ADMINISTRATIVE POLICY STATEMENT
Michigan Health Link

Policy Name & Number	Date Effective
Policy Development Process-MI Health Link-AD-1417	06/01/2024
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.

Table of Contents

A. Subject

Policy Development Process

B. Background

HAP CareSource utilizes a systematic way to develop policies through a standard operating procedure that improves efficiency, increases productivity and quality, and provides consistent policy products to stakeholders and others. This process starts with the identification of a policy need, including policy intent and triage, and then, thorough research and collaboration leads HAP CareSource to determine best practice for our members.

According to the tenets 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 or more restrictive than the limitations that apply to medical conditions as covered by HAP CareSource policies. The policy development process ensures quality and consistency among both medical/surgical and behavioral health policies.

C. Definitions

- **Administrative Policies** – Provide guidance to providers on the administration of behavioral and/or physical health benefits.
- **AllMed** – A vendor with independent, external review specialists that complete impartial medical reviews prior to final medical policy approval and implementation.
- **Business Owner** – An individual who identifies a gap in information or benefits and recommends or requests that a topic be researched for possible creation or clarification of medical necessity criteria, reimbursement information, or administrative conditions to assist in providing consistent and quality services to CareSource members. The business owner supports the development of a policy.
- **Clinical Policy Governance Committee (CPGC)** – The official governing body comprised of medical and behavioral health subject matter experts charged with the approval of new or revised clinical policies relating to medical necessity determinations. The CPGC determines whether the proposed clinical policy is clearly defined, clinically evidenced-based, assures a high level of member safety and quality of care, and articulates a business value.
- **Medical/Clinical Policies** – Policies that contain medical criteria, including current evidence-based research, best practice, studies, etc., which determine what the member must meet for the provider to deliver a service.
- **PolicyTech** – Policy and procedure lifecycle management software for development and revision designed to centralize, build, and simplify workflows with tools, such as workflow automation, document creation and review, remote access, versioning, audit-ready reporting, and employee assessments.
- **Reimbursement Policy** – Addresses a topic in what must be met from a provider regarding billing/claims criteria to receive reimbursement for services provided.

- **Subject Matter Experts (SME)** – A person who is an authority on a particular topic or subject matter.

D. Policy

I. Pre-Policy Development

A. The business owner enters a policy intake into PolicyTech to start the policy development process.

B. To determine the intent, need, and priority of the request, collaboration occurs between the policy writer, member benefits coder, member benefits analyst, configuration, and an appropriate business owner, such as a SME and/or medical director.

C. If it is determined that there is a need for a policy, collaboration occurs between a multidisciplinary team to review codes and configuration, if applicable, and management determines if codes need to be sent to analytics to provide the policy team with additional data, such as financial data, claims, and/or utilization of benefits by members.

II. Policy Development

A. The policy writer researches the topic to develop a draft policy. This includes, but is not limited to the following resources:

1. state/federal regulations
2. state contracts
3. standard of care guidelines (eg, MCG Health, InterQual, American Society of Addiction Medicine)
4. Hayes
5. UpToDate
6. Policy Reporter
7. provider and member materials
8. professional society recommendations
9. published studies
10. Feedback from external sources
11. SMEs, including medical/surgical and/or behavioral
12. EncoderPro

B. After the policy is approved in the PolicyTech system on several levels by SMEs, management, writers, applicable departments, and others, a final policy revision is reviewed and approved by the following:

1. Benefits, Coding, and Support
2. Configuration
3. Utilization Management
4. Independent, external medical review specialists, when applicable
5. CPGC
6. State approval, if applicable

III. Post Policy Development

Providers and members of the health partner community are notified of new policies and/or changes to existing policies via HAP CareSource's marketing process. A standard operating procedure guides a uniform, consistent process allowing for adequate notice of new criteria or revisions as outlined by state or company requirements.

Upon adequate notice, policies are posted on HAP CareSource's website.

E. Conditions of Coverage

N/A

F. Related Policies/Rules

N/A

G. Review/Revision History

	DATES	ACTION
Date Issued	12/13/2023	Approved at Committee
Date Revised	03/13/2024	Review, no changes. Approved at Committee
Date Effective	06/01/2024	
Date Archived		

H. References

1. Mental Health Parity and Addiction Equity Act. US Centers for Medicare & Medicaid Services. Accessed March 4, 2024. www.cms.gov