The Georgia Collaborative ASO

Provider Handbook

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Effective Date: 7/1/2018
Quality Management Chapter Effective Date: 7/1/2019

Contents

Introduction to The Georgia Collaborative ASO

Overview

The Georgia Collaborative Administrative Services Organization (the Collaborative) assists the Georgia Department of Behavioral Health & Developmental Disabilities' (DBHDD) in its management of services and supports for Individuals receiving Community Behavioral Health and Rehabilitation Services (CBHRS), New Options Waiver (NOW), Comprehensive Supports Waiver (COMP), and state-funded behavioral health and intellectual and developmental disabilities services. The Collaborative was initiated in July 2015 and is comprised of three partner companies: Beacon Health Options, Behavioral Health Link, and Qlarant.

The Collaborative provides infrastructure focused on access to services, quality management and improvement, utilization management and review, data reporting, eligibility, claims payment, provider enrollment and information technology. The functions of the Collaborative satisfy federal and Medicaid requirements associated with both behavioral health and intellectual and developmental disabilities services via the external review and quality management systems.

The Georgia Collaborative ASO Provider Handbook is designed to provide guidance on how your organization will work with the Collaborative to provide high quality care to some of Georgia's most vulnerable citizens. We expect this provider handbook, in addition to all of the information contained on the Collaborative's website (www.georgiacollaborative.com) and links to other resources, will provide you with the tools necessary to ensure your success in providing high quality care that leads to lives of independence and recovery for the Individuals you serve.

Mission of The Georgia Collaborative ASO

We help people live their lives to the fullest potential. Our mission is made possible through effective partnerships with DBHDD, Individuals, and providers.

Vision of The Georgia Collaborative ASO

To improve the health and well-being of Individuals. The Collaborative makes this vision a reality by:

- Supporting recovery, resiliency, and independence
- Enhancing access to community services and ensuring the delivery of quality services to promote recovery and independence
- Providing a holistic, whole-health, and person-centered approach
- Leveraging technology through integrated and customizable platforms
- Coordinating complex clinical and operational systems to work efficiently
- Improving clinical outcomes and provider performance

Leadership Team

The Georgia Collaborative ASO Leadership Team	
Chief Executive Officer	Glenn Stanton
Chief Medical Officer	Mark Bradshaw, MD
Chief Operations Officer	Jessica Willhite, LPC
Chief Financial Officer	Karen Lee
Compliance Officer	Brianne Slover, LPC
Behavioral Health Administrative Director	Ashley Tricquet, LPC, CRC, MAC
Intellectual Disabilities Administrative Director	Sheyla Duvilaire, MS, MBA
Director of Quality Management	Nicole Griep, MSW
Director of Provider Relations	Jenny DeLoach
Director of Management and Information Systems	Gretchen Hudson
Director of Reporting and Analytics	Lena Gomes, PMP, CPC
Director of Independence Recovery and Advocacy	Jean Olshefsky, CPS, CARES
Executive Assistant	Hanya Whyte
The Georgia Collaborative ASO Partners	
Chief Executive Officer GCAL	Wendy Martinez Farmer, LPC
Qlarant **Director IDD Quality Reviews**	Marion Olivier, MSW

Contact Information

Georgia Crisis and Access Line (GCAL)	**Tel:** 800.715.4225 (24 hours a day, 7 days a week) **Website:** www.bhlweb.com
Customer Service	**Tel:** 855.606.2725 (Monday – Friday, 8:00am – 5:00pm)
EDI Helpdesk	**Tel:** 888.247.9311 (Monday – Friday, 8:00am – 6:00pm) **Email:** e-supportservices@beaconhealthoptions.com
Clinical Department	**Customer Service:** 855.606.2725 **Care Coordination Fax:** 855.858.1966 **Care Coordination**: GACARE@beaconhealthoptions.com **PASRR Fax:** 855.858.1965 **PASRR Email:** GAPASRR@beaconhealthoptions.com
TTY	**Tel:** 404.836.1741
Compliments, Complaints, Grievances, and General Feedback	**Tel:** 855.606.2725 (Monday – Friday, 8:00am – 5:00pm) **Email:** GACOFeedback@beaconhealthoptions.com
Fraud, Waste and Abuse	**Tel: 404.836.1668** **Safe To Say Ethics Hotline**: 888.293.3027 **Email:** GACompliance@beaconhealthoptions.com **Report by Mail:** Beacon Health Options Attn: Compliance Officer P.O. Box 56324 Atlanta, Georgia 30343
Provider Relations	**Email:** GACollaborativePR@beaconhealthoptions.com
Provider Enrollment	**Email:** GACollaborative@beaconhealthoptions.com
Quality Management	**Quality Management Contact List**: click here

Provider Relations

Overview

The Provider Relations Department is responsible for provider enrollment, programmatic oversight, training and the delivery of education programs across the state of Georgia. Additionally, the Provider Relations team assists providers with escalated issues related to, but not limited to: provider files, eligibility, authorizations, claims, clinical processes, quality processes and enrollment.

Please visit our Training and Education webpage for more information on upcoming training(s) or to access training materials: Training and Education

Provider Enrollment/Credentialing

The enrollment processes for new providers seeking to contract with the Department of Behavioral Health and Developmental Disabilities (DBHDD) or existing providers seeking to expand to additional locations and/or services complies with DBHDD standards as well as other state and/or federal laws, rules and regulations. The Collaborative manages the application process for providers seeking approval for Behavioral Health Medicaid services under Category of Service 440, Community Behavioral Health and Rehabilitation Services (CBHRS), IDD Waivers - 680, New Option Waiver (NOW) and 681, Comprehensive Waiver (COMP). Final approval for those providers and agencies seeking to enroll as a provider is completed by DBHDD and DCH. The enrollment process requires formal approval for all behavioral health and IDD providers, including, individual practitioners where applicable and agencies (clinics, facilities or programs).

Providers are reviewed and approved for designated services at specific locations. Should providers render services for which they are not approved (or at a site for which they are not authorized), service authorization and payment are subject to denial. Providers should seek approval through the Collaborative enrollment process to add additional services and site locations to existing contracts with DBHDD, prior to delivery of service to avoid denial and non-payment.

New Provider Enrollment

The entire process for a new provider to become contracted with DBHDD, including obtaining a Medicaid provider ID, may take 120-180 days. Factors that may contribute to longer approval timeframes may include: the type(s) of service(s) applied for, completeness of application and provider responsiveness. For more information, providers may refer to the Open Enrollment Forum training materials for the discipline in which they are interested and the Provider Enrollment Frequently Asked Questions (FAQ's) sections of the Collaborative website.

For additional information regarding specific policies and procedures for the Provider Enrollment processes, please refer to:

a. Behavioral Health: Policy (01-111)
   https://gadbhdd.policystat.com/policy/1574803/latest/
b. Intellectual and Developmental Disabilities: Policy (02-701)
   https://gadbhdd.policystat.com/policy/1564479/latest/

New Provider Application Process

In order to become a contracted DBHDD provider, the following steps must be completed:

1. Attendance at Provider Enrollment Forum for New Providers
2. Letter of Intent (LOI) submitted to The Collaborative
3. New Provider Application submitted to the Collaborative (upon request)
4. Site Visits (when applicable)
5. Department of Community Health (DCH) Application
6. DBHDD Approval
7. DCH Approval
8. New Provider Orientation
9. Letter of Agreement (LOA) Execution by DBHDD
10. Provider Network Activation by the Collaborative

1. **Attendance at Provider Enrollment Forum:** The enrollment process for new providers begins with required attendance of the Provider Enrollment Forum for New Providers for their specific discipline (BH or IDD). Please visit our website to see when the next Provider Enrollment Forum is scheduled to occur. Please note, a certificate of attendance must be obtained.

2. **Letter of Intent sent to the Collaborative:** After attendance at the Provider Enrollment Forum, providers must submit a complete and signed Letter of Intent (LOI) including all required supporting documentation. An LOI and a list of the required supporting documentation can be obtained by clicking here: Link to forms
    a. LOI's must be typed, printed and mailed via USPS with copies of supporting documents to the following address:

    Georgia Collaborative ASO Enrollment
    PO Box 56324
    Atlanta, GA 30343

    b. LOIs cannot be submitted until the first day of the month following attendance at Provider Enrollment Forum. For example, if the Provider Enrollment Forum is July 10, the LOI cannot be submitted until August 1.
    c. LOIs must be signed and submitted within 30 calendar days of attendance at the Enrollment Forum
    d. Providers will receive an acknowledgement letter via email from the Collaborative Enrollment Department within five (5) business days of receipt: GAcollaborative@beaconhealthoptions.com
    e. **LOI Timeline:** LOIs will be reviewed to ensure each Pre-Qualifier is included in submission. The Collaborative Enrollment Department will determine if applicants meet all applicable pre-qualifiers set forth by DBHDD within 30 calendar days of receipt. During this time, should there be deficiencies this will be communicated to the provider via email. The provider will have five (5) business days to correct identified deficiencies and return via email to the Collaborative Enrollment Department. Failure to respond or submit requested documentation may result in a determination to close the LOI.
    f. **Approved LOI:** Providers whose LOI's are approved will receive an email notification with an Invitation to Apply. The next step in the process is submitting a New Provider Application, which must be submitted within 30 calendar days of invitation**.**

3. **New Provider Application submitted to The Georgia Collaborative ASO:** The provider has 30 calendar days after the LOI approval to submit a New Provider

Application. An email notification will be sent to the provider after the LOI approval confirming the next steps in the process. The application process will adhere to the LOI timeframes for review and approval.

a. Timeline: The Collaborative Credentialing Department will review the application within 30 calendar days of receipt. During this time, deficiencies will be communicated to the provider via email. The provider will have five (5) business days to correct identified deficiencies and return via email to the Collaborative Enrollment Department. Failure to respond or submit the requested documentation may result in closure of the application.
b. Incomplete Application: A letter requesting corrections will be emailed, if the provider fails to submit a complete and signed enrollment application, including all required supporting documentation. Providers will have one opportunity to submit the corrects, and this must be received within five (5) business days.

4. **Site Visits:** As part of the approval process, the applicable DBHDD Field Office staff may conduct a site visit of all locations. Site visits include an inspection using DBHDD site and operations standards. Providers will be notified via email with instructions from the Collaborative Enrollment Department if they are required to schedule a site visit. Site visits must be scheduled by the provider with DBHDD Field Offices within 14 days of receipt of notice. The DBHDD Field Office has 30 days to complete the inspection and submit to: GA_enrollment@beaconhealthoptions.com. For additional information pertaining to site visits, please refer to DBHDD policy and attachments for IDD and BH providers.

5. **Department of Community Health (DCH) Application:** As part of the approval process, providers may be required to submit an online DCH Application to obtain a Medicaid Provider ID. Providers will be notified via email with instructions from the Collaborative Enrollment Department if they are required to obtain a Medicaid Provider ID.

6. **DBHDD Approval:** The Collaborative Enrollment Department will submit the entire application packet to DBHDD to recommend approval or denial.

7. **DCH Approval:** The DCH will either approve or deny the Medicaid Provider application. Approvals are sent directly to DBHDD. The DCH will communicate denials directly to the provider. Providers are given appeals rights by DCH. For more information, please refer to the Medicaid Policies and Procedures Part I.

8. **New Provider Orientation:** Providers are notified of their final approval by DBHDD. If approved, the provider must attend a New Provider Orientation. If the application is not approved, the provider must complete the process again starting with Provider Enrollment Forum (#1 above).

9. **Letter of Agreement (LOA) Execution by DBHDD:** Once New Provider Orientation is completed, DBHDD will issue a Letter of Agreement (LOA) within 10 business days. Provider has 10 business days to sign and return to DBHDD (via email or mail).

10. **Provider Network Activation by The Georgia Collaborative ASO:** Once the LOA is fully executed, DBHDD will notify the Collaborative for activation within the DBHDD provider network.

Key Points to Remember

The following are key points to remember when applying to become a new provider:

- **Email Address:** Email is the standard form of communication after the initial LOI is received and processed by the Collaborative Enrollment Department; therefore, it is imperative that the applicant identify an appropriate point of contact and supply a correct email address that is regularly checked to ensure receipt of information and timeliness of additional correspondence that may be required during the process. Providers can expect to receive email correspondence from GACollaborative@beaconhealthoptions.com. To ensure receipt of emails from this mailbox, providers may wish to add this email address to their approved contact list or address book.
- **Incomplete Information:** Failure of a provider to submit a complete and signed LOI or application, including all required supporting documentation, within the specified amount of time outlined, may result in closure of the LOI or application.
- **DBHDD Policy:** As stipulated in DBHDD policy (links below), decisions to approve or deny initial Letters of Intent (LOIs) or applications and/or to submit a given enrollment application for further review are made by DBHDD and DCH, as well as the Collaborative. For further details, please review the following DBHDD policies:
    a. Behavioral Health: Policy (01-111) https://gadbhdd.policystat.com/policy/1574803/latest/
    b. Intellectual and Developmental Disabilities: Policy (02-701) https://gadbhdd.policystat.com/policy/1564479/latest/

Please contact the GACollaborative@beaconhealthoptions.com for additional questions regarding the enrollment process.

Additional information about the enrollment processes can be found in our Frequently Asked Questions document, on our website under the Provider Enrollment section.

New Provider Access to Network

After receiving an approval to become a DBHDD provider, the following steps must be completed:

1. New Provider Orientation
2. Letter of Agreement
3. Provider File Activated
4. ProviderConnect Access and Training

1. **New Provider Orientation:** Providers that are new to the DBHDD network of approved providers will be required to participate in New Provider Orientation Training prior to receiving their official Letter of Agreement (LOA) from DBHDD. These trainings are designed to assist new providers with gaining a better understanding of DBHDD policies and procedures and the Collaborative policies and procedures as they relate to service delivery.
    i. Each orientation session will be conducted in a webinar format and will include:
        1. Overview of the mission, vision, and expectations of DBHDD and the Collaborative
        2. Overview of each key function of the Collaborative: Utilization Review, Quality Management, GCAL, Compliance and Reporting, health care analytics, eligibility, claims, and future provider education and training

3. General review of the onsite review processes by the Quality Management Department

ii. Registration details will be sent to providers via email

i. Providers must register and complete New Provider Orientation within 30 days of receiving approval letter from DBHDD

2. **Letter of Agreement:** Once a provider has completed the orientation process, DBHDD will issue a Letter of Agreement (LOA) that must be signed and returned to DBHDD within 10 business days.
3. **Provider File Activated:** Once an LOA has been executed, DBHDD will notify the Collaborative to activate the appropriate service locations and associated approved services in the Connects system. The Collaborative will notify providers in writing once this has occurred.
4. **ProviderConnect Access and Training:** After the Provider File has been activated, providers will enroll in the ProviderConnect Training conducted by the Collaborative. Once the training has been completed, providers can begin submitting registrations and authorizations via ProviderConnect. Please refer to the ProviderConnect User Guide for additional information. Batch providers will receive information from Provider Relations regarding system access. Please refer to the Batch Companion Guide for more information.

Existing DBHDD Providers

Application Process: All applications from existing providers must be typed and emailed to GA_Enrollment@beaconhealthoptions.com or printed and mailed with copies of supporting documents to the following address:

Georgia Collaborative ASO Enrollment
PO Box 56324
Atlanta, GA 30343

Adding a Service/Location: Existing DBHDD providers wanting to add a service or a location must follow the guidelines below. Providers must provide services for a minimum of one year before applying for new services or locations. Behavioral Health provider's last two Quality Review scores must be at least 80% or above in order to add a service(s) or location. For IDD providers to add a location or service, they must be accredited or certified through DBHDD Compliance. Please refer to the Quality Management section for further information regarding the Quality Reviews.

- **Adding a service to an existing location:**
    1. Existing DBHDD providers who wish to add services must complete the Existing Provider Application (either IDD or BH).
        a. The application may be completed online, printed or saved, and submitted via email with all required supporting documentation
        b. The Application for Existing Providers can be obtained from the Collaborative website
        c. Failure of a provider to submit a complete and signed enrollment application and all required supporting documentation, may result in closure of the application request.
    2. Department of Community Health (DCH) Application

a. Providers will be notified via email with instructions from the Collaborative Enrollment Department if they are required to obtain a new Medicaid Provider ID

3. DBHDD Approval
    a. the Collaborative Enrollment Department will submit the entire application packet to DBHDD to recommend approval or denial
4. DCH Approval
    a. The DCH will either approve or deny the Medicaid Provider application. Approvals are sent directly to DBHDD. The DCH will communicate denials directly to the provider. Providers are given appeals rights by DCH. For more information, please refer to the Medicaid Policies and Procedures Part I

- **Adding a Location:**
    1. Existing DBHDD providers who want to add a location must complete an Application for Existing Providers found on the Collaborative website.
        a. The application may be completed online, printed or saved, and then submitted with all required supporting documentation.
    2. Site Visit
        a. As part of the approval process, the applicable DBHDD Field Office staff may conduct a site visit of all locations
        b. Site visits include an inspection using DBHDD site and operations standards
        c. Providers will be notified via email with instructions from the Collaborative Enrollment Department if they are required to schedule a site visit
        d. Site visits must be scheduled by the provider with the DBHDD Field Office within 14 days of receipt of notice
        e. The DBHDD Field Office has 30 days to complete the inspection and submit the results to: GA_enrollment@beaconhealthoptions.com
        f. For additional information pertaining to site visits, please refer to DBHDD policy and attachments for IDD and BH providers
    3. Department of Community Health (DCH) Application
        a. Providers will be notified via email with instructions from the Collaborative Enrollment Department if they are required to obtain a new Medicaid Provider ID
    4. DBHDD Approval
        a. the Collaborative Enrollment Department will submit the entire application packet to DBHDD to recommend approval or denial
    5. DCH Approval
        a. The DCH will either approve or deny the Medicaid Provider application. Approvals are sent directly to DBHDD. The DCH will communicate denials directly to the provider. Providers are given appeals rights by DCH. For more information, please refer to the Medicaid Policies and Procedures Part I

- **Timeline:** Providers will receive an email from the Collaborative Enrollment Department (GA_Enrollment@beaconhealthoptions.com) within five (5) business days acknowledging receipt of the application. the Collaborative Enrollment Department will determine if the application is complete within thirty (30) calendar days of receipt. Deficiencies will be communicated to the provider, via email. The provider must correct

deficiencies within five (5) business days. Failure to do so may result in closure of application.

- **Application Completion:** Providers who successfully completes an application will receive an email notification from the Collaborative Enrollment Department, defining next steps in the process, which may include a site visit and DCH application, if applicable.

- **Incomplete Information:** Failure to submit a complete and signed enrollment application and all required supporting documentation within specified timeframe provided in email communication, may result in closure of request for addition of services/locations. If the application materials do not meet the requirements, providers may choose to re-apply during the next open enrollment cycle for the discipline in which they are interested in providing services.

Provider File Maintenance (change of address, staffing, mailing address, etc.): All providers are required to report to the Collaborative any changes of address, mailing address, agency name and staffing changes as applicable. This reporting process is essential to the Collaborative maintaining accurate provider files for DBHDD. The Change of Information Form must be submitted along with DCH Change of Information Form for approved Medicaid services. Providers are asked to notify GA_enrollment@beaconhealthoptions.com at least thirty (30) days prior to a planned change. Requested information will include:

- Name of Agency
- Address Information (Include updated Healthcare Facility Regulation license, if required)
- Point of Contact Information (e.g. CEO, Clinical Director, IDD Director, etc.)
- Licensure/Accreditation/Insurance Information/updates

Deactivation of Participation: Providers who wish to dis-enroll as a Medicaid and DBHDD provider may do so at any time by submitting the Georgia Medicaid Termination Request Form to the Collaborative. Please note that once the Medicaid number(s) are terminated, the number(s) cannot be reactivated at a later time.

Change of Ownership or Legal Entity: Providers who wish to change ownership and/or legal entity.

- If same legal entity will remain in place, but ownership will change, providers must request Change of Ownership instructions from Gacollaborative@beaconhealthoptions.com.
- If a new legal entity is created, providers must submit complete ***New*** Provider Enrollment process described above.

The Collaborative Provider Identification Numbers

Once a provider is approved, there are several different Provider Identification Numbers assigned:

1. **Georgia Collaborative Provider Number:** A unique six-digit number with a three-letter contract prefix (e.g. GAC123456) assigned by the Collaborative.
    - This is the primary number used by the Collaborative in identifying providers in the DBHDD network.

- This number is also required for submitting authorizations via ProviderConnect or through the batch process.

2. **Vendor Number:** Identifies where services are or were rendered. A provider may have multiple vendor locations and each vendor location is given a five-digit number preceded by two (2) letters. (e.g. GA23456).

3. **Pay-to Vendor Number:** For providers with multiple locations, a pay-to vendor number is issued by the Collaborative and indicates the mailing address for payments. Providers are encouraged to register with PaySpan Health to receive electronic payments. A provider can have more than one pay-to vendor number and each number needs to be registered with PaySpan.

4. **National Provider Identifier (NPI):** Providers must have an NPI through the National Plan & Provider Enumeration System. The NPI is a unique ten-digit identification number issued to health care providers in the United States by the CMS. Please note: the NPI is different from the Collaborative Provider Number. Health and Human Services adopted the NPI as a provision of HIPAA. This number is also contained in the Connects system and can be used to locate a provider records for claims, referrals and authorization purposes within ProviderConnect.

   Individual providers should use their social security number in lieu of NPI numbers on enrollment documents.

   For additional information, please refer to the National Plan & Provider Enumeration System website.

Provider Training

The Collaborative offers ongoing provider training throughout the year. The different types of training are outlined below.

New Provider Orientation

Providers that are new to the DBHDD network of approved providers will be required to participate in the New Provider Orientation Training prior to receiving their official Letter of Agreement by DBHDD. These trainings will be offered in a webinar format and are designed to assist new providers with gaining a better understanding of DBHDD policies and procedures and the the Collaborative policies and procedures as they relate to service delivery.

Each orientation session will be conducted in a webinar format and will include:

- Overview of the mission, vision, goals and expectations of DBHDD and the Collaborative Overview of each key function of the Collaborative: Utilization Review, Quality Management, GCAL, Compliance and Reporting and health care analytics.
- General review of the onsite review processes

Ongoing Education and Training

A variety of face-to-face and webinar sessions will be scheduled each quarter for BH, IDD, and Specialty providers, focusing on the provider community at large. The trainings will provide specific information regarding the DBHDD and the Collaborative systems and processes to

specific groups of providers in an effort to teach specific skills applicable to services rendered. Industry best practices material will be included to assist providers with benchmarking their results and understanding and interpreting the results.

All provider training activities will be coordinated through the Collaborative's Provider Relations Manager/Trainer. Providers will be notified via email and the Collaborative's Constant Contact list serve when trainings are posted on the Collaborative website. Registration will be required for face-to-face trainings, and some service-specific webinars due to the high volume of participants.

Topics may include:

- Treatment Planning
- Documentation
- Safety Plans
- CSU Service Guidelines
- Transition Planning/Community Life Integration
- ACT Service/Service Guidelines
- Psycho-social Rehabilitation versus Community Support
- Focused Outcome Areas (FOA) Person Centered Practices
- FOA-Community Life
- FOA-Choice
- FOA-Safety
- FOA-Whole Health
- FOA-Rights
- ProviderConnect Overview

Technical Assistance

Technical Assistance calls will highlight the areas where providers have challenges and immediate solutions to any issues will be offered when available. Provider Relations will partner with various departments within the Collaborative to provide ongoing technical assistance and education. Providers may request additional technical assistance, as needed.

Training Requests

Providers can submit training requests via email to the Provider Relations Department GAcollaborativePR@beaconhealthoptions.com. Past training webinars are posted on the Collaborative website for reference.

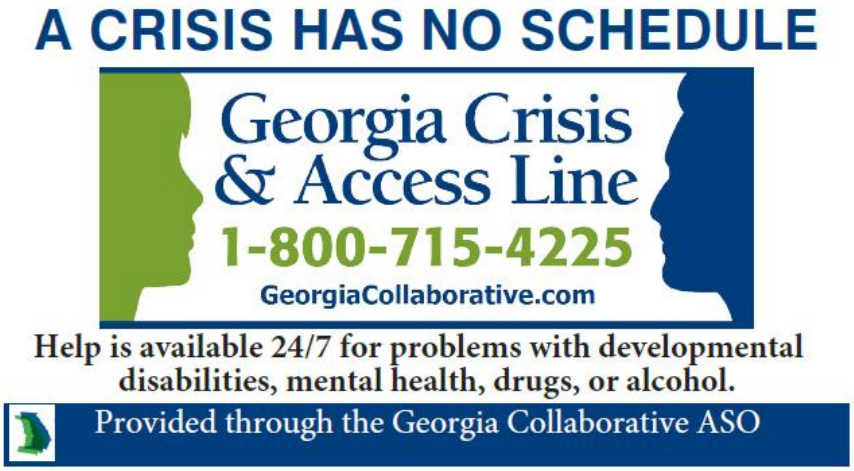
Provider Inquiries

If a provider has a question related to registration, credentialing, eligibility, authorization, claims, etc. these may be submitted through an inquiry in ProviderConnect, by contacting Customer Service (1-855-606-2725) or by contacting Provider Relations at gacollaborativePR@beaconhealthoptions.com. Inquiries will be routed to the appropriate team for resolution within five business days.

Georgia Crisis and Access Line

Overview

Partnering with Behavioral Health Link (BHL), the Collaborative is responsible for the provision and management of a 24/7 Crisis and Access Line – The Georgia Crisis and Access Line (GCAL). GCAL was launched by DBHDD in 2006 and BHL has operated the program since its inception. Accredited by CARF as a Crisis and Information Call Center, by the American Association of Suicidology as a Crisis Center and by URAC as a Health Call Center, BHL operates GCAL from a crisis contact center in Atlanta, Georgia.



Key Functions

GCAL provides telephonic crisis intervention, clinical triage, and referral for Georgians in need 24/7/365.

Other key functions of GCAL include:

- 24/7/365 Mobile Crisis Dispatch for all State Funded Behavioral Health and Developmental Disability Mobile Crisis Response Teams
- 24/7/365 Preferred Point of Entry for State Contracted Inpatient Beds
- 24/7/365 Preferred Point of Entry for Crisis Stabilization Units and State Hospitals
- 24/7/365 Initial Authorization for CSU, State Hospital, and State Contracted Inpatient Bed Admissions

Access to Services Through GCAL

Individuals can access DBHDD funded services directly through the provider they choose or through the Georgia Crisis and Access Line (GCAL) 24/7 at 1.800.715.4225. DBHDD has policies in place that address contractual expectations related to access to services for Individuals and sets forth acuity guidelines to specify timeframe expectations based on the urgency of the Individual's needs.

- Policy (01-200): Comprehensive Community Provider (CCP) Standards for Georgia's Tier 1 Behavioral Health Safety Net

- Policy (01-230): Community Medicaid Provider (CMP) Standards for Georgia's Tier 2 Behavioral Health Services

When assisting Individuals in accessing care through Georgia Crisis and Access Line, Clinicians use the DBHDD Acuity Guidelines listed below to guide decisions related to the severity of an Individual's symptoms and appropriate timelines for receipt of care.

Acuity	Intensity *(One or more of the following is present)*	Potential Responses
Emergent	*A life threatening condition exists as caller presents:* ▪ Suicidal/homicidal intent ▪ Actively psychotic ▪ Active withdrawal (Alcohol, Barbiturates) ▪ Disorganized thinking or reporting hallucinations which may result in harm to self/others ▪ Imminent danger to self/others ▪ Unable to care for self	*For an Emergency / Crisis:* ▪ Immediately arrange to be seen within *two hours* ▪ If suicidal/homicidal with means, call 911/Police ▪ If active withdrawal, send to nearest ER for medical clearance
Urgent	▪ No suicidal/homicidal intent ▪ Denies suicidal plan/means/capability ▪ Expresses hopelessness, helplessness, sense of burdensomeness, disconnectedness or anger ▪ May develop suicidal intent without immediate help ▪ Potential to progress to need for emergent services ▪ May express distress/impairments that compromise functioning, judgment and/or impulse control ▪ May have withdrawal signs/symptoms from non-life threatening substances: Cocaine, Methadone, Heroin ▪ Dependence on Alcohol, Benzodiazepines or Barbiturates, but not in active withdrawal and no history withdrawal seizures or DTs	*For Severe Situation:* ▪ Offer Mobile Crisis ▪ Offer an urgent appointment in no later than three calendar days ▪ Instruct caller to re-contact BHL if condition worsens
Routine	▪ Impacts caller's ability to participate in daily living ▪ Markedly decreased the caller's quality of life ▪ Caller acknowledges some distress/concerns ▪ No evidence of danger of harm to self/others ▪ No marked impairments in judgment or impulse control ▪ Severity warrants assessment and possibly services ▪ SA issues with possibility of substance dependence	*For Distressed Caller:* ▪ Assist in identifying a provider and warm transfer to the provider during business hours or give the phone number after hours. Contact BHL/GCAL again if condition worsens.

GCAL Provider Interface

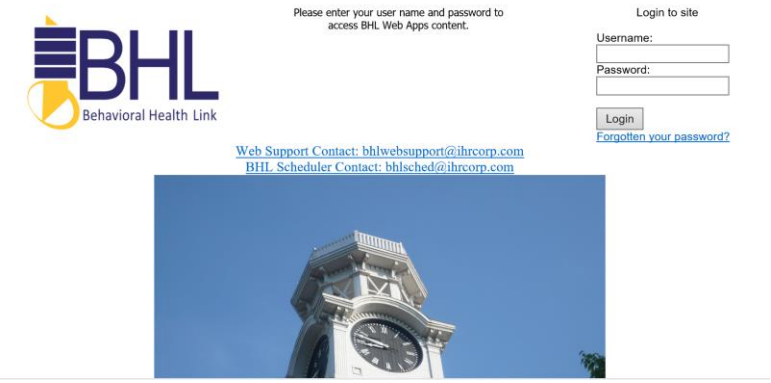
Emergent Referrals
When GCAL identifies an Individual with emergent needs, a referral may be made for Mobile Crisis Response Services (MCRS), Crisis Stabilization Unit, Behavioral Health Crisis Center walk-in evaluation, connection to Assertive Community Treatment team (if the Individual is already enrolled in ACT), State-Contracted Inpatient Facility, or State Hospital. All communications between GCAL and the agency being referred to are made electronically, in real-time using bhlweb.com and tracked until the provider confirms individual is receiving services.

NOTE: should an Individual require admission to an acute facility, GCAL will provide an initial authorization. For more information on the initial authorization process see the ProviderConnect section of this handbook.

Urgent Referrals
Urgent referrals are made for Individuals who need connection to a provider within 72 hours. If an Individual is already enrolled with a provider, GCAL will recommend reconnection and notify the provider of the Individual's call to GCAL using a secure alert email with the triage documentation attached. All Tier 1 and Tier 2+ providers are required to provide electronic urgent appointments for GCAL's use. GCAL documents the distribution of those appointments, by sending an alert email at the time the appointment is made with the triage documentation attached.

Routine Referrals
Individuals identified as needing routine services will be given a choice of providers. During business hours, GCAL will warm transfer the caller to the identified agency. After hours, GCAL will give the Individual the agency phone number to contact on the next business day. In both cases, GCAL will place the triage on an access table on bhlweb.com for the provider to access the reason for referral and initial clinical information gathered

Bhlweb.com
Bhlweb.com is a secure, HIPAA-compliant website used to facilitate referrals to Mobile Crisis Teams for behavioral health and developmental disabilities, Crisis Stabilization Units, State-Contracted Inpatient Beds, and State Hospitals. Technical support for bhlweb.com users is available 24/7 via bhlwebsupport@ihrcorp.com.



ProviderConnect

Overview

The Collaborative utilizes ProviderConnect for the registration and authorization processes. This section outlines the system-specific components of the registration and authorization process within ProviderConnect. ProviderConnect is an easy-to-use online application that providers can use to complete service requests. Providers have the ability to access this system and their information 24 hours a day, seven days a week, excluding scheduled maintenance.

The following functions are completed through ProviderConnect:

- Registration for each Individual
- Verify Individual's eligibility and registrations
- Enter an authorization request for an Individual
- Search authorizations
- Submit discharge reviews
- Enter a claim
- Search claims
- Super user only: add a new authorized user for the agency

In addition, ProviderConnect contains links to other resources such as:

- Compliance
- The Georgia Collaborative ASO Provider Handbook
- Forms

ProviderConnect User Guide

The Collaborative offers a ProviderConnect User Guide. The User Guide includes detailed information on accessing ProviderConnect and all functions stated above.

Registration

Providers must ensure that Individuals are registered in the Collaborative system prior to requesting authorization.

- A registration is a separate process from authorization for services.
- A registration results in an Individual receiving a unique consumer ID (CID) which enables the Individual to be tracked throughout the system. A CID follows the Individual throughout the system and is not unique to the provider. The Collaborative uses "best match" logic to reduce the likelihood of duplicate CIDs being created for one Individual.
- The registration process requires that providers answer questions that will determine the fund source the Individual is potentially eligible to receive. Services for individuals are based on the provider's credentialed services and Individual's available funding (e.g. Medicaid, state funded services). The connection to this braded funding is done by the Collaborative based on logic built into the system. Providers should answer questions to the best of their ability to ensure appropriate funds are assigned and Individuals are eligible for the correct funds.

- Most registrations remain active for a period of 365 days.
- Individuals must have an active registration prior to providers submitting an authorization request.
- The registration is able to be updated when an Individual's demographic information changes.
- NOTE: Verification of eligibility and/or identification of benefits is not a clinical process and authorization is not a guarantee of payment.

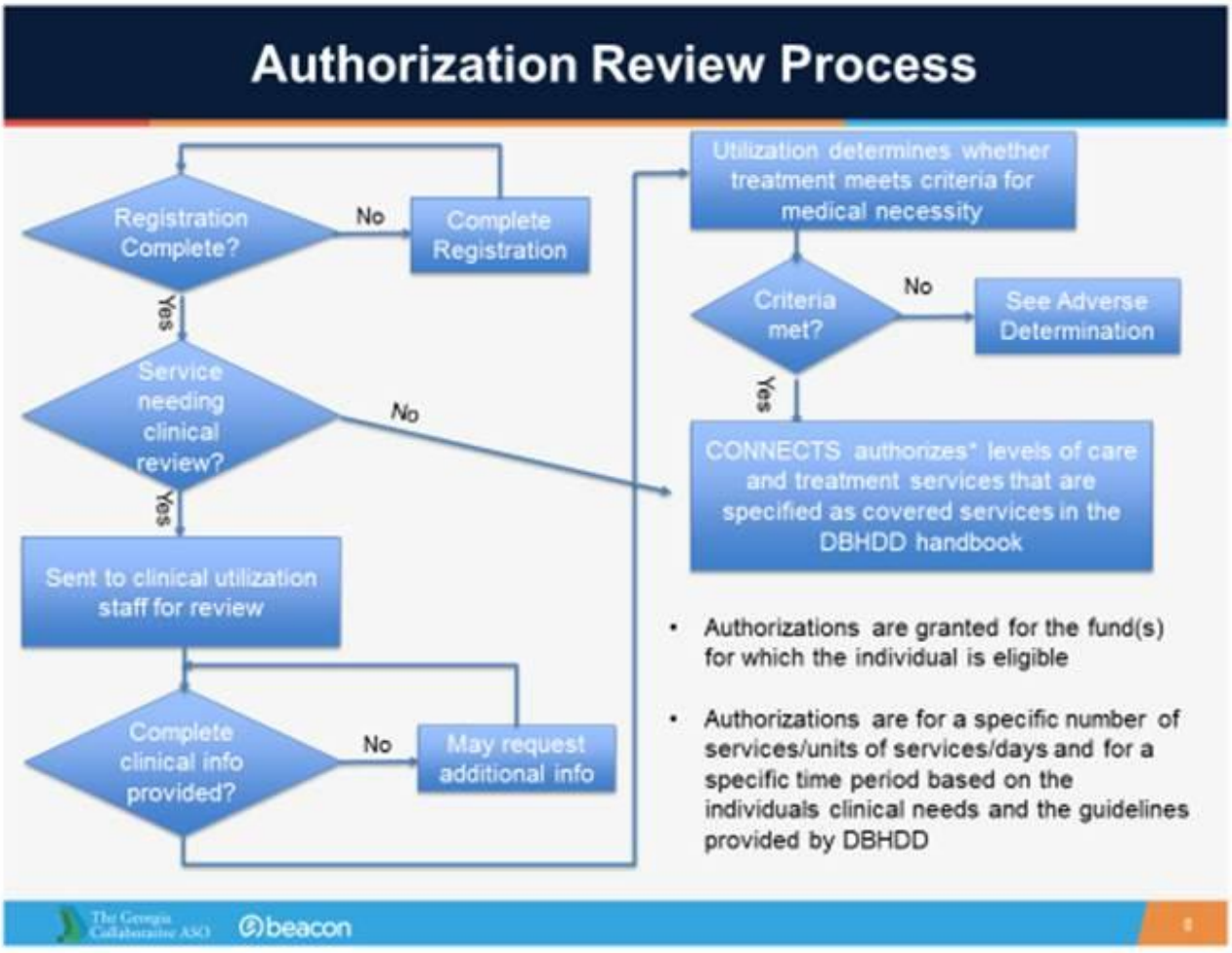
Authorization

An authorization submission verifies the Individual's eligibility and registration for specific services and the funding source that is required for claims payment.

- **Combination of Care (CoC):** Four-part classification to differentiate services provided to an individual. This consists of: Level of Service (LOS), Type of Service (TOS), Level of Care (LOC), and Type of Care (TOC).
- **Initial:** Authorization submissions for new CoC for an Individual is called Initial authorization request.
- **Concurrent:** Authorizations submissions for continued services under the same CoC are called Concurrent authorization requests.
- **Update:** Authorization submissions for edits to an existing authorization is called Update authorization requests.
- **Episode of Care:** All authorized services for a specific individual/provider combination from initial through discharge (if completed).
- **Authorization numbers:** Each unique combination of care requires a new initial request to begin services and will get a new authorization number. Please refer to the Claims Procedures and Electronic Submission section of this handbook for more information.
- Each authorization submission is provider-specific (as opposed to the registration which is Individual-specific and not unique to a provider).
- Providers must include in the authorization all service classes that are ordered as part of the Individual's plan of care.
- Any outpatient concurrent requests should be submitted within 30 days prior to expiration of the most recent authorization.
    - Any higher level of care (Crisis Stabilization, Inpatient State Contracted Bed, Inpatient Detoxification and Psychiatric Residential Treatment) concurrent authorization requests should be entered on or before the last covered day of service.
- NOTE: Some concurrent submissions require the completion of the CANS / ANSA assessment. Example: All concurrent requests for non-intensive outpatient services will require CANS or ANSA.

  Please refer to the ProviderConnect User Guide for more detailed information.

High-Level Registration and Authorization Process Flow

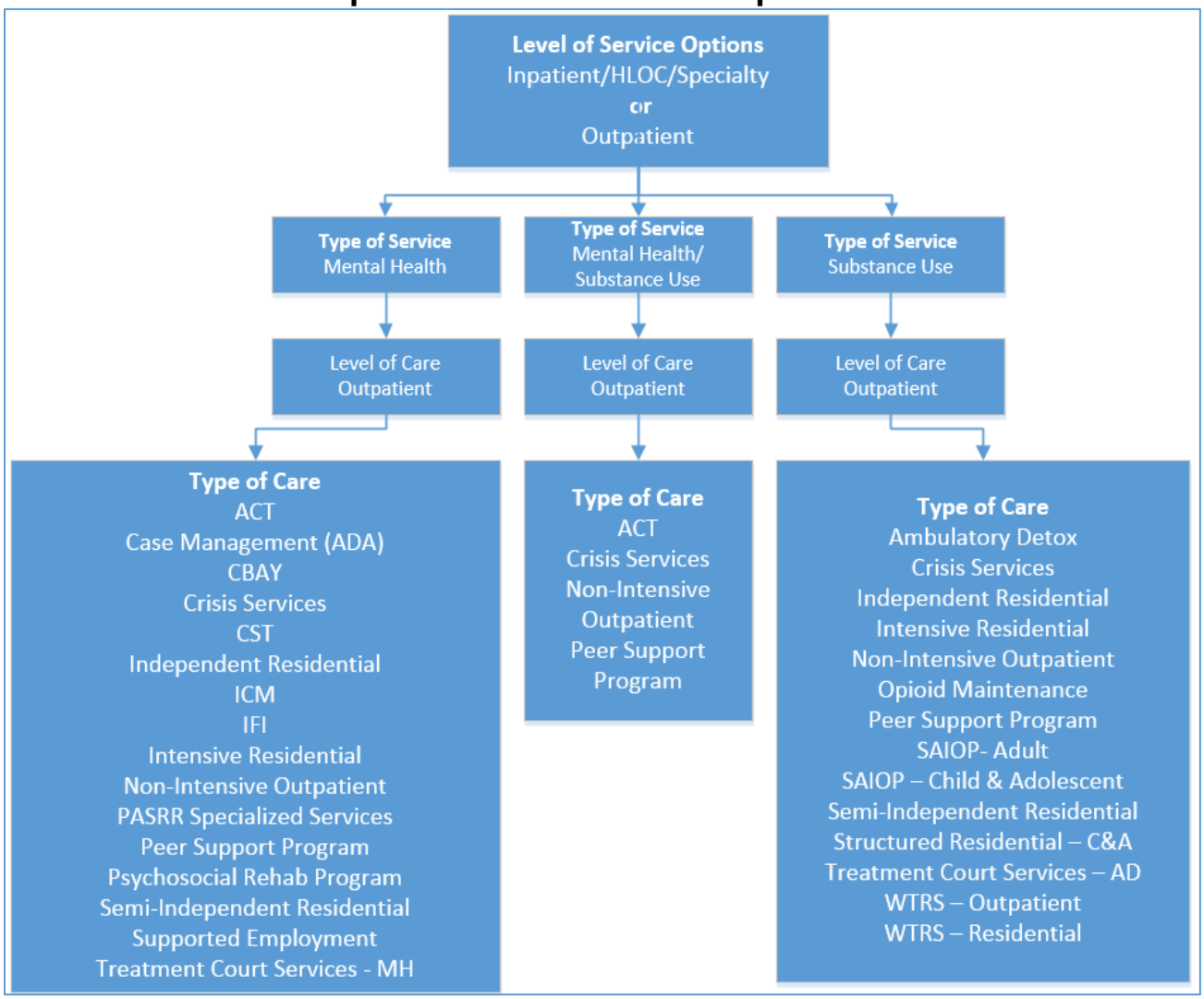


Note: The mechanism for requesting authorizations varies for higher levels of care.

- Initial inpatient and CSU referrals and authorizations are requested through the GCAL
- Concurrent reviews for inpatient and CSU are requested through the Collaborative Concurrent reviews for Inpatient are completed through ProviderConnect or the batch process
- Concurrent reviews for CSU's may be requested through ProviderConnect or the batch processes
- PRTF is requested (initial and concurrent) exclusively through ProviderConnect
- All other services can be requested via ProviderConnect or the batch processes

- **Outpatient Level of Care:** The below graphic illustrates how Behavioral Health Outpatient levels of care would be requested through the web-based ProviderConnect portal.
    1. To request community based outpatient services, the provider must first determine the Level of Service – **Inpatient/High Level of Care(e.g. CSU)/Specialty or Outpatient**. For outpatient services select **Outpatient** (see the first row of the illustration below)
    2. Type of Service is either mental health, substance use or co-occurring mental health/substance use. Co-occurring should only be selected if the provider will be *actively treating both*. NOTE: Some services are only covered under one or the other type of service.
    3. For Outpatient Services, the provider will have an option to select the Type of Care and then the services requested within each.
        a. Example: If a provider is requesting non-intensive services (Individual counseling, group counseling, nurse, etc.) to treat co-occurring diagnoses, the provider would select: Outpatient > Mental Health/Substance Use > Non-Intensive Outpatient > Select appropriate services (e.g. Individual, Family, Group, etc.).

Authorization Request Decision Tree: Outpatient Level of Care



- **Levels of Service:** Providers can view the Levels of Service grid in the DBHDD Provider Manual for Community Behavioral Health Providers.
- Algorithms designed in conjunction with DBHDD determine if the request will be authorized or pend for clinical review by a Beacon Utilization Care Manager.

Note: *Services previously known as the "Core Service Package" have changed to "Non-Intensive Outpatient Services".*

- **Individualized Service Requests:** Authorization submissions need to be individualized to request the specific services that are medically necessary for the Individual:
  - Providers will identify those services they wish to request for the Individual.
  - Please keep the Individual's needs in mind and plan for services that may be needed throughout the authorization period; for instance, if someone is not initially in group, but the goal is to begin group in another month, providers would want to request that service at the time of authorization.

- Individuals do not progress in a straight, linear manner in their treatment and recovery – it is best to anticipate setbacks and request additional sessions that may be needed for those setbacks.
- The Service Matrix shows the maximum units that can be authorized for the timeframes.
- These are guidelines to assist in planning, providers should request only those services and units they anticipate needing for successful treatment for the given timeframe.

- **Place of service:** In addition to requesting the service, providers must indicate the Place of Service (POS). The POS that is indicated in the Service Matrix is a suggested POS that can be used for authorization submissions. Not all services need to be provided at that location.

Updates to an Authorization

Due to the changing needs of Individuals there may be times where an authorization needs to be updated. Updates to the authorization fall into two categories: 1) adding additional service classes and 2) adding additional units to existing service classes.

Adding Additional Service Class(es)
When a provider identifies a need for additional service class(es) to be added to an authorization, they may submit an update via ProviderConnect or the batch system. Updates to add additional service class(es) may include one or more services within the Type of Care. An update request that is adding service classes not already on the authorization may use the original start date of the authorization. You may include multiple service classes on a single update request.

Adding Additional Units to Existing Service Class (es)
Updates to add additional units may be made to one or more service classes within an authorization. When adding additional units to an existing service class(es) the update start date must be after the original start date. You may request an update to add additional units to multiple service classes at a time.

In both scenarios, Updates can only be made to any authorization that has an expiration date within the last six months. Please refer to the ProviderConnect User Guide for additional information.

Discharge Submission

A discharge submission should be submitted immediately when an Individual discharges from services.

The Collaborative recommends the following timeframes for submission of discharges:

- Inpatient: 48 hours
- CSU: 48 hours
- PRTF / CBAY: 24 hours
- Residential Detoxification: 48 hours
- Outpatient services: 72 hours

For outpatient services, a discharge submission should be only submitted when an Individual is no longer receiving **any** services under the outpatient type of service from that provider agency.

A discharge from any of the Outpatient Levels of Service will discharge **all** authorizations within an Outpatient Level of Service for that specific provider agency.

NOTE: A discharge from outpatient services does not affect an authorization for higher level of care services (i.e., CSU, Inpatient, Residential Detox, or PRTF).

CANS/ANSA

The CANS/ANSA is the functional assessments used for children and adults, respectively

- Initial requests for Non-Intensive Outpatient Services do not require the CANS/ ANSA. All other outpatient services require CANS/ ANSA information on initial, concurrent, and discharge requests.
- PRTF requires CANS at admission
- CSU requires CANS/ ANSA on concurrent reviews
- Inpatient and Residential Detoxification do not require CANS/ ANSA

Key Points to the Authorization Process

- Authorization requests are categorized into four tiers: Level of Service (LOS), Type of Service (TOS), Level of Care (LOC), and Type of Care (TOC).
- Providers are encouraged to check all authorizations for accuracy before entering any subsequent authorizations, updates, discharges, or claims.
- **Registration**
  - Individuals must have an active registration for the appropriate funding source for the services being requested prior to an authorization being submitted. Failure to do so may result in the determination of the authorization request being delayed.
- **Initial Authorizations**
  - Each unique combination of care requires a new initial request to begin services and will get a new authorization number.
    - Example, the Individual is receiving TOC Non-Intensive Outpatient services and TOC Psychosocial Rehabilitation. Two separate authorization requests will be needed and each will be issued its own unique authorization number.
  - More than one initial authorization request during the same episode of care will only be allowed if there is a change in Type of Service and Level of Care
  - When entering an initial authorization request, you may not have a start date prior to an already existing authorization that has the same Type of Service, Level of Care and Type of Care
- **Concurrent Authorizations**
  - When entering a concurrent authorization request, you may not have a start date prior to an already existing authorization that has the same Type of Service and Type of Care.
  - Concurrent authorizations should be entered on or before the expiration date of the existing authorization.
  - Concurrent authorizations may be submitted up to 30 days prior to the expiration of the existing authorization.
  - Start dates for concurrent authorizations should be in chronological order, with providers being mindful to leave no gaps in coverage.

- **Updates to Authorizations**
  - Updates are permitted to add additional services that fall within the same Type of Service, Level of Care and Type of Care on a specific authorization. Providers should NOT enter a concurrent authorization to add services.
  - Updates are permitted to add additional units that fall within the same Type of Service, Level of Care, Type of Care, and Service Class when units within the effective date and expiration date have been exhausted due to high clinical need. Providers should NOT enter a concurrent authorization to add units.
  - Updates can only be made to an authorization with an expiration date within the last six months.
  - Updates can be made to an authorization request that has been discharged as long as the date of the update is within the episode of care.
- **Discharges**
  - A discharge from any of the Outpatient Levels of Service will discharge **all** authorizations within an Outpatient Level of Service for that specific provider. A discharge should only be submitted if the Individual is no longer active in any outpatient service at the provider agency.
    - Example: Individual is receiving Non-Intensive Outpatient services to include Psychosocial Rehabilitation-Individual and Intensive Case Management. The Individual is no longer in need of Psychosocial Rehabilitation-Individual. Do not discharge. You will only discharge when they complete their entire episode of outpatient care at your agency.
  - A discharge from higher levels of care (Inpatient State Contracted Beds, CSU, Residential Detoxification, Psychiatric Residential Treatment Facility) should be entered when the Individual leaves that Level of Care; being sure to enter the discharge against the authorization for that Level of Care
    - Example: Individual is receiving Non-Intensive Outpatient; the Individual enters a CSU and discharges after 6 days. The facility enters a discharge connected for the CSU level of care only, resulting in no disruption to Non-Intensive Outpatient episode of care.
  - The Collaborative recommends the following timeframes for submission of discharges:
    - Inpatient: 48 hours
    - CSU: 48 hours
    - PRTF / CBAY: 24 hours
    - Residential Detoxification: 48 hours
    - Outpatient services: 72 hours

Clinical Department

Overview

The Collaborative's Clinical Department is based on an understanding that the unique needs of each Individual are supported in the context of hope, recovery, resiliency, and independence. The Clinical Department is organized into three main, interconnected functions: 1) Utilization Management, 2) Care Coordination Program, and 3) Pre-admission Screening and Resident Review (PASRR). Each of these functions creates and supports systems of care that achieve a systematic and coordinated approach to superior quality that is clinically appropriate, cost effective, data-driven, and person-centered. We integrate this approach to ensure best-practice treatment and supports that achieve the Individual's personal goals.

Utilization Management

The Collaborative's Clinical Utilization Management program encompasses management of care from the point of entry through discharge using medical necessity criteria as defined by DBHDD. Behavioral Health (BH) providers are required to comply with utilization management policies, procedures and associated review processes. Providers who only offer Intellectual Developmental Disabilities (IDD) services currently do not engage with The Collaborative's utilization management program. Utilization processes for IDD services are managed through the DBHDD Regional Field Offices. However, behavioral health services for individuals that have dual BH and IDD diagnoses are supported.

Examples of utilization review activities in the utilization management program include determinations of medical necessity for pre-authorization, concurrent review, retrospective review, discharge planning, and coordination of care.

The Utilization Management program incorporates processes to address:

1. Easy and early access to clinically-appropriate behavioral health treatment
2. Working collaboratively with providers in promoting delivery of quality care
3. Addressing the needs of special populations, such as children, the elderly, and Individuals with comorbid conditions
4. Identification of common behavioral health conditions and trends related to these conditions
5. Identification of vulnerable populations for care coordination, education, and outreach

Requests for Services

Requests for services can be completed in three ways:

- Georgia Crisis and Access Line (GCAL)
- The Georgia Collaborative ASO's ProviderConnect
- Provider EHR communicating to Beacon Health Options via the batch process

GCAL - Providers may request initial authorization for services listed below by contacting GCAL:

- Crisis Stabilization Units
- Behavioral Health Crisis Centers
- Inpatient State Contracted Beds

ProviderConnect - Providers utilize the Collaborative's ProviderConnect or batch submission for access to all other community-based services to include:

- Psychiatric Residential Treatment Facilities (PRTF (ProviderConnect only)
- Community Based Alternatives for Youth (CBAY)
- Residential Services
- All other community-based behavioral health treatment, adult residential services, and traditional outpatient services

Please refer to the Batch Resource Guide for further information.

Clinical Criteria / Medical Necessity

Utilization Management processes determine medical necessity based on the most recent version of the Service Guidelines contained within the Georgia DBHDD Provider Manual for Community Behavioral Health Providers. For PRTF/CBAY level of care, the most recent version of the Georgia DBHDD PRTF/CBAY policy is used.

Clinical Review Process

Provider cooperation in efforts to review care is an integral part of utilization management activities. Subject to the terms of DBHDD's provider requirements and applicable state and/or federal laws and/or regulations, providers must register the Individual and request authorization from the Collaborative in a timely manner. Providers must have an initial and/or concurrent authorization prior to a request for claims payment. the Collaborative may request clinical/rehabilitative information during the clinical review process to ensure the ongoing need for services is appropriate as defined by DBHDD.

The following will outline the processes for the different levels of care:

- Emergent/Urgent Services
  - Crisis Stabilization Units
  - Behavioral Health Crisis Centers
  - Regional State Hospitals
  - Inpatient State Contracted Beds
- Non-Urgent Residential Services
  - Psychiatric Residential Treatment Facilities / Community Based Alternatives for Youth (PRTF/CBAY)
- Non-Urgent/Routine Services
  - All other community-based behavioral health treatment, adult residential services, and traditional outpatient services

Emergent/Urgent Services

- Crisis Stabilization Units
- Behavioral Health Crisis Centers
- Residential Detoxification
- Regional State Hospitals
- Inpatient State Contracted Beds

Initial Authorization: Providers must request initial authorizations for DBHDD-funded, urgent / emergent services directly through the Georgia Crisis and Access Line (GCAL) 24/7 at 1.800.715.4225. Please refer to the GCAL section of this handbook for further information. For

Residential Detoxification, providers will request initial authorizations through ProviderConnect or batch.

For Initial Authorization from GCAL, providers will use the electronic resources at www.bhlweb.com for referrals and bed tracking. All facilities will receive referrals via www.bhlweb.com on either the CSU/State Contract Bed Referrals Status Boards, BHCC Notification Boards, or the State Hospital Notification Boards. These applications provider an electronic communication with ProviderConnect, allowing all data to come together for the benefit of continuity of care.

Upon determining medical necessity for this level of care, the provider must use the electronic referral bed board and the electronic admission bed board found at www.bhlweb.com in a manner consistent with the practices outlined by DBHDD. Admissions must be placed on the appropriate bed board within eight (8) hours of admission, preferably before midnight, to ensure timely authorization.

Concurrent Review: A concurrent review refers to all reviews after the initial authorization is requested and approved for a service. Providers seeking concurrent authorizations for urgent / emergent services (e.g. State Contracted Inpatient, CSU, Residential Detox) should request these via ProviderConnect or batch. In accordance with best-practice standards, the concurrent review must be conducted on or before the last covered day identified on the initial authorization. Providers are encouraged to be as thorough and precise as possible with completing the required data fields on the authorization request. In addition to current symptoms, behaviors and functional status, providers should clearly document the comprehensive discharge plan including the date of expected discharge and request the number of days and units consistent with the Individual's specific needs. The UM will complete their review. If the information necessary to make a determination is not available or does not appear to meet medical necessity, the request will be referred to a Peer Advisor for additional review. The request will result in either an authorization or an adverse determination (please see the Adverse Determination section).

Discharge: Discharge planning begins at admission. Discharge information should be submitted via ProviderConnect immediately upon the Individual leaving the facility. Accurate and timely discharge information is a key factor in ensuring the Individual's timely access to continuing aftercare services. Additionally, timely submission of discharges ensures accuracy of authorization information which supports timely payment of claims and data reporting.

Regional State Hospitals: GCAL is the preferred point of entry of all state hospital admissions. All State Hospitals use the electronic resources on www.bhlweb.com for referrals. Once admitted to a Regional State Hospital, all utilization management activities are completed by the state hospital and are not included in this process.

Non-Urgent/Residential Services

- Psychiatric Residential Treatment Facility (PRTF)/Community Based Alternatives for Youth (CBAY)

PRTF and CBAY levels of care are considered intensive higher levels of care. PRTF is a separate, stand-alone entity providing a range of comprehensive services to treat the psychiatric condition of a youth or emerging adult in an intensive residential structure under the direction of a physician. The purpose of the service is to improve the resident's condition or prevent further

regression so that residential services are no longer necessary. Determinations for this level of care will be based on the medical necessity criteria as outlined in DBHDD contract and policy documents. Due to the intensity of these services the Collaborative completes a thorough clinical review of any pre-certification requests.

PRTF/CBAY Initial Pre-Certification: Initial Pre-certifications/referrals to a PRTF/CBAY level of care must be reviewed clinically and authorized by a Utilization Care Manager. In accordance with DBHDD guidelines, referrals to a PRTF/CBAY may be submitted by CSUs, Tier I, Tier II, and Tier II+ providers treating a child who appears to be in need of PRTF level of care. Prior to submitting the request for services, the provider should review the medical necessity criteria and discuss the service and its components with the legal guardian and all treating providers to determine if the youth or emerging adult will respond more positively in a community-based environment versus a residential environment. Referring providers must complete a PRTF referral by submitting the necessary documentation through ProviderConnect as an initial authorization.

Once all documentation is received and complete, a medical necessity determination will be made within five business days by the clinical team. Requesting providers will be notified via ProviderConnect of the referral outcome. The referring provider should use that information to coordinate admission to a PRTF/CBAY provider. Admission to the PRTF/CBAY provider must happen within the 30-day authorization period of the pre-certification.

PRTF Admissions: Once the PRTF provider agrees to admission, the PRTF provider will submit an initial authorization request to the Collaborative. Per DBHDD policy, the admission must be entered via ProviderConnect within one business day of the youth or emerging adult entering the facility. This request will be reviewed by a Utilization Care Manager to confirm that the youth was pre-certified for PRTF level of care and the admission falls within the thirty-day allowable time frame. Once confirmed, an authorization will be issued.

PRTF Concurrent Reviews: Concurrent reviews must be submitted via ProviderConnect. Any request for concurrent services must be submitted five (5) business days before the last covered day for clinical review. All concurrent requests for PRTF reviews will pend for the Utilization Care Manager's review within five (5) business days. Providers are encouraged to be as thorough and precise as possible with completing the required data fields in ProviderConnect. Should the Utilization Care Manager need additional information to make a medical necessity determination, outreach will be made to the PRTF facility. There may be times when the requested authorization is referred for a Peer-to-Peer Review to ensure collaboration between the utilization team and the requesting provider as it relates to the Individual's plan of care. Should a Peer-to-Peer review be needed to determine medical necessity for the request, the discussion must be completed on or before the last covered day of the previous request.

PRTF Discharges: Per DBHDD policy, discharge information should be submitted via ProviderConnect within 24 hours of the Individual leaving the facility. Accurate and timely discharge information is a key factor in ensuring the Individual's timely access to Care Coordination services. Additionally, timely submission of discharges ensures accuracy of authorization information which supports timely payment of claims and data reporting.

PRTF Lateral Transfers: There may be times when the needs of a youth or emerging adult cannot be met by the treating PRTF. When this occurs, the treating PRTF or CME may submit a referral/pre-certification information to receive approval for a lateral transfer to another PRTF

services. The treating PRTF will follow the same processes outlined above for Pre-Certification/Referrals.

PRTF Extended Therapeutic Leave: There may be times when it is clinically indicated for a youth or emerging adult to be away from the facility for a therapeutic/transitional leave of longer than three (3) consecutive days or for more than four (4) days in a thirty-day period. These situations must be prospectively reviewed by the Collaborative. Therapeutic leave requests are submitted using the Therapeutic Leave Form or can be submitted via email to The Collaborative at GA PRTF@beaconhealthoptions.com. The PRTF provider must clearly document the need for therapeutic leave and the data supporting the need, to include how this leave supports the treatment and discharge plan. The request must also include the amount and type of supportive services that will be delivered while the youth is on leave to ensure the leave is safe and effective for the youth or emerging adult and their family. The request should include how the youth or emerging adult and their family have responded to any previous leave. The request must be submitted five (5) business days in advance of the leave. Additional information related to Extended Therapeutic Leave is documented in DBHDD policy 01-314 PRTF Documentation Requirements.

PRTF Funding Changes: There will be times when a youth or emerging adult has a funding change and will require authorization for PRTF during an already existing episode of care. When this occurs, the PRTF will submit an initial request for authorization via ProviderConnect with a completed referral packet. If any documentation is missing or unable to be obtained, the provider should submit an attestation as to what document is unavailable, what efforts were made to obtain it and what the barriers are to obtaining it. Inability to provide a specific document is not a reason to delay submission of the request. Per DBHDD policy 01-310 PRTF Application Process for Admissions all requests for a change in funding source must be submitted within five (5) business days of the funding source change to be considered for retro-active authorization.

CBAY Admissions: Once the CBAY Care Management Entity (CME) provider agrees to admission, the CBAY CME provider must submit an initial authorization request to the Collaborative via ProviderConnect. For youth or emerging adults receiving CBAY MFP, in addition to the authorization request, providers must submit a standard inquiry with the first 30-day plan by the last covered day of the pre-certification period.

CBAY Concurrent Reviews: Concurrent reviews for CBAY should be submitted by the CME via batch. The authorization request must be submitted on or before the last covered day of the previous authorization. For youth or emerging adults receiving CBAY MFP, in addition to the authorization request, CME providers must submit a standard inquiry via ProviderConnect including the Discharge Day Checklist and updated Action Plan for the first concurrent review and an updated action plan for all subsequent concurrent reviews.

CBAY Discharges: Discharge information should be submitted via batch upon the youth or emerging adult transitioning out of CBAY services. Accurate and timely discharge information is a key factor in ensuring the Individual's timely access to Care Coordination services. Additionally, timely submission of discharges ensures accuracy of authorization information which supports timely payment of claims and data reporting.

CBAY Lateral Transfers: There may be times when the needs of a youth or emerging adult cannot be met by the treating CBAY. When this occurs, the treating PRTF or CME may submit a referral/pre-certification information to receive approval for a lateral transfer to another CBAY

services. The treating PRTF will follow the same processes outlined above for Pre-Certification/Referrals. For youths or emerging adults who would like to transfer from one CME to another, the current CME will discharge and coordinate a transfer. The new CME will submit a new authorization request to start the day following the discharge from the previous CME.

CBAY Interim Plans: There may be times when a youth or emerging adult enters crisis or their individual needs require an updated action plan. When this occurs, the CBAY CME will submit a standard inquiry via ProviderConnect with the updated action plan. The Utilization Care Manager updates the existing authorization to reflect the needs of the youth or emerging adult. Interim plans should be submitted at the time the need arises with minimal delay to ensure the authorization is issued in a timely fashion to meet the needs of the youth or emerging adult.

Non-Urgent/Routine Services

- All other community-based, outpatient and residential services

All of the other community-based, outpatient, and residential services should be requested via ProviderConnect or the batch process. Prior to requesting an authorization, the provider should confirm that the Individual is registered and has appropriate funding sources available to support the service being requested and the provider has an agreement in place with DBHDD to provide the service and funding combination being requested. Services that are available for a given type of care along with authorization timeframes and maximum units available for request can be reviewed on the Covered Services and Level of Care Guideline page and in the Provider Manual for Community Behavioral Health Providers. These are guidelines to assist in planning; providers should request only those services and units they anticipate needing for successful treatment for the given timeframe. Neither verification of eligibility nor authorization guarantees payment.

When submitting an authorization request, providers should be requesting services that are consistent with the Individual's specific needs as outlined in the treatment plan, requesting only the services, start date and number of units needed for that authorization request. When completing the request, Providers are encouraged to be as thorough and precise as possible with populating the required data fields. Failure to adequately provide a clear clinical presentation supporting medical necessity for the service requested may result in the request being reviewed for an Adverse Determination.

Initial Authorization: Initial authorization requests for outpatient services should be submitted via ProviderConnect or the batch system in a timely fashion. It is possible that the clinical information provided may not support medical necessity resulting in an adverse determination and a recommendation for an alternative level of care. (See Adverse Determination section).

Concurrent Authorizations: Concurrent authorization requests should be submitted prior to the expiration identified on the previous authorization. The concurrent authorization request may be submitted up to thirty (30) days prior to the expiration date of the existing authorization. Start dates for concurrent reviews should be in chronological order, with providers being mindful to leave no gaps in coverage. A concurrent review cannot have a start date prior to the start date of an already existing authorizations with the same Type of Care and Type of Services. A Utilization Care Manager will review the clinical documentation presented in the authorization. If the request meets medical necessity based on the review of information provided in the authorization request, the Utilization Care Manager authorizes the services requested. In instances where a review does not meet clinical criteria, the request may be forwarded to a Peer

Advisor for review. (See Adverse Determination section).

Updates to an Authorization: Due to the changing needs of an Individual, there may be times where an authorization needs to be updated. Updates to the authorization fall into two categories: 1) adding additional services and 2) adding additional units. When a provider identifies a need for additional services to be added to an authorization, they may submit an update via ProviderConnect or batch. Updates to add additional services may include one or more services within the same Type of Care. Updates to add additional units may be made to one or more Service Classes within an authorization. However, the start date for additional services or units must be after the original start date of the authorization. Updates can only be made to an authorization that has not yet expired or has an expiration date that is within the past six (6) months. Please refer to the ProviderConnect section of the handbook for more information.

PASRR Specialized Services: Specific providers are credentialed to offer PASRR Specialized Services. Individuals who receive these services must have a valid PASRR Level II authorization that recommends PASRR specialized services. Providers of PASRR Specialized Services should submit initial and concurrent authorization requests using the ProviderConnect system. PASRR Specialized Service providers are recommended to submit a copy of the existing PASRR Level II determination, clearly showing the OBRA code, as an attachment to the authorization request. If the PASRR Level II determination does not indicate a need for specialized services, the request for PASRR Specialized Services may result in an adverse determination. In addition to documentation of the Level II determination being submitted, providers should follow all processes related to non-urgent/routine outpatient authorization requests, as documented above.

Individual Recovery/Resiliency Plans

Providers must develop an Individualized Recovery/Resiliency Plan (IRP) for Individuals receiving behavioral health services. The IRP for an Individual and documentation of interventions and progress towards IRP goals may be requested as part of the authorization process when conducting authorization reviews for specific services or in specific situations.

Adult Needs and Strengths Assessment (ANSA) / Child and Adolescent Needs and Strengths (CANS)

The ANSA/CANS functional assessment cumulative data are used to determine the match between the services requested and intended population for the service. For example, elements from the ANSA which indicate that the Individual has significant substance use impairments but the authorization request is for mental health services only. This may indicate that the provider should provide substance use services as well as mental health services. ANSA/CANS are required at concurrent review and planned discharge for most Levels of Service.

Discharge Planning

Discharge planning is an integral part of treatment and begins with the initial review. As an Individual is transitioned from inpatient and/or higher levels of care, the Utilization Care Manager will review/discuss with the provider the discharge plan for the Individual with a focus on promoting the Individual's engagement in the recovery process. Providers are expected to complete discharge reviews at the end of treatment. These reviews should be submitted via ProviderConnect or batch. Discharge information, entered in a timely fashion, is essential to Individuals receiving ongoing support services following a treatment episode.

Care Coordination Program

The Collaborative's Care Coordination Program is a community-based program designed to support and serve Individuals within the behavioral health and co-occurring developmental disability population with the most complex care needs or during critical transition periods. Being in the community allows the Care Coordination Program to support the individual in partnership with all community-based providers, DBHDD regional offices, facilities, Individuals, families, and any other stakeholders to ensure access to high quality services so Individuals can reach their recovery goals. The goal of the Care Coordination program is to ***Connect the Unconnected***.

What is Care Coordination?

- A support offered by the Collaborative
- Community-based
- For Individuals supported by DBHDD
- For Individuals with complex care needs or during critical transition periods
- For children, adolescents, and adults
- Supports care integration
- Optional and elected by the Individual or their guardian
- Supports are provided at no charge to the Individual

Care Coordination is NOT:

- Duplicative of provider services
- For Individuals with IDD only
- A "billable" support (supports *are* voluntary and provided at no charge to the Individual)
- Time-limited

How does an Individual engage in Care Coordination?

- Examples include:
    - An Individual is discharged from an acute level of care (hospital, PRTF, CSU, etc.)
    - Referral from providers; Self / Family / Supports
- Care Coordination is comprised of three distinct entities:
    - Community Transition Specialists
    - Specialized Care Coordination
    - Certified Peer Specialists

Data Reporting and Analysis

In addition to referrals to Care Coordination, the Collaborative uses data reporting analytics to ensure that the Individuals with the highest needs are identified for engagement. Data reporting and analysis is an ongoing review of an Individual's services and utilization to ensure the "right care at the right time." This approach allows identified Individuals to be connected to the Care Coordination Teams – Community Transition Specialists, Specialized Care Coordination, and Certified Peer Specialists.

Community Transition Specialists

The Community Transition Specialists (CTS) provide outreach and discharge appointment coordination to support an Individual's transition from an acute level of care to a community-based provider. The CTS works with facility discharge planners and community providers to

support aftercare services. We recognize that these level of care transitions can be challenging for an Individual. The CTS may attend discharge planning meetings and facility meetings to strengthen transitions for Individuals at risk for multiple hospitalizations. Community Transition Specialists are either Certified Peer Specialists (CPS) or Certified Addiction Recovery Empowerment Specialists (CARES)

The role of the CTS is to:

- Utilize their lived experience to facilitate recovery and resiliency
- Support engagement of Individuals with their community provider for aftercare appointment(s) within seven (7) days or 30 days of discharge
- Identify barriers for provider engagement and community tenure (e.g. transportation, child care, location, provider choice, access to medication)
- Identify Individuals who qualify for Specialized Care Coordination

Inpatient facilities are encouraged to support the CTS by:

- Submitting a Discharge Summary via ProviderConnect or batch submission within contractual timeframes
- Use accurate diagnosis and specific after-care appointment information in the Discharge Summary
- Scheduling follow-up visits within seven (7) calendar days of discharge
    - NOTE: It is important to notify the providers that the appointment is a post-hospital discharge and that an appointment is needed in seven (7) calendar days

Outpatient providers are encouraged to support the CTS by:

- Making every attempt to schedule appointments within seven (7) calendar days for Individuals being discharged from inpatient care.
- Providers are encouraged to contact those Individuals who are “no show” and reschedule the appointment.

Specialized Care Coordinators

Specialized Care Coordinators (SCC) are licensed behavioral health clinicians who provide clinical oversight for Individuals with complex clinical histories and/or multiple hospitalizations. An SCC seeks to outreach and engage the Individual’s provider(s), support network, and community-based services to best support the entire system of care. The SCC will routinely outreach to community-based providers and medical providers to support the Individual’s treatment, resolve service barriers, and partner with providers to create innovative ways to maximize an Individual’s community tenure. The SCC partners with community agencies to provide access or knowledge of critical services that may be missing in the continuum. The role of the SCC is to:

- Assess service barriers that are driving high recidivism risks by asking the question, “What is the missing piece?”
- Plan for development of a holistic care plan with the Individual to establish clear goals for recovery and community tenure
- Collaborate with the Individual through a system of care model to develop interactions with all providers (medical, PCP, community providers, Regional Offices, IDD services, etc.), as clinically indicated,
- Evaluate with the Individual the need for a Certified Peer Specialist or additional Care Coordination support and adjustment of the Care Plan

- Coordinate with state hospitals, crisis stabilization, and inpatient units to promote coordination of care.

When requesting Specialized Care Coordination, please:

- Discuss the recommendation with the Individual and gain permission for referral to the program.
- If the Individual is in an inpatient facility, contact the Utilization Care Manager and refer the Individual for Specialized Care Coordination.
- Alert the Collaborative, via the Utilization Care Manager, of the discharge plans and assure the SCC is aware of any barriers to success of the plan.

Certified Peer Specialists

Certified Peer Specialists (CPS) are Individuals who have lived experience with a mental illness and/or a substance use challenge which allows them to uniquely connect in a meaningful way with Individuals thereby showing by example that long-term recovery is attainable. They are also trained in principles of recovery and resiliency, wrap-around services, and traditional peer support.

The role of the CPS is to:

- Assist Individuals with identifying barriers to maintaining community tenure and finding services and/or supports to move through those barriers,
- Connect Individuals to community resources and support by identifying both traditional and non-traditional resources,
- Assist with applications for resources and services,
- Encourage Individuals to focus on their strengths and abilities for long range health and wellness,
- Coach Individuals about self-care and self-advocacy,
- Support Individuals and their support network for continued treatment engagement,
- Assist in developing a Whole Health Action Management (WHAM) plan, and
- Educate and develop a Wellness Recovery Action Plan (WRAP)

Adverse Clinical Determinations

Overview

Clinical Review: A review of the clinical information provided within the request to determine medical necessity. The Utilization Care Manager may find that a request for services does not appear to meet medical necessity criteria for the requested level of care. When this happens, the Utilization Care Manager will refer the request to a Peer Advisor.

Peer Advisor: The Peer Advisor will be either a board-certified physician (MD) or a licensed psychologist (PsyD / PhD), depending on the licensure level of the provider ordering the service. Depending upon the services requested and the clinical information contained within the request. The Peer Advisor will make a determination based on a Record Review or conduct a Peer-to-Peer Review when necessary.

Peer-to-Peer Review: In a Peer-to-Peer review, the Peer Advisor engages in a discussion with the treating provider to obtain information that was not available to the UM at the time of the review. This clinical discussion allows the Peer Advisor the opportunity to gain insight into the treating provider's anticipated goals, interventions and predicted timeframes for treatment. The Peer Advisor may request more information from the provider to support specific treatment

protocols and ask about treatment alternatives. The Peer-to-Peer review may result in either an authorization or an adverse determination.

Record Review: A Record Review is an intensive review of the clinical information provided within the request to determine medical necessity and is conducted by a licensed psychologist or board-certified physician. A Record Review will be conducted when a peer-to-peer review is not needed or cannot occur.

Adverse Determination: When an adverse determination is made, the treating provider is notified of the decision and asked to notify the Individual. For those services covered by Medicaid, the treating provider and Individual will be notified in writing.
All written adverse determination notices will include:

a. The principal reason(s) for the adverse determination
b. A statement that indicates the clinical rationale, guidelines or protocols used to make the adverse determination
c. Rights to and instructions for initiating a Reconsideration/Appeal, including the opportunity to request an expedited review if applicable, and information about the Fair Hearing process (Medicaid only)
d. The right to request a Reconsideration/Appeal verbally, in writing, or via fax transmission
e. The timeframe for requesting a Reconsideration/Appeal
f. The opportunity for the Individual and/or provider to submit written comments, documents, records, and other information relating to the Reconsideration/Appeal

Notification of an adverse determination indicates medical necessity was not met and the service will not be funded through the requested funding source. When a provider, Individual or the Individual's authorized representative requests Reconsideration, Appeal or Fair Hearing of an adverse determination, the provider may not bill or charge the Individual until all reviews available to the Individual have been exhausted by the Individual or, where applicable, by the requesting provider.

Reconsiderations, Appeals and Fair Hearings

Providers must inform the Individual of adverse determinations and any subsequent review rights. When authorized by the Individual, the provider may request a Reconsideration, Appeal and, in the case of Medicaid funded services, a Fair Hearing. Individual rights to Reconsiderations, Appeals and Fair Hearing are limited to those available under the Individual's funding source and the specific level of care being requested. See table below for more information.

Reconsideration: When an adverse determination is issued based on a record review, a reconsideration may be available (see table below). Reconsiderations are conducted by the Collaborative and may be conducted by the same Peer Advisor who issued the adverse determination. Reconsiderations can be requested via verbal notification to the Utilization Care Manager, contacting customer service, or through an inquiry in ProviderConnect. See table below for more information.

Appeal: An appeal is conducted by a different Peer Advisor at the Collaborative than the Peer Advisor who issued the adverse determination. See table below for more information. Appeals can be requested via verbal notification to the Utilization Care Manager, contacting customer service, or through an inquiry in ProviderConnect. See table below for more information.

Fair Hearing: For Medicaid funded services, the Individual has the right to a Fair Hearing conducted by the Georgia Office of State Administrative Hearings (OSAH). Fair hearings must be requested in writing to DBHDD as outlined in the adverse determination letter. There are no alternative methods for requesting a Fair Hearing. For State Funded services, Individuals do not have the right to a Fair Hearing. See table below for more information.

Timeframes for Requesting a Reconsideration, Appeal or Fair Hearing

Upon notification of an Adverse Determination, the Individual or requesting provider may request the appropriate level of review based on the following time frames, Level of Care and Type of Care.

Level of Care	Type of Review	Request Timeframe	Notification of Determination
Urgent/Emergent (Inpatient, CSU, Residential Detox)	Reconsideration or Appeal	The request should be made within 72 hours of the adverse determination being issued.	Verbal notification will be made within three business days. ProviderConnect will display determination within one business day of the determination.
PRTF/CBAY	Reconsideration	The request should be made within three business days of the adverse decision being issued. Request for reconsideration may only be made when the adverse decision was made via record review (no Peer-to-Peer took place).	Verbal notification will be made within three business days. ProviderConnect will display determination within one business day of the determination.
PRTF/CBAY	Appeal	The request for Appeal should be made within 30 days of the adverse determination being issued. An expedited review may be requested where there is belief that a delay in decision would place the youth or emerging adult at serious risk.	Expedited reviews will result in a determination within 72 hours of the request. Non-expedited will result in a determination within14 days of the request. Verbal notice will be made to the provider and the Individual within the decision timeframe. ProviderConnect will display the determination within one business day of the determination. Written notice will be mailed to the Individual and provider within one business day of the determination.
PRTF/CBAY	Fair Hearing for Medicaid services only	Must be requested in writing to the address listed on the adverse decision letter within 15 calendar days upon receipt of the Appeal Notification at the mailing address of the legal guardian of the youth or emerging adult as evidenced by Certified Mail documentation.	Timeframe for determinations and notifications are determined by Office of State Administrative Hearings. ProviderConnect will display the determination after receiving notice from DBHDD legal counsel.

Level of Care	Type of Review	Request Timeframe	Notification of Determination
Outpatient	Reconsideration	The request should be made within three business days of the adverse determination being issued. Request for reconsideration may only be made when the adverse decision was made via record review (no Peer-to-Peer).	Verbal notification will be made within three business days. ProviderConnect will display determination within one business day of the determination.
Outpatient	Appeal	The request for appeal should be made within 30 days of the adverse decision being issued.	Verbal notification to the provider and the Individual within 14 days of the request. ProviderConnect will display the determination within one business day of the determination.
Outpatient	Fair Hearing for Medicaid services only	Must be requested in writing to the address listed on the adverse decision letter within 15 calendar days of when the Appeal written notification was received at the mailing address of the Individual or legal guardian as evidenced by the Certified Mail documentation.	Timeframe for determinations and notifications are determined by Office of State Administrative Hearings. ProviderConnect will display the determination after receiving notice from DBHDD legal counsel.

Preadmission Screening and Resident Review (PASRR)

Overview

Preadmission Screening and Resident Review (PASRR) is a federal requirement designed to prevent the inappropriate placement of Individuals with mental illness or intellectual and developmental disabilities in long-term care. PASRR requires that all applicants to a Medicaid-certified nursing facility be evaluated for mental illness, intellectual and developmental disabilities, and/or a related condition; be offered the most appropriate setting for their needs (in the community, a skilled nursing facility, or in an acute care setting); and receive the services that they need in the appropriate setting.

PASRR Level II Process

The Level I PASRR process and referral to the Level II PASRR process is completed by the Georgia Medical Care Foundation (GMCF/Alliant). The PASRR Level II process is initiated when a Level I referral identifies that a person may have a mental illness (MI), intellectual/developmental disability (ID/DD), or a related condition (RC) that produces similar impairments to an ID/DD. GMCF/Alliant will make a referral to the Collaborative when the Level I screening tool indicates that a Level II evaluation is needed.

Process: Within 24 hours of receiving a referral from GMCF, the Collaborative will request and gather pertinent medical records. Once the requested medical records are received by the Collaborative, they are reviewed by the PASRR assessor, who is a fully licensed professional (LPC, LCSW, LMFT, RN, Licensed Psychologist, or MD). If there is not enough detail in the medical records, or, if further clinical assessment is needed to make a proper evaluation, a face-to-face evaluation is completed at the Individual's convenience.

Following the clinical review process, the PASRR assessor completes a written Summary of Findings, which includes a determination of the need for Nursing Facility level of care, and recommendations to address the treatment needs of the Individual. When clinically indicated, the PASRR assessor makes recommendations for Specialized Services for individuals with a serious mental illness (SMI), intellectual/developmental disability (ID/DD), or a related condition (RC). The completed Summary of Findings with the Omnibus Budget Reconciliation Act (OBRA) determination code is sent to the Individual and the referring facility.

Timeline: The outcome determination is made within seven (7) business days of receipt of the original referral.

Specialized Services: Specialized Services may be recommended through the Level II process. Specialized Services for serious mental illness (SMI) include behavioral health assessment, treatment planning, individual and family counseling, crisis services, psychiatric evaluation, and medication management. If recommended, Specialized Services for SMI are offered by a provider who comes to the Skilled Nursing Facility to work directly with residents. When Specialized Services are recommended as part of the Level II Determination, PASRR Specialized Service providers may request these services through ProviderConnect. Please see Non-Urgent / Routine section of this section for more information. Specialized services for an intellectual/developmental disability (ID/DD) or related condition (RC) should be coordinated through the regional DBHDD Field Office.

PASRR Level II Appeals Process

If placement in a skilled nursing facility is not approved, the Individual/referring facility has the right to appeal this decision. There are two levels of appeal.

- First Level Appeal: A first level appeal must be submitted to the Collaborative within ten (10) business days of receipt of the Adverse Determination. In order to submit an appeal, the request and supporting documentation is faxed to the Collaborative. The appeal is reviewed by a board-certified physician or licensed psychologist with the Collaborative. Results of the appeal will be sent to the Individual and referring facility within seven (7) business days after receipt.
- Second Level Appeal: If the Individual/referring facility is not satisfied with the First Level Appeal outcome, a request for a Second Level of Appeal must be faxed to the Collaborative within ten (10) business days of the First Level Appeal decision. The Second Level Appeal is forwarded to the DBHDD Medical Director for final determination. Results of the Second Level Appeal will be provided to the Individual/referring facility within five (5) business days.

Claims Procedures & Electronic Submission

Overview

Beacon Health Options processes the claims for DBHDD state-funded services only on behalf of the Collaborative and maintains claims processing procedures designed to comply with the requirements of state, and federal rules and/or regulations. Medicaid claims for Individuals who are covered under Age, Blind and Disabled Medicaid continue to be submitted in accordance with processes set forth by the DCH through its GAMMIS system.

Medicaid/GAMMIS

The Collaborative does **not** process claims for the provision of Medicaid services to Medicaid beneficiaries. The Department of Community Health (DCH), through its GAMMIS vendor, DXC, pays those claims directly to providers. The instructions throughout this section do not apply to those Medicaid service claims. When these claims are submitted to GAMMIS, the claims must be submitted with the GA Client Authorization number beginning with a "9" in the Provider Connect System (12-digit number, please add a trailing "0" if not 12 digits). All authorizations issued that are payable by GAMMIS are transmitted on a daily basis and should be viewable in GAMMIS systems within 48 hours of the authorization being issued. Providers should ensure they are searching the Medicaid identification number for the vendor location attached to the authorization. If you are not able to view your authorization in GAMMIS you may call Beacon Health Options Customer service, 855-606-2725, for additional information. If a Medicaid claim is resulting in a denial or other problem, please contact GAMMIS.

State-Funded Services

To electronically submit claims, providers are encouraged to use ProviderConnect. Electronically submitting claims allows for more efficient claims processing. Electronic claim submission is also accepted via batch submission through local EMR systems or from billing clearinghouses. When using the services of a Clearinghouse, providers must reference the Collaborative's Payer ID, FHC & Affiliates, to ensure Beacon receives those claims.

State-Funded Claim Submission Guidelines: Unless otherwise identified in the contract or provider agreement, or through a DBHDD time limited waiver (provided under special circumstances) providers must file or submit claims within 90 calendar days from the date of service or the date of discharge for inpatient admission. Claims received after the above noted 90-day time period may be denied due to lack of timely filing. Claims must match the authorization applicable to covered services for which the claim applies. All billings are considered final after the 90-day time period has expired.

Claims for covered services rendered to Individuals should be submitted electronically or by using the electronic equivalent of a UB-04/CMS-1450 or CMS-1500 or successor forms, with all applicable fields completed and all elements/information required by the Collaborative included.

Electronically submitted claims must be in a HIPAA 5010 compliant format. In addition, the claim should be free from defect or impropriety (including lack of required substantiating documentation) or circumstance requiring special treatment that prevents timely payment. If additional information is required, the provider will forward information requested for the purpose of consideration and in obtaining necessary information relating to coordination of benefits, subrogation, and verification of coverage, and health status.

Please refer to the ProviderConnect User Guide and Batch Resource Guide.

Requests for Additional Information: Upon request by the Collaborative, or its authorized designee, providers must promptly furnish requested documentation or information related to and/or in support of claims submitted. Failure to do so may result in denial of payment for covered services rendered to Individuals.

State-Funded Claim Processing: The Collaborative will process complete and accurate claims only for state-funded services submitted by approved providers for covered services rendered to Individuals in accordance with normal claims processing policies and procedures, the payment terms included in the provider contract/agreement, and/or applicable state and/or federal laws and which meet the timeliness of claims processing policy.

Normal claims processing procedures may include, without limitation, the use of automated systems which compare claims submitted with diagnosis codes and/or procedure codes and associated billing or revenue codes. Automated systems may include edits that result in an adjustment of the payment to the provider for covered services or in a request for submission of clinical records.

No payment is due for covered services or claims submitted unless the covered services are clearly and accurately documented in the clinical record prior to submission of the claim in accordance with the DBHDD Provider Manual for Community Behavioral Health Providers.

Payment for services rendered to Individuals is impacted by the terms in the provider contract/agreement, the Individual's eligibility at the time of the service, whether the services were covered services, if the services were medically necessary, compliance with any pre-authorization/notification requirements, timely submission of the claim, claims processing procedures, overpayment recovery, and/or coordination of benefits activities.

Clearinghouses: Electronic claim submission is also accepted through clearinghouses. When using the services of a Clearinghouse, the Payer ID you will use for the Collaborative is FHC & Affiliates to ensure we receive those claims.

PaySpan® Health: To be paid through an electronic funds transfer, providers must use PaySpan Health. PaySpan Health enables providers to receive payments automatically in their bank account of choice, receive email notifications immediately upon payment, view remittance advices online, and download an 835 file to use for auto-posting purposes.

Provider Summary Vouchers: Provider Summary Vouchers (PSVs) or remittance advices are the documents that identify the amount(s) paid. Providers can access PSVs through PaySpan or ProviderConnect.

Overpayment Recovery: Providers should routinely review claims and payments in an effort to determine if the provider has received any overpayments. The Collaborative will notify providers of overpayments identified by the Collaborative, clients and/or government agencies, and/or their respective designees. Overpayments include, but are not limited to: (a) claims paid in error; (b) claims allowed/paid greater than billed; (c) duplicate payments; (d) payments made for Individuals whose authorization is or was terminated; (e) payments made for services in excess of applicable benefit limitations; (f) payments made in excess of amounts due in instances of third party liability and/or benefits; and (g) payments made without sufficient documentation as required by DBHDD.

Subject to the terms of the provider contract/agreement and applicable state and/or federal laws and/or policies, the Collaborative or its designee (Beacon) will pursue recovery of overpayments through: (i) adjustment of the claim or claims in question creating a negative balance reflected on the Provider Summary Voucher (PSV) (claims remittance); and/or (ii) written notice of the overpayment and request for repayment of the claims identified as overpaid. Failure to respond to any written notice of and/or request for repayment of identified overpayments in the time period identified in the notice/request is deemed approval and agreement with the overpayment; thereafter the Collaborative will adjust the claim or claims in question creating a negative balance. Any negative balance created will be offset against future claims payments until the negative balance is zeroed out and the full amount of the overpayment is recovered. The Collaborative may use automated processes for claims adjustments in the overpayment recovery process.

In those instances, in which there is an outstanding negative balance as a result of claims adjustments for overpayments for more than 90 calendar days, the Collaborative reserves the right to issue a notice for re-payment. Should a provider fail to respond and/or provide amounts requested within the 30 calendar days of the date of the notice for re-payment, the Collaborative will notify DBHDDH who will pursue all available legal and equitable remedies, including without limitation placing the outstanding overpayment amount (negative balance) into collections.

If the provider disagrees with an overpayment recovery and/or request for re-payment of an overpayment, the provider may request review to the Collaborative in writing such that the written request for review is received by the Collaborative on or before the date identified in the notice of overpayment recovery or request for re-payment of an overpayment. Please attach a copy of your written request for review and include the following information; provider's name, identification number and contact information, Individual name, and number, a clear identification of the disputed items to include the date of service and the reason the disputed overpayments are being contested. These requests should be submitted through an inquiry in ProviderConnect or by contacting Customer Service (1-855-606-2725).

Requests for Review: Providers may request review of the Collaborative's claims determination. All requests for review must be submitted in writing or made telephonically to Customer Service within 60 calendar days or the time period specified in the provider agreement (if any) from the date of the Collaborative's original claim determination. These requests should be submitted through an inquiry in ProviderConnect or by contacting Customer Service (1-855-606-2725).

Requests for review received beyond the above noted time period will not be reviewed and are considered "expired."

State-Funded Claims Disputes: Providers must exhaust all administrative processes concerning unresolved claims disputes pursuant to the terms of the provider contract/agreement, and more specifically any dispute resolution provisions, prior to pursuing any legal or equitable action.

Quality Management

Overview

The focus of the Collaborative's Quality Management department is to monitor and evaluate quality across the entire range of services provided by the DBHDD network of providers.

The Department of Behavioral Health and Developmental Disabilities (DBHDD) has delegated Behavioral Health (BH) and Intellectual/Developmental Disabilities (IDD) quality reviews to the Collaborative. These reviews are focused on person-centered practices and provider performance. The purpose of these reviews is to determine adherence to DBHDD standards and to assess the quality of the service delivery system through various sources including:

- Interviews with Individuals receiving services
- Employee records
- Record reviews, and
- Observations of services provided, when appropriate

The overall goal of the review process is to identify practices that are person-centered, show respect for Individual rights, and provide evidence the Individual is included in decision making and provided choice. The key processes aligned with this goal are:

- Behavioral Health Quality Review (BHQR)
    - Non-intensive Outpatient BHQR
    - Assertive Community Treatment (ACT) BHQR
    - Intensive Case Management (ICM) BHQR
- Crisis Stabilization Unit Quality Review (CSUQR)
- IDD Quality Enhancement Provider Review (QEPR)
- IDD Quality Technical Assistance Consultation (QTAC)

The Review Process: Onsite reviews are part of the overall review/consultation process. If a provider renders services for both IDD and BH populations, the QEPR and BHQR may be conducted simultaneously. When appropriate, service-specific reviews, such as Crisis Stabilization Unit Quality Review, may be added to the review process. Additionally, if ACT or ICM are provided, additional records may be added to a BHQR to focus on those services in particular.

The purpose of combining or coordinating reviews are to reduce administrative burden on providers and provide an opportunity to review the organization as a whole while evaluating all systems and practices. The Collaborative's staff will work together to generate recommendations for improvement to support quality improvement for service systems for all populations.

Individual Safety: If at any point during any of the quality review processes, abuse, neglect, and/or exploitation is suspected, the Collaborative staff will follow the necessary reporting procedures outlined by DBHDD policy. As part of the initiative to analyze the quality of care to Individuals served by the provider network, Critical/Adverse Incidents may be part of the quality review process. Providers may be asked to present policies and procedures related to reporting Critical/Adverse Incidents.

Recommendations for Improvement: As a result of the review process, recommendations for improvement will be generated and provided to DBHDD. The review and analysis of the cumulative collected data will be used to develop training and education for stakeholders and will be shared across regions to promote improvement of quality within the service delivery system. Additionally, a Statewide Annual Report is generated and posted to the Collaborative's website.

Individual and Provider Feedback: The Collaborative encourages providers and Individuals to give feedback through a satisfaction survey measuring opinions regarding the Collaborative's Quality Management processes. Providers will be sent a link to a survey upon completion of a Quality Review. Comments will be reviewed on a regular basis. Trends or patterns of feedback will be presented to management and DBHDD (if necessary) for action. Information regarding specific employees will serve as a component of the employee review process.

Behavioral Health Reviews

The purpose of the quality reviews are to determine adherence to DBHDD standards and to assess the quality of the service delivery system through different sources including:

- Interviews with Individuals receiving services,
- Individual behavioral health record reviews, and
- Observations/site visits of service locations and services provided, when appropriate.

Quality Management completes two quality reviews: Behavioral Health Quality Review (BHQR) and the Crisis Stabilization Quality Review (CSUQR). The BHQR Tools and CSUQR Tools are both available on the Collaborative's website. The BHQR and CSUQR includes Pre-Onsite, Onsite, and Post-Onsite processes. The specific factors that contribute to the scores are derived from adherence to specific requirements from the DBHDD Provider Manual and DCH Provider Manual .

Review Categories: There are several categories of reviews:

- **Scheduled** – The routine, scheduled BHQR of providers identified by DBHDD occurs based on the agreed upon schedule set forth by DBHDD and the Collaborative.
    - During certain fiscal years or periods throughout a year, the Collaborative may conduct scheduled reviews of specific services and/or providers as requested by DBHDD. Beyond the current random selection of all services a provider may offer, additional records are currently being selected for special focus and review of:
        - Crisis Stabilization Units: up to 15 records
        - Assertive Community Treatment (ACT): up to 15 records
        - Intensive Case Management (ICM): up to 15 records

- **Ad Hoc** – At times, DBHDD may request an unscheduled or shortened notification review for providers.

- **Special –** DBHDD or DCH may request a "special review". These reviews do not fit into the categories listed above. The entity requesting the review determines the desired requirements/parameters.

Review Frequency: The frequency of quality reviews for existing behavioral health providers is based on the scores obtained during the BHQRs and CSUQRs.

Overall and Billing Scores

90% - 100%

- BHQR: Both the Billing and Overall scores are 90% or above
- CSUQR: Overall score 90% or above
- A scheduled annual review
- Individual interviews may be conducted in-person or by phone
- A desk review may be available if the provider has an EMR

89% and below

- BHQR: Either the Billing or the Overall score is 89% or less
- CSUQR: Overall score is 89% or less
- A scheduled semi-annual onsite review
- Individual interviews maybe conducted in-person or by phone
- Providers must obtain two subsequent Overall and Billing scores of 90% or above in order to be placed back on an annual review frequency

New Providers

- Providers that have not been previously reviewed by the Collaborative will be reviewed onsite at least three times within the first two years regardless of scores
- New providers will be reviewed approximately six months from the initial date of billed services

Selection of Records: The selection of records is determined by a review of the available Medicaid and/or State Funded claims/encounters during a specified period of time prior to a provider's Scheduled, Ad Hoc, or Special Review. At the request of DBHDD, the Collaborative will complete Ad Hoc or Special reviews in which the claims selection may be restricted to specific services. Providers will receive specific instructions in the review notification for service-specific reviews.

Sample Size: The BHQR sample size is based on the number of unique Individuals served within the last six months. If a provider has services that are a special focus such as ACT, ICM, SE, etc. (in addition to other services), additional service-specific records will be included in the sample. The CSUQR sample size will include up to 15 Individuals. Providers serving less than five Individuals are monitored and added to the review process once at least 5 Individuals have been served; however, these providers can be selected for an ad hoc review at the direction of DBHDD. For both the BHQR and the CSUQR, an oversample will be included to assure full sample sizes are met. The BHQR sample sizes are below:

Provider Size	Individuals Served (within 6 months)	Sample Size
Small	≤ 50	Minimum 5 ; Maximum 10
Medium	51-100	20
Large	≥ 101	30

BHQR and CSUQR Pre-Onsite Activities

Notification of Reviews: Notification of scheduled reviews will typically occur via e-mail two weeks prior to the BHQR/CSUQR start date. Notification of Special or Ad Hoc Reviews may have a shortened notification timeframe or, in some cases, there will be no advance notification. The following applies to Scheduled Reviews:

- **Rescheduling of BHQR/CSUQR Dates**: Reviews will only be rescheduled based upon request by DBHDD or if there is a conflicting review occurring during the same time (e.g., a provider may have an accreditation survey scheduled the same week).
    - Providers with key staff who may be out of town during the scheduled review will need to have a substitute sit in for them in their absence. The absence of key staff will not result in rescheduling of a review.
- **Response to Notification:** Providers who do not respond to their initial review notification within two business days will receive a follow-up phone call.
  If no provider response is received within five business days of the original review notification, DBHDD will be notified. The review will be canceled and the provider will receive a score of "0%" for the review; in addition, prior authorizations for the individuals that are contained in the review sample will be revoked, thereby denying all future claims against those authorizations and potentially resulting in the recovery of claims paid.
- **Emergency Situations**: Providers who respond to a BHQR/CSUQR notification but later experience an emergency will have one business day to notify the lead Quality Assessor of the emergency. Emergency situations will be handled on a case-by-case basis.
- **Failure to be available for the BHQR/CSUQR**: Quality Assessors will wait one hour on the scheduled first day of the review for a provider who may be late. The Quality Assessor will call contact numbers for the provider to determine when the provider may be arriving before deciding to leave the location and canceling the BHQR/CSUQR. Failure to be available for a scheduled review will result in a "0%" score for the BHQR/CSUQR, DBHDD will be notified, and prior authorizations for the individuals that are contained in the review sample will be revoked, thereby denying all future claims against those authorizations and potentially resulting in the recovery of claims paid.

Off-Site Storage: Providers are required to maintain all served Individuals' records onsite (DBHDD approved service locations) for a minimum of 90 days following the last date of service or discharge date (whichever is later). Records must be presented within the timeframes indicated below in the Individual Names/Record Delivery section. Records not submitted within these timeframes will not be accepted for review. If the review sample contains Individual names who have been discharged for more than 90 days from the review date *and* the provider stores archived records at an off-site storage facility (such as Iron Mountain) these records must be produced within 24 hours of the review start time.

Research: The Collaborative conducts fact-finding research with available data prior to going onsite. The purpose is to analyze as much information as applicable and reduce the time spent in the provider's working environment. Information gathered includes, but is not limited to:

- authorization data
- complaints/grievances
- billing and payment histories
- credentialing compliance

- special requests from DBHDD
- prior results of onsite reviews
- technical assistance provided by the Collaborative.

Duration of BHQR: The number of days the onsite review will take depends on the size and services provided. Scheduled BHQRs typically take between 2-5 days.

BHQR and CSUQR Onsite Activities

Entrance Interview: An Entrance Interview will be conducted, with detailed information given regarding the number of records to be reviewed, estimated timeframe of review, review tools, Individual Interviews, and how the review will be scored.

Individual Names/Record Delivery: On the first day of the review, the provider will receive the review sample which consists of a list of Individual names, identifying Medicaid or State identification numbers, and the Individual's birthdate. Individual names will not be given in advance.

- **Thirty (30) minutes after the Lead Quality Assessor's arrival and the provider receiving the list of Individual names, the provider will supply the following information:**
    - The location of each record (if the provider has records at multiple DBHDD-approved service locations)
        - Per DBHDD, providers are required to maintain Individual records on site at DBHDD-approved service locations for a minimum of 90 days following the last date of service or discharge date for the Individual served
    - Organizational charts for each program
    - All team meeting logs and staff to Individual ratios
    - Schedules, Program Plans, Policies & Procedures, and Minutes (to support policy implementation - as needed)

Any of this information received after the 30-minute limit cannot be accepted and will not be considered for the review.

- **Within two hours of receiving the list of Individual names from the lead Assessor:**
    - All onsite records will be delivered to Assessors to be checked in.
    - Those providers who utilize Electronic Health/Medical Records (EH/MR) shall provide the Assessors access to **all** records identified in the sample.
    - For providers who are transitioning from paper records to electronic medical records – it is required that all forms of the medical record be available and accessible to the Assessors for the duration of the BHQR/CSUQR. Any record (paper or electronic) not supplied within the allotted timeframe will be considered to have not been delivered and these records will be scored as "No" on all areas.
    - All remaining records from other DBHDD-approved service locations will be delivered to Assessors and checked in by 4:00 PM on the first day of the review. Any records presented after 4:00 PM will be treated as if they had not been delivered and all items for those records will be scored as "No" on all areas. Providers are required to maintain Individuals' records onsite (DBHDD approved service locations) for a minimum of 90 days following the last date of service or the discharge date for the Individual served. Records must be presented within the timeframes indicated in

Individual Names/Record Delivery; records not submitted within stated timeframes will not be accepted for review. If the review contains Individuals who have been discharged more than 90 days from the review date *and* the provider stores archived records at an off-site storage facility (such as Iron Mountain) these records must be produced within 24 hours of the review start time.

Records must be presented within the timeframes indicated above; records not submitted within stated timeframes cannot be accepted by the Assessors.

Staff Credentialing/Licensure Review: During the review, Assessors will request specific information pertaining to staff credentialing/licensure. The information requested may include:

- Copies of licenses and credentials for each identified licensed, credentialed, registered, certified staff member
- For applicable staff, documentation of completion of the Standard Training Requirements (STR) as indicated in the DBHDD Provider Manual
- Documentation of criminal background screening
- Both agency-provided and paraprofessional training documentation must be provided to include spreadsheets, certificates, etc.
- Attestations for Supervisee/Trainees and Addiction Counselor Trainees /Counselors in Training
- All supervision logs
- College diplomas and/or internal memo of review of transcript (if the diploma does not indicate the area of study to justify a "helping profession") for those staff whose billing level is degree-dependent

Timeline for submission of staff credentialing/licensure: two hours. Any information received after the two-hour timeframe will not considered for the review.

Individual Interviews: Individual Interviews will be conducted as a part of the BHQR/CSUQR process. These interviews will be conversational in nature and conducted by the Collaborative's Quality Management Assessors. Information gathered will serve to assess the Individual's quality of life and the level of satisfaction with the provider and services rendered.

- Interviews with Individuals receiving services are strictly voluntary. If an Individual declines to be interviewed, or a legal guardian does not give permission to participate, Assessors will select an alternate Individual to interview.
    - Providers or Assessors may select Individuals served for the interview process.
    - Providers will identify/schedule the Individuals to be interviewed prior to the start of the BHQR/CSUQR process.
    - Assessors can select alternate and/or additional Individuals to interview.
    - Interviews can be conducted face-to-face or telephonically.
    - Interviews will be conducted prior to completion of the review, typically after the first day of the review.

Quality Review Logistics: The following equipment and supports must be provided for the review:

- Tables and chairs to accommodate the assessment team. The review notification will identify the number of Quality Assessors that will be participating in the review.
- Any computers or electronic equipment needed to access the provider's electronic medical/health record
- Access to a copy machine / printer, and paper

- Any copies of records requested during any review process will be the sole responsibility of the provider, including the cost of record reproduction.

Record Review: The provider must ensure that each current Individual service record is submitted to the Collaborative for review. This may mean the provider submits multiple volumes and/or provides access to paper and electronic medical records. If information is determined to be missing or all volumes of the current record are not submitted for review, the Assessor will reject any additional volumes not submitted according to the above-stated timeframes. Additional information related to the Record Review:

- **Subpoenaed Records:** Providers who have had Individual records subpoenaed should ensure that copies are made of relevant information (i.e., assessment, treatment plan, verification of diagnosis, orders, and eight to twelve weeks of progress notes, etc.) so the Assessors will have information for the review. If the provider is unable to produce the records, or legible copies of the records, these records will be scored as "0" and prior authorizations for the individuals contained in the review sample will be revoked, thereby denying all future claims against those authorizations and potentially resulting in the recovery of claims paid.
- **Electronic Health/Medical Records:** Providers using Electronic Health/Medical Records (EH/MR) should have all documentation available and accessible for the Assessor during the entire BHQR/CSUQR process. Providers who are transitioning from paper records to electronic medical records must have all forms of the Individual medical record available and accessible for the Assessors for the duration of the review.
- **Missing Information:** Assessors will consider only documentation that is contained in the "official" medical record. If an Assessor determines information is not in the record, the provider will have 15 minutes to review the record in an attempt to locate the required documentation in the record supplied as outlined above. Information that is not filed within the Individual record prior to the start of the review will not be considered as present in the medical record. All requested records must be available and accessible to the Assessors for the duration of the BHQR/CSUQR process.
- **Altering of Records:** Records must not be altered once the BHQR/CSUQR has begun. If at any point during the review process, the provider alters a record (paper or electronic), aside from current service delivery and documentation of the same, the record will receive a score of "0. Additionally, prior authorizations for the individuals that are contained in the review sample will be revoked, thereby denying all future claims against those authorizations and potentially resulting in the recovery of claims paid.
- **Voiding/Adjusting of Claims:** Providers may not void/adjust any claims after the date of the BHQR/CSUQR notification. Providers may resume voiding/making adjustments claims after the Exit Conference. Voids submitted prior to the date of BHQR/CSUQR notification will be accepted. Documentation to support a voided/adjusted claim must be presented at the time of the review and include the date of adjustment.

BHQR Scoring: The overall score is derived from a review of Individual medical records utilizing the components of the Collaborative's BHQR Tool. The BHQR Tools are located on the Collaborative's website.

There are four (4) sections of the BHQR Tool, each representing 25% of the total score:

- **Assessment & Planning**
  - Score calculated by total possible Yes answers vs. No answers (NA excluded)
- **Compliance with Service Guidelines**
  - Score calculated by total possible Yes answers vs. No answers (NA excluded)

- **Focused Outcome Areas**
    - Score calculated by total possible Yes answers vs. No answers (NA excluded)
- **Billing Validation**
    - Score calculated by percentage of justified paid dollar amount vs. the unjustified dollar amount for the reviewed claims
        - The BHQRs will review three (3) payer sources: Medicaid is the sum of paid claims; Fee-for-Service (FFS) is the sum of paid encounters; State Contracted Services (SCS) is the estimated sum based on service rates multiplied by service units
    - A billing review will be completed of randomly selected claims paid by Medicaid and State Contracted Services (Fee for Service and Encounters) for all Individual records.
    - In the event a billing requirement is not met, the Assessor will copy any and all documentation to support the findings.
    - The documentation copied to address the specific Medicaid and DBHDD requirements may include copies of:
        - progress notes,
        - the progress notes immediately prior to and following the date billed if no progress notes are present for the date billed,
        - billing history detailing the erroneous billing,
        - orders/recommendations supporting services rendered,
        - treatment plans and/or agency authorization page, and/or
        - other documentation necessary to illustrate the deficiency
    - Provider personnel will be asked to sign a confirmation of billing discrepancy document on any information absent from the chart and to acknowledge any billing discrepancy identified. This confirmation will be witnessed by the Assessor and accompany any supporting documentation copied from the Individual record. The provider's signature indicates the agency was made aware of the discrepancy and does not constitute agreement with the findings or in any way diminish the provider's right to appeal.
    - All supporting documentation related to reviews will be maintained at the Collaborative's office.
    - Providers have the opportunity to appeal review findings once the final assessment has been posted. See Appeals Process at the end of this section for further information.
    - It is Quality Management's policy to photocopy or scan any documentation to support discrepancies/deficiencies identified during a review.
- **Overall Score**
    - The Overall score is calculated by averaging the four areas: Billing Validation, Focused Outcome Areas, Assessment and Planning, Compliance with Service Guidelines. Each area accounts for twenty-five percent (25%) of the overall score.
- **Quality Risk Items**
    - During Quality Reviews, items may be identified that could indicate significant risk to the Individuals served, the provider agency, or to the Statewide provider network. At the direction of DBHDD, the Overall score (if applicable) is reduced in 2% increments for each Quality Risk Item, with a maximum of 10% reduction total.
    - Quality Risk Items are based on DBHDD Policies and the DBHDD Provider Manual.
    - Quality Risk Items for the BHQR:

- Provider lacks proof of criminal records checks on an employee, staff, and/or contractor
- Services provided at a site not approved by Medicaid
- Safety/Crisis Plan is lacking for those needing a plan in at least three records
- Duplicated documents in three or more records (i.e., duplicated BHAs, IRPs, progress notes)
- High utilization without clinical justification in three or more records
- Provider does not have a nurse on-site for at least 10 hours per week
- Required staff are not filled for more than 90 days within a program (i.e. ACT Team Leader)
- Five or more repeat Quality Improvement Recommendations in any category from previous review
- Blank, yet signed, releases of information in three or more records.
- Contact frequency requirement not met within three or more records per the Service Guidelines in DBHDD Provider Manual
- The Columbia Suicide Severity Rating Scale (CSSR-S) is not present in three or more records (Tier 1 & Tier 2+ providers only)

CSUQR Scoring: The overall score is derived from a review of Individual medical records utilizing the components of the Collaborative's CSUQR Tool. The CSUQR Tools are located on the Collaborative's website.

There are three (3) scored sections of the CSUQR Tool, each representing 33.3% of the total score. Each score is calculated by total possible Yes answers vs. No answers (NA excluded):

- **Individual Record Review**
- **Focused Outcome Areas**
- **Compliance with Service Guidelines**

- **Overall Score**
  - The Overall score is calculated by averaging the three areas: Individual Record Review, Focused Outcome Areas, and Compliance with Service Guidelines. Each area accounts for one third of the overall score.
- **Quality Risk Items:** During Quality Reviews, items may be identified that could indicate significant risk to the Individuals served, the provider agency, or to the Statewide provider network. At the direction of DBHDD, the Overall score (if applicable) is reduced in 2% increments for each Quality Risk Item, with a maximum of 10% reduction total.
  - Quality Risk Items are based on DBHDD Policies and the DBHDD Provider Manual.
  - Quality Risk Items for the CSUQR:
    - Provider lacks proof of criminal records checks on an employee, staff, and/or contractor
    - Safety/Crisis Plan is lacking for those needing a plan in at least three records
    - Duplicated documents in three or more records (i.e., duplicated BHAs, IRPs, progress notes)
    - Required staff are not filled for more than 90 days within a program
    - Five or more repeat Quality Improvement Recommendations within the Individual Record Review and Focused Outcome Areas from previous review

- At least one repeat Quality Improvement Recommendation within Service Guidelines
- Blank, yet signed, releases of information in three or more records
- When an Individual is discharged to a homeless shelter, alternatives were not documented/explored in three or more records
- The Columbia Suicide Severity Rating Scale (CSSR-S) is not present in three or more records
- Medication error in at least one record:
    - Verbal order(s) not signed by prescriber within 24 hours
    - Medication Administration Record did not contain all required criteria
    - Provider did not adhere to medication error policy and procedure
- The RN does not document the status of the Individual every 24 hours in three or more records
- A discharge summary was not entered into the ASO ProviderConnect/Batch system within 48 hours of Individual's discharge from CSU in three or more records
- Orders for admission is not present in three or more records

Program Visit: The Collaborative's Quality Assessors may, at any point during a BHQR, choose to visit a program location. During a CSUQR, a tour of the facility will occur.

Exit Interview: Upon completion of the review, the Assessor will identify a time for the formal exit interview. Typically, the exit interview will last one to two hours. DBHDD and the Collaborative request, at a minimum, the following staff to participate if schedules permit:

- Executive Director/Program Director
- Clinical Director
- Utilization Manager
- Clinical Team Leads
- DBHDD staff members are invited to attend and participate in all parts of the review.

BHQR and CSUQR Post-Onsite Activities

The Assessors will collect any needed additional follow-up information from providers and complete the quality review approval process.

Final Assessment: The Final Assessment will be posted to the Collaborative's website and distributed to the reviewed provider and DBHDD within 30 days of the Exit Interview. The Final Assessment will include all scores, significant findings, and recommendations developed during the BHQR/CSUQR or special review process. Recommendations documented in the report are intended to assist the provider in developing quality improvement initiatives. Based on review outcomes, the Collaborative will coordinate training, technical support, and/or additional consultation as applicable.

Appeals: A provider may appeal their BHQR and CSUQR findings up to ten (10) business days following receipt of their written Final Assessment. The date of notification is the date the email was sent notifying the agency's identified staff persons of the posting of the Final Assessment to the Collaborative's website. The provider must utilize the Review Appeal Form to request an

appeal and submit any supporting documentation with the initial appeal. Please refer to the Appeals Process at the end of this section for further information.

Intellectual and Developmental Disabilities Reviews

The quality review processes for IDD services determine whether the current service delivery systems are promoting positive outcomes and independence through person centered practices. They are designed to improve quality by using two key activities: the Quality Enhancement Provider Review (QEPR) and Quality Technical Assistance Consultation (QTAC).

Standardized tools were developed in collaboration with DBHDD and stakeholders and are available on the Collaborative website. The tools help determine if standards from Provider manuals are met. The table below describes the tool and corresponding review activity.

Tool	Review Activity
Support Coordination Record Review (SCRR)	Review of Support Coordinator's records
Provider Record Review (PRR)	Review of the provider's records
Service Guidelines (SG)	Review of the provider's records
Administrative Review	Review of provider's administrative records
Staff Qualifications & Training (Staff Q&T)	Review of provider's employee records
Individual Service Plan Quality Assurance Checklist (ISP QA Checklist)	Review of the Individual's ISP

The SCRR and PRR are designed around six Focused Outcome Areas (FOAs) to ensure all aspects of an Individual's life are explored and practices to support outcomes in these areas are met by the service delivery network:

- Person Centered Practices
- Whole Health
- Safety
- Rights
- Choice
- Community

The Service Guidelines, Administrative Review and Staff Qualifications and Training tools evaluate specific requirements outlined by DBHDD in the provider manuals. Information requested from a Provider will be limited to that which is necessary to conduct a thorough review and make meaningful recommendations to support improvement of services and supports rendered. Any copies of records requested during any review process will be the sole responsibility of the provider, including the cost of record reproduction.

Quality Enhancement Provider Reviews

The Quality Enhancement Provider Review (QEPR) will be utilized with providers and support coordination agencies. The QEPR uses a consultative approach to assist the provider organization in increasing the effectiveness of the service delivery systems and to meet the Individuals' communicated choices and preferences that matter most. Working collaboratively with the providers, Assessors identify the provider organization's strengths and opportunities for improvement in rendering person-driven and outcome-based supports and services. The QEPR Tools are located on the Collaborative website.

Up to 200 providers, including support coordination agencies, behavior support, and nursing and crisis service providers are selected to participate in the QEPR process each year. The valid and random sample are proportionate to the size of the providers who render HCBS waiver and state-funded services.

The QEPR includes the following activities: Pre-onsite, Onsite, and Post-onsite processes.

- Please note: Providers who have had Individual records subpoenaed should ensure copies are made of relevant information (i.e., assessments, Individual Service Plan, orders, annual documentation requirements, staff personnel/training records, and one year of progress notes, etc.) so the Assessors will have information for the review. If the provider is unable to produce the records, or legible copies of the records, these records will be scored as "0".

QEPR Pre-Onsite Activities

1. Select the sample of providers to receive a QEPR.
2. Notification of the scheduled review will occur via email up to two weeks in advance with the provider.
   3. Reviews will only be rescheduled based upon request by DBHDD or if there is a conflicting review occurring during the same time (e.g.., a provider may have an accreditation survey scheduled the same week).
      a. Providers with key staff who may be out of town during the scheduled review will need to have a substitute sit in for them in their absence. The absence of key staff will not result in rescheduling of a review.
   - If no provider response is received within five business days of the original review notification, DBHDD will be notified. The review will be canceled and the provider will receive a score of "0" on the review.
   - If the provider is a "no show" for the review and has not notified the Lead Assessor within one hour of scheduled start time of the review, it will result in a "0" score.
4. Provider's Staff List will be emailed to the provider with the notification of a scheduled QEPR. The list will assist the Assessor in determining which staff will be reviewed using the Administrative Staff Qualifications and Training tool.
5. The list of individuals selected for the NCI Adult In-Person Survey will be sent via secure email prior to the start date of the QEPR.
6. The Lead Assessor will call the provider after initial notification to develop a schedule for the onsite review activities including entrance conference, individual interviews, and exit conference.
7. Support Coordination Agencies: the QEPR will include a review of the individuals' ISP using the ISP QA Checklist and a review of the support coordinator's records using the SCRR located in the IDD Connects system.

QEPR Onsite Activities

- Conduct Entrance Conference.
- Records Request:
    - Immediately following the entrance conference, a list of individual and personnel records will be given to the provider. The provider has two (2) hours to deliver all on site records/access to EMR for staff training and personnel and individuals records to the Assessors. For any record not delivered during this timeframe, all indicators will be scored as "No". Individual names will not be given in advance.
    - All remaining individual records or staff training and personnel records from other DBHDD-approved service locations will be delivered to Assessors and checked in by 4:00 PM on the first day of the review. Any records presented after 4:00 PM will be treated as if they had not been delivered and all items for those records will be scored as" No" on all areas
- Conduct review of staff and personnel records using the Administrative Staff Qualifications and Training tool.
- Conduct review of administrative records.
- Conduct NCI Adult In-Person Survey interviews.
- Conduct individual record reviews.
- Conduct the Exit Conference to present the preliminary QEPR findings.

National Core Indicators (NCI) Adult In-Person Survey: Randomly selected sample of 480 individuals are chosen from the provider sample each year. Individuals selected will be interviewed during the week of the QEPR. The purpose of the interview is to gain insight about the services provided from the individual's perspective. These results are not included in the QEPR overall score.

Missing Information: Assessors will only consider documentation that is contained in the "official" medical record. Information that is not filed within the Individual record prior to the start of the review will not be considered as present in the medical record. All requested records must be available and accessible to the Assessors for the duration of the QEPR process.

Altering of Records: Records cannot be altered once the QEPR has begun. If at any point during the review process, the provider alters the Individual record (paper or electronic), the record will receive a score of "0" for the record review.

QEPR Post-Onsite Activities

1. The Collaborative will generate and distribute the QEPR report within 30 days of completion of the onsite review.
2. When applicable, the Collaborative will return within 90 days after the QEPR to conduct a Quality Technical Assistance Consultation (QTAC) to support and provide guidance to the provider on improvements to the service delivery system.

QEPR Final Assessment: A comprehensive report will include the relevant or significant findings and recommendations developed during the QEPR process. The QEPR Final Assessment will be posted to the Georgia Collaborative ASO website and emailed to the provider. The recommendations documented in the report will be sent to the provider for use in developing quality improvement initiatives. This report will include the following information:

- Provider identifying information, region(s) number of individual records reviewed, location of review, and review dates and periods
- Scores for each of the key areas reviewed and an overall score
- Quality of care concerns
- Immediate action items
- Overall strengths of the organization's systems and practices
- Overall results of the Provider Record Review or Support Coordinator Record Review, Service Guidelines, and Administrative review

QEPR Appeals: The Quality Department will notify the provider's identified staff that the Final Assessment has been posted to the Collaborative's website. A provider may appeal their QEPR findings up to ten (10) business days following receipt of their written Final Assessment. The provider must utilize the QEPR Appeal Form to request an appeal and submit any supporting documentation. Please see the Appeals Process at the end of this section for further information.

Quality Technical Assistance Consultations (QTAC)

Providers may receive a Quality Technical Assistance Consultation (QTAC) as a result of a QEPR, Quality of Care Concern, or a referral from an external source (see below). The QTAC is a process used to remediate systemic issues and concerns that are identified through different review processes for providers and the service delivery system. This process utilizes a consultative approach to assist providers in their efforts to increase the effectiveness of their service delivery systems both at the individual level and provider level for organizational procedures and practices. The QTAC affords DBHDD and contracted providers the opportunity to solicit technical assistance for specific needs in the service delivery milieu. This process offers providers and support coordinators resources to mitigate barriers that impact service delivery while also identifying organizational strengths and supports quality improvement at the Individual and systematic levels.

Guidelines and the criteria on how a referral is generated are indicated below:

Quality Reviews:

- Quality of Care Concerns: Generated from issues identified during a QEPR or continues issue found during the QTAC.
- QEPR: Will occur approximately 90 days after the QEPR Exit Conference.
    - A QTAC can also occur approximately 30 days after the QEPR Exit Conference for immediate action items.

External Referrals:

- Critical Incidents
    - Based upon a review of the last 12 months of "closed" critical incidents. Typically, between 2-4 or more incidents relating to the same issue(s) for the same provider or same Individual within the last 12 months (that are not duplicate reports) constitutes a referral. However, there are instances when one critical incident may be a referral based upon the specific circumstances or significance of the issue. These cases are corroborated between the Collaborative and DBHDD staff.
- Complaints and grievances

    - DBHDD has received complaints and grievances and has determined the Collaborative is the best resource to provide the technical assistance.
- Other Requests
    - Providers who have been identified by DBHDD who need assistance.
    - Providers who would like to receive technical assistance and have already received a QEPR.
    - New Providers within the preceding 12-month period that have not gone through certification or accreditation. Verification of non-certification is confirmed by DBHDD.

Once approved, the QTAC manager will determine if the QTAC can be completed via desk review or if it requires an Onsite review and will then assign the QTAC to an Assessor to begin completing the QTAC. The QTAC will include the following: Pre-Onsite, Onsite and Post-Onsite activities.

QTAC Pre-Onsite Activities

- The Collaborative gathers and reviews internal and external information about the provider organization, support coordination, and/or the Individual.
- The Collaborative schedules the QTAC with the provider. If the QTAC is confirmed with the provider but the provider is a "no show" and has not notified the Lead Assessor, the review will result in a referral to DBHDD to follow up with the provider or support coordinator.
- Develop a schedule with the provider for the onsite review activities, which could include interviews with Individuals and staff and review of records.
- If selected, make arrangements for the provider to submit documents for a Desk Review and complete the Desk Review
- Complete the desk review QTAC.

QTAC Onsite Activities

- Conduct the QTAC with the provider to explain the process and confirm logistics.
- Depending on the specific issue(s) or concerns identified for the QTAC, one or more of the following activities may be completed as part of the QTAC:
    - Complete Individual and staff interviews necessary to address the specific issues.
    - Conduct administrative review of provider's policy and procedures or employee records.
    - Conduct record reviews.
        - The provider has two hours to have available the records on the date of request. Records not presented by this time frame will be scored as "no."
- Conduct the closing conference to present the findings from the QTAC to the provider
- or support coordinator.

QTAC Post-Onsite Activities

- Generate and distribute QTAC report within 30 business days of the onsite/desk review.
- Determine the final disposition of the QTAC:
    - Onsite Follow Up needed: Another onsite QTAC will be scheduled with the provider to follow up on recommendations made during the initial QTAC.
    - Desk Review Follow Up needed: A desk review will be scheduled with the provider to follow up on recommendations made during the initial QTAC.
    - DBHDD Follow Up needed: A referral is made back to DBHDD for further technical assistance and follow up or other actions.

    - Closed: No further action is warranted.
- When applicable, schedule a return date for another QTAC.

QTAC Report: Both the provider and DBHDD will receive notification that the QTAC report has been completed within 30 business days of completion. The QTAC report will include a summary of the follow up review activities, identifying areas of concern, any significant trends or areas of improvement deserving recognition and/or any additional recommendations/technical assistance provided.

Additional IDD Quality Review Activities

National Core Indicators (NCI)

The State of Georgia participates in the National Core Indicators. These indicators are used to assess the outcomes of services provided to Individuals and families. Indicators address key areas of concern including employment, rights, service planning, community inclusion, choice, and health and safety. As a participating state, Georgia has opted to utilize the NCI Adult In-Person survey and two mailed surveys.

Using a sampling methodology approved by DBHDD and Human Services Research Institute (HSRI), the Adult In-Person survey will be conducted with Individuals selected for the sample each year. The Individual has the option to participate and if he or she declines, another Individual will be selected from an oversample. If the person agrees to participate, the interview will be conducted during the QEPR. This is to reduce administrative burden on providers.

For the mailed surveys, a random sample is selected each year for the Family Guardian and Adult Family surveys. A post card is mailed to the perspective participant letting them know they were selected and encouraging participation. Any returned postcards with an updated address are updated and then the surveys are mailed. The surveys are described below:

- **Family Guardian Survey**: This survey is for family members or legal guardians to identify how well the service delivery system assists them and their adult family member with an intellectual or developmental disability and who does not live with them. It evaluates the quality of services the Individual is receiving from the family member or guardian's perspective.
- **Adult Family Survey**: This survey is for family members to identify how well the service delivery system assists them and their adult family member with an intellectual or developmental disability that lives with them in the family home. It evaluates the quality of services the Individual is receiving from the family member's perspective.

Surveys that are completed and returned are entered into the ODESA system for future evaluation and analysis done by Human Services Research Institute (HSRI). These reports are made available to DBHDD and posted on the NCI website at www.nationalcoreindicators.org.

Individual Service Plan Quality Assurance (ISP QA) Checklist

Those Individuals selected to participate in the NCI Adult In-Person survey sample will also have their Individual Service Plan (ISP) reviewed to evaluate the quality of the document and information contained in the document. This review will use the ISP QA Checklist and be conducted via desk review. A report will be generated based upon the results and uploaded to the individual's record in the IDD Connects system.

Appeals Process

A provider may appeal their BHQR, CSUQR, and/or QEPR findings up to ten (10) business days following receipt/notification of their Final Assessment Report. The date of notification is the date the email was sent notifying the agency's identified staff persons that the Final Assessment Report has been posted to the Collaborative's website. The provider must utilize the Review Appeal Form to request an appeal and submit any supporting documentation.

A provider may only appeal review findings based on:

- Differences in interpretation regarding factual matters
- Differences in interpretation of DBHDD policy

Providers may not appeal findings based on:

- A recommended change to DBHDD policy
- A suggestion that an existing DBHDD policy is inappropriate

Note: Appeals sometimes alert DBHDD of potential improvements in policy. Providers should follow current policy as written until policy is changed and official notification is made public.

Level One

The provider must submit their appeal request on the Review Appeal Form via e-mail or fax to the Resolution Coordinator. The appeal must detail each decision from the review the Provider wishes to appeal and include a rationale for the appeal. If additional documentation needs to be sent, the provider may fax or mail this information. For QEPR appeals, the provider should ensure the documents include the QEPR review ID number, the provider's name and contact information and accompanied by the IDD Quality Review Appeal Form. It is the provider's responsibility to ensure that Protected Health Information (PHI) is redacted within documentation sent with the appeal, including (but not limited to): the Individual's name, identification numbers, etc. Providers are to refer to consumers using the Individual Key provided to them during the review. If additional documentation is requested, the provider must respond to the request within three (3) business days or the information will not be considered in the appeal.

- IDD Quality Review Appeal Form
- BH/CSU Quality Review Appeal Form

A determination will be made based on the information submitted, a review of the agency's Final Assessment, supporting documentation, and interviews with appropriate quality review staff (if applicable). The Level One Appeal determination will be sent to the provider within ten (10) business days of receipt of the appeal. The response will include:

- A determination to uphold or overturn the review findings
- If overturned, what steps will be taken to correct review findings
- If upheld, the rationale to maintain review findings

Level Two

If, after receiving the Level One Appeal response the provider is not satisfied, they may file a Level Two (the final level) appeal. The Level Two appeal must be submitted by the Executive Director/CEO of the provider agency or their designee. To show continuity between the appeal levels, the Level Two Appeal must be submitted on the returned Level One Appeal Form. The Level Two Appeal can be submitted via e-mail to the Resolution Coordinator or by Fax (855-858-

1965) within ten (10) business days of receipt of the Level One review appeal response. While the agency can amend the rationale for their appeal, no new issues or supporting documentation can be presented in the Level Two Appeal. Please refer to the appeals form located on the on the Collaborative's website under Quality Management for additional information.

The Collaborative will convene a meeting of the Appeals Committee (AC). The AC is comprised of DBHDD employees, representatives from DBHDD service provider agencies, and one representative from the Collaborative. There are 11 voting members, six (6) of whom represent service provider agencies. The selection of provider agency representatives takes into account agency location, target populations, services provided, commitment to IDD and behavioral health services quality improvement in Georgia, and knowledge of service guidelines. If an AC member's agency is involved in the appeal, he or she will be recused from the appeal process.
The Collaborative's AC meets and reviews all available information regarding the Level Two Appeal within twenty (20) business days of receipt. A quorum of six (6) members must be achieved in order to make a Level Two Appeal Determination; at least half of the attendees must be provider representatives.

Once the AC has made the final determination to uphold or overturn an appealed review finding, the Collaborative will respond in writing to the provider within five (5) business days of the AC meeting. The response will include:

- A determination to uphold or overturn the review finding(s)
- If overturned, what steps will be taken to correct review findings
- If upheld, the rationale to maintain review findings

Intervention Program Desk Reviews

Overview

The purpose of the Driving Under the Influence (DUI) Desk Review is to determine adherence to DBHDD standards outlined in the DUI Procedure Manual and to assess the quality of service delivery. The DUI Procedure Manual is posted on the DBHDD website.

The DUI Desk Review consists of a record review of Clinical Evaluators and Treatment Providers included on the DBHDD Registry of DUI Treatment Providers. The Registry of Treatment Providers is a list of providers who have been approved by DBHDD to provide treatment for multiple DUI offenders that are required by Georgia law to undergo treatment.
Clinical Evaluators and Treatment Providers are defined as:

- **Clinical Evaluator**
  - A Clinical Evaluation is conducted by a DBHDD-approved professional who is certified in the field of addiction.
  - DUI offenders must select a Clinical Evaluator from the DBHDD-approved list.
  - Based on their findings, the Clinical Evaluator may recommend treatment. Treatment means attendance and participation in the type of program recommended by the Evaluator.

- **Treatment Provider**
  - If recommended, the offender must attend a DBHDD-approved treatment program.

- The Registry of Treatment Providers is a list of providers who have been approved by DBHDD to provide treatment for multiple DUI offenders who are required by Georgia law to undergo treatment.

The DUI Desk Review Tools are available on the Collaborative's website. The specific factors that contribute to the scores are derived from adherence to the DBHDD DUI Procedure Manual and captured in the DUI Desk Review scoring Tool.

Review Frequency: Each provider is eligible for review up to one time per year for each service provided unless otherwise directed by DBHDD**.**

Notification of Reviews: Providers are notified via email that they have been selected for a record review. Providers have seven (7) business days to submit requested documentation upon receipt of notification. If there is no response, a second notification is sent via email. DBHDD is notified if a provider requests an extension, requests to be removed from the DUI Registry, or if a provider does not respond.

Selection of Records: Per DBHDD direction:

- Assessors select three Clinical Evaluators and three Treatment Providers each month for a desk review
- A total of 30 records are reviewed each month; five (5) from each type of provider
- The providers are selected from a master list provided by the DBHDD DUI Intervention Program Director and Program Manager
- Those providers with the highest utilization are prioritized for review

Record Review Process:

- There are two (2) types of scoring tools utilized:
  - Clinical Evaluator Review Tool
  - Treatment Provider Review Tool
- Each Tool consists of 18 questions and an Overall score is derived

Reporting Results:

- Assessors report provider scores with relevant details regarding trends, provider strengths, growth areas, and any noncompliance issues to the DUI Program Manager via a monthly summary
- Assessors provide telephone consultation and Technical Assistance to providers per DBHDD request
- The DUI Program Manager provides the scores to providers

Compliance Department

Overview

The operations of the Collaborative Compliance Department are administered by the Compliance/Program Integrity Department, led by the Compliance Officer. The Compliance Officer functions independently of any other department at the Collaborative and has several responsibilities, including, but not limited to:

- Establishing and maintaining all necessary policies and procedures to support the Fraud & Abuse Action plan
- Conducting Provider Audits, either desk or in person
- Reporting findings to the Compliance Committee (members from both the Collaborative and DBHDD)
- Reporting suspected fraud, waste and abuse to DBHDD
- Ensuring that the Collaborative is following all standard guidelines to ensure the protection of Protected Health Information (PHI)

HIPPA/Privacy Issues

Providers and their business associates interacting with the Collaborative should make every effort to keep protected health information secure. If a provider does not use email encryption, the Collaborative recommends sending protected health information to Beacon through an inquiry in ProviderConnect or by secure fax. This expectation does not in any way relieve the provider of reporting in accordance with DBHDD Policy regarding HIPAA.

Reporting of Fraud, Waste, and Abuse

The Collaborative interacts with employees, providers and Individuals using standard clinical and business ethics seeking to establish a culture that promotes the prevention, detection and resolution of possible violations of laws and unethical conduct. In support of this, the Collaborative's compliance and anti-fraud plan was established to prevent and detect fraud, waste, or abuse in the provider network through effective communication, training, review, and investigation.

The reporting of suspected fraud, waste, and abuse is intended to circumvent the misappropriation of Federal, State, and Local funds. Fraud is considered an act of purposeful deception committed by a person or behavioral health/IDD provider to gain an unauthorized benefit. Abuse committed by a behavioral health/IDD provider means activities that are inconsistent with standard fiscal, business, or medical practices, and that result in unnecessary costs to the DCH and DBHDD. Waste is considered to be the thoughtless or careless expenditure, consumption, mismanagement, use, or squandering of healthcare resources, including incurring costs because of inefficient or ineffective practices, systems, or controls.

Providers should report fraud, waste, and abuse, or suspicious activity thereof, such as inappropriate billing practices (e.g., billing for services not rendered, up coding, use of CPT codes not documented in the medical record, etc.). Reports and questions may be made in writing to the Collaborative at the address below or by calling the following numbers or hotlines:

Beacon Health Options/ Georgia Collaborative ASO
Attn: Katie Cossette, Compliance Officer
P.O. Box 56324
Atlanta, GA 30343
404.836.1668

Report by Email:
GACompliance@beaconhealthoptions.com
Safe To Say Ethics Hotline:
888-293-3027
Beaconsafetosay.ethix360.com

Provider Audits

The Compliance Department completes Provider Audits per your provider arrangement(s) with DBHDD. There is no schedule for Provider Audits, but if selected providers are notified via email or regular mail. Provider Audits are conducted by the Compliance Department either by desk review or on site at the provider location. These Audits will assess accurate, complete and timely claims/encounter submissions for the audit review period. The purpose of these Audits is to ensure medical records comply with medical record standards, paid services are documented appropriately, and providers are adhering to DBHDD regulatory and contractual requirements. The Provider Audit is designed to detect and deter fraud, waste, and abuse, and determine whether the provider met the error rate threshold of 10% established by the collaborative and DBHDD.

Please note: The Provider Audit is a separate and distinct process from the behavioral health (BH) and intellectual and developmental disabilities (IDD) Quality Reviews and from any Georgia Medicaid program integrity processes (although this work can be complementary and supportive of these processes).

The Provider Audit may include, but is not limited to: financial, administrative, current and past staff rosters, and clinical records. For the purposes of the Provider Audits, the clinical record includes, but is not limited to: assessments, treatment plans, progress notes, medication prescriptions and monitoring, the modalities and frequency of treatment furnished, and results of clinical tests. It may also include summaries of the: diagnosis, functional status, strengths, symptoms, prognosis, and progress to date.

Compliments, Complaints and Grievances

Overview

The Collaborative welcomes feedback from providers and Individuals. Through this feedback, opportunities for improvement in processes and services provided by the Collaborative are identified. Compliments, complaints, and grievances are routed through the Collaborative's Performance Improvement Department.

Complaints and grievances regarding providers and/or DBHDD will be referred to DBHDD for appropriate follow up.

Compliments and General Feedback

If an Individual or provider would like to provide general feedback or compliments to the Collaborative, please email GACOFeedback@beaconhealthoptions.com.

Provider and Individual Complaints and Grievances

A provider or Individual may file a complaint or grievance to the Resolution Coordinator. The Resolution Coordinator will collect and analyze the content of complaints and grievances when received and will provide a timely response to resolve all issues related to the Collaborative. The process includes categorizing complaints, tracking/trending, and reporting up to the Quality Management Committee (QMC). The QMC is comprised of leadership from the Collaborative. The QMC in turn makes recommendations for remedial action and/or other improvement actions. Complaints and grievances are also reported to DBHDD for their review and recommendations, when appropriate.

Complaint: Provider and Individual complaints regarding issues related to the Collaborative in terms of the provider contract/agreement or performance (e.g. service complaints, complaints about the Collaborative's policies and procedures) should be submitted following the steps outlined below. Please note: Complaints and grievances regarding providers and/or DBHDD will be referred to DBHDD for appropriate follow up.

- **Email:** GACOFeedback@beaconhealthoptions.com
- **Telephone:** 855.606.2725 (Monday – Friday, 8:00am – 5:00pm)
- **Timeline:** The Collaborative will acknowledge receipt of provider complaints verbally or in writing, and thereafter will investigate and attempt to reach a satisfactory resolution of the complaint within 30 calendar days of receipt of the complaint. A one-time extension of 15 calendar days can be taken by the Collaborative when a resolution cannot be reached within the above noted 30 calendar day timeframe and the extension is solely for the benefit of an Individual.
- **Notification of Resolution:** The Collaborative will notify the provider or Individual verbally or in writing of the proposed resolution to the complaint, along with the procedure for filing a grievance should the provider not be satisfied with the proposed resolution.

Grievance: If the provider or Individual is not satisfied with the proposed resolution of the complaint, the provider may request a formal grievance, either verbally or in writing. Providers will be sent the Grievance Form with their Notification of Resolution to their original complaint.

- **Email:** GACOFeedback@beaconhealthoptions.com
- **Telephone:** 855.606.2725 (Monday – Friday, 8:00am – 5:00pm)

- **Timeline:** The grievance should be submitted within 90 calendar days of receipt of the Collaborative's proposed resolution to the initial complaint. The Collaborative Leadership Committee (who were not involved in review of the initial complaint) will review provider grievance requests.
- **Notification of Resolution:** Notice of the grievance decision will be issued within 30 calendar days of receipt of the grievance request. A one-time extension of 15 calendar days can be taken by the Collaborative when a resolution cannot be reached within the above noted 30-calendar-day timeframe and the extension is solely for the benefit of an Individual.

Helpful Resources

- Georgia Collaborative ASO website: www.georgiacollaborative.com
- GCAL website: www.bhlweb.com
- ProviderConnect User Guide
- ProviderConnect
- Batch Resources
- PaySpan Health
- DBHDD provides direction to providers via the contracts and agreements as well as the policies posted on DBHDD PolicyStat and the DBHDD Provider Manuals.
    - PolicyStat
    - DBHDD Provider Manuals
    - DBHDD website
- Department of Community Health

Glossary of Terms

Acronym	Definition
AC	Appeals Committee
ACT	Assertive Community Treatment
ANSA	Adult Needs and Strengths Assessment
ASO	Administrative Service Organization
BHL	Behavioral Health Link
BHQR	Behavioral Health Quality Review
CCM	Clinical Care Manager
CCP	Comprehensive Community Provider
CANS	Child and Adolescent Needs and Strengths
CARES	Certified Addition Recovery
CARF	Commission on Accreditation of Rehabilitation Facilities
CBAY	Community Based Alternatives for Youth
CBHRS	Community Behavioral Health and Rehabilitation Services
CID	Consumer Identification
CIS	Case Management System (for IDD)
CME	Care Management Entity
CMP	Community Medicaid Provider
CMS	Center for Medicaid Medicare Services
COC	Combination of Care
COMP	Comprehensive Supports Waiver
CPS	Certified Peer Specialists
CSU	Crisis Stabilization Unit
CSUQR	Crisis Stabilization Units Quality Review
CTS	Community Transition Specialists
DDSS	Developmental Disabilities Service Specific
DBHDD	Department of Behavioral Health and Developmental Disabilities
DCH	Department of Community Health
DUI	Driving while Under the Influence
EDI	Electronic Data Interchange
EH/MR	Electronic Health/ Medical Record
EMR	Electronic Medical Record
FFS	Fee for Service
FOA	Focused Outcome Areas
GCAL	Georgia Crisis and Access Line
GMCF	Georgia Medical Care Foundation
GACF	Georgia Collaborative ASO Crisis/Temporary/Unknown/Incomplete (Claims)
HLOC	Higher Level of Care
HSRI	Human Services Research Institute
IDD	Intellectual Developmental Disabilities
IOSA	Individual Observation Staff Assessment
IRP	Individualized Recovery/ Resiliency Plan
LOC	Level of Care
LOS	Level of Service
MCRS	Mobile Crisis Response Services
MI	Mental Illness

MRO	Medicaid Rehabilitation Option
MSTR	Minimum Standard Training Requirements
NCI	National Core Indicator
NOW	New Options Waiver
OBRA	Omnibus Budget Reconciliation Act
ODESA	Online Date Entry Survey Application
OSAH	Office of State Administrative Hearings
PASSAR	Preadmission Screening and Resident Review
PCP	Primary Care Physician
PCR	IDD Person-Centered Review
PHI	Protected Health Information
POS	Place of Service
PRR	Provider Review Record
PRTF	Psychiatric Residential Treatment Facility
PSV	Provider Summary Voucher
QEPR	IDD Quality Enhancement Provider Review
QQMS	Qlarant Quality Management System
QTAC	IDD Quality Technical Assistance Consultation
RC	Related Condition
ROCI	Review of Critical Incidents
SCC	Specialized Care Coordinators
SCI	Support Coordination Interview
SCRR	Support Coordination Record Review
SCS	State Contracted Services
SFAD	State Funded Adult (Behavioral Health)
TOC	Type of Care
TOS	Type of Service
URAC	Utilization Review Accreditation Commission
WRAP	Wellness Recovery Action Plan
WHAM	Whole Health Action Management Plan