

ADMINISTRATIVE POLICY STATEMENT

Michigan Medicaid

Policy Name & Number	Date Effective
Policy Development Process-MI MCD-AD-1376	07/01/2025
Policy Type	
ADMINISTRATIVE	

Administrative Policy Statements 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 or Certificate of Coverage documents, Medical Policy Statements, Provider Manuals, Member Handbooks, and/or other plan policies and procedures.

Administrative Policy Statements do not ensure an authorization or payment of services. Please refer to the plan contract (often referred to as the Evidence of Coverage or Certificate of Coverage) for the service(s) referenced in the Administrative Policy Statement. Except as otherwise required by law, if there is a conflict between the Administrative Policy Statement and the plan contract, then the plan contract 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

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 is achieved through identifying a policy need, including policy intent and triage, and then, thorough research and collaboration allows HAP CareSource to determine best practice for members.

According to the tenets of the 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** – Policies written to provide guidance to providers on the administration of behavioral and/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 HAP 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 and 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, professional organization-supported best practice guidelines, regulatory requirements, 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, version history, audit-ready reporting, and employee assessments.

The Subcategories of Policy Type not selected. Policy Statement detailed above has received due consideration as defined in the Subcategories of Policy Type not selected. Policy Statement Policy and is approved.

- **Reimbursement Policy** – Policies that specify billing and claims criteria, which allow providers to receive reimbursement for services provided.
- **Subject Matter Expert (SME)** – A person who is an authority on a particular topic or subject.

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 SME and/or medical director.
- C. If determined that a policy would be beneficial, a multidisciplinary team reviews codes and configuration, if applicable, and management determines if analytics are needed in order to provide the policy team with additional data, such as financials, claims, and/or member utilization of benefits.

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. federal and state regulations
 2. state contracts
 3. standard of care guidelines (ie, MCG Health, InterQual, American Society of Addiction Medicine)
 4. Hayes
 5. UpToDate
 6. PolicyReporter
 7. provider and member materials
 8. professional society recommendations
 9. peer-reviewed published studies
 10. feedback from external sources
 11. SMEs, including medical/surgical and/or behavioral/substance use
- B. The draft policy is then approved in PolicyTech in several stages by SMEs, management, writers, applicable departments and others. A final policy revision is then 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

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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

DATE		ACTION
Date Issued	09/27/2023	New policy. Approved at Committee.
Date Revised	03/13/2024	Review, no changes. Approved at Committee.
	04/09/2025	Annual review, Approved at Committee.
Date Effective	07/01/2025	
Date Archived		

H. References

1. *Mental Health Parity and Addiction Equity Act (MHPAEA)*. Centers for Medicare & Medicaid Services. Accessed March 27, 2025. www.cms.gov

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