REIMBURSEMENT POLICY STATEMENT
Georgia Medicaid

Policy Name & Number	Date Effective
Behavioral Health Service Frequency Guidelines-GA MCD-PY-1694	01/01/2026
Policy Type	
REIMBURSEMENT	

Reimbursement Policies prepared by CareSource and its affiliates are intended to provide a general reference regarding billing, coding and documentation guidelines. Coding methodology, regulatory requirements, industry-standard claims editing logic, benefits design and other factors are considered in developing Reimbursement Policies.

In addition to this Policy, Reimbursement of services is subject to member benefits and eligibility on the date of service, medical necessity, adherence to plan policies and procedures, claims editing logic, provider contractual agreement, and applicable referral, authorization, notification and utilization management 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 federal or state coverage mandate, Evidence of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other policies and procedures.

This Policy does not ensure an authorization or Reimbursement of services. Please refer to the plan contract (often referred to as the Evidence of Coverage) for the service(s) referenced herein. If there is a conflict between this Policy 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. CareSource and its affiliates may use reasonable discretion in interpreting and applying this Policy to services provided in a particular case and may modify this Policy at any time.

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
Behavioral Health Service Frequency Guidelines

B. Background
Medical necessity review, sometimes called prior authorization (PA), is the process by which a specific item, service, or medication is assessed for appropriateness prior to administration. Federal regulations allow managed care organizations (MCOs) to use medical necessity review to limit services in an effort to prevent unnecessary utilization and ensure quality of care (§ 1902(a)(30)) of the Social Security Act (the Act), 42 CFR § 438.210). Such limitations aim to ensure that care is necessary, cost-effective, and aligned with clinical standards.

Through federal regulations, states can develop methods and procedures which aim to limit unnecessary utilization of medical care and services (42 CFR §§ 440.230, 438.210). MCOs must adopt practice guidelines that reflect clinical evidence and expert consensus and use these guidelines when making utilization management decisions. Prior authorization review criteria must be applied consistently, and any decisions to deny services must be made by individuals with appropriate clinical expertise to address the member's health care needs.

Reviews ensure that care is medically appropriate and cost-effective by limiting member access to unnecessary care while preserving access to needed services. In addition, improper, fraudulent, or wasteful payments can be limited by reducing use of services, items, and medications historically overused or misused. Care can be directed to the least restrictive setting, which benefits members and aligns the setting with the severity of the condition, diagnosis and treatment needs.

C. Definitions
- **Non-Participating Provider** – A health care professional or facility not credentialed or approved by CareSource and without a provider agreement to provide services to CareSource members in accordance with CareSource requirements.

D. Policy
I. A review of medical necessity, or prior authorization (PA), is required once session limitations have been met.
   A. Claims presented for services in D.II. exceeding limitations without PA will be denied.
   B. Service limitations start on January 1 each calendar year.
   C. Providers may end-date PA requests for December 31, as appropriate. If a PA is approved for a psychotherapy service with dates of service from 1 calendar year (CY) into the following CY, those services may be delivered according to the approved PA. Regardless of a provider's active PA, all sessions billed on behalf of the member will count toward the session limits from January 1 of each CY. Unused units in the current year will not extend into a new CY.
   D. Non-participating providers require a review of medical necessity at the first session.

II. Providers should refer to CareSource's Procedure Code Lookup Tool and any published network notifications at caresource.com/ga/providers/tools-resources and the annual *Prior Authorization List* at caresource.com/ga/providers/provider-portal. These resources will provide the most current information on any service limits required prior to medical necessity review. The following services and associated limits apply per member per calendar year (CY) before a review of medical necessity is required:

Service	Limit per CY Before PA Required
Psychiatric diagnostic evaluation with or without medical services	3 encounters per member
Psychotherapy, 30-, 45- or 60-minute sessions	24 combined sessions/encounters
Behavioral health counseling and family psychotherapy (with or without patient present)	24 combined sessions/encounters
Alcohol and/or drug services; intensive outpatient, including assessment, counseling, crisis intervention, activity therapies or education	PA required
Mental health assessment and service plan development by nonphysician	16 units
Community psychiatric supportive treatment, face-to-face	PA required
Assertive community treatment, face-to-face	PA required
Skills training and development	32 units
Comprehensive community support services	PA required
Psychosocial rehabilitation services, per 15 mins	52 units
Community-based wrap-around services, per diem	PA required
Intensive outpatient psychiatric services, per diem	PA required
Case management	PA required

III. DCH publishes lists of covered and non-covered services in applicable provider manuals. Claims submitted for any noncovered services (ie, sensitivity training, sexual competency training, hypnotherapy, telephone referrals) will be denied.

IV. All medical necessity reviews will be conducted according to DBHDD's *Provider Manual* service descriptions, admission and continuing stay criteria, discharge criteria and required service components. It is the responsibility of the provider or facility to follow service exclusions, billing and reporting requirements, documentation requirements and staffing requirements included in state guidance. Providers and facilities should reference only the approved codes for the provider or organization based on the agency's network participation agreement.

V. All behavioral health services will be subject to the same utilization management and cost-sharing requirements as other behavioral and medical benefits in compliance with Mental Health Parity and Addiction Equity Act. 42 U.S.C. § 300gg-26; 45 C.F.R. Part 146.

E. Conditions of Coverage

I. Providers are required to verify member eligibility and medical necessity requirements if a medical necessity review is required for each visit.

II. All required claims information must be submitted on a clean claim within timely filing limits from the date of service.

III. If the state Medicaid agency publishes a maximum restrictive unit, those limits will be applied to the applicable service or code. Since maximum units are coding edits rather than medical necessity edits, state Medicaid agencies or fiscal agents may have units of service edits that are more restrictive than maximum edits. In such cases, these more restrictive edits would be applied to the claim.

IV. Some codes may only be billable by certain practitioner levels (eg, psychological testing codes by a licensed psychologist, medical detoxification by a medical practitioner). It is the responsibility of the provider to bill appropriately and in accordance with state and/or federal regulations.

F. Related Policies/Rules

Behavioral Health Service Record Documentation Standards
Medical Necessity Determinations

G. Review/Revision History

	DATE	ACTION
Date Issued	07/30/2025	New policy. Approved at Committee.
Date Revised		
Date Effective	01/01/2026	
Date Archived		

H. References

1. Coverage and Authorization of Services, 42 C.F.R. § 438.210 (2024).
2. *Georgia Medicaid Provider Manual*. CareSource; 2023. Accessed July 10, 2025. www.caresource.com
3. Medicaid and CHIP Payment and Access Commission. *Advising Congress on Medicaid and CHIP Policy.* MACPAC; 2024. Accessed July 10, 2025. www.macpac.gov
4. *Policies and Procedures for Psychological and Therapy Services, Part II.* Georgia Dept of Community Health. Updated July 1, 2025. Accessed July 10, 2025. www.mmis.georgia.gov
5. Practice Guidelines, 42 C.F.R. § 438.236 (2020).
6. Prior Authorization, GA CODE ANN. § 33-46-20 to 32 (2025).
7. *Provider Manual for Community Behavioral Health Providers.* Georgia Dept of Behavioral Health & Developmental Disabilities. Accessed July 10, 2025. www.dbhdd.org
8. Sufficiency of Amount, Scope and Duration, 42 C.F.R. §§ 440.230 (2024).

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

GA-MED-P-4284804 Issue date 07/30/2025 Approved DCH 08/19/2025

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