Hospital Services

For access to this presentation, please visit: www.mmis.georgia.gov -> Provider Information -> Provider Notices and select “ Hospital Services Workshop August 2021

Georgia Department of Community Health

gainwell

Agenda

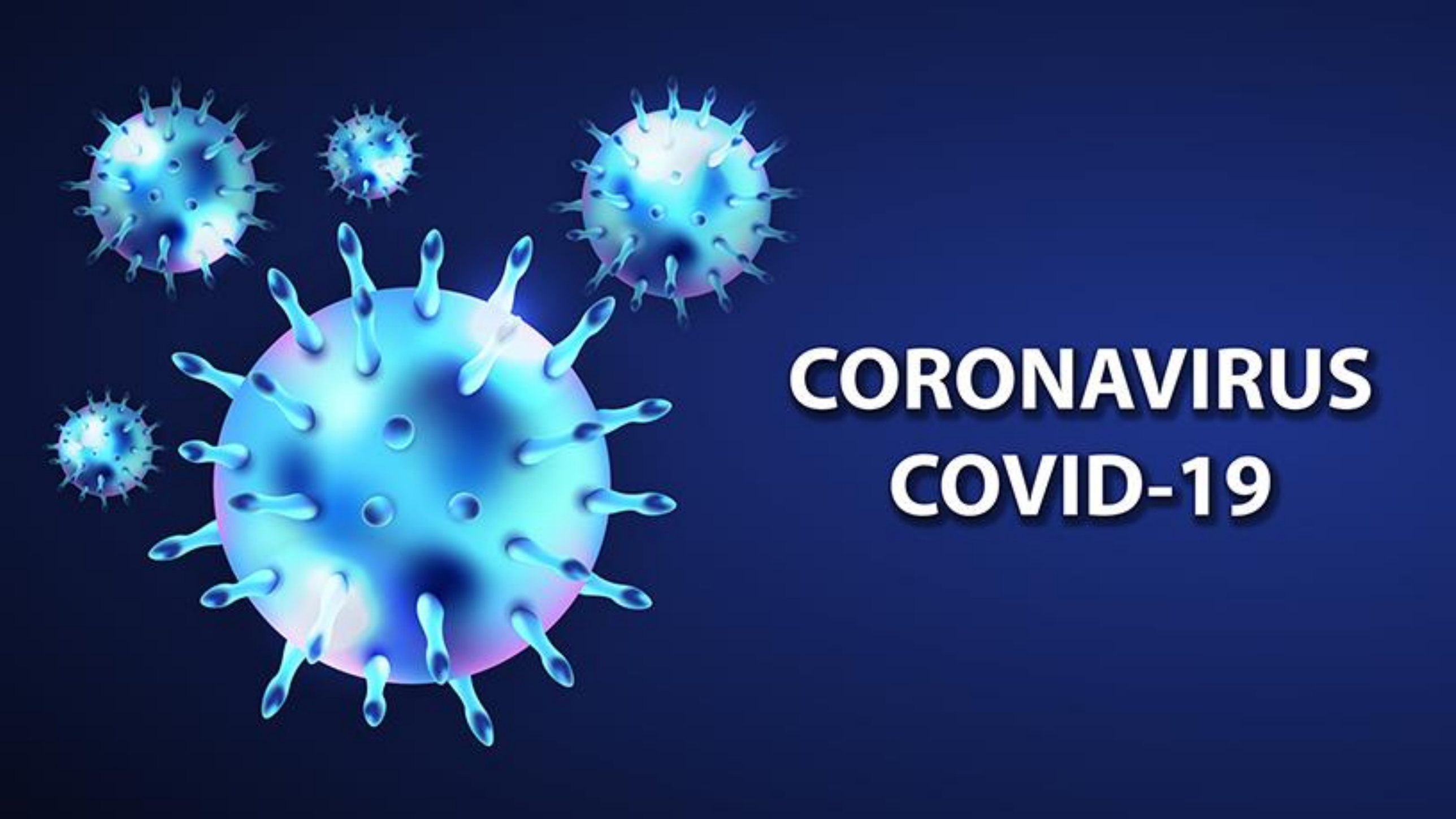
- COVID-19 Diagnosis
- COVID-19 ICD-10 Procedure
- COVID-19 HCPCS Codes
- Attachment Codes
- Duplicate Revenue Codes
- Appeals Submission
- Timely Filing
- DMA-501

Mission

The Georgia Department of Community Health

We will provide Georgians with access to affordable, quality health care through effective planning, purchasing, and oversight.

We are dedicated to A Healthy Georgia.


CORONAVIRUS
COVID-19

Coronavirus COVID-19

The National Health Emergency was enacted on March 13, 2020 as a result of Acute Respiratory Syndrome (SARS-CoV-2) commonly known as COVID-19 or Coronavirus.

COVID-19 Diagnosis Codes

(*continued)*

Message

Type	ALL PROVIDER TYPES
Subject	ICD-10-CM COVID-19 Diagnosis Codes

Message

Dear Providers,

The Department of Community Health is updating the Georgia Medicaid Management Information System (GAMMIS), with the following new ICD-10-CM COVID-19 diagnosis codes: Z11.52, Z20.822, Z86.16, M35.81, M35.89, and J12.82. The codes will be opened on March 4, 2021 with an effective date of January 1, 2021.

This notification is to inform providers that have submitted claims with the new COVID-19 diagnosis codes that they will receive a notice of claim denial (edit 4410 – Secondary Diagnosis Invalid Returned From Grouper) until the codes are opened on March 4, 2021.

The Department of Community Health will automatically reprocess any claims with dates of service from January 1, 2021 through March 3, 2021, for the new ICD-10-CM COVID-19 diagnosis codes identified above, that denied with edit code 4410. All claims will be reprocessed by March 31, 2021.

Providers may bill the new ICD-10-CM COVID-19 diagnosis codes starting on March 4, 2021.

Thank you for your patience during the implementation of the new ICD-10-CM COVID-19 diagnosis codes. We will provide updates as soon as possible.

Effective Date	02/26/2021
Sent Date	02/26/2021

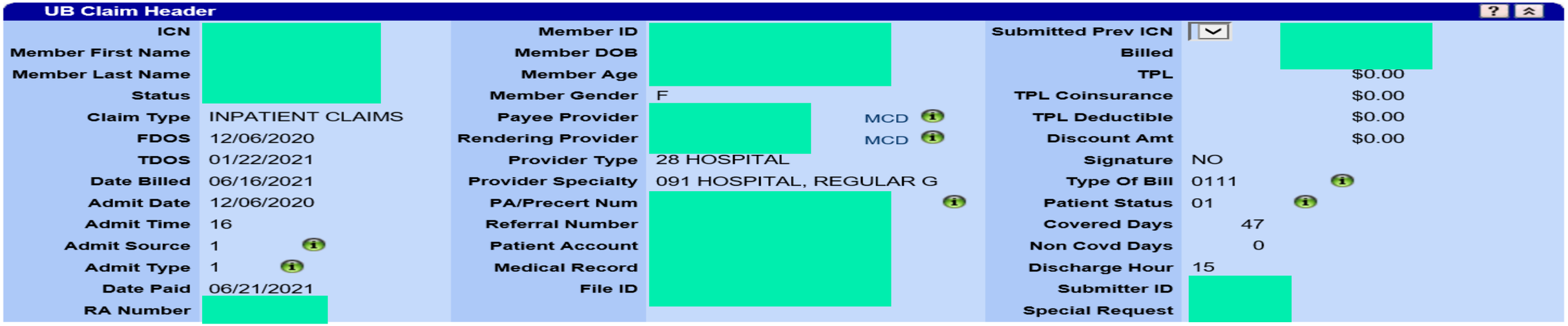
COVID-19 Diagnosis Codes

(*continued)*

EDIT: 2925/4410

DESCRIPTION: DIAGNOSIS NOT COVERED FOR DOS

This edit is triggered when providers submit claims outside of the effective date of the diagnosis.



UB Claim Header

ICN		Member ID			Submitted Prev ICN		
Member First Name		Member DOB			Billed		
Member Last Name		Member Age			TPL		$0.00
Status		Member Gender	F		TPL Coinsurance		$0.00
Claim Type	INPATIENT CLAIMS	Payee Provider		MCD	TPL Deductible		$0.00
FDOS	12/06/2020	Rendering Provider		MCD	Discount Amt		$0.00
TDOS	01/22/2021	Provider Type	28 HOSPITAL		Signature	NO	
Date Billed	06/16/2021	Provider Specialty	091 HOSPITAL, REGULAR G		Type Of Bill	0111	
Admit Date	12/06/2020	PA/Precert Num			Patient Status	01	
Admit Time	16	Referral Number			Covered Days	47	
Admit Source	1	Patient Account			Non Covd Days	0	
Admit Type	1	Medical Record			Discharge Hour	15	
Date Paid	06/21/2021	File ID			Submitter ID		
RA Number					Special Request		

Method of Correction: Diagnosis codes must be effective on the date of admission. Providers are to verify if the diagnosis codes are covered on the admit date.

COVID-19 Diagnosis Codes

(*continued)*

Claim Diagnosis

Seq Code	Diagnosis Code	ICD	Description	Qualifier	POA
1	I63.512	ICD-10	CEREB INFRC D/T UNSP OCCLS OR STENOS OF LEFT MID CEREB ART	ABK	Y - Yes
10	I10	ICD-10	ESSENTIAL (PRIMARY) HYPERTENSION	ABF	Y - Yes
11	I48.91	ICD-10	UNSPECIFIED ATRIAL FIBRILLATION	ABF	Y - Yes
12	R47.01	ICD-10	APHASIA	ABF	Y - Yes
13	R29.810	ICD-10	FACIAL WEAKNESS	ABF	Y - Yes
14	I82.461	ICD-10	ACUTE EMBOLISM AND THROMBOSIS OF RIGHT CALF MUSCULAR VEIN	ABF	N-No
15	I82.452	ICD-10	ACUTE EMBOLISM AND THROMBOSIS OF LEFT PERONEAL VEIN	ABF	N-No
16	I82.462	ICD-10	ACUTE EMBOLISM AND THROMBOSIS OF LEFT CALF MUSCULAR VEIN	ABF	N-No
17	I82.611	ICD-10	ACUTE EMBOLISM AND THOMBOS OF SUPERFIC VEINS OF R UP EXTREM	ABF	N-No
18	I82.612	ICD-10	ACUTE EMBOLISM AND THOMBOS OF SUPERFIC VEINS OF L UP EXTREM	ABF	N-No
19	E87.0	ICD-10	HYPEROSMOLALITY AND HYPERNATREMIA	ABF	N-No
2	J96.01	ICD-10	ACUTE RESPIRATORY FAILURE WITH HYPOXIA	ABF	N-No
20	E11.65	ICD-10	TYPE 2 DIABETES MELLITUS WITH HYPERGLYCEMIA	ABF	Y - Yes
21	T38.0X5A	ICD-10	ADVERSE EFFECT OF GLUCOCORT/SYNTH ANALOG, INIT	ABF	N-No
22	D72.829	ICD-10	ELEVATED WHITE BLOOD CELL COUNT, UNSPECIFIED	ABF	N-No
23	Z78.1	ICD-10	PHYSICAL RESTRAINT STATUS	ABF	
24	R13.12	ICD-10	DYSPHAGIA, OROPHARYNGEAL PHASE	ABF	Y - Yes
25	R29.720	ICD-10	NIHSS SCORE 20	ABF	Y - Yes
3	J96.02	ICD-10	ACUTE RESPIRATORY FAILURE WITH HYPERCAPNIA	ABF	N-No
4	G93.6	ICD-10	CEREBRAL EDEMA	ABF	N-No
5	G93.5	ICD-10	COMPRESSION OF BRAIN	ABF	N-No
6	G92	ICD-10	TOXIC ENCEPHALOPATHY	ABF	N-No
7	G81.91	ICD-10	HEMIPLEGIA, UNSPECIFIED AFFECTING RIGHT DOMINANT SIDE	ABF	Y - Yes
8	Z92.82	ICD-10	S/P ADMN TPA IN DIFF FAC W/N LAST 24 HR BEF ADM TO CRNT FAC	ABF	
9	Z20.822	ICD-10	CONTACT WITH AND (SUSPECTED) EXPOSURE TO COVID 19	ABF	Y - Yes
99	023			DR	
A	I63.512	ICD-10	CEREB INFRC D/T UNSP OCCLS OR STENOS OF LEFT MID CEREB ART	ABJ	

COVID-19 ICD-10 Procedure Codes

In response to the COVID-19 pandemic, the Centers for Medicare & Medicaid Services (CMS) implemented 12 new ICD-10 procedure codes to describe the introduction or infusion of therapeutics, including remdesivir and convalescent plasma, into the International Classification of Diseases, Tenth Revision, Procedure Coding System (ICD-10-PCS), effective August 01, 2020.

COVID-19 ICD-10 Procedure Codes

(*continued)*

Assignment of the new ICD-10-PCS procedure codes is as follows:

Procedure Code	Description	*O.R.	MDC	MS-DRG
XW013F5	Introduction of Other New Technology Therapeutic Substance into Subcutaneous Tissue, Percutaneous Approach, New Technology Group 5	N		
XW033E5	Introduction of Remdesivir Anti-infective into Peripheral Vein, Percutaneous Approach, New Technology Group 5	N		
XW033F5	Introduction of Other New Technology Therapeutic Substance into Peripheral Vein, Percutaneous Approach, New Technology Group 5	N		
XW033G5	Introduction of Sarilumab into Peripheral Vein, Percutaneous Approach, New Technology Group 5	N		
XW033H5	Introduction of Tocilizumab into Peripheral Vein, Percutaneous Approach, New Technology Group 5	N		
XW043E5	Introduction of Remdesivir Anti-infective into Central Vein, Percutaneous Approach, New Technology Group 5	N		
XW043F5	Introduction of Other New Technology Therapeutic Substance into Central Vein, Percutaneous Approach, New Technology Group 5	N		

COVID-19 ICD-10 Procedure Codes

(*continued)*

Procedure Code	Description	*O.R.	MDC	MS-DRG
XW043G5	Introduction of Sarilumab into Central Vein, Percutaneous Approach, New Technology Group 5	N		
XW043H5	Introduction of Tocilizumab into Central Vein, Percutaneous Approach, New Technology Group 5	N		
XW0DXF5	Introduction of Other New Technology Therapeutic Substance into Mouth and Pharynx, External Approach, New Technology Group 5	N		
XW13325	Transfusion of Convalescent Plasma (Nonautologous) into Peripheral Vein, Percutaneous Approach, New Technology Group 5	N		
XW14325	Transfusion of Convalescent Plasma (Nonautologous) into Central Vein, Percutaneous Approach, New Technology Group 5	N		

*As the procedure codes are designated as non-O.R. procedures, there is no assigned MDC or MS-DRG. The ICD-10 MS-DRG assignment is dependent on the reported principal diagnosis, any secondary diagnoses defined as a complication or comorbidity (CC) or major complication or comorbidity (MCC), procedures or services performed, age, sex, and discharge status.

COVID-19 ICD-10 Procedure Codes

(*continued)*

EDIT: 4414

Description: ICD Procedure Invalid Return from Grouper

EDIT: 2325

Description: Non-Covered ICD-10 Procedure

This edit is triggered when the surgical procedure codes is not effective on the date of admission.

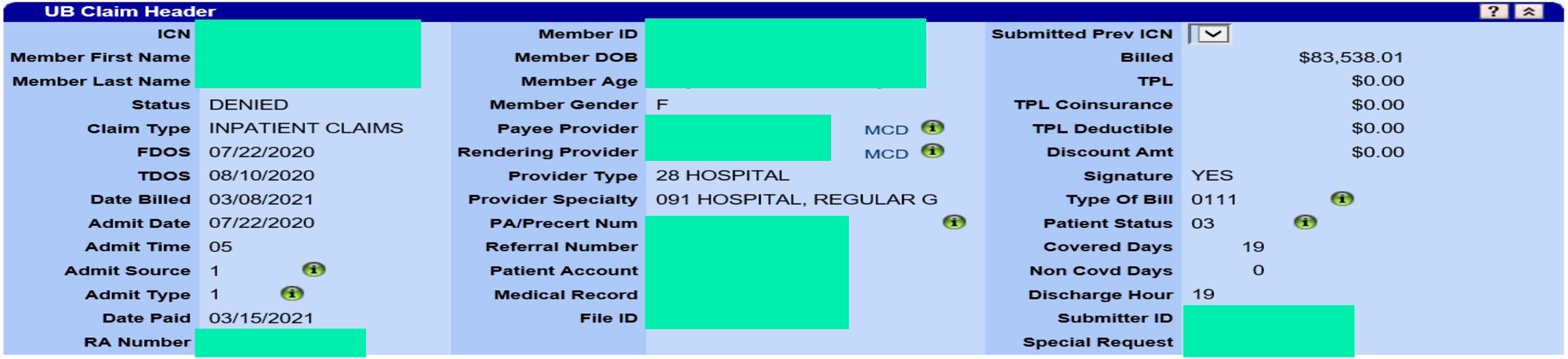
EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description	Benefit Plan	Financial Payer	Rpt
0	S	4757	.00	0	HOSPITAL ACQUIRED CONDITIONS PRESENT AT ADMISSION			Yes
0	S	4414	83,538.01	0	ICD PROCEDURE INVALID RETURNED FROM GROUPER			Yes
0	S	2325	.00	0	NON-COVERED ICD-10 PROCEDURE		GA	Yes

Method of Correction: The ICD-10 codes must be effective on the date of admission. Providers are to verify if the ICD-10 codes are covered on the admit date.

COVID-19 ICD-10 Procedure Codes

(*continued)*



UB Claim Header

ICN		Member ID		Submitted Prev ICN	
Member First Name		Member DOB		Billed	$83,538.01
Member Last Name		Member Age		TPL	$0.00
Status	DENIED	Member Gender	F	TPL Coinsurance	$0.00
Claim Type	INPATIENT CLAIMS	Payee Provider	MCD	TPL Deductible	$0.00
FDOS	07/22/2020	Rendering Provider	MCD	Discount Amt	$0.00
TDOS	08/10/2020	Provider Type	28 HOSPITAL	Signature	YES
Date Billed	03/08/2021	Provider Specialty	091 HOSPITAL, REGULAR G	Type Of Bill	0111
Admit Date	07/22/2020	PA/Precert Num		Patient Status	03
Admit Time	05	Referral Number		Covered Days	19
Admit Source	1	Patient Account		Non Covd Days	0
Admit Type	1	Medical Record		Discharge Hour	19
Date Paid	03/15/2021	File ID		Submitter ID	
RA Number				Special Request	

UB ICD Procedure Codes

Seq#	ICD Code	ICD	Description	Qualifier	Date
1	XW033E5	ICD-10	INTRODUCE REMDESIVIR IN PERIPH VEIN, PERC, NEW TECH 5	BBR	8/1/2020

COVID-19 Lab HCPCS

COVID-19 Lab HCPCS Codes:

U0005, 0202U, 0240U and 0241U

Effective January 1, 2021, for COS 070 Outpatient Services

COVID-19 Lab HCPCS

(continued)

EDIT: 3427

Description: Laboratory HCPCS code must be billed on an outpatient claim with lab revenue codes.

This edit is triggered: When the appropriate HCPCS laboratory code is not billed on Outpatient Hospital or Outpatient Crossover claim.

Detail List

#	ST	FDOS	TDOS	Rev Code	Proc-Mod	Units Billed	Amt Billed	Non Cov	SG
1	P	5/13/2021	5/13/2021	250		2	11.97	0	N
2	P	5/13/2021	5/13/2021	260	96372	1	101.00	0	N
3	D	5/13/2021	5/13/2021	300	0241U	1	220.00	0	N
4	P	5/13/2021	5/13/2021	300	87651	1	145.00	0	N
5	P	5/13/2021	5/13/2021	450	99282	1	254.00	0	N
6	P	5/13/2021	5/13/2021	636	J0696	1	2.44	0	N

Method of Correction: Resubmit claim with the correct HCPCS COVID lab code (U0005, 0202U, 0240U, and 0241U), if dates of service are on or after January 1, 2021

COVID-19 HCPCS

(*continued)*

Error List

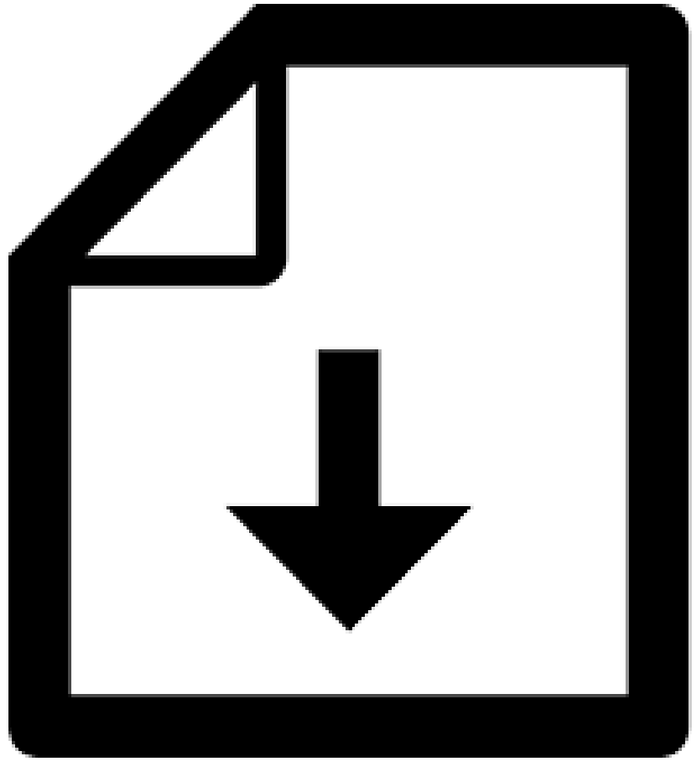
Claim Dtl#	Status	Disp Line	ESC	ESC Description	EOB	Amt Saved	Benefit Plan	Financial Payer	Date/Time	User ID	O
1	P	1	4005	ALLOWED AMOUNT HIGH VARIANCE - DETAIL	0351		TXIX	GA	7/6/2021 12:10:44		S
2	P	1	4005	ALLOWED AMOUNT HIGH VARIANCE - DETAIL	0351		TXIX	GA	7/6/2021 12:10:44		S
3	D	3	3427	HCPCS CODE MUST BE LABORATORY	3427				7/6/2021 12:10:44		S
4	P	1	4005	ALLOWED AMOUNT HIGH VARIANCE - DETAIL	0351		TXIX	GA	7/6/2021 12:10:44		S
5	P	1	4005	ALLOWED AMOUNT HIGH VARIANCE - DETAIL	0351		TXIX	GA	7/6/2021 12:10:44		S
6	P	1	4005	ALLOWED AMOUNT HIGH VARIANCE - DETAIL	0351		TXIX	GA	7/6/2021 12:10:44		S

View History

EOB List

Dtl#	Origin	EOB	Adj Amt	Adj Units	EOB Description	Benefit Plan	Financial Payer	Rpt	HIPAA F
1	S	0351	.00	0	PLEASE CHECK SUBMITTED CHARGE FOR QUANTITY BILLED	TXIX	GA	Yes	Claim/se
1	S	9981	8.06	0	PRICING ADJUSTMENT - PROVIDER PERCENT OF CHARGE PRICING APPLIED	TXIX	GA	No	Charge e
2	S	0351	.00	0	PLEASE CHECK SUBMITTED CHARGE FOR QUANTITY BILLED	TXIX	GA	Yes	Claim/se
2	S	9981	67.97	0	PRICING ADJUSTMENT - PROVIDER PERCENT OF CHARGE PRICING APPLIED	TXIX	GA	No	Charge e
3	S	3427	220.00	0	A LABORATORY HCPCS CODE MUST BE BILLED ON AN OUTPATIENT CLAIM WITH LAB			Yes	Claim/se
4	S	0351	.00	0	PLEASE CHECK SUBMITTED CHARGE FOR QUANTITY BILLED	TXIX	GA	Yes	Claim/se
4	S	9905	120.33	0	OUTPATIENT LAB PRICING APPLIED	TXIX	GA	Yes	The Ben
5	S	0351	.00	0	PLEASE CHECK SUBMITTED CHARGE FOR QUANTITY BILLED	TXIX	GA	Yes	Claim/se
5	S	9981	170.94	0	PRICING ADJUSTMENT - PROVIDER PERCENT OF CHARGE PRICING APPLIED	TXIX	GA	No	Charge e
6	S	9918	1.90	0	PRICING ADJUSTMENT - MAX FEE PRICING APPLIED	TXIX	GA	Yes	Charge e
6	S	0351	.00	0	PLEASE CHECK SUBMITTED CHARGE FOR QUANTITY BILLED	TXIX	GA	Yes	Claim/se

Attachment Codes



Attachment Codes

Appendix D Attachment Codes Effective November 1, 2010, the following HIPAA attachment codes have replaced the previous attachment codes that were being assigned to those claims that required an attachment for claims' processing. The "Old Attachment Code" column identifies those attachment codes previously used. "HIPAA Attachment Codes" column identifies the replaced attachment codes. Also included in this column is a brief description of the HIPAA attachment code. The "Comments" column explains the type of attachment that is not self-explanatory and need further clarification.

Attachment Codes

(*continued)*

Attachment Codes Crosswalk

Old Attachment Code	HIPAA Attachment Code		Comments
04	AS	Admission Summary	History & Physical or progress notes
05			
12			
04	B3	Physician Order	
21	B4	Referral Form	Hospice Referral form, Revocation Form, Election Form, Hospice Discharge Form, Hospice Transfer Form, Hospice Physician Certification and Recertification Form
01	CT	Certification	DMA-964, DMA-400 (DFCS issued letter), Temporary Medicaid Certification Form, Supplemental Security Income Letter, DMA-304, Death Certificate
05			
12			
14			
21			
04	DA	Dental Models	

Attachment Codes

(*continued)*

04	DS Discharge Summary	
05		
12		
06	EB Explanation of Benefits	EOMB, TPL, Remittance Advice
09		
11		
04	NN Nursing Notes	

Attachment Codes

(*continued)*

Old Attachment Code	HIPAA Attachment Code	Comments
04	OB Operative Notes	
05		
12		
04	OZ Support Data for Claim	This can be any miscellaneous documentation needed to support processing a claim
05		
12		
21		
04	RB Radiology Films	
04	RR Radiology Reports	
04	RT Report of Test and Analysis	
Note: If you are unable to find the appropriate attachment code for documentation being submitted as an attachment, please use "OZ".		

Accommodation Codes

Accommodation Codes

EDIT: 4226

Description: Inpatient claim not covered due to denied accommodation code.

This edit is triggered when providers submit inpatient claims with same revenue code for same date of service on multiple lines.

Detail List

#	ST	FDOS	TDOS	Rev Code	Proc-Mod	Units Billed	Amt Billed	Non Cov	SG
1	D	3/31/2021	4/4/2021	111		1	585.00	0	N
2	D	3/31/2021	4/4/2021	111		3	1,755.00	0	N
3	D	3/31/2021	4/4/2021	250		3	282.00	0	N
4	D	3/31/2021	4/4/2021	250		8	360.00	0	N
5	D	3/31/2021	4/4/2021	250		10	11.00	0	N
6	D	3/31/2021	4/4/2021	258		1	15.00	0	N
7	D	3/31/2021	4/4/2021	260		5	886.00	0	N
8	D	3/31/2021	4/4/2021	272		1	87.00	0	N
9	D	3/31/2021	4/4/2021	274		3	273.00	0	N
10	D	3/31/2021	4/4/2021	300		1	86.00	0	N
11	D	3/31/2021	4/4/2021	300		5	120.00	0	N
12	D	3/31/2021	4/4/2021	301		12	1,757.00	0	N
13	D	3/31/2021	4/4/2021	302		1	193.00	0	N
14	D	3/31/2021	4/4/2021	305		6	530.00	0	N
15	D	3/31/2021	4/4/2021	306		6	488.00	0	N
16	D	3/31/2021	4/4/2021	320		1	766.00	0	N
17	D	3/31/2021	4/4/2021	350		1	1,210.00	0	N
18	D	3/31/2021	4/4/2021	361		4	4,269.00	0	N
19	D	3/31/2021	4/4/2021	402		1	579.00	0	N
20	D	3/31/2021	4/4/2021	450		1	1,122.00	0	N
21	D	3/31/2021	4/4/2021	636		106	6,490.65	0	N
22	D	3/31/2021	4/4/2021	710		1	403.00	0	N

Method of Correction: Submit revenue codes for same dates of service on one line showing total units and total charges.

Provider Appeals Process

Appeals

Provider Initial Review

- DMA-520

  Initial review (DMA-520) must be submitted online through the Georgia Medicaid Management Information System (GAMMIS - www.mmis.georgia.gov). Providers must submit initial review request within 30 days of the date of the denial or claim payment.

Please Note:

Providers may NOT bypass the GAMMIS claims submission attachment process. Please follow DCH's submittal processes and submit a new claim with the appropriate attachment indicator (OZ, NN, B4, etc.) and then attach the supporting documentation to the claim in the GAMMIS web portal. Bypassing the established initial review processes and moving directly to Alliant's auto-adjustment process will not be accepted.

Appeals

(continued)

- DMA-520A Provider Inquiries for Clinical Reviews for Medical Necessity

  Providers must submit the inquiry electronically via the GAMMIS Web Portal (www.mmis.georgia.gov) secure home page link: Prior Authorization/Medical Review Portal/Provider Inquiry Form (DMA-520A). Providers must submit initial review request within 30 days of the date of the denial or claim payment.

Reconsideration Request:

If you have received an initial denial or requests for additional documentation, please submit your request for Reconsideration regarding your clinical review with all supporting documentation electronically via the web portal (www.mmis.georgia.gov) to the Prior Authorization/Medical Review Portal/Provider Inquiry Form (DMA-520A). This information must be submitted within thirty (30) days from the date of the denial.

The edits reviewed by Alliant are posted on the GAMMIS Web Portal under the Medical Review tab.

Appeals

(*continued)*

Second Level Appeal

Administrative Review: Review must be submitted online through the Georgia Medicaid Management Information System (GAMMIS - www.mmis.georgia.gov) within 30 days of the date of the notification of the proposed adverse action or initial review determination. Request must include all supporting documentation and an explanation of what the provider wishes DCH to review.

Third Level Appeal:

Provider Administrative Law Hearing: A request for a hearing must be in writing and received by DCH within 15 business days after the date the provider received the decision from the appeal.

Timely Filing

Timely Filing

- Timely Claim Submission: Must be received by the Division within six (6) months from the month in which service was rendered.
- Timely Adjustment: Must be received within three (3) months from the month of payment
- Timely Appeal: Must submit initial review request within 30 days of the date of the denial of claim payment.
- Retro Timely Filing: Must be received within 6 months from the date of eligibility approval.

Timely Filing

(continued)

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

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

  - The original claims to be submitted within 180 days or 6 months from date of service.
  - A claim that was denied for missing or erroneous information must be resubmitted to correct the misinformation within three months from the month of the date of service or when the denial occurred, whichever is later.

Timely Filing

(continued)

Example:

DOS	Paid/Denied Date	Resubmit/Adjustment	(365 days)
July 1, 2020	December 30, 2020	January 31/March 31, 2021	June 30, 2021

- 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.**

DMA-501 FORM

When primary payer such as a commercial plan or Medicare adjusts a claim, the adjusted claim does not automatically crossover.

If Medicaid has already paid on the claim that adjusted, submit an Adjustment Request Form, DMA-501, to Medicaid using the new payment information.

When a primary payer such as a commercial plan or Medicare adjusts a claim and a new EOB or EOMB is received.

Complete an Adjustment Request Form (DMA-501). Remember, only Medicaid paid claims can be adjusted.

Submit the Adjustment Request through the GAMMIS web portal at www.mmis.georgia.gov.

Attach a copy of the EOB or RA/EOMB showing the primary payer's adjustment. If the primary payer adjusts a claim that Medicaid denied, no adjustment is needed.

DMA-501 FORM

(continued)

Please Return To:
Gainwell Technolgies
P.O. Box 105208
Tucker, GA 30085-5208

ADJUSTMENT REQUEST FORM

Adjustment Requests must be received within three months from the month of Medicaid payment.

1. Internal Control Number (ICN) of the **paid** claim to be adjusted as shown on the Remittance Advice

3. Provider Name/Address

Provider Number:

Phone Number ( )

Contact Person

Member Medicaid Information

2. Medicaid Number

Member Name (Last, First, Initial)

4. Reason for adjustment (check one box)

- ☐ A. Member Medicaid ID linking issue
- ☐ B. Payee Change
- ☐ C. Provider receives payment from a third party such as Medicare after Medicaid has made a payment and the adjustment/claim is untimely. (attach all EOMBs that apply to this adjustment)
- ☐ D. Patient Liability update - provider receives an updated Summary Notification Letter indicating the member's patient liability amount changed after the 90 day adjustment window and the claim is untimely.

5. Please list the information to be corrected in Blocks 5A-5D. If the information to be corrected does not have a line number enter z e r o in the line number field. COB applied should always be line #0.

5A Line to be Corrected	5B Information to be Changed	5C From (Current) Information	5D To (Corrected)

6. Explanation for Adjustment

7. FOR DCH USE ONLY

CCN_____FS Line Amount $ _____

Provider Signature_____Date _____

- DMA 501 Rev. (07/21)

DMA-501 FORM

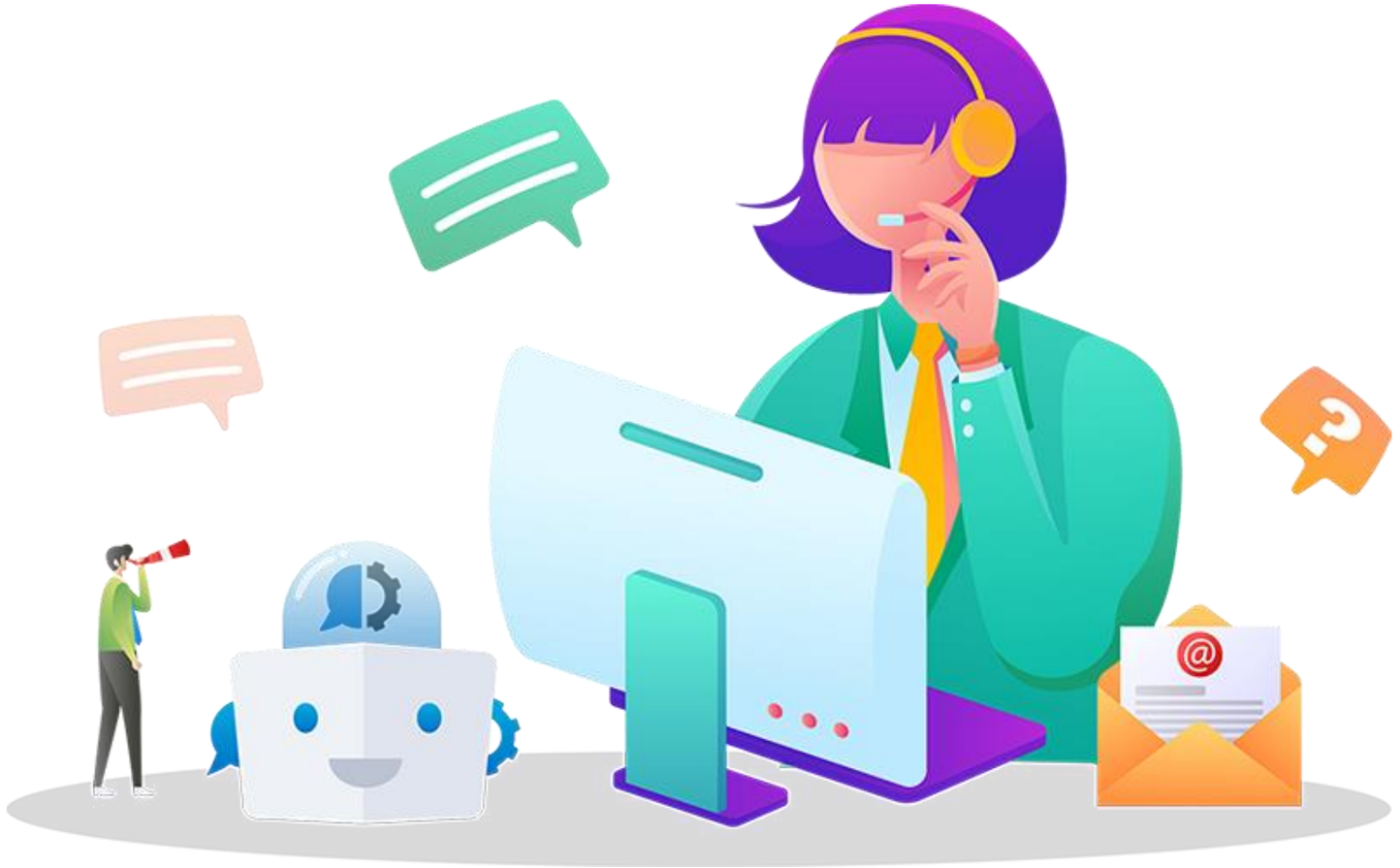
(continued)

HOW TO COMPLETE THE DMA-501 ADJUSTMENT REQUEST FORM

Providers are allowed to adjust one claim per form.

- Blocks 1 - 3 must be completed for each claim adjusted.
- In Block 4, check Box “B” for a COB adjustment or check Box “D” for a Medicare adjustment.
- In Block 5A (Line to be Corrected), enter zero (0) if you are adjusting the total paid or the total patient liability for the claim. If you are only adjusting a line number, enter the line number corresponding to the claim that Medicaid has processed.
- In Block 5B (Information to be Changed), show what data field of the paid claim is changing. For example, on a facility claim, if the prior payment is changing, enter “Box 54 A - prior Payments.”
- In Block 5C (From (Current) Information), enter the incorrect information that was submitted on the original claim processed by Medicaid. This will be the same information that appears on the RA from Medicaid or Medicare.
- In Block 5D (To (Corrected) Information), enter the corrected amount from the adjusted EOB or RA/EOMB.

Contact Us



Contact Provider Representatives

Our Provider Services Contact Center (PSCC) can be reached at
800-766-4456
and is available 7 a.m. to 7 p.m. EST
Monday through Friday (except state holidays) to service inquiries.
Or
through the **Contact Us** function on the
Georgia Medicaid Management Information System (GAMMIS)

at www.mmis.georgia.gov

IVRS Overview

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

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, Haralson, Paulding, Polk

Territory 5: SE Metro
Clayton, DeKalb, Rockdale

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

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

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

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

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

Territory 11 State Wide
Hospital Field Representative

Provider Relations Field Services

Territory	Region	Rep
1	North Georgia	Vacant
2	Fulton	Deandra Murray
3	NE Georgia	Carolyn Thomas
4	NW Georgia	Danny Williams
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 Bentley
South	Hospital Rep	Janey Griffin-Weaver

Provider Relations Field Services

(*continued)*

State-Wide Consultants

Brenda Hulette
Anita Hester
Sharée C. Daniels

Contact My Provider Rep Directly

Login to the MMIS system with your username and password

Contact My Provider Rep Directly

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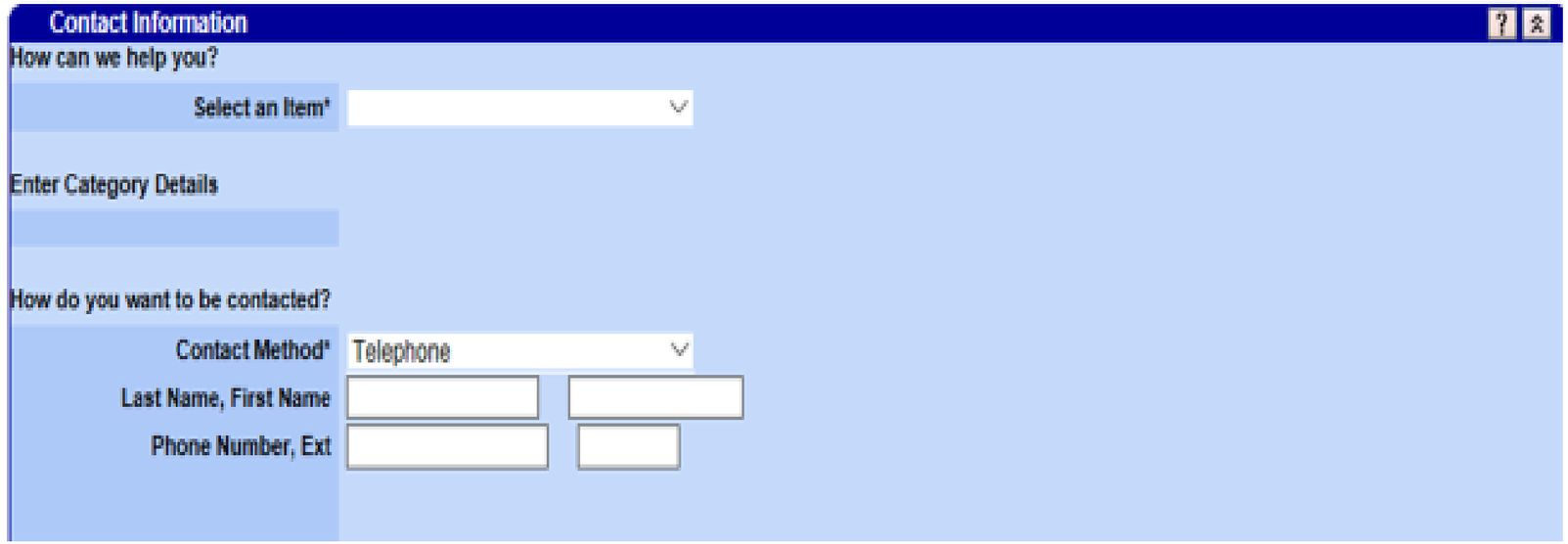

Contact My Provider Rep Directly

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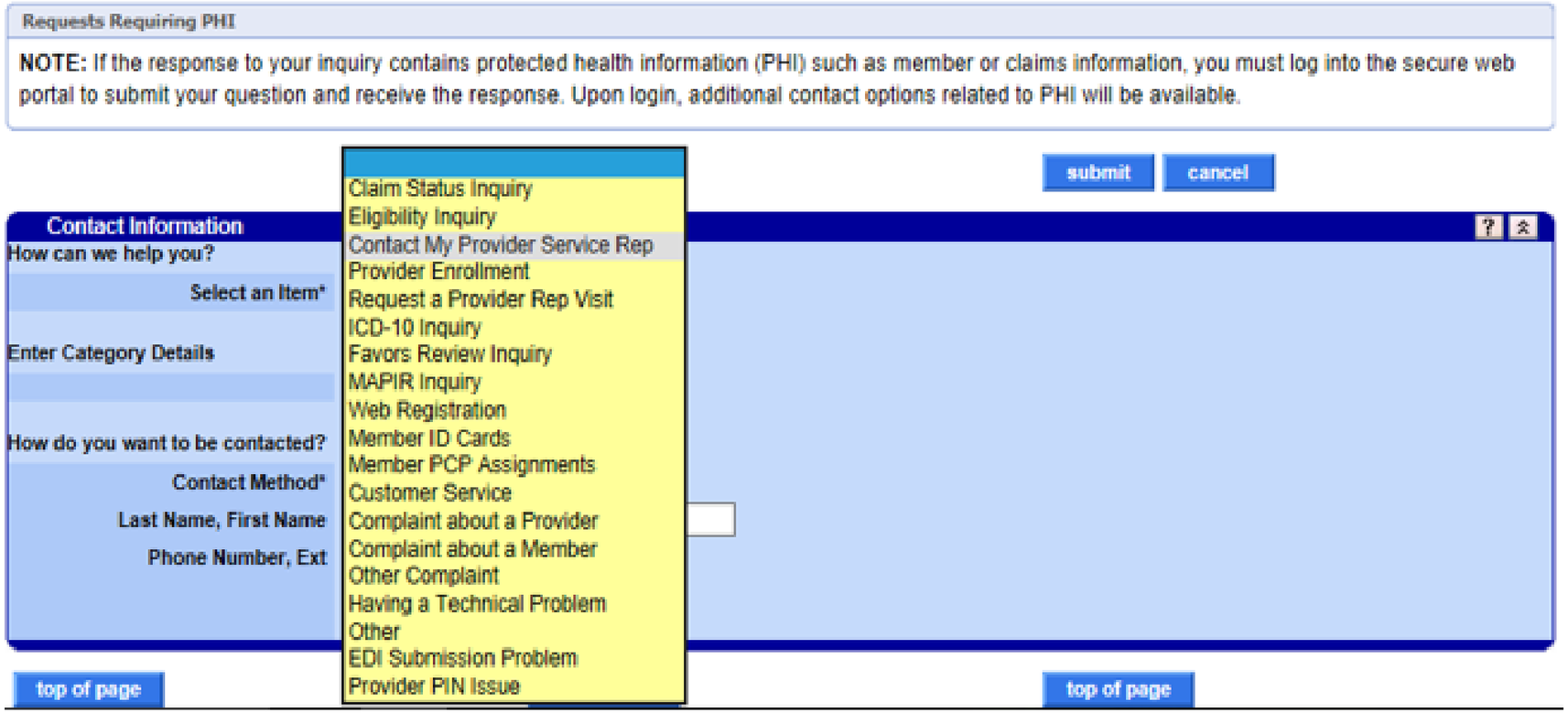

Contact My Provider Rep Directly

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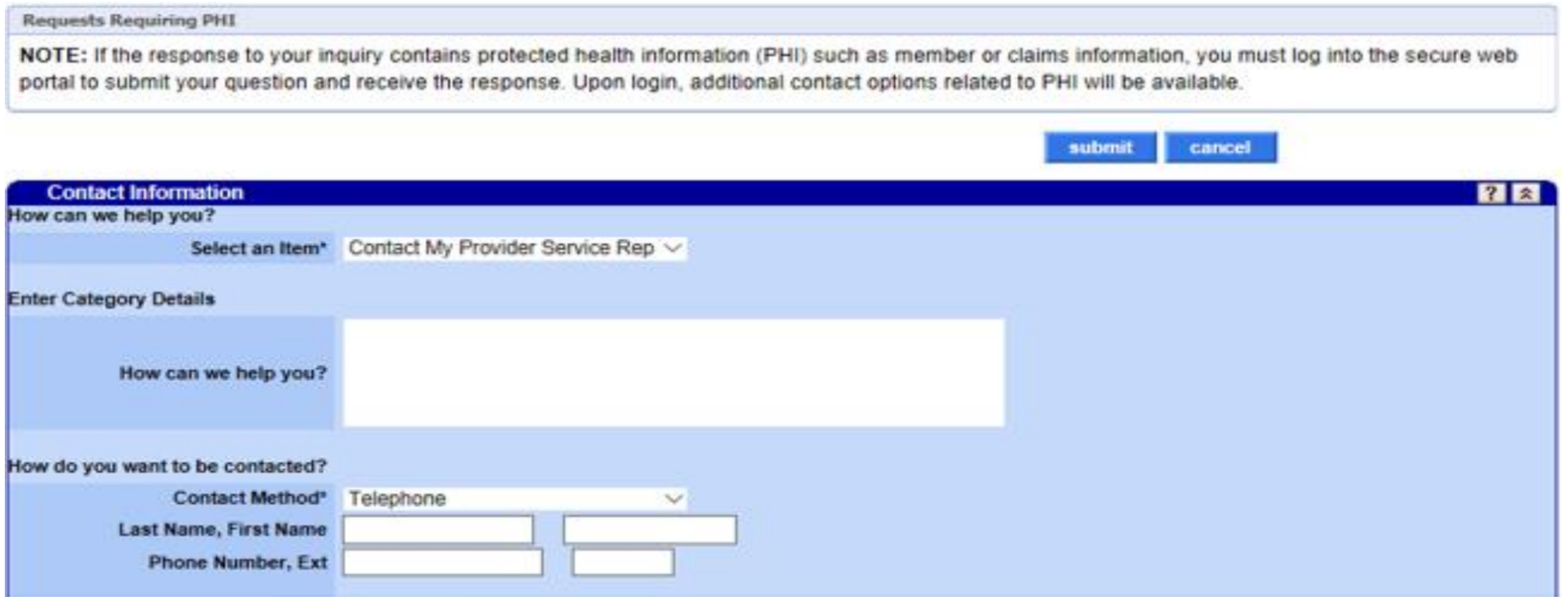

Contact My Provider Rep Directly

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Contact My Provider Rep Directly

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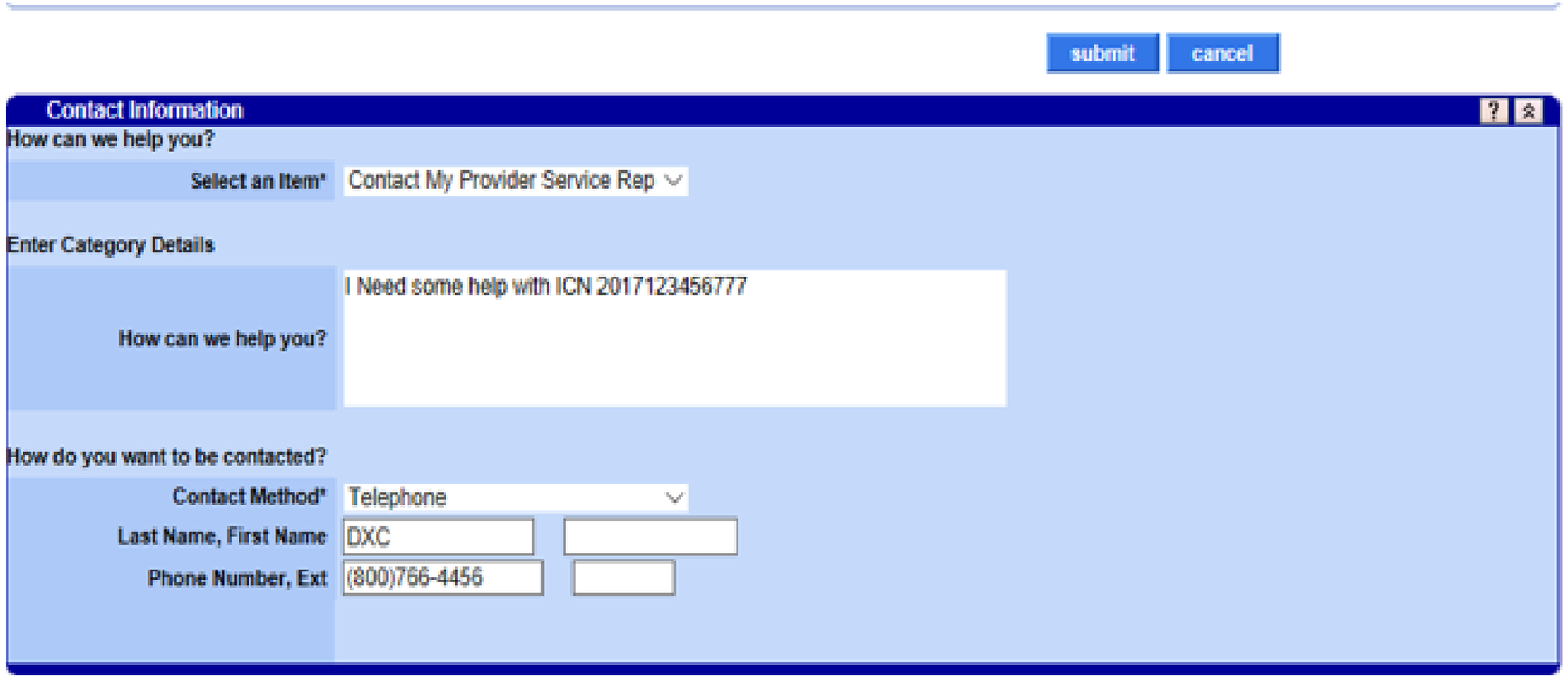

Session Review

You should now understand:

- COVID-19 Diagnosis, ICD-10 Procedure and HCPCS Codes
- How to submit claims with attachment codes
- How to identify duplicate revenue codes
- The process of appeals
- Timely filing submission
- When to submit the DMA-501 form

Questions