



ADMINISTRATIVE POLICY STATEMENT TrueCare

Policy Name & Number	Date Effective
Policy Development Process-TrueCare-AD-1314	07/01/2025-05/31/2026
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**

TrueCare 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 TrueCare 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 TrueCare 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 TrueCare 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, 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.
- **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 Expert (SME)** – A person who is an authority on a particular topic or subject.

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

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. standard of care guidelines (ie, MCG Health, Interqual, American Society for Addiction Medicine)
 4. Hayes
 5. UpToDate
 6. Policy Reporter
 7. provider and member materials
 8. professional society recommendations
 9. peer-reviewed published studies
 10. feedback from external sources
 11. subject matter experts, including medical/surgical and/or behavioral
- 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 TrueCare'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 TrueCare's website.

E. Conditions of Coverage
 N/A

F. Related Policies/Rules
 N/A

G. Review/Revision History

	DATE	ACTION
Date Issued	02/26/2025	Approved at Committee.
Date Revised		
Date Effective	07/01/2025	
Date Archived	05/31/2026	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. Mental Health Parity and Addiction Equity Act. US Centers for Medicare and Medicaid Services. Accessed December 12, 2024. www.cms.gov

Approved by DOM 04/17/2025