ADMINISTRATIVE POLICY STATEMENT
GEORGIA MEDICARE ADVANTAGE

Policy Name		Policy Number	Date Effective
Policy Development Process		AD-0910	01/01/2021
Policy Type			
Medical	**ADMINISTRATIVE**	Pharmacy	Reimbursement

Administrative Policy Statements 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

CareSource utilizes a systematic way to develop policies. This process starts with the identification of a policy need; and then though research and collaboration leads CareSource to determine best practice for our members.

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.

C. Definitions

- **Medical/Clinical** – Policies written to provide guidance to a provider as to what medical and/or behavioral criteria must be met in order for the provider to provide a service.
- **Administrative** – Policies written to provide the provider with the administration of behavioral or physical health benefits.
- **Clinical Policy Governance Committee (CPGC)** – Is the official governing body charged with the approval of new or revised clinical policies that relate to medical necessity determinations. The CPGC is responsible for determining whether the proposed clinical policy is clearly defined, is clinically evidenced-based, assures a high level of member safety and quality of care, and articulates a business value.
- **Subject Matter Experts** – A person who is an authority on a particular topic or subject matter.
- **Business Owner** – Individual who assists in moving the policy concept into fruition. The official owner of a policy.

D. Policy

I. Pre-Policy Development
   A. The policy writer or business owner enters a policy intake to start the policy development or revision process.
      1. 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.
      2. If it is determined that there is a need for a policy,
         a. Collaboration occurs between a multidisciplinary team to review codes.
         b. Codes are then sent to analytics to provide the policy team with applicable data.

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

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

B. A final policy revision is reviewed and approved by
   1. Configuration;
   2. CPGC (which includes behavioral and medical SMEs); and
   3. State approval, if applicable.

III. Providers are notified of changes per CareSource marketing process.

E. Conditions of Coverage

F. Related Policies/Rules

Medical Necessity Determinations

G. Review/Revision History

DATES		ACTION
Date Issued	09/30/2020	
Date Revised		
Date Effective	01/01/2021	
Date Archived		

H. References

1. Centers for Medicare & Medicaid Services. (n.d.) Mental Health Parity and Addiction Equity Act. Retrieved September 24, 2020 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.