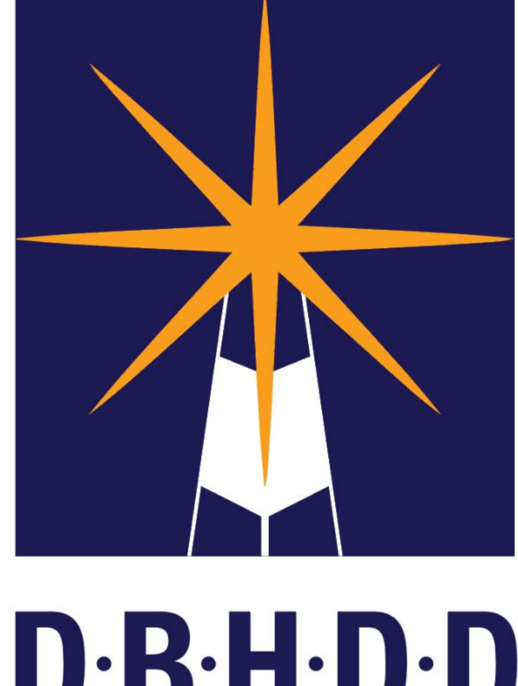


D·B·H·D·D

Georgia Department
of Behavioral Health
& Developmental
Disabilities

BE D·B·H·D·D
BE COMPASSIONATE
BE PREPARED
BE RESPECTFUL
BE PROFESSIONAL
BE CARING
BE EXCEPTIONAL
BE INSPIRED
BE ENGAGED
BE ACCOUNTABLE
BE INFORMED
BE FLEXIBLE
BE HOPEFUL
BE CONNECTED
BE D·B·H·D·D

Welcome to the Quarterly DBHDD All-State Provider Meeting!

Todays Agenda…

Topic	Time	Presenter
Opening Welcome and Updates	9:00 am-9:15 am	Ronald Wakefield, Division Director IDD, DBHDD
Field Office Updates	9:15 am-9:30 am	Allen Morgan, Director of Field Operations
5% Payment Rate Increase- Updates	9:30 am-9:45 am	Ron Singleton, IDD Budget Manager
Office of Waiver Services Updates • American Rescue Plan Act • Appendix K, COMP & NOW Renewals	9:45 am-10:30 am	Ashleigh Caseman, Director of the Office of Waiver Services
OHW Updates and Provider Training Announcements	10:30 am-10:45 am	Dana Scott, Director of the Office of Health and Wellness & Karen Cawthon, OHW Project Manager
Community Services Update	10:45 am-11:00 am	Jeff Thompson, Director of Community Services Robert Bell, Director of Community Supports
Fingerprinting Process	11:00 am – 11:15 am	Melissa Jeffers, RN, BSN Manager, Information Data Unit Division of Strategy, Technology, and Performance
Claims Denial Process	11:15 am – 12:00 pm	Danny Williams, Statewide Consultant Rep, MMIS Gainwell Representative
Question and Answers	12:00 pm-12:30 pm	All

Opening Welcome & Updates from Ron Wakefield, Division Director IDD, DBHDD

Field Office Updates

Allen Morgan
Director of Field Operations
Division of Developmental Disabilities

Georgia
Department of
Behavioral Health
& Developmental
Disabilities

5% Payment Rate Increase Updates

Ron Singleton,
IDD Budget Manager
Division of Developmental Disabilities

Georgia
Department of
Behavioral Health
& Developmental
Disabilities

5% Increase Implementation

Implementing the 5% rate increase required four primary stages and included DBHDD staff, the Department of Community Health (DCH) and the Georgia Collaborative ASO (Beacon Health Options). Guidance and support for all rate increase information was provided by DBHDD staff.

- **Stage 1**
  - ➢ IDD Connects Service Rate Increase Update (Beacon) – July 2022 (Completed)
- **Stage 2**
  - ➢ GAMMIS/Medicaid System Fee Schedule Update (DCH) – July 2022 (In Process)
- **Stage 3**
  - ➢ IDD Connects Prior Authorization Update & Submission to Medicaid (Beacon) (In Process)
- **Stage 4**
  - ➢ IDD Connects Prior Authorization Claims Reprocess (DCH) August 2022 (Pending)

5% Increase Implementation: Stage 1 (Completed)

IDD Connects was updated to reflect rates with the 5% increase for ISPs and prior authorizations newly generated (NOW, COMP and State Funded). The NOW and COMP prior authorizations will be submitted to Medicaid for approval. Upon approval by Medicaid, the services will be billable at the higher rate.

These updates will not include services with $1.00 unit rates. ISPs and prior authorizations with services authorized with $1.00 per unit will be updated next month (Stage 3) by Beacon. For example, below is a prior authorization service line for Special Medical Supply Services, one of several services with a rate of $1.00. One line reflects the prior authorization's current status while the other reflects the service line after the Beacon update.

Current Status

Service Name	Procedure Code	Units	Start Date	End Date	Authorized Amount	Rate
Specialized Medical Supplies	T2028	3800	3/5/2022	3/4/2023	**$3,800**	$1.00

Beacon Update (Stage 3)

Service Name	Procedure Code	Units	Start Date	End Date	Authorized Amount	Rate
Specialized Medical Supplies	T2028	3990	3/5/2022	3/4/2023	**$3,990**	$1.00

5% Increase Implementation: Stage 1 (Update)

ISPs and prior authorizations generated on or after July 6, 2022, reflect the new rates. This also includes service lines for prior authorizations that were updated on or after July 6, 2022.

We are aware that the Authorized (Allowed) Amounts are updating and in most cases are showing the previous amounts. These prior authorization will be systematically updated by Beacon Health Options (Stage 3) and resent to Medicaid for updates.

INCORRECT

Service Name	Units	Start Date	End Date	Authorized Amount	Rate
Community Access - Group	5760	8/25/2022	8/24/2023	**$19,641.60**	$3.58

CORRECT

Service Name	Units	Start Date	End Date	Authorized Amount	Rate
Community Access - Group	5760	8/25/2022	8/24/2023	**$20,620.80**	$3.58

5% Increase Implementation: Stage 2 (In Process)

Historically, NOW and COMP services were reimbursed based on the service/procedure code and rate listed on the prior authorization. For example, Community Access Group Services (CAG), with a current rate of $3.41 per unit (Appendix K [3/1/2021]), would be the reimbursement rate if this rate was listed and approved on the prior authorization.

Within the Medicaid system is a Fee Schedule (Rate Table) which contains the service/procedure code and associated rate. Providers approved for CAG have the service procedure code and rate(s) linked to the active Medicaid provider number.

The Medicaid system can be configured to allow for reimbursement based on the **Prior Authorization** rate or by the rate listed in the **Fee Schedule (Rate Table)**.

Fee Schedule (Rate Table)

Procedure	Modifier	Rate	Effective Date	End Date
T2025	HQ	$3.04	11/01/2008	12/10/2014
T2025	HQ	$3.10	12/11/2014	02/28/2021
T2025	HQ	$3.41	03/01/2021	06/30/2021
T2025	HQ	$3.58	07/01/2021	12/31/2299

5% Increase Implementation: Stage 2 (Update)

Please continue to submit claims using the **Authorized Rate** approved on the prior authorization until further notice. You will be notified when the Fee Schedule (Rate Table) is active for billing at the higher rates for prior authorizations approved prior to July 6, 2022.

Fee Schedule (Rate Table)

Procedure	Modifier	Rate	Effective Date	End Date
T2025	HQ	$3.04	11/01/2008	12/10/2014
T2025	HQ	$3.10	12/11/2014	02/28/2021
T2025	HQ	$3.41	03/01/2021	06/30/2021
T2025	HQ	$3.58	07/01/2021	12/31/2299

5% Increase Implementation: Stage 3 (In Process)

Prior authorizations with active dates from July 1, 2021, will be updated with a 5% rate increase. This will include those service rates currently reflecting the 10% rate increase approved in the March 1, 2021, Appendix K and the addition rate increases to Support Coordination Services, LPN Nursing Services and Financial Support Services approved in the March 1, 2020, Appendix K.

Beacon Health Options will systematically update these prior authorizations and transmitted them Medicaid for approval. All of the associated ISPs for these prior authorizations will also be updated by Beacon Health Options.

5% Increase Implementation: Stage 4 (Pending)

Upon approval of the prior authorizations within the Medicaid system, DCH will be notified. Shortly after, all paid claims for the impacted services with an effective date July 1, 2021, or after will be reprocessed systematically by DCH. No actions will be needed from the approved billing providers.

Below is an example of a July 2021 claim for Community Access Group Services. The original paid amount of the claim, based on a rate of $3.41 per unit, was $341.00. The claim will be reprocessed based on a rate of $3.58 per unit which will total $358.00. The billing provider will receive the difference of the paid amounts as shown below.

ORIGINAL CLAIM

Service Name	Procedure Code	Units Paid	Amount Paid	Start Date	End Date	Unit Rate
Community Access - Group	T2025-HQ	100	$341.00	7/12/2021	7/16/2021	$3.41

REPROCESSED CLAIM

Service Name	Procedure Code	Units Paid	Amount Paid	Start Date	End Date	Unit Rate
Community Access - Group	T2025-HQ	100	$358.00	7/12/2021	7/16/2021	$3.58

Difference	**$17.00**

5% Increase Implementation: Stage 4 (Continued)

Below is an example of a July 2021 claim for Specialized Medical Services. The original reimbursement (paid) amount of the claim, based on a rate of $1.00 per unit, was $1,000.00. The claim will be reprocessed based on a rate of $1.00 per unit but with an additional 5%. The total will increase to $1,050.00. The billing provider will receive the difference of the paid amounts as shown below. All services that are authorized using a rate of $1.00 will be reprocessed in this manner, including the services for Participant Direction.

ORIGINAL CLAIM

Service Name	Procedure Code	Units	Amount Paid	Start Date	End Date	Unit Rate
Specialized Medical Supplies	T2028	1000	$1,000.00	7/12/2021	7/16/2021	$1.00

REPROCESSED CLAIM

Service Name	Procedure Code	Units	Amount Paid	Start Date	End Date	Unit Rate
Specialized Medical Supplies	T2028	1050	$1,050.00	7/12/2021	7/16/2021	$1.00

Difference	**$50.00**

5% Increase: Troubleshooting for Billing

If you experience billing difficulties, please be sure to reach out to your Gainwell Representative for assistance. Information and guidance for contact information can be found at:

https://www.mmis.georgia.gov/

For general questions about the 5% increase, please contact the DBHDD Provider Issue Management System (PIMS) at:

Provider Issue Management System (PIMS)

Office of Waiver Services- Updates

Ashleigh Caseman
Director of Waiver Services
Office of Waiver Services
Division of Developmental Disabilities

Georgia
Department of
Behavioral Health
& Developmental
Disabilities

Today's Topics

Appendix K Updates

American Rescue Plan Act (ARPA) Updates- Rate Study

COMP & NOW Renewals Updates

Appendix K Updates

Appendix K continues to be in effect for NOW and COMP waivers

- In addition to the existing Appendix K modifications, DBHDD is implementing an amended Appendix K with a 5% provider rate increase from FY22 Appropriations Bill [HB-81] for all NOW and COMP services (retro 7.1.21)

- There is a current amendment pending CMS approval for 2% FY23 Appropriations Bill [HB-911].

  - Federal Public Health Emergency (PHE) renewed July 14,2022 for 90 days by HHS

  - Reminder Appendix K can be in effect for up to 6 months post federal PHE

APPENDIX K: Emergency Preparedness and Response

Background:

This standalone appendix may be utilized by the state during emergency situations to request amendment to its approved waiver. It includes actions that states can take under the existing Section 1915(c) home and community-based waiver authority in order to respond to an emergency. Other activities may require the use of various other authorities such as the Section 1115 demonstrations or the Section 1135 authorities.[i] This appendix may be completed retroactively as needed by the state.

Appendix K-1: General Information

General Information:

A. **State:** Georgia

B. **Waiver Title:** Comprehensive Supports Waiver Program (COMP) New Options Waiver (NOW)

C. **Control Number:** GA.0323.R04.09 GA.0175.R06.08

Rate Study

DBHDD has an approved ARPA spend plan initiative for a rate study to be conducted for ALL NOW and COMP waivers services

- Many NOW and COMP waiver services have not had a comprehensive review 15 years
- Most recent rate study implemented in 2015 (implemented in 2017) for CRA, CLS and Respite services
- Senate Bill 610 approved FY22 General Assembly REQUIRES a rate study to be conducted every 4 years beginning in FY24 and thereafter, however DBHDD taking the initiative to start sooner

Burns & Associates a Division of HMA timeline….

Intellectual/Developmental Disability Rate Study

PHASE ONE

Background Research and Initial Meetings (May-June)

Task 1: Conduct background research to document service requirements

Task 2: Facilitate kickoff meetings with DBHDD project team and provider advisory group to discuss current issues with service delivery and payment rates, and goals for the rate study

PHASE TWO

Data Collection (June-August)

Task 3: Design and administer provider survey

Task 4: Conduct other research and analysis such as collecting benchmark cost data

PHASE THREE

Rate Development (September-December)

Task 5: Develop draft rate models

Task 6: Facilitate public comment process

Task 7: Finalize rate models and develop implementation plan

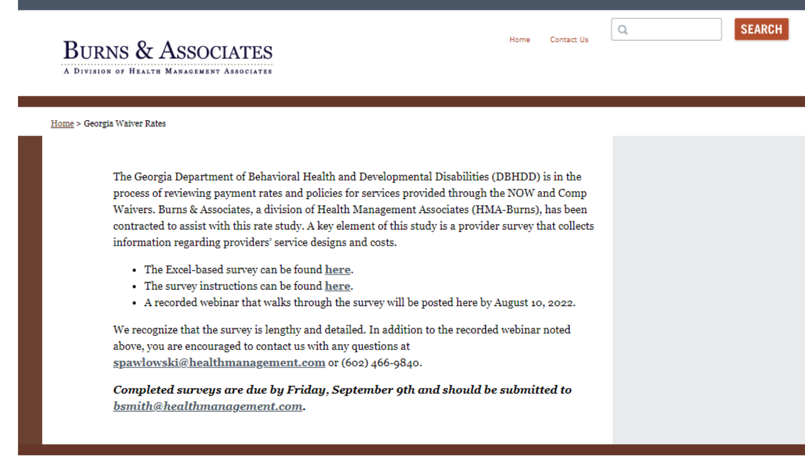
ADDITIONAL OPPORTUNITIES

- Stakeholder advisory group to offer feedback at key stages of the project
  - Provide perspectives on current issues and review draft provider survey
  - Review provider survey results
  - Review draft rate models
- Provider survey that all providers will be invited to complete
- Public comment process during which all interested stakeholders will be invited to submit written feedback on the draft rate models

Rate Study- Provider Survey Announcement!

- The IDD Rate study for all NOW and COMP waiver services is **currently underway!** Providers will have until **September 9th** to complete the provider survey located here:

www.burnshealthpolicy.com/GeorgiaWaiverRates/



- The website includes the following:
  - The Excel-based survey
  - The survey instructions
  - A recorded webinar that walks through the survey

- Please advise the survey is lengthy and detailed. In addition to the recorded webinar noted above, you are encouraged to contact HMA with any questions at spawlowski@healthmanagement.com or (602) 466-9840
- Completed surveys are again due by **Friday, September 9th** and should be submitted to bsmith@healthmanagement.com

COMP Renewal- Updates

- Approved on July 14th, 2022
- Approval includes telehealth options for several services, new service- Assistive Technology, rate increase for Interpreting Services, and more!
- DCH and DBHDD will be working in partnership to operationalize the renewal over next several quarters- be sure to review DCH manuals on quarterly basis for updates (1.1, 4.1, 7.1, 10.1)

NOW Renewal – Updates

- ✓Approved by DCH board for final adoption on July 18, 2022
- ✓Goal to align with approved COMP changes
- ✓Submitted to CMS by DCH on August 2, 2022

Thank you to everyone who provided feedback during public comment process- your input is valued!

Resources

To review the entire Georgia initial spending plan visit:
https://dch.georgia.gov/programs/hcbs

To review the Appendix K Emergency Preparedness Response Plan visit:

https://dch.georgia.gov/announcement/2020-04-10/state-georgia-announces-approval-appendix-k-emergency-preparedness-response

To review the COMP renewal approval notice visit:

CMS approves 1915c renewal | Georgia Department of Community Health

Office of Health and Wellness Updates

Dana Scott, DNP, RN

Director Office of Health & Wellness, Division of Disabilities

Georgia Department of Behavioral Health & Developmental Disabilities

OHW Updates

ADDITIONAL STAFFING

PROVISION OF RN OVERSIGHT

TECHNICAL ASSISTANCE

Additional Staffing-Medical

- Be purposeful and clear of need (Medical and/or Behavioral)
- As is determined and informed by
  - Assessed documented need
  - Physician ordered assistance (i.e., gate/ambulation/turn/transfers)
  - Additional consideration of indicated of clinical acuity
  - Additional consideration of indicated assistance needs

Provision of RN Oversight Policy: 02-808

The process by which a licensed Registered Nurse determines the appropriateness of the development, delegation, coordination, training, intervention and documentation of health-related tasks.

RN Oversight: Documentation/Evidence of

- Documented/Pattern of routine RN Assessment of individual at least monthly
- Evidence of indicated HCP's
  - Date
  - Full name of RN response for development
  - Credentials of RN responsible for development
  - Inclusion of recommendations driven by MD order/RN Assessment
  - Evidence of training (i.e., Proxy caregiving, HCP's)
  - Evidence of review of Tracking logs (i.e., bowel, seizure, weight, skin)
  - Evidence of current and annual assessments (i.e., H/P, mammogram, dental assessments)

    Note: Parties responsible for the scheduling of annual assessments and medical appoints may be based upon provider arrangement or environment of care (i.e., individual lives with family who makes and transports medical appointments)

Provision of RN Oversight Policy: 02-808

- Assessment a primary function performed by RN
- RN oversight is facilitated by partnerships/agreements with
  - Families
  - Residential providers
  - Clinical Providers
  - Pharmacies

- Partnerships may result in written agreements/protocols that:
  - Are agreed upon by providers supporting the individual
  - Direct Assigned functions such as
    - Notification/Communication
    - Documentation
    - Transportation
    - Acquisition of (i.e., medications)
    - Training
  - Drive compliance and accountability

Clinical Technical Assistance:

The CDC defines technical assistance as the process of providing targeted support to an organization with a development need or problem.

Source: https://www.cdc.gov/healthyschools/professional_development/videos/pd101/05-technical_assistance.pdf

Technical Assistance

- OHW clinicians can offer targeted support when providers identify a need or encounter a clinical problem.
- For example: Nurse workforce shortage establish unique support challenges. Technical assistance may be sought if:
  - Provider is turning to proxy caregiving
  - Individual in support has a new medical diagnosis
  - There is a need to interpret practical application of policy
  - There is a need to confirm the need for clinical oversight

Office of Health & Wellness Provider Training Announcements

Office of Health & Wellness
2022 Virtual Nursing Education Series
presented in May 2022
is now available on the DBHDD Website.

https://dbhdd.georgia.gov/be-connected/improving-health-outcomes-initiative-collaborative-learning-center

OHW Emory Curriculum

- Web Based Training Series available through Emory.

- Send email to shannon.l.smith@dbhdd.ga.gov
- to be added to registration list.

- CEU Credits are available.

Reminder: HRST Advanced Rater In-app Training Launched in May 2022

Existing Raters

- Any Rater who has an Online Rater Training completion date before May 16, 2022, will have a full year (May 16, 2023) to complete the now required (In-app) Advanced Rater Training.
- Your HRST Service Representatives, along with the new HRST Dashboard, will be regularly reminding Raters of the need to complete Advanced Rater Training on or prior to May 16, 2023, to avoid having their account placed in a "View Only" status.

Reminder: HRST Advanced Rater In-app Training

Future Raters

- Any Rater who has an Online Rater Training completion date after May 16, 2022, will have (6) six months to complete Advanced Rater Training after completing Online Rater Training.
- Again, your HRST Service Representative and the new HRST Dashboard will help Raters remember this deadline to avoid having their account placed in "View Only" status.

HRST Provider Admins

What is a Provider Admin?

A Provider Admin is an HRST user who has access to see data across their provider agency. This includes additional Dashboard cards and reports with information related to Persons Served screenings, User training progress, etc.

Who should I choose as my provider's admin?

It is recommended to specify two people who have oversight over your agency. Data offered to Provider Admins is intended to show the overall status of your HRST users and Persons Served.

The people you wish to designate as Provider Admins must have an active HRST account.

HRST Provider Admins – Call To Action

If you have not submitted Provider Admins to HRST (Please respond today)

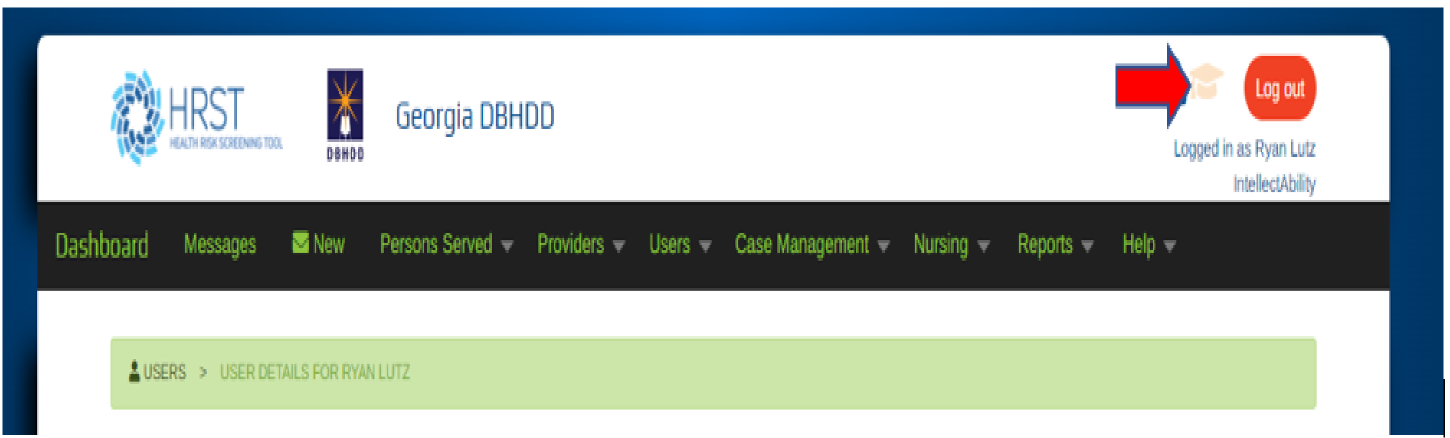
How do I submit my provider's admins?
Initially, please fill out the following form with at least two users who will be Provider Admins: https://zfrmz.com/hGiT4FP0iFTuIviwH2fg

After the launch, any updates or additional users you wish to designate the Provider Admin role to can be submitted through the HRST Helpdesk at GASupport@ReplacingRisk.com

HRST User Requested Courses Launched in May 2022

New functionality was introduced to allow users to request trainings to be added to their trainings tab from within the HRST. This design allows a user to request trainings for themselves only and not on behalf of any other user.

Click on the training cap icon in the top right corner of HRST to automatically navigate to the Training Tab



Available Courses

- You will see “Available Courses” which are the courses that can be requested and sent directly to IntellectAbility’s support team for approval.
- Note – Only certain courses need to be requested, while other courses with no prerequisites can be added directly by a user without any approval needed.
- Under that you will see “My Assigned Courses”, this will show you what courses you have currently assigned and any courses that were requested and approved.
- Simply navigate into this section of the HRST and request what courses you would like to add with the click of a button. If a course is approved or rejected, you will receive an email notification directly from GAsupport@replacingrisk.com notifying you the status and a statement on why.

OHW eLearn Courses

- **Healthcare Plan eLearn course for Provider RN Staff**

This 30-minute, self-paced course will teach you all the information you will need to easily create and update Healthcare Plans in the HRST. **clicking here will access flyer**

- **Provider Nursing Assessment eLearn course for RN Staff**

This 30-minute, self-paced course will teach you all the information you will need to easily create and update Provider Nursing Assessments in the HRST. **clicking here will access flyer**

The RN can request the course assignment directly in the HRST Application under Training Tab.

Curriculum in IDD Healthcare eLearn course by IntellectAbility

- **Training available through Relias and DBHDD University for Physicians, NP, and Nurses**
- **This course can be stopped and started at the convenience of the learner.**
- **There is no cost for this course and CME and CEU credits are available.**

If you are interested in registering, please send an email to martha.thweatt@dbhdd.ga.gov for instructions on accessing the course.

The next HRST Clinical Reviewer Virtual Class is September 7th

HRST Clinical Reviewer eLearn Course to launch later this year!

Annual HRST Screening Update Tracker to launch Winter 2022

Office of Community Services Updates

Jeff Thompson
Director of Community Services
Division of Disabilities

Robert Bell
Director of Community Support
Division of Disabilities

Georgia
Department of
Behavioral Health
& Developmental
Disabilities

Family Support Manager Announcement

Welcome!

Olivia Nickens

Family Support
Participant Direction
Waiver Supplemental Services

olivia.nickens@dbhdd.ga.gov

Reminder on 30 Day Notices

- As a reminder for providers, when a 30-day notice must be given, it is to be made to DBHDD to the RSA at the Field Office in which the participant resides.
- Additionally, "a minimum of a 30 days' notice when terminating COMP/NOW services to an individual. The provider must agree to be a part of the transition process with the support coordinator and DBHDD Field Office and continue to provide COMP/NOW services until a new provider is identified and transition to this provider occurs in order to assure continuity of care and maintenance of health and safety for the individual."
- **from Part II NOW/COMP, 908. Termination of Individual Services Requirements plus see your LOA**

Support Coordination Visits

- As a reminder, visits made by Support Coordination Agencies may be in person or virtual at the discretion of the Support Coordination Agency. More visits are being done in person, but safety is still the watchword.
- This is applicable to all service sites.

Belton and What To Expect

- Due to the Pandemic the training is being offered remotely
- Identified staff are expected to participate in the training
- If there are issues where providers are unable to attend the upcoming training notification should be sent to GCDHH at the earliest convenience as there is a late cancellation charge
- Provider staff are expected to leave their camera on during the training otherwise the instructor is unable to gauge progress
- The Sign Language Proficiency Interview (SLPI) will be administered when the trainer feels the staff is ready

What is the Purpose? Part I

- Having staff who can sign
- Staff trained about the communication needs of Deaf Individuals
- Individual Service Planning instruction provided in manner consistent with communication needs
  - Eye contact
  - Visual gestural prompts
  - Physical Prompts
  - Identifying language of preference on Communication Assessment Report

What is the Purpose? Part II

- Environmental accommodations in provider settings: Visual fire alarms in all common shared settings Flashing door knock signalers (residential front door, and bedroom doors) Closed Captioning on televisions

- Required forms available in ASL…If not available in ASL having an ODS Approved Interpreter to assist communication needs

- Video content that is captioned if used for participant orientation to services

Taking it a step further

ASL Fluent Group Homes

Employing Deaf professionals

Employing Deaf paraprofessionals

Deaf Specific Programming

Deaf individuals in key leadership

Communication access across the organization

Comprehensive training curriculums focused on linguistic access

Contact Information

Robert Bell
Director of Community Support
robert.bell@dbhdd.ga.gov

Criminal History Records and Image

Georgia Department of Behavioral Health & Developmental Disabilities

Melissa Jeffers, Information Data Unit Manager

August 11, 2022

Criminal History Record Process

Issues that delay background check processing

- Failure to register the applicant in Gemalto
- Failure to provide registration forms to DBHDD
- Inaccurate information in Gemalto (ex. SSN, email addresses of applicants) causes restart
- Requesting attestations when fingerprint locations are open

Attestation Allowances

During the Public Health Emergency, there is a partial suspension of the fingerprinting requirement:
ONLY IF FINGERPRINTING SERVICES ARE NOT AVAILABLE IN YOUR AREA

Attestation Requests

As of this month, there are 106 open fingerprint locations across the state of Georgia. Attestations will not be accepted if there are fingerprint locations available near the applicant or agency.

1. You can check for open locations through Gemalto.
   1. If locations are available, follow the regular process for registering applicants.
   2. If there is not a location available, email the Attestation Form, Attachment A to COVID-19 2020: DBHDD Community Developmental Disability Services Policy Modifications - 7/1/2021 to dbhdd-crs@dbhdd.ga.gov for approval.
2. You must retain the signed Attestation Form and the approval email for audit purposes.
3. If the attestation request is denied, the applicant must be processed per Policy 04-104, Criminal History Record Check for DBHDD Network Provider Applicants, 04-104.

Attestation Requests (continued)

When the Public Health Emergency (PHE) ends:

1. All employees hired under Attestations must have a background check within sixty (60) days.
2. The provider is responsible for starting the process.
3. If a fingerprint location is currently available, have employees complete the fingerprint-based background check as soon as possible. You do not have to wait for the PHE to end.

Criminal History Record Process Overview

1. Registration
   a. Register applicant in Gemalto, and
   b. Email completed/signed Registration Forms to DBHDD
2. DBHDD staff reviews/approves registration and Registration Forms
3. Once registration is approved, Gemalto will email the applicant to proceed to a fingerprint location
4. Once fingerprinted, DBHDD staff reviews information and enters it into the CHRIS database
5. Provider pulls applicant's eligibility letter from CHRIS and maintains it in applicant's file

Fingerprint Registration

Fingerprint Registration is a multi-step process, and approval requires **all** of the following steps to be completed:

1. Register the applicant in Georgia Applicant Processing Services (GAPS) – Gemalto
2. Ensure the applicant completes an application for employment
3. Give the applicant a copy of the Non-Criminal Justice Applicant's Privacy Rights attached to policy 04-104, Criminal History Record Check for DBHDD Network Provider Applicants
4. Have the applicant sign and date the Privacy Rights to confirm it was received and read
5. Retain the signed Privacy Rights, eligibility letter, and application in the applicant's personnel file

Registration Forms

- Registration Forms are attached to policy 04-104, Criminal History Record Check for DBHDD Network Provider Applicants
- Both pages of the attachment are required
  - The registration form must be filled out and signed by the applicant
  - The cover sheet must include the provider contact information
- Email both pages to dbhdd.reg@dbhdd.ga.gov

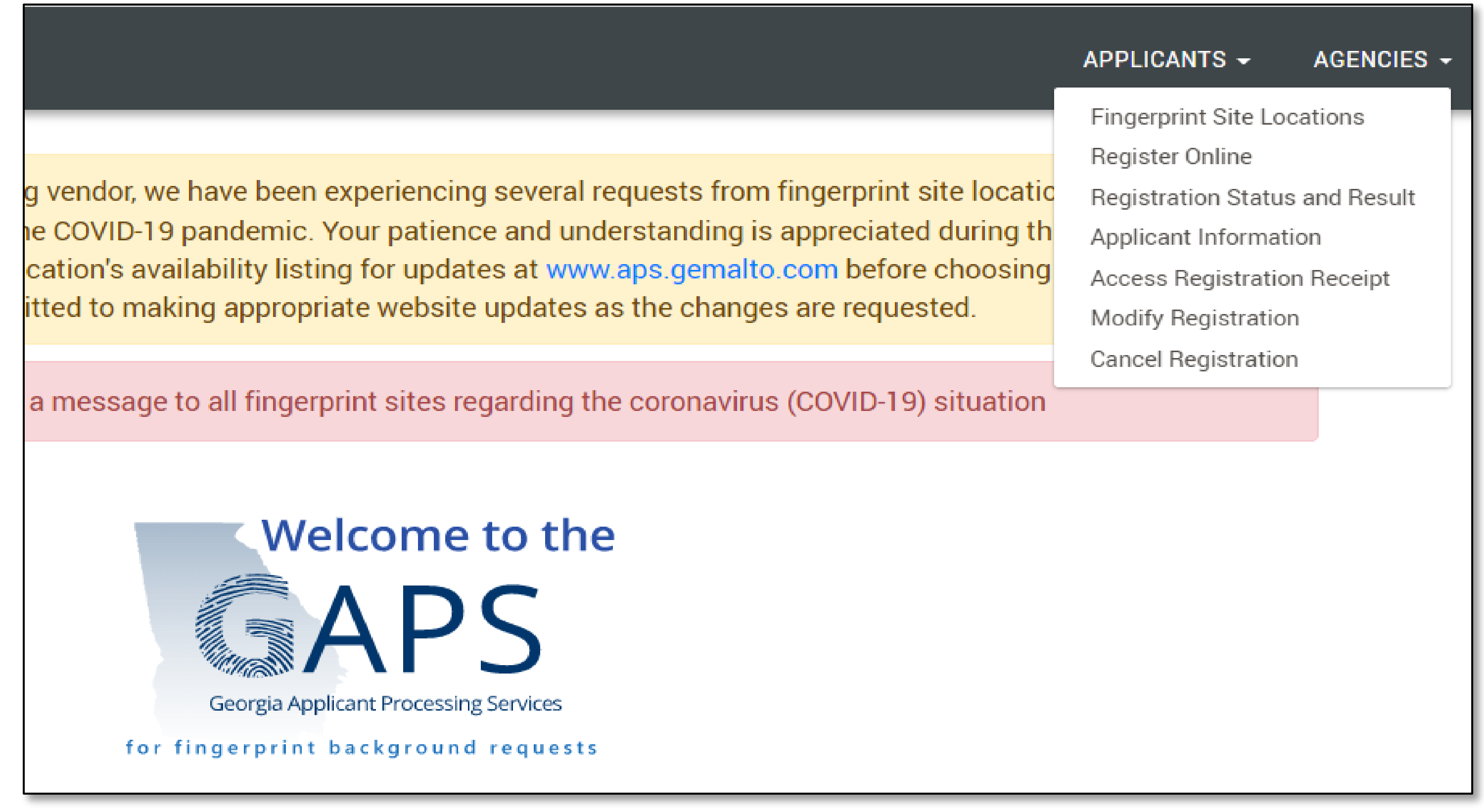
How to Check an Applicant’s Registration Status

- Providers have direct access to an applicant’s status in Gemalto and do not need to reach out to DBHDD for status checks
- The registration status will display and includes:
  - Registration Date
  - Approval Date
  - Fingerprint Date
  - Response Date
  - Email address the notification was sent

How to Check an Applicant's Registration Status (continued)

Go to Georgia Applicant Processing Services (GAPS) – Gemalto. In the upper right corner,

- Select Applicants
- Select Registration Status and Result



Eligibility Letters in CHRIS

- Providers access applicant eligibility letters through CHRIS
- If the eligibility letter is available, a pdf of the letter will display, and providers will be able to download the letter
- Letter Status definitions:
  - Eligible – applicant is eligible for employment
  - Ineligible – applicant is NOT eligible for employment
  - Under Review – additional information is needed for eligibility determination – Provider should tell the applicant to email dbhdd-crs@dbhdd.ga.gov for their next step. DBHDD will also inform the applicant.

How-To Guides

- Step-by-Step Guides for different parts of the Criminal History Record process are available on the DBHDD website, *Background Policy & Gemalto Information page*
  - *How to Search for Open Fingerprint Locations*
  - *How to Register an Applicant for Fingerprints*
  - *How to Check Applicant's Registration Status*
  - *CHRIS Registration Guide*
  - *How to Access Letters in CHRIS*

IMAGE and Incident Reporting

Image and Incident Reporting

- All providers need to have at least one person registered in Image to report incidents in accordance with Reporting Deaths and Other Incidents in Community Services, 04-106
- A backup person registered is highly encouraged to maintain compliance with reporting
- To learn more about Image, you can access training resources, including the registration guide through DBHDD University

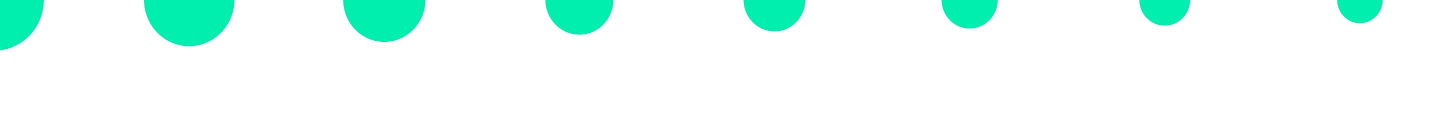
Resources:

For questions about CHRIS: DBHDD-CRS@dbhdd.ga.gov
For attestation submission: DBHDD-CRS@dbhdd.ga.gov
For registration submission: DBHDD.Reg@dbhdd.ga.gov
For questions about IMAGE: Image.App@dbhdd.ga.gov

Melissa Jeffers, Manager, Information Data Unit:
Melissa.Jeffers@dbhdd.ga.gov

Jennifer Rybak, Director, Office of Incident Management and Compliance: Jennifer.Rybak@dbhdd.ga.gov

Medicaid MMIS Web Portal Basics



Agenda

- MMIS Web Portal Basics
- Member Eligibility
- Prior Authorization Research
- Claim Submission & Claim History Research
- Timely Filing
- Provider Claim Appeal
- Accessing the Remittance Advice
- Contacting Gainwell Technologies
- Overview of the Interactive Voice Response
- Session Review
- Closing, Questions, and Answers

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MMIS Web Portal Basics

Eligibility Verification

(continued)

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

- GAMMIS website www.mmis.georgia.gov (secure Web Portal only)
- Interactive Voice Response System (IVRS)
- Provider Services Contact Center (PSCC)

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

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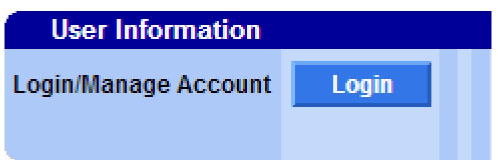
Eligibility Verification

- Eligibility verification is the first and most important step in billing any claim.
- Eligibility should be verified prior to each visit to the office or facility or dispensing of any equipment or treatment.
- Verifying eligibility allows you to determine:
  - Is the member currently eligible?
  - Is the member eligible for this service?
  - Does the member have other coverage?
  - Has the member reached coverage limitations?
  - Does the member have a spend-down or patient liability that will affect the claim?
  - Is the member in a CMO? If so, which CMO?

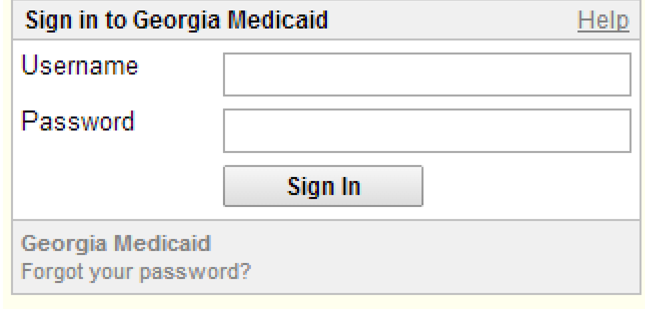
Logging into the Secure Web Portal

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

Click the Login button.



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



2. Click the Web Portal link.

Applications

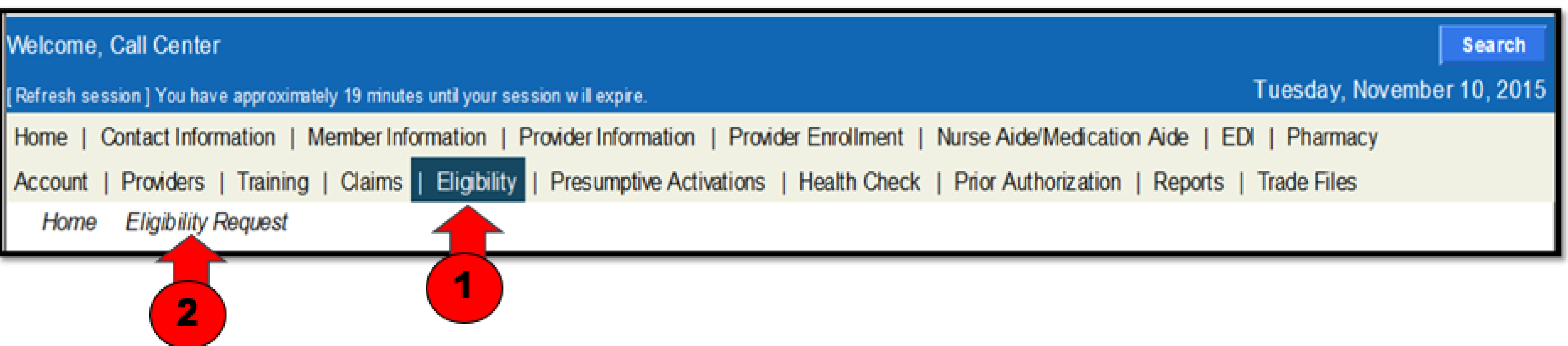
Application	Description
MEUPS Account Management	Manages contact information, password, and authorizations for applications.
Web Portal	Web Portal Production

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

Eligibility Verification

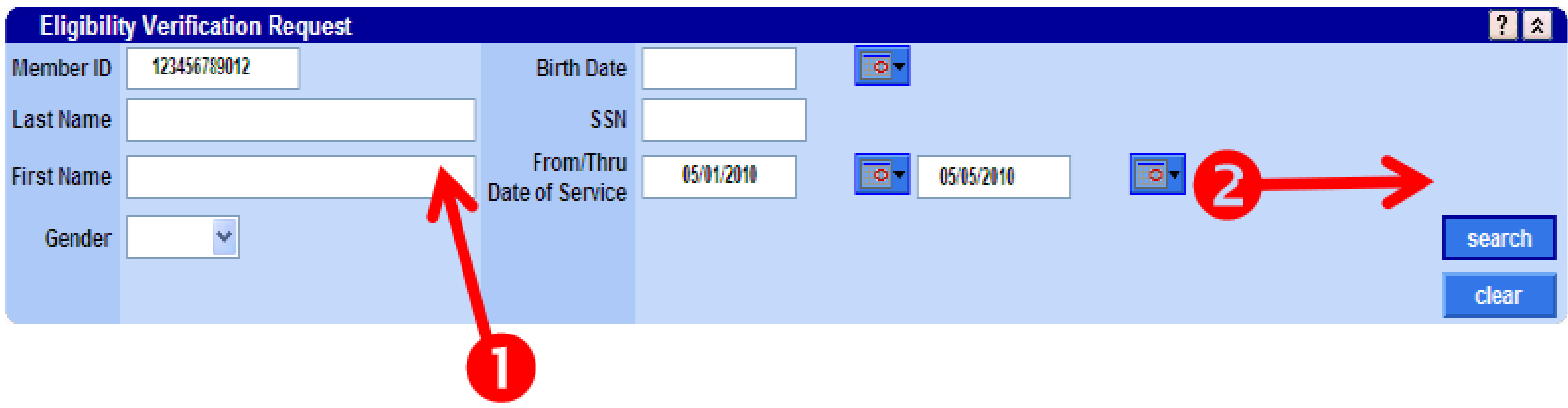
(continued)

- GAMMIS website www.mmis.georgia.gov (secure Web Portal only)
- Eligibility
- Eligibility Request



Eligibility Verification

(continued)



Member ID Information

Field	Value	Field	Value
Member ID		First Name	TEST MEMBER
Birth Date	04/14/1991	Last Name	MEDICAID FAIR
Address 1	2 PEACHTREE ST NW	Middle Initial	
Address 2(County)	060 - FULTON	Name Suffix	
City	ATLANTA	Gender	F
State	GA	Transaction Date/Time	06/05/2019 09:27:45
Zip	30303-3141	Confirmation #	19156000EN

Member Transactions

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	MEDICAID

Managed Care

Provider Name	Plan Name	Provider Phone	Effective Date	End Date
PEACH STATE HEALTH PLAN - ATLANTA	Georgia Families	(866)874-0633	06/05/2019	06/05/2019

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	1 - Medical Care	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Inactive for Service Type Code selected.	33 - Chiropractic	06/05/2019	06/05/2019				
Active	35 - Dental Care	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	
Active	47 - Hospital	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	48 - Hospital - Inpatient	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	50 - Hospital - Outpatient	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	3.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	86 - Emergency Services	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	
Active	88 - Pharmacy	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	3.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	98 - Professional (Physician) Visit - Office	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	2.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	AL - Vision (Optometry)	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	1.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	MH - Mental Health	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	
Active	UC - Urgent Care	06/05/2019	06/05/2019	MC - Medicaid	104 - LIM - Adult	0.00	

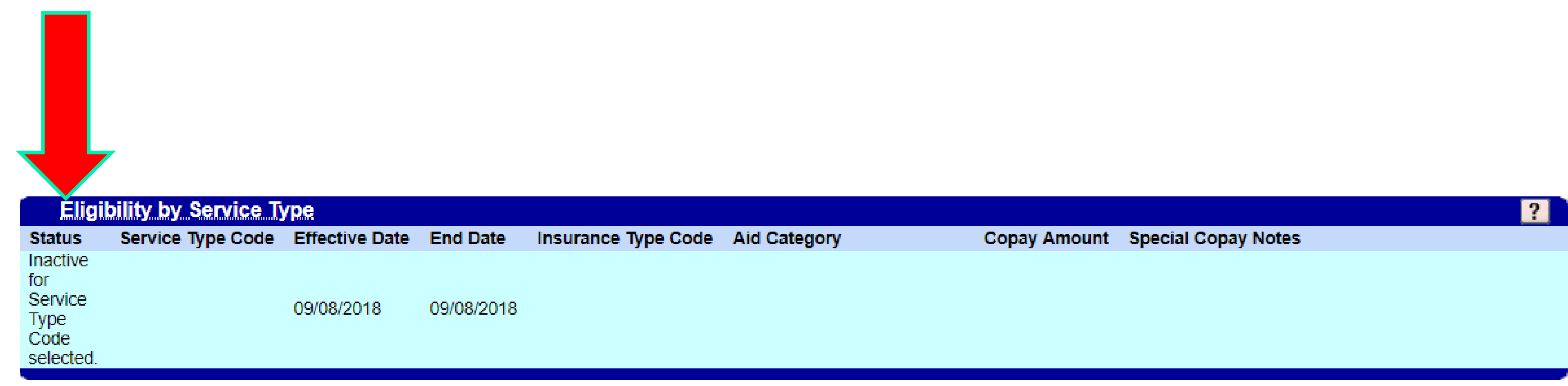
Service Limits

Benefit Information	Procedure Code	Units/Amount Allowed	Units/Amount Used	Time Period
6259 CALENDAR YEAR OFFICE VISITS EXCEEDED		10	3	23 - 1 Calendar Years

Eligibility Verification

(continued)

Member's Eligibility is Inactive with no Medicaid Benefits.



Eligibility by Service Type

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

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Eligibility Verification

(continued)

Member's Eligibility is Inactive with no Medicaid Benefits
Member has Medicare Part B Premiums paid to Medicare only

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	661 - Spec. Low Income Mcre Benefic.	Provides payment of the monthly Medicare Part B premium only (SLMB-COE 466, 661 QI-COE 662)

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Inactive for Service Type Code selected.	1 - Medical Care	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	33 - Chiropractic	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	35 - Dental Care	06/08/2018	06/08/2018				
Inactive for Service Type Code selected.	47 - Hospital	06/08/2018	06/08/2018				
Inactive for Service Type	48 - Hospital - Inpatient	06/08/2018	06/08/2018				

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Eligibility Verification

(continued)

- ***This member has CCSP Medicaid – Payment for CCSP Services***
- ***QMB Medicare Part A and Medicaid as secondary & covers coinsurance and deductible up to Medicaid allowed amount only.***

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	259 - Community Care Waiver	MEDICAID
Active	30 - Health Plan Benefit Coverage	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	Provides payment of Medicare Part A premium for those individuals who must pay a premium for Part A, Medicare coinsurance, deductible and Medicare Part B premium only. QMB will not cover any medical service that is not covered by Medicare. (QMB- COE 460 or 660.)

CCSP Benefits

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	1 - Medical Care	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Inactive for Service Type Code selected.	33 - Chiropractic	06/08/2018	06/08/2018				
Active	35 - Dental Care	06/08/2018	06/08/2018	MC - Medicaid	259 - Community Care Waiver	0.00	
Active	47 - Hospital	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	48 - Hospital - Inpatient	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	50 - Hospital - Outpatient	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	3.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.
Active	86 - Emergency Services	06/08/2018	06/08/2018	MC - Medicaid	259 - Community Care Waiver	0.00	
Active	88 - Pharmacy	06/08/2018	06/08/2018	MC - Medicaid	660 - Qualified Medicare Beneficiary	3.00	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.

Eligibility Verification
(continued)

Member has Active SSI Medicaid Benefits

Benefit Plans

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Special Notes or Limitations
Active	30 - Health Plan Benefit Coverage	11/01/2018	11/16/2018	MC - Medicaid	303 - SSI - Disabled	MEDICAID

Eligibility by Service Type

Status	Service Type Code	Effective Date	End Date	Insurance Type Code	Aid Category	Copay Amount	Special Copay Notes
Active	1 - Medical Care	11/01/2018	11/16/2018	MC - Medicaid	303 - SSI - Disabled	12.50	The co-payment amount for the service may vary. Please check the Medicaid/Peachcare for Kids Policy Manual for the exact co-payment amount.

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Eligibility Verification

(continued)

Retroactive eligibility claims must be received by the division within (six) months after the date in which the determination of retroactive eligibility was made.

Retroactive Eligibility

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

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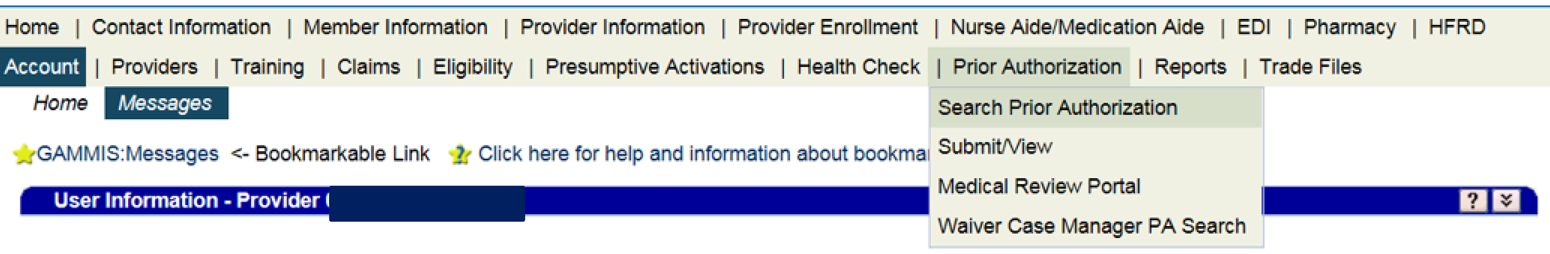
Prior Authorization Search

Prior Authorization Search

Visit: www.mmis.georgia.gov

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

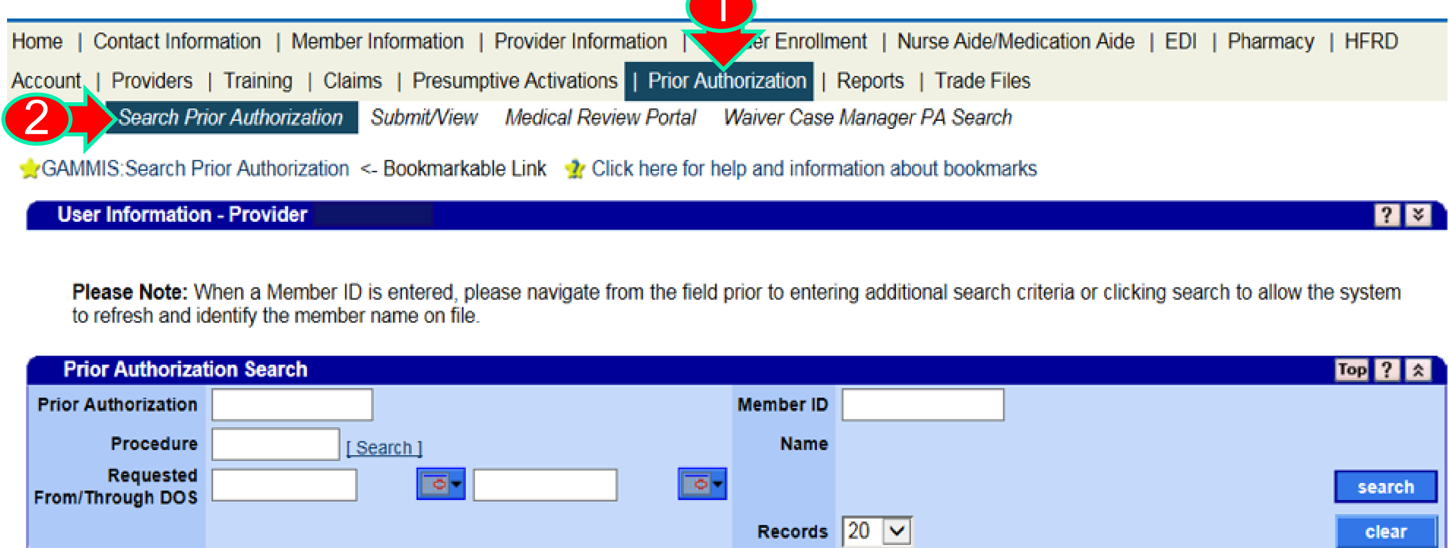


Prior Authorization Search

(continued)

Visit: www.mmis.georgia.gov

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



Search for a Prior Authorization 1 of 2 ways:

- Enter the member's prior authorization number and select search

Or

- Enter the Member ID and the requested from/through date of service and select search

Prior Authorization Search

(result example)

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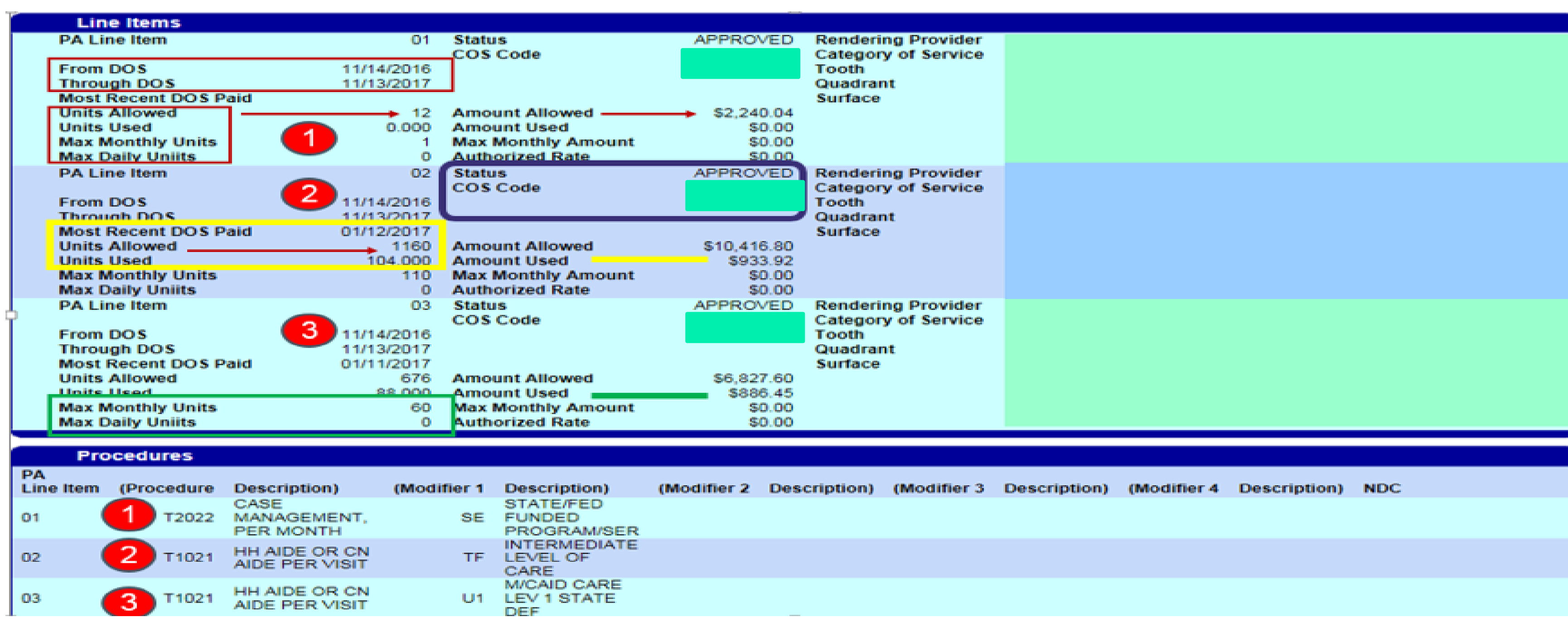
Prior Authorization Search

(continued)



Line Items

Field	Value	Field	Value	Field
PA Line Item	01	Status	APPROVED	Rendering Provider
		COS Code		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		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		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							

Acceptable Claim Types and Submissions

The provider can submit the following claim types:

- Professional – CMS 1500

Claims, Claim adjustments, and Claim resubmissions can be submitted via:

- Electronically through a clearinghouse (None PSS & CLS Services)
- Through the Georgia Medicaid Web Portal (None PSS & CLS Services)
- EVV Software (PSS and CLS claims)

Personal Support Services (PSS) or Community Living Supports (CLS) through SOURCE, CCSP, NOW, COMP, ICWP, and / or GAPP, all Electronic Visit Verification (EVV)-related claims as designated by the 21st Century Cures Act are required to include EVV information and be submitted via the State EVV solution, Netsmart software

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Rate and Unit References

- ➢Comprehensive Support Waiver Program Manual Chapters 1300 – 3600

  Appendix A – Reimbursement Rates for “COMP” Services

- ➢New Options Waiver Program Manual Chapters 1300 – 3400

  Appendix A – Reimbursement Rates for “NOW” Services

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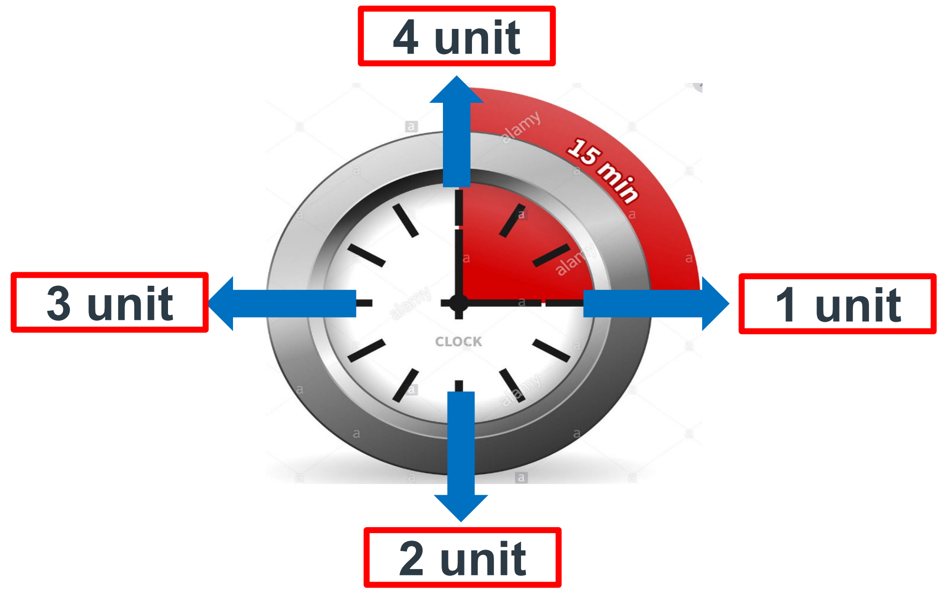
Billing and Unit Calculation Example

- **NOW/Comp Example:**

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

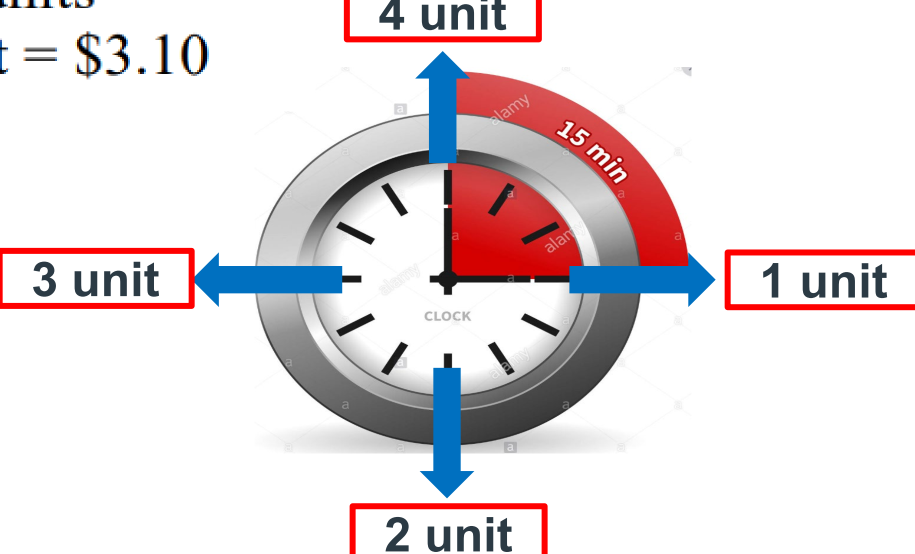


Billing and Unit Calculation Example

(continued)

Prevocational Services:

Prevocational Services (T2015)
Unit = 15 minutes
Daily Limit = 24 units
Monthly Limit = 504 units
Annual Limit = 5760 units
Maximum rate per unit = $3.10



New Professional Claim Billing Information

1

Home | Contact Information | Me[illegible] Information | Provider Information | Provider Enrollment | Nurse Aide/Medication Aide | EDI | Pharmacy | HFRD

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

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

GAMMIS:Claims <- Bookmarkable Link Click here for help and information about bookmarks

2

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

This site is for testing purposes only!

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

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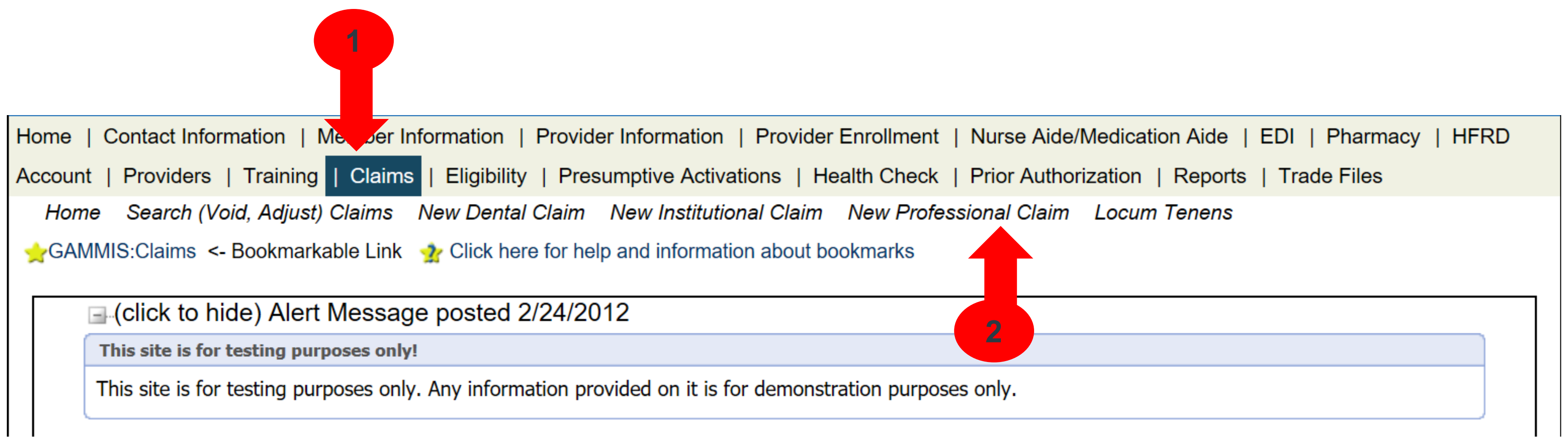
MMIS Web Claim Submissions

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

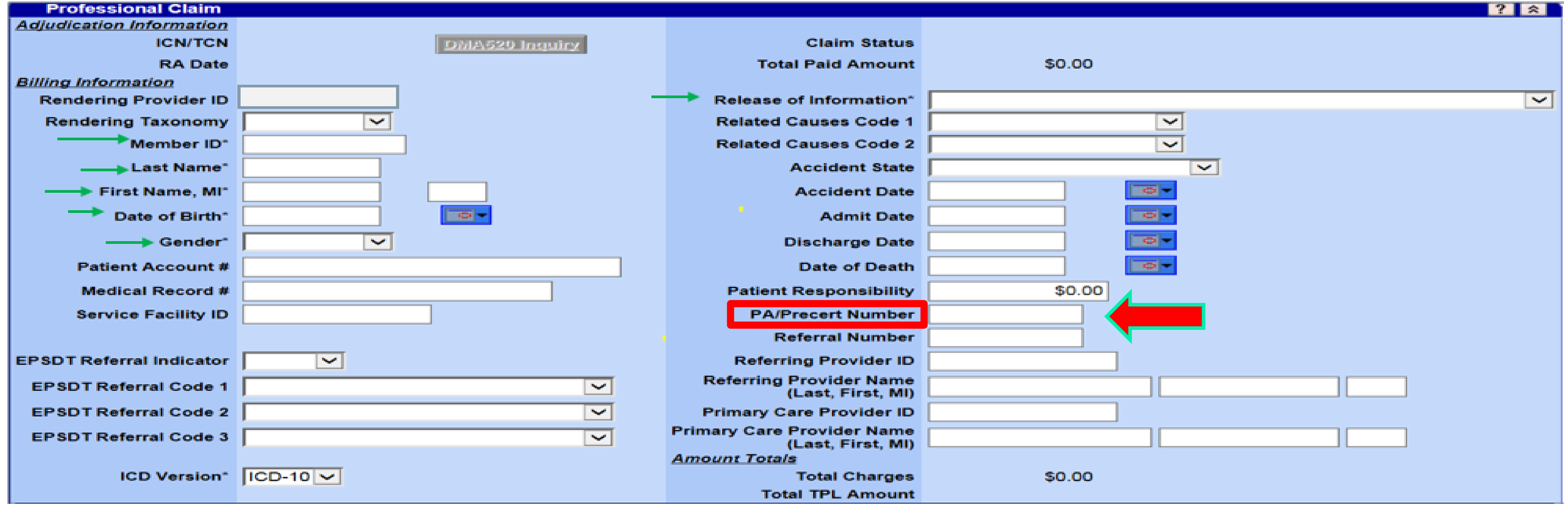
Professional Billing Information



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).



An asterisk (*) indicates required information, all other fields are optional.

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

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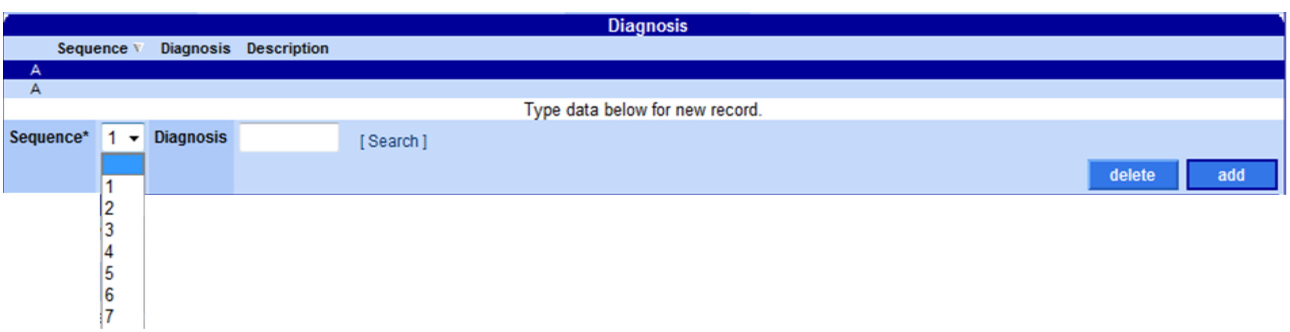
Diagnosis

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.



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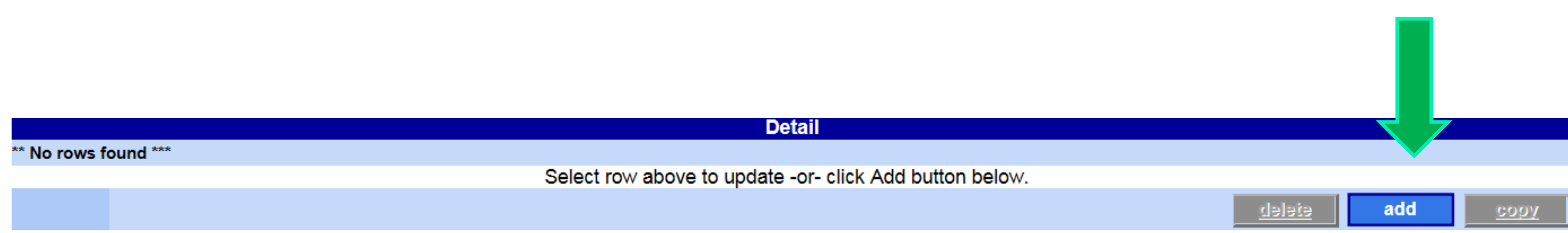
Detail



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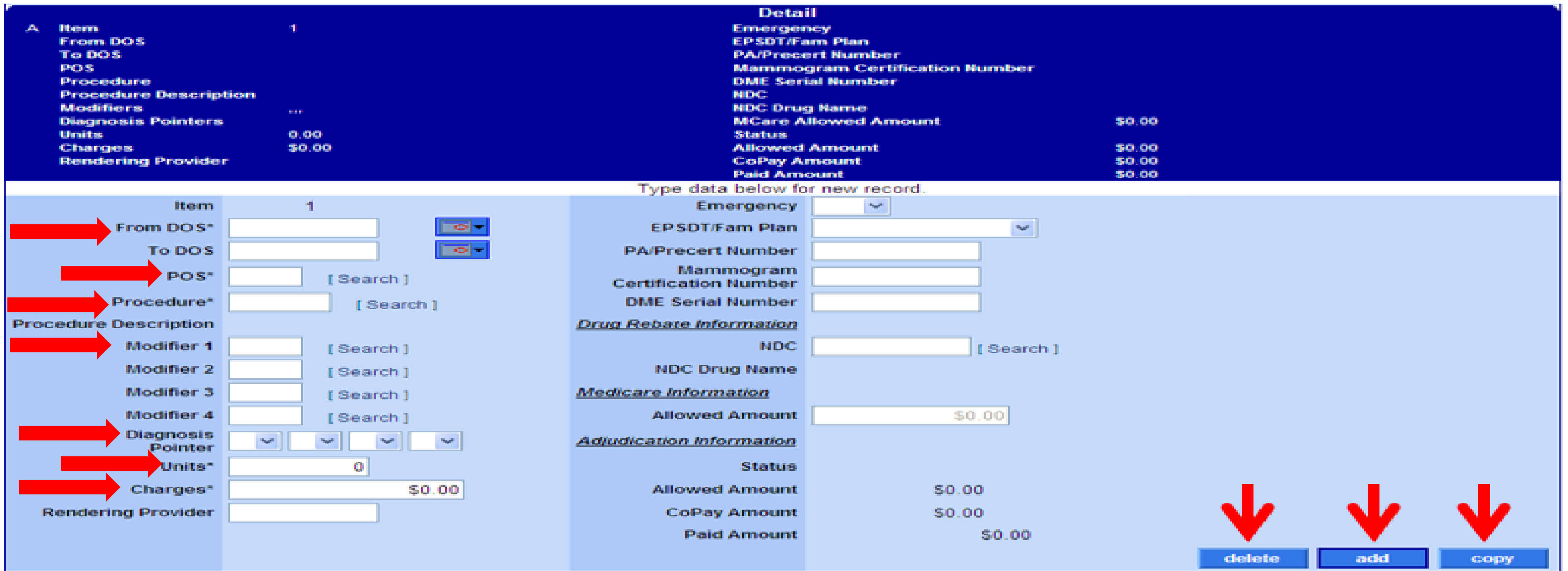
Claims Detail

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



Submit

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

Home Search (Void, Adjust) New Dental Claim New Institutional Claim New Professional Claim

(click to hide) Alert Message posted 10/1/2015

ICD-10 Is Live

If your date of service requires you to submit ICD-9 codes, select ICD-9 from the ICD Version field prior to entering any ICD-9 codes.

User Information - Provider

Provider Billing Manuals

submit cancel

Professional Claim

Adjudication Information

ICN/TCN DMA520 Inquiry

RA Date

Billing Information

Rendering Provider ID

Rendering Taxonomy

Member ID*

Last Name*

First Name, MI*

Date of Birth*

Gender*

Patient Account #

Medical Record #

Service Facility ID

EPSDT Referral Indicator

EPSDT Referral Code 1

EPSDT Referral Code 2

EPSDT Referral Code 3

ICD Version* ICD-10

Claim Status

Total Paid Amount $0.00

Release of Information*

Related Causes Code 1

Related Causes Code 2

Accident State

Accident Date

Admit Date

Discharge Date

Date of Death

Patient Responsibility $0.00

PA/Precert Number

Referral Number

Referring Provider ID

Referring Provider Name (Last, First, MI)

Primary Care Provider ID

Primary Care Provider Name (Last, First, MI)

Amount Totals

Total Charges $0.00

Total TPL Amount

Diagnosis

Internal Control Number (Claim Number)

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

22	12010	999	999
Region	**Julian Date**	**Batch**	**Sequence**
Claim Type	*Year and Day*	Internal Use Only	

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

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Claims Status

Once a claim has been processed, its status will be:

- **Paid:** Some or all services may be reimbursable.
- **Denied:** No part of the claim was found to be reimbursable.
- **Suspended:** Further processing is needed. The final determination may be dependent upon further review or receipt of additional information.

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New Claim, Not Submitted

- If the claim is new and has not been submitted, the submit and cancel buttons appear.

Provider Billing Manuals

submit cancel

Professional Claim

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

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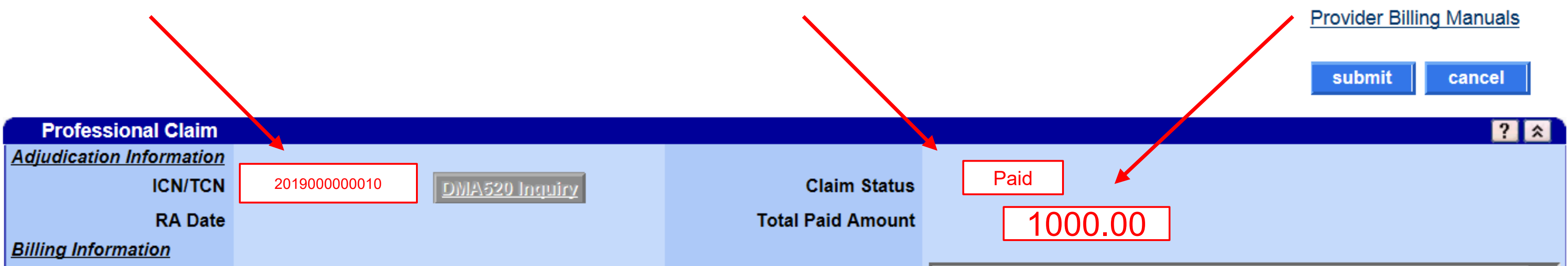
Claim Status – Top of the Claim

Claim number – Internal Control Number (ICN)

Status – Paid, Denied or Suspended

Total Paid amount



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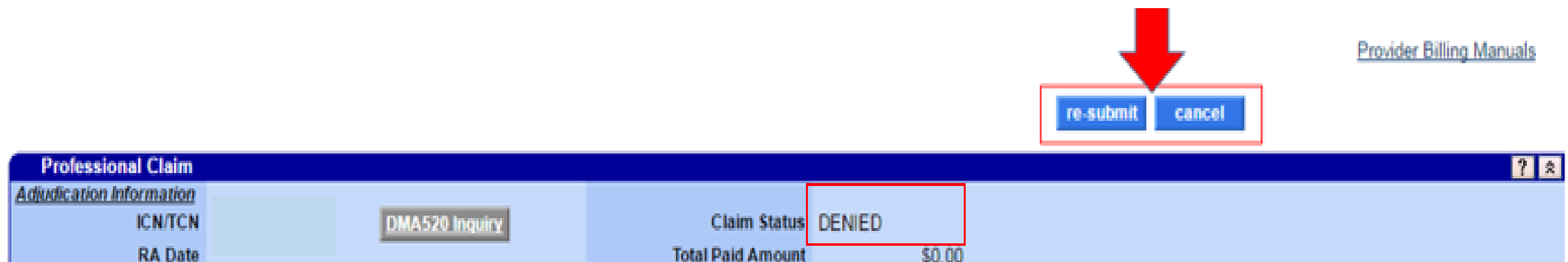
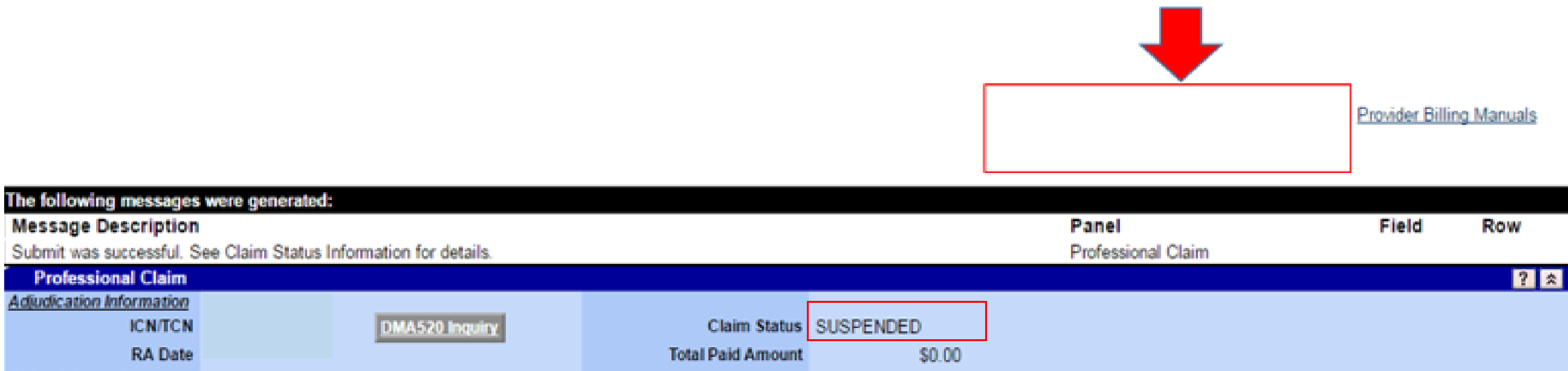
Denied Claim

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



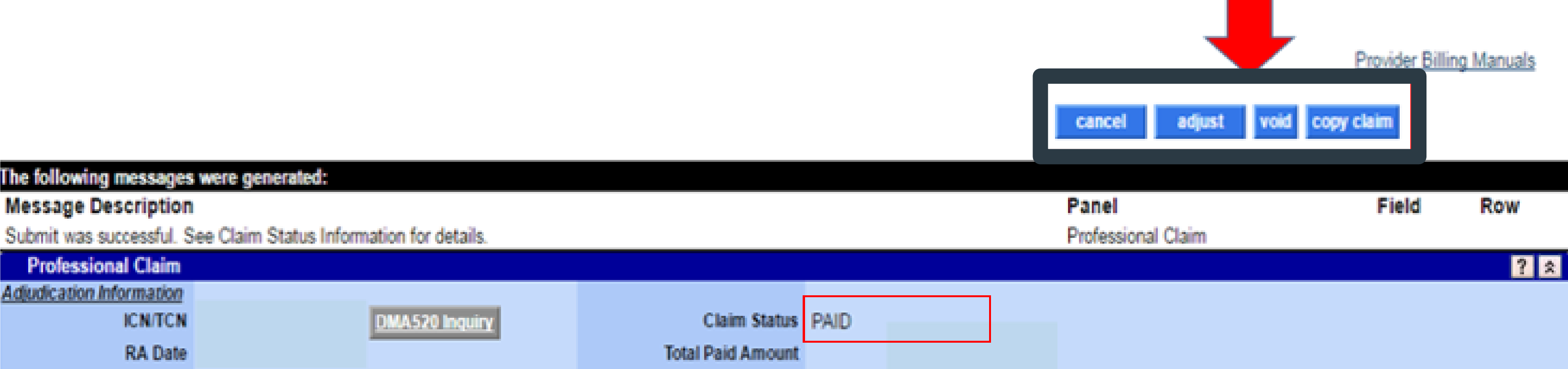
Suspended Claim

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



Paid Claim with the Adjust Option

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



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Common Denials

- 535: Adjustment exceeds timely filing period
- 3000: PA units exhausted or partially available
- 3011: DOS not within PA/Precert effective dates
- 4021: No Coverage for Billed Procedure
- 5035, 5037 or 5042: Exact Duplicate
- 5038 or 5043: Possible Duplicate
- 5044: Possible conflict (with another waiver)
- 5115: Service not allowed during hospital stay

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Claims History Research

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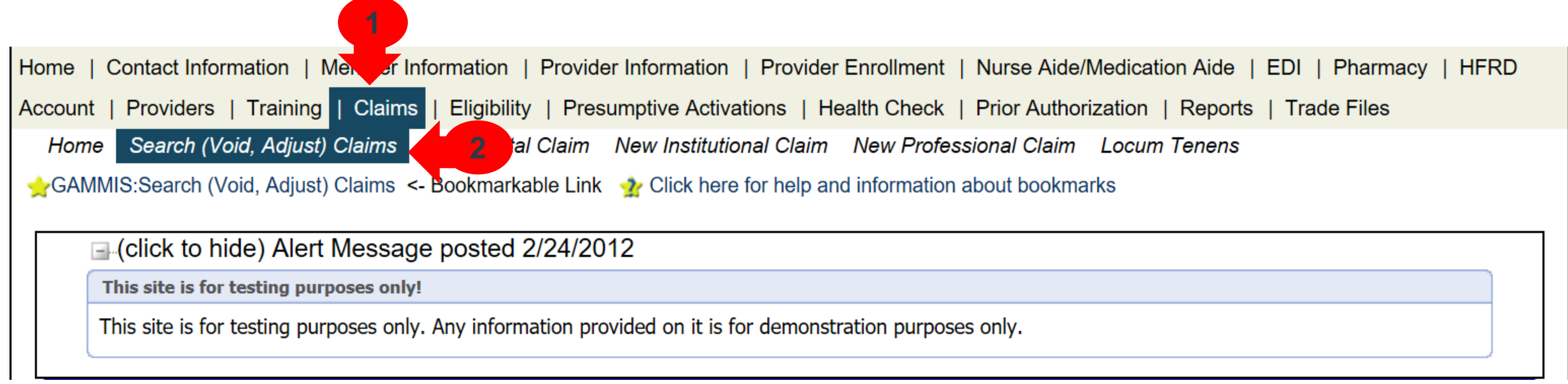
Claims History Search



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Claims History Search

(continued)

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

Claim Type = Professional

Status Type Options = Paid, Denied, Suspended

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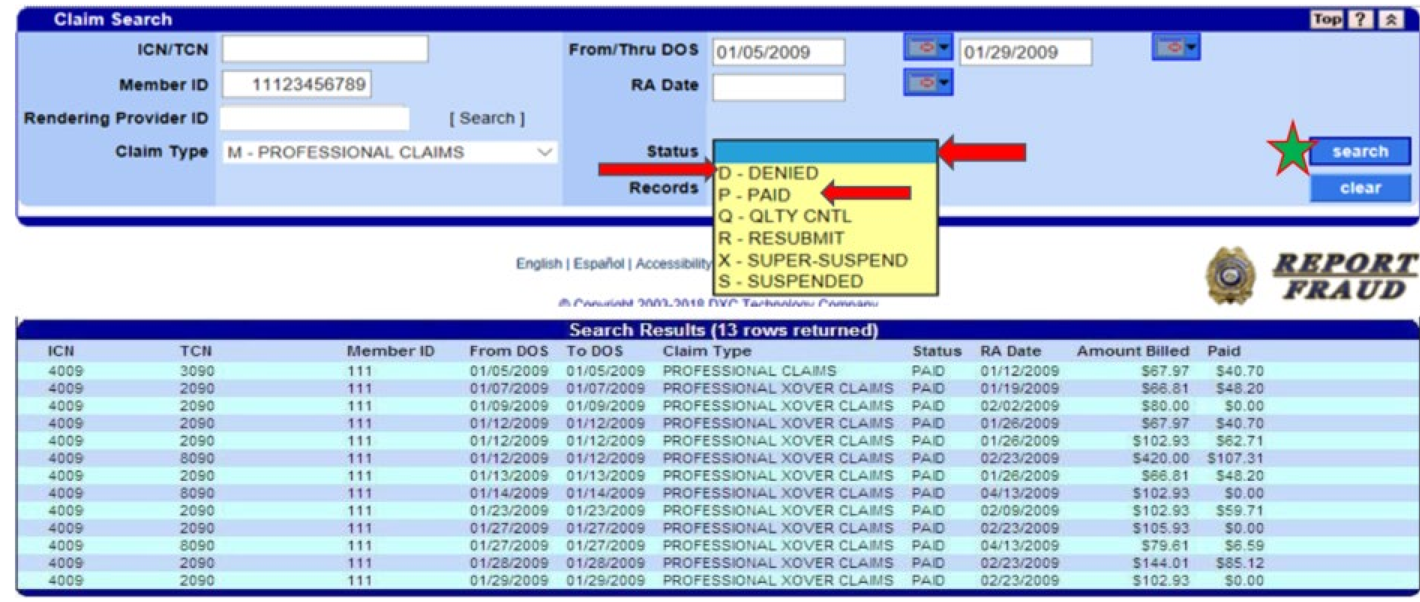
Claims History Search

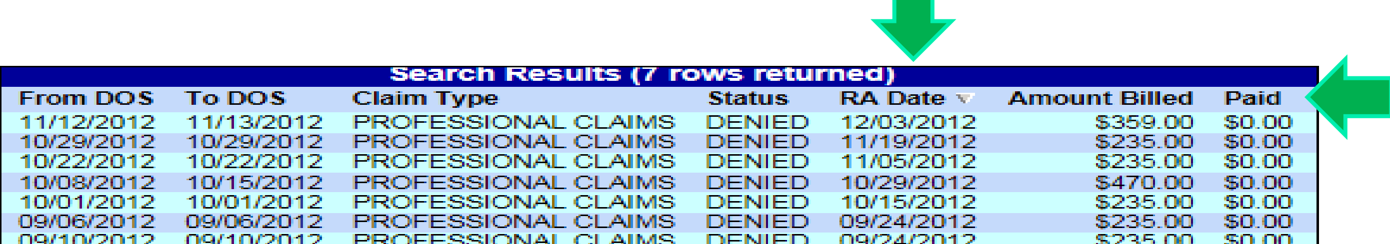
(continued)



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

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

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Claim Corrections

Search and locate your most current claim number (ICN), select it

- Move down to your **detail** line and select the line that needs to be corrected
- Make your corrections to your detail line

Example 1: if you billed 20 units and it should be 40 units, correct to 40 units and total charge

Example 2: If you billed 40 units and it should have been 20 units, correct to 20 units and total charge

- Move to the top and select **Adjust**

Note: Adjustments must be made within 90 days of paid date

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Timely Filing Rules

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

- Claim adjustment – Within three months of the month of payment
- Claim resubmission – Within three months of the month the denial occurred
- Crossover claim – Within 12 months of MOS
- Secondary/TPL claim – Within 12 months of MOS
- One year (365 days) Claims Submission Edit (NEW)

One Year (365 Days) Claim Submission Edit

Example:

DOS	Original Submit Claim **Denied Date:**	1st Resubmit **Adjustment**	2nd Adjustment **(365 days)**
July 1, 2016	December 30, 2016	March 31, 2017	June 30, 2017

- All claim submissions and adjustments to denied claims are to be completed according to policy by 365 days. Other timely submission and resubmission system edits will remain in GAMMIS according to policy (there is no time limit for adjusting a claim that reverses payment back to the Department).
- Please refer to the Georgia Medicaid Part 1 - Policies and Procedures Manual, Chapter 200. The Timely Resubmission policy outlined in Section 204 will still be enforced to include this new one year or 365 days guideline.
    - *Banner Message posted June 14, 2017

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DMA-520 Initial General Claim Denial Review

How to appeal denied claims

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DMA-520 Claim Inquiry Guidelines

- Only one DMA-520 form may be electronically submitted per inquiry. All data fields must be completed on the e-form in Georgia Medicaid Management Information System (GAMMIS).
- For new inquiries, a Contact Tracking Number (CTN) will be provided. Please use this CTN and the Claim ICN to track your appeal request.
- For previously submitted inquiries, the status will be provided along with the option to electronically upload supporting documentation. **Include ALL supporting documentation for your appeal via the CTN.**
- If the CTN status is CLOSED, you will not be able to upload supporting documentation.

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DMA-520 Commonly Reviewed Edits – Gainwell Technologies

535 ADJUSTMENT EXCEEDS TIMELY FILING PERIOD	5087 SVC BILLED INCL IN HLTH CHCK SEPARATE BILL NOT CVD.
5674 SERVICE NOT ALLOWED DURING HOSPITAL STAY	3051 PA/PRECERT HEADER STATUS IS DENIED OR SUSPENDED
607 ATTACHMENT INDICATED BUT NOT YET RECEIVED	1087 MEMBER NOT ELIGIBLE FOR NH ON DOS
1018 NO/PARTIAL PRICING SEGMENT ON FILE FOR PROVIDER	1825 ORDERING PROV NOT ACTIVE/ELIGIBLE
2505 MEMBER COVERED BY PRIVATE INSURANCE	4027 DIAGNOSIS NOT ALLOWED FOR DATE OF SERVICE
2502 MEMBER COVERED BY MEDICARE B - NO ATTACHMENT	6704 MCARE PART-B DEDUCT GREATER THAN YEARLY ALLOWABLE
5628 POSSIBLE DUPLICATE	3423 DIAGNOSIS BILLED IS NOT VALID FOR COS
1770 INPATIENT PART-B CLAIMS REQUIRE AN EOB ATTACHMENT:	4801 BILLING RULE NOT FOUND FOR THE BILLED PROCEDURE
2017 MEMBER SERVICES COVERED BY CMO PLAN:	2521 MEDICARE PART B WILL COVER SOME INPATIENT SERVICES
545/512 TIMELY FILING – HEADER	3041 PA/PRECERT LINE STATUS IS DENIED OR SUSPENDED
2003 MEMBER INELIGIBLE ON DETAIL DATE OF SERVICE	4039 DIAGNOSIS CANNOT BE USED AS PRINCIPAL DIAGNOSIS
4038 THE NATIONAL DRUG CODE IS NOT VALID FOR THE DOS:	5934 SERVICE ALLOWED IN INPATIENT SETTING ONLY

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Tips

- Bill claims within six months from the date of service. Keep up with your denials and submitted documentation.
- Research your claims denials.
- Review the Part 1 and Part 2 policy manuals and applicable fee schedules.
- Contact the Gainwell Technologies' Call Center for questions.
- Consult with your assigned Gainwell Technologies Field Representative.

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DMA-520 Documentation

Examples:

- EOBs (If Applicable)
- Claims Submissions History - Timely Filing (If Applicable)

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DMA-520 Form (Gainwell Technologies) - Initial Provider Review

- The DMA-520(s) must be submitted via the GAMMIS Web Portal at: www.mmis.georgia.gov.
- Claims must complete the payment cycle.
- Search for your denied ICN.
- Select DMA-520 and complete all required fields.
- DMA-520 appeal request must be requested within **30 days** of the claim's denial or adverse action.
- (**Blue DMA-520** Option will appear if timely)

DMA-520 – Not Appeal Eligible

Institutional Claim

Adjudication Information

ICN/TCN [DMA520 Inquiry]

Claim Status

RA Date

Total Paid Amount $0.00

Billing Information

Not Eligible for an Appeal

Rendering Provider ID	0000	Release of Information*	
Rendering Taxonomy		From Date*	
Member ID*		To Date*	
Last Name*		Admission Date	
First Name, MI*		Admission Hour	
Date of Birth*		Admission Type*	
Gender*		Admit Source	[Search]
Patient Account #		Discharge Hour	
Medical Record #		Patient Status*	[Search]
Attending Physician		PA/Precert Number	
Operating Physician		Referral Number	
Other Operating Physician		Referring Provider ID	
Service Facility ID		Referring Provider Name (Last, First, MI)	
Type of Bill*		Patient Responsibility	$0.00
Type of Bill Frequency*		*Amount Totals*	
ICD Version*	ICD-10	Total Charges	$0.00

DMA-520 - Appeal Eligible

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

Thursday, July 17, 201

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

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

Home   Search (Void, Adjust)   New Dental Claim   New Institutional Claim   New Professional Claim

User Information - Provider

Provider Billing Manuals

re-submit   cancel

Professional Claim

Adjudication Information

ICN/TCN		Claim Status	DENIED
RA Date	06/25/2014	Total Paid Amount	$0.00

DMA520 Inquiry

Billing Information

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

DMA-520 Form

(continued)

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

submit clear

DMA Claim Inquiry Form

Provider Demographic Information

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

Contact Information

The person who should be contacted regarding this inquiry.

Contact Name (Last, First)*	
Contact Phone, Ext*	
Contact E-Mail Address*	

Claim Information

See the submitted claim values below and the adjudication results.

ICN	2219000000000	Member ID	2211000000000
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR TEST MEMBER
From DOS	04/12/2019	RA Date	04/15/2019
To DOS	04/12/2019	Claim Status	DENIED

Inquiry Request

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

Claim Inquiry Reason*	
Written Explanation*	
Date of Inquiry	04/15/2019

DMA-520 Inquiry Requirements

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

- **Example:**

- Member Eligible For CMO/Retro Eligibility
- Other Inquiry Not listed
- Procedure Not Covered
- Timely Filing

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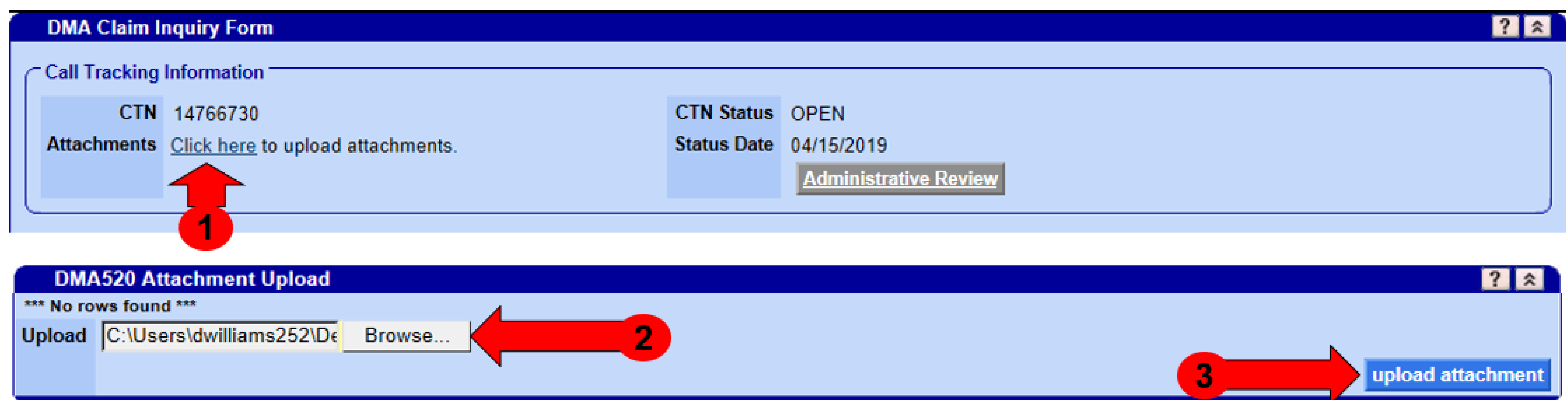
Submit DMA-520

- Submit your DMA-520
- CTN Tracking number is received
- Upload any supporting documents

DMA-520 Upload Attachments

The DMA-520 Attachment upload panel allows the user to add documents to inquiries.

1. Click here to indicate you will be submitting an attachment.
2. Select the browse button to allow you to choose a file to upload to your inquiry (file type: jpg, tif or pdf).
3. Select the upload attachment button to associated your file to the provider inquiry.



DMA-520 E-mail Notification

You will receive an e-mail from DoNotReply@gammis.com notifying you here is a response regarding the submitted DMA-520.

Georgia DCH Email Request -	
Email Link:	Click here to access the GAMMIS web portal.
From:	State of Georgia DCH
Reference Provider ID:	REF007790440
CTN:	14766730-1
Details:	This link was sent on 4/15/2019 10:32:29 AM You will need to have a valid user name and password to access the letter on the DCH website. Once authenticated on the GAMMIS Web portal, navigate to the "Reports" menu, then select "Letters". Choose the letter CTM-1934-O:PSCC Claim Status Letter from the list and click the search button. Letters are sorted by date, so select the letter with the date of 4/15/2019 . **Notice: Online letters may not be available for viewing for up to one business day.**

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DMA-520 Response Letter

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

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

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

GAMMIS:Letters <- Bookmarkable Link Click here for help a[...]mation about bookmarks

1

2

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

This site is for testing purposes only!

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

User Information - Provider

PDF Reader Required

NOTE: If you don't have a PDF reader already installed, Adobe Acrobat Reader is required to view these documents. Click here to obtain the latest version of the free Adobe Reader.

File Download Issues

Some users may have difficulty downloading files. Often this is caused by pop-up windows being blocked or by security settings in the browser. Click here for help with download issues.

Letters

Letter* CTM-1934-O: PSCC Claim Status

From Date* 01/01/2019 To Date* 04/30/2019 search

Records 20 clear

Search Results (2 rows returned)

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

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DMA-520 Response Letter

(continued)

September 27, 2021

CTM-1934-O/XX/56318291
Atlanta City Hospital
123 Peachtree Street
Atlanta, GA 30331

Attn: DMA Submitter

Re: Written Correspondence concerning claim status

CTN - QUESTION NUM: 35501408-1

Dear Provider:

Thank you for contacting Gainwell Technologies. We received your DMA-520 or written correspondence for review. Gainwell has researched the issue. The result and explanation of our findings are as follows:

Provider's Inquiry

Member Name: Patient's Name
Date(s) of Service: April 17, 2021
Billed: $2,190.00

ICN: Claim Number
The Claim Processed On: September 13, 2021
Remittance Advice: 11355856

Gainwell's Response:

- The claim date of service is past the timely filing limit. Claims with the date past the filing time need to have documentation stating reason(s) why the claim should be reconsidered for processing.
- An error occurred during the processing of the claim or additional supporting documentation as included with your inquiry. Gainwell has resubmitted the claim for processing. Please allow thirty days for the claim to be reprocessed.
- The claim was paid.
- The claim was partially paid. See explanation codes below.
- ✓ The claim was denied. See explanation codes below.
- Other.

CTM1934O 10/18

If you have any questions, please contact our Provider Services Group, open Monday through Friday, 7am to 7pm at 800-766-4456 or Member Contact Center at 1-866-211-0950 or 770-325-2331.
Out of State Providers, please call 800-766-4456.

DMA-520 Administrative Review

DCH Second Level Appeal

DMA-520 Administrative Review

(DCH – Provider Review)

2nd Level Administrative Review Inquiry Guidelines

The Department Of Community Health offers any provider the opportunity to request an administrative (2nd level) review associated with a DMA-520 Inquiry form [Claim denial for payment or proposed adverse action (i.e. untimely filing, procedure code invalid)]. It must be submitted electronically through GAMMIS at www.mmis.georgia.gov.

- Must be requested/received within 30 days of the date of the proposed adverse action notification (the blue Administrative review option will appear if timely).
- Once the status of your DMA-520 shows as "CLOSED," the option to request an Administrative/2nd Level review will appear. There is no appeal rights once the Administrative Review button is grayed out.

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Administrative Review Supporting Documentations

- EOBs (if applicable)
- Claims Submissions History – Timely Filing (if applicable)
- Member Eligibility Screen Print (if applicable)
- Member Lock in and Member update information – fax time stamp to member services (if applicable)
- EOBs from Primary (if applicable)

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2nd Level/Administrative Review

- To initiate the Administrative Review, Search for your Claim ICN and click the DMA-520 button and then the Administrative Review button.
- The information previously indicated on the DMA-520 Claim Inquiry Form will auto populate into the Administrative Review.
- Make sure the contact information is up to date.
- Add information in the Written Explanation box to explain the reason for the administrative review.
- Submit your online request and a new CTN will be assigned.
- The CTN status will be "OPEN" and you will have the option to upload supporting attachments/documentation.

- Note: The DCH does not have a time limit to respond to Administrative Reviews.

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2nd Level/Administrative Review

(continued)

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

Home Search (Void, Adjust) New Dental Claim New Institutional Claim New Professional Claim

User Information - Provider

Provider Billing Manuals

re-submit cancel

Professional Claim

Adjudication Information

ICN/TCN

DMA520 Inquiry

Claim Status DENIED

RA Date 06/25/2014

Total Paid Amount $0.00

Billing Information

Rendering Provider ID

Release of Information* Y - SIGNED STMT PERMITTING RELEASE

Rendering Taxonomy

Related Causes Code 1

Member ID*

Related Causes Code 2

Last Name*

Accident State

First Name, MI*

Accident Date

Date of Birth*

Admit Date

Gender* F - Female

Discharge Date

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2nd Level/Administrative Review

(continued)

DMA Claim Inquiry Form

Call Tracking Information

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

Provider Demographic Information

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

Contact Information

The person who should be contacted regarding this inquiry.

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

Claim Information

See the submitted claim values below and the adjudication results.

ICN	2219000000000	Member ID	2211000000000
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR TESTING
From DOS	04/11/2019	RA Date	04/15/2019
To DOS	04/11/2019	Claim Status	DENIED

Inquiry Request

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

Claim Inquiry Reason	Other Inquiry Issue Not Listed Above
Written Explanation	Please advise all details to support this inquiry.
Date of Inquiry	04/15/2019

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2nd Level/Administrative Review

(continued)

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

submit | clear

Administrative Review Form

Provider Demographic Information

Name	MEADOWS, BILL	Address 1	100 PEACHTREE STREET
Medicaid Provider ID		Address 2	
Reference Provider ID	REF007790440	City, State	TUCKER, GA
		Zip	30084-1000

Contact Information

The person who should be contacted regarding this inquiry.

Contact Name (Last, First)*

Contact Phone, Ext*

Contact E-Mail Address*

Claim Information

See the submitted claim values below and the adjudication results.

ICN	2219000000000	Member ID	2211000000000
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR TESTING
From DOS	04/11/2019	RA Date	04/15/2019
To DOS	04/11/2019	Claim Status	DENIED

Inquiry Request

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

Written Explanation*

Date of Inquiry 04/15/2019

Update/Validate Contact and Explanation

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2nd Level/Administrative Review

(continued)

The following messages were generated:

Message Description	Panel	Field Row
Your request has been accepted for processing. Your tracking number is 14766733. To review the status of this request, pull up the ICN, select DMA520 Inquiry and then Administrative Review. Once the request has been processed, you will receive an email notifying you that there is a letter available with the response of this request.	Administrative Review Form	

Administrative Review Form

Call Tracking Information

CTN	14766733	CTN Status	OPEN
Attachments	Click here to upload attachments.	Status Date	04/15/2019

Provider Demographic Information

Name	MEADOWS, BILL	Address 1	100 PEACHTREE STREET
Medicaid Provider ID	007106015A	Address 2	
Reference Provider ID	REF007790440	City, State	TUCKER, GA
		Zip	30084-1000

Contact Information

The person who should be contacted regarding this inquiry.

Contact Name (Last, First)	DXC	TECHNOLOGY
Contact Phone, Ext	(800)766-4456	
Contact E-Mail Address	providerrelations.fieldservices@dxc.com	

Claim Information

See the submitted claim values below and the adjudication results.

ICN	2219101000001	Member ID	222116845092
Claim Type	PROFESSIONAL CLAIMS	Member Name (Last, First)	MEDICAID FAIR TESTING
From DOS	04/11/2019	RA Date	04/15/2019
To DOS	04/11/2019	Claim Status	DENIED

Inquiry Request

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

Written Explanation	Please enter as much information to help support your appeal.
Date of Inquiry	04/15/2019

2nd Level/Administrative Review

(continued)

Upload ALL supporting documentation that is applicable to the request for Administrative Review.

2nd Level/Administrative Review Status

- To review the status of your request, search for your Denied ICN, select DMA-520 Inquiry and then select Administrative Review.
- Once your request has been processed, you will receive an e-mail notifying you that there is a letter with the response for the request.

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DMA-520 Inquiry Requirements

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

- **Example:**

- Member Eligible For CMO/Retro Eligibility
- Other Inquiry Not listed
- Procedure Not Covered
- Timely Filing

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Administrative Law Hearing

Administrative Law Hearing

(continued)

- Whenever the opportunity for Administrative Review is available to the provider, the Administrative Review process must be completed for the provider to be entitled to a hearing. Issues at hearings are limited to those issues that have been reviewed/addressed through the Administrative Review process.

- A request for a hearing must be in writing and received by the Administrative Review division within 15 business days after the date the provider received the decision from the division.

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Administrative Law Hearing

(continued)

The Request for Hearing must include the following information:

1. A clear expression by the provider or authorized representative that he/she wishes to present his/her case to an Administrative Law hearing. Identification of the adverse Administrative Review decision or other division action being appealed and all issues that will be addressed at hearing. Issues at hearing are limited to those issues that have been submitted for Administrative review.
2. A copy of the Adverse Action Letter, Administrative Review Response, or Final Denial Notice.
3. A specific statement of why the provider believes the Administrative Review decision or other Division action is wrong.
4. A statement of the relief sought.

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Administrative Law Hearing
(continued)

- **Request for hearing must be sent to:**

Georgia Department of Community Health Legal Services Section

40th Floor, 2 Peachtree Street, NW

Atlanta, GA 30303-3159

Part I Policy Section: 506 Medicaid/PeachCare for Kids Provider Administrative Law Hearing

References

- Part I Policies and Procedures for Medicaid/PeachCare for Kids® Manual; Chapter 500 for the policies on Appeals.
- Provider Notices, Provider Messages and quarterly Provider manual updates
- DCH iNewsletter at www.dch.Georgia.gov/publications

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Claim Supporting Documentation Attachment Codes

Attachment Code	Description
03	Report Justifying Treatment Beyond Utilization Guidelines
04	Drugs Administered
05	Treatment Diagnosis
06	initial assessment
07	Functional Goals
08	Plan of Treatment
09	Progress Report
10	Continued Treatment
11	Chemical Analysis
13	Certified Test Report
15	Justification for Admission
21	Recovery Plan
77	Completed Referrral Form
A3	Allergies/Sensitivities Document
A4	Autopsy Report
AM	Ambulance Certification
AS	Admission Summary
B2	Prescription
B3	Physician Order
B4	Hospice Referral Form - Medical Review
BR	Benchmark Testing Results
BS	Baseline
BT	Blanket Test Results
CB	Chiropractic Justification
CK	Consent Form(s)
CT	Certfication
D2	Drug Profile Document
DA	Dental Models
DB	Durable Medical Equipment Prescription
DG	Diagnostic Report
DJ	Discharge Monitoring Report
DS	Discharge Summary
EB	EOB (Coordination of Benefits or Medicare Secondary Payor)
HC	Health Certificate
HR	Health Clinic Records

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Attachment Code	Description
I5	Immunization Record
IR	State School Immunization Records
LA	Laboratory Results
M1	Medical Record Attachment
MT	Models
NN	Nursing Notes
OB	Operative Note
OC	Oxygen Content Averaging Report
OD	Orders and Treatments Document
OE	Objective Physical Examination (including vital signs) Document
OX	Oxygen Therapy Certification
OZ	Support Data for Claim
P4	Pathology Report
P5	Patient Medical History Document
P6	Periodontal Charts
PE	Parenteral or Enteral Certification
PN	Physical Therapy Notes
PO	Prosthetics or Orthotic Certification
PQ	Paramedical Results
PY	Physician's Report
PZ	Physical Therapy Certification
RB	Radiology Films
RR	Radiology Reports
RT	Report of Tests and Analysis Report
RX	Renewable Oxygen Content Averaging Report
SG	Symptoms Document
V5	Death Notification
XP	Photographs

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DMA-520/Administrative Review Timelines

General Claim Appeal ->	DMA-520 -> Administrative Review -> Administrative Law Hearing	Time Frames
Claim Denys	General Claim Denial	
Step 1	Correct Claim via the MMIS Web Portal, Check with the Call Center/Field Services Rep.	
Step 2	Submit DMA-520 via your denied claim on the MMIS Web Portal	within 30 days of your claim denial date
GWT - MMIS Response	DMA-520 Denial Letter is Returned	worked within 72 business hours
Step 3	Submit an Administrative Review via your denied claim on the MMIS Web Portal by selecting DMA-520	within 30 days from the DMA-520 denial letter
DCH Response	Administrative Review decision letter (if denied, can request an Admin. Law Hearing)	No time frames
Step 4	Administrative Law Hearing (Must include DMA-520 & Administrative Review Denial Letter and may include any and all supporting documentation	Request must be submitted within 15 days from the Administrative Review denial letter

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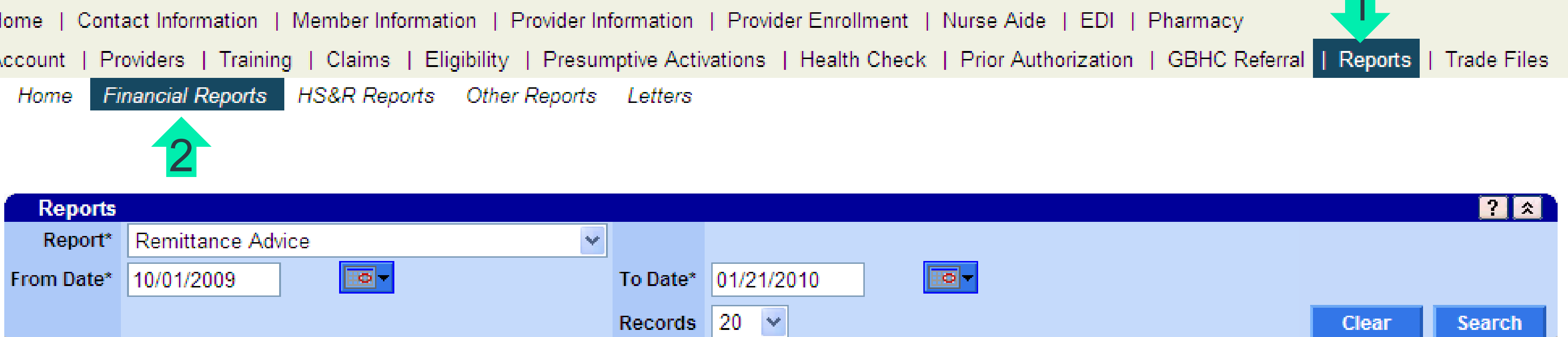
Accessing the Remittance Advice

Accessing the Remittance Advice

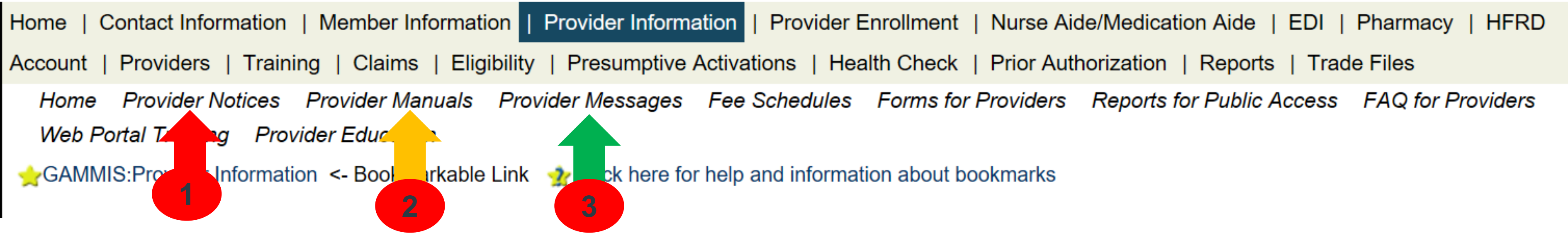
- Select **Report**, then **Financial Reports** from the menu. Next, select **Remittance Advice** from the Report drop down menu.
- Enter the date span
- Click Search



- For a full comprehensive Remittance Advice with all details, please access using your Payee ID Account info. For help, contact EDI at: 1-877-261-8785 or speak to your local Field services rep for assist.

Policy Information

Policy Information and Updates



Provider Information and Provider Notices

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

Account | Providers | Training | Claims | Eligibili... alth Check | Prior Authorization | Reports | Trade Files

Home *Provider Notices* *Provider Manuals* ... *Forms for Providers* *Reports for Public Access* *FAQ for Providers*

Web Portal Training *Provider Education*

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

GAMMIS:Provider Messages <- Bookmarkable Link ... on about bookmarks

User Information - Provider

Banner Messages

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

Messages Search Panel

Keyword

Year

Provider Type

Records 20

search

clear

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Provider Information and Provider Manuals

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

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Provider Notices
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Home *Provider Notices* *Provider Manuals* ... *Forms for Providers* *Reports for Public Access* *FAQ for Providers*
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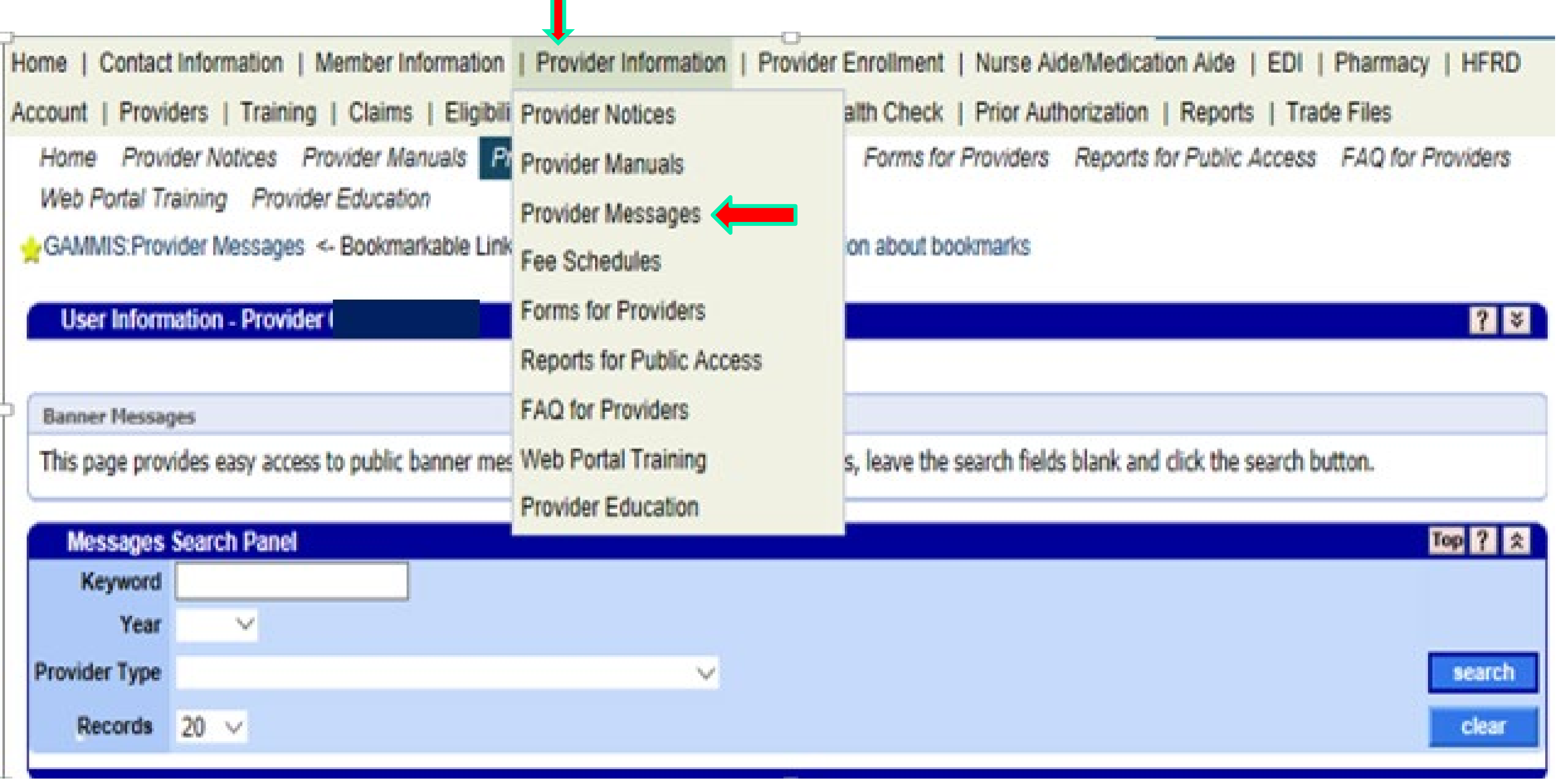
Provider Information and Provider Messages



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Provider Information and Provider Messages

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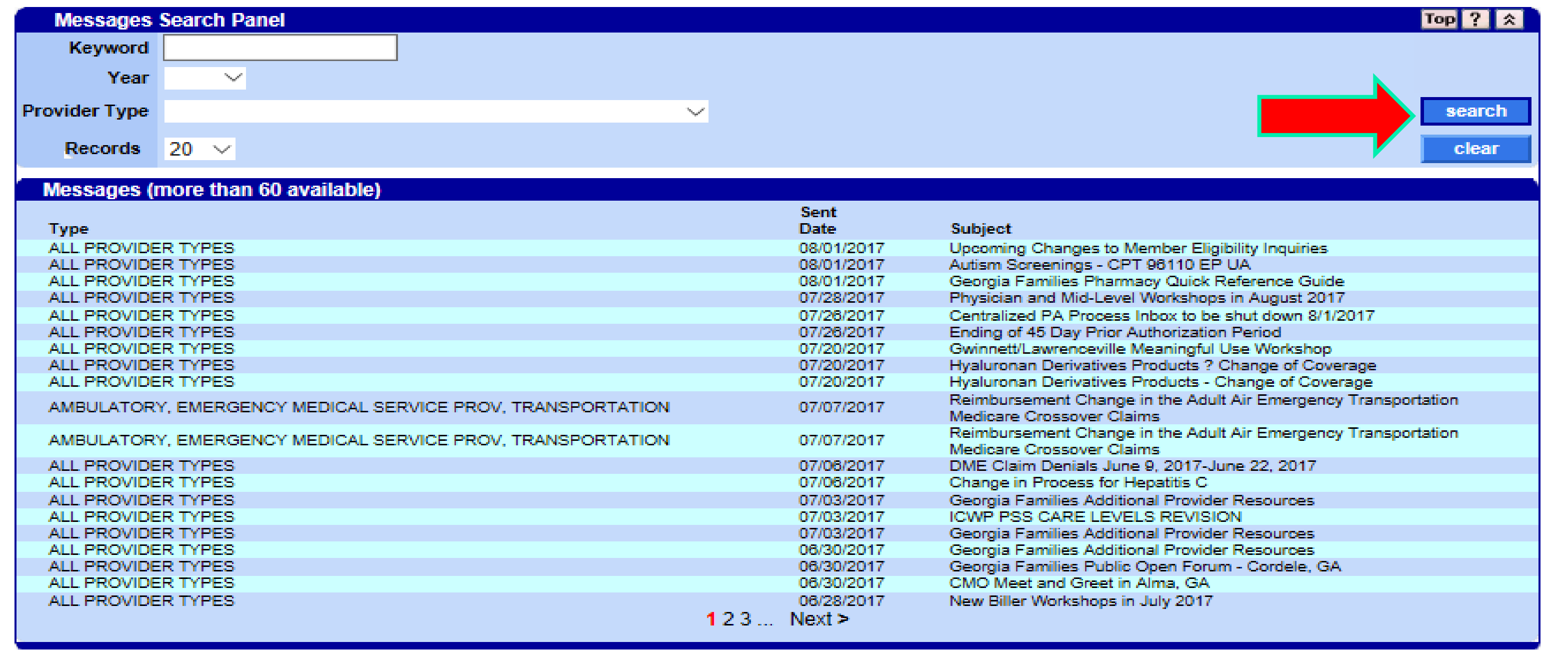

Messages Search Panel

Keyword:
Year:
Provider Type:
Records: 20

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Messages (more than 60 available)

Type	Sent Date	Subject
ALL PROVIDER TYPES	08/01/2017	Upcoming Changes to Member Eligibility Inquiries
ALL PROVIDER TYPES	08/01/2017	Autism Screenings - CPT 96110 EP UA
ALL PROVIDER TYPES	08/01/2017	Georgia Families Pharmacy Quick Reference Guide
ALL PROVIDER TYPES	07/28/2017	Physician and Mid-Level Workshops in August 2017
ALL PROVIDER TYPES	07/26/2017	Centralized PA Process Inbox to be shut down 8/1/2017
ALL PROVIDER TYPES	07/26/2017	Ending of 45 Day Prior Authorization Period
ALL PROVIDER TYPES	07/20/2017	Gwinnett/Lawrenceville Meaningful Use Workshop
ALL PROVIDER TYPES	07/20/2017	Hyaluronan Derivatives Products ? Change of Coverage
ALL PROVIDER TYPES	07/20/2017	Hyaluronan Derivatives Products - Change of Coverage
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/07/2017	Reimbursement Change in the Adult Air Emergency Transportation Medicare Crossover Claims
AMBULATORY, EMERGENCY MEDICAL SERVICE PROV, TRANSPORTATION	07/07/2017	Reimbursement Change in the Adult Air Emergency Transportation Medicare Crossover Claims
ALL PROVIDER TYPES	07/06/2017	DME Claim Denials June 9, 2017-June 22, 2017
ALL PROVIDER TYPES	07/06/2017	Change in Process for Hepatitis C
ALL PROVIDER TYPES	07/03/2017	Georgia Families Additional Provider Resources
ALL PROVIDER TYPES	07/03/2017	ICWP PSS CARE LEVELS REVISION
ALL PROVIDER TYPES	07/03/2017	Georgia Families Additional Provider Resources
ALL PROVIDER TYPES	06/30/2017	Georgia Families Additional Provider Resources
ALL PROVIDER TYPES	06/30/2017	Georgia Families Public Open Forum - Cordele, GA
ALL PROVIDER TYPES	06/30/2017	CMO Meet and Greet in Alma, GA
ALL PROVIDER TYPES	06/28/2017	New Biller Workshops in July 2017

1 2 3 ... Next >

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IVRS Overview

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

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

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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

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Provider Relations Field Services

(continued)

State-Wide Consultants

Brenda Hulette

Danny Williams

Sharée C. Daniels

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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

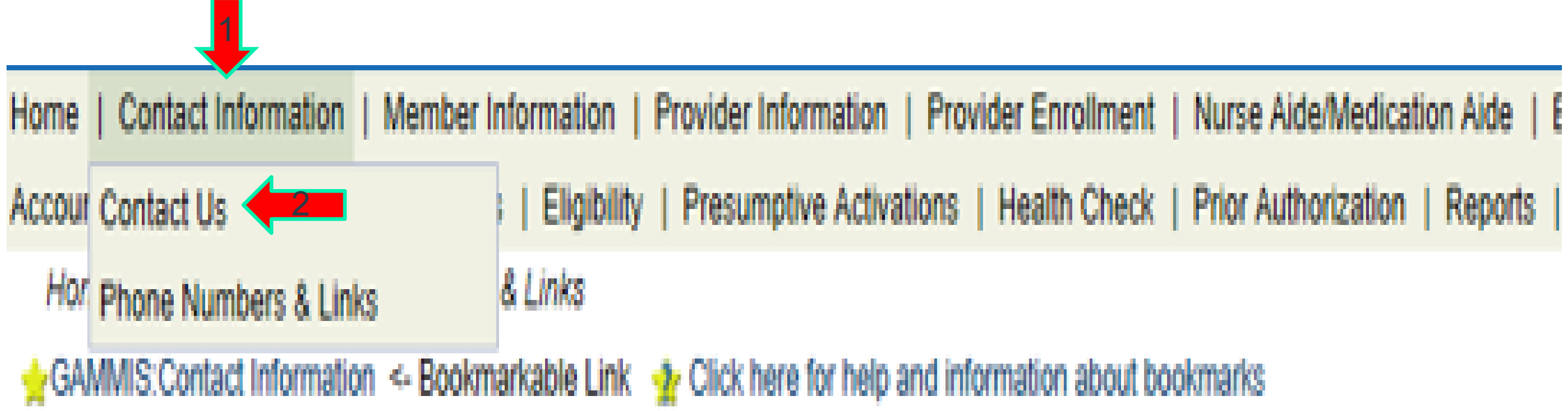
Territory 10: South GA
Atkinson, Baker, Ben Hill, Barrien, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Seminole, Thomas, Tift, Turner, Worth

Territory 11 State Wide
Hospital Field Representative

080_291_07_1206

Contact My Provider Rep Directly

Login to the MMIS system with your username and password



Contact My Provider Rep Directly

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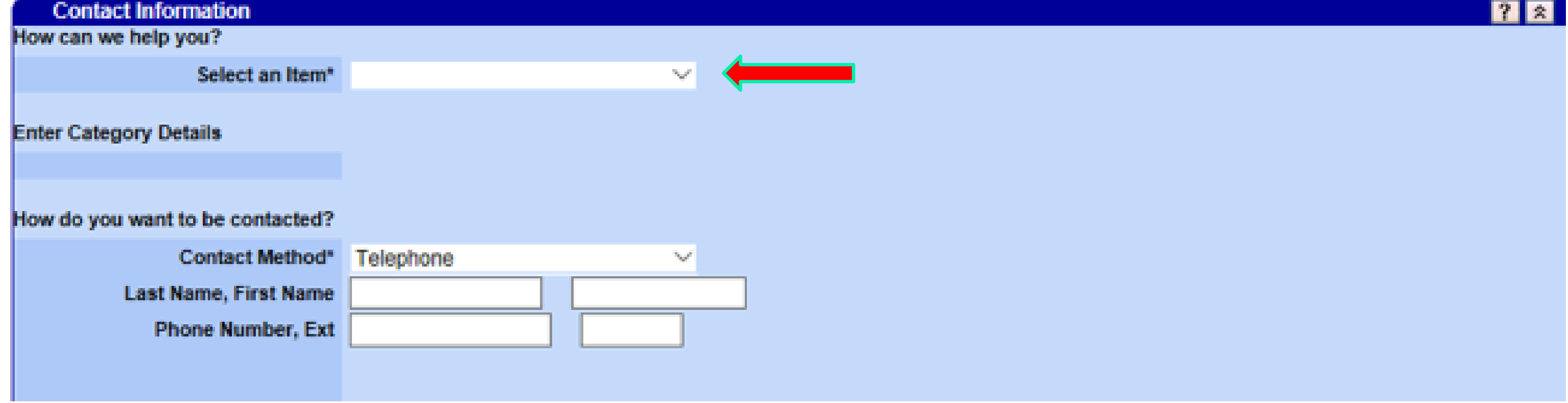

Contact My Provider Rep Directly

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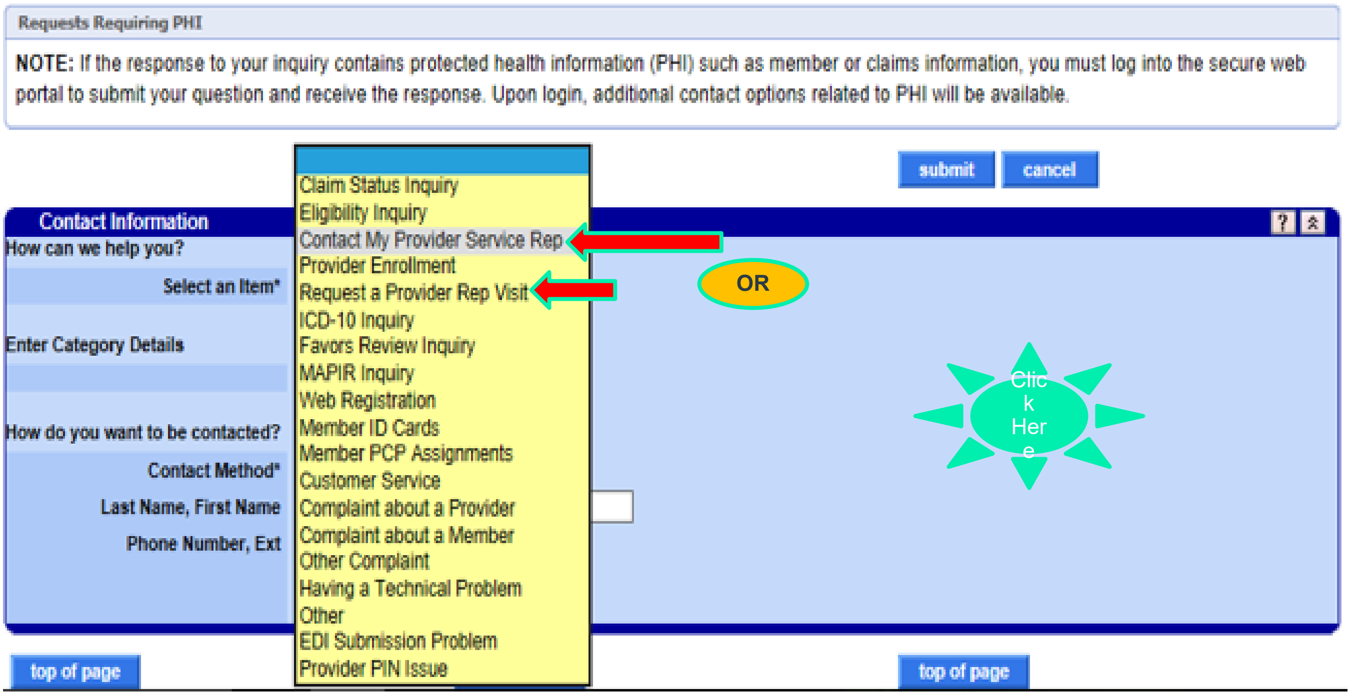

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Contact My Provider Rep Directly

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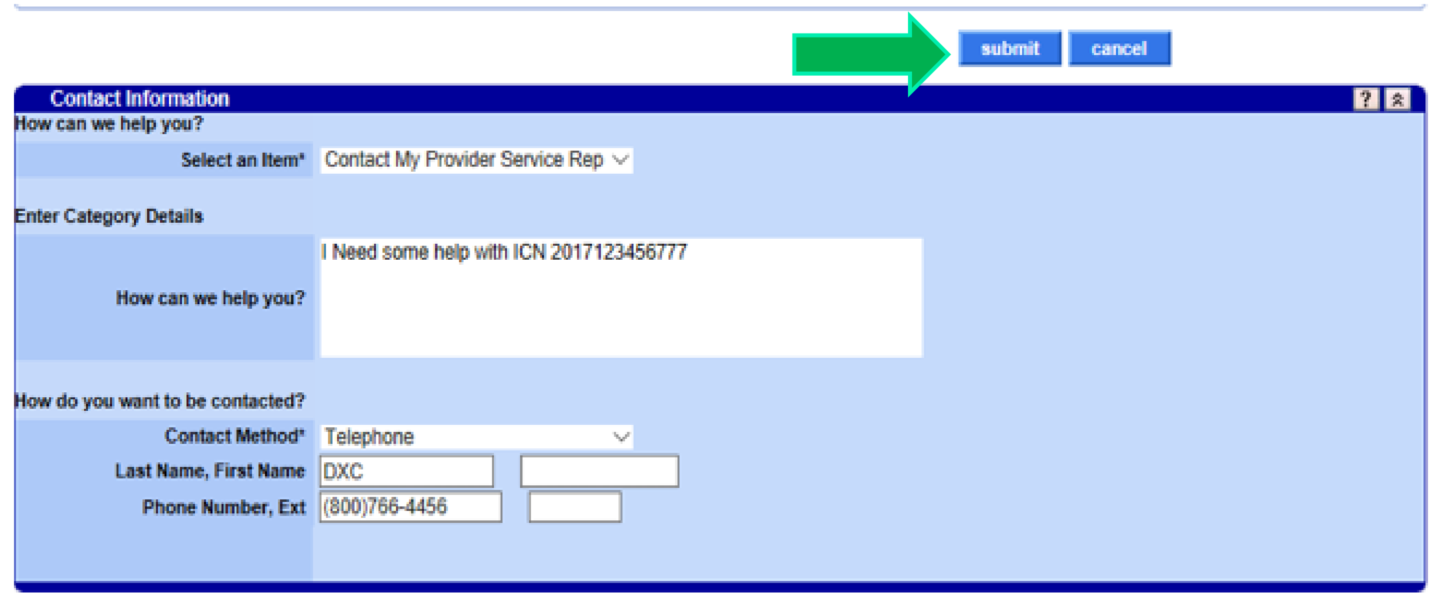

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Session Review

You should now be able to:

- Utilize the GAMMIS
- Understand timely filing policy
- How to submit a Claim Appeal
- Access the Remittance Advice
- Understand how to obtain Policy Information and Updates
- Contact Gainwell Technologies about information concerning Georgia Medicaid

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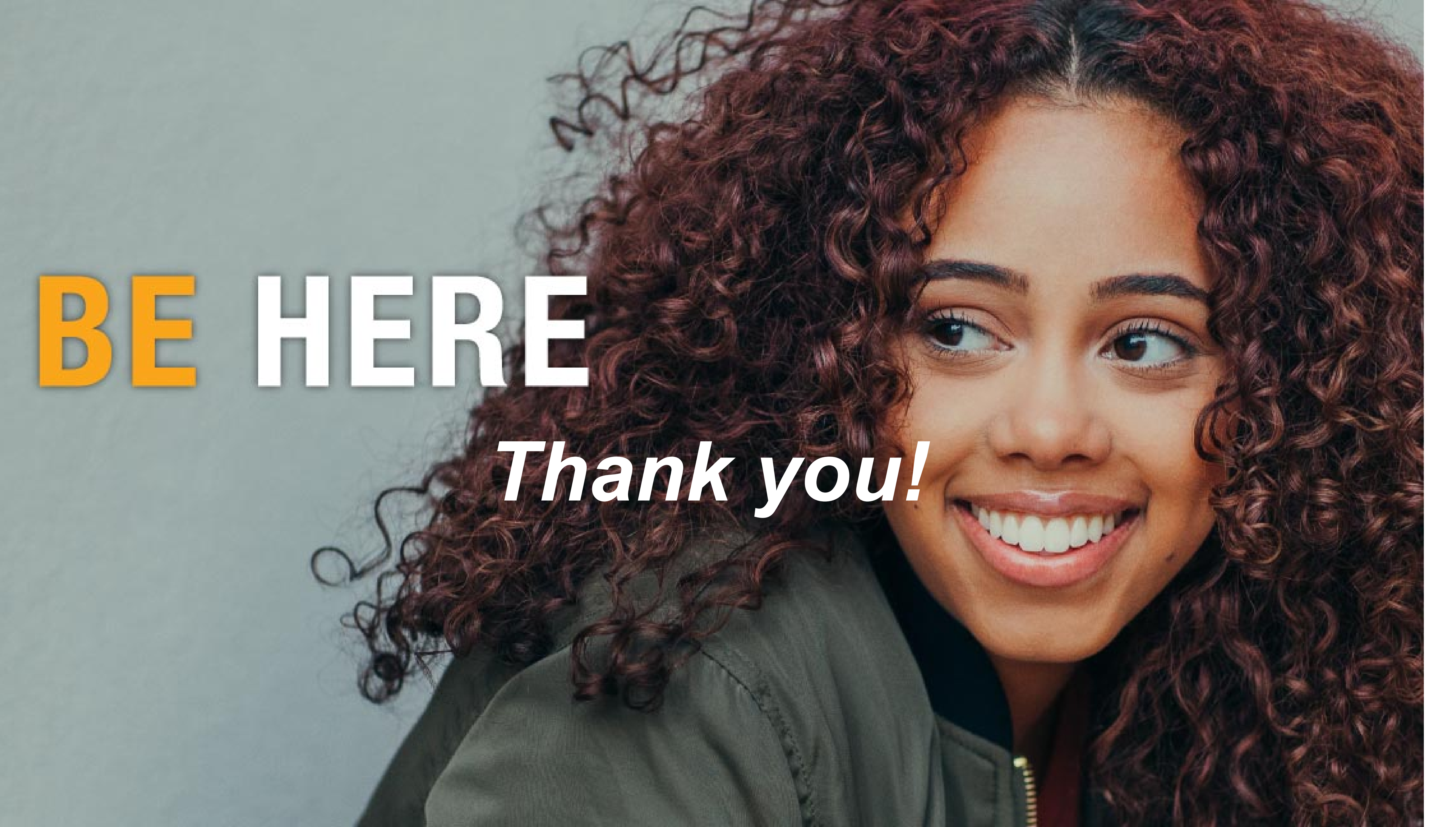
Thank you

Closing

Questions & Answers

Contact
brand@gainwelltechnologies.com
gainwelltechnologies.com

Gainwell Technologies
1775 Tysons Blvd.
McLean, VA 22102


BE HERE
Thank you!

Provider Q & A

BE D·B·H·D·D

Georgia Department of Behavioral Health & Developmental Disabilities

Next Quarterly All-State IDD Provider Meeting scheduled for November 10, 2022