The Department of Community Health (DCH) and HP Enterprise Services would like to thank everyone who attended the first Georgia Medicaid Fair! The event was a huge success, with more than 950 registered providers in attendance.
The fair took place May 19, 2011 at the Georgia World Congress Center in Atlanta, Georgia. Attendees included the DCH Commissioner, as well as DCH and HP Enterprise Services leadership. Guest speakers presented on a number of topics, including:

- General Billing
- Crossover Claims
- Dental Services
- Durable Medical Equipment
- Eligibility/Third Party Liability
- Health Check
- Home Health
- Hospice
- Hospital

- Nursing Facility
- Physician Services
- Prior Authorization
- Provider Enrollment
- Waiver Programs
- Children’s Intervention Services/
  Children’s Intervention School Services
- Behavioral Health
- Long-Term Care Eligibility

Additionally, DCH business partners including Amerigroup, Peach State Health Plan, WellCare, Georgia Medical Care Foundation (GMCF), Health Management Services, Avesis, Scion, SXC, Maximus, Magellan, Cenpatico, Dentquest, and PSI were also present.

For those unable to attend, presentations can be viewed on the Web Portal (https://mmis.georgia.gov) under Provider Information, Provider Notices.

The next Georgia Medicaid Fair is scheduled for:
November 16, 2011 at the CenterPlex
240 Coliseum Drive, Macon Georgia 31217.

Details coming soon!
Here’s what you need to be ready!

Register
Federal and state registrations are required for Georgia’s Medicaid EHR Incentives Program. Federal registration is now available for dually eligible hospitals through the Centers for Medicare and Medicaid Services (CMS) website: www.cms.gov/EHRIncentivePrograms/. Eligible Professionals began the registration process on September 5, 2011. Visit www.dch.georgia.gov/ehr for more information.

Eligible Professionals
Physicians, Dentists, Nurse Practitioners, Certified Nurse-Midwives, Pediatricians:
• Review your provider file(s)
• Add your Payee NPI to your Provider Payee number
• GBHC providers should add your NPI to your group number
• Register with CMS and the Department of Community Health (DCH) now!

Eligible Hospitals
• Register with CMS and DCH now!

For More Information
Visit these websites to learn more, or email us directly at medicaidincentives@dch.ga.gov.
• CMS – Medicare & Medicaid Incentive Program: www.cms.gov/EHRIncentivePrograms
• DCH – Georgia’s Medicaid EHR Incentives Program: www.dch.georgia.gov/ehr
• GA-HITREC – For Certified EHR Technology Technical Assistance: www.ga-hitrec.org/gahitrec or 404-752-1015 or 877-658-1990
• EHR Certification & List of Certified EHRs – Office of the National Coordinator: http:onc-chpl.force.com/ehrcert

For more information about upcoming webinars and other Medicaid EHR incentive program events, please visit http://dch.georgia.gov/ehr or send an e-mail to MedicaidIncentives@dch.ga.gov.
The Georgia Department of Community Health (DCH) requires a face-to-face encounter with patients before physicians may certify need for durable medical equipment (DME) under the Georgia Medicaid program. This requirement is in accordance with the Affordable Healthcare for All Americans Act (Section 6407) and other applicable policy. A condition for reimbursement is that all DME providers comply with the Medicaid policy requirements and documentation standards for face-to-face encounters for initial and replacement equipment, supplies and modifications.

A “face-to-face encounter” is defined as a visit during which the specific need for the equipment is addressed, and one in which the patient is seen by a:

- treating physician
- nurse practitioner
- clinical nurse specialist working in collaboration with the physician, or
- physician assistant under the supervision of the physician.

The face-to-face encounter must occur during the six months preceding the written order for DME and must be completed prior to any service delivery by the DME provider.

**History and Physical**

The examination provided by the physician (or other medically qualified professional) must be recorded in the patient’s medical record. The medical record should include the results of the face-to-face encounter along with the associated medical and diagnosis information which supports the medical need for the requested equipment and/or supplies.
Prescription and Attestation Statement

The DME supplier must complete all steps that are necessary to obtain documentation that the face-to-face encounter has occurred as a part of the confirmation of the order. The date of the face-to-face encounter must be specifically stated in the documentation in the member file with the DME supplier. The prescription and attestation statement documenting the face-to-face encounter must be sent to the equipment supplier within 30 days after the completion of the encounter. All documentation must be retained in the member’s record for a minimum of five years and made available to DCH upon request.

Prior Authorizations

Through the Georgia Medical Care Foundation (GMCF), DCH’s quality improvement organization, providers must attest to a face-to-face encounter on all prior authorization (PA) requests. An attestation statement must be submitted, which requires a “Yes” or “No” response and the date of the patient’s last office visit.

Prior authorizations may be approved for up to 12 months. A face-to-face encounter is required every six months during the 12-month prior authorization period. Long-term rentals require a face-to-face encounter every six months.

Subsequent DME Items

A separate examination for each subsequent DME item prescribed is not necessary if the medical justification for the item that is ordered has been previously established in the clinical findings of the prescriber. This examination must be held through a face-to-face encounter conducted within the previous six months by the prescriber.

Repairs

Standard and customary repairs associated with the regular usage of equipment are excluded from the face-to-face requirement. Orders and prescriptions for expendable items, such as oxygen or drugs, are also excluded from the face-to-face encounter requirement; however, these products remain subject to applicable benefit coverage and limitations for those products.
**FREQUENTLY ASKED QUESTIONS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is a face-to-face encounter required for all DME or just the ones requiring PAs?</td>
<td>It is required for all DME.</td>
</tr>
<tr>
<td>Is it sufficient for the physician or office staff to document the face-to-face encounter by adding a line to the physician order/Certificate of Medical Necessity (CMN) with the date it took place?</td>
<td>Yes.</td>
</tr>
<tr>
<td>Is it sufficient to document in the patient’s record that the patient verbally verified that they were seen by the physician on the date of the prescription for the equipment?</td>
<td>No.</td>
</tr>
<tr>
<td>Do we need to obtain a copy of the chart notes for the face-to-face encounter in case of an audit?</td>
<td>No.</td>
</tr>
<tr>
<td>The existing Medicaid Oxygen (O2) CMN requests the &quot;Date last seen by Physician,&quot; but that date must be within 90 days of the initial or recertification date. Does the face-to-face encounter policy (that requires the member to be seen within six months) overrule the Medical O2 CMN policy?</td>
<td>Certain DME items may have more stringent requirements. The requirements for the item and the face-to-face encounter requirement will apply simultaneously.</td>
</tr>
<tr>
<td>Does the face-to-face encounter requirement apply to items that may be needed for the duration of the member’s life, such as Mic-Key extensions and Continuous Positive Airway Pressure (CPAP) supplies?</td>
<td>Yes.</td>
</tr>
<tr>
<td>Does the face-to-face encounter requirement apply to long-term rentals that extend beyond six months?</td>
<td>Yes, the physician will need to verify that the rental is still necessary.</td>
</tr>
</tbody>
</table>
**FREQUENTLY ASKED QUESTIONS**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>If new and/or additional equipment is ordered after the physician has seen the member, is another face-to-face encounter required?</td>
<td>No. A separate encounter is not necessary if the medical justification for the equipment has been previously established by the prescriber during the six-month period preceding the written order.</td>
</tr>
<tr>
<td>How is the face-to-face encounter handled if a member has multiple PAs with renewals due at different times resulting from the equipment/supplies being ordered at different times?</td>
<td>The prescribing provider can evaluate multiple concerns at one visit. Only during the preceding six-month period preceding the order is a face-to-face encounter required.</td>
</tr>
<tr>
<td>The manual allows for a Respiratory Therapist or Sleep Technician to sign and date the CMN after the initial rental of a CPAP unit. Is it still necessary for a member to see a prescribing provider prior to a therapist approving the supplies for a CPAP?</td>
<td>Yes.</td>
</tr>
</tbody>
</table>
HP Enterprise Services along with the Department of Community Health announces that we have begun accepting all inbound HIPAA compliant 5010 transactions beginning July 6, 2011 and have the ability to return outbound HIPAA compliant 5010 transactions for those trading partners that are ready to receive them.

Trading Partners may test their inbound transactions using the Georgia Health Partnership Ramp Management System using the following link:

https://sites.edifecs.com/index.jsp?gamedicaid

This site is configured to provide support to providers and vendors submitting electronic transactions to Georgia Medicaid & PeachCare for Kids® using the HIPAA compliant ANSI ASC X12N format. The site provides a number of utilities to test, troubleshoot and verify that transactions have processed successfully against the Georgia Program requirements.

Trading Partners and Physicians who submit claims and other HIPAA health care transactions electronically must comply with the 5010 transactions by the January 1, 2012 deadline. **Those who do not prepare for the deadline will be at risk for cash-flow interruptions.**

All Trading Partners are encouraged to test their transactions, this includes:

- Providers
- Clearinghouses
- Billing Agents
- Software Vendors

Trading Partners must have a compliant transaction pass Ramp Manager before HP will accept their production files. 5010 Companion guides and documentation can be located on the EDI section of the Georgia Medicaid Website located at [www.mmis.georgia.gov/EDI](http://www.mmis.georgia.gov/EDI).

Questions can be directed to the EDI Services Help Desk at 877-261-8785 or 770-325-9590 between the hours of 8:00 a.m. – 5:00 p.m. EST.
Healthcare is evolving. The Georgia Department of Community Health (DCH) recently implemented an enhanced Medicaid Management Information System (MMIS) and launched the Medicaid Electronic Health Records (EHR) Incentives Program. These developments, along with changes to the requirements from regulatory and benchmarking authorities, have produced agility and innovation in the administration of health care. In addition, the conversion from ICD-9 to ICD-10 (International Classification of Diseases Tenth Revision) transaction coding sets is coming soon. To prepare your practice, providers are encouraged to begin planning for the transition as soon as possible.

What is the ICD-10 conversion?

October 1, 2013, marks the date that ICD-9 Codes will be replaced by the Tenth Revision, ICD-10. These code sets are used to differentiate diagnoses and procedures in virtually all treatment settings. Diagnostic and procedural codes are connected to nearly every system and business process in health plan and provider organizations, including reimbursement and claim processes. In converting to ICD-10, the code field expands from five to seven positions to accommodate the larger size of the ICD-10 transaction codes.

How will this conversion affect you and your practice?

ICD-10 will affect diagnoses and inpatient procedure coding for providers who submit a health care claim covered by the Health Insurance Portability and Accountability Act (HIPAA). ICD-10 is not exclusive to Medicare or Medicaid claims.

Georgia Medicaid will be able to use the detailed information from ICD-10 coding to improve care management of patients and increase efficiency in claims adjudication through identification of specific health conditions, diagnoses and procedures. This will lead to better data for fraud and abuse monitoring, electronic health records, and quality assurance of clinical and administrative processes. The ICD-10 implementation will ultimately improve DCH’s ability to accurately compensate Medicaid providers and reduce the incidence of improper payments.

What is the timeline for transition to ICD-10?

Providers conducting health care transactions electronically will need to upgrade from version 4010/4010A to version 5010 by January 1, 2012. The 5010 Project is a precursor to the ICD-10 Project. Every entity subject to HIPAA and transmitting electronic claims must switch to version 5010 transaction standards by January 1, 2012.

Beginning October 1, 2013, ICD-10 diagnoses and procedure codes must be used for all health care services provided in the United States.
How will the ICD-10 transition impact claims payments?

Claims with ICD-9 codes for services provided on or after October 1, 2013 cannot be paid. Additionally, all provider claims must be compliant with ICD-10 by October 1, 2013.

DCH’s Role

DCH is currently working to accommodate the upcoming 5010 standard, identify ICD codes within the MMIS and assess the impact of transitioning to ICD-10. DCH is also developing a communications and implementation strategy to transition Medicaid providers to these new standards.

The Provider’s Role

ICD-10 will impact the operation of every practice. Every provider and their staff should become actively engaged in learning more about it. For Georgia Medicaid ICD-10 conversion information, please refer to the ICD-10 Remediation Project Fact Sheet and ICD-10 Remediation Project frequently asked questions (FAQs) located on the DCH Web site at www.dch.georgia.gov/ICD10. Also, visit the Centers for Medicare and Medicaid Services (CMS) Web site at www.cms.gov/ICD10. In an effort to keep providers informed and engaged in the implementation of 5010 and ICD-10, DCH will publish information on the DCH website as the project continues. We look forward to the feedback as we work together to improve Medicaid.
HP Enterprise Services has been returning a number of claims to providers for mistakes that, in most cases, can be avoided if claims are checked thoroughly before being submitted. Below are the most common mistakes we have been seeing, notes regarding the mistakes, and a few changes we are working on.

<table>
<thead>
<tr>
<th>Return Reason</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>To Date of Service (TDOS) is missing</td>
<td>Ensure that the date of service is entered on the claim.</td>
</tr>
<tr>
<td>Medicare Paid Date is less than 45 days of claim receipt date</td>
<td>Submit crossover claims 45 days after the Medicare paid date.</td>
</tr>
<tr>
<td>Deductible and Amount Paid are both equal to zero</td>
<td>Ensure the deductible and/or amount paid are not equal to zero.</td>
</tr>
<tr>
<td>Deductible, Coinsurance, and Amount Paid by Medicare are all equal to zero</td>
<td>Ensure the deductible, coinsurance and/or amount paid are not equal to zero.</td>
</tr>
<tr>
<td>Part B claims only - Calculated amount in field locator 54A is incorrect</td>
<td>The calculation should be the sum of Medicare net payment plus the Medicaid net payment (coinsurance and deductible).</td>
</tr>
<tr>
<td>Part B claims only - Missing attachments</td>
<td>The most prevalent attachment that is missing from claims seems to be Exhaustion of Benefits Letter, form DMA 460. Please ensure it is submitted with the claim.</td>
</tr>
<tr>
<td>Dates of Service (DOS) on the claim does not match the DOS on the Explanation of Medical Benefits (EOMB)</td>
<td>Ensure the correct EOMB is submitted with the claims and the dates of service are the same.</td>
</tr>
<tr>
<td>Provider number missing or invalid</td>
<td>Enter the provider number in field 33b on CMS 1500 forms, field 57 on UB04 forms and field 58 for ADA 2006 dental forms. Please ensure the correct ID qualifier is used.</td>
</tr>
</tbody>
</table>
### RETURNED TO PROVIDER (RTP) Continued...

<table>
<thead>
<tr>
<th>Return Reason</th>
<th>Required Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>Missing provider signatures</td>
<td>Ensure claims and adjustment request forms are submitted with provider signature.</td>
</tr>
<tr>
<td>Missing or invalid ICN numbers on adjustments</td>
<td>Ensure the Internal Control Number (ICN) number to be adjusted is on the request form.</td>
</tr>
<tr>
<td>Reason for adjustment is not indicated on the form</td>
<td>Ensure the adjustment reason is indicated on the adjustment request form.</td>
</tr>
<tr>
<td>Untimely filing</td>
<td>Medicaid claims have a filing time limit of 90 days. Medicare claims have a filing limit of one year.</td>
</tr>
</tbody>
</table>

Crossover claims are being mailed to the incorrect PO Box. In order to ensure that your crossover claims are processed timely and accurately, please submit to:

**HP Enterprises**  
P.O. Box 105203  
Tucker, Georgia 30085-5203

Medical appeals submitted on the DMA 520A Provider Inquiry Form should be mailed directly to GMCF not to HP Enterprise Services. Please submit to:

**GMCF**  
P.O. Box 105330  
Atlanta, Georgia 30348

### mail to field TIP

- If a provider wishes to have their correspondence mailed to someone other than themselves, an “Attention Name” must be listed on the submitted application (paper or Web Portal) under the Mail To Address field.

- If an Attention Name is not listed on the submitted application (paper or Web Portal), the correspondence will be mailed to the listed provider.
Be Smart. Plan Before You Start!

On October 29, 2010, the Georgia Department of Community Health (DCH) announced that the Centers for Medicare and Medicaid Services approved its application for an 1115 Family Planning demonstration waiver, the Planning for Healthy Babies℠ (P4HB) program.

P4HB was designed to help reduce the number of small babies born at risk for life-long health challenges, such as developmental delays, respiratory illness and loss of vision. The program provides no-cost family planning services to women in Georgia because healthy moms are more likely to have healthy babies.

The P4HB program extends coverage for family planning services to women who may not otherwise qualify for Medicaid Benefits. The program officially began January 1, 2011, and extends thru December 31, 2013.

The expansion of eligibility increases access to the full spectrum of family planning services by permitting a higher income range of women to have coverage and allowing them access to private health care providers, as well as county health departments and community health centers. The Family Planning waiver will:

- Extend family planning coverage to women who may not otherwise have access to care, thereby reducing the rate of unintended pregnancies.
- Extend family planning coverage for other services to meet the health care needs of women who have delivered a Very Low Birth Weight (VLBW) baby.
- Help reduce Georgia’s Low Birth Weight (LBW)/VLBW rates from 9.5% to 8.6% over 5 years.
- Help reduce Medicaid costs by reducing the number of unintended pregnancies in women who otherwise would be eligible for Medicaid pregnancy-related services.

The P4HB program expands eligibility for family planning services to women who:

- Are ages 18-44 and a US citizen.
- Are Georgia residents.
- Lose their Medicaid coverage after 60 days postpartum.
- Meet income requirements of being below or equal to 200% of the Federal Poverty Level (FPL).

The P4HB program consists of three components that eligible members may enroll into:

- **Family Planning,** which provides family planning and family planning-related services only for eligible participants for the duration of the waiver.
- **Inter-Pregnancy Care,** which provides family planning and additional services for women for 24 continuous months who have delivered a VLBW baby.
- **Resource Mother,** which provides a specially-trained case manager to women enrolled in traditional Medicaid plans who have delivered a VLBW baby. This outreach is available for 24 continuous months after the birth of a VLBW baby.
The services covered include:

- Family planning initial or annual exams (one per year), including lab tests for Sexually Transmitted Infections (STIs), pap smears and pregnancy tests.
- Prescriptions for contraceptives and treatment for infections identified during routine family planning visits. Treatment for HIV and Hepatitis B are not covered.
- Follow-up family planning visits (up to four per year)
- Counseling and referrals to:
  - Social services
  - Primary health care providers
- Tubal Ligation (Sterilization)
- Multi-vitamins with Folic Acid/Folic Acid Supplements
- Hepatitis B and Tetanus-Diptheria vaccines
- Patient education and counseling

Additionally, women who have given birth to an infant weighing less than three pounds, five ounces qualify for many special services under the Inter-Pregnancy Care component of the waiver that are aimed at keeping them from having another VLBW or premature birth. These special services include primary care, limited dental, substance abuse and medications for chronic conditions. Providers are required to complete a form that verifies that the woman has delivered a VLBW baby. These forms can be downloaded from the Planning for Healthy Babies website, www.planning4healthybabies.org, or from the Care Management Organizations (CMO) websites.

It is important for providers to understand what this means for them:

- Providers can now continue to see their clients after they have delivered. Those clients who were enrolled in Right from the Start Medicaid, who would typically lose their Medicaid coverage after 60 days, should be encouraged to apply for the P4HB program so they can continue to see the provider for their family planning services.
- Providers will be able to offer the same procedures and utilize the same codes they currently use when providing family planning services to Medicaid recipients. This includes members in Amerigroup, Peach State and Wellcare.
- The procedures or services provided or performed should be for the primary purpose of family planning.
- Procedures and services should carry a primary diagnosis of family planning or an FP modifier included on claims.
- Providers should become familiar with covered services under the P4HB waiver. Providers should inform the member (prior to rendering service) of the specific non-covered services and obtain a written waiver of liability that explains the member will be held liable for payment.
It is important for providers to understand what this means for them:

- Inpatient admission and emergency room services are only covered when it is related to a family planning service and/or complication, such as a perforated uterus from an Intrauterine Device (IUD) insertion or complication sterilization procedure (SP).
- There are no fee-for-service benefits for P4HB members. Women must select a CMO within 30 days of being approved; if not, a CMO will be auto-assigned. They will not be covered for services until they have selected a CMO plan. There is no retroactive coverage for services.

How will providers identify these members?

Women enrolled in P4HB can be identified in the Georgia Medicaid Management Information System (GA MMIS) by their Category of Eligibility and by the color of their benefit card when they present for services. This is consistent with each of the three CMOs.

- **Family Planning Only** (Category of Eligibility (COE) 181) - will present a pink card
- **Inter-Pregnancy Care** (COE 180) - will present a purple card
- **Resource Mother** for women in Low Income Medicaid (COE 182) or Resource Mother Outreach for women enrolled in the Aged, Blind and Disabled program (COE 183) - will present a yellow card

Eligibility of benefits can be obtained by accessing the GA MMIS Web portal to confirm eligibility. Each CMO Web portal has information for providers to access for specific details about the P4HB program.

**Women can obtain more information and enroll in the program by:**

- Applying online at [www.planning4healthybabies.org](http://www.planning4healthybabies.org).
- Contacting their local Public Health Department. Applications are available at local Public Health Departments and some Division of Family and Children Services (DFCS) offices.
- Requesting to have an application mailed directly to them by calling 1-877-P4H-B101 or 1-877-744-2101.
- Speaking with their physician; physicians can also copy and distribute applications and information to pregnant clients at their offices.
- Reviewing additional information at [https://dch.georgia.gov/p4hb](https://dch.georgia.gov/p4hb) or calling 1-877-744-2101.
upcoming changes PROVIDER ENROLLMENT

The Department of Community Health (DCH) and HP Enterprise Services have implemented several new provider enrollment background screening processes to help in its efforts to reduce fraud, waste and abuse in the Georgia Medicaid/PeachCare for Kids® programs.

Risk-Based Screenings

Providers will be classified into three different categories - “limited,” “moderate” and “high,” based on the varying levels of enrollment review that will be conducted. For example:

- “Limited” providers include physicians/non-physician practitioners, medical groups, clinics, ambulatory surgery centers, end-stage renal disease facilities, hospitals, mammography screening centers.
- “Moderate” providers include community mental health centers, comprehensive outpatient rehabilitation facilities, hospice organizations, independent diagnostic testing facilities, independent clinical laboratories, and ambulance services suppliers.
- “High” providers include newly enrolled durable medical equipment and newly enrolled home health agencies.

Background Checks

All prospective providers, owners and managing employees will undergo a background check that will include checking their names and identifiers against several federal databases to determine if the provider is qualified for enrollment. Also, providers whose categories of service are considered “moderate” or “high” will be subject to unannounced site visits to determine if their facility is operational and functional. Lastly, providers and owners of “high” risk categories of service will be subject to criminal background checks, including fingerprinting. To prevent duplication of services, newly enrolled Medicare providers would not be required to undergo background screening when they apply for Medicaid/PeachCare for Kids.

Re-enrollment

Again, to help reduce fraud, waste and abuse, every five years all providers will be required to re-enroll with the Medicaid/PeachCare for Kids programs. Backgrounds checks as described above will be required. It is the intent of DCH and HP Enterprise Services that these process changes be done in such a manner as to prevent unnecessary burdens being placed on the provider community.

For questions or concerns, please do not hesitate to contact David Ostrander, Director, DCH Provider Enrollment, at dostrander@dch.ga.gov.
revised ENROLLMENT APPLICATIONS

The Department of Community Health (DCH) Provider Enrollment has implemented revised enrollment applications. The revised enrollment applications are located on the Web Portal (https://mmis.georgia.gov) under Provider Enrollment. Any applications submitted on the old enrollment forms after July 1, 2011, will be returned to the listed contact person.

power of attorney PAYEE SUBMISSION

Effective July 1, 2011, a scanned or faxed copy of the Power of Attorney for Payee will be accepted provided that:

1. The submitted Power of Attorney for Payee reflects the raised notary seal and all signatures can clearly be seen in a scanned or faxed copy.

2. If the notary seal is an ink seal, it can be clearly seen in a scanned or faxed copy.

If the notary seal and all signatures are unclear or illegible when the document is scanned or faxed, the faxed or scanned Power of Attorney for Payee will be returned to the sender and an original Power of Attorney for Payee will have to be submitted.

DCH reserves the right to reject a scanned or faxed copy of a Power of Attorney for Payee.
Providers must submit requests for initial review of a denial of a claim on the DMA-520 Provider Inquiry Form which is located in the Billing Manual and on the Web Portal (www.mmis.georgia.gov, under the Forms and Documents section). Providers must submit requests for initial review within 30 days of the date of the denial of claim payment.

Providers will receive a response to the inquiry in the same media type as the request. If the request is submitted on the DMA-520 Provider Inquiry Form, the response letter will be mailed to the location address on file. All inquiries regarding claim denials sent through the Contact Us feature will be responded to by secured e-mail transmittal.

Providers will have 30 days from the date of the initial review determination to request an administrative review.

**General Claim Payments**

A provider may request an initial review of a denial of a claim payment by mailing a DMA-520 Provider Inquiry Form with supporting documentation to:

Provider Correspondence  
HP Enterprises  
P.O. Box 105200  
Tucker, Georgia 30085-5200

Providers may inquire about a claim denial by submitting an e-mail request through the Contact Us page on the Web Portal at www.mmis.georgia.gov.
Requirements for the DMA-520 Form

When completing the DMA-520 Provider Inquiry Form, you are required to submit the Rendering Provider ID Number along with the location address that is linked to the Rendering Provider ID, and the provider’s full name (first and last) or payee name of the facility. Also required is the member’s full first and last name along with the member’s Medicaid ID number and a valid date of service.

**Update = Requests and Corrected Claims**

Please be advised that update requests and corrected claims should be sent to the following addresses and should not be sent with a DMA-520 Provider Inquiry Form for processing.

<table>
<thead>
<tr>
<th>Type of Update Request/Claim Correction</th>
<th>Issue of Inquiry</th>
<th>Mailing Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Updates</td>
<td>Hospice Lock-in, Eligibility, End-stage Renal Disease (ESRD) Form, Hospice Revocation</td>
<td>PO Box 105200, Tucker GA, 30085-5200</td>
</tr>
<tr>
<td>Provider Enrollment Updates</td>
<td>W-9, Clinical Laboratory Improvement Amendments (CLIA) Certification, Power of Attorney</td>
<td>PO Box 105201, Tucker GA, 30085-5201</td>
</tr>
<tr>
<td>TPL/Finance/Buy-In Updates</td>
<td>DMA 410 Form, Medicare Buy-In, DMA 460 Form</td>
<td>PO Box 105207, Tucker GA, 30085-5207</td>
</tr>
<tr>
<td>Adjustments and Voids</td>
<td>DMA 501 Form</td>
<td>PO Box 105206, Tucker GA, 30085-5206</td>
</tr>
<tr>
<td>Corrected Claims</td>
<td>CMS 1500, UB04, Crossover, American Dental Association (ADA) Dental claims</td>
<td>• For CMS 1500 claims, send to PO Box 105202, Tucker GA, 30085</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For UB04 claims, send to PO Box 105204, Tucker GA, 30085</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For Crossover claims send to PO Box 105203, Tucker GA, 30085</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• For ADA Dental Claims, send to PO Box 105205, Tucker GA , 30085</td>
</tr>
</tbody>
</table>
WORKSHOPS

To register online, visit [www.hp.com/go/GPW2011](http://www.hp.com/go/GPW2011). Upon receipt of your registration, a confirmation notice will be sent via email to the address provided on the registration. Review the confirmation email for accuracy, the confirmation email will include the facility location of the session.

If you have any questions regarding the Medicaid Workshops in June, please contact HP via email at GAworkshopregistration@hp.com.

<table>
<thead>
<tr>
<th>City/Territory</th>
<th>Facility</th>
<th>Date/Session</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dalton – Territory 1</td>
<td>N.W. Georgia Trade Center</td>
<td>9/14/2011 AM/PM</td>
</tr>
<tr>
<td>Atlanta – Territory 2</td>
<td>Georgia Tech</td>
<td>9/14/2011 AM/PM</td>
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<tr>
<td>Duluth – Territory 3</td>
<td>Gwinnett Center</td>
<td>9/22/2011 AM/PM</td>
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<tr>
<td>Carrollton – Territory 4</td>
<td>Tanner Medical Center</td>
<td>9/21/2011 AM/PM</td>
</tr>
<tr>
<td>Lithonia – Territory 5</td>
<td>Hilton Garden Inn</td>
<td>9/21/2011 AM/PM</td>
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<tr>
<td>Columbus – Territory 6</td>
<td>Columbus Civic Center</td>
<td>9/21/2011 AM/PM</td>
</tr>
<tr>
<td>Augusta – Territory 7</td>
<td>Peter S. Knox Conference Center</td>
<td>9/28/2011 AM/PM</td>
</tr>
<tr>
<td>Macon – Territory 8</td>
<td>Macon Marriott Convention Ctr (formerly the Macon Centerplex)</td>
<td>9/28/2011 AM/PM</td>
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<tr>
<td>Savannah – Territory 9</td>
<td>Memorial University Medical Center</td>
<td>9/26/2011 AM/PM</td>
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<tr>
<td>Thomasville – Territory 10</td>
<td>Archbold Medical Center</td>
<td>9/28/2011 AM/PM</td>
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<tr>
<td>Territory / Representative</td>
<td>Counties</td>
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<td>----------------------------</td>
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</tr>
<tr>
<td>1 North GA</td>
<td>Bartow, Catoosa, Chattooga, Cherokee, Dade, Dawson, Fannin, Floyd, Forsyth, Gilmer, Gordon, Habersham, Hall, Lumpkin, Murray, Pickens, Rabun, Stephens, Towns, Union, Walker, White, Whitfield</td>
<td></td>
</tr>
<tr>
<td><strong>Pete Goodrich, Field Service Representative (FSR)</strong></td>
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<tr>
<td>2 Atlanta</td>
<td>Fulton</td>
<td></td>
</tr>
<tr>
<td><strong>Shay Daniels, FSR</strong></td>
<td></td>
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</tr>
<tr>
<td>3 Northeast GA</td>
<td>Banks, Barrow, Clarke, Elbert, Franklin, Gwinnett, Hart, Jackson, Madison, Oconee, Walton</td>
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<tr>
<td><strong>Stanfinie Clayton, Interim FSR</strong></td>
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<tr>
<td>4 Northwest GA</td>
<td>Carroll, Cobb, Douglas, Haralson, Paulding, Polk</td>
<td></td>
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<tr>
<td><strong>Shareé Daniels, FSR</strong></td>
<td></td>
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<tr>
<td>5 Southeast Metro</td>
<td>Clayton, DeKalb, Rockdale</td>
<td></td>
</tr>
<tr>
<td><strong>Shemekia Brown, FSR</strong></td>
<td>Butts, Chattahoochee, Coweta, Fayette, Harris, Heard, Henry, Jasper, Jones, Lamar, Marion, Meriwether, Monroe, Muscogee, Newton, Pike, Spalding, Talbot, Taylor, Troup, Upson</td>
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<tr>
<td>6 Middle GA</td>
<td>Baldwin, Burke, Columbia, Glascock, Greene, Hancock, Jefferson, Jenkins, Johnson, Lincoln, McDuffie, Morgan, Oglethorpe, Putnam, Richmond, Screven, Taliaferro, Warren, Washington, Wilkes</td>
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<tr>
<td><strong>Amber Smith, FSR</strong></td>
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<tr>
<td>7 Augusta</td>
<td>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</td>
<td></td>
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<tr>
<td><strong>Anthony Banks, FSR</strong></td>
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<tr>
<td>8 Southwest GA</td>
<td>Appling, Bacon, Bryan, Bulloch, Camden, Candler, Charlton, Chatham, Effingham, Emanuel, Evans, Glynn, Jeff Davis, Long, Liberty, McIntosh, Montgomery, Tattnall, Toombs, Treutlen, Ware, Wayne</td>
<td></td>
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<tr>
<td><strong>Jill McCrary, FSR</strong></td>
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<tr>
<td>9 Southeast GA</td>
<td>Atkinson, Baker, Ben Hill, Berrien, Brantley, Brooks, Clinch, Coffee, Colquitt, Cook, Decatur, Early, Echols, Grady, Irwin, Lanier, Lowndes, Miller, Mitchell, Pierce, Seminole, Thomas, Tift, Turner, Worth</td>
<td></td>
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<tr>
<td><strong>Sabine Fortune, FSR</strong></td>
<td></td>
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<tr>
<td>10 South GA</td>
<td>Hospital Field Representative</td>
<td></td>
</tr>
<tr>
<td><strong>Donna Hendley, FSR</strong></td>
<td></td>
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<tr>
<td>11 Statewide</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Janey Griffin, FSR</strong></td>
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</tr>
</tbody>
</table>

You may contact your Field Service Representative by calling the Provider Services Contact Center at 1-800-766-4456 between the hours of 7:00 a.m. – 7:00 p.m. EST, Monday through Friday, excluding state holidays. You may also submit a “Contact Us” inquiry on the Web Portal.