The Georgia Collaborative ASO

GAC000032

Grady Memorial Hospital Corporation

Behavioral Health Quality Review Final Assessment

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Records Reviewed: 35

Date Range of Review: 5/1/2023 - 5/5/2023

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 as an opportunity 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: 11/14/2022	79%	54%	91%	90%	81%
Review Date: 05/16/2022	89%	76%	95%	91%	92%
FY22 Statewide Average	90%	79%	94%	91%	95%

Note: The FY22 Statewide Averages represent the mean of scores for all reviewed providers.

Summary of Significant Review Findings

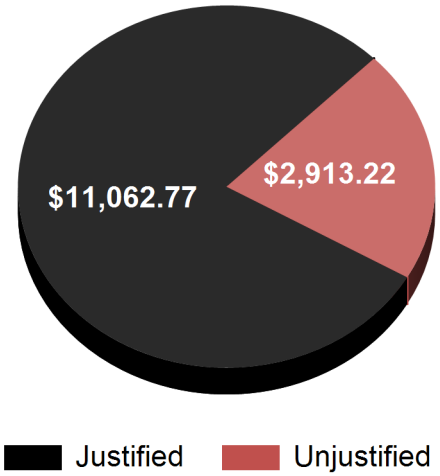
Strengths and Improvements:

- The provider's electronic medical record (EMR) contains helpful alerts for staff such as "history of violence" as well as indication when an individual is overdue for a COVID vaccine booster. In addition, one individual's face sheet noted that they had stopped smoking after 40 years. This is a recurring strength for the provider.
- Service orders were embedded within each progress note.
- A record evidenced excellent documentation of an individual's suicidal ideation (SI) history. The clinician gained additional information regarding symptomology and crisis planning from a collateral contact with the individual's mother.
- The Assertive Community Team (ACT) team nurse practitioner documented reviewing lab results with an individual and provided recommendations based on findings.

Opportunities for Improvement:

- Twenty-nine claims were unjustified due to individual recovery plans (IRPs) that were expired or did not include all billed services. This is a recurring issue that negatively impacted scoring in several categories.
- The majority of transition/discharge plans did not contain clinical benchmarks that were measurable and unique to the individual.
- Five of seven applicable records (one ACT, one Intensive Case Management (ICM)) where the individual was assessed to be at high or moderate risk for suicide, did not contain documented evidence of ongoing assessment at each visit, as required.
- Ten of 27 records reviewed (four ACT, one ICM) did not evidence documentation that demonstrated the plan was reassessed based upon any changing needs, circumstances, and/or response by the individual.
- The majority of ACT records reviewed did not evidence that the ACT team was working with informal support systems/collateral contacts at least two to four times per month.
- Minimum contacts were not always met, as required.
- The file of one supervisee trainee's (S/T) record lacked evidence that 0.5 of the two required hours of online cultural competence training were completed and that supervision was completed in February 2023.
- The ACT team did not have all required staff. One of the three teams was missing an addiction practitioner and a certified peer specialist (CPS).

Billing Validation



	Medicaid	State Funded Services	Total
Justified	$4,213.97	$6,848.80	$11,062.77
Unjustified	$867.43	$2,045.79	$2,913.22
Total	$5,081.40	$8,894.59	$13,975.99

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	# of Discrepancies
Performance Standards	Intervention unrelated to the IRP	29
	Content does not support code billed	7
	Content does not support units billed	7
	Content of note does not match service definition	6
	Minimum contacts not met per DBHDD Service Guidelines	6
	Non-billable activity billed	4
	Content of documentation is not unique	1
	High utilization without justification	1
	Multiple services billed at same time	1
Quantitative Standards	Billing code is missing or different from code billed	3
	Date of service incorrect/missing	1
	Staff credential missing	1
	Staff credential not supported by documentation	1

Billing Validation: 79%

Strengths and Improvements:

The following were improvements from the previous Behavioral Health Quality Review (BHQR) in 11/2022:

- All records contained corresponding service orders for the services provided.
- There were no mutually exclusive services billed.
- There were no missing progress notes.
- All progress notes reviewed were filed within seven calendar days.

Opportunities for Improvement:

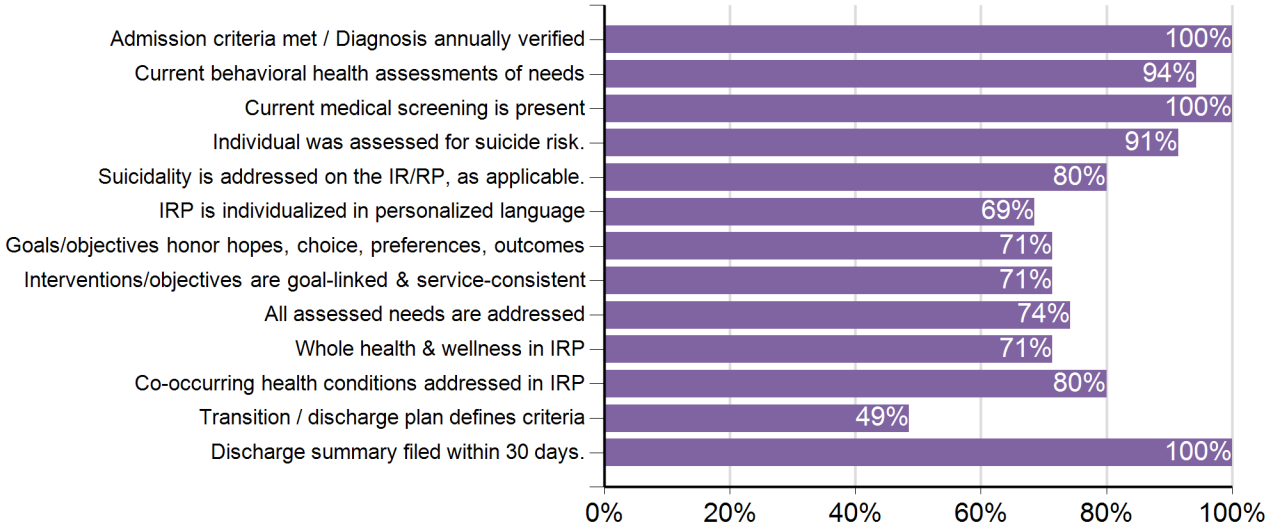
Performance Standards

- The intervention was unrelated to the IRP in 29 progress notes. This was a reoccurring issue from the previous BHQR in 11/2022. Examples included:
  - The majority (20) of unjustified claims were due to the following services not being planned on the IRPs: ICM, Group Outpatient Services, Medication Administration, Community Transition Planning (CPT), and Family Counseling.
  - In three records, the IRP was expired, resulting in nine (9) unjustified claims.
    - One IRP expired on 3/16/2022 and there was no current IRP within the record.
    - In another record, the IRP expired on 11/24/2022 and was not updated until 2/23/2023.
    - In the third record, the IRP expired on 4/16/2022 as the most recent IRP was updated on 4/16/2021.
- The content did not support the code billed in seven (7) progress notes reviewed. In all seven progress notes, the collateral contact modifier (UK) was documented, but the individual was seen face-to-face for the session.
- The content did not support the units billed in seven (7) progress notes. Examples included:
  - Four ACT progress notes documented brief check-ins with the individual.
  - A Case Management (CM) progress note documented completion of a Georgia Housing Voucher Program (GHVP) application and confirmed submission of documents on 1/19/2023; however, the same staff member documented similar information on 1/10/2023 regarding the GHVP within the same record.
- The content of the note did not match the service definition in six (6) progress notes reviewed. Examples included:
  - The content of two notes reviewed for Psychosocial Rehabilitation- Individual (PSR-I) reflected referral and linkage interventions.
  - In another record, Crisis Intervention was billed but there was no documented crisis within the progress note.
  - A CM progress note documented interventions that were medical in nature and did not reflect service coordination, resource linkage, or monitoring for progress.
- In six (6) progress notes reviewed, the minimum contacts were not met per DBHDD Service Guidelines. This included ICM, CM, and PSR-I notes. This is a recurring issue from the previous BHQR 11/2022.
- Non-billable activities were documented in four (4) progress notes reviewed. In three CM notes, documentation reflected administrative tasks such as scanning and emailing documentation to another agency staff member. Another CM note contained documentation of a staff member reviewing the record to ensure documents had been completed.
- The content was not unique in one CM note on 2/21/2023. It was duplicated from a CM note on 2/10/2023 within the same record.
- One record contained high utilization of services as an individual had already been seen and assessed by a licensed clinical social worker (LCSW) for an hour and a medical doctor (MD) for 30 minutes, both of which can provide a verified diagnosis. The Diagnostic Assessment encounter for the same day captured six (6) minutes for another MD to confirm the findings of the previous MD.
- Multiple services were billed at the same time within one record reviewed. A progress note for Service Plan Development (SPD) overlapped with time in/time out for a BHA. The time documented for SPD time was 4:00-5:00pm and the BHA was 4:25-5:46pm.

Quantitative Standards

- Three (3) claims were unjustified as the billing code documented was different than the code billed. Within two ACT progress notes, the code documented on the notes did not include the practitioner modifier, with the code documented as "UX" rather than "U4". Another progress note contained a code documented as H2011U5U7 as the staff member met individual at their residence; however, the code billed was H2011GTU5.
- The date of service was incorrect on one (1) ICM progress note. The date of service on the progress note was documented as 1/3/2023; however, the claim was billed for a date of service of 1/4/2023.
- Within one Group Counseling note, the staff credential was missing. The staff member did not include the supervisee trainee (S/T) credential within the progress note.
- One claim was unjustified due to the staff credential not supported by documentation. The personnel file of one S/T lacked evidence that 0.5 of the two required hours of online cultural competence training were completed and that supervision was completed in February 2023.

Assessment & Planning



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

Assessment & Planning: 79%

Strengths and Improvements:

- All individuals reviewed met admission criteria, an improvement from the previous BHQR in 11/2022.
- All individuals within ACT and ICM services were assessed for suicidal risk, a continued strength.
- Co-occurring health conditions were addressed within all applicable ICM records reviewed.

Opportunities for Improvement:

- The only applicable record reviewed for ACT services failed to address suicidality on the IRP. The individual was admitted to a crisis center in March 2023 due to increasing psychosis and reporting thoughts of harming herself and her granddaughter who lives in the home with her. The IRP was not reviewed/updated upon discharge, and therefore, suicidality was not added to the IRP when it became a known issue for the individual.
- Eleven (31%) of 35 records (three ACT, two ICM) did not contain an IRP written in language personalized for the individual. Documentation was vague, subjective, and similar objectives and interventions were seen across records. In addition, IRPs were duplicated from previous plans. Examples included,
    - One individual's IRP had not been changed since 2020. The goal statements were the same for the past 11 versions of the IRP.
    - Two IRPs were expired. In one record, the IRP had not been updated since 4/16/2021.
- Ten (29%) of 35 records reviewed (three ACT, one ICM) did not goals and objectives that honored hopes, choice, preferences, and outcomes. An IRP for one individual receiving ACT services addressed reducing drug use and attending Narcotics Anonymous/Alcoholics Anonymous (NA/AA) when there was no diagnosis of a substance use disorder nor was a drug use issue identified in the assessment. Another individual had a goals of obtaining a house, a car, and employment; however, there were no objectives or interventions to support this.
- Ten (29%) of 35 (three ACT, two ICM) records did not contain interventions and objectives that were goal-linked and service consistent. The plan should represent an accurate reflection of the individual and their desired outcomes. For example, an individual receiving ICM services wanted to address their depression; however, the objectives were not consistent with addressing depression and reducing or assessing the causes of the depression.
- Nine (26%) of 35 records (three ACT, one ICM) did not reflect that the individual's assessed needs were addressed. One individual's legal issues and legal requirements were not addressed. Another individual stated that they wanted to enter the work force and had a stressor of having financial difficulties; however, neither were addressed on their IRP.
- Ten (29%) of 35 records (three ACT, two ICM) did not address whole health and wellness on the IRP.
- Co-occurring health conditions were not addressed on the IRP in two (50%) of four applicable ACT records. In both instances, plans were duplicated and; therefore, current health issues were not addressed. This was a recurring issue noted in the previous BHQR in 11/2022.
- Eighteen (51%) records (two ACT, four ICM) did not contain all components required of transition/discharge plans. Specifically, records did not contain measurable clinical outcomes toward discharge. Examples included,
    - *"[Individual] will step down in medication management services within the next 1 year when the symptoms of anxiety are in remission."*
    - *"[Individual] will step down in medication management services within the next 1 year when the symptoms of auditory hallucinations are in remission."*

Focused Outcome Areas

Focused Outcome Areas: 92%

Strengths and Improvements:

- All (100%) applicable ICM records documented safeguards utilized for medications known to have substantial risk or undesirable effects (lab work, assessments, Abnormal Involuntary Movement Scale (AIMS), etc.), an improvement from 67% in the previous BHQR.
- "Suicide history" flags were present in 89% of records for individual with a known history of suicidality (this included 100% of ICM records). This was an improvement from 58% of records in the previous review.
- When applicable, all records included a psychiatric or other advance directive; or, documentation indicated the individual had either denied the existence of a directive or declined to have it in their record.

Opportunities for Improvement:

Safety

- Documentation within two of six applicable records (one ACT) did not support that clinically-appropriate steps were taken and that linkages were made when the individual had been assessed to be at risk. For example,
  - Upon intake, an individual had suicidal thoughts with a clear plan and access to means (walk on expressway, incite police to shoot him by shooting other people. He reported he owned a gun and bullets, but they were not kept together). He was seeking to return to the ACT program (he was previously receiving ACT in 2017), but documentation stated he did not meet admission criteria. However, there was no documentation that other levels of care were discussed with the individual other than Medication Management with "safety check" phone calls. These safety calls were discontinued after one month and the individual had not been seen or called since the last Psychiatric Treatment appointment on 3/24/2023. Additionally, the individual had missed a Psychiatric Treatment appointment on 4/14/2023, but there were no documented attempts to follow-up with the individual after this missed appointment.
  - The IRP of an individual receiving ACT services was not reviewed and updated upon discharge from a psychiatric hospital.
- When an individual was hospitalized or in a crisis stabilization unit (CSU) within the last six months for suicidal ideation/behavior, their record was not flagged for high risk of suicide for four months following discharge in the one applicable ACT record. The individual was admitted to a CSU from 3/14/2023 until 3/20/2023 and the record was not flagged for high risk of suicide after this. This is a recurring issue noted in the previous BHQR in 11/2022.
- Five of seven applicable records (one ACT, one ICM) did not contain documented evidence of ongoing assessment at each session for at least four months when the individual was assessed to be at high or moderate risk for suicide. This is a recurring issue noted in the previous BHQR in 11/2022. Examples included,
  - A Columbia Suicide Rating Scale (C-SSRS) Since Last Visit was not completed for an individual within the ACT program at each contact upon discharge from the hospital on 3/20/2023. A C-SSRS was completed on six dates. The individual received services 18 days following their discharge from the

hospital.
    - Another individual within the non-intensive outpatient program (NIOP) was at risk for suicide and was not re-assessed at each visit. Documentation evidenced that the individual endorsed suicidal ideation in 2/2023 and again in 4/2023.

Rights

- One applicable record within the ACT program did not document that the individual/guardian had signed acknowledgement of rights and responsibilities at least annually. This is a recurring issue for the provider.

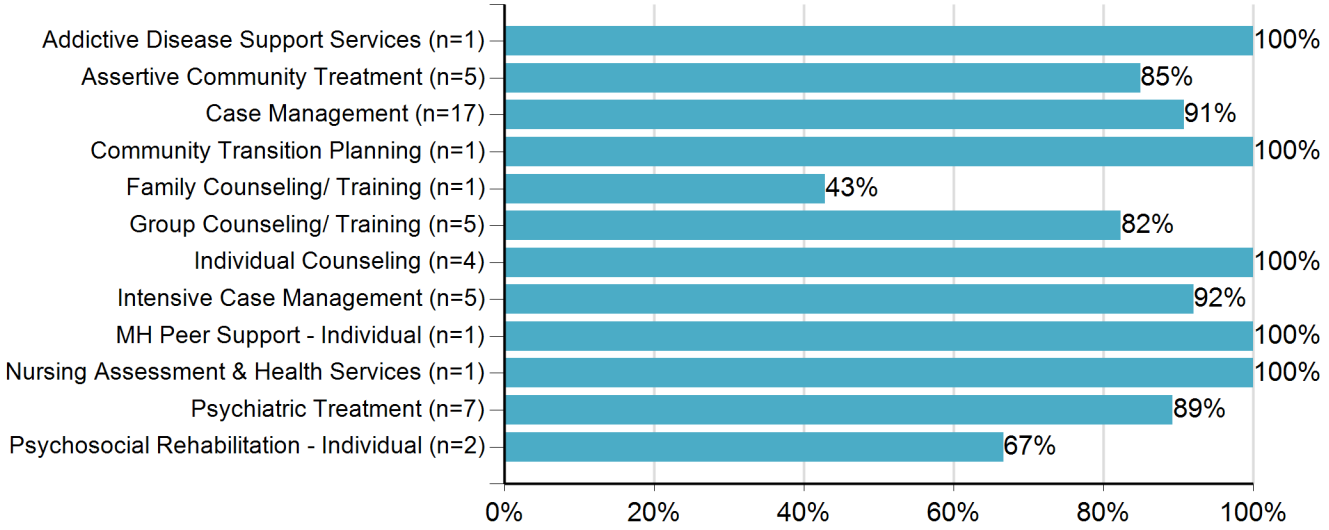
Person Centered

- Two ICM records did not demonstrate the individual was receiving individualized services. An example included, progress notes demonstrated several areas of concern for one individual, but none were noted on the IRP. It was unclear that their services were individualized.
- One ACT record did not demonstrate that the person was an active participant in the planning and receiving of services. The IRP had been duplicated multiple times; therefore, it was not clear that the individual was involved.
- Another record within the ACT program lacked documentation that the person was an active participant in modifying the plan and/or services. The plan did not reflect the current needs of the individual because the IRP had been duplicated several times.
- Ten of 27 records reviewed (four ACT, one ICM) did not contain documentation that demonstrated the plan was reassessed based upon any changing needs, circumstances and/or response by the individual. This is a recurring issue noted in the last BHQR in 11/2022. Examples included,
    - The individual's plan within the ACT program had elements that were not appropriate to where he was in treatment. It addressed suicidality and substance abuse, which did not seem to apply. Further, his plan lacked specifics relevant to his current situation regarding his living, learning, working, and social environments.
    - Financial assistance and employment were current needs of an individual receiving NIOP services (as stated on the BHA); however, the most recent IRP, 2/2023, did not evidence these needs. The plan was not updated.

Community Life

- Within two ACT records, documentation of transition planning was not evident throughout service delivery. An example included, documentation evidenced that an individual hadn't progressed toward certain discharge indicators; however, there was no change in his plan or treatment to address his lack of progress toward the indicators that were holding him back or keeping him from actually transitioning.
- One ICM record did not reflect that informed choice drove the selection of housing options. Housing was not addressed for the individual.
- Within two ICM records, documentation did not support the individual was assessed for any need to make a “stay or go” decision in their living, learning, working, and/or social environments. In both instances, there was no assessment of needs documented.
- Six of 26 applicable records (one ACT, two ICM) did not include documentation that supported the individual was assisted with setting goals for specific, chosen environments. An example included, one individual stated they wanted to enter the work force, but there were no goals found related to vocation.

Service Guidelines



Service Guidelines: 89%

Strengths and Improvements:

- Treatment team meeting logs within ICM contained evidence that the individual was discussed at least one time month over the past six months, an improvement from 60% of records in the previous BHQR.
- All Mental Health (MH) Peer Support- Individual records reviewed contained documentation of the individual's progress (or lack of) toward specific goals and objectives on the treatment plan, an improvement from none in the previous review.
- Contact was made at least twice per month with individual in the sample who received Addictive Disease Support Services (ADSS). This is a continued strength for the provider.
- Documentation within Nursing Assessment and Health Services progress notes supported education related to identified health issues including (but not limited to) medication, nutrition, and infectious disease assessment, testing, and referral occurred. One individual had a history of seizures and falling. These issues were addressed extensively with the individual. In addition, lab results were routinely reviewed with the individuals.

Opportunities for Improvement:

Assertive Community Treatment (ACT)

- There was no documented evidence that the ACT team was working with informal support systems/collateral contacts at least two to four times per month in 60% (three of five) of records. In one record, the individual used a wheelchair and depended on family to help get to appointments and manage daily living needs. The individual stated they would like their daughter and granddaughter involved, but there was not evidence of the ACT team working with these supports at least twice monthly.
- In 33% (one of three) of applicable records, there was no documentation to support that the ACT team was working with the individual towards the educational or vocational needs and interests listed on the IRP.
- In 33% (one of three) of applicable records, there was no documentation of the individual's involvement in transition planning. Documentation was focused on maintaining the current level of care rather than assessing for transition to a lower level of care (which seemed appropriate for the individual).
- The ACT team did not have all required staff in 40% (two of five) of records reviewed. One team was missing an addiction specialist and a CPS.

Intensive Case Management (ICM)

- In 25% (one of four) of applicable records, the individual did not have a goal on the IRP to obtain or maintain housing of their choice. The individual had been unhoused for years yet there was not a goal on the IRP regarding living environment.
- In 40% (two of five) of records, a minimum of four contacts were not made with the individual per month. One individual had two contacts in December 2022, and three contacts each in March and April 2023. The other individual only had two contacts in March 2023. There were no attempted contacts documented.

Family Counseling/Training

- The one record reviewed for Family Counseling did not have this service listed on the IRP and therefore lacked documentation indicating:
  - Achievement of specific goals defined and agreed upon by the individual and family member (or parents/responsible caregivers) and specified in the IRP.
  - The individual's progress (or lack of) toward specific goals/objectives on the treatment plan.
  - The staff interventions reflected in the progress notes were related to the staff interventions listed on the treatment plan.
  - The service was provided as planned within the IRP.

Case Management

- More than half (55%; six of eleven) of the records reviewed lacked evidence of a minimum of two contacts per month. For example, in one record, there was only one contact in February 2023, and no contacts in January, March, or April 2023.

Group Counseling/Training

- In 50% (one of two) of records, Group Counseling services were not provided by an appropriately licensed or credentialed clinician. The staff member's records lack evidence that 0.5 of the two (2) required hours of online cultural competence training were completed and that supervision was completed in February 2023.
- In 60% (three of five) of records, progress notes did not contain documentation of the individual's progress (or lack of) toward specific goals/objectives on the treatment plan. For example, in one record, the notes did not address the individual's progress; the notes only described the individual's participation in music therapy group.

Psychosocial Rehabilitation-Individual (PSR-I)

- Neither record reviewed contained documentation to support that:
  - The individual was trained in specific skills. In both records, PSR-I notes documented referral/resource coordination rather than skills training.
  - There was not a minimum of two contacts each month documented. In one record, there was only one contact for this service (2/10/22). In the other record, there was only one contact in March 2023 and none in November 2022, December 2022, or January 2023.

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, Quality Improvement Recommendations are made based on 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
	# Yes	**# No**	**# N/A**	**SCORE***
	5	**0**	**1**	**100%**

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

Additional Comments on Practices

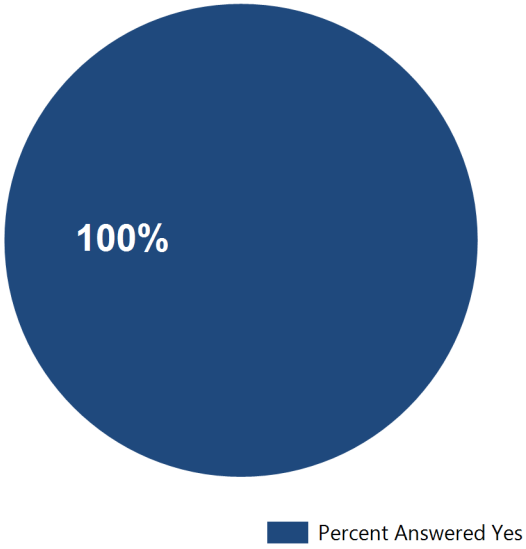
Additional strengths and concerns beyond the general scope of the review were discovered by reviewers. Additional issues/practice concerns may have the potential to impact service delivery, quality of care, or may represent a risk to the provider.

- Goals, objectives, and interventions for PSR-I were the same as for Case Management. Claims were billed PSR-I for Case Management activities and it appeared that there was some confusion about the difference in service definition for each of these services.
- Within some progress notes, billing codes for Group Skills Training included the "HR" modifier which is for another service: Multi-Family Group Training.
- Interchanging of pronouns was found within documentation.

Individual Interviews

Individual Interviews Conducted: 3

Individual Interviews are not calculated into the Overall Score



- Individuals felt supported in moving toward their desired goals and dreams. One individual reported, *"They started me on the path to where I am now. I was homeless a year ago and now I have a home."*
- All individuals interviewed said that they can access appointments, provider staff, and other agency supports in a timely manner when requested. One individual reported, *"Their availability is constant. I can get appointments when I need them. They reach out to me when they don't hear from me."*
- When asked, "What about this agency makes you keep coming back?" individuals shared:
  - *"My experience with Grady has been lifechanging. I have been given hope."*
  - *"They have been a great help to me."*
  - *"They identified my diagnosis right away and they helped me to work on my issues."*
  - *"I am so grateful for the support I have received from them."*
  - *"I am in a new residence and this has given me life."*
  - *"Everyone is very personable."*
  - *"The people I work work really care about helping others."*

Quality Improvement Recommendations

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 recommendations below.

Recommendations: Current and Prior Review

Billing Validation - Quantitative

- Ensure all Quantitative Standards are met in documentation.

Billing Validation - Performance Standards

- Ensure all Performance Standards are met in documentation.

Assessment and Planning

- Ensure treatment/recovery/service plans address co-occurring health conditions and concerns.

Focused Outcome Areas - Safety

- Ensure there is documented evidence of ongoing assessment when an individual has been assessed to be at risk for suicide.
- Ensure the record has been flagged for high risk of suicide for at least four months if the individual/youth was hospitalized or in a CSU within the last six months for suicidal ideation/behavior.

Focused Outcome Areas - Person Centered

- Ensure individuals served are assessed and re-assessed for changing needs and circumstances and updated plans are reflective of current assessments.

Compliance with Service Guidelines - All

- Ensure documentation addresses individuals' progress toward specific goals and objectives.
- Ensure services are provided as planned on IRPs.
- Ensure the minimum required contacts are met for all services (as required).

Recommendations: Current Review

Provider Level

- Ensure all supervisee/trainee (S/T) attestations are complete and updated annually and that they participate in monthly supervision, as required.

Assessment and Planning

- Ensure treatment/recovery/service plans are individualized and in the language of the individual served.
- Ensure stated goals honor the stated hopes, choices, preferences, and desired outcomes of the individual(s) served.
- Ensure objectives and interventions are relevant to stated goals of individuals and consistent with services provided.
- Ensure treatment/recovery/service plans address all areas of assessed need.
- Ensure treatment/recovery/service plans contain goals, objectives, and interventions that promote whole health and wellness.
- Ensure transition/discharge plans define criteria for discharge, planned discharge date, and specific services.

Focused Outcome Areas - Safety

- Ensure documentation supports 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 - Community Life

- Ensure individuals are assisted in setting overall rehabilitation goals in their living, learning, working, or social environments as desired and needed.

Compliance with Service Guidelines - All

- Ensure all services are provided by appropriately-credentialed staff.

Assertive Community Treatment (ACT)

- Ensure the ACT team is working with informal supports/collateral contacts as required.
- Ensure the ACT Team is working with the individual toward their educational or vocational needs and interests.

Intensive Case Management (ICM)

- Ensure the individual has a goal on the IRP to obtain or maintain housing of their choice, and that this goal is updated (at a minimum) at each reauthorization.

Compliance with Service Guidelines - Additional Recommendations

Assertive Community Treatment

- Ensure there is documentation of the individual's involvement in transition planning.
- Ensure the ACT teams have all required staff.

Family Counseling/Training

- Ensure documentation indicates achievement of specific goals defined and agreed upon by the individual and family member (or parents/responsible caregivers) and specified in the IRP.
- Ensure staff interventions reflected in the progress notes are related to the staff interventions listed on the treatment plan.

Psychosocial Rehabilitation- Individual

- Ensure individuals are trained in specific skills in the areas of self-management and crisis prevention; interpersonal, community coping, and functional skills relevant to living, education, working, or socializing; minimizing the effects and impact of symptoms of illness; reducing life stresses, and; gaining access to needed community supports and services.

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/