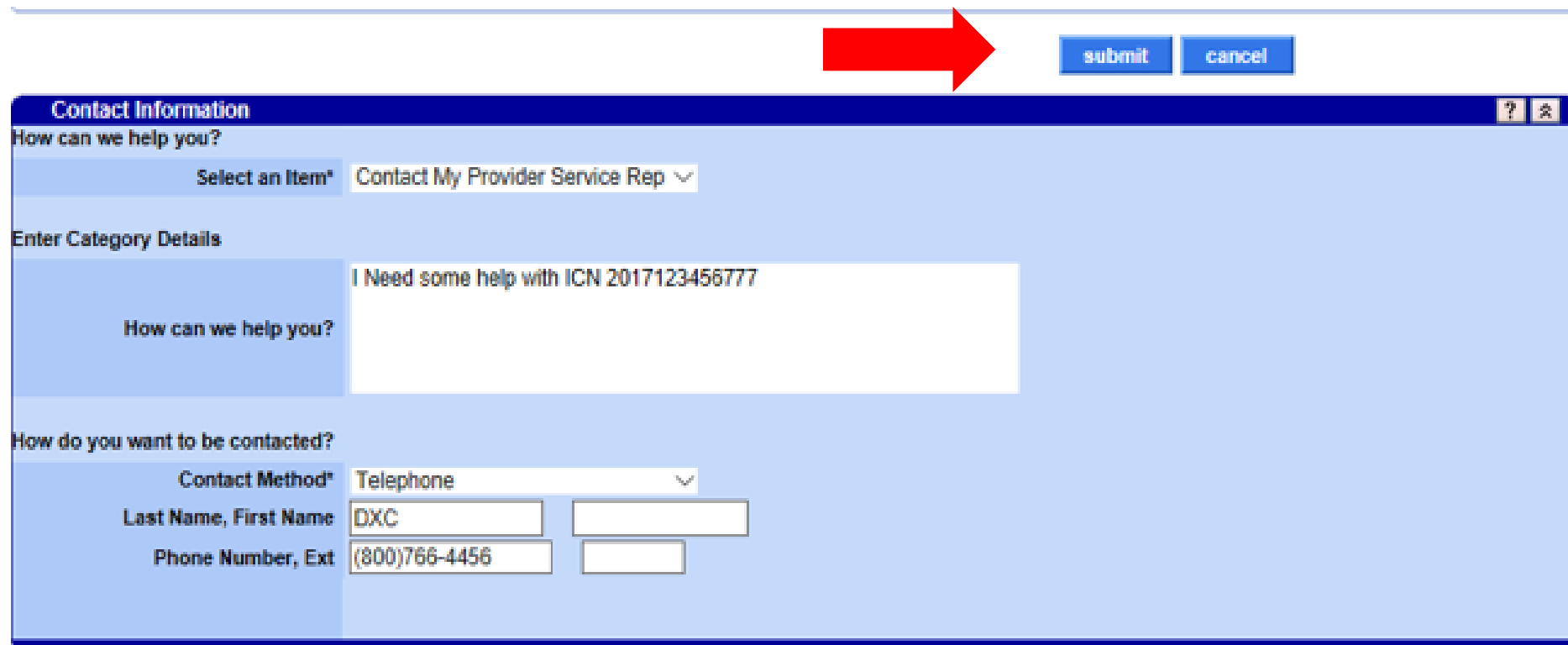
Click Here

top of page top of page

# Contact My Provider Rep Directly

(continued)

Please provide all details pertaining to your issue, including ICN, member ID, etc.



The screenshot shows a web form titled "Contact Information" with a blue header bar. A red arrow points from the top of the form to the "submit" button. The form contains the following fields:

- How can we help you?**
  - Select an Item\*: Contact My Provider Service Rep (dropdown menu)
- Enter Category Details**
  - How can we help you?: I Need some help with ICN 2017123456777 (text input)
- How do you want to be contacted?**
  - Contact Method\*: Telephone (dropdown menu)
  - Last Name, First Name: DXC (text input)
  - Phone Number, Ext: (800)766-4456 (text input)

# Contact My Provider Rep Directly

(continued)

## The following messages were generated:

Your request has been processed. Your tracking number is 20763193.

Providers may call the Provider Contact Center at (770) 325-9888 or toll-free at (800) 766-4456. Members may call the Member Contact Center at (770) 325-2331 or toll-free at (866) 211-0950.

## Contact Information



How can we help you?

Select an Item\*

Enter Category Details

How can we help you?

How do you want to be contacted?

Contact Method\*

Last Name, First Name

Phone Number, Ext

# Session Review

You should now be able to:

- Identify general billing information and policy changes
- Resolve common concerns relating to claim denials
- Remittance Advice Navigation
- Perform functions using the IVRS and Web Portal

# Questions and Answers



**Thank you!**

