ADMINISTRATIVE POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Medical Necessity Determinations-GA MCD-AD-0038	02/01/2026-06/30/2026
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statement prepared by CareSource and its affiliates are derived from literature based on and supported by clinical guidelines, nationally recognized utilization and technology assessment guidelines, other medical management industry standards, and published MCO clinical policy guidelines. Medically necessary services include, but are not limited to, those health care services or supplies that are proper and necessary for the diagnosis or treatment of disease, illness, or injury and without which the patient can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of a body organ or part, or significant pain and discomfort. These services meet the standards of good medical practice in the local area, are the lowest cost alternative, and are not provided mainly for the convenience of the member or provider. Medically necessary services also include those services defined in any Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

Administrative Policy Statements prepared by CareSource and its affiliates do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced in the Administrative Policy Statement. If there is a conflict between the Administrative Policy Statement and the plan contract (i.e., Evidence of Coverage), then the plan contract (i.e., Evidence of Coverage) will be the controlling document used to make the determination.

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy.

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A. Subject

Medical Necessity Determinations

B. Background

The term *medical necessity* has been used by health plans and providers to define benefit coverage. Medical necessity definitions vary among entities, including the Centers for Medicaid and Medicare Services (CMS), the American Medical Association (AMA), state regulatory bodies, and most healthcare insurance providers, but definitions most often incorporate the idea that healthcare services must be "reasonable and necessary" or "appropriate," given a patient's condition and the current standards of clinical practice.

Payors and insurance plans may limit coverage for services that are reasonable and necessary if the service is provided more frequently than allowed under a national coverage policy, a local medical policy, or a clinically accepted standard of practice.

International Classification of Diseases (ICD) guidelines instruct the clinician to choose a diagnosis code that accurately describes a clinical condition or reason for a visit and support medical necessity for services reported. To better support medical necessity for services reported, providers should apply universally accepted healthcare principles that are documented in the patient's medical record, including diagnoses, coding with the highest level of specificity, specific descriptions of the patient's condition, illness, or disease and identification of emergent, acute and chronic conditions.

CareSource will determine medical necessity for a requested service, procedure, or product based on the hierarchy within this policy.

C. Definitions

- **Condition** – A disease, illness, injury, disorder, of biological, cognitive, or psychological basis for which evaluation, monitoring and/or treatment are indicated.
- **Medical/Surgical (M/S) Benefits** – Benefits for items or services for medical conditions or surgical procedures defined by the State for the analysis of mental health parity compliance as diagnostic codes listed in all chapters other than Chapter 5 of the current ICD manual.
- **Medically Necessary Services (includes concepts of Medically Necessary and Medical Necessity)** – Care based upon generally accepted medical practices in light of Conditions at the time of treatment which are:
  - Required to correct or ameliorate a defect, physical or mental illness, or a Condition.
  - Appropriate and consistent with the diagnosis and the omission of which could adversely affect the eligible Member's Condition.
  - Compatible with the standards of acceptable medical practice in the United States.

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- Provided in a safe, appropriate, and cost-effective setting given the nature of the diagnosis and the severity of the symptoms.
- Not provided solely for the convenience of the Member or the health care provider.
- Not primarily custodial care unless custodial care is a covered service or benefit under the Member's evidence of coverage.
- Provided when there is no other effective and more conservative or substantially less costly treatment, service and setting available.

For Medicaid children under 21 years of age, care that is necessary to correct or ameliorate physical and Behavioral Health disorders, a defect, or a condition identified during an EPSDT screening or preventive visit, regardless of whether those services are included in the State Plan, but are otherwise allowed pursuant to 1905(a) of the Social Security Act.

- **Mental Health/Substance Use Disorder (MH/SUD) Benefits** – Benefits for items or services for mental health or substance abuse conditions defined by the State for the analysis of mental health parity compliance as diagnostic codes listed in Chapter 5 of the current ICD manual.

D. Policy

According to the rules of Mental Health Parity Addiction Equity Act (MHPAEA), coverage for the diagnosis and treatment of a behavioral health disorder will not be subject to any limitations that are less favorable than the limitations that apply to medical conditions as covered under this policy. The reviewer will determine medical necessity based on the following hierarchy:

A. Benefit contract language.
B. Federal and state laws and regulations, including state waiver regulations when applicable.
C. Georgia State Plan
D. Georgia Medicaid Policies and Procedures Manuals
E. CareSource medical policy statements, as approved by the State.
F. Nationally accepted evidence-based clinical guidelines, such as MCG Health and American Society of Addiction Medicine.
G. Professional judgment of the medical or behavioral health reviewer based on the following potential resources, which may include, but are not limited to:
    1. Clinical practice guidelines published by consortiums of medical organizations and generally accepted as industry standard.
    2. Evidence from 2 published studies from major scientific or medical peer-reviewed journals less than 5 years old (preferred) and/or less than 10 years (required) to support the proposed use for the specific condition as safe and effective.
    3. National panels and consortiums, such as NIH (National Institutes of Health), CDC (Centers for Disease Control and Prevention), AHRQ (Agency for Healthcare Research and Quality), NCCN (National Comprehensive Cancer Network), or SAMHSA (Substance Abuse and Mental Health Services

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Administration). Studies must be approved by a United States institutional review board (IRB) accredited by the Association for the Accreditation of Human Research Protection Programs (AAHRPP) to protect vulnerable minors.

4. Commercial review organizations, such as Up-to-Date and Hayes.
5. Consultation from a like-specialty peer.
6. National specialty/sub-specialty societies such as the American Psychiatric Association and the American Board of Internal Medicine.

E. Conditions of Coverage

I. The following does not guarantee coverage or claims payment for a procedure or treatment under a plan (not an all-inclusive list):
   A. A physician has performed or prescribed a procedure or treatment.
   B. The procedure or treatment may be the only available treatment for an injury, sickness, or behavioral health disorder.
   C. The physician has determined that a particular health care service is medically necessary or medically appropriate.

II. Experimental, investigational or cosmetic procedures, drugs, services or devices or those not recognized by the Federal Food and Drug Administration, the United States Public Health Service, Medicaid and/or the Department's contracted peer review organization as universally accepted treatment, are not covered.

F. Related Policies/Rules

Experimental or Investigational Item or Service

G. Review/Revision History

	DATE	ACTION
Date Issued	09/01/2017	
Date Revised	06/01/2020	Added definitions, removed hyperlinks, updated external review organizations and age requirements.
	04/01/2020	Added ASAM.
	01/25/2021	Added waiver regulations.
	03/09/2022	Annual review.
	06/21/2023	Annual review. Updated medical necessity definition according to change in State regulation. Updated specialty chart. Approved at Committee.
	07/03/2024	Annual review: Removed chart from D.6. Approved at Committee
	10/08/2025	Annual review: revised definitions, updated hierarchy, added E.II. Approved at Committee.
Date Effective	02/01/2026	
Date Archived	06/30/2026	This Policy is no longer active and has been archived. Please note that there could be other Policies that may have some of the same rules incorporated and CareSource reserves the right to follow CMS/State/NCCI guidelines without a formal documented Policy.

The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.

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H. References

1. Definitions, GA. CODE ANN. § 33-20A-31 (2023).

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The ADMINISTRATIVE Policy Statement detailed above has received due consideration as defined in the ADMINISTRATIVE Policy Statement Policy and is approved.