CareSource

MEDICAL POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Certified Community Behavioral Health Clinics-GA MCD-MM-1863	11/01/2026
Policy Type	
MEDICAL	

Medical Policy Statements are developed from a review of the available evidence-based, clinical information based on and supported by clinical guidelines from medical specialties, peer-reviewed medical and scientific studies, nationally recognized utilization and technology assessment guidelines, and other medical management industry standards to aid in determining the medical necessity of a service. Medically necessary services are defined in the plan-specific Evidence of Coverage, Member Handbooks, Provider Manuals, Medical Policy Statements, and/or other plan policies and procedures.

Medical Policy Statements do not guarantee an authorization or payment of services. Please refer to the plan contract (e.g., Evidence of Coverage, Member Handbook) for the service(s) referenced in the Medical Policy Statement. Except as otherwise required by law, if there is a conflict between the Medical Policy Statement and the plan contract and/or provider agreement, then the plan contract and/or provider agreement will be the controlling document. Reasonable discretion may be used in interpreting and applying this Policy Statement to services provided in a particular case, and the policy may be modified at any time. Medical Policy Statements may be superseded by federal and state laws and regulations, as applicable. In the case of a discrepancy between the Policy Statement's effective date and any applicable legal or regulatory requirement, the law or regulation will govern.

Coverage for mental health and substance use disorder (MH/SUD) benefits are provided at the same level as coverage for medical and surgical (M/S) benefits, as required by the Mental Health Parity and Addiction Equity Act (MHPAEA). MH/SUD benefits are not subject to limits or requirements that are more restrictive than those that apply to M/S benefits.

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A. Subject

Certified Community Behavioral Health Clinics

B. Background

Certified Community Behavioral Health Clinics (CCBHCs) provide a federally mandated comprehensive range of behavioral health (BH) services, including primary care screening and monitoring of individuals across the lifespan. CCBHCs respond to critical needs of vulnerable populations by providing a trauma-informed, evidence-based and person-centered approach to treatment and support. Focus is on care coordination and integrated treatment to improve individual outcomes for members medically determined to need prevention, rehabilitation and treatment services to anyone seeking help for BH diagnoses or conditions, regardless of place of residence, ability to pay or age.

CCBHCs are granted certification by the Dept of Behavioral Health and Developmental Disabilities (DBHDD), a requirement to access a daily bundled rate, and are required to follow federal and state criteria. Federal criteria, provided by the Substance Abuse and Mental Health Services Administration (SAMHSA), require 9 core services:

- crisis services
- outpatient mental health and substance use services
- person- and family-centered treatment planning
- community-based mental health care for veterans
- peer family support and counselor services
- targeted case management
- outpatient primary care screening and monitoring
- psychiatric rehabilitation services
- screening, diagnosis and risk assessment

CCBHCs must provide evidence-based practices (EBPs) for treating BH diagnoses across the lifespan with tailored approaches for adults, children, and families. Treatments and recovery supports must be appropriate for the phase of life and development of the person receiving services. EBPs must also be developmentally appropriate, youth guided and family/caregiver driven. Level of functioning must be considered with developmental or other cognitive diagnoses.

Providers should consult the *Georgia DBHDD Provider Manual for Community Behavioral Health Providers (DBHDD Manual)* for details about service description, required components, staffing, billing and reporting requirements for individual services.

C. Definitions

- **Adult –** A member over the age of 18 years old, including 65+ years old and members under age 18 if an emancipated minor under Georgia law or if adult services are otherwise clinically or developmentally indicated.
- **Individualized Treatment Plan (ITP) –** Addresses a member's BH, medical and preventative needs based on information obtained through the initial and

comprehensive evaluations, while respecting the member's goals and preferences to support care in the least restrictive setting possible.

- **Youth –** A member under the age of 18 years old or 18-21 years if still in high school or when otherwise developmentally or clinically indicated to continue services and assistance with transitioning to adult services.

D. Policy

I. General Guidelines

A. Providers must be certified by DBHDD as a "Georgia Certified Community Behavioral Health Clinic" and maintain compliance with the standards set by SAMHSA and the State of Georgia, including any quality metrics or measures set by the State or CareSource.

B. Services must be provided by appropriately trained staff who are able to meet the treatment plan needs of members receiving services at the CCBHC, within the scope of their respective state licenses, certifications, registrations and in accordance with federal, state and local laws.

C. Screening, assessment and diagnosis may be provided through telehealth or telemedicine services, if needed and appropriate for the member.

D. CCBHCs must adhere to the appropriate sections of service definitions for specific service(s) outlined by the DBHDD for staffing, clinical operations, service accessibility and documentation requirements. This is also true for discharge criteria, any service exclusions and any clinical exclusions.

II. Admission Criteria

A review of medical necessity is required for CCBHC services. Authorization will be granted for 180 days. CareSource considers CCBHC services medically necessary when **all** the following criteria are met:

A. The individual meets the definition for eligibility as defined in Part I, Section I of the *DBHDD Manual*, with emphasis on Section C and the defined priority for child, adolescent and adult services.

B. The member is diagnosed with the following:

1. a BH condition, including co-occurring conditions and those within the 0-3 age range
2. a co-occurring BH condition and an Intellectual/Developmental Disability (IDD) diagnosis
3. a traumatic brain injury (TBI), a co-occurring BH condition, and meeting the above criteria

C. An ITP is submitted with included orders for specific service(s) requested that adhere to DBHDD Service Definitions and follow requirements in that *Manual.*

D. Any additional required documentation addressed in D.III. is submitted for review within the required timeframes.

III. Required Documentation for Review

Written documentation and supporting information from the provider must include **all** the following:

A. Preliminary triage, including risk assessment, demonstrates acuity of needs. Triage will determine urgency of services:
   1. For critical needs (ie, emergency, crisis) the appropriate services are provided immediately, and an initial evaluation is done within 1 business day of service request.
   2. For routine needs, an initial evaluation is completed within 10 business days of service request.

B. An initial evaluation must include the following:
   1. initial diagnosis, source of referral and reason for seeking care
   2. immediate clinical care needs related to the BH diagnosis
   3. list of all current prescriptions and over-the counter medications, herbal remedies and dietary supplements and indications
   4. summary of previous BH treatments focusing on what helped or did not
   5. any alcohol and/or other drug use
   6. assessment of risk to self or others, including suicide risk factors, and other concerns for personal safety, such as intimate partner violence
   7. medical care needs for physical health, including any applicable referrals or follow-up as required
   8. US Armed Services status, current or past
   9. any justice system involvement, including juvenile justice or child welfare involvement for children or youth

C. Within 60 calendar days of the initial request for services, a comprehensive evaluation must be completed and contain at least the following:
   1. need for services, including symptom onset, severity and circumstances
   2. relevant social supports and needs (eg, housing, education, family/caregiver, insurance, legal)
   3. cultural or environmental factors that may affect the treatment plan
   4. pregnancy and/or parenting status, as applicable
   5. BH history, including previous trauma, treatments or hospitalization and a description of past interventions that were or were not effective
   6. pertinent medical history and any major health conditions
   7. current medication list, including any prescriptions, over-the counter, herbal medications and supplements
   8. physical examination, including mental status, depression screening and substance use screening
   9. cognitive impairment screening
   10. imminent risk assessment (ie. suicide, withdrawal, overdose, danger to self or others, other critical conditions and threats)
   11. factors to be considered during treatment planning (eg. strengths, goals, preferences)
   12. need for additional services (eg, peer and family/caregiver support, targeted case management, psychiatric rehabilitation)
   13. any social services needs for adults or child welfare agencies for children and youth, as appropriate

14. any referrals for primary care providers or other appropriate health care professionals for physical examination and further evaluation
15. member preferences for use of technologies (eg, telehealth, video conferencing, remote patient monitoring)

D. Evidence that the ITP is informed by the initial and comprehensive evaluation as well as ongoing assessment. The ITP must be person and family-centered, as appropriate based on member wishes and any legal guardianship situations.

IV. Continuing Stay Review

CSRs will be granted for 180-day periods. CareSource considers CCBHC services medically necessary when the following continuing stay criteria are met:

A. The member continues to meet admission criteria in D. II.
B. A copy of the comprehensive treatment plan completed within the required timeframe is provided with documented need for continuing stay based on the service definition(s) within the *DBHDD Manual* for the specific CCBHS service(s) provided or requested.
C. The member's treatment plan has been reviewed and updated as needed but no less frequently than every 6 months.

E. Conditions of Coverage

NA

F. Related Policies/Rules

NA

G. Review/Revision History

	DATE	ACTION
Date Issued	01/28/2026	New policy. Approved at Committee.
Date Revised		
Date Effective	11/01/2026	
Date Archived		

H. References

1. Certified community behavioral health clinics (CCBHCs). Substance Abuse and Mental Health Services Administration. Accessed December 2, 2025. www.samhsa.gov
2. *Georgia-Certified Community Behavioral Health Clinic (Ga-Certified CCBHC) Certification Criteria*. Updated October 10, 2025. Accessed December 10, 2025. www.dbhdd.georgia.gov
3. *Policies and Procedures for Community Behavioral Health Rehabilitation Services*. Georgia Dept of Community Health. Updated October 1, 2025. Accessed December 2, 2025. www.mmis.georgia.gov
4. Protecting Access to Medicare Act. Public Law 113-93, Section 223. (2014).

5. *Provider Manual for Community Behavioral Health Providers*. The Dept of Behavioral Health and Developmental Disabilities. Updated December 1, 2025. Accessed December 2, 2025. www.dbhdd.org

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