The Georgia Collaborative ASO

Advantage Behavioral Health Systems

Behavioral Health Quality Review Final Assessment	
Address: **240 Mitchell Bridge Road, Athens, GA 30606**	
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Individual Records Reviewed: **35**	Current Review Frequency: **Annual**
Staff Records Reviewed: **7**	Date Range of Review: **11/10/2025 - 11/13/2025**

The Georgia Collaborative ASO, in partnership with the Department of Behavioral Health and Developmental Disabilities (DBHDD), believes in accessible, high-quality care that leads to a life of recovery and independence. The provider should note any recommendations and reminders of DBHDD requirements as opportunities for quality improvement activities. The review is intended to measure the quality of your organization's systems and practices in adherence to DBHDD policies and standards. The Overall Score is calculated by averaging the categories below.

	Overall Score	Billing Validation	Focused Outcome Areas	Assessment & Planning	Service Guidelines
Review Date: 12/09/2024	89%	90%	91%	82%	91%
Review Date: 04/22/2024	88%	85%	94%	83%	89%
FY25 Statewide Average	89%	79%	94%	90%	94%

Note: The FY25 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

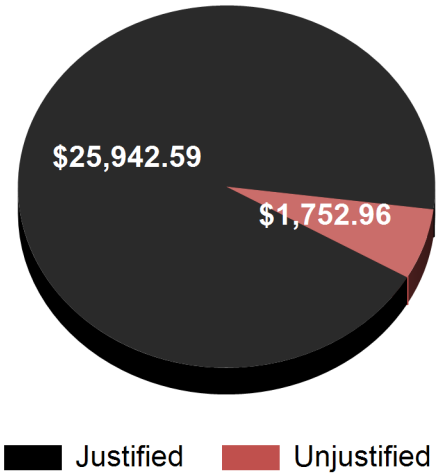
Strengths and Improvements:

- The provider utilized a detailed system in the electronic medical record (EMR) to flag a variety of risks tailored to each individual. An example included an individual's record that was flagged for both "high risk for suicide" and "high risk for fatal overdose."
- An individual indicated that he was "not likely" to use the safety plan and the provider documented: "Updated and changed the plan. Client now voices likelihood of using the plan."
- The provider facilitated strength-based group counseling sessions focused on healthy relationships in recovery. The session emphasized learning and developing strategies to build healthy, stable, long-term relationships. Evidence-based couples therapy frameworks were incorporated, including the Gottman Sound Relationship House, Woodsfellow's Love Cycles, Fear Cycles, and relational empowerment therapy.
- The provider demonstrated individualized, person-centered care by completing a comprehensive diagnostic assessment that honored the individual’s stated preferences and treatment goals. The nurse practitioner respected the client’s decision to decline psychiatric medication, supported her continued use of melatonin for sleep, and affirmed her preference to focus on individual counseling to address emotional and spiritual growth needs. This reflects a strengths-based, collaborative approach that aligns services with the individual’s assessed needs and values.
- A staff credentialing review was conducted, and all five staff members met the requirements for their respective credentials.

Opportunities for Improvement:

- Five of 18 applicable records did not address suicidality on the individual's individualized recovery plan (IRP).
- The whole health and wellness of the individual was not addressed on the IRP in nine records.
- Transition/discharge plans lacked one or more of the three required components in 10 records.
- Ten of 25 applicable records lacked documentation of communication with external referral sources to obtain the results of testing, treatment, and follow-up, as clinically indicated.
- Two of eight applicable records did not contain evidence that clinically appropriate actions or steps were taken and linkages/referrals were made if the individual has been assessed to be at risk for suicide (within the past six months).
- Nine out of 29 applicable records lacked evidence the individual/guardian had signed a formal acknowledgment of rights and responsibilities at least annually.
- Five of 16 records with documented need for releases of information (ROI) did not contain them.
- Seven progress notes were lacking documentation of where the service occurred, which is required when billing the "U7" (out-of-clinic) modifier.

Billing Validation



	Medicaid	State Funded Services	Total
Justified	$11,187.28	$14,755.31	$25,942.59
Unjustified	$1,145.47	$607.49	$1,752.96
Total	$12,332.75	$15,362.80	$27,695.55

The Billing Validation Score is the percentage of justified billed units vs. paid/billed units for the reviewed claims. Paid dollars are calculated based on payer: Medicaid is the sum of paid claims; State Funded Services are Fee for Service and State Funded Encounters combined (State Funded Encounters is the estimated sum of the value of accepted encounters).

Standard	Reason	# Discrepancies
Performance Standards	Minimum contacts not met per DBHDD Service Guidelines	3
	Multiple services billed at same time	3
	Content does not support units billed	2
	Content does not support code billed	1
	Content of note does not match service definition	1
	Non-billable activity billed	1
Quantitative Standards	Location missing	7

Billing Validation: 94%

Strengths and Improvements:

The following were improvements from the previous behavioral health quality review (BHQR) 12/2024:

- Assessors did not identify any evidence of duplicated progress notes.
- All progress notes contained responses to the intervention.
- All services provided were listed on the IRP before the date of service.

Opportunities for Improvement:

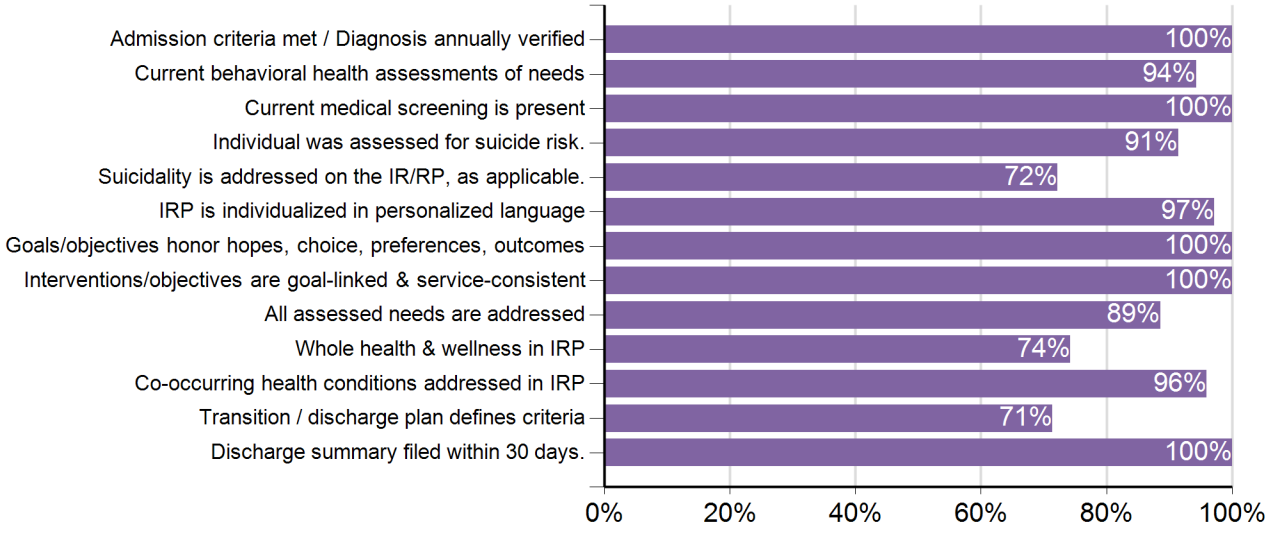
Performance Standards

- Minimum service contacts for Community Support (CS) and Adult Addictive Disease Services (ADSS) were not met per DBHDD Service Guidelines resulting in three unjustified claims.
- Services were billed simultaneously, resulting in three unjustified claims.
  - An Assertive Community Treatment (ACT) session was billed with the individual and also for a collateral contact with the individual's family member at the same time by the same staff member.
  - An ACT session was billed at the same time as another ACT service where all but five minutes of the two contacts overlapped.
  - Case Management (CM) was billed at the same time as Mental Health (MH) Peer Support Program.
- The content of two progress notes did not support the units billed. Time for transportation and breaks was not backed out of MH Peer Support Program claims. The group visited three different locations during this session.
- The content of one progress note did not support the code billed. For example, ADSS was billed to meet with the individual's family members, but the "UK" modifier was not used for the collateral contact.
- The content of one progress note did not match the definition of the services billed. For example, MH Peer Support Individual was billed when the individual attended MH Peer Support Program.
- One claim was partially unjustified due to non-billable activity. MH Peer Support Program was billed from 9:00 AM to 1:30 PM with a lunch break from 11:45 AM to 12:15 PM for five units, resulting in one unjustified unit.

Quantitative Standards

- Seven progress notes were lacking documentation of where the service occurred, which is required when billing the "U7" (out-of-clinic) modifier. An example included, a claim for Community Support Team (CST) that listed the location as "community setting."

Assessment and Planning



When all responses to a question are "Not Applicable", no percentage is displayed.

Assessment and Planning: 91%				*Indicators scoring below 80%*
	Yes	No	NA	%
Suicidality is addressed on the IR/RP, as applicable.	13	5	17	72%
Whole health & wellness in IRP	26	9	0	74%
Transition / discharge plan defines criteria	25	10	0	71%

Assessment and Planning

Strengths and Improvements:

- Co-occurring health conditions were addressed on the IRP within 96% of applicable records. This is an improvement from 59% in the previous BHQR 12/2024.
- The record of one individual who had been discharged from services contained a discharge summary that was filed within 30 days. This is a continued strength for the provider.

Opportunities for Improvement:

- Five of 18 applicable records (two ACT) did not address suicidality on the individual's IRP. This is a recurring issue noted on the two previous BHQRs (12/2024 and 4/2024). Examples included,
  - an individual's record was flagged for "high risk for suicide" to include documentation of "Individual identifies suicidal ideations as reasoning for presenting to the hospital."
  - an individual who reported a "suicidal plan to go in a store and buy poisonous chemicals and ingest them."
- Planning for the individual's whole health and wellness was missing from IRPs in nine records (to include three ACT records). This is a recurring issue noted on the three previous BHQRs (12/2024, 4/2024, and 6/2023). Opportunities for whole health and wellness could include addressing sleep hygiene, smoking cessation, exercise options, meditation, and other activities.
- Transition/discharge plans in 10 records (two ACT) lacked one or more of the three required components. This is a recurring issue noted on the four previous BHQRs (12/2024, 4/2024, 6/2023, and 2/2022). The following examples lacked clinical benchmarks or clear outcomes for the individual to achieve:
  - *"[Individual] will discharge if she continues to work on meeting her treatment plan goals, keep all her appointments, take her meds as prescribed, and utilize her identified coping skills to manage her mood swings, affective thoughts, suicidal ideations, and improve adult daily living skills and social functioning in six months."*
  - *"[Individual] will discharge to outpatient medication management when he has met his independent living goals."*
  - *"Client will be discharged when treatment goals are met."*
  - *"When client is able to meet all goals for peer support, client will step down to outpatient services only."*

Focused Outcome Areas

Focused Outcome Areas: 94%				*Indicators scoring below 80%*
Whole Health - 87%	**Yes**	**No**	**NA**	**%**
Documentation of communication with external referral sources and providers to obtain results of testing, treatment, and follow-up.	16	10	9	62%
Safety - 95%	**Yes**	**No**	**NA**	**%**
Documentation supports that clinically-appropriate actions or steps were taken and linkages/referrals were made if the individual has been assessed to be at risk for suicide (within the past six months).	6	2	27	75%
Rights - 90%	**Yes**	**No**	**NA**	**%**
Individual/guardian has signed formal acknowledgement of rights and responsibilities at least annually (13 months).	20	9	6	69%
Releases of Information contain all required components.	11	5	19	69%

Focused Outcome Areas

Strengths and Improvements:

- In records where individuals were assessed to be at high or moderate risk for suicide (within the past six months), there was documented evidence of ongoing assessment within 88% of applicable records. This is an improvement from 67% in the prior BHQR 12/2024.
- All records contained a safety/crisis plan that directed in advance, the individual's desires, wishes, and plans in the event of a crisis.

Opportunities for Improvement:

Whole Health

- Ten of 26 applicable records (four ACT) lacked documentation of communication with external referral sources to obtain the results of testing, treatment, and follow-up, as clinically indicated. This is a reoccurring issue noted on the previous BHQR (12/2024). Examples of opportunities to communicate and coordinate with other healthcare providers included:
  - An individual visited the emergency room three times in the past 12 months for auditory hallucinations.
  - Another individual had multiple medical hospitalizations resulting in the amputation of fingers and a leg.
  - An individual was being treated for prostate cancer.

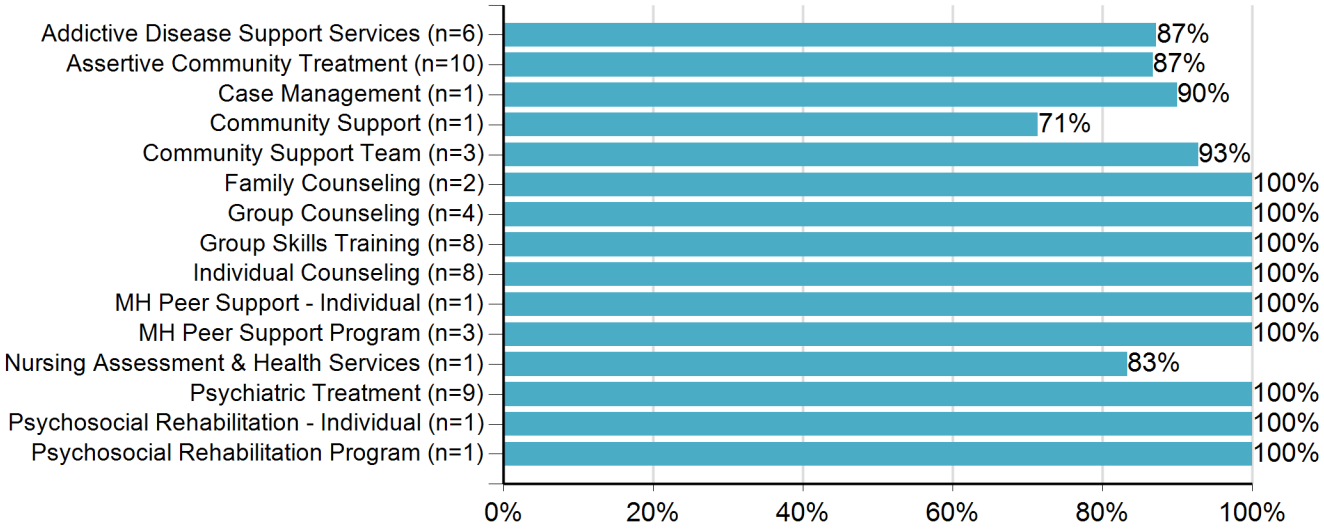
Safety

- Two of eight applicable records (one ACT) did not contain evidence that clinically appropriate actions or steps were taken and linkages/referrals were made when the individual had been assessed to be at risk for suicide (within the past six months).
  - An individual who twice attempted to overdose on psychiatric medications and attempted to end their life by cutting did not have suicidality addressed on their IRP.
  - Another individual whose record was flagged with "high risk for suicide," had disclosed suicidal ideation, and had previously attempted to hang themself did not have suicidality addressed on their IRP nor had this addressed in Individual Counseling sessions.

Rights

- Nine of 29 applicable records (one ACT) lacked evidence of the individual/guardian having signed a formal acknowledgment of rights and responsibilities at least annually. This is a recurring issue noted on the four previous BHQRs (12/2024, 4/2024, 6/2023, and 2/2022).
- Five of 16 records with documented need for releases of information (ROI) did not contain them. In each record, there was documentation of a member of staff speaking with an individual's family member, parole/probation officer, etc. Examples included:
  - an ACT staff member spoke with the individual's spouse, but an ROI was not present in the record
  - an ACT staff member coordinated with the individual's parent, but there was no current ROI within the record
  - an ACT Staff member called the individual's mother but the ROI had expired in May, 2025

Service Guidelines



n = the sample size (records) reviewed specific to the service

Service Guidelines: 93%				*Indicators scoring below 80%*
Addictive Disease Support Services - 87%	**Yes**	**No**	**NA**	**%**
Coordination with family and significant others is documented and with adult individual's permission. Answer "Yes" if attempt is made, but permission is not given. (Review authorization period.)	0	5	1	0%
Assertive Community Treatment - 87%	**Yes**	**No**	**NA**	**%**
ACT conducts Recovery Planning Meetings w/staff, individual, family/informal supports at least quarterly and prior to reauthorization.	3	7	0	30%
The psychiatrist for this team participates in weekly team meetings.	0	10	0	0%
Case Management - 90%	**Yes**	**No**	**NA**	**%**
There are a minimum of two (2) contacts per month, with at least one (1) face-to-face in a non-clinic setting. (Review authorization period.)	0	1	0	0%
Community Support - 71%	**Yes**	**No**	**NA**	**%**
Staff are meeting the monthly minimum requirement of two (2) contacts per month. (Review authorization period.)	0	1	0	0%
There is evidence of skill building/teaching, i.e. documentation supports interventions that assist in the development of the interpersonal, community coping and functional skills.	0	1	0	0%
Community Support Team - 93%	**Yes**	**No**	**NA**	**%**
CST Team Meeting logs document that the individual was discussed, even briefly, at least one time per week.	0	3	0	0%
Nursing Assessment & Health Services - 83%	**Yes**	**No**	**NA**	**%**
Nursing goals and objectives are individualized and address health issues to include (but not limited to) medical, physical, nutritional, and behavioral needs.	0	1	0	0%

Service Guidelines

Strengths and Improvements:

- All applicable records contained documented evidence that the ACT Team worked with informal support systems at least twice per month. This is an improvement from the previous BHQR 12/2024 where this occurred in 44% of applicable records.
- The minimum monthly contact requirements were met for all applicable CST, ADSS, and PSR-I records. This is an improvement from the previous review.
- Group skills training sessions contained documentation of the use of evidenced based practices including the Substance Abuse and Mental Health Service Administration (SAMHSA) Anger Management treatment manual.

Opportunities for Improvement:

Addictive Disease Support Services (ADSS)

- There was no evidence of coordination with family and significant others in any of the five applicable records. This is a recurring issue noted in previous BHQRs (12/2024, 4/2024, and 6/2023). One example is an individual who lived with a family member and had a supportive sibling, but there was no evidence of staff engaging the family in ADSS service provision.

Assertive Community Treatment

- Seven of 10 records did not contain documentation of recovery planning meetings with staff, the individual, and family/informal supports at least quarterly and prior to the reauthorization of services. This is a recurring issue noted in previous BHQRs (12/2024, 4/2024, 6/2023, and 2/2022). An example included, one record did not have evidence of any recovery planning meetings.
- The psychiatrist was not participating in weekly team meetings in all applicable records. This is a reoccurring issue noted in previous BHQR (12/2024).

Community Support (CS)

- The one CS record reviewed did not contain evidence of skill building/teaching to assist with development of interpersonal, community coping, and functional skills that the individual needs to achieve goals in their environments of choice. There were only two CS contacts documented in the record in an authorization period and both were coordination with the individual's parent (no documented direct contact with the individual).

Community Support Team (CST)

- All three records were lacking documentation in the CST Team Meeting logs. There must be documentation that the individual was discussed, even briefly, at least once per week. There were no CST Team Meeting notes from 4/29/2025 to 5/13/2025 and from 7/1/2025 to 7/11/2025.

Nursing Assessment and Health Services

- In the one applicable record reviewed, goals and objectives relevant to nursing services were not individualized and did not address the individual's assessed and documented diagnoses.

The minimum contacts were not met within **Case Management and Community Support.**

Overall Programmatic

The Programmatic standards below, relevant to services reviewed during this BHQR, are not currently calculated into any scored area of the review; however, the provider will be reminded of the requirements and recommendations will be made based upon the findings.

Provider-Level Indicators		
1	Where applicable, all services are provided at approved Medicaid sites.	Yes
2	On-site nurse is present 10 hours/week.	Yes
3	Staff safety and protection policies/procedures are present.	Yes
4	Quality Assurance Plan includes assuring/monitoring quality of services for individuals at risk for suicide.	Yes

5	The provider employs an ASL-fluent practitioner.			N/A
6	The provider has policies and procedures for providing reasonable accommodations to individuals who are deaf/hard of hearing.			Yes
7	The provider had obtained the appropriate DBHDD-approved criminal records background check on all reviewed staff members by their hire date.			Yes
	# Yes	**# No**	**# N/A**	**SCORE***
	6	**0**	**1**	**100%**

** Overall Programmatic Score is not calculated into the Overall score at this time.*

Additional Comments on Practices

Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- A paraprofessional (PP) staff member was lacking one hour of Corporate Compliance training in the Relias system. The minimum training topics and hours must be met to use the PP credential.
- A certified peer specialist's (CPS) electronic signature did not include their credential.
- There were several billing risks/exceptions identified in records that were outside of the billing sample for this review. They included:
  - an ACT service billed by a registered nurse on 8/26/2025 where the note stated the session occurred via telephone, but the "U7" out-of-clinic modifier was used,
  - an ACT claim for 9/15/2025 was billed using the "U7" modifier but the description of the location was, "saw client in the community" without specifying the location. As the U7 modifier indicates a community location, the specific location is required in documentation,
  - in another record, ACT was billed twice as out-of-clinic contacts, but the notes stated, "met with client outside Advantage Behavioral Health Pavilion," which would be considered in-clinic as using the U7 modifier requires the use (and expense) of travel for the member of staff to provide service to the individual,
  - one progress note for MH Peer Program used male pronouns twice in the intervention section of the progress note for a cisgender female. The response section contained female pronouns.

Individual Interviews

Each individual is asked a standard set of questions; a sampling of responses is listed below. Individual interviews are not calculated into the Overall score. For a complete list of questions, please refer to the Georgia Collaborative's website.

Individual Interviews Conducted: 4

- Individuals felt that they could access appointments, provider staff, and other agency supports in timely manner when requested. Examples included:
  - *"They can scheduled me next week for Individual Counseling and within the next couple of weeks for the psychiatrist."*
  - *"They can get you in anytime by tomorrow. If they had time they would work you in."*
- All individuals were involved in the development of, and updates to, IRPs. Examples included:
  - *"They are helping me find a job and help me work through my depression."*
  - *"I'm working on getting a job and I'm in therapy."*
- The individual and their guardian shared they were satisfied with their supports and services. Individuals reported:
  - *"They have helped me feel better mentally. I've been doing a lot of work on myself."*
  - *"The therapist and doctor are really nice."*
- When asked, "What about this agency makes you keep coming back?", individuals replied:
  - *"The counselor is very good and so are the staff. They are good people. They are real friendly. They seem to be real trustworthy and they believe in helping you. They always seem to know the right thing to say."*
  - *"My therapist is really understanding and listens to me. She has helped me learn things I didn't know about myself."*
  - *"They really listen and try to help me as best they can."*

Quality Improvement Requirements

Providers are reminded of the responsibility to maintain internal processes which ensure immediate and permanent corrective actions on issues identified during the quality review process. DBHDD may request corrective action plans (CAPs) as quality review findings warrant as well as review agencies' internal documentation regarding corrective actions and ongoing quality assurance and quality improvement. Please refer to the comments documented in each section above for specific information pertaining to the requirements below.

Requirements: Current and Prior Review

Billing Validation

- Quantitative documentation standards must be met for all submitted claims.
- Performance documentation standards must be met for all submitted claims.

Assessment and Planning

- Suicidality must be addressed on the IR/RP when the individual is assessed as having any suicide risk.
- Treatment/recovery/service plans must contain goals, objectives, and interventions that promote whole health and wellness of the individual.
- Transition/discharge plans must define criteria for discharge to include clinical benchmark(s), planned discharge date, and specific services for ongoing support.

Focused Outcome Areas - Whole Health

- Communication with external referrals and resources must occur to determine the results of testing, treatment, and referral.

Focused Outcome Areas - Rights

- Individuals must be informed of their rights and responsibilities at the onset of services and at least annually thereafter.

Compliance with Service Guidelines - Addictive Disease Support Services (ADSS)

- Documentation should support coordination efforts with the individual's family and significant others when the individual requests/permits it.

Compliance with Service Guidelines - All Services

- Minimum required contacts must be met for all services (as required).

Compliance with Service Guidelines - Assertive Community Treatment (ACT)

- The ACT team must complete a treatment plan review with the staff, the individual, family, and other informal supports prior to the reauthorization of services.
- The ACT team psychiatrist must participate in ACT team meetings at least weekly and review each case with the physician extender on a monthly basis.

Compliance with Service Guidelines - Outpatient Counseling

- Nursing objectives and interventions must be individualized and address health issues to include (but not limited to) the individual's unique medical, physical, nutritional, and behavioral needs.

Requirements: Current Review

Focused Outcome Areas - Safety

- Documentation must support that clinically-appropriate actions or steps were taken and linkages or referrals were made based upon the findings/outcome of suicide risk assessment.

Focused Outcome Areas - Rights

- Releases of information must contain all required components.

Compliance with Service Guidelines - Community Support

- Individuals receiving Community Support services must receive training in the use of specific skills based on their unique needs and learning styles.

Providers have the opportunity to appeal review findings for up to ten (10) business days following notification that their written Final Assessment has been saved to the Collaborative's website. For appeals procedures and submission requirements, access the Georgia Collaborative's website to review the appeals process in the Quality Management section of the Provider Handbook and for a current version of the Review Appeal Form at this link: https://www.georgiacollaborative.com/providers/behavioral-health-providers/