Qualified Health Plans offered in North Carolina by CareSource North Carolina Co., d/b/a CareSource

ADMINISTRATIVE POLICY STATEMENT
North Carolina Marketplace

Policy Name & Number	Date Effective
Policy Development Process-NC MP-AD-1293	01/01/2023-11/30/2023
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

Policy Development Process

B. Background

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 CareSource to determine best practice for 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 CareSource policies. The policy development process ensures quality and consistency among both medical/surgical and behavioral health policies.

C. Definitions

- **Administrative Policies** - Policies written to provide guidance to providers on administration of behavioral or physical health benefits.
- **AllMed** - A vendor with independent, external review specialists, who 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 is responsible for determining 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 written with medical criteria, including current evidence-based research, best practice, studies, etc., which will determine what the member must meet for the provider to deliver a service.
- **PolicyTech** - Policy and procedure lifecycle management software for policy development and revision designed to centralize, build, and simplify policy and procedure workflows. Users have 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, business owner, member benefit's coder, member benefit's analyst, configuration, and an appropriate business owner, such as a subject matter expert (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 sent to analytics to provide the policy team with additional data, such as financial data, claims and/or usage of benefits by members.

II. Policy Development

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

1. State/federal regulations
2. State contracts
3. MCG Health
4. Hayes
5. UpToDate
6. Policy Reporter
7. Provider and member materials
8. Professional society recommendations
9. Standard of care guidelines
10. Published studies
11. Feedback from external sources
12. Subject matter experts, including medical/surgical and/or behavioral
13. EncoderPro

B. After the policy is approved in the PolicyTech system on several levels by subject matter experts, 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 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 CareSource's website.

E. Conditions of Coverage
NA

F. Related Policies/Rules
NA

G. Review/Revision History

	DATE	ACTION
Date Issued	10/12/2022	
Date Revised		
Date Effective	01/01/2023	
Date Archived	11/30/2023	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.

H. References

1. Centers for Medicare & Medicaid Services. (n.d.) Mental Health Parity and Addiction Equity Act. Retrieved September 13, 2022 from www.cms.gov.

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