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 -> 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

- 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

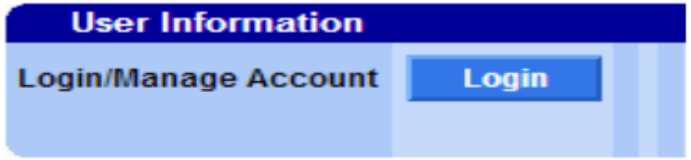
Policy Information and Updates

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

Logging into the Secure Web Portal

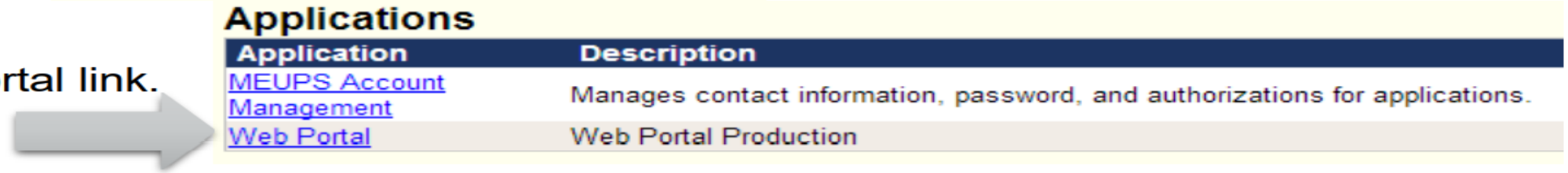
To get started, login to the secure GAMMIS Web Portal at www.mmis.georgia.gov.

Click the Login button.



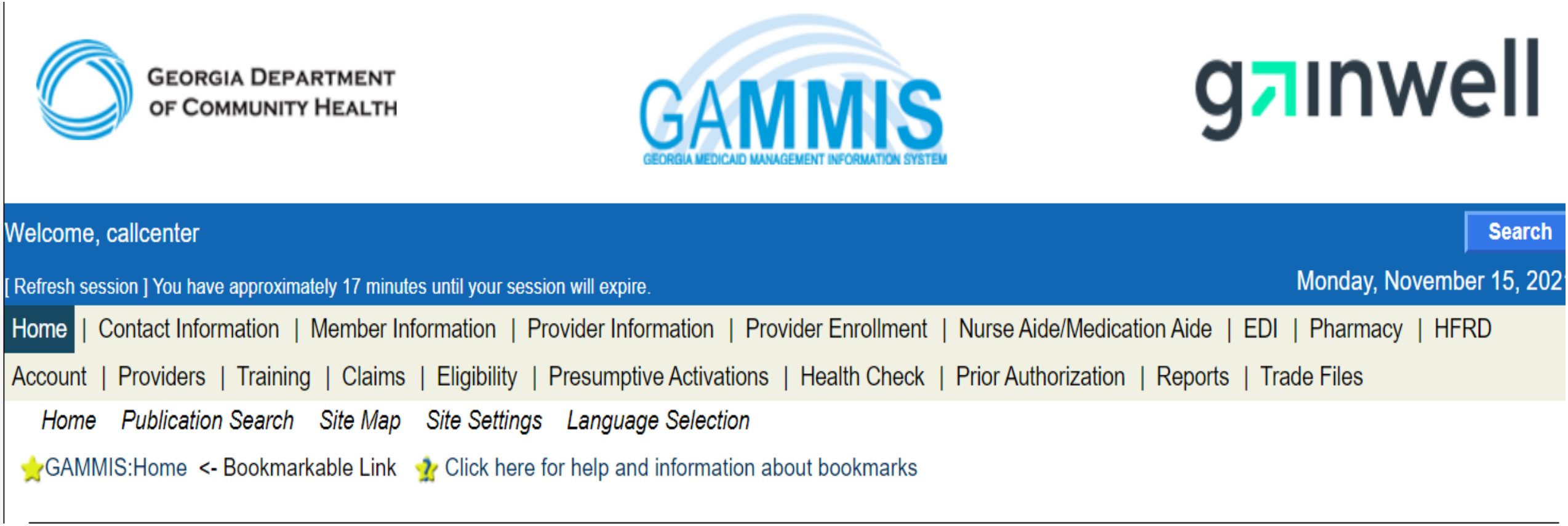
1. Enter your Username and Password and click the Sign In button.

2. Click the Web Portal link.



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

GAMMIS Secure Web Portal



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
- Interactive Voice Response System (IVRS)

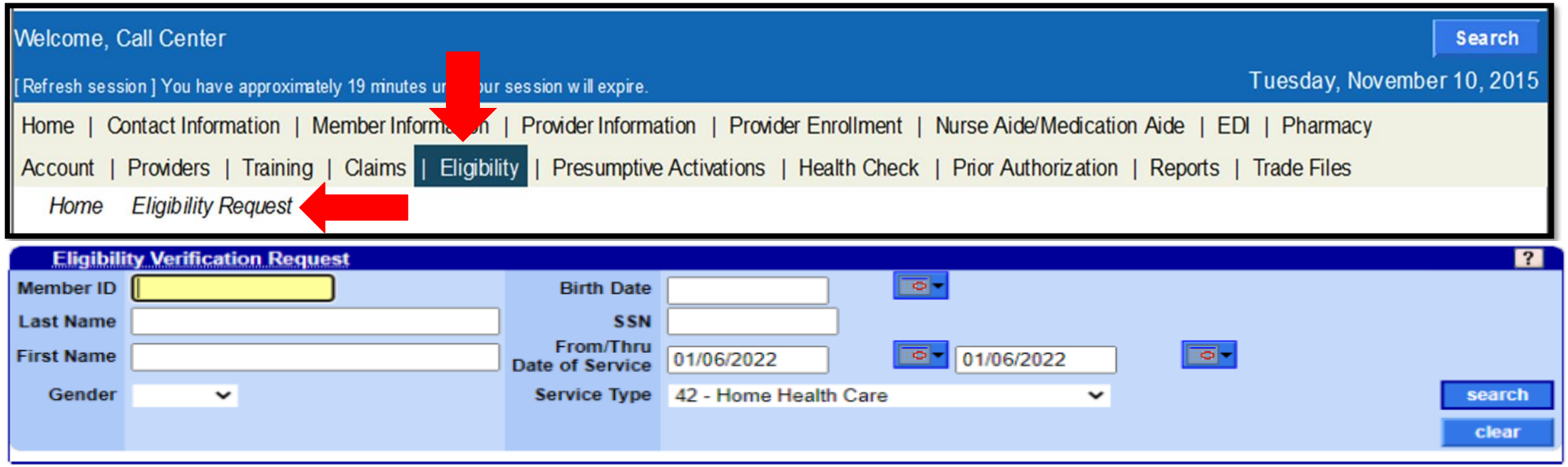
The IVRS and the GAMMIS website are available 24 hours a day.

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)



- [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

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)

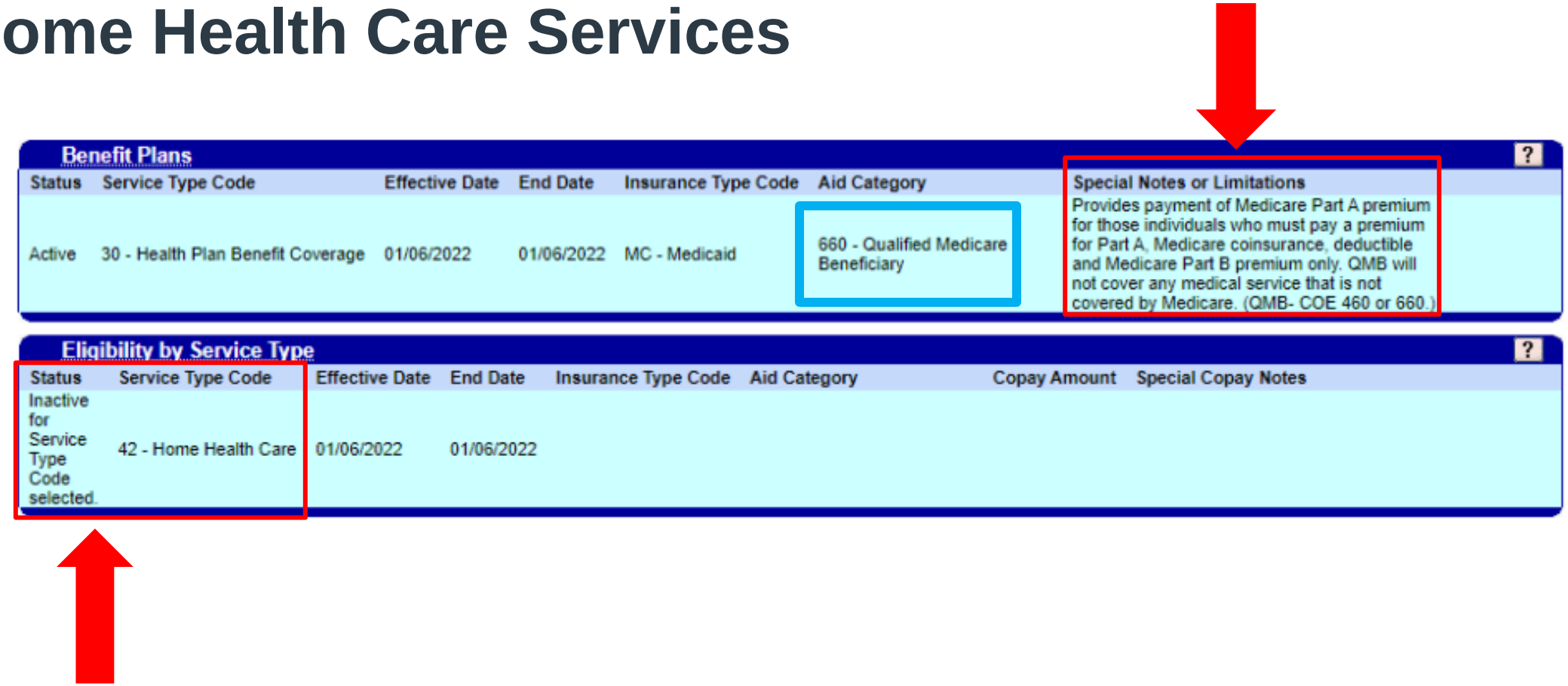
Eligibility by Service Type

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	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				

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CCSP Medicaid & QMB Benefits

CCSP 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.)

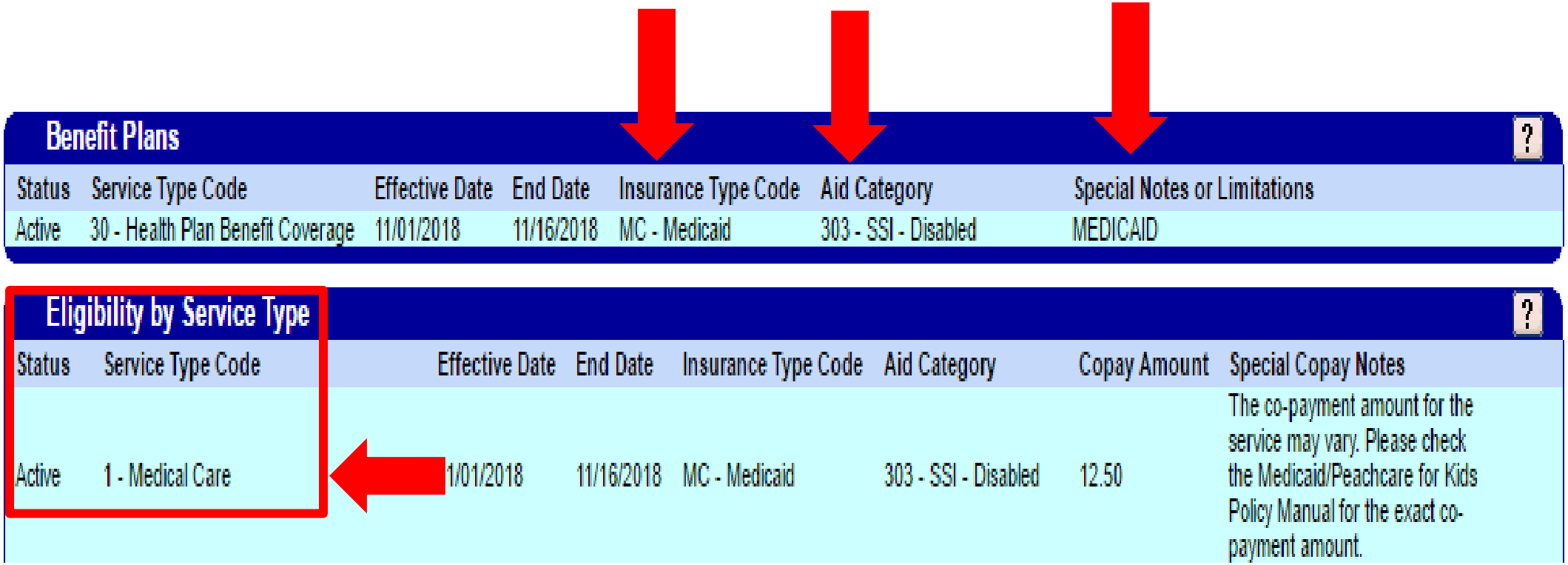
Eligibility by Service Type

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.

Eligibility Verification

(continued)

Retro Medicaid Benefits

Retroactive Eligibility

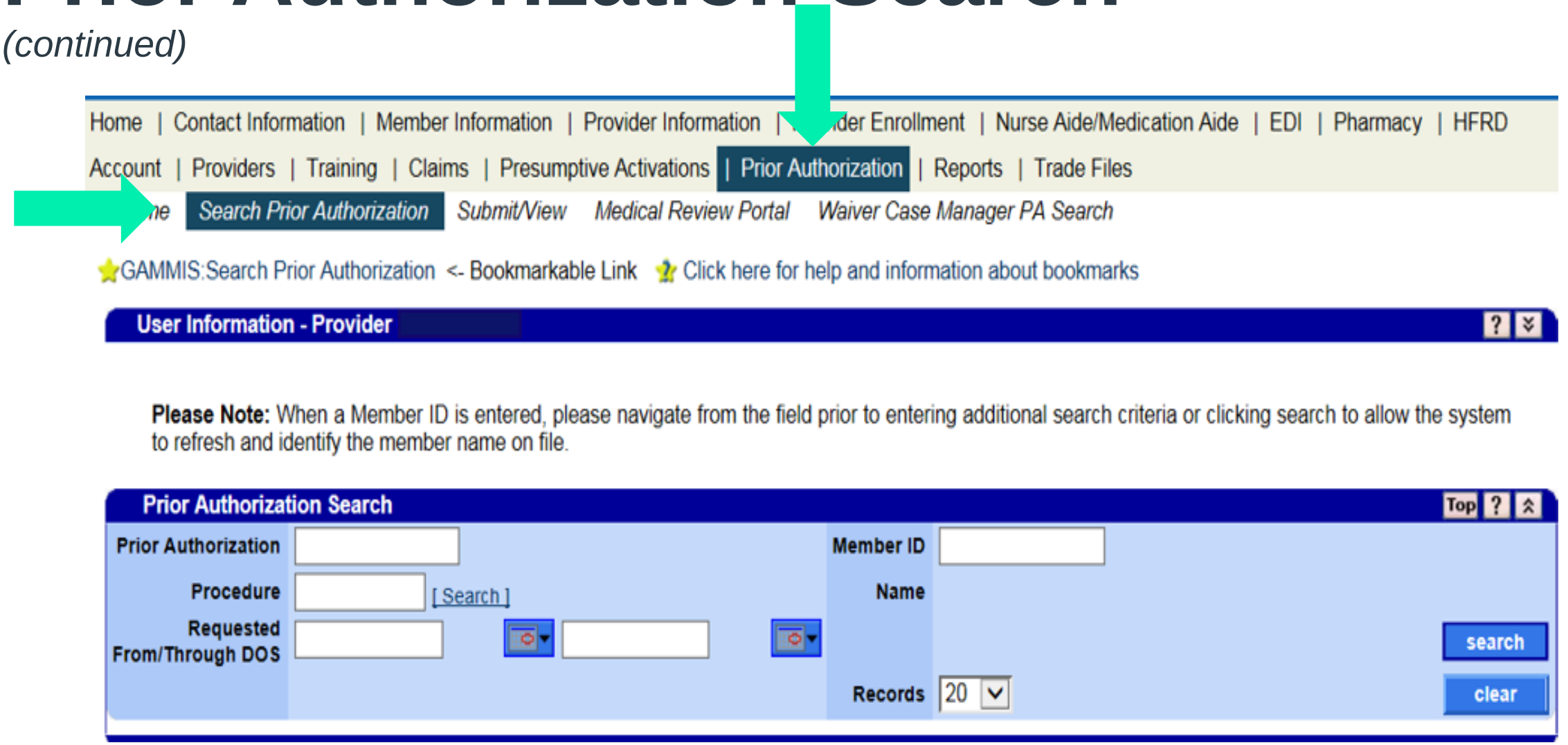
Retroactive Begin Date	Retroactive End Date	Retroactive Eff (Update) Date
06/08/2018	06/08/2018	08/11/2018

- **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)



Prior Authorization Search

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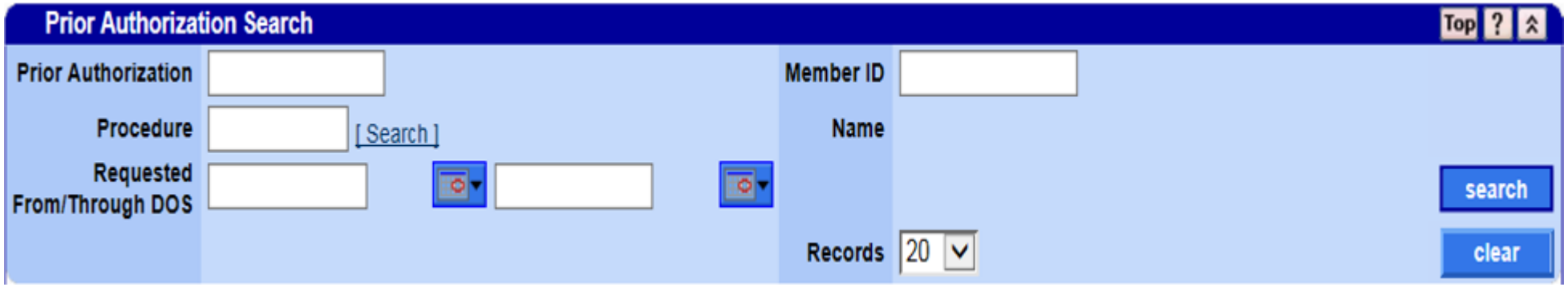
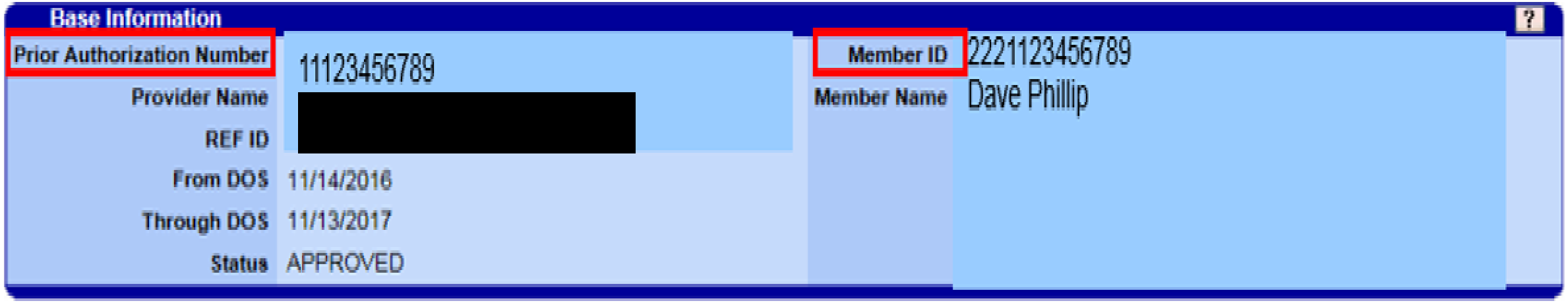


Prior Authorization search can be done in either of the following ways:

- 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)



Prior Authorization Search

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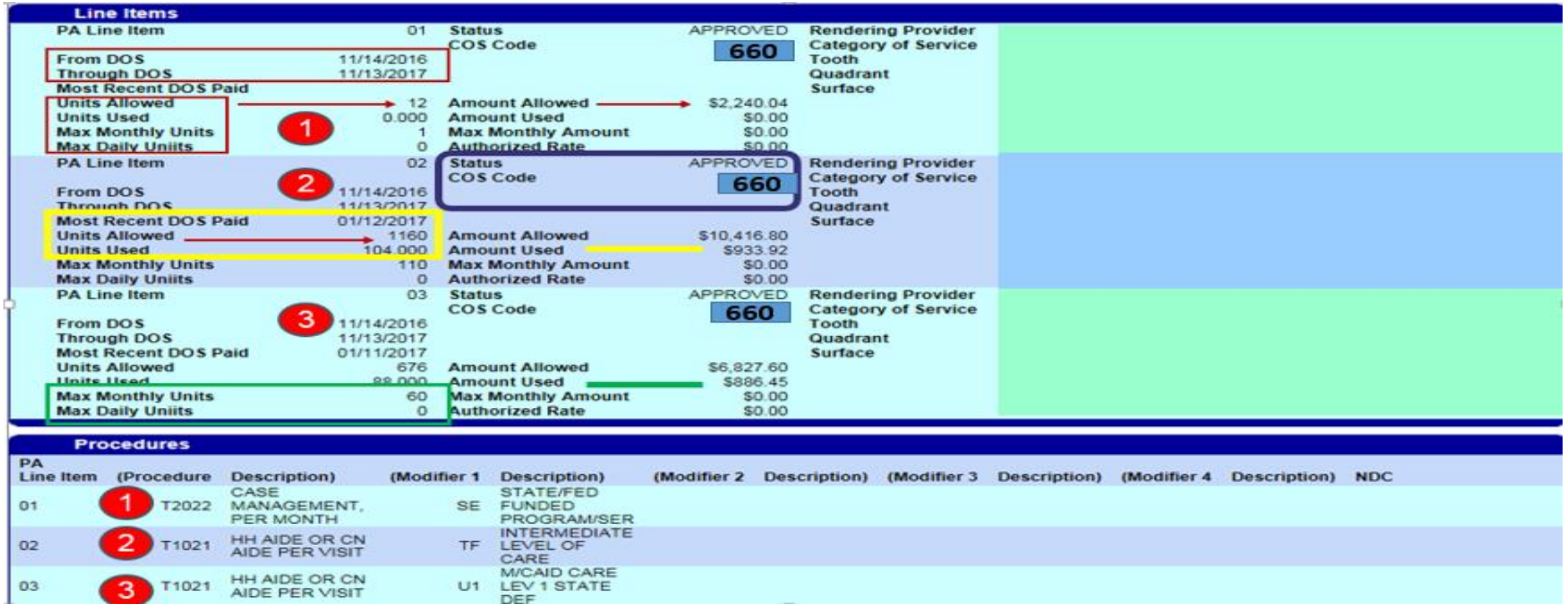


Line Items

PA Line Item	01	Status	APPROVED	Rendering Provider	
		COS Code	660	Category of Service	
From DOS	11/14/2016			Tooth	
Through DOS	11/13/2017			Quadrant	
Most Recent DOS Paid				Surface	
Units Allowed	12	Amount Allowed	$2,240.04		
Units Used	0.000	Amount Used	$0.00		
Max Monthly Units	1	Max Monthly Amount	$0.00		
Max Daily Uniits	0	Authorized Rate	$0.00		
PA Line Item	02	Status	APPROVED	Rendering Provider	
		COS Code	660	Category of Service	
From DOS	11/14/2016			Tooth	
Through DOS	11/13/2017			Quadrant	
Most Recent DOS Paid	01/12/2017			Surface	
Units Allowed	1160	Amount Allowed	$10,416.80		
Units Used	104.000	Amount Used	$933.92		
Max Monthly Units	110	Max Monthly Amount	$0.00		
Max Daily Uniits	0	Authorized Rate	$0.00		
PA Line Item	03	Status	APPROVED	Rendering Provider	
		COS Code	660	Category of Service	
From DOS	11/14/2016			Tooth	
Through DOS	11/13/2017			Quadrant	
Most Recent DOS Paid	01/11/2017			Surface	
Units Allowed	676	Amount Allowed	$6,827.60		
Units Used	88.000	Amount Used	$886.45		
Max Monthly Units	60	Max Monthly Amount	$0.00		
Max Daily Uniits	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	T2022	CASE MANAGEMENT, PER MONTH	SE	STATE/FED FUNDED PROGRAM/SER							
02	T1021	HH AIDE OR CN AIDE PER VISIT	TF	INTERMEDIATE LEVEL OF CARE							
03	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

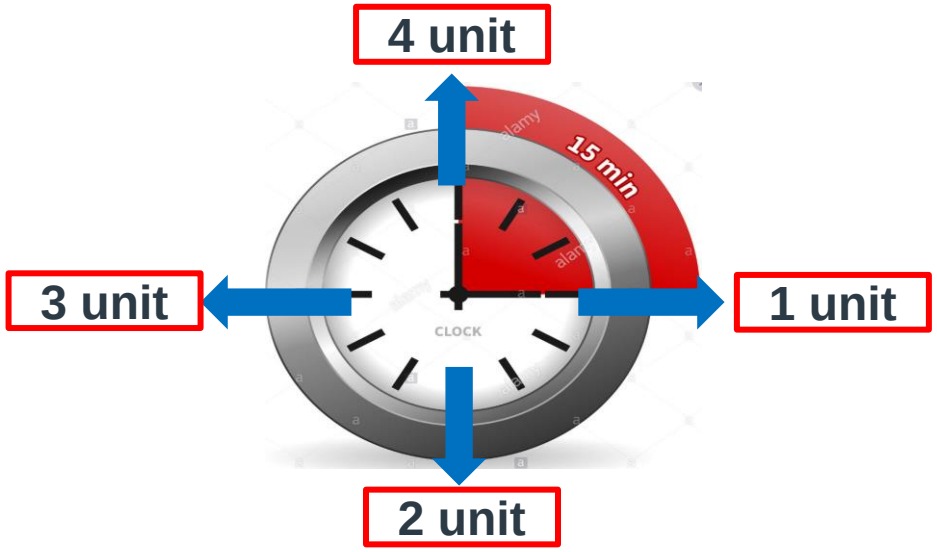
Claims, Claim adjustments, and Claim resubmissions can be submitted in two ways:

- 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:**

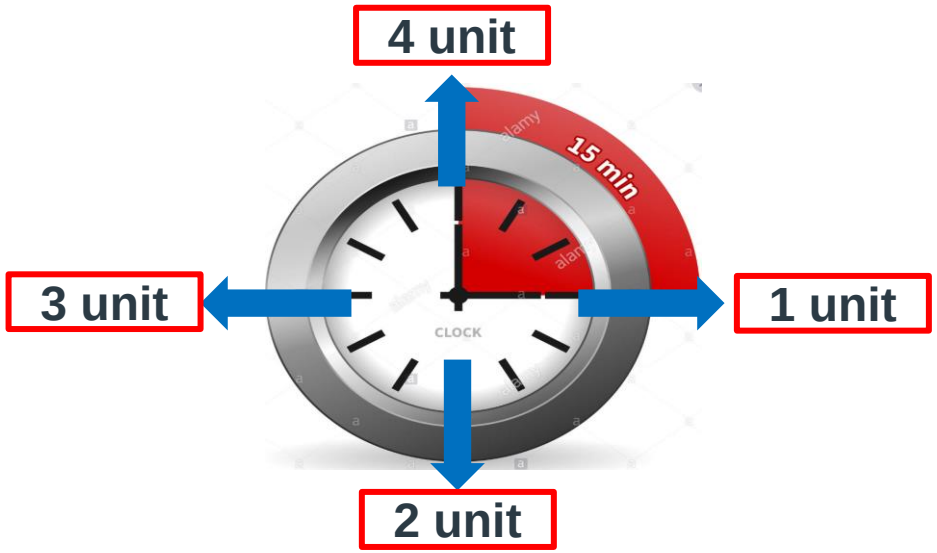
Description	Procedure Code	Modifier	Rate
Community Living Support	T2025	U5	$6.35 per 15 minutes
Community Access	T2025	HQ	$3.10 per 15 minutes Daily limit is 24 units, Monthly 504 units Annual Limit 5760 units



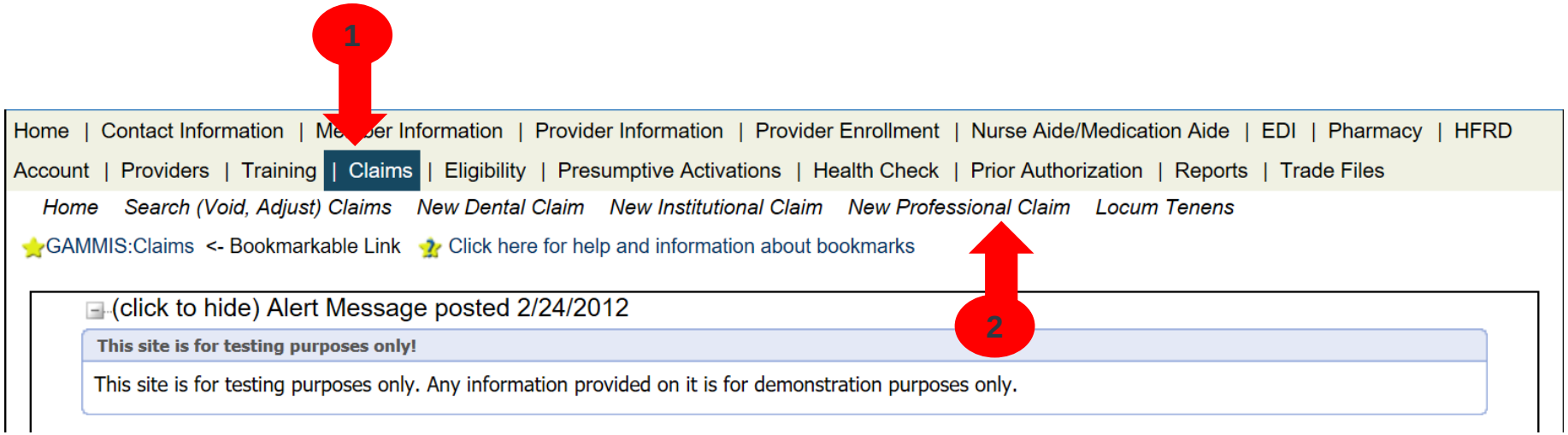
Billing and Unit Calculation Example

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



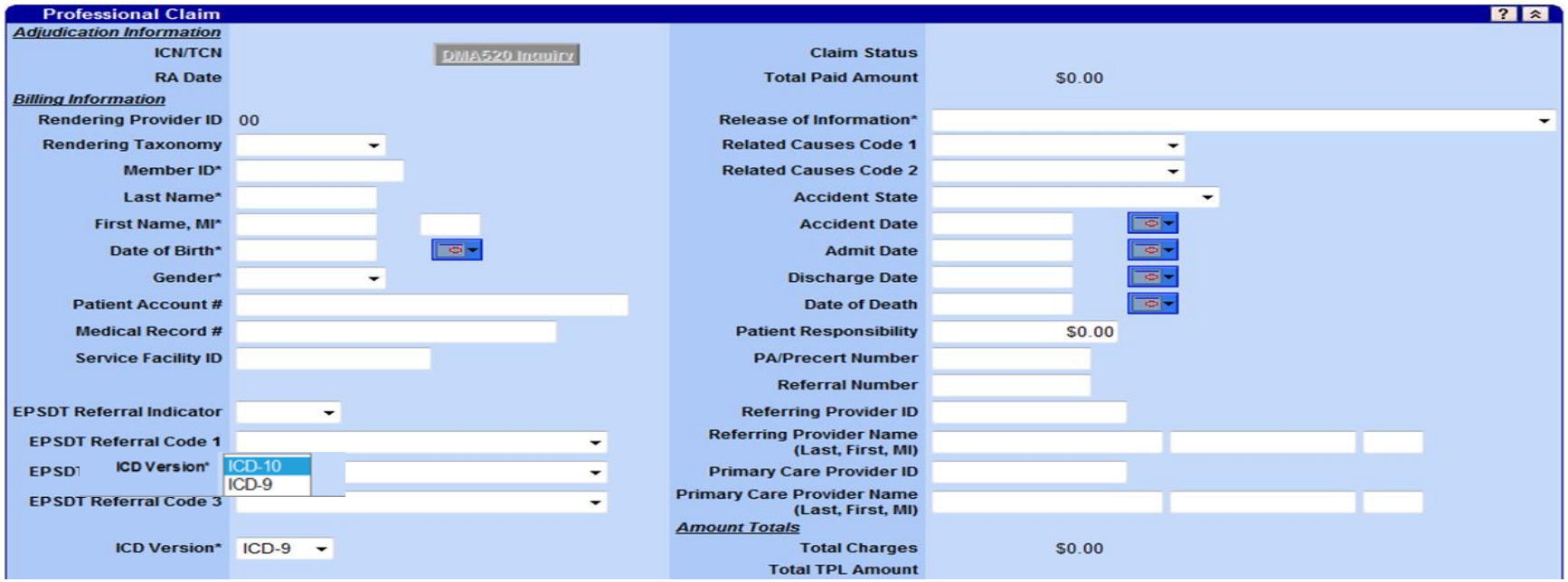
Professional Billing Information



Professional Claim

Header Panel 1

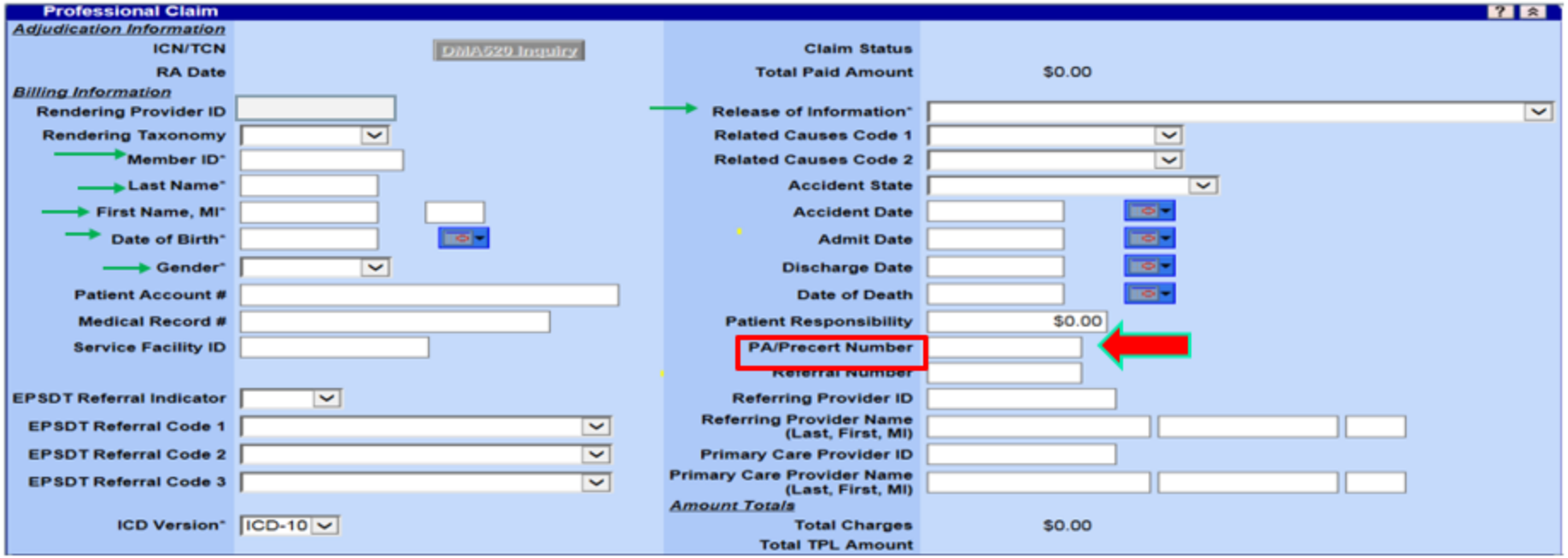
Enter the required information indicated by an asterisk (*) on each panel and as much optional information as possible.



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).

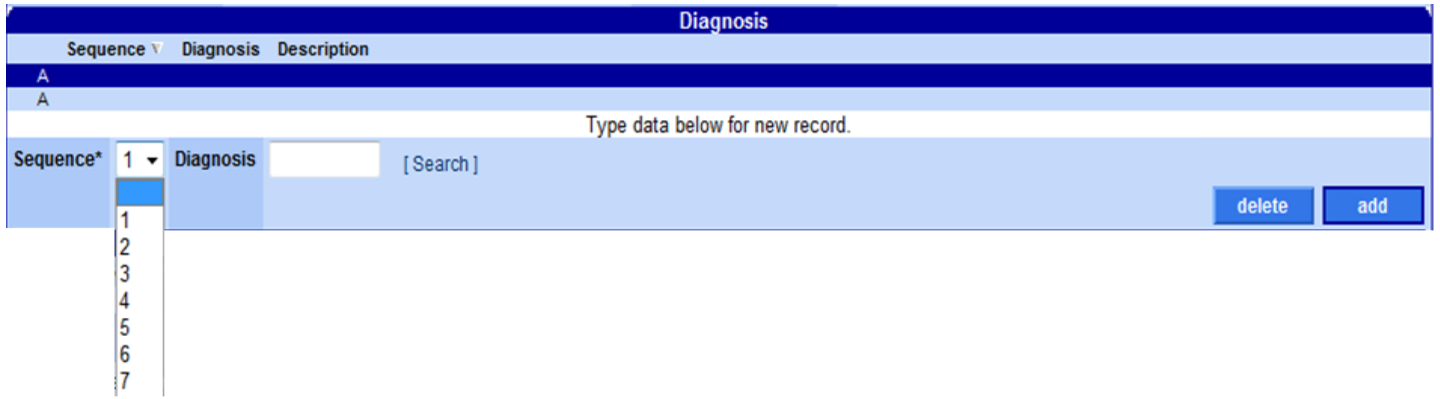


Diagnosis

Section 2

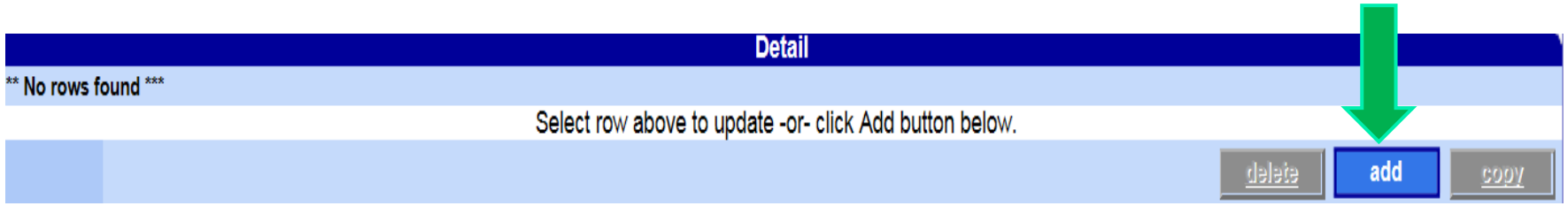
Allows entry of up to 10 diagnoses

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



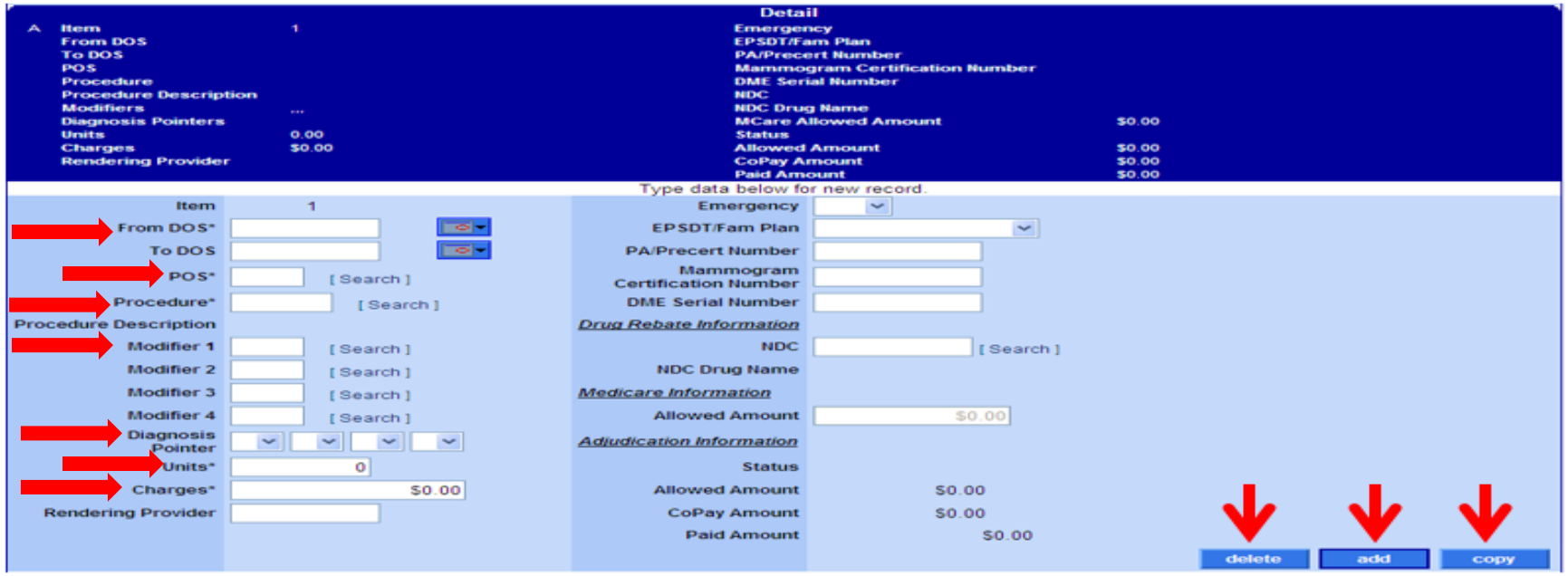
Detail

Section 3

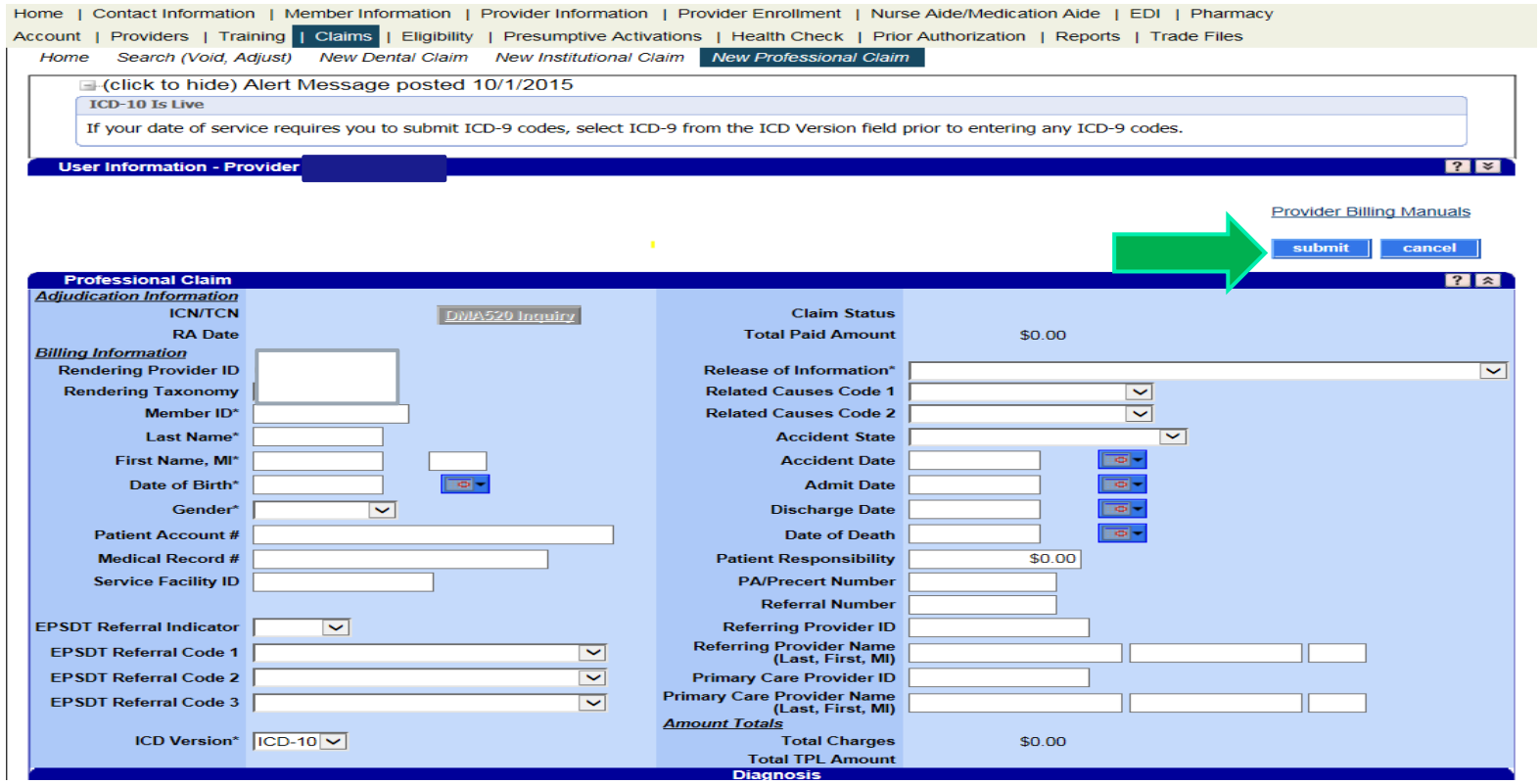


Claims Detail

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



Submit



Internal Control Number (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
Claim Type	*Year and Day*	*Internal Use Only*	

- EVV claims will always start with 20 - Example: 2022123456789
- Web Portal keyed claims will start with 22 - 22221234567 8
- Corrected or Voided claims will start with 59 - Example: 5922123456789

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

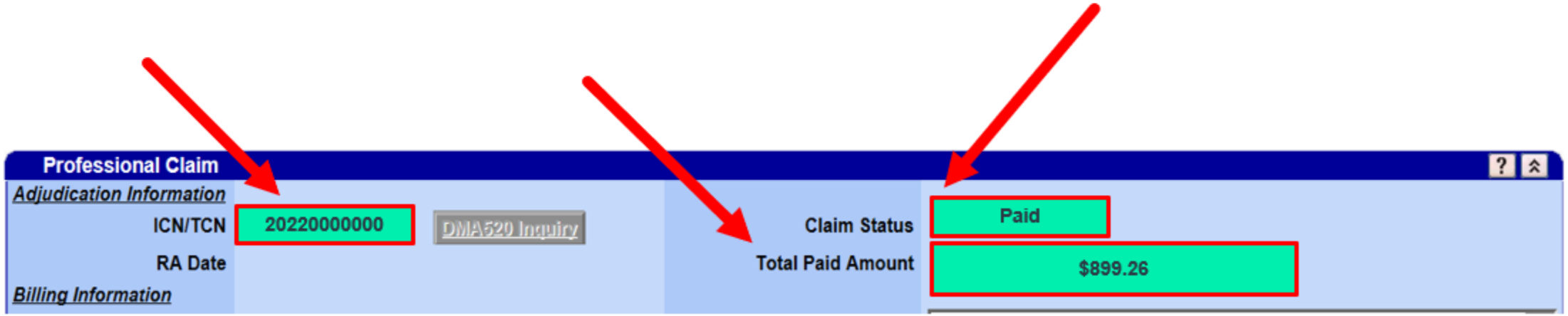
Claim Status

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**



Claim Denial Reason

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

Claim Status Information

Claim Status	DENIED
Claim ICN	2221000000001
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	1st Resubmit	2nd 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	Due Midnight each Thursday
MMIS Web Portal Claim corrections/submissions	Due Midday (12N) on Friday
Week Remittance Advices Availability	Monday
EFT Payment Deposits	Thursday

Common Claim Denials

Common Claim Denials

- **0872**: First diagnosis code not on file
- **1072:** EVV Services mut be Submitted to EVV Vendor
- **1410:** 1st ICD-10 Diagnosis is a header or Parent Code
- **1430:** 1st 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

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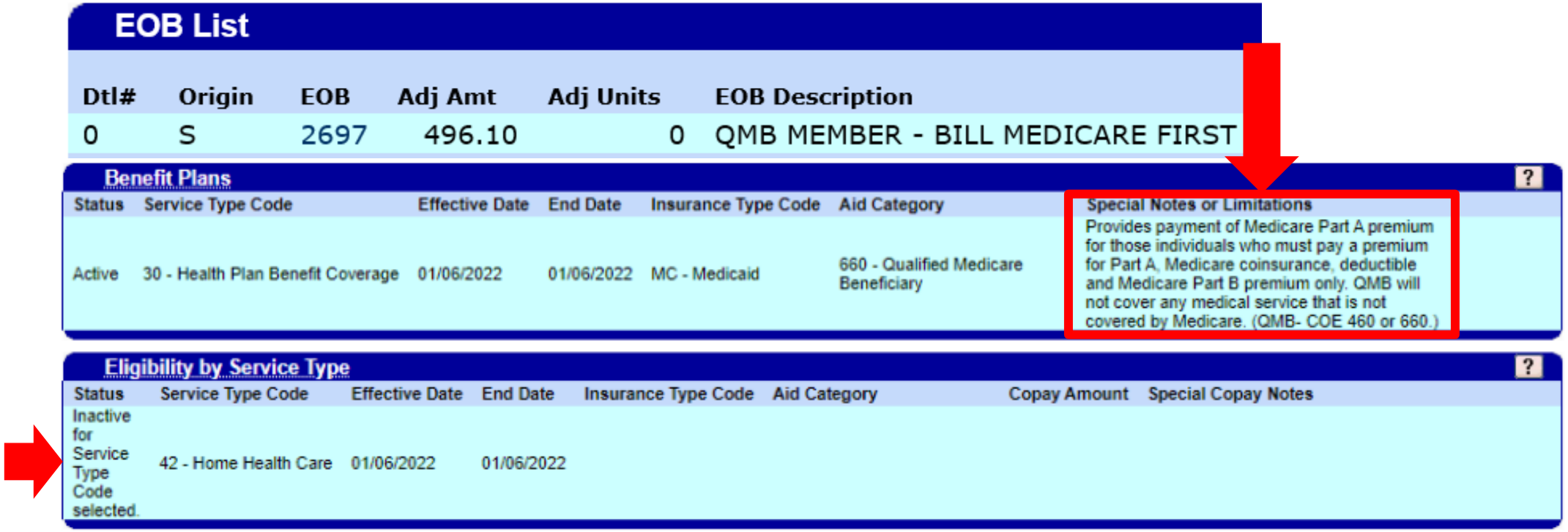


EOB List

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.)

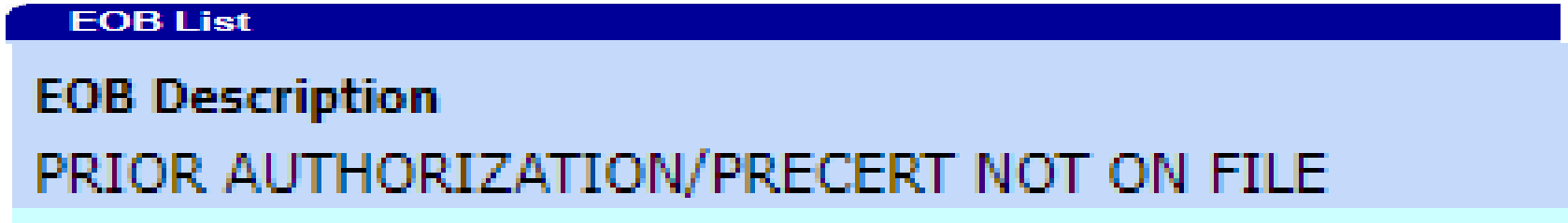
Eligibility by Service Type

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)



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/PRECERT 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)

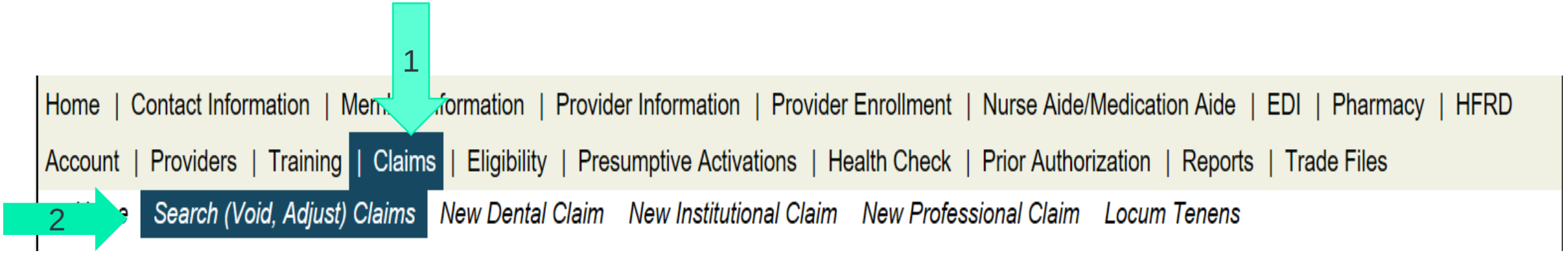
Ways to search for outstanding claims:

- 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

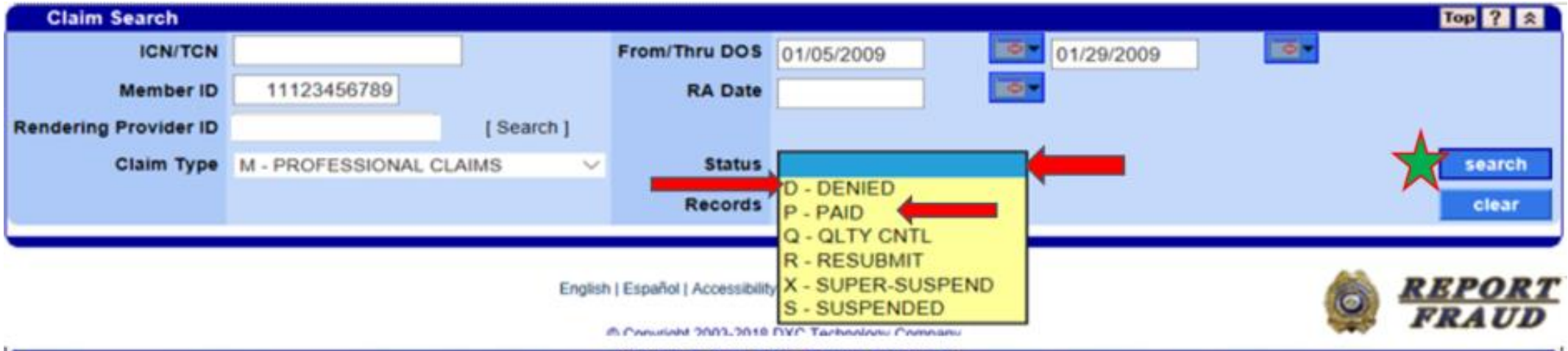


Ways to search for outstanding claims

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

Claims History Search

(continued)



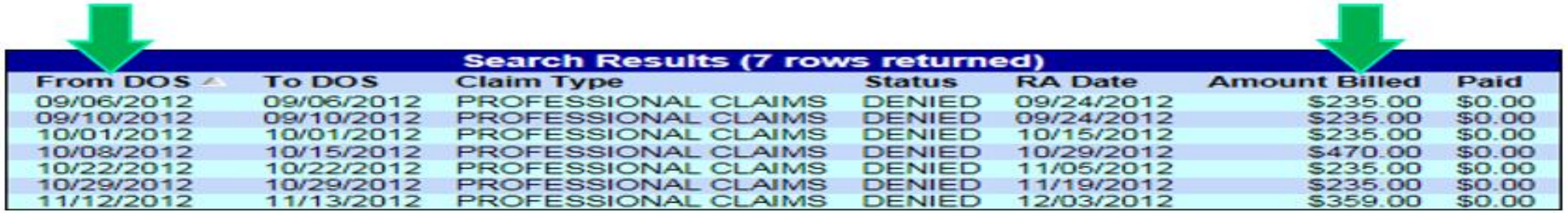
Search Results (13 rows returned)

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

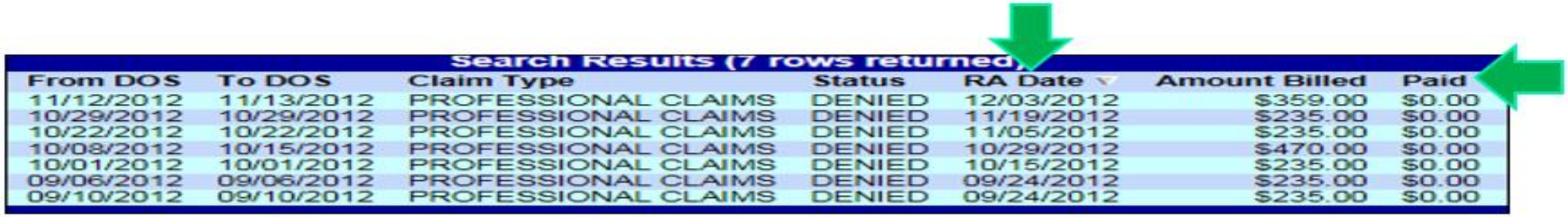
(continued)

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

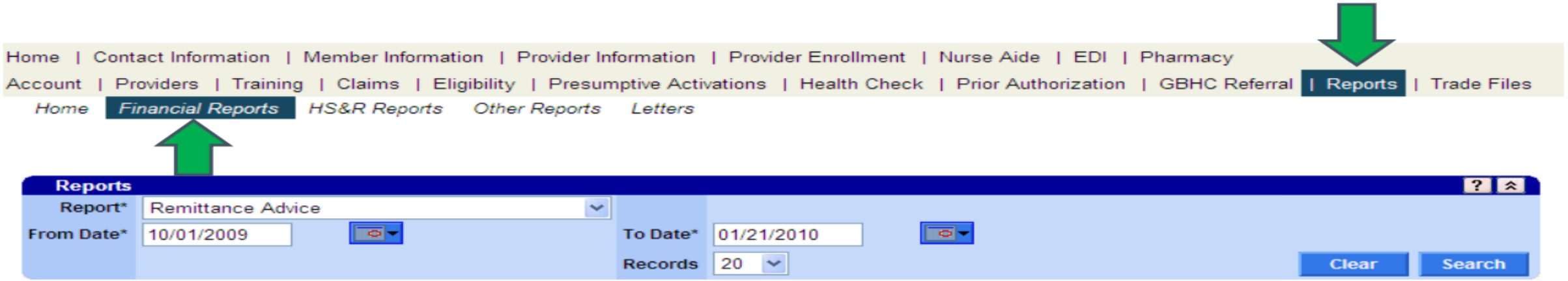
Remittance Advice (RA)

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



- 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.

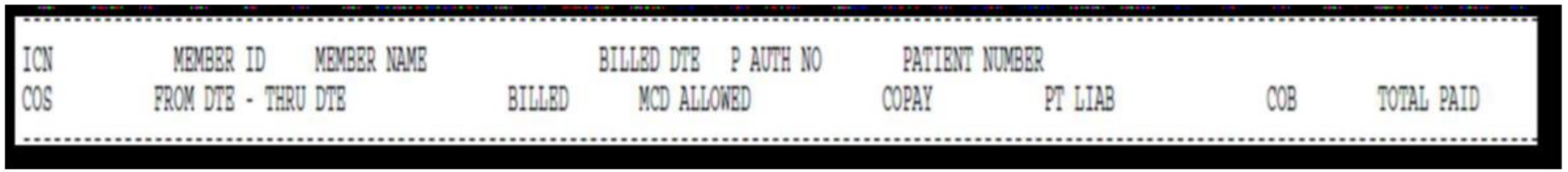
EFFECTIVE NOVEMBER 1, 2015 ALL PERSONAL SUPPORT AIDES MUST BE PAID OVERTIME FOR ANY HOURS THEY WORK THAT ARE OVER 40 IN A WORK WEEK. CURRENTLY AN AIDE WHO WORKS MORE THAN 40 HOURS A WEEK IS BEING PAID THE SAME HOURLY PAY RATE FOR THE OVERTIME HOURS AS THEY ARE FOR THE REGULAR HOURS. SERVICES ARE AUTHORIZED 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? 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 O VERTIME, 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)

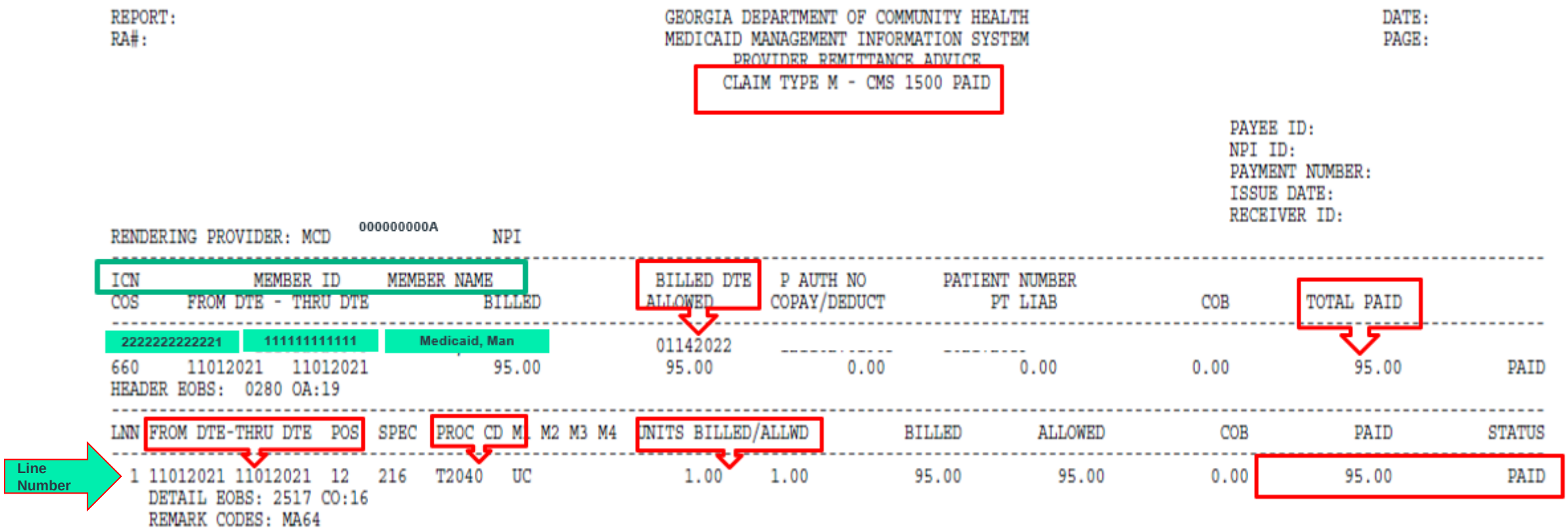
Claims data lines includes:

- 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

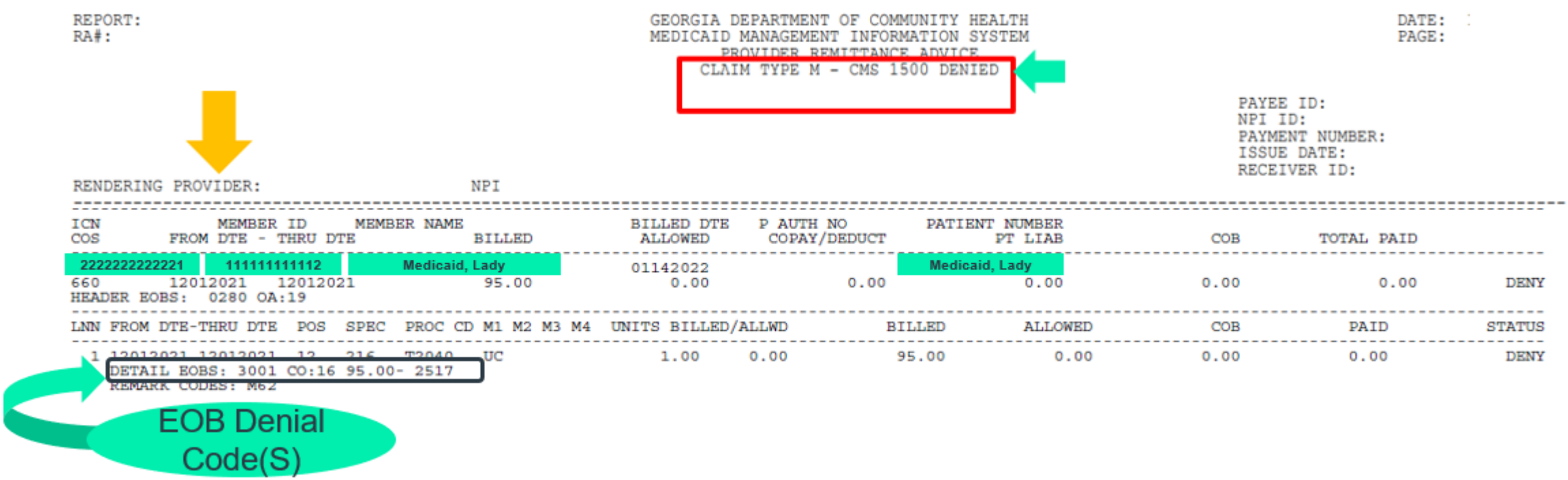


- Detail Line Number, FDOS-TDOS, POS, Provider Specialty, Procedure Code, Modifiers, Units Billed/Units Allowed, Billed Amount, Medicaid Allowed Amount, COB, Total Paid, Claim Status

Remittance Advice (RA) – Paid Claims



Remittance Advice (RA) – Denied Claims



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	STATUS
1	11012021 11302021	12	030	T2022					1.00	1.00	PAID

2222222222221 **111111111111** **Medicaid, Man** 12032021

590	11012021 11302021	-175.00	-175.00	-0.00	-0.00	-0.00	-175.00

5922222222221 **111111111111** **Medicaid, Man** 12032021

590	11012021 11302021	175.00	0.00	0.00	0.00	0.00	0.00	PAID

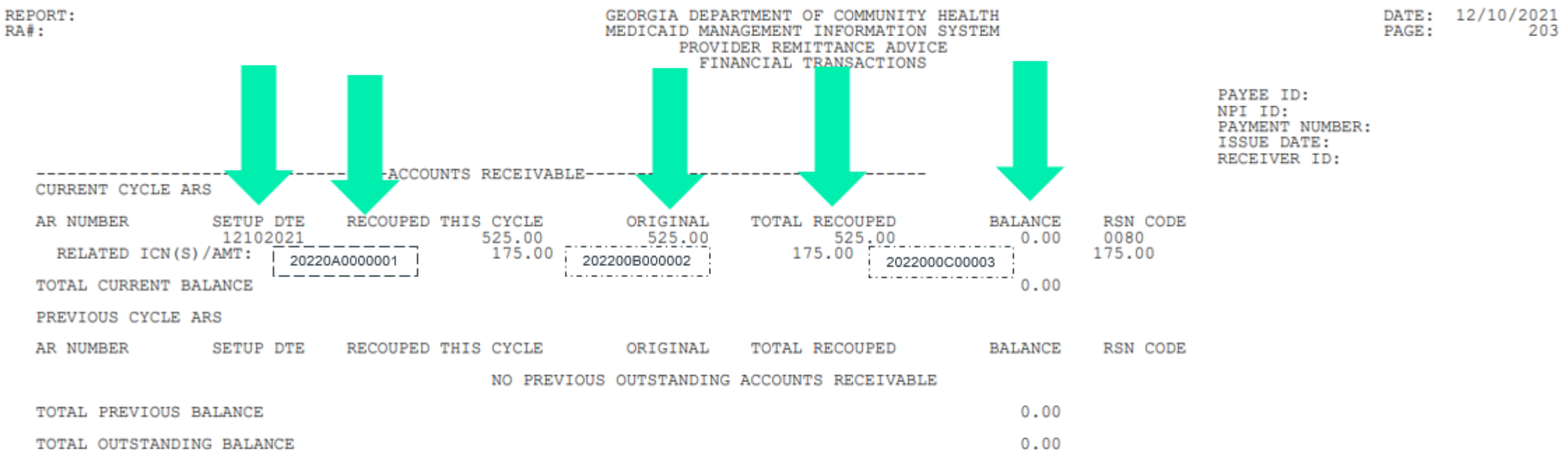
ADJ RSN: 8515
HEADER EOBS: 8515 OA:23 175.00-
HEADER REMARK CODES: N142

LNN	FROM DTE-THRU DTE	POS	SPEC	PROC CD	M1	M2	M3	M4	UNITS	BILLED/ALLWD	STATUS
1	11012021 11302021	02	030	T2022					1.00	1.00	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	2022000C00003	175.00

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

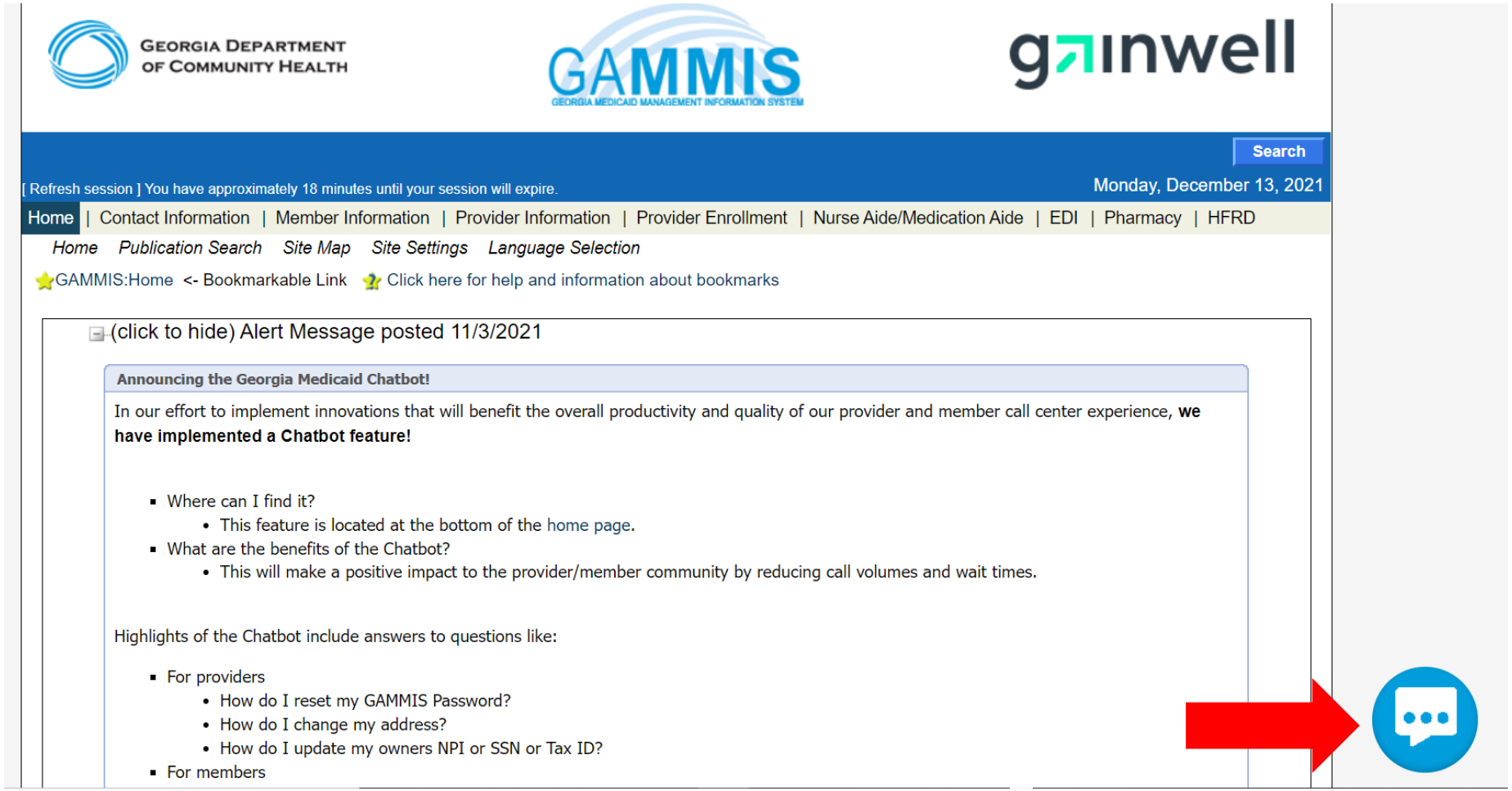
- How do I change my address?
- How do I reset my GAMMIS password?
- How do I update owners NPI or SSN or Tax ID?

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)*



IVRS Overview

The Interactive Voice Response System (IVRS) allows users to call and conduct inquiries or transactions on the Georgia Medicaid Management Information System (GAMMIS) using a touch-tone telephone.

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

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

Territory 1 N GA
Bartow, Catoosa, Chatooga, Cherokee, Dade, Dawson, Fannin, Floyd, Forsyth, Gilmer, Gordon, Habersham, Hall, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, Union, Walker, White, Whitfield

Territory 2 Atlanta
Fulton

Territory 3 NE GA
Banks, Barrow, Clarke, Elbert, Franklin, Gwinnett, Hart, Jackson, Madison, Oconee, Walton

Territory 4: NW GA
Carroll, Cobb, Douglas, Harolson, Paulding, Polk

Territory 5: SE Metro
Clayton, DeKalb, Rockdale

Territory 6: Middle GA
Butts, Chattahoochee, Coweta, Fayette, Harris, Heard, Henry, Jasper, Jones, Lamar, Marion, Meriwether, Monroe, Muscogee, Newton, Pike, Spalding, Talbot, Taylor, Troup, Upson

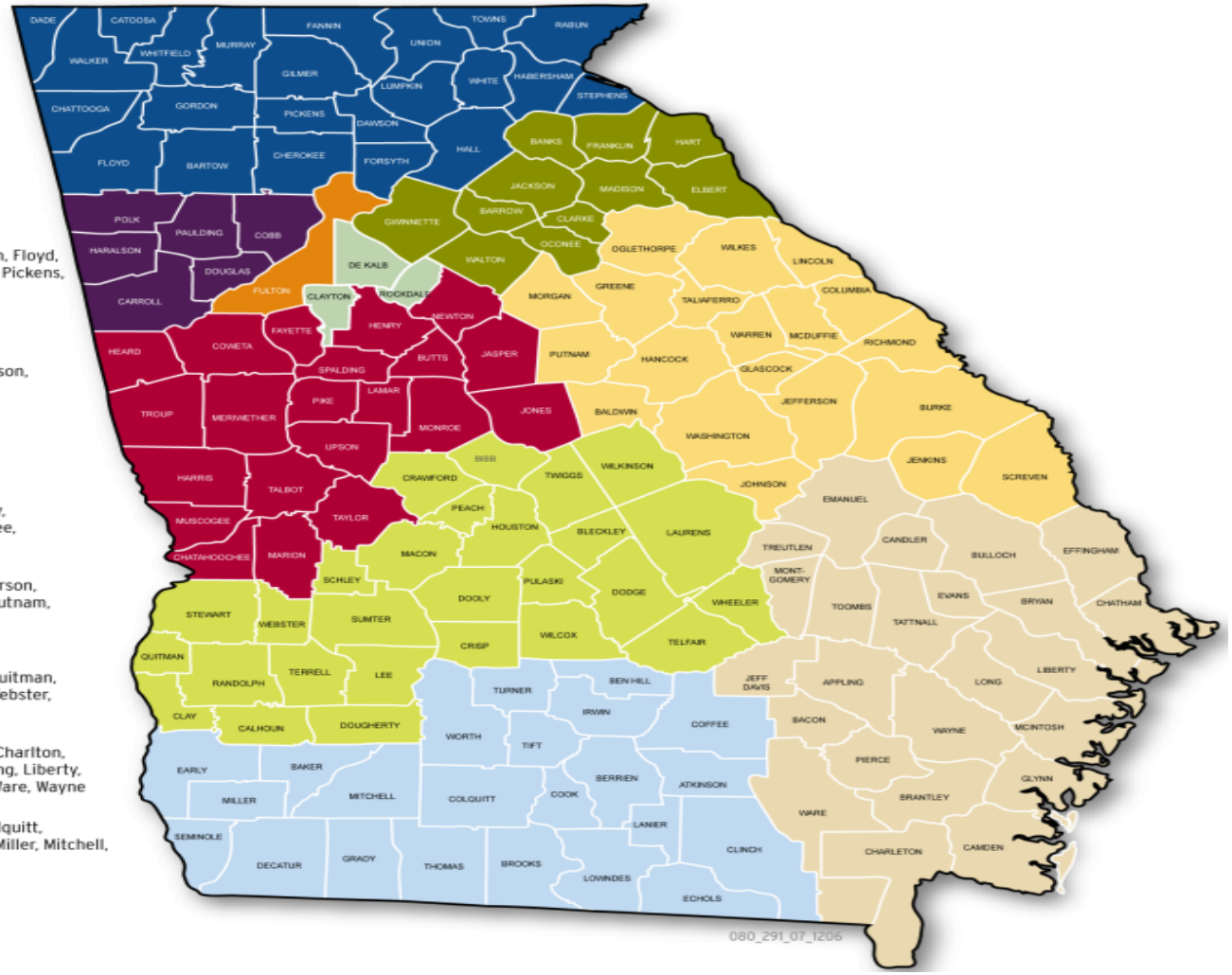
Territory 7: Augusta
Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes

Territory 8: SW GA
Bibb, Bleckley, Calhoun, Clay, Crawford, Crisp, Dodge, Dooly, Dougherty, Houston, Laurens, Lee, Macon, Peach, Pulaski, Quitman, Randolph, Stewart, Schley, Sumter, Telfair, Terrell, Twiggs, Webster, Wheeler, Wilcox, Wilkinson

Territory 9: SE GA
Appling, Bacon, Bryan, Bulloch, Brantley, Camden, Candler, Charlton, Chatham, Effingham, Emanuel, Evans, Glynn, Jeff Davis, Long, Liberty, McIntosh, Montgomery, Pierce, Tattnall, Toombs, Treutlen, Ware, Wayne

Territory 10: South GA
Atkinson, Baker, Ben Hill, Barrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Tift, Turner, Worth

Territory 11 State Wide
Hospital Field Representative



Provider Relations Field Services Representatives

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

Provider Relations Representatives

State-Wide Consultants

Sharée C. Daniels
Brenda Hulette
Danny Williams

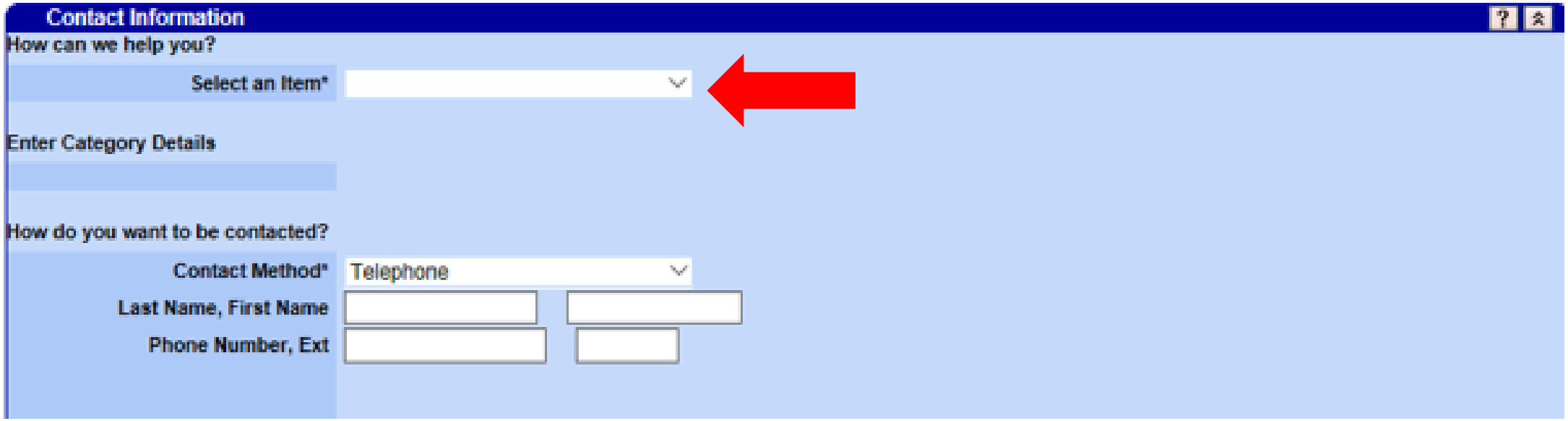
Contact My Provider Rep Directly

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

Contact My Provider Rep Directly

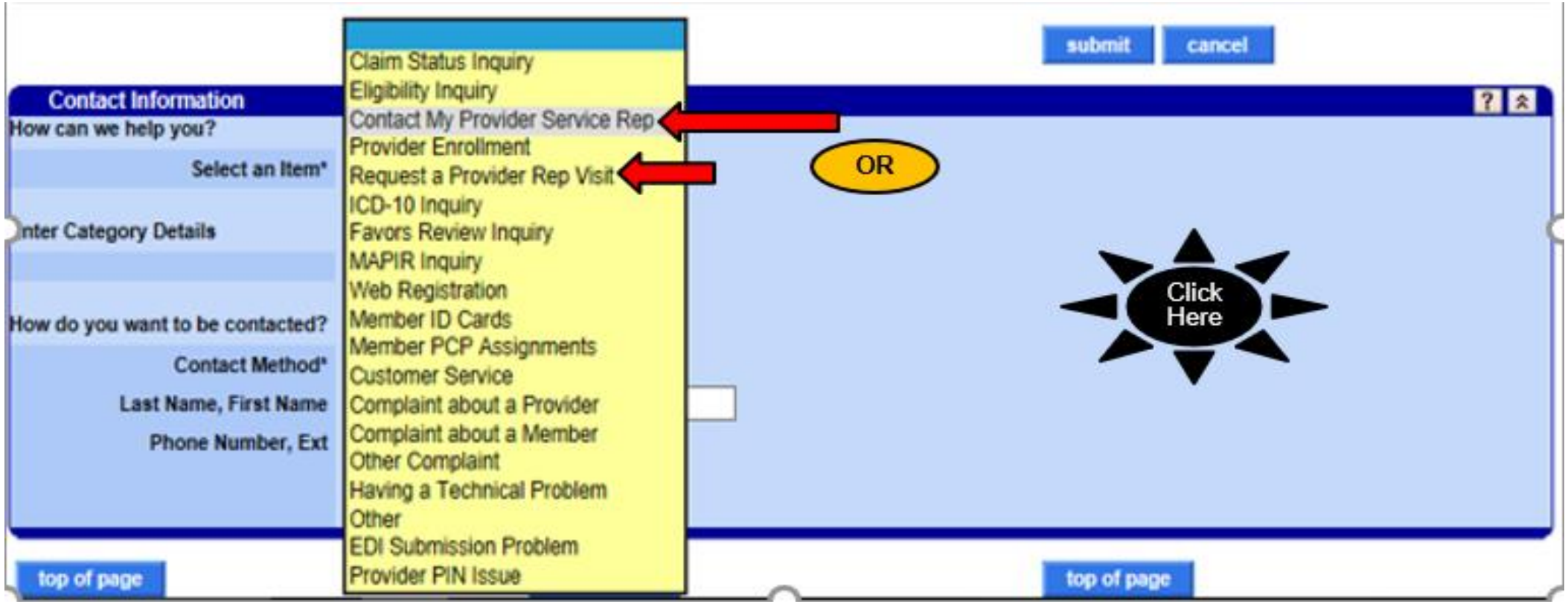
(continued)

Select an Item



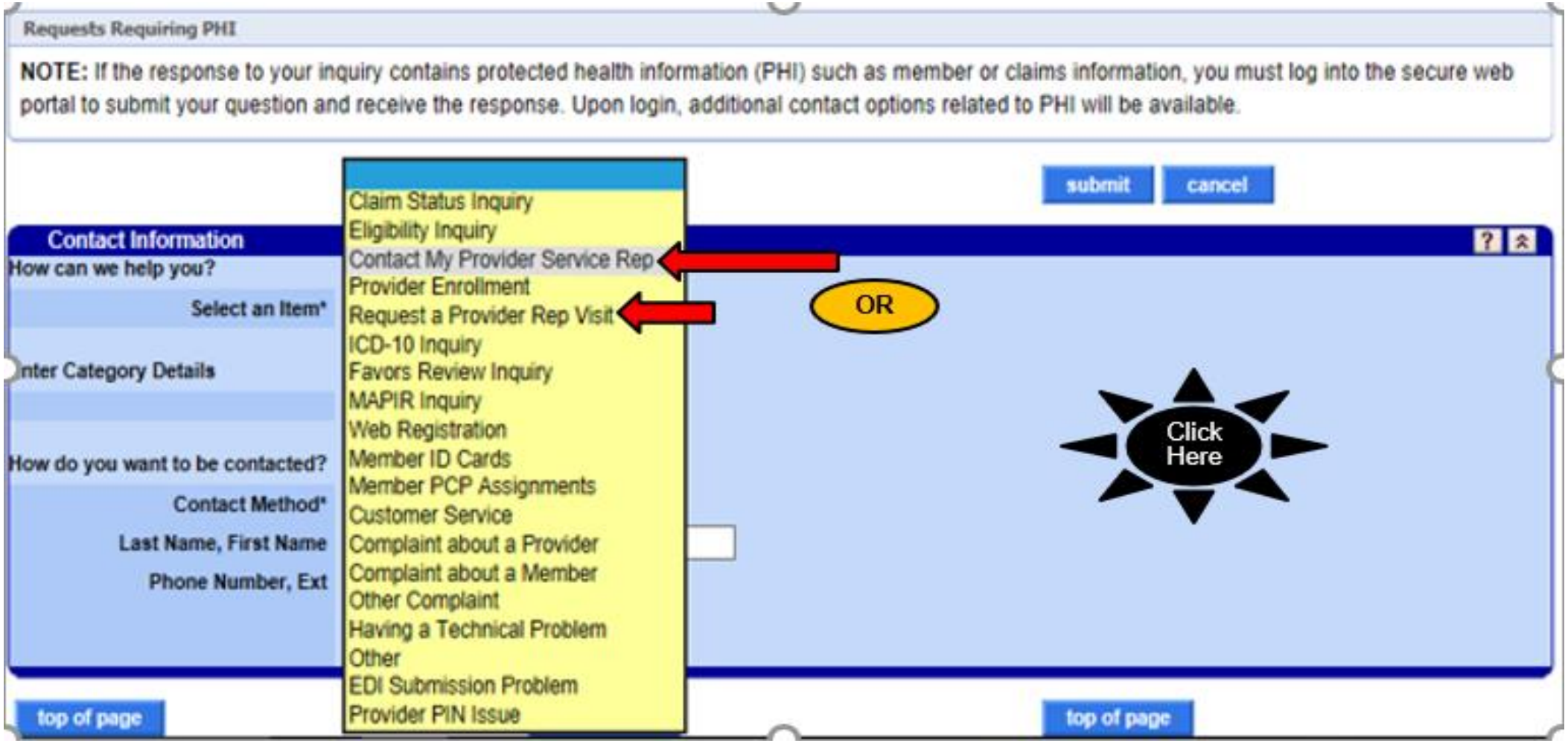
Contact My Provider Rep Directly

(continued)



Contact My Provider Rep Directly

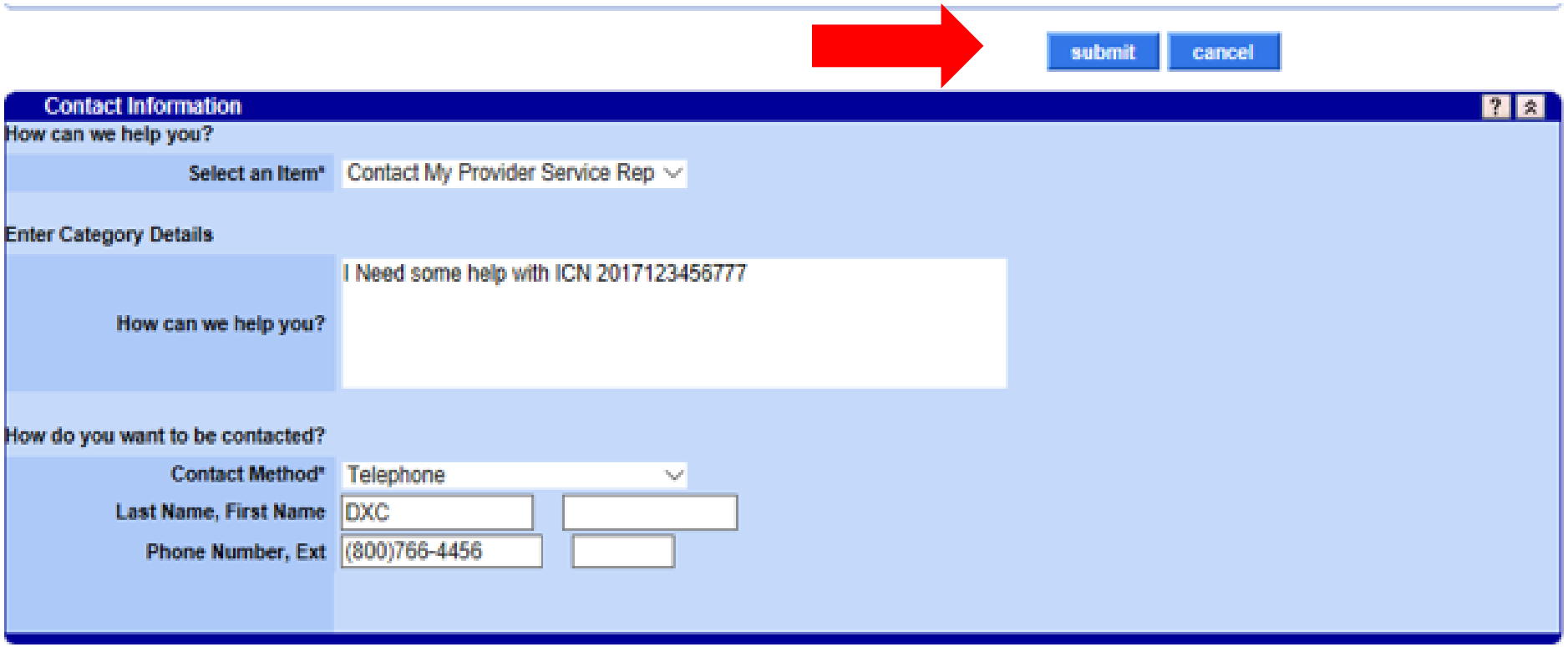
(continued)



Contact My Provider Rep Directly

(continued)

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



Contact My Provider Rep Directly

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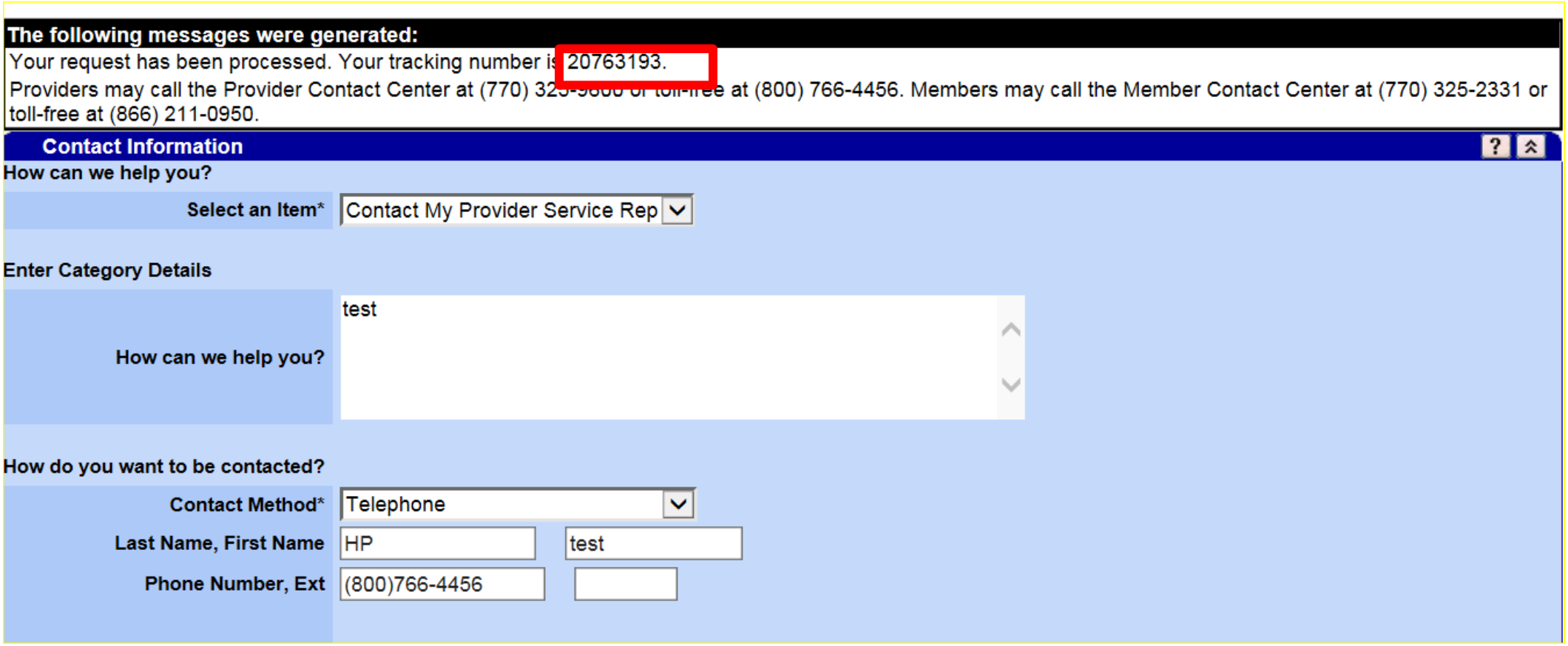

Session Review

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!