COLORADO
Department of Health Care Policy & Financing

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Prior Authorization and Retrospective Reviews for Outpatient Psychotherapy

Frequently Asked Questions - December 2025

Overview

The Regional Accountable Entities (RAEs), which administer capitated behavioral health benefits in Colorado Medicaid, are contractually required to ensure that they are only paying for medically necessary psychotherapy services. Specifically, the Department of Health Care Policy and Financing (HCPF) has directed the RAEs to develop strategies to address the unmanageable growth in outpatient psychotherapy and ensure services are medically necessary. This includes an expectation that the RAEs create prior authorization and retroactive review processes focusing specifically on outpatient psychotherapy that exceeds 24 sessions in a state fiscal year (July through June). This policy intends to produce cost saving primarily through avoided costs, by having providers document the need for extended services that exceed clinical standard best practices and preventing overutilization without justification.

The Governor's Executive Order and accompanying budget documentation removed the prohibition on prior authorization review (PAR) of services, restoring it as an option available to the RAEs. Strategies to manage this trend may include prior authorization review, retrospective review or pending payment reviews. However, there is no requirement that utilization management is performed in a specific way or in every case. HCPF and RAEs recognize that some people will need more than 24 services, and RAEs will approve this extension when medically necessary. RAEs will determine what process makes the most sense for their region and will implement unique approaches based on the needs of their networks. Providers rendering only medically necessary services should see no change to their reimbursement.

Frequently Asked Questions (FAQs)

What is changing and when does it take effect?

- Effective January 1, 2026, Regional Accountable Entities (RAEs) are permitted to prior authorize psychotherapy services beyond 24 sessions per member in a given state fiscal year (July 1 - June 30), in any combination of the impacted psychotherapy codes (with the exception of crisis codes) and across all provider types.

- RAEs are directed to consider focused strategies in their retrospective medical necessity review process when a member has received more than 24 of the impacted psychotherapy services in any combination during the first two quarters of State Fiscal Year 2025-2026. While there is no change to the retroactive review and recoupment policy, RAEs and HCPF data shows this is an area with increasing and unmanageable trends that require additional review and oversight.

- Prior authorization is not a cap on services, authorization to continue services will be granted if more than 24 services are medically necessary. A RAE may approve a certain number of sessions, may recommend an alternative level of care (higher or lower) or an unlimited number of sessions.

What is the reason for this change?

- In response to escalating total Medicaid costs, reductions in federal funds, and new federal policies related to HR.1 (the One Big Beautiful Bill Act), HCPF is auditing and reviewing cost trends across every program and making adjustments to policies in order to maintain as much quality, access, and coverage as possible for our members.

- This policy change was authorized following the 2025 Special Legislative Session and the passage of SB25B 001, which allows the Governor to suspend or discontinue, in whole or in part, the functions or services of any department, board, bureau, or agency of the state government by Executive Order if the Governor determines that there are not, or will not be, sufficient revenues available for expenditure during the fiscal year to carry on the functions of State government and to support its agencies and institutions.

- The changes to the outpatient psychotherapy policy are necessary to address increasing trends in outpatient psychotherapy utilization and avoid service cuts that

could limit member access to necessary services. This is one of the many difficult reductions and monitoring actions we are implementing to address the unsustainable growth in Medicaid costs. This policy will help ensure that members are receiving the most clinically appropriate services in terms of type, frequency, extent, site, and duration.

- The increased use of medical necessity reviews has been communicated to the RAEs and other stakeholders since June 2025 when HCPF released the Medicaid Sustainability: Behavioral Health and Managed Care Actions memo. This is a normal course of business for a benefit where HCPF has seen abrupt change in provider behavior and increased utilization.

How long will this policy be in effect?

- This policy remains in effect, as long as it is authorized under the Executive Order of the Governor. In order to continue beyond the Executive Order, state statute would need to change to allow for the RAEs to continue use of PARs for outpatient psychotherapy. This statutory change is requested as part of HCPF's R-06 Budget Request.

Why is medical necessity important and what is the definition?

- Medical necessity is the most basic and essential requirement for Medicaid reimbursement and a critical component to ensuring effective member care and stewardship of taxpayer dollars. In order for Medicaid to pay for services, these basic requirements must be met, and all providers enrolled in Medicaid sign a contract committing to only provide and seek reimbursement for medically necessary care.

- Medical necessity as defined in Colorado Code of Regulations (CCR) 10 CCR 2505-10 8.076.1.8 means a Medical Assistance program good or service:
    a) Will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability. This may include a course of treatment that includes mere observation or no treatment at all;
    b) Is provided in accordance with generally accepted professional standards for health care in the United States;

c) Is clinically appropriate in terms of type, frequency, extent, site, and duration;
d) Is not primarily for the economic benefit of the provider or primarily for the convenience of the client, caretaker, or provider;
e) Is delivered in the most appropriate setting(s) required by the client's condition;
f) Is not experimental or investigational; and
g) Is not more costly than other equally effective treatment options.

- Medical necessity for children and youth is under Early and Periodic Screening, Diagnostic and Treatment (EPSDT) policy, defined under 10 CCR 2505-10 8.280.4.E.

What is the criteria used by RAEs to determine medical necessity?

- All RAEs utilize industry standard, evidence-based clinical decision support products such as InterQual, Milliman/MCG, etc. to determine if the state's medical necessity criteria is met. American Society of Addiction Medicine (ASAM) criteria is used by all RAEs to determine medical necessity for substance use disorder (SUD) services. Services can only be denied by a Colorado Licensed Physician or Psychiatrist.

Does this change anything else in Senate Bill (SB) 22-156?

- The prohibition of prior authorization review on services is the only provision of SB22-156 that has been modified through Executive Order. All other provisions remain unchanged. The RAEs remain prohibited from retroactively recovering provider payments after 12 months from the date a claim was paid, except in certain circumstances, such as fraud. As long as the services were billed appropriately, rendered by an enrolled provider in good standing, to an eligible Medicaid member, and were medically necessary, payments will not be recouped. If the service is determined to not be medically necessary, the federal government requires that Medicaid recoup the funds as an overpayment. If providers are only rendering medically necessary services and adhering to federal and state Medicaid law, they will see no change to their reimbursement.

What changes are happening for retrospective reviews?

- RAEs have the option to use retrospective reviews of all covered services to ensure the appropriate use of state Medicaid funds. Retroactive reviews are a standard process for identifying fraud, waste and abuse outside of managed care in physical

health and other covered Medicaid services and no changes have been made to that policy. Retrospective medical necessity reviews allow members to access services without waiting for a prior authorization to determine the services are medically necessary.

- The RAEs have flexibility in how they implement this oversight, but if a RAE determines during a retroactive review that the RAE reimbursed for services that were not medically necessary, for any service, the RAE must treat those payments as overpayments and recoup. If a RAE retrospectively identifies a payment error from lack of medical necessity, they are permitted to recoup the funds from the provider.

How does HCPF monitor the RAEs' retrospective review process?

- HCPF is required by federal and state regulations to have a third party External Quality Review vendor monitor RAEs' utilization management policies and procedures. This independent vendor performs a sample review of denials and determines whether each RAE demonstrates compliance with federal and state managed care regulations.

What is the likelihood of recoupment? What type of support is available for providers if recoupment is required?

- Recoupment is reserved for circumstances where medical necessity has not been demonstrated through documentation. In the case where recoupment is required, SB 22-156 gives providers protections around recoupments and provides for repayment plans for any recoupment over $1,000.

- RAEs are required to audit when they identify abnormalities within their system and are required to retrospectively assess medical necessity. This process is not to deny members benefits but rather to help determine that these are the most appropriate services. The intent of the retrospective reviews would not be to recoup every single dollar but identify potential fraud, waste and abuse trends and identify opportunities for provider training. The RAEs may also work with providers to correct billing errors, provide training on how to document appropriately, or take corrective action requiring additional oversight or termination of a contract.

- The estimated cost savings are primarily calculated based on costs avoided. While recoupment is an essential component of program integrity, the general fund savings will be considered during the rate reset to the RAE capitations to account for the

change. This won't be a clawing back of dollars, it will be a prospective adjustment to capitation rates to account for policy changes.

Does this create a parity violation?

- Conducting medical necessity reviews, retrospectively or prospectively, for psychotherapy service does not inherently create a parity violation.
- CMS final rule establishes the parameters for applying parity requirements to an entire classification of benefits (inpatient, outpatient, emergency, or prescription drugs), and not on a service-by-service basis. PARs and retroactive medical necessity reviews are also required of certain physical health benefits.
- Colorado Medicaid conducts retrospective and prospective reviews on an array for fee-for-service physical health benefits, as appropriate.

What provider types and codes are included?

- This applies across all provider types and any combination of the impacted psychotherapy codes: 90832, 90833, 90834, 90836, 90837, 90838, 90839, 90840, 90846, 90847, 90849, 90853.

Does this apply to sessions delivered by one provider or all sessions delivered to a member? How can a provider know what services the member is receiving elsewhere?

- This applies to total sessions that a member receives across all providers. Like with any other payer, it is incumbent upon the provider to determine, through the assessment process, if a member is receiving services elsewhere and incorporate that into their treatment plan. Providers are expected to collaborate with other providers serving the same member through use of a Release of Information (ROI) form.
- Providers can also contact the member's RAE to inquire about the total number of sessions that have been authorized and/or paid for that member to date.

What is the logic for 24 sessions?

- The 24 session count was based on a review of clinical best practices and data showing trends where costs were increasing at an alarming rate. This number was

included in the Governor's Executive Order supporting documents after reviewing utilization information provided by HCPF.

- It is appropriate to review the medical necessity of ongoing services and collaborate with the RAE to determine whether additional sessions or a different level or type of care is needed.

Are providers allowed to recoup funds from a member?

- No, the provider is not permitted to recoup funds from the member.

How does the medical necessity requirement comply with the "no reject" policy?

- Federal Medicaid laws are very clear that only medically necessary services are covered and eligible for federal match. The policy has always been that providers only render medically necessary care. So the safety net provider standards are that they provide medically necessary and provider directed assessment, treatment and support services. A provider is not required to perform a service unless it "will, or is reasonably expected to prevent, diagnose, cure, correct, reduce, or ameliorate the pain and suffering, or the physical, mental, cognitive, or developmental effects of an illness, condition, injury, or disability" and is not "primarily for the convenience of the client, caretaker, or provider." (*See* Colorado Code of Regulations, 10 CCR 2505-10 8.076.1.8.)

For more information contact

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