

Georgia Medicaid Common Denials Presentation



For access to this presentation, please visit: www.mmis.georgia.gov → Provider Information →
Provider Notices → “Presentation – Medicaid Common Denials – December 2022”



Agenda

- Common Eligibility Denials
- Common Procedure Code Denials
- Common Prior Authorization and Precertification Denials
- Common Miscellaneous Denials
- Contacting Gainwell Technologies
- Closing - Questions and Answers





***MEDICAL
CLAIM***

DENIED

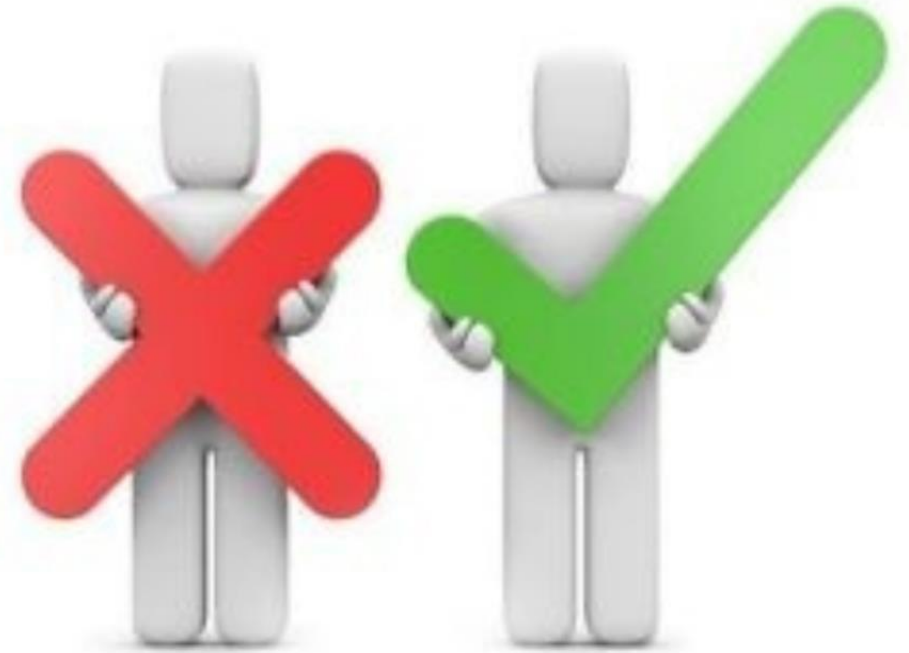


Common Eligibility Denials



- The most common eligibility denials come from NOT checking eligibility.

*****Once the PHE comes to an end, members will once again be required to recertify for their benefits as per usual policy.*****



ELIGIBLE OR NOT???

Common Eligibility Denials

(continued)

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 **Eligibility Request**

Eligibility Verification Request				?
Member ID		Birth Date		
Last Name		SSN		
First Name		From/Thru Date of Service		
Gender		Service Type	30 - Health Plan Benefit Coverage	
				search
				clear

Search Criteria combinations:

- [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]



Common Eligibility Denials

(continued)

Edit 2003 - Member Ineligible on Detail Date of Services

This edit is triggered when the claim detail dates of service do not fall within or are equal to the beginning and ending dates in any recipient eligibility segment.

Edit 2078 - Member has Partial Eligibility for Detail DOS

This edit is triggered when/ if only partial eligibility was found on detail DOS.

Edit 2017 - Member Services are Covered by CMO Plan

This edit is triggered when a member has a lock-in segment with one of the CMOs (WellCare, Amerigroup, PeachState, CareSource).

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	03/01/2016	03/31/2016	MC - Medicaid	135 - Newborn Child	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	03/01/2016	03/31/2016	MC - Medicaid	135 - Newborn Child	0.00		

Managed Care						?
Provider Name		Plan Name	Provider Phone	Effective Date	End Date	
WELLCARE HEALTH PLANS, INC - ATL		Georgia Families	(866)231-1821	01/01/2016	01/02/2016	

Common Eligibility Denials

(continued)

Edit 2504 - Member Covered by Private Insurance; no attachments

This edit is triggered if the member has private coverage that is not exhausted using the header FDOS-TDOS Span. There is no claim attachment and the TPL amount on the claim is zero.

COB ?						
Coverage Type	Payer Identifier	Carrier Name	Carrier Address	Policy Number	Effective Date	End Date
PBM/Drug	0000006574	WELLPOINT PHARMACY MANAGEMENT	PO BOX 9080, OXNARD, CA, 93031	257219533	01/01/2016	01/31/2016
Mental Health/Behav MGD Care	000000A074	BCBS GEORGIA	PO BOX 9907, COLUMBUS, GA, 31908	XKQ361A6465103	01/01/2016	01/31/2016
MGD Care/Standard	000000A074	BCBS GEORGIA	PO BOX 9907, COLUMBUS, GA, 31908	XKQ361A6465103	01/01/2016	01/31/2016

Method of Correction - Verify the COB information and bill the claim to the appropriate Insurance Carrier first, re-submit your claim with the Primary Carrier's EOB information or resubmit your claim with the DMA-410 COB notification form. **Medicaid is always the payer of last resort.**

Common Eligibility Denials

(continued)

COB Updates

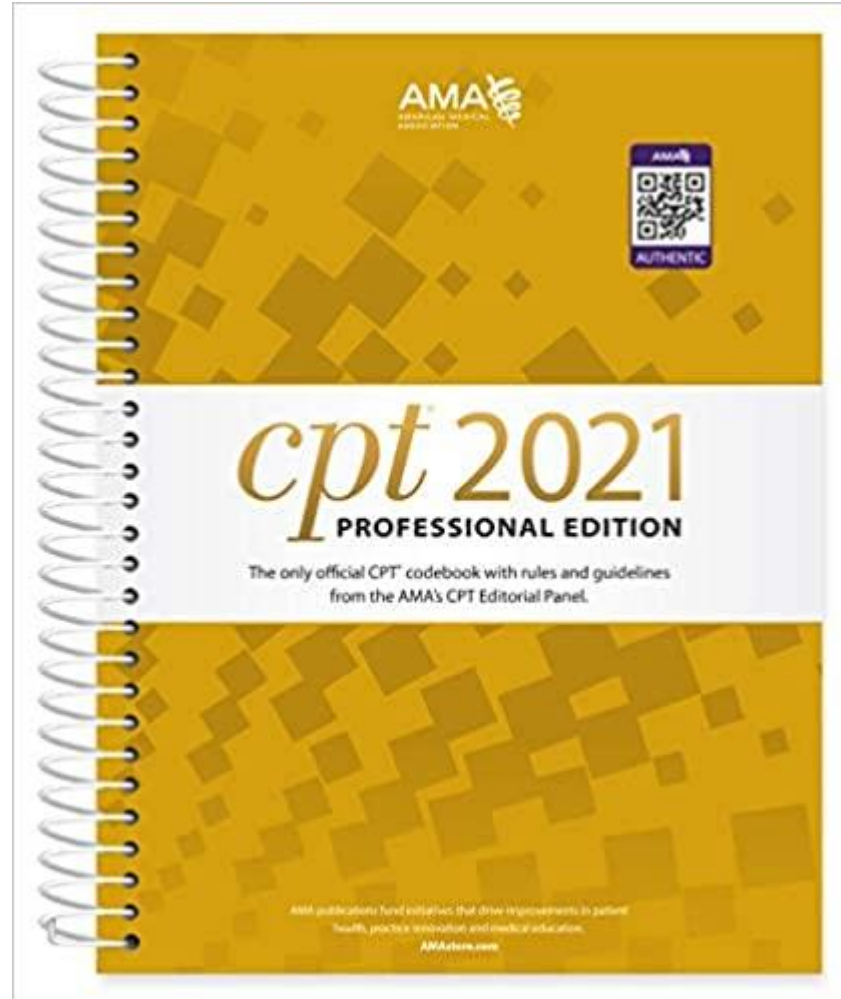
Member ID Information		Member Transactions	
Member ID	22	First Name	BABY BOY
Birth Date		Last Name	D
Address 1	8372 DR	Middle Initial	
Address 2(County)	031 - CLAYTON	Name Suffix	
City	RIVERDALE	Gender	M
State	GA	Transaction Date/Time	01/17/2017 11:36:47
Zip	30296-1289	Confirmation #	17017

Effective February 23, 2017, the **DMA-410: EB-TPL form** will need to be submitted via the GAMMIS Web Portal when updating a member's COB information.

To provide this information, upload a scanned image of the **member's insurance card** for COB updates to the GAMMIS Web Portal at www.mmis.georgia.gov. Perform an eligibility request for the member in question, select the new Member Transactions button and follow the instructions provided on the member transactions page.

Note: Providers need to continue using the paper DMA-410-Form for Section I: Co-Payment Notification, and Section II: COB Non-Coverage Affidavit.

Common Procedure Code Denials



Common Procedure Code Denials

(continued)



*****The most common procedure denials come from NOT performing a procedure code search.*****

Welcome, callcenter Search

Refresh session] You have approximately 15 minutes until your session will expire. Monday, April 08, 2019

[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](#) [Secure Home](#) [Demographic Maintenance](#) [Direct Exchange Addresses](#) [Provider Rates](#) [Bed Registry](#) [Procedure Search](#) [EOB Search](#)

[Recredential/Revalidation](#) [Change of Information](#)

★GAMMIS:Procedure Search <- Bookmarkable Link ★ Click here for help and information about bookmarks

Enrolled Categories of Service for 007106027A ?

COS	Description	Effective Date	End Date	Status	Status Reason
430	The Physician Services Program provides reimbursement for a broad range of medical service	10/01/2017	12/31/2299	Active	Active

Procedure Search ? ⬆

Procedure Code* Procedure Code Date* ⚙

Place of Service* [\[Search \]](#) search clear

Note: All fields are required.

Common Procedure Code Denials

(continued)

COS	Description	Effective Date	End Date	Status	Status Reason
430	The Physician Services Program provides reimbursement for a broad range of medical service	12/01/1973	12/31/2299	Active	Medicare Only

Procedure Search			
Procedure Code*	99213	Procedure Code Date*	04/08/2019 
Place of Service*	11 [Search]		

Procedure Information			
Procedure Code	99213	Description	OFFICE/OUTPATIENT VISIT EST
Gender		PA Required	The PA Required column will indicate whether the service requires either a Precert
Minimum Age			Prior Authorization. The possible values are:
Maximum Age			N - No PA is not required
			Y - Yes PA is required
			X - Yes PA is required
			Z - Yes Precert is required

Covered Categories of Service (29 rows returned)								
COS	Claim Type	Modifiers	Min Age	Max Age	Gender	From	Thru	PA Required
010						01/01/2000	12/31/2299	Z - Yes Precert is required
070		Including 0-3 from 95 GQ GT				01/01/2017	12/31/2299	N - No PA is not required
080						01/01/2000	12/31/2299	N - No PA is not required
200	C					07/01/2000	12/31/2299	N - No PA is not required
230	B,M	Including 0-4 from 24 25 52 57 AJ FP GT U1				01/01/2006	12/31/2299	N - No PA is not required
270		Including 1-1 from FP , Including 0-1 from U1				01/01/2013	12/31/2299	N - No PA is not required
430	M	Including 0-1 from 52 AJ FP GT HA TM , Including 0-4 from 24 25 27 57 58 59 78 79 91 95 E1 E2 E3 E4 F1 F2 F3 F4 F5 F6 F7 F8 F9 FA GQ LC LD LM LT RC RI RT T1 T2 T3 T4 T5 T6 T7 T8 T9 TA				01/01/2017	12/31/2299	N - No PA is not required

Common Procedure Code Denials

(continued)

Edit 4257 - Modifier Restriction For Proc Billing Rule

This edit is triggered when the claim modifier does not meet the procedure billing rule modifier configuration in GAMMIS.

Detail List														? ^	
#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed	DX Rel1	DX Rel2	DX Rel3	DX Rel4	Emer	POS	TPL Amount	TPL Coinsuran	
1	D	3/24/2016	3/24/2016	90112 - GP 59	225.00	3	1	2				11	.00		
2	D	3/24/2016	3/24/2016	97032 - GP 59	165.00	3	2	1				11	.00		
2	D	1	4257	MODIFIER RESTRICTION FOR PROC BILLING RULE			4257		SSI	GA			3/25/2016 16:07:10		
2	D	2	4821	PLACE OF SERVICE RESTRICTION ON PROC BILLING RULE			4821		SSI	GA			3/25/2016 16:07:10		
430	Including 0-2 from HA TM , Including 0-4 from 24 25 27 57 58 59 78 79 91 E1 E2 E3 E4 F1 F2 F3 F4 F5 F6 F7 F8 F9 FA LC LD LM LT RC RI RT T1 T2 T3 T4 T5 T6 T7 T8 T9 TA 04/01/2003 12/31/2299 N - No PA is not required														

Method of Correction - Review the Part 2 **program specific manual** to determine what codes are billable and also check the **Procedure Search panel** to determine the billing rules for the code. The procedure search results will show the applicable COSs, associated modifiers, claim types, age restrictions, and if a PA/Precert is required. Once reviewed, submit or resubmit the claim. In this example, the modifier(s) can be corrected on the GAMMIS Web Portal.

Common Procedure Code Denials

(continued)

Edit 4801 - Billing Rule Not Found for Billed Proc

This edit is triggered when there are no billing rules for the procedure under the provider contract for the date of service in GAMMIS.

Edit 4871 - Claim Type Restriction on Proc Billing Rule

This edit is triggered when claim type is not within the claim type restriction of the billing rule for the Procedure Code in GAMMIS.

Detail List													
#	ST	FDOS	TDOS	Proc-Mod	Amt Billed	Units Billed	DX Rel1	DX Rel2	DX Rel3	DX Rel4	Emer	POS	TPL Amount
1	D	3/24/2016	3/24/2016	3066F -	.01	1	3					11	.00

Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer
1	D	1	4801	BILLING RULE NOT FOUND FOR THE BILLED PROCEDURE	4801		TXIX	GA
1	D	3	4871	CLAIM TYPE RESTRICTION ON PROC BILLING RULE	4871			

Method of Correction - Review the Part 2 **program specific manual** to determine what codes are billable and also check the **Procedure Search panel** to determine the billing rules for the code. The procedure search results will show the applicable COSs, associated modifiers, claim types, age restrictions, and if a PA/Precert is required. Once reviewed, submit or resubmit the claim.

Common Procedure Code Denials

(continued)

Edit 4316 - Diagnosis Restriction for Billed Procedure

This edit is triggered when the diagnosis is not allowed for the billed procedure in GAMMIS.

Error List											?
Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time	User ID	
1	D	1	4316	DIAG RESTRICTION FOR BILLED PROC	4316		SSI	GA	3/24/2016 21:07:24		
1	D	6	4714	AGE RESTRICTION ON PROC BILLING RULE	4714		SSI	GA	3/24/2016 21:07:24		

Method of Correction - Review the diagnosis associated with the procedure in question. Correct the diagnosis if applicable. If the diagnosis is correct, your claim has denied because the procedure you are billing for is only payable to a certain diagnosis code.

Common Prior Authorization and Precertification Denials



**Prior Authorization
is not a guarantee of
payment.**

Common Prior Authorization and Precertification Denials

(continued)

There are several reasons why a claim might be denied after it is submitted, even if prior authorization was obtained.

1. The member has become ineligible for services and is no longer covered by the health plan.
2. Services are not billed with the CPT/HCPCS code identified in the prior authorization.
3. Additional services, not included in the initial prior authorization, that also require prior authorization are submitted on the claim.

*****The final determination of whether to pay for service is made by thoroughly reviewing the member's plan *and* the payer's medical coverage policy on the day of service.*****

Common PA/Precert. Denials

(continued)

Edit 3011 - DOS Not Within PA/Precert Effective Dates

This edit is triggered when the date on the claim is outside the approved dates on the PA/Precert.

Method of Correction - Providers may **submit a Change Request Form to Alliant Health/GMCF** through the Medical Review Portal within 30 days of the PA request date or within 30 days of the date of service.

Edit 3052 - PA Units/Amount Exhausted

This edit is triggered when the approved number of units have all been used.

Method of Correction - **Check PA/Precert for accuracy.** Provider may need to submit a request for a new authorization or a request for more units.

Edit 3001 - PA Not On File

This edit is triggered when the PA number entered on the claim is invalid or the PA has not crossed over into GAMMIS.

Method of Correction - **Correct PA number** on the GAMMIS web portal then resubmit claim. If the PA number is valid notify a Gainwell Technologies representative.

Common PA/Precert. Denials

(continued)

Edit 3044 - Provider Number Does Not Match Prior Authorization

This edit is triggered when GAMMIS can not make an ID match to the rendering provider ID on the claim and the rendering provider ID on the prior authorization.

Error List									
Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	
1	D	1	3044	PROVIDER NUMBER DOES NOT MATCH PRIOR AUTHORIZATION	3044				

Method of Correction - Review the authorization to determine the correct provider ID to bill on the claim. If the authorization was obtained with the wrong provider ID, a **Change Request Form** may be submitted to Alliant Health/GMCF through the Medical Review Portal within 30 days of the requested date or date of service.



COMMON

MISCELLANEOUS DENIALS



Common Miscellaneous Denials - NCCI Procedure to Procedure

Edit 5928 - NCCI procedure to procedure (PTP) (Service not payable with another service on the same date)

This edit is triggered when:

- Same Rendering provider, member, and date of service appear on a history claim.
- Composite (greater) procedure exists on history claim and component (lesser) procedure exists on the current claim.
- The procedure pair is found in the NCCI Procedure to Procedure panel for the detail DOS.
- Appropriate NCCI modifier is not used on the claim.

*****NCCI Procedure-to-Procedure (PTP) files are sent by CMS each quarter. Visit the CMS website to familiarize yourself with NCCI methodology.*****

Common Miscellaneous Denials -MUE

Edit 5930 - NCCI Medically Unlikely Edit – Practitioner

This edit is triggered when billed units of service exceed the NCCI Medically Unlikely Edit.

Method of Correction - Review Code information to determine the billable units. **Correct units billed** and resubmit the claim.

Edit 5932 - Service Allowed Inpatient Setting Only

This edit is triggered when the POS on the claim is not a facility.

Method of Correction - Services must be rendered in an inpatient setting **(POS 21) only**.

*****Note: MUEs are updated quarterly by CMS. Visit the CMS website to familiarize yourself with MUE methodology.*****

Common Miscellaneous Denials - ICD-10

Edit 4280/4281/4282/4283 - ICD-10 DIAGNOSIS CODE IS NOT SPECIFIED

Error List										
Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time	
1	D	2	4280	1ST ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1430			GA	3/25/2016 10:07:34	
1	D	2	4281	2ND ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1431			GA	3/25/2016 10:07:34	
1	D	2	4282	3RD ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1432			GA	3/25/2016 10:07:34	
1	D	2	4283	4TH ICD-10 DIAGNOSIS CODE IS NOT SPECIFIC	1433			GA	3/25/2016 10:07:34	

Claim Diagnosis				
Seq Code	Diagnosis Code	ICD	Description	Qualifier
1	M25.569	ICD-10	PAIN IN UNSPECIFIED KNEE	ABK
2	M25.579	ICD-10	PAIN IN UNSPECIFIED ANKLE AND JOINTS OF UNSPECIFIED FOOT	ABF
3	M25.539	ICD-10	PAIN IN UNSPECIFIED WRIST	ABF
4	M25.519	ICD-10	PAIN IN UNSPECIFIED SHOULDER	ABF

Method of Correction - Review the diagnosis code set for each diagnosis and **use the most accurate code** for patient diagnosis.

*****Note: Some Unspecified Codes may be used as a 1st diagnosis if there is not a more specified diagnosis code. Please note that some unspecified codes when billed may deny in the GAMMIS.*****

Common Miscellaneous Denials

(continued)

Edit 1002 - Rendering Provider not eligible to render service

This edit is triggered when the rendering provider is either not enrolled for the detail dates of service (DOS) span or is not enrolled in the assigned provider program/category of service.

Error List									
Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time
1	D	2	1002	REND PROV NOT ELIGIBLE TO RENDER SVC ON THIS PGM	0096				3/20/2017 12:44:34

Method of Correction - Verify the providers **contract effective date** via the Demographic Maintenance Panel.

Note: If a provider is suspended or terminated, service will not be reimbursed for payment. If the determined provider file is suspended, the provider should send a Change of Information form requesting re-activation of the account. If terminated, the provider will need to submit a new enrollment application.

*****Note: Please be mindful of the mandatory revalidation enrollment process with which providers are required to comply in order to avoid suspension and/ or termination from the Medicaid Program.*****

Common Miscellaneous Denials – EMA

Edit 2274 - Emergency Medical Assistance No Attachment

This edit is triggered when services for an EMA member are billed and no attachments are included.

Error List ?										
Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time	
1	D	2	2274	EMERGENCY MEDICAL ASSISTANCE - NO ATTACHMENT - DTL	2278		EMA	GA	3/28/2016	

Method of Correction - Review EMA Guidelines in the Part 1 Policy and Procedures Manual Section 208.

*****Note: Documentation must be submitted in the order it appears in section 208.**

History and Physical, Admission Notes, Discharge Summary, Operative Report (if applicable), Physician Progress Notes, Deliveries or C-section claims only; Anesthesia claims only; Anesthesia report and L&D or C-Section Op reports.***



Common Timely Filing Denials



Edit: 512, 516, and 545 - Timely Filing

These edits are triggered when a claim is submitted outside of the six month or one year timeframe.

- 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
- **Crossover** claim -Within **12 months** of MOS
- **Secondary/TPL** claim -Within **12 months** of MOS



One Year (365 Days) Claim Submission Edit

New system enhancements have been made to limit a **claim's life cycle to a maximum of one year (365 days)**. The claim life cycle is the timeline for the total claims process from the date of service to original submission and through the last date by which resubmission (provider adjustment) must occur to remain timely.

This system modification means that the new one-year timely submission and resubmission processes requires the following:

- The **original claims to be submitted within 180 days or six months** from date of service.
- A claim that was denied for missing or erroneous information be **resubmitted to correct the misinformation within three months** from the month of the date of service or when the denial occurred, whichever is later.



One Year (365 Days) Claim Submission New Edits - 515 for DTL and 516 for HDR

(continued)

Example:

	Original Submit Claim	1 st Resubmit	2 nd Adjustment
DOS	Denied Date:	Adjustment	(365 days)
July 1, 2020	December 30, 2020	March 31, 2020	June 30, 2020

- 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

Common Service Limit Denials

Edit 6259 - Calendar Year Office Visits Exceeded

This edit is triggered when the member has exceeded 10 office visits within one year.

Method of Correction - Verify data on claim was captured correctly.

*****Note: Verify under Member Eligibility on the GAMMIS Web-Portal Service Limits Panel prior to the rendering of these services to avoid denial. For claims that are still timely, providers have the option to submit a request for additional office visits upon documentation supporting medical necessity. The request must be submitted to Alliant Health Solutions via the Prior Authorization tab.*****

Edit 6694 - One Preventative Visit Per Calendar Year

This edit is triggered when the member has received more than one preventative visit within one calendar year.

Method of Correction - Verify data on claim was captured correctly.

*****Note: Verify under Member Eligibility on the GAMMIS Web Portal Service Limits Panel prior to the rendering of these services to avoid denial.*****

Common Miscellaneous Denials - Duplicate

Edit 5646/5042/5048 - Exact Duplicate

This edit is triggered when claim has the same member information, DOS, procedure code, modifier, and provider number as a history claim.

ICN	Member ID	Rendering Provider ID	FDOS	TDOS	Claim Type	Status	Date Paid	Amount Billed	Amount Paid
			02/09/2016	02/09/2016	PROFESSIONAL XOVER CLAIMS	DENIED	03/28/2016	\$200.00	\$0.00
			02/09/2016	02/09/2016	PROFESSIONAL XOVER CLAIMS	PAID	03/28/2016	\$200.00	\$0.00

Method of Correction - No correction is needed. Claim is an exact duplicate of a claim in the history file. Search claim panel with member ID, DOS, and Claim Type to locate paid claim in history.

*****If you cannot locate the paid claim, contact Gainwell Technologies.*****



Working Your Denied Claims



Claims Management Tips

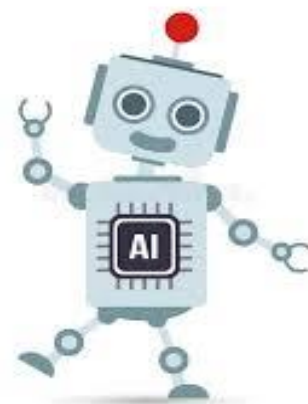
Reviewing, correcting, and re-submitting denied claims is central to your **revenue management**.

- Assign dedicated staff person to denials if possible.
- Document receipt of denials, reasons for denied payment and deadline for resubmission.
- Always review denial reasons (read twice, act once.)
- Make corrections involving missing or inaccurate info.
- Review clinical reasons for denial (service, diagnosis, etc.) with treating provider.
- Make any corrections possible.
- Re-submit claims in a timely manner.



*****Denials = revenue delay, revenue loss.*****





Banner Message Alert

Coming Soon Multi-Factor Authentication 08/23/2022

Dear Georgia Medicaid Providers:

In our effort to implement innovations that will benefit the overall security access for the GAMMIS Web portal site, **we will be implementing Multi-Factor Authentication (MFA) for provider, agent, and billing agent user types as early as November 29, 2022.**

- This enhancement will be accessed from the GAMMIS Web Portal site (www.mmis.georgia.gov)
- The main benefit of MFA is to **enhance security access** to the GAMMIS Web Portal site by using more than a username and password.

There will be webinar **training sessions forthcoming** to cover the implementation and MFA process.

Providers are encouraged to send their practice managers and billing staff, as well as business associates, including billing/service agents that access the secured area of the GAMMIS Web Portal site.

Please stay tuned for more information and webinar training session dates. We look forward to this new enhancement!

Thank you for your continued participation in the Georgia Medicaid program.

Introducing GABBY™

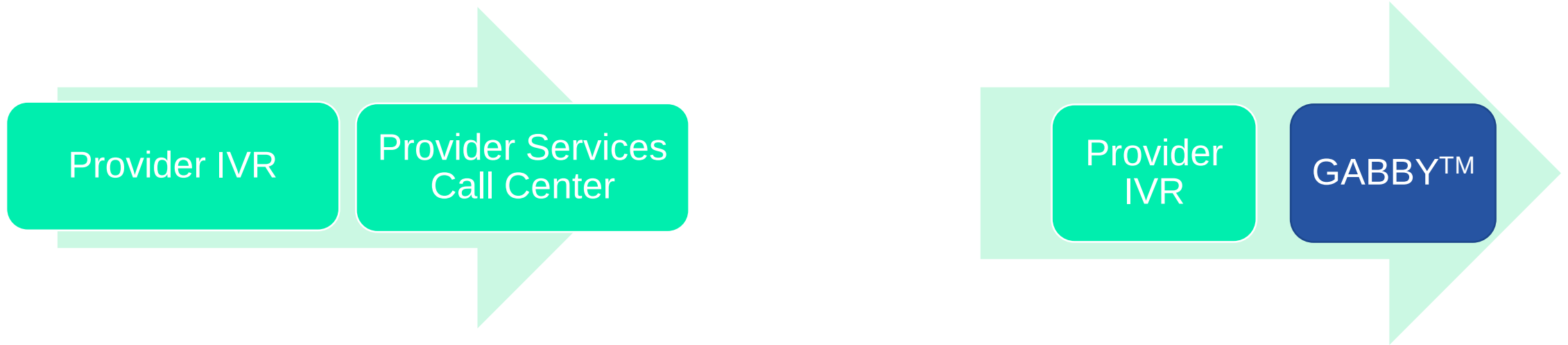
- **Who Is Gabby™?** Gabby™ is a Virtual Agent (or VA) positioned as an intermediary, self-service application between the existing Provider Interactive Voice Response System (or IVR) and the Provider Services Call Center.
- Gabby™ lets callers complete the **same provider transactions available in the current IVR** (and then some!) using natural-language and conversational, Artificial Intelligence (or AI) technology – which means that Gabby™ *listens* to the caller and responds accordingly, all while learning through each interaction.

Who Is GABBY™?

- Virtual Agent (VA)
- Self-Service Provider Application
- Natural-Language
- Conversational
- Artificial Intelligence (AI)
- Listens and Learns



How to Reach GABBY™



Previously, callers dialing into the Provider IVR would transfer to the Provider Services Call Center.

With the implementation of the Virtual Agent, in most cases, callers that would normally be routed to the Provider Services Call Center will now transfer to GABBY™ instead.

******There are some exceptions: for example, callers looking for help with Web Portal password resets will continue to be transferred to the MEUPS Help Desk, while all callers transferring from the Prior Authorization call flow will continue to be transferred to Alliant/GMCF.******

Why GABBY™

Why transfer to GABBY™?

- Using conversational AI, **GABBY™ lets callers lead the conversation** by simply asking what you need, listening to your response, and then processing your request.
- With GABBY™, **callers can simply speak their Provider ID – numbers and letters**. If GABBY™ ever has trouble understanding the caller, i.e., GABBY™ hears the letter ‘M’ instead of the letter ‘N’, GABBY™ will prompt the caller to speak a word (*any* word) that starts with the correct, desired letter (say “Nancy” or “Nifty”) – and off you go.
- GABBY™ **gives callers the opportunity to complete the same self-service transactions available in the Provider IVR**, using state-of-the-art, intelligent, natural-language voice recognition instead – all while maintaining the option to still transfer to a Call Center agent, if need be.

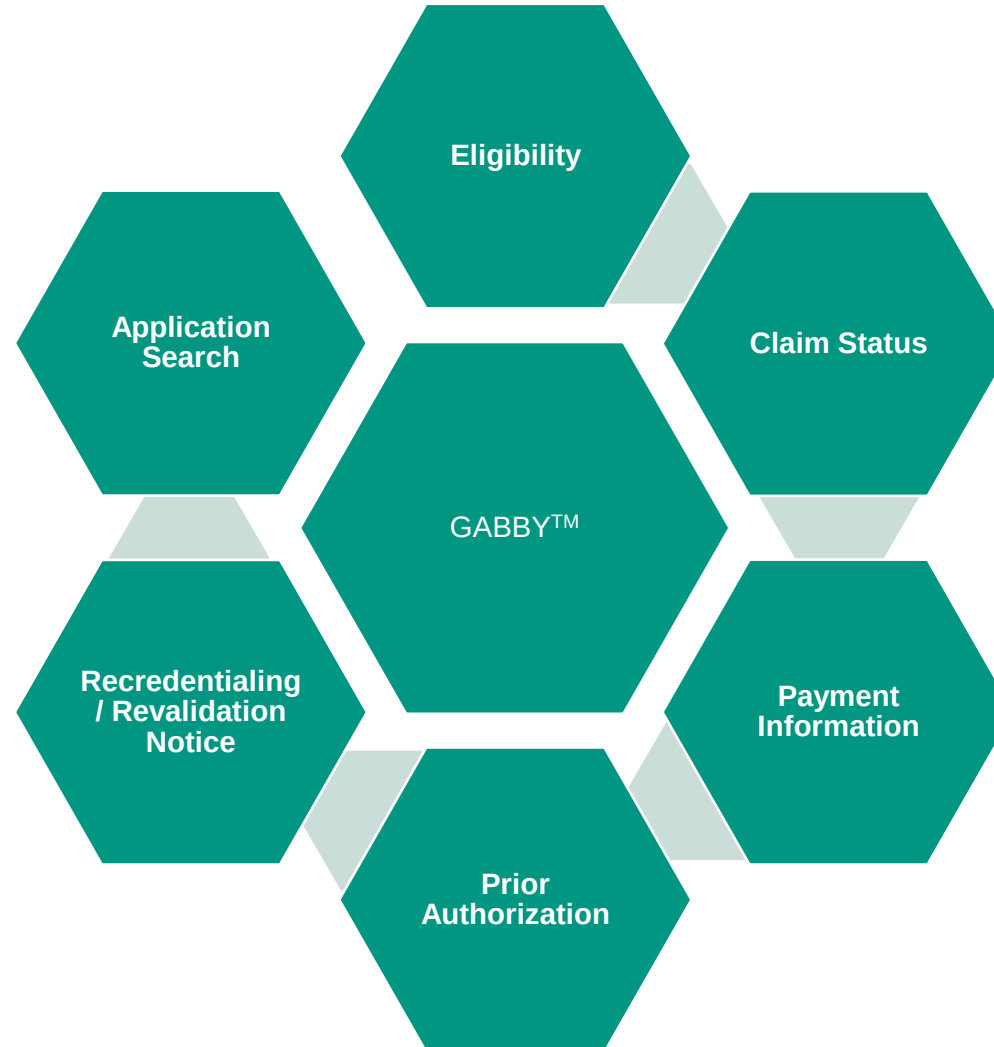
Special Note about GABBY™

SPECIAL NOTE:

Speak your associated PID instead of your NPI. Speaking your NPI only signals GABBY™ to transfer the call to CVO desk.

My ID's 123456789N

What All Can GABBY™ Do?



Contact Us

Our Provider Services Contact Center (PSCC)

can be reached at

800-766-4456

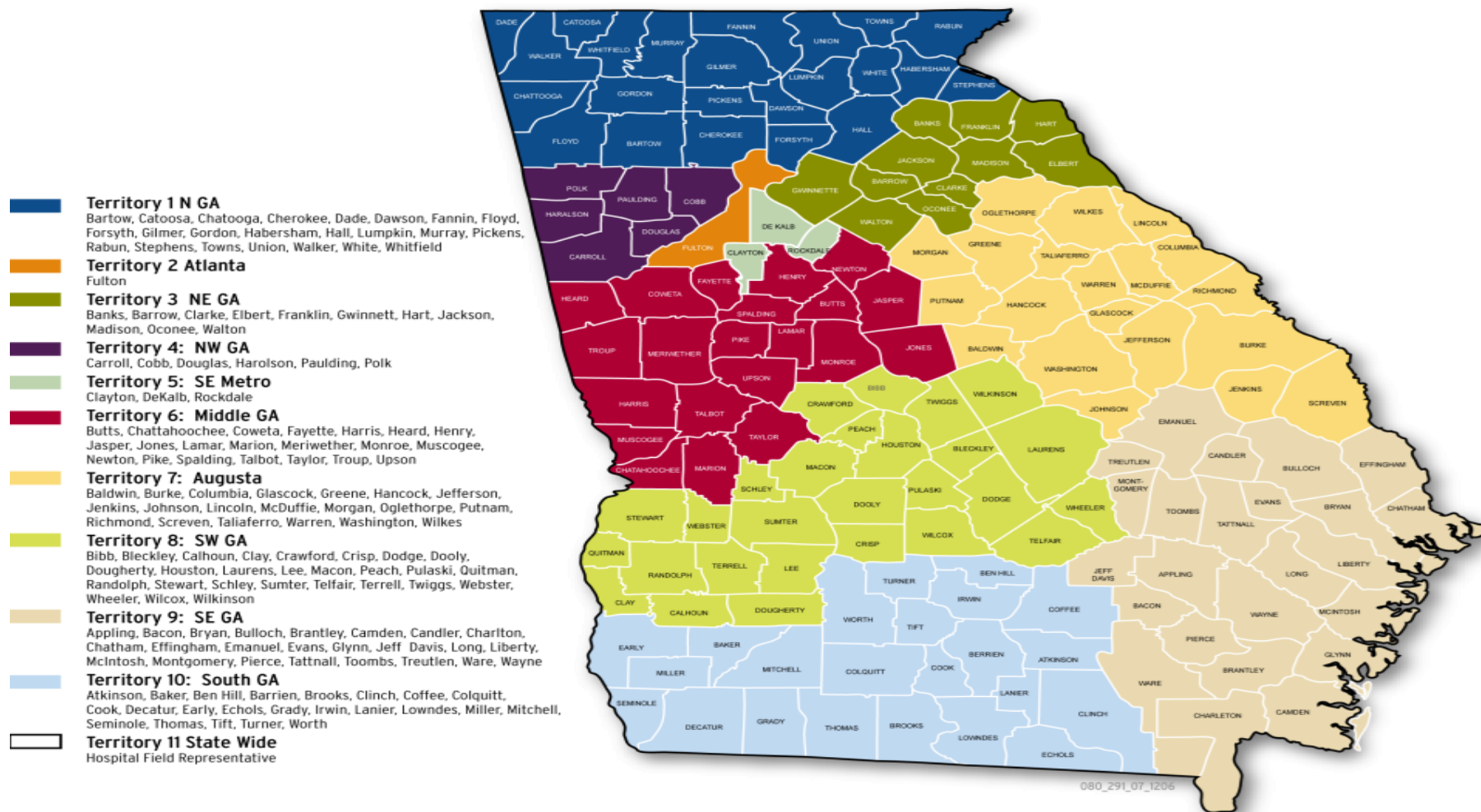
and is available 7 a.m. to 7 p.m. EST

Monday through Friday (except state holidays) for service inquiries.

Please note the Web Portal is available 24/7



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	Tierra Johnson
5	SE Metro	Ebony Hill
6	Middle Georgia	Shawnteel Bradshaw
7	Augusta	Jessica Bowen
8	SW Georgia	Jill McCrary
9	SE Georgia	Kendall Telfair
10	South Georgia	Anitrus Johnson
North	Hospital Rep	Sherida Banks
South	Hospital Rep	Janey Griffin

Provider Relations Field Services Representatives

State-Wide Consultants:

Sharée C. Daniels

Brenda Hulette

Danny Williams

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

Contacting your Field Representative



visit our website:

www.mmis.georgia.gov

Contact My Provider Rep Directly

Login to the MMIS system with your username and password

GEORGIA DEPARTMENT OF COMMUNITY HEALTH

GAMMIS

Search

Refresh session | You have approximately 16 minutes until your session will expire. Friday, October 06, 2017

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 show) Message posted 10/5/2017

User Information

Login/Manage Account **Login**

Members

- Register for Secure Access
- Member Information

Providers

- PIN Activation
- Provider Information

Upcoming Events

ICD-10 Implementation Announcement - DXC Technology will begin accepting ICD-10 diagnoses and surgical procedures on October 1, 2015. Per the federal mandate, claims submitted for services rendered on or after October 1, 2015 must include ICD-10 codes. Claims submitted for services rendered before October 1, 2015 must continue to include ICD-9 codes. Refer to the UB 04 billing manual for ICD-10 rules specific to this claim type. ICD-10 has no direct impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS). Please continue to review the announcements provided on the Provider

Contact My Provider Rep Directly

(continued)

Select the Web Portal option

Georgia Medicaid Home

Jane Doe

, Welcome to Georgia Medicaid

Applications

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



Contact My Provider Rep Directly

(continued)

Select Contact Information, Contact Us



The screenshot shows the top navigation bar of the GAMMIS website. A red arrow labeled '1' points to the 'Contact Information' link in the top row. Below it, a red arrow labeled '2' points to the 'Contact Us' link in the second row. The 'Contact Us' link is highlighted with a light yellow box. Below the navigation bar, there is a section titled 'Phone Numbers & Links' and a footer area with a star icon, the text 'GAMMIS:Contact Information <- Bookmarkable Link', and a link to 'Click here for help and information about bookmarks'.

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*

Telephone

Last Name, First Name

Phone Number, Ext

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.



submit

cancel

Contact Information

How can we help you?

Select an Item*

Contact My Provider Service Rep

Enter Category Details

How can we help you?

I Need some help with ICN 2017123456777

How do you want to be contacted?

Contact Method*

Telephone

Last Name, First Name

DXC

Phone Number, Ext

(800)766-4456

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) 325-9000 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*

Contact My Provider Service Rep

Enter Category Details

How can we help you?

test

How do you want to be contacted?

Contact Method*

Telephone

Last Name, First Name

HPtest

Phone Number, Ext

(800)766-4456

You should now know...



- How to avoid some Common Eligibility Denials by utilizing the Member Verification Panel
- How to avoid some Common Procedure Denials by utilizing the Procedure Search Panel
- How to understand and correct Prior Authorization and Precertification Denials
- How to understand and correct Common Claim Denials



Thank you

Contact

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