Provider Handbook

Effective Date: 7/1/2026

Contents

Introduction to the Georgia Collaborative ASO

Overview

The Georgia Department of Behavioral Health and Developmental Disabilities (DBHDD) contracts with Carelon Behavioral Health (Carelon) to provide administrative services in support of Georgia's publicly-funded, Behavioral Health and Intellectual and Developmental disabilities (IDD) services system.

The covered population includes adults and children who are eligible for fee-for-service Medicaid and those who are uninsured, as well as individuals with intellectual and developmental disabilities.

Services include:

- ✓ Maintaining a 24/7 crisis and access line for behavioral health and intellectual and developmental disability services.
- ✓ Using state-of-the-art technologies to create efficiencies and improve the quality of care.
- ✓ Providing focused utilization management and review services for intensive services and a streamlined process for less intensive services.
- ✓ Quality Management oversight and consultation for all behavioral health and intellectual and developmental disability providers.

Operating together as the Georgia Collaborative ASO, Carelon partners with long-time Georgia health care participant Qlarant (formerly the Delmarva Foundation):

Carelon is a national leader in behavioral health management, serving 40 million people across all 50 states. Carelon ensures full-spectrum, high-quality care for a wide range of partners: regional and specialty health plans; employers and labor organizations; and federal, state, and local governments. In Georgia, Carelon is accountable for all of the DBHDD contractual requirements and provides oversight and infrastructure to support the Collaborative. In particular, it also performs the functions of provider enrollment, preadmission screening and resident reviews (PASRR), utilization management, care coordination, behavioral health quality management, reporting, claims payment and Information system infrastructure that includes an on-line case management application for persons with intellectual and developmental disabilities.

Qlarant, is a nationally recognized organization for supporting quality management systems that deliver services for Individuals with Intellectual and Developmental Disabilities (IDD). Qlarant specializes in quality improvement and assurance for state programs in an effort to establish performance standards and person-centered data collection solutions that drive better service and outcomes. In Georgia, Qlarant conducts Quality Enhancement Provider Reviews, and other quality oversight and reporting services relevant to the IDD quality management system.

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 its 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	Jessica Foust, LPC
Chief Medical Officer	Mark Bradshaw, MD
Chief Financial Officer	Karen Lee
Director, GCAL Call Center	Bari Blake, LPC
Director Network Relations	Renee Jolissaint, LCSW
Behavioral Health Administrative Director	Ashley Tricquet, LPC, CRC, MAC
Director, Clinical Quality	Katie Cossette, MBA, LCSW
Director of Quality Management	Nicole Griep, MSW

Director of Information Technology	Jennifer Djang-Riccio, LPC, LCMHC
Director of Data Management and Reporting	Lena Gomes, PMP, CPC
Intellectual and Developmental Disabilities Administrative Director	Brian Erdoes
Director of Independence and Recovery Advocacy	Jean Olshefsky, CPS, CARES
Executive Assistant	Hanya Whyte, CAP, OM
The Georgia Collaborative ASO Partners	
Director IDD Quality Reviews, Qlarant	Nancy Overs-Ikard, MBA

Contact Information

Georgia Crisis and Access Line (GCAL)	**Tel:** 800.715.4225 (24 hours a day, 7 days a week) **Website:** **https://csp.carelon.com/ga/sign-in**
Customer Service (Questions regarding Eligibility, Authorizations and Claims)	**Tel:** 855.606.2725 (Monday – Friday, 8:00am – 5:00pm)
EDI Helpdesk (Questions regarding ProviderConnect user credentials)	**Tel:** 888.247.9311 (Monday – Friday, 8:00am – 6:00pm)
Clinical Department	**Care Coordination Fax:** 855.858.1966 **Care Coordination Email**: GACARE@Carelon.com **PASRR Fax:** 855.858.1965 **PASRR Email:** GAPASRR@Carelon.com
Compliments, Complaints, Grievances, and General Feedback	**Tel:** 855.606.2725 (Monday – Friday, 8:00am – 5:00pm) **Email:** GACOFeedback@Carelon.com

Fraud, Waste and Abuse	**Email:** Report.now@dbhdd.ga.gov
Provider Relations (Questions regarding escalated claims or authorization issues)	**Email:** GACollaborativePR@Carelon.com
Provider Enrollment (Questions regarding the status of a submission or credentialing question)	**Email:** GACollaborative@Carelon.com
Provider Enrollment Documentation Submission (application and document submission ONLY – no correspondence)	**Email:** GAEnrollment@Carelon.com
Quality Management	**Email:** GAQuality@Carelon.com

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 contracts 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 is decided by DBHDD and DCH. The enrollment process requires formal approval for all Behavioral Health and IDD providers and service locations.

Provider documentation submitted is 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 and/or recoupment. 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 could include: the type(s) of service(s) applied for, completeness and accuracy of application(s) and provider responsiveness to requests from the Collaborative or DCH for additional information. For more information, providers may refer to the Provider Enrollment Forum training materials for the discipline in which they are interested and the Provider Enrollment Frequently Asked Questions (FAQs) 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

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 and upon request)
5. Department of Community Health (DCH) Application (upon request)
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
11. ProviderConnect Access and Training

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 will be issued and the certificate is a required document for the submission of an LOI.

2. **Letter of Intent sent to the Collaborative:** After attendance at the Provider Enrollment Forum, providers must submit a complete and signed LOI, including all required supporting documentation. An LOI and a list of the required supporting documentation (Pre-Qualifiers) can be obtained by clicking here: Link to Forms

a. Email is the preferred method of submission; however, if a hard copy is sent by the provider, the LOI must be typed, printed and mailed via USPS with copies of supporting documents to the following address:

Georgia Collaborative Enrollment
740 West Peachtree St NW, Atlanta, GA 30308

OR

Email to: GAEnrollment@Carelon.com

b. LOIs may be submitted beginning the first day of the open enrollment period for the discipline in which a provider is applying for, typically the month following each Provider Enrollment Forum. LOIs will be accepted through the last day of open enrollment period, typically the last day of the month following the Provider Enrollment Forum. For example, if the Provider Enrollment Forum is July 10, the LOI may be submitted as early as August 1, but would not be accepted after August 31.
c. Providers will receive an acknowledgement letter via email from the Collaborative Enrollment Department (GAcollaborative@Carelon.com) within five (5) business days of receipt of the LOI submission.
d. **LOI Timeline:** LOIs will be reviewed within 30 calendar days of receipt of the LOI to ensure each Pre-Qualifying document is included and accurate in submission. PreQualifier checklists for each discipline can be found in the Agency or Individual LOI. The Collaborative Enrollment Department will determine if applicants meet all applicable pre-qualifiers set forth by DBHDD. After the initial review is completed, any deficiencies identified will be communicated to the provider via email. The provider will have ten (10) business days to correct identified deficiencies and return via email to the GAenrollment@Carelon.com. Failure to respond or submit requested documentation by the due date may result in a determination to close the LOI.
e. **Approved LOI:** Providers whose LOIs 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:** An email notification will be sent to the provider after the LOI approval confirming the next steps in the process. The provider has 30 calendar days after the LOI approval to submit a New Provider Application. The application review and notification process will adhere to the LOI timeframes outlined above for approval.
    a. 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 corrections within ten (10) 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, based upon service requested. 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: GAenrollment@Carelon.com. For additional information pertaining to site visits, please refer to DBHDD policy and attachments for BH providers.

5. **Department of Community Health (DCH) Application:** As part of the approval process, new providers will be required to submit an online DCH Application to obtain a Medicaid Provider ID. Existing providers may be required to submit an online DCH Application depending upon the request type. 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 application packet to DBHDD recommending approval or denial. DBHDD will forward the recommendation to DCH.

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 Provider Manuals for Community Providers

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 the Provider Enrollment Forum (#1 above).

   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

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

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. The Provider has 10 business days to sign and return to DBHDD (via email).

10. **Provider Network Activation by The Georgia Collaborative ASO:** Once a LOA has been executed, DBHDD will notify the Collaborative to activate the appropriate service locations and associated approved services in the Carelon IT system: Connects. The Collaborative will notify providers in writing once this has occurred in the form of an ASO Completion Letter.

11. **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.

12. **IDDConnects:** IDD Providers will also gain access to IDDConnects, the case management system utilized by IDD providers. In the ProviderConnect Training above, as an IDD provider, you will also receive training on IDDConnects.

Key Points to Remember

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

- **Email Address:** Email is the standard mode 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 correspondence that may be required during the process. Providers can expect to receive email correspondence from GACollaborative@Carelon.com. To ensure receipt of emails from this mailbox, providers should 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@Carelon.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.

Existing DBHDD Providers

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

Georgia Collaborative Enrollment
740 West Peachtree St NW, Atlanta, GA 30308

OR

Email to: GAEnrollment@Carelon.com

Adding a Service/Location: Existing DBHDD providers wanting to add a service or a location must meet the following criteria:

- Providers must have provided 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. Please refer to the Quality Management section for further information regarding the Quality Reviews.
- IDD providers to add a location or service, must be accredited or certified through DBHDD's Office of Incident Management and Compliance.
- Instructions on completing and submitting an Existing Provider Application can be found in PDF and recording format via the Existing Provider Workshop.

- **Adding a Service to an Existing Location:**
    1. Existing DBHDD providers who wish to add services or locations must complete the Existing Provider Application (either IDD or BH).
        a. The application must be typed and submitted via email with all required supporting documentation.
        b. The application for existing providers can be found here.
        c. Failure of a provider to submit a complete, accurate and signed enrollment application, including 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. Providers adding certain specialty services, such as behavioral health residential services may require the assignment of 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 Provider Manuals for Community Providers
- **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 should be typed and then submitted via email 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 (e.g. behavioral health and/or IDD Host Homes).
    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: GAenrollment@Carelon.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 Provider Manuals for Community Providers

- **Timeline:** Providers will receive an email from the Collaborative Enrollment Department (GACollborative@Carelon.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 ten (10) business days. Failure to do so may result in closure of application.

- **Application Completion:** Providers who successfully complete 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.

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 GA Collaborative ASO Change of Information Form must be submitted for approved Medicaid services. The Staff Update Form is required to notify of applicable staff changes. Providers are asked to notify GAenrollment@Carelon.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
- Instructions on completing and submitting these forms can be found in PDF and recording format via the Existing Provider Workshop.

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. Please refer to DBHDD policy 04-119, Actions Necessary upon Closure, Suspension of Services, or Termination of a DBHDD Community Services Provider prior to submitting this form.

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@Carelon.com.
- If a new legal entity is created, providers must submit complete the ***New*** Provider Enrollment process described above.

The Collaborative Provider Identification Numbers

Once a provider is approved, there are several different Provider Identification Numbers assigned in addition to the National Provider Identifier:

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, IDDConnects 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

As described above, 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 from DBHDD. These trainings will be offered in a webinar format and are designed to assist new providers with gaining a better understanding of DBHDD and 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 department. 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@Carelon.com. Past training webinars are posted on the Collaborative's 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@Carelon.com. Inquiries will be routed to the appropriate team for resolution within five business days.

Systems and Portals

ProviderConnect

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

The following functions may be performed 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

For more information about ProviderConnect, or to login, click here.

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

Batch Processes

Batch submission allows submitters to send files to the Georgia Collaborative ASO using standardized format. These files can be created through a practice management software and uploaded to the Georgia Collaborative ASO for processing through our ProviderConnectSM portal or Secure File Transfer Protocol (SFTP). The Georgia Collaborative can accept registration, authorization and discharge files. The Availity system can accept 837i and 837p HIPAA compliant claim files.

You must have an electronic account set up before you are able to connect with us to submit batch files. You will need to complete the Online Services Account Request Form for Georgia Providers if you do not currently have an electronic account.

All files that are uploaded will have corresponding response files. The response files can be accessed through the EDI homepage or via the SFTP application. If you want access to the 277CA and 999 response files for claims you will need to contact the EDI Helpdesk to have your account set up in Availity.

The Collaborative offers several Batch Submission User Guides. The user guides include detailed information about the required fields for Batch submission.

IDDConnects

An innovative, web-based Case Management System for Individuals receiving IDD services, providers and other stakeholders.

The following functions may be performed in IDDConnects:

- Submit, view and track applications
- View and track determinations
- View and monitor service delivery
- Submit, view and download documentation and reports
- View demographic and eligibility information
- View and submit ISP and authorization information

The Collaborative offers several IDDConnects User Guides. The user guides include detailed information on accessing the portal and the functions stated above.

For more information about IDDConnects, or to login, click here.

GCAL Provider Interface/Crisis Safety Platform

The Crisis Safety Platform (CSP) 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 CSP users is available through the Zendesk online ticketing system.
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

For more information about GCAL and CSP, please click here.

Registration

Providers must ensure that Individuals requesting services are registered in the Collaborative system prior to requesting a service 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. Additional information, including provider responsibilities can be found in the DBHDD policy 01-107: *Payment by Individuals for Community Based Services*
- Most registrations remain active for a period of 365 days. Additional information regarding the Registration process can be found in the Registration section of the ProviderConnect User Guide.
- Individuals must have an active registration prior to providers submitting an authorization request.
- The registration may be updated when an Individual's demographic information changes.
- NOTE: Verification of eligibility and/or identification of benefits is not a clinical process and registration and/or authorization does not guarantee 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.

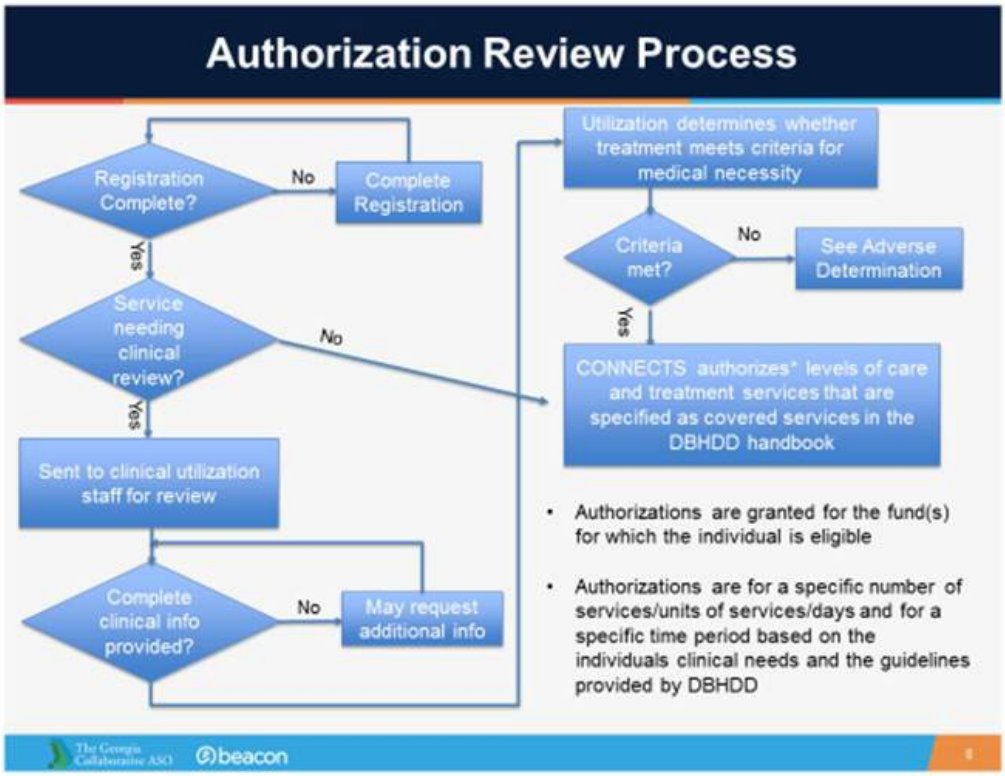
- **Combination of Care (CoC):** Four-part classification to differentiate services provided to an individual. This consists of: Level of Service (LOS), Type of Service (TOS), Level of Care (LOC), and Type of Care (TOC).
- **Initial:** Authorization submissions for new CoC for an Individual is called 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 an
- 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.

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

An overview of the Authorization process is presented immediately below. The following Clinical Program description provides additional detail on the clinical processes and criteria.

High-Level Authorization Process Flow

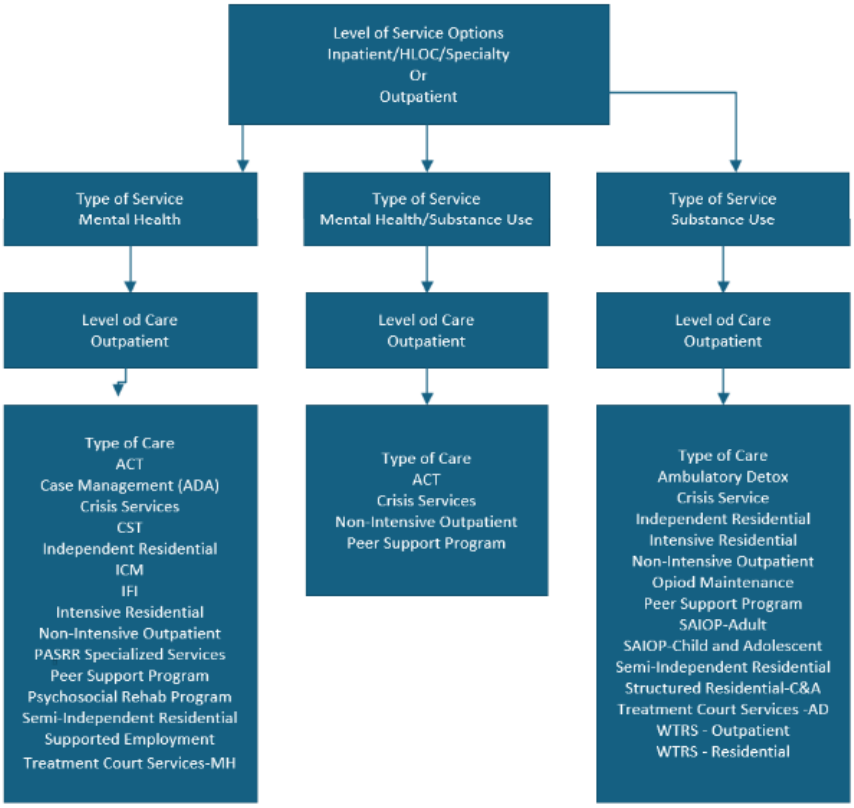


Note: The mechanism for requesting authorization varies for higher levels of care.

- Initial inpatient and CSU referrals and authorizations are requested through 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

1. **Levels of Service** The LOS is based on the intensity of the services requested on an authorization. Inpatient/Specialty: The highest LOS are inpatient services, such as state-contracted bed (SCB) inpatient services, state hospital inpatient services and crisis stabilization (CSU) services
2. Outpatient: The outpatient LOC includes traditional outpatient services that are provided in the community or an office setting, such as individual and family therapy and group therapy
3. 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)
4. 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.
5. For Outpatient Services, the provider will have an option to select the Type of Care and then the services requested within each.
   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 Carelon Behavioral Health 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 as outlined in the DBHDD Provider Manual for Community Behavioral Health Providers.
    - Providers will identify those services they wish to request for the Individual.
    - Providers must 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 therapy, 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 in the DBHDD Provider Manual for Community Behavioral Health Providers 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 following timeframes for submission of discharges are expected:

- 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).

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.

Clinical Department

Overview

The approach of 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 ensure services that are medically necessary, clinically appropriate, cost effective, data-driven, and person-centered.

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. 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 the 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

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.

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.

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	*For Severe Situation:* ▪ Offer Mobile Crisis

	▪ 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	▪ Offer an urgent appointment in no later than three calendar days ▪ Instruct caller to re-contact GCAL 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 GCAL again if condition worsens.

Emergent Referrals
When GCAL is contacted about or 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, the ER or Jail requesting the referral and the agency receiving the referrals take place electronically and in real time, using Carelon's Crisis Safety Platform (CSP) and tracked until the provider confirms the 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.

Routine Referrals
Individuals identified as needing routine services will be given a choice of providers. GCAL will give the Individual the agency phone number to contact.

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 CSP or by calling 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, providers will use the electronic resources on CSP for referrals and bed tracking. All facilities will receive referrals through CSP which provides 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 Crisis Safety Platform in a manner consistent with the practices outlined by DBHDD.

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, functional status, and medications with dosages and frequency, 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 Behavioral Health Care Manager (BH CM) will complete the review. If the information necessary to make a determination is not available or does not appear to meet DBHDD medical necessity criteria, 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 within 48 hours of the Individual leaving the inpatient/CSU 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 CSP for referrals. Once admitted to a Regional State Hospital, all utilization management activities are conducted by the state hospital and are not included in this process.

Non-Urgent/Residential Services

- Psychiatric Residential Treatment Facility (PRTF)

PRTF level of care is considered an intensive higher level 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 Initial Pre-Certification: Initial Pre-certifications/referrals to a PRTF level of care must be reviewed clinically and authorized after a discussion of the Individual's clinical presentation with the ASO's Medical Director. In accordance with DBHDD guidelines, referrals to a PRTF 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 provider. Admission to the PRTF 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 Behavioral Health 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 Behavioral Health 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 Behavioral Health 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 Care Management Entity (CME) may submit a referral/pre-certification information to receive approval for a lateral

transfer to another PRTF. 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. 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. Providers should contact the Behavioral Health Care Manager for additional information regarding Therapeutic Leave requests.

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 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.

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 Orientation to Service Authorization page 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 Behavioral Health Care Manager may review the clinical documentation presented in the authorization and may request additional documentation to support the request. If the request meets DBHDD medical necessity criteria based on the review of information provided in the authorization request, the Behavioral Health 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. Please see the full PASRR description below. 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.

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 Behavioral Health 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.

Adverse Clinical Determinations

Overview

Clinical Review: A review of the clinical information provided within the request to determine medical necessity. The Behavioral Health Care Manager may find that a request for services does not appear to meet DBHDD medical necessity criteria for the requested level of care. When this happens, the Behavioral Health 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 (Psy.D./ Ph.D.), 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 telephonic review with the treating provider and/or a record review.

Peer-to-Peer Review: In a Peer-to-Peer review, the Peer Advisor engages in a telephonic discussion with the treating provider to obtain information that was not available to the Behavioral Health Care Manager 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 DBHDD medical necessity criteria 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.

Authorization Determination Timeframes

Level of Care	Type of Review	Standard
Inpatient, CSU, Residential Detox	Initial	Authorization decision (GCAL): 30 minutes from the time the ASO receives complete clinical information. Peer to peer review decision: 120 minutes from initiation of peer review process
PRTF	Initial	Authorization decision: 5 business days including time for peer to peer review, if indicated.
Inpatient, CSU, Residential Detox	Concurrent	Authorization decision: 4 business hours from the time the ASO receives complete clinical information. Peer to peer review decision: 120 minutes from initiation of peer review process
PRTF	Concurrent	Authorization decision: 5 business days inclusive of peer review process if indicated.
Inpatient, CSU, Residential Detox	Retrospective (Individual no longer in treatment)	Authorization decision: 30 calendar days from receipt of request for review
All Outpatient	Initial	Authorization decision: 5 business days inclusive of peer review process if indicated
All Outpatient	Concurrent	Authorization decision: 5 business days inclusive of peer review process if indicated

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 Behavioral

Health 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 Behavioral Health 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	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	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 (Medicaid Services only).

Level of Care	Type of Review	Request Timeframe	Notification of Determination
PRTF	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.
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.

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 an Individual in partnership with community-based providers, DBHDD regional offices, facilities, an Individual's, supports and families. This wrap around care ensures 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 get identified for potential engagement 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
    - Data Reporting and Analysis - the Collaborative uses data reporting analytics to ensure 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.”

- Care Coordination is comprised of three distinct entities:
    - Specialized Care Coordination
    - Certified Peer Specialists

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 recovery resources. 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 Behavioral Health Care Manager and refer the Individual for Specialized Care Coordination.
- Alert the Collaborative, via the Behavioral Health 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 showing by example that long-term recovery is attainable. CPS' are 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 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 based on an Individual's preferences
- 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)

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 must be faxed to the Collaborative at 855.858.1965. 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

Carelon Behavioral Health processes the claims for DBHDD state-funded services only 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 the Aged, Blind and Disabled Medicaid eligibility categories 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 by the Collaborative that are payable by GAMMIS are electronically 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 Carelon Behavioral Health Customer service, 855-606-2725, for additional information. If a Medicaid claim is resulting in a denial or other problem, please contact GAMMIS. Providers have 180 calendar days from the date of service to submit Medicaid claims. Claims submitted after this time-frame may be denied due to lack of timely filing.

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 Carelon 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 (Carelon) 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 (effective 7/1/2026)

Overview

The focus of the Collaborative's Quality Management department is to monitor and evaluate quality across the range of services provided by Georgia's Department of Behavioral Health and Developmental Disabilities (DBHDD) network of providers.

The 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:

- individual record reviews,
- employee records,
- interviews with individuals receiving services, 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 individuals' rights, provide evidence that 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 Services
    - Assertive Community Treatment (ACT)
    - Intensive Case Management (ICM)
- Certified Community Behavioral Health Clinic Quality Review (CCBHCQR)
- Crisis Stabilization Unit Quality Review (CSUQR)
    - Crisis Service Center (CSC)
- Housing Quality Review (HQR)
    - Crisis Respite Apartments (CRA)
    - Community Residential Rehabilitation Levels I, II, & III (CRR)
- IDD Quality Enhancement Provider Review (QEPR)
- IDD Quality Technical Assistance Consultation (QTAC)

The Review Process: Quality reviews are part of the overall review/consultation process. If a provider renders services for both the IDD and BH populations, the QEPR, BHQR, HQR, CCBHCQR and/or CSUQR may be conducted simultaneously. If ACT, ICM, CRA, or CSC services are provided, additional records will be added to the BHQR or CSUQR, as appropriate, to focus on those services.

The purpose of combining or coordinating reviews is to reduce administrative burden on providers and allow 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's Quality Department staff will follow the necessary reporting procedures as outlined by DBHDD policies. As part of the initiative to analyze the quality of care to individuals served by the provider network, a Critical/Adverse Incident report 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, quality improvement requirements are generated and given to the provider and DBHDD. Provider-level requirements are noted within the provider's exit conference report which is shared during the exit conference and immediately sent to the provider via email and the final assessment report which is subsequently posted on the Collaborative's website within 30 days following the review. The analysis of data collected through reviews across the network will be used to develop training and education for stakeholders. These trainings will be shared across the state to promote improvement of quality within the service delivery system. Additionally, an annual report to DBHDD is generated and posted to the Collaborative's website.

Provider Feedback: The Collaborative encourages providers 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.

Behavioral Health Reviews

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

- individual behavioral health record reviews,
- interviews with individuals receiving services, and
- observations and site visits of service locations and services provided, when appropriate.

Quality Management completes four types of quality reviews: Behavioral Health Quality Review (BHQR), Certified Community Behavioral Health Center Quality Review (CCBHCQR), Crisis Stabilization Unit Quality Review (CSUQR) and Housing Quality Review (HQR). Quality review tools are available on the Collaborative's website. The BHQR, CCBHCQR, CSUQR, and HQR include pre-review, onsite review, and post-review processes. The specific factors that contribute to the scores are derived from adherence to specific requirements from the DBHDD Provider Manual and the DCH Provider Manual.

Review Categories: There are several categories of reviews:

- **Scheduled** – The routine, scheduled quality review is based upon DBHDD contract requirements with the Collaborative and providers' performance and scoring on prior reviews. All review schedules are approved by DBHDD. 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 selected for special focus and review of:
    - Crisis Stabilization Units (CSU): up to 15 records
    - Crisis Service Centers (CSC): up to five records
    - Housing Quality Reviews (HQR): dependent on the number of individuals served
    - Assertive Community Treatment (ACT): up to 10 records
    - Intensive Case Management (ICM): up to 10 records
- **Ad Hoc** – At times, DBHDD may request that Quality Management conduct unscheduled or ad hoc audits of BH and IDD providers. An ad hoc audit is outside of a routine quality review. Ad hoc audits are designed to detect and deter fraud, waste, and abuse. Justification for an ad hoc audit includes, but is not limited to:
    - fraud, waste, and abuse identified during quality reviews or suspected by the Collaborative or DBHDD
    - a provider's adherence to DBHDD regulatory and contractual requirements
    - breach of HIPAA-protected health information
    - questionable claims/encounters submission practices
    - health, safety, or environmental issues
    - referral by various departments within DBHDD routed through the DBHDD Office of Performance Analysis and Quality Improvement (OPAQI)
    - Please refer to the Ad Hoc Audits section of the Provider Handbook for additional information
- **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, HQRs, CCBHCQRs and CSUQRs during each DBHDD fiscal year.

Overall and Billing Scores

85% - 100% (results in an annual review frequency when the following conditions are met):

- BHQR: Both the Billing and Overall scores are 85% or above for at least two consecutive previous reviews
- CCBHCQR: Both the Billing and Overall scores are 85% or above for at least two consecutive previous reviews
- CSUQR: Overall score 85% or above for at least two consecutive previous reviews
- HQR: Both the Billing and Overall scores are 85% or above for at least two consecutive previous reviews

84% and below (results in a semi-annual review frequency when the following conditions are met):

- BHQR: Either the Billing or the Overall score is 84% or less
- CCBHCQR: Either the Billing or the Overall score is 84% or less
- CSUQR: Overall score is 84% or less
- HQR: Either the Billing or the Overall score is 84% or less
- Providers must obtain two consecutive Overall and Billing scores of 85% or above to be placed on an annual review frequency

New Providers

- Providers that have not been previously reviewed by the Collaborative will be reviewed at least three times within the first two years, regardless of scores. The provider will then be placed on a review cycle based on their second and third review scores achieved.
- These “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 or recipients of services. Providers will receive specific instructions in the review notification for service-specific reviews.

Sample Size: The BHQR, CCBHCQR, CSUQR, and HQR sample sizes are based on the number of unique individuals served within the last six months. If a provider has billed for services that are a special focus such as ACT, ICM, CSC, etc. (in addition to other non-intensive outpatient services), additional service-specific records will be included in the sample (see below). Providers serving fewer than five individuals are monitored and added to the review process once at least five individuals have been served; however, these providers can be selected for an ad hoc review, regardless of sample size, at the direction of DBHDD. For the BHQR, CCBHCQR, CSUQR, and HQR review types, an oversample will be included to assure full sample sizes are met. The sample sizes are below:

Provider Size	Individuals Served (within 6 months)	BHQR Sample Size
Small	≤ 50	5 – 10
Medium	51 – 250	20
Large	251 – 3,000	30
X-Large	≥ 3,001	40

- Crisis Stabilization Unit Quality Review (CSUQR): up to 15 records
- Housing Quality Review (HQR): dependent upon the number of individuals served
- Crisis Service Centers (CSC): adds up to five records to the CSUQR
- Assertive Community Treatment (ACT): adds up to 10 records to the BHQR
- Intensive Case Management (ICM): adds up to 10 records to the BHQR

BHQR, CSUQR, and HQR Pre-Review Activities

Notification of Reviews: Notification of scheduled reviews will typically occur via e-mail two weeks prior to the BHQR/CCBHCQR/CSUQR/HQR's planned 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 BHQR/CCBHCQR/CSUQR/HQR Dates**: Reviews will be rescheduled based only upon the request by DBHDD or due to another review occurring during the same time (e.g., a provider may have an accreditation survey scheduled the same week). Please Note: providers with key staff members who are out of town or on leave during a scheduled review must have a substitute to replace them in their absence. The absence of key staff members will not result in the 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. Responding late to a review notification will not cause the start date of the review to change. 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 (along with other actions), as directed by DBHDD.
- **Communication:** Once confirmation of receipt of the notification has been received, the lead quality assessor will communicate with the provider to coordinate provider-specific review processes (i.e., access to records and individual interview scheduling).
- **Emergency Situations**: Providers who respond to a BHQR/CCBHCQR/CSUQR/HQR 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/CCBHCQR/CSUQR/HQR**: Quality assessors will wait one hour on the scheduled first day of the review for a provider who may be late. The lead 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/CCBHCQR/CSUQR/HQR. Failure to be available for a scheduled review will result in a "0%" score and DBHDD will be notified.
- **Not Currently Providing Services:** If the provider is not currently providing services to individuals but has not submitted a resignation letter to DBHDD, the review will continue as planned and the sample for the review will be based on paid claims for services rendered.
- **Touch Base Phone Call:** After the provider's receipt of the review notification, and before the beginning of the review, the lead assessor will contact the provider for a pre-review touch base phone call. During this call, the provider will be oriented to the various documents to prepare for the upcoming review. Providing or updating these documents prior to the initiation of fieldwork is expected and will help minimize time spent on site by quality assessors.
- **Pre–review Documentation:** Providers will have three business days following receipt of the review notification to provide the following documents/information:
    - BHQR, CCBHCQR, HQR, & CSUQR
        - Programmatic Documentation Checklist
        - Detailed checklists of documents specific to the review type and services reviewed (i.e., policies, procedures, organizational plans, staff to individual ratio, etc.).
    - Key Staff Survey
    - Documentation Location Survey
        - Location of documents required for the review (within the EMR or paper)
        - Form to be completed and sent to the lead assessor(s) prior to start of review that outlines where documentation is located within the EMR or if documentation must be scanned and emailed or sent via e-fax.

Off-site Storage: Providers are required to maintain all served individuals' records onsite (at 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), the provider must supply documentation from the off-site storage facility and 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 the review. 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 reviews

- technical assistance provided by the Collaborative.

Duration of Quality Reviews: The number of days a review will require depends upon a number of factors including the sample size, services provided, and the provider's record keeping system. Scheduled reviews typically take between two to five days.

BHQR, HQR and CSUQR Onsite Review Activities

Quality Assessors: Quality assessors will work both onsite and remotely for all quality reviews, depending on the provider's electronic medical record. The provider will be informed of the number of onsite assessors during the touch base phone call.

Entrance Conference: An entrance conference is conducted at the beginning of the review. This meeting will provide detailed information regarding the number of records to be reviewed, estimated timeframe of the review, review tools, individual interviews, and how the review will be scored. The entrance conference may be conducted via video conferencing technology, such as Microsoft Teams.

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, identification numbers, and dates of birth.

- The Individual Key will be delivered to providers during the entrance conference. Individuals' names will not be given in advance of the entrance conference.
- **Within thirty (30) minutes of receiving the list of individuals' names, the provider will supply the location of each record** (if the provider has records at multiple DBHDD-approved service locations, has records stored off site, etc.)
- **Within two hours of receiving the list of individuals' names:**
    - All records will be delivered to assessors to be checked in (paper and electronic).
    - Those providers who utilize electronic health/medical records (EMR) shall provide the assessors access to all records identified in the sample.
    - EMR platforms must be configured to allow assessors full administrative access (view-only) to all components of the EMR. The access must include:
        - the ability to validate each document's creation date, time, and author
        - timestamp of signatures
        - dates, timestamps, and author(s) of any edits, amendments, or late entries, and
        - dates and timestamps for documents uploaded into the EMR
    - Any document associated with a review that is not filed in the EMR, such as documentation of CST/ACT treatment team meetings (most recent 90 days), logs associated with informal support/contacts for ACT, CRA referral/housing plans, GA Housing Need and Choice Surveys, etc. must also be delivered within two hours.
    - 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/CCHBCQR/CSUQR/HQR. Any record (paper or electronic) (or portion of a record) not supplied within the allotted timeframe will be considered to have not been delivered and these records will be scored "No" in all areas relevant to the documentation not supplied.

- **All remaining records from other DBHDD-approved service locations will be delivered to the assessors and checked in by 4:00 PM on the first day of the review.**
    - Any records (or portions of records) presented after 4:00 PM will be treated as if they had not been delivered and all relevant indicators for those records will be scored as "No".
    - 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 the Individual Names/Record Delivery form. Records not submitted within stated timeframes will not be accepted for review.**
- If the review contains names of individuals 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.

Staff Credentialing/Licensure Review: During the review, assessors will request specific information pertaining to a chosen staff member's credentialing and licensure. The information requested may include:

- Copies of licenses and credentials for each identified licensed, credentialed, registered, and/or certified staff member
- For applicable staff members, documentation of their completion of the standard training requirements, as indicated in the DBHDD Provider Manual
- Documentation of a DBHDD-approved criminal records background check
- Both agency-provided and online paraprofessional training documentation must be provided to include transcripts, certificates, etc.
- Attestations for supervisee/trainees (S/T), certified alcohol and drug counselor trainee (CADC-T), and certified counselors in training (CCIT)
- All supervision logs
- College diplomas and/or an internal memo of review of transcript (if the diploma does not indicate the area of study to justify a "helping profession") for those staff members whose billing level is degree-dependent
- If an assessor determines that information is missing, the provider will be notified via email who will have 15 minutes to locate the required documentation.

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

Individual Interviews: Individual interviews will be conducted as a part of the BHQR/CCBHCQR/CSUQR/HQR process. These interviews will be conversational in nature and conducted by the Collaborative's quality assessors. Information gathered will serve to assess the individual's experience and 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/CCBHCQR/CSUQR/HQR 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 on the first day of the review while assessors are awaiting record submission.

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

- Tables and chairs are needed to accommodate the assessment team. The lead quality assessor will inform the provider of the number of quality assessors during pre-review activities.
- Any computers or electronic equipment needed to access the provider's electronic medical/health record should be ready when assessors arrive on site.
- Access to a copy machine, printer, and paper may be required.
- Any copies of records requested during any review process will be the sole responsibility of the provider, including the cost of record reproduction.

Documentation Supporting Findings: It is Quality Management's policy to photocopy/scan/download any documentation to support any discrepancies/deficiencies identified during a review. To reduce any risk of compromise of protected health information, quality assessors will save documentation electronically or scan paper documentation when possible. This information is saved to a secure server that is HIPAA-compliant.

- Copies of all supporting documentation related to reviews will be retained by the Collaborative.
- 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 where no progress note is present to support the date billed
  - billing history detailing any erroneous billing
  - orders/recommendations supporting services rendered
  - assessments
  - individual recovery/resiliency plans
  - agency authorization page(s), and/or
  - other documentation necessary to illustrate any deficiency

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 records subpoenaed should ensure that copies are made of relevant information (i.e., assessment, treatment plan, verification of diagnosis, orders, 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 "No" in all applicable areas.
- **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/CCBHCQR/CSUQR/HQR 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.

When a provider is transitioning from one EMR to another EMR, assessors will need access to both (or all) systems relevant to the scope of the review.

- **Feedback Form/Missing Documentation:** Assessors will consider only documentation that is contained in the medical record submitted for review. If an assessor determines that information is not in the record, the provider will be emailed a missing documentation spreadsheet/feedback form that contains indicators not met, with comments detailing the reason(s) for the "no" score. Providers will have 15 minutes to review the record to locate the required documentation. Information that is not filed within the individual's 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/CCBHCQR/CSUQR/HQR process. Information sent/returned/submitted after the documentation delivery deadline will not be reviewed/considered.
- **Altering of Records:** Records must not be altered once the BHQR/CCBHCQR/CSUQR/HQR 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".
- **Voiding/Adjusting of Claims:** Providers may not void or adjust any claims after the date of the BHQR/ CCBHCQR/CSUQR/HQR notification. Providers may resume voiding and adjusting claims after the exit conference. Voids submitted prior to the date of BHQR/CCBHCQR/CSUQR/HQR notification will be accepted. Documentation to support a voided or adjusted claim must be presented at the time of the review and include the date of adjustment.

BHQR and CCBHCQR Scoring: The overall score is derived from a review of individuals' medical records utilizing the components of the Collaborative's BHQR and CCBHCQR Tool. The quality review tools are located on the Collaborative's website.

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

- **Assessment & Planning**
  - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **Compliance with Service Guidelines**
  - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **Focused Outcome Areas**
  - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **Billing Validation**
  - **BHQR Billing Validation** score is calculated as a percentage of justified paid dollar amount vs. the total dollar amount for the reviewed claims. Quality reviews sample three payer sources:
    - Medicaid: score is based on the sum of paid claims
    - fee-for-service (FFS) score is based on the sum of paid encounters
    - state-contracted services (SCS) is based on the estimated sum of service rates multiplied by service units
  - **CCBHCQR Billing Validation** has two different scores:
    - The **Billing Quality** score is calculated into the Overall Score for the review. This score is the result of a review of documentation associated

with triggering and non-triggering events as part of the T1040 CCBHC claims submitted for payment. Calculation of this score is based on the number of triggering and non-triggering events supported by documentation against the total number of triggering and non-triggering events reviewed in the sample. For a T1040 claim to pay, there must be at least one valid triggering event for that date of service.

        - The **T1040 Payment Validation** score is <u>not</u> calculated into the Overall score for the review. This score represents the percentage of reviewed T1040 claims justified based upon *a* review of records and the supporting documentation for each triggering event associated with the T1040 claims. If all triggering events associated with a T1040 claim fail, then the T1040 claim fails. Conversely, if any triggering event for *a* T1040 claim passes, then the T1040 claim passes for the purposes of this review. Potential recoupment of funds is based upon this score.
    - A billing sample review of randomly selected claims paid by Medicaid, SCS, and FFS will be a part of the review for all records.
    - In the event a billing requirement is not met, the assessor will copy documentation to support the findings.
    - Provider personnel will be sent a Billing Discrepancy Report containing all identified billing discrepancies. The provider will be asked to verify receipt of the document; however, the provider's acknowledgement only indicates the agency was made aware of the discrepancy and does not constitute agreement with the findings nor diminish the provider's right to appeal.
- **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.
- **Appeals:** Providers will have the opportunity to appeal review findings once the final assessment has been posted. See Appeals Process at the end of the Quality Management section for further information.

<u>CSUQR Scoring:</u> The Overall Score is derived from a review of individuals' medical records utilizing the components of the Collaborative's CSUQR Tool. The quality review 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.

- **Individual Record Review**
    - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
    - Crisis Service Center record reviews are included in the Individual Record Review section
- **Focused Outcome Areas**
    - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **Compliance with Service Guidelines**
    - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **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.
- **Appeals:** Providers will have the opportunity to appeal review findings once the final assessment has been posted. See Appeals Process at the end of the Quality Management section for further information.

HQR Scoring: The overall score is derived from a review of individuals' medical records utilizing the components of the Collaborative's HQR Tool. The HQR 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 Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **Compliance with Service Guidelines**
    - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **Site Visit**
    - Score calculated by total Yes answers divided by the sum of Yes and No answers (NA responses are excluded)
- **Billing Validation**
    - The billing score is calculated by percentage of justified encounters vs. the unjustified encounters for the reviewed claims. Encounters are calculated based on current service rates multiplied by service units.
    - A billing review will be completed of randomly selected encounters/dates of services for all individual records.
    - In the event a billing requirement is not met, the assessor will copy documentation to support the findings.
    - Provider personnel will be sent a Billing Discrepancy Report containing all identified billing discrepancies. The provider will be asked to verify receipt of the document; however, the provider's acknowledgement only indicates the agency was made aware of the discrepancy and does not constitute agreement with the findings nor diminish the provider's right to appeal.
- **Appeals:** Providers will have the opportunity to appeal review findings once the final assessment has been posted. See Appeals Process at the end of the Quality Management section for further information.

Site Visit: For CSUQRs, Medication Assisted Treatment providers, and Housing Quality Reviews, a tour of all facilities/apartments/residences will occur unless directed otherwise by DBHDD. The site visit may occur the week prior to the entrance conference. The Collaborative's quality assessors may, at any point during a BHQR or CCBHCQR, choose to visit a program location.

Exit Conference: Upon completion of the review, the lead assessor will identify a time for the formal exit conference. The exit conference may be conducted onsite or via video conference. Notification of the exit conference will be sent to DBHDD, the Collaborative, and provider staff members, typically two hours prior to the meeting and will last approximately one hour. DBHDD and the Collaborative request, at a minimum, the following staff members 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, CCBHCQR, HQR, and CSUQR Post-Review Activities

The assessors will collect any needed additional follow-up information from providers and complete an internal 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 conference. For quality reviews with less than five individuals sampled, only a summary of scores will be posted, to protect the identity of individuals sampled (the full Final Assessment Report will be sent separately to both DBHDD and the provider). The Final Assessment will include all scores, significant findings, and recommendations developed during the BHQR/CCBHCQR/CSUQR/HQR or special review process. Recommendations/requirements documented in the report are intended to assist the provider in developing quality improvement initiatives that might correct or remediate any identified deficiencies. Based on review outcomes, the Collaborative will coordinate training, technical support, and/or additional consultation, as applicable.

Appeals: A provider may appeal their BHQR, CCBHCQR, HQR and CSUQR findings up to ten (10) business days following notification that their written final assessment has been posted to the Collaborative's website. The notification date is the date the email was sent informing 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 must submit any supporting documentation with the initial appeal. Please refer to the Appeals Process at the end of the Quality Management section for further information.

Intellectual and Developmental Disabilities Reviews

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

The IDD quality review tools include six Focused Outcome Areas (FOAs) to ensure aspects of an individual's life are explored and practices to support outcomes in these areas are met by the service delivery network:

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

These tools were developed in collaboration with DBHDD and are available on the Collaborative's website. They help determine if standards from DBHDD Provider Manual and DCH Provider Manuals are met. 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 rendered. Any copies of records requested during any review process will be the sole responsibility of the provider, including the cost of record reproduction.

Review Categories: There are several categories of reviews:

- **Scheduled** – The routine, scheduled quality review is based upon DBHDD contract requirements with the Collaborative and providers' performance and scoring on prior reviews. All review schedules are approved by DBHDD. 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.
- **Ad Hoc** – At times, DBHDD may request that Quality Management conduct unscheduled or ad hoc audits of BH and IDD providers. An ad hoc audit is outside of a routine quality review. Ad hoc audits may include, but are not limited to:
    - a provider's adherence to DBHDD regulatory and contractual requirements
    - breach of HIPAA-protected health information
    - questionable claims/encounters submission practices
    - health, safety, or environmental issues
    - referral by various departments within DBHDD routed through the DBHDD Office of Performance Analysis and Quality Improvement (OPAQI)
    - Please refer to the Ad Hoc Audits section of the Provider Handbook for additional information
- **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.

Quality Enhancement Provider Reviews (QEPR)

The QEPR is completed 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 individuals' communicated choices and preferences that matter most. Working collaboratively with providers, quality assessors identify the provider organization's strengths and opportunities for improvement in rendering person-driven and outcome-based supports and services.

Up to 180 providers are reviewed each year. Traditional service providers, support coordination agencies, and specialty service providers for behavior supports, nursing, therapy, and crisis services are selected to participate in the QEPR process. The valid and random sample is proportionate to the size of the providers who render Home and Community-Based Services HCBS waiver and state-funded services.

The QEPR includes the following activities: pre-review, on-site review, and post-review processes.

- Please note: Providers who have had individual records subpoenaed should ensure copies are made of relevant information (i.e., assessments, orders, annual documentation requirements, employee personnel/training records, and progress notes, etc.) so quality assessors will have information for the review.

- If the provider is unable to produce any record requested, or legible copies of the records, these records will be scored as “No” or “0”.

QEPR Pre-Review Activities

1. Select the provider sample to receive a QEPR.
2. **Notification of Reviews:** Notification of the scheduled review will occur via email two weeks in advance.
    - **Rescheduling QEPR 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 whose key staff members may be out of town during the scheduled review will need to have a substitute participate in their absence. The absence of key staff members 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.
    - **Emergency Situations:** Providers who respond to a QEPR 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 QEPR:** 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 QEPR. Failure to be available for a scheduled review will result in a “0%” score for the QEPR and DBHDD will be notified.
    - **Not Currently Providing Services:** If the provider is currently no longer providing services to individuals, has not submitted a resignation letter to DBHDD, and plans on continuing to provide services in the future, the review will continue as planned and the sample for the review will be based on paid claims for services rendered.
3. **Touch base Communication Prior to the Review:** The lead quality assessor will contact the provider after receiving the review notification for a pre-review touch base call. During this call, providers will be oriented to the various documents to prepare for the upcoming review. Providing or updating these documents prior to the initiation of fieldwork is expected and will help minimize time spent on site by quality assessors.
    - Providers will have three business days following the touch base call to provide the following documents/information:
        - QEPR Documentation Checklist
        - Detailed checklists of documents specific to the QEPR (i.e., policies, procedures, organization quality improvement plans, staff to individual ratio, etc.).
        - Location of documents required for the review (within the EMR or paper).
    - A list of service locations (i.e., day and residential)
    - Key Staff Contact List

- Employee List Spreadsheet
  - The “Employee List” spreadsheet will assist providers with submitting the list of employees required for the review. The spreadsheet includes the employee’s full name, date of hire, and title, which will assist the quality assessor in determining which staff members’ records will be reviewed using the Staff Qualifications and Training review component.

4. **Support Coordination Agencies:** The QEPR will include a review of the individual’s ISP using the Individual Service Plan Quality Assurance Checklist and a review of the support coordinator’s records located in the State case management system using the SC QEPR Tools.
5. **National Core Indicators (NCI):** The list of individuals selected for the NCI Adult In-Person Survey (IPS) will be sent via secure email prior to the start date of the QEPR.
6. **Duration of Reviews:** The number of days a review will take depends upon several factors such as the sample size, services provided, and the provider’s record-keeping system. Generally, scheduled reviews take between two to five days.

QEPR Onsite Review Activities

Entrance Conference: An entrance conference is conducted at the beginning of the review. This meeting will provide information regarding the number of records to be reviewed, estimated timeframe of review activities, QEPR tools used, individual interviews logistics (when applicable), and how the review will be scored. The entrance conference will be conducted via video conferencing technology, such as Microsoft Teams.

Quality Assessors: Quality assessors will work both onsite and remotely for all quality reviews, depending on the provider’s electronic medical record. The provider will be informed of the number of onsite assessors during the touch base phone call.

Records Request/Record Delivery:

- Immediately following the entrance conference, a list of individual and personnel records selected for the review will be given to the provider.
- **The provider has two (2) hours to deliver all records or grant access to EMR for staff training and personnel and individuals records** to the quality assessors. 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” in all areas. **Individual names will not be given prior to the entrance conference**.
- EMR platforms must be configured to **allow <u>full</u> administrative access (view-only)** to all components of the EMR. The access must include:
  - the ability to validate document creation date, time, and author
  - timestamp of signatures
  - dates, timestamps, and author(s) of any edits, amendments, or late entries, and
  - dates and timestamps for documents uploaded into the EMR.
- **All remaining individual records or staff training and personnel records from other DBHDD-approved service locations will be delivered to quality 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.
- **Records must be presented within the timeframes indicated above. Records not submitted within stated timeframes cannot be accepted by quality assessors.**

- The provider must ensure that each 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 record are not submitted for review, the assessor will reject any additional volumes not submitted according to the above-stated timeframes.
- **Review of staff training and personnel records**: Based on the employee records selected, the quality assessor will review specific staff training records and other personnel information using the Staff Qualifications and Training review component.
- **Administrative Review**: Specific policies and procedures and other organizational information will be reviewed (results are not included in the QEPR Overall score).
- **NCI Adult In-Person Survey interviews:** Individuals who receive services from a provider who is selected for a QEPR will be interviewed during the week of the QEPR (results are not included in the QEPR overall score).
- **Informal Observations:** The quality assessor will request to conduct a tour of the provider's locations (i.e., day services and residential sites). The quality assessor will specify the selected location and time. (results are not included in the QEPR Overall score).
- **Record Reviews:**
    - **Missing Information**: Quality assessors will only review documentation that is contained in the "official" medical record. Information that is not filed within the individual's record prior to the start of the review will not be considered as present in the medical record. If the provider maintains separate records specific to services (i.e., nursing, developmental disabilities professional, etc.) provided, these records must be presented at the beginning of the review. All requested records must be available and accessible to the assessors for the duration of the QEPR process. Any documentation not located in the record will be included on the QEPR Missing Documentation Checklist form, and it will be emailed to the provider. **Providers will have 15 minutes per record to submit missing documentation.** Information sent/returned/submitted after the documentation delivery deadline will not be reviewed/considered.
    - **Altering Records**: Records must not be altered once the QEPR has begun. If at any point during the review process, the provider alters the individual and/or personnel record (paper or electronic), the record will receive a score of "0" for the record review. Documentation, staff training, or policies completed after the start of the review will not be accepted or alter the corresponding indicator's score.
- **Exit Conference:** Upon completion of the review, the lead assessor will identify a time for the formal exit conference. Notification of the exit conference will be sent to DBHDD, the Collaborative, and the provider's staff at least two hours prior to the meeting. The exit conference can be conducted onsite or remotely to review preliminary results. Typically, the exit conference will last one to two hours. Staff members of DBHDD are invited to attend and participate in all parts of the review.

QEPR Post-Review Activities

1. The Collaborative will generate and distribute the QEPR final assessment within 30 days of the exit conference.
2. Ninety (90) days after a QEPR, the Collaborative may conduct a QTAC to support and provide guidance to the provider on improvements to the service delivery system. In addition, when quality of care concerns or immediate action items are identified during a

QEPR, the assessor may return onsite within 30 days to complete a QTAC. See the Quality Technical Assistance Consultations section below for more information.

QEPR Final Assessment: The QEPR final assessment will be posted to the Collaborative's website within 30 days of the exit conference. For QEPRs with four or less individuals reviewed, only the first page of the report will be posted. The recommendations documented in the report will be sent to the provider and are intended to assist the provider in developing quality improvement initiatives. This comprehensive report will identify the relevant or significant findings and recommendations developed during the QEPR process and 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, Staff Qualifications and Training review, and Administrative Review

QEPR Appeals: A provider may appeal their QEPR findings for up to ten (10) business days following notification that their written final assessment has been posted to the Collaborative's website. The notification date is the date the email was sent informing the agency's identified staff persons of the posting of the final assessment to the Collaborative's website. The provider must utilize the QEPR Appeal Form to request an appeal and must submit any supporting documentation with the initial appeal. Please refer to the Appeals Process at the end of the Quality Management section for further information.

Quality Technical Assistance Consultations (QTAC)

Providers may receive an onsite or remote Quality Technical Assistance Consultation (QTAC) as a result of a QEPR, Quality of Care Concern (QCC), Immediate Action Item (IAI), or a referral from an external source (see below). The QTAC process is used to remediate systemic issues and concerns that are identified through the different review processes for providers and the service delivery system. A consultative approach is used to assist providers in their efforts to increase the effectiveness of their service delivery systems both at the individual level and provider level. This process affords DBHDD and contracted providers the opportunity to solicit technical assistance and offers providers (including support coordination) resources to mitigate barriers that impact service delivery while also providing technical assistance to support quality improvement at the individual and systematic levels.

The table below identifies the different types of QTACs available, their description and when they would occur:

QTAC Type	Description	Referral Reason and Timeline
QEPR Follow-Up QTAC	• Occurs approximately 90 days after the QEPR exit conference • Reviews the provider's progress made on addressing	• Providers with the following QEPR scores will be required to participate in a QEPR Follow-Up QTAC: ○ Overall score: below 85% OR

	the recommendations generated from the QEPR	○ below 80% on Safety and Whole Health FOA • The follow-up will be scheduled within 90 days of the QEPR exit conference date
Quality of Care Concerns (QCC) QTAC	• Occurs within 30 days of the QEPR exit conference • Reviews documented evidence of how the provider addressed the QCC or IAI	• Providers that have an identified QCC or IAI during a QEPR will be required to participate in a QCC QTAC review within 30 days from QEPR exit conference, regardless of the QEPR overall score
Training QTAC	• Training may consist of specialized topics selected by the provider or support coordination agency based upon results of the QEPR • Formal training in person-centered thinking or person-centered documentation may also be requested	• DBHDD may request a provider receive technical assistance or training • Providers or support coordination (SC) agencies may request up to two QTACs for technical assistance or training after receipt of a QEPR in the last 12-month period • Trainings can be conducted onsite or remotely
DBHDD QTAC Request	• DBHDD has received a complaint, grievance, or the provider needs technical assistance and DBHDD has determined the Collaborative is the best resource to provide the technical assistance	• This QTAC will occur within 30 days of the request from DBHDD

Providers with an overall QEPR score of 85% or above and score 80% and above in Safety and Whole Health FOA, will not be required to participate in a QEPR follow-up QTAC, unless the provider has a QCC or IAI. The provider may request training as technical assistance through the QTAC process.

The QTAC manager will determine if the QTAC can be completed via desk review or if it requires an on-site visit. The QTAC will include the following: Pre-QTAC activities, QTAC activities, and Post-QTAC activities.

Pre-QTAC Activities

- The quality assessor contacts the provider via email to confirm the QTAC date established at the time the QEPR exit conference.
  - The QEPR Follow-up or QCC QTAC Checklist is provided along with additional information to complete QTAC activities. The Checklist with the supporting documentation should be returned within three business days.
- **Failure to be available for the QTAC:** The quality assessor will wait one hour from the scheduled time 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 cancel the QTAC and report as a “no show”. Failure to be available for a scheduled QTAC will result in a referral to DBHDD to follow up with the provider.

QTAC Activities

- The quality assessor will explain the process and confirm logistics with the provider.
- Depending on the specific issue(s) or concerns identified during the QEPR, one or more of the following QTAC activities may be completed:
    - Provide technical assistance in the specified area of need
    - Provide resources, individualized training, and customized examples on how to enhance quality and improve practices
    - Conduct administrative review of the provider’s policy and procedures or employee records
    - Conduct record reviews
        - For onsite reviews, the provider has two hours to submit records. Records not presented within this time will not be used and documented in the report.
        - For desk reviews, the provider will need to submit all requested documentation at least two business days prior to the QTAC date.
    - QEPR follow-up QTACS: the provider’s progress made on addressing the recommendations generated from the QEPR will be reviewed.
    - 30-Day QTACs (QCCs and/or IAIs): the provider will need to address all concerns identified within 30 days of the QEPR exit conference.
        - If the QCCs and/or IAIs are not resolved, the quality assessor will schedule another 30-day QTAC. If concerns continue to be unresolved after the 2nd QTAC, DBHDD will be notified.

- The quality assessor will meet with the provider to present the results from the QTAC.

Post-QTAC Activities

- Generate and distribute the QTAC report within 30 days of the exit conference. The report will include a summary of the review activities, identify areas of concern, any significant trends or areas of improvement deserving recognition, any additional recommendations, and technical assistance provided.
- When applicable, schedule a return date for another QTAC.

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 the key areas of employment, rights, service planning, community inclusion, choice, and health and safety. As a participating state, Georgia has opted to utilize the NCI In-Person Survey (IPS) and two mailed family surveys.

Using a sampling methodology approved by DBHDD and Human Services Research Institute (HSRI), the NCI-IPS 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 and receives services from a provider selected for the QEPR process that year, the interview will be conducted during the QEPR in an effort to reduce administrative burden on providers.

Individuals receiving services from a provider who will not receive a QEPR during the current fiscal year will be contacted by an assessor to determine if they would like to participate. If they agree, the provider who serves these individuals may be contacted to assist with the logistics for the NCI interview to be conducted via Microsoft Teams

Surveys that are completed and returned are entered into the ODESA system for future evaluation and analysis done by HSRI. These reports are made available to DBHDD and posted on the NCI website at National Core Indicators.

NOW/COMP Waiver Application Performance Measures (NCW) The NCW reviews collect data that DBHDD uses solely to report statewide results for performance measures identified in the Comprehensive Supports Waiver (COMP) and New Options Waiver (NOW) manuals, fulfilling a requirement to address the Centers for Medicare and Medicaid Services (CMS) assurances and sub-assurances for Home and Community-Based Waiver Services.

Ad Hoc Audits

At times, DBHDD may request that Quality Management conduct ad hoc audits of BH or IDD providers. An ad hoc audit is outside of a routine quality review. Ad hoc audits are designed to detect and deter fraud, waste, and abuse. Justification for an ad hoc audit includes, but is not limited to:

- fraud, waste, and abuse identified during quality reviews or suspected by the Collaborative or DBHDD
- the provider's adherence to DBHDD or DCH regulatory and contractual requirements
- breach of HIPAA-protected health information
- questionable claims/encounters submission practices
- health, safety, or environmental issues
- referral by various departments within DBHDD routed through DBHDD Office of Performance Analysis and Quality Improvement (OPAQI)

Please note: The ad hoc audit is a separate and distinct process from the BHQR, CCBHCQR, CSUQR, HQR, QEPR, or other Georgia Medicaid program integrity processes (although this work can be complementary to and supportive of these processes). The ad hoc audit may include a review of (but is not limited to): claims submissions, medical records, administrative practices, policies/procedures, current and past staff rosters, site visits, individual/staff interviews, and staff credentialing/licensure/ personnel files. Additionally, assessors may request documentation or other information beyond the scope of a routine quality review. Ad hoc audits will be jointly developed by the Collaborative and DBHDD and may have a narrower focus than a regularly scheduled quality review.

Notification: Notification of an ad hoc audit will typically be less than 72 hours, or, in some cases, there will be no advance notification.

Location: Audits will be conducted either by desk review or in person/on site as jointly agreed upon by DBHDD and the Collaborative.

Selection of Individual Medical Records: The selection of records is determined by a review of the available Medicaid and/or state-funded claims/encounters during a specified period prior to a provider's audit. At the request of DBHDD, the claims selection may be restricted to specific services or individuals. Providers will receive specific instructions in the audit notification pertaining to the records that will be requested.

Individual Key/Staff Key: The individual key/staff key will be delivered on the first day of the audit utilizing the current processes for a scheduled quality review. Timeframes for records delivery will be provided at that time. Records not submitted within the allotted timeframe will be treated as not presented for the audit and no credit will be given for late submissions.

Duration of an Ad Hoc Audit: The duration of an ad hoc audit will be based on the number of requested records in the sample/information to be reviewed.

Entrance Conference/Exit Conference: The lead assessor will inform the provider whether an entrance or exit conference will occur.

Record Review: Procedures for the record review will mirror a routine/scheduled review. Please refer to the Record Review section in either the BH or IDD Quality Review sections of this handbook. Note: the record review portion of the ad hoc audit may be completed off site.

Program/Site Visit: The Collaborative's quality assessors may, at any point during an ad hoc audit, choose to visit a program location.

Individual/Staff Interviews: The Collaborative's quality assessors may, at any point during an ad hoc audit, request interviews with individuals receiving services or staff members providing services.

Final Report: The Collaborative will produce a final report on the results of the audit within 15 days of the completion of the ad hoc audit. The final report will be submitted to DBHDD OPAQI and DBHDD programmatic leadership. As appropriate, reports may be shared with the provider, other DBHDD offices, and DBHDD sister agencies.

Appeals Process

A provider may appeal their BHQR, CCBHCQR, CSUQR, HQR, and/or QEPR findings up to ten (10) business days following notification that their written final assessment has been posted to the Collaborative's website (or emailed to the QEPR provider for less than four records). The notification date is the date the email was sent informing 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 must submit any supporting documentation with the initial appeal.

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 by using the Review Appeal Form. This form must be completed and submitted by e-mailing GACOFeedback@becaonhealthoptions.com. The form must detail each decision from the review the provider wishes to appeal and include a rationale for each appeal. Refer to the appeal form for more detailed instructions. If additional documentation needs to be sent, the provider should fax or e-mail this information separately, ensuring that all protected health information (PHI) is sent securely. A separate appeal form must be used if a provider is appealing review findings from multiple types of reviews (BHQR, CSUQR, CCBHCQR, HQR, and/or QEPR).

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

It is the provider's responsibility to ensure that no protected health information (PHI) is sent with the appeal form. PHI should be redacted within the appeal form, including (but not limited to): the individual's name, date of birth, identification numbers, etc. Providers must refer to consumers using the Individual Key report provided to them during the review. Supporting documentation should be sent separately, ensuring PHI is sent securely, by fax or email as noted in the appeal form. 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. The provider must submit all supporting documentation to be considered with the Level One Appeal. Additional supporting documentation will not be considered in the Level Two Appeal.

A determination will be made based upon the information submitted with the appeal, a review of the agency's final assessment, supporting documentation collected during the review, and interviews with appropriate quality review staff members (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 determination, the provider is not satisfied, they may file a Level Two Appeal (the final level). 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. Any additional comments, clarifications, or rebuttals to the Level One Appeal the provider would like considered must be submitted via e-mail to GACOFeedback@beaconhealthoptions.com within ten (10) business days of receipt of the Level One Appeal determination. 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 forms located on the on the Collaborative's website under Quality Management for additional information. A link to these forms is also provided above.

The Collaborative will convene a meeting of the Appeals Committee (AC). The AC is comprised of DBHDD employees and representatives from DBHDD service provider agencies. There are 14 voting members, six (6) of whom represent service provider agencies. To maintain a process free from bias and undue influence, membership of the AC remains confidential. The selection of provider agency representatives considers the provider agency's location, target populations, services provided, commitment to IDD and BH services quality improvement in Georgia, and knowledge of the DBHDD Provider Manual's service guidelines.

The AC meets and reviews all available information regarding the Level Two Appeal within twenty (20) business days of receipt. If an AC member's agency submits a Level Two Appeal, he or she will be recused from the AC's process and decisions regarding that appeal.

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

Driving Under the Influence (DUI) Intervention Program Desk Reviews

The purpose of the DUI Intervention 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 and Clinical Evaluators is a list of providers who have been approved by DBHDD to provide clinical evaluations and/or substance abuse treatment to 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.

- **Ad Hoc Fidelity Review** – At times, DBHDD may request assessors complete an additional onsite or desk review of a clinical evaluator or treatment provider. The provider may be given a shortened notification of the upcoming review. The results of an ad hoc Fidelity Review are reported to DUI Program Manager.

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
- 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
    - The Overall score is derived by averaging the provider level programmatic score and the record review score. Both the provider level and the record review score is calculated by total Yes answers divided by the sum of Yes and No answers (NA excluded).

Reporting Results:

- Assessors report provider scores with relevant details regarding trends, provider strengths, growth areas, and any compliance issues to the DUI Program manager via a monthly summary
- Assessors provide telephone consultation and technical assistance to providers per DBHDD request
- The DBHDD DUI program manager will communicate the scores to providers