Behavioral Health Provider Manual

peach state health plan™

1-866-874-0633

pshp.com

PSHP_041218_0016

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Behavioral Health at Peach State Health Plan

Peach State Health Plan provides integrated quality physical and behavioral health services to our members. Our integrated services strive to address the whole person and ensure our members have better health outcomes. Peach State Health Plan's Quality Improvement (QI) programs are focused on the impact physical and behavioral healthcare services have on the quality of care that our members receive.

Peach State Health Plan is committed to bringing the best care possible to our members, through innovative health services in the communities where they live. We partner with our provider communities to educate and assist physical health and behavioral health providers in the appropriate exchange of healthcare information. We utilize both behavioral health and medical utilization reports to measure quality outcomes and share them with our Quality Improvement Committee Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any identified deficiency shared with the QI committee quarterly. Benchmarks for performance are measured, and non-compliance with the required performance standards prompts a corrective action plan to address and/or resolve any identified deficiency. Partnering with our providers continuous improvement ensures our members receive the care they need to live healthy lives and thrive.

ELIGIBILITY AND ENROLLMENT ELIGIBILITY FOR THE PEACH STATE HEALTH PLAN PROGRAM

The State of Georgia has the sole responsibility for determining eligibility for the Medicaid program and whether Medicaid beneficiaries are eligible for enrollment in Georgia Families (GF). DCH or its Agent will determine eligibility for PeachCare for Kids® and will collect applicable premiums eligibility. Individuals that are not enrolled in the Georgia Medicaid program and are interested in applying for the Peach State Health Plan Program should be referred to the local DFCS office in the county in which the individual lives.

The member has an opportunity to select a primary care provider (PCP) with the assistance of a Selection Counselor. Individuals who do not make a voluntary PCP selection are assigned to a PCP via an automated assignment process that links the member with an appropriate PCP.

Member eligibility in Peach State Health Plan is effective at 12:01 a.m. on the first (1st) Calendar Day after the Member's selection or Auto Assignment to Peach State and may be confirmed by any of the Eligibility Verification systems described below. Eligibility categories are as follows:

- Low Income Families.
- Transitional Medicaid.
- Pregnant Women (Right from the Start Medicaid – RSM).
- Children (Right from the Start Medicaid – RSM).
- Children (newborn).
- Women Eligible Due to Breast and Cervical Cancer.
- Refugees – Individuals, as defined under O.C.G.A. § 38-3-3, including but not limited to those who have the required Immigration and Naturalization Service (INS) documentation.
- Planning for Health Babies 1115 Demonstration Waiver Participants.
- PeachCare for Kids® – The Children's Health Insurance Program (CHIP) in Georgia.

Verifying Enrollment

Providers are responsible for verifying eligibility every time a member schedules an appointment, and when they arrive for services. PCPs should also verify that a member is their assigned member. To verify enrollment call the Provider Services Department at 1-866-874-0633.

72 Hour Eligibility Rule

Providers will be required to verify member eligibility via the MMIS web portal at https://www.mmis.georgia.gov/ portal/ prior to providing services to Peach State Health Plan members. Providers that verify eligibility and submit claims for services within 72 hours after the verification process will have their claims honored. Listed below are instructions and procedures that must be followed in order to comply with this policy:

- Eligibility verification must be completed via the MMIS web portal https://www.mmis.georgia.gov/ portal/
- Providers must print and maintain a valid copy of the eligibility screen shot and provide the information to the plan in the event that a claim reconsideration or appeal is required to process the claim. The screen shot must contain a date/time stamp in order to be considered valid.
- In order to reimburse providers for these services, in most case you will need to initiate an appeal and supply the plan with proof that verification was obtained via the GHP web portal within the 72 hour time frame.

Appeals should be submitted to:
Peach State Health Plan
P.O. Box 3000
Farmington, MO 63640-3812

Please Note: This policy only applies if the steps identified above are followed. As a reminder, Medicaid is the payer of last resort; therefore this policy does not supersede the CMS guidelines related to

Peach State Health Plan has the capability to receive an ANSI X12N 270 health plan eligibility inquiry and generate an ANSI X12N 271 health plan eligibility response transactions through Peach State Health Plan. Providers also may verify member enrollment through Peach State Health Plan's website at www.pshp.com. For more information on conducting these transactions electronically contact:

Peach State Health Plan
C/o Centene EDI Department
1-800-225-2573, extension 25525
or by e-mail at:
EDI@centene.com

Until the actual date of enrollment with Peach State Health Plan, Peach State Health Plan is not financially responsible for services the prospective member receives. In addition, Peach State Health Plan is not financially responsible for services members receive after their coverage has been terminated. However, Peach State Health Plan is responsible for those individuals who are Peach State Health Plan members at the time of a hospital inpatient admission and change health plans during that confinement.

Provider Quick Reference Guide

IMPORTANT NUMBERS

Department	Phone	Fax
Prior Authorization / Utilization Management	(800) 704-1483	Inpatient: (844) 263-1379 Outpatient: (844) 870-5064
Provider Relations	(866) 874-0633	(888) 659-5834
Grievance/Complaints/Appeals	(800) 947-0633	(866) 704-3063
Quality Management/Incident Reports	(800) 947-0633	(866) 714-7991
Credentialing	(800) 947-0633	866) 694-3730
Claim Support	(866) 324-3632	

Claims Address	Health Plan Contact Information
Peach State Health Plan PO Box 6700 Farmington, MO 63640-3811 1-866-324-3632	Peach State Health Plan 1100 Circle 75 Parkway, Suite 1100 Atlanta, GA. 30339 1-866-874-0633 www.pshp.com

Member ID Card

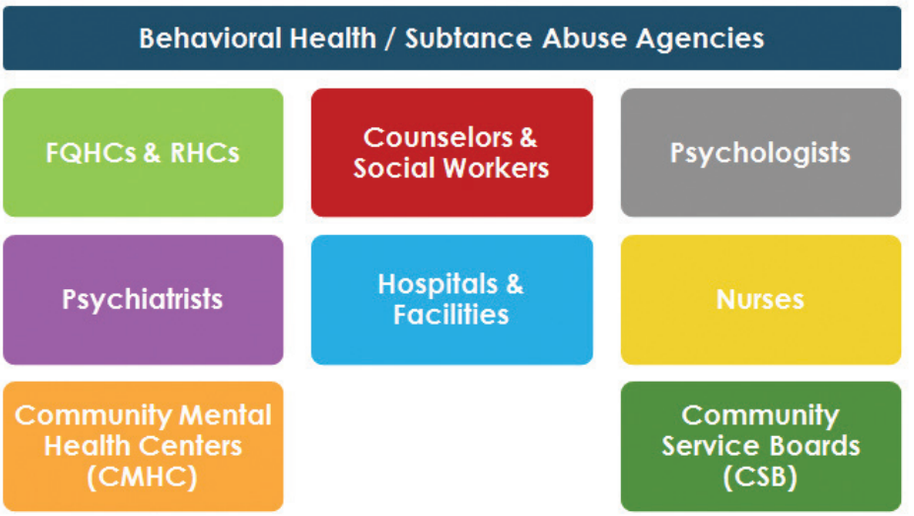
Provider Network Participation

Peach State Health Plan contracts with behavioral health solo practitioners, groups, Community Service Boards (CSB), Comprehensive Medicaid Provider (CPM), Specialty Providers and hospitals/facilities that consistently meet or exceed Peach State Health Plan's clinical quality standards and are comfortable practicing within the managed care arena. This includes an understanding of Peach State Health Plan covered benefits and utilization under managed Behavioral Health care.

Effective July 1, 2017, the State of GA and Peach State Health Plan have expanded the behavioral health provider network to include the following:

- In network psychiatrists who agree to serve as PCPs for Members who have a primary diagnosis of a Severe Persistent Mental Illness. If a psychiatrist would like to serve as a PCP for a member, they can

contact Provider Relations for the submittal process.



- Peach State Health Plan will begin contracting with providers with the capacity to serve as a Behavioral Health Home. The Behavioral Health Home is an integrated model of care intended to serve members that meet clinical criteria and have coexisting medical, mental health and/or substance use conditions requiring care management Participating Behavioral Health Homes will provide care coordination services, comprehensive care management, health promotion and coaching; health information/ education; preventative health; mental health and substance abuse services; comprehensive transitional care; patient and family support; community linkage; and interdisciplinary care plan meetings. If you are interested in learning more about participating in the Behavioral Health Home program, contact Provider Relations.

Each provider will be provided with a copy of their fully executed agreement with Peach State Health Plan. The agreement will indicate the provider's effective date in the network, and the initial term and renewal term provisions in Peach State Health Plan's provider network. The agreement will also indicate the cancellation/termination policies. There is no "right to appeal" when either party chooses not to renew the agreement.
The provider network may consist of the following types of providers:

Peach State Health Plan contracts its provider network to support and meet the linguistic, cultural and other unique needs of every individual member. This includes the capacity to communicate with members in other languages other than English and communicate with those members who are deaf or hearing impaired.

Contracting with Peach State Health Plan

Peach State Health Plan consistently monitors network adequacy. Network providers are selected on the following standards:

- Clinical expertise
- Ability to accept new patients
- Culturally diverse
- Potential for high volume referrals
- Specialties that best meet our members' needs such as providers that speak other languages

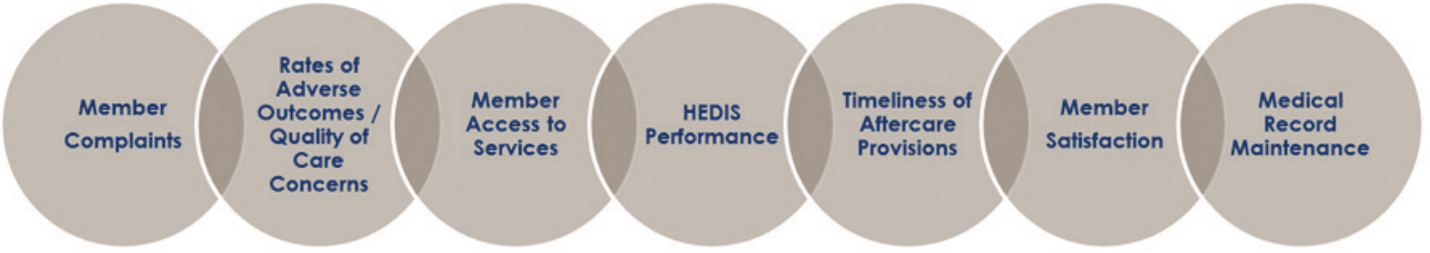
- Geographic location considering distance, travel time, means of transportation and access for members with physical disabilities

Peach State Health Plan does not require providers to sign exclusive agreements as a condition of contracting. Additionally, we have no stipulations in our agreements requiring providers to participate in multiple product lines. If you have questions or need additional clarification regarding this policy, please contact the Network Manager.

Peach State Health Plan does not use incentives to promote barriers to care and services. Peach State Health Plan will not make decisions regarding hiring, promoting, or terminating providers based upon the likelihood, or perceived likelihood, that the individual will support, or tend to support, the denial of benefits. Peach State Health Plan employees, medical directors, and clinical consultants who conduct utilization management (UM) activities are compensated through hourly fees or salaried positions. Peach State Health Plan does not permit or provide compensation, bonuses, or incentives to employees or agents based on Per Member Per Month (PMPM) data, the amount of volume of adverse determinations, reductions or limitations on inpatient days or lengths of stay, benefits, services, or frequency of contacts with healthcare providers or patients. UM decision making is based on the appropriateness of care and service, and existence of coverage.

Provider Performance

Peach State Health Plan monitors provider performance to ensure quality care is provided to Peach State Health Plan members. Peach State Health Plan's Quality Improvement team evaluates provider performance on the following indicators:



If at any time a provider demonstrates negative trends in member complaints, adverse outcomes/quality of care concerns, and/or member access rates, Peach State Health Plan's Quality Improvement team advises the Peach State Health Plan Peer Review committee of the need to review the findings. Upon recommendation from the committee, Peach State Health Plan may issue a corrective action plan (CAP) for any provider not meeting performance standards. The CAP is monitored by the Quality Improvement team and evaluated by the Peer Review committee. Peach State Health Plan adopts a collaborative approach to the development and maintenance of provider CAPs and provides technical assistance to providers. Failure to comply with the CAP and demonstrate adherence to CAP items could result in further compliance action, up to and including termination from the Peach State Health Plan network.

Provider Access & Density Standards

Peach State Health Plan must ensure provider accessibility is maintained to ensure compliance with established standards of coverage for members throughout the state. The following standards have been established by Peach State Health Plan for the State of Georgia:

Provider	Access Standard
Outpatient Behavioral Health Practitioners	Urban/Suburban: 1 provider within 30 miles Rural: 1 provider within 45 miles
Inpatient Providers	Urban/Suburban: 1 provider within 30 miles Rural: 1 provider within 45 miles

Peach State Health Plan Medicaid members may access behavioral health and substance use disorder services through several mechanisms. Members do not need a referral from their primary care provider (PCP) to access covered behavioral health or substance abuse services. Caregivers or medical consenters may self-refer members for behavioral health services. Assessments for behavioral health services do not require an authorization or approval from Peach State Health Plan

Peach State Health Plan adheres to National Committee for Quality Assurance (NCQA) and state accessibility standards for member appointments. Providers are expected to meet and maintain compliance with the state's wait times for appointments with Medicaid Covered Persons as set forth herein, or as otherwise amended by the state. Providers must make every effort to assist Peach State Health Plan in providing appointments within the provided timeframes.

Network providers must ensure that services provided are available on a basis of twenty-four (24) hours a day, seven (7) days a week, as the nature of the member's behavioral health condition dictates. Network providers will offer hours of operation that are no less than the hours of operation offered to commercial insurance enrollees, and shall ensure members with disabilities are afforded access to care by ensuring physical and communication barriers do not inhibit members from accessing services.

- Routine Care: within within 10 business days
- Urgent Care: within 48 hours
- Emergency Care immediately, on a twenty-four (24) hour basis, seven (7) days a week:
- Discharge (from hospital/acute care): within seven (7) days of discharge

Network providers should call the Provider Relations department at (800) 874-0633 if they are unable to meet these access standards on a regular basis. Please note that the repeated inability to accept new members or meet the access standards can result in suspension and/or termination from the network. All changes in a network provider's status will be considered in the re-credentialing process.

TRANSPORTATION SERVICES

To arrange transportation for a Medicaid or PeachCare for Kids® member, the member should contact the Non-Emergency Transportation (NET) vendor that services the member's home county.

Urgent same day or next day transportation is available for an acute sick visit to the primary care provider (PCP) or urgent care center, or if discharged from the hospital. In situations where urgent transportation is needed and cannot be coordinated with the NET vendor in a timely fashion, Member Services Representatives will coordinate transportation arrangements.

NET regions and contact information:

Region	Contact Number	Vendor Name
Atlanta	404-209-4000	Southeastrans
Central	1-888-224-7981	LogistiCare
Southwest	1-888-224-7985	LogistiCare
North	1-866-388-9844	Southeastrans
Southeast/East	1-888-224-7988	LogistiCare

PeachCare for Kids® provides transportation for members in all of the six regions. Call Southeastrans at 1-800-657-9965 at least 3 days before your appointment to schedule transportation. Urgent same day or next day transportation is available for acute sick visit to primary care provider (PCP) or urgent care center, or if discharged from the hospital.

Provider Credentialing

Providers are required to be registered on the CAQH (Council for Affordable Quality Healthcare) portal in order to be considered for participation in the Peach State Health Plan Network. All provider information should be current and in an active status. If you are not registered, please complete the registration process online at www.caqh.org.

The Credentialing Verification Organization (CVO) will streamline the credentialing process. The CVO team will review all supporting documents for accuracy. Upon verification of the information submitted and completion of the credentialing process, the CVO Credentialing Committee will notify Peach State Health Plan of their final decision on the provider's credentialing status. To initiate the application process to join the Provider Network, please visit www.pshp.com and go to "Join Our Network."

Credentialing

Providers must submit, at a minimum, the following information when applying for participation with Peach State Health Plan:

- Complete, signed, and dated Standardized Credentialing Application or CAQH (Council for Affordable Quality Healthcare) application
- Signed attestation of the correctness and completeness of the application, history of loss of license and/or clinical privileges, disciplinary actions, and/or felony convictions; lack of current illegal substance registration and/or alcohol abuse; mental and physical competence, and ability to perform the essential functions of the position, with or without accommodation
- Copy of current malpractice insurance policy fact sheet that includes expiration dates, amounts of coverage and provider's name, or evidence of compliance with state regulations regarding malpractice coverage
- Copy of current Drug Enforcement Administration (DEA) registration certificate, if applicable
- Copy of W-9
- Copy of current unrestricted license to practice in the state of Georgia
- Current copy of specialty/board certification certificate, if applicable
- Curriculum vitae listing, at a minimum, a five-year work history with any gaps in employment clearly addressed
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Completed Provider Specialty Profile
- Centers for Medicare & Medicaid Services (CMS) Disclosure form

- Signed and dated release of information form.
- Copy of enumeration letter issued by NPPES (National Plan and Provider Enumeration System), depicting the providers' unique National Provider Identifier (NPI).

Facilities must submit at a minimum the following information when applying for participation with Peach State Health Plan:

- List of current professional Mental Health/Chemical Dependency staff privileged to admit and/or treat patients in your facility (include license type, address, telephone numbers, dates of birth, and Social Security numbers
- Copy of The Joint Commission/CARF/COA/AOA accreditation letter with dates of accreditation
- Copy of the state or local license(s) and/or certificate(s) under which the facility operates
- Copy of Clinical Laboratory Improvement Amendments (CLIA), if applicable
- Copy of current Drug Enforcement Administration (DEA) registration certificate, if applicable
- Copy of professional and general liability insurance policy with the limits of coverage per occurrence and in aggregate, name of liability carrier, and insurance effective date and expiration date (Month/Day/Year)
- Listing of satellite locations and services offered at each location (include copies of accreditation, license, insurance, CLIA, and DEA certificate, if applicable)
- Copy of Credentialing Procedures
- Centers for Medicare & Medicaid Services (CMS) Disclosure form
- Facilities contracted under as a Comprehensive Medicaid Provider and a Specialty Provider must submit a copy of their contract with the Department of Behavioral Health and Developmental Disabilities.
- Facilities contracted under a Peach State Health Plan Facility Agreement that list a rendering NPI in box 24-J of the claim form that is different than the facility's billing NPI (box 33-A), must submit an electronic (Excel) roster of clinicians rendering covered services with their credentialing materials (include name, date of birth, Social Security number, NPI, Medicaid provider ID, license type, address, and telephone number)

Non-Accredited Facilities
For organizations that are not accredited and licensed, an on-site evaluation will be scheduled and conducted by the Department of Community Health (DCH) to review the scope of service available at the facility, physical plant safety, and the quality improvement program. A current center for Medicare and Medicaid Services (CMS) certificate will be accepted in lieu of a formal site visit, and can be utilized to augment the information required to assess compliance with Peach State Health Plan standards.

You must include the following in addition to the items above:

- Copy of state or local Fire/Health Certificate
- Copy of Quality Assurance Plan
- Description of Aftercare or Follow-up Program
- Organizational Charts including staff to patient ratio

Council for Affordable Quality Healthcare (CAQH)

Peach State Health Plan utilizes the CVO and CAQH to streamline the credentialing/re-credentialing process. If you are not registered, please complete the registration process online at www.caqh.org. or contact the helpdesk at 888-599-1771.

Provider Rosters

Peach State Health Plan requires a listing of rendering providers, who are employed behavioral health

professionals, to admit and/or treat patients. This list should include individual clinician names, dates of birth, Social Security numbers, NPIs, Medicaid provider IDs, license types, addresses, and telephone numbers. Peach State Health Plan will require quarterly updates to this listing to ensure accuracy. Please note that the information provided may be accessed by Peach State Health Plan for network accessibility and member referral services.

Re-Credentialing

The Credentialing Verification Organization (CVO) will perform re-credentialing for both current and new providers every three (3) years. Providers requiring re-credentialing will be notified by the Department of Community Health (DCH) at least 90 calendar days in advance of the re-credentialing due date.
If you are a current network provider belonging to more than one Care Management Organization (CMO) and have a different credentialing effective date with either plan, then your re-credentialing due date will be based on the earliest initial credentialing or re-credentialing effective date. Therefore, initial re-credentialing with the CVO may be performed earlier that the three (3) year cycle due to the transition.

Quality indicators including but not limited to, complaints, appointment availability, critical incidents, and compliance with discharge appointment reporting will be taken into consideration during the re-credentialing process.

Peach State Health Plan will verify the following information submitted for credentialing and/or re-credentialing:

- Georgia License through appropriate licensing agency
- Board certification, residency training, or medical education
- National Practitioner Data Bank (NPDB) and HIPDB claims
- Five years of work history
- Federal sanction activity including Medicare/Medicaid services (OIG-Office of Inspector General and EPLS – Excluded Parties List System)

Once the application is completed, the CVO and the Credentialing Committee will render a final decision on acceptance following its next regularly scheduled meeting.

It is the provider's responsibility to notify Peach State Health Plan of any of the following within ten (10) days of the occurrence:

- Any lawsuits related to professional role
- Licensing board actions
- Changes to NPI and TIN
- Malpractice claims or arbitration
- Disciplinary actions before a state agency and Medicaid/Medicare sanctions
- Cancellation or material modification of professional liability insurance
- Member complaints against practitioner
- Changes in fiscal address and/or billing address
- Any situation that would impact a provider's ability to carry out the provisions of their formal Written Agreement with Peach State Health Plan ("Agreement"), including the inability to meet member accessibility standards. Changes or revocation with DEA certifications, hospital staff changes, or NPDB or Medicare sanctions.

Site Visits

Any entity executing a Facility Agreement will require an accreditation from The Joint Commission (JCAHO)/ Commission on Accreditation of Rehabilitation Facilities (CARF)/Council on Accreditation (COA). In the event such entity is not accredited, a site visit will be required as a component of the credentialing process. Failure to pass the site visit will result in the facility being ineligible to participate in the Peach State Health Plan network, in which case the provider will be notified.

Additionally, providers may also have a site visit conducted by a Peach State Health Plan representative as part of the credentialing/re-credentialing process. Failure to pass the site visit may result in a Corrective Action Plan (CAP) that must be satisfied before being considered for admission to the network. Providers are subject to an on-site visit at any time with or without cause.

Peach State Health Plan reserves the right to conduct provider site visit audits. Site visits may be conducted as a result of member dissatisfaction, or as part of a chart audit. The site visit auditor reviews the quality of the location where care is provided and will evaluate the accessibility and adequacy of the treatment and waiting areas.

Provider Verification

Provider's state identification information, license, TIN, legal entity name, Doing Business As (D.B.A.) and other pertinent information must be valid and verified with the Department of Community Health. Any discrepancies between the provider information and the state file must be validated by the provider and the state.

National Provider Identifier (NPI)

A National Provider Identifier, or NPI, is a unique 10-digit identification number issued to healthcare providers in the United States by the Centers for Medicare and CMS. The NPI has replaced the unique provider identification number (UPIN) as the required identifier for Medicare services, and is used by other payers, including commercial healthcare insurers. The transition to the NPI was mandated as part of the Administrative Simplifications portion of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The NPI number can be obtained online through the National Plan and Provider Enumeration System (NPPES) pages on CMS's website. Turnaround time for obtaining a number is from one to 20 days.

Medicaid Number

Providers are required to obtain a Medicaid Number in order to provide covered services for a Medicaid product. This Medicaid number can be obtained through the state Medicaid office by calling (800) 766-4456. Peach State Health Plan will verify this information before contracting. All provider information on file with the Georgia Department of Community Health will be utilized for authorization of covered Medicaid services and claims payment.

Medicare Number

Providers are required to obtain a Medicare number in order to provide covered services for Medicare. For additional information, please contact CMS and Medicare Provider Enrollment at (855) 696-0705. All provider information on file with CMS will be utilized for authorization of covered Medicare services and claims payment. Please note that Peach State Health Plan will verify this information via CMS.

Right to Review and Correct Information

Should a provider receive a denial for participation from CVO, you may have a right to appeal. The notification from DCH will outline in detail the appeal process. You can also email your questions/concerns to Georgia Medicaid at cvo.dch@dch.ga.gov or contact your local HP Provider Relations representative at 1-800-766-4456. If additional assistance is needed, please visit www.mmis.ga.gov

All providers participating with the Peach State Health Plan Network have the right to review the information obtained by Peach State Health Plan to evaluate their credentialing/re-credentialing application. This includes information obtained from any outside primary sources such as the National Practitioner Data Bank – Healthcare Integrity and Protection Data Bank, malpractice insurance carriers and the Composite State Board of Medical Examiners and other state board agencies. Providers do not have the right to review references, personal recommendations, or other information that is peer review protected.

Providers have the right to correct any information submitted by another party should he or she believe any of the information used in the credentialing/re-credentialing process to be erroneous, or should any information gathered as part of the primary source verification process differ from that submitted by a provider. To request release of such information, a written request must be submitted to the Peach State Health Plan Credentialing Department. Providers will have fourteen (14) calendar days following receipt of the requested information to provide a written explanation detailing the error. The Peach State Health Plan Credentialing Committee will then include this information as part of the credentialing/re-credentialing process.

Status Change Notification

Providers must notify Peach State Health Plan immediately of:

- Any change in licensure and/or certifications that are required under federal, state, or local laws for the provision of covered behavioral health services to members,
- A change in the provider's hospital privileges, or
- A change in panel status (open/closed panel).

All changes in a provider's status will be considered in the re-credentialing process. Please call 1-866-874-0633 to notify Peach State Health Plan of a status change.

Provider Demographic/Information Updates

Providers should provide Peach State Health Plan with as much advance notice as possible of any demographic/information updates. Provider information such as address, phone numbers and office hours is used in our provider directory, and having the most current information accurately reflects our provider network. Please use the Provider Change Form located at www.pshp.com/providerresources to notify us of any changes.

Please notify Peach State Health Plan immediately of any updates to your Tax Identification Number (TIN), service site address, phone/fax number, or ability to accept new referrals in a timely manner so that our systems are current and accurately reflect your practice. In addition, we ask that you please respond to any questionnaires or surveys submitted regarding your referral demographics.

Referral Periods

Providers are required to notify Peach State Health Plan when they are not available for appointments. Providers may place themselves in a "no referral" hold status for a set period of time without jeopardizing

their overall network status. Providers must call or write to the Peach State Health Plan Provider Relations department to set up a "no referral" period. Providers must have a start date and an end date indicating when they will be available again for referrals.

A "no referral" period will end automatically on the set end date. "No referral" is set up for providers for the following listed reasons.

- Vacation
- Full practice
- Personal leave
- Other personal reasons

The Peach State Health Plan Provider Relations department can be reached at 866-874-0633.

Reporting and Metric Requirements

Providers may be required to submit timely to Peach State Health Plan reports or performance metrics as required by Peach State Health Plan's contract with the Department of Community Health, and/or Peach State Health Plan's requirements for NCQA accreditation. Such metrics shall include, but are not limited to: provider rosters by service location; compliance rates with timely ambulatory follow-up after a hospitalization; average number of days to receive an emergent appointment; average number of days to receive a routine appointment; network adequacy and similar measures. Peach State Health Plan and providers shall work together to find solutions when performance standards are not met.

Network Suspension and Termination

New applicants who are declined participation in the Peach State Health Plan Network have the right to request a reconsideration of the decision in writing within fourteen (14) calendar days of formal notice of denial. All written requests should include additional supporting documentation in favor of the applicant's reconsideration for participation. Reconsiderations will be reviewed by the Credentialing Committee at the next regularly scheduled meeting, no later than sixty (60) days from the receipt of the additional documentation. The applicant will be sent a written response to his/her request within two (2) weeks of the final decision.

If a network provider has been suspended or terminated by Peach State Health Plan, he/she may contact the Provider Relations department at 866-874-0633 to request further information or discuss how to appeal the decision.

For a formal appeal of the suspension or termination of contract privileges, the provider should send a written request. Please note that the written request should describe the reason(s) for the request and include any supporting documents. To comply with the appeal process, the request must be postmarked within thirty (30) days from the receipt of the suspension or termination letter. Peach State Health Plan will use the Provider Dispute Policy to govern its actions. Details of the Provider Dispute Policy will be provided to the provider with the notification of suspension/termination, or you may request a copy by calling 866-874-0633.

Provider Request to Terminate

Providers requesting to terminate from the network must adhere to the termination provisions set forth in their agreement with Peach State Health Plan. This notice can be mailed or faxed to the Provider Relations department. The notification will be acknowledged by Peach State Health Plan in writing and the provider

will be advised on procedures for transitioning members if indicated.

Peach State Health Plan fully recognizes that a change in a provider's participation status in Peach State Health Plan's provider network is difficult for members. Peach State Health Plan will work closely with the terminating provider to address the member's needs and ensure a smooth transition as necessary. A provider who terminates his/her contract with Peach State Health Plan must notify all Peach State Health Plan members who are currently in care at the time and who have been in care with that provider during the previous six (6) months. Treatment with these members must be completed or transferred to another Peach State Health Plan provider within three (3) months of the notice of termination, unless otherwise mandated by state law. The provider needs to work with the Peach State Health Plan Care Management Department to determine which members might be transferred, and which members meet Continuity of Care Guidelines to remain in treatment.

For a formal appeal of the suspension or termination of contract privileges, the network provider should send a written request to Peach State Health Plan to the attention of the Compliance Department:

Peach State Health Plan
Administrative Review
1100 Circle 75 Pkwy, Suite 1100
Atlanta, GA 30339

Peach State Health Plan's Right to Terminate

Please refer to your agreement with Peach State Health Plan for a full disclosure of causes for termination. As stated in your agreement, Peach State Health Plan shall have the right to terminate the agreement by giving written notice to the provider upon the occurrence of any of the following events:

- Termination of Peach State Health Plan's obligation to provide or arrange mental health/substance use disorder services for members;
- Restriction, qualification, suspension or revocation of provider's license, certification or membership on the active medical staff of a hospital or Peach State Health Plan participating provider group;
- Provider's loss of liability insurance required under the agreement with Peach State Health Plan;
- Provider's exclusion from participation in Peach State Health Plan programs;
- Provider's exclusion from participation in the Medicare or Medicaid program;
- Provider's insolvency or bankruptcy, or provider's assignment for the benefit of creditors;
- Provider's conviction, guilty plea, or plea of nolo contendere to any felony or crime involving moral turpitude;
- Provider's ability to provide services has become impaired, as determined by Peach State Health Plan, at its sole discretion;
- Provider's submission of false or misleading billing information;
- Provider's failure or inability to meet and maintain full credentialing status with Peach State Health Plan
- Provider's breach of any term or obligations of the agreement;
- Any occurrence of serious misconduct which brings Peach State Health Plan to the reasonable interpretation that a provider may be delivering clinically inappropriate care; or
- Provider's breach of Peach State Health Plan Policies and Procedures.

Discontinuation

A provider may be discontinued if required elements and prime source verification cannot be obtained by Peach State Health Plan. An application may be discontinued if it meets the following criteria:

1. Provider non-responsive to three (3) Provider Data Management outreach attempts for missing or

incomplete items

2. The application has exceeded thirty (30) days from receipt of initial documentation

Prior to discontinuing any provider application, Peach State Health Plan will notify the provider of its intent to discontinue. The provider will then have five (5) business days to respond with the required items for provider application completion. If the application has been discontinued, the applicant is notified in writing that their application will not be processed. This written notification includes the reason for the determination. Following notification, the applications and documentation submitted to Peach State Health Plan will be destroyed in accordance with NCQA standards.

Provider Education & Training

Peach State Health Plan makes outreach to new providers, groups, and facilities to offer an initial orientation within thirty (30) calendar days of being placed on active status. Additional trainings are provided, upon request, to all providers and their staff regarding the requirements of their contract and special needs of the enrollees. Peach State Health Plan shall also conduct ongoing trainings, as deemed necessary by Peach State Health Plan or the Georgia Department of Community Health, in order to ensure compliance with program standards and their contract. Peach State Health Plan will post information, updates, bulletins, and other pertinent information on its website.

Clinical Training

In support of quality services to members, Peach State Health Plan will offer a variety of clinical training opportunities to providers. The Clinical Training program is committed to achieving the following goals:

- Promote provider competence and opportunities for skill-enhancement
- Promote Recovery & Resiliency
- To sustain and expand the use of Evidence Based practices (e.g., Cultural Competency, Motivational Interviewing, Integrated Healthcare, Mental Health First Aid, Substance Use Overview, SBIRT)
- To assist in providing at least two (2) hours annually to all CHB staff related to suicide risk assessment, prevention and post-venation strategies

Clinical trainings for providers will be offered at various times throughout the year. Network providers can also contact Peach State Health Plan to request additional clinical trainings or topics specific to your organization. Clinical trainings may be offered live or in a webinar format.

Electronic Transactions & Functionality

Our provider website allows providers and office staff access to key information at their convenience, 24 hours a day / 7 days a week. Providers may register to gain access to secure functionality which includes:

- Member eligibility verification
- Electronic Professional and Institutional claims submission and status checks
- Authorization requests and status inquiries
- Training information
- Claim adjustments
- Online EOPs
- Email
- Downloadable forms and important links

Peach State Health Plan distributes its Member Rights and Responsibilities to members and providers upon enrollment and annually thereafter. They can also be found on our website.

Electronic Claims Submission

In the best interests of our providers, state clients, and our own internal operations, Peach State Health Plan's preferred mechanism for claim submission is through Electronic Data Interchange (EDI). An electronically filed claim leads to a faster, more accurate process; allows the use of the information sooner in care of our members; and is better for our environment. Our experiential data shows that when providers prepare and submit claims electronically, the time from service to submission to Peach State Health Plan is abbreviated by more than half the time compared to claims submitted on paper. This means that we obtain the data earlier, can process the claim faster, our Case Managers can utilize the information sooner in the care of our members, and we can display the information sooner to our providers. Our technology allows us to validate much of the data submitted at the earliest possible stage in the process, which results in more accurate and complete data received.

We do recognize that provider capabilities related to submitting electronic claims vary based on a provider's technological support and expertise. We also recognize smaller providers face unique challenges. This is why we support a growing variety of online, EDI, and Electronic Funds Transfer (EFT) for claim payment options so each provider can select the best approach for their practice.

Peach State Health Plan's network providers may choose to submit their claims through a clearinghouse and accepts EDI transactions through the following vendors;

Trading Partner	Payer ID	Contact Number
Change Healthcare	68050	(800) 845-6592
Relay Health/McKesson	68051	(800) 527-8133
Capario/Proxy Med	68052	(800) 792-5256

Direct Data Entry (DDE) Claim Form

Our website allows for the HIPAA compliant entry of individual professional and institutional claims via form templates directly through our provider portal at provider.pshpgeorgia.com. When claims are submitted utilizing this interactive template on our portal, the data goes through the same rigor for data and field validation as do HIPAA 837 transactions.

When a provider submits a professional claim via our online Direct Data Entry (DDE) form, we will receive and process the claim within two (2) business days of receipt, providing a status of paid, denied, or pended along with the corresponding reason codes and descriptions. Payments and denials will be received on the next check run and pends will be routed appropriately and finalized within required timelines. This method of claims filing (along with any other electronic form of claims submission) reduces paper and improves the timeliness of claims data, as well as provides the obvious direct benefit to the submitting provider. This service level is made possible through the integration of our provider portal, EDIFECS, and AMISYS Advance, our core claims processing system.

Claim Adjustments and Additional Claim Information

Providers can submit claim adjustments and additional information electronically on our provider website, such as an Explanation of Benefit (EOB) from another insurance carrier further ensuring that claim submissions are complete. The ability to submit this information electronically enables faster overall turnaround time (TAT) in claim adjudication and payment.

HIPAA 837 Batch Claims

Peach State Health Plan supports the online submission of Health Insurance Portability and Accountability Act, (HIPAA) 837 batch claims directly through our provider website. Supporting this feature is our EDICECS Ramp Manager tool which facilitates the process for EDI on-boarding. EDICECS Ramp Manager is an interactive tool that allows providers to test their EDI transactions directly with us and, once approved, certify them for direct submission of HIPAA 5010 claim transactions to us. EDIFECS Transaction Manager,

another component of our EDIFECS system, will allow Peach State Health Plan to continuously monitor provider EDI submission patterns which help to ensure consistent levels of EDI service. Beyond claim and remit transactions, providers connecting directly via EDI will receive direct assistance from our EDI Help Desk to implement the broader HIPAA transaction set, including 270/271 Eligibility Inquiry and Response; the 276-277 Claim Status Inquiry and Response; the 278 Service Authorization Request and Response; and (for providers sufficiently equipped) HL7 based transactions, such as the Continuity of Care Document (CCD) and Scheduling Interface Unsolicited (SIU) for collaborative scheduling.

HIPAA 837 Professional & Institutional EDI Claims

Peach State Health Plan supports over 60 trading partners across 13 states who file HIPAA 837 EDI claims on behalf of our providers. In fact, we will accept claims from any clearinghouse that meets our performance and service quality standards and can implement our HIPAA companion guides.

Electronic Funds Transfer (EFT)

Like EDI claims submissions, Electronic Funds Transfer (EFT) via the Automated Clearinghouse (ACH) affords both our providers and PSHP administrative and financial efficiencies, and we actively encourage our providers to sign up for PaySpan Health, the EFT option we offer. To initiate EFT directly with Peach State Health Plan, complete an EFT Agreement. Upon acceptance, Peach State Health Plan will deposit payment for claims directly into the assigned bank account.

To register with PaySpan:

- Access the PaySpan website at www.payspanhealth.com and select "Register Now".
- A registration code is needed.
- To generate a registration code, select "Request a Registration Code" from the "New Enrollment" screen, input the requested information and select " Peach State Health Plan " from the "Affected Payer" drop down box.
- The enrollment process takes only 5-10 minutes to complete.
- You will set up a profile of your practice, specify bank accounts (multiple accounts if you desire), and specify other preferences for the management of checks, EFTs, ERAs, or online institutions of claims payment information.
- PaySpan may be reached at (877) 331-7154.

Customer Service & Standards of Care

Peach State Health Plan operates a toll-free emergency and routine Behavioral Health Services Hotline at 866-874-0633, answered by a live voice and staffed by trained personnel, Monday through Friday 8:00 a.m. – 5:00 p.m. EST. After hours services are available through the Nurse Advice Line during evenings, weekends and holidays.

The Provider Services department strives to support the mission statement in providing quality, cost-effective behavioral health services to our customers. We strive for customer satisfaction on every call by doing the right thing the first time and we show our integrity by being honest, reliable and fair.

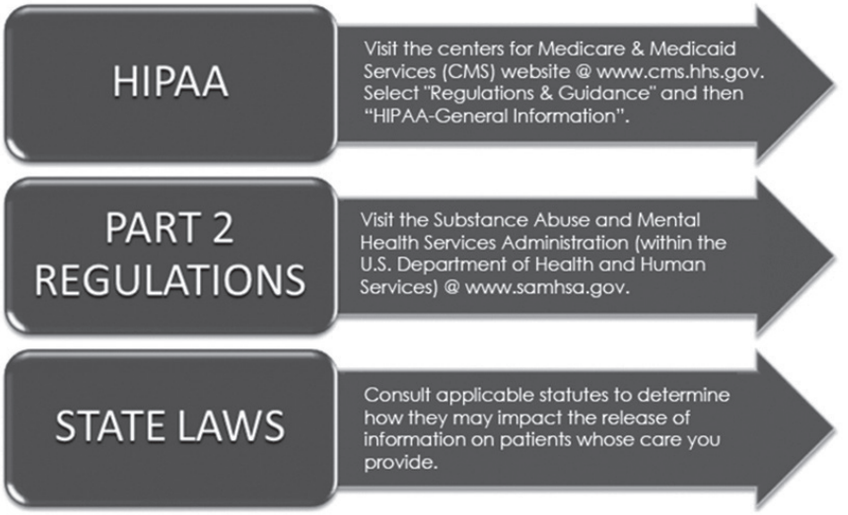
The Provider Services department's primary focus is to facilitate the authorization of covered services for members for treatment with a specific clinician or clinicians. The Provider Services department provides the member with information about providers and assists members in selecting a provider who can meet their specific needs. Licensed clinicians on staff in the Clinical department are available to provide referrals for, and assessment of, the level of urgency of a caller presenting special needs.

In addition to working with members, the Peach State Health Plan's Provider Services department assists providers with the following:
Providers may freely communicate with patients about their treatment, regardless of benefit coverage limitations.

Nurse Advice Line

Our members have many questions about their health, their primary care provider and access to emergency care. Our health plan offers a nurse triage service to encourage members to talk with their physician and to promote education and preventive care.

Nurse Advice Line is our 24-hour nurse line for members. The Registered Nurses provide basic health education, nurse triage and answer questions about urgent or emergency access, all day long.



The staff often answers questions about pregnancy and newborn care. In addition, members with chronic problems, like asthma or diabetes, are referred to case management for education and encouragement to improve their health.

Members may use the Nurse Advice Line to request information about providers and services available in your community after the health plan is closed. Providers can use it to verify eligibility any time of the day. The Nurse Advice Line staff is conversant in both English and Spanish and can offer the Language Line for additional translation services. The nurses document their calls in a web-based data system using Barton Schmitt, M.D. triage protocols for pediatrics and McKesson proprietary suite of products to perform triage services for adults. These protocols are widely used in nurse call centers and have been reviewed and approved by physicians from around the country.

We provide this service to support your practice and offer our members' access to a RN every day. If you have any additional questions, please call the Nurse Advice Line at 1-800-704-1484.

Interpretation/Translation Services

Peach State Health Plan is committed to ensuring that staff and subcontractors are educated about, remain aware of, and are sensitive to the linguistic needs and cultural differences of its members. In order to meet this need, Peach State Health Plan is committed to the following:

- Having individuals available who are trained professional interpreters for Spanish and American Sign Language, and who will be available on site or via telephone to assist providers with discussing technical, medical, or treatment information with members as needed.
- Providing free Language Line services that will be available twenty-four (24) hours a day, seven (7) days a week in 140 languages to assist providers and members in communicating with each other when there are no other translators available for the language.
- In-person interpreter services are made available when Peach State Health Plan is notified in advance of the member's scheduled appointment in order to allow for a more positive encounter between the member and provider; telephonic services are available for those encounters involving urgent/emergent situations, as well as non-urgent/emergent appointments as requested at no charge to the member.
- Providing TTY access for members who are hearing impaired through 1-800-659-7487.
- Peach State Health Plan's Nurse Advice Line provides 24 hour access, seven days a week for interpretation of Spanish or the coordination of non-English/Spanish needs via the Language Line.
- Providing or making available Peach State Health Plan Member Services and Health Education materials in alternative formats as needed to meet the needs of the members, such as audio tapes or language translation; all alternative methods must be requested by the member or designee.

Providers must call Member Services at 1-800-704-1484 if interpreter services are needed. Please have the member's ID number; date/time service is requested and any other documentation that would assist in scheduling interpreter services.

Federal and State Laws Governing the Release of Information

The release of certain information is governed by a myriad of federal and/or state laws. These laws often place restrictions on how specific types of information may be disclosed, including, but not limited to, mental health, alcohol /substance use disorder treatment and communicable disease records. For example, the federal Health Insurance Portability and Accountability Act (HIPAA) requires that covered entities, such as health plans and providers, release protected health information only when permitted under the law, such as for treatment, payment and operations activities, including care management and coordination. However, a different set of federal rules place more stringent restrictions on the use and disclosure of alcohol and substance abuse treatment records (42 CFR Part 2 or "Part 2"). These records generally may not be released without consent from the individual whose information is subject to the release. Still other laws at the state level place further restrictions on the release of certain information, such as mental health, communicable disease, etc.

Contracted providers within the Peach State Health Plan network are independently obligated to know, understand and comply with these laws. Peach State Health Plan takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable federal and/or state confidentiality and privacy law.

Please contact the Peach State Health Plan Privacy Officer by phone or in writing with any questions about

our privacy practices. Please instruct any member to contact Member Services with any questions they may have about our privacy practices.

No Show Appointments

A no show is defined as a failure to appear for a scheduled appointment without notification to the provider with at least twenty-four (24) hours advance notice. No show appointments must be recorded in the member's record. A "no show" appointment may never be applied against a member's benefit maximum. Peach State Health Plan members may not be charged a fee for a "no show" appointment.

Member Treatment Requirements

Providers are required to:

- Offer integrated behavioral healthcare by sending initial and quarterly (or more frequently if clinically indicated) summary reports of a Member's behavioral health status to the PCP, with the Member's or the Member's legal guardian's consent
- Refer members with known or suspected physical health problems or disorders to the member's PCP for examination and treatment;
- Only provide physical health services if such services are within the scope of the clinical licensure;
- All providers must ensure members that are discharging from an inpatient psychiatric or crisis stabilization unit (CSU) acute care are scheduled for outpatient follow-up and/or continuing treatment prior to discharge. The outpatient appointment must be set before discharge and must occur within seven (7) days of the member's discharge from an inpatient psychiatric setting or crisis stabilization unit;
- Contact members who have missed appointments within twenty-four (24) hours to reschedule;
- Ensure all members receive effective, understandable and respectful treatment provided in a manner compatible with their cultural health beliefs and practices and preferred language;
- Make referrals or admissions of members for covered behavioral health services only to other participating healthcare practitioners/providers (those that participate in the Peach State Health Plan or Peach State Health Plan provider network), except as the need for emergency care may require, or where Peach State Health Plan specifically authorizes the referral, or as otherwise required by law;
- Comply with all state and federal requirements governing emergency, screening and post-stabilization services; and
- Provide member's clinical information to other practitioners/providers treating the member, as necessary to ensure proper coordination and treatment of members who express suicidal or homicidal ideation or intent, consistent with state law
- Hospital provider must submit a discharge summary to Peach State Health Plan and the member's PCP within 24 hours of discharge.
- Have a crisis plan for each member seen for crisis management and avoidance of unnecessary emergency room visits..

Provider Standards of Practice

Providers are requested to:

- Submit all documentation in a timely fashion;
- Comply with Peach State Health Plan 's Utilization Management Programs;
- Cooperate with Peach State Health Plan 's QI Program (e.g., allow review of or submit requested charts, receive feedback);
- Support Peach State Health Plan 's access standards;
- Use the concept of medical necessity and evidence-based Best Practices when formulating a treatment plan and requesting ongoing care;

- Coordinate care with other clinicians as appropriate, including consistent communication with the PCP as indicated in the Peach State Health Plan QI Program;
- Assist members in identifying and utilizing community support groups and resources;
- Maintain confidentiality of records and treatment and obtain appropriate written consents from members when communicating with others regarding member treatment;
- Notify Peach State Health Plan of any critical incidents;
- Notify Peach State Health Plan of any changes in licensure, any malpractice allegations and any actions by your licensing board (including, but not limited to, probation, reprimand, suspension or revocation of license);
- Notify Peach State Health Plan of any changes in malpractice insurance coverage;
- Complete credentialing and re-credentialing materials as requested by Peach State Health Plan; and
- Maintain an office that meets all standards of professional practice.

Provider shall ensure that wait time in the provider's office do not exceed the following for pediatric and adults:

Scheduled Appointments	Waiting time shall not exceed sixty (60) minutes. After thirty (30) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.
Work-in or Walk-In Appointments	Waiting time shall not exceed ninety (90) minutes. After forty-five (45) minutes, patient must be given an update on waiting time with an option of waiting or rescheduling appointment.

Provider shall ensure that provider's response times for returning calls after-hours are as follows:

Urgent Calls	Shall not exceed twenty (20) minutes.
Other Calls	Shall not exceed one (1) hour.

Provider Office Standards

Peach State Health Plan requires the following:

- Office must be professional and secular.
- Signs identifying office must be visible.
- Office must be clean, and free of clutter with unobstructed passageways.
- Office must have a separate waiting area.
- Waiting area must have adequate seating to support the current member volume.
- Clean restrooms must be available.
- Office environment must be physically safe.
- Providers must have a professional and fully-confidential telephone line and twenty-four (24) hour availability
- Member records and other confidential information must be locked up and out of sight during the work day
- Medication prescription pads and sample medications must be locked up and inaccessible to members.

The provider's office must have evidence of the following:

- Child Abuse and HIPAA privacy posters are posted in the provider's waiting room/reception area;
- The provider has a complete copy of the Patient's Bill of Rights and Responsibilities, available upon request by a member, at each office location; and
- The provider's waiting room/reception area has a consumer assistance notice prominently displayed in the reception area.

Advance Directives

Peach State Health Plan is committed to ensuring that its members know of and are able to avail themselves of their rights to execute advance directives. Peach State Health Plan is equally committed to ensuring that its providers and staff are aware of and comply with their responsibilities under federal and state law regarding advance directives.

Providers delivering care to Peach State Health Plan members must ensure adult members 18 years of age and older receive information on advance directives and are informed of their right to execute advance directives. Providers must document such information in the permanent medical record.

Peach State Health Plan recommends to its providers that:

- The first point of contact in the provider's office should ask if the member has executed an advance directive; the member's response should be documented in the medical record.
- If the member has executed an advance directive, the first point of contact should ask the member to bring a copy of the advance directive to the PCP's office and document this request. An advance directive should be included as a part of the member's medical record, including mental health directives.
- If an advance directive exists, the physician should discuss potential medical emergencies with the member and/ or family member/significant other (if named in the advance directive and if available) and with the referring physician, if applicable. Discussion should be documented in the medical record.
- If an advance directive has not been executed, the first point of contact within the office should ask the member if they desire more information about advance directives. You may obtain a copy online at www.aging.dhr. georgia.gov.
- If the member requests further information, member advance directive education/information should be provided.
- Community Health Services representatives will assist members with questions regarding advance directives; however, no employee of Peach State Health Plan may serve as witness to an advance directive, or as a member's designated agent or representative.

If you have any questions regarding advance directives contact:

Provider Services Department
1-866-874-0633
www.pshp.com

If the member feels the advance directive is not being followed, they may file a complaint to:

Georgia Department of Community Health
Healthcare Facilities Regulations
2 Peachtree Street, NW
Atlanta, Georgia 30303
Toll free: 1-800-878-6442

Integrated Care

Peach State Health Plan encourages and supports collaborative efforts among primary care providers and other medical/surgical healthcare providers and mental health providers. We support whole-person healthcare because physical conditions and mental illness are not independent phenomena, and the treatment of both must be coordinated.

Physical health conditions can and often do exacerbate mental health conditions or can trigger mental health issues, such as depression following a cardiac event. Mental health conditions can and often do impact physical health conditions. For example, a person with depression may lack the motivation or energy to follow the physical therapist's recommendations for rehab after a surgery.

The treatment and medication regimens for physical and mental health conditions can interact negatively. For example, many psychotropic medications can cause weight gain, which can exacerbate metabolic syndrome or diabetes.

Even differential diagnosis can be complicated if the assessment fails to consider potential physical causes for apparent mental conditions, such as psychosis-like symptoms triggered by high liver enzymes in members with liver disease.

Communication with the Primary Care Provider

Peach State Health Plan will require Behavioral Health providers to send initial and quarterly (or more frequently if clinically necessary) summary reports of a member's behavioral health status to the PCP, with the member's or the member's legal guardian's consent. The coordination of care for a member should be clearly documented in the member's chart. Reports such as this, will be reviewed during quality audits conducted by Peach State Health Plan.
Providers can identify the name and number for a member's PCP on the front-side of the Member ID Card. Providers should refer members with known or suspected untreated physical health problems or disorders to the PCP for examination and treatment. Peach State Health Plan will monitor compliance with this requirement thru periodic provider audits. A PCP Communication form is available at www.pshp.com/providerresources for your use.
Providers are required to communicate with the member's PCP at minimum of every 90 days or whenever there is a behavioral health problem/change in treatment plan that can affect the member's medical condition or the treatment being rendered by the PCP, but also with other behavioral health clinicians who may also be providing service to the member. Examples of some of the items to be communicated include:

- Prescription medication, especially when the medication has potential side effects, such as weight gain, that could complicate medical conditions, such as diabetes;
- The member is known to abuse over-the-counter, prescription or illegal substances in a manner that can adversely affect medical or behavioral health treatment;
- The member has lab work indicating need for PCP review and consult;
- The member is receiving treatment for a behavioral health diagnosis that can be misdiagnosed as a physical disorder (panic symptoms can be confused with heart attack symptoms); and
- The member's progress toward meeting the goals established in their treatment plan.

Peach State Health Plan provides a form for your convenience in communicating with a member's PCP and other providers, which is available on the Peach State Health Plan website. Peach State Health Plan recommends that you use all means of available communication to coordinate treatment for members in your care. All communication attempts and coordination activities must be clearly documented in the member's medical record.

Peach State Health Plan requires that providers report specific clinical information to the member's PCP in order to preserve the continuity of the treatment process. With appropriate written consent from the member, it is the provider's responsibility to keep the member's PCP abreast of the member's treatment status and progress in a consistent and reliable manner. When applicable, such consent shall meet the requirements set forth in 42 CFR 2.00 et seq. If the member requests this information not be given to their

PCP, the provider must document this refusal in the member's treatment record, and if possible, the reason why.

The following information should be included in the report to the PCP:

- A copy or summary of the intake assessment
- Written notification of member's noncompliance with treatment plan (if applicable)
- Member's completion of treatment
- The results of an initial psychiatric evaluation, and initiation of and major changes in psychotropic medication(s) within fourteen (14) days of the visit or medication order
- The results of functional assessments

Caution must be exercised in conveying information regarding substance use disorders, which is protected under separate federal law. Peach State Health Plan monitors communication with the PCP and other caregivers through audits. Failure to adhere to these requirements can be cause for termination from the network.

Preventative Behavioral Health Programs

Peach State Health Plan offers preventative behavioral health programs for our members. A brief description of the programs including who is eligible to participate is listed below. Peach State Health Plan encourages you to refer your members to the programs directly when you see an unmet need. If you would like more information about the programs, or if you have suggestions as to how we can improve our preventative behavioral health programs, please contact the Provider Relations department at 866-874-0633.

Benefits, Covered Services & Authorizations

Covered Services

Peach State Health Plan shall provide a full range of medically necessary services authorized under the State Plan, and specified in the Georgia Department of Community Health (DCH) Part II Policies and Procedures for the Medicaid FFS program, CMO contract and the Georgia respective Medicaid provider manuals. Covered services include:

- Inpatient hospital services for behavioral health and substance use disorder conditions
- Outpatient hospital services for behavioral health and substance use disorder conditions
- Psychiatric Evaluation and Treatment
- Community based Acute Residential Treatment
- Crisis Intervention
- Partial Hospitalizationt
- Intensive Outpatient Treatment
- Medication Management
- Psychological Testing
- Electroconvulsive Therapy (ECT)
- Community Support Services
- Face-to-Face Case Management
- Disease Management
- Telemedicine

For a listing of service codes, limitations, and authorization requirements, please refer to the Georgia Covered Services and Authorization Guidelines located at www.pshp.com/providers/resources/behavioral-health. Providers should refer to their agreement with Peach State Health Plan to identify which services

they are contracted and eligible to provide. All services performed must be medically necessary.

Medical Records

Peach State Health Plan requires treatment records to be maintained in a manner that is current, detailed and organized and which permits effective and confidential patient care and quality review. The adopted standards facilitate communication, coordination and continuity of care and promote efficient, confidential and effective treatment. Medical records must be prepared in accordance with all applicable state and federal rules and regulations, and signed by the medical professional rendering the services. Peach State Health Plan requires the confidentiality of medical records in accordance with 42 CFR, Part 431, Subpart F. This includes confidentiality of a minor's consultation, examination, and treatment for a sexually transmissible disease in accordance with
s. 384.30(2), F.S.

Medical Record Guidelines

Peach State Health Plan requires compliance with the privacy and security provisions of the Health Insurance Portability and Accountability Act (HIPAA). Peach State Health Plan's minimum standards for provider medical record keeping practices include medical record content, medical record organization, ease of retrieving medical records, and maintaining confidentiality of patient information. The following 13 elements reflect a set of commonly accepted standards for behavioral health treatment record documentation.

1. Each page in the treatment record contains the patient's name or ID number.
2. Each record includes the patient's address, employer or school, home and work telephone numbers including emergency contacts, marital or legal status, appropriate consent forms and guardianship information, if relevant.
3. All entries in the treatment record are dated and include the responsible clinician's name, professional degree and relevant identification number, if applicable.
4. The record is legible to someone other than the writer.
5. Medication allergies, adverse reactions and relevant medical conditions are clearly documented and dated. If the patient has no known allergies, history of adverse reactions or relevant medical conditions, this is prominently noted.
6. Presenting problems, along with relevant psychological and social conditions affecting the patient's medical and psychiatric status, and the results of a mental status exam, are documented.
7. Special status situations, when present, such as imminent risk of harm, suicidal ideation or elopement potential, are prominently noted, documented and revised in compliance with written protocols.
8. Each record indicates what medications have been prescribed, the dosages of each and the dates of initial prescription or refills.
9. A medical and psychiatric history is documented, including previous treatment dates, provider identification, therapeutic interventions and responses, sources of clinical data and relevant family information. For children and adolescents, past medical and psychiatric history includes prenatal and perinatal events, along with a complete developmental history (physical, psychological, social, intellectual and academic). For patients 12 and older, documentation includes past and present use of cigarettes and alcohol, as well as illicit, prescribed and over-the-counter drugs.
10. A Diagnostic and Statistical Manual (DSM) diagnosis is documented, consistent with the presenting problems, history, mental status examination and/or other assessment data.
11. Treatment plans are consistent with diagnoses, have both objective, measurable goals and estimated

timeframes for goal attainment or problem resolution, and include a preliminary discharge plan, if applicable. Continuity and coordination of care activities between the primary clinician, consultants, ancillary providers and healthcare institutions are included, as appropriate.

12. Informed consent for medication and the patient's understanding of the treatment plan are documented.
13. Progress notes describe patient strengths and limitations in achieving treatment plan goals and objectives and reflect treatment interventions that are consistent with those goals and objectives. Documented interventions include continuity and coordination of care activities, as appropriate. Dates of follow-up appointments or, as applicable, discharge plans are noted.

Records and Documentation

Providers need to retain all books, records and documentation related to services rendered to members as required by law and in a manner that facilitates audits for regulatory and contractual reviews.

The provider will provide Peach State Health Plan, and other regulatory agencies access to these documents to ensure financial solvency and healthcare delivery capability, and to investigate complaints and grievances, subject to regulations concerning confidentiality of such information. Access to documentation must be provided upon reasonable notice for all inpatient care. This provision shall survive the termination and/or non-renewal of an agreement with Peach State Health Plan.

Record Keeping and Retention

The clinical record is an important element in the delivery of quality treatment because it documents the information to provide assessment and treatment services. You may access sample forms that providers are encouraged to use for members on the Peach State Health Plan website.

As part of our ongoing quality improvement program, clinical records may be audited to ensure the quality and consistency of provider documentation, as well as the appropriateness of treatment. Before charts can be reviewed or shared with others, the member must sign an authorization for release.

Chart Audits of member records will be evaluated in accordance with these criteria. Clinical records require documentation of all contacts concerning the member, relevant financial and legal information, consents for release/disclosure of information, release of information to the member's PCP, documentation of member receipt of the Statement of Member's Rights and Responsibilities, the prescribed medications with refill dates and quantities, including clear evidence of the informed consent, and any other information from other professionals and agencies. If the provider is able to dispense medication, the provider must conform to drug dispensing guidelines set forth in the Envolve Pharmacy Solutions (Peach State Health Plan's Pharmacy Benefit Manager) drug formulary.

Providers shall retain clinical records for members for as long as is required by applicable law. These records shall be maintained in a secure manner, but must be retrievable upon request.

Confidentiality & Privacy

Peach State Health Plan abides by applicable federal and state laws which govern the use and disclosure of mental health information and alcohol/substance use disorder treatment records.

Similarly, Peach State Health Plan's contracted providers are independently obligated to comply with

applicable laws and shall hold confidential all member records and agree to release them only when permitted by law, including but not limited to 42 CFR 2.00 et seq., when applicable.

Health Insurance Portability and Accountability Act (HIPAA)

The administrative simplification provisions of the Health Insurance Portability and Accountability Act (HIPAA), which was signed into law in 1996, require the implementation of measures to standardize electronic transactions in the healthcare industry while protecting the security and privacy of health information used or disclosed in any medium, including oral communications.

As covered entities under these regulations, network providers are obligated to comply with them and any other applicable federal/state laws governing the use and disclosure of mental health information. For more information about HIPAA, please visit the Centers for Medicare & Medicaid Services (CMS). From this CMS main page, select "Regulations and Guidance" and then "HIPAA – General Information."

Peach State Health Plan takes privacy and confidentiality seriously. We have established processes, policies and procedures to comply with HIPAA and other applicable confidentiality/privacy laws.
Please contact the Peach State Health Plan Privacy Officer by phone or in writing with any questions about our privacy practices. Please instruct any member to contact Member Services with any questions they may have about our privacy practices.

Quality Improvement

We are dedicated to providing quality services and programs to improve the lives of our members.
The Peach State Health Plan Quality Improvement (QI) program utilizes the principles of Continuous Performance Improvement (CPI). This approach allows us to implement focused, rapid improvement interventions that are data driven and member focused.

Our QI program is highly integrated with clinical services, access issues pertaining to providers and services, credentialing, utilization, member satisfaction, provider satisfaction, PCP communications, and administrative office operations, as well as Peach State Health Plan's QI program. Each key task and core process is monitored for identification and resolution of problems and opportunities for improvement and intervention.

We embrace a culture of quality across the organization. The systematic approach to the use of industry standard quality metrics allows for creative, targeted initiatives designed to continually drive performance and improve member outcomes. We are committed to providing quality care and clinically appropriate services for our members. In order to meet our objectives, providers must participate and adhere to our programs and guidelines.

Our website contains a wealth of information and we encourage you to visit www.pshpgeorgia.com/providers/quality-improvement, where you will find information about the QI program. This includes descriptions of Peach State Health Plan's clinical and service quality initiatives, and an evaluation of our performance.

Civil Rights

Peach State Health Plan provides covered services to all eligible members regardless of age, race, religion, color, disability, sex, sexual orientation, national origin, marital status, arrest or conviction, or military participation.

All medically necessary covered services are available to all members. All services are provided in the same manner to all members. All persons or organizations connected with Peach State Health Plan who refer or recommend members for services shall do so in the same manner for all members.

Monitoring Clinical Quality

Each year, and at various intervals throughout the year, Peach State Health Plan audits and measures the following:

- Access standards for care;
- Behavioral Health HEDIS Measure Performance;
- Adherence to Clinical Practice Guidelines;
- Treatment record compliance;
- Communication with PCPs and other behavioral health practitioners;
- Critical Incidents;
- Member safety;
- Member confidentiality;
- High-risk member identification, management and tracking;
- Discharge appointment timeliness and reporting;
- Re-admissions;
- Grievance procedures;
- Potential over- and under-utilization;
- Provider satisfaction;
- Member satisfaction; and
- Completion of Functional Assessments.

How Peach State Health Plan Monitors Quality

Peach State Health Plan conducts surveys and conducts initiatives that monitor quality. These activities may include any of the following:

- Provider satisfaction surveys;
- Medical treatment record reviews;
- Grievance investigation and trending;
- Review of potential over- and under-utilization;
- Member satisfaction surveys;
- Outcome tracking of treatment evaluations;
- Access to care reviews;
- Appointment availability;
- Discharge follow-up after inpatient or partial hospitalization reporting;
- Crisis response;
- Monitoring appropriate care and service;
- Provider quality profiling; and
- Outcome of functional assessments.

Provider Participation in the QI Process

Peach State Health Plan providers are expected to monitor and evaluate their own compliance with performance requirements to ensure the quality of care and service provided.

Providers are expected to meet Peach State Health Plan's performance requirements and ensure member treatment is efficient and effective by:

- Cooperating with medical record reviews and reviews of telephone and appointment accessibility;
- Cooperating with Peach State Health Plan's complaint review process;
- Participating in provider satisfaction surveys; and
- Cooperating with reviews of quality of care issues and critical incident reporting.

In addition, providers are invited to participate in Peach State Health Plan's QI committees and in local focus groups.

Member Concerns about Providers

Members who have concerns about Peach State Health Plan providers should contact Peach State Health Plan to register their concern. All concerns are investigated, and feedback is provided on a timely basis. It is the provider's responsibility to provide supporting documentation to Peach State Health Plan, if requested. Any validated concern will be taken into consideration when re-credentialing occurs, and can be cause for termination from the provider network.

Monitoring Satisfaction

Satisfaction surveys are conducted periodically by Peach State Health Plan. These surveys enable Peach State Health Plan to gather useful information to identify areas for improvement. Providers may be requested to participate in the annual survey process. The survey includes a variety of questions designed to address multiple facets of the provider's experience with our delivery system. Feedback from providers enables Peach State Health Plan to continuously improve systems, policies and procedures.

Critical Incident Reporting

A Critical Incident is defined as any occurrence which is not consistent with the routine operation of a mental health/substance use disorder provider. It includes, but is not limited to:

- Injuries to members or member advocates
- Suicide/homicide attempt by a member while in treatment
- Death due to suicide/homicide
- Sexual battery
- Medication errors
- Member escape or elopement
- Altercations involving medical interventions
- Any other unusual incident that has high risk management implications

A Critical Incident Report should be reported to Peach State Health Plan's Grievance and Appeals department. Please contact us at 866-874-0633 to start the process.

Cultural Competency

Cultural competency within the Peach State Health Plan network is defined as "a set of interpersonal skills that allow individuals to increase their understanding, appreciation, acceptance and respect for cultural differences and similarities within, among and between groups and the sensitivity to know how these differences influence relationships with members."

Peach State Health Plan is committed to the development, strengthening, and sustaining of healthy provider/ member relationships. Members are entitled to dignified, appropriate and quality care. When healthcare services are delivered without regard for cultural differences, members are at risk for sub-

optimal care. Members may be unable or unwilling to communicate their healthcare needs in an insensitive environment, reducing effectiveness of the entire healthcare process.

The Peach State Health Plan vision for culturally competent care is:

- Care is given with the understanding of, and respect for, the member's health related beliefs and cultural values
- Peach State Health Plan staff respect health related beliefs, interpersonal communication styles and attitude of the members, families and communities they serve
- Each functional unit within the organization applies a trained, tailored approach to culturally sensitive care in all member communications and interactions
- All Peach State Health Plan providers and practitioners support and implement culturally sensitive care models to Peach State Health Plan members
- The Peach State Health Plan goal for culturally sensitive care is to support the creation of a culturally sensitive behavioral health system of care that embraces and supports individual differences to achieve the best possible outcomes for individuals receiving services

Providers must ensure the following:

- Members understand that they have access to medical interpreters, signers, and TTY services to facilitate communication without cost to them
- Care is provided with consideration of the members' race/ ethnicity and language and its impact/ influence on the members' health or illness
- Office staff that routinely come in contact with members have access to, and participate in, cultural competency training and development
- The office staff responsible for data collection makes reasonable attempts to collect race and language specific member information
- Treatment plans are developed and clinical guidelines are followed with consideration of the member's race, country of origin, native language, social class, religion, mental or physical abilities, heritage, acculturation, age, gender, sexual orientation and other characteristics that may result in a different perspective or decision-making process
- Office sites have posted and printed materials in English, Spanish, or other prevailing languages within the region
- Provision of verbal and written notices to members informing them of their rights to receive language assistance services.

Health Disparity Facts

- Government-funded insurance consumers face many barriers to receiving timely care.
- Households headed by Hispanics are more likely to report difficulty in obtaining care.
- Government-funded insurance consumers are more likely to experience long wait times to see healthcare providers.
- African-American Medicaid consumers experience longer waits in emergency departments and are more likely to leave without being seen.
- Government-funded insurance consumers are less likely to receive timely prenatal care, more likely to have low birth weight babies and have higher infant and maternal mortality.
- Government-funded insurance consumers that are children are less likely to receive childhood immunizations
- Patient race, ethnicity, and socioeconomic status are important indicators of the effectiveness of healthcare
- Health disparities come at a personal and societal price.

Understanding the Need for Culturally Competent Services

Research indicates that a person has better health outcomes when they experience culturally appropriate interactions with providers. The path to developing cultural competency begins with self-awareness and ends with the realization and acceptance that the goal of cultural competency is an ongoing process. Providers should note that the experience of a member begins at the front door. Failure to use culturally competent and linguistically competent practices could result in the following:

- Member's feelings of being insulted or treated rudely
- Member's reluctance and fear of making future contact with the provider's office
- Member's confusion and misunderstanding
- Non-compliance by the member
- Member's feelings of being uncared for, looked down upon and devalued
- Parents' hesitance to seek help for their children
- Unfilled prescriptions
- Missed appointments
- Provider's misdiagnosis due to lack of information sharing
- Wasted time for the member and provider
- Increased grievances or complaints

The road to developing a culturally competent practice begins with the recognition and acceptance of the value of meeting the needs of your patients. Peach State Health Plan is committed to helping you reach this goal.

Take the following into consideration when you provide services to members:

- What are your own cultural values and identity?
- How do/can cultural differences impact your relationship with your patients?
- How much do you know about your patient's culture and language?
- Does your understanding of culture take into consideration values, communication styles, spirituality, language ability, literacy, and family definitions?

Coordination of Care

Peach State Health Plan's coordination of care process is designed to ensure the coordination and continuity of care during the movement between providers and settings. During transitions, patients with complex medical needs are at risk for poorer outcomes due to medication errors and other errors of communication among the involved providers and between providers and patients/caregivers.

Continuity of healthcare means different things to different types of caregivers, and can be of several types:

- Continuity of information, means including information from prior events in order to coordinate care that is appropriate to the patient's current circumstance.
- Continuity of personal relationships. It includes recognizing that an ongoing relationship between patients and providers is the foundation that connects care over time and bridges discontinuous events.
- Continuity of clinical management.

Inpatient Notification Process

Inpatient providers (including Crisis Stabilization Units) are required to notify Peach State Health Plan of emergent and urgent admissions (Emergency Behavioral Healthcare) following the admission.

Authorization is required to track inpatient utilization, enable care coordination, initiate discharge planning and ensure timely claim(s) payment. Emergency Behavioral Healthcare requests indicate a condition in clinical practice that requires immediate intervention to prevent death or serious harm (to the member or others) or acute deterioration of the member's clinical state, such that gross impairment of functioning exists and is likely to result in compromise of the member's safety. An emergency is characterized by sudden onset, rapid deterioration of cognition, judgment or behavior and is time limited in intensity and duration (usually occurs in seconds or minutes, rarely hours, rather than days or weeks). Thus, elements of both time and severity are inherent in the definition of an emergency.

All inpatient admissions require authorization. The number of initial days authorized is dependent on medical necessity and continued stay is approved or denied based on the findings in concurrent reviews.

Members meeting criteria for inpatient treatment must be admitted to a contracted hospital or crisis stabilization unit. Members in need of emergency and/or after hours care should be referred to the nearest participating provider for evaluation and treatment, if necessary.

The following information must be readily available for the Peach State Health Plan Utilization Manager when requesting initial authorization for inpatient care:

- Name, age, and Medicaid ID number of the member
- Diagnosis, indicators, and nature of the immediate crisis
- Alternative treatment provided or considered
- Treatment goals, estimated length of stay, and discharge plans
- Family or social support system
- Current mental status

For prior-authorizations during normal business hours, Network providers should call: -1-866-874-0633.

Outpatient Notification Process

Providers must adhere to the Covered Professional Services & Authorization Guidelines on the website when rendering services. Peach State Health Plan does not retroactively authorize treatment. Please refer to the Covered Professional Services & Authorization Guidelines to identify which services require prior authorization.

Outpatient Treatment Request (OTR)/ Requesting Additional Sessions

Depending on the services being authorized, Providers will use the appropriate Portal as described below:

- Effective March 1, 2017, providers began submitting OTRs for Outpatient Behavioral Health Services including Assertive Community Treatment and Intensive Family Intervention (IFI) services via the GA Centralized Portal: https://www.mmis.georgia.gov/portal/

Providers may call the Provider Relations department at 1-866-874-0633 to check the status of an OTR or can access via the portal. Providers should allow up to three (3) business days to process non-urgent requests.

IMPORTANT:

- The OTR must be completed in its entirety. The diagnosis as well as all other clinical information must be evident. Failure to complete an OTR in its entirety can result in authorization delay and/or denials.
- Peach State Health Plan will not retroactively certify routine sessions. The dates of the authorization request must correspond to the dates of expected sessions. Treatment must occur within the dates of

the authorization
- Failure to submit a completed OTR can result in delayed authorization and may negatively impact your ability to meet the timely filing deadlines which will result in payment denial.

Peach State Health Plan's utilization management decisions are based on medical necessity and established Clinical Practice Guidelines. Peach State Health Plan does not reimburse for unauthorized services, and each agreement with Peach State Health Plan precludes providers from balance billing (billing a member directly) for covered services with the exception of copayment and/or deductible collection, if applicable. Peach State Health Plan's authorization of covered services is an indication of medical necessity, not a confirmation of member eligibility, and not a guarantee of payment.

Guidelines for Psychological Testing

Psychological testing must be prior authorized for either inpatient or outpatient services utilizing the portal process as outlined above. Testing, with prior authorization, may be used to clarify questions about a diagnosis as it directly relates to treatment.

It is important to note that:

- All psychological testing must be requested through the Peach State Health Plan Secure Provider Portal.
- Testing is not used to confirm previous results that are not expected to change.
- A comprehensive initial assessment should be conducted by the requesting psychologist prior to requesting authorization for testing. No authorization is required for this assessment if the practitioner is contracted and credentialed with Peach State Health Plan.

Peach State Health Plan's Utilization Management Program

The Peach State Health Plan Utilization Management department's hours of operation are Monday through Friday (excluding holidays) from 8:00 a.m. to 5:30 p.m. Additionally, clinical staff is available after hours, on weekdays and on weekends to conduct clinical review or, if needed, to discuss urgent UM issues. UM staff can be reached via our toll-free number at (800) 947-0633. The Utilization Management team is comprised of qualified behavioral health professionals whose education, training and experience corresponds with the Utilization Management reviews they conduct.

Peach State Health Plan is committed to compliance with the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and the Interim Final Rule and subsequent Final Ruling. Peach State Health Plan will ensure compliance with MHPAEA requiring parity of both quantitative limits (QTLS) applied to MH/SUD benefits and non-quantitative limits (NQTLS). Peach State Health Plan administers benefits for Substance Use Disorder (SUD) and/or services for mental health conditions as designated and approved by the contract and plan benefits. MHPAE does not preempt state law, unless law limits application of the act. We support access to care for individuals seeking treatment for mental health conditions as well as substance use disorders and believe in a "no wrong door" approach. Our strategies, evidentiary standards and processes for reviewing treatment services are no more stringent than those in use for medical/surgical benefits in the same classification when determining to what extent a benefit is subject to NQTLs.

The Utilization Management program strives to ensure that:

- Member care meets Peach State Health Plan's medical necessity criteria
- Treatment is specific to the member's condition, is effective and is provided at the least restrictive, most clinically appropriate level of care
- Services provided comply with Peach State Health Plan's quality improvement requirements
- Utilization management policies and procedures are systematically and consistently applied
- Focus for members and their families centers on promoting resiliency and hope

Peach State Health Plan's utilization review decisions are made in accordance with currently accepted behavioral healthcare practices, taking into account special circumstances of each case that may require deviation from the norm stated in the screening criteria. Peach State Health Plan's medical necessity criteria are used for the approval of medical necessity. Plans of care that do not meet medical necessity guidelines are referred to a licensed physician advisor or psychologist for review and peer to peer discussion.

Peach State Health Plan conducts utilization management in a timely manner to minimize any disruption in the provision of behavioral healthcare services. The timeliness of decisions adheres to specific and standardized timeframes yet remains sufficiently flexible to accommodate urgent situations. Utilization Management files includes the date of receipt of information and the date and time of notification and resolution.

Peach State Health Plan's Utilization Management department is under the direction of our licensed Medical Director or physician designee(s). The Utilization Management staff regularly confers with the Medical Director or physician designee on any cases where there are questions or concerns.

The Utilization Management's decision making process is based on appropriateness of care and service and existence of coverage. Peach State Health Plan does not specifically reward practitioners or other individuals for issuing denials of coverage or services. Financial incentives for UM decision makers do not encourage decisions that result in under-utilization.

Medical Necessity

Member coverage is not an entitlement to utilization of all covered benefits, but indicates services that are available when medical necessity criteria are satisfied. Member benefit limits apply for a calendar year regardless of the number of different behavioral health practitioners providing treatment for the member.

Peach State Health Plan uses Interqual criteria for mental health for both adult and pediatric guidelines. Interqual is a nationally recognized instrument that provides a consistent, evidence-based platform for care decisions and promotes appropriate use of services and improved health outcomes. Peach State Health Plan utilizes the American Society of Addiction Medicine Patient Placement Criteria (ASAM) for substance abuse medical necessity criteria.

ASAM and the Interqual criteria sets are proprietary and cannot be distributed in full; however, a copy of the specific criteria relevant to any individual need for authorization is available upon request. ASAM and Interqual criteria are reviewed on an annual basis by the Peach State Health Plan Provider Advisory Committee that is comprised of network providers as well as Peach State Health Plan clinical staff.

Peach State Health Plan is committed to the delivery of appropriate service and coverage, and offers no organizational incentives, including compensation, to any employed or contracted UM staff based on the quantity or type of utilization decisions rendered. Review decisions are based only on appropriateness of care and service criteria, and UM staff are encouraged to bring inappropriate care or service decisions to the attention of the Medical Director.

Concurrent Review

Peach State Health Plan's Utilization Management department will concurrently review the treatment and status of all members in inpatient (including crisis stabilization units) and partial hospitalization settings

through contact with the member's attending physician or the provider's Utilization and Discharge Planning departments. The frequency of review for all higher levels of care will be determined by the member's clinical condition and response to treatment. The review will include evaluation of the member's current status, proposed plan of care and discharge plans.

Notice of Adverse Benefit Determination

When Peach State Health Plan determines that a specific service does not meet criteria and will therefore not be authorized, Peach State Health Plan will submit a written notice of adverse benefit determination (or, denial) notification to the rendering network provider and the member. The notification will include the following information/ instructions:

- The reason(s) for the proposed adverse benefit determination in clearly understandable language.
- A reference to the criteria, guideline, benefit provision, or protocol used in the decision, communicated in an easy to understand summary. A statement that the criteria, guideline, benefit provision, or protocol will be provided upon request.
- Information on how the provider may contact the Peer Reviewer to discuss decisions and proposed adverse benefit determinations. When a determination is made where no peer-to-peer conversation has occurred, the Peer Reviewer who made the determination (or another Peer Reviewer if the original Peer Reviewer is unavailable) will be available within one (1) business day of a request by the treating provider to discuss the determination.
- Instructions for requesting an appeal including the right to submit written comments or documents with the appeal request, the member's right to appoint a representative to assist them with the appeal, and the timeframe for making the appeal decision.
- Instructions for requesting an expedited appeal for all urgent precertification and concurrent review of clinical adverse decisions.
- The right to have benefits continue pending resolution of the appeal, how to request that benefits be continued, and the circumstances under which the member may be required to pay the costs of these services.

Peer Clinical Review Process

If the Utilization Manager is unable to certify the requested level of care based on the information provided, they will initiate the peer review process.

For both mental health and chemical dependency service continued stay requests, the physician or treating practitioner is notified about the opportunity for a telephonic peer-to-peer review with the Peer Reviewer to discuss the plan of treatment. The Peer Reviewer initiates at least three (3) telephone contact attempts within twenty-four (24) hours prior to issuing a clinical determination. All attempts to reach the requestor are documented in the Utilization Management Record.

When a determination is made where no peer-to-peer conversation has occurred, a provider can request to speak with the Clinical Consultant who made the determination within one (1) business day.

The Peer Reviewer consults with qualified board certified sub-specialty psychiatrists when the Peer Reviewer determines the need, when a request is beyond his/ her scope, or when a healthcare practitioner provides good cause in writing. As a result of the Peer Clinical Review process, Peach State Health Plan makes a decision to approve or deny authorization for services. Treating practitioners may request a copy of the medical necessity criteria used in any denial decision. Copies of the Peach State Health Plan medical necessity criteria are available on our website. If you would like a paper copy of the criteria, contact Provider Services.

The treating practitioner may request to speak with the Peer Reviewer who made the determination after any denial decision. If you would like to discuss a denial decision, contact Peach State Health Plan.

Appeals Process

For cases where authorization has been denied because the case does not meet the necessary criteria, the appeals process, described in your denial letter is the appropriate means of resolution. Please send appeals request to:

Peach State Health Plan
Attn: Appeals Department
12515-8 Research Blvd, Suite 400
Austin, TX 78759
Fax: 866-714-7991

Discharge Planning

Follow-up after hospitalization is one of the most important markers monitored by Peach State Health Plan in an effort to help members remain stable and to maintain treatment compliance after discharge. Follow-up after discharge is monitored closely by the National Committee for Quality Assurance (NCQA), which has developed and maintains the Health Plan Employer Data and Information Set (HEDIS). Even more importantly, increased compliance with this measure has been proven to decrease readmissions and helps minimize no-shows in outpatient treatment.

While a member is at an inpatient provider receiving acute care services, Peach State Health Plan's Utilization Managers and Case Managers work with the provider's treatment team to make arrangements for continued care with outpatient providers. Every effort is made to collaborate with the outpatient provider to assist with transition back to the community and a less restrictive environment as soon as the member is stable. Discharge planning should be initiated upon admission.

Prior to discharge from an inpatient setting, an ambulatory follow-up appointment must be scheduled with a licensed behavioral health clinician to occur within seven (7) calendar days after discharge. Peach State Health Plan's Care Coordination and Case Management staff follow-up with the member prior to this appointment to remind him/her of the appointment. If a member does not keep his/her outpatient appointment after discharge, Peach State Health Plan asks that providers inform the health plan as soon as possible. Upon notification of a no-show, Peach State Health Plan's Care Coordination staff will follow up with the member and assist with rescheduling the appointment and provide resources as needed to ensure appointment compliance.

Psychotropic Medications

Peach State Health Plan will monitor psychotropic medication usage in partnership with Envolve Pharmacy Solutions to identify any medications for physical conditions prescribed by psychiatric practitioners as well as to review psychotropic medications prescribed by primary care providers (PCPs).

A comprehensive evaluation to include a thorough health history, psychosocial assessment, mental status exam, and physical exam should be performed before beginning treatment for a mental or behavioral disorder.

The role of non-pharmacological interventions should be considered before beginning a psychotropic medication, except in urgent situations such as suicidal ideation, psychosis, self-injurious behavior,

physical aggression that is acutely dangerous to others, severe impulsivity endangering the member or others, or when there is marked disturbance of psycho-physiological functioning (such as profound sleep disturbance), marked anxiety, isolation, or withdrawal.

Continuity of Care

When members are newly enrolled and have been previously receiving behavioral health services, Peach State Health Plan will continue to authorize care as needed to minimize disruption and promote continuity of care. Peach State Health Plan will work with non-participating providers (those that are not contracted and credentialed in Peach State Health Plan's provider network) to continue treatment or create a transition plan to facilitate transfer to a participating Peach State Health Plan provider. In addition, if Peach State Health Plan determines that a member is in need of services that are not covered benefits, the member will be referred to an appropriate provider and Peach State Health Plan will continue to coordinate care including discharge planning.

Peach State Health Plan network staff can also arrange a Single Case Agreement (SCA) when it becomes necessary to utilize out-of-network providers (providers not contracted with Peach State Health Plan) to provide covered services. Peach State Health Plan will utilize out-of-network providers, if necessary, to meet the member's clinical, accessibility or geographical needs when the network is inadequate for their specific situation. Before utilizing an out-of-network provider, Peach State Health Plan makes every attempt to refer members to participating providers who are contracted and credentialed with Peach State Health Plan.

Single Case Agreements are required for the purposes of addressing the following:

- Network accessibility within the member's geographic area
- Providers are not available with the appropriate clinical specialty, or are unable to meet special need(s) of the specific member
- Providers do not have timely appointment availability
- It is clinically indicated to maintain continuity of care
- Transition of care from an established out-of-network provider to a participating Peach State Health Plan provider

Intensive Case Management (ICM)

The Case Management department provides a unique function at Peach State Health Plan. The essential function of the department is to increase community tenure, reduce recidivism, improve treatment compliance, and facilitate positive treatment outcomes through the proactive identification of members with complex or chronic behavioral health conditions that require coordination of services and periodic monitoring in order to achieve desirable outcomes. Peach State Health Plan Case Managers are licensed behavioral health professionals with at least three years' experience in the mental health field.

Peach State Health Plan's Intensive Case Management functions include:

- Early identification of members who have special needs
- Assessment of member's risk factors and needs
- Contact with high-risk members discharging from hospitals to ensure appropriate discharge appointments are arranged and members are compliant with treatment
- Active coordination of care linking members to behavioral health providers and, as needed, medical services including linkage with a physical health Case Manager for members with coexisting behavioral and physical health conditions, and residential, social and other support services where needed
- Development of a case management plan of care
- Referrals and assistance to community resources and/or behavioral health practitioners
- For members not hospitalized but in need of assistance with overcoming barriers to obtaining behavioral

health services or compliance with treatment, Peach State Health Plan offers Care Coordination

Peach State Health Plan's Care Coordinators are not licensed clinical staff and cannot make clinical decisions about what level of care is needed or assess members who are in crisis.

Peach State Health Plan's Care Coordination functions include:

- Coordinate with Peach State Health Plan, member advocates or providers for members who may need behavioral health services
- Assist members with locating a provider
- Serve as a resource to inpatient discharge planners needing services for members
- Coordinate requests for out-of-network providers by determining need/access issues involved
- Facilitate all requests for inpatient psychiatric consults for members in a medical bed.
- Care Coordinators can also arrange a Single Case Agreement (SCA) when it becomes necessary to utilize out-of-network providers (providers not contracted with Peach State Health Plan) to provide covered services. Peach State Health Plan will utilize out-of-network providers, if necessary, to meet the member's clinical, accessibility or geographical needs when the network is inadequate for their specific situation. Before utilizing an out-of-network provider, Peach State Health Plan makes every attempt to refer members to participating Network providers who are contracted and credentialed with Peach State Health Plan.

Clinical Practice Guidelines

Peach State Health Plan has adopted many of the clinical practice guidelines published by the American Psychiatric Association and the American Academy of Child and Adolescent Psychiatry (AACAP), as well as evidence-based practices for a variety of services. Clinical practice guidelines adopted for adults include but are not limited to treatment of:

For children, Peach State Health Plan has adopted guidelines for Depression in Children and Adolescents, Assessment and Treatment of Children and Adolescents with Anxiety Disorders and Attention Deficit/ Hyperactivity Disorder. Clinical Practice Guidelines may be accessed through our website, or you may request a paper copy of the guidelines by contacting your Provider Relations representative or by calling 866-874-0633.

Claims

Peach State Health Plan adjudicates claims for covered services for covered persons. Claims with a primary diagnosis not related to behavioral health or substance use disorders will be denied. If providers receive such a denial, please evaluate the service performed. If the covered services are performed by a licensed behavioral health provider, please resubmit with an appropriate primary diagnosis. Claims for medical conditions or services should be submitted to Peach State Health Plan.

Peach State Health Plan Claims Department Responsibilities

Peach State Health Plan's claims processing responsibilities are as follows:

- To reimburse clean claims (see clean claim section below) within the timeframes outlined by the State of Georgia.

Claims eligible for payment must meet the following requirements:

- The member is effective (eligible for coverage through Peach State Health Plan) on the date of service
- The service provided is a covered service (benefit of Peach State Health Plan) on the date of service
- Peach State Health Plan's prior authorization processes, if applicable, were followed

Peach State Health Plan's reimbursement is based on clinical licensure, covered service billing codes and modifiers, and the compensation schedule set forth in the provider's agreement with Peach State Health Plan. Reimbursement from Peach State Health Plan will be accepted by the provider as payment in full, not including any applicable copayments.

Clean Claim

Unless otherwise defined in the agreement, a clean claim is a claim submitted on an approved or identified claim format (CMS-1500 or CMS-1450 ("UB-04"), or their electronic equivalents or successors, which contains all data fields required by Peach State Health Plan and the state for final adjudication of the claim. The required data fields must be complete and accurate. A clean claim must also include Peach State Health Plan's published requirements for adjudication, such as NPI Number, TIN or medical records, as appropriate. Claims lacking complete information will be returned to the provider for completion before processing, or information may be requested from the provider on an Explanation of Benefit (EOB) form. Either will cause a delay in payment.

Claim Payment

A Clean Claim will be processed with 15 business days of receipt of the claim. A non-clean claims will be adjudicated (finalized as paid or denied) within thirty (30) days of receipt of the electronic claim

Explanation of Payment (EOP)

An Explanation of Payment (EOP) is provided with each claim payment or denial. The EOP will detail each service being considered, the amount eligible for payment, copayments, and the amount reimbursed. If you have questions regarding your EOP, please contact Provider Relations at 866-874-0633.

Timely Filing

Please submit claims immediately after providing services. Claims must be received within one hundred eighty days (180), from the date the service(s) are rendered. Claims submitted after this period will be denied for payment.

Please submit a clean claim on a CMS-1500 Form or a CMS-1450 Form ("UB-04"), or their electronic equivalents or successors. A clean claim is one in which every line item is completed in its entirety.

If contracted as a group or individual provider, please ensure the rendering provider's NPI number is listed in field 24J if you are billing with a CMS-1500 Form. If billing as a Federally Qualified Health Center (FQHC), please ensure the center's NPI number is listed in field 24J if you are billing with a CMS-1500 Form.

Hard copy claims must be submitted to the following address for processing and reimbursement.

Peach State Health Plan
P.O. Box 6700
Farmington, MO 63640-3816

Common Claims Processing Issues

It is the provider's responsibility to obtain complete information from Peach State Health Plan and the member, and then to carefully review the claim form prior to submitting claims to Peach State Health Plan for payment. Failure to do so may prevent delays in processing and reimbursement.

Some common problem areas are:

- Failure to obtain prior authorization
- Federal TIN not included
- Rendering provider's NPI number not included in field 24J (CMS-1500)
- Insufficient member ID number (If needed, providers should call Peach State Health Plan to request the member's Medicaid ID prior to submitting a claim.)
- Multiple dates of services billed on one professional claim form (CMS-1500, or electronic equivalents or successor claim form) are not listed separately
- A copy of, and not an original, claim form was submitted (Only original forms will be accepted for adjudication.)
- Claim form not signed by provider
- Insufficient or unidentifiable description of service performed
- For services requiring an authorization:
    - Visits or days provided exceed the number of visits or days authorized
    - Date of service is prior to or after the authorized treatment period
    - Provider is billing for unauthorized services, such as using the wrong CPT Code
- For services with established benefit limits, member has exceeded benefits

Services that require prior authorization, that are rendered without first obtaining the authorization, may be denied. Peach State Health Plan reserves the right to deny payment for services provided that were/are not medically necessary.

Imaging Requirements for Paper Claims

Peach State Health Plan uses an imaging process for claims retrieval. To ensure accurate and timely claims capture, please observe the following claims submission rules:

DO	DON'T
Submit all claims in a 9" x 12" or larger envelope	Use red ink on claims forms
Complete forms correctly and accurately with black or blue ink only (or typewritten)	Circle any data on claim forms
Ensure typed print aligns properly within the designated boxes on the claim form	Add extraneous information to any claim form field
Submit on a proper form: CMS-100 or CMS-1450 ("UB04")	Use highlighter on any claim form field
Refrain from submitting hand written whenever possible	Submit carbon copied claim forms
	Submit claim forms via fax

Web Portal Claim Submission

Peach State Health Plan also offers our contracted providers and their office staff the opportunity to register for our Secure Web Portal. You may register by visiting www.provider.pshpgeorgia.com and creating a username and password.

Through the Secure Provider Portal, providers can:

- Check member eligibility
- Submit and manage claims
- Submit and view prior authorizations
- Review and download payment history

- View member gaps in care
- Secure message Peach State Health Plan
- Manage multiple accounts

EDI Clearinghouses

Contact us securely and confidentially Electronic Data Interchange (EDI) is a method for transferring data between different computer systems/networks. Providers may choose to submit their claims through a

clearinghouse. Peach State Health Plan accepts EDI transactions through the following vendors using Payer ID 68068. Note: Emdeon is now Change Healthcare..

Billing Policies

The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires all healthcare providers and payers to use universal standards for electronic billing and administrative transactions (healthcare claims, remittance advice [RA], eligibility verification requests, referral authorizations and coordination of benefits).

Member Hold Harmless

Under no circumstances is a member to be balance billed for covered services or supplies. If the provider uses an automatic billing system, bills must clearly state that they have been filed with the insurer and that the participant is not liable for anything other than specified copayments (if any).

Please Note:

- A provider's failure to obtain authorization for a service(s) does not qualify/allow the provider to bill the member for service(s).
- Peach State Health Plan members may not be billed for missed sessions ("No-Show").

Claim Status

Please do not submit duplicate bills for authorized services. If your clean claim has not been adjudicated within fifteen (15) days, please call Peach State Health Plan's Claims Provider Relations department at 866-874-0633 to determine the status of the claim.

To expedite your call, please have the following information available when you contact Peach Provider Services:

- Member's Name
- Member's Date of Birth
- Member's ID Number
- Date of Service
- Procedure Code Billed
- Amount Billed
- Authorization Number, if applicable

- Provider's Name
- Provider's NPI Number
- Provider's Tax Identification Number

Claim Reconsideration

If a claim discrepancy is discovered, in whole or in part, the following action may be taken:

Call the Peach State Health Plan Claims Support at 866-874-0633. The majority of issues regarding claims can be resolved through the Claims department with the assistance of our Claims Support Liaisons.

When a provider has submitted a claim and received a denial due to incorrect or missing information, a corrected claim should be submitted. When submitting a paper claim for review or reconsideration of the claims disposition, the claim must clearly be marked as RESUBMISSION along with the original claim number written at the top of the claim. When filing electronically, follow established guidelines to indicate the corrected claim is a resubmission, providing identifying information of the original claim. Failure to identify a corrected claim as a RESUBMISSION may result in the claim being denied as a duplicate. Corrected hard copy resubmissions should be sent to:

Peach State Health Plan
P.O. Box 7200
Farmington, MO 63640

For issues that do not require a corrected resubmission the Adjustment Request Form can be utilized. The Claims Support Liaison can assist with determining when a corrected resubmission is necessary and when an Adjustment Request Form can be utilized.

For untimely requests for authorizations, providers and facilities are advised to submit the claim for processing. The claim will be denied for "services not authorized" at which time the provider may initiate the appeal process. A decision was made within thirty (30) calendar days of receipt of the request..

Retro authorizations will only be granted in rare cases. Repeated requests for retro authorizations may result in termination from the network due to inability to follow policies and procedures. If the authorization contains unused visits, but the end date has expired, please call Provider Relations at 866-874-0633 and ask the representative to extend the end date on your authorization.

If a resubmission has been processed and you are still dissatisfied with Peach State Health Plan's response, you may file a claims appeal of this decision by writing to the address listed below:

Peach State Health Plan
Attn: Appeals
P.O. Box 6000
Farmington, MO 63640

Complaints, Grievances & Appeals

If the time arises when a provider or member disagrees with any of Peach State Health Plan's policies or services and he/she would like to request a review of an unfavorable determination, they may file a complaint, grievance or appeal.

What is a Provider Complaint?

A complaint is defined as any dissatisfaction, expressed by a provider orally or in writing, regarding any aspect of Peach State Health Plan's operations, including but not limited to, dissatisfaction with Peach State

Health Plan's administrative policies.

Peach State Health Plan has established and maintains an internal system for the identification and prompt resolution of network provider complaints. If a network provider is not satisfied with the resolution of a complaint, an appeal can be filed. Network providers will not be discriminated against because of a complaint.

To express a complaint in writing, please mail to the following:

Peach State Health Plan
Attn: Quality Improvement Department
1100 Circle 75 Pkwy, Suite 1100
Atlanta, GA 30339

To express a complaint by phone, please call Peach State Health Plan at: 866- 874-0633.

Peach State Health Plan will acknowledge the network provider's complaint within five (5) business days and will resolve the complaint within thirty (30) calendar days.

What is a Member Complaint?

A complaint is dissatisfaction about any matter other than an adverse benefit determination. (An adverse benefit determination is defined as the denial or limited authorization of a requested service; the reduction, suspension or termination of a previously authorized service; or denial in whole or in part, of payment for a service; failure to allow member a different provider to obtain services outside of the network if the member lives in a rural area and only has Peach State Health Plan coverage; failure to provide services in a timely manner, failure to provide member a timely response to a decision on an appeal or grievance, and denial of payment for care.) Possible subjects for complaints include, but are not limited to, the quality of care or services provided, and aspects of interpersonal relationships such as rudeness of a practitioner or employee, or failure to respect the member's rights.

Peach State Health Plan has established and maintains a grievance system for the identification and prompt resolution of complaints with applicable federal and state laws and regulations which affords our network providers and members the opportunity to initiate a complaint. A complaint can be filed either orally or in writing and, as determined by the State, either with the State or with the Health plan, by a member or a family member or person acting on the member's behalf. Peach State Health Plan's Member Services department is available to assist providers, members, or member representatives with initiating a complaint. Complaints can be filed in writing or by calling 866-704-1484.

To express a complaint in writing, please mail or fax the complaint to the following:

Peach State Health Plan
Attn: Grievance and Appeals
1100 Circle 75 Pkwy, Suite 1100
Atlanta, GA 30339
Fax: 866-532-8855

Peach State Health Plan members can file a complaint/grievance at any time. Peach State Health Plan has ninety (90) calendar days to respond to and resolve the complaint. The goal is to resolve all complaints in a timely manner.

What is an Administrative Review?

An administrative review is a written request for a review/determination of an adverse action made by Peach State Health Plan. An administrative review can be filed either orally or in writing (Further, unless the enrollee requests an expedited resolution, an oral appeal must be followed by a written, signed appeal) by the member or authorized representative acting on behalf of the member, with the member's written consent.

Peach State Health Plan has developed and maintains an administrative review system that complies with applicable Federal and State law and regulations. An administrative review must be filed with Peach State Health Plan within sixty (60) calendar days from the date of the notice of Peach State Health Plan's notice of adverse benefit determination. Members may continue to seek covered services while the administrative review is being resolved.

If the member is still receiving the services that are under administrative review and the services are covered services, the services may continue until a decision is made on the administrative review. If it is determined that the services were not medically necessary or appropriate, the member will be responsible for paying for the service (s). This continuation of coverage or treatment applies only to those services which, at the time of the service initiation, were approved by Peach State Health Plan and were not terminated because the benefit coverage for the service was exhausted.

A member or authorized representative has the right to request an administrative review if Peach State Health Plan denies or limits a request for a Covered Service; fails to allow member a different provider to obtain services outside the network if the member lives in a rural area and only has Peach State Health Plan coverage; fails to provide servies in a timely manner, fails to provide member a timely response to a decision on an appeal or grievance, and denies payment for care. The Peach State Health Plan Appeals Coordinator is available to assist a member in the understanding and use of the Peach State Health Plan Administrative Review Process.

Please submit administrative review requests in writing, by mail, or by fax to the following at:

Peach State Health Plan
Attn: Appeals Department
1100 Circle 75 Pkwy, Suite 1100
Atlanta, GA 30339
Fax: 866-832-88551

To submit a request for an Administrative Review, please call Peach State Health Plan at: 866-704-1484.

Expedited Administrative Review Request

Administrative Law Hearing at the Department of Community Health
The State will maintain an independent Administrative Law Hearing process as defined in the Georgia Administrative Procedure Act (0.C.G.A Title 50, Chapter 13) and as required by federal law, 42 CFR 431.200 et seq. The Administrative Law Heating process shall provide Medicaid members an opportunity for a hearing before an Administrative Law Judge.

A member or member's authorized representative may request in writing an Administrative Law Hearing within thirty (30) Calendar Days of the date the Notice of Adverse Benefit Determination is mailed by Peach State Health Plan. The parties to the Administrative Law Hearing shall include Peach State Health Plan as well as the Member, Member's Authorized Representative, or representative of a deceased Member's estate. A provider cannot request an Administrative Law Hearing on behalf of a Member. The request for the

Administrative Law Hearing should be mailed to:

Department of Community Health
Legal Services Section
Division of Medical Assistance
Two Peachtree Street, NW-40th Floor
Atlanta, Georgia 30303-3159

PeachCare for Kids® members do not have access to the Medicaid Administrative Law Hearing process. If a PeachCare for Kids® member is dissatisfied with a Notice of Adverse Benefit Determination issued through a Peach State Health Plan Administrative Review, the member can request a review of the decision by the State Management Review Committee (level two) in writing to:

Department of Community health
PeachCare for Kids®
2 Peachtree Street, NW
Atlanta, GA 30303-3159

Second level review by Peach State Health Plan following grievance disposition or administrative review by Peach State Health Plan, should adhere to the following:

- Submit a grievance or a request for administrative review to Peach State Health Plan , and
- Are not satisfied with Peach State Health Plan's disposition of the grievance or administrative review may request a second level review by peach State Health Plan of Peach State Health Plan's disposition of the grievance or administrative review. Peach State's second level review of an administrative review determination by Peach State Health Plan has no impact on the member's concurrent right to request a fair hearing from the state. Members may file second level review requests in writing with peach State within 30 days of the date of Peach State Health Plan 's determination on a grievance or Notice of Adverse Benefit Determination.

Mail requests to:

Peach State Health Plan
Attn: Appeals/Grievance Coordinator
1100 Circle 75 Pkwy Suite 1100
Atlanta GA 30339

Expedited Appeals

Members and authorized representatives also have the right to request that Peach State Health Plan expedite an administrative review, if the timeframe of a standard administrative review would seriously jeopardize the individual's health or life. Expedited administrative reviews are not offered retrospectively. For an expedited administrative review in which the member is currently an inpatient in a hospital, the attending physician may act as the member's authorized representative without a signed written consent from the member.

To submit an expedited administrative review in writing, please mail or fax the request to the following:

Peach State Health Plan
Attn: Appeals Department
1100 Circle 75 Pkwy, Suite 1100
Atlanta, GA 30339
Fax: (866) 532-8855

To initiate your expedited administrative review by phone, please call Peach State Health Plan at: 800-704-

1484

If the expedited administrative review relates to an ongoing emergency or denial to continue a hospital stay, Peach State Health Plan will resolve the expedited administrative review seventy-two (72) hours after receipt of the request.

If Peach State Health Plan determines that the administrative review request does not qualify to be expedited, the member will be notified immediately and the resolution will be made within thirty (30) calendar days.

The Peach State Health Plan Appeals Coordinator can assist the member with their expedited administrative review. The member may also have their Network provider, a friend, a relative, legal counsel or another spokesperson assist them.

If Peach State Health Plan extends the timeframe for the decision and issuance of notice of adverse benefit determination, Peach State Health Plan shall give the Member written notice of the reason for the decision to extend the timeframe and inform the enrollee of the right to file a Grievance if he or she disagrees with that decision. Peach State Health Plan shall issue and carry out its determination as expeditiously as the Member's health requires and no later than the date the extension expires.

Civil Rights

Peach State Health Plan provides covered services to all eligible members regardless of: age, race, religion, color, disability, sex, sexual orientation, national origin, marital status, arrest, or conviction record, or military participation.

All medically necessary covered services are available to all members. All services are provided in the same manner to all members. All persons or organizations connected with Peach State Health Plan who refer or recommend members for services shall do so in the same manner for all members.

Waste, Abuse & Fraud

Peach State Health Plan takes the detection, investigation, and prosecution of fraud and abuse very seriously, and has a WAF program that complies with state and federal laws. Peach State Health Plan, in conjunction with its management company, Centene Corporation, successfully operates a billing errors/ waste, abuse and fraud unit. If you suspect or witness a provider inappropriately billing or a member receiving inappropriate services, please call our anonymous and confidential hotline at 1-866-685-8664. Peach State Health Plan and/or Centene take all reports of potential waste, abuse or fraud very seriously and investigate all reported issues.

Authority and Responsibility

The Peach State Health Plan Vice President of Compliance has overall responsibility and authority for carrying out the provisions of the compliance program.
Peach State Health Plan is committed to identifying, investigating, sanctioning and prosecuting suspected fraud and abuse.

The Peach State Health Plan provider network must cooperate fully in making personnel and/or subcontractor personnel available in person for interviews, consultation, grand jury proceedings, pre-trial conferences, hearings, trials and in any other process, including investigations, at Peach State Health Plan or the subcontractor's own expense.

These are the primary agencies to which incidents or practices of abuse and/or fraud are to be reported:

Peach State Health Plan
Office of Compliance
1100 Circle 75 Pkwy
Suite 1100
Atlanta, GA 30339

Department of Community Health
Program Integrity Unit
Two Peachtree Street, NW - 40th Floor
Atlanta, GA 30303-3159
1-800-533-0686